





IHS/638 Tribal Facility Billing Guide

Ambulatory Surgery Center (ASC)

DFSM Provider Training

October 11, 2022

AHCCCS

Arizona Health Care Cost Containment System

This training material is designed for IHS/638 Tribal providers only and provides general billing and claim submission guidance for services performed in an Ambulatory Surgery Center setting.

Training Objectives:

- The definition of an ASC.
- Specific ASC billing requirements, rate schedule.
- Claim Form Type
- Modifiers, SG, “50” bilateral procedures and “51” multiple surgery reductions.
- Billing other professional services and more.

Ambulatory Surgery Center

- An Ambulatory Surgical Center (ASC) is a certified, free-standing facility that operates exclusively for the purpose of furnishing outpatient surgical services that are on the approved ASC list.
- Ambulatory surgical centers can be identified as:
  - A hospital-based entity, or
- A freestanding outpatient surgical center that operates exclusively for the purpose of furnishing outpatient surgical procedures *that does not require a hospital stay*.

Medicare ASC Guidelines

- All IHS/638 Tribal ASCs must be approved by CMS.
- Medicare approves all surgical procedure codes that can be performed in an ASC setting. AHCCCS follows Medicare's guidelines.
- Surgical procedures that are *excluded* from the Medicare ASC list will not be considered.
- Inpatient designated procedure codes are not allowed to be performed at an ASC and are not payable by AHCCCS.

Ambulatory Surgery Center Provider Type 43

- Ambulatory Surgery Centers including 638 Tribal ASCs are assigned provider type 43 with AHCCCS FFS.
- A separate and distinct NPI number should be utilized for the reporting of ASC services.
- Within each provider type, mandatory and optional Categories of Service (COS) codes are identified and defined by mandatory license requirements.
- The provider must submit documentation of license and/or certification for each mandatory COS to provider assistance via APEP.

Prior Authorization Is Not Required For Services Performed in an IHS/638 Tribal Facility

- Surgical procedures performed at an IHS/638 tribal facility will not require a prior authorization but may require the submission of a consent form(*i.e., voluntary sterilization*) based on the procedure rendered.
- Note: A procedure performed at a non-IHS/638 facility including an ASC, the standard DFSM PA requirements may apply. Providers should review the current PA Requirements list for guidance.
- https://www.azahcccs.gov/PlansProviders/Downloads/MedicalCodingResources/ProcedurePARequirements4-2021.xlsx

Provider Remittance Advices

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Provider Remittance Advice Notices

When PT 43 (ASC) is billing services under a distinct NPI that is not affiliated with the hospital.	When a PT 43 (ASC) and hospital are billing using the same NPI number.
Individual remittance advice for ASC services.	All payments will be identified on the same remittance advice.
Easier posting of payments.	Easier posting of payments.
Claim denials will be identified on a separate remittance advice.	Posting of payments (combined)
Facilities have more control scheduling same day surgeries.	Claim denials for AIR and ASC services will be included on the same remittance advice.







Ambulatory Surgery Center Payment Information

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Services Included in the ASC Fee Schedule

- The ASC Capped Fee Schedule payment covers all services provided in the ASC including but not limited to:
  - Nursing and technician services,
  - Medical supplies,
  - Surgical dressings,
  - Splints & casts,
  - Blood,
  - Materials for anesthesia, and/or
  - Equipment and use of the facility.
- AHCCCS follows guidelines set forth by the CMS and standard coding rules established by the American Medical Association (AMA).

ASC Reimbursement

- The AHCCCS ASC fee schedule will assign a rate to each allowable CPT codes. This structure is similar to the Medicare ASC structure, but rates will be AHCCCS specific.

- The AHCCCS ASC fee schedule may have fees established as $0.00 for CPT codes that are allowable in the ASC setting but are included in the fees associated with the *surgical procedures.*

ASC Reimbursement (cont)

- Unlike other AHCCCS fee schedules, if the fee for the procedure is $0.00 for the claim date of service, the allowed amount should be $0.00 (zero pay).
- Providers can view the current and historical rates on the FFS Rates webpage.
- The appearance on this website of a code and rate is not an indication of coverage, nor a guarantee of payment.

- AHCCCS ASC FFS RATES AND CODES

Billing ASC Facility Charges

Billing ASC Facility Charges

Category	Billing Information
Claim Form Type	CMS 1500/837-P (EDI)
Place of Service Codes	24 (ASC)
Surgical CPT Procedure Code(s)	10000-69999
Modifier SG required) on all ASC **facility** claims only.	• The SG modifier must be entered on each line of service billed. • Use other modifiers in conjunction with the SG modifier if applicable based on national coding standards.
Reimbursement	The facility services are reimbursement based on the CPT codes billed.

