CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 1616	Date: OCTOBER 17, 2008
	Change Request 6184

This Transmittal is no longer sensitive and is being re-communicated. The Transmittal Number and the date of Transmittal remain the same. The only change is the word "Draft" is removed from Attachment B and Business Requirements 6184.1. All other information remains the same.

SUBJECT: Implementation of an ASC HCPCS Payment Indicator File

I. SUMMARY OF CHANGES: This document issues instructions to contractors to modify their systems to accept the new ASC HCPCS Payment Indicator File (Attachment A) and ensure that it properly interfaces with the ASCFS, ASC Drug File(s), and all other ASC module programming as appropriate.

NEW / REVISED MATERIAL
EFFECTIVE DATE:*January 1, 2009
IMPLEMENTATION DATE: January 5, 2009

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	14/60/60.3/Applicable ASC Messages for Certain Payment Indicators Effective for Services on or after January 1, 2009

III. FUNDING:
SECTION A: For Fiscal Intermediaries and Carriers:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their operating budgets.

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.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

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

Attachment – Business Requirements

Pub. 100-04	Transmittal: 1616	Date: October 17, 2008	Change Request: 6184

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SUBJECT: Implementation of an ASC HCPCS Payment Indicator File

EFFECTIVE DATE: January 1, 2009

IMPLEMENTATION DATE: January 5, 2009

I. GENERAL INFORMATION

A. Background: As required by section 626 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), CMS implemented a revised ASC payment system January 1, 2008.

In Transmittal 1325 (CR5680), issued August 29, 2007, CMS provided supporting ASC file record layouts of the ASCFS and ASC Drug File to interface with the instructions issued to implement the revised ASC payment system. The ASCFS includes rates for all services that are eligible for payment under the revised ASC payment system except contractor–priced items/services and separately paid drugs and biologicals, and the ASC Drug File provides the rates for all drugs and biologicals that are eligible for separate payment under the revised ASC payment system.

Using defined "payment indicators" (72 FR 67189-67190), CMS identifies each covered service that is eligible for ASC payment and the payment methodology by which the payment amount is calculated. The payment indicators also indicate which services' costs are packaged into the payment for other services and which surgical procedures are excluded from Medicare payment.

For CY 2008, contractors did not have access to the ASC payment indicators for all services and, therefore, were unable to accurately determine the specific reason for nonpayment in all cases.

B. Policy: CMS is providing to contractors a file of the ASC payment indicators that are assigned to each HCPCS code in order to enhance their ability to identify both separately payable and non-separately payable (packaged) services, as well as non-payable services. This information will enable contractors to provide detailed messaging in the processing and disposition of ASC claims for all HCPCS codes submitted by ASCs. The ASC payment indicator file will be updated annually and issued each January with the revised ASCFS. Revisions to the ASC payment indicator file will be reissued quarterly when necessary.

Thus, in addition to the ASCFS and ASC Drug File(s), CMS will provide to contractors a more comprehensive list of HCPCS codes and the payment indicator assigned to each of the codes. Beginning January 1, 2009, contractors shall process ASC claims using the revised ASC HCPCS Payment Indicator file and will provide messaging to ASCs and beneficiaries, in part, based on the "messaging " provided in the business requirements below.

In this Change Request (CR), we are issuing instructions to contractors to modify their systems to accept the new ASC HCPCS Payment Indicator File (Attachment A) and ensure that it properly interfaces with the ASCFS, ASC Drug File(s), and all other ASC module programming as appropriate.

Attachment A (below) is the file layout for the new ASC HCPCS Payment Indicator File and Attachment B (below) is a revised list of the ASC payment indicators and their definitions. The CY 2009 proposed revised definition for payment indicator F4 is included in that list. The CY 2009 definitions will not be made final until publication of the CY 2009 OPPS/ASC final rule. Contractors will be notified electronically to download and replace the ASC HCPCS Payment Indicator File (Attachment B) with the final file in November 2008

II. BUSINESS REQUIREMENTS TABLE

Use "Shall" to denote a mandatory requirement

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	
6184.1	Medicare contractors shall use Attachment B for informational purposes when programming HCPCS messaging indicators.	X			X		X				
6184.1.1	Effective for services performed on or after January 1, 2009, contractors shall identify ASC payment indicators via a file provided by CMS. Filename: MU00.@BF12390.ASC.CY09.IND.V1101 **CMS will provide date of retrieval via a separate e-mail communication.**	X			X		X				
6184.1.2	For programming and testing, Contractors shall download TEST ASC HCPCS payment indicator file Filename: MU00.@BF12390.ASC.CY09.IND.TST0815 **A test file will be available in mid-August and CMS will provide date of retrieval via a separate e-mail communication.**	X			X		X				
6184.2	If ASC payment indicator = **C5, M6, U5, or X5,** in positions 19 and 20, contractors shall deny the service and use the following messages: MSN 16.2 - This service cannot be paid when provided in this location/facility. Claim Adjustment Reason 5 - The procedure code/bill	X			X		X				

