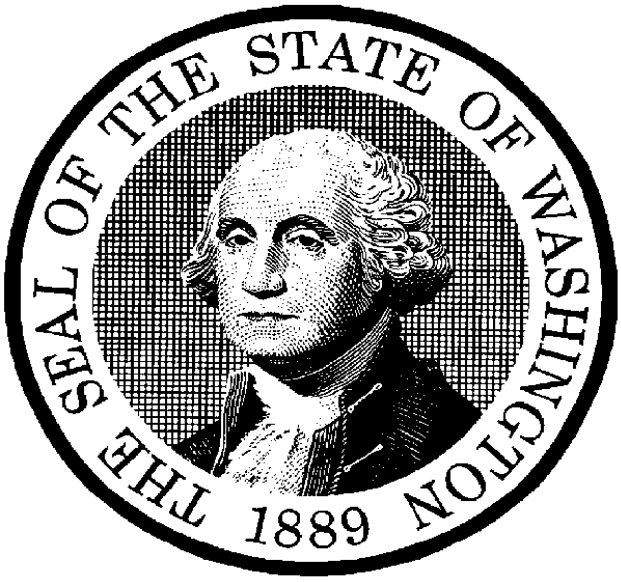
Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Health and Recovery Services Administration (HRSA)



Ambulatory Surgery Centers

Billing Instructions

About this publication

This publication supersedes all previous billing instructions for Ambulatory Surgery Centers and is published by the Washington State Department of Social and Health Services, Health and Recovery Services Administration.

Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

HRSA's Billing Instructions and Numbered Memoranda

To download and print DSHS/HRSA provider numbered memoranda and billing instructions, go to the DSHS/HRSA website at: http://hrsa.dshs.wa.gov (click ***Billing Instructions and Numbered Memorandum***).

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Important Contacts

A provider may use HRSA's toll-free lines for questions regarding its program. However, HRSA's response is based solely on the information provided to HRSA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern HRSA's programs.

How can I use the Internet to…

Find information on becoming a DSHS provider?

Visit Provider Enrollment at:
http://hrsa.dshs.wa.gov/ProviderEnroll/

Click ***Sign up to be a DSHS WA state Medicaid provider*** and follow the on-screen instructions.

Ask questions about the status of my provider application?

Visit Provider Enrollment at:
http://hrsa.dshs.wa.gov/ProviderEnroll/

- Click ***Sign up to be a DSHS WA state Medicaid provider***
- Click ***I want to sign up as a DSHS Washington State Medical provider***
- Click ***What happens once I return my application?***

Submit a change of address or ownership?

Visit Provider Enrollment at:
http://hrsa.dshs.wa.gov/ProviderEnroll/

- Click ***I'm already a current Provider***
- Click ***I want to make a change to my provider information***

Payments, denials, claims processing, or HRSA managed care organizations?

Visit the Customer Service Center for Providers at:
http://hrsa.dshs.wa.gov/ProviderEnroll/

- Click ***I'm already a current Provider***
- Click ***Frequently Asked Questions***

Or call/fax:
800.562.3022, Option 2 (toll free)
360.725.2144 (fax)

Or write to:
HRSA Customer Service Center
PO Box 45562
Olympia, WA 98504-5562

If I don't have access to the Internet, how do I find information on…

Becoming a DSHS provider, ask questions about the status of my provider application, or submit a change of address or ownership?

Call Provider Enrollment at:
800.562.3022 (toll free)

Or write to:
HRSA Provider Enrollment
PO Box 45562
Olympia, WA 98504-5562

If I don't have access to the Internet, how do I find information on… (cont.)

Private insurance or third-party liability, other than HRSA managed care?

Office of Coordination of Benefits
PO Box 45565
Olympia, WA 98504-5565
800.562.6136 (toll free)

How do I find out about Internet billing (electronic claims submission)?

Visit:
WinASAP and WAMedWeb:
http://www.acs-gcro.com

Click ***Medicaid*** then ***Washington State***.

All other HIPAA transactions:
https://wamedweb.acs-inc.com

To enroll with ACS EDI Gateway for HIPAA Transactions and/or WinASAP 2003, visit:
http://www.acs-gcro.com

Click ***Medicaid***, then ***Washington State***, then ***Enrollment***.

Or call ACS EDI Gateway, Inc. at:
800.833.2051 (toll free)
After you submit the completed EDI Provider Enrollment form, ACS will send you the link and information necessary to access the web site. If you are already enrolled but cannot access the website, please call ACS toll free at 800.833.2051.

How do I check on a client's eligibility status?

Call ACS at:
800.833.2051 (toll free)

Or call HRSA at:
800.562.3022 (toll free) and choose option #2

You may also access the WAMedWeb Online Tutorial at:
http://maa.dshs.wa.gov/wamedwebtutor

Where do I send paper claims?

Claims Processing
PO Box 9248
Olympia WA 98507-9248

How do I obtain copies of billing instructions or numbered memoranda?

To view an electronic copy, visit:
http://hrsa.dshs.wa.gov

Click ***Billing Instructions/Numbered Memoranda***

How do I obtain DSHS forms?

