

**CHAPTER: 3**  
**SECTION: 7.1**  
**TITLE: AMBULATORY SURGICAL CENTER (ASC) REIMBURSEMENT**

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**AUTHORITY:** 38 CFR 17.270(a), 17.272(b), and 17.274

**RELATED AUTHORITY:** 32 CFR 199.14(d)

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## **I. EFFECTIVE DATE**

A. The payment system described in this section is effective for all listed ambulatory surgery procedures provided on or after November 1, 1994.

B. Extracorporeal shock wave lithotripsy effective November 1, 1998.

## **II. DEFINITION(S)**

A. Facility charges or ancillary charges. For the purposes of this policy, these charges are included in the prospective payment methodology that relates to facility overhead. Examples include: nursing and technical services, take home medications, supplies, splints, casts, equipment directly related to the surgical procedure, intraocular lens implant, anesthesia materials, diagnostic and therapeutic tests directly related to the procedure, and administrative, recordkeeping and housekeeping items and services.

1. Ancillary Charges Provided by a Freestanding ASC. Ancillary charges associated with ambulatory surgical procedures must be included in the CPT surgical codes used for facility charges. If itemized, these charges will not be cost shared.

2. Ancillary Charges Provided by a Hospital. Ancillary charges associated with ambulatory surgical procedures provided by a hospital and not included in the CPT surgical code charge will be paid as billed.

B. Incidental procedure. An incidental procedure is performed at the same time as a more complex primary procedure. However, the incidental procedure requires little additional physician resources and/or is clinically integral to the performance of the primary procedure.

### III. POLICY

#### A. Background.

1. Effective December 19, 1980, services provided by authorized hospital-based or freestanding ambulatory surgery centers became covered CHAMPVA benefits and were paid as billed.

2. Effective with services provided on or after November 1, 1994, the CHAMPVA reimbursement methodology for facility charges associated with procedures performed in an ambulatory surgery setting (includes both hospital based settings and freestanding surgical centers) was changed to a prospective payment system. (See [Chapter 3, Section 7.1A](#), Addenda 1, for the ambulatory surgery procedure code listing.) This methodology, modeled after Medicare, is based on the categorization of certain ambulatory surgical procedures into eleven payment groups. Each payment group is established on a cost-basis and adjusted for area labor costs based on the **Medicare Economic Index (MEI)**. Payment rates are also adjusted for the performance of multiple procedures. This adjustment calculates payment allowing 100% of the allowable charge for the highest priced procedure and 50% on all others. Actual payment however is based on the calculated payment rate or the billed charge, whichever is less.

3. Payment rates established under this prospective payment system for ambulatory surgery only apply to facility charges. The rate does not include physician fees, anesthesiologist fees, or fees of other professional providers authorized to render ambulatory surgery procedures and bill independently for them. Professional fees must be submitted separately from facility fees. If the professional fee is for anesthesia services, the appropriate anesthesia code must be used on the claim. This payment rate does not apply to laboratory, x-rays or diagnostic procedures (other than those directly related to the surgical procedure); surgically implanted prosthetic devices (except IOLs); ambulance services; leg, arm, and back braces; artificial limbs; and durable medical equipment 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 CPT code for the surgical procedure includes the diagnostic or radiology procedure as part of the code description. Diagnostic procedures performed prior to the date of ambulatory surgery are processed separately and are paid under CMAC or other appropriate payment methodologies.

#### B. Reimbursement System.

1. **Applicability.** This prospective payment system is to be used regardless of where the ambulatory surgery procedures are provided, e.g., a freestanding ambulatory surgery center (ASC), hospital-based ASC (regardless of whether it is certified by Medicare as an ASC), hospital outpatient department, or hospital emergency room.

a. The CHAMPVA rates are the same ambulatory surgery payment rates utilized by TRICARE. The rates are updated on or about November 1 each year from the MSA and corresponding wage indexes for ambulatory surgery centers. Additions or deletions to the procedure payment rates will be given to CHAMPVA as they occur, but the actual payment rate will be updated only on an annual basis.

b. The inclusion or omission of any given procedure in Addenda 1 cannot be the basis for appealing any claim.

c. An Ambulatory Surgical Center must be Medicare certified for services to be covered.

d. Reimbursement of ambulatory surgical procedures will be subject to ClaimCheck® guidelines.

2. State Waiver. Ambulatory surgery services provided in a hospital based ASC (either in an outpatient department or in an emergency room) in Maryland are exempt from this system. (Services in freestanding ambulatory surgical centers are not exempt and are to be reimbursed using the procedures set forth in 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.

3. 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/TRICARE.

b. Beneficiary cost sharing under this methodology is 25 percent of the CHAMPVA allowable amount with no outpatient deductible. The beneficiary is also responsible for charges associated with noncovered services.

c. 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 procedures guidelines.

d. Multiple Procedures. The following rules are to be followed whenever more than one procedure is included on an ambulatory surgery claim.

(1) If all the procedures on the claim are included in Addenda 1, the claim is to be reimbursed at the lesser of 100 percent of the group payment rate or the billed charge for the major procedure (the procedure which allows the greatest payment) and the lesser of 50 percent of the group payment rate or the billed charge for each of the other procedures.

Note: 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 will be made for each procedure, however, only one procedure will be reimbursed at 100% of the allowable charge.

(2) For multiple surgical procedures involving the fingers or toes, reimbursement is at 100 percent of the allowable for the first procedure, 50 percent for the second, and benefits for the third and subsequent procedures are limited to 25 percent of the allowable.

e. If the claim includes procedures that are not listed in Addenda 1, the following rules applied.

(i) If the services are provided in a freestanding ASC, and the procedures are not listed in Addenda 1, the facility charges will be denied. These charges are the responsibility of the beneficiary. Claims for the related professional services can be processed and reimbursed as outpatient services.

(ii) If the services are provided in a hospital, the allowable amount for procedures in Addenda 1 is based on the lesser of the group payment amount or billed charge. The allowable amount for procedures not listed in Addenda 1 is based on the billed charge for that procedure.

#### IV. POLICY CONSIDERATIONS

A. Double Coverage. Ambulatory surgery claims which involve payments by another third-party payer are to be processed under the three-step double coverage computation.

B. Subsequent Hospital Admissions. If a beneficiary is admitted to a hospital subject to the DRG-based payment system as a result of complications 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 in combination with ASC procedures are to be followed. Emergency room services are billed separately unless related to an inpatient stay.

C. Rebundling of Procedures. Reimbursement for claims involving multiple procedures will conform to the rebundling guidelines contained in [Chapter 3, Section 5.3, \*Rebundling of Procedure Codes\*](#).

D. CHAMPVA In-House Treatment Initiative (CITI) claims. CITI ambulatory surgery claims are subject to the same reimbursement and guidelines.

#### V. EXCLUSIONS

A. The ASC payment methodology does not apply to services received by CHAMPVA beneficiaries while traveling in foreign countries.

TRANSMITTAL #: 56  
DATE: 06/26/2003  
TRICARE CHANGE #: C14

- B. Incidental procedures should not be billed for or reimbursed separately.

**\*END OF POLICY\***