Fee Schedule Guidelines

Ambulatory Surgery Center

For use with the following code ranges: 10021-19499, 20005-29999, 30000-39402, 40490-49999, 50020-59899, 60000-69990, 70010-79999,90371-95941, 0042T-0468T, A4216-A9700, C1713-C9800, G0130-G0458, J0120-J9999, P9041-P9047, Q0138-Q9983, V2630-V2790

WSI
North Dakota Workforce Safety & Insurance
Revised 7/2017

Notice

The five character numeric codes included in the North Dakota Fee Schedule are obtained from 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. The five character alphanumeric codes included in the North Dakota Fee Schedule are obtained from HCPCS Level II, copyright 2014 by Optum360, LLC. HCPCS Level II codes are maintained jointly by The Centers for Medicare and Medicaid Services (CMS), the Blue Cross and Blue Shield Association (BCBSA), and the Health Insurance Association of America (HIAA).

The responsibility for the content of the North Dakota Fee Schedule is with WSI and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in North Dakota Fee Schedules. Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, and are not part of CPT, and the AMA does not recommend their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of North Dakota Fee Schedule should refer to the most current Current Procedural Terminology, which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply. CPT is a registered trademark of the American Medical Association.

The WSI Fee Schedule is not a guarantee of payment. The fact that WSI assigns a procedure or service a HCPCS code and a payment rate does not imply coverage by WSI, but indicates the maximum allowable payment for approved services. Services represented are subject to provisions of WSI including: compensability, claim payment logic, applicable medical policy, benefit limitations and exclusions, bundling logic, and licensing scope of practice limitations.

Any changes made to Pricing Methodology are subject to the North Dakota Public Hearing process. WSI reserves the right to implement changes to the Payment Parameters, Billing Requirements, and Reimbursement Procedures as needed. WSI incorporates all applicable changes into the relevant Fee Schedule Guideline at the time of implementation, and communicates these changes in Medical Providers News, available on the WSI website at www.workforcesafety.com/news/medical-providers. WSI reviews and updates all Fee Schedule rates on an annual basis, with additional updates made on a quarterly basis when applicable.

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

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Ambulatory Surgery Center Pricing Methodology

Ambulatory Surgery Center (ASC) Pricing Methodology outlines the methods used by Workforce Safety & Insurance (WSI) to determine the final rates represented on the ASC Fee Schedule. The ASC Fee Schedule uses the procedure codes and descriptions as defined by the Healthcare Common Procedure Coding System (HCPCS), their respective payment status indicators, and payment amounts. In accordance with North Dakota Administrative Code 92-01-02-29.2, any provider who renders treatment to a claimant under the jurisdiction of WSI is reimbursed according to the rates assigned in the WSI Fee Schedule. Providers may access the complete ASC Fee Schedule and other resources referenced within this document by visiting the Medical Provider section of the WSI website: www.workforcesafety.com.

Status Indicators

WSI assigns one of the following payment status indicators to each HCPCS code within the ASC Fee Schedule:

Indicator	Description	Pricing Methodology
A2	Surgical procedure on the ASC list	Service is payable under the ASC Fee Schedule
D5	Discontinued odes	Service is not payable. Code was discontinued effective beginning of the calendar year.
J7	Corneal tissue acquisition, New Technology Intraocular Lens, and Pass Through Devices provided in an ASC setting	Service is payable at 120% of the invoice cost when provided in conjunction with a covered ASC procedure.
J8	Device intensive procedure; paid at adjusted rate	Procedure portion of the service is payable under the ASC Fee Schedule. Device portion of the service is payable at 120% of the invoice cost.
K2	Brachytherapy Sources, Unclassified Drugs, Non pass-through drugs and biologicals provided in an ASC setting	Service is payable per the Outpatient Hospital Fee Schedule when provided in conjunction with a covered ASC procedure.
N1	Packaged code	Service is not separately payable. Payment is packaged into the payment for another service.
P3	Office Based Surgical Procedures and MPFS based Radiology Services	Service is payable under the ASC Fee Schedule.

Calculation of the Reimbursement Rate

- For HCPCS codes assigned a WSI payment status indicator of “A2” or “P3”, WSI applies the following formula to determine the maximum allowable reimbursement rate:

ASC HCPCS Weight	X	WSI Conversion Factor	=	Reimbursement Rate

For 2017, the Conversion Factor is $105.49.

The ASC HCPCS Weight is the weight assigned by Medicare 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). 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.

- For HCPCS codes assigned a payment status indicator of “J8” (ASC device intensive procedures) pricing is determined by splitting the total Medicare ASC payment into a procedure portion and a device portion using the published device offset percentage. WSI prices the procedure portion by dividing the procedure portion by the Medicare ASC Conversion Factor multiplied by the WSI ASC Conversion Factor. WSI prices the device portion based on the device portion plus 20%.

- For HCPCS codes identified in Medicare’s Addendum EE as non-payable in the ASC setting, which WSI deems payable in the ASC setting, pricing is determined by multiplying the weight identified in the Outpatient Hospital Fee Schedule by the ASC Conversion Factor.

