AMBULATORY SURGICAL CENTER FEES

NOTE: This schedule does not apply to ambulatory surgery performed in a hospital.

Licensed Physician Ambulatory Surgical Centers, Licensed Podiatry Ambulatory Surgical Centers, and Licensed Freestanding Ambulatory Surgical Centers providing surgical treatment facilities shall be paid per the following schedule:

INSTRUCTIONS:

1. Surgical procedure codes have been assigned a maximum facility fee rate which is indicted in the ASC rate column.

2. The following indicators are located in the "ASC Indicator" column. These indicators define services which are payable in an ASC setting:

Indicator	Payment Indicator Definition
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
D5	Deleted/discontinued code; no payment made.
F4	Corneal tissue acquisition, hepatitis B vaccine; paid at reasonable cost.
G2	Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
H2	Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
J7	OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.
J8	Device-intensive procedure; paid at adjusted rate.
K2	Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
K7	Unclassified drugs and biologicals; payment contractor-priced.
L1	Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made.
L6	New Technology Intraocular Lens (NTIOL); special payment.
N1	Packaged service/item; no separate payment made.
P2	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.

P3	Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.
R2	Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.
Z2	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.
Z3	Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.
Excluded	Can't be performed in an ASC setting.

3. The facility fee includes the following:
    - The operating room.
    - The usual and customary drugs and surgical supplies for the procedure.
    - The recovery room.

4. The facility fee does not include the following:
    - Surgeon and anesthesiologist charges.
    - Extraordinary surgical supplies, prosthetics, implant devices or drugs. When billing for these supplies and drugs, the Surgical Center or Office Operatory shall provide the payer with a copy of the invoice documenting the actual cost of these supplies and drugs. The payer shall reimburse the Surgical Center or Office Operatory the cost of these supplies and drugs in addition to the facility fee.
    - Services outlined per the definitions listed above as separately reimbursable.

5. Fee "Unbundling" and uniform definition for surgical procedures:
   Procedures that are an integral part of the main operation should be considered as necessary adjuncts not separate entities. Surgical procedures shall be billed based upon uniform definitions found in the most current version of the National Correct Coding Initiative (NCCI) (The "Medicare global fee period" included in the definition will not be used). Further information on this publication is available at:

   http://www.cms.gov/NationalCorrectCodInitEd/

   The NCCI Edits Manual may also be obtained by purchasing the manual, or sections of the manual, from the National Technical Information Service (NTIS) by contacting NTIS at 1-800-363-2068 or 703-605-6060 or at http://www.ntis.gov/products/cci.aspx

6. Multiple Surgeries: Payment for multiple surgeries billed in accordance with the unbundling rule above will be as follows:
    - 100% of the facility fee for the primary procedure
    - 50% of the facility fee for the secondary procedure
    - 30% of the facility fee for the third, fourth, or fifth procedures.