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Meet the Presenter…

On the topic:
CPT Coding Fundamentals

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MBA, CPA, CMC, CMIS, CMOM
Faculty
Practice Management Institute
CPT Coding Fundamentals

Presented by:
Maxine Collins, MBA, CPA, CMC, CMOM, CMIS
Faculty, Practice Management Institute

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Agenda

• Overview of Medical Coding Resources – The Reimbursement Process
• The “Language of Coding”
• The “Coding Equation”
• A Journey through the CPT-4 Coding Manual
• Example Coding Exercises
• Code Edits Claims are Processed Through
  – NCCI Edits
  – Private Payer Edits
• Coverage Guidelines
  – Medicare’s LCDs/NCDs
  – Private Payer Coverage Determinations

Tools Required for Correct Coding

• Current year updates of coding manuals:

<table>
<thead>
<tr>
<th>TOOL</th>
<th>DESCRIPTION</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT-4 (Revised annually)</td>
<td>CURRENT PROCEDURAL CODING MANUAL</td>
<td>COPYRIGHTED AND PUBLISHED BY THE AMERICAN MEDICAL ASSOCIATION</td>
</tr>
<tr>
<td>ICD-9-CM</td>
<td>INTERNATIONAL CLASSIFICATION OF DISEASES, 9TH REVISION, CLINICAL MODIFICATION, SIXTH EDITION</td>
<td>ORIGINALLY PUBLISHED BY THE WORLD HEALTH ORGANIZATION (WHO) AND ADAPTED BY THE U.S.</td>
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<td>INTERNATIONAL CLASSIFICATION OF DISEASES, 10TH REVISION, CLINICAL MODIFICATION</td>
<td>ICD-10-CM: THE COMPLETE OFFICIAL DRAFT CODE SET (Effective 10/01/2015)</td>
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<td>HCPCS</td>
<td>HEALTHCARE COMMON PROCEDURAL CODING SYSTEM</td>
<td>UMBRELLA SYSTEM HCPCS MANUAL CONTAINING A-V CODES FOR SERVICES AND SUPPLIES ADMINISTERED AND PUBLISHED BY CMS</td>
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<tr>
<td>MEDICAL DICTIONARY</td>
<td>ANY PUBLISHED MEDICAL DICTIONARY</td>
<td>FOR UNDERSTANDING OF CLINICAL TERMINOLOGY</td>
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<td>SOURCE DOCUMENT</td>
<td>DOCUMENTATION BY PROVIDER IN THE MEDICAL RECORD</td>
<td>FOR AN ITEM TO BE CODED AND BILLED, IT MUST BE SUBSTANTIATED BY DOCUMENTATION IN THE RECORD</td>
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<tr>
<td>GOOD COMMUNICATION</td>
<td>COMMUNICATION WITH THE PROVIDER OF THE SERVICE</td>
<td>IN ORDER TO VERIFY SERVICES RENDERED AND CONDITIONS RECORDED</td>
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</tbody>
</table>
The Coding Equation

• WHAT was done? CPT/HCPCS
• WHY was it done? ICD-10-CM

• Reimbursement = Procedure (CPT) + Need (ICD-10-CM) (ICD-10-CM on 10/01/2015) x Insurance Benefits

• ICD-9-CM/ICD-10-CM must be linked to the correct CPT/HCPCS code(s) to show “medical necessity” of the services provided.

CPT-4® Coding Procedural Coding
What Services Were Provided and Can Be Billed?
CPT Coding

• **CPT – Current Procedural Terminology**
  - Current Procedural Terminology, CPT-4 – Coding system
  - Copyrighted and maintained by the American Medical Association (AMA)
  - Published each fall with codes becoming effective on **January 1st** of the following year.
    - **No grace period**
    - **New or revised codes/instructions, modifiers must be used on claim forms beginning on January 1st of each year.**
    - **Revisions in each edition are implemented by the CPT Editorial Panel with assistance of physicians from all specialties of medicine.**

CPT – Quote from Introduction from Manual

• “Current Procedural Terminology (CPT), Fourth Edition is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care providers. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of services”.

