ASCs face more billing, coding and reimbursement challenges than ever before – as Medicare, BC/BS and other payors continue to make it more difficult to obtain reimbursement – compounded by compliance threats and the gearing up of Medicare RAC Audits. ASCs must keep up with coding and claim/billing requirements and changes and ensure that your staff has the knowledge and tools necessary to maximize all possible ways of (legally) getting paid. There are many avenues to explore at your ASC (which you might not have considered), that can immediately and directly add to your facility’s bottom line.

The following areas need to be reviewed at the ASC for possible gaps in efficiencies and to improve the collections for your Center:

- Scheduling
- Insurance Verification processes
- Patient Financial Responsibility
- Pre-Certification processes
- Capturing of Charges for Cases
- Correct Coding of Cases
  - Ortho. Procedures Frequently Miscoded
  - GI Procedures Frequently Miscoded
  - Urology Procedures Frequently Miscoded
  - Eye Procedures Frequently Miscoded
  - GYN Procedures Frequently Miscoded
  - Pain Management Procedures Frequently Miscoded
  - Diagnosis Coding
  - Terminated Procedures
- Timely Filing of Claims
- Patient Statements
- Insurance Follow-up processes
- Collections processes
- Payment Reconciliations
- Appeals of Denied Claims

### Scheduling

The first place to start reviewing your ASC for possible lost revenue is at the front-end of cases. The Scheduling area is very important, since this is the area where the case usually starts. The Schedulers are given some important information that is key to the future reimbursement for the case.
It is very important during the scheduling of cases that might have been caused by an accident (usually Orthopedic cases) for the scheduler to inquire specifically with the scheduling physician’s office if the injury was a Workers’ Comp. injury or caused by a car (or other) accident. If the injury was the result of an accident, the scheduler needs to obtain important information that will be needed for reimbursement, such as the Date of Injury (DOI), the Workers’ Comp. or Insurance Carrier’s name, address, the Claim Adjuster’s name and phone number, the Case Manager’s name and phone number, and the Claim or Case Number for the claim. These cases usually require strict approvals on the front-end, which can affect the scheduling of the case and the involvement of a nurse case manager. This information should be obtained during the Insurance Verification process. They also usually require a lot of documentation.

Another example of a procedure where the scheduling piece can mean a significant difference in proper reimbursement for the ASC would be with Colonoscopy procedures. With the scheduling of Colonoscopy procedures, asking the right questions during the scheduling process is very important and can mean the difference between the ASC being reimbursed as expected or having your claim denied.

At the time the physician’s office contacts the ASC to schedule a Colonoscopy procedure, the Scheduler needs to inquire as to the nature of the Colonoscopy procedure to be performed. Is the Colonoscopy procedure being performed as a Diagnostic Colonoscopy procedure for symptomatology OR is the Colonoscopy procedure being performed as a Screening Colonoscopy procedure only?

The importance of asking these questions so the ASC can perform Insurance Verification procedures with the amount of detail necessary to assure proper reimbursement and not have any surprises on the back end.

The relationship between the Scheduling and Insurance Verification processes are tied together closely. At the time benefits are checked, the necessary questions to be asked for Colonoscopy benefits depends on the payor and whether the case will be a Diagnostic Colonoscopy procedure or a Screening Colonoscopy procedure. If the case was scheduled as a Screening Colonoscopy procedure, the employee performing Insurance Verification procedures needs to be clear in stating to the payor that the Center needs benefits for a Screening Colonoscopy procedure (rather than just inquiring for benefits for the non-specific Colonoscopy procedure only). Many payors have vastly different benefits for Screening vs. Diagnostic Colonoscopy procedures performed for symptomatology (such as Rectal Bleeding, Constipation, Abdominal Pain, etc.). These differences can cause both the physician and the ASC to be paid less by the payor, and result in the patient having a much higher out-of-pocket amount owing for his/her procedure.

It is very important that benefits are properly explained to patients prior to the procedure being performed. When payors are asked for benefits for (non-specific) “Colonoscopy” procedures only, they will normally give the benefits available for Diagnostic Colonoscopy procedures. Many managed care plans have vastly different benefits for Screening vs. Diagnostic Colonoscopy procedures. Which can lead to the patient owing vastly different amounts for the procedure – depending on whether a Biopsy or Polypectomy were performed. It is important that the Insurance Verifier obtain the benefits for both Screening and Diagnostic Colonoscopy procedures if the study is scheduled as a Screening study, since sometimes a Colonoscopy set up as a Screening procedure can become a Diagnostic study during the procedure, if a problem is found. Keep in mind that if a problem (such as a Biopsy is taken of a suspicious area or a Polyp is removed) is found during a Screening study, the coding/billing (and subsequent benefits of how the claim would be reimbursed) would then be billed using the appropriate Diagnostic Colonoscopy procedure code for the procedure performed, instead of being billed with a Screening Colonoscopy code.
Insurance Verifications/  
Patient Financial Responsibility

As discussed above, the Insurance Verification process is extremely important to the ASC’s proper reimbursement for the case. First of all, if your Center is not performing Insurance Verifications on EVERY CASE, you are definitely leaving money on the table. Remember, even though the benefits information is usually coming from the scheduling physician’s office, their information might not have been updated recently and there may have been a change in the patient’s coverage, of which the physician’s office is unaware. Do not assume that the physician’s office has verified the benefits before they provide it to the ASC. It is extremely important to verify that the patient does have the insurance coverage that is reflected on the insurance card information given to the ASC. Insurance Verifications must always be performed prior to the procedure being performed and the following information should be verified:

• The patient DOES have coverage with the payor for the expected Date of Service, and the effective date of his/her coverage.

• For injury cases, it is essential during the Insurance Verification process that it is clear (information hopefully obtained during the Scheduling process) that the injury was a Workers’ Comp. injury or caused by a car (or other) accident. If it is a Workers’ Comp. case or other liability carrier, the patient’s regular health insurance (or Medicare) usually will not be involved with the payment for the case. Thus, the verifier must call the appropriate carrier who will be paying the case for proper verification of benefits. These cases usually require strict up-front approvals, which can effect the scheduling of the case and the involvement of a nurse case manager. Be sure to obtain full details on all of the payor’s requirements for these cases, to assure proper reimbursement for the case.

• If your ASC is not a Participating Provider with the payor, be sure to obtain out-of-network benefits for non-par providers. If the plan is an HMO, there may not be any benefits for out-of-network providers and your claim will be denied.

