

TITLE 471 - NEBRASKA MEDICAL ASSISTANCE PROGRAM SERVICES

CHAPTER 26-000 - AMBULATORY SURGICAL CENTER (ASC) SERVICES

26-001 Standards for Participation: NMAP covers facility services provided by ambulatory surgical centers in connection with certain surgical procedures. To participate in the Nebraska Medical Assistance Program, an ambulatory surgical center must:

1. Be certified as meeting the requirements for an ASC under Medicare;
2. Have an agreement with CMS under Medicare to participate as an ASC; and
3. Have an agreement with the Nebraska Department of Health and Human Services to participate in NMAP. NMAP covers ASC facility services for only the surgical procedures defined in 471 NAC 26-004. The ASC must accept the Department's payment for the facility services as payment in full for those services defined as ASC facility services in 471 NAC 26-002.

26-001.01 Definition of an ASC: An ASC is a distinct entity that operates exclusively to provide outpatient surgical services to patients. An ASC may be either:

1. Independent (not part of a provider of services or any other facility); or
2. Operated by a hospital (under the common ownership, licensure, or control of a hospital).

26-001.01A ASC's Operated by Hospitals: If an ASC is operated by a hospital, it may be covered under Medicare as an independent ASC or as a hospital-affiliated ambulatory surgical center (HAASC). The Department enrolls ASC's to participate in NMAP as they are enrolled to participate in Medicare. To be covered as a Medicare-participating ASC operated by a hospital, a facility must:

1. Elect to do so, and continued to be covered as an ASC unless CMS determines there is good cause to do otherwise;
2. Be a separately identifiable entity, physically, administratively, and financially independent and distinct from other operations of the hospital; and
3. Meet all Medicare's requirements for independent ASC's.

Facilities operated by a hospital as Medicare-participating ASC's are paid according to 471 NAC 26-005. Other HAASC's are paid according to 471 NAC 10-010.06.

26-001.02 Provider Agreement: The provider must complete and sign Form MC-19, "Medical Assistance Provider Agreement," (see 471-000-90) and

submit it to the Department to be approved for provider enrollment.

26-002 Covered ASC Procedures: NMAP covers ASC facility services performed in connection with procedures on the list of covered ASC procedures in 471-000-409, state defined ASC Services code(s). These procedures are organized in several groups that refer to the facility payment amount available for each group. The ASC receives the same payment for each procedure within a particular group.

The list of covered ASC procedures indicates which procedures may be covered if performed in an ASC; NMAP does not require that these procedures must be performed in an ASC. The general rules regarding the medical necessity of a specific procedure for a specific client apply to ASC services as they do to all other services covered by NMAP.

26-003 Covered ASC Facility Services: ASC facility services are items and services provided by an ASC in connection with a covered surgical procedure defined in 471 NAC 26-002. These items and services are those that would otherwise be covered by NMAP if provided on an inpatient or outpatient basis in a hospital in connection with that surgical procedure.

The fee for ASC facility services includes payment for:

1. Nursing, technician, and related services;
2. Use of ASC facilities;
3. Drugs, biologicals, surgical dressings, splints, casts, and appliances and equipment directly related to the provision of a surgical procedure;
4. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
5. Administrative, record keeping, and housekeeping items and services;
6. Blood, blood plasma, platelets, etc.; and
7. Materials for anesthesia.

The fee for ASC facility services does not include payment for medical and other health services, such as physicians' services and prosthetic devices for which payment may be made under other NMAP payment plans, except for intraocular lenses. See 471 NAC 26-004, ASC Services Not Included in the ASC Facility Services Fee.

26-003.01 Nursing, Technician, and Related Services: The fee for ASC facility services includes payment for all services provided by nurses and technical personnel who are employees of the ASC in connection with covered procedures. In addition to nursing staff, this includes orderlies, technical personnel, and others involved in patient care.