• “The main body of the material is listed in six sections. Each section is divided into subsections with anatomic, procedural, condition, or descriptor subheadings. The procedures and services with their identifying codes are presented in numeric order with one exception – the entire Evaluation and Management section (99201-99499) appears at the beginning of the listed procedures. These items are used by most physicians in reporting a significant portion of their services”.
What Is HCPCS?
CPT Current Procedural Terminology

- Systematic listing of procedures & services performed by physicians
- **Healthcare Common Procedure Coding System (HCPCS)** National System composed of:
  - Level I – CPT - Copyright of the American Medical Assn.
  - Level II – HCPCS Level II – Published and administered by the Centers for Medicare and Medicaid
- Level I – CPT - Five-digit codes numerical code:
  - Category I – Physician services
  - Category II – Quality codes
  - Category III – Temporary Codes
  Level I codes – Can be modified by adding a two-digit number (25, 25, etc.) to give additional information; or by Level II Alpha/numeric modifiers (RT, TC, etc.)

---

Overall Coding System
HCPCS – Healthcare Common Procedural Coding System

<table>
<thead>
<tr>
<th>DESCRIPTION (LEVEL I CODES COPYRIGHTED BY AMA)</th>
<th>CODE RANGE</th>
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<tr>
<td>LEVEL I, CATEGORY I CODES:</td>
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<tr>
<td>Evaluation and Management</td>
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<td>00100-01999, 99100-99140</td>
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<td>Surgery</td>
<td>10021-69990</td>
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<tr>
<td>Radiology (Including Nuclear Medicine and Diagnostic Ultrasound)</td>
<td>70010-79999</td>
</tr>
<tr>
<td>Pathology and Laboratory</td>
<td>80047-89398</td>
</tr>
<tr>
<td>Medicine (except Anesthesiology)</td>
<td>90281-99199, 99500-99607</td>
</tr>
<tr>
<td>LEVEL I, CATEGORY II CODES:</td>
<td></td>
</tr>
<tr>
<td>Set of supplemental tracking codes used for performance measurement</td>
<td>0001F-9007F</td>
</tr>
<tr>
<td>LEVEL I, CATEGORY III CODES</td>
<td></td>
</tr>
<tr>
<td>Emerging technology</td>
<td>0019T-0380T</td>
</tr>
<tr>
<td>LEVEL II – HCPCS MANUAL (MAINTAINED BY CMS) NOTE: Not covered in detail in this session.</td>
<td>Alpha/Alpha-Numeric Modifiers</td>
</tr>
</tbody>
</table>
“Key” Points for CPT

• Part of the Transaction Code Set Standards of HIPAA.

• CPT codes contain definitive and recognized definition/description of the service performed with the exception of the “unlisted” codes appearing in each section.

“Key” Points for CPT

• CPT codes describe:
  – Medical procedures
  – Services
  – Supplies
  – Along with any applicable instructions/modifiers, etc.

• CPT codes are five numeric digit codes. (i.e., 45378)
“Key” Points for CPT

- CPT codes are *revised annually by the AMA and revisions are effective on 01/01 of each year.*

- The **importance of accurate coding** of the procedures, services rendered and supplies provided cannot be **overemphasized for appropriate reimbursement.**

Organization of CPT Book

- **Guidelines**
  - At the beginning of each section
  - Provide information to interpret and report procedures and services in that section
  - Subheadings or subsections also have special instructions
  - Critical to using CPT correctly!
Example of what can be found in the Guidelines…

Measuring and Coding the Removal of a Lesion

If you use the measurements from the pathology report, you are losing revenue since payment is based on the size of the lesion when excised, not after it has gone through pathology.

Steps to Basic CPT Coding

1. Read the source document. Never assume!

2. Identify main term and modifying terms.

3. Locate main term in the CPT index.

4. Look for subterms indented below the main term.

5. Jot down the tentative code range.
Steps to Basic CPT Coding


7. Read the description & instructional notes.

8. Verify the code matches the procedure statement provided in the record.

9. Assign a modifier if necessary.

10. Assign the code.

Remember!

- Index is NOT substitute for the main text of the CPT Manual

- NEVER CODE FROM THE INDEX!

