

## § 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.*<sup>1</sup> The ASC agrees to charge

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

the beneficiary or any other person only the applicable deductible and co-insurance amounts for facility services for which the beneficiary—

(1) Is entitled to have payment made on his or her behalf under this part; or

(2) Would have been so entitled if the ASC had filed a request for payment in accordance with § 410.165 of this chapter.

(c) *Refunds to beneficiaries.* (1) The ASC agrees to refund as promptly as possible any money incorrectly collected from beneficiaries or from someone on their behalf.

(2) As used in this section, *money incorrectly collected* means sums collected in excess of those specified in paragraph (b) of this section. It includes amounts collected for a period of time when the beneficiary was believed not to be entitled to Medicare benefits if—

(i) The beneficiary is later determined to have been entitled to Medicare benefits; and

(ii) The beneficiary's entitlement period falls within the time the ASC's agreement with CMS is in effect.

(d) *Furnishing information.* The ASC agrees to furnish to CMS, if requested, information necessary to establish payment rates specified in §§ 416.120–416.130 in the form and manner that CMS requires.

(e) *Acceptance of assignment.* The ASC agrees to accept assignment for all facility services furnished in connection with covered surgical procedures. For purposes of this section, assignment means an assignment under § 424.55 of this chapter of the right to receive payment under Medicare Part B and payment under § 424.64 of this chapter (when an individual dies before assigning the claim).

(f) *ASCs operated by a hospital.* In an ASC operated by a hospital—

(1) The agreement is made effective on the first day of the next Medicare cost reporting period of the hospital that operates the ASC; and

(2) The ASC participates and is paid only as an ASC, without the option of converting to or being paid as a hospital outpatient department, unless

not subject to the part B deductible and co-insurance provisions.

CMS determines there is good cause to do otherwise.

(3) Costs for the ASC are treated as a non-reimbursable cost center on the hospital's cost report.

(g) *Additional provisions.* The agreement may contain any additional provisions that CMS finds necessary or desirable for the efficient and effective administration of the Medicare program.

[47 FR 34094, Aug. 5, 1982, as amended at 51 FR 41351, Nov. 14, 1986; 56 FR 8844, Mar. 1, 1991]

#### § 416.35 Termination of agreement.

(a) *Termination by the ASC—(1) Notice to CMS.* An ASC that wishes to terminate its agreement must send CMS written notice of its intent.

(2) *Date of termination.* The notice may state the intended date of termination which must be the first day of a calendar month.

(i) If the notice does not specify a date, or the date is not acceptable to CMS, CMS may set a date that will not be more than 6 months from the date on the ASC's notice of intent.

(ii) CMS may accept a termination date that is less than 6 months after the date on the ASC's notice if it determines that to do so would not unduly disrupt services to the community or otherwise interfere with the effective and efficient administration of the Medicare program.

(3) *Voluntary termination.* If an ASC ceases to furnish services to the community, that shall be deemed to be a voluntary termination of the agreement by the ASC, effective on the last day of business with Medicare beneficiaries.

(b) *Termination by CMS—(1) Cause for termination.* CMS may terminate an agreement if it determines that the ASC—

(i) No longer meets the conditions for coverage as specified under § 416.26; or

(ii) Is not in substantial compliance with the provisions of the agreement, the requirements of this subpart, and other applicable regulations of subchapter B of this chapter, or any applicable provisions of title XVIII of the Act.

(2) *Notice of termination.* CMS sends notice of termination to the ASC at