



**News Flash** – The Medicare Billing Information for Rural Providers, Suppliers, and Physicians, which consists of charts that provide billing information for Rural Health Clinics, Federally Qualified Health Centers, Skilled Nursing Facilities, Home Health Agencies, and Critical Access Hospitals, is available at <http://www.cms.hhs.gov/MLNProducts/downloads/RuralChart.pdf> on the CMS website.

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## Revised Payment System for Ambulatory Surgical Centers (ASC) in Calendar Year (CY) 2008

### Provider Types Affected

Ambulatory Surgical Centers (ASCs) billing Medicare contractors (carriers or Part A/B Medicare Administrative Contractors (MACs)) for services provided to Medicare beneficiaries.

### Provider Action Needed



#### STOP – Impact to You

The Centers for Medicare & Medicaid Services (CMS), pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), is implementing significant revisions to the payment system for ASC services beginning with services rendered on or after January 1, 2008.



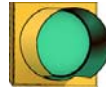
#### CAUTION – What You Need to Know

CMS has issued a final rule (available at [http://www.cms.hhs.gov/ASCPayment/04\\_CMS-1517-F.asp#TopOfPage](http://www.cms.hhs.gov/ASCPayment/04_CMS-1517-F.asp#TopOfPage) on the CMS website) that describes the revised payment system. Beginning in CY 2008, the revised ASC payment system will provide a transition to the revised rates for currently covered ASC services through three years of transitional payments that are based on a blend of the payment rates from the existing system and the revised payment rates calculated according to the methodology of the revised payment system. CMS also has issued a combined OPPS/ASC proposed rule (available at [http://www.cms.hhs.gov/ASCPayment/05\\_CMS-1392-](http://www.cms.hhs.gov/ASCPayment/05_CMS-1392-)

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[P\(ASC\).asp#TopOfPage](#) on the CMS website) that proposes updates to the payment rates and other pertinent ratesetting information for CY 2008.



### GO – What You Need to Do

Be sure your billing personnel are aware of the new system and the coding requirements of the new system in order to assure prompt and accurate payment. See the rest of this article for details and watch for additional *MLN Matters* articles as the CY 2008 OPPTS/ASC final rule with updated payment rates is published and the system is implemented.

## Overview

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On August 2, 2007, CMS published a final rule, CMS-1517-F ([http://www.cms.hhs.gov/ASCPayment/04\\_CMS-1517-F.asp#TopOfPage](http://www.cms.hhs.gov/ASCPayment/04_CMS-1517-F.asp#TopOfPage)), establishing the policies for the revised payment system for ASCs. This final rule was followed by a proposed rule, CMS-1392-P ([http://www.cms.hhs.gov/ASCPayment/05\\_CMS-1392-P\(ASC\).asp#TopOfPage](http://www.cms.hhs.gov/ASCPayment/05_CMS-1392-P(ASC).asp#TopOfPage)), that proposes the CY 2008 ASC conversion factor and proposed ASC payment rates, in coordination with the proposed hospital Outpatient Prospective Payment System (OPPS) update.

The ASC final rule outlines the policies for the revised ASC payment system to be implemented January 1, 2008. As recommended by the November 2006 Government Accountability Office report on ASC payment, CMS will implement the revised ASC payment system using OPPTS relative payment weights as a guide.

There are currently about 4,600 ASCs enrolled in Medicare. Total Medicare expenditures for CY 2006 payments to ASCs are estimated at about \$2.5 billion. Medicare ASC expenditures for CY 2008 are expected to be approximately \$3 billion.

The final rule greatly expands the types of procedures that are eligible for Medicare payment when performed in the ASC setting and also limits payments for procedures that are performed predominantly in physicians' offices to the amount that would be paid for the non-facility practice expense (PE) under the Medicare Physician Fee Schedule (MPFS). The proposed rule includes no proposals to change these final ASC payment policies.

