Ambulatory Surgery Center

Reimbursement Policy ID: RPC.0036.DEDS

Recent review date: 01/2025

Next review date: 10/2026

AmeriHealth Caritas VIP Care reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas VIP Care use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.
To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses the allowable facility services and reimbursement of those services in an ambulatory surgery center (ASC).

Exceptions

N/A

Reimbursement Guidelines

The unit of payment in the ASC payment system is the individual surgical procedure.

When the ASC performs multiple surgical procedures in the same operative session that are subject to the multiple procedure discount, payment is 100 percent of the highest paying surgical procedure on the claim, plus 50 percent of the applicable payment rate(s) for the other ASC covered surgical procedures subject to the multiple procedure discount that are furnished in the same session.

Reimbursement is 50 percent of the rate if a surgical procedure is terminated due to the onset of medical complications after the patient has been prepared for surgery and taken to the operating room but before anesthesia has been induced or the procedure initiated.

A procedure performed bilaterally in one operative session is reported as two procedures, either as a single unit on two separate lines or with "2" in the unit's field on one claim line. The multiple procedure reduction of 50 percent applies to all bilateral procedures subject to multiple procedure discounting.

The fee paid to the facility shall include but is not limited to:

- Nursing, technician and related services.
- Use of the facility.
- Drugs, biologicals, surgical dressings, supplies, splints, casts and appliances and equipment directly related to the provision of surgical services.
- Administrative, recordkeeping and housekeeping items and services.
- Materials for anesthesia.

Prior authorization is required for an ASC procedure. A claim for a service considered non-covered by AmeriHealth Caritas VIP Care will be denied payment.

Claims for ambulatory surgery procedures or services must be submitted with Place of Service 24 for reimbursement.

Definitions

Ambulatory Surgery Center (ASC)
A certified ambulatory surgery center (ASC) may be either hospital-operated or independent. If hospital-operated, the ASC must be a separately identified entity, physically and administratively distinct from other inpatient operations of the hospital. An ASC may not provide a surgical procedure on a Medicare patient when, before surgery, an overnight hospital stay is anticipated. In cases where hospitalization after surgery is warranted, the ASC must be able to provide immediate transfer to a hospital.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. https://www.cms.gov/medicare/enrollment-renewal/providers-suppliers/ambulatory-surgical-centers.
VII. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c14.pdf.

Attachments

N/A

Associated Policies

RPC.0036.DEDS Multiple Procedure Payment Reduction
RPC.0006.DEDS Bilateral Procedure

Policy History

06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
01/2025	Reimbursement Policy Committee Approval
11/2024	Annual review • Updated to biennial policy • No major changes
04/2024	Revised preamble
01/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by AmeriHealth Caritas VIP Care from Policy History section
01/2023	Template revised Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added