ASC CODING, BILLING & COLLECTIONS

Presented by

Melanie Maycock, CASC, CCA

Audiodeducator.com

Agenda

- Review Medicare and Commercial Billing & Coding rules for ASC
- Review Correct POS Billing
- Understand NCCI edits and coding bundled procedures for ASC
- Review Correct Implant coding
- Understand Bilateral Billing requirements for Medicare & Commercial payers
- Review frequently overlooked private payer contract pitfalls

ASC vs. HOPD

- CMS uses payment categories to reimburse procedures performed at HOPDs
- ASC Coding & Billing is a blend of physician & HOPD guidelines
- Medicare vs. Commercial payers payment guidelines

- ASCs receive less than 65% of HOPD reimbursement
- The revised ASC payment rates are based on the ambulatory payment classifications (APCs) used to group procedures under the OPPS. Per the MMA, the revised ASC payment system is budget neutral. So, the payment rates are intended to ensure that Medicare expenditures under the revised payment methodology for ASCs will approximate the expenditures that would have occurred in the absence of the revised ASC payment system.

An ASC for Medicare purposes is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients. The ASC must enter into a participating provider agreement with CMS. An ASC is either independent (i.e., not a part of a provider of services or any other facility), or operated by a hospital (i.e., under the common ownership, licensure or control of a hospital). If an ASC is the latter type, it has the option either of being covered as an ASC or continuing as an HOPD surgery department.

- 1500 vs. UB-04
- POS 22- HOPD
- POS 24- Free-standing ASC
- POS 11- Physicians' Office
- POS audits are a focal point for RAC/OIG

- Use place of service code **24** (Ambulatory Surgical Center) for physician charges for services provided in the ASC facility. The Medicare global fee policies will be applied to physician services provided in an ASC.
- In a past audit of claims processed by NHIC , the Office of Inspector General (OIG) discovered that physicians incorrectly coded the place of service on 81 of 100 sampled claims by using the "office" place of service even though they performed the services in an outpatient hospital setting or an ambulatory surgical center. This resulted in an overpayment to the physician. Medicare has established different RVUs (Relative Value Units) for services performed in a facility versus a non-facility setting.
- The correct place of service code ensures that Medicare is not duplicating payment to the physician and the facility for any part of the practice expense incurred to perform a Medicare service. **The payments to the physicians are higher when the services are performed in non-facility settings.**
- **This is a RAC automated audit issue**

KEY DIFFERENCES BETWEEN MEDICARE & COMMERCIAL PAYERS

Covered vs. Non-covered Procedures

Educate schedulers and providers on Covered vs. Non-covered procedures

Provide ABN for non-covered Medicare Procedures prior to service

Bill patients for ABN related procedures

- Challenges arise when non-covered procedures are scheduled and coded correctly as unlisted (not payable by CMS)
- Review covered procedures and provide feedback to avoid the pressure of re-coding for payment
- CMS non-covered procedures may be paid by commercial/WC carriers

- Ancillary Services N1
- Implants
- Fluoroscopy
- Medications
- Bilateral Procedures

Ancillary Services N1

- Packaged service/item; no separate payment made
- Procedures & services that are considered as integral to the procedure and paid as a part of the primary procedure

Coding Bilateral Procedures

Bilateral Billing Options

Coding is often payer driven

- • Bill the same code as two line items, using the –RT Modifier on one code and the –LT Modifier on the other code. (***Medicare)
- • Bill bilateral procedures as two line items with no Modifier on the 1st code and a –50 Modifier on the 2nd line item (same code).
- • Bill the procedure as a single line item on the claim with a –50 Modifier on the procedure code at 2x the fee

- Modifier 50 should not be used unless payer mandated
- As a rule, bill bilateral procedures on 2 lines with LT, RT modifiers
- Examples:

Example 1 Correct Coding	**HCPCS**	**Def**	**PI**	**QTY**	**ASC Charge**	**Medicare Payment Rate**
Bilateral procedure reported on 2 lines	15823	Revision of upper lid	A2	1	$1,000	$800
Bilateral procedure reported on 2 lines	15823	Revision of upper lid	A2	1	$1,000	$800
Example 2 Incorrect Coding	**HCPCS**	**Def**	**PI**	**QTY**	**ASC Charge**	**Medicare Payment Rate**
Bilateral procedure reported on 2 lines	15823-50	Revision of upper lid	A2	1	$2,000	$800

Implant Coding

- CMS Device Intensive Procedures: http://ascassociation.org/device2011.pdf
- Remember that “device intensive” procedures may not apply to all payers (63650/L8680)
- Commercial payers may use C or L codes-review contracts-request additions

