



Ambulatory Surgery – Facility Payment Policy

(Same-day surgical procedures)

Policy

Fallon Community Health Plan (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.

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

- FCHP Direct Care/FCHP Select Care
- Commonwealth Care
- Companion Care
- FCHP MassHealth
- Major Medical
- Fallon Preferred Care
- Fallon Senior Plan™
- Fallon Senior Plan Preferred
- Summit ElderCare®
- NaviCareSM

Reimbursement

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 charges which are \$2,500 or more.
- Bilateral surgeries are typically reimbursed at 150% of the contracted allowable rate for the both procedures when billed on one line with the -50 modifier appended to the procedure code. 100% to be paid for first procedure, 50% to be paid for second procedure. 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*.

FCHP *does not reimburse:*

Ambulatory surgical day procedures if they are deemed:

- Not medically necessary

- Those services that require preauthorization by the Plan when authorization was not obtained. The member may not be billed for non-authorized services when performed by contracted providers at contracted facilities
- Services provided by residents.
- Services resulting in inpatient admission. Reimbursement for these services will be included in the inpatient reimbursement.

Observation services related to an ambulatory surgical procedure. These are considered part of the routine recovery period for the procedure and are included in the reimbursement for the ambulatory surgical procedure.

Referral/notification/prior authorization requirements

Summit ElderCare requires prior authorization for all non-emergency outside services. Please contact the referring Summit ElderCare PACE site for assistance.

NaviCareSM requires that all non-emergency services be authorized in advance. Please contact an Enrollee Service Representative at (877) 700-6996 for assistance.

Prior authorization is required for select ambulatory/same day surgical procedures and/or services.

The ordering physician is required to obtain prior authorization for:

- Unlisted CPT codes.
- The applicable codes found on the List of Procedures Requiring Preauthorization located in the Managing Patient Care section of the Provider Manual under PCP Referral and Plan Prior Authorization Process.

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 procedure with the highest intensity is reimbursed at full payment; others are reimbursed in accordance with CMS guidelines or pursuant to contractual agreement.

Attempted surgical procedure

- FCHP will review supporting documentation and will reimburse at a reduced rate of the contractual fee schedule based on the level of services provided when modifiers -73 or -74 are affixed to indicate discontinued outpatient procedures; the appropriate modifier must be appended and supporting documentation should be submitted with the claim.

Modifiers

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

- -25 Significant separately identifiable service on the same day as another E&M
- -50 Bilateral procedure
- -52 Reduced services
- -58 Staged or related procedure or service by same physician on same day
- -59 Distinct procedural service
- -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
- -AS Services provided by PA, NP or CNS
- -SG Surgical facility (ASC modifier)
ASC claims that are submitted on CMS-1500 forms must be submitted with the –SG modifier. Without the –SG modifier, claims will deny as a duplicate or for missing this modifier

Policy history

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| Origination date: | 11/01/08 |
| Previous revision date(s): | 11/01/08 - New policy 07/01/09 - Added language in the Reimbursement section discussing ASC services that result in inpatient admission and observation care. Clarified bilateral procedure language in the Reimbursement section. Clarified reference to the global surgery payment policy and the verbiage under Referral/notification/ preauthorization requirements. Clarified the need for modifier –SG under Billing/coding guidelines. |
| Connection date & details: | January 2010 – Changed threshold for which operative notes may be requested from \$5,000 to \$2,500. |

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.