



September 11, 2023

The Honorable Chiquita Brooks-LaSure, Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
CMS-1772-P  
Mail Stop C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

**Via online submission at [www.regulations.gov](http://www.regulations.gov)**

**Re: Medicare Program: Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems and Quality Reporting Programs**

Dear Administrator Brooks-LaSure:

The Ambulatory Surgery Center Association (ASCA) appreciates the opportunity to comment on the proposals in the calendar year (CY) 2024 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System proposed rule (“Proposed Rule”) (88 Fed. Reg. 145, July 31, 2023). While the rule includes certain positive policy proposals, much work needs to be done to ensure that all Medicare beneficiaries have access to the high-quality lower-cost surgery center setting.

The Centers for Medicare & Medicaid Services (CMS) recently announced that the Medicare Shared Savings Program saved Medicare \$1.8 billion in 2022 compared to spending targets for the year.<sup>1</sup> ASCs save Medicare more than **\$5 billion** on an annual basis simply by existing as an alternative to hospitals.<sup>2</sup> CMS should adopt policies that encourage migration of more procedures to the ASC setting to generate even greater savings.

Most ASCs operate as small businesses and must run efficiently to remain viable and continue to provide savings to Medicare and needed care to its beneficiaries. As of June 2023, there were 6,223 Medicare-certified ASCs, and approximately 54 percent have only one or two operating rooms.<sup>3</sup> These facilities must purchase the same equipment, devices and implants as hospitals to perform surgery. Smaller ASCs often pay more for supplies since they lack the purchasing power of a hospital or a large health system.

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<sup>1</sup> <https://www.hhs.gov/about/news/2023/08/24/medicare-shared-savings-program-saves-medicare-more-1-8-billion-2022-continues-deliver-high-quality-care.html> (accessed 9/1/2023).

<sup>2</sup> State Cost Savings (2021) analysis file based on the CMS ASC LDS 2021 claims data that was used for the 2023 final rule.

<sup>3</sup> CMS staff provided the current number of CMS-certified ASCs. Provider of Services Current Files, available at <https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/provider-of-services-file-hospital-non-hospital-facilities/data> is being updated, so OR data represents the latest update available (May 2022).

The past few years have been particularly challenging, beginning with COVID-19 restrictions starting in early 2020 and supply chain issues and increased costs that persist today. ASCs compete with hospitals and other health care providers for the same short supply of nurses and other staff, with shortages projected to grow over the next several years.<sup>4</sup> Anesthesia costs are skyrocketing due to many factors,<sup>5</sup> including declining physician reimbursement and the inordinate impact of the No Surprises Act on anesthesia providers. The threat these challenges have to the economic viability of the ASC community cannot be overstated.<sup>6</sup>

ASCs must comply with state and federal regulations<sup>7</sup> comparable to those required of hospital outpatient departments (HOPDs), along with an ever-growing Medicare quality reporting program that will mandate the use of expensive third-party vendors for compliance beginning in 2025. And yet, CMS payment policies continue to allow surgery center reimbursement rates to languish.

We welcome the opportunity to collaborate with CMS on the payment policy proposals outlined in this letter that would encourage the clinically appropriate migration of services into the ASC setting—providing the Medicare program and its beneficiaries with a substantial savings opportunity while ensuring continued access to the high-quality care that surgery centers provide and beneficiaries deserve.

Specifically, we make the following requests:

- **Conversion Factor.** As proposed, CMS should continue use of the hospital market basket as the annual update mechanism for ASC payments indefinitely. We appreciate the two-year extension, but request that it become the permanent means of measuring inflation for ASC payments.
- **ASC Weight Scalar Adjustment.** CMS must discontinue the ASC weight scalar. When CMS aligned the ASC and HOPD update factors in 2019, it became clear that this secondary scaling adjustment must be eliminated to truly align the payment systems and motivate increased migration of surgery to the ASC setting.
- **Procedures Permitted in ASCs.** We implore CMS to add clinically safe procedures, such as total shoulder arthroplasty, to the ASC Covered Procedures List (ASC-CPL). In addition, CMS must provide a clear rationale for declining to add procedures to the ASC-CPL that are requested by surgeons performing these procedures on an outpatient basis safely every day.
- **Quality Reporting.** ASCA supports ASC Quality Reporting (ASCQR) Program measures that foster facility improvement and provide the public with information needed to select an appropriate site of care. When these elements are lacking, the measures only serve to increase the burden on facilities without providing any benefit to patients or healthcare facilities.

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<sup>4</sup> <https://www.aacnnursing.org/news-data/fact-sheets/nursing-shortage>

<sup>5</sup> <https://vmghealth.com/thought-leadership/blog/understanding-solving-the-new-reality-for-anesthesia-services/>

<sup>6</sup> <https://www.beckersasc.com/asc-coding-billing-and-collections/this-trend-could-reduce-the-number-of-ascs.html>

<sup>7</sup> <https://www.advancingsurgicalcare.com/safetyquality/federalrequirementsgoverningascs> (Accessed September 2021)

## Annual Payment Update Policies

### **ASCA supports CMS' extended use of the hospital market basket as the annual update mechanism for ASC payments.**

Since CMS aligned the ASC payment system to the OPPS in 2008 to encourage high-quality, efficient care in the most appropriate outpatient setting and align payment policies to eliminate payment incentives favoring one care setting over another,<sup>8</sup> the ASC community has urged CMS to adopt the same update factor for both the ASC and OPPS payments. We appreciate that CMS took this first, necessary step toward better alignment of the payment systems. We support the alignment of OPPS and ASC update factors and using the hospital market basket for updating ASC rates.

The COVID-19 pandemic arose during the second year of CMS' five-year pilot for aligning the ASC and OPPS update factors which has limited both ASCA and the agency's ability to fully assess the success of the policy. Medicare fee-for-service (FFS) volume in 2020 was significantly lower than 2019 volume, and while there was a rebound in 2021, it is still below 2019 figures.<sup>9</sup> As such, ASCA appreciates that CMS has proposed to extend the five-year trial for an additional two years.

Although overall volume is still rebounding from the COVID-19 pandemic, there are still promising signs of migration from the higher-cost HOPD setting to surgery centers. ASC volume growth for our top four codes by volume, a cataract code and three gastroenterology codes<sup>10</sup>, has outpaced that for HOPDs. That said, payment policy reform (such as elimination of the ASC weight scalar) is necessary to further the migration of appropriate procedures to the surgery center setting.

### ***Request for Cost Data***

In this proposed rule, CMS once again expresses a desire to “assess the feasibility of collaborating with stakeholders to collect ASC cost data in a minimally burdensome manner” and “propose a plan to collect such information.” If CMS chooses to collect cost data to develop a market basket (the only credible reason for adding such a reporting burden on surgery centers), the agency should establish a market basket that can be applied to both the ASC and HOPD setting to ensure that payments using the same relative weights remain aligned over time.

