CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1325	**Date: AUGUST 29, 2007**
	Change Request 5680

NOTE: This Transmittal is no longer sensitive and is being re-communicated November 2, 2007. The Transmittal Number, date of Transmittal and all other information remain the same.

Subject: Testing and Implementation of 2008 Ambulatory Surgical Center (ASC) Payment System Changes

I. SUMMARY OF CHANGES: This CR provides the background, policy, and contractor instructions to test and implement the 2008 revised ASC payment system.

New / Revised Material
Effective Date: January 1, 2008
Implementation Date: January 7, 2008

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	1/30.3.1/Mandatory Assignment on Carrier Claims
R	4/120/General Rules for Reporting Outpatient Hospital Services
R	4/180.1/General Rules
R	14/Table Of Contents
R	14/10/General
R	14/10.1/Definition of Ambulatory Surgical Center (ASC)
R	14/10.2/Ambulatory Surgical Center Services on ASC List
R	14/10.3/Services Furnished in ASCs
R	14/10.4/Coverage of Services in ASCs Which Are Not ASC Facility Services
R	14/20/List of Covered Ambulatory Surgical Center Procedures
R	14/20.1/Nature and Applicability of ASC List

R	14/20.2/Types of Services Included on the List
R	14/30/Rate-Setting Policies
R	14/30.1/Where to Obtain Current Rates and List of Covered Services
R	14/40/Payment for Ambulatory Surgery
R	14/40.1/Payment to Ambulatory Surgical Centers for Non-ASC Services
R	14/40.2/Wage Adjustment of Base Payment Rates
R	14/40.3/Payment for Intraocular Lens (IOL)
R	14/40.4/Payment for Terminated Procedures
R	14/40.5/Payment for Multiple Procedures
R	14/40.6/Payment for Extracorporeal Shock Wave Lithotripsy (ESWL)
N	14/40.7/Offset for Payment for Pass-Through Devices Beginning January 1, 2008
N	14/40.8/Payment When a Device is Furnished With No Cost or With Full or Partial Credit Beginning January 1, 2008
N	14/40.9/Payment for Presbyopia Correcting IOLs (P-C IOLs) and Astigmatism Correcting IOLs (A-C IOLs)
R	14/50/ASC Procedures for Completing the Form CMS-1500
R	14/60/Medicare Summary Notices (MSN), Claim Adjustment Reason Codes, Remittance Advice Remark Codes (RAs)
N	14/60.1/Applicable Messages for NTIOLs
N	14/60.2/Applicable Messages for ASC 2008 Payment Changes Effective January 1, 2008
R	18/60.1.1/Deductible and Coinsurance
R	19/20/Carrier and FI Designation
R	19/40.2.1/Provider Enrollment with FI - Ambulatory Surgical Services
N	19/80.9/Carrier Claims Processing and Payment Policy for ASC Claims
R	19/100.3.3/FI - Social Admissions
R	19/100.6/FI - Ambulatory Surgical Center (ASC) - Medicare Part B - Payment Policy
R	19/100.6.1/FI - ASC - Medicare Part B - Claims Processing
R	19/100.8/FI - CAH Swing-bed - Medicare Part A - Payment Policy
R	19/100.8.2/FI - CAH Swing-bed - Inpatient Ancillary Claims - Medicare Part B - Payment Policy
R	19/100.10.1/FI - Vaccines and Vaccine Administration - Claims Processing
R	19/100.11/FI - Physical Therapy, Occupational Therapy, Speech-Language

	Pathology and Diagnostic Audiology Services - Payment Policy
R	19/100.11.1/FI - Physical Therapy, Occupational Therapy, Speech-Language Pathology and Diagnostic Audiology Services - Claims Processing
R	26/10.7/Type of Service (TOS)

III. FUNDING:
No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

Unless otherwise specified, the effective date is the date of service.

Attachment – One-Time Notification

Pub. 100-04	Transmittal: 1325	Date: August 29, 2007	Change Request: 5680

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SUBJECT: Testing and Implementation of 2008 Ambulatory Surgical Center (ASC) Payment System Changes

Effective Date: **January 1, 2008**
Implementation Date: January 7, 2008

I. GENERAL INFORMATION

A. Background: Section 626 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires implementation of a new ASC payment system not later than January 1, 2008. In part, this section requires that ASCs be paid the lesser of the actual charge or ASC fee schedule payment rates. Final ASC payment rates cannot be established until after publication of the CY 2008 outpatient prospective payment system (OPPS) final rule; therefore, the final list of ASC payable Healthcare Common Procedure Coding System (HCPCS) codes for 2008 and their corresponding payment rates will not be available until November 2007. Consequently, this transmittal includes an attachment of the file layout and a test file, which contractors can use to develop and test their systems.

The final file of HCPCS codes and payment rates, with the exception of drugs and biologicals, will be available for download in November 2007. The final file for drugs and biologicals will be available for download in mid- to late- December 2007. The phase 2 testing and implementation instruction will provide contractors with the final file names. The Centers for Medicare and Medicaid Services (CMS) will notify contractors by e-mail when these files are available for them to download. This transmittal includes payment file retrieval instructions for contractors via the CMS Mainframe Telecommunications System that can be used to access specific payment files on or after the specified retrieval date provided in CMS's notification. CMS' Division of Data Systems will release the files listed below in the business requirements.

The ASC payment amounts will be released shortly after publication of the ASC final rule in the Federal Register in November. A link to this rule will be available on the CMS Web site at: http://www.cms.hhs.gov/center/asc.asp

There is a separate mainframe data file (file name "ASCFS") for testing purposes that reflects the type of changes contractors should expect in the final ASC list of payable codes. Contractor files should be updated with the final "additions", "deletions", and "complete" data files, which will be available around November 2007. These changes shall not be publicized until after the publication of the American Medical Association's 2008 Common Procedural Terminology (CPT-4) codes which usually occurs by the first of November.

Transmittal 1245, CR 5572, issued May 18, 2007, provided contractors with the design and analyses instructions for the 2008 revised ASC payment system.

B. Policy: Effective for dates of service on or after January 1, 2008, Medicare will implement a revised ASC payment system. The components and policies of the revised system are explained in Transmittal 1245.

In addition to the revised payment system instructions explained in Transmittal 1245, contractors will pay ASCs a reduced amount for certain procedures when the ASC receives a partial credit for more than 20 percent of the cost of the device. For certain procedure codes that include payment for a device, ASCs will be required to include an FC modifier on the procedure code to report that the ASC received a partial credit for more than 20 percent of the cost of the device. The design and analysis requirements will be explained in a future CR. For those procedure codes where the FC modifier may be applicable, CMS will provide contractors with a price for the procedure code both with and without the FC modifier. The FC modifier pricing determination is performed prior to the application of the multiple procedure pricing reductions.

NOTE: Revisions to §20, 100.8 and 100.8.2 in chapter 19 of Pub.100-04, Medicare Claims Processing Manual, are included with this CR. There are no policy changes attached to these sections. However, changes to chapter 19 should be reviewed in their entirety since changes were made to other sections of the chapter specifically for this CR.

Included in this CR are revisions to the Claims Processing Manual, Pub. 100-04, chapter 1, sec.30; chapter 18, sec. 60; chapter 4, sec. 120 and sec. 180.1; chapter 14, chapter 26, sec. 10; and chapter 19 (various sections). Also included in this CR are changes to the Benefit Policy Manual, Pub.100-02, chapter 15, sec. 260. Contractors shall implement these manual revisions.

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5680.1	Contractors shall download from the CMS mainframe the file MU00.@BF12390.ASC.CY08.FS.V1101 Note: Wage related information reflects the CBSA values. **Date of retrieval will be provided in a separate email communication from CMS**	X			X				X			
5680.2	Contractors and shared systems maintainers shall use the ASCFS file fields and values to properly process ASC claims submitted for dates of service on or after January 01, 2008.	X			X				X			
5680.2.1	Contractors shall assign ASCs to their applicable CBSA payment locality using an Excel spreadsheet crosswalking MSAs to CBSAs developed by CMS. File name:	X			X							

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	MU00.@AAA2390.ASC.FY08.XWALK.#070119 **(File is available for immediate download).**											
5680.2.2	Shared Systems shall allow users to link ASC providers to their applicable CBSA payment locality.								X			
5680.2.3	The shared system shall be modified to price ASC services based on the lower of the submitted charge or the ASCFS payment rate for ASC facility services performed on or after January 01, 2008.								X			
5680.3	Shared systems shall no longer rely on the SG modifier to assign TOS F for services performed in an ASC setting (for dates of service on or after January 01, 2008). **NOTE:** The SG modifier is used to assign TOS F for dates of service prior to January 01, 2008.								X			
5680.3.1	Shared system shall assign type of service code F to codes billed by specialty 49 for Place of Service 24 for dates of service on or after January 1, 2008.								X			
5680.3.2	Contractors and CWF shall ignore the SG modifier if billed by ASCs for dates of service on or after January 01, 2008.	X			X						X	
5680.4	Shared systems shall not allow facility payments to be made to specialties other than ASCs (specialty 49) for ASC approved surgical procedures (i.e., procedure indicator S) that are furnished in an ASC setting [POS 24].								X			
5680.5	Contractors deny services not included on the ASC facility payment files (ASCFS and ASC DRUG files) when billed by ASCs (specialty 49). Use remittance reason code 8, remark code N95 and MSN 16.8.	X			X							
5680.6	Contractors shall download from the CMS mainframe the file MU00.@BF12390.ASC.CY08.DRUG.V1101 **NOTE:** These code payment rates are unadjusted and are not subject to wage index calculations.	X			X				X			

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	Date of retrieval will be provided in a separate email communication from CMS.											
5680.6.1	Contractors and shared system maintainers shall use the "ASC DRUG" file fields and values and properly process ASC drug claims.	X			X				X			
5680.7	Contractors and shared systems shall ensure that both the "ASCFS" and "ASC DRUG" files interface properly.	X			X				X			
5680.7.1	Contractors shall accept a subset of HCPCS "C" codes used to pay ASCs for certain drugs, devices and procedures. **NOTE:** The subset of HCPCS C codes are included in the ASCFS file.	X			X							
5680.8	Contractors shall accept the expanded list of ASC billable codes with TOS F (i.e., codes that are on the ASCFS and ASC Drug files) for dates of service on or after January 01, 2008.	X			X							
5680.9	Contractors and shared systems shall cutback the payment for certain ASC procedures when billed in conjunction with certain pass through devices by the same provider for the same date of service. The ASC code pair record layout is attached.	X			X				X			
5680.9.1	Contractors shall download from the CMS mainframe the file MU00.@BF12390.ASC.CY08.CPAIR.V1101 **NOTE:** The payment offset amount represents the percent that the specific procedure payment rate should be reduced when a specific ASC device/procedure code pair appear on a claim. The percent reduction should be applied to the wage adjusted CBSA procedure payment rate. For example 63 percent would be displayed in the code pair table as 06300. **Date of retrieval will be provided in a separate email communication from CMS.**	X			X				X			
5680.9.2	Contractors should check the claim for each code pair in the look-up table in the order they are listed in the look-up table. If one pass through device could pair with multiple	X			X				X			

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	procedures on the look-up table, the contractor should apply the cutback to the first code pair it identifies by going through the look-up table sequentially. If there is more than 1 unit of a code pair on the claim, the contractor should take an offset for each code pair (without using the same unit of a pass through device or procedure in more than one code pair).											
5680.10	Contractors shall make an ASC facility payment for pass-through devices furnished in conjunction with a Medicare approved ASC surgical procedure.	X			X				X			
5680.10.1	Contractors shall price Pass-through devices based on acquisition cost or invoice.	X			X							
5680.10.2	If pass-through devices are not billed or are not processed on the same claim as an approved ASC surgical procedure, contractors shall check history for an approved ASC surgical procedure on the same date by the billing ASC provider.	X			X				X			
5680.10.3	If there is no approved ASC surgical procedure on the same date for the billing ASC in history, contractors shall return pass-through device claims/line items as unprocessable using Reason Code 16, Remark Code MA109 and, at contractor discretion, remark code M16 may also be generated.	X			X							
5680.11	Contractors shall pay ASCs for approved ASC procedures included in ASCFS.	X			X				X			
5680.11.1	Contractors shall deny ancillary services on the ASCFS (i.e., radiology technical component) billed by specialties other than specialty 49 provided in an ASC setting (POS 24) using Reason Code 171, Remark Code M97, (M16 optional) and MSN message 16.2.	X			X							
5680.11.2	Contractors shall pay ASCs reduced amounts for HCPCS submitted with the FB modifier. The reduced rates will be included on the ASC files furnished by CMS.	X			X				X			
5680.11.3	Contractors shall perform the FB modifier pricing determination prior to the application of the multiple procedure pricing reductions.	X			X				X			
5680.11.4	Contractors shall pay ASCs reduced amounts	X			X				X			

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	for HCPCS submitted with the FC modifier. The reduced rates will be included on the ASC files furnished by CMS.											
5680.11.5	Contractors shall perform the FC modifier pricing determination prior to the application of the multiple procedure pricing reductions.	X			X				X			
5680.12	Contractors shall continue to pay ASC claims for surgical procedures with modifier 73 (discontinued outpatient procedure prior to administration of anesthesia) and modifier 74 (discontinued outpatient procedure after administration of anesthesia).	X			X							
5680.12.1	Contractors shall apply a 50% allowed charge reduction for those ASC surgical procedures billed with modifier 73.	X			X				X			
5680.12.2	The Shared System shall ensure that multiple procedure reductions do not apply to approved ASC services billed with modifier 73.								X			
5680.13	Contractors shall apply a 50% reduction for approved procedures billed with modifier 52.	X			X				X			
5680.13.1	The Shared System shall ensure that multiple procedure reductions do not apply to approved ASC surgical services billed with modifier 52.								X			
5680.14	Contractors and shared systems shall apply 50% multiple surgery procedure payment reductions. HCPCS codes subject to the payment reduction policy are identified on the ASCFS file provided by CMS.	X			X				X			
5680.14.1	Contractors and shared systems shall use the lower of the submitted charge or the ASCFS amount in determining the ranking of procedures for multiple surgery reductions.	X			X				X			
5680.14.2	Contractors and shared systems shall use the lower of the submitted charge or ASCFS amount in applying the multiple surgery pricing reduction.	X			X				X			
5680.14.3	The Shared System shall apply modifier 51 to procedures that are subject to the multiple procedure reductions.								X			
5680.15	Contractors shall continue to pay for "contractor priced" items (e.g., corneal tissue acquisition) for which Medicare does not	X			X				X			

