

ASC Coding and Billing Fundamentals

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Objectives

- Guidelines/Regulations
- Covered Surgical Procedures
- Ancillary Supplies Separately Reportable
- Correct Use of Modifiers
- Review Documentation
 - CMS Standpoint
 - Third Party Standpoint



CMS Regulations/Guidance

ASC Definition:

For Medicare purposes, an ASC is a distinct entity in operation for the exclusive purpose of furnishing outpatient surgical services to patients.

It is either independent or operated by a hospital.



CMS Regulations

To be able to provide and bill services performed in an ASC, the ASC must enter into a participating provider agreement with CMS.



CMS Regulations

Part of the ASC enrollment process requires certification. This certification is achieved through survey showing compliance with the conditions for coverage by state regulation.



CMS Regulations

A hospital-operated facility has the option of being considered by Medicare to be either an ASC or to be a provider based department of the hospital as defined in 42 CFR 413.65.



CMS Regulations

Payment for ASC services are made under Part B and should be submitted on a CMS-1500 claim form.



CMS Regulations

Approved Surgical Procedures

Medicare publishes a list of covered procedures annually. Updates to this list are published annually.



CMS Regulations

Services included in the ASC payment for a covered surgical procedure include but are not limited to:

- Nursing, technician and related services
- Use of facility where procedure is performed
- Any laboratory testing performed under CLIA
- Drugs and biologicals for which separate payment is not allowed.



CMS Regulations

- Medical and surgical supplies not on pass-through status
- Equipment
- Surgical dressings
- Implanted prosthetic devices not on pass through status
- Splints, casts, and related devices



CMS Regulations

- Radiology services for which separate payment is not allowed under OPPS, and other diagnostic or interpretive services
- All administrative or housekeeping services
- Materials, including supplies/equipment for administration and monitoring of anesthesia
- Supervision of the services of an anesthesiologist by the operating surgeon



CMS Regulations

There are some services that separate or additional payment is allowed. These services include:

- Brachytherapy sources
- Implantable items that have “pass-through” status under OPPS
- Certain items and services CMS designates as contractor prices (procurement of corneal tissue)



CMS Regulations

- Drugs and biologicals for which separate payment is allowed
- Radiology services for which separate payment is allowed



CMS Regulations

The complete list of ASC covered surgical procedures, covered ancillary services, applicable payment indicators and other information are available on the CMS website at:

<http://www.cms.gov/ascpayment/>



CMS Covered Procedure Information

Included in the file is the following:

- Addendum AA – Final ASC covered surgical procedures including comments, payment indicators and final payment amount for CY
- Addendum BB – Final ASC Covered Ancillary Services Integral to Covered Surgical Procedures (including Packaged Services) for CY.



CMS Covered Procedure Information

- Addendum DD1 – Final ASC Payment Indicators for CY
- Addendum DD2 – Final ASC Comment Indicators for CY
- Addendum EE – Surgical Procedures to be Excluded from Payment for CY



CMS Addendum AA Example

HCPCS Code	Short Descriptor	Subject To Multiple Procedure Discounting	Final CY 2012 Comment Indicator	Final CY 2012 Payment Indicator	Final CY 2012 Payment Weight	Final CY 2012 Payment
10021	Fna w/o image	Y		P2	1.5259	\$65.04
10022	Fna w/image	Y		G2	4.3315	\$184.64
11312	Shave skin lesion	Y	CH	P2	1.4194	\$60.50
11313	Shave skin lesion	Y		P2	1.4194	\$60.50
11400	Exc tr-ext b9+marg 0.5 < cm	Y		P3		\$86.80
49082	Abd paracentesis	Y	NI	G2	5.2152	\$222.31
49083	Abd paracentesis w/imaging	Y	NI	G2	5.2152	\$222.31

Example Addendum BB

HCPCS Code	Short Descriptor	Final CY 2012 Comment Indicator	Final CY 2012 Payment Indicator	Final CY 2012 Payment Weight	Final CY 2012 Payment
C1716	Brachytx, non-str, Gold-198		H2		\$35.00
C1840	Telescopic intraocular lens	NI	J7		
C8902	MRA w/o fol w/cont, abd		Z2	7.2284	\$308.13
J0696	Ceftriaxone sodium injection		N1		
J0800	Corticotropin injection		K2		\$2,516.22
70190	X-ray exam of eye sockets		Z2	0.6064	\$25.85
70200	X-ray exam of eye sockets		Z2	0.6064	\$25.85

Example Addendum DD1

Indicator	Payment Indicator Definition
A2	Surgical procedure on ASC list in CY 2007; payment based on OPPS relative payment weight.
D5	Deleted/discontinued code; no payment made.
G2	Non office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
H2	Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
J7	OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.
J8	Device-intensive procedure; paid at adjusted rate.
K2	Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
K7	Unclassified drugs and biologicals; payment contractor-priced.

Example Addendum DD2

CI	Comment Indicator Meanings
CH	Active HCPCS code in current year and next calendar year, payment indicator assignment has changed; or active HCPCS code that is newly recognized as payable in ASC; or active HCPCS code that is discontinued at the end of the current calendar year.
NI	New code for the next calendar year or existing code with substantial revision to its code descriptor in the next calendar year, interim payment indicator assignment; comments will be accepted on the interim payment indicator for the new code.

