



North Dakota Workforce
Safety & Insurance

Payment Policy
Ambulatory Surgical Center
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The five character codes included in the North Dakota Fee Schedule are obtained from the Current Procedural Terminology (CPT®), copyright 2014 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physicians.

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Disclaimer Language

The fact that a procedure or service is assigned a HCPCS code and a payment rate does not imply coverage by WSI, but indicates only how the procedure or service may be paid if covered by the program. The existence of a procedure code on this list is not a guarantee that the code is covered.

For reference purposes, the sections of the North Dakota Administrative Code that regulate medical services are **92-01-02-27 through 92-01-02-46**. The NDAC can be viewed at the North Dakota Legislative Council web site: <http://www.state.nd.us/lr/information/acdata/html/92-01.html>

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ASC Payment Methodology

Workforce Safety & Insurance shall reimburse Ambulatory Surgical Center (ASC) services using the ASC Fee Schedule in conjunction with the ASC payment status indicators and the ASC payment parameters.

WSI will update the Ambulatory Surgical Center Fee Schedule conversion factor each year based on the hospital Market Basket increase published by CMS in the Outpatient Prospective Payment System final rule. Appropriate adjustments will be made for the APC weight changes (if necessary).

ASC Fee Schedule

The payment amounts on the WSI ASC Fee Schedule are based on the following:

- Payment for most ASC services is made based on the formula:

WSI Conversion Factor X ASC HCPCS Weight

- CPT or HCPCS codes with a payment indicator of J8 (ASC device intensive procedures) will be paid by splitting the total Medicare ASC payment into a procedure portion and a device portion using the published device offset percentage. The procedure portion will be paid by dividing the procedure portion by the Medicare ASC conversion factor times the WSI ASC conversion factor. The device portion will be paid by taking the device portion times 1.2.
- The payment will be the “lesser of” the amount indicated on the WSI ASC fee schedule or the billed amount.
- The ASC conversion factor will be updated each year based on the prior year’s conversion factor times the hospital Market Basket increase published by CMS in the OPPI/ASC final rule. Appropriate adjustments will be made for ASC HCPCS weight changes (if necessary). Conversion factor:
 - 2013 \$95.10
 - 2014 \$97.48
 - 2015 \$100.31
- The HCPCS weight is the Medicare weight as indicated in the listings of HCPCS codes in the final Ambulatory Surgery Center rule published in the Federal Register each year (commonly known as Addendums AA and BB).
 - Except as noted below, where Addendums AA or BB contain a HCPCS code with a payment amount but no weight, the weight is computed by taking the Medicare payment amount divided by the Medicare conversion factor.

- HCPCS codes with a payment status indicator of H2, K2 or K7 will be paid at the same rate as the Outpatient Hospital Fee Schedule.
- HCPCS codes with a payment status indicator of F4, J7 or L6 will be paid based on invoice cost plus 20%.
- WSI has adopted Medicare's packaging policies relating to ASC services.

With the following exceptions, the only services considered for payment under the WSI ASC fee schedule are those with a valid HCPCS code that have been identified by Medicare as payable in an ASC setting. These HCPCS codes are identified in Addendums AA and BB of the final OPSS rule. The exception to this is:

- HCPCS codes in Addendum EE with an Outpatient Hospital Fee Schedule payment status indicator other than C will be paid based on the Outpatient Hospital weights times the ASC conversion factor.

The WSI ASC Fee Schedule contains all HCPCS codes (Level I and Level II codes), their respective payment status indicators, descriptions, weights, and payment amounts.

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ASC Fee Schedule Payment Parameters

The following payment parameters more fully define the ASC payment system and provide detail as to how the amounts on the WSI ASC fee schedule are applied during the claims adjudication processes.