26-003.02 Use of ASC Facilities: The fee for ASC facility services includes payment for operating and recovery rooms, patient preoperation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with covered procedures.

26-003.03 Drugs, Biologicals, Surgical Dressings, Supplies, Splints, Casts, Appliances, and Equipment: The fee for ASC facility services includes payment for all supplies and equipment commonly provided by the ASC in connection with covered procedures. Coverage of drugs and biologicals is limited to those which cannot be self-administered.

The following supplies and dressings are included in the ASC facility services fee:

1. Primary surgical dressings that are usually applied first by a physician in the ASC setting. These surgical dressings are therapeutic and protective coverings applied to lesions on the skin or openings to the skin required as a result of surgical procedures; and
2. Splints, casts, and other supplies, such as supplies required for the patient and ASC staff, that is, gowns, masks, drapes, hoses, scalpels, etc., whether disposable or reusable.

26-003.04 Diagnostic or Therapeutic Services and Items: The fee for ASC facility services includes payment for items and services provided by ASC staff in connection with covered procedures. With respect to diagnostic tests, many ASC's perform simple tests just before surgery, primarily urinalysis and blood hemoglobin or hemotocrit, which are generally included in their facility charges. To the extent that these simple tests are included in the ASC's facility charges, they are considered facility services. Under NMAP, diagnostic tests are not covered in laboratories independent of a physician's office, rural health clinic, or hospital unless the laboratory meets Medicare's requirements for independent laboratories; therefore, diagnostic tests performed by the ASC other than those generally included in the facility's charge are not included in the fee for ASC facility services. The ASC's laboratory may be certified as a independent lab by Medicare; in this case, the ASC may bill NMAP separately for the tests performed.

The ASC may make arrangements with an independent laboratory or other laboratory, such as a hospital laboratory, to perform diagnostic tests required before surgery; however, the necessary laboratory tests will generally have been done outside the ASC before surgery is scheduled because the tests results may determine whether the client's surgery should be performed on an outpatient basis.

26-003.05 Administrative. Record Keeping. and Housekeeping Items and Services: The fee for ASC facility services includes payment for the general administrative functions necessary to run the facility, such as scheduling, cleaning, utilities, and rent.

26-003.06 Blood and Blood Products: The fee for ASC facility services includes payment for blood and blood products. No separate or additional payment is made for blood and blood products.

26-003.07 Materials for Anesthesia: The fee for ASC facility services include payment for the anesthetic and any materials, disposable or reusable, necessary for its administration.

26-004 ASC Services Not Included in the ASC Facility Services

Fee: NMAP makes a single payment (the fee for ASC facility services) to an ASC which covers "facility services" provided by the ASC in connection with a covered procedure. The ASC may provide a number of items and services covered by NMAP which are not included in the fee for ASC facility services. The ASC may be part of a medical complex that includes other entities, such as an independent laboratory, a supplier of durable medical equipment, ambulance services, or a physician's office, which NMAP covers separately. Items or services which are not included in the fee for ASC facility services are:

1. Physicians' services;
2. The sale or rental of durable medical equipment for use in the patient's home;
3. Prosthetic devices, that is, artificial legs, arms, and eyes;
4. Ambulance services;
5. Orthotic devices, that is, leg, arm, back, and neck braces; and
6. Services provided by an independent laboratory. The ASC may provide these services and bill NMAP for them in addition to the fee for ASC facility services. Refer to the appropriate chapter in Title 471 for coverage conditions and payment policies.

26-004.01 Physicians' Services: This category includes most covered services provided in ASC's which are not considered ASC facility services. Physicians' services include services of anesthesiologists administering or supervising the administration of anesthesia to ASC patients and the patient's recovery from the anesthesia. Physicians' services also include any routine pre- and post-operative services, such as office visits, consultations, diagnostic tests, removal of stitches, and changing of dressings. See 471 NAC 18-004.17, Surgery, and 471 NAC 18-006, Payment for Physicians' Services.