## Background

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Since 1982, Medicare has paid for certain surgical procedures, including cataract removal, lens replacement, and colonoscopies, when performed in freestanding or hospital-based ASCs. Currently, Medicare pays for more than 2,500 surgical procedures on the ASC approved list, based on a simple fee schedule comprised of nine unadjusted prospectively determined payment rates. The rates of the nine payment groups, prior to the "limitation on payments" adjustment, range from \$333

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to \$1339. Provider payments include a separate adjustment for geographic wage variations. Medicare makes a separate payment to physicians for professional services. ASC payment rates were last rebased in March 1990 using cost, charge, and utilization data from a 1986 survey of ASC costs.

With the passage of the MMA, Congress required CMS to revise the ASC payment system no later than January 1, 2008. In August of 2006, CMS issued a proposed rule encompassing proposed changes to OPPS policies and payment rates for CY 2007 and the proposed new payment methodology for ASCs. The OPPS and CY 2007 ASC provisions were finalized in November 2006, and the CY 2008 ASC policies related to the revised payment system were finalized in the August 2, 2007 final rule.

### **Provisions in the Final and Proposed Rules**

#### **Expanded List of ASC Procedures:**

In the ASC final rule, CMS expands access to procedures in the ASC setting by providing ASC payment for approximately 790 additional surgical procedures in CY 2008. CMS excludes from Medicare ASC payment only those surgical procedures determined to pose a significant safety risk to beneficiaries or that are expected to require an overnight stay following the procedure in the ASC.

CMS continues to identify surgical procedures as those listed by the American Medical Association (AMA) within the surgical range of Current Procedural Terminology (CPT) codes. CMS also includes within the scope of surgical procedures those services that are described by alphanumeric Healthcare Common Procedure Coding System (HCPCS) codes (Level II HCPCS codes) or Category III CPT codes that directly crosswalk or are clinically similar to procedures in the CPT surgical range.

In the OPPS/ASC proposed rule for CY 2008, CMS proposes to make a few revisions to the list of covered surgical procedures by adding several procedures to the list and updating the list of covered ancillary services in coordination with the proposed OPPS update. In addition, based on review of the most recent utilization data, a number of surgical procedures newly added for payment in CY 2008 in the ASC final rule are proposed to be designated as office-based procedures in the proposed rule and, therefore, would be subject to the "office-based" payment methodology that CMS outlined in the final rule.

#### **Revised Payment Rates:**

The revised ASC payment rates will be based on the ambulatory payment classifications (APCs) used to group procedures under the OPPS. Per the MMA, the revised ASC payment system is budget neutral. That is, the payment rates are intended to ensure that Medicare expenditures under the revised payment methodology for ASCs in CY 2008 will approximate the expenditures that would have occurred in the absence of the revised ASC payment system.

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To establish the budget neutrality adjustment for the revised ASC payment system, CMS took into account the expected migration of surgical procedures among ASCs, physicians' offices, and hospital outpatient departments (HOPDs). CMS assumed that approximately 25 percent of the HOPD volume of new ASC surgical procedures will migrate from hospitals to ASCs during the first two years of implementation of the revised ASC payment system and that 15 percent of the volume of new ASC surgical procedures currently provided in physicians' offices will migrate to ASCs during the first four years of the revised ASC payment system. CMS makes no proposal to revise this methodology in the OP/ASC proposed rule.

The illustrative budget neutrality adjustment for CY 2008 in the final rule is based on those assumptions and estimated CY 2008 OP/ASC and MPFS rates and full CY 2005 utilization data. The estimated ASC CY 2008 budget neutrality adjustment factor in the final rule is 67 percent. In the proposed rule, the budget neutrality adjustment factor is somewhat lower, 65 percent, due to proposed changes in OP/ASC payment rates as a result of APC recalibration, including the proposal to expand the size of the OP/ASC payment bundles, as well as use of CY 2006 claims and utilization data. Based on the budget neutrality adjustment factor in the proposed rule, the proposed ASC conversion factor for CY 2008 is calculated as  $0.65 \times \$63.693$  (proposed CY 2008 OP/ASC conversion factor) = \$41.400.