• Obtain the applicable Co-payment and Deductible information.

• Obtain information about any Secondary Coverage the patient may have and perform the same Insurance Verification procedures with that payor.

With some payors, the Insurance Verification information can be obtained on-line, which can save time.

We strongly recommend that the ASC discuss the benefits information with the patient prior to the surgery and thoroughly inform the patient of the amount they will be expected to pay. Make it clear that the owing amount is due prior to the surgery, and if that is a problem, set up a payment plan with the patient and have him/her sign some sort of document promising to pay the owing portion. Make sure the patient understands that the fees you are explaining to him/her are for the ASC owing amounts only, and that he/she will receive separate bills from other providers (such as the surgeon, the anesthesiologist, lab, etc.). Make sure that the ASC employee discussing the patient’s financial responsibility with the patient is familiar with the ASC’s fees and how they are set, and that the employee is giving out correct information. The patient’s financial responsibility information should be given to the patient in writing.

Prior to the procedure being performed (usually at the time of the patient’s Pre-op visit or on the procedure date), collect the owing co-pay and deductible amounts from the patient. Don’t wait to bill all of these owing fees to the patient after the surgery – **if your ASC routinely waits until AFTER the procedure to collect this money, you are leaving money on the table!** The likelihood that you will be able to collect all
of the owing fees after the surgery lessens the longer you wait to attempt to collect this money from the patient. It is important to let patients know they have an obligation and they are expected to pay their owing portion. Give patients options:

1. Your ASC needs to accept credit cards as a payment option for patients – this is very important! If you don’t accept credit cards, call your bank and set it up so you can.
2. Remind patients to bring their checkbooks with them at the time you are going to expect them to pay.
3. Have the ability to accept cash payments (keep a cash lockbox locked up and have good reconciliation procedures in place and employee accountability) from those patients who wish to pay in cash.
4. Work out realistic payment plans on the front-end with those patients who cannot pay the entire owing portion at the time of service.
5. Remember that in 2001, CMS took away the ASC’s ability to charge Medicare patients for procedures which are not on Medicare’s ASC List of covered procedures by having them sign an ABN. It is a compliance risk to charge patients for these procedures if the procedure is covered in another setting (such as the hospital).
6. If there are complicated financial arrangements to be made or the patient or responsible party becomes disruptive during financial discussions taking place in a common area (such as the ASC’s lobby), have a place available out of the common area to move the discussion to, so as to not be disruptive and concerning to other patients and their families.

At the time of verification, the ASC employee should inquire as to whether or not a Pre-Certification/Authorization is required for the procedure(s) being performed and the correct telephone number for the authorization (which might differ from that printed on the patient’s insurance card). This information should immediately be provided to the ASC employee responsible for Pre-Certifications. Don’t count on the doctor’s office to obtain the Pre-Cert. for your ASC.

It is very important to record all of the Insurance Verification information obtained in detail, preferably on a good form which prompts all pertinent questions and areas of inquiry. It is important to record the name of the person at the payor’s office from which the information was obtained (try to get a last name, or at least an initial for the last name – don’t just put “spoke to Debbie”, since there might be 10 Debbies at the company), the exact telephone number/extension of that person, the date the verification was performed, and the name of the ASC employee performing the verification.

When the front-desk staff have their first face-to-face encounter with the patient, they need to get a copy of the front and back of all of the patient’s insurance cards and a copy of the patient’s (and responsible party’s, if different) driver’s license. Be sure the ASC’s registration documents prompt a correct and current address and home and work telephone numbers for the patient and/or responsible party.

For Plastic/Cosmetic Surgery cases, it is extremely important to collect in full for the procedure prior to the case being performed. Since these are self-pay/cash-basis procedures involving discretionary spending, these patients should not be allowed to string out their payments over a long period of time. If you do allow payment plans for these patients, only allow payments to be broken down into 2-4 payments, and try to collect at least one-half of the total charge prior to the surgery date.

For those cases involving a claim to be filed with a payor with which the ASC does not have a contract, there is a possibility the payor might issue the ASC’s check to the insured, instead of to the ASC directly. Inquire as to payment policies when the ASC is non-par at the time of insurance verification, so you know the check will be coming to the patient/insured, instead of to the ASC. Be very clear with the patient in these circumstances that they will be receiving the check and that he/she must notify the ASC as soon as
payment is received and that he/she must immediately endorse the insurance check over to the ASC or write a personal check for the full amount upon receipt. The patient should sign something (e.g., a Promissory Note) before the surgery ensuring the payment will be made to the ASC by them, when this circumstance arises.

**Pre-Certifications/Authorizations**

Just as insurance benefits must be verified, the ASC must inquire on all cases if any Pre-Certifications or Authorizations are required for the case. If the information is known on the front-end, it is very important to inquire about authorizations for ALL of the procedures being performed – not just the first procedure listed on the scheduling form. If an authorization is not required for the first procedure, but is required for the second procedure listed, if the question is not asked, part or all of the claim could be denied for this omission.

If procedures that were scheduled/originally planned were not performed or additional procedures (not authorized on the front-end) were done during the case, another phone call needs to be made to the payor’s Pre-Cert. Department immediately after the surgery to inform them of the change, so they can alter the authorization information in their system, and ensure that the claim will be processed properly. Many payors only have a window of 24 hours after the procedure has been performed to notify them that the original authorized procedure was changed when the patient was in the OR.

Remember, obtaining the Pre-Certification does not mean the patient has insurance benefits, and it does not substitute for performing the Insurance Verification procedures. These authorizations are usually performed by nurses in a different part of the company from the benefits areas, or the company performing the authorization can be a totally separate company from the payor who will process the claim. These Pre-Certification nurses do not have any benefits information.

Be sure to obtain a Pre-Cert. Number or other type of proof that the authorization was obtained. Be sure to input the Pre-Cert. Number obtained in the appropriate area on the claim form. If the Pre-Cert. number is missing on the claim form, the claim will likely be denied. It is important to record the name of the person at the payor from which the authorization was obtained (try to get a last name, or at least an initial for the last name), the exact telephone number/extension of that person, the date the authorization was performed, and the name of the ASC employee obtaining the authorization. If the person issuing the authorization for the payor (or for some Workers’ Comp. cases) informs the ASC employee that she/he will be issuing a written authorization letter, request that the letter be issued immediately and faxed to the Center that day. Have some procedure in place to keep up with any delays to the Pre-Cert. information, so that no one “drops the ball” prior to the procedure being performed and everyone thinks a Pre-Cert. was obtained, but their letter never arrives or the payor’s phone call with the authorization number was never returned.

