CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 2020	**Date: August 6, 2010**
	Change Request 7078

SUBJECT: Clarification of Billing Requirement for Ancillary Services Performed in the Ambulatory Surgical Center (ASC) by Entities Other Than ASCs

I. SUMMARY OF CHANGES: This CR will clarify a requirement originally created in CR 5680 and to ensure consistency among contractors. The requirement (5680.11.1) informed contractors to deny the technical component for all ancillary services appearing on the ASCFS when billed by specialties other than ASCs (specialty 49) when place of service is ASC (POS = 24). Since the technical component is also included in the global fee, we want to make sure the global payment is also being denied. The professional component shall be the only payment allowed for ancillary codes billed by physicians when the POS is ASC.

EFFECTIVE DATE: *September 7, 2010
IMPLEMENTATION DATE: September 7, 2010

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	14/60/2/Applicable Messages for ASC 2008 Payment Changes Effective January 1, 2008

III. FUNDING:
For Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs) and/or Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. 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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 2020	Date: August 6, 2010	Change Request: 7078

SUBJECT: Clarification of Billing Requirement for Ancillary Services Performed in the Ambulatory Surgical Center (ASC) by Entities Other Than ASCs

EFFECTIVE DATE: **September 7, 2010**

IMPLEMENTATION DATE: September 7, 2010

I. GENERAL INFORMATION

A. Background:

This CR will clarify a requirement originally created in CR 5680 to ensure consistency among contractors. The requirement (5680.11.1) informed contractors to deny the technical component for all ancillary services appearing on the ASCFS when billed by specialties other than ASCs (specialty 49) when place of service is ASC (POS = 24). Since the technical component is also included in the global fee, we want to make sure the global payment is also being denied. The professional component shall be the only payment paid for ancillary codes billed by specialties other than ASCs when POS is ASC.

B. Policy:

Publication 100-04, Chapter 14, Section 60.2 is being updated to reflect this change.

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	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7078.1	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	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
	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 to patient 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).										
7078.2	Contractors shall **deny globally billed** 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. 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.	X			X						
7078.3	Contractors shall not search and adjust for previously processed claims.	X			X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A/B MAC	DME MAC	FI	CARRIER	RHHI	Shared-System Maintainers				OTHER
							FISS	MCS	VMS	CWF	
7078..4	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 message within one 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.	X			X						

IV. SUPPORTING INFORMATION

Section 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:
	CR 5680.11.1 is the related business requirement. This CR amends that requirement.

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

V. CONTACTS

Pre-Implementation Contact(s): For claims processing issues, contact Yvette Cousar at Yvette.cousar@cms.hhs.gov or (410) 786-2160. For policy issues, contact Chuck Braver at Charles.braver@cms.hhs.gov or (410) 786-6719.

Post-Implementation Contact(s): Appropriate Project Officer or Contractor Manager

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Regional Home Health Intermediaries (RHHIs),* and/or *Carriers:*

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

Section B: *For Medicare Administrative Contractors (MACs)*:

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. 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.

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.