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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 107
6010.55-M
DECEMBER 7, 2009**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: AMBULATORY SURGICAL CENTER (ASC) REIMBURSEMENT UPDATES
FOR FISCAL YEAR (FY) 2010

CONREQ: 14919

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change provides ASC reimbursement updates for FY 2010.

EFFECTIVE DATE: November 1, 2009.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

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Acting Chief, Medical Benefits and
Reimbursement Branch

ATTACHMENT(S): 3 PAGE(S)
DISTRIBUTION: 6010.55-M

**CHANGE 107
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REMOVE PAGE(S)

CHAPTER 9

Section 1, pages 5 through 7

INSERT PAGE(S)

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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.

(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.

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 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 as outlined 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 ASC payments. Periodically the rates will be recalculated using the steps in [paragraph II.A.4.d](#).

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

c. The group payment rates that are effective November 1, 2003, have been recalculated using the steps in [paragraph II.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.

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

e. The rates were updated by 0.6% effective November 1, 2009.

B. Reimbursement for procedures not listed on TMA's ambulatory surgery web site. Prior to January 28, 2000, these procedures were to be denied if performed in an ASC and reimbursed in accordance with [Chapter 1, Section 24](#). Effective January 28, 2000, ambulatory surgery procedures that are not listed on TMA's ambulatory surgery web site, and are performed in either a freestanding ASC or hospital may be cost-shared. These procedures are reimbursed at the lesser of billed charges or network discount. On May 1, 2009 (implementation of OPPS), these non-ASC procedures are subject to [Chapter 13](#) discounting of surgical, bilateral and terminated procedures.

C. Reimbursement System On Or After May 1, 2009 (Implementation of OPPS).

1. For ambulatory surgery procedures performed in an OPPS qualified facility, the provisions in [Chapter 13](#) shall apply.

2. For ambulatory surgery procedures performed in freestanding ASCs and non-OPPS facilities, the provisions in [paragraph II.A](#). shall apply, except as follows:

a. Contractors will no longer be allowed to group other procedures not listed on TMA's ambulatory surgery web site. On May 1, 2009 (implementation of OPPS), these groupers will be end dated. Only ambulatory surgery procedures listed on TMA's ambulatory surgery web site are to be grouped.

b. Multiple and Terminated Procedures. For services rendered on or after May 1, 2009 (implementation of OPPS), the professional services shall be reimbursed according to the multiple surgery guidelines in [Chapter 13, Section 3, paragraph III.A.5.b](#). and [c](#).

c. Discounting for Multiple Surgical Procedures. For services rendered on or after May 1, 2009 (implementation of OPPS), discounting for multiple surgical procedures are subject to the provisions in [Chapter 13, Section 1](#).

d. Discounting for Bilateral Procedures. For services rendered on or after May 1, 2009 (implementation of OPPS), 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 [\(7\)](#).

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D. CAHs. Effective December 1, 2009, ambulatory surgery services performed in CAHs shall be reimbursed under the reasonable cost method, reference [Chapter 15, Section 1](#).

E. Claims for Ambulatory Surgery.

1. Claims for facility charges must be submitted on a CMS 1450 UB-04. Claims for professional charges may be submitted on either a CMS 1450 UB-04 or a CMS 1500 (08/05) claim form. The preferred form is the CMS 1500 (08/05). When professional services are billed on a CMS 1450 UB-04, the information on the CMS 1450 UB-04 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). The facility claim shall be submitted on the CMS 1450 UB-04, the procedure code will be shown in Form Locator (FL) 44.

NOTE: Claims from ASCs must be **submitted** on the CMS 1450 UB-04 claim form. Claims not submitted on the appropriate claim form will be denied.

b. TRICARE Encounter Data (TED). 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.

F. 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.

G. 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 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.

H. Cost-Shares for Ambulatory Surgery Procedures. All surgical procedures performed in an outpatient setting shall be cost-shared at the ASC cost-sharing levels. Refer to [Chapter 2, Section 1, paragraph I.C.3.g](#).

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