Nuances of ambulatory surgery center fees,

Outside of clinical and patient safety concerns, the decision to render services in an ambulatory surgery center (ASC) also may depend on coverage. OMSs must consider the patient's insurance carrier and whether the procedure is covered when performed in an ASC.

The federal government has established many of the regulatory guidelines that govern the ambulatory surgery center industry. Each year, CMS publishes the Outpatient Prospective Payment System (OPPS) and ASC Payment System Rule. The OPPS/ASC sets site-of-service restrictions for certain surgical procedures under the Medicare program and outlines the payment methodology for both outpatient and ambulatory covered care. For example, surgical codes representing procedures typically performed on an inpatient basis, such as open-heart surgery, would not be eligible for payment if performed in and reported by an ASC.

The rule includes a list of surgical procedures eligible for Medicare payment when provided in an ASC as well as those procedures that are excluded. Medicare may pay for such ineligible procedures if furnished in other settings, such as hospital outpatient departments, or limit coverage to inpatient status, including only those on the Inpatient Only (IPO) list. These lists are revised each year, with procedures evaluated for addition or removal based on CMS's codified patient safety criteria and site-of-service patterns in Medicare claims data.

It is imperative for OMSs and their staff to continually monitor CMS policies for changes to site-of-service restrictions as they may impact a patient's treatment and coverage under certain circumstances. For instance, if an OMS renders a service to a beneficiary in an ASC and the procedure is on the IPO List, Medicare will not pay the professional or facility fees, nor for the anesthesia services that were rendered.

The OPPS/ASC final rule, including the complete list of codes covered or excluded for payment in an ambulatory surgery center, may be found at CMS.gov/MedicareMedicare-Fee-Service-PaymentASCPaymentASC-Regulations-and-Notices/CMS-1753-fc.

CMS also has established the way in which an ASC is paid for facility costs. Procedures are grouped into ambulatory payment classifications (APCs) by similarities in clinical characteristics and resource costs. Each category carries a rate at which all procedures within that APC are paid, including the

facility items and services furnished in connection with the surgery. For instance, CPT®* code 21040 (excision of benign tumor or cyst of mandible, by enucleation and/or curettage) is categorized under APC 5164 Level 4 ENT Procedures and would be reimbursed at the same rate as others within the same category, such as CPT code 42972 (control of nasopharyngeal hemorrhage, primary or secondary).

Whether a surgeon can report and charge a facility fee depends on the accreditation status of the office. A practice can only charge a facility fee in conjunction with professional services if that practice has gone through the rigorous process of accreditation as an ASC and obtained a license to operate an ambulatory surgical center within their state. Nationally recognized accrediting bodies include The Joint Commission and the Accreditation Association for Ambulatory Health Care.

An OMS practice that is accredited as an ASC may report and bill a facility fee to cover the cost of supplies, equipment and staff for certain procedures. For Medicare and private payers that follow CMS guidelines, such procedures are those approved for payment in an ASC setting that do not have practice expenses built into the surgical code on the professional side. It is important to note anesthesia services are billed separately either by the ASC or directly by the individual anesthesia provider. The OMS would not report or bill professional provider-based anesthesia services in this case.

Some OMS offices may be accredited through an office-based surgery program, but currently such facilities do not have

the ability to bill a surgery center fee. It is inappropriate to report or charge a facility fee unless ASC accreditation is obtained.

The reporting of ASC services and facility fees is variable throughout the industry. The standard format for Medicare and Medicaid is the CMS-1500 form; however, some carriers may require ASC facility claims to be filed on the UB-04 form with the appropriate revenue code. Other variables include the use of modifier SG (Ambulatory Surgical Center Facility Service) and Place of Service Code 24 (Ambulatory Surgical Center).

Many but not all commercial insurers follow CMS policy, so it is encouraged that each payer be contacted individually for their methodology when verifying a patient's coverage for services provided in an ASC.

AAOMS annually monitors the OPPS/ASC payment system rule and remains involved in efforts to ensure site-of-service coverage restrictions do not limit access to quality oral and maxillofacial surgical care and services. The Committee on Healthcare Policy, Coding and Reimbursement has submitted a nomination to CMS for several OMS procedures to be considered for addition to the ASC Covered Procedures List for CY 2023.

For additional information on ASC coding and payment considerations, refer to the AAOMS Coding Paper, Ambulatory Surgical Center Coding and Billing. ■

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