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	provide a payment amount using existing ASC pricing methodologies and payment policies.											
5680.16	Contractors shall no longer pay ASCs separately for implantable devices previously paid under the DMEPOS fee schedule for dates of service on or after January 1, 2008.	X			X				X			
5680.16.1	Contractors shall deny separately billed implantable devices using Remark Codes M97, M15 and MA109 (M16 optional) and MSN message 16.32, if there is a related, approved surgical procedure for the billing ASC for the same date of service, also include MSN message 16.8. **NOTE:** Only pass-through devices may be paid separately. All other device payments are included in the procedure payment rate.	X			X							
5680.17	Contractors shall make payment for separately billable brachytherapy sources furnished by ASCs when furnished in conjunction with a Medicare approved ASC surgical procedure.	X			X				X			
5680.17.1	If brachytherapy sources are not billed or are not processed on the same claim as the related surgical procedure, contractors shall check history for an approved ASC surgical procedure performed on the same date by the billing ASC provider.	X			X				X			
5680.17.2	Contractors shall price brachytherapy sources based on acquisition cost or invoice if the code is on the ASCFS and has a carrier priced indicator.	X			X							
5680.17.3	If there is no approved ASC surgical procedure on the same date for the billing ASC in history, contractors shall return the brachytherapy sources claims as unprocessable using Reason Code 16, Remark Code MA109 and, at contractor discretion, remark code M16 may also be generated.	X			X							
5680.18	Contractors shall pay ASCs for ancillary services included in the ASCFS file when furnished in conjunction with a Medicare approved ASC surgical procedures.	X			X				X			

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5680.18.1	When ancillary services are not billed or processed on the same claim as the related surgical procedure, contractors shall check history for an approved ASC surgical procedure on the same date for the billing ASC.	X			X				X			
5680.18.2	If there's no approved ASC surgical procedure in history, contractors shall return as unprocessable ASCFS ancillary services billed by ASCs using Reason Code 16, Remark Code MA109 and, at contractor discretion, remark code M16 may also be generated.	X			X							
5680.19	Contractors shall pay ASCs for drugs billed under HCPCS C9399 (unclassified drug or biological).	X			X				X			
5680.19.1	Contractors shall determine the approved charge for code C9399 based on 95% of the AWP.	X			X							
5680.19.2	Contractors shall use published drug compendia, to establish AWPs for pricing drugs billed via HCPCS code C9399.	X			X							
5680.19.2.1	Contractors shall use invoice for pricing drugs billed via HCPCS C9399 only if the drug AWP does not appear in the current published drug compendia.	X			X							
5680.19.3	When any drug code on the ASC Drug File including C9399 is not billed or processed on the same claim as the ASC approved surgical procedure, contractors shall check history for an approved ASC surgical procedure on the same date for the billing ASC.	X			X				X			
5680.19.4	If there is no approved ASC surgical procedure on the same date for the billing ASC in history, contractors shall return as unprocessable any drug code on the ASC Drug file including C9399 using Reason Code 16, Remark Code MA109 and, at contractor discretion, remark code M16 may also be generated.	X			X							
5680.20	Contractors shall pay 80 percent of the approved charge for ASC services (except for screening colonoscopies and flexible sigmoidoscopies). The approved charge is the lesser of the submitted charge or the Medicare	X			X				X			

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	defined wage adjusted payment rate.											
5680.21	Contractors shall continue to pay 75 percent of the approved charge for screening colonoscopies and flexible sigmoidoscopies performed in ASCs. **NOTE:** This change is being implemented in July 2007 via CR 5387, Transmittal 1160.	X			X				X			
5680.21.1	Contractors shall apply 25% coinsurance for G0104.	X			X				X			
5680.22	Contractors shall do system maintenance to apply an end date of December 31, 2007 to the $150 IOL logic that currently exists. **NOTE:** The hard coded system logic that excludes the $150 for IOLs for multiple surgery reduction will not apply effective for dates of services on or after January 1, 2008.	X			X							
5680.23	The IHS designated carrier shall process IHS ASC claims (1500 and/or 837P) for dates of service on or after January 01, 2008.											IHS carrier
5680.24	Effective with dates of service on or after January 1, 2008, contractors shall return to provider (RTP) claims submitted on type of bill 83X.			X								IHS Intermediary

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DME RC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
5680.25	After this CR is no longer sensitive or controversial, a provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv			X	X				X			IHS Carrier

Number	Requirement	Responsibility (place an "X" in each applicable column)										
		A/B MAC	DME MAC	FI	CARRIER	DMERC	RHHI	Shared-System Maintainers				OTHER
								FISS	MCS	VMS	CWF	
	message within 1 week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.											

IV. SUPPORTING INFORMATION

A. For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

B. For all other recommendations and supporting information, use this space:

The ASC file record layouts are attached.

V. CONTACTS

Pre-Implementation Contact(s):

ASC Payment Policy: Chuck Braver at chuck.braver@cms.hhs.gov or 410-786-6719

Carrier/ AB MAC Claims Processing Issues: William Stojak at william.stojak@cms.hhs.gov or 410-786-6984 or Yvette Cousar at yvette.cousar@cms.hhs.gov or 410-786-6986.

FI/AB MAC claims processing issues: Susan Guerin at susan.guerin@cms.hhs.gov or 410-786-6138

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

A. *For Fiscal Intermediaries, Carriers, and the Durable Medical Equipment Regional Carrier (DMERC),* use only one of the following statements:

No addition funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

B. *For Medicare Administrative Contractors (MAC)*, use the following statement:

The contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the Statement of Work (SOW). The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the contracting officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the contracting officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

3 Attachments

ASCFS Record Layout

(for 1/1/2008 update)

Field Name	Positions	Length	
HCPCS	1-5	5	ASC Procedures and Devices NOTE: The ASC FS File will contain a record for each HCPCS/CBSA
Filler (Space)	6	1	
Modifier	7-8	2	
Filler (Space)	9-11	3	
ASC Group	12-16	5	
Filler (Space)	17	1	
CBSA	18-22	5	
Filler (Space)	23	1	
Wage Index	24-28	9v9999 (9.9999)	
Filler (Space)	29-33	5	
Procedure Indicator	34	1	S—Surgical Procedure A—Ancillary Service C—Carrier Priced
Filler (Space)	35	1	
Coinsurance 25% Indicator	36	1	Y—Yes N—No
Filler (Space)	37	1	
Multi-Procedure Discount Indicator	38	1	0--Surgical Procedure for which multi adjustment does not apply 1--Surgical Procedure for which multiple payment adjustments can apply 9—Concept of multiple procedure adjustment does not apply
Filler (Space)	39	1	
FB Mod Reduced Price	40-46	9(5)v99 ($$$$$.cc)	Field is zero filled when FB/FC Modifier Field has value of “N”

Filler (Space)	47	1	
Price	48-54	9(5)v99 ($$$$$.cc) Field is zero filled for carrier priced codes	
Filler (Space)	55	1	
FC Mod	56-62	9(5)v99 ($$$$$.cc) Field is zero filled when FB/FC Modifier Field has value of “N”	
Filler (Space)	63	1	
Group Price	64-70	9(5)v99 ($$$$$.cc)	
Filler (Space)	71	1	
FB/FC Modifier	72	1	Y—Yes N—No
Filler (Space)	73	1	
Year (Update)	74-81	8	YYYYMMDD—Effective date of prices
Filler (Space)	82-110	29	

ASC Drug Record Layout

(for 1/1/2008 update)

Field Name	Positions	Length	
HCPCS	1-5	5	
Filler (Space)	6	1	
Modifier	7-8	2	
Filler (Space)	9	1	
ASC Drug Status Indicator	10	1	A—Drug Fee Provided C—Carrier Priced code
Filler (Space)	11	1	
Drug Price	12-18	9(5)v99 ($$$$$.cc)	Field is zero-filled for carrier priced codes
Filler (Space)	19	1	
Year (Update)	20-27	8	YYYYMMDD—Effective date of prices
Filler (Space)	28-50	23	

ASC Code Pair Record Layout

(for 1/1/2008 update)

Field Name	Positions	Length	
Device HCPCS	1-5	5	
Filler (Space)	6	1	
Device HCPCS Modifier	7-8	2	
Filler (Space)	9	1	
ASC Procedure HCPCS	10-14	5	
Filler (Space)	15	1	
ASC Procedure HCPCS Modifier	16-17	2	
Filler (Space)	18	1	
Procedure Percent Multiplier	19-23	9v9(4) (9.9999) ***For example 63 percent would be displayed as 06300***	
Filler (Space)	24-26	3	
Year (Update)	27-34	8	YYYYMMDD—Effective date of prices
Filler (Space)	35-60	26	

30.3.1 - Mandatory Assignment on Carrier Claims

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The following practitioners who provide services under the Medicare program are required to accept assignment for all Medicare claims for their services. This means that they must accept the Medicare allowed amount as payment in full for their practitioner services. The beneficiary's liability is limited to any applicable deductible plus the 20 percent coinsurance.

Assignment is mandated for the following claims:

- Clinical diagnostic laboratory services and physician lab services;
- Physician services to individuals dually entitled to Medicare and Medicaid;

Services of physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives, certified registered nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians/nutritionists, anesthesiologist assistants, and mass immunization roster billers.

NOTE: The provider type Mass Immunization Roster Biller can only bill for influenza and pneumococcal vaccinations and administrations. These services are **not** subject to the deductible or the 20 percent coinsurance.

- Ambulatory surgical center services; (No deductible and 25% coinsurance for colorectal cancer screening colonoscopies {G0105 and G0121) *and effective for dates of service on or after January 1, 2008, G0104 also applies);*

- Home dialysis supplies and equipment paid under Method II;

- Drugs and biologicals; and,

- Ambulance services

When these claims are inadvertently submitted as unassigned, carriers process them as assigned.

Note that, unlike physicians, practitioners, or suppliers bound by a participation agreement, practitioners/entities providing the services/supplies identified above are required to accept assignment only with respect to these services/supplies (unless they have signed participation agreements which blanket the full range of their services).

The carrier system must be able to identify (and update) the codes for those services subject to the assignment mandate.

For the practitioner services of physicians and independently practicing physical and occupational therapists, the acceptance of assignment is not mandatory. Nor is the

acceptance of assignment mandatory for the suppliers of radiology services or diagnostic tests. However, these practitioners and suppliers may nevertheless voluntarily agree to participate to take advantage of the higher payment rate, in which case the participation status makes assignment mandatory for the term of the agreement. Such an agreement is known as the Medicare Participating Physician or Supplier Agreement. (See §30.3.12.2 Carrier Participation Agreement.) Physicians, practitioners, and suppliers who sign this agreement to participate are agreeing to accept assignment on all Medicare claims. The Medicare Participation Agreement and general instructions are on the CMS Web site.

120 - General Rules for Reporting Outpatient Hospital Services

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Hospitals use the ANSI X12N 837 I or the hardcopy Form CMS-1450 UB-*04* to bill for covered outpatient services (type of bill 13X or 83X, and 85X). See:

- Medicare Benefit Policy Manual, Chapter 6, for definition of an outpatient;
- Medicare Claims Processing Manual, Chapter 3, "Inpatient Part A Hospital Billing," for outpatient services treated as inpatient services; and
- Medicare Claims Processing Manual, Chapter 25, for general instructions for completing the ANSI X12N 837 I or the hardcopy Form CMS-1450 UB-*04.*

The HCPCS code is used to describe services where payment is under the Hospital OPPS or where payment is under a fee schedule or other outpatient payment methodology. Line item dates of service are reported for every line where a HCPCS code is required under OPPS. For providers paid via OPPS, FIs return to provider (RTP) bills where a line item date of service is not entered for each HCPCS code reported, or if the line item dates of service reported are outside of the statement-covers period. This includes those claims where the "from and through" dates are equal.

NOTE: *Effective for dates of service on or after January 1, 2008, the FI no longer processes claims on TOB 83X for ASCs. All IHS ASC providers must submit their claims to the designated carrier.*

180.1 - General Rules

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Hospitals subject to OPPS are required, beginning with claims with dates of service on or after August 1, 2000, to report in Form Locator 6 "Statement Covers Period From Date" the earliest date that services were rendered. As a result, preoperative laboratory services will always have a line item date of service within the "from and through" dates on the claim.

Indian Health Service hospitals continue to bill for surgeries utilizing bill type 83X. For other hospitals outpatient surgery subject to the ASC payment limit with dates of service prior to August 1, 2000, is reported on bill type 83X, and surgeries performed August 1, 2000 and later are reported with bill type 13X.

NOTE: *Effective for dates of service on or after January 1, 2008, the FI no longer processes claims on TOB 83X for ASCs. All IHS ASC providers must submit their claims to the designated carrier.*

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Chapter 14 - Ambulatory Surgical Centers

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10 - General

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

*Prior to January 1, 2008, p*ayment is made under Part B for certain surgical procedures that are furnished in ASCs and are approved for being furnished in an ASC. These procedures are those that generally do not exceed 90 minutes in length and do not require more than 4 hours recovery or convalescent time. *Prior to January 1, 2008, Medicare does* not pay an ASC for those procedures that require more than an ASC level of care, or for minor procedures that are normally performed in a physician's office.

Prior to January 1, 2008, the CMS publishes updates to the list of procedures for which an ASC may be paid each year. The complete list of procedures is *available on the CMS Web site at: http://www.cms.hhs.gov/ascpayment/*. These *files include* applicable codes, payment groups, and payment amounts for each ASC group before adjustments for regional wage variations. Applicable wage indices are also published via *change requests*.

Beginning January 1, 2008, payment is made to ASCs under Part B for all surgical procedures except those that CMS determines may pose a significant safety risk to beneficiaries or that are expected to require an overnight stay when furnished in an ASC. Beginning January 1, 2008, payment is made to ASCs under Part B for certain ancillary services such as certain drugs and biologicals, pass through devices, brachytherapy sources, and radiology procedures. Beginning January 1, 2008, Medicare does not pay an ASC for procedures that are excluded from the list of covered surgical procedures or covered ancillary services. Medicare continues to pay ASCs for new technology intraocular lenses and corneal tissue acquisition as it did prior to January 1, 2008.

Beginning January 1, 2008, the CMS publishes updates to the list of procedures for which an ASC may be paid each year. In addition, CMS publishes quarterly updates to the lists of covered surgical procedures and covered ancillary services to establish payment indicators and payment rates for newly created Level II HCPCS and Category III CPT codes. The complete lists of ASC covered surgical procedures and ASC covered ancillary services, the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustments for regional wage variations, the wage adjusted payment rates, and wage indices are available on the CMS Web site at: http://www.cms.hhs.gov/ascpayment/.

