HANDBOOK

FOR

CODING GUIDELINES

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HEALTH INFORMATION MANAGEMENT

Department of Veterans Affairs

VHA Handbook for Coding Guidelines may differ from official coding guidelines based on carrier requirements and/or data capture requirements.

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HANDBOOK FOR CODING GUIDELINES

I. POLICY

To establish clear, standard data collecting guidelines for coding and documenting all levels of patient care in all sites of service, e.g., inpatient, outpatient, life support unit, ambulatory surgery, home health, etc. The development and use of coding guidelines will be in accordance with the highest standards for accurate abstracting and coding of health information throughout the Department of Veterans Affairs.

II. SCOPE

Complete and accurate diagnostic and procedural coded data are necessary for research, epidemiology, outcomes and statistical analysis, financial and strategic planning, reimbursement, evaluation of quality of care, and communication to support the patient's treatment. Diagnoses and procedures will be coded utilizing the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM); Current Procedural Terminology, 4th Edition (CPT-4); the CMS Common Procedural Coding System (HCPCS); and/or other classification systems that may be required such as Diagnostic and Statistical Manual of Mental Disorders (DSM- IV).

III. PURPOSE

To ensure minimal variation in coding practices; accuracy, integrity, and quality patient data; and improve the quality of the documentation within the body of the medical record to support code assignment.

IV. STANDARDS OF ETHICAL CODING

The Official Coding Guidelines, published by the Cooperating Parties (American Hospital Association, American Health Information Management Association, Centers for Medicare and Medicaid Service, and the National Center for Health Statistics), should be followed in all facilities regardless of payment source.

A. Diagnoses that are present on admission or diagnoses and procedures that occur during the current encounter are to be abstracted after a thorough review of the entire medical record. Those diagnoses that are not applicable to the current encounter should not be abstracted.

B. Selection of the principal diagnosis and principal procedure, along with other diagnoses and procedures, must meet the definitions of the Uniform Hospital Discharge Data Set (UHDDS).

1. The principal diagnosis is defined in the UHDDS as, "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital care."

2. In accordance with UHDDS definitions, all significant procedures are to be reported.

(a) A significant procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk, or requires specialized training.

(b) When more than one procedure is reported, the principal procedure is to be designated. In determining which of several procedures is principal, the following criteria apply:
(1) The principal procedure is one that was performed for definitive treatment rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication.
(2) If there appears to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure.

C. Assessment must be made of the documentation in the chart to ensure that it is adequate and appropriate to support the diagnoses and procedures selected to be abstracted.

D. Medical record coders should use their skills, their knowledge of ICD-9-CM, CPT, and HCPCS, and any available resources to select diagnostic and procedural codes.

E. Medical record coders should not change codes or narrative of codes so that the meanings are misrepresented. Nor should diagnoses or procedures be included or excluded because the payment will be affected. Statistical clinical data is an important result of coding, and maintaining the integrity of a quality database should be a conscientious goal.

F. Physicians should be consulted for clarification when there is conflicting or ambiguous documentation in the chart.

G. The medical record coder is a member of the healthcare team and, as such, should assist physicians who are unfamiliar with ICD-9-CM, CPT or DRG methodology by suggesting resequencing or inclusion of diagnoses or procedures when needed to more accurately reflect the occurrence of events during the encounter.

H. The medical record coder is expected to strive for the optimal payment to which the facility is legally entitled, but it is unethical and illegal to maximize payment by means that contradicts regulatory guidelines.

Reference: AHIMA Standards of Ethical Coding

I. Coding is based on the service provided regardless of whether it is a billable service. The encounter should be coded based on the service provided as documented with the appropriate codes following coding guidelines. Correct code assignment has no bearing on billable versus non-billable, nor should diagnoses or procedures be included or excluded to affect the payment. In the cases where an Insurance carrier (third party payer) requires a specific code assignment that is different than the way we routinely code/collect data, documentation should be obtained from the carrier and standard operating procedure should be documented in order to clearly outline the difference in process. An example of this would be coding sequence, if a particular payer required codes to be submitted in a particular order which altered from standard coding practice, documentation of this requirement by this payer along with the standard operating procedure would be needed.

V. DEFINITIONS

A. **Ambulatory Care:** All types of health services provided on an outpatient basis, in contrast to services provided in the home or to persons who are hospitalized. The term ambulatory care usually implies that the patient has come to a location other than his home to receive care or services and has departed the same day. Ambulatory care services are often referred to as outpatient services.

B. **Ancillary Services:** Those services other than room, board, medical, and nursing services, such as laboratory, radiology, pharmacy, and therapy services that are provided to patients in the course of care. An ancillary service does not include the exercise of independent medical judgment in the overall diagnosing, evaluating and/or treating the patient's conditions. An ancillary service is usually the result of an encounter.

C. **CMS:** Centers for Medicare & Medicaid Services (CMS) is a Federal agency within the Department of Health and Human Services that administers all aspects of Medicare, Medicaid and Child Health Insurance Programs. This agency was formerly named Health Care Financing Administration (HCFA).

D. **Coding:** The process of assigning a number (alpha, numeric, or a combination of both) from a recognized and approved coding classification system that properly identifies and defines medical services, procedures and diagnoses.

E. **Correct Coding Initiative:** Definitions by CMS of procedures that cannot be reported together because 1) they are considered bundled because it is the standard of care, violates the separate procedure CPT rule, or payment is specifically prohibited; or 2) the procedures are mutually exclusive because one is more extensive, the codes contain a definition of with and without an additional service, or codes are in the same family.

F. **CPT:** Current Procedural Terminology, 4th Edition, published by the American Medical Association (AMA). A listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians (or under the supervision of a physician). The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians, patients, and third parties.

G. **Diagnosis:** The identity of a medical condition, cause or disease.

H. **DRG:** A method of dividing hospital patients into clinically coherent Diagnostic Related Groups based on the consumption of resources. Patients are assigned to the groups based on their principal diagnosis (the reason for admission, determined after study), secondary diagnosis, procedures performed and the patient's age, sex, and discharge status. These groups form the basis of one payment methodology for inpatient care.

I. **Down Coding:** A process used by insurance carriers to change the procedure code submitted to one of a lower Value. Insurance claims examiners are trained to match codes and descriptions. If they don't match, the claims examiner has an opportunity to substitute a code with a lower Value, which could mean lower reimbursement. Procedure code and procedure description mismatch, and diagnosis code not supporting the level of care are the two most common opportunities for insurance carrier to down code.

J. **DSS Identifier:** Decision Support System (DDS) is a new VHA term that was effective on October 1, 1996 which characterizes VHA Ambulatory Care Clinics by a six-character descriptor. A primary stop code and a secondary stop code compose the DSS Identifier. DSS Identifiers are also known as stop codes. The DSS Identifiers assist VA medical centers in defining outpatient production units, which are critical for costing outpatient VHA work.

K. **E-Code:** Code describing the external cause of an injury. E-codes cover an extensive range of mishaps, such as auto accidents, train wrecks, and even poisoning.

L. **Elective Surgery:** Surgery which need not be performed on an emergency basis, because reasonable delay will not affect the outcome of surgery unfavorably. Such surgery is usually necessary and may be major.

M. **E&M Code:** A subsection of CPT codes entitled Evaluation & Management codes introduced in 1992 to classify physician services. These non-technical services are provided by most physicians for the purpose of diagnosing and treating diseases, counseling and evaluating patients.

N. **Encounter:** An encounter is a professional contact between a patient and a practitioner vested with primary responsibility for diagnosing, evaluating and/or treating the patient's condition. Document non face-to-face encounters with clinical significance as a Historical Note in CPRS. Historical notes do not generate workload. Reference: VHA Directive 2004-053 dated September 29, 2004.

O. **Event Capture:** Software package, in addition to Patient Care Encounter, utilized by VHA to capture workload.

P. **Face-to-face encounters:** For coding purposes, *face-to-face time* is defined as only that time that the provider spends face-to-face with the patient and/or family. This includes the time spent obtaining a history, performing an examination, and counseling the patient.

Q. **Facility:** A facility includes all services performed under the jurisdiction or umbrella of the three digit level VHA facility code to include the Medical Center, SNF, CBOCs, CORF, Mental Health, Home Health, Domiciliary, etc.

R. **Fraud and Abuse:** Fraud is the act of intentionally submitting false information (or omitting true information) in order to obtain payment from an insurance company or Medicare. Abuse occurs when a provider unintentionally submits false information, but should have known better had the provider been familiar with the Medicare manual or updates from the Fiscal Intermediary.

S. **HCFA:** Health Care Financing Administration (HCFA), renamed Centers for Medicare & Medicaid Services (CMS), is a Federal agency within the Department of Health and Human Services that administers all aspects of Medicare, Medicaid and Child Health Insurance Programs.

T. **HCPCS:** Healthcare Common Procedural Coding System (HCPCS) is a coding system developed by CMS to standardize coding systems used to process Medicare claims on a national basis. The HCPCS coding system is used to bill primarily for supplies, materials and injections. It is also used to bill for certain procedures and services that are not defined in CPT. HCPCS is a three level coding system which incorporates CPT, national and local level codes. HCPCS Level I is CPT codes. HCPCS Level II national codes report additional medical services and supplies. HCPCS Level III codes are assigned and maintained by individual state Medicare carriers. Level III codes may not be used for medical reimbursement reporting after October 16, 2002.

U. **ICD-9-CM:** A statistical classification developed by the World Health Organization and modified for use within the United States to classify morbidity and mortality information for statistical purposes, and for the indexing of hospital records by disease and operations for data storage and retrieval.

V. **Inpatient:** A patient who has been admitted to a hospital or other health facility for the purpose of receiving diagnostic treatment or other medical service. VHA inpatients are classified on the Gains and Loss sheet and through the Patient Treatment File (PTF).

W. **Long Term Care:** Services required by persons who are chronically ill, aged, or disabled, in an institution or at home on a long-term basis. The term is often used more narrowly to refer only to long-term institutional care such as that provided in nursing homes and mental hospitals.

X. **Medical Necessity:** Medical necessity is defined as tests and services that are determined to be reasonable and necessary. Documentation supporting diagnosis codes assigned for procedures performed must be maintained in the record and is legible. Physicians must provide the specific symptom, sign or diagnosis at the time the service is ordered. Each facility should have a process in place to identify appropriateness of services to be rendered.

Y. **Medical Record:** A patient file containing sufficient information to clearly identify the patient, to justify the patient's diagnosis and treatment, and to accurately document the results. The record serves as a basis for planning and continuity of patient care and provides a means of communication among physicians and any other professionals involved in the patient's care. The record also serves as a basis for review, study, and evaluations on serving and protecting the legal interests of the patient, hospital, and responsible practitioner. A patient file may be paper, electronic, other storage media, or a combination thereof.

Z. **Modifier:** A modifier provides the means by which the reporting provider can indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code.

AA. **Most Extensive Procedures:** When CPT descriptors designate several procedures of increasing complexity, only the code describing the most extensive procedure actually performed should be submitted.

BB. **Mutually Exclusive Code Pairs:** These CPT codes represent services or procedures that, based on either the CPT definition or standard medical practice, would not or could not reasonably be performed at the same session by the same provider on the same patient. Mutually exclusive procedures are those procedures that cannot be reasonably performed during the same session.

CC. **Non-Count vs. Count Clinic:** A clinic in VISTA is set up as a non-count clinic or a count clinic. A non-count clinic workload will not be included in any workload purposes. A count clinic will be included in workload statistics.

DD. **Non-Physician Practitioner:** A health care professional who is not a physician. Examples of Non-Physician Practitioners are nurse practitioners, physician assistants, and certified registered nurse anesthetists.

EE. **Outpatient:** A patient who is receiving ambulatory care at a hospital or other facility without being admitted to the facility.

FF. **Outpatient Visit:** The visit of an outpatient to one or more units or facilities located or directed by the provider maintaining the outpatient health care services (clinic, physician office, hospital/medical center) within one calendar day.

GG. **Patient Class:** A patient class is a methodology under the Resource Planning and Management section to categorize patients into various work groups for pricing future budgetary target allowances.

HH. **PCE:** Patient Care Encounter is VISTA software which enables transmission of an ambulatory encounter, inpatient professional fees, or ancillary service data to the National Patient Care Database. A patient must be assigned to a clinic through either scheduling or through the Automated Information Collection System (AICS) manual data entry option. PCE direct data entry, PIMS checkout, AICS, Laboratory and Radiology are the only nationally released applications currently entering data into PCE.

1. Inpatient professional fees can be captured under the Patient Care Encounter software or through Event Capture. Basic PCE information needed before an encounter is created is:

   - Time of admission,
   - Time of discharge,
   - Time of consult,
   - Time of subsequent visits (if adding a separate entry/date),
   - Time of procedure/surgical operation, and
   - Determination as to whether treatment is for a service-connected or environmental contaminant exposure condition.

2. Information to enter through PCE:
   - ICD-9-CM codes for diagnoses for each encounter created,
   - CPT codes for E&M and/or surgical procedure/operation encounter created,
   - Attending, admitting and discharge encounter created.

3. Lab and radiology do require diagnostic information. The request for other ancillary tests should include the sign or symptom that occasioned the diagnostic test. The physician who is expected to read the results should be listed as the primary provider. The technician can be entered as a secondary provider. A perception of "unbundling" can occur if you enter into PCE the technician with the technical portion and the reading with the physician.

II. **Place of Service:** Information about the location where the service was provided. This will include the 3-digit medical center identifier, with any applicable suffixes, as well as the DSS identifiers.

JJ. **Patient Treatment File (PTF)**:

1. Principal Diagnosis: Defined as "that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care". **Note:** VHA Directive 10-94-041 changed our position in coding from the "primary" diagnosis to "principal" diagnosis. For all discharges prior to October 1, 1994, the principal diagnosis termed “DXLS” was defined as the situation responsible for the major part of the patient's length of stay.

2. Procedure: A significant procedure is one that is:
   - Surgical in nature,
   - Carries a procedural risk,
   - Carries an anesthetic risk, or
   - Requires special training.

When more than one procedure is performed, the principal procedure is:
- Procedure performed for definitive treatment, or
- Procedure was necessary to take care of a complication.

If there appears to be two procedures that can be designated as principal, then the one most related to the principal diagnosis should be selected as the principal procedure.

3. Secondary or Additional Diagnoses: All conditions that coexist at the time of admission, that develop subsequently, or that affect the treatment received and/or the length of stay. These secondary diagnoses are interpreted as those that require:
   - Clinical evaluation,
   - Therapeutic intervention,
   - Diagnostic procedures,
   - Extended length of stay, or
   - Increased nursing care and/or monitoring.

4. Currently, a maximum of 13 diagnostic codes may be submitted on the PTF final disposition transaction (TT701). Therefore, professional judgment is required to prioritize and sequence pertinent diagnoses to paint a clear picture of the hospitalization while ascertaining the correct DRG assignment. The following guideline may be of assistance to coders. However, we urge coders to work with their supervisor on local policy decisions.
   - Principal condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care
   - Complications/Comorbid Conditions (CC)
   - Acute conditions should take precedence over chronic conditions
   - Other codes, i.e. V-codes, E-codes.

5. The PTF allows for thirty-two procedure records (TT601) for a period of hospitalization. The procedure transaction can accommodate five ICD-9-CM code entries performed at any date and time during a period of hospitalization. PTF allows for ten surgical transactions (TT401). If you have more than five codes, it is recommended to either delete the extra codes based on clinical importance or to create another transaction with the same date but a different time interval (e.g. one minute apart).

6. The PTF allows for the entry of twenty-five patient movement transactions (TT501) for a period of hospitalization. Five codes may be reported per movement. If more than twenty-five movements exist, supervisory utilities must be used to flag selected movements for non-transmission.

7. Professional Fee Transaction (TT801) screen was created to capture inpatient visits, procedures and consults that are not captured in any other package (e.g., radiology). This is an optional transaction. Each CPT code may have up to eight diagnosis codes assigned. Two modifiers may be assigned to each CPT code. This data transmits only to the Integrated Billing Package.

KK. **Provider:** A business entity which furnishes health care to a consumer; it includes a professionally licensed practitioner who is authorized to operate a health care delivery facility (ASTM 1384-91). For VHA purposes, a VHA medical center, to include its identified divisions and satellite clinics, is considered to be the business entity furnishing health care at the organizational level.

LL. **Separate Procedures:** These CPT codes may occasionally be provided as part of a more comprehensive procedure and at those times these codes with a designation of a "separate procedure" should be submitted with their related and more comprehensive codes. This indicated that the procedure, while possible to perform separately, is generally included in the more comprehensive procedure code and should not be billed separately.

MM. **Skilled Nursing Facility:** A facility with an organized professional staff that provides medical, continuous nursing, and various other health and social services to patients who are not in an acute phase of illness, but who require primarily restorative or skilled nursing care on an inpatient basis.

NN. **Unbundling:** The practice of a provider billing for multiple components of a service that were previously included in a single fee. For example, if dressings and instruments were included in a fee for a minor procedure, the fee for the procedure remains the same, but there are now additional charges for the dressings and instruments.

OO. **Upcoding:** The process of selecting a code for a service that is more intense, extensive, or has a higher charge, than the service actually provided.

PP. **Visit:** An episode of care in one or more clinics within a calendar day.

QQ. **With/Without Services:** Certain CPT descriptors designate that procedures performed "with" or "without" other services. Submit only the code describing the service actually performed.

VI. INPATIENT CODING GUIDELINES

A. The Official Guidelines for Coding and Reporting can be found in the *Coding Clinic for ICD-9-CM*, a publication of the American Hospital Association.

B. VHA guidelines for inpatient coding:

1. When a patient is transferred to a private hospital for a procedure and subsequently returns for follow-up care, the principal diagnosis remains the condition for which the patient was transferred. Code V58.49 is to be assigned as an additional code. When a patient is transferred to a private hospital for a procedure and returns within the same calendar day, the procedure is coded as a part of the current hospitalization. If a patient has a procedure done at another VHA facility, the VHA facility performing the procedure should capture the procedure for their workload credit, not the referring facility.

2. When a patient is admitted after having a procedure in the ambulatory setting, and there is a complication, assign the complication as the principal diagnosis. **Note:** Pain, nausea, and vomiting are not routinely considered to be postoperative complications. If there is no complication documented, then assign the reason for the surgery as the principal diagnosis. If the admission is for some other condition unrelated to the surgery, assign that condition as the principal diagnosis.

3. When an inpatient of the domiciliary has an ambulatory procedure, the procedure is not coded into the current admission in the Patient Treatment File (PTF).

4. When an inpatient of the facility's nursing home care unit has an ambulatory procedure, the procedure is coded into the current NHCU admission in the Patient Treatment File.

5. When a patient is admitted for substance abuse or inpatient psychiatry, it is not necessary to code the therapy (i.e., one-to-one, group or recreation). Therapies are considered part of the substance abuse treatment. If your facility has value in capturing this data, it should be included in your own local coding policy.

6. When the record contains documentation of substance or alcohol abuse/dependence that is unrelated to care rendered during the current period of hospitalization, these diagnoses are not coded.

7. Use 414.01 for a patient with CAD and no mention of a past history of CABG. It can be assumed that a native coronary vessel is occluded. However, the physician can still be queried if unclear.

8. The fifth digit subclassification for use with category 410 is determined by the episode of care. If a patient has a myocardial infarction during the current period of hospitalization, a fifth digit of "1" is assigned. If a patient has a myocardial infarction at another facility, and is subsequently transferred to this facility, the fifth digit remains "1". If the patient is discharged to home during any portion of the eight -week post infarct period and is readmitted, the fifth digit of "2" is assigned.

9. When coding transfusion of blood, plasma, or platelets (site specific decision), enter the code only once per PTF bed movement for each specific blood transfusion.

10. Do not assign the code for malignancy if the primary site is no longer present. Assigning a code from the "V10" category as an additional diagnosis should identify the previous primary site. An exception to this guideline will occur if the reason for admission/treatment is for a previously excised neoplasm. For example, a patient had a malignant lesion removed but returns in two weeks to have a wide excision done to make sure that all of the neoplasm was excised. This would be considered part of the initial care for the cancer and the appropriate cancer code would be coded. Reference: Coding Clinic, Fifth Issue 1994

11. When coding radiation and/or chemotherapy, enter the code only once per PTF bed movement for each treatment.

12. All operations (01.0 - 86.99) are to be coded.

13. The following diagnostic and non-diagnostic procedures are to be coded. Each medical center may make its own determination to add to this list.

A-Lines	Intubation
Arteriography using contrast	Irrigation
BiPAP	MRI
Catheterization, cardiac	MUGA scan
Chemotherapy	Pyelogram, intravenous, retrograde
Cholangiogram, intra-operative	Radiation therapy
CPAP	Rehab/detox
DPT Thallium (Dipyridamole Persantine)	Swan-Ganz
ECT	TPN
ESWL	Transfusions
Feeding tubes-gastric/nasogastric	Ventilation, mechanical
Gastric lavage	

14. E-codes are used, when appropriate, to identify injury, poisoning, or adverse affects. A poisoning code cannot be used with a therapeutic use code.

15. Assign separate codes for multiple injuries such as fracture of tibia and fibula unless a combination code can be used. The code for the most serious injury is sequenced first. Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site.

16. Sputum/blood/urine cultures are not to be used for determining a more definitive code. Query the physician for more specifics.

17. Procedure codes are to be used at their highest level of specificity.

18. Surgical procedures, which were started but not completed, are to be coded as far as the procedure went.
    - assign a code for exploratory procedure if a cavity or space was entered.
    - assign a code for incision if a site was opened but the cavity or space was not entered.
    - assign a code for conversion from a laparoscopic to open procedure as appropriate.
    - no procedure code is assigned if an incision was not made. Code canceled procedures to the V64 category.

19. When the cause of the acute exacerbation of COPD is not clearly identified, or the physician indicates COPD with acute exacerbation without further indication of the cause, the correct code assignment is 491.21.

20. All secondary diagnoses that require the following are to be coded:
    - Clinical evaluation
    - Diagnostic procedures
    - Extended length of hospital stay
    - Increased nursing care and/or monitoring
    - Therapeutic treatment

21. Diagnosis listed on the summary as historical information or status-post procedures performed on a previous stay that have no bearing on the current stay are not to be coded.

22. Conditions that are an integral part of the disease process are not assigned as additional codes.

23. Conditions that are not an integral part of the disease process are coded when present.

24. Abnormal findings are not coded unless the physician indicates their clinical significance.

25. Any post-operative complication is to be coded when the record reflects tests, increased monitoring by nursing, and/or treatment of the complication. Query the physician.

26. Symptom codes are not to be used when a more definitive diagnosis is present in the record as to the cause of the symptom.

27. When diagnostic statements are identified as "possible", "probable", "suspected", or "rule out", it will be coded as a confirmed diagnosis. If the diagnostic statement says "ruled out", it will not be coded.

