Ambulatory Surgery – Facility Payment Policy

(Same-day surgical procedures)

Policy

The Plan reimburses medically necessary surgical services provided by both outpatient (Non-Ambulatory Surgical Centers) and Ambulatory Surgical Center-designated facilities.

This policy also applies to Ambulatory Surgical Centers (ASCs) that specialize in pain management services provided on an ambulatory surgical basis.

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 Plan 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.

Reimbursement

The Plan does reimburse for ambulatory surgical day procedures as follows:

Outpatient surgery procedures:

- Outpatient surgeries are reimbursed per contractual arrangement.

Facility services:

- Facility services that are directly related to the procedure performed, including but not limited to: Anesthesia, operating room, recovery room, implantable device (biochemical materials or devices intended by the physician to remain in the body for at least 30 days), pharmacy and supplies. Bilateral surgeries are typically reimbursed at 150% of the contracted allowable rate for the 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 made.
- Facilities reimbursed according to the Medicare ASC fee schedule will follow the payment methodology in the CMS Ambulatory Surgical Center Billing Guide.

Bundled services:

- The Plan 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:

- The Plan closely aligns with CMS guidelines in determining which procedure codes are subject to multiple procedure reduction. Reference the CMS website for information on specific procedure codes.
- When multiple surgical services are performed at the same session, the procedure with the highest intensity is reimbursed at full payment; when allowed, others are reimbursed at 50% of the contracted fee or pursuant to contractual arrangement.
- No additional payment is made beyond five services.

Payments are subject to post-payment audits and retraction of overpayments.

The Plan does not reimburse:

- Ambulatory surgical day procedures if they are deemed:

    - Not medically necessary.
    - Services that require prior authorization 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

PCP referrals are required for all specialty visits for most products. For a description of products and services requiring a PCP referral, please refer to the PCP referral and prior authorization grid located in the *Managing Patient Care* section of the *Provider Manual* under *PCP Referral and Plan Prior Authorization Process*.

The ordering physician is required to obtain prior authorization for:

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

Fallon Health Weinberg and Navicare® models of care are based on patient care coordination; therefore, we encourage referring providers to contact the member's designated navigator if there are questions or concerns prior to prescribing tests, supplying equipment, or providing any other additional appointments or services that may not routinely be authorized or may require prior authorization.

Summit ElderCare® is based on member care coordination; therefore, the referring Summit ElderCare PACE site must be contacted for approval, prior to coordinating and/or rendering services.

Billing/coding guidelines

Bundled services:

- The Plan 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; when allowed, others are reimbursed at 50% of the contracted fee or pursuant to contractual arrangement.
- No additional payment is made beyond five services.

Attempted surgical procedure:

- The Plan 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.
- 51 - Multiple procedures.
- 52 – Partially Reduced/Eliminated services.
- 58 - Staged or related procedure or service by same physician on same day.

- 59 - Distinct procedural service.
- 73 - Prior Discontinued Ambulatory Surgical Center (ASC) or Outpatient Hospital
- 74 - After Anesthesia Administration - Discontinued Ambulatory Surgical Center (ASC) or Outpatient Hospital.
- 76 - Repeat procedure by same physician.
- 77 - Repeat procedure by another physician.
- 78 - Return to Operating Room for related surgery during post op period
- 79 - Unrelated procedure or service by the same physician on the same day.
- AS - Services provided by PA, NP, or CNS.
- FB - Item provided without cost to provider, supplier, or practitioner, or full credit received for replacement device (e.g.: covered under warranty, replaced due to defect, free samples).
- FC - Partial credit received for replaced device.

Place of service

This policy applies to services rendered in the ambulatory surgery setting.

Policy history

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. 3/1/2010 – Changed threshold for which operative notes may be requested from $5,000 to $2,500. 7/1/2010 – removed requirement to submit ASC claims submitted on CMS-1500 forms with the SG modifier; added modifiers FB and FC. 7/1/2011 - Clarified discussion of Multiple Surgical Services and added Modifier 51 for use by Ambulatory Surgery Centers. 11/1/2013 - Added that policy also applies to ASCs that specialize in pain management services provided on an ambulatory surgery basis. 05/01/2015 - Changed threshold for which operative notes may be requested from $2,500 to $5,000 and noted prepayment review process. Moved to new template. 01/01/2016 - Moved to new Plan template. 05/01/2016 - Annual review. 05/01/2017 - Annual review.
Connection date & details:	November 2017 – Added implantable definition. October 2018 – Removed operative note request process October 2019 – Annual review, no updates.

The criteria listed above apply to Fallon Health plan and its subsidiaries. This payment policy has been developed to provide information regarding general billing, coding, and documentation guidelines for the Plan. 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. The Plan reserves the right to

apply this payment policy to all of the Plan companies and subsidiaries. The Plan routinely verifies that charges billed are in accordance with the guidelines stated in this payment policy and are appropriately documented in the medical records. Payments are subject to post-payment audits and retraction of overpayments.