It is very difficult to obtain authorizations after the surgery is performed, so have good processes in place to assure that on those cases that do require authorizations, you have the authorization completed before the procedure is performed. Allow plenty of time to obtain authorizations, as they can be time-consuming. Don’t assume the physician’s office is going to get the surgery authorized – the ASC is usually on their own to be sure they have their own authorization prior to the surgery being performed. If it is a complicated case, you may want to arrange it so that the person performing the authorization (if he/she is not clinical staff) has access to a nurse to help explain the procedure to the payor, so as not to further delay the process.
Capturing of Charges for Cases/Correct Coding of Cases

Prior to billing the case, be sure all pertinent charge information is known. This includes the very important Implants used in the case. It is advantageous to be familiar with your facility’s contracts with payors and their policies on reimbursing for supplies and Implants. Some payors only allow the billing of some Implants, which may be referred to as a “carve-out” in their contract with the ASC. Since we all know that Medicare reimburses for few Implants, don’t assume that all of the other payors always follow Medicare rules and this keeps you from billing Implants to any payors – this is a mistake and you are leaving money on the table.

For example, some payors do not include the payment for IOLs in their payment for the 66984, 66892 and 66983 Cataract codes. For those payors, it is important to bill the IOL as a separate line item using HCPCS code V2630 for Anterior Chamber IOLs and V2632 for Posterior Chamber IOLs (do not bill these codes to Medicare). Of course, if a New Technology IOL (NTIOL) is used (instead of a standard IOL that would fall into the V-codes), use the Q1003 HCPCS code.

Be sure you have captured all of your billable charges. Always include a copy of the paper invoice when billing for Implants and file the claim as a paper claim, instead of an electronic claim, if an Implant is being billed. Bill Implants to Workers’ Comp. carriers (unless your state does not allow this), to accident carriers, to payors with whom your ASC has a contract that allows or does not prohibit the billing of Implants, and to those payors with whom your ASC does not have a contract. Use the appropriate HCPCS codes (5-digit codes that start with a letter, instead of a number), when they exist (good for orthopedic procedures – L8699 being the most common, and there are some good ones for use for podiatry cases). Some payors require the ASC to bill Implants with the more general 99070 supply code.

It is very important NOT to bill from the ASC’s Schedule. The coder should have an OP Report in hand and read it thoroughly for proper coding of all of the procedures performed in the case. Coding from the Schedule without an OP Report in hand is risky - both from a compliance standpoint (risk of billing procedures not performed, which is Fraudulent) and from a lost reimbursement perspective (by not billing for procedures that were performed that did not appear on the Schedule for the patient’s case). Do not code from the summary section at the beginning of the OP Report – it is imperative to read the entire OP Report and code only those procedures that are documented in the body of the OP Report. The summary section may only list some of the procedures performed – resulting in lost reimbursement for the ASC. Or, the summary section may state a procedure was performed, which was not documented in the body of the OP Report, which can result in a compliance issue for the Center.

Review your coding processes to be sure for each case:

- Do NOT code from the schedule
- Your facility’s coder is reviewing each code billed on cases involving multiple procedures in the CCI Unbundling material
- Your billing staff is using Modifiers appropriately, according to the individual requirements of each plan’s contract
- Monitor physicians’ use of “Canned” OP Reports and be sure they are documenting enough information that is tailored to that patient’s surgery to pass a payor’s audit
• Bill for Fluoroscopy used during procedures and Implants used to those payors with which the ASC does not have a contract, those payors who do not exclude those charges from the contracts the ASC does have, to Indemnity plans, and to Workers’ Comp. and accident payors. If you are trying to “bill everyone the same”, append the –GY Non-Covered Modifier to those codes which are disallowed by Medicare or other payors when billing Medicare, but that charge might be reimbursed by another payor.

Proper coding of cases is very important and effects proper reimbursement for the Center – or can exposes the ASC to compliance risks – more than anything else in the reimbursement process. The proper coding of ASC procedures is very complicated and cannot be adequately addressed in this session, however, the ASC managers should do all they can to assure the coding for the ASC is done correctly and that the Center’s staff has as much exposure as possible to coding and billing training for ASC procedures. Since many coders hired by ASCs come to their positions with a background in either hospital or physician practice coding/billing, they may not know about the billing of ASC services, which is a hybrid, and not like either setting from which the employee is usually experienced. Proper training on the front-end when he/she is hired to code for ASC facility services is very important. If your ASC outsources billing to a billing service, be sure that the company who is doing the facility’s coding is experienced and understands ASC coding and that the billing service is billing for the ASC’s services correctly. It is wise to have an independent organization audit the billing service’s claims for your cases at least once per year.

**Special Coding of Procedures Frequently Miscoded**

If your facility is doing ALL or most of the coding for the ASC using superbill documents where the physicians code, and no one at your facility is checking the OP Report with the surgeon’s coding, you are probably leaving money on the table.

➢ **Orthopedic Procedures Frequently Miscoded**

**Chondroplasty Procedures**

Chondroplasty (or Debridement) procedures are frequently mis-coded due to confusion over the CCI Unbundling edits for these codes. To clarify, the first thing to understand about when a Chondroplasty procedure is billable and when it is not (regardless of whether the 29877 code is Unbundled in the CCI edits with a notation of Allowed or Not Allowed), is to understand that Chondroplasties ARE billable when performed with other Arthroscopic Knee procedures when the Chondroplasty procedure is documented as performed in a *Separate Compartment* from the other procedure from which it is Unbundled. The key is understanding which compartment the surgeon is in when the Chondroplasty is performed and which compartment he/she was in when performing the other Knee Arthroscopy procedure(s). Thorough review of these OP Reports is essential.

Use the 29999 Unlisted Arthroscopy CPT code for a Debridement of the ACL – not the 29877 Chondroplasty code. The Patella, Medial and Lateral Compartments can be debrided – but not the ACL. Chondroplasties are not separately billable when performed with an Abrasion Arthroplasty procedure (29879), as that procedure includes a Chondroplasty.

