ATTACHMENTS
FREE STANDING AMBULATORY SURGICAL CENTER (FSASC) SERVICES

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MABB-087-004-0
Date: 9/1/87

Free Standing Ambulatory Surgical Center Services

FORM APPROVED OMB NO 0938 0008

HEALTH INSURANCE CLAIM FORM

(CHECK APPLICABLE PROGRAM BLOCK BELOW)

MEDICARE (MEDICARE NO.)	MEDICAID (MEDICAID NO.)	CHAMPUS (SPONSOR'S SSN)	CHAMPVA (VA FILE NO.)	FECA BLACK LUNG (SSN)	OTHER (CERTIFICATE SSN)
[ ]	[P]	[ ]	[ ]	[ ]	[ ]

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Recipient Im A.
2. PATIENT'S DATE OF BIRTH: MM | DD | YY
3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL): Same
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown WI 53725
   TELEPHONE NO
5. PATIENT'S SEX: MALE [X] FEMALE [ ]
6. INSURED'S I.D. NO. (FOR PROGRAM CHECKED ABOVE INCLUDE ALL LETTERS): 1234567890
7. PATIENT'S RELATIONSHIP TO INSURED: SELF [X] SPOUSE [ ] CHILD [ ] OTHER [ ]
8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)
   [ ] INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER): OI - P
10. WAS CONDITION RELATED TO:
    A. PATIENT'S EMPLOYMENT: YES [ ] NO [X]
    B. ACCIDENT: AUTO [ ] OTHER [X]
11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE): M - 6
    TELEPHONE NO.
11a. CHAMPUS SPONSOR'S STATUS: [ ] ACTIVE DUTY [ ] DECEASED [ ] RETIRED — BRANCH OF SERVICE
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW
    SIGNED / DATE / / / / / / /
13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW
    SIGNED (INSURED OR AUTHORIZED PERSON) / / / / / / / /

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ◄ ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)
15. DATE FIRST CONSULTED YOU FOR THIS CONDITION
16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES / / / / / / / / / /
16a. IF EMERGENCY CHECK HERE [ ]
17. DATE PATIENT ABLE TO RETURN TO WORK / / / / / / /
18. DATES OF TOTAL DISABILITY FROM / / / / / / / / / THROUGH / / / / / / / / /
    DATES OF PARTIAL DISABILITY FROM / / / / / / / / THROUGH / / / / / /
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY)
20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED / DISCHARGED
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE)
22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES [ ] NO [ ] CHARGES
23. A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE NUMBERS 1, 2, 3, ETC. OR DX CODE
    1. 216.5
    2.
    3.
    4.
    B. EPSDT YES [ ] NO [X]
    FAMILY PLANNING YES [ ] NO [X]
    PRIOR AUTHORIZATION NO

24. A. DATE OF SERVICE FROM / TO	B.* PLACE OF SERVICE	C. PROCEDURE CODE (IDENTIFY)	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G.* T.O.S.	H. LEAVE BLANK
06/10/88	B	11401	EXCISION BENIGN 0.6 CM		XX XX	1.0	F	
								Patient Spenddown $

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS) (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF)
    DATE MM/DD/YY I.M. PROVIDER
26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) / / YES [ ] / [ ] NO / /
27. TOTAL CHARGE: XX XX
28. AMOUNT PAID: XX XX
29. BALANCE DUE: XX.XX
30. YOUR SOCIAL SECURITY NO.
31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.: I.M. Billing, 1 W Williams, Anytown WI 53725
    I.D. NO. 87654321
32. YOUR PATIENT'S ACCOUNT NO.: 1234JED
33. YOUR EMPLOYER I.D. NO. / / / / / / / / / / /

* PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK
REMARKS:

APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 6/83

Form HCFA-1500 (C-2) (1-84) Form OWCP-1500
Form CHAMPUS-501 Form RRB-1500

790-002/7 (2-PLY)

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS FOR FREE STANDING AMBULATORY SURGICAL CENTERS

* *

To avoid unnecessary denial or inaccurate claim payment, providers must utilize the following claim form completion instructions. Enter all required data on the face of the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless 'optional' or 'not required' is specified.

