





IHS/638 Tribal Facility Billing Guide

Ambulatory Surgery Center (ASC)

DFSM Provider Training

July 2023

AHCCCS

Arizona Health Care Cost Containment System

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

Training Objectives:

- ASC billing.
- ASC rates.
- Claim Form Type
- Modifiers (Surgery and Anesthesia).
- 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 Ambulatory Surgery Center 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 approved 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

- AHCCCS covered 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 performed.
- Important Note: A covered procedure performed at a non-IHS/638 facility including an ASC, the standard DFSM PA requirements may apply. Providers should review the current FFS Authorization Guidelines 05 2021

Provider Remittance Advices

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Remittance Advice Notices

The ASC is submitting services under a separate and distinct NPI number separate from the hospital (PT 02).	The 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 for the ASC.	Posting of payments (combined) for all services.
Claim payments and denials will be identified on a separate remittance advice under the ASC NPI number.	Claim payments and denials for services reimbursed at the AIR and ASC services will be included on the same remittance advice.







Ambulatory Surgery Center Payment Information

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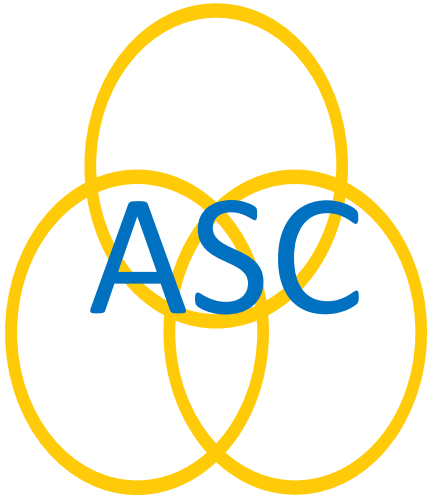
Services Included in the ASC Fee Schedule

- The ASC Capped Fee Schedule payment covers all services provided in the ASC setting 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. The AHCCCS ASC payment structure is similar to Medicare's ASC structure, but rates will be specific based on the AHCCCS FFS rate for the procedure code.

- 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 Information (cont.)

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

Billing ASC Facility Charges

Billing ASC Facility Charges

Description	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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Modifiers
Bilateral (50) and Multiple (51)

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

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.

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

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.

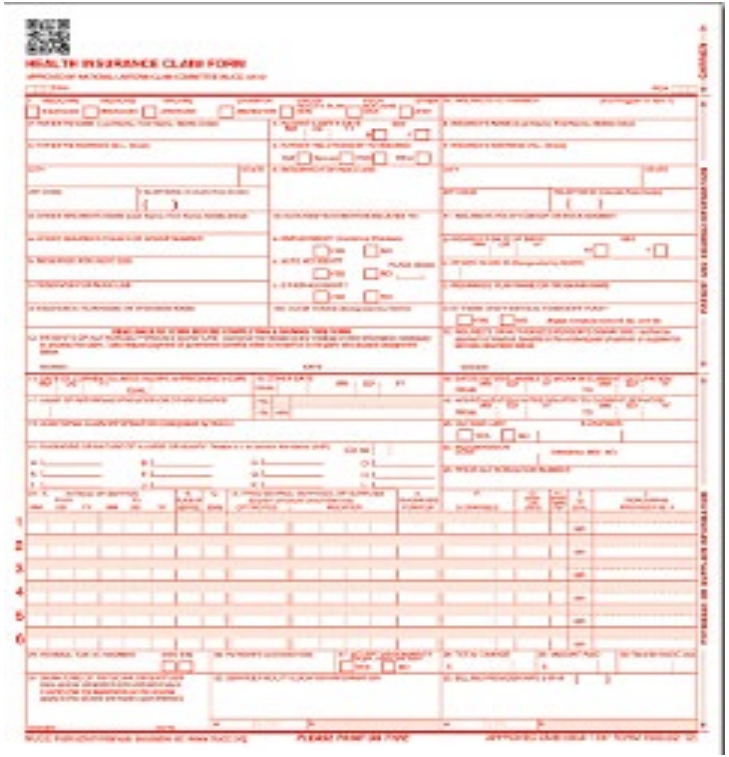
- Each secondary surgery procedure code(s) must include **modifier 51** on each line of service and will be reimbursed at 50% of the AHCCCS capped fee schedule or billed charges, whichever is less.

- 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 The Professional Services For The Surgeon

Billing Professional Services

- Form Type - CMS 1500/837P (EDI)
- Date of Service
- Place of Service – 24 (ASC)
- CPT codes (10000 – 69999)
- Billed Charges
- Units
- Modifiers *(if applicable)*



Additional Billing Information

- 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.
- The ASC and the Surgeon should bill the same surgery CPT codes.
- The rules applicable to multiple and bilateral procedures also apply to the professional/surgeon services.

