

NCP Title
Ambulatory Surgical Centers (ASCs)

Contractor's Provision Number:
ASC-001

Description:

In order to encourage beneficiaries and physicians to use less costly alternatives to inpatient hospital facilities for surgical procedures which may be safely and effectively performed on an ambulatory basis, Part B of Medicare provides for payment of a facility fee for services furnished by Medicare certified ambulatory surgical centers (ASCs) in connection with designated covered surgical procedures.

HCPCS/CPT Section:

N/A

Definitions:

Ambulatory surgical center or ASC means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, has an agreement with CMS to participate in Medicare as an ASC, and meets the conditions set forth.

An ASC service means facility services that are furnished in an ASC.

Covered surgical procedures means those surgical and other medical procedures that meet the criteria specified 42-CFR §416.65 and are published by CMS in the Federal Register.

Facility services means services that are furnished in connection with covered surgical procedures performed in an ASC, or in a hospital on an outpatient basis.

Indications and Limitations of Coverage:

I. Definition of Ambulatory Surgical Center

- A. *An ASC for purposes of this benefit is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. It enters into an agreement with CMS to do so. An ASC is either:*
 - 1. *Independent (i.e. not a part of a provider of services or any other facility), or*
 - 2. *Operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). If an ASC is the latter type, it has the option either of being covered under Medicare as an ASC, or of continuing to be covered as a hospital-affiliated ASC as such entities were covered prior to the enactment of ASC legislation on December 5, 1998.*
 - 3. *To be covered as an ASC operated by a hospital, a facility:*
 - a. *Elects to do so, and continues to be covered unless CMS determines there is good cause to do otherwise.*
 - b. *Is a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of*

the hospital with costs for ASC treated as non-reimbursable cost center on the hospital's cost report; and

- c. Meets all requirements with regard to health and safety, and agrees to the assignment, coverage and payment rules applied to independent ASCs.*
- 4. To be eligible to enter into an agreement with CMS, a facility must be surveyed and approved as complying with the conditions for coverage for ASCs.*

II. Payment Under Medicare Part B

- A. Payment is made under Part B for facility services furnished by ambulatory surgical centers (ASCs) in connection with certain surgical procedures. To receive coverage and payment of its services under this provision, a facility must be certified as meeting the requirements for an ASC and enter into a written agreement with CMS.*
 - 1. Assignment is mandated for claims for ambulatory surgical center services.*
 - 2. The law ties coverage of ambulatory surgical center (ASC) services under Part B to specified surgical procedures, which are contained in a list, developed and periodically revised. The list governs coverage of facility services furnished by ASCs.*
 - 3. With respect to facility services, payment is made for a procedure performed on a Medicare beneficiary only if it is on the list. (The payment is the ASC facility services amount, subject to wage index adjustment and applicable deductible and coinsurance).*
 - 4. All the general coverage rules regarding the medical necessity of a given procedure for a given patient are applicable to ASC services in the same manner as all other covered services.*
 - 5. The codes are listed in numerical order and the payment group for each procedure is indicated. The group payment amount is lowest for group 1 and highest for group 9.*
 - 6. The instructions in MCM §4630 regarding rebundling of CPT codes apply to coverage of ASC facility services and are incorporated by reference into this section.*

III. Ambulatory Surgical Center Services on ASC List

- A. ASC services are those surgical procedures that are identified by CMS on an annually updated ASC listing. Some medical services covered by Medicare are not on the list. The rendering provider may bill these as Part B services but not as ASC services.*

The ASC payment rate includes only the specific ASC services. All other non-ASC services such as physician services, prosthetic devices, may be covered and separately billable under Medicare Part B. The Medicare definition of covered facility services includes services that would be covered if furnished on an inpatient or out patient 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 patient's needing surgical procedures. It includes all services and procedures in connection with covered procedures furnished by nurses, technical personnel and other involved in patient's 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, prosthetic devices other than intra-ocular lenses (IOLs), anesthesiologists services, DME, etc.).

