SECTION 5: BILLING AND REIMBURSEMENT GUIDELINES

of the Professional Provider Office Manual

5.47 AMBULATORY SURGERY CENTERS

This is a subsection of Section 5: Billing and Reimbursement Guidelines of the *Professional Provider Office Manual*. If Blue Cross and Blue Shield of Louisiana makes any procedural changes, in our ongoing efforts to improve our service to you, we will update the information in this subsection and notify our network providers. For complete *Professional Provider Office Manual* information, please refer to the other sections of this manual. Contact information for all manual sections is available in the Manual Reference Section.

For member eligibility, benefits or claims status information, we encourage you to use iLinkBlue (www.lablue.com/ilinkblue), our online self-service provider tool. Additional provider resources are available on our Provider page at www.lablue.com/providers.

This manual is provided for informational purposes only and is an extension of your Professional Provider Agreement. You should always directly verify member benefits prior to performing services. Every effort has been made to print accurate, current information. Errors or omissions, if any, are inadvertent. The Member Contract/Certificate contains information on benefits, limitations and exclusions, and managed care benefit requirements. It also may limit the number of days, visits or dollar amounts to be reimbursed.

As stated in your agreement: This manual is intended to set forth in detail our policies. Louisiana Blue retains the right to add to, delete from and otherwise modify the *Professional Provider Office Manual* as needed. This manual and other information and materials provided are proprietary and confidential and may constitute trade secrets.

AMBULATORY SURGERY CENTERS

Outpatient reimbursement consists of both outpatient procedures and diagnostic and therapeutic services. Outpatient procedures include most services contained within the surgery section of CPT code books as well as significant procedures defined in the Medicine Section such as cardiac catheterizations.

Louisiana Blue edits the facility's outpatient coding upon claims submission for accuracy and internal consistency. Such editing may require Louisiana Blue to reassign reimbursement and/or medical codes for services that have been unbundled or incorrectly coded or to reject codes for mutually exclusive or incidental procedures. Reimbursement for incidental procedure codes is factored into the reimbursement for the primary procedure codes. For more information regarding code editing, please refer to the Code Editing section of this manual.

After editing the claim, outpatient procedures are reimbursed according to the allowable charge. All other services, including diagnostic and therapeutic services, are bundled to the outpatient procedure allowable charge. If multiple procedures are performed, the primary procedure is reimbursed based on 100% of the allowable charge and the secondary procedure(s) are reimbursed based on 50% of the allowable charge. Select procedures are exempt from the multiple procedure discount and will be reimbursed at 100% of the allowable charge.

The following modifiers may impact reimbursement:

- Modifier 50 - Bilateral: Refer to the Modifier section of this manual for detailed billing and reimbursement information.
- Modifier 52 - Reduced Services: Reimbursed at 50% of the allowable charge.
- Modifier 73 - Discontinued Procedure: Reimbursed at 50% of the allowable charge.

The total reimbursement amount for the claim is the lesser of the eligible billed charges or the sum of the reimbursement amounts for all procedure codes. Codes without established fees may be reviewed and reimbursed at a Plan determined allowable charge or standard discount as determined by Plan.

"Outpatient procedure(s)" means medically necessary procedure(s) performed at the facility that, according to accepted professional medical judgment, cannot be safely rendered in a physician's office and does not require overnight hospitalization.

Procedures normally performed in a physician's office that meet the following criteria, as determined by Plan, will not be considered medically necessary outpatient procedures:

- Can be performed in the physician's office setting without perceived increase in risk or adverse effect on the quality of care.
- Is usually the primary or sole procedure being performed.
- Does not usually require general anesthesia.
- Does not involve complex pre-service care or post-service recovery from anesthesia.

Reimbursement for outpatient procedures includes, but is not limited to, the following:

- Pre-service blood tests, urinalysis and other necessary laboratory and radiological procedures directly related to the procedure.
- Pre-service preparation.
- Use of facility, including pre-service area, operating rooms, primary and secondary recovery rooms.
- Equipment, monitors, anesthesia and supplies, drugs, implants, prostheses and nourishments.
- All pre-operative services should be included on the bill in conjunction with the procedure performed.

Reimbursement for outpatient procedures does not include the following:

- Administration of anesthesiology/anesthesia by anesthesiologists' services.
- Professional pathologists' services.
- Professional radiology services.
- Diagnostic or therapeutic tests not directly related to the procedure.