Washington State Health Care Authority

Medicaid Provider Guide

Ambulatory Surgery Centers

Washington State Health Care Authority

A Billing Instruction

About This Publication

This publication supersedes all previous Agency *Ambulatory Surgery Centers Medicaid Provider Guides* published by the Washington State Health Care Authority.

Note: The Agency now reissues the entire billing manual when making updates, rather than just a page or section. The effective date and revision history are now at the front of the manual. This makes it easier to find the effective date and version history of the manual.

Effective Date

The Effective date for this publication is: 04/01/2012

What Has Changed?

Reason for Change	Effective Date	Section/ Page No.	Subject	Change
Update to mpg	April 1, 2012	C.1	Authorization	Add general guidelines.
Provider Notice 12-24	April 1, 2012	Page C.2	Authorization Requirements for Surgical Procedures.	Add language regarding submitting authorization requests through Qualis Health for selected surgical procedures and spinal injections.
Provider Notice 12-24	April 1, 2012	Page C.3	Authorization Requirements for Surgical Procedures.	Add hyperlink for Physician-Related Services/Healthcare Professional Services.

How Can I Get Agency Provider Documents?

To download and print Agency provider notices and Medicaid provider guides, go to the Agency website at http://hrsa.dshs.wa.gov (click the **Medicaid Provider Guides and Provider Notices** link).

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Important Contacts

Note: This section contains important contact information relevant to ambulatory surgery centers. For more contact information, see the Agency *Resources Available* web page at:
http://hrsa.dshs.wa.gov/Download/Resources_Available.html

<table>
<tr><th>Topic</th><th>Contact Information</th></tr>
<tr><td>Becoming a provider or submitting a change of address or ownership</td><td rowspan="5">See the Agency Resources Available web page at:
http://hrsa.dshs.wa.gov/Download/Resources_Available.html</td></tr>
<tr><td>Finding out about payments, denials, claims processing, or Agency managed care organizations</td></tr>
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<tr><td>Requesting prior authorization</td></tr>
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Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in this provider guide. Please refer to the Agency *Glossary* at http://hrsa.dshs.wa.gov/download/medical_assistance_glossary.htm for a more complete list of definitions.

Ambulatory Surgery Center (ASC) - Any distinct entity certified by Medicare as an ASC that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization.

Benefit Service Package - A grouping of benefits or services applicable to a client or group of clients.

Coinsurance-Medicare – The portion of reimbursable hospital and medical expenses, after subtraction of any deductible, which Medicare does not pay. Under Part A, coinsurance is a per day dollar amount. Under Part B, coinsurance is 20 percent of reasonable charges.

Health Care Financing Administration Common Procedure Coding System (HCPCS) – Coding system established by the Health Care Financing Administration (now known as the Center for Medicare and Medicaid Services [CMS]) to define services and procedures.

Maximum Allowable - The maximum dollar amount a provider may be reimbursed by the Agency for specific services, supplies, or equipment.

Pilot Project - A new payment methodology for procedures performed in ambulatory surgery centers. At the end of the pilot project the Agency will evaluate the program and decide whether to expand, change or end the pilot project. The project is expected to be for dates of service January 1, 2012 through approximately December 2013.

Pilot Project Procedure Codes - Are procedure codes that have been selected by the Agency to be paid using the pilot project methodology.

Usual and Customary – The fee that the provider usually charges non-Medicaid customers for the same service or item. This is the maximum amount that the provider may bill the Agency.

Ambulatory Surgery Centers

What Is the Purpose of the Ambulatory Surgery Centers Program?

The purpose of the Ambulatory Surgery Centers (ASC) program is to reimburse providers for the facility costs of surgical procedures that can be performed safely on an ambulatory basis in an ambulatory surgery center.

Who Should Use This Provider Guide?

Ambulatory surgery centers that have a valid Core Provider Agreement with the Agency should use this provider guide. Hospital-based ASCs must bill in accordance with the Agency Outpatient Hospital Services Provider Guide.

What Is Covered?

The Agency covers the procedure codes listed in the fee schedule when the service is medically necessary and not solely for cosmetic treatment or surgery.

Where Do I Find Procedure-Specific Information?

Authorization requirements, expedited prior authorization (EPA) lists, Centers of Excellence provider lists, coverage criteria (age, diagnostic, GAU client eligibility, etc.), sterilization requirements and forms, and unit limitations may be found in the appropriate program publications.

