

Medicare Claims Processing Manual

Chapter 14 - Ambulatory Surgical Centers

Table of Contents (Rev. 2020, 08-06-10)

[Transmittals for Chapter 14](#)

[Crosswalk to Old Manuals](#)

10 - General

10.1 - Definition of Ambulatory Surgical Center (ASC)

10.2 - Ambulatory Surgical Center Services on ASC List

10.3 - Services Furnished in ASCs Which Are Not ASC Facility Services or Covered Ancillary Services

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

20 - List of Covered Ambulatory Surgical Center Procedures

20.1 - Nature and Applicability of ASC List

20.2 - Types of Services Included on the List

20.3 - Rebundling of CPT Codes

30 - Rate-Setting Policies

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

40 - Payment for Ambulatory Surgery

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

40.2 - Wage Adjustment of Base Payment Rates

40.3 - Payment for Intraocular Lens (IOL)

40.4 - Payment for Terminated Procedures

40.5 - Payment for Multiple Procedures

40.6 - Payment for Extracorporeal Shock Wave Lithotripsy (ESWL)

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

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

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

50 - ASC Procedures for Completing the Form CMS-1500

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

60.1 - Applicable messages for NTIOLs

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

60.3 - Applicable Messages for Certain Payment Status Indicators on the ASCFS Effective for Services on or after January 1, 2009

70 - Ambulatory Surgical Center (ASC) HCPCS Additions, Deletions, and Master Listing

10 - General

(Rev. 1514; Issued: 05-23-08; Effective: 01-01-08; Implementation: 06-23-08)

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

Prior to January 1, 2008, the CMS published 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 were 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. Also, beginning January 1, 2008, separate payment is made to ASCs under Part B for certain ancillary services such as certain drugs and biologicals, OPPS pass-through devices, brachytherapy sources, and radiology procedures. Medicare does not pay an ASC for procedures that are excluded from the list of covered surgical procedures. 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 as payment in full for services with respect to those services defined as ASC services. The physician and anesthesiologist may bill and be paid for the professional component of the service also.

Certain other services such as lab services or non-implantable DME may be performed when billed using the appropriate certified provider/supplier UPIN/NPI.

10.1 - Definition of Ambulatory Surgical Center (ASC)

(Rev. 1865, Issued: 12-04-09, Effective: 01-01-10, Implementation: 01-04-10)

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 have in effect an agreement with CMS obtained in accordance with 42 CFR 416 subpart B (General Conditions and Requirements). 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). A hospital-operated facility has the option of being considered by Medicare either to be an ASC or to be a provider-based department of the hospital as defined in 42 CFR 413.65.

To participate in Medicare as an ASC operated by a hospital, a facility:

- Elects to do so.
- 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 416.25-49.

Related survey requirements are published in the State Operations Manual, Pub. 100-07, Appendix L.

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

A hospital-operated facility that decides to discontinue participation in Medicare as an ASC must terminate its ASC agreement with CMS. Guidance regarding the termination of ASC agreements with CMS is provided in 42 CFR 416.35. Voluntary terminations are those initiated by an ASC and, as specified in 42 CFR 416.35, an ASC may terminate its agreement either by sending written notice to CMS or by ceasing to furnish services to the community.

To participate in Medicare as a provider-based department of the hospital, the hospital must comply with CMS requirements to certify the hospital-operated facility as a provider-based department of the hospital as described in 42 CFR 413.65, including meeting all of the hospital conditions of participation specified in 42 CFR 482. See Pub

100-07, State Operations Manual, Appendix A, "Survey Protocol, Regulations and Interpretive Guidelines for Hospitals," for information on survey requirements.

Certain Indian Health Service (IHS) and Tribal hospital outpatient departments may elect to enroll and be paid as ASCs. See Pub. 100-04, chapter 19 for more information.

10.2 - Ambulatory Surgical Center Services on ASC List

(Rev. 1572; Issued: 08-08-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

Covered ASC services are those surgical procedures that are identified by CMS on a listing that is updated at least annually. Some surgical procedures covered by Medicare are not on the ASC list of covered surgical procedures. For surgical procedures not covered in ASCs, the related professional services may be billed by the rendering provider as Part B services and the beneficiary is liable for the facility charges, which are non-covered by Medicare.

