Calendar Year (CY) 2008 Revised Ambulatory Surgical Center (ASC) Payment System
Questions and Answers

Payment Methodology

1. Why did CMS change the ASC payment system in CY 2008?

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required CMS to revise the ASC payment system no later than January 1, 2008.

2. How does CMS develop payment rates under the revised CY 2008 payment system?

The revised ASC payment system is based on the hospital outpatient prospective payment system (OPPS). The standard ASC payment for most ASC covered surgical procedures is calculated by multiplying the ASC conversion factor ($41.401 for CY 2008) by the ASC relative payment weight (set based on the OPPS relative payment weight) for each separately payable procedure. Per the MMA, contractors will pay ASCs based on the lesser of the actual charge or the standard ASC payment rate. Payment rates for surgical procedures that are commonly performed in physicians' offices and for the technical component of covered ancillary radiology procedures cannot exceed the Medicare physician fee schedule (MPFS) non-facility practice expense (PE) amount. Payment policies for drugs and biologicals and other covered ancillary services mirror the OPPS as well.

The complete lists of ASC covered surgical procedures and ASC covered ancillary services, the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustment for regional wage variations, the wage adjusted payment rates, and wage indices are available on the CMS web site at http://cms.hhs.gov/ascpayment/. See also instructions in the Medicare Claims Processing Manual, Chapter 14, Sections 30 and 40.

3. Why did CMS base the revised ASC payment system on the OPPS?

The Government Accountability Office (GAO) studied ASC costs and found that the relativity of costs among ASC procedures was comparable to their relativity of costs in hospital outpatient departments. According to the GAO report, released in November 2006, ASCs experience greater efficiencies in furnishing surgical services than hospital outpatient departments, resulting in surgical procedures being less costly when performed in that setting of care. In the CY 2008 OPPS/ASC final rule, CMS estimates that ASCs should be paid about 65 percent of the OPPS payment rates for the same surgical procedures.

4. What does CMS mean when it says the revised ASC payment system is budget neutral?

Per the MMA, in CY 2008 Medicare expenditures under the revised ASC payment system must approximate the expenditures that would have occurred in the absence of the revised ASC payment system.

5. Does CMS adjust ASC payment under the revised ASC payment system for geographic differences in wages based on where the ASC is located?

Starting in 2008, CMS adjusts for geographic differences in wages using the Core Based Statistical Area (CBSA) geographic locality definitions established in 2003 by the Office of Management and Budget (OMB). These geographic locality definitions replace the Metropolitan Statistical Area (MSA) definitions that were used as the basis for ASC wage adjustments prior to January 1, 2008. Adopting the CBSA geographic definitions is consistent with wage index policy under other CMS payment systems. The ASC payment system is one of the last to adopt the CBSA definitions. The wage index assigned to a specific ASC reflects the geographic labor area where an ASC is physically located. ASCs may not appeal for wage index reclassification as this process is specific to hospitals.

Additionally, starting in 2008 the wage index values used to adjust payment for procedures under the revised ASC payment system are based on the 2008 pre-reclassification wage index that CMS uses to pay almost all non-acute providers. These wage indices do not include acute inpatient specific adjustments, including reclassification, floor provisions, or occupational mix adjustments. The pre-reclassification wage index by CBSA is available on CMS's website at: http://www.cms.hhs.gov/ASCPayment/04f_CMS-1392-FC(ASC).asp#TopOfPage.

Payment rates for each ASC covered surgical procedure and ancillary service before adjustment for regional wage variations and wage indices are available on the CMS web site at http://www.cms.hhs.gov/ascpayment/. See the Medicare Claims Processing Manual, Chapter 14, Section 40.2 for more information.

6. Under the revised ASC payment system, has CMS changed the labor-related share percentage used to adjust payment for variations in wages due to geographic differences?

Beginning in 2008, CMS has adopted 50 percent as the labor-related share percentage used to adjust payment under the revised ASC system. Under the previous ASC payment system, CMS applied the wage index to 34.45 percent of the payment for a procedure. In our August 2, 2007 ASC final rule, we finalized a labor-related share of 50 percent because we believe that this percentage provides a more accurate representation of the present day labor-related proportion of ASC costs than the previous percentage. Therefore, under the revised ASC payment system, 50 percent of payments for all services subject to adjustment for variation in wage differences is adjusted for geographic area differences.