To **view and download** DSHS forms, visit DSHS Forms and Records Management Service on the web:
http://www1.dshs.wa.gov/msa/forms/eforms.html

Definitions & Abbreviations

This section contains definitions, abbreviations, and acronyms used in these billing instructions that relate to Medicaid. The definitions are presented as a guide for the provider's use. They are not intended to be inclusive, nor are they intended to inhibit professional judgment. The criteria apply to all providers and contractors. For a more complete list of definitions and abbreviations, see HRSA's *General Information Booklet*.

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.

Client – An applicant approved for, or recipient of, DSHS medical care programs.

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.

Core Provider Agreement - A basic contract that HRSA holds with medical providers serving HRSA clients. The provider agreement outlines and defines terms of participation in the Medicaid program.

Department - The state Department of Social and Health Services.

Expedited Prior Authorization (EPA) - The process of authorizing selected services in which providers use a set of numeric codes to indicate to HRSA which acceptable indications, conditions, diagnoses, and/or criteria are applicable to a particular request for services.

Health and Recovery Services Administration (HRSA) - The administration within DSHS authorized by the secretary to administer the acute care portion of Title XIX Medicaid, Title XXI state-children's health insurance program (S-CHIP), Title XVI, and the state-funded medical care programs, with the exception of certain nonmedical services for persons with chronic disabilities.

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.

Managed Care – A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services.
(WAC 388-538-050)

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

Medicaid - The state and federally funded Title XIX program under which medical care is provided to persons eligible for the:

- Categorically needy program; or
- Medically needy program.

Medical Identification (ID) Card – The form the Department of Social and Health Services uses to identify clients of medical programs. Medical ID cards are good only for the dates printed on them. Clients will receive a Medical ID card in the mail each month they are eligible.

Medically Necessary - See WAC 388-500-0005.

Medicare - The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the Social Security Act. Medicare includes the following:

- "Part A" covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

- "Part B" is the supplementary medical insurance benefit (SMIB) covering the Medicare doctor's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

- "Part D" is the Medicare prescription drug insurance benefit, covering prescription drugs for a medically accepted indication; biological products; insulin; vaccines and some medical supplies associated with the injection of insulin.

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each Medical Assistance client and which consists of:

- First and middle initials (or a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

Prior Authorization – Approval required from HRSA prior to providing services, for certain medical services, equipment, or supplies based on medical necessity.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client.

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

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 HRSA.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

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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 these billing instructions?

Ambulatory Surgery Centers that have a valid Core Provider Agreement with HRSA should use these billing instructions. Hospital-based ASCs must bill in accordance with HRSA's Outpatient Hospital Services Billing Instructions.

What is covered?

HRSA 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 Program for Clients Age 21 and Older Billing Instructions;
- Dental Program for Clients Through Age 20 Billing Instructions;
- HRSA-Approved Family Planning Provider Billing Instructions;
- Physician-Related Services Billing Instructions;
- Vision Care Billing Instructions;

Prior Authorization

To receive prior authorization, a provider must send or fax a request for authorization along with medical justification to:

Health and Recovery Services Administration
PO Box 45506
Olympia, WA 98504-5506
Fax: 360.586.1471

Client Eligibility

Who is eligible?

Most medical assistance clients are eligible for Ambulatory Surgery Center services **except** clients presenting Medical Identification (ID) Cards with one of the following identifiers:

Exceptions:

Medical ID Card Identifier	Medical Program
CNP-Emergency Medical Only	**Categorically Needy Program-Emergency Medical Only** – These clients are not eligible for Ambulatory Surgery Center services.
LCP-MNP – Emergency Medical Only	**Limited Casualty Program – Medically Needy Program – Emergency Medical Only –** These clients are not eligible for Ambulatory Surgery Center services.
Family Planning Only	**Family Planning** – These clients may receive only sterilization services.
GA-U No Out of State Care	**General Assistance – Unemployable** These clients are restricted to services as addressed by parent programs (e.g., Dental Program for Clients Age 21 and Older). The eligibility of the parent program applies as well.

Are clients enrolled in managed care eligible for services provided in an Ambulatory Surgery Center?

Clients with an identifier in the HMO column on their Medical ID Card are enrolled in one of HRSA's managed care plans. 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.

To prevent billing denials, please check the client's Medical ID Card prior to scheduling services and at the **time of service** to make sure proper authorization or referral is obtained from the PCP and/or plan.

Primary Care Case Management (PCCM) clients will have the identifier PCCM in the HMO column on their Medical ID Cards. Please make sure these clients have been referred by their PCCM prior to receiving services. The referral number is required in field 17A on the 1500 claim form. (See the *Billing* section for further information.)

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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, HRSA reimburses the lesser of the billed amount or up to 100 percent of HRSA'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 HRSA's maximum allowable. The Department does not make additional reimbursement for subsequent surgical procedures.

- The provider must identify the:

  ✓ Primary procedure (the procedure with the highest reimbursement rate) with modifier **U1; and**

  ✓ Secondary procedure with modifier **U2**.

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.

