Ambulatory Surgery Center

Reimbursement Policy ID: RPC.0036.0900

Recent review date: 08/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, and other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, or when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses the allowable facility services and reimbursement of those services in an ambulatory surgery center (ASC).

Exceptions

N/A

Reimbursement Guidelines

The health plan provides a single payment to ASCs for covered surgical procedures, which includes ASC facility services that are furnished in connection with the covered procedure including the following:

- Nursing services, services furnished by technical personnel, and other related services;
- Patient use of the ASC facility where the surgical procedure is performed;
- Any laboratory testing performed under a Clinical Laboratory Improvement Amendments of 1988 (CLIA) certificate of waiver;
- Drugs and biologicals for which separate payment is not allowed;
- Surgical dressings, supplies, splints, casts, appliances, and equipment;
- Administrative, recordkeeping, and housekeeping items and services;
- Blood, blood plasma, and platelets, with the exception of those to which the blood deductible applies;
- Materials, including supplies and equipment for the administration and monitoring of anesthesia;
- Supervision of the services of an anesthetist by the operating surgeon;
- Implantable devices and related accessories and supplies;
- Radiology services for which payment is packaged under the payment system.

Ambulatory surgery procedures or services reported on claim form CMS-1500 must be submitted with Place of Service 24, and ambulatory surgery procedures or services reported on claim form CMS-1450 must be reported with bill type 83x or revenue code 490 for reimbursement.

Definitions

Ambulatory Surgery Center (ASC)
A certified ambulatory surgery center (ASC) may be either hospital-operated or independent. If hospital-operated, the ASC must be a separately identified entity, physically and administratively distinct from other inpatient operations of the hospital. In cases where hospitalization after surgery is warranted, the ASC must be able to provide immediate transfer to a hospital.

Place of Service (POS) — 24
Place of Service (POS) — 24 represents a freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis.

Edit Sources

I. Current Procedural Terminology (CPT).
II. Healthcare Common Procedure Coding System (HCPCS).
III. Centers for Medicare and Medicaid Services (CMS).
IV. The National Correct Coding Initiative (NCCI) .
V. https://nhmmis.nh.gov/portals/wps/wcm/connect/0c6a5509-272d-4eba-b4c3-e8519ee4a4b0/NH+Medicaid+rebranded+ASC+Provider+Manual+1-26-18.pdf?MOD=AJPERES&CVID=m9FVj7I.
VI. New Hampshire Medicaid Fee Schedule.

Attachments

N/A

Associated Policies

RPC.0036.0900 Multiple Procedure Payment Reduction

RPC.0006.0900 Bilateral Procedure
RPC.0063.0900 Place of Service

Policy History

09/2026	• Removed the next review date • Replaced the plan name with “the health plan”
08/2026	Reimbursement Policy Committee Approval
07/2026	Biennial review • Added Place of Service definition and policy
06/2025	Minor updates to formatting and syntax
04/2025	Revised preamble
01/2025	Reimbursement Policy Committee Approval
11/2024	Annual review • Updated to biennial policy • No major changes
04/2024	Revised preamble
03/2024	Reimbursement Policy Committee Approval