

Ambulatory Surgical Center (ASC) Reimbursement

Issue Date: August 26, 1985
Authority: [32 CFR 199.14\(d\)](#)

1.0 APPLICABILITY

1.1 This 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 the Defense Health Agency (DHA) and specifically included in the network provider agreement.

1.2 Reimbursement of surgical procedures performed in an ASC prior to the implementation of the reasonable cost method for Critical Access Hospitals (CAHs) and implementation of TRICARE's Outpatient Prospective Payment System (OPPS), and thereafter, freestanding ASCs (FASCs), and other providers who are exempt from the TRICARE OPPS and provide scheduled ambulatory surgery. For purposes of this section, these facilities are known as non-OPPS facilities. Non-OPPS facilities include any facility not subject to the OPPS as outlined in [Chapter 13, Section 1, paragraph 3.4.1.2](#).

2.0 REIMBURSEMENT OF AMBULATORY SURGERY

2.1 This reimbursement policy applies to surgical procedures performed in FASCs and other TRICARE providers who are exempt from the TRICARE OPPS which provide scheduled ambulatory surgery. For purposes of this section, facilities exempt from TRICARE OPPS (known as non-OPPS facilities) are outlined in [Chapter 13, Section 1, paragraph 3.4.1.2](#). Ambulatory surgery services performed in CAHs shall be reimbursed under the reasonable cost method (reference [Chapter 15, Section 1](#)).

2.2 State Waiver

Ambulatory surgery services provided by FASCs in Maryland are not exempt from this system and are to be reimbursed using the procedures set forth in this section. (See [Chapter 1, Section 24, paragraph 2.5](#) for payment of professional services related to ambulatory surgery.)

3.0 POLICY

3.1 Ambulatory surgery procedures performed by providers described in [paragraph 2.0](#) will be reimbursed 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). No additional benefits are payable outside the ASC payment rate; e.g., revenue codes 260, 450, 510, 636, etc.

3.2 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.

3.3 This payment rate does not include items such as physicians' fees (or fees of other professional providers authorized to render the services 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 (DME) for use in the patient's home.

Note: A radiology and diagnostic procedure is considered directly related to the performance of the surgical procedure only if it is an inherent part of the surgical procedure, e.g., the Common Procedure Terminology (CPT) code for the surgical procedure includes the diagnostic or radiology procedure as part of the code description (i.e., CPT¹ procedure code 47560).

3.4 Ambulatory Surgery Payment Rates

3.4.1 DHA, or its data contractor, will calculate the payment rates and will provide them electronically to the claims processing contractors **annually**. The electronic media will include the locally-adjusted payment rate for each payment group for each MSA and will identify, by procedure code, the procedures in each group and the effective date for each procedure. The MSAs and corresponding wage indexes will be those used by Medicare.

3.4.2 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's physical address (as opposed to its billing address) is to be used. This crosswalk may be updated periodically throughout the year and sent to the contractors.

3.4.3 In order to calculate payment rates, only those procedures with at least 25 claims nationwide during the database period will be used.

3.4.4 The rates were initially calculated using the following steps.

3.4.4.1 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:

- 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;
- Applying the Cost-to-Charge Ratio (CCR) using the Medicare CCR for FASCs for TRICARE ASCs.

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- Calculating a median cost for each procedure; and
- Updating to the year for which the payment rates were in effect by the Consumer Price Index-Urban (CPI-U).

3.4.4.2 Procedures were placed into one of 10 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.

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

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

- Calculating a volume-weighted ratio of TRICARE payment rates to Medicare payment rates for those procedures with sufficient data;
- Applying the ratio to the Medicare payment rate for each procedure; and
- Assigning the procedure to the appropriate payment group.

3.4.5 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 Diagnosis Related Group (DRG) relative weight multiplied by the national large urban adjusted standardized amount. This amount will be adjusted by the applicable hospital wage index.

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

3.4.7 Grouping and Additions to the ASC Procedure List for Dates of Service on or after March 1, 2017

3.4.7.1 Effective March 1, 2017, only those procedures listed on DHA's ambulatory surgery web site shall be cost-shared in FASCs. Upon evaluation, TRICARE may add additional procedures to the list. Groupings shall be accomplished in accordance with the following procedures:

3.4.7.1.1 Prior to March 1, 2017, DHA shall:

- Step 1: Review all allowed ASC charges in the ASC Calendar Years (CYs) 2014 and 2015 for procedures not included on TRICARE's ASC list, and identify those procedures with at least 25 claims in either calendar year.
- Step 2: Deflate the billed charges to the base period, and shall then update the base year charges forward to the current ASC fiscal year using the ASC annual update factors. Then the most recent Medicare ASC CCR (1994, 0.483) shall be used to convert the charges to costs. The procedure shall then be placed in one of the eleven TRICARE payment groups.

- Step 3: For codes with less than 25 claims in CY 2014 or 2015, the surgery codes shall be evaluated to determine if there is a similar code within a group on the current TRICARE ASC list. If so, the code shall be assigned to the similar group. Information about the code's grouping under Medicare's current ASC fee schedule shall be utilized to support the grouping.
- Step 4: Shall compare all procedures assigned to a group under this methodology with the current Medicare ASC payment. If assignment using these methods results in an amount less than would be paid under the current Medicare payment, TRICARE shall raise the rates for that procedure to equal the amount paid by Medicare. This step shall only occur for newly-added procedures to the ASC list.

