IHS/638 Tribal Facility Billing Guide
Ambulatory Surgery Center (ASC)

DFSM Provider Training
January 19, 2024

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:

- Definition of Ambulatory Surgical Center
- AHCCCS Remittance Advice
- ASC Payment Information
- Billing ASC Facility Charges
- Billing Guidelines for Modifier 50 and 51
- Additional Billing Information
- Billing Anesthesia Services and Modifiers
- ASC billing
- ASC rates
- Billing dental services

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 procedure*s that does not require a hospital stay*.

Medicare Ambulatory Surgery Center Guidelines

- All IHS/638 Tribal ASCs must be approved by the Center for Medicare Services (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 by AHCCCS Fee-For-Service.
- Inpatient designated procedure codes are not allowed to be performed at an ASC and are not payable by AHCCCS FFS.

Ambulatory Surgery Center Provider Type 43

- Ambulatory Surgery Centers including IHS/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 Services via the AHCCCS Provider Enrollment Portal (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.
- Some procedures performed in a ASC setting may require the submission of a consent form(*i.e., voluntary sterilization*) based on the procedure performed.
- Providers should review the current Ambulatory Surgical Center (ASC) FFS Rates & Codes
- Important Note: A covered procedure performed at a non-IHS/638 facility including an ASC, the standard DFSM PA requirements may apply.
- Fee-For-Service Authorization Guidelines

Provider Remittance Advices

AHCCCS
Arizona Health Care Cost Containment System

Remittance Advice Notices

The ASC has a separate and distinct NPI number from the facility/hospital.	The ASC and facility/hospital are billing using the same facility NPI number.
Individual remittance advice for ASC services only will be issued.	All payments will be identified on the same remittance advice for inpatient, outpatient and ASC services.
Easier posting of payments for the ASC services.	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 all services reimbursed at the AIR and ASC rates will be included on the same remittance advice.




Ambulatory Surgery Center Payment Information

Services Included in the ASC Fee Schedule

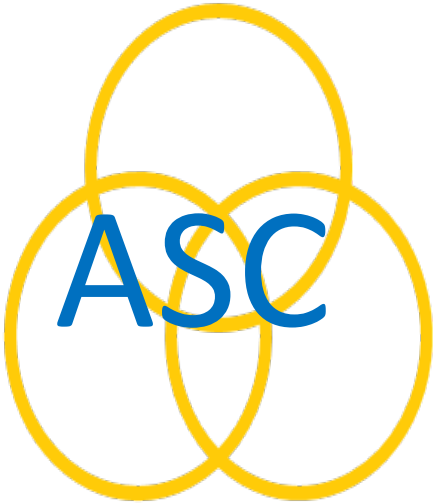
- The ASC Capped Fee Schedule payment covers all services provided in the ASC setting including but not limited to:
  - Nursing and technician services,
  - Medical supplies,
  - Surgical dressings,
  - Splints & casts,
  - Blood,
  - Materials for anesthesia, and/or
  - Equipment and use of the facility.

- 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

AHCCCS
Arizona Health Care Cost Containment System

Billing Modifiers

Bilateral (50)
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 (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) .

Billing Example:

- On line number 1 enter the bilateral procedure code with modifier 50, an addition,
- Calculate 1.5 amount in the charge field and enter 1 in the unit field.

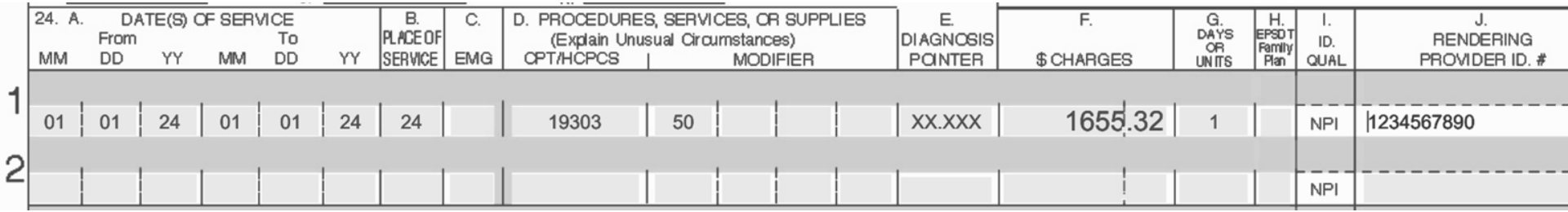
- Fee-For-Service Chapter 10 Individual Practitioner Services

Bilateral Procedures Modifier 50

- CMS has defined certain CPT 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 the body during the same operative session.
- Per AMA coding guidelines, Modifier 50 can be reported for bilateral procedures performed during the same operative session by the same physician in either the same or separate operative areas.