The three compartments of the knee joint are the inner (medial), the outer (lateral), and the kneecap (patella or also called patello-femoral), which includes the Trochlear Groove.
Once you have clarified that the procedures were performed in different compartments, the following guidelines for coding Chondroplasty procedures should be followed:

- If the Chondroplasty is performed in the *same* compartment with the other Arthroscopic surgery procedures, it would be considered bundled in most cases, and would not be separately-billable. Check the CCI Unbundling material to be sure.

- The surgeon must document that the Chondroplasty was done in a different compartment than the repair or excision (in order to bill it with other procedures).

- Use the –59 modifier on the 29877 Chondroplasty code, to indicate it was performed in a separate area, when it is billable to payors other than Medicare.

- Chondroplasties can only be coded *once per joint*, regardless of how many compartments the surgeon debrides – i.e., if the Chondroplasty procedures are performed in more than one compartment, only use the 29877 code once.

- Special Instructions for billing Chondroplasty procedures on Medicare patients:
  1. Use the G0289 code in place of the 29877 code when billing Chondroplasties performed in a separate compartment to Medicare.
  2. Medicare does NOT reimburse ASCs for the G0289 code, so the –GY Not-Covered Modifier should be appended when billing this code to Medicare. It is useful to bill it because Medicare does reimburse the surgeon for this code and ASCs need to give Medicare the information that this procedure is being performed in ASCs, in hopes the code will be added to the Medicare ASC List in the future.
  3. The –59 Modifier is not needed when billing the G0289 code.
  4. Continue to use the 29877-59 code for payors other than Medicare.
  5. In order for the G0289 code to be billable to Medicare, the physician is required to document in the OP Report that he/she spent at least 15 minutes performing the Chondroplasty in the separate compartment from the other arthroscopic knee procedures.
  6. The G0289 code is also for use for the Removal of Loose Bodies or Foreign Bodies performed in a separate compartment from the other Knee Arthroscopy procedure from which the usual Chondroplasty/Loose Body/Foreign Body codes are Unbundled in the CCI Unbundling material. The same documentation and billing requirements apply.
  7. If a Chondroplasty was the ONLY procedure performed, use the 29877 code on Medicare claims, as usual, and it should be payable.

**Tendon Grafts with ACL Repair Procedures**

In some circumstances, the harvest of a Hamstring Tendon Graft is billable when used for Arthroscopic ACL Repairs, however, the majority of times this is not separately billable. The 20924 code for the harvest of a Tendon Graft states “from a distance”, and billing this code with the 29888 ACL Repair code is not allowed, because the tendon graft is usually obtained from a separate incision on the *same knee*, which does not constitute a far enough distance for billing purposes to bill it separately, according to the CPT Assistant publication. It is only billable when it is obtained from the ankle area on the same leg, from the opposite knee, etc. This is confusing because the 20924 code is not Unbundled from the 29888 code, but nevertheless, it is not billable when the graft is obtained from the *same knee*. 
GI Procedures Frequently Miscoded

When a GI procedure has to be stopped or is not completed because of problems with the scope, irregular patient anatomy, encountering a tumor, or a poor prep, the ASC should append either a -52 Reduced Procedure or the -74 Discontinued Procedure Modifier to the CPT code for the procedure that was terminated. The choice of modifier would depend on the preference of the payor to whom the claim is being submitted.

When the word “Snare” appears in a Colonoscopy OP Report as the technique used to remove a polyp, use a Snare procedure code, rather than a code driven by the temperature. For example, if the OP Report states a polyp was removed by “Cold Snare” or “Hot Snare”, use the 45385 Snare Polypectomy Colonoscopy code.

For either a Colonoscopy or EGD, if the one lesion is biopsied, and a separate lesion is removed during the same case, code both the biopsy of the lesion and the removal of the separate lesion – as long as the lesions are at least one cm. apart. Append a -59 Modifier to the biopsy procedure, if it is Unbundled from the excision procedure.

If an EGD is performed with a biopsy, and then the physician removes the scope and performs an Esophageal Dilation by unguided sound, it should be billed using two CPT codes – CPT code 43239 for the EGD with a biopsy and code 43450 for the Esophageal Dilation.

If an EGD is performed with a biopsy, and then the physician performs an Esophageal Dilation using the scope instrument itself, only the 43239 EGD with Biopsy code is billable. If no Biopsy is performed and the only procedure performed is an Esophageal Dilation using the scope instrument itself, only the 43235 Diagnostic EGD code is billable.

Use code 43243 for an EGD with injection sclerosis of esophageal and/or gastric varices.

Use code 45381 for a Colonoscopy in which Saline is injected to raise a polyp, ink is injected or Tattooing of a lesion is performed. This code is not usually Unbundled from the Biopsy or Polypectomy codes.

If the physician attempts – but fails – to remove a polyp by one (example, Snare) technique, but is successful at removing the polyp via another technique (such as Hot Biopsy Forceps) only bill the CPT code for the procedure that was successful (45384).

If an EGD with a Polypectomy by Cold Biopsy Forceps is performed, use the 43258 Ablation code – not the 43239 Biopsy code.

Use code 45380 for Colonoscopy procedures performed with Biopsies and/or the Removal of all or portions of Polyps using Cold Biopsy Forceps.

Use code 45383 for colon polyps treated by the Ablation technique, where a polyp is removed using the APC, laser, heat probe, or other device to cauterize it or the remnants of a polyp previously removed during a colonoscopy procedure. Use this code also when polyps are Fulgurated.

Colonoscopy procedures performed through Stomas (Ileostomy and Colostomy patients) are coded from section 44388-44397 codes.
**Urology Procedures Frequently Miscoded**

**Bladder Tumors**

The physician’s documentation in the OP Reports for Bladder Tumors must be extremely detailed to correctly code these procedures. These codes have special guidelines. Bill one code for each size/area of lesion removed. Bill the applicable code once for Single or Multiple Tumors in the same size section. For example, if the surgeon fulgurates 2 Small lesions, 1 Medium tumor, and 3 Large tumors, bill code 52234 x 1, code 52235 x 1, and code 52240 x 1. DO NOT add tumor sizes together to code these procedures – each tumor should be measured individually to determine the appropriate category from which to code. If the physician does not properly document tumor sizes in the OP Report, the Path. Report will not be helpful if the tumors were fulgurated, instead of excised and sent for pathology. These codes fall in the 52224-52240 section.

