



**Office of Policy**

**Ambulatory  
Surgery Center  
Billing Guidelines**

Revised September 2021

**TABLE OF CONTENTS**

NEW CHANGES FOR 9/1/2021 ..... 4

1. AMBULATORY SURGERY CENTER BILLING OVERVIEW .....5

    1.1 PROVIDER ENROLLMENT ..... 6

    1.2 WEBINARS ..... 6

2. SPECIAL CASES BILLING INSTRUCTIONS .....6

    2.1 ADJUSTMENTS TO PAID CLAIMS ..... 6

    2.2 DENIED/PROBLEM CLAIMS ..... 7

    2.3 PRIOR AUTHORIZATION REQUIREMENTS..... 7

    2.4 UTILIZATION REVIEW – THIRD PARTY LIABILITY POST PAYMENTREVIEW ..... 8

    2.5 BILLING FOR SERVICES REQUIRING SPECIAL DOCUMENTATION ..... 9

        2.5.1 ABORTIONS .....9

        2.5.2 STERILIZATION ..... 10

        2.5.3 HYSTERECTOMY SERVICES ..... 10

    2.6 COORDINATION OF BENEFITS / THIRD PARTY LIABILITY .....11

        2.6.1 THIRD PARTY LIABILITY ..... 11

        2.6.2 NON-COOPERATIVE PATIENTS ..... 11

        2.6.3 MEDICARE PRIMARYS ..... 12

    2.7 NATIONAL CORRECT CODING INITIATIVE.....13

        2.7.1 EDITS ..... 13

        2.7.2 CORRECT CODING MODIFIER INDICATORS..... 13

        2.7.3 MODIFIERS 59, XE, XS, XP, AND XU ..... 13

2.7.4 MISCELLANEOUS ..... 14

3. ENHANCED AMBULATORY PATIENT GROUPS..... 14

3.1 MODIFIERS THAT AFFECT EAPG REIMBURSEMENT LOGIC .....15

3.2 CANCELLED SURGERY MODIFIER 73 AND MODIFIER 74 .....15

APPENDIX A – EAPG 835 AND REMITTANCE ADVICE EXAMPLES .....16

## **NEW CHANGES FOR 9/1/2021**

Underlined text indicates new language.

- The reference to ODM MITS Web Portal has been changed to "ODM Provider Web Portal" throughout this document. (Refer to Sections [1.1](#), [2.1](#), [2.2](#), [2.4](#), [2.5.1](#), [2.5.2](#), [2.5.3](#))
- Website links have been updated throughout the document. (Refer to Sections [1](#), [1.1](#), [2.1](#), [2.7.4](#))
- A clarification was added to the Adjustments to Paid Claims section. (Refer to Section [2.1](#))
- A clarification was added to the Denied/Problem Claims section. (Refer to Section [2.2](#))
- The contact information for the contracted vendor reviewing medical prior authorization requests has been updated. (Refer to Section [2.3](#))
- An introductory paragraph was added to the Billing for Services Requiring Special Documentation to clarify what additional documentation must be submitted. (Refer to Section [2.5](#))
- An update was added to the requests for providers for third party payers. (Refer to Section [2.7.3](#))
- An update was added to the National Correct Coding Initiative section. (Refer to Section [2.7.1](#), [2.7.3](#))
- A paragraph was removed to clarify Ambulatory Patient Groups. (Refer to Section [3](#))
- An update was added to the list of Modifiers that Affect EAPG Reimbursement Logic. (Refer to Section [3.1](#))

# 1. AMBULATORY SURGERY CENTER BILLING OVERVIEW

The Ohio Department of Medicaid (ODM) Ambulatory Surgery Center (ASC) Billing Guidelines contain basic billing information for Ohio Medicaid ASC providers regarding Fee-For-Service ASC facility claims. It is intended to be a supplemental guide to assist providers with specific Medicaid policy from a billing perspective when submitting a claim electronically or through the web portal.

ODM ASC Billing Guidelines are based on rules of the Ohio Administrative Code (OAC). Effective July 1, 2015, ODM is no longer publishing transmittal letters or utilizing eManuals, including the Ohio Department of Job and Family Services (ODJFS) Legal Policy Central Calendar.

