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# Implementation of 2008 Ambulatory Surgical Center (ASC) Payment System Changes

## Provider Types Affected

Providers who bill contractors (Fiscal Intermediaries, carriers and Medicare Administrative Contractors (A/B MAC) for ambulatory surgical center services for Medicare Beneficiaries

## What You Need to Know

The Centers for Medicare & Medicaid Services (CMS) is required to implement a new Ambulatory Surgical Center (ASC) payment system no later than January 1,

2008. An overview of the new system has already been provided in the MLN Matters article SE0742, which is available at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0742.pdf on the CMS website. CR 5680, from which this article is taken, provides additional information on the background, policy, and instructions that your Medicare contractor will use to implement this revised payment system.

## Background

Section 626 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) requires the Centers for Medicare & Medicaid Services (CMS) to implement a new Ambulatory Surgical Center (ASC) payment system not later than January 1, 2008. In part, the law requires that ASCs be paid the lesser of the actual charge or the ASC fee schedule payment rates. See MLN Matters article SE0742 at *http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0742.pdf* for an overview of the new ASC payment system.

In addition to the new payment instructions, ASCs will be paid a reduced amount for certain procedures when you receive a partial credit for more than 50 percent of the cost of a medical device. You will need to include an FC modifier on certain procedure codes that include payment for a device, to report that you received a partial credit for more than 50 percent of the cost of the device. For those procedure codes where the FC modifier may be applicable, CMS will provide Medicare contractors with a price for the procedure code, both with and without, the FC modifier.

CR 5680 also includes a number of changes to two Medicare manuals as summarized below. (Only the key changes/revisions are included in this article). These revised manual instructions are attached to CR5680.

## Revisions to the Medicare Claims Processing Manual

(These revisions are attached to CR5680 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1325CP.pdf on the CMS website.)) Key revisions are:

## Chapter 1 (General Billing Requirements)

### Section 30.3.1 (Mandatory Assignment on Carrier Claims)

For colorectal cancer screening colonoscopies (G0105 and G0121), there is no deductible and a 25 percent coinsurance. Effective January 1, 2008, for service G0104, there will be no deductible and the 25 percent coinsurance rate will apply.

## Chapter 4 (Part B Hospital (Including Inpatient Hospital Part B and OPPS)

### Section 120 (General Rules for Reporting Outpatient Hospital Services)

Effective for dates of service on or after January 1, 2008, the Medicare contractor no longer processes claims on TOB 83X for ASCs. All ASC providers (including Indian Health Service providers) must submit their claims to the designated carrier or A/B MAC

### Section 180.1 (General Rules)

Effective for dates of service on or after January 1, 2008, the Medicare contractor no longer processes claims on TOB 83X for ASCs. All ASC providers (including Indian Health Service providers) must submit their claims to the designated carrier or A/B MAC

## Chapter 14 (Ambulatory Surgical Centers)

### Section 10 (General)

Beginning January 1, 2008, Medicare will:

- Pay 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;
- Pay ASCs (under Part B) for certain ancillary services such as certain drugs and biologicals, pass through devices, brachytherapy sources, and radiology procedures;
- Continue to pay ASCs for new technology intraocular lenses and corneal tissue acquisition as it did prior to January 1, 2008; and
- Not pay ASCs for procedures that are excluded from the list of covered surgical procedures or covered ancillary services.

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 the Centers for Medicare & Medicaid Services (CMS). The *State Operations Manual*, which you can find at

*http://www.cms.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=1&sortOrder=ascending&itemID=CMS1201984&intNumPerPage=10* describes the certification process.

Section 10.2. (Ambulatory Surgical Center Services on ASC List)

Under the new payment system, ASC services for which payment is included in the ASC payment include, but are not limited to:

- Nursing technician, and related services;
- Use of the facility where the surgical procedures are performed;
- Any laboratory testing performed under a clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate waiver;
- Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS);
- Medical and surgical supplies not on pass-through status under Subpart G of Part 419.62 of 42 CFR located at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42*;
- Equipment;
- Surgical dressings;
- Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status under Subpart G of Part 419.62 of 42 CFR located at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42*);
- Implanted DME and related accessories and supplies not on pass-through status under Subpart G of Part 419 of 42 CFR located at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&rgn=div8&view=text&node=42:3.0.1.1.6.7.1.1&idno=42*;
- Splints and casts and related devices;
- 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 procedures;
- Administrative, recordkeeping and housekeeping items and services;

- Materials, including supplies and equipment for the administration and monitoring of anesthesia; and
- Supervision of the services of an anesthetist by the operating surgeon.