We know that HOPDs and ASCs incur many of the same types of costs, but we do not know if they are weighted the same. We welcome the opportunity to discuss how we might potentially use a simple, cost-effective survey or other low-burden data collection activity, perhaps voluntary in nature, and suggest as a starting point an effort to identify and calculate expense categories as a percentage of total expenses to help determine the appropriate weights and price proxies for the ASC setting.

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<sup>8</sup> CY 2007 OPPS/ASC Proposed Rule (<https://www.cms.gov/newsroom/press-releases/cms-revises-payment-structure-ambulatory-surgical-centers-and-proposes-policy-and-payment-changes>)

<sup>9</sup> Based on CMS PSPS Data for 2019 through 2021.

<sup>10</sup> The top four codes by volume in the ASC setting in 2021 were: 66984, 43239, 45380 and 45385.

Under any such undertaking, CMS must recognize the variability among facilities and that cost experience can differ greatly depending on factors such as specialties served, size of the facility and geographic location. There are already excessive administrative burdens placed on surgery center staff to meet current regulations and requiring any formal cost reports from ASCs would run counter to the agency's desire to promulgate rules and establish policies that allow facilities to maintain efficiency in the Medicare program. We welcome the opportunity to collaborate on this endeavor.

### **ASCA encourages CMS to discontinue the ASC weight scalar.**

While the alignment of update factors was a positive first step, the lack of alignment on other policies leads to ASC reimbursement rates that are less than 50 percent on average of the HOPD rate for the same procedures. In too many markets, surgeries that could be performed in surgery centers continue to be provided predominantly in hospitals, which we attribute to Medicare's failure to pay competitive rates to ASCs. Lack of alignment for the ASC (secondary) weight scalar threatens outpatient access to care and stifles the ability of our facilities to perform all the Medicare cases that potentially could be absorbed. This lack of migration comes at a high price to the Medicare program and the taxpayers who fund it.

Since the payment systems were aligned, CMS has taken the relative weights in the OPPS, which have already been scaled, and then applied a secondary weight scalar, known as the ASC weight scalar, before arriving at the ASC payment weights. CMS' antiquated cost containment mechanisms – trying to maintain budget neutrality in silos for each payment system – penalizes migration to a lower-cost setting because that shift ultimately leads to reductions in reimbursement rates for those providing the care.

Gastrointestinal endoscopies are among the highest-volume procedures performed in ASCs, accounting for five of the top ten codes by volume in 2021. There were more than 1.6 million GI procedures performed in ASCs in 2021, just within this group of five codes.<sup>11</sup> However, approximately 50 percent of these procedures are still performed in the HOPD setting, even though our clinicians believe at least 90 percent would be appropriate for the ASC setting. Taking out current savings (cases already performed in surgery centers instead of HOPDs), if 90 percent of these six GI endoscopies were performed in ASCs instead of HOPDs, the volume migration would represent more than \$774 million in additional ("new") savings annually. The total *annual* savings to the Medicare program would be more than \$1.4 billion *for these five codes alone*.

However, since CMS tries to maintain the same level of spending year over year, only accounting for a small update for inflation, any increase in volume would lead to stagnation or a decrease in reimbursement rates. There is no evidence of a growing difference in capital or operating costs in the two settings to support this growing payment differential. By applying a secondary weight scalar to the ASC payment system, the positive impact of the conversion factor alignment is negated, and CMS will not achieve long-term savings.

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<sup>11</sup> The five CPT codes are: 43239, 45380, 45385, G0105, and 45378.

Under the statute that implemented the current ASC payment system in 2008, CMS was only required to apply this budget neutrality adjustment in the first year of implementation of the new payment system.<sup>12</sup> CMS continued the scalar after the initial year of the new ASC payment system pursuant to its own perceived authority and not pursuant to any identified statutory requirement. As such, CMS has the authority to likewise discontinue the scalar at its discretion under the same rationale. ASCA implores CMS to encourage additional savings and greater access to surgery centers for Medicare beneficiaries by eliminating the ASC weight scalar.

ASCA recognizes that the elimination of the ASC weight scalar would represent an initial increase in cost to the Medicare program (a cost that will only increase each year that the scalar exists and continues to depress rates) until volume shifts to the ASC setting and cost savings are achieved. While this would be the right thing to do and save billions of dollars for the Medicare program in the long run, we also propose an alternative: that CMS combine the OPPS and ASC utilization and mixes of services to establish a single weight scalar. In other words, CMS could apply a single budget neutrality calculation to the OPPS and ASC payment systems. By incorporating the ASC volume into the OPPS weight scalar calculations, CMS would further the alignment of the payment systems and more accurately scale for outpatient volume across both sites of service.

### Wage Index Considerations

Wage index is another area in which there is a lack of alignment between ASC and HOPD reimbursement methodology.

Hospitals can request geographic reclassifications that raise the hospital wage index, depending on the distance between the hospital and the country line of the area to which it seeks reclassification. Unfairly, ASCs cannot seek reclassification.

Hospitals in frontier states receive payment based on a wage index floor at 1.0. A frontier state is defined as a state in which “at least 50 percent of counties located within the State have a reported population density less than 6 persons per square mile,”<sup>13</sup> (excluding Alaska and Hawaii). South Dakota is one of the frontier states. While the state rural wage index for surgery centers in the state is 0.8073, hospitals in South Dakota receive the “floor” wage index of 1.0. We request that CMS apply these policies for ASCs – geographic reclassifications and wage index floors – to allow for further alignment between the ASC payment system and OPPS.

### Proposed Addition to the List of ASC Covered Surgical Procedures

While we support in theory the addition of dental codes to the ASC Covered Procedures List (ASC-CPL), we are extremely disappointed that G0330 is the only code proposed for addition from the sixty-three codes ASCA submitted to CMS for consideration in March 2023 (Full list

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<sup>12</sup> See Social Security Act 1833(i)(D)(ii): *In the year the system described in clause (i) is implemented*, such system shall be designed to result in the same aggregate amount of expenditures for such services as would be made if this subparagraph did not apply, as estimated by the Secretary and taking into account reduced expenditures that would apply if subparagraph (E) were to continue to apply, as estimated by the Secretary.

<sup>13</sup> 42 CFR 412.64 (m)(i).

found in Appendix A). In addition, the strings attached to coverage for G0330 make it unclear whether ASCs will even be able to perform these procedures in our setting.