The standard ASC payment for most ASC covered surgical procedures is calculated as the product of the estimated ASC conversion factor and the ASC relative payment weight (set based on the OP/ASC relative payment weight) for each separately payable procedure. Per Section 626 of the MMA, contractors will pay ASCs based on the lesser of the actual charge or the standard ASC payment rate. Payment rates for surgical procedures that are commonly performed in physicians' offices and for the technical component of covered ancillary radiology procedures cannot exceed the MPFS non-facility PE amount. Payments to ASCs for covered surgical procedures and certain covered ancillary services are geographically adjusted using the Inpatient Prospective Payment System (IPPS) pre-reclassification wage index values, with 50 percent as the labor-related factor.

#### **Implementation and Updates:**

There is a four year transition period for implementation of the rates for procedures on the CY 2007 ASC list of covered procedures. For those procedures, payment will be based on a blend of the revised ASC payment rates and the current ASC rates. Thus, for CY 2008, the payment rates for procedures subject to the transition are comprised of a 25/75 blend, specifically 25 percent of the CY 2008 revised ASC rate plus 75 percent of the CY 2007 ASC rate; in CY 2009, the ratio will change to 50/50; and for CY 2010 it will be 75/25. Beginning in CY 2011, ASC payment rates will be calculated according to the policies of the revised payment system. HCPCS codes newly payable in the ASC setting beginning in CY 2008 will not be subject to this blended transitional payment methodology.

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In the annual updates to the ASC payment system, CMS will set ASC relative payment weights equal to the OPSS weights and then scale the ASC weights in order to maintain budget neutrality in the ASC payment system. Without scaling, changes in the OPSS relative payment weights for nonsurgical services could cause an increase or decrease in ASC expenditures due to differences in the mix of services provided by HOPDs and ASCs. For CY 2008, the final payment rates will be published in the CY 2008 OPSS/ASC final rule issued later this year. CMS also will publish an additional *MLN Matters* article around this time.

The statute requires a zero percent ASC update through CY 2009. Beginning in 2010, CMS will update the ASC conversion factor by the Consumer Price Index for All Urban Consumers (CPI-U).

**ASC Payment for Device-Intensive Procedures:**

A modified payment methodology will be used to establish the ASC payment rates for device-intensive procedures, defined as ASC covered surgical procedures that, under the OPSS, are assigned to APCs for which the device cost is greater than 50 percent of the APC's median cost. Payment for the high cost devices is packaged into the associated procedure payments under the revised ASC system, as it is under the OPSS. CMS pays the same amount for the device-related portion of the procedure cost under the revised ASC payment system as under the OPSS. However, payment for the service portion of the ASC rate will be calculated according to the standard ratesetting methodology, using the ASC budget neutrality adjustment. Therefore, using the budget neutrality adjustment factor in the proposed rule, the service portion of the proposed ASC payment for the device-intensive procedure would be about 65 percent of the corresponding OPSS service payment, just like the payment for other surgical procedures under the revised ASC payment system. The sum of the ASC device and service portions constitutes the complete ASC device implantation procedure payment. ASCs will no longer bill separately for these devices.

The same policy related to full credit and no cost implantable device replacement that applies to the OPSS will apply to ASC payments. That is, when a replacement device is supplied to the ASC at no cost or with full credit by the manufacturer, Medicare ASC payment for the procedure to implant the device will be reduced by the device portion of the ASC payment to account for the lower cost to the facility to furnish the procedure. Medicare provides the same amount of payment reduction based on the estimated device cost included in the ASC procedure payment that would apply under the OPSS for performance of those procedures under the same circumstances.

