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On the topic:

The Fundamentals of Medical Coding
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The Fundamentals of Medical Coding

Presented by
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Introduction

• Coders are charged with the responsibility of selecting the most correct codes for optimal reimbursement while at the same time protecting the practice from violations due to improper coding.

• Coding is not an exact science. Many times the coder is required to research, investigate, and use very technical procedures to find the most proper code.

Introduction

• A medical coder’s main role is to convert the words documented in a patient visit note (service or procedure) by the healthcare provider, and then assign the appropriate diagnosis code(s) and procedure (CPT® or HCPCS) code(s).

• Medical coding is a system of numeric and alpha-numeric digits representing the diagnosing and treatment of a patient, and is used to avoid miscommunication between practices and third-party payers.
Introduction

• Accurate medical coding is vital to the healthcare industry.
• Certified medical coders must demonstrate required skills through timed testing in:
  – ICD-10-CM
  – HCPCS Level II
  – CPT (including Modifiers)
  – Medical Anatomy/Terminology
  – Ability to extract pertinent documentation from medical records

Course Objectives

• To familiarize you with the coding process
• To introduce you to the ICD-10-CM, CPT®, HCPCS Level II - what they are, what’s in them and how to use them
• To demonstrate how the coding books will help you code if you use them
• To show you how to translate documentation from coding to the CMS 1500
• To show you how to “paint a picture” of the condition and service rendered to a patient
What is Documentation and Why is it Important?

• Medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history including past and present illnesses, examinations, tests, treatments, and outcomes.

• The medical record chronologically documents the care of the patient and is an important element contributing to high quality care.

• Many claims denials occur because the providers do not submit sufficient documentation to support the service billed. Frequently, documentation is insufficient to demonstrate medical necessity.

The Medical Record Facilitates

• The ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time.

• Communication and continuity of care among physicians and other health care professionals involved in the patient's care;

• Accurate and timely claims review and payment;

• Appropriate utilization review and quality of care evaluations; and

• Collection of data that may be useful for research and education.
What Do Payers Want and Why?

Because insurance carriers have a contractual obligation to their enrollees, these payers may require reasonable documentation that services are consistent with the health insurance coverage provided. They may request information to validate:

- the site of service;
- the medical necessity and appropriateness of the diagnostic and/or therapeutic services provided; and/or
- that services provided have been accurately reported.

General Principles of Medical Record Documentation

- The principles of documentation listed below are applicable to all types of medical and surgical services in all settings.
- For Evaluation and Management (E/M) services, the nature and amount of physician work and documentation varies by type of service, place of service and the patient’s status.
- The general principles listed on the next slides may be modified to account for these variable circumstances in providing E/M services.
General Principles

1. The medical record should be complete and legible.
2. The documentation of each patient encounter should include:
   – reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   – assessment, clinical impression or diagnosis;
   – plan for care; and
   – legible identity and date of the observer.

3. If not documented, the rationale for ordering diagnostic and other ancillary services should be easily inferred.
4. Past and present diagnoses should be accessible to the treating and/or consulting physician.
5. Appropriate health risk factors should be identified.
6. The patient’s progress, response to and changes in treatment, and revision of diagnosis should be documented.
7. The CPT and ICD-10-CM codes reported on the health insurance claim form or billing statement should be supported by the documentation in the medical record.
Examples of Improper Claims

- Billing for services that you did not actually render
- Billing for services that were not medically necessary
- Billing for services performed by an improperly supervised or unqualified employee
- Billing for services performed by an employee excluded from participation in Federal health care programs
- Billing for services of such low quality that they are virtually worthless
- Billing separately for services already included in a global fee, like billing for an evaluation and management service the day after surgery

The Medical Record

- The Medical record is a legal document that serves as a chronological record of pertinent facts and observations about a patient’s health.
- It is used by the physician and other health care professionals to evaluate and plan the patient's immediate treatment, and to monitor his/her health care over time.
- The Office of Inspector General (OIG) continues to launch audit initiatives through multiple sources to determine whether Medicare is making erroneous payments based on the documentation in the medical records compared to what services (codes) were submitted.
Physician Documentation

- Maintain accurate and complete medical records and documentation of the services you provide.
- The Medicare Program may review beneficiaries’ medical records.
- Good documentation helps you address challenges raised about the integrity of your claims.
- “If you didn’t document it, it’s the same as if you didn’t do it.”

Coverage and Payments Related to Diagnostic (ICD-10-CM Code Selection (LCD/NCD))

- Medicare pays for medical items and services that are "reasonable and necessary" for a variety of purposes.
- Medicare has a number of policies, including National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), formerly known as Local Medical Review Policies (LMRP), that describe coverage criteria.
- In a small number of cases, Medicare may determine if a method of treating a patient should be covered on a case-by-case basis.
Reading a Source Document

• All coding comes from a source document. This may be in the form of a superbill, operative report, progress notes, etc.

• When reviewing the documentation, use a sheet of paper to write down all conditions and procedures performed.

• IMPORTANT: Be sure that the documentation in the patient’s records supports the E/M (Evaluation and Management) or any other code reported.
Utilizing Proper E/M Documentation Techniques

• Reason for visit
• History elicited
• Areas examined
• Diagnosis, known and suspected
• Plan of treatment or therapy
• Lab and test results and the change in management they initiate
• Date and legible identity of observer

Methods to Prompt Physicians in Documentation Practices

• pre-printed forms and templates
• SOAP notes
  – S - Subjective information (patient complaint)
  – O - Objective information (history and physical, lab and test results)
  – A - Assessment (what do the above mean; diagnosis)
  – P - Plan (plan of treatment/management)
Examples

7/11/XX
S: Patient complains of cough, sore throat for 3 days. No n/v or fever. Sinus clear.
T: 99'
P: 74
B/P: 120/80
R: 12
A: Imp: URI/Possible strep throat
P: Plan: C/S to R/O strep, Robitussin DM ii tsp. Q6H PRN ASA Q4H, RTC x 3 days

7/2/XX
S: Patient twisted L ankle this am.
O: Moderate swelling at left ankle. Limited ROM, Pain.
X-ray: transverse fracture left fibular malleolus.
T: 99.8'
P: 72
R: 12
B/P: 188/70
A: Dx: fx L ankle
P: Plan: Ankle cast. ASA ii Q4H PRN. RTC x 8 weeks or if swelling or discoloration of toes is noted.

