I. BCBSM’s Ambulatory Surgery Facility Programs

Traditional

BCBSM’s Traditional Ambulatory Surgery Facility Program includes all facilities that are licensed in Michigan as a freestanding surgical outpatient facility (FSOF) whether the facility is considered freestanding or hospital/provider-based by CMS. The facility provides surgery and related care that can be performed without requiring inpatient hospital care and it is located in a structure that is other than the office of a physician or other private practice office.

BCBSM Traditional participation for ambulatory surgery facilities is on a formal basis only. Facility services provided in a non-participating ambulatory surgery facility are not reimbursed to either the facility or the member. However, the participation status of the facility does not affect BCBSM's reimbursement for professional services, which are billed separately.

The following information applies to services for members enrolled in BCBSM’s Traditional product. Please note that members enrolled in BCBSM's (non-Medicare) PPO and Point of Service products (e.g., Community Blue PPO, Blue Preferred PPO, Blue Preferred Plus PPO, and Blue Choice POS, etc.) use the BCBSM Traditional network unless a separate network for ambulatory surgical facility services has been established for them, however, restrictions may apply. Members of other Blue Cross Blue Shield (BCBS) Plans also use the Traditional network. Member benefits and eligibility should be verified for all BCBSM or BCBS members prior to providing services.

Medicare Advantage PPO

Licensed ASFs that are recognized as freestanding ASCs by CMS are eligible to apply for affiliation in the BCBSM Medicare Advantage PPO network which became effective January 1, 2010 for individual and group customers. To be in the MA PPO network, freestanding ASFs are not required to participate in the Traditional network but must meet all of the same requirements for Traditional participation. ASFs that are considered “provider-based” to a hospital by CMS do not need to separately apply for the MA PPO network because they will be paid through the hospital.

Medicare Supplemental

Licensed and Medicare certified ASFs that are considered freestanding by CMS may also be eligible for reimbursement for patients with BCBSM's Medicare Supplemental coverage, regardless of the facility's BCBSM Traditional program participation status. However, certain BCBSM customer groups prohibit payments of Supplemental benefits to non-participating ASFs. If the facility is considered freestanding by CMS (i.e., ordinarily bills Medicare on a 1500 claim form or its electronic equivalent for the ASF’s facility services), a Provider Identification Number (PIN) will need to be established for receipt of BCBSM Medicare Supplemental payments.

For licensed ASFs that are considered provider-based by CMS, the Medicare Supplemental coverage is paid to the hospital so there is no need for a separate PIN.
II. BCBSM’s Evidence of Need

(EON) requirement as referenced in the BCBSM Ambulatory Surgery Facility Participation Agreement has been suspended. Facilities applying for participation will not be subject to the separate BCBSM EON minimum surgical volume requirements.

III. BCBSM’s Ambulatory Surgery Facility Qualification Requirements for Traditional and MA PPO

In order to participate with BCBSM an ASF facility must, at minimum, have and maintain the following:

- Have a physical structure other than the office of a physician, dentist, podiatrist or other private practice office, offering surgical procedures and related services that can be performed without requiring inpatient hospital care.

- Be fully licensed by the state of Michigan as a freestanding surgical outpatient facility and meet any requirements of applicable federal law.

- Have full, unrestricted accreditation as an ambulatory health care provider by at least one national accreditation organization such as the Joint Commission on Accreditation of Healthcare Organizations (JC), the American Osteopathic Association (AOA), or the Accreditation Association for Ambulatory Health Care (AAAHC), or any additional accreditation organization approved by BCBSM. For AAAHC, BCBSM does accept the Early Option Survey (EOS) Accreditation. However, the participation agreement will be terminated when the AAAHC accreditation expires unless the facility obtains unrestricted, full three year accreditation immediately following expiration of the one year EOS accreditation.

- Be Medicare certified as a supplier of ambulatory surgical services or be determined by Medicare to be provider-based as an extension or part of a Medicare certified hospital. (Note: for the MA PPO network the ASF must be designated as freestanding (i.e., non provider-based) by CMS.)

