



An Independent Licensee of the Blue Cross
and Blue Shield Association

**EXHIBIT A
TO PARTICIPATING AMBULATORY SURGERY CENTER (ASC)
AGREEMENT
REIMBURSEMENT METHODOLOGY
TRADITIONAL**

THIS EXHIBIT TO PARTICIPATING AMBULATORY SURGERY CENTER (ASC) AGREEMENT is effective January 1, 2005 and replaces and supercedes any prior rate exhibits.

I. GENERAL REIMBURSEMENT PROVISIONS

1. By virtue of ASC's participation in Corporation's Participating Provider Network, ASC agrees to accept as payment in full for services provided to Members, the lesser of ASC's billed charge or the Ambulatory Surgery Center Fee Schedule maximum allowable. The Fee Schedule, by Procedure Code, is attached hereto as Attachment 1. This Fee Schedule will be reviewed annually and may be revised from time to time in accordance with Section 8.1 of the Participating ASC Agreement.
2. Services for which ASC may be reimbursed by Corporation and/or Members under this Agreement are those set forth in the Ambulatory Surgery Center Fee Schedule by Procedure Code, Attachment I. ASC shall not bill Corporation or Members for any Covered Service that is not listed on the Regence BlueShield of Idaho ASC Fee Schedule, Attachment I. Such services, if provided, must be written off by the ASC.
3. Where the Member's Health Plan provides for payment of copayment, coinsurance or deductibles by the Member, payment by Corporation for Covered Services shall be the fee schedule amount less the applicable copayment, coinsurance and/or deductible.

II. REIMBURSEMENT PAYMENT METHODOLOGY

1. **Included in the ASC reimbursement rates for the services listed in Attachment 1 are the following:**
 - a. The use of operating and recovery rooms, preparation area, emergency equipment, observation room, waiting rooms, and lounges by the patients and relatives.
 - b. Administrative services including but not limited to scheduling, record keeping, appointment, housekeeping and related items, coordination for discharge, utilities and rent.

- c. Services provided by nurses, orderlies, technical staff and others.
- d. Preoperative and intraoperative radiology including, but not limited to, chest x-rays provided by the ASC.
- e. Preoperative and intraoperative laboratory services performed under a Clinical Laboratory Improvement Amendments certificate of waiver.
- f. Anesthetic and any materials, disposable or re-useable, needed to administer anesthesia.
- g. Drugs and biologicals including preparation, administration and monitoring of patient.
- h. Surgical dressings, supplies, splints, casts, appliances and equipment related to the surgical procedure.
- i. Intraocular lenses for insertion during or after cataract surgery.
- j. Supervision of the services of an anesthesiologist by the operating surgeon.
- k. Therapeutic items.
- l. Three (3) units of blood and blood products per procedure.

2. Multiple procedure reimbursement methodology

- a. In cases involving multiple procedures during the same operative session, the procedure with highest allowable ASC reimbursement rate listed in Attachment 1 shall be deemed the primary procedure.
- b. If more than one procedure is billed, the primary procedure will be reimbursed at the maximum allowable amount set forth in Attachment 1. The next five procedures will be reimbursed at the percentages set forth in the Provider Administrative Manual.
- c. An operative report is required when seven (7) or more procedures are reported. The Corporation's physician reviewer shall have the discretion to determine the rate at which the 7th procedure and above will be reimbursed.
- d. All procedures, including but not limited to bilateral procedures, performed in one operative session shall be billed together. A covered surgical procedure that is performed bilaterally in one operative session should be reported as two procedures. The bilateral procedure should be reported by appending the bilateral Modifier-50 to the second line item procedure code. Bilateral procedures performed in one operative session shall be reimbursed using the same methodology as that used for multiple procedures.
- e. Multiple procedure reimbursement rules are applied to "add-on" procedure codes. For example, the allowable amount for an add-on code is 50% of the fee listed on Attachment 1.

3. Reimbursement methodology for terminated procedures

- a. Procedures terminated for any reason are not eligible for reimbursement with the following exceptions:
 - Company shall reimburse ASC at the percentage of the maximum allowable rate set forth in the Provider Administrative Manual, if the procedure is terminated due to medical necessity after the patient has been prepared for surgery and taken to the operating room but before anesthesia has been induced. ASC must use modifier -73 when billing for procedures terminated prior to the administration of anesthesia.
 - Company shall reimburse ASC at the percentage of the maximum allowable rate set forth in the Provider Administrative Manual, if the procedure is

terminated due to medical necessity after anesthesia has been administered. ASC must use modifier –74 when billing for procedures terminated after the administration of anesthesia.

- b. For any terminated procedure ASC must submit an operative report that specifies the following:
- The reason for termination.
 - Services actually performed.
 - Supplies actually provided.
 - Services not performed that would have been if surgery had continued.
 - Supplies not provided that would have been if surgery had continued.

4. Reimbursement Methodology for Implants

Implants are defined as material(s) inserted into the body, including living, inert, or biological material (i.e. screws, grafts, plates or fixation devices) used for the purpose of creating stability (to correct, protect, or stabilize a deformity) where the majority of the product is left under the skin after surgery. Corporation does not reimburse separately for mesh, sutures, suture anchors, staples, wire, catheters, vascular stents, stents used in the intestinal tract, and devices associated with sterilization or fertility procedures. Corporation reimburses separately for other implants subject to the following conditions:

- a. Corporation requires that implants must be billed at invoice cost, less any rebates and/or discounts received by the ASC. Corporation requires ASC to bill implants using the most descriptive HCPCS code and Corporation will allow up to actual acquisition cost, including shipping, handling, and tax. Shipping, handling, and tax must be prorated for the billed implant for invoices including supplies other than the billed implant. If there is no HCPCS code available for a certain implant, the Corporation will accept the appropriate unspecified code with an explanation of each item and the corresponding charge.
- b. Upon request, Corporation requires the actual invoice for the implant billed. Invoices dated later than sixty (60) days after the date of service will not be accepted. This requirement applies to quarterly retrospective audits described in 4.d as well.
- c. Corporation requires ASC to include a description of implant items on both electronic and paper claims. ASC may bill an electronic or paper claim; however, a description of all implant items is required on both electronic and paper claims. Invoices are only required upon request.
- d. Corporation will conduct quarterly retrospective audits of ASC's charges for implants. Within this audit, Corporation will request invoices for audited claims and any other documentation showing discounts that are not listed on the invoice. Invoices must identify which implants listed on the invoice apply to the claim being audited. Upon request, ASC has twenty (20) days to submit this information to Corporation. During the audit, if Corporation finds that ASC is billing more than acquisition cost, ASC will be required to refund any overpayments made by Corporation to ASC and to provide copies of invoices for all subsequent claims submitted prior to payment. If ASC continues to bill above acquisition cost, or does not provide copies of requested invoices within required timeframe, Corporation will no longer allow reimbursement to ASC for implants as a separate reimbursable item.

5. Reimbursement for Medically Necessary Overnight Observation

Corporation will reimburse for medically necessary overnight observation. Overnight observation may be medically necessary when a patient is not ready for discharge after the customary post-operative recovery period for the procedure(s) performed. CPT code 99199-SG has been added to Attachment 1 of this Exhibit A for medically necessary overnight observation.