AMBULATORY SURGICAL CENTER
PAYMENT SYSTEM

Learn about these Ambulatory Surgical Center (ASC) Payment System topics:

- ASC definition
- ASC payment
- Payment rates
- ASC Payment System updates
- Ambulatory Surgical Center Quality Reporting (ASCQR) Program
- Resources

ASC Definition

An ASC is a distinct entity that operates exclusively to furnish outpatient surgical services to patients who do not require hospitalization, and are typically discharged less than 24 hours following admission. Medicare ASC patients should not need active medical monitoring at midnight on the day of the procedure.

The Centers for Medicare & Medicaid Services (CMS) recognizes Medicare participating ASCs as those that meet certification requirements and enter a legal agreement with them according to 42 Code of Federal Regulations (CFR) § 416 Subpart B (General Conditions and Requirements) to get Medicare payment.
An ASC can be:

- Independent (not part of a provider of services or any other facility)
- Operated by a hospital (under the common ownership, licensure, or control of a hospital), if it meets all the following conditions:
  - Be a separately identifiable entity, separately certified and enrolled in Medicare with a supplier approval and agreement distinct from the hospital’s Medicare provider agreement
  - Be physically, administratively, and financially independent and distinct from other hospital operations
  - Treat ASC costs as a non-reimbursable cost center on the hospital’s cost report
  - Agree to the same assignment, coverage, and payment rules applied to independent ASCs
  - Be surveyed, approved, and comply with the ASC conditions for coverage in 42 CFR § 416 Subpart C

A hospital-operated ASC is not the same as a provider-based outpatient surgery hospital department, that is, an ASC cannot be provider-based to a hospital. A provider-based outpatient hospital department, including an outpatient surgery department:

- May be on or off-campus
- Is an integral part of the hospital, subject to hospital conditions of participation
- Is not separately Medicare-enrolled or Medicare-certified or subject to ASC coverage conditions

Each ASC must abide by the quality and safety regulations, known as the Conditions for Coverage (CfCs). The CfCs are divided into conditions, and each condition has several standards. In general, the CfCs contain requirements for ASCs related to:

- Governance
- Medical staffing
- Compliance with State licensure
- Safe surgical procedures
- Infection prevention and control
- Pharmaceutical service
- Patient assessment and discharge
- Medical records
- Emergency preparedness
- Quality Assessment and Performance Improvement
- Patient Rights
- Laboratory and Radiologic safety
- Nursing
- ASC environment, including fire safety
ASC Payment

CMS implemented a revised ASC Payment System effective January 1, 2008.

The revised ASC Payment System expanded the eligible types of procedures in the ASC setting and excluded procedures that pose a significant patient safety risk or require active medical monitoring at midnight on the day of the procedure. The Final Rule implementing the revised ASC payment system also implemented a 4-year payment transition for existing ASC covered procedures.

ASCs get a single Medicare payment for covered surgical procedures, including ASC facility services furnished with the covered procedure. Examples of covered ASC facility services are:

- Nursing services, technical personnel furnished services, and other related services
- Drugs and biologicals (when Medicare makes no Outpatient Prospective Payment System [OPPS] separate payment), surgical dressings, supplies, splints, casts, appliances, and equipment
- Administrative, recordkeeping, and housekeeping items and services
- Blood, blood plasma, and platelets, except when the blood deductible applies
- Materials, including supplies and equipment for administering and monitoring anesthesia
- Intraocular lenses
- Implantable devices, except devices with OPPS pass-through status
- OPPS-packaged radiology services

For calendar year (CY) 2020, CMS added to the ASC list of covered surgical procedures. Refer to the 2020 Final Rule for newly added ASC covered procedures.

Medicare pays ASCs separately for covered ancillary services integral to a covered surgical procedure, such as certain services furnished immediately before, during, or after the procedure. Covered ancillary services include:

- Certain drugs and biologicals
- Radiology services integral to the surgical procedure
- Brachytherapy sources
- Implantable pass-through status devices
- Corneal tissue acquisition

Certified providers or suppliers may furnish and bill for other services in an ASC that are not considered ASC services.
Table 1 gives payment and billing examples of items or services that are not ASC services.

