(4) The national ASC payment rate for CY 2011 and subsequent calendar years for a covered surgical procedure designated in accordance with §416.166 is the payment rates for the procedure calculated under the methodology described in paragraph (a) of this section.

(5) Covered ancillary services described in §416.164(b) and surgical procedures identified as covered when performed in an ASC under §416.166 for the first time beginning on or after January 1, 2008, are not subject to the transitional payment rates applicable in CYs 2008 through 2010 for ASC facility services.

(d) *Limitation on payment rates for office-based surgical procedures and covered ancillary radiology services and certain diagnostic tests.* Notwithstanding the provisions of paragraph (a) of this section, for any covered surgical procedure under §416.166 that CMS determines is commonly performed in physicians' offices or for any covered ancillary radiology service or diagnostic test under §416.164(b)(5), excluding those listed in paragraphs (d)(1) and (d)(2) of this section, the national unadjusted ASC payment rates for these procedures and services will be the lesser of the amount determined under paragraph (a) of this section or the amount calculated at the nonfacility practice expense relative value units under §414.22(b)(5)(i)(B) of this chapter multiplied by the conversion factor described in §414.20(a)(3) of this chapter.

(1) The national unadjusted ASC payment rate for covered ancillary radiology services that involve certain nuclear medicine procedures will be the amount determined under paragraph (a) of this section.

(2) The national unadjusted ASC payment rate for covered ancillary radiology services that use contrast agents will be the amount determined under paragraph (a) of this section.

(e) *Budget neutrality.* (1) For CY 2008, CMS establishes the conversion factor to result in budget neutrality as estimated by CMS in accordance with paragraph (a)(1) of this section.

(2) For CY 2009 and subsequent calendar years, CMS adjusts the ASC relative payment weights under §416.167(b)(2) as needed so that any updates and adjustments made under §419.50(a) of this subchapter are budget neutral as estimated by CMS.

[72 FR 42545, Aug. 2, 2007, as amended at 75 FR 72264, Nov. 24, 2010; 76 FR 74582, Nov. 30, 2011; 77 FR 277, Jan. 4, 2012; 77 FR 68558, Nov. 15, 2012; 79 FR 67030, Nov. 10, 2014; 81 FR 79879, Nov. 14, 2016; 83 FR 59178, Nov. 21, 2018; 84 FR 61490, Nov. 12, 2019; 86 FR 63993, Nov. 16, 2021]

§416.172 Adjustments to national payment rates.

(a) *General rule.* Contractors adjust the payment rates established for ASC services to determine Medicare program payment and beneficiary coinsurance amounts in accordance with paragraphs (b) through (g) of this section.

(b) *Lesser of actual charge or geographically adjusted payment rate.* Payments to ASCs equal 80 percent of the lesser of—

(1) The actual charge for the service; or

(2) The geographically adjusted payment rate determined under this subpart.

(c) *Geographic adjustment*—(1) *General rule.* Except as provided in paragraph (c)(2) of this section, the national ASC payment rates established under §416.171 for covered surgical procedures are adjusted for variations in ASC labor costs across geographic areas using wage index values, labor and nonlabor percentages, and localities specified by the Secretary.

(2) *Exception.* The geographic adjustment is not applied to the payment rates set for drugs, biologicals, devices with OPPS transitional pass-through payment status, and brachytherapy sources.

(d) *Deductibles and coinsurance.* Part B deductible and coinsurance amounts apply as specified in §§410.152(a) and (i)(2) of this subchapter.

(e) *Payment reductions for multiple surgical procedures*—(1) *General rule.* Except as provided in paragraph (e)(2) of this section, when more than one covered surgical procedure for which payment is made under the ASC payment system is performed during an operative session, the Medicare program payment amount and the beneficiary coinsurance amount are based on—

(i) 100 percent of the applicable ASC payment amount for the procedure

with the highest national unadjusted ASC payment rate; and

(ii) 50 percent of the applicable ASC payment amount for all other covered surgical procedures.

(2) *Exception: Procedures not subject to multiple procedure discounting.* CMS may apply any policies or procedures used with respect to multiple procedures under the prospective payment system for hospital outpatient department services under Part 419 of this subchapter as may be consistent with the equitable and efficient administration of this part.

(f) *Interrupted procedures.* (1) Subject to the provisions of paragraph (f)(2) of this section, when a covered surgical procedure or covered ancillary service is terminated prior to completion due to extenuating circumstances or circumstances that threaten the well-being of the patient, the Medicare program payment amount and the beneficiary coinsurance amount are based on one of the following:

(i) The full program and beneficiary coinsurance amounts if the procedure for which anesthesia is planned is discontinued after the induction of anesthesia or after the procedure is started;

(ii) One-half of the full program and beneficiary coinsurance amounts if the procedure for which anesthesia is planned is discontinued after the patient is prepared for surgery and taken to the room where the procedure is to be performed but before the anesthesia is induced; or

(iii) One-half of the full program and beneficiary coinsurance amounts if a covered surgical procedure or covered ancillary service for which anesthesia is not planned is discontinued after the patient is prepared and taken to the room where the service is to be provided.

(2) Beginning CY 2016, if the covered surgical procedure is a device-intensive procedure, the full device portion of the ASC device-intensive procedure is removed prior to determining the Medicare program payment amount and the beneficiary coinsurance amount identified in paragraph (f)(1)(ii) of this section.

(g) *Payment adjustment for new technology intraocular lenses (NTIOLs).* A payment adjustment will be made for insertion of an IOL approved as belonging to a class of NTIOLs as defined in subpart G.

(h) *Special payment for certain code combinations*—(1) *Eligibility.* A code combination is eligible for the payment specified in paragraph (h)(2) of this section if the code combination is—

(i) Eligible for a comprehensive APC (C–APC) complexity adjustment under the OPPS; and

(ii) Comprised of a separately payable surgical procedure, that is listed on the ASC Covered Procedures list (§ 416.166), and one or more packaged add-on codes that are listed on the ASC covered procedures or ancillary services lists (§ 416.164(b)).

(2) *Calculation of payment.* (i) Except as specified in paragraph (h)(2)(ii) of this section, CMS calculates the payment for code combinations that meet the eligibility requirements in paragraph (h)(1) of this section by applying the methodology specified in § 416.171(a) to the OPPS C–APC complexity-adjusted relative weights.

(ii) For primary procedures assigned device-intensive status that are a component of a code combination that is eligible for payment under paragraph (h)(2) of this section, the primary procedure of the code combination retains its device-intensive status, and—

(A) The device portion is equivalent to the device portion of the device-intensive APC under the OPPS (§ 419.44(b) of this subchapter); and

(B) The non-device portion is calculated in accordance with the methodology specified in § 416.171(a).

[72 FR 42545, Aug. 2, 2007, as amended at 80 FR 70604, Nov. 13, 2015; 87 FR 72291, Nov. 23, 2022]

§ 416.173 Publication of revised payment methodologies and payment rates.

CMS publishes annually, through notice and comment rulemaking in the FEDERAL REGISTER and/or via the Internet on the CMS Web site, the payment methodologies and payment rates for ASC services and designates the covered surgical procedures and covered ancillary services for which CMS will