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Meet the Presenter…

On the topic:
The ABCs of CPT Coding

Maxine Collins,
MBA, CPA, CMC, CMIS, CMOM
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The ABCs

A. **Accurate CPT© Coding – Why is it so Important?**

B. **Billing efficiencies that maximize reimbursement for services rendered, while maintaining…**

C. **Compliancy in coding and billing that is substantiated by the medical record documentation.**

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**Introduction**

- This presentation focuses on the needs of new coders and highlights the importance of correct coding to achieving maximum reimbursement for the physician and other healthcare provider while assuring that he/she remains in compliance with all Federal and state rules and regulations. Of utmost importance as well is accomplishing the goals of patient satisfaction, office productivity and efficiency.

- Some of the topics covered include:
  - Understanding the importance of assigning the correct, appropriate CPT© code(s) on a CMS claim form - that is substantiated by the underlying documentation.
  - Understanding how HIPAA rules under the Administrative Simplification section apply to CPT©.
  - Learning to navigate through your manual to appropriately locate and assign codes.
  - Understanding how current computer technologies can aid in coding correctly and efficiently.
  - Reviewing the importance of proper use of Modifier(s) and when required.
  - Dealing with unbundling, fragmenting, and modifiers.
Who Benefits From Accurate Coding?

- Patients pay premiums and they want results.
- Medical staff receive fewer rejected claims, operate more efficiently, and avoid fraud and abuse allegations when coding properly.
- Insurers stand to profit with incorrectly submitted claims by delaying ultimate payment. However, claims that are coded properly will mean less work for them and they know it.
- Physicians – It’s how they are reimbursed and protects against fraud and abuse.

Why Is It Important to Code Properly?

- Correct coding is key to submitting appropriate claims. To ensure claims are accurate, it is necessary to use valid codes that capture all services provided as substantiated by the documentation in the medical record.

What Are the Objectives of Third-Party Payers?

- They are obligated to pay benefits under policies sold.
- Customer satisfaction.
- Satisfy executives of corporations who purchase insurance for their firms, paying hefty premiums in the process.
- SAVE MONEY - MAKE A PROFIT.
Health Insurance Portability and Accountability Act of 1996

• It’s the Law
• Health care providers, health plans, payers, and other HIPAA-covered entities must comply with Administrative Simplification.
• The requirements apply to all providers who conduct electronic transactions, not just providers who accept Medicare or Medicaid.
• Enforcing Administrative Simplification requirements is essential to ensuring the health care community reaps the benefits of standardized transactions and reduced administrative costs.

Code Sets Overview

• Under HIPAA, HHS adopted specific code sets for diagnoses and procedures used in all transactions.
  – About Code Sets
    • Code sets classify medical:
      – Diagnoses
      – Procedures
      – Diagnostic tests
      – Treatments
      – Equipment and supplies
    • They inform diverse health care functions, from billing to tracking public health.
  – HIPAA Code Sets
    • Code sets outlined in HIPAA regulations include:
      – ICD-10 – International Classification of Diseases, 10th edition
      – Health Care Common Procedure Coding System (HCPCS)
      – CPT – Current Procedure Terminology
      – CDT – Code on Dental Procedures and Nomenclature
      – NDC – National Drug Codes
What is CURRENT PROCEDURAL TERMINOLOGY (CPT)?

• “The Language of Coding”
• CPT is a listing of descriptive terms and identifies codes for reporting medical services and procedures performed by physicians.
• The first volume appeared in 1966 and was published by the AMA. The main purpose of CPT is to provide a standard and uniform language to communicate among patients, doctors and third-party payers.
• Each procedure, service or supply has a five-digit numerical code. A number system is used to simplify the reimbursement process for insurance carriers, eliminating the need to read lengthy reports for services.
• These five-digit numbers can be modified by adding a two-digit number to give additional information about the service.

