CHAPTER 13
SECTION 9.1

AMBULATORY SURGICAL CENTER REIMBURSEMENT

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I. APPLICABILITY

The policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by TMA and specifically included in the network provider agreement.

II. ISSUE

How are ambulatory surgery procedures to be reimbursed?

III. BACKGROUND

A. Reimbursement System

1. General. Payment for ambulatory surgery procedures will be made using prospectively determined rates. The rates will be: established on a cost-basis, divided into eleven payment groups representing ranges of costs, and adjusted for area labor costs based on Metropolitan Statistical Areas (MSAs).

2. Applicability. This payment system applies to all ambulatory surgery procedures identified in the list in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15. (Creation and updating of Addendum 1, Section 1 through Section 15 is the responsibility of TMA, and the inclusion or omission of any given procedure in Addendum 1, Section 1 through Section 15 cannot be the basis for appealing any claim. Changes to Addendum 1, Section 1 through Section 15 will be provided to the contractors whenever they are made.) The payment system is to be used regardless of where the ambulatory surgery procedures are provided--that is, in a freestanding ambulatory surgery center (ASC), in a hospital outpatient department, or in a hospital emergency room. (Throughout this instruction, ASC refers only to freestanding ambulatory surgery centers.) The payment rates established under this system apply only to the facility charges for ambulatory surgery. The facility rate is a standard overhead amount that includes nursing and technician services; use of the facility; drugs including take-home drugs for less than $40; biologicals; surgical dressings, splints, casts and equipment directly related to provision of the surgical procedure; materials for anesthesia; intraocular lenses (IOLs); and administrative, recordkeeping and housekeeping items and services. The rate does not include items such as physicians' fees (or fees of other

professional providers authorized to render the services identified in Addendum 1, Section 1 through Section 15 and to bill independently for them); laboratory, X-rays or diagnostic procedures (other than those directly related to the performance of the surgical procedure); prosthetic devices (except IOLs); ambulance services; leg, arm, and back braces; artificial limbs; and durable medical equipment for use in the patient's home.

3. Ambulatory Surgery Payment Rates.

a. TMA, or its data contractor, will calculate the payment rates and will provide them (on magnetic media) to the claims processing contractors. The magnetic media will include the locally-adjusted payment rate for each payment group for each Metropolitan Statistical Area (MSA) and will identify, by procedure code, the procedures in each group and the effective date for each procedure. Additions or deletions to the list of procedures will be given to the contractors as they occur, but the magnetic media will be provided only on an annual basis. The MSAs and corresponding wage indexes will be those used by Medicare for ambulatory surgery centers.

b. In addition to the payment rates, the contractors will be provided a zip code to MSA crosswalk, so that they can determine which payment rate to use for each ambulatory surgery provider. For this purpose the zip code of the facility (as opposed to its billing address) is to be used. This crosswalk may be updated periodically throughout the year and sent to the contractors.

c. In order to calculate payment rates, only those procedures with at least twenty-five claims nationwide during the database period will be used.

d. The rates were initially calculated using the following steps.

(1) For each ambulatory surgery procedure, a median standardized cost was calculated on the basis of all ambulatory surgery charges nationally under TRICARE during the one-year database period. The steps in this calculation included:

(a) Standardizing for local labor costs by reference to the same wage index and labor/non-labor-related cost ratio as applies to the facility under Medicare;

(b) Applying the cost-to-charge ratio using the Medicare cost-to-charge ratio for freestanding ambulatory surgery centers for ASCs and the Medicare cost-to-charge ratio for hospital outpatient settings for all charges from hospitals;

(c) Calculating a median cost for each procedure; and

(d) Updating to the year for which the payment rates were in effect by the Consumer Price Index--Urban.

(2) Procedures were placed into one of ten groups by their median per procedure cost, starting with $0 to $299 for Group 1 and ending with $1,000 to $1,299 for Group 9 and $1,300 and above for Group 10. Groups 2 through 8 were set on the basis of $100 fixed intervals.

(3) The standard payment amount per group will be the volume weighted median per procedure cost for the procedures in that group.

(4) Procedures for which there was no or insufficient (less than 25 claims) data were assigned to groups by:

(a) Calculating a volume-weighted ratio of TRICARE payment rates to Medicare payment rates for those procedures with sufficient data;

(b) Applying the ratio to the Medicare payment rate for each procedure; and

(c) Assigning the procedure to the appropriate payment group.

e. The amount paid for any ambulatory surgery service under these procedures cannot exceed the amount that would be allowed if the services were provided on an inpatient basis. The allowable inpatient amount equals the applicable DRG relative weight multiplied by the national large urban adjusted standardized amount. This amount will be adjusted by the applicable hospital wage index.

f. As of November 1, 1998, an eleventh payment group is added to this payment system. This group will include extracorporeal shock wave lithotripsy.

