TABLE OF CONTENTS

PAGE

**4.01** **DEFINITIONS** 1

4.01-1 Ambulatory Surgical Center 1

4.01-2 Facility Services 1

**4.02** **MEMBER ELIGIBILITY** 1

**4.03** **DURATION OF CARE** 1

**4.04** **COVERED SERVICES** 1

**4.05** **NON-COVERED SERVICES** 3

**4.06** **POLICIES AND PROCEDURES** 4

 4.06-1 Professional Staff 4

 4.06-2 Member Records 4

 4.06-3 Program Integrity 4

**4.07** **REIMBURSEMENT** 5

4.07-1 General Reimbursement Policy 5

4.07-2 Reimbursement for Multiple Procedures 5

Effective

6/15/16

 4.07-3 Reimbursement of Physician Services for Covered Services in an ASC 5

**4.08** **BILLING INSTRUCTIONS** 5

4.01 **DEFINITIONS**

4.01-1 **Ambulatory Surgical Center (ASC)** means a freestanding facility that operates exclusively for the purpose of providing surgical services to persons not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following admission. The ASC must be certified by Medicare and comply with applicable licensure requirements, if any, in the State or Province in which it operates.

Ambulatory Surgical Centers reimbursed as part of an acute care hospital are excluded as providers under this Section of the *MaineCare Benefits Manual*.

4.01-2 **Facility Services** means items and services furnished by an ASC in connection with a covered surgical procedure.

4.02 **MEMBER ELIGIBILITY**

Individuals must meet the financial eligibility criteria set forth in the *MaineCare Eligibility Manual*. Some members may have restrictions on the type and amount of services they are eligible to receive.

The provider is responsible for verifying a member’s eligibility for MaineCare prior to providing services on each occasion that services are provided. See Chapter I of the *MaineCare Benefits Manual* for more information on verifying eligibility.

4.03 **DURATION OF CARE**

Each MaineCare member is eligible for as many covered services as are medically necessary. The Department reserves the right to request additional information to determine medical necessity.

4.04 **COVERED SERVICES**

Covered services are those items and services, stated below, which are furnished by an ASC in connection with a covered surgical procedure. Unless otherwise stated below, only covered surgical procedures currently on the Medicare-approved list of ASC covered procedures are allowed. See the Federal Registrar for the annual ASC final rule or <http://www.cms.hhs.gov/ASCPayment/> for the current listing. Covered surgical procedures are those that would not be expected to pose a significant safety risk to a member when performed in an ASC, and for which standard medical practice dictates that the member would not typically be expected to require active medical monitoring and care at midnight following the procedure.

Effective

6/15/16

Coding for covered services is based on the latest version of the American Medical Association’s standard Current Procedural Terminology (CPT) codes and can be accessed through the Department’s website at: [https://mainecare.maine.gov/](https://mainecare.maine.gov/ProviderHomePage.aspx) .

4.04 **COVERED SERVICES** (cont.)

A. The following items and services are covered services and are included in the all-inclusive rates for reimbursement in this Section of the *MaineCare Benefits Manual*:

(1) Nursing, technical personnel and other related services;

These include all services in connection with covered procedures furnished by nurses, technical personnel and other support staff involved in patient care who are employees of the ASC.

(2) Use of surgical center facilities;

(3) Drugs and biologicals for which separate payments are not allowed under the hospital outpatient prospective payment system (OPPS);

Effective

6/15/16

(4) Any laboratory testing performed under a *Clinical Laboratory Improvement Amendments of 1988* (CLIA) certificate of waiver.

(5) Medical and surgical supplies not on pass-through status under 42 CFR 419.66 Subpart G;

(6) Equipment;

(7) Surgical dressings;

(8) Implanted prosthetic devices, including intraocular lenses (IOLs), (payment for presbyopia-correcting intraocular lens and astigmatism-correcting intraocular lens will be a the rate of a conventional intraocular lens) and related accessories and supplies not on pass-through status under 42 CFR 419.66 Subpart G;

(9) Implanted DME and related accessories and supplies not on pass-through status under 42 CFR 419.66 Subpart G;

(10) Splints and casts and related devices;

(11) Radiology services for which separate payment is not allowed under the OPPS, and other diagnostic tests or interpretive services that are integral to a surgical procedure;

(12) Administrative, recordkeeping and housekeeping items and services;

(13) Materials, including supplies and equipment for the administration and monitoring of anesthesia; and

(14) Supervision of the services of an anesthetist by the operating surgeon.