Example 1	HCPCS	Def	PI	QTY	ASC Charge	Medicare Payment Rate
Packaged Device billed to Medicare	62361	Implant Spine Infusion pump	H8	1	$12,000	$10,000
Example 2						
Packaged Device billed to Medicare	62361	Implant Spine Infusion Pump	H8	1	$2,500	$2,500
	C1891	Infusion Pump	N1	1	$8,500	$0

DEVICE INTENSIVE PROCEDURES

HCPCS Code	2011 National ASC Rate
24361	$7,068.23
24363	$7,068.23
24366	$7,068.23
25441	$7,068.23
25442	$7,068.23
25446	$7,068.23
27446	$7,068.23
33206	$6,816.91
33207	$6,816.91
33208	$8,393.22
33212	$5,803.96
33213	$6,597.53
33214	$8,393.22
33224	$9,373.10
33225	$9,373.10
33240	$22,212.75
33249	$25,360.04
33282	$4,712.19
53440	$5,852.95
53444	$5,852.95
53445	$10,175.11
53447	$10,175.11
54400	$5,852.95
54401	$10,175.11
54405	$10,175.11
54410	$10,175.11
54416	$10,175.11
55873	$6,561.39
61885	$13,816.04
61886	$17,849.58
62361	$12,221.29
62362	$12,221.29
63650	$3,707.45
63655	$5,223.67
63685	$13,816.04
64553	$3,707.45
64555	$3,707.45
64560	$3,707.45
64561	$3,707.45
64565	$3,707.45
64568	$21,333.84
64575	$5,223.67
64577	$5,223.67
64580	$5,223.67
64581	$5,223.67
64590	$13,816.04
65770	$6,118.05
69714	$7,068.23
69715	$7,068.23
69717	$7,068.23
69718	$7,068.23
69930	$29,056.15

Most Commonly Used Implants

- C1713 – Anchor/Screw
- L8630 – Metacarpophalangeal Joint Implant
- L8631 – Metacarpophalangeal Joint Replacement Implant
- L8641 – Metatarsal Joint Implant
- L8642 – Hallux Implant
- L8699 or 99070 – Misc. Implants
- L8600 - Silicone (or equal) Breast Implants
- C1789 – Non-Silicone Breast Implants
- C1781 or L8699 or 99070 - Hernia Mesh
- C1771 – Sling/TVT Tape
- C2627 - Suprapubic/Cystoscopic Catheter

- C2614 – Probe for Percutaneous Lumbar Discectomy
- C2622 - Prosthesis, Penile, noninflatable
- L8603 - Collagen Implants
- L8606 - Durasphere® Implants
- Q1003 - Category 3 New Technology IOLs
- V2632 – Regular Posterior Chamber IOL
- V2630 – Regular Anterior Chamber IOL
- V2788 – Presbyopia-Correcting IOL Lens
- V2787 – Astigmatism-Correcting IOL Lens
- L8612 - Aqueous Shunt

ANCILLARY SERVICES

- Be sure to code for covered ancillary services:
- Brachytherapy;
- Implantable items that have pass-through status under the OPPS;
- Items and services that CMS designates as contractor-priced, such as the procurement of corneal tissue;

- Drugs and biologicals for which separate payment is allowed under the OPPS; (updated quarterly)
- Radiology services for which separate payment is allowed under the OPPS.
- Do not automatically follow CMS guidelines when coding ancillary services to commercial/WC payers

ASC Association Resources

- Medicare Rate Calculator
- Separately Payable Procedures
- Packaged Procedures
- ASC List Changes
- Covered Ancillary Procedures
- Device Intensive Procedures
- Office-Based Procedures
- Discount Exempt
- Patient Cost-Sharing Waived Procedures

ASC Association 2011 Rate Calculator

HCPCS Code	2011 National ASC Rate	2011 Local ASC Rate	Locally Medicare Pays	Locally Patient Pays
0099T	$693.59	$693.59	$554.87	$138.72
0100T	$1,586.79	$1,586.79	$1,269.43	$317.36
0101T	$1,249.23	$1,249.23	$999.38	$249.85
0102T	$1,249.23	$1,249.23	$999.38	$249.85
0123T	$945.91	$945.91	$756.73	$189.18
0124T	$98.72	$98.72	$78.98	$19.74
0186T	$907.78	$907.78	$726.22	$181.56
0190T	$907.78	$907.78	$726.22	$181.56
0191T	$1,675.21	$1,675.21	$1,340.17	$335.04
0192T	$1,675.21	$1,675.21	$1,340.17	$335.04

