PROCEDURAL CODING: CPT AND HCPCS

Learning Outcomes

After studying this chapter, you should be able to:

5.1 Explain the CPT code set.
5.2 Describe the organization of CPT.
5.3 Summarize the use of format and symbols in CPT.
5.4 Assign modifiers to CPT codes.
5.5 Apply the six steps for selecting CPT procedure codes to patient scenarios.
5.6 Explain how the key components are used in selecting CPT Evaluation and Management codes.
5.7 Explain the physical status modifiers and add-on codes used in the Anesthesia section of CPT Category I codes.
5.8 Differentiate between surgical packages and separate procedures in the Surgery section of CPT Category I codes.
5.9 State the purpose of the Radiology section of CPT Category I codes.
5.10 Code for laboratory panels in the Pathology and Laboratory section of CPT Category I codes.
5.11 Code for immunizations using Medicine section CPT Category I codes.
5.12 Contrast Category II and Category III codes.
5.13 Discuss the purpose of the HCPCS code set and its modifiers.
Procedure codes, like diagnosis codes, are an important part of the medical billing cycle. Physicians use standard procedure codes to report the medical, surgical, and diagnostic services they provide. Payers use these reported codes to determine payments. Accurate procedural coding ensures that providers receive the maximum appropriate reimbursement.

Procedure codes are also used to establish guidelines for the delivery of the best possible care for patients. Medical researchers track various treatment plans for patients with similar diagnoses and evaluate patients’ outcomes. The results are shared with physicians and payers so that best practices can be implemented. For example, this type of analysis has shown that a patient who has had a heart attack can reduce the risk of another attack by taking a class of drugs called beta blockers.

In the practice, usually the physicians, medical coders, or medical insurance specialists assign procedure codes. Medical insurance specialists verify the procedure codes and use them to report physicians’ services to payers. This chapter provides a fundamental understanding of how to assign procedure codes so that medical insurance specialists can work effectively with claims. Knowledge of procedural coding—and of how to stay up-to-date—is the baseline for compliant billing.


The procedure codes for physicians’ and other healthcare providers’ services are selected from the *Current Procedural Terminology* code set, called CPT, which is owned and maintained by the American Medical Association (AMA).

**History**

The AMA first produced CPT in 1966. Its wide use began in 1983 when the Health Care Financing Administration (now named the Centers for Medicare and Medicaid Services, or CMS) decided that the CPT codes would be the standard for physician procedures paid by Medicare, Medicaid, and other government medical insurance programs.

CPT lists the procedures and services that physicians across the country commonly perform. There is also a need for codes for items that are used in medical practices but are not listed in CPT, such as supplies and equipment. These codes are found in the Healthcare Common Procedure Coding System, referred to as HCPCS and pronounced “hick-picks.” Officially, CPT is the first part (called Level I) of HCPCS, and the supply codes are the second part (Level II). Most people, though, refer to the codes in the CPT book as *CPT codes* and the Level II codes as *HCPCS codes*.

**Types of CPT Codes**

There are three categories of CPT codes:

- Category I codes
- Category II codes
- Category III codes

**Category I Codes**

CPT Category I codes—which are the most numerous—have five digits (with no decimals). Each code has a descriptor, which is a brief explanation of the procedure:

99204 Office or other outpatient visit for evaluation and management of a new patient
00730 Anesthesia for procedures on upper posterior abdominal wall
32552 Removal of indwelling tunneled pleural catheter with cuff
70100 Radiologic examination, mandible; partial, less than 4 views
80400 ACTH stimulation panel; for adrenal insufficiency
96360 Intravenous infusion, hydration; initial, 31 minutes to 1 hour

Although the codes are grouped into sections, such as Surgery, codes from all sections can be used by all types of physicians. For example, a family practitioner might use codes from the Surgery section to describe an office procedure such as the incision and drainage of an abscess.

**Category II Codes**

**Category II codes** are used to track performance measures for a medical goal such as reducing tobacco use. These codes are optional; they are not paid by insurance carriers. They help in the development of best practices for care and improve documentation. These codes have alphabetic characters for the fifth digit:

- 3271F Low risk of recurrence, prostate cancer (PRCA)
- 4000F Tobacco use cessation intervention, counseling

**Category III Codes**

**Category III codes** are temporary codes for emerging technology, services, and procedures. These codes also have alphabetic characters for the fifth digit:

- 0182T High dose rate electronic brachytherapy, per fraction

A temporary code may become a permanent part of the regular Category I codes if the service it identifies proves effective and is widely performed.

**Updates**

CPT is a proprietary code set, meaning that it is not available for free to the public. Instead, the information must be purchased, either in print or electronic format, from the AMA, which publishes the revised CPT codes.

During the year, practicing physicians, medical specialty societies, and state medical associations send their suggestions for revision to the AMA. This input is reviewed by the AMA’s Editorial Panel, which includes physicians as well as representatives from America’s Health Insurance Plans (AHIP), CMS, the American Health Information Management Association (AHIMA), the American Hospital Association (AHA), and BlueCross BlueShield. The panel decides what changes will be made in the annual revision of the printed reference book.

**BILLING TIP**

**Defining Provider in CPT**

The term *provider* means either a physician or another type of qualified healthcare professional, such as a physician assistant.

**BILLING TIP**

**Updating Vaccine Codes and Category III Codes**

Both vaccine product codes and Category III codes are released twice a year and have a six-month period for implementation. Offices billing these services should check for updates at the CPT website.

The annual changes for Category I codes are announced by the AMA on October 1 and are in effect for procedures and services provided after January 1 of the following year. The code books can be purchased in different formats, which range from a basic listing to an enhanced edition. The AMA also reports the new codes on its website.
Category II and III codes are prereleased on the AMA website and can be used on their implementation date even before they appear in the printed books.

**THINKING IT THROUGH 5.1**

1. Which organization owns and maintains the CPT code set?

**5.2 Organization**

CPT is made up of the main text—sections of codes—followed by appendixes and an index. The main text has the following six sections of Category I procedure codes:

- **Evaluation and Management**
  - Codes 99201–99499
- **Anesthesia**
  - Codes 00100–01999
- **Surgery**
  - Codes 10021–69990
- **Radiology**
  - Codes 70010–79999
- **Pathology and Laboratory**
  - Codes 80047–89398
- **Medicine**
  - Codes 90281–99607

Table 5.1 summarizes the types of codes, organization, and guidelines of these six sections of Category I codes. These are followed by the Category II and Category III code sections.

<table>
<thead>
<tr>
<th>Section</th>
<th>Definition of Codes</th>
<th>Structure</th>
<th>Key Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and Management</td>
<td>Physicians’ services that are performed to determine the best course for patient care</td>
<td>Organized by place and/or type of service</td>
<td>New/established patients; other definitions; Unlisted services, special reports; Selecting an E/M service level</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>Anesthesia services by or supervised by a physician; includes general, regional, and local anesthesia</td>
<td>Organized by body site</td>
<td>Time based; Services covered (bundled) in codes; Unlisted services/special reports; Qualifying circumstances codes</td>
</tr>
<tr>
<td>Surgery</td>
<td>Surgical procedures performed by physicians</td>
<td>Organized by body system and then body site, followed by procedural groups</td>
<td>Surgical package definition; Follow-up care definition; Add-on codes; Separate procedures; Subsection notes; Unlisted services/special reports</td>
</tr>
<tr>
<td>Radiology</td>
<td>Radiology services by or supervised by a physician</td>
<td>Organized by type of procedure followed by body site</td>
<td>Unlisted services/special reports; Supervision and interpretation (professional and technical components)</td>
</tr>
<tr>
<td>Pathology and Laboratory</td>
<td>Pathology and laboratory services by physicians or by physician-supervised technicians</td>
<td>Organized by type of procedure</td>
<td>Complete procedure; Panels; Unlisted services/special reports</td>
</tr>
<tr>
<td>Medicine</td>
<td>Evaluation, therapeutic, and diagnostic procedures by or supervised by a physician</td>
<td>Organized by type of service or procedure</td>
<td>Subsection notes; Multiple procedures reported separately; Add-on codes; Separate procedures; Unlisted services/special report</td>
</tr>
</tbody>
</table>
THINKING IT THROUGH 5.2

Would you expect to locate codes for the following services or procedures in CPT? What range or series of codes would you investigate, Service or Procedure Range or Series?

1. Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
2. Echocardiography
3. Radiologic examination, nasal bones, complete
4. Home visit for evaluation and management of an established patient
5. Drug test for amphetamines
6. Anesthesia for cardiac catheterization

The Index

The assignment of a correct procedure code begins by reviewing the physician's statements in the patient's medical record to determine the service, procedure, or treatment that was performed. Then the index entry is located; it provides a pointer to the correct code range in the main text. Using the CPT index makes the process of selecting procedure codes more efficient. The index contains the descriptive terms that are listed in the sections of codes in the CPT.

Main Terms and Modifying Terms

The main terms in the index are printed in boldface type. There are five types of main terms:

1. The name of the procedure or service, such as echocardiography, extraction, and cast
2. The name of the organ or other anatomical site, such as stomach, wrist, and salivary gland
3. The name of the condition, such as abscess, wound, and postpartum care
4. A synonym or an eponym for the term, such as Noble Procedure, Ramstedt operation, and Fowler-Stephens orchiopexy
5. The abbreviation for the term, such as CAT scan and ECMO

Many terms are listed more than one way. For example, the kidney biopsy procedure is listed both as a procedure—Biopsy, kidney—and by the site—Kidney, biopsy.

A main term may be followed by subterms that further describe the entry. These additional indented terms help in the selection process. For example, the procedure “repair of tennis elbow” is located beneath repair under the main term elbow (see Figure 5.1).

Code Ranges

A range of codes is shown when more than one code applies to an entry. Two codes, either sequential or not, are separated by a comma:

Cervix

Biopsy ................. 57500, 57520

More than two sequential codes are separated by a hyphen:

Spine

CT Scan

Lumbar ................. 72131–72133
Cross-References

The cross-reference *See* is a mandatory instruction. It tells the coder to refer to the term that follows it to find the code. It is used mainly for synonyms, eponyms, and abbreviations. For example, the cross-reference “See Electrocardiography” follows EKG (see Figure 5.1). Also, under Elbow, the cross-reference “See Humerus; Radius; Ulna” points to those main terms if the entry is not located under Elbow (see Figure 5.1).
Typographic Conventions
To save space, some connecting words are left out and must be assumed by the reader. For example:

Harvesting
  Cartilage Graft
  Ear ................. 21235

should be read “harvesting a cartilage graft from the ear.” The reader supplies the words a and from the.

The Main Text
After the index is used to point to a possible code, the main text is read to verify the selection of the code (see Figure 5.2 on page 150).

Each of the six sections of the main text lists procedure codes and descriptors under subsection headings. These headings group procedures or services, such as Therapeutic or Diagnostic Injections or Psychoanalysis; body systems, such as Digestive System; anatomical sites, such as Abdomen; and tests and examinations, such as Complete Blood Count (CBC). Following these headings are additional subheadings that group procedures, systems, or sites. For example, Figure 5.2 illustrates the following structure, in which the body system appears as the subsection followed by a procedure subgroup:

Surgery Section <The Section>
  Musculoskeletal System <The Subsection>
    Endoscopy/Arthroscopy <The Procedure Subgroup>

The section, subsection, and code number range on a page are shown at the top of the page, making it easier to locate a code.

BILLING TIP
Correct Coding Procedure
Never select a code based on only the index entry because the main text may have additional entries and important guidelines that alter the selection.

Guidelines
Each section begins with section guidelines for the use of its codes. The guidelines cover definitions and items unique to the section. They also include special notes about the structure of the section or the rules for its use. The guidelines must be carefully studied and followed in order to correctly use the codes in the section. Some notes apply only to specific subsections. The guidelines list the subsections in which these notes occur, and the notes themselves begin those subsections (see Figure 5.2).

Unlisted Procedures
Most sections’ guidelines give codes for unlisted procedures—those not completely described by any code in the section. For example, in the Evaluation and Management section, this unlisted code is provided:

99499 Unlisted evaluation and management service

Unlisted procedure codes are used for new services or procedures that have not yet been assigned either Category I or III codes in CPT. When an unlisted code is reported to a payer, documentation of the procedure should accompany the claim. Often the operative report or a letter from the physician describing the procedure meets this need.
Some section guidelines suggest the use of *special reports* for rare or new procedures, especially unlisted procedure codes. These reports, which are mandatory, permit payers to assess the medical appropriateness of the procedures. The guidelines cover the information that should be in the report, such as a description of the nature, extent, and need for the procedure plus additional notes on the symptoms or findings.

