



RICK SNYDER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
WORKERS' COMPENSATION AGENCY
KEVIN A. ELSENHEIMER
DIRECTOR

MIKE ZIMMER
DIRECTOR

**Reference Guide to Calculate Michigan
Workers' Compensation Maximum Allowable Payment for Ambulatory Surgical Center/Free
Standing Outpatient Facility
Fee Schedule Effective: 12/26/2014**

- **Note:** Codes listed with "0" or not listed are BR (By Report). A BR procedure is reimbursed at the provider's usual and customary charge or reasonable amount, defined in the definition section of the Health Care Services Rules, whichever is less.
- The absence or presence of a code does not indicate workers' compensation coverage.
- Please refer to the Health Care Services Manual for additional information.

**AMBULATORY SURGICAL CENTER (ASC)/FREE STANDING
OUTPATIENT FACILITY (FSOF)**

Payment for surgical procedures performed in Ambulatory Surgical Center (ASC)/Free Standing Outpatient Facility (FSOF) and payment for ASC/FSOF covered Ancillary Services integral to performed procedures.

Calculate the Michigan Maximum Allowable Payment (MAP) using the following formula:
(Formula Component 1.30 below represents Medicare + 30%)

**Medicare Payment Amount fee x 1.3 (Michigan Multiplier) = Michigan MAP,
rounded**

IMPORTANT NOTES:

1. The Medicare "October 2014 ASC Approved HCPCS Code and Payment Rates" file is the data source used for fee calculations and is available on our website.
2. The fee can be calculated by taking the Medicare fee from the column labeled *Payment* on the appropriate tab (surgical or ancillary), round and multiply by 1.30 to get the Michigan Maximum Allowable Payment, rounded.

Health Care Services Rules for reference:

- **R418.10923b Billing for ambulatory surgery center (ASC) or freestanding surgical outpatient facility (FSOF).**

Rule 923b. (1) An ASC or FSOF shall be licensed by the Michigan department of community health under part 208 of the code or if it has an agreement with the centers for Medicare and Medicaid services (CMS) to participate in Medicare. The owner or operator of the facility shall make the facility available to other physicians, dentists, podiatrists, or providers who comprise its professional staff. The following apply:

(a) When a surgery procedure is appropriately performed in the ASC or FSOF and CMS has not assigned a payment code for that procedure, the procedure shall be considered BR.

(b) The ASC or FSOF shall be reimbursed the maximum allowable paid for the payment code, taking into consideration the multiple procedure rule for facilities as defined by CMS.

(2) Billing instructions in this rule do not apply to a hospital-owned freestanding surgical outpatient facility billing with the same tax identification number as the hospital.

(3) An ASC or FSOF shall bill the facility services on the CMS 1500 claim form and shall include modifier SG to identify the service as the facility charge. The place of service shall be "24." The appropriate HCPCS or CPT procedure code describing the service performed shall be listed on separate lines of the bill.

(4) Modifier 50, generally indicating bilateral procedure, is not valid for the ASC or FSOF claim. Procedures performed bilaterally shall be billed on 2 separate lines of the claim form and shall be identified with modifiers, LT for left and RT for right.



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STEVE ARWOOD
DIRECTOR

(5) An ASC or FSOF shall only bill for outpatient procedures that, in the opinion of the attending physician, can be performed safely without requiring inpatient overnight hospital care and are exclusive of such surgical and related care as licensed physicians ordinarily elect to perform in their private offices.

(6) The payment for the surgical code includes the supplies for the procedure.

(7) Durable medical equipment, the technical component (-TC) of certain radiology services, certain drugs, and biologicals that are allowed separate payment under the outpatient prospective payment system (OPPS) will be provided separate from the rules on the agency's website, www.michigan.gov/wca.

(8) Items implanted into the body that remain in the body at the time of discharge (such as plates, pins, screws, mesh) from the facility are reimbursable when they are designated by CMS as pass through items. These pass through items will be provided separate from these rules on the agency's website, www.michigan.gov/wca. The facility shall bill implant items with the appropriate HCPCS code that is reimbursable under the OPPS. A report listing a description of the implant and a copy of the facility's cost invoice, including any full or partial credit given for the implant, shall be included with the bill.

(9) Those radiological services that are allowed separate payment under the OPPS will be provided separate from the rules on the agency's website, www.michigan.gov/wca. When radiology procedures are performed intraoperatively, only the technical component shall be billed by the facility and reimbursed by the carrier. The professional component shall be included with the surgical procedure. Pre-operative and post-operative radiology services may be globally billed.

(10) At no time shall the ASC or FSOF bill for practitioner services on the facility bill.

(11) When an allowed drug or biological, provided separate from these rules on the agency's website, www.michigan.gov/wca, is billed by the ASC or FSOF, it shall be listed by the appropriate HCPCS or CPT procedure code. All of the following apply:

- (a) Each allowable drug or biological shall be listed on a separate line.
- (b) Units administered shall be listed for each drug or biological.
- (c) A dispense fee shall not be billed.

- **R 418.101023** Reimbursement for ASC or FSOF.

Rule 1023. (1) Reimbursement for surgical procedures performed in an ASC or FSOF shall be determined by using the ASC rate published by CMS. The formula for determining the maximum allowable paid (MAP) for a surgical procedure in an ASC or FSOF is determined by multiplying the (Medicare ASC rate) X (1.30). The MAP shall be published in the health care services fee schedule.

(2) When 2 or more surgical procedures are performed in the same operative session, the facility shall be reimbursed at 100% of the maximum allowable payment or the facility's usual and customary charge, whichever is less, for the procedure classified in the highest payment group. Any other surgical procedures performed during the same session shall be reimbursed at 50% of the maximum allowable payment or 50% of the facility's usual and customary charge, whichever is less. A facility shall not un-bundle surgical procedure codes when billing the services.

(3) When an eligible procedure is performed bilaterally, each procedure shall be listed on a separate line of the claim form and shall be identified with LT for left and RT for right. At no time shall modifier 50 be used by the facility to describe bilateral procedures.

(4) Implants are included in the maximum allowable paid unless the CMS list it as a pass through item. Pass through items will be provided on the agency's website, www.michigan.gov/wca. If an item is implanted during the surgical procedure and the ASC or FSOF bills the implant and includes the copy of the invoice, then the implant shall be reimbursed at the cost of the implant plus a percent markup as follows:

- (a) Cost of implant: \$1.00 to \$500.00 shall receive cost plus 50%.
- (b) Cost of implant: \$500.01 to \$1000.00 shall receive cost plus 30%.
- (c) Cost of implant: \$1000.01 and higher shall receive cost plus 25%.

(5) Laboratory services shall be reimbursed by the maximum allowable payment as determined in R 418.101503.

(6) When a radiology procedure is performed intra-operatively, only the technical component shall be billed by the facility and reimbursed by the carrier. The professional component shall be included with the surgical procedure. Pre-operative and post-operative radiology services may be globally billed.

(7) When the freestanding surgical facility provides durable medical equipment, the items shall be reimbursed in accord with R 418.101003b.