Basic CPT Coding Review

June 20, 2013  10 am - 12 Noon MDST

© Irene Mueller, EdD, RHIA

Objective
Assign correct CPT codes by applying knowledge of
• Basic CPT coding conventions, and
• Basic CPT coding process.
CPT

- Common Procedural Terminology
- AMA publishes annually (since 1966)
- Provides a uniform language (nomenclature)
- Seeks to convey as much info as possible in single code
- Widely performed medical, surgical, dx proc.
- Code for procedure does NOT mean 3rd party payers will reimburse

CPT History

- 1966 – first published, 4-digit numbers
- 1970 – 5-digit numbers introduced
- 1983 – CPT adopted as part of HCPCS
  - Mandated to report MC Part B physician serv.
- 1986 – CPT required for MA reporting
  - OBRA Act mandated CPT for Outpt Hospital surgical procedures
- 1996 – HIPAA data sets
CPT Hx

• 1996 – HIPAA code sets
  – CPT/HCPCS – procedure code sets for
    • Physician services, PT, OT, Radiology, CLS, other medical dx procedures, hearing and vision, transportation (including ambulance)
  – ICD-9-CM – Dx code set, inpt hospital procedures
  – CDT – dental services
  – NDC – drugs

CPT Hx

• 2004 – MC Prescription Drug, Improvement, and Modernization Act (MMA)
  – New, revised, deleted CPT codes must be implemented 1/1 every year, NO grace period
CPT

- Part of federal government’s HCPCS (Healthcare Common Procedure Coding System)
- Level I = CPT codes
- Level II = HCPCS codes
- Used to report
  - Reimbursable Physician services
  - Hospital services (significant outpatient surgeries for MC beneficiaries)
    - Incisions, introductions, suturing, excisions, destructions, repairs, amputations, endoscopies, manipulations

CPT & Providers

- Home Healthcare
- Hospice Agencies
- Outpt Hospital Departments
  - Amb Surg, ED, Outpt Lab, Outpt Radiology
- Physicians who are employees (VA, etc.)
- Physicians who see pts in
  - Office
  - Clinic
  - Patient homes
CPT-4 to CPT-5

- Transition began in 2000, finished in 2003
- CPT now supports
  - EDI
  - CPR (EMR, EHR)
  - Reference/Research Databases
  - Tracking new technology/performance measures
- Elimination of ambiguous terms
- Guidelines more comprehensive, easier, more specific
- Glossary of terms

Early Release of CPT Codes

- New codes released 6 months before they take effect
- January early release codes
  - Implemented in July
- July early release codes
  - Implemented in January
- Information posted on AMA’s CPT website
Future Improvements

- To Address needs of
  - Hospitals
  - MCOs
  - LTC

- Workgroups
  - Conscious sedation
  - Molecular Pathology

CPT Code Book

- Introduction – general information for coders
- Sections
  - Major Subsections
    - Categories
      - Subcategories
- Appendices
- Index
- Guidelines – beginning of each section
- Notes – subsections, headings, codes
CPT Sections

• Category I codes
• Six sections
  – Evaluation and Management
  – Anesthesia
  – Surgery
  – Radiology
  – Path and Lab
  – Medicine (has anesthesia qualifiers - reported with anesthesia codes)

ANY code in ANY section may be assigned for procedures performed by ANY qualified physician/hc professional

QHP

• “A ‘physician or other qualified healthcare professional’ is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service.”

• CPT Code Book
QHP

• Distinct from “clinical staff”. A clinical staff member is a person who works under the supervision of a physician or other qualified healthcare professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.
• Other policies may also affect who may report specific services.

CPT Appendices

• Located between Medicine Section & Index
• Review Annually for changes
• Appx A – List of all CPT modifiers with detailed descriptions
• Appx B – Changes (additions, deletions, revised codes) CPT, Cat II, III
• Appx C – Clinical examples for E/M codes
• Appx D – List of Add-On codes + symbol
CPT Appendices

- Appx E – List of -51 modifier EXEMPT codes
  - ⊘ - forbidden symbol

- Appx F – List of -63 modifier EXEMPT codes

- Appx G – List of codes that include moderate (conscious) sedation
  - ⊙ - bull’s eye symbol

- Appx H – Alphabetic (by clinical condition) index of performance measure/topic

CPT Appendices

- Appx I – Modifiers for genetic testing (Lab)

- Appx J – Information on EMG and medicine section codes for motor and nerve studies