### Special Reports

- **Example of Code Listings from the Musculoskeletal System Subsection of the Surgery Section**

  - **Procedure subgroup**
    - **Endoscopy/Arthroscopy**
      - Surgical endoscopy/arthroscopy always includes a diagnostic endoscopy/arthroscopy.
      - When arthroscopy is performed in conjunction with arthrotomy, add modifier 51.
  - **Notes**
  - **Common descriptor**
  - **Semicolon**
  - **Indented terms**

  - **Looking up terms in the CPT index identifies index entries to be checked in the list of codes and definitions:**
    - **Arthroscopy**
      - **Diagnostic**
        - Elbow .................................. 29830
        - Hip .................................... 29860
        - Knee .................................. 29870
        - Metacarpophalangeal Joint ............ 29900
        - Shoulder ............................... 29805
        - Temporomandibular Joint ............. 29800
        - Wrist .................................. 29840
      - **Surgical**
        - Ankle .................................. 29891 - 29899
        - Elbow ................................. 29834 - 29838

  - **Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)**
    - 29800
  - **Arthroscopy, temporomandibular joint, surgical**
    - 29804
  - **Arthroscopy, shoulder, diagnostic, with or without synovial biopsy (separate procedure)**
    - 29805
  - **Arthroscopy, shoulder, surgical; capsulorrhaphy**
    - 29806
  - **Arthroscopy, shoulder, repair of SLAP lesion**
    - 29807
  - **Arthroscopy, shoulder, with removal of loose body or foreign body**
    - 29819
  - **Arthroscopy, shoulder, synovectomy, partial**
    - 29820
  - **Arthroscopy, shoulder, synovectomy, complete**
    - 29821
  - **Arthroscopy, shoulder, debridement, limited**
    - 29822
  - **Arthroscopy, shoulder, debridement, extensive**
    - 29823
  - **Arthroscopy, shoulder, distal clavicle including distal articular surface (Mumford procedure)**
    - 29824
  - **Arthroscopy, shoulder, with lysis and resection of adhesions, with or without manipulation**
    - 29825
  - **Arthroscopy, elbow, diagnostic, with or without synovial biopsy (separate procedure)**
    - 29830
  - **Arthroscopy, elbow, surgical; with removal of loose body or foreign body**
    - 29834
  - **Arthroscopy, elbow, synovectomy, partial**
    - 29835
  - **Arthroscopy, elbow, synovectomy, complete**
    - 29836
  - **Arthroscopy, elbow, debridement, limited**
    - 29837
  - **Arthroscopy, elbow, debridement, extensive**
    - 29838

- **Notes**
- **Subgroup**
- **Indented terms**

### FIGURE 5.2 Example of Code Listings from the Musculoskeletal System Subsection of the Surgery Section

*special report* note explaining the reasons for a new, variable, or unlisted procedure or service.
The Appendixes

The fourteen appendixes in the American Medical Association publication of CPT contain information helpful to the coding process:

1. Appendix A—Modifiers: A complete listing of all modifiers used in CPT with descriptions and, in some cases, examples of usage.
2. Appendix B—Summary of Additions, Deletions, and Revisions: A summary of the codes added, revised, and deleted in the current version.
3. Appendix C—Clinical Examples: Case examples of the proper use of the codes in the Evaluation and Management section.
4. Appendix D—Summary of CPT Add-on Codes: List of supplemental codes used for procedures that are commonly done in addition to the primary procedure.
5. Appendix E—Summary of CPT Codes Exempt from Modifier 51: Codes to which the modifier showing multiple procedures cannot be attached because they already include a multiple descriptor.
6. Appendix F—Summary of CPT Codes Exempt from Modifier 63.
7. Appendix G—Summary of CPT Codes That Include Moderate (Conscious) Sedation.
8. Appendix H—Alphabetical Clinical Topics Listing.
10. Appendix J—Electrodiagnostic Medicine Listing of Sensory, Motor, and Mixed Nerves.
11. Appendix K—Product Pending FDA Approval.

5.3 Format and Symbols

Format

Semicolons and Indentions

To save space in the book, CPT uses a semicolon and indentions when a common part of a main entry applies to entries that follow. For example, in the entries listed below, the procedure partial laryngectomy (hemilaryngectomy) is the common descriptor. This same descriptor applies to the four unique descriptors after the semicolon—horizontal, laterovertical, anterovertical, and antero-latero-vertical. Note that the common descriptor begins with a capital letter, but the unique descriptors after the semicolon do not. Also note that after the first listing, the second, third, and fourth descriptors are indented. Indenting visually reinforces the relationship between the entries and the common descriptor.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>31370</td>
<td>Partial laryngectomy (hemilaryngectomy); horizontal</td>
</tr>
<tr>
<td>31375</td>
<td>laterovertical</td>
</tr>
<tr>
<td>31380</td>
<td>anterovertical</td>
</tr>
<tr>
<td>31382</td>
<td>antero-latero-vertical</td>
</tr>
</tbody>
</table>
This method shows the relationships among the entries without repeating the common word or words. Follow this case example in Figure 5.2:

[Index Entry: Arthroscopy, Surgical, Elbow . . . . . . . . . . 29834–29838
Main Text: 29838 Arthroscopy, elbow, surgical; debridement, extensive

Cross-References
Some codes and descriptors are followed by indented see or use entries in parentheses, which refer the coder to other codes. For example:

82239 Bile acids; total
82240 cholylglycine
(For bile pigments, urine, see 81000–81005)

Examples
Descriptors often contain clarifying examples in parentheses, sometimes with the abbreviation e.g. (meaning for example). These provide further descriptions, such as synonyms or examples, but they are not essential to the selection of the code. Here are examples:

87040 Culture, bacterial; blood, aerobic, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)
50400 Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; simple
50405 complicated (congenital kidney abnormality, secondary pyeloplasty, solitary kidney, calyceoplasty)

Symbols for Changed Codes
These three symbols have the following meanings when they appear next to CPT codes:

● A bullet (a solid circle) indicates a new procedure code. The symbol appears next to the code only in the year that it is added.
▲ A triangle indicates that the code’s descriptor has changed. It, too, appears only in the year the descriptor is revised.
▶◀ Facing triangles (two triangles that face each other) enclose new or revised text other than the code’s descriptor.

Symbol for Add-On Codes
A plus sign (+) next to a code in the main text indicates an add-on code. Add-on codes describe secondary procedures that are commonly carried out in addition to a primary procedure. Add-on codes usually use phrases such as each additional or list separately in addition to the primary procedure to show that they are never used as stand-alone codes. For example, the add-on code +15003 is used in addition to the code for surgical preparation for a skin graft site (15002) to provide a specific percentage or dimension of body area that was involved beyond the amount covered in the primary procedure.

Symbol for Moderate Sedation
In CPT, the symbol ● (a bullet inside a circle) next to a code means that moderate sedation is a part of the procedure that the surgeon performs. This means that for compliant coding, moderate sedation is not billed in addition to the code. Moderate
sedation is a mild, drug-induced depression of consciousness during which patients can respond to verbal commands. This type of sedation is typically used with procedures such as bronchoscopies.

Symbol for FDA Approval Pending
Also used is the symbol *(a lightning bolt). This symbol is used with vaccine codes that have been submitted to the Food and Drug Administration (FDA) and are expected to be approved for use soon. The codes cannot be used until approved, at which point this symbol is removed.

Symbol for Resequenced Codes
As new procedures are developed and widely adopted, CPT has encountered situations in which not enough numbers are left in a particular numerical sequence of codes to handle all new items that need to be included. Also, at times codes need to be regrouped into related procedures for clarity.

Beginning with CPT 2010, the AMA decided to change the way this situation had been accommodated. Previously, if more procedures were to be added than numbers were available, the entire list would be renumbered using new numbers and moved to the place in CPT where the list would be in numerical order. This approach often caused large groups of code numbers to have to be renumbered—creating confusion and requiring lots of updating of medical practice forms and databases.

The AMA decided to use the idea of resequencing rather than renumbering and moving codes. Resequencing is the practice of displaying the codes outside of numerical order in favor of grouping them according to the relationships among the code descriptors. This permits out-of-sequence code numbers to be inserted under the previous key procedural terms without having to renumber and move the entire list of related codes.

The codes that are resequenced are listed twice in CPT. First, they are listed in their original numeric position with the note that the code is now out of numerical sequence and referring the user to the code range containing the resequenced code and description.

46220 Code is out of numerical sequence. See 46200–46288.

Second, the code and its descriptor appear in the group of codes to which it is related, as shown below:

# 46220 Excision of single external papilla or tag, anus

THINKING IT THROUGH 5.3
1. Find the following codes in the index of CPT. Underline the key term you used to find the code.
   A. Intracapsular lens extraction
   B. Coombs test
   C. X-ray of duodenum
   D. Unlisted procedure, maxillofacial prosthetics
   E. DTaP immunization

(continued)
5.4 CPT Modifiers

A CPT modifier is a two-digit number that may be attached to most five-digit procedure codes (see Table 5.2 on page 155). Modifiers are used to communicate special circumstances involved with procedures that have been performed. A modifier tells private and government payers that the physician considers the procedure to have been altered in some way. A modifier usually affects the normal level of reimbursement for the code to which it is attached.

For example, the modifier 76, Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional, is used when the reporting physician repeats a procedure or service after doing the first one. A situation requiring this modifier to show the extra procedure might be:

Procedural Statement: Physician performed a chest X-ray before placing a chest tube and then, after the chest tube was placed, performed a second chest X-ray to verify its position.

Code: 71020 76 Radiologic examination, chest, two views, frontal and lateral; repeat procedure or service by same physician

The modifiers are listed in Appendix A of CPT. However, not all modifiers are available for use with every section’s codes:

- Some modifiers apply only to certain sections. For example, the modifier 23, Unusual Anesthesia, is used only with codes that are located in the Anesthesia section, as its descriptor implies.
- Add-on codes cannot be modified with 51, Multiple Procedures, because the add-on code is used to add increments to a primary procedure, so the need for multiple procedures is replaced by procedures added on.
- Codes that begin with ⟨∥⟩ (a circle with a backslash) also cannot be modified with 51, Multiple Procedures.
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>E/M</th>
<th>Anesthesia</th>
<th>Surgery</th>
<th>Radiology</th>
<th>Pathology</th>
<th>Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Increased Procedural Service</td>
<td>Never</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>23</td>
<td>Unusual Anesthesia</td>
<td>Never</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>24</td>
<td>Unrelated E/M Service by the Same Physician During a Postoperative Period</td>
<td>Yes</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
</tr>
<tr>
<td>25</td>
<td>Significant, Separately Identifiable E/M Service by the Same Physician on</td>
<td>Yes</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
</tr>
<tr>
<td></td>
<td>the Same Day of the Procedure or Other Service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26</td>
<td>Professional Component</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>32</td>
<td>Mandated Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>33</td>
<td>Preventive Services</td>
<td>Yes</td>
<td>Never</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Never</td>
</tr>
<tr>
<td>47</td>
<td>Anesthesia by Surgeon</td>
<td>Never</td>
<td>Never</td>
<td>Yes</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
</tr>
<tr>
<td>50</td>
<td>Bilateral Procedure</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>51</td>
<td>Multiple Procedures</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Never</td>
</tr>
<tr>
<td>52</td>
<td>Reduced Services</td>
<td>Yes</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>53</td>
<td>Discontinued Procedure</td>
<td>Never</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>54</td>
<td>Surgical Care Only</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>55</td>
<td>Postoperative Management Only</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>56</td>
<td>Preoperative Management Only</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
</tr>
<tr>
<td>57</td>
<td>Decision for Surgery</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
</tr>
<tr>
<td>58</td>
<td>Staged or Related Procedure or Service by the Same Physician During the</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>Postoperative Period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>59</td>
<td>Distinct Procedural Service</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>62</td>
<td>Two Surgeons</td>
<td>Never</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Never</td>
<td>—</td>
</tr>
<tr>
<td>63</td>
<td>Procedure Performed on Infants Less Than 4 kgs</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>66</td>
<td>Surgical Team</td>
<td>Never</td>
<td>Never</td>
<td>Yes</td>
<td>Yes</td>
<td>Never</td>
<td>—</td>
</tr>
<tr>
<td>76</td>
<td>Repeat Procedure by Same Physician or Other Qualified Health Care</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>Professional</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>77</td>
<td>Repeat Procedure by Another Physician or Other Qualified Health Care</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>Professional</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>78</td>
<td>Unplanned Return to the Operating/Procedure Room by the Same Physician or</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td></td>
<td>Other Qualified Health Care Professional Following Initial Procedure for a</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Related Procedure During the Postoperative Period</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>79</td>
<td>Unrelated Procedure or Service by the Same Physician During the Postoperative Period</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>80</td>
<td>Assistant Surgeon</td>
<td>Never</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>81</td>
<td>Minimum Assistant Surgeon</td>
<td>Never</td>
<td>—</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>82</td>
<td>Assistant Surgeon (When Qualified Resident Surgeon Not Available)</td>
<td>Never</td>
<td>—</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>90</td>
<td>Reference (Outside) Laboratory</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>91</td>
<td>Repeat Clinical Diagnostic Laboratory Test</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>92</td>
<td>Alternative Laboratory Platform Testing</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>99</td>
<td>Multiple Modifiers</td>
<td>—</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
<td>—</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Source: CPT 2013.
Note: Physician in this table denotes either a physician or a qualified healthcare professional.
Key: Yes — commonly used
      — — not usually used with the codes in that section
      Never — not used with the codes in that section
What Do Modifiers Mean?
The use of a modifier means that a procedure was different from the description in CPT, but not in a way that changed the definition or required a different code. Modifiers are used mainly when:

▶ A procedure has two parts—a technical component (TC) performed by a technician, such as a radiologist, and a professional component (PC) that the physician performs, usually the interpretation and reporting of the results
▶ A service or procedure has been performed more than once, by more than one physician, and/or in more than one location
▶ A service or procedure has been increased or reduced
▶ Only part of a procedure has been done
▶ A bilateral or multiple procedure has been performed
▶ Unusual difficulties occurred during the procedure

Assigning Modifiers
Modifiers are shown by adding a space and the two-digit code to the CPT code. For example, a physician providing radiologic examination services in a hospital would report the modifier 26, Professional Component, as follows:

73090 26

This format means professional component only for an X-ray of the forearm. (In effect, it means that the physician who performed the service did not own the equipment used, so the fee is split between the physician and the equipment owner.)

Two or more modifiers may be used with one code to give the most accurate description possible. The use of two or more modifiers is shown by reporting 99, Multiple Modifiers, followed by the other modifiers, with the most essential modifier listed first.

Procedures: Multitrauma patient’s extremely difficult surgery after a car accident; team surgery by orthopedic surgeon and neurosurgeon. The first surgical procedure carries these modifiers:

27236 99, 66, 51, 22

THINKING IT THROUGH 5.4

1. In CPT, what is the meaning of the symbol in front of code 93503?
2. Based on Appendix A of CPT, what modifiers would you assign in each of the following cases? Why?

CASE A.
Patient has recurrent cancer; surgeon performed a colectomy, which took forty-five minutes longer than the normal procedure due to dense adhesions from the patient’s previous surgery.

CASE B.
Surgeon operating on an ingrown toenail administers a regional nerve block.

CASE C.
Patient was scheduled for a total diagnostic colonoscopy, but the patient went into respiratory distress during procedure; surgeon stopped the procedure.

CASE D.
Puncture aspiration of a cyst in the left breast and a cyst in the right breast.

CASE E.
A neurological surgeon and an orthopedic surgeon worked as cosurgeons.
5.5 Coding Steps

The correct process for assigning accurate procedure codes has six steps, as shown in Figure 5.3.