Carriers are not concerned with whether a given item or service is a covered ASC facility service, unless the ASC makes a separate charge for it. Where a separate charge is made the carrier must determine whether the item or service falls into the categories described in the following section. If the item or service falls into one of those categories, payment is made following the applicable rules for such items and services found elsewhere in this section. If the item or service does not fall into one of these categories described, the claim is denied.

B. *Examples of covered ASC facility services include:*

(It isn't appropriate to bill these services separately to Medicare Part B.)

1. *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.

2. *Use by the Patient of the ASC's 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.

3. *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.

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 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 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. These are included in the rate for the service (HCPCS code).

4. *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 ASCs 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 42 CFR 405.1310.) 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.

5. *Administrative, Recordkeeping and Housekeeping Items and Services*

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

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

While covered procedures are limited to those 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.

7. *Materials for Anesthesia*

These include the anesthetic itself, and any materials, whether disposable or re-usable, necessary for its administration.

8. *Intraocular Lenses (IOLs) and New Technology IOLs (NTIOLs) - 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:

- a. *Anterior chamber angle fixation lenses;*
- b. *Iris fixation lenses;*
- c. *Irido-capsular fixation lenses; and*
- d. *Posterior chamber lenses.*
- e. *NTIOL Category 1 (as defined in "Federal Register" Notice, VOL 65, dated May 3, 2000. **NOTE: This category expired May 18, 2005.***
- f. *NTIOL Category 2 (as defined in "Federal Register" Notice, VOL 65, dated May 3, 2000. **NOTE: This category expired May 18, 2005.***
- g. *NTIOL Category 3 (as defined in Federal Register Notice of Excluded Medicare Benefits (NEMB), 71 FR 4586, dated January 27, 2006): This category will expire on February 26, 2011.*

While the FDA has approved many IOLs and NTIOLS, it may consider some IOLs and NTIOLS to be experimental. Medicare does not cover or pay for experimental items or services. Note that while generally no separate charges for intraocular lenses (IOLs) are allowed, approved NTIOLS may be billed separately in addition to the facility rate. (See number 9)

9. *Payment for Intraocular Lens (IOL)*

Payment for facility services furnished by an ASC for IOL insertion during or subsequent to cataract surgery includes an allowance for the lens. The procedures that include insertion of an IOL are:

- a. *Payment Group 6:CPT-4 Codes 66985 and 66986*
- b. *Payment Group 8:CPT-4 Codes 66982, 66983 and 66984*

Medicare does not pay physicians or suppliers for an IOL furnished to a beneficiary in an ASC after July 1, 1988. Medicare denies separate claims for IOLs furnished to ASC patients beginning March 12, 1990. Also, effective March 12, 1990, procedure codes 66983 and 66984 are treated as single procedures for payment purposes.

Refer to 42 CFR 416.185 for discussion of New Technology Intraocular Lenses (NTIOLs). While the carrier claims processing systems allow no separate charges for conventional intraocular lenses (IOLs), the cost of the IOL is bundled into the ASC facility fee; NTIOLs may be billed separately in addition to the facility fee. Medicare pays an additional \$50 on the following NTIOLs Q1001 (Category 1, Model AMO Array Multifocal lens) and Q1002 (Category 2, Model Elastic Ultraviolet-Absorbing Silicone Posterior Chamber Lens) when billed for dates of service from May 18, 2000 through May 18, 2005. Effective for dates of service on and after May 19, 2005, Medicare will no longer reimburse the additional \$50 and these two codes will be invalid for Medicare.

Effective for dates of service on and after February 27, 2006, through February 26, 2011, Medicare will pay an additional \$50 for NTIOL [Category 3 (Reduced Spherical Aberration); Model Advanced Medical Optics (AMO) Tecnis® IOL, model numbers Z9000, Z9001, and ZA9003]. HCPCS code Q1003 has been created to bill for the additional \$50. Q1003 shall be billed on the same claim as the surgical insertion procedure.

Any subsequent IOLs recognized by CMS as having the same characteristics as the first IOL recognized by CMS for a payment adjustment (those of reduced spherical aberration) will receive the same adjustment for the remainder of the 5-year period established by the first recognized IOL. Contractors and providers will be aware that HCPCS Q1003, along with one of the approved procedures codes (66982, 66983, 66984, 66985, 66986) are to be used on all NTIOL Category 3 claims associated with reduced spherical aberration from February 27, 2006, through February 26, 2011.

