Provider Network News

Ambulatory Surgery Centers (ASC) and Hospital Ambulatory Surgery Centers (HASC) Reimbursement Guidelines

Call to Action

The purpose of this communication is to remind providers of the reimbursement guidelines for Parkland Community Health Plan (PCHP), which outlines and standardizes reimbursement for outpatient surgery. This guideline is for general freestanding Ambulatory Surgical Centers (ASCs) and acute care hospitals, and applies to CHIP and Medicaid lines of business. Non-contracted providers will be reimbursed according to Texas Medicaid guidelines. PCHP adheres to the reimbursement guidelines for freestanding Ambulatory Surgical Centers and Hospital Ambulatory Surgical Centers (HASC) and written in the Texas Medicaid Provider Procedural Manual (TMPPM)

How this Impacts Providers—Policy Guidelines are as Follows:

The ASC and HASC reimbursement represent a global payment and includes room charges and supplies. ASC and HASC reimbursement guidelines are as follow:

Day surgeries for scheduled or unscheduled procedures applies to surgeries that are not inpatient at the time the day surgery is performed. Day surgeries can be performed in a Freestanding ASC, Hospital based HASC, or outpatient hospital setting. Furthermore, Day Surgery procedures are defined as Type of Service (TOS) F and represent an all-inclusive/global service.

ASC/HASC claims for Scheduled Day Surgeries required the following:

HASC

- UB claim for required
- TOB 0131
- Complete billing provider name, NPI and HASC taxonomy code
- HASC services are billed with revenue code 360-369 and 490.
- HCPC/CPT Surgery code

ASC

- CMS1500 claim form is required
- POS 24
- Surgery code CPT code
- Complete billing provider’s name, NPI and ASC taxonomy code

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Reimbursement

ASC/HASC reimbursement is based of TMHP ASC/HASC fee table PRCR405

- **Prior to 06/2023**
  - Reimbursement of ASC/HASC procedures was based on CMS-approved Ambulatory Surgical code Grouping 1-9 and 10 per HHSC payment schedule and locality.

Effective 06/01/2023

- All ASC/HASC services are reimbursed based of the applicable rate as reported on the TMHP ASC/AHSC fee schedules for TOS F.

Reimbursement guidelines Include:

- Reimbursement is limited to the lesser of the amount reimbursed to an ASC for similar services, the hospital's actual charge, or the allowable cost determined by HHSC.
- When multiple surgical procedures are performed on the same day, only the procedure with the highest code pricing is reimbursed.
- The ASC or HASC payment represents a global payment and includes room charges and supplies. Cover services provided are submitted as one inclusive charge.
- All facility services provided in conjunction with the surgery (e.g., laboratory, radiology, anesthesia supplies, medical supplies are considered part of the global payment and cannot be itemized or submitted separately.
- Global payment exception – Certain pieces of equipment, (e.g., cochlear implants, implantable infusion pumps, and neurostimulator devices) may be reimbursed separately from the ASC or HASC global rate.
- HASC/ASC providers classified as high-volume providers receive an additional payment increase of 5.2 as indicated on this table.
- Reimbursement is made on revenue code 360, 361, 369 and 490.

Incomplete Day Surgeries

Facilities must use either one of the following diagnosis codes or one of the following modifiers to indicate that a surgical procedure (TOS F) was not completed:

Diagnosis Codes	
Z5309	Procedure and treatment not carried out because of other contraindication
Z5329	Procedure and treatment not carried out because of patient's decision for other reasons
Z538	Procedure and treatment not carried out for other reasons

Modifier	Description
73	Discontinued outpatient procedure prior to anesthesia administration
74	Discontinued outpatient procedure after anesthesia administration

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Claims for incomplete or canceled surgery procedures requires the operative reports for reimbursement. The reimbursement is dependent of the extent to which the anesthesia or surgery proceeded, the percent reimbursement is as follow:

- 0% Procedure is terminated before the facility has used substantial resources
- 33% Procedure is terminated prior to the administration of anesthesia.
- 67% Procedure is terminated after the administration of anesthesia but before incision.
- 100% Procedure is terminated after incision.

Emergency or Unscheduled day surgery performed in a hospital should be billed as follows:

- Unscheduled procedures must be billed as an outpatient procedure under the hospital NPI and taxonomy code with TOB 131.
- Emergency procedures where the member was first treated in the emergency room must be billed with the emergency services and unscheduled surgery on the same claim using the hospital NPI and taxonomy code with TOB 131.
- If the member is placed in observation, the observation period must be included on the same claim as the emergency services and unscheduled surgery.
- Complications following unscheduled or emergency day surgery should be billed as follows:
  - If the member requires inpatient admission following observation, charges from the observation period must be included on the inpatient claim with TOB 111 and billed using the hospital NPI and taxonomy code. The principal diagnosis included on the claim must indicate complication of surgery.
    - The day surgery and emergency services must not be included on the inpatient claim.

The above reimbursement guidelines apply to CHIP and STAR lines of business.

TMPPM References:
4.5. Claims Filing and Reimbursement
4.5.1 Outpatient Claims Information
4.2.3.2 Complications Following Elective or Schedule Day Surgeries
4.2.3.3 Inpatient Admission after Day Surgery
4.2.3.4 Emergency or Unscheduled Day Surgeries
4.2.3.5 Complications Following Emergency or Unscheduled Day Surgeries
4.2.3.6 Incomplete Day Surgeries
6.4.2.1 ASC and HASC Global Services