Ambulatory Surgical Center Services

Medicaid and Other Medical Assistance Programs

MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

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My NPI/API:

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Key Contacts and Websites

See the Contact Us link in the menu on the Montana Healthcare Programs Provider Information website, http://medicaidprovider.mt.gov, for a list of key contacts and websites.

Introduction

Thank you for your willingness to serve members of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for **ambulatory surgical center services.** Other essential information for providers is contained in the separate *General Information for Providers* manual. Providers should review both manuals.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of contacts on the Contact Us page on the Provider Information website. There is also space on the inside front cover to record your NPI/API for quick reference when calling Provider Relations.

Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through provider notices and replacement pages. When replacing a page in a paper manual, file the old pages and notices in the back of the manual for use with claims that originated under the old policy.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. **In the event that a manual conflicts with a rule, the rule prevails.** Links to rules are available on the Provider Information website. Paper copies of rules are available through the Secretary of State's office. See the Contact Us page on the Provider Information website. In addition to the general Medicaid rules outlined in the *General Information for Providers* manual, the following rules and regulations are also applicable to the ambulatory surgical center program:

Providers are responsible for knowing and following Medicaid laws and regulations.

- Code of Federal Regulations (CFR)
  - 42 CFR 416
- Montana Codes Annotated (MCA)
  - MCA 50-5-101
- Administrative Rules of Montana (ARM)
  - ARM 37.86.1401–37.86.1406 Ambulatory Surgical Centers

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Claims Review (MCA 53-6-111 and ARM 37.85.406)

The Department is committed to paying Medicaid providers' claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). See the Contact Us page on the Provider Information website.

Medicaid manuals, manual replacement pages, provider notices, fee schedules, forms, and more are available on the Provider Information website.

Covered Services

General Coverage Principles

Medicaid covers almost all ambulatory surgical center services when they are medically necessary. This chapter provides covered services information that applies specifically to ambulatory surgical center services. Like all healthcare services received by Medicaid members, these services must also meet the general requirements listed in the Provider Requirements chapter of the *General Information for Providers* manual.

Ambulatory Surgical Center Services (ARM 37.86.1402)

Covered surgical procedures can only be rendered by a licensed ambulatory surgical center. Clinic services must be provided by a clinic that is licensed as an outpatient facility by the appropriate licensing entity of the state where the facility is located and meet the requirements for participation in Medicare. Clinic services must be provide by or under the direction of a licensed physician or, where appropriate, a licensed dentist.

All of the following are conditions for coverage of listed ambulatory surgical center procedures:

- Covered surgical procedures are limited to those procedures that do not generally exceed a total of 90 minutes operating time and a total of 4 hours recovery or convalescent time.
- If the covered surgical procedure requires anesthesia, the anesthesia must be local or regional anesthesia, or general anesthesia of 90 minutes or less duration.
- Covered surgical procedures may not be of a type that generally result in extensive blood loss; require a major or prolonged invasion of body cavities; directly involve major blood vessels; are generally emergent or life threatening in nature; or can safely be performed in a physician's or dentist's office.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services (ARM 37.86.2201–2235)

The EPSDT Well-Child program covers all medically-necessary services for children age 20 and under. Providers are encouraged to use a series of screening and diagnostic procedures designed to detect diseases, disabilities, and abnormalities in the early stages.

Some services are covered for children that are not covered for adults, such as the following:

- Nutritionist services
- Respiratory therapy

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- Therapeutic family and group home care
- Substance dependency inpatient and day treatment services
- School-based services

All prior authorization and Passport approval requirements must be followed. For more information about the recommended well-child screen and other components of EPSDT, see the EPSDT Well-Child chapter in the *General Information for Providers* manual.

Coverage of Specific Services (ARM 37.86.1405)

Medicaid follows Medicare's rules for coverage of most services. The following are coverage rules for specific ambulatory surgical center services.

Clinic Services, Covered Procedures (ARM 37.86.1405)

Ambulatory surgical center (ASC) services:

Use the fee schedule for your provider type to verify coverage for specific services.

