



Ambulatory Surgery Center Payment Policy

The effective date for this publication is: 9/1/12

The procedure codes and fee schedule amounts in this document do not necessarily indicate coverage or payment. All coverage and payments are subject to Offender Health Plan Coverage, exclusions, limitations, and pre-authorization requirements. For detailed coverage information, refer to the Department of Corrections (DOC) *Offender Health Plan, Billing Instructions and Payment Policies*. For directions on submitting claims to ProviderOne, see the ProviderOne Billing and Resource Guide.

Fees in this publication are subject to change without notice. Although we make every effort to ensure the accuracy of the fees in our publications, changes or corrections may occur throughout the year.

Visit the DOC web site at www.doc.wa.gov/business/healthcareproviders to download the latest versions of this fee schedule, and all other DOC publications mentioned in this document.

DOC ASC Payment Policy

Refer to the 2012 CPT® and HCPCS coding books for complete code descriptions

Ambulatory Surgery Center Payment Policy

Table of Contents

I. General Information	3
II. Billing Information	3
III. Packaged Services and Supplies	3
A. ASC Services and Supplies that May be Paid Separately	4
B. Other Services Provided by ASCs that May be Paid Separately.....	4
IV. Multiple Surgery Rules	4
A. Payment Rule for Multiple Procedures (modifier 51)	4
B. Payment Rule for Bilateral Procedures (modifier 50).....	4
C. Payment Rules for Terminated Procedures	5
<u>1.</u> Termination of a Procedure After Anesthesia (Modifier 74)	5
<u>2.</u> Termination of a Procedure Before Anesthesia (Modifier 73)	5
V. Request for Pre-Authorization	5

DOC ASC Payment Policy

Refer to the 2012 CPT® and HCPCS coding books for complete code descriptions

I. General Information

The Department of Corrections (DOC) Ambulatory Surgery Center Fee Schedule contains the maximum allowances for services provided in ambulatory surgery centers (ASC). All DOC coverage rules regarding the medical necessity of a given procedure for a given patient are applicable to ASC services in the same manner as all other covered services.

DOC follows Medicare payment policies and billing requirements for ASCs.

The list of procedures covered in an ASC includes the majority of procedures covered in an outpatient hospital setting. The ASC payment rates are based on the ambulatory payment classifications (APCs) used to group procedures under the Outpatient Prospective Payment System (OPPS).

The standard ASC payment for covered surgical procedures is calculated by multiplying the DOC ASC conversion factor by the APC payment weight for each separately payable procedure.

Conversion Factor	Coverage Description
\$62.83	most surgical procedures
\$96.47	pain management and gastrointestinal procedures (see the fee schedule for a list of specific CPT and HCPCS codes paid using this conversion factor)

II. Billing Information

Claims with dates of service on and after September 1, 2012 must be submitted through the ProviderOne system. Refer to the ProviderOne Billing and Resource Guide for all questions how to submit Fee-for Service claims.

Ambulatory Surgery Centers should bill the same procedure code(s) reported by the surgeon, and for any information required to understand your remittance advice or obtain electronic claim status.

The ASC charges must be billed with place of service code "24." The modifier "TC" must be used unless the code has no professional component.

III. Packaged Services and Supplies

ASC services for which payment is included in the ASC allowed amount for a covered procedure include, but are not limited to the following:

- Administrative, record keeping and housekeeping items and services
- Anesthesia supplies/materials
- Blood, blood plasma, and platelets
- Drugs and biologicals for which separate payment is not allowed under the outpatient prospective payment system (OPPS).
- Implanted DME and related accessories and supplies not on pass-through status
- Implanted prosthetic devices not on pass-through status, including intraocular lenses (IOLS) inserted during or subsequent to cataract surgery.
- Nursing, technician and related services

DOC ASC Payment Policy

Refer to the 2012 CPT® and HCPCS coding books for complete code descriptions

- Radiology services for which separate payment is not allowed under the OPPS and other diagnostic or therapeutic services or items integral to the surgical procedure (including routine pre-op lab services)
- Surgical dressings, surgical trays, supplies, splints, screws, casts, post-op shoes
- Use of ASC facilities (including operating/recovery rooms and patient preparation areas)