Example Addendum EE

HCPCS Code	Short Description
11004	Debride genitalia & perineum
11005	Debride abdom wall
11006	Debride genit/per/abdom wall
11008	Remove mesh from abd wall
15756	Free myo/skin flap microvasc
15757	Free skin flap microvasc
15758	Free fascial flap microvasc

CMS – ASC Billing Guidelines

An ASC must not report separate line items, HCPCS codes or any other charges for procedures, services, drugs, devices or supplies that are packaged into the payment allowance for covered surgical procedures. The allowance for the surgical procedure itself, includes all of these other services or items.



CMS – ASC Billing Guidelines

For device-intensive procedures, a modified payment methodology will be used to establish ASC payment for these surgical procedures.

This methodology can be very confusing. We will get paid for the device, but we do not submit a separate line item for the device.



CMS – Correct Device Intensive

Example	Code	Description	Payment Indicator	Units	Billed Amount	Medicare ASC Allowed Amount	Medicare Payment to Provider	Beneficiary Payment to Provider
Claim should have one detail line which includes the code for the surgical procedure with the cost for the procedure and the cost for the implanted device.	54405	Insert multi-comp penis pros	J8	1	\$16,000.00	\$10,346.97	\$8,277.58	\$2,069.39

CMS – Incorrect Device Intensive

Example	Code	Description	Payment Indicator	Units	Billed Amount	Medicare ASC Allowed Amount	Medicare Payment to Provider	Beneficiary Payment to Provider
Incorrect	54405	Insert multi-comp penis pros	J8	1	\$5,000.00	\$10,346.97	\$4000.00 (billed amount x 80%)	\$1000.00 (billed amount x 80%)
	C1813	Prosthesis, penile, inflatable	N1	1	\$11,000.00	\$0.00	\$0.00	\$0.00



CMS – ASC Billing Guidelines

- IOLs and NTIOLs
 - No longer eligible for payment February 27, 2011.
 - Q1003 will deny.
 - Medicare will pay the same amount of cataract extraction with A-C IOL insertion that is paid for cataract extraction with conventional IOL insertion.
 - Codes for A-C IOL should be reported with codes for IOL (66982, 66983, 66984)



CMS – ASC Billing Guidelines

Billing for drugs and biologicals that are eligible for separate payment is strongly encouraged by CMS. ASCs should report with the correct HCPCS code and correct number of units.

If two or more drugs or biologicals are mixed together and administered, the correct HCPCS code should be used for each substance administered.



CMS – ASC Billing Guidelines

Modifiers recognized for ASC claim filing are:

- 52 Reduced services
- 59 Distinct separate procedure
- 73 Procedure discontinued after prep for surgery
- 74 Procedure discontinued after anesthesia administered
- RT
- LT



CMS – ASC Billing Guidelines

Modifiers recognized for ASC claim filing are:

- TC Technical component
- FB Device furnished at no cost/full credit
- FC Device furnished at partial credit
- PT Colorectal screening converted to diagnostic or therapeutic procedure/surgery



CMS – ASC Billing Guidelines

Modifiers recognized for ASC claim filing are:

- PA Wrong body part
- PB Surgery wrong patient
- PC Wrong surgery on patient
- GW Surgery not related to hospice patients terminal condition



Commercial Plans

- Commercial plans may or may not follow CMS policy for ASC claim filing.
- Check carrier site for information on claim filing.
- Check YOUR contract with payer.
- Following slides will show policies for some of the major carriers.



Aetna ASC Guidelines

Claims submitted on UB04 (CMS1450)



Aetna ASC Guidelines

Modifiers recognized for ASC claim filing are:

- 73 Procedure terminated after prep for procedure (25% of facility payment).
- 74 Procedure terminated after administration of anesthesia (50% if facility payment).
- 59 Distinct procedural service



Aetna ASC Guidelines

Modifiers recognized for ASC claim filing are:

- PA Wrong body part
- PB Surgery wrong patient
- PC Wrong surgery on patient



Aetna ASC Guidelines

- **Implants** can be reimbursable, check your contract and the carrier website.
- Have to dig a little on the website and remember, not all codes have a published policy.



Enter the CPT or HCPCS code: Search

OR

Select a code by Category:

- Cosmetic
- Cosmetic
- Experimental - Investigational
- Incidental
- Medically Necessary
- Never Effective
- Not a Medical Service
- Other Payment Policies

Note: Only those codes impacted by Aetna's clinical or payment policies will be identified by this search. In addition, some plans may differ in their coverage. This tool does not disclose the instances when the coverage may not be Aetna's standard. For assistant surgery inquiries relating to the coverage of Assistant Surgeon charges, follow Step 1 - Clinical & Payment Policy Code Lookup, then use Step 2, Code Editing Tool.