7. Are all services/items that receive payment under the revised ASC system adjusted for geographic differences in wage?

No, not all services/items that receive payment under the revised ASC payment system are adjusted for geographic differences in wage. Services for which payment is exempt from geographic wage adjustment are: brachytherapy sources; drugs and devices eligible for pass-through payment under the OPPS; corneal tissue acquisition; separately payable drugs and biologicals; unclassified drugs and biologicals; and the payment adjustment for New Technology Intraocular Lenses (NTIOLS).

8. Will CMS adjust ASC payment for terminated procedures under the revised ASC payment system?

As under the pre-2008 ASC payment system, contractors pay 50 percent of the revised ASC payment rate if a surgical procedure is terminated due to the onset of medical complications after the patient has been prepared for surgery and taken to the operating room but before anesthesia has been induced (ASCs should report such an occurrence using modifier -73). Contractors make full payment of the facility rate if a medical complication arises which causes the procedure to be terminated after inducement of anesthesia or initiation of the procedure (ASCs should use modifier -74).

Beginning January 1, 2008, contractors also apply a 50 percent payment reduction for discontinued radiology procedures and other procedures that do not require anesthesia (ASCs should use modifier -52 to report such an occurrence).

ASC surgical procedures billed with modifier -73 or -52 shall not be subjected to further pricing reductions (i.e., the multiple procedure price reduction rules will not apply). For more information, see the Medicare Claims Processing Manual, Chapter 14, Section 40.4.

9. Will CMS adjust ASC payment for multiple procedures performed during the same operative session under the revised ASC payment system?

When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, contractors pay 100 percent of the highest paying surgical procedures on the claim, plus 50 percent of the applicable wage adjusted payment rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session. In determining the ranking of procedures for application of the multiple procedure reduction, contractors shall use the lower of the billed charge or the ASC payment amount. The multiple procedure reduction is the last pricing routine applied to applicable ASC procedure codes.

ASC surgical procedures billed with modifier -73 or -52 shall not be subjected to further pricing reductions (i.e., the multiple procedure price reduction rules will not apply). The OPPS/ASC final rule for the relevant payment year specifies whether or not a surgical procedure is subject to multiple procedure discounting for that year.

Addendum AA of the CY 2008 OPPS/ASC final rule, available at http://www.cms.hhs.gov/ASCPayment/04f_CMS-1392-FC(ASC).asp#TopOfPage, indicates whether or not a surgical procedure is subject to multiple procedure discounting for CY 2008. For more information, see the Medicare Claims Processing Manual, Chapter 14, Section 40.5.

10. Will CMS provide any time for ASCs to adjust to the changes of the revised ASC payment system?

Due to the significant changes in payment under the revised ASC payment system, CMS is providing a four-year transition to the fully implemented revised ASC rates. Accordingly, CY 2008 payment for surgical procedures on the CY 2007 list of covered surgical procedures will be made based on a blend of 75 percent of the CY 2007 rate and 25 percent of the revised ASC rate. For CY 2009, the blend will be 50/50, and for CY 2010 the blend will be made up of 25 percent of the CY 2007 rate and 75 percent of the revised ASC rate. The revised ASC rates will be fully implemented in CY 2011. Payment for covered surgical procedures added for ASC payment in CY 2008 or later and payment for covered ancillary services that are not paid separately under the existing ASC payment system will not be subject to a transition.

11. Will the revised ASC payment system be updated every year? Can ASCs and other interested parties have a say in what happens?

Updates will be made to the revised ASC payment system annually in conjunction with the OPPS rulemaking cycle. In these annual updates, CMS will set ASC relative payment weights equal to the OPPS weights and then scale the ASC weights 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 in the mix of services provided by hospital outpatient departments and ASCs). ASCs and other interested parties will have the opportunity to submit public comment letters following the release of the OPPS/ASC proposed rule, issued each year around July 1 for the following year. The OPPS/ASC final rule is published around November 1 for the following year.

In addition to the annual update provided in the final rule, CMS updates the lists of payable drugs, brachytherapy sources, pass-through devices, and other services on a quarterly basis. The quarterly updates are available on the CMS web site at http://cms.hhs.gov/ascpayment/.

12. Will there be an annual update to the revised ASC payment system for inflation?

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

13. CMS' policy under the revised ASC payment system is to pay the lesser of the MPFS non-facility practice expensive (PE) amount or the ASC rate according to the standard revised payment methodology for covered ancillary radiology services and office-based surgical procedures added to the ASC list in CY 2008 or later. Does that mean that in some years a procedure or service could be paid at the MPFS rate and in other years it would be paid at the revised ASC rate? Why did CMS implement this policy?