To be paid under this provision, a facility must be certified as meeting the requirements for an ASC and must enter into a written agreement with CMS. The certification process is described in the State Operations Manual.

ASCs must accept Medicare's payment for such procedures as payment in full for the facility service with respect to those services defined as ASC facility services. The physician and anesthesiologist may bill and be paid for the professional component of the service also.

Certain other services may be performed in an ASC facility, billed by the appropriate certified provider/supplier, or in certain cases by the ASC facility itself, and paid outside of the facility rate.

10.1 - Definition of Ambulatory Surgical Center (ASC)

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

An ASC for Medicare purposes is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. The ASC must enter into a "participating provider" agreement with CMS. An ASC is either independent (i.e., not a part of a provider of services or any other facility), or operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). If an ASC is the latter type, it has the option either of being covered under Medicare as an ASC, or of continuing to be covered as a hospital-affiliated outpatient surgery department as such entities were covered prior to the enactment of ASC legislation on December 5, 1980. To be covered as an ASC operated by a hospital, a facility:

- Elects to do so, and continues to be so covered unless CMS determines there is good cause to do otherwise;
- Is a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital with costs for the ASC treated as a non-reimbursable cost center on the hospital's cost report;
- Meets all the requirements with regard to health and safety, and agrees to the assignment, coverage and payment rules applied to independent ASCs; and
- Is surveyed and approved as complying with the conditions for coverage for ASCs in 42 CFR 416.40-49.

Related survey requirements are published in the State Operations Manual.

If a facility meets the above requirements, it bills the carrier on Form CMS-1500 or the related electronic data set and is paid the ASC payment amount.

If a hospital based facility decides not to become a certified ASC it bills the fiscal intermediary (FI) on Form CMS-1450 or the related EDI data set and is subject to hospital outpatient billing and payment rules. It is also subject to hospital outpatient certification and participation requirements.

Certain IHS and Tribal hospitals may elect to enroll and be paid as a certified ASC. See Pub. 100-04, chapter 19 for more information.

10.2 - Ambulatory Surgical Center Services on ASC List

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Covered ASC services are those surgical procedures that are identified by CMS on an annually updated ASC listing. Some *surgical procedures* covered by Medicare are not on the *ASC list of covered surgical procedures.* These may be billed by the rendering provider as Part B services but not as ASC services.

Under the ASC payment system, Medicare will make facility payments to ASCs only for the specific ASC covered surgical procedures on the ASC list of covered surgical procedures. In addition, Medicare will make separate payment to ASCs for certain covered ancillary services that are provided integral to a covered ASC surgical procedure. All other non-ASC services such as physician services, prosthetic devices, may be covered and separately billable under Medicare Part B. The Medicare definition of covered *ASC* facility services *for a covered surgical procedure* includes services that would be covered if furnished on an inpatient or outpatient basis in connection with a covered surgical procedure. This includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use to patients needing surgical procedures. It includes all services and procedures *provided* in connection with covered *surgical* procedures furnished by nurses, technical personnel and others involved in patient care. These do not include physician services, or medical and other health services for which payment may be made under other Medicare provisions (e.g., services of an independent laboratory located on the same site as the ASC, prosthetic devices other than intraocular lenses (IOLs), anesthetist *professional* services, *non-implantable* DME).

ASC services for which payment is included in the ASC payment for a covered surgical procedure under 42CFR416.65 include, but are not limited to-

(a) Included facility services:

(1) Nursing, technician, and related services;

(2) Use of the facility where the surgical procedures are performed;

(3) Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver;

(4) Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS);

(5) Medical and surgical supplies not on pass-through status under Subpart G of Part 419 of 42 CFR;

(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 42 CFR;

(9) Implanted DME and related accessories and supplies not on pass-through status under Subpart G of Part 419 of 42 CFR;

(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;

(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.

Under the revised ASC payment system, the above items and services fall within the scope of ASC facility services, and payment for them is packaged into the ASC payment for the covered surgical procedure. There is a payment adjustment for insertion of an IOL approved as belonging to a class of NTIOLs, for the 5-year period of time established for that class, as set forth at 42CFR416.200.

Covered ancillary items and services that are integral to a covered surgical procedure, as defined in 42CFR416.61, and for which separate payment to the ASC is allowed include:

(b) Covered ancillary services

(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 procurement of corneal tissue;

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

(5) Certain radiology services for which separate payment is allowed under the OPPS.

Where a separate charge is made the carrier must determine whether the item or service falls into the categories described in the following section. If the item or service falls into one of those categories, payment is made following the applicable rules for such items and services found elsewhere in this chapter. If the item or service does not fall into one of the categories described, the claim is denied.

Examples of covered ASC facility services include:

- Nursing services, services of technical personnel, and other related services;
- The use by the patient of the ASC facilities;
- Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment;
- Diagnostic or therapeutic items and services;
- Administrative, recordkeeping, and housekeeping items and services;
- Blood, blood plasma, platelets, etc., except for those to which the blood deductible applies;
- Materials for anesthesia; and
- Intraocular lenses (IOLs) except for new technology IOLs (NTIOLs) (refer to 42 CFR 416.180-200).

Definitions of ASC Facility Services:

Nursing Services, Services of Technical Personnel, and Other Related Services

These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the ASC. In addition to the nursing staff, this category includes orderlies, technical personnel, and others involved in patient care.

Use by the Patient of the ASC Facilities

This category includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services.

Drugs, Biologicals, Surgical Dressings, Supplies, Splints, Casts, Appliances, and Equipment

This category includes all supplies and equipment commonly furnished by the ASC in connection with surgical procedures. See the following paragraphs for certain exceptions. Drugs and biologicals are limited to those which cannot be self-administered. See the Medicare Benefit Policy Manual, Chapter 15, §50.2, for a description of how to determine whether drugs can be self-administered.

Under Part B, coverage for surgical dressings is limited to primary dressings, i.e., therapeutic and protective coverings applied directly to lesions on the skin or on openings to the skin required as the result of surgical procedures. (Items such as Ace bandages, elastic stockings and support hose, Spence boots and other foot coverings, leotards, knee supports, surgical leggings, gauntlets and pressure garments for the arms and hands are used as secondary coverings and therefore are not covered as surgical dressings.) Although surgical dressings usually are covered as "incident to" a physician's service in a physician's office setting, in the ASC setting, such dressings are included in the facility's services.

However, surgical dressings may be reapplied later by others, including the patient or a member of his family. When surgical dressings are obtained by the patient on a physician's order from a supplier, e.g., a drugstore, the surgical dressing is covered under Part B. The same policy applies in the case of dressings obtained by the patient on a physician's order following surgery in an ASC; the dressings are covered and paid as a Part B service by the DMERC.

Similarly, "other supplies, splints, and casts" include only those furnished by the ASC at the time of the surgery. Additional covered supplies and materials furnished later are generally furnished as "incident to" a physician's service, not as an ASC facility service. The term "supplies" includes those required for both the patient and ASC personnel, e.g., gowns, masks, drapes, hoses, and scalpels, whether disposable or reusable. These are included in the rate for the service (HCPCS code).

Beginning January 1, 2008, the ASC facility payment for drugs and biologicals includes those drugs and biologicals that are not usually self-administered and that are considered to be packaged into the payment for the surgical procedure under the OPPS. Also, beginning January 1, 2008, Medicare makes separate payment to ASCs for drugs and biologicals that are furnished integral to an ASC covered surgical procedure and that are separately payable under the OPPS.

Diagnostic or Therapeutic Items and Services

These are items and services furnished by ASC staff in connection with covered surgical procedures. Many ASCs perform diagnostic tests prior to surgery that are generally included in the facility charges, such as urinalysis, blood hemoglobin, hematocrit levels, etc. To the extent that such simple tests are included in the ASC facility charges, they are considered facility services. However, under the Medicare program, diagnostic tests are not covered in laboratories independent of a physician's office, rural health clinic, or hospital unless the laboratories meet the regulatory requirements for the conditions for coverage of services of independent laboratories. (See *42CFR416.49*) Therefore, diagnostic tests performed by the ASC other than those generally included in the facility's charge are not covered under Part B and are not to be billed as diagnostic tests. If the ASC has its laboratory certified, the laboratory itself may bill for the tests performed.

The ASC may make arrangements with an independent laboratory or other laboratory, such as a hospital laboratory, to perform diagnostic tests it requires prior to surgery. In general, however, the necessary laboratory tests are done outside the ASC prior to scheduling of surgery, since the test results often determine whether the beneficiary should have the surgery done on an outpatient basis in the first place.

Administrative, Recordkeeping and Housekeeping Items and Services

These include the general administrative functions necessary to run the facility e.g., scheduling, cleaning, utilities, and rent.

Blood, Blood Plasma, Platelets, etc., Except Those to Which Blood Deductible Applies

While covered procedures are limited to those not expected to result in extensive loss of blood, in some cases, blood or blood products are required. Usually the blood deductible results in no expenses for blood or blood products being included under this provision. However, where there is a need for blood or blood products beyond the deductible, they are considered ASC facility services and no separate charge is permitted to the beneficiary or the program.

Materials for Anesthesia

These include the anesthetic itself, and any materials, whether disposable or re-usable, necessary for its administration.

Intraocular Lenses (IOLs) and New Technology IOLs (NTIOLs)

The ASC facility services include IOLs (effective for services furnished on or after March 12, 1990), and NTIOLs (effective for services furnished on or after May 18, 2000), approved by the Food and Drug Administration (FDA) for insertion during or subsequent to cataract surgery.

FDA has classified IOLs into the following categories, any of which are included:

1. Anterior chamber angle fixation lenses;

2. Iris fixation lenses;

3. Irido-capsular fixation lenses; and

4. Posterior chamber lenses.

5. NTIOL Category 1 (as defined in “Federal Register” Notice, VOL 65, dated May 3, 2000). Note: This category expired May 18, 2005

6. NTIOL Category 2 (as defined in "Federal Register" Notice, VOL 65, dated May 3, 2000). Note: This category expired May 18, 2005

7. NTIOL Category 3 (as defined in Federal Register Notice, 71 FR 4586, dated January 27, 2006): This category will expire on February 26, 2011.

Note that while generally no separate charges for intraocular lenses (IOLs) are allowed, approved NTIOLS may be billed separately in addition to the facility rate. (See §40.3.)

10.3 - Services Furnished in ASCs

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

A single payment is made to an ASC, which includes all "facility services" furnished by the ASC in connection with a covered procedure. However, a number of items and services covered under Medicare may be furnished in an ASC which are not considered facility services, and which the ASC payment does not include. These non-ASC services are covered and paid for under the applicable provisions of Part B. In addition, the ASC may be part of a medical complex that includes other entities, such as an independent laboratory, supplier of durable medical equipment, or a physician's office, which are covered as separate entities under Part B. In general, an item or service provided in a separate part of the complex is not considered an ASC service, except as defined above.

Examples of payment and billing for items or services that are not ASC facility services

Items not included in the ASC facility rate	**Who may receive payment**	**Submit bills to:**
Physicians' services	Physician	Carrier
The purchase or rental of non-implantable durable medical equipment (DME) to ASC patients for use in their homes.	Supplier- An ASC can be a supplier of DME if it has a supplier number from the National Supplier Clearinghouse.	DMERC
Implantable DME and accessories	ASC	Carrier
Non-implantable prosthetic devices	Supplier. An ASC can be a supplier of non-implantable prosthetics if it has a supplier number from the National Supplier Clearinghouse.	DMERC
Implantable prosthetic devices except intraocular lenses (IOLs and NTIOLs), and accessories	ASC	Carrier

Items not included in the ASC facility rate	**Who may receive payment**	**Submit bills to:**
Ambulance services	Certified Ambulance supplier	Carrier
Leg, arm, back and neck braces	Supplier	DMERC
Artificial legs, arms, and eyes	Supplier	DMERC
Services furnished by an independent laboratory	Certified lab. ASCs can receive lab certification and a CLIA number.	Carrier
Procedures NOT on the ASC list	Physician	Physician bills Carrier for procedure and any implantable prosthetics/DME using the ASC as the place of service. See Pub. 100-04, Chapter 12, section 20.4

Examples of payment and billing for items or services that are ASC facility services ***beginning January 1, 2008***

Items included in the ASC facility rate beginning January 1, 2008	***Who may receive payment beginning January 1, 2008***	***Submit bills to:***
Implantable DME and accessories	*ASC*	*Carrier*
Implantable prosthetic devices except intraocular lenses (IOLs and NTIOLs), and accessories	*ASC*	*Carrier*

10.4 - Coverage of Services in ASCs Which Are Not ASC Facility Services

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Physicians' Services - This category includes most covered services performed in ASCs which are not considered ASC facility services. *Physicians who furnish services in ASCs may bill for and receive separate payment under Part B.* Physicians' services include the services of anesthesiologists administering or supervising the administration of anesthesia to *beneficiaries in ASCs* and the *beneficiaries'* recovery from the anesthesia. The term physicians' services also includes any routine pre- or post- operative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, and other services which the individual physician usually includes in the fee for a given surgical procedure.

Implantable Durable Medical Equipment (DME) - If the ASC furnishes items of implantable DME to patients, the ASC bills *and receives payment from the local carrier for the surgical procedure and the implantable device.* When the surgical procedure is not on the ASC list, the physician bills the carrier for both the surgical procedure and the implanted device, coding the ASC as the place of service on the bill (See Pub. 100-04, Chapter 12, section 20.4).

Non-implantable Durable Medical Equipment - *If the ASC furnishes items of non-implantable DME to beneficiaries, it is treated as a DME supplier, and all the rules and conditions ordinarily applicable to DME are applicable, including obtaining a supplier number and billing the DME MAC where applicable.*

Prosthetic Devices – An ASC may bill and receive separate payment for prosthetic devices, other than intraocular lenses (IOLs) that are implanted, inserted, or otherwise applied by surgical procedures on the ASC list of approved procedures. The ASC bills the local Carrier and receives payment according to the DMEPOS fee schedule. However, an intraocular lens (IOL) inserted during or subsequent to cataract surgery in an ASC is included in the facility payment rate.

If the ASC furnishes other non-implantable prosthetic devices to *beneficiaries*, the ASC is treated as a supplier, and all the rules and conditions ordinarily applicable to suppliers are applicable, including obtaining a supplier number and billing the DMERC where applicable.

Ambulance Services - If the ASC furnishes ambulance services, the facility may obtain approval as an ambulance supplier to bill covered ambulance services.

Leg, Arm, Back and Neck Braces - These items of equipment, like prosthetic devices, are covered under Part B, but are not included in the ASC facility payment amount. If the ASC furnishes these to *beneficiaries*, it is treated as a supplier, and all the rules and conditions ordinarily applicable to suppliers are applicable, including obtaining a supplier number and billing the DMERC where applicable.

