

26-002 Covered ASC Procedures: NMAP covers ASC facility services performed in connection with procedures on ~~Medicare's~~ the list of covered ASC procedures in 471-000-409, state defined ASC Services code(s). These procedures are organized in several groups that refer to the facility payment amount available ~~under Medicare~~ for each group. The ASC receives the same payment for each procedure within a particular group.

~~Medicare's~~ The list of covered ASC procedures indicates which procedures may be covered if performed in an ASC; NMAP does not require that these procedures must be performed in an ASC. The general rules regarding the medical necessity of a specific procedure for a specific client apply to ASC services as they do to all other services covered by NMAP.

26-003 Covered ASC Facility Services: ASC facility services are items and services provided by an ASC in connection with a covered surgical procedure defined in 471 NAC 26-002. These items and services are those that would otherwise be covered by NMAP if provided on a inpatient or outpatient basis in a hospital in connection with that surgical procedure.

The fee for ASC facility services includes payment for -

1. Nursing, technician, and related services;
2. Use of ASC facilities;
3. Drugs, biologicals, surgical dressings, splints, casts, and appliances and equipment directly related to the provision of a surgical procedure;
4. Diagnostic or therapeutic services or items directly related to the provision of a surgical procedure;
5. Administrative, record keeping, and housekeeping items and services;
6. Blood, blood plasma, platelets, etc.; and
7. Materials for anesthesia.

The fee for ASC facility services does not include payment for medical and other health services, such as physicians' services and prosthetic devices for which payment may be made under other NMAP payment plans, except for intraocular lenses. See 471 NAC 26-004, ASC Services Not Included in the ASC Facility Services Fee.

26-003.01 Nursing, Technician, and Related Services: The fee for ASC facility services includes payment for all services provided by nurses and technical personnel who are employees of the ASC in connection with covered procedures. In addition to nursing staff, this includes orderlies, technical personnel, and others involved in patient care.

26-003.02 Use of ASC Facilities: The fee for ASC facility services includes payment for operating and recovery rooms, patient preoperation areas, waiting rooms, and other areas used by the patient or offered for use by the patient's relatives in connection with covered procedures.

3. Recasting and resplinting, when provided on a date other than the date the surgical procedure was performed.

When these dressings and supplies are obtained by the patient on a physician's order from a supplier other than the ASC facility, they are covered under 471 NAC 7-000 ff.

26-004.03 Ambulance Services: Ambulance services are not included in the fee for ASC facility services. Ambulance services provided by the ASC are covered as ASC services only if provided in conjunction with a covered ASC procedure and only when any other form of transportation is contraindicated for the patient's condition. Licensure and other ambulance policy is covered in 471 NAC 4-000.

26-004.04 Laboratory Services: Except for those laboratory services included in ASC facility services under 471 NAC 26-003.04, laboratory services are covered in 471 NAC 10-003.04 and 18-004.29.

#### 26-005 Payment for ASC Services

26-005.01 Fee for ASC Facility Services: NMAP pays a fee for ASC facility services provided in an ASC in connection with covered ASC procedures at the rate established by Medicare for that group of procedures in 471-000-409.

If one covered ambulatory surgical procedure is provided in a single operative session, NMAP pays 100 percent of the applicable group rate. For example, excision of a benign lesion is a "group 1" procedure; therefore, NMAP would pay 100% of the "group 1" rate.

If more than one covered surgical procedure is provided in a single operative session, NMAP pays 100 percent of the applicable group rate for the procedure with the highest rate. NMAP pays for other covered ambulatory surgical procedures performed in the same operative session at 50 percent of the applicable group rate for each procedure. For example, hammertoe repair is a "group 4" procedure and tenotomy is a "group 1" procedure. Payment for these procedures performed in a single operative session in an ASC would be 100% of the "group 4" rate and 50% of the "group 1" rate.

26-005.02 (Reserved)

26-005.03 Payment for Services Not Included in the ASC Facility Services Fee:  
The fee for facility services does not include payment for physicians' services or other services not directly related to the performance of the surgical procedure. (See 471 NAC 26-004.) The ASC may bill for these services in addition to the fee for ASC facility services and will be paid according to the appropriate NMAP payment plan.

26-005.04 Payment for State-Defined Services: NMAP ~~may~~ covers payment for facility services provided in connection with ~~certain~~ state-defined services provided in an ASC. See 471 NAC 18-004.17E.

### 26-006 Billing Requirements

26-006.01 Required Forms: When billing NMAP, the ASC shall submit on the appropriate form or electronic format (see Claim Submission Table at 471-000-49).

All claims for ASC services must include the date of surgery and the physician's name and license number.

26-006.02 Procedure Codes: To claim the ASC facility fee, the ASC shall use the appropriate HCPCS/CPT procedure codes as outlined in claim completion instructions (see 471-000-52) and see 471-000-409, state defined ASC Services code(s).

The ASC shall use HCPCS/CPT procedure codes when billing for practitioner services and laboratory services. Regulations listed in 471 NAC 4-000 must be used for ambulance services. Regulations listed in 471 NAC 7-000 must be used for durable medical equipment and medical supplies.