Wisconsin medical assistance recipients receive a medical assistance ID card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. This card should always be presented prior to rendering the service. Please use the information exactly as it appears on the ID card to complete the Patient and Insured (subscriber) Information section.

Program Block/Claim Sort Indicator

Enter the appropriate **CLAIM SORT INDICATOR** for the service billed in the Medicaid check box in the upper left-hand corner of the claim form. Claims submitted without this indicator are denied.

'D' - Corrective Shoes
- Durable Medical Equipment (unless dispensed by a therapist)
- Hearing Aids

'M' - Independent Nurse
- Mental Health - 51.42 Board Operated AODA, Day Treatment, Psychotherapy
- Nurse Midwife
- Rehabilitation Agency
- Community Care Organization

'P' - Chiropractor
- Family Planning
- Free Standing Ambulatory Surgery Center

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NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR FREE STANDING AMBULATORY SURGICAL CENTERS

* *

- Independent Laboratory and Radiology
- Mental Health - Non-51.42 Board Operated AODA, Day Treatment, Psychotherapy
- Physician
- Rural Health Agency

'T' - Therapy - Occupational, Physical, Speech and Hearing
- Durable Medical Equipment Dispensed by Occupational, Physical or Speech Therapist

'V' - Vision - Optometrist, Optician, Dispensing Ophthalmologist

ELEMENT 1 - PATIENT NAME
Enter the recipient's last name, first name and middle initial as it appears on his/her current medical assistance identification card.

ELEMENT 2 - PATIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., January 5, 1978 would be 01/05/78) as it appears on his/her medical assistance identification card.

ELEMENT 3 - INSURED'S NAME
If the recipient's name (element #1) and insured's name (element #3) are the same, enter 'SAME' or leave the element blank. When billing for a <u>newborn</u>, enter the mother's last name, first name, middle initial and date of birth in MM/DD/YY format.

ELEMENT 4 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence; if the recipient is a resident of a nursing home, enter the name and address of the nursing home.

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NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR FREE STANDING AMBULATORY SURGICAL CENTERS

* *

ELEMENT 5 - PATIENT'S SEX
Specify if male or female with an 'X'.

ELEMENT 6 - INSURED'S ID NUMBER
Enter the recipient's ten digit medical assistance ID number as found on his/her medical assistance identification card.

ELEMENT 7 - PATIENT'S RELATIONSHIP TO INSURED (not required)

ELEMENT 8 - INSURED'S GROUP NUMBER (not required)

ELEMENT 9 - OTHER INSURANCE
Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP if the service is one of those identified in the Billing Information section of the WMAP Provider Handbook, Part A. When the recipient's medical assistance card indicates other coverage, one of the following codes MUST be indicated. The description is not required, nor is the policyholder, plan name, group number, etc.

Code	Description
OI-P	PAID by other insurance
OI-D	DENIED by other insurance, benefits exhausted, deductible not reached, non-covered service, etc.
OI-C	Recipient or other party will NOT COOPERATE
OI-S	SENT claim, but insurance company did not respond
OI-R	RECIPIENT denies coverage
OI-E	ERISA plan denies being prime
OI-A	Benefits NOT ASSIGNABLE
OI-H	Denied payment. Private health maintenance organization (HMO) or health maintenance plan (HMP) denied payment due to one of

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR FREE STANDING AMBULATORY SURGICAL CENTERS

* *

the following: non-covered/family planning service, or paid amount applied to the recipient's coinsurance/deductible.

If the recipient's medical assistance card indicates no other coverage, the element may be left blank.

ELEMENT 10 - IS CONDITION RELATED TO
If the condition is the result of an employment-related, auto or other accident, enter an 'X' in the appropriate box for items 'A' and 'B'.

ELEMENT 11 - INSURED'S ADDRESS
This element is used by the WMAP for Medicare information. Medicare must be billed prior to the WMAP. When the recipient's medical assistance card indicates Medicare coverage, one of the following Medicare disclaimer codes MUST be indicated. The description is not required.

Code	Description
M-1	Medicare benefits exhausted
M-5	Provider not Medicare certified
M-6	Recipient not Medicare eligible
M-7	Service denied/rejected by Medicare
M-8	Not a Medicare benefit

If the recipient's medical assistance card indicates no Medicare coverage, this element may be left blank.