CPT

• Sections are set up anatomically. They take the body and go outside to inside, top to bottom, front to back.
• Each code describes something different and unique. Codes can change each year. Outdated codes do not get reimbursed well, if at all.
• Each major section of CPT has its own set of rules, notes and instructions. Coders MUST read these in order to code properly.
• The CPT code set is published ANNUALLY. With hundreds of additions, deletions and revisions each year, coders must have access to new books each calendar year and be prepared for use by the January 1 effective date.
• CPT is a part of a larger system of coding for government claims called the Healthcare Common Procedure Coding System (HCPCS)
HCPCS – Categories of Codes

- **Level I – National**
  - CPT – Physician Services – Category I
    - Created by AMA to report physician services.
    - Codes are numeric (12001) with two digit modifiers (22).
    - Level II modifiers may be used in conjunction with Category I codes.
  - CPT - Performance Measurement – Category II
    - Created by AMA to reduce the need for record abstraction.
    - Tracking for quality of care compliance.
    - Numeric/alpha (0001F) Do not replace Category I CPT codes.
  - CPT – Emergent Technology – Category III

- **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).
    - These codes are primarily for non-physician services.
    - They include ambulance, dental, durable medical equipment, medications, and other services.
### HCPCS Compared

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>LEVEL I CPT</th>
<th>LEVEL II National</th>
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<td>CMS</td>
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<tr>
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<td>-22</td>
<td>TC</td>
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<tr>
<td>Coding Range</td>
<td>00100-99607</td>
<td>A0021-V5364</td>
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<td>AA-ZZ</td>
</tr>
<tr>
<td>Updated</td>
<td>Annually</td>
<td>Quarterly/Published Annually</td>
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### CMS Levels I and II

<table>
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<tr>
<th>CODE RANGE</th>
<th>CODE DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level I:</td>
<td>Reserved for CPT - Anesthesia Services</td>
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<tr>
<td>00000 to 09999</td>
<td>Reserved for CPT</td>
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<td>Reserved for CPT</td>
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<tr>
<td>Level II:</td>
<td>Transportation services including ambulance</td>
</tr>
<tr>
<td>A0000 to A0999</td>
<td>Transportation services including ambulance</td>
</tr>
<tr>
<td>A2000 to A2999</td>
<td>Chiropractic Services - Codes deleted. See CPT.</td>
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<tr>
<td>A4000 to A9999</td>
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<td>B4000 to B9999</td>
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<td>C1000 to C9999</td>
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<tr>
<td>D0000 to D9999</td>
<td>Dental procedures</td>
</tr>
<tr>
<td>E0100 to E9999</td>
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</tr>
<tr>
<td>G0000 to G9999</td>
<td>Temporary Procedures/Professional Services</td>
</tr>
<tr>
<td>H0001 to H9999</td>
<td>Behavioral Health and/or Substance Abuse Treatment Services</td>
</tr>
</tbody>
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**Introduction to the CPT Manual**

Let’s take a tour!

- 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 affected.
- The main body of the Category 1 section in the CPT manual is listed in six sections. Each section is divided into subsections with anatomic/procedural condition, or description subheading.
## Major Sections

<table>
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<th>Codes</th>
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<tr>
<td>Anesthesiology</td>
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<tr>
<td>Surgery</td>
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<td>Radiology (Including Nuclear Medicine and Diagnostic Ultrasound)</td>
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<tr>
<td>Pathology and Laboratory</td>
<td>80047 – 89398</td>
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<td>Medicine</td>
<td>90281 – 99199, 99500 – 99607</td>
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<tr>
<td>Category II Codes</td>
<td>0001F – 7025F</td>
</tr>
<tr>
<td>Category III Codes</td>
<td>0019T – 0328T</td>
</tr>
</tbody>
</table>

## Symbols – Back of Front Cover of the Professional edition

Symbols are used to show changes from one year to the next. They warn the coder of a change, deletion, alteration or new code. Symbol is located before the number for one edition only and then becomes a standard code in subsequent annual printings.

- **●** New procedure (this "bullet" is placed before the number)
- **▲** Changed or altered procedure description from last edition (triangle placed before number)
- **圈子** Exempt from Modifier 51
- **+** Add-on Code
- **⊙** Conscious/Moderate Sedation Included
- **/\** Pending FDA Approval
- **#** Out of Numerical Sequence Code
Major Sections

• The Appendix
  – Appendix A-P gives additional information on modifiers, summaries of added, deleted and revised codes, as well as examples.

