ICD-9, CPT/E/M's & HCPCS Coding Updates 2010

Presented by: Deanna Stops, CPC,CPC-H, CPC-I, IHS

ICD–9–CM

- OVERVIEW
- NO DEFINITIVE DIAGNOSIS?
- PRIMARY, SECONDARY DX'S
- CO-MORBIDITIES, HISTORY OF DX'S

Medicare

- All patient visits must have valid diagnosis codes
- Exclude ambulance suppliers
- All patient visits should be coded to the highest specificity

Additional Diagnoses

- What are secondary diagnoses, co-morbidities, and History Of categories?
- Combination codes and multiple codes
- Diabetic Manifestations 250.XX
- CHF – 428.0

- CHF – 428.0
- Results of fluid collection in lungs, HTN, congestion, and edema of tissue.
- If documented by the provider as due to or complicated by:
  - Hypertension
  - Pulmonary Edema
  - Asthma

- Cellulitis - Location, identify bacteria after study, lab cultures. Underlying diseases.
- Pain Management – Location, type of tx
- Aftercare – Therapies -cardiac rehab, PT, fx's
- **With the exception** of radiotherapy, chemo, and immunotherapy for neoplastic conditions

- Late effects – A condition produced after an acute phase of an illness or injury has resolved. No time limit for these conditions. First code the condition described for the late effect, and then the code for late effect.
- Code these due to complication factors
- If the medical documentation supports or defines medical necessity

NO DEFINITIVE DIAGNOSIS?

- Signs, Symptoms, & Lab Findings

Signs, Symptoms, & Lab Findings

- Every time treatment is administered, a diagnosis must be identified/coded.
- If the diagnosis has not been established, it is appropriate to document the symptoms.
- Medical documentation must support code assignment

- Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when an established diagnosis has NOT been determined by the physician

- V01-V89.09
  - Assigned as first-listed diagnosis for:
    - Admissions for evaluation
    - Following an accident that would ordinarily result in health problem, BUT there is none
  - Car accident, driver hits head, no apparent injury, admit to R/O head trauma – V71.4
  - Never a secondary diagnosis

- Who is paying attention?

Uses of ICD–9–CM

- Fiscal entities track health care costs
- The tracking of diagnosis codes are used to determine usage of health care which leads to establishing health care costs
- RAC audits not just for CPT coding but for medical necessity.

Uses of ICD–9–CM

- Research…
  - Can predict health care trends
  - Assist in meeting future healthcare needs
    - Newer cancer centers are built if patient use warrants

Uses of ICD–9–CM

- Use and results are evident every day
  - Newscaster reference to number of AIDS cases
  - Newspaper article about measles epidemic
  - H1N1 outbreak across the nation

ICD–9–CM Principles/Practices

Four groups function together to maintain ICD–9–CM:

- Centers for Medicare and Medicaid Services (CMS), formerly known as Health Care Financing Administration (HCFA)
- National Center for Health Statistics (NCHS)
- American Health Information Management Association (AHIMA)
- American Hospital Association (AHA)

Your Job

- Translate documentation into ICD–9–CM codes
  - Bell's Palsy = 351.0
- Assign code to highest level of specificity
- Medical record must substantiate diagnosis code assignment

Ethics

- Coders need to an have in-depth knowledge of medical terminology, anatomy/physiology, and pharmacology
- Coders need to understand medical documentation, coding guidelines, terminology, and coding conventions

Ethics

- Documentation must support diagnosis
- For Example:
  - For services provided the diagnosis justifies services
- If in doubt, check it out; don't make assumptions

Format of the ICD-9-CM

- Volume 1, Diseases, Tabular List (diagnosis) (17 chapters)
- Volume 2, Diseases, Alphabetic Index (diagnosis) (3 sections)
- Volume 3, Procedures, Tabular List and Alphabetic Index (Inpatient)

Volume 1, Diseases, Tabular List

- Contains code numbers
- 001.0-999.9 Diagnosis codes describe condition
- V and E codes = Supplemental information
- Two major divisions
  - Classification of Diseases and Injuries (codes 001.0- 999.9)
  - Supplementary Classification (V codes and E codes)

Volume 2, Diseases, Alphabetic Index

- Appears first in book (may vary with publishers)
- Terms and code numbers verified in Volume 1
- **Never code directly from Index!**
- Read all notes and follow instructions (e.g., see also)
- Tables (e.g., Drugs/Chemicals, Hypertension, Neoplasm)