Stakeholders who want to receive notification when ODM original or final files a rule package may visit the Ohio Joint Committee on Agency Rule Review's (JCARR) RuleWatch at [www.rulewatchohio.gov](http://www.rulewatchohio.gov) where an account can be created to be notified of rule actions by rule number or department.

Stakeholders can subscribe to receive notification when a clearance or business impact analysis (BIA) is posted for public comment on the Ohio Business Gateway here: <http://business.ohio.gov/reform/enotify/subscription.aspx>.

OAC rules are available at <http://codes.ohio.gov/oac/5160-22>

Per OAC rule 5160-1-19, all claims must be submitted to ODM through one of the following formats:

- (1) Electronic Data Interchange (EDI) in accordance with standards established under the Health Insurance Portability and Accountability Act (HIPAA) of 1996; or
- (2) The Medicaid Information Technology System (MITS) web portal.

Providers submitting claims electronically to ODM must use the most current version of the EDI 837 Professional (P) format. The official EDI standards for all EDI transactions are developed and maintained by the Accredited Standards Committee (ASC) X12. The ODM 837P Companion Guide has been created as a supplemental guide and can be accessed through ODM's EDI website at:

<https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/HIPAA-5010-implementation/companion-guides/guides>.

For additional information, please contact the Interactive Voice Response System (IVR) at 1-800-686-1516, or visit the Ohio Department of Medicaid website:

<http://www.medicaid.ohio.gov>.

## **1.1 PROVIDER ENROLLMENT**

All provider enrollments must be initiated through the ODM Provider Web Portal. More information regarding provider enrollment may be found at:

<https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/enrollment-and-support/provider-enrollment/provider-enrollment-lp>.

## **1.2 WEBINARS**

The Department has recorded webinars pertaining to the policy and reimbursement for ASCs.

An overview of the Enhanced Ambulatory Patient Group (EAPG) methodology can be viewed here: <https://attendee.gotowebinar.com/recording/5547934847121846795>

An overview about submitting Prior Authorizations can be viewed here: <https://attendee.gotowebinar.com/recording/1363716958699805953>.

## **2. SPECIAL CASES BILLING INSTRUCTIONS**

### **2.1 ADJUSTMENTS TO PAID CLAIMS**

An adjustment can be completed if there is missing or incorrect information on a claim. Through the ODM Provider Web Portal, the paid claim can be voided so the corrected claim can be submitted; this process can also be submitted through EDI.

Information pertaining to electronic adjustments submitted via EDI 837 transactions can be found on ODM's EDI website at:

<https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/HIPAA-5010-implementation/companion-guides/guides>.

When adjusting a claim, the code set originally used to submit the claim will be the code set used when adjusting the claim.

## 2.2 DENIED/PROBLEM CLAIMS

Denied or problem claims should be resubmitted to the Department through the ODM Provider WebPortal for reprocessing (indicate that the ODM 06653 Medical Claim Review Request Form is attached). The Medical Claim Review Request Form (ODM 06653) and instructions are available here: [Medicaid Forms](#).

The following are some examples of when this process must be used:

- Denied claims for clinical editor rejections (age/diagnosis conflicts) – also attach a copy of the Medicaid remittance advice showing the denial. On the ODM 06653 Medical Claim Review Request Form, indicate why the diagnosis code in question is used.
- Medicare Crossover/TPL primary denials – also attach the primary payer’s remittance advice for the denied claim, which will indicate the reason for the denial.
- Timely filing denials – also attach a copy of the remittance advice highlighting the claim in question as well as documentation to support timely filing.

## 2.3 PRIOR AUTHORIZATION REQUIREMENTS

Pursuant to Ohio Revised Code (ORC) 5160.34, a list of ASC services that require prior authorization is available on the ODM website (<http://medicaid.ohio.gov/PROVIDERS/PriorAuthorizationRequirements.aspx>). Examples of services that would require prior authorization include investigational/experimental procedures and plastic surgery. Prior authorization is not required when Medicare is the primary payer.

