9

9 Ambulatory Surgical Centers (ASC)

The policy provisions for ASC providers can be found in the *Alabama Medicaid Agency Administrative Code,* Chapter 38.

Ambulatory surgical services are procedures typically performed on an inpatient basis that can be performed safely on an outpatient or ambulatory surgical center (ASC) basis.

9.1 Enrollment

HP enrolls ASC providers and issues provider contracts to applicants who meet the licensure and/or certification requirements of the state of Alabama, the Code of Federal Regulations, the *Alabama Medicaid Agency Administrative Code*, and the *Alabama Medicaid Provider Manual*.

Refer to Chapter 2, Becoming a Medicaid Provider, for general enrollment instructions and information. Failure to provide accurate and truthful information or intentional misrepresentation might result in action ranging from denial of application to permanent exclusion.

Federal requirements mandate providers re-enroll periodically with the Alabama Medicaid program. Providers will be notified when they are scheduled to re-enroll. Failure to re-enroll and provide appropriate documentation to complete enrollment will result in an end-date being placed on the provider file. Once a provider file has been closed for failure to timely re-enroll, providers will have to submit a new application for enrollment.

National Provider Identifier, Type, and Specialty

A provider who contracts with Alabama Medicaid as an ASC provider is added to the Medicaid system with the National Provider Identifiers provided at the time application is made. Appropriate provider specialty codes are assigned to enable the provider to submit requests and receive reimbursements for ASC-related claims.

NOTE:
All ten characters are required when filing a claim effective.

ASC Providers are assigned a provider type of 02 (ASC). Valid specialties for ASC providers include the following:

- Ambulatory Surgical Center (020)
- Lithotripsy (520)

Enrollment Policy for Ambulatory Surgical Center Providers

To participate in the Alabama Medicaid Program ASC providers must meet the following requirements:

- Certification for participation in the Title XVIII Medicare Program
- Approval by the appropriate licensing authorities
- Possess a copy of a transfer agreement with an acute care facility (refer to the *Alabama Medicaid Agency Administrative Code* rule no. 560-X-38-05 for details)

9.2 Benefits and Limitations

This section describes program-specific benefits and limitations. Refer to Chapter 3, Verifying Recipient Eligibility, for general benefit information and limitations.

ASC services are items and services furnished by an outpatient ambulatory surgical center in connection with a covered surgical procedure.

Rates of reimbursement for ASC services include, but are not limited to:

- Nursing, technician and related services
- Use of an ambulatory surgical center
- Lab and x-ray, drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision of the surgical procedure
- Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure
- Administrative, record keeping, and housekeeping items and services
- Materials for anesthesia

NOTE:

Outpatient dental care (procedure code D9420) must be prior approved and is covered only for recipients under the age of 21. The dentist is responsible for obtaining prior approval from the Alabama Medicaid Agency Dental Program at (334) 242-5472. Dental services provided to SOBRA adult females are non-covered.

ASC services do not include items and services for which payment may be made under other provisions. Ambulatory surgical center services do not include:

- Physician services
- Lab and x-ray not directly related to the surgical procedure
- Diagnostic procedures (other than those directly related to performance of the surgical procedure)
- Prosthetic devices (except intraocular lens implant)
- Ambulance services
- Leg, arm, back, and neck braces
- Artificial limbs
- Durable medical equipment for use in the patient's home

ASC services are reimbursed by means of a predetermined fee established by Medicaid. All ASC procedures will be reimbursed at the lesser of the predetermined rate for the procedure or the provider's submitted charge less the copay amount.

NOTE:

Ambulatory surgical center services are limited to three encounters each calendar year.

Medicaid pays for a surgical procedure performed on an outpatient basis for a Medicaid recipient only if the procedure is on the approved surgical list found in Appendix I.

Covered Surgical Procedures

Covered surgical procedures are procedures that meet the following criteria:

- Surgical procedures commonly performed on an inpatient basis in hospitals but may be safely performed in an ambulatory surgical center setting
- Surgical procedures limited to those requiring a dedicated operating room and generally requiring a post-operative recovery room or short-term (not overnight) convalescent room
- Surgical procedures not otherwise excluded under 42 C.F.R. § 416.65 or other regulatory requirement
- Procedure codes within the range of 10000-69XXX

Medicaid maintains a listing of the covered surgical procedures in Appendix I, ASC Procedures List. This list is reviewed and updated on a quarterly basis. Providers should refer to the fee schedule before scheduling outpatient surgeries since some procedures are restricted to recipients under age 20 and others may require prior authorization.

