

# PART B



# Ambulatory Surgery Center Billing Guide June 2009

J14 A/B MIAC

**NHIC, Corp.**

# Ambulatory Surgery Center Billing Guide

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### INTRODUCTION

The Provider Outreach and Education Team at NHIC, Corp. developed this guide to provide you with Medicare Part B Ambulatory Surgery Center billing information. It is intended to serve as a useful supplement to other manuals published by NHIC, and not as a replacement. The information provided in no way represents a guarantee of payment. Benefits for all claims will be based on the patient's eligibility, provisions of the Law, and regulations and instructions from the Centers for Medicare & Medicaid Services (CMS). It is the responsibility of each provider or practitioner submitting claims to become familiar with Medicare coverage and requirements. All information is subject to change as federal regulations and Medicare Part B policy guidelines, mandated by the Centers for Medicare & Medicaid Services (CMS), are revised or implemented.

This information guide, in conjunction with the NHIC website ([www.medicarenhic.com](http://www.medicarenhic.com)), J14 A/B MAC Resource (monthly provider newsletter), and special program mailings, provide qualified reference resources. We advise you to check our website for updates to this guide. To receive program updates, you may join our mailing list by clicking on "Join Our Mailing List" on our website. Most of the information in this guide is based on Publication 100-2, Chapter 15, Publication 100-4, Chapter 12, 14, and 32 of the CMS Internet Only Manual (IOM). The CMS IOM provides detailed regulations and coverage guidelines of the Medicare program. To access the manual, visit the CMS website at <http://www.cms.hhs.gov/manuals/>

If you have questions or comments regarding this material, please call the appropriate NHIC Customer Service Center for your state. The telephone numbers are listed at the end of this guide.

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### GENERAL INFORMATION

**Ambulatory Surgical Centers (ASCs)** specialize in providing [surgery](#), pain management, and certain diagnostic (e.g., colonoscopy) services in an [outpatient](#) setting. Overall, the services provided can be generally called **procedures**. In simple terms ASC qualified procedures can be considered procedures that are more intensive than that done in the average doctors office but not so intensive as to require a hospital stay. The general coverage rules regarding the medical necessity of a particular procedure for a particular patient are applicable to ASC services in the same manner as all other covered services. To be paid under this provision, a facility must be certified as meeting the requirements for an ASC and must enter into a written agreement with the Centers for Medicare & Medicaid Services (CMS).

The list of covered procedures merely indicates procedures which are covered and paid for if performed in the ASC setting. It does not require such procedures to be performed in such settings. The choice of a location to operate is a professional judgment of the patient's physician based on the beneficiary's individual clinical needs and preferences.

#### Prior to January 1, 2008

Payment is made under Part B for certain surgical procedures that are furnished in an ASC and are approved for being furnished in an ASC. These procedures are those that generally do not exceed 90 minutes in length and do not require more than four hours recovery or convalescent time. Medicare will not pay an ASC for those procedures that require more than an ASC level of care, or for minor procedures that are normally performed in a physician's office.

Coverage of ASC services is only applicable to specified surgical procedures, which are contained in a list revised and published periodically by CMS. If a procedure is not on the list, no ASC facility payment is allowed. The surgical procedure list includes applicable codes, payment groups, and payment amounts for each ASC group before adjustments for regional wage variations. Medicare pays ASCs for new technology intraocular lenses.

#### Effective January 1, 2008

Payment is made to ASCs under Part B for all surgical procedures except those that CMS determines may pose a significant safety risk to Medicare patients or that are expected to require an overnight stay when furnished in an ASC.

Payment is made to ASCs for certain ancillary services such as certain drugs and biologicals, pass through devices, brachytherapy sources, and certain radiology procedures. Medicare does not pay an ASC for procedures that are excluded from the list of covered surgical procedures or covered ancillary services. Medicare pays ASCs for new technology intraocular lenses and corneal tissue acquisition. To be covered ancillary services for which separate payment is made, these items and services must be provided integral to covered surgical procedures, that is, immediately before, during, or immediately after the covered surgical procedure.

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Section 626 of the Medicare Prescription Drug Improvement, and Modernization Act of 2006 (MMA) requires the implementation of a new Ambulatory Surgical Center payment system. In part, this section requires that the ASCs be paid the lesser of the actual charge or ASC fee schedule payment rates. Under the revised ASC payment system, CMS will publish quarterly updates to the lists of covered surgical procedures and covered ancillary services to establish payment indicators and payment rates for newly created HCPCS and CPT codes. The complete list of covered procedures and covered ancillary services, applicable payment indicators, and payment rules for each covered surgical procedure and covered ancillary service can be found on the CMS Web sites:

[www.cms.hhs.gov/ascpayment/](http://www.cms.hhs.gov/ascpayment/)

Contractor specific fees are available on the NHIC website at:

[http://www.medicarenhic.com/ne\\_prov/fee\\_sched\\_asc.shtml](http://www.medicarenhic.com/ne_prov/fee_sched_asc.shtml)

### DEFINITION OF AN ASC

An ASC for Medicare purposes is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. The ASC must enter into a participating provider agreement with CMS. An ASC is either independent (i.e., not a part of a provider of services or any other facility), or 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 continuing to be covered as a hospital-affiliated outpatient surgery department. To be covered as an ASC operated by a hospital, a facility:

- Elects to do so, and continues to be so covered unless CMS determines there is good cause to do otherwise;
- Is a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital, with costs for the ASC treated as a non-reimbursable cost center on the hospital's cost report;
- Meets all the requirements with regard to health and safety, and agrees to the assignment, coverage and payment rules applied to independent ASCs; and
- Is surveyed and approved as complying with the conditions for coverage for ASCs.

If a facility meets the above requirements, it bills NHIC on Form CMS-1500 or the related electronic equivalent and is paid the ASC payment amount.

If a hospital based facility decides not to become a certified ASC it bills the fiscal intermediary (FI) on Form CMS-1450 or the related EDI equivalent and is subject to hospital outpatient billing and payment rules. It is also subject to hospital outpatient certification and participation requirements.

