Ambulatory Surgical Center Changes for 2008

April 2008

Objectives

- Discuss key provisions of the CY 2008 ASC Final Rule
- Review the latest information provided by the Centers for Medicare & Medicaid Services (CMS)
- Discover ASC resources available

Background

- Medicare began paying for surgeries performed in ASCs in 1982
- Medicare allowed payment for 2,500 surgical procedures
- Payments range from $333 - $1339
- Payment method last reviewed in March 1990
- MMA of 2003 required revision to ASC payment system
- The Final Rule addresses the CY 2008 changes

Topics Of Interest

- Expanded List of ASC Procedures
- Revised Payment Rates
- Do the Math!
- Transition Schedule
- ASC Payment for Device-Intensive Procedures
- Payment for Ancillary Services
- Physician Payment of Non-covered ASC Procedures
- Billing Procedures

Expanded List of ASC Procedures

- Payment for 790 additional surgical procedures in CY 2008

- Payment exclusion for surgical procedures
  - Pose a significant safety risk
  - Require an overnight stay

Revised Payment Rates

- Assumptions
  - CMS took into account the expected migration of surgical procedures
  - 25% of newly approved procedures will migrate from outpatient hospital to ASC
    - During 1st two years of implementation
  - 15% of newly approved procedures will migrate from physician offices to ASC
    - During 1st four years of implementation

Do the Math!

- ASC conversion factor for CY 2008

0.65	x	$63.694	=	$41.4011
Budget neutrality adjustment factor		CY 2008 OPPS conversion factor		CY 2008 ASC conversion factor

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CY 2008 ASC CF x ASC relative payment weight = National Group ASC Rate

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$$\left(\text{National Group ASC Rate} \times .5\right) + \left[\left(\text{National Group ASC Rate} \times .5\right) \times \text{Wage Index}\right]$$

Do the Math!

CPT Code 10140

Lucas County, OH – CBSA 45780

$$\left(\text{National Group ASC Rate} \times .5\right) + \left[\left(\text{National Group ASC Rate} \times .5\right) \times \text{Wage Index}\right]$$

Do the Math!

CPT Code 10140

Lucas County, OH – CBSA 45780

(National Group ASC Rate x .5) + [(National Group ASC Rate x .5) x Wage Index]

($76.94 x .5) + [($76.94 x .5) x .9431]

Do the Math!

CPT Code 10140

Lucas County, OH – CBSA 45780

(National Group ASC Rate x .5) + [(National Group ASC Rate x .5) x Wage Index]

($76.94 x .5) + [($76.94 x .5) x .9431]

$38.47 + [$38.47 x .9431]

Do the Math!

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(National Group ASC Rate x .5) + [(National Group ASC Rate x .5) x Wage Index]

($76.94 x .5) + [($76.94 x .5) x .9431]

$38.47 + [$38.47 x .9431]

$38.47 + $36.28

Do the Math!

CPT Code 10140

Lucas County, OH – CBSA 45780

$$\left(\text{National Group ASC Rate} \times .5\right) + \left[\left(\text{National Group ASC Rate} \times .5\right) \times \text{Wage Index}\right]$$

$$(\$76.94 \times .5) + [(\$76.94 \times .5) \times .9431]$$

$$\$38.47 + [\$38.47 \times .9431]$$

$$\$38.47 + \$36.28$$

$74.75

Transition Schedule

- Four year transition period for implementation of the approved CY 2007 ASC procedures rates
  - In 2008, 25% of CY 2008 method; 75% of CY 2007 method
  - In 2009, 50% of CY 2008 method; 50% of CY 2007 method
  - In 2010, 75% of CY 2008 method; 25% of CY 2007 method
  - In 2011, 100% of CY 2008 method
- CPT/HCPCS codes newly payable in CY 2008 at ASC setting will not be subject to transitional payment

1st Year Transition Schedule Example

CPT Code	Payment Indicator	2007 ASC Payment Rate	CY 2008 Fully Implemented Payment	CY 2008 1st Transition Year Payment
66984	A2	$973.00	$988.03	$976.76

Multiply by 75% = $729.75 **+** Multiply by 25% = $247.01 **=**

Example: CY 2008 Newly-Payable Service

CPT Code	Payment Indicator	Fully Implemented Payment Weight	CY 2008 Fully Implemented Payment	CY 2008 1st Transition Year Payment
67101	P3	8.1049	$335.55	$335.55

Multiply by 41.4011

(ASC CF)

Addendum AA

Addendum

- **Addendum AA-** a list of covered surgical procedures under the revised ASC payment system. Included are surgical procedures that receive packaged payment through the payment for covered surgical procedures, as well as those that are paid separately.
- **Addendum BB -** a list of radiology services and other covered ancillary services eligible for ASC payment under the revised ASC payment system when provided integral to an ASC covered surgical procedure.
- **Addendum DD1** - a list of ASC payment indicators used in Addenda AA and BB to provide payment information regarding covered surgical procedures and covered ancillary services, respectively, under the revised ASC payment system.
- **Addendum DD2** - a list of ASC comment indicators to be used in Addenda AA and BB.

- http://www.cms.hhs.gov/ASCPayment/04f_CMS-1392-FC(ASC).asp#TopOfPage

Incorrect Payment Amounts

- Palmetto GBA found that ASC facility claims submitted from 1/1/08 – 3/21/08 with 2008 dates of service were paid using an incorrect pricing file.
- This resulted in underpayments to ASC facilities.
- As of 3/22/08, our system has been updated and claims received will be reimbursed correctly.
- We will identify and automatically adjust all underpaid services for additional reimbursement.
- Also, providers that received ASC fee schedules from us as a result of a request sent to our Disclosure department will be sent updated fee schedules as soon as they become available.