Prior authorization will be granted if a service that is typically not covered is proven to be medically necessary for a recipient. Per OAC rule 5160-1-11, Ohio Medicaid will cover medically necessary services rendered by out-of-state providers if those services are not available within Ohio; the services must be prior authorized to be performed by the out-of-state provider. More information regarding Medicaid’s prior authorization policy can be found in OAC rule 5160-1-31.

Procedures that require prior authorization are never exempt from prior authorization, so a retrospective review for PA can be requested. A claim submitted with a procedure code that requires a PA will never pay without an approved authorization.

If PA is required for both the ASC facility and Physician, only the ASC facility must obtain prior authorization. Either the ASC facility or the Physician/Physician group can request the prior authorization for the ASC. The important part is that the ASC facility’s NPI must be used in the ‘service provider’ field and the approved PA number must be submitted on the ASC facility claim. The PA number does not need to be included on the Physician claim.

Permedion is the contracted vendor responsible for reviewing medical prior authorization requests. For assistance with submitting a prior authorization request, please follow the directions located here: [Microsoft PowerPoint – Entering a PA 2017 \(ohio.gov\)](#).

## **2.4 UTILIZATION REVIEW – THIRD PARTY LIABILITY POST PAYMENT REVIEW**

The Department has contracted with Health Management Systems, Inc. (HMS) to supplement its Medicaid third party liability (TPL) recovery activities. Following their claim review, HMS will issue a notice of its findings. ASCs have 90 days from the date of the notice to:

- 1) Review its records;
- 2) Bill the respective commercial carrier, if it has not already done so; and
- 3) Forward documentation to HMS to either refute the impending recoupment action for every claim the commercial carrier denies or confirm receipt of payment from the third party to validate the impending recoupment.

Failure to respond to or provide proper justification for removing a claim from this initiative will result in the payment being recouped via the claims down adjustment process at the close of the cycle. In order to rebill the claim(s), providers must first seek authorization through HMS to validate the request. Providers who have repeatedly neglected to respond to recoupment cycles may be prevented from rebilling claims. The following documentation should be provided to HMS, when seeking to rebill the Department for refund or payment as secondary:

- 1) A copy of the cycle detail, highlighting the recipient's name and date of service; and
- 2) A copy of the explanation of medical benefits (EOMB) letter from the third party, reflecting the status of the claim(s).

This information should be sent by fax, to the HMS Recoupment Team at (877) 256-1226 with the subject line "Refund" or "Payment as Secondary," whichever applies. Please note that the list of valid requests is sent to ODM for action on the last Friday of each month. The list of ICNs is then removed by ODM from the table and will be given a new ICN number that starts with the region code 56. This new ICN number will be on a remittance advice and is to be put on the claim in the Portal when reprocessing.

When submitting your new claim to the Department via the ODM Provider Web Portal, put the ICN number with the region code 56 from your remittance advice in the supporting data for delayed resubmission field. When submitting via EDI, you must include the ICN number of the recoupment claim in the REF Segment P4. The claim will deny for timely filing if this is not included. After those steps are complete, follow the prompts until completion of your claim.

In the event you are still experiencing problems, complete the ODM 06653 form. In section 6 of this form ("Explanation of the Request"), put the statement "This is part of the HMS takeback



process.” Include the takeback EOMB/letter from HMS with the submission of the ODM 6653 form. When selecting the ‘ATTACHMENTS’ panel in the ODM Provider Web Portal, locate the ‘TYPE OF DOCUMENT’ field and choose ‘REFERRAL FORM (OHIO 6653)’ from the dropdown menu. This will allow the provider’s attachments to connect to the claim record, and suspend as designed for manual review.

For all claims, HMS determines if a provider can resubmit a claim to the Department for payment. The following EOBs will be assigned accordingly, and will only allow claims to be resubmitted as indicated.

- 1) EOB 8200: TPL Contractor recovery because Medicare is primary. Provider is not able to adjust claim and must contact TPL Contractor.
- 2) EOB 8201: TPL Contractor recovery because a Commercial Insurance is primary. Provider is not able to adjust claim and must contact TPL Contractor.
- 3) EOB 8210: TPL Contractor take reversal – Provider is able to resubmit for Medicare Cost Sharing.
- 4) EOB 8211: TPL Contractor take reversal – Provider is able to resubmit for Commercial Insurance Cost Sharing.

