ASC BILLING and CODING STRATEGIES

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Important Dates

- Oct. 1, 2013 - 2014 ICD-9 updates go into effect
- Jan. 1, 2014 - CPT Changes
  - CPT Assistant – monthly coding updates/clarifications
  - Medicare Part B News – Carrier List serves (monthly updates)
  - New Devices
- Jan. 1 and Jul. 1, 2014 - Category III Code updates
- HCPCS Codes Quarterly Update (Jan. 1, Apr. 1, Jul. 1, Oct. 1)
ICD-9 Updates

• The last regular, annual updates to both ICD-9-CM and ICD-10 code sets were made on October 1, 2011

• October 1, 2013 there will be only limited code updates to both the ICD-9-CM and ICD-10 code sets to capture new technologies and diseases

• On October 1, 2014, there will be only limited code updates to ICD-10 code sets to capture new technologies and diagnoses

  There will be no updates to ICD-9-CM, as it will no longer be used for reporting.

• On October 1, 2015, regular updates to ICD-10 will begin.
2014 ICD-9 Updates

• **NO** New, Revised or Deleted ICD-9 diagnosis codes

• **NO** Revised or Deleted ICD-9 procedure codes

Only 4 New ICD-9 procedure codes

• 00.96 – Infusion of 4-Factor Prothrombin Complex Concentrate

• 14.81 – Implantation of epiretinal visual prosthesis

• 14.82 – Removal of epiretinal visual prosthesis

• 14.83 – Revision or replacement of epiretinal visual prosthesis
CPT Code Changes

2013 CPT Changes
• Selective and Non-Selective Catheter Placements
  • **ALL** associated RSI (Radiological Supervision and Interpretation) codes and angiography codes now packaged into the primary CPT code

2012 CPT Changes
• Arthroscopic chondroplasty code 29877 packaged into arthroscopic meniscectomy codes 29880-29881
• Arthroscopic subacromial decompression code 29826 was revised and changed to an add-on code
  
  *(Subsequent coding clarification on use of 29822-29823)*
1. Arthroscopic subacromial decompression is performed as a “stand-alone” procedure

2. Arthroscopic limited debridement 29822 bundles into the arthroscopic subacromial decompression 29826

*(ADD-ON CODES CANNOT BE BILLED AS A PRIMARY PROCEDURE)*

**AMA Guidelines**

*When an arthroscopic subacromial decompression is performed as a “stand alone” it usually involves the removal of soft tissue and bone – therefore, the coder can report 29822. If additional extensive work is performed the coder may report 29823.*
CCI Edits and Bundling

CMS Guidelines

• Effective Apr. 1, 2012 the edit bundling CPT code 29822 into 29826 will be removed

• After Apr. 1, 2012, the provider may resubmit the claim if the local A/B MAC permits, or appeal previously denied claims involving the NCCI edit code pair

(Opportunity to increase revenue on previously denied claims when the ASC remains updated to changes)
What are NCCI Edits?

- CMS developed the NCCI to prevent inappropriate payment of services that should not be reported together.

- Column One and Column Two. Each edit column contains pairs of CPT codes that in most instances should not be reported together.

- If a provider reports the two codes of an edit pair, the column two code is denied, and the column one code is eligible for payment.

- However, if it is clinically appropriate to utilize an NCCI-associated modifier, both the column one and column two codes are eligible for payment.
How do you know when an appropriate modifier may be used?

• A modifier should not be appended to a code solely to bypass an NCCI edit if the clinical circumstances do not justify its use.
• If the Medicare Program imposes restrictions on the use of a modifier, the modifier may only be used to bypass an NCCI edit if the Medicare restrictions are fulfilled.
• One of the misuses of modifier –59 is relates to a “different procedure or surgery”.
• The edit indicates that the two procedures/surgeries cannot be reported together if performed at the same anatomic site and same patient encounter.
• However, if the two procedures/surgeries are performed at separate anatomic sites or at separate patient encounters on the same date of service, modifier –59 may be appended to indicate that they are different procedures/surgeries on that date of service.
NCCI Edit Guidelines

Arthroscopic rotator cuff repair – 29827
Arthroscopic debridement of labral tear – 29822-59

• CMS considers the shoulder joint to be a single anatomic structure.

• An NCCI procedure to procedure edit code pair consisting of two codes describing two shoulder joint procedures should never be bypassed with an NCCI-associated modifier when performed on the ipsilateral (same) shoulder joint.

