



Mississippi Medicaid
Provider Reference Guide
For Part 210
Ambulatory Surgical Center

*This is a companion document to the
Mississippi Administrative Code Title 23
and must be utilized as a reference only.*

Table of Contents

Ambulatory Surgical Center	1
Dual Eligibles.....	2
Documentation Requirements.....	2
Covered Services	2
Non-Covered Services	3
Canceled Procedures.....	3
Elective Cancellation of Procedures Not Related to the Beneficiary’s Medical Condition.....	3
Canceled or Incomplete Procedures Related to the Beneficiary’s Medical Condition	3
Reimbursement	3
Bilateral Procedures	4
Payment for Multiple Procedures	4
Billing for Multiple Surgery	4
Reimbursement for Multiple Surgery	4
Add On Codes.....	6
Reimbursement for Bilateral Procedures	6
Reimbursement for Endoscopy Procedures	6
Modifiers.....	6
Exempt Procedures	6
Endoscopy.....	6
Hysterectomy	6
Sterilization.....	6
Corneal Tissue Implants	6
Dentoalveolar Structures.....	7
Co-Payment.....	7

Ambulatory Surgical Center

Medicaid, as authorized by Title XIX of the Social Security Act, is a federal and state program of medical assistance to qualified individuals. Each state designates a state agency as the single state agency for the administration of Medicaid. State law has designated the Division of Medicaid, Office of the Governor, as the single state agency to administer the Medicaid program in Mississippi.

Ambulatory Surgical Center (ASC) shall mean a publicly, or privately owned institution not considered a part of a hospital, in accordance with its function. In addition, it must be operated by its own organized medical and administrative staff primarily for the purpose of providing elective surgical treatment for “outpatients” whose recovery under normal and routine circumstances will not require “inpatient” care. Such facility, as herein defined, does not include the offices of private physicians or dentists, whether practicing individually or in groups, but does include facilities engaged in such outpatient surgery, whether using the name “ambulatory surgical” facility or a similar or different name. If the facility is considered to be operated by a hospital or hospital holding, leasing, or management company, whether for-profit or non-profit, it must be a separate, identifiable entity which is physically, administratively and financially independent and distinct from other operations of any hospital. Once licensed and certified as such, the “facility” will not be allowed to revert to the position as a component part of any hospital without securing a Certificate of Need to do so.

An ASC provider’s participation in the Mississippi Medicaid program is entirely voluntary. However, if a provider does choose to participate in Medicaid, the provider must accept the Medicaid payment as payment in full for those services covered by Medicaid. The provider cannot charge the beneficiary the difference between the usual and customary charge and Medicaid’s payment. The ASC provider cannot accept payment from the beneficiary, bill Medicaid, and then refund Medicaid’s payment to the beneficiary.

To obtain a Mississippi Medicaid provider number, the Ambulatory Surgical Center must submit a copy of their Medicare certification (copy of letter from Medicare which advises that a provider is certified as an ASC and provides them with their Medicare provider number). This information must be submitted with their Mississippi Medicaid enrollment packet. No Medicaid provider number will be issued without the Medicare certification.

The Mississippi Medicaid program purchases needed health care services for beneficiaries as determined under the provision of the Mississippi Medical Assistance Act. The Division of Medicaid (DOM) is responsible for formulating program policy. DOM staff is directly responsible for the administration of the program. Under the direction of DOM, the fiscal agent is responsible for processing claims, issuing payments to providers, and for notifications regarding billing. Medicaid Policy as it relates to these factors is initiated by DOM.

Dual Eligibles

If a beneficiary is covered under both Medicare and Medicaid, then Medicare is the primary source for care and coverage, and all services must first be billed to Medicare, even though the beneficiary is eligible for Medicaid.

Documentation Requirements

All professional and institutional providers participating in the Medicaid program are required to maintain records that will disclose services rendered and billed under the program and, upon request, make records available to representatives of DOM or Office of Attorney General in substantiation of any or all claims. These records should be retained a minimum of five (5) years in order to comply with all state and federal regulations and laws.

Providers must maintain proper and complete documentation to verify the services provided. The provider has full responsibility for maintaining documentation to justify the services provided.

