HEALTHCON

Understanding The Ambulatory Surgery Center

Amy C. Pritchett

BSHA, CCS, CPC-I, CPC, CPMA, CDEO, CANPC, CASCC, CEDC, CRC, CMDP, CMPM, C-AHI, ICDCT-CM/PCS

Disclaimer

- This presentation is for general education purposes only. The information contained in this presentation and handouts is not intended to be, and is not, legal advice or even particular business advice relevant to your personal circumstances. The laws, regulations and policies pertaining to the subject matter of this presentation are open to interpretation. It is your responsibility to seek private counsel with your attorney to determine whether and how these laws, regulations, and policies apply to your specific case before applying the concepts addressed in this lecture

- **Attendance at this presentation should not be construed as creating an attorney-client relationship with the speaker, nor should the information presented be construed as legal advice.** Remaining for this presentation indicates that you acknowledge and agree with the above

Agenda

- What is an Ambulatory Surgery Center
- What are the Guidelines for ASC under CMS
- Discuss some of the “Approved” Surgical Procedures and Definitions
- Overview of CMS Addenda AA, BB, DD1, DD2, and EE
- Packaged Services and Separate Payment Definitions
- Submitting Claims to Medicare for Reimbursement
- Submitting Claims to Commercial Payers for Reimbursement
- Applicable modifiers utilized in the ASC
- ASC Quality Reporting Measures

What is an Ambulatory Surgery Center

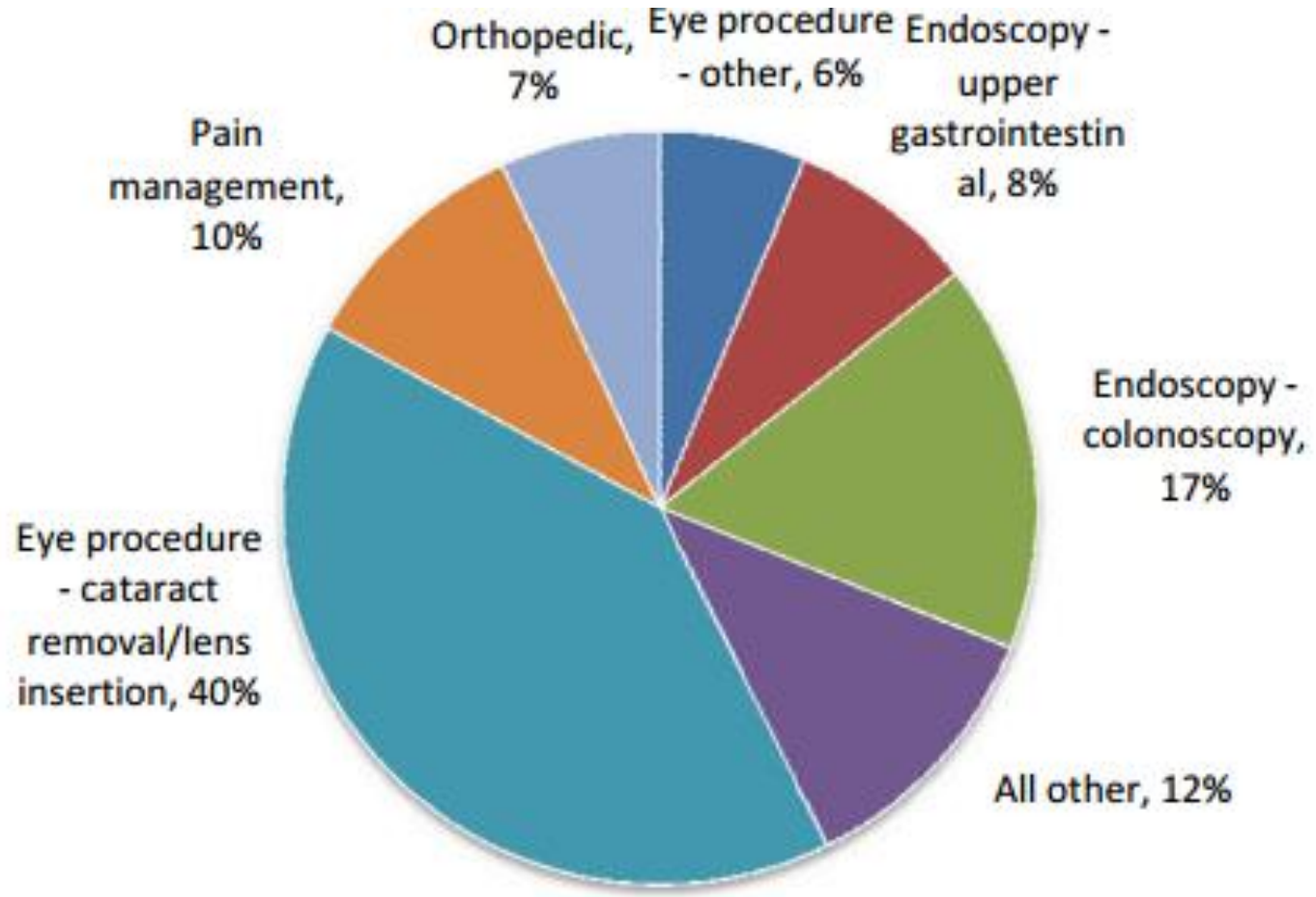
What is An ASC?

- A distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients
- The ASC must have in effect an agreement with CMS
- An ASC can either be independent or operated by a hospital
- Independent: Not part of a provider of services or another facility
- Operated: Under the common ownership, licensure or control of a hospital

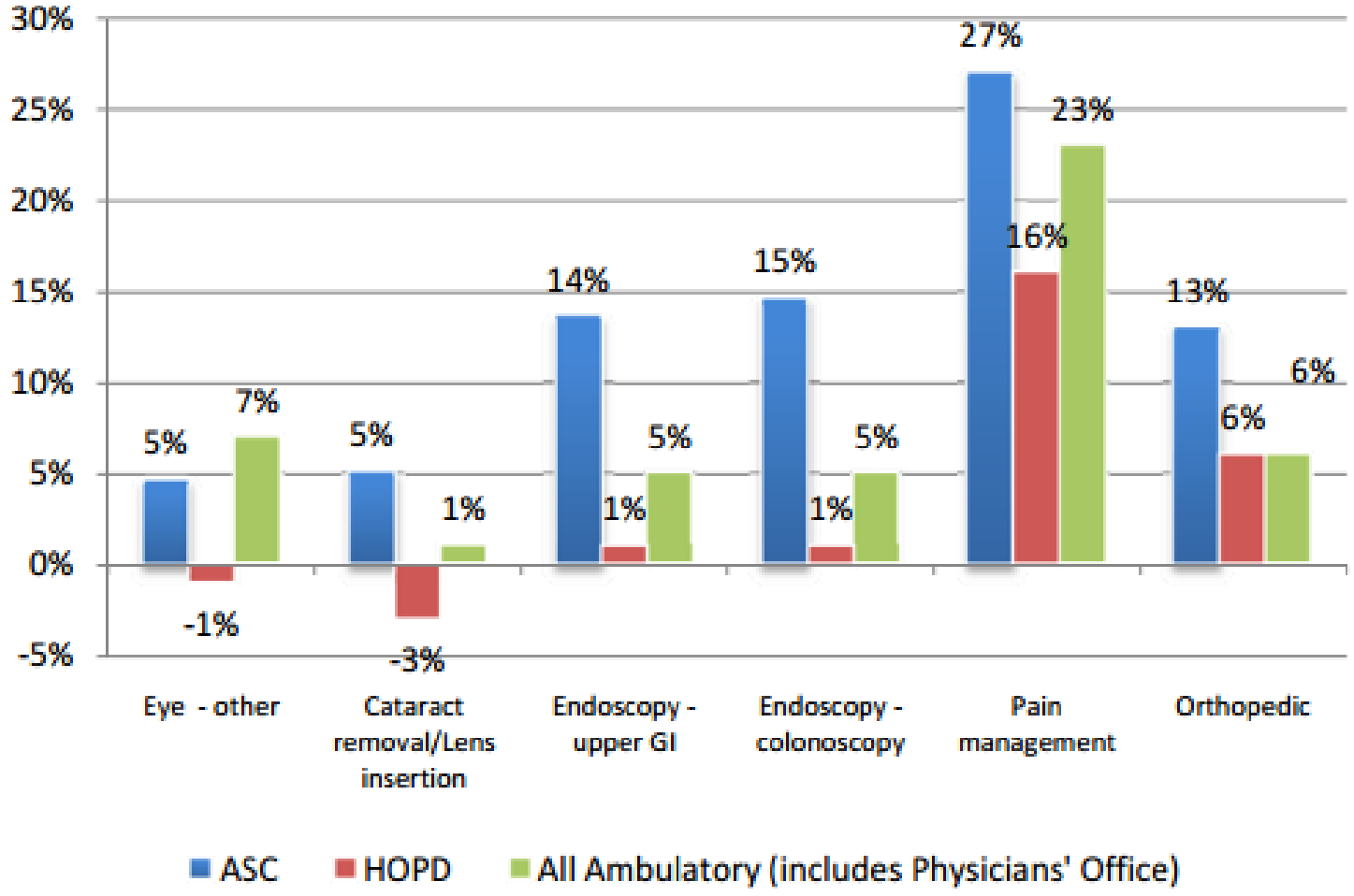
History of the ASC

- The first Ambulatory Surgery Center was established in Phoenix, AZ in 1970
- It was opened by 2 physicians who wanted to provide timely surgical services to their patients and community and avoiding the expense of regular hospitals
- In 1982 Medicare approved payment on approximately 200 procedures between four payment groups with rates of 231.00-336.00 based on a cost survey of 40 ASC's
- In 1987, Medicare modified the ASC list to include 1,535 procedures
- As of today, Medicare beneficiaries can have more than 3,500 procedures performed in an ASC
- Medicare beneficiaries receive approximately 40% of their care provided in ASC's

