AMBULATORY SURGERY FACILITY APPLICATION
FOR BCBSM TRADITIONAL OR MEDICARE ADVANTAGE PPO PARTICIPATION

GENERAL INFORMATION

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 attached application and 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. Be sure to verify benefit and eligibility 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, including EON. 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), please contact BCBSM’s Provider Enrollment department (1-800-822-2761) to establish a Provider Identification Number (PIN) 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. Evidence of Need (EON)

All facilities that apply for participation with BCBSM’s Traditional or MA PPO network must meet BCBSM’s Evidence of Need (EON) requirement. EON requires that Facility surgical volumes are in compliance with the state of Michigan’s Certificate of Need (CON) standards. New applicants must have a minimum four months of case volume to obtain EON approval. New applicants may be eligible for an adjustment to the EON minimum volume requirement. The amount of the adjustment is based on BCBSM market share and will only be allowed if the facility has not provided services to BCBSM members.

NOTE: Prior to submitting this application, all facilities must complete a BCBSM EON Attestation, and receive written EON approval from BCBSM, except as stated above. For more information on the EON requirements or to obtain a copy of the EON Attestation form, check the provider enrollment section of our website (bcbsm.com), or contact Ellen Ward at 313-448-5223 or via e-mail to eward@bcbsm.com.

Participating facilities will be certified for continued compliance with the EON requirement approximately every three years as part of the facility re-credentialing process.

For changes of ownership, the new owner/applicant does not need to re-qualify for EON approval but must be EON compliant at the time of the facility’s next recertification.

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 (JCAHO), the American Osteopathic Association (AOA), or the Accreditation Association for Ambulatory Health Care (AAAHC), or any additional accreditation organization approved by BCBSM. If you have questions regarding whether the accreditation status you are seeking is accepted by BCBSM, such as the level or length of accreditation, please contact the person listed at the end of the Application’s Instructions section. 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. Facilities that have more than the minimum number of operating rooms must still meet all Evidence of Need volume requirements.

- 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.

- Meet the BCBSM Evidence of Need requirements at the time of initial application and at the time of recertification, as applicable. (See Section II above)

- 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. For the first year of the program (through December 31, 2010), the BCBSM Payment Rate for freestanding ASFs will be 100% of the facility’s CMS payment rate(s). 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 will be sent if/when the facility is approved for participation. If, however, the facility would like to review the agreements prior to submitting the application, you may request a sample copy from BCBSM’s Provider Contracting department, or, 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.

NOTE: The information supplied in this application is general information only and is subject to change without notice. The application does not constitute a provider agreement or a provider manual and members’ benefit plans will vary.
AMBULATORY SURGERY FACILITY
APPLICATION INSTRUCTIONS

Complete this application **only after** obtaining EON approval, as described in Section II of the General Information section of this application, and only after the facility believes it meets all other BCBSM requirements and has all documents BCBSM requires (e.g., Medicare/CMS certification, accreditation). Print (in ink) or type the information required in the space provided. If the application was retrieved from the provider enrollment section of the BCBSM website (bcbsm.com), you may print, complete and mail the application. Be certain that the application is complete and all required attachments are enclosed at the time of submission to BCBSM. Please do not put the application in a binder or use sheet protectors, folders or dividers.

If the ASF is freestanding and already participates in BCBSM's Traditional program but now wishes to participate in its MA PPO Program, please contact the person listed at the end of this section. An application may not be necessary.

Please mail (do not fax) the completed application, along with the required attachments to:

Patricia Helfrick, RN
Blue Cross Blue Shield of Michigan
Provider Contracting - Mail Code 513E
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

Contact the person listed at the end of this section if you do not receive a letter within two weeks from the date you sent the application. It takes approximately two weeks for us to review a complete application. Incomplete applications may be returned, delaying the review process.

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 both parties sign the BCBSM ASF Traditional participation agreement and/or the BCBSM MA PPO Participation Agreement. If the facility is approved and offered one or both participation agreements, it will be asked to retain the agreement(s) for its record and return the signed Signature Document(s) to BCBSM. The countersigned copy of the Signature Documents will be returned to the facility after its BCBSM ASF facility code has been activated for billing purposes, generally within three weeks of our receipt of the signed Signature Documents. The effective date for MA PPO is the date indicated on the Signature Document. The effective date for participation in the BCBSM Traditional ASF program will be the date approval is granted by BCBSM and is not retroactive to the date the application was submitted or received. If this application pertains to an ownership change where the prior owner was a BCBSM participating ASF and BCBSM approves an agreement effective date retroactive to the date of the ownership change, this is not in any way a guarantee that old claims will process for the new owner. The facility is still subject to any applicable claims filing limitations.