Under the ASC payment system, Medicare makes facility payments to ASCs only for the specific ASC covered surgical procedures on the ASC list of covered surgical procedures. In addition, Medicare makes 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 and prosthetic devices may be covered and separately billable under other provisions of 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, 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 OPSS, 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. ASCs must incorporate charges for packaged services into the charges reported for the separately payable services with which they are provided. Because contractors pay the lesser of 80 percent of actual charges or the ASC payment rate for the separately payable procedure, and because this comparison is made at the claim line-item level, facilities may not be paid appropriately if they unbundle charges and report those charges for packaged codes as separate line-item charges.

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.

NOTE: Effective for services on or after January 1, 2009 for allowed ASC claims, if modifier = TC, Contractors must ensure ordering/referring physician name is present in block 17 and ordering/physician NPI is present in block 17B of the CMS-1500 for paper claims.

Effective for dates of service on or after January 1, 2009 for allowed ASC claims, if modifier = TC, Contractors must ensure ordering physician name and NPI is present in Loop 2420E NM1 (NM101=DK, NM102=1, NM103=provider's last name, NM104=provider's first name, NM108=XX, NM109=provider's NPI)

Effective for dates of service on or after January 1, 2009 for allowed ASC claims, if modifier = TC, Contractors must ensure referring physician name and NPI is present in Loop 2310A/2420F NM1 (NM101=DN, NM102=1, NM103=provider's last name, NM104=provider's first name, NM108=XX, NM109=provider's NPI)

If this information is missing, contractors shall return as unprocessable and use Claim Adjustment Reason Code 16 - Claim/service lacks information which is needed for adjudication. Also use the appropriate remittance advice remark codes:

- N264 - Missing/incomplete/invalid ordering provider name
- N265 - Missing/incomplete/invalid ordering provider primary identifier
- N285 - Missing/incomplete/invalid referring provider name
- N286 - Missing/incomplete/invalid referring provider primary identifier

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. Payment for these is included in the rate for the surgical procedure.

Beginning January 1, 2008, the ASC facility payment for a surgical procedure includes payment for 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 OPSS. 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 OPSS.

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 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 agents that are not paid separately under the OPPS, 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 and an adjustment to the facility payment will be made for those lenses that are eligible. (See §40.3.)

10.3 - Services Furnished in ASCs Which Are Not ASC Facility Services or Covered Ancillary Services

(Rev. 1514; Issued: 05-23-08; Effective: 01-01-08; Implementation: 06-23-08)

A single payment is made to an ASC for facility services furnished by the ASC in connection with a covered surgical procedure. Additional payments may be made to the ASC for covered ancillary services, specifically brachytherapy sources, certain implantable devices with pass-through status under the OPSS, corneal tissue acquisition, drugs and biologicals for which separate payment is allowed under the OPSS, and radiology services for which separate payment is allowed under the OPSS. To be covered ancillary services for which separate payment is made, these items and services must be provided integral to covered surgical procedures, that is, immediately before, during, or immediately after the covered surgical procedure.

However, a number of items and services covered under Medicare may be furnished in an ASC which are not considered ASC services, and which payment for ASC services 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 services:

Items not included in payment for ASC services	Who may receive payment	Submit bills to:
Physicians' services (including surgical procedures excluded from ASC payment)	Physician	Carrier or A/B MAC
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, Carrier or A/B MAC as directed by the current DME jurisdiction list
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, Carrier or A/B MAC, as directed by the current DME jurisdiction list
Ambulance services	Certified Ambulance supplier	Carrier or A/B MAC
Leg, arm, back and neck braces	Supplier	DMERC, Carrier or A/B MAC, as directed by the current DME jurisdiction list
Artificial legs, arms, and eyes	Supplier	DMERC, Carrier or A/B MAC, as directed by the current DME jurisdiction list
Services furnished by an independent laboratory	Certified lab. ASCs can receive lab certification and a CLIA number.	Carrier or A/B MAC
Facility services for surgical procedures excluded from the ASC list	ASC	ASC bills beneficiary for facility charges associated with the non-covered procedure

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

Items included in payment for ASC facility	Who may receive	Submit
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services beginning January 1, 2008	payment beginning January 1, 2008	bills to:
Implantable DME and accessories without OPPS pass-through status	ASC	Carrier or A/B MAC
Implantable nonpass-through prosthetic devices (except NTIOLs), and accessories without OPPS pass-through status	ASC	Carrier or A/B MAC
Radiology services for which there is no separate OPPS payment	ASC	Carrier or A/B MAC
Drugs and biologicals for which there is no separate OPPS payment	ASC	Carrier or A/B MAC