Future Annual Updates

- In Annual Updates to the ASC payment system:
  - CMS will set ASC relative payment weights equal to OPPS weights
  - Next, CMS will scale the ASC weights to maintain budget neutrality
- CMS will NOT update the ASC conversion factor until CY 2010

Payment for Device-Intensive Procedures

- In the revised ASC system, payment for these high cost devices is packaged into the associated procedure payment
- ASCs will no longer bill separately for these devices
- When the device is provided at no cost, Medicare payment reduced by the device portion

Payment for Covered Ancillary Services

- Separate payment available
  - Ancillary services that are considered integral and provided immediately before, during or after covered surgical procedure
  - Drugs and devices that are eligible for pass-through payment under the OPPS
  - Addendum BB -- ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2008 (Including Ancillary Services for Which Payment is Packaged)

Physician Payment for Non-covered Procedures

- In CY 2008, Medicare pays physicians at the facility PE payment amount, rather than the non-facility PE amount, for furnishing non-covered procedures in ASCs.
  - To make payments more consistent with the policy under the OPPS.

Billing Procedures

Reporting Separately Payable Ancillary Services

- Report separately payable ancillary services with an accurate number of units
- Pay special attention to dosages of drugs and biologicals and the units included in code descriptors

Billing Procedures

For example:

- HCPCS code J1260
  - Injection, dolasetron mesylate, 10mg
- Typical dose = 100 mg
- Report as 10 units of HCPCS code J1260
  - If only 1 unit reported, Medicare will pay only one-tenth of allowable amount

Billing Procedures

Reporting Charges for Separately Payable Services

- Medicare contractors will make payment based on the lower of actual charges for separately payable procedures and services, or the ASC payment rate

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ASC Charge = $1,000

Medicare payment = $2,000

Payment will be based on ASC charge

Billing Procedures

Reporting Charges for Separately Payable Services

- Avoid reporting 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

Billing Procedures

Reporting Charges for Separately Payable Services - INCORRECT

Example	CPT / HCPCS Code	ASC Charge	Medicare Allowed Amt	Medicare Paid Amt
Charges reported on separate lines	62361	$2,500	$10,000	$2,500 x 80% = $2,000
	C1891	$9,500	n/a	n/a

Billing Procedures

Reporting Charges for Separately Payable Services - CORRECT

Example	CPT Code	ASC Charge	Medicare Allowed Amt	Medicare Paid Amt
Charges reported as packaged	62361	$12,000	$10,000	$10,000 x 80% = $8,000

Billing Procedures

Billing Bilateral Procedures

- 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 CPT modifier 50 is not prohibited, it will NOT be recognized for ASC payment purposes.
  - Its use may result in incorrect payment to ASCs.
- The multiple procedure reduction of 50 percent will apply to all bilateral procedures subject to multiple procedure reduction.

Billing Procedures

Billing Bilateral Procedures - INCORRECT

Example	CPT Code	CPT Modifier	ASC Charge	Medicare Allowed Amt	Medicare Paid Amt
Bilateral procedure reported on one line with bilateral modifier	15823	50	$2,000	$800	$800 x 80% = $640

Billing Procedures

Billing Bilateral Procedures - CORRECT

Example	CPT Code	ASC Charge	Medicare Allowed Amt	Medicare Paid Amt
Bilateral procedure reported on two lines	15823	$1,000	$800	$800 x 80% = $640
	15823	$1,000	$800	($800 x 50%) x 80% = $320

Billing Procedures

Billing Bilateral Procedures - CORRECT

Example	CPT Code	Units	ASC Charge	Medicare Allowed Amt	Medicare Paid Amt
Bilateral procedure reported: 1 line, 2 units	15823	2	$2,000	$1,600	[$800 + ($800 x 50%)] x 80% = $960

FAQs

Q: Are we still required to submit HCPCS modifier SG on ASC claims?

A: Effective for services rendered on or after January 1, 2008, HCPCS modifier SG is no longer valid.

Reference:

- CMS Web site: http://www.cms.hhs.gov/center/asc.asp
- CMS "Calendar Year (CY) 2008 Revised Ambulatory Surgical Center (ASC) Payment System Questions and Answers": http://www.cms.hhs.gov/ASCPayment/downloads/ASCQAs123107.pdf

FAQs

Q: What are the requirements for reporting HCPCS modifier TC under the revised ASC payment system?

A: ASCs are required to report HCPCS modifier TC when billing for facility charges associated with HCPCS codes that have both a technical component and a professional component (e.g., radiology services) under the MPFS

FAQs

Q: Why did CMS base the revised ASC payment system on the hospital outpatient prospective payment system (OPPS)?

A: 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.

FAQs

Q: Can ASCs and other interested parties have a say in what happens?

A: 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.

Resources

http://www.cms.hhs.gov/center/asc.asp

- List of codes and fees
- Frequently Asked Questions (FAQs)
- Final rule
- Sign up for email updates!
- MLN Matter Articles
- Transmittals
- Educational resources
- Coding and Billing

Resources

http://www.cms.hhs.gov/manuals/downloads/clm104c14.pdf

- **Medicare Claims Processing Manual**
  - **Chapter 14 - Ambulatory Surgical Centers**

Resources

- www.PalmettoGBA.com/boh
- www.PalmettoGBA.com/bwv
  - Modifier Look-up tool
  - Denial finder
  - ASC Articles
  - Physician/Supplier Guide
  - What's New?
  - Learning & Education

Thank You for Attending!!!
Please complete your evaluations!