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Billing Essentials at Your ASC

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Disclosures

- Fisher & Paykel Healthcare, Inc.: consultant/speaker's bureau
- Butterfly, Inc.: consultant/speaker's bureau

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Objectives

- Understand HOW the ASC facility gets reimbursed
- Learn why case costing is critical in maintaining a profitable business model
- Learn what WE can control regarding getting
  - The RIGHT patient
  - With the RIGHT insurance
  - Into the RIGHT OR/procedure room
  - In the RIGHT pavilion/building/facility/site
  - At the RIGHT time
  - In the RIGHT order

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HOW the ASC facility gets reimbursed

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HOW the ASC facility gets reimbursed

SOCIETY FOR AMBULATORY ANESTHESIA
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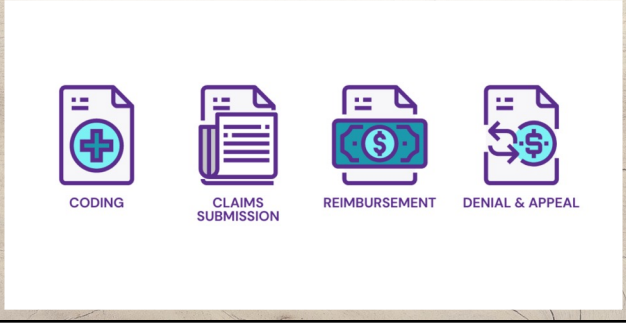
- SIMPLE: Submit claims to insurance companies, collect reimbursements for procedures or services performed in the ASC or doctor's office.
- REALITY: Coding, claims submission, reimbursement, denials and appeals



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HOW the ASC facility gets reimbursed Abbreviations and Acronyms: CPT

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- CPT® (Current Procedural Terminology)
  - Codes offer doctors, health care professionals and facilities a uniform language for coding medical **services and procedures** to streamline reporting, increase accuracy and efficiency.
  - CPT codes are also used for administrative management purposes such as claims processing and developing guidelines for medical care review.

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HOW the ASC facility gets reimbursed: CODING

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- Determines the sum of money one is going to be reimbursed and makes sure that all regulatory standards are being met
- Necessitates the utilization of International Classification of Diseases (ICD) and Current Procedural Terminology (CPT) codes to precisely delineate the diagnoses and procedures done on the patient.
- Can only have ONE fee schedule for insured patients

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HOW the ASC facility gets reimbursed Abbreviations and Acronyms: ICD-10-CM

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- International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) Codes
  - The standard transaction code set for diagnostic purposes under the Health Insurance Portability and Accountability Act (HIPAA).
  - It is used to track health care statistics/disease burden, quality outcomes, mortality statistics and billing.
  - ICD-10-CM codes are used to describe **why** a service or procedure was performed.

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HOW the ASC facility gets reimbursed Abbreviations and Acronyms: HCPCS

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- Healthcare Common Procedure Coding System (HCPCS)
  - A set of health care procedure codes based on the American Medical Association's Current Procedural Terminology (CPT).
  - HCPCS includes three levels of codes:
    - Level I consists of the American Medical Association's Current Procedural Terminology (CPT) and is numeric.
    - Level II codes are alphanumeric and primarily include non-physician services such as ambulance services and prosthetic devices, and represent items and supplies and non-physician services, not covered by CPT-4 codes (Level I).
    - Level III codes, also called local codes, were developed by state Medicaid agencies, Medicare contractors, and private insurers for use in specific programs and jurisdictions

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HOW the ASC facility gets reimbursed Abbreviations and Acronyms

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- CPT and HCPCS codes and modifiers describe a **service** and how it was performed. ICD-10-CM codes are used to show **why** a service was performed.
- If CPT/HCPCS predicate ***how much*** a physician or other qualified provider (facility) will be paid for a service, ICD-10-CM predicates ***IF*** s/he/it will get paid as these codes establish medical necessity and are used to confirm whether the scenario in which the service was provided conforms with the payer's coverage policies.

