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***Ambulatory Surgery Centers***

# Ten tips to improve your ASC's coding

*Second part of a 2-part series.*

Being paid correctly depends on the accuracy of your coding. Some of the most common coding and billing problems are easy to correct and can directly affect your facility's bottom line. This 2-part series discusses steps your ambulatory surgery center (ASC) can take to make sure your coding is accurate and complete. Tips 1 through 5 were in the February *OR Manager.*

### 6. Claim form issues

Incomplete or incorrectly completed claim forms can result in unnecessary denials. Check claim forms and electronic claim systems periodically to ensure claims are complete and correct. Systems issues may be causing denials you are not even aware of—until the denials start piling up, costing you money.

A good way to spot claim form issues is to note denial reasons on payor EOBs (explanation of benefits) and look for trends. Go back to claims that were denied for incomplete-claims reasons or claim-form errors. Review each field, trying to spot the problem.

If you can't figure out what is causing a system problem and correct the problem yourself, ask your systems people to assist you. If the reason is human error by your staff, educate them. Inform them about how errors are causing claims to be denied, and instruct them in the correct way to bill to stop the problems.

From time to time, print out a hard copy of your facility's completed claim forms (UB-04 and CMS-1500) and check them to be sure:

- the fields are populating correctly
- the CPT and diagnosis codes are entered correctly (if the diagnosis code is supposed to be 5 digits, ensure it is printing on the claim as 5 digits)
- there are no extra or missing modifiers, revenue codes are correct, place of service (POS) is correct, etc.

### 7. Documentation

Operative reports, correct coding, insurance verification, and data entry are the foundation for getting paid correctly. When documentation is the cause of incorrect coding, the reason may be poor operative report documentation. Other problems that can contribute to incorrect coding are: coding from documents other than the operative report (such as the schedule, orders, superbill, etc), coders not reading the entire op report, or coding only from the report procedure summary.

Here are common documentation problems and suggested solutions:

- **Poor op report documentation.** Educate physicians on documentation requirements and perform regular reviews of op reports for improvement. Continuing problems may need to be addressed by the board of directors.
- **Coding from other documents.** For correct billing, code only from the operative report—make this a facility policy. You can miss procedures if coding from other documentation. Procedures originally listed on the schedule or superbill may not have been performed, or additional procedures may have been added. Billing improperly from these documents can cause a compliance issue or reimbursement problems.

## *Top ASC coding and billing problems*

1. Unbundling
2. Separate procedures
3. Upcoding and undercoding
4. Diagnosis coding issues
5. Proper modifier usage
6. Claim form issues
7. Documentation
8. Correct coding of procedures
9. Terminated procedures
10. Implants

- **Not reading the entire op report.** Procedures can be missed if the entire op report is not reviewed. Procedures may be documented in the body of the op report that are not listed in the summary section. There may be procedures documented in the summary section that are not documented in the body of the report, which should not be billed.

Medicare requires that only procedures documented in the body of the op report are to be billed. If you are sure the procedure was performed, but it is not documented in the body of the op report, and if there is another official document to confirm it was performed (such as a pathology report to confirm that a biopsy was taken), you can bill for the procedure. Ask the surgeon to do an addendum to the op report with this information.

If physicians list diagnosis and/or CPT procedure codes on op reports, the coder must still examine the entire op report to be sure the codes are correct and everything to be coded is pertinent and properly documented. If the physician's codes are incorrect, the ASC should bill with the correct codes.

### *Avoid "canned" operative reports*

There are times when physicians use "canned" operative reports instead of doing an individualized op report for that patient and the procedure performed—a significant compliance issue. Many times these canned operative reports leave out details, such as the patient's pre- and postoperative diagnoses, which should be individualized to each patient's condition. For example, in pain management, the medication and dosage/amount injected may be omitted. The report may not contain details specific to the patient's surgery, such as problems during the procedure, any patient physical anomalies, any complications during the procedure, or if the procedure was performed on the right or left side.

Medicare and other payors take a dim view of the use of canned op reports, which they refer to as "cloned records." This can also cause an issue in an ASC's state survey and could be a potential malpractice issue for both the surgeon and facility, especially if complications arise and are not properly documented.

## 8. Correct coding of procedures

Make sure you read operative reports in their entirety. Do not code from charge tickets or superbill documents or from the surgery schedule. Be sure each service billed is properly documented prior to billing. Only procedures described in the body of the op report are to be coded.

Always check the CCI unbundling material when coding multiple procedures. Always use the current CCI material because it is updated quarterly.

Sequence CPT codes on the claim from highest to lowest Medicare payment amount or highest to lowest payment groupers for payors that use this payment method. Sequence CPT codes from highest to lowest RVUs for other payors that do not go by payment groupers.