- **Effective Date** – The WSI ASC fee schedule was implemented in January 2004.
- **Annual/Quarterly Updates** – The ASC fee schedule will be updated in January of each year and will be effective for the calendar year. However, any delay by Medicare in publishing the hospital Market Basket increase, in updating its–weights, or both, will cause a corresponding delay in the update of the WSI conversion factor and weights. Quarterly updates for HCPCS codes and weights provided by Medicare will be incorporated into the WSI ASC fee schedule.
- **“Lesser Of” Payments** – Services will be paid at the “lesser of” the amount indicated on the WSI ASC fee schedule or the billed amount.
- **Packaged Procedures** – There are several HCPCS codes on the ASC fee schedule with a payment status indicator of “N1”. These are packaged services and will not receive separate payment.
- **Non-Packaged Services** – WSI will allow separate payment, in addition to the payment for the procedure, for certain ancillary services, high cost devices, drugs and biologicals when the costs of these items have not been packaged into the payment for the procedure. WSI will only allow separate payment for these items **if provided in conjunction with, and on the same day as, a covered ASC procedure**. These items can not be furnished as stand alone items and be paid to an ASC.
- **Multiple Procedure Discounting** – WSI has incorporated the same ASC multiple procedure discounting methodology as those enforced by Medicare.
- **Bilateral & Discontinued Procedure Discounting** – WSI has incorporated the same payment adjustments for bilateral procedures and discontinued procedures as the Medicare ASC fee schedule.
- **New Codes with no Payment** – New codes that have not been assigned a payment amount by Medicare (either through the ASC payment system or through the Medicare Part B fee schedules) will be paid at 85% of billed charges.
- **CCI Edits** – WSI will use the same set of CCI edits as the Medicare ASC fee schedule.
- **Modifier Usage** – WSI will not require the use of all of the modifiers required by the Medicare ASC fee schedule. Those modifiers required by WSI on ASC claims include: 50, 51, 53, 59, 73, 74, 76, 77, 78, 79, FB, FC & SG.

- **Provider-Based ASCs** – WSI will recognize an ASC as provider-based if the hospital is billing Medicare for the ASC services as provider-based. WSI may request documentation to support provider-based status.
- **Device Offsets** – WSI will incorporate Medicare’s device offset methodology for those instances where replacement devices are provided at either no cost by the manufacturer or where the ASC received a credit of 50 percent or more of the estimated cost of the new replacement device. WSI will use the offset percentages published by Medicare when determining the appropriate payment offset amounts for those procedures involving replacement devices.

ASCs must bill using modifiers FB or FC when a device is replaced at either no cost or at an amount that is 50 percent or more of the cost of the replacement device. The appropriate modifier should be attached to the procedure code and not to the device HCPCS code.

WSI will incorporate Medicare’s pass-through device offset methodology. WSI will use the offset percentages published by Medicare when determining the appropriate amounts for those procedures involving pass-through devices.

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ASC Multiple Procedure and Bilateral Procedure Discounting

Multiple Procedures

For HCPCS codes with a “Y” in the “Multiple Procedure Discounting” field. If the code is the highest weighted code use:

$$\text{Fee Schedule Amount X Units X } ((1 + .5 (\text{units}-1))/ \text{units})$$

If the code is **not** the highest weighted code use:

$$\text{Fee Schedule Amount X Units X.5}$$

For HCPCS codes with an “N” in the “Multiple Procedure Discounting” field, there is no discounting.

Any HCPCS codes with a “Multiple Procedure Discounting” field indicator of “Y” and a modifier of 76, 77, 78, or 79 is **not** subject to multiple procedure discounting and should be paid at the fee scheduled amount. These modifiers represent a return to the OR or treatment area and indicate the procedure was not done during the same operative session.

Bilateral Procedures

If modifier 50 is attached to a procedure code and the procedure code is the highest weighted code use:

$$\text{Fee Schedule Amount X Units X } ((1+.5)/\text{units})$$

If modifier 50 is attached to a procedure code and the procedure code is **not** the highest weighted code use:

$$\text{Fee Schedule Amount X Units X.5 } ((1+.5)/\text{units})$$

With these formulas it won't matter whether a bilateral procedure is billed on one line with a unit of one or on one line with units of two. However, the formulas won't work if a bilateral procedure is billed on two lines. Therefore, it is required that providers bill bilateral procedures on one line with a modifier of 50 and either one or two units.

Discontinued Procedure Modifiers

If modifier 73 is attached to a procedure code and the procedure code is the highest weighted code use:

$$\text{Fee Schedule Amount X Units X } (.5/\text{units})$$

If modifier 73 is attached to a procedure code and the procedure code is **not** the highest weighted code use:

$$\text{Fee Schedule Amount X Units X } .5(.5/\text{units})$$

If either modifier 74 or 52 is attached to a procedure code, the charge will pay as if no modifier were present (i.e., with normal multiple procedure discounting).