- Read the guidelines for each section
Index

• The starting point
• Located at the back
• Listed procedures in alphabetical order
• Organized by main terms (bold text)
• Entries are listed as:
  - Procedures
  - Anatomical Sites
  - Conditions
  - Synonyms
  - Eponyms
  - Abbreviations

How To Look Up a CPT Code

• CPT contains instructions for the Use of the CPT Index:
  – Main Terms:
    • The index is located in the back of most CPT manuals and is organized by main terms.
    • Each main term can stand alone, or be followed by up to three modifying terms. There are four primary classes of main entries:
      – 1. Procedure or service
        » For example: Endoscopy, Anastomosis; Splint
      – 2. Organ or other anatomic site
        » For example: Tibia, Colon, Salivary Gland
      – 3. Condition
        » For example: Abscess; Entropion
      – 4. Synonyms, Eponyms, and Abbreviations
        » For example: EEG, Bricker Operation
Conventions Used In the CPT Index

• As a space-saving convention, certain words infer some meaning. This convention is primarily used when a procedure or service is listed as a subterm. For example:
  – Knee
    • Incision (of)
  • In this example, the word in parentheses (of) does not appear in the index, but it is inferred. As another example:
    – Pancreas
      • Anesthesia (for procedures on)
  • In this example, as there is no such entity as pancreas anesthesia, the words in parentheses are inferred. That is, anesthesia for procedures in the pancreas.

Procedure/Organ/Key Word

Be sure to utilize key words.

What is the code for an upper gastrointestinal endoscopy with biopsy?

✓“gastrointestinal”
✓“endoscopy”
✓“biopsy”
Procedure/Organ/Key Word

What is the code for I&D of an abscess on the ankle?

✓“I&D”
✓“Incision and Drainage”
✓“Incision”
✓“Drainage”
✓“Abscess”
✓“Ankle”

Tabular List of Codes - Format

• Section
  - Subsection
    • Heading
      • Subheading
        ➢ Procedure codes
Tabular List of Codes – Located Towards Front of Manual

• Parent codes
  – Developed as stand-alone descriptions of the procedures
  – From the capital letter to the semi-colon

• Indented Codes
  – From the semi-colon to the end
  – The second part changes, but the first part remains the same, but is not reprinted

Format Example

27715 Osteoplasty, tibia and fibula, lengthening or shortening
27720 Repair of nonunion or malunion, tibia; without graft
     27722 with sliding graft
     27724 with iliac or other autograft
     27725 by stynotosis, with fibula, any method
Symbols Used in the Code Section of CPT

<table>
<thead>
<tr>
<th>SYMBOL</th>
<th>DESCRIPTION</th>
</tr>
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<tbody>
<tr>
<td>△</td>
<td>REVISED CODE</td>
</tr>
<tr>
<td>●</td>
<td>NEW CODE</td>
</tr>
<tr>
<td>×</td>
<td>NEW OR REVISED TEXT</td>
</tr>
<tr>
<td>+</td>
<td>ADD-ON CODE</td>
</tr>
<tr>
<td>◎</td>
<td>EXEMPTION TO MODIFIER 51</td>
</tr>
<tr>
<td>✈</td>
<td>MODERATE SEDATION INCLUDED</td>
</tr>
<tr>
<td>🌧️</td>
<td>PRODUCT PENDING FDA APPROVAL</td>
</tr>
<tr>
<td>🛋️</td>
<td>REINSTATED OR RECYCLED CODE</td>
</tr>
<tr>
<td>#</td>
<td>OUT-OF-NUMERICAL SEQUENCE CODE</td>
</tr>
</tbody>
</table>

Evaluation And Management Codes – First Section in CPT

- **E/M SECTION:**
  - Divided into broad categories such as office visits, hospital visits, and consultations.
  - Most of the categories are further divided into two or more subcategories of E/M services:
    - There are two subcategories of office visits:
      - New patient
      - Established patient
    - There are two subcategories of hospital visits:
      - Initial
      - Subsequent
    - The subcategories are further classified into levels of E/M services that are identified by specific codes.
  - Code range for E/M codes: 99201-99499
Evaluation and Management (E/M) Coding 99201-99499

