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TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 23  
6010.58-M  
DECEMBER 8, 2009**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE REIMBURSEMENT MANUAL (TRM), FEBRUARY 2008**

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:** 14920

**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.

**Reta Michak  
Acting Chief, Medical Benefits and  
Reimbursement Branch**

**ATTACHMENT(S):** 2 PAGE(S)  
**DISTRIBUTION:** 6010.58-M

**CHANGE 23**  
**6010.58-M**  
**DECEMBER 8, 2009**

**REMOVE PAGE(S)**

**CHAPTER 9**

Section 1, pages 5 and 6

**INSERT PAGE(S)**

Section 1, pages 5 and 6

### **2.1.5.3.2 Discounting for Bilateral Procedures**

**2.1.5.3.2.1** Following are the different categories/classifications of bilateral procedures:

- Conditional bilateral (i.e., procedure is considered bilateral if the modifier 50 is present).
- Inherent bilateral (i.e., procedure in and of itself is bilateral).
- 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).

**2.1.5.3.2.2** 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.

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

### **2.1.5.3.3 Modifiers for Discounting Terminated Surgical Procedures**

**2.1.5.3.3.1** 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.

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

- 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 OPSS claims, or the CHAMPUS Maximum Allowable Charge (CMAC) for individual professional providers.
- 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.

### **2.1.5.3.4 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](#).

### **2.1.5.3.5 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

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### Chapter 9, Section 1

#### Ambulatory Surgical Center (ASC) Reimbursement

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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.

#### 2.1.6 Updating Payment Rates

**2.1.6.1** The rates will be updated annually by TMA by the same update factor as is used in the Medicare annual updates for ASC payments.

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

#### 2.2 Reimbursement for Procedures Not Listed On TMA's Ambulatory Surgery Web Site

Ambulatory surgery procedures that are not listed on TMA's ambulatory surgery web site, and are performed in either a freestanding ASC may be cost-shared, but only if doing so results in no additional costs to the program.

#### 2.3 Reimbursement System On Or After May 1, 2009 (Implementation Of OPPS)

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

**2.3.2** For ambulatory surgery procedures performed in freestanding ASCs and non-OPPS facilities, the provisions in [paragraph 2.1](#) shall apply, except as follows:

- 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.
- 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, paragraphs 3.1.5.2 and 3.1.5.3](#).
- 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 3](#).
- 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, paragraphs 3.1.5.3.6 and 3.1.5.3.7](#).

#### 2.4 CAHs

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