CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1572	**Date: AUGUST 8, 2008**
	Change Request 6129

SUBJECT: New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services

I. SUMMARY OF CHANGES: ASCs have been able to bill for certain diagnostic services since January 1, 2008. CMS has determined that beginning January 1, 2009, the ordering/referring physician must be reported on claims for diagnostic services submitted by ASCs. This requirement already exists for other Part B claims containing diagnostic services in accordance with Section 1833(q) of the Social Security Act.

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
R	14/10/2 - Ambulatory Surgical Services on ASC List

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: 1572	Date: August 8, 2008	Change Request: 6129

SUBJECT: New Requirement for Ordering/Referring Information on Ambulatory Surgical Center (ASC) Claims for Diagnostic Services

EFFECTIVE DATE: January 1, 2009

IMPLEMENTATION DATE: January 5, 2009

I. GENERAL INFORMATION

A. Background: Prior to January 1, 2008, ASCs could not be paid for diagnostic radiology services since these services were not included on the list of ASC-approved procedures. Effective for services on or after January 1, 2008 several radiology codes were added to the list of payable ASC procedures. Since ASCs can now bill for these services with the TC modifier, claims from ASCs for these services must be in compliance with Section 1883 (q) of the Act, which requires that physician ordering/referring information be included on all claims for payable services when there had been a referral by a referring physician.

CMS has determined that beginning January 1, 2009, the ordering/referring physician must be reported on claims for diagnostic radiology services by ASCs, as it is for other Part B claims for diagnostic services (modifier TC). The name of the ordering/referring physician name must be present in block 17 and the NPI of the physician must be present in block 17B of the CMS-1500 (or in Data Element Loops 2420E and 2310A of the 837P).

This new change will also be outlined in Publication 100-04, Chapter 14, §10.2 for ASCs.

B. Policy: Section 1833(q) of the Social Security Act requires that all physician and non physician practitioners that meet the §1861(r) and 1842(b)(18)(C) definition must have a NPI for all claims for services ordered or referred by one of these providers include the name and NPI of the ordering/referring provider. Effective January 1, 1992, a physician or supplier that bills Medicare for a service or item must show the name and NPI of the ordering/referring provider on the claim form, if that service or item was the result of an order or referral from another provider. Carrier claims processing guidelines are also outlined in Publication 100-04, Chapter 1, § 80.3.2.1.2(a).

Lastly, if the NPI of the ordering/referring provider cannot be obtained by the biller and it cannot be found on the NPI Registry, the billing provider (in the X12N 837 transactions) or the service provider (in the NCPD 5.1 transactions) may be used in the ordering/referring field on a temporary basis (and until further notice) and this use is subject to postpayment review. For further information, refer to CR 6093 which will be released in final shortly.

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	
6129.1	Effective for services on or after January 1, 2009 for allowed ASC claims, if modifier = TC, Contractors must ensure ordering/referring physician name is present in block 17 and ordering/physician NPI is present in block 17B of the CMS-1500 for paper claims.	X			X						
6129.1.1	Effective for services on or after January 1, 2009 for allowed ASC claims, if modifier = TC, Contractors must ensure ordering physician name and NPI is present in Loop 2420E NM1 (NM101=DK, NM102=1, NM103=*provider’s last name*, NM104=*provider’s first name*, NM108=XX, NM109=*provider’s NPI*)	X			X						
6129.1.2	Effective for services on or after January 1, 2009 for allowed ASC claims, if modifier = TC, Contractors must ensure referring physician name and NPI is present in Loop 2310A/2420F NM1 (NM101=DN, NM102=1, NM103=*provider’s last name*, NM104=*provider’s first name*, NM108=XX, NM109=*provider’s NPI*)	X			X						
6129.2	Contractors shall send the ordering/referring NPI to CWF.	X			X			X			
6129.3	Contractors shall return as unprocessable claims for radiology (modifier TC) services without the ordering/referring physician name and NPI on the claim.	X			X						
6129.3.1	If this information is missing, contractors shall return as unprocessable and use Claim Adjustment Reason Code 16 - Claim/service lacks information which is needed for adjudication.	X			X						
6129.3.2	If this information is missing, contactors shall also use the appropriate remittance advice remark codes: N264 - Missing/incomplete/invalid ordering provider name N265 - Missing/incomplete/invalid ordering provider primary identifier N285 - Missing/incomplete/invalid referring provider name N286 - Missing/incomplete/invalid referring provider primary identifier	X			X						
6129.4	Contractors shall educate ASC facility providers of this new requirement for ASC diagnostic radiology services performed on or after January 1, 2009 via the MLN	X			X						

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	
	Matters Article and by other appropriate means determined by the contractor.										

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	
6129.5	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 supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.	X			X						

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:

V. CONTACTS

Pre-Implementation Contact(s): For Carrier billing issues, contact Yvette Cousar, (410) 786-2160 or yvette.cousar@cms.hhs.gov; for policy issues, contact Chuck Braver at (410) 786-6719 or chuck.braver@cms.hhs.gov

Post-Implementation Contact(s): Appropriate regional office or MAC project officer.