### Certification

Any hospital, clinic, physician or physician group wishing to participate and establish a Medicare approved ASC should contact:

**Maine:**

Division of Licensing and  
Regulatory Services  
41 Anthony Avenue  
11 State House Station  
Augusta, ME 04333

Phone Number: 1-207-287-9300

Web site: <http://www.maine.gov>

**Massachusetts:**

Division of Health Care Quality, DPH  
99 Chauncy Street, 2<sup>nd</sup> Floor  
Boston, MA 02111

Phone Number: 1-617-753-8100

Web site: <http://www.mass.gov>

**New Hampshire:**

Health Facilities Administration, DPH  
129 Pleasant Street  
Concord, NH 03301

Phone Number: 1-603-271-4967

Web site: <http://www.state.nh.us>

**Vermont:**

Division of Licensing & Protection  
103 South Main Street  
Waterbury, VT 05671-2306

Phone Number: 1-802-241-2345

Web site: <http://vermont.gov>

**Rhode Island:**

Office of Facilities Regulation  
RI Department of Health  
3 Capital Hill  
Providence, RI 02908-5097

Phone Number: 1-401-222-3999

Web Site: <http://www.health.ri.gov/>

### ASC SERVICES INCLUDED ON ASC LIST

The ASC payment rate includes only the specifically identified ASC services, included on the ASC payment list. All other non-ASC services such as physician services, prosthetic devices, etc. may be covered and separately billable under Medicare Part B. The Medicare definition of covered 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 patient's 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'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), anesthetist's professional services, and non-implantable durable medical equipment (DME).

ASC services for which payment is included in the ASC payment for a covered surgical procedure include, but are not limited to the following.

#### Included facility services:

- Nursing, technician, and related services;
- Use of the facility where the surgical procedures are performed;
- Any laboratory testing performed under a CLIA certificate of waiver;
- Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS); *(effective January 1, 2008)*
- Medical and surgical supplies not on pass-through status; *(effective January 1, 2008)*
- Equipment;
- Surgical dressings;
- Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status; *(effective January 1, 2008)*
- Implanted DME and related accessories and supplies not on pass-through status; *(effective January 1, 2008)*
- Splints and casts and related devices;
- 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; *(effective January 1, 2008)*
- Administrative, recordkeeping and housekeeping items and services;
- Materials, including supplies and equipment for the administration and monitoring of anesthesia; and
- Supervision of the services of an anesthetist by the operating surgeon.

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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.

### Effective January 1, 2008:

Covered ancillary items and services that are integral to a covered surgical procedure, and for which separate payment to the ASC is allowed are identified below.

### Covered ancillary services:

- Brachytherapy sources;
- Certain implantable items that have pass-through status under the OPPS;
- Certain items and services that CMS designates as contractor-priced, including, but not limited to, the procurement of corneal tissue;
- Certain drugs and biologicals for which separate payment is allowed under the OPPS;
- Certain radiology services for which separate payment is allowed under the OPPS.

### Definitions of covered ASC facility services include:

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

- **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's 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. 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.

- **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 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 and paid by the Durable Medical Equipment Medicare Administrative Contractor (DME MAC).

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. These are included in the rate for the surgical procedure.

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Effective January 1, 2008, the ASC Facility Payment for drugs and biologicals includes those drugs and biologicals that are not usually self administered and that are considered to be packaged into the payment for a surgical procedure under the OPPS. Also, Medicare makes separate payment for ASC drugs and biologicals that are furnished integral to an ASC covered surgical procedure and are separately payable under the OPPS.

- **Intraocular Lenses (IOLs) and New Technology Intraocular Lenses (NTIOLs)**  
ASC facility services include IOLs and NTIOLs 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:
  - Anterior chamber angle fixation lenses;
  - Iris fixation lenses;
  - Irido-capsular fixation lenses; and
  - Posterior chamber lenses.
  - Presbyopia-Correcting (P-C-IOL) (effective May 3, 2005)
  - Astigmatism-Correcting (A-C IOL) (effective January 22, 2007)
  - NTIOL Category 3 (expires February 26, 2011)

No separate payment for intraocular lenses (IOLs) is allowed, however, NTIOLS may be billed separately and an adjustment to the facility payment will be made for those lenses that are eligible.

- **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'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.

### **SERVICES FURNISHED IN AN ASC WHICH ARE NOT ASC FACILITY SERVICES**

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. Following is a chart as to who may receive payment and where to submit the bill.

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Examples of payment and billing for items or services that are **not** ASC facility services for claims with dates of service *prior to January 1, 2008*.

Items NOT Included in the ASC Facility Rate	Who May Receive Payment	Submit Bills To:
Physicians' services	Physician	A/B MAC
The purchase or rental of <b>non-implantable</b> durable medical equipment (DME) to ASC patients for use in their homes	Supplier  <b>NOTE:</b> An ASC can be a supplier of DME if it has a supplier number from the National Supplier Clearinghouse	DME MAC
<b>Implantable</b> DME and accessories	ASC	A/B MAC
<b>Non-implantable</b> prosthetic devices	Supplier	DME MAC
<b>Implantable</b> prosthetic devices except certain intraocular lenses (IOLs and NTIOLs), and accessories	ASC	A/B MAC
Ambulance services	Certified Ambulance supplier	A/B MAC
Leg, arm, back, and neck braces	Supplier	DME MAC
Artificial legs, arms, and eyes	Supplier	DME MAC
Services furnished by an independent laboratory	Certified lab. ASCs can receive lab certification and a <u>CLIA</u> number.	A/B MAC
Procedures NOT on the ASC list	Physician	Physician bills A/B MAC for procedure and any <b>implantable</b> prosthetics/DME. ASC bills beneficiary for facility charges associated with the non-covered procedure

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Examples of payment and billing for items or services that **are** ASC facility services for claims with dates of service *effective January 1, 2008*.

