CPC® Certification Review

AAPC

AMA Disclaimer

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Getting the most out of this training

Key guideline review

- Multiple choice processing
- Time management
- Process of elimination
- Marking your books

Process of Elimination

Training covers the process of elimination:

- Look at the answers first.
- Are there key instructions or guidelines for the answers provided?
- Are there parenthetical statements for CPT® or “code first” statements?
- Typically can eliminate 2 answers immediately

Time Management

Just over 2 minutes per question

- Mark difficult questions and come back to them later
- Read the question first, and then the scenario
- No specific format for completion

Marking Your Books

- Underline main terms
- Highlight key points
- Write effective reminders, such as guidelines

Compliance and Regulatory / Business of Medicine

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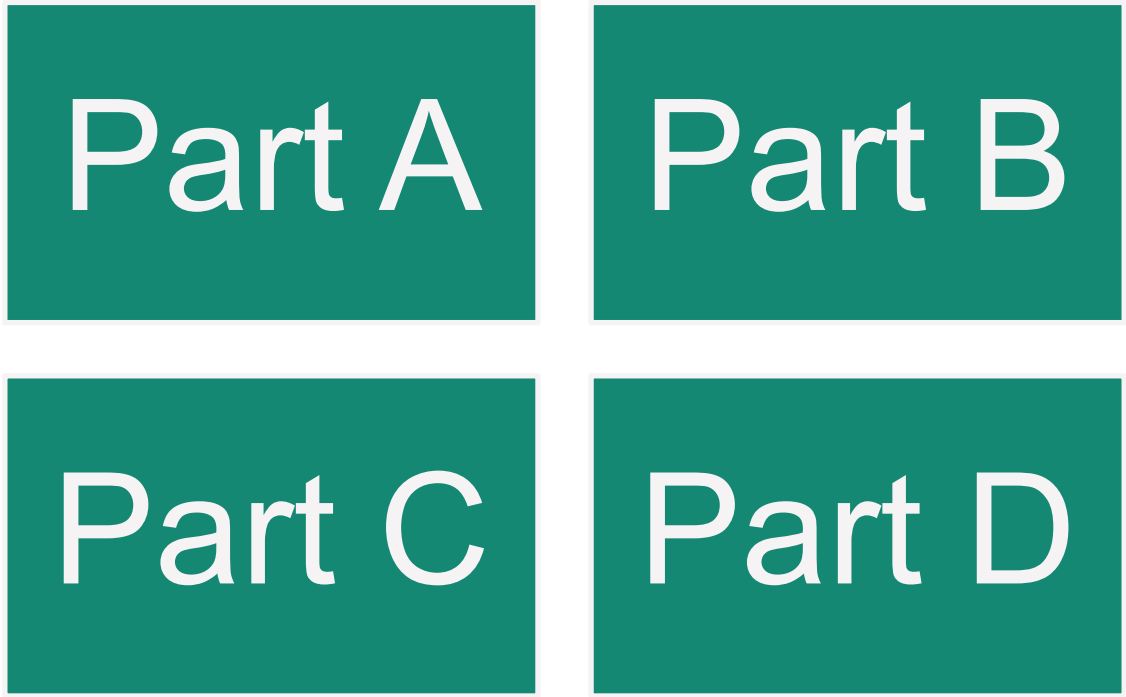
Payers

Self-Pay vs. Insurance

- Self-pay
- Insurance
  - Private (commercial) insurance
    - BCBS
    - Aetna
    - Cigna
  - Government insurance
    - Medicare
    - Medicaid
    - TriCare

Medicare

Services Covered by Different Parts of Medicare



Medical Necessity

Services or supplies that:

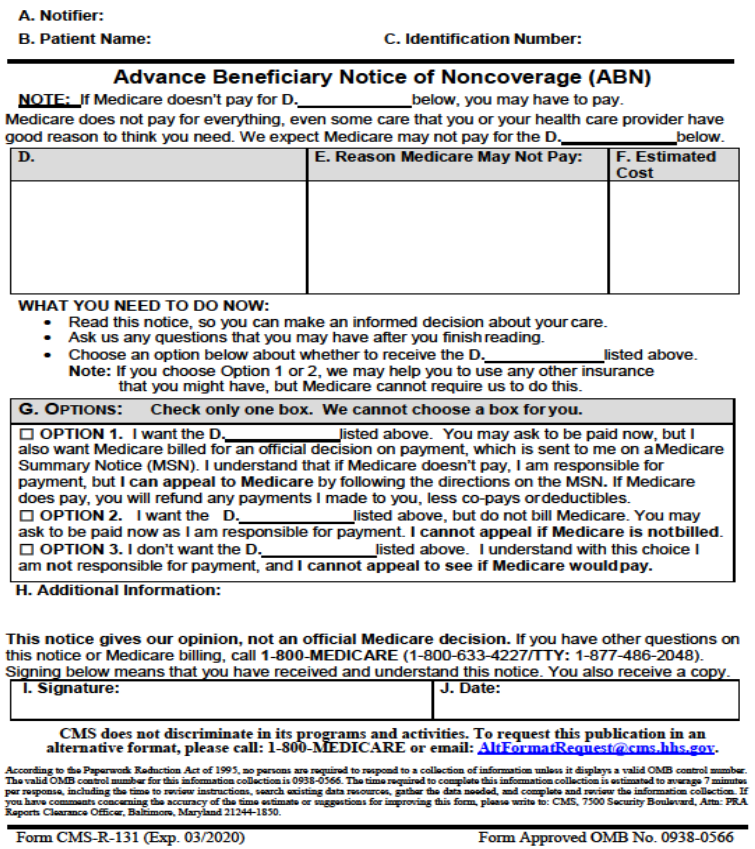
- are proper and needed for the diagnosis or treatment of your medical condition,
- are provided for the diagnosis, direct care, and treatment of your medical condition,
- meet the standards of good medical practice in the local area, and
- aren’t mainly for the convenience of you or your doctor.

National Coverage Determinations

- National Coverage Determinations (NCD) help to spell out CMS policies on when Medicare will pay for items or services.
  - Each Medicare Administrative Carrier (MAC) is then responsible for interpreting national policies into regional policies (LCDs).
  - LCDs only have jurisdiction within their regional area.

Advance Beneficiary Notice

- Providers are responsible for obtaining an ABN prior to providing the service or item to a beneficiary.
  - The form must be filled out in its entirety as well as the potential cost to the patient and the reason why Medicare may deny the service.
  - Only the approved Form CMS-R-131 is valid for Medicare beneficiaries and the forms may not be altered other than to add the practice name on the form.



A. Notifier:

B. Patient Name: C. Identification Number:

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for D._____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D._____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the D._____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the D._____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the D._____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the D._____ listed above. I understand with this choice I am not responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566

HIPAA

- National standards for electronic healthcare transactions and code sets
- National unique identifiers for providers, health plans, and employers
- Privacy and Security of health data

Health Insurance Portability and Accountability Act (HIPAA)

Code Sets

- HCPCS – Healthcare Common Procedure Coding System
- CPT® - Current Procedural Terminology
- CDT - Dental Procedures and Nomenclature
- ICD-10-CM (ICD-9-CM Prior to October 1, 2015) – International Classification of Diseases, 10th revision, Clinical Modification
- NDC – National Drug Codes

- Although HIPAA mandates the use of the specified code sets, it does not mandate the use of its conventions or guidelines, except for the ICD-10-CM.

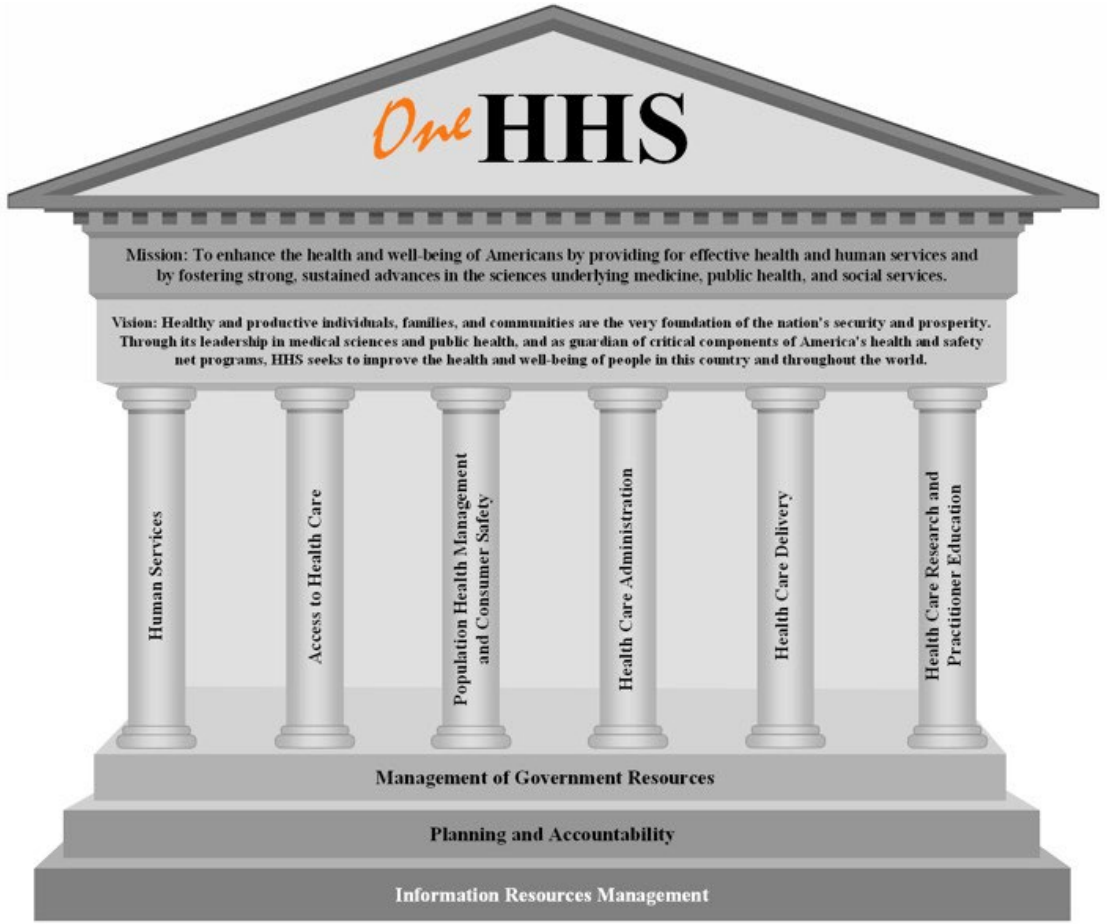
HITECH

The Health Information Technology for Economic and Clinical Health Act

- Promote the adoption and meaningful use of health information technology
- Strengthened HIPAA
- Patient audit trail

OIG Compliance

OIG Compliance



OIG Compliance Plan

- Conduct internal monitoring and auditing.
- Implement compliance and practice standards.
- Designate a compliance officer or contact.
- Conduct appropriate training and education.
- Respond appropriately to detected offenses and develop corrective action.
- Develop open lines of communication with employees.
- Enforce disciplinary standards through well-publicized guidelines.

Reviewing an Operative

Operative Report Elements

- Date and Time of the Procedure
- Pre- and Post-operative Diagnosis
- List of all Procedures Performed
- Type of Anesthesia
- Estimated Blood Loss
- Surgeons
- Indications of the Procedure
- Findings
- Procedure Description
- Signatures

Merit-Based Incentive Payment Systems (MIPS)

Quality Payment Program:

- Eligible Clinicians
  - Physicians include: Doctors of chiropractic, dental medicine, dental surgery, medicine, optometry, osteopathy, and podiatric medicine.
- Exclusions
  - First year in Medicare
  - Qualifying APM Participant
  - Do meet the low volume threshold
- Submitter Types
  - As an individual
  - Group, Virtual Group
  - As an APM entity

Merit-Based Incentive Payment Systems (MIPS)

MIPS Performance Categories:

- Quality
  - Must submit at least six quality measures during the 12-month period
- Promoting Interoperability
  - Must report measures from each of the four objective measures for 90 continuous days
- Improvement Activities
  - Must report a combination of high and medium weighted measures for 90 continuous days
- Cost
  - CMS analyzes data from both Part A and Part B claims to calculate the overall cost of the patient care.

Advanced Alternative Payment Models (APM)

- An APM is a group of clinicians who have voluntarily come together in an organized way to deliver coordinated high-quality care to Medicare patients.

- Advanced APM entities agree to:
  - Use of certified EHR technology (Must be certified under 2015 criteria);
  - Base payment on quality measures comparable to MIPS; and
  - Either bear more than nominal risk for financial losses or is a Medical Home Model expanded under CMS Innovation Center authority.

ICD-10-CM

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ICD-10-CM Layout

- Coding Conventions
- Index to Diseases and Injuries (Alphabetic Index)
- Table of Neoplasms
- Table of Drugs and Chemicals
- Index to External Cause of Injuries
- Tabular List
- Official ICD-10-CM Guidelines for Coding and Reporting

Index to Diseases and Injuries: History

History
- family (of) (*see also* History, personal (of))
  - alcohol abuse Z81.1
  - allergy NEC Z84.89
  - anemia Z83.2
  - arthritis Z82.61
  - asthma Z82.5
  - blindness Z82.1
  - cardiac death (sudden) Z82.41
  - carrier of genetic disease Z84.81
  - chromosomal anomaly Z82.79
  - chronic
    - disabling disease NEC Z82.8
    - lower respiratory disease Z82.5

Personal (of) (*see also* History, family (of))
- abuse
  - childhood Z62.819
    - forced labor or sexual exploitation in childhood Z62.813
    - physical Z62.810
    - psychological Z62.811
    - sexual Z62.810
  - adult Z91.419
    - forced labor or sexual exploitation Z91.42
    - physical and sexual Z91.410
    - psychological Z91.411
- alcohol dependence F10.21

Table of Neoplasms

Neoplasm Index	Malignant Primary	Malignant Secondary	Ca in situ	Benign	Uncertain Behavoir	Unspecified Behavior
Neoplasm, neoplastic	C80.1	C79.9	D09.9	D36.9	D48.9	D49.9
abdomen, abdominal	C76.2	C79.8-	D09.8	D36.7	D48.7	D49.89
cavity	C76.2	C79.8-	D09.8	D36.7	D48.7	D49.89
organ	C76.2	C79.8-	D09.8	D36.7	D48.7	D49.89
viscera	C76.2	C79.8-	D09.8	D36.7	D48.7	D49.89
wall (see also Neoplasm, abdomen, wall, skin	C44.509	C79.2-	D04.5	D23.5	D48.5	D49.2
connective tissue	C49.4	C79.8-	-	D21.4	D48.1	D49.2
skin	C44.509					

Table of Drugs and Chemicals

Substance	Poisoning, Accidental (unintentional)	Poisoning, Intentional self-harm	Poisoning, Assault	Poisoning, Undetermined	Adverse effect	Underdosing
1-propanol	T51.3X1	T51.3X2	T51.3X3	T51.3X4	---	---
2-propanol	T51.2X1	T51.2X2	T51.2X3	T51.2X4	---	---
2, 4-D (dichlorophen-oxyacetic acid)	T60.3X1	T60.3X2	T60.3X3	T60.3X4	---	---
2, 4-toluene dilsocyanate	T65.0X1	T65.0X2	T65.0X3	T65.0X4	---	---
2, 4, 5-T (trichloro-phenoxyacetic acid)	T60.1X1	T60.1X2	T60.1X3	T60.1X4	---	---
14-hydroxydihydro-morphinone.	T40.2X1	T40.2X2	T40.2X3	T40.2X4	T40.2X5	T40.2X6
A						
ABOB	T37.5X1	T37.5X2	T37.5X3	T37.5X4	T37.5X5	T37.5X6
Abrine	T62.2X1	T62.2X2	T62.2X3	T62.2X4	---	---
Abrus (seed)	T62.2X1	T62.2X2	T62.2X3	T62.2X4	---	---
Absinthe	T51.0X1	T51.0X2	T51.0X3	T51.0X4	---	---
beverage	T51.0X1	T51.0X2	T51.0X3	T51.0X4	---	---
Acaricide	T60.8X1	T60.8X2	T60.8X3	T60.8X4	---	---

ICD-10-CM Layout

External Cause of Injuries Index

- External cause codes describe how an injury occurred
- Read the notes at the beginning of ICD-10-CM Chapter 20 External Causes of Morbidity
- NEVER primary

Fall, falling (accidental) W19-
    building W20.1-
        burning (uncontrolled fire) X00.3-
    down
        embankment W17.81-
        escalator W10.0-
        hill W17.81-
        ladder W11-
        ramp W10.2-
        stairs, steps W10.9-

Coding Conventions and Guidelines

Overview

- Conventions for the ICD-10-CM
- Official ICD-10-CM Guidelines for Coding and Reporting

ICD-10-CM Official Guidelines for Coding and Reporting

Referencing the Guidelines

- Guidelines found at beginning of the ICD-10-CM code book

Section I. Conventions, General Coding Guidelines and Chapter Specific Guidelines

A. Conventions for the ICD-10-CM
   1. The Alphabetic Index and Tabular List
   2. Format and Structure
   3. Use of codes for reporting purposes
   4. Placeholder character
   5. 7th Characters
   6. Abbreviations
      a. Alphabetic Index abbreviations
      b. Tabular List abbreviations
   7. Punctuation
   8. Use of “and”
   9. Other and Unspecified codes

Coding Conventions

Abbreviation NOS

- Not otherwise specified
- Lacks information to use a more specific code

Index to Diseases and Injuries:

Sinusitis (accessory) (chronic) (hyperplastic) (nasal) (nonpurulent) (purulent) J32.9

Tabular List:

J32.9 Chronic sinusitis, unspecified
Sinusitis (chronic) NOS

Coding Conventions

Parentheses

- Enclose supplementary words
- Nonessential modifiers

Pneumonia (acute) (double) (migratory) (purulent) (septic) (unresolved) J18.9
with
lung abscess J85.1
due to specified organism – *see* Pneumonia, in (due to)
influenza – *see* influenza, with, pneumonia
adenoviral J12.0
adynamic J18.2
alba A50.04
allergic (eosinophilic) J82
alveolar – *see* Pneumonia, lobar
anaerobes J15.8
anthrax A22.1

Coding Conventions

With

- Means “associated with” or “due to” when it appears in a code title, the Alphabetic Index, or an instructional note in the Tabular List.
- Presumed causal relationship between the main term and the terms listed under the entry “with.”