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

(Rev. 1514; Issued: 05-23-08; Effective: 01-01-08; Implementation: 06-23-08)

Physicians' Services - This category includes most covered services performed in ASCs which are not considered ASC 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 a single payment from the local contractor for the covered surgical procedure and the implantable device, as long as the implantable device does not have pass-through status under the OPPS. When the surgical procedure is not on the ASC list, the physician bills for his or her professional services and the ASC may bill the beneficiary for the facility charges associated with the procedure.

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 – Prior to January 1, 2008, an ASC was allowed to bill and receive separate payment for implantable prosthetic devices, other than intraocular lenses (IOLs) that were implanted, inserted, or otherwise applied by surgical procedures on the ASC list of approved procedures. The ASC billed the local Carrier and received payment

according to the DMEPOS fee schedule. However, an intraocular lens (IOL) inserted during or subsequent to cataract surgery in an ASC was included in the facility payment rate.

Beginning January 1, 2008, payment for implantable prosthetic devices without OPPS pass-through status is included in the ASC payment for the covered surgical procedure. ASCs may not bill separately for implantable devices without OPPS pass-through status.

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 as directed by the jurisdiction list.

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 non-implantable prosthetic devices, are covered under Part B, but are not included in ASC payment for ASC services. 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 non-implantable prosthetic devices and braces, this equipment is not considered part of an ASC facility service and so is not included in ASC payment for ASC services. 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 payment for covered surgical procedures. 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. 1514; Issued: 05-23-08; Effective: 01-01-08; Implementation: 06-23-08)

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 are deemed to pose significant safety risk to beneficiaries in ASCs and are not eligible for designation and coverage as ASC covered surgical procedures. Procedures that can only be reported by using an unlisted Category I CPT code are excluded from consideration because there are no specifically descriptive codes that can be evaluated for safety risk.

20.3 - Rebundling of CPT Codes

(Rev. 1, 10-01-03)

B3-2266.3

The general CCI rebundling instructions apply to processing claims from ASC facilities services. In general, if an ASC bills a CPT code that is considered to be part of another more comprehensive code that is also billed for the same beneficiary on the same date of service, only the more comprehensive code is covered, provided that code is on the list of ASC approved codes.

Refer to Chapter 23 for a description of these instructions.

30 - Rate-Setting Policies

(Rev. 1514; Issued: 05-23-08; Effective: 01-01-08; Implementation: 06-23-08)

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; payments for facility costs are paid to the ASC.

Prior to the revised ASC payment system implemented January 1, 2008, the ASC payment rate was 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, the revised ASC payment system includes the following features:

ASC payment rates for most services are based on a percentage of the hospital outpatient prospective payment system (OPPS) rates. Unless statutorily prohibited, 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 flexible 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 for most services are geographically adjusted using the pre-reclassification wage index values that CMS uses to pay non-acute providers. The adjustment for geographic wage variation will be made based on a 50 percent labor related share.

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

30.1 - Where to Obtain Current Rates and Lists of Covered Services (Rev. 1514; Issued: 05-23-08; Effective: 01-01-08; Implementation: 06-23-08)

The CMS performs the functions and calculations described above and publishes a list of covered surgical procedures and covered ancillary services for which an ASC may be paid each year, as well as quarterly updates via Medicare 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 services are subject to the usual Medicare Part B deductible and coinsurance requirements. There is no deductible and a 25 percent coinsurance is applied to colorectal cancer screening colonoscopies and screening flexible sigmoidoscopy services performed in the ASC setting.

Prior to the revised ASC payment system implemented January 1, 2008, the ASC facility payment rate was a standard overhead amount based on CMS' estimate of a fair fee and the costs incurred by the ASCs providing the procedures. HCPCS codes for procedures covered in the ASC were compiled into 9 groups with a separate rate set for each group.