28. V-codes (V01.0 - V82.9) may be used for circumstances other than a disease, symptom, problem, or injury. Follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They infer that the condition has been fully treated and no longer exits. They should not be confused with aftercare codes which explain current treatment for a healing condition or its sequelae. V-codes are to be used when a condition co-exists at the time of admission and/or has a bearing on the current stay. This would include, but not be limited to, lack of housing (V60.0), person living alone (V60.3), history of cancer (V10.XX), and status-post artificial opening (V44.X). For additional guidance on the use of V codes, refer to *AHA Coding Clinic*.

29. Diagnoses should be sequenced as follows: Principal diagnosis is the first code; acute conditions and complications take precedence over chronic, co-morbid conditions.

30. When a condition is stated as "acute" and "chronic", code both conditions, sequencing the acute condition first.

31. Code fractures as closed unless specified as open.

32. Code only the most severe degree of burn when different degrees of burn occur at the same site.

33. Principal diagnosis code assignments for domiciliary patients are assigned based on the treating specialty and diagnosis. Codes listed below should be sequenced as principal when appropriate to the period of hospitalization:
    - V57.22 Vocational Rehabilitation
    - 309.81 Post Traumatic Stress Disorder
    - 303.9x Alcohol Dependence (w/Rehabilitation also code 94.61 or 94.67)
    - 304.xx Drug Dependence (w/Rehabilitation also code 94.64 or 94.67)
    - 312.31 Gambling Addiction
    - Other principal diagnosis as appropriate.

34. Principal diagnosis code assignment for respite care patients is the condition responsible for the care of the patient. Code "V60.5" or “V60.4” is assigned as an additional code.

35. A late effect is the residual effect (manifestation) after the acute phase of an illness or injury has terminated. There is no time limit on when a late effect code can be used. The residual may be apparent early, such as in cerebrovascular accident cases, or it may occur months or years later, such as that due to a previous injury.

36. Patients who are admitted while on mechanical ventilation should be assigned the appropriate procedure code from 96.7x. The duration should be calculated based on the date and time the patient was placed on mechanical ventilation. Patients who are discharged and remain on mechanical ventilation should have the appropriate code from 96.7x assigned based on duration from the initial date of ventilation until discharge or transfer. When coding mechanical ventilation greater than 96 hours, the PTF 601 transaction should be reported using the first date and time for appropriate capture in Austin. Under VERA it is assumed that a patient is extubated prior to transfer to a different treating specialty. In order to capture BDOC for continuous mechanical vent patients from one treating specialty to another, a corresponding PTF 601 entry needs to be created for each patient movement using the date and time the patient was transferred. VERA only includes 96.72 when calculating BDOC.

37. Dialysis treatments must be tallied and documented on each patient movement date within a period of hospitalization (as a TT601) to ensure inclusion with specific treating specialties, i.e., Medical Intensive Care Unit.

38. Traumatic brain injury patients who are admitted for rehabilitation should be coded to the "V57.xx" category with a code for current injury or late effect (905.0 or 907.0) listed as an additional code, as appropriate. Use additional codes for the specific residuals. A patient with a history of traumatic brain injury is coded to V15.5 if no residuals are present.

VII. PROFESSIONAL COMPONENT CODING GUIDELINES FOR INPATIENT STAYS

Note: Evaluation and Management (E&M) services are used to capture the provider's professional services performed in an inpatient setting. The Diagnostic Coding and Reporting Guidelines for Outpatient Services (Hospital-Based and Physician Office) should guide coders when coding inpatient diagnoses for physician professional services.

Reference: Coding Clinic, Third Quarter 2000, Page 6&7

A. **Admission**

1. **Initial Hospital Care:** The admission history and physical will be abstracted and coded with the appropriate Evaluation and Management code (99221 - 99223), admission diagnosis, and attending provider based on the level of inpatient care. The professional fee is not coded for a clinic physician or ER physician if they are also the attending physician of record. The 10-10m produced by the clinic physician or ER physician will be captured in PCE as an outpatient E&M level of service.

2. The Initial Hospital Care includes all related E&M services provided by the attending physician within a 24-hour period. It is intended to be reported for the first hospital encounter with the patient by the attending physician. This date may not be the same as the admission date to the hospital. If the attending writes a note which links to documentation provided by a resident or other providers the day prior, it will only add to the completeness of the Initial Hospital Care admission code. The coder is to use all available documentation referenced by the provider. If the attending physician does not see the patient within 24 hours of admission, the encounter would be coded as a subsequent hospital care visit.

3. **Subsequent Hospital Care**: Per day, includes the review of diagnostic studies and changes in the patient's status since the last assessment for codes 99231-99233 based on the level of care.

4. **Admission for Postoperative Management**: A patient comes in for a scheduled outpatient surgical procedure. The procedure is performed as an outpatient. The patient is admitted as in inpatient after surgery.

    - The scheduled outpatient procedure should always be coded in PCE, not PTF.

- If the patient was admitted after the outpatient procedure due to a complication, assign the complication as the principal diagnosis.
- If the patient was admitted after the outpatient procedure but there is no complication documented that led to the admission, assign the reason for surgery as the principal diagnosis and the appropriate aftercare V code as secondary in PTF.
- If the patient was admitted after the outpatient procedure for some other condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis in PTF.

Note: Inpatient only procedures should be admitted prior to surgery for capture in PTF. If an administrative error occurs and the patient is admitted after the inpatient procedure, the time of the admission should be changed in Bed Control to reflect admission prior to the procedural time noted in the surgical package.

Reference: Coding Clinic, Third Quarter 2003

B. **Consultations**

1. Inpatient Consultation (99251-99255): These codes are used for an initial consultation visit for an inpatient, nursing home care unit, or a partial hospital setting. These codes are only used once per inpatient stay by the reporting consultant.

2. Follow-up Inpatient Consultation Visit: Any follow-up visits by the consultant will be coded using the subsequent hospital care codes (99231-99233) or subsequent nursing facility care codes (99307-99310).

3. Outpatient Consultation (99241-99245): These codes are used in an outpatient or ambulatory care setting, including domicillary and hospital observation stays. Confirmatory consultations may be requested by any number of appropriate individuals. When a consultation is mandated by a third-party payer, modifier -32 should be appended to the level of consultation code reported.

4. A consultation initiated by a patient and/or family, and not requested by a physician, is not reported using the consultation codes but may be reported using the office visit codes, as appropriate.

5. Consultations can be paid for pre-op clearance associated with a surgery provided that the consultation requirements are met.

6. Effective August 26, 1999, CMS issued clarification and alterations which result in major changes to the way physicians are allowed to report consultations.
   - A consultation is an opinion and must be requested by a physician or other appropriate source.
   - This request must be documented in the patient's medical record.
   - The opinion must be communicated, in writing, to the referring physician or appropriate source. The consulting physician may initiate diagnostic and or therapeutic services in order to formulate the opinion.

C. **Critical Care Admissions**

1. For patients admitted to critical care, the codes 99291 (30 minutes to 74 minutes of critical care) and 99292 (each additional 30 minutes) are to be used for the care of the unstable critically ill or unstable critically injured patients who require constant physician attendance.

2. If the total duration of critical care provided by the physician is less than 30 minutes, the appropriate evaluation and management code, e.g., 99232, 99233 should be used. Services for a patient who is not critically ill but happens to be in the critical care unit are reported using subsequent hospital care codes (99231 - 99233).

3. Subsequent visits documented by attending physicians will be coded.

4. If critical care is required upon presentation to the emergency department, only critical care codes (99291 - 99292) may be reported. Emergency department codes will not be paid when billed with the same date of service as critical care.

5. If there is a hospital visit early in the day and at that time the patient does not require critical care, but the patient requires critical care later in the day, both the critical care and the hospital visit may be paid.

6. Critical care cannot be paid on the day the physician also bills a procedure code with a global surgical period unless the critical care is billed with the CPT modifier 25 (pre-operative) and –24 (post-operative) to indicate that the critical care is a significant, separately identifiable evaluation and management service that is above and beyond the usual pre- and post-operative care associated with the procedure that is performed. An ICD-9 code in the range of 800.00-959.9 (except 930-939) is acceptable documentation by Medicare that the critical care was unrelated to the surgery.

7. Both primary physician and intensivist services can be covered on the same day provided there is a written request for the intensivist's services by the primary physician; the intensivist bills for a consultation or critical care but not both; and the record justifies payment to the primary physician by documentation which supports significant or a substantial contribution to the patient's care.

8. Only one physician may bill for a given hour of critical care even if more than one physician is providing care to the critically ill patient. There are no absolute limits on the numbers of critical care services that can be billed per day or per hospital stay.

D. **Deaths**

1. Use the CPT codes 99238 - 99239 when a physician pronounces the patient dead, completes the death summary, and talks with the deceased patient's family. In cases where the MOD pronounces the patient dead and the attending physician completes the death summary, code 99238 or 99239 using the documentation from both staff physicians.

Reference: CPT Assistant Volume 8, Issue 3, March 199)

2. Bereavement care visits should be entered as collateral visits since no credit clinics may be entered in PCE or transmitted to Austin after a veteran expires. These visits may also be entered in Event Capture. The diagnosis code would be V62.82, Bereavement, uncomplicated. The procedure code would be 90899.

E. **Staff Visits**

1. All documented staff visits during the acute care stay will be coded when the documentation supports the assignment of a CPT code for each billable episode of care or other processes as established locally.

2. The same provider may see the patient more than once during the day and only one E/M code is assigned. The documentation may be combined to reflect the level of service.

3. Prolonged Service codes (99354-99357) may be used to reflect the face-to-face time spent above and beyond the usual service. The prolonged codes are used in addition to other E/M services. The time spent does not need to be continuous, but must be on the same day.

4. Critical Care codes (99291 or 99292) may be coded when the patient is critically ill or injured. The presence of a patient in an Intensive Care Unit does not, by itself, allow for the use of these codes. A high complexity of medical decision-making is required to assess and treat the patient.

5. The determination of the E/M code selection should be based on the attending physician's documentation. This documentation can be either
    - A separate attending note,
    - A separate addendum to a resident's note,
    - An attending countersignature to a resident note, or
    - A resident note which names the specific attending and his or her agreement.

F. **Nursing Facility Discharge (99315-99316)**

A nursing facility discharge service represents the time required by the physician for the final nursing facility service and work at discharge. The code(s) include, as appropriate, final examination of the patient (or pronouncement of death), discussion of the nursing facility stay, instructions for continuing care, preparation of discharge records, prescriptions and referrals. More than 30 minutes of service must be clearly documented by time and content to be considered reasonable and necessary. These codes (99315-99316) must be reported for the actual date of service on which the physician-patient encounter occurred.

G. **Transfer/Discharge Codes**

The discharge date should also be abstracted and coded to reflect the total amount of time spent by a physician on the discharge of a patient. This is a time-driven E&M code. There are two codes to choose from:

- 99238 - Hospital discharge day management: 30 minutes or less
- 99239 - Hospital discharge day management: More than 30 minutes

Since time is an issue for discharge codes, assign the lowest code unless the time is available.

VIII. LONG TERM CARE CODING GUIDELINES

A. The diagnostic listing in LTC is dynamic and dependent on many factors and has a longer time frame than an acute care stay. ICD-9-CM codes are assigned upon admission, concurrently as diagnoses arise, at the time of discharge, transfer, or expiration of the resident. Other diagnoses present (i.e., chronic conditions), which affect the resident's continued care should also be coded.

B. The UHDDS definition of principal diagnosis (as used in the acute care setting) applies to LTC.
Reference: Coding Clinic, Fourth Quarter 2003

C. The "first listed diagnosis" is the diagnosis which is chiefly responsible for the admission to, or continued residence in the nursing facility and should be sequenced first. For example, when coding an admission to the facility, the "first listed diagnosis" is the condition chiefly responsible for the admission to the facility. If coding diagnoses during the resident's stay, it is the condition chiefly responsible for the continued stay in the facility.

D. When the patient is admitted to long term care (LTC) following treatment of an acute CVA, a code from category 438, Late effects of cerebrovascular disease, is assigned for the LTC admission. Coding guidelines state that the residual condition (438.xx) is sequenced first, followed by the cause of the late effect. In the case of cerebrovascular disease, the combination code describes both the residual and the cause. Code 436, Acute, but ill-defined, cerebrovascular disease is reserved for the initial (first) episode of care for the acute CVA.

E. A patient is admitted to a long-term care facility for nonspecific reasons such as generalized weakness, debility, or deterioration (or "old age"), rather than for a specific diagnosis. It would be appropriate to assign codes for the symptoms (i.e., generalized weakness, gait disturbance, debility, etc.).

F. A resident in a long-term care facility has a diagnosis of "mental status changes." Assign code 780.9, Other general symptoms, for the diagnosis of mental status changes.

G. When a patient is transferred from a hospital to a nursing home for continued recovery following an acute inferior wall myocardial infarction, the correct code assignment is an acute inferior wall myocardial infarction (410.42).

H. When a patient is transferred to a nursing home for convalescence and strengthening following major surgery, code from subcategory V58.4x. Assign codes for any symptoms such as weakness, gait disturbance, pain, etc. as additional diagnoses.

I. Since hospital stays are shorter, patients are now arriving at the nursing home before complete resolution of an illness or injury. If a patient still has an active condition that is still being treated, the condition may be coded. The late effects of an illness or injury should be coded when they are present. A late effect is the residual condition that remains after the acute phase of an illness or injury. Late effects include conditions documented as sequela of a previous illness or injury. For example, when a patient is admitted to a nursing home because of the residual effects from a CVA, a code from category 438, Late effects of cerebrovascular disease is assigned.

J. When a patient is admitted to the LTC specifically for rehabilitative physical therapy, assign code V57.1, Care involving use of rehabilitation, Other physical therapy, as the first listed code. Assign code V54.8, Other orthopedic aftercare, as an additional diagnosis.

K. Respite Care: Principal diagnosis code assignment for respite care patients is the condition responsible for the care of the patient. Code "V60.5" or "V60.4" is assigned as an additional code.

Reference: Coding Clinic, Fourth Quarter 1999

IX. HOME HEALTH

A. Home Health Services

1. Training and education of the home health patient is included in the code for the actual home visit. A separate code would not be used to include education.

2. Counseling and coordination of care is also included in the home visit. A separate code will not be used to include counseling and coordination of care. If counseling and coordination of care constitutes more than 50% of the encounter, then time is the dominant factor in determining the level of care. Documentation of this counseling and coordination of care must be in the medical record.

3. Telephone calls made to a patient will be recorded only as 99371, 99372 or 99373, which are telephone calls. No other CPT code will be used for talking to a patient on the telephone. These telephone codes incorporate education, training, and coordination of care. No other Evaluation and Management code will be used with a telephone CPT code. These codes can be utilized by any provider to capture workload credit as telephone calls are non-billable.

4. Interdisciplinary 90-day summary is performed on home health patients on a regular basis to review current medical treatment and evaluate possible changes to the treatment plan. Interdisciplinary providers (dietitian, pharmacist, social worker, and home health nurse) meet under the supervising provider.

   The following elements are always reviewed:
   - Problems (lab or x-ray results),
   - Medications,
   - Psychosocial situation, and
   - Diet.

   This 90-day summary will **not** be coded with CPT or ICD-9-CM codes. The medical record must contain evidence that the summary took place and that there was medical necessity and medical decision-making involved in the summary meeting.

5. For patients who have been scheduled for a home health visit, but who are not home when the Home Health Nurse arrives at the appointed time, **will not be** coded using CPT or ICD-9-CM codes. However, the attempt to make the visit will be documented in the medical record.

6. As of January 1, 1998, 99375 will be used for care plan oversight for Home Health and 99378 for Hospice instead of the HCPCS codes G0064 and G0065.

7. Medicare requires home care agencies to use CMS Common Procedure Coding Systems (HCPCS) not CPT codes for home care billings. There are specific codes for each discipline, including home health aides. New reporting codes were implemented July 1, 1999. These include "service units" that code the visits according to 15 minute increments of time "spent actively treating the beneficiary". (Please refer to Medicare Transmittal for further information.)

Medicare Transmittal No. A-99-6 Date FEBRUARY 1999
Change Request 588
SUBJECT: Information Requirements for Home Health Services -- 15 Minute Increment Reporting

Definition of Service Visit:
The term "home health services" means the following. They must be services furnished to an eligible individual, who is under the care of a physician, by a home health agency (HHA) or by others who are under arrangement with such agencies, in accordance with a plan of care established by the physician. Services must be periodically provided on a visiting basis and in an approved place of residence such as the individual's home. A visit is defined as an encounter of personal contact with the patient by the staffs of the HHA, or others who are under arrangements with the HHA, for purposes of providing a covered home health service.

Instructions to Providers: Use the HCFA Common Procedure Coding System to Report 15 Minute Increments for each visit in each discipline, there must be a numeric code that identifies the discipline and records the elapsed time of the visit in 15 minute increments. HCFA Common Procedure Coding System (HCPCS) codes should be used to identify the visit and report the 15 minute increments. The codes below should be used for bill types 32x and 33x (home health services under a plan of care).

Six new HCPCS codes have been created to identify the services of each discipline, each indicating 15 minute units of service that are being reported. Reporting of 15 minute increments as required in this Program Memorandum in no way affects the reporting of 15 minute increments for outpatient rehabilitation services. or physical therapy visits (revenue code 421) report the following code:
G0151 services of physical therapist under a home health plan of care, each 15 minutes

For occupational therapy visits (revenue code 431) report the following code:
G0152 services of occupational therapist under a home health plan of care, each 15 minutes

For speech-language pathology visits (revenue code 441) report the following code:

G0153 services of speech and language pathologist under a home health plan of care, each 15 minutes

For skilled nursing visits (revenue code 551) report the following code:

G0154 services of skilled nurse under a home health plan of care, each 15 minutes

For medical social services visits (revenue code 561) report the following code:

G0155 services of clinical social worker under a home health plan of care, each 15 minutes

For home health aide visits (revenue code 571) report the following code:
G0156 services of home health aide under a home health plan of care, each 15 minutes

Time of Service Visit:
The timing of the service visit will begin:
1) At the beneficiaries' place of residence; and
2) When delivery of services has actively begun.

Time during a service visit does not include:
1) Time incurred during travel to and from the beneficiaries' place of residence; or
2) Time used for administrative services and/or duties.

The time counted should be time spent actively treating the beneficiary. For example, if a beneficiary interrupts a treatment to talk on the telephone for other than a minimal amount of time (less than 3 minutes), then the time the beneficiary spends on the telephone and not engaged in therapy does not count in the amount of service. Other non-treatment related interruptions would follow the same principle. If the beneficiary is late returning home from a doctor's appointment, the waiting time of the home health agency personnel also cannot be counted as treatment time.

3

If the professional spends time with the family or other caretakers in the home teaching them to care for the beneficiary, this activity is counted as treatment time. If the nurse calls the physician to report on the beneficiary's condition while in the beneficiary's home, this can also be counted as treatment time.

Counting of 15 Minute Increments
When counting the number of 15 minute intervals, do not report services lasting less that 8 minutes. Time intervals for larger numbers of units are as follows:

1 unit ≥ 8 minutes to < 23 minutes
2 units ≥ 23 minutes to <38 minutes
3 units ≥ 38 minutes to <53 minutes
4 units ≥ 53 minutes to <68 minutes
5 units ≥ 68 minutes to <83 minutes
6 units ≥ 83 minutes to <98 minutes
7 units ≥ 98 minutes to <113 minutes
8 units ≥ 113 minutes to <128 minutes
The pattern continues for longer periods of time.

B. **Hospice**

Code V66.7, Encounter for palliative care, was created to classify encounters for end-of-life care, hospice care and terminal care. Code V66.7 **may not** be used as the principal diagnosis. Sequence first the underlying disease, such as carcinoma, etc. Code V66.7 may be assigned as an additional code to identify patients who receive palliative care in any health care setting, including a hospital.

Reference: AHA Coding Clinic 1st Quarter, 1998

X. OUTPATIENT CODING GUIDELINES

A. Evaluation and Management (E&M) services are used to capture the provider's professional services performed in either an inpatient or outpatient setting. The Diagnostic Coding and Reporting Guidelines for Outpatient Services (Hospital-Based and Physician Office) should guide coders when coding either outpatient or inpatient diagnoses for physician professional services.

Reference: Coding Clinic, Third Quarter 2000, Page 6&7

B. VHA guidelines for outpatient coding:

1. In selecting the correct level of service for E&M encounters, specific documentation must be present for the three components of the visit: History, Physical Examination, and Medical Decision-making.

2. The Subjective, Objective, Assessment, and Plan (SOAP) format is an acceptable format to document the above three key components for an outpatient visit. All three key components must be documented for an initial outpatient visit and two out of the three for an established outpatient visit. If counseling and coordination of care is over 50% of the visit, then **TIME** becomes the key component in determining the level of service. Documentation of topics discussed, conclusions, instructions, and persons involved must be completed by the provider of service.

   Note: The amount of time needs to be documented by the physician or provider in order to use a code for prolonged service that is 50% or more. All referrals for ancillary tests and procedures must be documented in the medical record as part of an encounter along with the reason for each referral.

3. Bundling and Unbundling (Fragmenting): Below are the Medicare CMS bundling guidelines, as well as industry standards, for coding multiple surgery procedures. Procedures considered "incidental" are included in the code for the primary procedure and no additional coding is required.

4. *Coding and billing staff should not unbundle CPT codes. Unbundling* is the billing of multiple procedure codes for a group of procedures that are covered by a single comprehensive code. Unbundling includes fragmenting one service into component parts and reporting separate codes for related services when a comprehensive code includes them all and coding both the surgical approach and the procedure separately.

   For example, a patient undergoes a simple removal of a foreign body (20520) and has an injection (20550), the injection is a component code of the simple removal and would not be coded. Unbundling also refers to the use of incompatible codes for ICD-9 and CPT or the use of two contradictory CPT codes. **Obtain a current CMS "Bundles List" from Trailblazer Health Enterprises, LCC – Texas, VHA's fiscal intermediary for Medicare.**

5. Diagnostic and procedure codes selected on the Encounter Form must match the documentation in the medical record in order to satisfy medicolegal requirements and to determine medical necessity. Diagnoses must be coded to the highest level of specificity. Some diagnoses require coding to the fifth digit for billing and reporting the patient encounter. Procedures will not be 'unbundled'.

6. The appropriate code or codes from 001.0 and V82.9 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

7. The diagnosis, condition, problem, symptom, injury or other reason for the encounter or visit which is chiefly responsible for services provided should be sequenced first. List additional codes that describe any coexisting conditions (reasons that affect care rendered during the visit).

8. Do not code conditions that were previously treated and no longer exist. Code all documented conditions that coexist at the time of the encounter/visit and require or affect patient care, treatment, or management.

9. V-codes (V01.0 - V82.9) may be used to code encounters for circumstances other than a disease, symptom, problem, or injury. Follow-up codes are for use to explain continuing surveillance following completed treatment of a disease, condition, or injury. They infer that the condition has been fully treated and no longer exits. They should not be confused with aftercare codes which explain current treatment for a healing condition or its sequelae. Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and repeated visits. Should a condition be found to have recurred on the follow-up visit, then the diagnosis code should be used in place of the follow-up code. For additional guidance on the use of V codes, refer to *AHA Coding Clinic*.