Use code 52353 for a Lithotripsy, Electrohydraulic or Laser treatment by Cystourethroscopy for a Stone (Calculus) of the Kidney, Ureter or Bladder. If a Lithotripsy of a Stone is performed by Extracorporeal Shockwave (ESWL), use code 50590.

**Eye Procedures Frequently Miscoded**

**“Difficult” Cataract Procedures**

The 66982 code is used to bill “Difficult” Cataract Extraction procedures for those patients with special problems which make the procedure more difficult, require the surgeon to utilize unusual techniques, and involve a higher risk.

Patients in this category include:

1. Pediatric patients (under age 8)
2. Patients with weakened or absent lens support structures from:
   - Glaucoma
   - Small pupils
   - Male Patients on Flomax
   - Subluxated Lens
   - Pseudoexfoliation
   - Trauma
   - Marfan Syndrome
   - Uveitis

Special coding provisions when using the 66982 code require that you can only use this code for issues the physician identified prior to the surgery. The code cannot be used for difficulty with a normal cataract procedure or obstacles that come up (unexpectedly) during the normal cataract surgical procedure. For diagnosis coding of this procedure, list the Cataract code first, then use the diagnosis code (i.e., Glaucoma, etc.) for the problem that made the surgery fall into the “difficult” category as the second diagnosis code.
GYN Procedures Frequently Miscoded

Laparoscopic Lysis of Adhesions

Laparoscopy procedures often include Lysis of (incidental) Adhesions, which are not separately billable most of the time. The only time the Lysis of Adhesions procedure would be separately billable from other laparoscopic procedures from which the Lysis procedure is Unbundled in the CCI Unbundling material would be if the Lysis of Adhesions procedure is performed for a different medical reason (with documented separate medical necessity – i.e., a different diagnosis) than the laparoscopy, the Lysis procedure was performed in a different area than the other laparoscopy, and the surgeon documents in the OP Report that he/she spent a significant amount of time performing the Lysis procedure. If all of these circumstances are met, you can bill the Lysis of Adhesions procedure using the -59 Modifier.

Sling/TVT Tape Procedures

The Sling Operation for Stress Incontinence performed Laparoscopically is coded 51992. Use the 57288 code if the procedure is performed as an Open procedure. According to the CPT Assistant newsletter, CPT code 57288 describes the placement of fascia or other materials at the urethrovessical junction to encircle and suspend the urethra for treatment of stress incontinence. The ends of the sling are pulled toward the symphysis pubis and fastened to the rectus abdominus sheath. This procedure is a combined anterior vaginal and abdominal approach. In code 51992, the endopelvic fascia is opened and a tunnel is dissected between the urethra and vaginal mucosa, sling material (cadaver or synthetic) is then passed through the tunnel and secured to Cowper's ligament bilaterally. If tape is used in the procedure, don’t forget to bill for the TVT tape implant - the C1771 HCPCS code can be used to bill for the sling supply to some payors, if the payor reimburses for Implants – however, don’t use C-codes to bill implants to Medicare. Other possible codes to use instead (depending on the payor) include L8699 or 99070.

Hysteroscopy Procedures

- Use code 58555 for a Diagnostic Hysteroscopy, which would not be billable if a more extensive procedure is performed using the hysteroscope. This code is designated as a “Separate Procedure” in the CPT book.
- When a Hysteroscopy procedure includes a biopsy or polypectomy, and is performed with or without a D & C, it is coded 58558.
- When Essure® or similar Implants are used for birth control, use code 58565 for the placement of these devices performed using a hysteroscope.
- ACOG (the American College of Obstetricians and Gynecologists physician association) directs to use code 58563 for any Endometrial Ablation procedure performed under Hysteroscopic Guidance (by endometrial resection, electrosurgical ablation, or thermoablation) – whether the Hysteroscope remains in the uterus during the ablation procedure or not.
- Use code 58353 for a Thermal Endometrial Ablation procedure performed without Hysteroscopic Guidance (such as those performed with a balloon).
Myomectomy/Fibroid Excision Procedures

Myomas are growths in the uterus, which are more commonly referred to as fibroids or fibroid tumors, and they are the most common growth of the female genital tract. These tumors are benign and they are usually characterized as round, firm masses of the muscle wall of the uterus. Myomas are composed of smooth muscle and connective tissue, they can grow to be quite large, and are very common, as they affect as many as 30 percent of women. The growth of fibroid tumors is thought to be stimulated by a woman’s Estrogen. Common symptoms of fibroids include dysfunctional uterine bleeding, cramps, abdominal pain and pressure.

According to the AMA CPT Assistant, there are several different types of uterine fibroids, which are classified based upon their location:

- **Intracavitary myomas** are fibroids that are located inside of the uterus.
- **Submucous myomas** are fibroids located partially in the uterine cavity and partially in the wall of the uterus.
- **Intramural myomas** are fibroids usually located in the wall of the uterus. Their size can range from microscopic to larger than a grapefruit.
- **Pedunculated myomas** are fibroids connected to the uterus by a stalk.

Coding of these procedures is based on the method of approach to remove the fibroids, the number of myomas removed, and the total weight of the tissue removed.

Use code 58140 for an open Myomectomy procedure, involving the excision of 1 to 4 intramural fibroid tumor(s) of the uterus with a total weight of 250 grams or less and/or removal of surface myomas, performed via an abdominal approach.

Use code 58145 for an open Myomectomy procedure involving the excision of 1 to 4 intramural fibroid tumor(s) of the uterus with a total weight of 250 grams or less and/or removal of surface myomas, performed via a vaginal approach.

Use code 58146 for an open Myomectomy procedure involving the excision of 5 or more intramural fibroid tumor(s) of the uterus with a total weight greater than 250 grams, performed via an abdominal approach.

Code 58545 is for a Laparoscopic Myomectomy with the excision of 1-4 Intramural Myomas with a total weight of 250 grams or less and/or the Removal of Surface Myomas.

Code 58546 is for a Laparoscopic Myomectomy excision of 5 or more Intramural Myomas with total weight greater than 250 grams.