Diabetes, diabetic (mellitus) (sugar) E11.9
with
amyotrophy E11.44
arthropathy NEC E11.618
autonomic (poly)neuropathy E11.43
cataract E11.36
Charcot's joints E11.610
Chronic kidney disease E11.22

ICD-10-CM Official Guidelines for Coding and Reporting

Referencing the Guidelines

- A documented reference appears as Section I.C.4.a.2.
- This indicates the guideline is found in:
  - Section I. Conventions, General Coding Guidelines and Chapter Specific Guidelines
  - Section I.C. Chapter-Specific Coding Guidelines
  - Section I.C.4. Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00-E89)
  - Section I.C.4.a. Diabetes mellitus
  - Section I.C.4.a.2. Type of diabetes mellitus not documented

ICD-10-CM Official Guidelines for Coding and Reporting

Guideline Reference: I.C.4.a.2.

Section I. Conventions, General Coding Guidelines and Chapter Specific Guidelines

C. Chapter Specific Coding Guidelines

4. Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00-E89)

a. Diabetes mellitus
The diabetes mellitus codes are combination codes that include the type of diabetes mellitus, the body system affected, and the complications affecting that body system. As many codes within a particular category as are necessary to describe all of the complications of the disease may be used, They should be sequenced based on the reason for a particular encounter. Assign as many codes from categories E08-E13 as needed to identify all of the associated conditions that the patient has.

1) Type of diabetes
The age of a patient is not the sole determining factor, though most type 1 diabetics develop the condition before reaching puberty. For this reason type 1 diabetes mellitus is also referred to as juvenile diabetes.

2) Type of diabetes mellitus not documented
If the type of diabetes mellitus is not documented in the medical record the default is E11.-, Type 2 diabetes mellitus.

3) Diabetes mellitus and the use of insulin, oral hypoglycemics, and injectable non-insulin drugs

Locating the ICD-10-CM Code

Code Structure

- **Chapter** – based on body system or condition.
  - Example: Chapter 4: Endocrine, Nutritional, and Metabolic Diseases (E00-E89)
- **Section** - A group of three-character categories
  - Example: Diabetes mellitus (E08-E13)
- **Categories** - Three-character code numbers
  - Example: E11 Type 2 diabetes mellitus

Locating the ICD-10-CM Code

Code Structure

- **Subcategories** can be 4, 5, or 6 characters
  - 4th character further defines the site, etiology, and manifestation or state of the disease or condition.
    - Example: E11.6 Type 2 diabetes mellitus with diabetic arthropathy
  - 5th or 6th character represent the most accurate level of specificity.
    - Example: E11.610 Type 2 diabetes mellitus with diabetic neuropathic arthropathy

Locating the ICD-10-CM Code

Code Structure

- 7th character extenders
  - Example:
    T16 Foreign body in ear

    The appropriate 7th character is to be added to each code from category T16

    A = initial encounter

    D = subsequent encounter

    S = sequela

T16.1XXA Foreign body in right ear, initial encounter

Locating the ICD-10-CM Code

Step-by-step instructions

1. Find the documented diagnosis
2. Determine the main term
3. Look up the main term in the Index to Diseases and Injuries (Alphabetic Index)
4. Find the code in the Tabular List
5. Review all conventions and notes associated with the code

Locating the ICD-10-CM Code

Main Term

- What is the disease?
- What is the illness?
- What is the symptom?

Acute Bronchitis

Main Term: Bronchitis

Locating the ICD-10-CM Code

Main Term

- Ruptured ovarian cyst
- Abdominal pain
- Chronic sinusitis
- Febrile convulsions

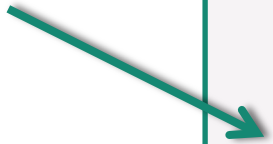
Locating the ICD-10-CM Code

- Look up the main term in the Index to Diseases and Injuries (Alphabetic Index)

Bronchiolitis – *continued*
respiratory, interstitial lung disease J84.115
Bronchitis (diffuse) (fibrinous) (hypostatic) (infective) (membranous) J40
with
influenza, flu, or grippe - *see* Influenza, with, respiratory manifestations NEC
obstruction (airway) (lung) J44.9
tracheitis (15 years of age and above) J40
acute or subacute J20.9
chronic J42
under 15 years of age J20.9
acute or subacute (with bronchospasm or obstruction) J20.9
with
bronchiectasis J47.0
chronic obstructive pulmonary disease J44.0

Locating the ICD-10-CM Code

Look for the subterm "acute"



Bronchiolitis – *continued*
respiratory, interstitial lung disease J84.115
Bronchitis (diffuse) (fibrinous) (hypostatic)
(infective) (membranous) J40
with
influenza, flu, or grippe - *see* Influenza, with, respiratory manifestations NEC
obstruction (airway) (lung) J44.9
tracheitis (15 years of age and above) J40
acute or subacute J20.9
chronic J42
under 15 years of age J20.9
acute or subacute (with bronchospasm or obstruction) J20.9
with
bronchiectasis J47.0
chronic obstructive pulmonary disease J44.0

Locating the ICD-10-CM Code

Find the code in the Tabular List

√4th J20 Acute Bronchitis

INCLUDES

acute and subacute bronchitis (with) bronchospasm
acute and subacute bronchitis (with) tracheitis
acute and subacute bronchitis (with) tracheobronchitis, acute
acute and subacute fibrinous bronchitis
acute and subacute membranous bronchitis
acute and subacute purulent bronchitis
acute and subacute septic bronchitis

EXCLUDES1

bronchitis NOS (J40)
tracheobronchitis NOS (J40)

EXCLUDES2

acute bronchitis with bronchiectasis (J47.0)
acute bronchitis with chronic obstructive asthma (J44.0)
acute bronchitis with chronic obstructive pulmonary disease (J44.0)
allergic bronchitis NOS (J45.909-)
bronchitis due to chemicals, fumes and vapors (J68.0)
chronic bronchitis NOS (J42)
chronic mucopurulent bronchitis (J41.1)
chronic obstructive bronchitis (J44.-)
chronic obstructive tracheobronchitis (J44.-)
chronic simple bronchitis (J41.0)
chronic tracheobronchitis (J42)

J20.9 Acute bronchitis , unspecified

Locating the ICD-10-CM Code

- Read all notes
- associated with the code

√4th J20 Acute Bronchitis

INCLUDES

acute and subacute bronchitis (with) bronchospasm
acute and subacute bronchitis (with) tracheitis
acute and subacute bronchitis (with) tracheobronchitis, acute
acute and subacute fibrinous bronchitis
acute and subacute membranous bronchitis
acute and subacute purulent bronchitis
acute and subacute septic bronchitis

EXCLUDES1

bronchitis NOS (J40)
tracheobronchitis NOS (J40)

EXCLUDES2

acute bronchitis with bronchiectasis (J47.0)
acute bronchitis with chronic obstructive asthma (J44.0)
acute bronchitis with chronic obstructive pulmonary disease (J44.0)
allergic bronchitis NOS (J45.909-)
bronchitis due to chemicals, fumes and vapors (J68.0)
chronic bronchitis NOS (J42)
chronic mucopurulent bronchitis (J41.1)
chronic obstructive bronchitis (J44.-)
chronic obstructive tracheobronchitis (J44.-)
chronic simple bronchitis (J41.0)
chronic tracheobronchitis (J42)

J20.9 Acute bronchitis , unspecified

CPT®, Surgery Guidelines, HCPCS Level II, and Modifiers

CPC Review

Introduction to CPT®

- The CPT® code set includes three categories of medical nomenclature with descriptors.
  - Category I
  - Category II
  - Category III

Introduction to CPT®

Instructions for use of the CPT® code book

- Unlisted procedure
- CPT® use by any qualified healthcare professional
- Parenthetical notes
- Accuracy and quality of coding
  - Related guidelines
  - Parenthetical instructions
  - Other coding resources

CPT® Guidelines

- Referenced in the introduction of each section and subsection of the CPT® code book
- Applicable to the section being referenced
- Define the information necessary for choosing the correct code

CPT® Conventions and Iconography

Used throughout the CPT® code book and include:

- Indentations
- Code symbols - iconology
- Parenthetical instructions

CPT® Conventions and Iconography

; The semicolon and the conventional use of indentions

The use of the semicolon divides the description of a code into two parts:

- The “stand-alone” code or the “common portion of the procedure” code descriptor
- The indented descriptor is dependent on the preceding “stand-alone” code

CPT® Conventions and Iconography

- + The “add-on” code symbol - Add-on codes are never reported alone. They are always modifier 51 exempt.
- ● The red bullet - new procedure code
- ▲ The (blue) triangle - code revision
- ► ◄ Opposing triangles - indicate new and revised text other than the procedure descriptors

CPT® Conventions and Iconography

- The circle with a line through it - exempt from the use of modifier 51
- The lightening bolt symbol - codes for vaccines that are pending FDA approval.
- # The number symbol – Re-sequenced and are out of numerical order

Category I CPT® Codes

The CPT® code book divides Category I CPT® codes into six main section titles:

- Evaluation and Management
- Anesthesiology
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine

Category I CPT® Codes

- Section titles have subsections divided by anatomic location, procedure, condition, or descriptor subheadings.
- The subheadings, structured by CPT® conventions, may list alternate coding suggestions in parenthetical instructions.
- Example:
  - Section: Surgery (10021-69990)
  - Subsection: Integumentary System
  - Subheading: Skin, Subcutaneous and Accessory Structures
  - Category: Debridement

Alternate coding suggestions →

(For dermabrasions, see 15780 – 15783)
(For nail debridement, see 11720-11721)
(For burn(s), see 16000-16035)
(For pressure ulcers, see 15920-15999)

The CPT® Code Book

- CPT® Sections
- Section Guidelines
- Section Table of Contents
- Notes
- Category II codes
- Category III codes
- Appendices A-T
- Alphabetic Index

CPT® Code Basics

- Review medical documentation thoroughly and gather additional reports
- Reference the alphabetical index for a CPT® numerical code and/or code range.
  - Condition
  - Procedure or service
  - Anatomic site
  - Synonyms, eponyms, and abbreviations
- Review the numerical code and/or code range for specific descriptions
- Follow CPT® Guidelines, Conventions, and Iconology

Category II CPT® Codes

- Alphanumeric format, with the letter “F” in the last position, eg, 0001F
- Optional “performance measurement” tracking codes
- Used to report Quality to Medicare under Quality Payment Program
- Formerly referred to as Physician Quality Reporting System (PQRS)

Category III CPT® codes

- Temporary codes
- Alphanumeric structure, with a “T” in the last position, eg, 0042T
- Can be reported alone, without an additional Category I code
- “If a Category III code is available, this code must be reported instead of a Category I unlisted code.”

CPT® Appendices

Appendix A - Modifiers categorized:

- Modifiers applicable to CPT® codes
- Anesthesia Physical Status Modifiers
- CPT® Level I Modifiers approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use
- Level II (HCPCS/National) Modifiers

CPT® Appendices

- Appendix B - changes and additions to the CPT® codes from the previous year
- Appendix C - clinical E/M examples for different specialties
- Appendix D – Add-on Codes

CPT® Appendices

- Appendix E – Exempt from the use of modifier 51 (multiple procedures)
- Appendix F – Exempt from the use of modifier 63 (procedures performed on infants less than 4kg)
- Appendix G – Removed from the CPT® code book (2017).

CPT® Appendices

- Appendix H – Alphabetic Index of Performance Measures by Clinical Condition or Topic
  - Available only on the AMA website
  - www.ama-assn.org.
- Appendix I – Genetic Testing Code Modifiers
  - Removed from the CPT® code book (2013)
- Appendix J - Electrodiagnostic Medicine Listing of Sensory, Motor, and Mixed Nerves

CPT® Appendices

- Appendix K - Product Pending FDA Approval
- Appendix L - Vascular Families
  - Based on the assumption that a vascular catheterization has a starting point of the aorta
- Appendix M - Crosswalk to Deleted CPT® Codes
- Appendix N - Summary of Re-sequenced CPT® Codes
- Appendix O – Multianalyte Assays
  - Laboratory use

CPT® Appendices

- Appendix P – CPT® Codes that May Be Used for Synchronous Telemedicine Services
  - These codes are used with real-time telemedicine services when appended with modifier 95.
- Appendix Q – Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) Vaccines
- Appendix R – Digital Medicine-Services Taxonomy
- Appendix S – Artificial Intelligence Taxonomy for Medical Services and Procedures
- Appendix T – CPT codes That May Be Used for Synchronous Real-Time Interactive Audio-Only Telemedicine Services

National Correct Coding Initiative (NCCI)

- Implemented by CMS
- Promotes correct coding methodologies
- Controls the improper assignment of codes that results in inappropriate reimbursement

Medicare publishes CCI:

https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html

Sequencing

Based on RBRVS

- Physician Work
- Practice Expense
- Professional Liability/Malpractice Insurance

Highest RBRVS listed first

https://www.cms.gov/apps/physician-fee-schedule/overview.aspx

CPT® Assistant

- Articles answering everyday coding questions
- CCI bundling information
- E/M billing guidance
- Current code use and interpretation
- Case studies demonstrating practical application of codes
- Anatomical illustration charts and graphs for quick reference
- Information for appealing insurance denials
- Information to validate code usage when audited

CPT® Global Surgical Package

- Includes a standard package of preoperative, intraoperative, and postoperative services
- Payer policies may vary
- May be furnished in any service location
  - For example, a hospital, an ambulatory surgical center (ASC), or physician office

CPT® Global Surgical Package

Included in the surgery package and not separately billable:

Inclusive

- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical)
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
- Evaluating the patient in the post-anesthesia recovery area
- Writing orders
- Typical postoperative follow-up care

CMS Global Surgical Package

- Major Surgery: Has a preoperative period of 1 day with 90 days for the postoperative period.
- Minor Surgery: The preoperative period is the day of the procedure with a postoperative period of either 0 or 10 days depending on the procedure.

