CHAPTER 1126. AMBULATORY SURGICAL CENTER SERVICES AND HOSPITAL SHORT PROCEDURE UNIT SERVICES

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Authority

The provisions of this Chapter 1126 issued under section 443.3(1) of the Public Welfare Code (62 P.S. § 443.3(1)), unless otherwise noted.

Source

The provisions of this Chapter 1126 adopted October 7, 1988, effective immediately and apply retroactively to April 1, 1987, 18 Pa.B. 4587, unless otherwise noted.

Cross References

This chapter cited in 55 Pa. Code § 1101.31 (relating to scope); 55 Pa. Code § 1150.59 (relating to PSR program); and 55 Pa. Code § 1163.32 (relating to hospital units excluded from the DRG prospective payment system).

GENERAL PROVISIONS

§ 1126.1. Policy.

The MA Program pays for same day surgical services provided to eligible MA recipients. Payment is made to participating, independently operated ambulatory surgical centers and hospital short procedure units under this chapter and Chapter 1101 (relating to general provisions).

Cross References

This section cited in 55 Pa. Code § 1126.53 (relating to limitations on covered procedures).

§ 1126.2. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

ASC—Ambulatory surgical center—A facility licensed by the Department of Health which provides outpatient surgical treatment. The term does not include individual or group practice offices of private physicians or dentists, unless the offices have a distinct part used solely for outpatient surgical treatment on a regular and organized basis.

SPU—Short procedure unit—A unit of a hospital organized for the delivery of ambulatory surgical, diagnostic or medical services.

Same day surgical services—Specified surgical, diagnostic and medical treatment provided to patients who do not require hospitalization, but who require constant medical supervision for a limited amount of time following the procedure performed.

SCOPE OF BENEFITS

§ 1126.21. Scope of benefits for the categorically needy.

Categorically needy recipients not enrolled in health maintenance or health insuring organizations are eligible for ambulatory surgical services, subject to this chapter.

§ 1126.22. Scope of benefits for the medically needy.

Medically needy recipients not enrolled in a health maintenance or health insuring organization are eligible for ambulatory surgical services, subject to this chapter.

§ 1126.23. Scope of benefits for State Blind Pension recipients.

State Blind Pension recipients are not eligible for ambulatory surgical services under the MA Program unless the recipient is also categorically needy or medically needy.

§ 1126.24. Scope of benefits for General Assistance recipients.

General Assistance recipients, age 21 to 65, whose MA benefits are funded solely by State funds, are eligible for medically necessary basic health care benefits as defined in Chapter 1101 (relating to general provisions). See § 1101.31(e) (relating to scope).

Source

The provisions of this § 1126.24 adopted December 11, 1992, effective January 1, 1993, 22 Pa.B. 5995.

PROVIDER PARTICIPATION

§ 1126.41. Participation requirements.

(a) In addition to the participation requirements established in Chapter 1101 (relating to general provisions), an independently operated ASC or hospital SPU shall:

(1) Be enrolled in the MA Program as an ASC or a hospital SPU.

(2) Abide by applicable Federal and State statutes and regulations, including, but not limited to, Title XIX of the Social Security Act (42 U.S.C.A. §§ 1396—1396p), the Public Welfare Code (62 P. S. §§ 101—1503) and applicable licensing statutes.

(3) Have an established schedule of charges for billing third parties and private payors that is published and made available to the general public.

(4) If requested, furnish information to the Department necessary to establish rates as specified in § 1126.53 (relating to limitations on covered procedures), in the form and manner the Department requires.

(b) In addition to the participation requirements set forth in subsection (a), a hospital SPU shall:

(1) Be enrolled as a provider of ambulatory surgical services separately from, and in addition to, the hospital's enrollment with the Department as a provider of inpatient services.

(2) Be part of an institution that is licensed as a hospital by the Department of Health and meets the requirements for participation in Medicare. An SPU meeting those qualifications is eligible to participate and be compensated as a provider of same day surgical services.

(3) Submit to the Department information regarding the bed complement and location of the distinct part ambulatory surgical unit.

