2013 CPT®, HCPCS II and ICD-9-CM Coding Update

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About Your Faculty

• BS Health Science- SUNY Cortland (1996)

• Consultant, DoctorsManagement, LLC – 2013-Present

• President- Modern Conventions in Compliance, Inc. – 2004-2013

• Senior Consultant- Medical Management Institute – 1995-2003

Class will begin at 8:30am and will conclude no later than 5:00 pm each day
  - Day 3 will conclude around the lunch hour

Be sure to have your coding manuals on hand each day (CPT [Professional Edition-AMA], HCPCS II, & ICD-9-CM)

Lunch will be on your own around 12:00pm and we will take mini-breaks throughout the day

It is suggested that you use highlighters to mark up your manuals to assist during any certifications examinations you choose to sit for (e.g., CPC)
Agenda Day #1

Introduction to CPT Coding

- All CPT® References made to page numbers will be based on 2013 CPT® Professional Edition, authored by the American Medical Association (AMA)
- Structure, layout and design, place of service designation, table of contents,
- CPT® Introduction, symbols and appendices
- Anatomy and Medical Terminology Primer
- Category I, II, III CPT codes

Evaluation and Management Services (E&M)

- 1st Major Chapter of CPT1st major section of CPT®
- Outpatient versus Inpatient, New versus Established, Initial versus Subsequent, Observation, Consultations, Critical Care, Prolonged Services, Preventive Medicine, etc...
- “KEY” components and selecting levels of E&M service
Wrap Up and Review of Day 1
• Q&A and final discussions of CPT Basics and E&M

Surgical Package and Modifiers
• These discussions will include concepts that apply to all surgical sections of CPT
• Modifiers
• Pre-operative and post-operative periods
• How to “break out” services rendered in the global period
• CPT definitions versus Medicare and various 3rd party payers
• “Separate procedures” and unlisted procedures

Pertinent Surgical Coding Concepts
• Considering that this is a program geared toward primary care services and rural health, all surgical chapters are not discussed in elaborate detail...rather chapter highlights will be provided
Agenda Day #3

Wrap Up Days 1 & 2

• Radiology, Path & Lab, Medicine conclusions
• Depending on time, we may engage in some

HCPCS II

• CMS release schedule, using the index, HCPCS II modifiers, DME and DMERCs, G-codes, J-codes, etc.

ICD-9-CM & ICD-10 Introduction

• Volume I and Volume II, Neoplasms, CMS reporting guidelines & ICD-10 introduction
Healthcare’s Future in the United States

- **1945** - Medicare was first conceptualized
- **1965** - Medicare and Medicaid are enacted
  - Medicare Part A (hospital) and Medicare Part B (Physician)
- **1972** - HMOs are first introduced
- **1988** - ICD-9 codes become required on claims
- **1992** - HCFA (now CMS) adopts the RBRVS (fee for service replaces usual and customary)
- **1996** - Balanced Budget Act is passed allowing for single conversion factor and for all services/specialties and increases services of non-physician practitioners (85%)
  - Medicare Part C (Advantage)
- **1998** - **Current** - HIPAA (TCS, Privacy & Security) is phased in over time and still being tailored to this day (e.g., HITECH, 2013 “Mega” Rule, etc.)
- **2003** - Medicare Modernization Act enacted
  - Medicare Part D (Prescription Drug Plans)
- **2014** - ICD-10 (PCS and CM) mandated; ICD-9-CM (Vol I, II, & III) become obsolete
- **2030** - In 2010, 48 million beneficiaries compared to 80 million by 2030 (‘baby boomers’)
Introduction To Medical Coding

• What are the manuals intended to do?
  – Do all payers recognize the same “code sets?”

• How many levels of codes are there?
  – ‘Levels’ versus ‘Categories’

• How do you locate codes?
  – Index, Anatomically, Memorization, etc...

• When should modifiers be applied?
  – Level I versus Level II

• What is bundling?
  – NCCI Edits
General Coding Concepts

- **CPT**: What you do. Created by AMA (updated annually).
- **HCPCS II**: Temporary codes. *Supplies and DMF*. Created by CMS (updated annually).

- Remember HIPAA: no more level III codes (federal mandate) with TCS.
Effective Timelines

**CPT**

Released Oct-Nov
Effect Jan 1st

**HCPCS II**

November each yr
Effective Jan 1st
Unless otherwise instructed

**ICD-9-CM**

August each Yr.
Effective Oct. 1st
No more grace period!

**COMING SOON...**

ICD-10
October 1, 2014
General CPT® Layout

- Inside Cover-
  - Symbols of CPT®
  - Many Modifiers (complete listing in Appendix A)
    - Physical Status (discussed in Anesthesia chapter)
    - HCPCS II (discussed in detail on Day 3)

- 1st Page of 2013 Professional Edition CPT®
  - 1st page in 2013 manual provides tabs to reference important pages throughout the manual
  - Complete listing of Place of Service Codes (POS)

- Page ix
  - Table of Contents
CPT® Layout and Table of Contents

- Introduction
- Evaluation and Management (99xxx)
- Anesthesia (0xxxx)
- Surgery (1xxxx – 6xxxx)
- Radiology (7xxxx)
- Pathology and Laboratory (8xxxx)
- Medicine (9xxxx)
- Category II (xxxxF) - outcomes measures (optional, pg 561)
- Category III (xxxxT) - emerging technology (must use rather than unlisted, Category I codes pg. 579)
- Appendix A-O
- Alphabetic Index
Defining “Time” Within CPT®

- On page xii of 2013 Professional Edition CPT®”

  - “Time is the face-to-face time with the patient” (unless otherwise specified)
  
  - “A unit of time is attained when the mid-point is passed”

  - When a distinct procedure is performed during the time-based service (eg. CPR during critical care), the time spent performing the distinct procedure “should not be included in the time used for reporting the time-based service.”

  - “For continuous services that last beyond midnight, use the date the service began and report the total units of time”
  
  - For E&M services, time in the outpatient setting is defined as “face-to-face” opposed to “unit/floor time” in the inpatient setting (Pages 7-8 of 2013 CPT)
Symbols of CPT®

- New code (Appendix B)
- ▲ Revised code - changed definition or terms (Appendix B)
- ; Separates “base definition” from “indented” code definitions
- ▶ New or revised text
- + Add-On Codes (Appendix D)
- Ø Modifier “–51” exempt (Appendix E)
- ✐ See “CPT Assistant” for additional guidance
- ✐ See “Clinical Examples in Radiology”
- ◐ Include conscious sedation (Appendix G)
- ✯ FDA approval pending (Appendix K)
- # Re-sequence codes (Appendix N)
- ○ Recycled or Reinstated code
CPT® APPENDICES

- **APPENDIX A** – Modifiers (some HCPCS II included)
- **APPENDIX B** - Additions, revisions, deletions for this year
- **APPENDIX C** - Clinical examples (Evaluation and Management (E&M))
- **APPENDIX D** - “add-on” codes
- **APPENDIX E** - Modifier 51 (multiple procedures) exempt codes
- **APPENDIX F** – Exempt from modifier -63 (infant<4kg.)
- **APPENDIX G** – Include conscious sedation
- **APPENDIX H** – Performance measures by condition
- **APPENDIX I** – Genetic testing code modifiers
- **APPENDIX J** – Electrodiagnostic medicine of sensory, motor and mixed nerves (for nerve conduction
- **APPENDIX K** – Products (vaccines) awaiting FDA approval
- **APPENDIX L** – Vascular families (added in 2006)
- **APPENDIX M** – Deleted code crosswalk (added in 2006)
- **APPENDIX N** – New in 2011 (deleted code crosswalk)

2013 Update:
Appendix O
Multianalyte Assays with Algorithmic Analyses
Locating CPT® Codes

- **Anatomically:**
  - Codes range from head to toe and from outside to inside
    - (e.g., incision comes before excision in each chapter)

- **Indexing:**
  - The Alphabetic Index (pages 669-885, 2013 CPT® Professional Edition)
  - Main Terms
    - Procedure or service (e.g., Laparoscopy)
    - Organ or anatomic site (e.g., Liver or Humerus)
    - Condition (e.g., Abscess)
    - Eponym, synonym, abbreviations (e.g., Morton’s Neuroma)

- **TIP:**
  - NEVER CODE DIRECTLY FROM THE INDEX; CONSULT TABULAR LIST
Anatomy and Medical Terminology

- **Ante** - before
- **Retro** - after
- **Ipsa** – same side
- **Contra** - opposite side
- **Endo** – within
- **Sub** – under
- **Hypo** - low
- **Hyper** - high
- **Epi** – around surface
- **Posterior** - back
- **Anterior** - front

- **Oscopy** - visual exam of
- **Plasty** - repair of
- **Rrhaphy** - sutured repair
- **Ectomy** – excision
- **Ostomy** – to create an artificial opening
- **Itis** – inflammation of
- **Ology** - the study of
- **Megaly** - enlargement
- **Otomy** - incision into

Pages xiv-xv of 2013 CPT – Great reference for prefix, suffix, roots, positions, conditions

Page xviii provides various figures to describe Body Planes (great for dissecting OP notes)
Categories of E&M Services

- Office/outpatient (New/Established)
- Hospital observation (Initial/Subsequent/Discharge)
- Hospital inpatient (Initial/Subsequent/Discharge)
- Consultations (CMS discontinued payment in 2010)
- Emergency department
- Critical Care (Inpatient/Outpatient-AGE)
- Nursing Home Services (Initial/Subsequent/Discharge)
- Domiciliary, Rest Home, Custodial Care (New/Established)
- Home Services (New/Established)
- Prolonged services (Inpatient vs. Outpatient)

- Case Management Services (Anticoagulant MGT, Team Conferences)
- Care Plan Oversight (Home Health, Hospice, Nursing Facility)
- Preventive medicine (New/Established/AGE-specific)
- Non-Face-to-Face Physician Services (Telephone, On-Line Medical Evaluations)
- Neonatal/Pediatric/Newborn Care (Inpatient/Outpatient/Transport)
- Complex Chronic Care Coordination services (New 2013)
- Transitional Care Management Services (New 2013)
2013 Updates- Evaluation and Management

- 82 E&M definition updates to include “or other qualified healthcare professional”

- 2 new codes (99485-99486) to describe the non-face to face work performed by the “control physician” during interfacility transport.
  - Patient age, medical condition and total time must be documented

- 3 new time based codes (99487-99489) to report services provided to patients with “Complex Chronic Care Coordination” needs
  - For individuals residing at home, or in domiciliary, rest-home or assisted living
  - Typical patients have 1 or more chronic conditions expected to last at least 12 months or until death

- 2 new codes (99495-99496) for Transitional Care Management Services (TCM)
  - For established patients with moderate to high complexities of MDM during transitions from inpatient care back to community setting (e.g., home, domiciliary, rest-home assisted living)
Evaluation & Management (E&M) Services

• For the sake of argument, a preventive E/M service differs from a problem-oriented E/M service only in that a patient who presents for the former lacks a current chief complaint.

