CMS Manual System

Pub. 100-20 One-Time Notification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 42 **Date: JANUARY 16, 2004**

CHANGE REQUEST 2979

I. SUMMARY OF CHANGES: This transmittal notifies carriers to pay ASCs a facility fee for HCPCS code G0260. It also notifies carriers to add CPT code 27096 to the file of approved ASC procedures effective July 1, 2003.

NEW/REVISED MATERIAL - EFFECTIVE DATE: July 1, 2003
***IMPLEMENTATION DATE: February 2, 2004**

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N/A	

III. FUNDING: *Medicare contractors only:

These instructions should be implemented within your current operating budget.

IV. ATTACHMENTS:

	Business Requirements
	Manual Instruction
	Confidential Requirements
X	**One-Time Notification**

One-Time Notification

Pub. 100-20	Transmittal: 42	Date: January 16, 2004	Change Request 2979

SUBJECT: Payment to Ambulatory Surgical Centers (ASCs) for G0260 and to Physicians for 27096 When 27096 is Performed in an ASC

I. GENERAL INFORMATION

A. Background: CMS published a Final Rule in the Federal Register on March 28, 2003 (CMS-1885-FC) to update the list of Medicare approved ASC procedures effective for services furnished on or after July 1, 2003. HCPCS code G0260, sacroiliac joint injection of anesthetic agents or steroids, was added to the ASC list. CR 2574 issued February 28, 2003 provided instructions regarding implementation of the updated ASC list.

CMS has recently become aware that some carriers are not paying the ASC facility fee for G0260 when performed in an ASC. Since G0260 was added to the list of Medicare approved ASC procedures for services furnished on or after July 1, 2003, carriers need to make sure G0260 is added to their list of ASC approved procedures.

CMS has also become aware that, because of several inadvertent coding conflicts, physicians are being paid incorrectly when they perform CPT code 27096 in an ASC. Medicare payment for physicians' services may differ, depending upon whether the service is furnished in a facility such as a hospital or ASC or in an office or physician clinic setting. Place of service code (POS) is used to identify where the procedure is furnished. When a physician bills for a service performed in an ASC, the carrier must review the HCPCS code against the list of procedures approved for ASCs. If the HCPCS code is not on the ASC list, carriers pay physicians the non-facility rate under the Medicare Physicans' Fee Schedule (MPFS). If the HCPCS code is on the ASC list, carriers pay physicians the facility rate under the MPFS.

B. Policy: HCPCS code G0260 is not payable under the Medicare Physician Fee Schedule. Rather, physicians use HCPCS code 27096 to bill for sacroiliac joint injection of anesthetic agents or steroids.

HCPCS code 27096, Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid, is not on the list of Medicare approved ASC procedures because ASCs are to report HCPCS code G0260 when a therapeutic sacroiliac joint injection is administered to a beneficiary in an ASC.

Because HCPCS code 27096 is not on the list of ASC approved procedures, under current Medicare physician fee schedule rules, carriers would pay the non-facility rate for HCPCS code 27096 when performed in an ASC. However, this results in an overpayment for the service because the ASC is also paid for facility services furnished

in connection with a sacroiliac joint injection of anesthetic agents or steroids under HCPCS code G0260.

Therefore, we are instructing carriers to add CPT code 27096 to their file of ASC approved procedures, to ensure that claims from physicians that perform 27096 in an ASC are paid the lower "facility rate" under the Medicare physician fee schedule.

C. Provider Education: No provider education is required; this is strictly a business requirement for carriers to correct an error in claims processing files.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement #	Requirements	Responsibility
2979.1	Carriers shall take action to ensure they pay a facility fee to ASCs for HCPCS code G0260 billed for services furnished on or after July 1, 2003.	Carriers
2979.2	Carriers shall pay HCPCS code 27096 for physician claims at the facility rate when HCPCS code 27096 is billed and place of service (POS) = 24 (ASC).	Carriers
2979.3	Carriers shall not search and adjust claims that have already been processed unless brought to their attention.	Carriers

III. SUPPORTING INFORMATION & POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: July 1, 2003 **Implementation Date: February 2, 2004** **Pre-Implementation Contact(s):** **Yvette Cousar at (410)786-2160 for Part B claims processing** **Chuck Braver at (410) 786-6719 for coding and/or payment issues** **Post-Implementation Contact(s): Appropriate regional office**	**These instructions should be implemented within your current operating budget.**