

AMBULATORY SURGICAL CENTER (ASC) REIMBURSEMENT PRIOR TO IMPLEMENTATION OF OPPTS, AND THEREAFTER, FREESTANDING ASC REIMBURSEMENT

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I. APPLICABILITY

The policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

Reimbursement of surgical procedures performed in an Ambulatory Surgical Center (ASC) prior to **implementation of Outpatient Prospective Payment System (OPPS)**, and thereafter, Freestanding ASCs.

III. BACKGROUND

A. Reimbursement System.

1. General. Ambulatory surgery procedures performed in ASCs will be reimbursed using prospectively determined rates. The rates will be: established on a cost-basis, divided into eleven payment groups representing ranges of costs, and adjusted for area labor costs based on Metropolitan Statistical Areas (MSAs). Effective **upon implementation of OPPTS**, ambulatory surgery procedures performed in a hospital outpatient department, hospital emergency room, or hospital based ASC will be reimbursed under the hospital OPPTS. (Refer to [Chapter 13, Section 1](#), for more detailed coverage guidelines.)

2. Applicability. This payment system applies to all ambulatory surgery procedures identified in the list in Chapter 9, [Addendums A and B](#). (Creation and updating of Chapter 9, [Addendums A and B](#) is the responsibility of TMA, and the inclusion or omission of any given procedure in Chapter 9, [Addendums A and B](#) cannot be the basis for appealing any claim. Changes to Chapter 9, [Addendums A and B](#) will be provided to the contractors whenever they are made.) The payment system is to be used for ambulatory surgery procedures performed prior to **implementation of OPPTS**, regardless of where the ambulatory surgery procedures are provided, that is, in a freestanding ASC, in a hospital outpatient department, or in a hospital emergency room. Effective **upon implementation of OPPTS**, the payment

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system is to be used for ambulatory surgery procedures provided in freestanding ASCs. The payment rates established under this system apply only to the facility charges for ambulatory surgery. The facility rate is a standard overhead amount that includes nursing and technician services; use of the facility; drugs including take-home drugs for less than \$40; biologicals; surgical dressings, splints, casts and equipment directly related to provision of the surgical procedure; materials for anesthesia; intraocular lenses (IOLs); and administrative, recordkeeping and housekeeping items and services. The rate does not include items such as physicians' fees (or fees of other professional providers authorized to render the services identified in Chapter 9, [Addendums A and B](#) and to bill independently for them); laboratory, X-rays or diagnostic procedures (other than those directly related to the performance of the surgical procedure); prosthetic devices (except IOLs); ambulance services; leg, arm, and back braces; artificial limbs; and durable medical equipment for use in the patient's home.

NOTE: A radiology and diagnostic procedure is considered directly related to the performance of the surgical procedure only if it is an inherent part of the surgical procedure, e.g., the CPT code for the surgical procedure includes the diagnostic or radiology procedure as part of the code description (i.e., CPT¹ procedure code 47560).

3. State Waiver. Ambulatory surgery services provided by freestanding ASCs in Maryland are not exempt from this system and are to be reimbursed using the procedures set forth in this section. (See [Chapter 1, Section 24, paragraph III.E.](#) for payment of professional services related to ambulatory surgery.)

4. Ambulatory Surgery Payment Rates.

a. TMA, or its data contractor, will calculate the payment rates and will provide them (on magnetic media) to the claims processing contractors. The magnetic media will include the locally-adjusted payment rate for each payment group for each Metropolitan Statistical Area (MSA) and will identify, by procedure code, the procedures in each group and the effective date for each procedure. Additions or deletions to the list of procedures will be given to the contractors as they occur, but the magnetic media will be provided only on an annual basis. The MSAs and corresponding wage indexes will be those used by Medicare for ambulatory surgery centers.

b. In addition to the payment rates, the contractors will be provided a zip code to MSA crosswalk, so that they can determine which payment rate to use for each ambulatory surgery provider. For this purpose the zip code of the facility (as opposed to its billing address) is to be used. This crosswalk may be updated periodically throughout the year and sent to the contractors.

c. In order to calculate payment rates, only those procedures with at least twenty-five claims nationwide during the database period will be used.

d. The rates were initially calculated using the following steps.