• The Index
  – procedures (biopsy, ligation, incision and drainage)
  – anatomic sites (nerve, ligament, mandible, tibia)
  – conditions (neoplasm, miscarriage, fracture, paralysis)
  – synonyms (E B Virus – Epstein Barr Virus, Factor VIII – Clotting Factor)
  – eponyms (names for a person, i.e. Marshall-Marchetti-Krantz procedure)
  – abbreviations (CBC, ESRD, EEG, TMJ)

To Locate a Code

1. Check for the procedure performed.
2. Check for organ involved.
3. If neither is listed, try the condition or key word from 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
• In subsequent codes, the second part changes, but the first part remains the same, but is not reprinted.

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 (i.e., common, plantar, flat), milia, or other benign, premalignant (i.e., 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”
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.
• These must be read and followed in order 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.
• Review the emerging technology Category III codes before choosing to use an unlisted code or a listed code with modifiers.
(Separate Procedure)

- Some of the listed procedures are commonly carried out as integral parts of a total service, and as such, do not warrant a separate identification.
- When, however, such a procedure is performed independently of, and is not immediately related to, other services, it may be listed as a "separate procedure."
- Thus, when a procedure that is ordinarily a component of a larger procedure is performed alone for a specific purpose, it may be considered to be a separate procedure.

Proper Coding with CPT

1. Identify the procedures, tests, services, equipment, supplies, etc. from the source document (i.e., superbill, medical records, etc.). Look for any modifying or extenuating circumstances.
2. Identify 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 use codes from the main body of CPT.
7. Ensure you have followed all notes and guidelines at the beginning of the section.
Proper Coding with CPT

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 have to utilize "unlisted procedure" codes in that section. Only use these as a last resort. Submit with a 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 (and therefore "charged") 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.

Surgery Section

• GENERAL: Codes 10021–10022. This section describes fine needle aspiration codes.

• Integumentary System. Codes 10030 – 19499. This section covers procedures on the skin, subcutaneous and accessory structures, nail and breast. Included are the removal/destruction of lesions, plastic repairs, burns and other surgeries.
Specific guidelines for this subsection

- Debridement
- Biopsy
- Removal of Skin Tags
- Excision, benign/malignant lesions
- Wound/Laceration Repairs
- Adjacent Tissue Transfer or Rearrangement
- Skin Replacement Surgery and Skin Substitutes
- Application of Skin Replacements and Skin Substitutes
- Skin Grafts

Integumentary System Exercises (Codes 10030 – 19499)

1. Fine needle aspiration, without imaging guidance

2. Total excision of 2.75 cm for malignant lesion of arm. (Margins of 1.25 cm included)

3. Biopsy of six lesions. Two on face, one on leg, and three on patient’s back.

4. Excision of benign lesion of trunk, excised diameter over 4.0
Musculoskeletal System

- **Codes 20005 – 29999.** This section describes procedures on the supporting structures of the body, which include the bones, muscles and tendons. Casting and strapping is included.
  - **Subcategories**
  - **General Guidelines**
Musculoskeletal System Exercises (Codes 20005 – 29999)

1. Segmental mandibular osteotomy with genioglossus advancement
2. Sequestrectomy for osteomyelitis forearm/uina
3. Percutaneous skeletal fixation of distal radius fracture due to falling down the stairs at home.

