CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-02 Medicare Benefit Policy	Centers for Medicare & Medicaid Services (CMS)
Transmittal 77	**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	15/Table Of Contents
R	15/260/Ambulatory Surgical Center Services
R	15/260.1/Definition of Ambulatory Surgical Center (ASC)
R	15/260.2/Ambulatory Surgical Center Services
R	15/260.4/Coverage of Services in ASCs Which Are Not ASC Services
R	15/260.5/List of Covered Ambulatory Surgical Center Procedures
R	15/260.5.1/Nature and Applicability of ASC List
R	15/260.5.2/Nomenclature and Organization of the List

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. 100-02	Transmittal: 77	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	DMERC	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	DME RC	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	

260 - Ambulatory Surgical Center Services

(Rev.77; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

Facility services furnished by ambulatory surgical centers (ASCs) in connection with certain surgical procedures are covered under Part B. To receive coverage of and payment for its services under this provision, a facility must be certified as meeting the requirements for an ASC and enter into a written agreement with CMS. Medicare periodically updates the list of covered procedures and related payment amounts through release of regulations and *change requests*. The ASC must accept Medicare's payment for such procedures as payment in full with respect to those services defined as ASC facility services.

Where services are performed in an ASC, the physician and others who perform covered services may also be paid for his/her professional services; however, the "professional" rate is then adjusted since the ASC incurs the facility costs.

260.1 - Definition of Ambulatory Surgical Center (ASC)

(Rev.77; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

An ASC for purposes of this benefit is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. It enters into an agreement with CMS to do so. 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 the hospital based surgery center is certified as an ASC it is considered an ASC and is subject to rules for ASCs. If a hospital based surgery center is not certified as an ASC it continues under the program as part of the hospital. In *that* case the applicable *hospital* outpatient payment rules apply. This *is the outpatient prospective payment system* (OPPS), for most hospitals, or may be provisions for hospitals excluded from OPPS. See the Medicare Claims Processing Manual, Chapter 4, for billing and payment requirements for hospital outpatient services.

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 at 42 CFR, Part 482. See chapter 19, section 40.2.1 of Pub. 100-04, Medicare Claims Processing Manual, for more information on IHS hospital outpatient departments billing for ASC services.

260.2 - Ambulatory Surgical Center Services

(Rev.77; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The ASC facility services are services furnished in an ASC in connection with a covered surgical procedure that are otherwise covered if furnished on an inpatient or outpatient basis in a hospital in connection with that procedure. Not included in the definition of facility services are medical and other health services, even though furnished within the

ASC, which are covered under other portions of the Medicare program, or not furnished in connection with covered surgical procedures. This distinction between covered ASC facility services and services which are not covered ASC facility services is important, since the facility payment rate includes only the covered ASC facility services. Services, which are not covered ASC facility services such as physicians' services and prosthetic devices other than intraocular lenses (IOLs), may be covered and billable under other Medicare provisions.

Since there is no uniformity among ASCs as to what items and services they include in their facility fee or charge, the Medicare definition of covered facility services is both inclusive and exclusive. The regulations specify what are and are not facility services. Facility services are items and services furnished in connection with listed covered procedures, which are covered if furnished in a hospital operating suite or hospital outpatient department in connection with such procedures. These do not include physicians' 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, *anesthetist professional services, non-implantable DME*).

Examples of covered ASC facility services include:

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's 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; and

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 below for certain exceptions. Drugs and biologicals are limited to those that cannot be self-administered. (See §60.)

Coverage policy for surgical dressings is similar to that followed under Part B. 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

generally used as secondary coverings and therefore are not covered as surgical dressings.) Surgical dressings usually are applied first by a physician and 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, others may reapply surgical dressings later, including the patient or a member of the patient's family. When the patient on a physician's order obtains surgical dressings 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 local Part B *contractor*, included in the definition of facility services.

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.

Diagnostic or Therapeutic Items and Services

These are items and services furnished by ASC staff in connection with covered surgical procedures. With respect to diagnostic tests, many ASCs perform simple tests just before surgery, primarily urinalysis and blood hemoglobin or hematocrit, which are generally included in their facility charges. To the extent that such simple tests are included in the ASC's 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 as such and are not billed to the carrier as diagnostic tests. If the ASC has its laboratory certified as meeting the regulatory conditions, then the laboratory itself bills the *contractor* (or the beneficiary) 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 even 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 reusable, necessary for its administration.

Intraocular Lenses (IOLs)

Effective for services furnished on or after March 12, 1990, ASC facility services include intraocular lenses approved by the Food and Drug Administration (FDA) for insertion during or subsequent to cataract surgery.

