

Free Standing Ambulatory Surgical Centers

For surgery in an outpatient hospital setting please refer to “Outpatient Services” within the “Hospital Guidelines” portion of this manual.

Ambulatory Surgical Centers (ASC) provide an alternative setting for surgical procedures that would otherwise be performed in a hospital on an outpatient basis. Most ambulatory surgery centers are freestanding facilities, although some may be co-located with a hospital, physician office or clinic. All ASC's sharing a location must meet the state's criteria for licensure.

All surgical centers must have a registered nurse on duty at all times when patients are in the facility.

Facility Accreditation

Before reimbursement can be approved, or contracted for facility fees, a freestanding ASC must be credentialed. The freestanding ASC must have current Medicare office certification.

Complete credentialing requirements can be accessed either in this manual or on our Web site at www.wa.regence.com/provider.

Note: Please refer to the “Credentialing” section in this manual for detailed information regarding credentialing of all practitioners.

How Payment Is Determined

Reimbursement is based on a fee schedule. Fees for multiple procedures are calculated as follows:

- The code with the highest fees is reimbursed at 100%.
- The subsequent codes are reimbursed at 50% of the fee.
- Any code not subject to cuts is removed from consideration before reductions are applied.
- For any single procedure code, reimbursement is never more than the charged amount.

Note: *The fee schedule or percentage of charges amount will be multiplied by the appropriate facility accreditation percentage.*

Unlisted codes (defined by CPT® as a code used for services or procedures that do not have a specific code) that are covered CPT® Category III Codes, may be reimbursed at percentage of charges or as outlined in your contract.

ASC's are not reimbursed for:

- Minor surgeries customarily performed in a physician's office and for which use of a facility is generally considered part of the physician's office overhead. (e.g., where the RVU assigned includes a consideration for overhead)
- Procedures usually performed in an inpatient or outpatient hospital setting

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Billing Guidelines

- Include the –SG modifier on all surgical codes billed.
- Facility charges should be submitted on an HCFA 1500 claim form.
- All line items must be submitted on one claim. Do not bill separate procedures on multiple claim forms.
- Use ‘24’ or other designated appropriate place of service code for a freestanding ASC.

Services Included in the ASC Facility Fee

The maximum allowable is intended to include, but is not limited to the following:

- Use of facility, including operating room, recovery and/or short stay rooms, prep areas, and use of waiting rooms and lounges created for members and relatives
- Administrative functions such as scheduling or cleaning, utilities and rent
- Nursing, technical staff, orderlies and others involved in member care connected to the procedure, intravenous therapy, and other related services.
- Drugs (including take home), biologicals (blood), surgical dressings, supplies, splints, casts, appliances, non-custom braces, disposable infusion pain control pump, and equipment related to the provision of care
- Implants, including but not limited to the following: screws, plates, anchors, pins, and wires
- Diagnostic testing such as urinalysis, blood hemoglobin or hematocrit, pre-operative chest x-ray, and therapeutic items and services directly related to the procedure/service
- Anesthetic and any materials, disposable or re-useable, needed to administer anesthesia
- Intraocular lenses for insertion during or after cataract surgery

Services Not Included in the ASC Facility Fee

These items should be **billed separately** from the facility fee with appropriate HCPC or CPT® coding.

- Physician’s and other individually contracted provider services, including anesthesia
- The sale, lease or rental of durable medical equipment to ASC members for use in their homes
- Leg, arm, back and neck custom braces
- Artificial legs, arms and eyes
- Services furnished by an independent laboratory
- Ambulance services
- The technical component of radiological services related to the surgical procedure(s)
- Prosthetic devices defined as those items that are permanent replacements to existing body parts. Invoices are to be submitted upon request. Shipping and handling are not separately reimbursed.

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Physician's Charges

The physician's charge is the *professional's* fee for performing the surgery and related diagnostic and therapeutic services. This includes the administration or the supervision of the administration of local anesthesia or IV sedation. The professional fees are billed separately by the performing physician. The facility and performing physician codes must be the same.