Ambulatory Surgical Center Services

PURPOSE

This policy defines ambulatory surgical center (ASC) services and covered ND Medicaid services provided at an ASC.

APPLICABILITY

ELIGIBLE PROVIDERS

To receive payment from ND Medicaid, the eligible servicing and billing provider's National Provider Identifiers (NPIs) must be enrolled on the date of service with ND Medicaid. Servicing providers acting as a locum tenens provider must enroll with ND Medicaid and be listed on the claim form. Please refer to provider enrollment for additional details on enrollment eligibility and supporting documentation requirements.

An ASC must meet Medicare's Conditions for Coverage (CFCs) and be enrolled with ND Medicaid as an ASC. Evidence of meeting Medicare's CFCs can be either the ASC being enrolled with Medicare or accreditation from one of the following organizations.

- Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- Healthcare Facilities Accreditation Program (HFAP)
- Institute for Medical Quality (IMQ)
- The Joint Commission (TJC)

An ASC may be independent or operated by a hospital.

ELIGIBLE MEMBERS

Providers are responsible for verifying a member's eligibility before providing services. Eligibility can be verified using the ND Medicaid MMIS Portal or through the Automated Voice Response System (AVRS) by dialing 1.877.328.7098.

Refer to the Member Eligibility manual for additional information regarding eligibility including information regarding limited coverage categories.

COVERED SERVICES AND LIMITS

GENERAL PROVIDER POLICIES

The General Provider Policies details basic coverage requirements for all services. Basic coverage requirements include:

- The provider must be enrolled in ND Medicaid;
- Services must be medically necessary;
- The member must be eligible on the date of service; and
- If applicable, the service has an approved service authorization.

Procedures/surgeries listed on the ND Medicaid ASC fee schedule are covered within an ASC. Members may receive ASC-covered services within applicable lifetime limits. Certain procedure(s) may require service authorization.

LIMITS

An ASC is only paid the facility fee for the surgical procedure. An ASC may not bill any other services.

SEPARATELY COVERED SERVICES RENDERED IN AN ASC

The following services and supplies are not included in the ASC facility fee and may be billed separately by an enrolled provider other than the ASC.

- Professional services: physician, anesthesiologist (administration or supervision of the administration of anesthesia), and certified registered nurse anesthetists (CRNA) services;
- Laboratory, x-ray, or diagnostic procedures other than those directly related to the performance of the surgical procedure;
- Prosthetic devices;
- Ambulance services;
- Durable medical equipment for use in the member's home; and
- Pathology services.

SERVICE AUTHORIZATION REQUIREMENTS

Certain procedures/surgeries performed in an ASC require a Service Authorization to be submitted and approved before the surgery/procedure is performed. The Procedure Code Look-up Tool can be utilized to determine Service Authorization requirements for CPT® and HCPCS codes.

All ASC services provided out of state require an approved Service Authorization.

Please see the Service Authorization Policy for complete details.

NON-COVERED SERVICES

GENERAL NON-COVERED SERVICES

The Noncovered Services Policy contains a general list of services that are not covered by North Dakota Medicaid.

ASC not covered services include:

- Services performed in an ASC that are not listed on the ASC Fee Schedule;
- Sterilization or hysterectomy procedures that do not meet the consent criteria outlined in the Sterilization and Hysterectomy Policy;
- ASC procedures/surgeries that are performed by a provider who is not enrolled with ND Medicaid on the date of service on which the procedure/surgery was performed; and
- Procedures/surgeries provided without obtaining a Service Authorization when required.

DOCUMENTATION REQUIREMENTS

GENERAL REQUIREMENTS

Providers must keep legible medical and financial records that fully justify and disclose the extent of services provided and billed to ND Medicaid. Records must be retained for at least 7 years after the last date the claim was paid or denied. Providers must follow the documentation requirements in the Provider Requirements Policy.

REIMBURSEMENT METHODOLOGY AND CLAIM INSTRUCTIONS

TIMELY FILING

ND Medicaid must receive an original Medicaid primary claim within one hundred eighty (180) days from the date of service. The time limit may be waived or extended by ND Medicaid in certain circumstances. The Timely Filing Policy contains additional information.

THIRD-PARTY LIABILITY

Medicaid members may have one or more additional source of coverage for health services. ND Medicaid is generally the payer of last resort. Providers must pursue the

availability of third-party payment sources. The Third Party Liability Policy contains additional information.

CLIENT SHARE (RECIPIENT LIABILITY)

Client share (recipient liability) is the monthly amount a member must pay toward the cost of medical services before the Medicaid program will pay for services received. The Client Share Policy contains additional information.

REIMBURSEMENT

A claim for services must be submitted at the provider's usual and customary charge. Payment for services is limited to the lesser of the provider's usual and customary charge or the ND Medicaid calculated reimbursement.

When multiple surgical procedures rendered in the ASC are billed for the same patient on the same date of service, multiple surgical reduction guidelines may be applied if the lesser service is subject to multiple payment procedure reduction (MPPR) and will be reimbursed at 50% of the published fee schedule amount in effect on the date of service.

The following services and supplies are included in the ASC facility fee and may not be billed or paid separately:

- Use of facility (operating and recovery rooms, patient preparation areas, waiting rooms, and all other areas used by the patient or offered for use by persons accompanying the patient).
- Nursing and technician services provided by ASC employees (e.g., nurses, technicians, orderlies).
- Drugs, biologicals, surgical dressings, supplies, splints, casts appliances, and equipment commonly furnished by the ASC in connection with surgical procedures. Drugs and biologicals are limited to those that cannot be self-administered.
- Urinary supplies, such as collection devices, indwelling and external catheters, drainage bags, leg straps, external urethral clamps, irrigation supplies (bulbs, syringes, tubing, sterile saline, or water), insertion trays, and perianal fecal collection pouches.
- Administrative, record keeping, and housekeeping services necessary to operate the facility (e.g., scheduling, cleaning, utilities, rent).
- Blood, blood plasma, and platelets.
- Pre-operative pregnancy tests.

- Anesthetic and any supplies, whether disposable or reusable, necessary for its administration.

CLAIM FORM

ASC services must be billed using the CMS 1500 or 837P. Detailed claim instructions are available on the ND Medicaid Provider Guidelines, Policies & Manual webpage.

CLAIM REQUIREMENTS

- All services rendered in an ASC should be reported under the Place of Service Code 24.
- Modifier SG – Ambulatory surgery center (ASC) facility service is not mandatory on ASC claims but is accepted as informational.

DEFINITIONS

Ambulatory Surgical Center – an outpatient surgical center that operates exclusively for the purpose of providing surgical services to patients who do not require hospitalization and expected duration of services does not exceed 24 hours.

Multiple Procedure Payment Reduction (MPPR) – A CMS (Centers for Medicare and Medicaid Services) policy that reduces the payment for certain multiple procedures performed on the same patient by the same provider on the same day. This reduction typically applies to the practice expense component of the procedure, with the first (highest-valued) procedure paid at 100% and subsequent procedures at a reduced rate of 50%.

REFERENCES

- North Dakota Administrative Code
- North Dakota Century Code
- Code of Federal Regulations

RELATED POLICIES

- Service Authorizations
- Procedure Code Look-up Tool

CONTACT

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POLICY UPDATES

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Section	Summary
	Format updates and clarifications throughout.