# The economics of gynecologic surgery: 13 coding tips to ensure fair payment

## How to get appropriate compensation for your expertise and time

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The payment structure for physicians is changing. Our government, the American public, purchasers, and employers are unhappy with the fee-for-service system as it currently exists, and are pushing to drive the system into what is called "value-based purchasing."

But what is value?

One way to define it is quality divided by cost—but how do we measure quality?

At present, insurers are measuring your quality based on some nebulous definition created at United Healthcare or Blue Cross Blue Shield—looking specifically at your "efficiency," based on the costs attributed to you, as revealed in the codes you and others submit to payers.

Let's say you perform minimally invasive surgery, and the referring physician ordered a lot of tests before sending the patient to you. Are you aware that all of those costs may be attributed to you in an administrative system?

ACOG is working hard to establish *clinical* systems rather than administrative ones to determine the true cost of care. We may want to think of obstetrics and gynecology as primary care and take advantage of advanced payment models and the opportunities afforded to accountable care organizations, but the truth is, insurers frequently do not consider us primary care. Although some of us may develop medical homes for women's health care, we are unlikely to collect a per-patient, per-month income like primary care physicians do. That means that we need to be more assertive in negotiating contracts with insurers.

In this article, I offer recommendations for such negotiations and explain how to determine what you can and cannot accept in terms of payment.

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## You are the responsible party

Some of us do our own coding and some of us do not. However, if that coding is inaccurate, it is the physician who goes to jail, not the coder. You are personally responsible and liable for the coding submitted under your provider number.

Clearly, we need to do a better job of advocating for ourselves. We need to lobby. Legislators and bureaucrats are less likely to target people who have strong lobbyists working consistently on their behalf.

Accountable care organizations may have some leverage in negotiating lower prices, and some market forces may come into play in large systems. It remains to be seen which models will succeed as new payment structures develop. The overarching question: What can we do today to optimize our payments, given the system that we have? Here are 13 tactics that can enhance your bottom line.

### 1. Know the rules

To play the game, you must know the rules. You need to know what systems payers are

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using to determine your reimbursement—and you have to understand those systems as well as, or better than, the payers do. Then you'll be able to use them to your advantage.

Payers are well aware that we don't like to focus on this end of practice, that what we really want to do is spend the day practicing medicine. However, we need to learn these details because we're leaving money on the table every single day.

### 2. Educate yourself

With the change to the International Classification of Diseases (ICD) scheduled to take effect on October 1, 2015, many of us are worried that payers are going to reject our claims because of our lack of familiarity with ICD-10.

Rest assured. There are crosswalks from ICD-9 to ICD-10. ACOG has published an information sheet for both obstetrics and gynecology that pairs typically used ICD-9 codes with their ICD-10 counterparts. And because it is published by ACOG, payers will find it hard to claim that it's inaccurate.

ACOG also offers half-day courses on ICD-10 coding for both physicians and staff.

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**You aren't required to code for variables such as obesity and diabetes to get paid—but you do need to use codes to reflect these conditions to ensure that you aren't classified as a low-risk provider when you are treating a higher-risk cohort**

### 3. Record your decision-making process

When I audit medical charts, I often discover that this process has been neglected. Instead, the coder has relied on documentation from the electronic health record and a basic description of the treatment plan. But a plan is just that—what someone *intends* to do. It doesn't convey the decision-making that underlies it. What was the differential diagnosis? What did you discuss with the patient? These details are critical for appropriate coding of the level of service—whether it's high, intermediate, or low.

### 4. Refine your approach to coding

Recognize that the system is currently set up to pay physicians for the services we provide—and that service must be justified by the appropriate diagnosis code. Tougher cases, or high-risk patients, tend to have longer surgeries and hospital stays, and their outcomes often are not as good as those of more typical patients. They may have more complications because they're obese or have severe diabetes, for example. If so, it is critical that these other conditions—obesity and severe diabetes—be included with the principal diagnosis code so that risk stratification is possible. Otherwise, we will be held to the same standard as someone treating a routine, low-risk case.

Risk stratification is being performed according to algorithms in the payers' software—and payers are unlikely to share the details with us. However, the only real data payers have to run through these algorithms come from diagnosis coding. Even though you're not required to code for variables such as obesity and diabetes in order to get paid for what you do, you do need to use those additional codes to make risk stratification possible—so that you don't get inappropriately placed into a group of low-risk providers when you are treating a higher-risk cohort.