Volume 2, Sections

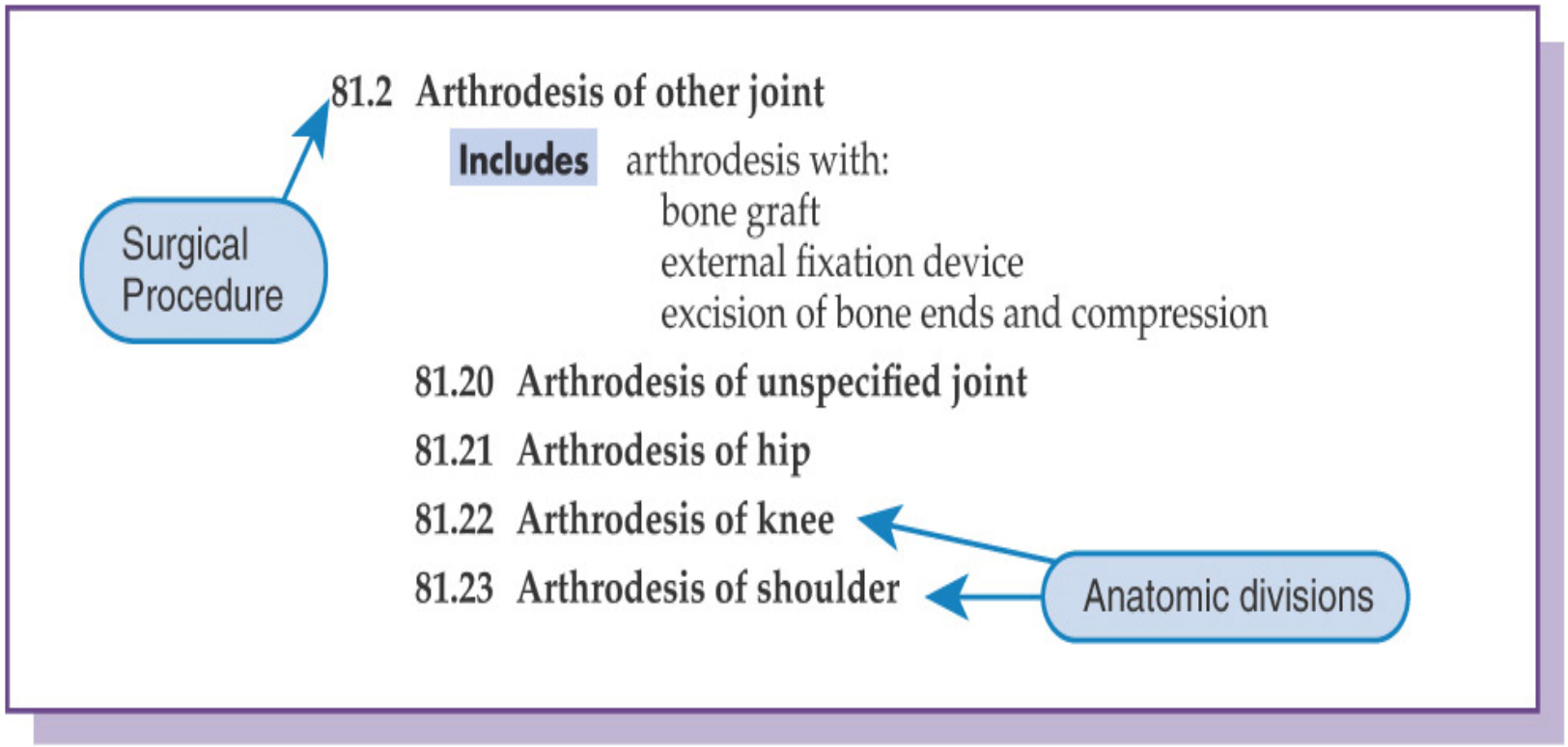
- Section 1, Index to Diseases
- Section 2, Table of Drugs and Chemicals
- Section 3, Index to External Causes of Injuries and Poisonings (E Codes)
  - Never primary diagnosis
  - Medicare does not accept for professional billing

Volume 3, Procedures, Tabular List and Alphabetic Index

- Not used for physician services
- Index and Tabular List used for procedures and therapies
- Inpatient settings only
- Procedures and therapies
- Maximum 4 digits
  - 20.41 Simple mastoidectomy

Volume 3, Procedures

Figure: 2.14



Volume 3, Surgical procedures. (Modified from Buck CJ: *2010 ICD-9-CM, Volumes 1, 2, & 3, Professional Edition,* St. Louis, 2010, Saunders.)

- 90% of codes refer to surgical procedures

Volume 3, Procedures

- Procedures done in physician's office or outpatient ASC are coded using CPT codes
  - Surgeon uses CPT to report services to inpatients
- Volume 3, Procedure codes are used by hospitals to code facility services provided to inpatients

V Codes (V01.0-V89.09)

- Patient not ill but encounters health services
  - e.g., Vaccination
- Patient presents for treatment
  - e.g., Chemotherapy
- Some V codes are primary only (e.g., V58.11, encounter for chemotherapy)
- Factors that influence patient's health status
  - e.g., Personal history of [PHO] malignant tumor, organ transplant
  - Birth status and outcome of delivery

V Codes…

- “History of” codes (V10-V19) may be used as secondary codes if:
  - **Impacts** current care or treatment
  - Supports additional ancillary services
  - Personal and family history can support high risk conditions or assist in monitoring a condition through test and therapy

E Codes (E800-E999)

- Supplementary Classification of External Causes of Injury and Poisoning
- Alpha-numerical designations for injuries and poisonings
- Provides additional information about external causes
- Never a principal (inpatient) diagnosis
- Separate E code index

E Codes (E800-E999)

- Provides additional information about external causes
- Never a principal (inpatient) diagnosis
- Separate E code index
  - Locate the E Code index in your ICD-9-CM now

Appendices A - E

- **Appendix A**: Morphology of Neoplasms
  - Used in conjunction with codes from Chapter 2, Neoplasm
- **Appendix B**: Glossary of Mental Disorders, Deleted 2004
- **Appendix C**: Drugs
- **Appendix D**: Industrial Accidents
- **Appendix E**: Three Digit Categories

ICD-9-CM Documents Medical Necessity

- Diagnoses establish medical necessity
- Services and diagnoses must correlate
- Correct diagnosis codes allow:
  - Accurate reimbursement
  - Fewer rejected claims
  - Reduced risk of sanctions/fines from audit

Primary/Principal Dx's

- The condition established after study is chiefly responsible for patient to present for healthcare services/appt.
- When two or more of the diagnoses equally meet the criteria for principal diagnosis, either condition can be sequenced first.
  - Consider the circumstances of diagnostic workup/therapy provided (labs, procedures/x-rays)

Selection of First-Listed Diagnosis

- Condition for encounter
  - What patient presented, is not necessarily most serious condition noted
- Documented
- Chiefly responsible for services provided
- Also list co-existing conditions

Sequencing Diagnosis

- Code, if applicable, any causal condition first
- May be primary diagnosis if no causal condition is applicable, known, or documented
- Instructional note in Tabular List

Code, If Applicable, Any Causal Condition First

Example: 707.10, Ulcer of lower limb, except decubitus; states:

- Chronic venous hypertension with ulcer (459.31)

- If ulcer caused by chronic venous hypertension:
  - First: 459.31 chronic venous hypertension
  - Second: 707.10 ulcer of lower limb

Primary, Secondary Dx's

- Etiology = Course of disease
- Manifestation = Symptom
- Etiology + Manifestation = Combination codes
  - Diabetes = Disease
  - Chronic Kidney Disease (CKD) = Symptom
  - Sequence the disease first, and then sequence the manifestation

Multiple Coding

Kimmelstiel (-Wilson) disease or syndrome
(intercapillary glomerulosclerosis) 250.4 *[581.81]*

Etiology, first code, diabetes

Manifestation, second code, nephrosis

Modified from Buck CJ: *2010 ICD-9-CM, Volumes 1, 2, & 3, Professional Edition,* St. Louis, 2010, Saunders.