Yes, that is what may happen. Because the final CMS policy calls for ASC payments to be the lesser of the ASC rate based on the OPPS relative payment weight or the MPFS nonfacility PE amount, in one year an office-based surgical procedure or covered ancillary radiology service may be paid at the nonfacility PE amount and in the next year, the ASC rate may be the lower of the two rates and payment would be made for that year at the ASC rate. Each year, all of the payment rates will be updated, and we will make the comparisons between the MPFS and revised ASC rates for each proposed and final rule as part of the annual updates to the system. In the proposed rule, we will publish a complete list of the procedures that are proposed as payable in ASCs, along with the proposed payment indicator (that signals the proposed methodology for providing payment for each service) and rate for each.

This policy ensures that there is no payment incentive for services that are currently performed frequently in the physician office setting to move to the more resource-intensive ASC setting.

14. Do the Medicare deductible and standard coinsurance apply for colorectal cancer screening services under the revised ASC payment system?

As under the pre-2008 payment system, there is no deductible and a 25 percent coinsurance is applied to colorectal cancer screening colonoscopies performed in the ASC setting (HCPCS codes G0105 and G0121). Additionally, effective January 1, 2008, there is no deductible and a 25 percent coinsurance is applied to screening flexible sigmoidoscopy services (HCPCS code G0104).

Covered Items and Services

15. What procedures and services are payable when performed in the ASC setting under the revised ASC payment system?

Under the ASC payment system, Medicare will make facility payments to ASCs only for the specific ASC covered surgical procedures on the ASC list of covered surgical procedures published in Addendum AA of the OPPS/ASC final rule for the relevant payment year. Addendum AA to the CY 2008 OPPS/ASC final rule is available at http://www.cms.hhs.gov/ASCPayment/04f_CMS-1392-FC(ASC).asp#TopOfPage. In addition, Medicare will make separate payment to ASCs for certain covered ancillary services that are provided integral to a covered ASC surgical procedure. Covered ancillary services include the following:

- Brachytherapy sources;
- Certain implantable items with pass-through status under the OPPS;
- Certain items and services that CMS designates as contractor-priced, including, but not limited to, the procurement of corneal tissue;
- Certain drugs and biologicals for which separate payment is allowed under the OPPS; and
- Certain radiology services for which separate payment is allowed under the OPPS.

Other non-ASC services such as physician services and prosthetic devices may be covered and separately billed under Medicare Part B. See the Medicare Claims Processing Manual, Chapter 14, Section 10.2 for more information.

16. What ASC services are included in the ASC payment for a covered surgical procedure under the revised ASC payment system?

ASC services for which payment is included in the ASC payment for a covered surgical procedure include, but are not limited to, the following:

- Nursing, technician, and related services;
- Use of the facility where the surgical procedures are performed;
- Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver;
- Drugs and biologicals for which separate payment is not allowed under the OPPS;
- Medical and surgical supplies not on pass-through status under the OPPS;
- Equipment;
- Surgical dressings;
- Implanted prosthetic devices, including intraocular lenses, and related accessories and supplies not on pass-through status under the OPPS;
- Implanted DME and related accessories not on pass-through under the OPPS;
- Splints and casts and related devices;

- Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedure;
- Administrative, recordkeeping, and housekeeping items and services;
- Materials, including supplies and equipment for the administration and monitoring of anesthesia; and
- Supervision of the services of an anesthetist by the operating surgeon.

Under the revised ASC payment system, the above items and services fall within the scope of ASC facility services, and payment for them is packaged into the ASC payment for the covered surgical procedure. See the Medicare Claims Processing Manual, Chapter 14, Section 10.2 for more information.

17. How does CMS determine which procedures are payable in the ASC setting under the revised payment system?

CMS' final policy 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 ASCs. CMS defines "surgical procedure" as any procedure reported by the CPT codes in the surgical range as defined by CPT codes between 10000 and 69999, the same definition used under the pre-2008 ASC payment system. CMS also includes within the scope of ASC covered surgical procedures those surgical procedures that are described by HCPCS alphanumeric codes (Level II HCPCS codes) or Category III CPT codes that directly crosswalk or are clinically similar to procedures in the CPT surgical range that are on the ASC list.

