



Red tape 101: Coding and credentialing:

by **David T. Cooke, MD;**
Judi Smedra, CPMSM, CPCS;
and **Joshua A. Broghammer, MD**



Getting past the red tape to maximize your practice

Some might say the simplest aspect of being a surgeon is operating. North American surgery residency programs are excellent in preparing the surgeon to walk into the operating room comfortable with his or her ability to help the patient. But the question remains if our training programs prepare us to confront the most nonintuitive aspects of our specialty—specifically, managing the institutional red tape we encounter every day. The bureaucracy we face includes, but is not limited to, the specifics of coding for medical services rendered, hospital credentialing, purchasing new technology, and constructing an efficient outpatient clinic. Presenting all of these components and additional topics regarding red tape would engender a very large textbook that may prove to be outdated before it hits the shelves. For the scope of this article, we present two subjects: (1) how to navigate the alphabet soup of coding, touching on the definitions of and differences in International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes, Current Procedural Terminology (CPT),* and evaluation and management (E/M) codes, why they are important, and how knowledge of these systems might make our practice financially efficient; and (2) how to navigate the process of credentialing, both for clinical privileges (whether it's starting

*All specific references to CPT (Current Procedural Terminology) terminology and phraseology are © 2008 American Medical Association. All rights reserved.

your surgical career or changing or adding clinical venues) and for specific technical privileges.

ICD-9-CM, CPT, and E/M: Understanding the alphabet

by David T. Cooke, MD

For a surgeon at any point of his or her career—whether it is during residency, as new faculty, or in an established practice—it may be difficult to understand and grasp the complexities of coding for medical services provided. Inaccurate coding can lead to inefficiencies in reimbursement and loss of data related to morbidity, mortality, and practice patterns. The following is a primer for the alphabet soup of ICD-9-CM, CPT, and E/M and a list of educational resources.

ICD-9-CM

The ICD-9-CM is modeled after the World Health Organization's (WHO) Ninth Revision of the International Classification of Diseases (ICD-9). The ICD is used to provide descriptive and unique codes for disease diagnoses and conditions and allows for statistical tracking of morbidity and mortality. The assigned codes assist in data acquisition and maintenance, reimbursement of services in the hospital and outpatient settings, and outcomes research.

The ICD coding system has been developed over the past 100 years. In 1948, the WHO took the charge of periodically revising and updating the system. Many countries make their own modifications based on the WHO's published system. The U.S. National Center for Health Statistics (NCHS) modified the ICD-9 to make it more germane to U.S. health care. The ICD-9-CM contains a list of numeric disease codes; an alphabetical index of diseases; and a classification system of diagnostic, surgical, and other procedures. The NCHS and the Centers for Medicare & Medicaid Services (CMS) are responsible for managing all changes to the ICD-9-CM.

In 1992, the WHO completed the 10th revision of the ICD. The NCHS has modified the ICD-10, and the ICD-10-CM is now available to the public. Additional elements found in the ICD-10-CM include information important in outpatient encounters, additional injury codes, combination

diagnosis/symptom codes that make it easier to code a condition, laterality, and easier code specificity.¹ In August 2008, the U.S. Department of Health and Human Services proposed a rule to adopt the ICD-10-CM to replace the current ICD-9-CM. Under that proposal, implementation of the ICD-10-CM will begin October 1, 2013.

For further information on ICD-9-CM, access to an ICD-9-CM CD-ROM, and to view the ICD-10-CM, visit www.cdc.gov/nchs/icd9.htm.

CPT

The CPT is a system of assigning five-digit codes for accurately identifying surgical procedures and medical and diagnostic services. The extensive codes are used to provide information on services rendered to physicians, patients, clinical administration, and third-party payors. The CPT is currently in its fourth edition; the American Medical Association (AMA) is responsible for modifying and updating the system.

The AMA first published the CPT in 1966. In 1983, the CPT was adopted by CMS, and in 1987, CMS required the use of CPT for coding outpatient surgical procedures. CPT is currently used in the Medicare and Medicaid programs and is the most common system adopted by nongovernmental insurers to describe health care services rendered. The resource-based relative value scale (RBRVS) is a formula used by CMS to determine reimbursement for health care services rendered by a health care provider. The RBRVS determines a relative value unit (RVU) based on the procedure, geographic region where the surgery is performed, and a fixed conversion factor that is updated annually. A RVU is assigned to a specific CPT code, and serves as a benchmark for the reimbursement of that procedure. The AMA has a limited online resource (https://catalog.ama-assn.org/Catalog/cpt/cpt_search.jsp?_requestid=927229) for finding a relative value associated with a CPT code.

