

supply when used in a surgical procedure as determined by CMS under §416.174;

(5) Medical and surgical supplies not on pass-through status under subpart G of part 419 of this subchapter;

(6) Equipment;

(7) Surgical dressings;

(8) Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status under subpart G of part 419 of this subchapter;

(9) Implanted DME and related accessories and supplies not on pass-through status under subpart G of part 419 of this subchapter;

(10) Splints and casts and related devices;

(11) Radiology services for which separate payment is not allowed under the OPPS and other diagnostic tests or interpretive services that are integral to a surgical procedure, except certain diagnostic tests for which separate payment is allowed under the OPPS;

(12) Administrative, recordkeeping and housekeeping items and services;

(13) Materials, including supplies and equipment for the administration and monitoring of anesthesia; and

(14) Supervision of the services of an anesthetist by the operating surgeon.

(b) *Covered ancillary services.* Ancillary items and services that are integral to a covered surgical procedure, as defined in §416.166, and for which separate payment is allowed include:

(1) Brachytherapy sources;

(2) Certain implantable items that have pass-through status under the OPPS;

(3) Certain items and services that CMS designates as contractor-priced, including, but not limited to, the acquisition or procurement of corneal tissue for corneal transplant procedures;

(4) Certain drugs and biologicals for which separate payment is allowed under the OPPS;

(5) Certain radiology services and certain diagnostic tests for which separate payment is allowed under the OPPS; and

(6) Non-opioid pain management drugs and biologicals that function as a supply when used in a surgical procedure as determined by CMS under §416.174.

(c) *Excluded services.* ASC services do not include items and services outside the scope of ASC services for which payment may be made under part 414 of this subchapter in accordance with §410.152, including, but not limited to—

(1) Physicians' services (including surgical procedures and all pre-operative and postoperative services that are performed by a physician);

(2) Anesthetists' services;

(3) Radiology services (other than those integral to performance of a covered surgical procedure);

(4) Diagnostic procedures (other than those directly related to performance of a covered surgical procedure);

(5) Ambulance services;

(6) Leg, arm, back, and neck braces other than those that serve the function of a cast or splint;

(7) Artificial limbs;

(8) Nonimplantable prosthetic devices and DME.

[72 FR 42545, Aug. 2, 2007, as amended at 79 FR 67030, Nov. 10, 2014; 80 FR 70604, Nov. 13, 2015; 83 FR 59178, Nov. 21, 2018; 86 FR 63992, Nov. 16, 2021]

§416.166 Covered surgical procedures.

(a) *Covered surgical procedures.* Effective for services furnished on or after January 1, 2022, 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.

(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 and/or via the internet on the CMS website 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 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 —

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(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 life-threatening in nature;

(5) Commonly require systemic thrombolytic therapy;

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

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

(8) Are otherwise excluded under § 411.15 of this chapter.

(d) *Additions to the list of ASC covered surgical procedures.* Surgical procedures are added to the list of ASC covered surgical procedures as follows:

(1) *Pre-proposed rule covered procedures list (CPL) recommendation process.* On or after January 1, 2024, an external party may recommend a surgical procedure by March 1 of a calendar year for the list of ASC covered surgical procedures for the following calendar year.

(2) *Inclusion in rulemaking.* If CMS identifies a surgical procedure that meets the requirements at paragraph (a) of this section, including a surgical procedure nominated under paragraph (d)(1) of this section, it will propose to add the surgical procedure to the list of ASC covered surgical procedures in the next available annual rulemaking.

[86 FR 63992, Nov. 16, 2021, as amended at 87 FR 72291, Nov. 23, 2022]

§ 416.167 Basis of payment.

(a) *Unit of payment.* Under the ASC payment system, prospectively determined amounts are paid for ASC services furnished to Medicare beneficiaries in connection with covered surgical procedures. Covered surgical procedures and covered ancillary services are identified by codes established under the Healthcare Common Procedure Coding System (HCPCS). The unadjusted national payment rate is determined according to the methodology described in § 416.171. The manner in which the Medicare payment amount and the beneficiary coinsurance amount for each ASC service is determined is described in § 416.172.

(b) *Ambulatory payment classification (APC) groups and payment weights.* (1) ASC covered surgical procedures are classified using the APC groups described in § 419.31 of this subchapter.

(2) For purposes of calculating ASC national payment rates under the methodology described in § 416.171, except as specified in paragraph (b)(3) of this section, an ASC relative payment weight is determined based on the APC relative payment weight for each covered surgical procedure and covered ancillary service that has an applicable APC relative payment weight described in § 419.31 of this subchapter.