Specialties Served In An ASC



Growth Of ASC's



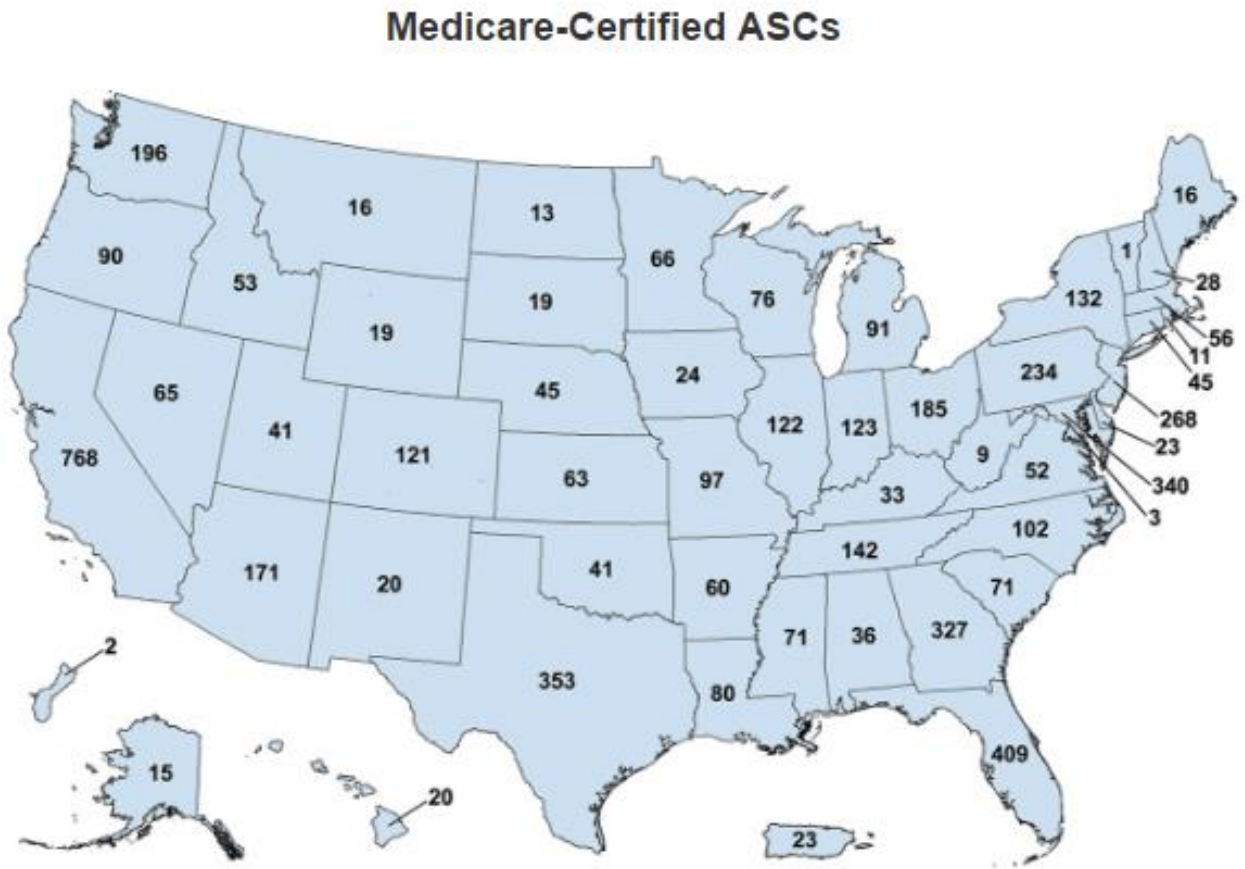
Growth By Procedure Type

Surgical service	Percent of volume	Rank	Percent of volume	Rank
Cataract surgery w/ IOL insert, 1 stage	19.7%	1	18.6%	1
Upper GI endoscopy, biopsy	8.7	2	8.5	2
Colonoscopy and biopsy	6.0	3	6.0	3
Diagnostic colonoscopy	5.0	4	2.6	9
After cataract laser surgery	4.8	5	4.5	6
Lesion removal colonoscopy	4.8	6	5.4	4
Injection spine: lumbar, sacral (caudal)	4.0	7	3.4	7
Inject foramen epidural: lumbar, sacral	4.0	8	4.6	5
Inject paravertebral: lumbar, sacral*	2.1	9	2.8	8
Colorectal screen, high-risk individual	1.7	10	2.1	10
Lesion remove colonoscopy	1.5	11	1.1	15
Colorectal screen, not high-risk individual	1.4	12	0.9	20
Upper GI endoscopy, diagnosis	1.4	13	1.9	11
Cystoscopy	1.3	14	1.2	13
Cataract surgery, complex	1.3	15	1.6	12
Revision of upper eyelid	1.1	16	1.0	18
Inject spine, cervical or thoracic	0.9	17	1.0	17
Upper GI endoscopy, insertion of guide wire	0.8	18	0.8	21
Injection procedure for sacroiliac joint, anesthetic	0.8	19	1.1	14
Carpal tunnel surgery	0.7	20	0.7	22
Total	71.9		70.5	

Medicare Payments to ASC

Medicare payments (in billions of dollars)	$3.2	$3.3	$3.4	$3.6	$3.7	$3.8
Medicare payments per FFS beneficiary	$102	$104	$106	$110	$113	$116
Percent change per FFS beneficiary from previous year	5.3%	2.0%	2.0%	4.2%	2.1%	3.1%

ASC Total Facilities By State

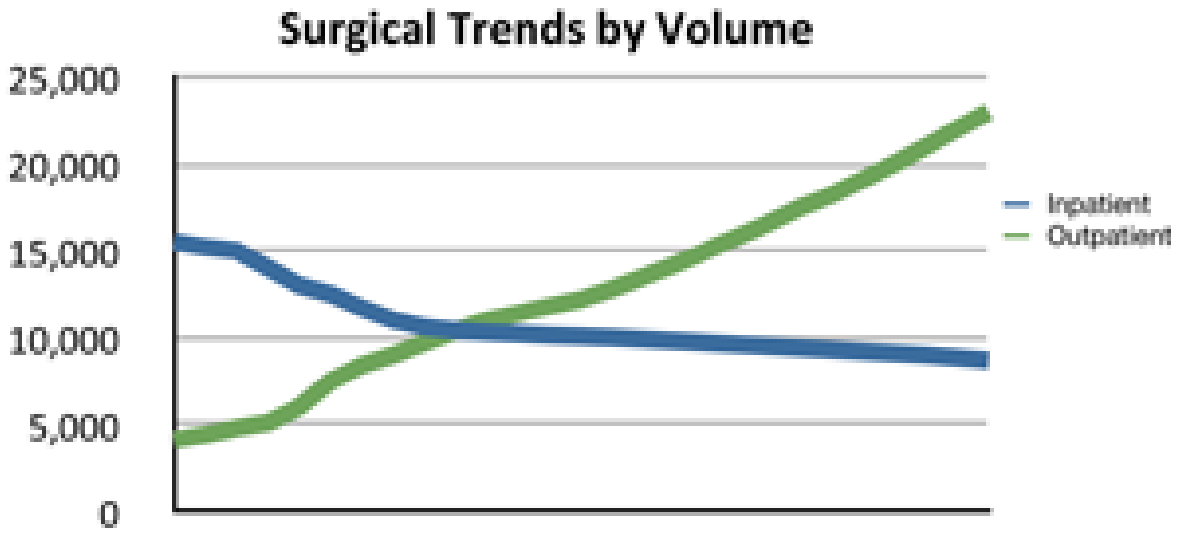


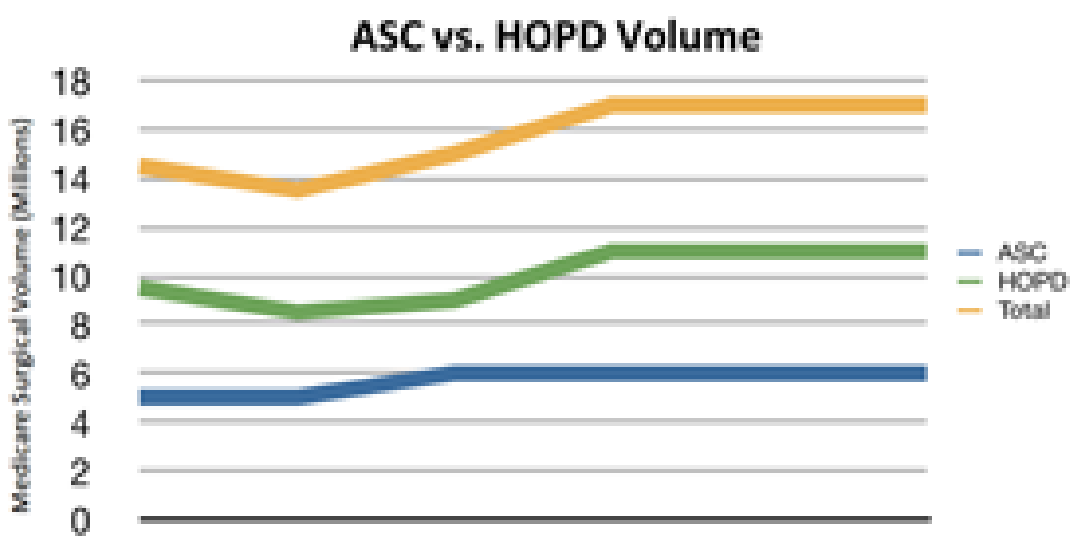
Medicare ASC versus HOPD

Characteristic	ASC	HOPD
Medicaid status		
Not Medicaid	86.4%	77.2%
Medicaid	13.6	22.8
Race/ethnicity		
White	87.0	83.8
African American	6.9	10.0
Other	6.0	6.1
Age		
Under 65	14.7	21.9
65 to 84	78.9	67.4
85 or older	6.4	10.7
Sex		
Male	42.8	44.7
Female	57.2	55.3

Surgical Trends By Volume and Resource

approximately 117,700 full-time workers."