Items Included in the ASC Facility	Who may receive payment	Submit bills to:
Implantable DME and accessories without OPPS pass-through status	ASC	A/B MAC
Implantable nonpass-through prosthetic devices (except NTIOLs) and accessories without OPPS pass-through status	ASC	A/B MAC
Radiology services for which there is no separate OPPS payment	ASC	A/B MAC
Drugs and biologicals for which there is no separate OPPS payment	ASC	A/B MAC

### COVERAGE OF SERVICES IN AN ASC WHICH ARE NOT ASC FACILITY SERVICES

- **Ambulance Services**  
If the ASC furnishes ambulance services, the facility may obtain approval as an ambulance supplier to bill covered ambulance services.
- **Artificial Legs, Arms and Eyes**  
Like non-implantable 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 suppliers are applicable, including obtaining a supplier number and billing the DME MAC where applicable.
- **Durable Medical Equipment (DME) (Implantable)**  
If the ASC furnishes items of implantable DME to patients, the ASC bills and receives a single payment from NHIC for the covered surgical procedure and the implantable device, as long as the implantable device does not have pass-through status under the OPPS. When the surgical procedure is not on the ASC list, the physician bills for his or her professional services and the ASC may bill the beneficiary for the facility charges associated with the procedure.
- **Durable Medical Equipment (DME) (Non-implantable)**  
If the ASC furnishes items of non-implantable DME to patients, the ASC is treated as a DME supplier and all rules and conditions ordinarily applicable to DME are applicable. This includes obtaining a supplier number and billing the DME MAC where applicable.

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- **Leg, Arm, Back and Neck Braces**

These items of equipment, like non-implantable 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 suppliers are applicable, including obtaining a supplier number and billing the DME MAC where applicable.

- **Physicians' 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.

- **Prosthetic Devices**

Prior to January 1, 2008, an ASC was allowed to bill and receive separate payment for implantable prosthetic devices, other than intraocular lenses (IOLs) that were implanted, inserted, or otherwise applied by surgical procedures on the ASC list of approved procedures. The ASC billed NHIC and received payment according to the DMEPOS fee schedule. However, an intraocular lens (IOL) inserted during or subsequent to cataract surgery in an ASC was included in the facility payment rate.

Beginning January 1, 2008, payment for implantable prosthetic devices without OPPS pass-through status is included in the ASC payment for the covered surgical procedure. ASCs may not bill separately for implantable devices without OPPS pass-through status. If the ASC furnishes **non-implantable** prosthetic devices to beneficiaries, 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 as directed by the jurisdiction list.

- **Services of an 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 considered ASC facility services, and 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 NHIC as a laboratory. Otherwise, the ASC makes arrangements with a covered laboratory or laboratories for laboratory services. If the ASC has a certified independent laboratory, the laboratory itself bills NHIC.

# CODING AND REIMBURSEMENT

## Facility and Physician Allowance

Generally, there are two primary elements in the total cost of performing a surgical procedure:

- Cost of the physician's professional services for performing the procedure; and
- Cost of services furnished by the facility where the procedure is performed (for example, surgical supplies, equipment, and nursing services).

The professional fee is paid to the physician; the facility fee is paid to the ASC. Physician coding and ASC coding of the procedures performed should match.

## Facility Services

### Prior to January 1, 2008:

The ASC payment rate is a standard overhead amount based on CMS's estimate of a fair fee and the costs incurred by the ASCs providing the procedure. The HCPCS procedures for services covered by the ASC are grouped into pricer groups and a rate is set for each group. The ASC payment rates for each ASC covered procedure is based on the payment rates for the pricer groups, but capped at the hospital outpatient prospective payment system (OPPS) payment rate for the procedure. The Metropolitan Statistical Areas (MSAs) are used as the basis for ASC wage adjustments.

### Effective January 1, 2008:

With implementation of the revised ASC payment system, the payment rates for most covered ASC surgical procedures and covered ancillary services are established prospectively based on a percentage of the hospital OPPS rates. There is an annual adjustment of the payment rates for inflation. The update for inflation begins with the CY 2010 ASC payment rates when the statutory requirement for a zero update no longer applies.

CMS adjusts for geographic differences in wages using the Core Based Statistical Area geographic locality definitions established in 2003 by the Office of Management and Budget (OMB).

ASC facility services are subject to the usual Medicare Part B deductible and coinsurance requirements. In general, the Medicare program pays ASCs 80 percent of the lesser of the actual charge or the ASC facility payment rate for the covered services performed. The beneficiary pays 20 percent of the lesser of the submitted charge or the ASC facility payment rate for the covered services performed.

**EXCEPTION on coinsurance and deductible:** Effective for colorectal cancer screening colonoscopies (G0105 and G0121) performed on and after January 1, 2007, there is no deductible and a 25 percent coinsurance payment applies.

### Physician Services

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 carrier pays the **facility** fee from the MPFS to the physician. The facility fee is for services done in a facility other than the physician's office and is less than the nonfacility fee for services performed in the physician's office. Physician services for ASC surgical services will be reimbursed at 80% of the Medicare Physician Fee Schedule (MPFS) with deductible and coinsurance applied.

**Note:** For procedures with dates of service prior to January 1, 2008, the carrier pays the nonfacility fee from the MPFS to the physician for codes not on the ASC list.

Use place of service code **24** (Ambulatory Surgical Center) for physician charges for services provided in the ASC facility. The Medicare global fee policies will be applied to physician services provided in an ASC. In a past audit of claims processed by NHIC, the Office of Inspector General (OIG) discovered that physicians incorrectly coded the place of service on 81 of 100 sampled claims by using the "office" place of service even though they performed the services in an outpatient hospital setting or an ambulatory surgical center. This resulted in an overpayment to the physician. Medicare has established different RVUs (Relative Value Units) for services performed in a facility versus a nonfacility setting. The correct place of service code ensures that Medicare is not duplicating payment to the physician and the facility for any part of the practice expense incurred to perform a Medicare service. The payments to the physicians are higher when the services are performed in non-facility settings.

Physicians are required to submit a separate claim for their professional service. Under no circumstances should a physician's bill for their professional services be included on the same claim as the ASC facility charge.

