

Payment Policy for Ambulatory Surgery Center Services in the Facility Payment

OWCP pays the lesser of the billed charge (the ASC's usual and customary fee) or the maximum allowed rate. The base maximum allowable rate for any ASC surgical procedure is 200% of the maximum allowable rate for physician's professional charge as determined from RVU and conversion factor values associated with each CPT/HCPCS code, and from GPCI values associated with site of service.

State waiver: Ambulatory surgery services provided in a hospital-based ambulatory surgery center in Maryland are exempt from this section. The Maryland Health Services Cost Review Commission establishes rates for hospital-based ambulatory surgery services in Maryland. Since Maryland hospitals are required to bill these rates, reimbursement for ambulatory services is to be based on the billed charge. Freestanding non-hospital based ambulatory surgery centers in the state of Maryland are **not** covered under the Maryland state waiver for hospital inpatient, hospital outpatient and hospital-based ambulatory surgery centers.

ASC Services Included in the Facility Payment

Facility payments for ASCs include the following services which are not paid separately:

- Nursing services, services of technical personnel, and other related services
- Use by the patient of ASC facilities including the operating room and the recovery room
- Drugs, including take-home medications, biological, surgical dressings, supplies, splints, casts, appliances and equipment directly related to the surgical procedure
- Diagnostic or therapeutic items and services directly related to the surgical procedure (including simple preoperative laboratory tests, e.g., urinalysis, blood hemoglobin or hematocrit)
- Administrative, record keeping and housekeeping items and services
- Blood, blood plasma, platelets, etc.
- Materials for anesthesia; and
- Intraocular lenses (IOLs).

ASC Services Not Included in the Facility Payment

Facility payments for ASCs do not include the following services which may be paid separately:

- Professional services including physicians
- Laboratory services
- X-ray or diagnostic procedures other than those directly related to the performance of the surgical procedure
- Prosthetics and implants except intraocular lenses (**Please note: all prosthetics and implants are not payable. The specific payable codes are identified in the tab "ASC Allowable Ancillary and non-payable codes are identified in the tab "Bundled Ancillary Service or Item"**)
- Ambulance services
- Leg, arm, back and neck braces

- Artificial limbs; and
- DME for use in the patient's home

ASC Procedures Covered for Payment

All procedures covered by OWCP in an ASC are included in the list of surgical procedures allowable for facility fee payment to Ambulatory Surgery Centers (file name: Effective_June_30_2021_asc_pymt_grp.xls) available online at:

<http://www.dol.gov/OWCP/regs/feeschedule/fee.htm>

Note that inclusion in this list does not mean that a procedure is automatically payable. Prior authorization for elective procedures, appropriateness to the accepted condition and other program requirements must also be met.

ASC Procedures Not Covered for Payment

Surgical procedures that are not included in the list of surgical procedures allowable for facility fee payment to Ambulatory Surgical Center are not covered for payment to an Ambulatory Surgery Center. This list does not include procedures that are currently performed on an ambulatory basis in a physician's office and that do not generally require the more elaborate facilities of an ASC. Neither does the list include procedures that are appropriately performed in an inpatient hospital setting but would not be safely performed in an ASC. We recognize that there are some procedures that might be appropriately performed in ASC for the younger patient who is generally healthy. But for the larger number of OWCP program beneficiaries whose health is more likely to be compromised by disability and age, an ASC may be a questionable setting for those same procedures. Therefore, we are including in the list only those procedures that can be safely performed in an ASC on the general OWCP population in at least a significant number of cases. The resulting list of procedures allows ASCs to furnish OWCP program beneficiaries with a broad range of surgical services that reflect the practice of contemporary surgery without compromising patient safety.

Bundled Services

Bundled codes are covered procedures that are billable but not separately payable. Payments for bundled codes are included in the payment for the services to which they are incident. These codes are located on the "List of Surgical Procedures Allowed for facility payment to Ambulatory Surgery Center," on the Bundled Procedures tabs.

ASC Billing Information

Modifiers required for ASC

Modifier –SG must be appended as the first modifier to all surgical procedure codes (CPT/HCPCS) billed by an Ambulatory Surgery Center.

Modifiers accepted for ASC

OWCP will accept all valid CPT and HCPCS modifiers, though only a few will affect payment.