(c) In addition to the participation requirements set forth in subsection (a), an ASC shall be certified as meeting the Medicare requirements at 42 CFR 416 (relating to ambulatory surgical services).

(d) If abortions are performed in an ASC, the facility shall be licensed/approved by the Department of Health to provide this service.

(e) Out-of-State ASCs and SPUs providing services to Commonwealth recipients shall, in addition to complying with the appropriate requirements of this section, either be Medicare certified or be approved by the appropriate agency of the state in which the ASC or SPU is located as meeting standards comparable to Medicare.

(f) The Department reserves the right to refuse to enter into a provider agreement with a licensed ASC or hospital SPU whenever it determines that it is in the Department's best interests to do so.

§ 1126.42. Ongoing responsibilities of providers.

Ongoing responsibilities of providers are established in § 1101.51 (relating to ongoing responsibilities of providers).

PAYMENT FOR SAME DAY SURGICAL SERVICES

§ 1126.51. General payment policy.

(a) Payment is made for support services related to procedures provided by participating ASCs and SPUs. Payment is subject to the conditions and limitations established in this chapter and Chapters 1101 and 1150 (relating to general provisions; and medical assistance program payment policies).

(b) A fee determined by the Department is paid to an ASC or an SPU for support services relating to a covered procedure provided to an eligible recipient at the facility.

(c) The ASC or SPU is considered the provider regardless of whether the facility is operated directly by the enrolled provider or through contract between the provider and other organizations or individuals. The enrolled provider is responsible for the delivery of service and for billings.

(d) When two or more compensable procedures are performed during the same ASC or SPU stay, the services relating to the procedure carrying the highest payment shall be paid in full with no allowance for additional procedures.

(e) The fee paid to the facility shall include but is not limited to:

(1) Nursing, technician and related services.

(2) Use of the facility.

(3) Drugs, biologicals, surgical dressings, supplies, splints, casts and appliances and equipment directly related to the provision of surgical procedures.

(4) Administrative, recordkeeping and housekeeping items and services.

(5) Materials for anesthesia.

(f) The ASC or SPU shall submit invoices to the Department in accordance with the instructions in the Provider Handbook.

(g) If an ASC or SPU has a fee schedule based on the patient's ability to pay, the Department will consider the provider's usual and customary charge to the general public to be the most frequent charge to the self-paying public for the same service in the preceding calendar month.

(h) The Department will pay the lesser of the facility's charge to the general public or the amount determined as the fee that the facility is eligible to bill.

(i) Payment will be retroactively denied for sterilizations found to be out of compliance with § 1126.55 (relating to payment conditions for sterilizations) and for abortions found to be out of compliance with § 1141.57 (relating to payment conditions for necessary abortions).

(j) Payment will be made for services provided to Commonwealth Medical Assistance recipients by an out-of-State ASC or hospital SPU only if residents in a given area generally receive their care in that particular facility. This will apply when the out-of-State facility is closer to, or substantially more accessible from, the residence of the recipient than the nearest facility within this Commonwealth that is adequately equipped to deal with, and is available for the treatment of, the individual's illness or injury.

(k) Payment will be made to ASC/SPU facilities for services provided to patients who, in conjunction with a same day service, are transferred to a hospital due to complications.

(l) Payment will be made under Chapter 1163 (relating to inpatient hospital services) for care provided to patients who, due to complications, must be transferred to inpatient hospital care.

(m) Compensable diagnostic medical services, including preadmission testing, electrocardiograms and diagnostic or therapeutic radiology services provided in conjunction with same day surgical services are compensable to the hospital or the ASC in addition to the payment for support services if the facility is otherwise eligible to provide the services, and if the services are provided prior to the day of admission. Diagnostic services provided on the day of admission are considered ancillary services and are included under the support component paid to facilities for a procedure.

§ 1126.52. Payment criteria.

(a) The Department will establish maximum reimbursement fees for same day surgical services based on the criteria established in § 1150.62 (relating to payment levels.)

(1) The level of reimbursement will be consistent with efficiency, economy and quality of care.

(2) The level of reimbursement will be sufficient to assure availability of services.