**Note:** Although the physician can be reimbursed for a procedure performed in an ASC not on the ASC list, no facility payment will be made to the ASC.

### Rebundling of CPT Codes

The national correct coding initiative (NCCI) rebundling instructions apply to processing claims from ASC facilities. In general, if an ASC bills a CPT code that is considered to be part of another more comprehensive code that is also billed for the same beneficiary on the same date of service, only the more comprehensive code is covered, provided that code is on the list of ASC approved codes.

### Payment for Corneal Tissue

For dates of service *prior to January 1, 2008*, payment for corneal tissue used in an approved ASC procedure is separately payable to **either** the ASC or surgeon. *Effective January 1, 2008*, payment for corneal tissue is separately payable **only** to the ASC. Procedure code V2785 (processing, preserving, and transporting corneal tissue) must be used to report this service. A copy of the invoice from the eye bank which provided the corneal tissue is required.

**Note:** Providers must provide the invoice upon request.

### Payment for Intraocular Lens (IOL)

The procedures that include insertion of an IOL are CPT codes 66982, 66983, 66984, 66985, and 66986. *Prior to January 1, 2008*, payment for facility services furnished by an ASC for IOL insertion during or subsequent to cataract surgery includes an allowance for the lens. The ASC payment system logic that excluded \$150 for IOLs for purposes of the multiple surgery reduction in cases of cataract surgery no longer applies. *Beginning January 1, 2008*, the Medicare payment for the IOL is included in the Medicare ASC payment for the associated surgical procedure. ASCs should not report separate charges for conventional IOLs because their payment is included in the Medicare payment for the associated surgical procedure.

### Payment for New Technology Intraocular Lenses (NTIOLs)

Effective for dates of service on and after February 27, 2006, through February 26, 2011, Medicare will pay an additional \$50 for Category 3 NTIOLs. 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-Category 3) 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 procedure codes (66982, 66983, 66984, 66985, and 66986) are to be used on all Category 3 NTIOL claims associated with reduced spherical aberration from February 27, 2006, through February 26, 2011. The list of Category 3 NTIOLs is available on the CMS Web site at: [http://www.cms.hhs.gov/ASCPayment/08\\_NTIOLs.asp#TopOfPage](http://www.cms.hhs.gov/ASCPayment/08_NTIOLs.asp#TopOfPage).

Medicare contractors:

- Shall return as unprocessable any claims for NTIOLs containing Q1003 alone or with a code other than one of the above listed procedure codes.
- Shall deny payment for Q1003 if services are furnished in a facility other than a Medicare-approved ASC.
- Shall deny payment for Q1003 if **billed** by an entity other than a Medicare-approved ASC.

### Payment For Presbyopia-Correcting Intraocular Lens (P-C IOL) and Astigmatism-Correcting Intraocular Lens (A-C IOLs)

Medicare will allow beneficiaries to pay additional charges associated with insertion of a P-C IOL or A-C IOL following the extraction of a cataract:

- 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.
- 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 exceeds 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.

When a beneficiary requests insertion of a P-C IOL or A-C IOL instead of a conventional IOL following removal of a cataract:

- Prior to the procedure to remove a cataract and insert a P-C IOL or A-C IOL, the facility and the physician must inform the beneficiary that Medicare will not make payment for services that are specific to the insertion, adjustment or other subsequent treatments related to the P-C or A-C functionality of the IOL.
- The P-C or A-C functionality of a IOL does not fall into a Medicare benefit category, and, therefore, is not covered. Therefore, the facility and physician are not required to provide an Advanced Beneficiary Notice to beneficiaries who request a P-C or A-C IOL.
- Although not required, NHIC strongly encourages facilities and physicians to issue a Notice of Exclusion from Medicare Benefits to beneficiaries in order to clearly identify the non-payable aspects of a P-C or A-C IOL insertion.

When a beneficiary requests insertion of a P-C or A-C IOL instead of a conventional IOL following removal of a cataract and that procedure is performed, the beneficiary is responsible for payment of facility and physician charges for services and supplies attributable to the P-C or A-C functionality of the IOL:

- In determining the beneficiary's liability, the facility and physician may take into account any additional work and resources required for insertion, fitting, vision acuity testing, and monitoring of the P-C or A-C IOL that exceed the work and resources attributable to insertion of a conventional IOL.

For dates of service prior to January 1, 2008, when a beneficiary receives a P-C or A-C IOL following removal of a cataract, ASCs shall report the same CPT code that is used to report removal of a cataract with insertion of a conventional IOL. Physicians and ASCs may also report an additional HCPCS code, V2788, to indicate any additional charges that accrue when a P-C or A-C IOL is inserted in lieu of a conventional IOL. NHIC will deny this procedure code as not covered. This is billable to the beneficiary.

Effective January 1, 2008, HCPCS code V2788 is no longer valid to report non-covered charges associated with the **A-C IOL**. HCPCS code V2787 (*Astigmatism correcting function of intraocular lens. Non-covered by Medicare*) should be used to report non-covered charges for the **A-C IOL** functionality of the inserted intraocular lens. HCPCS code V2788 continues to be billable for the **PC-IOL**.

**Note:** A list of PC-IOLs and A-C IOLs can be accessed on the CMS Web site at :

<http://www.cms.hhs.gov/HospitalOutpatientPPS/Downloads/PCIOL-ACIOL.pdf>.

### Facility Reimbursement for Multiple Procedures

More than one surgical procedure may be performed in the same operative session. Special rules apply to this situation. When two or more procedures are performed that are subject to the multiple procedure discount, the ASC will be reimbursed at the full rate for the procedure classified with the highest payment. Any other procedures performed during the same session are reimbursed at 50% of the procedure's applicable payment.

A procedure performed bilaterally in one operative session is reported as two procedures. Report the CPT code as 2 line items, **not** 1 line item with 2 units. Payment for eligible bilateral procedures will be reimbursed at 150% of the applicable rate. Procedures eligible for the bilateral payment adjustment are determined by CMS.