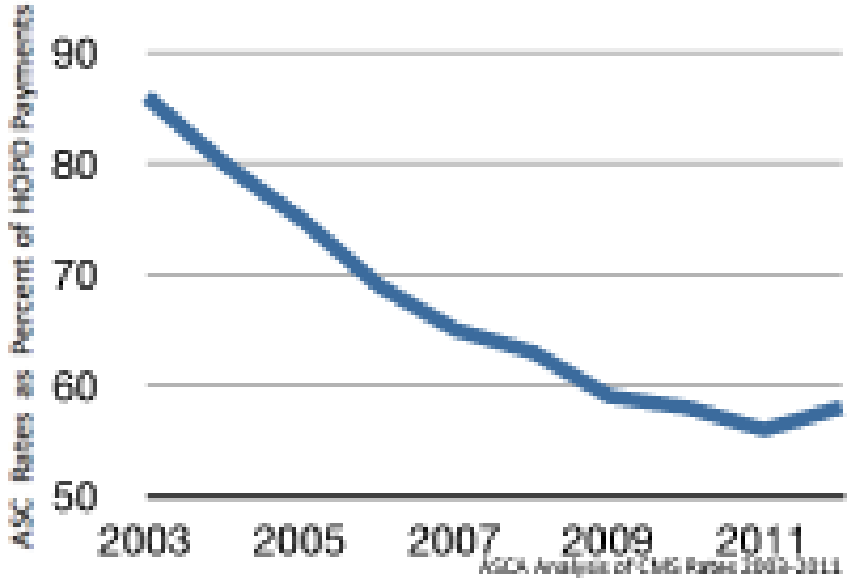
Cost Comparison Of ASC vs. HOPD

Cost Comparison:
ASC v. Hospital Outpatient Department

	Patient Cost		Medicare Cost	
	ASC Co-pay	HOPD Co-pay	Total Procedure Cost ASC	Total Procedure Cost HOPD
Cataract	$193	$490	$964	$1,670
Upper GI Endoscopy	$68	$139	$341	$591
Colonoscopy	$76	$186	$378	$655

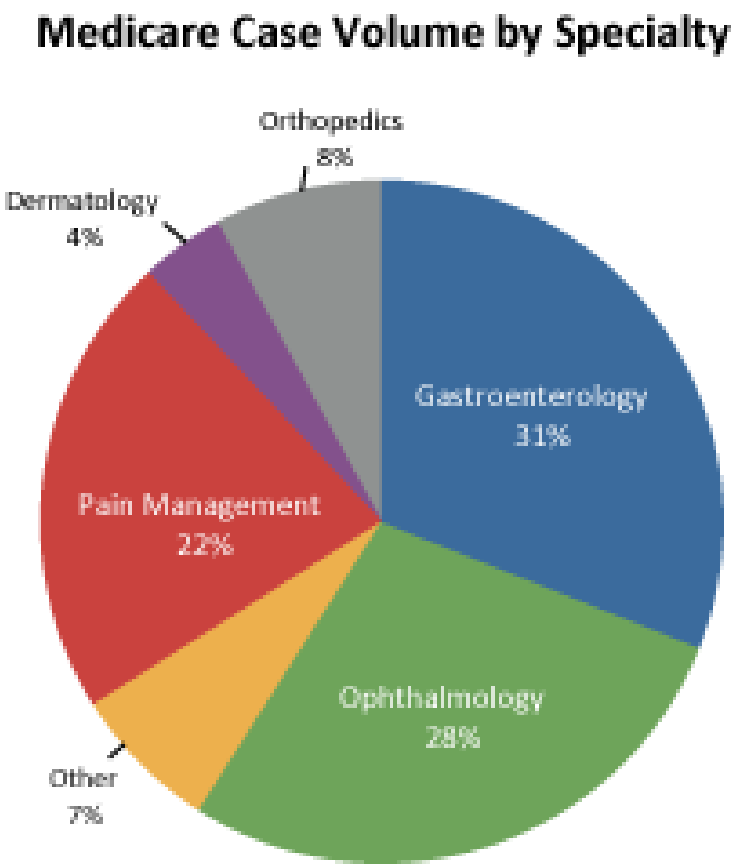
ASCA Analysis of CMS Rates Effective 1 Jan. 2012

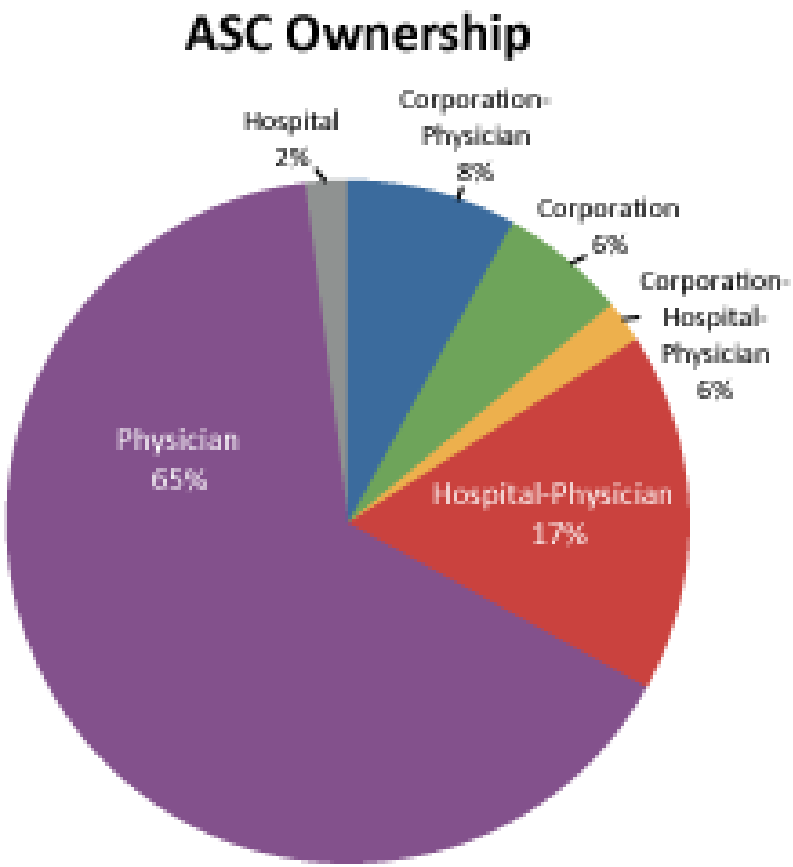
The Gap Between ASC and HOPD Payments Has Widened Significantly



ASCA Analysis of CMS Rates 2003-2011

Medicare Case Volume By Specialty



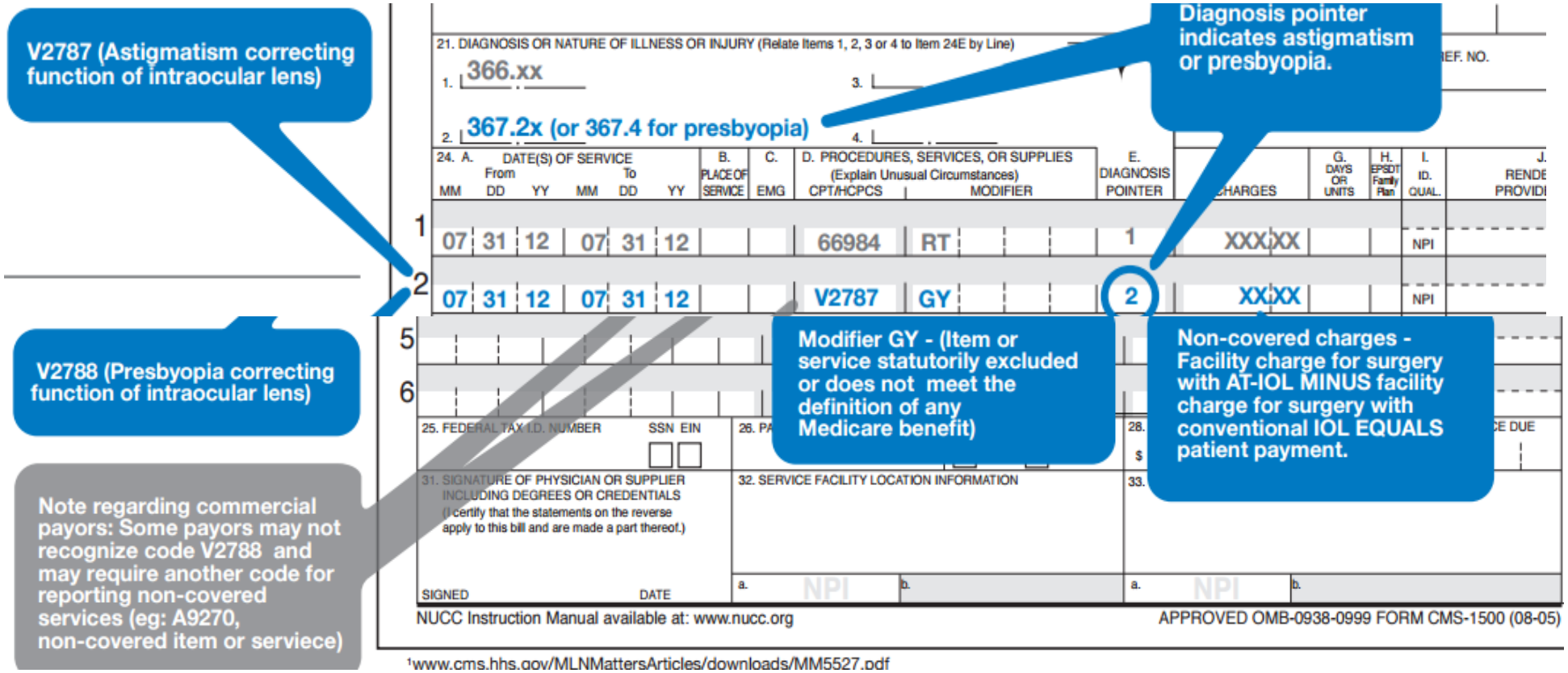


Claims Submission
Medicare Claims Only

Claim Submission

- ASC payment for services are made under Medicare Part B
- ASC services are submitted on a CMS-1500 claim form
- ASCs are reimbursed by APC rates under OPPS
- ASC Place of Service (POS) code is 24
- Type of Service (TOS) code is F billed by specialty (49)
- Covered ancillary services should be billed on same claim as related to the ASC surgical procedure(s)