Number	Requirement	A / B MAC	D M E MAC	F I	C A R R I E R	R H H I	F I S S	M C S	V M S	C W F	OTHER
	type is inconsistent with place of service. RA Remark N428 - Service/procedure not covered when performed in this place of service.										
6184.3	Contractors shall assign beneficiary liability for facility charges to CPT codes billed with ASC payment indicators of **C5, E5, U5, and X5** in positions 19 and 20.	X			X			X			
6184.4	If ASC payment indicator = **E5 or Y5** in positions 19 and 20, contractors shall deny the service and use the following messages: MSN 16.10 - Medicare does not pay for this item or service. Claim Adjustment Reason Code 96 - Non covered charges. RA Remark Codes - N425 - Statutorily excluded service(s) and M16 - **Alert**: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.	X			X			X			
6184.5	If ASC payment indicator = **D5** in positions 19 and 20, contractors shall return the service as unprocessable and use the following messages: Claim Adjustment Reason Code 181 - Procedure code was invalid on the date of service. RA Remark N56 - Procedure code billed is not correct/valid for the services billed or the date of service billed.	X			X			X			
6184.6	If ASC payment indicator = **L1**, **N1** or **S1** in positions 19 and 20, contractors shall deny the service and use the following messages: MSN 16.32 Medicare does not pay separately for this service. Claim Adjustment Reason Code 97 - The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated.	X			X			X			

Number	Requirement	A / B MAC	D M E MAC	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
	RA Remark N390 - This service cannot be billed separately.										
6184.7	If ASC payment indicator = **B5** in positions 19 and 20, contractors shall return the services as unprocessable and use the following messages: Claim Adjustment Reason Code 125 - Submission/billing error. RA remark code M51 - Missing/incomplete/invalid procedure code and RA remark code M16 - **Alert**: Please see our web site, mailings or bulletins for more details concerning this policy/procedure/decision.	X			X			X			
6184.8	If ASC payment indicator = **A2, F4, G2, H2, H7, H8, J7, J8, K2, K7, L6, P2, P3, R2, Z2 or Z3** in positions 19 and 20, contractors shall continue processing ASC claims using current methodology.	X			X			X			

III.   PROVIDER EDUCATION TABLE

Number	Requirement	A / B MAC	D M E MAC	F I	C A R R I E R	R H H I	Shared-System Maintainers				OTHER
							F I S S	M C S	V M S	C W F	
6184.9	A provider education article related to this instruction will be available at http://www.cms.hhs.gov/MLNMattersArticles/ shortly after the CR is released. You will receive notification of the article release via the established "MLN Matters" listserv. Contractors shall post this article, or a direct link to this article, on their Web site and include information about it in a listserv message within one week of the availability of the provider education article. In addition, the provider education article shall be included in your next regularly scheduled bulletin. Contractors are free to	X			X						

Number	Requirement	Responsibility (place an "X" in each applicable column)									
		A / B M A C	D M E M A C	F I	C A R R I E R	R H H I	FISS	MCS	VMS	CWF	OTHER
							Shared-System Maintainers				
	supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.										

IV. SUPPORTING INFORMATION

Section A: For any recommendations and supporting information associated with listed requirements, use the box below:
Use "Should" to denote a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

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

V. CONTACTS

Pre-Implementation Contact(s): ASC Payment Policy: Chuck Braver at chuck.braver@cms.hhs.gov or 410-786-6719;. Carrier/ AB MAC Claims Processing Issues: Yvette Cousar at yvette.cousar@cms.hhs.gov or 410-786-2160.

Post-Implementation Contact(s): Regional Office

VI. FUNDING

Section A: For *Carriers*:

No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

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.

Attachments A and B

ASC HCPCS Payment Indicator File

Field Name	Positions	Length	
HCPCS	1-5	5	
Filler	6	1	
Modifier 26/TC	7-8	2	
Filler	9	1	
Year	10-17	8	MMDDCCYY
Filler	18	1	
ASC Payment Indicator	19-20	2	(See Attachment B)
Filler	21-50	30	

CY 2009 ASC Ambulatory Surgical Center (ASC) Payment Indicators

ASC_Payment Indicator Definitions

A2:Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.

