

CPT Coding

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MHA631
Health Insurance

Lecture 6



Objectives

- Understand an Overview of CPT.
- Explore CPT Core Components.
- Discuss CPT Sections (Evaluation/Management & Surgery).

Overview of CPT

- **Current Procedural Terminology (CPT)** is published by the American Medical Association (AMA) and includes codes for procedures performed and services provided to patients.
- AMA first published CPT in 1966, and subsequent editions expanded its descriptive terms and codes for diagnostic and therapeutic procedures.

Overview of CPT

- CPT is a listing of descriptive terms and identifying codes for reporting medical services and procedures.
- It provides a uniform language that describes medical, surgical, and diagnostic services to facilitate communication among providers, patients, and insurers.

Overview of CPT

- Be sure to purchase updated coding manuals to avoid billing delays and claims rejections.
- If outdated codes are submitted on claims, providers and healthcare facilities will incur administrative costs associated with resubmitting corrected claims and delayed reimbursement for services provided.

Overview of CPT

- CPT codes are used to report services and procedures performed on patients:
 - By providers in offices, clinics, and private homes.
 - By providers in institutional settings such as hospitals, nursing facilities, and hospices.
 - By a hospital outpatient department (e.g., ambulatory surgery, emergency department, and outpatient laboratory or radiographic procedures).

Overview of CPT

- Procedures and services submitted on a claim must be linked to the ICD-9-CM code that justifies the need for the service or procedure.
- That ICD-9-CM code must demonstrate *medical necessity* for the service or procedure to receive reimbursement consideration by insurance payers.

CPT Core Components

CPT Guidelines

- Guidelines are located at the beginning of each CPT section, and should be carefully reviewed before attempting to code.
- Guidelines define terms and explain the assignment of codes for procedures and services located in a particular section.

Unlisted Procedures/Services

- An **unlisted procedure** or **unlisted service** code is assigned when the provider performs a procedure or service for which there is no CPT code.
- When an unlisted procedure or service code is reported, a special report (e.g., copy of procedure report) must accompany the claim to describe the nature, extent, and need for the procedure or service along with the time, effort, and equipment necessary to provide the service.

CPT Index

- The **CPT index** is organized by alphabetical main terms printed in boldface.
- The main terms represent procedures or services, organs, anatomic sites, conditions, eponyms, or abbreviations.
- The main term is followed by sub-terms that modify the main term. The sub-terms are followed by additional sub-terms that are indented.

CPT Index

N	
Cross-referenced term	N. Meningitidis <i>See</i> Neisseria Meningitidis
Main term	Nails
Subterm (not indented)	Avulsion.....11730-11732 Biopsy.....11755 Debridement.....11720-11721 Evacuation Hematoma, Subungual.....11740
Range of codes to investigate	
Subterm (indented)	

FIGURE 7-4 Selection from CPT index (CPT copyright 2009 American Medical Association. All rights reserved.)

CPT Modifiers

- CPT modifiers clarify services and procedures performed by providers.
- Although the CPT code and description remain unchanged, modifiers indicate that the description of the service or procedure performed has been altered.
- CPT modifiers are reported as two-digit numeric codes added to the five-digit CPT code.

CPT Modifiers

EXAMPLE: 30630-77.

A patient undergoes repair of a deviated nasal septum (code 30630), which was unsuccessful. The patient undergoes repeat repair of the deviated nasal septum by a different surgeon (modifier -77). The same CPT code is assigned, and a modifier is added to indicate the repeat repair.

CPT Sections

- CPT organizes Category I procedures and services within six sections:
 - Evaluation and Management (E/M) (99201–99499).
 - Anesthesia (00100–01999, 99100–99140).
 - Surgery (10021–69990).
 - Radiology (70010–79999).
 - Pathology and Laboratory (80047–89356).
 - Medicine (90281–99199, 99500–99607).

Evaluation and Management Section

Overview of E/M Section

- The Evaluation and Management (E/M) section (codes 99201–99499) is located at the beginning of CPT because these codes describe services most frequently provided by physicians.
- Accurate assignment of E/M codes is essential to the success of a physician's practice because most of the revenue generated by the office is based on provision of these services.