ELEMENT 11A - (not required)

ELEMENTS 12 - 13
(Not required, provider automatically accepts assignment through medical assistance certification.)

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NATIONAL HCFA 1500 CLAIM FORM
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* *

ELEMENT 14 - DATE OF ILLNESS OR INJURY (not required)

ELEMENT 15 - DATE FIRST CONSULTED FOR CONDITION (not required)

ELEMENT 16 - (not required)

ELEMENT 16A - EMERGENCY
Enter an 'X' if emergent.

ELEMENT 17 - (not required)

ELEMENT 18 - (not required)

ELEMENT 19 - REFERRING PHYSICIAN
This is an optional element. The name and provider number of the physician performing the service may be entered in this element, if available.

ELEMENT 20 - HOSPITALIZATION DATES (not required)

ELEMENT 21 - NAME AND ADDRESS OF FACILITY (not required)

ELEMENT 22 - LAB WORK, PLACE OF SERVICE (not required)

ELEMENT 23A - DIAGNOSIS
The International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. List the primary diagnosis first. Etiology ('E') codes may not be used as a primary diagnosis.

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ELEMENT 23B - EPSDT/FAMILY PLANNING INDICATOR/PRIOR AUTHORIZATION NUMBER

EPSDT

If the services were performed as a result of an EPSDT/HealthCheck referral, check 'YES'; otherwise check 'NO'. EPSDT/HealthCheck indicators may not be left blank; a positive or negative response must be indicated.

Family Planning

If the recipient is receiving family planning services only, enter an 'X' in 'YES'. If none of the services are related to family planning, enter an 'X' in 'NO'.

NOTE: If the services reported are a combination of family planning services and services related to other diagnoses, the family planning indicators must be left blank.

To ensure accurate reporting of family planning services (enabling the State to receive Federal Financial Participation monies), the Diagnosis Code Reference must be utilized. Please refer to 'Diagnosis Code Reference' - element 24D for detailed instructions on the use of this claim form element.

Prior Authorization

The seven digit prior authorization number from the approved prior authorization form must be entered in element 23B. The physician performing the service is responsible for obtaining prior authorization where WMAP guidelines require it. The FSASC is responsible for obtaining the prior authorization number from the physician. Refer to Attachment 6 for the list of services subject to prior authorization.

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NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
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* *

ELEMENT 24 - SERVICES

Element 24A - Date of Service

In column A, enter the month, day and year in MMDDYY format for each procedure. It is allowable to enter up to four dates of service per line item for each procedure if:

* All dates of service are in the same calendar month.
* All procedures performed are identical.
* All procedures were performed by the same provider.
* The place and type of service is identical for all procedures.
* The same diagnosis is applicable for each procedure.
* The charge for all procedures is identical. (Enter the charge per service following the description in element 24C.)
* The number of services performed on each date of service is identical.

Element 24B - Place of Service

Enter the appropriate place of service code in column B for each service. Refer to Attachment 4 of this bulletin for a list of allowable place of service codes for FSASC providers.

Element 24C - Procedure Code and Description

Enter the appropriate procedure code and matching description of the service performed. Enter a written description which is concise, complete and specific.

NOTE: Ambulatory surgery center providers are allowed only one maximum allowable fee per day per recipient. A list of allowable procedures and applicable medical assistance maximum fees is included in Attachment 3 and 3a. No separate reimbursement is made for injection, laboratory or radiology services.

ATTACHMENT 2
NATIONAL HCFA 1500 CLAIM FORM
COMPLETION INSTRUCTIONS
FOR FREE STANDING AMBULATORY SURGICAL CENTERS

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Element 24D - Diagnosis Code Reference

When multiple procedures relating to the diagnoses are submitted, column D must be utilized to relate the procedure performed (element 24C) to a specific diagnosis in element 23A.

The diagnosis code itself may be entered in column D, or enter the line number from element 23A (i.e., 1, 2, 3 or 4) of the appropriate diagnosis as shown on the claim example.

Element 24E - Charges

Enter the total charge for each line item.

Element 24F - Days or Units

Enter the total number of services billed on each line item.

Element 24G - Type of Service (TOS)

Enter the appropriate type of service code. Refer to Attachment 4 of this bulletin for a list of allowable type of service codes for FSASC providers.

