

# AMBULATORY SURGICAL CENTERS PAYMENT SYSTEM

payment**basics**

Revised:  
October 2007

Since 1982, Medicare has covered surgical procedures provided in freestanding or hospital-based ambulatory surgical centers (ASCs). ASCs are distinct facilities that furnish only ambulatory surgery; the most common procedures are cataract removal and lens replacement, colonoscopy, and other eye procedures. According to CMS's preliminary estimate, payments to ASCs were \$2.9 billion in 2006, including both program and beneficiary spending.

Beginning in January 2008, Medicare will pay for surgery-related facility services provided in ASCs—such as operative nursing, recovery care, anesthetics, drugs, and other supplies—using a payment system based on the hospital outpatient prospective payment system (OPPS). (Medicare pays for the related physician services—surgery and anesthesia—under the physician fee schedule.) In contrast to the old ASC payment system, which has only nine procedure groups, the new ASC system will have several hundred procedure groups. Like the OPPS, the new ASC payment system will set payments for individual services using a set of relative weights, a conversion factor, and adjustments for geographic differences in input prices. The new ASC system will be phased in over four years.

## Defining the products that Medicare buys

The unit of payment in the ASC payment system is the individual surgical procedure. Each of the 3,300 procedures approved for payment in an ASC is classified into an ambulatory payment classification (APC) group on the basis of clinical and cost similarity. All services within an APC have the same payment rate. The ASC system uses the same payment groups (APCs) as the OPPS.

Within each APC, the Centers for Medicare & Medicaid Services (CMS) packages integral items and services with the primary service. As under the OPPS, CMS pays separately for:

- corneal tissue acquisition,
- brachytherapy sources,
- certain radiology services, and
- many drugs.

In addition, ASCs can receive separate payments for implantable items that are eligible for pass-through payments under the OPPS. Pass-through payments are for specific, new technology items that are used in the delivery of services. The purpose of these payments is to help ensure beneficiaries' access to technologies that are too new to be well represented in the data that CMS uses to set OPPS rates.

Currently, CMS applies stringent criteria to determine which surgical procedures qualify for payment in ASCs. The criteria exclude procedures that are frequently performed in physician offices, exceed 90 minutes of operating room time or 4 hours of recovery room time, or pose a safety risk. CMS has loosened these rules and, in 2008, will begin paying for all procedures that do not pose a significant safety risk when performed in an ASC *and* do not require an overnight stay. CMS plans to update the list of approved procedures annually.

## Setting the payment rates

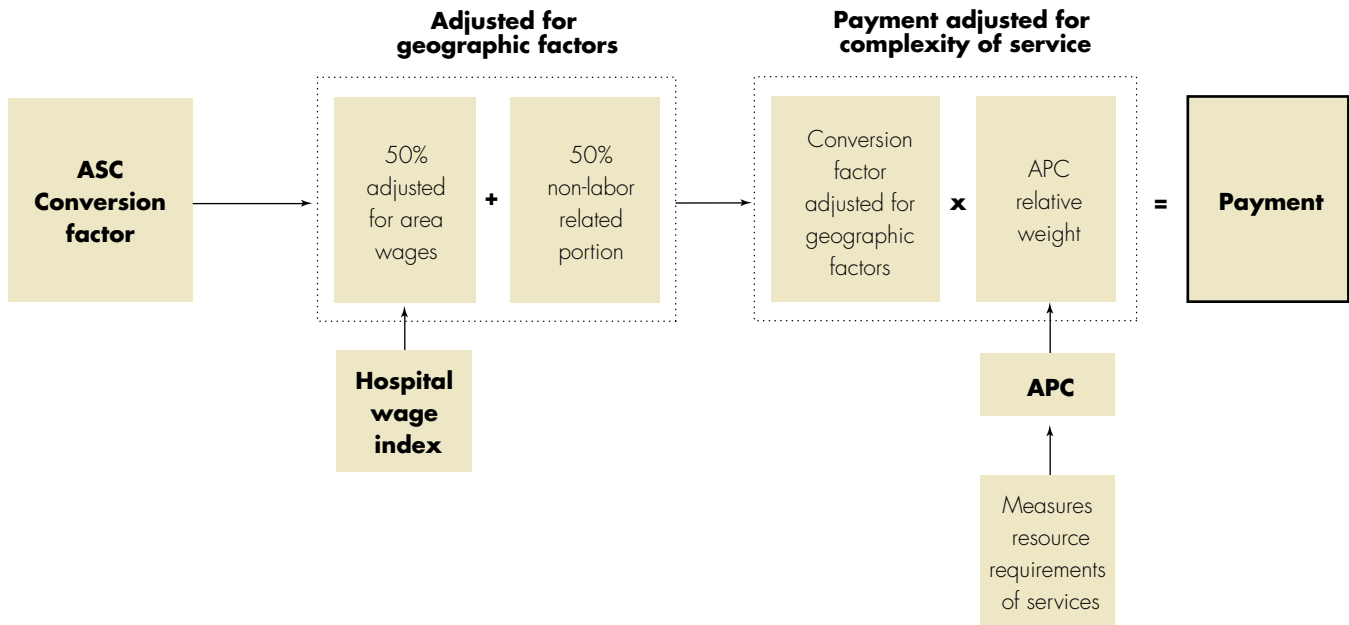
The relative weights for most procedures in the ASC payment system will be the same as the relative weights in the OPPS. These weights are based on the median cost of the services in that payment group. The ASC system will use a conversion factor (or average payment amount) to translate