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ASC Billing Requirements

The major WSI billing requirements for ASC services are as follows:

- All free standing ASCs and non provider-based hospital operated ASCs will be required to bill for their services on a CMS 1500 claim form. Modifier SG should be attached to all of the line(s) for the facility fees.
- Surgical HCPCS codes must be billed with units that equal the number of times the procedure was performed as indicated by the code's description.
- The charges for packaged items (those HCPCS codes with a status of "N1") should be included in the charge for the procedure itself.
- When multiple procedures are performed, they should appear on separate lines on the claim, each with SG and 51 modifiers, the appropriate number of units and an appropriate charge. The NCCI edits apply in these situations.
- When a procedure is performed bilaterally, the appropriate HCPCS code should be reported on one line with the bilateral modifier (50) attached (in addition to the SG modifier).
- When an operative session is terminated either prior to or subsequent of the administration of anesthesia (modifiers 73 or 74), only the planned procedure(s) may be reported on the claim. Any claim with a 73 or 74 modifier that contains more than 1 procedure code will be reviewed. WSI may request records to substantiate multiple planned procedures.

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Payment Status Indicators for the ASC Fee Schedule

Indicator	Service	Status
A2, G2, P2 & R2	Surgical procedure on the ASC list	Priced by: Medicare Assigned ASC Weight X WSI ASC Conversion Factor. Paid at the lesser of the billed charge or the fee schedule amount.
D5	Discontinued Codes	Deleted Effective Beginning of Calendar Year.
F4	Corneal tissue acquisition; hepatitis B vaccine	Paid at reasonable cost plus 20% based on submitted invoice when provided in conjunction with a covered ASC procedure.
H2	Brachytherapy sources	Paid at the same rate as the Outpatient Hospital Fee Schedule when provided in conjunction with a covered ASC procedure. Paid at the lesser of the billed charge or the fee schedule amount.
J7	Pass through device	Paid at reasonable cost plus 20% based on submitted invoice when provided in conjunction with a covered ASC procedure.
J8	Device intensive procedure; paid at adjusted rate	Priced by: Procedure portion priced based on ASC Procedure weight percentage X WSI ASC Conversion Factor; Device portion priced based on device percentage of Medicare ASC payment X 1.2. Paid at the lesser of the billed charge or the fee schedule amount.
K2	Non pass-through drugs and biologicals	Paid at the same rate as the Outpatient Hospital Fee Schedule when provided in conjunction with a covered ASC procedure. Paid at the lesser of the billed charge or the fee schedule amount.
K7	Unclassified drugs	Paid at the same rate as the Outpatient Hospital Fee Schedule when provided in conjunction with a covered ASC procedure. Paid at the lesser of the billed charge or the fee schedule amount.
L1	Influenza vaccine; pneumococcal vaccine	Not Separately Payable. Packaged Into Payment for Other Services.
L6	New Technology Intraocular Lens	Paid at reasonable cost plus 20% based on submitted invoice when provided in conjunction with a covered ASC procedure.
N1	Packaged service or item	Not Separately Payable. Packaged Into Payment for Other Services.
P3	Office Based surgical procedure	Priced by: Medicare National Amount / Medicare ASC Conversion Factor X WSI ASC Conversion Factor. Paid at the lesser of the billed charge or the fee schedule amount.
Z2	Radiology services – ASC weights	Priced by: Medicare Assigned ASC Weight X WSI ASC Conversion Factor. Paid at the lesser of the billed charge or the fee schedule amount.
Z3	Radiology services – MPFS based	Priced by: Medicare National Amount / Medicare ASC Conversion Factor X WSI ASC Conversion Factor. Paid at the lesser of the billed charge or the fee schedule amount.

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Provider Remittance Advice

WSI processes medical service billings weekly. A remittance advice is sent to the provider with the reimbursement check, providing information to the provider about the service, including the patient's name, date of service, procedure billed, submitted amount, and paid amount. The remittance advice also includes reason codes or explanation of benefits (EOB) codes, to explain any reductions in payment of a service or denial of payment.

Some EOB codes allow the patient to be billed for the denied charges, or for the balance of reduced charges. These instances are identified by the statement "CONTACT CLAIMANT FOR PAYMENT". When these EOB codes occur, WSI also sends a "NOTICE OF NON-PAYMENT" EOB to the patient regarding the reduced or denied charges, to inform the patient of their responsibility for the charges.

If an EOB code does not state the patient may be contacted for payment, any reduction or denial of services is not billable to the patient, the employer, or another insurer.

Copies of remittance advices can be obtained by calling 1-800-777-5033. You can access the list of our EOB codes on our website in the library section.