AMBULATORY SURGICAL CENTERS PAYMENT SYSTEM

*payment***basics**

Revised: October 2009

Since 1982, Medicare has covered surgical procedures provided in freestanding or hospital-based ambulatory surgical centers (ASCs). ASCs are distinct facilities that furnish ambulatory surgery; the most common procedures are cataract removal and lens replacement, colonoscopy, and other eye procedures. According to the Centers for Medicare & Medicaid Services (CMS), Medicare payments to ASCs were $3.1 billion in 2008, including both program spending and beneficiary cost sharing.

In January 2008, Medicare began paying for facility services provided in ASCs—such as nursing, recovery care, anesthetics, drugs, and other supplies—using a payment system based on the hospital outpatient prospective payment system (OPPS). (Medicare pays for the related physician services—surgery and anesthesia—under the physician fee schedule.) In contrast to the old ASC payment system, which had only nine procedure groups, the new ASC system has several hundred procedure groups. Like the OPPS, the new ASC payment system sets payments for individual services using a set of relative weights, a conversion factor (or average payment amount), and adjustments for geographic differences in input prices. The new ASC system is being phased in over four years.

Defining the products that Medicare buys

The unit of payment in the ASC payment system is the individual surgical procedure. Each of the approximately 3,400 procedures approved for payment in an ASC is classified into an ambulatory payment classification (APC) group on the basis of clinical and cost similarity. All services within an APC have the same payment rate. The ASC system uses the same payment groups (APCs) as the OPPS.

Within each APC, CMS packages most ancillary items and services with the primary service. CMS pays separately for certain ancillary services when they are integral to surgical procedures:

- corneal tissue acquisition,
- brachytherapy sources,
- certain radiology services, and
- many drugs.

In addition, ASCs can receive separate payments for implantable items that are eligible for pass-through payments under the OPPS. Pass-through payments are for specific, new technology items that are used in the delivery of services. The purpose of these payments is to help ensure beneficiaries' access to technologies that are too new to be well represented in the data that CMS uses to set OPPS rates.

In 2008, CMS substantially expanded the list of services that qualify for facility payment in ASCs. Medicare began paying for all procedures that do not pose a significant safety risk when performed in an ASC *and* do not require an overnight stay. CMS updates the list of approved procedures annually. Previously, CMS applied more stringent criteria to determine which surgical procedures would receive payment in ASCs.

Setting the payment rates

The relative weights for most procedures in the ASC payment system are based on the relative weights in the OPPS. These weights are based on the median cost of the services in that payment group. The ASC system uses a conversion factor (or average payment amount) to translate the relative weights into dollar amounts. The ASC conversion factor is based on a percentage of the OPPS conversion factor. CMS sets this percentage to ensure budget

This document does not reflect proposed legislation or regulatory actions.

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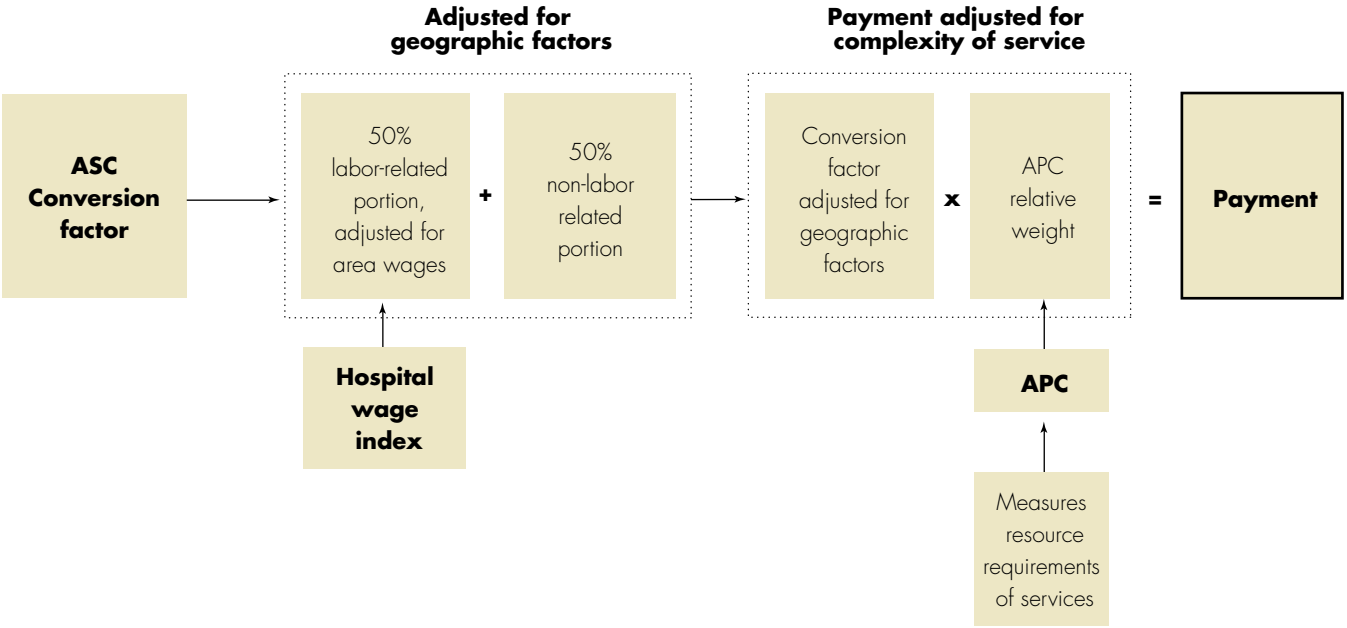
Figure 1 Ambulatory surgical center prospective payment system