Modifiers affecting payment for ASC

Modifier -50, bilateral modifier

Modifier -50 identifies cases where a procedure typically performed on one side of the body is performed on both sides of the body during the same operative session. Providers must bill using a single line item for each procedure performed and append modifier -50 to indicate that a procedure was performed bilaterally. The bilateral procedure will be paid at 200% + 50% of the allowed amount for that procedure.

Example: Bilateral Procedure, Modifier -50, Chicago, IL. *(zip code 00523)

Line item On bill	CPT Code modifier	Maximum allowable	Bilateral policy applied	Max allowed amount
1	64721-SG-50	\$1,337.71	\$2,006.56 ¹	\$2,006.56 ¹
Total allowed amount				\$2,006.56 ¹

1. Bilateral procedure is paid at 150% of maximum allowed amount.

Modifier -51, multiple surgical procedures modifier, Chicago, IL. * (zip code 00523)

Modifier -51 identifies when multiple surgeries are performed on the same patient at the same operative session. Providers must bill using separate line items for each procedure performed. Modifier -51 should be applied to the second and subsequent line items. The total payment equals the sum of 200% of the maximum allowable fee for the highest valued procedure according to the fee schedule, plus 50% of the maximum allowable fee for the subsequent procedures with the next highest values according to the fee schedule.

Example: Multiple Procedure, Modifier -51, Chicago, IL. * (zip code 00523)

Line item On bill	CPT code modifier	Maximum payment	Multiple procedures policy applied	Allowed amount
1	29881-SG	\$1,702.93		\$1,702.93 ¹
2	64721-SG-51	\$1,340.72	\$670.36	\$ 670.36 ²
Total allowed amount				\$2,373.29 ³

1. Highest valued procedure is paid at 200% of maximum allowed amount.

2. When applying the multiple procedure payment policy, the secondary procedure billed with a modifier -51 is paid at 50% of the maximum allowed amount for that line item.

3. Represents sum of allowed amounts for line 1 + line 2.

* Pricing examples given in this document are **for purposes of illustration only** and reflect RVU and GPCI values that are subject to change.

If the same procedure is performed on multiple levels the provider must bill using the proper number of units to indicate the number of levels.

Modifier -73, discontinued procedure prior to the administration of anesthesia

Modifier -73 is used when a physician cancels a surgical procedure due to the onset of medical complications subsequent to the patient's preparation, but prior to the administration of anesthesia. Payment will be at 50% of the maximum allowable fee for the primary procedure only. Multiple and bilateral procedure pricing will not apply.

Modifier -74, discontinued procedure after administration of anesthesia

Modifier -74 is used when a physician terminates a surgical procedure due to the onset of medical complications after the administration of anesthesia or after the procedure was started. Payment will be at 85% of the maximum allowable fee. Multiple and bilateral procedure pricing may apply to this if appropriate to the circumstances.

Implanted Durable Medical Equipment & Prosthetic Implants

Implants must be billed on a separate line using the appropriate HCPCS code. Many implant items have maximum fees under the OWCP fee schedule and the appropriate HCPCS codes should be used. If no maximum allowable levels are set by the fee schedule, OWCP will pay acquisition cost for implants when the bill is accompanied by a copy of the original invoice clearly showing invoice cost less applicable discounts.

Exception: Intraocular Lenses

Intraocular lenses, including new technology lenses, are bundled into the fee for the associated procedure. Please include the cost of the lens in the charge for the procedure. It is permissible to include a line on the bill with the HCPCS code for an intraocular lens (e.g., V2630, V2631 and V2632) and its associated cost for information purposes only.

Acquisition Costs Policy

Acquisition cost equals the wholesale cost plus shipping, handling and sales tax, net of all discounts. These items must be billed together as one charge. Wholesale invoices for all devices must be retained in the provider's office files for a minimum of three years. A provider must submit a hard copy of the wholesale invoice when an individual device or supply costs \$150.00 or more, or upon request. Payment of a provider's bill may be delayed if this information is not submitted.

Spinal Injections

Injection procedures are billed in the same manner as all other surgical procedures with the following considerations:

1. For purpose of multiple procedures discounting, each procedure in a bilateral set is considered to be a single procedure.
2. For injection procedures which require the use of fluoroscopic localization and guidance, ASCs may no longer bill separately for the technical component of the radiological CPT code (e.g., 77003 –TC). Payment for these codes is bundled into payment for the primary procedure.

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