CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 3031	**Date: August 22, 2014**
	Change Request 8768

SUBJECT: Update to Pub. 100-04, Chapter 14 to Provide Language-Only Changes for Updating ASC X12

I. SUMMARY OF CHANGES: This CR contains language-only changes for updating ASC X12 language in Pub 100-04, Chapter 14. Also, reference to the A/B MACs replaces reference to the old contractor types in the sections that are included in this CR. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: January 1, 2012
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: September 23, 2014

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-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	14/ Table of Contents
R	14/10.1/ Definition of Ambulatory Surgical Center (ASC)
R	14/10.2/ Ambulatory Surgical Center Services on ASC List
R	14/20/ List of Covered Ambulatory Surgical Center Procedures
R	14/50/ ASC Procedures for Completing the ASC X12 837 Professional Claim Format or the Form CMS-1500

III. FUNDING:
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 obliged 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

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3031	Date: August 22, 2014	Change Request: 8768

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EFFECTIVE DATE: January 1, 2012
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I. GENERAL INFORMATION

A. Background: This CR contains language-only changes for updating ASC X12 language in Pub 100-04, Chapter 14.

B. Policy: Also, reference to the A/B MACs (B) replaces reference to the old contractor types in the sections that are included in this CR. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility							
		A/B MAC			DME MAC	Shared-System Maintainers			Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8768.1	A/B MACs shall be aware of the updated language for ASC X12 in Pub. 100 - 04, Chapter 14.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Not Applicable, 123-456-7890

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 14 - Ambulatory Surgical Centers

Table of Contents
(Rev.3031, Issued: 08-22-14)

10.1 - Definition of Ambulatory Surgical Center (ASC)

(Rev. 3031, Issued: 08-22-14, Effective: 01-01-12, Implementation: 09-23-14)

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 *using the ASC X12 837 professional claim format or, in rare cases,* on Form CMS-1500 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. 3031, Issued: 08-22-14, Effective: 01-01-12, Implementation: 09-23-14)

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 419of 42 CFR;

(10) Splints and casts and related devices;

(11) Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedure;

(12) Administrative, recordkeeping and housekeeping items and services;

(13) Materials, including supplies and equipment for the administration and monitoring of anesthesia; and

(14) Supervision of the services of an anesthetist by the operating surgeon.

Under the revised ASC payment system, the above items and services fall within the scope of ASC facility services, and payment for them is packaged into the ASC payment for the covered surgical procedure. 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 dates of service on or after January 1, 2009 for allowed ASC claims, if modifier = TC, *contractors must ensure that either:*

- *ordering physician name and NPI or*
- *referring physician name and NPI*

are present on electronic or paper claims.

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 *DME MAC*.

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 OPPS. Also, beginning January 1, 2008, Medicare makes separate payment to ASCs for drugs and biologicals that are furnished integral to an ASC covered surgical procedure and that are separately payable under the OPPS.

Diagnostic or Therapeutic Items and Services

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

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

Administrative, Recordkeeping and Housekeeping Items and Services

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

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

While covered procedures are 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.)

20 - List of Covered Ambulatory Surgical Center Procedures

(Rev. 3031, Issued: 08-22-14, Effective: 01-01-12, Implementation: 09-23-14)

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://cms.hhs.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/ASC-Regulations-and-Notices.html*

50 - ASC Procedures for Completing the *ASC X12 837 Professional Claim Format or the* Form CMS-1500

(Rev. 3031, Issued: 08-22-14, Effective: 01-01-12, Implementation: 09-23-14)

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.