Ambulatory surgical center payment system (ASCPS) errors

Payment errors	Correct payment practice
Category 1: Application of 320% multiplier versus ambulatory surgical center's (ASC's) usual and customary charges	
The insurer: • limited the 320% payment to the line charge rather than to the total charge for the bill; • paid 100% of the charge for the overall bill; • paid 100% of the charge for some procedures or services; • paid 85% of the charge for the overall bill; or • paid 75%, 80% or 85% of the charge for a procedure in the federal addenda.	• Payment to an ASC for covered surgical procedures and ancillary services is the lesser of: – the ASC's usual and customary charges for all services, supplies and implantable devices provided; or – the Medicare ASCPS payment for the services, including the applicable geographic adjustment, times the Minnesota workers' compensation multiplier of 320%. • If the Medicare ASCPS amount for the bill, multiplied by the 320% multiplier, is less than the ASC's usual and customary charge for all services, supplies and implantable devices provided, the entire 320% amount must be paid. • The usual and customary charge language applies to the entire bill, so payment is at usual and customary charge only if the **total** charge is less than the **total** 320% amount. • Legislation passed in 2021 clarifies this application. See section 6 at www.revisor.mn.gov/laws/2021/0/Session+Law/Chapter/12/.

Category 2: Multiple surgical procedure discount for services in the ASCPS	
The insurer: • applied the multiple-procedure discount to ineligible procedures in the federal addenda; • applied the multiple-procedure discount to a procedure in the federal addenda where there was just one such procedure on the bill; • applied the multiple-procedure discount to a procedure in the federal addenda where there was just one such procedure along with a procedure outside of the addenda; • paid for a subsequent procedure (a procedure other than the most expensive) in the federal addenda at 50% of charge rather than 50% of the 320% amount (the Medicare amount times 320%); • paid for a subsequent procedure (other than the most expensive) in the federal addenda at 37.5%, rather than 50%, of the 320% amount (the Medicare amount times 320%); or • failed to apply the multiple-procedure discount.	• When more than one surgical procedure **that is subject to the multiple procedure discount** (according to the Medicare addenda) is performed in the same operative session, special payment rules apply. – Step 1: The covered surgical procedure with the highest payment rate in Column G of Addendum AA is paid at the full Minnesota payment rate.[1] – Step 2: For any other procedure performed in the same operative session that is subject to the multiple procedure discount according to this column, payment is 50% (0.5) of the Minnesota payment rate. • This multiple-procedure discount is only applicable when more than one procedure on the bill is in Addendum AA and is identified as subject to multiple procedure discounting in that addendum. Column D of Addendum AA indicates whether a service is subject to the multiple procedure discount. • Legislation passed in 2021 clarifies multiple procedure rules for ASCs. See section 6 at www.revisor.mn.gov/laws/2021/0/Session+Law/Chapter/12/.

[1]The Minnesota payment rate = Medicare payment rate x ((.5 x wage index) + .5) x 320%.

Category 3: Payment for compensable services not in the ASCPS	
The insurer: • paid according to the relative value fee schedule; • made a zero payment for a non-denied procedure; • paid for a non-surgical (non-implant) service not in the federal addenda; • paid for an implant; • paid for a service without an HCPCS code; • paid 85% of the charge for a procedure not in the federal addenda; or • applied a multiple-procedure discount to a procedure outside of the federal addenda where there was just one such procedure along with a procedure in the addenda.	• All services on the ASC bill should be paid according to the requirements in Minn. Stat. § 176.1363. When the federal addenda indicate zero payment, proper payment is just that. • For services listed on the ASC fee schedule with a payment rate of $0, that is the correct payment. • All payment provisions for services provided by the ASC are contained in Minn. Stat. § 176.1363. No other fee schedule applies to ASC facility services. • The relative value fee schedule, in particular, applies to professional services; the services at issue under ASCPS are the facility services provided by the ASC. • The ASCPS payment amount under Minn. Stat. § 176.1363, subdivision 2, includes payment for **all** implantable devices, even if the Medicare ASCPS would otherwise allow separate payment for these devices. • If a **surgical procedure** provided by an ASC is compensable under Minn. Stat. chapter 176, but is not listed in addendum AA or BB of the Medicare ASCPS, payment must be 75% of the ASC's usual and customary charge for the procedure with the highest charge. – Payment for each additional compensable surgical procedure not listed in addendum AA or BB is 50% of the ASC's usual and customary charge. • If a bill includes a line item charge without a HCPCS code, it is not separately payable.