10. Do not code diagnoses documented as "probable," "suspected," "questionable," "rule out," or a "working diagnosis" as you would when coding inpatient diagnoses. Code the conditions(s) to the highest degree of certainty for that encounter/visit, using symptoms, signs, or other reason(s) for the visit.

11. When only diagnostic services are provided during an encounter or visit, first sequence the symptom, sign, condition, problem, or other reason for the encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter /visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses (if the current treatment affects the care rendered during the visit); for example, Complete Blood Count, liver profile for a patient on methotrexate for rheumatoid arthritis.

12. When therapeutic services are the only services provided during an encounter or visit, first sequence the diagnosis, condition, problem, or other reason for the encounter/visit shown in the medical record. The only exception is that the appropriate V code is used for patients receiving chemotherapy, radiation therapy, or rehabilitation services.

13. For patients receiving only preoperative evaluations, sequence a code from category V72.8 to describe the pre-op services and code the reason for the surgery as an additional diagnosis. Also, code any findings related to the preoperative evaluation.

14. For routine and administrative examinations (general checkup, etc.), first list the appropriate V code for the examination. If a diagnosis or condition is discovered, it should be coded as an additional code.

15. For ambulatory surgery cases, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis, at the time the diagnosis is confirmed, code the postoperative diagnosis. The operative report and pathology report will be the only documents to code from.

16. If the outpatient surgery is not performed due to a contraindication, code the reason for the surgery as first listed (reason for the encounter) and add a code from the V64 category to explain the contraindication.

17. Chronic conditions treated on an ongoing basis may be coded and reported as many times as the patient received treatment and care for the condition.

18. Using codes for referring a patient for a test: A lab draw, EKG, or any other test not performed in the clinic area will not be coded by the clinic. If the patient is referred to the lab or for an EKG or x-ray, this is already included in the E&M code. The clinic or ancillary location that performs the actual test will use the code to describe that test.

XI. EVALUATION AND MANAGEMENT CODING:

Please note that E&M guidelines are under revision. You may use either 1995 or 1997.

A. **New Patient**

New Patient codes can only be used if any physician within the same specialty in the clinic has not seen the patient within three (3) years or not seen at the facility with a three (3) year period. If a physician has not seen the patient in a particular specialty within a three-year period, this would constitute a new patient visit. If an initial visit and procedure (i.e., minor surgery) are performed on the same day of service, then both may be coded separately. (See modifier 25)

1. A veteran who lives in Ohio, treated at the VHAMC in Cincinnati, is now seen for the first time as a winter visitor at the VHAMC in Miami, Florida. The veteran would be a new patient to Miami. If he returns next year to Miami, he is then classified as an established patient if seen by the same treating specialty.

2. A veteran is seen by his primary physician who refers the patient to an urologist. This is the first time the veteran has been seen by an urologist (or by an urologist within the last three years). This veteran is considered a new patient for the urology visit.

3. A veteran who is seen for the first time by a primary care physician, returns the following year to be seen by another primary care physician. This veteran visit is not considered a new patient but as an established patient.

4. A veteran is seen for the first time by a primary care physician at the VAMC as a new patient. The patient is seen by another primary care physician at the Medical Center's CBOC the following week. This veteran visit is not considered a new patient but as an established patient.

B. **Established Patient**

An Established Patient is one who has received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three (3) years.
Some suggested guidelines for coding office visits for established patients.

1. **99211 - Minimal**
   Examples:
   - Visit for supervised drug screening
   - Visit for cursory check of hematoma one day after venipuncture
   - Visit for blood pressure check
   - Visit to redress an abrasion
   - Visit for instructions on the use of peak flow meter
   - Visit to review test result

2. **99212 - Problem-focused -** Most often seen for only one problem or related problems.
   Examples:
   - Visit for complaint of sore throat and headache
   - Visit for an upper respiratory infection
   - Visit for a recheck of a chronic condition, such as diabetes

3. **99213 - Expanded Problem-focused** - Most often seen for more than one chronic problem or low level of complexity. Used by primary care and specialists.
   Examples:
   - Visit for management of hypertension with mild fatigue on a beta blocker regimen
   - Visit for monitoring insulin-dependent diabetes with stable coronary artery disease
   - Visit for stable cirrhosis of the liver

4. **99214 - Detailed** - Most often seen for more than one chronic condition and one or more acute conditions.
   Examples:
   - Evaluation of regional enteritis, diarrhea and low grade fever
   - Visit for routine review of non-insulin dependent diabetes, obesity, hypertension and congestive heart failure

5. **99215 - Comprehensive** - Most often seen for moderate to highly severe presenting problem(s).
   Examples:
   - Visit for one-year post-therapy for lymphoma with new lymphadenopathy
   - Visit for recent history of fatigue, weight loss, intermittent fever, and presenting diffuse adenopathy and splenomegaly
   - Visit for evaluation of recent onset of syncopal attacks in a 70-year-old patient

C. **Ancillary Services**

1. A lab draw, EKG or any other test that was not performed in the clinic area will not be coded by the clinic. If the patient is referred to the lab or EKG or X-ray, this is already included in the E&M code. The clinic or ancillary location that performs the actual test will use the code to describe that test.

2. **Medication Refill:** The following guidelines should be followed:
   - New patient - VA physicians are obligated to examine the patient and make an independent medical decision on whether to prescribe medications. Thus, a diagnosis code along with new patient (E&M) code is in order rather than a “V” code.
   - Established patient - A provider encounter that is solely to order a refill then the appropriate chronic conditions for the medication should be coded.
   - Patient seen for assessment and treatment and the note mentions prescription refill then it is appropriate to code the diagnosis and/or for the condition(s) the patient was seen.

D. **Consultation vs. Referral Services:** (refer to Attachment F for Quick Reference Chart)

1. A consultation is a service provided by a physician for the further evaluation and/or management of the patient (i.e. opinion/advice). The physician's opinion must be expressed in a report that follows medical record documentation requirements (i.e. who requested the consultation, what tests were ordered, the diagnosis, and treatment recommended). If the consulting physician initiates a diagnostic or therapeutic service at the request of the attending physician (the person in charge of the patient), the service qualifies as a consultation.

2. Referral for procedures, patient "walk-ins", and self-referrals are not considered a consultation. A physician cannot perform a consultation on his/her own patient, however, they can for preoperative clearance. Example: A patient scheduled for a prostatectomy has previously had a myocardial infarction. The surgeon requests a consultation for preoperative clearance from the cardiologist.

3. Once the consulting physician assumes responsibility for the patient's continuing care, any subsequent services rendered by that physician are no longer a consultation. Further visits are billed as “established office visits”.

4. If the “requesting” physician requests another consultation for the same/different problem, the consultant may bill another consultation. There is only one initial consult per admission/per consultant.

5. The term *referral* has two meanings. It can be used to describe a situation in which one physician sends a patient to another for the second physician's opinion OR it can represent a situation in which the attending physician feels that he or she is unable to treat the patient's condition and sends the patient to another physician for treatment.

6. Consultations are no longer a physician only service when performance is within a non-physician’s scope of practice under State law. When the three key components (history, examination, and medical decision making) are not documented during a consultation, code 99499. Reference: Medicare Carriers Manual, Section 15506, dated September 27, 2001 but effective July 1, 2001

E. **Pre and Post-Operative Consultations and Follow-Up Care**

A primary care physician or specialist who performs a pre-operative consultation for a new or established patient at the request of the surgeon may code the encounter as a consultation as long as it meets the "Consultation" criteria. The surgeon's request must be documented in the medical record as well as the consultant's opinion. The consultation request must not be for "convenience" or "routine". Any follow-up care should be coded using the appropriate follow-up E&M visit code.

F. **Care Plan Oversight**

1. Care plan oversight includes the following physician activities: development or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan, and/or adjustment of medical therapy. Care plan oversight does not include the routine pre- and post-service work associated with visits and procedures. Also, telephone calls with patients and/or families are not included. These codes usually fall after placement of a patient. The team conference code is normally used when initially coordinating activities for a patient. These codes are only used when the patient has required complex or multidisciplinary care modalities and the physician is reviewing all their data and directing future care.

2. A physician can bill for their time managing the care of patients under the care of a home health agency, in a nursing home or in a hospice when the physician documents 30 minutes of services performed for that month. This service does not have to be continuous, as documentation and TIME are the key components. Only one physician may report his time with respect to a patient in a given month.

3. Medicare will not pay for care plan oversight of a patient in a nursing home.

4. Consults with internal staff and telephone calls by the physician to the patient or the patient's family cannot be billed separately, but are inclusive in the physician oversight code.

5. The physician must have had a face-to-face encounter with the patient within the last six months before the first month for which the care plan oversight services are billed.

G. **Concurrent Care**

The care of two or more physicians or providers for the same patient during the same episode of care is called *Concurrent Care* (acting in conjunction with each other for the betterment of the patient's condition). These services are evaluated for medical necessity. In general, two physicians cannot treat the same patient for the same condition. The physician is still caring for (treating) the patient, rather than simply rendering an opinion (which would be a consultation), so these visits are considered regular visits on a concurrent care basis. Separate, unrelated diagnoses must be present for which there is active treatment during the same episode of care. Monitoring low level chronic conditions during an acute inpatient stay is usually not considered medically necessary.

H. **Emergency Room Visits**

1. Documentation maintained in the medical record must include, as appropriate to the service, an emergency visit that includes:
   - Demographic information
   - Nursing notes
   - Physician's emergency documentation
   - Test results
   - Treatment

2. Diagnosis and CPT surgical procedure codes (if applicable) are assigned by the coder based on the diagnosis and procedure recorded by the treating physician in the emergency room record. The physician's emergency medical record documentation and test results are reviewed to assist in code assignment. The patient's reason for the visit is to be entered in the admitting diagnosis field for billing. Coding will be responsible for providing the reason for the visit within the comments field within QuadraMed CCM (PCE) or other method as locally established.
   Reference: Medlearn Matters Number MM3437

3. The Emergency Department has its own Evaluation and Management (E&M) codes for services provided and no distinction is made between new and established patients. However, ER services must be properly differentiated between "emergent" care and "urgent" care for coding purposes. Appendix D of the CPT manual contains clinical examples to assist you.

   - *Emergent Care* is needed for a medical condition manifesting itself by acute symptoms of ufficient severity such that the absence of immediate medical attention could reasonably result in serious impairment or dysfunction of a bodily organ or function. An E&M code from the range (99281 - 99288) is assigned. Emergent care requires the site-specific services and qualified staff to be available 24/7.

   - *Urgent Care* means services are furnished to an individual who requires services to be provided within 12 hours in order to avoid the likely onset of an emergency medical condition. An E&M code from the range (99201 - 99215) is assigned. Urgent care services are site-specific but are not a true Emergent Care Center. The urgent care facility is not available 24/7.

4. Triage services performed are not coded separately when assigning a code for these encounters.

5. Code (99285) can be used even if all the key components have not been satisfied due to the urgency of the patient's clinical condition and mental status.

6. If a patient receives critical care services in the emergency department, appropriate codes from that subsection should be reported provided the requirements for critical care are met. Time is a key factor in selecting critical care codes.

7. Other Emergency Services (CPT 99288) includes physician directed emergency care or advanced life support where the physician is located in a hospital emergency or critical care department and is in two-way voice contact with ambulance or rescue personnel outside the hospital. The physician directs the performance of necessary procedures.

I. **Face to Face Encounters**

1. Providers also spend time doing work before and after the face-to-face encounter performing such tasks as reviewing records and tests, arranging for further services, and communicating with others through written reports and the telephone. This non-face-to-face time, also called pre- and post-encounter time, is not included in extending the time component of the service. However, the pre- and post-encounter work is included as part of calculating the level of service and selecting the appropriate E&M code.

2. Since pre- and post-encounter time and work is included in the E&M code for the visit, then a separate code for such effort is not allowed.

Note: Tasks related to administrative functions, or related to the day-to-day operation of a facility, are not essentially clinical in nature and *do not meet* the definition of evaluation and management codes and guidelines. These tasks **are not** considered encounters and are not part of the coding of ambulatory care services.

J. **Medical Student:**

The documentation of an E/M service by a medical student is limited to documentation related to the review of systems and/or past family/social history. The teaching physician or resident may not refer to a student's documentation of history of present illness, physical exam findings or medical decision making in his or her personal note. These portions must be physically verified and re-documented.

K. **Nurse Visits**

Patients come for services performed by a nurse without further care by a physician or other independent provider, use CPT code 99211 (Minimal Visit) for these visits. Generally, nursing staff is limited to use of the lower E&M level CPT code, however, nurses are not just limited to 99211. A nurse can utilize an appropriate procedure code for services performed, when ordered by a physician and not in conjunction with a physician visit, when defined within their scope of practice.

L. **Observation Patients**

An observation patient is one who presents with a medical condition with a significant degree of instability or disability, and who needs to be monitored, evaluated or assessed for either admission to inpatient status or assignment to care in another setting. Observation services are not considered a routine service prior to or after a diagnostic or OPT therapeutic procedure.

1. Patients admitted to Observation Unites are considered outpatients even through a PTF is generated and data is entered and sent to ADPC. Thus, outpatient coding guidelines must be used when selecting the principal diagnosis.

2. **The principal diagnosis must be coded to the highest degree of specificity.** The diagnosis, condition, problem, sign/symptom, injury or other reason that caused the admission to Observation should be coded as the principal diagnosis. Any additional codes that describe any coexisting conditions that may affect the stay should be added as additional codes. **Do not code** diagnoses documented as "probable", "suspected", "questionable", "ruled out" or a "working diagnosis".

3. The observation V codes should be used in very limited circumstances when a person is being observed for a suspected condition that is ruled out. Observation codes are not to be used if an injury or illness or any sign or symptom related to the suspected condition are present. In such cases, the diagnosis/ symptom code is used with the corresponding E code to identify any external cause.

4. Codes from the V71.0 - V71.9 series are assigned as a PDX for encounters or admissions to evaluate the patient's condition when there is some evidence to suggest the existence of an abnormal condition; following an accident or other incident that ordinarily results in a health problem; and where no supporting evidence of the suspected condition is found and no treatment is currently required.

5. **Observation Patients admitted for Postoperative Management:** A patient comes in for a scheduled outpatient surgical procedure. The procedure is performed as an outpatient. The patient is admitted to observation. *Reference: Coding Clinic, First Quarter 2003*

   - The scheduled outpatient procedure should always be coded and entered into the surgical package and not PTF.
   - If the patient was admitted after the outpatient procedure for a complication, code the reason for the surgery and then the complication code.
   - If the patient was admitted after the outpatient procedure but there is no complication documented that led to the admission, assign the reason for surgery as the principal diagnosis and the appropriate aftercare V code as secondary in PTF.
   - If the patient was admitted after the outpatient procedure for some other condition unrelated to the surgery, assign the unrelated condition as the principal diagnosis in PTF.

   Note: Inpatient only procedures should be admitted prior to surgery for capture in PTF. If an administrative error occurs and the patient is admitted after the inpatient procedure, the time of the admission should be changed in Bed Control to reflect admission prior to the procedural time noted in the surgical package.

6. **Observation Patients Admitted to Inpatient Status:** A separate PTF is generated and data is entered. In assigning the principal diagnosis for patients admitted to inpatient status following Observation in the same hospital, use the Uniform Hospital Discharge Data Set (UHDDS) guidelines. UHDDS defines the principle diagnosis as *that condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.* An observation patient is one who presents with a medical condition with a significant degree of instability or disability, and who needs to be monitored, evaluated and assessed for either admission to inpatient status or assignment to care in another setting. Observation services are not considered a routine service prior to or after a diagnostic or OPT therapeutic procedure.

7. **Patients Admitted to the Observation Unit and Discharged on the Same Date:** Use the E&M observation codes or inpatient care services (including admission and discharge services, CPT codes 99234 - 99236). To assign them, the patient must remain in observation status for a minimum of eight hours and the physician must see the patient at least twice during the stay. If a patient remains in observation for fewer than eight hours, but is nonetheless admitted and discharged on the same calendar date, the coding changes. In this instance, the physician would assign only an observation code (99218-99220).

8. **Patients Admitted to Observation and Discharged on the Next Date:** Use the initial day observation codes (99218 - 99220) for the first day, then the discharge from observation code, 99217, for the second day. CPT code (99217) can be used for the discharge day management to report all services provided to the patient on discharge from Observation status, provided the discharge is other than the initial date of Observation status.
   Reference: ED Coding Alert, The Coding Institute, Sample Issue, received December 2001

9. **Patient Admitted to the Observation Unit, then Admitted to the Hospital on the Same Day:**
   - Same physician – bill only the initial hospital care code (99221 – 99223).
   - Different physicians – Physician who admitted to observation would bill the appropriate observation code and the physician who admitted the patient to the hospital would bill the initial hospital care code.

M. **Office Visit and Ambulatory Procedure**

The charge for an office visit (E&M code) is included in the charge for a minor office surgery. An office visit can be billed separately when the visit is for a separate and significant E&M service above and beyond the procedure performed. Different diagnoses are not required. In these cases, modifer-25 must be added to the appropriate E&M code.

N. **Patient Transport**

1. Patient transport codes can only be used to report the physical attendance and direct face-to-face care by a physician during the interfacility transport of a critically ill or injured patient (99291 and 99292). Face-to-face care begins when the physician assumes primary responsibility of the patient at the referring hospital/facility, and ends when the receiving hospital/facility accepts responsibility for the patient's care. Only the time the physician spends in direct face-to-face contact with the patient during the transport should be recorded. Patient transport services involving less than 30 minutes should not be reported.

2. Procedures or services performed by other members of the transport team may not be reported by the supervising physician. Routine monitoring evaluations and initiation of mechanical ventilation performed by the physician are to be included in the face-to-face time and not reported separately. Whereas, time spent by the physician performing separately reportable services or procedures should not be included in the face-to-face time. The direction of emergency care to transporting staff by a physician located in a hospital or other facility by two-way communication is not considered direct face-to-face care and should be reporting using code 99288. Reference: CPT Changes 2002 – New E&M codes

O. **Preventive Medicine Services**

1. When a patient visits the office for an annual examination without complaints, solely to obtain medications, or routine diagnostic tests for screening purposes only without complaints, codes from the Preventive Medicine section should be used. The primary diagnosis code is V70.0, Routine General Medical Examination at a Health Care Facility. Usually, preventive medicine services are asymptomatic examinations for which there is no diagnosis, symptom, or complaint. Preventive medicine services are limited to visits where nothing is "wrong" with the patient. The visit remains "routine" and no medical problems are found.

2. If an abnormality is encountered or a preexisting problem is addressed in the process of performing a preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem-oriented E&M service, then the appropriate office/outpatient code should also be reported, with the modifier –25 appended to indicate that a significantly, separately identifiable evaluation and management service was provided by the same physician on the same day as the preventive medicine service. The appropriate preventive medicine service code is additionally reported. If chronic conditions exist but are considered stable and not the focus of the visit, these chronic conditions should be listed as secondary diagnoses.

3. The extent and focus of these services depend on the age of the patient. Preventive Medicine codes can only be used one time per year. These codes include counseling, anticipatory guidance, and risk factor reduction interventions, which are provided at the time of the examination. Immunizations and ancillary studies, including radiology, laboratory, or other procedures are reported separately. History of Present Illness is not necessary as the patient is not being seen for a complaint. The patient's ROS, PFSH, and physical exam should be comprehensive based on specific age and gender. This is not synonymous with the comprehensive term used in E/M codes (99201-99215).

4. If an abnormality is encountered, or a pre-existing problem is addressed, during the same encounter and if the problem is significant enough to require additional work to perform the key components of a problem oriented E&M service, then the appropriate office visit code, 99201-99215, should also be reported. Modifier-25 should be added to the office visit code.

   Please note: An insignificant or trivial problem encountered, which does not require additional work, should not be reported separately.

5. The preventive medicine service should match the "V" diagnostic code. The E&M service should match the diagnostic code that indicates the disease, condition, or symptom.

6. The "comprehensive" examination for Preventive Medicine is not synonymous with the "comprehensive" examination under E&M office visits. The comprehensive history obtained as part of the preventive medicine E&M service is not problem-oriented, and does not involve a chief complaint or present illness. It does, however, include a comprehensive system review and comprehensive or interval past, family, and social history, as well as a comprehensive assessment/history of pertinent risk factors. The comprehensive examination performed as part of the preventive medicine E&M service is multi-system, but to what extent is based on the age of the patient and identified risk factors.

Reference: CPT Assistant, August 1997

PREVENTIVE MEDICINE FACT SHEET		
Component	**Preventive Medicine Visit 99381-99397**	**Problem Oriented Visit 99201-99215**
Chief Complaint	Healthy patient, absence of complaints. Insignificant or trivial problem.	Chief Complaint Specified
History	Not problem oriented. No description of present illness. Assessment of pertinent risk factors.	Description of the history of present illness as appropriate for the presenting problem.
ROS&PFSH	Comprehensive assessment/history of pertinent risk factors. Comprehensive past, family and social history.	To the extent appropriate for the presenting problem.
Examination	Based on age and identified risk factors.	Based on presenting problem.
Medical Decision	Age and gender defined screenings and tests.	Ancillary services ordered for specific medical problems(s).

Q. **Prolonged Physician Services**

1. Payment will be allowed for procedure codes 99354 (prolonged physician service in the office or other outpatient setting; first hour), 99355 (prolonged physician service in the office or other outpatient setting; each additional 30 minutes), 99356 (prolonged physician service in the inpatient setting, first hour), and 99357 (prolonged physician service in the inpatient setting; each additional 30 minutes) when the following criteria are met:

The physician has furnished and billed one of the procedure codes listed in Column 1 as well as the corresponding code(s) in Column 2 for the patient on the same day.

	Column 1	Column 2
a.	Office or other Outpatient Setting:	
	99354	99201 - 99205 99212 - 99215 99241 - 99245
	99355	99354 plus one of the codes required for 99354 (3 codes)
b.	Inpatient Setting:	
	99356	99221 - 99223 99231 - 99233 99251 - 99255 99261 - 99263 99301 - 99303 99311 – 99313
	99357	99356 plus one of the codes required for 99356 (3 codes)

2. The time counted toward payment for prolonged evaluation and management services included only direct face-to-face contact between the physician and the patient whether or not the service was continuous.

3. The medical record documents the content of the highest level of evaluation and management service code, the duration and content of prolonged services that the physician personally furnished after the typical time of the evaluation and management service has been exceeded by at least 30 minutes.

R. **Team Conferences/Case Management**

Team conferences are performed by providers consulting with other providers or representatives of community agencies to coordinate activities of patient care. Providers must still document in the medical record with notes indicating meetings, topics discussed, attendees, changes to patient management, medication, new orders, etc. The time spent performing these services is considered workload and productivity for providers and personnel through Decision Support System (DSS). Team conferences where the patient is present (usually for the purposes of deciding a treatment plan in a complex case) may be recorded as an encounter and coded using G0175. This code requires that at least 3 disciplines exclusive of nursing be present.