4.04 **COVERED SERVICES** (cont.)

B. **Ancillary Services**

Effective

6/15/16

Ancillary items and services that are integral to a covered surgical procedure (defined above) and for which separate payment is allowed, include the following:

* 1. Brachytherapy sources;
	2. Certain implantable items that have pass-through status under the OPPS;
	3. Certain items and services that CMS designates as contractor-priced, including but not limited to, the procurement of corneal tissue;
	4. Certain drugs and biologicals for which separate payment is allowed under the OPPS.

Effective

6/15/16

* 1. Certain radiology services for which separate payment is allowed under the OPPS.

When an ASC bills for services covered under this Section of the *MaineCare Benefits Manual* for a given operative procedure, the physician(s) involved in performing the operative procedure is to bill for his or her professional services only under Chapter II, Section 90, and not for related ancillary services such as anesthesia supplies, which are covered services under this Section.

4.05 **NON-COVERED SERVICES**

Non-covered services are services that are not billable under this section of policy as ASC facility services. ASC facility services do not include physician or anesthetist services (Section 90; Section 14); laboratory (Section 55), radiology or diagnostic procedures (other than those directly related to the performance of the surgical procedure) (Section 101); ambulance services (Section 5); or non-implantable prosthetic devices and durable medical equipment (other than those that serve the function of a case or splint or are otherwise considered integral to the performance of a covered surgical procedure) (Section 60).

Effective

6/15/16

Covered procedures are limited to those not expected to result in extensive loss of blood, but in some cases, blood and blood products may be required. When there is a need for blood and blood products, they are considered facility services and no separate charge is permitted.

Other non-covered services include those services that cannot be safely performed in an outpatient setting or without support of a full array of hospital diagnostic and treatment services and equipment; and procedures that are not covered by MaineCare (e.g., cosmetic surgery).

Services are not separately billable unless specifically allowed under Medicare.

4.06 **POLICIES AND PROCEDURES**

4.06-1 **Professional Staff**

A physician is a doctor of medicine or osteopathy who possesses a current license to practice medicine or osteopathy in the State or Province in which the services are provided.

4.06-2 **Member Records**

There shall be a specific record for each member that shall include, but not necessarily be limited to:

A. The member’s name, address, and birth date;

B. The member’s social and medical history, as appropriate;

C. Operative reports or procedure/treatment descriptions, as appropriate;

D. A description of any tests ordered and performed and their results;

E. A description of treatment or follow-up care and dates scheduled for revisits;

F. Any medications and/or supplies dispensed or prescribed;

G. Any recommendations for and referral to other sources of care;

H. The dates on which all services were provided;

I. Written progress notes, which shall identify the services provided, pathology specimens obtained, and where sent, as applicable;

1. Informed consents; and
2. Assessment appropriate to the nature and scope of the procedure performed and the specific medical condition of the individual patient.

4.06-3 **Program Integrity**

See Chapter I of the *MaineCare Benefits Manual*, for Program Integrity procedures.

4.07 **REIMBURSEMENT**

Reimbursement for covered services shall be made as described below. The reimbursement rate is an all-inclusive rate and covers the facility costs described in 4.04(A).

Effective

6/15/16

4.07-1 **Reimbursement** is based on a fee schedule. The fee schedule reimburses at the lower of:

A. 100% of the lowest amount allowed by the Maine Medicare Part B carrier based on current Medicare rates; or

B. the provider’s usual and customary facility charge.

In accordance with Chapter I of the *MaineCare Benefits Manual*, it is the responsibility of the provider to seek payment from any other resources that are available for payment prior to billing the MaineCare Program.

4.07-2 **Reimbursement for Multiple Procedures**

When multiple procedures are performed in the same operative session, MaineCare will pay for the procedure that has the highest payment amount as final payment for all procedures performed. For purposes of this Section, an operative session is an ambulatory surgical visit in which one or more of the covered surgical procedures are performed.

Effective

6/15/16

4.07-3 **Reimbursement of Physician Services for Covered Services in an ASC**

Physician services for covered surgical procedures will receive separate payment under MaineCare Benefits Manual, Section 90, Physician Services. The reimbursement rate for services delivered with ASC as the Place of Service (POS) will receive the facility rate set forth in the physician fee schedule located at: <https://mainecare.maine.gov/> .

4.08 **BILLING INSTRUCTIONS**

Billing must be accomplished in accordance with the Department's billing instructions for the CMS 1500 that providers receive in their enrollment packages.