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(1) For each ambulatory surgery procedure, a median standardized cost was calculated on the basis of all ambulatory surgery charges nationally under TRICARE during the one-year database period. The steps in this calculation included:

(a) Standardizing for local labor costs by reference to the same wage index and labor/non-labor-related cost ratio as applies to the facility under Medicare;

(b) Applying the cost-to-charge ratio using the Medicare cost-to-charge ratio for freestanding ambulatory surgery centers for ASCs.

(c) Calculating a median cost for each procedure; and

(d) Updating to the year for which the payment rates were in effect by the Consumer Price Index--Urban.

(2) Procedures were placed into one of ten groups by their median per procedure cost, starting with \$0 to \$299 for Group 1 and ending with \$1,000 to \$1,299 for Group 9 and \$1,300 and above for Group 10. Groups 2 through 8 were set on the basis of \$100 fixed intervals.

(3) The standard payment amount per group will be the volume weighted median per procedure cost for the procedures in that group.

(4) Procedures for which there was no or insufficient (less than 25 claims) data were assigned to groups by:

(a) Calculating a volume-weighted ratio of TRICARE payment rates to Medicare payment rates for those procedures with sufficient data;

(b) Applying the ratio to the Medicare payment rate for each procedure; and

(c) Assigning the procedure to the appropriate payment group.

e. The amount paid for any ambulatory surgery service under these procedures cannot exceed the amount that would be allowed if the services were provided on an inpatient basis. The allowable inpatient amount equals the applicable DRG relative weight multiplied by the national large urban adjusted standardized amount. This amount will be adjusted by the applicable hospital wage index.

f. As of November 1, 1998, an eleventh payment group is added to this payment system. This group will include extracorporeal shock wave lithotripsy.

5. Payments.

a. General. The payment for a procedure will be the standard payment amount for the group which covers that procedure, adjusted for local labor costs by reference to the

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same labor/non-labor-related cost ratio and hospital wage index as used for ambulatory surgery centers by Medicare. This calculation will be done by TMA, or its data contractor. For participating claims, the ambulatory surgery payment rate will be reimbursed regardless of the actual charges made by the facility--that is, regardless of whether the actual charges are greater or smaller than the payment rate. For nonparticipating claims, reimbursement (TRICARE payment plus beneficiary cost-share plus any double coverage payments, if applicable) cannot exceed the lower of the billed charge or the group payment rate.

b. Procedures Which are Not in Chapter 9, [Addendums A and B](#) and Are Provided by an ASC. Only those procedures contained in Chapter 9, [Addendums A and B](#) are to be reimbursed under this reimbursement process. If a claim is received from an ASC for a procedure which is not in Chapter 9, [Addendums A and B](#), the facility charges are to be reimbursed using the process in [paragraph III.B](#).

c. Procedures Which Are Not in Chapter 9, [Addendums A and B](#) and Are Provided by a Hospital. If an ambulatory surgery procedure not contained in Chapter 9, [Addendums A and B](#) is provided by a hospital (either in an emergency room or in an outpatient department), the claim is to be reimbursed using the process in [paragraph III.B](#) below.

d. Multiple and Terminated Procedures. The following rules are to be followed whenever there is a terminated surgical procedure or more than one procedure is included on an ambulatory surgery claim. The claim for professional services, regardless of what type of ambulatory surgery facility provided the services and regardless of what procedures were provided, is to be reimbursed according to the multiple surgery guidelines in [Chapter 1, Section 16, paragraph III.A.1.a.](#) through [c.](#) and [Chapter 13, Section 3, paragraph III.A.5.b.](#) and [c.](#) for services rendered after **implementation of OPPTS**. For the facility charges, the following rules apply:

(1) Discounting for Multiple Surgical Procedures.

