ASC Facility Claims

Quick Reference Guide

Key Points

- TriWest requires that Ambulatory Surgery Centers (ASC) submit claims on a UB-04 claim form, or in an 837I electronic format for CCN Regions 4 and 5. Providers should continue to bill ASC claims for PC3 on CMS 1500 claim form (837P).
- If medically necessary, all routine lab, radiology, anesthesiology and associated ASC services are considered covered under the primary provider's authorization. A separate authorization letter is not required.

Overview

TriWest functions as a third-party administrator (TPA) for the U.S. Department of Veterans Affairs (VA) Community Care Network (CCN). To ensure that network providers are paid timely and at the correct rates, TriWest recommends that providers follow all appropriate coding requirements. Use this Quick Reference Guide to assist in proper VA CCN claim submission.

ASC Facility Claims

TriWest follows VA reimbursement guidelines for ASC claims. ASC facilities are required to bill services on a UB-04 (CMS-1450) claim form.

VA Referral Number Required – Follow this Process

- Ensure the VA referral number is submitted on your claim.
- The VA referral/authorization number should be inserted in the following claim forms in specific locations:
  - CMS UB04: Box 63 Treatment Authorization Codes field or EDI – two options
  - 2300 – REF (G1) Prior Authorization
  - 2300 – REF (9F) Referral Number
- TriWest provides an authorization letter, stating the range of covered care, to the primary provider prior to any services. The primary provider may be a surgeon or other provider who is responsible for the episode of care. The ASC is responsible for receiving the VA referral number or a copy of the authorization letter from the primary provider.
- All routine lab testing and/or X-ray services, when medically necessary, are included in the authorization. A servicing provider, such as an anesthesiologist, and the ASC used to perform the approved services, are also considered covered under the initial authorization letter.

- ASCs and any associated servicing providers should bill using the VA referral number. All durable medical equipment (DME) must have specific pre-authorization from VA unless an urgent and emergent need should arise during surgery. Please refer to the Quick Reference Guide on DME for more information.
- DME that does not fit the defined urgent/emergent criteria may be denied and cannot be subsequently billed to a Veteran, VA or TriWest.