**Step 1. Review Complete Medical Documentation**
The first step is to review the documentation of the patient’s visit and decide which procedures and/or services were performed and where the service took place (the place of service, which may be an office, a facility, or another healthcare setting).

**Step 2. Abstract the Medical Procedures from the Visit Documentation**
Then, based on knowledge of CPT and of the payer’s policies, a decision is made about which services can be charged and are to be reported.

---

**FIGURE 5.3** Procedure Code Assignment Flow Chart
Step 3. Identify the Main Term for Each Procedure
The next step is to identify the main term for each procedure. Main terms may be based on the:

- Procedure or service (such as repair, biopsy, evaluation and management, or extraction)
- Organ or body part (such as chest wall, prostate, or bladder)
- Condition or disease being treated (such as facial nerve paralysis)
- Common abbreviation (such as ECG or CT)
- Eponym (such as Cotte operation)
- Symptom (for example, fracture)

Step 4. Locate the Main Terms in the CPT Index
Next, locate the procedures in the index at the back of CPT. For each term a listing of a code or a code range identifies the appropriate heading and procedure code(s) in CPT. Some entries have a See cross-reference or a See also to point to another index entry.

Example

Code Range Index Entry
Graft
  Bone and skin......................... 20969–20970, 20972–20973

When a code range is listed, read the code descriptors for all codes within the range indicated in the index in order to select the most specific code.

If the main term cannot be located in the index, the medical insurance specialist reviews the main term selection with the physician for clarification. In some cases, a better or more common term can be used.

Step 5. Verify the Code in the CPT Main Text
The next step is to review the possible codes in the CPT section that the index entries point to. Check section guidelines and any notes directly under the code, within the code descriptor, or after the code descriptor. Items that cannot be billed separately because they are covered under another, broader code are eliminated.

The codes to be reported for each day’s services are ranked in order of highest to lowest rate of reimbursement. The actual order in which they were performed on a particular day is not important. When reporting, the earliest date of service is listed first followed by subsequent dates of service. For example:

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/17/2016</td>
<td>99204</td>
<td>$202</td>
</tr>
<tr>
<td>11/20/2016</td>
<td>43215</td>
<td>$355</td>
</tr>
<tr>
<td>11/20/2016</td>
<td>74235</td>
<td>$75</td>
</tr>
</tbody>
</table>

Step 6. Determine the Need for Modifiers
The circumstances involved with the procedure or service may require the use of modifiers. The patient’s diagnosis may affect this determination.
**THINKING IT THROUGH 5.5**

List all possible index entries for locating the service, and then assign the code. The first item is completed as an example.

**Index Entry Code**

1. Excision of mucous cyst of a finger: Excision, Cyst, Finger _______ 26160
2. Endoscopic biopsy of the nose: _____________________________________
3. Arthroscopic meniscectomy of the knee joint: _________________________
4. Drainage of a sublingual salivary gland cyst: __________________________
5. Cystoscopy with fragmentation of ureteral calculus: ____________________

---

### 5.6 Evaluation and Management Codes

The codes in the Evaluation and Management section (**E/M codes**, or **evaluation and management codes**) cover physicians’ services that are performed to determine the best course for patient care. The E/M codes are listed first in CPT because they are used so often by all types of physicians. Often called the cognitive codes, the E/M codes cover the complex process a physician uses to gather and analyze information about a patient’s illness and to make decisions about the patient’s condition and the best treatment or course of management. The actual treatments—such as surgical procedures and vaccines—are covered in the CPT sections that follow the E/M codes, such as the Surgery and Medicine sections.

Although CPT was first published in 1966, the Evaluation and Management section was not introduced until 1992. The E/M coding method came from a joint effort by CMS and the AMA to define ranges of services from simple to very complicated. Patients’ conditions require different levels of information gathering, analysis, and decision making by physicians. For example, on the low end of a range might be a patient with a mild case of poison ivy. On the opposite end is a patient with a life-threatening condition. The E/M codes reflect these different levels. There are five codes to choose from for an office visit with a new patient, for example, and another five for office visits with established patients. A financial value (fee or prospective payment) is assigned by a payer to each code in a range. To justify the use of a higher-level code in the range—one that is tied to a higher value—the physician must perform and document specific clinical facts about the patient encounter.

**BILLING TIP**

**Assigning E/M Levels**

In many practices, because of their complexity, physicians assign the E/M code levels, and then medical coders or insurance specialists check them against documentation.

**Structure**

Most codes in the E/M section are organized by the place of service, such as the office, the hospital, or a patient’s home. A few (for example, prolonged) are grouped by type of service. The subsections, detailed in **Table 5.3**, are as follows:

- Office or Other Outpatient Services
- Hospital Observation Services
- Hospital Inpatient Services
- Consultations
Emergency Department Services
Critical Care Services
Nursing Facility Services
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services
Home Services
Prolonged Services
Case Management Services
Care Plan Oversight Services
Preventive Medicine Service
Non-Face-to-Face Services
Special E/M Services
Newborn Care Services
Inpatient Neonatal Intensive Care Services and Pediatric and Neonatal Critical Care Services
Other E/M Services

<table>
<thead>
<tr>
<th>Table 5.3</th>
<th>E/M Categories and Subcategories</th>
<th>Code Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td>Subcategory</td>
<td></td>
</tr>
<tr>
<td>Office/other outpatient services</td>
<td>New patient</td>
<td>99201–99205</td>
</tr>
<tr>
<td></td>
<td>Established patient</td>
<td>99211–99215</td>
</tr>
<tr>
<td>Hospital observation services</td>
<td>Discharge services</td>
<td>99217</td>
</tr>
<tr>
<td></td>
<td>Initial services</td>
<td>99218–99220</td>
</tr>
<tr>
<td></td>
<td>Subsequent Observation Care</td>
<td>99224–99226</td>
</tr>
<tr>
<td>Hospital inpatient services</td>
<td>Initial hospital care</td>
<td>99221–99223</td>
</tr>
<tr>
<td></td>
<td>Subsequent hospital care</td>
<td>99231–99233</td>
</tr>
<tr>
<td></td>
<td>Same-day admission and discharge</td>
<td>99234–99236</td>
</tr>
<tr>
<td></td>
<td>Discharge services</td>
<td>99238–99239</td>
</tr>
<tr>
<td>Office or outpatient consultations</td>
<td>Initial consultations</td>
<td>99241–99245</td>
</tr>
<tr>
<td>Hospital consultations</td>
<td>Initial consultations</td>
<td>99251–99255</td>
</tr>
<tr>
<td>Emergency department services</td>
<td></td>
<td>99281–99288</td>
</tr>
<tr>
<td>Critical care services</td>
<td>Timed services</td>
<td>99291–99292</td>
</tr>
<tr>
<td>Nursing facility services</td>
<td>Initial care</td>
<td>99304–99306</td>
</tr>
<tr>
<td></td>
<td>Subsequent care</td>
<td>99307–99310</td>
</tr>
<tr>
<td></td>
<td>Discharge services</td>
<td>99315–99316</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>99318</td>
</tr>
<tr>
<td>Domiciliary, rest home, custodial</td>
<td>New patient</td>
<td>99324–99328</td>
</tr>
<tr>
<td></td>
<td>Established patient</td>
<td>99334–99337</td>
</tr>
<tr>
<td></td>
<td>Oversight services</td>
<td>99339–99340</td>
</tr>
<tr>
<td>Home services</td>
<td>New patient</td>
<td>99341–99345</td>
</tr>
<tr>
<td></td>
<td>Established patient</td>
<td>99347–99350</td>
</tr>
</tbody>
</table>
A New or Established Patient?

Many subsections of E/M codes assign different code ranges for new patients and established patients. A new patient (NP) has not received any professional services from the provider (or from another provider of the exact same specialty/subspecialty in the same group practice) within the past three years. An established patient (EP) has received professional services under those conditions (see Figure 3.1 on page 79 for a decision tree for determining patient status as NP or EP). The distinction is important because new patients typically require more effort by the provider and practice staff, who should therefore be paid more.

Table 5.3  
E/M Categories and Subcategories (concluded)

<table>
<thead>
<tr>
<th>Category</th>
<th>Subcategory</th>
<th>Code Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prolonged services</td>
<td>Direct patient contact</td>
<td>99354–99357</td>
</tr>
<tr>
<td></td>
<td>Without direct patient contact</td>
<td>99358–99359</td>
</tr>
<tr>
<td></td>
<td>Standby services</td>
<td>99360</td>
</tr>
<tr>
<td>Case management services</td>
<td>Anticoagulant management</td>
<td>99363–99364</td>
</tr>
<tr>
<td></td>
<td>Medical team conferences</td>
<td>99366–99368</td>
</tr>
<tr>
<td>Care plan oversight</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive medicine</td>
<td>New patient</td>
<td>99381–99387</td>
</tr>
<tr>
<td></td>
<td>Established patient</td>
<td>99391–99397</td>
</tr>
<tr>
<td></td>
<td>Individual counseling</td>
<td>99401–99409</td>
</tr>
<tr>
<td></td>
<td>Group counseling</td>
<td>99411–99412</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>99420–99429</td>
</tr>
<tr>
<td>Non-face-to-face services</td>
<td>Telephone services</td>
<td>99441–99443</td>
</tr>
<tr>
<td></td>
<td>Online medical evaluation</td>
<td>99444</td>
</tr>
<tr>
<td>Special E/M services</td>
<td></td>
<td>99450–99456</td>
</tr>
<tr>
<td>Newborn care</td>
<td></td>
<td>99460–99463</td>
</tr>
<tr>
<td></td>
<td>Delivery/birthing room attendance</td>
<td>99464–99465</td>
</tr>
<tr>
<td>Neonatal and pediatric critical care services</td>
<td>Pediatric patient transport</td>
<td>99466–99467, 99485–99486</td>
</tr>
<tr>
<td></td>
<td>Inpatient neonatal critical care services</td>
<td>99468–99469</td>
</tr>
<tr>
<td></td>
<td>Inpatient pediatric critical care services</td>
<td>99471–99476</td>
</tr>
<tr>
<td></td>
<td>Initial and continuing intensive care services</td>
<td>99477–99480</td>
</tr>
<tr>
<td>Complex chronic care coordination services</td>
<td></td>
<td>99487–99489</td>
</tr>
<tr>
<td>Transitional care management services</td>
<td></td>
<td>99495–99496</td>
</tr>
<tr>
<td>Other E/M services</td>
<td></td>
<td>99499</td>
</tr>
</tbody>
</table>

**BILLING TIP**

**New and Established Patients**

Be familiar with payers’ guidelines on new and established patients because some payers have special rules for deciding on the patient’s status when the specialty group has subspecialties (for example, a hand surgeon in a surgery practice).
The term *any professional services* in the definitions of new and established patients means that the established category is used for a patient who had a face-to-face encounter with a physician. The same rule applies to a patient of a physician who moves to another group practice. If the patient then sees the physician (or another of the same specialty) in the new practice, the patient is established. In other words, the patient is new to the practice but established to the provider.

**A Consultation or a Referral?**

To understand the subsection of E/M codes on consultations, review the difference between a consultation and a referral in coding terminology. A consultation occurs when a second physician, at the request of the patient’s physician, examines the patient. The second physician usually focuses on a particular issue and reports a written opinion to the first physician. The physician providing a consultation (“consult”) may perform a service for the patient but does not independently start a full course of treatment (although the consulting physician may recommend one) or take charge of the patient’s care. Consultations require use of the E/M consultation codes (the range from 99241 to 99255). Consultation requests and reports must be written documents that are placed in the medical records. Under most managed care guidelines, the reports should be reviewed and initialed by the primary care physician, with documentation of follow-up plans.

**BILLING TIP**

Consults: Three Rs

Coders remember the three Rs of consults: request opinion, render service, report back.

On the other hand, when the patient is referred to another physician, either the total care or a specific portion of care is transferred to that provider. The patient becomes a new patient of that doctor for the referred condition and may not return to the care of the referring physician until the completion of a course of treatment. Referrals require use of the regular office visit E/M service codes.

**COMPLIANCE GUIDELINE**

Medicare Does Not Pay Consult Codes

Because of fraudulent use of consult codes by some physicians—billing consults for what are new visits—in 2010 Medicare announced it would stop paying for both the outpatient and inpatient consult codes; providers must report these visits using regular office visit E/M codes.

Although people sometimes use these terms to mean the same thing, a referral and a consultation are different. This distinction is important to medical insurance specialists because the amounts that can be charged for the two types of service are different. Under a referral, the PCP or other provider is sending the patient to another physician for specialized care. If the sending provider requests a consultation, this is asking for the opinion of another physician regarding the patient’s care. The patient will be returned to the care of the original provider with the specialist’s written consultation report containing an evaluation of the patient’s condition and/or care.

**E/M Code Selection**

To select the correct E/M code, follow eight steps (see Figure 5.4).
Step 1. Determine the Category and Subcategory of Service Based on the Place of Service and the Patient’s Status

The list of E/M categories—such as office visits, hospital services, and preventive medicine services—is used to locate the appropriate place or type of service in the

Step 2. Determine the extent of the history that is documented.

Step 3. Determine the extent of the examination that is documented.

Step 4. Determine the complexity of medical decision making that is documented.

Step 5. Analyze the requirements to report the service level.

Step 6. Verify the service level based on the nature of the presenting problem, time, counseling, and care coordination.

Step 7. Verify that the documentation is complete.

Step 8. Assign the code.
Documentation: initial hospital visit to established patient

Index: Hospital Services
   Inpatient Services
   Initial Care, New or Established Patient

Code Ranges: 99221–99223

For most types of service, from three to five codes are listed. To select an appropriate code from this range, consider three key components: (1) the history the physician documented, (2) the examination that was documented, and (3) the medical decisions the physician documented. (The exception to this guideline is selecting a code for counseling or coordination of care when in some situations the amount of time the physician spends may be the only key component.)

**Step 2. Determine the Extent of the History That Is Documented**

History is the information the physician received by questioning the patient about the chief complaint and other signs or symptoms, about all or selected body systems, and about pertinent past history, family background, and other personal factors. (See Figure 2.2 on page 40 as an example of this documentation.)