Answers

Musculoskeletal System Exercises (Codes 20005 – 29999)

<table>
<thead>
<tr>
<th>Exercise</th>
<th>Code</th>
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</thead>
<tbody>
<tr>
<td>1. Segmental mandibular osteotomy with genioglossus advancement</td>
<td>21199</td>
</tr>
<tr>
<td>2. Sequestrectomy for osteomyelitis forearm/uina</td>
<td>25145</td>
</tr>
<tr>
<td>3. Percutaneous skeletal fixation of distal radius fracture due to falling down the stairs at home.</td>
<td>25606</td>
</tr>
<tr>
<td>4. Closed treatment of coccygeal fracture.</td>
<td>27200</td>
</tr>
</tbody>
</table>
Respiratory System

- **Codes 30000 – 32999.** This section covers services associated with the nose, sinuses, larynx, trachea, bronchi, lungs and pleura.
  - When coding respiratory surgical procedures, the diagnostic scope performed for introduction &/or exploration of the surgical procedure is bundled as a part of the procedure.
  - Lung allotransplantation involves three distinct components of physician work:
    - Cadaver donor pneumonectomy(s)
    - Backbench work
    - Recipient lung allotransplantation
  - These components of physician work are a part of all transplantation services.

Respiratory System Exercises
(Codes 30000 – 32999)

1. Excision nasal polyps, extensive  ____________
2. Thoracoscopy with diagnostic biopsies of lung infiltrates, unilateral.  ____________
3. Submucous resection of the nasal septum.  ____________
4. Laryngoscopy, direct, operative, with foreign body removal; with operating microscope.  ____________
Cardiovascular System

- **Codes 33010 – 37799.** This section covers the surgical procedures on the cardiac and vascular systems as well as the heart, veins and arteries.
- **Shunt** – A defect in the wall of the heart that allows blood from different chambers to mix so a shunt is placed to reroute the flow of blood.
- **Stent** – A stent is a tiny tube placed into an artery, blood vessel, or other duct to hold the structure open. Most of the time, stents are used to treat conditions that result when arteries become narrow or blocked.
- **Occlusion** – The partial or complete obstruction of blood flow in a coronary artery, as by a thrombus or the progressive buildup of atherosclerotic plaque.
- **Percutaneous** – Passed, done, or affected through the skin; certain heart conditions can be treated using nonsurgical (percutaneous) methods that use catheters.
- **Ischemia** – Reduced blood supply of the heart muscle
## Cardiovascular System Exercises (Codes 33010 – 37799)

1. Arterial catheterization for prolonged infusion therapy.  

2. Collection of blood specimen from a completely implantable venous access device.  


4. Transcatheter placement of an intravascular stent, percutaneous, initial vein.  

## Answers

<table>
<thead>
<tr>
<th>Exercise Description</th>
<th>Code</th>
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<tbody>
<tr>
<td>Arterial catheterization for prolonged infusion therapy</td>
<td>36640</td>
</tr>
<tr>
<td>Collection of blood specimen from a completely implantable venous access device</td>
<td>36591</td>
</tr>
<tr>
<td>Ruptured aneurysm repair, axillary-brachial artery.</td>
<td>35013</td>
</tr>
<tr>
<td>Transcatheter placement of an intravascular stent, percutaneous, initial vein.</td>
<td>37238</td>
</tr>
</tbody>
</table>
Digestive System

- **Codes 40490 – 49999.** This section includes procedures on the mouth and associated structures, salivary glands and ducts, pharynx, adenoids, tonsils, esophagus, stomach, intestines, appendix, rectum and anus, liver, biliary tract, pancreas, abdomen, peritoneum, omentum, as well as hernia repair.
  - Several types of endoscopic procedures are categorized in this section;
  - Codes are assigned based on the technique used, not the number of lesions, tumors and/or polyps removed;
  - Additional procedures performed on the same anatomical site or sites are assigned modifier 51;
  - When multiple anatomical sites are involved, each code for a specific separate site is assigned modifier 59.

Digestive System Exercises
(Codes 40490 – 49999)

1. Cryosurgical ablation of three liver tumors, open procedure, with/ultrasonic guidance

2. Mesh repair on incarcerated open incisional hernia

3. Laparoscopy, placement of adjustable gastric restrictive device.

4. Destruction of lesions in anus using cryosurgery.
Urinary System

- **Codes 50010 – 53899.** This section covers procedures on kidney, ureter, bladder and urethra. Surgical techniques include:
  - Cystoscopy
  - Urethroscopy
  - Cystourethroscopy
  - Renal Pelvis Catheter Procedures
  - Laparoscopy
  - Urodynamics
## Urinary System Exercises (Codes 50010 – 53899)

1. Cystourethroscopy with insertion of indwelling ureteral stents.
2. Transurethral incision of the prostate for benign hypertrophic prostatitis.