Artificial Legs, Arms and Eyes - Like prosthetic devices and braces, this equipment is not considered part of an ASC facility service and so is not included in the ASC facility payment rate. If the ASC furnishes these items to *beneficiaries*, it is treated as a supplier, and all the rules and conditions ordinarily applicable to suppliers are applicable, including obtaining a supplier number and billing the DMERC where applicable.

Services of Independent Laboratory - As noted in §10.2, only a very limited number and type of diagnostic tests are considered ASC facility services and these are included in the ASC facility payment rate. In most cases, diagnostic tests performed directly by an ASC are not considered ASC facility services *and* are not covered under Medicare. *Section* 1861(s) of the *Act* limits coverage of diagnostic lab tests in facilities other than physicians' offices, rural health clinics or hospitals to facilities that meet the statutory definition of an independent laboratory. *In order to bill for diagnostic tests as a*

laboratory, an ASC's laboratory must be CLIA certified and *enrolled* with the carrier as a laboratory *and the certified clinical laboratory must bill for the services provided to the beneficiary in the ASC.* Otherwise, the ASC makes arrangements with a covered laboratory or laboratories for laboratory services, as provided in 42 CFR 416.49.

20 - List of Covered Ambulatory Surgical Center Procedures

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The complete lists of ASC covered surgical procedures and ASC covered ancillary services, the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustments for regional wage variations, the wage adjusted payment rates, and wage indices are available on the CMS Web site at: http://www.cms.hhs.gov/ascpayment/.

20.1 - Nature and Applicability of ASC List

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The *ASC* list of covered procedures merely indicates procedures which are covered and paid for if performed in the ASC setting. It does not require *the covered surgical* procedures to be performed *only in ASCs.* The *decision regarding the most appropriate care setting for a given surgical procedure is made by the physician based on the beneficiary's individual clinical needs and preferences.* Also, all the general coverage rules *requiring that any procedure be reasonable and necessary for the beneficiary* are applicable to ASC services in the same manner as all other covered services.

20.2 - Types of Services Included on the List

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The Medicare approved procedures are all considered "surgical procedures" for purposes of ASC coverage, regardless of the use of the procedure. For example, many of the "oscopy" procedures listed - bronchoscopy, laryngoscopy, etc., may be employed for either diagnostic or therapeutic purposes, or even both at the same time, such as when the "oscopy" permits both detection and removal of a polyp. Those procedures are considered "surgical procedures" within the context of the ASC provision. Also, surgical procedures are commonly thought of as those involving an incision of some type, whether done with a scalpel or (more recently) a laser, followed by removal or repair of an organ or other tissue. In recent years, the development of fiber optics technology, together with new surgical instruments using that technology, has resulted in surgical procedures that, while invasive and manipulative, do not require incisions. Instead, the procedures are performed without an incision through various body openings. Those procedures, some of which include the "oscopy" procedures mentioned above, are also considered surgical procedures for purposes of the ASC provision, and several are included in the list of covered procedures.

The ASC list of covered surgical procedures is comprised of surgical procedures that CMS determines do not pose a significant safety risk and are not expected to require an overnight stay following the surgical procedure.

Surgical procedures are defined as Category I CPT codes within the surgical range of CPT codes, 10000 through 69999. Also considered to be included within that code range are Level II HCPCS and Category III CPT codes that crosswalk to or are clinically similar to the Category I CPT codes in the range.

The surgical codes that are included on the ASC list of covered surgical procedures are those that have been determined to pose no significant safety risk to Medicare beneficiaries when furnished in ASCs and that are not expected to require active medical monitoring at midnight of the day on which the surgical procedure is performed (overnight stay).

Procedures that are included on the inpatient list used under Medicare's hospital outpatient prospective payment system and procedures that can only be reported by using an unlisted Category I CPT code are deemed to pose significant safety risk to beneficiaries in ASCs and are not eligible for designation and coverage as covered surgical procedures.

30 - Rate-Setting Policies

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Generally, there are two primary elements in the total cost of performing a surgical procedure:

- The cost of the physician's professional services for the 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).

For ASC covered surgical procedures, the professional fee is paid to the physician; the facility fee is paid to the ASC.

Prior to the revised ASC payment system implemented January 1, 2008, the ASC payment rate is a standard overhead amount *based on* CMS's estimate of a fair fee and the costs incurred by the ASCs providing the procedure. To estimate this cost, the CMS surveyed audit costs incurred by a sample of ASCs. There is an *annual* adjustment for inflation based on *the* percentage increase in the consumer price index for urban consumers *in years when the ASC payment rates are not updated by a survey or otherwise. Over a number of years, there have been statutory requirements reducing or eliminating the inflation adjustment on a year by year basis. For example, the statute requires that the CPI adjustment factor be zero percent in FY 2005, the last quarter of CY 2005, and each CY from 2006 through 2009.*

Beginning January 1, 2008, Medicare will implement a revised ASC payment system. The revised ASC payment system includes the following features:

> *ASC facility payment rates for most services are based on a percentage of the hospital outpatient prospective payment system (OPPS) rates. There is annual adjustment of the payment rates for inflation based on the CPI-U. The update for inflation begins with the CY 2010 ASC payment rates when the statutory requirement for a zero update no longer applies.*
>
> *In general, the Medicare program pays ASCs 80 percent of the lesser of the actual charge or the ASC facility payment rate for the covered services performed. The beneficiary pays 20 percent of the lesser of the submitted charge or the ASC facility payment rate for the covered services performed. An exception to this is screening sigmoidoscopy and screening colonoscopy where Medicare pays 75 percent and the beneficiary pays 25 percent.*
>
> *Beginning with the implementation of the 2008 revised payment system, the labor related adjustments to the ASC payment rates are based on the Core-Based Statistical Area (CBSA) methodology. Payment rates will be adjusted using the hospital inpatient prospective payment system (IPPS) pre-reclassification wage index values associated with the June 2003 OMB geographic localities. The adjustment for geographic wage variation will be made based on a 50 percent labor related share.*

Detailed information on both the OPPS and ASC payment methodologies is available in the hospital outpatient and ASC final rules.

30.1 - Where to Obtain Current Rates and List of Covered Services

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The CMS performs the functions and calculations described above and publishes a list of procedures for which an ASC may be paid each year, including intra-year updates as needed, via Medicare *contractor* instructions. This includes applicable codes, payment groups, and payment amounts for each ASC group before adjustments for regional wage variations. Applicable wage indices that must be used to adjust payment for regional wage variations are also published via *contractor* instructions.

Regulations pertaining to Medicare rates for ASC facility services are contained in Part 416 of the Code of Federal Regulations, (42 CFR 416.)

ASC facility services are subject to the usual Medicare Part B deductible and coinsurance requirements.

The ASC facility fees are based on a prospectively determined rate that CMS estimates will approximate the costs incurred by ASCs generally in providing covered facility

services. HCPCS *for* procedures covered *in* the ASC are *compiled* into 9 groups *with* a *separate* rate set for each group. The number of such groups may change in subsequent CMS *contractor* instructions dealing with ASC facility fees. CMS informs carriers and intermediaries of new rates in a one time instruction whenever rate changes occur.

Beginning January 1 2008, CMS will update payment rates and payable procedure codes on a calendar year basis. Payable drugs and pass-through devices will be updated on a quarterly basis. The ASC payment rates result in several hundred separate pricer groups, with each group having a unique payment amount based on the unadjusted ASC payment rate. Also, CMS will calculate and make available to the claims processing contractors CBSA-specific wage adjusted payment rates for each of the ASC payable codes. The complete lists of ASC covered surgical procedures and ASC covered ancillary services, the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustments for regional wage variations, the wage adjusted payment rates, and wage indices are available on the CMS Web site at: http://www.cms.hhs.gov/ascpayment/ and available to contractors on the CMS mainframe.

40 - Payment for Ambulatory Surgery

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Prior to January 1 2008, the ASC payment rate is a standard overhead amount based on CMS's estimate of a fair fee and the costs incurred by the ASCs providing the procedure. The HCPCS procedures for services covered by the ASC are grouped into 9 groups and a rate is set for each group. In CY 2007, the ASC payment rates for each ASC covered procedure is based on the payment rates for the 9 groups, but capped at the OPPS payment rate for the procedure.

Beginning January 1, 2008, with implementation of the revised ASC payment system, the payment rates for most covered ASC surgical procedures and covered ancillary services are established prospectively based on a percentage of the OPPS payment rates. For more information on where to locate these prospective payment rates, see §30.1.1. There are a small number of covered ancillary services that are contractor-priced. These include pass-through devices and brachytherapy sources, which are contractor- priced based on acquisition cost or invoice. Drugs and biologicals for which product-specific HCPCS codes do not exist and are billed by ASCs using code C9399 (unclassified drug or biological), are also contractor-priced at 95% of the average wholesale price (AWP).

Under the revised ASC payment system effective January 1, 2008, Medicare makes separate payment to ASCs for corneal tissue acquisition (which is billed using V2785). Contractors pay for corneal tissue acquisition based on acquisition cost or invoice. In addition, contractors make payment adjustments for new technology intraocular lenses (NTIOLs). The NTIOL payment adjustment is an unadjusted payment subject to beneficiary coinsurance but not subject to the wage index adjustments.

Beginning January 1, 2008, Medicare payment for implantable durable medical equipment is included in the payment for the covered surgical procedure. The ASC facility payment for the surgical procedure is a bundled payment, which now includes the payment for these implantable items previously paid separately under the DMEPOS fee schedule. The one exception to this is pass-through devices which are paid separately.

Beginning January 1, 2008, covered ancillary items and services, such as pass-through devices, brachytherapy sources, separately payable drugs and biologicals, and radiology procedures, should be billed on the same claim as the related ASC surgical procedure(s). If an ASC bills for an ancillary service(s) separately (i.e., not on the same claim as the related surgical procedure) or a claim is split so that the ancillary service and related ASC surgical service(s) are on separate claims, the contractors will check claims history to determine if there is an approved surgical procedure for the same beneficiary, same provider, and same date. If there is no approved ASC surgical procedure on the same claim or in history for the same date, the ancillary service(s) shall be returned as unprocessable.

40.1 - Payment to Ambulatory Surgical Centers for Non-ASC Services

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

ASCs may furnish and be paid under other parts of Medicare Part B for certain services that are not considered ASC facility services. The usual Part B coverage and payment rules apply to such services. *For more information, see §10.3.*

40.2 - *Wage* Adjustment of Base Payment Rates

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The payment rates established for the groups of ASC procedures (see §30) are standard base rates that have been adjusted to remove the effects of regional wage variations. When carriers process claims for ASC facility services, they adjust the base rates to reflect the wage index value applicable to the area in which the ASC is located. The Medicare payment for ASC facility services is equal to 80 percent of the wage-adjusted standard payment rate. Beneficiaries are responsible for a 20 percent coinsurance payment for ASC facility services once their deductible is satisfied. The exception is for colorectal cancer screening colonoscopies (G0105 and G0121). Effective for these services performed on or after January 1, 2007, there is no deductible and a 25 percent coinsurance payment applies. Use Medicare Summary Notice (MSN) 61.41, "You pay 25% of the Medicare-approved amount for this service."

The wage index includes the wage and salary levels of certain health care professionals in both urban and nonurban locations, compared to a national norm of 1.0. Areas with above average wage levels have index numbers greater than 1.0, while areas with below average wage levels have index numbers below l.0.

Each *Metropolitan Statistical Area (MSA)* within a State has a separate index, and there is one index for all rural areas within a State.

Also, each group's payment rate has a labor and a nonlabor component, and only the labor component is adjusted for the wage index.

Carriers must adjust ASC payment rates by following these steps. Carriers round calculations to the fourth decimal place at each step.

1. Separate each group's payment rate into its labor (.3445) and nonlabor (.6555) components. To determine the payment rate that is subject to the labor adjustment for Group 6 and Group 8, first subtract the IOL allowance from each group's composite payment rate. (This is because IOLs are not subject to adjustment for labor costs, therefore the IOL allowance must be subtracted from the composite payment rate before applying the wage index adjustment, and then added back in the calculation as described in step 5).

2. Identify the appropriate wage index value for the ASC's location.

3. Multiply the labor component (payment rate multiplied by .3445 - Step 1) by the appropriate wage index value.

4. Add the adjusted labor component (Step 3) to the nonlabor component (payment rate multiplied by .6555 - Step 1) to determine the total adjusted payment rate.

5. For Groups 6 and 8, add the IOL allowance to the total adjusted payment rate (Step 4) to determine the total adjusted composite rate for the procedures in these groups.

This provides the ASC payment rate for the ASC. Round the final amount to the nearest *cent.*

Note that coinsurance (and deductible if applicable) is deducted from the payment amount.

EXAMPLE 1:

This example shows how to determine payment for an ASC with a wage index value of 1.0985 for a procedure in payment group 4 ($612). The labor related portion is 34.45 percent and the nonlabor related portion is 65.55 percent.

Use the steps illustrated in Example 1 to adjust payment rates for groups whose payment rate does not include an allowance for an IOL.

Wage Adjusted Rate

= (($612 x .3445) x 1.0985) + ($612 x 0.6555)

= ($210.83*4* x 1.0985) + $401.*166*

= $231.601*1* + $401.*166*

= $632.77

Final Payment

= $632.77 x .80

= $506.2*2*

EXAMPLE 2:

The following shows how to determine payment to an ASC for services furnished in January 2002 with a wage index value of 1.0714, for each of the procedures in Group 8 ($949). Use the steps in this example to calculate payment amounts for each of the procedures in Group 6 as well. Subtract $150 (the IOL allowance) from the composite payment rate ($949 for Group 8 and $806 for Group 6) before adjusting for wage variation.

Wage Adjusted Rate

= [(($949 - $150) x 0.3445) x 1.0714] + [($949 - $150) x 0.6555]

= [($799 x 0.3445) x 1.0714] + ($799 x 0.6555)

= ($*275.2555* x 1.0714) + $523.74*45*

= $*294.9087* + $523.74*45*

= $*818.6532*

Composite Adjusted Rate

= $*818.6532* + $150

= $*968.65*

Final Payment

= $*968.65* x .80

= $*774.92*

For dates of service on or after January 1, 2008, the ASC payment rates will be geographically wage adjusted based on the wage index for the CBSA. Beginning January 1, 2008, CMS calculates and makes available to the contractors CBSA-specific ASC facility payment rates. The IPPS pre-reclassification wage index values for urban and rural areas are used by CMS in the calculation of the ASC wage adjusted payment rates. With the implementation of the ASC revised payment system, the labor related portion of the payment rate is now 50 percent and the remaining non-labor related portion is 50 percent.