Element 24H - Recipient Spenddown

Enter the spenddown amount, when applicable, on the last detail line of element 24H directly above element 29. Refer to MAPB-087-037-X dated September 1, 1987 for information on recipient spenddown.

ELEMENT 25 - PROVIDER SIGNATURE AND DATE

The provider or the authorized representative must sign in element 25. The month, day and year the form is signed must also be entered.

NOTE: This may be a computer printed name and date, or a signature stamp.

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NATIONAL HCFA 1500 CLAIM FORM
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* *

ELEMENT 26 -
(Not required, provider automatically accepts assignment through medical assistance certification.)

ELEMENT 27 - TOTAL CHARGE
Enter the total charges for this claim.

ELEMENT 28 - AMOUNT PAID
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00.

ELEMENT 29 - BALANCE DUE
Enter the balance due as determined by subtracting the amount in element 24H and element 28 from the amount in element 27.

ELEMENT 30 - (not required)

ELEMENT 31 - PROVIDER NAME AND ID NUMBER
Enter the name, address, city, state and zip code of the billing provider. At the bottom of element 31 enter the billing provider's eight digit provider number.

ELEMENT 32 - PATIENT ACCOUNT NUMBER
Optional - provider may enter the patient's internal office account number. This number will appear on the EDS Remittance and Status Report (maximum of twelve characters).

ELEMENT 33 - (not required)

ATTACHMENT 3
HCPCS PROCEDURE CODE LIST FOR FREE STANDING AMBULATORY SURGICAL CENTERS (FSASC)

* *

All claims submitted on and after January 1, 1988 require codes from the HCFA Common Procedure Code System (HCPCS). The following list identifies procedures by a specific category of service which are allowable for FSASC's. Procedure codes not on this list may be considered for payment by submitting a written request and a claim to the WMAP's medical consultant. Requests should be mailed to the Bureau of Health Care Financing, P.O. Box 309, Madison, WI 53701. Procedures which are deemed unsafe for provision in a physician office setting but which do not require hospitalization will be considered for payment.

The WMAP reimburses FSASC's on a "Level of Payment" basis. Reimbursement is as follows: Level I - $75.00, Level II - $150.00, Level III - $225.00, and Level IV - $325.00.

Description	Procedure Code (TOS F)	Level of Payment*
INTEGUMENTARY		
Skin, Subcutaneous & Areolar	10120-10121, 10140	II
Excision-Debridement	11040	II
Benign Lesions	11401-11404, 11406	II
	11442	I
Malignant Lesions	11643	II
Nails	11700-11701, 11710-11711	I
Miscellaneous Repair	11770, 13120-13131	II
	12002, 12032	I
Tissue Transfer	14040	II
	14060	III
Skin Grafts	15100-15101, 15120-15121 15200, 15220	II
Other Grafts Misc.	15760, 15780-15782, 15790, 15820-15828,	II
	15785	I
	15831-15832	III
Decubitus Ulcers	15941, 15943	II
Destruction	17380	I

* Placement of procedure at a specific level of payment is reviewed periodically and is subject to change.

ATTACHMENT 3
HCPCS PROCEDURE CODE LIST FOR
FREE STANDING AMBULATORY SURGICAL CENTERS (FSASC)

* *

Description	Procedure Code (TOS F)	Level of Payment*
All other integumentary procedures not listed separately above	10000-17999	I
Breast	19000-19001, 19100-19101, 19120-19121, 19140, 19311, 19324-19325, 19328	II
	19182, 19316	III
	19499	I
MUSCULOSKELETAL		
Excision	20200, 20650, 20670, 20680	II
Head excision	21040	II
Repair, revision	21240, 21242	II
Fracture/Dislocation	21300, 21345-21347, 21360, 21365, 21385-21387, 21390, 21395, 21400-21401, 21406-21407, 21421-21422, 21431-21433, 21435, 21440, 21445, 21455, 21461-21462, 21470, 21480, 21485, 21490, 21493-21495, 21497, 21499	I
	21310, 21315, 21320, 21325, 21330, 21335, 21340, 21355, 21450-21451,	II
Neck/Thorax Soft Tissues	21556, 21800, 21805, 21810, 21820, 21825	I
	21502, 21620	II
Spine	22305, 22310, 22315, 22325-22327, 22330, 22335, 22345, 22355-22356, 22360-22361, 22370-22371, 22505	I
Arthrodesis	22600, 22605, 22615, 22617, 22620, 22640, 22645, 22655, 22670, 22680, 22700, 22720	II
Abdomen	22999	I