Carriers shall return as unprocessable any claims for NTIOLs containing Q1003 alone or with a code other than one of the above listed procedure codes.

Carriers shall deny payment for Q1003 if services are furnished in a facility other than a Medicare-approved ASC.

IV. Services Furnished in ASCs Which Are Not ASC Facility Services

- A. *A single payment is made to an ASC which includes all “facility services” furnished by the ASC in connection with a covered procedure. However, a number of items and services covered under Medicare may be furnished in an ASC which are not considered facility services, and which the ASC payment does not include. These non-ASC services are covered and paid for under the applicable provisions of Part B. In addition, the ASC may be part of a medical complex that includes other entities, such as an independent laboratory, supplier of durable medical equipment, or a physician’s office, which are covered as separate entities under Part B. In general, an item or service provided in a separate part of the complex is not considered an ASC service, except as defined above.*

Examples of payment and billing for items or services that are not ASC facility services

<i>Items not included in the ASC facility rate</i>	<i>Who may receive payment</i>	<i>Submit bills to:</i>
<i>Physicians’ services</i>	<i>Physician</i>	<i>Carrier</i>
<i>The purchase or rental of non-implantable durable medical equipment (DME) to ASC patients for use in their homes.</i>	<i>Supplier – An ASC can be a supplier of DME if it has a supplier number from the National Supplier Clearinghouse</i>	<i>Durable Medicare Equipment Regional Carrier (DMERC)</i>
<i>Implantable DME and accessories</i>	<i>ASC</i>	<i>Carrier</i>
<i>Non-implantable prosthetic devices</i>	<i>Supplier. An ASC can be a supplier of non-implantable prosthetics if it has a supplier number from the National Supplier Clearinghouse</i>	<i>DMERC</i>
<i>Implantable prosthetic devices except intraocular lenses (IOLs and NTIOLs) and accessories</i>	<i>ASC</i>	<i>Carrier</i>
<i>Ambulance services</i>	<i>Certified Ambulance supplier</i>	<i>Carrier</i>
<i>Leg, arm, back and neck braces</i>	<i>Supplier</i>	<i>DMERC</i>
<i>Artificial legs, arms and eyes</i>	<i>Supplier</i>	<i>DMERC</i>
<i>Services furnished by an independent laboratory</i>	<i>Certified lab. ASCs can receive lab certification and a CLIA number.</i>	<i>Carrier</i>
<i>Procedures Not on the ASC list</i>	<i>Physician</i>	<i>Physician bills Carrier for procedure and any implantable prosthetics/DME using the ASC as the place of</i>

		<i>service. See Pub. 100-4, Chapter 12, section 20.4</i>
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**B. Examples of items or services which are not ASC facility services:
(Services which may be billed separately to Medicare Part B)**

1. Physician's Services

This category includes most covered services performed in ASCs which are not considered ASC facility services. Consequently, physicians who perform covered services in ASCs receive separate payment under Part B. 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 post- operative services, such as office visits, consultations, diagnostic tests, removal of stitches, changing of dressings, and other services which the individual physician usually includes in the fee for a given surgical procedure.

2. The Sale, Lease, or Rental of Durable Medical Equipment to ASC Patients for Use in Their Homes. Durable Medical Equipment (DME)

If the ASC furnishes items of DME to patients, 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 DMERC where applicable

If the ASC furnishes items of implantable DME to patients, the ASC bills the local Carrier for the surgical procedure and the implantable device and receives payment from the local Carrier for those items. When the surgical procedure is not on the ASC list, the physician bills the Carrier for both the surgical procedure and the implanted device, coding the ASC as the place of service on the bill (See Pub. 100-4, Chapter 12, section 22.4).

3. Prosthetic Devices

An ASC may bill and receive separate payment for prosthetic devices, other than intraocular lenses (IOLs) that are implanted, inserted, or otherwise applied by surgical procedures on the ASC list of approved procedures. The ASC bills the local Carrier and receives payment according to the DMEPOS fee schedule. However, an intraocular lens (IOL) inserted during or subsequent to cataract surgery in an ASC is included in the facility payment rate.

