



MLN Matters®



Information for Medicare Fee-For-Service Health Care Professionals



News Flash - - The July 2008 version of the *Evaluation & Management Services Guide*, which provides evaluation and management services information about medical record documentation, International Classification of Diseases and Current Procedural Terminology codes, and key elements of service, is now available on the Centers for Medicare & Medicaid Services Medicare Learning Network at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/eval_mgmt_serv_guide-ICN006764.pdf on the CMS website.

MLN Matters® Number: MM6052 **Revised**

Related Change Request (CR) #: 6052

Related CR Release Date: September 26, 2008

Effective Date: January 1, 2008

Related CR Transmittal #: R1604CP

Implementation Date: January 5, 2009

Physician Payment Amounts When Physicians Furnish Excluded Procedures in Ambulatory Surgical Centers (ASCs)

Note: This article was updated on August 9, 2012, to reflect current Web addresses. All other information remains the same.

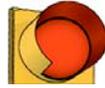
Provider Types Affected

Physicians and ASCs submitting claims to Medicare contractors (carriers and/or Part A/B Medicare Administrative Contractors (A/B MACs)) for ASC services provided to Medicare beneficiaries.

Provider Action Needed

Disclaimer

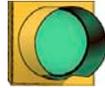
This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents

**STOP – Impact to You**

This article is based on Change Request (CR) 6052 regarding payment amounts provided when physicians furnish excluded procedures in ambulatory surgical centers (ASCs).

**CAUTION – What You Need to Know**

Effective for dates of service on or after January 1, 2008, Medicare will pay physicians at the facility rate for furnishing procedures in ASCs that are excluded from the list of covered ASC procedures. CR 6052 implements this policy beginning January 5, 2009. In essence, the fee paid on all physician services performed in ASCs (place of service code of 24) will be the lower facility fee and not the non-facility fee.

**GO – What You Need to Do**

See the Background and Additional Information Sections of this article for further details regarding these changes.

Background

Prior to January 1, 2008, physicians were paid for furnishing non-covered procedures in Ambulatory Surgical Centers (ASCs) at the non-facility amount. Beginning January 1, 2008, Medicare revised this policy to require payment to physicians at the facility payment amount which is in agreement with both the policy under the hospital outpatient prospective payment system (OPPS) and the revised ASC payment policy related to the list of covered services. The revised ASC payment system is based on the ambulatory payment classification (APC) groups and payment weights of the Outpatient Prospective Payment System (OPPS).

The Centers for Medicare & Medicaid Services (CMS) believes ASC facilities are similar, insofar as the delivery of surgical and related nonsurgical services, to hospital outpatient departments. Specifically, when services are provided in ASCs, the ASC, not the physician, bears responsibility for the facility costs associated with the service. This situation parallels the hospital facility resource responsibility for hospital outpatient services.

Under the revised ASC payment system, CMS adopted a policy that identifies, and excludes from ASC payment, only those procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay.

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As such, CMS believes that it would be inconsistent with the revised ASC payment system policies to pay the typically higher non-facility rate to physicians who furnish excluded ASC procedures. Because the excluded procedures have been specifically identified by CMS as procedures that could pose a significant risk to beneficiary safety or would be expected to require an overnight stay, CMS does not believe it would be appropriate to provide a payment based on the non-facility rate to physicians who furnish them in the ASC setting.

In addition, the proposed revision to the code of federal regulations (42CFR414.22(b)(5)(i)(A) and (B); see http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=ecfrbrowse/Title42/42cfr414_main_02.tpl on the Internet) imposes beneficiary liability for facility costs associated with surgical procedures that are not Medicare covered surgical procedures when performed in ASCs.

Under the revised ASC payment system, CMS has determined that the only surgical procedures excluded from ASC payment are those that pose a significant safety risk to beneficiaries or are expected to require an overnight stay when furnished in ASCs. **Therefore, CMS provides no payment to ASCs for these procedures.**

Note: CMS does not expect that these unsafe services will be furnished to Medicare beneficiaries in ASCs, and CMS expects that physicians and ASCs will advise beneficiaries of all of the possible consequences (including no Medicare ASC payments with concomitant beneficiary liability and significant surgical risk) if surgical procedures excluded from ASC payment were to be provided in ASCs.

Additional Information

The official instruction, CR6052, issued to your carrier and A/B MAC regarding this change may be viewed at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1604CP.pdf> on the CMS website.

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

News Flash - Flu Season Is Upon Us! Begin now to take advantage of each office visit as an opportunity to encourage your patients to get a flu shot. It's still their best defense against combating the flu this season. *(Medicare provides coverage of the flu vaccine without any out-of-*

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pocket costs to the Medicare patient. No deductible or copayment/coinsurance applies.) And don't forget, health care personnel can spread the highly contagious flu virus to patients. **Protect yourself. Don't Get the Flu. Don't Give the Flu. Get Your Flu Shot. Remember** - Influenza vaccine plus its administration are covered Part B benefits. Note that influenza vaccine is NOT a Part D covered drug. For information about Medicare's coverage of the influenza virus vaccine and its administration as well as related educational resources for health care professionals, please go to http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Flu_Products.pdf on the CMS website.

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