Is your ASC leaving money on the table?

Third in a series of articles on improving revenue.

You’ve made sure you’re doing all you can at the front end to line up your procedures for correct reimbursement—your staff is clued in to ask the right questions during scheduling and is meticulous about insurance verification and precertification, which were the subject of the previous articles.

Now you need to make sure you have good processes on the back end so you are coding and billing correctly. If a claim is denied, as some inevitably will be even with the best processes, you need to be prepared to stage a vigorous appeal.

Proper coding is the backbone of the billing process. Coding not only affects the center’s reimbursement. But sloppy coding, more than anything else in the reimbursement process, can expose the ASC to compliance risks.

Coding is complex. ASC managers should make sure the staff who do the coding are educated specifically in coding and billing for ASCs. Many coders are hired from hospitals or physician practices and do not know about billing for ASC services, which is a hybrid unlike either of those settings. ASC coding seminars are offered by the American Association of Ambulatory Surgery Centers (www.aaasc.org), FASA Inc (www.fasa.org), and private companies.

If your ASC outsources billing services, be sure the people doing the coding understand ASC coding, are experienced, and are billing for the ASC’s services correctly. Billing services should be reviewed by an experienced ASC auditor at least once a year.

Coding and billing tips

These are suggestions for coding and billing in a way that is most likely to earn your facility fair and timely reimbursement:

• Before billing for a case, be sure the staff has all of the pertinent information, including implants used in the case (sidebar).

• Don’t bill from the ASC’s surgical schedule. Instead, the coder should use the operative report and read it thoroughly to code for all of the procedures performed during the case. Coding from the schedule without an op report is dangerous. It is risky from a compliance standpoint—there is a chance of billing for procedures not performed, which is fraudulent. There is also the risk of lost revenue if all procedures are not billed for.

• Read the entire op report. Code only for procedures documented in the body of the op report. Don’t code from just the summary at the beginning of the op report. The summary may list only some of the procedures performed or list a procedure not documented in the body of the op report.

• For cases involving multiple procedures, be sure the coder reviews each code billed to see that it follows the latest edits of the government’s Correct Coding Initiative (CCI). The CCI edits reflect Medicare’s policy for proper billing of Part B services, including pairs of services that normally should not be billed by the same provider for the same patient on the same day. The CCI edits are available on the Centers for Medicare and Medicaid Services website (www.cms.gov) or from Ingenix (www.ingenix.com) or Decision Health (www.decisionhealth.com).

• Check that your billing staff is using coding modifiers appropriately, according to the requirements of each contract.
• Monitor physicians’ use of “canned” op reports to be sure they are documenting enough information about the patient’s surgery to pass the payor’s audit.
• Bill for fluoroscopy used during procedures to the following types of payors: Payors with which the ASC does not have a contract, payors that do not exclude radiology services from their contracts, indemnity plans, sometimes on workers’ comp cases, and accident payors. If you are trying to be consistent and bill all payors the same, append the –GY Noncovered Modifier to codes disallowed by Medicare or by other payors when billing fluoroscopy. The claim might be reimbursed by another payor.

Be timely with claims
Be familiar with payors’ contract requirements regarding timely filing of claims. Have policies to bill cases within a reasonable period of time after surgery. (Realize that some cases cannot be billed accurately until the pathology report comes back.)
Some payors, such as Medicare, require claims to be filed within 1 year of the date of service. Others require billing within as little as 90 days. HMOs typically have tighter billing timelines than other payors.
Have good processes for capturing all procedures performed and the information needed to file claims within the required timelines. One good way to capture all of the procedures performed is to cross-check the op report with the surgical schedule. Be aware of payor guidelines and requirements for billing of bilateral procedures and usage of modifiers.
Bill claims electronically whenever possible. Not all payors accept electronic claims, so be aware of payor requirements. Paper claims may be needed for cases with implants because a copy of the implant invoice must be sent with the claim.
Claims involving unlisted procedure codes must be billed as paper claims and sent with a copy of the op report. Because most workers’ comp carriers require a copy of the op report to process their claims, it may save time and money to submit those as paper claims. You might want to send them certified mail/return receipt requested for proof that the claim was submitted.

