Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash - The Medicare Billing Information for Rural Providers, Suppliers, and Physicians, which consists of charts that provide billing information for Rural Health Clinics, Federally Qualified Health Centers, Skilled Nursing Facilities, Home Health Agencies, and Critical Access Hospitals, is available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralChart.pdf on the CMS website.

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Revised Payment System for Ambulatory Surgical Centers (ASC) in Calendar Year (CY) 2008

Note: This article was updated on September 5, 2012, to reflect current Web addresses. This article was also revised on March 1, 2009 to delete Web addresses that no longer work. All other information remains the same.

Provider Types Affected

Ambulatory Surgical Centers (ASCs) billing Medicare contractors (carriers or Part A/B Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries.

Provider Action Needed

STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS), pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), is implementing significant revisions to the payment system for ASC services beginning with services rendered on and after January 1, 2008

CAUTION – What You Need to Know

On August 2, 2007, CMS issued a final rule that describes the revised ASC payment system. The revised ASC payment system provides a transition to the revised rates for currently covered ASC services from CY 2008 through CY 2010, during which time payments are based on a blend of the payment rates from the existing system and the revised payment rates calculated according to the methodology of the revised payment system. On November 27, 2007, CMS issued a combined OPPS/ASC final rule that includes updates to the ASC payment rates for CY 2008.

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GO – What You Need to Do

Be sure your billing personnel are aware of the new system and the coding requirements of the new system in order to assure prompt and accurate payment.

Overview

On August 2, 2007, CMS published a final rule, CMS-1517-F establishing the policies for the revised payment system for ASCs. This final rule was followed by a proposed rule, CMS-1392-P, that proposed an updated CY 2008 ASC conversion factor and payment rates, in coordination with the proposed hospital Outpatient Prospective Payment System (OPPS) update. The final rule implementing the OPPS and ASC updates was published on November 27, 2007.

The August 2, 2007 ASC final rule (CMS-1517-F) outlines the policies for the revised ASC payment system. As recommended by the November 2006 Government Accountability Office report on ASC payment, CMS used the OPPS relative payment weights as a basis for payment under the revised ASC payment system. The payment policies for the revised ASC payment system expand the types of procedures that are eligible for Medicare payment when performed in the ASC setting, limit ASC payments for procedures that are performed predominantly in physicians' offices to the amount that would be paid for the non-facility practice expense (PE) under the Medicare Physician Fee Schedule (MPFS), and allow for separate payment to ASCs for covered ancillary services that are provided integral to covered surgical procedures.

The November 27, 2007 OPPS/ASC final rule (CMS-1892-FC) provides updates to the CY 2008 ASC conversion factor and ASC payment rates.

There are currently about 4,800 ASCs enrolled in Medicare. Total Medicare expenditures for CY 2006 payments to ASCs are estimated at about $2.5 billion. Medicare ASC expenditures for CY 2008 are expected to be approximately $3 billion.

Background

Since 1982, Medicare has paid for certain surgical procedures, including cataract removal, lens replacement, and colonoscopies, when performed in freestanding or hospital-based ASCs. Under the previous ASC payment system, Medicare paid for more than 2,500 surgical procedures on the ASC approved list, based on a simple fee schedule comprised of nine unadjusted prospectively determined payment rates. The rates of the nine payment groups, prior to the "limitation on payments" adjustment, ranged from $333 to $1339. Provider payments included a separate adjustment for geographic wage variation, and Medicare made a separate payment to physicians for professional services. ASC payment rates were last rebased in March 1990 using cost, charge, and utilization data from a 1986 survey of ASC costs.

With the passage of the MMA, Congress required CMS to revise the ASC payment system no later than January 1, 2008. In August of 2006, CMS issued a proposed rule encompassing proposed changes to OPPS policies and updates to the CY 2007 OPPS and ASC payment rates and the revised payment methodology for ASCs for CY 2008 implementation. The CY 2007 OPPS and ASC provisions were finalized in a final rule published November 24, 2006, and ASC policies related to the revised payment system to be implemented CY 2008 were finalized in the August 2, 2007 final rule.

Final ASC Revised Payment System Policies

Expanded List of ASC Procedures:
In the August 2, 2007 ASC final rule (CMS-1517-F), Medicare revised its criteria for identifying surgical procedures eligible for inclusion on the list of covered ASC procedures. The revised criteria resulted in expanded beneficiary access to procedures in the ASC setting by allowing approximately 790 additional surgical procedures on the list for CY 2008. Under the revised criteria, Medicare excludes only those surgical procedures determined to pose a significant safety risk to beneficiaries or that are expected to require an overnight stay following the procedure from the list of covered surgical procedures.

