ASC Coding and Billing Fundamentals

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Objectives

• Guidelines/Regulations
• Covered Surgical Procedures
• Ancillary Supplies Separately Reportable
• Correct Use of Modifiers
• Review Documentation
  – CMS Standpoint
  – Third Party Standpoint
CMS Regulations/Guidance

ASC Definition:
For Medicare purposes, an ASC is a distinct entity in operation for the exclusive purpose of furnishing outpatient surgical services to patients.

It is either independent or operated by a hospital.

CMS Regulations

To be able to provide and bill services performed in an ASC, the ASC must enter into a participating provider agreement with CMS.
CMS Regulations

Part of the ASC enrollment process requires certification. This certification is achieved through survey showing compliance with the conditions for coverage by state regulation.

CMS Regulations

A hospital-operated facility has the option of being considered by Medicare to be either an ASC or to be a provider based department of the hospital as defined in 42 CFR 413.65.
 CMS Regulations

Payment for ASC services are made under Part B and should be submitted on a CMS-1500 claim form.

Approved Surgical Procedures

Medicare publishes a list of covered procedures annually. Updates to this list are published annually.
CMS Regulations

Services included in the ASC payment for a covered surgical procedure include but are not limited to:
• Nursing, technician and related services
• Use of facility where procedure is performed
• Any laboratory testing performed under CLIA
• Drugs and biologicals for which separate payment is not allowed.

CMS Regulations

• Medical and surgical supplies not on pass-through status
• Equipment
• Surgical dressings
• Implanted prosthetic devices not on pass through status
• Splints, casts, and related devices
CMS Regulations

- Radiology services for which separate payment is not allowed under OPPS, and other diagnostic or interpretive services
- All administrative or housekeeping services
- Materials, including supplies/equipment for administration and monitoring of anesthesia
- Supervision of the services of an anesthetist by the operating surgeon

CMS Regulations

There are some services that separate or additional payment is allowed. These services include:

- Brachytherapy sources
- Implantable items that have “pass-through” status under OPPS
- Certain items and services CMS designates as contractor prices (procurement of corneal tissue)
CMS Regulations

- Drugs and biologicals for which separate payment is allowed
- Radiology services for which separate payment is allowed

The complete list of ASC covered surgical procedures, covered ancillary services, applicable payment indicators and other information are available on the CMS website at:

http://www.cms.gov/ascpayment/
CMS Covered Procedure Information

Included in the file is the following:

- Addendum AA – Final ASC covered surgical procedures including comments, payment indicators and final payment amount for CY
- Addendum BB – Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures (including Packaged Services) for CY.

CMS Covered Procedure Information

- Addendum DD1 – Final ASC Payment Indicators for CY
- Addendum DD2 – Final ASC Comment Indicators for CY
- Addendum EE – Surgical Procedures to be Excluded from Payment for CY
## CMS Addendum AA Example

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Subject To Multiple Procedure Discounting</th>
<th>Comment Indicator</th>
<th>Payment Indicator</th>
<th>Payment Weight</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>10021</td>
<td>Fna w/o image</td>
<td>Y</td>
<td>P2</td>
<td>1.5259</td>
<td>$65.04</td>
<td></td>
</tr>
<tr>
<td>10022</td>
<td>Fna w/image</td>
<td>Y</td>
<td>G2</td>
<td>4.3315</td>
<td>$184.64</td>
<td></td>
</tr>
<tr>
<td>11312</td>
<td>Shave skin lesion</td>
<td>Y</td>
<td>CH</td>
<td>P2</td>
<td>1.4194</td>
<td>$60.50</td>
</tr>
<tr>
<td>11313</td>
<td>Shave skin lesion</td>
<td>Y</td>
<td>P2</td>
<td>1.4194</td>
<td>$60.50</td>
<td></td>
</tr>
<tr>
<td>11400</td>
<td>Exc tr-ex b9+marg 0.5 &lt; cm</td>
<td>Y</td>
<td>P3</td>
<td>$86.80</td>
<td></td>
<td></td>
</tr>
<tr>
<td>49082</td>
<td>Abd paracentesis</td>
<td>Y</td>
<td>NI</td>
<td>G2</td>
<td>5.2152</td>
<td>$222.31</td>
</tr>
<tr>
<td>49083</td>
<td>Abd paracentesis w/imaging</td>
<td>Y</td>
<td>NI</td>
<td>G2</td>
<td>5.2152</td>
<td>$222.31</td>
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</tbody>
</table>

