Reimbursement Policy

Ambulatory Surgical Center - Facility

Policy Number: SCO 4.114
Version Number: 1
Version Effective Date: 01/01/2016

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.

Prior-Authorization

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

Definitions

Ambulatory Surgery Center (ASC) – 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 a

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postoperative recovery room for patients who do not require hospitalization or overnight services upon completion of the procedure

Ambulatory Surgery Center Reimbursement
The Plan reimburses ASCs for covered services and certain separately reimbursed ancillary services and items. ASC services are reimbursed according to the Medicare ASC payment system and are subject to the National Correct Coding Initiative Edits (NCCI).

Services Included In the ASC Payment:
The following services are included in the ASC reimbursement:

- Nursing, technician, and related services
- Use of the facility where the surgical procedures are performed
- Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver
- Drugs and biologicals for which separate payment is not allowed under the hospital outpatient prospective payment system (OPPS)
- Medical and surgical supplies not on pass-through status
- Equipment
- Surgical dressings
- Implanted prosthetic devices, including intraocular lenses (IOLs), and related accessories and supplies not on pass-through status
- Implanted DME and related accessories and supplies not on pass-through status
- Splints and casts and related devices
- Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedure
- Administrative, recordkeeping and housekeeping items and services
- Materials, including supplies and equipment for the administration and monitoring of anesthesia
- Supervision of the services of an anesthetist by the operating surgeon.

Services Separately Reimbursed
The following ancillary items and services are separately reimbursable:

- Brachytherapy sources
- Certain implantable items that have pass-through status under the OPPS
- Certain items and services that CMS designates as contractor-priced, including, but not limited to, the procurement of corneal tissue
- Certain drugs and biologicals for which separate payment is allowed under the OPPS
- Certain radiology services for which separate payment is allowed under the OPPS
**Procedures Not Reimbursed in an ASC**

An ASC will not be reimbursed for surgical procedures that the Centers for Medicare and Medicaid Services (CMS) determines may pose a significant safety risk to an enrollee or that are expected to require an overnight stay when furnished in an ASC. These services are identified in Medicare’s ASC Addendum EE.

**Terminated Procedures**

- No payment is made for a procedure that is terminated before the patient is taken into the treatment or operating room.
- Reimbursement will be made at 50% of the surgical rate if a surgical procedure is terminated due to the onset of medical complications after the patient has been prepared for surgery and taken to the operating room but before anesthesia has been induced or the procedure initiated. This should be reported with modifier 73.
- Full reimbursement will be made if a medical complication arises which causes the procedure to be terminated after anesthesia has been induced or the procedure initiated. This should be reported with modifier 74.
- A 50 percent payment reduction will be made for discontinued radiology procedures and other procedures that do not require anesthesia will receive. This should be reported with Modifier 52.

**Multiple and Bilateral Procedures**

- When an ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, the highest paying surgical procedure is reimbursed at 100%, plus 50% of the applicable payment rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session.
- ASC surgical services billed with either the 52 modifier or the 73 modifier are not subject to the multiple procedure discounts.
- ASC surgical services billed with modifier 74 may be subject to the multiple procedure discount.
- A procedure performed bilaterally in one operative session is reported as two procedures, either as a single unit on two separate lines or with “2” in the units field on one line. The multiple procedure reduction of 50 percent applies to all bilateral procedures subject to multiple procedure discounting.

**ASC Payment Indicators**

Each HCPCS code is assigned to a payment status indicator. The status indicator identifies whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is reimbursed. The full list of HCPCS codes and the corresponding payment status indicators are listed in the ASC Addenda which can be accessed through the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html
<table>
<thead>
<tr>
<th>Indicator</th>
<th>Payment Indicator Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A2</td>
<td>Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.</td>
</tr>
<tr>
<td>D5</td>
<td>Deleted/discontinued code; no payment made.</td>
</tr>
<tr>
<td>F4</td>
<td>Corneal tissue acquisition, hepatitis B vaccine; paid at reasonable cost.</td>
</tr>
<tr>
<td>G2</td>
<td>Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.</td>
</tr>
<tr>
<td>H2</td>
<td>Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.</td>
</tr>
<tr>
<td>J7</td>
<td>OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.</td>
</tr>
<tr>
<td>J8</td>
<td>Device-intensive procedure; paid at adjusted rate.</td>
</tr>
<tr>
<td>K2</td>
<td>Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.</td>
</tr>
<tr>
<td>K7</td>
<td>Unclassified drugs and biologicals; payment contractor-priced.</td>
</tr>
<tr>
<td>L1</td>
<td>Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made.</td>
</tr>
<tr>
<td>L6</td>
<td>New Technology Intraocular Lens (NTIOL); special payment.</td>
</tr>
<tr>
<td>N1</td>
<td>Packaged service/item; no separate payment made.</td>
</tr>
<tr>
<td>P2</td>
<td>Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.</td>
</tr>
<tr>
<td>P3</td>
<td>Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.</td>
</tr>
<tr>
<td>R2</td>
<td>Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.</td>
</tr>
<tr>
<td>Z2</td>
<td>Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.</td>
</tr>
<tr>
<td>Z3</td>
<td>Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.</td>
</tr>
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Split Claim Billing

All related services must be reported on one claim. Subsequent related claims received after the initial claim will be denied. The initial claim must be resubmitted as a replacement claim.

Service Limitations

The following services are not reimbursed by the Plan:

- experimental procedures
- cosmetic procedures
- medically unnecessary procedures

Policy History

<table>
<thead>
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<th>Original Approval Date</th>
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<th>Policy Owner</th>
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<tr>
<td>09/09/2015</td>
<td>01/01/2016</td>
<td>Payment Policy</td>
<td>SCO Product Subgroup</td>
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Policy Revisions History

<table>
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Next Review Date

2017

Other Applicable Policies

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

References

- Centers for Medicare and Medicaid Services Claims Processing Manual 100-04, Chapter 14, Ambulatory Surgery Centers
- MassHealth Freestanding Ambulatory Surgery Center Manual, 130 CMR 423.000
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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