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Overview of E/M Section

- Most E/M services are **cognitive services**—this means that the provider must acquire information from the patient, use reasoning skills to process the information, interact with the patient to provide feedback, and respond by creating an appropriate plan of care.
- E/M services do not include significant procedural services (e.g., diagnostic tests or surgical procedures), which are coded separately. However, some services that arise directly from the E/M service provided are included (e.g., cleansing traumatic lesions, closing lacerations with adhesive strips, applying dressings, and providing counseling and educational services).

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Overview of E/M Section

- Accurate assignment of E/M codes depends on:
- (1) identifying the place of service (POS) and/or type of service (TOS) provided to the patient,
- (2) determining whether the patient is new or established to the practice,
- (3) reviewing the patient's record for documentation of level of service components,
- (4) applying CMS's Documentation Guidelines for Evaluation and Management Services, and
- (5) determining whether E/M guidelines (e.g., unlisted service) apply.

Place of Service (POS)

- **Place of service (POS)** refers to the physical location where health care is provided to patients (e.g., office or other outpatient settings, hospitals, NFs, home health care, or EDs).

EXAMPLE 1: The provider treated the patient in her office.

Place of Service: Office

E/M Category: Office or Other Outpatient Services

Type of Service (TOS)

- **Type of service (TOS)** refers to the kind of healthcare services provided to patients. It includes critical care, consultation, initial hospital care, subsequent hospital care, and confirmatory consultation.

EXAMPLE 1: The patient underwent an annual physical examination in the provider's office.

Type of Service: Preventive care

E/M Category: Preventive Medicine Services

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New and Established Patients

- A **new patient** is one who has not received any professional services from the physician, or from another physician of the same specialty who belongs to the same group practice, within the past three years.
- An **established patient** is one who has received professional services from the physician, or from another physician of the same specialty who belongs to the same group practice, within the past three years.

New and Established Patients

EXAMPLE 1: Sally Dunlop had a prescription renewed by Dr. Smith's office on January 1, 2005, but she did not see the physician. She has been Dr. Smith's patient since her initial office visit on March 15, 2002. On December 1, 2005, Dr. Smith treated Sally during an office visit.

New Patient: March 15, 2002.

Established Patient: January 1, 2005, and December 1, 2005.

Because she received professional services (the prescription renewal) on January 1, 2005, Sally Dunlop is considered an established patient for the December 1, 2005, visit.

New and Established Patients

EXAMPLE 2: Dr. Charles and Dr. Black share a practice. Dr. Charles is a general surgeon who treated Mary Smith in the office on July 1, 2005. Mary was first seen by the practice on February 15, 2002, when Dr. Black provided preventive care services to her. Mary returned to the practice on November 1, 2005, for her annual physical examination conducted by Dr. Black.

New Patient: February 15, 2002, and July 1, 2005.

Established Patient: November 1, 2005.

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Levels of E/M Services

- Evaluation and management (E/M) categories and subcategories contain codes that are classified according to level of services for reporting to third-party payers.
- The levels of E/M services code descriptions include seven components, six of which determine the level of E/M service code to be assigned:
 - History
 - Examination
 - Medical decision making
 - Counseling
 - Coordination of care
 - Nature of presenting problem
 - Time

Levels of E/M Services

- The **key components** of history, examination, and medical decision making are required when selecting an E/M level of service code.
- **Contributory components** include counseling, coordination of care, nature of presenting problem, and time; and they are used to select the appropriate E/M service code when patient record documentation indicates that they were the focus of the visit.

Key Components

- A **history** is an interview of the patient that includes the following elements: history of present illness (HPI) (including the patient's chief complaint, CC), a review of systems (ROS), and a past/family/social history (PFSH).
- A **physical examination** is an assessment of the patient's organ (e.g., extremities) and body systems (e.g., cardiovascular).