The multiple procedure payment reduction is the last pricing routine applied to applicable ASC procedure codes. In determining the ranking of procedures for application of the multiple procedure reduction, NHIC shall use the lower of the billed charge or the ASC payment amount. The ASC surgical services billed with modifier -52 and -73 shall not be subjected to further pricing reductions. (i.e., the multiple procedure price reduction rules will not apply). Payment for an ASC surgical procedure billed with modifier -74 may be subject to the multiple procedure discount if that surgical procedure is subject to the multiple procedure discount.

### Offset for Payment for Pass-Through Devices (Effective January 1, 2008)

Under the revised payment system, there can be situations where contractors must reduce (cut back) the approved payment amount for specifically identified procedures when provided in conjunction with a specific pass-through device. This reduction would only be applicable when services for specific pairs of codes are provided on the same day by the same provider.

Code pairs subject to this policy would be updated on a quarterly basis. CMS will inform contractors of the code pairs and the percent reduction taken from the procedure payment rate through a “look-up” table.

### **Payment When a Device is Furnished with No Cost or With Full or Partial Credit (Effective January 1, 2008)**

Contractors pay ASCs a reduced amount for certain specified procedures when a device is furnished without cost for which either a partial or full credit is received (e.g., device recall). For specified procedure codes that include payment for a device, ASCs are required to include an FB modifier on the procedure code when a device is furnished without cost for which full credit is received. If the ASC receives a partial credit of 50 percent or more of the cost of the device, the ASC is required to include an FC modifier on the procedure code. A single procedure should not be submitted with both the FB and FC modifier. The pricing determination related to the FB and FC modifiers is made prior to the application of the multiple procedure pricing reductions.

In order to report that the receipt of a partial credit of 50 percent or more of the cost of a device, ASCs have the option of either: 1) Submitting the claim for the procedure to NHIC after the procedure’s performance but prior to manufacturer acknowledgement of credit for a specified device, and subsequently contacting the contractor regarding a claims adjustment once the credit determination is made; or 2) holding the claim for the procedure until a determination is made by the manufacturer on the partial credit and submitting the claim with modifier -FC appended to the implantation procedure HCPCS code if the partial credit is 50 percent or more of the cost of the device. If choosing the first billing option, to request a claims adjustment once the credit determination is made, ASCs should keep in mind that the initial Medicare payment for the procedure involving the device is conditional and subject to adjustment.

### **Payment for Terminated Procedures**

At times, a scheduled ASC procedure may be terminated prior to or during the operative session. The following criteria determines 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:

- Payment is 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. For example, payment is denied if scheduled surgery is canceled or postponed because the patient on intake complains of a cold or flu.
- Payment at 50 percent of the rate is applied 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 (use modifier 73). For example, 50 percent is paid 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. Although some supplies and resources are expended, they are not consumed to the same extent had anesthesia been fully induced and the surgery completed.

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- Full payment of the facility rate is made if a medical complication arises which causes the procedure to be terminated after inducement of the anesthetic agent (use modifier 74). For example, full payment is made, 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. In this case, the resources of the facility are consumed in essentially the same manner and to the same extent as they would have been had the surgery been completed.

### Prior to January 1, 2008:

- The allowance for an unused IOL is deducted prior to calculating payment for a terminated IOL insertion procedure.

### Beginning January 1, 2008:

- Payment for the IOL is included in payment for the surgical procedure to implant the lens.
- NHIC applies a 50 percent payment reduction for discontinued radiology procedures and other procedures that do not require anesthesia. Facilities use the -52 modifier to indicate the discontinuance of these applicable procedures.

The reason for an ASC terminated surgery must be recorded in the medical record and must indicate the following:

- Reason for termination of surgery;
- Services actually performed;
- Supplies actually provided;
- Services not performed that would have been performed if surgery had not been terminated;
- Supplies not provided that would have been provided if the surgery had not been terminated;
- Time actually spent in each stage, e.g., pre-operative, operative, and post-operative;
- Time that would have been spent in each of these stages if the surgery had not been terminated; and
- CPT-4 code for procedure had the surgery been performed.

Documentation must be provided upon request.

The appropriate modifier must be submitted to identify the services. See the Claim Billing Requirements.

## **Payment for Extracorporeal Shock Wave Lithotripsy (ESWL)** **(Effective January 1, 2008)**

With the revised ASC payment system, contractors may pay for any of the ESWL services that are included on the ASC list of covered surgical procedures.

## CLAIM BILLING REQUIREMENTS

### Claim Submission Requirements:

- Assignment must be accepted.
- The services must be provided in connection with an ASC approved procedure.
- The place of service code must be 24.
- All services must be reasonable and medically necessary in accordance with §1862 (A) (1) (a) of the Social Security Act.
- Modifier -SG must be billed for the facility services for dates of service prior to January 1, 2008. For claims with date of service on and after January 1, 2008, the SG modifier is not required on ASC claims.

### Billing for Drugs and Biologicals:

ASCs are strongly encouraged to report charges for all separately payable drugs and biologicals, using the correct HCPCS codes for the items used. ASCs should not report HCPCS codes and separate charges for drugs and biologicals that receive packaged payment through the payment for the associated covered surgical procedure.

#### Two or more drugs or biologicals

Under the ASC payment system, if two or more drugs or biologicals are mixed together to facilitate administration, the correct HCPCS codes should be reported **separately** for each product used in the care of the patient. The mixing together of two or more products does not constitute a "new" drug as regulated by the Food and Drug Administration (FDA) under the New Drug Application (NDA) process. In these situations, ASCs are reminded that it is not appropriate to bill HCPCS code C9399. HCPCS code C9399 (Unclassified drug or biological) is for new drugs and biologicals that are approved by the FDA on or after January 1, 2004, for which a HCPCS code has not been assigned.

Unless otherwise specified in the long description, HCPCS descriptions refer to the non-compounded, FDA-approved final product. If a product is compounded and a specific HCPCS code does not exist for the compounded product, the ASC should include the charge for the compounded product in the charge for the surgical procedure performed.

