Know Your Rules

THERE IS NO GETTING AROUND THE GUIDELINES

By Tara Conklin, CPC

Go back for a moment to when you were a kid. That time you did something that got you into a whole lot of trouble. Even if your parents say you were a perfect child, I bet you can remember at least one moment when your friends or siblings looked at you with raised eyebrows and said, "Ooooo, you're gonna be in trouble!" I don't know which was more irritating, the fact that you had already deduced your fate or the way they put that extra emphasis on the word "trouble." Remember facing Mom and Dad and getting that look, the one that said "talking your way out of this is not an option"?

When it comes to coding, choosing not to follow the rules can lead to similar circumstances. I don't know about you, but I would rather face my Mom and Dad again than have two men in black standing on my door saying, "Ooooo, you're gonna be in trouble!"

IGNORANCE IS NOT BLISS

If there is one thing our friendly Inspector General makes very clear for all persons working in the medical field (among others) it's that ignorance of the "rules" is not an excuse. There are very specific laws, guidelines, rules, and downright simple facts governing every aspect of this field; our government says, quite clearly actually, that each one of us has the responsibility to know them and follow them. Everything you ever wanted to know about these laws, guidelines, rules, and simple facts is provided and is accessible, most for free, on state and federal websites or by calling the appropriate government agency. If you choose to be ignorant of these rules, you may find yourself staring at a scary person who won't just give you "that look," but will be more than happy to tell you that "talking your way out of this one is not an option."

WHAT'S UP DOC?

Physicians have a slew of guidelines to follow—here are a couple applicable to coding. The first is to write legibly. A coder, biller, or practice manager may take the time to decipher the physicians' chicken scratch, but an auditor absolutely will not. Why, you ask? The answer is simple: because the auditor doesn't have to. One of the first rules for reporting medical services is one I'm sure are familiar with: "If it's not dictated or legible, it's considered not done." I've worked with doctors whose handwriting resembled something more akin to an EKG read out than official medical documentation. If you are uncomfortable telling your physician to clean up his writing, get over it. If you're a physician who wouldn't dream of having your coder tell you to clean up your writing, as Cher so aptly told Nicholas Cage in *Moonstruck*, "SNAP OUT OF IT."

The other basic rule for physicians is that everything billed for must be documented in detail according to the coding requirements for that particular service, and each date of service must stand alone. The physician is ultimately responsible for every code billed out under his name.

BACK TO BASICS

It is the responsibility of anyone working with CPT, ICD-9-CM, and HCPCS codes to understand the appropriate coding and reporting guidelines. Furthermore, it's a greater responsibility to follow these guidelines. Coding is much more than picking up the appropriate coding manual, finding a code, putting it on a claim form, and sending it away for payment. The first and most important rule of coding and reporting is to stay up to date on coding changes. Each and every hospital, clinic, surgery center, insurance company, ambulance service, medical equipment provider, and medical practice is required by law to obtain and use the most up-to-date coding manuals. You must update and implement them every year.

Often the most common coding mistakes are made simply because the person choosing and applying the code has failed to read the guidelines already provided in the coding manuals. Experienced coders, auditors, practice managers, and even some physicians are diligent in knowing the basics. If this information is nothing new to you, then I applaud you. Unfortunately there are many of these same people flying by the seat of their pants. In this article we will take a look at some of the basic but all-too-important guidelines printed in black and white, right in our CPT.

PICK A CODE, ANY CODE

As mentioned a moment ago, it's not sufficient to choose just any code for reporting. I'm not talking about using a total hysterectomy code for reporting a colectomy. What I'm referring to are those times when you go looking for a code and find one that seems "pretty close" to the service performed and stick in on a claim.

If you turn to the first few pages of the CPT manual (those ones you always skip over and are often in pristine condition at the end of the year), you will find a page labeled "Introduction." On this page under the heading in red "Instructions for use of the CPT Codebook," you will find probably the most important information for using this book correctly. The first paragraph of this section states, "Select the name of the procedure or service that accu-

(continued on page 18)

(***Know Your Rules*** *continued from page 16)*

rately identified the service performed. Do not select a CPT code that merely approximates the service provided."