- Maintain a minimum of operating rooms, as follows:
  - facilities in a non-rural county must maintain a minimum of two operating rooms
  - facilities in a rural county must maintain a minimum of one operating room

Non-rural and rural counties are determined by the U.S. Department of Agriculture’s most recent Rural-Urban Continuum Code.

The definition of an operating room is the same definition used by the Michigan Department of Community Health (MDCH) in its Annual Hospital Statistical Survey. Rooms not designated by the MDCH as operating rooms (e.g., treatment rooms) will not be counted towards the minimum.

- Patients admitted to the ambulatory surgery facility must be under the care of a licensed physician. A physician should be available on-site at all times when a patient is on the facility’s premises. The ambulatory surgery facility should make provisions for patient care services that are appropriate to the needs of the patients and the community it serves.

- Have an organized medical staff, established in accordance with policies and procedures developed by the facility that is responsible for maintaining proper standards of medical care. Membership on the medical staff must be available to qualified physicians in the community. Criteria for membership on the medical staff will be established and enforced by a credentials evaluation program established by the facility.

- Have a written agreement with at least one acute care general hospital, within a reasonable travel time, as determined by BCBSM, to facilitate prompt transfer of patients requiring hospital care. The written agreement with a hospital shall provide that copies of the facility’s patient medical records shall be transmitted to the hospital where the patient is transferred.
Conduct program evaluation, utilization review and peer review to assess the appropriateness, adequacy and effectiveness of the program’s administrative and clinical components applicable to all patient services in accordance with the requirements of BCBSM and the appropriate accrediting and regulatory agencies.

The utilization management and peer review program will:

- assess the quality of care rendered to patients to assure that proper services are provided at the proper time by qualified individuals.
- identify, refer, report and follow up on quality of care issues and problems, and
- monitor all aspects of patient care delivery

The utilization management and peer review plan must be written and must identify purposes, goals, mechanisms and personnel responsible for all aspects of the plan, including:

- quality, content and completeness of medical records
- clinical performance
- quality and appropriateness of diagnostic and treatment procedures
- evaluation of tissue specimens
- medication utilization
- patient satisfaction
- quality and appropriateness of anesthesia, and
- arrangements for patients requiring hospitalization following ambulatory surgery

- Have a governing board that is legally responsible for the total operation of the facility and for ensuring that quality medical care is provided in a safe environment.

- The financial affairs of the ambulatory surgery center must be conducted in a manner consistent with prudent fiscal management. Records of its transactions shall be maintained in conformity with generally accepted accounting principles, and with BCBSM billing, reporting and reimbursement policies and procedures.

- Have an absence of fraud and illegal activities

- Maintains adequate patient and financial records

Note: It is BCBSM’s policy to recredential participating providers every 2-3 years to verify continued compliance with all qualification requirements.

IV. Ambulatory Surgery Facility Reimbursement for the Traditional Network

For Covered Services, BCBSM will pay a participating ASF the lesser of the facility’s charge or the approved BCBSM ASF payment amount that is in effect on the date of service, less any applicable member copayments or deductibles. ASF fees are established using the following methodologies:

1. Outpatient Surgical Procedures:

   a. For procedures commonly performed in physicians’ offices, as determined by BCBSM, the fees are based on a percentage of the technical component of the BCBSM physician fee for each procedure.

   b. For procedures that are not commonly performed in physicians’ offices, as determined by BCBSM, the fees are aligned with the hospital fees for the same procedure.

   c. In rare instances when procedures cannot be priced using the above methods, the payment is the facility’s charge multiplied by a percentage determined by BCBSM.
NOTE: Surgery fees are all inclusive. This means that the established fee covers all related services such as anesthesia, drugs, implants, recovery room, supplies, solutions, etc. There is no separate payment for these costs.

When two or more surgical procedures are performed during the same visit, BCBSM will reimburse the facility 125 percent of the highest fee procedure only. There is no separate payment for the additional procedure(s).

2. Laboratory and Radiology Procedures:
   a. Fees are determined using the technical component of the BCBSM physician fee for each procedure.

3. Other Procedures:
   a. EKGs are reimbursed a statewide percentage of charge payment until such time that BCBSM has established fees for these procedures. When fees are established, BCBSM will give the facility 60 days notice.