ICD-10-CM Official Guidelines for Coding and Reporting

- These guidelines are a set of rules that have been developed by the Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS) to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself.
- The diagnosis codes (Tabular List and Alphabetic Index) have been adopted under HIPAA for all healthcare settings.
- These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses and procedures that are to be reported.
The Guidelines are Organized into Sections

- **Section I** includes the structure and conventions of the classification and general guidelines that apply to the entire classification, and chapter-specific guidelines that correspond to the chapters as they are arranged in the classification.
- **Section II** includes guidelines for selection of principal diagnosis for non-outpatient settings.
- **Section III** includes guidelines for reporting additional diagnoses in non-outpatient settings.
- **Section IV** is for outpatient coding and reporting.

8 Steps to Correct Coding

2. Look up the main term in the alphabetic index and scan the subterm entries as appropriate. Review continued lines and additional subterms that may appear in the next column or the next page.
3. Note all parenthetical terms (nonessential modifiers) that help in code selection but do not affect code assignment. Shaded vertical guidelines in the index are provided to help determine the indentation level for each subterm in relation to the main terms.
8 Steps to Correct Coding

4. Pay close attention to the following instructions in the index:
   – “See,” “see also,” and “see category” cross references
   – “With”/“without” notes
   – “Omit code” notes
   – “Due to” subterms
   – Other instructions found in note boxes, such as “code by site”
   – Following references and Check Additional Character symbol in the indexes. The following references help coders locate those alphanumeric codes that are out of sequence in the tabular section.

5. Do not code from the alphabetic index without verifying the accuracy of the code in the tabular list. Locate the code in the alphanumerically arranged tabular list.

8 Steps to Correct Coding

6. To determine the appropriateness of the code selection and proper coding, read all instructional material:
   – “Includes” and both types of “Excludes” notes
   – “Use additional code” and “code first underlying disease” instructions
   – “Code also”
   – 4th, 5th, and 6th character requirements and 7th character extension requirements
   – Age and sex symbols

7. Consult the office ICD-10-CM guidelines which govern the use of specific codes. These guidelines provide both general and chapter-specific coding guidance.

8. Confirm and assign the correct code.
Locating a Code in ICD-10-CM

1. Locate the term in the Alphabetic Index.
2. Then verify the code in the Tabular List.
3. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List. It is essential to use both the Alphabetic Index and Tabular List when locating and assigning a code. The Alphabetic Index does not always provide the full code. Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular List. A dash (-) at the end of an Alphabetic Index entry indicates that additional characters are required. Even if a dash is not included at the Alphabetic Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required.

Level of Detail in Coding

- Diagnosis codes are to be used and reported at their highest number of characters available.
- ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6 or 7 characters.
- Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth characters and/or sixth and/or seventh characters, which provide greater detail.
ICD-10-CM Official Guidelines for Coding and Reporting

• Code or codes from A00.0 through T88.9; Z00-Z99.8
  – The appropriate code or codes from A00.0 through T88.9; Z00-Z99.8 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.

• Signs and symptoms
  – Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider.

• Conditions that are not an integral part of a disease process
  – Additional signs and symptoms that may not be associated routinely with a disease process should be coded when present.

• Multiple coding for a single condition
  – “Use additional code” notes are found in the Tabular List at codes that are not part of an etiology/manifestation pair where a secondary code is useful to fully describe a condition.
ICD-10-CM Official Guidelines for Coding and Reporting

- **“Code first”** notes are also under certain codes that are not specifically manifestation codes but may be due to an underlying cause.
- **“Code, if applicable, any causal condition first”**
  - Indicates that this code may be assigned as a principal diagnosis when the causal condition is unknown or not applicable.

ICD-10-CM Official Guidelines for Coding and Reporting

- **Acute and Chronic Conditions**
  - If the same condition is described as both acute (subacute) and chronic, and separate subentries exist in the Alphabetic Index at the same indentation level, code both and sequence the acute (subacute) code first.
- **Combination Code**
  - Two diagnoses, or
    - A diagnosis with an associated secondary process (manifestation)
    - A diagnosis with an associated complication
ICD-10-CM Official Guidelines for Coding and Reporting

• **Sequela (Late Effects)**
  – A sequela is the residual effect (condition produced) after the acute phase of an illness or injury has terminated.

• **Impending or Threatened Condition**
  – If it did occur, code as confirmed diagnosis.
  – If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for “impending” or “threatened” and also reference main term entries for “Impending” and for “threatened.”
  – If the subterms are listed, assign the given code.
  – If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.

ICD-10-CM Official Guidelines for Coding and Reporting

• **Reporting Same Diagnosis Code More than Once**
  – Each unique ICD-10-CM diagnosis code may be reported only once for an encounter. This applies to bilateral conditions when there are no distinct codes identifying laterality or two different conditions classified to the same ICD-10-CM diagnosis code.

• **Laterality**
  – Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right or is bilateral.
ICD-10-CM Official Guidelines for Coding and Reporting

- **Documentation for BMI and Pressure Ulcer Stages**
  - For the Body Mass Index (BMI), depth of non-pressure chronic ulcers, pressure ulcer stage, coma scale, and NIH stroke scale (NIHSS) codes, code assignment may be based on medical record documentation from clinicians who are not the patient's provider.

- ** Syndromes**
  - Follow the Alphabetic Index guidance when coding syndromes.

ICD-10-CM Official Guidelines for Coding and Reporting

- **Documentation of Complications of Care**
  - Code assignment is based on the provider’s documentation of the relationship between the condition and the care or procedure, unless otherwise instructed by the classification.

- **Borderline Diagnosis**
  - If the provider documents a "borderline" diagnosis at the time of discharge, the diagnosis is coded as confirmed, unless the classification provides a specific entry (e.g., borderline diabetes).
ICD-10-CM Official Guidelines for Coding and Reporting

• Use of Sign/Symptom/Unspecified Codes
  – Each healthcare encounter should be coded to the level of certainty known for that encounter.
  – If a definitive diagnosis has not been established by the end of the encounter, it is appropriate to report codes for sign(s) and/or symptom(s) in lieu of a definitive diagnosis.

Conventions of ICD-10-CM

• SECTION I. CONVENTIONS, GENERAL CODING GUIDELINES AND CHAPTER SPECIFIC GUIDELINES
  – The conventions, general guidelines and chapter-specific guidelines are applicable to all health care settings unless otherwise indicated. The conventions and instructions of the classification take precedence over guidelines.
  – The conventions for the ICD-10-CM are the general rules for use of the classification independent of the guidelines. These conventions are incorporated within the Alphabetic Index and Tabular List of the ICD-10-CM as instructional notes.
Conventions of ICD-10-CM

1. The Alphabetic Index and Tabular List
   – The ICD-10-CM is divided into the Alphabetic Index, an alphabetical list of terms and their corresponding code, and the Tabular List, a chronological list of codes divided into chapters based on body system or condition.