Legal Disclaimer:

NaviNet - Windows Internet Explorer

https://navinet.navimedix.com/Main.aspx

NaviNet

Plan Central Services Office Central NaviNet Central Action Items Customer Support

Aetna | Clinical & Payment Policy Code Lookup

L8614	Cochlear device, cochlear	CPB0013
L8615	Headset/headpiece for use with cochlear implant device, replacement	CPB0013
L8616	Microphone for use with cochlear implant device, replacement	CPB0013
L8617	Transmitting coil for use with cochlear implant device, replacement	CPB0013
L8618	Transmitter cable for use with cochlear implant device, replacement	CPB0013
L8619	Cochlear implant external speech processor, replacement	CPB0013
L8621	Zinc air battery for use with cochlear implant device, replacement, each	CPB0013
L8622	Alkaline battery for use with cochlear implant device, any size, replacement, each	CPB0013
L8623	Lithium ion battery for use with cochlear implant device speech processor	CPB0011
L8624	Lithium ion battery for use with cochlear implant device speech processor, ear	CPB0013
L8627	Cochlear implant, external speech processor, component, replacement	CPB0013
L8628	Cochlear implant, external controller component, replacement	CPB0013
L8629	Transmitting coil and cable, integrated, for use with cochlear implant device, replacement	CPB0013
L8630	Metacarpophalangeal joint implant	CPB0798
L8631	Metacarpal phalangeal joint replacement, two or more pieces, metal (e.g. stainless steel or cobalt chrome), ceramic-like material (e.g. pyrocarbon), for surgical implantation (all sizes, including entire system)	CPB0798
L8641	Metatarsal joint implant	CPB0708
L8642	Hallux implant	CPB0708
L8658	Interphalangeal joint spacer, silicone or equal, each	CPB0798
L8659	Interphalangeal finger joint replacement, 2 or more pieces, metal (e.g., stainless steel or cobalt chrome), ceramic-like material (e.g., pyrocarbon) for surgical implantation, any size	CPB0798

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Metatarsal Phalangeal Joint Replacement - Windows Internet Explorer

http://www.aetna.com/cpb/medical/data/700_799/0708.html

Metatarsal Phalangeal Joint Replacem...

...roduction as a means of changing or not to modify monitoring the arthroplasty procedure, and the overall prevalence or postoperative complications was 0.16 (1.7%). Based on these results, the authors concluded that first MPJ joint replacement with the Moje device remains promising, but still has room for improvement before the results match those obtained with larger joint (knee, hip) arthroplasty. Thus, more studies including larger number of patients with longer follow-up are needed to evaluate the long-term results of the Moje ceramic prosthesis for MPJ replacements. Furthermore, Gutlick and colleagues (2011) stated that the high loosening rate of the Moje prosthesis in the treatment of hallux rigidus caused disappointing medium-term results. Arthrodesis using an iliac crest bone graft is the standard salvage procedure.

CPT Codes / HCPCS Codes / ICD-9 Codes

CPT codes covered if selection criteria are met

28293	
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Other CPT codes related to the CPB

26535	
26536	

HCPCS codes covered if selection criteria are met

L8641	Metatarsal joint implant
L8642	Hallux implant

Other HCPCS codes related to the CPB

L8658	Interphalangeal joint spacer, silicone or equal, each
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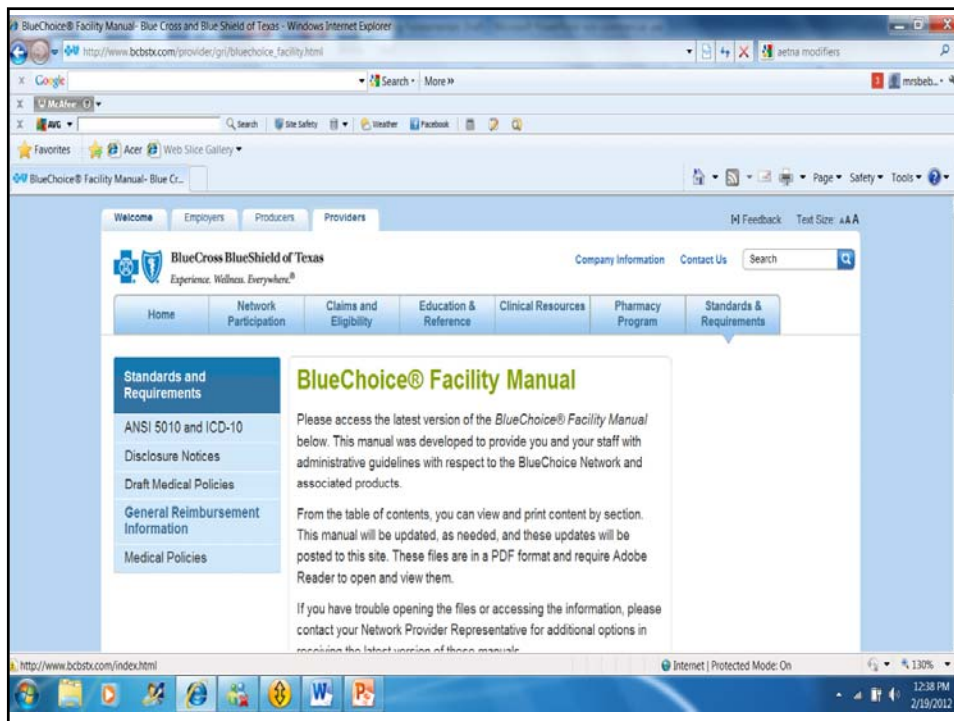
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BCBS ASC Guidelines

Check your BCBS carrier's website for information.

In Texas – www.bcbstx.com

Manuals can be found on the website for reimbursement and claim filing procedures.