For example:

- Dental-Related Services Medicaid Provider Guide
- Agency-Approved Family Planning Provider Medicaid Provider Guide
- Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide
- Vision Hardware for Clients 20 Years of Age and Younger

Client Eligibility

Who Is Eligible?

Please see the Agency *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

> **Note:** Refer to the *Scope of Coverage Chart* web page at: http://hrsa.dshs.wa.gov/Download/ScopeofHealthcareSvcsTable.html for an up-to-date listing of Benefit Service Packages.

Are Clients Enrolled in Managed Care Eligible?

YES! When verifying eligibility using ProviderOne, if the client is enrolled in an Agency managed care plan, managed care enrollment will be displayed on the Client Benefit Inquiry screen.

The client's managed care plan covers services provided at ambulatory surgery centers when the client's primary care provider (PCP) determines that the services are appropriate for the client's health care needs. You must bill the plan directly.

> **Note:** To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the plan. See the Agency *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.htm for instructions on how to verify a client's eligibility.

Are Clients Enrolled in Primary Care Case Management (PCCM) Eligible?

Yes! For the client who has chosen to obtain care with a PCCM, this information will be displayed on the client benefit inquiry screen in ProviderOne. These clients must obtain, or be referred for, services via a PCCM provider. The PCCM provider is responsible for coordination of care just like the PCP would be in a plan setting.

> **Note:** To prevent billing denials, please check the client's eligibility **prior** to scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained from the PCCM provider. Please see the Agency *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for instructions on how to verify a client's eligibility.

Authorization

General Guidelines

- Please note that authorization requirements are not a denial of service.
- When a service requires authorization, the provider **must properly request** written authorization in accordance with the Agency's rules, this Medicaid Provider Guide, and applicable numbered memos.
- When the provider does not properly request authorization, the Agency returns the request to the provider for proper completion and resubmission. The Agency does not consider the returned request to be a denial of service.

Prior Authorization

To receive prior authorization for a service to be performed in an ASC, a provider must send, or fax a request for authorization along with medical justification to the Agency (see the *Important Contacts* section).

Note: Please see the Agency *ProviderOne Billing and Resource Guide* at: http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for more information on requesting authorization.

Authorization Requirements for Surgical Procedures

[Refer to WAC 182-531-1700]

Changes in Authorization Requirements for Selected Surgical Procedures

Effective for dates of service on and after April 15, 2012, the Agency is expanding its prior authorization requirements to include selected surgical procedures. The medical necessity review for these procedures will be conducted by the Agency or Qualis Health.

Surgical Procedures that Require Medical Necessity Review by the Agency

To implement the prior authorization requirement for selected surgical procedures (including hysterectomies and other surgeries of the uterus), the Agency will also conduct medical necessity reviews for selected surgical procedures. The Agency will begin accepting requests for these medical necessity reviews April 1, 2012. For details about the PA requirements for these procedures, refer to:

- http://hrsa.dshs.wa.gov/download/Billing_Instructions_Webpages/Physician-Related_Services.html or
- http://hrsa.dshs.wa.gov/RBRVS/Index.html; and scroll down to Physicians-Related/Professional and Emergent Oral Healthcare Services, then select the most current Physician and Related Services fee schedule link. Select a procedure code and refer to the comments field for the accompanying submittal requirement.

Surgical Procedures that Require Medical Necessity Review by Qualis Health

The Agency and Qualis Health have contracted to provide web-based submittal for utilization review services to establish the medical necessity of selected surgical procedures in the following categories:

Spinal, including facet injections;

Major joints;

Upper and lower extremities;

Carpal tunnel release; and

Thoracic outlet release.

Qualis Health conducts the review of the request to establish medical necessity for surgeries, but **does not** issue authorizations. Qualis Health forwards its recommendations to the Agency.

For more information about the requirements for submitting medical necessity reviews for authorization please refer to the Agency's current published *Physician-Related. Services/Healthcare Professional Services Medicaid Provider Guide* online at: http://hrsa.dshs.wa.gov/download/Billing_Instructions_Webpages/Physician-Related_Services.html.

Payment

What Is Included in the Facility Payment?

