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Internal Medicine Coding Alert

ASC Payments: 5 Tips To Make Your ASC Coding Better

Check out the new 2011 payment rates for dermatology procedures performed in an ambulatory setting.

True or false: Modifier SG is required for all ambulatory surgical center (ASC) claims.

The answer is false for claims with dates of service after Jan. 1, 2008 -- and if you got that one right, you're on your way to ASC reimbursement bliss.

CMS has issued its latest quarterly update to the ASC Payment System, which includes HCPCS codes, modifiers, drugs and supplies that are payable for ASCs effective April 1.

With so many changes affecting ASCs every year, it's enough to make your head spin -- but despite all of the changes, some aspects of ASC reimbursement have remained the same. We've got the lowdown on how the ASC rules affect you.

1. Know where to find ASC-allowed services. CMS maintains a very specific list of codes payable for ASCs, but if you don't know how to access the list, you could be flying blind when it comes to reimbursement.

Resource: You can download the most recent ASC-allowable codes at www.cms.gov/ASCPayment/11_Addenda_Updates.asp, which includes not only the current quarter (which began on Jan. 1), but also any previous quarters in case you're battling older claims.

2. Remember the 'same-day global' rule. Every procedure the ASC bills has a "same-day" global period. This makes sense because the ASC is not reporting physician work services -- only facility fees. This applies to the coder working for the ASC, but not the physician who performed the service.

For instance, if a patient experiences postoperative bleeding after the repair of a superficial wound (12001-12018, Simple repair of superficial wounds ...) and the physician must return the patient to the ASC for control of bleeding on the same day, both the physician's coder and the ASC's coder should report the appropriate control-of-bleeding code appended with modifier 78 (Unplanned return to the operating/procedure room by the same physician or other qualified healthcare professional following initial procedure for a related procedure during the postoperative period) because the procedure occurred within the "same-day" global period for the ASC.

If, however, the physician returned the patient to the ASC the day after the initial surgery, the ASC coder would report the appropriate control-of-bleeding code with no modifier. For the ASC's purposes, the initial surgery's global period has expired, even though the surgery includes a 90-day global period for physician services. On the other hand, the surgeon's coder would report the bleeding-control code with modifier 78 appended because the physician's services follow the standard global rule.

Takeaway: The ASC coder should follow the "same-day" global rule, but the physician's coder should follow standard global period rules from the fee schedule.

3. You can skip modifier SG. In the past, when the ASC coder billed Medicare for any service performed in the ASC, he had to list modifier SG (ASC facility service) as the first modifier on the claim. However, that all changed with the issuance of CMS Transmittal 1410, which stated, "Effective for services on or after January 1, 2008, the SG modifier is no longer applicable for Medicare services." (To read the Transmittal, visit http://www.cms.gov/transmittals/downloads/R1410CP.pdf).

For dates of service prior to Jan. 1, 2008, ASC coders were required to list the SG modifier first on the claim -- without it, the claim would reject immediately.

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4. Discontinued surgery modifiers may differ. ASC coders may occasionally use modifier 52 (Reduced services) but won't use modifier 53 (Discontinued procedure). Instead, insurers usually require ASC coders to call on modifiers 73 (Discontinued outpatient hospital/ambulatory surgical center procedure prior to administration of anesthesia) or 74 (Discontinued outpatient hospital/ambulatory surgical center procedure after the administration of anesthesia), as appropriate.

"In the event that the physician must stop the procedure due to a medical complication or finding, the ASC will still collect a portion of their reimbursement if billed with modifier 73," says **Deb Bridges, CPC-H,** coder with University Suburban Health Center in Ohio.

"When the physician returns to the ASC with the patient to perform the aborted procedure at a later date or time, the ASC will receive full reimbursement for the completed procedure," Bridges adds.

Alternative: "If anesthesia is administered and subsequently the procedure is terminated because of risk to the patient, use modifier 74," Bridges advises. "Under these circumstances, the ASC will receive full reimbursement for the discontinued procedure."

Although the ASC won't report modifier 53, the surgeon might. "Modifier 53 is used by the physician to indicate the patient received anesthesia but the procedure was terminated due to a medical complication or a finding that would put the patient at risk if the procedure were to continue," Bridges adds.

5. Keep in contact with the surgeon's coder. One mistake that can kill your reimbursement is when the physician and the ASC report different codes for the same procedure. Because the physician and ASC should report the same codes for each surgery, any coding discrepancies should be ironed out before the claim is submitted.

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