The history is documented in the patient medical record as follows:

**History of present illness (HPI)** The history of the illness is a description of its development from the first sign or symptom that the patient experienced to the present time. These points about the illness or condition may be documented:

- Location (body area of the pain or symptom)
- Quality (type of pain or symptom, such as sudden or dull)
- Severity (degree of pain or symptom)
- Duration (how long the pain or symptom lasts and when it began)
- Timing (time of day the pain or symptom occurs)
- Context (any situation related to the pain or symptom, such as “occurs after eating”)
- Modifying factors (any factors that alter the pain or symptom)
- Associated signs and symptoms (things that also happen when the pain or symptom occurs)

**Review of systems (ROS)** The review of systems is an inventory of body systems. These systems are:

- Constitutional symptoms (such as fever or weight loss)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular (CV)
- Respiratory
- Gastrointestinal (GI)
- Genitourinary (GU)
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/lymphatic
- Allergic/immunologic

**Past medical history (PMH)** The past history of the patient’s experiences with illnesses, injuries, and treatments contains data about other major illnesses and
injuries, operations, and hospitalizations. It also covers current medications the
patient is taking, allergies, immunization status, and diet.

**Family history (FH)** The family history reviews the medical events in the
patient’s family. It includes the health status or cause of death of parents, brothers
and sisters, and children; specific diseases that are related to the patient’s chief com-
plaint or the patient’s diagnosis; and the presence of any known hereditary diseases.

**Social history (SH)** The facts gathered in the social history, which depend on
the patient’s age, include marital status, employment, and other factors.

The histories documented after the HPI are sometimes referred to as PFSH, for
past, family, and social history. This history is then categorized as one of four types
on a scale from lesser to greater extent of amount of history obtained:

1. **Problem-focused**: Determining the patient’s chief complaint and obtaining a
brief history of the present illness
2. **Expanded problem-focused**: Determining the patient’s chief complaint and obtaining
a brief history of the present illness, plus a problem-pertinent system review
of the particular body system that is involved
3. **Detailed**: Determining the chief complaint; obtaining an extended history of
the present illness; reviewing both the problem-pertinent system and additional
systems; and taking pertinent past, family, and/or social history
4. **Comprehensive**: Determining the chief complaint and taking an extended his-
tory of the present illness, a complete review of systems, and a complete past,
family, and social history

**Step 3. Determine the Extent of the Examination That Is Documented**

The physician may examine a particular body area or organ system or may conduct a
multisystem examination. The body areas are divided into the head and face; chest, includ-
ing breasts and axilla; abdomen; genitalia, groin, and buttocks; back; and each extremity.
The organ systems that may be examined are the eyes; the ears, nose, mouth, and
throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal;
skin; neurologic; psychiatric; and hematologic/lymphatic/immunologic.

The examination that the physician documents is categorized as one of four types
on a scale from lesser to greater extent:

1. **Problem-focused**: A limited examination of the affected body area or system
2. **Expanded problem-focused**: A limited examination of the affected body area or
system and other related areas
3. **Detailed**: An extended examination of the affected body area or system and
other related areas
4. **Comprehensive**: A general multisystem examination or a complete examination
of a single organ system

**Step 4. Determine the Complexity of Medical Decision Making That Is Documented**

The complexity of the medical decisions that the physician makes involves how
many possible diagnoses or treatment options were considered; how much infor-
mation (such as test results or previous records) was considered in analyzing the
patient’s problem; and how serious the illness is, meaning how much risk there is for
significant complications, advanced illness, or death.

The decision-making process that the physician documents is categorized as one
of four types on a scale from lesser to greater complexity:

1. **Straightforward**: Minimal diagnoses options, a minimal amount of data, and
minimum risk
2. **Low complexity**: Limited diagnoses options, a small amount of data, and low risk
3. **Moderate complexity:** Multiple diagnoses options, a moderate amount of data, and moderate risk
4. **High complexity:** Extensive diagnoses options, an extensive amount of data, and high risk

**Step 5. Analyze the Requirements to Report the Service Level**

The descriptor for each E/M code explains the standards for its selection. For office visits and most other services to new patients and for initial care visits, all three of the key components must be documented. If two are at a higher level and a third below that level, the standard is not met. This is stated in CPT as follows:

**99203 Office or other outpatient visit** for the evaluation and management of a new patient, which require these three key components:

- a detailed history
- a detailed examination
- medical decision making of low complexity

**BILLING TIP**

**Three Key Components**

This means that to select code 99203, the medical record must show that a detailed history and examination were taken and that medical decision making was at least at the level of low complexity.

For most services for established patients and for subsequent care visits, two out of three of the key components must be met. For example:

**99213 Office or other outpatient visit** for the evaluation and management of an established patient, which requires at least two of these three key components:

- an expanded problem-focused history
- an expanded problem-focused examination
- medical decision making of low complexity

Table 5.4 shows the type of decision tool many medical coders use to assign the correct E/M code for office visits with new and established patients.

**Step 6. Verify the Service Level Based on the Nature of the Presenting Problem, Time, Counseling, and Care Coordination**

**Nature of the presenting problem** Many descriptors mention two additional components: (1) how severe the patient’s condition is, referred to as the nature of the presenting problem, and (2) how much time the physician typically spends directly treating the patient. These factors, while not key components, help in selecting the correct E/M level. For example, the following wording appears in CPT after the 99214 code (office visit for the evaluation and management of an established patient):

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

**BILLING TIP**

**Two of Three Key Components**

This means that to select code 99213, the medical record must show that two of the three factors are documented.
The Time Factor

When a patient’s visit is mainly about counseling and/or coordination of care regarding symptoms or illness, the exact length of time the physician spends and documents is the controlling factor. If over 50 percent of the visit is spent counseling or coordinating care, time is the main factor. If an established patient’s visit is thirty minutes, for example, and twenty minutes are spent counseling, the E/M code is 99214.

The severity of the presenting problem helps determine medical necessity. Even if a physician documented comprehensive history and exam, with complex decision making, treating a minor problem like removal of uncomplicated sutures would not warrant a high E/M level.

Counseling Counseling is a discussion with a patient regarding areas such as diagnostic results, instructions for follow-up treatment, and patient education. It is mentioned as a typical part of each E/M service in the descriptor, but it is not required to be documented as a key component.
Care coordination  Coordination of care with other providers or agencies is also mentioned. When coordination of care is provided but the patient is not present, codes from the case management and care plan oversight services subsections are reported.

Step 7. Verify That the Documentation Is Complete
The documentation must contain the record of the physician’s work in enough detail to support the selected E/M code. The history, examination, and medical decision making must be sufficiently documented so that the medical necessity and appropriateness of the service could be determined by an independent auditor.

Step 8. Assign the Code
The code that has been selected is assigned. The need for any modifiers, based on the documentation of special circumstances, is also reviewed.

Reporting E/M Codes on Claims
Documentation Guidelines for Evaluation and Management
CMS and the AMA have published two sets of guidelines for documenting evaluation and management codes: the 1995 Documentation Guidelines for Evaluation and Management Services and a 1997 version. CMS and most payers permit providers to use either the 1995 or the 1997 E/M guidelines. Table 5.5 on pages 169–170 shows the items that can be documented to satisfy the general multisystem examination requirements under the 1997 Documentation Guidelines, which are most commonly used. There are guidelines similar to those in Table 5.5 for each major medical specialty.

BILLING TIP
Which Guidelines?
The medical practice should be clear about which set of guidelines, the 1995 or the 1997, it generally follows for E/M coding and reporting.

Office and Hospital Services
Office and other outpatient services are the most often reported E/M services. A patient is an outpatient unless admitted to a healthcare facility, such as a hospital or nursing home, for a twenty-four-hour period or longer.

▶ When a patient is evaluated and then admitted to a healthcare facility, the service is reported using the codes for initial hospital care (the range 99221–99223).
▶ The admitting physician uses the initial hospital care services codes. Only one provider can report these services; other physicians involved in the patient’s care, such as a surgeon or radiologist, use other E/M service codes or other codes from appropriate sections.
▶ Codes for initial hospital observation care (99218–99220), initial hospital care (99221–99223), and initial inpatient consultations (99251–99255) should be reported by a physician only once for a patient admission.

Emergency department services  An emergency department is hospital based and is available to patients twenty-four hours a day. When emergency services are reported, whether the patient is new or established is not applicable. Time is not a factor in selecting the E/M service code. The code ranges are 99281 to 99288.
<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
</table>
| Constitutional   | • Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (may be measured and recorded by ancillary staff)  
• General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming) |
| Eyes             | • Inspection of conjunctivae and lids  
• Examination of pupils and irises (eg, reaction to light and accommodation, size and symmetry)  
• Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and posterior segments (eg, vessel changes, exudates, hemorrhages) |
| Ears, Nose, Mouth, and Throat | • External inspection of ears and nose (eg, overall appearance, scars, lesions, masses)  
• Otoscopic examination of external auditory canals and tympanic membranes  
• Assessment of hearing (eg, whispered voice, finger rub, tuning fork)  
• Inspection of nasal mucosa, septum and turbinates  
• Inspection of lips, teeth and gums  
• Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils, and posterior pharynx |
| Neck             | • Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus)  
• Examination of thyroid (eg, enlargement, tenderness, mass) |
| Respiratory      | • Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement)  
• Percussion of chest (eg, dullness, flatness, hyperresonance)  
• Palpation of chest (eg, tactile fremitus)  
• Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs) |
| Cardiovascular   | • Palpation of heart (eg, location, size, thrills)  
• Auscultation of heart with notation of abnormal sounds and murmurs  
Examination of:  
• carotid arteries (eg, pulse, amplitude, bruits)  
• abdominal aorta (eg, size, bruits)  
• femoral arteries (eg, pulse, amplitude, bruits)  
• pedal pulses (eg, pulse amplitude)  
• extremities for edema and/or varicosities |
| Chest (Breasts)  | • Inspection of breasts (eg, symmetry, nipple discharge)  
• Palpation of breasts and axillae (eg, masses or lumps, tenderness) |
| Gastrointestinal (Abdomen) | • Examination of abdomen with notation of presence of masses or tenderness  
• Examination of liver and spleen  
• Examination for presence or absence of hema  
• Examination (when indicated) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses  
• Obtain stool sample for occult blood test when indicated |
| Genitourinary    | **Male:**  
• Examination of the scrotal contents (eg, hydrocele, spermatocele, tenderness of cord, testicular mass)  
• Examination of the penis  
• Digital rectal examination of prostate gland (eg, size, symmetry, nodularity, tenderness)  
**Female:**  
Pelvic examination (with or without specimen collection for smears and cultures) including  
• Examination of external genitalia (eg, general appearance, hair distribution, lesions)  
• Examination of urethra (eg, masses, tenderness, scarring)  
• Examination of bladder (eg, fullness, masses, tenderness)  
• Cervix (eg, general appearance, lesions, discharge) |

(continued)
Modifier 25

During an annual physical examination, an illness or clinical sign of a condition may be found that requires the physician to conduct an additional evaluation. In this case, the preventive medicine service code is reported first, followed by the appropriate E/M code for the new problem, adding the 25 modifier, Significant, Separate E/M Service.

### Table 5.5 General Multi-System Examination (continued)

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
</table>
| **•** Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or support)  
  • Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity) |
| **Lymphatic** | Palpation of lymph nodes in **two or more** areas:  
  • Neck  
  • Axillae  
  • Groin  
  • Other |
| **Musculoskeletal** |  
  • Examination of gait and station  
  • Inspection and/or palpation of digits and nails (eg, clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes)  
  Examination of joints, bones and muscles of **one or more of the following six** areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes:  
  • Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions  
  • Assessment of range of motion with notation of any pain, crepitation or contracture  
  • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity  
  • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements |
| **Skin** |  
  • Inspection of skin and subcutaneous tissue (eg, rashes, lesions, ulcers)  
  • Palpation of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening) |
| **Neurologic** |  
  • Test cranial nerves with notation of any deficits  
  • Examination of deep tendon reflexes with notation of pathological reflexes (eg, Babinski)  
  • Examination of sensation (eg, by touch, pin, vibration, proprioception) |
| **Psychiatric** |  
  • Description of patient’s judgment and insight  
  Brief assessment of mental status, including:  
  • Orientation to time, place and person  
  • Recent and remote memory  
  • Mood and affect (eg, depression, anxiety, agitation) |

### Content and Documentation Requirements

**Perform General Multi-System Examination**

<table>
<thead>
<tr>
<th>Level of Exam</th>
<th>Perform and Document</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem Focused</strong></td>
<td><strong>One to five</strong> elements identified by a bullet.</td>
</tr>
<tr>
<td><strong>Expanded Problem Focused</strong></td>
<td><strong>At least six</strong> elements identified by a bullet.</td>
</tr>
<tr>
<td><strong>Detailed</strong></td>
<td><strong>At least two</strong> elements identified by a bullet <strong>from each of six areas/systems</strong> or <strong>at least 12</strong> elements identified by a bullet <strong>in two or more areas/systems</strong>.</td>
</tr>
<tr>
<td><strong>Comprehensive</strong></td>
<td><strong>At least two</strong> elements identified by a bullet <strong>from each of nine areas/systems</strong>.</td>
</tr>
</tbody>
</table>
THINKING IT THROUGH 5.6

1. In which category—problem-focused, expanded problem-focused, detailed, or comprehensive—would you place these statements concerning patient history? Why?

CASE A
Patient seen for follow-up of persistent sinus problems including pain, stuffiness, and greenish drainage over the past twenty days. She continues to have left-sided pain in the forehead and maxillary areas and feels that her symptoms are worse around dust. She gets drainage into her throat, which causes her to cough. Review of systems reveals no history of diabetes or asthma. She has thyroid problems for which she takes Synthroid.

CASE B
Patient presents with a mild case of poison ivy on face and both hands contracted four days ago while gardening; has never been bothered by poison ivy before.