• Pages xxiv-xxvi provide some excellent tables [charts] designed to assist coders assign the accurate ‘levels’ of E&M service.

• Who are you seeing?
  – New, initial, established, subsequent, consultation, etc.

• Where are you seeing them?
  – Outpatient, inpatient, emergency department, home, etc.

• Why are you seeing them?
  – Preventive versus ‘problem-oriented’
New vs. Established Patients

A new patient is one who has not received any face to face professional service from the physician/qualified healthcare professional

or

another physician/qualified healthcare professional of the exact same specialty/subspecialty who belongs to the same group practice within the past three years

Medicare regulation states: "Physicians in the same group practice who are in the same specialty must bill and be paid as though they were a single physician."

Refer to the CPT “Decision Tree” on page 5 of 2013 CPT Professional
Important E&M Terminology

• **Concurrent Care**
  - The provision of similar services (e.g., hospital visits) to the same patient by multiple providers on the same date *(defined top page 5)*

• **Transfer of Care**
  - The process whereby a provider managing a patient “relinquishes” the responsibility to another provider *and that provider explicitly agrees to accept responsibility* *(defined top page 5)*

• **Consultation**
  - A “request” by one provider for another provider to offer an opinion and/or advice regarding the management of the patient… “The 3 R’s”

• **Time**
  - **Inpatient** - Unit/floor time *(defined page 8)*
  - **Outpatient** - Face-to-face time *(defined page 8)*
What Defines The Level of Evaluation and Management (E/M) Code?

- History
- Exam
- Medical Decision Making

“KEY” Components

- Nature of Presenting Problem
- Counseling
- Coordination of Care
- Time

Contributory Factors
Office and Other Outpatient Services

• **99201-99205**
  - New patient visits
  - Require all 3 “key” components
  - Remember new patients have not received professional services within previous three (3) years

• **99211-99215**
  - Established patient visits
  - Require 2 of the 3 “key” components
    - 99211 is a level of E&M service that typically does not require the presence of a physician

• **Tip:** Highlight the time frames and number of “key” components required for each of the codes in this section
Typical nurse visits include, patient education, injections, infusions, problem focused evaluations and specimen collection.

Per CPT, “Usually, the presenting problem(s) are minimal. Typically, five minutes are spent performing or supervising these services.”

General Requirements
- Non-Physician must be:
  - Employee or contractor for physician
    - Follow physician orders resulting from his/her evaluation of the patient
    - Be supervised by a physician

“Because medical necessity is required, vital signs and blood pressure checks may not be routinely performed at the time of another coded service in order to bill for a 99211 visit” (e.g., injections, INRs, etc.)
Observation Services
CPT® Codes 99217-99220 & 99224-99226

• Reserved for patients designated/admitted as “observation status” in the hospital
  – Observation is a “status”, not a physical location

• There are three “levels” for initial observation
  – 99218-99220
    – New in 2012: Times are now associated with these codes (30min/50min/70min thresholds)
    – Use “unit/floor time” concept

• There are three NEW “levels” for subsequent observation
  – #99224-99226 (resequenced)
  – 30min/50min/70min thresholds

• There is one code to report observation discharge
  – 99217
Troubleshooting Observation

- According to the AMA, the subsequent observation codes (99224-99226) are to be used for both the provider who initiates observation and any other provider who evaluates the patient...
  - CMS states that “consulting” physicians asked to evaluate the patient in observation should report these services with office or other outpatient visit codes, 99201-99215. (Report consultations to payers that still have consult coverage policies in place)
  - *We suggest (like Aetna and others) that the subsequent observation codes be employed by the provider who initiates observation... (CMS now concurs)*

- E/M services on same date as observation are not separately reported. Codes 99234-99236 are used to report same day observation and discharge or same day hospital admission and discharge (POS codes are very important)

- Always base code selections on “calendar dates”
  - Always select discharge code (e.g., 99217, 99238-9) based on whether the patient is inpatient or outpatient.
Hospital Inpatient Services

- 99221-99223 for initial hospital care (“admits”)
  - Defined as the “first hospital inpatient encounter by the admitting physician”

- 99231-99233 for inpatient rounds
  - “Clustering” levels of E/M for subsequent hospital visits can be an audit target (CMS 10/00)

- 99238, 99239 for inpatient discharges
  - You MUST document “>30 minutes” to support 99239

- 99234-99236 for same day admit/discharge
  - Same codes as observation but require POS 21
The request for consultation must be in writing

Therapeutic or diagnostic services may be provided during the course of a consultation

A written report to the requesting physician must be provided (outpatient setting only - ‘shared records’)

The requesting physician’s NPI goes in box 17b of the CMS 1500 claim form

Referrals are NOT to be coded as consultations

CMS placed moratorium on consultation services (1-1-2010)

The 3 R’s (Request, Render, Respond)
Emergency Department Services
99281-99285

• Only covered for patients registered in the ED of a hospital-based facility (POS 23).

• Any physician that provides services in the ED
  – Do not report ED code if called in to “consult”

• Not required to be an emergency service

• No distinction between new or established patients

• Includes History, Exam, and Decision Making (all 3 required)

• No typical time associated with these codes
Critical Care Services
99291-99292

**Critical care:** The direct delivery by a physician(s) of medical care for a critically ill or critically injured patient.

- A critical illness or injury is defined in 2013 CPT® Professional (page 23) as one that “acutely impairs one or more vital organ systems such that there is a high probability of imminent or life threatening deterioration in the patient’s condition”
  - i.e. CNS failure, circulatory failure, shock, renal failure, etc.

- Time must be documented (suggested to use clock time)

- Time does not need to continuous (may be cumulative per day)
• Critical care may be provided on multiple days even without a change in treatment as long as the patient’s condition continues to require a high complexity decision making.

• For any given period of time spent providing critical care services, the physician must devote his or her full attention to the patient, and therefore, cannot provide services to any other patient during the same period of time.

• See guidelines on pages 23-24 of CPT 2013 Professional
  – Same specialty providers are not permitted to report critical care
  – Distinct providers (and diagnoses) are permitted to report critical care
  – When one MD reports “per diem” code, others must refer to 99291-2
Nursing Facility Services
99304-99318

- **Initial Nursing Facility**
  - 99304-99306 (3 levels)
  - May report hospital discharge on same date

- **Subsequent Nursing Facility**
  - 99307-99310 (4 levels)
  - Frequency is an element of payer scrutiny

- **Nursing Facility Discharge**
  - 99315-99316
  - Like hospital d/c, must document “>30 min” to select 99316

- **Annual Assessment**
  - 99318
  - Requires only low complexity of MDM
  - Typically “30 minutes are spent”
Prolonged Service Codes

- Face-to-face (99354-99357)
- Non face-to-face (99358-99359)
- Inpatient verses outpatient
- These are all “add-on” codes and require the documentation of time
- Need to understand levels of basic E/M services before one can report these codes accurately
- The services need to be “unusual”
- Prolonged service of less than 30 minutes total duration on a given day is **not** reported separately (already in work of E/M)
- Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is **not** reported separately (“midpoint”)
Physician Standby Service

• Used only when standby is requested by another provider and when the provider is not rendering services to other patients

• CPT code 99360 is used for each full 30 minute period.

  – The “midpoint” concept does not apply
Care Plan Oversight

- 99374 – 99380 (not for use with Medicare claims)
  - These are time-specific codes (must document time)
  - Code selection depends on amount of time spent in a given calendar month (e.g., “15-29 minutes” versus “30 minutes or more”)
  - Home health (99374-5), Hospice (99377-8), and Nursing Facility (99379-99380)
  - These codes are used to report supervisory and coordination activities engaged in by the provider per calendar month

  - **G0180**: Initial Medicare approved Home Health Certification (MD only)
  - **G0181**: Physician supervision of a patient under care of a participating home health agency (99375)
  - **G0179**: Re-certification Medicare approved home health (MD only, each 60 days)
  - **G0182**: Physician supervision of a patient in a participating hospice (99378)

- Activities that work toward CPO time include provider time only;
  - review of charts, treatment plans, phone calls, team conferences, decision making, prescription changes, etc...
Preventive Medicine Services
99381 - 99397

- Age related codes (new vs. established)
  - 99381-99387 (new patients) and 99391-99397 (established patients)

- Includes history, examination, counseling/anticipatory guidance/risk factors and orders for lab/diagnostic procedures.

- May report “problem-oriented” E&M with a modifier -25 (significant separately identifiable) with sufficient documentation (highlight on page 35)
  - Must require additional work to perform the key components of a problem-oriented E/M service.
  - “vaccine/toxoid products, immunization administrations, ancillary studies involving laboratory, radiology, other procedures, or screening tests identified with a specific CPT code are reported separately.” (page 35 2013 CPT Professional)
Non-Face-to-Face Physician Services

- **Telephone Services** (99441-99443)
  - Codes are time-based
  - For established patients only
  - They are NOT paid by Medicare
  - For physicians and other providers able to report E&M services
    - Not reported if within 7 days of previous E&M or if decision to see in following 24 hours or “next available urgent visit appointment
    - Refer to 98966-98968 for SLP, PT, CSW, dietician, etc.