CMS evaluates the risk to beneficiary safety and the expected need for an overnight stay for all surgical procedures to assess procedures for addition to the ASC list of covered surgical procedures. CMS determined that procedures included on the inpatient list used for the OPPS should be excluded from the ASC list of covered surgical procedures. Those procedures are excluded because CMS believes that any procedure identified as unsafe for performance in hospital outpatient departments poses too great a risk to beneficiaries to be performed safely in ASCs. Procedures that are reported by CPT unlisted codes are also excluded because it is not possible to evaluate the safety of procedures for which there is no descriptive code.

18. How does CMS determine which surgical procedures can be performed safely in an ASC under the revised ASC payment system?

First, CMS excludes from consideration for payment under the revised ASC payment system all surgical procedures that are included on the inpatient list used in the OPPS and those that only can be reported by using one of the CPT unlisted codes. CMS determined that procedures that were deemed to be unsafe for performance in any but the hospital inpatient setting were not safe for performance in ASCs and that procedures for which there is no specifically descriptive code could not be evaluated for safety risk and so should be excluded from consideration.

For the remaining CPT codes in the surgical range and Level II HCPCS codes and Category III CPT codes that crosswalk to that range, CMS uses many of the existing clinical criteria under the pre-2008 ASC payment system to evaluate the safety risk associated with each procedure. These clinical criteria include those procedures that generally result in extensive blood loss; require major or prolonged invasion of body cavities; directly involve major blood vessels; are emergent or life-threatening in nature; or commonly require systemic thrombolytic therapy.

19. The ASC final regulation for the revised ASC payment system says that CMS excludes from coverage procedures that are expected to require an overnight stay. What does that mean? If a patient has to stay overnight for a procedure that is on the list of covered ASC surgical procedures, does that mean the claim for the procedure will be denied?

CMS excludes any surgical procedure for which standard medical practice dictates that the beneficiary typically would be expected to require active medical monitoring and care at midnight following the procedure (i.e., an overnight stay). CMS does not certify ASCs to provide overnight care to Medicare beneficiaries and determined that any surgical procedure for which the post-operative period of active medical monitoring is expected to extend to midnight is not appropriate for Medicare beneficiaries in ASCs. Thus, "overnight stay," for purposes of ASCs, means the patient recovery generally requires active monitoring by qualified medical personnel, regardless of whether it is provided in the ASC, beyond 11:59 P.M. of the day on which the surgical procedure was performed.

This does not mean that a beneficiary cannot remain in an ASC beyond midnight or that ASCs only should perform procedures on "typical" patients that would not be expected to require an overnight stay. CMS' use of "overnight stay" only applies to determinations about procedures for inclusion on the ASC list and should not be used to dictate care in individual cases.

20. Where can I find a list of procedures and ancillary services that are payable in the ASC setting and their associated payment rates under the revised ASC payment system?

ASC covered surgical procedures are published in Addendum AA of the OPPS/ASC final rule for the relevant payment year and covered ancillary services are in Addendum BB. Both Addenda AA and BB for CY 2008 are available at http://www.cms.hhs.gov/ASCPayment/04f_CMS-1392-FC(ASC).asp#TopOfPage. Quarterly updates will be available at http://cms.hhs.gov/ascpayment/.

The ASC list of covered procedures merely indicates procedures which are covered and paid if performed in the ASC setting. It does not require the covered surgical procedures to be performed only in ASCs. The decision regarding the most appropriate care setting for a given surgical procedure is made by the physician based on the beneficiary's individual clinical needs and preferences. Also, all general coverage rules requiring that any procedure be reasonable and necessary for the beneficiary are applicable to ASC services in the same manner as all other covered services. See the Medicare Claims Processing Manual, Chapter 14, Section 20.1.

21. What happens under the revised ASC payment system when an ASC provides a surgical procedure that is not on the ASC list of covered surgical procedures?

Medicare will make no payment for facility services to ASCs or physicians for procedures or services that are performed in ASCs but that are excluded from the list of covered ASC surgical procedures or that are not covered ancillary services. Physicians will receive payment for all surgical and nonsurgical services furnished in ASCs based on the facility PE RVUs and excluding the technical component payment, if applicable, consistent with physician payment for hospital outpatient department services.

Consistent with the current OPPS payment policy that prohibits facility payments to the hospital for noncovered services (such as those surgical procedures on the OPPS inpatient list) and makes the beneficiary liable for those charges, beneficiaries are responsible for the ASC charges for noncovered services furnished to them in ASCs.

Physician Services

22. How will physicians be paid for the services they provide in ASCs when the revised ASC payment system is implemented?

