Outpatient Billing Expert

Detailed information for APC and ASC payment systems in one easy-to-use manual
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Hospital Outpatient Prospective Payment System

FACILITY RESOURCES EXCLUDED FROM THE AMBULATORY PAYMENT CLASSIFICATION PAYMENT

The following resources (costs) used while treating Medicare beneficiaries on an outpatient basis are excluded from the prospective payment rates and are, therefore, separately payable, when appropriate:

- Physician services
- Nurse practitioner services
- Physician assistant services
- Certified nurse-midwife services
- Services of qualified clinical psychologists
- Certain services of an anesthetist
- Clinical social worker services
- Rehabilitation services
- Ambulance services
- Durable medical equipment (DME) supplied by the hospital for the patient’s home use
- Prosthetics and prosthetic supplies, some implants and orthotic devices (some items have been packaged into the ambulatory payment classification (APC) payment)
- Clinical diagnostic laboratory services (paid under the laboratory fee schedule)
- Dialysis services furnished to end-stage renal disease (ESRD) patients (paid under an ESRD-composite rate)
- Procedures and/or services that are considered unsafe when performed or provided in the outpatient setting
- Services specific to other sites of service, such as inpatient and nursing home services
- Critical access hospital outpatient services paid under the cost-based method
- Services provided to patients who are inpatients of a skilled nursing facility (SNF), subsequent to the assessment or creation of the comprehensive care plan but billable and covered under the SNF prospective payment system (PPS)
- Services otherwise not covered by Medicare, including those deemed unreasonable and/or unnecessary for diagnosing or treating an illness or disease
- Vaccines for influenza, pneumococcal pneumonia, and hepatitis B

FACILITY TYPES OF SERVICES INCLUDED IN OPPS

The following services are included within the scope of the hospital outpatient prospective payment system (OPPS):

- Surgical procedures
- Clinic visits
- Emergency department visits
- Partial hospitalization
- Psychiatric services
- Radiology
- Radiation therapy
- Diagnostic services and other diagnostic tests
- Surgical pathology
- Cancer chemotherapy

- Certain services furnished to inpatients that have exhausted Part A benefits otherwise are not covered Part A stay (e.g., diagnostic x-rays and certain other diagnostic services and radiation therapy)
- Partial hospitalization services in community mental health centers (distinct and organized intensive psychiatric outpatient day treatment program, designed to provide patients with profound and disabling mental health conditions an individualized, coordinated, comprehensive, and multidisciplinary treatment program)
- Services furnished to SNF inpatients that are not packaged into the SNF consolidated billing precisely because they are services that are commonly furnished by hospital outpatient departments and that SNFs would not be able to provide, such as cardiac catheterization, CT scans, magnetic resonance imaging, ambulatory surgery requiring the use of an operating room, emergency room services, radiation therapy, angiography, and lymphatic and venous procedures
- Supplies such as surgical dressings that can be used during surgery or other treatments in the hospital outpatient setting that are also on the DME and orthotic or prosthetic devices fee schedule (payment for such supplies, when they are used in the hospital, is packaged into the APC payment rate for the procedure or service with which the items are associated)
- Certain preventive services furnished to healthy individuals (such as colorectal screening)
- Antigens, splints, and casts, when furnished by home health agencies (HHA), and hospices

FACILITY RESOURCES INCLUDED IN APC PAYMENTS

For those services that are under APCs, typically all of the components of care are bundled with, or considered part of, the service. The following resources (costs) are directly related and integral to the performance of a procedure or service on an outpatient basis for Medicare beneficiaries and, therefore, are included in the APC payment rate. The following services and items are not separately payable:

- Use of an operating suite, procedure room or treatment room or area
- Use of the recovery room
- Use of an observation bed (other than in the specific situation discussed below)
- Drugs, biologicals, and other pharmaceuticals: medical and surgical supplies and equipment; surgical dressings, splints, casts, and other devices used for reduction of fractures or dislocations
- Supplies and equipment used for administering and monitoring anesthesia or sedation
- Intraocular lenses (IOL) and several other designated implants

DISCOUNTING FOR MULTIPLE SERVICES

Payments for those services identified with the letter “T” in the status indicator column are surgical procedures that are discounted when multiple procedures are performed in the same operative session. Full Medicare payment is made for the primary procedure and the patient will be responsible for the entire copayment. All other T procedures performed during the same operative session will be paid at 50 percent of the Medicare-allowed amount, and the patient will be responsible for 50 percent of the copayment.
## APC Group Information: Integumentary System

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<th>Coverage</th>
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</table>
Freestanding Ambulatory Surgery Centers

Chapter 14, section 10.1 of the Medicare Claims Processing Manual, Pub. 100-04, defines an ambulatory surgery center (ASC) as a supplier that:

- Has its own national identifier under Medicare
- Is a separate entity with respect to its licensure, accreditation, governance, professional supervision, administrative functions, clinical services, record keeping, and financial and accounting systems
- Has as its sole purpose the furnishing of services in connection with surgical procedures that do not require inpatient hospitalization

ASC PROCEDURES LIST

The ASC list is the list of procedures that CMS specifies can be safely and appropriately performed in an ASC, for which Medicare allows payment of an ASC facility fee. The following is the revised language from the Code of Federal Regulations (sections 416.65, "Covered Surgical Procedures") that characterizes the services included and excluded on the ASC list. The ASC list consists of those procedures that CMS, in consultation with appropriate trade and professional associations, specifies as being appropriately and safely performed in an ASC setting.