Be sure the ASC is documented as the "place of service" (POS) where the surgery was performed, which can be unclear if the operative report was dictated on the physician's office stationary or at the hospital. The POS on the claim form is 24 and bill type is 831 for ASCs.

### *Check for updates*

Check Medicare bulletins for updates and changes to LMRP/NCD/LCD medical policies for procedures performed in your facility. See if these policies affect procedures done, services provided, or implants and supplies/equipment used in your ASC.

If you cannot find a supporting diagnosis in the op report, review the history and physical and/or the pathology report for a symptom or pathology result covered on the LCD. Use the postoperative diagnosis listed on the operative report for coding rather than the preop diagnosis. If implants were used, check to see whether billing them to the payor is allowed. Bill x-rays and fluoroscopy services to payors that may reimburse for them but with which your facility does not have a contract, or your contract does not specifically prohibit billing of those services. Make sure you use

the appropriate anatomical modifier, digit modifiers, and lid modifiers. Bill multiple procedures at the full fee, leaving it to the payor to make multiple procedure reductions.

### 9. Billing for cancelled cases and terminated procedures

When your facility doesn't bill for terminated procedures or doesn't code them correctly using the appropriate modifiers, you can lose revenue. On the other hand, billing improperly for these procedures can pose a compliance risk. If the procedure was an elective cancellation, it cannot be billed.

Modifiers provide a way to report expenses incurred for preparing the patient for a procedure when the procedure is terminated:

- Modifier -73 is used to indicate the procedure was discontinued prior to anesthesia administration. To bill Medicare using the -73 modifier, the patient must physically be in the OR or procedure room where the procedure was to have been performed, and the ASC must have used "significant resources" (ie, the patient had IV fluids, was given preoperative medication, etc).
- Modifier -74 is used to indicate the procedure was discontinued after the administration of anesthesia. For billing purposes, anesthesia is defined to include local, regional block, moderate sedation, deep sedation, or general anesthesia.

When Modifier -73 is used to code the terminated procedure after the patient has been taken to the procedure room or OR, but the procedure is terminated prior to the administration of anesthesia, the procedure should be reimbursed at 50% of Medicare's allowable amount. When Modifier -74 is used after anesthesia has been induced, the procedure should be reimbursed by Medicare at 100% of the allowable amount. Procedures terminated before the patient enters the procedure room and prior to induction of anesthesia should not be billed to Medicare.

Procedure for billing CPT codes for terminated procedures:

- When anesthesia was administered only, but none of the planned procedures were started at all, bill the code for the first scheduled procedure with the -74 Modifier; the rest of the planned procedures are not billable.
- If several procedures were planned, and some (but not all) were completed:

  1. Bill procedures that were completed at full fee without the –74 Modifier.
  2. Bill any procedure started but not completed at full fee with the –74 Modifier.
  3. Procedures planned but not started at all are not billable.

An op report must be in the chart with detailed information about the reason the procedure was terminated.

### 10. Implants

It is very important to bill for implants used in procedures. Be familiar with the ASC's managed care contracts and the reimbursement policies for supplies and implants. Some payors allow billing of only certain implants, which the contract may refer to as "carve-outs." Don't assume payors follow Medicare guidelines when billing for implants—this mistake can cost your facility money.

For example, some payors do not include a regular intraocular lens (IOL) in the payment for cataract procedures (code 66984) as Medicare does. It is important to bill the IOL as a separate line item using the appropriate HCPCS code. A regular anterior chamber IOL is coded V2630, and a posterior chamber IOL is coded V2632 — neither of which should be billed to Medicare.

A few payors may require the more general supply code of 99070 for billing IOLs. Usually, the L8699 code should not be used for IOLs because more specific codes exist.

### Billing for implants

When billing for implants, include a copy of invoices. It is important for the physician to document in the operative report details of implants used, including the number of anchors or screws. Having supporting information in the op report that matches the implant invoice helps in the reimbursement process.

Payment for implants is totally at the payor's discretion. Medicare carriers vary

from state to state on which implants they cover. Sometimes, a payor reimburses for some implants but not others. If an implant is particularly expensive, and the payor denies your billing for implant, you should pursue vigorous appeals.

Now that Medicare bundles implants into the billing of the CPT code for a few procedures, implants for those procedures should not be listed separately on the claim. Examples of these are spinal cord neurostimulators and cochlear implants. Other than these few procedures, with Medicare, it is a good practice to bill for implants.

By checking all 10 of these tips, you can help to ensure your ASC is in a position to be paid appropriately for all the services it provides. ❖

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