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 Department's ambulatory surgery center 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;

- Bill the Department the acquisition cost (AC.) AC means the cost of an item excluding shipping, handling, and any applicable taxes as indicated by a manufacturers invoice (See WAC 388-550-1050.)

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 Billing Instructions*, *Physician-Related Services Billing Instructions*, *HRSA-Approved Family Planning Provider Billing Instructions*, 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
  R = Rate Update
  # = Not covered by this program
  Ø = Not covered by HRSA

How to view or download a copy of the Fee Schedule?

Visit HRSA's web site at http://maa.dshs.wa.gov/RBRVS/Index.html to view the new fee schedule, effective July 1, 2007.

Billing

What is the time limit for billing? [Refer to WAC 388-502-0150]

HRSA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. HRSA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

  ✓ HRSA requires providers to submit an **initial claim** to HRSA and obtain an ICN within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders HRSA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

Note: If HRSA has recouped a plan's premium, causing the provider to bill HRSA, the time limit is 365 days from the date the plan recouped the payment from the provider.

[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

Eligibility Established After Date of Service but Within the Same Month - If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill HRSA for the service.

- ✓ HRSA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:
  - ➢ DSHS certification of a client for a retroactive[2] period; or
  - ➢ The provider proves to HRSA's satisfaction that there are other extenuating circumstances.

- ✓ HRSA requires providers to bill known third parties for services. See page D.3 and/or WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to HRSA's billing limits.

• Resubmitted Claims

- ✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 24 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service. Providers must reference a timely claim number on an untimely resubmitted claim in order to prove timeliness or HRSA will deny payment.

Note:	HRSA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

- ✓ The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to HRSA by claim adjustment. The provider must refund overpayments to HRSA by a negotiable financial instrument, such as a bank check.

- ✓ The provider, or any agent of the provider, must not bill a client or a client's estate when:
  - ➢ The provider fails to meet these listed requirements; and
  - ➢ HRSA does not pay the claim.

- ✓ Bill one claim for all services per client, per date of service. Corrections to a final or partially paid claim must be billed as an adjustment to the initial claim.

Refer to HRSA's *General Information Booklet*, Section K, for instructions on how to correct any billing problems you experience (e.g., Adjustments/Rebillings).

[2] **Retroactive Certification:** An applicant receives a service, then applies to HRSA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill HRSA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill HRSA.

What fee should I bill the Department for eligible clients?

Bill the Department your usual and customary charge. Unless otherwise directed.

How do I bill for clients eligible for Medicare and Medicaid?

Refer to the Department/HRSA *General Information Booklet*, Section H, for instructions on how to bill for clients eligible for both Medicare and Medicaid.

Third-Party Liability

You must bill the insurance carrier(s) indicated on the client's Medical ID card. An insurance carrier's time limit for claim submissions may be different from HRSA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as the Department's, prior to any payment by the Department.

You must meet the Department's 365-day billing time limit even if you have not received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding the Department Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by the Department, or if you have reason to believe that the Department may make an additional payment:

- Submit a completed claim form to HRSA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the HRSA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the Comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on HRSA's website at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 800.562.6136.

What records must be kept? [WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Dental photographs/teeth models;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- **Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, *for at least six years from the date of service* or more if required by federal or state law or regulation.**

Notifying Clients of their Rights (Advance Directives)

All Medicare-Medicaid certified hospitals, nursing facilities, home health agencies, personal care service agencies, hospices, and managed health care organizations are federally mandated to give **all adult clients** written information about their rights, under state law, to make their own health care decisions.

Clients have the right to:

- Accept or refuse medical treatment;
- Make decisions concerning their own medical care; and
- Formulate an advance directive, such as a living will or durable power of attorney, for their health care.

Completing the 1500 Claim Form

Refer to DSHS's current *General Information Booklet* for instructions on completing the CMS-1500 Claim Form.

You may download this booklet from DSHS's website at:
http://hrsa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html.

The following CMS-1500 claim form instructions relate to the *Ambulatory Surgery Centers Billing Instructions*. Click the link above to view general CMS-1500 claim form instructions.

For questions regarding claims information, call HRSA toll-free:

800.562.3022 (option 2)

1500 Claim Form Field Descriptions

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).

Note: Hospital-based ASCs must bill using the UB-04 claim form. Detailed instructions on how to complete and bill according to the official UB-04 Data Specifications Manual is available from the National Uniform Billing Committee at: http://www.nubc.org/index.html.

Completing the 1500 Claim Form for Medicare Part B/Medicaid Crossovers

When billing for Medicare crossovers, be sure to attach the Medicare Explanation of Medicare Benefits (EOMB) to your claim. Refer to HRSA's current *General Information Booklet* for general instructions on completing the CMS-1500 claim form. You may download this booklet from HRSA's website at: http://hrsa.dshs.wa.gov/download/Billing%20Instructions%20Web%20Pages/General%20Information.html.

For questions regarding claims information, call HRSA toll-free:
800.562.3022 (option 2)

Billing Note: The CMS-1500 claim form used for Medicare/Medicaid Benefits Coordination, **cannot** be billed electronically.