• Used to describe MD/NPP services

• Components to determine the level of E/M
  – Key Components: History, Exam, Medical Decision-Making
  – Contributory Factors: Counseling, Coordination of Care, Presenting Problem,
  – Time

Evaluation and Management (E/M) Coding 99201-99499

• E/M code categories have different “key component” requirements

Example:

• New Patient Office Visits (99201-99205) requires 3 of 3 key components
• Established Patient Office Visits (99211-99215) requires 2 of 3 key components
Evaluation and Management (E/M)
Coding 99201-99499

History component includes:

- Chief Complaint (CC)
- History of Present Illness (HPI)
- Review of Systems (ROS)
- Past, Family and Social History (PFSH)

Physical Exam:

- Body Areas, or
- Organ Systems

Medical Decision-Making (MDM) measured by:

- Number of diagnosis and/or management options
- Amount and/or complexity of data obtained or reviewed
- Risk of significant complications, morbidity and/or mortality
E/M Codes

• We could spend a lot of time discussing E/M codes because they are always the subject of audit scrutiny. However, here are a few brief points:
  – **Looking at the first code in this Section – 99201** – we read that this is an **Office visit for a New Patient**. This level requires the satisfaction of what is called the 3 “key” components which must be substantiated by the documentation in the medical record:
    • A problem focused **history**;
    • A problem focused **examination**;
    • Straightforward **medical decision making**
  – **Presenting problems of the patient are self limited or minor** with the Physician typically spending 10 minutes face-to-face with the patient and/or family. This also includes **Counseling and/or coordination of care** with other providers or agencies that are provided consistent with the nature of the problem(s) and the patient’s and/or family’s needs.

Locating The Correct Level of an E/M Code Based On What Is Documented In The Medical Record

• **Exercise**: Physician saw an established patient for a follow-up visit for controlled hypertension and billed out the code 99214 on the claim form. Upon audit, it was determined that the physician actually documented the following in the medical record:
  – An expanded problem focused history;
  – An expanded problem focused examination;
  – Medical decision making of moderate complexity (Physician managed prescription medications of patient).
• What level was documented in the medical records and what should have the physician billed to the insurance carrier?
• For an established patient the physician must satisfy 2 of the 3 “key” components. (For a new patient he/she must meet requirements of 3 of the 3 “key” components)
The Correct Level Should Have Been

• Based on the documentation:
• Refer to the E/M section starting with code 99212.
• Look at the key components required for each level:
  – 99212 – PF, PF, Straightforward
  – 99213 – EPF, EPF, Low
  – 99214 – D, D, Moderated
  – 99215 - C, C, High complexity
• For the established patient we must meet or exceed 2 out of the 3 key components.
• The physician in this exercise met one requirement at the 99214 level (Moderate medical decision making); but only one.
• He/she met two required components at the 99213 level – the EPF History and The EPF Exam (2 out of the three) and, therefore, should have charged out a 99213.

Surgery Section - Let’s Try An Exercise In Procedural Coding

• 1. Laser destruction, benign facial lesion
  – Going to the CPT Index to “Laceration Repair” – It states See Specific Site.
  – Going to “Face”; “Lesion”; Destruction…..17000-17004. 17280-17286 – This gets us in the general section for the code but we would have to read several codes from this point to reach the accurate code descriptor. Many times in CPT for a facial lesion destruction, we would need to go to “Skin” to get to the accurate code more quickly.
Notes About Locating This Code

• If we had gone to the code we referenced first – 17000, we could have read important Instructional Notes preceding this section of codes:
  – **Destruction** – means the ablation of benign, premalignant or malignant tissues by any method, with or without curettement, including local anesthesia, and not usually requiring closure.
  – **Any method includes** electrosurgery, cryosurgery, laser and chemical treatment. Lesions include condylomata, papillomata, molluscum, contagiosum, herpetic lesions, warts (ie, common, plantar, flat), milia, or other benign, premalignant (eg actinic keratoses) or malignant lesions.
    • The information in parenthesis then further guides the coder to more specific coding.