An example of how CMS calculates a wage adjusted payment rate and how the contractors calculate the final Medicare payment rate excluding coinsurance is provided below.

EXAMPLE:

This example shows how CMS would determine the wage adjusted payment rate for CBSA with a wage index value of 1.0504 for a procedure with a national unadjusted payment rate of $900. The labor related portion is 50 percent and the nonlabor related portion is 50 percent.

Wage Adjusted Payment Rate

= (($900 x .5) x 1.0504) + ($900 x 0.5)
= ($450.00 x 1.0504) + $450.00
= $472.68 + $450.00
= $922.68

Medicare Program Payment (Excluding Beneficiary Coinsurance)

= $922.68 x .80
= $738.14

40.3 - Payment for Intraocular Lens (IOL)

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Payment for facility services furnished by an ASC for IOL insertion during or subsequent to cataract surgery includes an allowance for the lens. The procedures that include insertion of an IOL are:

Payment Group 6: CPT-4 Codes 66985 and 66986

Payment Group 8: CPT-4 Codes 66982, 66983 and 66984

Do not pay physicians or suppliers for an IOL furnished to a beneficiary in an ASC after July 1, 1988. Deny separate claims for IOLs furnished to ASC patients beginning March 12, 1990. Also, effective March 12, 1990, procedures 66983 and 66984 are treated as single procedures for payment purposes.

Refer to 42 CFR 416.185 for discussion of New Technology Intraocular Lenses (NTIOLs). While the carrier claims processing systems allow no separate charges for conventional intraocular lenses (IOLs), the cost of the IOL is bundled into the ASC facility fee, NTIOLs may be billed separately in addition to the facility fee. Medicare pays an additional $50 on the following NTIOLs Q1001 (Category 1, Model AMO Array Multifocal lens) and Q1002 (Category 2, Model Elastic Ultraviolet-Absorbing Silicone Posterior Chamber Lens) when billed for dates of service from May 18, 2000 through May 18, 2005. However, effective for dates of service on and after May 19, 2005,

Medicare will no longer reimburse the additional $50 and these two codes will be invalid for Medicare.

Effective for dates of service on and after February 27, 2006, through February 26, 2011, Medicare will pay an additional $50 for NTIOL [Category 3(Reduced Spherical Aberration), Model Advanced Medical Optics (AMO) Tecnis® IOL model numbers Z9000, Z9001, and ZA9003]. HCPCS code Q1003 has been created to bill for the additional $50. Q1003 shall be billed on the same claim as the surgical insertion procedure.

Any subsequent IOLs recognized by CMS as having the same characteristics as the first IOL recognized by CMS for a payment adjustment (those of reduced spherical aberration) will receive the same adjustment for the remainder of the 5-year period established by the first recognized IOL. Contractors and providers will be aware that HCPCS Q1003, along with one of the approved procedures codes (66982, 66983, 66984, 66985, 66986) are to be used on all NTIOL Category 3 claims associated with reduced spherical aberration from February 27, 2006, through February 26, 2011. See: *http://www.cms.hhs.gov/ASCPayment/05_NTIOLs.asp.* Additionally, contractors may obtain information on Medicare-approved NTIOLs at: http://www.cms.hhs.gov/center/coverage.asp.

Medicare Summary Notice (MSN) and Claims Adjustment Reason Codes

Carriers shall return as unprocessable any claims for NTIOLs containing Q1003 alone or with a code other than one of the above listed procedure codes. Use the following messages for these returned claims:

- Claim Adjustment Reason Code 16 - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.

- RA Remark Code M67 - Missing/Incomplete/Invalid other procedure codes.

- RA Remark Code MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.

Carriers shall deny payment for Q1003 if services are furnished in a facility other than a Medicare-approved ASC. Use the following messages when denying these claims:

- MSN 16.2 - This service cannot be paid when provided in this location/facility.

- Claims Adjustment Reason Code 58 - Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.

Carriers shall deny payment for Q1003 if **billed** by an entity other than a Medicare-approved ASC. Use the following messages when denying these claims:

- MSN 33.1 - The ambulatory surgical center must bill for this service.

- Claim Adjustment Reason Code 170 - Payment is denied when performed/billed by this type of provider.

Carriers shall deny payment for Q1003 if submitted for payment past the discontinued date (after the 5-year period, or after February 26, 2011). Use the following messages when denying these claims:

- MSN 21.11 - This service was not covered by Medicare at the time you received it.

Claim Adjustment Reason Code 27 - Expenses incurred after coverage terminated.

Beginning January 1, 2008, the Medicare payment for the IOL is included in the Medicare payment for the associated surgical procedure. Consequently, no separate payment for the IOL will be made, except for a new technology IOL as discussed under §40.3.1. If an ASC bills for a new technology IOL that is provided in association with a covered ASC procedure, the contractor will make a separate payment adjustment of $50 for the new technology IOL. The payment for the new technology IOL is subject to beneficiary coinsurance but is not wage adjusted. The hard coded system logic that excludes the $150 for IOLs for multiple surgery reduction will not apply effective for dates of services on or after January 1, 2008.

Contractors shall do system maintenance to apply an end date of December 31, 2007 to the $150 IOL logic that currently exists.

40.4 - Payment for Terminated Procedures

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The following criteria determine the appropriate ASC facility payment for a scheduled surgical procedure that is terminated due to medical complications which increase the surgical risk to the patient. Carriers may pay a different rate percentage in certain situations where documentation supports such action.

A. Carriers deny payment when an ASC submits a claim for a procedure that is terminated either for nonmedical or medical reasons before the ASC has expended substantial resources. For example, payment is denied if scheduled surgery is canceled or postponed because the patient on intake complains of a cold or flu.

B. Carriers pay 50 percent of the rate if a surgical procedure is terminated due to the onset of medical complications after the patient has been prepared for surgery and taken to the operating room but before anesthesia has been induced (use modifier 73).

For example, 50 percent is paid if the patient develops an allergic reaction to a drug administered by the ASC prior to surgery or if, upon injection of a retrobulbar block, the patient experiences a retrobulbar hemorrhage which prevents continuation of the procedure. Although some supplies and resources are expended, they are not consumed to the same extent had anesthesia been fully induced and the surgery completed. Carriers may pay a different percentage of the rate if, in an individual case, documentation supports such action. *Facilities* use a 73 modifier to indicate that the procedure terminated prior to induction of anesthesia.

C. Carriers make full payment of the facility rate if a medical complication arises which causes the procedure to be terminated after inducement of the anesthetic agent (use modifier -74). For example, carriers make full payment if, after anesthesia has been accomplished and the surgeon has made a preliminary incision, the patient's blood pressure increases suddenly and the surgery is terminated to avoid increasing surgical risk to the patient. In this case, the resources of the facility are consumed in essentially the same manner and to the same extent as they would have been had the surgery been completed. Facilities use a 74 modifier to indicate that the procedure terminated after inducement of anesthetic agent.

D. *Prior to January 1, 2008, c*arriers deduct the allowance for an unused IOL prior to calculating payment for a terminated IOL insertion procedure.

An ASC claim for payment for terminated surgery must be accompanied by an operative report that specifies the following:

- Reason for termination of surgery;
- Services actually performed;
- Supplies actually provided;
- Services not performed that would have been performed if surgery had not been terminated;
- Supplies not provided that would have been provided if the surgery had not been terminated;
- Time actually spent in each stage, e.g., pre-operative, operative, and post-operative;
- Time that would have been spent in each of these stages if the surgery had not been terminated; and
- *HCPCS* code for procedure had the surgery been performed.

E. Beginning January 1, 2008, payment for the IOL is included in payment for the surgical procedure to implant the lens.

F. Beginning January 1, 2008, contractors apply a 50 percent payment reduction for discontinued radiology procedures and other procedures that do not require anesthesia. Facilities use the -52 modifier to indicate the discontinuance of these applicable procedures.

G. Beginning January 1, 2008, ASC surgical services billed with the -52 or- 73 modifier are not subject to the multiple procedure discount.

40.5 - Payment for Multiple Procedures

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Each surgical procedure has its own CPT-4 code. When more than one surgical procedure is performed in the same operative session, special payment rules apply even if the services have the same CPT-4 code number.

When the ASC performs multiple *surgical* procedures in the same operative session *that are subject to the multiple procedure discount, contractors* base the ASC facility payment *rate,* plus 50 percent of the applicable wage adjusted *payment* rate*(s)* for the *other* ASC covered *surgical* procedures *subject to the multiple procedure discount that are* furnished in the same session. For example, if a Group 1, a Group 2, and a Group 3 procedure are all performed in the same operative session, base the ASC payment on 100 percent of the wage adjusted Group 3 rate plus 50 percent of the wage adjusted Group 1 rate, plus 50 percent of the wage adjusted Group 2 rate. If more than one procedure in the same payment group is performed, pay the full wage adjusted rate for one of the procedures and 50 percent of the wage adjusted rate for the remaining procedure(s).

In both of these examples, final payment is subject to the usual copayment and deductible provisions.

If CPT-4 codes 66985 or 66986, Group 6 procedures, are performed in the same operative session that a Group 7 procedure is performed, apply the 50 percent multiple procedure reduction to the wage adjusted portion of the Group 6 rate (i.e., the Group 6 payment amount minus the amount of the IOL add-on). Pay the full IOL allowance amount.

A procedure performed bilaterally in one operative session is reported as two procedures. Therefore, treat payment for a procedure performed bilaterally the same as payment for multiple procedures. For example, if sinusotomy, maxillary (antrotomy); intranasal (CPT-4 code 31020) is performed bilaterally in one operative session, report it as CPT-4 code 31020 performed two times. Calculate payment for bilateral procedures by multiplying the appropriate wage adjusted payment amount by 150 percent.

The multiple procedure payment reduction is the last pricing routine applied to applicable ASC procedure codes. In determining the ranking of procedures for application of the multiple procedure reduction, contractors shall use the lower of the billed charge or the ASC payment amount. The ASC surgical services billed with modifier -73 and -52 shall not be subjected to further pricing reductions. (i.e., the multiple procedure price reduction rules will not apply). Payment for an ASC surgical procedure billed with modifier -74 may be subject to the multiple procedure discount if that surgical procedure is subject to the multiple procedure discount.

40.6- Payment for Extracorporeal Shock Wave Lithotripsy (ESWL)

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

A ninth ASC payment group was established in a "Federal Register" notice (56 FR 67666) published December 31, 1991. The ninth payment group amount ($1,150) was assigned to only one procedure, CPT code 50590, extracorporeal shock wave lithotripsy (ESWL). However, a court order issued March 12, 1992, has stayed the Group 9 payment rate until the Secretary publishes all information relevant to the setting of the ESWL rate, receives comments, and publishes a subsequent final notice. This has not yet been completed.

In a previous instruction (Medicare Carrier's Manual Transmittal 1435), CMS advised carriers to make payment to ASCs for ESWL services furnished after January 29, 1992, and through the date when the ASC received notice from the carrier of the court order staying the Group 9 payment rate. This was a temporary measure to avoid penalizing ASCs that furnished ESWL services in accordance with the December 31, 1991, "Federal Register" notice and that could not have been expected to know that the March 12, 1992, court order set aside the ESWL provisions of that notice. Carriers do not make Medicare payment for ESWL as an ASC procedure when such services were furnished after the date that the carrier advised an ASC of the court order.

However carriers are instructed to retain all ASC claims for ESWL with a service date after January 29, 1992, and before the date when they were notified about the court order. It may be necessary to retrieve these clams for further action at some later date.

Beginning January 1, 2008 with the revised ASC payment system, contractors may pay for any of the ESWL services that are included on the ASC list of covered surgical procedures.

40.7 - Offset for Payment for Pass-Through Devices Beginning January 1, 2008

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Under the revised payment system, there can be situations where contractors must reduce (cut back) the approved payment amount for specifically identified procedures when provided in conjunction with a specific pass-through device. This reduction would only be applicable when services for specific pairs of codes are provided on the same day by the same provider.

Code pairs subject to this policy would be updated on a quarterly basis. CMS will inform contractors of the code pairs and the percent reduction taken from the procedure payment rate through a "look-up" table.

40.8 - Payment When a Device is Furnished With No Cost or With Full or Partial Credit Beginning January 1, 2008

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Contractors pay ASCs a reduced amount for certain specified procedures when a device is furnished without cost or for which either a partial or full credit is received (e.g., device recall). For specified procedure codes that include payment for a device, ASCs are required to include an FB modifier on the procedure code when a device is furnished without cost or for which full credit is received. If the ASC receives a partial credit for the device, the ASC is required to include the FC modifier on the procedure code. A single procedure code should not be submitted with both an FB and an FC modifier. The pricing determination related to the FB and FC modifiers is performed prior to the application of the multiple procedure pricing reductions.

40.9 - Payment for Presbyopia Correcting IOLs (P-C IOLs) and Astigmatism Correcting IOLs (A-C IOLs)

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

CMS payment policies and recognition of P-C IOLs and A-C IOLs are contained in Transmittal 636 (CR3927) and Transmittal 1228 (CR5527) respectively. A current list of CMS recognized P-C IOL and A-C IOL lenses are available on the CMS Web site at: http://www.cms.hhs.gov/center/asc.asp

50 - ASC Procedures for Completing the Form CMS-1500

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The Place of Service (POS) code is 24 for procedures performed in an ASC.

*Prior to January 1, 2008, t*ype of Service (TOS) code is "F" (ASC Facility Usage for Surgical Services) is appropriate when modifier SG appears on an ASC claim. Otherwise TOS "2" (surgery) for professional services rendered in an ASC is appropriate. *Beginning January 1, 2008, ASCs no longer are required to include the SG modifier on facility claims in Medicare. The contractors shall assign TOS code "F" to codes billed by specialty 49 for Place of Service 24.*

Modifier - TC is required unless the code definition is for the technical component only.