Medicare continued its policy to define surgical procedures as those listed by the American Medical Association (AMA) within the surgical range of Current Procedural Terminology (CPT) codes. It also included within the scope of surgical procedures those services that are described by alphanumeric Healthcare Common Procedure Coding System (HCPCS) codes (Level II HCPCS codes) or Category III CPT codes that directly crosswalk or are clinically similar to procedures in the CPT surgical range.

In the CY 2008 OPPS/ASC final rule (CMS-1392-FC), CMS revised the lists of covered surgical procedures and covered ancillary services in response to public comments and in order to maintain consistency with revised OPPS policies. In

addition, based on review of the most recent utilization data, a number of surgical procedures newly added for payment in CY 2008 in the ASC final rule were designated as office-based procedures and, therefore, are subject to the "office-based" payment methodology. A complete list of ASC covered surgical procedures, along with payment rates and payment indicators, is published in Addendum AA to this rule, and is available on the CMS website at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html on the CMS website. Information related to ASC covered ancillary services is available in Addendum BB of the rule, also available on the CMS ASC payment website.

ASC Payment Rates Under the Revised System:

The revised ASC payment rates are based on the ambulatory payment classifications (APCs) used to group procedures under the OPPS. Per the MMA, the revised ASC payment system is budget neutral. That is, the payment rates are intended to ensure that Medicare expenditures under the revised payment methodology for ASCs in CY 2008 will approximate the expenditures that would have occurred in the absence of the revised ASC payment system.

To establish the budget neutrality adjustment for the revised ASC payment system, CMS took into account the expected migration of surgical procedures among ASCs, physicians' offices, and hospital outpatient departments (HOPDs). The methodology assumed that approximately 25 percent of the HOPD volume of new ASC surgical procedures will migrate from hospitals to ASCs during the first two years of implementation of the revised ASC payment system and that 15 percent of the volume of new ASC surgical procedures currently provided in physicians' offices will migrate to ASCs during the first four years of the revised ASC payment system.

The illustrative budget neutrality adjustment factor of 67 percent for CY 2008 included in the August 2, 2007 final rule, (CMS-1517-F) was based on those assumptions and estimated CY 2008 OPPS and MPFS rates and full CY 2005 utilization data. The final ASC budget neutrality adjustment factor of 65 percent is presented in the OPPS/ASC final rule (CMS-1392-FC). The final budget neutrality adjustment factor is somewhat lower than the illustrative adjustment presented in the August 2, 2007 ASC final rule due to changes in OPPS payment rates as a result of APC recalibration, including the expansion of the size of the OPPS payment bundles, as well as use of CY 2006 claims and utilization data. Based on the final budget neutrality adjustment factor (65 percent), the ASC conversion factor for CY 2008 is calculated as 0.65 x $63.694 (CY 2008 OPPS conversion factor) = $41.401.

The standard ASC payment for covered surgical procedures is calculated as the product of the ASC conversion factor and the ASC relative payment weight (set

based on the OPPS relative payment weight) for each separately payable procedure. Per Section 626 of the MMA, under the revised ASC payment system, contractors will pay ASCs 80 percent of the lesser of the actual charge for the services or the ASC payment rate. ASC payment rates for covered surgical procedures that are determined to be "office-based" and covered ancillary radiology procedures may not exceed the MPFS non-facility PE amounts for those services.

Payments to ASCs for covered surgical procedures and certain covered ancillary services are geographically adjusted using the pre-reclassification wage index that CMS uses to pay non-acute providers, with 50 percent as the labor-related factor.

Implementation and Updates:

There is a four year transition period for implementation of the revised payment rates for procedures on the CY 2007 ASC list of covered procedures. For those procedures, payment is based on a blend of the revised ASC payment rates and the current ASC rates. Thus, for CY 2008, the payment rates for procedures subject to the transition are comprised of a 25/75 blend, specifically 25 percent of the CY 2008 revised ASC rate plus 75 percent of the CY 2007 ASC rate; in CY 2009, the ratio will change to 50/50; and for CY 2010 it will be 75/25. Beginning in CY 2011, the revised ASC payment rates will be fully implemented so that payment for all services will be calculated according to the policies of the revised payment system. Covered surgical procedures and ancillary services for which ASC payment is new beginning CY 2008 are not subject to this blended transitional payment methodology.

In the annual updates to the ASC payment system, ASC relative payment weights will be set equal to the OPPS weights and will be scaled in order to maintain budget neutrality in the ASC payment system. Without scaling, changes in the OPPS relative payment weights for nonsurgical services could cause an increase or decrease in ASC expenditures due to differences between the mix of services provided by HOPDs and ASCs.