Billing Guidelines ASC and Surgeon Modifier (50) Bilateral Procedure Modifier (51) Multiple Procedure

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Multiple and Bilateral Modifiers Billing Information

- The ASC and Surgeon claims must adhere to standard coding practices. This includes the use of modifiers when appropriate.
- Modifier 51 is used to identify multiple surgery and modifier 50 is used to identify bilateral surgical procedures.
- Not all claim submissions may require a modifier.
- Accurate coding is the responsibility of the biller/coder.

Billing Multiple Surgery Modifier 51

- Modifier 51 reports that a physician performed two or more surgical services during one treatment session. This billing guidance also applies to charges billed by the ASC (facility) and the surgeon.

- The first surgery code listed on the claim form should be the *principal or main* procedure and will be reimbursed at 100% of the AHCCCS capped fee schedule or billed charges, whichever is less.

- Each secondary surgery procedure code(s) must include **modifier 51** on each line of service and will be reimbursed at 50% of the AHCCCS capped fee schedule or billed charges, whichever is less.

- Claims with more than four secondary surgical procedures are subject to medical review and will require the submitter to provide a copy of the **operative report.**

Billing Bilateral Procedures Modifier 50

- Modifier 50 reports bilateral procedures performed during the same operative session by the same physician in either separate operative areas (e.g., hands, feet, legs, arms, ears) or in the same operative area (e.g., nose, eyes, breasts).
- CMS has defined certain codes as subject to the bilateral payment rule. This billing guidance also applies to charges billed by the ASC (facility) and the surgeon.
- Bilateral procedures are defined as surgical operations performed on both the right and left side of a patient's body during the same operative session requiring separate sterile fields and a separate surgical incision.

Billing Bilateral Procedures Modifier 50 (cont)

- ASC Facility - Bilateral procedures are reimbursed at 150% of the ASC rate for the facility and must be billed with the “50” modifier (if applicable).

- Surgeon – Bilateral procedures are reimbursed at 150% of the AHCCCS capped fee-for-service rate or billed charges whichever is less and must be billed with the "50" modifier (if applicable) .

- https://www.azahcccs.gov/PlansProviders/Downloads/FFSProviderManual/FFS_Chap10.pdf

Billing Professional Services Surgeon

Billing Professional Services

- Form Type - CMS 1500 / 837-P (EDI)
- The professional services are billed separately by each practitioner that has performed a AHCCCS covered service during the surgical encounter.
- All providers, including out-of-state providers, must register to be reimbursed for *covered services* provided to AHCCCS members.
- Place of Service – 24 (ASC)
- Surgical CPT procedure Code(s) range 10000 - 69999
- Modifiers *(if applicable)*
- NOTE: The ASC and the Surgeon should bill the same surgery CPT codes.
- Please note the rules applicable to multiple and bilateral procedures also apply to the professional/surgeon services.

Billing Anesthesia Services Provided In an ASC Setting

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Billing Capped FFS Rate for Anesthesia Services for Medical Procedures

- Anesthesia services must be provided by an AHCCCS registered provider type (anesthesiologist or certified registered nurse anesthetist (CRNA).
- Form Type: CMS 1500 / 837P (EDI)
- Place of Service – 24 (ASC)
- Anesthesia time begins when the provider of services physically prepares the patient for induction of anesthesia in the operating room (or equivalent) and ends when the provider of services is no longer in constant attendance.
- Anesthesia CPT procedure Code(s) range (00100 - 01999)
- Anesthesia time is reported on the claim submission in actual minutes. If units are billed this will result in an incorrect payment.
- Paper submissions, the begin and end time of the anesthesia administration must be entered on the claim form for i.e., (9:30am – 10:45am = 75 minutes).

Billing Anesthesia Services

Per 42 Code of Federal Regulations (CFR) §416.42(b) Administration of Anesthesia requires that, with certain exceptions, anesthesia be administered by:

- Qualified anesthesiologist,
- Physician qualified to administer anesthesia,
- Certified registered nurse anesthetist under the supervision of the operating surgeon, or
- Anesthesiologist assistant under supervision of a qualified anesthesiologist.

Anesthesia Modifiers

- Modifiers - One of four modifiers for anesthesia must be submitted with each service billed *(if applicable).*
- The following modifiers are to be used for ***anesthesia medical direction***:
  - **QK- Medical direction** of two, three or four concurrent anesthesia procedures
  - **QX- Anesthesia**, CRNA medically directed,
  - **QY- Medical direction** of one CRNA by anesthesiologist,
  - **AD** - Medical supervision by a physician,
  - **AA** - Anesthesia services are personally performed by an anesthesiologist.
  - Reimbursement of each provider will be at 50% (with the exception of AA which are reimbursed at 100%) of the AHCCCS capped fee schedule.