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In the proposed rule, CMS proposes to reduce the ASC payment by one half of the device offset amount for certain surgical procedures into which the device cost is packaged when an ASC receives a partial credit toward replacement of an implantable device. This partial payment reduction would apply to certain covered surgical procedures in which the amount of the device credit is greater than or equal to 20 percent of the cost of the new replacement device being implanted. The proposed policy mirrors the proposed policy under the OPSS for CY 2008.

**Payment for ASC Covered Ancillary Services:**

CMS will pay separately for certain covered ancillary services that are provided integral to covered surgical procedures in ASCs. The ancillary services must be provided immediately before, during, or after a covered surgical procedure to be considered integral and thereby, eligible for separate payment. Medicare also will provide separate payment to the ASC for drugs and devices that are eligible for pass-through payment under the OPSS.

In the proposed rule, CMS proposes to revise the definitions of "radiology and certain other imaging services" and "outpatient prescription drugs." The proposed revised definitions would exclude those ASC covered ancillary radiology services and covered ancillary drugs and biologicals from designation as "designated health services" subject to physician self-referral prohibitions.

As described above, payment for covered ancillary radiology services is made to ASCs at the lesser of the ASC rate or the amount of the nonfacility PE under the MPFS. To ensure that no duplicate payment is made, only ASCs may receive separate payment for the technical component of the covered ancillary radiology services that are separately payable under the OPSS.

Under the revised ASC payment system, Medicare will pay separately for all drugs and biologicals that are separately paid under the OPSS when they are provided integral to covered surgical procedures. Payment will be equal to the OPSS payment rates, without application of the ASC budget neutrality adjustment. In addition, as in the OPSS, the ASC payment rates for these items will not be adjusted for geographic wage differences.

CMS will make separate payment at contractor-priced rates for devices that have pass-through status under the OPSS when the devices are an integral part of a covered surgical procedure. CMS also provides separate payment for brachytherapy sources at the OPSS rates, or contractor-priced rates if OPSS rates are unavailable. CMS is proposing prospectively established payment rates for these sources in CY 2008 for both HOPD and ASC settings.

There is no change to payment policy for corneal tissue acquisition. Payment for corneal tissue acquisition will continue to be made at reasonable cost when corneal transplants are performed in ASCs.

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No other providers or suppliers may bill for covered ancillary services provided in ASCs integral to covered surgical procedures. This policy will ensure that packaged or separate payment is made to ASCs for all covered ancillary services integral to the performance of covered surgical procedures, thereby providing appropriate payment to ASCs for those services that are essential to the delivery of safe, high quality surgical care.

**Physician Payment for Non-Covered ASC Procedures:**

ASCs currently receive facility payments under the ASC payment system only for surgical procedures included on a list of ASC covered procedures. They receive no facility payment for any other procedures. Physicians are paid for their PE based on the facility PE relative value units (RVUs) for performing surgical procedures that are on the list. They are paid based on the non-facility PE, or technical component RVUs, for performing services that are not included on the list.

To make the payments to physicians who furnish noncovered procedures in ASCs more consistent with the policy under the OPPIs, and in recognition that under the revised ASC payment system only procedures that have been determined to pose a significant safety risk or are expected to require an overnight stay are excluded from the ASC list, CMS proposes to pay physicians at the facility PE payment amount, rather than the non-facility PE amount, for furnishing noncovered procedures in ASCs.

**New and Revised Billing Procedures**

**Reporting Separately Payable Ancillary Services:**

As described above, beginning January 1, 2008, Medicare will make separate payment to ASCs for certain ancillary items and services such as drugs and biologicals, brachytherapy sources, radiological procedures, and pass-through devices when they are provided integral to ASC covered surgical procedures. ASCs must report separately payable ancillary services with an accurate number of units in order for correct payment to be made. ASCs should be mindful of dosages of drugs and biologicals and the units included in the HCPCS code descriptors when reporting units. Inaccurate reporting of units for HCPCS codes may result in under- or overpayment.

