Medicare Reimbursement Changes for ASCs

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Coding professionals who work for ambulatory surgery centers (ASCs) should be aware of payment changes effective in 2007 and 2008. The changes seek to coordinate ASC payments with hospital outpatient departments at a rate intended to maintain neutrality between site-of-service choices for patients.

The 2007 ASC Rule

The 2007 rule includes 21 new codes on the ASC list and a provision for a 25 percent copayment for screening colonoscopies (HCPCS codes G0105 and G0121).[1] Other ASC procedures require a 20 percent copayment by the beneficiary. The Centers for Medicare and Medicaid Services (CMS) also implemented the Deficit Reduction Act provision that limits ASC procedures to the lesser of the outpatient prospective payment system rate or the ASC group payment. The code lists for the final rule are available on the CMS Web site. The requested procedures added to the ASC list for 2007 are shown in the table [below]. The most recent ASC list with associated groups and weights is available at www.cms.hhs.gov/ASCPayment/01_Overview.asp.

In addition to the 2007 changes, more ASC reimbursement reform is expected. Look for a separate final rule this spring to revise ASC payments in 2008 and beyond. In accordance with section 626 of the Medicare Prescription Drug Improvement and Modernization Act of 2003, CMS has proposed a new reimbursement system to be implemented January 1 of next year and fully operational as of January 1, 2009.[2] The Ambulatory Surgical Center Payment Modernization Act (HR 4042 and S. 1884) also provides a legislative backdrop for establishing a new ASC payment system.[3]

What Is an ASC?

ASCs specialize in providing diagnostic and therapeutic procedures that can be safely performed outside a hospital setting. Each year more than eight million procedures are carried out in 4,200 centers across the US.[4,5] These types of healthcare organizations are generally owned by more than one individual, may concentrate on a particular medical specialty (e.g., ophthalmology), and are some of the most highly regulated healthcare organizations in the country. Medicare has certified 85 percent of ASCs, and 43 states require a license to operate.[6]

ASC Reimbursement

In general, procedures performed in an ASC cost less than hospital outpatient facilities. Medicare has provided reimbursement for procedures in certified centers since 1980 and paid for services through a simple method that assigns CPT codes to specific ASC group numbers with an associated fee specified for each group. There were only 100 procedures eligible for ASC reimbursement in 1982. Today there are more than 2,500 codes on the ASC list. More than 90 percent of the procedures represented on the list are limited to 150 codes.

The list indicates procedures that Medicare covers and will pay for when performed in this setting. It does not require procedures to be performed in an ASC in order to be reimbursed. There are many procedures performed without surgery in this setting that are diagnostic or therapeutic, including many procedures involving endoscopes that don't involve an incision. The nine current ASC clinically disparate groups will increase to 221 groups under the new system.

ASCs receive a facility payment for a limited list of procedures under the current program. Under the current system it is estimated that Medicare pays an average of $320 more per case for procedures performed in hospital outpatient departments than for the same procedure in freestanding ASCs.[7] In the new system ASC reimbursement will be 62 percent of the amount paid to hospitals for outpatient procedures in 2008. This percentage will be recalculated each year by changing the corresponding conversion factors (currently $39.688 for ASCs compared to $64.013 for hospitals). The conversion factors are

multiplied by the corresponding weights in the ASC and APC systems to arrive at the amount paid. CMS will continue to adjust ASC payment amounts for geographic wage differences.

The new system aligns ASC payments more closely with the hospital outpatient prospective payment system, which also uses HCPCS codes as input data but groups cases in APCs for reimbursement. The Deficit Reduction Act of 2005 caps the calendar year 2007 ASC rate to the rate paid for the same procedure performed in a hospital at the outpatient prospective payment system rates using APC groups.

The proposed system to be implemented in 2008 will allow reimbursement for any procedure except those that the Health and Human Services secretary designates after consultation with specified organizations as posing a significant safety risk or that require an overnight stay. The first year payments are expected to be a 50-50 blend of the current method and the 2008 methods. In 2009 the new payment rates will be used exclusively using the new factors.

ASC billing and reporting instructions are available on the CMS Web site at www.cms.hhs.gov/manuals/downloads/clm104c14.pdf. Covered services for ASC reimbursement include:

- Services of nursing and technical personnel
- Patient use of the facility
- Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment
- Diagnostic or therapeutic items and services
- Administrative, record-keeping, and house-keeping items and services
- Blood, blood plasma, platelets (except those to which the blood deductible applies)
- Materials for anesthesia
- Intraocular lenses (an approved new technology, which may be billed separately in addition to the facility rate using the appropriate HCPCS Level II codes)

All of these services are included in the rate for the service, thus included in the HCPCS code reported for the facility fee.