Physicians who furnish services in ASCs may bill for and receive separate payment under Part B. Physicians' services include the services of anesthesiologists administering or supervising the administration of anesthesia to beneficiaries in ASCs and the beneficiaries' recovery from the anesthesia. The term physicians' services also includes any routine pre-or post- operative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, and other services which the individual physician usually includes in the fee for a given surgical procedure. Payment will be made under the MPFS based on the facility PE relative value units (RVUs), as it always has been.

23. Can physicians be paid for their services if performing procedures that are noncovered in the ASC setting under the revised ASC payment system?

Under the revised ASC payment system, if physicians perform surgical procedures that are not included on the ASC list of covered surgical procedures, CMS will pay physicians under the MPFS for those ASC noncovered procedures based on the lower facility PE RVU amount. Prior to CY 2008, if physicians furnished noncovered surgical procedures in ASCs, they were paid for their services under the MPFS based on the higher nonfacility PE RVUs.

Payment to physicians based on the lower facility PE rate is consistent with CMS' policy to allow payment to ASCs for all surgical procedures except those that it has determined are inappropriate for Medicare beneficiaries in ASCs because they pose a significant safety risk to beneficiaries or are expected to require an overnight stay following the procedure. This policy is also consistent with physician payment for services furnished in a hospital outpatient department setting. CMS does not expect this to have a

significant effect on physicians or beneficiaries because few, if any, of the excluded procedures likely will be performed in ASCs under the revised payment system.

If a physician performs a surgical procedure to implant an item of durable medical equipment in a surgical procedure that is not on the list of ASC covered surgical procedures, the physician bills the contractor for his or her professional services for performance of the surgical procedure and for the implanted device, coding the ASC as the place of service (POS code 24) on the bill. The physician is paid based on the facility PE RVUs for the surgical procedure and based on the DMEPOS fee schedule for the implanted device, when appropriate, and the beneficiary is liable for the other facility charges related to the surgical procedure. See the Medicare Claims Processing Manual, Chapter 14, Section 10.4.

24. Are radiology and other imaging services and outpatient prescription drugs provided in the ASC subject to the physician self-referral law under the revised ASC payment system?

No. Effective January 1, 2008, CMS changed the definitions of "radiology and certain other imaging services" and "outpatient prescription drugs" so that these services could be provided in ASCs by physicians who have an ownership interest in the ASC. The revised definitions also allow ASCs to bill Medicare for these separately payable, covered ancillary services when they are rendered to Medicare beneficiaries who had been referred by a physician with an ownership or investment interest in the ASC.

Devices

23. Prior to implementation of the revised ASC payment system, ASCs received separate payment for implantable devices. How will CMS pay for implantable devices under the revised system?

CMS uses a modified payment methodology to establish the ASC payment rates for procedures that are designated as "device-intensive." Device-intensive procedures are specified ASC covered surgical procedures that, under the OPPS, are assigned to certain device-dependent ambulatory payment classification groups (APCs, the payment groups used under the OPPS). Device-dependent APCs are groups of procedures that require the insertion or implantation of expensive devices. Payment for the high cost devices is packaged into the procedure payments under the OPPS. For the device-dependent APCs, CMS develops estimates of the "device offset percentage," the proportion of the procedures' costs that are attributable to the cost of the device. Under the revised ASC payment system, CMS identifies the covered surgical procedures for which the device offset percentage of the APC to which they are assigned under the OPPS is greater than 50 percent of the APC's median cost and designates those surgical procedures as device-intensive. CMS pays the same amount for the device-related portion of the procedure under the revised ASC payment system as under the OPPS. However, payment for the service portion of the ASC rate will be adjusted by the ASC conversion factor.

For example: If the OPPS payment for a device-intensive procedure is $7,000 and the device offset percentage is 75 percent, the device portion is about $5,250. The remaining $1,750 is the service portion of the procedure, the nondevice cost that the facility incurs when the device is implanted. Under the revised ASC payment system, CMS will pay the same amount for the device portion of the procedure as under the OPPS but will adjust the service portion, just as will occur for other OPPS surgical procedures when ASCs are paid for performance of these procedures. Thus, the ASC rate will be calculated by adjusting the OPPS service portion by the ASC conversion factor and that will be added to the full device portion of the OPPS rate to establish the full ASC payment rate for the procedure.

Because payment for procedures is based on the OPPS, which packages payment for implantable devices in the payment for the surgical procedures to implant them, ASCs will no longer bill separately under the Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) fee schedule for any implantable prosthetic devices.