- Appx K – List of products pending FDA approval that have CPT codes
  - ⚠ - flash symbol
CPT Appendices

- Appx L – List of vascular families
  - Helps in selection of branch artery families
- Appx M – Deleted Codes Crosswalk
- Appx N – Re-sequenced codes
  - # - number symbol
  - Next available code number is used, placed in correct TOPIC-related area in code sections

Guidelines

- General Guidelines in Introduction

- Section Guidelines
  - Define terms and explain code assignment for that section ONLY

- CPT Assistant
  - AMA
CPT Index
Punctuation Conventions

• **Boldfaced** Type
  – CPT category, subcategory, and code numbers
  – Main terms in Index

• *Italicized* Type
  – *See* cross-reference term in Index

• Cross-reference
  – Directs coders to another index entry

CPT Index
Punctuation Conventions

• Single code/Range of codes
  – Used in Index
  – , separates single codes, - indicates range of codes
  – ALL must be investigated before assigning code

• Inferred words
  – Words left out of index to save printing, space
<table>
<thead>
<tr>
<th>9 CPT Symbols</th>
</tr>
</thead>
<tbody>
<tr>
<td>• • - bullet = new procedure</td>
</tr>
<tr>
<td>• ▲ - triangle = revised code description –</td>
</tr>
<tr>
<td>• + plus = add-on code, can’t be assigned alone, do not use -51 with this</td>
</tr>
<tr>
<td>• ⊗ - forbidden (prohibitory) symbol = code is -51 exempt</td>
</tr>
<tr>
<td>• ⊙ - bull’s eye symbol = code INCLUDES conscious sedation adm. by procedure physician</td>
</tr>
<tr>
<td>• ✔ - flash symbol = codes for products pending FDA approval</td>
</tr>
<tr>
<td>• # - number symbol = re-sequenced code</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9 CPT Symbols</th>
</tr>
</thead>
<tbody>
<tr>
<td>• NOT listed in an Appendix</td>
</tr>
<tr>
<td>– ▲ ◊ - horizontal triangles = revised guidelines and notes</td>
</tr>
<tr>
<td>– ; - semi-colon = used to separate the common code description from the specific part of the code description</td>
</tr>
</tbody>
</table>
Add-On Codes

- + identifies
- Additional to/Associated with Main procedure
- NEVER performed/reported ALONE
  - Primary Code reported first
- NEVER use -51 with Add-on code
- Single Provider
- Example
  + 22328

Add-on Example

- 22325 Open treatment and/or reduction of vertebral fracture(s) and/or dislocation(s), posterior approach, 1 fractured vertebra or dislocated segment; lumbar
  - 22326 cervical
  - 22327 thoracic
- +22328 each additional fractured vertebra or dislocated segment (List separately in addition to code for primary procedure)
Semi-colon Example

- **62190** - Creation of shunt; subarachnoid/subdural -atrial, -jugular, -auricular

- **62192** - subarachnoid/subdural-peritoneal, -pleural, other terminus

Which code is correct for shunt shown?


CPT Surgical Package

- - 51 Modifier
- Starred procedure codes
  - Describe/Include ONLY surgical procedure as described by CPT definition
  - Associated pre- and postoperative services are not included in service - use -25 or -26
  - MC bundles
- Add-on Codes
  - NEVER reported alone
  - NEVER use - 51
Integral Services (not CPT coded)

- Fragmenting/Unbundling = Fraud/Abuse
- Local, topical, regional anesthesia
  - When done by physician performing procedure
- Sedatives
  - When done by Dr doing procedure
- Applying, managing, removing postop dressings/analgesic devices
- - More details in Surgery Guidelines

Integral Services

- Cleansing, shaving, prepping skin
- Documenting pre-, intra-, post-op procedures
- Draping/positioning of patient
- Inserting/removing drains, suction devices, dressings, pumps into SAME site
- Inserting IV access for meds
- Irrigating wound
- Providing surgical approach, closure, cultures, supplies (unless CMS states otherwise)
Global Procedures

- Global Procedures (Follow-up)
  - Dx procedures
  - Tx surgical care
    - Normal, routine, usual part of recovery
    - Follow-up care does NOT include
      - Complications
      - Exacerbations
      - Recurrence
      - Other diseases, conditions

- Minor surgery- 10 days
- Major surgery- 90 days

Surgical Package

- Surgery Guidelines
  - Related to integral services
  - Related to Global Package