- Are services that will be covered by Medicaid if provided in an outpatient ASC setting incident to provisions of physician or dental services to the patient where the services and supplies are furnished in the ASC on a physician's or dentist's order by ASC personnel under the supervision of ASC medical staff.
- Are limited as provided by ARM 37.86.1402(1)–(5) with the term *clinic* taken to mean ASC.
- Clinic services covered by the Medicaid program include physician services covered in ARM 37.86.101, ARM 37.86.104, and ARM 37.86.105.
- Clinic services covered by the Medicaid program include mid-level practitioner services covered in ARM 37.86.201, ARM 37.86.202, and ARM 37.86.205.

Passport

What is Passport to Health? (ARM 37.86.5101–5120)

Passport to Health is the primary care case management (PCCM) program for Montana Medicaid and Healthy Montana Kids (HMK) *Plus* members. The Passport to Health program provides case management-related services that include locating, coordinating, and monitoring primary healthcare services. To achieve this, the Passport program works with the state's other care coordination programs:

- Nurse First Advice Line
- Team Care
- Health Improvement Program

Medicaid and HMK *Plus* members who are eligible for Passport must enroll in the program (about 70% of Montana Medicaid and HMK *Plus* members are eligible). Each member has a designated Passport provider such as a physician, mid-level practitioner, or primary care clinic.

Passport members may change their Passport provider up to once per month, but the change will not be effective until the following month at the earliest, depending on the date the choice is made (ARM 37.86.5103–5104).

Additional Passport information is found in the *Passport to Health* manual, available on the Provider Information website.

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Prior Authorization

Prior authorization refers to a list of services that require approval from the Medicaid program prior to the service being rendered. If a service requires prior authorization, the requirement exists for all Medicaid members.

When prior authorization is granted, the provider is issued a prior authorization number that must be on the claim.

Medicaid does not pay for services when prior authorization requirements are not met.

See the Prior Authorization Information link in the menu on the Provider Information website.

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Coordination of Benefits

For Coordination of Benefits, providers should refer to the section on Third Party Liability in the Member Eligibility and Responsibilities chapter in the *General Information for Providers* manual.

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Billing Procedures

Claim Forms

Services provided by the healthcare professionals covered in this manual must be billed either electronically or on a CMS-1500 claim form. CMS-1500 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Member Cost Sharing (ARM 37.85.204 and ARM 37.85.402)

Cost sharing fees are a set dollar amount per visit, based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. There is no cost sharing cap. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice. Cost sharing for ambulatory surgical center services is $5.00 per visit.

The following members are exempt from cost sharing:

- Members under 21 years of age (i.e., EPSDT services)
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed)
- Inpatients in a hospital, skilled nursing facility, intermediate care facility, or other medical institution if the individual is required to spend all but their personal needs allowance on the cost of care.
- Medicaid members who also have Medicare or another insurance are exempt from cost sharing if the service is allowed by Medicare or paid by the other insurance, and Medicaid is the secondary payer.
- American Indians and Alaska Natives who have ever been treated at an IHS, Tribal, or Urban facility or through referral under contract health services with appropriate documentation.

Cost sharing may not be charged for the following services:

- Emergencies
- Family planning
- Hospice
- Independent lab and x-ray services
- Personal assistance services
- Home dialysis attendant services
- Home and community-based waiver services
- Non-emergency medical transportation services

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- Eyeglasses purchased by the Medicaid program under a volume purchasing arrangement
- EPSDT services

A provider cannot deny services to a Medicaid member because the member cannot pay cost sharing fees at the time services are rendered. However, the member's inability to pay cost sharing fees when services are rendered does not lessen the member's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid members, that same policy may be used for Medicaid members.

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Remittance Advices and Adjustments

See the *General Information for Providers* manual for information on remittance advices and adjustments.

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter to submit claims to Medicaid, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

Ambulatory Surgical Centers

Effective for dates of service on or after April 1, 2008, Montana Medicaid implemented a prospective ambulatory surgical center payment system in line with the Centers for Medicare and Medicaid Services (CMS) ambulatory surgical center methodology.

