Ambulatory Surgical Center

Provider Manual

Iowa Department of Human Services

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III. Provider-Specific Policies

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CHAPTER III. PROVIDER-SPECIFIC POLICIES

A. CENTERS ELIGIBLE TO PARTICIPATE

Ambulatory Surgical Centers (ASC) which are not part of a hospital are eligible to participate in the Medicaid program if they are certified to participate in the Medicare program (Title XVIII of the Social Security Act).

B. COVERAGE OF SERVICES

The services provided by ASCs are those services furnished by ASCs in connection with a covered surgical procedure. Many, but not all, Medicare-covered services are covered by Medicaid. See BASIS OF PAYMENT for additional information.

The ASC reimbursement for specific procedures performed covers the ASC operating site including administrative costs, ASC professional staff, and supplies.

If an ASC offers laboratory services or professional physicians' services which are not considered facility services, these services must be billed by the providers rendering such services.

C. EXCLUSIONS AND LIMITATIONS ON COVERED PROCEDURES

Covered surgical procedures shall be those medically necessary procedures that are eligible for payment under the same circumstances as physicians' services and performed on an eligible member.

1. Pre-Procedure Review

Surgical procedures affect health care expenditures significantly. To ensure that procedures are medically necessary, the Iowa Medicaid Enterprise (IME) Medical Services conducts a pre-procedure review program for the Medicaid program. This program entails reviewing selected high-quantity procedures when they are performed on an inpatient basis, in the outpatient unit of a hospital, or in a free-standing surgical unit.

Pre-procedure review is performed for all heart, lung, liver, stem cell, pancreas, and bone marrow transplants and for all bariatric procedures, as identified on the pre-procedure review list. Reviews are performed for members with traditional Medicaid and MediPASS coverage.

The following sections explain:

- How reviews are conducted
- What happens if the review is not obtained until after the member is discharged

a. Review Process

The following review process applies to all pre-procedure review activities. Pre-procedure review is conducted to evaluate the appropriateness of the procedures identified on the pre-procedure review list. Requests for review of these elective procedures must be submitted in writing to:

Iowa Medicaid Enterprise
Attn: Medical Prior Authorization
PO Box 36478
Des Moines, IA 50315

The request must provide the following information from the physician, on which the IME Medical Services will base its decision:

- Procedure planned
- Proposed admission date
- Proposed date of procedure
- Hospital or location of intended procedure
- Member's name and address
- Member's age
- Member's Medicaid ID number
- Attending physician's name
- Tentative diagnosis
- Orders
- History and chief complaint (include symptoms and duration of problem)

- Other medical history or problem
- Preadmission treatment
- Outpatient studies performed
- Medication

Pre-procedure review is conducted using criteria that have been developed by the applicable physician specialties. Questionable cases are referred to a physician reviewer for a determination of the medical necessity of the procedure. Denial letters are issued if the procedure is determined not to be medically necessary.

The IME provides validation numbers on all approved pre-procedure reviews. Claims sent to the IME without a validation prior authorization number will be denied. The hospital must notify the IME and request a retrospective review to determine the appropriateness of the procedure before receiving payment.

A sample of cases reviewed on a pre-procedure basis is selected for retrospective review. The information provided during the pre-procedure review is validated during the retrospective review process. A denial may be issued if the information provided during the precertification review is not supported by medical record documentation.

b. Procedure Review Obtained Following Discharge

If the provider discovers that pre-procedure review was not obtained with the IME before or immediately following the procedure and the member was discharged, the provider must request the IME review to determine the appropriateness of the procedure before receiving payment.

In addition, the hospital must send a copy of the complete medical record with the completed form to Iowa Medicaid Enterprise for a retrospective review. Hospital staff is reminded to identify the type of procedure review that is being requested (e.g., gastric stapling review).

Page 4 is reserved for future use.