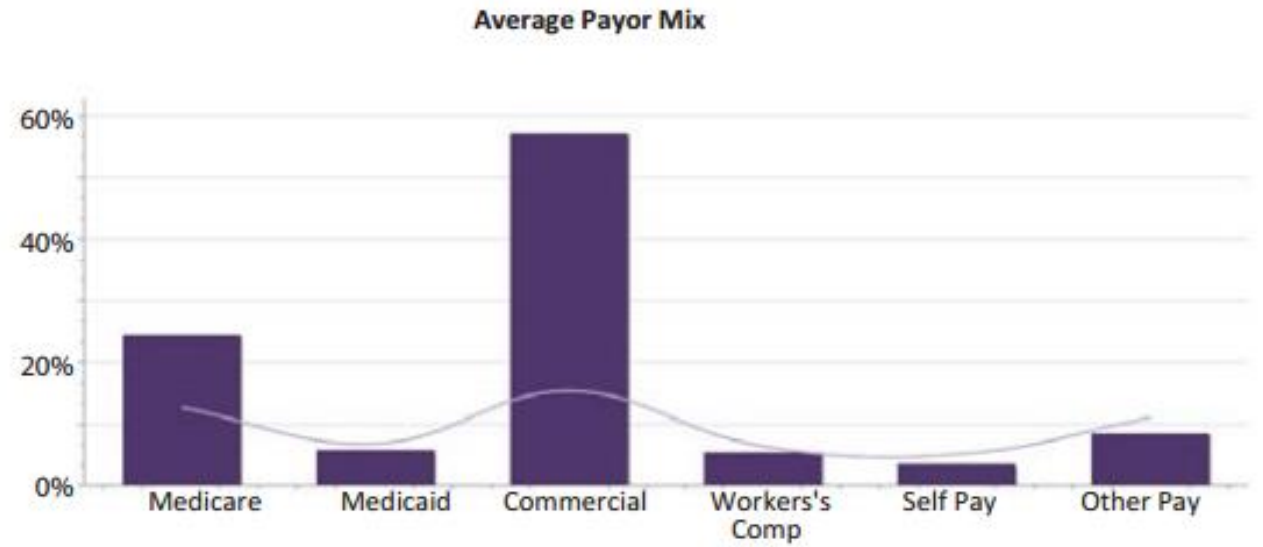
CMS 1500 Claim Example for ASC



[1]www.cms.hhs.gov/MLNMattersArticles/downloads/MM5527.pdf

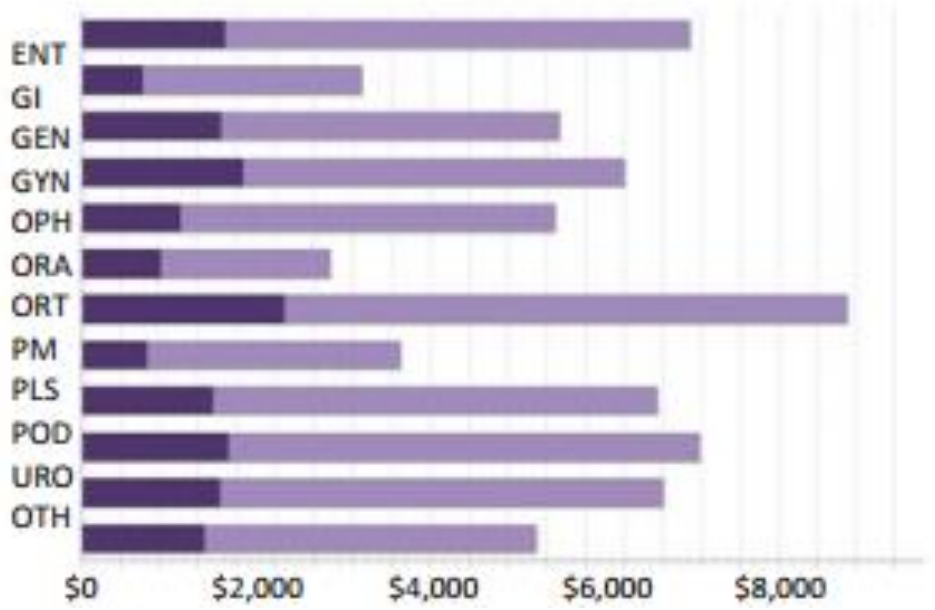
Payer Case Median Index

	Mean	Standard Dev.	25%	Median 50%	75%	90%
Medicare	24 %	13 %	14 %	24 %	34 %	40 %
Medicaid	6 %	7 %	1 %	3 %	7 %	15 %
Commercial	57 %	15 %	48 %	58 %	67 %	76 %
Worker's Comp	5 %	6 %	1 %	4 %	7 %	11 %
Self Pay	3 %	5 %	1 %	2 %	4 %	9 %
Other Pay	8 %	11 %	1 %	4 %	10 %	22 %



Revenue Per Case Type

Specialty	Gross Charges	Net Revenue
ENT	$7,847	$1,849
GI / Endoscopy	$3,610	$788
General Surgery	$6,152	$1,795
OB/GYN	$7,001	$2,081
Ophthalmology	$6,097	$1,273
Oral Surgery	$3,194	$1,026
Orthopedics	$9,874	$2,618
Pain Management	$4,106	$840
Plastic	$7,419	$1,696
Podiatry	$7,969	$1,893
Urology	$7,498	$1,788
Other	$5,853	$1,582



Payment Indicators

What Do They Mean to ASC Payment Rates

ASC Approved HCPCS Code Payment Rates

Updated 3/29/2017

- Addendum AA
  - 0 added, 0 deleted, 0 rate changes
- Addendum BB
  - 0 added, 0 deleted, 0 rate changes
- Addendum DD1
  - 0 changes
- Addendum DD2
  - 0 changes
- Addendum EE
  - 0 changes

Updated 12/30/2016

- Addendum AA
  - 117 added codes, 32 deleted codes, many codes with rate changes
- Addendum BB
  - 112 added codes, 53 deleted codes, many codes with rate changes
- Addendum DD1
  - 0 changes
- Addendum DD2
  - 1 change
- Addendum EE
  - 101 added codes, 55 deleted codes

Addendum AA Changes April 2017 Release

- Many changes were made to the ASC Addendum AA for April 2017
- One of the most drastic changes were to spinal procedures (i.e., fixation devices, biomechanical devices and stabilization devices)
- The changes show added content that now shows 22840-22859 are no longer subject to multiple procedure discounts
- Also, 22867 has been changed to a multiple procedure discount with the Payment Indicator of J8 (Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate

Payment Indicators Addendum DD1

Addendum DD1 -- Final ASC Payment Indicators for CY 2017	
Indicator	**Payment Indicator Definition**
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
B5	Alternative code may be available; no payment made
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 or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.
Z3	Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.

Payment Indicator A2

15820 Revision of lower eyelid (Payment = $771.98 as of 04/01/2017)

General Information

Source:	AA - ASC Covered Surgical Procedures
Code:	15820
Effective Date:	04/01/2017
Short Description:	Revision of lower eyelid
Payment Indicator:	A2 - **Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight**
Payment Weight:	17.154
Payment Rate:	$771.98
Subject to multi-procedure discounting?:	Y

21123 Reconstruction of chin (Payment = $940.94 as of 04/01/2017)

General Information

Source:	AA - ASC Covered Surgical Procedures
Code:	21123
Effective Date:	04/01/2017
Short Description:	Reconstruction of chin
Payment Indicator:	A2 - **Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight**
Payment Weight:	20.9084
Payment Rate:	$940.94
Subject to multi-procedure discounting?:	Y

Payment Indicator B5

- As per CMS Transmittal R1616CP
- Payment Indicator B5 is utilized when there is a G-Code that should be alternatively billed in lieu of a CPT code
- Example:
  - G0121 should be coded for a Medicare patient in lieu of 45378 CPT code for commercial payers
- Claim Adjustment Reason Code: 125- Submission/Billing Error
  - Remark M51: Missing/incomplete/invalid procedure code(s)

Payment Indicator D5

- Deleted/Discontinued Code; No payment made
- Claim Adjustment reason code 181- Procedure invalid on date of service
- Remark N56- Procedure code billed is not correct/valid for services billed or the date of services billed

Payment Indicator G2

0412T Rmvl cardiac modulj pls gen (Payment = $1,383.94 as of 04/01/2017)

