PROVIDER REIMBURSEMENT GUIDANCE			
Ambulatory Surgery - Medicare			
Original Date Approved	Effective Date Senior Care Options/One Care	Effective Date Medicare Advantage*	Revision Date
09/01/2022	11/01/2022	11/01/2022	

Scope: Commonwealth Care Alliance (CCA) Product Lines

☒ Senior Care Options MA
☒ One Care MA
☒ Medicare Preferred – (PPO) MA*
☒ Medicare Value - (PPO) MA*
☒ Medicare Preferred – (PPO) RI*
☒ Medicare Value - (PPO) RI*
☒ Medicare Maximum – (HMO DNSP) RI*

PAYMENT POLICY SUMMARY:

Commonwealth Care Alliance® (CCA) reimburses medically necessary surgical services provided in a freestanding Ambulatory Surgical Center (ASC).

AUTHORIZATION REQUIREMENTS:

Applicable CCA referral, notification and authorization policies and procedures apply. For more information on prior authorizations, please refer to the Prior Authorization Requirements in the plan specific Provider Manual.

REIMBURSEMENT GUIDELINES:

CCA reimburses for medically necessary services provided in an ambulatory surgery center when provided in accordance with the member's benefits. Services must be appropriate for the ASC level of care. Services will be reimbursed based upon the provider's contractual agreement.

- Facility services that are directly related to the procedure performed, including but not limited to: Anesthesia, operating room, recovery room, implantable device, pharmacy, and supplies.
    - Special situations occasionally apply when other reimbursement may be made.
- Facilities reimbursed according to the Medicare ASC fee schedule will follow the payment methodology in the CMS Ambulatory Surgical Center Billing Guide.

CCA does not reimburse the ASC for:

- Services which result in inpatient admission. Reimbursement for these services will be included in the inpatient reimbursement.
- Observation services related to the ambulatory surgical procedure. These are considered part of the routine recovery period for the procedure and are included in the reimbursement for the ambulatory surgical procedure.
- Medicare Inpatient only procedures performed in the ASC, when applicable.
- Services deemed not medically necessary.

BILLING and CODING GUIDELINES:

CCA requires all services provided by the ASC to be billed using the appropriate codes via 837-I or a UB-04 claim form.

Services billed by an office-based ASC should be billed via 837P or CMS 1500 using the appropriate CPT code with modifier SG.

All ASC claims will be subject to appropriate claims editing processes, including but not limited to bundling and payment reductions.

RELATED SERVICE POLICIES:

General Coding Payment Policy

Multiple Procedure Payment Reduction for Medical and Surgical Services Payment Policy

AUDIT and DISCLAIMER:

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 and adherence to plan policies, procedures, and claims editing logic. CCA has 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, CCA has the right to expect your office/facility to refund all payments related to non-compliance.

REFERENCES:

- CCA Website
- CMS Website
- Provider Manuals: Massachusetts / Rhode Island
- Prior Authorization Forms: Massachusetts / Rhode Island
- Commonwealth of Massachusetts MassHealth Provider Manual Series; Freestanding Ambulatory Surgery Center Manual; Subchapter Number and Title 4. Program Regulations (130 CMR 423.000)

POLICY TIMELINE DETAILS:

1. Effective 11/01/2022