Procedures on the ASC list are those surgical and other medical procedures that generally:

- Require surgical facilities and services of the kind that are typically provided in a hospital inpatient setting, but may safely be performed in an ASC
- Are not of a type that are commonly performed, or that may be safely performed, in physician offices
- Would not be expected to necessitate admission as an inpatient to a hospital either to perform the procedure or to recover from the procedure postoperatively
- Require a dedicated operating room (or suite) or procedure room and a room for postoperative recovery
- Are not otherwise excluded under section 405.310 of this chapter

Covered surgical procedures are limited to those that do not generally exceed a total of 90 minutes operating time and a total of four hours recovery or convalescent time. If the covered surgical procedures require anesthesia, the anesthesia must be local or regional anesthesia or general anesthesia of 90 minutes or less duration.

For the purposes of the ASC list, "surgical procedures" includes "scopy" procedures (e.g., bronchoscopy).

Procedures Excluded From the ASC List

A procedure with any of the following characteristics is not considered safe or appropriate in an ASC setting. A procedure with any of these characteristics is not reasonable or medically necessary in an ASC setting. Payment of an ASC facility fee for procedures excluded from the ASC list in accordance with any of the following characteristics is not allowed. A procedure is excluded from the ASC list if it:

- Generally results in extensive blood loss
- Requires major or prolonged invasion of body cavities
- Generally involves major blood vessels
- Is generally emergent or life-threatening in nature
- Requires admission to a hospital on an inpatient basis in order to have the procedure performed or to recover from the procedure

Federal law requires that the ASC list be reviewed and updated at least every two years. Currently, CMS modifies the list every year to reflect the annual changes made to the CPT code book and alphanumeric HCPCS codes. For example, if the American Medical Association (AMA) deletes a CPT code that has been on the ASC list, Medicare removes the code from the ASC list. These types of changes are effective with the new CPT code set on January 1 of each year.

In a more formal review, CMS reviews the ASC list against the standards for determining whether or not procedures are appropriate for the ASC setting or to determine if a code describing an altogether new procedure should be added to the ASC list. In this case, CMS uses a Federal Register notice and comment process to provide an opportunity for public comment on additions to or deletions from the list. This update is normally effective July 1 of every year.

No Physician Penalty

ASCs may only bill Medicare for a facility fee for a procedure on the Medicare-approved ASC list and performed at the ASC. However, physicians and qualified nonphysician practitioners are not restricted by the approved list of ASC procedures. They may bill and be reimbursed for any procedure that is performed in an ASC, whether or not it is a Medicare-approved ASC procedure. There appears to be some disparity among carriers, with some carriers only reimbursing physician fees if the procedure was on the Medicare-approved ASC list. In Medicare Program Memorandum B-01-43, July 2001, CMS clarified stating that any ASC procedure is payable.

CMS advised that physicians are paid the higher nonfacility practice expense relative value units (RVUs) when a procedure is performed in an ASC that is not on the Medicare-approved ASC list. This is because no separate facility payment will be made for this service.

CMS received questions as to whether the beneficiary could be billed for the ASC facility fee because the procedure was not on the Medicare-approved ASC list. The answer is that the ASC cannot bill the beneficiary. CMS says that the physician is paid the higher nonfacility practice RVUs because the ASC is in effect functioning as a physician’s office and the Medicare payment for the physician’s service includes payment for all practice expenses. The Medicare payment to the physician reflects payment for the whole service and the beneficiary cannot be charged in excess of the limiting charge for the physician service.

ASCs should be certain that they are monitoring all scheduled procedures for compliance with the Medicare-approved ASC list. Facility fees will continue to be denied if they are not on the list. ASCs faced with a situation where a service has been performed that is not on the approved ASC list have two choices. One is to simply write off the claim. The other is to negotiate a partial payment from the physician to cover some of the ASC costs. However, note that the practice expense RVUs are only a component of the physician payment and his entire payment may not be significantly high enough to cover all related ASC costs.

NOTE: Only those procedures included on the "ASC Group Information" table that begins on page ASC–1 are covered by Medicare. Any surgery that is not listed is not covered. Do not use the APC tables as they do not apply to freestanding ASCs.

ASC SCOPE OF SERVICES

CMS acknowledges that there is little uniformity among ambulatory surgery centers (ASC) as to what items they include in their facility fee or charge. Chapter 14, section 10.3 of the Medicare Claims Processing Manual, Pub. 100-04, states that the facility fee (the ASC group payment) covers services provided in connection with the covered surgical procedure. The facility payment (one of the nine group payments) is the reimbursement for the facility fee. The Medicare definition specifies what facility services are in addition to what facility services are not.

Facility services are generally, items and services furnished in connection with listed covered procedures that would be covered if furnished in a hospital operating suite or hospital outpatient department in connection with such procedures. The following list provides examples of ASC facility services included in the ASC facility payment.