Chapter 13

Medicaid Provider Manual

Ambulatory Surgical Centers

January 2011

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13.1 AMBULATORY SURGERY CENTERS (ASCS)

13.1.1 Description

Ambulatory Surgical Centers (ASCs) may be free standing or under the control of a hospital. ASCs must be Medicare certified by the Centers for Medicare and Medicaid Services (CMS) formerly known as the Health Care Financing Administration (HCFA).

13.1.2 Amount, Duration and Scope

a) The following applies:

- If the ASC is free standing, it is separate and independent from the provider of service.
- In the Medicaid Program, all outpatient surgical procedures performed in an acute care hospital, whether done in the distinct part of the facility called the ASC or in other operating rooms, are considered ASC services.
- The services covered in the ASC are surgical procedures that can safely be performed without an inpatient acute hospital admission. They are performed under anesthesia.

  Stays are generally less than twenty-four (24) hours.
- Professional services by the physician and anesthesiologists are distinct and separate from ASC services.

b) Covered ASC procedures are those procedures identified by CPT-4 codes and classified by Medicare into ASC Groups I through 9 that Med-QUEST recognizes.

13.1.3 Exclusions

a) Minor surgical procedures that do not require regional or general anesthesia operating room services and are not classified by Medicare in ASC groups I through 9. (Examples: suturing of simple lacerations, simple incision and drainage of abscesses, manipulative reduction of simple digital fractures/dislocations with or without digital blocks.)

b) Surgery that requires authorization when authorization is not obtained.

c) Female sterilization when Federal sterilization (Form 1146) requirements have not been met.

d) Experimental and investigative surgical procedures and surgical procedures of unproven benefit.

e) Surgical procedures for which an inpatient hospital admission is medically indicated.

f) Surgical procedures not designated by Medicare in ASC Groups l through 9.

g) Surgical procedures not covered by the Medicaid Program (Examples: Cosmetic surgery such as face-lifts, cosmetic breast augmentation, rhinoplasties).

13.1.4 Limitations

The following services are not included in the ASC rate and if applicable may be reimbursed separately:

- Ambulance services
- Anesthesiologist services (including the supervision of certified nurse anesthetists)
- Physician (surgeon, radiologist, pathologist) services
- Braces (arm, back, leg, neck)
- Durable Medical Equipment (rental or purchase) for use by the patient in his/her home
- Independent laboratory services
- Prostheses (redundant with artificial arms)
- Radiologic or diagnostic procedures not directly related to the surgical procedure

13.1.5 Authorization

Please refer to Appendix 1 for a list of services which must be prior authorized.

13.1.6 Coding and Claims Submission

a) Free standing ASCs

- Claims for procedures classified in ASC groups 1 through 9 by Medicare must be submitted on CMS (formerly HCFA) 1500 claim forms.
- Procedures must be coded with the most appropriate CPT-4 procedure code. Allowable prosthetic devices such as intraocular lenses and cochlear implants must be coded with appropriate HCPCS codes.

b) Hospital based ASCs and outpatient hospital surgery

- Claims for ASC or outpatient hospital services are submitted on UB-04 claim forms.
- Revenue Codes 49X or 36X should be used for procedures that have been assigned to ASC payment groups 1 through 9 by Medicare. The CPT-4 code that

best describes the procedure is required and must be entered in form locator (FL) block 44.

• Revenue Code 0929 should be used for outpatient procedures that are not recognized by Medicare as an ASC service but were provided under general anesthesia and required a recovery room stay may be billed with revenue code 0929. Claims billed with revenue code 0929 will be reviewed. CPT codes in the range 10000 to 69999 must be included on the 0929 claim line.

13.1.7 Reimbursement

a) Reimbursement for ASC Groupings

Although Medicare allows payment to ASC for certain surgical procedures not in ASC groups1 through 9, , for payment purposes, Medicaid acknowledges only ASC Groups 1, 2, 3, and 4. Payments for Medicare ASC groups 5 and above are paid at the ASC group 4 rate.

b) Multiple codes:

If more than one (1) CPT-4 code is listed, the following guidelines are followed:

• If one (1) CPT-4 code is designated by Medicare in ASC Groups 1 through 9, and the other(s) is/are not, payment at the appropriate Medicare-covered ASC group of the code will be extended.

• If two (2) or more CPT codes are in Medicare ASC groups 1 through 9, but the procedures are related, one payment is extended for the ASC Group listed first on the claim. Example: esophagoscopy for diagnosis with biopsy, esophagoscopy with removal of polyp(s) by hot biopsy forceps/cautery, esophagoscopy with removal of polyp(s) by snare technique.

• If two (2) or more CPT codes are in Medicare ASC groups 1 though 9, and the procedures are not directly related, payment for the first surgical procedure listed on the claim is extended at 100% of Medicaid's payment rate for the ACS group and at 50% of Medicaid's payment rate(s) for the other procedure(s).

c) Reimbursement is an all inclusive case rate and includes all items and services provided by the ASC related to the surgical procedure(s) including but not limited to:

• Administration services

• Anesthetic, Anesthetic material

• Appliances

• Biologicals

• Blood/blood products (except when the blood deductible applies)

- Casts
- Cleaning
- Dressings (primary dressing directly applied to the skin as a result of the surgical procedure)
- Drugs
- Equipment
- Hematocrit
- Hemoglobin
- Housekeeping
- Nursing services
- Operating room
- Orderlies
- Other diagnostic and therapeutic items and services (ECGs, rhythm strips, pulse oximetry, etc.)
- Patient prep area
- Record keeping
- Recovery room
- Rent
- Scheduling
- Splints
- Supplies
- Technical personnel
- Urinalysis
- Utilities
- Waiting room
- Prescription and over the counter (OTC) drugs

d) DMEPOS provided during surgical procedures performed in the ASC are not separately reimbursable unless the items are not part of the ASC group rate. Examples of items not included in the ASC group rate are intra-ocular and cochlear implants.