Ambulatory Surgical Center Transfer Procedures

The ambulatory surgical centers must have an effective procedure for the immediate transfer to a hospital of recipients requiring emergency medical care beyond the capabilities of the center. The hospital will have a provider contract with Medicaid. The center must have a written transfer agreement with said hospital, and each physician performing surgery in the center must have admitting privileges at said hospital. Changes in this submitted information will be made available to the HP as they occur.

Surgical Procedures Groups

The surgical procedures are classified into separate payment groups. All procedures within the same payment group are reimbursed at a single rate. These rates are subject to adjustment by Medicaid.

If one covered surgical procedure is furnished to a Medicaid recipient in an operative session, Medicaid pays either the submitted charges minus the copayment amount or the predetermined rate for the procedure minus the copayment, whichever is lowest.

If more than one covered surgical procedure is furnished to a Medicaid recipient in a single operative session, Medicaid pays the lesser of either the submitted charges or the full amount for the procedure with the higher predetermined rate less the copay amount. Other covered surgical procedures furnished in the same session will be reimbursed at the lesser of the submitted charges or at 50 percent of the predetermined rate for each of the other procedures, whichever is lowest.

Payment Adjustment for Provider Preventable Conditions (PPC's)

Medicaid is mandated to meet the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for Provider Preventable Conditions (PPC's) and Other Provider Preventable Conditions (OPPCs).

No reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider.

It is the responsibility of the provider to identify and report any PPC and not seek payment from Medicaid for any additional expenses incurred as a result of the PPC.

Non-payment of PPCs shall not prevent access to services for Medicaid beneficiaries.

To be reportable, PPC's must meet the following criteria:

- The PPC must be reasonable preventable as determined by a root cause analysis or some other means.
- The PPC must be within the control of the provider.
- The PPC must be clearly and unambiguously the results of a preventable mistake made and provider procedures not followed, and not an event that could otherwise occur.
- The PPC must result in significant harm. The OPPC's for considerations should be limited to those that yield a serious adverse result. Serious adverse result is defined as one that results in death, a serious disability or a substantial increase in the duration and/or complexity of care that is well beyond the norm for treatment of the presenting condition. A serious disability is defined as a major loss of function that endures for more than 30 days, is not present at the time services were sought and is not related to the presenting condition.
- Any process for identifying non-payable events must actively incorporate some element of case-by-case review and determination. While the source and cause of some adverse events may be clear, most would require further investigation and internal root cause analysis to determine the cause of the serious preventable event and to assign ultimate accountability.

OPPCs must be reported via encrypted emailing of the required information to:

AdverseEvents@medicaid.alabama.gov. Providers that do not currently have a password for the Adverse Event reporting may require one by contacting Patricia Williamson at patricia.williamson@medicaid.alabama.gov or via phone at 334-353-4142.

Reportable OPPCs include but are not limited to:

- Surgery on a wrong body part or site
- Wrong surgery on a patient
- Surgery on a wrong patient

The following information is required for reporting:

- Recipient first and last name
- Date of Birth
- Medicaid number
- Date event occurred
- Event type

A sample form is on the Alabama Medicaid Agency website at http://medicaid.alabama.gov/ under Programs/Medical Services/Hospital Services. Providers may submit their own form as long as it contains all of the required information.

9.3 Prior Authorization and Referral Requirements

Certain procedures require prior authorization. Please refer to the ASC Procedures List in Appendix I. A "Y" in the PA column on the list indicates surgical procedures that require prior approval. Payment will not be made for these procedures unless authorized prior to the service being rendered.

When filing claims for recipients enrolled in the Patient 1st Program, refer to Chapter 39, Patient 1st, to determine whether your services require a referral from the Primary Medical Provider (PMP).

All requests for prior approval must document medical necessity and be signed by the physician. Requests should be sent to HP, Attention Prior Authorization, P.O. Box 244032, Montgomery, Alabama 36124-4032.

The prior authorization number issued must be listed on the UB-04 claim form when billing for the prior authorization service.

NOTE:

It is the responsibility of the physician to obtain prior authorization for any outpatient surgical procedure to be performed in an outpatient hospital or ambulatory surgical center.

