



## Ambulatory Surgical Center/Free Standing Surgical Center Provider Specific

### Revision Table

<b>Revision Date</b>	<b>Sections Revised</b>	<b>Description</b>
7/1/02	All	Complete manual revision to reflect changes related to the MMIS and HIPAA compliance.
9/19/06	2.3 and 5.6	Added coverage and billing information for corneal tissue acquisition.
5/26/09	5.1	Update to reflect the change in how rates are paid.
11/11/09	3.0	Updated the Non-ASC/FSSC Facility Services example list to include dental services.
4/16/12	Overview	Removed obsolete number.

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## **Ambulatory Surgical Center / Free Standing Surgical Center Provider Specific Policy Manual**

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## **Ambulatory Surgical Center/Free Standing Surgical Center Provider Specific Policy**

Health care services are provided to the majority of Medicaid clients through a Managed Care Organization (MCO). Ambulatory Surgical Center/Free Standing Surgical Center (ASC/FSSC) services are included in the MCO benefits package. All Medicaid clients who are enrolled with an MCO must receive ASC/FSSC services through the MCO.

This manual reflects the policies as they relate to Medicaid clients who are exempt from managed care coverage (see list of those exempt from managed care coverage in the Managed Care section of the General Policy).

### **1.0 General Criteria**

#### **1.1 Applicability**

1.1.1 This manual contains information specifically applicable to Ambulatory Surgical Centers (ASCs) and Free Standing Surgical Centers (FSSCs). In addition, all rules and regulations in the General Policy and referenced in the provider Contract are applicable to ASC/FSSC providers.

#### **1.2 Surgical Center Definition**

1.2.1 ASCs and FSSCs, for the purpose of this manual, are defined as distinct entities that operate exclusively for the purpose of furnishing outpatient surgical services to patients.

#### **1.3 Required Certification**

1.3.1 ASCs or FSSCs may provide services through the Delaware Medical Assistance Program (DMAP) if the facility is certified by the Office of Health Facilities, Licensing and Certification under the rules and regulations of the State of Delaware's Board of Health for Free Standing Surgical Centers or a comparable certifying agency in the State in which the provider is located.

#### **1.4 Documentation**

1.4.1 All services must be fully documented and records available for review by the DMAP or its designees. Upon request, ASC/FSSC providers must produce photocopies of records for utilization review.

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## **2.0 Covered Services**

### **2.1 Surgical Procedures**

2.1.1 DMAP reimbursable services are those Medicare covered surgical procedures that are furnished by an ASC or FSSC and which are otherwise covered by the DMAP if furnished on an inpatient or outpatient basis in a hospital or a physician's office. The DMAP reimbursement for ASC represents the facility service cost only.

### **2.2 Examples of Covered Services**

2.2.1 Nursing services, services of technical personnel, and other related services.

2.2.2 The use by the patient of the ASC/FSSC facilities.

2.2.3 Drugs, biologicals, surgical dressings, supplies, splints, casts, appliances and equipment.

2.2.4 Diagnostic or therapeutic items and services.

2.2.5 Administrative, record keeping and housekeeping items and services.

2.2.6 Blood, blood plasma, platelets, etc., except for those to which the blood deductible applies.

2.2.7 Materials for anesthesia.

2.2.8 Intraocular lenses (IOLs).

### **2.3 Other Services**

2.3.1 Corneal tissue acquisition may be billed by the ASC/FSSC in addition to the covered services listed above.

2.3.2 All other services, such as physician professional services (Surgeons/Anesthesiologists), durable medical equipment for the use in the home, and laboratory and x-ray, must be billed to the DMAP under rules and policies applicable to those services. Provider manuals are available for these service providers.

## **2.4 Medicare Policies for ASCs**

- 2.4.1 DMAP coverage for ASC/FSSC follows the Medicare policies for ASCs, which states:  
"...the Medicare definition of covered [ASC] facility services is both inclusive and exclusive. The definition specifies what are not facility services as much as it details what are facility services. Generally, facility services are items and services furnished in connection with listed covered procedures that are covered if furnished in a hospital operating suite or hospital outpatient department in connection with such procedures. These do not include physician' services, or medical and other services for which payment may be made under other Medicare provisions (e.g., services of an independent laboratory located on the same site as the ASC)."

