Title 23: Division of Medicaid

Part 210: Ambulatory Surgical Centers

Chapter 1: General

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 including, but not limited to, physician services, lab, x-ray or diagnostic procedures, other than those directly related to performance of the surgical procedure.

D. The ASC payment rate includes all the costs incurred by the ASC in providing services in connection with performing a specific procedure including, but not limited to, surgical supplies, equipment, and nursing services.

E. The Division of Medicaid covers the cost of corneal tissue used in corneal transplant cases. The reimbursement will be one hundred percent (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 rule is applicable only to an ASC.

F. The Division of Medicaid covers medically necessary dental treatment in the ASC setting when all the following are met:

    1. Quality, safe, and effective treatment cannot be provided in an office setting,

    2. Inpatient hospitalization is not medically necessary [Refer to Miss. Admin. Code Part 204, Rule 1.11.B.], and

    3. Certain dental procedures have been prior authorized by the Division of Medicaid or designee.

Source: 42 C.F.R. Part 416; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 10/01/2019.

Rule 1.6: Reimbursement

A. Mississippi Medicaid Ambulatory Surgical Care (ASC) rates are set at eighty percent (80%) of the current Medicare ASC 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 the provider's usual and customary charges, whichever is less.

C. The Division of Medicaid reimburses for multiple procedures as outlined in Miss. Admin. Code Part 203, Chapter 4.

D. 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, cannot be billed and no payment will be made for the procedure. Services provided prior to the procedure may be billed and are subject to coverage rules for those services.

E. 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 are subject to coverage rules for those services. Clear documentation regarding the medical necessity for cancellation or termination of the procedure must be provided.

F. ASC providers must bill the procedure code that accurately reflects the dental services rendered as follows:

    1. Dental procedures performed by a Mississippi licensed dentist must be billed with a Code on Dental Procedures and Nomenclature (CDT).

    2. Dental procedures performed by a Mississippi licensed dentist who is also a Mississippi licensed physician can bill either a CDT code or a Current Procedural Terminology (CPT) code.

Source: 42 C.F.R. Part 416; Miss. Code Ann. §§ 43-13-117, 43-13-121.

History: Revised eff. 10/01/2019.