Part B Insider (Multispecialty) Coding Alert

Physician Notes: No Overnight Stays In ASCs For Patients, CMS Tells Surveyors

Sleepovers may be great for teenagers, but not for ambulatory surgery centers.

In a letter to state survey agencies, the **Centers for Medicare & Medicaid Services** clarifies that "there should be no planned overnight stays in an ASC for Medicare patients." If a patient does stay overnight in an ASC, it should be the result of "unanticipated conditions requiring continued observation or care within the capability of the ASC."

Generally, procedures in an ASC shouldn't require long stays, or extended recoveries, CMS notes. If an administrator knows in advance that a patient will require an overnight recovery, the surgery shouldn't happen in an ASC even if the procedure is on the ASC-approved list. The ASC should only keep someone overnight where an unexpected emergency requires care that the ASC is qualified to provide. Otherwise, you should transfer the patient to a hospital.

1. You shouldn't bill for "incident-to" services using the billing number of the ordering physician (or other practitioner) if that person didn't directly supervise the auxiliary personnel, according to Transmittal 148, issued April 23, which manualizes a rule in the Nov. 1, 2001 Federal Register.

2. If a provider submits a claim for a "medically unbelievable" service or there's a clear policy against paying for it, the carrier can deny a claim without launching a complex or routine medical review, even if the provider attaches plenty of documentation, CMS says in Transmittal 72, issued April 16.

3. Multiple categories of drugs are covered for ESRD patients and aren't included in the ESRD composite rate, CMS says in Transmittal 146, issued April 23. You can bill an administration charge for these drugs, determined by the most appropriate method of administration. CMS instructs carriers to pay for drugs in the appropriate category, based on the most appropriate method of administration.

4. Carriers should identify voluntary refunds sent in by providers under a corporate integrity agreement (CIA), and deposit all checks within 24 hours, CMS says in Transmittal 42, issued April 30.

5. Between 1998 and 2003 alone, the government spent $408 million on investigating, prosecuting and awarding whistleblowers in false claims cases -- and recovered over $5.2 billion in settlements and judgments, according to **Taxpayers Against Fraud**.

6. CMS put an end to statements of intent, which were originally set up to allow beneficiaries more time to file claims. According to a rule in the April 23 Federal Register, 98 percent of claims are filed on assignment, up from 52 percent almost 30 years ago. Only 4.4 percent of SOI requests are actually processed and paid.