A separate BCBSM facility code is assigned to each approved and contracted location. With the implementation of National Provider Identifiers (NPI) in 2008, 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. By choosing the same identification structure for your NPI numbers as your BCBSM provider codes, you will significantly improve our ability to accurately and promptly process your claims.
Upon completion of the application and contracting process, the facility’s provider consultant will deliver 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 BCBM 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, CMS 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. Before completing the application, please make/print additional copies. The application for the first location must be completed in its entirety (with all attachments submitted). For each additional application submitted, complete the following sections: General Information (1.0), Accreditation (4.0), Licensure (5.0), Medicare Certification (7.0), and Staffing (8.0), Transfer Agreement (10.0). For all other sections, indicate "same" where there is no difference. Where the information for a location is different than the first location, answer the questions and submit corresponding attachments. Before submitting the applications, please review all sections carefully to be sure appropriate information was completed for each location. If, however, you prefer to submit a "complete" application for each site, you may choose to do so.

Please direct any questions regarding completion of the application to:

**Patricia Helfrick, RN**  
Qualifications Consultant  
PHelfrick@bcbsm.com

**Telephone:**  313-448-7896  
**Fax:**  866-393-8533
BLUE CROSS BLUE SHIELD OF MICHIGAN
AMBULATORY SURGERY FACILITY APPLICATION

1.0 General Information

Indicate the type of application being submitted (check all that apply):

☐ The facility would like to formally participate in BCBSM’s Traditional Program
☐ The facility would like to formally participate in BCBSM’s MA PPO Program (freestanding only), or
☐ Ownership change involving a change in the facility’s federal Tax Identification Number. Please contact the person listed on the previous page regarding the ownership change before completing this application.

1.1 Business Name (This is the name the facility uses when doing business, or the DBA. It will be used for directories)
__________________________________________________________________________________

1.2 Facility Site Address (for directory) ______________________________________________________

Suite Number _______________ County __________________________

City ____________________________ State MI Zip code ______________

1.3 Facility’s Telephone Number (for directory) (_____) ______________________

1.4 Is the facility in a physical structure that is other than the office of a physician, dentist, podiatrist, or private practice offering surgical procedures, and does it provide outpatient surgical services that can be performed without requiring inpatient hospital care?
☐ Yes
☐ No

If “No,” explain: ______________________________________________________________________
__________________________________________________________________________________

1.5 Date facility began providing ambulatory surgery services to patients (MM/DD/YEAR) under the Tax ID indicated in 1.1. ______________

1.6 Is the facility accepting new patients at this time?
☐ Yes
☐ No

1.7 Indicate the days and hours the ASF is open to service patients
__________________________________________________________________________________

1.8 Remittance Address (This is the location where all BCBSM vouchers, checks and remittance advices should be sent.)
__________________________________________________________________________________

Suite Number _______________ County __________________________

City ____________________________ State __________ Zip code ______________
1.9 Enter the facility’s 10 digit National Provider Identifier (NPI) that will be used for billing ASF services

___________________________________________________________________________

1.10 Tax Name (This is the name on file with the IRS and may be different from the facility's business name)

__________________________________________________________________________________

1.11 Enter the facility’s federal tax identification number (TIN) ________________________________

1.12 Attach a copy of Federal Tax Deposit Coupon (form-8109), copy of IRS notification letter (form SS4-147c), EFTPS (form–9787), or another document issued by the IRS with the facility’s federal tax identification number (TIN) on it.

1.13 Check the applicable field:
☐ For Profit
☐ Nonprofit/Tax Exempt

1.14 If the facility is nonprofit, attach the IRS document authorizing tax exempt status.

1.15 Fiscal year end date (MM/DD/YEAR) ________________________________

1.16 Facility’s website (URL), if applicable ________________________________

Note: The percentage of ownership for items 1.17 and 1.18 combined must equal 100%.

1.17 List the following information for the facility if it is owned by an individual(s). Attach additional pages if necessary.

