

ACOG

Committee on
Coding and
Nomenclature

Committee Opinion



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Inappropriate Reimbursement Practices by Third-Party Payers

The American College of Obstetricians and Gynecologists (ACOG) Committee on Coding and Nomenclature believes that physicians must code accurately the services they provide and the diagnoses that justify those services for purposes of appropriate payment. This requirement is consistent with the rules established by the American Medical Association (AMA) Current Procedural Terminology Editorial Panel and published as the *Current Procedural Terminology* (CPT) and with those established by the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), which are published in the American Hospital Association's *ICD-9-CM Coding Clinic*. In fairness, payers should be equally obligated to pay physicians based on the CPT standards and accept for processing all ICD-9-CM codes recorded on the claim. Currently, no such obligation for payers exists.

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Inappropriate Billing Denials

Five frequently encountered billing situations account for most payers' inappropriate first-time total or partial denials of correctly coded services. Each of these situations can inappropriately deny payment to physicians for medically indicated and correctly coded services because of payers' payment policies.

1. *Inappropriately bundling correctly coded multiple surgical procedures*—*Current Procedural Terminology* clearly describes surgical procedures that may be performed to treat various conditions. Each CPT code describes a specific procedure that was valued under the Resource Based Relative Value Scale (RBRVS) on the basis of a description of the work it entails. Many patients, especially those with complex clinical situations, need more than one surgical procedure to be performed at an operative session. For instance, a patient may require a vaginal hysterectomy because of severe irregular bleeding, but also might require repair of a symptomatic cystocele and rectocele. Because no single CPT code describes this combination of procedures, the physician should apply multiple CPT codes with appropriate modifiers to the secondary procedures as mandated by

CPT rules. Furthermore, the physician should expect reimbursement for all of the provided services defined by the CPT codes.

Despite the accuracy of the above statement regarding reimbursement for multiple procedures, payers often cite the efforts of Medicare to reduce payments for inappropriately unbundled CPT codes by physicians as justification for denial of physician claims for appropriately coded services. Indeed, the Health Care Financing Administration has established the Correct Coding Initiative (CCI), a process for bundling together many services that should not be paid separately. The process continues to undergo refinement with input from the AMA and medical specialty societies.

Unfortunately, some commercial software products that do not adhere to either CPT or CCI guidelines are being used by third-party payers to identify CPT codes for services that will not be reimbursed when coded together. For example, some of these products incorrectly bundle anterior and posterior colporrhaphy with enterocele repair into the code for vaginal hysterectomy, presumably because all of these procedures are performed through a vaginal approach. The AMA Correct Coding and Policy Committee, with input from ACOG staff, has identified many instances of inappropriate denial of reimbursement with some of these commercial bundling products. Physicians should appeal such denials (see the box) and cite the content of this document in requesting appropriate payment for these services.

2. *Ignoring modifiers that explain qualifying circumstances*—Current Procedural Terminology modifiers provide a coding shorthand that helps explain situations for which either increased or reduced payment is justified. There is, at present, no insurance industry standard for recognizing modifiers.

The American College of Obstetricians and Gynecologists believes that third-party payers should follow existing CPT guidelines and coding options, including recognition of all CPT modifiers, to ensure that all circumstances concerning the service performed are recognized. Payers who ignore correctly applied CPT modifiers inappropriately underreimburse physicians for the services provided.

3. *Denying payment for diagnostic and therapeutic procedures performed on the same day of service*—In certain clinical situations, a diagnostic surgical procedure is performed to determine

Seven Steps for Appealing Denied Claims

Take these steps when appealing inappropriate reimbursement practices by third-party payers:

1. Keep in mind that this is a negotiation process that will succeed only if the insurer is convinced that a charge is fair for the patient and the physician. It is important to use accepted coding standards when attempting to show that an insurer's policy is wrong. Polite but direct communication is more likely to achieve desired results than confrontation.
2. Have your staff contact the claims department of the insurer and discuss the reason for denial with the claims processor. These discussions should be based on clinical facts that rely on the Current Procedural Terminology (CPT) code definition of the service and the standard of care implied by the CPT code as it was valued under the Medicare Resource Based Relative Value Scale (RBRVS) system. Document all communication with the insurer (date, person from office making the call, person spoken with, results).
3. If staff is unsuccessful, contact the medical director of the payer yourself. Maintain open lines of communication with the medical director to discuss inappropriate payment policies and accepted coding standards.
4. Involve the state medical society in disputes with insurers. Many state societies will become very involved when patterns of abuse emerge.
5. Contact the American College of Obstetricians and Gynecologists (ACOG) for assistance in dealing with inappropriately denied medically indicated services that are covered by the patient's insurance policy and clearly were correctly reported. Contact ACOG's Department of Health Economics by fax or mail after downloading a complaint form from ACOG's web site (www.acog.org), or call (202) 863-2447 for assistance.
6. Send a copy of any correspondence between the practice and the payer dealing with unresolved problems to the insurance commissioner or equivalent regulatory authority in your state.
7. Involve your patient when inappropriate billing problems cannot be resolved in other ways. Physicians are not responsible for the insurance plan selected by the patient. Many third-party payers will revise their payment policies when they receive a complaint from the patient or patient's employer or union.