Annual Updates
WSI updates the ASC Fee Schedule annually based on the weights published by The Centers for Medicare and Medicaid Services (CMS) in Addendums AA and BB. WSI updates the Conversion Factor each year based on the Hospital Market Basket increase published by CMS in the Outpatient Prospective Payment System final rule**.** Annual updates are effective for that calendar year. Any delay by CMS 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. WSI will incorporate quarterly updates for HCPCS codes and weights provided by Medicare into the ASC Fee Schedule.

Limitations of the Ambulatory Surgery Center Fee Schedule
The payment rates listed on the ASC Fee Schedule indicate the maximum allowable payment for approved services only. The fact that a procedure or service is assigned a HCPCS code and a payment rate does not imply coverage by WSI, but indicates the maximum allowable payment for approved services. The final payment rate may be impacted by the payment parameters and billing requirements enforced by WSI. Providers are encouraged to carefully review WSI’s Payment Parameters, Billing Requirements, and Reimbursement Procedures to avoid unneccesary delays and denials of payment.

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Ambulatory Surgery Center Payment Parameters

ASC Payment Parameters outlines the rules for payment adopted by WSI. While WSI has adopted many of Medicare's rules for payment, WSI has developed a set of unique rules that are applied to the final payment of approved services. The complete payment parameters enforced by WSI are as follows:

Authorization- Most ASC services require prior authorization. Providers should refer to the Utilization Review Guide for information on which services require authorization and the steps required to obtain authorization.

Bilateral Discounting (50)- If the procedure code is the highest weighted code, WSI prices it at 150% of the ASC Fee Schedule rate. If the procedure code is not the highest weighted code, WSI prices it at 75% of the ASC Fee Schedule rate.

Device Offsets- WSI incorporates Medicare's device offset methodology for those instances where the manufacturer provides replacement devices at either no cost or where the ASC received a credit of 50 percent or more of the estimated cost of the new replacement device. WSI uses the offset percentages published by Medicare when determining the appropriate payment offset amounts for those procedures involving replacement devices.

Discontinued Procedure Discounting (73, 74, 52)- For services billed with modifier 73, if the procedure code is the highest weighted code, WSI prices it at 50% of the ASC Fee Schedule rate. If the procedure code is not the highest weighted code, WSI prices it at 25% of the ASC Fee Schedule rate.

WSI prices procedures billed with modifiers 74 and 52 as if no modifier were present (i.e., with normal multiple procedure discounting).

"Lesser of" Payments- The rates presented on the ASC Fee Schedule represent the maximum WSI pays for the services provided; WSI pays the "lesser of" the billed charge or the Fee Schedule amount.

Multiple Procedure Discounting- WSI applies multiple procedure discounting to codes identified with a "2" in the "Multiple Procedure Discounting" field of the ASC Fee Schedule. If the procedure code is the highest weighted code, WSI prices it at 100% of the ASC Fee Schedule rate. If the procedure code is not the highest weighted code, WSI prices it at 50% of the ASC Fee Schedule rate.

WSI does not apply multiple procedure discounting to those procedures appended with the 76, 77, 78, or 79 modifiers.

NCCI Edits- WSI incorporates all applicable NCCI edits.

New Codes with no Payment- WSI pays for new codes that Medicare has not yet assigned a payment for (either through the ASC payment system or through the Medicare Part B Fee Schedules) at 85% of billed charges.

Non-Packaged Procedures- WSI allows separate payment for certain ancillary services, drugs, and biologicals, which WSI identifies with a status indicator “J7”. WSI only allows separate payment for these items when provided in conjunction with, and on the same day as, a covered ASC procedure. ASC providers cannot furnish these items as stand-alone items and receive payment.

Packaged Procedures- WSI incorporates Medicare’s packaging policies relating to ASC services. There are several HPCPS codes on the ASC Fee Schedule with a status indicator of “N1”. These are packaged services and a provider will not receive separate payment for them.

Pass-Through Devices- WSI incorporates Medicare’s pass-through device offset methodology. WSI uses the offset percentages published by Medicare when determining the appropriate amounts for those procedures involving pass-through devices.

Provider-Based ASCs- WSI recognizes 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.

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Ambulatory Surgery Center Billing Requirements

ASC Billing Requirements outlines the rules for billing adopted by WSI. WSI returns or denies inappropriately submitted bills. WSI notifies providers of inappropriately submitted bills via a return letter or remittance advice. Providers must correct any returned bills prior to resubmission.

Bilateral Procedures (50)- Providers must bill bilateral procedures with the appropriate HCPCS code on one line with the bilateral modifier (50) attached (in addition to the SG modifier).