- See Surgery Guidelines
Multiple Procedures

- Physician performs more than one procedure/service on same DATE, same session, or during post-op period
- -51 modifier
- -50 Bilateral procedure
  - Code book only has unilateral description
  - Do NOT use with -RT/-LT modifiers

Separate Procedures

- Procedures commonly carried out as an INTEGRAL component of another service
- Codes with “separate procedure” in description should NOT be reported in addition
- IF “separate procedure” is done along or is unrelated/distinct, it may be reported with modifier -59
- Ex: 57100
Separate Procedure

- Stated in code description
- Means procedure is “bundled” into larger, related procedure usually performed
- -59 modifier

Separate Procedure Example

- **20100** - Exploration of penetrating wound (separate procedure); neck
- 20101 – chest
- 20102 – abdomen/flank/back
- 20103 - extremity

- **20660** - Application of cranial tongs, caliper, or stereotactic frame, including removal (separate procedure)
Unlisted Procedure/Service

• Service is provided, BUT not listed in CPT
• All Unlisted procedures are listed in
  – Guidelines
  – End of subsections of major sections

• Ex: 15999

Notes

• Instructional Notes - Can be located in subsections, headings or categories, subheadings or subcategories, and codes
  – Two patterns
    • Blocked unindented notes (Ex: Note before 11300)
      – Below title of subsection, etc.
      – Apply to all codes in that part
    • Indented parenthetical notes (Ex: Note before 17000 Heading)
      – Below title of subsection, etc. (Ex: Note before 15002)
      – Below code description – apply only to that code, unless stated otherwise (Ex: Notes after 15151)

• Parenthetical Notes
  – IN code description to provide examples (examples are NOT required to be in documentation)
  – Ex: 11008
CPT Code Conventions

- Each/Each Additional
  - Specific descriptor that indicates need for add-on codes
  - Ex: 11200, 11201

- Descriptive Qualifier – part of code description that follows ;
  - Ex: 10080, 10081

Indentions

- Stand alone codes vs Indented codes
- Stand alone = complete description
  - Has info before AND after ;
- Indented Codes
  - Used to save space
  - Some descriptions NOT completely printed
  - Code description is indented and coder must refer back to common portion (BEFORE ;)
- Ex: 10021 and 10022
Break Time

Fluid Exchanges

CPT Code Structure

• Category I
  – Procedures/Services
  – 5 digit numeric (10021)
  – No decimal
• Category II
  – Optional, performance tracking
  – 5 characters
  – Alpha in last field (4000F, tobacco cessation intervention)
• Category III
  – Emerging Technologies (0012T, now 29866)
  – Can use modifiers with these
CPT Modifiers

- **Procedure Code Modifiers (Service-Related)**
  - 23 = Unusual anesthesia
- **Personnel Modifiers**
  - 62 = Two surgeons
- **Physical Status Modifiers**
  - P1 = Normal healthy patient
- **ASC Modifiers (27, 73, 74 unique to ASC)**
  - 73 = Discontinued Outpatient procedure
- **HCPCS Level II Modifiers**
  - Laterality, ambulance
  - E1 = Upper Left Eyelid

Modifier Sequencing

- **Service-related modifiers**
  - Most directly changes code description
- **CPT modifier, then HCPCS Level II modifier**
- **PS modifier first with anesthesia code**
- **Over 3 modifiers needed**
  - 99
CPT Modifiers

- Some used by Drs
- Some by Hospital (OutPt) only
- Some both can use

CPT Code Modifiers

- CPT modifiers
- Structure – 2 digit numerical
- Purpose - Notify payer that procedure/service has been changed by a particular circumstance
  - Professional AND technical component
  - Only partly performed
  - Increased/Reduced
  - Performed
    - More than ONE physician
    - More than ONE location
    - More than ONCE
  - Complicated by unusual events
  - Additional, connected service was performed
  - Bilateral (additional incision)
HCPCS Modifiers used with CPT Codes

• Appx A lists all modifiers that can be used with CPT codes
• Level II modifiers
  – 2 characters
  – Some alpha (RT, LT)
  – Some alphanumerical

-TC vs -26 Modifiers

• Certain CPT procedures are combination of physician component and technical component.
• When both components were performed by one facility then NO modifier needed
• - 26 = Professional Component
• -TC = Technical Component
• Do NOT use for professional/technical component only codes
-26 Modifier

- Billing for professional component requires physician interpret results of test.
- Results = image/tracing/report provided by machine.
- Dr must document separate report, which includes patient ID, date, indications, brief description of test (spirometry, or number of views) and findings and sign report. Findings in progress note NOT sufficient to bill -26

-TC/-26 Examples

- 93010: Electrocardiogram; interpretation and report.
  - Professional component ONLY
- 93005: Electrocardiogram; tracing only, without interpretation and report.
  - Technical component ONLY
CPT Coding Process

• 1. Read the source document and code only from the information listed. NEVER assume any additional information. Review the operative report closely when selecting procedures to be coded.

