Common Billing Mistakes Costing Your ASC Money and Correct Modifier & Revenue Code Usage for ASC Claims

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Common ASC Coding and Billing Mistakes

- Billing for items or services not actually rendered or not documented
- Billing Non-Covered ASC services as Covered Services
- Using incorrect CPT codes for new technology
- Billing Medicare for Cataract Extraction procedures when the ASC does NOT purchase the IOL for the case
- Splitting Cases/Dates on GI Scope Procedures
- Upcoding of CPT procedure or diagnosis codes
- Inappropriate Unbundling of CPT procedure codes
- Place of Service Issues on claims for procedures performed in ASC facilities

Common ASC Coding and Billing Mistakes (Cont.)

- Failure to refund Credit Balances in a timely manner
- Medical Necessity issues
- Billing improperly for “cancelled cases” vs. “terminated cases”
- Facet Injection & Transforaminal Epidural Pain Management Injections as OIG & RAC Audit focus issues (Medical Necessity & frequency)
- Billing Medicare patients for procedures which are not covered in an ASC facility by Medicare
- Changing the Date of Service on claims to correspond with coverage dates
Common ASC Coding and Billing Mistakes (Cont.)

- Waiving Co-pays/Deductibles, “Courtesy” Discounts, or “Insurance-Only” – HIPAA violation for ALL payors
- Fragmented Claims
- ASC Global Periods
- Use of Signature Stamps to Authenticate Documentation
- Use of “Canned” OP Reports to document procedures
- ASC as the Place of Service must be clear in OP Report documentation
- Incorrect patient billing of Premium IOL Lenses used in Cataract procedures

Procedures Not Covered by Medicare

Medicare Billing for Non-ASC List Procedures

Medicare’s direction is that when procedures which are not on Medicare’s ASC List of approved procedures are performed in an ASC, the case should be diverted to a place of service (the physician’s office or the hospital) where that procedure is covered.

ASCs cannot charge Medicare patients cash for procedures which are covered in another place of service that are not covered in ASC facilities.

Claim Form Issues

Medicare requires that the CPT procedure codes submitted on the ASC facility and the surgeon’s claims should be identical. There should be no discrepancies. However, if you know the surgeon is not billing the correct CPT codes, the ASC should bill codes which are supported by the OP Report documentation.

Incomplete or incorrectly completed claim forms can result in unnecessary denials for ASC facilities.

Be sure to check that electronic and paper claim fields are populating correctly and claims are running smoothly through your claims clearinghouse.
**Modifier Usage**

It is VERY important to understand how to use modifiers correctly on ASC facility claims. Although there are some similarities between the billing for ASC facility services and physician services (both bill to Part B Medicare), there are some distinct differences, which can cause lost revenue on the facility side if the ASC billing is not done correctly – many of these differences relate to modifier usage.

**Modifier Usage**

There are also some similarities between billing for ASC facility services and billing for hospital services (billing of ASC services on a UB-04 claim form to many non-Medicare payors and using Revenue Codes on these claims), there are also some distinct differences in ASC vs. hospital claims – hospitals bill surgical CPT codes using the 360 Rev. Code and ASCs should use the 490 Rev. Code.

Some of these differences relate to Modifier usage, as well. ASC facilities usually bill for the use of Implants differently than hospitals.

**Modifiers**

**-50 Bilateral Procedures Modifier**

For Bilateral procedures, use the -50 or -RT/-LT modifiers when an identical procedure is performed on both the Right and Left sides of the body on like body areas (hands, knees, eyes, feet, arms, etc.).

- Do not mix the -50 Modifier with –RT or –LT Modifiers.
- Do not use Bilateral Modifiers on those CPT codes with verbiage describing procedures as “Bilateral” or “Unilateral or Bilateral.”
Bilateral Procedures

Medicare (in most states) directs that Bilateral procedures are to be billed by ASC facilities with CPT codes without using the -50 Bilateral Procedure Modifier. The -RT/-LT Modifiers can usually be used and is the preferred method. Do NOT use these Modifier rules for other payors unless directed to do so. Bill Bilateral procedures using the Modifier requirements requested by each payor.

Billing Bilateral Procedures

The 5 usual methods for billing Bilateral procedures are:

- Bill the same code as two line items, using the –RT modifier on one code and the –LT modifier on the other code. (**OK for Medicare)
  
  64483-RT $700.00  
  64483-LT $700.00

- Bill bilateral procedures as two line items with no modifier on the 1st code and the -50 modifier on the 2nd line item (same code).
  
  64483 $700.00  
  64483-50 $700.00

- Bill the procedure as a single line item on the claim with a –50 modifier on the procedure code. Be sure to double the facility fee.
  