## **2.5 CPT Procedures Code Selection Cautions**

- 2.5.1 Providers are reminded to choose their CPT procedure codes carefully with the following cautions in mind:
- 2.5.1.1 Do not use multiple procedure codes when a single procedure code accurately describes the services rendered.
- 2.5.1.2 Some codes specify bilateral or unilateral. Be sure to utilize a code that correctly indicates this factor or use a modifier, if appropriate.

## **3.0 Non-Covered Services**

### **3.1 Examples of Non-ASC/FSSC Facility Services**

- 3.1.1 Services not covered by the DMAP include those excluded by Medicare.
- 3.1.2 Examples of items or services that are not ASC/FSSC facility services include:
- 3.1.2.1 Physicians' services
  - 3.1.2.2 The sale, lease, or rental of durable medical equipment to ASC/FSSC patients for use in their homes
  - 3.1.2.3 Prosthetic devices, except intraocular lenses (IOLs)
  - 3.1.2.4 Ambulance services
  - 3.1.2.5 Leg, arm, back and neck braces
  - 3.1.2.6 Artificial legs, arms, and eyes
  - 3.1.2.7 Services furnished by an independent laboratory
  - 3.1.2.8 Dental Services

### **3.2 DMAP Non-Covered Services**

- 3.2.1 No payment can be made to ASC/FSSC for facility services in connection with surgical procedures not covered by Medicare. In addition, the DMAP NEVER covers some services. These include, but are not limited to:
- Services which are not medically justified.
  - Cosmetic surgical procedures - defined as beautification or aesthetic surgery designed to improve the appearance of an individual by surgical alteration of a physical characteristic that is within the broad range of normal.
  - Procedures designated as experimental by the Medicare program.
  - Services denied by Medicare as not medically necessary.
  - Dental surgery for individuals age 21 and above.

- Infertility services.

3.2.2 For purposes of referral information, the DMAP also does not routinely cover orthotics and prosthetics for individuals age 21 and above.

## **4.0 Policies Regarding Sterilizations, Hysterectomies, and Abortions**

### **4.1 Sterilization / Hysterectomy Procedures**

- 4.1.1 The DMAP reimburses ASCs/FSSCs for voluntary sterilization and medically necessary hysterectomy procedures for eligible Medicaid clients if the procedure is covered by Medicare.
- 4.1.2 A requirement for payment is that EACH claim must be accompanied by either a Consent Form when a voluntary or elective sterilization is performed or an Awareness Form for medically necessary hysterectomy procedures that may result in sterilization. Refer to Appendix A for a copy of the Consent Form and Appendix B for a copy of the Awareness Form.
- 4.1.3 It is the responsibility of the attending physician to secure a properly executed form when a voluntary sterilization is requested or a hysterectomy is required. For billing purposes, the ASC/FSSC must secure the appropriate form from the operating surgeon. The DMAP does not cross-reference claims.
- 4.1.4 The DMAP will reimburse the ASC/FSSC and physicians (including anesthesiologists) who perform a voluntary sterilization or hysterectomy if the procedure meets the criteria set by federal and state regulations for payment.

### **4.2 Unilateral/Bilateral Sterilization Procedures**

- 4.2.1 Certain CPT procedure codes may describe a procedure that is performed for the purpose of voluntary sterilization or may describe a medically necessary procedure that may or may not result in sterilization. Claims for these procedures must be accompanied by either an Awareness or Consent Form depending on the exact nature of the surgery. A unilateral procedure requires an Awareness Form while a bilateral procedure requires a Consent Form. It is the responsibility of the ASC/FSSC to secure the appropriate form from the operating surgeon. The DMAP does not cross-reference claims.

### **4.3 Abortions**

- 4.3.1 The DMAP reimburses ASCs/FSSCs for abortion procedures for eligible Medicaid clients if Medicare covers the procedure.
  - 4.3.1.1 Endangerment to the Mother's Life
    - 4.3.1.1.1 Federal regulation, 42 CFR 441.203, permits the DMAP to reimburse for abortions if the "life of the mother would be endangered by the pregnancy."

