Learning Objectives

- The significance of OPPS as reimbursement policy and how this differs from coding policy
- Medicare Benefit Policy Manual Guidance regarding allowable ASC service
- Medicare Claims Processing Manual Guidance relative to payment for bundled services; contrast with OPPS reporting guidance even where no separate payment is made
- Understanding the meaning and implications of the ASC payment status indicators when coding ASC services
ASC Fundamentals

- What does an ASC bill for?
- When Coding ASC services, what are we actually representing?
- Do CPT® and CPT® Code Utilization Guidance Apply to ASC’s?
- Does CCI Apply to ASCs?
  - See Medicare Benefit Policy Manual, IOM Pub 100-2, Ch. 15 § 260.5.3
    - Instructions regarding the Correct Coding Initiative apply to coverage of ASC facility services.

ASC Fundamentals

- Benefit Policy Manual Guidance (IOM Pub 100-2, Ch. 15 §260)
  - Facility services furnished by ambulatory surgical centers (ASCs) in connection with certain surgical procedures are covered under Part B
  - The ASC must be certified as meeting the requirements for an ASC and enter into a written agreement with CMS
ASC Fundamentals

- Benefit Policy Manual Guidance (IOM Pub 100-2, Ch. 15 §260)
  - Medicare periodically updates the list of covered procedures and related payment amounts through release of regulations and change requests

- Where services are performed in an ASC, the physician and others who perform covered services may also be paid for his/her professional services; however, the “professional” rate is adjusted because the ASC incurs the facility costs

ASC Coverage Fundamentals

- Benefit Policy Manual Guidance (IOM Pub 100-2, Ch. 15 §260.2)
  - “The ASC facility services are services furnished in an ASC in connection with a covered surgical procedure that are otherwise covered if furnished on an inpatient or outpatient basis in a hospital in connection with that procedure.”

  “Not included in the definition of facility services are medical and other health services, even though furnished within the ASC, which are covered under other portions of the Medicare program, or not furnished in connection with covered surgical procedures.”
ASC Coverage Fundamentals

- Benefit Policy Manual Guidance (IOM Pub 100-2, Ch. 15 §260.2)
  - “This distinction between covered ASC facility services and services which are not covered ASC facility services is important, since the facility payment rate includes only the covered ASC facility service.”

- Services, which are not covered ASC facility services such as physicians’ services and prosthetic devices other than intraocular lenses (IOLs), may be covered and billable under other Medicare provisions.

- What is the coding significance of this distinction?

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ASC Coverage Fundamentals

- Benefit Policy Manual Guidance (IOM Pub 100-2, Ch. 15 §260.2)
  - “Since there is no uniformity among ASCs as to what items and services they include in their facility fee or charge, the Medicare definition of covered facility services is both inclusive and exclusive.”

  - The regulations specify what are and are not facility services. Facility services are items and services furnished in connection with listed covered procedures, which are covered if furnished in a hospital operating suite or hospital outpatient department in connection with such procedures.”

  - These do not include physicians’ services, or medical and other health services for which payment may be made under other Medicare provisions (e.g., services of an independent laboratory located on the same site as the ASC, anesthetist professional services, non-implantable DME).
ASC Coverage Fundamentals

Benefit Policy Manual Guidance (IOM Pub 100-2, Ch. 15 §260.2)

- Examples of Covered ASC Services:
  - Nursing Services, Services of Technical Personnel, and Other Related Services
  - Use by the Patient of the ASC’s Facilities
  - Drugs, Biologicals, Surgical Dressings, Supplies, Splints, Casts, Appliances, and Equipment
  - Diagnostic or Therapeutic Items and Services
  - Administrative, Recordkeeping, and Housekeeping Items and Services
  - Blood, Blood Plasma, Platelets, etc., Except Those to Which Blood Deductible Applies
  - Materials for Anesthesia
  - Intraocular Lenses (IOLs)

ASC Coverage Fundamentals

Benefit Policy Manual Guidance (IOM Pub 100-2, Ch. 15 §260.3)

- Services Furnished in ASCs Which are Not ASC Facility Services:
  - A number of items and services covered under Medicare may be furnished in an ASC which are not considered facility services, and which the ASC payment does not include.
  - These non-ASC services are covered and paid for under the applicable provisions of Part B.
  - In general, an item or service separately covered under Medicare is not considered an ASC service.

