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CHAPTER THIRTY-EIGHT

AMBULATORY SURGICAL CENTER SERVICES

Chapter 38 Ambulatory Surgical Center Services

Rule No. 560-X-38-.01 General

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

(2) Ambulatory surgical center services shall be reimbursed by means of a predetermined fee established by the Alabama Medicaid Agency. All ambulatory surgical center procedures shall be reimbursed at the lesser of the predetermined rate for the procedure less the copay amount. The fee is established at levels estimated to approximate the costs incurred by providers generally in providing covered services.

(3) Ambulatory surgical center services shall be limited to three (3) visits per calendar year.

Authority: 42 C.F.R. Sections 416.2, 416.39, and 416.40. Rule effective September 1, 1986.

Rule No. 560-X-38-.02 Participation

(1) In order to participate in the Title XIX Medicaid Program and to receive Medicaid payment for services, ASC providers must meet all of the following requirements:

(a) Certification for participation in the Title XVIII Medicare Program;

(b) Approval by the appropriate licensing authorities;

(c) Compliance with Title VI of the Civil Rights Act of 1964 and with Section 504 of the Rehabilitation Act of 1973; and

(d) Submit a letter requesting enrollment, a copy of a transfer agreement with an acute care facility (refer to Rule No. 560-X-38-.05 for details), and enter into a contract with the Alabama Medicaid Agency.

(e) Reimbursement is limited to services provided directly by the facility's staff in accordance with the capability as specified on the HCFA-377.

(2) The fiscal agent will be responsible for enrolling any Title XVIII (Medicare) certified Ambulatory Surgery Centers that wish to be enrolled as Qualified Medicare Beneficiary (QMB) only providers.

Authority: 42 C.F.R. Section 416.2, Section 416.39, and Section 416.40. Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360). Rule effective September 1, 1986. Rule amended July 13, 1989. Effective date of this amendment September 11, 1992.

Rule No. 560-X-38-.03 Payment

(1) Payment shall be made for a surgical procedure performed on a Medicaid recipient only if the procedure is on the approved list.

(2) Ambulatory surgical center services are items and services furnished by an outpatient ambulatory surgery center in connection with a covered surgical procedure.

(3) Rates of reimbursement for ambulatory surgical center services include, but are not limited to:

(a) Nursing, technician and related services;

(b) Use of an ambulatory surgery center;

(c) Lab and x-ray, drugs, biologicals, surgical dressings, splints, casts, appliances, and equipment directly related to the provision(s) of the surgical procedure(s);

(d) Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;

(e) Administrative, record keeping, and housekeeping items and services; and

(f) Materials for anesthesia.

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

(a) Physician services;

(b) Lab and x-ray not directly related to the surgical procedure;

(c) Diagnostic procedures (other than those directly related to performance of the surgical procedure);

(d) Prosthetic devices (except intraocular lens implant);

(e) Ambulance services;

(f) Leg, arm, back, and neck braces;

(g) Artificial limbs; and

(h) Durable medical equipment for use in the patient's home.

Authority: State Plan, Attachment 3.1-A; 42 C.F.R. Section 416.61, Section 416.65, and Section 416.120. Rule effective September 1, 1986. Effective date of this amendment March 12, 1988.

Rule No. 560-X-38-.04 Covered Surgical Procedures

(1) Covered surgical procedures are those procedures that meet the following standards:

(a) Those surgical procedures which are commonly performed on an inpatient basis in hospitals, but may be safely performed in an ambulatory surgical center setting;

(b) Those surgical procedures which are limited to those requiring a dedicated operating room and generally requiring a post-operative recovery room or short-term (not overnight) convalescent room; and

(c) Those surgical procedures which are not otherwise excluded under 42 C.F.R. Section 405.310 or other regulatory requirements.

(2) A listing of the covered surgical procedures shall be maintained by the Alabama Medicaid Agency and shall be furnished to all ASCs. This list shall be reviewed and updated on a regular basis by the appropriate staff of the Alabama Medicaid Agency.

Authority: 42 C.F.R. Section 405.310 and Section 416.65. Rule effective September 1, 1986.