- 4.3.1.1.2 Effective November 13, 1997 Federal law enacted new Hyde Amendment requirements for federally funded abortions. One of those requirements is that, in order for Medicaid to reimburse for an abortion, a physician must certify that a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, which would place the woman in danger of death unless an abortion is performed.
- 4.3.1.1.3 It is the responsibility of the ASC/FSSC to secure a copy of the Abortion Justification Form and complete medical record from the attending practitioner for their billing purposes. See Appendix C for a copy of the Abortion Justification Form.
- 4.3.1.2 Rape or Incest
- 4.3.1.2.1 Effective December 31, 1993, in compliance with the Hyde Amendment provision, the DMAP may reimburse for abortions to terminate pregnancies resulting from an act of rape or incest.
- 4.3.1.2.2 The practitioner must submit a letter stating that the request for the abortion is due to rape or incest and provide written documentation that the incident was reported to the police. In cases of incest where the victim is under 18 years of age, the incident must also have been reported to the Department of Services for Children, Youth and Their Families.
- 4.3.1.2.3 If an adult has just cause for not reporting a rape to the police, the practitioner must document the reason in writing. The DMAP will consider coverage on a case-by-case basis.
- 4.3.1.2.4 It is the responsibility of the ASC/FSSC to secure a copy of the practitioner's letter that documents the incident was reported to the police and, if applicable, to the Department of Services for Children, Youth and Their Families.

## 5.0 Reimbursement and Billing Instructions

### 5.1 Reimbursement

For dates of service through December 2007; ASC / FSSC rates are prospectively determined standard overhead amounts per procedure. Each covered service is assigned according to cost to one of several payment groups, each of which represents a reimbursement rate. Rates for each payment group are based on aggregate costs published by Center for Medicare and Medicaid Services (CMS). For dates of service on or after January 1, 2008; ASC/FSSC rates are paid based on the appropriate procedure code based rate established by CMS. Procedure code based rates vary depending on the county in which the billing ASC/FSSC provider is located.

### 5.2 Billing Instructions

- 5.2.1 ASC / FSSC claims must be billed on a CMS-1500 claim, or if billing electronically, the 837 Professional claim using appropriate surgical CPT-4 codes. The DMAP claims processing system will identify the appropriate group for pricing. If more than one surgical procedure is furnished in a single operative session, payment is based on the full rate for the procedure with the highest prospectively determined rate, and one half of the prospectively determined rate for each of the other covered procedures.
- 5.2.2 For individuals who are dually eligible for Medicare and Medicaid, Medicare is the primary payer. The DMAP may be billed for the co-insurance and deductible amounts. Refer to the General Billing Instruction section.
- 5.2.3 For individuals who have other health insurance, that insurance must be billed first and any balance may be billed to the DMAP. The DMAP considers all payments for the service and compares the amounts covered by other insurers to the DMAP maximum fee for the service. If the DMAP's fee has been met or exceeded by payments from the other insurer, no DMAP payment will be made. However, in this case, payment will be considered to be in full and the client may not be billed. Refer to the General Billing Policy section.

### 5.3 Billing for Terminated Procedures

- 5.3.1 The following criteria, also used by the Medicare program, must be met by an ASC/FSSC facility for a scheduled surgical procedure that is terminated due to medical complication that increase the surgical risk to the patient.
- 5.3.1.1 Do not bill the DMAP for a procedure that is terminated either for non-medical or medical reasons before the ASC/FSSC has expended substantial resources. For example, the DMAP must not be billed if scheduled surgery is canceled or postponed because the patient on intake complains of a cold or flu.