If the ASC furnishes other non-implantable prosthetic devices to patients, the ASC is treated as a supplier, and all the rules and conditions ordinarily applicable to suppliers are applicable, including obtaining a supplier number and billing the DMERC where applicable

4. *Ambulance Services*

If the ASC furnishes ambulance services, the facility may obtain approval as an ambulance supplier to bill covered ambulance services.

5. *Leg, Arm, Back and Neck Braces*

These items of equipment, like prosthetic devices, are covered under Part B, but are not included in the ASC facility payment amount. If the ASC furnishes these to patients, 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 DMERC where applicable.

6. *Artificial Legs, Arms, and Eyes*

Like prosthetic devices and braces, this equipment is not considered part of an ASC facility service and so is not included in the ASC facility payment rate. If the ASC furnishes these items to patients, 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 DMERC where applicable.

7. *Services of Independent Laboratory*

Only a very limited number and type of diagnostic tests are considered ASC facility services and these are included in the ASC facility payment rate. In most cases, diagnostic tests performed directly by an ASC are not only not considered ASC facility services, but are not covered under Medicare since §1861(s) of the statute limits coverage of diagnostic lab tests in facilities other than physicians' offices, rural health clinics or hospitals to facilities that meet the statutory definition of an independent laboratory. The ASC's laboratory must be CLIA certified and will need to enroll with the carrier as a laboratory. Otherwise, the ASC makes arrangements with a covered laboratory or laboratories for laboratory services, as provided in 42 CFR 416.49. If the ASC has a certified independent laboratory, the laboratory itself bills the carrier.

C. *Corneal Tissue – V2785*

1. *The expenses incurred by an ASC or a physician for processing, preserving and transporting corneal tissue can be reimbursed based on the eye bank's invoice charge plus not more than 10% for the corneal tissue transportation and preservation.*

2. *The charges are payable if billed in conjunction with 65105, 65710, 65730, 65750, 65755 and 67901.*

V. Presbyopia Correcting Intraocular Lens (P-C IOLs) or Astigmatism Correcting Intraocular Lens (A-C IOLs)

New 2006 HCPCS code: V2788:

Effective for dates of service on and after January 1, 2006, physicians, hospitals and ASCs may also bill the non-covered charges related to the presbyopia-correcting function of the IOL (P-C IOL) using HCPCS code V2788. Effective for dates of service on and after January 22, 2007, non-covered charges related to astigmatism-correcting function of the IOL (A-C IOL) can be billed using HCPCS code V2788.

When denying the non-payable charges submitted with V2788, contractors shall use an appropriate Medical Summary Notice (MSN) such as 16.10 (Medicare does not pay for this item or service) and an appropriate claim adjustment reason code such as 96 (non-covered charges) for claims submitted with the non-payable charges.

The new policy is effective for dates of service on and after May 3, 2005. On May 3, 2005, CMS issued CMS Ruling 05-01, which sets forth CMS policy concerning the requirements for determining payment for insertion of a Presbyopia-correcting intraocular lens following removal of a cataract under the Social Security Act (the act).

BENEFIT SUMMARY

<i>Benefit for Which Medicare Makes Payment</i>	<i>Services for Which Medicare Does NOT Pay – No Benefit Category</i>
<i>A conventional intraocular lens (IOL) implanted following cataract surgery.</i>	<i>The presbyopia-correcting functionality of an IOL implanted following cataract surgery. The astigmatism-correcting functionality of an IOL implanted following cataract surgery.</i>
<i>Facility or physician services and supplies required to insert a conventional IOL following cataract surgery.</i>	<i>Facility or physician services and resources required to insert and adjust a P-C IOL or A-C IOL following cataract surgery that exceed the services and resources furnished for insertion of a conventional IOL.</i>
<i>One pair of eyeglasses or contact lenses as a prosthetic device furnished after each cataract surgery with insertion of an IOL.</i>	<i>The accommodative change in eyeglass or contact lens power required to compensate for the gradual loss of near vision as presbyopia progresses. The surgical correction of cylindrical lenses of eyeglasses or contact lenses that may be required to compensate for imperfect curvature of the cornea (astigmatism).</i>
	<i>Eye examinations performed to determine the refractive state of the eyes specifically associated with insertion of a P-C IOL or A-C IOL (including subsequent monitoring services) that exceed the one-time eye examination following cataract surgery with insertion of a conventional IOL.</i>