DOM and/or the fiscal agent have the authority to request any patient records at any time to conduct a random sampling review and/or document any services billed by the ASC.

If an ASC's records do not substantiate services paid for under the Mississippi Medicaid program, as previously noted, the provider will be asked to refund to the Mississippi Medicaid program any money received from the program for such non-substantiated services. If a refund is not received within thirty (30) days, a sum equal to the amount paid for such services will be deducted from any future payments that are deemed to be due the ASC provider.

An ASC provider who knowingly and willfully makes or causes to be made false statement or representation of a material fact in any application for Medicaid benefits or Medicaid payments may be prosecuted under federal and state criminal laws. A false attestation can result in civil monetary penalties as well as fines, and shall automatically disqualify the ASC provider as a provider of Medicaid services.

Covered Services

“Ambulatory surgery” shall mean surgical procedures that are more complex than office procedures performed under local anesthesia, but less complex than procedures requiring prolonged postoperative monitoring and hospital care to ensure safe recovery and desirable results.

Services performed in an ASC do not require prior authorization.

Non-Covered Services

In keeping with the Mississippi Medicaid policy for not providing reimbursement for services that are noncovered, any non-covered procedure performed in an ASC setting will result in this portion, or possibly the entire claim, being disallowed. Eligibility for and payment of Medicaid services are subject to all terms and conditions and limitations of the Medicaid program.

Canceled Procedures

Elective Cancellation of Procedures Not Related to the Beneficiary's Medical Condition

When a surgical or other procedure is canceled due to scheduling conflicts of the operating suite or physician, beneficiary request, or other reason not related to medical necessity, the procedure may not be billed to Medicaid and no payment will be made for the procedure. Services provided prior to the procedure may be billed and will be covered subject to usual Medicaid policies for those services.

Canceled or Incomplete Procedures Related to the Beneficiary's Medical Condition

When a surgical or other procedure is canceled or terminated before completion due to changes in the beneficiary's medical condition that threaten his/her well-being, the services that were actually performed may be billed and will be covered subject to usual Medicaid policies for those services. There must be clear documentation regarding the medical necessity for cancellation or termination of the procedure.

Reimbursement

Reimbursable ASC services are facility services furnished in connection with covered surgical procedures to Medicaid beneficiaries by an ASC who is a Mississippi Medicaid provider. Payment made under the Medicaid ASC program will be in accordance with the Medicaid ASC Procedure Schedule or usual and customary charges, whichever is less.

To access the ASC Fee Schedule:

Go to www.medicaid.ms.gov

Click on the Providers Tab

Click on the Fee Schedules Tab

Click on the ASC Fee Schedule Tab

Bilateral Procedures

Refer to Surgery Part 203, Chapter 4, in the Administrative Code.

Payment for Multiple Procedures

Billing for Multiple Surgery

Multiple surgical procedures performed at an ASC by the same surgeon on the same patient and on the same date of service must be billed together on the same CMS-1500 claim form unless one claim form does not accommodate all of the procedures.

The primary surgical procedure must be listed first. Under Mississippi Medicaid, the primary procedure is recognized as the procedure which allows the greatest reimbursement from the Mississippi Medicaid ASC Fee Schedule. Each secondary procedure should be billed on subsequent lines following the primary procedure.

If a provider does not agree with the amount of payment on a particular surgical procedure, the claim must NOT be resubmitted. The provider must submit a written request for reconsideration to the Fiscal Agent's Medical Review Unit which includes an explanation or justification for a different payment.

If a provider receives a denial on a particular surgical procedure because the procedure is non-covered, incidental, mutually exclusive, rebundled to another procedure, investigative, or a procedure on which the medical necessity has not been established, the claim must NOT be resubmitted. If a provider does not agree with these determinations, the provider must submit to the Fiscal Agents' Medical Review Unit a written request for reconsideration which includes an explanation or justification for the request for payment.

Reimbursement for Multiple Surgery

For multiple surgeries performed on the same day, the following reimbursement criteria apply:

1. Multiple surgical procedures performed at the same operative setting through a single opening are reimbursable at the Medicaid rate for the procedure with the greatest reimbursement. The additional surgeries through this same opening are not reimbursable.

