



American Association of Oral and Maxillofacial Surgeons  
Ambulatory Surgical Center Coding and Billing



2011

**I. INTRODUCTION**

This coding paper will introduce AAOMS members and staff to the process of coding and billing for ambulatory surgery centers (ASC) and review resource materials, coding for surgical services, modifiers and billing formats for ambulatory surgery centers services.

Oral and Maxillofacial Surgery has a long and successful history of providing anesthesia services in combination with surgical procedures in an office environment. Traditionally, the office equipment, supplies, personnel and pharmaceuticals were reimbursed from the professional code component of the surgical fee and anesthesia fee. With the introduction of a resource-based relative value system (RBRVS), all surgical CPT codes were relative value adjusted based upon many factors, including site of service. This resulted in significant downward pressure on surgical fees, especially in the office surgical environments of the Oral and Maxillofacial Surgeon (OMS). Unlike the CDT coding systems for anesthesia, the Relative Value Units (RVUs) for medical anesthesia care only include reimbursement for the professional component of anesthesia and do not include allowances for drugs, equipment, and nursing staff. This has led to a reevaluation of the business logic of office-based surgery for medical procedures. Since the OMS provides both medical/surgical and dental surgical services, a thorough understanding of the economic assumptions of the ambulatory surgery industry is useful in practice development and management.

As the industry continues to evolve, it is imperative that the OMS has a working knowledge of ambulatory surgery center billing and coding. This is essential:

- To understand how the medical industry and the federal government reimburses ambulatory surgical facilities.
- To understand the difference between facility billing and reimbursement and non-facility billing and reimbursement
- To determine if OMS office based surgical services remain economically feasible
- To understand how the medical industry and the federal government reimburses anesthesia drugs and supplies.
- To determine whether an ASC is a viable economic strategy for your practice to pursue.

**II. RESOURCE MATERIAL**

There is no comprehensive treatise or current publication that addresses all the nuances of ASC facility billing. Because the industry is constantly in the state of flux, a practice manager must continue to use updated contemporary material. Essential coding tools and resources include:

- CPT Professional Edition (01-01-10)  
[www.ama-assn.org](http://www.ama-assn.org)
- HCPCS Level II (01-01-10)  
[www.ama-assn.org](http://www.ama-assn.org)
- ICD-9-CM Volumes 1 and 2 (10-01-09)  
[www.ingenixonline.com](http://www.ingenixonline.com)
- CPT Assistant Archives  
[www.ama-assn.org](http://www.ama-assn.org)
- Medicare through CMS  
[www.cms.gov/ASCPayment](http://www.cms.gov/ASCPayment)

These coding resources will give the practitioner and staff access to appropriate procedure and diagnosis codes for the reporting of ambulatory surgical services. In addition there are several national groups and societies that deal specifically with the ASC from construction, design and buildings, to surgical procedures and billing issues. These groups are easily located on the internet. They have current websites, monthly publications and regularly hold regional and annual meetings. These groups are also involved with advocacy issues on the state and federal levels.

### **III: AMBULATORY SURGERY CENTER FACILITY COVERED SERVICES**

The federal government has been the leader in the ASC industry. Medicare publishes a list of covered CPT codes when performed in the ASC with periodic updates and deletions. Therefore, it is mandatory that facility billers continue to monitor the annual revisions that occur under the ASC payment system. As part of the process of evaluating procedures, CMS looks at historic billing, billing trends and site of service patterns from Medicare billings. These edits lead to suggestions that are refereed by the insurance and provider industries.

CMS introduced the methodology for ambulatory surgery center payment many years ago. CMS has recently implemented a complete revision of the way it will pay for ASC services and the method of billing. Until 2008 CMS had placed covered services into 9 Groups or Groupers. The number of services was around 2,500 and fees ranged from \$333 to \$1,339. The new system has over 1,000 groups or APCs (Ambulatory Payment Classifications) which add over 3,300 more procedures. The fee paid ranges greatly but is based on 65% of the fees for the same procedure under the Hospital Out-Patient Prospective Payment System (OPPS). The CMS will automatically adjust the payment rates in the future. The new rates will be phased in over the next several years and will be at 100% of the OPPS 65% rate by 2011. The ASCs can now charge for drugs and biologicals and at the same rate as hospitals.

This forms the basis for billing and reimbursements for both Medicare and Medicaid and the private insurance carriers.

Some OMS offices may be accredited through a different program, such as the Office Based Surgery program from the Joint Commission. At the current time, these facilities do not have the ability to bill for drugs and biological (or a surgery center fee) as ASCs can, but some offices have had success in obtaining higher reimbursements by directly negotiating with carriers in their area. These increases in reimbursement may come as a global fee increase, or a “reward” payment or preferred status with that carrier.

The specifics for calculating the fees to charge Medicare can be found using an ASC Payment Calculator which provides the phase in percentage until 2011 as well as the wage index for geographic location. These calculators can be obtained from different sites such as the American Association of Ambulatory Surgical Centers (AAASC). The private insurance carriers usually follow Medicare Guidelines however they should be contacted individually for payment methodology.

In general, the commercial payers will follow the CMS ASC payment classifications. Individual ASCs negotiate contracts based upon the APC for specific CPT codes and mutually acceptable rates. It should be noted that many medical/surgical services provided by the OMS fall into the ASC list, while a large number of dental services do not. The entire list of covered ASC codes as well as their current payment rates, can be found at <http://www.cms.gov/ASCPayment>. By reviewing this list and comparing it to the common procedures provided in the OMS office, one can evaluate the efficacy of office based services.