- Coding or Reimbursement Instruction?
ASC Coverage Fundamentals

- Benefit Policy Manual Guidance (IOM Pub 100-2, Ch. 15 §260.4)
  - Physicians’ Services
  - The Sale, Lease, or Rental of Durable Medical Equipment (DME) to ASC Patients for Use in Their Homes
  - Non-implantable Durable Medical Equipment (DME)
  - Prosthetic Devices
  - Non-implantable Prosthetic Devices
  - Ambulance Services
  - Leg, Arm, Back, and Neck Braces
  - Artificial Legs, Arms, and Eyes
  - Services of Independent Laboratory

ASC Reimbursement

- Claims Processing Manual Guidance (IOM Pub 100-4, Ch. 14 §10)
  - Beginning January 1, 2008, payment is made to ASCs under Part B for all surgical procedures except those that CMS determines may pose a significant safety risk to beneficiaries or that are expected to require an overnight stay when furnished in an ASC.
  - Also, beginning January 1, 2008, separate payment is made to ASCs under Part B for certain ancillary services such as certain drugs and biologicals, OPPS pass-through devices, brachytherapy sources, and radiology procedures.
ASC Reimbursement

- Claims Processing Manual Guidance (IOM Pub 100-4, Ch. 14 §10)
  - “The complete lists [sic] of ASC covered surgical procedures and ASC covered ancillary services, the applicable payment indicators, payment rates for each covered surgical procedure and ancillary service before adjustments for regional wage variations, the wage adjusted payment rates, and wage indices are available on the CMS Web site at: http://www.cms.hhs.gov/ascpayment/”

ASC Reimbursement

- Claims Processing Manual Guidance (IOM Pub 100-4, Ch. 14 §20.3)
  - Rebundling of CPT® Codes
    - The general CCI rebundling instructions apply to processing claims from ASC facilities services. In general, if an ASC bills a CPT® code that is considered to be part of another more comprehensive code that is also billed for the same beneficiary on the same date of service, only the more comprehensive code is covered, provided that code is on the list of ASC approved codes.
  - Coding or Reimbursement Instruction?
OPPS Packaging

- Claims Processing Manual Guidance (IOM Pub 100-4, Ch. 4 §10.4)
  - Under the OPPS, packaged services are items and services that are considered to be an integral part of another service that is paid under the OPPS. No separate payment is made for packaged services, because the cost of these items and services is included in the APC payment for the service of which they are an integral part. For example, routine supplies, anesthesia, recovery room use, and most drugs are considered to be an integral part of a surgical procedure so payment for these items is packaged into the APC payment for the surgical procedure.

OPPS Packaging

- Claims Processing Manual Guidance (IOM Pub 100-4, Ch. 4 §10.4)
  - A. Packaging for Claims Resulting in APC Payments
    - If a claim contains services that result in an APC payment but also contains packaged services, separate payment for the packaged services is not made since payment is included in the APC. However, charges related to the packaged services are used for outlier and Transitional Corridor Payments (TOPs) [sic] as well as for future rate setting.
OPPS Packaging

Claims Processing Manual Guidance (IOM Pub 100-4, Ch. 4 §10.4)

A. Packaging for Claims Resulting in APC Payments

Therefore, it is extremely important that hospitals report all HCPCS codes consistent with their descriptors; CPT® and/or CMS instructions and correct coding principles, and all charges for all services they furnish, whether payment for the services is made separately paid or is packaged.

Coding or Reimbursement Instruction?

Payment Status Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Payment Indicator Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A2</td>
<td>Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.</td>
</tr>
<tr>
<td>D5</td>
<td>Deleted/discontinued code; no payment made.</td>
</tr>
<tr>
<td>F4</td>
<td>Corneal tissue acquisition, hepatitis B vaccine; paid at reasonable cost.</td>
</tr>
<tr>
<td>G2</td>
<td>Non-office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.</td>
</tr>
<tr>
<td>H2</td>
<td>Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.</td>
</tr>
<tr>
<td>H8</td>
<td>Device-intensive procedure on ASC list in CY 2007; paid at adjusted rate.</td>
</tr>
<tr>
<td>J7</td>
<td>OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.</td>
</tr>
<tr>
<td>J8</td>
<td>Device-intensive procedure added to ASC list in CY 2008 or later; paid at adjusted rate.</td>
</tr>
<tr>
<td>K2</td>
<td>Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.</td>
</tr>
<tr>
<td>K7</td>
<td>Unclassified drugs and biologicals; payment contractor-priced.</td>
</tr>
</tbody>
</table>
### Payment Status Indicators