Name: ___________________________________________ Ownership ________%

Home Address: ___________________________________________

Occupation: ___________________________________________

Name: ___________________________________________ Ownership ________%

Home Address: ___________________________________________

Occupation: ___________________________________________

Name: ___________________________________________ Ownership ________%

Home Address: ___________________________________________

Occupation: ___________________________________________

1.18 Provide the following information for the facility if an organization owns it or has managing control (e.g., hospital, corporation, governmental and/or tribal organizations, partnerships and limited partnerships, charitable and/or religious organizations, etc.)

Organization’s name

Percent ownership (if applicable)

___________________________________________________________________________ Ownership ________%

___________________________________________________________________________ Ownership ________%
2.0 Administration

2.1 Attach a copy of the Ambulatory Surgery Facility's organizational chart.

2.2 List the name and credentials of the Ambulatory Surgery Facility's administrator.

   Name ____________________________________________________________________________

   Credentials (Degrees/Certifications, etc.) _________________________________________________

   Administrator's scheduled number of hours per week at facility ______________________________

2.3 Attach a copy of the administrator's job description and qualifications.

2.4 Has the facility or an officer, director, owner (e.g., individuals or parent organizations) or principal (those with significant authority and responsibility) of the facility ever had any convictions, guilty pleas, nolo contendere pleas, remands to diversion programs, civil judgments or settlement of civil actions that are related to the provision or payment of health care services?

   ☐ Yes
   ☐ No

   If “Yes,” please explain:

   __________________________________________________________________________________

2.5 Has the facility or its owner(s) (e.g., individuals or parent organizations) ever been subject to a Corporate Integrity Agreement or been found to have been non-compliant with self-dealing and/or anti-kickback laws and regulations?

   ☐ Yes
   ☐ No

   If “yes,” please provide a complete explanation below and/or attach additional pages if necessary

   __________________________________________________________________________________

3.0 Governing or Advisory Board

3.1 Does the facility have a governing or, as an alternative, a community advisory board responsible to the governing board that is legally responsible for the total operation of the facility and for ensuring that quality care is provided in a safe environment?

   ☐ Yes
   ☐ No

3.2 Does the governing or advisory board include persons representative of a cross section of the community?

   ☐ Yes
   ☐ No

3.3 Attach a list of the name, city and state of residence, and occupation of all members of the governing board or advisory board.

3.4 Attach a copy of the policies and procedures that outline the functions and responsibilities of the board.
4.0 Accreditation

4.1 Check all that apply:
- JCAHO - Joint Commission on Accreditation of Health Care Organizations
- AOA - American Osteopathic Association
- AAAHC - Accreditation Association for Ambulatory Health Care
- None

4.2 Attach a copy of the facility's current accreditation certificate for all ambulatory surgical facility services provided. Note: For facilities covered under a hospital's general accreditation, the accreditation certificate must specifically reference that the ASF site was surveyed and is included in the hospital's accreditation.

4.3 If this application is being submitted due to a change of ownership, attach a copy of the letter indicating the transfer or extension of accreditation to the new owner.

5.0 Licensure

5.1 State the facility’s freestanding surgical outpatient facility license number, as issued by the state of Michigan, and its expiration date.

License # (permanent ID): ____________________________ Expiration Date: _______________

5.2 Attach a copy of the facility’s state of Michigan license as a Freestanding Surgical Outpatient Facility.

6.0 Professional Organization Memberships:

6.1 Check all the professional organization(s) in which the facility has current membership.
- Michigan Ambulatory Surgery Association
- Federated Ambulatory Surgery Association
- Other, please name: ______________________________________________________________

7.0 Medicare - Centers for Medicare and Medicaid Services (CMS)

7.1 Has the facility's license or Medicare number ever been revoked, suspended or terminated for ambulatory surgical services?
- Yes
- No
If “Yes,” explain:

________________________________________________________________________________
________________________________________________________________________________

7.2 Has the facility or any of its owners ever been excluded from state or federal programs?
- Yes
- No
If “Yes,” explain:

________________________________________________________________________________
________________________________________________________________________________

Nov 2009
7.3 Is the ASF authorized by CMS to bill Medicare using a hospital's Medicare facility code/NPI (i.e., the ASF is considered provider-based by Medicare and bills Medicare on a UB-04 claim form or its electronic equivalent, using a hospital's Medicare facility code/NPI.)

☐ Yes
☐ No

If "Yes," (i.e., the ASF is considered provider-based by Medicare) please answer questions 7.4 – 7.7 below, then skip to section 8.0
If “No,” (i.e., the ASF is considered non-provider-based/freestanding by Medicare) please skip to question 7.8 and answer questions 7.8 – 7.12.