2. Format and Structure
   – The ICD-10-CM Tabular List contains categories, subcategories and codes.

3. Use of codes for reporting purposes
   – For reporting purposes only codes are permissible, not categories or sub-categories and any applicable 7th character is required.

4. Placeholder character
   – The ICD-10-CM utilizes a placeholder character “X”. The “X” is used as a placeholder at certain codes to allow for future expansion.

5. 7th Characters
   – Certain ICD-10-CM categories have applicable 7th characters. The applicable 7th character is required for all codes within the category, or as the notes in the Tabular List instruct.
Conventions of ICD-10-CM

6. Abbreviations
   a. Alphabetic Index abbreviations
      • NEC “Not elsewhere classifiable”
      • NOS “Not otherwise specified”
   b. Tabular List abbreviations
      • NEC “Not elsewhere classifiable”
      • NOS “Not otherwise specified”

7. Punctuation
   – [ ] Brackets are used in the Tabular List to enclose synonyms, alternative wording or explanatory phrases. Brackets are used in the Alphabetic Index to identify manifestation codes.

   – ( ) Parentheses are used in both the Alphabetic Index and Tabular List to enclose supplementary words that may be present or absent in the statement of a disease or procedure without affecting the code number to which it is assigned. The terms within the parentheses are referred to as nonessential modifiers.

   – : Colons are used in the Tabular List after an incomplete term which needs one or more of the modifiers following the colon to make it assignable to a given category.
Conventions of ICD-10-CM

8. Use of “and”

9. Other and Unspecified codes
   a. “Other” codes
      • Codes titled “other” or “other specified” are for use when the information in the medical record provides detail for which a specific code does not exist.
   b. “Unspecified” codes
      • Codes titled “unspecified” are for use when the information in the medical record is insufficient to assign a more specific code.

10. Includes Notes
    – This note appears immediately under a three character code title to further define, or give examples of, the content of the category.

11. Inclusion terms
    – List of terms is included under some codes. These terms are the conditions for which that code is to be used.
Conventions of ICD-10-CM

12. Excludes Notes
   - Excludes1
     • It means “NOT CODED HERE!” An Excludes1 note indicates that the code excluded should never be used at the same time as the code above the Excludes1 note.
   - Excludes2
     • An excludes2 note indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time.

Conventions of ICD-10-CM

13. Etiology/manifestation convention ("code first," "use additional code," and "in diseases classified elsewhere" notes)
   - Certain conditions have both an underlying etiology and multiple body system manifestations due to the underlying etiology. For such conditions, the ICD-10-CM has a coding convention that requires the underlying condition be sequenced first, if applicable, followed by the manifestation.

14. “And”
   - The word “and” should be interpreted to mean either “and” or “or” when it appears in a title.
Conventions of ICD-10-CM

15. “With”
- The word “with” should be interpreted to mean “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.

16. “See” and “See Also”
- The “see” instruction following a main term in the Alphabetic Index indicates that another term should be referenced.
- A “see also” instruction following a main term in the Alphabetic Index instructs that there is another main term that may also be referenced that may provide additional Alphabetic Index entries that may be useful.

Conventions of ICD-10-CM

17. “Code also note”
- A “code also” note instructs that two codes may be required to fully describe a condition, but this note does not provide sequencing direction.

18. Default codes
- A code listed next to a main term in the ICD-10-CM Alphabetic Index is referred to as a default code.
ICD-10-CM Tabular List of Diseases and Injuries

| 1 | Certain infectious and parasitic diseases (A00–B99) |
| 2 | Neoplasms (C00–D49) |
| 3 | Diseases of the blood and blood–forming organs and certain disorders involving the immune mechanism (D50–D89)* |
| 4 | Endocrine, nutritional and metabolic diseases (E00–E89) |
| 5 | Mental and behavioral disorders (F01–F99) |
| 6 | Diseases of the nervous system (G00–G99) |
| 7 | Diseases of the eye and adnexa (H00–H59) |
| 8 | Diseases of the ear and mastoid process (H60–H95)* |
| 9 | Diseases of the circulatory system (I00–I99) |
| 10 | Diseases of the respiratory system (J00–J99) |

| 11 | Diseases of the digestive system (K00–K95)* |
| 12 | Diseases of the skin and subcutaneous tissue (L00–L99) |
| 13 | Diseases of the musculoskeletal system and connective tissue (M00–M99) |
| 14 | Diseases of the genitourinary system (N00–N99) |
| 15 | Pregnancy, childbirth and the puerperium (O00–O9A) |
| 16 | Certain conditions originating in the perinatal period (P00–P96) |
| 17 | Congenital malformations, deformations and chromosomal abnormalities (Q00–Q99) |
| 18 | Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified (R00–R99) |
| 19 | Injury, poisoning and certain other consequences of external causes (S00–T88) |
| 20 | External causes of morbidity (V00–Y99) |
| 21 | Factors influencing health status and contact with health services (Z00–Z99) |
ICD-10-CM Example 1

CODING EXAMPLE 1
Diagnosis: Hypertension

STEP 1: To find the correct ICD-10-CM code for hypertension, look up the diagnosis in the Alphabetic Index under the ‘H’ terms.

The term hypertension is expanded to read hypertension, hypertensive (accelerated) (benign) (essential) (idiopathic) (malignant) (systemic) and the ICD-10-CM code listed is I10.

ICD-10-CM Example 1

Diseases of the circulatory system (I00-I99)

Hypertensive diseases (I10-I15)

I10 Essential (primary) hypertension

STEP 2: Verify code I10 for hypertension by finding it in the Tabular List. This code is located in the Diseases of the circulatory system chapter (codes I00-I99).

The code is listed under Hypertensive diseases (codes I10-I15).

Code I10 is the code listed for essential (primary) hypertension.
1. Hypertension

First, Look Up Hypertension in the ICD-10-CM Manual Index

*Hypertension, hypertensive (accelerated) (benign) (essential) (idiopathic) (malignant) (systemic) [110]*

with
- heart involvement (conditions in I51.4 - I51.9 due to hypertension) — see Hypertension, heart
- kidney involvement — see Hypertension, kidney
- benign, intracranial G93.2
- borderline R03.0
- cardiorenal (disease) I13.10
- with heart failure I13.0
- with stage 1 through stage 4 chronic kidney disease I13.0
1. Hypertension

Second, Look Up Hypertension in the ICD-10-CM Coding Manual

Third, Note and Follow any Instructions/Guidelines before Selecting Code: I10

HCPCS

- HCPCS is a coding system used by most carriers. It stands for Healthcare Common Procedure Coding System.