In other words, close doesn't count. The code reported must be a clear and concise representation of the total service performed. Just because something walks like a duck and quacks like a duck does it necessarily mean it's a duck. Hey, the Ugly Duckling did all that and he turned out to be a swan.

When there is no code to accurately report the service provided, CPT goes on to instruct the coder to report the service using an unlisted procedure code from the appropriate section of the CPT book. When an unlisted code is used, the claim should be should be reported on a hard copy CMS 1500 claim with a brief description of the procedure listed in Box 19 on the claim form. A copy of the report or documentation should be sent along with the claim and an appropriate fee should be charge. The fee should be "fair and customary" as also required by federal guidelines. Unlisted procedures may often be performed alongside or in addition to valid CPT codes, in which case both should be submitted separately.

If the service you are reporting is accurately described in a CPT code but that same CPT code includes extra or additional services not performed, it would be appropriate to report the code for the services performed. To accurately show the service was reduced from the complete procedure described in the CPT code (not all parts of the procedure were performed), modifier -52 (reduced service) is appended to the CPT code prior to billing. Oh and by the way, that's not an option either.

THREE IS A MAGIC NUMBER

Now that you understand when to use unlisted procedure codes there is one more thing to clear up. CPT codes have a type of hierarchy to them. When looking for the appropriate CPT code for the service performed there is an order that must be followed. The first place to look is in the already established CPT codes provided, known as Category I. This refers to those codes that have a description and established relative value attached to them.

If, as in our example above, there is no Category I CPT code to accurately report the service, there is one other place to look before turning to an unlisted procedure code. Near the end of the CPT manual, directly after the Medicine Section, you will find the Category III Code section. The codes in this chapter look different from the rest of the CPT. They start with one or two "0's" and end in a "T." Like Category I CPT codes, they have specific descriptions attached to them. The difference between the two types of codes is that Category III codes do not have a relative value attached to them. They are temporary codes and they very much resemble a temporary employee. They aren't salaried yet and may or may not become permanent based on their performance.

These codes represent emerging technology, services, and procedures. They help facilitate the gathering of data for these services, which in turn is used to determine if the service warrants becoming a permanent CPT code, what that code will entail, and what the fee or RVU for the code will be. The life span of codes in this section can be as short as a year or may remain in Category III for several years in order to gather enough data. The complete description and life span of these codes is described in detail in the last paragraph of the guidelines found at the beginning of the section.

We want to concentrate on one specific sentence of this section, which is found in the first paragraph. This sentence states, "If a Category III code is available, this code *must* be reported instead of a Category I unlisted code." For example, the physician performed an insertion of a temporary prostatic urethral stent. In 2006 there is no code already established in the CPT for this service. However Category III code, 0084T, is available to report this specific procedure. Instead of billing 53899 for an unlisted urinary procedure, the coder is required to use the 0084T code. Since no value has been placed on these services, payment modifiers, such as 52, 53, or 22, are not necessary for Category III codes. Instead the physician attaches a fair market price to the procedure, adjusts the fee based on the extent of the service performed, and may send the claim electronically.

There is no getting around this guideline. Like the other rules we have learned, this also, is not an option.

The guidelines, rules, and laws governing our field can seem endless and daunting. However, knowing the basics of coding can often become the cornerstone of billing practice. The stronger that cornerstone, the stronger the company will become and the longer it will stand. It's not enough for one person in a practice to know the rules. The responsibility to adhere to these rules and communicate them falls upon all entities involved in the reimbursement process. This includes the physicians, coders, charge entry clerks, managers, billers, account representatives, and even third party billing companies. No one is exempt and all are responsible.

We have visited two of the basic rules of CPT coding—there are many more guidelines in each section of the CPT and the ICD-9. If you haven't read them in a while (or perhaps have never read them!), put down that copy of *The DaVinci Code* and pick up a coding manual. The reading will be well worth it. ▲

Tara Conklin is coding manager for Premier Medical Consultants in Largo, Florida. She can be reached at TLConklin@Gmail.com.