#### Correct reporting when used as implantable devices

ASCs are not to bill separately for drug and biological HCPCS codes when using these items as implantable devices (including as a scaffold or an alternative to human or nonhuman connective tissue or mesh used in a graft) during surgical procedures. As under the OPPS, ASCs are provided a packaged payment for surgical procedures that includes the cost of supportive items, including implantable devices without pass-through status. When using drugs and biologicals during covered surgical procedures as implantable devices, ASCs may include the charges for these items in their charge for the procedure.

### Correct Reporting of Units for Drugs

Ensure that units of drugs administered to patients are accurately reported in terms of the dosage specified in the full HCPCS code descriptor. That is, units should be reported in multiples of the units included in the HCPCS descriptor. For example, if the drug's HCPCS code descriptor specifies 6 mg, and 6 mg of the drug were administered to the patient, the units billed should be 1. As another example, if the drug's HCPCS code descriptor specifies 50 mg, but 200 mg of the drug were administered to the patient, the units billed should be 4. ASCs should not bill the units based on how the drug is packaged, stored, or stocked. That is, if the HCPCS descriptor for the drug code specifies 1 mg and a 10 mg vial of the drug was administered to the patient, 10 units should be reported on the bill, even though only 1 vial was administered. The HCPCS short descriptors are limited to 28 characters, including spaces, so short descriptors do not always capture the complete description of the drug. Therefore, before submitting Medicare claims for drugs and biologicals, it is extremely important to review the complete long descriptors for the applicable HCPCS codes.

### **Unprocessable Services:**

#### Effective January 1, 2008:

Covered ancillary items and services, such as pass-through devices, brachytherapy sources, separately payable drugs and biologicals, and radiology procedures, should be billed on the same claim as the related ASC surgical procedure(s). If an ASC bills for an ancillary service(s) separately (i.e., not on the same claim as the related surgical procedure) or a claim is split so that the ancillary service and related ASC surgical service(s) are on separate claims, the contractors will check claims history to determine if there is an approved surgical procedure for the same beneficiary, same provider, and same date. If there is no approved ASC surgical procedure on the same claim or in history for the same date, the ancillary service(s) shall be returned as unprocessable.

### **Ordering and Referring Information for Diagnostic Services:**

#### Effective January 1, 2009:

Since ASCs can now bill for diagnostic services with the TC modifier, the ordering/referring physician must be reported on claims for diagnostic services submitted by ASCs. The name of the ordering/referring physician must be present in block 17 and the NPI of the physician must be present in block 17B of the CMS-1500 for paper claims and appropriate data elements for electronic submissions. If the information is missing, the claim will be returned as unprocessable.

### **CLIA Number Required for Diagnostic Services:**

Certain diagnostic procedures allowable in an ASC setting require CLIA certification information submitted on their claims to be covered. All codes subject to the CLIA edits are found on the CMS Web site at: <http://www.cms.hhs.gov/CLIA/downloads/Subject.to.CLIA.pdf>.

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The CMS list should be checked periodically for updates. Currently, the following tests will be rejected if no CLIA number is submitted:

17311  
17312  
17313  
17314  
17315  
78110TC  
78111TC  
78120TC  
78121TC  
78122TC  
78130TC  
78191TC  
78270TC  
78271TC  
78272TC

CLIA numbers are to be submitted in Item 23 of the Form CMS-1500, or for electronic billing, in loop 2300REF2.

### Non ASC Approved Procedures:

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. In addition, non-ASC approved procedures have no appeal rights under the Medicare program.

### Modifiers:

The appropriate modifier must also be included when applicable.

Modifier	Description
52	Reduced Services
73	Discontinued Outpatient Hospital/ Ambulatory Surgical Center (ASC) procedure prior to the administration of anesthesia.
74	Discontinued Outpatient Hospital/ Ambulatory Surgical Center (ASC) procedure after administration of anesthesia.
FB	Item Provided Without Cost to Provider, Supplier or Practitioner Or Full Credit Received For Replacement Device (Examples, but not limited to, covered under warranty, replaced due to defect, free samples)
FC	Partial Credit Received for Replaced Device
SG	ASC Facility Service (for dates of service prior to January 1, 2008 only)

### NATIONAL CORRECT CODING INITIATIVE

The Centers for Medicare and Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to eliminate improper coding. CCI edits are developed based on coding conventions defined in the American Medical Association's Current Procedural Terminology (CPT) Manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practice.

For the NCCI Policy Manual and the latest version of the NCCI Edits refer to the following web site: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

If you have concerns regarding specific NCCI edits, please submit your comments in writing to:

National Correct Coding Initiative  
Correct Coding Solutions LLC  
P.O. Box 907  
Carmel, IN 46082-0907

### LIMITATION OF LIABILITY (ADVANCE BENEFICIARY NOTICE)

Services denied as not reasonable and medically necessary, under section 1862(a)(1) of the Social Security Act, are subject to the Limitation of Liability (Advance Beneficiary Notice (ABN)) provision. Thus, to be held liable for denied charge (s), the beneficiary must be given appropriate written advance notice of the likelihood of non-coverage and agree to pay for services. A written notice covering an extended course of treatment is acceptable, provided the notice identifies all services for which the provider believes Medicare will not pay.

If, as the course of treatment progresses, additional services are furnished for which the provider believes Medicare will not pay, the provider must separately notify the patient in writing that Medicare is not likely to pay for the additional services and obtain the beneficiary's signed statement agreeing to pay.

Complete instructions and the Advance Beneficiary Notice (ABN) forms can be found on the CMS website at the following address: <http://cms.hhs.gov/BNI/>

#### ABN Modifiers

Modifier **GA** should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as reasonable and necessary and they have on file an Advance Beneficiary Notification (ABN) signed by the beneficiary.

Modifier **GY** should be used when physicians, practitioners, or suppliers want to indicate that the item or service is statutorily non-covered, or is not a Medicare benefit.

Modifier **GZ** should be used when physicians, practitioners, or suppliers want to indicate that they expect that Medicare will deny an item or service as not reasonable and necessary and they **have not** had an Advance Beneficiary Notice (ABN) signed by the beneficiary.

