

Glossary of Terms

Reimbursement Information

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APC (Ambulatory Payment Classification)- Created in August 2000, APCs are groupings of CPT Codes that are both similar clinically and in terms of resource consumption. Each APC is assigned a prospective payment, which Medicare uses to reimburse hospitals for outpatient services.

APC Payment- The Medicare facility payment to the hospital for outpatient services.

MD Facility Payment- The Medicare payment to the physician when performing services in the inpatient, outpatient, or ambulatory surgery center location (national average).

MD Office Payment- the Medicare payment to the physician when performing services in the office setting (national average).

ASC (Ambulatory Surgical Center)- ASCs are facilities that provide outpatient surgical care. Medicare has approved over 3,000 procedures for which it will pay the ASC a facility fee. In 2008, Medicare started a 4-year transition of a new ASC payment system that will ultimately base ASC payments on a percentage (65%) of hospital outpatient APC payments.

MS-DRG (Medicare Severity Diagnosis Related Group)- Effective October 1, 2007, the Center for Medicare and Medicaid Services (CMS) replaced the Diagnosis Related Groups (DRG) System with the Medicare Severity DRG (MS-DRG) classification system to recognize severity of illness among patients. The new system, which will be phased in over a two-year period, expands the current list of 538 DRGs to a new list of 745 "severity-adjusted" DRGs. The MS-DRG sets the prospective payment for inpatient hospital services. Medicare assigns a patient discharge to a MS-DRG group based on ICD-9-CM Procedure and Diagnosis Code(s), sex, age, and other criteria.

ICD-9 (International Classification of Diseases) Procedure Codes- ICD-9 procedure codes are used to describe the medical and/or surgical procedures performed in the inpatient hospital setting.

ICD-9 (International Classification of Diseases) Diagnosis Codes- ICD-9 diagnosis codes are used by all providers in all settings to report the condition of the patient and answer the question of "why" something was done.

CPT® (Common Procedural Terminology) Codes- A uniform coding system developed by the American Medical Association to describe physician services and more recently used to report hospital outpatient facility services.

CMS (Centers for Medicare and Medicaid Services)- CMS is the federal agency responsible for administering the Medicare and Medicaid health insurance programs.

Medicare Pass-Through Codes (C-codes)- These device codes were created by Medicare in 2000 to compensate for new technology device costs that were omitted from Medicare's APC payment calculations. Over time, the reimbursement for most C-codes decreased, as Medicare captured more of the device costs in the base APC rate. In 2003, Medicare retired 95 of the 100 pass-through codes but reinstated them one year later on 1/1/04. The 95 reinstated C-codes do not trigger payment to the hospital however; Medicare is using them to accurately capture device cost information.

B-Codes- B-codes are one type of Healthcare Common Procedure Coding System (HCPCS) code that suppliers and providers can use to report services, procedures or supplies. In some cases, additional payment is rendered to the provider for HCPCS code submission.

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