Since CPT is instrumental in physician reimbursement, accuracy in coding is critical, especially for surgeons who perform myriad complicated procedures that must be documented precisely; thus, residents would benefit from some instruction regarding such procedures in their curricula. Novitsky et al examined 50 consecutive dictated operative notes by postgraduate

years 3, 4, and 5 residents.² The residents were unaware that the attending was also dictating the notes simultaneously. The researchers found a 28 percent error rate by the residents, including four cases of missed procedure and 10 cases where there was insufficient documentation for an appropriate CPT code and/or modifier. Their analysis concluded that the dictation errors would have reduced reimbursement by 9.7 percent during the study period. The results of this study underscore the importance of resident education and the formulation of a curriculum in the procedural and financial aspects of a surgical practice.

The AMA Board of Trustees authorizes a CPT editorial panel to manage and update CPT. The 17-member panel is composed of 11 physicians who are nominated by the national medical specialty societies and approved by the AMA Board of Trustees. In addition, four seats are filled by members of the American Health Insurance Plans, the American Hospital Association, the Blue Cross Blue Shield Association, and CMS. A larger group, the CPT advisory committee, offers advice on procedure codes, provides peer reviewed background, and suggests modifications to CPT. The editorial panel meets three times a year.

There are three categories of CPT codes. Category I codes are the only codes that have relative value associated with them and are the five-digit codes that describe the majority of procedures. Category II codes are optional codes with no relative value assignment; they are used for performance measurement and data acquisition for quality of care. Category III codes, which are used to evaluate emerging technology, are temporary codes used for collecting information on new procedures and technology, to justify increased usage of the product, or to facilitate the U.S. Food and Drug Administration's approval process. The category III codes may also be part of a clinical trial. They do not have relative value associated with them and therefore reimbursement for category III codes is up to the insurer.

The CPT codes are updated annually and come into effect January 1 of each year. Individuals can complete a "coding change request form" to suggest changes or new CPT codes. The proposed changes or additions are vetted by the CPT advisory

committee and, if deemed relevant, forwarded to the editorial panel for consideration. More information on CPT and available resources can be found at <http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt.shtml>.

E/M

E/M services encompass the visits and consultations that a surgeon performs in the ambulatory and inpatient setting. Diagnoses for these visits are assigned an ICD-9-CM code and services rendered are assigned a CPT code. E/M services have multiple categories, including office or other outpatient services, inpatient services, and emergency department services. Within those categories, there are multiple levels of services, including new patient and established patient. The visits and consultations are assigned an E/M code.

The level of reimbursement of visits is contingent upon clear documentation to assist in assigning an E/M code. Determining the level of E/M services requires three key components: patient history, physical exam, and medical decision making. Additional components that contribute to determining the level include counseling; coordination of care; nature of presenting problem; and time, which refers to face-to-face time in the ambulatory setting and patient's time spent on the unit/floor in the inpatient setting. For purposes of CPT coding, 14 systems are recognized in the review of systems aspect of patient history. In regard to comprehensive exam, a general multisystem exam or a complete exam of a single organ system is required.³

Clear and committed documentation of services rendered is key for accurate E/M coding and appropriate reimbursement. In the study by Kuo et al, the researchers studied their institution's financial records for the division of general surgery over a two-year period and found that actual inpatient E/M charges were 40 percent to 47 percent of predicted charges and concluded that E/M coding may be an underused source of revenue among academic departments of surgery.⁴

Although the intricacies of ICD-9-CM, CPT, and E/M can be difficult to master, understanding these systems is important to the financial success of a surgical practice. The American

College of Surgeons sponsors online courses and other educational resources as part of its Advanced Practice Management Webcasts to assist surgeons in maximizing the potential of their practice. For more information, visit <http://www.YourMedPractice.com/ACS>.