The lack of transparency in this section of the rule is confounding. In addition to the agency's failure to even mention sixty-two of the procedures we requested, there was no mention of the Pre-Proposed Rule CPL Recommendation Process that is to go into effect on January 1, 2024, with a deadline for submissions of March 1, 2024.

Currently, CMS is not required to disclose a rationale for excluding a given procedure and may simply ignore requests, as seen in this rule. As such, ASCA views this new process as a much-needed avenue through which CMS must show its work and respond to requests for additions to the ASC-CPL presented to the agency. The fact that there were absolutely no implementation details provided in this rule is troubling. Instead, CMS quietly released proposed Form CMS-10809 ASC CPL Pre-Proposed Rule Recommendation Request. Currently, the proposed form includes a place to state the code requested, whether the code has previously been on the ASC-CPL, and then asks, "Do you have any supporting documentation or information?" However, there is no guidance anywhere as to what documentation or information CMS will find compelling when considering codes for the ASC-CPL.

While CMS claims to "encourage stakeholders to submit procedure recommendations to be added to the ASC CPL, particularly if there is evidence that these procedures meet our criteria and can be safely performed in the ASC setting," the lack of additional guidance or response to codes that have been requested by the ASC community indicates that this is just lip service.

The current lack of transparency makes it difficult for clinicians to marshal the data needed to challenge these decisions since they are often not sure by what basis CMS will choose to exclude the codes. In the 2022 rulemaking cycle, CMS indicated that if the agency were to disagree with the addition of a nominated code, they would provide a rationale for exclusion in the final rule. As noted earlier, ASCA submitted codes for consideration earlier this year, and we have no idea whether the agency even considered any of those codes for addition. Transparency and a clear deadline for submission make this a better process for CMS, its stakeholders and the public.

CMS states in this rulemaking that the agency continues to "focus on maximizing patient access to care by adding procedures to the ASC CPL when appropriate." These are nice words but belied by a lack of action.

There are currently 375 codes that are payable in the HOPD setting but not on the ASC-CPL. CMS continues to mistakenly act as though there is a significant difference in safety between ASCs and HOPDs. This is belied by research that confirms that outcomes are remarkably similar, even adjusting for risk, between HOPDs and ASCs.<sup>14</sup> This is most likely because survey and certification requirements are also essentially the same in both settings.<sup>15</sup> Indeed, the primary difference between the settings is the much higher reimbursement rate HOPDs receive over surgery centers.

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<sup>14</sup> Elizabeth L. Munnich and Stephen Parente, "Returns to Specialization: Evidence from the Outpatient Surgery Market." *Journal of Health Economics*, 57, 2018.

<sup>15</sup> Sources: 42 CFR 416 & 482

The requirements for achieving and maintaining CMS certification were increased in 2008 with the overhaul of the ASC Conditions for Coverage (CfCs) and further safeguards have since been implemented to enhance patient safety and quality of care in ASCs. Physicians who invest in ASCs not only have their medical license to maintain, but also the viability of their facility and the livelihoods of all who they employ. They comply with rigorous standards, certifications and licensures and should be trusted to determine the most appropriate site of care for their patients.

### *Evaluating codes based on the “typical” Medicare beneficiary*

CMS indicates that additions to the ASC-CPL should be considered “in a carefully calibrated fashion to ensure that the procedure is safe to be performed in the ASC setting for a typical Medicare beneficiary.”

This is the third year this language has been used, yet there is still no guidance regarding the typical Medicare beneficiary. In the 2022 proposed rule, CMS referred to the typical beneficiary as one “whose health status is representative of the broader Medicare population.” CMS referenced the authority granted to the US Department of Health and Human Services (HHS) in the Social Security Act (SSA) to add codes and implies that by adding codes to the ASC-CPL Medicare has determined the procedure is safe to perform on the typical Medicare beneficiary. The SSA does *not* include any language of the sort.<sup>16</sup>

If CMS is truly adopting a standard of only allowing ASCs to perform procedures that are safe for the typical Medicare beneficiary, there would also need to be a much more detailed explanation of who this language represents, because on its face this language could practically eliminate the ASC-CPL altogether. It is much more reasonable to determine whether a subset of the population is suitable and allow for the clinician to then decide which of her patients are eligible for care in an ASC. Medicare is overspending with its short-sighted policy to exclude from consideration any code that may not be appropriate for the typical Medicare beneficiary – whoever that may be.

Also, if this “typical Medicare beneficiary” standard is the new norm, CMS should reassess its office-based payment policy. Currently, CMS is redirecting procedures to physicians’ offices, a site of service which the agency does not regulate, strictly on a volume-based approach. When 50 percent of the volume is performed in a physician’s office, ASCs are reimbursed at the lower office-based rate. There is no discussion of whether these procedures are safe; apparently CMS trusts physicians when performing procedures in their office but does not extend that same approach to physicians operating in ASCs.

Medicare beneficiaries – like our country’s population at large – are not a monolith. When CMS added total knee arthroplasty (TKA) to the ASC-CPL in 2020, the agency acknowledged that there is a “small subset of Medicare beneficiaries who may be suitable candidates to receive TKA procedures in an ASC setting based on their clinical characteristics.” Total knee arthroplasty (TKA) and total hip arthroplasty (THA) would not be added under the new criteria being used, which would be a huge loss to Medicare beneficiaries and taxpayers. In 2021, there were more than 20,894 TKAs and more than 9,224 THAs performed on Medicare FFS

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<sup>16</sup> See Social Security Act 1833(i)(1).

beneficiaries.<sup>17</sup> Medicare saved more than \$132 million in 2021 just because the agency approved these codes for addition to the ASC-CPL. By failing to add other joint replacement codes, such as total shoulder arthroplasty, that are safe for the ASC setting, Medicare is needlessly spending more taxpayer money.

### ***Total Shoulder Arthroplasty (CPT 23472) and Total Ankle Replacement (27702)***

As CMS acknowledges in the 2020 Proposed Rule and prior rulemaking, recent innovations have enabled surgeons to perform joint replacement procedures “on an outpatient basis on non-Medicare patients (both in the HOPD and in the ASC).” Innovations such as minimally invasive techniques, improved perioperative anesthesia, alternative postoperative pain management and expedited rehabilitation protocols” have made it possible for these procedures, along with other total joint replacement surgeries, to be performed in the outpatient setting. As previously mentioned, TKA and THA are already on the ASC-CPL. TKA was added in 2020, and THA was added in 2021.

Despite many private payors being hesitant to reimburse for total shoulder arthroplasty (TSA) until CMS chooses to do so, there is still significant volume being performed in our facilities. In 2022, there were approximately 6,000 TSAs performed in ASCs based upon a sample of all payer claims data,<sup>18</sup> with nearly 15 percent of those performed on patients with Medicare Advantage. As Medicare Advantage enrollment continues to rise,<sup>19</sup> CMS is creating a disparity in what is available to FFS Medicare beneficiaries compared to those with Medicare Advantage.