- HCPCS is divided into two levels.
HCPCS

• Level 1 National
  – CPT – Physician Services – Category I
    • Created by AMA to report physician services.
  – CPT – Performance Measurement – Category II
    • Created by AMA to reduce the need for record abstraction.
  – CPT – Emerging Technology – Category III
    • Temporary codes created by AMA to report new services and determine clinical efficacy, utilization, and outcomes of these procedures.

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HCPCS

• Level II National
  – HCPCS National Codes
  – Developed by CMS to report additional medical services and supplies not covered under Level I CPT codes.
  – Codes are alpha/numeric (A4460) with modifiers that are alpha/numeric (F1) or two letters, ranging from A-V (GA).
  – Include ambulance, dental, durable medical equipment, medications, and other services.

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CPT®

• CPT® stands for Current Procedural Terminology. It was developed by the American Medical Association (AMA) in 1966.
• It is a listing of descriptive terms and five-digit, numeric codes for reporting medical services and procedures performed by physicians.
• CPT® is revised and published annually by the AMA to keep pace with changes in medicine. January 1 each year is the effective date for use of the annual update of the CPT code sets.

Observations about CPT®

• The main purpose of CPT is to provide a standard and uniform language to communicate among patients, doctors and third-party payers.
• Sections are set up anatomically. They take the body and go outside to inside, top to bottom, front to back.
• Each major section has its own set of rules, notes, and instructions. Coders MUST read these in order to code properly.
Using the CPT® Coding Manual

- CPT® is a systematic listing of procedures and services performed by physicians and other health care professionals.
- Use of code(s) assumes performance or supervision by a physician.
- The codes may be used by other health providers, but reimbursement may be effected.

Major Sections

- The main body of the Category 1 section in the CPT manual is listed in six sections:
  - Evaluation and Management Services 99201 – 99499
  - Anesthesiology 00100 – 01999, 99100 – 99140
  - Surgery 10021 – 69990
  - Radiology 70010 – 79999
  - Pathology and Laboratory 80047 – 89398
  - Medicine 90281 – 99199, 99500 – 99607
  - Category II Codes 001F – 7025F
  - Category III Codes 0019T – 0328T
- Appendix A-O gives additional information on modifiers, summaries of added, deleted, and revised codes, as well as examples.
The Index

The alphabetical index is located behind the appendices, at the back of the book.

– Procedures
– Anatomic sites
– Conditions
– Synonyms
– Eponyms
– Abbreviations

Locating a Code

1. Check for the procedure performed.
2. Check for the organ involved.
3. If neither is listed, try the condition or key word for the source document.

Coding Description

In CPT you will find stand-alone codes, as well as parent and indented codes. All code descriptions (headings) begin with a capital letter and some are made up of two parts:

1. From the capital letter to the semi-colon
2. From the semi-colon to the end
Example

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27715</td>
<td>Osteoplasty, tibia and fibula, lengthening or shortening</td>
</tr>
<tr>
<td>27720</td>
<td>Repair of nonunion or malunion, tibia; without graft, (eg, compression technique)</td>
</tr>
<tr>
<td>27722</td>
<td>with sliding graft</td>
</tr>
<tr>
<td>27724</td>
<td>with iliac or other autograft (includes obtaining graft)</td>
</tr>
<tr>
<td>27725</td>
<td>by synostosis, with fibula, any method</td>
</tr>
</tbody>
</table>

Since code 27722 is not a main term (does not begin with a capital letter), it is not a complete code. The coder must look back (up) to find the first code or parent code which does begin with a capital letter and include the first portion (from the capital letter to the semi-colon) as a part of that indented code. In this case, the parent code is 27720.

Guidelines for CPT®

- There are guidelines at the beginning of each of the eight major sections that are unique to that particular section.
- There are special notes and rules for coding subsections.
- Read and follow them to accurately code procedures.
Unlisted Procedures

• Medicine and health care technology change rapidly and codes will not be available for new advanced procedures between annual revision dates.

• Unlisted Procedure Codes are available for those procedures that do not have descriptor codes assigned to them.

• Payment will be slower because unlisted codes are hand adjudicated and the reimbursement amount decided by carrier based on information that you provide.

Symbols

● New procedure ("bullet" is placed before code)

▲ Changed or altered procedure description from last edition (triangle placed before number)

_exempt from Modifier 51

+ Add-on Code

Conscious/Moderate Sedation Included

Pending FDA Approval

Out of Numerical Sequence Code
Proper Coding With CPT®

1. Identify the procedures, tests, equipment, supplies, etc. from the source document. Look for modifying or extenuating circumstances.

2. Identify the main terms and sub-terms.

3. Locate the procedure or service in the index by checking procedure, anatomic site, synonym, eponym, and abbreviated entries as necessary.

4. When you have found the procedure, service, or alpha wording desired, identify the code number next to it and refer to that code section in the basic manual. Be sure they match.

5. If a range of codes is given for the procedure, read the description of each entry within the range to make the proper selection that matches or fits as closely as possible to what was actually done.

6. NEVER CODE DIRECTLY FROM THE INDEX! Always used codes from the main body of the CPT®.

7. Ensure you have followed all notes and guidelines at the beginning of the section.

8. If the exact code is not what you are looking for, you may need to use a modifier.

9. If there is not a proper code, you may need to utilize “unlisted procedure” codes in that section. Only use these as a last resort. Submit with special report.
10. Check and recheck that you have the proper code and have not transposed any digit. Errors in the code will mean denial.

11. Ensure what you have coded is documented in the medical record.

12. Inclusion or exclusion of a code in the CPT® does not guarantee reimbursement by third-party payers.

13. Incorrect coding leads to incorrect reimbursement, and possible “flagging” for audits, fraud and abuse for which there are heavy penalties.

14. Ensure that all database information needed on the claim is entered for proper reimbursement.

HCPCS Level 1 CPT Exercises
1. Simple I&D of Multiple Skin Abscesses

First, Look Up Simple I&D of Multiple Skin Abscesses in the CPT Manual Index

<table>
<thead>
<tr>
<th>Incision and Drainage</th>
<th>Ovarian</th>
<th>58800-58805</th>
</tr>
</thead>
<tbody>
<tr>
<td>See Drainage; Incision</td>
<td>Abdomen</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td>Fluid</td>
<td>49082, 49083</td>
</tr>
<tr>
<td>Pancreatitis</td>
<td>48000</td>
<td></td>
</tr>
<tr>
<td>Abscess</td>
<td>20005</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td>49020, 49040</td>
<td></td>
</tr>
<tr>
<td>Open</td>
<td>49040</td>
<td></td>
</tr>
<tr>
<td>Spinal Cord</td>
<td>63172, 63173</td>
<td></td>
</tr>
<tr>
<td>Thyroid Gland</td>
<td>60000</td>
<td></td>
</tr>
<tr>
<td>Tongue</td>
<td>41000-41006, 41015, 60000</td>
<td></td>
</tr>
</tbody>
</table>