NOTE: When a claim can be resubmitted, and EOB 8210 or 8211 has been assigned, the resubmitted claims MUST include the ICN of the recoupment claim in the REF Segment P4. The resubmitted claim will deny for timely filing if this is not included.

## **2.5 BILLING FOR SERVICES REQUIRING SPECIAL DOCUMENTATION**

Medicaid Advisory Letter (MAL) No. 612, Guidelines for Completing Ohio Department of Medicaid Form ODM 03199, “Acknowledgment of Hysterectomy Information,” Ohio Department of Medicaid Form ODM 03197, “Abortion Certification Form,” and U.S. Department of Health and Human Services Form HHS-687, “Consent for Sterilization” provides additional guidance regarding what documentation must be submitted before Medicaid providers can receive payment for abortion, sterilization, or hysterectomy services. The MAL is located here: [Medicaid Handbook Transmittal Letter \(MHTL\) No \(ohio.gov\)](#).

### **2.5.1 ABORTIONS**

Please refer to OAC rule 5160-17-01 for ODM requirements regarding reimbursement of abortion procedures. The requirements of OAC rule 5160-17-01 apply only to those abortions, which are induced, and not to those of a spontaneous nature which are normally otherwise defined as miscarriages.

Reimbursement for abortion services is restricted to the following circumstances:

- 1) Instances in which the mother suffers from a physical disorder, physical injury, or

physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself; or

- 2) Instances in which the pregnancy was the result of an act of rape; or
- 3) Instances in which the pregnancy was the result of an act of incest.

Invoices for abortion services subject to the above requirements must be submitted through the ODM Provider Web Portal or through EDI with the ODM 03197 form attached. Reimbursement will not be made for ASC facility services, associated services, or laboratory tests if the abortion service is not eligible for reimbursement, regardless of whether the abortion itself is billed to the Department.

### **2.5.2 STERILIZATION**

Please refer to OAC rule 5160-21-02.2 for ODM requirements regarding reimbursement of sterilization procedures. The OMB 0937-0166 Consent for Sterilization Form must be attached to all claims for sterilization procedures. The Consent for Sterilization Form should always be obtained, in case the patient becomes Medicaid eligible retrospectively. For the sterilization services to be reimbursed, the date of the informed consent must occur at least 30 days, but not more than 180 days, prior to the date of the sterilization; this is not applicable in cases of premature delivery or emergency abdominal surgery. These claims can be submitted through the ODM Provider Web Portal with the appropriate attachment or through EDI indicating the appropriate attachment will be submitted separately.

### **2.5.3 HYSTERECTOMY SERVICES**

Please refer to OAC rule 5160-21-02.2, which describes the requirements regarding reimbursement for hysterectomy services. All invoices submitted to the Department for hysterectomies (whether performed as a primary or secondary procedure) or for medical procedures directly related to such hysterectomies, must include a copy of the ODM 03199 Acknowledgement of Hysterectomy Information Form. A consent form must be completed when a recipient is eligible for both the Medicare and Medicaid programs and requires a hysterectomy. However, a hysterectomy consent form should always be obtained, in case the patient becomes Medicaid eligible retrospectively. The completed consent form does not have to be submitted with the Medicare crossover claim, but must be forwarded separately to Medicaid as an attachment. If the claim is rejected by Medicare, submit a Medicaid claim with the Medicare rejection attached. In the "Provider Remarks" section of the invoice, enter the following: Consent form submitted (date submitted).

All hysterectomies also require prior authorization. Prior authorization allows all providers the opportunity to submit a prior authorization request, even retrospectively.

All invoices for hysterectomies, along with an attached ODM 03199 Acknowledgement of Hysterectomy Information Form, can be submitted through the ODM Provider Web Portal with

the appropriate attachment or through EDI indicating the appropriate attachment will be submitted separately.

## **2.6 COORDINATION OF BENEFITS / THIRD PARTY LIABILITY**

### **2.6.1 THIRD PARTY LIABILITY**

For Medicaid to pay secondary or tertiary, the primary payer's conditions of participation must be followed. For example, if the primary payer denies a claim because the patient went out of network or the services did not meet the primary payer's medical necessity requirements, Medicaid will not be responsible for those charges. Please refer to OAC rules 5160-1-05 and 5160-1-08 for further information regarding Medicaid coordination of benefits policies.

