CMS Issues a Revised Payment System For Services Provided In Ambulatory Surgery Centers

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Recently, the Centers for Medicare and Medicaid Services ("CMS") published proposed and final rules which will have a significant impact on how ambulatory surgery centers ("ASCs") receive reimbursement for services. On July 16, 2007, CMS issued "Medicare and Medicaid Programs: CY 2008 Proposed Changes; Proposed Rule," which among other proposed changes, establishes proposed revisions to the payment system for ambulatory surgery centers (the "Proposed Rule"). The Proposed Rule was published in the Federal Register on August 2, 2007 at 72 Fed. Reg. 42628. In addition, on August 2, 2007, CMS published "Medicare Program; Revised Payment System Policies for Services Furnished in Ambulatory Surgical Centers (ASCs) Beginning in CY 2008; Final Rule," in the Federal Register at 72 Fed. Reg. 42470 (the "Final Rule"). While several elements of the Proposed Rule were also addressed in a Final Rule, it should be noted that the Proposed Rule is subject to a comment period and its provisions may be changed prior to becoming final.

CMS first began providing reimbursement for services provided in ASCs in 1982. Since that time, the number of ASCs enrolled in the Medicare program has grown to almost 5,000 in 2007. Under the current rules, Medicare reimburses ASCs for approximately 2,500 types of surgical procedures at the ASC payment rate. This reimbursement is based on a simple fee schedule comprised of nine different prospectively determined group rates. The ASC payment rate is intended to reimburse the ASC for the facility cost only. The current ASC payment rate is referred to herein as the "Current ASC Rate." Anesthesiologists and other treating professionals are paid separately under Medicare's physician fee schedule ("MPFS").

The Final Rule drastically changes how Medicare will reimburse ASCs and the Proposed Rule has the potential for additional significant changes. This article outlines the key provisions of the Final Rule which becomes effective January 1, 2008 as well as the any discrepancies between the Final Rule and the Proposed Rule.

I. Summary of Key Final Rule and Proposed Rule Provisions

The Final Rule and the Proposed Rule include several core concepts which are summarized briefly here. Additionally, several of the concepts, and CMS statements regarding such concepts, are discussed more extensively in part II.

1. The Revised Payment Rates. The Final Rule sets the ASC payment rates using the hospital outpatient prospective payment system ("OPPS") as a guide. Essentially, the payment structure links the two payment systems. Thus, rather than billing pursuant to nine different ASC group rates as services are billed under the Current ASC Rate, ASCs will now bill pursuant to numerous different ambulatory payment classifications ("APCs").

The illustrative CY 2008 ASC list included in the Final Rule sets the payment for services performed at an ASC at approximately 67% of the corresponding payment rates for similar services performed as hospital outpatient services, the discount intended to account for the lower cost of furnishing the services in an ASC setting. Under the Proposed Rule, CMS estimates the CY 2008 ASC payment rate to be about 65% of the OPPS rates. The methodology outlined in the Final Rule and the Proposed Rule is the same, however, the Proposed Rule uses more recent data and is effected by updated OPPS rates due to the inflation adjustment to hospital outpatient department ("HOPD") rates, in 2008 (an annual increase). The Final Rule's illustrative rates have been updated in the Proposed Rule and may change when the Proposed Rule becomes final. Going forward, the inflationary adjustment for ASC rates is slightly different than the inflationary adjustment for HOPD rates and thus the exact relationship between the two rates may vary.

2. Timing and Implementation of the Final Rule. The revisions set forth in the Final Rule will be implemented beginning in January 2008. The new ASC payment rates (the "Revised ASC Rate") will be phased in over a 4 year transition period. Throughout 2007, 100% of all payments to ASCs will be based on the existing Current ASC Rate. In 2008, 25% of total payments will be based on the Revised ASC Rate and 75% on the Current ASC Rate. The percentages will continue to change over the next 3 years. In 2009, the payments will be a blended 50%-50% rate. In 2010, 75% of all payments will be based on the Revised ASC Rate and 25% on the Current ASC Rate. Finally, in 2011, the conversion will be complete and all payments will be based on the Revised ASC Rate pursuant to the APC rate structure. The Proposed Rule outlines a similar transition period.

