

**DEPARTMENT OF SOCIAL AND HEALTH SERVICES
HEALTH AND RECOVERY SERVICES ADMINISTRATION
Olympia, Washington**

To: Ambulatory Surgery Centers
Managed Care Organizations **Memo #: 09-51**
Issued: June 30, 2009

From: Douglas Porter, Assistant Secretary **For information contact:**
Health and Recovery Services 1-800-562-3022, option 2, or go to:
Administration (HRSA) <http://hrsa.dshs.wa.gov/contact/prucontact.asp>

Subject: Ambulatory Surgery Centers (ASC): Prior Authorization Changes; Change in the Timeframe Allowed to Resubmit, Modify, or Adjust Initial Claims; Billing Reminders; and Policy Clarifications

Effective for dates of service on and after July 1, 2009, the Department of Social and Health Services (DSHS) will:

- No longer require prior authorization for certain procedure codes in the Ambulatory Surgery Centers (ASC) Fee Schedule; and
- Change the timeframe in which providers may resubmit, modify, or adjust initial claims submitted to DSHS.

This memo also contains billing reminders and clarifies existing policies.

Overview

All policies previously published remain the same unless specifically identified as changed in this memorandum.

DSHS will not be implementing the Outpatient Prospective Payment System (OPPS) for ASCs at this time.

DSHS will continue to cover only the following services in an ASC:

- Services that cannot safely and routinely be performed in a physician's office; and
- Services that can safely be performed outside of the hospital setting.

DSHS uses the Year 2007 Medicare Fee Schedule Database (MFSDB) ASC groups for procedure codes valid in 2007 and has assigned ASC groups to procedure codes for later years, including the new 2009 procedure codes.

Fee Schedule Change

DSHS corrected an error on the ASC Fee Schedule. Procedure code G0393 has been and continues to be noncovered in an ASC setting.

Prior Authorization Changes

Effective for dates of service on and after July 1, 2009, DSHS will no longer require authorization for the following procedure codes:

15170	15171	15175	15176		
19297	19298	20982	55706	69310	69320

Retroactive to dates of service on and after July 1, 2008, DSHS no longer requires prior authorization (PA) for CPT code 40720. If you submitted a claim with CPT code 40720 and received no payment, resubmit a new claim. If you submitted a claim and received some payment, but CPT code 40720 was denied based on the PA requirement, submit an adjustment.

Change in Billing Timelines [Refer to WAC 388-502-0150]

Resubmitting, Modifying, or Adjusting Initial Claims

Effective for claims with a date of service or admission on or after July 1, 2009:

- Within 24 months of the date a service was provided to a client, a provider may resubmit, modify, or adjust an initial claim, **other than a prescription drug claim or a claim for major trauma services**.
- After 24 months from the date a service was provided to a client, DSHS does not accept any claim for resubmission, modification, or adjustment. **This 24-month period does not apply to overpayments that a provider must refund to DSHS by a negotiable financial instrument, such as a bank check.**

Note: If a provider fails to bill a claim according to these requirements and DSHS denies payment of the claim, the provider or any provider's agent cannot bill the client or the client's estate. The client is not responsible for the payment.

Note: DSHS still requires providers to bill within 365 days in order to establish initial timeliness standards when any of the following apply:

- The date the provider furnishes the service to the eligible client;
- The date a final fair hearing decision is entered that impacts the particular claim;
- The date a court orders DSHS to cover the services;
- The date DSHS certifies a client eligible under delayed certification criteria; or
- The date a DSHS managed plan or Basic Health Plus client's premium has been recouped by DSHS.

Policy Statements

- All procedures performed in an ASC are subject to the program specific guidelines.

For example: Surgeries are subject to the Physician-Related Services Washington Administrative Code (Chapter 388-531 WAC) and billing instructions. Dental procedures are subject to the Dental-Related Services WAC (Chapter 388-535 WAC) and billing instructions.

- DSHS updates coverage and PA information.
- Bill DSHS your usual and customary charge.
- You must bill one claim for all services per client, per date of service.
- You must bill any corrections to a final paid or partially paid bill as an adjustment.

Dental Policy Reminders for ASCs

DSHS covers dental-related services, including oral and maxillofacial surgeries that are provided in an ASC, if the dental-related services are:

- Medically necessary; and
- Provided in accordance with Chapter 388-535 WAC; and

At least one of the following is true:

- The client is a client of the Division of Developmental Disabilities;
- The client is eight years of age or younger; or
- The dental service is prior authorized by DSHS.

The performing dentist must send in a request for authorization, and the services must be covered on the ASC fee schedule. The request must contain the procedure codes that will be billed on the claim form the dentist uses to bill for the service.

Note: DSHS does not consider services provided in an ASC to be emergency services.

DSHS requires providers to report dental services, including oral and maxillofacial surgeries, using CDT codes. **Exception:** Oral surgeons may use CPT codes **listed in DSHS's Dental Program Fee Schedule** only when the procedure performed is not listed as a covered CDT code in the DSHS/HRSA Dental Program Fee Schedule.

When billing for dental services, ASCs must use the same procedure code(s) that a dentist would use to bill as long as the procedure code is appropriate on an ASC claim.

Clarification of Implantable Device Billing Procedures

DSHS reviews claims for implantable devices on a case-by-case basis.

To bill DSHS for implantable devices:

- Submit the manufacturer's invoice with the Medicare-required or relevant HCPCS procedure code written on the invoice;

Note: DSHS will deny claims for implants when a HCPCS code is available for the device, but it is not on the invoice.

- For items that are not purchased individually, write on the invoice how many individual items were in the box or carton;
- Submit an itemized list of components and invoiced costs for each item used for the implant procedure;
- Write the code for the primary procedure (not L8699) on the itemized list;
- Complete the CMS-1500 Claim Form and place an "X" in field 19. For an electronic submission place an "X" in the Comments section; and
- Bill HCPCS code L8699.

Providers Are Required to Bill According to NCCI Standards

“Medicare’s National Correct Coding Initiative (NCCI)” is a national standard for the accurate and consistent description of medical goods and services using procedural codes. The standard is based on coding conventions defined in the American Medical Association’s Current Procedural Terminology (CPT®) manual, current standards of medical and surgical coding practice, input from specialty societies, and analysis of current coding practices. The Centers for Medicare and Medicaid Services (CMS) maintain NCCI policy.

DSHS payment systems require consistent input to operate correctly. By complying with this standard, you make it possible for DSHS to make accurate and timely payment.

Information about NCCI standards can be found online at:

<http://www.cms.hhs.gov/nationalcorrectcodinitied/>.

Note: Where CPT and HCPCS codes both exist for the same service, providers must bill with the CPT code or the HCPCS code, not both.

How Do I Conduct Business Electronically With DSHS?

You may conduct business electronically with DSHS by accessing the WAMedWeb at <http://wamedweb.acs-inc.com>.

Later in 2009, DSHS will replace its current Medicaid Management Information System with a new payment processing system named ProviderOne. When fully operational, ProviderOne will pay about 100,000 providers who serve the one million people qualifying for DSHS services each year. Please visit <http://hrsa.dshs.wa.gov/ProviderOne> for more information.

How Can I Get DSHS/HRSA Provider Documents?

To obtain DSHS/HRSA provider numbered memos and billing instructions, go to the DSHS/HRSA website at <http://hrsa.dshs.wa.gov> (click the **Billing Instructions and Numbered Memorandum** link). These documents may be downloaded and printed.