I
s your coding on target? Many ambulatory surgery centers (ASCs) are coding incorrectly for procedures and thus are not getting full payment from Medicare or private insurers, according to coding expert Stephanie Ellis, RN, CPC, president of Ellis Medical Consulting in Brentwood, Tenn.

Ellis, who advises ASCs on coding issues, offered these tips for sharpening your ASC’s coding.

Code correctly for presbyopia-correcting lenses

As of May 2005, Medicare allows ASCs to bill patients for the additional costs of inserting presbyopia-correcting intraocular lenses (IOLs) after cataract surgery. The new lens not only replaces the cataract lens but accommodates to near, intermediate, and far vision. Patients pay about $450 to $650 for each lens after the $150 covered by Medicare.

Medicare changed its policy to allow ASCs to bill Medicare beneficiaries for this procedure but did not establish new codes to identify the presbyopia-correcting lenses, which has confused some ASC billing departments, Ellis says.

Kathy Bryant, executive director of the Federated Ambulatory Surgery Association, says ASCs should continue to bill Medicare for removal of cataract with insertion of a conventional IOL even when using a presbyopia-correcting IOL, using one of the following codes:

- **66982**: Extracapsular cataract removal with insertion of intraocular lens prosthesis (one-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage.

  Ellis notes that the 66982 code applies for difficult cataract surgeries when the patient has glaucoma, uveitis, or other conditions documented prior to the procedure. When complications arise during a regular cataract procedure, Medicare is still billed the regular cataract code of 66984 (see below).

- **66983**: Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one-stage procedure)

- **66984**: Extracapsular cataract removal with insertion of intraocular lens prosthesis (one-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification).

For more information about presbyopia-correcting IOLs, see the August 2005 OR Manager, p 27.

Are you undercoding for colonoscopies?

Many ASCs undercode for colonoscopies and therefore frequently are underpaid, Ellis says.

“If you use more than one method for removing colon polyps, such as a biopsy in one spot, a polypectomy by hot biopsy forceps in another, and a snare removal in yet another, you can bill each procedure separately and be reimbursed for 3 procedures,” Ellis says.

On the other hand, some ASCs overcode for colonoscopies. “If you do a polypec-
tomy and a biopsy on the same lesion, you can bill only for the polypectomy,” she says.

Avoid common coding errors for ACL repairs

Ellis cautions about miscoding for anterior cruciate ligament repairs (ACL).

“When you take tendons from the back of the same knee, even with a separate incision, you cannot code 20924—tendon graft ‘from a distance,’” Ellis says. “When you take tendons from the same knee, you may code only 29888—arthroscopic ACL repair/augmentation or reconstruction—alone.

“To use the 20924 code for harvesting the tendon ‘from a distance,’ you have to take tendons from another part of the body, such as the back of the other knee or the ankle area,” she notes.

Be sure lesion sizes are accurate

Be sure surgeons are listing the accurate size of lesions that are removed, Ellis advises.

“Doctors can be lax in operative reports about listing the size of lesions,” she says. “If you don’t have the proper information about the real size of the lesion, it can really change the reimbursement picture for your ASC.”

For instance, if the actual size of a lesion excised is 3.2 cm, but the physician does not list the size in the operative report, and the tissue has shrunk in preservative so that pathology lists it as 2.8 cm, the code changes from 11404, which is covered by Medicare, to 11403, which is not.

“Without the surgeon’s notes, billers must use the size of the lesion listed in the pathology report,” she says.

Everyone in the OR has a role to play in proper coding, Ellis stresses. “It’s very important that the staff present in the case understand that they are party to knowledge that can be used by the billing office for reimbursement,” Ellis says. “It’s a great idea for the OR nursing staff to keep disposable rulers handy to give to surgeons to measure lesion sizes and to remind the physician to list the sizes of all lesions in the operative report.”

—Leslie Flowers

Leslie Flowers is a freelance writer in Indianapolis.