Ambulatory Surgery Center

Reimbursement Policy ID: RPC.0036.5400

Recent review date: 05/2025

Next review date: 10/2026

AmeriHealth Caritas District of Columbia reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. AmeriHealth Caritas District of Columbia may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses the allowable facility services and reimbursement of those services in an ambulatory surgery center (ASC). These services are reimbursed with enhanced ambulatory payment grouping (EAPG). The base rate is the dollar value that is multiplied by the final EAPG weight for each EAPG on a claim to determine the total allowable Medicaid payment for a visit. The EAPG national relative weights are calculated by 3M Health Information Systems based on Medicare claims data.

Exceptions

N/A

Reimbursement Guidelines

Enhanced ambulatory patient grouping (EAPG) is a group of outpatient procedures, encounters, or ancillary services which reflect similar patient characteristics and resource utilization and incorporate the use of Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other associated publications and services.

Multiple surgery deduction is paid at 100% of the payment group rate for the primary procedure on claim line one, 50% if the payment group for the secondary procedure on claim line two and 25% of the tertiary procedure on line three, 25% of all additional procedures. Multiple payment for a single bilateral procedure in one day is 150% of the payment group rate. It is billed on line one of the claim using modifier 50.

Standard coding conventions apply when assigning modifiers.

Prior authorization may be required for an ASC procedure. A claim for a service considered non-covered by AmeriHealth Caritas District of Columbia will be denied payment.

Claims for ambulatory surgery procedures or services must be submitted with Place of Service 24 for reimbursement.

Definitions

Ambulatory Surgery Center (ASC)
A certified ambulatory surgery center (ASC) may be either hospital-operated or independent. If hospital-operated, the ASC must be a separately identified entity, physically and administratively distinct from other inpatient operations of the hospital. In cases where hospitalization after surgery is warranted, the ASC must be able to provide immediate transfer to a hospital.

Enhanced Ambulatory Patient Groups (EAPG)
Enhanced ambulatory patient groups (EAPGs) are a patient classification system designed to explain the amount and type of resources used in an ambulatory visit. Services provided in each EAPG have similar clinical characteristics and similar resource use and cost.

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).

Attachments

N/A

Associated Policies

RPC.0036.5400 Multiple Procedure Payment Reduction

Policy History

06/2025	Minor updates to formatting and syntax
05/2025	Reimbursement Policy Committee Approval
04/2025	Revised preamble
11/2024	Annual review • Updated to biennial policy • No major changes
04/2024	Revised preamble
01/2024	Reimbursement Policy Committee Approval
08/2023	Removal of policy implemented by AmeriHealth Caritas District of Columbia from Policy History section
01/2023	Template revised • Preamble revised • Applicable Claim Types table removed • Coding section renamed to Reimbursement Guidelines • Associated Policies section added