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HOW the ASC facility gets reimbursed: CLAIMS SUBMISSION

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- Essential to ensure that the claims have all the necessary details and are in compliance with the applicable standards.
- The claims should contain all of the patient data, as well as the correct diagnosis and procedure codes for services rendered and the associated charges.
- Accurate claim submission is paramount to ensure timely and accurate payments for services provided.

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HOW the ASC facility gets reimbursed: REIMBURSEMENT

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- The payer will assess the accuracy of the claim and either approve or deny the request for reimbursement.
- Determines whether the provider receives payment for services rendered.
  - Preauthorization may be required for some insurers and procedures
- Reimbursement rates for ASCs are typically lower than those of inpatient or hospital settings.
- To ensure that providers receive adequate reimbursement, it is essential for them to understand the reimbursement process and work with payers to negotiate favorable rates.

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HOW the ASC facility gets reimbursed: REIMBURSEMENT

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- Common Payers:
  - Medicare
  - Medicaid
  - Workers' Compensation
  - Private Insurance
  - Self Pay
  - Personal Injury (Lien cases)

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HOW the ASC facility gets reimbursed: REIMBURSEMENT

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- Common Payers: Medicare
  - Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category).
  - National coverage determinations (NCDs) are made through an evidence-based process, with opportunities for public participation.
  - In the absence of a national coverage policy, an item or service may be covered at the discretion of the Medicare contractors based on a local coverage determination (LCD).
  - https://www.cms.gov/medicare/coverage/determination-process

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HOW the ASC facility gets reimbursed: REIMBURSEMENT

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- CMS (Centers for Medicare & Medicaid Services):
  - CMS.gov ASC Payment Rates can be found at https://www.cms.gov/medicare/payment/prospective-payment-systems/ambulatory-surgical-center-asc/asc-payment-rates-addenda
  - Covered Procedures List
    - Procedure codes which may be performed in an ASC under the Medicare program as well as the ASC payment group assigned to each of the procedure codes.
    - The ASC payment group determines the amount that Medicare pays for facility services furnished in connection with a covered procedure.
    - No significant additions or changes for 2025

CMS.gov

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- CMS (Centers for Medicare & Medicaid Services):
  - Facilities are paid on the "100-50-25-25-0" rule
    - Also known as "Subject to Multiple Procedure Discounting"
  - Device intensive procedures may pay differently from year to year
    - J8 payment indicator: Device-intensive procedure; paid at adjusted rate.
      - CPT 63650 Percutaneous implantation of spinal neurostimulator electrode array: 49.02% of the payment offsets device cost
    - J7 payment indicator: OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.

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- CMS
  - Also available on The Ambulatory Surgery Center Association (ASCA) website under "Medicare Resources" Medicare Rate Calculator:
    - A members-only resource that clearly and easily shows your Medicare payment rates for ASC-payable procedures.
    - By selecting your state and county from the drop-down menus, the calculator automatically finds your local wage index and calculates the total payment, Medicare payment and beneficiary copayment for each procedure.
    - The calculator is made available when new rates are released by the Centers for Medicare & Medicaid Services (CMS), most notably in the summer for the proposed payment rule and in the fall for the final payment rule.
    - New calculators are also posted for regular quarterly updates, as well as any ad hoc updates to the payment rates at other times
  - https://www.ascassociation.org/medicare/rate-calculator

ASCA Ambulatory Surgery Center Association

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- CMS (Centers for Medicare & Medicaid Services):
  - Prior Authorization Demonstration for Certain Ambulatory Surgical Center (ASC) Services (CMS-10884)
    - These targeted services can potentially be provided as cosmetic procedures, rather than medically necessary procedures, resulting in improper or fraudulent payments.
      - Blepharoplasty, botulinum toxin injections, rhinoplasty, panniculectomy, and vein ablation.
    - California, Florida, Texas, Arizona, Ohio, Tennessee, Pennsylvania, Maryland, Georgia, and New York.
    - https://www.cms.gov/medicare/regulations-guidance/legislation/paperwork-reduction-act-1995/pra-listing/cms-10884