NCCI EDITS

- CMS assigned ASC physician CCI edits
- Remember to check reimbursement for billing order
- Do not confuse CMS edit requirements with commercial- (AAOS, AMA, ASIPP, ETC)
- Establish edit guidelines for commercial coding
- Review your payer contracts and payments for incorrect edits for example: 29877/G0289(*Arthroscopy, knee, surgical, for removal of loose body, foreign body, debridement/shaving of articular cartilage (chondroplasty*)

ASC Modifiers

- Not all modifiers are ASC appropriate
- 73-Terminated in the O.R/Before anesthesia
- 74-Terminated in the O.R./After anesthesia
- 59-Distinct procedure-unbundle codes
- TC-Technical Component
- 50/51-Not appropriate for ASC coding
- 52-discontinued procedure (radiology)
- FB-Device provided at no cost to ASC

TERMINATED PROCEDURES

- Do not bill procedures cancelled in Pre-op

- Payment at 50 percent of the rate is applied if a surgical procedure is terminated due to the onset of medical complications after the patient has been prepared for surgery and taken to the operating room but before anesthesia has been induced (use **modifier 73**). For example, 50 percent is paid if the patient develops an allergic reaction to a drug administered by the ASC prior to surgery which prevents continuation of the procedure. Although some supplies and resources are expended, they are not consumed to the same extent had anesthesia been fully induced and the surgery completed

- Full payment of the facility rate is made if a medical complication arises which causes the procedure to be terminated **after inducement of the anesthetic agent (use modifier 74**). For example, full payment is made, if after anesthesia has been accomplished and the surgery is terminated to avoid increasing surgical risk to the patient. In this case, the resources of the facility are consumed in essentially the same manner and to the same extent as they would have been had the surgery been completed.
- **MULTIPLE PROCEDURES**:
- Bill procedures performed in full prior to the termination with no modifier
- Bill the procedure that was not completed as above

Coding Separate Procedures- Modifier 59

- Unbundled procedures or those designated as “Separate Procedures” may be billable when the procedure is not considered component of another procedure, but a distinct, independent procedure, such as:
- Different site or organ system;
- Separate incision/excision;
- Separate compartment;
- Separate lesion.

Modifier 59 Example

- Example: Knee coding- 3 compartments
- Lateral, Medial, Patellar
- Use Modifier 59 to indicate that a procedure was done in a different compartment and to unbundle that bundled code.

Coding Technical Components
TC Modifier

- ASCs should use the –TC Modifier on radiology and Fluoroscopy codes to indicate that only the Technical component is being billed
- 72275-TC- technical component reflects the cost to the ASC
- 72275-26-Professional component reflects the cost to the physician

Medical Necessity

- A coder should be familiar with NCD/LCD Medical Necessity Guidelines and should be mindful of the required links between procedures and ICD-9 coding
- Know the difference between making sure you've left no money on the table and fraudulent coding

- If the physician lists the DX/CPT codes on the Op Report, the coder is still responsible for reviewing the report to determine that the procedures are documented correctly
- If additional information is needed, the physician can create an addendum to the operative report
- Corrections must be noted as an addendum and dated
- The original operative report cannot be altered

Coding Tools

- Melanie Maycock
- 734-673-5917
- melaniemaycock@gmail.com

- ASC Association: http://ascassociation.org/medicare2011/
- On Demand Education-ASC Billing: http://www.wpsmedicare.com/part_b/education/on_demand/_files/asc/2010_asc.html
- Medicare Coverage Database: **http://www.cms.hhs.gov/center/coverage.asp**

- CMS NCCI Edits www.cms.gov/nationalcorrectcodinited/
- CMS Bilateral Billing Guide http://www.cms.gov/MLNMattersArticles/downloads/SE0742.pdf

- CMS ASC Center http://www.cms.gov/center/asc.asp (Join the CMS ASC mailing list)
- NCCI POS Crosswalk: http://www.ncci.com/documents/MedData-CrossWalk.pdf
- National coverage determinations http://www.cms.hhs.gov/mcd/search.asp

CEU Quiz

- Modifier 26 is appropriate for ASC claims T F
- Match the POS:

ASC _____	A. 11
HOPD _____	B. 22
MD Office____	C. 24

- Professional NCCI edits are used for both ASC and Physician claims T F
- Implants are never billed with ASC claims T F
- Modifier 59 is not used in ASC Billing T F

Match the Modifier A. TC B. 26 C. 74 D. 73

1. Spinal Stim is implanted using fluoroscopic guidance –non-Medicare patient 77003-_____

2. In O.R, patient has not been intubated when a rise in BP causes the surgeon to cancel the planned procedure-62287 _____

3. In Pre-op, patient is determined to have a fever and procedure 62287 is cancelled by anesthesia _____

- All payers accept Modifier 50 on ASC claims T F
- N1 procedures should never be billed T F
- Ancillary services are always packaged into the payment for the primary procedure T F