No combination code, use individual code(s) in this order

- **250.4x & 581.81**

Acute and Chronic Conditions

- If the same condition is described as both acute and chronic, and separate subentries exist in the alphabetic index at the same indentation level, code both the acute and chronic condition, and sequence the acute code first.

For example:

- Acute/Chronic Sinusitis
- Acute Sinusitis = 461.0 – 461.9
- Chronic Sinusitis = 473.0 – 473.9

How specific should your ICD-9 code be?

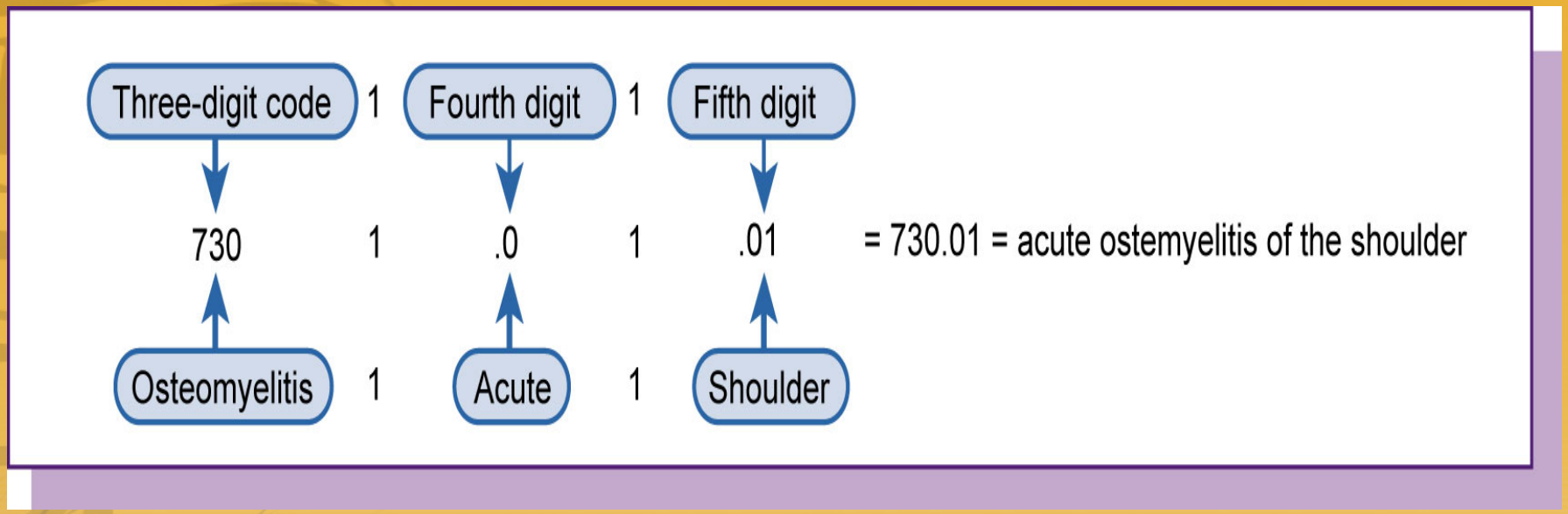
- Assign to the highest level possible, based on documentation
- If 4-digit code exists, do not report 3-digit code
- If 5-digit code exists, do not report 4-digit code

Highest level of specificity

- 3-digit code used ONLY if no 4 or 5 digit code
- Where 4 and/or 5 digits are provided, they must be assigned to provide greater specificity (detail)
- Diagnoses NOT coded to full digits available are **invalid**
- Claims bounce!

Specificity in ICD-9-CM Codes

Figure: 2.9



- Each digit adds to the specificity (detail)

Diagnosis Coding

- Based on Official Guidelines
  Reports diagnosis based on latest physician's diagnosis
  - Includes pathologist and radiologist

Diagnosis Coding—Outpatient

- Each report stands on its own to report service. Example:
- Patient presents with “cough”
  - Reports diagnosis as cough
- Physician orders chest x-ray
- Radiologist’s diagnosis is “pneumonia”
  - Reports diagnosis as pneumonia
- If radiology report is available at time of coding, both services reported with “pneumonia”

Inpatient Coding

- Services reported at end of hospital stay
  - All medical documents available at that time
- Facility (hospital) coders also report outpatient services provided in outpatient departments
  - Report based on outpatient guidelines

Remember

- Assign to the highest level possible, based on documentation
- If 4-digit code exists, do not report 3-digit code
- If 5-digit code exists, do not report 4-digit code

Uses of V Codes

- Not sick BUT receives health care (e.g., vaccination)
- Services for known/resolving disease/injury (e.g., chemotherapy)
- Codes for “aftercare” (e.g., surgery or fracture)
- A circumstance/problem that influences patient’s health, but **NOT** current illness/injury
  - Example: Organ transplant status
  - Example: Birth status and outcome of delivery (newborn)

Diagnostic Guideline I

- Do **NOT** code diagnoses documented as probable, suspected, questionable, rule out, or working diagnoses
- Rather, **code** condition(s) to suspected highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for visit

CPT Coding – Evaluations and Management

Three Factors of E/M Codes

- Place of service
- Type of service
- Patient status

Place of Service

Explains setting of service

- Office
- Emergency department
- Nursing home

Type of Service

Physicians provide many types of services

Examples:

- Consultations
- Admissions
- Office visits

Four status types

- New patient
- Established patient
- Outpatient
- Inpatient

New Patient

- Has not received any face-to-face service in past 3 years from:
  - The physician
  - From another physician of the same specialty and in same the group
- New patients more labor intensive for physician and staff

Established Patient

- Has received face-to-face services in past 3 years from:
  - The physician
  - Another physician of **same specialty** in same group
- Medical record available with current, relevant information

Outpatient

- Patient who has **not** been admitted to a health care facility

  Example:
  Patient receives services at clinic
  or same-day surgery center

Inpatient

- Patient who has been formally admitted to a health care facility
  - Physician dictates:
    - Admission orders
    - H&P
    - Request for consultations

Levels of E/M Service Based On

1. Nature of presenting problems
2. **Skill** required to provide service
3. **Time** spent
4. Level of **knowledge** necessary to treat patient
5. **Effort** required
6. **Responsibility** required/assumed
    - Key components are stated on the certification examination

E/M Levels Are Divided Based On

- Key components (KC)
  - History
  - Examination
  - Medical decision making
- Contributory factors (CF)
  - Counseling
  - Coordination of care
  - Nature of presenting problem

Encounters

- Every encounter contains varying amounts of KC & CF
- **More** of each component/factor
  - Higher level of service
- **Less** of each component/factor
  - Lower level of service

Four Elements of a History

1. Chief Complaint (CC)
2. History of Present Illness (HPI)
3. Review Of Systems (ROS)
4. Past, Family, and/or Social History (PFSH)

Chief Complaint (CC)—Subjective

- Reason for encounter
  - Patient's current complaint usually presented in patient's own words
- Documented in medical record for each encounter

History of Present Illness (HPI)

- Subjective information provided by patient regarding:
  - Development of CC
  - Location
  - Quality
  - Severity
  - Duration
  - Timing
  - Context
  - Modifying factors
  - Associated signs and symptoms
- Provider must document

HPI on Audit Form

- HPI Elements

HPI elements →

HISTORY ELEMENTS	Documented
HISTORY OF PRESENT ILLNESS (HPI)	
1. Location (site on body)	✗
2. Quality (characteristic: throbbing, sharp)	✗
3. Severity (1/10 or how intense)	✗
4. Duration* (how long for problem or episode)	✗
5. Timing (when it occurs)	✗
6. Context (under what circumstances does it occur)	✗
7. Modifying factors (what makes it better or worse)	✗
8. Associated signs and symptoms (what else is happening when it occurs)	✗
*Duration not in CPT as an HPI Element — TOTAL	8
LEVEL	

Figure: 1.1

Review of Systems (ROS)

- Depends on CC
  - Example: Not usually review of musculoskeletal system for CC of chest pain
- Situations in which the patient cannot discern differences
  - Example: Patient who sustained trauma from an auto accident

ROS *(Continued)*

- Constitutional—general, fever, weight
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary
- Neurologic
- Psychiatric
- Endocrine
- Hematologic
- Allergic/ immunologic

Past, Family, and/or Social History PFSH)

- **Past and social history** contains relevant information about past
  - Major illnesses/injuries
  - Operations
  - Hospitalizations
  - Immunizations
  - Dietary status
  - Sexual history
  - Other relevant social factors
- Past includes present medications
- Social includes tobacco and alcohol use

Four History Levels

1. Problem focused
2. Expanded problem focused
3. Detailed
4. Comprehensive

Problem-Focused History

- Brief history focused on CC
- HPI
- No PFSH
- No ROS

Expanded Problem-Focused History

- Brief history focused on CC
- HPI
- No PFSH
- ROS as it pertains to presenting problem

Detailed History

- Extended history
- HPI
- Pertinent PFSH
- Extended ROS

Comprehensive History

- Extended history
- HPI
- Complete PFSH
- Comprehensive ROS

Summary of Elements Required for Each Level of History

		Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
History	HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
	ROS	None	Problem-pertinent 1	Extended 2-9	Complete 10+
	PFSH	None	None	Pertinent 1	Complete 2-3

Examination

- Four levels of examination
  - Problem focused
  - Expanded problem focused
  - Detailed
  - Comprehensive

Problem-Focused Examination

- Affected body area and/or organ system
- One of either BA or OR

Expanded Problem-Focused Examination

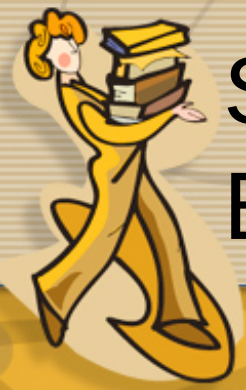
- Affected body area and/or organ system
- Other related body area(s) and/or organ system(s)
- 2-3 BA or OR (or combinations)

Detailed Examination

- Extended examination of affected body area(s) and/or related organ system(s)
- Up to 7 BA or OR (or combinations)

Comprehensive Examination

- Eight or more organ systems
- Eight or more BA or OR, combinations



Summary of Elements Required for Each Level of Examination (1995)

	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
Examination	Limited to affected BA or OS	Limited to affected BA or OS and other related OS(s)	Extended of affected BA(s) and other related OS(s)	8+

Medical Decision Making (MDM) Complexity

- Based on number of possible diagnoses and/or treatment options
- **Based on number of possible diagnoses and/or various ways condition can be treated

Three Elements of Medical Decision Making (MDM)

1. Number of diagnostic or management options
   - Minimal, limited, moderate, or extensive
2. Amount and/or complexity of data to be reviewed by physician
   - Minimal, limited, moderate, or extensive
3. Risk of complications or death
   - Minimal, low, moderate, or high

Risks

- Risks of morbidity (poor outcome), complications, or mortality (death) with problem and/or treatment
- Other diseases or factors that affect outcome

  Examples
  - Diabetes
  - Extreme age

Risks

- Urgency as it relates to risks

  Examples:

  - Myocardial infarction
  - Ruptured appendix

Four Risk Levels

1. Minimal
2. Low
3. Moderate
4. High

Risk Levels (cont.)