Second, Look Up Simple I&D of Multiple Skin Abscesses in the CPT Manual

Third, Note any Guidelines here or at the Beginning of this Section before Selecting Code: 10061
2. Barium Enema with Contrast, for Colon Examination

First, Look Up Barium Enema with Contrast, for Colon Examination in the CPT Manual Index

Surgically Altered Stomach
   Ultrasound Examination .................. 43242
Barium Enema  74270, 74280
Barker Operation
   See Tonsil, Excision
Baroreflex Activation Device
   Implantation/Replacement ............ 0266T-0268T

Or

Enema
   Contrast .................. 74270, 74280
   Home Visit for Fecal Incontinence ........ 99511
   Therapeutic for Intussusception ........... 74283

Second, Look Up Barium Enema with Contrast, for Colon Examination in the CPT Manual

74270 Radiologic examination, colon; contrast (eg, barium) enema, with or without KUB
   CPT Changes: An Insider’s View 2009
   CPT Assistant May 03:19
74280 air contrast with specific high density barium, with or without glucagon

Third, Note any Guidelines here or at the Beginning of this Section before Selecting Code: 74270
Healthcare Common Procedure Coding System (HCPCS)

- CPT is a stand-alone system for many private carriers. However, CPT is actually one of 2 levels in HCPCS (hik-piks).
  - Healthcare
  - Common
  - Procedure
  - Coding
  - System

Levels of HCPCS

- Currently there are two levels of HCPCS:
  
<table>
<thead>
<tr>
<th>Level</th>
<th>CPT</th>
<th>5 digits</th>
<th>all numeric</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>CPT</td>
<td>5 digits</td>
<td>all numeric</td>
</tr>
<tr>
<td>Level 2</td>
<td>National (HCPCS)</td>
<td>5 digits</td>
<td>alpha-numeric A-V + 4 numbers</td>
</tr>
</tbody>
</table>

- Modifiers at each level:
  
<table>
<thead>
<tr>
<th>Level</th>
<th>Modifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 1</td>
<td>-80, -22</td>
</tr>
<tr>
<td>Level 2</td>
<td>-TC, -LT</td>
</tr>
</tbody>
</table>
Level II

• The local Medicare carrier decides use of Level II.
• They are also responsible for providing instructions for their use.
• All Medicare carriers use the HCPCS codes and most of the Medicaid carriers are presently converting.

<table>
<thead>
<tr>
<th>HCPCS Codes Used</th>
<th>LEVEL 1 CPT</th>
<th>LEVEL 2 National</th>
</tr>
</thead>
<tbody>
<tr>
<td>Responsible Agent</td>
<td>American Medical Association</td>
<td>CMS</td>
</tr>
<tr>
<td>Examples of Codes Used</td>
<td>96372</td>
<td>T1502</td>
</tr>
<tr>
<td>Example of Modifier</td>
<td>-22</td>
<td>TC</td>
</tr>
<tr>
<td>Coding Range</td>
<td>00100-99499</td>
<td>A0021-V5364</td>
</tr>
<tr>
<td>Modifier Range</td>
<td>-20 - 99</td>
<td>A-V</td>
</tr>
<tr>
<td>Updated</td>
<td>Annually</td>
<td>Annually</td>
</tr>
<tr>
<td>Percent of Coding System (Approx.)</td>
<td>80%</td>
<td>15%</td>
</tr>
<tr>
<td>Key Emphasis</td>
<td>Physician</td>
<td>Physician</td>
</tr>
</tbody>
</table>

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How to Use HCPCS

- HCPCS uses the same conventions as the CPT coding system to indicate new, revised, or reinstated codes.

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>▲</td>
<td>New code</td>
</tr>
<tr>
<td>→</td>
<td>Revised code</td>
</tr>
<tr>
<td>✓</td>
<td>Reinstated or recycled code</td>
</tr>
<tr>
<td>×</td>
<td>Deleted words have been removed from this year's edition</td>
</tr>
</tbody>
</table>

- Codes deleted from the previous year’s active list appear with a strikethrough.
- Codes that are not covered by Medicare are noted.
- The notation “carrier discretion” means to contact the carrier for specific coverage information on the code.
- “Special coverage instructions” are designed to reference the online CMS Manual System Pub. 100 manuals.
- Some codes are cross referenced to other Level II HCPCS codes, specific CPT codes or to the CPT manual.
### HCPCS Code Structure

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A codes</td>
<td>Ambulance and transportation services, medical and surgical supplies, respiratory DME, administrative, miscellaneous and investigational services/supplies.</td>
</tr>
<tr>
<td>B codes</td>
<td>Enteral and parenteral therapy services/supplies.</td>
</tr>
<tr>
<td>C codes</td>
<td>CMS Hospital Outpatient Payment System. Medicare ASC and OPPS claims.</td>
</tr>
<tr>
<td>D codes</td>
<td>Dental procedures.</td>
</tr>
<tr>
<td>E codes</td>
<td>Durable medical equipment such as walkers, hospital beds, infusion supplies, etc.</td>
</tr>
<tr>
<td>G codes</td>
<td>Temporary procedures/professional services. As these codes are often changed to CPT® codes within a given time period, these codes should be reviewed and updated annually.</td>
</tr>
<tr>
<td>H codes</td>
<td>Behavioral health and/or substance abuse treatment services.</td>
</tr>
<tr>
<td>J codes</td>
<td>Injectable drugs, which can be injected subcutaneously, intramuscularly or intravenously. Must specify the drug amount injected as these codes specify dosage. Chemotherapy drugs.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>K codes</td>
<td>Temporary codes assigned to durable medical equipment (DME) regional carriers.</td>
</tr>
<tr>
<td>L codes</td>
<td>Orthotic/prosthetic devices and procedures.</td>
</tr>
<tr>
<td>M codes</td>
<td>Medical services, which are either not covered by Medicare or have special coverage instructions.</td>
</tr>
<tr>
<td>P codes</td>
<td>Laboratory services, which are either not covered by Medicare or have special coverage instructions.</td>
</tr>
<tr>
<td>Q codes</td>
<td>Temporary procedures, services and supplies that have special coverage instructions for Medicare.</td>
</tr>
<tr>
<td>R codes</td>
<td>Diagnostic radiology services concerning portable x-rays/EKGs.</td>
</tr>
<tr>
<td>S codes</td>
<td>Temporary National Codes Established by Private Payers</td>
</tr>
<tr>
<td>T codes</td>
<td>Temporary National Codes Established by Medicaid – Not valid for Medicare</td>
</tr>
<tr>
<td>V codes</td>
<td>Vision, audiology and speech-language pathology services.</td>
</tr>
</tbody>
</table>