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

Anterior chamber angle fixation lenses;
Iris fixation lenses;
Irido-capsular fixation lenses; and
Posterior chamber lenses.

While FDA has approved many IOLs, it still considers some IOLs investigational. The fact that they are covered under Medicare is an exception to the general policy not to cover experimental or investigational items or services. The exception is made because the Congress, recognizing the widespread use of IOLs, directed the FDA to study them without interfering with availability to patients.

The carrier determines whether the item or service falls into the categories described in the following section. If it determines the item or service does fall into one of those categories, it makes payment 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 carrier denies the claim.

Covered ASC surgical procedures 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.

Under the revised ASC payment system, Medicare makes facility payments to ASCs only for the specific ASC covered surgical procedures and covered ancillary services that are provided integral to a covered ASC surgical procedure.

See chapter 14, section 10 of Pub. 100-04, Medicare Claims Processing Manual for examples of covered ASC services for which payment is included in the ASC payment for a covered surgical procedure under 42CFR416.65.

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.

260.4 - Coverage of Services in ASCs, Which are Not ASC Services

(Rev.77; 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' services were covered before coverage of ASC services, and the ASC amendment did not change this. Consequently, physicians who perform covered services in ASCs receive payment under the existing Part B system. Physicians' services include the services of anesthesiologists administering or supervising the administration of anesthesia to *beneficiaries in* ASC*'s* 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 *that the individual physician usually includes in the fee for a given surgical procedure.*. The *contractor* applies the same criteria, limits and understandings to physicians' services for procedures *furnished* in the ASC that *are* applied to the procedures *furnished* by the same physicians on an inpatient hospital basis.

The Sale, Lease, or Rental of Durable Medical Equipment (DME) to ASC Patients for Use in Their Homes

Non-implantable Durable Medical Equipment (DME) *- 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

Prosthetic devices, other than intraocular lenses (IOLs), whether implanted, inserted, or otherwise applied by covered surgical procedures, are covered, but are not included in the ASC facility payment amount. However, §4063(b) of P.L. 100-203 amended §1833 (i)(2)(A) of the Act to mandate that payment for an intraocular lens (IOL) inserted during or subsequent to cataract surgery in an ASC be included in the facility payment rate.

This bundling of the payment for an IOL with the facility fee is effective for services furnished on or after March 12, 1990. More information on coverage of prosthetic devices may be found in §120. Further information on the coverage of IOLs may be found in §260.2.

Non-Implantable Prosthetic Devices *- If the ASC furnishes 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 DME MAC where applicable.*

Ambulance Services

If the ASC furnishes ambulance services, they are covered as ambulance services pursuant to the terms and conditions of the Medicare Benefit Policy Manual, Chapter 10, "Ambulance Services," §§10. *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. Coverage of these items is described in §130. *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 DME MAC 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. Information regarding the coverage of these items is set out in §130. *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 DME MAC where applicable.*

Services of Independent Laboratory

As noted in §260.2, only a very limited number and type of diagnostic tests are considered ASC facility services and 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. (See §§80.1 for a description of independent laboratories and covered services.) *In order to bill for diagnostic tests as a laboratory, an ASC's laboratory must be CLIA certified and enrolled with the contactor 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*. If the ASC has a certified independent laboratory, the laboratory itself bills the carrier, pursuant to §§80.

260.5 - List of Covered Ambulatory Surgical Center Procedures

(Rev.77; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The law ties coverage of ambulatory surgical center (ASC) services under Part B to specified surgical procedures, which are contained in a list revised and published periodically by CMS. Groupings and related prices are also published periodically. These are published in the Federal Register and on the CMS Web site.

Beginning January 1, 2008, under the revised ASC payment system, CMS will update the list of covered surgical procedures, relative payment weights and national unadjusted payment rates, annually. The updates will be proposed and finalized in the Federal Register concurrent with updates to the hospital outpatient prospective payment system.

260.5.1 - Nature and Applicability of ASC List

(Rev.77; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The ASC list of covered surgical procedures indicates procedures that are covered and may be paid for if performed in the ASC setting. There is no requirement that the covered surgical procedures 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.

260.5.2 - Nomenclature and Organization of the List

(Rev.77; Issued: 08-29-07; Effective: 01-01-08; Implementation: 01-07-08)

The listed procedures are all considered "surgical procedures" for coverage purposes under the ASC provision, regardless of the specific use to which the procedure is put. For example, many of the "oscopy" procedures listed - bronchoscopy, laryngoscopy, etc., may be employed for either diagnostic or therapeutic purposes, or 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 utilizing 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.

Beginning January 1, 2008, 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.