**Table 1. Items or Services Not Included in Payment for ASC Services**

<table>
<thead>
<tr>
<th>Items or Services Not Included</th>
<th>Who Gets Payment</th>
<th>Where to Submit Bills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians’ services (including surgical procedures excluded from ASC payment)</td>
<td>Physician</td>
<td>Medicare Administrative Contractor (MAC)</td>
</tr>
<tr>
<td>Non-implantable Durable Medical Equipment (DME) purchase or rental for home use</td>
<td>DME supplier</td>
<td>Durable Medical Equipment Medicare Administrative Contractor (DME MAC)</td>
</tr>
<tr>
<td>Non-implantable prosthetic devices</td>
<td>DME supplier</td>
<td>DME MAC</td>
</tr>
<tr>
<td>Ambulance services</td>
<td>Certified ambulance supplier</td>
<td>MAC</td>
</tr>
<tr>
<td>Leg, arm, back, and neck braces</td>
<td>DME supplier</td>
<td>DME MAC</td>
</tr>
<tr>
<td>Artificial legs, arms, and eyes</td>
<td>DME supplier</td>
<td>DME MAC</td>
</tr>
<tr>
<td>Independent laboratory services</td>
<td>Certified laboratory (ASCs can apply for and participate as a Clinical Laboratory Improvement Act [CLIA] laboratory)</td>
<td>MAC</td>
</tr>
<tr>
<td>Surgical procedures excluded from ASC list</td>
<td>Not covered by Medicare</td>
<td>Patient may be liable</td>
</tr>
<tr>
<td>(listed in the OPPS/ASC Final Rule Addendum E)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The ASC patient coinsurance is 20 percent of the Medicare ASC payment after meeting the yearly Part B deductible. The Affordable Care Act waives the coinsurance and deductible for certain Medicare preventive services.
Payment Rates

CMS updates the ASC Payment System annually using relative payment weights equal to OPPS relative payment weights for the same services, and then scales the ASC weights to maintain budget neutrality from year to year. CMS scales ASC relative payment weights to eliminate differences in the total payment weight between the current and upcoming CY by:

- Holding ASC use and mix of services constant from the most recent available full year claims data
- Comparing the covered ASC surgical procedures and separately payable ancillary services total payment weight (using the current CY’s ASC relative payment weights) to the total payment weight using the applicable upcoming CY OPPS relative payment weights

The ratio of the current CY to the upcoming CY total payment weight is the **weight scalar**. CMS applies it to the upcoming CY relative payment weights to maintain budget neutrality.

CMS annually adjusts the ASC **conversion factor** (CF) for budget neutrality by removing the effects of changes in wage index values for the upcoming year compared to the current year and makes a productivity adjustment. The productivity adjustment reduces the ASC Payment System annual update factor.

In the past, without another update factor, CMS updated the ASC CF using the Consumer Price Index for All Urban (CPI-U) Consumers. However, beginning CY 2019 through 2023, CMS updates the ASC Payment System using the hospital market basket update.

CMS is finalizing an update to the ASC rates for CY 2020 using the hospital market basket rate equal to 2.6 percent for ASCs that meet quality reporting requirements. CMS based this change on the projected hospital market basket increase of 3.0 percent minus a 0.4 percentage point adjustment for multi-factor productivity (MFP). This change helps promote site-neutrality between hospitals and ASCs and encourages moving services from the hospital setting to the lower cost ASC setting.

ASCs get the lesser of the actual charge or the ASC payment rate for each procedure or service. CMS sets the standard ASC covered surgical procedures payment rate using the ASC CF and the ASC relative payment weight product for each separately payable procedure or service.

CMS establishes alternate payment methods for office-based procedures, device-intensive procedures, covered ancillary radiology services, and drugs and biologicals.

CMS makes a geographic payment adjustment for covered surgical procedures and certain covered ancillary services using the pre-floor and pre-reclassified hospital wage index values, with a labor-related factor of 50 percent. CMS makes an additional adjustment when the ASC furnishes multiple surgical procedures in the same encounter or when ASC personnel discontinue procedures prior to their initiation or the administration of anesthesia.
Table 2 outlines alternate methods to establish payment rates for some surgical procedures and ancillary services.