**Provider-based ASFs complete questions 7.4 – 7.7**

7.4 Provide the facility’s Medicare information below:

- Hospital’s name __________________________________________________________
- Hospital’s address ______________________________________________________
- Hospital’s BCBSM hospital code __________________________________________
- Hospital’s federal Tax ID _________________________________________________
- Hospital’s Medicare Facility Code _________________________________________
- ASF’s Medicare effective date ____________________________________________

7.5 Attach a copy of the letter issued by CMS authorizing the facility to bill ASF services through the hospital’s Medicare facility code (i.e., approving the ASF as provider-based).

7.6 If the facility has had a Medicare recertification survey subsequent to the initial CMS certification, attach a copy of the most current state of Michigan survey report, or the follow-up letter (if applicable) that verifies the facility is in substantial compliance with all state and federal regulatory requirements.

7.7 If this application is being submitted due to a change of ownership, attach a copy of the CMS letter indicating authorization of the change of ownership.

**Freestanding (non-provider-based) ASFs complete questions 7.8 – 7.12**

7.8 Attach a copy of the letter issued by CMS that reflects the facility’s Medicare Certification status as a supplier of ambulatory surgical services and that includes the Supplier Number assigned.

7.9 If the facility has had a Medicare recertification survey subsequent to the initial CMS certification, attach a copy of the most current state of Michigan survey report, or the follow-up letter (if applicable) that verifies the facility is in substantial compliance with all state and federal regulatory requirements.

7.10 Is the ASF currently being reimbursed by BCBSM for ASF claims under BCBSM’s Medicare Supplemental coverage?

☐ Yes
☐ No

If Yes, indicate the BCBSM Medicare Supplemental PIN ________________________

7.11 Attach a copy of the letter issued by CMS that reflects the facility’s Medicare Part B Provider Identification Number (PIN) and its effective date.

7.12 If this application is being submitted due to a change of ownership, attach a copy of the CMS letter indicating authorization of the change of ownership.
8.0 **Staffing**

(Note: for purposes of this application only, the term “physician” includes MD/DO/DPM.)

8.1 **Attach a current staff roster with credentials (e.g., MD, DO, DPM, RN, etc.) job titles and full time equivalents (FTEs) for all professional/clinical staff (including physicians).**

8.2 **Attach copies of current Michigan licenses for all professional/clinical staff listed in 8.1. Note – it is only necessary to provide copies of licenses for ten physicians.**

8.3 Indicate the name of the physician director responsible for direction of medical care at the facility.

__________________________________________________________________________________

8.4 Medical director's specialty ____________________________

8.5 Indicate below whether the physician medical director is board certified or board eligible in the above specialty.

- ☐ Board Certified
- ☐ Board Eligible

8.6 Indicate whether the medical director is directly employed or contracted by the facility.

- ☐ Employed
- ☐ Contracted

8.7 Indicate the medical director's average number of hours worked per week at the ambulatory surgical facility. _______________

8.8 Is membership on the facility's medical staff available to qualified physicians in the community?

- ☐ Yes
- ☐ No

8.9 Is criteria for membership on the medical staff established and enforced by a credentials evaluation program established by the facility?

- ☐ Yes
- ☐ No

8.10 Is a Michigan licensed physician present on-site at all times when a patient is on the facility's premises?

- ☐ Yes
- ☐ No

8.11 **Attach a copy of the facility's policy and procedure regarding physician coverage during hours of operation.**

8.12 **Attach copies of policies defining the requirements and processes for obtaining physician surgical staff privileges at the facility.**
9.0 Surgical Specialties and Operating Rooms

9.1 Indicate below if the Ambulatory Surgery Facility is “single specialty” or “multiple specialties.
☐ Single specialty ASF (i.e., the facility performs surgery in one body system)
☐ Multiple specialty ASF specialty (i.e., the facility performs surgery in more than one body system.)

9.2 Indicate below the surgical categories of services currently available at the facility (check all that apply.)
☐ Auditory        ☐ Female Genital        ☐ Nervous
☐ Cardiovascular  ☐ Integumentary    ☐ Respiratory
☐ Digestive       ☐ Male Genital       ☐ Urinary
☐ Eye/Ocular Adnexa ☐ Musculoskeletal

9.3 Indicate below the total number of operating rooms the facility is currently licensed for. The definition of an “operating room” is the same definition used by the MDCH in its Annual Hospital Statistical Survey.