A “presbyopia-correcting IOL” is indicated for primary implantation in the capsular bag of the eye for the visual correction of aphakia (absence of the lens of the eye) following removal of a cataract that is intended to provide near, intermediate and distance vision without the need for eyeglasses or contact lenses. Effective for services furnished on or after May 3, 2005, CMS now recognizes the following as presbyopia-correcting IOLs:

Crystalens™, manufactured by Eyeonics, Inc.

AcrySol RESTOR™, manufactured by Alcon Laboratories, Inc.

ReZoom™, manufactured by Advanced Medical Optics, Inc.

Per CMS-1536-Ruling, effective for services on and after January 22, 2007, Medicare will allow beneficiaries to pay additional charges (which are non-covered by Medicare as these additional charges are not part of a Medicare benefit category) for insertion of an A-C IOL.

- Regular astigmatism is a visual condition where part of an image is blurred due to uneven corneal curvature. A normal cornea has the same curvature at all axes, whereas the curvature of an astigmatic cornea differs in two primary axes, resulting in vision that is distorted at all distances.*
- The A-C IOL is intended to provide what is otherwise achieved by two separate items; an implantable conventional IOL (one that is not astigmatism-correcting) that is covered by Medicare, and the surgical correction, eyeglasses or contact lenses that are not covered by Medicare.*

Effective for services furnished on or after January 22, 2007, CMS now recognizes the following as A-C IOLs:

- Acrysof® Toric IOL (models: SN60T3, SN60T4, and SN60T5), manufactured by Alcon Laboratories, Inc.*
- Silicon® IP Toric IOL (models: AA4203TF and AA4203TL), manufactured by STAAR Surgical.*

A. Payment Policy for Physician Services and Supplies

- 1. For an IOL inserted following removal of a cataract in a hospital, on either an outpatient or inpatient bases, that is paid under the hospital Outpatient Prospective Payment System (OPPS) or the Inpatient Prospective Payment System (IPPS), respectively; or in a Medicare-approved ambulatory surgical center (ASC) that is paid under the ASC fee schedule:
 - a. Medicare does not make separate payment to the hospital or the ASC for an IOL inserted subsequent to extraction of a cataract. Payment for the IOL is packaged into the payment for the surgical cataract extraction/lens replacement procedure.*
 - b. Any person or ASC, who presents or causes to be presented a bill or request for payment for an IOL inserted during or subsequent to cataract surgery for which payment is made under the ASC fee schedule, is subject to a civil money penalty.**
- 2. For a P-C IOL or A-C IOL inserted subsequent to removal of a cataract in a hospital, on either an outpatient or inpatient bases, that is paid*

under the OPPS or IPPS, respectively: or in a Medicare-approved ASC that is paid under the ASC fee schedule:

- a. The facility shall bill for removal of a cataract with insertion of a conventional IOL, regardless of whether a conventional, P-C IOL, or A-C IOL is inserted. When a beneficiary receives a P-C IOL or A-C IOL following removal of a cataract, hospitals and ASCs shall report the same CPT code that is used to report removal of a cataract with insertion of a conventional IOL.*
- b. There is no Medicare benefit category that allows payment of facility charges for services and supplies required to insert and adjust a P-C IOL or A-C IOL following removal of a cataract that exceed the facility charges for services and supplies required for the insertion and adjustment of a conventional IOL.*
- c. There is no Medicare benefit category that allows payment of facility charges for subsequent treatments, services and supplies required to examine and monitor the beneficiary who receives a P-C IOL or A-C IOL following removal of a cataract that exceed the facility charges for subsequent treatments, services and supplies required to examine and monitor a beneficiary after cataract surgery followed by insertion of a conventional IOL.*

B. Payment Policy for Physician Services and Supplies

- 1. For an IOL inserted following removal of a cataract in a physician's office:*

Medicare makes separate payment, based on reasonable charges, for an IOL inserted subsequent to extraction of a cataract that is performed at a physician's office.