### LOCAL COVERAGE DETERMINATION (LCD)

Local Coverage Determinations are developed by the local Medicare contractor in the absence of a national Medicare payment policy. These policies describe specific criteria which determine whether an item or service is covered by Medicare and under what circumstances. LCDs are updated as new information and technology occurs in the field of medicine. NHIC has Local Coverage Determinations providing guidelines for various types of services. The LCDs can be found on the CMS website. The links for each state can be found on our website at:

[http://www.medicarenhic.com/ne\\_prov/policies.shtml](http://www.medicarenhic.com/ne_prov/policies.shtml)

### NATIONAL COVERAGE DETERMINATION (NCD)

National Coverage Determinations are policies developed by CMS that indicates whether and under what circumstances certain services are covered under the Medicare program. NCDs are the same for all contractors across the country. More information about national coverage can be obtained through this website: <http://www.cms.hhs.gov/mcd/search.asp>

### MEDICARE FRAUD AND ABUSE

As the CMS J14 A/B MAC for Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, NHIC fully supports the CMS initiative for program safeguards and shares the following information for your use:

**Fraud** is the intentional deception or misrepresentation that the individual knows to be false, or does not believe to be true and makes, knowing that the deception could result in some unauthorized benefit to himself/herself or some other person. The most frequent line of fraud arises from a false statement or misrepresentation made, or caused to be made, that is material to entitlement or payment under the Medicare program. Attempts to defraud the Medicare program may take a variety of forms. Some examples include:

- Billing for services or supplies that were not provided;
- Misrepresenting services rendered or the diagnosis for the patient to justify the services or equipment furnished;
- Altering a claim form to obtain a higher amount paid;
- Soliciting, offering, or receiving a kickback, bribe, or rebate;
- Completing Certificates of Medical Necessity (CMNs) for patients not personally and professionally known by the provider; and
- Use of another person's Medicare card to obtain medical care.

**Abuse** describes incidents or practices of providers that are inconsistent with accepted sound medical practices, directly or indirectly resulting in unnecessary costs to the program, improper payment for services that fail to meet professionally recognized standards of care, or services that are medically unnecessary. Abuse takes such forms as, but is not limited to:

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- Unbundled charges;
- Excessive charges;
- Medically unnecessary services; and
- Improper billing practices.

Although these practices may initially be considered as abuse, under certain circumstances they may be considered fraudulent. Any allegations of potential fraud or abuse should be referred to Safeguard Services (SGS).

If you wish to report fraud, or have any questions on Medicare Fraud and Abuse, please contact:

**New England:**

Maureen Akhouzine, Manager  
Safeguard Services (SSG)  
75 William Terry Drive  
Hingham, MA 02043  
Phone 1-781-741- 3282  
Fax 1-781-741-3283  
[maureen.akhouzine@eds.com](mailto:maureen.akhouzine@eds.com)

A single number to report suspected fraud is the national OIG fraud hot line: **1-800-HHS-TIPS (1-800-447-8477)**. Information provided to hotline operators is sent out to state analysts and investigators.

## TELEPHONE AND ADDRESS DIRECTORY

### Provider Interactive Voice Response (IVR) Directory

All actively enrolled providers must utilize the IVR for: **Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date.** The IVR can also assist you with the following information: Seminars, Telephone Numbers, Addresses, Medicare News and Appeal Rights.

Available 24 hours/day, 7 days/week (including holidays)

888-248-6950

### Provider Customer Service Directory

Our Customer Service representatives will assist you with questions that cannot be answered by the IVR, such as policy questions, specific claim denial questions, 855 application status, redetermination status (formerly Appeals). Per CMS requirements, the Customer Service representatives may **not** assist providers with Beneficiary Eligibility, Deductible, Claim Status, Check Status and Earnings to Date unless we are experiencing IVR system problems. This rule applies even if the caller has obtained the code.

#### Hours of Operation:

8:00 a.m. to 4:00 p.m. Monday - Friday

866-801-5304

#### Dedicated Reopening Requests Only

#### Hours of Operation:

8:00 a.m. to 12:00 p.m. and 12:30 p.m. to 4:00 p.m. Monday - Friday

877-757-7781

## MAILING ADDRESS DIRECTORY

Initial Claim Submission

Maine

P.O. Box 2323  
Hingham, MA 02044

Massachusetts

P.O. Box 1212  
Hingham, MA 02044

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New Hampshire	P.O. Box 1717 Hingham, MA 02044
Rhode Island	P.O. Box 9203 Hingham, MA 02044
Vermont	P. O. Box 7777 Hingham, MA 02044
EDI (Electronic Data Interchange)	P.O. Box 9104 Hingham, MA 02044
Written Correspondence	P.O. Box 1000 Hingham, MA 02044
Medicare Reopenings and Redeterminations **See note below	P.O. Box 3535 Hingham, MA 02044
Medicare B Refunds	P.O. Box 5912 New York, NY 10087-5912
Medicare Secondary Payer (Correspondence Only)	P.O. Box 9100 Hingham, MA 02044
Provider Enrollment	P.O. Box 3434 Hingham, MA 02044
Medicare Safeguard Services	P.O. Box 4444 Hingham, MA 02044

\*\* Requests may be faxed to NHIC at **1-781-741-3534** using the new fax cover sheet that can be downloaded from our Web site:  
[www.medicarenhic.com](http://www.medicarenhic.com)

### Durable Medical Equipment (DME)

Durable Medical Equipment (DME) Medicare Administrative Contractor:

NHIC, Corp.

Provider Service Line: 1-866-419-9458

Please view the website to find the appropriate address:

<http://www.medicarenhic.com/dme/contacts.shtml>

### Reconsideration (Second Level of Appeal)

First Coast Service Options Inc.  
QIC Part B North Reconsiderations  
P.O. Box 45208  
Jacksonville, FL 32232-5208

### INTERNET RESOURCES

The Internet is a very valuable tool in researching certain questions or issues. NHIC has a comprehensive website that serves as a direct source to Medicare as well as a referral tool to other related websites that may prove to be beneficial to you.