In addition, Medicare will pay ASCs separately for certain covered ancillary services that are provided integral to a covered ASC surgical procedure. The services are:

- Brachytherapy sources;
- Certain implantable items that have pass-through status under the Outpatient Prospective Payment System (OPPS);
- Certain items and services that CMS designates as contractor-priced, including, but not limited to, the procurement of corneal tissue;
- Certain drugs and biologicals for which separate payment is allowed under the OPPS; and
- Certain radiology services for which separate payment is allowed under the OPPS.

Beginning January 1, 2008, the ASC facility payment for drugs and biologicals includes those that are not usually self-administered, and are considered to be packaged into the payment for the surgical procedure under the outpatient prospective payment system (OPPS). 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 are separately payable under the OPPS.

### Section 10.4. (Coverage of Services in ASCs, Which Are Not ASC Facility Services)

### Physician Services

Includes most covered services performed in ASCs, which are not considered ASC facility services. Consequently, physicians who perform covered services in ASCs may bill and receive separate payment under Part B. Physicians' services include the services of anesthesiologists administering or supervising the administration of anesthesia to beneficiaries in ASC's and the beneficiaries' recovery from the anesthesia.

### Implantable Durable Medical Equipment (DME)

If the ASC furnishes items of implantable DME items to beneficiaries, the ASC bills and receives payment from the local carrier or A/B MAC for the surgical procedure and the implantable device. When the surgical procedure is not on the ASC list, the physician bills the carrier or A/B MAC for both the surgical procedure and the implanted device, coding the ASC as the place of service (POS code 24) on the bill.

### Non-Implantable DME

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.

### Services of Independent Laboratory

As noted in the *Medicare Claims Processing Manual*, Chapter 14, *Section 10.2*., only very limited numbers and types of diagnostic tests are considered ASC facility services and are included in the ASC facility payment rate. Since *Section 1861(s)* of the Act limits coverage of diagnostic lab tests in facilities other than physicians' offices, rural health clinics, or hospitals to those that meet the statutory definition of an independent laboratory, in most cases, diagnostic tests that an ASC performs directly are not considered ASC facility services and not covered under Medicare.

The ASC's laboratory must be CLIA certified and will need to enroll with the carrier or A/B MAC, as a laboratory and the certified clinical laboratory must bill for the services provided to the beneficiary in the ASC. Otherwise, the ASC must make arrangements with a covered laboratory or laboratories for laboratory services, as set forth in 42CFR416.49 located at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=737c29dc4bb9dd89c5b72ca82f9b40c5&rgn=div8&view=text&node=42:3.0.1.1.3.3.1.10&idno=42* on the Internet.

### Section 20 (List of Covered Ambulatory Surgical Center Procedures)

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; and the wage adjusted payment rates, and wage indices are available at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html on the CMS website.

Section 20.1 (Nature and Applicability of ASC List)

The ASC list of covered procedures 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. In addition, 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.

Section 20.2. (Types of Services Included on the List)

The Medicare approved procedures are all considered "surgical procedures" for purposes of ASC coverage, regardless of the use of the procedure. For example, many of the "oscopy" procedures listed - bronchoscopy, laryngoscopy, etc., may be employed for either diagnostic or therapeutic purposes, or even both at the same time, such as when the "oscopy" permits both detection and removal of a polyp. Those procedures are considered "surgical procedures" within the context of the ASC provision. In addition, surgical procedures are commonly thought of as those involving an incision of some type, whether done with a scalpel or (more recently) a laser, followed by removal or repair of an organ or other tissue.

In recent years, the development of fiber optics technology, together with new surgical instruments using that technology, has resulted in surgical procedures that, while invasive and manipulative, do not require incisions. Instead, the procedures are performed without an incision through various body openings. Those procedures, some of which include the "oscopy" procedures mentioned above, are also considered surgical procedures for purposes of the ASC provision, and several are included in the list of covered procedures.

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 and 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 and procedures that can only be reported by using an unlisted Category I CPT code are deemed to pose significant safety risk to beneficiaries in ASCs and are not eligible for designation and coverage as covered surgical procedures.

