

(1) The actual charge for the service; or

(2) The geographically adjusted payment rate determined under this subpart.

(c) *Geographic adjustment*—(1) *General rule.* Except as provided in paragraph (c)(2) of this section, the national ASC payment rates established under §416.171 for covered surgical procedures are adjusted for variations in ASC labor costs across geographic areas using wage index values, labor and nonlabor percentages, and localities specified by the Secretary.

(2) *Exception.* The geographic adjustment is not applied to the payment rates set for drugs, biologicals, devices with OPPS transitional pass-through payment status, and brachytherapy sources.

(d) *Deductibles and coinsurance.* Part B deductible and coinsurance amounts apply as specified in §§410.152(a) and (i)(2) and 489.30(b)(6) of this chapter.

(e) *Payment reductions for multiple surgical procedures*—(1) *General rule.* Except as provided in paragraph (e)(2) of this section, when more than one covered surgical procedure for which payment is made under the ASC payment system is performed during an operative session, the Medicare program payment amount and the beneficiary coinsurance amount are based on—

(i) 100 percent of the applicable ASC payment amount for the procedure with the highest national unadjusted ASC payment rate; and

(ii) 50 percent of the applicable ASC payment amount for all other covered surgical procedures.

(2) *Exception: Procedures not subject to multiple procedure discounting.* CMS may apply any policies or procedures used with respect to multiple procedures under the prospective payment system for hospital outpatient department services under Part 419 of this subchapter as may be consistent with the equitable and efficient administration of this part.

(f) *Interrupted procedures.* (1) Subject to the provisions of paragraph (f)(2) of this section, when a covered surgical procedure or covered ancillary service is terminated prior to completion due to extenuating circumstances or circumstances that threaten the well-

being of the patient, the Medicare program payment amount and the beneficiary coinsurance amount are based on one of the following:

(i) The full program and beneficiary coinsurance amounts if the procedure for which anesthesia is planned is discontinued after the induction of anesthesia or after the procedure is started;

(ii) One-half of the full program and beneficiary coinsurance amounts if the procedure for which anesthesia is planned is discontinued after the patient is prepared for surgery and taken to the room where the procedure is to be performed but before the anesthesia is induced; or

(iii) One-half of the full program and beneficiary coinsurance amounts if a covered surgical procedure or covered ancillary service for which anesthesia is not planned is discontinued after the patient is prepared and taken to the room where the service is to be provided.

(2) Beginning CY 2016, if the covered surgical procedure is a device-intensive procedure, the full device portion of the ASC device-intensive procedure is removed prior to determining the Medicare program payment amount and the beneficiary coinsurance amount identified in paragraph (f)(1)(ii) of this section.

(g) *Payment adjustment for new technology intraocular lenses (NTIOLs).* A payment adjustment will be made for insertion of an IOL approved as belonging to a class of NTIOLs as defined in subpart G.

(h) *Special payment for certain code combinations*—(1) *Eligibility.* A code combination is eligible for the payment specified in paragraph (h)(2) of this section if the code combination is—

(i) Eligible for a comprehensive APC (C-APC) complexity adjustment under the OPPS; and

(ii) Comprised of a separately payable surgical procedure, that is listed on the ASC Covered Procedures list (§416.166), and one or more packaged add-on codes that are listed on the ASC covered procedures or ancillary services lists (§416.164(b)).

(2) *Calculation of payment.* (i) Except as specified in paragraph (h)(2)(ii) of