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## Code Properly to Prevent Lost Revenue

Tips for reducing rejection/denial rates **BY ANGELA MATTIODA**



An ASC's coding staff plays a key role in avoiding claims denials. By ensuring accurate coding and data entry, an ASC is more likely to receive correct, complete payment for services rendered. Any number of coding-related issues might cause a loss of revenue. Understanding these issues and how to effectively respond when they arise will help keep cash flowing in and denials away.

### Correct CPT Codes 'Not Authorized'

Surgeons intending to perform a specific procedure might need to change their plan after starting surgery. Any such change could result in a denial since the procedure performed differs from the authorized procedure. In many specialties and when dealing with health maintenance organization (HMO) policies, it would be appropriate to request an authorization for a range of codes that relate to the intended procedure. This can eliminate the possibility of authorizing the incorrect code.

If there is a discrepancy between the issued code(s) and authorized code(s), the biller should communicate immediately with the surgeon's office staff or the HMO's primary care referring physician to request adding the code to the authorization before it processes and is denied.

If you must wait for the denial to appeal, make sure your appeal is detailed. Include the authorization timeline of the original code, an explanation of why a different procedure was performed and documentation to support medical necessity.

“Assign the screening diagnosis as the primary diagnosis, even if there are findings, and the diagnosis describing the findings as the secondary diagnosis.”

—Angela Mattioda  
*Surgical Notes RCM*

### Colonoscopy Screening Versus Diagnostic Coding Discrepancies

Another common denial relates to coding colonoscopy procedures. Screening and diagnostic colonoscopies are processed based on the patient's specific insurance policy. If there are lower GI symptoms indicated in the operative report or history and physical (H&P), the screening will turn into a diagnostic colonoscopy. A screening colonoscopy may be covered by the patient's policy whereas a diagnostic colonoscopy may not be covered, leaving the patient with a higher out-of-pocket responsibility. The Centers for Medicare & Medicaid Services (CMS) has specific guidelines related to preventative procedures (found at [www.medicare.gov/coverage/colorectal-cancer-screenings.html](http://www.medicare.gov/coverage/colorectal-cancer-screenings.html)) that many payers follow.

To avoid denials for colonoscopy procedures, verify benefits for both screening and diagnostic colonoscopies, and obtain the appropriate authorizations. Verify the benefits with the screening diagnosis code (Z12.11) versus a diagnosis code that will be used as the secondary that indicates findings (K63.5). This upfront discussion with the payer will help you determine how the payer will handle the

case in either event. Educate patients that their out-of-pocket cost could significantly increase if there are findings during their screening colonoscopy. If the colonoscopy is performed for diagnostic purposes due to presenting signs or symptoms, the procedure will typically be covered as a surgical service under the patient's benefit plan.

Coders should be knowledgeable of coding guidelines to ensure the correct use of diagnosis codes, order of diagnosis codes and use of applicable modifiers. Assign the screening diagnosis as the primary diagnosis, even if there are findings, and the diagnosis describing the findings as the secondary diagnosis (Note: This can change depending on Medicare local coverage determination [LCD] or payer requirements). Some payers might still process according to the original reason for the colonoscopy (e.g., screening).

### Unlisted CPT Codes or Non-Covered Procedures

It is never compliant to choose a listed code because it is “close” to the performed procedure.

Recognize in advance when an unlisted code will be used and obtain the appropriate authorization. If the claim is denied, submit an appeal and include a copy of the operative report, H&P and other clinical notes that justify medical necessity. In the appeal, it might be necessary to provide a comparable procedure code and description and note the differences between the procedure performed and the comparable code. If the unlisted procedure involved more time or expertise, that should also be in the appeal. The comparable procedure code should have a similar approach and anatomical site.

The advice and opinions expressed in this column are those of the author and do not represent official Ambulatory Surgery Center Association policy or opinion.

Unfortunately, Medicare will not pay unlisted codes and, as noted earlier, payers often follow CMS guidelines. Many payers will process the claim based on their fee schedule, which typically does not cover unlisted codes.

### Improper Coding of Bilateral Procedures

Payers often have different guidelines on billing for bilateral procedures. Some might require reporting two-line items while others will require one-line items with the appropriate modifier. CMS ASC coding guidelines require the use of right (-RT) and left (-LT) modifiers.

When billing the Department of Labor (DOL), ensure its authorization exactly matches the claim. DOL might authorize a bilateral procedure to be billed with modifier -50 or a bilateral to be billed with -RT/-LT modifiers on two-line items. The claim must be billed exactly as it was authorized.

### LCD/NCD-Medical Necessity Denials

Coders and billers should communicate with the provider and provider's office to discuss LCD requirements. The more knowledge obtained from the provider's office on specific payer policies and its requirements for medical necessity, the better. Coders should code specific to the operative report. If the provider omits details in their dictation that would support a diagnosis code payable per the LCD, the claim will be denied. Note: If no LCD is available, coders should check for national coverage determinations (NCD).

### Not Coding per Payer Rules and Contract/State-Specific Regulations

Billers must double check payer-specific guidelines and policies to keep denial percentages low. Create a matrix for in-network and out-of-network payers that outlines all important and applicable information needed for coding and billing. It should include payment methodology, how the con-



tract handles unlisted/non-covered codes and how payers handle implants and billing requirements. A common example of a rule that should be noted in the matrix is if the payer requires G0260 or 27096 to report a sacroiliac joint injection.

A good practice is for billers to enter charges in payer groupings to help maintain focus on payer-specific rules. Consider medical necessity requirements by payer when reviewing charges. Immediately communicate any potential medical necessity issues to the provider and staff.

### Incorrect or Missing Modifiers

Modifiers are billed based on payer-specific guidelines. A few common modifier issues involve bilaterals or performing multiple procedures during the same session. An example would be modifier -59, used to indicate the procedure was distinct or independent from other procedures performed during the same case and to identify pro-

cedures not normally reported together (due to the National Correct Coding Initiative or CCI edits). It would be appropriate to use modifier -59 if a procedure was performed in a different anatomical site/compartments, by a separate incision or for a separate injury.

### Stay Cash Positive

Significant cost is tied to reworking claims due to unnecessary errors. The coding and billing team should be certified and have all necessary tools available to ensure clean claim submissions. Following best practices and having a strong quality assurance program in place will substantially reduce an ASC's denial and rejection rate and decrease any impact to a facility's revenue stream. «

Angela Mattioda is vice president of revenue cycle management services for Surgical Notes RCM in Dallas, Texas. Write her at [amattioda@surgicalnotes.com](mailto:amattioda@surgicalnotes.com).