Beginning January 1, 2008, CMS updates payment rates and codes for covered surgical procedures and covered ancillary services on a calendar year basis. Payable services are updated on a quarterly basis. Also, CMS calculates and makes available to the claims processing contractors CBSA-specific wage-adjusted payment rates for each of the ASC payable codes to which geographic adjustment applies. 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. 1514; Issued: 05-23-08; Effective: 01-01-08; Implementation: 06-23-08)

Prior to January 1, 2008, the ASC payment rate was 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 codes for procedures covered in the ASC were grouped into 9 groups and a rate was set for each group. In CY 2007, the ASC payment rate for each ASC covered procedure was 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. There are a small number of covered ancillary services that are contractor-priced. These include OPPS pass-through devices, which are contractor-priced. Medicare pays the same amount for drugs and biologicals that are paid separately under the OPPS when those drugs and biologicals are provided integral to covered surgical procedures. New drugs and biologicals for which product-specific HCPCS codes do not exist and are billed by ASCs using HCPCS code C9399 (unclassified drug or biological), are also contractor-priced at 95% of the average wholesale price (AWP). Medicare pays the same amount for brachytherapy sources under the revised ASC payment system as it pays hospitals under the OPPS if prospective rates are available. If prospective rates for brachytherapy sources are not available under the OPPS, ASC payment for brachytherapy sources is made at contractor-priced rates.

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 payment for the surgical procedure is a bundled payment which includes the payment for the implantable items previously paid separately under the DMEPOS fee schedule. The one exception to this is OPPS pass-through devices which are paid separately.

Medicare contractors calculate payment for each separately payable procedure and service based on the lower of 80 percent of actual charges or the ASC payment rate. The charge-to-payment rate comparison occurs at the line-item level. ASCs should not report separate line-item HCPCS codes or charges for items that are packaged into payment for covered surgical procedures and therefore, are not paid separately (e.g., nonpass-through implantable devices). Instead, it is important that ASCs incorporate charges for packaged services into the charges reported for the separately payable services with which they are provided. Facilities may not be paid appropriately if they

unbundle charges and report those charges for packaged codes as separate line-item charges.

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 contractor checks 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. 1514; Issued: 05-23-08; Effective: 01-01-08; Implementation: 06-23-08)

The payment rates established for ASC procedures (see §30) are standard base rates that have been adjusted to remove the effects of regional wage variations. When contractors process claims for ASC services, they adjust the base rates for services subject to geographic adjustment to reflect the wage index value applicable to the area in which the ASC is located. The Medicare payment for ASC services is equal to 80 percent of the wage-adjusted standard payment rate. Beneficiaries are responsible for a 20 percent coinsurance payment for ASC services once their deductible is satisfied. The exception is for colorectal cancer screening colonoscopies and screening flexible sigmoidoscopies. There is no deductible and a 25 percent coinsurance payment applies for these services. Use Medicare Summary Notice (MSN) 18.23, "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 1.0.

Each Core-Based Statistical Area (CBSA) within a State has a separate index. If a specific city or county does not have a CBSA value, the default is to the overall state wage index.

For dates of service on or after January 1, 2008, the ASC payment rates are 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 payment rates for services subject to geographic adjustment. The wage index values for urban and rural areas that CMS applies to all non-acute providers are used 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 50 percent and the remaining non-labor related portion is 50 percent.

There is no adjustment for geographic wage differences for the following:

Corneal tissue acquisition;
Drugs and devices that have pass-through status under the OPPTS;
Brachytherapy sources;
Payment adjustment for NTIOLs; and
Separately payable drugs and biologicals.

40.3 - Payment for Intraocular Lens (IOL) **(Rev. 1514; Issued: 05-23-08; Effective: 01-01-08; Implementation: 06-23-08)**

Prior to January 1, 2008, 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

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

Beginning January 1, 2008, the Medicare payment for the IOL is included in the Medicare ASC payment for the associated surgical procedure. Consequently, no separate payment for the IOL is made, except for a payment adjustment for NTIOLs established according to the process outlined in 42 CFR 416.185. ASCs should not report separate charges for conventional IOLs because their payment is included in the Medicare payment for the associated surgical procedure. The ASC payment system logic that excluded \$150 for IOLs for purposes of the multiple surgery reduction in cases of cataract surgery prior to January 1, 2008 no longer applies, effective for dates of service on or after January 1, 2008.

Effective for dates of service on and after February 27, 2006, through February 26, 2011, Medicare pays an additional \$50 for specified Category 3 NTIOLs that are provided in

association with a covered ASC surgical procedure. The list of Category 3 NTIOLS is available at: http://www.cms.hhs.gov/ASCPayment/08_NTIOLs.asp#TopOfPage.

