Coding in the Ambulatory Surgery Center

by Cindi Peterson, BA, RHIT, CASC

There are more than 4,200 ambulatory surgery centers (ASCs) nationwide, performing more than 8 million surgical procedures annually.[1] With the increased volume of outpatient procedures, there is no shortage of opportunities for coding professionals.

ASC coding can prove demanding, however, for even the most experienced coder. Much of the challenge comes from the required knowledge base for coding in a multispecialty environment with both ICD-9-CM and CPT. Coders also must adhere to strict guidelines for reimbursement from both public and private payers with differing rules. This article explores some of the challenges of coding in an ambulatory surgery center.

Multiple Code Sets

Coding in the ASC environment involves complex reimbursement guidelines. Medicare service payment requires ICD-9-CM codes for diagnoses and CPT-4 codes for procedures. The Centers for Medicare and Medicaid Services (CMS) makes the final coverage determination for ASC procedures. The approved procedure list, known as the ASC list, includes those procedures that can safely and appropriately be performed in the ASC setting. Procedures that are not included on the ASC list are not reimbursed for the Medicare recipient.[2]

Each year CMS reviews the ASC list and adds or deletes procedures according to the annual American Medical Association CPT code changes.[3] Payment rates are then adjusted. The ASC list currently includes approximately 2,500 approved surgical procedures. Although these guidelines are created and used for reimbursement for the Medicare population, third-party payers have also adopted and adapted many of the same guidelines. Coding professionals must be proactive in monitoring the noncovered procedures to prevent Medicare patients from paying out of pocket for a costly outpatient procedure. They must also stay abreast of modifications to the ASC list and monitor changes and updates as they occur.

ASC Payment

Another component of ASC reimbursement is the prospective payment system. Designed by CMS, the system is based on a set of nine payment groups. Each group has a predetermined reimbursement value. CMS assigns CPT-4 codes to one of the nine payment groups according to the total cost of the procedure. The set fee for ASC payment groups is adjusted based on geographic factors and evaluated and published in October of each year. Many third-party payers have adopted this grouper methodology in designing their fee schedules. The current ASC reimbursement rate for ASC procedures was implemented by CMS in 2004 and is broken down in "ASC Payment Rates," below.

Because Medicare and managed care reimbursement is not optimal and many contracts with third-party payers are based on the grouper methodology, accurate coding is essential for the financial well-being of the facility.

Payer Contracts

Diagnostic and procedure codes are assigned based on documentation in a patient's medical record. Medicare specifies that when multiple procedures are performed during the same surgical encounter, the highest level CPT-4 code from the ASC list will be reimbursed at 100 percent; all other procedures are be reimbursed at 50 percent. Third-party payers generally base their reimbursement on a similar formula but occasionally include a 25 percent reimbursement level for multiple codes. Coding professionals must understand each payer's contract in depth to report the coded data accurately and for the facility to receive appropriate reimbursement.

ASC Payment Rates

Facility services furnished on or after April 1, 2004	
Group	**Payment**
1	$333
2	$446
3	$510
4	$630
5	$717
6	$826 ($676 + $150 for IOLs)
7	$995
8	$973 ($823 + $150 for IOLs)
9	$1,339

Effective management requires surveillance of third-party payer contracts and applied knowledge of each formula included in the contract. Coders should be included in contract negotiations and setting fee schedules since they have the ultimate responsibility of assigning codes to file the claim with the payer. Additionally, all third-party payer communication bulletins should be directed to coders so current information on billing and coding are implemented.

ASC Modifiers

Coding for ambulatory surgery procedures also requires modifier assignment. Level I (CPT) and level II (HCPCS) modifiers have been approved for outpatient procedures, specifically ASC reporting since the modifiers add information about the procedures performed.

The modifier's original use was to report the physician's professional services; however, they have been adopted to apply to outpatient facility fees as well. Commonly, the CPT level I modifiers applied to ASC coding are those that report reduced services, bilateral procedures, multiple procedures, distinct procedural services, and returns to the operating room. Modifiers are used on both Medicare and third-party payer claims. "Examples of ASC Coding," above, illustrates the appropriate codes, group, and payment for two procedures.

This outline shows two procedures—bilaterial hammertoe repairs and torn medial and lateral meniscus—broken down by code, modifier, payment group, and payment rate. Clearly, coding professionals must be knowledgeable in order to accurately assign codes in the ASC setting.

Examples of ASC Coding							
Bilateral Hammertoe Repairs, Digits 2-4							
Diagnosis Description	ICD-9-CM Diagnosis	Procedure Description	CPT Code	HCPCS Level II Modifier	Modifier Description	ASC Pay-ment Group	ASC Payment Rate
Hammertoe	735.4	Bilateral Hammertoe Repairs, digits 2-4	28285	T1	Lt foot 2nd digit	3	$510
			28285	T6	Rt foot 2nd digit	3	$510
			28285	T2	Lt foot 3rd digit	3	$510
			28285	T7	Rt foot 3rd digit	3	$510
			28285	T3	Lt foot 4th digit	3	$510
			28285	T8	Rt foot 4th digit	3	$510
Left Meniscectomy Cancelled Following Administration of Anesthesia							

Torn medial and lateral meniscus	836.0, 836.1	Left Menis-cectomy	29881	74	Discontinued procedure af-ter anesthesia administration	4	$630 Reduced by 50% for a discontinued procedure

Emerging Technologies

The ASC setting has also seen advances in technology, with special equipment, implants, and less invasive surgical techniques. Emerging technologies include radio frequency techniques for cosmetic and pain management procedures as well as microneurosurgery and procedures for urinary incontinence. These procedures require additional or new technology and supplies. Coders must keep up to date on this changing technology through resources such as the Internet, vendor information, and professional publications.

New techniques and procedures can complicate payer policies as they may include or exclude certain supplies and equipment approved for reimbursement. Medicare's local carrier determinations (LCDs) govern if payment will be made for certain equipment and supplies. Coders must code each patient's procedure with a comprehensive understanding of the LCD rules or reimbursement will be negatively affected.

Abstracting

Coders in the ASC setting may also be required to abstract case findings and report these to a cancer registry. Biopsies and tissue removal are common practices in the ASC, and occasionally a pathology may indicate a neoplasm. ASCs are required (as are hospitals) to report neoplasms to a state cancer registry. This is a painstaking task since it is a very specialized area of coding that requires reporting more than 80 individual data elements either by hardcopy template or electronically. The assignment of topography and histology using the International Classification of Diseases for Oncology (ICD-O) is one more demanding task added to the busy coder's responsibilities.

A variety of coding expertise is required of the coding professional in the ASC setting. Greater levels of education are needed to ensure that coding is accurate and compliant and appropriate reimbursement is captured. It is predicted that surgical procedures being performed on inpatients will continue to migrate to the outpatient arena. Exceptional skills and knowledge will be required for the coding professional to keep pace with the changing landscape of the outpatient setting.

Notes

1. Federated Ambulatory Surgery Association. "Frequently Asked Questions about Ambulatory Surgery Centers." Available online at www.fasa.org/faqaboutasc.html.

2. Center for Medicaid and Medicare Services (CMS). "Ambulatory Surgical Center Base Eligibility Fees." Available online at www.cms.hhs.gov/ascpayment.

3. CMS. "HCPCS Background Information." Available online at www.cms.hhs.gov/medicare/hcpcs.

Reference

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Cindi Peterson *(lpeterson@rockfordambulatory.com) is director of business operations at Rockford Ambulatory Surgery Center in Rockford, IL.*

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