HI253

Introduction to CPT Coding

January, 2018

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History:

- 1966
  - CPT first published (by AMA)
- 1970
  - Five-digit codes replaced four-digit codes
- 1983
  - Adopted as part of HCPCS
  - CPT also called HCPCS level I
  - Mandated for reporting Medicare Part B services
- 1986
  - HCPCS was required for reporting Medicaid services
  - OBRA mandated reporting CPT codes for hospital outpatient surgical procedures
- 1996
  - HIPAA named CPT and HCPCS level II as procedure code sets for physician services, and so on
- 2004
  - MMA required implementation of new, revised, and deleted CPT codes each January 1

Overview of CPT

- CPT codes are reported for:
  - Home health care and hospice agencies
  - Outpatient hospital departments
  - Physicians who are employees of a health care facility
  - Physicians who see patients in their offices or clinics and in patients' homes
- CPT codes/descriptions are based on consistency with contemporary medical practice performed throughout the country
- CPT code assignment
  - Simplifies reporting
  - Assists in the accurate identification of procedures and services for third-party payer consideration
- Medical necessity for service/procedure
  - Procedures and services reported on a claim must be linked to ICD-10-CM code that justifies need for service or procedure

CPT Guidelines

- Some services are considered integral to the standard of practice
  - This means that certain medical and surgical services are not assigned CPT codes
  - Such services include:
    - Administering local, topical, or regional anesthetic (by physician performing procedure)
    - Administering sedatives (by physician performing procedure)
    - Applying, managing, and removing postoperative dressings and analgesic devices
    - Cleansing, shaving, and prepping of skin
    - Documenting preoperative, intraoperative, and postoperative procedures provided
    - Draping and positioning of patient
    - Inserting and removing drains, suction devices, dressings, and pumps into same site
    - Inserting intravenous access for medication
    - Irrigating a wound
    - Providing surgical approach, closure, cultures, and supplies (unless CMS policy states otherwise)

CPT Categories

There are three categories of CPT Codes:

- Category I
  - Procedures/services identified by a five-digit CPT code and descriptor nomenclature
  - These are codes traditionally associated with CPT
  - Organized into six sections
- Category II
  - Optional “performance measurements” tracking codes
  - Assigned alphanumeric identifier with letter in last field (e.g., 1000F)
  - Located after Medicine section
- Category III
  - Contain “emerging technology” temporary codes
  - Assigned for data collection purposes
  - Assigned alphanumeric identifier with letter in last field (e.g., 0003T)
  - Located after Category II codes
  - Archived after five years if they are not accepted for placement within Category I sections of CPT

Organization of CPT Category I Codes

Six sections

- Evaluation and Management (E/M) (99201–99499)
- Anesthesia (00100–01999, 99100–99140)
- Surgery (10021–69990)
- Radiology (70010–79999)
- Pathology and Laboratory (80047–89398)
- Medicine (90281–99199, 99500–99607)