2. Abortions

Legislation enacted by the Iowa General Assembly restricts payment for abortions through the Medicaid program to the following situations:

- The attending physician certifies in writing on the basis of professional judgment that continuing the pregnancy would endanger the life of the pregnant woman.

  Federal funding is available in these situations only if the woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused or arising from the pregnancy itself that would place the woman in danger of death unless an abortion is performed.

- The attending provider certifies in writing on the basis of provider's professional judgment that the fetus is physically deformed, mentally deficient or afflicted with a congenital illness and states the medical indications for determining the fetal condition.

- The pregnancy is the result of rape, that the incident was reported to a law enforcement agency or public or private health agency, which may include a family physician, within 45 days of the date of the incident, and that the report contains the name, address, and signature of the person making the report. An official of the agency must also certify in writing.

- The pregnancy is the result of incest, that the incident was reported to a law enforcement agency or public or private health agency, which may include a family physician, within 150 days of the incident, and that the report contains the name, address, and signature of the person making the report. An official of the agency or physician must so certify in writing.

a. Certification Regarding Abortion, Form 470-0836

A copy of form 470-0836, *Certification Regarding Abortion*, must be attached to the physician's claim if payment is to be made for an abortion. Payment cannot be made to the attending physician, to other physicians assisting in the abortion, to the anesthetist, or to the hospital or ambulatory surgical center if the required certification is not submitted with the claim for payment. Click here to access this form online.

In case of a pregnancy resulting from rape or incest, a certification from a law enforcement agency, public or private health agency, or family physician is required, as set forth above. It is the responsibility of the recipient, someone acting in her behalf, or the attending physician to obtain the necessary certification from the agency involved. Form 470-0836 is also to be used for this purpose.

It is the responsibility of the physician to make a copy of form 470-0836 available to the hospital, other physicians, CRNAs, anesthetists, or ambulatory surgical centers billing for the service. This will facilitate payment to the hospital and other physicians on abortion claims.

Treatment is required for a spontaneous abortion or miscarriage where all the products of conception are not expelled.

All abortion claims must be billed with the appropriate diagnosis and procedure code indicating the abortion on the hospital claim and the appropriate diagnosis and CPT abortion procedure code on the practitioner claim.

The reason for the abortion must be identified on form 470-0836, *Certification Regarding Abortion*. This form must be attached to the claim for payment, along with the following documentation:

- The operative report
- The pathology report
- Laboratory reports
- The ultrasound report
- The physician's progress notes
- Other documents that support the diagnosis identified on the claim

b. Covered Services Associated With Non-Covered Abortions

The following services are covered even if performed in connection with an abortion that is not covered:

- Services that would have been performed on a pregnant woman regardless of whether she was seeking an abortion, including:
  - Pregnancy tests.
  - Tests to identify sexually transmitted diseases (e.g., chlamydia, gonorrhea, syphilis).
  - Laboratory tests routinely performed on a pregnant member, such as Pap smear and urinalysis, hemoglobin, hematocrit, rubella titre, hepatitis B, and blood typing.
- Charges for all services, tests, and procedures performed post abortion for complications of a non-covered therapeutic abortion, including:
  - Charges for services following a septic abortion.
  - Charges for a hospital stay beyond the normal length of stay for abortions.

NOTE: Family planning or sterilizations must not be billed on the same claim with an abortion service. These services must be billed separately.

c. Non-Covered Services

The following abortion-related services are **not** allowed when the abortion is not covered by federal or state criteria:

- Physician and surgical charges for performing the abortion. These charges include the usual, uncomplicated preoperative and postoperative care and visits related to performing the abortion.
- Hospital or clinic charges associated with the abortion. This includes:
  - The facility fee for use of the operating room.
  - Supplies and drugs necessary to perform the abortion.

