CfC (Conditions for Coverage)

UPDATE: 2/11/2010

Clarification on H&P Requirement Prior To ASC Procedure (Angela Mason-Elbert of CMS:

"Each patient that is seen in an ASC must have a comprehensive medical history and physical assessment (H&P) not more than 30 days before the date of the scheduled surgery. The H&P is to determine if the patient has any underlying conditions that would put the patient at risk for having such a procedure or to identify any new or existing co-morbid conditions that would require additional interventions. Additionally, the H&P could provide evidence that the ASC is not the appropriate setting for this particular procedure. The H&P, as long as it is comprehensive, can be completed the day prior to the procedure and even on the day of the procedure. It does not have to be completed prior to scheduling the procedure."

UPDATE 5/18/2009

Medicare announced that it will allow an exception for the patient notices required in advance of the day of the procedure in certain cases. Specifically, the Centers for Medicare and Medicaid Services (CMS) said:

It is not acceptable for the ASC to provide the required notice for the first time to a patient on the day that the surgical procedure is scheduled to occur, unless:

- the referral to the ASC for surgery is made on that same date; and
- the referring physician indicates, in writing, that it is medically necessary for the patient to have the surgery on the same day, and that

surgery in an ASC setting is suitable for that patient.

In such situations the ASC must provide the required notice prior to obtaining the patient's informed consent. Cases of surgery occurring on the same day it is scheduled are expected to be rare, since ASCs typically perform elective procedures. Frequent occurrence of such cases may represent noncompliance with the advance notice requirement.

This information and new interpretive guidelines are available at www.ascassociation.org/coverage. As the ASC Association analyzes these guidelines more information will be available on the web site.

(Finalized October 30, 2008)

The OPPS/ASC (Outpatient Prospective Payment System for Ambulatory Surgery Centers) final rule modernizes **Medicare's ASC Conditions for Coverage (CfC)**. The rule reflects current ASC practice by focusing on the care provided to patients and th impact of that care on patient outcomes. Specifically, the new CfCs:

- Define an ASC as a distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following admission.
- Strengthen Patients' rights regarding disclosure of physician financial interests in the ASC; advance directives; the grievance process; and confidentiality of clinical records.
- Impose stronger obligations on the governing body of an ASC to oversee its quality assessment and performance improvement (QAPI) program, while allowing ASCs flexibility to use their own information to assess and improve patient services, outcomes, and satisfaction.

- Emphasize the importance of infection control practices.
- Strengthen the requirements for assessing the patient’s condition at admission to verify that the surgery is appropriate and safe for the patient in an ASC setting, and at discharge to ensure appropriate post-surgical care for the patient.
- Require the ASC to adopt a disaster preparedness plan.