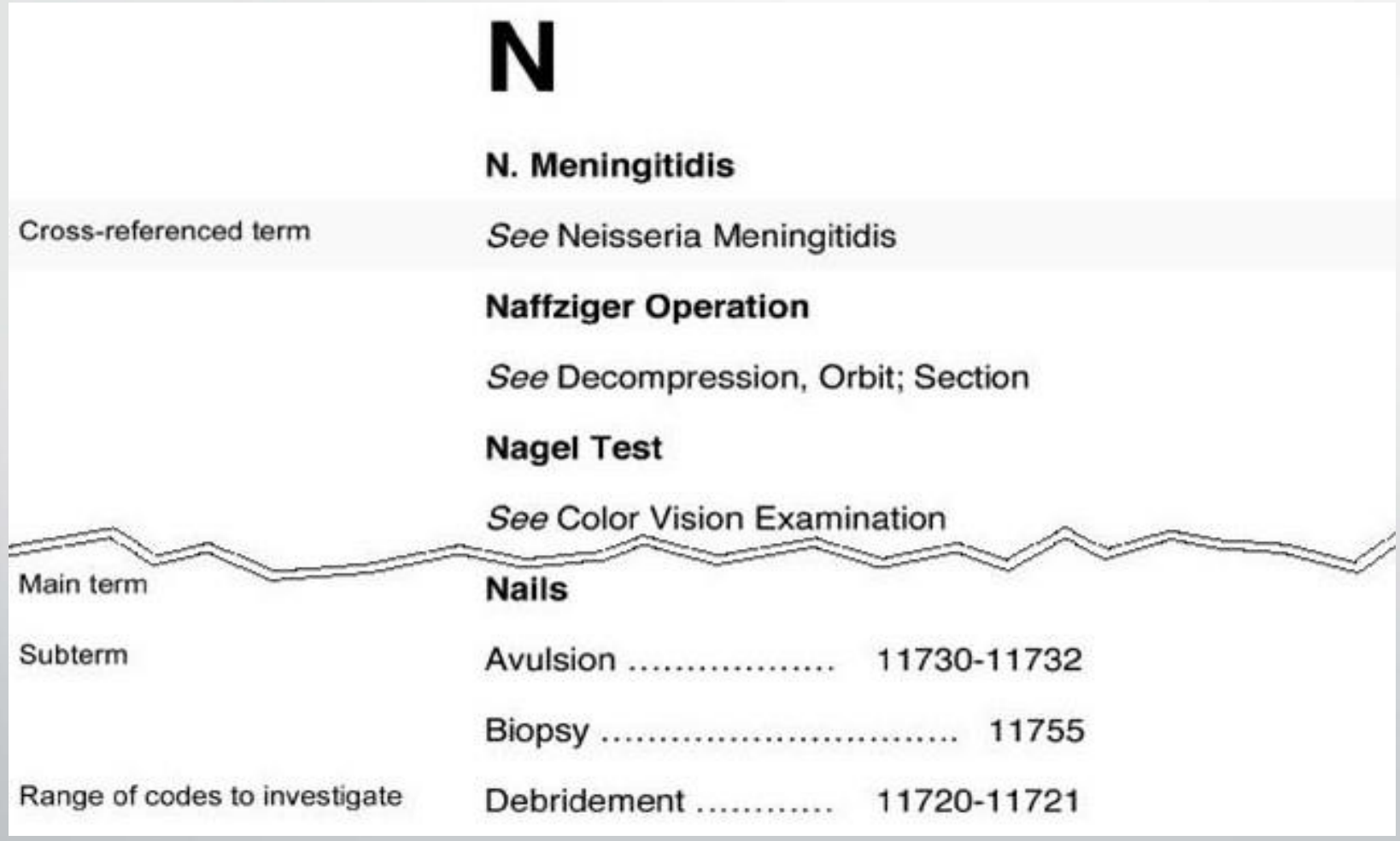
Number Format

- Five-digit code number and narrative description identify each procedure and service listed in CPT category I
- Most procedures and services contain stand-alone descriptions
- To save space, some descriptions are indented
  - Coder must refer to common portion of code description located before semicolon

CPT Index

- Organized by alphabetical main terms printed in boldface
- Main terms represent procedures or services, organs, anatomic sites, conditions, eponyms, or abbreviations
- Main term may be followed by indented terms that modify the main term (called *subterms*)
- CPT index organizes procedures and services according to:
  - Procedure or service (e.g., arthroscopy)
  - Organ or other anatomic site (e.g., ankle)
  - Condition (e.g., wound)
  - Synonyms (e.g., finger joint or intercarpal joint)
  - Eponyms (e.g., Billroth I or II)
  - Abbreviations (e.g., EKG)

Selection from CPT Index



CPT Index

- To locate a CPT code:
  - Review patient record documentation to locate the service and/or procedure performed
  - Locate main term in index
- Boldfaced type
  - Main terms
- Italicized type
  - Cross-reference term *See*
    - Directs coders to index entry under which codes are listed