1. Minimal: Self-limited
   - Wasp bite

Risk Levels (cont.)

2. Low: Several minimal levels or one level that is more than minimal
   - Multiple wasp bites

Risk Levels (cont.)

3. Moderate
   - One chronic condition
     - Diabetes
   - Two or more stable but chronic conditions
     - Controlled high blood pressure and diabetes
   - Undiagnosed condition with unknown prognosis
     - Example: Breast lump
   - Acute illness
     - Example: Pneumonia

Risk Levels (cont.)

4. High
   - One or more chronic illnesses with severe current exacerbation

   Example:
   - Malignant hypertension and uncontrolled diabetes Illness or injury that is life-threatening

   Examples:
   - Myocardial infarction
   - Cardiac arrest

MDM Elements

- MDM Complexity Elements

MDM ELEMENTS	Documented
# OF DIAGNOSIS/MANAGEMENT OPTIONS	
1. Minimal	
2. Limited	
3. Multiple	✗
4. Extensive	
LEVEL	3
AMOUNT AND/OR COMPLEXITY OF DATA TO REVIEW	Documented
1. Minimal/None	
2. Limited	
3. Moderate	✗
4. Extensive	
LEVEL	3
RISK OF COMPLICATION OR DEATH IF NOT TREATED	Documented
1. Minimal	
2. Low	
3. Moderate	✗
4. High	
MDM LEVEL	3

Figure: 1.11

MDM Levels

Figure: 1.12

MDM*	1	2	3	4
	Straightforward	Low	Moderate	High
Number of DX or management options	Minimal	Limited	Multiple	Extensive
Amount or complexity of data	Minimal/None	Limited	Moderate	Extensive
Risks	Minimal	Low	Moderate	High
			MDM LEVEL	3

*To qualify for a given type of MDM complexity, 2 of 3 elements in the table must be met or exceeded.

Levels of MDM

MDM level

- Levels of MDM complexity
- To qualify for a given type of MDM complexity, 2 of 3 elements must be met or exceeded.

Contributory Factors

1. Counseling
2. Coordination of care
3. Nature of presenting problem
4. Time

1. Counseling (face-to-face)

- Provided to patient or family members
- Discussion of diagnosis, test results, impressions, recommendations
- Medical documentation must support that more than 50% of visit was counseling

2. Coordination of Care (face-to-face)

- Work done on behalf of patient by physician to provide care

  Example: Arrangements made for admission to a rehabilitation hospital or nursing facility

3. Nature of Presenting Problem

- Type of problem patient presents to physician
- Foundation upon which the key components are factored

4. Time

- Direct face-to-face: Physician and patient together
- Time: Documentation must support patient in/out, 50% of total time spent counseling.
  Example: Clinic visit or at bedside in hospital
- To use to assign code, beginning and ending times documented in medical record
- Unit/Floor: Time spent by physician on patient's unit or floor, also at patient's bedside
  Example: Reviewing patient records or at chart desk and then with patient

Types of Presenting Problems

- Minimal
- Self-limiting
- Low
- Moderate
- High

Minimal Presenting Problem

- May not require a physician
  Example: A dressing change or removal of an uncomplicated suture

Self-Limiting Presenting Problem

- Self-limiting problems are minor and with a good outcome predicted
  Examples: Sore throat or a slightly irritated skin tag

Low-Risk Presenting Problem

- Without treatment, low risk
  Example: A middle-aged healthy male with an upper respiratory infection

Moderate-Risk Presenting Problem

- Without treatment, moderate risk Example: An elderly male with pneumonia

High-Risk Presenting Problem

- Without treatment, high risk Example: An elderly male in very poor health with severe pneumonia

Hospital Observation Status (99217-99220 and 99234-99236)

- Not officially admitted to a hospital
- Patient not ill enough to admit but is too ill not to be monitored
- Read notes at beginning of subsection
- Observation services are **not** codes for “inpatient” services

Hospital Observation

- Observation admission can only be reported for **first** day of service by admitting physician
- When patient admitted on observation status and discharged on same day
  - Use code from 99234-99236 (Observation or Inpatient Care Services category)

Hospital Observation

- Patient in hospital overnight for observation but **less** than **48 hours**
  - 1st day: 99218-99220 (Initial Observation Care)
  - 2nd day: 99217 (Observation Care Discharge Services)

Hospital Observation

- If observation stay longer than 48 hours
  - 1st day: 99218-99220 (Initial Observation Care)
  - 2nd day: 99212-99215 (Established Patient, Office or Other Outpatient)
  - 3rd day: 99217 (Observation Care Discharge)

Initial Observation Care

- Services immediately prior to admission bundled into observation service
  Example: Office visit prior to observation, bundled into observation service
- CAH - PPS

Hospital Inpatient Services (99221-99239)

- Officially admitted to a hospital setting
- **Total** (all day and night)
- **Partial** (all day and no night, or all night and no day, or a variation)

Types of Physician Status

- **Attending:** Primary or admitting physician
- **Consultant:** Physician whose opinion and advice are requested by attending physician

Types of Care

- **Concurrent care** given to patient by multiple physicians of different specialties

  Example: Pulmonologist and cardiologist both treating patient for different conditions at same time

Three Types of Hospital Inpatient Services

1. Initial – (99221 – 99223)

   First service includes admission

   - Initial paperwork
   - Initial plans and orders

- Used only once for each admission

Types of Hospital Inpatient Services

2. Subsequent Hospital Care (99231 – 99233)

- After initial service
- Physician reviews patient's progress using documentation, information received from nursing staff, examination of patient

Hospital Discharge Services

3. Hospital Discharge Services (99238, 99239)

- Final day of hospital stay when patient was in hospital for more than 1 day
- Documentation indicates final patient status
- Codes based on time
  - Time does not need to be continuous
- Beginning and ending time or total time must be documented to assign extended discharge code

Final Status of Patient

- Condition
- Medications
- Plan for return to physician
- How hospital stay progressed
- Discharged to home, nursing facility, etc.
- Only **attending** physician can use a discharge code
- Code is based on time spent in service
- Beginning and ending time must be documented or use lowest-level code