In fact, several ASCs that enrolled as hospitals during the hospital without walls program established during the COVID-19 pandemic were able to perform several hundred TSAs on Medicare FFS beneficiaries. All facilities reported positive outcomes.

There have been more than one hundred peer-reviewed articles published on the topics of outpatient joint replacement, appropriate patient selection, multi-modal pain management, rapid rehabilitation and clinical outcomes. Attached as Appendix B to this comment letter are several studies that specifically speak to outpatient total shoulder arthroplasty and total ankle replacement safety. These procedures are performed on other patient populations as outpatient procedures.

### ***CMS exclusionary criteria***

In 2022 rulemaking, CMS reverted to prior exclusionary criteria: *(1) generally result in extensive blood loss; (2) require major or prolonged invasion of body cavities; (3) directly involve major blood vessels; (4) are generally emergent or life threatening in nature; (5) commonly require systemic thrombolytic therapy.* While we have reservations as to how they can be interpreted—

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<sup>17</sup> Based on analysis of 2021 CMS PSPS data.

<sup>18</sup> Based on an analysis performed by ECG Management Consultants using Stratason payer claims data (<https://stratason.com>) on a national level. The Stratason database contains approximately 2.1 billion claims per year, estimated to capture approximately 50-60 percent national coverage.

<sup>19</sup> <https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/> (accessed 9/1/2023).

they are imprecise and subjective—we do not oppose these criteria if they are used as guidance for exclusion as opposed to an automatic refusal to consider.

There are procedures, for instance, that “involve major blood vessels” that are extremely safe for the outpatient setting. CMS should continue to evaluate codes on a case-by-case basis to determine whether that “involvement” leads to a heightened risk of negative outcomes.

Two criteria in the CFR that are particularly problematic are those that require “active medical monitoring and care at midnight following the procedure” and the automatic denial of all unlisted codes.

### Active Medical Monitoring and Care Past Midnight

CMS-certified ASCs are facilities for patients “not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission.” However, for Medicare beneficiaries, CMS seems to be interpreting “hospitalization” as equivalent to “active medical monitoring and care at midnight following the procedure.” If non-Medicare beneficiaries are permitted to stay in an ASC up to 24 hours, it should be clear that the same standard applies to Medicare beneficiaries. A procedure can be extremely safe yet a beneficiary might still be best served by staying overnight or would feel more comfortable spending the night. It is also unclear what is meant by “medical monitoring and care.”

### Unlisted Codes

The Code of Federal Regulations §416.166 - *Covered surgical procedures* states that “covered surgical procedures do not include those surgical procedures that...can only be reported using a CPT unlisted surgical procedure code.” There is no safety rationale for this provision and commercial payers commonly provide surgery centers with the flexibility to use unlisted CPT codes to report procedures. Facilities must document why they need to use the unlisted code and receive approval from the payer to be reimbursed. This is also a practice CMS permits for HOPDs and physician offices but not for ASCs and is yet another example of an area where CMS could make a simple change and derive savings for both the Medicare program and its beneficiaries.

If providers can choose to perform these procedures in HOPDs (facilities that we have already shown to be often identical to ASCs) and physician offices that are not regulated by the federal government, a blanket exclusion in the ASC setting is nonsensical. ASCA requests that CMS revise the Code of Regulations to eliminate this restriction.

### **Dental Codes**

ASCA has been working with national dental organizations<sup>20</sup> regarding the potential for ASCs to help mitigate the current operating room shortage affecting access to dental procedures for patients that require monitored anesthesia. ASCA very much appreciates CMS’ inclusion of

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<sup>20</sup> American Academy of Pediatric Dentistry (AAPD), American Dental Association (ADA) and the American Association of Oral and Maxillofacial Surgeons (AAOMS).

dental rehabilitation (HCPCS G0330) and 25 additional dental codes on the ASC-CPL, and we are hopeful that the inclusion of these procedures will also encourage other payers to expand coverage of dental procedures in ASC settings.

However, it is unclear to us why the Proposed Rule so narrowly limits the dental procedures eligible for inclusion on the ASC-CPL. For the reasons set forth in comments filed by the dental organizations, all dental procedures eligible for Medicare payment in HOPDs (with the exception of dental imaging and dental evaluation and management services) are invasive procedures impacting either hard or soft tissue and are therefore surgical procedures eligible for coverage in the ASC setting. Likewise, these procedures (except dental imaging and dental evaluation and management services) meet the regulatory requirements for inclusion on the ASC-CPL and may be safely performed in an ASC. For these reasons, we request that CMS include all dental procedures eligible for Medicare payment under the OPPS—apart from dental imaging and dental evaluation—on the ASC-CPL and that CMS include dental imaging and dental evaluation codes on the ASC Ancillary Services List (under Addendum BB). This approach would ensure that packaging policies are consistent in the HOPD and ASC settings.

We are also puzzled by CMS' proposed requirement that, to be covered by Medicare, dental rehabilitation (G0330) must be billed along with a covered but non-payable dental ancillary service. We are aware of no safety or other reason for imposing this additional billing requirement and request that CMS either clarify why this additional billing requirement is needed or refrain from finalizing it in the 2024 OPPS/ASC Final Rule.

Finally, ASCA requests that CMS work with the dental organizations to ensure that dental procedures are properly classified into APCs, based on clinical and resource-related criteria, to ensure that the amounts paid for the facility services involved are appropriate when these procedures are performed in both hospital outpatient and ASC settings.

### **Device-Intensive ASC Covered Surgical Procedures**

ASCA has been working with the agency for years to address the device offset threshold and its impact on ASC volume and we appreciate the agency recognized in 2022 the key role that device costs can play in a facility's ability to perform these procedures. ASCA has long-requested that CMS determine the percentage the device accounts for in the ASC setting to determine device-intensive status and we are grateful that CMS agrees that this is a more appropriate calculation method.

ASCA encourages further enhancements to the device-intensive policies. CMS should use the most accurate data available, including external invoices, to calculate the device-intensive threshold to ensure adequate reimbursement for procedures. This would have the effect of designating additional procedures as device-intensive and allow for additional migration of procedures from the higher-cost HOPD setting. CMS will accept invoices for the device intensive assessment if there is no available claims data. The agency should expand its policy of using invoices for the device intensive assessment to include consideration of invoices when there are fewer than twenty single frequency claims. When there are so few claims it is

functionally equivalent to having no available claims data and thus is a logical extension of existing policy that can facilitate appropriate payment to ASCs.