- Charges associated with routine, uncomplicated preoperative and postoperative visits by the member.
- Physician charges for administering the anesthesia necessary to induce or perform an abortion.
- Charges for laboratory tests performed before performing the non-covered abortion to determine the anesthetic or surgical risk of the member (e.g., CBC, electrolytes, blood typing).
- Drug charges for medication usually provided to or prescribed for a member who undergoes an uncomplicated abortion. This includes:
  - Routinely provided oral analgesics.
  - Antibiotics to prevent septic complication of abortion and Rho-GAM (an immune globulin administered to RH-negative women who have an abortion).
- Charges for histo-pathological tests performed routinely on the extracted fetus or abortion contents.
- Uterine ultrasounds performed immediately following an abortion.

3. Cosmetic Surgery

Cosmetic surgery or expenses incurred in connection with such surgery is not covered under the Medicaid program except when required for the prompt (i.e., as soon as medically feasible) repair of accidental injury or for the improvement of the functioning of a malformed body member.

For the purposes of this program, cosmetic reconstructive or plastic surgery is surgery which can be expected primarily to improve physical appearance of which is performed primarily for psychological purposes or which restores form but which does not correct or materially improve the bodily functions.

When a surgical procedure primarily restores function, whether or not there is also a concomitant improvement in physical appearance, the surgical procedure does not fall within the provisions of this policy.

Coverage under the program is generally not available for cosmetic, reconstructive or plastic surgery. However, under certain limited circumstances payment for otherwise covered services and supplies may be provided in connection with cosmetic, reconstructive, or plastic surgery as follows:

- Correction of a congenital anomaly.
- Restoration of body form following an accidental injury.
- Revision of disfiguring and extensive scars resulting from neoplastic surgery.

Generally, coverage is limited to those cosmetic, reconstructive or plastic surgery procedures provided no later than 12 months subsequent to the related accidental injury or surgical trauma. However, special consideration or exception will be given to cases involving children who may require a growth period.

4. Hysterectomies

Payment will be made only for a medically necessary hysterectomy that is performed for a purpose other than sterilization and only when one or more of the following conditions are met:

- A member or her representative has signed an acknowledgment that she has been informed orally and in writing from the provider authorized to perform the hysterectomy that the hysterectomy will make the member permanently incapable of reproducing.

  This statement may be added to either the surgery consent form, written on the claim form, or on a separate sheet of paper. The member or her representative receiving the explanation must sign the statement.

  The following language is satisfactory for such a statement:

  > *"Before the surgery, I received a complete explanation of the effects of this surgery, including the fact that it will result in sterilization.*
  >
  > *(Date) (Signature of member or person acting on her behalf)"*

  The vehicle for transmitting the acknowledgment that the member received the explanation before the surgery should not be the *Consent for Sterilization*, form 470-0835 or 470-0835S.

The statement must be submitted to the IME with the related Medicaid claims.

- The member was already sterile before the hysterectomy. The physician must certify in writing that the member was already sterile at the time of the hysterectomy and must state the cause of the sterility. The following language is satisfactory for such a statement:

> *"Before the surgery, this patient was sterile and the cause of that sterility was _____.*
>
> *(Physician's signature) (Date)"*

This statement may be added to either the surgery consent form, written on the claim form, or a separate sheet of paper. A physician must sign any document stating the cause of sterility. This includes a history and physical, operative report, or claim form.

The statement must be submitted to the IME with the related Medicaid claims.

- The hysterectomy was performed as the result of a life-threatening emergency in which the physician determined that prior acknowledgment was not possible. The physician must include a description of the nature of the emergency.

  If the physician certifies that the hysterectomy was performed for a life-threatening emergency and includes a description of the nature of the emergency, the claim will be reviewed on an individual basis. Payment will be permitted only in extreme emergencies.

  Where the member is about to undergo abdominal exploratory surgery or a biopsy, and removal of the uterus could be a potential consequence of the surgery, the member should be informed of this possibility and given an opportunity to acknowledge in writing the receipt of this information.