For claims where another payer is primary, Medicaid's reimbursement will be no more than the Medicaid Maximum. If the prior payer has already paid more than the Medicaid Maximum, Medicaid's payment will be \$0.00.

### **2.6.2 NON-COOPERATIVE PATIENTS**

Providers must bill third-party insurance companies prior to billing Medicaid. Providers who are attempting to work with "uncooperative" recipients also have the option to contact the administrative agency (County Department of Job and Family Services or CDJFS) and speak with the recipient's case worker about the recipient's lack of cooperation in regard to complying with requests regarding third party insurance. If the recipient's caseworker is unresponsive to the provider's request for assistance for a TPL issue, the provider may contact the caseworker's supervisor to address the issue.

OAC rule 5160-1-13.1, Medicaid Recipient Liability, describes circumstances under which a provider may "bill" Ohio Medicaid recipients. In accordance with OAC rule 5160-1-13.1(C), Providers are not required to bill the Ohio Department of Medicaid (ODM) for medicaid-covered services rendered to eligible recipients. However, providers may not bill recipients in lieu of ODM unless:

- 1) The recipient is notified in writing prior to the service being rendered that the provider will not bill ODM for the covered service; and
- 2) The recipient agrees to be liable for payment of the service and signs a written statement to that effect prior to the service being rendered; and
- 3) The provider explains to the recipient that the service is a covered medicaid service and other medicaid providers may render the service at no cost to the recipient."

In addition, there are recent updates to OAC rules that may help encourage recipients to comply with the required requests from providers and third-party payers.

- 1) OAC rule 5160:1-2-10, Medicaid: Conditions of Eligibility and Verifications
  - a. OAC rule 5160:1-2-10(B)(7)(a): The recipient must cooperate with requests from a third-party insurance company to provide additional information that is required to authorize coverage or obtain benefits through the third-party insurance company.
  - b. OAC rule 5160:1-2-10(B)(7)(b): The recipient must cooperate with requests from a Medicaid provider, managed care plan, or a managed care plan's contracted provider to provide additional information that is required for the provider or plan to obtain payments from a third-party insurance company for Medicaid covered services.
  - c. OAC rule 5160:1-2-10(B)(7)(c): The recipient must cooperate with requests from a third-party insurance company, Medicaid provider, managed care plan, or a managed care plan's contracted provider to forward or return to the third-party insurance company, Medicaid provider, managed care plan, or managed care plan's contracted provider any payments received from the third-party insurance company for Medicaid covered services when the provider has billed the third-party insurance company for Medicaid covered services provided to the recipient and the third-party insurance company has sent payment to the recipient for Medicaid covered services the recipient received from the provider.
  
- 2) OAC rule 5160:1-2-01, Medicaid: Administrative Agency Responsibilities
  - a. If information needed to determine a recipient's initial or continuing eligibility for a medical assistance program must be verified, but was not submitted with the application, the administrative agency must deny an application for medical assistance or terminate eligibility if a recipient fails or refuses, without good cause, after two verification requests to cooperate by providing necessary verifications or by providing consent for the administrative agency to obtain verifications.

Providers may communicate with recipients about their responsibility to provide information that is required in order to maintain their eligibility in the medical assistance program, such as verifying third party coverage.

### **2.6.3 MEDICARE PRIMARYS**

For claims where Medicare is primary, Medicaid reimbursement is limited to the lesser of the required Medicare cost sharing or the Medicaid maximum payment. For complete details on how these calculations are made please refer to OAC rule 5160-1-05.3, Payment for "Medicare Part B" cost sharing, or OAC rule 5160-1-05.1, Payment for "Medicare Part C" cost sharing.

## **2.7 NATIONAL CORRECT CODING INITIATIVE**

ODM follows the National Correct Coding Initiative (NCCI), which is a national program that consists of coding policies and edits, that are applied against claims for procedures/services performed by the same provider for the same recipient on the same date of service. The NCCI analyzes and edits claims based upon Current Procedural Terminology (CPT)/Healthcare Common Procedure Coding System (HCPCS) codes reported by ASC providers for procedures/services rendered to Medicaid recipients.

