Medicare Learning Network

PAYMENT SYSTEM FACT SHEET SERIES

Ambulatory Surgical Center Fee Schedule

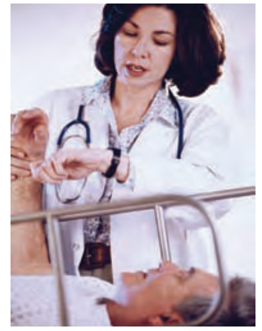
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

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 be either:

- 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

Effective January 1, 2008, in accordance with the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, CMS implemented 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 (CMS-1517-F), which was published in the ***Federal Register*** on August 2, 2007. The ASC final rule greatly expanded the types of procedures eligible for payment in the ASC setting and excluded from eligibility only those procedures that pose a significant safety risk to beneficiaries or are expected to require active medical monitoring at midnight when furnished in an ASC. The rule also provided for a four-year transition to the fully implemented revised ASC payment rates. The November 2007 OPPS/ASC final rule with comment period (CMS-1392-FC) provided the final calendar year (CY) 2008 ASC payment rates and listed in Addendum AA all surgical procedures that qualified for separate payment under the revised ASC payment system in CY 2008. The November 2008 OPPS/ASC final rule with comment period (CMS-1404-FC) provides the final CY 2009 ASC payment rates. The above-mentioned final rules can be accessed at **http://www.cms.hhs.gov/ASCPayment** on the CMS website.



Medicare makes a single payment to ASCs for covered surgical procedures, which includes ASC facility services that are furnished in connection with the 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 made 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;
- Radiology services that are separately paid under the OPPS;
- Brachytherapy sources;

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 Excluded from the ASC List (listed in Addendum EE to the OPPS/ASC final rule with comment period)	Not covered by Medicare	Beneficiary is liable

- Implantable devices with OPPS pass-through status; and
- Corneal tissue acquisition.

The covered ancillary services that qualify for payment under the revised ASC payment system in CY 2009 are displayed in Addendum BB to the OPPS/ASC final rule with comment period.

Certain services may be furnished in ASCs and billed by the appropriate certified provider or supplier. The chart above depicts examples of payment and billing for items or services that are not included in 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 Medicare ASC payment after the yearly Part B deductible has been met, with the exception of a beneficiary coinsurance of 25 percent of the ASC payment for screening colonoscopies and screening flexible sigmoidoscopies.

HOW PAYMENT AMOUNTS ARE DETERMINED

All procedures and services approved for ASC payment and categorized into one of the payment groups used in the hospital OPPS. As mandated by the MMA, the revised ASC payment system was implemented to be budget neutral for Medicare. As discussed in the November 2007 OPPS/ASC final rule with comment period, the ASC budget neutrality adjustment factor was 65 percent of the OPPS payment rates for the same surgical procedures and was used to calculate the CY 2008 ASC conversion factor.

In the annual updates to the ASC payment system, CMS sets relative payment weights equal to OPPS weights for the same services and then scales the ASC weights in order to maintain budget neutrality. For CY 2009, the ASC relative payment weights were scaled to eliminate any difference in the total payment weight between CY 2008 and CY 2009. The relative payment weights for CY 2009 were scaled according to the following method—holding ASC utilization and mix of services constant from CY 2007, CMS compared the total payment weight using the CY 2008 ASC relative payment weights under the 75/25 blend (of the CY 2007 payment rate and the revised ASC payment rate) with the total payment weight using the CY 2009 ASC relative payment weights under the 50/50 blend (of the CY 2007 ASC payment rates and the revised ASC payment rate) to take into account the changes in the OPPS relative payment weights between CY 2008 and CY 2009.

The ratio of the CY 2008 to CY 2009 total payment weight is the weight scaler applied to the CY 2009 relative payment weights. In addition, the conversion factor for CY 2009 was adjusted for budget neutrality by removing provider-level changes, most notably a change in wage index for the upcoming year.

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. ASCs are paid the lesser of the actual charge or the ASC payment rate. The standard payment for ASC covered surgical procedures is calculated as the product of the ASC conversion factor and the ASC relative payment weight for each separately payable procedure. There are alternate methodologies for calculating payments for covered ancillary radiology services, office-based procedures, drugs and biologicals, and device-intensive procedures. Payments for covered surgical procedures and certain covered ancillary services are 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.

CY 2009 is the second in the four-year transition period for implementation of the revised ASC payment rates. All procedures on the ASC list of covered surgical procedures for CY 2007 are subject to the transitional payment methodology. The payment rates during the transition period are a blend of the CY 2007 rate and the rate for the pertinent CY. The blended transitional rates are described below:

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

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

- Office-based procedures are procedures that are furnished in physicians' offices at least 50 percent of the time and that CMS classifies as "office-based." ASC payment is made at the lower of the ASC rate or the nonfacility practice expense (PE) relative value unit (RVU) amount of the Medicare Physician Fee Schedule (MPFS) for the relevant year.
- Device-intensive procedures are ASC covered surgical procedures that, under the OPPS, are assigned to ambulatory payment classifications (APC) for which the estimated device offset percentage is greater than 50 percent of the APC's median cost. Device-intensive procedures are 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 or transitional ratesetting methodology, as appropriate.
- Separately payable radiology services are paid the lower of the ASC rate or the technical component or nonfacility PE RVU (whichever applies) payment amount of the MPFS for the same year. Only ASCs may receive separate Medicare payment for the facility costs of covered ancillary radiology services.
- Separately payable drugs and biologicals are those for which separate payment is made under the OPPS. ASCs are paid the same amount that is paid under the OPPS.
- Brachytherapy sources are paid at the same amount as the OPPS rates if a prospective OPPS rate is available. Otherwise, ASCs are paid at contractor-priced rates. These payments are not adjusted for geographic wage differences.

Under the revised ASC payment system, ASCs continue to submit claims on the CMS-1500 claim form.

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.