

§ 416.75

(i) A total of 90 minutes operating time; and

(ii) A total of 4 hours recovery or convalescent time.

(2) If the covered surgical procedures require anesthesia, the anesthesia must be—

(i) Local or regional anesthesia; or

(ii) General anesthesia of 90 minutes or less duration.

(3) Covered surgical procedures may not be of a type that—

(i) Generally result in extensive blood loss;

(ii) Require major or prolonged invasion of body cavities;

(iii) Directly involve major blood vessels; or

(iv) Are generally emergency or life-threatening in nature.

(c) *Publication of covered procedures.* CMS will publish in the FEDERAL REGISTER a list of covered surgical procedures and revisions as appropriate.

[47 FR 34094, Aug. 5, 1982, as amended at 71 FR 68226, Nov. 24, 2006]

§ 416.75 Performance of listed surgical procedures on an inpatient hospital basis.

The inclusion of any procedure as a covered surgical procedure under § 416.65 does not preclude its coverage in an inpatient hospital setting under Medicare.

§ 416.76 Applicability.

The provisions of this subpart apply to facility services furnished before January 1, 2008.

[71 FR 68226, Nov. 24, 2006]

Subpart E—Prospective Payment System for Facility Services Furnished Before January 1, 2008

§ 416.120 Basis for payment.

The basis for payment depends on where the services are furnished.

(a) *Hospital outpatient department.* Payment is in accordance with part 419 of this chapter.

(b) [Reserved]

(c) *ASC—(1) General rule.* Payment is based on a prospectively determined rate. This rate covers the cost of services such as supplies, nursing services,

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equipment, etc., as specified in § 416.61. The rate does not cover physician services or other medical services covered under part 410 of this chapter (for example, X-ray services or laboratory services) which are not directly related to the performance of the surgical procedures. Those services may be billed separately and paid on a reasonable charge basis.

(2) *Single and multiple surgical procedures.* (i) If one covered surgical procedure is furnished to a beneficiary in an operative session, payment is based on the prospectively determined rate for that procedure.

(ii) If more than one surgical procedure is furnished in a single operative session, payment is based on—

(A) The full rate for the procedure with the highest prospectively determined rate; and

(B) One half of the prospectively determined rate for each of the other procedures.

(3) *Deductibles and coinsurance.* Part B deductible and coinsurance amounts apply as specified in § 410.152 (a) and (i) of this chapter.

[56 FR 8844, Mar. 1, 1991; 56 FR 23022, May 20, 1991, as amended at 71 FR 68226, Nov. 24, 2006]

§ 416.121 Applicability.

The provisions of this subpart apply to facility services furnished before January 1, 2008.

[71 FR 68226, Nov. 24, 2006]

§ 416.125 ASC facility services payment rate.

(a) The payment rate is based on a prospectively determined standard overhead amount per procedure derived from an estimate of the costs incurred by ambulatory surgical centers generally in providing services furnished in connection with the performance of that procedure.

(b) The payment must be substantially less than would have been paid under the program if the procedure had been performed on an inpatient basis in a hospital.

(c) For services furnished on or after January 1, 2007, and before the effective date of implementation of a revised payment system, the ASC payment rate for a surgical procedure is the

lesser of the ASC payment rate established under paragraph (a) of this section or the prospective payment rate for the procedure established under §419.32 of this chapter. The lesser payment amount is determined prior to application of any geographic adjustment.

[56 FR 8844, Mar. 1, 1991, as amended at 71 FR 68226, Nov. 24, 2006]

§416.130 Publication of revised payment methodologies.

Whenever CMS proposes to revise the payment rate for ASCs, CMS publishes a notice in the FEDERAL REGISTER describing the revision. The notice also explains the basis on which the rates were established. After reviewing public comments, CMS publishes a notice establishing the rates authorized by this section. In setting these rates, CMS may adopt reasonable classifications of facilities and may establish different rates for different types of surgical procedures.

[47 FR 34094, Aug. 5, 1982, as amended at 56 FR 8844, Mar. 1, 1991]

§416.140 Surveys.

(a) *Timing, purpose, and procedures.* (1) No more often than once a year, CMS conducts a survey of a randomly selected sample of participating ASCs to collect data for analysis or reevaluation of payment rates.

(2) CMS notifies the selected ASCs by mail of their selection and of the form and content of the report the ASCs are required to submit within 60 days of the notice.

(3) If the facility does not submit an adequate report in response to CMS's survey request, CMS may terminate the agreement to participate in the Medicare program as an ASC.

(4) CMS may grant a 30-day postponement of the due date for the survey report if it determines that the facility has demonstrated good cause for the delay.

(b) *Requirements for ASCs.* ASCs must—

(1) Maintain adequate financial records, in the form and containing the data required by CMS, to allow determination of the payment rates for covered surgical procedures furnished to

Medicare beneficiaries under this subpart.

(2) Within 60 days of a request from CMS submit, in the form and detail as may be required by CMS, a report of—

(i) Their operations, including the allowable costs actually incurred for the period and the actual number and kinds of surgical procedures furnished during the period; and

(ii) Their customary charges for each surgical procedure furnished for the period.

[47 FR 34094, Aug. 5, 1982, as amended at 56 FR 8845, Mar. 1, 1991]

Subpart F—Coverage, Scope of ASC Services, and Prospective Payment System for ASC Services Furnished on or After January 1, 2008

SOURCE: 72 FR 42545, Aug. 2, 2007, unless otherwise noted.

§416.160 Basis and scope.

(a) *Statutory basis.* (1) Section 1833(i)(2)(D) of the Act requires the Secretary to implement a revised payment system for payment of surgical services furnished in ASCs. The statute requires that, in the year such system is implemented, the system shall be designed to result in the same amount of aggregate expenditures for such services as would be made if there was no requirement for a revised payment system. The revised payment system shall be implemented no earlier than January 1, 2006, and no later than January 1, 2008. The statute provides that the Secretary may implement a reduction in any annual update for failure to report on quality measures as specified by the Secretary. The statute also requires that, for CY 2011 and each subsequent year, any annual update to the ASC payment system, after application of any reduction in the annual update for failure to report on quality measures as specified by the Secretary, be reduced by a productivity adjustment. There shall be no administrative or judicial review under section 1869 of the Act, section 1878 of the Act, or otherwise of the classification system, the relative weights, payment amounts,