# Ambulatory Surgical Centers
# Medical Claims Processing Guidelines

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## Disclaimer

Highmark Health Options' medical claims payment and prior-authorization policy is a reference resource regarding payment and coverage for the services described. This policy does not constitute medical advice and is not intended to govern and/or otherwise influence medical necessity decisions.

## Policy Scope

**Purpose**
Intended to serve as a processing guide for submitting medical claims as they relate to Ambulatory Surgical Centers (ASCs) and Free-Standing Surgical Centers (FSSCs).

This policy specifically applies to Providers submitting claims under ASC and FSSC provisions outlined in DMMA documentation, regulators and internal Highmark Health Options (HHO) resources. ASCs and FSSCs are distinct entities that operate exclusively for the purpose of furnishing outpatient surgical services to patients.

## Reimbursement Guidelines

**CMS-1500 Billing**
ASC and FSSC claims must be billed on a CMS-1500 claim, or if billing electronically, the 837 Professional claim using appropriate surgical CPT-4 codes. Providers must use National Place of Service Code 24 to specify that the service(s) were rendered at an ASC or FSSC facility.

**Coordination of Benefits**
ASCs are subject to all HHO Coordination of Benefits Policies. For individuals who have other health insurance, that insurance must be billed first, and the provider must attach the primary insurer's explanation of benefits to the claim sent to HHO for reimbursement. HHO considers all payments for the service and compares the amounts covered by other insurers to the HHO maximum fee for the service. If HHO's fee has been met or exceeded by payments from the other insurer, no payment will be made, and the member may not be billed.

**Covered Services**
Examples of services that are covered and reimbursed at an ASC or FSSC facility include:

- Surgical procedures that are furnished by an ASC or FSSC.
- Nursing services, services of technical personnel, and other related services.
- Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment.
- Diagnostic or therapeutic items and services.
- Administrative, record keeping and housekeeping items and services.
- Blood, blood plasma, platelets, etc., except for those to which the blood deductible applies.
- Materials for anesthesia.
- Intraocular lenses (IOLs).

**Non-Covered Services**
Examples of items or services that are non-ASC and FSSC facility services include:

- Physicians' services.
- The sale, lease, or rental of durable medical equipment to ASC and FSSC patients for use in their homes.
- Prosthetic devices, except intraocular lenses (IOLs).
- Ambulance services.
- Leg, arm, back and neck braces.
- Artificial legs, arms, and eyes.
- Services furnished by an independent laboratory.
- Dental services (administered for children age 18 and under through DMAP)
- Cosmetic surgical procedures.
- Services which are not medically justified.
- Infertility services.

**Reimbursement**
HHO will reimburse at the DMMA ASC Rate Schedule unless otherwise stated in the provider's contract.

The DMAP details for ASC and FSSC reimbursement rates are as follows:

For dates of service on or after Jan. 1, 2008; ASC and FSSC rates are paid based on the appropriate procedure code-based rate established by CMS. Procedure code-based rates vary depending on the county in which the billing ASC and FSSC provider is located.

**Non-Par ASC Reimbursement**
All out-of-network and out-of-state ASCs and FSSCs are reimbursed based off of the Delaware ASC county-specific rates. County-specific rates will apply based off of the nearest Delaware county to the out-of-network or out-of-state provider.

**Rendering and Performing Providers**
All ASCs and FSSCs are required to submit both rendering and performing provider information on all claims. ASCs and FSSCs rendering and performing providers are required for the encounter to successfully pass through for state encounter submission.

The following modifiers should be used appropriately when billing the claim:

**Table 1 – Modifiers Impacting ASC Fee Schedule Rates**

| Modifier | Description |
|---|---|
| **TC** | Technical component of a test only (no interpretation performed). |
| **FB** | Item provided without cost to provider, supplier or practitioner, or credit received for replacement device; examples include, but not limited to, covered under warranty, replaced due to defect, free samples. |
| **FC** | Partial credit received for replaced device. |

**Terminated Procedures**
Providers must identify procedures that are terminated prior to inducement of the anesthetic agent due to the onset of medical complications by reporting a modifier of "53," resulting in one-half reimbursement of the normal rate for the procedure. If the procedure must be terminated after the inducement of the anesthetic agent, providers must report a modifier of "74" and will be reimbursed the full rate of the procedure.