- **On-line Medical Evaluations** (99444)
  - Established patients only
  - For physicians only
    - Not reported if within 7 days of previous E&M or if decision to see in following 24 hours or “next available urgent visit appointment
    - Refer to 98969 for NPP on-line evaluation
Newborn Care Services
CPT codes 99460-99465

• For newborns (neonates) in the first days following birth prior to discharge home

  - Attendance at delivery (99464) and delivery/birthing room resuscitation (99465) are not separately reportable (parenthetical reference under 99465)

  - 99460 - initial care of newborn, per day (hospital of birthing center), normal newborn
  - 99461 - initial care of newborn, per day, (other than hospital of birthing center) normal newborn
  - 99462 - subsequent hospital care, normal newborn
  - 99463 - same day admit and discharge of normal newborn
  - 99464 - attendance at delivery
  - 99465 - delivery/birthing room resuscitation
Pediatric Critical Care Patient Transport

99466 – Critical care services delivered by a physician, face-to-face, during an inter-facility transport of a critically ill or critically injured pediatric patient, 24 months of age or less; first 30-74 minutes or hands on care during transport

+ 99467 – each additional 30 minutes (list separately in addition to code for primary service)

• New CPT codes 99485 and +99486 for supervision by a control physician of interfacility transport care of critically ill pediatric patient (≤24 months old)
  ‐ Includes 2-way communication w/ transport team
  99485 – first 30 minutes
  +99486 – each additional 30 minutes

Services less than 30 minutes are not reported separately
# Neonatal and Pediatric Critical Care (per diem codes)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99468</td>
<td><strong>Initial</strong> inpatient neonatal critical care</td>
</tr>
<tr>
<td>99469</td>
<td><strong>Subsequent</strong> inpatient neonatal critical care</td>
</tr>
<tr>
<td>99471</td>
<td><strong>Initial</strong> inpatient pediatric critical care, <em>(29 days through 24 months)</em></td>
</tr>
<tr>
<td>99472</td>
<td><strong>Subsequent</strong> inpatient pediatric critical care <em>(29 days through 24 months)</em></td>
</tr>
<tr>
<td>99475</td>
<td><strong>Initial</strong> inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, <em>2 through 5 years of age</em></td>
</tr>
<tr>
<td>99476</td>
<td><strong>Subsequent</strong> inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, <em>2 through 5 years of age</em></td>
</tr>
</tbody>
</table>

Remember, for ALL outpatient critical care, use 99291-2
Complex Chronic Care Services

• New 2013 CPT codes (99487-+99489)

• Patient centered management and support services for patients:
  – Who reside at home, or in a domiciliary, rest home or assisted living
  – Who typically have 1 or more chronic or continuous conditions expected to last at least 12 months or until death of the patient
  – Per month codes
  – Code selection depends on whether patient is seen during calendar month
    – 99487 (no face to face visit per month)
    – 99488 (one face to face visit per month)
    – +99489 (add-on for “each additional 30 minutes” per calendar month)

– Time spent during day of face to face visit is not to be counted
Transitional Care Management Services (TCM)

• New 2013 CPT codes (99495-99496)

• For established patients whose medical and/or psychosocial problems require moderate or high complexities of MDM during transitions in care
  - From inpatient setting to the patient’s community setting (e.g., home, domiciliary, rest home or assisted living)

  - TCM begins on day of discharge and continues for next 29 days
  - TCM requires one face to face visit within specified time frame
  - First face to face visit of TCM is not reported separately (subsequent reported separately)

  - **99495**
    - Requires communication with patient/caregiver w/in 2 business days of discharge
    - Moderate MDM and a face to face visit w/in 14 days (not separately reportable)
  
  - **99496**
    - Requires communication with patient/caregiver w/in 2 business days of discharge
    - High MDM and a face to face visit w/in 7 days (not separately reportable)
E&M Documentation Guidelines

- Chief complaints
- Preventive vs. Problem-Oriented
- Complete reviews of systems
- 1995/1997 examination guidelines
- Using time to drive level of E&M
- When to report modifiers
- Global period concepts
- Coding patterns
- Audits (OIG, CERT, RAC, ZPIC, etc.)
History - Subjective

- **Chief complaint** – clear, concise statement detailing the reason the patient is presenting today, usually in the patient’s own words

  - According to CMS, the CC may be combined with the HPI

- HPI (history of present illness)
- ROS (review of system)
- PFSH (past family social history)
History of Present Illness-HPI

- **Location** – where is it. (pain in LLQ abdomen)
- **Quality** – how does it feel – (diffuse-achy, tingling, numb etc)
- **Severity** – how bad is it (1 – 10 for pain)
- **Duration** – how long (3 days)
- **Timing** – when does the symptom occur (worse after meals)
- **Context** - what happen to caused it (abdominal pain after eating 25 oysters)
- **Modifying factors** - what did the patient do in an attempt to alleviate their symptoms. (took otc)
- **Associated signs and symptoms** – what else is bothering the patient. (diarrhea & vomiting)
An inventory of the body systems of the patient to determine if the patient is experiencing additional signs and/or symptoms

Expand on remarkable symptoms

A complete ROS – 10 or more systems – Positive or pertinent negative responses must be individually documented with a statement that all other systems are negative. In the absence of such a notation, at least ten systems must be individually documented.
Past, Family, and Social History-(PFSH)

• **Past history** – patient’s experience with illness and/or injury

• **Family history** – patient’s family experience with illness

• **Social history** – age relevant review of the patient’s social activities
History Documentation Reminders

- CC, ROS and PFSH may be listed as separate elements of history or included in documentation of the HPI

- Provider can use and get credit for history elements (not HPI) obtained at another visit as long as it is relevant and referenced
  - “Remainder of ROS and PFSH unchanged since 11/26/2012”

- ROS and/or PFSH may be recorded by ancillary staff or patient as long as the provider documents confirmation of the information

- **TIP:**
  - If unable to obtain a history from the patient or other source, document the patient’s condition that precludes getting it and you can be credited for a comprehensive level of history.
Determining the Level of History

<table>
<thead>
<tr>
<th>Subjective (history)</th>
<th>Past, Family, and/or Social History (PFSH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of Present Illness (HPI)</td>
<td>Past Medical</td>
</tr>
<tr>
<td>Location</td>
<td>Family Medical</td>
</tr>
<tr>
<td>Quality</td>
<td>Social</td>
</tr>
<tr>
<td>Severity</td>
<td></td>
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<td>Duration</td>
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<td>Timing</td>
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<td>Context</td>
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<tr>
<td>Associated Signs &amp; Symptoms</td>
<td></td>
</tr>
<tr>
<td>Modifying Factors</td>
<td></td>
</tr>
<tr>
<td>Review of Systems (ROS)</td>
<td></td>
</tr>
<tr>
<td>Constitutional</td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
</tr>
<tr>
<td>Ears/Nose/Mouth/Throat</td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td></td>
</tr>
<tr>
<td>Genitourinary</td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td>Integumentary</td>
<td></td>
</tr>
<tr>
<td>Neurologic</td>
<td></td>
</tr>
<tr>
<td>Psychiatric</td>
<td></td>
</tr>
<tr>
<td>Endocrine</td>
<td></td>
</tr>
<tr>
<td>Hematologic/</td>
<td></td>
</tr>
<tr>
<td>Lymphatic</td>
<td></td>
</tr>
<tr>
<td>Allergy/Immunologic</td>
<td></td>
</tr>
</tbody>
</table>

Remember to always start in the highest level of history and work toward the lowest level – the element located in the lowest level will determine the overall level of history.

<table>
<thead>
<tr>
<th>Type of History</th>
<th>History of Present Illness (HPI)</th>
<th>Review of Systems (ROS)</th>
<th>Past, Family, and/or Social History (PFSH)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td>Brief = 1</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td>Brief = 1</td>
<td>Problem Pertinent = 1</td>
<td>N/A</td>
</tr>
<tr>
<td>Detailed</td>
<td>Extended = 4</td>
<td>Extended = 2</td>
<td>Pertinent = 1</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Extended = 4</td>
<td>Complete = 10</td>
<td>Complete = 3</td>
</tr>
</tbody>
</table>
Examinations - Objective

- **1995 guidelines**
  - Count the number of systems/areas
  - Single system exams are not well-defined...

- **1997 guidelines**
  - Count the number of “elements” or “bullets” performed
  - Single system exams are defined
  - Harder to meet without templates/macros
Examination Documentation Reminders

• A notation of “abnormal” without elaboration is insufficient documentation.

• Unlike history, examinations can not be ‘deferred’

• A brief statement/notation indicating negative or normal findings is sufficient.

• Normal or negative findings must be listed by body area or organ system.

• Page 9 of 2013 CPT states the only difference between an Expanded Problem Focused examination and a Detailed examination is that one is “limited” and the other is “extended”
  – You will need to determine which guidelines suit your providers best and consider local carrier instruction
### Determining Level of Physical Examination

<table>
<thead>
<tr>
<th>'95 - Body Areas</th>
<th>'97 - Elements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Body Areas / Organ Systems</td>
<td>Multi - Sys</td>
</tr>
<tr>
<td>Problem</td>
<td>1 - 5</td>
</tr>
<tr>
<td>Expanded</td>
<td>6 - 11</td>
</tr>
<tr>
<td>Detailed</td>
<td>12 - 17</td>
</tr>
<tr>
<td></td>
<td>18 / 9</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Number of Diagnosis and/or Management Options

## Table I: Diagnosis and/or Management Options

Indicate the number of each type of problem category below. Multiply the number of the occurrence of problems by the value for each category and indicate the category total. Add each category total down to determine the total value.

<table>
<thead>
<tr>
<th>Category of Problems</th>
<th>Occurrence of Problem</th>
<th>Value</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-limited or minor</td>
<td>[max. 2] x</td>
<td>1</td>
<td>=</td>
</tr>
<tr>
<td>Established problem to provider, stable, improved</td>
<td>x</td>
<td>1</td>
<td>=</td>
</tr>
<tr>
<td>Established problem to provider, worsening</td>
<td>x</td>
<td>2</td>
<td>=</td>
</tr>
<tr>
<td>New problem to provider, no additional work-up planned</td>
<td>[max. 1] x</td>
<td>3</td>
<td>=</td>
</tr>
<tr>
<td>New problem to provider, additional work-up planned</td>
<td>x</td>
<td>4</td>
<td>=</td>
</tr>
</tbody>
</table>

1 Grand Total
# Amount and Complexity of Data

## Table II: Amount and Complexity of Data

Indicate each type of data that is documented by circling the corresponding value. Add all the values circled to find the total value.

<table>
<thead>
<tr>
<th>Data Type</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and/or order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the radiology section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order of tests in the medicine section of CPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with performing physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records and/or obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old medical records and/or obtaining history from someone other than patient and/or discussion of case with another health care provider</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing, or specimen itself (not simply a review of the report)</td>
<td>2</td>
</tr>
<tr>
<td><strong>2 Grand Total</strong></td>
<td></td>
</tr>
</tbody>
</table>