Bill Forms- Providers may submit medical bills for ASC services in the following formats:

- CMS 1500 form with the SG modifier appended to each CPT code
- UB-04 form with the 831 type of bill with appropriate revenue and CPT code(s)

Bill Form Submission- WSI offers the following options for bill submission:

Electronic Billing- A provider may submit medical charges via EDI through one of WSI's clearinghouses:

- **iHCFA:** This option allows a provider to submit professional (CMS-1500/837p) charges along with supporting medical documentation. Contact iHCFA EDI Support Services at 973-795-1641 (option 2) for additional information.
- **Noridian:** This option allows a provider to submit professional (CMS-1500/837p) and institutional (UB-04/837i) charges without medical documentation attachment through Noridian. A provider must mail all supporting medical documentation to WSI at the address provided below or fax it to 701-328-3793. Contact Noridian EDI Support Services at 800-967-7902 for additional information.

Paper Billing- Providers may submit bills in red and white paper format with supporting medical documentation to WSI at the following address:

Workforce Safety & Insurance
PO Box 5585
Bismarck, ND 58506

Coding- Providers are required to bill using only current and appropriate HCPCS Level I (CPT) and HCPCS Level II codes for ASC services.

Device Offsets- ASC providers must bill using modifiers FB or FC when a provider replaces a device at either no cost or at an amount that is 50 percent or more of the cost of the replacement device. The provider must attach the appropriate modifier to the procedure code and not to the device HCPCS code.

Discontinued Procedures (73, 74)- When an operative session is terminated either prior to or subsequent of the administration of anesthesia (modifiers 73 or 74), only the primary planned procedure may be reported on the claim.

Medical Documentation- A provider must submit medical documentation to support all billed charges. WSI's Documentation Policies are available for detailed information on documentation requirements.

Medical Necessity- Providers are required to bill using the same medical necessity guidelines as they use for Medicare.

Modifiers- WSI requires use of the following modifiers on ASC claims: 50, 51, 59, 73, 74, 76, 77, 78, 79, FB, FC & SG.

Multiple Procedures- When multiple procedures are performed, providers must bill each line with SG and 51 modifiers, the appropriate number of units, and an appropriate charge. WSI applies the NCCI edits to multiple procedures.

National Provider Identification (NPI)- WSI requires entities who are eligible for NPI to be registered with National Plan & Provider Enumeration System. When applicable, WSI requires providers to include the NPI at both the rendering provider and billing provider levels.

Payment Packaging- WSI packages the payment of HCPCS codes assigned a status indicator "B" into the pricing for other related services.

Timely Filing- Providers must submit bills to WSI within 365 days of the date of service.

Units- Providers must bill surgical HCPCS codes with the number of units equal to the number of times the procedure was performed, as indicated by the code's description.

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Ambulatory Surgery Center Reimbursement Procedures

ASC Reimbursement Procedures outlines how WSI communicates bill processing information and issues payment to medical providers. In addition, it outlines the WSI's requirements for reimbursement. Providers are encouraged to familiarize themselves with WSI's Reimbursement Procedures to reduce repetition of bill processing information and delays in payment.

Provider Registration- Prior to reimbursement for treatment, providers are required to register with WSI. To register, complete the Payee Registration and Substitute W-9 form.

Payment Address- The remittance address submitted on the provider registration form must match the address submitted on the CMS-1500 box 33 or UB 04 box 2. In the event the address submitted on a bill does not match the registered address, WSI will return the bill.

Remittance Advice- WSI issues remittance advice for processed medical bills each Friday. A provider must refer to the remittance advice for bill status information, which includes the following: patient name, date of service, procedure billed, submitted amount, and paid amount. The remittance advice also includes reason codes, which explain any reductions or denials of payment for a service. Providers in need of a duplicate remittance advice can request these by contacting our customer service department at 1-800-777-5033.

> **Reason Codes-** Certain reason codes allow the provider to bill the patient for the denied charges, or for the balance of reduced charges. The remittance advice reason codes identify the cause for the determination and specifically state that the provider may bill the patient. When these reason codes occur, WSI also sends a "Notice of Non-Payment" letter to the patient informing them of their responsibility for the charges.
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> **In accordance with North Dakota Administrative Code 92-01-02-45.1, if a reason code does not state that a provider may bill the patient, the provider cannot bill the charges for reduced or denied services to the patient, the employer, or another insurer.**
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> **Bill Status Inquiries**- WSI will not process requests for bill status inquiries of large volume or repetitive requests for the status of processed medical bills. In addition, WSI requests that the provider allow two (2) months from the date of bill submission before inquiring on bill status. This allows adequate time for WSI to process the bill and for the provider to receive the remittance advice.

Overpayments- When an overpayment occurs on a medical bill, WSI will notify the provider of the overpayment in a letter. WSI allows 30 days from the date of the letter for the provider to issue the requested refund. If a provider does not issue the refund within 30 days of the date of the letter, WSI will begin withholding the overpayment from future payments.

Medical Services Disputes- North Dakota Administrative Code 92-01-02-46 provides the procedures followed for managed care disputes. Providers who wish to dispute a denial or reduction of a service charge must file the Medical Bill Appeal (M6) form along with supporting documentation within 30 days after the date of the remittance advice. WSI will not address a provider dispute submitted without the M6 form.

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