- 2. For a P-C IOL or A-C IOL inserted following removal of a cataract in a physician's office:*
 - a. A physician shall bill for a conventional IOL, regardless of whether a conventional, or P-C IOL, or A-C IOL is inserted.*
 - b. There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust a P-C IOL or A-C IOL following removal of a cataract that exceed the physician charges for services and supplies for the insertion and adjustment of a conventional IOL.*
 - c. There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services and supplies required to examine and monitor a beneficiary following removal of a cataract with insertion of a P-C IOL or A-C IOL that exceed the physician charges for services and supplies to examine and monitor a beneficiary following removal of a cataract with insertion of a conventional IOL.*

3. *Physicians inserting an IOL, or P-C IOL or, A-C IOL in an office setting may bill code V2632 (posterior chamber intraocular lens) for the IOL or the P-C IOL, or A-C IOL, which is paid on a reasonable charge basis.*
4. *For a P-C IOL or A-C IOL inserted following removal of a cataract in a hospital or ASC:*
 - a. *A physician may not bill Medicare for a P-C IOL or A-C IOL inserted during a cataract procedure performed in those settings because payment for the lens is included in the payment made to the facility for the entire procedure.*
 - b. *There is no Medicare benefit category that allows payment of physician charges for services and supplies required to insert and adjust a P-C IOL or A-C IOL following removal of a cataract that exceed physician charges for services and supplies required for the insertion of a conventional IOL.*
 - c. *There is no Medicare benefit category that allows payment of physician charges for subsequent treatments, services and supplies required to examine and monitor a beneficiary following cataract surgery with insertion of a conventional IOL.*

VI. Payment for Multiple and Bilateral Procedures

- A. *General – Multiple surgeries are separate procedures performed by a physician on the same patient at the same operative session or on the same day for which separate payment may be allowed.*
 1. *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.*
 2. *When multiple ASC covered procedures are performed in the same operative session, base payment for ASC facility services on the full wage adjusted rate of the procedure classified in the highest payment group and on 50 percent of the applicable wage adjusted rate for any other ASC covered procedure(s) furnished in the same session.*
 3. *If more than one procedure in the same payment group is performed, pay the full wage adjusted rate for one of the procedures and 50 percent of the wage adjusted rate for the remaining procedure(s).*
 4. *Final payment is subject to the usual co-payment and deductible provisions.*
- B. *General – Bilateral surgeries are procedures performed on both sides of the body during the same operative session or on the same day.*
 1. *A procedure performed bilaterally in one operative session is reported as two procedures.*

2. *Treat payment for a procedure performed bilaterally the same as payment for multiple procedures*
3. *Calculate payment for bilateral procedures by multiplying the appropriate wage adjusted payment by 150%.*

VII. Terminated Procedures

- A. *The following criteria determine the appropriate ASC facility payment for a scheduled surgical procedure that is terminated due to medical complications which increase the surgical risk to the patient.*
 1. *Payment will be denied when an ASC submits a claim for a procedure that is terminated either for non-medical or medical reasons before the ASC has expended substantial resources.*
 2. *Payment will be 50 percent of the rate if a surgical procedure is terminated due to the onset of medical complications after the patient has been prepared for surgery and taken to the operating room but before anesthesia has been induced.*
 - a. *For example, payment will be 50 percent if the patient develops an allergic reaction to a drug administered by the ASC prior to surgery or if, upon injection of a retrobulbar block, the patient experiences a retrobulbar hemorrhage which prevents continuation of the procedure.*
 3. *Full payment of the facility rate will be made if a medical complication arises which causes the procedure to be terminated after inducement of the anesthetic agent.*
 - a. *For example, make full payment if, after anesthesia has been accomplished and the surgeon has made a preliminary incision, the patient's blood pressure increases suddenly and the surgery is terminated to avoid increasing surgical risk to the patient.*
 4. *An ASC claim for payment for terminated surgery must be accompanied by an operative report that specifies the following.*
 - a. *Reason for terminated surgery;*
 - b. *Services actually performed;*
 - c. *Supplies actually provided;*
 - d. *Services not performed that would have been performed if surgery had not been terminated;*
 - e. *Supplies not provided that would have been provided if surgery had not been terminated;*
 - f. *Time actually spent in each stage, e.g., pre-operative, operative, and post-operative;*
 - g. *Time that would have been spent in each of these stages if the surgery had not been terminated; and*
 - h. *CPT-4 code for procedure had the surgery been performed.*

