# Part B Insider (Multispecialty) Coding Alert

## Part B Coding Coach: Guest Columnist: Annette Grady, CPC, CPC-H, CPC-P,)S--Avoid These Common ASC Coding Mistakes Or Face Denials

**If you're new to surgery center coding, make modifier SG your friend**

Any orthopedic coder who has suddenly been led into the world of ambulatory surgery center (ASC) coding knows that ASCs present unique challenges. The answers to your ASC coding questions can be hard to find, but you can increase your coding accuracy if you break ASC coding down into a few simple rules.

**Rule: Find Out What Qualifies as an ASC**

An ASC is a freestanding facility, other than a physician's office, where surgical and diagnostic services are provided on an ambulatory basis. Most physicians today work out of a -free standing- ASC facility and many have partial or complete ownership. ASCs are very advantageous to patients and generally provide a great cost-effective and quality service. Typically, an ASC procedure will not exceed 90 minutes, and does not require more than four hours of recovery or convalescent time.

Insurance payment methodologies vary greatly in the ASC setting, and some basic differences are:

Medicare (CMS) bases its payment on nine payment groups for the ASC, whereas they base payment to the outpatient hospital surgery center on the Ambulatory Payment Classifications (APC). Payment can differ dramatically depending on where the physician performs the surgery.

Historically, the payment data comes from different sources. Outpatient hospital payment is based on utilization of resources and costs, and it generally costs the outpatient hospital more to provide a service than an ASC freestanding center.

Another difference is that CMS requires ASCs to submit a CMS-1500 form, but CMS requires outpatient hospitals to utilize the UB92. Be aware that many commercial payors request the UB92 claim form for ASCs; therefore you need to have knowledge and a software system that can handle both types of claims.

CMS reimburses ASCs using nine national payment rates, which are then adjusted using a local carrier wage index. For information on the nine payment rates and the wage indexes, visit the CMS Web site at www.cms.hhs.gov/Transmittals/Downloads/AB03116.pdf.

**Rule: List Modifier SG First**

When the ASC bills Medicare, the ASC coder should list the place of service (POS) as -24- on the CMS-1500 form. The ASC must submit the claim as -assigned,- and CMS will deny any services that are not on Medicare's approved list of payable ASC services. Physicians may submit their professional services as either assigned or unassigned, but the ASC must submit assigned claims only.

**Remember:** The ASC cannot ask the patient to sign an advanced beneficiary notice (ABN) for a service that is not on the approved list, nor can the ASC bill the Medicare patient for any unpaid balance. When the service is not covered in an ASC, Medicare will make no facility payment but the physician can still collect for his portion of the surgery.

When you bill Medicare for any service that your surgeon performs in an ASC, you must list modifier SG (ASC facility service) as the first modifier on the claim. The National Correct Coding Initiative (NCCI) also applies to ASC claims and is

the same version that the physician currently uses. Note that outpatient hospital surgery centers are one version behind.

**Rule: Physician and ASC Must Coordinate Coding**

As with outpatient services, ASCs should code what the surgeon documents--which is easier said than done at times. Be aware that carriers have seen instances where the surgeon bills a procedure that is not payable in an ASC, but the ASC submits a CPT code that is payable in the ASC. The ASC has the responsibility to discuss this issue with the surgeon to ensure that both parties submit matching procedure codes that describes the actual procedure that the surgeon performed. If the procedure that the surgeon performed is not payable in an ASC, the ASC cannot change the code to an ASC-payable procedure.

Carriers have also encountered situations where the ASC facility bills for services but the surgeon does not submit any charges, or the ASC bills for multiple procedures when the surgeon only submits one surgical procedure code. The most important key item to remember is that documentation in the medical record must support the services billed to Medicare.

**Payment May Change in ASC**

Surgeons shouldn't always expect to collect the same fees in the ASC that they collect in the office. Certain office-based services are subject to a facility-based (previously site-of-service) reduction when the physician performs them in an ASC. This reduction only applies to services on the CMS list of ASC-covered services.

Medicare payment for procedures not on the ASC list, but performed in an ASC, include payment for all practice expenses (no separate payment for an ASC facility fee).

**For example:** Suppose an orthopaedic surgeon performs a meniscectomy on the patient's right knee (29881-RT) and a joint injection in the left knee (20610-LT) during an ASC operative session. The following chart breaks down the payment difference:

If the physician chooses to perform a service not on the approved ASC listing, the ASC should make arrangements with that physician for reimbursement since Medicare pays the physician the ASC's portion of the payment. Many ASCs use the difference between facility versus the non-facility reimbursement, and then bill that amount to the physician.

**Best practice:** If this occurs, you should ask the physician sign a document stating that he understands that the procedure is not on the ASC list and that he will be responsible for reimbursing the ASC the difference between the facility and non-facility reimbursement.

**Calculate Whether ASC Will Make Profit**

Any supplies that the surgeon uses are not separately reimbursable in the ASC. Medicare's fee includes the cost of the supplies, so in some instances, the cost of a surgical device, such as an implant, can outweigh the reimbursement that you can collect from Medicare for the procedure. This chart shows you the breakdown:

**Modifiers Differ for Terminated Procedures**

Surgeons can terminate procedures that they perform in the ASC at any time, but the ASC should bill different modifiers than the surgeon under these circumstances. If the physician terminates the procedure prior to anesthesia, the ASC should append modifier 73 (Discontinued outpatient procedure prior to anesthesia administration). If the physician discontinues the procedure after anesthesia, the ASC should append modifier 74 (Discontinued outpatient procedure after anesthesia administration) to the procedure code.

The physician should not append modifiers 73 and 74 to his claim. Instead, he should append the outpatient modifiers 53(Discontinued procedure) or 52 (Reduced services), depending on the circumstances.

To support using the discontinued service modifiers, the ASC should include the following information in the

documentation:

- Reason for termination
- Services actually performed
- Supplies provided
- Time spent in each stage (pre-operative, operative and post-operative)

**Expect Full Payment With Modifier 74**

If the surgeon terminates the procedure after inducing anesthesia, CMS will pay the ASC the full facility rate. Their rationale is that the facility's resources are consumed in essentially the same manner and to the same extent as they would have been had the surgery been completed. Make sure that you have clear and supporting documentation for the termination.

If the physician terminates the procedure prior to anesthesia, CMS will make a 50-percent payment to the ASC if the termination is 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. An example would be if the patient develops an allergic reaction to a drug administered by the ASC prior to surgery. Some diagnoses to help support the claim would be V64.1 (Surgical or other procedure not carried out because of contraindication) or V64.3 (Procedure not carried out for other reasons).

**Payment Rules Don't Mimic Outpatient Regs**

If the surgeon performs a bilateral procedure in one operative session at an ASC, the ASC should report it to Medi-care as two procedures (other payors may have different rules). CMS instructs ASCs to report bilateral surgeries on two separate line items with the LT and RT modifiers appended.

CMS will pay 150 percent of the appropriate wage-adjusted payment amount for procedures with the LT and RT modifiers. Note that endoscopic payment rules do not apply to the ASC center as they do for physician services. Other rules may vary so therefore it is very important to communicate with your payors for their rules.

**Annette Grady, CPC, CPC-H, CPC-P, OS** is the director of education at Coding MetriX Inc., and is an officer on the AAPC National Advisory Board.