BCBS of Texas ASC Guidelines

BCBS requires a **UB-04** be submitted for ASC claims.

CPT®/HCPCS codes should be reported for each surgical procedure performed.

Reimbursement of procedures is 100% of contracted rate for first procedure and additional procedures are per providers contract.

Manual states ICD-9 Procedures can be used.



BCBS of Texas ASC Guidelines

- **Modifiers** recognized for ASC claim filing are:
 - Claim filing manual states:
“modifiers **not** recognized on the UB-04”.
 - For bilateral procedure report the CPT®/HCPCS code on two (2) separate lines.



BCBS of Texas ASC Guidelines

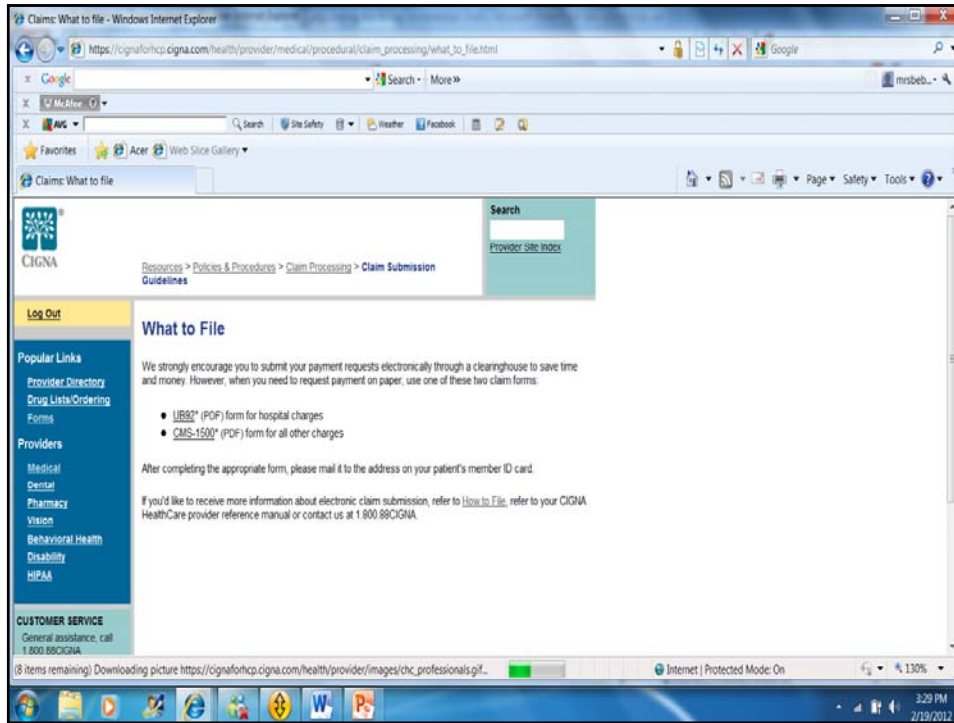
- **Implants** are reimbursed per provider contract for the following revenue codes:
 - 0274 Prosthetic devices
 - 0275 Pacemakers
 - 0278 Other implants



Cigna ASC Guidelines

- What Claim Form does Cigna accept for ASCs?

