BETTER BENEFITS – MORE CHOICES

Good News about the Medicare Prescription Drug, Improvement and Modernization Act of 2003!

PAYMENT FOR SERVICES IN AMBULATORY SURGICAL CENTERS

Background

- Calculating payment to **ambulatory surgical centers** (ASCs) for facility services furnished in connection with approved surgical procedures involves the use of three different sets of figures.
  - Providers and Medicare contractors must **examine claims to see if the reported service appears on the list of procedures approved** for performance in an ASC.
  - The list of approved procedures is updated annually to reflect CPT changes implemented by AMA that affect the ASC list of approved procedures, and biennially to add to or delete from the ASC list in accordance with established criteria for procedures that are safely and appropriately performed in an ASC.
  - The **last update of the list of approved procedures was effective January 1, 2004**.

- Each of the approved procedures is assigned to one of nine payment groups.
  - The dollar amounts corresponding to each payment group have been updated on a fiscal year basis, with changes made effective October 1.
  - The **update amount is set equal to the percentage increase in the consumer price index (CPI)** for all urban consumers.
  - However, from FY 1998 – FY 2002, Congress required that the CPI percentage be reduced by 2 percentage points prior to its application to group payment rates.
  - **Two of the payment groups include an allowance for intraocular lenses** (IOL) associated with specific cataract surgeries. The allowance for IOLs is not updated per the CPI.
  - Interested parties can request updates of payment allowances for new technology IOLs. If approved, an additional payment of $50 is allowed for a new technology IOL for a period of five years.

- The **group payment amount corresponding to an approved procedure does not represent the final payment to an ASC**.
  - Prior to Medicare's paying for these services, the group payment amount is adjusted for geographic variation in labor costs.
  - The adjustment factor used is the hospital wage index.
    - ⇒ Only a portion of the group payment amount, **34.45 percent, is adjusted by the hospital wage index**.
    - ⇒ The remainder of the group payment amount, **65.55 percent, is unchanged**.

- So, the formula for calculating the geographically adjusted payment to an ASC is:

((Group Payment Amount x 0.3445) x Wage Index) + (Group Payment Amount x 0.6555) = Geographically Adjusted Payment Amount

- Medicare **carriers pay 80 percent of the allowed amount** and the beneficiary is responsible for the remaining 20 percent as their co-payment.

- **ASCs may bill and receive separate payment** under the DMEPOS fee schedule for implantable prosthetic devices that are inserted in connection with a surgical procedure. Payment for the professional services of the physician or surgeon is made separately, under the Medicare Physician Fee Schedule.

New Provision

- The **MMA modifies updates to ASC group payment amounts in terms of the allowed percentage increase and the calendar basis on which they are made**.

- For FY 2004, beginning on April 1, 2004, the payment update is set equal to the CPI for all urban consumers for the 12-month period ending March 31, 2003, minus three percentage points.

  - As the CPI for that 12-month period was estimated to be 3.0 percent, the update for ASC payments during FY 2004, reverted to zero percent, from April 1, 2004 through September 30, 2004.

- For FY 2005, the final quarter of calendar year 2005, and for calendar years 2006 through 2009, the update for ASC payments is set at zero percent. This provision not only holds spending flat, but also **shifts the payment update to a calendar, as opposed to a fiscal year basis.**

- Section 626 of the MMA eliminates the requirement that CMS conduct surveys of ASCs in order to determine costs incurred by ASCs to perform procedures on the ASC list. Instead, **CMS is to modify the ASC payment methodology, taking into account recommendations contained in a GAO report required under Section 626(d)**. These modifications are to take place sometime between January 1, 2006 and January 1, 2008. There will be no administrative or judicial review of the key aspects of this updated payment methodology.

- The GAO is required to study the **relative costs of procedures furnished in ASCs compared to hospital outpatient departments (HOPDs)** and **how accurately the ambulatory payment categories used in HOPDs reflect procedures furnished in ASCs**. The GAO is to consider data submitted by ASCs concerning these matters.

- The **GAO report is to contain recommendations** on the appropriateness of using the groups of covered services and relative weights established under the hospital outpatient prospective payment system as the basis for payment in ASCs, and, if they are appropriate, **whether ASC payments should be based on a uniform percentage of the PPS rates or should vary based on specific procedures or types of services**.

- The GAO is also required to **make recommendations on whether a geographic adjustment should be made** to ASC payments, and if so, what the labor and non-labor portions, (typically the portion of the payment subject to adjustment) of such payment should be.