3. New Procedures Eligible For Payment in ASCs. The Final Rule also significantly increases the number of procedures eligible for payment when performed in an ASC adding approximately 790 new procedures to the list of eligible procedures. The Proposed Rule adds a few additional procedures. However, many of the newly eligible

ASC procedures are simple procedures which are currently performed in physician offices. In essence, these simple procedures can now be performed in ASCs. However, CMS wants to prevent these procedures from being performed in ASC if the most efficient setting for providing quality care is a physician office. Therefore, when a procedure is performed in an ASC, the physician will not receive a site-of-service differential. Instead, the ASC will be paid at the lesser of the ASC rate or what is called the MPFS non-facility practice expense ("PE") amount. In essence, Medicare will pay the lesser of the true ASC payment rate or the site-of-service differential or facility payment that a physician would have received. The Final Rule sets out procedures that will be subject to this cap in FY2008 and the Proposed Rule, based on more up to date information, proposes additional procedures subject to the cap.

4. Ancillary Services. Many services currently provided in an ASC are considered "Stark Services" and are not separately payable. Under the Final Rule, certain of these services will now be eligible for payment when furnished in an ASC. Generally, these are services that are provided before, during or immediately after a surgical procedure including: radiology services, drugs and biological services that are separately payable under the OPPS, devices that are eligible for pass-through payment under the OPPS, brachytherapy services, and corneal tissue acquisition. Under the Final Rule, payment is made to the ASC at the lesser of the ASC rate or the amount of the nonfacility PE under the MPFS. Only the ASC may seek payment for these ancillary services and the physician may not bill for the non-facility component under the MPFS. Additionally, Medicare will pay an ASC separately for all drugs and biologicals at the OPPS payment rate that are currently separately paid under the OPPS when these drugs and biologicals are provided as part of covered surgical procedures.

While the Proposed Rule does not propose any changes to these policies, it does propose revisions to the Stark Law definitions of "radiology and certain other imaging services" and "outpatient prescription drugs" to exclude those services that are covered ancillary services. The end result of the change would permit a physician to refer those services to an ASC in which he or she had a financial interest and the ASC would be able to bill for such services without violating the Stark Law.

5. ASC Payment for Device Intensive Procedures. The Final Rule provides a change in payment for certain high cost devices. A device is deemed "high cost" if the cost of the device is more than half of the median cost of the procedure. Pursuant to the Final Rule, the ASC will be paid the full amount for the device, just as a hospital is paid pursuant the HOPD rate. Therefore, the ASC will receive 100% of the corresponding HOPD rate for the device cost and the services portion of the procedure would be about 65% of the OPPS service payment (as it is with any surgical procedure payment).

In the Proposed Rule, CMS also proposes a lower payment to the ASC by one half of the device portion of the ASC payment for certain surgical procedures into which the device cost is packaged, when the ASC receives a partial credit toward replacement of an implantable device. This partial payment reduction would apply to certain covered surgical procedures in which the amount of the device credit is greater than or equal to 20% of the cost of the new replacement device being implanted.

6. Physician Billing. Currently, if a procedure is not on the ASC list, a physician may perform the procedure in an ASC and receive both the normal physician service component as well as the higher non-facility PE amount. Pursuant to the Proposed Rule, a physician will receive a payment as though he or she performed the services in the facility that receives payment. The intent here is to assure that a physician does not receive an extra payment for providing a service where the surgery center itself is receiving a facility payment for that service.

II. CMS Commentary on Final Rule and Proposed Rule

1. Overview of CMS View of Rates. CMS has commented that its intent in changing the ASC payment system is to encourage ASC operators to adjust the mix of procedures performed in ASCs. By a redistribution of ASC payments, CMS plans to more aggressively shift certain procedures to ASCs. Specifically, CMS stated in the Final Rule:

> We believe the revised ASC payment system represents a major stride towards encouraging greater efficiency in ASCs and promoting a significant increase in the breadth of surgical procedures performed in ASCs, because it more appropriately distributes payments across the entire spectrum of covered surgical procedures, based on a coherent system of relative payment weights that are related to the clinical and facility resource characteristics of those procedures.