Notes - Continued

• We could have started with code 17000 and would have found that it refers to **actinic keratoses**........we would have then continued reviewing the codes in this section until arriving at 17110.
• This points out the importance of the Guidelines at the beginning of each section of CPT, as well as the Notes that appear for the section of Codes. By reading and recognizing the instructional information given for the section of codes, the coder is equipped to code accurately while ensuring that are possible codes to indicate the services rendered are being coded, billed and collected.
One More Way to Arrive at 17110

• We could also have referenced “Skin; Destruction; Benign Lesions”
  – Here we would find the specific code also for the Benign Lesions:
    • One to Fourteen  ..................17110
    • Fifteen or More  ...................17111

• Not 100% of the time, but very often, the code can be more quickly found by referencing the Anatomic site. If this doesn’t work, then the coder must look for the Procedure, the Condition, an Abbreviation, Eponym, or Synonym.

• Wasn’t that fun?

Another Coding Exercise

• 2. Permanent removal distal half, left great toenail.
  – The coder will not be able to look-up “toenail” in the Index – it is not there.
  – However, you can reference “Nails”; then to “Excision”.................we are lead to code range 11750-11752.
  – Code 11750 reads, “Excision of nail and nail matrix, partial or complete” (e.g., ingrown or deformed nail, for permanent removal);
  – 11752 with amputation of tuft of distal phalanx

• The key terms here are “partial or complete” and “permanent removal.” The documentation doesn’t mention anything about amputation of tuft of distal phalanx, does it?

• Therefore, our code is 11750 TA. Yes, we have to have a modifier on this one to indicate that it is “Left foot, great toe”
Global Surgery Components

Global Fee/Package:
- Global period apply only to surgeon and assistant surgeon.
- Per CPT guidelines, the following services are always included in addition to the operation per se:
  ✓ local infiltration, metacarpal/metatarsal/digital block or topical anesthesia;
  ✓ subsequent to the decision for surgery
  ✓ immediate postoperative care
  ✓ writing orders;
  ✓ evaluating patient in the post-anesthesia recovery area;
  ✓ typical postoperative follow-up care.

Examples: Services Included in Global Period:
- Removal of staples 10 days after a surgical procedure
- Visit with a patient prior to surgery to answer any last minute questions
- Post-operative visit in the office to check on wound healing

Examples: Services NOT Included in Global Period:
- Visit where the decision to perform procedure/surgery was made
- Visit during the post-op period for a problem unrelated to the surgery
Global Surgery Components

Example of Global Payment:

CPT code 33512 – coronary artery bypass, vein only; 3 coronary venous grafts

Allowed payment (80%) = $2,001.40

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<table>
<thead>
<tr>
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<tr>
<td>Pre-op</td>
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<tr>
<td>Intra-op</td>
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</tr>
<tr>
<td>Post-op</td>
<td>7%</td>
<td>$140.00</td>
</tr>
</tbody>
</table>

Pre-operative Service:
- Includes all pre-op visits in or out of the hospital 1 day before surgery on globals greater than 10 days
- Refers to physician services (visit/consult) – may not be billed separately.
- Includes H & P.

Intra-operative Service:
- Services usual and necessary part of surgery
- Services for complications that do not require an additional trip to OR
- Medical treatment or office surgery for complication is not reimbursed separately.
Global Surgery Components

Post-operative Service:
Includes services performed by surgeon for 90 days post-op unless:

- Problem is unrelated to diagnosis for which surgery was performed
- Requires a different diagnosis than that for original service
- Added treatment other than normal recovery from surgery

Unbundling/Fragmenting

Unbundling:
• Billing separately for the various parts of the global package.