S. **Telephone Contacts**

Telephone calls to the patient or other health care professional to coordinate the medical management of a patient are considered encounters and may be reported separately using the appropriate level of service in CPT code 99371, 99372, or 99373. Telephone contacts are not limited to physicians and may be utilized by any health care provider. However, telephone calls made by the provider on the same day of the visit, either during, before, or after, is included as part of the visit and is reflected in the evaluation and management code. A separate telephone encounter may not be reported on the same day as an in-person encounter. The call should be documented to include the topics discussed and person contacted, etc., to support utilization of the code. A telephone call contributes to the comprehensiveness of the visit and level of service**.** ***Note: Telephone calls are non-billable from a MCCR perspective.***

T. **Computer Data Analysis/Medical Decision-Making**

This is a service that is usually part of an encounter coded with an E&M visit code. *Do not code for encounters.*

XII. MEDICINE

A. Asthma

If a patient has asthma, avoid using ICD-9 code 493.9x. Find out if the patient has extrinsic asthma (caused by something in one's environment) which is coded as 493.0x; or if it's intrinsic asthma (caused by an internal mechanism or element within the body) which is coded as 493.1x. If a patient receives a nebulizer breathing treatment in the clinic and a bronchodilator medication is used, bill 94640 for the treatment as well as the HCPCS code for the drug. Alupent, which is commonly used, is coded as J7668.

B. Chemotherapy

1. Intravenous or intra-arterial push is defined as an injection in which the healthcare professional who administers the substance/drug is continuously present to administer the injection and observe the patient; or an infusion of 15 minutes or less. The health care professional must be continuously present.

2. If a patient has to come back for a separately identifiable service on the same day, or has 2 IV lines per protocol, these services are separately coded and reported with modifier –59.

3. Chemotherapy drug administration is broken down into three categories. As of January 1, 2005, CMS has bundled 99211 into the chemotherapy administration codes and can no longer be reported on the same day.

4. The following procedures are considered a part of the infusion or injection codes listed below:
    a. Use of local anesthesia
    b. IV start (time spent attempting to insert the IV is not included)
    c. Access to indwelling IV, subcutaneous catheter or port
    d. Flush at conclusion of infusion
    e. Standard tubing, syringes and supplies (for declotting a catheter or port, see 36550)

Chemotherapy Administration	Code
Subq/IM non-hormonal anti-neoplastic drug administration	96401
Subq/IM hormonal anti-neoplastic drug administration, eg. Zoladex	96402
Intralesional chemo administration up to and including 7 lesions	96405
Intralesional chemo administration more than 7 lesions	96406
IV with push technique for anti-neoplastic drug for single or initial substance/drug	96409
IV push technique, each additional substance/drug (add-on code)	96411
IV infusion for anti-neoplastic drug administration up to 1 hour, single or initial substance/drug	96413
IV infusion for anti-neoplastic drug each additional hour, 1-8 hours (add-on code)	96415
Prolonged (more than 8 hours) infusions using portable or implantable pumps for anti-neoplastic drug administration	96416
Prolonged infusion, each additional sequential infusion (different substance/drug), up to one hour (add-on code)	96417
Intra-arterial, push technique	96420
Intra-arterial, infusion technique, up to one hour	96422
Intra-arterial, infusion technique, each additional hour up to 8 hours (add-on code)	96423
Intra-arterial, prolonged infusion (more than 8 hours) requiring the use of a portable or implantable pump	96425
Administration into pleural cavity, requiring and including thoracentesis	96440
Administration into peritoneal cavity, requiring and including peritoneocentesis	96445
Administration into CNS (e.g. intrathecal), requiring and including spinal puncture	96450

Nonchemotherapy Injections/Infusions (Therapeutic, Diagnostic, Prophylactic Administration)	Code
Initial up to one hour, specify substance/drug (e.g. Decadron infusion for neurotoxicity, initial first hour	90765
Each additional hour up to 8 hours for reporting additional hours beyond the first hour of sequential infusion and also the second and subsequent hours of the initial drug. Use these codes for infusion intervals of greater than 30 minutes beyond 1-hour increments (add on code for 90765 and 90767) (e.g. Decadron infusion for neurotoxicity 90 minutes or more)	90766
Additional sequential infusion, up to 1 hour for a second substance/drug. Specify substance/drug (add on code for 90765, 90774, 96409, and 96413)	90767
Concurrent infusion with primary substance/drug. Use only once per encounter per patient (add on code for 90765 and 96413)	90768
Subcutaneous or intramuscular injection, specify substance or drug	90772
Intra-arterial injection, specify substance or drug	90773
Intravenous push, single or initial substance/drug, specify substance or drug	90774
Each additional sequential IV push of a new substance/drug (add-on code)	90775
Unlisted intravenous or intra-arterial injection of infusion	90779
• E&M service performed during same encounter for infusion use modifier -25 with the E&M code and the appropriate infusion code. A different diagnosis is not required	-25
Hydration Administration	**Code**
Intravenous infusion, hydration (prepackaged fluid and/or electrolyte solutions such as normal saline); initial, up to 1 hour	90760
Hydration infusion of greater than 30 minutes beyond 1-hour increments or hydration greater than 30 minutes provided as a secondary or sequential service after a different initial infusion or chemotherapy service is provided, each additional hour, up to 8 hours.	90761
Hydration performed prior to chemotherapy infusion use modifier –59	-59
E&M service performed during same encounter for hydration use modifier -25 with the E&M code in addition to hydration code	-25

A quantity should be given to the billers for any add-on codes to fill in the quantity on the profee for proper reimbursement.

5. Refills/Maintenance (96521, 96522, or 96523)
    a. These codes are generally not used when chemotherapy administration is given on the same date of service.
    b. Port flushing only use 99211. Do not report a maintenance code when flushing.
    c. If chemotherapy is received via usual routine, and the pump is filled on the same date of service, for future use, affix modifier -59 appropriately for pre-filling the pump.

6. Hydration codes, 90760 and 90761, are used when NO drugs have been added to the fluids. If drugs are added, it becomes a therapeutic infusion (90765 or 90767).

7. Drugs and injectables require that attention be paid to the billing unit contained in the code description. In addition, if a provider must discard the remainder of a single-use vial or other package after administering it to the patient, the amount of discarded drug along with the administered amount should be reflected in the code description.

8. Administration of anti-anemia drugs and anti-emetic drugs by injection or infusion for cancer patients is not considered chemotherapy administration.

9. When performing a nonchemotherapy IV push or infusion, which is an inherent part of the primary procedure (eg, administration of contrast material for diagnostic imaging study), the IV push or infusion is not reported separately.

Reference: CMS Transmittal 566

C. **DIGMA (Drop In Group Medical Appointments)**

1. Multiple patients are seen as a group for follow-up or routine care in a shared medical appointment. These visits are voluntary for patients and provide a secure but interactive setting in which patients have improved access to their physician, the benefit of counseling with additional members of a health care team, and can share experiences and advice with one another. Documentation must support the diagnosis and level of service and must reflect the care provided to the individual veteran.

2. DIGMAs can be coded two ways for providers:

   a) If a provider examines a member of the group in a separate room and conducts a private medically necessary face-to-face visit, separate from the group, the appropriate level of service may be coded. The group setting would have no impact on the history, medical decision-making and physical exam on this E/M encounter.

   b) If services are provided within a group setting with no separate individual face-to-face service, CPT code 99499 should be used. Do not confuse a DIGMA appointment with group sessions, i.e. diabetic group counseling (G0109).

3. **Note:** There are new HCPCS modifiers developed by CMS (Pub. 100-04, Transmittal 14, Change 2856, October 24, 2003) for use with HCPCS code R0075 (Transportation of portable x-ray equipment and personnel to home or nursing home, per trip to facility or location, more than one patient seen). At this time, we are not recommending their use with DIGMA visits unless your local insurance carrier is requesting their use.
   - UN Two patients served
   - UP Three patients served
   - UQ Four patients served
   - UR Five patients served
   - US Six patients or more served

D. **Cardiovascular System - Miscellaneous**

1. Vascular procedures such as venipuncture are coded only if a physician inserts the catheter into the blood vessel.

2. A physician must supervise cardiac rehabilitation (93797-93798).

3. Codes 93000-93010 cover 12-lead or greater EKG's. Code 93000 covers the complete, global EKG service (the recording and interpretation/report). Code 93005 covers only the recording. Code 93010 covers the interpretation only. There may be times when a provider requests an over-read of the test due to questionable findings. The knowledge and the expertise of the second reader should be above and beyond that of the first reader and must contribute substantially to the interpretation in order to bill for the second reading. Date of EKG will be the date the tracing was actually performed, not the date of the interpretation.

   Hospital: 93005 EKG technical component. Code may be used when coding outpatient EKG technical component separately from the professional component. The inpatient technical component of an EKG is included in the DRG.

   93010 EKG professional component. Code is to be used when coding inpatient professional fees. It can also be coded separately from the technical component for outpatient EKGs. This code is to be used when the EKG is performed at a CBOC and the interpretation is done at the Medical Center.

   93000 This is a global code.

CBOC: 93005 EKG performed at CBOC, interpretation done at the Medical Center (
93000 EKG, interpretation and report are all done at the CBOC.

NOTE: Coding should reflect services performed at that location. Additionally, VA utilizes the codes/data for workload capture. For example, if an EKG tracing is performed at an outlying community based clinic, code 93005 is assigned by the clinic. When the EKG tracing is read and interpreted by a physician at the Medical Center, code 93010 is assigned at the Medical Center. The ideal process would be to establish a non-count EKG Interpretation clinic when the interpretation is read at the Medical Center using code 93010 and the tracing is performed at a community based clinic. A process will need to be established at the facility so MCCR can retrieve the data for billing.

4. Echocardiographies (99307-93350) differentiate between 2D, 2D transesophageal (TEE) or Doppler. Read descriptions 93325 and 93350 carefully. The complete TEE procedure is covered by 93312. Code 93313 is specific for placement of the probe only. Code 93314 covers the technical component along with the professional interpretation and a report. Code 93313-26 would describe a case where a physician only interpreted and reported TEE findings.

5. Stress tests (93015-93018) are considered a level 2 by CMS (Transmittal B-01-28 dated April 19, 2001) for a procedure that must be performed under the direct supervision of a physician. Direct supervision means the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.

E. **Cardiac Catheterization**

1. According to CPT, cardiac catheterizations include:
   - Introduction, positioning, and repositioning of the catheter(s).
   - Obtaining blood sample for measurement of blood gases or dilution curves and cardiac output measurements (Pick or other method, with or without rest and exercise and/or studies) with or without electrode placement.
   - Recording of intracardiac and intravascular pressure
   - Final evaluation and report of procedures.

2. Code the actual cardiac catheterization using a code from the 93501-93533 range, after making note of what these codes include (refer to above section). Reference: CPT Changes 2002

3. If injection procedure(s) are performed, select the appropriate code(s) from 93539-93545.

4. Next, codes from 93555-93556 are selected to report any "imaging supervision, interpretation and report for injection procedures during cardiac catheterization". Each code covers angiography of different structures. Read CPT's complete description for 93555-93556.

5. When multiple injection procedures are performed, report all of the applicable injection codes, but report the applicable S&I codes (93555-56) only once. Both 93555 and 93556 may be reported on the same bill as long as each code is reported only once.

6. Note: Codes 93561 and 93562 are not to be used with cardiac catheterization codes.

F. **Diabetes Mellitus**

1. Diagnostic coding for diabetes requires coding to the fifth digit. Select the appropriate four-digit code and add the appropriate fifth digit to your code as follows:
   Type II or unspecified type, not stated as uncontrolled
   Type I (juvenile type) not stated as uncontrolled
   Type II or unspecified type, uncontrolled
   Type I (juvenile type), uncontrolled

Then select the secondary diagnostic code that identifies the manifestation. For example:
250.51 - DM with ophthalmic manifestations, Type I
365.44 - Glaucoma

2. Do not code abnormal findings or diagnosis based on abnormal laboratory value alone, i.e. do not assign a code for uncontrolled diabetes based on a high blood glucose reading. Uncontrolled diabetes occurs when blood sugars are not maintained at an acceptable level for the patient's particular treatment regimen. The physician must document uncontrolled within the record in order to code uncontrolled. Clinical indications as determined by the facility are to be used only to determine whether the physician should be contacted to add "uncontrolled diabetes mellitus" to the documentation.

3. Blood glucose levels may temporarily fluctuate due to surgery, nutritional status, or infection, and would not necessarily constitute "uncontrolled diabetes".

4. The administration of insulin has no bearing on code assignments as they relate to diabetes mellitus. Only the type of diabetes, (Type 1 or Type II) determines the code assignment. Do not code insulin-requiring diabetes as Type I without specific documentation from the physician as to the Type I or II.

5. Never assume that a patient who is being treated with insulin is a Type I diabetic. Some adult onset diabetes patients are given insulin to correct temporary deficiencies, but are not dependent on insulin to sustain life.

6. If a Type II diabetic is receiving long-term use of insulin, an additional code of V58.67 can be used as a secondary code.

7. CMS approved two G codes to be used by non-physicians for approved diabetic programs, G0108 and G0109. These two codes can be used by nurses, dieticians and pharmacists.

G. **Digestive System - Endoscopies**

1. For esophageal dilation without visualization, use codes 43450-43456.

2. Determine the route in coding colonoscopies
   - via colostomy (44388 – 44397)
   - via colotomy (45355)
   - via rectum (45378-45392)

3. All diagnostic endoscopies are "separate procedures" and should not be coded in addition to surgical endoscopies.

4. Endoscopy codes specify the type of instrument used, the purpose of the endoscopy and the site of application.

5. If during a colonoscopy, a polyp is removed and another area of the colon is biopsied, it is proper to code both procedures.

6. When coding endoscopies, distinguish between the following:
   - Proctosigmoidoscopy - exam of the rectum and sigmoid colon.
   - Sigmoidoscopy – exam of the rectum, sigmoid colon and part of the descending colon.
   - Colonoscopy – exam of the entire colon, from rectum to cecum and possible examination of terminal ileum.

7. Upper GI Endoscopy including Endoscopic Ultrasound (EUS) (Code 43259): If the person doing the original diagnostic endoscopy has access to the EUS and the clinical situation requires an EUS, the EUS may be done at the same time. The procedure, diagnostic and EUS, is reported under the same code, CPT 43259. Interpretation, whether by a radiologist or endoscopist, is reported under CPT code 76975-26.

8. **Incomplete Colonoscopies**: When a patient has tried to prepare for a full colonoscopy, and the prep fails so a full colonoscopy cannot be completed, use modifier –53. Modifier –53 is also used when an adverse event occurs during the procedure. When the performing physician elects not to do a full colonoscopy and has passed the splenic flexure after a full preparation for the procedure, use modifier –52. When the scope does not pass by the splenic flexure, choose the appropriate sigmoidoscopy code.

H. Injection, Immunization and Vaccination Coding Rules

The rules for CPT coding of these procedures depends upon the type of procedure and the person performing the procedure. The following are rules and examples for each possibility.

1. Injections of therapeutic substances ordered by a physician during a physician/patient encounter.
   - This procedure is covered in the physician E&M code used for the encounter.
   - No drug administration codes are required by CMS, only the appropriate HCPCS "J" codes for each injected drug.

   Note: There may be a few insurers who are willing to pay for the administration charge.

2. Injections of therapeutic substances under the supervision of a physician given by a nurse but not seen by the physician.
   - One method to code this correctly is to use a code for the administration process, 90772 and an additional "J" HCPCS Level II code to indicate the name of the drug and the dosage.
   - A second method is to use 99211 E&M code to indicate a non-physician provider service. In this case you **do not** use additional codes to indicate the injection process or the drug administered. These are subsumed under 99211.

3. One immunization given at the time of a separately identifiable office or other outpatient service.
   - Use 90471 as the immunization administration code which includes percutaneous, intradermal, subcutaneous, intramuscular, jet, and/or intranasal or oral administration.
   - Use 90476-90749 to indicate the vaccine product code.
   - Use the appropriate E&M code to separately indicate the physician service.

4. More than one immunization given at the time of a separately identifiable office or other outpatient service.
   - Use 90471 for the first administration code.
   - Use 90472 for each additional administration code.
   - Use codes from 90476-90749 to indicate the exact products being administered.
   - Use the appropriate E&M code to separately indicate the physician service. For example, a patient receiving Polio, inactive, MMR and a separate varicella vaccine would be reported as 90471, 90472, 90472, 90713, 90707, and 90716. A separate E&M code would also be used to indicate the office visit.

5. Allergen immunotherapy only
   - Use codes 95115 (for single injection) or 95117 (for multiple injections). These codes include all professional services required to perform this therapy.

6. Allergen immunotherapy and additional E&M services
   - See number 5 above and use the appropriate E&M code to identify the additional services provided.

7. TB Test (Intradermal PPD): V74.1, 86580. The follow-up visit for reading of the result is coded 99211

8. Pneumonia Vaccine: V03.82 and 90732 for the vaccine.

9. Flu Vaccine: V04.81 and 90658 for the vaccine.

10. For those vaccinations given by an agency or facility other than DVA, the follow-up visits for injection site evaluation and dressing changes is to be coded as 99211 with a diagnostic code of V58.89. If a reaction or complication were found, this would be coded based on the specificity of the documentation by the provider (i.e., 999.3, infection from vaccination with the appropriate E code). If a complication occurs in which a procedure is performed, the procedure code (i.e. debridement) would be coded in lieu of the 99211. Note: Dressing changes should not be coded separately as they are considered bundled into the E&M code.

Reference: Coding Answer Book, 2004, pp 17301-17306; Medicare Transmittal 1667 and VHA Directive 2003-016 dated March 10, 2003, "Billing Procedures for Providing VA Health Services to Reservists and National Guard Service Members who Develop Reactions to the Smallpox Vaccine". CPT Assistant, November, 1999, pp. 47-48, July, 2001, pp. 2,12.

I. Outpatient Dialysis

1. When the patient is seen as an outpatient for dialysis, the Monthly Capitation Payment (MCP) payment codes are appropriate. 90920 or 90921 is for the full month of ESRD related services and is an all-inclusive code for the month. CMS requires a physician to round on each patient at least once during each billing cycle. The physician is not required to be present during each treatment. When a patient spends part of the month as a hospital inpatient, or when the outpatient services are initiated after the first of the month, the dialysis services provided each day will be coded to either 90924 or 90925. You will need to work with your MCCR department to clarify your internal procedures for use of the MCP payment codes.

2. If the patient is admitted as an inpatient for no other reason than to receive maintenance dialysis, i.e. the only diagnosis is ESRD, the dialysis will be considered an outpatient service reimbursed under the MCP only.

3. CPT code (90999) will be used for the facility charge for hemodialysis. CMS effective January 1, 2003 now requires the following "G" codes to report the Urea Reduction Ratio (URR) for the dialysis patient. Specific Medicare supplementary policies may also require.
   - G1 Most recent URR of less than 60%
   - G2 Most recent URR of 60% to 64.9%
   - G3 Most recent URR of 65% to 69.9%
   - G4 Most recent URR of 70% to 74.9%
   - G5 Most recent URR of 75% or greater
   - G6 ESRD patient for whom less than 6 dialysis sessions have been provided in a month

   Reference: HMS's Strategy Advisor, September 20, 2002. www.hma.com/Articles/20020920.html

4. CPT codes (90935 and 90937) are to be used for outpatient acute dialysis services (that is, patients who are expected to regain their renal function).

   Reference: CMS Transmittal 1810 dated July 25, 2003

5. The primary diagnosis should always be V56.0, Encounter for Dialysis, with a secondary diagnosis for the condition being treated (i.e., ESRD, chronic kidney disease).

J. **Inpatient Dialysis**

1. Evaluation and management services for subsequent hospital visits (99231 - 99233) will not be paid when billed on the same date of service by the same physician as inpatient dialysis (90935, 90937, 90945 and 90947).

2. Separate payment may be made for an initial hospital visit (99221 - 99223), an initial inpatient consultation (99251 - 99255) or a hospital discharge service (99238) when billed on the same date as an inpatient dialysis service. In order for the payment to be made, the E&M service must be unrelated to the treatment of the patient's ESRD and could not have been furnished during the dialysis treatment. These services should be billed with modifier -25 to indicate that they are significant, separately identifiable services.

3. When the patient is admitted, the physician can assign one of four CPT codes (90935, 90937, 90945, 90947) for care based on the following:

   - If the physician sees the patient and there are no complications, the physician must sign the dialysis note and assign a CPT code of 90935 or 90945 depending on the type of dialysis.

   - If the physician repeatedly sees the patient for a problem, the problem/condition must be documented and the attending physician must assign a CPT code of 90937 or 90947, depending on the type of dialysis.

   - If the physician does not see the patient while the dialysis treatment is performed, the professional component will not be coded. The treatment will be coded by ICD-9-CM and will be part of the DRG.

4. Code V56.0, Admission for extracorporeal dialysis (hemodialysis) or code V56.8, Admission for other dialysis (peritoneal), is assigned as the principal diagnosis for such admissions, with an additional code for the renal condition. If the patient is admitted for other reasons but continues to receive dialysis therapy during the hospital stay, code V45.1 as a secondary diagnosis.

K. **Sleep Studies**

1. Sleep studies refer to the continuous and simultaneous monitoring and recording of various physiological and pathophysiological parameters of sleep for 6 or more hours with physician review, interpretation and report.

2. a. Polysomnography is distinguished from sleep studies by the inclusion of sleep staging which is defined to include:
   - 1-4 lead electroencephalogram (EEG)
   - electro-oculogram (EOG)
   - submental electromyogram (EMG)

   a. For a study to be reported as polysomnography, sleep must be recorded and staged.

   b. The patient is monitored continuously throughout the night, recordings are made as well. A trained technologist is present throughout the entire procedure.

3. If recording of sleep is less than 6 hours, report appropriate CPT codes with modifier –52 for Reduced Services.

4. Sleep services (95805-95811) include recording, interpretation and report completion.

   a. 95807 requires monitoring of four specific parameters:
      - Ventilation (nasal and/or oral airflow)
      - Respiratory effort (motion of thorax and/or abdomen, diaphragm EMG or pleural pressure
      - Heart rate or EKG
      - Oxygen saturation

   b. When two studies are performed independently of each other, i.e. 95816 (EEG) with 95808, you may report both codes. The EEG used during polysomnography differs from that performed for separate diagnostic purposes. **Do not** use the EEG code to report the EEG recording component of the sleep study.

5. The EEG, autonomic function, and evoked potential services (95812-95829, 95920-95930 and 95950-95962) include recording, interpretation by a physician and report.

6. For interpretation only, report the appropriate CPT code with modifier –25, professional component.

7. For an unattended sleep study, report code 95806. Unattended recording is utilized by physicians in the diagnosis of selected patients with suspected sleep disorders. Unattended by a technologist, the test is done with a portable recording device, recording of 7-8 hours of airflow, respiratory effort, oximetry, and heart rate.

8. Report code 95811 for the initiation of continuous positive airway pressure therapy or bilevel ventilation. NCPAP – nasal continuous positive airway pressure is a therapy initiated during a complex polysmnography.

9. EKG or pulse oximetry are included in the sleep study services. Refer to the Correct Coding Initiative to identify Comprehensive and Component codes.

