

screening flexible sigmoidoscopy and screening colonoscopy services, the payment amounts must not exceed the payment rates established for the related diagnostic services.

(5) Section 1833(a)(1) of the Act requires 100 percent payment for preventive services described in section 1861(w)(2) of the Act (excluding electrocardiograms) to which the United States Preventive Services Task Force (USPSTF) has given a grade of A or B for any indication or population. Section 1833(b)(1) of the Act also specifies that the Part B deductible shall not apply with respect to preventive services described in section 1861(w)(2) of the Act (excluding electrocardiograms) to which the USPSTF has given a grade of A or B for any indication or population.

(b) *Scope.* This subpart sets forth—

(1) The scope of ASC services and the criteria for determining the covered surgical procedures for which Medicare provides payment for the associated facility services and covered ancillary services;

(2) The basis of payment for facility services and for covered ancillary services furnished in an ASC in connection with a covered surgical procedure;

(3) The methodologies by which Medicare determines payment amounts for ASC services.

[72 FR 42545, Aug. 2, 2007, as amended at 75 FR 72264, Nov. 24, 2010; 77 FR 68558, Nov. 15, 2012]

#### §416.161 Applicability of this subpart.

The provisions of this subpart apply to ASC services furnished on or after January 1, 2008.

#### §416.163 General rules.

(a) Payment is made under this subpart for ASC services specified in §§416.164(a) and (b) furnished to Medicare beneficiaries by a participating ASC in connection with covered surgical procedures as determined by the Secretary in accordance with §416.166.

(b) Payment for physicians' services and payment for anesthesiologists' services are made in accordance with part 414 of this subchapter.

(c) Payment for items and services other than physicians' and anesthesiologists' services, as specified in

§416.164(c), is made in accordance with §410.152 of this subchapter.

#### §416.164 Scope of ASC services.

(a) *Included facility services.* ASC services for which payment is packaged into the ASC payment for a covered surgical procedure under §416.166 include, but are not limited to—

(1) Nursing, technician, and related services;

(2) Use of the facility where the surgical procedures are performed;

(3) Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver;

(4) Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS), with the exception of non-opioid pain management drugs and biologicals that function as a supply when used in a surgical procedure as determined by CMS under §416.174;

(5) Medical and surgical supplies not on pass-through status under subpart G of part 419 of this subchapter;

(6) Equipment;

(7) Surgical dressings;

(8) Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status under subpart G of part 419 of this subchapter;

(9) Implanted DME and related accessories and supplies not on pass-through status under subpart G of part 419 of this subchapter;

(10) Splints and casts and related devices;

(11) 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, except certain diagnostic tests for which separate payment is allowed under the OPPS;

(12) Administrative, recordkeeping and housekeeping items and services;

(13) Materials, including supplies and equipment for the administration and monitoring of anesthesia; and

(14) Supervision of the services of an anesthesiologist by the operating surgeon.

(b) *Covered ancillary services.* Ancillary items and services that are integral to a covered surgical procedure, as