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Ambulatory Surgery Center (ASC)

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Overview

An Ambulatory Surgery Center (ASC) is a permanent facility with equipment and an organized staff of professional health care providers for the primary purpose of performing surgical procedures on an outpatient basis. An ASC provides treatment by or under the direct supervision of a professional health care provider; does not provide inpatient accommodations; and is not, other than incidentally, a facility used as an office or clinic for the private practice of a professional health care provider.

Ambulatory surgery centers must be accredited by the Accreditation Association for Ambulatory Health Care (AAAHC), accredited by The Joint Commission, the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) or certified by Medicare to be reimbursed according to Blue Cross Blue Shield of North Dakota’s ASC fee schedule.

Billing Guidelines

Licensed ASC services must be billed on the CMS-1500 claim form with the NPI for the ASC and place of service code 24, whether the ASC is hospital-based or free standing. Modifier SG may be submitted to identify ASC facility services; however, it is not required. Services are identified using the most appropriate CPT®/HCPCS code.

Modifiers that affect reimbursement for facility services include:

1. Modifier 50 – Bilateral procedure. Services must be submitted on separate lines for correct reimbursement.
2. Modifier 73 – Discontinued outpatient procedure prior to anesthesia induction. This identifies a situation where an outpatient surgical or diagnostic procedure was scheduled to be performed but, due to extenuating circumstances or a condition that threatens the well-being of the patient, the physician cancels the

surgery or diagnostic procedure following the surgical preparation prior to the induction of anesthesia (local, regional block[s] or general). The appropriate procedure code is reported with modifier 73. This is not for elective cancellation of a service prior to the administration of anesthesia. Elective cancellation of a service prior to administration of anesthesia should not be reported.

3. Modifier 74 – Discontinued outpatient procedure after anesthesia administration. This identifies a situation where, due to extenuating circumstances or those that threaten the well being of the patient, the physician terminates a surgical or diagnostic procedure after the administration of anesthesia or after the procedure was started (eg, incision made, intubation started, scope inserted). The appropriate procedure code is reported with modifier 74.
4. Other HCPCS modifiers that are informational in nature and identify the specific site of a procedure include, but are not limited to:
 - E1-E4 Eyelids
 - F1-FA Fingers
 - T1-TA Toes
 - LT, RT Left, Right

Reimbursement

Ambulatory surgery centers are reimbursed a facility fee that includes the majority of supplies/services required for the specific procedure performed. Fee schedule rates are based on Medicare's proposed ASC APC rates, when available, with the exception of certain significant ASC surgical procedures. Procedures without an ASC APC rate, excluding packaged services, are priced equal to the hospital outpatient rate. BCBSND packages status indicator "N1" procedures and items related to surgeries. This includes most devices, implants, and supplies. These procedures and items do not receive separate payment. The significant ASC surgical procedures are specified in the annual reimbursement letter that providers receive with their fee schedules.

Services performed in an ASC are reimbursed based on the full/half/half payment methodology. The primary procedure is the one with the highest fee schedule value. Bilateral procedures (identified by use of modifier 50) are considered multiple procedures and are reimbursed full plus half of the fee schedule amount. Services identified by a non-specific procedure code may be held for review and individually priced if a fee schedule rate is not available. Services billed with modifier 73 are reimbursed at half of the rate. Services billed with Modifier 74 do not receive a separate reduction.

Some of the services included in the facility fee reimbursement are:

1. Services of nursing and technical staff.
2. Use of the facility and equipment where the procedure is performed.
3. Items and services directly related and integral to the pre-operative preparation of patients upon admission for surgery; to the performance of a surgical

procedure(s); and to the post-op and/or post-anesthesia care before discharge. These items and services include, but are not limited to, CLIA-waived lab tests; drugs and biologicals; medical and surgical supplies and equipment; splints, casts and other devices such as pins, screws, and external fixation devices used for reduction of fractures and dislocations; and imaging or diagnostic services integral to the surgical procedure.

4. Administrative services such as record keeping and housekeeping.
5. Materials, supplies and equipment for the administration and monitoring of anesthesia. *Professional services for the administration of anesthesia are billed on a separate CMS-1500 by the anesthesiologist/CRNA using their individual NPI.*
6. Allowance for standard or conventional intraocular lenses (IOLs) for cataract surgery.

Bilateral Surgeries Performed in an ASC

Surgical procedure codes must be submitted on separate lines for correct reimbursement. Surgical codes should be submitted on the same claim for the same surgical session. Units for procedure codes on the ASC fee schedule must always be one (1). Codes billed with more than one unit will be returned for correction. Modifiers should be used if different sites need to be identified; however, surgical procedures performed bilaterally must be submitted as two separate line items to receive the correct reimbursement. Modifier 50 may be appended to one of the lines but a bilateral procedure cannot be billed as only one line with modifier 50. ASC claims billed with a single line with Modifier 50 will be returned for correction.