Billing Anesthesia Services Provided In an ASC Setting

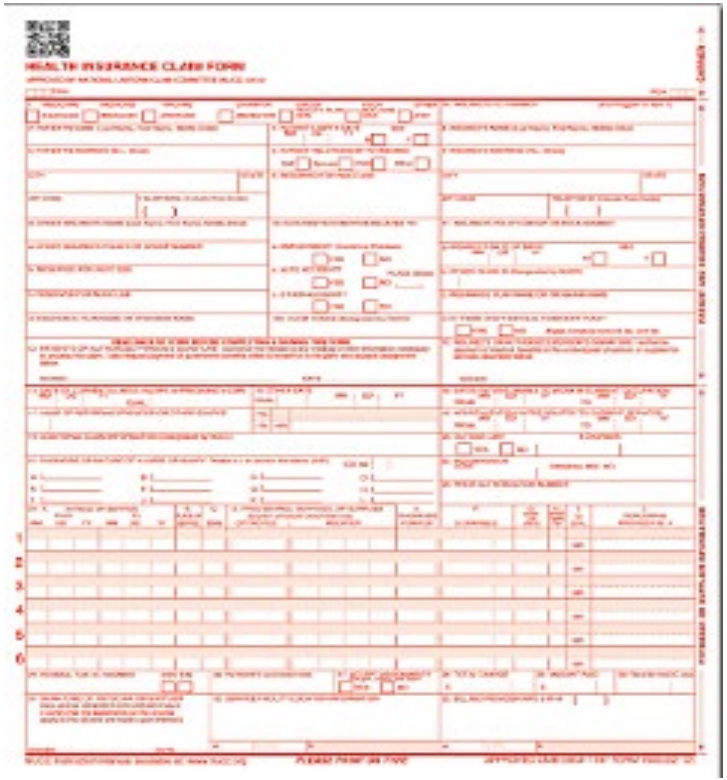
Billing Anesthesia Services

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.

Billing Capped FFS Rate for Anesthesia Services

- 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 CPT procedure Code(s) range (00100 - 01999)



Billing Anesthesia Time

- 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 time is billed in actual minutes. If units are billed this will result in an incorrect payment.
    - 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).
- Anesthesia services (except epidurals) require the continuous physical presence of the anesthesiologist or certified registered nurse anesthetist (CRNA).

Billing Anesthesia Modifiers

Modifier	Description of Use
AA	Anesthesia services performed personally by an AHCCCS registered *anesthesiologist.*
AD	Medical Supervision by a *physician.* (check if more than 4)

Reimbursement of each provider will be at 50% (the exception to this payment rule is when the anesthesia service is performed by an AHCCCS registered anesthesiologist and reported with modifier "AA". In this scenario the claim will be reimbursed at 100% of the AHCCCS capped fee schedule.

Billing Anesthesia Modifiers

Modifier	Description of Use
QK	Medical direction by a physician of two, three or four concurrent anesthesia procedures.
QX	Anesthesia service is performed by a Certified Registered Nurse Anesthetist (CRNA) with medical direction by a *physician.*
QY	Medical direction of one Certified Registered Nurse Anesthetist by an *anesthesiologist.*

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) (D0110 – D9999) services performed under anesthesia are not an ASC surgery but are dental services.

Dental services (CDT) must be billed on the UB-04 (Institutional) claim form with the revenue code 0512 (Dental). Covered dental services will be reimbursed at the All-Inclusive Rate (AIR) in effect for the date of service.

Special billing guidelines may apply for dental services provided to members enrolled in the KidsCare program. Providers should refer to the IHS/638 Tribal Provider Billing Manual, Chapter 9, Hospital and Clinic Services for current billing information.


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

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DFSM Provider Education and Training

The AHCCCS Provider Training Unit can assist providers with the following:

- AHCCCS Online Provider Portal Training:
  - How to submit and status claims and prior authorization using the AHCCCS Online Provider Portal;
- How to use the Transaction Insight Portal (for the submission of accompanying documentation);
- Provide clarification on AHCCCS policies and system updates;
- Changes to the program; and
- Other details.

For training requests please contact the DFSM Provider Training Team at **ProviderTrainingFFS@azahcccs.gov**

DFSM Provider Education and Training

Note: The provider training and medical coding teams cannot instruct providers on how to code or bill for a particular service. For example, questions regarding the use of modifiers, billing combination of codes, place of service etc., should be directed to your organization's coder/biller for guidance.

Note: Questions regarding the processing of claims by the AHCCCS Complete Care (ACC) Health Plans should be directed to the appropriate ACC Health Plan.

Who to contact?

- Questions on AHCCCS Fee-for-Service rates email **FFSRates@azahcccs.gov**
- Questions on AHCCCS Coding email: **CodingPolicyQuestions@azahcccs.gov**

Need Help!

If you need assistance with the following:

Questions about warrants, paper EOBs, or EFTs please contact the Division of Business & Finance (DBF) at ahcccswarrantinquiries@azahcccs.gov or call **(602) 417-5500. Hours: 10:00 AM – 4:00 PM Arizona Time.**

To check the status of your EFT, please email the Division of Business & Finance (DBF) at ahcccsfinanceeft@azahcccs.gov

Questions related to electronic transactions or to request an ERA transaction setup email servicedesk@azahcccs.gov or contact **(602) 417-4451. Hours: 7:00 AM – 5:00 PM Arizona Time.**

Providers should use the AHCCCS Online website as the first step in checking the status of the prior authorizations and claims. Our Provider Services representatives are skilled to provide help to many *basic* prior authorization and claims questions. To reach **Provider Services call (602) 417-7670.**

Provider Services Call Center Operation Hours: **Monday-Friday from 7:30 A.M. - 5:00 P.M.**

Providers should not call the Provider Services if they have questions on rates, CPT/HCPCS codes and modifiers, billing questions, the address a check was mailed to, and payment details for approved claims. Providers should refer to the AHCCCS Website Plans/Providers for more information.

Thank You.