

POLICY AND PROCEDURE

DEPARTMENT: IlliniCare Health Medical Management	DOCUMENT NAME: ASC Steerage Policy & Procedure
PAGE: 1	REPLACES DOCUMENT:
APPROVED DATE:	RETIRED:
EFFECTIVE DATE: 8/1/2018	REVIEWED/REVISED:
PRODUCT TYPE: Medicaid, Ambetter	REFERENCE NUMBER:

SCOPE:

IlliniCare Health Medical Management Department

PURPOSE:

Ambulatory surgery centers (ASC) operate for the purpose of offering outpatient surgical services to members in an environment appropriate for low risk procedures on members with low risk health status. They serve as a high-quality, cost-effective alternative to inpatient surgical services. This policy provides guidance for when surgical services are medically appropriate to be provided in an ASC and can be redirected from an inpatient or outpatient hospital setting. A comprehensive list of these services is located on the CMS website:

<https://www.cms.gov/apps/ama/license.asp?file=/Medicare/Medicare-Fee-for-Service-Payment/ascpayment/downloads/AddendaAABB.zip>

POLICY:

In accordance and compliance with the Health Plan contract with the State of Illinois, to qualify for redirection, an ASC would need to be located within the 30 mile/30 minute Urban area standard of travel distance/time or 60 mile/60 minute Rural area standard according to the demographic of the member's permanent residence.

Procedures appropriate for an ASC should be redirected from an outpatient hospital setting when the above criteria are met. These procedures should be considered medically necessary per InterQual guidelines and include, but may not be limited to:

Procure Code	Procedure Description
43239	UPPER GASTROINTESTINAL ENDOSCOPY, FOR BIOP & OR COLL OF SPEC
66984	EXTRACAPSULAR CATARACT RMVL
45378	COLONOSCOPY, FIBEROPTIC, BEY SPL FLEX, DIAGN W W/O COLON DECOMP
45380	COLONOSCOPY, W BIOPSY & OR COLLECT OF SPEC BY BRUSH OR WASH
45385	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE-WITH REMOVAL OF TUMOR
58558	YSTEROSCOPY SURGICAL
58661	LAPRSCPY W/REMOV ADNEXAL STRUCTURES

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Procure Code	Procedure Description
47563	LAPRSCPY, CHOLECYSTMY W/CHOLANGIOG
49650	LAPRSCPY, REP INGUINAL HRNIA INITL
49505	REPR INIT ING HERNIA 5 YR/MORE; REDUCIBLE
66982	EXTRACAPSULAR CATARACT REMOVAL WITH INSERTION OF INTRAOCULAR LENS PROSTH
69436	TYMPANOSTOMY,GENERAL ANESTHESIA;UNILATERAL
43235	UPPER GASTROINTESTINAL ENDOSCOPY INCLUDING ESOPHAGUS, STOMACH, AND EITHE
42820	TONSILLECTOMY AND ADNOIDECTOMY;UNDER AGE 12
52332	CYSTOURETHROSCOPY,W INSERT OF INDWELL URETERAL STENT
49585	REPR UMBILICAL HERNIA 5 YR/OVER; REDUCIBLE
00810	INTESTINAL ENDOPIC PROC.
67108	RPR RETINA DETACH W VITRECTOMY
00740	ENDOSCOPIC PROC UPPER GI
G0121	COLORECTAL CANCER SCREENING; COLONOSCOPY ON INDIVIDUAL NOT MEETING CRITE
52310	CYSTOURETHROSCOPY,W REM OF FOR BODY,CALC,OR URETER STE;SIMP
45381	COLONOSCOPY, FLEXIBLE, PROXIMAL TO SPLENIC FLEXURE; WITH DIRECTED SUBMUC
67228	EXTENSIVE RETINOPATHY 1+ SESS PHOTOCOAGULATION
45330	SIGMOIDOSCOPY,FLEXIBLE,FIBEROPTIC;DIAGNOSTIC
00142	LENS SURGERY
00400	NOC INTEGUMENT/SUBCU. TISSUE CHEST
00910	NOC TRANSURETHRAL PROC
G0105	COLORECTAL CANCER SCREENING; COLONOSCOPY ON INDIVIDUAL AT HIGH RISK
00300	NOC INTEGUMENT NECK IN SUBCUTANEOUS
00902	ANORECTAL PROC. (INC BIOPSY)
76942	ULTRASONIC GUIDANCE NEEDLE BX-RAD S & I
00750	NOC HERNIA REPAIRS UPPER ABDOMEN
01820	CLSD PRO RADIUS/ULNA/WRIST/HND BNS
00126	TYMPANOTOMY
01480	NOC OPN PRO LWR LG/ANKLE/FT

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PROCEDURE:

Prior authorization will be required for **CMS ASC Covered Surgical Procedures**, when scheduling in a hospital setting. These procedure codes will not require prior authorization when scheduled in an Ambulatory Surgery Center (ASC), and performed by a PAR Provider. Failure to request prior authorization for these procedures will result in an administrative denial of submitted charges.

General process:

- Provider submits prior authorization for performing one of the CMS ASC Covered Surgical Procedures in a hospital setting. These will be submitted to the dedicated UM fax line and will be retrieved by the delegated UM staff member(s). Communication path with the provider will be as follows:
 - UM sends fax sheet back stating that the procedure should be done at an ASC
 - Provider faxes/calls with justification for needing procedure in hospital setting (UM will approve), or changes place of service to ASC
- **If the Provider states there is no ASC** within the time/distance travel standard. The following will occur:
 - UM will respond to the provider with approval to perform in a hospital setting
 - Or UM will reroute the call to member/provider services to provide the location information for a PAR ASC within the required standards.

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REFERENCES:

N/A

ATTACHMENTS:

CMS ASC Covered Surgical Procedures list

DEFINITIONS:

N/A

REVISION LOG

REVISION	DATE

POLICY AND PROCEDURE APPROVAL

The electronic approval retained in Compliance 360, Centene's P&P management software, is considered equivalent to a physical signature.

Director of Department: _____ Signature on file _____

Vice President of Department: _____ Signature on file _____