  This includes C-sections when there is a reasonable expectation a hysterectomy will be performed, such as in the event of an acreta.

5. Sterilizations

Federal regulations provide that payment shall not be made through the Medicaid program for sterilization of a member under the age of 21 at the time of consent or who is legally mentally incompetent or institutionalized.

"Sterilization" means any medical procedure, treatment, or operation for the purpose of rendering an individual incapable of reproducing and which is not a necessary part of the treatment of an existing illness or medically indicated as an accompaniment to an operation of the genital urinary tract. For purpose of this definition, mental illness or intellectual disability is not considered an illness or injury.

A "legally mentally incompetent" member is one who has been declared mentally incompetent by a federal, state or local court for any purpose unless the court declares the member competent for purposes which include the ability to consent to sterilization.

An "institutionalized" member is one who is involuntarily confined or detained under a civil or criminal statute in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness, or confined under voluntary commitment in a mental hospital or facility for the care and treatment of mental illness.

The same revision of federal regulations provide that payment may be made through the Medicaid program for the sterilization of a member aged 21 or over when the consent form is signed, who is mentally competent and noninstitutionalized in accordance with the above definitions under certain conditions.

a. Requirements

The following conditions must be met:

- The member to be sterilized must voluntarily request the services.
- The member to be sterilized must be advised that the member is free to withhold or withdraw consent to the procedure at any time before the sterilization without prejudicing the member's future care or loss of other project or program benefits to which the member might otherwise be entitled.

- The member to be sterilized must be given an explanation of the procedures to be performed by a knowledgeable informant upon which the member can base the consent for sterilization. An "informed consent" is required.

  "Informed consent" means the voluntary knowing assent from the member on whom the sterilization is to be performed after the member has been given a complete explanation of what is involved and has signed a written document to that effect.

  If the member is blind, deaf, or does not understand the language used to provide the explanation, an interpreter must be provided. The member to be sterilized may be accompanied by a witness of the member's choice.

  The informed consent shall not be obtained while the member to be sterilized is in labor or childbirth, seeking to obtain or obtaining an abortion, or under the influence of alcohol or other substance that affects the member's state of awareness.

  The elements of explanation which must be provided are:

  - A thorough explanation of the procedures to be followed and the benefits to be expected.
  - A description of the attendant discomforts and risks, including the possible effects of the anesthetic to be used.
  - Counseling concerning alternative methods of family planning and the effect and impact of the proposed sterilization, including the fact that it must be considered to be an irreversible procedure.
  - An offer to answer any inquiries concerning the proposed procedure.

  The member must give "informed consent" at least 30 days but not more than 180 days before the sterilization is performed except when emergency abdominal surgery or premature delivery occurs.

  For an exception to be approved when emergency abdominal surgery occurs, at least 72 hours must have elapsed after consent was obtained.

  For an exception to be approved when a premature delivery occurs, at least 72 hours must have elapsed after the informed consent was obtained, and the documentation must also indicate that the expected delivery date was at least 30 days after the informed consent was signed.

b. Consent for Sterilization, Form 470-0835 or 470-0835S

The "informed consent" shall be obtained on form 470-0835, *Consent for Sterilization*, or the Spanish version, form 470-0835S, *Formularo de Consentimiento Requerido*. The individual must be 21 years of age or older at the time of consent. An equivalent Medicaid form from another state is accepted.

Click here to view the English consent form online.

Click here to view the Spanish consent form online.

Consent forms may be requested by contacting IME Provider Services at (800) 338-7909 or locally in Des Moines at (515) 256-4609. To request forms by mail, send a written request to the following address:

Iowa Medicaid Enterprise
Form Requests
PO Box 36450
Des Moines, IA 50315

The physician's copy of the consent must be completely executed in all aspects (no substitute form is accepted) according to the above directions and attached to the claim in order to receive payment.

