PAYMENT SYSTEM FACT SHEET SERIES

Ambulatory Surgical Center Fee Schedule

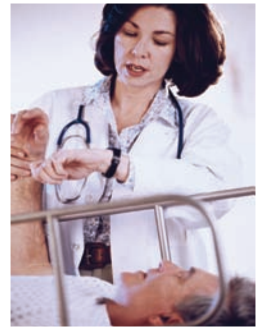
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

An **Ambulatory Surgical Center (ASC)** for Medicare purposes is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. ASCs must be certified as meeting the requirements for an ASC and must enter into a participating provider agreement with the Centers for Medicare & Medicaid Services (CMS). An ASC can either be:

- Independent (not part of a provider of services or any other facility); or
- Operated by a hospital (under the common ownership, licensure, or control of a hospital). To be covered as an ASC operated by a hospital, the facility:
  - Elects the coverage and is covered as such unless CMS determines that there is good cause to do otherwise;
  - Is a separately identifiable entity that is physically, administratively, and financially independent and distinct from other operations of the hospital, with costs for the ASC treated as a non-reimbursable cost center on the hospital's cost report;
  - Meets all requirements regarding health and safety and agrees to the assignment, coverage, and payment rules applied to independent ASCs; and
  - Is surveyed and approved as complying with the conditions for coverage for ASCs.

AMBULATORY SURGICAL CENTER PAYMENT

Beginning in calendar year (CY) 2008, in accordance with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS is implementing a revised ASC payment system using the Outpatient Prospective Payment System (OPPS) relative payment weights as a guide. The policies for the revised ASC payment system were made in the ASC final rule, which was published on August 2, 2007 and can be accessed at **http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1517f.pdf** on the CMS website. The ASC final rule greatly expands the types of procedures that are eligible for payment in the ASC setting and excludes from the ASC list of covered surgical procedures only those procedures that pose a significant safety risk to beneficiaries or are expected to require an overnight stay when furnished in an ASC. The November 2007 OPPS/ASC final rule with comment period provides the final CY 2008 revised ASC payment rates and lists all procedures in Addendum AA that qualify for payment under the revised ASC payment system in CY 2008 because they do not pose a significant safety risk when furnished in an ASC and do not require an overnight stay. The OPPS/ASC final rule can be accessed at **http://www.cms.hhs.gov/Hospitaloutpatientpps/downloads/cms1392fc.pdf** and **http://www.cms.hhs.gov/ASCPayment** on the CMS website.



Medicare makes a single payment to ASCs for covered services, which includes ASC facility services that are furnished in connection with a covered procedure. Examples of covered ASC facility services that are paid through the payment for covered surgical procedures include the following:

- Nursing services, services furnished by technical personnel, and other related services;
- Patient use of ASC facilities;
- Drugs and biologicals for which separate payment is not allowed under the OPPS, surgical dressings, supplies, splints, casts, appliances, and equipment;
- Administrative, recordkeeping, and housekeeping items and services;
- Blood, blood plasma, and platelets, with the exception of those to which the blood deductible applies;
- Materials for anesthesia;
- Intraocular lenses;
- Implantable devices, with the exception of those devices with pass-through status under the OPPS; and
- Radiology services for which payment is packaged under the OPPS.

Medicare also pays ASCs separately for covered ancillary services that are integral to a covered surgical procedure billed by the ASC, specifically certain services that are furnished immediately before, during, or immediately after the covered surgical procedure. Covered ancillary services include:

- Drugs and biologicals that are separately paid under the OPPS;

Examples of Items or Services Not Included in ASC Payments for Covered Surgical Procedures or Covered Ancillary Services

Items or Services Not Included	Who Receives Payment	Submit Bills to
Physicians' Services	Physician	Carrier or A/B Medicare Administrative Contractor (MAC)
Purchase or Rental of Non-Implantable Durable Medical Equipment (DME) to ASC Patients for Use in their Homes	Supplier (ASC can be a supplier of DME if it has a supplier number from the National Supplier Clearinghouse [NSC])	DME MAC
Non-Implantable Prosthetic Devices	Supplier (ASC can be a supplier of DME if it has a DME supplier number from the NSC)	DME MAC
Ambulance Services	Certified Ambulance Supplier	Carrier or A/B MAC
Leg, Arm, Back, and Neck Braces	Supplier	DME MAC
Artificial Legs, Arms, and Eyes	Supplier	DME MAC
Services Furnished by Independent Laboratory	Certified Laboratory (ASC can receive laboratory certification and a Clinical Laboratory Improvement Amendments number)	Carrier or A/B MAC
Facility Services for Surgical Procedures Not on ASC List (listed in Addendum EE of the November 2007 OPPS/ASC final rule)	Not covered by Medicare	Beneficiary is liable

- Radiology services that are separately paid under the OPPS;
- Brachytherapy sources;
- Implantable devices with OPPS pass-through status; and
- Corneal tissue acquisition.

Addendum BB of the November 2007 OPPS/ASC final rule lists those covered ancillary services that qualify for separate payment under the revised ASC payment system in CY 2008 when they are furnished integral to covered surgical procedures in ASCs.

Certain services may be furnished in ASCs and billed by the appropriate certified provider or supplier or, in certain cases, billed by the ASC facility itself and paid outside the ASC payments for covered surgical procedures or covered ancillary services. The chart above depicts examples of payment and billing for items or services that are not included in the ASC payments for covered surgical procedures or covered ancillary services.

