Reimbursement Policy

Free Standing Surgical Facility Services

Policy Number: 4.114
Version Number: 5
Version Effective Date: 04/01/2016

Product Applicability

- All Plan Products

Well Sense Health Plan
- New Hampshire Medicaid
- NH Health Protection Program

Boston Medical Center HealthNet Plan
- MassHealth
- Qualified Health Plans/ConnectorCare/Employer Choice Direct
- Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan reimburses covered services based on the provider’s contractual rates with the Plan and the terms of reimbursement identified within this policy. Reimbursement for a surgical procedure performed at a surgical center consists of two components, a facility component and a professional component. This policy defines the reimbursement terms applicable to the facility only. For professional reimbursement terms, please reference the Plan’s Physician and Non-Physician Practitioner Services reimbursement policy, 4.608.

Prior-Authorization

Please refer to the Plan’s Prior Authorization Requirements Matrix at www.bmchp.org.
Definitions

Freestanding Ambulatory Surgery Center – A facility, geographically independent of any other health-care facility, that operates autonomously and functions exclusively for the purpose of providing outpatient same-day surgical, diagnostic, and medical services requiring a dedicated operating room and postoperative recovery room. Such services provide diagnosis or treatment through operative procedures requiring general, local or regional anesthesia and must be furnished to patients who do not require hospitalization or overnight services upon completion of the procedure, but who require constant medical supervision for a limited amount of time following the conclusion of the procedure. A freestanding ambulatory surgery center does not include individual or group-practice offices of private physicians, dentists or podiatrists and does not include any clinic devoted exclusively to the performance of any single surgical procedure or specialty.

Provider Reimbursement

Services and Supplies Included in Facility Reimbursement Rates
Rates of payment for freestanding ambulatory surgery center facility services shall be the lower of the provider’s charges, or the provider’s contractual agreement with the Plan, based on the payment assigned to the procedure. The facility component is an all-inclusive fee that includes all rent, equipment, utilities, supplies, and other overhead expenses. This fee also includes, but may not be limited to:

- Surgical center facilities and equipment
- Nursing services, technical services and other related services
- Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment directly related to the provision of the surgical procedures
- Administrative, recordkeeping and housekeeping items and services
- Materials for anesthesia
- Blood
- Urinalysis and blood hemoglobin and hematocrit
- Diagnostic or therapeutic services related to the provision of the surgical procedure.

Multiple Procedures

If more than one reimbursable surgical procedure requiring an unrelated operative incision is provided in a single operative session, the full maximum fee is 100% for the operative procedure assigned the highest payment rate and 50% of the payment rate for each additional reimbursable procedure.

Bilateral Procedures

If a reimbursable surgical procedure provided in a single operative session is performed bilaterally, the full maximum fee is 150% of the payment rate for the operative procedure.

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**Cancelled Procedures**
The Plan will not reimburse a surgical center for any surgical procedures that are cancelled or postponed, for any reason, before the patient is taken into the treatment or operating room.

**Terminated Procedures**
Modifier 73 (Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia) and modifier 74 (Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) procedure after administration of anesthesia) should be used to indicate a terminated procedure. The facility must submit an operative report for any claim submitted that includes charges for a terminated procedure. If a report is not submitted, the claim line will be denied. Reimbursement for a terminated procedure will be determined based on the documentation submitted with the claim.

**Pricing for Prosthetic Devices**
All prosthetic devices, except intraocular lenses, whether implanted, inserted, or otherwise related to procedures on the current list of reimbursable surgical procedures, are reimbursable separately from the surgical center facility component at the rates established in the provider’s agreement with the Plan, or the provider’s charges, whichever is less.

**Corneal Tissue Transplant**
Corneal tissue transplant material and ocular prosthetics may be billed by freestanding ambulatory surgical centers based on the coding below. Both codes require a manufacturer/vendor invoice for reimbursement. Claims with supporting invoices must always be submitted to the Plan via postal mail.

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>V2785</td>
<td>Processing, preserving and transporting corneal tissue</td>
</tr>
<tr>
<td>L8699</td>
<td>Prosthetic implant, not otherwise specified</td>
</tr>
</tbody>
</table>

Additionally, claims that include the cost of orthotic-/prosthetic-type materials are not billable on the physician component of the claim – they must be billed on the facility claim for reimbursement.