24. Are procedures involving implantable devices (including device-intensive procedures) subject to wage adjustment when performed in the ASC?

Procedure payments into which payment for devices is packaged, including those for device-intensive procedures, are subject to the adjustment for geographic differences in wage. Because the labor-related share is 50 percent under the revised ASC payment system, the local wage index adjustment is applied to 50 percent of the national payment rate for the procedure involving the device. Payment rates for each covered surgical procedure before adjustment for regional wage variations, the wage adjusted payment rates, and wage indices are available on the CMS web site at http://www.cms.hhs.gov/ascpayment/.

25. Under the revised ASC payment system, do ASCs receive separate payment for devices that are paid as pass-through devices under the OPPS?

Pass-through status under the OPPS is granted to new implantable devices that meet explicit OPPS criteria, including demonstrated substantial clinical improvement for patients. Under the OPPS, devices with pass-through status are paid separately for two to three years at hospital charges adjusted to cost. CMS provides separate payment to ASCs at contractor-priced rates for devices that are included in device categories with pass-through status under the OPPS when the devices are an integral part of a covered surgical procedure. Payment for these devices is not subject to the wage adjustment, while payment for procedures used to implant pass-through devices is subject to the wage adjustment.

There can be situations where contractors must reduce the approved ASC payment amount for a specifically identified procedure when provided in conjunction with a specific device with OPPS pass-through status. This occurs when the payment for the procedure in which the device is implanted already includes the cost of a different, predecessor device that can be implanted through the same procedure and, therefore, the procedure payment reduction is intended to prevent contractors from paying twice for the

device. This reduction would be applicable only when services described by specific pairs of device and procedure codes are provided on the same day by the same provider. Code pairs subject to this policy are updated on a quarterly basis when a new pass-through device is approved under the OPPS. There are no code pairs to which this policy applies as of January 2008. CMS informs contractors of the code pairs and the percent reduction taken from the procedure payment rate through a "look-up" table on the ASC website at **{** HYPERLINK "http://www.cms.hhs.gov/ASCPayment/" **}**. See the Medicare Claims Processing Manual, Chapter 14, Section 40.7.

26. How should ASCs bill for packaged implantable devices under the revised ASC payment system? How should ASCs bill for separately payable devices with pass-through status under the OPPS?

ASCs should not report separate line item HCPCS codes or charges for devices and other services or items that are packaged into payment for covered surgical procedures and therefore not paid separately.

ASCs will bill separately for devices that have pass-through status under the OPPS when provided integral to covered surgical procedures and will be paid separately under the revised ASC payment system. ASCs should use the appropriate Level II HCPCS codes to report the devices. Only two devices have pass-through status under the OPPS as of January 2008: 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 will determine the payment amount for each of the pass-through devices.

27. Under the revised ASC payment system, CMS implemented a new policy for instances in which ASCs receive full credit for a replacement device, or receive the replacement device at no cost. How should these cases be billed?

The same policy related to full credit and no cost implantable device replacement that applies to the OPPS will apply to ASC payments. 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 will be 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. The beneficiary coinsurance will be adjusted to reflect the reduced payment amount.

ASCs should report the occurrence of a no cost or full credit device to CMS by reporting the –FB modifier on the line with the procedure code in which the no cost or full credit device is used when the device is on the list of specified devices to which this policy applies. Remember that payment for devices is typically packaged into payment for the device implantation procedure, and ASCs should not report packaged devices as a separate line item on the claim. The lists of affected devices, covered ASC surgical

procedures, and reduction amounts are located at http://www.cms.hhs.gov/HospitalOutpatientPPS/ on the CMS website.

28. Does CMS reduce payment under the revised ASC payment system for instances in which ASCs receive partial credit for a replacement device? How should these cases be billed? What if the ASC does not know if or how much credit they will receive from the manufacturer at the time the replacement device is implanted in the patient?

CMS reduces payment to ASCs for instances in which manufacturers provide ASCs with partial credit for replacement devices due to warranty, recall, or field action. ASCs should report the occurrence of a partial credit device to CMS by reporting the –FC modifier on the line with the procedure code for all cases in which the device being implanted is on the list of creditable devices; the procedure code in which the device is used is on the list of covered ASC surgical procedures to which this policy applies; and the ASC received a credit of 50 percent or more of the estimated cost of the new replacement device. The lists of devices, ASC procedures, and reduction amounts are available at http://cms.hhs.gov/HospitalOutpatientPPS/ on the CMS website. Remember that ASCs are required to report the –FC modifier with the code for the device implantation procedure and not with the code for the device (payment for devices is typically packaged into payment for the device implantation procedure, and ASCs should not report packaged devices as a separate line item on the claim). The beneficiary coinsurance will be adjusted to reflect the reduced payment amount.