**TIP**

You do not get 2 pts for independent review if you are also billing the global service.
<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedures</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One self-limited or minor problem, e.g., cold insect bite, tinea corporis</td>
<td>Laboratory tests requiring venipuncture</td>
<td>Rest</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chest x-rays</td>
<td>Gargles</td>
</tr>
<tr>
<td></td>
<td></td>
<td>EKG/EEG</td>
<td>Elastic bandages</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urinalysis</td>
<td>Superficial dressings</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ultrasound, e.g., echocardiography</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>KOH prep</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>Two or more self-limited or minor problems</td>
<td>Physiologic tests not under stress, e.g., pulmonary function tests</td>
<td>Over-the-counter drugs</td>
</tr>
<tr>
<td></td>
<td>One stable chronic illness, e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH</td>
<td>Non-cardiovascular imaging studies with contrast, e.g., barium enema</td>
<td>Minor surgery with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</td>
<td>Superficial needle biopsies</td>
<td>Physical therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Clinical laboratory tests requiring arterial puncture</td>
<td>Occupational therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Skin biopsies</td>
<td>IV fluids without additives</td>
</tr>
<tr>
<td>Moderate</td>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test</td>
<td>Elective major surgery (open, percutaneous, or endoscopic) with no identified risk factors</td>
</tr>
<tr>
<td></td>
<td>Two or more stable chronic illnesses</td>
<td>Diagnostic endoscopies w/ no identified risk factors</td>
<td>Prescription drug management</td>
</tr>
<tr>
<td></td>
<td>Undiagnosed new problem with uncertain prognosis, e.g., lump in breast</td>
<td>Deep needle or incisional biopsy</td>
<td>Therapeutic nuclear medicine</td>
</tr>
<tr>
<td></td>
<td>Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis</td>
<td>Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization</td>
<td>IV fluids with additives</td>
</tr>
<tr>
<td></td>
<td>Acute complicated injury, e.g., head injury with brief loss of consciousness</td>
<td>Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis</td>
<td>Closed treatment of fracture or dislocation without manipulation</td>
</tr>
<tr>
<td>High</td>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td>Cardiovascular imaging studies with contrast with identified risk factors</td>
<td>Elective major surgery (open, percutaneous, or endoscopic) with identified risk factors</td>
</tr>
<tr>
<td></td>
<td>Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure</td>
<td>Cardiac electrophysiological tests</td>
<td>Emergency major surgery (open, percutaneous, or endoscopic)</td>
</tr>
<tr>
<td></td>
<td>An abrupt change in neurological status, e.g., seizure, TIA, weakness, sensory loss</td>
<td>Diagnostic endoscopies w/identified risk factors</td>
<td>Parenteral controlled substances</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discography</td>
<td>Drug therapy requiring intensive monitoring for toxicity</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Decision not to resuscitate or to de-escalate care because of poor prognosis</td>
</tr>
</tbody>
</table>
• Take the results of each of the 3 charts
• **2 of the 3 elements** must meet or exceed the requirements on the far left
  – If 2 elements are in the same level, that is the complexity of MDM
  – If each element is in a different level, choose middle level intensity MDM

### Chart for the Overall Level of Medical Decision Making

Indicate below the level of each element measured (diagnosis/management options; amount and complexity of data; and overall risk). If at least two elements meet or exceed a certain level of decision making, then select that level.

<table>
<thead>
<tr>
<th>Overall Complexity of Medical Decision Making</th>
<th>1 Diagnosis/Management Options</th>
<th>2 Amount and Complexity of Data</th>
<th>3 Risk of Complications, Morbidity, etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Straightforward</td>
<td>minimal (0-1)</td>
<td>minimal (0-1)</td>
<td>minimal</td>
</tr>
<tr>
<td>Low</td>
<td>limited (2)</td>
<td>limited (2)</td>
<td>low</td>
</tr>
<tr>
<td>Moderate</td>
<td>multiple (3)</td>
<td>moderate (3)</td>
<td>moderate</td>
</tr>
<tr>
<td>High</td>
<td>extensive (4+)</td>
<td>extensive (4+)</td>
<td>high</td>
</tr>
<tr>
<td>CPT® Code</td>
<td>Time Threshold</td>
<td>CPT® Code</td>
<td>Time Threshold</td>
</tr>
<tr>
<td>-----------</td>
<td>-----------------</td>
<td>-----------</td>
<td>-----------------</td>
</tr>
<tr>
<td>99201</td>
<td>10 minutes</td>
<td>99221</td>
<td>30 minutes</td>
</tr>
<tr>
<td>99202</td>
<td>20 minutes</td>
<td>99222</td>
<td>50 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>30 minutes</td>
<td>99223</td>
<td>70 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>45 minutes</td>
<td>99231</td>
<td>15 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>60 minutes</td>
<td>99232</td>
<td>35 minutes</td>
</tr>
<tr>
<td>99211*</td>
<td>5 (no MD presence)</td>
<td>99233</td>
<td>35 minutes</td>
</tr>
<tr>
<td>99212</td>
<td>10 minutes</td>
<td>99238</td>
<td>≤ or equal to 30 min.</td>
</tr>
<tr>
<td>99213</td>
<td>15 minutes</td>
<td>99239</td>
<td>&gt; 30 minutes</td>
</tr>
<tr>
<td>99214</td>
<td>25 minutes</td>
<td>99251</td>
<td>20 minutes</td>
</tr>
<tr>
<td>99215</td>
<td>40 minutes</td>
<td>99252</td>
<td>40 minutes</td>
</tr>
<tr>
<td>99241</td>
<td>15 minutes</td>
<td>99253</td>
<td>55 minutes</td>
</tr>
<tr>
<td>99242</td>
<td>30 minutes</td>
<td>99254</td>
<td>80 minutes</td>
</tr>
<tr>
<td>99243</td>
<td>40 minutes</td>
<td>99255</td>
<td>110 minutes</td>
</tr>
<tr>
<td>99244</td>
<td>60 minutes</td>
<td>99291, +99292</td>
<td>30-74, +30 minutes</td>
</tr>
<tr>
<td>99245</td>
<td>80 minutes</td>
<td>99354, +99355, 99356, +99357</td>
<td>30-74, +30 minutes</td>
</tr>
</tbody>
</table>
Selecting E/M Based on Time

• For visits that involves more than 50 percent counseling or coordination of care, time can determine the level of coding.

• For example, if a 20-minute office visit with an established patient involved more than 10 minutes of counseling and coordination of care, you could automatically code the visit as a 99213.
Anesthesia Reporting Guidelines

- Only 2 changes for 2013 (...or other qualified healthcare professionals, e.g. 01991)

- Reporting anesthesia services presents a very unique set of factors in terms of code selection.
  - Base units (ASA)
  - Time units (typically 15 minute increments)
  - Moderate Conscious Sedation (99143-99150)
  - Concurrency (more than 1 case)
  - Medical Direction (CRNAs)
  - Separately reportable services and “unusual forms of monitoring”
    - Swan-Ganz (93503), Post-op pain epidurals, A-line, etc.
  - CPT Modifiers
    - 23 (unusual anesthesia) and 47 (Anesthesia by the surgeon)
  - Multiple/separate procedures
    - Select the “most complex” only

- Time unit + Base unit * C.F. = Allowed Amount
Physical Status and Qualifying Circumstances

• Read question carefully to determine if a physical status modifier (P1-P6) is appropriate
  – P1 – normal healthy patient
  – P2 – mild systemic disease
  – P3 – severe systemic disease
  – P4 – severe...constant threat to life
  – P5 – moribund pt. not expected to survive w/o surgery
  – P6 – brain-dead patient with donor organs

• Be aware of the qualifying circumstance codes
  – +99100 – extreme age (>70yrs or <1yr)
  – +99116 – use of total body hypothermia
  – +99135 – use of controlled hypotension
  – +99140 – emergency services
Anesthesia Chapter Highlights

• Codes are listed from head to toe (00100-01860)
  – Modifiers are imperative to identify anesthesia provider(s) and type

• Anesthesia for Radiological Procedures (01916-01936)
  – Cardiac cath (01920), interventional radiology (01924-01926), percutaneous image guided spinal procedures (01935-01936)

• Anesthesia for Burn Excisions and Debridement (01951-01953)
  – Must be familiar with Total Body Surface Area (TBSA) measurements
  – Less than 4% - 01951
  – Between 4%-9% - 01952
  – Each additional 9% (or part thereof) - +01953

• Anesthesia for Obstetrics (01958-01969)
  – Read carefully to select accurate code (vaginal, C-section, hysterectomy, abortion, etc.)
HCPCS II Anesthesia Modifiers

• **AA** - Personally performed by anesthesiologist

• **QK** - Medical direction of 2, 3, 4 concurrent cases (MD claim)

• **QX** - CRNA service with medical direction (CRNA claim)

• **QY** - Medical direction of one CRNA (MD claim)

• **QZ** - CRNA service without medical direction

• **AD** – *Supervision* of more than 4 concurrent cases

• **QS** - Monitored Anesthesia Care (MAC)

• **G8** - monitored anesthesia care for deep complex, complicated, or markedly invasive surgical procedure.

• **G9** - monitored anesthesia care for patient who has history of severe cardiopulmonary condition
  - Medical direction requires that the Anesthesiologist is present at induction, emergence, monitor at “frequent” intervals, and be available throughout the entire case
### The Surgical Package

<table>
<thead>
<tr>
<th>Pre-operative</th>
<th>Intra-operative</th>
<th>Post-operative</th>
</tr>
</thead>
</table>
| Minor - day of surgery  
(Modifier 25 is applicable) |  | Minor - 0 or 10 |
| Major - day of and day before surgery  
(Modifier 57 is applicable) |  | Major - 90 day post-op  
+1 day pre-op day of surgery  
92 global days |

*Global Period* determined by payer  [Not AMA]
TheAMA does not define a global period in terms of post-op days...
  - According to CMS and RBRVS, surgical procedures carry 0, 10 or 90 days post-op periods

You are not permitted to “sneak in” another E/M visit on the day of or the day prior to surgery after the initial decision has been made.
  - Modifiers -25 and -57

Separate procedures are not to be reported with more extensive codes to which they are related (page 58 of 2013 Professional CPT®)
  - Only if modifier -59 applies (“distinct”)

Unlike anesthesia services, when multiple procedures are performed (and not ‘bundled’, they should be listed from most extensive to least extensive and modifier -51 (multiple procedures) should be consulted.
Items NOT Included in the Surgical Package

- Initial decision for surgery (25/57)
- Other MD services (different specialty/group)
- Visits unrelated to surgical diagnosis (24)
- Complications following surgery (78)
- Unrelated surgical procedures (79)
- Unrelated critical care services (24/25)
- Staged/related/distinct procedures (58/59)
Deciphering the OP Notes

- Pre-operative vs. Post-operative diagnoses

- Select code(s) from the body of the note (not from the preoperative indications). Notes are to maintain heading, indications, body, findings.

- Pay careful attention to the approach (e.g., open vs. laparoscopy, anterior vs. posterior).

- Look for language indicative of surgical modifiers:
  - 22 (increased)
  - 50 (bilateral)
  - 62 (co-surgery)
  - 80/82 (assist at surgery—Modifier –AS for NPP assist)
  - 52 and 53 (reduced vs. discontinued)
National Correct Coding Initiative (NCCI)

- Commonly referred to as “bundling” issues
  - Now includes list of “Medically Unlikely Edits” (MUE)
  - MEE (Mutually Exclusive Edits)
- Created under CMS contract with Adm. Federal – Early in 1996
- Saved $96 million in the 1st 6 months/$200 mil in 1st year.
- Updated quarterly-Version 20.1 (April 1, 2013)

0- never unbundle the code
1- unbundle only with allowable modifier
9- not bundled/may bill
• Two codes in a code pair edit often by definition represent different procedures. The provider cannot use the -59 modifier for such an edit based on the two codes being different procedure codes.

• However, if the two procedures are performed at separate sites or at separate patient encounters (sessions) on the same date of service, the modifier -59 may be employed.