2. Using the office visit E/M codes, which code would you select for each of these cases?

CASE A
Chart note for established patient:
S: Patient returns for removal of stitches I placed about seven days ago. Reports normal itching around the wound area, but no pain or swelling.
O: Wound at lateral aspect of the left eye looks well healed. Decision made to remove the 5-0 nylon sutures, which was done without difficulty.
A: Laceration, healed.
P: Patient advised to use vitamin E for scar prophylaxis

CASE B
Initial office evaluation by oncologist of a sixty-five-year-old female with sudden unexplained twenty-pound weight loss. Comprehensive history and examination performed with medical decision making of high complexity.

CASE C
Office visit by established patient for regularly scheduled blood test to monitor long-term effects of Coumadin; nurse spends five minutes, reviews the test, confirms that the patient is feeling well, and, after speaking with the physician on the medications, states that no change in the dosage is necessary.

3. If a physician sees a patient in the hospital and the patient comes to the office for a follow-up visit, is the follow-up encounter coded for a new or established patient?

Preventive medicine services
Preventive medicine services are used to report routine physical examinations in the absence of a patient complaint. These codes, in the range 99381 to 99397, are divided according to the age of the patient. Counseling is coded from code range 99401 to 99429. Immunizations and other services, such as lab tests that are normal parts of an annual physical, are reported using the appropriate codes from the Medicine and the Pathology and Laboratory sections (see pages 179–180).
5.7 Anesthesia Codes

The codes in the Anesthesia section are used to report anesthesia services performed or supervised by a physician. These services include general and regional anesthesia as well as supplementation of local anesthesia. Each anesthesia code includes the complete usual services of an anesthesiologist:

- Usual preoperative visits for evaluation and planning
- Care during the procedure, such as administering fluid or blood, placing monitoring devices or IV lines, laryngoscopy, interpreting lab data, and nerve stimulation
- Routine postoperative care

**Example**

*Anesthesiologist Report:* Initial meeting with seven-year-old patient in good health, determined good candidate for required general anesthesia for tonsillectomy. Surgical procedure conducted April 4, 2016; patient in the supine position; administered general anesthesia via endotracheal tube. Routine monitoring during procedure. Following successful removal of the right and left tonsils, the patient was awakened and taken to the recovery room in satisfactory condition.

00170 P1 Anesthesia for intraoral procedures, including biopsy; not otherwise specified

(The modifier P1 is discussed below.)

Postoperative critical care and pain management requested by the surgeon are not included and can be billed in addition to the main anesthesia code by the anesthesiologist.

Anesthesia codes are reimbursed according to time. The American Society of Anesthesiologists assigns a base unit value to each code. The anesthesiologist also records the amount of time spent with the patient during the procedure and adds this to the base value. Difficulties, such as a patient with severe systemic disease, also add to the value of the anesthesiologist’s services.

**Structure**

The Anesthesia section’s subsections are organized by body site. Under each subsection, the codes are arranged by procedures. For example, under the heading *Neck*, codes for procedures performed on various parts of the neck (the integumentary system; the esophagus, thyroid, larynx, trachea; lymphatic system; and the major vessels) are listed. The body-site subsections are followed by two other subsections: (1) radiological procedures—that is, anesthesia services for patients receiving diagnostic or therapeutic radiology—and (2) other or unlisted procedures.

**Physical Status Modifiers**

In addition to the standard modifiers, anesthesia codes utilize modifiers that describe the patient’s health status. Because the patient’s health has a large effect on the level of difficulty of anesthesia services, anesthesia codes are assigned a physical status modifier. This modifier is added to the code. The patient’s physical status is selected from this list:

- P1 Normal, healthy patient
- P2 Patient with mild systemic disease
- P3 Patient with severe systemic disease
- P4 Patient with severe systemic disease that is a constant threat to life
- P5 Moribund patient who is not expected to survive without the operation
- P6 Declared brain-dead patient whose organs are being removed for donation purposes
Add-On Codes for Qualifying Circumstances

Four add-on codes are used to indicate that the administration of the anesthesia involved important circumstances that had an effect on how it was performed. As add-on codes, these do not stand alone but always appear in addition to the primary anesthesia procedure code. These four codes apply only to anesthesia and are described in the notes for the Anesthesia section.

+99100 Anesthesia for patient of extreme age (under one year or over age seventy)
+99116 Anesthesia complicated by utilization of total body hypothermia
+99135 Anesthesia complicated by utilization of controlled hypotension
+99140 Anesthesia complicated by specified emergency conditions

Reporting Anesthesia Codes

Anesthesia services for Medicare patients and most other patients are reported using codes from the Anesthesia section. However, medical insurance specialists should be aware that some private payers require anesthesia services to be reported by procedure codes from the Surgery section rather than by codes from the Anesthesia section. The anesthesia modifier is added to the procedure code.

THINKING IT THROUGH 5.7

1. What is the meaning of the modifier P3 when it appears with an anesthesia CPT code?

5.8 Surgery Codes

The codes in the Surgery section are used for the many hundreds of surgical procedures performed by physicians. This is the largest procedure code section, with codes ranging from 10021 to 69990.

Surgical Package

As defined in CPT, surgical package codes include all the usual services in addition to the operation itself:

- After the decision for surgery, one related E/M encounter on the date immediately before or on the date of the procedure
- The operation: preparing the patient for surgery, including injection of anesthesia by the surgeon (local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia), and performing the operation, including normal additional procedures, such as debridement
- Immediate postoperative care, including dictating operative notes and talking with the family and other physicians
- Writing orders
- Evaluating the patient in the postanesthesia recovery area
- Typical postoperative follow-up care

A complete procedure includes the operation, the use of a local anesthetic, and postoperative care, all covered under a single code.
Example

Procedural Statement: Procedure conducted eight days ago in office to correct hallux valgus (bunions) on both feet; local nerve block administered, correction by simple exostectomy. The global period for this procedure is ten days. Saw patient in office today for routine follow-up; complete healing.

Code: 28290 50 Bunion correction on both feet

In the Surgery section, the grouping of related work under a single procedure code is called a surgical package or global surgery rule. Government and private payers assign a fee to a surgical package code that reimburses all the services provided under it. The period of time that is covered for follow-up care is referred to as the global period. After the global period ends, additional services that are provided can be reported separately for additional payment. For most payers, there are two possible global preoperative periods—zero days and one day. Usually, there are three possible postoperative global periods: zero days, ten days, and ninety days.

Two types of services are not included in surgical package codes. These services are billed separately and are reimbursed in addition to the surgical package fee:

- Complications or recurrences that arise after therapeutic surgical procedures.
- Care for the condition for which a diagnostic surgical procedure is performed.

Routine follow-up care included in the code refers only to care related to recovery from the diagnostic procedure itself, not the condition. For example, a diagnostic colonoscopy is performed to examine a growth in the patient’s colon. An office visit after the surgery to evaluate the patient for chemotherapy because the tumor is cancerous is billed separately, not with code 99024 for a postoperative follow-up visit included in global service.

Separate Procedures

Some procedural code descriptors in the Surgery section are followed by the words separate procedure in parentheses. Separate procedure means that the procedure is usually done as an integral part of a surgical package—usually a larger procedure—but that in some situations it is not. If a separate procedure is performed alone or along with other procedures but for a separate purpose, it may be reported separately. For example:

42870 Excision or destruction lingual tonsil, any method (separate procedure)

Lingual tonsil excision is a separate procedure. It is usually a part of a routine tonsillectomy and so cannot be reported separately when a tonsillectomy is performed. When it is done independently, however, this code can be reported.

Structure

Most of the Surgery section’s subsections are organized by body system and then divided by body site. Procedures are grouped next, under headings followed by specific procedures. For example:

Subsection: DIGESTIVE SYSTEM
Site: Lips
Heading—type of procedure: Excision
Description—specific procedure: 40490 Biopsy of lip

The exceptions to the usual subsection structure are the Laparoscopy/Hysteroscopy subsection, which groups those operative procedures, and the Maternity Care and Delivery subsection, organized by type of service, such as postpartum care.
Modifiers

A number of modifiers are commonly used to indicate special circumstances involved with surgical procedures.

- **22 Increased procedural services**: Used with rare, unusual, or variable surgery services; requires documentation.
- **26 Professional component**: Used to report the professional components when a procedure has both professional and technical components.
- **32 Mandated service**: Used when the procedure is required by a payer or is a government, legislative, or regulatory requirement.
- **33 Preventive services**: Used to indicate that the primary purpose of a service is the delivery of an evidence-based preventive services.
- **47 Anesthesia by surgeon**: Used when the surgeon (rather than an anesthesiologist) administers regional or general anesthesia (local/topical anesthesia is bundled in the surgical code).
- **50 Bilateral procedure**: Used when identical bilateral procedures were performed during the same operation, either through the same incision or on separate body parts, such as left and right bunion correction. Attach the bilateral modifier to the code for the first procedure to indicate that the procedure was done bilaterally. For example, to report a puncture aspiration of one cyst in each breast:
  
  19000 50  Puncture aspiration of cyst of breast

  The trend in annual updates is to replace bilateral codes with unilateral codes to which modifier 50 is attached if needed. However, a few codes are defined as bilateral procedures. For example:
  
  32853  Lung transplant, double (bilateral sequential or en bloc)

- **51 Multiple procedures**: Used to identify a second procedure or multiple procedures during the same operation. The additional procedures are the same type and done to the same body system. Attach the modifier to the second procedure code. For example, to report two procedures, a bunionectomy on the great toe and, in the same session, correction of a hammertoe on the fourth toe:
  
  28290  Hallux valgus (bunions) correction
  28285 51  Hammertoe correction

- **52 Reduced services**: Used when a procedure is less extensive than described. The modifier is attached to the procedure code. It is not used to identify a reduced or a discounted fee. Instead, usually, the normal fee is listed, and the payer determines the amount of the reduction.
- **53 Discontinued procedure**: Used when the procedure is discontinued due to circumstances that threaten the patient’s well-being—for example, surgery discontinued because the patient went into shock during the operation.
- **54 Surgical care only**: Added to the surgery code when the surgeon performs only the surgery itself, without preoperative or postoperative services. The payer will reduce the fee to reflect only that part of the surgical package.
- **55 Postoperative management only**: Added to the surgery code when the physician provides only the follow-up care in the global period after another physician has done the surgery. The payer will reduce the fee to reflect only that part of the surgical package.
- **56 Preoperative management only**: Added to the surgery code when the physician provides only preoperative care. The payer will reduce the fee to reflect only that part of the surgical package.
- **58 Staged or related procedure or service by the same physician during the postoperative period**: Used when the physician performs a postoperative procedure (1) as planned
during the surgery to be done later, (2) that is more extensive than the original procedure, or (3) for therapy after diagnostic surgery.

▶ **59 Distinct procedural service:** Used for a different encounter or procedure for the same patient on the same day. A different patient encounter, an unrelated procedure, a different body site or system, or a separate incision or injury must be involved. The modifier may also be used to describe the requirement for critical care and nonroutine pain management. If a separate procedure is performed with other procedures, the 59 modifier is added to the separate code to show that it is a distinct, independent procedure, not part of a surgical package.

▶ **62 Two surgeons:** Used when a specific surgical procedure requires two surgeons, usually of different specialties; each appends the modifier to the surgical code. Usually each surgeon performs a distinct part of the procedure and dictates a separate operative report. If each surgeon reports different surgical procedure codes, the modifier is not used.

▶ **63 Procedure performed on infants less than 4 kgs:** Used when the patient is an infant weighing less than 4 kgs.

▶ **66 Surgical team:** Used in very complex procedures that usually require the simultaneous services of physicians of different specialties. Usually used to report transplant-type procedures only.

▶ **76 Repeat procedure or service by same physician or other qualified healthcare professional:** Used when a physician repeats a procedure performed earlier.

▶ **77 Repeat procedure by another physician or other qualified healthcare professional:** Used when a physician repeats a procedure done by another physician.

▶ **78 Unplanned return to the operating/procedure room by the same physician or other qualified healthcare professional following initial procedure for a related procedure during the postoperative period:** Used when the patient develops a complication during the postoperative period that requires an additional procedure by the same physician.

▶ **79 Unrelated procedure or service by the same physician during the postoperative period:** Used when a second, unrelated surgical procedure is performed by the same physician during the postoperative period.

▶ **80 Assistant surgeon:** Used when a physician assists another during a surgical procedure. Each physician reports the services using the same code, but the assistant surgeon appends the modifier to the code.

▶ **81 Minimum assistant surgeon:** Used when an assistant surgeon assists another during only part of a surgical procedure.

▶ **82 Assistant surgeon (when qualified resident surgeon not available):** Used in teaching hospitals where residents usually assist with surgery but none was available during the reported procedure, so a surgeon performed the assistant's work.

▶ **90 Reference (outside) laboratory:** Used when laboratory procedures are done by someone other than the reporting physician.

▶ **91 Repeat clinical diagnostic laboratory test:** Used when laboratory procedures are repeated.

▶ **92 Alternative laboratory platform testing:** Used when laboratory testing is being performed using a kit or transportable instrument that wholly or in part consists of a single-use, disposable analytical chamber.

▶ **99 Multiple modifiers:** Used when more than one modifier is required; the 99 modifier is appended to the basic procedure, followed by the other modifiers in descending order.

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**Reporting Surgical Codes**

Surgical package codes often are “bundled” by payers. Bundling is using a single payment for two or more related procedure codes. Bundled payment combinations are based on payers’ judgment of the correct value for the physician’s work. As an example of a bundled code, CPT 27370 codes an injection procedure for knee arthrography.
If this code is billed, payers will not also pay for any of these codes on the same day of service:

20610 Injection of major joint
76000 Fluoroscopy (separate procedure)
77003 Fluoroscopic guidance

Because 27370 is bundled, neither 20610, 76000, nor 77003 should be billed with it; payment for each of these codes is already included in the payment rate.

When such services are billed, physicians must report the bundled code rather than each of the other codes separately. Reporting anything that is included in the bundled code is considered **unbundling**, or **fragmented billing**. Doing so causes denied claims and may result in an audit.

### Reporting Sequence

When payers reimburse multiple surgical procedures performed on the same day for the same patient, they pay the full amount of the first listed surgical procedure, but they often pay reduced percentages of the subsequent procedures. For maximum payment when multiple procedures are reported, the most complex or highest-level code—the procedure with the highest reimbursement value—should be listed first. The subsequent procedures are listed with the modifier 51 (indicating multiple procedures).

