Ambulatory Surgical Centers

Policy

Mass General Brigham Health Plan reimburses contracted providers for covered; medically necessary ambulatory surgical services rendered in an Ambulatory Surgical Center (ASC).

Reimbursement

Providers are reimbursed according to the plan's network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.

Covered services are defined by the member's benefit plan. The manner in which covered services are reimbursed is determined by the Mass General Brigham Health Plan's Payment Policy and by the provider's agreement with Mass General Brigham Health Plan. Member liability amounts may include but are not limited to copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member's benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

Mass General Brigham Health Plan reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to Coding Provider Payment Guidelines for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Observation Services

Ambulatory Surgical Care reimbursement is inclusive of reimbursement for post-procedure time for normal recovery services. In the rare circumstance in which the patient's post-procedural course of care requires treatment beyond this allotted time, the member should be admitted either to observation or to inpatient status. The typical process for admission applies in either case. The facility must have authorization to admit the patient to an observation status.

Mass General Brigham Health Plan Reimburses

- The facility component of the surgery, in accordance with the provider contract in effect at the time services are rendered.
- The facility component at an all-inclusive rate in accordance with the provider contract in effect at the time services were rendered.
- The facility component for a bilateral procedure performed in a single operative session, at the full maximum 150% of the ASC allowable rate for the operative procedure.
- For Commercial and Medicaid line of business, the facility component when multiple independent procedures are performed at the same session as follows, unless otherwise specified in the provider's contract:
  - 100% of the ASC allowable rate for the procedure classified in the highest ASC payment group.
  - 50% of the ASC allowable rate for the procedure classified in the second highest ASC payment group.
  - 25% of the ASC allowable rate for the procedure classified in the third highest ASC payment group

  ***Note**: Mass General Brigham Health Plan determines the primary procedure based on the highest allowable rate, not the charge*
- For Medicare Advantage line of business, see CMS Medicare Claims Processing Manual Chapter 14 - Ambulatory Surgical Centers

Mass General Brigham Health Plan Does *Not* Reimburse

- Observation services billed for normal recovery time
- Recovery room charges
- Services resulting in an inpatient admission at the same facility. Such services are included in the reimbursement for the resulting inpatient admission

Provider Payment Guidelines and Documentation

Although this guideline addresses the ASC facility component only, physician coding and ASC coding of the procedures performed must match.

- Mass General Brigham Health Plan follows CMS OPPS guidelines for ascertaining surgical services appropriate to the Ambulatory Surgical setting. Please refer to CMS for more information on specific services that may be delivered in this site of service.
- Submit ASC claims for the facility component on a UB-04 Form, with Revenue Code 0490. CPT/HCPCS codes must be reported for each procedure/service rendered.
- Submit Professional services on a separate claim with place of service code (POS) 24 (Ambulatory Surgical Center).

Modifiers

Modifier	Descriptor	Comments
50	Bilateral Procedure	Industry standard multiplier may apply
51	Multiple Procedures	Industry standard reduction may apply
52	Reduced services	Industry standard reduction may apply
59	Distinct separate procedure	Industry standard reduction may apply
73	Procedure discontinued after prep for surgery; prior to the administration of anesthesia	Industry standard reduction may apply
74	Procedure discontinued after anesthesia administered; after administration of anesthesia	Industry standard reduction may apply

Related Documents

General Coding and Billing
Modifiers
Mass General Brigham Health Plan Referral and Authorization User Guides
Not Payable Per MassHealth Code Set
Medicare Claims Processing Manual, Chapter 14 - Ambulatory Surgical Centers
Observation Services
Unlisted Code usage requirements

Publication History

Topic: Ambulatory Surgical Centers	Owner: Network Management

March 14, 2011	*Original documentation*
April 19, 2011	*Updated limitations and documentation*
July 30, 2018	*Template update; updates to prior authorization guidelines; clarification of guidance surrounding post-procedure time for recovery services*
January 1,2019	*Document restructure; codes, code descriptor and references updated*
September 1,2019	*Clarification on multiple procedures rules*
January 1, 2023	*Document rebrand; updated references*

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider's agreement, the terms and conditions of the provider's agreement shall prevail. Payment policies are intended to assist providers in obtaining Mass General Brigham Health Plan's payment information. Payment policy determines the rationale by which a submitted claim for service is processed and paid. Payment policy formulation takes into consideration a variety of factors including: the terms of the participating providers 'contract(s); scope of benefits included in a given member's benefit plan; clinical rationale, industry-standard procedure code edits, and industry-standard coding conventions.

Mass General Brigham Health Plan includes Mass General Brigham Health Plan, Inc., and Mass General Brigham Health Plan Health Partners Insurance Company.