General Information

Source:	AA - ASC Covered Surgical Procedures
Code:	0412T
Effective Date:	04/01/2017
Short Description:	Rmvl cardiac modulj pls gen
Payment Indicator:	G2 - **Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight**
Payment Weight:	30.7522
Payment Rate:	$1,383.94
Subject to multi-procedure discounting?:	N
Comment Indicator:	
Note(s):	

33233 Removal of pm generator (Payment = $3,673.00 as of 04/01/2017)

General Information

Source:	AA - ASC Covered Surgical Procedures
Code:	33233
Effective Date:	04/01/2017
Short Description:	Removal of pm generator
Payment Indicator:	G2 - **Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight**
Payment Weight:	81.6168
Payment Rate:	$3,673.00
Subject to multi-procedure discounting?:	N
Comment Indicator:	
Note(s):	

Payment Indicator H2

- Brachytherapy sources that are paid separately when provided integral to a surgical procedure

- Examples:

C1719 Brachytx, ns, non-hdrir-192 (Payment = $33.83 as of 04/01/2017)
C2616 Brachytx, non-str,yttrium-90 (Payment = $16,507.73 as of 04/01/2017)
C2634 Brachytx, non-str, ha, i-125 (Payment = $120.52 as of 04/01/2017)
C2635 Brachytx, non-str, ha, p-103 (Payment = $25.70 as of 04/01/2017)
C2636 Brachy linear, non-str,p-103 (Payment = $18.65 as of 04/01/2017)
C2638 Brachytx, stranded, i-125 (Payment = $37.97 as of 04/01/2017)
C2639 Brachytx, non-stranded,i-125 (Payment = $35.70 as of 04/01/2017)
C2640 Brachytx, stranded, p-103 (Payment = $73.22 as of 04/01/2017)

Payment Indicator J7

- OPPS Pass-through devices
- Paid separately when provided integral to a surgical procedure on the ASC list
- Payment is contractor-priced
- Examples:

C1822 Gen, neuro, HF, rechg bat (Payment = Contractor-Priced as of 04/01/2017)
C1841 Retinal prosth int/ext comp (Payment = $70,687.74 as of 04/01/2017)
C1842 Retinal prosth, add-on (Payment = $70,687.74 as of 04/01/2017)
C2613 Lung bx plug w/del sys (Payment = Contractor-Priced as of 04/01/2017)
C2623 Cath, translumin, drug-coat (Payment = Contractor-Priced as of 04/01/2017)

Payment Indicator J8

- ASC Device Intensive Procedures
- Paid by splitting the Medicare ASC payment into procedure and device portion
- The procedure portion is paid by dividing the portion of Medicare conversion factor x the ASC conversion factor
- The device portion will be paid by taking the device portion x 1.2
- The payment will be the lesser of the amount on the ASC fee schedule or the billed amount

Device Intensive Procedure

- Claim should only have 1 line for payment of the surgical procedure only
- This one line item should include the cost for procedure and device implanted

CPT Code	Description	Payment Indicator	Units	Billed Amount	Medicare Allowed Amount	Payment to ASC
54405	Insertion of multi-compartment, inflatable penile prosthesis, including placement of pump, cylinders and reservoir	J8	1	$17,500.00	$10,845.87	$7,591.11

Payment Indicator K2

- Drugs and Biologicals paid separately when integral to a surgical procedure on the ASC List
- Effective 4/1/2017 as per MLN/Article MM9998
- Payment for non-pass through drugs, biologicals and therapeutic radiopharmaceuticals continues to be made at the following rate
- ASP+6%
- Provides payment for acquisition and pharmacy over-head associated with the drug or radiopharmaceutical.
- CY 2017 a single payment of ASP + 6% is made to provide payment for both the acquisition cost and overhead cost of these pass-through drugs

Payment Indicator K2

- Payments for drugs and biologicals based on ASP's will be updated on a quarter basis
- You can find updated payment rates at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html
- 4/1/2017 Updated ASC Drugs and Biologicals with OPPS Pass-Through Status

HCPCS Code	Long Descriptor	Short Descriptor	ASC PI
C9484	Injection, eteplirsen, 10 mg	Injection, eteplirsen	K2
C9485	Injection, olaratumab, 10 mg	Injection, olaratumab	K2
C9486	Injection, granisetron extended release, 0.1 mg	Inj, granisetron ext	K2
C9487	Ustekinumab, for intravenous injection, 1 mg	Ustekinumab IV inj, 1 mg	K2
C9488	Injection, conivaptan hydrochloride, 1 mg	Conivaptan HCL	K2
J7328	Hyaluronan or derivative, gel-syn, for intra-articular injection, 0.1 mg	Gel-syn injection 0.1 mg	K2

Payment Indicator K7

- Unclassified drugs and biologicals
- Payment contractor-priced
- There is only one on the list for 4/1/2017

C9399 Unclassified drugs or biolog (Payment = Contractor-Priced as of 04/01/2017)

Payment Indicator L1

- Influenza or Pneumococcal vaccines
- Packaged Items/Services
- No separate payment is made

90685 Iiv4 vacc no prsv 0.25 ml im (Payment = Packaged Item/Service as of 04/01/2017)

General Information

Source:	BB - Covered (and packaged) Ancillary Services Integral to Covered Surgical Procedures
Code:	90685
Effective Date:	04/01/2017
Short Description:	Iiv4 vacc no prsv 0.25 ml im
Payment Indicator:	L1 - **Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made**
Payment Weight:	
Payment Rate:	
Subject to multi-procedure discounting?:	
Comment Indicator:	
Note(s):	Defined as a preventive service with $0 coinsurance as required by sections 4104 and 10406 of the Affordable Care Act.

Payment Indicator P2

- Office-Based Surgical Procedures
- Added to ASC in CY 2008 or later with Medicare Physician Fee Schedule (MFPS)
- This is for non-facility practice expenses and payment is based on OPPS relative payment weight

25630 Treat wrist bone fracture (Payment = $108.05 as of 04/01/2017)

General Information

Source:	AA - ASC Covered Surgical Procedures
Code:	25630
Effective Date:	04/01/2017
Short Description:	Treat wrist bone fracture
Payment Indicator:	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**
Payment Weight:	2.4009
Payment Rate:	$108.05
Subject to multi-procedure discounting?:	Y
Comment Indicator:	

Payment Indicator P3

- Office-Based Surgical Procedures
- Based on MPFS non-facility PE RVU's
- Payment is based on MPFS non-facility

10081 Drainage of pilonidal cyst (Payment = $171.55 as of 04/01/2017)

General Information

Source:	AA - ASC Covered Surgical Procedures
Code:	10081
Effective Date:	04/01/2017
Short Description:	Drainage of pilonidal cyst
Payment Indicator:	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**
Payment Weight:	
Payment Rate:	$171.55
Subject to multi-procedure discounting?:	Y
Comment Indicator:	
Note(s):	

Payment Indicator R2

- Office-based surgical procedure added to ASC list in CY 2008 or later
- Without MFPS Non-Facility PE RVUs
- Payment is based on OPPS relative payment weight

31002 Irrigation sphenoid sinus (Payment = $561.53 as of 04/01/2017)

General Information

Source:	AA - ASC Covered Surgical Procedures
Code:	31002
Effective Date:	04/01/2017
Short Description:	Irrigation sphenoid sinus
Payment Indicator:	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**
Payment Weight:	12.4776
Payment Rate:	$561.53
Subject to multi-procedure discounting?:	Y

Payment Indicator Z2

- Radiology services paid separately when provided integral to a surgical procedure on the ASC list
- Paid based on OPPS Relative payment weight

77084 Magnetic image bone marrow (Payment = $243.14 as of 04/01/2017)

General Information

Source:	BB - Covered (and packaged) Ancillary Services Integral to Covered Surgical Procedures
Code:	77084
Effective Date:	04/01/2017
Short Description:	Magnetic image bone marrow
Payment Indicator:	Z2 - **Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight**
Payment Weight:	5.4027
Payment Rate:	$243.14

Payment Indicator Z3

- As like with Payment Indicator P3
- This is a list of Radiology services paid separately when provided integral to a surgical procedure on the ASC list
- These are paid by MPFS (Medicare Physician Fee Schedule) and not on OPPS

76000 Fluoroscope examination (Payment = $38.76 as of 04/01/2017)

General Information

Source:	BB - Covered (and packaged) Ancillary Services Integral to Covered Surgical Procedures
Code:	76000
Effective Date:	04/01/2017
Short Description:	Fluoroscope examination
Payment Indicator:	Z3 - **Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs**
Payment Weight:	
Payment Rate:	$38.76
Subject to multi-procedure discounting?:	

Comment Indicators DD2

Addendum DD2 -- Proposed ASC Comment Indicators for CY 2017	
CI	**Comment Indicator Meanings**
CH	Active HCPCS code in current year and next calendar year, payment indicator assignment has changed; or active HCPCS code that is newly recognized as payable in ASC; or active HCPCS code that is discontinued at the end of the current calendar year.
NI	New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year, interim payment indicator assignment; comments will be accepted on the interim payment indicator for the new code.
NP	New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year as compared to current calendar year, proposed ASC payment indicator; comments will be accepted on the proposed ASC payment indicator for the new code.