Covered Diagnosis Codes, ICD-9:

N/A

Coding Guidelines:

- A. When billing for an Ambulatory Service Center (ASC) facility service:
 - 1. All ASC claims must be submitted as assigned.
 - 2. Report the patient's diagnosis or condition with an ICD-9 code. The ICD-9 code should be coded to the highest level of specificity, listing the primary condition in the first position in Item 21 on the CMS-1500 claim form or the electronic equivalent.
 - 3. List the place of service as 24.
 - 4. Report the appropriate CPT/HCPCS code for the procedure(s) performed.
 - 5. Use the appropriate modifier. Modifiers direct prompt and correct payment of the claims submitted. Documentation modifiers must be billed in the first modifier field.
 - 6. The modifier SG must be on the claim.
 - 7. List the specialty 49 provider number in Item 33.
- B. Services covered separately.
 - 1. Physician services must be billed by the performing physician under his/her provider number.
 - 2. Refer to Durable Medical Equipment Regional Carriers (DMERC) for services billable to them.
 - 3. Ambulance services must meet medical necessity and must be billed with the ambulance supplier number.
 - 4. An independent laboratory can bill laboratory services. Pathology technical services (obtaining the specimen) are considered part of the ASC facility fee. The professional component of the pathology service is billed under the performing physician number or under the referring laboratory provider number. When the ASC is certified as an independent laboratory, this does not apply.
 - 5. New Technology Intraocular Lenses (NTIOLs).
Effective for dates of service on and after May 19, 2005, Medicare will no longer reimburse the additional \$50 and these two codes (Q1001, Q1002) will be invalid for Medicare.
 - a. NTIOL claims must be billed using two (2) line times on form CMS-1500.
 - b. One line item must be for one of the following procedures: 66983, 66984, 66985, 66986, whichever appropriately describes the surgical insertion procedure that was performed.
 - c. In addition, a second line must show whichever Medicare approved NTIOL was furnished, either Q1001 or Q1002.
 - d. Q1003, NTIOL Category 3 claims associated with reduced spherical aberration is valid from February 27, 2006 through February 26, 2011. Q1003 must be billed on the same claim with 66982, 66983, 66984, 66985 or 66986. Carriers shall only pay for Q1003 when furnished in a Medicare-approved ASC.
 - 6. Corneal Tissue - V2785 - Processing, preserving and transporting corneal tissue.
 - a. Attach a copy of the invoice to the CMS-1500 form. If the invoice is not attached, Medicare will deny assigned claims.

- b. If submitting electronically, the invoice charge (excluding any expense for the preserving and transporting) should be entered in the narrative record in the fields indicated below.

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- C. Terminated procedures. Due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure. Do not submit a claim for the elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient.

- 1. Use modifier 73 to indicate a discontinued procedure, prior to the administration of anesthesia, in an Ambulatory Surgical Center.
- 2. Use modifier 74 to indicate a discontinued procedure, after administration of anesthesia, in an Ambulatory Surgical Center. The claim must be accompanied by:
 - a. Operative report;
 - b. Reason for terminated surgery;
 - c. Services actually performed;
 - d. Supplies actually provided;
 - e. Services not performed that would have been performed if surgery had not been terminated;
 - f. Supplies not provided that would have been provided if surgery had not been terminated;
 - g. Time actually spent in each stage, e.g., pre-operative, operative, and post-operative;
 - h. Time that would have been spent in each of these stages if the surgery had not been terminated; and
 - i. CPT-4 code for procedure had the surgery been performed.

Documentation:

Records must be made available to the Carrier upon request. The patient's medical record should be legible, contain the relevant medical history and physician findings conforming to the medical criteria stated above.

Reasons for Denial:

Claim submission without appropriate diagnosis and not meeting all criteria listed in "Indications and Limitations of Coverage" section above.