Clean claims every time
Here’s advice for helping to ensure claims will be processed properly the first time they are submitted:
• Check every field of the claim to be sure it is completed properly before submitting the claim.
• Keep patients’ insurance and demographic information up to date. Do thorough insurance verification and check on precertification for every case performed in your ASC.
• It is wise to manage your ASC’s fee schedule and update fees every year.
• To avoid duplicate claim filings, be sure payments are posted in a timely manner. Do not submit a paper claim for the same services if the claim is already being submitted electronically. Electronic claims typically are paid faster than paper claims.

Don’t give up on denied claims
Following the processes outlined above should decrease denied claims dramatically. But some claims will be denied. When this happens, we encourage vigorous appeals. Insurance companies bank on making the “hassle factor” so great that you give up. Don’t give in.
All payors have appeal processes, but they vary greatly. The appeal procedure should be outlined in your provider manual for the plan. Review the appeal procedures and follow them to the letter. Pay close attention to timeliness. Many appeals are unsuccessful because the appeal deadline requirements were not followed.
Some advice on appeals to Medicare as well as most other payors:
• Include additional documentation to support your position. Don’t keep working your way up the appeal ladder with the same information previously submitted, which does not bolster your position.
• Get the surgeon who performed the procedure involved. If your claim has been
denied, it is likely the surgeon’s claim was denied as well.
• Realize that 85% of claims denied for medical necessity are denied for one simple
reason—the diagnosis code used on the claim. This is the first thing to check.
  If it is a Medicare claim, check if there is an LRMP (Local Medicare Review Policy) or
  LCD (Local Coverage Determination) in effect for the procedure (there are many—
colonoscopies, some pain management procedures, blepharoplasties, etc).
  If there is one, the policy will give you a list of the diagnosis codes allowed for
  billing that procedure. Don’t fraudulently bill with a code on the list if none of the
codes applies. But if you are able to find a symptom or diagnosis that fits for a con-
dition documented in the op report, pathology report, or history and physical, you
can use that condition to get the claim reprocessed.
• If the claim was denied because the ASC’s procedure coding does not match the
coding on the physician’s claim, find out what codes the physician billed and see
if your coding was correct. If it’s obvious the physicians’ office coded the claim
incorrectly, and you believe your coding is correct, pursue your appeal based on
your correct coding. Do not follow the physician’s coding if you know it is incor-
rect. Your ASC is responsible for its own facility coding. If the ASC uses the cor-
rect codes, you are safe even if the coding is different than the physician’s.
  With these processes and a well-educated staff, your ASC is in a strong position to
  avoid leaving money on the table.

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Getting paid for implants

Medicare reimburses for few (if any) implants for procedures done in an ASC
setting. But don’t assume all payors follow Medicare, and don’t let that keep you
from billing any payors for implants.
These are some tips for billing for implants:
• Know your contracts. For each of your payors, know their contract terms for cov-
erage of supplies and implants. Some payors allow billing only for some
implants, often referred to as a “carve out” from the contract.
  For example, some payors do not include payment for intraocular lenses (IOL) in
  their payment for the 66984 cataract code. For these payors, the IOL is billed as a
  separate line item using HCPCS codes V2630 for anterior chamber IOLs and
  V2632 for posterior chamber IOLs. Do not bill these codes to Medicare. Of course,
  if a high-tech IOL is used, use the appropriate Q code; these implants are usual-
  ly reimbursed by Medicare.
• File a paper claim rather than an electronic claim when billing for implants and
  include a copy of the paper invoice.
• Bill implants to workers’ comp carriers (unless your state does not allow this), to
  accident carriers, to payors whose contracts allow or do not prohibit billing of
implants, and to payors with whom your ASC does not have a contract.
• Use the appropriate HCPCS codes when they exist (these 5-digit codes start with
  a letter instead of a number). These generally are good for orthopedic procedures,
with L8699 being the most common. Some payors require billing implants with
the more general 99070 supply code.