ATTACHMENT 3
HCPCS PROCEDURE CODE LIST FOR FREE STANDING AMBULATORY SURGICAL CENTERS (FSASC)

* *

Description	Procedure Code (TOS F)	Level of Payment*
Shoulder	23500, 23505, 23510, 23515, 23520, 23525, 23530, 23532, 23540, 23545, 23550, 23552, 23570, 23575, 23580, 23585, 23600, 23605, 23610, 23615, 23620, 23625, 23630, 23650, 23655, 23658, 23660, 23665, 23670, 23675, 23680, 23700	I
	23190, 23415, 23480, 23485	II
	23350	IV
Humerus & Elbow	24500, 24505, 24510, 24515, 24530, 24531, 24535, 24536, 24538, 24540, 24542, 24545, 24560, 24565, 24570, 24575-24581, 24583, 24585-24588, 24600, 24605, 24610, 24615, 24620, 24625, 24635, 24640, 24650, 24655, 24660, 24665, 24666, 24670, 24675, 24680, 24685, 24700,	I
	24000, 24305, 24310	II
	24220	IV
Forearm & Wrist	25115, 25116, 25500, 25505, 25510, 25515, 25530, 25535, 25540, 25545, 25560, 25570, 25575, 25600, 25605, 25610, 25611, 25615, 25620, 25622, 25624, 25626, 25628, 25630,	I
Forearm & Wrist	25635, 25640, 25645, 25660, 25665, 25670, 25675, 25676, 25680, 25685, 25690, 25695,	
	25145, 25146, 25248, 25290, 25330-25332	II
	25111, 25112, 25295, 25320, 25565	III
	25246, 25700	IV
Hands & Fingers	26055, 26600, 26605, 26610, 26615, 26641, 26645, 26650, 26655, 26660, 26665, 26670, 26675, 26680, 26685, 26686, 26700, 26705, 26710, 26715, 26720, 26725, 26727, 26730, 26735, 26740, 26742, 26743, 26744, 26746, 26750, 26755,	I

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HCPCS PROCEDURE CODE LIST FOR FREE STANDING AMBULATORY SURGICAL CENTERS (FSASC)

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Description	Procedure Code (TOS F)	Level of Payment*
Hands & Fingers (continued)	26760, 26770, 26775, 26780, 26785	
	26951, 26952, 26060, 26070, 26426, 26428, 26450, 26455, 26460, 26525, 26530, 26531, 26535, 26536, 26540, 26541, 26545, 26565, 26567	II
	26040, 26120, 26160, 26560	III
Pelvis & Hip Joint	27190-27192, 27195, 27196, 27200-27202, 27210-27212, 27214, 27220, 27222, 27224, 27225, 27230, 27232, 27234-27236, 27238, 27240, 27242, 27244, 27246, 27248, 27250, 27252-27259, 27275	I
	27003, 27146, 27147, 27151, 27156	II
	27093, 27095	IV
Femur - Knee Joint	27500, 27502, 27504, 27506, 27508, 27510, 27512, 27514, 27516-27520, 27522, 27524, 27530, 27532, 27534, 27536-27538, 27540, 27550, 27552, 27554, 27556, 27557, 27560, 27562, 27564, 27566, 27570	I
	27315, 27320, 27405, 27407, 27409	II
	27334	III
	27370, 27375-27378	IV
Leg & Ankle Joint	27685, 27750, 27752, 27754, 27756, 27758, 27760, 27762, 27764, 27766, 27780-27782, 27784, 27786, 27788, 27790, 27792, 27800, 27802, 27804, 27806, 27808, 27810, 27812, 27814, 27816, 27818, 27820, 27822, 27823, 27830-27832, 27840, 27842, 27844, 27846, 27848, 27860	I
	27884, 27605, 27606	II
	27630	III
	27648	IV

