Washington State Department of Labor & Industries

Payment Policies for Healthcare Services

Provided to Injured Workers and Crime Victims

Chapter 32: Ambulatory Surgery Centers (ASCs)

Effective July 1, 2023

Link: Look for possible **updates and corrections** to these payment policies on L&I's website.

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Modifiers

The following CPT®, HCPCS, and/or local code modifiers apply to this chapter:

–50 (Bilateral procedures)

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 separate line items for each procedure performed. Modifier **–50** must be applied to the second line item. The second line item will be paid at **50%** of the allowed amount for that procedure.

–51 (Multiple procedures)

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 line item. The total payment equals the sum of:

- **100%** 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.

If the same procedure is performed on multiple levels, the provider must bill using separate line items for each level.

–52 (Reduced services)

Under certain circumstances, a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service can be identified by its usual procedure number and the addition of modifier **–52**, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

A 50% payment reduction will be applied for discontinued radiology procedures and any other procedures that don't require anesthesia.

Note: Don't use this modifier for ASC procedures/services that require anesthesia. Instead, refer to modifiers -73 and -74.

–73 (Discontinued procedures 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. Multiple and bilateral procedure pricing will apply to this, if applicable.

–74 (Discontinued procedures 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 **100%** of the maximum allowable fee. Multiple and bilateral procedure pricing will apply to this, if applicable.

–99 (Multiple modifiers)

Modifier **–99** must be used when more than four modifiers affect payment. Payment is based on the policy associated with each individual modifier that describes the actual services performed. For billing purposes only, modifier **–99** must go in the modifier column with the individual descriptive modifiers that affect payment listed in the remarks section of the billing form.

Payment policy: All ASC services

Prior authorization

Procedures not on L&I's ASC fee schedule require prior authorization. Specifically:

- Under certain conditions, the director, the director's designee, or self-insurer, at their sole discretion, may determine that a procedure not listed on L&I's ASC fee schedule may be authorized in an ASC.
    - For example, this may occur when a procedure could be harmful to a particular patient unless performed in an ASC.
- The healthcare provider must submit a written request and obtain approval from the insurer prior to performing any procedure not on the ASC procedure list. Requests for coverage under these special circumstances require prior authorization. The written request must contain:
    - A description of the proposed procedure with associated CPT® or HCPCS procedure codes, *and*
    - The reason for the request, *and*
    - The potential risks and expected benefits, *and*
    - The estimated cost of the procedure.
- The healthcare provider must provide any additional information about the procedure requested by the insurer.

What facilities qualify for payment

To qualify for payment for ASC services, an ASC must:

- Be licensed by the state(s) in which it operates, unless that state doesn't require licensure, *or*
- Have at least 1 of the following credentials:
    - Medicare (CMS) Certification as an ASC, *or*
    - Accreditation as an ASC by a nationally recognized agency acknowledged by CMS, and
- Have an active ASC provider account with L&I.

Services that can be billed

L&I uses the CMS list of procedure codes covered in an ASC, plus additional procedures determined to be appropriate.

L&I's rates for ASC procedures are based on a modified version of the current system developed by CMS for ASC services. L&I expanded the CMS list by adding some procedures CMS identified as excluded procedures.

Link: All procedures covered in an ASC are listed online in the fee schedule.

Services that aren't covered

Procedure codes not listed in L&I's ASC fee schedule aren't covered in an ASC.

Additional information: Who to contact to become accredited or Medicare certified as an ASC

For national accreditation, contact:

- Accreditation Association for Ambulatory Health Care
- American Osteopathic Association
- Commission on Accreditation of Rehabilitation Facilities
- Joint Commission on Accreditation of Healthcare Organizations
- QUAD A

For Medicare certification, contact:

Department of Health, Office of Health Care Survey
Facilities and Services Licensing
PO BOX 47874
Olympia, WA 98504-7874
360-236-4983

Links to related topics

If you're looking for more information about…	Then see…
Administrative rules for ASC payment policies	Washington Administrative Code (WAC) 296-23B
Becoming an L&I provider	Become A Provider on L&I's website
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services (including ASCs)	Fee schedules on L&I's website

Need more help?

Call L&I's Provider Hotline at **1-800-848-0811** or email **PHL@lni.wa.gov**

