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Coding and Reimbursement: The Lifeline of the Urologist's Office

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Coding rules and regulations change constantly, and this volume of *Urologic Clinics of North America* is not intended to be a coding and reimbursement course. Hopefully, all readers of this issue periodically send their staff (physicians and coders) to courses to learn the latest wrinkles in coding. Accurate coding depends on the information sources that the coding staff has available. A valuable and comprehensive compilation of many information resources is included at the end of this article.

According to the jointly sponsored *2003 Medical Group Management Association—American Urological Association Cost Survey for Urology Practices*, the mean cost of running urology offices, including medical liability insurance, employees' salaries, rent, utilities, supplies, and benefits, composes an average of 50.07% of office revenue (actual reimbursement of services, not gross charges) [1]. The only way to lower this number, the overhead, is to increase the efficiency and accuracy of billing operations.

M. Ray Painter, MD, president of Physician Reimbursement Systems, who consults for urology practices throughout the country, has stated that by learning and improving the coding and billing process, he has seen many offices increase revenue 5% to 15% a year. One old rule still applies, however: "If you did it, document it; if you document it, charge for it; if you didn't document it, you can't charge for it." With good documentation, proper coding and appropriate reimbursement follow.

Coding must be done correctly and ethically. According to the *Code of Ethics*, from the American Academy of Professional Coders (AAPC), "Members shall use only legal and ethical means in all professional dealings, and shall refuse to cooperate with or condone by silence, the actions of those who engage in fraudulent, deceptive or illegal acts" [2]. Coding and billing staff must have the reassurance that when a problem or error is discovered, the situation will be corrected, errors will be eliminated, and no one will be punished.

All offices must have policies that include

- An office compliance plan
- How to handle billing errors and how to correct them
- How to handle inquiries by patients

The urologists ultimately are responsible for any billing infractions. The name at the bottom of the Centers for Medicare and Medicaid Services (CMS) 1500 form belongs to the physician: physicians are responsible for what is on the bills they send, either solo practitioners, members of a large group, or those academic university practices. In an audit, it does not make any difference if someone claims to not know coding was being done in a particular way. The Office of the Inspector General does not allow ignorance as a defense. That is why urologists must be involved in the oversight of coding staff. Their names at the bottom of the form mean that they are the ones the agents from the Office of the Inspector General visit if there is a problem. If urologists and their practices follow the rules, they have nothing to fear.

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It is, therefore, imperative for offices to keep current on

- New coding directives
- New guidelines
- Medicare bundling edits (*National Correct Coding Initiative* [*NCCI*])
- New carrier coverage determinations
- Quarterly drug payment updates
- Yearly changes to *Current Procedural Terminology* (*CPT*)
- Twice yearly changes to *International Classification of Diseases, Ninth Revision* (*ICD-9*) diagnosis terminology

History of *Current Procedural Terminology*: the language of coding

Medical coding is a language. Billing is built on trust: a *CPT* procedure code coupled with an *ICD-9* diagnosis code is sent in and money is sent back [3,4]. *CPT* translates the service provided to the patient into dollars, and the reason for the medical service into a language that insurance carriers can understand. The development of medical coding began in 1966 with publication of the first American Medical Association (AMA) *CPT* nomenclature book. The first edition of the *CPT* contained surgical procedures with limited sections on medicine, radiology, and laboratory services. In 1983, the CMS (formerly Health Care Financing Administration) adopted *CPT* nomenclature as part of the *Healthcare Common Procedure Coding System* (*HCPCS*), known as hick-picks [5]. *CPT* codes were required to report services for Part B of the Medicare program. In October 1986, CMS mandated that state Medicaid agencies use *HCPCS* codes. In July 1987, CMS required that *CPT* codes be used to report outpatient hospital procedures. Through the Health Insurance Portability and Accessibility Act of 1996 (HIPAA), *CPT* codes became the national standard for reporting services to insurance carriers in 2000.

Keeping up to date—resources

It is imperative that coding staff work with valid and timely coding tools. Just as surgeons cannot operate without the proper instruments, office billing staff cannot do their job without up-to-date resources. Manuals must be purchased every year to ensure appropriate coding of medical claims and eliminate the denials of inappropriately billed claims. The absolute minimum reference sources that must be purchased new every year include

- *CPT*
- *ICD-9, Clinical Modification* (*ICD-9-CM*)
- *HCPCS*, which lists national Medicare codes, to report medical services, supplies, drugs, and certain procedures not defined by *CPT*.
- *NCCI*, which is essential in billing claims for Medicare beneficiaries. *NCCI* is updated quarterly and includes edits established by AdminaStar Federal, the Medicare contractor for the edits. These edits tell which *CPT* codes can be billed together, which are reimbursed separately, and which cannot be billed together [6].

Grace period eliminated

In 2005, CMS eliminated the grace period for Medicare claims. In the past, physicians' offices and carriers had 90 days to implement new codes or eliminate deleted codes before claims would face denial. With the elimination of the grace period, when a code is effective, it must be implemented in the coding vocabulary. *CPT* codes are updated every January 1; *ICD-9-CM* diagnosis codes are updated April 1 and October 1; and *HCPCS* codes are updated either January 1 or July 1. Medicare reimbursement in the form of relative values are updated each January.

Hiring essential staff

Once the resources are available, they are only as good as the people using them. Hiring staff that is knowledgeable of the coding rules and government regulations and who have a sense of the importance of ethical and accurate coding is vital. Understanding coding takes years of application, research, skill, and a basic drive to get the job done correctly. Ideal coders should understand how to use all the coding resources, be self-motivated, and be willing to investigate and research when the information provided does not sound right. When a claim is denied unjustly, staff must be diligent in pursuing the payment of the claim through appropriate appeal processes.

Certifications

There are two national organizations that certify individuals as professional coders:

- AAPC. This is the only organization devoted solely to the advancement of coding.