REIMBURSEMENT

Reimbursement for surgical procedures performed in an ambulatory surgical center (ASC) is a flat fee per service in accordance with the four payment groups established for ambulatory surgery services specified on the Medicaid fee schedule. Reimbursement amounts can be found on the Professional Services Fee Schedule. (See Appendix A for information on how to obtain a copy of the fee schedule).

The flat fee reimbursement is for facility charges only, which covers all operative functions associated with the performance of a medically necessary surgery including the following:

1. Admission;
2. Patient history and physical;
3. Laboratory tests;
4. Operating room staffing;
5. Recovery room charges; and
6. All supplies related to the surgical care of the beneficiary and discharge.

The flat fee excludes payments for the physician performing the surgery, the radiologist and the anesthesiologist when these professionals are not under contract with the ambulatory surgery center.

For those surgical procedures not included in the payment groupings on the Medicaid fee schedule, the reimbursement is the established flat fee for the service.

Never Events

Reimbursement will not be provided for "never events" or medical procedures performed in error that are preventable and have a serious, adverse impact to the health of the beneficiary. Reimbursement will not be provided when the following occurs:

1. The wrong surgical procedure is performed on a beneficiary;
2. A surgical or invasive procedure is performed on the wrong body part; or
3. A surgical or invasive procedure is performed on the wrong beneficiary.

Billing

Ambulatory surgical center claims are completed on the CMS 1500 or 837P. There should only be one (1) line item per claim form.

Only one (1) procedure code may be reimbursed per outpatient surgical session.