

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

### Centers for Medicare & Medicaid Services

#### 42 CFR Part 416

[CMS-1885-FC]

RIN 0938-AM02

#### Medicare Program; Update of Ambulatory Surgical Center List of Covered Procedures Effective July 1, 2003

**AGENCY:** Centers for Medicare & Medicaid Services (CMS), HHS.

**ACTION:** Final rule with comment period.

**SUMMARY:** This final rule with comment period will make additions to and deletions from the current list of Medicare approved ambulatory surgical center (ASCs) procedures. In addition, it responds to comments received on the June 12, 1998 proposed rule (63 FR 32290) that addressed proposed additions to and deletions from the list of ASC covered procedures. This rule also implements requirements of section 1833(i)(1) and (2) of the Social Security Act.

**DATES:** *Effective date:* These regulations are effective for services furnished on or after July 1, 2003.

*Comment date:* We will consider comments on new proposed additions to and deletions from the ASC list of covered procedures if we receive them at the appropriate address, as provided below, no later than May 27, 2003.

**ADDRESSES:** Mail written comments (1 original and 2 copies) to the following address: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1885-FC, P.O. Box 8013, Baltimore, MD 21244-8013.

To insure that mailed comments are received in time for us to consider them, please allow for possible delays in delivering them.

Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. In commenting, please refer to file code CMS-1885-FC.

If you prefer, you may deliver (by hand or courier) your written comments (1 original and 2 copies) to one of the following addresses: Room 445-G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201 or Room C5-14-03, 7500 Security Boulevard, Baltimore, MD 21244-8013.

(Because access to the interior of the HHH Building is not readily available to

persons without Federal Government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for commenters wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and could be considered late.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

**FOR FURTHER INFORMATION CONTACT:** Bob Cereghino, 410-786-4675.

#### **SUPPLEMENTARY INFORMATION:**

##### **Inspection of Public Comments**

Comments received timely will be available for public inspection as they are received, generally beginning approximately 2 weeks after the close of the comment period, at the headquarters of the Centers for Medicare and Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 5 p.m. To schedule an appointment to view public comments, please call (410) 786-7197.

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##### **I. Background**

###### **A. Legislative History**

Specific provisions of the proposed rule are discussed in detail in Section II below.

Section 1832(a)(2)(F)(i) of the Social Security Act (the Act) provides that benefits under the Medicare Supplementary Medical Insurance program (Part B) include payment for facility services furnished in connection with surgical procedures we specify and which are performed in an ambulatory surgical center (ASC). We are to review and update the list of ASC procedures biennially. To participate in the Medicare program as an ASC, a facility must meet the standards specified under section 1832(a)(2)(F)(i) of the Act and 42 CFR 416.25, which sets forth general conditions and requirements for ASCs.

Generally, there are two primary elements in the total cost of performing a surgical procedure—the cost of the physician's professional services for performing the procedure and the cost of services furnished by the facility where the procedure is performed (for example, surgical supplies and equipment and nursing services). Section 1833(i)(2)(A) of the Act addresses what the ASC facility fee is intended to represent and how the amount of the Medicare payment for ASC facility services is to be determined. It requires us to review and update ASC payment amounts annually.

The ASC payment rate is to be a standard overhead amount established on the basis of our estimate of a fair fee that takes into account the costs incurred by ASCs generally in providing facility services in connection with performing a specific procedure. The Report of the Conference Committee accompanying section 934 of the Omnibus Budget Reconciliation Act of 1980 (Pub. L. 96-499), which enacted the ASC benefit in December 1980, states that this overhead factor is expected to be calculated on a prospective basis using sample survey and similar techniques to establish reasonable estimated overhead allowances, which take account of volume (within reasonable limits), for each of the listed procedures. (See H.R. Rep. No. 1479, at 134 (1980).) To estimate the amount of those reasonable allowances, we are required by section 1833(i)(2)(A)(i) of the Act to survey the actual audited costs incurred by a representative sample of facilities in connection with a representative sample of procedures. Because payment for ASC facility services is subject to the usual Medicare Part B deductible and coinsurance requirements, Medicare pays participating ASCs 80 percent of the prospectively-determined rate, adjusted for regional wage variations. Section 1833(i)(2)(A)(ii) of the Act requires that the ASC payment rates result in substantially lower Medicare