ASCs should use HCPCS code Q1003 to bill for a Category 3 NTIOL. HCPCS code Q1003, along with one of the approved surgical procedure codes (CPT 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. The payment adjustment for the NTIOL is subject to beneficiary coinsurance but is not wage-adjusted.

Any subsequent IOL recognized by CMS as having the same characteristics as the first NTIOL recognized by CMS for a payment adjustment as a Category III NTIOL (those of reduced spherical aberration) will receive the same adjustment for the remainder of the 5-year period established by the first recognized IOL.

40.4 - Payment for Terminated Procedures

(Rev. 1514; Issued: 05-23-08; Effective: 01-01-08; Implementation: 06-23-08)

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

A. Contractors deny payment when an ASC submits a claim for a procedure that is terminated before the patient is taken into the treatment or operating room. For example, payment is denied if scheduled surgery is canceled or postponed because the patient on intake complains of a cold or flu.

B Contractors 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 or the procedure initiated (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. Facilities use a 73 modifier to indicate that the procedure was terminated prior to induction of anesthesia or initiation of the procedure.

C. Contractors make full payment of the surgical procedure if a medical complication arises which causes the procedure to be terminated after anesthesia has been induced or the procedure initiated (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 was terminated after administration of anesthesia or initiation of the procedure.

An ASC claim for payment for terminated surgery must include an operative report kept on file by the ASC, and made available, if requested by the contractor. The operative report should specify 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.

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

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. 1514; Issued: 05-23-08; Effective: 01-01-08; Implementation: 06-23-08)

When more than one surgical procedure is performed in the same operative session, special payment rules apply, even if the procedures have the same HCPCS code.

When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, contractors pay 100 percent of the highest paying surgical procedure on the claim, plus 50 percent of the applicable payment rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session. The OPPS/ASC final rule for the relevant

payment year specifies whether or not a surgical procedure is subject to multiple procedure discounting for that year. Final payment is subject to the usual copayment and deductible provisions.

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 do 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.

A procedure performed bilaterally in one operative session is reported as two procedures, either as a single unit on two separate lines or with "2" in the units field on one line. The multiple procedure reduction of 50 percent applies to all bilateral procedures subject to multiple procedure discounting. For example, if lavage by cannulation; maxillary sinus (antrum puncture by natural ostium) (CPT code 31020) is performed bilaterally in one operative session, report 31020 on two separate lines or with "2" in the units field. Depending on whether the claim includes other services to which the multiple procedure discount applies, the contractor applies the multiple procedure reduction of 50 percent to the payment for at least one of the CPT code 31020 payment rates.

40.6 - Payment for Extracorporeal Shock Wave Lithotripsy (ESWL) (Rev. 1514; Issued: 05-23-08; Effective: 01-01-08; Implementation: 06-23-08)

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 did 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 were 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 claims 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. 1669, Issued: 01-13-09, Effective: 01-01-09, Implementation: 01-05-09)

Contractors pay ASCs a reduced amount for certain specified procedures when a specified 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 modifier –FB on the procedure code when a specified device is furnished without cost or for which full credit is received. If the ASC receives a partial credit of 50 percent or more of the cost of a specified device, the ASC is required to include modifier –FC on the procedure code if the procedure is on the list of specified procedures to which the -FC reduction applies. A single procedure code should not be submitted with both modifiers –FB and -FC. The pricing determination related to modifiers –FB and -FC is made prior to the application of multiple procedure payment reductions. Contractors adjust beneficiary coinsurance to reflect the reduced payment amount. Tables listing the procedures and devices to which the payment adjustments apply, and the full and partial adjustment amounts, are available on the CMS Web site.

In order to report that the receipt of a partial credit of 50 percent or more of the cost of a device, ASCs have the option of either: 1) Submitting the claim for the procedure to their Medicare contractor after the procedure’s performance but prior to manufacturer acknowledgement of credit for a specified device, and subsequently contacting the contractor regarding a claims adjustment once the credit determination is made; or 2) holding the claim for the procedure until a determination is made by the manufacturer on

the partial credit and submitting the claim with modifier –FC appended to the implantation procedure HCPCS code if the partial credit is 50 percent or more of the cost of the device. If choosing the first billing option, to request a claims adjustment once the credit determination is made, ASCs should keep in mind that the initial Medicare payment for the procedure involving the device is conditional and subject to adjustment.