## Example Addendum BB

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Descriptor</th>
<th>Final CY 2012 Comment Indicator</th>
<th>Final CY 2012 Payment Indicator</th>
<th>Final CY 2012 Payment Weight</th>
<th>Final CY 2012 Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>C1716</td>
<td>Brachytx, non-ste, Gold-198</td>
<td>H2</td>
<td></td>
<td></td>
<td>$35.00</td>
</tr>
<tr>
<td>C1840</td>
<td>Telescopic intracocular lens</td>
<td>NI</td>
<td>J7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C5902</td>
<td>MRA w/o fol w/cent, abl</td>
<td>Z2</td>
<td>7.2284</td>
<td></td>
<td>$308.13</td>
</tr>
<tr>
<td>J0696</td>
<td>Ceftriaxone sodium injection</td>
<td>N1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J0800</td>
<td>Corticosterin injection</td>
<td>K2</td>
<td></td>
<td></td>
<td>$2,516.22</td>
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<td>J0190</td>
<td>X-ray exam of eye sockets</td>
<td>Z2</td>
<td>0.6064</td>
<td></td>
<td>$25.85</td>
</tr>
<tr>
<td>J0200</td>
<td>X-ray exam of eye sockets</td>
<td>Z2</td>
<td>0.6064</td>
<td></td>
<td>$25.85</td>
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</tbody>
</table>
### Example Addendum DD1

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Payment Indicator Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A2</td>
<td>Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.</td>
</tr>
<tr>
<td>D5</td>
<td>Deleted/discontinued code; no payment made.</td>
</tr>
<tr>
<td>G2</td>
<td>Non-office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.</td>
</tr>
<tr>
<td>H2</td>
<td>Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.</td>
</tr>
<tr>
<td>J7</td>
<td>OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.</td>
</tr>
<tr>
<td>J8</td>
<td>Device-intensive procedure; paid at adjusted rate.</td>
</tr>
<tr>
<td>K2</td>
<td>Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.</td>
</tr>
<tr>
<td>K7</td>
<td>Unclassified drugs and biologicals; payment contractor-priced.</td>
</tr>
</tbody>
</table>

### Example Addendum DD2

<table>
<thead>
<tr>
<th>CI</th>
<th>Comment Indicator Meanings</th>
</tr>
</thead>
<tbody>
<tr>
<td>CH</td>
<td>Active HCPCS code in current year and next calendar year; payment indicator assignment has changed; or active HCPCS code that is newly recognized as payable in ASC; or active HCPCS code that is discontinued at the end of the current calendar year.</td>
</tr>
<tr>
<td>NI</td>
<td>New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year; interim payment indicator assignment; comments will be accepted on the interim payment indicator for the new code.</td>
</tr>
</tbody>
</table>
### Example Addendum EE

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Short Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11004</td>
<td>Debride genitalia &amp; perineum</td>
</tr>
<tr>
<td>11005</td>
<td>Debride abdom wall</td>
</tr>
<tr>
<td>11006</td>
<td>Debride genit/abdom wall</td>
</tr>
<tr>
<td>11008</td>
<td>Remove mesh from abd wall</td>
</tr>
<tr>
<td>15756</td>
<td>Free myo/skin flap microsurg</td>
</tr>
<tr>
<td>15757</td>
<td>Free skin flap microsurg</td>
</tr>
<tr>
<td>15758</td>
<td>Free fascial flap microsurg</td>
</tr>
</tbody>
</table>

### CMS – ASC Billing Guidelines

An ASC must **not** report separate line items, HCPCS codes or any other charges for procedures, services, drugs, devices or supplies that are **packaged** into the payment allowance for covered surgical procedures. The allowance for the surgical procedure itself, includes all of these other services or items.
CMS – ASC Billing Guidelines

For device-intensive procedures, a modified payment methodology will be used to establish ASC payment for these surgical procedures.

This methodology can be very confusing. We will get paid for the device, but we do not submit a separate line item for the device.

<table>
<thead>
<tr>
<th>Example Code</th>
<th>Description</th>
<th>Payment Indicator</th>
<th>Units</th>
<th>Billed Amount</th>
<th>Medicare ASC Allowed Amount</th>
<th>Medicare Payment to Provider</th>
<th>Beneficiary Payment to Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>54405</td>
<td>Insert multi-comp penis prosthesis</td>
<td>J8</td>
<td>1</td>
<td>$16,000.00</td>
<td>$10,346.97</td>
<td>$8,277.58</td>
<td>$2,069.39</td>
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</tbody>
</table>

Claim should have one detail line which includes the code for the surgical procedure with the cost for the procedure and the cost for the implanted device.
CMS – Incorrect Device Intensive