CPT Index

- Single Codes and Code Ranges
  - Index code numbers for specific procedures may be represented as a:
    - Single code number
    - Range of codes separated by a dash
    - Series of codes separated by commas
    - Combination of single codes and ranges of codes
  - All codes should be investigated before assigning a code for procedure or service

CPT Appendices

- Appendix A
  - List of modifiers and descriptions
- Appendix B
  - Annual CPT coding additions, deletions, and revisions
- Appendix C
  - Clinical examples for codes found in E/M section
- Appendix D
  - List of add-on codes identified with plus symbol (✚)
- Appendix E
  - List of codes exempt from modifier -51
- Appendix F
  - List of codes exempt from modifier -63
- Appendix G
  - Summary of CPT codes identified with bull's eye symbol
  - Codes bull's eye symbol include Moderate (Conscious) Sedation

CPT Appendices

- Appendix H
  - List of alphabetical clinical topics
  - Removed from CPT coding manual and placed online at AMA's website
- Appendix I
  - Removed from CPT coding manual
- Appendix J
  - List of electrodiagnostic medicine listing of sensory, motor, and mixed nerves
- Appendix K
  - List of codes pending Food and Drug Administration (FDA) approval
- Appendix L
  - List of vascular families
- Appendix M
  - Summary of cross-walked deleted and renumbered codes from 2007 to 2009
- Appendix N
  - Summary of resequenced CPT codes
- Appendix O
  - Multianalyte Assays with Algorithmic Analyses (MAAA)

CPT Symbols

- Bullet located to the left of code identifies new procedures and services (●)
- Triangle located to the left of code identifies revision of code description (▲)
- Horizontal triangle symbols surround revised guidelines and notes (►◄)
- Plus sign identifies add-on codes for procedures commonly, but not always, performed at the same time and by the same surgeon as the primary procedure (✚)
- Circle with slash identifies forbidden or prohibited codes exempt from modifier -51 ⃠

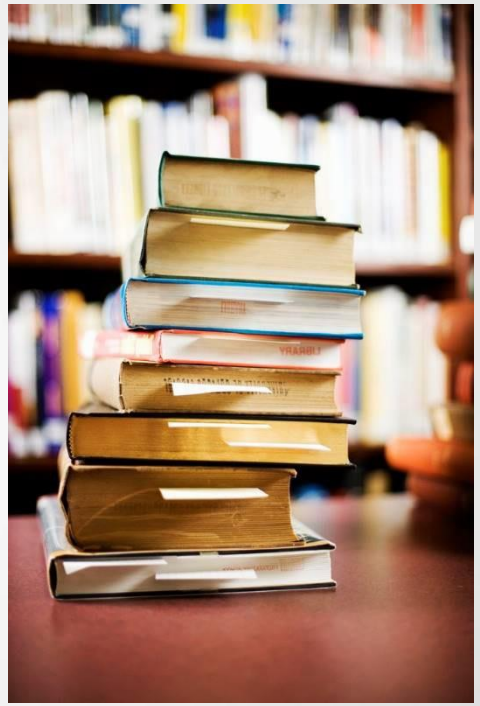
CPT Symbols

- References to *CPT Assistant*, *Clinical Examples in Radiology*, and *CPT Changes* are represented by a blue, green, or red solid circle with a white arrow through the circle. 
- Flash identifies codes that classify products pending FDA approval 
- Number symbol indicates out-of-numerical sequence codes (#)
- 5-Sided Star indicates the use of "Telemedicine" 

CPT Sections, Subsections, Categories, and Subcategories

- CPT Category I codes are organized according to six sections
  - Subsections
  - Categories
  - Subcategories
- Guidelines are located at the beginning of each CPT section
- The following are located in CPT subsections, categories, subcategories, and codes:
  - Notes, including parenthetical notes
  - Descriptive qualifiers

Descriptive Qualifiers



- Terms that clarify assignment of CPT code
- Can occur in the middle of main clause or after semicolon
- May or may not be enclosed in parentheses
- Read all code descriptions very carefully to properly assign CPT codes that require descriptive qualifiers

Example Code: Bone/Joint Studies

- CPT codes 77071–77084 classify bone and joint studies
- **Index: Osseous Survey: Range 77074-77076**

- **EXAMPLE**: Nine-day-old infant underwent osseous survey.

