First part of a 2-part series.

Is your ambulatory surgery center (ASC) having claims denied? Are you missing out on revenue or opening yourself to compliance risks because of coding problems?

Being paid correctly and staying within legal bounds depend on the accuracy of your coding. Fortunately, the most common coding and billing problems are easy to correct. And correcting them can go right to your facility’s bottom line.

This 2-part series will discuss 10 steps your ASC can take to make sure you and your coders are up to speed.

1. Unbundling of CPT codes

   Unbundling is the practice of billing separately for each part of a surgical procedure. It is an unethical practice.

   The individual components, or incidental services, of a surgical case should not be coded when the primary procedure code includes these components. For example, the code for a surgical procedure includes closure of the surgical wound. (Surgical procedure codes are in the 20000-60000 sections in the CPT book.) Unbundling occurs if a facility also codes and charges separately for the surgical closure with a repair code from the 10000 section when the surgery code already includes that service.

   To avoid unbundling:

   • Check each CPT procedure code to be billed with every other procedure code to be billed in the current Correct Coding Initiative (CCI) unbundling material to see if any of the codes are components of any other code.

   • Pay close attention to code selection by coding with the most accurate and complete code available, using CPT guidelines.

   Update CCI unbundling material quarterly. If the unbundling guidelines are not followed, your claim can be denied. Unbundling could also be construed as improper billing and could flag an audit with a payor. If you regularly unbundle procedures that should not be billed together, you risk stiff penalties from Medicare and other payors.

   In some—very few—cases, even though one code is unbundled from another listed procedure, it can be billed anyway using a –59 modifier. An example is code 29875 for a synovectomy performed in a separate compartment from an arthroscopic knee meniscectomy, as long as the operative note is specific in describing that the synovectomy was performed in a separate compartment.

   A procedure performed in a separate area, by a separate incision, performed in a separate compartment, etc, might be billable, even though it is unbundled in the CCI material. Check the operative note and the CPT book descriptions carefully and assess the correct modifier usage. You also might want to contact the payor’s medical review or coding department for guidance. Usually, if the codes are unbundled, the unbundled code is not billable.

   CCI unbundling edits are published by Medicare for use with Medicare claims. Not all payors abide by Medicare’s CCI edits. Some payors have their own unbundling guidelines that do not coincide with the Medicare CCI material. If your facility receives an unbundling denial from a payor other than Medicare that does not coincide with the
published CCI edits, you can try an appeal citing the published CCI edits, but the appeal will not be successful in all cases.

2. Separate procedures

Procedures designated as “separate procedures” in the CPT book must be treated differently from other procedures. If these procedures are not coded and billed correctly, the payor may deny the code. A separate procedure, by definition, is a component of a more complex service and usually is not separately billable. These services are typically an integral component of a more extensive service. When these services are performed alone or not as part of a larger or more inclusive procedure, the “separate procedure” can be reported. When the “separate procedure” is carried out independently or distinctly from other procedures, it may be reported by itself or with the -59 modifier in some instances. Examples are when the procedure performed was:

• unrelated or distinct from other procedure(s)/service(s) provided during the same case
• performed independently
• performed in a different compartment
• performed at a different site or organ system
• involved a separate incision/excision
• involved a separate lesion or
• entailed treatment of a separate injury (or area of injury in extensive injuries).

If you notice a denial of a procedure on an EOB (explanation of benefits) that has language similar to an unbundling denial, but the codes are not unbundled in the CCI material, it is usually because of “separate procedure” status in the CPT book.

3. Upcoding and undercoding

Upcoding of CPT codes means coding a procedure with a more comprehensive code than the procedure actually performed. Undercoding is when the code billed does not adequately represent a more extensive procedure performed, which costs the ASC revenue. Upcoding and undercoding both pose significant problems for ASCs. Upcoding has a higher compliance risk because your facility will be reimbursed at a higher level than you are entitled to. If your facility upcodes, it can be flagged for an audit with a payor and result in accusations of fraud, along with stiff legal penalties. Undercoding is more common and costs your facility revenue because you are not coding the procedure performed accurately.

