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8.324.10 AMBULATORY SURGICAL CENTER SERVICES

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TITLE 8 SOCIAL SERVICES
CHAPTER 324 ADJUNCT SERVICES
PART 10 AMBULATORY SURGICAL CENTER SERVICES

8.324.10.1 ISSUING AGENCY: New Mexico Human Services Department.
[2/1/95; 8.324.10.1 NMAC - Rn, 8 NMAC 4.MAD.000.1, 11/1/04]

8.324.10.2 SCOPE: The rule applies to the general public.
[2/1/95; 8.324.10.2 NMAC - Rn, 8 NMAC 4.MAD.000.2, 11/1/04]

8.324.10.3 STATUTORY AUTHORITY: The New Mexico medicaid program is administered pursuant to regulations promulgated by the federal department of health and human services under Title XIX of the Social Security Act, as amended and by the state human services department pursuant to state statute. See NMSA 1978, section 27-2-12 et. seq. (Repl. Pamp. 1991).
[2/1/95; 8.324.10.3 NMAC - Rn, 8 NMAC 4.MAD.000.3, 11/1/04]

8.324.10.4 DURATION: Permanent
[2/1/95; 8.324.10.4 NMAC - Rn, 8 NMAC 4.MAD.000.4, 11/1/04]

8.324.10.5 EFFECTIVE DATE: February 1, 1995
[2/1/95; 8.324.10.5 NMAC - Rn, 8 NMAC 4.MAD.000.5, 11/1/04]

8.324.10.6 OBJECTIVE: The objective of these regulations is to provide policies for the service portion of the New Mexico medicaid program. These policies describe eligible providers, covered services, noncovered services, utilization review, and provider reimbursement.
[2/1/95; 8.324.10.6 NMAC - Rn, 8 NMAC 4.MAD.000.6, 11/1/04]

8.324.10.7 DEFINITIONS: [RESERVED]

8.324.10.8 MISSION STATEMENT: The mission of the New Mexico medical assistance division (MAD) is to maximize the health status of medicaid-eligible individuals by furnishing payment for quality health services at levels comparable to private health plans.
[2/1/95; 8.324.10.8 NMAC - Rn, 8 NMAC 4.MAD.002, 11/1/04]

8.324.10.9 AMBULATORY SURGICAL CENTER SERVICES: New Mexico medicaid program (medicaid) pays for medically necessary health services furnished to eligible recipients, including covered services furnished in ambulatory surgical centers [42 CFR Section 440.20(a)]. This part describes eligible providers, covered services, service limitations and general reimbursement methodology.
[2/1/95; 8.324.10.9 NMAC - Rn, 8 NMAC 4.MAD.759, 11/1/04]

8.324.10.10 ELIGIBLE PROVIDERS:

A. Upon approval of New Mexico medical assistance program provider participation application by the New Mexico medical assistance division (MAD), ambulatory surgical centers certified to participate in medicare under Title XVIII of the Social Security Act as free-standing ambulatory surgical centers are eligible to be reimbursed by medicaid for providing services as ambulatory surgical centers.

(1) The centers for medicare and medicaid (CMS) certify ambulatory surgical centers based on surveys and recommendations submitted by the licensing and certification bureau of the New Mexico department of health (DOH).

(2) Ambulatory surgical centers which are not free-standing but are part of an accredited and certified hospital are subject to 8.311.2 NMAC, *Hospital Services* [MAD-721].

B. Once enrolled, providers receive and are responsible for maintenance of a packet of information, including medicaid program policies, billing instructions, utilization review instructions and other pertinent material from MAD. To be eligible for medicaid reimbursement, providers are bound by MAD policies, procedures, billing instructions, reimbursement rates, and all audit, recoupment and withholding provisions unless superceded by federal law, federal regulation or the specific written approval of the MAD director. Providers must be enrolled as medicaid providers before submitting a claim for payment to MAD claims processing contractor.

