Chapter 2
Coding, Billing, and Reimbursement for Procedures

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Introduction

Coding, billing, and reimbursement are an integral part of the procedures performed in today’s modern medical office. Gone are the days when one could learn a procedure and then just expect payment for services rendered. Performing the actual procedure is only part of the process. At times, billing and coding can be even more complicated and time-consuming than actually performing the procedure itself. However, once learned, procedure billing can become as routine as office visit billing. Appropriate billing with concomitant reimbursement is very satisfying and can gradually change the emphasis and tenor of a clinician’s practice. It is crucial that, before instituting a new office procedure, the clinician and the billing staff review the proper billing and coding to ensure that payment will occur.

Procedure Coding

As seen in the various procedure chapters in this book, included within each chapter are appropriate codes that must be compatible with the procedures discussed and shown. If a clinician is seeing a patient for diagnoses other than just the procedure, each diagnosis and procedure need to be coded separately. For instance, if a patient is being seen for a gynecologic exam and requests that her Intrauterine Device (IUD) be removed, the clinician would code the appropriate health maintenance code for the exam, use a -25 modifier, and then code for the IUD removal [1]. If the patient prefers to return another day for the IUD removal, one would only code for the actual procedure on the IUD removal visit.
Many procedures have global codes. Thus, if a procedure such as a Bartholin’s gland excision requires a second visit for a recheck, the recheck is considered part of the original global procedure code and would not be billed as a second office visit. Similarly, if there are sutures being removed for a procedure done in the office, the suture removal should be covered in the global fee. There are some exceptions to the rule: for example, one can bill separately for a visit to review and discuss treatment options of colposcopy pathology.

Coding compatibility with the procedure is essential to ensure payment. Checking with the Local Medical Review Processes (LMRP) in the state of the practice is essential, as this will lead the practitioner and his/her office staff to use the appropriate diagnosis codes as per the Centers for Medicare and Medicaid Services (CMS). Medicare’s website (http://www.cms.hhs.gov) is an excellent place to start [2]. There are stipulations for which ICD 9 (International Classification of Diseases, 9th Revision, Center for Disease Control and Prevention) codes will be covered by private payers and CMS for a specific procedure. Thus, a code that sounds appropriate in one state may be covered while another code will not be covered. Reviewing the state’s LMRP will decrease the number of rejected claims and improve the efficiency of the billing process. Inadvertent coding discrepancies also may be found by office staff who are assigned to check rejected claims. It is imperative to have someone in your financial office who is prepared to review rejected claims, particularly for procedures, and who can pursue the reasons for rejection. As billing improves, rejected claims decrease in number.

Coding also can be improved and facilitated by using specific coding software, some of which may even be accessed by either an electronic medical record or a handheld electronic device. There are many coding and billing software packages available in the market that will help promote effective coding [3].

**Documentation of Procedures**

All procedures need appropriate notes written by the clinician. Size and location of excised lesions should be documented, as reimbursement is determined by size, location, number of lesions removed, and the pathology of the lesion (benign versus malignant). Billing should be submitted based not only on the size of the lesion but also on the size of the margins. For instance, if a 1 cm lesion is removed using a margin of 0.2 cm on each side, the size would be considered 1.4 cm [4]. Follow-up should be clearly stated in order to document whether a subsequent visit should be considered part of the procedure.

Coding and billing for skin procedures is further complicated by the specific pathologic diagnosis of the lesion itself. For instance, coding for removal of a benign versus malignant lesion may be difficult until the biopsy results have returned to the office, which may be anywhere from 10 to 14 days after the date the actual procedure is performed. However, removal of a malignancy is generally
reimbursed at an average of two to three times the amount of the removal of a benign lesion. Thus, in some instances in which the CPT® (AMA, Chicago, IL) code may be dramatically changed by the pathology results, it may be advisable to hold billing the particular procedure until the pathology report returns and is reviewed.