### **2.7.1 EDITS**

NCCI methodologies consists of two types of edits:

- 1) Procedure to Procedure (PTP): Edits that define pairs of CPT/HCPCS codes that should not be reported together. NCCI methodologies for this edit are applied to current and historical claims.
- 2) Medically Unlikely Edits (MUEs): Edits that define, for many CPT/HCPCS codes, the maximum number of units of service that are, under most circumstances, billable by the same provider, for the same recipient on the same date of service.

### **2.7.2 CORRECT CODING MODIFIER INDICATORS**

There are two Correct Coding Modifier Indicators (CCMI):

- 1) CCMI 0: The reported CPT codes should never be reported together by the same provider for the same recipient on the same date of service.
- 2) CCMI 1: The reported CPT codes may be reported together only in defined circumstances which are identified on the claim using specific NCCI-associated modifiers.

PTP edit files include a column which identifies whether the combination of CPT codes billed is allowed with a CCMI (0 = not allowed, 1 = allowed, 9 = not applicable).

### **2.7.3 MODIFIERS 59, XE, XS, XP, AND XU**

The following modifiers provide greater reporting specificity in situations where modifier 59 was previously reported. Modifier 59 is an accepted modifier on ASC facility claims.

NCCI will eventually require the use of these modifiers rather than modifier 59 with certain edits. The following modifiers may be utilized in lieu of modifier 59 whenever possible:

- 3) XE - "Separate Encounter: A service that is distinct because it occurred during a separate encounter." This modifier should only

be used to describe separate encounter on the same date of service.

- 4) XS – “Separate Structure: A service that is distinct because it was performed on a separate organ/structure.”
- 5) XP – “Separate Practitioner: A service that is distinct because it was performed by a different practitioner.”
- 6) XU – “Unusual Non-Overlapping Service: The use of a service that is distinct because it does not overlap usual components of the main service.”

#### **2.7.4 MISCELLANEOUS**

Billed detail claim lines with a unit-of-service value greater than the established MUE value for the CPT/HCPCS code OR a pair of CPT/HCPCS codes that should not be reported together will result in that detail line being denied for payment.

All currently active Medicaid PTP edits and MUEs, as well as information about the NCCI program are published on the Medicaid NCCI webpage at: <https://www.medicaid.gov/medicaid/program-integrity/ncci/index.html>. These files are updated on a quarterly basis. The PTP edit files contain the effective date of every edit and the deletion date of prior edits. This information can be used to verify whether a PTP edit was valid on the date of service of the claim in question and whether use of a PTP associated modifier would allow the claim to bypass the edit. The MUE edit files are applicable to claims processed in the current quarter and with dates of service in the current quarter. MUE edit files do not contain historical information.

It is important that providers access the Medicaid NCCI edit file at the above webpage and not the Medicare NCCI files on the CMS webpage. Medicaid NCCI edits are significantly different from Medicare NCCI edits.

### **3. ENHANCED AMBULATORY PATIENT GROUPS**

ASC facility services are subject to a prospective payment methodology utilizing the Enhanced Ambulatory Patient Group (EAPG) system maintained by 3M Health Information Systems.

CPT and HCPCS codes will be updated annually on January 1 of each year. Providers that submit ASC facility claims with from/through dates that span January 1 of the given year, should bill these services using two separate claims:

- 1) One claim should be submitted for ASC services with dates of service prior to January 1 of the given year; and
- 2) One claim should be submitted for ASC services with dates of service on or after January 1 of the given year.

Example remittance advices are provided in [Appendix A](#).