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* *

Description	Procedure Code (TOS F)	Level of Payment*
Foot	28280, 28400, 28405, 28406, 28410, 28415, 28420, 28430, 28435, 28440, 28445, 28450, 28455, 28460, 28465, 28470, 28475, 28480, 28485, 28490, 28495, 28500, 28505, 28510, 28515, 28520, 28525, 28540, 28545, 28546, 28550, 28555,	I
	28570, 28575, 28580, 28585, 28600, 28605, 28606, 28610, 28615, 28630, 28635, 28640, 28645, 28660, 28665, 28670, 28675	I
	28010, 28011, 28020, 28110-28114, 28116, 28118, 28119, 28150, 28230, 28232, 28234, 28240, 28285, 28288, 28290	II
	28090, 28092, 28104, 28208, 28299	III
Casts and Splints	29705	I
Arthroscopy	29815, 29819-29823, 29825, 29830, 29834-29838, 29870-29872, 29874-29877, 29879, 29881, 29882, 29884, 29886, 29887, 29890, 29894-29898	IV
RESPIRATORY		
Nose	30410	I
	30110, 30800, 30999	II
	30500, 30620, 30930	III
	30400	IV
Accessory Sinuses	31030, 31200	III
Larynx	31505, 31526, 31536	II
Trachea & Bronchi	31620, 31621, 31625-31628 31630, 31635, 31640, 31645, 31646, 31650, 31651, 31656, 31659	III
CARDIOVASCULAR	37609	III
	37785, 37787	IV
HEMIC & LYMPHATIC	38500, 38720, 38721	III

ATTACHMENT 3
HCPCS PROCEDURE CODE LIST FOR FREE STANDING AMBULATORY SURGICAL CENTERS (FSASC)

* *

Description	Procedure Code (TOS F)	Level of Payment*
DIGESTIVE		
Lips	40500, 40530	II
Vestibule of Mouth	40808, 40819	II
Tongue, Floor of Mouth	41806, 41899	I
	41100, 41105	II
Pharynx, Adenoids, Tonsils	42810, 42815, 42825, 42830	III
	42820	IV
Esophagus	43200, 43202, 43220, 43235, 43239, 43245	II
Intestines	44340	III
Rectum	45300, 45303, 45305, 45905	I
	45100, 45310, 45330, 45331, 45333	II
	45378, 45380, 45385	IV
Anus	46220, 46270	II
	46940, 46942	III
	46221, 46230, 46250, 46255, 46257, 46258, 46260, 46261, 46262	IV
Liver	47000, 47100	III
Abdomen, Peritoneum	49580	III
	49300-49303, 49500, 49505, 49510, 49515, 49520, 49525, 49530, 49535, 49550, 49552, 49555	IV
URINARY SYSTEM		
Endoscopy, Cystoscopy	52005, 52270	I
	52280, 52281, 52285, 52601	II
	52000, 52204	III
	52214, 52224, 52234, 52235, 52238	IV
Urethra	53670	I
	53020, 53025, 53660	II
MALE GENETAL		
Penis	54150, 54152, 54160, 54161	I
	54100	II

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HCPCS PROCEDURE CODE LIST FOR
FREE STANDING AMBULATORY SURGICAL CENTERS (FSASC)

* *

Description	Procedure Code (TOS F)	Level of Payment*
Testis	54500, 54505, 54506, 54521, 54640, 54660, 54661	III
	54520	IV
Epididymis	54900, 54901	I
	54840, 54860, 54861	IV
Tunica Vaginalis	55040, 55041	IV
Vas Deferens	55200, 55250, 55450	I
	55400, 55401	IV
Spermatic Cord Prostate	55700, 55801, 55810, 55812, 55815, 55821, 55831, 55840, 55842, 55845	II
	55530	IV
FEMALE GENITAL SYSTEM		
Perineum	56100, 56200	II
Vulva & Introitus	56500, 56505, 56506, 56507, 56510	I
	56600, 56700	II
	56420, 56515, 56680	III
Vagina	57454	II
	57000, 57060, 57250, 57400, 57450, 57451	III
	57020, 57135, 57200, 57300	IV
Cervix Uteri	57500, 57513, 57520	II
	57510, 57800	III
Corpus Uteri	58301	I
	58340	III
	58120	IV
Oviduct	58600, 58605, 58615	IV
Ovary	58990	III
	58980, 58982, 58983, 58984, 58985, 58986, 58987	IV
Maternity/Delivery Abortion	59300, 59800, 59801, 59810, 59811, 59820, 59830, 59840, 59841, 59850, 59851	IV

