BlueCross BlueShield of Wyoming
An Independent Licensee of the Blue Cross and Blue Shield Association

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Provider Highlights

Blue Cross Blue Shield of Wyoming
Ambulatory Surgery Center (ASC) Reimbursement Guidelines

The ASC maximum allowance includes nursing and technician services; use of the facility; drugs including take-home drugs; biologicals; surgical dressings, casts and equipment directly related to provision of the surgical procedure and materials for anesthesia. The rate does not include items such as physicians' fees; laboratory, X-rays, EKGs, and durable medical equipment for use in the patient's home.

The listing of a maximum allowance does not guarantee payment or benefits. The complexity of the procedure must warrant the use of an ambulatory surgery center, and the member's benefit plan must provide benefits for the particular service. To verify coverage for a specific procedure, please contact our Member Service Department at 1-800-442-2376.

The current list of ASC maximum allowances can be found in the bulletin board section of The Healthcare Online Resource – THOR.

- **How are special supply items reimbursed?**

Supply items are generally included in the facility reimbursement with the following exception: When the cost of a device or multiple devices permanently inserted into the body exceeds $750 and is not included in the maximum allowance, you may be reimbursed the invoice amount of this item plus 10%, less any deductible and/or coinsurance amounts. Some allowances assume inclusion of the cost of implants. When implants are billed separately, allowances for other facility services may be reduced. Shipping and handling charges may not be billed separately. An invoice must be submitted with the claim to be considered for reimbursement. All other supply items and disposables are included in the facility reimbursement.

All implants must be billed using L8699. The ambulatory surgery center must bill for the special supply item on the same claim as the facility charges.

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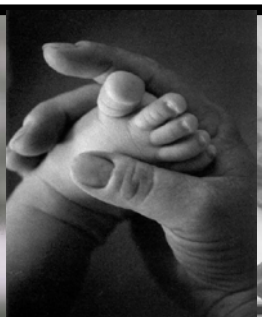


- **How is the reimbursement for multiple and bi-lateral procedures calculated?**

BCBSWY will use the following schedule when calculating the allowable reimbursement for multiple surgeries:

Primary Procedure – The lesser of the provider's charge or 100% of the ASC maximum allowance.
Second Procedure – The lesser of the provider's charge or 50% of the ASC maximum allowance.
3rd – 5th Procedure – The lesser of the provider's charge or 25% of the ASC maximum allowance

The primary procedure is the procedure with the highest maximum allowance. The maximum allowance of the other procedures determines their rank (i.e. the procedure with the second highest maximum allowance is second, the procedure with the third highest maximum allowance is third, etc.)

Charges that are considered incidental or integral to the primary procedure will not be reimbursed in addition to the primary procedure. No more than five facility charges for surgical procedures will be considered for reimbursement during the same 24-hour period.

- **How is the reimbursement for multiple injections/multiple levels calculated? How will multiple scopes performed in the same setting be reimbursed?**

BCBSWY will use the guidelines for multiple and bi-lateral procedures explained above when reimbursing injections and multiple scopes. However, the additional procedure must be a separately billable procedure. In determining bundling and unbundling of services, BCBSWY will follow the same guidelines utilized for services billed by the physician.

- **How are incidental procedures reimbursed?**

No facility reimbursement is provided when the procedure can be performed in the physician's office, or is not medically indicated. Additionally, no reimbursement is to be made for incidental procedures performed in conjunction with other procedures, which are not classified as incidental.

Claim filing instructions

All claims for surgical facility charges must be submitted on the CMS 1500. Procedure codes used by the facility must match procedure codes billed by the surgeon.

Do not attach the SG modifier to supplies or services such as implants or radiology services. Use the TC modifier when billing for the technical component of radiology services.

HCPCS code L8699 must be used to bill for implants.

These guidelines will be utilized in the processing of facility charges filed by Ambulatory Surgery Centers licensed in Wyoming and contracting with Blue Cross Blue Shield of Wyoming as a Participating Ambulatory Surgery Center.

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