(b) The Department developed the fees as follows:

(1) Using paid claims history for services provided between July 1, 1985 and June 30, 1986, the Department identified claims for same day admissions and discharges.

(2) The cost for each claim was calculated by applying the hospital's cost to charge ratios, as reported on its cost report for Fiscal Year 1984-1985.

(3) The Statewide average cost of each procedure was determined by first totaling the costs for all cases of a specific procedure. Each total was divided by the number of occurrences for that procedure.

(4) The fee for the ASC/SPU support component was determined by increasing the Statewide average cost of each procedure to account for inflation between the fiscal year represented by the data base and the fiscal year of implementation. The inflation factors used were 4.7% for Fiscal Year 1985-86, and 1.95% for Fiscal Year 1986-87.

(5) New procedures may be added to the ASC/SPU established list of procedures and fees after a sufficient number of occurrences are recorded in the Department's files and enough data are obtained to establish a fee. Changes made in the list are subject to review by the Department's professional medical staff and the recommendations of the Department's medical and hospital subcommittees.

§ 1126.53. Limitations on covered procedures.

(a) Payment will be made for same day surgical procedures listed by the department as compensable when provided under § 1126.1 (relating to policy).

(b) Payment for procedures that are appropriate for same day surgery but are not yet included in the established list of covered ASC/SPU services is limited to:

(1) The specific fee for each procedure developed by the Department when enough data is obtained to establish a fee.

(2) Prior to establishment of a fee, the Statewide average cost of same day surgery developed by the Department.

(c) Payment will be made for services performed in an approved ASC/SPU only if the service could not be appropriately and safely performed in the practitioner's office, the clinic or the emergency room of a hospital, because the medi-

cal needs of the patient require less than 24-hour care, and the use of inpatient hospital resources, especially an operating room, and in some cases administration of general anesthesia.

Cross References

This section cited in 55 Pa. Code § 1126.41 (relating to participation requirements).

§ 1126.54. Noncompensable services and items.

(a) The Department does not pay ASCs and SPUs for services directly or indirectly related to, or in conjunction with:

(1) A service not designated by the Department as appropriate to be performed in an ASC or SPU.

(2) A service that does not conform to the requirements of this chapter.

(3) A sterilization performed on individuals 20 years of age or younger.

(4) A sterilization performed on individuals 21 years of age or older who have not signed the Consent Form for Sterilization at least 30 days but not more than 180 days prior to the sterilization.

(5) Abortion procedures performed on individuals if a Physician Certification for an Abortion form has not been completed.

(6) A service provided by an ambulatory surgical center that does not meet the Federal Medicare requirements at 42 CFR 416 (relating to ambulatory surgical services).

(7) Procedures and medical care performed in connection with sex reassignment.

(8) Medical, dental or surgical procedures which may be provided in a clinic or practitioner's office without undue risk to the patient.

(9) Plastic or cosmetic surgery for beautification purposes—for example, otoplasty for protruding ears or lop ears, rhinoplasty—except for internal nasal deformity—nasal reconstruction, excision of keloids, mammoplasty, silicone or silastic implants, dermabrasion, skin grafts and lipectomy. Plastic surgery is compensable if performed for the purpose of improving the functioning of a deformed body member.

(10) A dental case involving oral rehabilitation or restorative services, except for procedures performed for treatment of a secondary diagnosis, unless:

(i) The nature of the surgery or the condition of the patient precludes the procedure in the dentist's office.

(ii) A physician or dentist has documented in the patient's medical record the medical justification for performing the procedure in an ASC/SPU setting.

(11) Diagnostic tests and procedures that can be performed in a clinic or practitioner's office and diagnostic tests and procedures not related to the diagnosis.

(12) Services and items for which full payment equal to or in excess of the Medical Assistance fee, is available through Medicare, other financial resources or other health insurance programs.

(13) Services and items not ordinarily provided to the general public.

(14) A diagnostic or therapeutic procedure solely for experimental, research or educational purposes.

(15) A procedure that is not listed under the Medical Assistance Fee Schedule.

(16) A service that is not medically necessary.

