Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
www.mass.gov/masshealth

MassHealth
Transmittal Letter FAS-27
December 2013

TO: Freestanding Ambulatory Surgery Centers Participating in MassHealth

FROM: Kristin L. Thorn, Medicaid Director

RE: Freestanding Ambulatory Surgery Center Manual (Revisions to MassHealth Regulations-Affordable Care Act)

This letter transmits revisions to the freestanding ambulatory surgery center program regulations in Subchapter 4 of the *Freestanding Ambulatory Surgery Center Manual*.

The revised regulations implement a change in coverage for the diagnosis of infertility. This change was prompted by requirements of the Affordable Care Requirement regarding coverage of Essential Health Benefits.

These regulations are effective January 1, 2014.

MassHealth Website

This transmittal letter and attached pages are available on the MassHealth website at www.mass.gov/masshealth.

Questions

If you have any questions about the information in this transmittal letter, please contact MassHealth Customer Service at 1-800-841-2900, e-mail your inquiry to providersupport@mahealth.net, or fax your inquiry to 617-988-8974.

NEW MATERIAL
(The pages listed here contain new or revised language.)

Freestanding Ambulatory Surgery Center Manual

Pages 4-1, 4-2, 4-9, and 4-10

OBSOLETE MATERIAL
(The pages listed here are no longer in effect.)

Freestanding Ambulatory Surgery Center Manual

Pages 4-1 and 4-2 — transmitted by Transmittal Letter FAS-6

Pages 4-9 and 4-10 — transmitted by Transmittal Letter FAS-9

423.401: Introduction

130 CMR 423.000 establishes the requirements for the provision and reimbursement of freestanding ambulatory surgery center services under the MassHealth Program. MassHealth pays for freestanding ambulatory surgery center services that are medically necessary and appropriately provided in the most cost-effective setting; that is, the total cost of the service (for example, the rate of payment for the corresponding payment group including directly related ancillaries, plus the cost of prosthetic devices or implants) does not exceed the cost to Medicaid of providing that same service in any other medically appropriate setting, as determined by the MassHealth agency or its agent. The quality of the services delivered to MassHealth members must meet professionally recognized standards of care.

423.402: Definitions

The following terms used in 130 CMR 423.000 shall have the meanings given in 130 CMR 423.402, unless the context clearly requires a different meaning.

Emergency — the unexpected onset of symptoms or a condition requiring immediate medical or surgical care that is beyond the treatment capabilities of the freestanding ambulatory surgery center.

Freestanding Ambulatory Surgery Center — a facility, geographically independent of any other health-care facility, that operates autonomously and functions exclusively for the purpose of providing outpatient same-day surgical, diagnostic, and medical services requiring a dedicated operating room and a postoperative recovery room. These surgical, diagnostic, and medical services provide diagnosis or treatment through operative procedures requiring general, local, or regional anesthesia, and must be furnished to patients who do not require hospitalization or overnight services upon completion of the procedure, but who require constant medical supervision for a limited amount of time following the conclusion of the procedure. A freestanding ambulatory surgery center does not include individual or group-practice offices of private physicians, dentists, or podiatrists, and does not include any clinic devoted exclusively to the performance of any single surgical procedure or specialty. A freestanding ambulatory surgery center must be an entity subject to a determination of need by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, s. 25C. These centers are referred to as surgical centers in 130 CMR 423.000.

Individual Consideration — a designation given to a claim that will receive individual consideration (I.C.) to determine payment where a fee could not be established.

Operative Report — a report that states the operation performed, the name of the recipient, the date of the operation, the preoperative diagnosis, the postoperative diagnosis, the names of the surgeon and his or her assistants, and the technical procedures performed.

423.403: Eligible Members

(A) MassHealth Members and Recipients of Emergency Aid to the Elderly, Disabled and Children Program.

(1) The MassHealth agency pays for freestanding ambulatory surgery services provided to MassHealth members, subject to the restrictions and limitations described in the MassHealth regulations. The services covered and the members covered under each coverage type are described in 130 CMR 450.105: *Coverage Types*.

(2) For information on covered services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program, see 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*.

(B) Member Eligibility and Coverage Type. For information on verifying member eligibility and coverage type, see 130 CMR 450.107: *Eligible Members and the MassHealth Card*.

423.404: Provider Eligibility

Payment for the services described in 130 CMR 423.000 will be made only to in-state and out-of-state surgical centers participating in the Medical Assistance Program on the date of service. The MassHealth agency has established the provider eligibility requirements listed below for in-state and out-of-state providers. Providers must meet all of these requirements to participate in the Medical Assistance Program as a surgical center.