(a) If all the procedures on the claim are included in Chapter 9, [Addendums A and B](#), the claim is to be reimbursed at 100% of the group payment rate for the major procedure (the procedure which allows the greatest payment) and 50% of the group payment rate for each of the other procedures. This applies regardless of the groups to which the procedures are assigned--i.e., if all the procedures are assigned to the same group, payment is to be made for each procedure.

(b) If the claim includes procedures included in Chapter 9, [Addendums A and B](#) as well as procedures not included in Chapter 9, [Addendums A and B](#), the following rule is to be followed.

Each service is to be reimbursed according to the method appropriate to it. That is, the allowable amount for procedures in Chapter 9, [Addendums A and B](#) is to be based on the appropriate group payment amount while the allowable amount for procedures not in Chapter 9, [Addendums A and B](#) is to be based on the process in [paragraph III.B](#) below. Regardless of the method used for determining the reimbursement

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for each procedure, only one procedure (the procedure which allows the greatest payment) is to be reimbursed at 100%. All other procedures are to be reimbursed at 50%. If the contractor is unable to determine the charges for each procedure (i.e., a single billed charge is made for all procedures), the contractor is to develop the claim for the charges using the steps contained in the TRICARE Operations Manual. If development does not result in usable charge data, the contractor is to reimburse the major procedure (the procedure for which the greatest amount is allowed) if that can be determined (e.g., the major procedure is in Chapter 9, [Addendums A and B](#) or is identified on the claim) and deny the other procedures using EOB message "Requested information not received". If the major procedure cannot be determined, the entire claim is to be denied.

(2) Discounting for Bilateral Procedures.

(a) Following are the different categories/classifications of bilateral procedures:

1 Conditional bilateral (i.e., procedure is considered bilateral if the modifier 50 is present).

2 Inherent bilateral (i.e., procedure in and of itself is bilateral).

3 Independent bilateral (i.e., procedure is considered bilateral if the modifier 50 is present, but full payment should be made for each procedure (e.g., certain radiological procedures).

(b) Terminated bilateral procedures or terminated procedures with units greater than one should not occur. Line items with terminated bilateral procedures or terminated procedures with units greater than one are denied.

(c) Inherent bilateral procedures will be treated as a non-bilateral procedure since the bilateralism of the procedure is encompassed in the code.

(d) The above bilateral procedures will be discounted based on the application of discounting formulas appearing in [Chapter 13, Section 3, paragraph III.A.5.c.\(6\)](#) and (7).

(3) Modifiers for Discounting Terminated Surgical Procedures.

(a) Industry standard modifiers may be billed on outpatient hospital or individual professional claims to further define the procedure code or indicate that certain reimbursement situations may apply to the billing. Recognition and utilization of modifiers are essential for ensuring accurate processing and payment of these claim types.

(b) Industry standard modifiers are used to identify surgical procedures which have been terminated prior to and after the delivery of anesthesia.

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1 Modifiers 52 and 73 are used to identify a surgical procedure that is terminated prior to the delivery of anesthesia and is reimbursed at 50% of the allowable; i.e., the Ambulatory Surgery Center (ASC) tier rate, the Ambulatory Payment Classification (APC) allowable amount for OPPTS claims, or the CHAMPUS Maximum Allowable Charge (CMAC) for individual professional providers.

2 Modifiers 53 and 74 are used for terminated surgical procedures after delivery of anesthesia which are reimbursed at 100% of the appropriated allowable amounts referenced above.

(4) Unbundling of Procedures. Contractors should ensure that reimbursement for claims involving multiple procedures conforms to the unbundling guidelines contained in [Chapter 1, Section 3](#).