### **CMS should request that Congress implement an ASC co-pay cap.**

While recent changes to the device-intensive threshold have increased the number of device-intensive codes on the ASC-CPL, they have also shone a spotlight on how the lack of alignment in the HOPD and ASC payment systems creates a barrier to access for Medicare beneficiaries. While there is a statutory cap on the patient responsibility when a procedure is done in a hospital, including an HOPD, that policy is not in place for the surgery center setting. Even though the Medicare beneficiary's patient responsibility is capped, the hospital is made whole by the Medicare program. Perversely, the lack of a co-pay cap in the ASC setting encourages beneficiaries to receive care in the hospital, increasing costs to the Medicare program for no clinical reason.

In years past, this had not been a prominent issue for surgery centers due to the lack of codes for which the reimbursement rate was high enough to trigger a potential cap in our setting, but this is changing as higher-cost procedures in general have been added to the ASC-CPL, and as more procedures have been identified as device-intensive. There are 167 codes on the 2024 proposed ASC-CPL for which the patient responsibility based on the national reimbursement rate would be higher in the ASC than the HOPD; all but three of those codes are device-intensive. Many orthopedic codes, such as total joint replacements, are included in that group. Beneficiaries who would otherwise have access to the high-quality, convenient surgery center setting are disadvantaged by this lack of alignment in policy. As this requires a statutory fix, ASCA will be working with Congress to address this issue and we request that CMS advise Congress to create a co-pay cap for the ASC setting as well.

### **CMS should not adjust the device portion of payments by local wage index.**

The impact of the concerns raised above in the wage index section of our comments are exacerbated for device-intensive codes. There are rural communities where the wage index is so low that it is financially untenable for facilities to perform device-intensive procedures on Medicare beneficiaries. To address this CMS should refrain from adjusting the device portion of the payment by the local wage index. This is consistent with the agency's policy for separately payable drugs and biologics and it is highly unlikely that a facility in a rural community is getting a better deal on device prices than ASCs in large cities.

One example of how significantly the wage index can impact device-intensive codes is for a cardiology code, CPT code 33240. The 2024 proposed national rate for 33240 is \$22,789.80 and CMS estimates the device costs at \$18,083.71. In rural Alabama, where the local wage index is currently 0.6604, the 2024 proposed reimbursement rate for 33240 is \$16,802.31, which is **\$1,281.40 less than** the device costs. This issue impacts all communities with a lower wage index and causes access issues for Medicare beneficiaries.

### **ASC Payment for Combinations of Primary and Add-On Procedures Eligible for Complexity Adjustments under the OPPIs**

ASCA strongly supports complexity adjustments in the ASC setting and commends CMS for implementing a policy that provides an opportunity for better access to Medicare beneficiaries and significant cost savings to the Medicare program.

As CMS notes in this rule, while add-on codes (N1) do not come with additional reimbursement (packaged into primary code), the addition of the add-on codes to a primary procedure code often changes the complexity of the procedure, making it more costly to perform attributed to the labor as well as the implants and supply costs.

For ASCs, this problem is most obvious in the packaging of additional levels for spine codes. The majority of anterior cervical discectomy and fusion (ACDF) and lumbar spine fusion procedures involve hardware (e.g. instrumentation and application of cages), implants and grafts, and when multiple levels are performed the number of implants, hardware and grafts increases based upon the number of levels that are performed. While the add-on CPT codes for these procedures indicate that an implantable, graft and hardware are used in the case, coupled with the additional level surgical procedure codes for the case, these add-on codes have a payment indicator of N1, meaning they are packaged with no additional payment.

We wish to work with CMS to determine if there is a way to expand this policy to include the spine case code combinations that are performed with the add-on codes so that the ASC will be reimbursed fairly to offset the increased cost with the add-on codes that are needed in these cases. The case code combinations for spine that are most performed with the add-on codes with the payment indicator N1 include the following:

### **Cervical Fusion**

Scenario 1:

Primary CPT code 22551

Add-on codes with payment indicator N1: 20930, 20931, 20936, 20937, 20938, 22552, 22845, 22853, 22854, 22859

Scenario 2:

Primary CPT code 22554

Add-on codes with payment indicator N1: 20930, 20931, 20936, 20937, 20938, 22585, 22845, 22853, 22854, 22859

### **Lumbar Fusion**

Primary CPT code 22612

Add-on codes with payment indicator N1: 20930, 20931, 20936, 20937, 20938, 22840, 22842, 22853, 22854, 22859, 22614

It should be noted that the majority of these cases have more than one add-on code when performed which also increases the complexity and cost of performing the case.

In addition, ASCA has concerns that the volume of cases with the N1 payment indicator are not being captured. We have heard anecdotally that it is common for facilities to leave these codes off claims even when they are being performed in conjunction with other surgical codes.

Therefore, this suggests that some code combinations may not be meeting the criteria for complexity adjustment because they may not be captured in the HOPD Medicare claims data.

We also understand that claims may be denied by Medicare Administrative Contractors (MACs) when add-on codes with the payment indicator of N1 appear with the primary code, even though the primary code is payable. CMS must clarify in the billing claims processing manual that HOPDs are permitted to bill all add-on codes and confirm that the entire claim will not be denied by the MACs when an add-on code that is not payable is billed.

### **Payment for Non-Opioid Pain Management Treatments**

ASCA supports the separate payment for the cost of non-opioid pain management drugs that function as surgical supplies when they are furnished in the surgery center setting. As part of our continued desire to align the HOPD and ASC payment systems, we encourage CMS to establish this same policy for the HOPD setting.

We also encourage CMS to consider reimbursing for other peri-operative non-opioid pain management tools, such as pain blocks represented by CPT codes 64415, 64416, 64417, 64445, 64446, 64447, 64448, 64450, that decrease use of post-op opioids. These codes are listed on ASC Addenda AA, meaning they are reimbursed as surgical codes only, primarily for chronic pain management. Many physicians use the pain blocks described by the surgical codes above to mitigate the post-operative pain that is otherwise typically addressed with short-term opioid use. CMS could apply the same OPPS drug packaging threshold for consideration of these codes, which is proposed at \$135. If applied to the codes above, 64415, 64416, 64417, 64446 and 64448 would be eligible for reimbursement as they all have rates well above \$135.

For many interventions an anesthesiologist employs ultrasound guidance, often CPT 76942, to locate the nerve that needs to be blocked and injects medication (one of the pain codes listed above) to supplement the other anesthetic agents and minimize a patient's post-operative pain. The therapeutic effects of the pain block can last up to 72 hours, by which time much of the immediate post-operative severe pain has diminished and is usually responsive to non-narcotic pharmaceuticals. Pain blocks are routinely administered to non-Medicare patients in conjunction with a wide range of procedures but, unfortunately, the present lack of reimbursement by Medicare makes these valuable therapies cost-prohibitive for use on Medicare beneficiaries. ASCA supports separate payment for non-opioid pain management products to reduce the prescription and use of opioids after surgery.