4. Payments.

a. General. The payment for a procedure will be the standard payment amount for the group which covers that procedure, adjusted for local labor costs by reference to the same labor/non-labor-related cost ratio and hospital wage index as used for ambulatory surgery centers by Medicare. This calculation will be done by TMA, or its data contractor. For participating claims, the ambulatory surgery payment rate will be reimbursed regardless of the actual charges made by the facility--that is, regardless of whether the actual charges are greater or smaller than the payment rate. For nonparticipating claims, reimbursement (TRICARE payment plus beneficiary cost-share plus any double coverage payments, if applicable) cannot exceed the lower of the billed charge or the group payment rate.

b. Procedures Which are Not in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15 and Are Provided by an ASC. Only those procedures contained in Addendum 1, Section 1 through Section 15 are to be reimbursed under this reimbursement process. If a claim is received from an ASC for a procedure which is not in Addendum 1, Section 1 through Section 15, the facility charges are to be denied using EOB message 8, Provider not TRICARE-authorized for this service. These charges are the responsibility of the beneficiary. Claims for the related professional services can be processed and reimbursed as outpatient services.

c. Procedures Which Are Not in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15 and Are Provided by a Hospital. If an ambulatory surgery procedure not contained in Addendum 1, Section 1 through Section 15 is provided by a hospital (either in an emergency room or in an outpatient department), the claim is to be reimbursed based on the billed charges and cost-shared as outpatient services.

d. Multiple Procedures. The following rules are to be followed whenever more than one procedure is included on an ambulatory surgery claim. The claim for professional services, regardless of what type of ambulatory surgery facility provided the services and regardless of what procedures were provided, is to be reimbursed according to the multiple surgery guidelines in Chapter 13, Section 3.7. For the facility charges, the following rules apply:

(1) If all the procedures on the claim are included in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15, the claim is to be reimbursed at 100 percent of the group payment rate for the major procedure (the procedure which allows the greatest payment) and 50 percent of the group payment rate for each of the other procedures. This applies regardless of the groups to which the procedures are assigned--i.e., if all the procedures are assigned to the same group, payment is to be made for each procedure.

(2) If the claim includes procedures included in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15 as well as procedures not included in Addendum 1, Section 1 through Section 15, the following rules are to be followed.

(a) If the services are provided in an ASC, all procedures which are not on the list are to be denied. If more than one procedure on the list is on the facility claim, reimbursement is to be 100 percent of the group payment rate for the major procedure (the procedure which allows the greatest payment) and 50 percent of the group payment rate for each of the other procedures.

(b) If the services are provided in a hospital, each service is to be reimbursed according to the method appropriate to it. That is, the allowable amount for procedures in Chapter 13, Section 9.1, Addendum 1, Section 1 through Section 15 is to be based on the appropriate group payment amount while the allowable amount for procedures not in Addendum 1, Section 1 through Section 15 is to be based on the billed charge for that procedure. Regardless of the method used for determining the reimbursement for each procedure, only one procedure (the procedure which allows the greatest payment) is to be reimbursed at 100 percent. All other procedures are to be reimbursed at 50 percent. If the contractor is unable to determine the charges for each procedure (i.e., a single billed charge is made for all procedures), the contractor is to develop the claim for the charges using the steps contained in the Operations Manual. If development does not result in usable charge data, the contractor is to reimburse the major procedure (the procedure for which the greatest amount is allowed) if that can be determined (e.g., the major procedure is in Addendum 1, Section 1 through Section 15 or is identified on the claim) and deny the other procedures using EOB message “Requested information not received”. If the major procedure cannot be determined, the entire claim is to be denied.

(3) Unbundling of Procedures. Contractors should ensure that reimbursement for claims involving multiple procedures conforms to the unbundling guidelines contained in Chapter 13, Section 1.4 and the Operations Manual.

(4) Incidental Procedures. The rules for reimbursing incidental procedures as contained in Chapter 13, Section 3.7, are to be applied to ambulatory surgery procedures reimbursed under the rules set forth in this 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.

5. Updating Payment Rates. The rates will be updated annually by TMA by the same update factor as is used in the Medicare annual updates for ambulatory surgery center payments. Periodically the rates will be recalculated using the steps in paragraph III.A.3.d. above.

B. Claims for Ambulatory Surgery

1. Claim Forms. Claims submitted by the facility for the facility charges may be submitted on either a UB-92 or a HCFA 1500 claim form, while all those for professional charges must be billed on the HCFA 1500.

2. Claim Data.

a. Billing Data. The claim must identify all procedures which were performed (by CPT-4 or HCPCS code) and indicate if the bill is for facility charges or professional charges. (If the claim is submitted on a UB-92, the procedure code will be shown in FL 44.)

b. HCSR Data. All ambulatory surgery services are to be reported on the HCSR using the appropriate CPT-4 code. The only exception is services which are billed using a HCPCS code and for which no CPT-4 code exists. These services are to be reported on the HCSR using one of the codes in the ADP Manual, Chapter 2, Addendum F, Figure 2-F-1.

C. Wage Index Changes. If, during the year, Medicare revises any of the wage indexes used for ambulatory surgery reimbursement, such changes will not be incorporated into the TRICARE payment rates until the next routine update. These changes will not be incorporated regardless of the reason Medicare revised the wage index.

D. Subsequent Hospital Admissions. If a beneficiary is admitted to a hospital subject to the DRG-based payment system as a result of complications, etc. of ambulatory surgery, the ambulatory surgery procedures are to be billed and reimbursed separately from the hospital inpatient services. The same rules applicable to emergency room services are to be followed.

E. Sole Community Hospitals. Sole community hospitals are not recognized under this reimbursement system and are not exempt from it. Any hospital that has been designated as a sole community hospital under another payment system, such as the DRG-based payment system, or under Medicare will be reimbursed under the same procedures described in this Section 9.1 for any other provider.

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