Fragmenting:
• Coding/charging each procedure step separately
• Notation of “Separate Procedure” is a warning that this code is part of, or one step of larger procedure
Examples of Unbundling/Fragmenting

Upper gastrointestinal endoscopy with biopsy of the stomach = 43239

Improper to report:
43235 (upper gastrointestinal endoscopy…diagnostic…)
43605 (biopsy of the stomach…)

43605 is not intended to be used with an endoscopic procedure (from the National Correct Coding Policy Manual for Part B Medicare Carriers)

National Correct Coding Initiative (NCCI)

• Commonly known as NCCI Edits

• Purpose:
  – Develop a correct coding methodologies
  – Control improper coding that leads to inappropriate increased in payment in Part B
  – Promote correct coding nationwide
  – Assist physicians in correctly coding their services for payment
Definitions in the Correct Coding Initiative

Correct Coding: reporting of a group of procedures with the appropriate comprehensive codes

Unbundling: billing of multiple procedures codes for a group of procedures that are covered by a single comprehensive code

Mutually Exclusive Codes: codes that represent services that cannot reasonably be performed in the same session

Unbundling/Fragmenting

• Fragmenting one service into component parts and coding each as a separate procedure

• Reporting separate codes for related services when one comprehensive code includes all related services

• Breaking out bilateral procedures when one code is appropriate
Unbundling/Fragmenting

• Down coding a service in order to use an additional code when one higher code level, more comprehensive is appropriate.

• Separating a surgical approach from a major surgical service.

Examples of Unbundling/Fragmenting

Exploratory laparotomy – 49000

Note: “(separate procedure)” follows description

If the exploratory laparotomy leads to any other procedures (cholecystectomy, colon resection, hysterectomy, etc.), the procedure done, NOT the exploratory laparotomy, is coded.
Separate Procedures

• Services “should not be reported in addition to code for total procedure or service of which it is considered an integral component”
• If the service is performed independently, unrelated or distinct from other procedures provided at the time, it may be reported by itself or in addition to other services by attaching modifier -59

Add-on Codes

• Carried out in addition to a primary procedure
  – Exempt from modifier 51
  – CPT descriptors – “list separately in addition to primary procedure” or “each additional”
  – Must never be reported as a stand-alone code
Examples of Add-on Codes

64831  Suture of digital nerve, hand or foot; one nerve

+ 64832  each additional digital nerve (list separately in addition to code for primary procedure)

22325  Open tx and/or reduction of vertebral fx and/or dislocation, posterior approach, one fx vertebrae or dislocated segment; lumbar

+ 22328  each additional fx vertebrae or dislocated segment (list separately…)

Appendices in CPT Manual

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<th>DESCRIPTION</th>
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<td>A</td>
<td>List of all modifiers applicable to CPT codes. A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers enable health care professionals to effectively respond to payment policy requirements established by other entities.</td>
</tr>
<tr>
<td>B</td>
<td>Summary of Additions, Deletions, and Revisions for the current year.</td>
</tr>
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<tr>
<td>H</td>
<td>Has been removed – formerly –Alphabetical Clinical Topics Listing for the Category II Codes.</td>
</tr>
<tr>
<td>I</td>
<td>Genetic Testing Code Modifiers — Has been removed from the CPT code set due to addition of more than 100 molecular pathology codes to 2012 code set and more codes to 2013 code set that resulted in deletion of stacking codes (83890-83914) The genetic testing code modifiers formerly described in Appendix I applied to those stacking codes, and therefore, the Appendix and modifiers have been removed from the code set.</td>
</tr>
<tr>
<td>J</td>
<td>Electrodiagnostic Medicine Listing of Sensory, Motor, and Mixed Nerves</td>
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<td>K</td>
<td>Product Pending FDA Approval</td>
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<tr>
<td>L</td>
<td>Vascular Families-Assignment of branches to first, second, and third order in the table makes the assumption that the starting point is catheterization of the aorta.</td>
</tr>
<tr>
<td>M</td>
<td>Renumbered CPT codes – Citations Crosswalk – Current code(s); Deleted/Former Code; Year Code Deleted; Citations Referencing Former Code- Applicable to Current Code(s)</td>
</tr>
<tr>
<td>N</td>
<td>Summary of Resequenced CPT Codes</td>
</tr>
</tbody>
</table>
Modifiers (Appendix A)

- 2-digit codes appended to the end of 5-digit procedure codes

- Alter or modify the service/procedure
  - Without altering/modifying the basic definition of the procedure

- Some affect reimbursement
  - Others are “informational only”

E/M Modifiers

- 24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period

- 25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service
### Example for Modifier -25

Carriers will pay separately for administration of a therapeutic or prophylactic injection, code 96372, in addition to an E/M on the same day.

