Washington State Department of Labor & Industries
Workers' Compensation Services

Payment Policies for Healthcare Services
Provided to Injured Workers and Crime Victims

Chapter 32: Ambulatory Surgery Centers (ASCs)

Effective July 1, 2019

Link: Look for possible **updates and corrections** to these payment policies at:

www.Lni.wa.gov/ClaimsIns/Providers/Billing/FeeSched/2019/

Note: More information about ASC payments can be found in WAC 296-23B.

Table of contents

Definitions

- **CPT® code modifiers affecting ASC payment:**

–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

Modifier –52 identifies circumstances when a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the **modifier –52**, signifying that the service is reduced.

A **50%** payment reduction will be applied for discontinued radiology procedures and other procedures that do not require anesthesia (ASCs should use **modifier –52** to report such an occurrence).

–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 does not require licensure, *or*
- Have at least one 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.

Note: For contact information about how to become accredited or Medicare certified as an ASC, see below.

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.

Note: 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 at: http://www.lni.wa.gov/FeeSchedules

Services that aren't covered

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

Note: Also see Prior authorization, above.

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

For national accreditation, contact:

Accreditation Association for Ambulatory Health Care
5250 Old Orchard Road, Suite 200
Skokie, IL 60077
847-853-6060; www.aaahc.org/

American Association for Accreditation of Ambulatory Surgery Facilities
5101 Washington Street, Suite #2F
PO BOX 9500 Gurnee, IL 60031
888-545-5222; www.aaaasf.org/

American Osteopathic Association

142 East Ontario Street

Chicago, IL 60611

800-621-1773; www.osteopathic.org/

Commission on Accreditation of Rehabilitation Facilities

6951 East Southpoint Road

Tucson, AZ 85756

888-281-6531; www.carf.org/

Joint Commission on Accreditation of Healthcare Organizations

One Renaissance Blvd.

Oakbrook Terrace, IL 60181

630-792-5000; www.jcaho.org/

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 email: fslhhhacs@doh.wa.gov
https://www.doh.wa.gov/AmbulatorySurgicalFacilities

Links: Related topics

If you're looking for more information about…	Then go here:
Administrative rules for ASC payment policies	Washington Administrative Code (WAC) 296-23B: http://apps.leg.wa.gov/wac/default.aspx?cite=296-23B
Becoming an L&I provider	L&I's website: www.Lni.wa.gov/ClaimsIns/Providers/Becoming/
Billing instructions and forms	Chapter 2: Information for All Providers
Fee schedules for all healthcare facility services (including ASCs)	L&I's website: http://www.lni.wa.gov/FeeSchedules

▸ **Need more help?** Call L&I's Provider Hotline at **1-800-848-0811**