When a claim for physician's services for sterilization is denied either due to the failure to have the consent form signed at least 30 days and not more than 180 days before the date service is provided, or failure to use the official consent form, 470-0835 or 470-0835S, any claim submitted by the ambulatory surgical center, hospital, anesthesiologists, assistant surgeon, or associated providers for the same operation or procedure will also be denied.

It is the responsibility of the ambulatory surgical center, hospital, and other providers associated with the sterilization services to obtain a photocopy of the completed consent form which must be attached to their claim when submitted to the IME for payment.

All names, signatures, and dates on the consent form must be fully, accurately, and legibly completed. The only exceptions to this requirement are that:

- The "Interpreter's Statement" is completed only if an interpreter is actually provided to assist the individual to be sterilized.
- The information requested pertaining to race ethnicity designation is to be supplied voluntarily on the part of the member, but is not required.

It is the responsibility of the provider obtaining the consent form to verify that the member requesting the sterilization is at least 21 years of age on the date that the member signs the form. If there is any question pertaining to the true age of the member, the member's birthdate must be verified.

The "Statement of Person Obtaining Consent" may be completed by any qualified professional capable of clearly explaining all aspects of sterilization and alternate methods of birth control which are available to the member.

The "Physician's Statement" must be completed fully and signed by the **physician performing the sterilization** and dated when signed. It is important that one of the paragraphs at the bottom of this statement which is not used, be crossed out as per instructions.

Since the physician performing the sterilization will be the last to sign the consent form, the physician should provide a photocopy of the fully completed consent form to every other Medicaid provider involved in the sterilization for which a claim will be submitted; i.e., ambulatory surgical center, hospital, anesthetist, assistant surgeons, etc.

It is the responsibility of all other providers associated with the sterilization to obtain a photocopy of the fully completed consent form from the physician performing the sterilization, to be attached to the provider claim which is submitted to the Iowa Medicaid Enterprise for payment.

The only signatures which should be on the completed consent form are those of the member, interpreter (if interpreter services were provided), the provider obtaining the consent form, and the physician performing the sterilization.

6. Excluded Services

Cosmetic, reconstructive, or plastic surgery performed in connection with certain conditions is specifically excluded. These conditions are:

- Dental congenital anomalies, such as absent tooth buds, malocclusion, and similar conditions.
- Procedures related to transsexualism or hermaphroditism, except as specifically provided for in this policy.
- Cosmetic, reconstructive, or plastic surgery procedures performed primarily for psychological reasons or as a result of the aging process.
- Breast augmentation mammoplasty, surgical insertion or prosthetic testicles, and penile implant procedures, whether or not they would otherwise qualify for coverage under this policy.
- Any procedure performed for personal reasons, to improve the appearance of an obvious feature or part of the body which would be considered by an average observer to be normal and acceptable for the member's age, ethnic or racial background.
- Cosmetic, reconstructive, or plastic surgical procedures which are justified primarily on the basis of a psychological or psychiatric need.
- Face lifts and other procedures related to the aging process.
- Reduction mammoplasties, unless there is medical documentation of intractable pain not amenable to other forms of treatment as the result of increasingly large pendulous breasts.
- Panniculectomy and body sculpture procedures, unless there is medical documentation to support medical necessity.
- Repair of sagging eyelids, unless there is demonstrated and medically documented significant impairment of vision.
- Rhinoplasties, unless there is evidence of accidental injury occurring within the past six months which resulted in significant obstruction of breathing.
- Chemical peeling for facial wrinkles.
- Dermabrasion of the face.

- Revision of scars resulting from surgery or a disease process, except disfiguring and extensive scars resulting from neoplastic surgery.
- Removal of tattoos.
- Hair transplants.
- Electrolysis.

When it is determined that a cosmetic reconstructive or plastic surgery procedure does not qualify for coverage under this program, all related services and supplies, including any institutional costs, are also excluded.