Sources of Information:

Final Rule as published in the Federal Register on May 3, 2002. 42 CFR §416.2, PM-B-99-18/00-29. MCM 2265, 2265.1, MCM 2266, 2266.1, 2266.2, 2266.3, MCM 3040.4, MCM 4826, MCM 4827, MCM 5243. 5243.4, 5243.5, CRIL 56-87. CMS IOM Pub. 100-4, Chapter 14: 10.2, 10.3, 10.4, CP-REV-636, CP-REV-639. Change Request 4184, December 30, 2005, IOM Pub 100-4, Chapter 32, Section 120. Change Request 4361 (Q1003), April 21, 2006. Change Request 5026 (Services furnished in ASC that are not ASC facility services), May 5, 2006. Change Request 5026, Transmittal 975, June 9, 2006. Change Request 5527, Transmittal 1228, April 27, 2007.

History:

Former Wisconsin policy - GSURG-022. Archived policy may be requested from Freedom of Information (FOI).

DATES

Wisconsin

Effective Date: 11/01/2002, 05/03/2005, 01/01/2006, 02/27/06, 06/05/2006.
08/01/2006, 05/29/2007, *01/01/2008

Date Published: 11/01/2002, Article 10/01/2005, Article 02/01/2006, Article
06/01/2006, Article 08/01/2006, Article 06/01/2007, *Article
01/01/2008

Revision Date & #: *01/01/2008, NCP retired - Providers referred to CMS IOM
Publication 100-02, Chapter 15, Section 260 and 100-04, Chapter 14;
06/01/2007, five, Pub. 100-04, Chapter 32, 08/01/2006, four (Pub.
100-04, Chapter 12, Section 22.4 should be Section 20.4. 06/01/2006,
three (New HCPCS code Q1003), (Services furnished in ASC that are
not ASC facility services). 02/01/2006, two (New HCPCS code:
V2788). 10/01/2005, one, (Revised §III, §IV; New §V; Old V now
VI, Old VI now VII, Coding§C5 updated)

Illinois

Effective Date: 11/01/2002, 05/03/2005, 01/01/2006, 02/27/06, 06/05/2006.
08/01/2006, 05/29/2007, *01/01/2008

Date Published: 11/01/2002, Article 10/01/2005, Article 02/01/2006, Article
06/01/2006, Article 08/01/2006, Article 06/01/2007, *Article
01/01/2008

Revision Date & #: *01/01/2008, NCP retired - Providers referred to CMS IOM
Publication 100-02, Chapter 15, Section 260 and 100-04, Chapter 14;
06/01/2007, five - NCP retired, Pub. 100-04, Chapter 32, Section 120.
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VI, Old VI now VII, Coding§C5 updated)

Michigan

Effective Date: 11/01/2002, 05/03/2005, 01/01/2006, 02/27/06, 06/05/2006.
08/01/2006, 05/29/2007, *01/01/2008

Date Published: 11/01/2002, Article 10/01/2005, Article 02/01/2006, Article
06/01/2006, Article 08/01/2006, Article 06/01/2007, *Article
01/01/2008

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ASC that are not ASC facility services). 02/01/2006, two (New
HCPCS code: V2788). 10/01/2005, one, (Revised §III, §IV; New §V;
Old V now VI, Old VI now VII, Coding§C5 updated)

Minnesota

Effective Date: 11/01/2002, 05/03/2005, 01/01/2006, 02/27/06, 06/05/2006.

08/01/2006, 05/29/2007, *01/01/2008
Date Published: 11/01/2002, Article 10/01/2005, Article 02/01/2006, Article
06/01/2006, Article 08/01/2006, Article 06/01/2007, *Article
01/01/2008
Revision Date & #: *01/01/2008, NCP retired - Providers referred to CMS IOM
Publication 100-02, Chapter 15, Section 260 and 100-04, Chapter 14;
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06/01/2006, three (New HCPCS code Q1003), (Services furnished in
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HCPCS code: V2788). 10/01/2005, one, (Revised §III, §IV; New §V;
Old V now VI, Old VI now VII, Coding§C5 updated)

Comments:

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