• 2. Using information available in record, analyze procedure statement provided by physician. Identify main term and applicable subterms for procedure(s).

• 3. Locate the main term in the CPT index. A main term could be
  – procedure performed. (Guidelines) (Esophagogastroduodenoscopy)
  – procedure’s abbreviation. (EGD)
  – organ or anatomical site. (stomach)
  – condition or diagnosis. (bleeding ulcer)
  – synonym. (hemorrhage)
  – eponym. (Billroth I or II procedure)

• 4. Look for subterms.
Using CPT Index

- At end of code book
- Coder will need to use several methods
  - CPT Index much less consistent than ICD
  - May need to search by body part
  - Key skill of med terminology translation
    - Synonyms
      - Reduction = manipulation in CPT
      - Cardiac, try Heart
- Index directs you to code number, NOT page number.

CPT Index

- Alphabetical by Main Terms
- **Main Terms** are bolded
  - Subterms that modify main terms are indented
CPT Coding Process

• 5. Select (and write down) **tentative** code or range of codes for each procedure.

• 6. **Locate each tentative code in correct section** of CPT.

• **NEVER** code just from Index!

CPT Coding Process

• 7. **Read any notes** and closely check for diagnoses or specific procedures within code descriptions.

• 8. **Verify that code matches procedure** statement in record.

• 9. If necessary, **assign modifier(s).**

• 10. **Assign code.**

• 11. **Sequence** codes correctly
Unbundling

- Unintentional
  - Results from mis-understanding of coding
- Intentional
  - Manipulates coding in order to maximize payment
  - Fragmented, Related Services, Breakout, Downcoding, Surgical Approaches
- Correct coding requires reporting group of procedures with appropriate comprehensive code

Source Documentation

- Documentation is a key resource in assigning correct CPT codes
  - Most common method for communication among clinical, administrative, and reimbursement staff.
  - AHIMA Standards for Ethical Coding
    - Documentation to back up EVERY code submitted
- Common types of source documents include:
  - Surgical (operative) report
  - Procedure report
  - Dictated record of the physician’s findings
  - Superbill, charge ticket, or fee slip
Source Documentation

- When reading/listening to a source document (transcribed, handwritten, or dictated), it is important to **ID the indication** (reason, diagnosis, or symptom) for the procedure and if the procedure was completed.
- All components of the service or procedure being performed must be identified, including:
  - diagnostic/therapeutic **procedure or service**
  - **approach** – endoscopic; incisional; excisional; repair; introduction or removal; percutaneous or other
  - **components** of the procedure/service
  - the **level** of key components (E&M codes)

Source Documentation

- Coders must identify sentences describing findings or comments. They include important information **supporting the medical necessity** (need) for the procedure (and are **required for coding the diagnosis** using ICD-9-CM).
- Ex: “After introduction of the cystoscope, a ureteral stricture was observed.”

What dx and procedural info does this sentence contain?
Source Documentation

• A procedure may have multiple components, such as a cystoscope with pyelogram and cystoscopy with ureteral stent placement.

• A coder must claim (bill) all CPT codes that describe procedure, but be sure to be in compliance with CPT and payer guidelines.

Source Documentation

• The closure sentences in an op/procedure report give detailed information, including
  – instrument removal,
  – sutures and other closures,
  – dressing applications,
  – patient’s status at end of procedure,
  – D/C instructions and follow-up care (if appropriate).

• Usually, these descriptions do not affect code assignment.