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), Carriers, and Regional Home Health Carriers (RHHIs)* use only one of the following statements:

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)*, use the following statement:

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.

10.2 - Ambulatory Surgical Center Services on ASC List

(Rev. 1572; Issued: 08-08-08; Effective Date: 01-01-09; Implementation Date: 01-05-09)

Covered ASC services are those surgical procedures that are identified by CMS on a listing that is updated at least annually. Some surgical procedures covered by Medicare are not on the ASC list of covered surgical procedures. For surgical procedures not covered in ASCs, the related professional services may be billed by the rendering provider as Part B services and the beneficiary is liable for the facility charges, which are non-covered by Medicare.

Under the ASC payment system, Medicare makes facility payments to ASCs only for the specific ASC covered surgical procedures on the ASC list of covered surgical procedures. In addition, Medicare makes separate payment to ASCs for certain covered ancillary services that are provided integral to a covered ASC surgical procedure. All other non-ASC services, such as physician services and prosthetic devices may be covered and separately billable under other provisions of Medicare Part B. The Medicare definition of covered ASC facility services for a covered surgical procedure includes services that would be covered if furnished on an inpatient or outpatient basis in connection with a covered surgical procedure. This includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use to patients needing surgical procedures. It includes all services and procedures provided in connection with covered surgical procedures furnished by nurses, technical personnel and others involved in patient care. These do not include physician services or medical and other health services for which payment may be made under other Medicare provisions (e.g., services of an independent laboratory located on the same site as the ASC, anesthetist professional services, non-implantable DME).

ASC services for which payment is included in the ASC payment for a covered surgical procedure under 42CFR416.65 include, but are not limited to-

(a) Included facility services:

(1) Nursing, technician, and related services;

(2) Use of the facility where the surgical procedures are performed;

(3) Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver;

(4) Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS);

(5) Medical and surgical supplies not on pass-through status under Subpart G of Part 419 of 42 CFR;

(6) Equipment;

(7) Surgical dressings;

(8) Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status under Subpart G of Part 419 of 42 CFR;

(9) Implanted DME and related accessories and supplies not on pass-through status under Subpart G of Part 419of 42 CFR;

(10) Splints and casts and related devices;

(11) 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 procedure;

(12) Administrative, recordkeeping and housekeeping items and services;

(13) Materials, including supplies and equipment for the administration and monitoring of anesthesia; and

(14) Supervision of the services of an anesthetist by the operating surgeon.

Under the revised ASC payment system, the above items and services fall within the scope of ASC facility services, and payment for them is packaged into the ASC payment for the covered surgical procedure. ASCs must incorporate charges for packaged services into the charges reported for the separately payable services with which they are provided. Because contractors pay the lesser of 80 percent of actual charges or the ASC payment rate for the separately payable procedure, and because this comparison is made at the claim line-item level, facilities may not be paid appropriately if they unbundle charges and report those charges for packaged codes as separate line-item charges.

There is a payment adjustment for insertion of an IOL approved as belonging to a class of NTIOLs, for the 5-year period of time established for that class, as set forth at 42CFR416.200.

Covered ancillary items and services that are integral to a covered surgical procedure, as defined in 42CFR416.61, and for which separate payment to the ASC is allowed include:

(b) Covered ancillary services

(1) Brachytherapy sources;

(2) Certain implantable items that have pass-through status under the OPPS;

(3) Certain items and services that CMS designates as contractor-priced, including, but not limited to, the procurement of corneal tissue;

(4) Certain drugs and biologicals for which separate payment is allowed under the OPPS;

(5) Certain radiology services for which separate payment is allowed under the OPPS.

NOTE: Effective for services on or after January 1, 2009 for allowed ASC claims, if modifier = TC, Contractors must ensure ordering/referring physician name is present in block 17 and ordering/physician NPI is present in block 17B of the CMS-1500 for paper claims.

Effective for dates of service on or after January 1, 2009 for allowed ASC claims, if modifier = TC, Contractors must ensure ordering physician name and NPI is present in Loop 2420E NM1 (NM101=DK, NM102=1, NM103=provider's last name, NM104=provider's first name, NM108=XX, NM109=provider's NPI)

Effective for dates of service on or after January 1, 2009 for allowed ASC claims, if modifier = TC, Contractors must ensure referring physician name and NPI is present in Loop 2310A/2420F NM1 (NM101=DN, NM102=1, NM103=provider's last name, NM104=provider's first name, NM108=XX, NM109=provider's NPI)

If this information is missing, contractors shall return as unprocessable and use Claim Adjustment Reason Code 16 - Claim/service lacks information which is needed for adjudication. Also use the appropriate remittance advice remark codes:

N264 - Missing/incomplete/invalid ordering provider name

N265 - Missing/incomplete/invalid ordering provider primary identifier

N285 - Missing/incomplete/invalid referring provider name

N286 - Missing/incomplete/invalid referring provider primary identifier

Definitions of ASC Facility Services:

Nursing Services, Services of Technical Personnel, and Other Related Services

These include all services in connection with covered procedures furnished by nurses and technical personnel who are employees of the ASC. In addition to the nursing staff, this category includes orderlies, technical personnel, and others involved in patient care.