> […] As a result of the redistribution of payments across the expanded breadth of surgical procedures for which Medicare will provide an ASC payment, we believe that ASCs may change the mix of services they provide over the next several years. The revised ASC payment system should encourage ASCs to expand their service mix beyond the handful of the highest paying procedures which comprise the majority of ASC utilization under the existing ASC payment system. […] [W]e believe that under the revised ASC payment system, each ASC has the opportunity to adapt to the payment decrease for its most frequently performed procedures by offering an increased breadth of procedures, still within the clinical specialty area, and receive payments that are adequate to support continued operations.
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> […] For those procedures that will be paid a significantly lower amount under the revised payment system than they are currently paid, we believe that their current payment rates, which are closer to the OPPS payment rates than other ASC procedures, are likely to be generous relative to ASC costs, so ASCs would, in all likelihood, continue performing those procedures under the revised payment system.
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> […] We estimate that payments for most of the highest volume colonoscopy and upper gastrointestinal endoscopy procedures will decrease under the revised payment system. In fact, payment decreases also are expected for the gastrointestinal surgical specialty group overall. We believe that decreased payments for so many of the gastrointestinal procedures are because current ASC payment rates are close to the OPPS rates. Procedures with current payment rates that are nearly as high as their OPPS rates are affected more negatively under the revised payment system then procedures for which ASC rates have historically been much lower than the comparable OPPS rates. The payment decreases expected in the first year under the revised ASC payment system for some of the high volume gastrointestinal procedures are not large (all less than 7 percent). We believe that ASCs can generally continue to cover their costs for these procedures, and that ASCs specializing in providing those services will be able to adapt their business practices and case mix to manage declines for individual procedures.
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> In CY 2008, we also are adding hundreds of surgical procedures to the already extensive list of procedures for which Medicare allows payment to ASCs, creating new opportunities for ASCs to expand their range of covered surgical procedures. For the first time, ASCs will be paid separately for covered ancillary services that are integral to covered surgical procedures, including certain radiology procedures, costly drugs and biologicals, devices with pass-through status under the OPPS, and brachytherapy sources.[1]

2. Surgical Procedures Covered Under the Revised ASC Payment System. The new rules for ambulatory surgical center payments more broadly define which procedures are included on the list of procedures that may be reimbursed when performed in an ASC (the "ASC Procedure List"), and thus which procedures will be performed at ASCs. Generally, any procedure listed on the OPPS Outpatient Surgical Procedures List is eligible for payment if such procedure is actually performed in an ASC. The ASC Procedure List excludes procedures on the OPPS Inpatient List as well as any procedure that is expected to require active medical monitoring and care at night following the procedure (that is, a procedure requiring an overnight stay). In addition, the ASC Procedure List excludes any procedures that pose a significant risk to a Medicare patient. The Final Rule outlines "covered surgical procedures" as follows:

> (a) Covered surgical procedures. Effective for services furnished on or after January 1, 2008, covered surgical procedures are those procedures that meet the general standards described in paragraph (b) of this section (whether commonly furnished in an ASC or a physician's office) and are not excluded under paragraph (c) of this section.
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> (b) General standards. Subject to the exclusions in paragraph (c) of this section, covered surgical procedures are surgical procedures specified by the Secretary and published in the Federal Register that are separately paid under the OPPS, that would not be expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC, and for which standard medical practice

1 72 Fed. Reg. 42542-43 (August 2, 2007).

dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure.

(c) *General exclusions*. Notwithstanding paragraph (b) of this section, covered surgical procedures do not include those surgical procedures that—

(1) Generally result in extensive blood loss;

(2) Require major or prolonged invasion of body cavities;

(3) Directly involve major blood vessels;

(4) Are generally emergent or lifethreatening in nature;

(5) Commonly require systemic thrombolytic therapy;

(6) Are designated as requiring inpatient care under § 419.22(n) of this subchapter;

(7) Can only be reported using a CPT unlisted surgical procedure code; or

(8) Are otherwise excluded under §411.15 of this subchapter.[2]

A. Inflationary Updates. The Final rule provides that in annual updates to the ASC payment system, CMS will set the ASC relative payment weights equal to the OPPS weights and then scale the ASC weights in order to maintain budget neutrality for ASC payment system (that is, keeping total estimated expenditures under the Revised ASC Rate the same as they are under the Current ASC Rate). While the Final Rule requires 0% update through CY2009, beginning in 2010, CMS will update the ASC conversion factor based on the percentage increase in the Consumer Price Index for all Urban Consumers (US city average). This inflationary update may be smaller than the hospital inflationary update and CMS reserves the right to review this update if it leads to more inflation than expended.

B. Office Based Procedures. The Revised ASC Rate system adds a significant number of office based procedures to the ASC Procedure List. However, the payment rate for these procedures is not generous. In essence, payment is capped for office based surgical procedures at the lesser of the MPFS non-facility PE amount or the ASC rate developed according to the standards of the revised ASC payment system. Further, if an ASC bills a facility fee, the practice physician is not entitled to also bill for a non-facility PE amount. ASCs will be eligible for payment for such services beginning in 2008.