ATTACHMENT 3
HCPCS PROCEDURE CODE LIST FOR-
FREE STANDING AMBULATORY SURGICAL CENTERS (FSASC)

* *

Description	Procedure Code (TOS F)	Level of Payment*
ENDOCRINE SYSTEM		
Thyroid	60280	II
NERVOUS SYSTEM		
Craniectomy, Craniotomy	61535	III
Spine, Spinal Cord	62280	I
Neuroplasty	64412	I
	64702, 64704, 64708, 64712, 64713, 64714, 64716, 64718, 64719, 64721, 64722, 64726, 64727	III
Somatic Nerves	64774, 64776, 64778, 64782, 64783, 64784, 64786	II
	64831, 64836	III
EYE & OCULAR ADNEXA		
Eyeball	65091	IV
	65230	III
Cornea	65420	III
Iris	66625	IV
Lens	66800, 66801, 66802	III
Cataract	66830, 66940, 66983, 66984	IV
Ocular Adnexa Muscles	67311-67313, 67320, 67331, 67332	III
Eyelids	67800, 67808, 67840, 67880, 67914, 67921	III
Reconstruction Surgery	67930, 67961	III
Lacrimal	68820, 68830, 68840	III
	68899	IV
AUDITORY SYSTEM		
External Ear	69145, 69300	III
	69301	IV

ATTACHMENT 3
HCPCS PROCEDURE CODE LIST FOR FREE STANDING AMBULATORY SURGICAL CENTERS (FSASC)

* *

Description	Procedure Code (TOS F)	Level of Payment*
Middle Ear	92018, 92584	I
	69420, 69425, 69436, 69437	II
	69620	III
	69501, 69631, 69660	IV
Arthrography	73040, 73041, 73085, 73086, 73115, 73116, 73525, 73526, 73580, 73581, 73615, 73616	IV
Urography, Retrograde	74420	IV

ATTACHMENT 3a

HCPCS DENTAL PROCEDURE CODE AND COPAYMENT CONVERSION TABLE
FOR FREE STANDING STANDING AMBULATORY SURGICAL CENTERS

The HCFA Common Procedure Code System (HCPCS) is required for claims submitted on and after January 1, 1988. Please refer to the following table.

PROCEDURE CODE		MOD.	NEW DESCRIPTION	COPAYMENT
PRIOR TO 01/01/88	EFFECTIVE 01/01/88			
07230	D7230	n/a	Removal of impacted tooth	n/a

ATTACHMENT 4

FREE STANDING AMBULATORY SURGICAL CENTERS

* *

PLACE OF SERVICE (POS) CONVERSION TABLE

Prior to 01/01/88	Effective 01/01/88	New Description
9	B	Ambulatory Surgical Center

TYPE OF SERVICE (TOS) CONVERSION TABLE

Prior to 01/01/88	Effective 01/01/88	New Description
9	F	Free Standing Ambulatory Surgical Centers

ATTACHMENT 5

PROCEDURES REQUIRING SECOND SURGICAL OPINION (SSOP)

* *

Wisconsin Medical Assistance Program requires a second surgical opinion program for selected elective surgical procedures provided. Under this program, medical assistance payment for specific elective surgical procedures require WMAP approval following: (1) procurement of a second examination/opinion by the BHCF from another physician; or (2) waiver of the requirement by the BHCF when such second examination/opinion cannot reasonably be obtained. FSASC procedures currently requiring the physician to obtain SSOP include the following services:

Procedure	CPT-4 Code
Cataract Extraction	66983, 66984
Non-Obstetrical D&C	58120, 57520
Hemorrhoidectomy	46255-46262
Hernia Repair, Inguinal	49500; 49505-49525
Tonsillectomy and/or Adenoidectomy	42820-42836
Adenoidectomy	42820-42826; 42830-42836
Varicose Vein Surgery	37885, 37887

ATTACHMENT 6

PROCEDURES REQUIRING PRIOR AUTHORIZATION

* *

Free standing ambulatory surgical center providers are advised that the Wisconsin Medical Assistance Program requires prior authorization for certain surgical procedures. The physician performing the surgery is responsible for obtaining and following all requirements of prior authorization. Procedures requiring prior authorization include but are not limited to the following services:

1. All covered physician services if provided out-of-state under non-emergency circumstances by a provider who does not have border status.