### Section 30 (Rate-Setting Policies)

Generally, there are two primary elements in the total cost of performing a surgical procedure:

- The cost of the physician's professional services for performing the procedure; and,
- The cost of services furnished by the facility where the procedure is performed (e.g., surgical supplies and equipment and nursing services). For a discussion of the ASC payment methodology, see MLN Matters article SE0742 at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0742.pdf on the CMS website.

### Section 40.3. (Payment for Intraocular Lens (IOLs)

Beginning January 1, 2008, the Medicare payment for the IOL is included in the Medicare payment for the associated surgical procedure. Consequently, no separate payment for the IOL will be made, except for a new technology IOL as discussed under the *Medicare Claims Processing Manual*, Chapter 14, Section 40.3.1. If an ASC bills for a new technology IOL that is provided in association with a covered ASC procedure, the contractor will make a separate payment adjustment of $50 for the new technology IOL. The payment for the new technology IOL is subject to beneficiary coinsurance but is not wage adjusted. The hard coded system logic that excludes the $150 for IOLs for multiple surgery reduction will not apply effective for dates of services on or after January 1, 2008.

### Section 40.4 (Payment for Terminated Procedures)

Facilities use a 73 modifier to indicate that the procedure terminated prior to induction of anesthesia.

Prior to January 1, 2008, carriers or A/B MACs deduct the allowance for an unused IOL prior to calculating payment for a terminated IOL insertion procedure.

Beginning January 1, 2008, payment for an IOL is included in the payment for the surgical procedure to implant the lens.

Beginning January 1, 2008, Medicare contractors will 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.

Beginning January 1, 2008, ASC surgical services billed with the -52 or- 73 modifiers are not subject to the multiple procedure discount.

Section 40.5. (Payment for Multiple Procedures)

Each surgical procedure has its own CPT-4 code. When more than one surgical procedure is performed in the same operative session, special payment rules apply even if the services have the same CPT-4 code number.

When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, contractors base the ASC facility payment rate on 100% of the highest paid procedure, plus 50 percent of applicable wage adjusted rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session.

The multiple procedure payment reduction is the last pricing routine applied beginning January 1, 2008 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 will not be subjected to further pricing reductions (i.e., the multiple procedure price reduction rules will 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.

Section 40.6 (Payment for Extracorporeal Shock Wave Lithotripsy (ESWL))

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.

Section 40.7 (Offset for Payment for Pass-Through Devices Beginning January 1, 2008)

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 quarterly. The CMS will inform Medicare contractors of the code pairs and the percent reduction taken from the procedure payment rate through a "look-up" table.

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

Contractors pay ASCs a reduced amount for certain specified procedures when a device is furnished without cost or for which either a partial or a full credit is received (e.g., device recall). For specified procedure codes that include payment for a device, ASCs are required to include an FB modifier on the procedure code when a device is furnished without cost or for which full credit is received.

If the ASC receives a partial credit for the device, the ASC is required to include the FC modifier on the procedure code. A single procedure code should not be submitted with both a FB and a FC modifier. The pricing determination related to the FB and FC modifiers is performed prior to the application of the multiple procedure pricing reductions.

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

CMS payment policies and recognition of P-C IOLs and A-C IOLs are contained in Transmittal 636 (CR3927) and Transmittal 1228 (CR5527) respectively. See http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/index.html for a current list of CMS recognized P-C IOL and A-C IOL lenses

Section 50 (ASC Procedures for Completing the Form CMS-1500)

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. Modifier – TC is required unless the code definition is for the technical component only.

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

Section 60.1 (Applicable messages for NTIOLs)

Carriers or A/B MACs will return, as unprocessable, any claims for NTIOLs containing Q1003 alone or with a code other than one of the procedure codes listed in Section 40.5.2, Chapter 14, of the *Medicare Claims Processing Manual.* They will 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; and
- 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.

Carriers or A/B MACs will deny payment for Q1003 if services are furnished in a facility other than a Medicare-approved ASC and use the following messages when denying these claims:

- MSN 16.2 - This service cannot be paid when provided in this location/facility; and
- 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 or A/B MAC will deny payment for Q1003 if billed by an entity other than a Medicare-approved ASC and use the following messages when denying these claims:

- MSN 33.1 - The ambulatory surgical center must bill for this service; and
- Claim Adjustment Reason Code 170 - Payment is denied when performed/billed by this type of provider.