Example: How to Submit a Claim for a Bilateral Procedure

- In this example, the bilateral CPT code is 19303.
- Modifier 50 must be included to identify a bilateral procedure.
- The next step will be to determine the correct charge amount to bill based upon if you are an IHS or 638 provider type.
- Multiply the rate in effect on the date of service by 150% to get the total charge amount.
- In the units field, enter 1.



	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	01	01	24	01	01	24	24		19303	50				XX.XXX	1655.32	1		NPI	1234567890
2																		NPI	

Multiple Surgery
Modifier 51

AHCCCS
Arizona Health Care Cost Containment System

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.**

Example: How to Submit a Multiple Surgery Claim

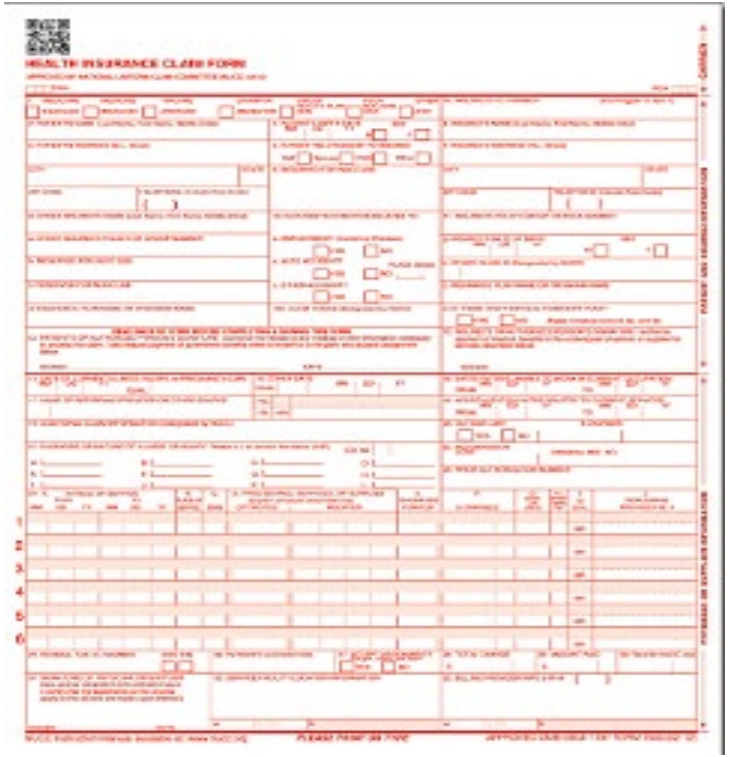
- In this example, three surgical procedures were performed.
- Providers should bill the procedure with the highest allowance as the primary procedure.
- Modifier 51 must be entered on all secondary lines of service.
- Reimbursement for each additional procedure is based on 50% of the AHCCCS allowed amount.
- In the units field, enter the correct number of unit(s) for the procedure.

	24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER				E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	01	01	24	01	01	24	24		45385						1100.00	1		NPI	1234567890
2	01	01	24	01	01	24	24		45380	51					750.00	1		NPI	1234567890
3	01	01	24	01	01	24	24		45378	51					450.00	1		NPI	1234567890
4																		NPI	

Additional Billing Information

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.

Medical Supervision - Medical Direction

Medical Direction

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,

Reimbursement: Each provider will be reimbursed at 50% of the AHCCCS capped fee schedule

Medical Supervision

The following modifier is used for anesthesia medical supervision when more than four concurrent anesthesia procedures:

AD - Medical supervision.

Reimbursement: Each provider will be reimbursed at 50% of the AHCCCS capped fee schedule.

Billing Anesthesia Service Times

- **Start Time:** When the anesthesia practitioner begins to physically prepare the patient for anesthesia services in the operating room or an equivalent area.
- **End Time:** When the anesthesia practitioner transfers care in the PACU to a qualified professional
- **Minutes not Units:** 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 i.e., (9:30am – 10:45am = 75 minutes).
- **Physical Presence:** Anesthesia services (except epidurals) require the continuous physical presence of the anesthesiologist or certified registered nurse anesthetist (CRNA).

