BY RIVA LEE ASBELL

Medicare ASC Surgical Coding & Claims Processing Potpourri

Treatment of complications related to surgery presents ASC management problems involving many aspects including: the actual surgery, financial issues, scheduling details as well as getting paid, and paid properly, for the cases. Here, we will discuss Medicare payment issues related to ASC reimbursement.

Coding For Surgical Complications

Primarily, ASC coding differs significantly from physician surgical coding in that you are billing a *facility* fee — not a fee for the surgeon's work. In Medicare parlance, that means you're getting reimbursed for such things as equipment usage, supplies, staff salaries, and so on, and the fee for a given procedure on CMS's fee schedule includes all of those items. It makes no difference if the procedure performed is the original procedure, or results from an untoward result, or is or is not in the postoperative period.

Using CPT Unlisted Codes

Perusal of CPT (Current Procedural Terminology) codes reveals unlisted codes — those that end in xxx99 — for various categories of surgeries. These are codes that are mandated for use when the proper and exact code for a given procedure doesn't match the description of any one of the existing CPT codes. An example of an unlisted code is CPT code 67999 described as: "Unlisted procedure, eyelids." The physician payment of any xxx99 code involves Medicare removing the claim from routine processing and reviewing it individually for payment. There is no such mechanism for processing xxx99 ASC claims. Therefore, codes ending in '99' cannot be used for ASC coding.

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Modifiers

Modifiers used in Medicare ASC surgical coding differ significantly from those used in physician surgical coding. See the "Excerpts from WPS Medicare Global Modifier Fact Sheet," which provides a listing of the most common modifiers you'll be using when coding surgery in the ASC for Medicare claims. Below are links to WPS Medicare's website and the Modifier Fact Sheets:

- ***http://www.wpsmedicare.com/j8macpartb/resources/modifiers/***
- ***http://www.wpsmedicare.com/j8macpartb/resources/modifiers/globalsurgmodifiers.shtml***

Notably absent from ASC use are modifiers 58, 78 and 79, which are used for enabling payment for *physician* surgical procedures *performed in the global period* that fall into one of the following categories: lesser to greater, diagnostic to therapeutic or staged procedures (modifier 58); procedures **related** to the original procedure (modifier 78); procedures **unrelated** to the original operation (modifier 79). There is no global period in facility billing.

When a patient is readmitted to an ASC during the global surgery period, it is important to keep in mind, once again, that the ASC payment varies from physician payment methodology and only appropriate modifiers approved for ASC use by Medicare — not the ASC modifier section in CPT — should be used. Complications related to an original surgery should not be coded with modifier 78 for the ASC claim even though it would appear on the

Q&A

Q. We've had two unplanned returns to the OR within the 90-day global period in the last couple of months. Our biller used Modifier 78, and both claims were denied. Case 1 was a Gunderson flap failure and was billed 65782 and 67880 with modifier 78. Case 2 was a medically necessary IOL exchange with modifier 78. What modifier should we use, if any?

A. In Case 1, the codes used are 65872 (Ocular surface reconstruction; limbal conjunctival autograft [includes obtaining graft]) and 67880 (Construction of intermarginal adhesions, median tarsorrhaphy, or canthorrhaphy).

There are several issues to address in this question. There is not sufficient information to code the case. In complicated cases like this, it is difficult to code without the benefit of having the operative notes and chart documentation. Modifier 78 was not appropriate for the ASC claims and may have contributed to the rejection. In addition to incorrectly using modifier 78, there may have been a problem with the diagnosis coding.

The same goes for Case 2. Without the diagnoses, procedure codes, operative notes and chart documentation, it is not possible to determine if there was medical necessity. If it were only refractive problems, the claims processor may have determined there was no medical necessity. For ASC coding, modifier 78 was unnecessary.

Q. Can the ASC bill the patient for the extra cost incurred with "Dropless Surgery"?

A. For ASC billing, medications are either packaged with the method of delivery (N1 designation on Schedule BB) or may be billed to Medicare separately (K2 designation). Patients cannot be billed for the drugs or the method of delivery. Furthermore, any charge for Dropless Surgery is prohibited from being included as an item in the premium IOL package or buried in any other charges to the patient.

Q. An iStent was inserted under difficult circumstances (poor view, patient movement and bleeding). The surgeon placed it, but at a post-op visit, he could see it was barely hanging on. What, if anything, can he bill to reposition it? He's concerned it may fall out of the trabecular meshwork. Is it possible to use repair operative wound, since there is no code to reposition an iStent?

A. *(Listserv answer: note there is no way for the ASC to bill for the procedure)* "After a lot of discussion, it would be appropriate to use the unlisted CPT code for the repositioning. Use CPT code 65920 if removing the implant." physician claim. Nor should modifiers 58 or 79 be used, even though they might be applicable to physician coding. The ASC is entitled to full payment according to the ASC fee schedule.

