



Ambulatory Surgery Centers Provider Guide

January 1, 2016

Washington State
Health Care Authority

About this guide*

This publication takes effect January 1, 2016, and supersedes earlier guides to this program.

Washington Apple Health means the public health insurance programs for eligible Washington residents. Washington Apple Health is the name used in Washington State for Medicaid, the children's health insurance program (CHIP), and state-only funded health care programs. Washington Apple Health is administered by the Washington State Health Care Authority.

What has changed?

Subject	Change	Reason for Change
Client eligibility - PCCM	Removed language regarding PCCM. Providers should use the agency's <i>ProviderOne Billing and Resource Guide</i> to verify client eligibility.	Information located in another source
How do providers get paid for corneal tissue?	Added information about billing and payment for corneal tissue processing (HCPCS procedure code V2785).	Billing change effective 1/1/16
Surgical procedures requiring a medical necessity review by Qualis Health	Added information about checking client eligibility.	Clarification

How can I get agency provider documents?

To download and print agency provider notices and provider guides, go to the agency's [Provider Publications](#) website.

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* This publication is a billing instruction.

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Resources Available

Topic	Resources Information
Request for prior authorization	See the agency's list of Resources Available .
Additional information regarding this program	Contact the Customer Service Center .
Additional Medicaid agency resources	See the agency's list of Resources Available .

Definitions

This section defines terms and abbreviations, including acronyms, used in these billing instructions. See the agency's [Washington Apple Health Glossary](#) 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.

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.

Ambulatory Surgery Centers

[Refer to [WAC 246-330-105](#) and [chapter 70.230 RCW](#)]

What is the purpose of this 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.

What is covered?

The agency covers the procedure codes listed in the [fee schedule](#) when the surgical services are medically necessary and not solely used for cosmetic treatment or surgery.

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

For example:

- [Dental-Related Services Medicaid Provider Guide](#)
- [Family Planning Medicaid Provider Guide](#)
- [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#)

Client Eligibility

Who is eligible?

Please see the agency [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.

Note: Refer to the [Health Care Coverage Program Benefit Packages and Scope of Service Categories](#) for a current listing of Benefit Packages.

Are clients enrolled in an agency-contracted managed care organization (MCO) eligible?

If the client is enrolled in an agency-contracted managed care organization (MCO), enrollment will be displayed on the Client Benefit Inquiry screen in ProviderOne. To prevent billing denials, please check the client's eligibility **before** scheduling services and **at the time of the service**, and make sure proper authorization or referral is obtained from the MCO.

The client's MCO 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. Providers must bill the MCO directly.

Note: See the agency's [ProviderOne Billing and Resource Guide](#) for instructions on how to verify a client's eligibility.

Authorization

What are the general guidelines for authorization?

- Authorization requirements are not a denial of service.
- When a service requires authorization, the provider **must properly request** written authorization under the agency's rules and this Medicaid provider guide.
- 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

When prior authorization is required for services performed in an ambulatory surgery center (ASC), a provider must send or fax a request for authorization along with medical justification to the agency. (See [Resources Available](#)).

Note: Please see the agency's [ProviderOne Billing and Resource Guide](#) for more information on requesting authorization.

What are the specific authorization requirements for surgical procedures?

[Refer to [WAC 182-531-1700](#)]

Surgical procedures requiring a 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 conduct medical necessity reviews. For details about the prior authorization (PA) requirements for these procedures, refer to either:

- [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#)
- [Physician-Related/Professional Services Fee Schedule](#) (Select a procedure code and refer to the comments field for the accompanying authorization submittal requirement.)

Surgical procedures requiring a 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
- 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. The agency must authorize any surgical procedures.

For more information about the requirements for submitting medical necessity reviews for authorization please refer to the agency's current [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#).

Note: To prevent billing denials, check the client's eligibility **before** scheduling services and at the **time of the service** and make sure proper authorization or referral is obtained. Providers must receive authorization from the client's primary care provider before providing services, **except for emergency services**. See the agency's [ProviderOne Billing and Resource Guide](#) 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 all the following:

- 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
- Materials and supplies for anesthesia

Payment for multiple surgical procedures

For providers performing multiple surgical procedures in a single operative session, the agency reimburses either:

- 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 either:

- 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 more than two surgical procedures.

To expedite payment of claims, bill all surgeries performed during the same operative session on the same claim. This includes secondary claims with payment by a primary commercial insurance and Medicare crossover claims.

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 (for example, intraocular lens)
- Ambulance or other transportation services
- Leg, arm, back, and neck braces
- Artificial legs, arms, and eyes
- Implantable devices

How do providers get paid for implantable devices?

To receive payment for implantable devices, providers must:

- Use one of the following HCPCS procedure codes (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 HCPCS procedure codes (C1713, C1718, L8699) only once per claim. Bill multiple units if appropriate.
- 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](#).)

How do providers get paid for corneal tissue?

Effective for claims with dates of service on and after January 1, 2016, the agency will pay for corneal tissue processing (HCPCS procedure code V2785) by acquisition cost (AC). To receive payment, providers must:

- Bill the amount paid to the eye bank for the processed eye tissue.
- Attach invoice to claim.

The agency will update the [Ambulatory Surgery Centers Fee Schedule](#) to reflect this change.

Where is the fee schedule located?

To view or download a fee schedule, see the agency's [online fee schedule](#).

The notations in the code status 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 (such as, [Dental – Related Services Medicaid Provider Guide](#), [Physician-Related Services/Healthcare Professional Services Medicaid Provider Guide](#), and [Family Planning Medicaid Provider Guide](#)).

Billing

What are the general billing requirements?

Providers must follow the Medicaid agency’s [ProviderOne Billing and Resource Guide](#). These billing requirements include:

- What time limits exist for submitting and resubmitting claims and adjustments
- When providers may bill a client
- How to bill for services provided to primary care case management (PCCM) clients
- How to bill for clients eligible for both Medicare and Medicaid
- How to handle third-party liability claims
- What standards to use for record keeping

How is the the CMS-1500 Claim form completed?

Note: Refer to the agency [ProviderOne Billing and Resource Guide](#) for general instructions on completing the CMS-1500 Claim Form.

When billing for the facilities, ensure that all procedures are billed on the claim. Please make all adjustments on the *original* claim.

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).
24D.	ASC Modifier	Enter SG
33B.	Taxonomy Code	Enter 261QA1903X

To prevent claim denials, you must submit claims with agency-designated taxonomy and the ASC modifier.