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- Common Payers: Medicaid
  - A program that is jointly funded by the federal government and individual states, which provides health insurance to individuals with limited financial resources.
  - The services that are covered and the amount of reimbursement for these services differ depending on the state in which the patient resides

Ohio Department of Medicaid

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HOW the ASC facility gets reimbursed: REIMBURSEMENT

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- Common Payers: Workers' Compensation
  - Usually state run
  - Reimbursement for the same procedure differs by state
  - Usually a predetermined facility payment per CPT code
  - Cannot balance bill the worker

Ohio Bureau of Workers' Compensation

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HOW the ASC facility gets reimbursed: REIMBURSEMENT

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- Common Payers: Private Insurance
  - Reimbursement and coverage levels depend on the individual's policy.
  - Certain private health insurance plans may need pre-approval for specific treatments or have constraints regarding the site at which the procedure is carried out.

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HOW the ASC facility gets reimbursed: REIMBURSEMENT

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- Common Payers: Private Insurance
  - IN versus OUT of network FACILITY and/or PROVIDERS
    - The federal No Surprises Act (NSA) became effective Jan. 1, 2022
    - When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you should not be charged more than your plan's copayments, coinsurance and/or deductible.
    - This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services.
    - These providers cannot balance bill you and may not ask you to give up your protections not to be balance billed. If you get other types of services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

https://www.cms.gov/medical-bill-rights

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- Common Payers: Self-Pay
  - Uninsured
  - Insurance does not cover the requested procedure
  - Prices and payment structure should be established well in advance to cover all costs (staffing, implants, disposables, etc.) and overhead.
  - Often includes presumed anesthesia fees
    - Often based on estimated surgical and anesthesia times
    - Keep on top of case length accuracy!
    - Are ultrasound-guided blocks common and included in the fee?

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- Common Payers: Personal Injury (Lien cases)
  - A lien is a legal right to a portion of an asset.
  - When physicians/facilities provide services to treat patients on a lien, it means the patient immediately receives treatment, and payment of the bill is deferred.
  - The treating physician/facility then waits to be paid until the personal injury claim is settled or resolved.
  - After the personal injury attorney has obtained a verdict or a settlement, the personal injury lawyer will pay that medical bill directly from the amount obtained.
  - Financing companies that buy liens from doctors and facilities before litigation is complete are also becoming more common with the practice.

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HOW the ASC facility gets reimbursed: REIMBURSEMENT

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- Common Payers: Personal Injury (Lien cases)
  - The largest risk for physicians/facilities is that the plaintiff will not win the lawsuit or receive a settlement, and the provider will be uncompensated or 50% of the award will not fully compensate the provider.
  - Physicians/facilites also cannot be certain if they will be paid the entire portion of the bill for their services.
  - An additional risk is that providers must wait sometimes six months to a year (or years) for the resolution of a plaintiff's case.

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HOW the ASC facility gets reimbursed: DENIAL AND APPEAL

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- Understand the reasons behind a denial, as well as the proper steps for appealing the decision.
- An appeal should include any additional information or documentation that should be included with the submission.
- Depending on the payer, there may also be strict deadlines that must be adhered to for successful appeals.
- Appealing a denial is an option, and providers should take advantage of this opportunity whenever possible.

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Case Costing

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Case Costing: Definition

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- An accounting method that captures FULL costs of specific procedures and episodes of care by calculating all direct and indirect costs
  - Direct costs: Costs directly related to medical treatment, such as salaries, travel, equipment, and supplies
  - Indirect costs: Costs that are not directly related to medical treatment, such as administrative expenses
  - Facility expenses: Costs related to the physical facility, such as buildings, utilities, maintenance, and fixed equipment
    - Can be direct or indirect costs

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Case Costing: Why Do It?

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- Improves budget forecasting
- Better understand expenses and profit margin (the percentage of revenue left after paying expenses)
- Identify areas for cost savings
- Negotiate more effectively with insurers and payers
- Prompt price competition between vendors
- Change physician behavior
- Better understand and evaluate the profitability of different types of procedures to make informed decisions about pricing and resource allocation.