3.4.7.1.2 Contractors may bring additional procedures that are not on the ASC list to the attention of DHA, for evaluation by DHA for inclusion on the ASC list, which shall be updated on an annual basis.

3.4.7.1.3 Newly-added procedure rates developed through the procedures established in paragraph 3.4.7.1 apply only to FASCs. Other non-OPPS providers (i.e., those listed in Chapter 13, Section 1, paragraph 3.4.1.2 except FASCs), are not subject to the newly-added rates for surgical procedures and shall continue to be paid in accordance with the Chapter 1, Section 24. DHA shall notate those procedures that are newly-added within the listing posted to the DHA web site.

3.4.7.2 Newly-added procedures will be added to the ASC list on the effective date of each ASC update year (November 1). The first group of newly-added procedures (described in paragraph 3.4.7.1.1) shall be added to the list before March 1, 2017, and will be effective for a partial year, i.e., March 1 through October 31, 2017.

3.5 Payments

3.5.1 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 ASCs by Medicare. This calculation will be done by DHA, 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.

3.5.2 Procedures Which Do Not Have An Ambulatory Surgery Rate and Are Provided by an FASC

3.5.2.1 Only those surgical procedures that have an ambulatory surgery rate listed on DHA's ambulatory surgery web site (<http://www.health.mil/rates>) are to be reimbursed under this reimbursement process. Effective March 1, 2017, if a claim is received from an ASC for a surgical procedure which is not listed on DHA's ambulatory web site, and the service was provided on or after March 1, 2017, the claim shall be denied.

3.5.2.2 Non-surgical services, such as evaluation and management visits, laboratory, and radiology services are to be paid in accordance with TRICARE's allowable charge methodology (see Chapter 5).

3.5.3 Multiple and Terminated Procedures

3.5.3.1 Discounting for Multiple Surgical Procedures

3.5.3.1.1 Professional services shall be reimbursed according to the multiple surgery guidelines in Chapter 1, Section 16, paragraph 3.1.

3.5.3.1.2 Discounting of multiple surgical procedures is subject to the provisions in Chapter 13, Section 3.

Note: Effective March 1, 2017, FASCs shall be reimbursed for only those surgical services on TRICARE's ASC list (see paragraph 3.5.2).

3.5.3.2 Discounting for Bilateral Procedures

3.5.3.2.1 Bilateral procedures will be discounted based on the application of discounting formulas appearing in Chapter 13, Section 3, paragraphs 3.1.5.3.6 and 3.1.5.3.7.

3.5.3.2.2 Modifiers for Discounting Terminated Surgical Procedures

3.5.3.2.2.1 Industry standard modifiers may be billed on outpatient hospital or individual professional claims to further define the procedure code or indicate that certain reimbursement situations may apply to the billing. Recognition and utilization of modifiers are essential for ensuring accurate processing and payment of these claim types.

3.5.3.2.2.2 Industry standard modifiers are used to identify surgical procedures which have been terminated prior to and after the delivery of anesthesia.

- Modifiers 52 and 73 are used to identify a surgical procedure that is terminated prior to the delivery of anesthesia and is reimbursed at 50% of the allowable; i.e., the ASC tier rate, the Ambulatory Payment Classification (APC) allowable amount for OPPOS claims, or the CHAMPUS Maximum Allowable Charge (CMAC) for individual professional providers.
- Modifiers 53 and 74 are used for terminated surgical procedures after delivery of anesthesia which are reimbursed at 100% of the appropriated allowable amounts referenced above.

3.5.3.2.3 Unbundling of Procedures

Contractors should ensure that reimbursement for claims involving multiple procedures conforms to the unbundling guidelines as outlined in Chapter 1, Section 3.

3.5.3.2.4 Incidental Procedures

The rules for reimbursing incidental procedures as contained in [Chapter 1, Section 3](#), 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.

3.6 Updating Payment Rates

The rates will be updated annually by DHA by the same update factor as is used in the Medicare annual updates for ASC payments.

- The rates were updated by 1.2% effective November 1, 2014.
- The rates were updated by 1.2% effective November 1, 2015.
- The rates were updated by 1.1% effective November 1, 2016.

3.7 Claims for Ambulatory Surgery

3.7.1 Claim Forms

Claims for facility charges must be submitted on a Centers for Medicare and Medicaid Services (CMS) 1450 UB-04. Claims for professional charges may be submitted on either a CMS 1450 UB-04 or a CMS 1500 Claim Form. The preferred form is the CMS 1500 Claim Form. When professional services are billed on a CMS 1450 UB-04, the information on the CMS 1450 UB-04 should indicate that these services are professional in nature and be identified by the appropriate CPT-4 code and revenue code.

3.7.2 Billing Data

The claim must identify all procedures which were performed (by CPT-4 or HCPCS code). The facility claim shall be submitted on the CMS 1450 UB-04, the procedure code will be shown in Form Locator (FL) 44.

Note: Claims from ASCs must be submitted on the CMS 1450 UB-04 claim form. Claims not submitted on the appropriate claim form will be denied.

3.8 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.

3.9 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 ER

services are to be followed.

3.10 Cost-Shares For Ambulatory Surgery Procedures

All surgical procedures performed in an outpatient setting shall be cost-shared at the ASC cost-sharing levels. Refer to [Chapter 2, Section 1, paragraph 1.3.3.7](#).

3.11 Exclusions

Surgical procedures that do not have an ambulatory surgery rate listed on DHA's ambulatory surgery web site are excluded from cost-sharing in freestanding ASCs.

- END -