**For example, a typical dosage for the drug reported by HCPCS code J1260 (Injection, dolasetron mesylate, 10mg) is 100 mg. ASCs using 100 mg in the care of a patient will report a 100 mg dose of dolasetron mesylate as 10 units of HCPCS code J1260. Failure to report the correct number of units will result in under- or overpayment. In the case of J1260, if the ASC were to report only one unit for HCPCS code J1260, when it provided one 100 mg dose, it would receive only one-tenth of the Medicare payment for that drug.**

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Additionally, ASCs will bill separately for devices that have pass-through status under the OPSS when provided integral to covered surgical procedures and, therefore, will be paid separately under the revised ASC payment system. ASCs should use the appropriate Level II HCPCS codes to report the devices. Only two devices currently have pass-through status under the OPSS: C1821 (Interspinous process distraction device (implantable)) and L8690 (Auditory osseointegrated device, includes all internal and external components). For these two devices only, ASCs should report the code for the device and its charge. The Medicare contractor will determine the payment amount for each of the pass-through devices.

ASCs also will need to report the number of units for brachytherapy sources that are provided integral to covered surgical procedures. Medicare will pay the same amount for the sources under the revised ASC payment system as it pays hospitals under the OPSS if prospective OPSS rates are available. The ASC will report and charge Medicare and the beneficiary coinsurance for all brachytherapy sources that are ordered by the physician for a specific beneficiary, acquired by the ASC, and implanted in the beneficiary in the ASC in accordance with high quality clinical care standards.

In the case where most, but not all, prescribed and acquired sources are implanted in the beneficiary, Medicare will cover the relatively few brachytherapy sources that were ordered and acquired but not implanted due to specific clinical consideration. These non-implanted sources may be billable to Medicare only under the following circumstances:

- The sources were specifically acquired by the ASC for the particular beneficiary according to a physician's prescription that was consistent with standard clinical practice and high quality brachytherapy treatment. The sources that were not implanted in that beneficiary were not implanted in any other patient;
- The sources that were not implanted were disposed of in accordance with all appropriate requirements for their handling; and
- The number of sources used in the care of the beneficiary but not implanted would not be expected to constitute more than a small fraction of the sources actually implanted in the beneficiary.

#### **Reporting Charges for Separately Payable Procedures and Services:**

Under the revised payment system, ASCs must report charges for all separately payable procedures and services in order to receive correct payment. Medicare contractors will make payment based on the lower of actual charges for separately payable procedures and services, or the ASC payment rate. ASCs should not report separate line item HCPCS codes or charges for procedures, services,

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drugs, devices, or supplies that are packaged into payment for covered surgical procedures and therefore not paid separately.

Because section 1833(a)(1) of the Social Security Act, as amended by section 626(c) of the MMA, requires ASCs to be paid the lesser of 80 percent of actual charges or the amount that would be paid by Medicare for each separately payable procedure and service, Medicare contractors will compare billed charges to the ASC payment rate at the line-item level. Therefore, it is important that ASCs incorporate charges for packaged services into the charges reported for the separately payable services with which they are provided. Facilities may not be paid appropriately if they unbundle charges and report those charges for packaged codes as separate line-item charges.

**For example, the single charge reported for a device-intensive procedure should include not only the charges associated with the service such as operating room time and recovery room use, but also the charges associated with the implantable device.** Unlike the current ASC payment system, the revised payment system packages device payment into the payment for the associated procedure (i.e., the device is not paid separately). If the ASC bills a procedure code for a device-intensive procedure and fails to include charges for the device in establishing the single line item charge for the covered surgical procedure, the procedure charge may be lower than the Medicare payment rate for that procedure code, which includes payment for the device. The contractor would make payment based on the provider's charges, possibly resulting in underpayment.