XIII. SURGERY

A. Anesthesia

1. The administration of anesthesia should be reported using five-digit CPT procedure codes (00100 - 01999). If the surgeon or assistant surgeon administers the anesthesia, an anesthesia code is not assigned. This is inclusive in the surgery code.

2. Codes 99143 and 99145 are specific to the reporting of conscious sedation when it is administered by the physician who is also performing the procedure but requires the presence of an independent trained observer to assist in the monitoring of the patient. When anesthesia is administered by other than the physician performing the procedure in a facility setting, then use codes 99148-99150. When these services are perfomed by the second physician in a nonfacility setting codes 99148-99150 are not reported. Moderate sedation does not include minimal sedation (anxiolysis), deep sedation, or MAC (00100-0199).

3. MAC (monitored anesthesia care) must be provided by qualified anesthesia personnel. If the anesthetist started the IV and monitored the MAC (during a regional or general anesthesia) but the surgeon did the actual administration of the drug, modifier –47 would be added to the procedure code.

4. Facilities must ensure start and stop times for anesthesia are documented. Anesthesia time starts when the anesthesia practitioner begins to prepare the patient for anesthesia services in the operating room or the equivalent area and ends when the anesthesia practitioner is no longer furnishing services to the patient.

5. Anesthesia CPT-4 codes may be entered into PCE or Event Capture System for all procedures. It is suggested that an "inpatient clinic" be set-up to capture all inpatient professional fees using PCE to include anesthesia codes. Anesthesia codes shall not be entered into the Surgical Package. The decision to use PCE or Event Capture is a local decision.

6. A separate allowance should not be made for a consultation (pre-op work-up) performed by an anesthesiologist prior to definitive surgery (within 24 hours of surgery). This service should be considered part of the care covered by the anesthesia allowance. Payment may be made for a consultation in either of the following circumstances:

   a) Consultation results in a decision not to administer anesthesia during that hospital stay and documentation of the circumstances is provided.

   b) The consultation is not preparatory to surgery, e.g., for a respiratory problem.

7. Monitored Anesthesia Care: Monitored anesthesia care (MAC) involves the intraoperative monitoring of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedure. MAC also included the performance of a preanesthetic examination and evaluation, prescription of the anesthesia care required, administration of any necessary oral or parenteral medications (e.g., atropine, demerol, valium) and provision of indicated postoperative anesthesia care. The QS modifier should be added to the procedure code in addition to other applicable modifiers to identify the services as monitored anesthesia care. Medical records must document the need for MAC especially for those surgical procedures that can be safely and effectively performed under conscious sedation administered by the physician performing the procedure, e.g., colonoscopy.

8. In unusual circumstances, i.e., complicated trauma case, in which it is medically necessary for both the CRNA and the anesthesiologist to be involved completely and fully in a single case, each provider should be assigned an appropriate anesthesia code.

9. The following medical and surgical services may be coded when either furnished in conjunction with the anesthesia procedure or as a separate service, provided they are medically necessary and not precluded by the Correct Coding Initiative: Swan-Ganz catheter insertion, Central venous pressure (CVP) line insertion, Intra-arterial lines, Emergency intubation, Critical care visits, and Transesophageal echocardiography.

10. Any patient controlled analgesia (PCA) service performed after the anesthesia care has ended, including initial set-up, subsequent adjustments, or follow-up is considered routine post-operative pain management, regardless of who performs it and is not separately coded. In addition, when PCA is administered for non-surgical pain management, it is considered to be an integral part of a doctor's medical care and is not separately coded.

11. Insertion of an epidural or subarachnoid catheter and injection of an anesthetic should be reported as procedure 62318-62319. Daily hospital management of the epidural drug administration (01996) occurs after insertion of an epidural or subarachnoid catheter is placed primarily for anesthesia administration during an operative session, but retained for post-operative pain management. Code (01996) is eligible after the day on which the catheter was inserted. An epidural injection administered as a therapeutic agent in the treatment of a non-surgical condition (e.g. chronic low back pain) should be reported under code 62310-62311 (single injection) or 62318-62319 (via indwelling catheter).

12. When an injection/nerve block is administered postoperatively by an anesthesiologist in the recovery room, it is considered part of the anesthesia time. Any subsequent adjustments or injections concerning this treatment are considered routine postoperative pain management, regardless of who performs it and should not be coded.

13. When surgery is aborted after general or regional anesthesia induction has taken place, report this situation using unlisted procedure code 01999.

Reference: Medicare Part B Reference Manual, February 2002, Anesthesia Billing Guide

B. **Assistant at Surgery**

Some surgical procedures require a primary surgeon and an assistant surgeon. Payment will not be made for the services of assistants at surgery furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service. Modifier 80 or 82 is required.

C. **Co-Surgery**

Co-surgery refers to a single surgical procedure which requires the skill of two surgeons (usually with different skills) of the same or different specialties performing parts of the same procedure simultaneously. Co-surgery has been performed if the procedure(s) performed is part of and would be billed under the same surgical code. Modifier -62 is required for each surgeon.

D. **Follow-up Visits to a Non-surgeon**

Each surgery has a follow-up visit at either 0, 10 or 90 days (see Federal Register volume 64, No. 211, dated 11/2/99). This rule applies when these services are performed by a surgeon or surgery assistant. If another physician outside of the specialty group performing the surgery does the follow-up, modifier –55 would be attached to the surgery code. **Note**: When submitting a bill for another surgeon, the date of service must be the original date of surgery and it cannot be billed until at least one visit has been provided.

Reference: March 18, 2003 VHA Coding Council Call

E. **Global Surgical Package**

1. The payment for a surgical procedure includes a standard package of preoperative, intraoperative, and postoperative services. The preoperative period included in the global fee for **major** surgery is 1 day. The postoperative period for **major** surgery is 90 days. The postoperative period for **minor** surgery is either 0 or 10 days depending on the procedure. For endoscopic procedures (except procedures requiring an incision), there is no postoperative period.

2. Visits to a patient in an intensive care or critical care unit are also included if the services are unrelated and made by the surgeon within this global surgical period.

3. The following services **are** included in the payment amount for a global surgery:

   - Preoperative Visits – Preoperative visits after the decision is made to operate beginning with the day before the day of surgery for major procedures and the day of surgery for minor procedures.
   - Intraoperative Services – Intraoperative services that are normally a usual and necessary part of a surgical procedure.
   - Complications Following Surgery – All additional medical or surgical services required of the surgeon during the postoperative period of the surgery because of complications which do not require additional trips to the operating room.
   - Postoperative Visits – Follow-up visits within the postoperative period of the surgery that is related to recovery from the surgery.
   - Postsurgical Pain Management – By the surgeon.
   - A history and physical performed by the surgeon or assistant surgeon within the 24-hour pre-operative period is included in the surgery code. Post-operative visits within the CPT post-operative global period are included in the surgery code

4. The following services **are not** included in the payment amount for a global surgery:

   - The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery.
   - Services of other physicians except where the surgeon and the other physician(s) agree on the transfer of care.
   - Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complication of the surgery.
   - Treatment for the underlying condition or an added course of treatment which is not part of the normal recovery from surgery.
   - Clearly distinct surgical procedures during the postoperative period which are not re-operations or treatment for complications (A new postoperative period begins with the subsequent procedure.)
   - Treatment for postoperative complications which requires a return trip to the operating room.
   - Ancillary services such as radiology, laboratory and EKGs, are not included in the surgical global package and should be coded separately.

Reference: Medicare Part B Reference Manual Chapter 22 Global Surgery Services

5. Non-Global Preoperative Services. Consists of evaluation and management (E&M) services (preoperative examinations) that are not included in the global surgical package and diagnostic tests performed for the purpose of evaluating a patient's risk of perioperative complications and optimizing perioperative care. Preoperative examinations may be billed by using an appropriate CPT code (e.g., new patient, established patient, or consultation). Such non-global preoperative examinations are payable if they are medically necessary. All claims for preoperative medical examination and preoperative diagnostic tests must be accompanied by the appropriate ICD-9 code for preoperative examination (V72.81 through V72.84). Additionally, the appropriate ICD-9 code for the condition(s) that prompted surgery must also be documented on the claim. Reference: Medicare Carrier Manual Transmittal 1701

Note: VHA directives do not follow the above guidelines and call for separate coding for all ambulatory care visits prior to or after surgery. Pre-operative visits should be coded with a CPT code that reflects the level of service provided. Post-operative visits should be coded using CPT code 99024 if within the established global period. Reusing the surgical procedure code is not valid.

F. **Multiple Procedures**

Multiple surgeries are separate procedures performed by a physician on the same patient at the same operative session or on the same day. Multiple surgeries are distinguished from procedures that are components of or incidental to a primary procedure. A modifier should be utilized to reflect multiple procedures. Intraoperative services, incidental surgeries or components of surgeries will not be separately reimbursed.

G. **Pre/Post-Op Consultations and Follow-up**

A primary care physician or specialist who performs a pre-operative consultation for a new or established patient at the request of the surgeon may code the encounter as a consultation as long as it meets *consultation* criteria. The surgeon's request must be documented in the medical record, as well as the consultant's opinion. The consultation request must not be for *convenience* or *routine*. Any follow-up care should be coded using the appropriate follow-up E&M visit code.

H. **Surgical Tray**

Certain procedures allow the billing of supplies in addition to the procedure itself. When a separate payment is allowed, use code A4550 or 99070 for a surgical supply tray used during the course of a procedure. Note that only one tray can be billed regardless of the number used.

I. **Suture Removal**

1. If the suture removal is performed by the surgeon during the global period after the surgery, the suture removal would not be reported separately, since this is included as part of the normal, uncomplicated follow-up care related to surgery. Code V58.3 (attention to surgical dressings and sutures) and 99024 (postoperative follow-up visit).

2. If the suture removal was performed by a physician other than the surgeon who performed the surgery, the modifier -55 (postoperative management only) would be appended to the surgical procedure code to indicate that this physician (not the original surgeon or same group surgical specialty) is providing the postoperative care.

Note: Removal of sutures by other than the operating surgeon may be coded as a level of E/M service if suture removal is the only postoperative service performed. The E/M level most often will be a 99211 or 99212 if the visit involves only the removal. Using modifier -55 states this provider will be assuming all care of the patient related to the surgery for the entire post-op period.

Reference: Coding Answer Book, Section 23176, CAB 12/01

J. **Team Surgery**

Team surgery refers to a single procedure; however, it requires the skills of more than two surgeons of different specialties, working together to carry out various portions of a complicated surgical procedure. Modifier 66 is required for each surgeon.

K. **Digestive System - Hemorrhoidectomy/Fissurectomy**

1. For the codes 46255 (Hemorrhoidectomy internal and external, simple), 46257 (with fissurectomy) and 46258 (fistulectomy with or without fissurectomy), a simple hemorrhoidectomy involves no plastic procedures as opposed to complex or extensive where plastic procedure is needed.

2. For the codes 46260 (hemorrhoidectomy, internal and external, complex or extensive), 46261 (with fissurectomy) and 46262 (with fistulectomy with or without fissurectomy), the need for a plastic procedure would indicate a complex or extensive hemorrhoidectomy.

3. For the code 46270 (fistulectomy/fistulotomy; subcutaneous), 46275 (fistulectomy; submuscular), and 46280 (fistulectomy; complex or multiple), submuscular fistulectomy involves division of the sphincter muscle as opposed to subcutaneous where muscle is not involved. Complex is excision of multiple fistulas.

4. For the code 46285 (surgical treatment of anal fistula (fistulectomy/fistulotomy); second stage), the physician performs a second stage excision or incision or an anal fistula. The incision is usually left open to allow continued drainage.

L. **Digestive System -Miscellaneous**

1. Separate codes are not available for bilateral hernia repairs, use modifier -50.

2. Code selection for dilation of the esophagus depends on whether the procedure was a direct or indirect visualization and, if indirect, the dilation technique.
   - For direct visualization with a scope, the correct code is 43220; an additional code, 43226, is also reported if a wire is inserted to guide the dilation.
   - For indirect visualization, the method of dilation (i.e. unguided sound, bougie, guide wire, string, balloon, Starck or retrograde) must be known to determine the correct code from 43450 to 43456 range.
   - Bariatric Surgery is performed to treat morbid obesity. These 2006 code additions identify different elements involved in providing this type of care, including laparoscopic placement of adjustable band, 43770, laparoscopic revision of the band, 43771, laparoscopic removal of the band, 43772, laparoscopic removal and replacement of the band component, 43773, and laparoscopic removal of the band and subcutaneous port component are coded to 43886-43888.

Reference: AMA, CPT Changes, 2006, An Insider's View

M. **Female Genital System - Laparoscopy/Hysteroscopy**

1. Surgical procedure performed via laparoscopy for both male and female will be found in this subsection.

2. A laparoscopy permits the visualization of the peritoneal cavity using a laparoscope through the anterior abdominal wall. The surgeon will make an incision at the inferior rim of the umbilicus. A needle is inserted into the abdominal cavity and carbon dioxide or nitrous oxide is insufflated to distend the abdominal wall. Additional incisions will be made so the surgeon can insert the laparoscope and any additional instruments for the procedure(s) being performed and visualization of the abdominal cavity.

3. The surgeon may also perform a pelviscopy. This procedure involves insertion of a fiberscope through the abdominal wall. The difference between the pelviscopy and the laparoscopy is the pelviscopy is used for therapeutic procedures for the female genital system only.

4. The hysteroscopy is a direct visualization of the cervical canal and uterine cavity through a hysteroscopy. This is performed to examine the endometrium and to perform a surgical procedure such as a D&C, removal of a foreign body, or removal of a cervical polyp. Again, the hysteroscopy is performed on female patients only.

5. CPT code 58660, laparoscopy with adhesions destruction (salpingolysis, ovariolysis) has been designated as a separate procedure in 1998. If the surgeon performs lysis of adhesions in addition to a procedure on the ovaries and/or fallopian tubes, the coder will not code the lysis of adhesions separately. However, if the lysis of the adhesions is extensive and involves additional time in the OR, the adhesions are described as dense and adds increase risk to the patient, then the coder may assign 58660.

6. When the surgeon performs a hysteroscopy with a D&C, coding guidelines indicate that CPT code 58558 will be assigned.

7. When a surgeon performs a laparoscopic procedure and CPT does not have a specific code for the procedure, the coder will assign the site specific "unlisted" laparoscopy/hysteroscopy procedure codes.

N. **Female Genital System – Miscellaneous**

1. The coder should determine the type of approach for the surgical procedure. Hysteroscopy and laparoscopy procedures will be assigned in the laparoscopy/hysteroscopy subsection. The remaining procedures will be listed in the female genital subsection.

2. The coder must identify the area of the female genital system that the procedure is being performed. CPT subdivides the vulva, perineum and introitus as one section, the vagina as another section and the cervix uteri as another section. In addition, the uterus, oviduct (fallopian tube) and ovary have their own section within this subsection.

3. A nonobstetrical dilation and curettage (D&C) will be assigned 58120.

4. Do not code pelvic examination under anesthesia when performed in addition to a D&C. Assign code for D&C only.

5. LOOP Conization versus LEEP Conization of Cervix.
   - Coders will see surgeons use LOOP and LEEP interchangeably in operative reports.
   - LOOP – this electrodissection conization is a procedure that is a deep dissection of the cervix.
   - LEEP – this electrodissection conization is not as deep and therefore, is more superficial than the LOOP procedure.
   - The coder will assign 57522 regardless if the procedure is documented as a LOOP or a LEEP conization of the cervix.
   - If the LOOP or LEEP is performed via a colposcopy, the coder will assign CPT code 57460.

6. For endometrial sampling in conjunction with colposcopy, use 58110, in addition to the procedure performed (57420-57421, 57452-57461).

O. **Integumentary System – Removal of Lesions**

When a physician removes a malignant lesion, do not automatically code from the 11600-11646 section of the CPT book. Carefully review the documentation to see if the physician made a wide excision and if it was necessary to go into soft tissue. Codes from the Musculoskeletal section may more appropriately describe the service and the reimbursement rate is substantially higher. For example, the excision of a tumor of the hand or finger (subcutaneous) may be coded as 26115.

1. The following information is needed to accurately code the removal of lesions:
   - whether lesion is malignant or benign,
   - site or body part involved with lesion,
   - size of the lesion, including margins, in centimeters before it is removed; when more than one dimension for a lesion is provided, select the largest dimension for coding,
   - method of removing the lesion, e.g., paring, shaving, debridement,
   - type of wound closure/repair: simple, intermediate, complete
   - repairs of the same classification and location should be added together and reported as a single item, and
   - re-excision of a malignant lesion performed to ensure all of the malignancy has been excised should be coded as an excision of a malignant lesion even if the lesion is no longer present.

Assist your coding with this conversion chart	
0.24 – 0.39 inch	0.6 – 1.0 cm
0.40 – 0.79	1.1 – 2.0
0.80 – 1.19	2.1 – 3.0
1.20 – 1.57	3.1 – 4.0
>1.57	>4.0
1.02 – 2.95	2.6 – 7.5
2.99 – 4.93	7.6 – 7.5
4.94 – 7.89	7.6 – 12.5
7.9 – 11.8	12.6 – 20.0
>11.8	>30
THE INCHES HAVE BEEN ROUNDED FOR CLARITY. 1 INCH = 2.54 CENTIMETERS; 1 CENTIMETER = 0.3937008 INCHES.	

2. With CPT2003, measurement of the lesion now includes margins. Check with your Surgical and Pathology Departments to ascertain the location of the correct size of the lesion in the medical record before coding. If tissue is excised beyond the margin for repair approximation, it is not counted. The code for excision of a benign or malignant lesion includes simple closure.

3. Use more than one procedure code if the same procedure is performed on different anatomical sites with different incisions.

4. Shaving is the sharp removal by transverse incision or horizontal slicing to remove epidermal and superficial dermal lesions without a full-thickness dermal excision. This includes local anesthesia, chemical or electrocauterization of the wound. The wound does not require suture closure. See codes 11300-11313.

5. Simple repair refers to suturing of a superficial wound involving skin and/or subcutaneous tissues, without significant involvement of deeper structures. It includes local anesthesia and chemical or electrocauterization of wounds not closed. Do not assign a procedure code for application of Steri-Strips to close a wound.

6. Intermediate repair describes the repair of wounds that require layered closure. Deeper layers of such wounds are usually involved, such as superficial (non-muscle) fascia, so at least one of the layers requires separate closure. Remember that the use of two kinds of sutures do not indicate layered closure. Single-layer closure of contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair.

7. Complex repair describes the repair of wounds requiring reconstructive surgery (more than layered closure), complicated wound closure or unusual and time-consuming repair techniques to obtain the best functional and cosmetic result (i.e., scar revisions, debridement of traumatic or avulsed lacerations, extensive undermining or retention sutures). Creation of the defect may be included and any necessary preparation for repair or the debridement and repair of complicated lacerations of avulsions.

8. Debridement or decontamination of a wound is coded separately only when a wound requires prolonged cleansing, when appreciable amounts of devitalized tissue are removed, or when debridement is a separate procedure without immediate primary closure. In these instances, codes from the 11040-11044 range are assigned. There should be supporting documentation by the physician that will justify the use of the debridement code.

9. When a wound repair requires that blood vessels, tendons, or nerves be repaired, such repairs are reported under the appropriate system (cardiovascular, musculoskeletal, nervous) and the skin repair is not coded.

10. The simple ligation of vessels in an open wound and the simple exploration of exposed nerves, blood vessels or tendons in an open wound are considered part of the repair of the wound and are not separate procedures.

11. Do not use complex repair codes for 1cm less than or any repairs other than eyelids, nose, ears, and/or lips. Use simple/intermediate repairs.

12. All wounds repaired in the same classification-simple, intermediate or complex-should be measured and documented in centimeters, whether curved, angular or stellate. (Example: The patient has an open wounds of the forehead, 1.5cm, of the chin, 1.0 cm, and of the nose, 0.5cm. The wounds were repaired in a simple closure. Assign CPT code 12013 for the repair of the wounds, as it equals 3.0 cm.)

13. The principal procedure is the more complicated type of repair when more than one classification of wounds is repaired.

14. For full-thickness repair of lip or eyelid, see the appropriate anatomical section of the CPT book.

15. When frozen section pathology reveals margin excisions that are not adequate, a single excision code should be used to report the additional excision and re-excision(s) necessary at the same operative session. Similarly, re-excision procedures performed to widen margins at subsequent operative sessions should be reported by using the code appropriate to identify the size, location, and type of excision performed. The –58 modifier should be appended if the re-excision is performed during the post-operative period of the primary excision procedure.

P. **Integumentary System - Skin Grafts**

1. Free skin grafts should be identified by the size and location of the defect (recipient area) and the type of graft. Use codes in this section as additional codes when closures from other subsections require skin grafts. Free skin grafts include: pinch grafts, split-thickness grafts and full-thickness grafts.

2. Flaps (skin and/or deep tissues) refer to recipient area when flap is being attached to final site.

3. Skin grafts are identified by the size and location of the defect and the type of graft (free, pedicle, flap or other). Skin graft codes may be used for both primary and secondary procedures.

4. Included in the subsection “Adjacent Tissue Transfer or Rearrangement” are the following types of repairs using skin flaps: Z-plasty, W-plasty, rotation flap, advancement flap, and double pedicle flap.

5. In a pedicle flap procedure, a flap of skin is lifted from a healthy site on the patient's body. A portion of the skin is immediately grafted to the new site. The rest of the flap can be grafted to the new site once sufficient blood flow has been established. Pedicle flap procedures are used in the repair of defects or reconstructive surgery. The following procedures are often performed in pedicle flap repair of reconstruction:
   - Selection of donor site
   - Major debridement or excisional preparation of recipient area
   - Creation of open or tube pedicle at donor site
   - Attachment of pedicle flap to recipient site
   - Repair of donor site (application of skin graft or local flaps is considered an additional separate procedure).

If a patient has a flap graft of this type with repair of the donor site, then two codes would be required – one for all of the procedures described above from range 14000-14350 as well as the repair of the donor site.

6. There are several types of other flaps and grafts:
   - **Muscle flap** is a layer of muscle that has been dissected and moved to a new site.
   - **Myocutaneous flap** is a muscle flap with overlying skin and connective tissue.
   - **Split thickness grafts** include the epidermis and part of the dermis.
   - **Full thickness grafts** includes the epidermis and the entire dermis.
   - **Pedicle flap grafts** are full thickness grafts that include not only the skin and subcutaneous tissue, but also subcutaneous blood vessels to ensure a continued blood supply to the graft.
   - **Free flap graft** is a full thickness skin graft that is dissected with its capillary bed intact but does not have its nerve supply, blood vessels, skin, muscle or other tissues (such as cartilage and bone).
   - **Allograft/homograft** is a tissue graft from one person to another.
   - **Autograft** is a graft from one part of the patient's own body to another site.
   - **Xenograft/heterograft** is a graft from an animal to a human (usually temporary and designed to protect the skin until the patient has skin available for grafting (i.e.: burn patients covered with pig skin).

7. Assign as an additional code, a code for a free skin graft performed on the donor site if it is required to close the donor site. If extensive repair or excision is performed prior to the free skin graft, then that procedure should be listed first and the skin graft should be listed next.