Pain Management Procedures Frequently Miscoded

**Sacroiliac Joint Injections**

When coding sacroiliac joint injections (frequently referred to as SI Joint Injections), ASC coders are frequently faced with a quandary about which code to use. The coding choices are CPT
Codes 27096, G0260 and 20610 – the key to correctly coding these procedures is understanding in what circumstances to use each code,

Code 27096 - Injection procedure for Sacroiliac Joint Arthrography and/or Anesthetic/Steroid

Code G0260 - Injection procedure for Sacroiliac Joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without Arthrography

Code 20610 - Injection; major joint or bursa

When billing for an SI joint injection performed with arthrography imaging, the choice is narrowed down to 27096 or G0260 – with the final decision being based on the payor to which the claim is being filed.

When the SI joint injection claim is being filed to Medicare, the ASC must use code G0260 to bill the SI Joint Injection. This is one of those rare situations where the ASC’s claim coding will NOT match the physician’s claim coding for the same procedure, as the professional (physician) claim for the SI joint injection will be billed to Medicare using the 27096 code, which is not covered by Medicare for the ASC.

The ASC should use code 27096 to bill SI joint injections to payors other than Medicare, unless the payor specifically requests the G-code instead of the 27096 code. Per CPT Assistant guidance, the 27096 code is to be used only when imaging confirmation of intra-articular needle positioning is used in the procedure.

For the radiology component used to perform SI joint injections, use code 73542-TC for Arthrography, which may not be covered by all payors. For Fluoroscopy used in SI joint injections not performed with Arthrography use code 77003-TC. If the payor does not cover these codes, don’t bill them or bill them using the –GY Non-Covered Modifier preceding the –TC Modifier.

According to CPT Assistant guidance, if an SI joint injection is performed without the use of radiologic guidance, neither the G-code nor the 27096 should be billed. SI Joint Injections performed without the use of guidance should be billed using the 20610 code for an Injection into a Major Joint (which is paid at a very low amount by Medicare). The 20610 code would be used by both the physician and the ASC facility for that type of procedure.

Diagnosis Coding

Do you know how important diagnosis codes are to getting your claims paid? The answer is VERY important. Diagnosis codes are the mechanism for providing payors with the “what” and “why” procedures were performed. They describe diagnoses, signs, symptoms, chronic and acute problems, and conditions and provide the tools to report the Medical Necessity of the procedure(s) performed. Over 85% of claim denials for “Medical Necessity” reasons are a result of incorrect or non-specific diagnostic coding. If you get a denial for “Medical Necessity” reasons, the first thing to look at is the diagnosis code for your appeal.

Familiarize yourself with Medicare Medical Policies for procedures performed in your ASC. If there is a Medicare Local Coverage Determination (LCD) Policy for a procedure performed in
your ASC (Colonoscopies, Cataracts, Blepharoplasties, some Pain Management, ENT procedures, etc.), print those policies from the Medical Policy section of your Medicare Carrier’s website and follow those diagnosis listings carefully on all Medicare claims. If you list as the first diagnosis on a Medicare claim a diagnosis from the LCD policy, there should not be a denial for Medical Necessity reasons. However, if you list as the first diagnosis on a Medicare claim a diagnosis that is not on the LCD (such as Hemorrhoids on a Colonoscopy claim), your claim will likely be denied.

E-codes are used on Workers’ Comp. claims to convey how an accident happened. They are not to be used as the first diagnosis or the only diagnosis on a claim. Do not use them on Medicare claims.

Coding Neoplasms

Codes for Neoplasms are located in the Neoplasm Table in Volume I of the ICD-9 book and are located according to site or anatomic location of the tumor.

Tips for Coding Neoplasms:

- If the documentation does not indicate whether the malignant tumor is primary or secondary, code it as primary.
- Unless the coding book indicates otherwise, assume the following are usually secondary (metastatic) sites: Bone, brain, meninges, peritoneum, pleura, spinal cord, and retroperitoneum.
- Wait until the path report comes back prior to coding the claim for those procedures that look like a malignant process might be involved (i.e., a Breast tumor, patients with previous cancer who have a new growth, use of the word “suspicious” in the documentation, etc.), as the exact diagnosis is needed for correct coding of neoplasms.

- Terms for Neoplasms:
  Malignant – Cells which spread/multiply with an invasive nature to other parts of the body
  Primary Site – The area of the body or organ that was the original site of the malignancy
  Secondary Site – The area of the body or organ to which the tumor has metastasized or spread to and grown
  Ca. In Situ – A pre-malignant condition where a tumor is undergoing malignant changes, but is still localized at the point of origin
  Benign – Cells that grow, but are non-invasive in nature and do not spread to distant sites
  Uncertain Behavior – Neoplasms which are changing in nature, and are neither malignant nor benign at the time of diagnosis, but may undergo malignant changes in the future
  Unspecified Nature – The documentation does not specify the behavior of the neoplasm as malignant or benign.
Terminated Surgical Procedures

Procedures which are Cancelled or Postponed
If a procedure is cancelled due to medical or non-medical reasons before the ASC has expended substantial resources, no payment is allowed by Medicare. **Do not bill.**

Procedures which are Terminated Before Anesthesia has been Induced
If a procedure on a Medicare patient is terminated due to medical complications after the patient has been prepared for surgery and is taken to the procedure room or OR where the procedure was to be performed, but before anesthesia has been induced, Medicare should reimburse at 50% of the allowed amount. Append the –73 Modifier to the billed CPT code for the 1st procedure that was planned/scheduled, but was not performed.

***The patient MUST be physically located in the OR or procedure room when the procedure is called off in order to bill Medicare. If the procedure is called off when the patient is in the Pre-Op or pre-procedure holding area, it is not billable to Medicare.

Procedures which are Terminated After Anesthesia has been Induced
If a procedure on a Medicare patient is terminated due to medical complications after anesthesia has been induced, Medicare should reimburse at 100% of the allowed amount. Append the –74 Modifier to the billed CPT code if the 1st procedure has been started and the patient has received anesthesia for the case.

- When anesthesia was administered only, but none of the procedures which were planned were started at all, bill the code for the 1st procedure with the -74 Modifier and the rest of the planned procedures are not billable.
- If several procedures were to be performed and some (but not all) planned procedures were completed, bill as follows:
  1. Bill procedure(s) which were completed at full fee **without** the –74 Modifier.
  2. Bill those procedure(s) which were started but were not completed at full fee with the –74 Modifier.
  3. Those procedures which were planned but were not started at all are not billable.

Termination of an IOL Procedure
If a procedure involving an IOL insertion, in which the IOL was not inserted, the allowance for the unused IOL will be deducted from the ASC’s payment prior to calculating their payment. Be sure to write a letter to Medicare notifying them the IOL was opened, so you will be reimbursed – since the IOL must be wasted.