Note: ASC (ambulatory surgical center), APC (ambulatory payment classification). The APC is the service classification system for the outpatient prospective payment system and ASC payment system. CMS uses methods different from the one shown here to set payment rates for new, office-based procedures; separately payable radiology services; separately payable drugs; and device-intensive procedures (where the cost of the device accounts for more than half of the total procedure payment). For example, payment for new, office-based procedures and separately payable radiology services equals the lower of the ASC rate (as determined by the method shown above) or the practice expense portion of the physician fee schedule payment rate that applies when the service is furnished in a physician's office (this amount covers the equipment, supplies, nonphysician staff, and indirect costs of a service).

neutrality: Total payments under the new ASC payment system should equal total payments under the old ASC payment system. The 2009 ASC conversion factor is 62.7 percent of the OPPS conversion factor ($41.39). The ASC rates are less than the OPPS rates because of the budget neutrality requirement.

CMS uses methods different from the one described above to set ASC payment rates for new, office-based procedures; separately payable radiology services; separately payable drugs; and device-intensive procedures. New, office-based procedures are services that CMS began paying for in ASCs in 2008 that are performed in physician offices at least 50 percent of the time. Payment is the lower of the ASC rate (based on the methodology described above) or the practice expense portion of the physician fee schedule rate that applies when the service is furnished in a physician's office (this amount covers the equipment, supplies, nonphysician staff, and indirect costs of a service). In capping ASC rates at physician fee schedule rates, CMS seeks to minimize financial incentives to shift services from physician offices to ASCs. CMS applies the same policy to separately payable radiology services. When separately-payable drugs are provided in ASCs, CMS pays ASCs the same amount it pays under the OPPS.

Device-intensive procedures are defined as OPPS services where the device cost is packaged into the procedure payment *and* the cost of the device accounts for more than half of the total payment (such as a spine infusion pump). When these procedures are provided in ASCs, CMS divides the payment for these services into a device portion (which includes the cost of the device) and a non-device portion.

CMS pays the ASC the same amount it would pay under the OPPS for the device portion of the service but pays 62.7 percent of the OPPS amount for the non-device portion of the service.

To account for geographic differences in input prices, CMS adjusts the labor portion of the ASC rate (50 percent) by the hospital wage index. CMS does not adjust the non-labor portion (the remaining 50 percent). The labor portion of the rate is based on a survey of ASCs conducted by the Government Accountability Office.

As in the OPPS, ASC payment rates are adjusted when multiple surgical procedures are performed during the same operative session. In this case, the ASC receives full payment only for the procedure with the highest payment rate; payments for the other procedures are reduced to one-half of their usual rates.

CMS updates the ASC relative weights annually based on changes to the OPPS procedure groups and relative weights and the physician fee schedule practice expense amounts. CMS annually reviews and revises the OPPS procedure groups and their weights. The review considers changes in medical practice and technology, the addition of new services, new outpatient cost data, and other information.

Because the OPPS relative weights usually change each year by a small amount, CMS adjusts the new weights so that projected program spending based on the current mix of services does not change. However, the mix of services in ASCs differs from that of the OPPS. Therefore, using the new OPPS relative weights could increase or decrease total ASC spending. To ensure that ASC spending does not change as a result of the new weights, CMS adjusts each ASC relative weight by the same factor. This factor in 2009 is 0.975; in other words, each ASC weight is reduced by 2.5 percent.

Beginning in 2010, the ASC conversion factor will be updated annually based on the consumer price index for all urban consumers (the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 eliminated the payment update for ASC services through 2009). ■