(5) Incidental Procedures. The rules for reimbursing incidental procedures as contained in [Chapter 1, Section 3](#), are to be applied to ambulatory surgery procedures reimbursed under the rules set forth in this section. That is, no reimbursement is to be made for incidental procedures performed in conjunction with other procedures which are not classified as incidental. This limitation applies to payments for facility claims as well as to professional services.

6. Updating Payment Rates.

a. The rates will be updated annually by TMA by the same update factor as is used in the Medicare annual updates for ambulatory surgery center payments. Periodically the rates will be recalculated using the steps in [paragraph III.A.4.d](#).

b. The rates were updated by 3.2% effective November 1, 1995. This update included the wage indexes as updated by Medicare.

c. The rates were updated by 2.6% effective November 1, 1996. This update included the wage indexes as updated by Medicare.

d. The rates were updated by 0.6% effective November 1, 1997. This update included the wage indexes as updated by Medicare.

e. There was no update to the rates effective November 1, 1998. However, the wage indexes were updated in accordance with Medicare.

f. The rates were updated by 0.8% effective November 1, 1999. This update included the wage indexes as updated by Medicare.

g. The rates were updated by 1.0% effective November 1, 2000. This update included the wage indexes as updated by Medicare.

h. The rates were updated by 0.9% effective November 1, 2001. This update included the wage indexes as updated by Medicare.

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i. The rates were updated by 3.0% effective November 1, 2002. This update included the wage indexes as updated by Medicare.

j. The group payment rates that are effective November 1, 2003, have been recalculated using the steps in [paragraph III.A.4.d](#). However, we used 100 claims rather than 25 claims to calculate a rate for individual procedures, because it produced more statistically valid results while still resulting in calculated rates for about 83% of TRICARE ambulatory surgery services. In addition, the rates were updated by the Medicare update factor of 2.0% and included the wage indexes as updated by Medicare.

k. The rates were reduced by 2.0% effective April 1, 2004.

B. Reimbursement for procedures not in Chapter 9, [Addendums A](#) and [B](#). Prior to January 28, 2000, these procedures were to be denied if performed in an ASC and reimbursed in accordance with [Chapter 1, Section 25](#) if performed in a hospital. Effective January 28, 2000, ambulatory surgery procedures that are not in Chapter 9, [Addendums A](#) and [B](#), and are performed in either a freestanding ASC or hospital may be cost-shared, but only if doing so results in no additional costs to the program.

C. Claims for Ambulatory Surgery.

1. Claims for facility charges must be submitted on a UB-92. Claims for professional charges may be submitted on either a UB-92 or a CMS 1500 claim form. The preferred form is the CMS 1500. When professional services are billed on a UB-92, the information on the UB-92 should indicate that these services are professional in nature and be identified by the appropriate CPT-4 code and revenue code.

2. Claim Data.

a. Billing Data. The claim must identify all procedures which were performed (by CPT-4 or HCPCS code) and indicate if the bill is for facility charges or professional charges. (If the claim is submitted on a UB-92, the procedure code will be shown in FL 44.)

b. TED Data. All ambulatory surgery services are to be reported on the TED using the appropriate CPT-4 code. The only exception is services which are billed using a HCPCS code and for which no CPT-4 code exists. These services are to be reported on the TED using one of the codes in the TRICARE Systems Manual, [Chapter 2, Addendum O](#).

D. Wage Index Changes. If, during the year, Medicare revises any of the wage indexes used for ambulatory surgery reimbursement, such changes will not be incorporated into the TRICARE payment rates until the next routine update. These changes will not be incorporated regardless of the reason Medicare revised the wage index.

E. Subsequent Hospital Admissions. If a beneficiary is admitted to a hospital subject to the DRG-based payment system as a result of complications, etc. of ambulatory surgery, the

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ambulatory surgery procedures are to be billed and reimbursed separately from the hospital inpatient services. The same rules applicable to emergency room services are to be followed.

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