C. Device Intensive Procedures. The Revised ASC Rate includes a specific payment rate and rule for device intensive procedures. This has long been viewed as a challenging issue for ASCs. CMS has stated the following in the Proposed Rule:

> Under the final policy of the revised ASC payment system, we use a modified payment methodology to establish the ASC payment rates for device-intensive procedures. We identify device-intensive procedures as covered surgical procedures that, under the OPPS, are assigned to those device-dependent APCs for which the "device offset percentage" is greater than 50 percent of the APC's median cost. The device offset percentage is our best estimate of the percentage of device cost that is included in an APC payment under the OPPS. The CY 2008 proposed device-dependent APCs and device offset percentages are discussed in section IV.A. of this proposed rule.
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> According to the final ASC policy, payment for implantable devices is packaged into payment for the covered surgical procedures, but we utilize a modified ASC methodology based on OPPS data to establish payment rates for the device-intensive procedures under the revised ASC payment system.
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> […] We also reduce the amount of payment made to ASCs for device-intensive procedures assigned

2 *Id*. at 42546.

> to certain OPPS APCs in those cases in which the necessary device is furnished without cost to the ASC or the beneficiary, or with a full credit for the cost of the device being replaced. A full discussion of that policy may be found in section XVI.F. of this proposed rule.[3]

An example of this calculation is provided in the Final Rule for insertion of a cochlear implant, CPT code 69930 (Cochlear device implantation, with or without mastoidectomy), as follows:

OPPS CY 2007 national unadjusted payment rate	$25,499.72
OPPS CY 2007 device offset percent	84.61%
OPPS/ASC device portion	$21,575.31 ($25,499.72 x 0.8461)
OPPS service portion	$3,924.41
OPPS relative payment weight attributable to service (OPPS service portion divided by estimated CY 2008 OPPS conversion factor)	61.8047 ($3,924.41/63.497)
ASC service portion (OPPS relative payment weight for service portion multiplied by estimated CY 2008 ASC conversion factor)	$2,629.36 (61.8047 x $42.543)
CY 2007 ASC payment (without device payment)	$995
ASC service payment	$1,403.59 (0.25 x $2,629.36) + (0.75 x $995)
Estimated CY 2008 ASC total payment (sum of service payment and device payment)	$22,978.90 ($1,403.59 + $21,575.31)

D. Multiple and Interrupted Procedures. Under the Final Rule, payments may be discounted if multiple procedures are performed in an ASC as part of a single case. However, certain procedures will not be subject to this discount. CMS explained the rule as follows:

> Specifically, when more than one covered surgical procedure is provided by an ASC in a single operative session to a Medicare beneficiary, the procedure with the highest ASC payment rate would be paid 100 percent of the ASC payment amount, and ASC payments for any other surgical procedures not expressly exempt from the discounting policy would be reduced by half. Certain ASC covered surgical procedures with relatively high fixed costs would be specifically exempt from the ASC multiple procedure discounting policy, consistent with the current OPPS multiple procedure discounting policy for those surgical procedures assigned to a status indicator other than "T" under the OPPS. We […] further believe that adopting an ASC policy that parallels the OPPS discounting policy would assist in timely and coordinated updates to the multiple procedure discounting status of services payable under both payment systems.[5]

Furthermore, the Final Rule proposes an additional limitation on payments made for interrupted procedures. CMS clarified the proposed Final Rule as follows:

> [W]e are clarifying here the payment policies for interrupted procedures in ASCs. First, procedures requiring anesthesia that are terminated after the patient has been prepared for surgery and taken to the operating room but before the administration of anesthesia will be reported with modifier 73,

3 *Id.* at 42779.
4 *Id.* at 42560
5 *Id.* at 42514.

and the ASC payment for the covered surgical procedure will be reduced by 50 percent. Second, procedures and services not requiring anesthesia that are partially reduced or discontinued at the physician's discretion will be reported with modifier 52, and the ASC payment for the covered surgical procedure or covered ancillary service will be reduced by 50 percent. Third, procedures requiring anesthesia that are terminated after the administration of anesthesia or the initiation of the procedure will be reported with modifier 74, and the full ASC payment for the covered surgical procedure will be provided.[6]

E. Transition to Revised Payment Rates. The revised payment rates will take effect over a four-year transition period. ASCs will benefit from this longer phase-in with respect to procedures that are currently reimbursed at a rate which is higher than the OPPS and will be disadvantaged by this phase-in with respect to procedures that are currently reimbursed at a rate which is lower than 65% of the now current OPPS. CMS has stated:

> We believe a transition period of 4 years, comparable to transition periods provided under other payment systems (for example, the recent practice expense changes to the MPFS) and as suggested in comments concerning this issue, will provide a reasonable and balanced approach to implementation that addresses two important objectives, in particular offering sufficient notice and time for ASCs to adapt to the revised payment system and providing more accurate and appropriate ASC payments for covered surgical procedures. The contribution of CY 2007 ASC payment rates to the blended transitional rates will decrease by 25 percentage point increments each year of transitional payment, until CY 2011, when we will fully implement the ASC payment rates calculated under the final methodology of the revised payment system.[7]

Procedures new to ASC payment for 2008 or later calendar years, including device-intensive procedures added to the ASC Procedure List in 2008 or later, receive payments determined according to the final methodology of the revised ASC payment system, without a transition.

Because of the transitional phase in period, the Revised ASC Rate will have a smaller impact on payments for ASC services in 2008. The impact of the phase in is illustrated by this table showing ASC payments broken down by surgical specialty group.

ESTIMATED CY 2008 IMPACT OF THE REVISED ASC PAYMENT SYSTEM ON ESTIMATED AGGREGATE CY 2008 MEDICARE PROGRAM PAYMENTS UNDER THE 75/25 TRANSITION BLEND AND WITHOUT A TRANSITION, BY SURGICAL SPECIALTY GROUP[8]

Surgical Specialty Group	Estimated CY 2008 ASC payments (in millions)	Estimated CY 2008 percent change with transition (75/25 blend	Estimated CY 2008 percent change without transition (fully implemented
(1)	(2)	(3)	(4)
Eye and ocular adnexa	$1,365	1	5
Digestive system	721	-4	-15
Nervous system	274	2	-5
Musculoskeletal system	167	24	97

6 *Id.* at 42517.
7 *Id.* at 42520.
8 *Id.* at 42541.

Integumentary system	85	4	15
Genitourinary system	76	10	38
Respiratory system	23	16	65
Cardiovascular system	8	25	95
Auditory system	4	30	85
Hemic and lymphatic systems	2	28	110
Other systems	0.1	19	75F.

F. Ancillary Services. Under the new rules, an ASC will be able to bill for certain ancillary services when such services are performed in the ASC. This change will require an adjustment to the Stark Law and will allow ASCs to bill for certain procedures that they were previously prohibited from billing.

> [U]nder the final policy of the revised ASC payment system, covered ancillary services that are integral to a covered ASC surgical procedure will be allowed separate payment. These covered ancillary services, which are outside of the scope of ASC facility services defined at § 416.2 and described at new § 416.164(a) for which payment is packaged into the ASC payment for covered surgical procedures, are defined at § 416.2 and described at new § 416.164(b) as follows: brachytherapy sources; certain implantable items that have pass-through status under the OPPS; certain items and services that we designate as contractor-priced (payment rate is determined by the Medicare contractor) 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. […]
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> We will consider to be outside the scope of ASC services, as set forth in § 416.164(c), the following items and services, including, but not limited to: physicians' services (including surgical procedures and all preoperative and postoperative services that are performed by a physician); anesthetists' services; radiology services (other than those integral to performance of a covered surgical procedure); diagnostic procedures (other than those directly related to performance of a covered surgical procedure); ambulance services; leg, arm, back, and neck braces other than those that serve the function of a cast or splint; artificial limbs; and nonimplantable prosthetic devices and DME.[9]

The new Ancillary Services rule includes certain separate payments for radiology services, certain types of brachytherapy services related to implant of the needle during brachytherapy, and certain other services. Regarding radiology services, CMS commented that its incentive was to properly reimburse ASCs for these ancillary procedures without encouraging the shifting of these services from physician offices or independent diagnostic testing facilities ("IDTFs") to ASCs.

> We will, therefore, provide separate payment to ASCs for certain ancillary radiology services when they are integral to the performance of a covered surgical procedure billed by the ASC on the same day, provided that separate payment for the radiology service would be made under the OPPS.
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> We specify that a radiology service is integral to the performance of a covered surgical procedure if it is required for the successful performance of the surgery and is performed in the ASC immediately

9 *Id.* at 42495.