HCPCS Level II

Types of Level II Codes

- Permanent National Codes maintained by the CMS HCPCS Workgroup
  - Responsible for additions, deletions, revisions
  - Updated annually

- Temporary National Codes maintained by the CMS HCPCS Workgroup
  - Responsible for additions, deletions, revisions
  - Updated quarterly

A Code

- Codes include:
  - Ambulance codes
  - Ambulance modifiers to indicate origin and destination of transport
  - Medical and surgical supplies

G Code

- Codes include:
  - Temporary codes
  - Some CMS service/procedure codes
  - CMS Quality Reporting codes

HCPCS Level II

G codes

- Professional healthcare procedures/services with no CPT® codes
- Example:
  - G0412 – G0415 – unilateral or bilateral
  - 27215 – 27218 – unilateral only, use modifier 50 for bilateral

H codes

- Used by state Medicaid agencies for mental health services such as alcohol and drug treatment services

J Code

- J codes include drugs administered to patients.
- Most codes list a specific dose per code.
- Reporting concepts include:
  - Amount of medication administered – Quantity billing is common
  - Route of administration (intra-arterial, intravenous, intramuscular, intrathecal, subcutaneous, inhaled, oral, etc…)
- Select the correct code for the correct route of administration.

J Code

- Appendix A: Table of Drugs and Biologicals

L Code

- Primarily orthotic and prosthetic supplies, devices and services
- Coding concepts:
  - Product
  - Anatomic site
  - Number
  - Size

Q Code

- Codes includes are temporary codes
- Can be added, changed and deleted quarterly
- Coding concepts:
  - Anatomic site
  - Number
  - Size
  - Type of procedure
  - Patient age

S Code

- These codes are temporary national, non-Medicare, codes
- Coding concepts include:
  - Anatomic site
  - Number
  - Size
  - Age
  - Type of procedure

HCPCS Level II

Appendices:

- Table of Drugs
  - Names of Drugs, dosage, delivery method, J code
- Level II modifiers
  - May be used with some CPT® codes, i.e., LT/RT
- List of Abbreviations
- Medicare References
- Jurisdiction List
- Deleted Code Crosswalk

- (each publisher may have different appendices)

Modifiers

22 – Increased Procedural Service

- Service provided is greater than that usually required for the listed procedure

24 - Unrelated E/M by the same physician during a postoperative period

Global Package Modifiers

- 25 - Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service

- 57 - Decision for surgery

Global Package Modifiers

- 58 - Staged or related procedure or service by the same physician during the postoperative period
- 78 - Unplanned return to the operating/ procedure room by the same physician following initial procedure for a related procedure during the postoperative period
- 79 - Unrelated procedure or service by the same physician during the postoperative period

Surgical Modifiers

- 50 - Bilateral Procedure
- 51 - Multiple Procedures
- 52 - Reduced Services
- 53 - Discontinued Procedure

Modifier 59 – Distinct Procedural Service

- Procedures not normally reported together
- Different Session or Patient Encounter
- Different Procedure or Surgery
- Different Site or Organ System
- Separate Incision/Excision
- Separate Lesion

Modifier 59 – Distinct Procedural Service

CMS provides a subset of modifier 59:

- XE - Separate Encounter, a service that is distinct because it occurred during a separate encounter;
- XS - Separate Structure, a service that is distinct because it was performed on a separate organ/structure;
- XP - Separate Practitioner, a service that is distinct because it was performed by a different practitioner; and
- XU - Unusual Non-Overlapping Service, the use of a service that is distinct because it does not overlap usual components of the main service.

Multiple Surgeon Modifiers

62 – Two Surgeons

- Work together as primary surgeons
- Perform distinct parts of a procedure
- Dictate op report of their distinct part
- Each will submit the same code and append modifier 62

66 – Surgical Team

- Highly complex procedures
- Require differently specialties
- Modifier 66 appended to procedures coded by the surgical team

Assistant Surgeon Modifiers

80 – Assistant Surgeon

- Assistant surgeon present for entire or substantial portion of the operation
- Reports the same surgical procedure with modifier 80 appended

81 – Minimum Assistant Surgeon

- Circumstances present that require the services of an asst surgeon for a short time. Minimal assistance.
- Reports the same surgical procedure with modifier 81 appended

82 – Assistant Surgeon (when qualified resident surgeon not available)

- Used in a teaching hospital that employs residents
- No residents available and another surgeon is used

Ancillary Modifiers

- Global – a procedure containing both a technical and a professional component
- Modifier 26 – Professional Component
- Modifier TC – Technical Component

10000 Series
Integumentary System

CPC Review

AAPC

Anatomy of the Skin

Epidermis

- Top layer
  - Made up of 4-5 layers; function is protection

Dermis

- Mid layer
  - Blood vessels, connective tissue, nerves, etc.

Subcutaneous Tissue

- Connective tissue and adipose tissue

ICD-10-CM: Integumentary

- Chapter 2: Neoplasms
- Chapter 12: Diseases of the Skin and Subcutaneous Tissue
- Chapter 19: Injury and Poisoning

ICD-10-CM: Integumentary

Chapter 12: Diseases of the Skin and Subcutaneous Tissue

- Skin infections (bacterial and fungal)
- Inflammatory conditions of the skin
- Other disorders of the skin
  - Corns and calluses
  - Keloid scars
  - Keratosis

Inflammatory Conditions of the Skin

Erythema multiforme:

- Code for erythema multiforme
- Code associated manifestation
- Code percent of skin exfoliation (L49.0-L49.9)
- An additional E code if drug induced

Pressure Ulcers

Decubitus ulcers/bed sores

Coding

- Identify the location of the ulcer
- Identify the stage of the ulcer
- Ulcers present on admission but healed at the time of discharge, assign the code for the site and stage of the pressure ulcer at the time of admission
- Ulcers evolving to a higher stage, two separate codes should be assigned: one code for the site and stage of the ulcer on admission and a second code for the same ulcer site and the highest stage reported during the stay

Injury and Poisoning

Wounds

- Superficial injuries (abrasions, burns, blisters, insect bites, splinters)
- Contusions (bruises, hematomas)
- Open wounds (lacerations, punctures, open bites)

Burns (fire, heat source, hot appliance)

Corrosions (chemicals)

Burns

- Location
- Severity (degree) of burn
- Total Body Surface Area (TBSA)

Disorders of the Breast

Category N60-N65 - Disorders of the breast

Category N60 - Mammary dysplasia

Category N65– Deformity and disproportion of reconstructed breast

- N65.0 Deformity of reconstructed breast
- N65.1 Disproportion of reconstructed breast

Fine Needle Aspiration (FNA)

- 10021 Fine needle aspiration biopsy, without imaging guidance; first lesion
  - \+ 10004 each additional lesion
- 10005 Fine needle aspiration biopsy, including ultrasound guidance; first lesion
  - \+ 10006 each additional lesion
- 10007 Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion
  - \+ 10008 each additional lesion
- 10009 Fine needle aspiration biopsy, including CT guidance; first lesion
  - \+ 10010 each additional lesion
- 10011 Fine needle aspiration biopsy, including MR guidance; first lesion
  - \+ 10012 each additional lesion

(For percutaneous needle biopsy other than fine needle aspiration, see 19081-19086 for breast, 20226 for muscle, 32400 for pleura, 32408 for lung or mediastinum, 42400 for salivary gland, 47000 for liver, 48102 for pancreas, 49180 for abdominal or retroperitoneal mass, 50200 for kidney, 54500 for testis, 54800 for epididymis, 60100 for thyroid, 62267 for nucleus pulposus, intervertebral disc, or paravertebral tissue, 62269 for spinal cord)

Skin, Subcutaneous, and Accessory Structures

Incision and Drainage

- Simple
- Complicated*

- * Complicated = placement of a drain, presence of infection, hemorrhaging that requires ligation, extensive time

Debridement

Debridement

- Method for removing dead tissue, dirt, or debris from infected skin, burn or wound
- Based on percent of body surface area

Debridement of necrotizing soft tissue

- Based on area of body being debrided

Active Wound Care

- 97597-97606

Biopsy

- Biopsies are reported by technique.
- Obtaining of tissue during another procedure is not considered a separate biopsy.
- Simple closure repair included.
- When more than one biopsy is performed by different techniques during the same encounter, only one primary biopsy code is reported and the add-on codes for the additional techniques are used.

Biopsy

- **Tangential** (shave, scoop, saucerize, curette) is performed with a sharp blade, such as a flexible biopsy blade, obliquely oriented scalpel or curette to remove a sample of epidermal tissue
- **Punch** requires a punch tool to remove a full-thickness cylindrical sample of skin.
- **Incisional** requires the use of a sharp blade to remove a full-thickness sample of tissue via vertical incision or wedge
  - Remember simple closure is included in the biopsy codes.

Skin, Subcutaneous, and Accessory Structures

Removal of Skin Tags

- 11200 up to and including 15 lesions
- 11201 add-on code for each additional 10 lesions

Shaving of Epidermal Lesions 11300-11313

- Include local anesthesia & chemical/electrocauterization of wound
- Select codes on size and anatomic location

Skin, Subcutaneous, and Accessory Structures

Excision of Lesions – Benign or Malignant

Pay attention to the guidelines for these codes

- Simple closure is included. Do not report separately.
- Report separately each lesion excised.
- Codes are selected based:
  - Anatomic location
  - Size (lesion plus margins)
- Malignant lesions: append modifier 58 if the patient has follow-up, re-excision during the postoperative period

Skin, Subcutaneous, and Accessory Structures

Coding Tip

- Underline the different anatomical options
- Add notes to the page where you see the codes, such as “code **PER** lesion”

Nails

- Fingernails and/or toenails
- Trimming or Debridement

Integumentary System

Pilonidal Cyst

- Coded according to complexity of excision
  - Simple
  - Extensive
  - Complicated

Wound Repair

- Codes for wound closure using sutures, staples or tissue adhesive
- If only adhesive strips used, the service is coded using E/M only.
- Two important guidelines:
  - Measure and report size in centimeters (cm)
  - When MULTIPLE wounds are repaired, add together the lengths of those in the same classification (repair type) and same anatomic grouping. DO NOT add together lengths from different classifications.

Wound Repair

Definitions for types of wound repair are found in guidelines

- **Simple** repair – wound is superficial and requires single layer closure
- **Intermediate** repair – wound is deeper and requires layered closure of one or more deeper layers of subcutaneous tissue or superficial fascia. It includes limited undermining. It also includes a heavily contaminated wound that requires extensive cleaning or removal of particulate matter
- **Complex** repair – wound requires more than a layered closure, scar revision, debridement, extensive undermining, stents or retention sutures.

Wound Repair

Book preparation tip

- Make notes from guidelines on the pages where the codes are found:
  - Add together wounds by **type** and by **anatomical grouping**

- Underline or highlight the different anatomical groupings

Adjacent Tissue Transfer

Pay attention to the guidelines for these codes

- These codes do not apply to direct closure or rearrangement of traumatic wounds.
- The excision of benign or malignant lesions is not separately reportable with Adjacent Tissue Transfer when done for the same lesion.
- Skin grafts necessary to close a secondary defect is separately reportable.

Repair

Skin Replacement Surgery & Skin Substitutes

- 15002-15005 based on size of repair and site
- 15040-15261 reported for autografts and tissue cultured autografts
- 15271-15278 reported for skin substitute grafts
- 15050 is pinch graft measured in centimeters
- All other skin graft codes are determined by the size of the defect in square centimeters
- Square centimeters calculation **length in cm x width in cm**

Skin Replacement Surgery & Skin Substitutes

- The section starts with codes for the surgical preparation of the recipient site and are based on the anatomical area and size of the wound preparation.
- Harvest and placement of the skin graft is reported based on:
  - Type of graft
    - Examples include Split thickness, full thickness, epidermal, etc.
  - Location
    - Where the graft is going, not from where the graft is taken
  - Size
    - Measurement is square centimeters for adults and children ten years and older.
    - Patients less than ten years of age is measured by percentage.

Destruction

Ablation by any method other than excision

- Electrosurgery
- Cryosurgery
- Laser treatment
- Chemical treatment

- Benign/premalignant based on number of lesions
- Malignant lesion according to location and size in centimeters

Destruction

Guidelines:

- Type of lesion (benign, malignant, premalignant)
- Location of the lesion
- Size or lesion diameter

- Destruction methods: ablation, electrosurgery, cryosurgery, laser, chemical, surgical curettement
- Report separately each lesion destroyed.

Mohs Micrographic Surgery

Mohs Micrographic Surgery

- Removal of complex or ill-defined skin cancer
- Physician acts as surgeon and pathologist
- Removes tumor tissues and performs histopathologic exam
- Repair of site may be reported separately

- Stage = each deeper layer of tissue removed
- Block = smaller pieces of each stage that will be examined for cancer

Mohs Micrographic Surgery

To report Mohs surgery:

- Know the anatomic location
- Number of stages (how many layers of tissue removed)
- Number of blocks per stage (how many specimens were created from the layer)

Breast Biopsy

- Performed as percutaneous or open.
- Codes are divided by type of imaging guidance (stereotactic, ultrasound, or magnetic resonance).
- Code per lesion biopsied

Mastectomy

- 19301 Mastectomy, partial (eg. lumpectomy, tylectomy, quadrantectomy, segmentectomy);
- 19302 with axillary lymphadenectomy

- 19303 Mastectomy, simple, complete

- 19305 Mastectomy, radical, including pectoral muscles, axillary lymph nodes

- 19306 Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)

- 19307 Mastectomy, modified radical, including axillary lymph nodes, with or without pectoralis minor muscle, but excluding pectoralis major muscle

20,000 Series
Musculoskeletal System

CPC Review

AAPC

Anatomy

Skeleton

- Axial
- Appendicular

- Muscles – assist with heat production and posture
- Ligaments – attach bones to other bones
- Tendons – attach muscles to bones
- Cartilage – acts as a cushion between bones in a joint

ICD-10-CM Coding

Laterality

- 1— Right
- 2— Left
- 3— Bilateral
- 9— Unspecified

- When the laterality is not documented, unspecified is used
- If a bilateral option is not available, 2 codes will be reported
- When a bilateral condition exists, and there is a bilateral code, the bilateral code is reported even if only one side is being treated for that encounter.

Diseases of the Musculoskeletal System and Connective Tissue

Chapter 13

- Arthropathy – pathology or abnormality of a joint
- Dorsopathies – disorders affecting the spinal column
- Rheumatism – non-specific term for any painful disorder of the joints, muscles, or connective tissue
- Enthesopathies – disorders of ligaments
- Bursitis – inflammation of the bursa
- Pathological fractures

Injury and Poisoning

Sprains and Strains

Fractures

- Comminuted
- Impacted
- Simple
- Greenstick
- Pathologic
- Compression
- Torus or Incomplete

Guidelines for Fracture Treatment

Fracture Guidelines

- Fracture treatment includes application and removal of first cast or traction device only. Subsequent replacement of cast and/or traction device may require an additional listing.
- Treatments:
  - **Closed**: fracture site is not surgically exposed/opened
  - **Open**: either fracture site is surgically opened to visualize the repair or site is opened remove from fracture site to insert an intramedullary nail
  - **Percutaneous**: Neither open or closed. Fixation (pins) are placed across the fracture site, usually under fluoroscopy
  - **Manipulation**: Attempted reduction or restoration of a fracture to normal alignment by applied force.

Fracture Coding

Coding Note

- Pay close attention to Fracture/Dislocation sections
  1. Treatment type – Closed, Open, Percutaneous, Arthroscopic
  2. Bone treated

CPT® : Musculoskeletal System

Formatted by anatomic site:

- General
- Head, Neck (soft tissues) and Thorax
- Back and Flank
- Spine (vertebral column)
- Abdomen
- Shoulder, Humerus and Elbow
- Forearm and Wrist
- Hand and Fingers
- Pelvis and Hip Joint
- Femur and Ankle Joint
- Foot and Toes
- Application of Casts and Strapping
- Endoscopy/ Arthroscopy

Musculoskeletal System

“General” subheading

- Many different anatomic sites

Other subheadings

- Divided by anatomic site, procedure type, condition and description
  - Incision, excision, introduction or Removal, Repair, Revision and/or Reconstruction, Fracture and/or dislocation, Arthrodesis, Amputation

Wound Exploration

- Used for wounds resulting from a penetrating trauma.
- Describe surgical exploration and enlargement of wound, extension of dissection, debridement, removal of foreign body, ligation of minor blood vessels.
- No thoracotomy or laparotomy is done. If those approaches are necessary, report those codes, not these.
- Wound repair is separately reportable.