Coverage is available for otherwise covered services and supplies required in the treatment of complications resulting from a non-covered incident of treatment, but only when the subsequent complications represent a separate medical condition such as systemic infection, cardiac arrest, acute drug reaction, or similar conditions.

Coverage shall not be extended for any subsequent care or procedure related to the complication that is essentially similar to the initial non-covered care. Examples of complications similar to the initial period of care would be repair of facial scarring resulting from dermabrasion for acne or repair of a prolapsed vagina in a biological male who has undergone transsexual surgery.

7. Interpreter Services

Interpretative services may be covered, whether done orally or through sign language. Interpreters must provide only interpretation services for the agency. The services must facilitate access to Medicaid covered services.

In order for interpretation services to be covered by Iowa Medicaid, the services must meet the following criteria:

- Provided by interpreters who provide only interpretive services
- Interpreters may be employed or contracted by the billing provider
- The interpretive services must facilitate access to Medicaid covered services

Providers may only bill for these services if offered in conjunction with an otherwise Medicaid covered service. Medical staff that are bilingual are not reimbursed for the interpretation but only for their medical services.

a. Documentation of the Service

The billing provider must document in the member's record the:

- Interpreter's name or company,
- Date and time of the interpretation,
- Service duration (time in and time out), and
- Cost of providing the service.

b. Qualifications

It is the responsibility of the billing provider to determine the interpreter's competency. Sign language interpreters should be licensed pursuant to 645 Iowa Administrative Code 361. Oral interpreters should be guided by the standards developed by the National Council on Interpreting in Health Care.

Following is the instruction for billing interpretive services when that service is provided by an outside commercial translation service:

- Bill code T1013
  - For telephonic interpretive services use modifier "UC" to indicate that the payment should be made at a per-minute unit.
  - The lack of the UC modifier will indicate that the charge is being made for the 15 minute face-to-face unit.
- Enter the number of minutes actually used for the provision of the service. The 15 minute unit should be rounded up if the service is provided for 8 minutes or more.

NOTE: Because the same code is being used but a conditional modifier may be necessary, any claim where the UC modifier is **NOT** used and the units exceed 24 will be paid at 24 units.

D. BASIS OF PAYMENT

The basis for ambulatory surgical center payment is based on covered surgical and dental procedures as listed on the fee schedule published on the Department's website.

Click here to view the fee schedule for Ambulatory Surgical Center.

Each covered procedure is identified by a procedure code and assigned to one of nine numerical levels. Each of the nine numerical levels is assigned a separate reimbursement fee from 1 (lower) to 9 (higher).

Multiple Procedures

If medically necessary, multiple procedures are billed according to the following hierarchy:

- The most costly ASC procedure is billed in accordance with the established fee schedule.
- A secondary ASC procedure is billed at 50% of the established fee for the procedure.

E. PROCEDURE CODES AND NOMENCLATURE

Medicaid recognizes Medicare's National Level II Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology (CPT) codes. However, all HCPCS and CPT codes are not covered. Surgical procedures not covered by Medicare may be identified as payable by Medicaid. Reimbursement rates are established by the Medicaid program for those surgical procedures.

Providers who do not have Internet access can obtain a copy upon request from the Iowa Medicaid Enterprise (IME).

It is the provider's responsibility to select the code that best describes the item dispensed. Claims submitted without a procedure code will be denied. Refer coverage questions to the IME.

F. BILLING POLICIES AND CLAIM FORM INSTRUCTIONS

Claims for Ambulatory Surgical Centers are billed on federal form CMS-1500, *Health Insurance Claim Form*.

To view a sample of the CMS-1500, click here.

To view billing instructions for the CMS-1500, click here.

Refer to Chapter IV. Billing Iowa Medicaid for claim form instructions, all billing procedures, and a guide to reading the Iowa Medicaid Remittance Advice statement.

The Billing Manual can be located online at: https://dhs.iowa.gov/sites/default/files/All-IV.pdf.