Consultation Services (99241-99255)

- Another physician's opinion or advice is requested
- Either inpatient or outpatient
- Request must be from appropriate source
- Requires three R's

  - Request, Render, Report

  To report to Medicare vs Private Payers

Emergency Department (ED) Services (99281-99288)

- Codes for new and established patients
- Qualified ED (AKA: ER) must be open 24 hours a day, unscheduled visits
- Typically provided by ED staff

Critical Care & ED Codes

- ED services often require additional codes from Critical Care Services
  - Example: Multiple organ failure
- Critical Care Services are provided to patients in **life-threatening situations**
- Codes are time based
  - Total time of less than 30 minutes is reported with appropriate E/M code

Critical Care Services (99291 and 99292)

- 99291 & 99292 are used to report length of time a physician spends caring for critically ill patient
- 99291: 30-74 minutes
- 99292: Each additional 30 minutes
- Codes report inpatient CC for patients <5 years
- Outpatient CC services for all patients regardless of age
  - Except CC transport >24 months

Prolonged Services (99354-99359)

- Time codes for inpatient and outpatient
- For face-to-face patient contact or non-face-to-face patient services
- Codes for first 30-74 minutes
- If less than 30 minutes, do not report service as prolonged
- **ADD ON CODE:**
  - Report in addition to primary E/M service

CPT Modifiers

- Used to describe alterations to CPT code
- Full list, CPT, Appendix A:
  - Anesthesia Physical Status Modifiers
  - Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use
  - Level II HCPCS/National Modifiers

Modifier Functions

- Altered service
  (i.e., more or less)
- Altered circumstance
  (i.e., repeat; unrelated)
- Bilateral
- Multiple
- Only portions of service
  (i.e., professional service only)
- More than one surgeon

CPT Modifier

- 22 – Unusual/Increased Procedural Services
  Not used with E/M's
- 23 - Unusual Anesthesia
- 24 - E/M service not related to surgery is separately billable; If E/M provided during post-op global period, no separate payment for usual post-op care related to the surgical procedure.
- Used on E/M codes

25 - Significant, Separately Identifiable E/M Service

- 25- Significant, Separately Identifiable E/M Service by the Same Physician on the same day of the Procedure or Other Service
- Documentation must support service

  Example: Patient seen for sinus congestion, physician performs H&P, prescribes decongestant, notes lesion on back, and removes
- Code: Procedure + E/M-25

-26 Professional Component

- Professional Component (physician = 26)
- Technical Component (technician + equipment =TC)

  Example: Radiologist reviews x-rays taken by supervised technician at a facility

  Radiologist -26

  Technician -TC

-32 Mandated Service

- 32- Mandated Service,by payer, workers' comp, or official body
- Example: Workers' comp requests examination of person currently receiving disability benefits
- 47- Anesthesia by Surgeon, Append to Procedure code

- 50 – Bilateral Procedure

  Example: Same procedure on both hands

  Caution: Some codes describe bilateral procedures, do not use -50
- 51- Multiple Procedures
- 52- Reduced Services

- 53- Discontinued Services, Do not use when:
  - -Patient cancels scheduled procedure
  - -With E/M codes
  - -With time-based code
- 54- Surgical care only
- 55- Post Operative Management Only

- 56- Preoperative Management Only
- 57- Decision for Surgery

  -Used with E/M 99201 – 99499, and

  -Medicine Opthamologic Services 92012 & 92014

  -Day before or day of surgery

- 58- Staged/Related by Same Physician During Postoperative Period
  - Example: Multiple skin grafts completed in several sessions
  - Global period starts over

59 Distinct Procedural Service

- Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day.

  This modifier is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances.

  Documentation must support a different session, different procedure or surgery, different site or organ system.

- 62- Two Surgeons
- 63- Procedure Performed on Infants less than 4 kg
- 66- Surgical Team
- 76- Repeat Procedure or Services by Same Physician
- 77- Repeat Procedure by Another Physician

- 78- Unplanned Return to the Operating/Procedure Room by the Same Physician following Initial Procedure for a Related Procedure During the Postoperative Period
- 79- Unrelated Procedure or Service by **Same** Physician During Postoperative Period
- 80- Assistant Surgeon

- 90- Reference (Outside) Laboratory
- 91- Repeat Clinical Diagnostic Laboratory Test
- 92- Alternative Laboratory Platform Testing
- 99- Multiple Modifiers

-90 Reference (Outside) Laboratory

- Physician has business relationship with outside lab
- Physician pays lab
- Physician bills payer for lab services

-91 Repeat Clinical Diagnostic Laboratory Test

- Repeat same laboratory tests on same day for multiple test results
- Not tests rerun to confirm original test results
- Not malfunction of equipment or technician error

-92 Alternative Laboratory Platform Testing

- Used to report a laboratory test using portable instrument or kit
- Usually single use
  - 86701–86703 HIV testing

Example: 86701-92

-99 Multiple Modifiers

- Used when service needs more than one modifier but payer only allows for one modifier with each code

HPI on Audit Form

- HPI Elements

HPI elements →

HISTORY ELEMENTS		Documented
HISTORY OF PRESENT ILLNESS (HPI)		
1. Location (site on body)		✗
2. Quality (characteristic: throbbing, sharp)		✗
3. Severity (1/10 or how intense)		✗
4. Duration* (how long for problem or episode)		✗
5. Timing (when it occurs)		✗
6. Context (under what circumstances does it occur)		✗
7. Modifying factors (what makes it better or worse)		✗
8. Associated signs and symptoms (what else is happening when it occurs)		✗
**Duration not in CPT as an HPI Element*	TOTAL	8
	LEVEL	

Figure: 1.1

HPI Levels

Figure: 1.2

History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	**Brief 1-3**	**Brief 1-3**	**Extended 4+**	**Extended 4+**
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	None	None	Pertinent 1	Complete 2-3
			HISTORY LEVEL	4