  64483-50 $1,400.00

- Bill the same code as two line items with no modifiers. (**Medicare)
  
  64483 $700.00  
  64483 $700.00

- Bill the procedure as a single line item on the claim form with no modifier on the code and put a “2” in the Units column on the claim. Be sure to double the facility fee. (**Medicare)
  
  64483 $1,400.00  
  2 Units

Modifiers

-51 Multiple Procedures

ASCs should not use the –51 Modifier when billing their CPT codes. This modifier is for use on physician claims only, unless directed by the payor to use it on ASC facility claims.

-52 Reduced Services

Use this modifier when a procedure is partially reduced or eliminated at the physician’s discretion.

-58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

Use this modifier to indicate the performance of a procedure or service during the Global Period that was:

1. Staged;
2. More extensive than the original procedure; or
3. For therapy following a diagnostic surgical procedure.
Modifiers

-59 Distinct Procedural Service
Use this modifier to indicate the procedure was distinct or independent from other procedures performed during the same case, to identify procedures not normally reported together (due to CCI edits or “Separate Procedure” status in the CPT book), but which are appropriate to bill under circumstances such as:
- Procedure was performed in a different compartment/area
- Procedure performed at a different site or organ system
- Procedure was performed by a separate incision
- Procedure was a different excision area
- Procedure was performed on a separate lesion or was a separate injury not normally encountered or performed on the same day by the same surgeon.

Unbundling

Check each procedure code appropriate for the case with every other procedure code to be billed in the current Medicare CCI Unbundling Edits to see if any of the codes are components of another code to be billed. If codes are Unbundled, they might both be billable (using -59 modifier on the Unbundled code) under the following circumstances:
1. Performed at a different site or in a different organ system;
2. Separate incision/excision;
3. Separate compartment;
4. Separate lesion

Terminated Procedure Modifiers

-73 Terminated/Discontinued Ambulatory Surgery Center Procedure Prior to the Administration of Anesthesia
Used to indicate that a procedure was terminated due to medical complications after the patient had been prepared for surgery and taken to the OR, but before anesthesia was induced. To bill using this modifier, the patient MUST be IN the OR or procedure room where the procedure was to have been performed – if the pt. was in the Pre-OP area, don’t bill procedure to Medicare. Bill only the main CPT code for the procedure in this situation.

-74 Terminated/Discontinued Ambulatory Surgery Center Procedure After the Administration of Anesthesia
This modifier is appended to the CPT code for the intended procedure(s) to indicate that a procedure was terminated due to medical complications after anesthesia for the procedure was induced.
Terminated Procedures

Medicare Rules for Billing Terminated Procedures
- Cancelled or Postponed Procedures – Not billable.
- Terminated before Anesthesia is induced - use modifier -73 – reimbursed at 50% of allowable. To bill using the modifier, the patient MUST be in the OR or procedure room where the procedure was to be performed. If in the Pre-OP area, it is not billable.
- Terminated after Anesthesia is induced - use modifier -74 – reimbursed at 100% of allowable.
- Termination of an IOL Procedure.

Terminated Procedures

Required Documentation of Terminated Procedures for Medicare patients:
- Reason surgery was terminated
- Services actually performed
- Supplies actually provided/used
- Supplies not provided/used
- Services not performed
- Time actually spent in each surgical stage
- Time that would have been spent had the intended procedure(s) been completed
- CPT codes for procedure (had full procedure been performed)
This information can be documented by a nurse, but must be signed by the surgeon.

ASC Facility Global Period

The “Global Period” or “Post-operative Period” for ASC facilities is 24 hours from the time the surgery begins (for Medicare patients) – it is NOT 10 or 90 days like the physician’s Global Period. However, some payors may consider the Global Period to be 48 – 72 hours for ASC facilities.
If you receive a denial for what sounds like a global period issue (even if you were past the 24 hour period), the payor may not understand ASC claim rules and may think it is the same as those for physicians, so append the appropriate global period modifier like the physician would have to use and resubmit the claim.
Modifiers

-76 Repeat Procedure or Service by Same Physician
Use this modifier only if an identical procedure is performed following the initial procedure by the same surgeon.

-77 Repeat Procedure or Service by Another Physician
Use this modifier when a different physician repeats the same procedure that had previously been performed by another physician. It is usually assumed to occur on the same day that the initial procedure was performed.

-78 Unplanned Return to the OR for a Related Procedure During the Postoperative Period
Failure to use this modifier when necessary will probably result in a claim denial. This is the most common Global Period Modifier ASCs will use – it is for a return to the OR for a post-op hemorrhage.