Use by the Patient of the ASC Facilities

This category includes operating and recovery rooms, patient preparation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with surgical services.

Drugs, Biologicals, Surgical Dressings, Supplies, Splints, Casts, Appliances, and Equipment

This category includes all supplies and equipment commonly furnished by the ASC in connection with surgical procedures. See the following paragraphs for certain exceptions. Drugs and biologicals are limited to those which cannot be self-administered. See the Medicare Benefit Policy Manual, Chapter 15, §50.2, for a description of how to determine whether drugs can be self-administered.

Under Part B, coverage for surgical dressings is limited to primary dressings, i.e., therapeutic and protective coverings applied directly to lesions on the skin or on openings to the skin required as the result of surgical procedures. (Items such as Ace bandages, elastic stockings and support hose, Spence boots and other foot coverings, leotards, knee supports, surgical leggings, gauntlets and pressure garments for the arms and hands are used as secondary coverings and therefore are not covered as surgical dressings.) Although surgical dressings usually are covered as "incident to" a physician's service in a physician's office setting, in the ASC setting, such dressings are included in the facility's services.

However, surgical dressings may be reapplied later by others, including the patient or a member of his family. When surgical dressings are obtained by the patient on a physician's order from a supplier, e.g., a drugstore, the surgical dressing is covered under Part B. The same policy applies in the case of dressings obtained by the patient on a physician's order following surgery in an ASC; the dressings are covered and paid as a Part B service by the DMERC.

Similarly, "other supplies, splints, and casts" include only those furnished by the ASC at the time of the surgery. Additional covered supplies and materials furnished later are generally furnished as "incident to" a physician's service, not as an ASC facility service. The term "supplies" includes those required for both the patient and ASC personnel, e.g., gowns, masks, drapes, hoses, and scalpels, whether disposable or reusable. Payment for these is included in the rate for the surgical procedure.

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

Diagnostic or Therapeutic Items and Services

These are items and services furnished by ASC staff in connection with covered surgical procedures. Many ASCs perform diagnostic tests prior to surgery that are generally included in the facility charges, such as urinalysis, blood hemoglobin, hematocrit levels, etc. To the extent that such simple tests are included in the ASC facility charges, they are considered facility services. However, under the Medicare program, diagnostic tests are not covered in laboratories independent of a physician's office, rural health clinic, or hospital unless the laboratories meet the regulatory requirements for the conditions for coverage of services of independent laboratories. (See *42CFR416.49*) Therefore, diagnostic tests performed by the ASC other than those generally included in the facility's charge are not covered under Part B and are not to be billed as diagnostic tests. If the ASC has its laboratory certified, the laboratory itself may bill for the tests performed.

The ASC may make arrangements with an independent laboratory or other laboratory, such as a hospital laboratory, to perform diagnostic tests it requires prior to surgery. In general, however, the necessary laboratory tests are done outside the ASC prior to scheduling of surgery, since the test results often determine whether the beneficiary should have the surgery done on an outpatient basis in the first place.

Administrative, Recordkeeping and Housekeeping Items and Services

These include the general administrative functions necessary to run the facility e.g., scheduling, cleaning, utilities, and rent.

Blood, Blood Plasma, Platelets, etc., Except Those to Which Blood Deductible Applies

While covered procedures are not expected to result in extensive loss of blood, in some cases, blood or blood products are required. Usually the blood deductible results in no expenses for blood or blood products being included under this provision. However, where there is a need for blood or blood products beyond the deductible, they are considered ASC facility services and no separate charge is permitted to the beneficiary or the program.

Materials for Anesthesia

These include the anesthetic agents that are not paid separately under the OPPS, and any materials, whether disposable or re-usable, necessary for its administration.

Intraocular Lenses (IOLs) and New Technology IOLs (NTIOLs)

The ASC facility services include IOLs (effective for services furnished on or after March 12, 1990), and NTIOLs (effective for services furnished on or after May 18, 2000), approved by the Food and Drug Administration (FDA) for insertion during or subsequent to cataract surgery.

FDA has classified IOLs into the following categories, any of which are included:

1. Anterior chamber angle fixation lenses;

2. Iris fixation lenses;

3. Irido-capsular fixation lenses; and

4. Posterior chamber lenses.

5. NTIOL Category 1 (as defined in "Federal Register" Notice, VOL 65, dated May 3, 2000). Note: This category expired May 18, 2005

6. NTIOL Category 2 (as defined in "Federal Register" Notice, VOL 65, dated May 3, 2000). Note: This category expired May 18, 2005

7. NTIOL Category 3 (as defined in Federal Register Notice, 71 FR 4586, dated January 27, 2006): This category will expire on February 26, 2011.

Note that while generally no separate charges for intraocular lenses (IOLs) are allowed, approved NTIOLS may be billed separately and an adjustment to the facility payment will be made for those lenses that are eligible. (See §40.3.)