General

Excision & Biopsy

- Muscle or Bone
- Depth of wound or tissue excised

Introduction or Removal

- Injections
- Foreign body removal

Trigger Point Injections

- Aponeurosis is an abnormal sheet like extension of the tendon. Injection of a tendon or ligament is the medical therapeutic procedure to reduce the aponeurosis formation
- Trigger points are painful knots of muscle that are tight and do not relax.
- Codes are available for injections with or without medication.
- Codes are selected based on the number of muscles treated, not the number of needles or injections placed.

Spine

Anatomy

- Cervical C1-C7
  - C1 Atlas
  - C2 Axis
- Thoracic T1-T12
- Lumbar L1-L5

Spinal Instrumentation

- Segmental
- Non-segmental

Osteotomy

- Osteotomy procedures are reported when portion(s) of the vertebral segment(s) are removed in preparation for spinal deformity correction.
- Key concepts include anatomic site and complexity.
- Columns:
  - Anterior – anterior 2/3 of the vertebral body
  - Middle – posterior ½ of vertebral body and pedicle
  - Posterior – articular facets, lamina and spinous process

Bone Grafting and Vertebral Column

Guidelines

- Bone grafting procedures are separately reportable.
- Instrumentation is separately reportable.
- When arthrodesis (fusion) is also performed, it is reported in addition to the primary procedure with modifier -51.
- When 2 surgeons work together as primary surgeons performing distinct parts of a single procedure, each surgeon reports his distinct work by appending modifier -62 to the procedure code.

Vertebroplasty

- Vertebroplasty is the injection of material into the vertebral body (rounded portion) to reinforce the structure. This is done under imaging guidance.

- Vertebral augmentation is the process of cavity creation (lifting) after compression fracture of the spine. Bone cement is injected into the vertebral body and fractures to prevent recurrent collapse.

- Location of the vertebral body guides code selection.

Vertebroplasty

Key to coding:

- Number of levels
- Location (cervical, thoracic, lumbar)
- Imaging guidance not reported separately
- Modifier 50 not reported

Application of Casts and Strapping

Cast application is billable if:

- It is a replacement cast during follow-up or after care for a fracture
- It is an initial service performed without restorative treatment or procedure to stabilize or protect a fracture, injury or dislocation or to provide comfort to a patient.

Endoscopy/Arthroscopy

- Divided by body area – shoulder, elbow, wrist, hip, knee, ankle
- Surgical endoscopy/arthroscopy includes a diagnostic endoscopy/arthroscopy
- Multiple surgical procedures performed through scope may be reported
- “Separate procedure” – included in more extensive procedure

Endoscopy/Arthroscopy

Many services can be reported as either arthroscopic or as open incisional services.

- Look for key words in the operative report such as scope or port to identify an arthroscopic procedure.
- Watch parenthetical statements under the codes for services that are included with other arthroscopic services

HCPCS Level II

Orthotic and Prosthetic

Basic Orthopedic Supplies

- Crutches
- Canes
- Walkers
- Traction Devices
- Wheelchairs
- Other orthopedic supplies

30000 Series Respiratory, Hemic, Lymphatic, Mediastinum, Diaphragm and Cardiovascular Systems

CPC Review

AAPC

Respiratory System

- Nose
- Larynx
- Pharynx
- Trachea
- Bronchi
- Bronchioles
- Lungs

Alveoli

- Located at the ends of the bronchioles
- Function is gas exchange (CO_2 and O_2)

Pleura

Mediastinum and Diaphragm

- Mediastinum-thoracic cavity between the lungs that contains the heart, aorta, esophagus, trachea, thymus gland

- Diaphragm-muscle that divides the thoracic cavity from the abdominal cavity

Hemic and Lymphatic Systems

- Network of channels
- Structures dedicated to circulation and production of lymphocytes
- Three interrelated functions
  - Removal for interstitial fluid from tissues
  - Absorbs and transports fatty acids to circulatory system
  - Transport antigen presenting cells to lymph nodes

Hemic and Lymphatic Systems

Spleen

- Located left side of stomach
- Reservoir for blood cells
- Produces lymphocytes involved in fighting infection

ICD-10-CM: Respiratory

- Acute Upper Respiratory Infections (J00-J06)
- Influenza and Pneumonia (J09-J18)
- Other acute lower respiratory Infections (J20-J22)
- Other diseases of Upper Respiratory tract (J30-J39)
- Chronic Lower Respiratory diseases (J40-J47)
  - Bronchitis (J40-J42)
  - Emphysema (J43)
  - COPD (J44)
  - Asthma (J45)

ICD-10-CM

U00-U85

- U07.0 Vaping-related disorder
- U07.1 COVID-19
- U09.9 Post COVID-19 condition, unspecified

- Codes for Special Services

ICD-10-CM

Mediastinum and Diaphragm

- Diaphragm Herniation
- Diaphragmatic Paralysis
- Thymic hyperplasia

Hemic and Lymphatic Systems

- Lymphoma
- Lymphadenitis
- Hypersplenism
- Splenic Rupture
- Leukemia

Rules/Guidelines

Respiratory procedures

- Progress downward from the head to the thorax

Parenthetical statements

- Directions on how to use specific codes
- Apply to codes above parenthetical note; not below

Most codes are unilateral

Use modifier 50 if bilateral procedure performed

- Unless code descriptor states bilateral

Nose

Rhinotomy

Excision

- Biopsy code
- Removal of lesions, cysts, and/or polyps
- Turbinates

Rhinectomy

Nose

Introduction

- Therapeutic turbinate injection
- Prosthesis for deviated nasal septum
  - Plug placed by physician

Removal of foreign body

- Office setting
- Facility setting
  - General anesthesia

Nose

Repair

- Rhinoplasty
- Septoplasty, Atresia, Fistulas, Dermatoplasty

Destruction

- Turbinate mucosa

Epistaxis

Coding concepts include:

- Anatomical site
- Complexity

- Codes are unilateral and require use or RT or LT
- Bilateral nosebleed would require modifier -50.

Accessory Sinuses

Four pairs of sinuses: frontal, ethmoid, sphenoid and maxillary

Procedures

- Obliterative
- Non-obliterative

Endoscopies

- Diagnostic/Surgical
- All surgical endoscopies always include a diagnostic endoscopy

The Larynx

- Laryngotomy
- Laryngectomy
- Pharyngolaryngectomy
- Arytenoidectomy
- Incision
  - Emergency endotracheal intubation
  - Change of tracheotomy tube

The Larynx

Endoscopy

- Use of operating microscope or telescope
  - Parenthetical statement instructs not to code the operating microscope
- Direct visualization
  - View anatomical structures via bronchoscope inserted into laryngoscope
- Indirect visualization
  - Structures viewed in a laryngoscopic mirrored reflection

Trachea and Bronchi

Endoscopy

- Many bronchoscopy codes
  - Use common portion of main or parent code (up to the semicolon) as the first part of each indented code descriptor under the parent code
- Bronchoscopy codes
  - Bronchial lung biopsies
  - Foreign body removals
  - Stent or catheter placements
  - Flexible or rigid scopes
  - Many parenthetical statements

Trachea and Bronchi

Excision and Repair

- Carinal reconstruction
  - Needed after removal of cancer at this site
- Tracheal tumor excision
  - Thoracic and intrathoracic
- Stenosis and anastomosis excision
- Injury suturing
- Tracheostomy scar revision

Lungs and Pleura

Incision codes

- Thoracostomy
- Thoracotomy
- Pneumonostomy
- Pleural scarification
- Decortication

Lungs and Pleura

Excision

- Biopsies
  - Read parenthetical statement directions
- Pleurectomy

Removal

- Thoracentesis
- Total pneumonectomy
- Lobectomy
- Resections

Lungs and Pleura

Introduction and Removal

- Thoracostomy (chest tube)

Endoscopy

- Diagnostic vs. surgical
- VATS

Lungs and Pleura

Lung Transplantation

- Three steps to all transplants:
  - Harvesting
  - Backbench
  - Insertion
- Live donors
  - Rare
  - Only one lobe donated
- Cadaver donors
  - Most commonly used

Coding tip:

- Note unilateral vs bilateral
- Note services with or without cardiopulmonary bypass assistance

Lungs and Pleura

Surgical collapse therapy/thoracoplasty

- Resection
- Thoracoplasty

Other procedures

- Lung lavage
- Tumor ablation
- Unlisted - 32999

Pulmonary

Ventilator Management

Other Procedures

- Spirometry
- Pulmonary capacity studies
- Respiratory flow studies
- Pulmonary stress testing
- Inhalation treatment
- Oxygen uptake
- Pulse oximetry

Mediastinum & Diaphragm

Mediastinum

- Mediastinotomy – based on approach
- Excision (cyst, tumor)
- Endoscopy

Diaphragm

- Hernia repair
- Resections

Hemic and Lymphatic Systems

Spleen

- Splenectomy
  - Code selection based on type
- Splenorrhaphy
  - Reported when a ruptured spleen is repaired

General

- Bone marrow or stem cell services

Hemic and Lymphatic Systems

Lymph Nodes & Lymphatic Channels

- Drainage of lymph node abscess
- Biopsy or Excision
  - Code selection based on method and location
- Lymphadenectomy
  - Limited – removes only lymph nodes
  - Radical – removal of lymph nodes, glands, and surrounding tissue
- Injection Procedures
- Lymphangiography

Heart

4 Chambers

- Two atria
- Two ventricles

Three layers

- Endocardium
- Myocardium
- Epicardium

Valves

- Atrioventricular valves
  - Tricuspid
  - Bicuspid (Mitral)
- Semilunar valves
  - Pulmonary
  - Aortic

Oxygenation Process

- RA > tricuspid valve > RV
- RV > pulmonary valve > pulmonary artery
- LUNGS (gas exchange) > pulmonary vein >
- LA > mitral valve > LV
- LV > aortic valve > BODY via arteries
- BODY > via veins > RA

Electrical Conduction in the Heart

- Conduction begins in **sinoatrial node** of right atrium
  - Nature’s pacemaker
  - Firing causes contraction of muscle
- Moves to **atrioventricular node**
- Then to **Bundle of His** along septum
- Then to **Purkinje fibers** along the surface of ventricles

Coronary Arteries & Blood Vessels

Arteries

- Carry oxygenated blood
- Take blood away from heart to the body

Veins

- Carry deoxygenated blood
- Bring blood back to the heart from the capillary beds

Capillaries

- Connect arteries and veins

Circulations

Pulmonary Circulation

- Pushes deoxygenated blood into the lungs
- Carbon dioxide removed and oxygen added
- Blood flows to the left atrium

Systemic Circulation

- Blood flows from left atrium into the left ventricle
- Pumped to the body to deliver oxygen and remove carbon dioxide

ICD-10-CM Coding

- Chapter 01: Infectious and parasitic diseases
- Chapter 02: Neoplasms
- Chapter 09: Diseases of the Circulatory System
- Chapter 17: Congenital Anomalies
- Chapter 18: Signs, Symptoms and Ill-Defined Conditions

ICD-10-CM: Hypertension

Hypertensive Disease

- I10 Essential (primary) Hypertension
  - Includes high blood pressure, arterial, benign, essential, malignant, primary, systemic
- I11- Hypertension with heart disease (presumed relationship exists between hypertension and heart disease)
- I12- Hypertensive chronic kidney disease (presumed relationship exists between hypertension and chronic kidney disease)
- I13- Hypertensive heart and chronic kidney disease
- I15- Secondary Hypertension
- I16- Hypertensive Crisis

ICD-10-CM: Arteriosclerosis

CAD of native coronary artery (I25.10)

- The patient is not a heart transplant
- The patient has CAD with no history of CABG
- The patient had a prior PTCA of native coronary artery and the patient is admitted with re-occlusion of this lesion

ICD-10-CM Coding

- Endocarditis
- Heart Failure
- Pericarditis
- Peripheral Arterial Disease (PAD)
- Valve Disorders
- Myocardial Infarction (MI)
  - Acute MI
  - Chronic MI and Old MI

ICD-10-CM Coding

Myocardial Infarction (MI)

- Acute MI
- Chronic MI and Old MI

CPT® Coding

Surgical Section

Radiology Section

- Heart
- Vascular
- Diagnostic Ultrasound (various CPT®s)
- Radiologic Guidance
- Nuclear Medicine

Medicine Section

- Cardiovascular
- Noninvasive Vascular Diagnostic Studies

Pacemakers/Defibrillators

- Pacemaker System and Pacing cardioverter-defibrillator system
- To code these procedures, you need to know:
  - Type of system
  - Whether the placement is temporary or permanent
  - Whether the device is single, dual, multiple leads, or leadless
  - Placement of electrodes (transvenous, endoscopic for epicardial placement, epicardial, coronary sinus)
  - The procedure performed (removal, replacement, insertion)
  - Components removed, replaced, or inserted (pulse generator, leads)
    (All at once or individually)

Pacemakers/Defibrillators

- Type of pacemaker
  - Permanent
  - Temporary
- Type of procedure
  - Initial
  - Removal
  - Conversion
- Amount of leads
- Placement
  - Transvenously
  - Epicardially
- Approach
  - Open
  - Endoscopic

Subcutaneous Cardiac Rhythm Monitor and Implantable Hemodynamic Monitors

- Implantable loop recorder (ILR) –an event recorder that is activated by irregular cardiac activity.
- Wireless pressure sensor for hemodynamic monitoring – sensor is placed in the pulmonary artery via a right heart catheterization.

Cardiac Valve Procedures

- Aortic Valve
- Mitral Valve
- Tricuspid Valve
- Pulmonary Valve

Coronary Artery Bypass Grafting (CABG)

3 sets of codes:

Material Used	Code(s) billed
Vein **only**	33510 - 33516
Artery	33533 - 33536
Artery **and** Vein	33533 – 33536 33517 - 33523

Add a note in your books with codes 33510 – 33516:
DO NOT BILL WITH 33533 - 33536

Coronary Artery Bypass Grafting (CABG)

Beware of the add-on codes:

- +33508 – Endoscopy, surgical, including video-assisted harvest of vein(s) for CABG
- ⦸ 33509 – Harvest of upper extremity artery, 1 segment, for CABG, endoscopic
- +33572 – Coronary endarterectomy, open, in conjunction with CABG
- +33530 – Reoperation, CABG or valve procedure, more than 1 month after the original operation
- +35500 – Harvesting of an upper extremity vein
- +35572 – Harvesting of a femoropopliteal vein
- ⦸ 35600 – Harvest of upper extremity artery, 1 segment, for CABG, open

Bypass Grafts

Non-coronary vessels

- Vein
- In-situ vein
  - Vein is left in native location
- Other than vein

Code by type/location

Central Venous Access Devices (CVAD)

Placed for frequent access to bloodstream

Tip of catheter must terminate in the:

- Subclavian
- Brachiocephalic
- Iliac
- Inferior or superior vena cava

Code by

- Procedure (insertion, repair, replacement, removal, etc.)
- Tunneled or not
- With pump or port
- Patient age

See CVAP table in CPT®

Interventional Procedures

Vascular Injection Procedures

- Selective catheterizations should be coded to the highest level accessed within a vascular family
- The highest level accessed includes all of the lesser order selective catheterizations used in the approach
- Additional second and/or third order arterial catheterization within a vascular family of arteries or veins supplied by a single first order should be coded

CPT®: Cardiovascular

Hemodialysis (36800-36815)

Portal Decompression (37140-37183)

- Treat hypertension/occlusion of portal vein
- TIPS (37182, 37183) diverts blood from the portal vein to the hepatic vein

Transcatheter Procedures

- Removal of clot
  - Arterial (37184-37186)
  - Venous (37187-37188)
  - Other (37191-37216)
  - Foreign body retrieval, stent placement, etc.

