



Ambulatory Surgery – Facility Payment Policy

(Same-day surgical procedures)

Policy

FCHP reimburses medically necessary surgical services provided by both outpatient (Non-ASC) and ASC-designated facility services.

Definitions

Outpatient Surgical Services (Non-ASC) provide surgical services that typically do not require an overnight stay. These services may include pain management and certain diagnostic services that can be performed in an outpatient setting. These services are billed utilizing CPT surgical codes. Facilities are reimbursed subject to all FCHP outpatient billing and payment, bundling and global package rules. Additionally, outpatient surgical services are defined as major or minor. Major surgical services typically have a 90-day post-op period and minor surgeries have either a 0- or 10-day post-op global period.

Ambulatory Surgical Centers (ASCs) also specialize in providing surgery, pain management and certain diagnostic services in an outpatient setting. These services are also billed utilizing CPT surgical codes.

Benefits application

Commercial

- FCHP Direct Care/FCHP Select Care
- Commonwealth Care
- Companion Care
- FCHP MassHealth
- Major Medical
- Fallon Preferred Care

Senior Plan

- Fallon Senior Plan™
- Fallon Senior Plan Preferred

Reimbursement

FCHP *does not* reimburse:

Ambulatory surgical day procedures if they are deemed:

- Not medically necessary
- Those services that require pre-authorization by the Plan when authorization was not obtained. The member may not be billed for non-authorized services.
- Services provided by residents.

FCHP *does* reimburse for ambulatory surgical day procedures as follows:

Outpatient surgery procedures

- Outpatient surgeries are reimbursed per contractual agreement.

Facility services

- Facility services that are directly related to the procedure performed including but not limited to anesthesia, operating room, recovery room, implantable device, pharmacy and supplies. Operative notes may be requested for facility and/or provider charges which are \$5,000 or more.
- Bilateral surgeries are typically reimbursed at 150% of the contracted allowable rate for the second procedure when billed on one line with the -50 modifier appended to the procedure code. Special situations occasionally apply when other reimbursement will be paid.
- Facilities reimbursed according to the Medicare ASC fee schedule will follow the payment methodology in the *CMS Ambulatory Surgical Center Billing Guide*.

Referral/notification/preauthorization requirements

Preauthorization is required for select ambulatory/same day surgical procedures and/or services. Please utilize the pre-authorization tool (link below) found on the FCHP Web site to determine if a procedure requires pre-authorization.

Billing/coding guidelines

Bundled services

- FCHP only reimburses the more “intensive” CPT code when a procedure is considered to be part of a more comprehensive procedure or a single more comprehensive CPT code more accurately describes a group of procedures.

Multiple surgical services

- When multiple surgical services are performed at the same session, the primary procedures are reimbursed according to the Medicare guidelines or pursuant to contractual agreement.

Attempted surgical procedure

- When modifier -73 is affixed to indicate that anesthesia has begun and for extenuating circumstances that pose a threat to the patient’s well being the procedure is discontinued, FCHP will reimburse at 50% of the contractual fee schedule, appropriate modifier must be appended.

Reduced surgical procedures

- When modifier -74 is affixed to indicate reduced services, FCHP will reimburse at 100% of the contractual fee schedule.

[Global Surgical Payment Policy](#)

(at www.fchp.org/Providers/Medical_payment_policies.htm)

Note: Use modifier -24 for post-op services when billing for services that are unrelated to the surgical procedure; notes are required.

Modifiers

The following is a list of modifiers often used in surgical billing for both ASC and Non-ASC:

- -24 services unrelated to surgical service during post-operative period
- -25 Significant separately identifiable service on the same day as another E&M
- -50 Bilateral procedure
- -52 Reduced services
- -53 Discontinued service (Professional side only; Facility uses 73/74)
- -54 Surgical service only
- -55 Post-op surgical service only
- -56 Preoperative management only
- -57 E&M service provided on same day as major surgery
- -58 Staged or related procedure or service by same physician on same day
- -59 Distinct procedural service
- -62 Two surgeons
- -66 Team surgery
- -73 Discontinued outpatient procedure prior to administration of anesthesia
- -74 Discontinued outpatient procedure after anesthesia administration
- -76 Repeat procedure or service by same physician
- -77 Repeat procedure by another physician
- -78 Unplanned return to the operating/procedure room for a related procedure on the same day
- -79 Unrelated procedure or service by the same physician on the same day
- -80 Assistant at surgery
- -82 Qualified resident
- -AS Services provided by PA, NP or CNS
- -SG Surgical facility (ASC modifier)

Policy history

Origination date: 06/30/08
Previous revision date(s): N/A
Current review date & details: This is a new policy.

This payment policy has been developed to provide information regarding general billing, coding and documentation guidelines for FCHP. Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member individual benefit plans may apply and this policy is not a guarantee of payment. FCHP reserves the right to apply this payment policy to all FCHP companies and subsidiaries.