60 - Medicare Summary Notices (MSN), *Claim Adjustment Reason Codes, Remittance Advice Remark Codes (RAs)*

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

60.1 - Applicable Messages for NTIOLs

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Carriers shall return as unprocessable any claims for NTIOLs containing Q1003 alone or with a code other than one of the procedure codes listed in 40.5.2. Use the following messages for these returned claims:

- *Claim Adjustment Reason Code 16 - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.*

- *RA Remark Code M67 - Missing/Incomplete/Invalid other procedure codes.*

- *RA Remark Code MA130 - Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.*

Carriers shall deny payment for Q1003 if services are furnished in a facility other than a Medicare-approved ASC. Use the following messages when denying these claims:

- *MSN 16.2 - This service cannot be paid when provided in this location/facility.*

- *Claims Adjustment Reason Code 58 - Payment adjusted because treatment was deemed by the payer to have been rendered in an inappropriate or invalid place of service.*

Carriers shall deny payment for Q1003 if billed by an entity other than a Medicare-approved ASC. Use the following messages when denying these claims:

- *MSN 33.1 - The ambulatory surgical center must bill for this service.*

- *Claim Adjustment Reason Code 170 - Payment is denied when performed/billed by this type of provider.*

Carriers shall deny payment for Q1003 if submitted for payment past the discontinued date (after the 5-year period, or after February 26, 2011). Use the following messages when denying these claims:

- *MSN 21.11 - This service was not covered by Medicare at the time you received it.*

- *Claim Adjustment Reason Code 27 - Expenses incurred after coverage terminated.*

60.2 - Applicable Messages for ASC 2008 Payment Changes Effective January 1, 2008

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Contractors shall deny services not included on the ASC facility payment files (ASCFS and ASC DRUG files) when billed by ASCs (specialty 49) using the following messages:

- *Claim Adjustment Reason Code 8 - The procedure code is inconsistent with the provider type/specialty.*
- *RA Remark Code N95 - This provider type/provider specialty may not bill this service.*
- *MSN 26.4 - This service is not covered when performed by this provider.*

If there is no approved ASC surgical procedure on the same date for the billing ASC in history, contractors shall return pass-through device claims/line items, brachytherapy claims/line items, drug code (including C9399) claims/line items, and any other ancillary service claims/line items such as radiology procedure claim/line items on the ASCFS list or ASCDRUG list as unprocessable using the following messages:

- *Claim Adjustment Reason Code 16 - Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remark codes whenever appropriate.*
- *RA Remark Code MA 109 - Claim processed in accordance with ambulatory surgical guidelines.*
- *RA Remark Code M16 - Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision (at contractor discretion).*

Contractors shall deny all ancillary services (i.e., radiology technical component) on the ASCFS list billed by specialties other than specialty 49 provided in an ASC setting (POS 24) using the following messages:

- *MSN 16.2 - This service cannot be paid when provided in this location/facility.*
- *Claim Adjustment Reason Code 171 - Payment is denied when performed/billed by this type of provider in this type of facility.*
- *RA Remark Code M97 - Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.*

- *RA Remark Code M16 - Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision (at contractor discretion).*

Contractors shall deny separately billed implantable devices using the following messages:

- *MSN 16.32 – Medicare does not pay separately for this service.*

- *RA Remark Code M97 - Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.*

- *RA Remark Code M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed;*

- *RA Remark Code MA 109 - Claim processed in accordance with ambulatory surgical guidelines.*

- *RA Remark Code M16 - Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision.(contractor discretion)*

If there is a related, approved surgical procedure for the billing ASC for the same date of service, also include the following message:

- *MSN 16.8 - Payment is included in another service received on the same day.*

60.1.1 – Deductible and Coinsurance

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

There is no deductible and no coinsurance or copayment for the fecal occult blood tests (G0107 and G0328). Prior to January 1, 2007 deductible and coinsurance apply to other colorectal procedures (G0104, G0105, G0106, G0120, and G0121). After January 1, 2007, the deductible is waived for those tests.

NOTE: A 25 percent coinsurance applies for all colorectal cancer screening colonoscopies (G0105 and G0121) performed in ASCs and non-OPPS hospitals effective for services performed on or after January 1, 2007. The 25 percent coinsurance was implemented in the OPPS PRICER for OPPS hospitals effective for services performed on or after January 1, 1999.

A 25 percent coinsurance also applies for colorectal cancer screening sigmoidoscopies (G0104) performed in non-OPPS hospitals effective for services performed on or after January 1, 2007. *Beginning January 1, 2008, colorectal cancer screening sigmoidoscopies (G0104) are payable in ASCs, and a 25 percent coinsurance applies.* The 25 percent coinsurance for colorectal cancer screening sigmoidoscopies was implemented in OPPS PRICER for OPPS hospitals effective for services performed on or after January 1, 1999.

Medicare Claims Processing Manual

Chapter 19 – Indian Health Services

20 - Carrier and FI Designation

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The designated carrier and FI enroll IHS operated facilities, process IHS institutional claims, IHS physician and practitioner claims for IHS or tribally owned facilities and hospitals. The designated carrier may also enroll tribally operated facilities and process the practitioner claims for these facilities, if the tribally operated facility chooses. All intermediaries and carriers were notified of this selection.

Should other intermediaries and carriers receive misdirected enrollment requests or paper claims for IHS physicians or practitioners, they shall forward them to the designated carrier. However, the carriers that have tribally operated practitioners currently enrolled with them may continue to service these practitioners. In addition, for all tribally operated facilities, including Federally Qualified Health Centers (FQHCs) providing non-FQHC services, IHS physicians and practitioners may enroll with and submit bills to their local carriers, if they choose. Carriers shall service these tribally operated facilities and their practitioners in accordance with their normal procedures. However**,** IHS operated facilities may only enroll with and submit bills to the designated carrier. Tribally owned and operated facilities, while having a choice to bill their local carrier or the designated carrier, are prohibited from billing both entities.

See Chapter 1, §10.1.9 of Pub. 100-04, Medicare Claims Processing Manual, for more information on misdirected claims.

40.2.1 - Provider Enrollment with FI - Ambulatory Surgical Services

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

For dates of service prior to January 1, 2008, IHS providers that want to bill for surgeries on the ambulatory surgical center (ASC) list and receive the ASC rate must contact their designated FI. IHS providers are certified by one of several national accrediting organizations recognized by the Centers for Medicare and Medicaid Services (CMS) and meet the conditions for performing ASC procedures.

The IHS hospital outpatient departments are not certified as separate ASC entities. The ASC indication merely means that CMS approved them to bill for ASC services and be paid based on the ASC rates for services on the ASC list. In order to bill for ASC services, the hospital outpatient department must meet the conditions of participation for hospitals defined in 42 CFR, Part 482.

Authority for Medicare to pay IHS hospital outpatient departments using the freestanding ASC rates was incorporated into Public Health Service regulations on December 27, 1989. The first IHS hospital requested to bill separately for ASC procedures at the appropriate ASC group payment amounts in March 1987. HCFA (now CMS) approved payment of the ASC group payment amounts for dates of service on or after October 1, 1987. Previously, the hospital was reimbursed for ASC procedures at the Office of Management and Budget (OMB) negotiated all inclusive rate (AIR) for outpatient hospital services. The rationale for approving this request was that the hospital was already JCAHO certified, encompassing the ability to perform outpatient surgical procedures, and that acute care hospitals providing surgical inpatient or outpatient services can perform any surgical procedures within their capacity and capability.

*For dates of service prior to January 1, 2008, i*n order for IHS providers to bill for ASC procedures and receive payment based on the ASC rates published in the **Federal Register**, the designated FI must update the IHS/ASC cert indicator on the provider file to 'Y'. A 'Y' in this field indicates that the IHS provider or ASC is certified under IHS and their claims should be processed through ASC Pricer, ensuring the IHS provider is paid based on the ASC price rather than the AIR. Reimbursement is made based on the AIR until the FI updates the IHS/ASC cert indicator to a 'Y'.

See §§100.6 and 100.6.1 of this chapter for information on the payment policy and claims processing for ASC services.

NOTE: *Effective for dates of service on or after January 1, 2008, the FI no longer processes claims for IHS ASCs. All IHS ASC providers, including hospital outpatient departments requesting payment based on freestanding ASC rates and ASCs affiliated with a hospital but operating as a distinct entity for the purpose of performing outpatient surgical services must enroll with and submit their claims to the designated carrier.*

80.9 - Carrier Claims Processing and Payment Policy for ASC Claims
(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Effective for services on or after January 1, 2008, the designated IHS carrier shall accept and pay for claims submitted by IHS and tribal hospitals that elect to enroll as ASC facilities. See Pub. 100-04, Medicare Claims Processing Manual, Chapter 14, for information on ASC claims processing. See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, for information on ASC payment policy.

100.3.3 - FI - Social Admissions
(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Social admissions for patient and family convenience are not covered by Medicare. They are not billable to Medicare by IHS providers (including CAHs) on either TOB 11X (hospital inpatient) or 12X (hospital inpatient Part B). For admissions before surgery, only the scheduled surgery and related services may be billed on TOB 83X (ambulatory surgical center) if the surgery is performed on an outpatient basis and on TOB 11X if the surgery is performed on an inpatient basis. When placing a patient in a room for social reasons after discharge from an inpatient stay this portion of inpatient care may not be billed to Medicare. Medicare disallows payment for inpatient Medicare Part B ancillary services during a social admission stay when there is another bill from a different facility for an outpatient service. A TOB 12X from the admitting facility with a 13X (hospital outpatient) TOB from another hospital, a 72X (hospital based or freestanding renal dialysis center) TOB from a renal dialysis facility (RDF) or an 83X TOB from an ASC would create an inappropriate duplicate payment. Consequently, CWF will send an unsolicited response to the designated FI on receipt of the 13X, 72X or 83X bill.

See Chapter 4, §240.2 of Pub. 100-04, Medicare Claims Processing Manual, for more information on social admissions.

NOTE: *Effective for dates of service on or after January 1, 2008, the FI no longer processes claims for IHS ASCs (TOB 83X). All IHS ASC providers must submit their claims to the carrier.*

100.6 - FI - Ambulatory Surgical Center (ASC) - Medicare Part B - Payment Policy
(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Qualified IHS providers are reimbursed at the ASC rates published in the **Federal Register**. Medicare Part B deductible and coinsurance amounts apply to ASC services, but are waived by the IHS.

See §40.2.1 of this chapter for information on enrolling with the designated FI to receive payment for ASC services based on the ASC rates.

NOTE: *Effective for dates of service on or after January 1, 2008, the FI no longer processes claims for IHS ASCs. All IHS ASC providers must submit their claims to the carrier.*

100.6.1 - FI - ASC - Medicare Part B - Claims Processing

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Charges are reported under revenue code 0360 (operating room services) or 0490 (ambulatory surgical care) on TOB 83X (ambulatory surgical center). ASC surgeries are identified with CPT codes 10000-69979 only. One bill is required for all services provided on the day a surgical procedure is performed.

*Exception: Revenue code 0276 (intraocular lenses) and charges may be reported separately to report the intraocular lens for cataract surgeries.

The attending/operating UPINs are required in Form Locators 82 and 83 (A-B) on all 83X TOBs.

If all surgeries performed are not on the ASC list published in the **Federal Register** they should not be reported as surgeries, but rather as clinic visits with TOB 13X and revenue code 0510 (clinic).

If an admission occurs within 1 day of the ASC services, those charges must be included on the inpatient claim, if the principal diagnosis for admission and those outpatient services are the same.

The MSN is suppressed.

NOTE: *Effective for dates of service on or after January 1, 2008, the FI no longer processes claims for IHS ASCs. All IHS ASC providers must submit their claims to the carrier.*

100.8 - FI - CAH Swing-bed - Medicare Part A - Payment Policy

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The IHS CAH swing-bed services are paid *101 per cent of* an all inclusive facility specific per diem rate. Medicare Part A coinsurance is applied to IHS CAH swing-bed inpatient bills, but is waived by the IHS.

100.8.2 - FI - CAH Swing-bed - Inpatient Ancillary Claims - Medicare Part B - Payment Policy

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The IHS CAHs are paid for covered inpatient Medicare Part B ancillary services based upon 101 percent of an all inclusive facility specific per *diem* rate that is established on a yearly basis from prior year cost report information. Medicare Part B deductible and

coinsurance amounts are applied to inpatient Medicare Part B ancillary services, but are waived by the IHS.

100.10.1 - FI - Vaccines and Vaccine Administration - Claims Processing

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

These vaccines are reported on TOB 12X, 13X, 83X, or 85X along with the appropriate revenue codes and HCPCS codes as found in billing instructions in Chapter 18, §10.2 of Pub. 100-04, Medicare Claims Processing Manual.

No clinic visit shall be billed if vaccine and its administration are the only service received. Vaccines and their administration may be billed with or without a clinic visit.

The MSN is suppressed.

NOTE: *Effective for dates of service on or after January 1, 2008, the FI no longer processes claims for IHS ASCs (TOB 83X). All IHS ASC providers must submit their claims to the carrier.*

100.11 - FI - Physical Therapy, Occupational Therapy, Speech-Language Pathology and Diagnostic Audiology Services - Payment Policy

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Effective January 1, 2006, IHS providers are paid separately from the AIR for physical therapy, OT, speech-language pathology and diagnostic audiology services. Payment for services to IHS providers on TOB 12X, 13X or 83X is made based on the MPFS. Payment for services to IHS CAHs on TOB 85X is made based on reasonable cost.

The Medicare Part B deductible and coinsurance apply to therapy services and diagnostic audiology services, but are waived by the IHS.

NOTE: *Effective for dates of service on or after January 1, 2008, the FI no longer processes claims for IHS ASCs (TOB 83X). All IHS ASC providers must submit their claims to the carrier.*

100.11.1 - FI - Physical Therapy, Occupational Therapy, Speech-Language Pathology and Diagnostic Audiology Services - Claims Processing

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Therapy services and diagnostic audiology services are reported on TOB 12X, 13X, 83X or 85X using the appropriate revenue code and HCPCS codes.

No clinic visit shall be billed if a therapy service or a diagnostic audiology service is the only service received. These services may be billed with or without a clinic visit.

The MSN is suppressed.

NOTE: *Effective for dates of service on or after January 1, 2008, the FI no longer processes claims for IHS ASCs (TOB 83X). All IHS ASC providers must submit their claims to the carrier.*

10.7 - Type of Service (TOS)

(Rev.1325; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Medicare carriers must use the following table to assign the proper TOS. Some procedures may have more than one applicable TOS. For claims received on or after April 3, 1995, CWF will produce alerts on codes with incorrect TOS designations. Effective July 3, 1995, CWF is rejecting codes with incorrect TOS designations.

The only exceptions to this table are:

- Surgical services billed with the ASC facility service modifier SG must be reported as TOS F. The indicator F does not appear on the TOS table because its use is dependent upon the use of the SG modifier. *Effective for services on or after January 1, 2008, the SG modifier is no longer applicable for Medicare services. ASC Providers should discontinue applying the SG modifier on ASC facility claims.*

- Surgical services billed with an assistant-at-surgery modifier (80-82, AS,) must be reported with TOS 8. The 8 indicator does not appear on the TOS table because its use is dependent upon the use of the appropriate modifier. (See Pub. 100-04, Medicare Claims Processing Manual, Chapter 12, "Physician/Practitioner Billing," for instructions on when assistant-at-surgery is allowable.)