Because ASCs may not know the amount of credit the manufacturer will provide for the replacement device at the time of implantation, ASCs will have the option of either: (1) submitting the claim for the device replacement procedure to their Medicare contractor after the procedure's performance but prior to manufacturer acknowledgement of credit for a replacement device, and subsequently contacting the contractor regarding a claims adjustment once the credit determination is made; or (2) holding the claim for the device replacement procedure until a determination is made by the manufacturer on the partial credit and submitting the claim with the FC modifier appended to the implantation procedure code if the partial credit is 50 percent or more of the cost of the replacement device. If choosing the first billing option, to request a claim adjustment once the credit determination is made, ASCs should keep in mind that the initial Medicare payment for the procedure involving the replacement device is conditional and subject to adjustment.

29. Now that the ASC payment system is based on the OPPS payment system, do the procedure-to-device edits and device-to-procedure edits apply to ASCs billing under the revised ASC payment system?

The OPPS procedure-to-device edits and device-to-procedure edits do not apply to ASCs. ASCs are instructed not to report as a separate line item HCPCS codes or charges for devices and other services or items that are packaged into payment for covered surgical procedures and therefore not paid separately.

Covered Ancillary Services

30. How will CMS pay for drugs and biologicals under the revised ASC payment system?

ASCs will receive separate payment at the OPPS rate for drugs and biologicals that receive separate payment under the OPPS when they are provided integral to covered ASC surgical procedures. Under the OPPS for CY 2008, separate payment is made for drugs and biologicals with mean per day costs greater than $60, while payment for drugs and biologicals with mean per day costs less than or equal to $60 is packaged into the payment for the covered procedure with which they are performed. In CY 2008, OPPS separate payment for most drugs and biologicals is made at the rate of ASP (average sales price) plus 5 percent, and ASCs will receive that same payment rate. Drugs and biologicals for which product-specific HCPCS codes do not exist and are billed by ASCs using code C9399 (unclassified drug or biological) are also contractor-priced at 95 percent of the average wholesale price. See the Medicare Claims Processing Manual, Chapter 14, Section 40.

31. How should ASCs bill for separately payable drugs and biologicals under the revised ASC payment system?

ASCs must report the HCPCS codes and units for each drug and biological used in the care of the beneficiary and integral to a covered surgical procedure.

32. How will CMS pay for brachytherapy sources under the revised ASC payment system?

Separate payment will be made for brachytherapy sources provided integral to covered ASC surgical procedures. Medicare will pay the same amount for the 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 will be paid for the sources at contractor-priced rates.

33. How should ASCs report and charge brachytherapy sources under the revised ASC payment system?

ASCs must report the HCPCS codes and number of units for the brachytherapy sources acquired by the ASC and implanted in beneficiaries integral to covered surgical procedures.

34. What happens, under the revised ASC payment system, in cases where most, but not all, of the brachytherapy sources prescribed and acquired are implanted in the beneficiary?

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

35. Do implanted brachytherapy sources qualify for the physician referral exception for implants furnished by an ASC?

Yes, CMS is interpreting 42 C.F.R. § 411.355(f) to include implanted brachytherapy sources.

36. How will CMS pay for radiology and other imaging services under the revised ASC payment system?

Medicare will make separate payment to ASCs for radiology and other imaging services that are separately paid under the OPPS and are provided integral to a covered ASC surgical procedure. The amount of payment to the ASC for the services will be the lesser of the ASC rate calculated according to the standard methodology or the non-facility PE amount under the MPFS.

37. If an ASC is enrolled as an Independent Diagnostic Testing Facility (IDTF), how should it bill for radiology services that are necessary for the surgical procedures being performed?

Under the revised ASC payment system, only the ASC may bill for radiology services that are provided integral to a covered surgical procedure. The IDTF may not bill for services that are provided by the ASC.

38. What are the requirements for reporting the –TC modifier under the revised ASC payment system?

ASCs are required to report the -TC modifier when billing for facility charges associated with HCPCS codes that have both a technical (-TC) component and a professional component (e.g., radiology services) under the MPFS. ASCs may access their local Medicare contractors' websites for additional information regarding the HCPCS codes that must be billed with the -TC modifier.