Covered services that are provided in an ASF by professional providers (e.g., surgeons) and that are directly related to the surgical procedure are billed separately to BCBSM.

The ASF Rate Schedule is available on web-DENIS and the rates are not negotiable. Participating providers are required to bill BCBSM for covered services for BCBS members and to accept BCBSM’s payment as payment in full for covered services, except for any applicable member copayments and/or deductibles.

V. Medicare PPO Reimbursement

Reimbursement for ASFs that participate in the MA PPO network is made at the lesser of billed charges or the BCBSM Payment Rate(s) for the applicable service, less any applicable member copayments or deductibles. Out-of-network providers are reimbursed at the CMS payment rate(s) but the member will be subject to additional out-of-network copayments and/or deductibles which must be collected from the member.

VI. The BCBSM Participation Agreements

The BCBSM Ambulatory Surgical Facility Participation Agreement and/or the BCBSM Medicare Advantage PPO Participation Agreement are available on the bcbsm.com ASF home web page. The Traditional agreement is available as a link in the participation chapter of the provider manual on web-DENIS for those providers that already have web-DENIS access. The Traditional contract is also on file with the Michigan Office of Financial and Insurance Regulation (OFIR). The terms and conditions of the agreements are not negotiable.

The applicable participation agreement signature documents for each BCBSM network/program being requested on the application are available on the ASF home web page and must be completed, signed and returned with a completed facility application form.

NOTE: This is general information only and is subject to change without notice.

After we review the application and accompanying documentation, we may contact the designated representative of the facility to set up an appointment for an on-site visit. The on-site visit includes a review of a sample of medical records to evaluate the applicant's compliance with BCBSM requirements, as outlined in this application. The facility must be ready for the on-site review at the time of submitting the application. If the facility is approved for program participation, the appropriate participation agreement(s) will be offered. If the facility is not approved, we will send notification in writing indicating the reason(s) for the denial.

The facility may not submit claims and is not eligible for reimbursement unless and until the facility is approved by BCBSM for participation and BCBSM has issued a signed letter of approval to the facility for the networks requested. The effective date for the approved networks will be indicated in the approval letter sent to the facility. Effective dates are not retroactive to the date the application was submitted or received.
A separate BCBSM facility code is assigned to each approved and contracted location. With the implementation of National Provider Identifiers (NPI BCBSM crosswalks the claims from the facility’s NPI to the BCBSM facility code (i.e., BCBSM’s internal identifier) for processing. Therefore, BCBSM recommends obtaining one NPI (in accordance with federal guidelines), for each location and provider type. Federal guidelines also allow for an NPI to be obtained for unique combinations of tax ID, location and taxonomy (specialty) codes.

Upon completion of the application and contracting process, the facility will receive a welcome package with information on how to sign up for electronic billing and access to web-DENIS, BCBSM’s web-based information system for providers. Through web-DENIS the facility will have access to provider manuals, newsletters (e.g., The Record), rate schedules, and patient data such as contract eligibility and benefits. It is the facility’s responsibility to be familiar with and to adhere to all BCBCM billing and benefit requirements. It is also the responsibility of the facility to ensure its billing department (or billing agency) is compliant with all of BCBSM’s billing requirements.

Participating ASF facilities must bill BCBSM on a UB-04 electronic claim form. With a few exceptions, BCBSM no longer accepts facility paper claims. Facilities that would like more information about internet claims submission or that wish to bill electronically should contact BCBSM’s Electronic Data Input (EDI) Helpline at (800) 542-0945 for electronic billing information after their BCBSM facility code has been received.

Facilities that participate in the Traditional or MA PPO programs must notify BCBSM immediately of any change in the facility’s ownership, tax identification number, Medicare certification status, CMS certification number, NPI, address, telephone number, etc.

**Multiple Locations**

If the facility is applying for participation (or an ownership change) for more than one location, each location must meet all requirements in order to be approved. A separate BCBSM facility code is issued for each approved location and each approved location receives its own participation agreement. A separate application must be submitted for each location.