26-004.02 Durable Medical Equipment: The following items are not included in the fee for ASC facility services; when provided by the ASC facility in connection with a covered procedure, the ASC may bill for these services in addition to the ASC facility services fee:

1. Ace bandages, elastic stockings and support hose, Spence boots and other foot coverings, leotards, knee supports, surgical leggings,

gauntlets, and pressure garments for the arms and hands, and which are generally used as secondary coverings;

2. Surgical dressings that are reapplied later by others, including the patient or a family member;

3. Recasting and resplinting, when provided on a date other than the date the surgical procedure was performed.

When these dressings and supplies are obtained by the patient on a physician's order from a supplier other than the ASC facility, they are covered under 471 NAC 7-000 ff.

26-004.03 Ambulance Services: Ambulance services are not included in the fee for ASC facility services. Ambulance services provided by the ASC are covered as ASC services only if provided in conjunction with a covered ASC procedure and only when any other form of transportation is contraindicated for the patient's condition. Licensure and other ambulance regulations are covered in 471 NAC 4-000.

26-004.04 Laboratory Services: Except for those laboratory services included in ASC facility services under 471 NAC 26-003.04, laboratory services are covered in 471 NAC 10-003.04 and 18-004.29.

26-005 Payment for ASC Services

26-005.01 Fee for ASC Facility Services: For services provided on or after January 1, 2008, NMAP will utilize the 2006 Medicare ambulatory surgical center group rates to reimburse for an ambulatory surgical center service. Reimbursement will be the surgical group rate specific to the procedure as established in 471-000-409.

If one covered ambulatory surgical procedure is provided in a single operative session, NMAP pays 100 percent of the applicable group rate. For example, excision of a benign lesion is a "group 1" procedure; therefore, NMAP would pay 100% of the "group 1" rate.

If more than one covered surgical procedure is provided in a single operative session, NMAP pays 100 percent of the applicable group rate for the procedure with the highest rate. NMAP pays for other covered ambulatory surgical procedures performed in the same operative session at 50 percent of the applicable group rate for each procedure. For example, hammertoe repair is a "group 4" procedure and tenotomy is a "group 1" procedure. Payment for these procedures performed in a single operative session in an ASC would be 100% of the "group 4" rate and 50% of the "group 1" rate.

26-005.02 (Reserved)

26-005.03 Payment for Services Not Included in the ASC Facility Services Fee: The fee for facility services does not include payment for physicians' services or other services not directly related to the performance of the

surgical procedure. (See 471 NAC 26-004.) The ASC may bill for these services in addition to the fee for ASC facility services and will be paid according to the appropriate Medicaid payment plan.

26-005.04 Payment for State-Defined Services: Medicaid may cover payment for facility services provided in connection with certain state-defined services provided in an ASC. See 471 NAC 18-004.17E.

26-005.05 Non-Payment of Other Provider Preventable Conditions (OPPCs): Effective on or after the effective date of this regulation for facility services rendered by an ambulatory surgical center, payment will be denied for the following OPPCs:

1. Wrong surgical or other invasive procedure performed on a patient;
2. Wrong surgical or other invasive procedure performed on the wrong body part;
3. Wrong surgical or other invasive procedure performed on the wrong patient.

26-006 Billing Requirements

26-006.01 Required Forms: When billing Medicaid, the ASC must submit on the appropriate form or electronic format (see Claim Submission Table at 471-000-49).

All claims for ASC services must include the date of surgery and the physician's name and license number.

26-006.02 Procedure Codes: To claim the ASC facility fee, the ASC must use the appropriate HCPCS/CPT procedure codes as outlined in claim completion instructions (see 471-000-52) and see 471-000-409, state defined ASC Services code(s).

The ASC must use HCPCS/CPT procedure codes when billing for practitioner services and laboratory services. Regulations listed in 471 NAC 4-000 must be used for ambulance services. Regulations listed in 471 NAC 7-000 must be used for durable medical equipment and medical supplies.

