

CHAPTER 507 AMBULATORY SURGICAL CENTER

TABLE OF CONTENTS

SECTION	PAGE NUMBER
Background	2
Policy	2
507.1 Provider Participation	2
507.2 Covered Services	2
507.3 Prior authorization	2
507.4 non-Covered Services	2
507.5 documentation requirements	3
507.6 payment and limitations	3
Glossary	3
References	3
Change Log	4

DISCLAIMER: This chapter does not address all the complexities of Medicaid policies and procedures, and must be supplemented with all State and Federal Laws and Regulations. Contact BMS Fiscal Agent for coverage, prior authorization requirements, service limitations and other practitioner information.

CHAPTER 507 AMBULATORY SURGICAL CENTER

BACKGROUND

The Bureau for Medical Services (BMS) defines an Ambulatory Surgical Center (ASC) as any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization, are certified by the Centers for Medicare and Medicaid Services (CMS) to participate as an ASC, and is licensed by the appropriate State regulatory agency.

This chapter sets forth requirements regarding payment and processing of services provided by Ambulatory Surgical Centers to eligible West Virginia Medicaid members.

POLICY

507.1 PROVIDER PARTICIPATION

To participate in West Virginia Medicaid, providers must be approved through BMS' fiscal agent contractor enrollment process prior to billing for any services. [Chapter 300, Provider Participation Requirements](#) presents an overview of the minimum requirements that providers must meet to enroll in and be reimbursed by the West Virginia Medicaid Program.

507.2 COVERED SERVICES

The West Virginia Medicaid Program covers medically necessary services provided by an ASC to eligible members within coverage/benefit limitations in effect on the date of service. Coverage and benefit limitations are subject to change as Federal regulations and State policies dictate. West Virginia Medicaid uses the Medicare Approved ASC Covered Surgical Procedures list and the Surgical Procedures Excluded from Payment in ASCs list as resources. The services provided by ASCs are those surgical procedures which may safely be performed in the ASC setting. The ASC is authorized by Federal and State law and regulation to perform these services. These services are identified on the [BMS Ambulatory Surgical Center Fee Schedule](#).

507.3 PRIOR AUTHORIZATION

West Virginia Medicaid requires prior authorization for certain surgeries performed in place of service 24 (Ambulatory Surgical Center). Services that require prior authorization are identified on the [utilization management contractor's \(UMC\) website](#). The surgeon must request prior authorization via the [UMC web-based portal](#). If the surgery is authorized by the UMC, separate prior authorization numbers for the surgeon and the ASC facility are assigned. The surgeon or facility may access the prior authorization number via the web-based portal. The prior authorization number must be included on the claim form in order to be eligible for reimbursement.

Prior authorization requirements governing the provision of all West Virginia Medicaid services will apply pursuant to [Chapter 100, General Information](#).

507.4 NON-COVERED SERVICES

Non-covered services for Ambulatory Surgery Centers include, but are not limited to:

CHAPTER 507 AMBULATORY SURGICAL CENTER

- Surgical procedures that cannot be safely performed in an outpatient setting or without support of the full array of hospital diagnostic and treatment services and equipment.
- Procedures not covered by Medicaid including, but not limited to, cosmetic surgery.
- Medical equipment or supplies dispensed for use in the patient's home.

Non-covered services are not eligible for a West Virginia Department of Human Services (DoHS) Fair Hearing or a Desk/Document review.

507.5 DOCUMENTATION REQUIREMENTS

Documentation and record retention requirements governing the provision of all West Virginia Medicaid services will apply pursuant to [Chapter 100, General Information](#) and [Chapter 300, Provider Participation Requirements](#) of the Provider Manual.

The following procedures are examples that require submission of additional supporting documentation:

- Hysterectomy – Services must be provided in conformance with all requirements in [Chapter 519, Practitioner Services, Policy 519.19 Women's Health Services](#).
- Sterilization – Services must be provided in conformance with all requirements in [Chapter 519, Practitioner Services, Policy 519.15 Reproductive Health Services](#).

507.6 PAYMENT AND LIMITATIONS

Payments for services performed in an ASC are calculated at an approved percentage of the Medicare fee schedule. Bilateral and multiple surgery reimbursements methodologies apply. The ASC reimbursement does not include the surgeon fees.

Please refer to [Chapter 600, Reimbursement Methodologies](#) for additional information.

Supplies and other items incidental to the surgical procedures performed are not covered for separate payment. The cost of such items is included in the payment for the surgical procedure.

If the member is enrolled in a Medicaid Managed Care Organization (MCO), reimbursement will be made by the MCO based upon the contracted rate between the ASC and the MCO.

GLOSSARY

Definitions in [Chapter 200, Definitions and Acronyms](#) apply to all West Virginia Medicaid services, including those covered by this chapter.

REFERENCES

West Virginia State Plan references Ambulatory Surgical Centers at sections [3.1-A\(9\)](#), [3.1-B\(9\)](#), [supplement 2 to attachments 3.1-A and 3.1-B\(9\)](#) and reimbursement at [4.19-B\(9\)](#).

CHAPTER 507 AMBULATORY SURGICAL CENTER

CHANGE LOG

REPLACE	TITLE	EFFECTIVE DATE
Entire Chapter	Ambulatory Surgical Center	September 16, 2015