Endovascular Revascularization

Treat occlusive disease in lower extremities

Three territories

- Iliac (common iliac, internal iliac and external iliac)
- Femoral/Popliteal (considered a SINGLE territory)
- Tibial/Peroneal (anterior tibial, posterior tibial, peroneal arteries)

Codes arranged in a hierarchy for each territory

- stent placement with atherectomy (highest)
- stent placement
- atherectomy
- angioplasty (lowest)

Bundled into Endovascular Revascularization

- Vascular access
- Catheter placement
- Traversing the lesion
- Imaging related to the intervention (previously billed as the supervision and interpretation code for the specific intervention)
- Use of an embolic protection device (EPD)
- Imaging for closure device placement
- Closure of the access site

Radiology Vascular Procedures

Diagnostic angiography

- Sometimes separately reportable
- Diagnostic angiography performed at a separate setting from an interventional procedure is separately reportable
- Diagnostic angiography performed at the time of an interventional procedure is NOT separately reportable if it is specifically included in the interventional code descriptor

CPT®: Cardiovascular Medicine Section

- Therapeutic services and procedures
- Cardiography
- Cardiovascular monitoring services
- Implantable wearable cardiac device evaluations
- Echocardiography
- Cardiac Catheterizations
- Intracardiac Electrophysiological Procedures/Studies
- Peripheral Arterial Disease Rehabilitation
- Noninvasive physiologic studies and procedures
- Other procedures

Percutaneous Coronary Interventions

Major coronary arteries:

- Left circumflex (LC) and its marginal branches
- Left anterior descending (LD) and its diagonal branches
- Right coronary (RC) and the posteriolateral and posterior descending branches

- All interventions MUST identify the artery, or its branch being touched using modifiers LC, LD, RC

Percutaneous Coronary Interventions

- Each branch (LD, LC, RC) is reported as its OWN intervention
- The add-on code MUST match or share the SAME modifier as the primary.
- Example:
  - Stents were placed in the left anterior descending and the left circumflex …… 92928-LD, 92928-LC
  - Stents were placed in the left anterior descending and its first diagonal …… 92928-LD, 92929-LD

ECG and Stress Testing

- Codes for ECG and Stress Testing include professional and technical concepts already
- TC and 26 modifiers are NOT needed to properly report the providers' service

Technical Component	Professional Component
Machine ownership Technician cost Overhead Supplies used	Supervision of test Interpretation and reporting of results

ECG and Stress Testing

	ECG routine with at least 12 leads	CV Stress Test	Rhythm ECG, 1-3 leads
Global (Tech and Professional)	93000	93015	93040
Supervision Only		93016	
Technical Only	93005	93017	93041
Professional Only	93010	93018	93042

Cardiac Catheterization

Most common access point – femoral artery

There are two code families for cardiac catheterization:

- Congenital heart disease
- All other conditions

- Catheter insertion, injection(s), and imaging are combined in one code for all other conditions but separately billable for congenital conditions.

Cardiac Catheterization

For congenital conditions, bill injections separately

	Inside only	Including coronary arteries	Congenital conditions
Right heart	93451	94356	93593 or 93594
Right heart and CABG		94357	
Left heart	93452	93458	93595
Left heart and CABG		93459	
Combined	93453	93460	93596 or 93597
Combined with CABG		93461	

40000 Series Digestive System

CPC Review

Digestive System

Lips/Mouth

- Teeth
- Gums
- Tongue

Pharynx

- Conduit for respiration and digestion

Esophagus

- Conduct food from the pharynx to the stomach
- Peristaltic action moves the food

Digestive System

Stomach

- Cardia
- Fundus
- Pylorus (antrum)
- Body

Small Intestine (small bowel)

- Duodenum
- Jejunum
- Ileum

Large Intestine (large bowel)

- Cecum (appendix attached)
- Colon
  - Ascending colon
  - Transverse colon
  - Descending colon
  - Sigmoid colon
  - Rectum
  - Anus

Digestive System

Pancreas

- Endocrine and exocrine organ
- Secretes insulin into the bloodstream

Liver (Hepatic)

- Largest organ and largest gland

Gallbladder/Biliary System

ICD-10-CM: Digestive

- Chapter 1: Infectious and Parasitic Diseases
- Chapter 2: Neoplasms
- Chapter 11: Disease of the Digestive System
- Chapter 17: Congenital Anomalies
- Chapter 18: Signs, Symptoms, and Ill-Defined Conditions

Diseases of the Digestive System

Esophageal and Swallowing Disorders

- Barrett's Esophagus
- Esophagitis
- Esophageal varices
- Mallory-Weiss Tear
- Hiatal Hernia
- Swallowing Disorders/Dysphagia

- Gastritis and Peptic Ulcer Disease
- Gastrointestinal Bleeding
- Gastroenteritis

Diseases of the Digestive System

- Inflammatory Bowel Disease (IBD)
- Irritable Bowel Syndrome (IBS)
- Foreign Bodies
- Diverticular Disease
  - Diverticulosis
  - Diverticulitis

Diseases of the Digestive System

Anorectal Disorders

- Rectal prolapse
- Abscess
- Hemorrhoids
- Anal fissure
- Anal fistula

- Pancreatitis
- Benign and Malignant Neoplasms of the Gastrointestinal Tract
- Congenital Disorders

Digestive System

Organized by anatomic site and procedure

Endoscopy

- Visualization of a hollow viscus or canal by means of an endoscope or scope
- Laparoscope is an endoscope

Guidelines

- Diagnostic services are listed as separate procedure
- When done in conjunction with a surgical service (diagnostic becomes surgical), only the surgical service is billable.

Digestive System

Lips

- Vermilionectomy
- Cheiloplasty

Mouth

- Vestibuloplasty
- Glossectomy
- Palatoplasty

Digestive System

Pharynx, Adenoids and Tonsils

- Tonsillectomy
- Adenoidectomy
- Biopsy
- Pharyngoplasty
- Pharyngostomy

Esophagus

Esophagoscopy

- Esophagoscopy is direct visualization of the esophagus only
- Can be performed multiple ways. Pay attention to the parent codes:
  - Rigid transoral
  - Flexible transnasal
  - Flexible transoral
- Pay attention to the service performed (biopsy, foreign body removal, injection, etc.)

Esophagogastroduodenoscopy (EGD)

- EGD includes visualization of the esophagus, stomach and proximal duodenum or jejunum
- Also known as an Upper GI exam
- Many parenthetical statements
- If duodenum/jejunum is not examined:
  - Report with modifier 52 if repeat exam is not planned
  - Report with modifier 53 if repeat exam is planned

Endoscopic Retrograde Cholangiopancreatography

- Visualization of the biliary or pancreatic duct systems
- Considered complete if one or more of the ductal system(s) is visualized
- Many guidelines to review

Digestive System

Stomach

- Gastrectomy
- Bariatric and Gastric Bypass
- Endoscopic procedures

Gastric Bypass

Treatments for morbid obesity include bariatric surgery and gastric bypass.

Procedures include:

- Roux-en-Y
- Banding
- Laparoscopic gastric restriction
- Open gastric restrictive procedures
- Gastric bypass

Digestive System

Intestines (except rectum)

- Incision
  - Enterolysis
  - Exploratory procedures
- Endoscopic
  - Small intestines
  - Beyond the second portion of the duodenum and stomal endoscopy
  - Colonoscopies
- Enterostomy

Digestive System

Rectum

- Incision – drainage of abscesses
- Excision
  - Proctectomy – partial or complete
- Endoscopy
  - Proctosigmoidoscopy
  - Sigmoidoscopy
  - Colonoscopy

Anus

- Hemorrhoids

Endoscopy

- Proctosigmoidoscopy – exam of the rectum
- Sigmoidoscopy – exam of the rectum and sigmoid colon
- Colonoscopy – exam of the entire colon from the rectum to the cecum
- Colonoscopy through stoma – exam of the colon from a colonoscopy stoma to the cecum

Digestive System

- Liver
- Biliary Tract
- Pancreas

Digestive System

Abdomen, Peritoneum, and Omentum

- Exploratory laparotomy
- Drainage of abscess – open or percutaneous
- Laparoscopy
- Hernia codes
  - Type of hernia
  - Strangulated or incarcerated
  - Initial or subsequent repair

HCPCS: Digestive System

Colorectal cancer screening

- G0104-G0106
- G0120-G0122

50000 Series
Urinary System, Male Genital System and Female Genital System

CPC Review

AAPC

Anatomy: Urinary System

- Two kidneys (filters)
- Renal pelvis/one per kidney (funnels urine into ureters)
- Two ureters (to bladder)
- One bladder (storage)
- One urethra (exit)

- Nephro = kidney
- Renal = related to kidney
- Pyelo = renal pelvis

Anatomy: Male Reproductive System

Testicles (sperm production, contained in scrotum)

Duct system (transport sperm)

- Epididymis
- Vas deferens

Accessory glands (contribute to ejaculate)

- Seminal vesicles
- Prostate gland

Penis

- shaft
- glans
- prepuce

ICD-10-CM: Urinary

Look primarily to N00-N99

Listed anatomically

- Kidney
- Ureters
- Bladder
- Urethra

ICD-10-CM: Urinary

Inflammation N00-N08

- Nephritis
- Glomerulonephritis

Renal failure (acute) (N17-)

Chronic Kidney Disease (CKD) (N18-)

- ESRD
- With hypertension (I12)
- With diabetes (E11.22)

ICD-10-CM: Urinary

Renovascular disease (N25.-)

- Report underlying condition first
  - Central diabetes inspidus (E23.2)
  - Nephrogenic diabetes insipidus (N25.1)

- Small Kidney (N27.-)
- Pyelonephritis (N12)
- Hydronephrosis (N13.-)
- Calculi (N20.-)

ICD-10-CM: Urinary

VUR (N13.-)

- Backflow or urine into ureter

Cystitis (N30.-)

- Bladder inflammation

Voiding disorders (N31.-, N32.-)

- Urinary incontinence (N39.-, R32)

UTI (N39.0)

- Report organism, when known

ICD-10-CM: Male Genital System

Look primarily to N40-N53

Listed anatomically

- Prostate
- Testes
- Penis

Also…

- Congenital Anomalies
- Neoplasms
- Signs/Symptoms

ICD-10-CM: Male Genital System

- BPH
- Hyperplasia
- Prostatitis
- PSA
- Dysplasia
  - PIN III
  - PIN I or II

ICD-10-CM: Male Genital System

Spermatic cord, Testis, Tunica Vaginalis, Epididymis

- Hydrocele
- Orchitis

Penis

- Phimosis
- Balanitis
- Routine circumcision
- Male infertility
- Peyronie’s disease

ICD-10-CM: Male Genital System

Congenital Anomalies

- Cryptorchidism
- Hypospadias
- Epispadias

- Neoplasms (by location)
- Injury
- Signs and Symptoms

CPT®: Urinary

Arranged by location/procedure type

- Incision, excision, repair, etc.
- Bilateral vs. Unilateral
- Operating Microscope (69990) may be separate
- Surgical endoscopy always includes diagnostic endoscope

CPT®: Kidney

Incision (“otomy”)

- Nephrotomy = incision of kidney
- Pyelotomy = incision of renal pelvis
- Nephrolithotomy
- Percutaneous removal of calculi
  - Nephrostomy tract

Excision (“ectomy”)

- e.g., nephrectomy
- Radical
- Ablation

CPT®: Kidney

Repair

- Ureteral repair
- Creation of ureteral conduit

Introduction (aspiration, injection, instillation)

- Ureteral stents
- Catheter changes
- Bladder irrigation and/or instillation

Kidney Abscess

- Treatment for renal abscess or renal stone extraction may require a nephrostomy tube to be placed.
- Often performed under CT guidance.
  - Report radiological guidance separately.
- Percutaneous removal of stones is coded by the size of the stone
  - Usually under fluoroscopic guidance and via existing nephrostomy tube/tract.
  - If no existing tube/tract, a nephrostomy tract must be created and reported

CPT®: Urinary

Laparoscopy

- Code by procedure

Endoscopy

- Performed through natural or created opening

Other Procedures of Kidney

- Renal Transplantation
- Lithotripsy
- Percutaneous ablation of renal tumors
- Cryotherapy for renal tumors

Urodynamics

CPT®: Male Genital System

- Penis
- Incision
- Destruction
- Excision
  - Excision of plaque
  - Penectomy
  - Circumcision

Introduction

Repair

- Hypospadia/epispadia
- Prosthesis

- Manipulation

Penile Implants

Type

- Inflatable
- Non-inflatable
- Multi-components

- Initial
- Repair
- Removal
- Removal and replacement

Transurethral Resection of Prostate (TURP)

- Prostate resection can be done transurethrally or open. Watch the approach.

52601 Transurethral electrosurgical resection of prostate, including control of postoperative bleeding, complete (vasectomy, meatotomy, cystourethroscopy, urethral calibration and/or dilation, and internal urethrotomy are included)

- **Watch the parenthetical statements for guidance on other approaches and repeat or staged procedures**

Orchiopexy

Orchiopexy is the surgical fixation of undescended testis in the scrotum.

3 approaches:

- OPEN - Inguinal
- OPEN - Abdominal
- LAPAROSCOPIC

Anatomy

External genitalia

- Mons pubis
- Labia (majora and minora)
- Hymen
- Bartholin’s glands
- Clitoris
- Urethra

Internal Genitalia

- Vagina
- Uterus
- Cervix
- Fallopian tubes (“tubes” or oviducts)
- Ovaries

ICD-10-CM: Female Genital System

- Chapter 14: Disease of the Genitourinary System
- Chapter 15: Complications of Pregnancy, Childbirth, and the Puerperium
- Chapter 2: Neoplasms
- Chapter 21: Z Codes

ICD-10-CM: Female Genital System

Female Genitourinary System

Complications of Pregnancy, Childbirth, and the Puerperium

- Have sequencing priority
- Report any condition that affects pregnancy (labor, delivery, post-partum)
- If pregnancy is incidental to condition treated, report Z33.1 as secondary code
  - Must document that condition treated does not affect pregnancy
- Only for mother, not newborn

ICD-10-CM: Female Genital System

Routine outpatient prenatal visits w/o complication

- First pregnancy
- Subsequent pregnancy
- First-listed diagnosis
- Not to be used with other Chapter 15 Codes

High-risk Pregnancy

- Code from category O09
- First-listed diagnosis
- May be reported with other Chapter 15 codes

CPT®: Female Genital System

Surgery

Arranged by anatomy “outside to inside”

- Terms used to describe external female genitalia
  - Perineum
  - Vulva
  - Pudenda
  - Introitus

Consider terminology to determine procedure

- -ectomy = removal
- etc.

CPT®: Female Genital System

Vulva

Vagina

- 57022 - Only CPT® code related to obstetrical complications NOT in labor/delivery section

Cervix Uteri

- Os = opening of cervix

Vaginectomy

Surgical removal of all or part of the vagina.

- Depth of tissue removed:
  - Simple – removal of skin and superficial subcutaneous tissue
  - Radical – removal of skin and deep subcutaneous tissue
- Area of tissue removed:
  - Partial – Removal of less than 80% of the vulvar area
  - Complete – Removal of more than 80% of the vulvar area

D & C

- D&C is a surgical procedure in which the cervix is dilated, and the uterine lining is scraped.
- The service can be either diagnostic or therapeutic:
  - 58120 Dilation and curettage, diagnostic and/or therapeutic (nonobstetrical)

Hysterectomy

There are multiple codes to report hysterectomy.

Coding concepts include:

- Approach – abdominal (open), vaginal, laparoscopic
- Total vs subtotal removal of the uterus
- With or without tubes (salpingectomy)
- With or without ovaries (oophorectomy)
- With or without total or partial vaginectomy
- Size of the uterus – less than or greater than 250 g

Maternity Care/Delivery

Antepartum care

- Initial visit during pregnancy
- Ongoing visits during pregnancy
  - Average of 13 visits (global OB package)

OB package includes…

- Antenatal care
- Delivery
- Episiotomy and repair
- Postpartum care

Maternity Care/Delivery

Postpartum care includes…

- Hospital visits
- 6-week checkup in the office
- Services related to cesarean delivery
  - e.g., two-week incision check

Unrelated encounters are reported separately

Maternity Care/Delivery

“Partial” maternity/delivery care

- Patient moves
- Change of coverage, etc.