The facility payment maximum allowable fee includes:

- The client's use of the facility, including the operating room and recovery room;
- Nursing services, technician services, and other related services;
- Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances, and equipment related to the care provided;
- Diagnostic or therapeutic items and services directly related to the surgical procedure;
- Administrative, recordkeeping, and housekeeping items and services; **and**
- Materials and supplies for anesthesia.

Facility Fee When Multiple Surgical Procedures are Performed

For providers performing multiple surgical procedures in a single operative session, the Agency reimburses the lesser of the billed amount, or up to 100 percent of the Agency's maximum allowable for the procedure with the highest group number. For the second procedure, reimbursement is the lesser of the billed amount or up to 50 percent of the Agency's maximum allowable. The Agency does not make additional reimbursement for subsequent surgical procedures.

Exception: Pilot project procedures are all paid at the lesser of billed charges, or the maximum allowable fee.

What Is Not Included in the Facility Payment?

The following services are not included in the facility payment:

- Physicians' professional services;
- The sale, lease, or rental of durable medical equipment to clients for use in their homes;
- Prosthetic devices (e.g., intraocular lens);
- Ambulance or other transportation services;
- Leg, arm, back, and neck braces;
- Artificial legs, arms, and eyes; and
- Implantable Devices.

Exception: Unless specifically noted in the fee schedule, the maximum allowable fee for the pilot project procedure codes include payment for implantable devices.

How Do I get Paid for Implantable Devices

To receive payment providers must:

- Use one of the following procedure code(s) (C1713, C1718, L8699) when billing for an implantable device;
- Bill for implantable devices on the same claim as the primary procedure code associated with the device. The primary procedure code must be covered on the Agency's ASC fee schedule. Claims may be denied without a primary procedure code appearing on the claim;
- Use procedure codes (C1713, C1718, L8699) only once per claim. Bill multiple units if appropriate; and
- Bill the Agency the acquisition cost (AC). AC means the cost of an item excluding shipping, handling, and any applicable taxes as indicated by a manufacturer's invoice (See WAC 182-550-1050.)

Exception: Unless specifically noted in the fee schedule, C1713, C1718 and L8699 may not be billed in combination with the pilot project procedure codes.

About the Fee Schedule

The notations in the policy column of the fee schedule are intended to alert providers that there is specific policy, regulation, or criteria related to the use of the code noted. Providers should review the program specific publications for details (e.g., *Dental Program for Clients Age 21 and Older Medicaid Provider Guide*, *Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide*, *Agency-Approved Family Planning Provider Medicaid Provider Guide*, etc.)

Fee Schedule Legend:

- **Prior Auth Column**

  BR = By Report
  EPA = Expedited Prior Authorization
  PA = Prior Authorization
  # = Not Covered
  L = The use of this procedure code may have certain restrictions (e.g., ages, authorization requirements, diagnosis, or facilities). Please see the program specific publications for details prior to providing this service.

- **Status Indicators**

  D = Discontinued Code

N = New Code
P = Policy Change
PP = This code is one of the pilot project procedure codes and pilot project rules apply.
** = This code is part of the pilot project but L8699 is billable for covered implantable medical devices separately when applicable when the claim includes supporting documentation.

R = Rate Update
= Not covered by this program
Ø = Not covered by the Agency

How Do I View or Download the Fee Schedule?

Visit the Agency's web site at http://hrsa.dshs.wa.gov/RBRVS/Index.html to view the fee schedule.

Billing

What Are the General Billing Requirements?

Providers must follow the Agency *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html. These billing requirements include, but are not limited to:

- Time limits for submitting and resubmitting claims and adjustments;
- What fee to bill the Agency for eligible clients;
- When providers may bill a client;
- How to bill for services provided to primary care case management (PCCM) clients;
- Billing for clients eligible for both Medicare and Medicaid;
- Third-party liability; and
- Record keeping requirements.

Completing the CMS-1500 Claim Form

> **Note:** Refer to the Agency *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html for general instructions on completing the CMS-1500 Claim Form.

The following CMS-1500 Claim Form instructions relate to Ambulatory Surgery Centers:

Field No.	Name	Entry
23.	Prior Authorization Number	When applicable. If the service you are billing for requires authorization, enter the nine-digit number assigned to you. Only one authorization number is allowed per claim.
24B.	Place of Service:	Enter *24* (ambulatory surgery center).