



Ambulatory Surgical Center (ASC) Fee Schedule Script

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)

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/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



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

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 shown here gives 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.

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.

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.

To find additional information about the ASC payment system, see <http://www.cms.hhs.gov/ASCPayment> on the CMS Website.

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 review the article on this topic in its entirety, please visit <http://www.cms.hhs.gov/MLNProducts/downloads/AmbSurgCtrFeepymtftsht508.pdf> on the CMS Website.