Billing Anesthesia Services Under Medical Direction

- Two separate claims must be filed for medically directed anesthesia procedures- one for the anesthesiologist and one for the CRNA.
- Medical direction can occur in several different scenarios. When billing for the anesthesia services, please refer to the following examples for appropriate modifier usage:
  - An anesthesiologist is medically directing one CRNA. The anesthesiologist should bill with the QY modifier and the CRNA should bill with the QX modifier.
  - An anesthesiologist is medically directing two, three or four CRNAs. The anesthesiologist should bill with the QK modifier and the CRNA should bill with the QX modifier.

Non-Covered Dental Services

Unlisted Procedure Code 41899

- CPT code 41899 is a by-report or unlisted procedure that may be used to identify other procedure (s) on teeth and gums.
- ASC unlisted code 41899 is for a surgeon to bill when no other surgical code matches. This is NOT a dental service code.
- Dental services performed under anesthesia are not an ASC surgery but are dental services that should be billed as a clinic visit with revenue code (0512) or, for KidsCare members billed on the ADA 2012 form.

Dental Billing Reminders

Important Dental Billing Information

Dental procedure codes (CDT) services performed under anesthesia are not an ASC surgery but are dental services.

Dental services (CDT) must be billed on the UB-04 with the revenue code 0512 (dental) and will be reimbursed at the All-Inclusive Rate (AIR).

Special billing guidelines may apply for dental services provided to KidsCare members.

Please refer to the IHS/Tribal Provider Billing Manual for current dental coding information and billing guidelines.


Division of Fee-for-Service Management (DFSM) Provider Education and Training Unit

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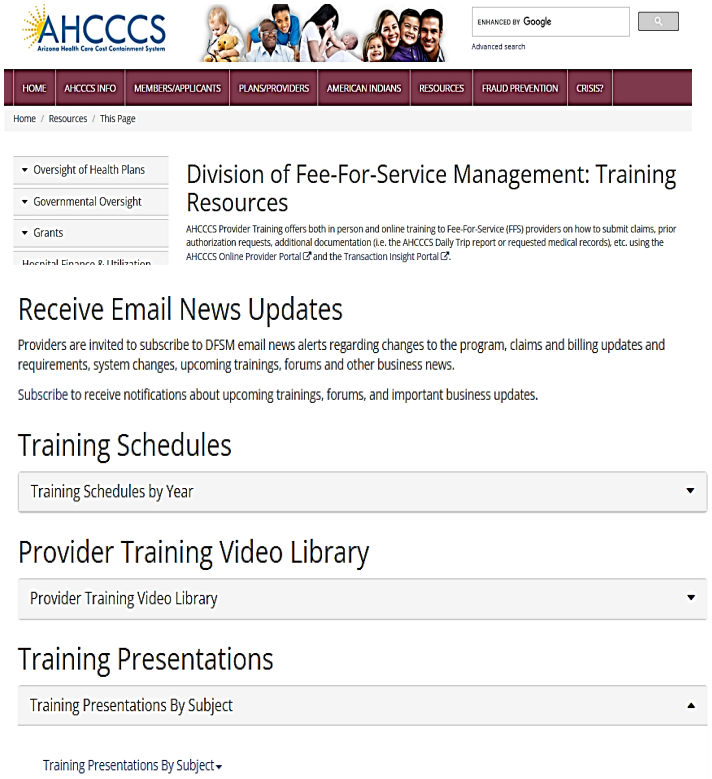
Provider Education And Training

- The DFSM Provider Training team offers training webinars and videos on many topics including how to submit and status claims and prior authorization requests, using the AHCCCS Online Provider Portal for the FFS programs including AIHP, TRBHAs and Tribal ALTCS.
- The training team also provides training on the Transaction Insight Portal application that is used to submit supporting claims documentation i.e., the AHCCCS Daily Trip report, explanations of benefits, Medical records and more.
- We also offer updates to program changes, system updates, and changes to the AHCCCS policy, guides and manuals.

Provider Education And Training Schedule

- The quarterly provider training schedules are posted to the provider training webpage. Registration is required to attend the scheduled trainings.
- To register, click the link below, select Training Schedule by Year, select the current quarter, and then select the training of your choice and complete the required information fields and submit.
- In addition to the training webinars the Provider Education team is available to assist providers with additional one-one training needs.

- https://www.azahcccs.gov/Resources/Training/DFSM_Training.html



Education And Training Questions

- **Rates** - Questions on AHCCCS FFS rates should be directed to the rates team at FFSRates@azahcccs.gov
- **Coding** - Questions on AHCCCS Coding should be directed to the coding team at CodingPolicyQuestions@azahcccs.gov
- **ACC Plan Claims** - Questions regarding the submission of claims to an AHCCCS Complete Care (ACC) Health Plan should be directed to the appropriate ACC Health Plan.
- Note: The Provider Training and the Coding teams cannot instruct providers on how to code or bill for a particular service. Providers should direct coding questions to your professional coder or biller.

- Providers can email the provider training team at: providertrainingffs@azahcccs.gov

Thank You.