### 3.1 MODIFIERS THAT AFFECT EAPG REIMBURSEMENT LOGIC

Modifier	Description	EAPG Function
25	Distinct Service	Allows assignment of a medical visit EAPG on the same claim/day as a significant procedure EAPG (Distinct and Separate Medical Visit + Significant Procedure)
27	Multiple E/M Encounters	Allows assignment of additional medical visit/services ancillary EAPG (Distinct and Separate Medical Visit {E&M} + Medical Visit)
50	Bilateral Procedure	Flags a code for additional payment (150%)
52	Terminated Procedure	Flags a code for terminated procedure discounting
59	Separate Procedure	Turns off consolidation – allows separate payment
73	Terminated Procedure	Flags a code for terminated procedure discounting
<u>JW</u>	<u>Drug/Biological Waste</u>	<u>Causes line to pay \$0</u>
PA, PB, PC	Never Event Modifiers	Causes line to not pay

### 3.2 CANCELLED SURGERY MODIFIER 73 AND MODIFIER 74

Modifier 73 should be used when a surgery is canceled prior to the administration of anesthesia while modifier 74 should be used when a surgery is canceled after the administration of anesthesia. The canceled surgery modifiers are only to be used when the entire scheduled surgery is canceled.

If more than one surgical procedure was scheduled to be performed during the surgery and at least one surgical procedure was performed, then the performed surgical procedure will be reimbursed. If it was determined during the surgery that one of the scheduled surgical procedure(s) was no longer necessary, but another surgical procedure was completed, then the surgery is not recognized as a canceled surgery. In this scenario, it is inappropriate to bill for the surgical procedure that was not performed.

# APPENDIX A – EAPG 835 AND REMITTANCE ADVICE EXAMPLES

## A.1 Paid Claim

Physician Claim			Top Nav ? A X		
ICN	2217136000104	Claim Type	PROFESSIONAL	*Status	PAID
Prev ICN	[Dropdown]	*Prov ID	[Redacted] NPI [Search]	*FDOS	07/14/2017
*Recipient ID	[Redacted] Search	Prov Type	46-AMBULATORY SURG	*TDOS	07/14/2017
Last Name	[Redacted]	Prov Spec	466-AMBULATORY SUR	Hosp FDOS	[Empty]
First Name	[Redacted]	Ref Prov1 ID	[Empty] [Search]	Hosp TDOS	[Empty]
DOB	[Redacted]	Ref Prov2 ID	[Empty] [Search]	Accident Date	[Empty]
Medicaid ID	[Redacted]	Signature	YES	*Date Billed	05/16/2017
Cert #	[Empty]	Accident	Yes	Copay Code	[Empty]
MRN	[Empty]	PAN	0	Date Paid	05/22/2017
RA Number	70308813	Submitter ID	[Empty]	Attachment	[Empty]
Referral Number	[Empty]	PA Number	[Empty]	Txn Type	[Empty]
		ICD Version	10	ClaimDiagnosis	01 - F321
			Display Claim XML	Copy	

EAPG														Top Nav ? A X		
Detail Number	Detail FDOS	Procedure	MOD1	MOD2	MOD3	MOD4	Allowed Units	EAPG Version	Initial EAPG	Final EAPG	Type	Category	Pay Action	Weight	Payment Amount	
1	07/14/2017	77014					1	3.9.16.4	00473	00473	4	25	02A	0.9086	\$53.62	
Detail Number	1	77014 - CT SCAN FOR THERAPY GUIDE					Detail FDOS	07/14/2017								
Procedure	77014	- CT SCAN FOR THERAPY GUIDE					Mod2	-								
Mod1	-						Mod4	-								
Mod3	-						EAPG Version	3.9.16.4								
Allowed Units	1						Final EAPG	00473 - CT GUIDANCE								
Initial EAPG	00473	CT GUIDANCE					Category	25 - RADIOLOGY								
Type	4	ANCILLARY					Weight	0.9086								
Pay Action	02A	FULL PAYMENT														
Payment Amount	\$53.62															

```

CLP*0*1*100*53.62*0*MC*2217136000104*24***0~
NM1*QC*1*[Redacted]
NM1*82*2*****XX*[Redacted]~
DTM*232*20170714~
DTM*233*20170714~
SVC*HC:77014*100*53.62**1~
DTM*472*20170714~
CAS*CO*45*46.38*0~
REF*1S*00473~
REF*HPI*[Redacted]~
AMT*B6*53.62~
    
```