#### **NHIC, Corp.**

<http://www.medicarenhic.com>

Upon entering NHIC's web address you will be first taken straight to the "home page" where there is a menu of information. NHIC's web page is designed to be user-friendly.

We encourage all providers to join our website mailing list. Just click the link on the home page entitled "Join Our Mailing List". You may also access the link directly at:

<http://visitor.constantcontact.com/email.jsp?m=1101180493704>

When you select the "General Website Updates", you will receive a news report every week, via e-mail, letting you know what the latest updates are for the Medicare program. Other Web News selections (Updates, EDI, etc.) will be sent out on an as-needed basis.

#### **Provider Page Menus/Links**

From the home page, you will be taken to the License for use of "Physicians' Current Procedural Terminology", (CPT) and "Current Dental Terminology", (CDT). Near the top of the page are two buttons, "Accept" and "Do Not Accept". Once you click "Accept", you will be taken to the provider pages.

On the left side of the web page you will see a menu of topics that are available. Explore each one and bookmark those that you use most often.

#### **Medicare Coverage Database**

<http://www.cms.hhs.gov/center/coverage.asp>

<http://www.cms.hhs.gov/mcd/indexes.asp>

The Medicare Coverage Database is an administrative and educational tool to assist providers, physicians and suppliers in submitting correct claims for payment. It features Local Coverage Determinations (LCDs) developed by Medicare Contractors and National Coverage Determinations (NCDs) developed by CMS. CMS requires that local policies be consistent with national guidance (although they can be more detailed or specific), developed with scientific evidence and clinical practice.

### Medicare Learning Network

<http://www.cms.hhs.gov/MLNGenInfo/>

The Medicare Learning Network (MLN) website was established by CMS in response to the increased usage of the Internet as a learning resource by Medicare health care professionals. This website is designed to provide you with the appropriate information and tools to aid health care professionals about Medicare. For courses and information, visit the web site. For a list of the Training Programs, Medicare Learning Network Matters articles and other education tools available, visit the website.

### Open Door Forums

<http://www.cms.hhs.gov/OpenDoorForums/>

CMS conducts Open Door Forums. The Open Door Forum addresses the concerns and issues of providers. Providers may participate by conference call and have the opportunity to express concerns and ask questions. For more information, including signing up for the Open Door Forum mailing list, visit the website.

### Publications and Forms

<http://www.cms.hhs.gov/CMSForms/>

<http://www.cms.hhs.gov/MedicareProviderSupEnroll/>

For your convenience CMS has published optional forms, standard forms, and SSA forms. By linking onto this website, you can access numerous CMS forms such as:

- Provider Enrollment CMS 855 forms (CMS 855B, 855I, & 855R)
- Medicare Participating Physician or Supplier Agreement (CMS 460)
- Advanced Beneficiary Notices (ABN) (CMS R-131)
- Notice of Exclusion from Medicare Benefits (NEMB) (20007)
- Medicare Redetermination Request Form (CMS 20027)
- Request for Reconsideration (CMS 20033)
- Medicare Managed Care Disenrollment form (CMS 566)

Advance Beneficiary Notice (ABN)

<http://cms.hhs.gov/BNI/>

American Medical Association

<http://www.ama-assn.org/>

CMS

<http://www.cms.hhs.gov>  
<http://www.medicare.gov>

CMS Correct Coding Initiative

<http://www.cms.hhs.gov/NationalCorrectCodInitEd/>

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**CMS Physician's Information  
Resource for Medicare**

<http://www.cms.hhs.gov/center/physician.asp?>

**Evaluation and Management Documentation Guidelines**

[http://www.cms.hhs.gov/MLNEdWebGuide/25\\_EMDOC.asp](http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp)

[http://www.cms.hhs.gov/MLNProducts/downloads/eval\\_mgmt\\_serv\\_guide.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/eval_mgmt_serv_guide.pdf)

**Federal Register**

<http://www.archives.gov/federal-register>

<http://www.gpoaccess.gov/index.html>

**HIPAA**

<http://www.cms.hhs.gov/HIPAAGenInfo/>

**National Provider Identifier (NPI)**

<http://www.cms.hhs.gov/NationalProvIdentStand/>

**NPI Registry**

<https://nppes.cms.hhs.gov/NPPES/NPIRegistryHome.do>

**U.S. Government Printing Office**

<http://www.gpoaccess.gov/index.html>

### Revision History:

Version	Date	Reviewed By	Approved By	Summary of Changes
1.0	October 2004	S. Kimball	B. Bedard	Created guide
2.0	05-25-05	S. Kimball	C. Stoker	Added CA info
3.0	09-21-06	S. Kimball & C. Stoker	M. Kelly & K. Leary	Annual update, NHIC name change, chart on services not included in ASC, new NTIOLs, new P-C IOLs
4.0	04-25-07	S. Kimball & C. Stoker	Michele Kelly	<b>Annual update</b> , updated procedure code website, facility service pricing, deductible & coinsurance; added fax documentation link for CA.
5.0	10-15-07	S. Kimball & C. Stoker	M. Kelly	<b>Annual Review</b> - Added A-C-IOL information and made other minor grammar and formatting changes. Updated to new Billing Guide Template.
6.0	04-01-08	S. Kimball & C. Stoker	M. Kelly	<b>Annual Review</b> Updated to 2008 Changes per CR 5680,5668, and 5853
7.0	10-01-08	S. Kimball	M. Clark	<b>Annual Review</b> Removed CA references
8.0	06/24/09	Susan Kimball	Mylene Clark	<b>Annual Review</b> Add RI state agency info, removed NHIC drug Web site, added CMS Web sites, updated charts, updated prosthetic devices, updated physicians services, updated IOLs, updated device credits, added billing for drugs & biologicals, added referring info

# **NHIC, Corp.**

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**Website:**

**<http://www.medicarenhic.com>**

**CMS Websites**

**<http://www.cms.hhs.gov>**

**<http://www.medicare.gov>**