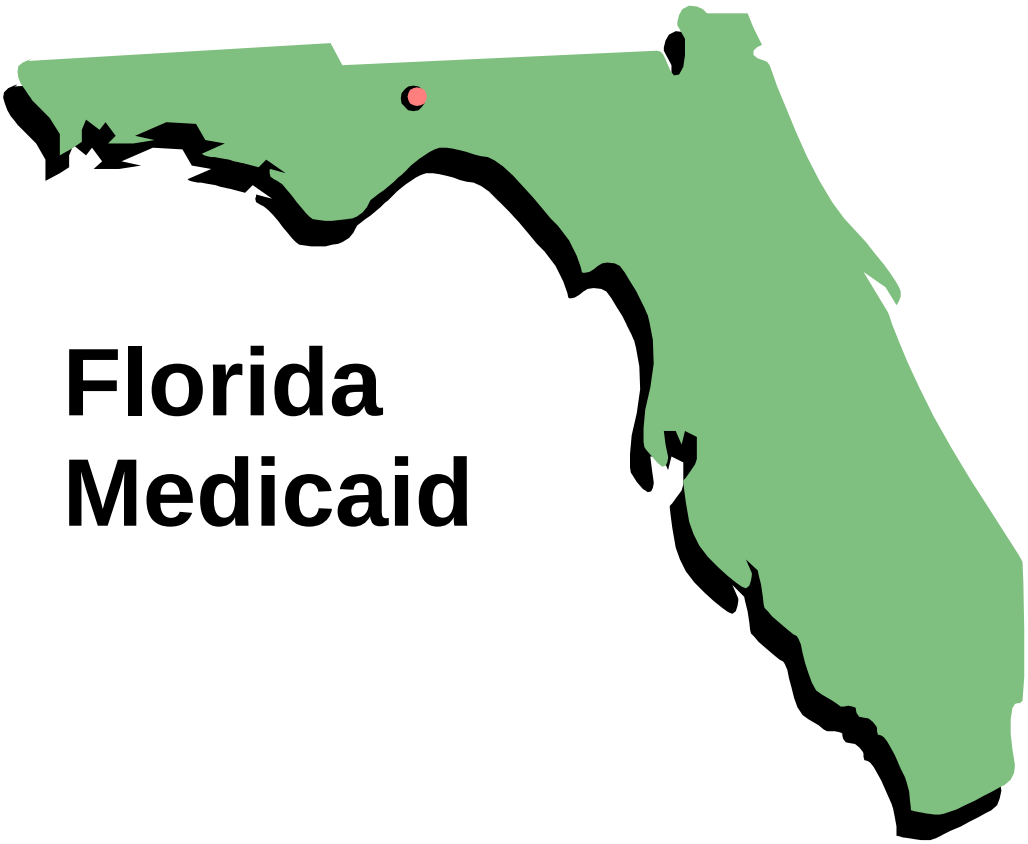

Florida Medicaid

Ambulatory Surgical Center Services Coverage Policy

Agency for Health Care Administration

January 2019

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1.0 Introduction

Florida Medicaid ambulatory surgical center (ASC) services provide outpatient surgical services to recipients not requiring hospitalization.

1.1 Florida Medicaid Policies

This policy is intended for use by providers that render ASC services to eligible Florida Medicaid recipients. It must be used in conjunction with Florida Medicaid's General Policies (as defined in section 1.3) and any applicable service-specific and claim reimbursement policies with which providers must comply.

Note: All Florida Medicaid policies are promulgated in Rule Division 59G, Florida Administrative Code (F.A.C.). Coverage policies are available on the Agency for Health Care Administration's (AHCA) Web site at http://ahca.myflorida.com/Medicaid/review/index.shtml.

1.2 Statewide Medicaid Managed Care Plans

Florida Medicaid managed care plans must comply with the service coverage requirements outlined in this policy, unless otherwise specified in the AHCA contract with the Florida Medicaid managed care plan. The provision of services to recipients enrolled in a Florida Medicaid managed care plan must not be subject to more stringent coverage limits than specified in Florida Medicaid policies.

1.3 Legal Authority

Florida Medicaid ambulatory surgical center services are authorized by the following:

- Sections 1832 and 1833 of the Social Security Act (SSA)
- Title 42, Code of Federal Regulations (CFR), Part 416
- Section 409.906, Florida Statutes (F.S.)

1.4 Definitions

The following definitions are applicable to this policy. For additional definitions that are applicable to all sections of Rule Division 59G, F.A.C., please refer to the Florida Medicaid Definitions Policy.

1.4.1 Claim Reimbursement Policy

A policy document found in Rule Division 59G, F.A.C. that provides instructions on how to bill for services.

1.4.2 Coverage and Limitations Handbook or Coverage Policy

A policy document found in Rule Division 59G, F.A.C. that contains coverage information about a Florida Medicaid service.

1.4.3 General Policies

A collective term for Florida Medicaid policy documents found in Rule Chapter 59G-1, F.A.C. containing information that applies to all providers (unless otherwise specified) rendering services to recipients.

1.4.4 Medically Necessary/Medical Necessity

As defined in Rule 59G-1.010, F.A.C.

1.4.5 Multiple Surgery Claim

A claim with multiple procedures performed on a patient in an ASC on the same day.

1.4.6 Provider

The term used to describe any entity, facility, person, or group enrolled with AHCA to furnish services under the Florida Medicaid program in accordance with the provider agreement.

1.4.7 Recipient

For the purpose of this coverage policy, the term used to describe an individual enrolled in Florida Medicaid (including managed care plan enrollees).

2.0 Eligible Recipient

2.1 General Criteria

An eligible recipient must be enrolled in the Florida Medicaid program on the date of service and meet the criteria provided in this policy.