### 5. Develop an understanding of RVUs

Another variable that changes regularly is relative value units (RVUs) under Medicare rules. ACOG's Committee on Health Economics and Coding—which enjoys the participation of AAGL, the American Urogynecologic Society (AUGS), the Society of Gynecologic Surgeons (SGS), and the Society of Gynecologic Oncology (SGO), as well as other organizations—tries to maintain the RVUs as up to date and appropriate as possible relative to other services in the fee schedule.

For example, about 10 years ago many urogynecologic procedures were getting bundled together when they were performed at the same time. We had only one or two ICD-9 codes to describe prolapse, with no separate codes to describe whether it affected the anterior, apical, or posterior compartment, even though we performed different procedures in the individual compartments. Payers were mapping all prolapse procedures to the same diagnosis code. So ACOG went to the National Center for Health Statistics, where ICD-9 coding was done—and developed a series of about 10 codes to describe the different areas that prolapse could affect.

That kind of nuanced coding is continuing today. In fact, we have a long list of areas to go forward with now that ICD-10 is scheduled to take effect. A good example involves new Pap smear guidelines, which recommend testing every 3 or 5 years except for patients who have undergone hysterectomy for benign disease. How do you code for a patient who has had a hysterectomy? There was no code for a woman with an absent cervix, so we created a "V-code," a code classification for factors that influence health status, so that it is possible to explain why a Pap smear was not performed.

As we go forward into a value-based system, specialists like us likely will be negotiating contracts according to RVU-based payments. That's why it's important for you to understand the resource-based relative value scale (RBRVS). It has three components: a work component, which makes up about 52% of the total RVUs; a practice expense, which makes up more than 45% of total RVUS; and, finally, a malpractice component, a small percentage. There also is a geographic adjustment and a uniform conversion factor.

When you hear about the sustainable growth rate (SGR) fix, and the fact that we're going to see a 20% or 24% reduction in payment, that talk is referring to a reduction in the conversion factor. Each component of the RVU is adjusted for geography and then multiplied by the dollar conversion factor to calculate the total RVUs. The work, practice, and malpractice components vary by where the service is provided.

Let's use placement of Essure inserts as an example. If you perform the procedure in the hospital, then the hospital buys the equipment, including the hysteroscope and light source. The hospital also pays for the room and staff and manages equipment sterilization. If, on the other hand, you perform the procedure in your office, all those responsibilities are yours. If it's done in your office, you get paid more but it also costs you more.

The Relative Value Update Committee, or RUC, plays a major role in determining RVUs. This committee is composed of 31 clinicians, including nonphysician providers, psychologists, and nurses who deliver services under the Medicare fee schedule. The RUC makes recommendations to the Centers for Medicare and Medicaid Services (CMS), but it is the Secretary of Health and Human Services who determines the final rule on RVUs.

Approximately 75% to 95% of the recommendations of the RUC are accepted by the Secretary and become law. So it's not the RUC or the American Medical Association (AMA) that determines RVUs; in the long run, it is CMS and the Secretary of Health and Human Services. We are fortunate that, when CMS assigns RVUs we're not happy with, we have an opportunity to appeal.

Under Medicare, all physician payments are based on the same conversion factor, regardless of specialty. That's not necessarily true for other payers, who may, essentially, do whatever they wish. These other payers frequently will contract at higher or lower rates, depending on how prevalent a specialist is in the community. Sometimes they use a higher conversion factor for surgical specialists than they use for primary care.

### 6. Find out which RVUs the payer is using

When you negotiate contracts with payers, and you are in private practice or part of a medical practice, it's important to know what year's RVUs the payer is using, as RVUs vary from year to year. For example, if the payer is using the RBRVS from 2002, it is paying you less than you should be getting. So when you look at a contract, you should determine not only whether the payer is anchoring your payment to the RBRVS but also whether it is keeping up with current RVUs as well. What dollar conversion factor is the payer using? What global periods—the same as CMS, or something different?

### 7. Determine what global period is in play

Some private payers use 6 postoperative weeks as the global period for a surgical procedure, whereas Medicare uses 90 days. You need to know which period is in play so that you don't leave money on the table if you

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**Some private payers use 6 postoperative weeks as the global period for surgery, whereas Medicare uses 90 days. You need to know which global period is in play to bill accurately.**

see the patient within 90 days but more than 6 weeks postoperatively.