Modifiers that affect reimbursement for ASC facility services include:

1. Modifier 73 - Discontinued outpatient procedure prior to anesthesia induction. This identifies a situation where an outpatient surgical or diagnostic procedure was scheduled to be performed but, due to extenuating circumstances or a condition that threatens the well being of the patient, the physician cancels the surgery or diagnostic procedure following the surgical preparation but prior to the induction of the anesthesia (local, regional block[s] or general). The appropriate procedure code is reported with modifier 73. This is not for elective cancellation of a service prior to the administration of anesthesia. Elective cancellation of a service prior to administration of anesthesia should not be reported.
2. Modifier 74 - Discontinued outpatient procedure after anesthesia administration. This identifies a situation where due to extenuating circumstances or those that threaten the well being of the patient, the physician terminates a surgical or diagnostic procedure after the administration of anesthesia or after the procedure

was started (eg, incision made, intubation started, scope inserted). The appropriate procedure code is reported with modifier 74.

3. Other HCPCS modifiers that are informational in nature and identify the specific site of a procedure include, but are not limited to:

* E1 - E4 - Eyelids

* F1 - FA - Fingers

* T1 - TA - Toes

* LT, RT - Left, Right

Bilateral surgeries are considered multiple surgeries. Bilateral surgeries are identified by modifier 50 (bilateral procedure). If only one bilateral surgery is billed, it is reimbursed at full plus half (150%) of the fee schedule amount. If another surgery is billed with the bilateral surgery, the highest rated procedure is paid at full (100%) and each additional procedure is paid at half (50%).

If the additional surgery is the highest rated, it is paid at full. Each side of the bilateral surgery is paid at half. For example:

CPT® Code	Modifier	ASC Fee Schedule Amount	Methodology	Reimbursement
20605	50	\$40.00	Half + Half	\$40.00
20610		\$50.00	Full	\$50.00

If the code that is billed bilaterally has the highest single rate, it is paid at full plus half for the other side. The other surgery is paid at half. For example:

CPT® Code	Modifier	ASC Fee Schedule Amount	Methodology	Reimbursement
20605		\$40.00	Half	\$20.00
20610	50	\$50.00	Full + Half	\$75.00

Multiple bilateral surgeries follow the same payment rules. The highest rated code, if bilateral, is paid at full plus half for the other side. An additional bilateral surgery is paid at half for each side. Other surgeries are paid at half. For example:

CPT® Code	Modifier	ASC Fee Schedule Amount	Methodology	Reimbursement
31267	50	\$2100.00	Full + Half	\$3150.00
31276	50	\$2000.00	Half + Half	\$2000.00
30520		\$1900.00	Half	\$950.00

Note: BCBSND pays the lesser of charges or the final calculated reimbursement.

Bilateral surgery pricing only applies to those codes where it is appropriate to use modifier 50.

Fee schedule amounts listed are examples only and do not represent actual BCBSND fee schedule amounts.

Supplies/Devices/Implants Paid in Addition to the ASC Facility Fee

Some supplies/devices/implants can be reimbursed in addition to the surgical allowance based on the established fee schedule amount or the invoice plus 20% if it is a non-rated code. These items must be identified by the appropriate HCPCS Level II code. The list of codes is updated and published annually. Supplies/devices/implants not on this list are non-covered as a provider liable charge. Listed below are items that are paid in addition to the surgical allowance for service dates on or after January 1, 2011.

D3460	Endodontic Endosseous Implant
J7310	Ganciclovir Long-Acting Implant
J7311	Fluocinolone Acetonide Implant
J7312	Dexamethasone Intravitreal Implant
J9202	Goserelin Acetate Implant
L8619	Cochlear Implant External Processor/Controller Replacement
L8689	External Recharge System Internal
L8695	External Recharge System External
Q4101	Apligraf

Q4102	Oasis Wound Matrix
Q4103	Oasis Burn Matrix
Q4104	Integra BMWD
Q4105	Integra DRT
Q4106	Dermagraft
Q4107	GraftJacket
Q4108	Integra Matrix
Q4110	Primatrix
Q4111	Gammagraft
Q4112	Cymetra Injectable
Q4113	GraftJacket Xpress
Q4114	Integra Flowable Wound Matri
Q4115	Alloskin
Q4116	Alloderm
Q4118	Matristem Micromatrix
Q4119	Matristem Wound Matrix
Q4121	Theraskin
Q4122	Dermacell

Q4123	Alloskin RT
Q4124	Oasis Tri-Layer Wound Matrix
Q4125	Arthoflex
Q4128	Flex HD or Allopatch HD
Q4129	Unite Biomatrix
Q4131	Epifix
Q4132	Grafix Core
Q4133	Grafix Prime
V2785	Corneal Tissue Processing
V5095	Semi-Implantable Middle Ear Hearing Prosthesis