<table>
<thead>
<tr>
<th>Example Incorrect</th>
<th>Code</th>
<th>Description</th>
<th>Payment Indicator</th>
<th>Units</th>
<th>Billed Amount</th>
<th>Medicare ASC Allowed Amount</th>
<th>Medicare Payment to Provider</th>
<th>Medicare Payment to Provider</th>
<th>Beneficiary Payment to Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect 54405</td>
<td>Insert multi-comp penis pros</td>
<td>J8</td>
<td>1</td>
<td>$5,000.00</td>
<td>$10,346.97</td>
<td>$4000.00</td>
<td>$1000.00</td>
<td>$1000.00</td>
<td></td>
</tr>
<tr>
<td>C1813</td>
<td>Prosthesis, penile, inflatable</td>
<td>N1</td>
<td>1</td>
<td>$11,000.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td>$0.00</td>
<td></td>
</tr>
</tbody>
</table>

CMS – ASC Billing Guidelines

- IOLs and NTIOLs
  - No longer eligible for payment February 27, 2011.
  - Q1003 will deny.
  - Medicare will pay the same amount of cataract extraction with A-C IOL insertion that is paid for cataract extraction with conventional IOL insertion.
  - Codes for A-C IOL should be reported with codes for IOL (66982, 66983, 66984)
Billing for drugs and biologicals that are eligible for separate payment is strongly encouraged by CMS. ASCs should report with the correct HCPCS code and correct number of units.

If two or more drugs or biologicals are mixed together and administered, the correct HCPCS code should be used for each substance administered.

Modifiers recognized for ASC claim filing are:

- 52 Reduced services
- 59 Distinct separate procedure
- 73 Procedure discontinued after prep for surgery
- 74 Procedure discontinued after anesthesia administered
- RT
- LT
CMS – ASC Billing Guidelines

**Modifiers** recognized for ASC claim filing are:

- TC Technical component
- FB Device furnished at no cost/full credit
- FC Device furnished at partial credit
- PT Colorectal screening converted to diagnostic or therapeutic procedure/surgery

CMS – ASC Billing Guidelines

**Modifiers** recognized for ASC claim filing are:

- PA Wrong body part
- PB Surgery wrong patient
- PC Wrong surgery on patient
- GW Surgery not related to hospice patients terminal condition
Commercial Plans

- Commercial plans may or may not follow CMS policy for ASC claim filing.
- Check carrier site for information on claim filing.
- Check YOUR contract with payer.
- Following slides will show policies for some of the major carriers.

Aetna ASC Guidelines

Claims submitted on UB04 (CMS1450)
Aetna ASC Guidelines

Modifiers recognized for ASC claim filing are:

– 73 Procedure terminated after prep for procedure (25% of facility payment).
– 74 Procedure terminated after administration of anesthesia (50% if facility payment).
– 59 Distinct procedural service

Aetna ASC Guidelines

Modifiers recognized for ASC claim filing are:

– PA Wrong body part
– PB Surgery wrong patient
– PC Wrong surgery on patient
Aetna ASC Guidelines

- **Implants** can be reimbursable, check your contract and the carrier website.

- Have to dig a little on the website and remember, not all codes have a published policy.
BCBS ASC Guidelines

Check your BCBS carrier’s website for information.

In Texas – www.bcbstx.com

Manuals can be found on the website for reimbursement and claim filing procedures.
BCBS of Texas ASC Guidelines

BCBS requires a UB-04 be submitted for ASC claims.

CPT®/HCPCS codes should be reported for each surgical procedure performed.

Reimbursement of procedures is 100% of contracted rate for first procedure and additional procedures are per providers contract.

Manual states ICD-9 Procedures can be used.

BCBS of Texas ASC Guidelines

• **Modifiers** recognized for ASC claim filing are:
  – Claim filing manual states:
    “modifiers not recognized on the UB-04”.
  – For bilateral procedure report the CPT®/HCPCS code on two (2) separate lines.
BCBS of Texas ASC Guidelines

- **Implants** are reimbursed per provider contract for the following revenue codes:
  - 0274 Prosthetic devices
  - 0275 Pacemakers
  - 0278 Other implants

Cigna ASC Guidelines

- What Claim Form does Cigna accept for ASCs?
Cigna ASC Guidelines

- Go to your state manual to find out
Cigna ASC Guidelines

- In Texas – we are credentialed as facility and file on an UB04.
Cigna ASC Guidelines

The next slides are screen shots to walk you through finding information on the Cigna website regarding modifiers, etc.
Cigna ASC Guidelines

- **Modifiers** recognized for ASC claim filing are:
  - 73 Discontinued procedure prior to anesthesia administration
  - 74 Discontinued procedure after anesthesia administration
  - PA Wrong body part
  - PB Surgery wrong patient
  - PC Wrong surgery on patient
Cigna ASC Guidelines

Incorrect Use of Modifier 73:

• Modifier 73 should not be used after the administration of anesthesia.