Total number of licensed operating rooms _____________

9.4 When the facility recently applied to BCBSM for an EON determination, did the facility indicate it would de-license operating rooms in order to meet BCBSM’s EON requirements?
☐ Yes
☐ No

If “Yes,” state the number of operating rooms indicated would be de-licensed: ___________________

9.5 Is the facility currently applying for Certificate of Need with the state of Michigan for additional operating rooms?
☐ Yes
☐ No

10.0 Transfer Agreements with Acute Care Hospitals

10.1 Indicate the name and location of the acute care hospital where the facility has a transfer agreement.
__________________________________________________________________________________
__________________________________________________________________________________

10.2 Indicate the average travel time from the facility to the acute care hospital indicated in 10.1 above and specify the mode of transportation (e.g., ambulance, car, helicopter, etc.)
__________________________________________________________________________________
__________________________________________________________________________________

10.3 Do the facility’s policies require that copies of the facility’s patient medical records be transmitted to the acute care hospital with the patient when the patient is transferred?
☐ Yes
☐ No

10.4 Attach a copy of the facility’s policy and procedure for emergency transfer to an acute care hospital. The document must include procedures for (but is not limited to): criteria for transfer, information to be sent with the patient, and who is to be notified in an emergency.

10.5 Attach a copy of the facility’s written transfer agreement with the acute care hospital identified in 10.1.
11.0 Medical Record Documentation

The medical record must contain documentation of the need for and the provision of all services rendered. All documentation must be clearly legible, signed, and dated.

11.1 Attach a copy of all of the facility's medical record forms.

11.2 Attach a copy of the policies and procedures that pertain to the facility's documentation requirements. This must include written policies and procedures for verbal and written orders.

11.3 Does the facility have a written policy describing the policies and procedures to be followed on the date of admission/surgery (e.g., checking for required pre-admission tests, history, current medications, allergies, discharge, etc.)?
☐ Yes
☐ No

11.4 Attach a copy of the facility's policies and procedures describing the procedures followed on the day of admission as indicated in 11.3 above.

12.0 Utilization Management

A utilization management system can result in improved member care and improved planning for more appropriate, effective, and efficient use of the facility's resources.

- The program must provide a written utilization evaluation system designed to review the appropriateness of admissions to the program, discharge practices, use of services, quality, timeliness and completeness of member records, and any other factors that may contribute to the effective utilization of program resources.

- Utilization management must be administered by a multidisciplinary committee of staff who provide direct member services. The committee shall meet at least on a quarterly basis.

- Written utilization management findings and recommendations should be made available to administrative and treatment staff for study and appropriate action.

12.1 Attach a copy of the facility's current utilization management policies and procedures.

12.2 Attach a copy of the names and credentials (i.e., MD, DO, RN, PT, etc.) of the Utilization Management Committee's members.

12.3 Attach minutes from the last two quarterly Utilization Management Committee meetings.

13.0 Financial and Billing Information

13.1 Does the facility maintain records of transactions that conform to generally accepted accounting principles?
☐ Yes
☐ No

13.2 Are billing charges uniformly applied (i.e., for identical services is the charge the same for all patients?)
☐ Yes
☐ No

If “No,” explain:
13.3 In the past five years, has the facility or any of its owners filed for a petition for relief under the U.S. Bankruptcy Code, or taken any action to dissolve, liquidate, terminate, consolidate, merge or sell all or substantially all of facility’s assets?
☐ Yes
☐ No

If “Yes,” explain:

__________________________________________________________________________________

13.4 Does the facility use a billing department or billing agency that is located outside Michigan?
☐ Yes
☐ No

If “Yes,” please indicate the contact person, company name, mailing address, telephone number, (and e-mail address if available) for the company or billing agency that is responsible for submitting claims for services provided at the facility.

Contact Person ________________________________
Company Name __________________________________
Mailing Address __________________________________
City __________________ State _______ Zip Code ______
Telephone Number (____) _______________________
E-mail Address __________________________________

14.0 Management Contracts

14.1 Does the facility have management contract(s) with an outside organization for the provision of core services (e.g., administrative services, staffing services, personnel management, etc.)
☐ Yes
☐ No

If “Yes,” please provide the name of the organization and describe the services provided by this outside entity in the space provided below. BCBSM may request a copy of the management contract at a later date.