If the surgeon’s office is coding the procedures accurately, and your facility is not coding accurately, your facility’s codes will not match the physician’s codes submitted for the same procedure. This can flag you for an audit with a payor and cause claim denials. If you are trying to match the physician’s codes, and you know the codes the physician is billing are incorrect, it is important for your ASC to code the case correctly. If there are denials, you can file an appeal.

4. Diagnosis coding issues

A majority of claim denials for the reason of “medical necessity”—about 85%, according to Medicare—are not because the procedure should not have been performed or was not medically necessary. Most often, these denials are because of diagnosis coding errors; that is, the diagnosis code billed did not make it clear to the payor that the procedure was done for sufficient reason for the payor to pay for it. For example, a diagnosis code that is not on Medicare’s LMRP, or Local Coverage Determination (LCD) policy, for colonoscopy procedures is hemorrhoids. If you bill for hemorrhoids as the first or only diagnosis on a colonoscopy claim to Medicare (even though hemorrhoids are a common finding during colonoscopy) your claim will likely be denied for medical necessity reasons.

If your ASC performs a procedure that has an associated Medicare LCD, and you are billing for a Medicare patient, consult the diagnosis coding list in the LCD for coding options. You have to find something on that list that is a diagnosis or symptom the patient has that supports the medical necessity of the procedure. This is either a symptom the patient experienced, causing the need for the procedure, or a finding during the procedure to justify the procedure being performed.
Do not make up a diagnosis the patient does not have so you can bill a diagnosis on the LCD list just to get paid. If the operative report is vague about diagnosis information (either before or after the procedure), it is acceptable to look to the pathology report for a postoperative diagnosis finding and/or to the history and physical for a preoperative symptom that might be on the LCD list.

5. Proper modifier usage

Incorrect modifier usage can lead to improper payment, causing compliance risks or claim denials or causing your facility to be underpaid. Compliance problems or risks can result when modifiers are appended to codes unnecessarily or used inappropriately to try to get claims paid. The opposite can also occur: When a modifier is needed and not used, a charge can be denied unnecessarily.

An example of a modifier error is when a facility is billing for a diagnostic cystoscopy (code 52000) performed with a diagnostic hysteroscopy (code 58555) during the same case. Though both procedures are designated in the CPT book as “separate procedures,” they are both billable because they were performed in separate areas involving separate organ systems. What can be confusing is that those 2 codes are not unbundled from each other.

Billing for both of these procedures might require the -59 modifier (for Distinct Procedural Service) to be appended to the 52000 code, which should be billed in the second position on the claim form, indicating 2 separate procedures were performed in separate body areas during the same case. The use of the -59 modifier in this case should keep your facility from experiencing a denial.

Inquire of each of your facility’s major payors how they want modifiers to be used. Not all payors follow Medicare’s requirements on using modifiers, especially for bilateral procedures. There are 5 ways to bill for bilateral procedures, and you might use different methods, depending on with which payer the claim is filed (sidebar). It is wise to keep a managed care “cheat sheet” with these special requirements.

In the next article, we’ll cover 5 more common coding and billing problems: Claim form issues, documentation (including “canned” operative reports), correct coding of procedures, bills for cancelled cases and terminated procedures, and implants. ◆

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Billing for bilateral procedures

The 5 usual methods for the billing of bilateral procedures:
• Bill the same code as 2 line items, using the –RT modifier on one code and the –LT modifier on the other (same) code.
• Bill the bilateral procedures as 2 line items with no modifier on the first code and a –50 modifier on the second line item (same code).
• Bill the procedure as a single line item on the claim form with a –50 modifier on the procedure code. Be sure if you use this method to double the facility fee.
• Bill the same code as 2 line items with no modifiers. (See Medicare note below.)
• Bill the procedure as a single line item on the claim form with no modifier on the procedure code, and put a “2” in the units column on the claim. Be sure if you use this method to double the facility fee.

Note: With the changes in the Medicare program for ASC billing for 2008, these last 2 methods are how Medicare is directing that bilateral procedures should be billed. If you experience denials from using either of these methods, you might want to try the first method using -RT/-LT modifiers. Do not use the -50 modifier on Medicare claims.