When warranted, to avoid reduced payment for multiple procedures, the modifier 59 is used to indicate distinct procedures rather than multiple procedures. This is usually done when the surgeon performs procedures on two different body sites or organ systems, such as the excision of a lesion on the chest as well as the incision and drainage (I & D) of an abscess on the leg.

### BILLING TIP

**Lesion Excision**

The choice of the correct code for the surgical removal of a lesion depends on the pathology report. There are different code ranges for benign lesions and malignant lesions. Coders should wait for a pathology report before coding lesion excisions from the benign or malignant code ranges.

### THINKING IT THROUGH 5.8

1. Rank the following codes in order from highest to lowest reimbursement level, and explain your rationale.
   - 44950 51
   - 44950 59
   - 44950 53

2. Review CPT code 44180 and determine whether it is correct to report a diagnostic laparoscopy (CPT code 49320) with a surgical laparoscopy.

### 5.9 Radiology Codes

The codes in the Radiology section are used to report radiological services performed by or supervised by a physician. Radiology procedures have two parts:

1. **The technical component**: The technologist, the equipment, and processing, including preinjection and postinjection services such as local anesthesia, placement of needle or catheter, and injection of contrast material

2. **The professional component**: The reading of the radiological examination and the written report of interpretation by the physician
Radiology codes follow the same types of guidelines as noted in the Surgery section. For example, some radiology codes are identified as separate procedure codes. These codes are usually part of a larger, more complex procedure and should not be reported as separate codes unless the procedure was done independently. Also, some codes are add-ons, such as those covering additional vessels that are studied after the basic examination. These codes are used with the primary codes, not alone.

**BILLING TIP**

**Professional Component Requirement**

Billing the professional component of a radiological procedure requires a written interpretation from the physician. This documentation contains the patient’s identifying information, the clinical indications for the procedure, the process followed, and the physician’s impressions of the findings.

**Unlisted Procedures and Special Reports**

New procedures are common in the area of radiology services. There are codes for nearly twenty unlisted code areas, such as:

- **78299** Unlisted gastrointestinal procedure, diagnostic nuclear medicine

When unlisted codes are reported, a special report must be attached that defines the nature, extent, and need for the procedure and describes the time, effort, and equipment necessary to provide it.

**Contrast Material**

For some radiological procedures, the physician decides whether it is best to perform the procedure with or without contrast material, a substance administered in the patient’s blood vessels that helps highlight the area under study. For example, computerized tomography (CT) and magnetic resonance imaging (MRI) provide different types of information about body parts and may be performed with or without contrast material. The term *with contrast* means only contrast materials given in the patient’s veins or arteries. Contrast materials administered orally or rectally are coded as without contrast.

**Structure and Modifiers**

The diagnostic radiology, diagnostic ultrasound, and nuclear medicine subsections of the Radiology section are structured by type of procedure, followed by body sites and then specific procedures. For example:

- **Type:** Diagnostic Ultrasound
- **Body site:** Chest
- **Procedure:** Echography, chest, B-scan and/or real time with image documentation

**BILLING TIP**

**Modifier 26**

If the physician does not own the equipment used for the radiology procedure, the modifier 26 is appended to the code, such as:

- **76511 26** Ophthalmic biometry by ultrasound echography, A-Scan

The radiation oncology subsection is organized somewhat differently. The first group of codes covers the planning services oncologists perform to set up a patient’s radiation therapy treatment for cancer.
The following modifiers are commonly used in the Radiology section: 22, 26, 32, 51, 52, 53, 58, 59, 62, 66, 76, 77, 78, 79, 80, 90, and 99. Table 5.2 on page 155 has a brief description of each modifier.

### Reporting Radiology Codes

Most radiology services are performed and billed by radiologists working in hospital or clinic settings. Medical practices usually do not have radiology equipment and instead refer patients to these specialists. In many cases, the radiologist performs both the technical and the professional components. Codes are selected based on body part, and the number/type of views.

#### THINKING IT THROUGH 5.9

1. Why are special reports frequently used when filing radiology claims?

### 5.10 Pathology and Laboratory Codes

The codes in the Pathology and Laboratory section cover services provided by physicians or by technicians under the supervision of physicians. A complete procedure includes:

- Ordering the test
- Taking and handling the sample
- Performing the actual test
- Analyzing and reporting on the test results

#### Panels

Certain tests are customarily ordered together to detect particular diseases or malfunctioning organs. These related tests are grouped under laboratory panels for reporting convenience. When a panel code is reported, all the listed tests must have been performed (otherwise, just the individual tests are billed). For example, the electrolyte panel requires these tests:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80051</td>
<td>Electrolyte panel</td>
</tr>
</tbody>
</table>

This panel must include the following:

- Carbon dioxide (82374)
- Chloride (82435)
- Potassium (84132)
- Sodium (84295)

Panels are bundled codes, so when a panel code is reported, no individual test within it may be additionally billed. Other tests that were performed outside that panel may be billed, of course.

#### BILLING TIP

**Laboratory Work**

Medicare does not permit a physician who does not perform the lab work to bill for it. However, other payers allow it. When the physician orders the lab test and then pays the lab (called the reference lab) for the service, the physician may then report that test. The modifier 90 is attached to the code for the lab test.
Unlisted Procedures and Special Reports

New developments are frequent in pathology and laboratory services. There are codes for twelve unlisted code areas, such as:

86486  Unlisted antigen, each

Any unlisted code must be submitted with a special report that defines the nature, extent, and need for the procedure and describes the time, effort, and equipment necessary to provide it.

Structure and Modifiers

Procedures and services are listed in the index under the following types of main terms:

- Name of the test, such as urinalysis, HIV, skin test
- Procedure, such as hormone assay
- Abbreviation, such as TLC screen
- Panel of tests, such as Complete Blood Count

The following modifiers are commonly used with pathology and laboratory codes: 22, 26, 32, 52, 53, 59, 90, and 91. Table 5.2 on page 155 has a brief description of each modifier.

Reporting Pathology and Laboratory Codes

Some medical practices have laboratory equipment and perform their own testing. In-office labs are guided by federal safety regulations from OSHA (the Occupational Safety and Health Administration), and the tests that can be performed are regulated by CLIA (the Clinical Laboratory Improvement Amendment of 1988). The CLIA certification program awards one of two levels of certification: (1) waived tests and provider-performed microscopy (PPM) procedures and (2) moderate- or high-complexity testing. The in-office lab with the first level can perform common tests, such as dipstick urinalysis and urine pregnancy, and PPM procedures such as nasal smears for eosinophils and pinworm exams.

If the medical practice does not have an in-office lab, the physician may either take the specimen, reporting this service only (for example, using code 36415 for venipuncture to obtain a blood sample), and send it to an outside lab for processing or refer the patient to an outside lab for the complete procedure.

THINKING IT THROUGH 5.10

1. If a test for ferritin and a comprehensive metabolic panel are both performed, can both be reported?
2. Is it correct to report a comprehensive metabolic panel and an electrolyte panel for the same patient on the same day?

5.11 Medicine Codes

The Medicine section contains the codes for the many types of evaluation, therapeutic, and diagnostic procedures that physicians perform. (Codes for the Evaluation and Management section described earlier in the chapter, 99201 to 99499, fall numerically at the end of this section, but they appear first in CPT because they are the most frequently used codes.) Medicine codes may be used for procedures and services done or supervised by a physician of any specialty. They include many procedures and services provided by family practice physicians, such as immunizations.
and injections. The services of many specialists, such as allergists, cardiologists, and psychiatrists, are also covered in the Medicine section. Some Medicine section codes are for ancillary services that are used to support diagnosis and treatment, such as rehabilitation, occupational therapy, and nutrition therapy.

Codes from the Medicine section may be used with codes from any other section. Add-on codes and separate procedure codes are included in the Medicine section. Their use follows the guidelines described for previous sections.

Structure and Modifiers

The subsections are organized by type of service. Many subsections have notes containing usage guidelines and definitions. Some services, for example, have subcategories for new and established patients.

The following modifiers are commonly used with codes in the Medicine section: 22, 26, 32, 51, 52, 53, 55, 56, 57, 58, 59, 76, 77, 78, 79, 90, 91, and 99. Table 5.2 on page 155 has a brief description of each modifier.

Reporting Medicine Codes

Some of the services in the Medicine section are considered Evaluation and Management services, even though they are not listed in the E/M section. For these codes, the 51 modifier, Multiple Procedures, may not be used. For example, if a physician makes a second, brief visit to a patient in the hospital and provides psychoanalysis, these services are reported separately:

- 99231 Subsequent hospital care, problem focused/straightforward or low complexity decision making
- 90845 Psychoanalysis

Immunizations require two codes, one for administering the immunization and the other for the particular vaccine or toxoid that is given. For example, when a patient receives an MMRV vaccine, these two codes are used:

- 90471 Immunization administration
- 90710 Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use

The descriptors for injection codes also require two codes, one for the injection and one for the substance that is injected (the exception is allergy shots, which have their own codes in the Allergy and Clinical Immunology subsection). For example, to report the intravenous administration of an anti-emetic:

- 96374 Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
- 99070 Supplies and materials supplied by physician, antiemetic

BILLING TIP

Immunizations and Office Visits

To report a patient’s visit for just an immunization, some medical practices use E/M 99211 along with a code for the immunization. This is a misuse of the E/M code, which requires some significant, separate E/M service. Code only the immunization.

Some commercial payers and Medicare use a HCPCS code, instead of CPT 99070, for the material that is injected.
5.12 Category II and III Codes

The Category II code set contains supplemental tracking codes to help collect data regarding services, such as prenatal care and tobacco use cessation counseling, that are known to contribute to good patient care. Having codes available reduces the amount of administrative time needed to gather these data from documentation.

The use of these codes is optional and does not affect reimbursement. The codes are not required for correct coding and are not a substitute for Category I codes.

Category II codes are four digits followed by an alphabetical character. They are arranged according to the following categories:

- Composite Codes
- Patient Management
- Patient History
- Physical Examination
- Diagnostic Screening Processes or Results
- Therapeutic, Preventive, or Other Interventions
- Follow-up or Other Outcomes
- Patient Safety
- Structural Measures

The Category III code set contains temporary codes for emerging technology, services, and procedures. If a Category III code is available for a new procedure, this code must be reported instead of a Category I unlisted code.

BILLING TIP

Category II and III Code Updates

Category II and III codes are released twice a year, on January 1 and July 1.

The codes in this section are not like CPT Category I codes, which require that the service or procedure be performed by many healthcare professionals in clinical practice in multiple locations and that FDA approval, as appropriate, has already been received. For these reasons, temporary codes for emerging technology, services, and procedures have been placed in a separate section of the CPT book. When a temporary service or procedure does meet these requirements, it is listed as a Category I code in the appropriate section of the main text.

Category III codes are four digits followed by an alphabetical character.

Note that the standard CPT modifiers can be used with Category III codes but not with Category II codes for which specific Category II modifiers can be used.

THINKING IT THROUGH 5.12

1. What source is used to verify that CPT Category II and III codes are current?
5.13 HCPCS

The national codes for products, supplies, and those services not included in CPT are in the HCPCS Level II code set. HCPCS codes permit physician practices to bill for items provided to patients in Medicare, Medicaid, and many private payers’ plans. Payers need to understand the medical necessity of these items for reimbursement, just as they do for CPT codes.

The Healthcare Common Procedure Coding System, referred to as HCPCS, was set up to give healthcare providers a coding system that describes specific products, supplies, and services that patients receive. HCPCS codes provide uniformity in medical services reporting and enable the collection of statistical data on medical procedures, products, and services. In the early 1980s, the use of HCPCS codes for claims was optional. With the implementation of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, HCPCS has become mandatory for coding and billing.

HCPCS is technically made up of two sections of procedural codes. Level I is the CPT (Current Procedural Terminology) maintained by the AMA. The second section is the HCPCS Level II codes that identify supplies, products, and services not in Level I. The Centers for Medicare and Medicaid Services (CMS) is responsible for maintaining the HCPCS code set.

Level II Codes

A Level II code is made up of five characters beginning with a letter followed by four numbers, such as J7630. The HCPCS Tabular List of codes has more than twenty sections, each of which covers a related group of items. For example, the E section covers durable medical equipment (DME), reusable medical equipment ordered by physicians for patients’ use at home, such as walkers and wheelchairs. Durable medical equipment:

► Can withstand repeated use
► Is primarily and customarily used for a medical purpose
► Generally is not useful to a person in the absence of an illness or injury
► Is appropriate for use in the home

HCPCS Level II codes can be used in conjunction with the CPT codes on bills for patients and on claims for Medicare, Medicaid, and other payers. As with CPT codes, reporting HCPCS codes does not guarantee payment. Each payer’s coverage and payment decisions apply. Also, decisions regarding the addition, deletion, and revision of HCPCS codes are made independent of the adjudication process. Table 5.6 details these sections and provides examples of entries.

**BILLING TIP**

DME MACs

CMS has four Durable Medical Equipment Medicare Administrative Contractors (DME MACs) that process Medicare claims for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

Permanent Versus Temporary Codes

The CMS HCPCS Workgroup is a code advisory committee made up of representatives from CMS and other government agencies. Its role is to identify services for which new codes are needed. Temporary codes may later be given permanent status if they are widely used.

**Permanent Codes**

The CMS HCPCS Workgroup maintains the permanent national codes that are available for use by all government and private payers. No code changes can be made
unless all panel members agree. Advisers from private payers provide input to the Workgroup.

Some codes are miscellaneous or not elsewhere classified (NEC) (as in ICD-10-CM codes). All payers use these codes to bill for items or services that do not have permanent national codes. Many of these codes are given permanent national status in the updating process.

**BILLING TIP**

*Attachments for Claims with Miscellaneous Codes*

Claims with miscellaneous codes are manually reviewed for medical necessity. Their use should be infrequent because it may delay payment and increase chances of denied claims.
Before using a miscellaneous code on a claim form, the medical insurance specialist should check with the payer to determine whether there is a specific code that should instead be used. For Medicare claims sent to one of the DME MACs, the medical insurance specialist should check with the Pricing, Coding Analysis, and Coding (PDAC) contractors under contract to CMS. The PDAC is responsible for providing assistance in determining which HCPCS codes describe DMEPOS items for Medicare billing purposes.

