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The ASC Medicare Payment System: Billing Quandaries and Words of Wisdom

Like all things in life, something new takes time to comprehend and understand. The new Medicare ASC payment system is no different. As ASCs want to continue their streamline of revenue from payors for services they provide, it becomes imperative for business and coding staff to learn the “in’s and out’s” of ASC coding rules and claim form processing to maintain that continuous revenue.

One item we must consider and often do not think of is the processing of claims for this new payment system from the fiscal intermediary aspect. In a recent audio teleconference provided by Medicare for ASCs, it was noted that questions from ASC

“ If a ruling is not understandable, call and find out specific details from the payor ”

billing and coding staff were not easily answered by the Medicare staff, and many times they had no answer at all.

Coding is coding and submitting a claim form for payment is an easy process, right? We should think this task is fairly uncomplicated, but as we know from previous history, coding is not always black and white. Many times payors apply their own rules and everything becomes a dark tunnel of gray matter. In addition, claim form submissions have their own idiosyncrasies to challenge us even further. Let’s now look at some key items for clean

claim submissions and some words of wisdom.

First and foremost, always develop a good line of communication with your Medicare provider representative. Know names, find out who is in charge of ASC claims, is there a supervisor? Write it down. If a ruling is not understandable, call and find out specific details from the payor. Remember this is new to them as well, and there will be glitches and snags to work out before all is said and done.

In order to be reimbursed by Medicare, the ASC facility must be certified and enter into a “participating provider” agreement with CMS. When we view this from a national perspective, remember there are 4,600 ASC centers enrolled with CMS and they expect to make approximately \$ 3 billion in payment to these providers. The new payment system is a “packaged” system, meaning a procedure performed is expected to provide certain services that have already been valued as part of the “packaged” service payment. There are many items that can be billed for separately, but you must also be enrolled as that type of provider, such as DMERC, CLIA lab, Independent radiology facility, etc.

There are some items that CMS will pay for separately and you will want to research your addendums of the CMS payment system.

Some of these items are:

- Brachytherapy sources
- Implantable items that have pass-through status under OPPTS, (outpatient prospective payment system).
- Certain items that CMS has designated as contractor-priced such as procurement of corneal tissue.
- Drugs and biologicals for which separate payment is allowed under OPPTS.

- Radiology services for which separate payment is allowed under OPPS.

Now, let's take a look at some reimbursement issues with the ASC payment system. Pass-through status for devices are granted to new devices that will lead to substantial clinical improvement for the patient. These devices may be paid for a period of two to three years and then are incorporated into the bundled package payment.

Currently, there are only 2 devices that have pass-through status under OPPS of as January 2008.

- C1821: Interspinous process distraction device (X-stop)
- L8690: Auditory osseointegrated device including internal and external components.

Remember CMS will publish quarterly updates about covered services in the ASC and any related payment changes and coding issues. This information may be found at www.cms.hhs.gov/ascpayment/.

Other key reimbursement issues are:

- ASC facilities are subject to deductible and coinsurance.
- Payable codes will be updated on an annual basis, but drugs


are updated every 3 months.

- Payment will be based upon a certain percentage of the OPPS payment rate.
- Other services such as ancillary items will be contractor priced and based on invoice cost. CMS has instructed that drugs and biologicals are billed with HCPCS code, C9399 and payment will be priced at 95% of the average wholesale price (AWP).
- Payment rates are adjusted also for geographic wage index.
- Labor related portion of the service is now 50% and non-labor related portion is 50%.
- Four year transition period to implement rates.

Example of payment: 64483

Injection, anesthetic agent and/or steroid, transforaminal epidural; lumbar or sacral, single level.

75% CY 2007 Payment Rate
 + 25% CY 2008 Fully Implemented Payment
 CY 2008 First Transition Year Payment
 CY 2007 payment = \$ 249.75 \$333.00 x 75%
 CY 2008 payment = \$73.02 \$292.07 x 25%
 \$249.75 + \$73.02 = \$322.77
 (CY 2008 first transition year payment)



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Now let's review some of the claim form billing quandaries for our CMS 1500 form.

1. The SG modifier is no longer required to be listed after the procedure code. CMS will not deny claims with the SG modifier, but it is no longer necessary due to NPI.

2. Bilateral procedures must be reported on two separate lines to received proper reimbursement. Payment will be the same as multiple procedures, 150%. CMS did state that if -50 modifier is used, rather than billing on two lines or two units, the claim will be denied. Physician claim form reporting is different than the ASC, as physician claims require a one line item with the -50 modifier and double price, one unit.

Let's view an example:

HCPCS	Description	PI	Units	ASC Change	Unadjusted CMS Payment Rate	Unadjusted CMS payment
15823-RT	Revision of Upper Eyelid	A2	1	\$1000	\$800	\$640
15823- LT	Revision of Upper Eyelid	A2	1	\$1000	\$800	\$320

Because the provider reports the bilateral procedure correctly on two separate lines, the provider will receive 100% of the first procedure and 50% of the 2nd procedure. Remember, CMS will deny the claim if reported as a one line item with a -50 modifier.

3. FC and FB Modifiers were established for reporting partial or full credit received by the ASC from the manufacturer for specific device procedures. For ASC services furnished on or after January 1, 2008, the partial credit policy applies to the same device and procedure pairs to which the no cost or full credit policy applies. Medicare payment will be reduced by 50 percent of the estimated cost of the device included in the procedure payment in cases in which the ASC reports that it received a credit of 50 percent or more of the cost of the new replacement device by appending the FC modifier to the device implantation procedure HCPCS code. Submit modifier FB when a device is furnished without cost or when full credit is received from the manufacturer. Submit modifier FC when partial credit is received. CMS also instructs never to report FB and FC on the same service.

Here are examples of reporting:

Full credit reporting:

HCPCS	Description	PI	Units	Unadj. ASC Payment	Offset Value	New Unadj. Payment
33240- FB	Implant ICD	J8	1	\$17,500	\$17,000	\$500

Partial credit reporting:

HCPCS	Description	PI	Units	Unadj. ASC Payment	Offset Value	New Unadj. Payment
33240- FC	Implant ICD	J8	1	\$17,500	\$8,500 (17,000 x 50%)	\$9,000 (8,500 + 500)

Do not report the C1721 as a separate line item, the device is included in the CPT procedure code of 33240 and if reported as such will cause potential underpayment.

4. ASCs now have clear defined modifiers for services that were terminated either prior to anesthesia, after anesthesia or procedure not requiring anesthesia but discontinued.

- a. Modifier 73 should be reported for services terminated before anesthesia, the ASC facility will receive a 50% payment.
- b. Modifier 74 should be reported for services terminated prior to anesthesia; the ASC facility will receive 100% of payment.
- c. Modifier 52 should be reported for services discontinued that are services not requiring anesthesia.
- d. Remember, the physician will report a different modifier of -53 for these circumstances.
- e. The 52 or 73 modifier are not subject to multiple procedure


discount.

f. The 74 modifier may be subject to the multiple procedure discount.

Documentation is key in utilizing these modifiers. A template or form should provide the following information:

- CPT code had surgery been performed
- Reason for termination
- Services actually performed
- Supplies actually provided
- Services not performed that would have been if surgery had not been terminated.
- Time actually spent in each stage (pre-op, intra-op and post-op)

5. Modifier TC is required unless the code definition is for technical component only.

As the year progresses more nuances and quirks will develop, but by years end, both facility and payor should have all processes smooth and streamlined for correct reimbursement. 



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