• Modifier 73 should **not** be used for a discontinued outpatient surgery/procedure billed by a physician.
  – Physicians should use modifier 53 to report physician charges for a discontinued surgery/procedure.
Cigna ASC Guidelines

- **Modifiers** recognized for ASC claim filing are:
  - TC technical component
  - F modifiers (100% reimbursement)
  - T modifiers (100% reimbursement)
• **Modifiers** recognized for POSSIBLE ASC claim filing are:
  – 50 Bilateral modifier
  – 51 Multiple procedure modifier
  – 59 Distinct procedural service

• **Implants** are paid according to policy R13 posted on the payer website.
• Policy states:
  – Will reimburse according to terms of contract
  – May require pre-certification for select implants and procedures.
  – May review or audit charges for implants and implant procedures
  – Will not reimbursement for implants determined to be experimental/investigation because of lack of FDA approval
Cigna ASC Guidelines

• Implant policy further states
  – Implants can be permanent or removed once they are no longer needed.
  – Correct coding must be utilized to bill implants and implant procedures. Cigna providers guidance for coding specific implant devices.
  – CPT®/HCPCS reporting should describe as specifically as possible the implant procedure and implant.
Implant Related Coverage Policies

<table>
<thead>
<tr>
<th>Coverage Policy</th>
<th>Policy Number</th>
<th>Link to Policy</th>
</tr>
</thead>
</table>

375.9 Unspecified acquired deformity of toe

Experimental/Investigational/Unproven/Not Covered:

HCPCS Codes Description
L8641 Metatarsal joint implant


References

Academy of Orthopaedic Trauma, American Academy of Orthopaedic Surgeons, American Orthopaedic Foot & Ankle Society.
UHC ASC Guidelines

Services billed on a UB04.
UHC ASC Guidelines

**Modifiers** recognized for ASC claim filing are:

- PA Wrong body part
- PB Surgery wrong patient
- PC Wrong surgery on patient

UHC ASC Guidelines

- **Implants** other services billed to UHC
  - Check your contract
  - Review the UHC administration guide (2012)
    - Gives information for clean claims
    - Special instructions for plans by region
      - River Valley entities have special instructions for revenue codes on page 165
Procedure Review

• Keller Bunion Repair procedure with implant

How to Code

Medicare
CPT _____________
HCPCS ____________

Performed bilaterally
CPT _______________
HCPCS ______________
### How to Code

<table>
<thead>
<tr>
<th>Aetna</th>
<th>BCBS of Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td>• CPT _______</td>
<td>• CPT ___________</td>
</tr>
<tr>
<td>• HCPCS ______</td>
<td>• HCPCS _______</td>
</tr>
<tr>
<td>• Performed bilaterally</td>
<td>• Performed bilaterally</td>
</tr>
<tr>
<td>– CPT _______</td>
<td>– CPT ___________</td>
</tr>
<tr>
<td>– HCPCS ______</td>
<td>– HCPCS _______</td>
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### How to Code

<table>
<thead>
<tr>
<th>Cigna</th>
<th>UHC</th>
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<tbody>
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<td>• HCPCS ______</td>
<td>• HCPCS ______</td>
</tr>
<tr>
<td>• Performed bilaterally</td>
<td>• Performed bilaterally</td>
</tr>
<tr>
<td>– CPT __________</td>
<td>– CPT __________</td>
</tr>
<tr>
<td>– HCPCS __________</td>
<td>– HCPCS __________</td>
</tr>
</tbody>
</table>
Procedure Review

• Urinary sling procedure to correct incontinence for male patient

How to Code

• Medicare
  – CPT ______________
  – HCPCS ______________
### How to Code
(if on carrier approved list)

<table>
<thead>
<tr>
<th>Aetna</th>
<th>BCBS of Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td>• CPT ________</td>
<td>• CPT ________</td>
</tr>
<tr>
<td>• HCPCS ______</td>
<td>• HCPCS ______</td>
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</table>

### How to Code
(if on carrier approved list)

<table>
<thead>
<tr>
<th>Cigna</th>
<th>UHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>• CPT ________</td>
<td>• CPT ________</td>
</tr>
<tr>
<td>• HCPCS ______</td>
<td>• HCPCS ______</td>
</tr>
</tbody>
</table>
Website links

- https://navinet.navimedix.com (Aetna)
- https://cignaforhcp.cigna.com
- www.unitedhealthcareonline.com
- www.bcbtx.com (enter your state abbreviation)

Thank you