<table>
<tr><td> </td><td>BILLING POLICY
No. 088</td></tr>
<tr><td colspan="2">AMBULATORY SURGICAL CENTERS</td></tr>
<tr><td>Effective date: Sept. 22, 2025

Date of origin: Apr. 15, 2025</td><td>Review dates: 6/2025, 7/2025</td></tr>
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APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Priority Heath covers services rendered in a freestanding ambulatory surgical center (ASC) as defined by the member's benefits. Procedures may require prior authorization.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Claims should be submitted on a HCFA 1500 form for all members, including commercial group and individual, Medicaid, and Medicare members.

Included facility services

Certain codes considered integral to other services provided in an ASC are included in the ASC facility payment and are therefore not separately reimbursable. Priority Health follows CMS bundling guidelines (status N1 or L1).

Implants

Implants should be coded with the applicable "C" HCPCS code defined for implants or devices approved as an OPPS device for ASC use.

HCPCS A4649 should be utilized to report other approved pass-through implants as defined by the contract language. Utilizing a HCPCS not outlined above will result in a claim denial. A brief description of the implant should be detailed as a note on the claim.

- Implants are reimbursed in accordance with ambulatory surgical center contract language.

Multiple procedure guidelines apply to ASC services.

Bilateral procedures

Bilateral procedures performed at an ASC should be billed as two procedures as:

- A single unit each on separate lines
- Two units on a single line

Note: Claims billed with modifier 50 will be denied

Get information on site review standards in our Provider Manual.

Certain services and items are included in the ASC reimbursement unless otherwise detailed in contract language.

- Nursing, technician and related services
- Use of facility where procedures are performed
- Any lab testing performed under a CLIA certificate of waiver (Clinical Laboratory Improvement Amendments of 1988)
- Drugs and biologicals for which separate payment is not allowed under the CMS OPPS for ASC
- Medical and surgical supplies not on a pass-through status under CMS OPPS for ASC
- Equipment
- Surgical dressings and supplies
- Implanted prosthetic devices, including standard intraocular lenses, procedure related accessories, DME and DME related items and supplies not on the CMS OPPS pass-through status
- Casts, splints and associated supplies and devices
- Radiology services where separate reimbursement is not allowed under CMS OPPS and other diagnostic tests or interpretive services that are integral to completing the procedure
- Administrative, record keeping and housekeeping items and services
- Supervision of anesthesia by operating surgeon
- Neurostimulators and related devices
- Infusion supplies such as ambulatory infusion pump, implantable infusion pumps and implantable programmable infusion pump replacements.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

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Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements necessary for any applicable defined guidelines.

Modifiers

Priority Health follows standard billing and coding guidelines, which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. Get more information on modifier use in our Provider Manual.

Modifier 53: Discontinued procedure

Reimbursement will be 50% off the base fee schedule (not including MSD reduction, bilateral pricing, etc.)

Use when:

- A service is terminated due to circumstances beyond the physician or health care provider's control, including conditions that threaten the patient's health.
- Use with both diagnostic and surgical CPT codes

Do not use:

- When cancellation of a procedure is elective
- With E/M or anesthesia codes
- ASC facility claims. Use modifier 73 or 74.

Modifier 73: Cancellation of a procedure before the administration of anesthesia

Reimbursement will be 50% of the base fee schedule.

Use when:

- Procedure is cancelled due to extenuating circumstances or a threat to patient well-being:
- Prior to the procedure starting/patient surgical preparation including sedation or being taken to the procedure room
- Prior to administration of local or general anesthesia or a regional block

Do not use when:

- The physician cancelled the surgical or diagnostic procedure
- Cancellation of the procedure is elective
- Surgeon cancelled or postponed because patient presented with cold or flu upon intake

Modifier 74 – Cancellation of a procedure after the administration of anesthesia and/or initiation of the procedure
Notes may be requested to determine the extent of services rendered. Bill using the usual procedure number. There will be no reduction to reimbursement.

Use when:
Cancellation must be due to extenuating circumstances or a threat to the life of the patient

- After procedure started (incision made, intubation started, scope inserted)
- After administration of anesthesia (local, general, or regional block)

Resources

- CMS claims processing manual

Related denial language

Providers may see the following denial codes in prism:

- pg3 – Not typically performed in an ASC setting
- pe6 – Packaged item/service billed separately

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
June 4, 2025	No changes made
July 11, 2025	• Added status indicator guidelines for facility services, following CMS bundling guidelines • Added information on implants done within an ASC • Added "Related denial language" section with prism denial codes effective 7/8/2025: pg3 and pe6