



Ambulatory Surgical Centers

Overview

An Ambulatory Surgical Center (ASC) (PT 46) is a distinct, freestanding ambulatory surgical facility that operates exclusively for the purpose of providing outpatient surgical services that do not require inpatient hospitalization, and the duration of services is not expected to exceed 24 hours following an admission. Ambulatory surgical centers can administer anesthesia (e.g., general, moderate sedation, regional), monitor the patient, provide postoperative care, and resuscitate, as necessary.

Covered services

Medicaid reimburses covered, medically necessary surgical procedures that have been assigned an ASC level by Medicaid (reference the Rates, Outpatient Surgery, ASC Groups and Procedures document on the Division of Health Care Financing and Policy (DHCFP) website:

<http://dhcfp.nv.gov/Resources/Rates/RatesCostContainmentMain/>), appropriately furnished in an ambulatory surgical center and authorized by the QIO-like vendor (DXC Technology is the QIO-like vendor and is referred to as Nevada Medicaid), when applicable.

Sterilization

When a sterilization procedure is performed, a Sterilization Consent Form must be submitted with the claim or be on file with the DHCFP QIO-like vendor. Failure to provide this form will result in claim denial when a copy of the form is not on file with Nevada Medicaid at the time the facility submits their claim. For additional requirements, see the Sterilization and Abortion Policy document at the Provider Billing Information website at:

https://www.medicaid.nv.gov/Downloads/provider/NV_Billing_Sterilization.pdf.

Non-covered services

Medicaid does not cover services that are not medically necessary, are not assigned an ASC level by Medicaid (reference the Rates, Outpatient Surgery, ASC Groups and Procedures document on the DHCFP website:

<http://dhcfp.nv.gov/Resources/Rates/RatesCostContainmentMain/>), are authorized to be performed at an Inpatient level of service, or are specified in the MSM as a non-covered benefit (e.g., experimental surgeries, fertility restoration).

Cosmetic surgery is not a Medicaid covered benefit, except for the immediate repair of an accidental injury or the improvement of a malformed body member which coincidentally serves some cosmetic purpose. Refer to MSM Chapter 200 Section 203.5 and Chapter 600 Section 603.10F.

Authorizations

Authorization does not guarantee payment of a claim. Payment is contingent upon eligibility, available benefits, contractual terms, limitations, exclusions, coordination of benefits and other terms and conditions set forth by the benefit program.

Services that require authorization

The following services must be prior authorized:

- Any procedure specified on the Provider Web Portal at <https://www.medicaid.nv.gov/hcp/provider/Home/tabid/135/Default.aspx> as requiring authorization. (Select "Authorization Criteria" under "Resources." You do not need to log in.) A prior authorization requirement applies to procedures performed in-state or out-of-state. Providers must also check the ASC



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Payment Groups and Procedures list to be sure that an ASC level is assigned to the code for reimbursement by Medicaid.

- Services that are normally performed in a physician's office, emergency room, urgent care, diagnostic center or clinic.
- Any procedure requiring prior authorization when performed in conjunction with a procedure exempt from authorization.

Prior authorization is not required for a Medicare Part B/Medicaid dual-eligible recipient when Medicare benefits are not exhausted.

Requesting authorization

To request authorization, complete form [FA-6](#) and use the [online prior authorization system](#) to complete/submit required information online.

Managed Care Organization versus Fee For Service

When a recipient is enrolled in a Managed Care Organization (MCO), request prior authorization from and submit claims to the MCO.

When a recipient is enrolled in the FFS plan, request prior authorization from and submit claims to the QIO-like vendor.

Rates

The ASC Payment Groups and Procedures list, specifying ASC levels assigned to specific CPT codes, is located at: <http://dhcfp.nv.gov/Resources/Rates/RatesCostContainmentMain/> (select "Rates," then accept the license agreement, then select "ASC Groups and Procedures" under "Outpatient Surgery.") Surgical procedure codes not on this list with a corresponding ASC level are not reimbursed by Medicaid when the surgery is performed in an ASC.

Reimbursement is an all-inclusive rate based on the ASC Level assigned to the surgical procedure.

Billing for BAHA, Cochlear, Baclofen Pump, Vagus Nerve Stimulator Implants

Reference [Web Announcement 929](#): "Update Regarding the All-Inclusive Reimbursement for Baha, Cochlear, VNS, and Baclofen Pump."

Medicaid reimburses these four implants using an all-inclusive rate that includes the Healthcare Common Procedure Coding System (HCPCS) device and all associated services for the ASC payment group.

A prior authorization must be obtained from Nevada Medicaid for the appropriate CPT surgical code.

A freestanding ASC (PT 46) must bill these implant devices using the CMS-1500 Claim Form, using the appropriate CPT code in the required Field 24D (Procedures, Services, or Supplies CPT/HCPCS Modifier) and the corresponding dollar amount from the table in Web Announcement 929 in the required Field 24F (\$ Charges). Bill all other services rendered on the same day in conjunction with the surgical code on single lines in Field 24D and zero dollar amount in Field 24F due to the all-inclusive rate.

For additional information regarding Cochlear, Baha, VNS, and Baclofen Pump implant policy, reference MSM Chapter 2000, Audiology Services, and Chapter 600, Section 603.10 Physician Services, In Outpatient Setting.

The physician/surgeon (PT 20) must obtain a separate prior authorization for the surgical procedure performed. Reference MSM Chapter 600.