8. CPT code 15000 is intended to be reported for the surgical preparation or creation of a recipient site by excision of open wounds, burn eschar or scar. This code has been revised to clarify the inclusion of excision preparation of burn wounds (scars), including tangential excisions. Code 15000 has also been revised to be body surface size dependent, to include excision preparation of the first 100 sq centimeters (or fraction thereof) in the treatment of adults. Code 15000 is no longer an add-on code and therefore may be reported when grafting is not recommended or will be delayed for a subsequent session: **Note:** CPT code 1500 should not be reported for the excision of benign (11400-11471) or malignant lesions (11600-11646), which are reported according to the morphology of the lesion.
   Reference: CPT Assistant, April 1999

9. Tissue-cultured skin grafts are coded differently from other skin graft codes. They are not harvested from donor sites. They are supplied by laboratories and arrive in the operating room in sterile containers that limit the size of the grafts.

Q. **Integumentary System - Breast Lesions**

1. When a lesion is removed from a previous mastectomy site, the site is considered the "trunk", not "breast", since the breast is no longer present.

2. In an excisional breast biopsy, the entire lesion – whether benign or malignant – is removed; assign the code for an excisional breast biopsy if the physician attempts to perform an incisional biopsy on a very small lesion and the pathological review finds that the entire lesion and all of the margins are free of tumor (the entire lesion was removed intact). Use code 19120.

3. In an incisional breast biopsy, the entire lesion is not removed. Only a portion of the lesion is removed and sent to pathology, assign CPT code 19101.

4. Code 19290 should be used in addition to code 19120 when the breast lesion has been identified by the preoperative placement of radiological wire needle localization. Code 19291 is used for each additional lesion identified by preoperative placement of a needle.

5. Partial mastectomy involves the partial removal of part of the breast tissue, leaving the breast nearly intact. Partial mastectomy procedures include lumpectomy, tylectomy, segmentectomy and quandrantectomy.

6. Simple complete mastectomy involves the removal of all of the breast tissue (without removing lymph nodes or muscle). Subcutaneous mastectomy involves the removal of breast tissue, leaving the skin of the breast and the nipple intact. This type of mastectomy usually requires that a breast implant be inserted.

7. Code 19140 should be used for any mastectomy done for gynecomastia.

R. **Male Genital System**

1. The coder should determine the type of prostatic biopsy that is performed in order to determine the correct CPT code assignment. CPT assigns 55700 for a needle or punch biopsy via any approach. If the biopsy is incisional, via any approach, assign 55705. For prostate needle biopsy saturation sampling for mapping, use Category III code, o137T.

2. Laser prostatectomy can be performed utilizing a variety of devices and operative techniques. Depending upon how it is performed and in some instances, why, will determine the CPT code that will be assigned. The coder should review the operative report carefully to determine the appropriate CPT code assignment.
   - **Transurethral laser-induced Prostatectomy (TULIP)** – This procedure uses a narrow free-beam or no contact laterally deflecting laser device to perform a prostatectomy. Assign 52648 for this procedure.
   - **Transurethral electrosurgical resection of the prostate** – In this approach, the surgeon utilizes an electrocautery knife to resect the prostate. Assign 52601 for this approach.
   - **Non-contact laser prostatectomy** – This is performed utilizing a non-contact laser. The surgeon will specify in the operative report the utilization of this type of laser. When this is specified, assign 52647 for this procedure.

3. The surgeon may also perform prostatectomy utilizing a number of different methods. The other types a coder may identify are:
   - **Transurethral two stage prostatectomy** – The surgeon may perform a prostatectomy in two stages. The surgeon will specify in the medical record and/or operative report that this is the first or second stage of a prostate. Assign 52612 for the first stage and 52614 for the second stage.
   - **Transurethral destruction of the prostate using microwave therapy** – The surgeon used microwave thermotherapy for this procedure. Assign 53850 for this procedure.
   - **Transurethral destruction of the prostate using radiofrequency** – During this procedure, the physician uses radiofrequency thermotherapy to destroy the prostate. Assign 53852 for this procedure.

4. A surgeon may also perform a transurethral resection of residual tissue of the prostate. The surgeon will document in the medical record that the patient has residual tissue to be resectioned. The coder should determine when the initial prostatectomy was performed in order to assign the correct CPT code. Assign 52620 if the procedure is after 90 days postop. CPT code 52630 is assigned when the regrowth is greater than one year postop.

5. Although CPT code 55520 (excision of spermatic cord lipoma) is a separate procedure, if done with an inguinal hernia repair (49495-49525), neither procedure is considered an inherently inclusive component of the other. Therefore, an inguinal hernia repair code may be reported in addition to the excision of spermatic cord lipoma (55520).

S. **Musculoskeletal System - Fracture-Dislocation**

1. Codes exist for an "open" versus a "closed" fracture and "open" versus a "closed" treatment of that fracture. Open treatment is used when the fracture is surgically exposed to the external environment. The fracture is visualized and internal fixation may be used. Closed treatment specifically means that the fracture site is not surgically opened.

2. Codes for the treatment of fractures includes the application and removal of the initial cast and/or traction device only. Do not code the initial cast separately. Subsequent replacement of the cast/traction device requires a code from 29000 to 29799. Effective in 1996, the cast/splint application may be utilized by a physician not expected to deliver further care to the patient, as in the ER.

3. Reduction of a fracture is used commonly in the medical community, yet the term "reduction" is not found often in the CPT classification system. Instead the term "manipulation" is used.

4. Exercise caution in coding fractures, especially when differentiating between the type of fracture and the type of treatment. A closed fracture may require either closed and/or open treatment, whereas an open fracture requires open treatment. Be sure to identify:
   - The site of the fracture.
   - Whether the fracture was open or closed.
   - Whether treatment was open or closed.
   - If the manipulation was part of the treatment.
   - If the procedure included soft tissue closure.
   - Whether the procedure included internal or external skeletal fixation of the fracture.

5. Exercise caution in coding dislocations, especially in differentiating between the types of dislocation and the types of treatment. Closed dislocations may require either closed and/or open treatment, whereas open dislocations require open treatment. Make certain to identify:
   - The site of the dislocation.
   - Whether the dislocation was open or closed.
   - If the treatment was open or closed.
   - Whether manipulation was part of the treatment.
   - Whether the procedure included soft tissue closures.
   - If the procedure included internal and external skeletal fixation of the dislocation.

6. If a cast is placed but no procedure is performed, the coder would report the appropriate E&M code, codes for the application of casts and strapping plus any supplies provided.

T. **Musculoskeletal - Bone Grafts and Biopsies**

1. Codes for obtaining autogenous (from the patient) bone, cartilage, tendon, fascia or other tissue grafts through separate incision are to be assigned only when graft is not listed as part of basic procedure. Therefore, a separate graft code would not be necessary if reconstruction and the graft repair were performed at the same time by the same surgeon.

2. For biopsy of soft tissue, choose the code according to site and to whether the biopsy is superficial or deep.

3. For needle or trocar bone biopsies, choose code 20220 or 20225, depending on site.

4. For needle or trocar bone marrow biopsy, use code 38221; and 38220 for bone marrow aspiration only. Reference: CPT Changes 2002

U. **Musculoskeletal System - Miscellaneous**

1. The term "complicated" is also used in the description of some musculoskeletal codes. (See 28193). This term implies that an infection occurred, or treatment was delayed or extensive surgery was performed requiring over and above the usual time for the procedure.

2. The diagnostic arthroscopy procedure code (29870-separate procedure) is not coded when a code in range 29871-29887 is used.

3. In a bunionectomy procedure, do not code the wire insertion separately. This is considered part of the bunionectomy.

4. For injection procedures of the spine such as myelography, discography, chemonucleolysis, and facet joints, use the correct code for the injection from the Nervous System subsection.

5. When the narrative description states "each tendon" or "each muscle" the code should be repeated as often as necessary. Higher reimbursement depends on the repetition.

6. Primary tendon (first time repair) repairs are grouped higher than secondary repairs (repairs subsequent to primary repairs).

7. When arthroscopy is performed in conjunction with arthrotomy, each procedure may be reported separately. The physician must clearly document all of the information necessary to correctly code these surgical procedures.

W. **Nervous System**

1. Assign 64721 for the open release of carpal tunnel; assign 29848 if the procedure is performed arthroscopically.

2. When coding epidural injections, the coder needs to determine the site of the injection and the agents being injected. When both an anesthetic and steroid are injected, assign the code that states "anesthetic substance (including narcotics)".

3. Types of injections that a coder may find when coding are:
   - Single injection involves one injection of a substance(s)
   - Differential injection involves the segmented injection of a substance(s) at fixed time intervals (e.g., 1 cc Xylocaine every 10 minutes)
   - Continuous injection involves infusion of a substance(s) over a continuous period of time (e.g., IV drip)

4. The physician may also insert a subarachnoid or epidural catheter for continuous drug infusion. Assign 62318 for continuous injection of drugs in the cervical or thoracic regional or 62319 for the lumbar, sacral (caudal). If connected to either an external pump, an implantable reservoir, or an implantable infusion pump, use either 62351 or 62350, with or without laminectomy.

5. A facet joint injection involves the injection of a steroid and an anesthetic agent into the facet joints of the vertebrae to alleviate chronic low back pain. Assign 64475 for a single level, lumbar and 64476 for each additional level of the lumbar area.

6. Excision of Morton's neuroma will not be found in this subsection. The correct CPT code for this procedure is found in the musculoskeletal subsection. The correct assignment is 28080.

X. Optometrists/Ophthalmologists

1. Medicare will pay optometrists for either the CPT evaluation and management codes (99201 - 99300 and 99304 - 99499) or the CPT general ophthalmologic service codes (92002 - 92014). Medicare will pay ophthalmologists for either the CPT evaluation and management codes (99201 - 99499) or the CPT general ophthalmologic service codes (92002 - 92014).

2. It is important to note that there is no mandate that states the ophthalmology codes (non-vested codes) must be used instead of the evaluation and management codes. The codes that most accurately identify the service(s) or procedure(s) performed should be used.
   Reference: CPT Assistant, Volume 8, Issue 8, August 1998

3. Evaluation and Management codes should not be used in conjunction with 92012 and 92014.

4. Payment for other services such as fitting, follow-up, and other similar services that are directly related to the furnishing of the eyeglasses or contact lenses is included in the payment for the glasses and contact lenses. Separate payment cannot be made for such a service, whether furnished by an ophthalmologist, an optometrist, or an optician.

5. Determination of a refractive state (92015) is not included in a comprehensive ophthalmologic service. This is to be coded separately.

6. If an optometry resident is licensed in the State in which the service is performed and he or she is authorized to perform such services in that State. VHA is still required to apply the resident supervision documentation requirements for these residents.

Y. Ophthalmologic System - Cataracts

1. Use code 66985 for insertion of intraocular lens (IOL) not associated with a concurrent cataract removal.

2. Definitions:
   - Intracapsular extraction – Surgical removal of the entire lens and its capsule.
   - Extracapsular extraction – Surgical removal of the front portion and nucleus of the lens, leaving the posterior capsule in place.
   - Anterior chamber intraocular lens – Inserted after intracapsular cataract extraction.
   - Posterior chamber intraocular lens – Generally inserted after extracapsular cataract extraction.

3. There is a note that lists the procedures that are included as part of the extraction of lens codes (66830-66985). This code range includes the following procedures:
   - Lateral canthotomy
   - Iridectomy
   - Iridotomy
   - Anterior capsulotomy
   - Posterior capsulotomy
   - Subconjunctival or sub-tendon injections

4. Also included are the use of other pharmacological agents, such as:
   - Viscoelastic agents – a liquid injected into the connective tissue collagen in order to maintain the shape of the anterior segment of the eye while the procedure is being performed.
   - Enzymatic zonulysis – the method used to break up adhesions or areas of fibrosis in the anterior chamber.

5. The most common cataract surgery is the phacoemulsification of the cataract with immediate lens implant. This is associated with the extracapsular extraction of the lens. When the physician performs this type of procedure, the coder will assign 66984.

6. Vitrectomy is the aspiration of the vitreous and replacement with a saline solution or vitreous to clear an opaque vitreous. Coders commonly overlook this procedure as an additional code when done with a cataract extraction. However, one must note that a vitrectomy can only be coded if a vitreous chamber tap is done. Some of the vitrectomies done with cataracts include:
   - 67015 – aspiration/release of vitreous pars plana approach
   - 67030 – discussion of vitreous strands pars plana approach (rarely performed)
   - 67031 – laser vitrectomy (non –invasive)
   - 67036-67040 – mechanical, pars plana approach

   Common terms associated with vitrectomy:
   - Paracentesis – insertion of knife/needle to remove vitreous
   - Air injection – air is used to replace the vitreous
   - Mechanical vitrectomy – an outcome or Microvax is used to cut and suction the vitreous instead of hand-held sponges and scissors.
   - Pars plana approach – the vitreous is released via an incision behind the iris (also called a posterior sclerotomy).

7. Stages of laser surgery:
   - Initial stage – first episode to cut vitreous strands
   - Additional stages to remove debris

Z. **Ophthalmologic System - Strabismus Surgery**

1. CPT strabismus surgery codes apply to procedures performed on one eye only. Therefore, each code under this heading is a unilateral code.

2. When multiple procedures are performed on one eye, the secondary procedures are reported with the –51 (multiple procedures) modifier unless the secondary procedures are “add-on” codes. The –51 modifier is never reported with “add-on” codes.

3. Before selecting a code for strabismus surgery, always identify the following key facts.

   a. Determine whether surgery was performed on one or both eyes.

   b. If performed on both eyes, determine whether any of the procedures were bilateral. This means that if the same procedure is performed on both eyes, then the procedure is bilateral. For example, when a horizontal muscle is operated on for the first time in the right and left eyes, code 67311 is used to report the fact that surgery was performed on horizontal muscles in each eye. It is reported twice or used with modifier 09950 (-50). The theory is that two incisions were made, one in each eye area.

      On the other hand, if a vertical muscle in the left eye is operated on for the first time and a horizontal muscle is corrected in the right eye for the first time, the procedures are not bilateral because a different code is used to report each procedure. In this case, codes 67314 and 67311 are reported.

c. When the patient has not had previous eye surgery, select the appropriate primary strabismus surgery code(s) from code range 67311-67318 to report the procedure(s) performed.

d. Identify which muscles have been operated on in each eye and then determine whether the operated muscles are horizontal, vertical, or oblique muscles. You will need this information to select the primary strabismus surgery code for each procedure performed.

e. Check the clinical history to learn whether the patient has had previous eye surgery or injury that did not involve the extraocular muscles. If that is the case, report code:

67331 Strabismus surgery on patient with previous eye surgery or injury that did not involve the extraocular muscles.

Use in addition to the code for the primary strabismus surgery. Because this code is an add-on code, do not add the –-1 (multiple procedures) modifier when reporting it.

If the patient has had previous eye surgery or injury that did involve the extraocular muscles, see code 67332.

f. Codes 67320, 67331, 67332, 67335 and 67340 are add-on codes in this subsection. This means that, when applicable, one or more of them are listed in addition to the basic strabismus procedure code to explain other important conditions related to the case and to indicate that additional payment is warranted for the additional work and risk involved in the procedure. Add-on codes are never reported with the –-1 modifier. They may, however, be reported with the –50 modifier, as appropriate.

AA. **Ophthalmologic System -Miscellaneous**

1. Codes for procedures involving only skin of the eyelid or orbit are found in the Integumentary system.

2. Retinal detachment codes require clear documentation of methodology and specify combination codes where appropriate. For example, if scleral buckling is performed with cryotherapy and photocoagulation, only code 67107 is needed to report all three procedures.

3. CPT differentiates between a foreign body removal and removal of implanted material in the eye. The codes 65205-65265 are for the removal of a foreign body. The codes for removal of implanted material are 65175 (ocular implant), 65920 (anterior segment implant), 67120 (posterior segment implant) and 67560 (orbital implant).

4. Repair of lacerations of the eyeball includes use of conjunctiva flap and restoration of anterior chamber, by air or saline injection when indicated.

5. An anterior vitrectomy involves removal of vitreous from in front of the iris. The pars plana vitrectomy involves an approach behind the iris.

6. Keratoplasty excludes refractive keratoplasty procedures, 65760, 65765, and 65767.

7. Corneal transplant includes the use of fresh or preserved grafts, and preparation of donor material.

BB. **Respiratory System -Upper**

1. Nasal antrostomies are also called antrotomies. An antrostomy is formation of an opening made in any antrum. An antrotomy is technically an incision into the antrum. The reason for the antrostomy is the key in coding these procedures. If an incision is made in the maxillary antrum for the purpose of removing maxillary sinus polyps only, then CPT code 31237 would be used .

2. Coders must know the difference between open and endoscopic surgery approaches. Open surgical nasal procedures are generally performed by making an incision into the skin or tissues inside a body opening, such as the mouth and nose. Endoscopy procedures utilize the endoscope inserted through the nostrils. Endoscopy codes 31231-31294 are for UNILATERAL procedural only. If a bilateral procedure is performed, the code must be reported twice, or modifier (-50) must be used. Surgical endoscopy codes always include the diagnostic endoscopy, so this should not be reported separately.

3. A Caldwell-Luc operation is a maxillary sinusotomy, technically. The physician creates an opening into the maxillary sinus through the oral cavity. This is to allow drainage of the sinus for treatment of irreversible maxillary sinusitis. An intraoral incision is made in the labial mucosa, exposing the canine fossa. This is perforated with a trocar and biting forceps to increase the opening into the maxillary sinus. Sinus mucosa is removed with curettes. A second opening is made from the nasal cavity into the inferior meatus, a trocar is used to perforate an opening into the inferior meatus. It is enlarged with biting forceps. Use code 31030 for the Caldwell-Luc operation. Use code 31032 for the Caldwell-Luc operation when antrochoanal polyps are removed. The typical ICD-9-CM procedure code assigned with 31030 is 22.31. 22.61 is used with 31032. CPT code 30920, 31000, 31020, and 31090 should **not** appear with codes 31030 or 31032.

4. Codes 30801 and 30802 are for cauterization of inferior or mural turbinates. Use code 30999 for superior or middle turbinates. Since this is a separate procedure, if this procedure is done with another nasal procedure though the same incision, such as a Caldwell-Luc procedure without polyp removal, then **only** code 31030 is reported. Separate procedures performed at the same time through the same incision are not coded separately.

5. Code 30930 is for fracture or outfracture of turbinate(s). More than one can be fractured.

6. Code 30130, excision turbinate, partial or complete, can be coded in addition to other nasal procedure codes if documented by the physician. 30130 is considered a unilateral procedure. For excision of superior or middle turbinate, use 30999.

7. Unless specified otherwise, all pharynx, adenoids and tonsil codes are bilateral.

CC. **Respiratory System - Lower**

1. If a transbronchial lung biopsy was done and no tissue is reported on the pathology report, the surgeon has still performed a transbronchial lung biopsy and the appropriate code is assigned (31628).

2. Many times a surgeon will perform a laryngoscopy for purposes of determining a diagnosis in this area of the respiratory system. CPT separates the types of laryngoscopy by direct, indirect, with or without operating microscope and if a fiberoptic scope was used for the procedure. The coder should thoroughly review the operative report to find out what was done and therefore, the correct code assignment as a result of the documentation.

   - **Indirect laryngoscopy** is when the larynx is seen with the use of mirrors placed within the throat and oral cavity. The physician will indicate in the operative report “indirect” or use of mirrors in order to identify this type of laryngoscopy.
   - **Direct laryngoscopy** is when a laryngoscope is used to view the larynx directly through the scope.
   - **Operating microscope** is clearly identified in the operative report by the surgeon when it is utilized. The coder should never assume that an operating microscope was used.

DD. **Urinary System—Diagnostic/Urodynamics**

1. Urodynamic procedures should be coded in addition to cystoscopies. These procedures may be performed separately or in combination.

2. “Exclusive of radiologic service” indicates that an additional code from the radiology section of CPT must be assigned in order to classify the radiological service performed.

3. The urinary subsection also separates endoscopy procedures from open procedures. Surgical endoscopy procedures include a diagnostic endoscopy. The coder will assign a diagnostic endoscopy only when no surgical procedure has been performed.

4. The transurethral prostate procedures are listed in the urinary section. Open prostate procedures are listed in the male genital system.

5. A meatotomy is performed to treat a meatal stricture, which is a narrowing of the urethra. This usually occurs in the male. A meatotomy involves taking a pair of scissors and cutting the meatus wider to make it larger. A meatotomy can be ventral, transverse or dorsal.

6. Impotence is defined as male erectile dysfunction. The two main categories of dysfunction are psychologic (302.72) and organic (607.84) with a "mixture" of factors often being present. Organic causes may be vascular, neurologic, hormonal, medical or drug-related. When a physical (organic) disorder partially accounts for the psychological factors contributing to erectile dysfunction, both diagnoses should be coded. Unspecified impotence is assumed to be psychogenic in nature per the ICD-9-CM code book. Due to our patient population, most patients fall under "organic" impotence. If impotence is unspecified, it is highly suggested a query be made to the treating physician before affixing the psychologic (302.72) code for impotence. Impotence resulting from a radical prostatectomy is coded to 997.99.

EE. **Urinary System - Ureter**

1. Indwelling ureteral catheters are inserted into the renal pelvis via the ureter to allow drainage when something, such as a tumor, is impinging on the ureters. Gibbons and double-J stents are the most common ureteral stents. The insertion of a temporary stent (52332) is included in code 52330 when performed and will not be reported separately. A permanent stent should be coded as 52332-51 in addition to the primary procedure.

2. The CPT code for insertion of the ureteral stent (52332) is used to report a unilateral procedure unless otherwise specified.

3. To report cystourethroscopic removal of a self-retaining, indwelling ureteral stent, assign 52310 for simple removal or 52315 for complicated removal.

4. To report removal and replacement of internally dwelling ureteral stents code 50382 via percutaneous approach that includes radiological supervision and interpretation.

5. To report removal of internally dwelling ureteral stents via percutaneous approach code 50384. This includes radiological supervision and interpretation.

6. To report removal and replacement of externally accessible transnephric ureteral stent requiring fluoroscopic guidance code 50387. This includes radiological supervision and interpretation.

7. To report removal of nephrostomy tube requiring fluoroscopic guidance code 50389. Without fluoroscopic guidance is considered a part of the E/M services.

FF. **Urinary System - Cystoscopy, Urethroscopy and Cystourethroscopy**

1. Cystoscopy (cystourethroscopy) allows direct visual examination of the bladder and urethra. Assign CPT code 52000 when a diagnostic cystourethroscopy is performed.

2. Many times the surgeon will perform a retrograde pyelography (retrograde ureteropyelography). In this procedure, one or both of the ureters are catheterized during a cystoscopic examination, and a contrast medium is injected slowly through the catheter. X-ray films are then taken. Assign 52005 for this procedure.

