- Reason for termination of surgery;
- Services actually performed;
- Supplies actually provided;
- Services not performed that would have been performed if surgery had not been terminated;
- Supplies not provided that would have been provided if the surgery had not been terminated;
- Time actually spent in each stage, e.g., pre-operative, operative, and post-operative;
- Time that would have been spent in each of these stages if the surgery had not been terminated; and
- HCPCS code for procedure had the surgery been performed.

D. Prior to January 1, 2008, carriers deduct the allowance for an unused IOL prior to calculating payment for a terminated IOL insertion procedure.

E. Beginning January 1, 2008, payment for the IOL is included in payment for the surgical procedure to implant the lens.

F. Beginning January 1, 2008, contractors apply a 50 percent payment reduction for discontinued radiology procedures and other procedures that do not require anesthesia. Facilities use the -52 modifier to indicate the discontinuance of these applicable procedures.

G. Beginning January 1, 2008, ASC surgical services billed with the -52 or- 73 modifier are not subject to the multiple procedure discount.

40.5 - Payment for Multiple Procedures

(Rev. 1514; Issued: 05-23-08; Effective: 01-01-08; Implementation: 06-23-08)

When more than one surgical procedure is performed in the same operative session, special payment rules apply, even if the procedures have the same HCPCS code.

When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, contractors pay 100 percent of the highest paying surgical procedure on the claim, plus 50 percent of the applicable payment rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session. The OPPS/ASC final rule for the relevant payment year specifies whether or not a surgical procedure is subject to multiple procedure discounting for that year. Final payment is subject to the usual copayment and deductible provisions.

The multiple procedure payment reduction is the last pricing routine applied to applicable ASC procedure codes. In determining the ranking of procedures for application of the multiple procedure reduction, contractors shall use the lower of the billed charge or the

ASC payment amount. The ASC surgical services billed with modifier -73 and -52 shall not be subjected to further pricing reductions. (i.e., the multiple procedure price reduction rules do not apply). Payment for an ASC surgical procedure billed with modifier -74 may be subject to the multiple procedure discount if that surgical procedure is subject to the multiple procedure discount.

A procedure performed bilaterally in one operative session is reported as two procedures, either as a single unit on two separate lines or with "2" in the units field on one line. The multiple procedure reduction of 50 percent applies to all bilateral procedures subject to multiple procedure discounting. For example, if lavage by cannulation; maxillary sinus (antrum puncture by natural ostium) (CPT code 31020) is performed bilaterally in one operative session, report 31020 on two separate lines or with "2" in the units field. Depending on whether the claim includes other services to which the multiple procedure discount applies, the contractor applies the multiple procedure reduction of 50 percent to the payment for at least one of the CPT code 31020 payment rates.

40.6 - Payment for Extracorporeal Shock Wave Lithotripsy (ESWL)

(Rev. 1514; Issued: 05-23-08; Effective: 01-01-08; Implementation: 06-23-08)

A ninth ASC payment group was established in a "Federal Register" notice (56 FR 67666) published December 31, 1991. The ninth payment group amount ($1,150) was assigned to only one procedure, CPT code 50590, extracorporeal shock wave lithotripsy (ESWL). However, a court order issued March 12, 1992, has stayed the Group 9 payment rate until the Secretary publishes all information relevant to the setting of the ESWL rate, receives comments, and publishes a subsequent final notice. This has not yet been completed.

In a previous instruction (Medicare Carrier's Manual Transmittal 1435), CMS advised carriers to make payment to ASCs for ESWL services furnished after January 29, 1992, and through the date when the ASC received notice from the carrier of the court order staying the Group 9 payment rate. This was a temporary measure to avoid penalizing ASCs that furnished ESWL services in accordance with the December 31, 1991, "Federal Register" notice and that could not have been expected to know that the March 12, 1992, court order set aside the ESWL provisions of that notice. Carriers did not make Medicare payment for ESWL as an ASC procedure when such services were furnished after the date that the carrier advised an ASC of the court order.

However carriers were instructed to retain all ASC claims for ESWL with a service date after January 29, 1992, and before the date when they were notified about the court order. It may be necessary to retrieve these clams for further action at some later date.

Beginning January 1, 2008 with the revised ASC payment system, contractors may pay for any of the ESWL services that are included on the ASC list of covered surgical procedures.