- 5.3.1.2 If a surgical procedure is terminated due to the onset of medical complications after the patient has been prepared for surgery and taken to the operating room but before anesthesia has been induced, DMAP will reimburse the facility one-half of the normal rate for the procedure. For example, if the patient develops an allergic reaction to a drug administered by the ASC/FSSC prior to surgery, or if, upon injection of a retrobulbar block, the patient experiences a retrobulbar hemorrhage which prevents continuation of the procedure, DMAP reimbursement will be halved. Providers must identify a terminated procedure in this category by reporting a modifier of “53”.
- 5.3.1.3 If a medical complication arises which causes the procedure to be terminated after inducement of the anesthetic agent, DMAP will reimburse the procedure at the full rate. For example, if, after anesthesia has been accomplished and the surgeon has made a preliminary incision, the patient's blood pressure increases suddenly and the surgery is terminated to avoid increasing surgical risk to the patient, DMAP will pay the full rate. In cases such as this, it is assumed that the resources of the facility are consumed in essentially the same manner and to the same extent as they would have been used had the surgery been completed.
- 5.3.2 A claim requesting DMAP payment for terminated surgery must be accompanied by an operative report that specifies the following:
- 5.3.2.1 Reason for termination of surgery
  - 5.3.2.2 Services actually performed
  - 5.3.2.3 Supplies actually provided
  - 5.3.2.4 Services not performed that would have been performed if the surgery had not been terminated
  - 5.3.2.5 Supplies not provided that would have been provided if the surgery had not been terminated
  - 5.3.2.6 Time actually spent in each stage, e.g. pre-operative, operative, and post-operative
  - 5.3.2.7 Time that would have been spent in each of these stages if the surgery had not been terminated
  - 5.3.2.8 CPT-4 code for procedure had the surgery been performed

## **5.4 Billing for Multiple Procedures**

- 5.4.1 When more than one surgical procedure is performed in the same operative session, special payment rules apply, even if the services have the same CPT-4

procedure code number. Claims that contain multiple surgeries for the same day and claims that are submitted separately, but for services to the same client on the same day will be suspended for review. These claims must have operative notes attached describing in detail the services provided.

## **5.5 Billing for Bilateral Procedures**

- 5.5.1 A procedure for which there is no bilateral code but which is performed bilaterally in one operative session is reported as two units of service with the same procedure code

## **5.6 Billing for Corneal Tissue Acquisition**

- 5.6.1 When billing for corneal tissue acquisition, use the appropriate HCPCS procedure code and attach the invoice from the supplying eye bank showing the actual cost incurred.

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## Consent Form

### 6.0 Appendix A – Consent Form

#### DELAWARE MEDICAL ASSISTANCE PROGRAM CONSENT FORM

**NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.**

##### CONSENT TO STERILIZATION

I have asked for and received information about sterilization from \_\_\_\_\_ (Doctor or Clinic). When I first asked for the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care or treatment. I will not lose any help or benefits from programs receiving Federal funds, such as A.F.D.C. or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT AND NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected these alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as \_\_\_\_\_. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by federally funded programs.

I am at least 21 years of age and was born on \_\_\_\_\_ Month Day Year. I, \_\_\_\_\_, hereby consent of my own free will to be sterilized by \_\_\_\_\_ (Doctor) by a method called \_\_\_\_\_. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

- Representatives of the Department of Health, Education and Welfare or Employees of programs or projects funded by that Department but only for determining if Federal laws were observed.
- I have received a copy of this form.

Signature \_\_\_\_\_ Date: \_\_\_\_\_ Month Day Year

You are requested to supply the following information, but it is not required:

- Race and ethnicity designation (Please Check)
- |   |   |
|---|---|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Black (not of Hispanic origin) |
| <input type="checkbox"/> Asian or Pacific Islander        | <input type="checkbox"/> Hispanic                       |
|   | <input type="checkbox"/> White (not of Hispanic origin) |

##### INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized: I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in \_\_\_\_\_ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

Interpreter \_\_\_\_\_ Date \_\_\_\_\_

DOC. NO. 35-07-01-89-08-02-ES-14

##### STATEMENT OF PERSON OBTAINING CONSENT

Before \_\_\_\_\_ signed the consent form, I explained to him/her the nature of the sterilization operation \_\_\_\_\_, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal Funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequence of the procedure.

