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Avoiding Common Pitfalls in Radiation Oncology Coding

by R. Lawrence White, M.D., F.A.C.R.

The 7700 series of radiation oncology codes is a comprehensive listing of almost all procedures performed in the specialty of radiation oncology. The listing is found in the *Physician's Current Procedural Terminology* (CPT) coding series, published by the American Medical Association. This coding system was developed over the last 15 years to reimburse physicians and facilities for patient diagnosis and treatment management and follow-up. The system's intent is to encourage high quality care that can be measured in improved outcome. As the "Patterns of Care" study in radiation oncology has shown, better quality care and equipment do result in improved, measurable outcomes.

The American College of Radiology (ACR) has worked closely with the American Medical Association (AMA) to develop and update the list of diagnostic radiology and radiation oncology codes for use nationwide. To clarify understanding of the definition and application of the various radiation oncology codes, ACR went one step further: it developed a users' guide in the late 1980s. This guide has been revised and continues to be the most definitive authority on radiation oncology code application.

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Under CPT coding there are two charges for almost all procedures: a technical charge and a professional charge. ACR originally designed this system in cooperation with the AMA to adequately cover both the professional and technical costs of running a quality, up-to-date radiation oncology facility.

A freestanding, privately owned facility that is not hospital-based follows a global fee schedule that combines the technical and professional components. In such freestanding or private facilities there is only one component for each procedure performed and recognized by the CPT system. In a hospital-based system, hospitals use a parallel procedural coding system that follows the professional coding system used by the radiation oncologist.

RBRVS AND RADIATION ONCOLOGY

The U.S. health care system continues to undergo sweeping changes in attempts to control rapidly escalating costs. The result has been some decreases over the last several years in reimbursement levels and a decrease in revenue for facilities, hospitals, and physicians in almost all areas of medicine.

Radiation oncology, although it accounts for only a small part of the total money spent for radiology services in the United States, has also suffered. Yet the overall decreases in revenue and reimbursements have been less than experienced by many other medical specialties. At the same time, there has been an increase in use of radiation oncology services in general and an increase in charges over the last three years for radiation oncology in total dollars.

Medicare's Resource-Based Relative Value Scale (RBRVS) system of payment, which was implemented in 1992, was an attempt to equalize and decrease payments for various procedures performed by many different medical specialties. As a result of the RBRVS system, there has been a general leveling of fees, including those for radiation oncology, around the country. In locations where radiation oncology reimbursement was high, factors have been introduced to uniformly lower charges in all categories. And in areas of the country where radiation oncology reimbursement was low, factors were added to raise professional and technical codes in all categories. The leveling effect has been accomplished through the use of regionally derived numerical factors that modify the overall value of each procedure either up or down.

Although procedures for radiation oncology may have become increasingly bundled under the relative value scale system, reimbursable values remained essentially the same. For example, as an attempt to make reimbursements more equitable across the country, Medicare switched from a daily management code to a weekly management code, which was about five times the reimbursable value of the daily code. The net result was

little change in reimbursement in most locations.

CODING THE RIGHT WAY

Radiation oncology facilities should develop a system for CPT coding that key personnel in the department can readily understand and use. Along with the administrative head of the facility, physicians should be involved in this development process, because they are the ones who prescribe, perform, and supervise all procedures. Administrators and physicians at the facility should meet and agree on how to classify each procedure that is coded.

Ideally, the system should be computerized. One or more daily treatments can be tracked through a computer scheduling system and charged the appropriate code. Since the CPT system's professional and technical components are parallel, both the physician and the facility will receive accurate credit for each procedure performed on each patient every day.

Unfortunately, many facilities do not yet have the computer capabilities to track and code daily procedures. In these facilities, a system must be designed to allow designated personnel to code each procedure performed on each patient every day. To assure accuracy in a noncomputerized system, there should be a designated administrative or technical person to code the technical procedures each day. The physician also needs to be responsible for coding each professional procedure performed on every patient every day. The physician and the administrative/technical person need to communicate closely on a regular basis. They must continually review and adjust the agreed-to level of coding so that the system remains parallel *and* accurate.

The administrator and physician responsible for coding should receive weekly or monthly summary data of each code that is used, including how frequently each is used. Reviewing such data is an easy way to identify coding errors and individual or institutional trends that suggest the system may not be working properly.

In addition, the chief physician and/or head administrator should doublecheck that each physician has coded appropriately so that there is not inconsistency within the facility. Before the codes are sent to the billing office each day or each week, the responsible physician and administrator should review the previous day or week's coding and document by initiating and dating that a review is being performed regularly.