## Answers

<table>
<thead>
<tr>
<th>Urinary System Exercises (Codes 50010 – 53899)</th>
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<tr>
<td>1. Cystourethroscopy with insertion of indwelling ureteral stents.</td>
</tr>
<tr>
<td>2. Transurethral incision of the prostate for benign hypertrophic prostatitis.</td>
</tr>
<tr>
<td>3. Biopsy of the bladder.</td>
</tr>
</tbody>
</table>
Male Genital System

- **Codes 54000 – 55899.** This section covers procedures on the penis, testis, epididymis, tunica vaginalis, scrotum, vas deferens, spermatic cord, seminal vesicles and prostate. Procedures included in this subsection:
  - Circumcision (based on the patient’s age)
  - Vasectomy
  - Prostate procedures
  - Laparoscopic procedures may be used for males or females;
  - When two or more procedures are performed laparoscopically, the subsequent procedures should be reported only when time and risk factors justify additional consideration for reimbursement.

Male Genital System Exercises
(Codes 54000 – 55899)

1. Simple-destruction of three lesions of the penis using cryosurgery. ____________
2. Newborn clamp circumcision. ____________
3. Bilateral vasectomy with three postoperative semen examinations. ____________
4. Implant of a three-piece inflatable penile prosthesis. ____________
Reproductive System Procedures

- **Code 55920.** Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application.
  - Only one code exists in this section.
Female Genital System

• **Codes 56405 – 58999.** This section covers procedures on the vulva, perineum and introitus, vagina, cervix uteri, corpus uteri, oviduct/ovary, and in vitro fertilization.

Female Genital System Exercises (Codes 56405 – 58999)

1. Colposcopy with multiple biopsies of the cervix uteri.
   
2. Destruction of a 2.5 cm vaginal lesion.

3. Surgical laparoscopy with lysis of adhesions.

4. Hysteroscopy with biopsy of the endometrium.
Maternity Care and Delivery

- **Codes 59000 – 59899.** This section covers antepartum, and postpartum care, delivery (vaginal, cesarean and delivery after previous cesarean delivery). Abortion is also covered in this section.
  - The global maternity care package consists of the antepartum, delivery and postpartum care of the patient.
Maternity Care and Delivery
Exercises (Codes 59000 – 59899)

1. Vaginal delivery.

2. Treatment of tubal ectopic pregnancy, abdominal approach.

3. Transabdominal amniinfusion, including ultrasound guidance.


Answers

<table>
<thead>
<tr>
<th>Maternity Care and Delivery Exercises (Codes 59000 – 59899)</th>
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<tr>
<td>2. Treatment of tubal ectopic pregnancy, abdominal approach.</td>
<td>59121</td>
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<tr>
<td>3. Transabdominal amniinfusion, including ultrasound guidance.</td>
<td>59070</td>
</tr>
<tr>
<td>4. Hysterorrhaphy of ruptured uterus.</td>
<td>59350</td>
</tr>
</tbody>
</table>
Endocrine System

• **Codes 60000 – 60699.** This section covers procedures to the thyroid gland, parathyroid, thymus, adrenal gland and carotid body. Note – For pituitary and pineal surgery, see the nervous system.

Endocrine System Exercises
(Codes 60000 – 60699)

1. Partial thyroid lobectomy, unilateral; with isthmusectomy.
   
   ______________________

2. Complete thyroidectomy.
   
   ______________________

3. Excision of carotid body tumor; with excision of carotid artery.
   
   ______________________

4. Aspiration of thyroid cyst.
  
   ______________________
Nervous System

- **Codes 61000 – 64999.** This section covers procedures to the skull, meninges, brain, spine and spinal cord (Note: for fracture or dislocation see musculoskeletal system), extracranial nerves, peripheral nerves, and autonomic nervous system. Procedures in this section are categorized as follows:
  - Approach
  - Definitive
  - Repair/reconstruction
  - Arthrodesis
  - Corpectomy
  - Diskectomy
  - Laminecetomy
  - Laminotomy
Nervous System Exercises (Codes 61000 – 64999)

1. Epidural injection of anesthesia agent, lumbar, single level.
2. Burr holes to drain an abscess of the brain.
3. Suture of a lacerated digital nerve in the hand.