HPI levels

- HPI Levels

ROS on Audit Form

- ROS Elements

ROS elements →

REVIEW OF SYSTEMS (ROS)	Documented
1. Constitutional (e.g., weight loss, fever)	
2. Ophthalmologic (eyes)	✗
3. Otolaryngologic (ears, nose, mouth, throat)	✗
4. Cardiovascular	
5. Respiratory	✗
6. Gastrointestinal	✗
7. Genitourinary	✗
8. Musculoskeletal	
9. Integumentary (skin and/or breasts)	
10. Neurological	✗
11. Psychiatric	✗
12. Endocrine	
13. Hematologic/Lymphatic	
14. Allergic/Immunologic	
TOTAL	7
LEVEL	

Figure: 1.3

ROS Levels

Figure: 1.4

History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	**None**	**Problem Pertinent 1**	**Extended 2-9**	**Complete 10+**
PFSH	None	None	Pertinent 1	Complete 2-3
			HISTORY LEVEL	

ROS levels

- ROS Levels

PFSH on Audit Form

PFSH elements →

PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)	Documented
1. Past illness, operations, injuries, treatments, and current medications	✗
2. Family medical history for heredity and risk	✗
3. Social activities, both past and present	✗
TOTAL	3
LEVEL	

Figure: 1.5

- PFSH Elements

PFSH Levels

Figure: 1.6

History Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+
PFSH	**None**	**None**	**Pertinent 1**	**Complete 2-3**
			HISTORY LEVEL	

PFSH levels

- PFSH Levels

Completed History Section of Audit Form

- Completed History Section

HISTORY ELEMENTS		Documented	
HISTORY OF PRESENT ILLNESS (HPI)			
1. Location (site on body)		✗	
2. Quality (characteristic: throbbing, sharp)		✗	
3. Severity (1/10 or how intense)		✗	
4. Duration* (how long for problem or episode)		✗	
5. Timing (when it occurs)		✗	
6. Context (under what circumstances does it occur)		✗	
7. Modifying factors (what makes it better or worse)		✗	
8. Associated signs and symptoms (what else is happening when it occurs)		✗	
*Duration not in CPT as an HPI Element	TOTAL	8	
	LEVEL	4	HPI level
REVIEW OF SYSTEMS (ROS)		Documented	
1. Constitutional (e.g., weight loss, fever)			
2. Ophthalmologic (eyes)		✗	
3. Otolaryngologic (ears, nose, mouth, throat)		✗	
4. Cardiovascular			
5. Respiratory		✗	
6. Gastrointestinal		✗	
7. Genitourinary		✗	
8. Musculoskeletal			
9. Integumentary (skin and/or breasts)			
10. Neurological		✗	
11. Psychiatric		✗	
12. Endocrine			
13. Hematologic/Lymphatic			
14. Allergic/Immunologic			
	TOTAL	7	
	LEVEL	3	ROS level
PAST, FAMILY, AND/OR SOCIAL HISTORY (PFSH)		Documented	
1. Past illness, operations, injuries, treatments, and current medications		✗	
2. Family medical history for heredity and risk		✗	
3. Social activities, both past and present		✗	
	TOTAL	3	
	LEVEL	4	PFSH level

History Level	1	2	3	4	
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive	
HPI	Brief 1-3	Brief 1-3	Extended 4+	Extended 4+	
ROS	None	Problem Pertinent 1	Extended 2-9	Complete 10+	
PFSH	None	None	Pertinent 1	Complete 2-3	
			HISTORY LEVEL	4	History level

Figure: 1.7

Examination Elements—Objective

- Examination Elements

EXAMINATION ELEMENTS	Documented
CONSTITUTIONAL (OS)	
• Blood pressure, sitting	✗
• Blood pressure, lying	
• Pulse	✗
• Respirations	✗
• Temperature	
• Height	
• Weight	
• General appearance	✗
(Count as only 1) NUMBER	1
BODY AREAS (BA)	Documented
1. Head (including face)	
2. Neck	✗
3. Chest (including breasts and axillae)	
4. Abdomen	✗
5. Genitalia, groin, buttocks	
6. Back (including spine)	
7. Each extremity	
NUMBER	2
ORGAN SYSTEMS (OS)	Documented
1. Ophthalmologic (eyes)	✗
2. Otolaryngologic (ears, nose, mouth, throat)	✗
3. Cardiovascular	✗
4. Respiratory	✗
5. Gastrointestinal	✗
6. Genitourinary	
7. Musculoskeletal	
8. Integumentary (skin)	
9. Neurologic	
10. Psychiatric	
11. Hematologic/Lymphatic/Immunologic	✗
NUMBER	6
TOTAL BA/OS	9 (7) ← Total BA/OS

Figure: 1.8

Examination Levels

Figure: 1.9

Exam Level	1	2	3	4
	Problem Focused	Expanded Problem Focused	Detailed	Comprehensive
	Limited to affected BA/OS	Limited to affected BA/OS & other related OS(s)	Extended of affected & other related OS(s)	General multi-system (OSs only)
# of OS or BA	1	2-7 limited	2-7 extended	8+
			EXAMINATION LEVEL	3

Examination level

- Examination Levels

Summary of Elements Required for Each Level of MDM

- Only 2 of 3 categories must meet or exceed the element stated to assign the level

	Straightforward	Low	Moderate	High
Number of diagnoses or management options	Minimal	Limited	Multiple	Extensive
Amount or complexity of data to review	Minimal/None	Limited	Moderate	Extensive
Risk	Minimal	Low	Moderate	High