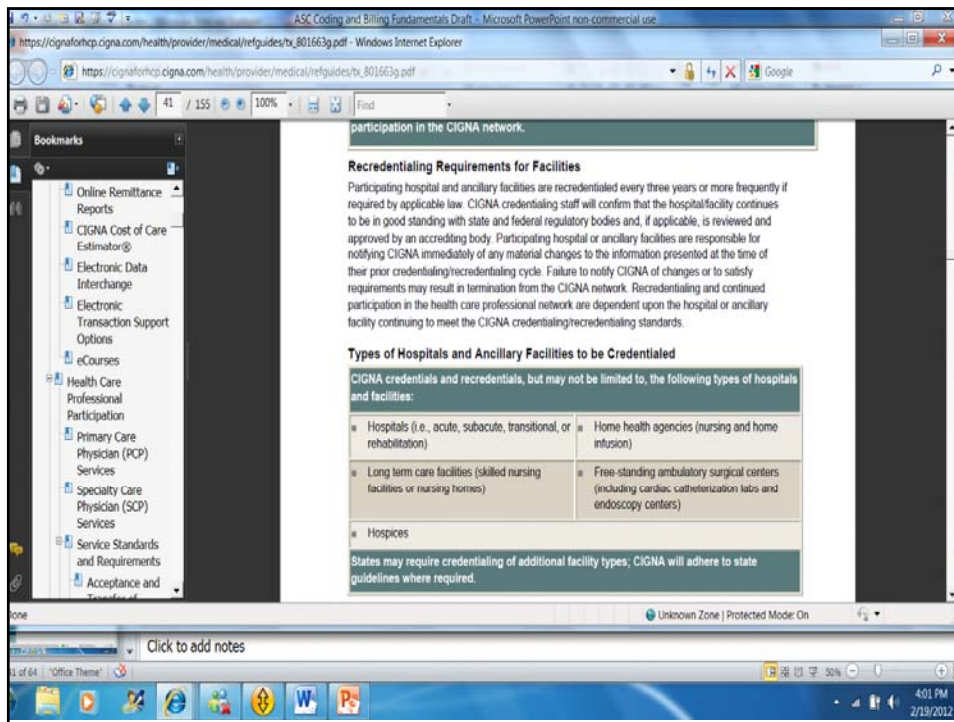




Cigna ASC Guidelines

- Go to your state manual to find out





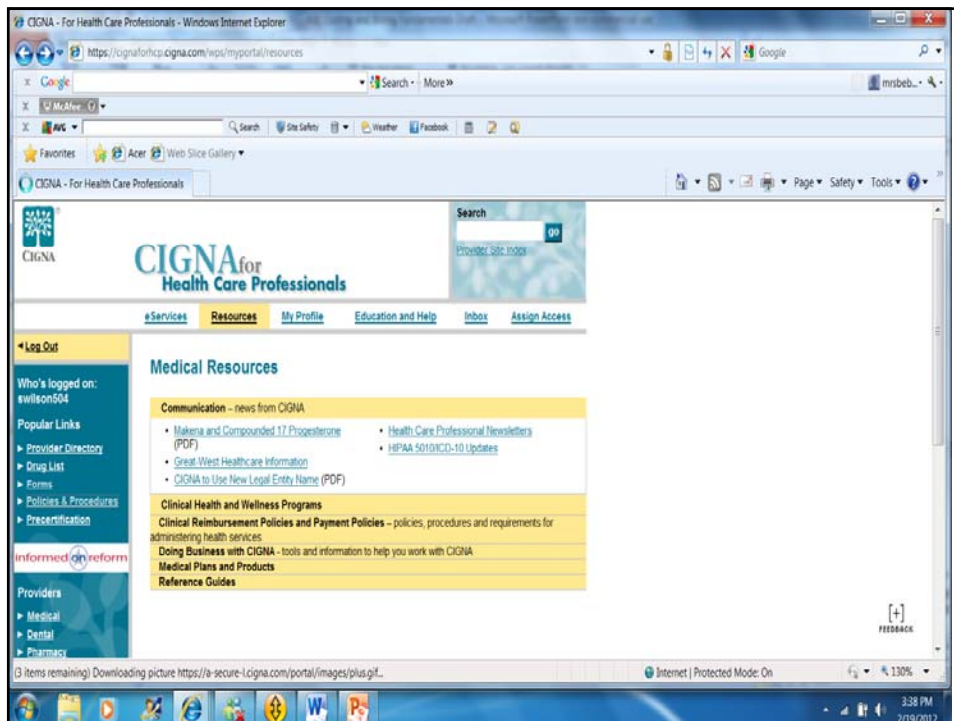
Cigna ASC Guidelines

- In Texas – we are credentialed as facility and file on an UB04.



Cigna ASC Guidelines

The next slides are screen shots to walk you through finding information on the Cigna website regarding modifiers, etc.



CIGNA - For Health Care Professionals - Windows Internet Explorer

https://cignaforhcp.cigna.com/wps/myportal/resources

Who's logged on: swtison04

Popular Links

- Provider Directory
- Drug List
- Forms
- Policies & Procedures
- Prescription

informed on reform

Providers

- Medical
- Dental
- Pharmacy
- Vision
- Behavioral Health
- Disability
- HIPAA

CUSTOMER SERVICE

General assistance, call 1.800.88CIGNA

Medical Resources

Communication - news from CIGNA

- Malena and Compounded 17 Progesterone (PDF)
- Great West Healthcare Information
- CIGNA to Use New Legal Entry Name (PDF)
- Health Care Professional Newsletters
- HIPAA 5010/ICD-10 Updates

Clinical Health and Wellness Programs

Clinical Reimbursement Policies and Payment Policies - policies, procedures and requirements for administering health services

- CAQH CORE Certification (PDF)
- CareCentra DMF HCPCS Codes (PDF)
- Claim Appeals Policies and Procedures
- Claim Policies and Procedures
- Claim Editing Procedures
- Clinical Claim Review Not Payable Reason Codes (PDF)
- Clinical Claim Review QRG (PDF)
- Coverage Positions/Criteria
- Evaluation and Management Correct Coding Fact Sheet (PDF)
- Medical Necessity Definitions
- Prescription Policies
- Referrals Policy
- Lab Information (PDF)
- Modifiers and Reimbursement Policies
- Never Events Fact Sheet (PDF)
- Never Events Fact Sheet - MS-CRIG Specific (PDF)
- Reasonable & Customary (RAC) Charges
- Reimbursement
 - EFT
 - ERA

Doing Business with CIGNA - tools and information to help you work with CIGNA

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CIGNA - Provider Portal - Modifiers and Reimbursement Policies - Windows Internet Explorer

https://cignaforhcp.cigna.com/health/provider/medical/edit/pk_0028_modifiers.html

Log Out

Popular Links

- Provider Directory
- Drug List
- Forms
- Medical
- Dental
- Pharmacy
- Vision
- Behavioral Health
- Disability
- HIPAA

CUSTOMER SERVICE

If you need...