Carriers or A/B MACs shall deny payment for Q1003 if submitted for payment past the discontinued date (after the 5-year period, or after February 26, 2011) and use the following messages when denying these claims:

- MSN 21.11 - This service was not covered by Medicare at the time you received it; and

- Claim Adjustment Reason Code 27 - Expenses incurred after coverage terminated.

Section 60.2 (Applicable messages for ASC 2008 payment changes effective January 1, 2008)

Contractors shall deny services not included on the ASC facility payment files (ASCFS and ASC DRUG files) when billed by ASCs (specialty 49) for POS 24 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; and

- 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 will 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 ASC DRUG 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; and.

- 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 all ancillary services (e.g., radiology technical component) on the ASCFS list billed by specialties other than specialty 49 provided in an ASC setting (POS 24) using 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;

- 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; and

- 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 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 Codes M15 - Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed;

- MA 109 - Claim processed in accordance with ambulatory surgical guidelines; and

- 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, they will also include the following message:

- MSN 16.8 - Payment is included in another service received on the same day.

## Chapter 19 (Indian Health Services)

### Section 40.2.1 (Provider Enrollment with FI or AB MAC - Ambulatory Surgical Services)

For dates of service prior to January 1, 2008, IHS providers that want to bill for surgeries on the ambulatory surgical center (ASC) list and receive the ASC rate must contact their designated FI or AB MAC. IHS providers are certified by one of

several national accrediting organizations recognized by the Centers for Medicare & Medicaid Services (CMS) and meet the conditions for performing ASC procedures.

IHS hospital outpatient departments are not certified as separate ASC entities. The ASC indication merely means that CMS approved them to bill for ASC services and be paid based on the ASC rates for services on the ASC list. In order to bill for ASC services, the hospital outpatient department must meet the conditions of participation for hospitals defined in 42CFR482 located at *http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=2196cd71379f6eba74e7f54cfe19fc60&tpl=/ecfrbrowse/Title42/42cfr482_main_02.tpl* on the Internet.

Authority for Medicare to pay IHS hospital outpatient departments using the freestanding ASC rates was incorporated into Public Health Service (PHS) regulations on December 27, 1989. The first IHS hospital requested and received approval from CMS to bill separately for ASC procedures at the appropriate ASC group payment amount for dates of service on or after October 1, 1987. Previously, the hospital was reimbursed for ASC procedures at the Office of Management and Budget (OMB) negotiated all-inclusive rate (AIR) for outpatient hospital services. The rationale for approving this request was that the hospital was already JCAHO certified; encompassing the ability to perform outpatient surgical procedures, and that acute care hospitals providing surgical inpatient or outpatient services can perform any surgical procedures within their capacity and capability.

Effective for dates of service on or after January 1, 2008, the FI or A/B MAC no longer processes claims for IHS ASCs. All IHS ASC providers, including hospital outpatient departments requesting payment based on freestanding ASC rates and ASCs affiliated with a hospital but operating as a distinct entity for the purpose of performing outpatient surgical services must enroll with and submit their claims to the designated carrier or A/B MAC.

## Chapter 26 (Completing and Processing Form CMS-1500 Data Set)

### Section 10.7 (Type of Service (TOS))

Effective for services on or after January 1, 2008, the SG modifier is no longer applicable for Medicare ASC services. ASC providers will no longer be required to bill the SG modifier on Medicare ASC facility claims.

## Revisions to the Medicare Benefit Policy Manual

Changes to this manual are basically the same, as appropriate, as those made to the *Medicare Claims Processing Manual.* The revised portions of the *Medicare Benefits Policy Manua*l are also attached to CR5680 at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R77BP.pdf on the CMS website.

## Additional Information

Should you have questions, please contact your carrier or A/B MAC at their toll free number at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

The two transmittals related to CR5680 are at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1325CP.pdf and http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R77BP.pdf no the CMS website. Attached to these transmittals are the revised manual chapters discussed in this article. These transmittals are the official instructions issued to your Medicare contractor.

Also, the MLN Matters article providing an overview of the new ASC payment system is at http://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnmattersarticles/downloads/SE0742.pdf on the CMS website.