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, 2024

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

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Modifiers

The CPT®, HCPCS, and/or local code modifiers which apply to this chapter (but aren't limited to) are:

Use	Payment Information
–50 (Bilateral surgery)	
Use this modifier to indicate when 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 side of the body the procedure was performed. Apply the modifier to the second line.	The total payment is made at **150%** of the global surgery fee schedule amount for the procedure as follows: • **100%** of the global surgery fee for the procedure on the first line. • **50%** of the global surgery fee for the procedure on the second line.
–51 (Multiple surgeries)	
Use this modifier to indicate when multiple procedures were performed at the same operative session by the same individual. Providers must bill using separate line items for each procedure performed. Apply the modifier to all line items but the primary procedure. If the same procedure is performed on multiple levels, the provider must bill using separate line items for each level.	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 procedure(s) with the next highest values according to the fee schedule.
–52 (Reduced services)	
Use this modifier to indicate when a service is reduced. Under certain circumstances, a service or procedure is partially reduced or eliminated at the discretion of the provider. This modifier provides a means of reporting reduced services without disturbing the identification of the basic service. **Note**: Don't use this modifier for ASC services that require anesthesia. Instead, refer to modifiers –73 and –74.	Payment is made at **50%** of the fee schedule level or billed charge, whichever is less.

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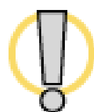
Use	Payment Information
–73 (Discontinued procedures prior to the administration of anesthesia)	
Use this modifier to indicate when a physician cancels a surgical procedure due to the onset of medical complications or extenuating circumstances subsequent to the patient's preparation (including sedation), but prior to the administration of anesthesia (local, regional block(s) or general). For use in ASC only.	Payment is made at **50%** of the fee schedule level or billed charge, whichever is less.
–74 (Discontinued procedures after administration of anesthesia)	
Use this modifier to indicate when a physician terminates a surgical procedure due to the onset of medical complications or extenuating circumstances after the administration of anesthesia (local, regional block(s) or general) or after the procedure was started. For use in ASC only.	This modifier doesn't affect payment but is necessary to describe the service performed.
–99 (Multiple modifiers)	
Use this modifier to indicate when more than 2 modifiers affect payment. For billing purposes only, include only this modifier with the service(s) performed on the billing form, along with any modifiers not affecting payment. In the remarks section of the billing form, include the individual descriptive modifiers that affect payment.	This modifier doesn't affect payment but is necessary to accommodate all modifiers billed. Payment is based on the policy associated with each individual modifier that describes the actual services performed.



Note: Many factors contribute to the resulting allowed amount. Therefore, there may be other factors aside from modifier usage that reduce or affect payment. Refer to the applicable payment policies and fee schedules for the service(s) being provided for more information.

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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 worker 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.

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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
- The Joint Commission
- 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?

Email L&I's Provider Hotline at PHL@Lni.wa.gov. If you would prefer a phone call, please email us your name and contact number.

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