Whether a system is computerized or done by hand, appropriate codes will sometimes not be indicated for performed procedures. Because mistakes occur in any system, care should be taken to spot any dropped charges.

The appropriate use of coding and using state-of-the-art procedures would result in a 10 to 30 percent increase in the net revenues of the facilities.

Perhaps more common than failure to code at all is failure to code properly. Most procedures are categorized as simple, intermediate, or complex. The physician and administrator responsible for the appropriate coding of all procedures must completely understand the difference between these categories for each procedure performed in the institution by staff physicians and technologists.

Periodically, perhaps monthly, an interdepartmental audit should be performed to assess if all the procedures scheduled and performed have actually been coded and submitted to the billing office. In our own department, for example, we found that no simulation charges had been submitted to the billing office for 12 percent of the patients who had been simulated the previous month. A random audit of a patient's bill at the completion of treatment helps to assure that all procedures have been coded during the course of treatment each day. Such an audit may also reveal missing charges that can amount to as much as 10 percent of all the procedures performed on a patient during a treatment period of one or two months. Failure to code even a small percentage of the hundreds of procedures performed each day in the radiation oncology facility can result in a tremendous decrease in revenue for both the hospital and the physicians.

CODING COMPLEXITIES

As the complexity of procedures and technologies has increased, the CPT coding system has changed to reflect the increased work performed by the facility and physician and the better value received by the patient. The accuracy of treatment planning, immobilization techniques, devices to level doses within the treatment volume, and the use of chemotherapy during radiation treatment all affect how a procedure is coded. All too often, facilities adopt more complex and improved procedures for better patient care but fail to reevaluate how the new procedures affect the various treatment and procedural codes. Sometimes the department administrator or a physician will initiate a change in procedures without notifying others. The result can be a nonparallel system for coding that may raise red flags from the payers, leading to an audit.

In my experience as a consultant to radiation oncology facilities, this failure seems to be the most common way to undervalue or undercode the level of worth for procedures and treatment that a facility administers. For the great majority of facilities in which I have been a consultant, the appropriate use of coding and using state-of-the-art procedures would result in a 10 to 30 percent increase in the net revenues of the facilities.

Radiation oncology facilities today must pay much more attention to the details of how the coding of procedures are performed in the unit. When procedures change or when new technology is acquired, the physician and administrator responsible for coding need to communicate and agree on whether new codes need to be assigned. For example, in a facility where the radiation oncologist decides to use computerized tomography planning on

all patients treated for prostate carcinoma, the level of treatment planning becomes more complex. Instead of an intermediate planning designation, computerized tomography treatment planning increases the level of complexity to the highest level. If the facility is fortunate enough to have three-dimensional planning for prostate carcinoma, complexity level of the simulation and of the weekly radiation therapy treatment would also be increased for those cancer patients who receive such treatment.

The use of mixed beams or special beams including electrons or neutrons, the need for wedges, and the use of compensating filters and multiple changes in field size and location also constitute complex treatment planning and must be coded as such. Complex treatment procedures also include use of custom cast or cut shields, special multiple changes in field size and location, and brachytherapy (including the use of remote afterloading equipment and combination of modalities of therapy such as hyperthermia.) Tangential fields running at oblique angles to the patient require considerable effort and expertise to achieve the correct angles of incidence. Rotational therapy, either as full rotation or partial rotation in the form of arc therapy, requires intense planning to avoid damaging normal structures and to concentrate the treatment beam on the area of interest. Finally, there are cases where even palliative treatment may become complex due to the proximity of critical structures, previous treatment fields, chemotherapy, or other situations requiring maximum precision of planning and set-up to avoid complications and ensure maximum desirable response.

THE PATH AHEAD

Today, reimbursement for radiation oncologists and radiation oncology facilities is undergoing tremendous change. Discounted fees for service and use of equipment and facilities are common. Bulk pricing for physician services and for use of facilities and equipment is increasing. In some markets, radiation oncology is capitated. Capitation allows for the sharing of risk between health care providers, who manage expensive resources, and health care payers, who manage payment for use of these resources. In the capitated system, the pressures are exactly opposite the fee-for-service system that we have long known. Under a capitated system, the incentive is in place for the facility and physician to do less care in a less sophisticated manner, or in some instances, to provide no care or alternatives at all.

Although we are extremely fortunate to still have a fee-for-service system in most markets, we must be careful to properly use the system that has been so carefully developed to appropriately reward us for quality care. Since we are being closely watched at this time of cross-constraints and health care reform, every radiation oncology facility must properly use the CPT coding system. ■