Answers

<table>
<thead>
<tr>
<th>Nervous System Exercises (Codes 61000 – 64999)</th>
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<td>1. Epidural injection of anesthesia agent, lumbar, single level.</td>
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<td>2. Burr holes to drain an abscess of the brain.</td>
<td>61150</td>
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<td>3. Suture of a lacerated digital nerve in the hand.</td>
<td>64831</td>
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<tr>
<td>4. Craniotomy for repair of encephalocele, base of skull.</td>
<td>62121</td>
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</tbody>
</table>
Eye and Ocular Adnexa

- **Codes 65091 – 68899.** This section covers procedures to the eyeball, anterior segment, posterior segment, ocular adnexa, and conjunctiva. Note- For diagnosis and treatment services (i.e., ophthalmological examinations and refractions) see the medicine section.

Eye and Ocular Adnexa Exercises (Codes 65091 – 68899)

1. Probing of nasolacrimal duct requiring general anesthesia.

2. Removal of a foreign body embedded in the eyelid.

3. Strabismus surgery involving the lateral rectus muscle.

4. Drainage of abscess in eyelid.
Auditory System

- **Codes 69000 – 69979.** This section covers procedures to the ear, external, middle and inner, the temporal bone and middle fossa approach. This section does not include diagnostic services such as audiometry and vestibular tests - see the medicine section.
Auditory System Exercises (Codes 69000 – 69979)

1. Revision mastoidectomy resulting in a radical mastoidectomy.

2. Removal of impacted cerumen of ear, requiring instrumentation.

3. Cochlear device implantation.

4. Removal of foreign body from external auditory canal with general anesthesia.

Answers

Auditory System Exercises (Codes 69000 – 69979)

<table>
<thead>
<tr>
<th>Exercise</th>
<th>Code</th>
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<td>1. Revision mastoidectomy resulting in a radical mastoidectomy.</td>
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<td>2. Removal of impacted cerumen of ear, requiring instrumentation.</td>
<td>69210</td>
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<tr>
<td>3. Cochlear device implantation.</td>
<td>69930</td>
</tr>
<tr>
<td>4. Removal of foreign body from external auditory canal with general anesthesia.</td>
<td>69205</td>
</tr>
</tbody>
</table>
Unbundling/Fragmenting

• **Unbundling**
  – Global packages include pre-op, intra-operative and post-op services as explained previously. The physician is not allowed to bill separately for the various parts of the global package.

• **Example:**
  – 47600 - Cholecystectomy - includes hospital admission (H & P), the surgical procedures, post-op visits in and out of hospital for 90 days, and services to take care of complications not requiring an additional trip to the operation room.
  – For Medicare, the global fee for office surgery also includes all supplies, which may not be billed separately (with a few exceptions mentioned earlier). For private insurance, each company should be contacted to find out what is/isn't included.

Unbundling/Fragmenting

• **Fragmenting**
  – All surgical procedures are made up of various steps: operative approach (incision, scope), each step of the surgery, and closure of the operative wound. The physician is not allowed to code each step and charge for it separately. The notation "(Separate procedure)" at the end of the code description is your warning that this code is a part of, or one step, in a larger procedure and cannot be used unless that procedure was the **ONLY** one performed at that time (See Appendix for list of fragmented codes).
Unbundling/Fragmenting

• Example:
  – Diagnosis: Abdominal swelling, mass or lump, right upper quadrant – R19.01
  – Procedure: A physician should not fragment the procedure into its component parts. For example, if a physician performs an upper gastrointestinal endoscopy with biopsy of the stomach, the physician should report CPT code 43239 (Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate: with biopsy, single or multiple).
  – As a result, it is improper to unbundle this procedure and report CPT code 43235 (Upper gastrointestinal endoscopy… diagnostic…), plus code 43605 (Biopsy of the stomach…), since 43605 is not intended to be utilized with an endoscopic procedure code. (Excerpt from the National Correct Coding Policy Manual for Part B Medicare Carriers).