• This type of edit may be bypassed only if the two procedures are performed on contralateral (opposite) joints.
AMA vs. CCI Edit Guidelines

58661 - Laparoscopy, surgical; with removal of adnexal structures (partial or total oophorectomy and/or salpingectomy)

AMA Guidelines

• Code 58661 describes a bilateral procedure, it would not be necessary to append Modifier 50 to indicate the procedure was performed bilaterally and it is not necessary to report modifier 52, Reduced Services for the removal of an ovary and/or fallopian tube on one side

CMS Guidelines

• CPT code 58661 has a status indicator of “1” in the Modifier -50 field indicating that a 150% payment adjustment applies for bilateral procedures
AMA vs. CCI Edit Guidelines

52005 – Cystourethroscopy, with ureteral catheterization

CMS Guidelines
• Code 52005 has a zero in the bilateral field (payment adjustment for bilateral procedure does not apply) because the basic procedure is an examination of the bladder and urethra (cystourethroscopy), which are not paired organs. The work RVUs assigned take into account that it may be necessary to examine and catheterize one or both ureters. No additional payment is made when the procedure is billed with bilateral modifier “-50.” It is inappropriate to bill code 52005 twice, once by itself and once with modifier “-51,” when both ureters are examined.

AMA Guidelines
• CPT code 52005 is inherently unilateral, and if performed bilaterally, modifier 50, Bilateral Procedure, should be appended.
P-STIM (New Devices)

- The P-Stim device is a single-use miniature electrical stimulator for **auricular acupuncture points** that is worn behind the ear with a self-adhesive electrode patch.

- The device is pre-programmed to be on for 180 minutes, then off for 180 minutes. The maximum battery life for this single-use device is 96 hours.

- A selection stylus that measures electrical resistance is used to identify 3 **auricular acupuncture points**. The P-Stim device connects to 3 **inserted acupuncture needles** with caps and wires.

- **Vendor recommended codes** 64555 and 95972
  
  *Percutaneous implantation of neurostimulator electrode array; peripheral nerve*
Inquiry Question:

• Would it be appropriate to report CPT code 64555 - percutaneous implantation of neurostimulator electrode array; peripheral nerve - for application of a PSTIM device which provides electrical stimulation to "auricular acupuncture“ sites on the ear.

• From a CPT coding perspective, the percutaneous placement and treatment using the PSTIM Neurostimulator device for the purpose of pain management, should be reported using code 64999, Unlisted procedure, nervous system.

• To further clarify, it would not be appropriate to report either code 64555, Percutaneous implantation of neurostimulator electrodes; peripheral nerve (excludes sacral nerve), nor 95972, Electronic analysis of implanted neurostimulator pulse generator.
An anesthesiologist may separately report an epidural or peripheral nerve block injection for postoperative pain management when the surgeon requests assistance with postoperative pain management.

1. When an epidural injection (62310-62319) is given for postoperative pain management it may be reported separately only if the mode of intraoperative anesthesia is general anesthesia and the adequacy of the intraoperative anesthesia is not dependent on the epidural injection.

2. A peripheral nerve block injection for postoperative pain management may be reported separately only if the mode of intraoperative anesthesia is general anesthesia, subarachnoid injection, or epidural injection, and the adequacy of the intraoperative anesthesia is not dependent on the peripheral nerve block injection.
Post Operative Pain Management
CCI Edit Guidelines

• An epidural or peripheral nerve block injection administered preoperatively or intraoperatively is not separately reportable for postoperative pain management if the mode of anesthesia for the procedure is monitored anesthesia care (MAC), moderate conscious sedation, regional anesthesia by peripheral nerve block, or other type of anesthesia not identified above.
FAST Procedure (New Devices)

- First known as “Focused Aspiration of Scar Tissue”
- Fasciotomy And Surgical Tenotomy
- Ultrasound guidance is used to identify pathologic tissue and guide the TX1 MicroTip (or Tenex hand piece) during tissue removal
- The TX1 MicroTip simultaneously debrides, cuts, and aspirates diseased tendon or other soft tissue in various musculoskeletal structures

Vendor recommended code – Percutaneous tenotomy/fasciotomy based on surgical site
**FAST Procedure (New Devices)**

- From a CPT coding perspective and according to our CPT Advisors, *code 24999, Unlisted procedure, humerus or elbow*, should be reported to describe the “ultrasound frequency” for the treatment of lateral epicondylitis using the "FAST [Focused Aspiration of Scar Tissue] ultrasound technique/system."

