

AMBULATORY SURGERY CENTER PAYMENT POLICIES

GENERAL INFORMATION

Information about L&I's ambulatory surgery center (ASC) requirements can be found in Chapter [296-23B](#) WAC.

WHO MAY BILL FOR ASC SERVICES

An ASC is an outpatient facility where surgical services are provided and that meets the following 3 requirements:

1. Must be licensed by the state(s) in which it operates, unless that state doesn't require licensure;
2. Must have at least 1 of the following credentials:
 - a. Medicare Certification as an ambulatory surgery center or
 - b. Accreditation as an ambulatory surgery center by a nationally recognized agency acknowledged by the Centers for Medicare and Medicaid Services (CMS) and
3. Must have an active ASC provider account with L&I.

BECOMING ACCREDITED OR MEDICARE CERTIFIED AS AN ASC

Providers may contact the following organizations for information:

National Accreditation

American Association for Accreditation of Ambulatory Surgery Facilities

5101 Washington Street, Suite #2F

PO BOX 9500 Gurnee, IL 60031

888-545-5222; www.aaaasf.org/

Accreditation Association for Ambulatory Health Care

3201 Old Glenview Rd., Suite 300

Wilmette, IL 60091

847-853-6060; www.aaahc.org/

American Osteopathic Association

142 East Ontario Street

Chicago, IL 60611

800-621-1773; www.osteopathic.org/

Commission on Accreditation of Rehabilitation Facilities

4891 East Grant Road

Tucson, AZ 85712

888-281-6531; <http://www.carf.org/>

Joint Commission on Accreditation of Healthcare Organizations

One Renaissance Blvd.

Oakbrook Terrace, IL 60181

630-792-5862; www.jcaho.org/

Medicare Certification

Department of Health
Office of Health Care Survey
Facilities and Services Licensing
PO BOX 47852
Olympia, WA 98504-7852
360-236-2905; e-mail: fslhhacs@doh.wa.gov
Web: www.doh.wa.gov/hsqa/fsl/HHHACS_home.htm

Please note it may take 3-6 months to get certification or accreditation.

ASC PAYMENTS FOR SERVICES

The insurer pays the lesser of the billed charge (the usual and customary fee) or L&I's maximum allowed rate.

L&I's rates are based on a modified version of the current system developed by Medicare for ASC services.

ASC Procedures Covered for Payment

L&I uses the CMS list of procedures covered in an ASC plus additional procedures determined to be appropriate. All procedures covered in an ASC are listed online at:

<http://feeschedules.Lni.wa.gov>

L&I expanded the list that CMS established for allowed procedures in an ASC. L&I added some procedures CMS identified as excluded procedures.

ASC Procedures Not Covered for Payment

Procedures not listed in the ASC fee schedule section of MARFS aren't covered in an ASC.

ASCs won't receive payment for facility services for minor procedures that are commonly done in an office setting or treatment room. See the next paragraph for exceptions to this policy. The provider performing these procedures may still bill for the professional component.

Process to Obtain Approval for a Noncovered Procedure

Under certain conditions, the director, the director's designee or self-insurer, at their sole discretion, may determine that a procedure not on L&I's ASC procedure list may be authorized in an ASC. For example, this may occur when a procedure could be harmful to a particular patient unless performed in an ASC. Requests for coverage under these special circumstances require prior authorization.

The health care provider must submit a written request and obtain approval from the insurer prior to performing any procedure not on the ASC procedure list. The written request must contain:

- A description of the proposed procedure with associated CPT[®] or HCPCS procedure codes,
- The reason for the request,
- The potential risks and expected benefits and
- The estimated cost of the procedure.

The healthcare provider must provide any additional information about the procedure requested by the insurer.

ASC BILLING INFORMATION

Modifiers Affecting Payment for ASCs

-50 Bilateral Procedures

Modifier -50 identifies cases where a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using separate line items for each procedure performed. Modifier -50 must be applied to the second line item. The second line item will be paid at **50%** of the allowed amount for that procedure.

-51 Multiple Procedures

Modifier -51 identifies when multiple surgeries are performed on the same patient at the same operative session. Providers must bill using separate line items for each procedure performed. Modifier -51 should be applied to the second line item. The total payment equals the sum of:

100% of the maximum allowable fee for the highest valued procedure according to the fee schedule, plus

50% of the maximum allowable fee for the subsequent procedures with the next highest values according to the fee schedule.

If the same procedure is performed on multiple levels the provider must bill using separate line items for each level.

-52 Reduced Services

Modifier -52 identifies circumstances when a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier -52, signifying that the service is reduced.

Beginning July 1, 2008 a **50%** payment reduction will be applied for discontinued radiology procedures and other procedures that don't require anesthesia (ASCs should use modifier -52 to report such an occurrence).

-73 Discontinued procedures prior to the administration of anesthesia

Modifier -73 is used when a physician cancels a surgical procedure due to the onset of medical complications subsequent to the patient's preparation, but prior to the administration of anesthesia. Payment will be at **50%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

-74 Discontinued procedures after administration of anesthesia

Modifier -74 is used when a physician terminates a surgical procedure due to the onset of medical complications after the administration of anesthesia or after the procedure was started. Payment will be at **100%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

-99 Multiple modifiers

Modifier -99 must be used when more than four modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the actual services performed. For billing purposes only, modifier -99 must go in the modifier column with the individual descriptive modifiers that affect payment listed in the remarks section of the billing form.