9.3.1 Patient 1st Referrals

By verifying eligibility, providers can get information regarding whether a recipient is enrolled in the Patient 1st program. If the recipient is enrolled in Patient 1st, the provider must document information regarding the recipient's primary medical provider (PMP) and obtain a referral for services prior to rendering services. A Patient 1st referral form is available; however, any method of documenting the required information is acceptable. The referral form must identify the PMP, the reason for the referral, authorized dates of service, and name of staff member giving referral.

As a specialty provider, ASCs are required to obtain a referral from the recipient's PMP before rendering services. Without a referral from the PMP, reimbursement cannot be made. Refer to Chapter 5, Filing Claims, for specifics on completing the UB-04 claim form with this referral information.

9.3.2 EPSDT Referrals

Children under 21 years of age can receive medically necessary health care diagnosis, treatment and/or other services to correct or improve conditions identified during or as a result of an EPSDT screening. Refer to Appendix A, EPSDT, for more specifics on obtaining these referrals.

9.4 Cost Sharing (Copayment)

The copayment amount for an ASC encounter is **$3.90** per encounter. The copayment does not apply to services provided for pregnant women, nursing facility residents, recipients less than 18 years of age, emergencies, family planning, and crossovers. Native American Indians that present an “active user letter” issued by Indian health Services (IHS) will be exempt from the Medicaid required copayment.

9.5 Completing the Claim Form

To enhance the effectiveness and efficiency of Medicaid processing, providers should bill Medicaid claims electronically.

ASC providers who bill Medicaid claims electronically receive the following benefits:

- Quicker claim processing turnaround
- Immediate claim correction
- Enhanced online adjustment functions
- Improved access to eligibility information

Refer to Appendix B, Electronic Media Claims Guidelines, for more information about electronic filing.

NOTE:
When filing a claim on paper, a UB-04 claim form is required. Medicare-related claims must be filed using the Medical Medicaid/Medicare Related Claim Form.

This section describes program-specific claims information. Refer to Chapter 5, Filing Claims, for general claims filing information and instructions.

For straight Medicaid claims, ASCs should bill Medicaid on the UB-04 claim form. Medicare-related claims should be filed using the Medical Medicaid/Medicare Related Claim Form.

9.5.1 Time Limit for Filing Claims

Medicaid requires all claims for ambulatory surgical center providers to be filed within one year of the date of service. Refer to Section 5.1.4, Filing Limits, for more information regarding timely filing limits and exceptions.

9.5.2 Diagnosis Codes

The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.

NOTE:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3, 4, or 5 digits).

9.5.3 Procedure Codes and Modifiers

ASC providers use the Current Procedural Terminology (CPT) coding system. The CPT manual lists most required procedure codes. This manual may be obtained by contacting the Order Department, American Medical Association, 515 North State Street, Chicago, IL 60610-9986. The (837) Institutional electronic claim and the paper claim have been modified to accept up to four procedure code modifiers.

Only procedures listed in the ASC Procedures List are reimbursable in the ambulatory surgical setting. The list of covered outpatient procedures is located in Appendix I.

NOTE:

Procedures not listed on the ASC Procedures List may be covered under special circumstances. Approval must be obtained prior to the surgery. Refer to Section 9.3, Prior Authorization and Referral Requirements, for more information. Prior to providing services, providers should inform recipients of their responsibilities for payment of services not covered by Medicaid.

9.5.4 Place of Service Codes

Place of service codes do not apply when filing the UB-04 claim form.

9.5.5 Required Attachments

To enhance the effectiveness and efficiency of Medicaid processing, your attachments should be limited to the following circumstances:

- Claims with Third Party Denials

NOTE:

When an attachment is required, a hard copy UB-04 claim form must be submitted.

Refer to Section 5.7, Required Attachments, for more information on attachments.

9.6 For More Information

This section contains a cross-reference to other relevant sections in the manual.

Resource	Where to Find It
UB-04 Claim Filing Instructions	Section 5.3
Medical Medicaid/Medicare-related Claim Filing Instructions	Section 5.6.1
Sterilization/Hysterectomy/Abortion Requirements	Section 5.7
Electronic Media Claims (EMC) Submission Guidelines	Appendix B
AVRS Quick Reference Guide	Appendix L
Alabama Medicaid Contact Information	Appendix N
ASC Procedures List	Appendix I