References

1. About the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM). Available at: <http://www.cdc.gov/nchs/about/otheract/icd9/abtcd10.htm>. Accessed February 25, 2009.
2. Novitsky YW, Sing RF, Kercher KW, et al. Prospective, blinded evaluation of accuracy of operative reports dictated by surgical residents. *Am Surg*. 2005;71(8):627-631.
3. Beebe M, Dalton JA, Espronceda M, et al, eds. *Current Procedural Terminology 2007*. Professional ed. Chicago, IL: American Medical Association; 2006.
4. Kuo PC, Douglas AR, Oleski D, et al. Determining benchmarks for evaluation and management coding in an academic division of general surgery. *J Am Coll Surg*. 2004;199(1):124-130.

Navigating the credentialing process

by Judi Smedra, CPMSM, CPCS;
and Joshua A. Broghammer, MD

The process of licensing and credentialing go hand in hand. Whether a new graduate or an established surgeon, the credentialing process can be both tedious and daunting. Applying for clinical and surgical privileges often leaves a surgeon feeling frustrated and helpless, with little control over the situation. The actual application does not always seem intuitive and can be redundant. Much of the reason for the complex nature of credentialing is, in many instances, the requirement for primary, source-verified documents, which adds time to processing and causes delays.

State licensing

Licensing requirements vary from state to state but are based on uniform principles. The main components of licensing include identity establishment, verification of medical and postgraduate training, examination history, disciplinary history, and board certification. In 1996, the Federation of State Medical Boards created

the Federation Credentials Verification Service (FCVS). For a fee, the service will collect data, acting as a bank of primary, source-verified, personal information to be used by state medical boards. This profile can be accessed in the future when the initial application has been completed. The FCVS profile is accepted in 48 states and two U.S. territories; 11 states require use of the FCVS for some of their applicants. A similar data bank of primary, source-verified information is collected by the American Medical Association in its Masterfile Program. These verified documents can be used for credentialing with a charge for each profile to the requesting hospital. Recent licensing changes in some states require fingerprinting and a background check at cost to the applicant.

Hospital credentialing

The fundamental aspect behind credentialing is one of patient safety. Although the specific credentialing protocols vary by institution, they are based on guidelines created by the Joint Commission, Centers for Medicare & Medicaid Services, the National Committee on Quality Assurance, and other regulatory agencies. The process attempts to verify the surgeon's identity, appropriateness of his or her training, and overall competency. There is no direct testable nomogram to measure for competency, but the best effort is made to verify quality via board eligibility or certification, peer references, and a review of disciplinary actions or licensure suspension. All hospitals are mandated by federal law to query the National Practitioner Data Bank and Healthcare Integrity and Protection Databank to look for any licensure suspension, suit settlements, disciplinary actions, or suspension of clinical privileges. A physical examination and background check is often required as well. The Office of the Inspector General is routinely queried for any Medicare/Medicaid sanctions.

As of January 1, 2008, The Joint Commission is now requiring that physicians applying for hospital privileges go through a "proctoring" plan as determined by the department chair at each institution. Once a physician has passed institutional credentialing, he or she is granted privileges to see patients. However, other obstacles may prevent the surgeon from practicing. Despite

For more information...

- **American College of Surgeons 2009 Coding Workshop Series for Surgeons and Their Staff:** Available at <http://www.facs.org/ahp/workshops/index.html>

- **Federation Credentialing Verification Service:** Available at <http://www.fsmb.org/fcvs.html>.

- **AMA Physician Masterfile:** Available at <http://www.ama-assn.org/ama/no-index/about-ama/2673.shtml>.

- **Medicare Provider-Supplier Enrollment:** Available at http://www.cms.hhs.gov/MedicareProviderSupEnroll/01_overview.asp.

- **Querying and reporting:** National Practitioner Databank and Healthcare Integrity and Protection Databank. Available at <http://www.npdb-hipdb.hrsa.gov/queryrpt.html>.

- **Register for the ACS Practice-Based Learning System:** Available at <http://www.facs.org/members/pbls.html>.

- **Accreditation requirements, medical staff:** The Joint Commission. *2009 Comprehensive Accreditation Manual for Hospitals (CAMH): The Official Handbook, E-edition*. January 1, 2009. MS.01.01.01-MS13.01.03.