Please note: The use of code L8699 is not a guarantee of payment. Since this code is “unspecified” in nature, a medical review will be required if the invoice indicates the material billed is not an ocular prosthetic. If during this review it is determined that the material was inappropriately billed, the claim line will be denied so that the facility can submit a corrected claim with an appropriate HCPCS code.

**Reimbursable Sterilization Services at Freestanding Ambulatory Surgery Center**
The Plan will reimburse a freestanding ambulatory surgery center facility for sterilization services only if all of the following conditions are met:

- The recipient has voluntarily given informed consent for the sterilization procedure
- The recipient is at least 18 years of age at the time consent is obtained

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• The recipient is not mentally incompetent
• The sterilization is performed by a licensed physician

Service Limitations

The Plan will not reimburse a surgical center for experimental, unproven, or otherwise medically unnecessary procedures or treatments performed at the center, including but not limited to:

• Cosmetic surgery
• Any surgical procedure that is identified as a non-covered benefit by the Plan

Applicable Coding and Billing Guidelines

Applicable coding is listed below, subject to codes being active on the date of service. Because the American Medical Association (AMA), Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes may not be all inclusive. These codes are not intended to be used for coverage determinations.

Policy History

<table>
<thead>
<tr>
<th>Original Approval Date</th>
<th>Original Effective Date</th>
<th>Policy Owner</th>
<th>Approved by</th>
</tr>
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<tbody>
<tr>
<td>07/05/2006</td>
<td>07/05/2006</td>
<td>Payment Policy</td>
<td>Payment Policy Committee</td>
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Policy Revisions History

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date</th>
<th>Approved by</th>
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<tbody>
<tr>
<td>06/04/2010</td>
<td>Policy revised to reflect new reimbursement terms. Payment groupings were abolished and replaced by fee-for-service methodologies.</td>
<td>06/04/2010</td>
<td>Payment Policy Committee</td>
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<tr>
<td>10/05/2011</td>
<td>Removed definitions and corrected spelling errors; added service limitations and corneal tissue transplant</td>
<td>10/05/2011</td>
<td>Payment Policy Committee</td>
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<tr>
<td>12/02/2013</td>
<td>Updated template, product applicability section, and references for BMC HealthNet Plan Qualified Health Plans, including ConnectorCare</td>
<td>12/02/2013</td>
<td>Payment Policy Committee</td>
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<tr>
<td>04/01/2016</td>
<td>New template, annual review, removed sex reassignment surgery statement and</td>
<td>04/01/2016</td>
<td>Payment Policy Committee</td>
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**Policy Revisions History**

| Podiatry statement from service limitations. Added modifiers to terminated procedure section |

**Next Review Date**

2018

**Other Applicable Policies**

- General Billing and Coding Guidelines, 4.31
- General Clinical Editing and Payment Accuracy Review Guidelines, 4.108
- Physician and Non Physician Practitioner Services, 4.608

**References**

- DHCFP Regulation 114.3 CMR 47.00 – Freestanding Ambulatory Surgical Facilities
- Centers for Medicare and Medicaid Services, Medicare Claims Processing Manual 100-04, Chapter 14, Ambulatory Surgical Centers
- Contract between The Office of Health and Human Services (EOHHS), and Boston Medical Center HealthNet Plan MassHealth
- Evidence of Coverage, Form No. BMCHP-CC-8
- Form of Contract between the Commonwealth Health Insurance Connector Authority and Boston Medical Center HealthNet Plan
- Evidence of Coverage, Form No. BMCHP CChoice-1
- BMC HealthNet Plan Qualified Health Plans, including ConnectorCare Evidence of Coverage

**Disclaimer Information**

This Policy provides information about the Plan’s reimbursement/claims adjudication processing guidelines. The use of this Policy is neither a guarantee of payment nor a final prediction of how specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement. Member cost-sharing (deductibles, coinsurance and copayments) may apply – depending on the member’s benefit plan. Unless otherwise specified in writing, reimbursement will be made at the lesser of billed charges or the contractual rate of payment. Plan policies may be amended from time to time, at Plan’s discretion. Plan policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization guidelines (including NCQA). The Plan reserves the right to conduct Provider audits to ensure compliance with this Policy. If an audit determines that the Provider did not comply with this Policy, the Plan will expect the Provider to refund all payments related to non-compliance. For more information about the Plan’s audit policies, refer to the Provider Manual.

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