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BY AAPC

Outpatient Facility Coding Alert

Reader Question: Safety and Timeframes Drive ASC and Non-ASC Lists

Question: I know that some procedures are on the "approved" list for performing in an ASC, but others aren't. What's the rationale behind the lists?

Montana Subscriber

Answer: CMS deems whether a procedure should be covered in an ASC setting, and many other payers follow those guidelines. The list of ASC covered services include surgical procedures that CMS determines do not pose a significant safety risk and are not expected to require an overnight stay following the surgery. For example, cataract surgery (66983, Intracapsular cataract extraction with insertion of intraocular lens prosthesis [1 stage procedure]) and knee arthroscopy with meniscus repair (29882, Arthroscopy, knee, surgical; with meniscus repair [medial OR lateral)) are approved for an ASC setting.

By contrast, procedures on Medicare's inpatient list under the hospital outpatient prospective payment system are deemed to pose significant safety risk to beneficiaries in ASCs. These procedures are not eligible for designation and coverage as ASC covered surgical procedures. Examples can include extensive procedures such as septal defect repair (33782, Aortic root translocation with ventricular septal defect and pulmonary stenosis repair [i.e., Nikaidoh procedure]; without coronary ostium reimplantation) and hip replacement (27130, Arthroplasty, acetabular and proximal femoral prosthetic replacement [total hip arthroplasty], with or without autograft or allograft) to calculus removal (48020, Removal of pancreatic calculus).

Note: Procedures that can only be reported with an unlisted Category I CPT® code are excluded from both lists. Medicare's reasoning for this stance is that the codes aren't specific or descriptive enough to evaluate for safety risk.