### **Key Comments on ASC Quality and Proposed Reporting Program Changes**

ASCs have long-embraced quality reporting. In 2006, the ASC Quality Collaboration (ASC QC) was established to develop, test and publicly report quality measures specific to the ASC setting. The ASC community proactively requested an ASCQR Program and began submitting data more than a decade ago. We support the collection and submission of publicly available data that can guide patients to the appropriate healthcare setting. However, the ASCQR Program has been foundering in recent years, and burdens are being imposed on facilities without any benefit to patients.

ASCA is concerned that CMS fails to adequately consider the cost burden on facilities when establishing new quality measures. A recent study<sup>21</sup> indicated that Johns Hopkins hospital's quality reporting compliance cost \$5,038,218.28 in personnel costs plus an additional \$602,730.66 in vendor fees annually. This did not include any quality improvement activities. While the cost to a surgery center would be significantly lower, it is not insignificant and should be addressed. At a certain point, CMS will be pricing facilities out of the ASCQR Program.

Beginning in 2025, ASCs will be required to contract with a third-party vendor to administer the Consumer Assessment of Healthcare Providers and Systems Outpatient and Ambulatory Surgery (OAS CAHPS). CMS maintains a list of approved vendors, but it is not clear that CMS knows how much their approved vendors charge. When ASCA surveyed the vendors, prices varied significantly, including one quote for \$20,000 per year. Given the costs, an ASC may make the decision to decline to participate in the ASCQR Program and accept the two percent penalty. This does not mean the facility will be any less safe – or that it will not be collecting quality metrics. Surgery centers will still be required to engage in quality improvement activities to maintain CMS certification. However, if the burden outweighs the benefit to patients and the facility, we might see ASCQR Program participation decline. ASCA implores CMS to add measures, or modify the measures already in the ASCQR Program, to reduce costs and encourage ASC participation.

The ASC QC will submit detailed comments on the aspects of the rule pertaining to the ASCQR Program, and ASCA supports the ASC QC's comments. In addition, we wish to highlight below our position on select policies.

### **ASCA opposes implementation of ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures.**

We question how this advances quality of care and do not believe there is meaningful consumer value to be derived from this type of data. CMS has not presented any evidence that measuring volume is a valid and reliable indicator of quality for low-risk procedures and surgeries that are performed in ASCs. The agency also has not presented any evidence supporting the notion that more volume results in better outcomes for low-risk procedures and surgeries.

Further, CMS has re-specified the measure in a manner that selects the highest volume procedures in each procedure category for data collection and reporting. These are the principal services performed by ASCs and those with which the centers are most experienced. By focusing on low-risk, high-volume services the measure evaluates the procedures presenting the least concern. ASCA does not support the reimplementing of this measure and would like to see CMS instead focus on outcome measures.

### **ASCA continues to request that ASC-11 be removed from the ASCQR Program.**

CMS' recognition in 2023 that implementing *ASC-11 Cataracts: Improvement in Patient's Visual Function within 90 Days Following Cataract Surgery* would represent an undue burden

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<sup>21</sup> Saraswathula A, Merck SJ, Bai G, et al. The Volume and Cost of Quality Metric Reporting. *JAMA*. 2023;329(21):1840–1847. doi:10.1001/jama.2023.7271

due to the continued impact of the COVID-19 pandemic on facilities was the correct decision. However, this measure would place an undue burden on our facilities regardless of the presence of a public health emergency (PHE) in this country.

This measure was developed, tested and previously endorsed by the National Quality Forum (NQF) as a clinician-level measure (NQF #1536), and it was never intended to measure facility performance. Importantly, there are *no publicly reported results* available in 2023 from the 2021 reporting period for Quality ID #303, the physician measure corresponding to ASC-11. According to the Quality Payment Program support contractor, this is because the standards for publicly reporting the measure were not met. Reporting standards were not met because *fewer than 20 reporters submitted data*. It will be difficult to coordinate the use of the survey between settings when physicians are not even choosing to report on this measure.

ASC-11 relies on the use of data obtained by the physician and recorded in the medical records housed in the physician office at two key points in time: (1) the patient's visit(s) with the physician during which the evaluation, examination and decision regarding surgery was made, and (2) the patient's visit(s) with the physician after surgery and during the post-operative 90-day global period. ASCs do not have access to these records. Asking ASCs to report this measure is administratively burdensome and not reflective of the attributes of the ASC facility or the actions of its staff during the patient's time in the facility.

ASCA supports CMS' decision to maintain ASC-11 as a voluntary measure but once again request that it simply be removed from the dataset altogether as it is not actionable by the facility and therefore of limited to no value to the patients served.

### **ASCA supports OAS CAHPS implementation with changes that will reduce the administrative and financial burden on our facilities.**

We appreciate the longer implementation period ASCs were given but continue to advocate for an electronic-only option to make the survey easier for our patients to complete and to decrease the financial burden on facilities.

### ***Cost to Facilities***

Besides the cost of finding and securing a third-party vendor, of which there are purportedly 15 that are CMS-approved,<sup>22</sup> the direct costs associated with the current modes of conducting this survey are higher than necessary.

Based on the data we have collected from vendors, a conservative estimate for the lowest possible cost to each facility would be at least \$4,000 per year. This amount could be higher depending on the mode and vendor selected by the ASC. As previously mentioned, ASCs are often small businesses and we request that CMS make every effort to decrease the cost to our facilities.

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<sup>22</sup> <https://oascahps.org/General-Information/Approved-Survey-Vendors> (accessed September 15, 2021).

Internet access and email accounts are common today and should be an approved mode for data collection. Survey vendors already offer electronic survey options to their customers and the return rates are as good as and often better than for other survey modes for patient populations of all ages. Incidentally, surveys currently under development for CMS involve text and email, not the traditional paper and phone modes.

### ***Implementation***

While there are purportedly 15 CMS-approved vendors, when ASCA reached out to them we received bounce back emails for several, and others were not currently working with any ASC clients, and seemed ill-equipped to ramp up efforts quickly. With more than 6,200 Medicare-certified ASCs, the vast majority of which are currently not using an OAS CAHPS survey, the few relevant vendors will be inundated shortly with facilities reaching out. ASCA believes that potentially only one, Press Ganey, is currently positioned to onboard a substantial number of facilities in the short window of time before implementation is mandatory.

