

Centers for Medicare & Medicaid Services, HHS

§416.1

(4) No payment is made for services of a “teaching physician” associated with moonlighting services, and the time spent furnishing these services is not included in the teaching hospital’s full-time equivalency count for the indirect GME payment (§412.105 of this chapter) and for the direct GME payment (§413.86 of this chapter).

(c) *Other settings.* Moonlighting services of a licensed resident in an approved GME program furnished outside the scope of that program in a hospital or other setting that does not participate in the approved GME program are payable under the physician fee schedule as set forth in §415.206(b)(1).

PART 416—AMBULATORY SURGICAL SERVICES

Subpart A—General Provisions and Definitions

Sec.

- 416.1 Basis and scope.
- 416.2 Definitions.

Subpart B—General Conditions and Requirements

- 416.25 Basic requirements.
- 416.26 Qualifying for an agreement.
- 416.30 Terms of agreement with CMS.
- 416.35 Termination of agreement.

Subpart C—Specific Conditions for Coverage

- 416.40 Condition for coverage—Compliance with State licensure law.
- 416.41 Condition for coverage—Governing body and management.
- 416.42 Condition for coverage—Surgical services.
- 416.43 Condition for coverage—Evaluation of quality.
- 416.44 Condition for coverage—Environment.
- 416.45 Condition for coverage—Medical staff.
- 416.46 Condition for coverage—Nursing services.
- 416.47 Condition for coverage—Medical records.
- 416.48 Condition for coverage—Pharmaceutical services.
- 416.49 Condition for coverage—Laboratory and radiologic services.

Subpart D—Scope of Benefits

- 416.60 General rules.
- 416.61 Scope of facility services.

- 416.65 Covered surgical procedures.
- 416.75 Performance of listed surgical procedures on an inpatient hospital basis.

Subpart E—Payment for Facility Services

- 416.120 Basis for payment.
- 416.125 ASC facility services payment rate.
- 416.130 Publication of revised payment methodologies.
- 416.140 Surveys.
- 416.150 Beneficiary appeals.

Subpart F—Adjustment in Payment Amounts for New Technology Intraocular Lenses Furnished by Ambulatory Surgical Centers

- 416.180 Definitions.
- 416.185 Payment review process.
- 416.190 Who may request a review.
- 416.195 A request to review.
- 416.200 Application of the payment adjustment.

AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

SOURCE: 47 FR 34094, Aug. 5, 1982, unless otherwise noted.

Subpart A—General Provisions and Definitions

§416.1 Basis and scope.

(a) *Statutory basis.* (1) Section 1832(a)(2)(F)(i) of the Act provides for Medicare Part B coverage of facility services furnished in connection with surgical procedures specified by the Secretary under section 1833(i)(1) of the Act.

(2) Section 1833(i)(1)(A) of the Act requires the Secretary to specify the surgical procedures that can be performed safely on an ambulatory basis in an ambulatory surgical center, or a hospital outpatient department.

(3) Section 1833(i)(2)(A) and (3) specify the amounts to be paid for facility services furnished in connection with the specified surgical procedures when they are performed, respectively, in an ASC, or in a hospital outpatient department.

(b) *Scope.* This part sets forth—

- (1) The conditions that an ASC must meet in order to participate in the Medicare program;
- (2) The scope of covered services; and

§ 416.2

(3) The conditions for Medicare payment for facility services.

[56 FR 8843, Mar. 1, 1991; 56 FR 23022, May 20, 1991]

§ 416.2 Definitions.

As used in this part:

Ambulatory surgical center or *ASC* means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, has an agreement with CMS to participate in Medicare as an ASC, and meets the conditions set forth in subparts B and C of this part.

ASC services means facility services that are furnished in an ASC.

Covered surgical procedures means those surgical and other medical procedures that meet the criteria specified in § 416.65 and are published by CMS in the FEDERAL REGISTER.

Facility services means services that are furnished in connection with covered surgical procedures performed in an ASC, or in a hospital on an out-patient basis.

[56 FR 8843, Mar. 1, 1991; 56 FR 23022, May 20, 1991]

Subpart B—General Conditions and Requirements

§ 416.25 Basic requirements.

Participation as an ASC is limited to facilities that—

- (a) Meet the definition in § 416.2; and
- (b) Have in effect an agreement obtained in accordance with this subpart.

[56 FR 8843, Mar. 1, 1991]

§ 416.26 Qualifying for an agreement.

(a) *Deemed compliance.* CMS may deem an ASC to be in compliance with any or all of the conditions set forth in subpart C of this part if—

(1) The ASC is accredited by a national accrediting body, or licensed by a State agency, that CMS determines provides reasonable assurance that the conditions are met;

(2) In the case of deemed status through accreditation by a national accrediting body, where State law requires licensure, the ASC complies with State licensure requirements; and

42 CFR Ch. IV (10–1–03 Edition)

(3) The ASC authorizes the release to CMS, of the findings of the accreditation survey.

(b) *Survey of ASCs.* (1) Unless CMS deems the ASC to be in compliance with the conditions set forth in subpart C of this part, the State survey agency must survey the facility to ascertain compliance with those conditions, and report its findings to CMS.

(2) CMS surveys deemed ASCs on a sample basis as part of CMS's validation process.

(c) *Acceptance of the ASC as qualified to furnish ambulatory surgical services.* If CMS determines, after reviewing the survey agency recommendation and other evidence relating to the qualification of the ASC, that the facility meets the requirements of this part, it sends to the ASC—

(1) Written notice of the determination; and

(2) Two copies of the ASC agreement.

(d) *Filing of agreement by the ASC.* If the ASC wishes to participate in the program, it must—

(1) Have both copies of the ASC agreement signed by its authorized representative; and

(2) File them with CMS.

(e) *Acceptance by CMS.* If CMS accepts the agreement filed by the ASC, returns to the ASC one copy of the agreement, with a notice of acceptance specifying the effective date.

(f) *Appeal rights.* If CMS refuses to enter into an agreement or if CMS terminates an agreement, the ASC is entitled to a hearing in accordance with part 498 of this chapter.

[56 FR 8843, Mar. 1, 1991]

§ 416.30 Terms of agreement with CMS.

As part of the agreement under § 416.26 the ASC must agree to the following:

(a) *Compliance with coverage conditions.* The ASC agrees to meet the conditions for coverage specified in subpart C of this part and to report promptly to CMS any failure to do so.

(b) *Limitation on charges to beneficiaries.*¹ The ASC agrees to charge

¹For facility services furnished before July 1987, the ASC had to agree to make no charge to the beneficiary, since those services were