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<tr>
<td>L1</td>
<td>Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made.</td>
</tr>
<tr>
<td>L6</td>
<td>New Technology Intraocular Lens (NTIOL); special payment.</td>
</tr>
<tr>
<td>N1</td>
<td>Packaged service/item; no separate payment made.</td>
</tr>
<tr>
<td>P2</td>
<td>Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.</td>
</tr>
<tr>
<td>P3</td>
<td>Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.</td>
</tr>
<tr>
<td>R2</td>
<td>Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.</td>
</tr>
<tr>
<td>Z2</td>
<td>Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.</td>
</tr>
<tr>
<td>Z3</td>
<td>Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.</td>
</tr>
</tbody>
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### CASE EXAMPLE

- **Background:**
  - XYZ Surgery Center is an ASC that bills a facility fee and supplies associated with surgical procedures performed within its ASC. At issue is a lumbar disc decompression technique known as Plasma Disc Decompression (PDD) utilizing an Arthrocare Spine Wand (a non-implantable DME Supply).
  - Beginning in April 2005, XYZ began separately reporting the facility fee for the PDD procedure (utilizing CPT® 62287) and the Spine Wand (utilizing CPT® 99070).
  - Subsequently, the fee for the Spine Wand was billed by a third party, ABC, which is a distributor and billing agent. The rationale for this transfer of billing responsibility was based on XYZ’s inability or unwillingness to finance the expense of the Spine Wand.
CASE EXAMPLE

“Percutaneous discectomy is done by any method to decompress the nucleus pulposus of a herniated lumbar intervertebral disc that may be pressing on nerve roots or the spinal cord, causing pain, disability, and loss of feeling. Percutaneous disc decompression is done for patients with a contained herniated disc that is bulging without rupture. Different percutaneous procedures include manual, automated and laser methods. All types of procedures involve inserting small instruments between the vertebrae into the middle of the disc and using radiographic monitoring to guide the instruments as herniated tissue is removed. Laser instruments burn or evaporate the disc. One advanced method, called DISC nucleoplasty, uses special plasma technology, instead of heat energy, to remove the tissue from the center of the disc. A Spine Wand is inserted through a needle into the center of the disc. A series of channels is made to remove the tissue precisely and without trauma. As tissue is removed from the nucleus, the disc is decompressed and the pressure exerted on the nearby nerve root is relieved. Use this code for percutaneous decompression of single or multiple lumbar levels.”

UCG Decision Health, ASC Payment Source, pg. 1642 (2010).

CASE EXAMPLE

Carrier Expert’s Argument:

- Separate reporting for the Spine Wand used in the procedure is unbundling or double billing since the fee for the device is already included within the facility fee associated with the surgical procedure.
- Wands are not durable medical equipment and therefore can’t be carved out. In a surgery setting, carve outs are generally used for products that are implantable.
CASE EXAMPLE

Analysis:
- Spine Wand is a consumable supply and not a simple probe.
- Assume that the carrier is not Medicare and that the binding guidance does not incorporate Medicare Policy. Instead CPT Editorial Panel Guidance is adopted.
  - And the answer is...?
- Assuming Medicare Policies Were Applicable...
  - Evaluate the ASC policies reviewed – which are coding policies...which are reimbursement policies?
  - How would this service be coded by the ASC before they transferred billing responsibility to the supplier?

Analysis (cont’d):
- Addendum BB - Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2011 (Including Ancillary Services for Which Payment is Packaged)
  - 99070?
    - Not Listed
  - C2614? (Probe, percutaneous lumbar discectomy)
    - Listed with Status Indicator N1
- Even assuming C2614 was the correct code for the Wand, would it be wrong to separately report?
- What about the OPPS reporting instructions?
CONCLUSION

- Be Cautious About Applying Medicare Policies Outside of Medicare.
- Even Where These Policies Apply;
  - Be Careful to Delineate Coding Policy (how a service should be represented) from Reimbursement Policy (how or if a service should be paid).
- Bottom Line – As long as there is no misrepresentation of a service that leads to unentitled payment, there is no error.

Questions?
Lunch – Be back in 1 hour