(3) Notwithstanding paragraph (b)(2) of this section, the relative payment weights for services paid in accordance with § 416.171(d) are determined so that the national ASC payment rate does not exceed the unadjusted nonfacility practice expense amount paid under the Medicare physician fee schedule for such procedures under subpart B of part 414 of this subchapter.

§ 416.171 Determination of payment rates for ASC services.

(a) *Standard methodology.* The standard methodology for determining the national unadjusted payment rate for ASC services is to calculate the product of the applicable conversion factor and the relative payment weight established under § 416.167(b), unless otherwise indicated in this section.

(1) *Conversion factor for CY 2008.* CMS calculates a conversion factor so that payment for ASC services furnished in CY 2008 would result in the same aggregate amount of expenditures as would be made if the provisions in this Subpart F did not apply, as estimated by CMS.

(2) *Conversion factor for CY 2009 and subsequent calendar years.* The conversion factor for a calendar year is equal to the conversion factor calculated for the previous year, updated as follows:

(i) For CY 2009, the update is equal to zero percent.

(ii) For CY 2010 through CY 2018, the update is the Consumer Price Index for All Urban Consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

(iii) For CY 2019 through CY 2025, the update is the hospital inpatient market basket percentage increase applicable under section 1886(b)(3)(B)(iii) of the Act.

(iv) For CY 2026 and subsequent years, the update is the Consumer Price Index for All Urban Consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved.

(v) For CY 2014 through CY 2018, the Consumer Price Index for All Urban Consumers update determined under paragraph (a)(2)(ii) of this section is reduced by 2.0 percentage points for an ASC that fails to meet the standards for reporting of ASC quality measures as established by the Secretary for the corresponding calendar year.

(vi) For CY 2019 through CY 2025, the hospital inpatient market basket update determined under paragraph (a)(2)(iii) of this section is reduced by 2.0 percentage points for an ASC that fails to meet the standards for reporting of ASC quality measures as established by the Secretary for the corresponding calendar year.

(vii) For CY 2026 and subsequent years, the Consumer Price Index for All Urban Consumers update determined under paragraph (a)(2)(iv) of this section is reduced by 2.0 percentage points for an ASC that fails to meet the standards for reporting of ASC quality measures as established by the Secretary for the corresponding calendar year.

(viii)(A) For CY 2011 through CY 2018, the Consumer Price Index for All Urban Consumers determined under paragraph (a)(2)(ii) of this section, after application of any reduction under paragraph (a)(2)(iv) of this section, is reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

(B) For CY 2019 through CY 2025, the hospital inpatient market basket update determined under paragraph (a)(2)(iii) of this section, after application of any reduction under paragraph (a)(2)(vi) of this section, is reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

(C) For CY 2026 and subsequent years, the Consumer Price Index for All Urban Consumers determined under paragraph (a)(2)(iv) of this section, after application of any reduction under paragraph (a)(2)(vii) of this section, is reduced by the productivity adjustment described in section 1886(b)(3)(B)(xi)(II) of the Act.

(D) The application of the provisions of paragraph (a)(2)(viii)(A), (B), or (C) of this section may result in the update being less than zero percent for a year, and may result in payment rates for a year being less than the payment rates for the preceding year.

(b) *Exception.* The national ASC payment rates for the following items and services are not determined in accordance with paragraph (a) of this section but are paid an amount derived from the payment rate for the equivalent item or service set under the payment system established in part 419 of this subchapter as updated annually in the FEDERAL REGISTER and/or via the Internet on the CMS Web site. If a payment rate is not available, the following items and services are designated as contractor-priced:

(1) Covered ancillary services specified in §416.164(b), with the exception of radiology services and certain diagnostic tests as provided in §416.164(b)(5) and non-opioid pain management drugs and biologicals that function as a supply when used in a surgical procedure as determined by CMS under §416.174.

(2) The device portion of device-intensive procedures, which are procedures that—

(i) Involve implantable devices assigned a CPT or HCPCS code;

(ii) Utilize devices (including single-use devices) that must be surgically inserted or implanted; and

(iii) Have a HCPCS code-level device offset of greater than 30 percent when calculated according to the standard OPPS ASC ratesetting methodology.

(3) Procedures using certain separately paid implantable devices that are approved for transitional pass-through payment in accordance with §419.66 of this subchapter.

(4) Notwithstanding paragraph (b)(2) of this section, procedures assigned to Low Volume APCs where the otherwise applicable payment rate calculated