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The Index

- All main terms are in boldface type
- Main term entries include tests, drugs, medical equipment, services, supplies, orthotics, protheses, therapies and some medical and surgical procedures
- Sub-terms are listed under the main term
- When possible, entries are listed under a “common” main term
- The “common” term may be a noun or a descriptor

Example

1. Main term as a descriptor – Breast prosthesis
   Breast
   prosthesis, L8000-L8039, L8600

2. Main term as a noun – Surgical tray
   Tray
   surgical, A4550

3. Common term – Wheelchair safety belt
   Belt
   Wheelchair, E0978, K0098
Locating HCPCS Codes – in the Index

1. Review the coding documentation and determine what description needs to be coded
2. Identify the main term
3. Locate the main term in the index
4. Look for sub-terms under the main term; look up the meaning of any unfamiliar abbreviations or terms
5. Note the code or code range found under the selected main term or sub-term
6. Locate the code in the alphanumeric list to ensure the specificity of the code. If a code range is provided, review all of the code narratives to determine the specific code
7. Some entries may be listed under more than one main term. If this is the case, review all codes choices
8. **Never code directly from the index.** Always verify the code in the alphanumeric list!

---

HCPCS/CPT Categories

- A0021 - A0999: Transportation Services Including Ambulance
- A4206 - A8004: Medical & Surgical Supplies
- A9150 - A9999: Administrative, Miscellaneous and Investigational
- B4034 - B9999: Enteral & Parenteral Therapy
- C1713 - C9899: CMS Hospital Outpatient Payment System
- D0120 - D9999: Dental Procedures
- E0100 - E8002: Durable Medical Equipment
- F0000 - F9999: Reserved For Future Use
- G0008 - G9472: Temporary Procedures/Professional Services
- H0001 - H2037: Behavioral Health and/or Substance Abuse Treatment Services
- I0000 - I9999: Reserved For Future Use
- J0120 - J8999: Drugs Administered Other than Chemotherapy Drugs (Exception: Oral Chemotherapy Drugs)
## HCPCS/CPT Categories

<table>
<thead>
<tr>
<th>Code Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>J9000 - J9999</td>
<td>Chemotherapy Drugs</td>
</tr>
<tr>
<td>K0001 - K0902</td>
<td>Temporary Codes Assigned to DME Regional Carriers</td>
</tr>
<tr>
<td>L0112 - L4631</td>
<td>Orthotics</td>
</tr>
<tr>
<td>L5000 - L9900</td>
<td>Prosthetics</td>
</tr>
<tr>
<td>M0075 - M0301</td>
<td>Other Medical Services</td>
</tr>
<tr>
<td>N0000 - N9999</td>
<td>Reserved For Future Use</td>
</tr>
<tr>
<td>O0000 - O9999</td>
<td>Reserved For Future Use</td>
</tr>
<tr>
<td>P2028 - P9615</td>
<td>Laboratory Services</td>
</tr>
<tr>
<td>Q0035 - Q9969</td>
<td>Temporary Codes Assigned by CMS</td>
</tr>
<tr>
<td>R0070 - R0076</td>
<td>Diagnostic Radiology Services</td>
</tr>
<tr>
<td>S0012 - S9999</td>
<td>Temporary National Codes Established for Private Payer</td>
</tr>
<tr>
<td>T1000 - T5999</td>
<td>Temporary National Codes Established by Medicaid</td>
</tr>
<tr>
<td>U0000 - U9999</td>
<td>Reserved For Future Use</td>
</tr>
<tr>
<td>V2020 - VS364</td>
<td>Vision, Hearing and Speech-Language Pathology Services</td>
</tr>
<tr>
<td>00000 - 99999</td>
<td>Reserved For CPT Services</td>
</tr>
</tbody>
</table>

## Modifiers

- A modifier is a two-digit numeric or alphanumeric character reported with a code.
- Modifiers are designed to give additional information needed to the commercial and federal payers to process a claim.
- Modifiers are HCPCS Level I codes, which we call CPT® (Current Procedural Terminology) codes and HCPCS Level II codes which we refer to as HCPCS codes.
Appropriate use of a modifier could be when:

- A service or procedure has both a professional and technical component, but both components are not applicable in this case.
- A service or procedure was performed by more than one physician.
- A service or procedure has been increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- A service or procedure was performed more than once.
- Unusual events have occurred.

Modifiers

- Two-digit numerical modifiers that are valid to use with CPT codes are listed in the CPT manual in Appendix A located at the back of the CPT manual.
- The addition of a modifier to CPT and HCPCS codes does not guarantee reimbursement.
- The entire list of modifiers is in CPT; to some coders this may infer an unrestricted application of the modifiers with all CPT codes. There are limitations for reporting of certain modifiers with specific CPT codes.
Modifiers

• Some modifiers are informational only, i.e. -24 and -25, and do not affect reimbursement but can determine if the service will be reimbursed or denied.
• Other modifiers such as -22 for unusual procedural service and -52 for reduced service will usually equate to an increase or decrease in reimbursement.
• There are two levels of modifiers within the HCPCS coding system. Level I (CPT) and Level II (HCPCS Level II) modifiers are applicable nationally for many third-party payers and all Medicare Part B claims.

Modifiers

• There will be times when CMS and commercial payers use modifiers differently than the way CPT intended.
• For instance, the appropriate use of -57 can be confusing. While the CPT manual defines this modifier as an E/M service that resulted in the initial decision to perform surgery, Medicare states that it should be used to indicate that the E/M service performed the day before or day of the surgery resulted in the decision for a major surgery.
HCPCS Modifiers

- In some instances, insurers instruct suppliers that a HCPCS code be accompanied by a code modifier to provide additional information regarding the service or item identified by the HCPCS code.
- Modifiers are used when the information provided by a HCPCS code descriptor needs to be supplemented to identify specific circumstances that may apply to an item or service.
- The level II HCPCS modifiers are either alphanumeric or two letters.