39. Did CMS change the payment policy for corneal tissue acquisition under the revised ASC payment system?

No, the payment policy for corneal tissue acquisition under the revised ASC payment system is the same as it is under the current (CY 2007) ASC payment system. The contractor will pay the ASC for corneal tissue acquisition based on acquisition cost or invoice.

40. Did CMS change the payment policy for new technology intraocular lenses (NTIOLs) under the revised ASC payment system?

No, Medicare's payment policy for NTIOLs is the same under the revised ASC payment system as it is under the CY 2007 ASC payment system. The contractors will make the same $50 payment adjustments for NTIOLs. The payment adjustment is subject to beneficiary coinsurance but not to wage index adjustment. Payment for intraocular

lenses that are not categorized as NTIOLs is included in the Medicare payment for the associated surgical procedure.

The list of NTIOLs assigned to currently active categories is available at http://www.cms.hhs.gov/ASCPayment/08_NTIOLs.asp#TopOfPage.

41. Can other providers or suppliers bill for covered ancillary services provided integral to covered ASC surgical procedures under the revised ASC payment system?

No. The ASC must bill for all services provided and it may bill only for those separately payable covered ancillary services listed in Addendum BB to the OPPS/ASC final rule that are provided integral to a covered surgical procedure listed in Addendum AA of that same rule. Both Addendum AA and Addendum BB of the CY 2008 OPPS/ASC final rule are available at http://www.cms.hhs.gov/ASCPayment/04f_CMS-1392-FC(ASC).asp#TopOfPage.

42. Do ASCs have to bill covered ancillary items and services, such as pass-through devices, brachytherapy sources, separately payable drugs and biologicals, and radiology procedures on the same claim as the related ASC surgical procedure(s) under the revised ASC payment system?

ASC should bill covered ancillary items and services, such as pass-through devices, brachytherapy sources, separately payable drugs and biologicals, and radiology procedures on the same claim as the related ASC surgical procedure(s). If an ASC bills for an ancillary service(s) separately (i.e., not on the same claim as the related surgical procedure) or a claim is split so that the ancillary service and related ASC surgical service(s) are on separate claims, the contractors will check claims history to determine if there is an approved surgical procedure for the same beneficiary, same provider, and same date. If there is no approved ASC surgical procedure on the same claim or in the history for the same date, the ancillary service(s) shall be returned as unprocessable. See the Medicare Claims Processing Manual, Chapter 14, Section 40.

Revised Billing Procedures

43. How will ASCs bill for their services under the revised ASC payment system beginning in CY 2008?

Effective for dates of service on or after January 1, 2008, fiscal intermediaries will no longer process claims on TOB 83X for ASCs. All ASC providers (including Indian Health Service providers) must submit their claims via the 837P electronic transaction or CMS-1500 to the designated carrier (see the Medicare Claims Processing Manual, Chapter 4, Sections 120 and 180.1 for more information).

Beginning January 1, 2008, ASCs no longer are required to include the SG modifier on facility claims in Medicare. The contractors shall assign TOS code "F" to codes billed by specialty 49 for Place of Service 24 (see the Medicare Claims Processing Manual, Chapter 14, Section 50).

On September 19, 2007, CMS issued detailed billing instructions in a MLN Matters article (SE0742) on how to correctly report services in order to receive accurate payment. Under the revised payment system, ASCs will continue to report HCPCS codes for covered surgical procedures and also will be required to report HCPCS codes for covered ancillary services in order to receive separate payment for them.

44. How should ASCs report charges for separately payable procedures and services under the revised ASC payment system? Why is it important to report specific charges for separately payable procedures and services only?

Under the revised payment system, ASCs must report charges for all separately payable procedures and services in order to receive correct payment. Medicare contractors will make payment based on the lower 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 and therefore not paid separately.

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 single charge reported for a device-intensive 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 the implantable device. Unlike the current ASC payment system, 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 device-intensive procedure and fails to include charges for the device in establishing the single line item charge for the covered surgical procedure, the procedure charge may be lower than the Medicare payment rate for that procedure code, which includes payment for the device. The contractor would make payment based on the provider's charges, possibly resulting in underpayment. See the MLN Matters article SE0742, available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf for billing examples illustrating this revised payment policy.

45. How should ASCs report bilateral procedures under the revised ASC payment system?

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 specifically prohibited according to CMS billing instructions, the modifier will not be recognized for payment purposes and 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. See the MLN Matters article SE0742, available at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0742.pdf for billing examples illustrating this revised payment policy.