Payment for medical services varies by facility

When it comes to reimbursement by Medicare, Medicaid or third-party medical insurance, there are notable differences between services performed in an office setting versus a facility setting such as a hospital (outpatient or inpatient) or an ambulatory surgical center (ASC). These differences primarily stem from the overhead costs associated with each setting.

Reimbursement components

Rather than base payments on provider charges, CMS established a standardized physician payment schedule in 1992 known as the resource-based relative value scale (RBRVS). Payments for services covered under Medicare and other payers using the RBRVS are determined by the complexity of the service and the resources needed to provide them. The payment is based upon three components:

- **Physician work (51 percent of a procedure's value)** – The time, effort and skills required by a physician to provide a service.
- **Practice expense (45 percent of a procedure's value)** – Costs for clinical staff, supplies, equipment and other practice overhead.
- **Professional liability (4 percent of a procedure's value)** – Costs for malpractice insurance coverage.

Payment for medical services varies by the setting in which the procedure is performed. In non-facility settings like an OMS office, payer reimbursement covers the surgeon's work and the practice's costs, including the practice's clinical staff time, utilities, supplies and equipment used during a procedure.

Conversely, when services are rendered in facility settings such as a hospital or ASC, the facility is providing these resources; therefore, the practice expense component of the surgeon's reimbursement is reduced, and the facility uses its own fee to recoup these costs for resources used during the surgery. The example below demonstrates the average Medicare reimbursement when the service is rendered in the office vs. the facility, according to the 2024 National Average Medicare Physician Fee Schedule:

- **21030** – Excision of benign tumor or cyst of maxilla or zygoma by enucleation and curettage
  - Surgeon's reimbursement in non-facility: $458.37
  - Surgeon's reimbursement in facility: $360.84

Facility-based services

Not all services are payable in the non-facility setting. CMS designates certain procedures as facility-based only (i.e., hospital outpatient, inpatient or ASC setting), evaluating them against the agency's long-standing patient safety criteria. These procedures lack a non-facility rate and are covered only when performed in approved facility settings, such as ASCs or hospitals. For example, the following codes do not have a non-facility price in the MPFS:

- **20902** – Bone graft, any donor area; major or large
- **21046** – Excision of benign tumor or cyst of mandible; requiring intra-oral osteotomy (e.g., locally aggressive or destructive lesion[s])
- **21048** – Excision of benign tumor or cyst of maxilla; requiring intra-oral osteotomy (e.g., locally aggressive or destructive lesion[s])

Inpatient Only list and other ASC exclusions

It is important to note that not all facility-based services are payable in an ASC or hospital outpatient setting. Some procedures are excluded from ASC payment but may be covered in hospital outpatient departments, while others are exclusively designated for hospital inpatient care and therefore included on the Inpatient Only (IPO) list.

For example, both CPT codes 21142 (Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, without bone graft) and 21146 (Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts) are currently excluded from Medicare payment in the ASC. While CMS recognizes 21142 for payment in hospital outpatient departments, 21146 is on the IPO list, meaning Medicare will only pay 21146 when furnished under inpatient status. Procedures that CMS deems are highly invasive, likely to result in major blood loss or require intensive postoperative care are typically designated as Inpatient Only.

Office-based designation

CMS designates some codes as "office-based" since they are performed more than 50 percent of the time in physicians' offices and have similar complexity to routine office procedures. This designation does not restrict where

these services may be rendered; however, if performed in a facility setting, they may be paid at the non-facility rate. CPT code 21127 (Augmentation, mandibular body or angle; with bone graft, onlay or interpositional [includes obtaining autograft]) is an example of a code that has been designated as office-based.

CMS fee schedule look-up

CMS annually updates the MPFS, detailing policy changes on its website at CMS.gov/Medicare/payment/fee-schedules/physician. CMS also has developed an online search tool that may be used to access Medicare pricing, relative value and payment policy information by CPT code. The tool is located at CMS.gov/Medicare/physician-fee-schedule/search/overview.

In addition, CMS publishes annual updates of the ASC-Covered Procedures List (CPL) as well as its list of services payable in the Outpatient Setting and list of Inpatient Only services available at CMS.gov/Medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-regulations-and-notices/cms-1809-fc.

- The complete ASC-CPL and rates may be found on the bottom of the CMS website under Addendum AA.
- The complete list of OPPS covered procedures and rates may be found on the bottom of the CMS website under NFRM OPPS Addendum A.
- The Inpatient Only list may be found in Addendum E on the bottom of the CMS website under 2025 NFRM OPPS Addenda.

Commercial carriers should be contacted individually to confirm payment methodologies for professional services or for fee-related inquiries. ■