Key Components

- **Medical decision making** refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by the:
 - Number of diagnoses or management options.
 - Amount and/or complexity of data to be reviewed.
 - Risk of complications and/or morbidity or mortality.
- The physician is responsible for determining the complexity of medical decision making, and that decision must be supported by documentation in the patient's chart.

Key Components

- Once the key components for extent of history and examination are determined, the type of medical decision making can be selected as follows:
 - Straightforward
 - Low complexity
 - Moderate complexity
 - High complexity
- Once the extent of history, extent of examination, and complexity of medical decision making are determined, select the appropriate E/M code.

Contributory Components

- CPT defines **counseling** as it relates to E/M coding as a discussion with a patient and/or family concerning one or more of the following areas: diagnostic results, and/or recommended diagnostic studies; prognosis; risks and benefits of management (treatment) options; instructions for management (treatment) and/or follow-up; importance of compliance with chosen management (treatment) options; risk factor reduction; patient and family education.

Contributory Components

- Some patients require counseling services (e.g., nutrition instruction, smoking cessation, and weight management) during an E/M visit. If provided, such counseling should be properly documented and the appropriate level of E/M code selected.
- **Coordination of Care** is when the physician makes arrangements with other providers or agencies for services to be provided to a patient.

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Contributory Components

- CPT defines **nature of the presenting problem** as “a disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for the encounter, with or without a diagnosis being established at the time of the encounter.”
- Five types of presenting problems are recognized:
 - Minimal,
 - Self-limited or minor,
 - Low severity,
 - Moderate severity,
 - High severity.

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Contributory Components

- **Time (Face-to-Face versus Unit/Floor)**
- **Face-to-face time** is the amount of time the office or outpatient care provider spends with the patient and/or family.
- **Unit/floor time** is the amount of time the provider spends at the patient's bedside and at management of the patient's care on the unit or floor (e.g., writing orders for diagnostic tests or reviewing test results). Unit/floor time applies to inpatient hospital care, hospital observation care, initial and follow-up inpatient hospital consultations, and nursing facility services.

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- Although the key components of history, examination, and medical decision making usually determine the E/M code, visits consisting predominantly of counseling and/or coordination of care are the exception.
- When the physician spends more than 50 percent of the encounter providing counseling and/or coordination of care, it is considered dominant and can be considered a key factor in selecting a particular E/M code. The extent of counseling must be documented in the patient's chart to support the E/M code selected.

Surgery Section

Surgery Section

- Coders must be aware that unbundling is not allowed; unbundling means assigning multiple codes to procedures/services when just one comprehensive code should be reported.
- Unbundling occurs when a code for the separate surgical approach (e.g., laparotomy) 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.

Surgery Section

EXAMPLE: A 54-year-old female patient underwent excision of ileo-anal reservoir with ileostomy, which required lysis of adhesions to gain access to the site of surgery. Review CPT Surgery code descriptions for 45136 and 44005. Report CPT code 45136 only because code 44005 is considered a component part of the total procedure (45136). Reporting both codes would be considered unbundling.

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Multiple Surgical Procedures

- Great care must be taken when billing **multiple surgical procedures** (two or more surgeries performed during the same operative session). The major surgical procedure (the procedure reimbursed at the highest level) should be reported first on the claim, and the lesser surgeries listed on the claim in descending order of expense.
- The ranking into major and minor procedures is done to accommodate the fact that most insurance companies will reduce the fee for the second surgery by 50 percent of the regular fee and for the third, fourth, and so on, by 50 to 75 percent. If a lesser procedure is listed first, it may be paid at 100 percent and the major or most expensive surgery reduced by 50 to 75 percent, resulting in a lower payment for the combined surgeries.

Key Takeaways

1. Current Procedural Terminology (CPT) is published by the American Medical Association (AMA) in 1966 and includes codes for procedures performed and services provided to patients.
2. CPT codes are used to report services and procedures performed on patients in various settings.
3. The Evaluation and Management (E/M) section is located at the beginning of CPT because these codes describe services most frequently provided by physicians.
4. Regarding surgery section: * unbundling is not allowed, * great care must be taken when billing multiple surgical procedures.



Thank You