- Report code 77076.

Example Osseous Survey Answers

- Index: Page 960
- Code Range: 77074-77076
- Code Descriptions: Page 475
- Code 77076 Osseous survey limited

CPT Modifiers

- Clarify services and procedures performed by providers
- Reported as two-digit numeric codes added to five-digit CPT code
- HCPCS level II national two-character alphanumeric modifiers also added to five-digit CPT code
- Functional modifier
  - Also called pricing modifier
  - Assists in reimbursement decision making
  - **Example**: procedure performed by assistant surgeon
- Informational modifier
  - Clarifies aspects of the procedure or service provided for the payer
  - **Example**: procedure performed on right or left side only

Examples of Modifiers

- 24 (Unrelated E/M service by same physician during postoperative period)
- 25 (Significant, separately identifiable E/M service by same physician on same day of procedure or other service)
- 57 (Decision for surgery)
- 22 (Increased procedural services)
- 52 (Reduced services)
- 53 (Discontinued procedure)
- 73 (Discontinued outpatient hospital/ ambulatory surgery center procedure prior to anesthesia)
- 74 (Discontinued outpatient hospital/ ambulatory surgery center procedure after anesthesia administration)

Examples of Modifiers

- 58 (Staged or related procedure or service by same physician)
- 59 (Distinct procedural service)
- 63 (Procedure performed on infants less than 4 kilograms)
- 78 (Return to operating room for related procedure during postoperative period)
- 79 (Unrelated procedure or service by same physician during postoperative period)
- 50 (Bilateral procedure)
- 27 (Multiple outpatient hospital E/M encounters on same date)
- 51 (Multiple procedures)
- 76 (Repeat procedure by same physician)
- 77 (Repeat procedure by another physician)

National Correct Coding Initiative (NCCI)

- Promotes national correct coding methodologies
- Controls improper code assignment
- NCCI edits are designed to detect *unbundling*, which involves reporting multiple codes for service when single comprehensive code should be assigned
- Implemented by CMS
- Used to process Medicare Part B claims for physician services and hospital outpatient procedures and services
- Two types
  - Column 1/column 2 edits
    - Code pairs that should not be billed together because one service inherently includes the other
    - Previously called comprehensive/component edits
  - Mutually exclusive edits
    - Code pairs that, for clinical reasons, are unlikely to be performed on the same patient on the same day

Unbundling CPT Codes

- Unbundling occurs when:
  - Coding staff unintentionally reports multiple codes based on misinterpreted coding guidelines
  - Reporting of multiple codes is intentional and is done to maximize reimbursement
  - One service is divided into its component parts, and a code for each component part is reported as if they were separate services
- Unbundling occurs when a code for the separate surgical approach is reported in addition to a code for the surgical procedure
- Procedures performed to gain access to an area or organ system are not separately reported

Partial Listing of National Correct Coding Initiative (NCCI) Edits

Table 8-3 Partial Listing of National Correct Coding Initiative (NCCI) Edits

NCCI Edit	Description	Disposition of Claim
1	Invalid diagnosis code	Return to Provider
2	Diagnosis and age conflict	Return to Provider
3	Diagnosis and sex conflict	Return to Provider
4	Medicare secondary payer alert	Suspend
19	Mutually exclusive procedure that is not allowed by CCI even if appropriate modifier is present	Line Item Rejection
20	Component of a comprehensive procedure that is not allowed by CCI even if appropriate modifier is present	Line Item Rejection
39	Mutually exclusive procedure that would be allowed by CCI if appropriate modifier were present	Line Item Rejection
40	Component of a comprehensive procedure that would be allowed by CCI if appropriate modifier were present	Line Item Rejection