Temporary Codes

All payers may also use the temporary national codes. When temporary codes become permanent national HCPCS Level II codes, the coding reference indicates the change.

- **C codes:** Valid only on Medicare claims and used specifically for the hospital outpatient prospective payment system
- **G codes:** For the professional component of services and procedures not found in the CPT
- **Q codes:** For drugs, medical equipment, and services that have not been given CPT codes and are not identifiable in the Level II codes but are needed to process a billing claim
- **K codes:** Developed to assist DMERCs when no permanent national codes exist for the product or supply
- **S codes:** For private insurers to identify drugs, services, supplies, and procedures; used by the Medicaid program but not reimbursable under Medicare
- **H codes:** For state Medicaid agencies to identify mental health services (alcohol and drug treatment)
- **T codes:** For state Medicaid agencies when there are not permanent national codes; can be used for private insurers but not for Medicare

HCPCS Updates

HCPCS Level II is a public code set. Information about the codes and updates is located on the CMS HCPCS website. Many publishers also print easy-to-use HCPCS reference books.

HCPCS Level II permanent national codes are released on January 1 of each year and are reviewed continuously throughout the year. Any supplier or manufacturer can ask CMS to make changes. Requests must be submitted in writing and must describe the reason for the proposed changes. CMS must receive requests by January 3 of the current year for the changes to be considered for the next January 1 release. Revisions received after the deadline are considered for the next annual update.

Temporary national codes are updated quarterly. Once established, temporary codes are usually implemented within ninety days to provide enough time to inform physician practices and suppliers about them via bulletins and newsletters.

The HCPCS website lists current HCPCS codes, has an alphabetical index of HCPCS codes by type of service or product, and has an alphabetical table of drugs for which there are Level II codes. The newly established temporary codes and effective dates for their use are also posted to allow for quick dissemination of coding requests and decisions.

HCPCS Coding Procedures

To look up codes in HCPCS Level II, follow the same coding conventions that are used to assign ICD-10-CM and CPT codes. When using ICD-10-CM, the coder first uses the Alphabetic Index to locate the appropriate diagnosis and then verifies the code selection using the Tabular List. Just as for coding using the CPT, the Index—arranged alphabetically and located at the end of the text—is used to find the main term, which is then verified in the code sections that are arranged numerically.
Researching HCPCS Codes

Publishers’ features vary for HCPCS code books, and the index, which is not a standard element because it is for both ICD-10-CM and CPT, is not always complete or helpful. Coders may need to look up a desired item by scanning through a probable listing if the item is not an indexed entry.

Billing Tip

Coding Steps

To assign HCPCS Level II codes, first look up the name of the supply or item in the index. The index is arranged alphabetically, with the main term in bold print followed by the HCPCS Level II code. Verify the code selection in the appropriate Tabular List section of the HCPCS Level II code book.

Assigning drug codes is made easier by the Table of Drugs in the HCPCS code book. It presents drugs in alphabetical order, followed by the dosage, the way the drug is administered (such as intravenously), and the HCPCS code.

Adenosine 6 mg IV J0150
Adenosine 30 mg IV J0152

Also to be checked are symbols next to some codes. Publishers use various symbols in HCPCS code books, but their meaning is always explained in the legend on the bottom of each page. The following example shows the symbols for new and revised codes used in one HCPCS code book:

- ▼ New
- ▶ Revised
- ◊ Deleted

Reporting Quantities

The coder should carefully review the description of quantities associated with HCPCS codes. Drug descriptions should be carefully checked to note the method of administration and the dosage. The selected code must match the administration method and dose that are documented in the medical record or on the encounter form.

The administration methods common in offices include:

- ▲ IV: Intravenous injection
- ▲ IM: Intramuscular injection
- ▲ IA: Intraarterial injection
- ▲ SC: Subcutaneous injection
- ▲ INH: Inhalant
- ▲ Oral: Taken by mouth
- ▲ Nasal Spray: Sprayed into the nostril

The dosage is described in appropriate quantities, such as milligrams (mg) or milliliters (ml). For example, the listing for Prednisone is:

J7506 Prednisone, oral, per 5 mg

If a patient’s dosage is 10 mg, the code to report is:

J7506 X2

The HCPCS code is followed by the quantity 2. If the patient has been administered 12 mg, the unit indicator is 3.

Multiple units of other items are also reported by the HCPCS code followed by the units. Five surgical stockings would be coded as:

A4495 X5
HCPCS Modifiers

Like CPT, HCPCS Level II uses modifiers, called Level II modifiers, to provide additional information about services, supplies, and procedures. For example, a UE modifier is used when an item identified by a HCPCS code is used equipment, and an NU modifier is used for new equipment. HCPCS Level II modifiers are made up of either two letters or one letter and one number:

- F5 Right hand, thumb
- HS Family/couple without client present

Payers may require the use of both Level II modifiers and CPT modifiers on claims. The modifiers in Table 5.7 are among the most prevalent.

HCPCS Modifiers for Never Events

The Medicare and Medicaid programs administered by CMS do not cover a surgical or other invasive procedure to treat a medical condition when the practitioner erroneously performs:

1. The correct procedure but on the wrong body part
2. The correct procedure but on the wrong patient
3. The wrong procedure on the patient

Each of these situations is called a never event because they are preventable events that should never occur in healthcare and therefore the policy is to never pay the healthcare provider for them. Noncoverage encompasses all related services provided in the operating room when the error occurs, including those separately performed by other physicians, and all other services performed during the same hospital visit.

Following the surgery, however, any reasonable and necessary services are covered regardless of whether they are or are not related to the surgical error.

CMS created three new HCPCS Level II modifiers for practitioners, ambulatory surgical centers (ASCs), and hospital outpatient facilities to use to report erroneous surgeries. Append one of the following HCPCS Level II modifiers to the CPT procedure codes for the surgery:

- PA Surgery wrong body part
- PB Surgery wrong patient
- PC Wrong surgery on patient

HCPCS Billing Procedures

There are specific procedures to be followed for Medicare and Medicaid patients and for patients with private insurance. Some procedures require both a CPT code and a HCPCS code, such as reporting both the administration of an injection and the material that was injected.

Medicare and Medicaid Billing

When medical insurance specialists are processing claims for patients who have Medicaid or Medicare, they should consult HCPCS code books to identify services reimbursable under HCPCS Level II. Symbols direct the biller or coder to Medicare billing rules that are reprinted in the appendices of the HCPCS code books. For example, here are the symbols from one publication:

- ♦ Not Covered by or Valid for Medicare
- ✢ Special Coverage Instructions Apply
- ★ Carrier Discretion

When the symbol for Special Coverage Instructions Apply appears, Medicare resources must be checked online.
### Table 5.7  Selected HCPCS Level II (National) Modifiers

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CA</td>
<td>Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission</td>
</tr>
<tr>
<td>E1</td>
<td>Upper left, eyelid</td>
</tr>
<tr>
<td>E2</td>
<td>Lower left, eyelid</td>
</tr>
<tr>
<td>E3</td>
<td>Upper right, eyelid</td>
</tr>
<tr>
<td>E4</td>
<td>Lower right, eyelid</td>
</tr>
<tr>
<td>FA</td>
<td>Left hand, thumb</td>
</tr>
<tr>
<td>F1</td>
<td>Left hand, second digit</td>
</tr>
<tr>
<td>F2</td>
<td>Left hand, third digit</td>
</tr>
<tr>
<td>F3</td>
<td>Left hand, fourth digit</td>
</tr>
<tr>
<td>F4</td>
<td>Left hand, fifth digit</td>
</tr>
<tr>
<td>F5</td>
<td>Right hand, thumb</td>
</tr>
<tr>
<td>F6</td>
<td>Right hand, second digit</td>
</tr>
<tr>
<td>F7</td>
<td>Right hand, third digit</td>
</tr>
<tr>
<td>F8</td>
<td>Right hand, fourth digit</td>
</tr>
<tr>
<td>F9</td>
<td>Right hand, fifth digit</td>
</tr>
<tr>
<td>GA</td>
<td>Waiver of liability statement issued as required by payer policy, individual case</td>
</tr>
<tr>
<td>GG</td>
<td>Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day</td>
</tr>
<tr>
<td>GY</td>
<td>Item or service statutorily excluded, does not meet the definition of any Medicare benefit or for non-Medicare insurers, is not a contract benefit</td>
</tr>
<tr>
<td>GZ</td>
<td>Item or service expected to be denied as not reasonable and necessary</td>
</tr>
<tr>
<td>LC</td>
<td>Left circumflex coronary artery</td>
</tr>
<tr>
<td>LD</td>
<td>Left anterior descending coronary artery</td>
</tr>
<tr>
<td>RC</td>
<td>Right coronary artery</td>
</tr>
<tr>
<td>LT</td>
<td>Left side (used to identify procedures performed on the left side of the body)</td>
</tr>
<tr>
<td>RT</td>
<td>Right side (used to identify procedures performed on the right side of the body)</td>
</tr>
<tr>
<td>QM</td>
<td>Ambulance service provided under arrangement by a provider of services</td>
</tr>
<tr>
<td>QN</td>
<td>Ambulance service furnished directly by a provider of services</td>
</tr>
<tr>
<td>TA</td>
<td>Left foot, great toe</td>
</tr>
<tr>
<td>T1</td>
<td>Left foot, second digit</td>
</tr>
<tr>
<td>T2</td>
<td>Left foot, third digit</td>
</tr>
<tr>
<td>T3</td>
<td>Left foot, fourth digit</td>
</tr>
<tr>
<td>T4</td>
<td>Left foot, fifth digit</td>
</tr>
<tr>
<td>T5</td>
<td>Right foot, great toe</td>
</tr>
<tr>
<td>T6</td>
<td>Right foot, second digit</td>
</tr>
<tr>
<td>T7</td>
<td>Right foot, third digit</td>
</tr>
<tr>
<td>T8</td>
<td>Right foot, fourth digit</td>
</tr>
<tr>
<td>T9</td>
<td>Right foot, fifth digit</td>
</tr>
<tr>
<td>TC</td>
<td>Technical component</td>
</tr>
</tbody>
</table>

Source: HCPCS 2013.
**Private Payer Billing**

When commercial payers want participating practices to use HCPCS codes instead of the corresponding CPT codes, they inform the practices. For example, plans from the BlueCross BlueShield Association send customers a monthly publication that outlines CPT and HCPCS changes, deletions, and additions as they relate to billing for services, procedures, and equipment.

**THINKING IT THROUGH 5.13**

Assign the correct modifiers for the following situations.

1. Right hand, fourth digit
2. Left foot, great toe
3. Ambulance service furnished directly by a service provider
   Using HCPCS Level II, assign the appropriate codes.
4. Ambulance service, basic life support, nonemergency transport
5. Breast pump, manual, any type
6. Injection, zidovudine, 10 mg
7. Wet mounts, including preparations of vaginal, cervical, or skin specimens
8. Hospital bed, total electric, with any type side rails, with mattress

**BillinG tip**

**Keep HCPCS Updates**

Retain HCPCS updates from private payers and keep them where they can be readily accessed when preparing claims.