Example:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213-25</td>
<td>Office Visit</td>
</tr>
<tr>
<td>J0456</td>
<td>Injection, azithromycin (Zithromax)</td>
</tr>
<tr>
<td>96372</td>
<td>Administration of Zithromax</td>
</tr>
</tbody>
</table>

If no E/M is medically necessary, you will code only for the injection and administration of that injectable.

### Example for Modifier -25

Administration of Vaccines and Toxoids (90460-90474)

Example:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212-25</td>
<td>Office Visit</td>
</tr>
<tr>
<td>90703</td>
<td>Tetanus Vaccine</td>
</tr>
<tr>
<td>90471</td>
<td>Administration of Vaccine</td>
</tr>
</tbody>
</table>

Medicare Specific Administration Codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>G0008</td>
<td>Administration of influenza vaccine</td>
</tr>
<tr>
<td>G0009</td>
<td>Administration of pneumococcal vaccine</td>
</tr>
<tr>
<td>G0010</td>
<td>Administration of hepatitis B vaccine</td>
</tr>
</tbody>
</table>
**E/M Modifiers**

- 32 Mandated service
- 33 Preventive Services
- 57 Decision for surgery

**Surgical Procedure Modifiers**

- 22 Increased Procedural Service
- 50 Bilateral Procedure
- 51 Multiple Procedure
- 52 Reduced Services
- 53 Discontinued Procedure
- 54 Surgical Care Only
- 55 Postoperative Management Only
- 56 Preoperative Management Only
- 58 Staged or Related Procedure/Service
- 59 Distinct Procedure
Surgical ProcedureModifiers

- 62 Two Surgeons
- 66 Surgical Team
- 76 Repeat Procedure by the Same Physician
- 77 Repeat Procedure by Another Physician
- 78 Return to Operating Room for Related Surgery During Postoperative Period
- 79 Unrelated Surgery During Post-Operative Period
- 80 Assistant Surgeon
- Other Modifiers: 26, 90, 91, 99

Medicare LCDs and NCDs

• National Coverage Determinations
• Local Coverage Determinations
• When the Medicare Contract is signed the Provider is agreeing to become aware of and knowledgeable of the NCDs and LCDs that effect the coding of his/her claims.
National Coverage Determinations- CMS Website

- Use the drop-down list below to select the NCD Chapter you would like to view and select the 'Go' button to anchor to the appropriate chapter. Select the NCD Title to view the details page for the specific record. You can also select items using their corresponding check boxes in the right column. After selecting the check boxes you can print the selected items or add them to your basket by selecting the ‘Print Selected’ or ‘Add to Basket’ buttons.

- NCD Index by Chapter/Section
  - [338 Records]
  - Chapter Navigation
  - Expand All
  - Collapse All
  - All sections on the page are Collapsed
  - 10: Anesthesia and Pain Management
    - [6 Records]
  - 20: Cardiovascular System
    - [42 Records]
  - 30: Complementary and Alternative Medicine
    - [12 Records]
  - 40: Endocrine System and Metabolism
    - [6 Records]

Benefit Category- Physicians' Services

- Note: This may not be an exhaustive list of all applicable Medicare benefit categories for this item or service.

- Indications and Limitations of Coverage
  In certain types of medical conditions, including when a patient is withdrawn and uncommunicative due to a mental disorder or comatose, the physician may contact relatives and close associates to secure background information to assist in diagnosis and treatment planning. When a physician contacts his patient's relatives or associates for this purpose, expenses of such interviews are properly chargeable as physician's services to the patient on whose behalf the information was secured. If the beneficiary is not an inpatient of a hospital, Part B reimbursement for such an interview is subject to the special limitation on payments for physicians' services in connection with mental, psychoneurotic, and personality disorders.