**Table 2 – Terminated Procedure Modifier**

| Modifier | Description |
|---|---|
| **53** | Discontinued surgical procedure due to extenuating circumstances or a threat to patient well-being. |
| **74** | Discontinued outpatient hospital and ambulatory surgery center (ASC) procedure, after administration of anesthesia. |

A claim requesting payment for terminated surgery must be accompanied by an operative report that specifies the following:

- Reason for termination of surgery.
- Services actually performed.
- Supplies actually provided.
- Services not performed that would have been performed if the surgery had not been terminated.
- Supplies not provided that would have been provided if the surgery had not been terminated.
- Time actually spent in each stage (e.g., pre-operative, operative, and postoperative).
- Time that would have been spent in each of these stages if the surgery had not been terminated.
- CPT-4 code for procedure had the surgery been performed.

**Multiple Surgeries**
If more than one surgical procedure is furnished in a single operative session, payment is based on the full rate for the procedure with the highest prospectively determined rate, and one half of the prospectively determined rate for each of the other covered procedures.

HHO requires providers to submit a single claim on a single operative session. Claims submitted for separate services to the same client on the same day will be reviewed to determine the appropriate payment.

All multiple surgery claims must have operative notes attached describing in detail the services provided.

**Sterilization and Hysterectomy Procedures**
ASCs and FSSCs may be reimbursed for voluntary sterilization and medically necessary hysterectomy procedures for eligible Medicaid clients. A requirement for payment is that each claim must be accompanied by either a consent form when a voluntary or elective sterilization is performed or an awareness form for medically necessary hysterectomy procedures that may result in sterilization.

It is the responsibility of the attending physician to secure a properly executed form when a voluntary sterilization is requested or a hysterectomy is required. For billing purposes, the ASC and FSSC must secure the appropriate form from the operating surgeon.

**Abortions**
HHO will reimburse ASC and FSSCs for abortion procedures in specific scenarios.

ASCs and FSSCs may be reimbursed for abortion procedures for eligible Medicaid clients. In order for HHO to reimburse for an abortion, a physician must certify that a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, which would place the woman in danger of death unless an abortion is performed.

It is the responsibility of the ASC and FSSC to secure a copy of the abortion justification form and complete medical record from the attending practitioner for their billing purposes. Additionally, ASCs and FSSCs may be reimbursed for abortions to terminate pregnancies resulting from an act of rape or incest. The practitioner must submit a letter stating that the request for the abortion is due to rape or incest and provide written documentation that the incident was reported to the police. In cases of incest where the victim is under 18 years of age, the incident must also have been reported to the Department of Services for Children, Youth and Their Families (DSCYF).

Providers must identify abortion procedures for pregnancies either certified as life threatening or resulting from rape or incest by using modifier G7 when billing for these services.

**Table 3 – Applicable Pregnancy Modifier for Abortion Services**

| Modifier | Description |
|---|---|
| **G7** | The pregnancy resulted from rape or incest, or pregnancy certified by physician as life threatening |

**Corneal Tissue Acquisition**
When billing for corneal tissue acquisition, use the appropriate HCPCS procedure code and attach the invoice from the supplying eye bank showing the actual cost incurred.

## Provider Requirements

All provider requirements for ASCs and FSSCs are specific to Delaware Medicaid. ASCs or FSSCs may provide services through Highmark Health Options (HHO) if the facility is certified by the Office of Health Facilities, Licensing and Certification under the rules and regulations of the State of Delaware's Board of Health for Free-Standing Surgical Centers or a comparable certifying agency in the State in which the provider is located.

## Reference

**Policy Update History**

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| May 14, 2021 | Provider Notification |