B5:Alternative code may be available; no payment made.

C5:Inpatient surgical procedure under OPPS; no payment made.

D5:Deleted/discontinued code; no payment made.

E5:Surgical Procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made.

F4: Corneal tissue acquisition, hepatitis B vaccine; paid at reasonable cost

G2: Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.

H2:Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate. NB: This may change due to legislation, prior to release of CR.

H7: Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.

H8:Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate.

J7:OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.

J8:Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate.

K2:Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.

K7:Unclassified drugs and biologicals; payment contractor-priced.

L1:Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made.

L6:New Technology Intraocular Lens (NTIOL); special payment.

M6:No payment made; paid under another fee schedule.

N1:Packaged service/item; no separate payment made.

P2:Office-based surgical procedure added to ASC list in CY 2008 or later with Medicare Physician Fee Schedule (MPFS) nonfacility practice expense (PE) relative value units (RVUs); payment based on OPPS relative payment weight.

P3:Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.

R2:Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.

S1: Service not surgical in nature; and not a radiology service payable under the OPPS, drug/biological, or brachytherapy source. Packaged item/service; no separate payment made.

U5:Surgical unlisted service excluded from ASC payment. No payment made.

X5:Unsafe surgical procedure in ASC. No payment made.

Y5:Non-Surgical Procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made.

Z2:Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.

Z3:Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.

Medicare Claims Processing Manual
Chapter 14 - Ambulatory Surgical Centers

Table of Contents
(Rev. 1616, 10-17-08)

60.3 – Applicable ASC Messages for Certain Payment Indicators Effective for Services Performed on or after January 1, 2009
(Rev. 1616; Issued: 10-17-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

*Contractors shall deny services for HCPCS with payment indicators **C5** (Inpatient surgical procedure under the OPPS; no payment made.), **M6** (No payment made; paid under another fee schedule), **U5** (Surgical unlisted service excluded from ASC payment. No payment made.), or **X5** (Unsafe surgical procedure in ASC. No payment made. Use the following messages:*

- *MSN 16.2 - This service cannot be paid when provided in this location/facility.*

- *RA Remark N428 - Service/procedure not covered when performed in this place of service.*

- *Claim Adjustment Reason Code 5 - The procedure code/bill type is inconsistent with place of service.*

*Contractors shall deny services for CPT codes with payment indicators **E5** (Surgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made.), or **Y5** (Non-surgical procedure/item not valid for Medicare purposes because of coverage, regulation and/or statute; no payment made.) and use the following messages:*

- *MSN 16.10 – Medicare does not pay for this item or service.*

- *Claim Adjustment Reason Code 96 – Non-covered charges.*

- *RA Remark Code - N425 - Statutorily excluded services.*

- *RA Remark Code M16 - **Alert**: Please see our web site, mailings, or bulletins for more details concerning this policy/procedure/decision.*

*NOTE: Contractors shall assign beneficiary liability for facility charges HCPCS codes billed with ASC payment indicators **C5, E5, U5** and **X5**.*

*Contractors return as unprocessable services for HCPCS with payment indicator **D5** (Deleted/discontinued code; no payment made.) and use the following messages:*

- *Claim Adjustment Reason Code 181 - Procedure was invalid on the date of service.*

- *RA Remark N56 - Procedure code billed is not correct/valid for the services billed or the date of service billed.*

*Contractors shall deny services for HCPCS with payment indicators **L1** (Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made.), **NI** (Packaged service/item; no separate payment made.) or **S1** (Service not surgical in nature; and not a radiology service payable under the OPPS, drug/biological, or brachytherapy source. Packaged item/service; no separate payment made.) and use the following messages:*

- *MSN 16.32 - Medicare does not pay separately for this service.*

- *Claim Adjustment Reason Code 97 - The benefit for this service is included in the payment allowance for another service/procedure that has already been adjudicated.*

- *RA Remark - N390 - This service cannot be billed separately.*

*Contractors shall return as unprocessable services for HCPCS with payment indicators **B5** (Alternative code may be available; no payment made.) and use the following messages:*

- *Claim Adjustment Reason Code - 125 - Submission/billing error.*

- *RA Remark - M51 - Missing/incomplete/invalid procedure code(s).*

- *RA Remark – M16 - **Alert**: Please see our web site, mailings or bulletins for more details concerning this policy/procedure/decision.*