• However, additional codes are sometimes required to describe manual or manipulation procedures or a layered or complex closure.
Examples

• Surgical temporomandibular joint (TMJ) arthroscopy
  – Temporomandibular Joint
    • Arthroscopy, surgical  29804

Examples

• Melanoma on cheek, confirmed by bx last week
• Excision of 3.5 cm diameter lesion

• 11644 - Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm
Examples

- Pt presents to ED with 4 wounds sustained in a motorcycle accident.
  - 3.0 cm wound of scalp – simple closure
  - 1.0 cm wound of neck – simple closure
  - 3.0 cm wound of the right hand – layered closure
  - 2.0 cm wound right foot – layered closure

- Same Body area? Size in cm
- Same Type of closure?
- Total and report once when???

Case Study

- Initial Office Visit Date: 3/28/XX
- Name: Mr. Patient  DOB: 9/12/XX ID: 2345
- Mr. Patient is 52-y-o white male who for last 2 months has experienced moderate chest discomfort, radiating to jaw when he shovels snow. Pain generally lasts ~5 minutes and relieved w/rest. He becomes SOB when he experiences the chest discomfort.

- Pt denies any chest pain or pressure at present time. He is diabetic and on insulin for past 10 years. He has no known allergies.
Case Study

• Mother living and well. His father diabetic and died when he was 40. Pt is not sure, but he thinks, his father had a stroke. He has no brothers or sisters.
• Mr. Patient is an electrical engineer, lives at home with wife and two teenage children. He does not smoke and, drinks an occasional beer.
• Present medications: NPH insulin, multiple vitamins.

Case Study

• PE: B/P 160/90. Pulse 90 and regular. Respiratory rate 20. Height 5'8". Weight 250 lbs. Face is somewhat flushed: Neck is supple. carotid upstroke 2 + without bruits. No JVD. Lungs are clear. Heart sounds somewhat distant; st, 52 regular; no systolic murmur appreciated. Abdomen is soft, non-tender. Abdominal aorta is not palpable. Femoral & pedal pulses are strong. No lower extremity edema, no clubbing or cyanosis. No lymphadenopathy or scars noted. Heme negative brown stool. Prostate not enlarged.
Case Study

- ECG done today in my office shows NSR, rate 90. No 51'-1' abnormalities. Tracing is within normal limits, CXR--negative. Normal cardiac silhouette.
- Given Mr. Patient's symptoms, diabetes, obesity, and probable family history, further work-up will include fasting lipid profile and nuclear stress test. After these tests, we can further discuss possible need for left heart catheterization.

Resources

- AMA CPT Web Site
  - www.ama-assn.org/go/cpt
  - (early releases)
- Evaluation and Management Services Guide. CMS. 2010.
Resources

• CPT - Current Procedural Terminology. AMA.
  – http://www.ama-assn.org/ama/pub/physician-
    resources/solutions-managing-your-practice/coding-
    billing-insurance/cpt.page

• Errata and Technical Corrections – CPT May 1, 2013. AMA
  – http://www.ama-assn.org/resources/doc/cpt/cpt-
    corrections-errata.pdf

Resources

• Global Surgery Fact Sheet. Medicare Learning
  Network.
  – http://www.cms.gov/Outreach-and-
    Education/Medicare-Learning-Network-
    MLN/MLNProducts/downloads/GloballSurgery-
    ICN907166.pdf

• Global Surgery Modifiers Fact Sheet. WPS; MC
  Contractor.
Resources

• Surgical Package FAQ. American College of Emergency Physicians.


Resources


  – http://library.ahima.org/xpedio/idcplg?IdcService=GET_HIGHLIGHT_INFO&QueryText=%28CPT+%29+%3E+%28xPublishSite%3Csubstring%3E%60BoK%60%29&dDocName=bok1_049886&HighlightType=HtmlHighlight&wExtensio
Resources


Resources

- Separate Procedures Can Be Separate -- Here's How. SuperCoder.com
Resources

• Free Quiz Archive. JustCoding.com
  – http://www.justcoding.com/free-quizzes

• Free Medical Coding Quiz Questions (250). RiteCode.com

• Modifier TC Fact Sheet, Modifier 26 Fact Sheet. WPS Health Insurance (MAC)

Resources

• CPT modifier 26. Railroad Medicare.
  – http://www.palmettogba.com/palmetto/providers.nsf/DocsCat/Providers~Railroad%20Medicare~Articles~Modifier%20Lookup~8EEL926770

• Modifier 26. Codapedia.com
Answers to 3rd Pre/Post Test

1. B  
2. C  
3. A  
4. B  
5. A  
6. B  
7. B  
8. B  
9. B  
10. D  
11. C  
12. C  
13. B  
14. C

Questions ???
ilemten@gmail.com

Thank You!