Modifiers and Reimbursement Policies

Notification of Policies That Will Be Updated:

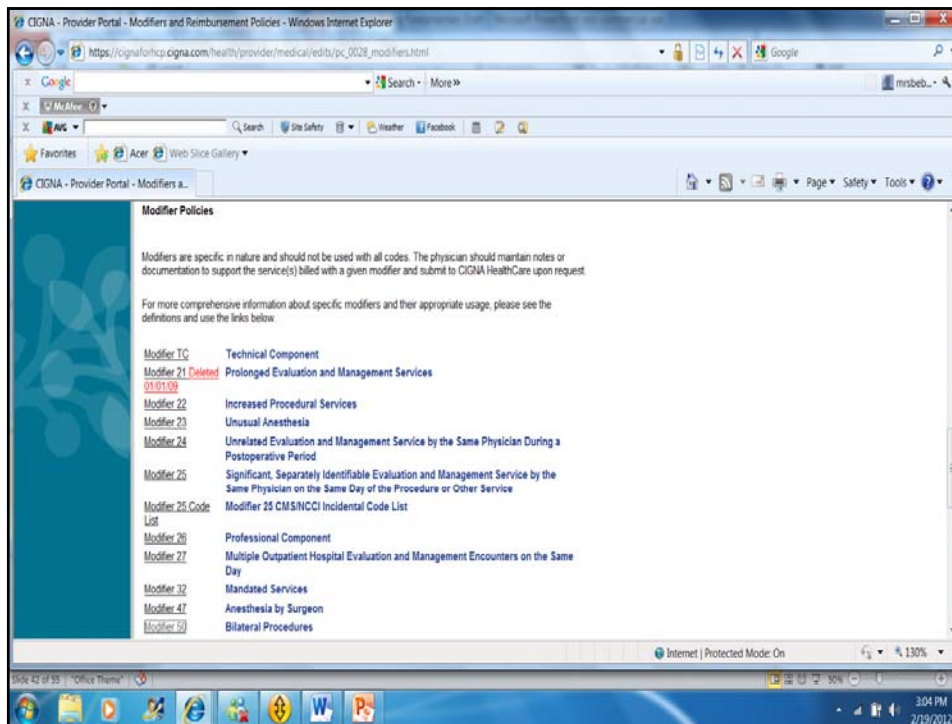
- Code Editing Guidelines effective October 17, 2011
- Code Edit Bulletin effective October 17, 2011
- R05 Never Events **Updated!**
- NCCI Editing for Facilities - Effective 09/01/2011 See policy and edit list below
- Modifier 80, 81, 82 and AS - Effective 07/01/2011
- R21 - Prescription (Effective 07/01/2011) **Updated!**

Introduction

A modifier is a two-digit numeric or alpha code used in conjunction with a procedure code to describe specific circumstances about the service provided. It allows doctors to indicate that a service differed in some way from the stated CPT® or HCPCS description, without actually changing the basic description of the service.

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Cigna ASC Guidelines

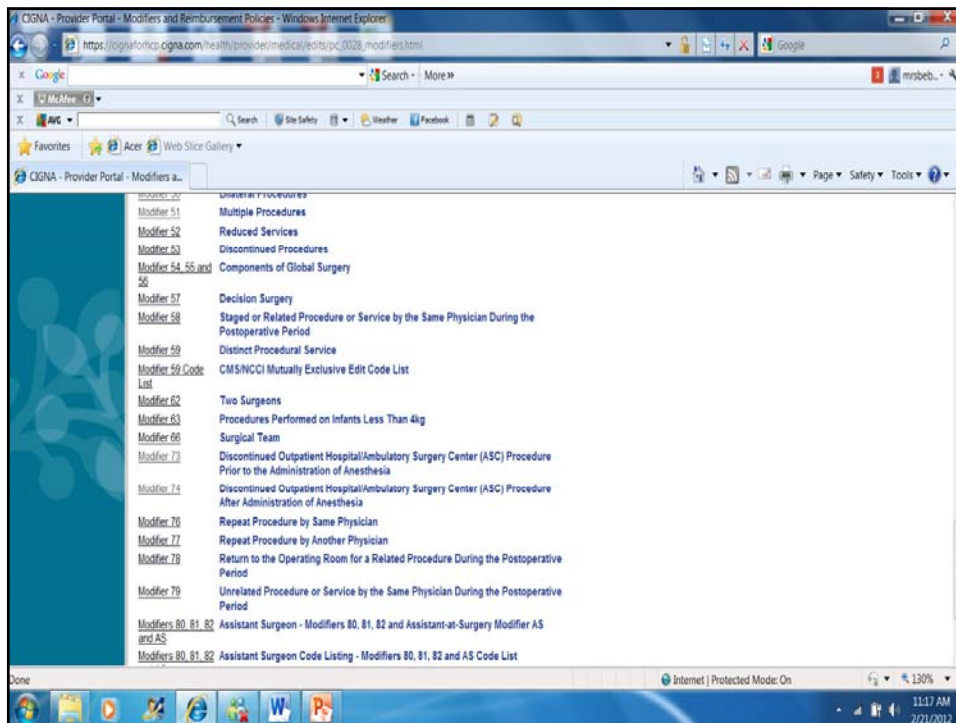
- **Modifiers** recognized for ASC claim filing are:
 - 73 Discontinued procedure prior to anesthesia administration
 - 74 Discontinued procedure after anesthesia administration
 - PA Wrong body part
 - PB Surgery wrong patient
 - PC Wrong surgery on patient