– This is a “last resort” modifier– let’s look at the definition
  – Page 596 (appendix A) of 2013 Professional CPT®
CPT® Modifiers

• Many of the modifiers are now located at the inside cover of CPT® with brief descriptions.

You may find a complete list of CPT® modifiers and many HCPCS II modifiers with Appendix A of 2013 CPT®

• Reminders:
  - Read definitions carefully; -50 (bilateral procedures) does not apply to skin or codes with bilaterally implied language (e.g., “one or both”, “unilateral or bilateral”, etc.)
  - Do not use modifier -51 (multiple procedure) if ☐ or ☐ symbols are apparent
  - Modifier -59 (distinct procedure) only if no other modifier works (e.g., separate procedures)
More Facts Related to Modifier -25

- From WPS (Medicare Contractor)

**The following statements are false:**
- I can always use this modifier for a new patient.
- I can always use this modifier when I did not plan the procedure.
- I can always use this modifier when the diagnoses are different.
- I can never use this modifier when the diagnoses are the same.

**Appropriate Usage**

- “Modifier 25 indicates that on the day of a procedure, the patient’s condition required a significant, separately identifiable E/M service, above and beyond the usual pre and post-operative care associated with the procedure or service performed”
The Integumentary System
(10021 – 19499)

• Excellent diagram of skin on page 61

• Be careful to code based on the actual procedure performed:
  – Major changes to debridement services (11042-11047)
  – Destruction of premalignant/benign lesions (add-ons)
  – Biopsy
  – Incision
  – Excision (remember to include margins...)
    – Benign
    – Malignant
  – Destruction
  – Repair
  – Breast procedures are located in a separate section

• Be aware of CPT nomenclature...
  – “or part thereof”
  – Intermediate repair replaced “layered closure” in 2009
Reporting Debridement

- **Debridement, subcutaneous tissue (includes epidermis and dermis, if performed);**
  - $\Delta$ [11042] - first 20 sq cm or less
  - $\#+$ [11045] - Each additional 20 sq cm (or part thereof)

- **Debridement, muscle and/or fascia (includes epidermis, dermis and subcutaneous tissue, if performed);**
  - $\Delta$ [11043] - first 20 sq cm or less
  - $\#+$ [11046] - Each additional 20 sq cm (or part thereof)

- **Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle/fascia if performed);**
  - $\Delta$ [11044] - first 20 sq cm or less
  - $\#+$ [11047] - Each additional 20 sq cm (or part thereof)

**For debridement of nails, refer to CPT codes 11720 (1 to 5) or 11721 (6 or more) – page 69 2013 CPT**
Reporting Biopsies and Skin Tag Removals

• A biopsy is defined as:
  - the medical removal of tissue from a living subject to determine the presence or extent of a disease (source: Wikipedia). “Bio” = life and “opsia” = to see

• Skin biopsies are reported with 11100 (1st lesion) and +11101 (each additional lesion)

• Other biopsies are categorized in specific anatomic sections of CPT

• Skin Tag Removals
  – 11200 (up to and including 15)
  – +11201 (each additional 10 lesions, or part thereof)
Reporting Excisions

- Benign (11400-11471)
- Malignant (11600-11646)

- Excision requires “full thickness” (through the dermis)
  - As opposed to shaving of epidermal/dermal lesions, use (11300-11313)
  - Report each lesion separately
  - Select code(s) based on:
    1. Greatest diameter **PLUS**
    2. Margin required for excision

- Measurement is made **prior** to excision
  - Intermediate and complex repair are coded separately!!

- For excision for hidradenitis, refer to 11400-11471
  - Hidradenitis is defined as “inflammation of sweat glands”
Repair (Closure)

- **Simple**
  - Superficial (epidermis)

- **Intermediate**
  - Include layered closure of one or more subcutaneous layer

- **Complex**
  - Require more than layered closure (extensive, traumatic lacerations)

1. Measure in centimeters
2. Add together, per classification and anatomic site (e.g., intermediate repair, face, ears, eyelids, nose, lips, mucous membranes, 12011-12018)
   - Use -59 on multiple classification (revised from 2012 CPT suggesting modifier -51)
3. Debridement is considered separate only when “gross contamination requires prolonged cleansing”
Destruction 17000-17286

- Do not confuse “destruction” with excision, debridement, biopsy, removal, etc.

- Benign, premalignant, malignant, etc.
  - Be aware of number (premalignant) and diameter (benign/malignant)

- “any method”
  - Includes electrosurgery, cryosurgery, laser and chemical treatment, per CPT®

- Tidbit:
  - A premalignant condition is a disease, syndrome, or finding that, if left untreated, may lead to cancer.

- Be aware of the CPT® language (i.e., nomenclature)
  - +17003 (“each”)
    - Max 13 units

- **Premalignant** (17000-17004)

- **Cutaneous Vascular Proliferative Lesions** (17106-17108) - common pediatric birthmarks

- **Benign** (17110-17111)

- **Malignant** (17260-17286)
Mohs Micrographic Surgery
17311-17315

• Also known as *chemosurgery* and has a cure rate cited by most studies between 97% and 99.8% for primary basal cell carcinoma

• Requires surgeon to also play role of pathologist (*“two separate and distinct capacities”*)
  – Or each MD would use appropriate codes for excision and surgical pathology

• Requires attention to:
  – Anatomic site(s)
  – Tissue blocks (specimens)
  – Stages

• Understanding of add-on coding is essential
  – +17312, +17314, and +17315

• If repair is required, report codes for repair, graft or flap separately

• Per CPT®, if on the same date as the biopsy to determine cancer, report biopsy separately with 11000-11001 with -59
Coding Breast Procedures

- **Incision**
  - Puncture aspiration of cyst (19000 for initial and +19001 for each additional)
  - Mastotomy (19020)

- **Excision**
  - Biopsy
    - Percutaneous without imaging guidance (19100), with imaging guidance (19102), vacuum assisted with imaging guidance (19103)
    - Open, incisional biopsy (19101)
      - For image guided placement of metallic localization clip during breast biopsy/aspiration, report CPT code +19295 with 19102 or 19103
  - For excision of breast lesion identified by preoperative placement of radiological maker, refer to 19125 (first lesion) and +19126 (each additional lesion)
    - Modifier -59 should not be required
Reporting Mastectomy Procedures

• CPT codes 19300-19307

• Report 19120 for excision of cyst, fibroadenoma or benign or malignant tumor (one or more lesions) – *do not report multiple with modifier -59*

• Partial (19301-19302)

• Complete (19303)

• Subcutaneous (19304)

• Radical/modified radical
  - Including pectoral muscles/axillary lymph nodes, report 19305
  - Including pectoral muscles/axillary lymph nodes and internal mammary lymph nodes ["Urban type"], report 19306
  - Modified radical, including axillary lymph nodes excluding pectoralis major, report 19307
    - For radical and modified radical mastectomies, refer to 19340 or 19342 for immediate or delayed insertion of breast prosthesis, respectively
Musculoskeletal System Coding
(20005 – 29999)

• Trigger Points are coded based on the number of muscles, not the number of injections (bundling issues)

• Injections- report injectables separately (Jxxxx)

• Type of fracture does NOT identify type of treatment

• Q4001-Q4051 for cast supplies

• 1\textsuperscript{st} application included in initial fracture care but replacement supplies and applications are billable \textit{(Application on Casts/Strapping, 29xxx)}

• Surgical scopes always include diagnostic scopes \textit{(Arthroscopy)}
Musculoskeletal Chapter Highlights

• Beginning on page 98 of 2013 CPT Professional, musculoskeletal codes are arranged from head to toe, with a specific section for spine/vertebral column
  – Codes 22010-22865 pertain to spinal procedures
  – 7 cervical segments, 12 thoracic segments, 5 lumbar segments and the sacrum

• Type of treatment has no coding correlation with the type of fracture
  – Definitions of open, closed and percutaneous skeletal fixation (page 92 of 2013 CPT Professional)

• Fracture care codes should only be used by the surgeon intends to provide restorative treatment and follow-up care (for other providers, refer to Application of Casts and Strapping)

• Re-reductions are coded with 76/77 modifiers, per CPT®

• Within each anatomic section, codes are arranged by incision, excision, removal, repair/revision/reconstruction, fracture care/dislocation
Biopsies of Muscle, Bone Vertebral Body

20200-20240

• Biopsy of muscle
  – 20200 – superficial
  – 20205 – deep

• Biopsy of muscle, percutaneous needle (through the skin)
  – 20206

• Biopsy, bone trocar, or needle, superficial
  – 20220 – superficial (e.g., ribs, ilium, sternum)
  – 20225 – deep (e.g., vertbral body, femur)

• Biopsy, bone trocar, or needle, open
  – 20240 – superficial (e.g., ribs, ilium, sternum)
  – 20245 – deep (e.g., humerus)
    – Biopsy of vertebral body coded 20250 (thoracic) or 20251 (lumbar or cervical)
Trigger Point Injections

• 20550
  - Injection(s), single tendon sheath or ligament

• 20551
  - Injection(s), single tendon origin and/or insertion

• 20552
  - Injection(s), single or multiple trigger points, 1 or 2 muscle(s)

• 20553
  - Injection(s), single or multiple trigger points, 3 or more muscles
Joint Injections

- 20600-20610
  - Small joint (20600 - e.g. finger)
  - Intermediate joint (20650 - e.g. elbow)
  - Large joint (20610 - e.g. knee/shoulder/hip)

- Specify location
- Specify injectable (J-code)
- Specify dosage (e.g. 40mg methylprednisolone - J1030)
- Remember modifiers
  - RT
  - LT
  - 50
Grafts (or Implants)

• CPT codes 20900-+20938 are used to report grafts specific to type (e.g., bone, allograft, autograft, etc.). Many are “add-ons” specific to spine surgery (20930-20938).

• Codes for obtaining grafts through separate incision are reported separately unless included in description.

• DO NOT report these codes with modifier -62 (co-surgery)
  - Bone (20900-20902)
  - Cartilage (20910-20912)
  - Fascia lata (20920-20922)
  - Tendon (20924)
  - Tissue (20926)
  - Allografts (+20930 +20931)...for spine surgery
  - Autografts (+20936 +20938)...for spine surgery
Spinal Instrumentation

- CPT codes +22840 – 22865

- **Segmental instrumentation** – fixation at each end and at least one other “bony attachment”

- **Non-segmental** instrumentation refers to fixation at each end of “construct” only

- Posterior versus anterior instrumentation
  - Code selection requires knowledge of the number of vertebral segments involved

- Parenthetical references provide codes with which the instrumentation procedures may be reported

- May be reported with more definitive procedures (e.g., laminectomy)
New Arthroplasty Revision Codes 2013

• Codes ●23473 and ●23474 added to report revision of total shoulder arthroplasty.
  - ●23473 pertains to humeral OR glenoid component while ●23474 pertains to humeral AND glenoid components.

