Fee Schedule Guidelines

Ambulatory Surgery Center

WSI
North Dakota Workforce Safety & Insurance

January 2026

Notice

The five character numeric codes included in the North Dakota Fee Schedule are obtained from Current Procedural Terminology (CPT®), copyright 2025 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 2025 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 (N.D.A.C.) that regulate medical services are **92-01-02-27 through 92-01-02-46**. The complete N.D.A.C. is accessible on the North Dakota Legislative Council website: http://www.legis.nd.gov/agency-rules/north-dakota-administrative-code.

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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. A provider 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.
D1	Ancillary dental service/item provided in an ASC setting	Service is payable under the ASC Fee Schedule when billed in conjunction with G0330.
D2	Non-office-based dental procedure added in CY 2024 or later and provided in an ASC setting	Service is payable under the ASC Fee Schedule.
D5	Discontinued codes	Service is not payable. Code was discontinued effective beginning of the calendar year.
F4	Corneal tissue acquisition, Hepatitis B vaccine	Service is payable at 85% of the amount billed.
J7	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	Drugs, biologicals, and radiopharmaceuticals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.	Service is payable under the ASC fee schedule when provided in conjunction with a covered ASC surgical 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.
S2	Skin substitute supply	Service is payable separately under the ASC fee schedule when provided integral to a covered ASC surgical procedure.
L6	Special payment; New Technology Intraocular Lense (NTIOL) or qualifying non-opioid devices	Service is payable at invoice cost.

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 2026, the Conversion Factor is $136.69.

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. A provider is 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 outline 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:

Advanced Beneficiary Notice (ABN) – A provider may utilize the ABN form to notify an injured employee of the costs associated with a recommended procedure that is: statutorily excluded from coverage, statutorily limited in quantity, deemed by WSI as not medically necessary to treat the work injury. To identify a charge accompanied with a signed ABN, a provider should append modifier GA to each applicable bill line. A provider should then submit the signed ABN along with the bill and medical documentation to WSI.

Authorization – Most ASC services require prior authorization. A provider 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.

Complexity-Adjusted Comprehensive Ambulatory Payment Classifications (C-APCs) – WSI follows Medicare's complexity adjustment in the payment rate for an eligible primary surgical procedure and packaged add-on code combination performed in an ASC setting. A provider must bill Medicare's new HCPCs C-codes when billing for these code pairs to qualify for the adjusted payment.

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 listed on the ASC Fee Schedule represent the maximum amount payable for services rendered. WSI pays the "lesser of" the billed charge or the Fee Schedule amount. This is done at the line level rather than the bill level.

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. An ASC provider 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 HCPCS 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 facility 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 a provider of inappropriately submitted bills via a return letter or remittance advice. A provider must correct any returned bills prior to resubmission.

Bilateral Procedures (50) – A provider is required to bill a bilateral procedure with the appropriate HCPCS code as a single line item with the bilateral modifier (50) appended (in addition to the SG modifier) to the line item.

Bill Forms – A provider may submit a medical bill for ASC services in either of the following formats:

- CMS 1500 form with the SG modifier appended to each CPT code
- UB-04 form with the 831 bill type, using appropriate revenue and CPT code combinations

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

Electronic Billing – A provider submitting more than 50 bills per year to WSI must send charges electronically through Carisk Intelligent Clearinghouse. This option allows for the electronic submission of professional (837p) and institutional (837i) charges along with supporting medical documentation. Contact Carisk at 888-238-4792 for additional information.

Paper Billing – A provider submitting less than 50 bills per year to WSI may send charges in red and white paper format with supporting medical documentation at the following address:

Workforce Safety & Insurance
PO Box 5585
Bismarck, ND 58506

Coding – A provider is required to bill using only current and appropriate HCPCS Level I (CPT) and HCPCS Level II codes for ASC services.

Device Offsets – An ASC provider must bill using modifier 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 – A provider is required to bill using the same medical necessity guidelines used for Medicare.

Modifiers – WSI requires use of the following modifiers on an ASC claim, as appropriate: 50, 51, 59, 73, 74, 76, 77, 78, 79, FB, FC & SG.

Multiple Procedures – When multiple procedures are performed, a provider 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 a provider 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 – A provider must submit bills to WSI within 365 days of the date of service.

Units – A provider 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 outline how WSI communicates bill processing information and issues payment to a facility. In addition, it outlines WSI requirements for reimbursement. A provider is encouraged to follow WSI Reimbursement Procedures to prevent delays in the payment processing of medical charges submitted to WSI.

Provider Registration – Prior to reimbursement for treatment, a provider is required to register the applicable Billing NPIs with WSI by completing the Medical Provider Payee Registration form. For additional information, visit the Provider Registration section of WSI's website.

Payment Address – WSI issues payment to the Pay-to Address registered on the Medical Provider Payee Registration form, regardless of the address submitted on the bill form. To update a payment address, a provider must resubmit the registration form for each applicable Billing NPI.

Remittance Advice – WSI issues remittance advices for processed medical bills each Friday. The remittance advice includes important information about a medical charge, including: patient name, date of service, procedure billed, billed amount, paid amount, and remittance advice reason codes. A provider should refer to the How to Read the WSI Remittance Advice document for assistance with interpretation of the remittance advice. This reference includes a sample remittance advice, along with definitions for significant fields within the remittance advice. Contact customer service at 1-800-777-5033 with questions or to obtain a duplicate remittance advice.

> **Reason Codes** – The WSI Remittance Advice Reason Codes document provides a comprehensive listing and description of the reason codes utilized by WSI. Each reason code identifies a cause for the adjudication of a medical charge and specifies whether a provider may bill a patient. When a reason code specifies a provider may bill a patient, WSI sends a "Notice of Non-Payment" letter to the patient informing them of their responsibility for the charge. In accordance with North Dakota Administrative Code 92-01-02-45.1, if a reason code does not state that a provider may bill a patient, the provider cannot bill the charge for the reduced or denied service to the patient, the employer, or another insurer.
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> **Bill Status Inquiries** – Bill status information is available 24/7 via myWSI. The Provider Bill Status application permits a registered user to view bill receipt status and processing details as well as export results. For access, a practice must submit a myWSI Portal Registration (M14) form for each group/billing NPI. With the availability of this resource, a provider or their TPA will not need to contact WSI via phone or email to inquire on the status of a billed charge.

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 a 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 withhold the overpayment from future payments.

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

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