Documentation
The documentation requirements for Medicare claims for discontinued procedures are quite laborious. The information can be captured on the OP Report or by completing a form with the information, or it can be recorded by a nurse. The surgeon must sign the documentation, regardless of who completes the required documentation.

Timely Filing of Claims
It is very important to be familiar with your facility’s payor contracts regarding their requirements for the timely filing of claims. Some payors require claims to be filed within one year of the date of service (Medicare), and some payor’s requirements are much more restrictive and have a timeline of as little as 30 days. HMOs typically have tighter timelines for timely filing than do other payor types.

Have good procedures in place at your facility for capturing all cases performed and necessary claim information on those cases to file claims within the required timelines. Checking the OP Reports with the Schedule is one good way to capture all of the cases. Have policies in place to bill out cases within some reasonable period of time after the surgery. Realize that some cases cannot be accurately billed until the Pathology Report comes back.

Bill claims electronically, whenever possible. Not all payors will accept electronic claims, so be aware of payor requirements. Those claims where you are billing for Implants may need to be filed as paper claims, due to the fact that a copy of the Implant invoice must be sent with the claim, for proper reimbursement. Those claims involving Unlisted procedure codes must be billed as paper claims and sent with a copy of the OP Report. Since most Workers’ Comp. carriers require a copy of the OP Report to process their claims, it will save you time and money to submit those as paper claims with the OP Report, and you might want to send them Certified Mail/Return Receipt Requested, for proof that the claim was submitted.

Be sure claim forms and electronic fields are thoroughly and correctly completed. Be aware of payor guidelines and requirements for billing of Bilateral procedures and for Modifier usage.

**Patient Statements**

For those patients carrying balances and/or with payment plans, it is very important to send out Patient Statements on a regular basis. For those patients with poor payment habits, add progressively strong dunning messages to Patient Statements and/or use progressively stronger collection letters. If a patient sends small payments that are not in keeping with payment plan guidelines, you might want to return his/her check with a strong letter reiterating the payment plan requirements and request that a check for the correct payment amount be returned immediately.

**Insurance Follow-Up**

It is very important to follow-up with payors on claim status consistently and at regular intervals. Usually, ASC staff performing follow-up duties work from some sort of an Aging Report generated from the ASC’s billing system. Those balances owing from insurance payors should be worked from highest to lowest balance – not alphabetically. Follow-up staff should contact the payor by telephone (many payors have electronic systems that can be accessed without speaking to a person, where a number of claims can be checked at the same time – if a person is contacted at the payor, they may limit the number of claims for different patients that can be checked) or via the internet to check claim status. Checking claim status involves the following elements:

- Did the payor receive the claim? If so, when? If not, inquire if you can fax the claim to the payor immediately, so that it can be put through for processing.
- Is the claim paid or denied?
- If the claim has paid, in what amount was the check issued, and what was the check date and when will the check be released and sent out?
• If the ASC is not a participating provider with the payor and the claim has paid, to whom was the check issued?
• If the claim was denied, what was the denial reason?
• If the claim was denied, what are the payor’s appeal procedures? (They may refer you back to the ASC’s provider manual with that payor for the appeal procedures).
• If the claim has not paid or denied and is suspended for some reason, what is the problem/question and what is the next step? Speak to a person at the payor and request that they fax you a letter with the requested/needed information so that you can immediately begin gathering the requested information for them to return to the payor as soon as possible to get the claim adjudicated.
• It is important to record the name of the person at the payor from which the information was obtained (try to get a last name, or at least the first name and an initial of the person’s last name), the exact telephone number/extension of that person, and the date of the telephone call. The ASC employee should make detailed notes of the conversation in the system and record his/her name as the employee obtaining the information.

If you have more than one person performing insurance follow-up procedures, you may want to divide the follow-up caseload by the payor (divide half of the payor alphabet and give to one employee and half to the other) or if you have a large Medicare payor mix, give Medicare to one employee and the rest of the payors to the other employee, etc. Consistency with allowing the employee to learn the habits and requirements of the payors whom they check regularly will speed up the process and improve efficiencies.

When you feel that the payor is “giving you the run around”, get the patient/insured involved. Let them know the payor is not processing your (legitimate) claim, and you might want to consider informing the patient that he/she might be billed for the balance. The patient/insured can be very helpful in negotiating with the insurance company in these problematic circumstances. If you continue to have problems being reimbursed by a particular payor, contact your Provider Relations Representative at the plan or speak with the head of the HR department at the insured’s employer to enlist their help with claim resolutions.

Check with your payor contracts and know the laws in your state for the length of time the payor has (legally) for processing “clean claims”. If the payor continually misses that claim processing deadline (which is frequently 30-45 days from the date the claim was received), do not hesitate to write a letter to your state’s Insurance Commissioner as a formal complaint. Forward a copy of that letter to the offending payor at the same time – you should receive a claim determination (hopefully, a check) shortly.

It is well worth the ASC Manager’s time to perform regular reviews of payor EOBs for denial reasons. Look for trends – this information will give you a wealth of information on operational issues in the ASC that can be improved and bring your money in more efficiently. Review the payment documentation (EOBs) closely to see if the carrier/payor:

• Paid on all of the charges billed at the contract rate.
• Denied any line items billed.
• Included an explanation for any unpaid or unprocessed charges.
• Changed anything (codes, charges, etc.) from their original billing (down-coded).

Correct any missing or incomplete information you can and resubmit the claim for re-consideration. If the claim has been denied, proceed with the appeals process discussed later. Be aware of the payor’s requirements for submitting “corrected claims”.
Collections

No one likes the collections process, and it can be laborious. However, persistence and tenacity pays off, and it is YOUR Center’s money you are fighting for – so forge ahead and don’t let the ball drop. For those patients with poor payment habits, add progressively strong dunning messages to Patient Statements and/or use progressively stronger collection letters. Then, if the account gets too old, ship it out to the collection agency. Have a relationship with a good collection agency, and ship accounts out to them when the account is no older than 120 days in age. You might want to give it to them at 90 days. The sooner the collection agency receives it, the fresher the information will be and the greater your chance of receiving your money. Don’t back down, and know that some cases may wind up in court. Have an open dialogue within your ASC at the Board level as to how far collection procedures will progress. Have these procedures in writing. Be consistent and fair with collections processes.