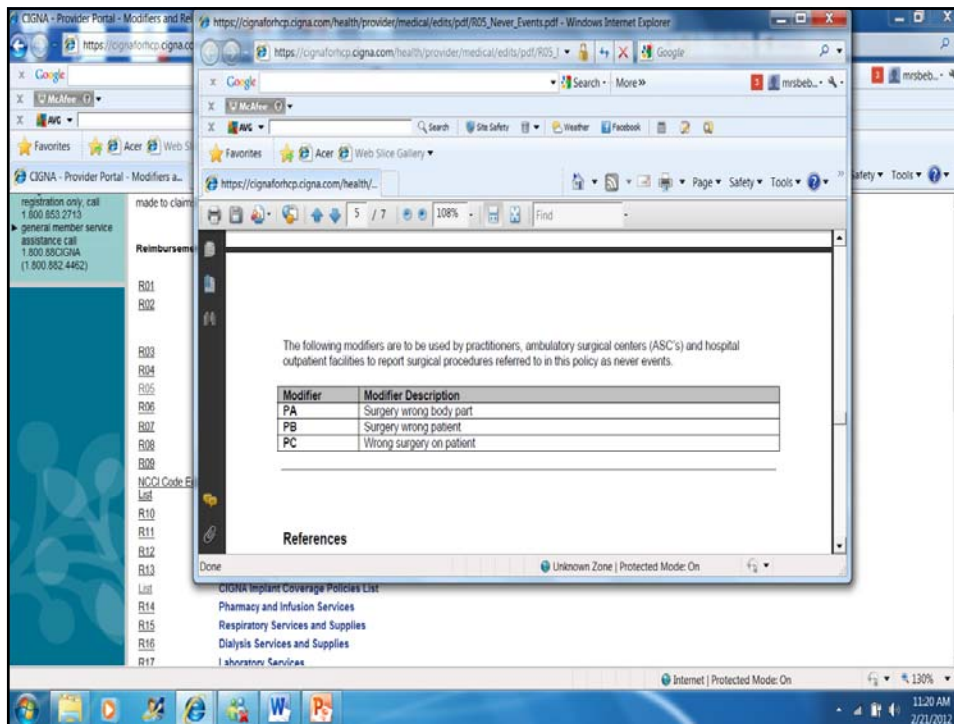


Cigna ASC Guidelines

Incorrect Use of Modifier 73:

- Modifier 73 should not be used after the administration of anesthesia.
- Modifier 73 should **not** be used for a discontinued outpatient surgery/procedure billed **by a physician**.
 - Physicians should use modifier 53 to report physician charges for a discontinued surgery/procedure.





Cigna ASC Guidelines

- **Modifiers** recognized for ASC claim filing are:
 - TC technical component
 - F modifiers (100% reimbursement)
 - T modifiers (100% reimbursement)



Cigna ASC Guidelines

- **Modifiers** recognized for POSSIBLE ASC claim filing are:
 - 50 Bilateral modifier
 - 51 Multiple procedure modifier
 - 59 Distinct procedural service



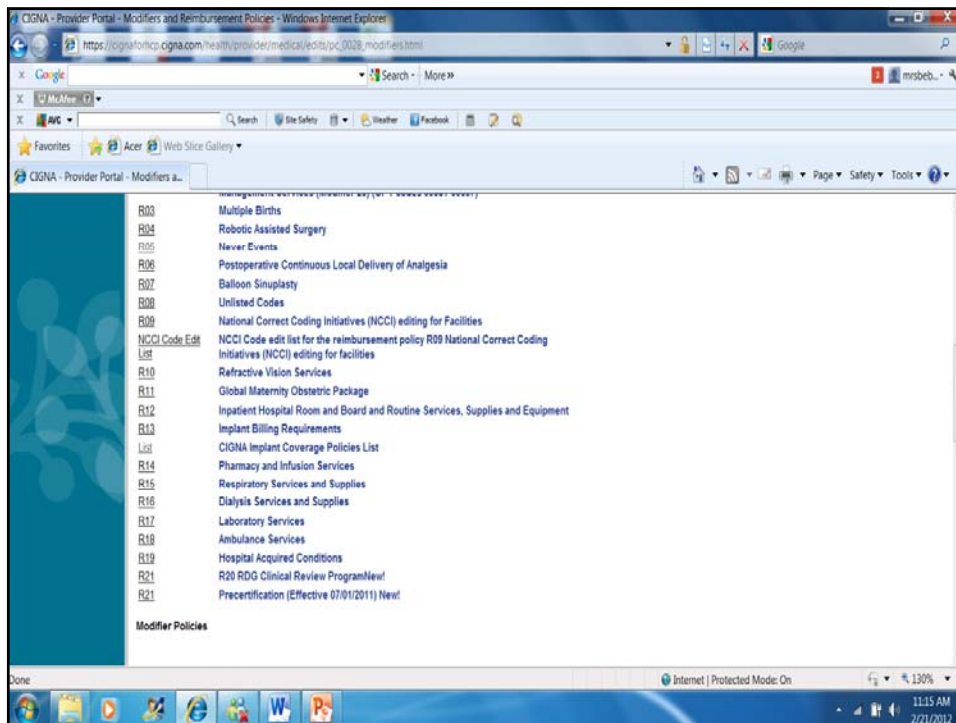
Cigna ASC Guidelines

- **Implants** are paid according to policy R13 posted on the payer website.
- Policy states:
 - Will reimburse according to terms of contract
 - May require pre-certification for select implants and procedures.
 - May review or audit charges for implants and implant procedures
 - Will not reimbursement for implants determined to be experimental/investigation because of lack of FDA approval