The beneficiary coinsurance for ASC covered surgical procedures and covered ancillary services is 20 percent of the ASC procedure payment after the yearly Part B deductible has been met, with the exception of a beneficiary coinsurance of 25 percent of the ASC procedure payment for screening colonoscopies and screening flexible sigmoidoscopies.

HOW PAYMENT AMOUNTS ARE DETERMINED

Beginning in CY 2008, about 3,400 procedures are approved for ASC payment and categorized into one of several hundred payment groups. In the November 2007 OPPS/ASC final rule, the budget neutrality adjustment for CY 2008 is 65 percent of the OPPS payment rates for the same surgical procedures. The budget neutrality adjustment was established by taking into account the expected migration of surgical procedures among ASCs, physicians' offices, and hospital outpatient departments. The budget neutrality adjustment is used to calculate the CY 2008 ASC conversion factor by multiplying the budget neutrality adjustment by the CY 2008 OPPS conversion factor, resulting in Medicare expenditures for ASC services in CY 2008 that are budget neutral compared to estimated CY 2008 spending for those services in the absence of the revised payment system.

In accordance with the statute, through CY 2009, there will be a zero percent ASC update for inflation

and beginning in CY 2010, the ASC conversion factor will be updated by the Consumer Price Index for All Urban Consumers. The standard payment for most ASC covered surgical procedures is calculated as the product of the estimated ASC conversion factor and the ASC relative payment weight for each separately payable procedure. In the annual updates to the ASC payment system, CMS will set relative payment weights equal to OPPS weights and then scale the ASC weights in order to maintain budget neutrality in the payment system so that Medicare expenditures will approximate expenditures that would have occurred in the absence of the revised payment system. ASCs will be paid the lesser of the actual charge or the standard ASC payment rate. Payments for covered surgical procedures and certain covered ancillary services are then geographically adjusted using the Inpatient Prospective Payment System pre-reclassification wage index values, with a labor-related factor of 50 percent. Payments are also adjusted when multiple surgical procedures are furnished in the same encounter or when procedures are discontinued prior to their initiation or the administration of anesthesia.

Beginning in CY 2008, there will be a four-year transition period for implementation of the revised ASC payment system, with the exception of Healthcare Common Procedure Coding System codes newly payable in the ASC setting, as described below:

- **CY 2008**—Payment rates will consist of 25 percent of the CY 2008 revised ASC rate plus 75 percent of the CY 2007 ASC rate;
- **CY 2009**—Payment rates will consist of 50 percent of the CY 2008 revised ASC rate plus 50 percent of the CY 2007 ASC rate;
- **CY 2010**—Payment rates will consist of 75 percent of the CY 2008 revised ASC rate plus 25 percent of the CY 2007 ASC rate; and
- **Beginning in CY 2011**—Payment rates will be calculated according to policies of the revised payment system.

Modified payment methodologies will be used to establish ASC payment rates for new, office-based procedures, device-intensive procedures, separately payable radiology services, separately payable drugs and biologicals, and brachytherapy sources as follows:

- ASCs that furnish new, office-based procedures that are furnished in physicians' offices at least 50 percent of the time will be paid the lower of the ASC rate or the nonfacility practice expense relative value unit amount of the Medicare Physician Fee Schedule (MPFS);
- ASCs that furnish device-intensive procedures, which are ASC covered surgical procedures that, under the OPPS, are assigned to ambulatory payment classifications (APC) for which the estimated device cost is greater than 50 percent of the APC's median cost will be paid:
  - A device-related portion of the procedure, which is the same amount the device is paid under the OPPS; and
  - A service portion, which is calculated according to the standard ratesetting methodology using the ASC budget neutrality adjustment;
- ASCs that furnish separately payable radiology services will be paid the lower of the ASC rate or the technical component payment amount of the MPFS. Only ASCs may receive separate Medicare payment for the facility costs of covered ancillary radiology services in order to ensure that no duplicate payment is made. ASC payment for covered ancillary radiology services is not subject to the four-year transitional payment;
- ASCs that furnish separately payable drugs will be paid the same amount that is paid under the OPPS (for CY 2008, Average Sales Price plus five percent for) without application of the ASC budget neutrality adjustment; and
- ASCs will be paid for brachytherapy sources the same amount as the OPPS rates for the same sources or at Contractor-priced rates if prospective OPPS rates are not available. These payments are not adjusted for geographic wage differences and are not subject to the ASC budget neutrality adjustment.

Under the revised ASC payment system, ASCs continue to submit claims on the CMS-1500 that they use for billing under the existing ASC payment system, and their current Contractors will continue to process those claims.

To find additional information about ASCs and the ASC payment system, visit **http://www.cms.hhs.gov/center/asc.asp** and **http://www.cms.hhs.gov/ASCPayment** on the CMS website.

This fact sheet was prepared as a service to the public and is not intended to grant rights or impose obligations. This fact sheet may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

The Medicare Learning Network (MLN) is the brand name for official CMS educational products and information for Medicare fee-for-service providers. For additional information visit the Medicare Learning Network's web page at **http://www.cms.hhs.gov/MLNGenInfo** on the CMS website.

Medicare Contracting Reform (MCR) Update

In Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) Congress mandated that the Secretary of the Department of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the new Medicare Administrative Contractor (MAC) authority. This mandate is referred to as Medicare Contracting Reform. Medicare Contracting Reform is intended to improve Medicare's administrative services to beneficiaries and health care providers. All Medicare work performed by Fiscal Intermediaries and Carriers will be replaced by the new A/B MACs by 2011. Providers may access the most current MCR information to determine the impact of these changes and to view the list of current MACs for each jurisdiction at **http://www.cms.hhs.gov/MedicareContractingReform/** on the CMS website.

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