

AMBULATORY SURGICAL CENTERS BILLING AND REIMBURSEMENT POLICY

Ambulatory Surgical Centers (‘ASC’) can be either independent (not part of a provider of services or any other facility) or operated by a hospital (under the common ownership, licensure, or control of a hospital). Payment policies apply to in-network and out-of-network ASCs. The following Neighborhood Health Plan of Rhode Island (‘Neighborhood’) products may receive services in an ASC setting: ACCESS ‘Rite-Care’ (MED, CSN, SUB, RHP, EFP), UNITY ‘Rhody Health Options’ (RHO), TURST ‘Medicaid Expansion’ (RHE) and SECURE, COMMUNITY, VALUE, PLUS, STANDARD, PARTNER, CHOICE, OR PREMIER ‘Health Benefit Exchange’ (HBE). Benefit coverage limits may apply. It is the ASC’s responsibility to verify eligibility, coverage and authorization criteria prior to rendering services. For information regarding benefits, please visit www.nhpri.org.

GENERAL BILLING INFORMATION

All ASCs (hospital/independent) should submit on a valid CMS 1450 (UB-04) form or EDI 837I format.
Valid Type of Bill (83X), revenue code, CPT/HCPCS and ICD-9 coding is required on every claim submission.
Claims using the wrong claim format will deny.

PRIOR AUTHORIZATION

Some medically necessary ambulatory surgeries and procedures require an authorization. Providers should confirm coverage and authorization requirements prior to rendering services.
A prior authorization reference guide is available at: NHPRI.org>Providers>Resources & FAQs>Prior Authorization Reference Guide.

EXCLUSIONS:

Plastic surgery for cosmetic reasons is not covered.
Surgical procedures for the purposes of gender reassignment are not covered.

REIMBURSEMENT GUIDELINES

Neighborhood payment guidelines are consistent with that of the Centers for Medicare & Medicaid Services Program (‘CMS’). Neighborhood makes a single payment to ASCs for covered surgical procedures, including ASC facility services furnished in connection with the covered procedure. Examples of covered ASC facility services include nursing services, the patient’s use of the ASC facilities, drug and biologicals not separately reimbursed under the Outpatient Prospective Payment System (‘OPPS’), surgical dressings, splints, casts, recordkeeping , housekeeping items, etc.

ASCs may receive payment for ancillary services which are separately paid under the OPPS. Covered ancillary services include:

- Brachytherapy sources
- Implantable devices with OPPS pass-through status
- Corneal tissue acquisition

- Drugs and biologicals separately payment under the OPPS
- Radiology services separately paid under the OPPS

Certain services may be furnished in ASCs and billed by the appropriate provider or supplier such as physician services or non-implantable prosthetic devices.

Neighborhood allows the same surgical procedures and ancillary services as CMS. Procedure codes not allowed in an ASC setting by CMS will be denied as non-contracted. These claims may be appealed for consideration of reimbursement; this includes unlisted surgical procedure codes.

BILLING

Submit the most updated industry-standard codes.

Submit a modifier, when applicable, with the corresponding CPT and/or HCPCS procedure code(s).

For more information regarding Modifier Billing Guidelines refer to NHPRI.org.>Providers>Resources & FAQs>Billing & Coding Information>Administrative Guidelines/Coverage Summaries and Billing Guidelines

Note: Annually and quarterly, HIPAA medical code sets undergo revision by CMS, AMA and CCI. Revisions include adding, deleting or redefining the description or nomenclature of new HCPCS, CPT procedure and ICD-9 diagnosis codes. As these revisions are made public, Neighborhood Health Plan of Rhode Island will update its system to reflect these changes.

Unlisted Surgical Procedure Codes

Submit the most appropriate unlisted surgical procedure code(s) available on a paper UB-04 form.

Submit supporting clinical documentation to accurately describe the unlisted surgical procedure code(s).

Unlisted procedure codes submitted without documentation will be denied.

Any procedure code(s) not listed on the provider's contract, including unlisted surgical procedure codes, submitted by an ASC will deny for a noncontracted service and will need to be appealed with appropriate clinical documentation. For more information regarding Unlisted procedure codes go to NHPRI.org.>Providers>Resources & FAQs>Billing & Coding Information>Administrative Guidelines/Coverage Summaries and Billing Guidelines

Multiple Surgical Procedures

Neighborhood applies an adjustment when multiple surgical procedures are furnished by the same physician for the same date of service.

Neighborhood follows the CMS Relative Value Units rules for multiple surgical reductions, the AMA CPT modifier -51 exempt codes, and add-on codes. Neighborhood will reimburse the highest surgical procedure at 100% and each additional separate procedure that is not considered bundled or denied at 50% of the allowable amount.

Bilateral Surgical Procedures

A bilateral surgery that uses a unilateral code should be reported on a single line with modifier 50, using one unit of service. This line item will be considered as one surgery however will be eligible for reimbursement equal to 150% of the amount applicable to the unilateral code on the date of service.

REFERENCES

CMS
AAPC

VERSION HISTORY:

Original Publication date:
Policy effective date:1/1/2015
Policy Changes:

DISCLAIMER:

This guideline is informational only, and not a guarantee of reimbursement. Claims payment is subject to Neighborhood Health Plan of RI benefit coverage, member eligibility, claim payment edit rules, coding and documentation guidelines, authorization policies, provider contract agreements and state or federal regulations. All services billed to Neighborhood for reimbursement is subject to audit. Effective dates noted reflects the date the long standing policy was documented or updated to assist with provider education, unless otherwise noted.