• Codes ●24370 and ●24371 added to report revision of total elbow arthroplasty.
  - ●24370 pertains to humeral OR ulnar component while ●24371 pertains to humeral AND ulnar components.
“Applications” of Casts and Strapping

• CPT Codes 29000-29799
  • Used to report:
    A. Replacement casting/strapping procedures or
    B. Initial fracture care service without “restorative” treatment

• Q4001-Q4051 for the supplies (HCPCS II)

• The following materials should be paid separately
  - Fiberglass Roll
  - Casting Padding
    - 24500-24685
    - 25500-25695
    - 26600-26785
    - 27500-27566
    - 27750-27848
    - 28400-28675
    - 29000-29750

Bill casting supplies separately
Respiratory System Essentials

- **Nose** (30000-30999)
- **Accessory Sinuses** (31000-31299)
- **Larynx** (31300-31599)
- **Trachea and Bronchi** (31600-31899)
- **Lungs and Pleura** (32035-32999)

  - **Laryngoscopy** - Visual examination of the larynx (vocal folds and the glottis)
    - **DIRECT** - carried out (usually) with the patient lying on his or her back, directly
    - **INDIRECT** - straight rod-mounted mirror inserted into the throat and used to look at the laryngeal inlet.

- Read codes carefully; most are considered unilateral so modifier -50 will come into play if procedures are performed bilaterally.

- 4 new surgical bronchoscopy codes added to 2013 CPT (insertion/removal bronchial valves)
  - 31647-+31651 (pages 162 and 163 of 2013 CPT Professional Edition)

- 2 new codes for Bronchial Thermoplasty (●31660-●31661) – [new asthma treatment]

- 4 new codes (●32554-●32557) for thoracentesis and pleural drainage (specify imaging guidance)
Respiratory System Highlights - Lungs/Pleura (Transplant) 32035-32999

• New Code for Stereotactic Radiation Therapy
  - **32701** - Thoracic targets, photon or particle beam, **entire course of treatment**
    - Surgeon is to report this code for identification of target for therapy and the radiation oncologist reports radiation oncology codes, 77295, 77331, 77370, 77373, 77375, and 77427-77499.

• For transplant services, consider:
  - **Donor services** (pneumonectomy[ies])
    - 32850 (cadaver donor)
  - **Backbench Work**
    - 32855 (unilateral) and 32856 (bilateral)
  - **Allotransplantation**
    - 32851-2 (single transplant w or w/o cardiopulmonary bypass) **or** 32853-4 (double transplant w & w/o cpbp)
Cardiovascular System Coding Essentials

- **Pacemakers:**
  - Include a pulse generator and one or more electrodes
    - **Single chamber** - pulse generator and one electrode in either the atrium or ventricle
    - **Dual chamber** - pulse generator and one electrode in the RT atrium and another in the RT ventricle

- **Pacing Cardioverter-Defibrillators (ICD):**
  - Includes pulse generator and electrodes
    - May require multiple leads, even when only one chamber is being paced
    - May be inserted in single chamber or in dual chambers

  - If an additional electrode is needed to achieve pacing of the LT ventricle (bi-ventricular pacing), for Pacemakers or ICDs, placement of the additional electrode maybe reported separately
    - 33224 or 33225 (transvenous) or
    - 33202 or 33203 (epicardial)
Coding Pacemakers and ICDs

• Know the device (Pacemaker or Cardioverter-Defibrillator)

• Know the procedure
  – Insertion of new/replacement system, battery only, electrodes, single/dual chamber, etc.
  – Upgrade
  – Repair
  – Revision
  – Removal
  – Removal with replacement
  – Repositioning

• There is a great chart on page 177 of 2013 CPT Professional which provide a clear crosswalk to the appropriate code(s) to report the many various options
Electrophysiologic (EP) Operative Procedures

• CPT codes 33250-33266
  – Surgical treatment of supraventricular dysrhythmias (e.g., arrhythmia and irregular heartbeat) where there is irregular electrical activity identified within the heart

• Codes are characterized as:
  – **Limited** - surgical isolation of supraventricular dysrhythmias by operative ablation
  – **Extensive** - “limited” and additional ablation of arterial tissue to eliminate supraventricular dysrhythmias
    – Must include operative ablation involving either the RT atrium, the atrial septum, or LT atrium

• Parenthetical references provide codes to report in addition, as appropriate

• 3 codes are “add-ons” for *operative tissue ablation and reconstruction of atria at time of other cardiac procedure* (e.g., maze procedure)
  – **Limited** (+33257)
  – **Extensive w/o cpbp** (+33258)
  – **Extensive w/ cpbp** (+33259)
Coronary Artery Bypass Graft (CABG) 33510-33536

• When reporting CABG surgery, be sure to carefully examine the numbers of venous and/or arterial grafts performed.

• When only venous grafts are performed, only one grafting code (33510-33516) is required. Procurement of the saphenous vein is included. To report the harvesting of an upper extremity vein, use 35500 in addition to the bypass procedure” (p. 185)

• When reporting combined venous and arterial graft procedures, two distinct codes are required for accurate coding; one for the number of venous grafts (+33517 - +33523) and a second code for the specific number of arterial grafts (33533-33536)

• Coronary endarterectomy (+33572) may be reported in addition – May require LC, LD or RC modifier
Digestive System

- Lips
- Vestibule of Mouth
- Tongue and Floor of Mouth
- Dentoalveolar Structures
- Palate and Uvula
- Salivary Glands and Ducts
- Pharynx, Adenoids and Tonsils
- Esophagus
- Stomach

- Intestines
- Meckel’s Diverticulum and Mesentery
- Appendix
- Rectum
- Anus
- Liver
- Bilary Tract
- Pancreas
- Abdomen, Peritoneum & Omentum
Payment Rules for Endoscopic Procedures

• Both codes in the same ‘family’
  – Report the *most extensive* code first
  – The subsequent scope is allowed at the difference b/w the highest surgical allowable and the ‘base procedure’ allowable

• Two unrelated scopes
  – Report the highest first and the second with modifier -51 (multiple procedures) unless modifier -51 exempt

*A surgical endoscopy *always includes a diagnostic endoscopy*
Tonsillectomy and Adenoidectomy

• Codes are specific to:
  – **Tonsillectomy only** (42825-42826)
    – Younger than 12 (42825) or 12 or older (42826)
  – **Tonsillectomy and Adenoidectomy** (42820-42821)
    – Younger than 12 (42820) or 12 or older (42821)
  – **Adenoidectomy only** (42830-42836)
    – Primary or Secondary:
      – Younger than 12 (42830, 42835) or 12 or older (42831 or 42836)
Endoscopy

- Endoscopy codes are located throughout the digestive chapter

- All surgical endoscopies include diagnostic endoscopies
  - Upper GI Endoscopy (e.g., ERCP, EGD) [43200-43273]
  - Small Intestine and Stomal (e.g., enteroscopy) [44360-44397]
  - Rectum and Large Intestine (e.g., colonoscopy) [45300-45392]
  - Anus (e.g., anoscopy) [46600-46615]
  
- When coding procedures involving the colon, coders may need to understand measurements that providers demonstrate for accurate code selection:
  - **Anus** - 0cm-4cm
  - **Rectum** - 4cm-16cm
  - **Rectosigmoid** - 15cm-17cm
  - **Sigmoid** - 17cm-57cm
  - **Descending** - 57cm-82cm
  - **Transverse** - 82cm-132cm
  - **Ascending** - 132cm-147cm
  - **Cecum** - 150cm+
Reporting Colonoscopies

• Knowing anatomy is imperative as CPT defines a colonoscopy as an exam of the entire colon (from rectum to cecum, requiring passage of splenic flexure)

• Diagnostic, Screening, Therapeutic (refer to modifier -53 for discontinued scopes)
  – If patient presents with signs/symptoms = diagnostic
  – If patient has problem identified (e.g., polyp or lesion) = diagnostic
  – If patient presents without signs/symptoms = screening

• For screening colonoscopy, consider ICD-9 selections:
  – V16.0 (family history of malignant neoplasm, colon)
  – V76.51 (special screening for malignant neoplasm, colon)
  – V12.72 (personal history of colonic polyps)

• Reporting screening colorectal scopes to Medicare:
  – G0105- colorectal cancer screening, colonoscopy for high risk patient
  – G0120- alternative to G0105 when barium enema is employed for colonoscopy
  – G0121- colorectal cancer screening, colonoscopy not meeting high risk criteria
  – G0104- colorectal cancer screening, flexible sigmoidoscopy
  – G0106- alternative to G0105 when barium enema is employed for flexible sigmoidoscopy
Coding Hernia Repair
49491-49659

• Type of hernia (e.g., inguinal, femoral, incisional, ventral, etc.)
  – OPEN vs. LAPAROSCOPIC

• Initial or recurrent

• Patients age plays a role in code selection
  – e.g., “6 months to younger than 5 years”

• Clinical presentation
  – Reducible, incarcerated, strangulated, etc...

+ 49568 - Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection
Includes kidneys, ureters, urinary bladder and urethra

- Kidney transplant codes (50300-50380) require:
  - Nephrectomy (50300-50320, recipient 50340),
  - Backbench work (50323-50329), and
  - Auto/allotransplantation (50360-50380)

- Success in this area of CPT requires good understanding of modifiers -50 and -51

- Urodynamics: page 284
  - 51725-51798- If interpretation/report only, refer to modifier -26
  - Modifier -51 should be reported on multiple procedures
Maternity Care/Delivery
59000-59899

• Antepartum Care = after the initial confirmation of pregnancy (approximately 13 visits)
  - 0-28 weeks gestation – monthly visits
  - 28-36 weeks gestation – bi-weekly visits
  - 36 weeks to delivery – weekly

• Uncomplicated vaginal or C-section delivery

• Postpartum care
Coding Challenges – Twin Births

- Vaginal deliveries – report CPT® 59409 or 59610 when performed by the same physician or group.

- Alternatively, report the global on the 1st infant, and delivery only on the 2nd with modifier -51 (multiple surgery).

- First infant delivered vaginally, report with CPT® 59409/59612 – with the 2nd infant delivered via C-section, report 2nd birth with CPT® 59510 or 59618 with modifier -51 (multiple surgery).

  - If both are delivered by C-section, report with CPT® 59510, along with modifier 22 (unusual procedural service)
Nervous System Reporting Guidelines
61000 - 64999

• Procedures performed on the skull, meninges and brain
  - Be aware of verbiage such as “initial” versus “subsequent” (e.g., subdural tap 61000-61001)

• Twist Drill, Burr Hole, or Trephine
  - Methods to access the brain for subdural/ventricular puncture, biopsy, etc.
  - 61105-61253
  - Burr is a drill used to create openings in a bone
  - Trephine is “a hole saw used in surgery to remove a circle of tissue or bone”

• Craniectomy/Craniotomy
  - These codes are grouped together and require consideration of terms such as:
    - Supratentorial versus Infratentorial (different regions of the brain)
Cranial Stereotactic Radiosurgery

- Used to report procedures that utilizes externally generated ionizing radiation to inactivate or eradicate targets in the cranium without making an incision.