preceding, during, or immediately following the covered surgical procedure. Based on our analysis of the OPPS data, we believe that, in most cases, a radiology service that is separately payable under the OPPS that is performed in the ASC on the same day as a covered surgical procedure will be provided integral to a covered surgical procedure, and the ASC will be able to receive separate payment for the service as a covered ancillary service. The separate ASC payments for these radiology services will be made at the lower of: (1) The amount calculated according to the standard methodology of the revised ASC payment system; or (2) the MPFS nonfacility practice expense amount for the service (specifically, for the technical component (TC) if the service's HCPCS code is assigned a TC under the MPFS). This is similar to our final payment policy for covered office-based surgical procedures added to the ASC list in CY 2008 or later years. Payment for the costs of the facility resources associated with the radiology service would have been made to IDTFs under the existing ASC payment system at the MPFS nonfacility practice expense amount. Therefore, we believe the revised payment system beginning January 1, 2008, will both ensure appropriate and equitable payment for covered ancillary radiology services integral to covered surgical procedures and not provide a payment incentive for migration of services from physicians' offices or IDTFs to ASCs.[10]

Regarding separate payments to ASCs for brachytherapy sources, CMS stated:

> Based on the comments received and our review of the issue, we have concluded that the most appropriate policy under the revised ASC payment system is to provide separate payment to ASCs for the brachytherapy sources as covered ancillary services implanted in conjunction with covered surgical procedures billed by ASCs. Further, as evidenced by our decisions regarding payment for other covered ancillary services under the CY 2008 revised ASC payment system, our intention is to maintain consistent payment and packaging policies across HOPD and ASC settings for covered ancillary services that are integral to covered surgical procedures performed in ASCs. Therefore, consistent with our policy to pay separately for some drugs, biologicals, and radiology services as covered ancillary services, we also believe that adopting a payment policy consistent with the OPPS for payment of brachytherapy sources is reasonable and appropriate to ensure that the comprehensive brachytherapy service can be provided by ASCs. The application of the brachytherapy sources is integrally related to the surgical procedures for insertion of brachytherapy needles and catheters, which are appropriate for performance in ASCs. There is a statutory requirement that the OPPS establish separate payment groups for brachytherapy sources related to their number, radioisotope, and radioactive intensity, as well as for stranded and non-stranded sources as of July 1, 2007, OPPS procedure payments do not include payment for brachytherapy sources. We agree with both MedPAC and the PPAC that consistent payment bundles between the two payment systems are desirable. Therefore, under the revised ASC payment system, we will pay ASCs separately for brachytherapy sources when they are provided in association with a surgical procedure not excluded from ASC payment and billed by the ASC on the same day. The ASC brachytherapy source payment rate for a given calendar year will be the same as the OPPS payment rate for that year or, if specific OPPS prospective payment rates are unavailable, ASC payments for brachytherapy sources will be contractor-priced. The ASC brachytherapy source payment rate will be established at its OPPS payment rate, without application of the ASC budget neutrality adjustment factor to the OPPS conversion factor. In addition, consistent with the payment of brachytherapy sources under the OPPS, the ASC payment rates for brachytherapy sources will not be adjusted for geographic wage differences. Because brachytherapy sources are implantable devices with relatively fixed costs for which we would not expect efficiencies that would permit ASCs to acquire them at lower costs than HOPDs, we believe it is most appropriate to pay for the brachytherapy sources at the same rates as the OPPS if possible.[11]

10 *Id*. at 42496-97.
11 *Id*. at 42498-99.

The new payment system also provides extensive reimbursement for certain drugs and biologicals and certain medical devices that are integral to a surgical procedure. CMS has stated:

> [W]e believe that the significant expansion of the procedures eligible for payment under the revised ASC payment system, in addition to evolving surgical practice, may necessitate the use of different drugs and biologicals in ASCs in the future. To ensure appropriate access to all surgical procedures that are safe for performance in ASCs, we believe it is prudent under the revised ASC payment system to provide separate payment in the ASC setting for drugs and biologicals that are integral to covered surgical procedures for which the ASC is billing, when the costs of those drugs and biologicals were not included in developing the base procedure payment weights under the OPPS. We do not believe it would be appropriate to select only a subset of these drugs and biologicals that are separately payable under the OPPS because we do not see a clear rationale for doing so.
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> We specify that a drug or biological is integral to the performance of a covered surgical procedure if it is required for the successful performance of the surgery and is provided in the ASC immediately preceding, during, or immediately following the covered surgical procedure. Based on our analysis of OPPS data, we believe that, in most cases, a drug or biological that is separately payable under the OPPS that is provided in an ASC on the same day as a covered surgical procedure will be provided as integral to the covered surgical procedure, and the ASC will be able to receive separate payment for the drug or biological as a covered ancillary service.[12]

G. Physician Payment for Procedures and Services Provided in ASCs. One of the more controversial aspects of the Proposed Rule prohibits physicians from receiving the PE increased payment for procedures performed at an ASC that have traditionally been performed in a physician's office. In the Proposed Rule, CMS stated:

> Under current policy, when physicians perform surgical procedures in ASCs that are included on the ASC list of covered surgical procedures, they are paid under the MPFS for the PE component using the facility PE RVUs. This is appropriate because the surgical procedures are those for which Medicare allows facility payment to ASCs. However, when physicians perform surgical procedures in ASCs that are not included on the ASC list of covered surgical procedures and for which Medicare does not allow facility payments to ASCs, physicians are paid for the PE component at the higher nonfacility PE RVUs (unless a nonfacility rate does not exist, in which case Medicare pays the physician at the facility rate). These policies are set forth in §414.22(b)(5)(i)(A) and (B), respectively. Furthermore, physician payment for nonsurgical services provided in ASCs, for which no facility payment is made to ASCs under the existing ASC payment system, varies based on local Medicare contractor policy.[13]

Here, CMS explains their proposed revisions to this policy as follows:

> The revised ASC payment system is based on the APC groups and payment weights of the OPPS. We believe ASCs are facilities that are similar, insofar as the delivery of surgical and related nonsurgical services, to HOPDs. Specifically, when services are provided in ASCs, the ASC, not the physician, bears responsibility for the facility costs associated with the service. This situation parallels the hospital facility resource responsibility for hospital outpatient services. Therefore, we believe it would be more appropriate for physicians to be paid for all services furnished in ASCs just as they would be paid for all services furnished in the hospital outpatient setting. In addition, because we have adopted a final policy for the revised ASC payment system that identifies and excludes from ASC payment only those procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay, we believe that it would be incongruous with the revised ASC payment system methodology to continue to pay the higher nonfacility rate to physicians who furnish excluded ASC procedures. Because these excluded procedures have been specifically identified by CMS as procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay, we do not believe it would be appropriate

12 *Id*. at 42500.
13 *Id*. at 42791.

> to provide payment based on the higher nonfacility PE RVUs to physicians who furnish them. In fact, we do not expect that the excluded procedures will be performed in ASCs after the revised ASC payment system is implemented on January 1, 2008. Therefore, we are proposing to revise §414.22(b)(5)(i)(A) and (B) to reflect this proposed policy.
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> We believe that the proposed revised policy would provide appropriate payment to physicians for services provided in the ASC facility setting and would encourage the most appropriate utilization of ASCs. For procedures that are not excluded from coverage under the revised ASC payment system, the ASC would be paid for the covered surgical procedure and associated covered ancillary services, and the physician would be paid for the professional work and facility PE associated with performing the procedure. In the case of noncovered surgical procedures or other noncovered services provided in ASCs, Medicare would make no payment to the ASC under the revised ASC payment system and no payment to the physician under the MPFS for the facility resources associated with providing those services. Although the current MPFS payment policy provides payment to the physician for some facility costs as if the service were being furnished in a physician's office, according to the final policy of the revised payment system, these services would not be covered ASC services. These services have been excluded from ASC payment for safety reasons, because they are expected to require an overnight stay, or because they are not surgical procedures, and they would not be covered by Medicare either directly, under the ASC payment system, or indirectly, through PE payments to the physicians who perform them.[14]

This portion of the Proposed Rule is not included in the Final Rule.

H. Payment Conversion Factor. The new payment structure will establish a rate of payment for procedures performed at an ASC that amounts to approximately 65% of the payment for such procedures performed in a hospital outpatient department. CMS has not yet released the exact conversion factor, but explains the process in the Proposed Rule as follows:

> As discussed in section XVI.C. of this proposed rule, we finalized our policy to base ASC relative payment weights and payment rates under the revised ASC payment system on APC groups and relative payment weights established under the OPPS in the July 2007 final rule for the ASC revised payment system. In that rule, we made final our proposal to set the ASC relative payment weight for certain office-based surgical procedures so that the national unadjusted ASC payment rate does not exceed the MPFS unadjusted nonfacility PE RVU amount. Our final policy is to calculate ASC payment rates by multiplying the ASC relative payment weights by the ASC conversion factor. In the July 2007 final rule for the revised ASC payment system, our estimate of the CY 2008 budget neutral ASC conversion factor was $42.542. In this proposed rule, the proposed ASC conversion factor for CY 2008 is $41.400. This new estimate of the ASC conversion factor differs from the estimate in the July 2007 final rule for the revised ASC payment system for a number of reasons, including: (1) use of the proposed OPPS relative payment weights for CY 2008; (2) use of the proposed MPFS nonfacility practice expense payment amounts for CY 2008; and (3) use of updated utilization data from CY 2006. Specific details regarding our final methodology for estimating the CY 2008 ASC conversion factor may be found in the July 2007 final rule for the revised ASC payment system.[15]