Rule No. 560-X-38-.05 Ambulatory Surgical Center Transfer Procedures

(1) The ambulatory surgical centers shall have an effective procedure for the immediate transfer to a hospital of patients requiring emergency medical care beyond the capabilities of the center. The hospital shall have a provider contract with the Alabama Medicaid Agency. The center shall have a written transfer agreement with said hospital, and each physician performing surgery in the center shall have admitting privileges at said hospital. The center shall furnish the Alabama Medicaid Agency with evidence of such prior to its enrollment. Changes in this submitted information will also be made available to the Medicaid Agency.

Authority: 42 C.F.R. Section 416.41. Rule effective September 1, 1986.

Rule No. 560-X-38-.06 Surgical Procedures Groups

(1) The surgical procedures shall be 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 the Alabama Medicaid Agency. The group payment amount is lowest for Group One procedures and highest for Group Nine. A provider shall receive the lesser of the submitted charge or the designated group charge less the copay amount.

Author: Solomon Williams, Associate Director, Institutional Services, Managed Care Division
Authority: 42 C.F.R. Section 405.310 and Section 416.65.
History: Rule effective September 1, 1986; **Amended:** Filed November 12, 2014; effective December 17, 2014.

Rule No. 560-X-38-.07 Submission of Claims

(1) Ambulatory surgical center services are treated as medical services. UB82 claim forms shall be submitted for payment listing facility provider number, HCFA Common Procedure Coding System (HCPCS) and ICD-9-CM diagnosis codes (dates services prior and up to September 30, 2015) or ICD-10-CM diagnosis codes (dates of services October 1, 2015 and forward).

(2) If one covered surgical procedure is furnished to a Medicaid recipient in an operative session, payment shall be at the lesser of the submitted charges, or l00 percent of the predetermined rate for the procedure.

(3) If more than one covered surgical procedure is furnished to a Medicaid recipient in a single operative session, payment shall be made at the lesser of the submitted charges, or at 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.

Author: Solomon Williams, Associate Director, Institutional Services

Authority: 42 C.F.R. Section 416.120.
History: Rule effective September 1, 1986. **Amended:** Filed August 27, 2015; effective October 1, 2015.

Rule No. 560-X-38-.08 Patient Signature

(1) Refer to Chapter One of the Alabama Medicaid Administrative Code Rule 560-X-1-.18(5)(a), as amended.

Authority: State Plan; Title XIX, Social Security Act; Alabama Medicaid Agency Administrative Code. Rule effective September 1, 1986.

Rule No. 560-X-38-.09 Billing and Sending Statement to Eligible Alabama Medicaid Recipients

(1) No eligible Alabama Medicaid recipient shall receive a bill or statement for covered services or items once the recipient has been accepted as a Medicaid patient. A recipient may be billed by the provider for noncovered services or items.

(2) The provider may send a notice to the recipient stating the recipient's claim is outstanding provided the notice indicates in bold letters: "THIS IS NOT A BILL."

(3) It is the responsibility of the provider to pursue any unpaid claim with the fiscal agent and/or Medicaid involving Medicaid covered services.

(4) No recipient is responsible for the difference between the covered charges billed and the amount paid by Medicaid for covered charges. A provider agrees to accept as payment in full the amount paid by Medicaid for covered services, and further agrees to make no additional charge(s) for covered services to the recipient, sponsor, or family of the recipient.

Authority: State Plan, Title XIX Social Security Act, 42 C.F.R. Section 447.15, Section 447.50, and Section 447.55. Rule effective September 1, 1986.

Rule No. 560-X-38-.10 Copayment (Cost-Sharing)

(1) Medicaid recipients are required to pay, and ambulatory surgery center providers are required to collect, the designated copayment amount for each visit. Refer to Rule #560-X-1-.25 General Chapter for copay information.

(2) A provider may not deny services to any eligible individual due to the individual's inability to pay the cost-sharing amount imposed.

Authority: State Plan, Attachment 4.18-A, Title XIX, Social Security Act, 42 C.F.R. Section 447.50, Section 447.55, and Section 447.15. Rule effective September 1, 1986.