The statute requires a zero percent update to ASC payments through CY 2009. Beginning in 2010, the ASC conversion factor will be updated by the Consumer Price Index for All Urban Consumers (CPI-U).

ASC Payment for Device-Intensive Procedures:

A modified payment methodology is used to establish the ASC payment rates for device-intensive procedures, defined as ASC covered surgical procedures that, under the OPPS, are assigned to APCs for which the device cost is greater than 50 percent of the APC's median cost. Payment for the high cost devices is packaged into the associated procedure payments under the revised ASC system, as it is under the OPPS. Medicare pays the same amount for the device-related portion of the procedure cost under the revised ASC payment system as under the OPPS. However, payment for the service portion of the ASC rate is calculated

according to the standard ratesetting methodology, using the ASC budget neutrality adjustment. Therefore, the service portion of the ASC payment for a device-intensive procedure is about 65 percent of the corresponding OPPS service payment, just like the payment for other surgical procedures under the revised ASC payment system. The sum of the ASC device and service portions constitutes the complete ASC procedure payment. ASCs should not report separate charges for devices.

The same policy related to full credit and no cost implantable device replacement that applies under the OPPS applies under the revised ASC payment system. That is, when a replacement device is supplied to the ASC at no cost or with full credit by the manufacturer, Medicare ASC payment for the procedure to implant the device is reduced by the device portion of the ASC payment to account for the lower cost to the facility to furnish the procedure. Medicare provides the same amount of payment reduction based on the estimated device cost included in the ASC procedure payment that would apply under the OPPS for performance of those procedures under the same circumstances.

In the CY 2008 OPPS/ASC final rule (CMS-1392-FC), CMS implemented a policy to reduce the ASC payment by one half of the device offset amount for certain surgical procedures into which the device cost is packaged when an ASC receives a partial credit toward replacement of an implantable device. This partial payment reduction policy applies to certain covered surgical procedures in which the amount of the device credit is greater than or equal to 50 percent of the cost of the new replacement device being implanted. The ASC policy mirrors the policy under the OPPS for CY 2008. A special edition MLN Matters article, SE0732, provides details and billing guidance on the OPPS/ASC partial device credit policy and is available at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0732.pdf on the CMS website.

Payment for ASC Covered Ancillary Services:

Medicare pays separately for certain covered ancillary services that are provided integral to covered surgical procedures in ASCs. The ancillary services must be provided immediately before, during, or after a covered surgical procedure to be considered integral and thereby, eligible for separate payment. Medicare also provides separate payment to the ASC for drugs and devices that are eligible for pass-through payment under the OPPS.

In the OPPS/ASC final rule with comment (CMS-1392-FC), CMS revised the definitions of “radiology and certain other imaging services” and “outpatient prescription drugs” to exclude those ASC covered ancillary radiology services and covered ancillary drugs and biologicals from designation as “designated health services,” which are subject to physician self-referral prohibitions. Implanted brachytherapy sources qualify for inclusion in 42 C.F.R. §411.355(f) and, as such, also are excepted from the physician self-referral prohibition.

As described above, payment for covered ancillary radiology services is made to ASCs at the lesser of the ASC rate or the amount of the nonfacility PE under the MPFS. To ensure that no duplicate payment is made, only ASCs may receive separate payment for the technical component of the covered ancillary radiology services that are separately payable under the OPPS.

Under the revised ASC payment system, Medicare pays separately for all drugs and biologicals that are separately paid under the OPPS when they are provided integral to covered surgical procedures. Payment is equal to the OPPS payment rates, without application of the ASC budget neutrality adjustment. In addition, as in the OPPS, the ASC payment rates for these items are not adjusted for geographic wage differences.

Medicare makes separate payment at contractor-priced rates for devices that have pass-through status under the OPPS when the devices are an integral part of a covered surgical procedure. Medicare pays the same amount for brachytherapy sources under the revised ASC payment system as it pays hospitals under the OPPS if prospective rates are available. For the first six months of CY 2008, when OPPS payments for brachytherapy sources are cost-based, ASCs are paid for brachytherapy sources at contractor-priced rates.

There is no change to payment policy for corneal tissue acquisition. Payment for corneal tissue acquisition continues to be made at reasonable cost when corneal transplants are performed in ASCs.

No other providers or suppliers may bill for covered ancillary services provided in ASCs integral to covered surgical procedures. This policy ensures that packaged or separate payment is made to ASCs for all covered ancillary services integral to the performance of covered surgical procedures, thereby providing appropriate payment to ASCs for those services that are essential to the delivery of safe, high quality surgical care.