ASCA strongly supports quality reporting measures that speak to the quality of care being provided by the facility and will help improve care as well as the patient experience. In addition, we have long supported more measures that allow beneficiaries to compare ASCs to HOPDs. We have serious concerns, however, that this survey will not be as helpful as it could be for facilities and potential patients alike until an electronic-only option is added as an approved survey mode.

### ***ASC-20 should be removed from the ASCQR Program.***

As ASCA feared when this measure was first proposed back in 2022 rulemaking, *ASC-20: COVID-19 Vaccination Coverage Among HCP* has placed an undue burden on our facilities and the implementation has been confusing, with definitions constantly changing midstream. In response to the 2022 proposal we wrote that “when a new measure is proposed for addition, particularly with such a short turnaround time for compliance, it must be clear that the benefits of the measure will outweigh the burden. This does not seem to be the case here.” Two years later, the benefits are even less clear.

The COVID-19 PHE ended on May 11, 2023. On May 31, CMS released a final rule that withdrew the regulations that had mandated COVID-19 vaccination for healthcare personnel (HCP). It has never been a requirement that facilities collect vaccination status of their patients and guests and many healthcare facilities no longer require patients and guests entering facilities to even wear masks anymore. And yet, surgery centers and other healthcare facilities must continue to report on HCP vaccination status monthly to avoid penalties. It is difficult to claim it is a matter of epidemiology when we do not know the vaccination status for a sizable number of the individuals coming through the facility daily, including the patients undergoing surgery.

We respectfully request that this measure be removed from the ASCQR Program.

In the absence of complete removal from the program CMS should move to an annual reporting requirement. This would at least reduce the burden of having to collect data monthly, especially when vaccination status is not changing as rapidly as it was previously. Review of the publicly

available measure data shows HCP vaccination rates have been essentially flat across provider and supplier settings, even prior to the end of the PHE. There have been no meaningful fluctuations from week to week, month to month, or quarter to quarter.

Consequently, there is no benefit to requiring ongoing intensive data collection for the sake of continuing to document a static rate of vaccination among HCP.

**ASCA opposes implementation of ASC-21: *THA/TKA PRO-PM* as proposed.**

CMS is proposing to adopt *ASC-21: Risk-Standardized Patient Reported Outcome-Based Performance Measure (PRO-PM) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) in the ASC Setting (THA/TKA PRO-PM)*, with voluntary reporting beginning with the CY 2025 and 2026 reporting periods followed by mandatory reporting beginning with the CY 2027 reporting period. This measure includes pre-operative data collected from 0-90 days before the procedure and post-operative data collected between 300-425 days after the procedure.

In this rule, CMS estimates an unrealistic cost burden for facilities – 20 minutes per year. This is based largely on the assumption that ASCs will use electronic health record (EHR) technology to facilitate compliance. The Office of the National Coordinator for Health Information Technology (ONC) estimates that at least 86 percent of office-based physicians and 96 percent of acute care hospitals are currently using an EHR, but we estimate that ***at most*** 50 percent of ASCs are using an EHR.<sup>23</sup> ASCs did not receive any federal funding for EHR adoption in the *Health Information Technology for Economic and Clinical Health Act of 2009* and are not currently contemplated by federal efforts. We should not be penalized for slower adoption of EHR technology.

Even facilities that use EHR technology will spend much more than 20 minutes a year to comply with this one measure. The amount of data ASCs would be required to collect and submit for this measure is substantial: a total of 44 to 47 data elements for each THA patient and a total of 46 to 49 data elements for each TKA patient when complete patient-reported outcome data is provided by the patient. Yet, the agency proposes ASCs be required to submit complete and matching preoperative and postoperative PRO data for at least 45 percent of their eligible elective primary THA/TKA procedures<sup>24</sup> to avoid future payment penalties. CMS ***must*** test this proposed measure in the ASC setting before implementation. The OAS CAHPS survey sees much lower response rates, as seen in the OAS CAHPS 2019 mode. The highest return rate was 39 percent for web plus mail follow-up for a much less onerous survey.

With ASC-21, if a patient does not respond to all the items on each of the instruments requiring their input (the preoperative and postoperative HOOS, JR or KOOS, JR, the mental health items from the PROMIS-Global or VR-12, the Health Literacy SILS2, the “Total Painful Joint Count” and the Oswestry Index Question), the patient PRO data submission would be considered

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<sup>23</sup> This estimate is based on a data from Definitive Healthcare, a 2021 survey of ASCA members and estimates from ASC-focused EHR vendors.

<sup>24</sup> We see a statement that a 50 percent minimum is proposed for ASCs at 88 FR 49883 but have elected to reference the 45 percent minimum as stated elsewhere. Clarification would be welcome.

incomplete. ASC staff are already worried about survey fatigue with the upcoming OAS CAHPS survey mandate and *ASC-21* will require even more information from patients.

A THA/TKA PRO-PM is just now being mandated in inpatient hospitals that have been working toward implementation for years. The proposal to begin voluntary reporting in ASCs in 2025 does not take the beginning of mandatory reporting for OAS CAHPS that same year into account. Given the extensive preparatory work needed for the THA/TKA PRO-PM, voluntary reporting in 2025 is not reasonable and should be delayed.

### **Closing Summary**

We appreciate the opportunity to provide feedback on the agency's latest proposal to reimburse and regulate surgery centers. As is clear from these comments, it is imperative that CMS improve its coordination with the healthcare community to improve the Medicare program. We welcome the opportunity to collaborate with CMS on the recommendations in this comment letter to ensure our facilities can continue to provide outstanding care to Medicare beneficiaries at a fair cost to the Medicare program.

Please contact Kara Newbury at [knewbury@ascassociation.org](mailto:knewbury@ascassociation.org) or (703) 836-8808 if you have any questions or need additional information.

Sincerely,



William Prentice  
Chief Executive Officer

### Appendix A – Codes Requested for Addition to the ASC-CPL

HCPSC Code	Short Descriptor
21141	Lefort i-1 piece w/o graft
21142	Lefort i-2 piece w/o graft
21143	Lefort i-3/> piece w/o graft
22633	Arthr d cmbn 1ntrspc lumbar
23470	Reconstruct shoulder joint
23472	Reconstruct shoulder joint
23473	Revis reconst shoulder joint
27702	Reconstruct ankle joint
33289	Tcat impl wrls p-art prs snr
37183	Revision tips
37191	Ins endovas vena cava filtr
37192	Redo endovas vena cava filtr
50543	Laparo partial nephrectomy
50544	Laparoscopy pyeloplasty
51990	Laparo urethral suspension
55866	Laps surg prst8ect rpbic rad
60252	Removal of thyroid
75571	Ct hrt w/o dye w/ca test
75572	Ct hrt w/3d image
75573	Ct hrt c+ strux cgen hrt ds
75574	Ct angio hrt w/3d image
75600	Contrast exam thoracic aorta
75605	Contrast exam thoracic aorta
75625	Contrast exam abdominl aorta
75630	X-ray aorta leg arteries
75710	Artery x-rays arm/leg
75716	Artery x-rays arms/legs
75726	Artery x-rays abdomen
75736	Artery x-rays pelvis
75756	Artery x-rays chest
75820	Vein x-ray arm/leg
75822	Vein x-ray arms/legs
75825	Vein x-ray trunk
75827	Vein x-ray chest
75831	Vein x-ray kidney
75833	Vein x-ray kidneys
75860	Vein x-ray neck

