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-10-PCS Procedure Codes**	**CPT Code/HCPCS**		**See Office Differential below**
Diagnosis Code ("Why" it was done)	**MD**	**ICD-10-CM** *International Classification of Diseases* Published by: World Health Organization (WHO) Clinically modified for use in the USA by CMS **Note**: ICD-10 became effective October 1, 2015.			
	Facility				
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 by site of service; see below for more information.)			
	Facility	**Medicare MS-DRGs** (Medicare Severity Diagnosis Related Groups) MS-DRGs are derived from ICD-10 Diagnosis & ICD-10 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. On average, private payers reimburse at 150% - 175% of Medicare rates for inpatient services.[1,2]	**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. On average, private payers reimburse at 200% of Medicare rates for outpatient services.[2]	**ASC Rates** ASCs are paid a percent (approximately 58% for 2016) of the corresponding hospital outpatient APC rate. Device costs for a very limited 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. On average, private payers reimburse at 100% - 150% of Medicare rates for physician specialist services.[2]

See important notes on the uses and limitations of this informations on reverse.

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References

1. White, C, et al. *High and Varying Prices for Privately Insured Patients Underscore Hospital Market Power*. Center for Studying Health System Change. Research Brief no. 27. September 2013
2. Selden T, et al. *The Growing Difference between Public and Private Payment Rates for Inpatient Hospital Care*. Health Affairs 34, NO. 12 (2015): 2147-2150

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Payer policies will vary and should be verified prior to treatment for limitations on diagnosis, coding or site of service requirements. The coding options listed within this guide are commonly used codes and are not intended to be an all-inclusive list. We recommend consulting your relevant manuals for appropriate coding options.

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