The table [below] provides examples of payment and billing for items and services that are not ASC facility services. The Correct Coding Initiative edits to prevent unbundling of services in other ambulatory settings also are applied to ASC claims. If an ASC reports a code that is considered to be part of another more comprehensive code, only the more comprehensive service will be paid, provided the procedure meets coverage requirements.

Some procedures, of course, are performed in a variety of settings. Because CMS is concerned about paying facility fees (in addition to professional services) for procedures that require limited resources (commonly performed in physician office locations), there is a proposal to cap payments at the amount paid to a physician performing the same procedure in the office setting.

21 Procedures Added to the ASC List for 2007

HCPCS	Short Descriptor	ASC Payment Group	ASC Payment Rate	ASC Copayment Amount
0176T	Aqu canal dilat w/o retent	9	$1,339	$267.80
0177T	Aqu canal dilat w/retent	9	$1,339	$267.80
G0392	AV fistula or graft arterial	9	$1,339	$334.75
G0393	AV fistula or graft venous	9	$1,339	$334.75
13102	Repair wound/lesion addon	1	$91.24	$18.25
13122	Repair wound/lesion addon	1	$91.24	$18.25
13133	Repair wound/lesion addon	1	$91.24	$18.25
13153	Repair wound/lesion addon	3	$91.24	$18.25
19295	Place breast clip, percut	1	$106.76	$21.35
19297	Place breast cath for rad	9	$1,339	$267.80
21356	Treat cheek bone fracture	3	$510	$102
22520	Percut vertebroplastythor	9	$1,339	$267.80

22521	Percut vertebroplastylumb	9	$1,339	$267.80
22522	Percut vertebroplasty add'l	9	$1,339	$267.80
31620	Endobronchial us addon	1	$333	$66.60
36818	AV fuse, uppr arm, cephalic	3	$510	$102
43257	Uppr GI scope w/thrml txmnt	3	$510	$102
43761	Reposition gastrostomytube	1	$333	$66.60
46946	Ligation of hemorrhoids	1	$333	$66.60
57267	Insert mesh/pelvic flr addon	7	$995	$199
61795	Brain surgery using computer	1	$302.04	$60.41

Note: Rows with darker shading indicate procedures where the lowest ASC grouper payment exceeded the outpatient PPS rate. These six procedures are capped at the outpatient rate due to provisions of the Deficit Reduction Act.

Items and Services That Are Not ASC Facility Services

Items Not Included in the ASC Facility Rate	Who May Receive Payment?	Who Receives Bills?
Physicians' services	Physician	Carrier
The purchase or rental of nonimplantable durable medical equipment (DME) to ASC patients for use in their homes	Supplier: An ASC can be a supplier of DME if it has a supplier number from the National Supplier Clearinghouse.	DMERC
Implantable DME and accessories	ASC	Carrier
Nonimplantable prosthetic devices	Supplier: An ASC can be a supplier of nonimplantable prosthetics if it has a supplier number from the National Supplier Clearinghouse.	DMERC
Implantable prosthetic devices except intraocular lenses (IOLs and NTIOLs) and accessories	ASC	Carrier
Ambulance services	Certified ambulance supplier	Carrier
Leg, arm, back, and neck braces	Supplier	DMERC
Artificial legs, arms, and eyes	Supplier	DMERC
Services furnished by an independent laboratory	Certified lab: ASCs can receive lab certification and a CLIA number.	Carrier
Procedures not on the ASC list	Physician	Physician bills carrier for procedure and any implantable prosthetics/DME using the ASC as the place of service. See Pub. 100-04, chapter 12, section 20.4

Notes

1. Centers for Medicare and Medicaid Services. "Final CY2007 Changes (CMS-1506-FC)." Available online at www.cms.hhs.gov/ASCPayment/06a_CMS1506fc.asp.
2. *Federal Register* 71, no. 163 (August 23, 2006). Available online at www.gpo.gov/su_docs/fedreg/a060823c.html.

3. GovTrack. “H.R. 4042[109]: Ambulatory Surgical Center Medicare Payment Modernization Act of 2005.” Available online at www.govtrack.us/congress/bill.xpd?bill=h109-4042.
4. Foundation for Ambulatory Surgery in America (FASA). “History of ASCs.” Available online at www.fasa.org/aschistory.html.
5. American Association of Ambulatory Surgery Centers (AAASC). “Summary of the Ambulatory Surgical Center Payment Modernization Act H.R. 4042 and S. 1884.” Available online at www.aaasc.org/documents/ASCModernizationActSummaryandFacts92305_002.doc.
6. FASA. “History of ASCs.”
7. AAASC. “Summary of the Ambulatory Surgical Center Payment Modernization Act H.R. 4042 and S. 1884.”

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