Following is a hypothetical example that illustrates the revised payment policy:

Correct Reporting								
Example	HCPCS	Description	PI	Units	ASC-Reported Charge	Unadjusted Medicare Payment Rate*	Unadjusted Medicare Payment to Provider	Unadjusted Beneficiary Payment to Provider
Claim 1: Charges for Packaged Device Rolled Into Charges for Separately Payable Procedure	62361	Implant spine infusion pump	H8	1	\$12,000	\$10,000	\$10,000 x .80 = \$8,000	\$10,000 x .20 = \$2,000
Because the Medicare payment rate is less than the reported charges for CPT code 62361, the provider receives total unadjusted payment (from Medicare and the beneficiary) of \$10,000. In this case, the amount set by Medicare for all costs of the procedure is paid.								

\* All payment rates are hypothetical.

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Incorrect Reporting								
Example	HCPCS	Description	PI	Units	ASC-Reported Charge	Unadjusted Medicare Payment Rate*	Unadjusted Medicare Payment to Provider	Unadjusted Beneficiary Payment to Provider
Claim 2: Charges for Packaged Device Reported on Different Line from Separately Payable Procedure	62361	Implant spine infusion pump	H8	1	\$2,500	\$10,000	\$2,500 x .80 = \$2,000	\$2,500 x .20 = \$500
	C1891	Infusion pump, non-programmable, permanent	N1	1	\$9,500	N/A	N/A	N/A
Because the reported charges for CPT code 62361 are less than the Medicare payment rate, the provider receives total unadjusted payment (from Medicare and the beneficiary) of \$2,500. In this case, the ASC will not receive the amount set by Medicare for all costs of the procedure, due to the ASC's incorrect separate reporting of packaged charges.								

\* All payment rates are hypothetical.

### **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 the -50 modifier is not prohibited specifically according to CMS billing instructions, the modifier will not be recognized for payment purposes and may result in incorrect payment to ASCs. The multiple procedure reduction of 50 percent will apply to all bilateral procedures subject to multiple procedure discounting.

The following page provides a hypothetical example that illustrates this payment policy:

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Correct Reporting								
Example	HCPCS	Description	PI	Units	ASC-Reported Charges	Unadjusted Medicare Payment Rate*	Unadjusted Medicare Payment to Provider with Multiple Procedure Reduction	Unadjusted Beneficiary Payment to Provider with Multiple Procedure Reduction
Claim 1: Bilateral Procedure Reported on Two Lines	15823	Revision of Upper Eyelid	A2	1	\$1,000	\$800	$\$800 \times .80 = \$640$	$\$800 \times .20 = \$160$
	15823	Revision of Upper Eyelid	A2	1	\$1,000	\$800	$(\$800 \times .50) \times .80 = \$320$	$(\$800 \times .50) \times .20 = \$80$
Because the provider reports the bilateral procedure on two separate lines, and because the multiple procedure reduction applies to 15823, the provider receives total unadjusted payment (from Medicare and the beneficiary) of \$1,200 for both procedures.								
Claim 2: Bilateral Procedure Reported on One Line with Two Units	15823	Revision of Upper Eyelid	A2	2	\$2,000	\$800 X 2	$[\$800 + (\$800 \times 0.50)] \times .80 = \$960$	$[\$800 + (\$800 \times 0.50)] \times .20 = \$240$
Because the provider reports the bilateral procedure using "2" in the units field, and because the multiple procedure reduction applies to 15823, the provider receives total unadjusted payment (from Medicare and the beneficiary) of \$1,200 for both procedures.								
Incorrect Reporting								
Claim 3: Bilateral Procedure Reported on One Line with Bilateral Modifier	15823 50	Revision of Upper Eyelid	A2	1	\$2,000	\$800	$\$800 \times .80 = \$640$	$\$800 \times .20 = \$160$
Because the provider reports the bilateral procedure using the bilateral modifier, the provider receives total unadjusted payment (from Medicare and the beneficiary) of \$800 for only one of the procedures.								

\* All payment rates are hypothetical.

## Additional Information

For more information regarding this and other ASC issues, CMS encourages you to use the ASC webpage at <http://www.cms.hhs.gov/ASCPayment> on the CMS website.

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