The HCPCS Modifiers Include:

| A modifiers | (AA-AZ) describe the individual providing a service such as AH used by a clinical psychologist to report services. |
| B modifiers | (BP-BU) describe beneficiary informed consent with respect to purchase/rental options. |
| C modifiers | (CC) describe procedure codes that were changed either for administrative reasons or because of an incorrectly filed code. |
| E modifiers | (E1-E4, EJ-ET) describe location (E1-E4--eyelid), ESRD services and emergency dental services. |
| F modifiers | (FA-F9, FP) describe location (FA-F9-hands) or (FP-service provided as part of Medicaid Family Planning Program). |
| G modifiers | (G1-G6, GA-GX) describe most recent URR reading (G1-GS), G8 describes ESRD patient with <6 dialysis sessions in one month, waiver of liability statement on file (GA) and GC, GE which describes services performed by a resident under the supervision of a teaching physician. |
| K modifiers | (K0-K4, KA-KS, KO-KQ) correspond to prosthetics/equipment (K0-K4, KA-KN) and drug unit dose formulation (KO-KQ). |
The HCPCS Modifiers Include:

| L modifiers | (LC-LT) correspond to location (LC, LD, LM, LT), leasing/rental (LL), laboratory services (LR) and intraocular lens implants (LS). |
| M modifiers | (MS) correspond to a six-month maintenance and servicing fee for parts and labor not covered under manufacturer/supplier warranty. |
| N modifiers | (NR, NU) describe conditions of durable medical equipment. |
| P modifiers | (PL) describe progressive addition lenses. |
| Q modifiers | (QG-Q9, QC-QZ) describe temporary procedures, services and supplies such as QW for CLIA waived test. |
| R modifiers | (RC-RT) describe location (RC, RI, RT) or services (Ra, RB, RD, RE, RR). |
| S modifiers | (SF, SG) describe second opinion by professional review organization (PRO) (SF) or Ambulatory Service (ASC) service (SG). |
| T modifiers | (TA-T9, TC) describe location TA-T9 (foot) or technical component (TC). |
| U modifiers | (UE) describes used durable medical equipment. |

Example of HCPCS Modifiers

| -AI  | Principle physician of record (Hospital Care) |
| -AK  | Nonparticipating physician |
| -AY  | Item or service furnished to an ESRD patient that is not for the treatment of ESRD |
| -GA  | Waiver of liability statement issued as required by payer policy, individual case |
| -GC  | This service has been performed in part by a resident under the direction of a teaching physician |
| -GY  | Item or service statutorily excluded, does not meet the definition of any Medicare benefit, or non-Medicare insurers, is not a contract benefit |
Example of HCPCS Modifiers

- **-GZ** Item or service expected to be denied as not reasonable or necessary
- **-PT** Colorectal cancer screening test; converted to diagnostic test or other procedure.
- **-Q6** Service furnished by a locum tenens physician
- **-QW** CLIA-waived test
- **-SF** Second opinion ordered by a professional review organization per Section 9401, P.L.99-272 (100% reimbursement – no Medicare deductible or coinsurance
- **-TC** Technical Component. Under certain circumstances a charge may be made for the technical component alone. Under those circumstances, the technical component charge is identified by adding modifier TC to the usual procedure number; technical component charges are institutional charges and not billed separately by physicians; however, portable X-ray suppliers only bill for technical component and should utilize modifier TC; the charge data from portable x-ray suppliers will then be used to build customary and prevailing profiles.

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X Modifiers

- **-XE** Separate encounter; a service that is distinct because it occurred during a separate encounter.
- **-XS** (Separate structure) A service that is distinct because it was performed on a separate organ/structure
- **-XP** Separate practitioner) A service that is distinct because it was performed by a different practitioner.
- **-XU** Unusual non-overlapping service) The use of a service that is distinct because it does not overlap usual components of the main service

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### Examples of Level I Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>-22</td>
<td>Increased Procedural Services</td>
</tr>
<tr>
<td>-23</td>
<td>Unusual Anesthesia</td>
</tr>
<tr>
<td>-24</td>
<td>Unrelated E/M Service by the Same Physician during a Postoperative Period</td>
</tr>
<tr>
<td>-25</td>
<td>Significant, Separately Identifiable E/M Service by the Same Physician on the Same Day of the Procedure or Other Service</td>
</tr>
<tr>
<td>-26</td>
<td>Professional Component</td>
</tr>
<tr>
<td>-32</td>
<td>Mandated Services</td>
</tr>
<tr>
<td>-33</td>
<td>Preventive Service</td>
</tr>
<tr>
<td>-47</td>
<td>Anesthesia by Surgeon</td>
</tr>
<tr>
<td>-50</td>
<td>Bilateral Procedure</td>
</tr>
<tr>
<td>-51</td>
<td>Multiple Procedures</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>-52</td>
<td>Reduced Services</td>
</tr>
<tr>
<td>-53</td>
<td>Discontinued Procedure</td>
</tr>
<tr>
<td>-54</td>
<td>Surgical Care Only</td>
</tr>
<tr>
<td>-55</td>
<td>Postoperative Management Only</td>
</tr>
<tr>
<td>-56</td>
<td>Preoperative Management Only</td>
</tr>
<tr>
<td>-57</td>
<td>Decision for Surgery</td>
</tr>
<tr>
<td>-58</td>
<td>Staged or Related Procedure/Service by the Same Physician</td>
</tr>
<tr>
<td>-59</td>
<td>Distinct Procedural Service</td>
</tr>
<tr>
<td>-62</td>
<td>Two Surgeons</td>
</tr>
<tr>
<td>-95</td>
<td>Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System</td>
</tr>
<tr>
<td>-99</td>
<td>Multiple Modifiers</td>
</tr>
</tbody>
</table>
Evaluation and Management Codes

**THE ANATOMY OF AN E/M CODE**

1. { 99201
2. { Office or other outpatient visit for the evaluation and management of a
3. { New patient (pt) which requires these
4. { Three key components:

   - a problem focused history;
   - a problem focused examination; and
   - straightforward medical decision making

5. { Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the pt’s and/or family’s (fam) needs.

6. { Usually, the presenting problem(s) are self-limited or minor. Physicians typically spend 10 minutes face-to-face with the pt and/or fam.

7. { Code Numbers 992 – to – 994

   Type and place of service

   Type of pt.

