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PRACTICE MANAGEMENT: COPING WITH 1990 CODING REVISIONS

Cavan Redmond

Changes in the newly revised Current Procedural Terminology *book can present problems to the unwary, but some users have developed strategies for making the most of the new codes.*

The *1990 Current Procedural Terminology (CPT-4)* book, published in January, contains a number of coding revisions that are affecting the way oncologists bill for procedures. In addition, the AMA included language in the chemotherapy administration section that some third-party payors are interpreting as the basis for exclusion of chemotherapy administration fees in a hospital setting. This article presents some of the strategies physicians have used to obtain adequate reimbursement, to effectively use the new codes, and to better manage their billings.

Administration Charges

One of the most significant changes to the 1990 CPT-4 book occurred in the chemotherapy administration section. This change involved a revision of the preamble to the chemotherapy administration section:

> *"Chemotherapy administration is coded when administered by a physician or a qualified assistant under the supervision of a physician, excluding chemotherapy administered by hospital or home health agency personnel."*

Controversy has arisen because of the phrase "excluding chemotherapy administered by hospital or home health agency personnel." Previous CPT- 4 coding books did not differentiate chemotherapy administration in the office from such administration in the hospital. Oncologists could charge for chemotherapy administration regardless of the setting. Individual carriers then made the determination of reimbursement for the charges. Traditionally, these reimbursement policies have varied throughout the country. However, because of the change in the 1990 preamble, it appeared as though the AMA had intentionally excluded chemotherapy administration in the hospital setting. This change caused a number of practices to re-evaluate how they were administering chemotherapy.

The result of the new coding is that some carriers have eliminated the professional charge for chemotherapy

Strictly interpreted, the proposed change excludes the 96000 series of codes, which apply to chemotherapy administration, from being reimbursed when administered by hospital personnel. The result of the new coding is that some carriers have eliminated the professional charge for chemotherapy, maintaining that chemotherapy consists of only a technical charge that is applicable only in an office or non-hospital setting.

The problem was severe enough that the American Society of Clinical Oncology (ASCO) successfully petitioned the AMA to clarify, in a letter to the Acting Administrator of the Health Care Financing Administration, that it was not "necessarily" the intention of the preamble to exclude reimbursement for hospital-based chemotherapy administration fees. Furthermore, the AMA Coding Panel agreed to delete the language "...excluding chemotherapy administered by hospital or home health personnel" from the 1991 CPT-4 book. In the meantime, a number of physicians are using the AMA's January 2, 1990, letter to HCFA when appealing denials to carriers.

Despite the AMA's clarification and promised deletion of the controversial phrase, many physicians who charge for chemotherapy as a professional service are experiencing reimbursement denials. A number of Medicare intermediaries are refusing to pay for any of the current professional chemotherapy administration charges, which is rendering a number of physicians without adequate means of recovering the cost of chemotherapy services provided to patients outside of their offices. Several practices have indicated that intermediaries' actions are affecting the way in which one out of every three patients is treated. The exclusion of a chemotherapy administration fee has already forced some practitioners to reduce the number of patients they treat in hospital-based outpatient chemotherapy centers. And an increasing number of practitioners are affiliating with freestanding centers.

For hospital-based oncologists, it is common for a hospital to bill for drugs and supplies, while the oncologist bills for professional charges like chemotherapy administration. Removal of this charge could create a financial void for both the oncologist and hospital. Without such fees, a hospital will have to provide oncologists with alternative methods of financial compensation. Otherwise, hospital-based physicians will no longer have the necessary financial incentive to perform the service.

Some of the oncologists who provide services in hospital-based outpatient chemotherapy centers are shifting their patients to alternate delivery sites. Oncologists who do not have the ability to provide chemotherapy in their offices and who cannot find an independent chemotherapy center will have no way of receiving reimbursement for chemotherapy administration. If the volume of patients being treated at hospital-based outpatient centers declines, centers may be forced to go through costly reorganizations.