Provider(s) must verify each recipient's eligibility each time a service is rendered.

2.2 Who Can Receive

Florida Medicaid recipients requiring medically necessary services performed in an ASC. Some services may be subject to additional coverage criteria as specified in section 4.0.

2.3 Coinsurance and Copayments

There is no coinsurance or copayment for this service in accordance with section 409.9081, F.S. For more information on copayment and coinsurance requirements and exemptions, please refer to Florida Medicaid's Copayments and Coinsurance Policy.

3.0 Eligible Provider

3.1 General Criteria

Providers must meet the qualifications specified in this policy in order to be reimbursed for Florida Medicaid ambulatory surgical center services.

3.2 Who Can Provide

Services must be rendered by an ASC that meets both of the following:

- Is licensed in accordance with Chapter 395, Part I, F.S. and Rule Chapter 59A-5, F.A.C.
- Has an agreement with the Centers for Medicare and Medicaid Services in accordance with 42 CFR 416 for the purpose of providing surgical services to recipients not requiring hospitalization

4.0 Coverage Information

4.1 General Criteria

Florida Medicaid covers services that meet all of the following:

- Are determined medically necessary
- Do not duplicate another service
- Meet the criteria as specified in this policy

4.2 Specific Criteria

Florida Medicaid covers services provided in an ASC in accordance with 42 CFR 416, the American Medical Association's Current Procedural Terminology, the applicable Florida Medicaid fee schedule, or as specified in this policy, for items and services ordinarily furnished for the purpose of performing surgery, including the following:

- Anesthesia services
- Dental procedures
- Drugs and biologicals
- Equipment
- Laboratory testing
- Medical and surgical supplies
- Nursing, technician, and related services
- Radiology services
- Surgical services
- Splints, casts, and related devices

4.2.1 Emergency Services
Florida Medicaid covers emergency services provided in an ASC when a recipient cannot be transferred to a hospital for treatment, leaving no other option than to provide services at the ASC location.

4.2.2 Terminated Procedures
Florida Medicaid covers services performed in an ASC that are terminated before the service or procedure is complete when the recipient's well-being is threatened by medical complications.

4.3 Early and Periodic Screening, Diagnosis, and Treatment
As required by federal law, Florida Medicaid provides services to eligible recipients under the age of 21 years, if such services are medically necessary to correct or ameliorate a defect, a condition, or a physical or mental illness. Included are diagnostic services, treatment, equipment, supplies, and other measures described in section 1905(a) of the SSA, codified in Title 42 of the United States Code 1396d(a). As such, services for recipients under the age of 21 years exceeding the coverage described within this policy or the associated fee schedule may be approved, if medically necessary. For more information, please refer to Florida Medicaid's Authorization Requirements Policy.

5.0 Exclusion

5.1 General Non-Covered Criteria
Services related to this policy are not covered when any of the following apply:

- The service does not meet the medical necessity criteria listed in section 1.0
- The recipient does not meet the eligibility requirements listed in section 2.0
- The service unnecessarily duplicates another provider's service

5.2 Specific Non-Covered Criteria
Florida Medicaid does not cover the following as part of this service benefit:

- Anesthesia and anesthesiologist services, billed separately
- Artificial limbs
- Durable medical equipment
- Leg, arm, back, and neck braces that do not serve the function of a cast or splint
- Non-implantable prosthetic devices
- Services furnished by an independent laboratory
- X-rays or diagnostic procedures not directly related to the performance of the surgical procedure

6.0 Documentation

6.1 General Criteria
For information on general documentation requirements, please refer to Florida Medicaid's Recordkeeping and Documentation Requirements Policy.

6.2 Specific Criteria
Providers must submit the following forms with the claim, as applicable:

- State of Florida Abortion Certification Form, AHCA MedServ Form 011, June 2016, incorporated by reference in Rule 59G-1.045, F.A.C.
- The U.S. Department of Health and Human Services' Consent for Sterilization Form - HHS-687 (10/12), incorporated by reference in Rule 59G-1.045, F.A.C.

7.0 Authorization

7.1 General Criteria
The authorization information described below is applicable to the fee-for-service delivery system. For more information on general authorization requirements, please refer to Florida Medicaid's Authorization Requirements Policy.

7.2 Specific Criteria
Providers must obtain authorization from the quality improvement organization for all ASC services.

8.0 Reimbursement

8.1 General Criteria
The reimbursement information below is applicable to the fee-for-service delivery system.

8.2 Claim Type
Professional (837P/CMS-1500)

8.3 Billing Code, Modifier, and Billing Unit
Providers must report the most current and appropriate billing code(s), modifier(s), and billing unit(s) for the service rendered, incorporated by reference in Rule 59G-4.002, F.A.C.

8.3.1 Modifier
Providers must include the following on the claim form as appropriate:

- 50 Procedure is performed bilaterally
- 73 Service is discontinued prior to the administration of anesthesia
- 74 Service is discontinued after the administration of anesthesia

8.4 Diagnosis Code
Providers must report the most current and appropriate diagnosis code to the highest level of specificity that supports medical necessity, as appropriate for this service.

8.5 Rate
Florida Medicaid reimburses for ASC services using the Enhanced Ambulatory Patient Grouping (EAPG) reimbursement methodology in accordance with Rule 59G-6.031, F.A.C., except for vagus nerve stimulator devices.

For EAPG codes and relative weights see http://ahca.myflorida.com/medicaid/Finance/finance/institutional/hoppps.shtml.

For rates for services reimbursed outside of the EAPG methodology in accordance with Rule 59G-4.002, F.A.C., see http://ahca.myflorida.com/medicaid/review/fee_schedules.shtml.