   Number of key components which must be met

   Key components

   Contributory factors

   Time typically spent face-to-face with pt/fam.
### E/M Categories and Sub-Categories

#### Office or Other Outpatient Services
- New Patient: 99201-99205
- Established Patient: 99211-99215

#### Hospital Observation Services
- Observation Care Discharge Services: 99217
- Initial Observation Care (new or established): 99218-99220
- Subsequent Observation Care: 99224-99226

#### Hospital Inpatient Services
- Initial Inpatient Care (new or established): 99221-99226
- Subsequent Inpatient Care: 99231-99233
- Observation or Inpatient Care Services (including Admission and Discharge Services): 99234-99236
- Hospital Discharge Services: 99238-99239

#### Consultations**
- Office or Other Outpatient Consultations (new or established): 99241-99245
- Inpatient Consultations (new or established): 99251-99255

#### Emergency Department Services
- New or Established Patient: 99281-99285
- Other Emergency Services: 99288

#### Critical Care Services
- 99289-99292

#### Nursing Facility Services
- Initial Nursing Facility Care (new or established): 99304-99306
- Subsequent Nursing Facility Care: 99307-99310
- Nursing Facility Discharge Services: 99315-99316
- Other Nursing Facility Services: 99318

#### Domiciliary, Rest Home (eg. Boarding Home), or Custodial Care Services
- New Patient: 99324-99328
- Established Patient: 99334-99337

#### Domiciliary, Rest Home (eg. Assisted Living Facility), or Home Care Plan Oversight Services
- 99339-99340

#### Home Services
- New Patient: 99341-99345
- Established Patient: 99347-99350

#### Prolonged Services
- Prolonged Service With Direct Patient Contact: 99354-99357
- Prolonged Service Without Direct Patient Contact: 99358-99359
- Prolonged Clinical Staff Services With Physician or Other Qualified Health Care Professional: 99415-99416
- Standby Services: 99360

#### Case Management Services
- Anticoagulation Management: 99363-99364
- Medical Team Conference: 99365-99366
- Direct Contact with Patient and/or Family: 99366
- Without Direct Contact with Patient and/or Family: 99367-99368
### Care Plan Oversight Services
- Preventive Medicine Services
  - New Patient: 99381-99387
  - Established Patient: 99391-99397
  - Counseling Risk Factor Reduction and Behavior Change Intervention
    - New or Established Patient: 99401-99404
    - Preventive Medicine, Individual Counseling: 99406-99409
    - Behavior Change Interventions, Individual: 99411-99412
    - Preventive Medicine, Group Counseling: 99420-99429

### Non-Face-to-Face Physician Services
- Telephone Services: 99441-99443
- On-Line Medical Evaluation: 99444
- Interprofessional Telephone/Internet Consultations: 99446-99449

### Special Evaluation and Management Services
- Basic Life and/or Disability Evaluation Services: 99450
- Work Related or Medical Disability Evaluation: 99455-99456

### Newborn Care Services
- Delivery/Birthing Room Attendance and Resuscitation: 99464-99465
- Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services
  - Pediatric Critical Care Patient Transport: 99466-99467
  - Inpatient Neonatal and Pediatric Critical Care: 99485-99486
  - Initial and Continuing Intensive Care Services: 99477-99480

### Care Management Services
- Chronic Care Management Services: 99490
- Complex Chronic Care Management Services: 99487-99490

### Transitional Care Management Services
- Advance Care Planning: 99497-99498

### Other E/M Services
- 99499
Documentation of E/M Services

• This publication provides definitions and documentation guidelines for the three key components of E/M services and for visits which consist predominately of counseling or coordination of care.
• The three key components - history, examination, and medical decision making - appear in the descriptors for office and other outpatient services, hospital observation services, hospital inpatient services, consultations, emergency department services, nursing facility services, domiciliary care services, and home services.
• Documentation guidelines are identified by the symbol DG.

Seven Components used in Defining Levels of E/M Services

1. history
2. examination
3. medical decision making
4. counseling
5. coordination of care
6. nature of presenting problem
7. time
Documentation of E/M Services

• The first three of these components (i.e., history, examination and medical decision making) are the key components in selecting the level of E/M services.

• Because the level of E/M service is dependent on all three key components, performance, and documentation of one component (e.g., examination) at the highest level does not necessarily mean that the encounter in its entirety qualifies for the highest level of E/M service.

Documentation of E/M Services

• These Documentation Guidelines for E/M services reflect the needs of the typical adult population.

• As an example, newborn records may include, under history of the present illness (HPI), the details of mother’s pregnancy and the infant’s status at birth; social history will focus on family structure; family history will focus on congenital anomalies and hereditary disorders in the family.
### New Patient Grid

<table>
<thead>
<tr>
<th>New Patient</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>Initial Visit</td>
</tr>
<tr>
<td>Place of Care</td>
<td>Initial Visit</td>
</tr>
<tr>
<td>Reflexology</td>
<td></td>
</tr>
</tbody>
</table>

#### Medical Decision Making

- **A** - Minimal
- **B** - Limited
- **C** - Moderate
- **D** - High

#### Review of Systems

- **Minimal**
- **Limited**
- **Moderate**
- **High**

#### Diagnosis

- **Problem Focused**
- **Comprehensive**

#### Risk of Complication

- **Minimal**
- **Limited**
- **Moderate**
- **High**

#### Treatment Plan

- **Surgical**
- **Medical**
- **Biological**
- **Other**

#### Follow-up

- **None**
- **Weekly**
- **Monthly**
- **Biennial**

### Established Patient Grid

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Summary

- As it has been demonstrated today, coding is a science that takes practice and patience.
- The basics illustrated in this seminar will help you develop the skills necessary for proper coding.
- However, this is by no means the end of your training. The entire coding system requires constant revisions and updating to stay abreast of the changes that take place.
- While you progress in your coding skills, always keep in mind the basics.

ICD-10-CM

- Find the condition in the alphabetic index.
- Verify the code in the Tabular section and identify the highest specificity
- Review the chapter-specific coding guidelines
- Follow all Note all parenthetical terms that help in code selection but do not affect code assignment.
- Pay close attention to all instructions (“See also”, “With”/”Without”, “Code first”/”Use additional code”, etc).
- Use the place holder “X” when needed.
- Include 7th character if needed.
- Never code directly from the index.
**CPT®**

- Review the coding documentation and determine what services needs to be coded
- Identify the main term
- Select the procedure or service that accurately describes what is supported by documentation and look them up in the index (e.g., organ, anatomic site, condition, synonyms, eponyms, abbreviations).
- Read the introduction to the section for instructions and guidelines.
- Review the guidelines at the beginning of each section.
- Pay attention to symbols and notes.
- Be sure the code completely describes the procedures performed; modify if necessary.
- Be sure the code matches documentation.
- **Never code directly from the index. Always code from the Tabular section.**

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**HCPCS**

- Review the coding documentation and determine what description needs to be coded
- Identify the main term
- Locate the main term in the index
- Look for sub-terms under the main term; look up the meaning of any unfamiliar abbreviations or terms
- Note the code or code range found under the selected main term or sub-term
- Locate the code in the alphanumeric list to ensure the specificity of the code. If a code range is provided, review all of the code narratives to determine the specific code
- Some entries may be listed under more than one main term. If this is the case, review all codes choices
- Note any symbols that may indicate coverage or other information.
- **Never code directly from the index. Always verify the code in the main alphanumeric list!**
Questions?

• Thank you for your attendance!

• Get your questions answered on PMI’s Discussion Forum:
  http://www.pmimd.com/pmiForums/rules.asp