*This document does not reflect proposed legislation or regulatory actions.*

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**Figure 1 Ambulatory surgical center prospective payment system**



Note: ASC (ambulatory surgical center), APC (ambulatory payment classification). The APC is the service classification system for the outpatient prospective payment system and ASC payment system. CMS uses methods different from the one shown here to set payment rates for new, office-based procedures; separately payable radiology services; separately payable drugs; and device-intensive procedures (where the cost of the device accounts for more than half of the total procedure payment). For example, payment for new, office-based procedures and separately payable radiology services equals the lower of the ASC rate (as determined by the method shown above) or the practice expense portion of the physician fee schedule payment rate that applies when the service is furnished in a physician's office (this amount covers the equipment, supplies, nonphysician staff, and indirect costs of a service).

the relative weights into dollar amounts. The ASC conversion factor will be based on a percentage of the OPPS conversion factor. CMS sets this percentage to ensure budget neutrality: Total payments under the new ASC payment system should equal total payments under the old ASC payment system. CMS estimates that the 2008 ASC conversion factor will be 65 percent of the OPPS conversion factor (\$41.40). The ASC rates will be less than the OPPS rates because of the budget neutrality requirement. This percentage will be finalized before January 2008.

CMS will use methods different from the one described above to set ASC payment rates for new, office-based procedures; separately payable radiology services; separately payable drugs; and device-intensive procedures. New, office-based procedures are services that CMS will begin paying for in ASCs in 2008 that

are performed in physician offices at least 50 percent of the time. Payment will be the lower of the ASC rate (based on the methodology described above) or the practice expense portion of the physician fee schedule payment rate that applies when the service is furnished in a physician's office (this amount covers the equipment, supplies, nonphysician staff, and indirect costs of a service). In applying this policy, CMS seeks to minimize financial incentives to shift services from physician offices to ASCs. CMS will apply the same policy to separately payable radiology services. When separately-payable drugs are provided in ASCs, CMS will pay the ASC the same amount it would pay under the OPPS.

Device-intensive procedures are defined as OPPS services where the device cost is packaged into the procedure payment and the cost of the device accounts for

more than half of the total payment (such as implanting a spine infusion pump). When these procedures are provided in ASCs, CMS will divide the payment for these services into a device portion (which includes the cost of the device) and a non-device portion. CMS will pay the ASC the same amount it would pay under the OPPS for the device portion of the service. However, CMS will pay the ASC less than the OPPS amount for the non-device portion of the service.

To account for geographic differences in input prices, CMS will adjust the labor portion of the ASC rate (50 percent) by the hospital wage index, beginning in 2008. CMS will not adjust the non-labor portion (the remaining 50 percent). The labor portion of the rate is based on a survey of ASCs conducted by the Government Accountability Office.

As in the OPPS, ASC payment rates are adjusted when multiple surgical

procedures are performed during the same operative session. In this case, the ASC receives full payment only for the procedure with the highest payment rate; payments for the other procedures are reduced to one-half of their usual rates.

CMS will update the ASC relative weights annually based on changes to the OPPS weights and the physician fee schedule practice expense amounts. CMS annually reviews and revises the OPPS APCs and their relative weights. The review considers changes in medical practice and technology, the addition of new services, new outpatient cost data, and other information. Beginning in 2010, the ASC conversion factor will be updated annually based on the consumer price index for all urban consumers (the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 eliminated the payment update for ASC services through 2009). ■