Physician Payment for Non-Covered ASC Procedures:

ASCs receive facility payments under the ASC payment system only for procedures included on the list of ASC covered procedures. They receive no facility payment for any other procedures. Prior to implementation of the revised ASC payment system on January 1, 2008, physicians were paid for their PE based on the facility PE relative value units (RVUs) for performing surgical procedures that were on the list of ASC covered surgical procedures. They were paid based on the non-facility PE, or technical component RVUs, for performing services that were not included on the list.

To make the payments to physicians who furnish noncovered procedures in ASCs more consistent with the policy under the OPPS, and in recognition that under the revised ASC payment system only procedures that have been determined to pose a significant safety risk or are expected to require an overnight stay are excluded

from the ASC list, beginning January 1, 2008, Medicare pays physicians at the facility PE payment amount, rather than the non-facility PE amount, for furnishing noncovered procedures in ASCs.

New and Revised Billing Procedures

Reporting Separately Payable Ancillary Services:
As described above, beginning January 1, 2008, Medicare makes separate payment to ASCs for certain ancillary items and services such as drugs and biologicals, brachytherapy sources, radiological procedures, and pass-through devices when they are provided integral to ASC covered surgical procedures. ASCs must report separately payable ancillary services with an accurate number of units in order for correct payment to be made. ASCs should be mindful of dosages of drugs and biologicals and the units included in the HCPCS code descriptors when reporting units. Inaccurate reporting of units for HCPCS codes may result in under- or overpayment.

For example, a typical dosage for the drug reported by HCPCS code J1260 (Injection, dolasetron mesylate, 10mg) is 100 mg. ASCs using 100 mg in the care of a patient will report a 100 mg dose of dolasetron mesylate as 10 units of HCPCS code J1260. Failure to report the correct number of units will result in under- or overpayment. In the case of J1260, if the ASC were to report only one unit for HCPCS code J1260, when it provided one 100 mg dose, it would receive only one-tenth of the Medicare payment for that drug.

Additionally, ASCs must bill separately for devices that have pass-through status under the OPPS when provided integral to covered surgical procedures in order to receive payment. ASCs should use the appropriate Level II HCPCS codes to report the devices. Only two devices currently have pass-through status under the OPPS: C1821 (Interspinous process distraction device (implantable)) and L8690 (Auditory osseointegrated device, includes all internal and external components). For these two devices only, ASCs should report the code for the device and its charge. The Medicare contractor determines the payment amount for each of the pass-through devices.

ASCs also need to report the number of units for brachytherapy sources that are provided integral to covered surgical procedures. The ASC must report and charge Medicare and the beneficiary coinsurance for all brachytherapy sources that are ordered by the physician for a specific beneficiary, acquired by the ASC, and implanted in the beneficiary in the ASC in accordance with high quality clinical care standards.

In the case where most, but not all, prescribed and acquired sources are implanted in the beneficiary, Medicare covers the relatively few brachytherapy sources that were ordered and acquired but not implanted due to specific clinical

consideration. These non-implanted sources may be billable to Medicare only under the following circumstances:

- The sources were specifically acquired by the ASC for the particular beneficiary according to a physician's prescription that was consistent with standard clinical practice and high quality brachytherapy treatment. The sources that were not implanted in that beneficiary were not implanted in any other patient;
- The sources that were not implanted were disposed of in accordance with all appropriate requirements for their handling; and
- The number of sources used in the care of the beneficiary but not implanted would not be expected to constitute more than a small fraction of the sources actually implanted in the beneficiary.

Reporting Charges for Separately Payable Procedures and Services:
Under the revised payment system, ASCs must report charges for all separately payable procedures and services in order to receive correct payment. Medicare contractors make payment based on the lower of 80 percent of actual charges for separately payable procedures and services, or the ASC payment rate. ASCs should not report separate line item HCPCS codes or charges for procedures, services, drugs, devices, or supplies that are packaged into payment for covered surgical procedures.

Because section 1833(a)(1) of the Social Security Act, as amended by section 626(c) of the MMA, requires ASCs to be paid the lesser of 80 percent of actual charges or the amount that would be paid by Medicare for each separately payable procedure and service, Medicare contractors will compare billed charges to the ASC payment rate at the line-item level. Therefore, it is important that ASCs incorporate charges for packaged services into the charges reported for the separately payable services with which they are provided. Facilities may not be paid appropriately if they unbundle charges and report those charges for packaged codes as separate line-item charges.