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Case Costing: Direct Costs

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- Staffing
- Specialized staffing
- Implants
- Supplies
- Equipment and instruments
- Pharmaceuticals
- Shipping fees
- Medical waste management
- Scrubs and laundry
- Janitorial Services
- Maintenance contracts

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Case Costing: Indirect Costs

- Billing costs
- Licenses/Fees/Taxes/Membership/Insurance Services
- Web site
- Fax/phone/Internet
- Fixed costs
  - Utilities, credit card fees
  - Office supplies
  - EMR, EHR, Computer OS
  - Transcription services
  - Service fees (Security, Parking, Landscaping)
- Prevention of data breaches, cybercrime, hacking and ransomware

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Case Costing: Measure and Report

- Track your pre- and post-change improvements
  - Spreadsheet, video, PowerPoint presentation, reports, newsletters
  - Report to physicians, management and STAFF how effective changes were
- Allow staff to generate and implement ideas
- Sustainability plan:
  - No one time events!
  - Review and report regularly
  - Assign staff members to be responsible for maintaining work and improvement and give them TIME to do the work

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What Can WE Control?

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- Judicious use of regional blocks, local infiltration, multimodal analgesia, aggressive prevention of PONV
  - Improve post operative pain
  - Reduce LOS in PACU
  - Improve patient, staff and surgeon satisfaction
  - Improve HOW we perform regional anesthesia
    - Use ultrasound when possible
    - Consider long-acting local anesthetics versus catheter placement

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- Consider long-acting local anesthetics versus catheter placement
  - **Interscalene Brachial Plexus Block**
    - April 6, 2018: FDA approves new use of bupivacaine Liposome for nerve block pain relief following shoulder surgeries
    - EXPAREL is reimbursed for procedures performed in ASCs using the code C9290
    - **BE COST AND TIME EFFECTIVE**:

	Pain Pump	Single-shot Bupivacaine Liposome
Kit/needle/tray	$113.95	$13.65
Pump	$200-450	
Meds	$78-235	$234*
Total	**$626-800**	**$247**

All prices taken from my personal Henry Schein pricing information last accessed 10/1/2024.

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- Consider long-acting local anesthetics versus catheter placement
  - EXPAREL is reimbursed for procedures performed in ASCs using the code C9290
  - As of October 1, 2024, EXPAREL is reimbursed at $1.45/mg (CMS)
    - Allowed amount for reimbursement:
      - $385.70 266 mg (20 mL) dose
      - $192.85 133 mg (10 mL) doce
  - The NOPAIN Act will provide separate ASP+6% Medicare reimbursement in HOPDs
    - Effective January 1, 2025, this new federal policy will provide separate reimbursement for proven non-opioid pain management options such as EXPAREL.
    - This will expand Medicare reimbursement beyond the ambulatory surgery center, where separate payment is already available via code C9290 for EXPAREL.

https://www.exparelpro.com/reimbursement

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- Consider other reimbursable medications to reduce LOS
  - Aponvie (aprepitant)
    - substance P/neurokinin-1 (NK1) receptor antagonist, indicated for the prevention of postoperative nausea and vomiting (PONV) in adults.
    - Administered as a single, 30-second IV injection prior to induction of anesthesia.
    - No need for IV fluid bag or oral administration 3 hours prior to surgery (Emend)
    - APONVIE is separately reimbursed by Medicare at ASP + 6% in HOPDs and ASCs under 3-year transitional pass-through status effective April 1, 2023
      - Average Sales Price + 6% in HOPDs and ASCs
      - Effective April 1, 2023, use C9145 when billing for APONVIE
        - Wholesale acquisition cost: $58.00/32mg vial
        - C9145: Inj, aponvie, 1 mg $1.86 ($59.52/vial)

APONVIE [package insert]. San Diego, CA: Heron Therapeutics Inc; 2022.
https://aponvie.com/pdf/PONV-Reimbursement-Guide.pdf

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What Can WE Control?

