ALABAMA DEPARTMENT OF INDUSTRIAL RELATIONS
ADMINISTRATIVE CODE

RULE

Division: Workers' Compensation
Chapter: Utilization Management and Bill Screening

480-5-5-.26 **AMBULATORY SURGERY CENTERS**.

(1) When medically appropriate, surgical procedures may be performed on an outpatient basis to reduce unnecessary hospitalization and to shift care to a less costly setting in accordance with Rule 480-5-5-.11(3). All free standing Ambulatory Surgery Centers (ASCs) licensed in Alabama shall be subject to the policies and methodology for determining reimbursement using the Maximum Fee Schedule for Ambulatory Surgery Centers or according to any mutually agreed reimbursement pursuant to Code of Alabama, 1975, §25-5-314.

(a) ASC facility services shall be those items and services provided by an ASC in connection with an authorized procedure including:

1. Nursing, technician and ancillary services;

2. Use of the ASC facility for preoperative services, surgery, and postoperative services;

3. Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment directly related to the performance of a surgical procedure;

4. Diagnostic or therapeutic services or items directly related to the performance of a surgical procedure;

5. Materials and supplies usually required for the administration of anesthesia; and,

6. Administrative, record keeping, and housekeeping items and services.

(b) Physician-owned/operated ASCs providing medical services other than elective (non-emergency) single-day surgery shall be covered by the Maximum Fee Schedule for Physicians and shall bill using the HCFA 1500 form.

(c) When requested, the ASC shall submit a copy of the charge master to the Department of Industrial Relations Workers' Compensation Division and/or an itemized

listing of the individual items and services that contribute to the charge.

(2) **Billing Information**

(a) ASCs shall use Form UB92 to bill for services rendered in workers' compensation cases. Any attachment to the UB92 claim form shall be labeled with the patient's name, identifying number and date of accident prior to submission to the employer/agent.

(b) ASCs shall use the five-digit procedure codes and descriptors of the CPT-4 procedure codes when billing for services rendered to workers' compensation claimants.

(c) Use of the CPT-4 Procedure Codes.

1. CPT-4 Codes shall not be translated into a facility billing system.

2. The ASC shall use the CPT-4 procedure code that represents separate and distinct surgical procedures. The Medicare Guidelines shall be used as a guideline to differentiate between separate or inclusive surgeries.

(d) Global Charge Concept

1. ASC surgical services shall be billed using a global charge concept; that is, the charges for the usual preoperative, operative and postoperative services shall be entered in the appropriate block of the UB92 as one total charge for the major surgical procedure performed.

2. The global billing concept includes charges for the following:

(i) Prevailing preoperative services that have been historically included within the global bill for nonworkers' compensation patients, shall be included for workers' compensation patients;

(ii) All facility personnel services;

(iii) Facility use, including prestaging and poststaging areas, operating room, and recovery room;

(iv) Usual supplies, dressings, splints, casts, pharmaceuticals and equipment

related to the surgical procedure(s);

(v) Anesthesia equipment, supplies, monitors, pulse oximetry, etc.;

(vi) Administrative services;

(vii) Standard laboratory tests including at least a CBC or hemogram and a urinalysis if done by the facility; and,

(viii) Surgical pathology services if done by the facility.

3. Global reimbursement for ASC services shall not include payment for professional services of the surgeon, anesthesiologist, nurse anesthetist, radiologist, pathologists, etc. These fees shall be billed separately by individual providers.

4. Multiple Procedures

(i) When multiple procedures are performed during the same surgical session, the reimbursement shall be made at 100 percent (100%) of the approved rate for the highest charge procedure and 50 percent (50%) of the approved rate for all additional procedures. Only separate and distinct surgical procedures shall be billed.

(ii) When applicable, the Medicare Guidelines shall be used in determining separate and distinct surgical procedures.

Author: Workers' Compensation Division
Statutory Authority: Code of Alabama, 1975, §25-5-293
History: Effective September 12, 1996
Amendment Effective: January 12, 2009