Ultrasound

- NOT included in OB global package
  - Some payers may include one U.S. in global package (standard of care)
- More than one U.S. may be performed

Delivery Services

Type of Delivery	Full Package	Delivery only	Delivery and Postpartum Visit
Vaginal	59400	59409	59410
C-Section	59510	59514	59515
VBAC	59610	59612	59614
Failed VBAC	59618	59620	59622

Antepartum Care	
1 – 3 visits	E/M only
4 – 6 visits	59425
7+ visits	59426

Twin Deliveries

Type of Delivery	1st Twin	2nd Twin
Both delivered vaginally	59400	59409-51
Both delivered by C-section	59510	
One delivered vaginally and one delivered by C-section	59510	59409-51

Abortion

Spontaneous

- Miscarriage
  - Complete
  - Missed
    - D&C may be required

Induced

- Therapeutic (medical termination of pregnancy)
  - Failed induced abortion
    - Hysterotomy

60000 Series
Nervous, Eye and Ocular Adnexa, and Auditory Systems

CPC Review

AAPC

Anatomy: Endocrine

Comprised of ductless glands that secrete hormones into the circulatory system

- Thyroid
- Parathyroid
- Thymus
- Adrenal glands
  - Medulla
  - Cortex

Anatomy: Endocrine

Pancreas

- Endocrine and digestive functions

Carotid body

- Contains glandular tissue

Pituitary gland

- Anterior and posterior lobes

Pineal gland

Structures classified elsewhere

- eg, kidneys, testes, ovaries

Anatomy: Nervous System

Comprised of two components

- CNS
  - Brain
  - Spinal Cord
- PNS
  - Nerves running throughout the body

Anatomy: Nervous System

Nerve Plexi

Cervical

- Head, neck, shoulders

Brachial

- Chest, shoulders, arms, hands

Lumbar

- Back, abdomen, groin, thighs, knees, calves

Sacral

- Pelvis, buttocks, genitals, thighs, calves, feet

Solar (Coccygeal)

- Internal organs

Anatomy: Nervous System

Spinal cord functions:

- Motor information to muscles
- Sensory information to brain
- Reflex coordination

- Segment (bone) vs. interspace (space between)
- Segments (Body, Lamina, Process [Spinous, Transverse], Foramen)
- Facet joints
  - One per side, where segments meet

Anatomy: Nervous System

The Brain

- Frontal lobe
  - Cerebrum
- Two temporal lobes
- Parietal lobes
  - Primary sensory cortex
- Occipital lobe
- Cerebellum
- Brainstem
- Ventricles

ICD-10-CM: Endocrine

Categories E00-E89, by location

- Thyroid
- Parathyroid
- etc.

Neoplasms (Chapter 2)

- Report neoplasm first
- Additional diagnosis as a result of neoplasm are secondary

ICD-10-CM: Endocrine

Addison's disease (E27.1)

Primary hyperparathyroidism (E21.0)

Diabetes

- Secondary diabetes (E08)
  - Always has an underlying cause
- Drug/Chemical induced (E09)
- Type 1 (E10)
- Type 2 (E11)
  - Systems affected
  - Complications/manifestations

ICD-10-CM: Nervous System

Inflammation

- Meningitis (lining of brain/spinal cord)
- Encephalitis (brain)
- Myelitis (spinal cord)
- Encephalomyelitis (brain and spinal cord)

Sleep disorders

Hereditary/degenerative disease of CNS

- Report underlying disease when instructed

ICD-10-CM: Nervous System

Pain (NEC) (G89)

- Pain control is reason for visit
- Do not report as primary if you know the underlying cause, and visit is to manage that diagnosis
- Acute vs. Chronic

Disorders of CNS

- Migraine (G43)
  - Status migrainosus
  - Aura
  - Intractable

ICD-10-CM: Nervous System

Disorders of PNS

- Trigeminal nerve disorder
- Neuritis
  - CTS

Neoplasms

- Use neoplasm table, by location and type

Thyroid Gland Excision

Concepts include:

- Partial or total removal
- Contralateral (opposite side)
- Malignancy
- Approach

CPT®: Endocrine

- Parathyroid, Thymus, Adrenals, Pancreas
- Endocrinology – Medicine section

CPT®: Nervous System

Skull, Meninges, and Brain

- Twist drill
- Burr holes
- Trephine
- Craniectomy/craniotomy

Skull base surgery

- Approach
- Definitive procedure
- Repair/reconstruction

Endovascular therapy

- Balloons or stents to treat arterial disease

CPT®: Nervous System

AV malformation

- Simple vs. complex

Intracranial aneurysm

- Simple vs. complex

Other techniques

- Anastomosis to bypass aneurysm
- Stereotaxis/Radiosurgery
  - Lesion treatment

CPT®: Nervous System

Cranial neurostimulators

- Pulse generator
- Electrodes
  - eg, for Parkinson's, epilepsy

Repair of skull

- Skull fracture
- Encephalocele

Neuroendoscopy

- CSF Shunt
  - Drain accumulation of CSF
  - May require revision

CPT®: Nervous System

Spine and Spinal Cord

- Injection, Drainage, Aspiration
  - Pay careful attention to notes and parenthetical instructions
  - Spinal tap (diagnostic /therapeutic)
  - Neurolytic injections
- “Pain pumps”
- Intrathecal catheter
- Laminectomy vs. Laminotomy
  - Complete vs. partial excision of lamina
  - Code by spinal region
  - Include decompression

Laminotomy (Hemilaminectomy) vs Laminectomy

- Laminotomy is also known as a Hemilaminectomy or removal of ½ of the lamina from one side of a vertebra.
- Laminectomy is a complete removal of the lamina on both sides of the vertebra which also results in the removal of the spinous process.
- The purpose is decompression of the spinal cord and/or spinal root.

Laminotomy (Hemilaminectomy) vs Laminectomy

Coding concepts include:

- Anatomical site (cervical, thoracic, lumbar)
- Segments vs Interspaces
- Number
- Approach (percutaneous, endoscopic, open)

CPT®: Nervous System

Decompression

- Must consider approach
- Discectomy
- Osteophytectomy (removal of bony outgrowth)
- Corpectomy (vertebral body resection)

- Intra/extradural excision of intraspinal lesion
- Stereotaxis/radiosurgery
- Spinal Neurostimulators
  - Electrodes
  - Pulse generator

CPT®: Nervous System

Extracranial nerves, PNS, Autonomic

- 12 pair cranial nerves
- 31 pair spinal nerves
- Autonomic ganglia/plexi

PNS

- Somatic nerves
- Autonomic nerves
  - Sympathetic and parasympathetic

CPT®: Nervous System

Facet Joint injections

- Nerve block
  - Unilateral
  - Focus on “joint” between vertebrae
- Nerve “destruction”
- Somatic or sympathetic nerve
- Number of levels
- If infused, duration

CPT®: Nervous System

Injection of sympathetic nerves

Peripheral Neurostimulators

- surface or percutaneous

Destruction by neurolytic agent

Neuroplasty

- Freeing of nerves from scar tissue

Transection/avulsion (divide/tear away)

Neuroplasty

- Neuroplasty is the surgical repair nerve tissue
- Anatomical site is the key concept.
- For nerve grafts, location and size of the graft are key coding concepts.

CPT®: Nervous System

Excision

- By nerve

Neurorrhaphy

- Suturing of nerve
- Without or with graft
- By nerve

Operating microscope

- Beware bundling issues

CPT®: Nervous System Medicine Section

Neurology/Neuromuscular

- Sleep studies
- EEG
- Muscle/ROM testing
- EMG
- Chemo guidance
- EP/Reflex testing
- Neurostimulator analysis/programming

Anatomy: Eye and Ocular Adnexa

Eyeball

- Sclera
- Cornea
- Pupil and Iris
- Choroid – vascular layer
- Retina – pigmented nerve layer

Optic nerve and Optic disc

Anatomy: Ear and Auditory System

Middle ear

- Tympanic membrane
- Ossicles – malleus, incus, stapes
- Eustachian tube

Inner ear

- Labyrinth
- Membranous labyrinth – hair cells
- Vibrations into nerve impulse
- Cochlea, vestibule, semicircular canal
- Balance – utricle, saccule
- Oval window, round window

ICD-10-CM: Sense Organs

- Chapter 7: Diseases of the Eye and Adnexa
- Chapter 8: Diseases of the Ear and Mastoid Process
- Chapter 2: Neoplasms

Eye and Ocular Adnexa

- Infection and Inflammation
- Neoplastic disease
- Injury
- Glaucoma
- Cataracts
- Retinopathy
- Retinal detachment
- Strabismus

Ear and Mastoid Process

- Diseases of the Ear and Mastoid Process
- Infectious and inflammation
- Neoplastic disease
- Injury
- Vertigo
- Hearing loss
- Congenital disorders

CPT®: Eye and Ocular Adnexa

Three procedures for removal of eye:

- Evisceration – removal of contents excluding the sclera
- Enucleation – removal of entire eyeball
- Exenteration – removal of everything down to the bone

Concepts include:

- With or without implant
- With or without muscle reattachment
- With or without bone or muscle removal

Secondary Implant Procedures

CPT®: Eye and Ocular Adnexa

Intraocular Lens Procedures (IOL)

- Cataract removal with IOL
- Intracapsular
- Extracapsular
- IOL exchange

CPT®: Eye and Ocular Adnexa

Ocular Adnexa

- Strabismus
  - horizontal
  - vertical
  - transposition

CPT®: Eye and Ocular Adnexa

Operating Microscope

- Most procedures on the eye are performed with a microscope and are included in the procedure code.
- Guidelines for use of microscope state “Do not report 69990 in addition to codes where use of the operating microscope is an inclusive component – 15756-15758, 15842, 19364, 19368, 20955-20962, 20969-20973, 22551, 22552, 22856-22861, 26551-26554, 26556, 31526, 31531, 31536, 31541, 341545, 31546, 31561, 31571, 43116, 43180, 43496, 46601, 46607, 49906, 61548, 63075-63078, 64727, 64820-64823, 64912, 64913, 63091-68850, 0184T, 0308T, 0402T, 0583T”

CPT®: Eye and Ocular Adnexa Medicine Section

Special Ophthalmological Services

- New patient vs established patient
- Contact lens fittings
- Ophthalmoscopy
- Fitting of glasses

CPT®: Auditory System

Auditory System

- Removal foreign body from external auditory canal
  - both ears
- Removal of cerumen – coding concepts include procedure used and unilateral vs bilateral

CPT®: Auditory System

Middle Ear

- Tympanostomy
- Mastoidectomy; complete
  -modified radical
  -radical

CPT®: Auditory System

Tympanoplasty

- Tympanoplasty is the surgical reconstruction or repair of the tympanic membrane (ear drum)
- Surgery can be done under either local or general anesthesia.
- Can be done:
  - without mastoidectomy, with antrotomy/mastoidotomy (cutting into the mastoid bone) or with mastoidectomy (removal of the mastoid bone)
  - with or without ossicular chain (hammer, anvil, stirrup) reconstruction

CPT®: Auditory System

Inner Ear

- Labyrinthectomy
- Temporal Bone, Middle Fossa Approach
- Microsurgery

CPT®: Auditory System Medicine Section

- Special Otorhinolaryngologic Services
- Otolaryngologic examination under general anesthesia
- Vestibular Function Tests
- Audiologic Function Tests with Medical Diagnostic Evaluation

Radiology

CPC Review

Radiologic Projections

- Oblique – slanting, neither frontal or lateral
- Lateral – side view, X-ray beam travels through the side of the body
- Anteroposterior – X-ray beam enters the body through the front and exits through the back
- Posteroanterior – X-ray beam enters the body through the back and exits through the front
- Cone – focused or spot view

Additional Terms

- Proximal – closer to the point of attachment to the body
- Distal – away from the point of attachment to the body
- Flexion – bending
- Extension – straightening

Diagnosis Coding

- Code the definitive diagnosis
- Code signs and symptoms if no definitive diagnosis is available
- Diagnostic tests
  - Code sign or symptom that prompted the test
  - Do not code questionable, rule out, or probably diagnoses
- Routine radiology
  - Z01.89 Radiological examination, NEC

CPT® Subsections

- Diagnostic Radiology (Diagnostic Imaging)
- Diagnostic Ultrasound
- Radiologic Guidance
- Breast, Mammography
- Bone/Joint Studies
- Radiation Oncology
- Nuclear Medicine

Guidelines

Supervision and Interpretation (S & I)

- Interventional radiologic procedures
- Report two codes:
  - Surgical code; or code from the medicine section
  - Radiologic supervision and interpretation

Administration of Contrast Material

- Contrast material administered intravascularly, intra-articularly, or intrathecally
- Oral and/or rectal contrast does not qualify

Modifiers

Technical Component (TC)

- Equipment
- Overhead
  - Supplies
  - Room
  - Gowns

Professional Component (26)

- Reading and interpretation

Diagnostic Radiology (Diagnostic Imaging)

Anatomical organization

Radiologic procedures include:

- Standard X-rays
- MRIs
- CTs

Diagnostic Radiology (Diagnostic Imaging)

Code Selection:

- Anatomical location
- Type of procedure
- Number of views
- Type of view (AP, PA, etc.)
- Laterality (unilateral, bilateral)
- Contrast material

Coding Tip

- Underline or highlight the anatomy
- Highlight the number of views
- Highlight or circle with/without contrast

Heart – Subsection Guidelines

Heart

- Stress
  - Cause the heart to work harder
- Cardiac MRI
  - Physiologic evaluation of the cardiac function
  - Velocity flow mapping
- Cardiac CT
  - Coronary calcium
  - Congenital heart disease

Vascular Procedures – Subsection Guidelines

Aorta and arteries

- Aortography – imaging of aorta and branches
- Angiography – imaging of arteries

Veins and lymphatics

- Lymphangiography – visualization of lymphatics
- Splenoportography – injection of contrast into the spleen to visualize the port vessel of the portal circulation
- Venography – imaging of veins

Vascular Procedures

Transcatheter procedures

- Supervision and interpretation codes
- Code with codes from:
  - Cardiovascular section
  - Medicine section

Diagnostic Ultrasound

High frequency sound waves to look at organs and other structures inside the body

Used to view:

- Heart
- Blood vessels
- Kidneys
- Other organs
- Fetus (during pregnancy)

Diagnostic Ultrasound

Required:

- Permanently recorded images with measurements
- Final written report for the patient’s medical record
- Exception – biometric measure

Diagnostic Ultrasound

Anatomic regions

- Complete – each element listed in parenthesis within the code description
- Limited – reported if less than complete is performed
- Not reported together

Definitions

- A-mode
- M-mode
- B-scan
- Real-time scan

Pelvis Ultrasound

Obstetrical

- Pregnant uterus
  - Review definitions in guidelines
- Fetal
  - Look for what specifically is being looked at (eg, umbilical artery in 76820)

Nonobstetrical

Ultrasonic Guidance

Includes guidance for:

- Pericardiocentesis
- Endomyocardial biopsy
- Vascular access
- Parenchymal tissue ablation
- Intrauterine fetal transfusion or cordocentesis
- Needle placement
- Chorionic villus sampling
- Amniocentesis
- Aspiration of ova
- Placement of radiation therapy fields

Radiologic Guidance

- Fluoroscopic
- Computed Tomography (CT)
- Magnetic Resonance (MRI)
- Other

Breast, Mammography

- Mammary ductogram or galactogram
- Digital Breast Tomosynthesis
- Mammography
  - Screening
  - Diagnostic

Bone/Joint Studies

- Bone age studies
- Bone length studies
- Osseous survey
- Joint survey
- Bone mineral density studies
- Bone marrow blood supply

Radiation Oncology

- Consultation: Clinical Management
- Clinical Treatment Planning
- Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services
- Stereotactic Radiation Treatment Delivery
- Other Procedures
- Radiation Treatment Delivery
- Neutron Beam Treatment Delivery
- Radiation Treatment Management
- Proton Beam Treatment Delivery
- Hyperthermia
- Clinical Intracavitary Hyperthermia
- Clinical Brachytherapy

Radiation Oncology Treatment

- Radiation treatment is reported in units of 5 fractions or treatment sessions.
- “Code 77427 is … reported if there are three or four fractions beyond a multiple of five at the end of a course of treatment; one or two fractions beyond a multiple of five at the end of a course of treatment are not reported separately.”