- Psychiatric treatment services that are subject to the outpatient mental health treatment limitation should be reported with TOS T.

- TOS H appears in the list of descriptors. However, it does not appear in the table. In CWF, "H" is used only as an indicator for hospice. The carrier should not submit TOS H to CWF at this time.

- For outpatient services, when transfusion medicine code appears on a claim that also contains a blood product, the service is paid under reasonable charge at 80%, coinsurance and deductible apply. When transfusion medicine codes are paid under the clinical laboratory fee schedule pay at 100%, coinsurance and deductible do not apply.

NOTE: For injection codes with more than one possible TOS designation, use the following guidelines when assigning the TOS:

When the choice is L or 1,

- Use TOS L when the drug is used related to ESRD; or

- Use TOS 1 when the drug is not related to ESRD and is administered in the office.

When the choice is G or 1:

- Use TOS G when the drug is an immunosuppressive drug; or
- Use TOS 1 when the drug is used for other than immunosuppression.

When the choice is P or 1,

- Use TOS P if the drug is administered through durable medical equipment (DME); or
- Use TOS 1 if the drug is administered in the office.

The place of service or diagnosis may be considered when determining the appropriate TOS. The descriptors for each of the TOS codes listed in the following table are:

Type of Service Indicators

0	Whole Blood
1	Medical Care
2	Surgery
3	Consultation
4	Diagnostic Radiology
5	Diagnostic Laboratory
6	Therapeutic Radiology
7	Anesthesia
8	Assistant at Surgery
9	Other Medical Items or Services
A	Used DME
B	High Risk Screening Mammography
C	Low Risk Screening Mammography
D	Ambulance

E	Enteral/Parenteral Nutrients/Supplies
F	Ambulatory Surgical Center (Facility Usage for Surgical Services)
G	Immunosuppressive Drugs
H	Hospice
J	Diabetic Shoes
K	Hearing Items and Services
L	ESRD Supplies
M	Monthly Capitation Payment for Dialysis
N	Kidney Donor
P	Lump Sum Purchase of DME, Prosthetics, Orthotics
Q	Vision Items or Services
R	Rental of DME
S	Surgical Dressings or Other Medical Supplies
T	Outpatient Mental Health Treatment Limitation
U	Occupational Therapy
V	Pneumococcal/Flu Vaccine
W	Physical Therapy

HCPCS RANGE and Applicable Type of Service (TOS) Code

First Code	Last Code	TOS
A0021	A0999	D
A4206	A4213	S
A4214	A4214	P
A4215	A4215	L, S
A4216	A4218	1, P, L

First Code	Last Code	TOS
A4220	A4236	P
A4244	A4247	S, L
A4248	A4248	L
A4250	A4250	9
A4253	A4253	P
A4254	A4254	A, P, R
A4255	A4259	P
A4260	A4270	9
A4280	A4280	P
A4281	A4290	9
A4300	A4301	S
A4305	A4306	9
A4310	A4359	P
A4360	A4360	9
A4361	A4434	P
A4450	A4452	P, L, S
A4454	A4455	P
A4458	A4458	9
A4460	A4463	S
A4464	A4464	P
A4465	A4465	9
A4470	A4510	P
A4520	A4554	9
A4556	A4572	P

First Code	Last Code	TOS
A4575	A4590	9
A4595	A4605	P
A4606	A4606	9
A4608	A4613	P
A4614	A4614	9
A4615	A4617	P
A4618	A4618	A, P, R
A4619	A4626	P
A4627	A4627	9
A4628	A4628	A, P, R
A4629	A4629	P
A4630	A4633	A, P, R
A4634	A4634	9
A4635	A4637	A, P, R
A4638	A4638	P
A4639	A4640	A, P, R
A4641	A4647	4
A4649	A4649	9
A4650	A4931	L
A4932	A4932	9
A5051	A5200	P
A5500	A5513	J
A6000	A6000	P
A6010	A6024	S

First Code	Last Code	TOS
A6025	A6025	9
A6154	A6215	S
A6216	A6216	S, L
A6217	A6248	S
A6250	A6250	S, L
A6251	A6259	S
A6260	A6260	S, L
A6261	A6266	S
A6402	A6402	S, L
A6403	A6512	S
A6513	A6530	P
A6531	A6532	P, S
A6533	A6551	P
A7000	A7002	A, P, R
A7003	A7004	P
A7005	A7006	A, P, R
A7007	A7008	P
A7009	A7009	A, P, R
A7010	A7011	P
A7012	A7012	A, P, R
A7013	A7013	P
A7014	A7017	A, P, R
A7018	A7020	P
A7025	A7039	A, P, R

First Code	Last Code	TOS
A7040	A7043	P
A7044	A7045	A, P, R
A7046	A7527	P
A8000	A8004	A, P, R
A9150	A9280	9
A9281	A9281	A, P, R
A9282	A9300	9
A9500	A9516	4
A9517	A9517	6
A9518	A9522	4
A9523	A9523	6
A9524	A9529	4
A9530	A9530	6
A9531	A9531	4
A9532	A9532	6
A9533	A9533	4
A9534	A9534	6
A9535	A9542	4
A9543	A9543	6
A9544	A9544	4
A9545	A9545	6
A9546	A9562	4
A9563	A9564	6
A9565	A9568	4

First Code	Last Code	TOS
A9600	A9605	6
A9698	A9698	4
A9699	A9699	6
A9700	A9999	9
B4034	B5200	E
B9000	B9006	A, P, R
B9998	B9999	E
C1000	C1008	9, S
C1009	C1009	9
C1010	C1011	0
C1012	C1014	9
C1015	C1018	0
C1019	C1019	9
C1020	C1021	0
C1022	C1022	9
C1024	C1043	9, S
C1045	C1045	4
C1047	C1048	9, S
C1050	C1050	9
C1051	C1057	9, S
C1058	C1058	4
C1059	C1059	9
C1060	C1063	9, S
C1064	C1066	4

First Code	Last Code	TOS
C1067	C1078	9, S
C1079	C1080	4
C1081	C1081	6
C1082	C1082	4
C1083	C1083	6
C1084	C1086	1, P
C1087	C1087	4
C1088	C1088	9
C1089	C1099	4
C1100	C1121	9, S
C1122	C1122	4
C1123	C1154	9, S
C1155	C1155	9
C1156	C1163	9, S
C1164	C1164	9
C1166	C1167	1, P
C1170	C1177	9, S
C1178	C1178	1, P
C1179	C1184	9, S
C1188	C1202	4
C1203	C1203	9
C1205	C1205	4
C1207	C1300	9
C1302	C1304	9, S

First Code	Last Code	TOS
C1305	C1305	9
C1306	C1324	9, S
C1325	C1325	4
C1326	C1337	9, S
C1348	C1350	4
C1351	C1359	9, S
C1360	C1360	9
C1361	C1773	9, S
C1774	C1774	9
C1775	C1775	4
C1776	C1799	9, S
C1800	C1806	4
C1810	C2631	9, S
C2632	C2632	9
C2633	C2633	9, S
C2634	C2636	9
C2637	C2637	4
C2676	C8891	9, S
C8900	C8920	4
C9000	C9010	1
C9011	C9011	9, S
C9012	C9020	1
C9100	C9103	4
C9104	C9106	1

First Code	Last Code	TOS
C9107	C9107	9, S
C9108	C9109	9
C9110	C9110	9, S
C9111	C9119	9
C9120	C9121	1, P
C9123	C9123	9, S
C9126	C9126	9
C9127	C9127	1
C9128	C9211	9
C9212	C9212	9, G
C9213	C9215	1
C9218	C9218	9
C9219	C9219	9, G
C9220	C9222	9
C9223	C9223	1, P
C9224	C9226	9
C9400	C9400	4
C9401	C9401	6
C9402	C9405	4
C9410	C9411	1, P
C9413	C9434	1
C9435	C9437	9
C9438	C9438	1, G
C9439	C9503	9

First Code	Last Code	TOS
C9701	C9701	9, S
C9703	C9703	9
C9704	C9704	2
C9708	C9708	4
C9711	C9711	9
C9713	C9713	2
C9714	C9715	6
C9716	C9717	2
C9718	C9721	1
C9722	C9723	4
C9724	C9724	2
C9725	C9725	6
D0120	D0180	1
D0210	**D0363**	4
D0415	D0999	5
D1110	D1351	1
D1510	D1525	9
D1550	D2710	1
D2712	D2712	9
D2720	D2792	1
D2794	D2794	9
D2799	D2910	1
D2915	D2915	9
D2920	D2933	1

First Code	Last Code	TOS
D2934	D2934	9
D2940	D2970	1
D2971	D2975	9
D2980	D3120	1
D3220	D3221	2
D3230	D3348	1
D3351	D3920	2
D3950	D3999	1
D4210	D4276	2
D4320	D4999	1
D5110	D5281	9
D5410	D5761	1
D5810	D5999	9
D6010	D6050	2
D6053	D6079	9
D6080	D6080	2
D6090	D6999	9
D7110	D7282	2
D7283	D7283	9
D7285	D7999	2
D8010	D9110	1
D9120	D9120	2
D9210	D9248	7
D9310	D9310	3

First Code	Last Code	TOS
D9410	D9450	1
D9610	D9630	9
D9910	D9999	1
E0100	E0144	A, P, R
E0145	E0146	R
E0147	E0164	A, P, R
E0165	E0166	R
E0167	E0168	A, P, R
E0169	E0169	R
E0170	E0179	A, P, R
E0180	E0182	R
E0184	E0185	A, P, R
E0186	E0187	R
E0188	E0189	A, P, R
E0190	E0190	9
E0191	E0192	A, P, R
E0193	E0196	R
E0197	E0200	A, P, R
E0202	E0202	R
E0203	E0203	9
E0205	E0205	A, P, R
E0210	E0210	A, P, R, L
E0215	E0230	A, P, R
E0231	E0231	R

First Code	Last Code	TOS
E0232	E0232	P
E0235	E0236	R
E0238	E0239	A, P, R
E0240	E0240	9
E0241	E0249	A, P, R
E0250	E0270	R
E0271	E0276	A, P, R
E0277	E0277	R
E0280	E0280	A, P, R
E0290	E0298	R
E0300	E0300	A, P, R
E0301	E0305	R
E0310	E0326	A, P, R
E0350	E0352	9
E0370	E0373	A, P, R
E0424	E0440	R
E0441	E0444	P
E0445	E0445	9
E0450	E0455	R
E0457	E0457	A, P, R
E0459	E0480	R
E0481	E0481	A, P, R
E0482	E0483	R
E0484	E0484	A, P, R

First Code	Last Code	TOS
E0485	E0486	P
E0500	E0550	R
E0555	E0555	P, R
E0560	E0562	A, P, R
E0565	E0570	R
E0571	E0574	A, P, R
E0575	E0575	R
E0580	E0580	P, R
E0585	E0585	R
E0590	E0590	9
E0600	E0601	R
E0602	E0604	9
E0605	E0605	A, P, R
E0606	E0606	R
E0607	E0607	A, P, R
E0608	E0608	R
E0609	E0615	A, P, R
E0616	E0616	9
E0617	E0617	9, R
E0618	E0619	R
E0620	E0629	A, P, R
E0630	E0636	R
E0637	E0638	A, P, R
E0639	E0640	9

First Code	Last Code	TOS
E0641	E0673	A, P, R
E0675	E0675	R
E0676	E0740	A, P, R
E0744	E0745	R
E0746	E0748	A, P, R
E0749	E0749	9
E0751	E0754	P
E0755	E0755	A, P, R
E0756	E0759	P
E0760	E0760	A, P, R
E0761	E0761	9
E0762	E0764	A, P, R
E0765	E0765	A, P
E0769	E0769	9
E0776	E0776	A, P, R, E
E0779	E0780	A, P, R
E0781	E0781	9, R
E0782	E0783	A, P, R
E0784	E0784	R
E0785	E0785	P
E0786	E0786	9
E0791	E0791	R
E0830	E0830	P
E0840	E0840	A, P, R

First Code	Last Code	TOS
E0849	E0849	A, P, R
E0850	E0900	A, P, R
E0910	E0941	R
E0942	E0945	A, P, R
E0946	E0946	R
E0947	E0957	A, P, R
E0958	E0958	R
E0959	E0967	A, P, R
E0968	E0968	R
E0969	E0982	A, P, R
E0983	E0983	R
E0984	E1030	A, P, R
E1031	E1060	R
E1065	E1069	A, P, R
E1070	E1160	R
E1161	E1161	A, P, R
E1170	E1200	R
E1210	E1213	A, P, R
E1220	E1220	P
E1221	E1225	R
E1226	E1227	A, P, R
E1228	E1228	R
E1229	E1239	A, P, R
E1240	E1295	R

First Code	Last Code	TOS
E1296	E1310	A, P, R
E1340	E1340	9
E1353	E1355	R
E1372	E1372	A, P, R
E1375	E1392	R
E1399	E1399	A, P, R
E1400	E1406	R
E1500	E1699	L
E1700	E1700	A, P, R
E1701	E1702	P
E1800	E1801	P, R
E1802	E1802	R
E1805	E1840	P, R
E1841	E1841	R
E1900	E1902	A, P, R
E2000	E2000	R
E2100	E2101	A, P, R
E2120	E2120	R
E2201	E2399	A, P , R
E2402	E2402	R
E2500	E2621	A, P, R
E8000	E8002	9
G0001	G0001	5
G0002	G0002	2

First Code	Last Code	TOS
G0004	G0007	5
G0008	G0009	V
G0010	G0010	1
G0015	G0016	5
G0022	G0024	1
G0025	G0025	S
G0026	G0027	5
G0030	G0050	4
G0101	G0102	1
G0103	G0103	5
G0104	G0105	2
G0106	G0106	4
G0107	G0107	5
G0108	G0113	1
G0114	G0114	3
G0115	G0116	T, 1
G0117	G0118	Q
G0120	G0120	4
G0121	G0121	2
G0122	G0122	4
G0123	G0124	5
G0125	G0126	4
G0127	G0127	2
G0128	G0128	1

First Code	Last Code	TOS
G0129	G0129	U
G0130	G0132	4
G0141	G0148	5
G0151	G0156	1
G0159	G0160	2
G0161	G0161	6
G0163	G0165	4
G0166	G0168	1
G0169	G0169	W, 1
G0170	G0171	2
G0172	G0172	U
G0173	G0174	2
G0175	G0175	1
G0176	G0177	U
G0178	G0178	6
G0179	G0182	1
G0184	G0187	2
G0188	G0188	4
G0190	G0203	1
G0204	G0234	4
G0235	G0235	1
G0236	G0236	4
G0237	G0239	1, U, W
G0240	G0240	1