Common Modifiers Approved for ASC

Common Modifiers

Modifier	Description
25	Significant, Separately identifiable E/M service by the same physician on the same day of the procedure or other service
27	Multiple Outpatient Hospital E/M Encounters on the Same Date
50	Bilateral Procedure
52	Reduced Services
58	Staged or related procedure or service by the same physician during the postoperative period
59	Distinct Procedural Service
73	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure prior to the administration of anesthesia
74	Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure after the administration of anesthesia
76	Repeat Procedure by Same Physician
77	Repeat Procedure by Another Physician
78	Return to the Operating Room for a related procedure during the postoperative period
79	Unrelated procedure or service by the same physician during the postoperative period

Common ASC Associated Modifiers

Modifier	Definition	Description/Instruction
TC	Technical Component	To report the technical component **Only** of a global service
26	Professional Component	To report the professional component **Only** of a global service
PT	No Definition	Used when billing a colonoscopy procedure that was scheduled as a screening; but a biopsy and/or polyp was excised during the procedure

Modifier FB and FC

- ASCs are paid a reduced amount for certain procedures when a specified devise is furnished without cost for which a partial or full credit is received
- This is the case with many manufacturer recalls
- For specified procedures codes that include the payment for a device, an ASC is required to report modifier FB on the procedure code when a specified device is furnished without cost or when full credit is received
- If the ASC receives a partial credit of 50% or more of the cost of the device, the ASC is required to include modifier FC on the procedure code, for which a reduction will apply
- A single procedure code should never be submitted with both FB and FC modifiers
- The pricing determination related to the FB and FC modifiers is made prior to the application of multiple procedure payment reductions

Multiple Procedure Reductions

- The multiple procedure payment reduction is applicable to all ASC codes
- When determining reductions of procedures the contractors will use the lower of the billed charge and/or the ASC payment amount
- The surgical services billed with a modifier -73 and/or -52 will not be subject to further price reductions (Multiple procedure reduction does not apply)
- The payment for a surgical procedure billed with modifier -74 may be subject to multiple procedure reductions if the surgical procedure discontinued is subject to the multiple procedure discount

Bilateral Services Modifier

- Bilateral services are billed differently by ASCs
- Bilateral surgery rules do apply
- DO NOT use modifier -50

- Example 1:

CPT Code	Modifier	Unit of Service
66984	RT	1
66984	LT	1

- Example 2:

CPT Code	Modifier	Unit of Service
66984	RTLT	2

Terminated Surgical Procedures

- A procedure that is terminated due to medical complications and/or the procedure increases the surgical risk of the patient
- ASC claim must be accompanied by an operative report
- A procedure that is terminated prior to the ASC has utilized resources will not be covered
- If an Intraocular Lens insertion is terminated, the allowance for the unused IOL will be deducted prior to the payment to the ASC
- NOC (Not Otherwise Classified) procedure codes should not be submitted for terminated ASC procedures

Terminated Surgical Procedures Continued

- Proper use of Modifier 73
  - Discontinued Outpatient/Ambulatory Surgical Center (ASC) procedure **prior to the administration of anesthesia**
  - Append modifier -73 to the ASC claim
  - Proper use of Modifier 74
  - Discontinued Outpatient/Ambulatory Surgical Center (ASC) procedure **after the administration of anesthesia**
  - Append modifier -74 to the ASC claim

Terminated Procedure CMS Guidelines

- If a procedure is terminated and the facility submits a claim for reimbursement with a modifier -74
- The operative report shall include the following:
  - Reason for the termination of the procedure
  - Services that were provided to the patient
  - Supplies that were provided in care of the patient
  - Services not performed that would have been if the procedure was not terminated
  - Actual time spent with the patient (pre-operative, operative and post-operative)
  - CPT code for the procedure that would have been performed

Multiple Procedures

- Special payment rules apply with Ambulatory Surgical Centers
- When multiple procedures are performed during the same surgical procedure
- 100% of the highest paying surgical procedure submitted on the claim plus
- 50% of the applicable payment rate(s) for other ASC covered surgical procedures

Separately Payable Ancillary Services

Covered Ancillary Services

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

Payable Ancillary Services

- Physician Services
- Ambulance Services
- Services furnished by an Independent Laboratory
  - Must be a Certified Laboratory
- Separately Payable DME Items
  - Non-Implantable prosthetic devices
  - DME supplier must have a DME supplier number from CMS and a separate NPI
  - ASC cannot also be the DME supplier
  - Purchase or rental of non-implantable DME to ASC patients for the home
  - Leg, arm, back and neck braces
  - Artificial legs, arms and eyes

Diagnostic and Therapeutic Services

- Certain diagnostic procedures are allowed in an ASC setting
- However, they require CLIA certification information to be submitted on claims to be covered
- If not submitted with a CLIA number, the following services will be rejected and no payment will be allowed

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

- CLIA numbers are to be submitted in Block 23 of the CMS-1500

Intraocular Lenses (IOLs) and New Technology Intraocular Lenses (NTIOL)

- The ASC facility services include all IOL and NTIOL that have been approved by the FDS for insertion during or subsequent to a cataract procedure
- IOLs are classified into the following categories
  - Anterior chamber angle fixation lenses
  - Iris fixation lenses
  - Irido-capsular fixation lenses
  - Posterior chamber lenses
  - Presbyopia-Correcting (PCIOL)
  - Astigmatism-Correcting (ACIOL)

**No separate payment for IOL is allowed, however NTIOLS may be billed separately in addition to the facility rate

Payment For Intraocular Lens (IOL)

- Physicians and/or suppliers are not paid for an IOL furnished in an ASC after July 1, 1988
- CPT codes 66982, 66983, 66984, 66985 and 66986 bundle the IOL furnished into the ASC payment
- ASCs should apply HCPCS code Q1003 to bill for a Category 3 NIOL
- Q1003 along with one of CPT codes listed above are to be used on all NTIOL Category 3 claims

CMS Regulations and Guidance

- Guideline 60.1- Applicable Messages for NTIOLs
- The Revision was issued on 11-10-2016
- Became effective: 02/10/2017
- Implementation Date: 02/10/2017
- Any claims for NTIOLs that contain HCPCS code Q1003 alone or with a code other than one of the procedure codes listed in 40.3
  - Payment Group 6: CPT Codes 69985 and 66986
  - Payment Group 8: CPT codes 66982, 66983 and 66984
- Will be denied when services are furnished in a facility other than Medicare-approved ASC

ESWL: Extracorporeal Shock Wave Lithotripsy

- In 1991, the Federal Register notice (56 FR 67666), which was published on December 31,1991 established the 9th ASC payment group
- The payment amount for this group was ($1,150) and was assigned to only one procedure code 50590
- Beginning January 1, 2008 the revised ASC system stated that any ESWL services that are included on the ASC approved list will be reimbursed

Items or Services Not Included	Who Receives Payment	Where to Submit Bills
Physicians' Services	Physician	Medicare Administrative Contractor (MAC)
Purchase or Rental of Non-Implantable Durable Medical Equipment (DME) to ASC Patients for Use in Their Homes	DME supplier A supplier of DME must have a DME supplier number from the National Supplier Clearinghouse (NSC) and a separate National Provider Identifier (NPI) An ASC may not simultaneously be a DME supplier	Durable Medical Equipment Medicare Administrative Contractor (DME MAC)
Non-Implantable Prosthetic Devices	DME supplier A supplier of DME must have a DME supplier number from the NSC and a separate NPI An ASC may not simultaneously be a DME supplier	DME MAC
Ambulance Services	Certified ambulance supplier	MAC
Leg, Arm, Back, and Neck Braces	DME supplier	DME MAC
Artificial Legs, Arms, and Eyes	DME supplier	DME MAC
Services Furnished by Independent Laboratory	Certified laboratory (ASC can receive laboratory certification and a Clinical Laboratory Improvement Amendments number)	MAC
Facility Services for Surgical Procedures Excluded From the ASC List (listed in Addendum EE to the OPPS/ASC Final Rule with Comment Period)	Not covered by Medicare	Patient is liable

Services Not Included in ASC Payments

New Device Pass-Through Policies

- For FY 2017 3 Categories were available
- C2623: Catheter, transluminal angioplasty, drug-coated, non-laser)
- C2613: Lung biopsy plug with delivery system
- C1822: Generator, neurostimulator (implantable), high frequency, with rechargeable battery and charging system
- Billed with Status Indicator J7
  - OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced

Regulations From CMS

- Medical and surgical supplies that are not on pass-through status
- Equipment
- Surgical Dressings
- Implanted prosthetic devices not on pass-through status
- Splints, casts and other surgical related devices

Restated Drugs Effective 4/1/2017

HCPCS	Effective I	Payment
J1130	20170101	$0.16
J1566	20170101	$31.70
J9207	20170101	$76.32

Drugs, Biologicals and Radiopharmaceuticals

CY 2017 HCPCS Code	CY 2017 Long Descriptor	CY 2017 Short Descriptor	ASC PI
A9587	Gallium ga-68, dotatate, diagnostic, 0.1 millicurie	Gallium ga-68	K2
A9588	Fluciciovine f-18, diagnostic, 1 millicurie	Fluciclovine f-18	K2
C9140	Injection, Factor VIII (antihemophilic factor, recombinant) (Afstyla), 1 I.U.	Afstyla factor viii recomb	K2
J0570	Buprenorphine implant, 74.2 mg	Buprenorphine implant 74.2mg	K2
J7175	Injection, factor x, (human), 1 i.u.	Inj, factor x, (human), 1iu	K2
J7179	Injection, von willebrand factor (recombinant), (Vonvendi), 1 i.u. vwf:rco	Vonvendi inj 1 iu vwf:rco	K2
J9034	Injection, bendamustine hcl (Bendeka), 1 mg	Inj., bendeka 1 mg	K2

Biosimilar Biological Products

- ASC payment will be the same payment rate in OPPS and Physician office setting
- The proper modifier must be included on the claim form

HCPCS Code	Short Descriptor	Long Descriptor	ASC PI	FDA Approval Date	Modifier	Modifier Effective Date
Q5101	Inj filgrastim g-csf biosim	Injection, Filgrastim (G-CSF), Biosimilar, 1 microgram	K2	03/06/2015	ZA-Novartis/Sandoz	01/01/2016
Q5102	Inj., infliximab biosimilar	Injection, Infliximab, Biosimilar, 10 mg	K2	04/05/2016	ZB-Pfizer/Hospira	04/05/2016

Skin Substitutes

- The SI Indicator must appended for separately reportable skin substitutes

CY 2017 HCPCS Code	CY 2017 Short Descriptor	CY 2017 SI	Low/High Cost Skin Substitute
Q4103	Oasis Burn Matrix	N1	High
Q4104	Integra BMWD	N1	High
Q4105	Integra DRT	N1	High
Q4106	Dermagraft	N1	High
Q4172	PuraPly, PuraPly antimic	K2	High

ASCs and Commercial Payers

Carriers That Accept Revenue Codes for ASC Reimbursement

- Aetna
- United Health Care
- Blue Cross and Blue Shield
- Cigna

Commercial Payers

- Utilizing the correct combination of codes is key to claims processing
- Revenue codes and procedure codes must accurately reflect the diagnosis and services rendered
- The 3 digit subcategories for Revenue codes are included in the National Uniform Billing Committee (NUBC) *Official UB-04 Data Specifications Manual*
- Most commonly billed services in the Hospital Based ASC

Revenue Code	Description	Level of Code	Description
360	Operating room services	CPT	Use CPT code(s) that describe operating room services rendered.
481	Cardiology cardiac cath lab	CPT	Use CPT code(s) that describe cardiology services rendered.
490	Ambulatory surgical care	CPT	Use CPT code(s) that describe ambulatory surgical care rendered.