#### **IV: COVERED COMPONENTS OF ASC SERVICES**

*Each APC is selected by using the appropriate CPT codes and each procedure contains a spectrum of services that are bundled into the ASC fee. Medicare defines the following list as included in the fee:*

- Nursing services, services of technical personnel and other related services;
- The use by the patient of the ASC facilities to include pre-operative, intra-operative and post-operative care, operating room and equipment;
- Drugs and biologicals for which separate payment is not allowed under the OPPIs;
- Equipment;
- Surgical dressings;
- Medical and surgical supplies not on pass-through status under the OPPIs,
- Splints, casts, appliances;
- Diagnostic or therapeutic items and services;
- Administrative, record keeping and housekeeping items and services;
- Blood, blood plasma, platelets, etc., except for those to which the blood deductible applies;

- Materials, including supplies and equipment used for the administration and monitoring of anesthesia;
- Intraocular lenses (IOLs);
- Radiology services for which separate payment is not allowed under the OPPI and other diagnostic tests or interpretive services that are integral to a surgical procedure.

## V: CODING FOR ASC SERVICES

In describing surgical services provided in a facility, the code is determined based upon the operation performed. Coding can either be performed by submitting codes described by the surgeon or by retrospectively coding from an operative report. The coding language that is used is CPT. This needs to be supplemented with an appropriate ICD-9-CM diagnosis code in order to complete the data requirements for ASC billing.

## VI: MODIFIERS

A great number of modifiers are used on ASC billing. These include the following:

- -76 Repeat procedure or service by same physician
- -77 Repeat procedure by another physician
- -78 Unplanned return to the operating/procedure room for a related procedure on the SAME DAY
- -79 Unrelated procedure or service by the same physician on the SAME DAY
- -50 Bilateral procedure
- -51 Multiple procedures (not for Medicare)
- -52 Reduced services
- -58 Staged or related procedure or service by same physician on same day
- -59 Distinct procedural service
- -73 Discontinued outpatient procedure prior to administration of anesthesia
- -74 Discontinued outpatient procedure after administration of anesthesia

## VII: BILLING FORMATS FOR ASC SERVICES

The preparation of a billing document for an ASC is variable. As part of the contracting process that occurs between a payer and an ASC, the format for the transactions will be clarified. The standard industry format for Medicare and Medicaid is for services to be reported on a CMS-1500 form. It is imperative that the **modifier SG** be appended to every CPT code in order to inform the carrier that the claim is actually billing for a **surgical facility** as opposed to the professional component of care.

On the commercial insurance side, most carriers do not accept the CMS-1500 form. The more common method of reporting services to a commercial carrier is with a UB-04 form as of May 2007. The new UB-04 form has a specific site for the addition of the National Provider Identifier Number (NPI). This format requires similar demographics and also the precise CPT code and its matched ICD-9-CM code. Additionally, UB-04 formats use revenue codes. The revenue

code that must be reported for an ambulatory surgery center is 490. This informs the carrier that the bill represents facility billing.

### **VIII: DIFFERENCES BETWEEN PROFESSIONAL BILLING & FACILITY BILLING**

One of the most fundamental differences between billing for professional services and billing for ambulatory surgery center services is the concept of the global surgical package. The global package applies to the professional component of a surgical service that is performed when using a surgical CPT code. On the professional side, this typically encompasses a 90-day follow-up. In the ASC billing methodology, no such surgical package exists. Therefore, every time a patient enters the operating room, this represents a unique and separate encounter and has no historical economic relationship to previous encounters. This is a very important difference and very often leads to the need for qualifying modifiers. Those modifiers listed above tend to clarify a situation such as return to the operating room on the same day, or return to the operating room by another doctor on a different date.

### **IX: ASC BILLING FOR NON-COVERED SERVICES**

There is considerable variation in the industry as to how ASC billing is performed for Medicare non-covered services. In general, most billing departments will assign an ASC APC "0" to designate that a certain code or code sets are not on the ASC list, which automatically puts them in a self-pay status. The facility knows a bill will not be sent out to a third party carrier and that it will be the patient's responsibility. This methodology is appropriate for procedures that are not on the ASC list and do not have a practice expense built into the CPT code on the professional side. In such cases, Medicare has increased the RVU to include the practice expense and so the procedure cannot be performed in an ASC. Therefore, it is inappropriate to additionally bill the patient a facility fee. However, services that fall totally outside of the coverage of Medicare and the ASC list can appropriately be billed at a usual and customary rate.

*Note: This paper should not be utilized as the sole reference in coding. Both diagnosis and treatment codes change frequently, and insurance carriers may differ in their interpretations of the codes.*

*Coding and billing decisions are personal choices to be made by individual oral and maxillofacial surgeons exercising their own professional judgment in each situation. The information provided to you in this paper is intended for educational purposes only. In no event shall AAOMS be liable for any decision made or action taken or not taken by you or anyone else in reliance on the information contained in this article. For practice, financial, accounting, legal or other professional advice, you need to consult your own professional advisers.*

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9700 West Bryn Mawr Avenue  
Rosemont, Illinois 60018-5701

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