Radiation Oncology Treatment

- Reduced services modifier is NOT necessary
- Code for the number of fractions or treatments the patient had during the months

Number of visits	Code(s) to report
1 or 2 only	77431
3-7 visits	77427
8-12 visits	77427 x 2
13-17 visits	77427 x 3
18-22 visits	77427 x 4
23-27 visits	77427 x 5
28-32 visits	77427 x 6

Nuclear Medicine

Diagnostic - Use of small amounts of radioactive material to examine organ function

- Thyroid function (Endocrine System)
- Renal (Gastrointestinal System)
- Bone (Musculoskeletal System)
- Heart (Cardiovascular System)
- Brain (Nervous System)

Therapeutic – uses radioactive material to treat cancer and other medical conditions affecting the thyroid gland

Nuclear Medicine

Provide metabolic and functional information of the body unlike CT and MRI

- PET scans create computerized images of chemical changes within the organ or tissue
- SPECT scans use radioactive tracers and a scanner to record data that a computer constructs into 2D or 3D images. SPECT can give detailed images of blood flow to tissues in the body.
- Planar studies are flat images of a 2D object (think xray)
- Tomographic studies create 3D images of 2D objects

Pathology and Laboratory 80000 Series

CPC Review

AAPC

Regulatory Terms

Clinical Laboratory Improvement Amendment (CLIA)

- CMS issues a waiver
- Approximately 80 tests
- Little risk of error
- For more info, see https://www.cms.hhs.gov/CLIA/10_Categorization_of_Tests.asp

Advance Beneficiary Notice (ABN)

- Non-covered laboratory tests
- Patient is responsible for payment
- For more info., Web search “CMS-R-131”

Modifiers

90 Reference or Outside Laboratory

- Billed by physician but performed by an outside laboratory

91 Repeat clinical diagnostic lab test

- Same test same day
- Not used if due to error
- Not used if there is a better code for a series of tests

92 Alternative laboratory platform testing

- Portable test kit
- Single use disposable chamber

99 Multiple modifiers

Organ or Disease-Oriented Panels

- Group of test commonly ordered together
- All test in the panel must be performed
- Additional tests can be coded also
- Some panels are included in other panels and should not be coded separately
- Be on the look out for “or” “and”

Definitions

Qualitative

- What is present

Quantitative

- How much is present

Presumptive Drug Class Screening

Presumptive Drug Test

- used to identify the use or non-use of a drug

Definitive Drug Testing

Definitive Drug

- Qualitative – positive/negative, present/absent
- Quantitative – amount or quantity present

Therapeutic Drug Assays

- Quantitative tests for drugs given for therapeutic purposes
- Can become toxic or too low for therapeutic benefit
- Measures specific drugs at specific intervals to determine if there is an appropriate and constant level of drug in the patient's system

Evocative Suppression Testing

- Baseline and subsequent measurement
- Supplies and drug billed separately
- Physician attendance
  - Use Prolonged care codes
- Prolonged infusion codes from Medicine section

Clinical Pathology Consultations

- Requested by attending physician
- Rendered by pathologist
- Written report provided
- Patient not present
  - Lab test
  - Specimen
  - Slide
- Limited – no patient history or medical records
- Comprehensive – complex problem with history and records

Urinalysis

- Urinalysis evaluates a sample of urine for the presence of disease, drugs, metabolites, etc.
- Done by a variety of methods.
- Care should be taken when selecting codes:
  - Automated vs non-automated
  - With or without microscopy
  - Intention (pregnancy test, volume measurement, etc. …)
- Usually covered under CLIA waived labs

Chemistry

- Material may be from any source (blood, sweat, urine, saliva, feces) unless otherwise specified
- Exams are qualitative unless specified
- When one analyte is measured from different sources or from specimens taken at different times, each can be separately reported.

Laboratory Tests

Hematology and Coagulation

- Immunology
- Microbiology
- Anatomic Pathology
  - Gross examination only
  - Gross and microscopic exam
  - Limited
  - Forensic
- These are further divided:
  - With brain
  - With brain and spinal cord
  - Infant

Cytopathology

Study of cells for disease

Obtained by several methods

- Washing or brushing
- Smears
- Fine needle aspiration

Cytogenetic studies are the study of cells for inherited disorders

Cytology

- Cytology is the examination of cells from the body under a microscope.
- Bethesda vs non-Bethesda
  - Bethesda reporting allows for uniform reporting of results
  - Samples of Bethesda reporting:
    - ASC
    - ASC-US
    - ASC-H
    - LSIL
    - HSIL

Surgical Pathology

Specimen – tissue sample

- Has to be separately identifiable

Divided into levels of progressive complexity

- Level I – gross
- Level II-VI gross and microscopic

Additional codes for special stains

Surgical Pathology

- Levels of surgical pathology give specific examples of tissue inspected and reason
  - 88305 Level IV – Uterus, w or wo tubes and ovaries, for prolapse
  - 88307 Level V – Uterus, w or wo tubes and ovaries, other than neoplastic/prolapse
  - 88309 Level VI – Uterus, w or wo tubes and ovaries, neoplastic

Pathology Consultation

Four types of consultations:

- Report on prepared slides
- Report on tissue requiring prep of slides
- Review records and specimen
- Consultation during surgery
  - Frozen sections
  - Cytology examination

Anesthesia

CPC Review

AAPC

Organization of Codes

Organized by anatomical location

- Head
- Neck
- Thorax
- Intrathoracic
- Spine and Spinal Cord
- Upper Abdomen
- Lower Abdomen
- Perineum
- Pelvis
- Upper Leg
- Knee and Popliteal Area
- Lower Leg
- Shoulder and Axilla
- Upper Arm and Elbow
- Forearm, Wrist, and Hand
- Radiological Procedures
- Burn Excisions or Debridement
- Obstetric
- Other Procedures

Finding the CPT® Code

Start in the Index

Look up Anesthesia

- Anatomical location
- Type of surgery
- Surgical approach

Types of Anesthesia

Local

- Included in CPT® code
- No separate anesthesia code

MAC - Monitored Anesthesia Care

- Decreased awareness

Regional

- Blocks
- Spinals
- Epidurals

General

- Unconscious

Anesthesia Terminology

- One-lung Ventilation (OLV)
- Pump Oxygenator
- Intraperitoneal – within the peritoneum
- Extraperitoneal/Retroperitoneal - space in the abdominal cavity behind the peritoneum

Intraperitoneal vs Extraperitoneal Organs

Intraperitoneal – within the peritoneum

- Upper abdomen - stomach, liver, gallbladder, spleen, jejunum, ascending and transverse colon
- Lower abdomen - appendix, cecum, ileum and sigmoid colon

Extraperitoneal/Retroperitoneal - space in the abdominal cavity behind or outside the peritoneal cavity

- Upper abdomen - kidneys and adrenal glands and lower esophagus
- Lower abdomen - ureter and urinary tract
- Other - aorta and inferior vena cava

Anesthesia Guidelines

Services included with the anesthesia code:

- Preoperative visits
- Postoperative visits
- Anesthesia during the procedure
- Administration of fluids/blood
- Usual monitoring
  - Unusual forms include CVP, Arterial line insertion, and Swan-Ganz and are coded separately

Anesthesia Fees

Base Units + Time Units + **Modifying Factors** = Total Anesthesia Units

Total Units * Conversion Factor = Anesthesia Fee

- Time is usually calculated in 15-minute increments unless payor contract says differently.
- Qualifying Factors are not billable to MEDICARE.

Anesthesia Time

- Time **begins** when the anesthesiologist begins to prepare the patient for anesthesia (either in the operating room or in an equivalent area) and **ends** when the patient is safely under postop supervision.

TIP:

- Place a chart in your book to help calculate time in 15 minute increments

Minutes	Unit(s)
15	1
30	2
45	3
60	4

Physical Status Modifiers

- Assigned by the anesthesia provider
- Coder needs to look for a diagnosis to report it
- Documented in anesthesia record

  - P1 - normal healthy
  - P2 - mild systemic disease
  - P3 - severe systemic disease – **1 unit**
  - P4 - constant threat to patient's life – **2 units**
  - P5 - not expected to survive w/o surgery – **3 units**
  - P6 - declared brain-dead patient

Qualifying Circumstances

- + 99100 - under 1 or over 70 years of age – **Additional 1 unit**
- + 99116 - anesthesia complicated by hypothermia – **Additional 5 units**
- + 99135 - anesthesia complicated by controlled hypotension – **Additional 5 units**
- + 99140 - anesthesia complicated by emergency – **Additional 2 units**

Coding Tip – Watch parenthetical statements below the anesthesia CPT codes to determine when these codes are NOT billable.

Modifiers – HCPCS Level II

Anesthesiologist Modifiers	
AA	Performed by anesthesiologist
AD	Medical supervised by physician; more than 4 concurrent anesthesia procedures
QK	Medical direction of 2-4 concurrent procedures *(cases happening at the same time)*
QY	Medical direction of one CRNA by an anesthesiologist
CRNA Modifiers	
QX	CRNA service: with medical direction by physician
QZ	CRNA without medical direction
Monitored Anesthesia Care	
QS	MAC (monitored anesthesia care)
G8	Monitored anesthesia care (MAC) for deep complex, complicated, or markedly invasive surgical procedures
G9	Monitored anesthesia care for patient who has history of severe cardiopulmonary condition

Coding Concepts

Multiple Surgeries

- Only one anesthesia code is selected
- Exception – anesthesia add-on codes
  - Example: +01968 Anesthesia for cesarean delivery following neuraxial labor analgesia/anesthesia
- Report most extensive or most complex
- Use total anesthesia time for all procedures

CPT® Modifiers

53 – Discontinued Procedures

- Used if surgeon discontinues the procedure

59 - Distinct procedural services

- Example: General anesthesia during surgery, then an epidural is placed for post op pain management.

Coding Concepts

Additional Anesthesia Modifiers

- **23** – Unusual Anesthesia
- **53** – Discontinued Procedure
- **73** – Discontinued Procedure **prior** to anesthesia administration
- **74** – Discontinued Procedure **after** to anesthesia administration

Evaluation and Management

CPC Review

AAPC

ICD-10-CM Coding

Primary diagnosis – reason for the visit

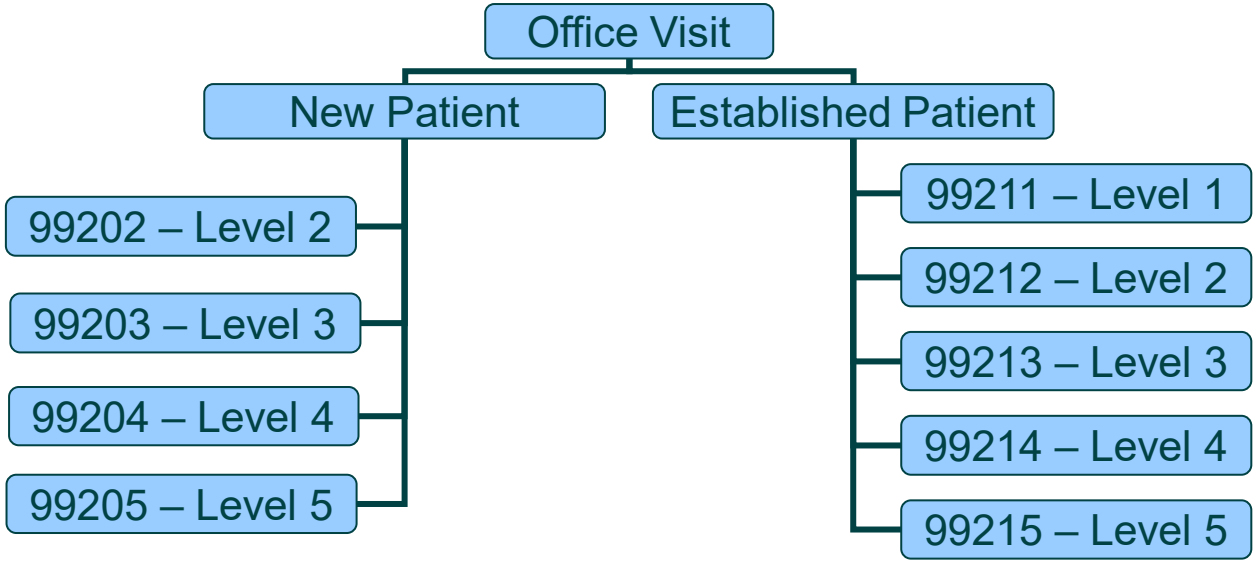
Signs and Symptoms

- Code only if no definitive diagnosis is stated
- Routinely associated with a disease process should not be coded separately

CPT® Coding

- Select the category or subcategory of service and review the guidelines;
- Review the level of E/M service descriptors and examples;
- Select the appropriate level of E/M service based on either:
  - Medical Decision Making (MDM), or
  - Total Time performed *on the date of service*

Categories and Subcategories



New vs. Established Patients

New Patient

- Patient who has not received any professional services from the physician/qualified health care professional or another physician qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice within the past 3 years.

Established Patient

- Patient who HAS received services in the past 3 years

New vs. Established Patients

- If a physician/qualified health care professional is **on call** or **covering** for another physician/qualified health care professional, the patient's encounter will be classified as it would have been by the provider who is not available.

Office or Other Outpatient Services

- Provided in the physician's office or other outpatient clinic or ambulatory facility
- New patient
- Established patient

Hospital Inpatient and Observation Care Services

- Codes used for inpatient facility and partial hospitalization as well as for patients designated in hospital outpatient “observation status”
- For patients admitted and discharged on the **same calendar date,** use codes 99234-99236.
- Subsequent hospital care codes used for subsequent visits while admitted
  - Includes reviewing medical record, test results, etc.

Hospital Inpatient and Observation Care Services

- Initial Hospital care is reported by the admitting physician on the first date of inpatient hospital care.
- For Medicare patients, these codes are also used by ALL providers who provide initial consultation services.
- The admitting physician is identified with modifier AI.

Hospital Inpatient or Observation Discharge Services

- Codes are based on time
- Includes time spent with the final exam, paperwork, writing prescriptions, talking with patient's family, etc.
- Parenthetical notes
  - How to code for concurrent care on the discharge date
  - Discharge of a Newborn see code 99238 or 99463

Consultations

Consultations

- Service provided by a physician whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or appropriate source

Divided by location

Three Rs to meet consultation criteria

Consultations

Medicare:

- Office Consultations
  - Report with new and established patient codes
- Inpatient Consultations
  - Report with initial hospital care codes for the first encounter regardless if performed by the admitting physician.
  - Use Modifier AI for the Principal Physician of Record

Emergency Department

- Does not distinguish between new/established
- Facility must be hospital-based and available 24 hours a day, 7 days a week
- Physician direction of EMS emergency care, advanced life support
- Services are selected based solely on **Medical Decision Making**.

Critical Care Services

- Critical care is dependent on patient status, not patient location.
- “A critical illness or injury acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient’s condition.”
- **Time based** service
- Some services are included in critical care. Pay close attention to the list of services in the Critical Care guidelines.
  - Any service NOT listed in the guidelines CAN be billed separately.
  - The time for performing these carved out services is not included in critical care.

Critical Care Services

- Services provided in a critical care unit to a patient who is not considered critically ill are reported with other E/M codes.
- Guidelines contain instructions for coding
  - Pediatric Critical Care
  - Neonatal Critical Care
- Critical Care and other E/M services may be coded on same date by the same provider.

Critical Care Services

Billing is based on location, time and patient age:

- Inpatient
  - Birth to 28 days – billed per day – 99468, 99469
  - 29 days to 24 months – billed per day – 99471, 99472
  - 2 years to 5 years – billed per day – 99475, 99476
  - 6 years and older – billed by minutes – 99291, 99292
- Outpatient
  - Any age - 99291, 99292

Critical Care Transport

Billing is based on location, time and patient age:

- Sending provider:
  - All ages - 99291, 99292
- Transport provider (face to face with patient during transfer)
  - Age birth to 24 months – 99466, 99467
- Control (receiving) provider
  - Age birth to 24 months – 99485, 99486

Nursing Facility Services

Nursing Facility Services

- Nursing facility
- Psychiatric residential treatment center
- Divided into Initial and Subsequent

Nursing Facility Discharge

- Similar to hospital discharge – instructions for care, prescriptions, etc.

Home or Residence Services

Seen in home by physician

- Home may be private residence, temporary lodging, or short-term accommodation
- Also includes assisted living facility, group home, custodial care facility or residential substance abuse facility.