Order of Procedures

The CPT codes should be placed on the claim in descending order of reimbursement with the highest paying procedure first. Currently, more codes are reimbursed at the same amount for the same family of codes in ASC payment, but there remains a differential on the physician side. Inadvertently, a given claim may not be put in the same order on the ASC claim. ASC coders should be aware of the physician side in order to make the claims have the same order (Figure 1).

Figure 1. ASC versus Physician Payment

Fees from Novitas-Solutions Inc. Medicare Fee Schedules ASC and Physicians (Metropolitan Philadelphia)

ASC Reimbursement	Physician Reimbursement
66984 (Cataract extraction/IOL) $883.58	66172 (Trabulectomy/scarring) $1,635.68
66172 (Trabulectomy/scarring) $883.58	66984 (Cataract extraction/IOL) $690.65

Claims Processing/Claims Splitting Prohibition

There have been recent communications from various Medicare Administrative Contractors (MACs) warning ASC billers not to split claims for multiple procedures performed at the same session by the same physician. This warning applies to:

- Submitting separate claims for each side when coding bilateral procedures, such as a bilateral functional blepharoplasties or entropion repairs
- Submitting separate claims for multiple procedures performed by the same surgeon during the same session, such as repair of retinal detachment with removal of an IOL that dropped into the vitreous using pars plana posterior vitrectomy + removal of IOL from posterior vitreous + insertion of secondary intraocular lens + suturing of the intraocular lens

ASC claims are paid by Part B Medicare and follow the payment rules for multiple procedures performed at the same session (applies to both ASC and physician payment), wherein the first procedure is paid at 100% of the allowed amount and the next four procedures are paid at 50% of the allowable for each procedure. When the claims are split, each claim is processed independently, and the facility may be erroneously paid at 100% of the fee schedule amount for each claim. In Figure 1, this would result in an erroneous payment of $1767.16 (2 x $883.58) instead of the correct payment of $1325.37 (1.5x $883.58).

The Office of the Inspector General (OIG) highlighted this problem in its January 2003 report, titled "Review Of Claims For Multiple Procedures Performed In The Same Operative Session In Ambulatory Surgical Centers" (http://oig.hhs.gov/oas/reports/region7/70302665.pdf). ■

EXCERPTS FROM WPS MEDICARE GLOBAL MODIFIER FACT SHEET

MODIFIER	DESCRIPTION	EXPLANATION
58	**Staged or Related Procedure or Service by the Same Physician During the Postoperative Period**	• Modifier 58 indicates the physician, or member of the same group, planned the performance of a procedure or service during the postoperative period prospectively or at the time of the original procedure. • Bill modifier 58 with the subsequent performed procedure. • Use during the post-operative period starting the day after the initial procedure. • Not appropriate for services performed on a single date of service. • Not appropriate when the MPFSDB indicates XXX global period. • Not appropriate with assistant at surgery. • **Not appropriate for Ambulatory Surgical Center's Facility fees.**
78	**Return to the Operating Room for a Related Procedure During the Postoperative Period**	• Used to indicate the performance of a procedure during the postoperative period or on the same day as the original procedure to treat complications, which required return to the operating room. • Bill modifier 78 with the CPT code describing the procedure(s) performed during the return trip. • Only use the procedure code for the original procedure if the identical procedure is repeated. • When the procedure code used to describe a service for treatment of complications is the same as the procedure code used in the original procedure, modifier 78 is still the correct modifier to use. • Modifier 78 reimbursement is intra-operative percentage only. • Use Modifier 78 to document treatment of complications only. • Use Modifier 78 to indicate services furnished in an operating room (OR). OR definition, for this purpose, is a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, laser suite, or endoscopy suite. It does not include a patient's room, minor treatment room, recovery room, or intensive care unit. • Does not apply to assistant at surgery services. • **Does not apply to Ambulatory Surgical Centers facility fees.**
79	**Unrelated Procedure or Service by the Same Physician During the Postoperative Period**	• Modifier 79 indicates the performance of a procedure or service during a post-operative period was unrelated to the post-operative care of the original procedure. • Bill Modifier 79 with the procedure performed. • Do not bill when the MPFSDB indicating XXX in the post-operative field. • Use modifier 79 on services during the post-operative period starting the day after the procedure. • Does not apply to assistant at surgery services. • **Does not apply to Ambulatory Surgical Center's facility fees.**

Author's Note: The last bullet in each of these descriptors states that these modifiers are not appropriate or should not be billed with Ambulatory Surgical Center's facility fees. Boldface inserted by author.