Current Procedural Terminology (CPT) has global surgical packages that include a 10-day or 90-day period. But those periods do not include services provided more than 24 hours before the procedure. They don't include the administration of anesthesia or conscious sedation. And they don't include management of complications, exacerbations, or recurrences. Nor do they include additional services that might be necessary due to the presence of another disease or injury.

Under Medicare, the rules are different. Medicare preoperative services begin 1 day before surgery. However, any preoperative intervention is included whether it's performed 1 day or 1 week before surgery. If it's simply a preoperative physical examination for the patient and you aren't performing significant evaluation and management, it's included in the global package, along with all the intraoperative work. In addition, under Medicare, you don't get paid for the management of complications unless a return to the operating room is required.

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**Make an effort to understand bundling and dispute resolution so that, if necessary, you can insert clauses into your contract that give you more rights**

### 8. Learn to use modifiers

As ObGyns, we often see patients for multiple conditions or problem reports, so you need to be aware that if a patient is within a global period and you do not submit a bill with a modifier to indicate special circumstances, the intervention will be bundled into the global and you will not get paid for it. Modifiers are two-digit codes that describe these separate services. They provide critical information to payers so that their computer programs separate these services out for payment.

Major surgical procedures don't include unrelated procedures that are performed at the same time of surgery. Nor do they include visits that take place during the global period that are unrelated to the original surgery. For example, if a patient presents with a breast lump after you performed a hysterectomy, and you do a work-up, you deserve full payment for that evaluation and management service. If you don't use a modifier, however, you won't get that payment.

### 9. Don't be passive when payers won't pay

Let's say you contract with HMOs or independent practice associations (IPAs), and they're not compensating you for the extra things you're doing and are failing to recognize surgical modifiers. What can you do about it?

You need to develop a profile of your typical patient. Because these organizations are individualizing it—they are saying that, in a typical scenario, this is the type of work you do. So these organizations offer a different kind of contract. Nevertheless, you can use your coding to help you determine what a fair payment should be, by going through your billing to determine what you've spent.

### 10. Analyze payer bundling

Medicare put in place a correct coding initiative (CCI) that lists services typically provided by the same person on the same day of service. The aim: to prevent separate payment for these services. These are "bundled" services. The CCI bundles are revised every quarter. They are listed on the ACOG Web site under "practice management."

On October 1, 2014, the CCI inappropriately bundled pelvic organ prolapse repair procedures into the vaginal hysterectomy codes. ACOG, AUGS, SGS, and AAGL are arguing vehemently as this article is going to press to ensure that these damaging bundles are rescinded.

Private payers can bundle anything, and it may or may not make sense or be fair. One ACOG resource is the book *Ob/Gyn Coding Manual: Components of Correct Procedural Coding*, which is revised every year. It has a tear-out page for every procedure code and will help you determine whether or not a bundle is appropriate.

You need to know about bundling and dispute resolution. Why? Because it is possible to insert clauses into your contract that give you some rights. Insurers have all the clout and you have nothing unless you fight for it.

You may see clauses such as "the company reserves the right to re-bundle to the primary procedure...." You shouldn't tolerate that. Rather, you want to say, "the company

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will use CCI bundled rules" so that you at least know what the rules are.

### 11. Don't be afraid to revise a contract

If we have to hold a payer harmless, the payer should hold us harmless as well. If we consult an insurer's Web site to confirm that a patient is covered, and we take her to surgery because we have evidence she has insurance, the insurer shouldn't be able to rescind payment 6 months later because the patient didn't pay for her insurance that month. That's not fair. The company told you she was covered, and you deserve to get paid for that surgery because you are relying on information from the company itself. So when you sign a contract, you need to ensure that you are being held harmless as well as the insurer.

### 12. Calculate your own RVUs

Use your claims software for data. Consult the Federal Register or ACOG to determine the total number of RVUs for a given CPT code. Multiply the RVUs by the quantity for each code. Let's say it's an evaluation and management visit, code 99213, and you've done 50 this month. That's 50 multiplied by 1.3 RVUs. Add all the codes together, then use your monthly profit and loss statement to determine what your expenses are. Divide your total expenses by the total number of RVUs to determine your practice cost per RVU. You then can decide on a conversion factor you can tolerate, and you can use this information when contracting with IPAs, HMOs, and other insurers.

### 13. Spend money to make money

There are many coding resources available to you. Coding is well worth what you spend on it because you can get it back in a heartbeat.

This information may not be easy to master, but it's critically important for your economic survival—to get what's rightfully yours and get paid fairly for what you do.