Reimbursement Strategies

Changes in the CPT-4 book have prompted varying responses from offices and insurance companies. In some states, the Medicare intermediary has sent notices to physicians stating that it will pay for hospital-based chemotherapy as it has in the past. But other intermediaries have already begun to deny claims.

Most individual physicians have found that they have neither the time nor the clout to directly challenge the denials by intermediaries and have petitioned for changes through their state oncology societies. Physicians and oncology societies have provided carriers with detailed explanations of how hospital personnel administer chemotherapy and the prescribing physician's role in the process, and provided copies of the AMA correspondence. In Indiana, the state oncology society's use of such techniques was successful in restoring the policy of reimbursement for chemotherapy administered by hospital personnel.

Other intermediaries are requiring the use of modifiers or have issued special local codes to be used for billing. These codes signal the carrier to treat the code as a hospital-administered chemotherapy. The most common modifiers are -27 or -WJ. Some offices have been instructed to use M0024, while still others use 9999.

Most of the offices that have aggressively pursued denied chemotherapy administration claims have been successful. Nevertheless, several offices have found their intermediary to be less than cooperative and, as a result, have begun to examine ways to change their affiliation with the hospital and to seek out other business partners. Where this has occurred, a new industry has emerged. Oncologists are being courted by companies offering chemotherapy facilities or facilities management. This arrangement is similar to some hospital-based practices in that an external source provides space and personnel in exchange for a fee. While the arrangement can provide the physician with a facility, it can necessitate complicated legal documents to protect the physician's interests.

Coding Changes

The new CPT code book affects virtually all of the 96000 series of codes. A total of 18 codes were collapsed into 16 new codes. The most significant change is the switch in some codes from wording that included the number of agents mixed for administration to wording that is site and type of administration specific. None of the new codes include any terminology relating to professional or technical charges; only the preamble contains reference to those charges.

The conversion of the new codes from deleted codes has been a trying experience for most offices. In some cases, the carrier has issued explicit instructions on how to convert the codes; others have sent ranges of deleted codes and ranges of converted codes; still others have only indicated that the new CPT code must be used beginning on "X" date. The table below contains suggested conversion codes received from various oncologists.

A number of offices have found it useful to completely overhaul their current method of billing chemotherapy administration. Some offices have gone as far as saying that every time a needle is inserted into a patient, a chemotherapy administration charge is applied. When chemotherapy is administered via push and infusion on the same visit, offices are billing, and receiving reimbursement for, both techniques.

Billing Techniques

The most common mistake practices are making is to adapt their current billing methods to the new codes by simply trying to convert all pre-existing codes. As a result, offices may be missing significant opportunities for capturing allowed charges under the new codes. The best course of action for a practice is to perform a comprehensive review of the procedures being performed, and to determine how they can be captured on a charge sheet or a route slip. Practices must make numerous policy decisions to take advantage of the current reimbursement environment.

The first step is to look at all of the activity surrounding a patient's visit. Every part of a practice should be evaluated on two levels: how the practice can be reimbursed for all of its services and supplies; and how to improve the fiscal management of the practice. There are a number of policies and procedures an office can employ to maximize reimbursement and to cover costs.

Charge Sheets

The most important and yet frequently overlooked practice management tool is the charge sheet (also known as a route slip, superbill, or procedure sheet). Most offices simply change the codes on the charge sheet as new codes come into existence. To make it a more effective tool, all of the procedures in the office should be evaluated and com-

Suggested Conversion Codes

DELETED CPT-4 CODE	CONVERSION RANGE	SPECIFIC CONVERSION
96500	96410-96414	96408
96501	96410-96414	96410
96504	96410-96414	96408
96505	96410-96414	96410
96508	96410-96414	96408
96509	96410-96414	96410
96510	96410-96414	96410
96511	96410-96414	96412
96512	96410-96414	96414
96524	96420-96425	96420, 96422, 96423
96526	96420-96425	96423, 96425
96535	96440, 96450, 96530	96440, 96445
96538	96440, 96450, 96530	96450
96540	96440, 96450, 96530	96450

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Review and corrections

Articles will be reviewed by two or more members of the editorial review board. Authors will be informed of acceptance, rejection, or need for revision within 6 to 8 weeks, but at times longer delays may be unavoidable. All articles are subject to copy editing. Author corrections and revisions should be kept to a minimum and must be received within seven days of receipt; after this time, no further changes may be made by the author.