  A physician may also have contacts with a patient's family and associates for purposes other than securing background information. In some cases, the physician will provide counseling to members of the household. Family counseling services are covered only where the primary purpose of such counseling is the treatment of the patient's condition. For example, two situations where family counseling services would be appropriate are as follows: (1) where there is a need to observe the patient's interaction with family members; and/or (2) where there is a need to assess the capability of and assist the family members in aiding in the management of the patient. Counseling principally concerned with the effects of the patient's condition on the individual being interviewed would not be reimbursable as part of the physician's personal services to the patient. While to a limited degree, the counseling described in the second situation may be used to modify the behavior of the family members, such services nevertheless are covered because they relate primarily to the management of the patient's problems and not to the treatment of the family member's problems.

- Cross Reference
  Medicare Benefit Policy Manual, Chapter 6
LCD Example – Novitas – Allergy Sensitivity Testing

• In Vivo Testing:

Allergy Sensitivity Testing:

These tests include the performance and evaluation of selective cutaneous and mucous membrane tests in correlation with history, physician examination, and other observations of the patient. The tests are performed to determine body sensitivity and reaction to the antigen for the purpose of diagnosing the presence of allergic reaction to antigenic stimuli. The number of tests performed should be judicious and dependent upon the history, physical findings and clinical judgment. All patients should not necessarily receive the same tests or the same number of sensitivity tests. Rather testing should be patient specific based on the history and physical examination.

These tests are injection of small amounts of antigen into the superficial layers of the skin. This is the preferred method for allergy testing. Medicare considers percutaneous (scratch, prick or puncture) testing medically reasonable and necessary when IgE-Medicated reactions occur to any of the following:

- Inhalants
- Foods,
- Hymenoptera (stinging insects)
- Specific drugs (such as penicillin or macromolecular agents)

Aetna.com Quarterly Newsletter

• Consult CPGs and PSGs as you care for patients We adopt evidence-based Clinical Practice Guidelines (CPGs) and Preventive Services Guidelines (PSGs) from nationally recognized sources. You’ll find them on our secure provider website.

• On the site, go to My Health Plans - Aetna Health Plan - Support Center - Clinical Resources. For a paper copy, call our Provider Service Center. Clinical Practice Guidelines Adopted Behavioral Health • Diagnosis, Evaluation and Treatment of Attention Deficit Hyperactivity Disorder in Children and Adolescents February 2014 • Helping Patients Who Drink Too Much February 2014 • Treatment of Patients With Major Depressive Disorder February 2014 Diabetes • Standards of Medical Care in Diabetes April 2015 Heart Disease • Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease February 2014 Preventive Service Guidelines Adopted • Gestational Diabetes Mellitus (GDM) in Asymptomatic Pregnant Women After 24 Weeks of Gestation* February 2014 • Mammogram Screening for Women Over 40** February 2014 • Prevention of the Initiation of Tobacco Use Among School-aged Children and Adolescents* February 2014 *U.S. Preventive Services Task Force **National Cancer Institute View our 2015 HEDIS® results We annually collect Healthcare Effectiveness Data and Information Set (HEDIS)* data from claims, encounters and other administrative data. We also collect data from chart reviews for certain clinical measures. We analyze these results to find opportunities for improvement, and design and implement quality improvement activities.
In Summary

✔ Learn CPT Nomenclature
  ○ Reading the guidelines
  ○ Use of Symbols, Appendices, Indexes

✔ Never code from the index

✔ Understand the importance of linking CPT with appropriate diagnosis codes

✔ Use modifiers, when necessary

Learn More!
Check Out Our Audio Library!

E/M Coding - Are You Leaving Money On the Table
Many providers get comfortable with codes that may not always fit the bill. Your practice could be losing money by undercoding. The attention is in the details. Help get your practice paid correctly when you understand correct E/M rules. See how the documentation guidelines provide the roadmap for exact coding of claims.

Making the Most of Modifiers
Correct modifier use is an important part of avoiding fraud and abuse or noncompliance issues, especially in coding and billing processes involving the federal and state governments. This session will provide a comprehensive review of CPT and HCPCS modifiers with specific emphasis on use of modifiers with E/M codes and clarification regarding the use of Modifier 33.
Questions?