(b) The Department will not pay for same day surgical services if the admission to the ASC or SPU is not certified under the Department's utilization review process applicable to the type of provider furnishing the service.

§ 1126.55. Payment conditions for sterilizations.

(a) Payment for certified sterilization procedures provided at ASCs/SPUs is made only if:

(1) The individual requesting sterilization has voluntarily given informed consent under subsection (b).

(2) The individual is 21 years of age or older at the time informed consent is obtained.

(3) The individual is not a mentally incompetent individual or an institutionalized individual. For the purposes of this chapter, a mentally incompetent individual is a person who has been declared mentally incompetent by a Federal, State or local court of competent jurisdiction unless that person has been declared competent for purposes which include the ability to consent to sterilization.

(b) An individual requesting sterilization has voluntarily given informed consent only if:

(1) A consent form has been completed correctly in accordance with the instructions in the provider handbook and within the time limit specified in subsection (c)(1).

(2) The person obtaining informed consent has explained orally the elements of informed consent that are included in the consent to sterilization section of the consent form.

(3) The person obtaining informed consent has advised the individual that a decision not to be sterilized will not result in the withdrawal or withholding of benefits provided by programs or projects receiving Federal funds and has offered to answer questions the individual may have concerning the sterilization procedure.

(4) The individual giving informed consent was permitted to have a witness chosen by that individual present when informed consent was given.

(5) The individual was offered a language interpreter, if necessary, or an appropriate interpreter if the individual is blind, deaf or otherwise handicapped.

(6) The requirements of additional Federal, State or local laws for obtaining consent have been met.

(c) A consent form is considered to be completed correctly only if:

(1) At least 30 days, but no more than 180 days, have passed between the date the individual gave written informed consent and the date of the sterilization procedure. In the case of a sterilization performed during emergency abdominal surgery, 72 hours shall have passed between the time of informed consent and the time of sterilization. In the case of sterilization performed during premature delivery, informed consent shall have been given at least 30 days before the expected date of delivery.

(2) The person obtaining informed consent has properly signed the consent form in accordance with instructions in the provider handbook on the same date that informed consent was given.

(3) Another witness or interpreter has properly signed the consent form in accordance with instructions in the provider handbook.

(4) The physician performing the sterilization procedure has certified and signed the physician's statement section of the consent form after the procedure has been performed.

Cross References

This section cited in 55 Pa. Code § 1126.51 (relating to general payment policy).

UTILIZATION CONTROL

§ 1126.71. Scope of utilization review process.

Same day surgical services provided to Medical Assistance recipients are subject to the utilization review procedures in Chapter 1101 (relating to general provisions), and in § 1163.72 (relating to utilization review: general).

ADMINISTRATIVE SANCTIONS

§ 1126.81. Provider misutilization.

If the Department determines that a provider billed for services inconsistent with this chapter and Chapter 1101 (relating to general provisions), provided incorrect information on the billing invoice regarding a patient's diagnosis or procedures performed during the period of hospitalization or otherwise violated the standards in the provider agreement, the provider is subject to the sanctions in Chapter 1101.

§ 1126.82. Administrative sanctions.

(a) If the ASC/SPU quality assurance/utilization review committee fails to review a Medical Assistance recipient's need for admission or fails to request

approval for the admission through the Department's Bureau of Policy and Program Development, the Department will deny payment for the stay.

(b) If the Department determines that a facility billed for services inconsistent with this chapter and Chapter 1101 (relating to general provisions), provided incorrect information on the billing invoice regarding a patient's diagnosis or procedures performed, the Department will deny payment for the claims.

(c) If the Department determines that an ASC/SPU claim has been inappropriately coded based on information in the patient's medical record or discovers coding errors, the Department will correct the claim for payment purposes.

RIGHT OF APPEAL

§ 1126.91. Provider right of appeal.

(a) The hospital's right of appeal is under Chapter 1101 (relating to general provisions).

(b) ASCs/SPUs and practitioners do not have the right to a separate appeal on the same case.

(c) For cases undergoing the appeal process, payment, including adjustments, will be withheld until the case is adjudicated.

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