Signature of Person Obtaining Consent \_\_\_\_\_ Date \_\_\_\_\_  
Facility \_\_\_\_\_  
Address \_\_\_\_\_

##### PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon \_\_\_\_\_ on \_\_\_\_\_ I explained to him/her the nature of the sterilization operation \_\_\_\_\_, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief the individual to be sterilized is at least 21 years old and appears mentally competent. He/She knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

**(Instructions for use of alternative final paragraphs:** Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

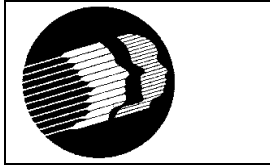
(1) At least thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- Premature delivery
- Individual's expected date of delivery:
- Emergency abdominal surgery: (describe circumstances):

Physician \_\_\_\_\_ Date \_\_\_\_\_

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# Awareness Form

## 7.0 Appendix B – Awareness Form

441.255 Sterilization by hysterectomy

(a) FFP is not available in expenditures for a hysterectomy if --

(1) It was performed solely for the purpose of rendering an individual permanently incapable of reproducing, or

(2) If there was more than one purpose to the procedure, it would not have been performed but for the purpose of rendering the individual permanently incapable of reproducing

(b) FFP is available in expenditure for a hysterectomy not covered by paragraph (a) of this section if --

(1) The person who secured authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing; and

(2) The individual or her representative, if any, has signed with a written acknowledgement of receipt of that information.

Patient's Name: \_\_\_\_\_

Medicaid No. \_\_\_\_\_ Date of Surgery \_\_\_\_\_

Physician's Name: \_\_\_\_\_

Surgical Procedure: \_\_\_\_\_

\*\*\*\*\*

**Section A:** Complete this section for patient's apparently presently capable of reproducing:

**1. Patient acknowledgement:**

It has been explained to me that the surgical procedure to be performed is medically necessary and as a result will render me permanently incapable of reproducing.

Date: \_\_\_\_\_

\_\_\_\_\_  
Patient's Signature (or Patient's Representative)

If required:

Date: \_\_\_\_\_

\_\_\_\_\_  
Interpreter's Signature

**2. Physician Certification:**

The surgical procedure to be performed on \_\_\_\_\_ is medically  
Patient's Name

indicated and is not solely for the purpose of rendering her permanently incapable of reproducing.

Date: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_

\*\*\*\*\*

**Section B:** Complete this section for other patients:

The surgical procedure to be performed on this patient is medically necessary and is unrelated to her ability to reproduce for the following reasons:

\_\_\_\_\_ This patient was surgically sterilized on \_\_\_\_\_  
approximate date

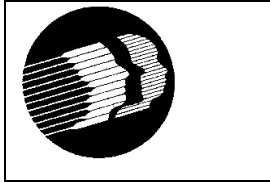
\_\_\_\_\_ This patient is post menopausal.

\_\_\_\_\_ This patient's reproductive capability will be maintained.

\_\_\_\_\_ Other as specified: \_\_\_\_\_

Date: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_

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### Abortion Justification Form

#### 8.0 Appendix C – Abortion Justification Form

Federal law has enacted new Hyde Amendment requirements for Federally funded abortions. One of those requirements is that, in order for Medicaid to reimburse for an abortion, a physician must certify that a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself, which would place the woman in danger of death unless an abortion is performed. Previously, a physician was required to certify only that, in the physician’s professional judgment, the life of the woman would be endangered if the fetus were carried to term.

The physician must complete this form and attach it to the claim being submitted for payment.

Client’s Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Medicaid ID#: \_\_\_\_\_

Primary Diagnosis for Abortion: \_\_\_\_\_

Other Diagnoses: \_\_\_\_\_

**STATEMENT OF JUSTIFICATION: The physician must detail the medical justification for the abortion and attach any pertinent information including laboratory tests, radiological evaluations, consultations, etc. If more space is needed additional pages may be attached.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, certify the above statement to be true

(Physician’s Live Signature)

and accurate.

Printed Name of Physician: \_\_\_\_\_

Physician’s Address: \_\_\_\_\_

\_\_\_\_\_

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