### Table 2. Alternate Payment Rate Methods

<table>
<thead>
<tr>
<th>Surgical Procedure/Ancillary Service</th>
<th>Payment Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office-based procedures in physicians’ offices at least 50 percent of the time that CMS classifies “office-based”</td>
<td>Paid at the lower of the ASC rate or the non-facility practice expense (PE) relative value unit (RVU) amount of the Medicare Physician Fee Schedule (PFS) for the relevant year.</td>
</tr>
<tr>
<td>Device-intensive procedures (ASC-covered surgical procedures when the estimated device offset percentage is greater than 30 percent of the HCPCS code’s mean cost)</td>
<td>Paid with the device-related portion of the procedure (Medicare pays an ASC and OPPS the same amount) and a non device-related portion (calculated according to the standard rate setting method).</td>
</tr>
<tr>
<td>Separately payable covered ancillary radiology services facility costs</td>
<td>Paid at the lower of the ASC rate or the technical component or non-facility PE RVU amount of the Medicare PFS for the same year (whichever applies).</td>
</tr>
<tr>
<td>Separately payable OPPS drugs and biologicals (except non-opioid pain management drugs that function as a supply when used in a surgical procedure)</td>
<td>Paid at the same amount as OPPS.</td>
</tr>
<tr>
<td>Non-opioid pain management drugs that function as surgical supplies, like Exparel, when furnished in the ASC setting</td>
<td>Average Sales Price (ASP) plus 6 percent.</td>
</tr>
<tr>
<td>Brachytherapy sources</td>
<td>Paid at the same amount as OPPS rates if a prospective OPPS rate is available. Otherwise, Medicare pays at contractor-priced rates. There is no payment adjustment for geographic wage differences.</td>
</tr>
<tr>
<td>Low-volume device-intensive procedures</td>
<td>Paid at the ASC rate (including device-intensive adjustments) not to exceed the OPPS payment rate for the procedure.</td>
</tr>
</tbody>
</table>

ASCs should submit claims on the CMS-1500 claim form.

## ASC Payment System Updates

Refer to the [Hospital Outpatient Regulations and Notices](https://www.cms.gov) page on the CMS website for the calendar year OPPS/ASC Final Rule, which explains final ASC payment policies, the ASC covered procedures list and associated payment rates, and information related to quarter addenda updates to the ASC payment system.
ASCQR Program

The ASCQR Program is a pay-for-reporting quality program for ASCs. The ASCQR Program requires ASCs to meet quality reporting requirements or get a 2.0 percentage point reduction in their annual fee schedule update.

Visit the ASC Quality Reporting or the QualityNet webpages for more information about ASCQR Program requirements.

Resources

Table 3. ASC Payment System Resources

<table>
<thead>
<tr>
<th>Resource</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASC Center</td>
<td>CMS.gov/Center/Provider-Type/Ambulatory-Surgical-Centers-ASC-Center</td>
</tr>
<tr>
<td>ASC Payment Rates, Coding, and Billing</td>
<td>CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment</td>
</tr>
<tr>
<td>Embedded Hyperlink</td>
<td>Complete URL</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>42 Code of Federal Regulations (CFR) § 416 Subpart B</td>
<td><a href="https://www.ecfr.gov/cgi-bin/text-idx?SID=5c153934c52d43aa28fb1e2a66e4749d&amp;m">https://www.ecfr.gov/cgi-bin/text-idx?SID=5c153934c52d43aa28fb1e2a66e4749d&amp;m</a></td>
</tr>
<tr>
<td></td>
<td>c=true&amp;node=pt42.3.416&amp;rgn=div5%20-%20sp42.3.416.b#se42.3.416_125</td>
</tr>
<tr>
<td>42 CFR § 416 Subpart C</td>
<td><a href="https://www.ecfr.gov/cgi-bin/text-idx?SID=ed3bb76df8e82ace30efafb1add3ca6a&amp;mc=true&amp;node=pt42.3.416&amp;rgn=div5#sp42.3.416.c">https://www.ecfr.gov/cgi-bin/text-idx?SID=ed3bb76df8e82ace30efafb1add3ca6a&amp;mc=true&amp;node=pt42.3.416&amp;rgn=div5#sp42.3.416.c</a></td>
</tr>
<tr>
<td>Deductible</td>
<td><a href="https://www.medicare.gov/your-medicare-costs">https://www.medicare.gov/your-medicare-costs</a></td>
</tr>
<tr>
<td>Hospital Outpatient Regulations and Notices</td>
<td><a href="https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices">https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices</a></td>
</tr>
<tr>
<td>QualityNet</td>
<td><a href="https://www.qualitynet.org/asc/ascqr">https://www.qualitynet.org/asc/ascqr</a></td>
</tr>
</tbody>
</table>

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