Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

News Flash – The Medicare Learning Network now has Tip Sheets available with important information on the EHR incentive programs. One tip sheet provides user friendly information about incentive payment amounts and describes how they are calculated for fee for service and Medicare Advantage providers. Another provides information on eligibility, timeframes, and maximum payments for the EHR, PQRI, and E-Prescribing program. These Tip Sheets are available at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html on the CMS EHR Incentive Programs website. Select the Medicare Eligible Professional tab on the left, and then scroll to "Downloads."

MLN Matters® Number: MM7078
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Related CR Release Date: August 6, 2010
Effective Date: September 7, 2010
Related CR Transmittal #: R2020CP
Implementation Date: September 7, 2010

Note: This article was updated on December 10, 2012, to reflect current Web addresses. All other information remains unchanged.

Clarification of Billing Requirement for Ancillary Services Performed in the Ambulatory Surgical Center (ASC) by Entities Other Than ASCs

Provider Types Affected

This article is for physicians and other providers submitting claims to Medicare contractors (carriers and Part A/B Medicare Administrative Contractors (A/B MAC)) for services on the Ambulatory Surgical Centers (ASC) Fee Schedule (ASCFS).

What You Need to Know

This article is based on Change Request (CR) 7078, which clarifies a requirement originally created in CR 5680 to ensure consistency among Medicare contractors. CR 7078 directs Medicare contractors:

- To deny the technical component for all ancillary services on the ASCFS list billed by specialties other than ASCs and where such services are provided in an ASC setting; and
- To deny globally billed ancillary services on the ASCFS list billed by specialties other than ASCs provided in an ASC setting.

The professional component is the only payment allowed for ancillary codes billed by physicians and must be billed separately.

Background

CR 7078 clarifies a requirement originally created in CR 5680, which is addressed in the MLN Matters® article available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM5680.pdf on the Centers for Medicare & Medicaid Services (CMS) website. The CR is intended to ensure consistency among all Medicare contractors. CR 7078 informs those contractors to deny the technical component for all ancillary services appearing on the ASCFS when billed by specialties other than ASCs (specialty 49) when place of service (POS) is ASC (POS = 24). Since the technical component is also included in the global fee, the global payment must also be denied. The professional component is the only payment paid for ancillary codes billed by specialties other than ASCs when POS is the ASC.

When denying the technical component for all ancillary services on the ASCFS list billed by specialties other than 49 provided in an ASC setting (POS 24), Medicare contractors will use the following messages:

- Claim Adjustment Reason Code 171 - Payment is denied when performed/billed by this type of provider in this type of facility. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.
- Remittance Advice Remark Code 97 – Not paid to practitioner when provided to patient in this place of service. Payment included in reimbursement issued the facility.
- Remittance Advice Remark Code M16 – Please see our Web site, mailings or bulletins for more details concerning this policy/procedure/decision (at contractor discretion).

When denying globally billed ancillary services on the ASCFS list if billed by specialties other than 49 provided in an ASC setting (POS 24), Medicare will use the following messages:

- Remittance Advice Remark Code N200 – The professional component must be billed separately

- Claim Adjustment Reason Code 4 – The procedure code is inconsistent with the modifier used or a required modifier is missing. Note Refer to the 835 healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.

Additional Information

If you have questions, please contact your Medicare carrier and/or MAC at their toll-free number which may be found at http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/provider-compliance-interactive-map/index.html on the CMS website.

The official instruction, CR 7078, issued to your Medicare carrier and/or MAC regarding this change may be viewed at http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R2020CP.pdf on the CMS website.