whether a therapeutic surgical procedure is required. When this occurs, it often is appropriate for the two procedures to be done at one time rather than at two distinct times. For example, if a diagnostic laparoscopy for a suspected benign condition reveals cancer, the physician may decide to perform a laparotomy to remove the cancer at the same operative session. In such a situation, many payers deny payment for the diagnostic laparoscopy even though performance of both the diagnostic and therapeutic procedures at the same time is medically indicated and requires additional physician work above that of the therapeutic procedure alone. In accordance with CPT guidelines, both procedures should be coded and the physician should be paid for both when the procedures have been documented appropriately and coded correctly. In the example, proper coding for the diagnostic service in addition to a therapeutic procedure would at the present time require the use of modifier -59 to identify the diagnostic procedure as distinct. In addition, however, the diagnostic procedure must be justified with a specific ICD-9-CM diagnostic code, which may or may not be the same as the ICD-9-CM code for the therapeutic procedure.

The practice by payers of bundling diagnostic and therapeutic procedures to reduce physicians' payment is inappropriate. Physicians have a legal obligation to code correctly. Insurers are equally obligated not to alter coding by physicians that is in accordance with approved CPT guidelines.

- 4. Precertifying consultations at a predetermined level*—Some payers require precertification of a consultation and typically authorize a predetermined level of service based on the diagnostic information provided by the physician who requested the consultation. By contrast, the CPT guidelines state that the correct level of consultation is determined by the extent of the history, physical examination, and complexity of the medical decision-making process for each patient. This definition of services was used by Medicare under RBRVS to assign the relative value for physician consultation. Each patient who requires a consultation does so with a medical history typically including co-morbidities that can dramatically alter the physician work required to provide this service. Often such co-morbidities will necessitate a more thorough history and physical examination and involve more complex medical decision making than required in their absence. For example, a

request for a consultation to assess fetal well-being in an otherwise healthy patient who has had an uneventful pregnancy will not resemble a consultation for this same problem when the patient has preexisting complications of pregnancy, such as cardiac disease, uncontrolled diabetes mellitus, or a history of poor obstetric outcomes.

Because it is not possible to determine prospectively the level of service that will be required to evaluate and recommend treatment based on the uniqueness of each patient's problems, payers should precertify for an unspecified level of consultation that is paid at the appropriate level once the service has been provided.

- 5. Denying diagnostic tests or studies performed at the same encounter as a distinct evaluation and management service*—The CPT manual states:

The actual performance and/or interpretation of diagnostic tests/studies ordered during a patient encounter are not included in the levels of [evaluation and management (E/M)] services. Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code.

With this statement, CPT has clarified that diagnostic tests and studies, including colposcopies, biopsies, diagnostic ultrasound examinations, and cystometrics, are ordered on the basis of clinical criteria for each patient and not as a routine service. This definition means that tests performed at the time of an outpatient or other E/M encounter are not to be paid as part of the E/M service, but rather are to be paid separately. The E/M codes in CPT were valued under the Medicare RBRVS fee schedule on the basis of the CPT guidelines; these values do not include any diagnostic tests or studies.

The payer may deny reimbursement of diagnostic tests or studies at the time of an E/M encounter because the payer's payment policies might have been formulated with a lack of understanding of CPT coding standards that separate physician work included with the E/M service from the diagnostic test or study. This lack of understanding may lead the payer to inappropriately include all services provided to the patient at the E/M encounter as part of that service. The payer also may deny payment because the physician failed to add a modifier -25 to the billed E/M code to bypass the payer's established coding edits to ensure appropriate payment for both services.

Possible Remedies

The physician should ensure that his or her billing staff are knowledgeable about:

- What is normally included and what is excluded from the service being billed (This information is provided in the most current edition of ACOG's *OB-GYN Coding Manual: Components of Correct Procedural Coding*.*)
- How to link each service billed with one or more specific ICD-9-CM diagnostic codes that specifically justifies the reason for the service (This information is available in the most current edition of ACOG's *ICD-9-CM: Diagnostic Coding in Obstetrics and Gynecology*.*)

- The correct application of CPT modifiers, when indicated (This information may be found in the appendixes of the current AMA CPT manual and in the current edition of ACOG's *CPT Coding in Obstetrics and Gynecology*.*)
- Billing rules established by individual payers

The billing office should communicate clearly the indication for performing all coded services on the same date of service by reporting the most specific ICD-9-CM diagnostic codes. In some encounters, the justification for all services rendered may be documented by a single ICD-9-CM code. When a patient has multiple complaints or problems, multiple ICD-9-CM codes should be used.

* These resources are available from the American College of Obstetricians and Gynecologists.