3. The surgeon may perform an intravenous pyelogram (excretory urography). This pyelogram involves the intravenous injection of dye/contrast medium at designated intervals; x-rays are taken to observe the rate of excretion. Ureteral catheterization is not performed during this procedure and it usually precedes the cystoscopy. Assign 52000 for this procedure.

GG. **Urinary System - Transurethral Surgery (Urethra and Bladder)**

1. Transurethral surgeries will include the diagnostic cystoscopy. Do not code the cystoscopy separately.

2. If the surgeon performs a urethral dilation to determine the size (French) of the cystoscope to be inserted, the coder will not code the dilation separately. It will be included in any additional procedures that are performed during the operative episode.

3. If the surgeon performs a cystoscopy and then performs a transurethral dilatation for a urethral stricture, the coder will assign 52281.

4. For cystoscopy, with removal of foreign body, calculus or ureteral stent form urethra or bladder, assign 52310 for simple removal or 52315 for complicated removal.

HH. **Urinary System – Lithotripsy**

1. Percutaneous lithotomy (lithotripsy) is a two stage procedure first requiring a percutaneous nephrostomy with dilation of the nephrostomy tract. Instruments such as a basket or lithotripter can then be inserted via the nephrostomy and stones are removed. Assign 50080 or 50081 depending upon the size of the stone that is removed.

2. Extracorporeal shock wave lithotripsy (ESWL) is a non-operative procedure utilizing ultrasound shock waves to aid in breaking up the stone(s) in the renal pelvis and/or ureter. The patient is then able to pass the stones with minimal discomfort. Assign 50590 for this procedure.

3. A surgeon may perform a transurethral ureteroscopic lithotripsy in lieu of an ESWL. In this procedure, a cystoscope is inserted through the urethra into the bladder. Catheters are passed through the scope into the opening where the ureters enter the bladder. Instruments are then passed into the ureters and manipulation and disintegration of the stones occur utilizing transcystoscopic electrohydraulic shock waves, ultrasound or laser. Assign 52353 for this procedure. CPT code 52325 would be assigned if a ureteroscopy was not performed.

II. **Urinary System - Urodynamics**

1. CPT has a section for urodynamics. The code range is 51725-51798. The procedure in this section may be performed separately or in combination. The coder will not find “separate procedure” in this section and therefore, may assign as many codes as needed for the procedure that is performed during the operative episode.

2. The types of procedures found in this section are:
   - Simple cystometrogram – measurement of the bladder’s capacity, sensation of filling and intravesical pressure
   - Complex cystometrogram – same as simple cystometrogram. In a complex procedure the physician utilizes a rectal probe to differentiate between abdominal pressure from bladder pressure.
   - Simple uroflowmetry – measures the time of voiding and the peak flow.

- Complex uroflowmetry – measures and records the mean and peak flow and the time taken to reach peak flow during continuous urination.
- Urethral pressure profile (UPP) – records pressures along the urethra as a special catheter is slowly withdrawn
- Electromyography studies of the anal or urethral sphincter – this records the muscle activity during voiding and gives a simultaneous recording of urine flow rate.

XIV. MENTAL HEALTH

A. Mental Health Services

1. Mental Health Services use ICD-9-CM codes (295 through 316) to classify mental disorders. CPT codes relating to mental health are found in the Psychiatry Subsection of the medicine Section. The codes are based on type of psychotherapy, whether E&M services were provided, face to face time, and place of service.

2. Caution must be given prior to using any codes identifying **interactive** psychotherapy (90810-90815). The physician provides **individual** interactive psychotherapy using play equipment, physical devices, a language interpreter, and other mechanism of communication. It involves the use of physical aids and non-verbal communication to overcome barriers to therapeutic interaction between the clinician and a patient who has not yet developed, or has lost, either the expressive language communication skills to explain his/her symptoms and response to the clinician if he/she were to use ordinary adult language for communication.

3. The American Medical Association (AMA) defines psychotherapy as:
   - the development of insight or affective understanding
   - the use of behavior modification techniques
   - the use of supportive interactions
   - the use of cognitive discussion of reality

   or the combination of any of the above to provide therapeutic change. Thus, the clinician establishes a professional contract with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

4. To report medical E&M services that are provided on a day when psychotherapy is **not** provided, use the E&M codes listed under "Office or Other Outpatient Services". If psychotherapy was provided, assign the appropriate psychotherapy with E&M code from the Psychiatry Subsection.

5. The Evaluation and Management services should not be reported separately, when reporting codes 90805, 90807, 90809, 90817, 90819, 90822, 90824, 90827, and 90829.

6. The consultation for psychiatric evaluation includes patient examination, exchange of information with the primary physician and other informants (i.e., nurses, family members), and preparation of a report. These consultative services (99241 - 99255) are limited to initial evaluation and do not include psychiatric treatment.

7. Pharmacological management (90862) includes prescription use and review of medication with no more than minimal medical psychotherapy. This code includes provision of minimal medical psychotherapy, and should be assigned alone when this is the only service actually performed. Pharmacological management (90862) is bundled into the psychiatric diagnostic interview exam (90801). 90862 is a psychiatric service code **only** and it stands alone without E&M code accompaniment.

   Reference: Physician Practice Coder Vol. #5, No. 7, July 1999

8. Other psychiatric procedures performed in addition to E&M services or psychotherapy, such as electroconvulsive therapy should also be coded.

9. Certified Addiction Therapist/Rehab Counselors**:** Professional services may only be covered if they meet the guidance provided by Medicare and if they are a MD, CP, CSW or CNS.

10. Code "90801" is for initial diagnostic assessment and generally can only be used once, at the outset of an illness or suspected illness. It may be utilized again for the same patient if a new episode of illness occurs after a hiatus, or on admission, or re-admission, to inpatient status due to complications of the underlying condition. All "individual psychotherapy" codes must have time spent with patient documented within their notes.

11. Psychological testing is based on time spent by the psychologist performing the administration, scoring, and the writing of the report along with time spent face-to-face with the patient.

12. Addiction Severity Index (ASI) is used during intake to assess the patient and is normally a part of the Evaluation and Management service delivery when done by a physician. If the ASI is used by other providers, the appropriate CPT codes are 96101-96103 in the initial assessment period.

13. Mental Health codes, without a timed increment, should not be reported in multiples.

14. A multiaxial evaluation is documented by Psychiatry using the *Diagnostic and Statistical Manual of Mental Disorders* by the American Psychiatric Association.
    - Axis I– Clinical Syndromes and V Codes (constitute the entire classification of mental disorders)
    - Axis II – Developmental disorders and Personality Disorders (disorders begin in childhood or adolescence and persists in stable form (without periods of remission or exacerbation) into adult life)
    - Axis III – Physical Disorders and Conditions (permits the clinician to indicate any current physical disorder or condition that is potentially relevant to the understanding or management of the case)
    - Axis IV – Severity of Psychosocial Stressors (provides a scale, the Severity of Psychosocial Stressors Scale – see PTF instructions) for coding the overall severity of a psychosocial stressor or multiple psychosocial stressors that have occurred in the year preceding the current evaluation and that may have contributed to the development, recurrent, or exacerbation of the mental disorder)
    - Axis V – Global Assessment of Functioning (permits the clinician to indicate his or her overall judgment of a person's psychological, social, and occupational functioning on a scale, the Global Assessment of Functioning Scale (GAF)(see PTF instructions), that assesses mental health-illness.

    When a person has both an Axis I and an Axis II diagnosis, the principal diagnosis or the reason for visit will be assumed to be on Axis I unless the Axis II diagnosis is followed by the qualifying phrase "principal diagnosis" or "reason for visit". DSM-IV-TR denotes the following:

    V71.09 When no Axis I or II diagnosis or condition is present, this should be indicated.

    799.9 When no Axis I diagnosis or condition is present and when there is insufficient information to make any diagnostic judgment about an Axis II diagnosis, "diagnosis deferred", this code should be indicated.

    NOTE: For more in-depth information on Mental Health, use of CPT codes by providers, please refer to the "Mental Health Fact Sheet". This can be retrieved off the Reasonable Charges web page.

B. **PRRTP (Psychosocial Residential Rehabilitation Treatment Programs)**

PRRTP is a distinct level of inpatient mental health care designed to provide comprehensive treatment and rehabilitative services. If a PRRTP is provided within a Domiciliary (DOM) unit/ward, CPT code (99324-99340) should be reported. Any service provided outside the DOM, the CPT code appropriate for the location or setting should be used.

C. **PTSD (Post-Traumatic Stress Disorder)**

Patients released following care and treatment (including rehabilitation) of PTSD will not be assigned a principal diagnosis from the V57 category. When a patient is released from any ward, service or specialized unit following care and treatment (including rehabilitation) for PTSD, the principal diagnosis will be coded as 308.3, acute post-traumatic stress disorder, or as 309.81, chronic post-traumatic stress disorder, as indicated by the physician responsible for the care of the patient.

XV. LABORATORY AND PATHOLOGY

A. Laboratory

1. Laboratory Panels: CMS has established HCPCS codes for the newly established laboratory panels. Do not submit codes for individual laboratory tests when a code for a grouping or "panel" exists for the services performed. For example: Lab performs only five out of six tests within a CPT panel. Each of the five tests would require a separate CPT code. If all six of the tests were performed, only the one CPT panel code would be coded.

2. Specimen Handling: When a urine specimen or pap smear is sent to a reference lab, code 99000 should be used to bill for specimen handling. Only one specimen collection charge can be billed per encounter. Collection of specimens by catheterization should be coded using Q0162.

3. Venipuncture: When blood is drawn to be sent to a reference lab, use code 36415 for the venipuncture (Use G0001 for Medicare). Collection by capillary stick does not qualify.

4. Abnormal Pap Smear: The professional component for interpretation of an abnormal pap smear (code 88141, P3001-26) furnished to a hospital inpatient may be separately eligible for reimbursement.

5. Hematology: Physician hematology services include microscopic evaluation of bone marrow aspiration and biopsies. It also includes those limited number of peripheral blood smears which need to be referred to a physician to evaluate the nature of an apparent abnormality identified by the technologist (85060, 38220, 85097, and 38221). Payment may be made for the professional component for the interpretation of an abnormal blood smear (code 85060) furnished to a hospital inpatient.

   Reference: CPT Changes for 2002

6. Blood Banking: Blood banking services of hematologists and pathologists are paid when analyses are performed on donor and/or patient blood to determine compatible donor units for transfusion where cross matching is difficult or where contamination with transmissible disease of donor is suspected (86077, 86078, and 86079). Do not report the 26 modifier.

7. Date of Service: When billing, the date of service should be reported as the date of specimen collection. When specimen collection spans more than a 24-hour period, the date of service should be reported as the date the collection began. For lab tests that require a specimen from stored collections, the date of service should be defined as the date the specimen was obtained from the archives.

   Reference: CMS Transmittal AB-02-129 dated 9-27-2002

8. Cascade Lab Testing: If a lab performs a test ordered by a physician, the lab should not perform further testing ("cascade testing" or reflexive testing") based on results of that test without an order from the treating physician. For example: If a patient's treating physician orders a CBC and the results of the CBC indicate hemoglobin to be low, the lab should not automatically perform a test to determine total iron binding capacity.

   Reference: www.empiremedicare.com/BENENEWS/BRF981/Cas.htm

9. Use of Lab Modifiers:

   a. Modifier –59: It is appropriate to use this modifier to report multiple service submissions on the same day. These situations usually involve microbiology where samples or cultures are taken from a patient from a different anatomical sites or different wounds. While the tests are the same, the services are distinct since they involve different sites.

b. Modifier –91: If an ordering physician requests a lab test that requires several of the same services (CPT code) be performed for the same patient on the same day, the lab should use modifier 91 to indicate that multiple identical clinical diagnostic lab tests were done on the same day. If the same anatomical would was recultured on the same day, then modifier 91 should be used instead of modifier 59.

Reference: www.empiremedicare.com/benenews/brf02-04/adm.htm

B. **Diagnostic Testing**

1. When a diagnostic test confirms a suspected diagnosis, the diagnosis should be coded, not the signs and/or symptoms that prompted the ordering of the test. The signs/symptoms can be reported as secondary diagnoses if their presence is not fully accounted for by the primary diagnosis. If the diagnostic test proves normal or did not provide a diagnosis, the primary diagnosis should be coded according to the signs and/or symptoms.

2. If for some reason, the interpreting physician does not have diagnostic information regarding the rational behind the ordering of the test and the ordering practitioner is unavailable, it is permissible by CMS standards to ask the patient or consult his/her medical record for clarification.

3. Incidental findings should never be coded as the primary diagnosis, even if they are far more serious than the primary diagnosis. For example, a patient who receives an X-ray for wheezing and is found to have degenerative joint disease of the spine will still have the symptoms of wheezing coded as the primary diagnosis.

4. In the case of unrelated or co-existing diagnoses (e.g., the wheezing was due to pneumonia, but the patient was also found to have hypertension), additional diagnoses may be reported (e.g., pneumonia is primary, hypertension secondary).

5. If a diagnostic test is ordered without sign/symptoms or some other prospective diagnosis, the corresponding screening diagnosis code (i.e. V code) will always be the primary diagnosis, even if the test results are abnormal. Any abnormality must be coded as a secondary diagnosis to the screening diagnosis code.

   Reference: Coding & Medicare Updates, The Medical Management Institute, October 2001

C. **Pathology Services**

1. Each medical center will need to establish internal procedures for capturing the professional fee component for pathology. Tissue extraction during surgery is part of the surgery.

2. Clinical pathology consultations generally consist of two types:

   a) A surgeon asks a pathologist whether, based on test results, patient history and medical records, the patient should be considered a candidate for surgery. The surgeon is requesting a medical judgment. Consultations of this nature are considered complex and should be reported under code 80502.

   b) An interpretive consultation (80500) is a consultation of limited duration requiring medical judgment in interpreting test findings and furnishing information directly related to the condition of the patient to the attending physician, which ordinarily cannot be furnished by a non-physician laboratory specialist.

XVI. RADIOLOGY

A. Radiology Services

1. Radiology procedures that require more than one CPT code will be captured within the Radiology file. Each site must review interventional radiology coding to see if procedures described by multiple codes are in the Radiology package and used appropriately.

2. When a radiology procedure is reduces, the correct reporting is to code the extent of the procedure performed. If no code exists for what has been done, report the intended code with modifier -52 appended.

B. Interventional Radiology: Non-Coronary Procedures

Interventional Radiology procedure codes include both diagnostic and therapeutic services. In most instances two codes are required for any one procedure. Most of the codes are distinct and don't inherently include other services that are easily performed at the same encounter or session. These procedures have no global period. Separate Evaluation and Management services performed the same day may be coded with the 25 modifier.

1. Arteriograms

a. Coding for these procedures requires determining the access site, the injection site and if these two differ, then the route used to get to the injection site. All vascular catheterizations are described as either selective or nonselective. In order to code vascular procedures correctly, you must know the puncture site, the final position of the catheter and whether normal anatomic conditions exist.

b. A vascular family is defined as a group of vessels that is fed by a primary vessel; the aorta, vena cava or vessel that was punctured. Vascular family includes:
   - Nonselective
   - First order – is the primary branch off of the nonselective vessel
   - Second order – any secondary branch and comes off of the first order vessel
   - Third order and higher – any tertiary branch and comes off of the second order vessel
   - Third order only applies to arterial procedures as no corresponding venous code exists.

   Example: The common carotid is first order because it connects to the aorta, the external carotid connects to the common carotid so it is 2nd order. Off the external carotid is the posterior auricular artery so it is 3rd order.

c. A non-selective catheterization means that an injection was performed inside the aorta, vena cava, or directly into the site punctured. Non-selective catheterization codes may be designated as bilateral with the 50 modifier when access is required from both sides. Vessels on the opposite sides (right and left) are separate vascular families. Nonselective codes include:

   Arterial System:
   36160 aorta, translumbar
   36200 aorta (femoral, axillary, or brachial or direct puncture)
   36100 carotid or vertebral
   36120 axillary or brachial (may be used as selective in certain circumstances)
   36140 extremity artery other than brachial or axillary (may be used as selective in certain circumstances)
   36145 arterial-venous dialysis shunt (regardless of which limb of graft or shunt is punctured)

Venous System:
36005 injection for contrast venography (use for injections into previously paced vascular access caths)
36010 superior or inferior vena cava
36400-36425 venipuncture
36481 portal vein

c. A selective catheterization means that the catheter must be manipulated, guided or moved from the aorta, vein or the vessel punctured into another part of the system. As a general rule, selective catheterization takes precedence over non-selective.

Arterial System:
36215-36218 thoracic, brachiocephalic arteries
36245-36248 abdominal, pelvic or lower extremity arteries

Venous System:
36011-36012 venous system
36013 right heart or main pulmonary artery
36014 right or left pulmonary artery
36015 segmental or subsegmental pulmonary artery

d. Within a vascular family the highest order catheterization is the primary code assigned. All the work necessary to reach this level is included in the code for that level. Note: Add-on codes exist for additional second/third order arteries after the first. There are no additional selective venous catheterization codes. Each additional second or third order vein catheterized is included in the code for the first vein and therefore not reported separately.

e. A separate selective catheterization code should be recorded for each injection site when the catheter has been moved from the aorta or the site accessed. If two punctures were performed to gain vascular access, both would be coded. It is possible to have 2 first order catheterization codes if , for example, the renal artery and the common iliac were studied. Add-on codes 36218 and 36248 are used for additional procedures in the same family and should be added to 36216-17 and 36246-47 respectively.

f. Supervision and Interpretation codes (75600-75774) will either contain a designation of selective or non-selective. These codes should be paired in definition with correct catheterization codes. A non-selective catheterization code may not go with a selective S&I code. 75774 is a selective add on code to be used after the first procedure in that vascular family. When a therapeutic procedure is performed, the S&I code is a separate service. Only when a full diagnostic service is necessary are both reported. See Transcatheter Procedures 2(e).

g. It sometimes may be necessary to perform aortography and also a separate study of the extremity where the access occurs. Code the catheterization of the aorta and also code the access site with the 59 modifier. Ipsilateral/contralateral studies are also coded by "unbundling" the access site with the 59 modifier.

h. Portal Vein system catheterization is a special case. If a specific vein is selected in addition to the portal vein it may be coded separately. The work for 36481 is much higher than for others and it would be listed as the primary procedure.

2. **Transcatheter Procedures**

a. These procedures are therapeutic in nature and include only the work described in the code. Angiography for guidance and documentation is included in the angioplasty. The placement of the catheter is reported in addition to the angioplasty. Modifier 59 is not necessary.

b. These procedures also have a paired Radiology Supervision and Interpretation code. The S&I code should agree with the procedure code. A diagnostic angiogram in conjunction with a therapeutic procedure is usually included. When the previous study is no longer valid, and documentation exists to support that, the additional S&I code may be reported.

c. There are codes for percutaneous and open. An alternative definition of open is "by cutdown".

d. If angioplasty is performed through an existing access, additional access should not be coded. For example: angiography is performed and then angioplasty performed immediately after.

e. Any full diagnostic angiography should be coded even if performed on the same date. Post procedure angiography is included in angioplasty, but not for embolization procedures. Do not report a diagnostic angiography S&I code unless a complete study has never been performed, or there is a clinical need to do another study. The additional need must be **clearly** documented in the record. Modifier 59 is required when this situation occurs.

f. Transluminal angioplasty should be coded for each *vessel* separately treated. All lesions in the same vessel are included in the one code.

g. If angioplasty and atherectomy are performed on the same vessel, both procedures should be coded. Note: Inflation of a positioning balloon catheter is not considered angioplasty.

h. Transcatheter infusion should be coded for each operative field. Example: If bilateral lower extremities are treated, the procedure is reported twice. Multiple vessels in the same leg would only have one code.

i. Angioscopy when performed in conjunction with these procedures may be coded using the add-on code 35400.

3. **Stents, Prostheses, and Endovascular Repair Procedures**

a. Stents, prosthetic placement and repair services do not include vascular access, diagnostic angiography, thrombolysis, or angioplasty.

b. These services are designated as percutaneous or open. Additional codes for a cutdown when placing a large prosthetic device are reported. See codes 34812-34813.

c. Angioplasty performed as a method of stent deployment or prosthetic placement is not coded separately.

d. As with angioplasty, post procedure angiography is included.

e. Add-on codes exist for additional placements after the first stent (37206 and 37208). Placement of extension devices for endovascular repair are reported separately.

f. Prostheses are coded by the type of the prosthetic, the location and the extent of the anomaly. When additional extensions are required, they are coded separately.

g. Both Category I and Category III CPT codes exist for different vessels to be repaired or a device deployed. Additional Category III CPT codes are added each year or converted to a Category I code to accommodate new technology. Be alert for these additions.

h. Supervision and Interpretation codes are paired with the actual procedure codes as they are for angiography. Parentheticals in the CPT book in both the 30000 and 70000 series guide the coder to the appropriate code for the other portion.

XVII. REHABILITATION

A. Audiology/Speech Pathology

Please refer to the latest edition of the Coding Handbook for Audiology and Speech Pathology.

B. Rehabilitation (KT, OT, and PT)

1. Services are covered when:
   - The therapy is performed to restore the patient's level of function which has been lost or reduced by illness or injury;
   - The therapy is reasonable and necessary for the treatment of a patient's condition;
   - There is expectation that the patient's condition or level of functioning will improve significantly in a reasonable and generally predictable period of time.

2. Services related to the general good and welfare of the patients, e.g., general exercises to promote overall fitness and flexibility and activities to provide diversion or general motivation, **do not** constitute physical therapy services. Palliative services provided solely for pain relief is not considered physical therapy.

3. Evaluation and management services performed on the same day for the same patient must be medically necessary. The patient's medical record must clearly document that a separate E&M service was performed in addition to the treatment.

4. Claims for specific rehab must indicate procedures or modalities performed and the appropriate ICD-9 diagnosis code must be indicated. When using procedure code 97039, 97139 or 97799 (unlisted physical medicine and rehabilitation codes), a description of the service or procedure is required.
   - **Supervised Modalities** - The application of a modality that does not require direct (one on one) patient contact by the provider: 97010-97028
   - **Constant Attendance Modality** - The application of a modality that requires direct (one-on-one) patient contact by the provider: 97032-97039
   - **Therapeutic Procedures** - Require one-on-one patient contact: 97110-97546
   - **Office Procedures** - When performing PT evaluations and reevaluations: 97001, 97002
   - **Tests and Measurements** - 97762, 97750, 97755
   - **EMG & Nerve Conduction Tests** - Technical and Professional Components: 95860, 95861, 95863, 95864, 95865, 95866, 95867, 95868, 95869
   - **EMG & Nerve Conduction Tests** - Technical Component Only: 95900, 95904, 95920, 95925, 95926, 95927, 95930-95937
   - **Neuromuscular Testing and Range of Motion** - 95831-95857
   - **Occupational therapy evaluation** - 97003
   - **Occupational therapy re-evaluation** - 97004
   - **Occupational therapist may report the following physical medicine procedures** – 97010-97039, 97110-97799
   - **Orthotic and Prosthetic Management** – 96660-97762

5. Rehab codes, without a timed increment, should not be reported in multiples.

6. Kinesiotherapy is the treatment of the effects of disease, injury, and congenital disorders by the use of therapeutic exercise and education. It is VHA policy that Kinesiotherapy treatment time and services provided within VA Nursing Home Care Units be documented in the Minimum Data Set (MDS). Physical modalities are not allowable for KT, and patients requiring such modalities must be provided by a physical therapist or by a PT assistant under the direction of a PT. (See the current VHA Directive on Kinesiotherapy.)