40.9 - Payment and Coding for Presbyopia Correcting IOLs (P-C IOLs) and Astigmatism Correcting IOLs (A-C IOLs)
(Rev. 1865, Issued: 12-04-09, Effective: 01-01-10, Implementation: 01-04-10)

CMS payment policies and recognition of P-C IOLs and A-C IOLs are contained in Transmittal 636 (CR3927) and Transmittal 1228 (CR5527) respectively.

Effective for dates of service on and after January 1, 2008, when inserting an approved A-C IOL in an ASC concurrent with cataract extraction, HCPCS code V2787 (Astigmatism-correcting function of intraocular lens) should be billed to report the non-covered charges for the A-C IOL functionality of the inserted intraocular lens. Additionally, note that HCPCS code V2788 (Presbyopia-correcting function of intraocular lens) is no longer valid to report non-covered charges associated with the A-C IOL. However, this code continues to be valid to report non-covered charges for a P-C IOL. The payment for the conventional lens portion of the A-C IOL and P-C IOL continues to be bundled with the ASC procedure payment.

Effective for services on and after January 1, 2010, ASCs are to bill for insertion of a Category 3 new technology intraocular lens (NTIOL) that is also an approved A-C IOL or P-C IOL, concurrent with cataract extraction, using three separate codes. ASCs shall use HCPCS code V2787 or V2788, as appropriate, to report charges associated with the non-covered functionality of the A-C IOL or P-C IOL, the appropriate HCPCS code 66982 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (one stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage); 66983 (Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)); or 66984 (Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification)), to report the covered cataract extraction and insertion procedure; and Q1003 (New technology, intraocular lens, category 3 (reduced spherical aberration) as defined in Federal Register notice, Vol. 65, dated May 3, 2000) to report the covered NTIOL aspect of the lens on claims for insertion of an A-C IOL or P-C IOL that is also designated as an NTIOL. Listings of the CMS-approved Category 3 NTIOLs, A-C IOLs, and P-C IOLs are available on the CMS Web site.

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, type 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. 1514; Issued: 05-23-08; Effective: 01-01-08; Implementation: 06-23-08)

Contractors shall return as unprocessable any claims for NTIOLs containing Q1003 alone or with a code other than one of the procedure codes listed in 40.3. 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.

Contractors 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.

Contractors 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.

Contractors 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.

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. 2020, Issued: 08-06-10, Effective: 09-07-10, Implementation 09-07-10)

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 the technical component for all ancillary services on the ASCFS list billed by specialties other than 49 provided in an ASC setting (POS 24) and use 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. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.*
- *Remittance Advice Remark Code M97 – Not paid to practitioner when provided in this place of service. Payment included in the reimbursement issued the facility.*
- *Remittance Advice 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 globally billed** ancillary services on the ASCFS list **if** billed by specialties other than 49 provided in an ASC setting (POS 24) and use the following messages:*

- MSN 16.2 – This service cannot be paid when provided in this location/facility.*
- N200 – The professional component must be billed separately*
- Claim Adjustment Reason Code 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. Note Refer to the 835 healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.*

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.

60.3 – Applicable ASC Messages for Certain Payment Indicators Effective for Services Performed on or after January 1, 2009

(Rev. 1616; Issued: 10-17-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

Contractors shall deny services for HCPCS with payment indicators **C5** (Inpatient surgical procedure under the OPPS; no payment made.), **M6** (No payment made; paid under another fee schedule), **U5** (Surgical unlisted service excluded from ASC payment.

No payment made.), or **X5** (Unsafe surgical procedure in ASC. No payment made. Use the following messages:

- MSN 16.2 - This service cannot be paid when provided in this location/facility.
- RA Remark N428 - Service/procedure not covered when performed in this place of service.
- Claim Adjustment Reason Code 5 - The procedure code/bill type is inconsistent with place of service.

Contractors shall deny services for CPT codes with payment indicators **E5** (Surgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made.), or **Y5** (Non-surgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made.) and use the following messages:

- MSN 16.10 – Medicare does not pay for this item or service.
- Claim Adjustment Reason Code 96 – Non-covered charges.
- RA Remark Code - N425 - Statutorily excluded services.
- RA Remark Code M16 - **Alert:** Please see our Web site, mailings, or bulletins for more details concerning this policy/procedure/decision.

