Health Care Authority

Ambulatory Surgery Centers

Billing Instructions

About This Publication

This publication supersedes all previous Department/MPA *Ambulatory Surgery Centers Billing Instructions* published by the Health and Recovery Services Administration, Washington State Department of Social and Health Services.

Note: The Department 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 of this publication is: **1/1/2011**.

2011 Revision History

This publication has been revised by:

Document	Subject	Issue Date	Pages Affected
10-85	Revise the definition for an Ambulatory Surgical Center (ASC); Update the *ASC Fee Schedule* with procedure code revisions; Add Year 2011 Current Procedural Terminology (CPT®) codes and Year 2011 Healthcare Common Procedural Coding System (HCPCS) codes to the *ASC Fee Schedule*; Update the *ASC Fee Schedule* with new authorization codes with budget reduction related changes; Make changes to the *Dental Program for Clients 21 and Older* that affect ASCs; and Implement new authorization codes.	**12/30/2010**	**Page 1**

How Can I Get Department/MPA Provider Documents?

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

Table of Contents

Important Contacts

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

Topic	Contact Information
Becoming a provider or submitting a change of address or ownership	See the Department/MPA *Resources Available* web page at: http://hrsa.dshs.wa.gov/Download/Resources_Available.html
Finding out about payments, denials, claims processing, or Department managed care organizations	
Electronic or paper billing	
Finding Department documents (e.g., billing instructions, # memos, fee schedules)	
Requesting prior authorization	

Definitions & Abbreviations

This section defines terms and abbreviations, including acronyms, used in these billing instructions. Please refer to the Department/MPA *ProviderOne Billing and Resource Guide* at http://hrsa.dshs.wa.gov/download/ProviderOne_Billing_and_Resource_Guide.html 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 Department for specific services, supplies, or equipment.

Medical ID Card – See *Services Card*.

Medically Necessary - See WAC 182-500-0005.

National Provider Identifier (NPI) – A federal system for uniquely identifying all providers of health care services, supplies, and equipment.

ProviderOne – Department of Social and Health Services (the Department) primary provider payment processing system.

ProviderOne Client ID- A system-assigned number that uniquely identifies a single client within the ProviderOne system; the number consists of nine numeric characters followed by WA.
For example: 123456789WA.

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

Services Card – A plastic "swipe" card that the Department issues to each client on a "one- time basis." Providers have the option to acquire and use swipe card technology as one method to access up-to-date client eligibility information.

- The Services Card replaces the paper Medical Assistance ID Card that was mailed to clients on a monthly basis.
- The Services Card will be issued when ProviderOne becomes operational.
- The Services Card displays only the client's name and ProviderOne Client ID number.
- The Services Card does not display the eligibility type, coverage dates, or managed care plans.

- The Services Card does not guarantee eligibility. Providers are responsible to verify client identification and complete an eligibility inquiry.

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 Department.

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 the Department should use these billing instructions. Hospital-based ASCs must bill in accordance with the Department/MPA Outpatient Hospital Services Billing Instructions.

What Is Covered?

The Department 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
- Department-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 the Department (see the *Important Contacts* section).

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

Client Eligibility

Who Is Eligible?

Please see the Department/MPA *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 a Department 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 Department/MPA *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 Department/MPA *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.

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

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; and

- 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 182-550-1050.)

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, Department-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 the Department

How Do I View or Download the Fee Schedule?

Visit the Department'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 Department/MPA *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 Department 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 Department/MPA *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).