(A) Procedures for Hospitalization. An in-state or out-of-state surgical center must have established procedures to ensure recipient transfer to a hospital in the event an emergency occurs that requires treatment beyond the capabilities of the surgical center. Either the surgical center must have a written transfer agreement with a hospital, or all the dentists, physicians, and podiatrists with surgical privileges at the surgical center must have admitting privileges at the hospital. The hospital must be a Massachusetts Medicaid-participating provider, and must be licensed to operate as a hospital in accordance 105 CMR 130.000: *Hospital Licensure* or with its own state's licensing agency.

(B) In-State Providers. To participate in the MassHealth Program, an in-state surgical center must:

(1) obtain a MassHealth provider number from the MassHealth agency;

(2) operate under a clinic license issued by the Massachusetts Department of Public Health, in accordance with regulations at 105 CMR 140.000; *Licensure of Clinics*;

423.414: Reimbursable Surgical Procedures

The MassHealth agency will pay surgical centers for those services listed in Subchapter 6 of the *Freestanding Ambulatory Surgery Center Manual* (see 130 CMR 423.401 for further requirements). All prosthetic devices, except intraocular lenses, whether implanted, inserted, or otherwise related to procedures on the current list of reimbursable surgical procedures, are reimbursed separately from the surgical center facility component. The above notwithstanding, providers must comply with the requirements specified in 130 CMR 423.401, which state that reimbursement is provided only for services that are medically necessary and furnished in the least costly medically appropriate setting.

423.415: Service Limitations

(A) The MassHealth agency will not pay a surgical center for experimental, unproven, or otherwise medically unnecessary procedures or treatments performed at the center, specifically including, but not limited to, sex-reassignment surgery, thyroid cartilage reduction, and any other related surgeries and treatment, including pre- and post-sex-reassignment surgery hormone therapy. Notwithstanding the preceding sentence, the MassHealth agency will continue to pay for post-sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993.

(B) The MassHealth agency will pay only for podiatry services that are certified to be necessary for the life and safety of the recipient. The MassHealth agency will reimburse for podiatry services as long as the podiatrist's claim has attached to it a written certification on letterhead from the recipient's primary care physician that attests that such services are medically necessary for the life and safety of the recipient and that contains a substantiating medical explanation. A surgical center must submit a photocopy of this written certification obtained by the podiatrist from the primary care clinician and attach it to the surgical center's claim when billing the MassHealth agency for services.

(C) The MassHealth agency will not pay a surgical center for the treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment); however, the MassHealth agency will pay a surgical center for diagnosis of male or female infertility.

423.416: Sterilization Services: Introduction

(A) Eligible Recipients. Female Medical Assistance recipients in categories of assistance 0, 1, 2, 3, 5, 6, 7, and 8 are eligible for sterilization services as described in 130 CMR 423.416 through 423.418. For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 4), see 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*.

(B) Definitions. The following definitions apply to sterilization services:

(1) Sterilization - any medical procedure, treatment, or operation that renders an individual permanently incapable of reproducing. A sterilization is "nontherapeutic" when the individual has chosen sterilization as a permanent method of contraception. A sterilization is "therapeutic" when it occurs as a necessary part of the treatment of an existing illness or injury or is medically indicated and performed in conjunction with surgery upon the genito-urinary tract.

(2) Mentally Incompetent Individual - an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes that include the ability to consent to sterilization.

(3) Institutionalized Individual - an individual who is:

(a) involuntarily confined or detained, under a civil or criminal statute in a correctional or rehabilitative facility, including a psychiatric hospital or other facility for the care and treatment of mental illness; or

(b) confined, under a voluntary commitment, in a psychiatric hospital or other facility for the care and treatment of mental illness.

(C) Reimbursable Services. The MassHealth agency will not pay a freestanding ambulatory surgery center for sterilization services for a male recipient. The MassHealth agency will pay for sterilization services provided to a female recipient only if all of the following conditions are met.

(1) The recipient has voluntarily given informed consent for the sterilization procedure in the manner and at the time described in 130 CMR 423.417, and such consent is documented in the manner described in 130 CMR 423.418.

(2) The recipient is at least 18 years old at the time consent is obtained.

(3) The recipient is not mentally incompetent or institutionalized.

(4) The sterilization is performed by a licensed physician.

(D) Assurance of Recipient Rights. No provider shall use any form of coercion in the provision of sterilization services. Neither the MassHealth agency nor any provider, nor any agent or employee of a provider, shall mislead any recipient into believing that a decision to have or not to have a sterilization will adversely affect the recipient's entitlement to benefits or services for which the recipient would otherwise be eligible. The MassHealth agency has strict requirements for confidentiality of recipient records for sterilization services as well as for all other medical services reimbursable under the Medical Assistance Program.

(E) Retroactive Eligibility. The MassHealth agency will not pay for a sterilization performed during the period of a recipient's retroactive eligibility unless all conditions for payment listed in 130 CMR 423.416(C) are met.