2. All medical, surgical, or psychiatric services aimed specifically at weight control or reduction, and procedures to reverse such services.

3. Surgical or other medical procedure of questionable medical necessity but deemed advisable in order to correct conditions that may reasonably be assumed to significantly interfere with a recipient's personal or social adjustment or employability.

4. Ligation of internal mammary arteries, unilateral or bilateral.

5. Omentopexy for establishing collateral circulation in portal obstruction.

6. Kidney decapsulation, unilateral and bilateral.

7. Perirenal insufflation.

8. Nephropexy: fixation or suspension of kidney (independent procedure), unilateral.

9. Circumcision, female.

10. Hysterotomy, non-obstetrical, vaginal.

11. Supracervical hysterectomy - subtotal hysterectomy with or without tubes and/or ovaries, one or both.

12. Hypogastric or presacral neurectomy (independent procedure).

ATTACHMENT 6

PROCEDURES REQUIRING PRIOR AUTHORIZATION

* *

13. Uterine suspension, with or without presacral sympathectomy.

14. Ligation of thyroid arteries (independent procedure).

15. Fascia lata by stripper when used as treatment for lower back pain.

16. Fascia lata by incision and area exposure, with removal of sheet, when used as treatment for lower back pain.

17. Ligation of femoral vein, unilateral and bilateral, when used as treatment for postphebitic syndrome.

18. Excision of carotid body tumor without excision of carotid artery, with excision of carotid artery, when used as treatment for asthma.

19. Sympathectomy, thoracolumbar or lumbar, unilateral or bilateral, when used as treatment for hypertension.

20. Splanchnicectomy, unilateral or bilateral, when used as treatment for hypertension.

21. Bronchoscopy -- with injection of contrast medium for bronchography or -- with injection of radioactive substance.

22. Basal metabolic rate (BMR).

23. Protein bound iodine (PBI).

24. Ballistocardiogram.

25. Icterus index.

26. Phonocardiogram with interpretation and report, and with indirect carotid artery tracings or similar study.

27. Angiocardiography, utilizing CO_2 method, supervision and interpretation only.

28. Angiocardiography -- single plane, supervision and interpretation in conjunction with cineradiography or -- multi-plane, supervision and interpretation in conjunction with cineradiography.

ATTACHMENT 6

PROCEDURES REQUIRING PRIOR AUTHORIZATION

* *

29. Angiography -- coronary, unilateral selective injection supervision and interpretation only, single view unless emergency.

30. Angiography -- extremity, unilateral, supervision and interpretation only, single view unless emergency.

31. Construction of artificial vagina.

32. Fabric wrapping of abdominal aneurysm.

33. Reversal of tubal ligation or tubal anastomosis.

34. Reversal of vasectomy.

35. Sterlizations, all.

36. Repair (tarso) levator.

37. Penile prosthesis.

38. Bone marrow transplant.

39. Tattoo removal.

40. Mammoplasty, reduction or repositioning; one-stage-bilateral.

41. Mammoplasty, reduction or repositioning; two-stage-bilateral.

42. Mammoplasty augmentation; unilateral and bilateral.

43. Rhinoplasty, primary.

44. Rhinoplasty, complete.

45. Rhinoplasty, including major septal repair.

46. Cingulotomy.

47. Dermabrasion.

48. Heart transplant.

49. Lipectomy.

50. Mandibular osteotomy.

51. Pancreas transplant.

ATTACHMENT 6

PROCEDURES REQUIRING PRIOR AUTHORIZATION

* *

52. Excision/surgical planning for rhinophyma.

53. Rhytidectomy.

54. Repair blepharoptosis, lid retraction.

55. Transsexual surgery.

56. Any other procedure not identified in the Physician's Current Procedural Terminology fourth edition (CPT-4) published by the American Medical Association.