For example, the charge reported for a procedure should include not only the charges associated with the service such as operating room time and recovery room use, but also the charges associated with implantable devices, supplies and any other services used in the procedure and packaged into the payment rate. Unlike the ASC payment system in effect prior to January 1, 2008, the revised payment system packages device payment into the payment for the associated procedure (i.e., the device is not paid separately). If the ASC bills a procedure code for a procedure (whether it is 'device-intensive' or not) and fails to include charges for the device in establishing the single line item charge for the covered surgical procedure, 80 percent of the procedure charge may be lower than the Medicare payment rate for that procedure code,

which includes payment for devices and all packaged services and supplies. The contractor would make payment based on the provider's charges, possibly resulting in underpayment.

Following is a hypothetical example that illustrates the revised payment policy:

Correct Reporting

Example	HCPCS	Description	PI	Units	ASC-Reported Charge	Unadjusted Medicare Payment Rate*	Unadjusted Medicare Payment to Provider	Unadjusted Beneficiary Payment to Provider
Claim 1: Charges for Packaged Device Rolled Into Charges for Separately Payable Procedure	62361	Implant spine infusion pump	H8	1	$12,000	$10,000	$10,000 x .80 = $8,000	$10,000 x .20 = $2,000
Because the Medicare payment rate is less than the reported charges for CPT code 62361, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $10,000. In this case, the amount set by Medicare for all costs of the procedure is paid.								

* All payment rates are hypothetical.

Incorrect Reporting

Example	HCPCS	Description	PI	Units	ASC-Reported Charge	Unadjusted Medicare Payment Rate*	Unadjusted Medicare Payment to Provider	Unadjusted Beneficiary Payment to Provider
Claim 2: Charges for Packaged Device Reported on Different Line from Separately Payable Procedure	62361	Implant spine infusion pump	H8	1	$2,500	$10,000	$2,500 x .80 = $2,000	$2,500 x .20 = $500
	C1891	Infusion pump, non-programmable, permanent	N1	1	$9,500	N/A	N/A	N/A
Because the reported charges for CPT code 62361 are less than the Medicare payment rate, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $2,500. In this case, the ASC will not receive the amount set by Medicare for all costs of the procedure, due to the ASC's incorrect separate reporting of packaged charges.								

* All payment rates are hypothetical.

Billing Bilateral Procedures:

Bilateral procedures should be reported as a single unit on two separate lines or with "2" in the units field on one line, in order for both procedures to be paid. While use of the -50 modifier is not prohibited according to Medicare billing instructions, the modifier is not recognized for payment purposes and if used, may result in

incorrect payment to ASCs. The multiple procedure reduction of 50 percent will apply to all bilateral procedures subject to multiple procedure discounting.

The following provides a hypothetical example that illustrates this payment policy:

Correct Reporting								
Example	HCPCS	Description	PI	Units	ASC-Reported Charges	Unadjusted Medicare Payment Rate*	Unadjusted Medicare Payment* to Provider with Multiple Procedure Reduction	Unadjusted Beneficiary Payment* to Provider with Multiple Procedure Reduction
Claim 1: Bilateral Procedure Reported on Two Lines	15823	Revision of Upper Eyelid	A2	1	$1,000	$800	$800 x .80 = $640	$800 x .20 = $160
	15823	Revision of Upper Eyelid	A2	1	$1,000	$800	($800 x .50) x .80 = $320	($800 x .50) x .20 = $80
Because the provider reports the bilateral procedure on two separate lines, and because the multiple procedure reduction applies to 15823, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $1,200 for both procedures.								
Claim 2: Bilateral Procedure Reported on One Line with Two Units	15823	Revision of Upper Eyelid	A2	2	$2,000	$800 X 2	[$800 + ($800 x 0.50)] x .80 = $960	[$800 + ($800 x 0.50)] x .20 = $240
Because the provider reports the bilateral procedure using "2" in the units field, and because the multiple procedure reduction applies to 15823, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $1,200 for both procedures.								
Incorrect Reporting								
Claim 3: Bilateral Procedure Reported on One Line with Bilateral Modifier	15823 50	Revision of Upper Eyelid	A2	1	$2,000	$800	$800 x .80 = $640	$800 x .20 = $160
Because the provider reports the bilateral procedure using the bilateral modifier, the provider receives total unadjusted payment (from Medicare and the beneficiary) of $800 for only one of the procedures.								

* All payment rates are hypothetical.

Additional Information

For more information regarding this and other ASC issues, including a list of frequently asked questions and answers, CMS encourages you to use the ASC

webpage at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html on the CMS website.