Ambulatory Surgical Center Payment Policy

Applies to the following Tufts Health Plan products:

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

The following payment policy applies to Tufts Health Plan contracting freestanding ambulatory surgical centers. For information on Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options click here.

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 surgical services including surgical day care (SDC) rendered in a freestanding ambulatory surgical center (ASC), as described below.

**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 website or by contacting Commercial Provider Services.

**Reconstructive and Cosmetic Surgery**
Services including surgery, procedures, supplies, medications or appliances used to change body structures in order to improve appearance and/or self-esteem are considered cosmetic and are **not covered**. Surgical services to improve the function of a body part or organ that has been adversely affected by illness, injury or congenital defect are covered with appropriate authorization. Refer to the Reconstructive and Cosmetic Surgery Medical Necessity Guidelines for more information.

**Investigational Procedures**
Surgical CPT codes and procedures that are classified as investigational in nature are not covered. Refer to the Noncovered Investigational Services Medical Necessity Guidelines for more information.

<table>
<thead>
<tr>
<th>Services Rendered</th>
<th>Cost Share (if applicable)</th>
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</thead>
<tbody>
<tr>
<td>SDC at outpatient facility or freestanding ASC</td>
<td>SDC copayment, coinsurance and/or deductible</td>
</tr>
<tr>
<td>SDC rendered at an ASC resulting in an inpatient stay at a separate facility</td>
<td>SDC copayment, coinsurance and/or deductible</td>
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<table>
<thead>
<tr>
<th>Cost Share (if applicable)</th>
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</thead>
<tbody>
<tr>
<td>Inpatient copayment, coinsurance and/or deductible</td>
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</table>

**AUTHORIZATION REQUIREMENTS**
ASC facility claims will be denied if a referral to the specialist/surgeon has not been obtained. All inpatient admissions require inpatient notification prior to services being rendered.

Prior authorization is required for interventional pain management, lumbar and cervical spine surgeries, and joint surgeries through National Imaging Associates, Inc. (NIA). Providers may contact NIA for prior authorization through RadMD.


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1 Commercial products include HMO, POS, PPO, Tufts Health Freedom Plan, and CareLinkSM when Tufts Health Plan is the primary administrator.
BILLING INSTRUCTIONS
Submit provider ID number in both the Provider and Payee ID indicator fields (24j, 32 and 33) in order for the claim to be processed as a freestanding surgical center claim.

Corneal Tissue Processing
Submit corneal tissue processing claims with HCPCS procedure code V2785 with the invoice amount. Invoices should be retained by the ASC for potential record audits.

Implants and Prosthetic Devices
- Submit implant and/or prosthetic device claims with procedure code 99070 or A4649 in accordance with the applicable financial exhibits of your provider agreement
- Attach the invoice for implants and/or prosthetic devices to the paper claim
- Implant and/or prosthetic device claim disputes for procedure code 99070 or A4649 must be faxed to 617.673.0308.

New Technology Intraocular Lenses
Reimbursement for new technology intraocular lenses (NTIOls) is considered part of the surgical procedure.

Presbyopia-Correcting Intraocular Lenses
Commercial members who request the insertion of a presbyopia-correcting intraocular lens (P-C IOL) instead of a conventional IOL following removal of a cataract will be responsible for the additional cost of the P-C IOL.

ASCs should submit the same CPT code that is used to report removal of a cataract with insertion of a conventional IOL. ASCs may also submit an additional HCPCS code, V2788 (Presbyopia-Correcting Intraocular Lenses), to indicate any additional charges that accrue when a P-C IOL is inserted in lieu of a conventional IOL.

COMPENSATION/REIMBURSEMENT INFORMATION
Compensation for freestanding ASCs is based on the provider’s contracted payment schedule and follows the CMS ASC Approved Surgical Code List. Procedure codes not on the CMS ASC Procedure Code List or procedures not included in the Additions to the Approved Ambulatory Surgical Center Procedure Code List will be denied as non-contracted procedure codes and must be appealed for consideration of compensation. This includes unlisted surgical procedure codes. Refer to your Provider Agreement for compensation rates.

Abrasion Arthroplasty
Tufts Health Plan will not separately compensate for procedure code 29879 (arthroscopy of knee with abrasion arthroplasty) when billed with procedure codes 29880–29881 (arthroscopy of knee with meniscectomy).

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.

Implants and Prosthetic Devices
Implants and/or prosthetic devices are reimbursed at the provider’s cost when the aggregate cost of the implant and/or prosthetic device is equal to or greater than $300 per case. The implants and/or prosthetics must be submitted on a separate claim from the surgical procedure done on the same day.

Surgical Global Day Period
Surgical procedures are assigned a global day period of 0, 10 or 90 day(s) by CMS based on the complexity of the procedure. Services rendered within the assigned specified numbers of global days, including evaluation and management services (E&M), are considered inclusive to the primary procedure.
Unlisted Surgical Procedure Codes
Any procedure code(s) not listed on the provider’s contract, including unlisted surgical procedure codes, submitted by an ASC will deny for a non-contracted service and must be appealed. Providers should follow the payment dispute process in order to dispute the claim.

ADDITIONAL RESOURCES
Bilateral and Multiple Surgical Procedures Facility Payment Policy
Emergency Department Services Facility Payment Policy
Non-covered/Nonreimbursable Services Facility Payment Policy

DOCUMENT HISTORY
• 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
• December 2014: Moved information about unlisted procedure codes to the Claims Submission payment policy, template updates
• November 2013: Template updates
• September 2013: Template conversion
• May 2012: Policy reviewed, removed drug and biological information, template updates
• April 2012: Template updates
• March 2012: Updated CareLink disclaimer language
• October 2011: Template updates, no content changes
• May 2011: Updated that effective for dates of service on or after May 1, 2011, Tufts Health Plan no longer provides an additional $50 payment for NTIOLs.
• February 2010: Added that effective for claims adjudicated on or after April 1, 2010, Tufts Health Plan will not reimburse a lipid panel test more than two times within a 365-day period
• November 2009: Removed laboratory-diagnosis code combination information for claims adjudicated on or after July 1, 2009. These edits are no longer effective. Removed two drug and biological edits (docetaxel and serum creatine and zolendronic acid). These edits are no longer effective.
• August 2009: Added information about new drug and biological edits.
• June 2009: Clarified add-on codes are not reimbursed if the primary procedure code has not been submitted on the same date of service. Added implants and prosthetic devices mailing address effective September 1, 2009.
• May 2009: Added laboratory-diagnosis code combination information.
• March 2009: Added NTIOL information.
• November 2008: Added that effective for dates of services on or after February 1, 2009, Tufts Health Plan will not reimburse the subcutaneous or intramuscular injection code when billed with the administration of vaccines and toxoids as the subcutaneous or intramuscular injection code is inappropriate to use for the administration of vaccines and toxoids.
• May 2008: Added Tufts Medicare Preferred and Presbyopia-Correcting Intraocular Lenses (P-C IOL's) information and revised the Additions to the Approved Ambulatory Surgical Center Procedure Code List.
• January 2017: 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 an office/facility did not comply with this payment policy, Tufts Health Plan will expect the office/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 CareLinkSM 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.