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Medicare Permits Ambulatory Surgical Centers to Submit Claims for Services of Physicians and Practitioners

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A recent revision to the Medicare Program Integrity Manual (MPIM) states that physicians and non-physician practitioners may reassign benefits to an ambulatory surgical center (ASC), if the arrangement complies with a pertinent exception to the prohibition against reassignment. **Transmittal 291, Reassignment and Ambulatory Surgical Centers (ASCs), Change Request 6470, June 12, 2009**. This change should require Medicare contractors to permit ASCs to bill Medicare for surgical procedures and anatomic pathology procedures performed by physicians, and for administration of anesthesia by physicians and certified registered nurse anesthetists (CRNAs).

The particular reassignment exceptions referred to in the MPIM revision are those permitting services performed by employees to be billed by the individual's employer, and permitting services furnished by physicians and other individuals under certain contractual arrangements (independent contractors) to be billed by the entity contracting for their services.

The MPIM states that an ASC does need not to separately enroll in Medicare as a group practice in order to receive reassigned payments. In the case of an ASC which is already enrolled in Medicare, the individual physician or non-physician practitioner furnishing the service and a representative of the ASC must sign and submit a CMS-855R to the Medicare contractor, providing for reassignment of benefits to the ASC.

Ober|Kaler's Comments: In recent years, ASCs have been increasingly interested in arrangements for the provision of anesthesia services that are different from the traditional model under which an independent anesthesiologist or CRNA provided and billed for administration of anesthesia. These alternative arrangements may raise complex legal issues under the Federal Anti-Kickback Statute (FAS) and state laws, including state kickback and self-referral prohibitions, particularly where the source of the anesthesia referral profits directly or indirectly from the anesthesiologist's or CRNA's

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The MPIM revision should facilitate an ASC's submission of Medicare claims for anesthesia services. However, it does not resolve other legal issues related to such arrangements, which will continue to require close attention. Arrangements related to an ASC's submission of claims for anatomic pathology services raise additional issues under the Medicare anti-markup rule that is applicable to diagnostic services, and direct billing requirements that may be part of state law.

Finally, ASCs should not assume that a private third-party payer will follow the new Medicare policy. Before an ASC implements an arrangement providing for its submission of claims for services of physicians and non-physician practitioners, it should confirm that private payers will pay the ASC for those services on the same basis as they would pay a physician or non-physician practitioner.