HCPSC Code	Short Descriptor
92960	Cardioversion electric ext
92961	Cardioversion electric int
93306	Tte w/doppler complete
93312	Echo transesophageal
93318	Echo transesophageal intraop
93600	Bundle of his recording
93602	Intra-atrial recording
93603	Right ventricular recording
93610	Intra-atrial pacing
93612	Intraventricular pacing
93615	Esophageal recording
93616	Esophageal recording
93618	Heart rhythm pacing
93619	Electrophysiology evaluation
93620	Electrophysiology evaluation
93624	Electrophysiologic study
93642	Electrophysiology evaluation
93650	Ablate heart dysrhythm focus
93653	Compre ep eval tx svt
93654	Compre ep eval tx vt
93656	Compre ep eval abltj atr fib
93660	Tilt table evaluation
C9602	Perc d-e cor stent ather s
C9604	Perc d-e cor revasc t cabg s
C9607	Perc d-e cor revasc chro sin

## Appendix B – Total Shoulder and Ankle Research

### Total shoulder vs. hip and knee arthroplasty: an analysis of perioperative outcomes

*Journal of Shoulder and Elbow Surgery (JSES)*

**Published:** July 7, 2023

**Conclusion:** Although performed less frequently, TSA is associated with significantly shorter hospital stays, lower likelihoods of readmission, and fewer complications than THA and TKA. These findings corroborate the relative safety of TSA and highlight its increasing utilization in the United States.

### The resiliency of elective total shoulder arthroplasty case volumes in the United States during the COVID-19 pandemic: a nationwide temporal trends analysis

*Journal of Shoulder and Elbow Surgery (JSES)*

**Published:** October 31, 2022

**Conclusion:** Using a nationwide sample, elective TSA precipitously declined during the second quarter of 2020. Patient demographics of those undergoing elective TSA in 2020 were similar in comorbidity burden. A large proportion of surgeries were transitioned to the outpatient setting, with rates of same-day discharge doubling over the study period despite no change in overall complication rates.

### Trends in outpatient vs inpatient TSA over time

*Journal of Shoulder and Elbow Surgery (JSES)*

**Published:** January 2022

Result: Authors found that 44.9 percent of outpatients in the late cohort (12,401 patients who underwent TSA between 2017 and 2019) were over 70. Overall the complication rate for outpatients in the late cohort was much lower (1.38 percent) than the inpatients (3.9 percent).

### Comparison of outpatient vs. inpatient anatomic TSA

*Journal of Shoulder and Elbow Surgery (JSES)*

**Published:** January 2022

**Conclusion:** When compared with a propensity score–matched cohort of inpatient counterparts, the present study found outpatient anatomic TSA (aTSA) was associated with significantly reduced severe adverse events and similar readmission rates. These findings support the growing use of outpatient aTSA in appropriately selected patients.

## **COVID-19 as a Catalyst for Same-Day Discharge Total Shoulder Arthroplasty**

*Journal of Clinical Medicine*

**Published:** December 2021

**Result:** Authors looked at TSA performed in two periods, before March 2020 and after May 2020. They found a higher rate of same-day discharge in the post-COVID era (87.3 percent vs 79.1 percent pre-COVID) and no change in 90-day readmission, reoperation, ED visits. “...outpatient shoulder arthroplasty is safe in not only selected patients, but in the majority of cases based on the findings of the current study.”

## **The Safety of Outpatient Total Shoulder Arthroplasty**

*International Orthopedics*

**Published:** January 2021

**Conclusion:** This study highlights that outpatient TSA could be a safe and effective alternative to inpatient TSA in appropriately selected patients. It was evident that outpatient TSA does not lead to increased readmissions, complications, or revision rates.

## **Outpatient Shoulder Arthroplasty at an Ambulatory Surgery Center Using a Multimodal Pain Management Approach**

*Journal of the American Academy of Orthopaedic Surgeons*

**Published:** October 2018

**Results:** No major complications, readmissions, revision surgeries, or deaths occurred in the outpatient cohort. The rate of 90-day complications was 9.5% and 17.5% for the outpatient and inpatient cohorts, respectively. All patients who had their shoulder arthroplasty as an outpatient were discharged home the day of surgery. No complications related to the outpatient protocol were observed.

## **Safety of Outpatient Shoulder Surgery at a Freestanding Ambulatory Surgery Center in Patients Aged 65 Years and Older: A Review of 640 Cases**

*Journal of the American Academy of Orthopaedic Surgeons*

**Published:** January 2018

**Finding:** Our findings are consistent with currently reported outpatient hospital-based data and illustrate the safety of outpatient shoulder procedures at a freestanding ambulatory surgery center in Medicare-age patients.

### Outpatient total shoulder arthroplasty in an ambulatory surgery center is a safe alternative to inpatient total shoulder arthroplasty in a hospital: a matched cohort study

*The Journal of Shoulder and Elbow Surgery*

**Published:** February 2017

**Finding:** Comparing two samples (30 patients matched for age/comorbidity) of patients undergoing total shoulder arthroplasty at an ASC and an inpatient hospital, there was no significant difference in 90-day episode-of-care complication rates such as hospital admission/readmission.

### The Safety Profile of Same-Day Outpatient Total Ankle Arthroplasty

*The Journal of Foot & Ankle Surgery*

**Published:** July 16, 2021

**Finding:** The present study suggests that TAA can be performed safely in an outpatient ambulatory setting.

### Safety of Outpatient Total Ankle Arthroplasty vs Traditional Inpatient Admission or Overnight Observation

*Foot & Ankle International*

**Published:** August 2017

**Results:** Eighty-one patients underwent TAA who met inclusion criteria, and 8 had a complication (10%). A significant difference in complication rate was seen among groups ( $P = .01$ ) but not rate of readmission or reoperation. Of 16 patients, 5 (31%) who were admitted for 2 or more nights following surgery had a complication, as opposed to 3 of 65 (5%) who were outpatient or admitted overnight ( $P = .01$ ). There were no differences in frequency of postoperative phone calls, narcotic refills, or visual analog scale pain scores at the first postoperative visit. There were no adverse medical events.