SOCIETY FOR AMBULATORY ANESTHESIA
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- Consider other reimbursable medications to reduce LOS
  - Barhemsys (amisulpride)
    - selective dopamine-2 (D2) and dopamine-3 (D3) receptor antagonist indicated in adults for:
      - prevention of postoperative nausea and vomiting (PONV), either alone or in combination with an antiemetic of a different class
      - treatment of PONV in patients who have received antiemetic prophylaxis with an agent of a different class or have not received prophylaxis
    - The recommended dosage is 5 mg (PONV prevention) or 10 mg (PONV Rescue treatment) as a single intravenous (IV) dose infused over 1 to 2 minutes. (No need for IV fluid bag)

1. Centers for Medicare & Medicaid Services. Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Application Summaries and Coding Recommendations. Third Quarter, 2023 HCPCS Coding Cycle. CMS website. Accessed May 3, 2024. https://www.cms.gov/files/document/2023-hcpcs-application-summary-quarter-3-2023-drugs-and-biologicals-posted-10/17/2023-updated-12/28.pdf **2.** Centers for Medicare & Medicaid Services. Addendum B Updates. CMS website. Released October 2023. Accessed May 3, 2024. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/addendum-b-updates/october-2023-0
Barhemsys [package insert]. Indianapolis, IN: Acacia Pharma Inc; 2022.

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- Consider other reimbursable medications to reduce LOS
  - Barhemsys (amisulpride)
    - The CMS has established the HCPCS Level II code J0184, "Injection, amisulpride, 1 mg," for Barhemsys, effective January 1, 2024.
    - Effective October 1, 2023, Barhemsys has been granted a transitional 3-year pass-through payment status by the CMS. Pass-through status provides additional payment for Barhemsys (ASP + 6%) for ASCs and HOPDs when billed to Medicare for a period of three years.
    - J0184: Inj, amisulpride, 1 mg $9.06
    - Wholesale acquisition cost:
      - 10mg $90.00; 5mg: $45.00

1. Centers for Medicare & Medicaid Services. Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) Application Summaries and Coding Recommendations. Third Quarter, 2023 HCPCS Coding Cycle. CMS website. Accessed May 3, 2024. https://www.cms.gov/files/document/2023-hcpcs-application-summary-quarter-3-2023-drugs-and-biologicals-posted-10/17/2023-updated-12/28.pdf **2.** Centers for Medicare & Medicaid Services. Addendum B Updates. CMS website. Released October 2023. Accessed May 3, 2024. https://www.cms.gov/medicare/payment/prospective-payment-systems/hospital-outpatient/addendum-b-updates/october-2023-0
Barhemsys [package insert]. Indianapolis, IN: Acacia Pharma Inc; 2022.

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- Judicious use of regional blocks, local infiltration, multimodal analgesia, aggressive prevention of PONV
  - Improve post operative pain
  - Reduce LOS in PACU
  - Improve patient, staff and surgeon satisfaction
  - Improve HOW we perform regional anesthesia
    - Use ultrasound when possible
    - Consider long-acting local anesthetics versus catheter placement
- MAC anesthesia may be more time and cost effective than GA/LMA/ETT
- TIVA versus inhalational agents for GA
- Multimodal analgesia

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- The RIGHT patient
- With the RIGHT insurance
- Into the RIGHT OR/procedure room
- In the RIGHT pavilion/building/facility/site
- At the RIGHT time
- In the RIGHT order

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SOCIETY FOR AMBULATORY ANESTHESIA
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- The RIGHT patient
  - Pre-op assessment: is the patient appropriate for an ASC?
- With the RIGHT insurance
  - Is that procedure covered at your ASC?
- Into the RIGHT OR/procedure room
  - Previous surgeon case length accuracy? Equipment needed elsewhere?
- In the RIGHT pavilion/building/facility/site
  - More profitable at an HOPD or inpatient?
- At the RIGHT time
  - Dialysis, elderly, NPO requirements, implant/equipment/staffing needs
- In the RIGHT order
  - Extended PACU needs for urination, irrigation, bleeding assessment

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