The Final Rule established the ASC conversion factor at $42.543, or approximately 67%, based on the OPPS conversion factor. In the Final Rule, CMS provided significant detail about how this conversion factor was reached, stating:

> After developing the estimated CY 2008 budget neutrality adjustment of 0.67 according to the policies established in this final rule, in order to determine the estimated CY 2008 ASC conversion factor we multiply the estimated CY 2008 OPPS conversion factor by the budget neutrality adjustment. At this time, our estimate of the CY 2008 OPPS conversion factor is $63.497. Multiplying the

14 *Id*. at 42791-792.
15 *Id*. at 42796.

estimated CY 2008 OPPS conversion factor by the 0.67 budget neutrality adjustment yields our estimated CY 2008 ASC conversion factor of $42.543 for this final rule.[16]

I. Impact on Payments. The Final Rule also includes estimates of the total costs and percentage changes for several top procedures performed in an ASC for the first year of inclusion. The table below compares the CY 2007 Payment (i.e. the payment currently received), the Estimated CY 2008 Transition Payment (i.e. the approximate payment which will be received in 2008 representing 75% Current ASC Rate-25% Proposed ASC Rate) and the Estimated CY 2008 Fully Implemented Payment (i.e. 100% of the Proposed ASC Rate). If the ultimate payment changes little over the time, the impact on ASCs will likely be negative. However if there is a positive change, the complete implementation of the new payment system will not have a great impact on the overall payments to ASCs.

ILLUSTRATIVE ASC COVERED PROCEDURES FOR CY 2008[17]

HCPCS Code	Short Descriptor	CY 2007 Payment	Estimated CY 2008 First Transition Year Payment	Estimated CY 2008 Fully Implemented Payment
(1)	(2)	(3)	(4)	(5)
66984	Cataract surg w/iol, 1 stage	$973.00	$981.09	$1,005.35
45378	Diagnostic colonoscopy	$446.00	$427.76	$373.04
43239	Upper GI endoscopy, biopsy	$446.00	$422.96	$353.85
45380	Colonoscopy and biopsy	$446.00	$427.76	$373.04
66821	After cataract laser surgery	$312.50	$288.45	$216.28
45385	Lesion removal colonoscopy	$446.00	$427.76	$373.04
62311	Inject spine l/s (cd)	$333.00	$317.40	$270.59
45384	Lesion remove colonoscopy	$446.00	$427.76	$373.04
64483	Inj foramen epidural l/s	$333.00	$317.40	$270.59
G0121	Colon ca scrn not hi rsk ind	$446.00	$417.98	$333.93
15823	Revision of upper eyelid	$717.00	$687.02	$597.07
66982	Cataract surgery, complex	$973.00	$981.09	$1,005.35
64476	Inj paravertebral l/s add-on	$333.00	$310.64	$243.57

16 *Id*. at 42531.
17 *Id*. at 42549-603.

G0105	Colorectal scrn; hi risk ind	$446.00	$417.98	$333.93
43235	Uppr gi endoscopy, diagnosis	$333.00	$338.21	$353.85
52000	Cystoscopy	$333.00	$318.83	$276.32
64475	Inj paravertebral l/s	$333.00	$317.40	$270.59
67904	Repair eyelid defect	$630.00	$654.63	$728.52
64721	Carpal tunnel surgery	$446.00	$524.35	$759.39
29881	Knee arthroscopy/ surgery	$630.00	$776.94	$1,217.77
43248	Uppr gi endoscopy/ guide wire	$446.00	$422.96	$353.85
62310	Inject spine c/t	$333.00	$317.40	$270.59
29880	Knee arthroscopy/ surgery	$630.00	$776.94	$1,217.77
64484	Inj foramen epidural add-on	$333.00	$317.40	$270.59
28285	Repair of hammertoe	$510.00	$599.75	$869.00
67038	Strip retinal membrane	$717.00	$935.84	$1,592.34
29848	Wrist endoscopy/ surgery	$1,339.00	$1,308.69	$1,217.77
64623	Destr paravertebral n add-on	$333.00	$317.40	$270.59
45383	Lesion removal colonoscopy	$446.00	$427.76	$373.04
26055	Incise finger tendon sheath	$446.00	$506.31	$687.24