



Administrative Code

Title 23: Medicaid Part 210

Table of Contents

Title 23: Medicaid.....	1
Table of Contents.....	1
Title 23: Division of Medicaid.....	1
Part 210: Ambulatory Surgical Center.....	1
Rule 1.1: General.....	1
Rule 1.2: Definitions.....	1
Rule 1.3: Provider Enrollment Requirements.....	2
Rule 1.4: Covered Services.....	2
Rule 1.5: Non-Covered Procedures.....	3
Rule 1.6: Reimbursement.....	3
Rule 1.7: Documentation Requirements.....	4
Rule 1.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT).....	4

Title 23: Division of Medicaid

Part 210: Ambulatory Surgical Center

Part 210 Chapter 1: General

Rule 1.1: General

- A. Medicaid considers an Ambulatory Surgical Center (ASC) a publicly, or privately, owned institution not considered a part of a hospital, in accordance with its function.
- B. 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.
- C. The facility 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.
- D. A facility considered to be operated by a hospital or hospital holding, leasing, or management company, whether for-profit or non-profit, must be a separate, identifiable entity which is physically, administratively and financially independent and distinct from other operations of any hospital.
- E. 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.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 416

Rule 1.2: Definitions

- A. Add-On Codes - Procedures performed in addition to the primary service/procedure and are never reported as a stand-alone code. Add-on codes describe additional intra-service work associated with the primary procedure.
- B. Ambulatory Surgery - Surgical procedure(s) that are more complex than office procedures, under local anesthesia, but less complex than procedures requiring prolonged postoperative monitoring and hospital care to ensure safe recovery and desirable results.
- C. Bilateral Procedures - Exact procedures identified by the same procedure codes which are performed on anatomically bilateral sides of the body during the same operative session.
- D. Laparoscopic Procedure - The performance of a procedure on interior organs and cavities of the body through a Laparoscope. A laparoscope is a flexible fiber optic instrument used to visual the interior of a body cavity or organ.
- E. Incidental Procedure- A procedure carried out at the same time as a primary procedure, but is

clinically integral to the performance of the primary procedure or requires little additional physician resources.

- F. Multiple Surgeries - Separate procedures performed by the same physician on the same patient at the same operative setting.
- G. Mutually Exclusive Procedures - The separate billing for two (2) or more procedures that are usually not performed for the same patient on the same date of service.
- H. Unbundled Procedures - The use of two (2) or more procedure codes to describe a procedure or event when a single procedure code exists that comprehensively describes the surgery performed.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 416

Rule 1.3: Provider Enrollment Requirements

Ambulatory surgical centers must satisfy all requirements set forth in Part 200, Chapter 4, Rule 4.8 in addition to the following provider type specific requirements listed below:

- A. National Provider Identifier (NPI), verification from National Plan and Provider Enumeration System (NPPES).
- B. Written confirmation from the IRS confirming your tax identification number and legal business name.
- C. Copy of Medicare certification letter:
 - 1. EOMB not acceptable.
 - 2. Must be from Medicare Intermediary.

Source: Miss. Code Ann. § 43-13-121; 43-13-117; 43-13-118; 43-13-129; 42 CFR § 416

Rule 1.4: Covered Services

- A. The Ambulatory Surgical Center (ASC) must have procedures for obtaining routine and emergency laboratory and radiology services from Medicare-approved facilities. The ASC, when contracting for those lab, x-ray and hospital services which directly relate to the surgical procedure, must be billed by the provider performing these services.
- B. ASC services must be Medicare-approved items and services furnished by an ASC in connection with a covered surgical procedure furnished to a Medicaid beneficiary.
- C. ASC services do not include items and services for which payment may be made under other provisions, such as physician services, lab, x-ray or diagnostic procedures, other than those

directly related to performance of the surgical procedure.

- D. Under the current ASC facility services payment system, the ASC payment rate includes all the costs incurred by the ASC in providing facility services in connection with performing a specific procedure, like surgical supplies, equipment, and nursing services.
- E. Medicaid covers 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 Medicaid program. This policy is applicable only to Ambulatory Surgical Centers.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 416

Rule 1.5: Non-Covered Procedures

Non-covered services and procedures as outlined in Part 200, Chapter 2, Rule 2.2 performed in an Ambulatory Surgical Center are subject to Medicaid rules for reimbursement.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 416

Rule 1.6: Reimbursement

- A. Mississippi Medicaid ASC rates are set at eighty percent (80%) of the current Medicare Ambulatory Surgical Center Payment System rate set by the Center for Medicare and Medicaid Services (CMS).
- B. Reimbursement is in accordance with the Medicaid ASC Procedure Schedule or usual and customary charges, whichever is less.
- C. Payment for Multiple Procedures: Rules for payment of multiple procedures, as outlined in Part 203, Chapter 4 will be applied.
- D. Canceled Procedures: Surgical or other procedures canceled due to scheduling conflicts of the operating suite or physician, beneficiary request, or other reason not related to medical necessity, must not be billed; and no payment will be made for the procedure. Services provided, prior to the procedure, may be billed and will be covered subject to policies for those services.
- E. Canceled or Incomplete Procedures Related to the Beneficiary's Medical Condition: For surgical or other procedures canceled or terminated before completion due to changes in the beneficiary's medical condition that threaten his/her well-being, only the services that were actually performed may be billed and will be covered subject to policies for those services. Clear documentation regarding the medical necessity for cancellation or termination of the procedure must be provided.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 416

Rule 1.7: Documentation Requirements

The physician and ASC must maintain auditable records that will substantiate the services provided. The ASC must maintain a medical record for each patient. Medical records must include at least the following:

- A. Patient identification;
- B. Significant medical history and results of physical examination;
- C. Pre-operative diagnostic studies, entered before surgery, if performed;
- D. Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body;
- E. Any allergies and abnormal drug reactions;
- F. Entries related to anesthesia administration;
- G. Documentation of properly executed informed patient consent; and
- H. Discharge diagnosis and instructions.

Source: Miss. Code Ann. § 43-13-121; 42 CFR § 416

Rule 1.8: Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)

The Division of Medicaid pays for all medically necessary services for EPSDT-eligible beneficiaries in accordance with Part 223 of this Title, without regard to service limitations and with prior authorization.

Source: Miss. Code Ann. § 43-13-121