- Read the guidelines carefully to determine the differences between simple and complex lesions
  - All lesions measuring 3.5cm or greater are complex
  - Any lesion w/in 5mm of optic nerve/optic chasm/optic tract or brainstem are complex (documentation is critical)

- Be aware of “add-on” codes ("each additional lesion")
  - +61797 (simple)
  - +61799 (complex)

➢ +61800 is reported for “application of stereotactic headframe"
Spinal Stereotactic Radiosurgery

- Used to report procedures that utilizes externally generated ionizing radiation to inactivate or eradicate targets in the cranium without making an incision.

- 63620 used to report Stereotactic Radiosurgery for 1 spinal lesion and add-on code +63621 for each additional spinal lesion

- For each course of treatment, 63621 may be reported only once per lesion

- 63621 is not to be reported more than 2 times during entire course of treatment
Reporting Removal of Impacted Cerumen

• “Separate procedure”

• “1 or both ears” per CPT definition (Modifier -50 does not apply)

• Many payers will not reimburse with office visit on same date
Radiology is the branch of medicine that uses x-ray or radiant energy to diagnose and treat disease.

Radiology procedures can be broken down into:
- The Technical component (TC) which includes the equipment, supplies, technical personnel and costs associated with the procedure.
- The professional component (26) includes the physician work in providing the service, interpretation and report.

Be aware of the use of contrast with certain services in this chapter (e.g., CT, MRI, etc.)
Pathology & Laboratory
80047 - 89398

- **Modifier 91** – repeat clinical diagnostic lab – multiple same test is run on the same day, same patient.

- **Modifier 90** – reference (outside) laboratory, when someone other than the treating physician performs the service.

- **Modifier -QW** – required by CMS to indicate the CLIA Waived Status – Clinical Laboratory Improvement Amendment s (1988)
Organ or Disease Oriented Panels
80047-80076

- All tests listed must be conducted, **do not** append modifier -52, for reduced service.

- When only a portion of the listed tests in a panel are performed, report each separately, rather than the panel.

- Additional tests not listed in the panel can be reported separately.
Pathology Consultations
80500-80502

• These codes are similar in nature to the E & M consult, in that they require a request for another physician requesting an opinion, and a written report is sent back to the requesting physician.

• Code selection is dependent upon whether there is a review of patient’s history and medical records.

• There are additional consultation codes found in surgical pathology CPT® 88321-88334.
Anatomic Pathology
88000 - 88099

• These codes identify the physician work involved in autopsies.

• The codes will be differentiated by the extent of the procedure performed;

• Gross examination – visual inspection

• With or without CNS – central nervous system

• Forensic exams are often performed due to a criminal investigation
The basis of reporting is determined by the number of labeled specimens. A specimen is tissue or tissues that are submitted for individual examination and diagnosis.

Two or more specimens from the same patient, are each appropriately assigned an individual code reflective of its proper level of service.

CPT® 88304 – 88309 require a gross and microscopic examination of the specimen and ascending levels of physician work.
This section includes a wide array of services that are either diagnostic or therapeutic.

Be careful to read all guidelines pertinent to each subsection.

Modifier -25 for a office visit along with a procedure may be indicated. In addition, modifier -51 for multiple procedures; pay special attention to the add-on codes—they will not be reported with modifier -51, as they are considered stand-alone codes intended for use with “primary” codes.
Immunization Administration for Vaccines/Toxoids

- **CPT® codes 90460–90474** are to be reported in addition to the vaccine and toxoid code 90476–90749.

- Note **CPT® codes 90460–90461** are reported when there is a face-to-face counseling of the patient and/or family during the administration. These are unique codes in that 90460 is reported for each vaccine product, even if included in the same administration (e.g., DTaP)

- These codes are used to report percutaneous, intradermal, subcutaneous or intramuscular injections.
2013 Psychiatry Highlights

• There are 2 new codes replacing those used in past for the diagnostic interviews
  - 90801 and 90802 are replaced with:
    ● 90791 – psychiatric diagnostic interview
    ● 90792 - psychiatric diagnostic interview with medical services

• These new codes may require “interactive complexity” (e.g., communication barriers, emotional family members, interpreters, translators, child welfare agencies, use of play equipment, abuse/neglect, etc.) which is reported with new add-on code +●90785

  – The “interactive complexity” code may be reported in addition to 90791-90792 (interviews), 90832-90838 (psychotherapy), 99201-99255 & 99304-99350 (E&M), 90953 (group psychotherapy)
Psychiatric Therapeutic Procedures

- **CPT® codes** ●90832 - +●90838 (replacements for 90804-90829) represent psychotherapy for the treatment of mental illness and behavioral disturbances.

- The times listed refer to **face-to-face** time and the time does **not** need to be continuous
  - ●90832 and ●90833 [“30 minutes”] (16-37 minutes)
  - ●90834 and ●90836 [“45 minutes”] (38-52 minutes)
  - ●90837 and ●90838 [“60 minutes”] (53+ minutes)

- The add-ons (+90833, +90836 and +90838) are to be reported in addition to E&M codes only when the psychotherapy and E&M are **“separately identifiable”** (the time for psychotherapy must be distinct)
Steps To Select Accurate Codes

• Medical and psychotherapeutic codes are separately identified as follows:

1) **Type and level of E&M is selected first** (99xxx)
   - Based on history, examination and MDM (key components)

2) **Time spent and documented for psychotherapy** (no “double-dipping”) time
   - E&M time not to be considered in psychotherapy code selection

3) **Different diagnosis (ICD-9-CM) is not required**

4) Is the patient in crisis or not? (90839-90840)

5) Is “interactive complexity “definition met? (90785)

• Use the parenthetical references to determine which E&M codes may be reported with the add-on psychotherapy codes +●90833, +●90836 & +●90838

• Prolonged service codes are not to be reported in addition
End-Stage Renal Disease Services

• **CPT® 90951 – 90962** are reported once per month to distinguish age-specific services, in an outpatient setting, based on the number of face-to-face physician visits.

• **Less than a full month** of dialysis – is reported with **CPT® codes 90967 – 90970**, based on the age of the patient (per day)

• **CPT® 90963 – 90966** are to report **home dialysis** per full month
Ophthalmology

- These codes represent the examination and evaluation of either new or established patients, ophthalmoscope, special services, contact lens services, fitting of ocular prosthesis and supplies.

- **CPT® 92002 & 92004** are determined by the depth of the evaluation (intermediate – comprehensive).
  - New patients are reported following the same rule found in the E & M section (3 yrs).

- Be aware of “separate procedures”
  - E.g., 92020 (gonioscopy)
    - Read coding guidelines under this code

- 2 codes (92071 and 92072) added in 2012 to report *fitting of contact lenses*

- Modifiers (e.g., -50, RT, LT, etc.) are often required for accurate coding
Cardiovascular Services

- Therapeutic services (e.g., CPR, code 92950)
- Coronary Therapeutic services (e.g., angioplasty, atherectomy, stent deployment, etc., 92920-92979)
- Cardiography (e.g., EKG, 93000)
- Cardiovascular Monitoring Services (e.g., Holters, 93224-93227)
- Implantable and Wearable Cardiac Device Evals (e.g., pacemaker programming, 93279-93281)
- Echocardiography (e.g., TTE, 93303-93308 and TEE, 93318)
- Cardiac Catheterization (e.g., RT, LT and Combined RT/LT heart catheterizations, 93541-93533)
  - Injection procedures (93561-93568) may need to be considered as well
- Intracardiac EP Procedures/Studies (e.g., Intracardiac catheter ablation of AV node, 93650)
- Peripheral Arterial Disease Rehabilitation, per session (e.g., 93668)
- Noninvasive Physiologic Studies/Procedures (e.g., Interrogation of ventricular assist device, 93750)
Cardiac Catheterizations
93451-93581

• Cardiac catheterizations are invasive diagnostic procedures, and at times performed along with angiography. These are studies to evaluate the circulation and movement of blood flow.

• Note the modifier -51 exempt (multiple procedure) symbol, next to the codes.

  – Pages 516-518 of 2013 CPT Professional Edition provide a helpful tool to assist in code(s) selection
Allergy Testing
95004 - 95075

• Using scratch, puncture or prick testing on the back or the arm, extracts of allergen are introduced intracutaneously and then examined for positive reactions.

• Note, the number of units, normally in the dozens will be determined based on the physician’s judgment.

• A significant, separate identifiable E & M can be reported in addition, with modifier -25.
Sleep studies (polysomnography) are tests to diagnose sleep apnea, night terrors, sleep walking and narcolepsy. They involve:

- Continuous and simultaneous recording of physiological parameters
- 3-lead EEG (frontal, central and occipital)
- Submental EMG (electromyogram)
- Left and right EOG (electro-oculogram), from which sleep is “staged”
- And 4 or more of the following additional “parameters”
  - Electrocardiogram (ECG)
  - Nasal and/or oral airflow
  - Respiratory effort
  - SpO2 (Oxyhemoglobin saturation)
  - Bilateral anterior tibialis EMG
Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions & Chemotherapy...

96360-96549

- **Hydration** (96360- +96361)
  - Minimum 31 minutes, add-on for “each additional hour” and requires minimum of 31 additional minutes.