Risk

- Presenting problems
- Diagnostic procedures
- Management options

TABLE 1–1

EXAMPLES OF LEVELS OF RISK

Levels of Risk	Presenting Problem or Problems
Minimal (Level 1)	One self-limited or minor problem (e.g., insect bite, tinea corporis)
Low (Level 2)	Two or more self-limited or minor problems One stable, chronic illness (e.g., well-controlled hypertension or non-insulin dependent diabetes, cataract, benign prostatic hypertrophy) Acute, uncomplicated illness or injury (e.g., cystitis, allergic rhinitis, simple sprain)
Moderate (Level 3)	One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment Two or more stable chronic illnesses Undiagnosed new problem with uncertain prognosis (e.g., lump in breast) Acute illness with systemic symptoms (e.g., pyelonephritis, pneumonitis, colitis) Acute complicated injury (e.g., head injury with brief loss of consciousness)
High (Level 4)	One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment Acute or chronic illnesses or injuries that pose a threat to life or body function (e.g., multiple trauma, acute myocardial infarction, pulmonary embolus, severe repository distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure) An abrupt change in neurologic status (e.g., seizure, transient ischemic attack, weakness, or sensory loss)

Auditing Tools

- Handouts available for 1995–1997

HCPCS Changes for 2010

HCPCS Updates

- HCPCS Level II Modifiers
- **AI** Principal physician of record
- AAPC Rationale:
  CMS no longer recognizes consultation services (CPT® 99241-99255), instructing instead, “Outside the context of telehealth services [G0425, G0426, G0427], physicians will bill an initial hospital care or initial nursing facility care code for their first visit during a patient’s admission to the hospital or nursing facility in lieu of the consultation codes these physicians may have previously reported.”

  Modifier AI is appended to differentiate services provided by the admitting physician of record from those of any consultants, for initial hospital inpatient and nursing facility admissions

- **Coordination of Care/Demonstration Project Items and Services**
- **G9141 Influenza a (H1N1) immunization administration (includes the physician counseling the patient/family)**
- **G9142 Influenza a (H1N1) vaccine, any route of administration**
- **AAPC Rationale**

  Effective Sept. 1, report code G9142 to describe the H1N1 vaccine supply, and one unit of G9141 for each administration of the H1N1 vaccine.

  Under the Medicare physician fee schedule, G9141 and G9142 have been assigned status indicator "X," indicating these codes represent an item or service that is not within the statutory definition of "physicians' services" for MPFS payment purposes. The H1N1 vaccine will be supplied at no cost to providers. Payment for G9141 will be the same as that for G0008 Administration of influenza virus vaccine.

- G0009 Administration of pneumococcal vaccine, which currently are based on CPT® code 90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid). Beneficiary copayment and deductible do not apply.

Drugs Administered Other Than Oral Method

- ***J0559:*** **Injection, Penicillin G Benzathine and Penicillin G Procaine, 2500 units**

AAPC Rationale:

- **Penicillin G Benzathine and Penicillin G Procaine are used to treat streptococcal and pneumococcal infections.**
- **To allow for more precise dosage reporting using a single code with a units multiplier J0530, J0540, and J0550 have been deleted, to be replaced by J0559, which specifies “2500 units.”**

- **J7611:** Albuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, 1 mg
- **J7612:** Levalbuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, concentrated form, 0.5 mg
- **J7613:** Albuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose, 1 mg
- **J7614:** Levalbuterol, inhalation solution, FDA-approved final product, noncompounded, administered through DME, unit dose, 0.5 mg

- **Albuterol (Proventil®, Proventil® HFA, Proventil® Repetabs, Vetolin®, Volmax®) and levalbuterol (Xopenex®)** are bronchodilators.

  The drugs block the actions of enzymes that cause the smooth muscles within the respiratory tract to contract, thereby allowing easier breathing. Albuterol and Levalbuterol are indicated for the prevention and relief of bronchospasm in patients with reversible obstructive pulmonary disease, and for the prevention of exercise-induced bronchospasm. These codes were reinstated in 2009 after having been deleted eight months earlier.

  The codes and descriptors have not changed; however, as of July 1, 2009 supply of these drugs received a payment indicator of “D,” meaning no payment is made. These include DME billable only by an enrolled supplier to the DME MAC and drugs and supplies billable by other providers and suppliers, such as ESRD facilities.

Chemotherapy Drugs

- **J9155** Injection, Degarelix, 1 mg
- AAPC Rationale:
- Degarelix (Firmagon®) is FDA-approved for treatment of patients with advanced hormone-dependent prostate cancer.
- Prostate cancer is the most common form of cancer in men, and the second leading cause of cancer death.

Orthotic Devices - Spinal

L0210, L1800, L1815, L1825, L1901, L2770, and L2861 (deleted)

AAPC Rationale:

- In April 2009, CMS made the determination that elastic garments do not meet the statutory definition of a brace because elastic garments are not rigid or semi-rigid devices, and labeled these items as non-covered with no benefit category on that date. The codes are deleted effective Jan. 1, 2010.

Temporary National Codes (Non-Medicare)

- **S0605** Digital rectal examination, male, annual
- AAPC Rationale:

  This change was revised to specify “male,” effective November 1, 2009 and is deleted effective Jan. 1, 2010. For digital rectal examination of a male, report G0102 *Prostate cancer screening; digital rectal examination,* or consider it part of the evaluation and management service billed with a CPT® code

J codes

- Appendix 1 – Table of Drugs
- ‘Unit Per’ are inclusive of all quantities up to and including the listed amount.
- ‘Route of Administration’ is the most common methods of delivering the drug in pharmaceutical info
- ‘IV’ includes all methods, infusion, timed pushes.
- ‘Var’ various routes of administration into joints, cavities, tissue, etc.
- ‘Othr’ administrations suppositories or catheters injections.
- Do not code from the index look up (Appendix 1)

- This information about the new HCPCS Level II code changes, is not intended to replace your code books.
- There are many other changes and revisions; however, these changes are seen more often as direct care services for I/T/U's facilities.

Coding Books

- Current year, complete code books are important tools that every coder requires to do the job.

Websites

Co-surgeons, Bilateral and Global Days:
http://www.trailblazerhealth.com/Tools/Fee%20Schedule/MedicareFeeSchedule.aspx

NCCI Edits:
http://www.cmshhs.gov/NationalCorrectCodinitEd/NCCIEP/list.asp#TopofPage

The End... Questions?