A word of caution – if you ever receive a check from a patient that is not for the full amount owing and the patient writes “final payment” or “payment in full” in the comment section in the lower left-hand corner of the check, do not cash the check. While this varies from state to state, in many states, if a vendor (the ASC, in this case) does cash and deposit a check with a statement of this type on the check, it can be considered that the vendor is accepting the lesser amount as payment in full, and you can void any further collections actions against that patient.

Payment Reconciliations

When the insurance company pays the claim and the Explanation of Benefits (EOB) is received by the ASC, the payment is posted to the account. This process must be done properly, and it is essential that the ASC have a well-trained, highly competent, and trusted employee in this position. The variety of EOBs that come from the different payors can be very confusing to interpret, which can affect proper posting to the patient’s account, which can have far-reaching consequences. It is essential to have detailed training for the payment posters at the Center. Have consistent written procedures for posting payments and adjustments in the system. You don’t want to (accidentally) bill a patient for a balance that should have been written off as a contractual adjustment. Be sure the poster understands how they are supposed to post a payment from an EOB when the payor has reimbursed globally with one payment amount and given no detail on the EOB by line item charge to match your claim form vs. posting an EOB that is paid based on the ASC’s claim form line item charges.

Appeals of Denied Claims

Finally, Appeals of Denied Claims are always an unwelcomed challenge. No one likes to have their claims denied. If you pay good attention to many of the processes discussed above, hopefully, your Center’s number of denied claims will dramatically decrease. However, some claims will be denied, and we encourage vigorous appeals when this occurs. Again, persistence and tenacity pays off. Insurance companies are banking on stringing things out long enough and making the “hassle factor” so high that you will give up. Don’t give in and give them their way! All payors have appeal procedures, however, each payor’s procedures can differ greatly from payor to payor. If your ASC has a contract with the payor, the appeal procedures should be outlined in your ASC’s provider manual for that plan. Review the payor’s appeal procedures and follow them to the letter. Pay close attention to timelines. Many appeals are unsuccessful due to not following their guidelines closely or missing deadlines. If your facility does not have a contract with the payor and your claim is denied, your appeal rights will likely be significantly more restricted.
Medicare’s appeal guidelines have five levels:

1. Redetermination
2. Reconsideration by Qualified Independent Contractor (QIC)
3. Administrative Law Judge Hearings
4. Departmental Appeals Board/Appeals Council Reviews
5. U.S. District Court Review

With Medicare appeals (as well as appeals to most other payors), it is very important to include some sort of additional documentation to support your position and not keep working your way up the appeal ladder with the same stale information that does not do anything to sway their decision and bolster your position to get the claim paid. Get the surgeon for the case involved to help you. If your claim has been denied, it is possible that the surgeon’s claim is being denied, as well. Sometimes, all that is needed is for the surgeon to write a letter of medical necessity with more information.

Realize that 85% of claims denied for Medical Necessity reasons are denied because of one simple thing – the payor doesn’t like the diagnosis code used on the claim. This is the first place to check when there is a denial for this reason. If it is a Medicare claim, check with Medicare to see if there is an LMRP or LCD policy in effect for the procedure (they have many – Colonoscopies, some Pain Management procedures, Blepharoplasties, etc.) – if there is one, the policy will provide you with a list of what diagnosis codes are allowed for the billing of the procedure. Don’t fraudulently bill a code on the list, if none of the codes apply, however, if you are able to find a code that fits for that patient for a condition or symptom the patient has that is documented in the OP Report, the Path. Report or the H & P for the case, you can use that condition to get the claim re-processed.

If the denial reason involves the ASC’s procedure coding not matching the coding on the physician’s claim, do some research into what codes the physician billed and see if your coding was correct. If it is obvious that the physician coded his/her claim incorrectly and you feel that your coding is correct, pursue your appeals based on your correct coding. Do not follow the physician’s coding if you know his/her coding is incorrect. The ASC is responsible for their own facility coding and if the physician is wrong and gets in trouble for that, the ASC will be safe billing the correct codes, even if they differed from the physician’s.

The Most Common Reasons for Medicare Claim Rejections

Claim rejections from Medicare are a particular problem for providers. The usual reasons for claim rejections include:

- The patient’s ID/Subscriber number is incorrect, missing, or placed in the wrong field on the claim form.
- The provider’s signature in the appropriate field on the claim form (field 31 on the CMS-1500 claim form or field 85 on the UB-92 claim form) is missing.
- There are incorrect Dates of Service or required dates are missing on the claim.
- The diagnosis does not correspond with or support the services billed, or lacks specificity (using non-specific codes).
- Procedure codes used on claims are missing, incorrect, or unlisted codes were used, without justification/explanation given.
- The field for the ASC’s fee on the claim has been left blank.
- The referring/ordering physician’s name and/or NPI # are missing from the claim form.
• Sending in another claim on a previously-filed claim (duplicate claims). It is best to call and check the status of a previously-filed claim before you send in another one.
• Claims not being filed in a timely manner (within 12 months of the date of service to Medicare).

Guidelines for “Clean” Claims

To assure claims are “clean” and will be processed properly the first time they are submitted, here are some suggestions:

• Check every field of the claim to be sure they are completed properly prior to transmitting the claims electronically or sending out paper claims.
• It is very important for the ASC to keep insurance and demographic information on patients up-to-date. It is very important to do thorough insurance verification and check on pre-certifications for every case performed in an ASC.
• It is wise for the ASC to manage their fee schedule and update fees every year.
• To avoid duplicate claim filings, be sure payments are posted in a timely manner, do not submit a paper claim for the same services if the claim is already going electronically. (Electronic claims are typically paid faster than paper claims).

If your claims are ever subject to post-payment audits (usually by Medicare or BC/BS), you can expedite the process by responding to their audit in the following manner:

• Be cooperative and pleasant.
• Submit all records requested in a timely manner.
• If you have been requested to supply OP Reports or copies of pathology results, be sure the lesion or pathology in question can be easily identified to the examining person.
• Submit only current records for that patient relating to the surgical case in question (not the patient’s entire chart, or information from previous cases performed for that patient on other dates of service).

As you can see from all of the different areas in the ASC we have reviewed, there are many possibilities where hidden money can be found by some improvement in operations that can be changed relatively painlessly – adding directly to your facility’s bottom line!

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