**Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options Ambulatory Surgical Center Payment Policy**

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

In addition to the specific information contained here, providers must adhere to the policy information outlined in the professional payment policies for Commercial and Tufts Medicare Preferred HMO/Tufts Health Plan SCO products, located in the Provider Resource Center or on the Payment Policies page.

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

**POLICY**

Tufts Medicare Preferred HMO and Tufts Health Plan SCO cover medically necessary surgical services including surgical day care (SDC) rendered in a freestanding ambulatory surgical center (ASC).

**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 our website or by contacting Provider Relations.

**Note:** There is no member responsibility for Tufts Health Plan SCO members.

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

**AUTHORIZATION REQUIREMENTS**

Inpatient notification is not required for ambulatory SDC services.

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

**BILLING INSTRUCTIONS**

- Submit the name of the rendering provider in box 17 of the CMS-1500 Form.
- Submit the 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.
- Submit the invoice for implants and/or prosthetic devices as an attachment to the paper claim.

**New Technology Intraocular Lenses**

Reimbursement for new technology intraocular lenses (NTIOLs) is considered part of the surgical procedure.

**Presbyopia-Correcting Intraocular Lenses**

There is no member responsibility for presbyopia-correcting intraocular lenses (P-C IOLs) for Tufts Health Plan SCO members.
Tufts Medicare Preferred HMO members who request the insertion of a 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 (P-C IOL) to indicate any additional charges that accrue when a P-C IOL is inserted in lieu of a conventional IOL.

Unlisted Surgical Procedure Codes
- Submit the most appropriate unlisted surgical procedure code(s) available on an official paper CMS-1500 form.
- Submit supporting clinical documentation to accurately describe the unlisted surgical procedure code(s). Unlisted procedure codes submitted without documentation will be denied.

COMPENSATION/REIMBURSEMENT INFORMATION
Reimbursement 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 provider’s contract, including unlisted surgical procedure codes, and not on the CMS ASC Procedure Code List will be denied as noncontracted procedure codes; and must be appealed with appropriate clinical documentation for consideration of compensation. This includes unlisted surgical procedure codes. Refer to your Provider Agreement for reimbursement rates. Providers should follow the payment dispute process in order to dispute the claim.

Abrasion Arthroplasty
Effective for dates of service on or after October 1, 2016, Tufts Health Plan does 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 will be 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.

DOCUMENT HISTORY
- January 2017: Template updates
- July 2016: Added abrasion arthroplasty edit effective for dates of service on or after October 1, 2016
- September 2015: Template conversion, template updates
- August 2014: Updated information about prior notice requirements for unauthorized services/items for Tufts Medicare Preferred HMO members, template updates
- November 2013: Added information regarding Tufts Health Plan Senior Care Options, template updates
- September 2013: Template conversion
- September 2012: Added information regarding the change to preregistration requirements for ambulatory surgical day services care, effective November 1, 2012, template updates
- May 2012: Policy reviewed, template updates
- May 2011: Updated that effective for dates of service on or after February 27, 2011, Tufts Health Plan Medicare Preferred no longer provides an additional $50 payment for NTIOLs
- January 2010: Removed references to the Tufts Medicare Preferred PPO product
June 2009: Clarified add-on codes are not reimbursed if the primary procedure code has not been submitted on the same date of service

March 2009: Policy created. Added NTIOL information and moved Tufts Medicare Preferred HMO information to its own document

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

**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 your office/facility did not comply with this payment policy, Tufts Health Plan will expect your office/facility to refund all payments related to non-compliance. For more information about Tufts Health Plan’s audit policies, refer to our website.

This policy provides information on Tufts Medicare Preferred HMO and Tufts Health Plan Senior Care Options claims adjudication processing guidelines. As every claim is unique, the use of this policy is neither a guarantee of payment nor a final prediction 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 guidelines when applicable, adherence to plan policies and procedures and claims editing logic.