Exceptions: If a second surgical procedure adds significant time, risk, or complexity to patient care:

- The surgery with the greater Medicaid allowed amount will be paid at the full amount

- The second surgery will be paid at half the Medicaid allowance. The secondary Procedure must be billed with Modifier-51.
 - No additional benefits are paid toward incidental, mutually exclusive, or unbundled procedures.
2. Multiple surgical procedures performed at the same operative setting through separate incisions are reimbursed as follows:
- The surgery with the greater Medicaid allowance amount will be paid that amount.
 - Secondary surgeries, except incidental, mutually exclusive, and unbundled procedures, will be paid at half their Medicaid allowance. These procedures must be identified with the Modifier-51. No benefits are provided for incidental, mutually exclusive, and unbundled procedures.
 - The exception is lesions, on which the maximum number allowed is two (2) lesions.

Modifier-51 indicates more than one surgical procedure was performed at the same operative session by the same provider. Modifier-51 identifies surgical procedures performed in combination, whether through the same or another incision or involving the same or different anatomy. Multiple related surgical procedures or a combination of medical and surgical procedures performed at the same session must be designated with modifier-51.

3. Secondary procedures must meet all of the following criteria:
- The secondary procedure is to correct a separate pathological condition
 - That pathological condition would have required intervention had an incision not already been present
 - The degree of difficulty, operative time and risk were significantly increased by the secondary procedure.
4. If, after a surgical procedure has been completed, it becomes necessary to return and perform a subsequent surgical procedure that same day, Medicaid will reimburse the full-allowed amount for each surgical setting in accordance with multiple surgery criteria. In such a case, the second surgical setting should be submitted on a hard copy CMS-1500 claim form with documentation that justifies the separate surgical setting and includes the operative report.

Add On Codes

Add on codes for covered surgical procedures will be reimbursed at 50% of the Medicaid allowable.

Reimbursement for Bilateral Procedures

Refer to Surgery Part 203, Chapter 4, in the Administrative Code.

Reimbursement for Endoscopy Procedures

Refer to Surgery Part 203, Chapter 4, in the Administrative Code.

Modifiers

The following modifiers must be utilized on claims for surgery:

51 – Multiple Procedure

When it is necessary to report multiple modifiers, the modifiers must be listed in numerical order.

Exempt Procedures

Refer to Surgery Part 203, Chapter 4, in the Administrative Code.

Endoscopy

Refer to Surgery Part 203, Chapter 4, in the Administrative Code

Hysterectomy

Refer to Hospital Inpatient, Part 202, Chapter 1, in the Administrative Code.

Sterilization

Refer to Hospital Inpatient, Part 202, Chapter 1, in the Administrative Code.

Corneal Tissue Implants

The Division of Medicaid (DOM) will reimburse Ambulatory Surgical Centers (ASC's) for the cost of corneal tissue used in corneal transplant cases. The reimbursement will be 100% of the cost reflected on the invoice from the donor supplier excluding transportation fees. Transportation fees are not covered under the Mississippi Medicaid program.

Ambulatory Surgical Centers may bill for the costs of corneal tissue by:

1. Filing a hard copy CMS 1500 form
2. Assigning HCPCS code V2785 for the corneal tissue
3. Attaching an invoice from the donor supplier which lists both the tissue costs and the transportation fees.

If an invoice is received without the transportation fees being listed, the claim will be denied until an invoice is received with the itemization. The fee for the corneal tissue must be included on the same CMS 1500 claim form as the fees for the corneal transplant.

This policy is applicable only to Ambulatory Surgical Centers.

Dentoalveolar Structures

Claims billed by an ASC for CPT code 41899 do not require prior approval. Providers must submit these claims with documentation verifying coverage criteria were met and justifying the necessity of performing the procedure in an ASC rather than the dentist's office. The claims will be reviewed by the fiscal agent's Medical Review Unit to determine appropriateness to pay.

At least one of the following criteria must be met:

- The patient's age is six (6) years old or less.
- The patient has a physically or mentally compromising condition.
- The patient is extremely uncooperative due to acute situational anxiety, attention deficit disorder, or emotional disorder.
- The patient has extensive orofacial and dental trauma.

Co-Payment

Refer to Administrative Code Part 200, Chapter 3, for Beneficiary Cost Sharing policy.