Add-On Codes (+)

• Some of the listed procedures are commonly carried out or performed in addition to the primary procedure.
• All add-on codes are exempt from the multiple procedure rules in CPT.
• These codes do not require the use of the -51 modifier (see Appendix E of the CPT Coding Manual for more information).
Modifiers

• Modifiers are extremely important in coding. A modifier is a two-digit number that "modifies" or alters the five-digit code to give a third-party payer the reason payment should be altered from the usual for that procedure code.

• Key reasons why modifiers are utilized with CPT codes:
  1. A service or procedure has both a professional and a technical component.
  2. A service is performed by more than one physician and/or in more than one location.
  3. A service has been increased or reduced.
  4. Only part of a service was performed.
  5. An adjunctive service was performed.
  6. A service or procedure was provided more than once.
  7. Unusual events occurred.
  8. A service was provided during a global period but is not included as part of the global reimbursement.

Before Using any Modifier

• Establish the need to change a procedure code.
• Identify how the code needs to be changed.
  – Example: Code says too much, not enough, partially correct, unusual circumstance, etc.
• Identify which modifier to use. Read the entire description of the modifier to be sure if completely applies to the procedure performed.
• Include documentation if necessary to describe circumstances not mentioned by code or modifier.
• A complete list of modifiers applicable to CPT codes can be found in Appendix A of CPT.
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

Modifier Exercises

1. Dr. Jones performed an appendectomy on William Tell. However, the operation took twice as long as usual because William weighs 375 pounds. Which modifier should be appended to the surgical procedure?

2. Dr. Williams performed a biopsy on the right external ear of Misty Johnson, a 71-year old female. Which HCPCS modifier will Medicare require you to append to the procedure code?

3. Lucy Hammons, a 45-year-old female, goes to see Dr. Velasquez at the referral of her family physician, Dr. Phil, for his opinion as to whether or not she needed surgery. After the evaluation and Lucy’s agreement, Dr. Phil schedules surgery for Monday. Which modifier should be appended to Dr. Phil’s consultation code for today’s evaluation?
## Answers

1. Dr. Jones performed an appendectomy on William Tell. However, the operation took twice as long as usual because William weighs 375 pounds. Which modifier should be appended to the surgical procedure?

   -22

2. Dr. Williams performed a biopsy on the right external ear of Misty Johnson, a 71-year old female. Which HCPCS modifier will Medicare require you to append to the procedure code?

   -RT

3. Lucy Hammons, a 45-year-old female, goes to see Dr. Velasquez at the referral of her family physician, Dr. Phil, for his opinion as to whether or not she needed surgery. After the evaluation and Lucy’s agreement, Dr. Phil schedules surgery for Monday. Which modifier should be appended to Dr. Phil’s consultation code for today’s evaluation?

   -57

## Modifier Exercises

4. Kris Kringle, a 50-year-old male, comes to see Dr. Snow for a complete physical examination, required by his insurance carrier. Which modifier should be appended to the procedure code?

5. Carlo Monterey, a 20-year old male, hurt his shoulder while camping. The clinic in the area took the x-ray, but did not have a radiologist, so Carlo brought the films to Dr. Daniel for interpretation and evaluation. Which modifier should Dr. Daniel’s coder append to the code for the x-rays?

6. Dr. Welby, and his surgical team, began the pancreatic transplantation procedure on MariLou. Once the incision had been made, the patient’s heartbeat became erratic and could not be brought back under control, so the procedure was discontinued. The procedure code reported requires two modifiers.
Questions?

- Thank you for your attendance!
- Get your questions answered on PMI's Discussion Forum:
  http://www.pmimd.com/pmiForums/rules.asp