__________________________________________________________________________________

15.0 Contact Person

15.1 Please give the following information for a contact person for any questions BCBSM may have regarding this application:

Name: __________________________________________
Title: __________________________________________
Address: _______________________________________
Telephone number: _____________________________
E-mail address: _________________________________
16.0 **Signature and Attestation**

I certify by my signature below that:

- I have reviewed the information in this application and to the best of my knowledge the answers given and the documents attached are a complete and accurate representation of this facility's operations.
- I understand that BCBSM may choose to do an on-site survey after review of this application to verify program compliance and to verify the accuracy of any information provided.
- All licenses for professional providers who provide direct patient care for this facility are current and valid in Michigan.
- Facility's Michigan license as a Freestanding Surgical Outpatient Facility is current and valid.
- Facility's accreditation is current and valid.
- Facility's Medicare certification as an extension of the hospital is current and valid (if applicable).
- Facility's Medicare certification as an Ambulatory Surgery Center is current and valid (if applicable).
- Facility is not currently an excluded entity by Medicare and does not employ individuals who are Medicare excluded individuals.
- The enclosed policies and procedures have been implemented and are enforced by this facility.
- The facility maintains financial records that conform to generally accepted accounting principles and practices.
- I understand the facility is not eligible to submit claims for payment under the Traditional or MA PPO programs until it is approved by BCBSM, both parties sign the participating agreement(s), BCBSM’s claims processing systems are activated, and the facility has received a copy of the countersigned agreement Signature Document(s) from BCBSM.
- I understand the effective date(s) for participation in the Traditional or MA PPO networks, if approved by BCBSM, is the date(s) designated by BCBSM and is not the date the application was sent or received.
- I understand BCBSM’s payment rates and the terms of its standard participation agreements are not negotiable.

**Note:** This application must be signed by the person at the facility who is responsible for the overall administration of the ambulatory surgery facility program.

**Authorized facility representative**

By ____________________________

(signature - required)

Name ____________________________

(print or type)

Title ____________________________

(print or type)

Date ____________________________

Return completed application with all attachments to:

Patricia Helfrick, RN
Blue Cross Blue Shield of Michigan
Provider Contracting - Mail Code 513E
600 E. Lafayette Blvd.
Detroit, MI 48226-2998
Checklist for Ambulatory Surgery Facility Application Attachments

- Federal Tax Deposit Coupon (form-8109), copy of the IRS notification letter (form SS4-147c), or EFTPS (form–9787)
- IRS document authorizing tax exempt status (if applicable)
- Facility's organizational chart
- Facility administrator's job description and qualifications
- Facility's governing board members and policy and procedures outlining the functions and responsibilities of the board
- Current JCAHO, AOA, or AAAHC accreditation certificate as an Ambulatory Surgical Facility
- Copy of accreditation extension letter to new owner for an ownership change (if applicable)
- Facility's Michigan license as a Freestanding Surgical Outpatient Facility
- If provider-based, the CMS letter authorizing the facility to bill ASF services through the hospital’s Medicare facility code
- If freestanding/non-provider-based, the CMS letter that reflects the facility’s status as a supplier of ambulatory surgical services
- If freestanding/non-provider-based, the CMS letter that reflects the facility’s Medicare Part B PIN and its effective date
- If the facility has had a Medicare recertification survey subsequent to the initial CMS certification, attach a copy of the most current state of Michigan survey report, or the follow-up letter (if applicable) that verifies the facility is in substantial compliance with all state and federal regulatory requirements.
- Medicare letter authorizing change of ownership (if applicable)
- Copy of the facility's current staff roster, with credentials, job titles, and full time equivalents
- Copies of current Michigan licenses for all professional/clinical staff. Note – it is only necessary to provide copies of licenses for ten physicians.
- Copy of the facility's policy and procedure regarding physician coverage during hours of operation
- Copies of policies defining requirements for obtaining physician surgical staff privileges at the facility
- Copy of the facility's policy and procedure for emergency transfer to an acute care hospital
- Copy of the facility’s written transfer agreement with an acute care hospital
- Facility’s medical record forms
- Facility’s policies and procedures pertaining to medical record documentation of ambulatory surgical procedures
- Copy of facility’s procedures followed on the day of admission
- Copy of facility’s utilization management policies and procedures
- Names and credentials of the utilization management committee’s members
- Copies of minutes from the last two quarterly utilization management committee meetings
- Attestation statement signed by an authorized facility representative