Commercial Payers

- Charges for supplies are part of the PRG and are not paid separately
- For hospital based ASC, the use of non-specific revenue codes for supplies, DME, prosthesis and implants indicate the revenue code that should be used for each type of supply utilized
- You must list the CPT or HCPCS code in form locator 44 of the UB-04 along with the revenue code listed in form locator 42

Acceptable Commercial Payer Revenue Codes for ASC Services

Revenue Code	Short Description	Used for	Processing
270	Med-sur supplies	General medical-surgical supplies (e.g., A4649, 99070)	General medical-surgical supplies are part of the PRG and will not be paid separately.
271	Non-ster supply	General medical supplies, nonsterile (e.g., A4649, 99070)	General medical-surgical supplies are part of the PRG and will not be paid separately.
272	Sterile supply	General medical supplies, sterile (e.g., A4927, A6257)	General medical-surgical supplies are part of the PRG and will not be paid separately.
274	Prosthetic/ Orthotic Devices	Prosthetic or orthotic devices (E.g., L1885, L3650)	For corresponding miscellaneous or recognized HCPCS codes that **have** a maximum allowable charge established, separate payment will be allowed based on the established maximum allowable charge. Separate payment will be allowed based on the eligible charge for the corresponding miscellaneous HCPCS code or recognized code **without** a maximum allowable charge established when the amount is $500 or greater. When a miscellaneous line charge is $10,000 or more, the claim must be accompanied by a manufacturer's invoice(s) supporting the cost of the miscellaneous items. The invoice must indicate which items were billed. Note: Eligible charges for items billed with miscellaneous codes or recognized HCPCS codes are subject to coinsurance or copayments and payment determination criteria as outlined in HMSA members' medical plan benefits.
275	Pacemaker	Pacemaker	
276	Intraocular Lens	Intraocular Lens	
278	Supply/implants	Other Implants, (e.g., L8500, L8600, L8699)	
290	Med equip/durab	DME (other than renal), general	
291	Med equip/rent	DME (other than renal), rental	
292	Med equip/new	DME (other than renal), purchase	

UB 04 Claim Example

42 Rev. Cd	43 Description	44 HCPCS/Rates	45 Serv. Date	46 Serv. Units	47 Total Charges	48 Non-Covered Charges	49
0250	PHARMACY-GENERAL		042617	2	16274	000	
0272	MEDICAL/SURGICAL SUPPLIE		042617	3	5157	000	
0360	OPERATING ROOM SERVICES-	64483RT	042617	1	164000	000	
0510	CLINIC-GENERAL CLASSIFIC	G046325	042617	1	62300	000	
0612	MAGNETIC RESONANCE TECHN	72148	042617	1	379400	000	
0636	PHARMACY-EXTENSION OF 02	Q9966	042617	50	30000	000	
0710	RECOVERY ROOM-GENERAL		042617	1	28500	000	

Covered Components of ASC Services

- Each APC is selected by using the appropriate CPT codes for each procedure and contains services that are bundled into the ASC fee
- CMS defines the following as a list included in the ASC fee:
  - Nursing services, technical personnel and other related services
  - The use by the patient of the ASC (pre-op, intra-op, post-op and OR equipment)
  - Drugs, Biologicals which separate payment is not allowed under OPPS
  - Surgical Dressings
  - Splints, casts and appliances
  - Diagnostic or therapeutic items and services
  - Blood, blood plasma, platelets, etc. Except for those to which the blood deductible applies
  - Intraocular lenses (IOL)
  - Radiology services which are not separately payable under OPPS and other diagnostic tests integral to the surgical procedure

2017 ASC Final Rule

2017 ASC Final Rule

- For CY 2017, CMS issued the final rule for increase of payment rates by 1.9%
- After the consideration of all policy changes to ASCs, the final ruling increased payments of $177 million for ASCs in CY 2017

Interventional Cardiology and Peripheral Interventions

- Interventional Cardiology procedures are not allowed in the ASC and therefore, no applicable changes apply
- Payment rates for Fem/Pop intervention are increased by 25% while other peripheral interventions remained the same pay rate
- 37246 and Add-on code 37247 are new codes for 2017
- They will be used to report arterial percutaneous transluminal angioplasty (PTA)
- 37248 and Add-on code 37249 are also new codes for 2017, they are also used to report venous PTA
- 36901-36909 are new codes for 2017 and will report diagnostic services and interventions within the dialysis circuit

Rhythm Management Services

- Rhythm Management Services
  - Ablation procedures are not allowed in the ASC and therefore no applicable changes apply
  - ICD/CRT-D system implants remained payable at $26,722.00
  - SICD system implant payment remained payable at $26,729.00
  - Single chamber pacemaker implants decreased 1.62% to a payable rate of $7,540.00
  - Dual chamber pacemaker implants payment rates increase 1.10% to a payable rate of $7,748.00
  - Single pacemaker replacement payment rates decreased 1.63% to a payable rate of %5,693.00
  - Dual chamber pacemaker replacement payments remained payable at $7,700.00

Rhythm Management Services

- Physician payment rates for single and dual pacemaker system implants decreased by a combined average range of $469-$543.00
- Defibrillator implantation physician payment decreased by 0.77% to a payable rate of $955.00
- S-ICD implant physician payment rates remained stable at a payment rate of $615.00
- Physician payment rates for ablation procedures for SVT, VT and AF decreased by an average of 0.43% for a payment range of $874.00-$1,174.00

2017 CY Variances in Reimbursement

CPT®	Abbreviated (Partial) Description	CY2017 Final Payment	CY2016 Final Payment	Variance 2017 Final vs. 2016 Final	
		$	$	$	%
Rhythm Management					
33206	Pacemaker - single chamber system, atrial lead	$7,587	$7,664	($77)	-1.00%
33207	Pacemaker - single chamber system, ventricular lead	$7,540	$7,664	($124)	-1.62%
33208	Pacemaker - dual chamber system implant	$7,748	$7,664	$84	1.10%
33240	Insertion of ICD / S-ICD pulse generator only with existing lead	$19,090	$19,581	($492)	-2.51%
33249	ICD system implant	$26,772	$26,658	$114	0.43%
33270	S-ICD system implant	$26,729	$26,658	$72	0.27%
33249 + 33225	CRT-D System implant (33249 & 33225 when performed on the same day)	$26,772	$26,658	$114	0.43%
33227	Pacemaker - single chamber replacement	$5,693	$5,787	($94)	-1.63%
33228	Pacemaker - dual chamber replacement	$7,700	$7,664	$36	0.48%
33229	Pacemaker - multiple lead replacement	$13,119	$12,616	$504	3.99%
33262	Defibrillator - single chamber replacement	$19,274	$19,581	($307)	-1.57%
33263	Defibrillator - dual chamber replacement	$19,473	$19,581	($108)	-0.55%
33264	Defibrillator - multiple lead replacement	$27,117	$26,658	$459	1.72%

Level 1 Pacemaker and Similar Procedures

5221	T	**Level1 Pacemaker and Similar Procedures** Repair single transvenous electrode (33218) Repair 2 transvenous electrodes (33220) Removal of transvenous pacemaker electrode - single (33234) Removal of transvenous pacemaker electrode - dual (33235) Removal of ICD pulse generator only (33241) Removal of ICD electrode(s) (33244) Removal of S-ICD electrode (33272) Repositioning of S-ICD electrode (33273)	$2,559	$2,490	$69	2.76%

33218		Repair lead pace-defib one	Y	G2	30.7522	$1,383.94
33220		Repair lead pace-defib dual	Y	G2	30.7522	$1,383.94
33224		Insert pacing lead & connect	Y	J8	171.5475	$7,720.15
33225		L ventricle pacing lead add-on	N	N1		
33241		Remove pulse generator	N	G2	30.7522	$1,383.94
33273		Repos prev impltbl subq dfb	Y	G2	30.7522	$1,383.94

Level 2 Pacemaker and Similar Procedures

5222	J1	**Level 2 Pacemaker and Similar Procedures** Insertion of single chamber pacemaker generator only (33212) Insertion of single transvenous electrode, pacemaker or ICD (33216) Insertion of 2 transvenous electrodes, pacemaker or ICD (33217) Single chamber pacemaker change out (33227) Removal of pacemaker generator only (33233) Insertion of S-ICD electrode (33271)	$6,974	$6,697	$277	4.13%