A. ASC Services and Supplies that May be Paid Separately

DOC will pay separately for certain covered ancillary services that are provided integral to covered surgical procedures in ASCs including the following:

- Brachytherapy sources
- Certain implantable items that have pass through status under OPPS
- Certain radiology services for which separate payment is allowed under the OPPS
- Corneal tissue procurement (HCPCS code V2785)
- Drugs and biologicals that are separately paid under the OPPS
- New Technology Intraocular Lens (NTIOLS)

B. Other Services Provided by ASCs that May be Paid Separately

- Ambulance services
- Artificial limbs
- Durable medical equipment for use in the patient's home
- Leg, arm, back and neck braces
- Professional services, including; physician services, surgeon, assistant surgeon, anesthesiologist and nurse anesthetist
- Pre/post-operative professional services (E/M codes subject to global surgery rules)
- Services furnished by an independent laboratory

IV. Multiple Surgery Rules

In general, the following procedure for multiple surgery rules applies. In some cases due to automated claims adjudication and additional logic built into the processing system, these rules may be overridden and procedures that might otherwise result in reduced payment may not have the reduction for multiple surgeries taken. Please contact DOC Customer Service if you have any questions regarding how the claim was processed for multiple surgeries as outlined below.

A. Payment Rule for Multiple Procedures (modifier 51)

If multiple procedures are performed on the same patient at the same operative session or on the same day, the total maximum allowance is equal to the sum of the following:

- 100% of the DOC ASC Fee Schedule allowed amount for the highest fee-schedule-valued procedure.
- 50% of the DOC ASC Fee Schedule allowed amount for any other ASC covered surgical procedure(s)

B. Payment Rule for Bilateral Procedures (modifier 50)

CPT® codes only are copyright 2012 American Medical Association. All Rights Reserved. Applicable FARS/DFARS apply

DOC ASC Payment Policy

Refer to the 2012 CPT® and HCPCS coding books for complete code descriptions

When a bilateral procedure is performed, the DOC allowed charge is based on 150% of the DOC ASC Fee Schedule amount. Providers must bill using the single procedure code with the modifier.

C. Payment Rules for Terminated Procedures

DOC will not pay claims for an ASC procedure that is terminated either for non-medical or medical reasons before expending substantial resources. For example, DOC would not pay a claim for a scheduled surgery that was cancelled or postponed because the patient on intake complained of a cold or flu.

1. Termination of a Procedure After Anesthesia (Modifier 74)

An ASC may be paid when a medical complication arises causing the covered procedure to be terminated after inducement of an anesthetic agent. Resources of the facility are consumed in essentially the same manner and to the same extent as they would have been had the surgery been completed. In these circumstances, modifier 74 (representing a discontinued procedure after administration of anesthesia) must be present with the procedure code.

2. Termination of a Procedure Before Anesthesia (Modifier 73)

An ASC may be paid when 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. Modifier 73 must be present with the procedure code. The DOC ASC Fee Schedule amount is generally reduced by 50% for payment of covered procedures in these situations.

Note: Supporting documentation may be requested on a periodic basis by DOC when modifiers 73 or 74 are used.

V. Request for Pre-Authorization

Pre-Authorization is not required for ASCs. In the unlikely event that the cost of a procedure (procedure plus implant) is estimated to exceed the DOC allowed amount ASCs may request a preauthorization. Preauthorization must be obtained prior to delivery of services to be considered for additional payment.

Please see our [website](#) for the appropriate fax number for Pre-Authorization. Fax your request and include the following information:

- Diagnosis code
- Provider/facility name, phone number, fax number
- Reason for requesting the pre-auth including supporting documentation
- Specific procedure being requested with CPT or HCPCS code
- Estimated cost of any implants (must submit invoice at the time of claim submission)
- DOC offender number