First Code	Last Code	TOS
G0241	G0243	2
G0244	G0247	1
G0248	G0249	5
G0250	G0250	1
G0251	G0255	4
G0256	G0256	2
G0257	G0259	1
G0260	G0260	F
G0261	G0261	2
G0262	G0262	4
G0263	G0264	1
G0265	G0267	5
G0268	G0268	2
G0269	G0272	1
G0273	G0274	6
G0275	G0278	2
G0279	G0283	1, U, W
G0288	G0288	4
G0289	G0291	2
G0292	G0292	1
G0293	G0294	2
G0295	G0295	1, U, W
G0296	G0296	4
G0297	G0300	2

First Code	Last Code	TOS
G0301	G0305	1
G0306	G0307	5
G0308	G0323	M
G0324	G0327	1
G0328	G0328	5
G0329	G0329	1, U, W
G0332	G0332	1
G0336	G0336	4
G0337	G0340	1
G0341	G0343	2
G0344	G0363	1
G0364	G0364	2
G0365	G0368	5
G0369	G0371	9
G0372	G0372	1
G0373	G0374	9
G0375	G0376	9
G0377	G0384	1
G0389	G0389	4
G0390	G0390	1
G0392	G0393	2
G0394	G0394	5
G3001	G9139	1
H0001	H2037	9

First Code	Last Code	TOS
J0120	J0210	P, 1
J0215	J0215	1, G
J0256	J0256	1, P
J0270	J0275	1
J0278	J0476	1, P
J0480	J0480	1, G
J0500	J0594	1, P
J0595	J0595	1
J0600	J0880	1, P
J0881	J0882	1, L
J0885	J0885	9
J0886	J0886	1, L
J0894	J1642	1, P
J1644	J1644	P, 1, L
J1645	J1670	P, 1
J1675	J1675	1, G
J1700	J1820	1, P
J1825	J1830	1
J1835	J2916	P, 1
J2920	J2930	G, 1
J2940	J3395	P, 1
J3396	J3396	9
J3400	J7199	1, P
J7300	J7306	9

First Code	Last Code	TOS
J7308	J7308	1
J7310	J7310	9
J7311	J7311	Q
J7315	J7320	1
J7330	J7330	P, 1
J7340	J7346	1
J7350	J7350	1, S
J7500	J7599	G, 1
J7607	J8499	P, 1
J8501	J8501	G, 1
J8510	J8521	P, 1
J8530	J8530	1, G, P
J8540	J8540	1
J8560	J8560	1, P
J8565	J8565	9
J8597	J8597	1
J8600	J8600	P, 1
J8610	J8610	P, G, 1
J8650	J8650	1,G
J8700	J9212	P, 1
J9213	J9216	G
J9217	J9999	P, 1
K0001	K0004	R
K0005	K0005	A, P, R

First Code	Last Code	TOS
K0006	K0007	R
K0008	K0008	P
K0009	K0012	A, P, R
K0013	K0013	P
K0014	K0100	A, P, R
K0101	K0101	R
K0102	K0108	A, P, R
K0109	K0113	P
K0114	K0116	A, P, R
K0119	K0123	G
K0137	K0169	P
K0170	K0171	A, P, R
K0172	K0173	P
K0174	K0174	A, P, R
K0175	K0176	P
K0177	K0177	A, P, R
K0178	K0178	P
K0179	K0181	A, P, R
K0182	K0182	P
K0183	K0192	A, P, R
K0193	K0195	R
K0268	K0270	A, P, R
K0277	K0283	P
K0284	K0284	A, P, R

First Code	Last Code	TOS
K0400	K0400	P
K0401	K0401	J
K0407	K0411	P
K0412	K0412	G
K0415	K0416	1
K0417	K0417	A, P, R
K0418	K0418	G
K0419	K0451	P
K0452	K0452	A, P, R
K0455	K0456	R
K0457	K0459	A, P, R
K0460	K0461	P, R
K0462	K0462	9
K0501	K0501	R
K0503	K0529	P
K0530	K0531	A, P, R
K0532	K0534	R
K0535	K0537	S
K0538	K0538	R
K0539	K0540	P
K0541	K0547	A, P, R
K0548	K0548	1, P
K0549	K0550	R
K0551	K0551	A, P, R

First Code	Last Code	TOS
K0552	K0597	P
K0600	K0608	A, P, R
K0609	K0609	P
K0610	K0614	L
K0615	K0617	A, P, R
K0618	K0619	P
K0620	K0626	S
K0627	K0627	A, P, R
K0628	K0629	J
K0630	K0649	P
K0650	K0669	A, P, R
K0670	K0670	P
K0671	K0730	R
K0731	K0732	P
K0733	K0737	A, P, R
K0738	K0739	P, R
K0740	K0899	A, P, R
L0100	L3963	P
L3964	L3966	A, P, R
L3967	L3967	P
L3968	L3970	A, P, R
L3971	L3971	P
L3972	L3972	A, P, R
L3973	L3973	P

First Code	Last Code	TOS
L3974	L3974	A, P, R
L3975	L8100	P
L8110	L8120	P, S
L8130	L9900	P
M0064	M0300	1
M0301	M0301	2
M0302	P7001	5
P9010	P9011	0
P9012	P9012	9
P9016	P9016	0
P9017	P9020	9
P9021	P9022	0
P9023	P9037	9
P9038	P9040	0
P9041	P9050	9
P9051	P9051	0
P9052	P9053	9
P9054	P9054	0
P9055	P9055	9
P9056	P9058	0
P9059	P9060	9
P9603	P9615	5
Q0034	Q0034	1
Q0035	Q0035	5

First Code	Last Code	TOS
Q0068	Q0068	9
Q0081	Q0081	1
Q0082	Q0082	9
Q0083	Q0085	1
Q0086	Q0086	9
Q0091	Q0091	1
Q0092	Q0092	4
Q0111	Q0115	5
Q0132	Q0136	9
Q0137	Q0137	1, L
Q0144	Q0144	1
Q0156	Q0161	P, 1
Q0163	Q0181	1
Q0182	Q0185	S
Q0186	Q0186	1
Q0187	Q0187	P, 1
Q0188	Q0188	9
Q0480	Q0505	P
Q0510	Q0514	9
Q0515	Q0515	1, P
Q1001	Q1005	F
Q2001	Q2018	1, P
Q2019	Q2019	1, G
Q2020	Q2022	1, P

First Code	Last Code	TOS
Q3000	Q3000	4
Q3001	Q3001	1
Q3002	Q3012	4
Q3013	Q3014	9
Q3017	Q3020	D
Q3025	Q3030	P, 1
Q3031	Q3031	5
Q4001	Q4051	S
Q4052	Q4053	1, P
Q4054	Q4055	1, L
Q4075	Q4077	P, 1
Q4078	Q4078	4
Q4079	Q4080	1, P
Q4081	Q4082	L, 1
Q4083	Q4086	1
Q5001	Q9940	L,1
Q9941	Q9944	1, P
Q9945	Q9964	4
R0070	R0075	4
R0076	R0076	5
S0009	S0011	P, 1
S0012	S0012	1
S0014	S0087	P, 1
S0088	S0088	9

First Code	Last Code	TOS
S0090	S0090	P, 1
S0091	S0093	9
S0096	S0098	1, P
S0104	S0104	1
S0106	S0108	9
S0112	S0112	1
S0114	S0118	9
S0122	S0132	1, P
S0133	S0133	9
S0135	S0135	1, P
S0136	S0168	9
S0170	S0170	1, P
S0171	S0178	9
S0179	S0179	1, P
S0181	S0187	9
S0189	S0189	1, P
S0190	S0201	9
S0206	S0206	2
S0207	S0207	9
S0208	S0215	D
S0220	S0400	9
S0500	S0592	Q
S0595	S0800	9
S0810	S0810	2, 9

First Code	Last Code	TOS
S0812	S0812	Q
S0820	S0830	9
S1001	S1002	P
S1015	S1016	9
S1025	S1025	1
S1030	S1030	P, R
S1031	S1031	A, P, R
S1040	S1040	P
S2050	S2053	2, 9
S2054	S2061	9
S2065	S2065	2
S2068	S2109	9
S2112	S2112	2
S2113	S2371	9
S2400	S2404	2
S2405	S2405	9
S2409	S2409	2
S2411	S3708	9
S3818	S3819	5
S3820	S4980	9
S4981	S4981	2
S4989	S8001	9
S8002	S8003	1
S8004	S8035	9

First Code	Last Code	TOS
S8037	S8037	4
S8040	S8210	9
S8260	S8260	P
S8262	S8270	9
S8300	S8300	S
S8301	S8434	9
S8450	S8452	P
S8460	S8470	9
S8490	S8490	S
S8940	S9528	9
S9529	S9529	5
S9533	S9590	9
S9800	S9800	1
S9802	T1014	9
T1015	T1015	1
T1016	T5999	9
V2020	V2615	Q
V2623	V2629	P
V2630	V2799	Q
V5008	V5299	K
V5336	V5336	1
V5362	V5364	1, W
00100	00103	7
00104	00104	T, 7

First Code	Last Code	TOS
00120	00860	7
00862	00862	N, 7
00864	01999	7
10021	11012	2
11040	11044	2, U, W
11055	20975	2
20979	20979	6
20982	29085	2
29086	29590	2, U, W
29700	36410	2
36415	36415	5
36416	36416	1
36420	36510	2
36511	36516	1
36520	38200	2
38204	38204	1
38205	38206	2
38207	38209	1
38210	38210	2
38211	38215	5
38220	38241	2
38242	38242	2
38300	50290	2
50300	50320	N

First Code	Last Code	TOS
50323	50546	2
50547	50547	N
50548	55845	2
55859	55859	6
55860	62230	2
62252	62252	1
62256	64530	2
64550	64550	2, U, W
64553	69990	2
70010	75893	4
75894	75896	6
75898	75898	4
75900	75954	6
75956	75959	4
75960	75968	6
75970	75970	4
75978	75989	6
75992	76082	4
76083	76085	1
76086	76091	4
76092	76092	B, C, 1
76093	76934	4
76936	76936	6
76937	76937	4

First Code	Last Code	TOS
76938	76938	6
76940	76940	4
76941	76942	6
76945	76945	4
76946	76965	6
76970	77051	4
77052	77052	1
77053	77056	4
77057	77057	1
77058	77084	4
77261	77370	6
77371	77373	4
77399	77799	6
78000	78264	4
78267	78268	5
78270	78999	4
79000	79001	6
79005	79005	4
79030	79100	6
79101	79101	4
79200	79440	6
79445	79445	4
79900	79999	6
80048	80440	5

First Code	Last Code	TOS
80500	80502	3
81000	88319	5
88321	88332	3
88333	89399	5
90281	90649	1
90655	90655	V
90656	90660	V
90665	90665	1
90669	90669	V
90675	90727	1
90732	90732	V
90733	90802	1
90804	90899	T, 1
90901	90911	U, W, 1
90918	90921	M
90922	90999	1
91000	91033	5
91034	91040	1
91052	91065	5
91100	91105	2
91110	91111	4
91120	91120	1
91122	91122	5
91123	91123	1

First Code	Last Code	TOS
91132	91133	5
91299	91299	2
92002	92014	1
92015	92015	Q
92018	92020	1
92025	92025	5
92060	92060	1
92065	92396	Q
92499	92504	1
92506	92508	W, 1, U
92510	92510	K, U, W
92511	92520	1
92525	92526	U, W, 1
92531	92548	1
92551	92596	K
92597	92598	W, 1
92599	92616	1
92617	92617	2
92620	92633	1
92640	92640	9
92700	92971	1
92973	92977	2
92978	92979	4
92980	92998	2

First Code	Last Code	TOS
93000	93350	5
93501	93545	2
93555	93556	4
93561	93662	2
93668	93668	9
93701	93744	5
93745	93745	1
93760	93888	5
93890	93893	6
93922	93990	5
94002	94005	1
94010	94450	5
94452	94610	1
94620	94621	5
94640	94668	1
94680	94772	5
94774	94774	1
94775	94776	9
94777	94777	1
94779	94799	5
95004	95251	1
95805	95830	5
95831	95852	U, W, 5
95857	95870	W, 5

First Code	Last Code	TOS
95872	95927	5
95928	95929	1
95930	95930	Q
95933	95962	5
95965	95967	4
95970	95975	5
95978	95991	1
95999	95999	5
96000	96003	1, W
96004	96004	1
96020	96020	4
96040	96103	1
96105	96115	U, W, 5
96116	96120	5
96150	96155	9
96400	96567	1
96570	96571	2
96900	96913	1
96920	96922	2
96999	96999	1
97001	97546	1, U, W
97597	97598	1
97601	97602	1, U, W
97605	97606	1

First Code	Last Code	TOS
97703	97799	1, U, W
97802	98962	1
99000	99002	9
99024	99060	1
99070	99071	9
99075	99091	1
99100	99150	7
99170	99170	5
99172	99173	Q
99175	99239	1
99241	99275	3
99281	99440	1
99450	99456	9
99499	99539	1
99551	99569	9
99600	99600	1
99601	99602	9
0001T	0002T	2
0003T	0003T	9
0005T	0009T	2
0010T	0010T	5
0012T	0020T	2
0021T	0021T	1
0023T	0023T	5

First Code	Last Code	TOS
0024T	0024T	2
0025T	0026T	9
0027T	0027T	2
0028T	0028T	4
0029T	0029T	9
0030T	0031T	5
0032T	0039T	2
0040T	0040T	4
0041T	0041T	5
0042T	0043T	4
0044T	0045T	9
0046T	0057T	2
0058T	0060T	5
0061T	0063T	2
0064T	0064T	5
0065T	0065T	1
0066T	0066T	2
0067T	0070T	4
0071T	0072T	2
0073T	0073T	4
0074T	0074T	1
0075T	0076T	6
0077T	0081T	2
0082T	0083T	6

First Code	Last Code	TOS
0084T	0084T	1
0085T	0085T	5
0086T	0086T	1
0087T	0087T	5
0088T	0088T	6
0089T	0089T	9
0090T	0102T	2
0103T	0110T	9
0111T	0111T	5
0115T	0117T	9
0120T	0126T	2
0130T	0133T	9
0135T	0137T	2
0140T	0140T	9
0141T	0143T	2
0144T	0154T	4
0155T	0158T	2
0159T	0159T	4
0160T	0161T	6
0162T	0162T	9
0163T	0173T	2
0174T	0175T	4
0176T	0177T	2
0001F	0500F	1

First Code	Last Code	TOS
0501F	0501F	9
0502F	6005F	1