[2/1/95; 8.324.10.10 NMAC - Rn, 8 NMAC 4.MAD.759.1 & A, 11/1/04]

8.324.10.11 PROVIDER RESPONSIBILITIES: Providers who furnish services to medicaid recipients must comply with all federal and state laws and regulations relevant to the provision of medical services, including but not limited to, Title XIX of the Social Security Act, the Medicare and Medicaid Anti-Fraud Act, and the State Medicaid Fraud Act. Providers also agree to conform to MAD policies and instructions as specified in this manual and its appendices, as updated. See 8.302.1 NMAC, *General Provider Policies*.

A. **Recipient eligibility determination:** Providers must verify that services they furnish are provided to eligible recipients.

(1) Providers may verify eligibility through several mechanisms, including the use of an automated voice response system, contacting the medicaid fiscal agent contractor eligibility help desk, contracting with a medicaid eligibility verification system (MEVS) vendor, or contracting with a medicaid magnetic swipe card vendor.

(2) Providers must verify that recipients are eligible for medicaid through out periods of continued or extended services. By verifying client eligibility, a provider is informed of restrictions that may apply to a recipient's eligibility.

B. **Requirements for updating information:** Providers must furnish in writing to MAD or MAD claims processing contractor with complete information on changes in their address, license, certification, board specialties, corporate name or corporate ownership, and a statement as to the continuing liability for the provider for any dissolution of other disposition of the health care provider or person. MAD or the MAD claims processing contractor must receive this information at least 60 days before the change. Any payment made by MAD based upon erroneous or outdated information is subject to recoupment.

C. **Documentation requirements:** Providers must maintain records to fully disclose the nature, quality, amount, and medical necessity of the services furnished to recipients who are currently receiving or who have received medical services in the past [42 CFR 431.107(b)]. Documentation supporting medical necessity must be legible and available to medicaid upon request. See 8.302.1 NMAC, *General Provider Policies.*

[2/1/95; 8.324.10.11 NMAC - Rn, 8 NMAC 4.MAD.759.2 & A, 11/1/04]

8.324.10.12 COVERED SERVICES:

A. Medicaid covers ambulatory surgical center facility services, as required by the condition of the recipient and if the following conditions are met:

(1) the surgical procedure and use of the facility are medically necessary and are covered by medicaid; and

(2) all medicaid requirements for the surgery, such as applicable consent forms or prior authorization requirements, are met by the physician.

B. See 8.310.2 NMAC, *Medical Services Providers*.

[2/1/95; 8.324.10.12 NMAC - Rn, 8 NMAC 4.MAD.759.3 & A, 11/1/04]

8.324.10.13 NONCOVERED SERVICES: Ambulatory surgical center services are subject to the limitations and coverage restrictions which exist for other medicaid services. If the surgery is non-covered, the anesthesia is non-covered. See 8.301.3 NMAC, *General Noncovered Services* [MAD-602].

A. **Direct payment to physician.** Ambulatory surgical centers are not reimbursed by medicaid for physician fees. Reimbursement for physician fees is made directly to the provider of the service.

B. **Services furnished to dual eligible recipients.** By federal regulation, the medicare program pays ambulatory surgical centers only for an approved list of specific surgical procedures. Medicare is the primary payment source for individuals who are eligible for both medicare and medicaid. For these recipients, medicaid will not pay an ambulatory surgical center for a surgical procedure denied by medicare. Ambulatory surgical centers must refer these recipients to facilities which medicare pays for the surgical procedure, such as an outpatient hospital.

[2/1/95; 8.324.10.13 NMAC - Rn, 8 NMAC 4.MAD.759.4 & A, 11/1/04]

8.324.10.14 PRIOR AUTHORIZATION AND UTILIZATION REVIEW: All medicaid services are subject to utilization review for medical necessity and program compliance. Reviews can be performed before services are furnished, after services are furnished and before payment is made, or after payment is made. See 8.302.5 NMAC, *Prior Authorization and Utilization Review*. Once enrolled, providers receive instructions and documentation forms necessary for prior authorization and claims processing.

A. **Prior authorization:** Certain procedures or services can require prior authorization from MAD or its designee. Services for which prior authorization was obtained remain subject to utilization review at any point in the payment process.

