Ambulatory Surgical Centers/Free Standing Surgical Centers

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Disclaimer

Highmark Health Options medical policy is intended to serve only as a general reference resource regarding coverage for the services described. This policy does not constitute medical advice and is not intended to govern or otherwise influence medical decisions.

POLICY STATEMENT

This policy provides information regarding the coverage of ambulatory surgical centers and/or free-standing surgical centers, as determined by applicable federal and/or state legislation.

This policy is designed to address medical necessity guidelines that are appropriate for the majority of individuals with a particular disease, illness or condition. Each person's unique clinical circumstances warrant individual consideration, based upon review of applicable medical records.

The qualifications of the policy will meet the standards of the National Committee for Quality Assurance (NCQA) and the Delaware Department of Health and Social Services (DHSS) and all applicable state and federal regulations.

PURPOSE

This policy outlines Highmark Health Options reimbursement for ambulatory surgical centers/free standing surgical centers.

DEFINITIONS

Highmark Health Options (HHO) – Managed care organization serving vulnerable populations that have complex needs and qualify for Medicaid. Highmark Health Options members include individuals and families with low income, expecting mothers, children, and people with disabilities. Members pay nothing to very little for their health coverage. Highmark Health Options currently services Delaware Medicaid: Delaware Healthy Children Program (DHCP) and Diamond State Health Plan Plus LTSS (DSHP Plus LTSS) members.

Ambulatory Surgical Center (ASC) – Modern health care facilities focused on providing same-day surgical care, which includes diagnostic and preventive procedures.

Free-Standing Surgical Center (FSSC) – A facility licensed as a free standing or ambulatory surgical center; which is operated solely for the purpose of providing outpatient surgical care.

PROCEDURES

Prior authorization is required.

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.

POST-PAYMENT AUDIT STATEMENT

The medical record must include documentation that reflects the medical necessity criteria and is subject to audit by Highmark Health Options at any time pursuant to the terms of your provider agreement.

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.

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 wellbeing
73	Discontinued outpatient hospital/ambulatory surgery center (ASC) procedure prior to the administration of anesthesia
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.

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
67	The pregnancy resulted from rape, 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.

Reference

POLICY UPDATE HISTORY

05/11/2023	Annual review; approved in reimbursement policy committee
05/22/2023	Approved in Governance