Part B Insider (Multispecialty) Coding Alert

ASC CODING: 2 Secrets To Successful ASC Coding

Pay attention to modifier differences in ASC setting

If your physician is opening an Ambulatory Surgery Center (ASC), you may find yourself confused by the different rules for ASC coding versus physician office coding. ASCs have some unique rules and situations.

What to do: Review the following two frequently asked questions to get the lowdown.

Question: I code for an ASC and my payer won't reimburse me for claims with modifiers 78 (Return to the operating room for a related procedure during the postoperative period) or 79 (Unrelated procedure or service by the same physician during the postoperative period). Should we appeal?

Answer: -An individual payer has the right to deny a claim, if it is within their guidelines to do so, and with many self-insured plans out there, the guidelines vary greatly regarding this issue,- says **Stephanie Ellis**, owner of **Ellis Medical Consulting, Inc**. in Brentwood, TN.

Most important issue: -The ASC's global period for all procedures performed in the facility is 24 hours,- Ellis says. -Most of the procedures performed in ASCs have a global period of 10 or 90 days defined, which is the global period for the operating physician's claims--not the facility's claims.-

Therefore, ASC coders will rarely need to use modifiers 78 or 79. One of the unusual cases when you-d use these modifiers would be if a patient underwent a procedure in the ASC and went to the recovery room to rest. While in recovery, the patient started to hemorrhage and the surgeon returned the patient to the OR to stop the hemorrhage.

-That is usually the only time that one of these modifiers would be needed,- Ellis says. -If the patient goes back into the OR at the same ASC for a procedure the following day and it is past 24 hours since the ending of the first procedure performed the day before, the ASC does not need to append modifiers 78 or 79 to their claim.-

-If the patient was taken back to the OR at the same ASC for a procedure within the 24-hour period after the first procedure was performed and the ASC used the 78 or 79 modifier and still had the claim denied, I would advise the ASC to pursue vigorous appeal procedures,- Ellis advises.

Question: Our ASC requires the orthopedic surgeon to dictate his CPT codes directly into the operative report. They tell us that this way, the surgeon and the ASC are sure to report the same code as one another. Our surgeon doesn't always select the correct code so I-m uneasy about this. Should we follow the ASC's advice?

Answer: -I don't think this is a good idea for many reasons,- says **Lisa Weston-Powell**, director of ambulatory surgery coding services at **The Coding Network**. -The coder will still have to read the report and assign codes based on what is documented and not what codes are dictated.-

Because the ASC and the surgeon must report the same code, it can be unsafe to rely solely on the surgeon's code selection.

The problem is that the ASC might report the code that the surgeon dictates, while the physician's office will bill a code based on the coder's assessment of the documentation. In many cases, the physician's coder will select a different code than the surgeon dictated, which means that the ASC and surgeon's office will bill separate codes. In those cases, Medicare will deny payment for the service to the ASC.

Best bet: Coordinate your billing and coding choices with the ASC to ensure that both are reporting accurate and matching codes.