B. **Eligibility determination:** Prior authorization of services does not guarantee that individuals are eligible for medicaid. Providers must verify that individuals are eligible for medicaid at the time services are furnished and determine if medicaid recipients have other health insurance.

C. **Reconsideration:** Providers who disagree with prior authorization request denials or other review decisions can request a re-review and a reconsideration. See 8.350.2 NMAC, *Reconsideration of Utilization Review Decisions* [MAD-953].

[2/1/95; 8.324.10.14 NMAC - Rn, 8 NMAC 4.MAD.759.5 & A, 11/1/04]

8.324.10.15 REIMBURSEMENT: Ambulatory surgical centers must submit claims for reimbursement on the CMS-1500 claim form or its successor. See 8.302.2 NMAC, *Billing for Medicaid Services*. Once enrolled, providers receive instructions on documentation, billing and claims processing.

A. **Inclusion of all services in the facility fee:** All services furnished by the facility are considered reimbursed in the facility fee and cannot be billed separately. The amount paid will be the lesser of the facility's usual and customary charge or the maximum allowed by medicaid.

B. **Reimbursement methodology:** The facility fee maximum is established at a level which considers the surgical procedure and the area in which the facility is located. Each surgical procedure is assigned to one of nine (9) surgical groups, based on the complexity of the procedure. Each of these surgical groups has a separate reimbursement level. The level of reimbursement is determined by medicaid by utilizing the medicare carrier for procedures payable to ambulatory surgical centers by medicare regulations. The list of surgeries payable under medicare regulations also designates the assigned surgical group for payment purposes. The list is available from the medicare carrier.

(1) For those procedures for which medicare has not established a reimbursement level, MAD assigns the procedure to one of the nine (9) surgical groups. The assignment is based upon the complexity of the procedure or its similarity to procedures within the surgical groups developed by medicare.

(2) Reimbursement is made at the level established by medicaid for that surgical group.

C. **Reimbursement for multiple procedures:** When more than one covered surgical procedure is performed during the same surgical encounter, reimbursement is made at the rate for the most complex procedure plus fifty percent (50%) of the applicable rate for any additional procedures.

D. **Reimbursement for laboratory services:**

(1) The following laboratory services are considered included in the facility fee and are not reimbursed separately:

(a) hematocrit;

(b) hemoglobin (colorimetric); and

(c) routine urinalysis, without microscopy.

(2) For an ambulatory surgical center to be reimbursed for laboratory tests which are not included in the facility fee, the following conditions must be met:

(a) ambulatory surgical center laboratories must be separately certified and enrolled as clinical laboratories with valid CLIA numbers;

(b) laboratory tests billed must fall within the approved laboratory specialties/ subspecialties for which the laboratory has been certified;

(c) laboratories must have separate New Mexico medical assistance program provider participation applications approved by MAD to bill for laboratory tests not included in the facility fee; and

(d) laboratory tests must be performed on the premises of ambulatory surgical centers and not sent out to reference laboratories. See 8.324.2 NMAC, *Laboratory Services* [MAD-751].

E. **Reimbursement for diagnostic imaging and therapeutic radiology services:** Diagnostic radiological, diagnostic ultrasound, peripheral vascular flow measurements and nuclear medicine studies furnished by a facility are considered covered services but payment is considered to be made within the facility fee and are not separately reimbursed services. See 8.324.3 NMAC, *Diagnostic Imaging and Therapeutic Radiology Services* [MAD-752].

[2/1/95; 8.324.10.15 NMAC - Rn, 8 NMAC 4.MAD.759.6 & A, 11/1/04]

HISTORY OF 8.324.10 NMAC:

Pre-NMAC History: The material in this part was derived from that previously filed with the State Records Center:
ISD-Rule 310.2200, Ambulatory Surgical Center Services, filed 12/17/85.
MAD Rule 310.22, Ambulatory Surgical Center Services, filed 4/17/92.

History of Repealed Material:
MAD Rule 310.22, Ambulatory Surgical Center Services, filed 4/17/92 - Repealed effective 2/1/95.