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Illustrations and Tables

Authors are encouraged to submit illustrations, tables, figures, sidebars, etc. that help clarify the text. Tables, figures, and sidebars should be typed on separate pages and their position indicated in the text. Photographs should be unmounted, glossy prints. Photographs will not be returned unless the author indicates "Please return" on the back of the prints. Photo captions should be listed on a separate page.

Footnotes and References

Footnotes should appear at the bottom of the page on which the corresponding text appears and should be cited in the text with an asterisk, dagger, etc. References should be limited in number and submitted on a separate page.

The following form should be used:

Books:

Last name of author, first initial; title; editor; publisher:city and state; year of publication.

Journals and Periodicals:

Last name of author, first initial; "title of article;" title of journal; number:volume; date of publication.

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pared to the CPT-4 book and insurance carriers' reports. The office should try to match every activity to a procedure code. For example, supplies should not be bundled into one catch-all code; they should be broken into individual codes. All chemotherapy administrations, office visits, and hospital visits should be assigned the procedure code that most accurately describes the services provided. A charge sheet should not contain a single code for office visits or hospital visits, but the entire range of applicable codes. One practice found that accurate recording of chemotherapy administration charges produced a 14 percent increase in reimbursement at the same time that the number of Medicare patients increased by six percent.

The charge sheet should be tailored to the physician's practice. It should not simply be a copy from another practice or a form recommended by a book. If the practice specializes in a particular type of oncology, then look for codes that better describe the type of procedures performed. For example, if a practice includes pediatric oncology patients, the laboratory section of the charge sheet should contain codes 36400 and 36410, which allow for a higher level of reimbursement based on age.

The charge sheet should contain a complete list of the ICD-9 codes and descriptions. One practice has placed all possible oncology and related ICD-9 codes on the back of the charge sheet and the oncologist simply circles the proper code.

Each member of the office uses the form for a different purpose, which means that designing a charge sheet necessitates the participation of everyone in the practice. The charge sheet should be changed as the procedures performed change, and as new codes become available. Using outdated forms typically leads to inaccurate records of the services provided to patients.

Laboratory Charges

Laboratory work is another commonly overlooked area. Medicare and Medicaid patients should be identified before lab work is performed. All lab work performed in-house should be billed accordingly. If the practice doesn't want to take on the burden of billing for outside lab work, let the outside lab bill for its services. However, if the carrier allows the charge, the office should bill for drawing of the lab specimen.

Other Suggestions

Since the publication of the 1990 CPT-4 book, a number of carriers have provided update bulletins and letters to practices. Such correspondence often contains information that can directly affect the way in which you bill. Everything from new codes to policies can be found in these materials. They are an important tool for your practice. When changes appear in bulletins, offices should institute the changes immediately and document what changes have been made.

It is not uncommon for offices to receive under- or overpayment from carriers. All explanations of benefits should be evaluated in detail. Payments should be matched to charges to make sure proper payment has been received. If a charge has been missed or improperly paid, the carrier should be notified immediately. If a charge has been wrongly denied for reimbursement, file an appeal. On the other hand, if you receive overpayment from the carrier, the overpayment should be returned the next time checks are written. Keeping overpayments produces an artificially high bank balance that must later be adjusted.

Summary

The new CPT-4 coding changes have been viewed by some offices as a major inconvenience that has imposed unwanted practice management changes. For these offices, practice management and reimbursement have become more difficult. Other offices have viewed the changes as an opportunity for reviewing policies, procedures, and practice management techniques. These offices have taken the proposed changes and looked for ways to make the changes work for them.

Because coding changes are inevitable for the foreseeable future, offices should search for ways to take advantage of the changes. The fact is that well-managed offices can continue to grow if change is seen as an opportunity, not an adversity. ■

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