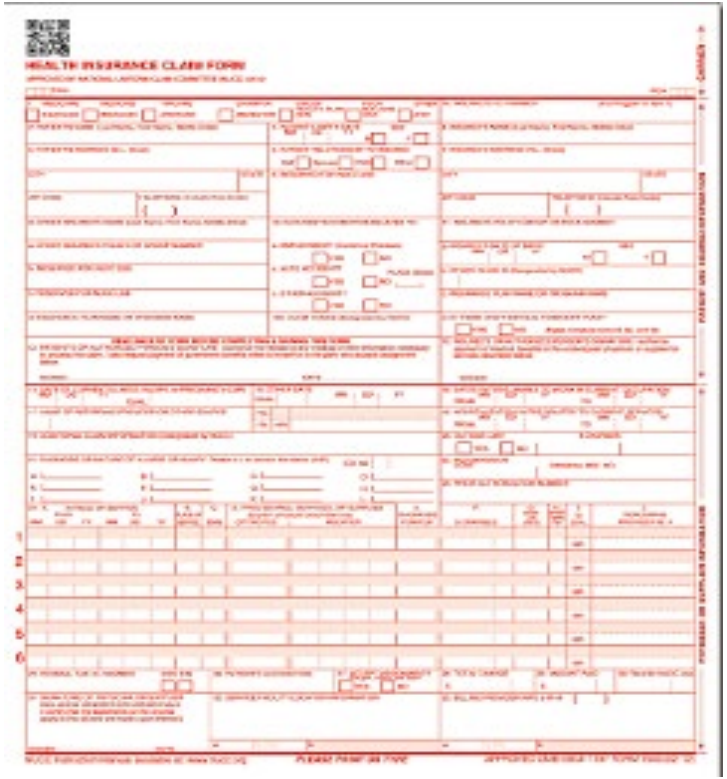
Billing Anesthesia Modifiers

- When a registered anesthesiologist is providing supervision or medical direction, both practitioners will be reimbursed at 50% of the AHCCCS allowed amount *(appropriate modifiers must be included on the claim form).*
- If the anesthesia services is performed personally by the registered anesthesiologist, the claim should be billed with modifier 'AA' and services will be reimbursed at 100% of the allowed amount.

Modifier	Description of Use
AA	Anesthesia services performed personally by an AHCCCS registered *anesthesiologist.*
AD	Medical Supervision by a *physician.*

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)



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. Refer to the following examples for appropriate modifier usage:

1. An anesthesiologist is medically directing one CRNA.

The anesthesiologist should bill with the QY modifier and the CRNA should bill with the QX modifier.

1. 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.

Dental Billing Reminders
Unlisted Procedure Code 41899

AHCCCS
Arizona Health Care Cost Containment System

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 American Dental Association (ADA) 2024 form.

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

AHCCCS
Arizona Health Care Cost Containment System

DFSM Provider Education and Training

The Provider training team conducts training webinars and E-learning presentations for Fee-for-Service (FFS) providers who service FFS members. Provider trainings are held weekly via Zoom.

AHCCCS offers free web-based applications for claims and prior authorization submissions through the AHCCCS Online Provider Portal and accompanying claim documentation using the 275 Foresight Transaction Insight Portal.

Additional training opportunities include NEMT, behavioral health services, Voids and Replacements, behavioral health, Claim Disputes, member verification, AHCCCS policies, systems and benefit changes, updates and more.

Fee-For-Service Provider Training Requests

FFS Providers can submit training requests to **ProviderTrainingFFS@azahcccs.gov**.

Your training request must include:

- Business email address,
- Full name and position title,
- AHCCCS Provider NPI or 6-digit provider ID number,
- Telephone number,
- Number of attendees,
- The specific type of training and include any questions you may have.

DFSM Training Contacts & Resources

For provider training requests email:

- ProviderTrainingFFS@azahcccs.gov

Provider Training Web Page:

- Division of Fee-For-Service-Management: Training Resources

AHCCCS Claims Clues:

- AHCCCS Claims Clues

Sign Up for the AHCCCS DFSM Email Alerts:

- DFSM Email Alerts Sign Up

Provider Services Contact Information

- For basic claims and prior authorization questions providers can contact the Provider Services Call Center Monday through Friday, 7:30 a.m. to 5:00 p.m. Phone: **(602) 417-7670**
- Our Provider Services representatives are skilled to provide help to many basic prior authorization and claims questions.
- Providers should use the AHCCCS Online Provider Portal as the first step in checking the status of your claims and prior authorizations. Questions that cannot be answered via the portal please contact provider services for assistance.
- Provider Services cannot assist providers with questions regarding Fee-for-Service (FFS) 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.

Division of Business and Finance (DBF)

The Division of Business and Finance (DBF) can assist providers with questions about warrants, paper Explanation of Benefits (EOB) and Electronic Funds Transfer (EFT).

Providers can email (DBF) at ahcccswarrantinquiries@azahcccs.gov or call (602) 417-5500.
Hours: 10:00 AM – 4:00 PM Arizona Time.

Electronic Transactions and 835/Electronic Remittance Advice (ERA)
Questions related to electronic transactions or to request an 835/ERA transaction setup email servicedesk@azahcccs.gov or contact (602) 417-4451.
Hours: 7:00 AM – 5:00 PM Arizona Time.

Thank You.