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BY AAPC

Outpatient Facility Coding Alert

Billing 101: Get Versed in Successfully Handling 3 Compliance Issues for ASCs

Follow these 3 steps to navigate all your claims.

Many aspects of coding and billing for ASC services are different from a physician's office or inpatient facility. Knowing what's required for bilateral and separate procedure payment, as well as timeliness of reporting for ASCs could pave the way to cleaner claims. .

Step 1: Identify the 5 Methods for Billing Bilateral Procedures

CMS defines a bilateral service as one in which the same procedure is performed on both sides of the body during the same operative session or on the same day. You have several options for reporting these procedures, depending on the payer's preference and which association's advice you're following. We'll use 64483 (Injection[s], anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance [fluoroscopy or CT]; lumbar or sacral, single level) as the example procedure.

- The Healthcare Common Procedure Coding System (HCPCS) uses modifiers LT (Left side) and RT (Right side) instead of modifier 50 (Bilateral procedure). If you're following HCPCS guidelines, you would submit 64483-RT with 64483-LT.
- CPT® indicates that "unless otherwise identified in the listing, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate five digit code."
- When reporting bilateral procedures on a single line, the American College of Surgeons (ACS) recommends doubling the fee because payers will reimburse for the lesser of the fee submitted or the payer allowable (64483-50 on a single line, with the facility fee doubled).

Sometimes you'll report a bilateral procedure as two line items with no modifiers. List each code (64483) with the associated fee on its own line.

Other payers request that you bill the procedure as a single line item on the claim form with no modifier on the code, but a "2" in the Units column on the claim to indicate the bilateral nature. If you follow this guideline, be sure to double the facility fee (64483 with the doubled fee and 2 units listed).

Step 2: Look for Separate Procedure Status of CPT® Codes

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 (Distinct procedural service) identifies procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.

The "Separate Procedure" designation for a code indicates that a procedure or service may be performed independently; unrelated or distinct from other procedures/services provided at the same time/in the same case; or considered an integral component of another procedure or service. Codes designated as separate procedures are usually not billable unless it is the ONLY procedure performed. You might be able to bill the code by appending the 59 modifier to indicate that the procedure is not considered a component of another procedure, but a distinct, independent procedure, under circumstances such as:

- Different site or organ system
- Separate incision/excision

- Separate compartment
- Separate lesion.

An example: The physician performs destruction of a premalignant lesion (17000, Destruction [eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement], premalignant lesions [eg, actinic keratoses]; first lesion) on the same day he biopsies another lesion (11100, Biopsy of skin, subcutaneous tissue and/or mucous membrane [including simple closure], unless otherwise listed; single lesion). You will need to append modifier 59 to code 11100 to indicate that the he performed the services at different anatomic sites. Verify that his documentation supports your coding.

Note for 2015, CMS has added four new modifiers known collectively as the X{EPSU} modifiers. These should be used in lieu of modifier 59 when appropriate. Download http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R1422OTN.pdf for more information.

Step 3: Don't Feel Pushed With the Coding Speed

Coders often have the urgency to code and submit within 24 hours of a service for optimal cost and time efficiency, but that metric isn't taking the entire process into consideration, says **George Kaplinksi,** vice president of operations for ASC billing services at Source Medical.

"Our goal is always to have the case out as quickly as possible but it's worth the time to be sure that all information is correct, rather than risk missing coding errors which can cause claim denials, receiving a reduce reimbursement or other issues that might delay payment," he says.

Be aware: Twenty-four hours is not always enough to collect all necessary related information and to make an error-free claim. Often, coders will need clarifications on physician dictation or need more information about the procedures before filing the claim.

"Our goal is coded and out-the-door in 48 to72 hours, but we want to make sure we are doing things right the first time, not just fast," says Kaplinksi.

Erroneous claims may prove very expensive, as surgery centers can incur substantial costs to correct the information including errors related to pathology, diagnosis codes that do not meet a payers medical necessity guidelines, or implants costs. For your best chance at successful filing, ensure all of the information is present prior to submission.