U.S. Coding & Payment by Site of Service The Where, What and Why of Reimbursement



		Hospital Inpatient	Hospital Outpatient	Ambulatory Surgical Center	Physician's Office
Procedure Code ("What" was done)	MD	CPT® Code/HCPCS Current Procedural Terminology (CPT)/Healthcare Current Procedural Coding System (HCPCS a.k.a. "hikpiks") Published respectively by: American Medical Association (AMA)/Centers for Medicare & Medicaid Services (CMS)			
	Facility	ICD-9-CM Procedure Codes	CPT Code/HCPCS		See Office Differential below
Diagnosis Code ("Why" it was done)	MD	ICD-9-CM International Classification of Diseases			
	Facility	Published by: World Health Organization (WHO) Clinically modified for use in the USA by CMS			
Payment	MD	Resource-Based Relative Value System (RBRVS) Controlled by CMS with input from AMA's RUC Committee (Each CPT Code is assigned Relative Value Units - RVUs) Used by Medicare and most Private Payers (Private rates vary widely Best estimate = ~110% to 130% of Medicare)			
	Facility	Medicare MS-DRGs (Medicare Severity Diagnosis Related Groups) MS-DRGs are derived from ICD- 9 Diagnosis & ICD-9 Procedure codes. They pay the hospital a lump sum per admission. Many Private Payers use DRGs but others use per-diems, case rates, and percent of charges.	Medicare APCs (Ambulatory Payment Classifications) APCs are groupings of similar CPT codes paying a single rate. Private Payers use a variety of mechanisms (some use APCs) to pay hospitals for their outpatient facility costs.	ASC Rates ASCs are paid a percent (approximately 60% for 2014) of the corresponding hospital outpatient APC rate. Device costs for a very <u>limited</u> number of "device-intensive" procedures will pay at 100%. Private payers tend to follow Medicare's lead in the ASC.	Office Differential There is no facility fee per se in the MD Office. There is an office-based (aka Non-Facility Based) differential for some procedure codes paid by Medicare and some private payers to compensate for the higher practice expense of office-based services.

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