Modifiers

-79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period
Use this Modifier to indicate than an unrelated procedure was performed by the same physician during the post-op period.

Anatomic Modifiers

-RT Right Side
-LT Left Side

It is extremely important to use the –RT and –LT Anatomic Modifiers on eye procedures and for podiatric procedures. Many orthopedic procedures require the use of these modifiers, as well. Not using them when they are necessary can effect reimbursement.

Modifiers

-TC Modifier
The –TC Modifier reflects that the Technical Component only of an x-ray or use of imaging is being billed for by the ASC.

Ophthalmology Modifiers
(Do not use –RT or –LT Modifiers with these modifiers)

- E1 Upper Left Eyelid
- E2 Lower Left Eyelid
- E3 Upper Right Eyelid
- E4 Lower Right Eyelid

Ophthalmology Medical Terminology (these are NOT modifiers to billing)

OD = Right Eye
OS = Left Eye
OU = Both Eyes
Modifiers

Digit Modifiers:
(Do not use –RT or –LT Modifiers with these modifiers)

Finger Modifiers
-FA Left hand, thumb
-F1 Left hand, second digit
-F2 Left hand, third digit
-F3 Left hand, fourth digit
-F4 Left hand, fifth digit

Right hand, thumb
Right hand, second digit
Right hand, third digit
Right hand, fourth digit
Right hand, fifth digit

Toe Modifiers
-TA Left foot, great toe
-T1 Left foot, second digit
-T2 Left foot, third digit
-T3 Left foot, fourth digit
-T4 Left foot, fifth digit

Right foot, great toe
Right foot, second toe
Right foot, third digit
Right foot, fourth digit
Right foot, fifth digit

Modifiers

It is not necessary to use -59 Modifiers with the Lid or Digit Modifiers, unless you need to report more than one procedure on the same Eyelid, Toe, or Finger, when it is separately-billable.

-SG Surgery Center

As of 2008, Medicare guidelines are that ASCs are NOT to use the –SG Modifier when submitting ASC claims to Medicare. This Modifier may be required by other payors on claims filed on CMS-1500 Claim Forms. It is NOT necessary to use the –SG Modifier on codes listed on claims filed on UB-04 claim forms going to other payors unless the payor specifically requires its use.

HCPCS Modifiers

-GX or -GY Modifier
Use when providing a services or item to a Medicare patient when that service or item is not covered by the Medicare program.

-GA Modifier
Use when an ABN or waiver form has been signed by a Medicare patient for a service not covered by Medicare (not a POS issue).

“Billing Everyone the Same” – Use the –GY or -GX Modifier
When billing CPT codes to a payor for a procedure you know is not covered by that payor, append –GY or -GX Modifier, which lets the payor know you are aware they don’t cover the service and you expect a denial for that charge.
Modifiers

- PT Modifier
  Use when billing a Colonoscopy claim to Medicare when the procedure was scheduled as a Screening study, but a biopsy was taken and/or a polyp was excised.

-33 Modifier
  Used the same way the –PT modifier is on Medicare claims, except it is used for claims filed to commercial payors in the same circumstance. Caution – many payors do not accept this modifier.

Wrong Site Surgery Modifiers:
- PA Modifier – surgery or other invasive procedure performed on the wrong body part.
- PB Modifier – surgery or other invasive procedure performed on the wrong patient.
- PC Modifier – the wrong surgery or other invasive procedure was performed on the patient.

Modifier Usage
It is important to append the appropriate –RT and –LT Anatomic Modifiers when needed to avoid unnecessary denials on claims. (e.g., Orthopedic, Podiatry, and Ophthalmology services).

Multiple Modifiers
When using more than one Modifier on a CPT code, append those modifiers which effect payment (i.e., Modifiers -GY, -59, -73, -74, -50, -52, etc.) before those modifiers which are informational in nature only (i.e., -LT, -T3, etc.). If using the –SG Modifier, it is always placed first on the CPT codes, followed by other modifiers.

Revenue Codes
Code 250 for Pharmacy Services
Code 270 for Medical/Surgical Supplies
Code 271 for Non-sterile Supplies
Code 272 for Sterile Supplies
Code 274 for Prosthetic/Orthotic Devices
Code 276 for IOL Implants (Cataracts)
Code 278 for Supplies
Code 278 for Other Implants
Code 320 for X-rays (Fluoroscopy) & other Imaging services
Code 360 for Surgical Procedures performed in a Surgical Hospital (NOT to be used by ASC facilities)
Code 370 for General Anesthesia
Code 378 for Other Anesthesia
Code 490 ASC Surgical Procedures – append this modifier to CPT procedure codes billed
Code 710 for Recovery Room Services (PACU)
QUESTIONS?

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