- **Credentialing and recredentialing:**

- National Committee on Quality Assurance. *2008 Health Plan Standards and Guidelines*. July 1, 2008. 277-339.

- Soper NJ, Fried GM. The fundamentals of laparoscopic surgery: Its time has come. *Bull Am Coll Surg*. 2008;93(9):30-32.



the rigorous process required by the hospital, a nearly duplicate application is mandated by insurers and third-party payors, adding another three to six months for clearance. Some hospitals negotiate contracts with insurers, automatically clearing the surgeon if the institutional vetting process is passed. This practice varies greatly and needs clarification prior to scheduling patients by a newly hired surgeon.

Credentialing for technical privileges

Technology plays an important role in the credentialing process. As new instruments and devices begin to flood the market, a hospital must ensure that its surgeons are using this technology in a safe, efficacious manner. Unfortunately, the hospital's perception of "state of the art" often lags behind that of the surgeon. One must determine if proctoring is required for certain modalities such as laparoscopy or use of lasers. If a partner is not available to supervise, then it is essential to clarify who is going to bear the cost of obtaining an outside proctor. This task is the surgeon's responsibility but can be negotiated with the hospital. Recent graduates who have modern, state-of-the-art training will find the proctoring process trying and unwarranted as they been supervised throughout their residency in the use of these more advanced technologies. Other documents—including course certifications from national meetings or training programs such as the College's Fundamentals of Laparoscopic Surgery course—can be used to demonstrate competency.

Retaining detailed case logs from both residency and practice can bolster the application. The College has an excellent Case Log System (American College of Surgeons Practice-Based Learning System). Individual surgeons can track outcomes to help improve the quality of care. In addition, this system can be used to accumulate cases for board certification and Maintenance of Certification.

Easing the burden of credentialing

The credentialing process cannot be circumvented but can be navigated by a proactive surgeon. Maintaining a repository of key documents eases the burden of the process and should include the following:

- Identification: Driver's license, passport, and/or birth certificate
- Education: Copies of collegiate and medical school diplomas and transcripts
- Training: Internship, residency, research, and fellowship certificates
- Board certification certificates
- Recent medical examination
- Current and expired medical licenses, Drug Enforcement Agency certificates, and state pharmaceutical board certificates
- Copies of malpractice certificates verifying coverage for the past 10 years
- Certification cards such as Advanced Trauma Life Support®, Advanced Cardiac Life Support, and so forth
- Documented training for laser use, advanced laparoscopy, fluoroscopy, and so forth
- Telephone and fax numbers for all training directors, faculty appointments, department chairs, and references (best to use references who have a reputation of being prompt in responding to requests)

The final assurances to help credentialing are simple steps. Complete the application legibly, enter all blank fields, submit all requested documents, and answer questions accurately. Contact references to inform them a request is submitted from your credentialing organization and confirm a receipt of the inquiry several weeks later. Each surgeon should establish a respectful, cooperative relationship with the medical staff coordinator at his or her institution. Willingness to work together will speed up the process, result in two-way communication, and allow the planning of an effective start date. Meticulous attention to detail and completion of these steps can lead to a successful outcome in an otherwise laborious process.

Physicians graduate from surgical residencies with the knowledge and training to diagnose, treat, and manage a wide array of medical illnesses. Despite the investment it takes to train a surgeon, there is often an educational gap when it comes to the administrative aspects of practice. New hires can be left to complete the credentialing process in a largely independent fashion and, when beginning a practice, the young surgeon has to learn expeditiously how to navigate the often unfamiliar billing and cod-

ing requirements. With increased knowledge and use of a few simple steps, both coding and credentialing can be streamlined to help build a successful practice. Ω

Dr. Cooke is assistant professor in the division of cardiothoracic surgery at the University of California–Davis Medical Center, Sacramento. He is a member of the RAS-ACS Communications Committee and Representative to the ACS Advisory Council for Cardiothoracic Surgery.



Ms. Smedra is director of medical staff affairs at the University of Kansas Medical Center, Kansas City.



Dr. Broghammer is assistant professor in the department of urology at the University of Kansas Medical Center, Kansas City. He is Vice-Chair of RAS-ACS and a member of the RAS-ACS Communications Committee.

