CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 1604	**Date: September 26, 2008**
	Change Request 6052

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

I. SUMMARY OF CHANGES: This Change Request implements current policy to require payment to physicians at the facility payment amount for physician services performed in ASCs. This comports with both the policy under the hospital outpatient prospective payment system and the revised ASC payment policy related to the list of covered services.

New / Revised Material
Effective Date: January 1, 2008
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	12/20/4.2/Site of Service Payment Differential
R	12/90/90.3/Physician Services Performed in Ambulatory Surgical Centers (ASC)

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:
One Time Notification
Manual Instruction
**Unless otherwise specified, the effective date is the date of service.*

Attachment – One-Time Notification

Pub. 100-04	Transmittal: 1604	Date: September 26, 2008	Change Request: 6052

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

Effective Date: January 1, 2008

Implementation Date: January 5, 2009

I. GENERAL INFORMATION

A. Background: Prior to January 1, 2008, payment to physicians for furnishing non-covered procedures in ASCs was at the non-facility amount. Beginning January 1, 2008, the policy is revised to require payment to physicians at the facility payment amount to comport with both the policy under the hospital outpatient prospective payment system 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 OPPS. We believe ASCs are facilities that 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. As such, we believe that it would be incongruous with the revised ASC payment system policies to pay the typically higher nonfacility 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, we do not believe it would be appropriate to provide a payment based on the nonfacility rate to physicians who furnish them in the ASC setting.

In addition, the revision to 42 CFR 414.22(b)(5)(i)(A) and (B), effective January 1, 2008, 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, and therefore, we provide no payment to ASCs for these procedures.

We do not expect that these unsafe services will be furnished to Medicare beneficiaries in ASCs. We expect 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 are provided in ASCs.

B. Policy: 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.

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	
6052.1	For dates of service on or after January 1, 2008, contractors shall pay the lower facility fee for ALL claims for physician services when performed in POS = 24 (ASC).	X			X			X			
6052.2	Contractors shall not search and adjust claims already processed unless bought to their attention.	X			X						

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	
6052.3	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: N/A
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: N/A

V. CONTACTS

Pre-Implementation Contact(s): Physician Payment Policy: Rick Ensor at frederick.ensor@cms.hhs.gov or 410-786-5617; 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 410-786-6986.

Post-Implementation Contact(s): Appropriate Regional Office

VI. FUNDING

Section A: For *Fiscal Intermediaries (FIs), 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.

20.4.2 - Site of Service Payment Differential

(Rev.1604, Issued: 09-26-08, Effective: 01-08-08, Implementation: 01-05-09)

Under the physician fee schedule, some procedures have a separate Medicare fee schedule for a physician's professional services when provided in a facility and a nonfacility. The CMS furnishes both fees in the MPFSDB update.

Professional fees, when the services are provided in a facility, are applicable to procedures furnished in the facilities. Site of service payment differentials also apply in an inpatient psychiatric facility and in a comprehensive inpatient rehabilitation facility.

Place of service code (POS) is used to identify where the procedure is furnished. The list of facilities where a physician's professional services are paid at the facility rate include:

- In hospitals (POS code 21-23);
- In skilled nursing facilities (SNF) for a Part A resident (POS code 31);
- In comprehensive inpatient rehabilitation facilities (POS 61);
- In inpatient psychiatric facilities (POS 51);
- In community mental health centers (CMHC) (POS code 53);
- In an approved ambulatory surgical center (ASC) for a HCPCS code included on the ASC approved list of procedures (POS code 24); *and*
- *In a Medicare-approved ASC for a procedure not on the ASC list of approved procedures with dates of service on or after January 1, 2008. (POS code 24)*

Physicians' professional services are paid at nonfacility rates for procedures furnished:

- In SNFs to Part B residents - (POS code 32);
- *In a patient's home (POS code 12); and*
- *In a facility or institution other than a hospital, skilled nursing facility, community mental health center or ASC (POS codes 49 or 99).*

Nonfacility fees are applicable to therapy procedures regardless of whether they are furnished in facility or nonfacility settings.

90.3 - Physicians' Services Performed in Ambulatory Surgical Centers (ASC)

(Rev.1604, Issued: 09-26-08, Effective: 01-08-08, Implementation: 01-05-09)

See Chapter 14, for a description of services that may be billed by an ASC and services separately billed by physicians.

The ASC payment does not include the professional services of the physician. These are billed separately by the physician. Physicians' services include the services of anesthesiologists administering or supervising the administration of anesthesia to ASC patients and the patients' recovery from the anesthesia. The term physicians' services also includes any routine pre- or postoperative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, and other services which the individual physician usually performs.

The physician must enter the place of service code (POS) 24 on the claim to show that the procedure was performed in an ASC.

The carrier pays the facility fee from the MPFSDB to the physician. The facility fee is for services done in a facility other than the physician's office and is *typically* less *than* the nonfacility fee for services performed in the physician's office.