- **Therapeutic, Prophylactic, Diagnostic Injections and Infusions** (96365-96379)
  - Many references to time based coding and methods of administration, only one “initial service code” should be reported (unless separate IV site required for distinct administration)

- **Chemotherapy and Highly Complex Drugs and Biological Administration** (96401-96549)
  - “Push” defined as: 1) provider presently administers, or
    2) infusion of “15 minutes or less”

- Report only one “initial” code per encounter, unless separate access sites are required
Physical Medicine & Rehabilitation, Medical Nutrition Therapy, Acupuncture, OMT, CMT,

- **Physical & Occupational Medicine & Rehabilitation**
  - Evaluations can be initial or re-evaluations (97001-97006)
  - Physical therapy, Occupational therapy, Athletic training
    - Modalities and Therapeutic Procedures (supervised vs. constant attendance)

- **Osteopathic Manipulative Treatment (OMT)**
  - E&M permitted with sig, sep identifiable and -25, based on # body areas

- **Medical Nutrition Therapy** (each 15 minutes)
  - 97802 (initial, individual), 97803 (re-assessment), 97804 (group, 30 min)

- **Acupuncture**
  - 15 minute increments, E&M permitted with sig, sep identifiable and -25, with or without electrical stimulation

- **Chiropractic Manipulative Treatment**
  - 98940-98943 based on number of spinal/extraspinal treatment regions
  - Medicare does not pay for E&M services and manipulation (bundled) according to CMS Pub. 100-02, ch. 15, section 240 (Chiropractic Services) & CMS Pub. 100-03, section 150.1 (Manipulation)
Services Rendered By Qualified Nonphysician Healthcare Professionals

• **Education and Training for Patient Self-Management** (98960-98962)
  - Each 30 minutes, and based on number of patients trained

• **Non-Face-to-Face Nonphysician Services**
  - **Telephone Calls** (98966-98968)
    - 5-10 min, 11-20 min, 21-30 min
    - Not related to services provided in previous 7 days
    - Not related to services scheduled w/in 24 hours or soonest appointment

• **On-Line Assessments** (98969)
  - Not related to services provided in previous 7 days
Category II and III Codes

• **Category II Codes:**
  - XXXX\text{F}
  - Tracking codes to track performance measures
  - Codes are “optional for use”
  - No RVUs associated (typically part of E&M services)

• **Category III Codes:**
  - XXXX\text{T}
  - Temporary codes for emerging technology
  - **MUST** be reported rather than Category I unlisted (e.g., xxxx\text{9})
  - Not listed for  \textgreater  than 5 years
2013 HCPCS II Coding:
A Guide to HCPCS II Coding

• Created and updated annually by CMS

• Many different vendors reproduce the code set in unique manuals, design, and structure

• Use tabs to separate different chapters and indices:
  – G-codes, J-codes, Q-codes, changes, modifiers, etc.
  – Roughly 30% of these codes are temporary in nature and may ultimately be assigned HCPCS Level I codes
HCPCS II Contents Sections

A  Transportation (ambulance) – Medical/Surgical Supplies
B  Enternal & Parenteral Therapy
C  Pass Through Items
D  Dental Procedures
E  Durable Medical Equipment-Ambulation Devices
G  Procedural/Professional Services
J  Drugs - other than Oral
K  DME Supplies
L  Orthotic & Prosthetic Procedures / Devices
M  Medical Services
P  Pathology & laboratory Services
Q  Temporary National Codes (Non-Medicare)
R  Diagnostic Radiology Services
S  Temporary National Codes
V  Vision & Hearing Services
Locating HCPCS II Codes

• Use the index much the same as you would in CPT®.
  – If you were looking for a code pertaining to a high powered wheelchair, you would first look up “wheelchair.”

• Be very careful of units (e.g. J-codes)

• Not all payers recognize all HCPCS II codes
  – HCPCS provides a method of uniform reporting on medical claims but payer policies will differ
  – HCPCS II is NOT intended to provide payment determinations
Common HCPCS II Modifiers

- **AS** - NPP assistant at surgery
- **E1-E4** - eyelids
- **FA-F9** - Fingers
- **TA-T9** - Toes
- **GA** - ABN (waiver) on file
- **GG** - performance and payment for screening and diagnostic mammograms on same date
- **GH** - screening mammogram converted to diagnostic mammogram
- **Q5** - substitute MD under reciprocal billing arrangement
- **Q6** - locum tenens MD service

- **GJ** - “opt-out” practitioner emergency service
- **GN** - outpatient speech language pathology
- **GO** - outpatient occupational therapy
- **GP** - outpatient physical therapy
- **GT** - via interactive audio and video telecommunication systems
- **GY** - statutorily excluded, not a Medicare benefit
- **GZ** - item or service expected to be denied as not reasonable or necessary
- **LC** - left circumflex coronary artery
- **LD** - left anterior descending artery
- **RC** - right coronary artery
- **QW** - CLIA waived test
Common HCPCS II Modifiers

- **LT**: left side
- **RT**: right side
- **P1-P6**: physical status
- **QK**: medical direction (2-4 concurrent anesthesia procedures)
- **QX**: CRNA service w/ medical direction
- **QY**: 1 CRNA w/ medical direction
- **QZ**: CRNA w/o medical direction
- **AA**: personally performed by anesthesiologist
- **AD**: medical *supervision* by anesthesiologist, >4 concurrent procedures
- **LM**: Left main coronary artery
- **RI**: Ramus intermedius coronary artery
2013 HCPCS II Update

• New modifiers to be appended to G8978-G9176 (also new) to describe functional limitation
  
  CH- 0 % impaired, limited or restricted
  CI- At least 1% but less than 20% impaired, limited or restricted
  CJ- At least 20% but less than 40% impaired, limited or restricted
  CK- At least 40% but less than 60% impaired, limited or restricted
  CL- At least 60% but less than 80% impaired, limited or restricted
  CM- At least 80% but less than 100% impaired, limited or restricted
  CN- 100% impaired, limited or restricted

• These modifiers are to be reported with the new codes G8978-G9176 for Medicare patients receiving outpatient therapy:
  – At outset (beginning) of treatment
  – On or before every 10 treatment days
  – At discharge from therapy
  – At any time the patient’s condition changes enough to warrant re-evaluation
Why Is ICD-9 Important?

• We have to use ICD-9 codes to get paid!

• Medical research, education, and administration purposes.

• To evaluate utilization patterns.

• To study the appropriateness of healthcare costs.

• Future reimbursement issues are based on what we submit now.
International Classification of Disease 9th Revision (ICD-9-CM)

1948 - WHO developed to track diseases

1955 - WHO modified to track mortality rates

1977 - 9th revision published

1988 - Congress passed Medicare Catastrophic Coverage Act requiring use of ICD-9 on all claims

1996 - mandated codes be of highest possible specificity

October 1, 2014 – ICD-10 Compliance Deadline
Selecting ICD-9 Codes

• Code reason for visit first

• Code to the highest level of known specificity

• Don’t code “probable, suspected, questionable or rule out”

• Code chronic diseases as often and as long as the patient receives treatment for them

• Code coexisting conditions affecting patient care at the time of the visit
Signs or Symptoms

If the diagnostic test was normal, the interpreting physician should code the sign(s) or symptom(s) that prompted the treating physician to order the study.
Steps to Select Code

1. Locate the main term in Volume 2 – the alphabetic index

2. After finding the code(s) in Volume 2, refer to Volume 1 for instructions and notes

- One exception...NEOPLASM TABLE
- May code directly from the neoplasm table in Volume 2
The Basics

• Select diagnosis codes to their **highest level of specificity** to reflect medical necessity as documented by the physician

• Sequence and **link ICD-9 codes to CPT codes** on claims

• When multiple ICD codes are used to accurately represent an encounter or service
Malignant, PRIMARY: Identifies site of original neoplasm.

Malignant, SECONDARY: Identifies a secondary cancerous neoplasm site; Malignant, Secondary should be used for all secondary cancers, even if primary malignancy has been arrested.

Malignant, CA IN SITU: Identifies cancerous neoplasm that are confined, or non-invasive.

Other Categories

BENIGN: Identifies a neoplasm that is non-cancerous.

UNCERTAIN BEHAVIOR: Tumor that has characteristics of a neoplasm, but there is not enough evidence to determine malignancy; behavior is unpredictable & needs further investigation by a physician.

UNSPECIFIED: So many changes have occurred that it is indeterminate as to where tumor began, or nature is unknown pending lab results.
Signs or Symptoms

If the diagnostic test was normal, the interpreting physician should code the sign(s) or symptom(s) that prompted the treating physician to order the study.
V Codes

- You use V codes when treatment or diagnosis is necessary for a condition or problem that is not caused by a disease or injury, but rather is due to certain circumstances. These codes are used to explain various reasons for patient encounters (eg. History, screening, etc.)
ICD-10 Introduction

- ICD-10 is much bigger with almost twice the categories of ICD-9.
- ICD-10 uses alphanumeric categories instead of numeric only.
- ICD-10 changed chapters, categories, titles and regrouped conditions.

- AHIMA estimates that “approximately 16 hours of coding training are likely needed for each coder to learn ICD-10-CM.”
  - Estimated to be about $84,000 for small MD practice to implement ICD-10
  - V and E codes will be incorporated into the main anatomical classification in ICD-10-CM

- ICD-10-CM codes alphanumeric and including all letters except U
  - A new chapter was added to ICD-10 (Chapter 22) for “Special Purposes [U00-U99]
  - ICD-10-CM are a maximum of seven characters, as opposed to five digits in ICD-9-CM
Structure of ICD-10

- 22 chapters as opposed to the 17 chapters in ICD-9

- ICD-10 has twice the number of “categories” of ICD-9

- Includes:
  - Tabular List
  - Inclusions and Exclusions
  - Alphabetic Index
  - Neoplasm Table
  - Table of Drugs/Chemicals
  - Additional coding RULES

- ICD-10 takes “laterality” in to account
  - Right side is always character 1
  - Left side character is 2
  - Bilateral character is 3
  - Unspecified side is either a character 0 or 9, depending on whether it is a fifth or sixth character

- “Granularity” simply refers to the various levels of coding for specificity

- Primary diagnosis concept remains unchanged
ICD-10 Introduction

- ICD-10 codes must be used on all HIPAA transactions, including outpatient claims with dates of service, and inpatient claims with dates of discharge on and after October 1, 2014.


- First ICD was created in 1893 and the WHO took control of clinical modifications in 1948

- The HIPAA transaction standard needed to migrate from 5 bytes to 7 bytes to accommodate ICD-10 codes

- Version 5010 also allows for more diagnoses to be reported on a single claim

- ICD-10 CM has some 155,000 codes (includes PCS)
ICD-10 Compare and Contrast

- ICD-9-CM has roughly 17,000 codes
- ICD-10-CM has 68,105 codes
  - ICD-10-PCS (procedure code system) has 86,000+ (total = approx 155,000 codes)

<table>
<thead>
<tr>
<th>Category</th>
<th>Etiology, Anatomic site, Manifestation,</th>
<th>Etiology, Anatomic site, Severity</th>
<th>Extension</th>
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<tbody>
<tr>
<td>ICD-9</td>
<td>XXX</td>
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<tr>
<td>January 1, 2010</td>
<td>Providers and payers should begin “testing” 5010 standards</td>
<td></td>
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<tr>
<td>December 31, 2010</td>
<td>Internal testing of Version 5010 must be complete to meet Level I Version 5010 compliance</td>
<td></td>
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</tr>
</tbody>
</table>
| January 1, 2011      | - CMS begins accepting Version 5010 claims  
                          - Version 4010 claims continue to be accepted                                                                                       |
| December 31, 2011    | External testing of Version 5010 for electronic claims must be complete to achieve Level II Version 5010 compliance                        |
| January 1, 2012      | Version 4010 claims are no longer accepted, must use the Version 5010 standard                                                            |
| October 1, 2014      | ICD-10 mandate (ICD-9 codes no longer accepted)                                                                                         |
Thanks for Having Me

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