

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 anesthetist by the operating surgeon.

(b) *Covered ancillary services.* Ancillary items and services that are integral to a covered surgical procedure, as defined in §416.166, and for which separate payment is allowed include:

(1) Brachytherapy sources;

(2) Certain implantable items that have pass-through status under the OPPS;

(3) Certain items and services that CMS designates as contractor-priced, including, but not limited to, the acquisition or procurement of corneal tissue for corneal transplant procedures;

(4) Certain drugs and biologicals for which separate payment is allowed under the OPPS;

(5) Certain radiology services and certain diagnostic tests for which separate payment is allowed under the OPPS; and

(6) 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.

(c) *Excluded services.* ASC services do not include items and services outside the scope of ASC services for which payment may be made under part 414 of this subchapter in accordance with §410.152, including, but not limited to—

(1) Physicians' services (including surgical procedures and all pre-operative and postoperative services that are performed by a physician);

(2) Anesthetists' services;

(3) Radiology services (other than those integral to performance of a covered surgical procedure);

(4) Diagnostic procedures (other than those directly related to performance of a covered surgical procedure);

(5) Ambulance services;

(6) Leg, arm, back, and neck braces other than those that serve the function of a cast or splint;

(7) Artificial limbs;

(8) Nonimplantable prosthetic devices and DME.

[72 FR 42545, Aug. 2, 2007, as amended at 79 FR 67030, Nov. 10, 2014; 80 FR 70604, Nov. 13, 2015; 83 FR 59178, Nov. 21, 2018; 86 FR 63992, Nov. 16, 2021]

#### §416.166 Covered surgical procedures.

(a) *Covered surgical procedures.* Effective for services furnished on or after January 1, 2022, covered surgical procedures are those procedures that meet the general standards described in paragraph (b) of this section (whether commonly furnished in an ASC or a physician's office) and are not excluded under paragraph (c) of this section.

(b) *General standards.* Subject to the exclusions in paragraph (c) of this section, covered surgical procedures are surgical procedures specified by the Secretary and published in the FEDERAL REGISTER and/or via the internet on the CMS website that are separately paid under the OPPS, that would not be expected to pose a significant safety risk to a Medicare beneficiary when performed in an ASC, and for which standard medical practice dictates that the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure.

(c) *General exclusions.* Notwithstanding paragraph (b) of this section, covered surgical procedures do not include those surgical procedures that —