Cigna ASC Guidelines

- Implant policy further states
 - Implants can be permanent or removed once they are no longer needed.
 - Correct coding must be utilized to bill implants and implant procedures. Cigna provides guidance for coding specific implant devices.
 - CPT®/HCPCS reporting should describe as specifically as possible the implant procedure and implant.



https://cignaforhcp.cigna.com/healthcare/provider/app/prot/content/health/provider/medical/edit - Windows Internet Explorer

https://cignaforhcp.cigna.com/healthcare/provider/app/prot/content/health/provider/medical/edit/CIGNA_Implant_Coverage_Policies_list.pdf

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https://cignaforhcp.cigna.com/healthc...

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Find

Implant Related Coverage Policies

Coverage Policy	Policy Number	Link to Policy
Artificial Retinal Devices	0457	http://www.cigna.com/customer_care/healthcare_professional/coverage_positions/medical/mm_0457_coveragepositioncriteria_artificial_re_tinal_devices.pdf
Autologous Chondrocyte Transplantation	0105	http://www.cigna.com/customer_care/healthcare_professional/coverage_positions/medical/mm_0105_coveragepositioncriteria_autologous_chondrocyte_transplantation.pdf
Bariatric Surgery	0051	http://www.cigna.com/customer_care/healthcare_professional/coverage_positions/medical/mm_0051_coveragepositioncriteria_bariatric_s_urgery.pdf

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CIGNA - Provider Portal - Modifiers and Reimbursement Policies - Windows Internet Explorer

http://www.cigna.com/customer_care/healthcare_professional/coverage_positions/medical/mm_0305_c - Windows Internet Explorer

http://www.cigna.com/customer_care/healthcare_professional/coverage_positions/medical/mm_0305_coveragepositioncriteria_hammer_to

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McAfee

AVG

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http://www.cigna.com/customer_care...

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Find

735.9 Unspecified acquired deformity of toe

Experimental/Investigational/Unproven/Not Covered:

HCPCS Codes	Description
L8641	Metatarsal joint implant

*Current Procedural Terminology (CPT) © 2010 American Medical Association: Chicago, IL.

References

Academy of Orthopedic Surgeons, Foot and Ankle Surgery, Hammer toe, Medical Guidelines

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http://www.cigna.com/customer_care/healthcare_professional/coverage_positions/medical/mm_0125_c- Windows Internet Explorer

http://www.cigna.com/customer_care/healthcare_professional/coverage_positions/medical/mm_0125_coveragepositioncriteria_intraocular_lens_jm

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http://www.cigna.com/customer_care...

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Covered when medically necessary:

CPT TM Codes	Description
66985	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
66986	Exchange of intraocular lens

HCPCS Codes	Description
C1780	Lens, intraocular (new technology)
Q1003	New technology intraocular lens category 3 (reduced spherical aberration)
V2632	Posterior chamber intraocular lens

ICD-9-CM Diagnosis Codes	Description
366.00-	Cataract

Done

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UHC ASC Guidelines

Services billed on a UB04.



UHC ASC Guidelines

Modifiers recognized for ASC claim filing are:

- PA Wrong body part
- PB Surgery wrong patient
- PC Wrong surgery on patient



UHC ASC Guidelines

- **Implants** other services billed to UHC
 - Check your contract
 - Review the UHC administration guide (2012)
 - Gives information for clean claims
 - Special instructions for plans by region
 - River Valley entities have special instructions for revenue codes on page 165



Procedure Review

- Keller Bunion Repair procedure with implant



How to Code

Medicare

CPT _____

HCPCS _____

Performed bilaterally

CPT _____

HCPCS _____



How to Code

Aetna

- CPT _____
- HCPCS _____

- Performed bilaterally
 - CPT _____
 - HCPCS _____

BCBS of Texas

- CPT _____
- HCPCS _____

- Performed bilaterally
 - CPT _____
 - HCPCS _____



How to Code

Cigna

- CPT _____
- HCPCS _____

- Performed bilaterally
 - CPT _____
 - HCPCS _____

UHC

- CPT _____
- HCPCS _____

- Performed bilaterally
 - CPT _____
 - HCPCS _____



Procedure Review

- Urinary sling procedure to correct incontinence for male patient



How to Code

- Medicare
 - CPT _____
 - HCPCS _____



How to Code (if on carrier approved list)

Aetna

- CPT _____
- HCPCS _____

BCBS of Texas

- CPT _____
- HCPCS _____



How to Code (if on carrier approved list)

Cigna

- CPT _____
- HCPCS _____

UHC

- CPT _____
- HCPCS _____



Website links

- <http://www.cms.gov/center/asc.asp>
- <https://navinet.navimedix.com> (Aetna)
- <https://cignaforhcp.cigna.com>
- www.unitedhealthcareonline.com
- www.bcbtx.com (enter your state abbreviation)



Thank you

