CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-20 One-Time Notification	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1042	**Date: February 3, 2012**
	Change Request 7472

Transmittal 1009, dated December 28, 2011, is being rescinded and replaced by Transmittal 1042, dated February 3, 2012 to split the effective and implementation dates across the January 2012 and April 2012 releases. This Transmittal is no longer sensitive and may now be posted to the Internet. All other information remains the same.

SUBJECT: Creation of New Indicator for Use on the Ambulatory Surgical Centers (ASCs) Payment Indicator File for Reporting Quality Measures

I. SUMMARY OF CHANGES: The CR announces the new indicator that contractors will need to add in their systems along with the appropriate claims action messages for the purposes of reporting ASC quality measures as mandated by the Tax Relief and Health Care Act of 2006.

EFFECTIVE DATE: January 1, 2012 – MCS Coding
April 1, 2012 – Full Implementation

IMPLEMENTATION DATE: January 3, 2012 – MCS Coding
April 2, 2012 – Full Implementation

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
N/A	

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:

One-Time Notification

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

Attachment – One Time Notification

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SUBJECT: Creation of New Indicator for Use on the Ambulatory Surgical Centers (ASCs) Payment Indicator File for Reporting Quality Measures

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Implementation Date: January 3, 2012 – MCS Coding
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I. GENERAL INFORMATION

A. Background:

The Tax Relief and Health Care Act provided the Secretary the authority to require Ambulatory Surgical Centers to report quality data to receive their full fee schedule amount. The CMS has previously been unable to implement this requirement. CMS stated in the CY 2011 OPPS Final Rule that we intended to propose a plan for linking Ambulatory Surgical Center (ASC) payment to reporting quality data in the following year. The Department of Health and Human Services recently submitted an ASC Value Based Purchasing Report to Congress that provides recommended measures and a target January 1, 2012 effective date for an ASC pay-for-reporting program. The ASC Quality Collaborative (ASC QC) has recommended six measures with National Quality Forum (NQF) endorsement to be used in implementing an ASC pay-for-reporting program.

B. Policy:

We intend to propose the following measures for ASC data collection in CY 2012 OPPS/ASC Notice of Proposed Rulemaking starting with calendar year 2012 claims for use starting with the CY 2014 payment determination (using HCPCS code based data collection):

- Patients Fall in ASC
- Patient Burn
- Hospital Transfer/Admission
- Wrong Site, Side, Patient, Procedure, Implant
- Prophylactic IV Antibiotic Timing
- Appropriate Surgical Hair Removal

ASC providers will report these HCPCS codes on claims beginning with dates of service on and after January 1, 2012. These HCPCS codes will be submitted with a 0 charge or a 01 cent charge, and will be automatically denied by the claims processing system. The codes will be passed to CMS reporting databases, and will later be analyzed to determine compliance with the reporting requirements.

These HCPCS codes will appear on the ASC Payment Indicator file with the January 2012 ASC Change Request (CR) update. The CMS has established a new indicator M5 (Quality measurement code used for reporting purposes only; no payment made) that will be tied to the HCPCS codes on the Payment Indicator file for services effective January 1, 2012. The CR announces the new indicator that contractors will need to add in their systems along with the appropriate claims action messages.

II. BUSINESS REQUIREMENTS 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	
7472.1	Contractors shall accept the new Payment Indicator **M5** on the ASC Payment Indicator File. **M5** = Quality measurement code used for reporting purposes only; no payment made. **NOTE:** This new payment indicator will identify the HCPCS codes used for performance measurement.	X			X						
7472.1.1	Payment Indicator M5 codes shall be processed with either a zero charge or a $0.01 charge (if required by the ASC's billing system).	X			X			X			
7472.1.2	Contractors shall deny HCPCS codes whose payment indicator is M5.	X			X			X			
7472.1.2.1	Contractors shall use the following messages when denying claims when the payment indicator = **M5** Medicare Summary Notice (MSN) 36.7 – This code is for informational/reporting purposes only. You should not be charged for this code. If there is a charge, you do not have to pay the amount. Remittance Advice N365 – This procedure code is not payable. It is for reporting/information purposes only. Claim Adjustment Reason Code – 96 Non-covered charge(s). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. Group Code CO	X			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	
	None.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:

X-Ref Requirement Number	Recommendations or other supporting information:
	None.

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

V. CONTACTS

Pre-Implementation Contact(s): For claims processing issues: Yvette Cousar at (410) 786-2160 or yvette.cousar@cms.hhs.gov and Mark Baldwin at (410) 786-8139 or mark.baldwin@cms.hhs.gov. For Policy issues:

Post-Implementation Contact(s):
Contact your Contracting Officer's Technical Representative (COTR) or Contractor Manager, as applicable.

VI. FUNDING

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

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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.