One can also attempt to bill for an unsuccessful procedure, though the likelihood of being reimbursed is obviously much less [5]. Some insurances do pay for an attempted procedure, while others do not. Attempted procedures that are unsuccessful should have a modifier -52 attached to show that the actual procedure was not completed. The payer will need to know the extent of what was done; attaching a copy of the office note to the claim will usually suffice.

**Health Maintenance Organization Billing**

Medical procedures are highly scrutinized by Health Maintenance Organizations (HMOs) due to the expense of the procedure itself. Some HMOs require prior authorization for procedures, which may include submitting prior office notes, labs, or radiology reports to substantiate the need for the actual procedure [6]. This varies nationally by region and by the policy negotiated by the patient’s employer. This is particularly pertinent in regard to payment for a contraception procedure, which is often considered a separate benefit purchased by some employers and not by others. In all cases, contacting the patient’s insurance company to check coverage for the particular procedure is a proactive measure that will save time and money. If there is a concern that the insurance will not cover the procedure, consider having the patient sign a document (Advance Beneficiary Notice or ABN) stating that she will be willing to pay for the procedure if it is considered a noncovered service by her insurance company.

Most insurance companies will consider the procedures listed in this book as billable procedures over and above any negotiated capitation rates. However, if the clinician is practicing in a primary care office, he or she should know specifically which procedures are considered billable. If the specific procedure is not listed in the insurance company’s billable list, the insurance company may deny payment, citing the procedure as part of standard care and covered by the capitation rate. The list of billable procedures may not be standardized, even by insurance vendors. It is vital to obtain the region’s billable procedure list from each one of the insurance companies that are accepted by an office. If a given procedure is not present on the billable list, the clinician may need to negotiate with the insurance company for inclusion of that particular procedure. Typically, this might involve a discussion with a medical director within the insurance company and a presentation of the number of such procedures performed so as to judge the competence of the clinician. Credentialing with the insurance company prior to initiation of a procedure will improve the likelihood of payment.
Durable Medical Goods

Durable goods, such as IUDs, may be stocked by an office if they are used on a frequent basis. Another alternative to stocking durable goods is to have the patient contact the supply company directly and for the patient to pay directly for the durable good. For example, at times, it is necessary for the practitioner to write a prescription for the actual IUD; in other cases, it can be ordered online. The IUD is then sent to the office in the patient’s name: when it is sent, the patient is called so that insertion can be scheduled. Some insurance companies will only reimburse for the cost of the insertion, but will not cover the cost of the actual IUD. Other insurance companies may cover both procedure and durable goods. It is always important to have the patient sign an ABN stating that she is willing to pay for the procedure and the durable good prior to performing the procedure. Alternatively, some offices require that the patient provide payment prior to the procedure.

Charity Care Procedures

Charity care services also may be available for procedures such as IUD insertion. The Arch Foundation was established as a not-for-profit institution to help low income women who have no insurance coverage for the levonorgestrel Intrauterine System. The copper IUD manufacturer has a similar program for low income women who are interested in an IUD. In each program, the clinician has to agree to put the IUD in at no cost to the patient.

Cosmetic Surgery Billing

Most cosmetic surgery is not covered by insurance companies and is considered an “out of pocket” expense. Most clinicians who provide cosmetic surgery will stipulate that the patient pay prior to the actual procedure being performed. It is best to do a consultation prior to the actual procedure and to clearly provide the price of each procedure both verbally and in writing. Payment is then made prior to the actual procedure.

Summary

Appropriate coding and billing improves women’s access to important health procedures, as practitioners are more likely to continue doing procedures for which they can be paid. Due to the coding specificity, tracking payment and improving the
process of payment are relatively easy tasks for any clinician’s practice. Familiarizing oneself and one’s billing staff with coding for procedures by type of procedure and by type of payment by specific insurance company will increase the likelihood of payment, thus rewarding the clinician for providing services that are requested by the patient or necessary for good clinical care.

References


Additional Resources

Web Sites

The physicians’ guide to handheld computer software: www.fphandheld.com
http://www.archfoundation.com/
The Arch Foundation: http://www.archfoundation.com
Primary Care Procedures in Women's Health
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