Ambulatory Surgical Center Payment Policy

Applies to the following Tufts Health Plan products:

☒ Tufts Health Plan Commercial
☒ Tufts Medicare Preferred HMO (a Medicare Advantage product)
☒ Tufts Health Plan Senior Care Options (SCO) (a dual-eligible product)

Applies to the following Tufts Health Public Plans products:

☒ Tufts Health Direct (a Massachusetts Qualified Health Plan [QHP]; a commercial product)
☒ Tufts Health Together (a MassHealth MCO Plan and Accountable Care Partnership Plans)
☒ Tufts Health RITogether (a Rhode Island Medicaid Plan)
☒ Tufts Health Unify (OneCare Plan; a dual-eligible product)

The following payment policy applies to Tufts Health Plan contracting freestanding ambulatory surgical centers. For information on professional surgical services, refer to the Surgery Professional Payment Policy.

In addition to the specific information contained in this policy, providers must adhere to the information outlined in the Professional Services and Facilities Payment Policy.

Note: Audit and disclaimer information is located at the end of this document.

POLICY
Tufts Health Plan covers medically necessary services including surgical day care (SDC) rendered in a freestanding ambulatory surgical center (ASC), in accordance with the member’s benefits.

GENERAL BENEFIT INFORMATION
Services and subsequent payment are pursuant to the member's benefit plan document. Member eligibility and benefit specifics should be verified prior to initiating services by logging on to the secure Provider portal or by contacting Provider Services.

Note: There is no member responsibility for covered services for Tufts Health Plan SCO, Tufts Health Unify, Tufts Health Together, or Tufts Health RITogether members.

REFERRAL/PRIOR AUTHORIZATION/NOTIFICATION REQUIREMENTS
Certain procedures, items and/or services may require referral and/or prior authorization. While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you must confirm that prior authorization has been obtained. For more information, refer to the Referral, Prior Authorization and Notification Policy.

Note: ASC facility claims will be denied if a referral to the specialist/surgeon has not been obtained.

BILLING INSTRUCTIONS
Unless otherwise stated, Tufts Health Plan follows industry-standard coding guidelines. Refer to current industry standard coding guidelines for a complete list of ICD, CPT/HCPCS, revenue codes, modifiers, and their usage. Providers may only bill the procedure code(s) in accordance with the applicable financial exhibits of their provider agreements and applicable fee schedules. For more information, refer to the Professional Services and Facilities Payment Policy.

Use of noncontracting labs may have the unintended consequence of subjecting the member to unnecessary services not ordered by the treating provider or other unreasonable financial exposure. In
such circumstances, Tufts Health Plan may hold the ordering provider accountable for any inappropriate behavior on the part of the nonparticipating lab that has been selected.

Submit claims with supporting documentation (e.g., invoices, operative notes) using industry-standard red paper claim forms. Claims requiring supporting documentation deny if submitted electronically.

**COMPENSATION/REIMBURSEMENT INFORMATION**

Providers are compensated according to the applicable network contracted rates and applicable fee schedules, regardless of the address where the service is rendered. For additional information, refer to the [Professional Services and Facilities Payment Policy](#).

If a member receives multiple levels of service within the same episode of care, compensation for the lower-intensity services will be bundled into the payment for the highest intensity services rendered:

1. Hospital inpatient services
2. Hospital surgical day care services
3. Hospital ambulatory/minor surgical services
4. Hospital observation bed services
5. Hospital emergency department (ED) services
6. Hospital urgent care clinic services
7. Hospital clinic services

**Bilateral and Multiple Surgical Procedures**

Tufts Health Plan applies multiple surgical procedures reduction when the same provider performs two or more surgical procedures, including procedures performed bilaterally and/or different procedures in multiple compartments in the same joint, on the same member within the same operative session. Refer to the [Bilateral and Multiple Surgical Procedures Facility Payment Policy](#) for additional information regarding multiple surgical procedures reduction.

**New Technology Intraocular Lenses**

Compensation for new technology intraocular lenses (NT-IOLs) is considered part of the surgical procedure. Refer to the Vision Services Payment Policies for [Commercial and Senior Products](#) and [Tufts Health Public Plans](#) for more information.

**ADDITIONAL RESOURCES**

- [Bilateral and Multiple Surgical Procedures Facility Payment Policy](#)
- [Joint Surgery Program](#)
- [Non-covered/Non-reimbursable Services Payment Policy](#)
- [Outpatient Facility Payment Policy](#)
- [Spinal Conditions Management Program](#)
- [Unlisted and Not Otherwise Classified Codes Payment Policy](#)

**DOCUMENT HISTORY**

- May 2022: Added existing hospital hierarchy compensation information
- May 2020: Reviewed by committee; added Senior Products and Tufts Health Public Plans content; removed information on member cost share and benefit specific information
- June 2018: Template updates
- January 2017: Template updates
- July 2016: Added abrasion arthroplasty edit effective for dates of service on or after October 1, 2016
- February 2016: Added fax number for the submission of implant and/or prosthetic device claim disputes
- September 2015: Template conversion, template updates
- August 2015: Added procedure code A4649
- July 2015: Added information regarding the Spinal Conditions Prior Authorization Program effective for dates of service on or after August 1, 2015, template updates

**AUDIT AND DISCLAIMER INFORMATION**

Tufts Health Plan reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in this payment policy. If such an audit determines that a provider/facility did not comply with this payment policy, Tufts Health Plan will expect the provider/facility to refund all payments related to noncompliance. For more information about Tufts Health Plan’s [audit policies](#), refer to the Provider website.
This policy provides information on Tufts Health Plan claims adjudication processes. As every claim is unique, this policy is neither a guarantee of payment, nor a final indication of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management requirements (when applicable), adherence to plan policies and procedures, and claims editing logic. An authorization is not a guarantee of payment. Claims for services subject to authorization may be reviewed for accuracy and compliance with payment policies.

This policy applies to the Tufts Health Plan products, as identified in the checkboxes on the first page, and to CareLink℠ for providers in Massachusetts and Rhode Island service areas. Providers in the New Hampshire service area are subject to Cigna’s provider agreements with respect to CareLink members. This policy does not apply to the Private Health Care Systems (PHCS) network (also known as Multiplan). Tufts Health Plan reserves the right to amend a payment policy at its discretion.