Socioeconomic tips of the month

Q. I read with interest your recent column on developing a practice compliance plan. Do you have any suggestions regarding coding issues on which my practice should focus its attention?

A. James Holloway, MD, FACS, the current College consultant for coding workshops and a former Medicare Carrier Medical Director for Kentucky, offers the following advice.

Some specific solutions for improving your coding capabilities include: (1) knowing how to link ICD-9-CM codes with proper CPT codes, (2) getting acquainted with available coding resources, and (3) understanding how to bill for co-surgeons.

Proper use of ICD-9-CM and CPT codes

It is important to remember that coding is ultimately the responsibility of the surgeon. Surgeons must take the time to learn how to use the ICD-9-CM and CPT books—resources linked to their livelihood—and to review changes in them on an annual basis. Surgeons should discuss these changes with their staff. Surgeons should regularly monitor Explanation of Medical Benefits forms. Denials need to be tracked correctly by staff and your billing companies, and rebilled.

ICD-9-CM diagnostic coding tells you why you did something, while CPT procedural coding tells you what you did. It is interesting to note that the ICD-9-CM was designed by the World Health Organization to track diseases. It was never intended to be used for collection of fees. Nonetheless, it should be the first resource to which surgeons turn. Often claims are submitted with only one diagnosis, which is fine for simple things. However, surgeons who refer to the ICD-9-CM codes first when billing for complicated services find that they are better able to appropriately apply CPT codes. For instance, if a claim is submitted for a high-level evaluation and management (E/M) code, such as a level four or five, the listing of comorbidities is vitally important because of the multiple conditions one must factor into providing care to the patient. The 1997 E/M documentation guidelines give great protection to the surgeon in that the guidelines are spelled out in enough detail so that no bureaucrat can come along and tell the surgeon "this is not what you say it was," provided you have followed the rules and documented thoroughly.

The CPT coding book, meanwhile, is a product of the CPT Editorial Panel of the American Medical Association, which comprises representatives from many of the recognized specialties. It undergoes constant review and change, although it takes about two years to approve a new or revised code. A large number of E/M and procedure code modifiers, when used appropriately, assist carriers in further understanding circumstances of what was done. For instance, when a service provided is greater than that usually performed, it may be identified and made eligible for higher reimbursement when a modifier –22 Unusual Procedural Services is added. Documentation is required that explains how this procedure differs from the usual procedure. Medicare also requires a copy of the operative report. Modifier -25 marks significant, separately identifiable E/M services provided by the same physician on the same day of a minor procedure or other service; modifier -57 indicates that an E/M service resulted in the initial decision to perform surgery; and modifier -59 indicates that a distinct procedural service was provided. Unfortunately, though, many insurance carriers do not honor modifiers.

All of the "shoulds" and "musts" are not difficult to do. Attend at least one coding symposium. Read the ICD-9-CM book to familiarize yourself with its methods. Each year you should read the CPT introduction for E/M codes and surgery section. Review the codes you use most frequently.

With changes in coding, it is possible that surgeons who don't keep current will lose income—for example, a colorectal surgeon who was not aware of a code added for taking down the splenic flexure lost considerable income because of not reporting the add-on code, CPT code 44139.

Knowing how to code is not enough, though. Surgeons should be aware of the individual coding policies of each major payor. There are CPT coding rules and conventions. There are HCFA coverage or payment rules. There are rules imposed by the private insurance companies, al-

though most of them profess to follow CPT rules. Such policies are covered in a provider's handbook and updates in newsletters or memorandums.

Learn about the available tools

Additionally, surgeons must keep abreast of the new technology that exists to help them with their coding efforts. It is estimated that 80 percent of surgeons' work will be repetitive. If a surgeon develops a listing or fee slip indicating the top 20 to 25 most frequently performed procedures and their most common diagnoses, he or she will alleviate 95 percent of the anguish and struggle that the coding staff experience. Currently, there are software systems available that link CPT codes with the various applicable ICD-9-CM codes. Surgeons and their staffs need to be aware of these aids, which staff can research and evaluate. The clear fact is that surgeons who do not take the time to learn coding are not paid correctly. It is not always correct to code what you hear in hospital coffee rooms without verification in your coding resources.

Properly bill for co-surgery

The most common areas of misunderstanding that take the longest to explain in the College's coding workshops are consultations, which were discussed in the October 1999 *Bulletin*, and co-surgery. Co-surgery is when two surgeons, acting as primary surgeons, join together to do a common procedure identified in one CPT code that requires the special skills of each surgeon. HCFA pays 125 percent of the regular fee and pays each surgeon 62.5 percent. The codes sent by the two surgeons should have identical ICD-9-CM and CPT codes, with Modifier -62 appended to the CPT surgical code. The biggest problem here is the lack of communication between the two surgeons. One or both surgeons may not understand the rules. This situation often results in difficulties for the two billing offices as well as difficult interpersonal surgical relationships.

In a typical case, a neurosurgeon may ask a general or thoracic surgeon for help in doing a spinal approach through the chest. Both surgeons may incorrectly expect to submit their bills in full, and to be paid 100 percent. A CPT code by the general or thoracic surgeon of "exploratory thoracotomy" is not accepted because there is no patient's diagnosis that would substantiate such a procedure code. There should be a clear understanding of the rule and of what is expected of each surgeon before the operation takes place.

In summary

Coding and reimbursement is the most important component of the business side of your practice. If you and your staff are not current on coding issues and are only collecting a percentage of your allowed charges because of not tracking your EOMBs and appealing denied claims, you are giving your surgery away and functioning as your own managed care organization by taking a lesser percentage of the allowed fee. Ω

"Socioeconomic tips of the month" responds to questions from Fellows and their staff, and provides useful tips for surgical practices. Developed by College staff and consultants, this information will be accessible on our Web site for easy retrieval and future access. If there are topics you would like to see addressed in future columns, please contact the Chicago staff of the Socioeconomic Affairs Department, tel. 312/202-5150, fax 312/202-5021, e-mail socioecon@facs.org.