**Chapter Summary**

<table>
<thead>
<tr>
<th>Learning Objective</th>
<th>Key Concepts/Examples</th>
</tr>
</thead>
</table>
| **5.1** Explain the CPT code set. Pages 144–146 | • CPT contains the HIPAA-mandated system of codes for physicians’ medical, evaluation and management, and procedural services.  
The CPT code set contains:  
• Category I codes for physician work  
• Category II codes for tracking performance measures  
• Category III codes for temporary assignment to emerging technologies, services, and procedures |
| **5.2** Describe the organization of CPT. Pages 146–151 | • CPT has an index that is used first in the process of selecting a code. It contains alphabetic descriptive main terms and subterms for the procedures and services contained in the main text.  
CPT contains the main text, which has six sections of Category I codes:  
• Evaluation and Management  
• Anesthesia  
• Surgery  
• Radiology  
• Pathology and Laboratory  
• Medicine  
as well as Category II and Category III codes  
• Codes are listed in the main text and are generally grouped by body system or site or by type of procedure.  
The AMA publication of CPT has fourteen appendixes that are organized by topic. |
<table>
<thead>
<tr>
<th>Learning Objective</th>
<th>Key Concepts/Examples</th>
</tr>
</thead>
</table>
| 5.3 Summarize the use of format and symbols in CPT. Pages 151–153 | - Each coding section of CPT begins with section guidelines that discuss definitions and rules for the use of codes, such as for unlisted codes, special reports, and notes for specific subsections.  
- When a main entry has more than one code, a semicolon follows the common part of a descriptor in the main entry, and the unique descriptors that are related to the common description are indented below it. Seven symbols are:  
  1. • (a bullet or black circle) indicates a new procedure code  
  2. ▲ (a triangle) indicates that the code’s descriptor has changed  
  3. ▲ (facing triangle) enclose new or revised text other than the code’s descriptor  
  4. + (a plus sign) before a code indicates an add-on code that is used only along with other codes for primary procedures  
  5. ○ (bullet in a circle) next to a code means that moderate sedation is a part of the procedure that the surgeon performs  
  6. ⚡ (lightning bolt) is used for codes for vaccines that are pending FDA approval  
  7. # (number sign) indicates a resequenced code |
| 5.4 Assign modifiers to CPT codes. Pages 153–156 | - A CPT modifier is a two-digit number that may be attached to most five-digit procedure codes to indicate that the procedure is different from the listed descriptor but not in a way that changes the definition or requires a different code.  
- Two or more modifiers may be used with one code to give the most accurate description possible. |
| 5.5 Apply the six steps for selecting CPT procedure codes to patient scenarios. Pages 157–159 | Six general steps are followed to assign correct CPT codes:  
- Step 1. Review complete medical documentation.  
- Step 2. Abstract the medical procedures from the visit documentation.  
- Step 3. Identify the main term for each procedure.  
- Step 4. Locate the main terms in the CPT Index.  
- Step 5. Verify the code in the CPT main text.  
- Step 6. Determine the need for modifiers. |
| 5.6 Explain how the key components are used in selecting CPT Evaluation and Management codes. Pages 159–171 | Key components for selecting Evaluation and Management codes are:  
- The extent of the history documented  
- The extent of the examination documented  
- The complexity of the medical decision making  
The steps for selecting correct E/M codes are:  
- Step 1. Determine the category and subcategory of service.  
- Step 2. Determine the extent of the history.  
- Step 3. Determine the extent of the examination.  
- Step 4. Determine the complexity of medical decision making.  
- Step 5. Analyze the requirements to report the service level.  
- Step 6. Verify the service level based on the nature of the presenting problem, time, counseling, and care coordination.  
- Step 7. Verify that the documentation is complete.  
- Step 8. Assign the code. |
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| 5.7 Explain the physical status modifiers and add-on codes used in the Anesthesia section of CPT Category I codes. Pages 172–173 | • The patient’s health has a considerable effect on the relative difficulty of anesthesia services.  
• Therefore, one of these physical status modifiers is added to the anesthesia code: P1 Normal, healthy patient  
P2 Patient with mild systemic disease  
P3 Patient with severe systemic disease  
P4 Patient with severe systemic disease that is a constant threat to life  
P5 Moribund patient who is not expected to survive without the operation  
P6 Declared brain-dead patient whose organs are being removed for donation purposes |
| 5.8 Differentiate between surgical packages and separate procedures in the Surgery section of CPT Category I codes. Pages 173–177 | • Many codes in the Surgery section represent all the usual services in addition to the operation itself, a concept referred to as the surgical package.  
• These usual services are not coded in addition to the surgery code that includes them.  
• Codes that are called separate procedures in their descriptors, however, can be reported when it is done alone rather than as part of a surgical package. |
| 5.9 State the purpose of the Radiology section of CPT Category I codes. Pages 177–179 | • The Radiology section of CPT contains codes reported for radiology procedures either performed by or supervised by a physician. |
| 5.10 Code for laboratory panels in the Pathology and Laboratory section of CPT Category I codes. Pages 179–180 | • Laboratory panels located in the Pathology and Laboratory section of CPT are single codes that represent a specific battery of tests.  
• To report a panel code, all the indicated tests must have been done, and any additional test is coded separately. |
| 5.11 Code for immunizations using Medicine section CPT Category I codes. Pages 180–182 | • Immunizations require two codes from the Medicine section, one for administering the immunization and the other for the particular vaccine or toxoid that is given. |
| 5.12 Contrast Category II and Category III codes. Page 182 | • Category II and Category III codes both have five characters—four numbers and a letter.  
• Category II codes are for tracking performance measures to improve patients' health.  
• Category III codes are temporary codes for new procedures that may or may not enter the Category I code set if they become widely used in the future. |
| 5.13 Discuss the purpose of the HCPCS code set and its modifiers. Page 183–189 | • The HCPCS code set provides a coding system for specific products, supplies, and services that patients receive in the delivery of their care. |
Review Questions

Match the key terms with their definitions.

1. **LO 5.10** panel  
   A. The physician’s skill, time, and expertise used in performing a procedure
2. **LO 5.4** professional component  
   B. Temporary codes for emerging technology, services, and procedures
3. **LO 5.8** separate procedure  
   C. Procedure code that groups related procedures under a single code
4. **LO 5.1** Category III codes  
   D. Code set providing national codes for supplies, services, and products
5. **LO 5.8** global period  
   E. The inclusion of pre- and postoperative care for a specified period in the charges for a surgical procedure
6. **LO 5.1** packaged code  
   F. CPT codes that are used to track performance measures
7. **LO 5.1** Category II codes  
   G. In CPT, a single code that groups laboratory tests that are frequently done together
8. **LO 5.3** add-on code  
   H. A procedure performed in addition to a primary procedure
9. **LO 5.13** HCPCS  
   I. A secondary procedure that is performed with a primary procedure and that is indicated in CPT by a plus sign (+) next to the code
10. **LO 5.4** modifier  
    J. A two-digit number indicating that special circumstances were involved with a procedure, such as a reduced service or a discontinued procedure

Select the letter that best completes the statement or answers the question.

1. **LO 5.12** Identify the correct structure of Category II codes in CPT.
   A. an alphabetical character followed by three digits
   B. an alphabetical character followed by four digits
   C. three digits followed by an alphabetical character
   D. four digits followed by an alphabetical character
2. **LO 5.6** When a physician asks a patient questions to obtain an inventory of constitutional symptoms and of the various body systems, the results are documented as the
   A. past medical history
   B. family history
   C. review of systems
   D. comprehensive examination
3. **LO 5.13** Temporary codes are what type of HCPCS codes?
   A. Q codes
   B. D codes
   C. T codes
   D. V codes
4. **LO 5.2, 5.6** The examination that the physician conducts is categorized as
   A. straightforward, low complexity, moderate complexity, or high complexity
   B. problem-focused, expanded problem-focused, detailed, or comprehensive
   C. straightforward, problem-focused, detailed, or highly complex
   D. low risk, moderate risk, or high risk
5. **LO 5.6** The three key factors in selecting an Evaluation and Management code are
   A. time, severity of presenting problem, and history
   B. history, examination, and time
   C. past history, history of present illness, and chief complaint
   D. history, examination, and medical decision making

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6. **LO 5.6** CPT code 99382 is an example of
   A. an emergency department service code
   B. a preventive medicine service code
   C. a consultation service code
   D. a hospital observation code

7. **LO 5.7** Anesthesia codes generally include
   A. preoperative evaluation and planning, normal care during the procedure, and routine care after the procedure
   B. preparing the patient for the anesthetic, care during the procedure, postoperative care, and pain management as required by the surgeon
   C. preoperative evaluation and planning, routine postoperative care, but not the administration of the anesthetic itself
   D. all procedures that are ordered by the surgeon

8. **LO 5.8** Surgery codes generally include
   A. all procedures done during the global period that comes before the surgery
   B. preoperative evaluation and planning, the operation and normal additional procedures, and routine care after the procedure
   C. all aspects of the operation, including preparing the patient for the surgery, performing the operation and normal additional procedures, as well as normal, uncomplicated follow-up
   D. preoperative evaluation and planning, routine postoperative care, but not the operation itself

9. **LO 5.8** When a Surgery section code has a plus sign next to it,
   A. it includes all procedures done during the global period that follows the surgery
   B. it covers preoperative evaluation and planning, the operation and normal additional procedures, and routine care after the procedure
   C. it cannot be reported as a stand-alone code
   D. it includes preoperative evaluation and planning, routine postoperative care, but not the surgical procedure

10. **LO 5.10** When a panel code from the Pathology and Laboratory section is reported,
    A. all the listed tests must have been performed
    B. 90 percent of the listed tests must have been performed
    C. 50 percent of the listed tests must have been performed
    D. all the listed tests must have been performed on the same day

Answer the following questions:

1. **LO 5.5** List the six steps in the procedural coding process.
2. **LO 5.6** List the three key components used to select E/M codes and the four levels each component has.

### Applying Your Knowledge

#### Case 5.1  Coding Evaluation and Management Services

Supply the correct E/M CPT codes for the following procedures and services.

A. **LO 5.4–5.6** Office visit, new patient; detailed history and examination, low complexity medical decision making
B. **LO 5.4–5.6** Hospital visit, new patient; comprehensive history and examination, highly complex case
C. **LO 5.4–5.6** Office consultation by the physician assistant for established patient; comprehensive history and examination, moderately complex medical decision making

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D. **LO 5.4–5.6** Initial comprehensive physical examination for sixty-four-year-old new patient

E. **LO 5.4–5.6** Medical disability examination by treating physician

F. **LO 5.4–5.6** Hospital visit to previously admitted patient; expanded problem-focused history and examination, twenty-five minutes spent at bedside

G. **LO 5.4–5.6** Hospital emergency department call for established patient with cardiac infarction; detailed history and examination, moderately complex decision making

H. **LO 5.4–5.6** Third visit to established, stable patient in nursing facility, medical record and patient’s status reviewed, no change made to medical plan

I. **LO 5.4–5.6** Home visit for new patient, straightforward case, problem-focused history and examination

J. **LO 5.4–5.6** Five-minute medical discussion telephone call to an established patient

### Case 5.2 Coding Anesthesia and Surgery Procedures

Supply the correct CPT codes for the following procedures and services:

A. **LO 5.5, 5.7, 5.8** Anesthesia for vaginal delivery only

B. **LO 5.5, 5.7, 5.8** Anesthesia services for patient age seventy-six, healthy, for open procedure on wrist

C. **LO 5.5, 5.7, 5.8** Incision and drainage of infected wound after surgery

D. **LO 5.5, 5.7, 5.8** Destruction of flat wart

E. **LO 5.5, 5.7, 5.8** Closed treatment of acromioclavicular dislocation with manipulation

F. **LO 5.5, 5.7, 5.8** Complicated drainage of finger abscess

G. **LO 5.5, 5.7, 5.8** Paring of three skin lesions

H. **LO 5.5, 5.7, 5.8** Postpartum D&C

I. **LO 5.5, 5.7, 5.8** Excision of chest wall tumor including ribs

J. **LO 5.5, 5.7, 5.8** Transurethral electro surgical resection of the prostate (TURP); patient has mild systemic disease; payer requires surgery codes

K. **LO 5.5, 5.7, 5.8** Amniocentesis, diagnostic

L. **LO 5.5, 5.7, 5.8** Ureterolithotomy on lower third of ureter

M. **LO 5.5, 5.7, 5.8** Tonsillectomy and adenoidectomy, patient age fifteen

N. **LO 5.5, 5.7, 5.8** Flexible sigmoidoscopy with specimen collection, separate procedure

O. **LO 5.5, 5.7, 5.8** Kidner type procedure

P. **LO 5.5, 5.7, 5.8** Application of short leg splint

Q. **LO 5.5, 5.7, 5.8** Unilateral transorbital frontal sinusotomy

R. **LO 5.5, 5.7, 5.8** Puncture aspiration of three cysts in breast

S. **LO 5.5, 5.7, 5.8** Posterior arthrodesis for scoliosis patient, eleven vertebral segments

T. **LO 5.5, 5.7, 5.8** Routine obstetrical care, vaginal delivery
Case 5.3  Coding Radiology, Pathology and Laboratory, or Medicine Procedures

Supply the correct CPT codes for the following procedures and services:

A. **LO 5.5, 5.9–5.11**  Subcutaneous chemotherapy administration
B. **LO 5.5, 5.9–5.11**  Material (sterile tray) supplied by physician
C. **LO 5.5, 5.9–5.11**  Routine ECG with fifteen leads, with the physician providing only the interpretation and report of the test
D. **LO 5.5, 5.9–5.11**  CRH stimulation panel
E. **LO 5.5, 5.9–5.11**  Automated urinalysis for glucose, without microscopy
F. **LO 5.5, 5.9–5.11**  Aortography, thoracic, without serialography, radiological supervision and interpretation
G. **LO 5.5, 5.9–5.11**  Bone marrow, smear interpretation
H. **LO 5.5, 5.9–5.11**  Physical therapy evaluation
I. **LO 5.5, 5.9–5.11**  Adenomatous polyposis coli (APC) full gene sequence analysis
J. **LO 5.5, 5.9–5.11**  Electrocardiogram at surgery, separate procedure

Case 5.4  Assigning Modifiers

A. **LO 5.4, 5.5, 5.8**  What is the meaning of each of the modifiers used in the following case example? A multi-trauma patient had a bilateral knee procedure as part of team surgery following a motorcycle crash. The orthopedic surgeon also reconstructed the patient’s pelvis and left wrist.

1.  99
2.  66
3.  51
4.  50

Supply the correct codes and modifiers for the following cases:

B. **LO 5.5, 5.8**  A surgeon administers a regional Bier block and then monitors the patient and the block while repairing the flexor tendon of the forearm.

C. **LO 5.5, 5.9**  Primary care provider performs a frontal and lateral chest X-ray and observes a mass. The patient is sent to a pulmonologist, who, on the same day, repeats the frontal and lateral chest X-ray. How should the pulmonologist report the X-ray service?

D. **LO 5.5, 5.8**  A day after surgery for a knee replacement, the patient develops an infection in the surgical area and is returned to the operating room for debridement. Which modifier is attached to the second procedure?

Case 5.5  Assigning HCPCS Codes

Supply the correct HCPCS codes for the following:

A. **LO 5.13**  Administration of hepatitis B vaccine_____
B. **LO 5.13**  Contact layer, sterile, sixteen square inches or less, each dressing_____
C. **LO 5.13**  Shoe lift, elevation, heel, tapered to metatarsals, per inch_____
D. **LO 5.13**  Screening Papanicolaou smear, cervical or vaginal, up to three smears by technician under physician supervision_____

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E. **LO 5.13** Electric heat pad, standard

F. **LO 5.13** Half-length bedside rails

G. **LO 5.13** Injection of bevacizumab, 10 mg

H. **LO 5.13** Brachytherapy source, nonstranded, nonhigh dose rate iridium-192, per source

I. **LO 5.13** Enteral nutrition infusion pump, with alarm

J. **LO 5.13** Infusion of 1000 cc of normal saline solution

K. **LO 5.13** Prednisone acetate injection up to 1 ml

L. **LO 5.13** Glucose test strips for dialysis

M. **LO 5.13** pHisoHex or Betadine solution

N. **LO 5.13** Distilled water used for nebulizer 1000 ml

O. **LO 5.13** Spring crutch, underarm

P. **LO 5.13** Walker heavy duty, multiple braking system

Q. **LO 5.13** Stationary infusion pump, parenteral

R. **LO 5.13** Assessment alcohol

S. **LO 5.13** Dacarbazine 400 mg

T. **LO 5.13** Miscellaneous durable medical equipment

**Case 5.6 Assigning HCPCS Modifiers**

Supply the correct HCPCS modifiers for the following:

A. **LO 5.13** Left foot, great toe

B. **LO 5.13** Technical component

C. **LO 5.13** Waiver of liability statement on file