- To further clarify, if performing the "FAST [Focused Aspiration of Scar Tissue] ultrasound technique/system” procedure in the foot or ankle region, *if the FAST procedure were performed on an Achilles or plantar fascia it would be reported using an unlisted procedure (eg, 27899, Unlisted procedure, leg or ankle, 28899, Unlisted procedure, foot or toes).*

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Category III code Updates

- Last Category III code in the CPT manual is 0318T
- Category III codes 0319T-0328T were implemented Jan. 1, 2013 but not found in the CPT manual
- Category III codes 0329T-0334T were implemented Jul. 1, 2013

(There are 16 Category III Codes not listed in the CPT Manual)

- Category III codes 0335T-0339T will be implemented Jan. 1, 2014


Category III Code/HCPCS Update

Effective Jul. 1, 2013

• 0334T - Sacroiliac joint stabilization for arthrodesis, percutaneous or minimally invasive (indirect visualization), includes obtaining and applying autograft or allograft (structural or morcelized), when performed, includes image guidance when performed (eg, CT or fluoroscopic)

Effective Jan. 1, 2014

• Extra-osseous subtalar joint implant for talotarsal stabilization (Subtalar arthroereisis)
Subtalar Arthroereisis

• Recently, some surgeons advocated coding the subtalar arthroereisis procedure as a treatment of a dislocation. This would be a misrepresentation of the dislocation treatment codes, as there is no anatomical evidence of a joint dislocation (ie, complete disruption of a joint) present at the subtalar joint when using this type of implant.

• The most appropriate CPT code to report a subtalar arthroereisis procedure is code 28899, Unlisted procedure, foot or toes. Alternatively, a temporary national HCPCS code (S2117) is defined as “arthroereisis, subtalar.”
Category III Code Updates

  • C1840 – Lens, intraocular telescopic
  • C9732 – Insertion of ocular telescope prosthesis including removal of crystalline lens

• Effective Jul. 1, 2012
  • C1840 – Lens, intraocular telescopic
  • 0308T – Insertion of ocular telescope prosthesis including removal of crystalline lens

• MILD (Minimally Invasive Lumbar Decompression)
  • Jan 1 – Mar 31  22899 or 64999
  • Apr 1 – Jun 30  C9729
  • Effective Jul 1  0275T
Category III Codes (New Devices)

- 0249T – *Ligation, hemorrhoidal vascular bundle(s), including ultrasound guidance*

- Aka. – THD (Transanal Hemorrhoidal Dearterialization)

- **Vendor Recommended Codes**
  - 46946 – *Hemorrhoidectomy, internal, by ligation other than rubber band*
  - 45505 – *Proctoplasty; for prolapse of mucous membrane*
  - 45541 – *Proctopexy, perineal approach*
  - 76998 – *Ultrasonic guidance, intraoperative*

Ligation of hemorrhoid uses ligature at the base of the actual hemorrhoid

THD ligates the artery high above the hemorrhoid to cut off blood supply and shrink hemorrhoid (minimally invasive)

Addtl. sutures in mucosa
Category III Codes

• When performing a Transarterial Hemorrhoidal Dearterialization (THD) the physician will place additional sutures below the THD to tighten the mucosa. Can suturing of this mucosa be additionally reported with CPT code 45505 Proctoplasty; for prolapse of mucous membrane taking into consideration that the procedure is performed endoscopically?

• It would not be appropriate to report code 45505, Proctoplasty; for prolapse of mucous membrane for suturing of the mucosa as it is an inclusive procedure and should not be separately reportable.
# HCPCS Code Updates

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<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
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<tbody>
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<td>J7321</td>
<td>Hyalgan/supartz inj per dose</td>
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<td>Orthovisc inj per dose</td>
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<tr>
<td>J7326</td>
<td>Gel-one</td>
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**Z2** Radiology service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.

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<tr>
<th>Code</th>
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<td>74420</td>
<td>Contrst x-ray urinary tract</td>
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**K2** Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.