RECIPIENT ID:	[Redacted]	RECIPIENT NAME:	[Redacted]	COUNTY:	02 ALLEN	MED REC NUM:	
CHARGE SOURCE:	EAPG						
2217136000104	071417	071417	100.00	53.62	0.00	0.00	0.00
0							53.62
SERVICE DATES	FROM	THRU	PL SERV	PROC CD	MODIFIERS	UNITS	FINAL EAPG
	071417	071417	24	77014		1.00	00473
						BILLED AMOUNT	100.00
						ALLOWED AMOUNT	53.62
						TPL AMOUNT	0.00
						PAID AMOUNT	53.62
						RENDERING PROVIDER	MCD [Redacted]



## A.2 Denied Claim

Physician Claim				Top Nav ? A X	
ICN	2217136000110	Claim Type	PROFESSIONAL	*Status	DENIED
Prev ICN		*Prov ID	[REDACTED] NPI [ Search ]	*FDOS	07/13/2017
*Recipient ID	[REDACTED] [ Search ]	Prov Type	46-AMBULATORY SURG	*TDOS	07/13/2017
Last Name	[REDACTED]	Prov Spec	466-AMBULATORY SUR	Hosp FDOS	
First Name	[REDACTED]	Ref Prov1 ID	[ Search ]	Hosp TDOS	
DOB	[REDACTED]	Ref Prov2 ID	[ Search ]	Accident Date	
Medicaid ID	[REDACTED]	Signature	YES	*Date Billed	05/16/2017
Cert #		Accident	Yes	Copay Code	
MRN	[REDACTED]	PAN	0	Date Paid	05/22/2017
RA Number	70308813	Submitter ID		Attachment	
Referral Number		PA Number		Txn Type	
		ICD Version	10	ClaimDiagnosis	01 - A040
			<a href="#">Display Claim XML</a> <a href="#">Copy</a>		
			<b>Details</b> 1		
			<b>Billed</b> \$10.00		
			<b>Net Billed</b> \$0.00		
			<b>Header TPL</b> \$0.00		
			<b>Submitted PL/SD</b> \$0.00		
			<b>Allowed Amt</b> \$0.00		
			<b>Total Detail TPL</b> \$0.00		
			<b>TPL Rec Amt</b> \$0.00		
			<b>Spenddown</b> \$0.00		
			<b>Copay</b> \$0.00		
			<b>Paid</b> \$0.00		

EAPG														Top Nav ? A X	
Detail Number	Detail FDOS	Procedure	MOD1	MOD2	MOD3	MOD4	Allowed Units	EAPG Version	Initial EAPG	Final EAPG	Type	Category	Pay Action	Weight	Payment Amount
1	07/13/2017	77014	TW				0							0	\$0.00
<b>Detail Number</b> 1								<b>Detail FDOS</b> 07/13/2017							
<b>Procedure</b> 77014 - CT SCAN FOR THERAPY GUIDE															
<b>Mod1</b> TW -								<b>Mod2</b> -							
<b>Mod3</b> -								<b>Mod4</b> -							
<b>Allowed Units</b> 0								<b>EAPG Version</b>							
<b>Initial EAPG</b> -								<b>Final EAPG</b> -							
<b>Type</b> -								<b>Category</b> -							
<b>Pay Action</b> -								<b>Weight</b> 0							
<b>Payment Amount</b> \$0.00															

```

CLP*0*4*10*0*0*MC*2217136000110*24***0~
NM1*QC*1*[REDACTED]**MR*[REDACTED]
NM1*82*2*****XX*[REDACTED]~
DTM*232*20170713~
DTM*233*20170713~
SVC*HC:77014:TW*10*0**0**1~
DTM*472*20170713~
CAS*OA*18*10*0~
REF*HPI*[REDACTED]~
  
```

RECIPIENT ID:	[REDACTED]	RECIPIENT NAME:	[REDACTED]	COUNTY:	02 ALLEN	MED REC NUM:	
CHARGE SOURCE:	EAPG						
	2217136000110	071317	071317	10.00	0.00	0.00	
SERVICE DATES							
FROM	THRU	PL SERV	PROC CD	MODIFIERS	UNITS	FINAL EAPG	BILLED AMOUNT
071317	071317	24	77014	TW	1.00		10.00
							TPL AMOUNT
							0.00
							RENDERING PROVIDER
							[REDACTED]
							DETAIL EOB# 0482