33212		Insert pulse gen sngl lead	Y	J8	126.1978	$5,679.28
33216		Insert 1 electrode pm-defib	Y	J8	115.8743	$5,214.69
33217		Insert 2 electrode pm-defib	Y	J8	121.4486	$5,465.55

Peripheral Interventions

Peripheral Interventions					
Iliac Artery Revascularization					
37220	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal angioplasty	$2,209	$2,288	($78)	-3.41%
37221	Revascularization, endovascular, open or percutaneous, iliac artery, unilateral, initial vessel; with transluminal stent placement(s), includes angioplasty within same vessel, when performed	$6,048	$5,984	$63	1.06%
37222	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal angioplasty (List separately in addition to code for primary procedure)	$0	$0	NA	NA
37223	Revascularization, endovascular, open or percutaneous, iliac artery, each additional ipsilateral iliac vessel; with transluminal stent placement(s), includes angioplasty within the same vessel, when performed (List separately in addition to code for primary procedure)	$0	$0	NA	NA

37220		Iliac revasc	Y	G2	49.1682	$2,212.72
37221		Iliac revasc w/stent	Y	J8	131.1948	$5,904.16
37222		Iliac revasc add-on	N	N1		
37223		Iliac revasc w/stent add-on	N	N1		

Additions to the List of ASC-Covered Surgical Procedures CY 2017

- The list of ASC covered surgical procedures saw the addition of 12 new codes related to spinal procedures

CPT Code	Long Descriptor	Final ASC Payment Indicator
20936	Autograft for spine surgery only (includes harvesting the graft); local (eg, ribs, spinous process, or laminar fragments) obtained from the same incision (List separately in addition to code for primary procedure)	N1
20937	Autograft for spine surgery only (includes harvesting the graft); morselized (through separate skin or fascial incision) (List separately in addition to code for primary procedure)	N1
20938	Autograft for spine surgery only (includes harvesting the graft); structural, biocortical or tricortical (through separate skin fascial incision)	N1
22552	Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy and decompression of spinal cord and/or nerve roots; cervical C2, each additional interspace (List separately in addition to code for separate procedure)	N1
22585	(Arthrodesis, anterior interbody, including disc space preparation, discectomy, osteophytectomy, and decompression of spinal cord and/or nerve roots; each additional interspace (List separately in addition to code for primary procedure))	N1
22840	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)	N1
22842	Posterior non-segmental instrumentation (eg, Harrington rod technique, pedicle fixation across 1 interspace, atlantoaxial transarticular screw fixation, sublaminar wiring at C1, facet screw fixation)	N1
22845	Anterior instrumentation; 2 to 3 vertebral segments	N1
22853	Insertion of interbody biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace (List separately in addition to code for primary procedure)	N1
22854	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh) with integral anterior instrumentation for device anchoring (eg, screws, flanges), when performed, to vertebral corpectomy(ies) (vertebral body resection, partial or complete) defect, in conjunction with interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	N1
22859	Insertion of intervertebral biomechanical device(s) (eg, synthetic cage, mesh, methylmethacrylate) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect (List separately in addition to code for primary procedure)	N1

Copy

2017 APC Changes

9 New Spine Codes for ASC in 2017

CPT CODE	DESCRIPTION
20936	Spine bone autograft local add-on
20937	Spine bone autograft morsel add-on
20938	Spine bone autograft structural add-on
22552	Additional neck spine fusion
22840	Posterior non-segmental instrumentation 1 interspace
22842	Posterior segmental instrumentation 3 to 6 vertebral columns
22845	Anterior instrumentation 2-3 vertebral segments
22853	Insertion of interbody biomechanical device(s) with integral anterior instrumentation for device anchoring when performed, to intervertebral disc space in conjunction with interbody arthrodesis, each interspace
22859	Insertion of intervertebral biomechanical device(s) to intervertebral disc space or vertebral body defect without interbody arthrodesis, each contiguous defect

Ambulatory Surgical Center Quality Reporting (ASCQR) Program

What Is ASCQR?

- A quality measure data reporting program
- Implemented by CMS for use in the ASC setting
- Exists to promote higher quality, more efficient healthcare for Medicare beneficiaries
- ASC's that meet program requirements during the calendar year receive full payment update for the coming year
- ASC's that do not participate and/or fail to meet requirements may receive a 2% reduction in payment update (much like PQRS counterpart)

Payment Determinations

- The CY 2017 payment determinations will be based on QDCs (Quality Data Codes) submitted on Medicare Fee-for-Service claims
- Dates are January 2015 through December 31,2015 that received at CMS no later than April 30, 2016
- The minimum threshold for reporting is at least 50% of Medicare claims meeting measure specifications

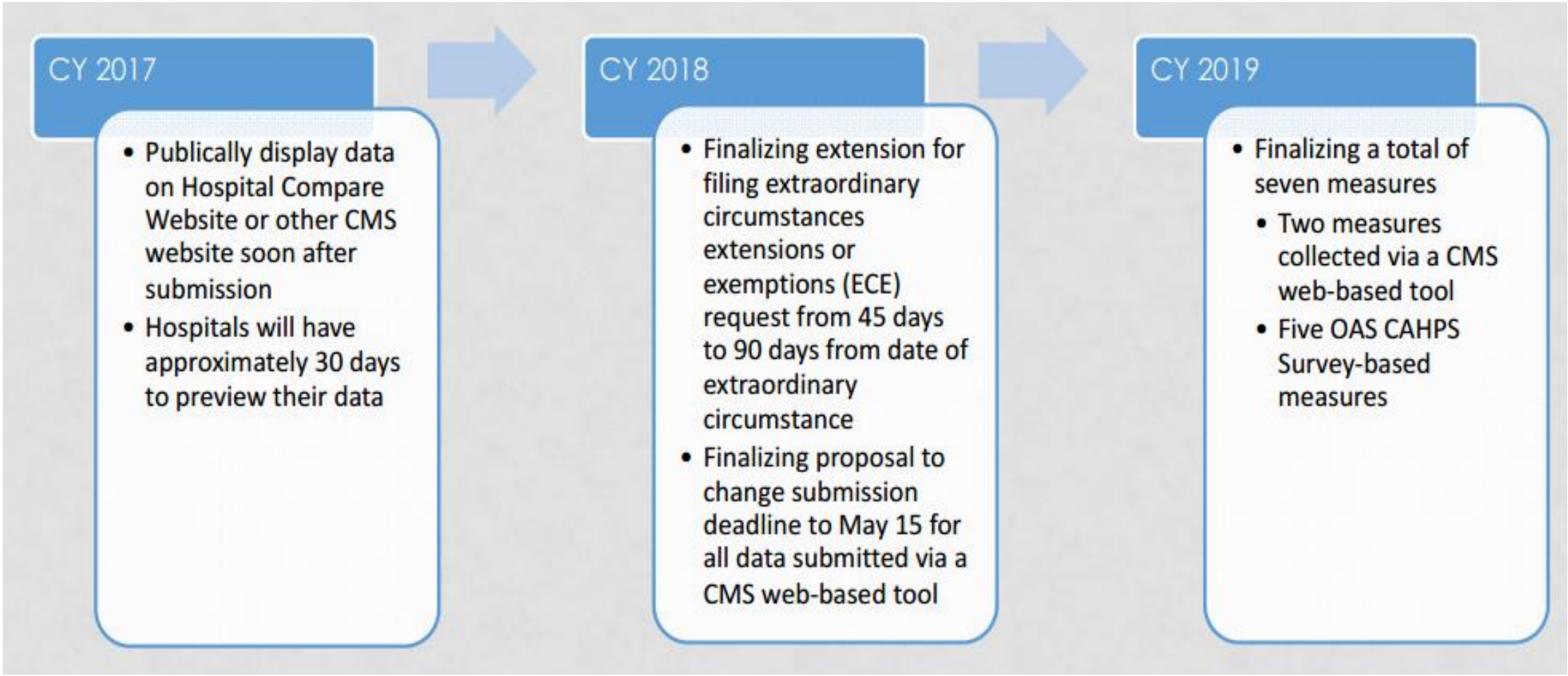
Measures

- QDCs are specified CPT or HCPCS (G-Codes) that are submitted to CMS
- Measures ASC-6, ASC-7, ASC-9 and ASC-10 are submitted to quality administrators
- Measure ASC-8 is reported to NHSN (National Healthcare Safety Network)
- Medicare claims that are submitted must have a minimum of 2 QDCs

ASCQR Measures 2017 and Beyond

ASC Measure	Description	Associated G-Code CPT Codes
ASC-1	Patient Burn	G8908-G8909
ASC-2	Patient Fall	G8910-G8911
ASC-3	Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	G8912-G8913
ASC-4	Hospital Transfer/Admission	G8914-G8915
ASC-5	Prophylactic Intravenous (IV) Antibiotic Timing	G8916-G8918
ASC-12	Facility Seven-Day Risk-Standardization Hospital Visit Rate after Outpatient Colonoscopy	
ASC-6	Safe Surgery Checklist Use	
ASC-7	ASC Facility Volume Data on Selected ASC Surgical Procedures	
ASC-8	Influenza Vaccination Coverage among Healthcare Personnel	
ASC-9	Endoscopy/Polyp Surveillance: Appropriate follow-up Interval for Normal Colonoscopy in Average Risk Patients	44388, 45378, G0121 Z12.11, Z83.71, Z86.010, Z80.0, Z85.038
ASC-10	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps	44388, 44389, 44392, 44394, 45378, 45380, 45381, 45384, 45385, G0105
ASC-11	Cataracts; Improvement in Patient Visual Function 90 days following Cataract Surgery	66840, 66850, 66852, 66920, 66930, 66940, 66982, 66983, 66984

Ambulatory Surgical Center Quality Reporting (ASCQR Program)



Questions?