



Clarification of Billing Requirement for Ancillary Services Performed in the Ambulatory Surgical Center (ASC) by Entities Other Than ASCs – JA7078

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Date Job Aid Revised: August 23, 2010

Effective Date: September 7, 2010

Implementation Date: September 7, 2010

Key Words MM7078, CR7078, R2020CP, Billing, Ancillary, CR5680, MM5680

Contractors Affected

- Medicare Carriers
- Part A/B Medicare Administrative Contractors (A/B MACs)

Provider Types Affected Physicians and other providers submitting claims to Medicare Carriers and A/B MACs for services on the ASC Fee Schedule (ASCFS) are affected.



- Change Request (CR) 7078 clarifies a billing requirement originally created in CR5680 for ancillary services performed in the ASC by entities other than ASCs. The CR is intended to ensure consistency among all Medicare contractors.
 - CR7078 informs those 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 (POS) is ASC (POS = 24).
 - Since the technical component is also included in the global fee, the global payment must also be denied.
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- CR7078 directs Medicare contractors:
 - To deny the technical component for all ancillary services on the ASCFS list billed by specialties other than ASCs and where such services are provided in an ASC setting; and
 - To deny globally billed ancillary services on the ASCFS list billed by specialties other than ASCs provided in an ASC setting.
- The professional component is the only payment allowed for ancillary codes billed by physicians and must be billed separately.

Denied Claim Messages

- **When denying the technical component** for all ancillary services on the ASCFS list billed by specialties other than ASCs (specialty 49) provided in an ASC setting (POS 24), Medicare contractors will use the following messages:
 - 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 97 – *Not paid to practitioner when provided to patient in this place of service. Payment included in 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).*
- **When denying globally billed** ancillary services on the ASCFS list if billed by specialties other than 49 provided in an ASC setting (POS 24), Medicare will use the following messages:
 - Remittance Advice Remark Code 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.*

Provider Needs to Know...

Background

CR7078 clarifies a requirement originally created in CR5680, which is addressed in the MLN Matters® article available at <http://www.cms.gov/MLN MattersArticles/downloads/MM5680.pdf> on the Centers for Medicare & Medicaid Services (CMS) website.

Operational Impact	N/A
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Reference Materials	The related MLN Matters® article can be found at http://www.cms.gov/MLN MattersArticles/downloads/MM7078.pdf on the CMS website. The official instruction (CR7078) issued regarding this change may be viewed at http://www.cms.gov/Transmittals/downloads/R2020CP.pdf on the CMS website.
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