This payment system prospectively determines amounts to be paid for covered surgical and ancillary services identified by codes and modifiers established under the CMS Healthcare Common Procedure Coding System (HCPCS). This payment system also indicates which costs are packaged and which surgical procedures are excluded.

Montana Medicaid rates follow the CMS quarterly ambulatory surgical center payment updates. Lists of payable HCPCS codes and their corresponding payment rates are available on the Montana Medicaid ASC fee schedules. CMS also publishes quarterly addendums indicating covered surgical and ancillary services and non-covered surgical services.

Whenever CMS proposes to revise the payment rate for ambulatory surgical centers, CMS publishes a notice in the Federal Register describing the revision. The notice also explains the basis on which the rates were established. After reviewing public comments, CMS publishes a notice establishing the rates authorized by this section. In setting these rates, CMS may adopt reasonable classifications of facilities and may establish different rates for different types of surgical procedures.

Providers should review the Montana Medicaid ASC fee schedules on the Montana Healthcare Programs website or the CMS website for a list of services and rates.

Other Issues

Outpatient Services

When Medicaid pays an ambulatory surgical center for outpatient services, the separate claim for the physician's services must show the ambulatory surgical center as the place of service (POS). This POS code (24) results in the physician receiving the facility fee listed in the physician fee schedule.

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Modifiers

- Review the guidelines for using modifiers in the CPT book, HCPCS book, and other helpful resources (e.g., CPT Assistant, APC Answer Letter).
- Always read the complete description for each modifier; some modifiers are described in the CPT book, while others are described in the HCPCS book.
- Medicaid accepts most of the same modifiers as Medicare, but not all.
- The Medicaid claims processing system recognizes three pricing modifiers and one informational modifier per claim line on the CMS-1500. Providers are asked to place any modifiers that affect pricing in the first two modifier fields.
- Discontinued or reduced service modifiers must be listed before other pricing modifiers on the CMS-1500.

How Payment Is Calculated on TPL Claims

When a member has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as third party liability or TPL. In these cases, the other insurance is the primary payer, and Medicaid makes a payment as the secondary payer. Medicaid will make a payment only when the TPL payment is less than the Medicaid allowed amount.

How Payment Is Calculated on Medicare Crossover Claims

When a member has coverage from both Medicare and Medicaid, Medicare is the primary payer. Medicaid will pay the coinsurance and deductible, less any TPL or incurment, on ambulatory surgical center (ASC) claims for these dually-eligible individuals.

Payment Examples for Dually-Eligible Members

A provider submits an ASC claim for a member who has Medicare and Medicaid coverage. The Medicare coinsurance and deductible are $65 and $185. This total ($250) becomes the Medicaid allowed amount. Medicaid will pay the total as long as no TPL or incurment amounts are applicable.

A provider submits an ASC claim for a member who has Medicare, Medicaid, and TPL. The Medicare coinsurance and deductible are $65 and $185. This $250 total becomes the Medicaid allowed amount. The other insurance company paid $225. This amount is subtracted from the Medicaid allowed amount leaving $25. Medicaid pays $25 for this claim. If the TPL payment had been $250 or more, this claim would have paid at $0.

A provider submits an ASC claim for a member who has Medicare, Medicaid, and a Medicaid Incurment. The Medicare coinsurance and deductible are $65 and $185. This total ($250) becomes the Medicaid allowed amount. The member owes $150 for his Medicaid incurment, so this amount is subtracted from the $250. Medicaid will pay the provider $100 for this claim.

Definitions and Acronyms

See the Definitions and Acronyms link in the menu on the Provider Information website for additional definitions and acronyms.

Ambulatory Surgical Center Services

Services that are provided in a licensed, freestanding ambulatory surgical center. Surgical center services do not include physician services, anesthesiologist services, ambulance services, or major prosthetic appliances such as intraocular lenses.

Clinic Services

Preventive, diagnostic, therapeutic, rehabilitative or palliative items or services provided under the direction of a physician by an outpatient facility that is not part of a hospital, but is organized and operated to provide medical care to outpatients independent of a hospital. Clinic services may be provided in surgical centers and public health departments. Clinic services do not include mental health center services as defined in ARM 37.88.901.

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