NOTE: Contractors shall assign beneficiary liability for facility charges HCPCS codes billed with ASC payment indicators **C5, E5, U5** and **X5**.

Contractors return as unprocessable services for HCPCS with payment indicator **D5** (Deleted/discontinued code; no payment made.) and use the following messages:

- Claim Adjustment Reason Code 181 - Procedure was invalid on the date of service.
- RA Remark N56 - Procedure code billed is not correct/valid for the services billed or the date of service billed.

Contractors shall deny services for HCPCS with payment indicators **L1** (Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made.), **NI** (Packaged service/item; no separate payment made.) or **S1** (Service not surgical in nature; and not a radiology service payable under the OPPS, drug/biological, or brachytherapy source. Packaged item/service; no separate payment made.) and use the following messages:

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

- Claim Adjustment Reason Code 97 - The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.
- RA Remark - N390 - This service cannot be billed separately.

Contractors shall return as unprocessable services for HCPCS with payment indicators **B5** (Alternative code may be available; no payment made.) and use the following messages:

- Claim Adjustment Reason Code - 125 - Submission/billing error.
- RA Remark - M51 - Missing/incomplete/invalid procedure code(s).
- RA Remark – M16 - **Alert:** Please see our web site, mailings or bulletins for more details concerning this policy/procedure/decision.

**70 - Ambulatory Surgical Center (ASC) HCPCS Additions, Deletions,
and Master Listing**
(Rev. 1, 10-01-03)
PM AB-03-032

The CMS Division of Data Systems (DDS) releases the ASC HCPCS, additions, deletions, and master listing files of ASC codes on a periodic basis. Instructions on how to retrieve these files from the CMS mainframe telecommunications system are also published on the same periodic basis. The Office of Information Services (OIS) announces the dates that the files are available.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R2020CP</u>	08/06/2010	Clarification of Billing Requirement for Ancillary Services Performed in the Ambulatory Surgical Center (ASC) by Entities Other Than ASCs	09/07/2010	7078
<u>R1865CP</u>	12/01/2009	January 2010 Update of the Ambulatory Surgical Center (ASC) Payment System	01/04/2010	6746
<u>R1698CP</u>	03/13/2009	April 2009 Update to the ASC Payment System; Summary of Payment Policy Changes/Manual Revisions	04/06/2009	6424
<u>R1669CP</u>	01/13/2009	January 2009 Update of the Ambulatory Surgical Center (ASC) Payment System	01/05/2009	6323
<u>R1616CP</u>	10/17/2008	Implementation of an ASC HCPCS Payment Indicator File	01/05/2009	6184
<u>R1572CP</u>	08/08/2008	New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services	01/05/2009	6129
<u>R1514CP</u>	05/23/2008	ASC Manualization	06/23/2008	6031
<u>R1325CP</u>	08/29/2007	Testing and Implementation of 2008 Ambulatory Surgical Center (ASC) Payment System Changes	01/07/2008	5680
<u>R1308CP</u>	07/20/2007	Testing and Implementation of 2008 Ambulatory Surgical Center (ASC) Payment System Changes – Replaced by Transmittal 1325	01/07/2008	5680
<u>R1160CP</u>	01/19/2007	Colorectal Cancer Screening Flexible Sigmoidoscopy and Colonoscopy Coinsurance Payment Change	07/02/2007	5387
<u>R975CP</u>	06/09/2006	Ambulatory Surgical Center (ASC) Claims Processing Manual Clarification	06/05/2006	5026

Rev #	Issue Date	Subject	Impl Date	CR#
<u>R942CP</u>	05/05/2006	Ambulatory Surgical Center (ASC) Claims Processing Manual Clarification	10/02/2006	5026
<u>R914CP</u>	04/21/2006	Additional \$50 Payment for New Technology Intraocular Lenses Furnished In Ambulatory Surgical Centers	05/22/2006	4361
<u>R639CP</u>	08/05/2005	Cessation of Additional \$50 Payment for New Technology Intraocular Lenses (NTIOLs)	10/03/2005	3901
<u>R001CP</u>	10/01/2003	Initial Publication of Manual	NA	NA

[Back to top of Chapter](#)