Separated by new and established patient

Prolonged Services

Prolonged Services

- Direct patient contact or without direct patient contact
- Settings are office/outpatient and inpatient
- Most are add-on codes

Standby Services

- Used to report time when a provider is on standby at the request of another provider
- Only report for more than 30 minutes duration
- Reported with additional units for each additional 30 minutes
- Do not report if the period of standby results in the performance of a procedure

Case Management & Medical Team Conference

Case Management Services

- Anticoagulant Management - Deleted

Medical Team Conference

- Requires three healthcare professionals
- Divided by direct contact or without direct contact

Care Plan Oversight Services

- Home Health Agency
- Hospice
- Nursing Facility
  - Billed on a monthly basis
  - For the amount of time physician spends overseeing care of patient

Preventive Medicine Services

- Two sets of codes: new or established
- For patients who are not ill, but to prevent future illness
- Extent of service will depend on patient age and risk factors
- If a problem is encountered that is significant to require additional work beyond that of the preventative visit, the appropriate office/outpatient code (99202-99215) should be billed with modifier 25 added.

Counseling Risk Factor Reduction and Behavior Change Intervention

- For patient without symptoms or established illness
- No distinction between new and established patient
- Preventive Medicine, Individual Counseling
- Behavior Change Intervention
- Preventive Medicine, Group Counseling

Non-Face-to-Face Physician Services

Telephone Services

- Must be provided by a physician
- Based on amount of time
- Patient must be established

On-Line Medical Evaluation

- Reported only once for the same episode of care during a 7-day period
- Must be provided by a physician

Special E & M Services

- Basic Life and/or Disability Evaluation Services
- Work Related or Medical Disability Evaluation Services
- Specific guidelines under each code

Newborn Care Services

Newborn Care Services

- Newborn care age 28 days or less
- Separated by location and by initial or subsequent visits

Delivery or Birthing Room Attendance and Resuscitation Services

- Attendance at delivery at request of delivering physician

Inpatient Neonatal Intensive Care
Pediatric & Neonatal Critical Care

- Pediatric Critical Care Patient Transport
- Inpatient Neonatal and Pediatric Critical Care
- Initial and Continuing Intensive Care Services

Inpatient Neonatal and Pediatric Critical Care Services

Defined by age of patient:

- Neonates 28 days of age or less
- Infant or young child 29 days through 24 months of age
- Young child two through five years of age

Initial and Continuing Intensive Care Services

- Used to report services to a child who is not critically ill – but requires intensive observation and frequent interventions
- 99477 used for Initial Hospital Care
- 99478-99480 used for Subsequent Intensive Care
  - Code selection based on the present body weight of the child

Chronic and Complex Chronic Care Coordination

- 2 or more chronic illnesses requiring coordination of care among multiple disciplines
- Reported by the provider overseeing the care plan and coordination
- Reported only once per month
- Code selection
- Time spent overseeing
- Whether a face-to-face encounter occurs

Advance Care Planning

- Advance Care Planning codes report face-to-face discussion of advance directives
- Based on time
  - Healthcare Proxy
  - Durable Power of Attorney for Healthcare
  - Living Will
  - Medical orders for Life-Sustaining Treatment

Evaluation and Management Coding Leveling

- Select the category or subcategory of service and review the guidelines
- Review the level of E/M service descriptors and examples
- Select the appropriate level of E/M service based on either:
  - Total Time
  - Medical Decision Making

EM Guidelines - Example

Level services based on either:

- Total time
- Medical Decision Making determination

- Example for Office or Other Outpatient Services

SF	Low	Moderate	High
• 99202 • 99212	• 99203 • 99213	• 99204 • 99214	• 99205 • 99215

Total Time Defined

- Preparing to see the patient (eg, review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests or procedures
- Referring and communicating with other health care professionals (not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- Care coordination (not separately reported)

Do NOT Count time spent on:

- Performance of other services separately reported
- Travel
- Teaching that is general and not limited to discussion that is required for the management of a specific patient

EM Example based on Total Time
Office or Other Outpatient Services

Est Pt Code	Time	New Pt Code	Time
99211			
99212	10-19	99202	15-29
99213	20-29	99203	30-44
99214	30-39	99204	45-59
99215	40-54	99205	60-74

Prolonged Services

99417 – Prolonged OUTPATIENT	99418 – Prolonged INPATIENT OR OBSERVATION
Used in conjunction with 99205, 99215, 99245, 99345, 99350, 99483	Used in conjunction with 99223, 99233, 99236, 99255, 99306, 99310
Do NOT report on the same date of service as 90833, 90836, 90838, 99358, 99359, 99415, 99416	Do NOT report on the same date of service as 90833, 90836, 90838, 99358, 99359
Do NOT report for any time unit less than 15 minutes	Do NOT report for any time unit less than 15 minutes

Prolonged Service – Example

Total Duration of New Patient Office and Other Outpatient Services (use with 99205)	Code
Less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99417 X 1
90-104 minutes	99205 X 1 and 99417 X 2
105 minutes or more	99205 X 1 and 99417 X 3 or more for each additional 15 minutes

Total Duration of Established Patient Office and Other Outpatient Services (use with 99215)	Code
Less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99417 X 1
70-84 minutes	99215 X 1 and 99417 X 2
85 minutes or more	99215 X 1 and 99417 X 3 or more for each additional 15 minutes

Medical Decision Making (MDM)

- Medically appropriate history
- Medically appropriate exam
  - Determined by the Physician/Healthcare provider
- Not counted in the level for office and other outpatient

Number and Complexity of Problems Addressed

Number and Complexity of Problems Addressed	
Minimal	□ 1 self-limited or minor problem
Low	□ 2 or more self-limited or minor problems; or □ 1 stable chronic illness; or □ 1 acute, uncomplicated illness or injury; or □ 1 stable, acute illness; or □ 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
Moderate	□ 1 or more chronic illness with exacerbation, progression, or side effects of treatment; or □ 2 or more stable chronic illnesses; or □ 1 undiagnosed new problem with uncertain prognosis; or □ 1 acute illness with systemic symptoms; or □ 1 acute complicated injury
High	□ 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; or □ 1 acute or chronic illness or injury that poses a threat to life or bodily function

Amount and Complexity of Data to be Reviewee and Analyzed

Category 1

- ☐ QTY: _____ Review of prior external note(s) from each unique source
- ☐ QTY: _____ Review of result(s) of each unique test
- ☐ QTY: _____ Ordering of each unique test

Independent Historian (IH) (Category 2 for Limited; Category 1 for Moderate/High)

- ☐ Assessment requiring independent historian(s)

Category 2

- ☐ Independent interpretation of a test performed by another physician or other qualified healthcare professional (not separately reported)

Category 3

- ☐ Discussion of management or test interpretation with external physician, other qualified healthcare professional or appropriate source (not separately reported)

Total	**0 or 1**	**1 of 2**	**1 of 3**	**2 of 3**
	1-Category 1 or less	2-Category 1 Indep. Historian (IH)	3-Category 1/IH 1-Category 2 1-Category 3	3-Category 1/IH 1-Category 2 1-Category 3
Data Level	**Minimal or none**	**Limited**	**Moderate**	**Extensive**

Risk and Complications and/or Morbidity or Mortality of Patient Management

Minimal	Minimal risk of morbidity from additional diagnostic testing or treatment Examples: From the Table of Risk (Rest, gargle, elastic bandages, superficial dressings)
Low	Low risk of morbidity from additional diagnostic testing or treatment Examples: From the Table of Risk (minor surgery w/o identified risks, PT/OT therapy, IV fluids w/o additives)
Moderate	Moderate risk of morbidity from additional diagnostic testing or treatment Examples: RX drug management Decision regarding minor surgery with identified patient or procedure risk factors Decision regarding major elective surgery w/o identified patient or procedure risk factors Diagnosis or treatment significantly limited by social determinants of health
High	High risk of morbidity from additional diagnostic testing or treatment Examples: Drug therapy requiring intensive monitoring for toxicity Decision regarding elective major surgery w/ identified patient or procedure risk factors Decision regarding emergency major surgery Decision regarding hospitalization or escalation of hospital level care Decision not to resuscitate or to de-escalate because of poor prognosis Parenteral controlled substances

MDM Calculation Guide

Final results of each of the three sections = Level of Medical Decision Making (MDM) • **You must meet or exceed 2 of 3 MDM elements to select the overall MDM level** ○ **Use any of the 2 components that meet or exceed** ○ **Drop the lowest one**				
Number and Complexity of Problems Addressed	Minimal	Low	Moderate	High
Amount and/or Complexity of Data to be Reviewed and Analyzed	Minimal or none	Limited	Moderate	Extensive
Risk of Complications and/or Morbidity or Mortality of Patient Management	Minimal	Low	Moderate	High
MDM Level	Straightforward	Low	Moderate	High

Modifiers

- Modifier 24 Unrelated evaluation and management service by the same physician during a postoperative period.
- Modifier 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.
- Modifier 32 Mandated Services
- Modifier 57 Decision for surgery

E/M Leveling

- Many factors to consider when determining a level of Evaluation and Management Service.
- Be sure to Review the Guidelines and code descriptions.

Modifiers

- **Modifier 24** Unrelated evaluation and management service by the same physician during a postoperative period.
- **Modifier 25** Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service.
- **Modifier 32** Mandated Services
- **Modifier 57** Decision for surgery

Medicine

CPC Review

AAPC

Medicine

- Immunizations
- Vaccines, Toxoids
- Psychiatry
- Biofeedback
- Dialysis
- Gastroenterology
- Ophthalmology
- Otorhinolaryngology
- Cardiovascular
- Pulmonary
- Endocrinology
- Neurology
- Genetics
- Nutritional Therapy
- Acupuncture
- Moderate Sedation

Medicine

- Non-invasive Diagnostic Vascular Studies
- Allergy & Clinical Immunology
- Special Dermatological Procedures
- Physical Medicine & Rehabilitation
- Qualifying Circumstances for Anesthesia
- Home Health Procedures/Services

Medicine and ICD-10-CM

- Alphabetic Index to Diseases
- Tabular List
- Official Guidelines for Coding and Reporting

Medicine Guidelines

- Multiple Procedures
- Add-on Codes
- Separate Procedures
- Unlisted Service or Procedure
- Special Report
- Materials Supplied by Physician

Immune Globulins

- Immune globulins
- Botulinum antitoxin
- Cytomegalovirus (CMV) immune globulin
- Diphtheria antitoxin
- Hepatitis B immune globulin
- Rabies immune globulin
- Tetanus immune globulin

Vaccines and Toxoids

- Vaccine Administration
  - with and without Physician counseling
- Vaccines
- Vaccination
- Immunization
- Toxins
- Toxoids

Immunizations and Immunization Administration

- Three sets of administration codes:

Code Description	Primary Code	Add-on Code
Immunization Administration **with counseling** billed **by component of the vaccine or toxoid** **any** route of administration	90460	90461
Immunization Administration percutaneous, intradermal, subcutaneous, intramuscular per vaccine	90471	90472
Immunization Administration intranasal, oral per vaccine	90473	90474

Psychiatry

- Consultation
- Follow-up by consultant
  - office visits
  - rest home, domicile
  - home
- Transfer of care – new or established pt.
- Diagnostic psychiatric evaluations

Dialysis

- Hemodialysis
- Miscellaneous Dialysis Procedures
- End-Stage Renal Disease Services (ESRD)
- Other Dialysis Procedures
- Age-specific, reported once per month
- outpatient; home services

Dialysis

Age	Full month – outpatient facility	Full month – home dialysis	Partial month outpatient – Bill PER DAY (ex. patient hospitalized, patient is transient, transplant received)
< 2 years	90951-90953	90963	90967
2 – 11 years	90954-90956	90964	90968
12 – 19 years	90957-90959	90965	90969
20+ years	90960-90962	90966	90970

Noninvasive Vascular Diagnostic Studies

- Cerebrovascular Arterial Studies
- Extremity Arterial Studies (Including Digits)
- Extremity Venous Studies (Including Digits)
- Visceral and Penile Vascular Studies
- Extremity Arterial-Venous Studies
- Duplex and Doppler

Allergy and Immunology

Allergy

- Allergy Testing
- Allergen Immunotherapy

Pulmonary Studies

Medical Genetics and Genetic Counseling Services

- Chromosome
- Gene
- Genetics
- Genetic counseling

Hydration

- Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and Other Highly complex Drug or Highly Complex Biologic Agent Administration.
- Time based codes

Non-Chemotherapy Complex Drugs and Substances

- Infusions – therapeutic, prophylactic or diagnostic
- Specific to time, technique, substances added and additional set-up
- Multiple drugs

Chemotherapy

Services included with chemotherapy:

- Use of local anesthesia
- IV start
- Access to indwelling IV, subcutaneous catheter or port
- Flush at conclusion of infusion
- Standard tubing, syringes and supplies
- Preparation of chemotherapy agent(s)

Chemotherapy

- Paracentesis
- Thoracentesis
- Peritoneocentesis
- Intrathecal
- Ventricular or Intraventricular

Physical Medicine and Rehabilitation

- Treatment plan
- Problem list
- Goals
- Physician review progress each 30 days
  - Progress made – recorded
  - Modify or discontinue therapy

Physical Medicine and Rehabilitation

Modalities

- Supervised
- Constant Attendance
- Diathermy, Vasopneumatic Devices

- Key concepts:
  - Anatomic site
  - Type of procedure
  - Number of body regions involved

Therapeutic Procedures

Wound Care Management Orthotic Management and Prosthetic Management

Active wound care

- Not to be reported with 11042-11047

Orthotic management and Prosthetic Management

- Orthotics
- Prosthetics

Medicine Section

- Acupuncture - Face-to-face time
- Osteopathic Manipulative Treatment (O.D.)
- Chiropractic Manipulative Treatment (CMT)

Education & Training for Patient Self-Management

Education and training

- Self Management
- How many in the group?

Telephone services – patient, parent, or guardian

- 24 hours
- 7 days

Online Medical Evaluation

- Online encounter or other electronic communication mode of the medical kind
- Includes all services provided

Moderate Sedation

- Neither local nor general anesthesia.
- Patient is still conscious and able to respond to verbal commands but is in a drug induced depression of consciousness.
- Patients are breathing on their own and not intubated.
- Code concepts include:
  - Age of the patient
  - Service provider
  - Time
- If the provider also performs the moderate sedation, an independent observer is required.

Special Services, Procedures and Reports

Miscellaneous services

- 99024 – “tracking”
- Mandatory on-call hospital personnel
- Patient encounters outside the normal posted business hours or special circumstances at the request of the patient.

Home Health Procedures/Services

Define home setting:

- Patient's residence
- Assisted living apartments
- Group homes
- Nontraditional private homes
- Custodial care facilities or schools

Medication Therapy Management Services

Performed by a pharmacist

Documentation required:

- Patient history
- Current medications
- Recommendations

Ophthalmology

- Services under General are broken out by new or established patient and type of service (limited or comprehensive)
- Special Ophthalmological Services include:
  - Testing (ex. Refraction, visual fields, glaucoma evaluation, etc)
  - Prescription and fitting of lenses
  - Assessment of eye muscles
  - Contact lens services
  - Spectacle (eyeglasses) services
- Ophthalmoscopy

Tips for Taking an AAPC Certification Exam

AAPC

ICD-10-CM

Highlight:

- Code first notes
- Use additional notes
- Excludes1, Excludes2

Make notes to reference important guidelines

Highlight key words in subsection guidelines:

- New vs. established
- Definitions such as simple, intermediate, complex repair
- Musculoskeletal section – open, closed, fixation, percutaneous, manipulation, etc.
- Parenthetical instructions

Exam Registration

www.aapc.com

You will receive a confirmation email including:

- Exam date and location of exam
- Proctor's name and telephone number
- Start time

Arrive at the exam early

- Allow for time to find a seat
- Arrange your books and supplies
- Book check

Day of the Exam – In-Person Exams

Arrive early

Bring:

- Code books
- Photo ID
- #2 pencils and eraser
- NO scrap paper (not allowed)

- Eat a healthy breakfast
- Bring light snacks and water (avoid loud and crunchy snacks)
- Bring a light jacket or sweater

Day of the Exam – Online Exams

Log in to the exam site early.

- You must have an external webcam that can be positioned to show your face, hands, keyboard and the surrounding area.
- You must have a reliable internet connection.
- Ensure the area is clear of all scraps of paper and notes.

Bring:

- Code books
- Photo ID

During the Test

- Listen carefully while proctor reads instructions
- Stay relaxed and confident
- Scan the entire test
  - Answer the easiest first
- Read all choices before answering
- Pace yourself
- Answer every question

Exam Completion

- Exam results released within 5-7 business days after AAPC receives the exam package from the proctor
- My AAPC area on the AAPC website
- Official documents mailed to you
- Exam results may NOT be released over the telephone

The End