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<tr>
<td>J7315</td>
<td>Opthalmic mitomycin (Mitosol)</td>
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*HCPCS Code J7315 should only be used for Mitosol and should not be used for compounded mitomycin or other forms of mitomycin.*

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Amount</th>
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<tr>
<td>J7320</td>
<td>Hyalgan/supartz inj per dose</td>
<td>K2</td>
</tr>
<tr>
<td>J7323</td>
<td>Euflexxa inj per dose</td>
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<tr>
<td>J7324</td>
<td>Orthovisc inj per dose</td>
<td>K2</td>
</tr>
<tr>
<td>J7325</td>
<td>Synvisc or Synvisc-One</td>
<td>K2</td>
</tr>
<tr>
<td>J7326</td>
<td>Gel-one</td>
<td>K2</td>
</tr>
</tbody>
</table>

**F4** Corneal tissue acquisition, hepatitis B vaccine; paid at reasonable cost.

<table>
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*Addenda BB – UPDATES QUARTERLY!*
1. **Addenda Updates**

The page contains Ambulatory Surgical Center (ASC) payment related annual and quarterly ASPS and Drug File Addenda.

Files described in the ASC annual and quarterly change request transmitters are accessible in the "Downloads" section below.

Notice: Please note that the payment indicators and payment rates for a number of services listed in Addenda AA and BB to the calendar year (CY) 2010 Outpatient Prospective Payment System (OPPS) Ambulatory Surgical Center (ASC) final rule with comment period have been revised since the original posting on October 30, 2009 and response on November 28, 2009.

The CY 2010 payment indicators and rates for many of the ASC services listed in Addenda AA and BB are based on the CY 2010 non-facility practice expenses (NPE) amounts under the Medicare Physician Fee Schedule (MPFS). Numerous corrections to several non-facility NPE relative values units, and a legislative change to the CY 2010 MPFS conversion factor update required revision of several ASC payment indicators and rates that were included in the Addenda to the CY 2010 OPPS/ASC final rule with comment period and posted on the CMS website.

The affected ASC payment indicators and rates have been updated in the revised Addenda AA and BB to the CY 2010 OPPS/ASC final rule with comment period posted December 31, 2010 on the CMS website at: http://www.cms.gov/ASC/PaymentRule/Addenda_updates.asp.

A correction notice will also be published in the Federal Register regarding these corrections.

The ASC payment indicators and rates displayed in the revised Addenda reflect a zero percent update to the MPFS conversion factor and are valid for the period January 1 through May 31, 2010.

2. **Downloads**

- October 2013 ASC Approved HCPCS Code and Payment Rates
- July 2013 ASC Approved HCPCS Code and Payment Rates
- April 2013 ASC Approved HCPCS Code and Payment Rates
- January 2013 ASC Approved HCPCS Code and Payment Rates
- October 2012 ASC Approved HCPCS Code and Payment Rates
- July 2012 ASC Approved HCPCS Code and Payment Rates
- April 2012 ASC Approved HCPCS Code and Payment Rates
- January 2012 ASC Approved HCPCS Code and Payment Rates

3. **Favorite Links**

- July 2013 Original Addenda
- July 2013 ASC Addenda Update
- July 2013 ASC Addendum
- July 2013 ASC Addenda Update
- July 2013 ASC Addendum
- July 2013 ASC Addendum Update
- July 2013 ASC Addendum Update 2013

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**http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ASCPayment/11_Addenda_Updates.html**
# HCPCS Code Updates

Addendum BB – Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures for CY 2013 (Including Ancillary Services for Which Payment is Packaged) to Reflect Revised Payment Rates Based on Changes to the Medicare Physician Fee Schedule Created by the American Taxpayer Relief Act of 2012

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## HCPCS Code Updates

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<th>N1</th>
<th>Packaged service/item; no separate payment made.</th>
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<td>Synthetic implnt urinary 1ml</td>
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<td>Aqueous shunt prosthesis</td>
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<td>Metatarsal joint implant</td>
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<td>L8658</td>
<td>Interphalangeal joint spacer</td>
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<td>L8659</td>
<td>Interphalangeal joint repl</td>
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<td>L8690</td>
<td>Aud osseo dev, int/ext comp</td>
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<tr>
<td>L8699</td>
<td>Prosthetic implant NOS</td>
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DVT Cuffs (Deep Vein Thrombosis)

- Vendor supplies DVT cuffs and machines at no cost to the ASC
- ASC then provides these items to patients and items are taken home
- Vendor bills the patient’s insurance

**Read contracts CAREFULLY -** Vendor may be billing these items as DME
Medicare Guidelines

Non-implantable Durable Medical Equipment

• If the ASC furnishes items of non-implantable DME to beneficiaries, it is treated as a DME supplier, and all the rules and conditions ordinarily applicable to DME are applicable, including obtaining a supplier number and billing the DME MAC where applicable.
THANK YOU!