C. **Spinal Cord Injuries**

1. VERA data source for SCI is the PTF N501 transactions. A patient that was classified as SCI New Injury in a prior year is reclassified into the SCI Old Injury patient class when s/he presents to a VA in all subsequent treatment years. Old Injury Class is a permanent class for new injury patients from prior years that are not institutionalized. These patients have ICD-9 diagnosis codes indicating quadriplegia (344.0) or paraplegia (344.1).

2. A SCI patient with 91 BDOC in an SCI bed (treating specialty 22) in a fiscal year will be considered institutionalized and be placed in the New and Institutionalized SCI Class and funded at a higher price. Also included as institutionalized are SCI patients with at least 31 BDOC in a LTC bed, including intermediate or nursing home care treating specialty. (This definition will include SCI patients with multiple sclerosis residing in a LTC bed for at least 31 BDOC).

SCI Para – New Injury

806.2-806.7	Fracture of vertebral column with SCI
952.1-952.4	Spinal cord injury w/o evidence of spinal bone injury

SCI Para – Old Injury

344.1	Paraplegia, or
907.2	Late effect of spinal cord injury

SCI Quad – New Injury

806.0x-806.1x	Fracture of vertebral column with SCI
806.8-806.9	Fracture of vertebral column with SCI
952.0	Spinal cord injury w/o evidence of spinal bone injury
952.8-952.9	Spinal cord injury w/o evidence of spinal bone injury

SCI Quad – Old Injury

344.0	Quadriplegia and quadriparesis

D. **Stroke Patients**

Prior to FY2005, the terms stroke or CVA without further specification were assigned to code 436. These terms have been reindexed to code 434.91 (Cerebral artery occlusion, unspecified with cerebral infarction). An embolic stroke or CVA will code to 434.11 and a thrombotic stroke or CVA to code 434.01. With these changes, stroke and CVA will always be coded as with infarction. The data source for the Stroke patient class is the PTF N501 transactions. A patient is included in the Stroke patient class in either of the two ways listed below.

1. A primary diagnosis of Stroke, CVA or Occlusion (430 - 436):

430	Subarachnoid Hemorrhage
431	Intracerebral Hemorrhage
432.x	Other and unspecified Intracranial Hemorrhage
433.xx	Occlusion and Stenosis of Precerebral Arteries
434.xx	Occlusion of Cerebral Arteries
435.x	Transient Cerebral Ischemia
436	Acute, but ill-defined, Cerebrovascular Disease
997.02	Iatrogenic cerebrovascular infarction or hemorrhage

Followed by one of the following conditions:

784.3	Aphasia
784.5	Other speech disturbance
787.2	Dysphagia
342.0x - 342.9x	Hemiplegia and Hemiparesis
*344.00 - 344.09	Quadriplegia and Quadriparesis

***Note**: Although this is considered appropriate criteria using ICD-9 guidelines, coding ICD-9 codes 344.00 or 344.1 will result in the patient being placed in a Spinal Cord Injury (SCI)-Old Injury patient class.

OR

2. A primary (or secondary) diagnosis of 438.xx (Late effects of cerebrovascular disease), excluding the following:

438.0 Cognitive deficits
438.10 Speech and language deficits, unspecified
438.19 Other speech and language deficits
438.6 Alteration of Sensations
438.7 Disturbance of Vision
438.83 Facial Weakness
438.85 Vertigo
438.89 Other late effects of cerebrovascular disease
438.9 Unspecified late effects of cerebrovascular disease

XVIII. CODING GUIDELINES FOR OTHER SERVICES

A. Chaplains

Code "99499" will be used to capture chaplain visits.

B. Compensated Work Therapy Services (CWTS)

Refer to VHA Directive 2005-12, Encounter and Workload Capture for Psychosocial Rehabilitation Vocational Programs, dated March 10, 2005.

C. Dental

Assign Level II (HCPCS) "D" codes for dental procedures.

D. Nutrition

1. Diabetic Self-Management Training (DSMT) consists of a multidisciplinary team who provides an outpatient, educational services to patients diagnosed with diabetes. A dietitian may not be a sole provider unless they are performing the services in a rural area.

2. Medical Nutrition Therapy (MNT) is education provided by a registered dietitian or a licensed nutritional professional to patients who are diagnosed with either diabetes or chronic renal insufficiency; ESRD not on dialysis, or a medical condition of a kidney transplant beneficiary for 36 months following transplant.

1. No facility CPT E/M codes can be used in addition to therapy codes. The correct use of CPT codes for documenting MNT or DSMT are 97802 (used once a year for initial assessment of a new patient); 97803 (re-assessment and intervention); and 97804 (group visits). 97804 can also be used when there is a change in a patient's condition that affects the nutritional status of the patient and the patient is attending in a group. **Note:** Medicare supplements may require the use of G0270, G0271, G0108, and G0109. S9469 (diabetic management program, dietitian visit) may also be used for non-Medicare insurance policies.

2. **Coding Scenario/Initial Visit:** Patient with chronic kidney disease has a referral from a nephrologists to receive dietary counseling from a registered dietitian employed by the VA system. This is the initial session. The session lasts 30 minutes. Code V65.3 for the principal diagnosis, with 585.x as secondary. Code 97802x2 for the CPT codes.

Reference: CMS Transmittal AB-02-15, CMS Transmittal AB-03-009, CMS Transmittal AB-02-059, CPT Assistant April, 2003, pp. 10-11, CPT Assistant, November, 2003, pp. 2-3

E. Pharmacists

1. Whether the services provided by clinical pharmacists are reimbursable is a carrier specific determination. The only E&M code recognized for clinical pharmacists is 99211. If the pharmacist calls a patient to report dosage changes or other care management, CPT codes 99371-99373 for Telephone Calls should be used. They may use other HCPCS codes as applicable.

2. **Medication Therapy Management (0115T – 0117T).** New in 2006, these three codes reflect workload conducted by a Clinical Pharmacist. These services do not require a physicians request but can be initiated by the patient. These codes reflect the service normally conducted by a pharmacist who reviews the patient's history and medication profile and their need to stop duplications, potential drug interactions or an under or overdosing of the patient. The codes also include the communication or recommendations made by the pharmacist to the patient's provider. These codes are not to be used to describe the provision of product-specific information at the point of dispensing or any other routine dispensing-related activities. The encounter must be face-to-face.

Reference: CPT Changes 2006 – An Insider's View

F. **Social Workers (See also Mental Health)**

1. Licensed, independent social workers that do not meet the Medicare or VHA criteria for clinical social workers are limited in use of AMA CPT codes. Clinical social workers recognized by Medicare may use specific CPT and HCPCS codes for services rendered and bill Medicare and most insurance companies that follow Medicare guidelines.

2. VHA Social Work Service adopted the Event Capture System (ECS) to capture inpatient and outpatient workload. The Directory of Nationally Accepted Procedures, VHA Social Work Event Capture System/Decision Support Date Entry 2001 document establishes a national standard for DSS workload entry using a system of DSS identifiers and Social Work Intermediate Product Numbers that are cross referenced to CPT/HCPCS codes, available on the Social Work website: http://vaww.va.gov/socialwork.

XVIX. SPECIAL SCREENING/VHA PROGRAMS CODING GUIDELINES

A. **AIDS/HIV+**

AIDS/HIV+ must be coded only when confirmed and specifically documented by the physician. Reference the following codes when assigning codes to document these diagnoses:

- V01.7 Patient exposed to HIV/AIDS
- V73.89 Patient requesting test for HIV/AIDS
- V65.44 Patient returns for results and is negative
- 795.71 Nonspecific serologic evidence with inconclusive test results
- V08 Patient confirmed HIV+
- 042 Patient with confirmed diagnosis and disease manifestations

B. **Blood Pressure Screening**

1. A blood pressure taken by the nurse or doctor during an encounter is included as part of the evaluation and management visit code.

2. Coding for 24 hour ambulatory blood pressure: This is utilizing a system such as magnetic tape and/or computer disk, for 24 hours or longer, including recording, scanning, analysis, interpretation, and reporting.
   - To describe the visit, which initiated the monitoring on the first day, use 99211 if no physician is involved,
   - Use the appropriate E&M office visit code if a physician sees the patient, and the appropriate procedure code for the second visit.
     - Use 93786 to describe the recording;
     - Use 93790 for the interpretation, and
     - Use 93788 for the scanning analysis.
     - To describe the entire process, use code 93784.

   The second encounter on the next day will be the code describing the appropriate procedure from the above choices. *Do not use 93784 for routine blood pressure monitoring.*

C. **Compensation and Pension Exams**

1. For life insurance or disability insurance exams, code 99450. This code applies to new and established patients. When using this code, no treatment or management is performed. The basic life or disability examination includes measurement of height, weight and blood pressure, completion of medical history following life insurance *pro forma*, collection of blood or urine sample following chain of custody protocol, and report and documentation. The use of this code would be appropriate for physician staffs who are asked to fill out a life insurance policy and disability statement for a patient.

2. Compensation and pension service performed by the **treating physician** is coded 99455. The treating physician is the person who is currently managing the condition. This code applies to new and established patients. When using this code, no treatment or management is performed. However, if diagnostic tests are performed by the same provider at the same time of the C&P exam, the diagnostic tests should be coded separately, i.e. nerve conduction studies, EEG, or psychological tests. Compensation and pension exams include medical history, examination, formulation of diagnosis, assessment of disability and stability and calculation of impairment, development of treatment plan if appropriate, and report and documentation.

3. Compensation and pension service performed by **other than the treating physician** is coded 99456. This is a person who has not seen the patient prevsiously and was asked to complete the disability evaluation. This code applies to new and established patients. When using this code, no treatment or management is performed. However, if diagnostic tests are performed by the same provider at the same time of the C&P exam, the diagnostic tests should be coded separately, i.e. nerve conduction studies, EEG, or psychological tests. Compensation and pension exams include medical history, examination, formulation of diagnosis, assessment of disability and stability and calculation of impairment, development of treatment plan if appropriate, and report and documentation.

4. The codes (99455 or 99456) may be used by a non-physicians performing compensation and pension exams (e.g. audiologists, optometrists, podiatrists, or psychologists) based on your medical center's organizational structure. The same rule from above will apply on the code selection.

5. Assign code V70.5 as the primary diagnosis. Secondary diagnoses may be added as appropriate.

D. **Military Sexual Trauma (MST)**

1. The ICD-9-CM code (995.83), Adult Sexual Abuse, should be utilized for all patients reporting current military sexual trauma. Good rule of thumb is within six months of the assault. It may be necessary to query the provider if you are uncertain as to whether this is a current or residual effect of the MST. Add additional codes to identify any associated injuries and appropriate perpetrator (E967.x), if known.

2. The majority of counseling MST victims will be based on a residual effect (condition produced) after the acute phase of an illness or injury has terminated. Prolonged Post-Traumatic Stress Disorder (309.81) occurs in about one-third of all MST cases. In addition to the principal diagnosis (residual effect), V15.41, History of physical abuse, should be coded as a secondary diagnosis for the documented history of sexual abuse or rape.

E. **Other Registry Examinations**

1. The principal diagnosis for veterans receiving VHA registry exams, i.e. Agent Orange and Veteran Post-Deployment exams, will be coded as V70.5, Health exam of defined subpopulation (includes Armed Forces personnel). The E&M code will be from the Preventive Medicine Section (99381-99397). In cases whereby a social worker conducts a POW registry examination to enroll the patient and performs a biopsychosocial assessment, code 96150 will be used.

2. **Exception:** If an abnormality is encountered or a pre-existing problem is addressed in the process of performing a preventive medicine evaluation and management service, and if the problem/abnormality is significant enough to require additional work to perform the key components of a problem oriented E&M service, then the appropriate office/outpatient E&M code should be reported, in addition, to the preventive medicine service code. Append modifier –25 to the office E&M code to indicate that a significantly, separately identifiable E&M service was provided by the same physician on the same day as the preventive medicine service. If the abnormality or pre-existing problem does not require any additional work, then the separate E&M service should not be reported. The abnormality or pre-existing problems treated should be included in the encounter as secondary diagnoses.

F. **Persian Gulf War Syndrome**

Gulf War Syndrome has not been assigned specific ICD-9 diagnosis codes. In the absence of specific diagnoses, code the symptoms or complaints using the 780-799 range of codes (fatigue, joint pain, headache, memory loss, abdominal pain, diarrhea, irregular temperatures, tumors, etc.). Additionally, use E999, Late effects of injury due to war operations. Do not assign the code 799.9, Other ill-defined and unknown causes of morbidity and mortality, since this is a non-specific code and does not reflect the patient's condition.

G. **Telemedicine:**

1. Telemedicine is generally described as the use of communication equipment to link health care practitioners and patients in different locations. Reimbursement for services furnished through telemedicine applications are available as a cost-effective alternative to the more traditional ways of providing medical care.

2. Most states that provide payment for services furnished using telemedicine technology do so in the form of a physician consultation. Non-physician practitioners may also be covered depending on their scope of practice under state law. Teleradiology is assumed to be covered by all 50 States because of its prevalent use in many Radiology practices.

3. States covering medical services that utilize telemedicine may reimburse for both the provider at the hub site for the consultation, and the provider at the spoke site for an office visit.

4. CMS is now covering some telemedicine services and modifiers can be used for this service. If the note clearly states the service is via "telemedicine" then use the appropriate CPT code and append the "telemedicine modifier –GT".

XX. MISCELLANEOUS CODING GUIDELINES

A **Biological Warfare**

1. **Anthrax**

a. There are three types of anthrax: cutaneous anthrax (022.0), inhalation anthrax (022.1), and gastrointestinal anthrax (022.2).

b. Terrorism involving biological weapons, such as anthrax, is coded to E979.6. The terrorism E-code is the only E-code that should be assigned. Additional E-code to reflect assault (E968.8) should not be assigned. An E code to reflect exposure to anthrax as an assault may be reported as E968.8, Assault by other specified means. Code E997.1, Injury due to war operations by nuclear weapons, biological warfare, is reserved for acts that take place as part of a declared war-that is, military action.

c. A confirmed case of anthrax is coded to Category 022 (Anthrax). If the patient had a confirmed or suspected exposure to anthrax without manifestation of the infection, use V01.81, Contact with or exposure to communicable diseases, anthrax, as the primary diagnosis. If diagnostic test results are positive but the diagnosis of anthrax has not been confirmed, the abnormal finding should be reported (795.31, Nonspecific positive findings for anthrax). If there is no exposure and the patient merely is worried, code V65.5, Person with feared complaint in whom no diagnosis is made. Code V71.82 for a patient who is admitted for observation and evaluation for suspected exposure to anthrax.

d. Code V07.39, Other prophylactic chemotherapy, should be assigned as an additional code to report that the patient was placed on prophylactic antibiotic therapy. This code description is misleading at first glance but the alphabetic index clearly directs the coder to code V07.39 for prophylactic antibiotics. Reference: Journal of AHIMA, January 2002

2. **E-codes for Terrorism**

a. When the cause of an injury is identified by the Federal Government (FBI) as terrorism, the first-listed E-code should be a code from category E979, Terrorism. The terrorism E-code is the only e-code that should be assigned. Additional E codes from the assault categories should not be assigned.

b. When the cause of an injury is suspected to be the result of terrorism code from category E979 should not be assigned. Assign a code in the range of E codes based circumstances on the documentation of intent and mechanism.

c. Assign code E979.9, Terrorism, secondary effects, for conditions occurring subsequent to the terrorist event.

Reference: ICD-9-CM Official Guidelines for Coding & Reporting

B. **Health and Behavioral Assessments**

1. Health and Behavioral Assessment codes (96150-96155) are intended to be used by non-physician practitioners who have specialty or subspecialty training in the assessment and treatment for biopsychosocial factors affecting a patient's physical health problems. Codes are not to be used with a psychiatric diagnosis or represent a preventive medicine service.

2. This service identifies efforts to assess a patient's behavior and emotional state, as well as the cognitive and/or social factors that are important to the prevention, treatment, or management of the physical health problem. The focus of the assessment is not on mental health but on the biopsychosocial factors important to physical health problems and treatments.

3. These codes are intended to be reported according to the time spent providing these services. Therefore, documentation should include the total amount of time spent with the patient.

4. For patients that require psychiatric service (90801-90899) as well as health and behavior assessment/intervention (96150-96155), report the predominant service performed. Do not report these codes together on the same date. Please see various clinical vignettes in the CPT Assistant, Volume 12, Issue 3, March 2002.

C. **Non-Physician Extenders: "Incident to"**

VHA's position is not to follow CMS "incident to" guidelines since we will be billing the non-physician extender at a reduced rate under their own identifier. This CMS provision does not apply. These practitioners are VHA employees not physician employees.

D. **Pain Management**

1. There are various types of pain procedures performed by anesthesiologists and other health care providers. These procedures can be coded using CPT-4:

- Joint Injections: 20600 – small joints (fingers & toes)
  20605 – medium joints (wrist, elbow & ankle)
  20610 – large joints (knee, SI joint)
- Trigger Point: 20552 – single or multiple TP, one or two muscles(s)
  20553 – single or multiple TP, three or more muscle(s)
- Common Injections:
  64405 – occipital nerve block
  64415 – brachial plexus block
  64417 – axillary nerve block
  64425 – ilioinguinal/iliohypogastric block
  64510 – stellate ganglion block
  65520 – lumbar sympathetic block
- Nerve Blocks: 64420-64421 – intercostal nerve blocks
  4479-80 and 64483-64484 – paravertebral nerve blocks
- Facet: 64470 – cervical or thoracic, single level
  64472 – cervical or thoracic, each additional level
  64475 – lumbar or sacral, single level
  64476 – lumbar or sacral, each additional level
  64622 – destruct, lumbar or sacral, single level
  64623 – destruct, lumbar or sacral, each additional level
  64626 – destruct, cervical or thoracic, signle level
  64627 – destruct, cervical or thoracic, each additional level

2. Codes 64470-64476 are considered unilateral procedures. When bilateral injections are performed (e.g., injections performed at both the left and right paravertebral facet joints), the "-50" modifier should be appended to the appropriate code.

3. Since procedures 64470-64476 are generally performed under radiological guidance, they may be reported in conjunction with the appropriate radiology service rendered (e.g., fluoroscopy 76005).

4. Codes 64470-64476 are not intended to be used for local anesthesia during surgical procedures. Local anesthesia by the surgeon is included in the surgical procedure.

5. CPT codes 64470 or 64475 should be used to bill for the first vertebral level injected. Only one unit may be billed per level, per side, no matter how many injections are performed per side.

6. CPT codes 64472 or 64476 should be used to bill for any additional levels injected. Only one unit may be billed per side, no matter how many injections are performed per side.

7. Codes 64472 and 64476 are add-on codes and must be billed in addition to codes 64470 or 64475.

8. The specific level(s) injected, (e.g., L2, L3) must be documented on the claim.

9. When more than one drug is injected into the same site, (e.g., steroids and anesthetics), only one injection code is allowed.

10. Codes 64470-64476 should **not** be used for facet joint nerve destruction/neurolysis.

11. Code 20552-20553 are reported one time per session, regardless of the number of injections or muscles injected. Therefore, it would not be appropriate to report code 20552, Injection(s); single or multiple trigger point(s), one or two muscle(s) twice for the two injections administered.

E. **Pulse Oximetry**

Pulse oximetry (94760-94762) is a simple non-invasive method of monitoring the percentage of hemoglobin (Hb) which is saturated with oxygen. The decision to do a pulse oximetry often comes as a result of an E/M visit. Pulse oximetry is considered a bundled service by CMS with an E/M service. Codes 94760 and 94761 have a status indicator of "T" in the physician fee schedule, meaning they are always bundled with any other service that was performed on a patient that day. Code 94762 (overnight monitoring) has an active status which means it can be paid as a separate service, but that still doesn't mean you can get paid separately when billed.

Reference: Part B Answer Book, December 2003

F. **<u>Query Forms</u>**

1. Coders are expected to consult physicians for clarification and additional documentation prior to code assignment when there is conflicting or ambiguous data in the health record. Coders should also assist and educate providers by advocating proper documentation practices, further specificity, and resequencing or inclusion of diagnoses or procedures when needed to more accurately reflect the acuity, severity, and the occurrence of events.

2. The process of querying providers must be a patient-specific process, not a general process. Asking "blanket" questions is not appropriate. The query form should
   - be clearly and concisely written
   - contain precise language
   - present the facts from the medical record and identify why clarification is needed
   - present the scenario and state a question that asks the provider to make a clinical interpretation of a given diagnosis or condition based on treatment, evaluation, monitoring, and/or services provided
   - "open-ended" questions that allow the provider to document the specific diagnosis are preferable to multiple-choice questions or questions requiring only a "yes" or "no" response
   - should not indicate the financial impact of the response to the query
   - not be designed so that all that is required is a provider signature

3. A query must be documented in the patient's medical record. A periodic review of the query practice should include a determination of what percentage of the query forms are eliciting negative and positive responses from the provider.

G. **Teaching Physician and Resident Requirements**:

1. VHA Handbook 1400.1, "Resident Supervision" is the primary guidance for the documentation of care in teaching settings. In terms of billing, VHA Directive, 2005-054, "Revised Billing Guidance for Services Provided by Supervising Practitioners and Residents" should be followed.

2. CMS has approved the use of a new modifier, "GR", for use by VHA effective for services provided on or after January 1, 2006. "GR" modifier is defined by CMS as a service provided in whole or in part by a resident at a Department of Veterans Affairs Medical Center or Clinic, supervised in accordance with VA policy. Prior to January 1, 2006, the "GC" modifier was utilized.

H. **Tobacco**

A patient who currently uses tobacco products is coded to 305.1, Tobacco Use Disorder. E869.4 should be used to identify nonsmokers who have been exposed to “second-hand smoke”. A patient who has a past history of using tobacco products, regardless of when the patient quit smoking, is coded to V15.82. **Note:** Previous coding guidelines, prior to Version 6.0, stated the patient had to have quite smoking for more than one year. If less than a year, the coder was instructed to use 305.1.

MODIFIERS - CPT

The CPT system contains thirty-one modifiers. Modifiers –50 (bilateral), -52(when used to indicate a discontinued procedure), -53, -73, and –74 apply only to surgical procedures. General guidelines for using modifiers appear in the form of questions to be considered. If the answer to any of the following is yes, then it is appropriate to use the applicable modifier.

- Will the modifier add more information regarding the anatomic site of the procedure?
- Will the modifier help to eliminate the appearance of duplicate billing?
- Would a modifier help to eliminate the appearance of unbundling?

All modifiers are listed in Appendix A of CPT. CPT modifiers and their definitions are explained below.

-21 Prolonged Evaluation and Management Services

This modifier reports services that take more time or are greater than the highest level E/M code in a particular category. This modifier is used with codes such as 99205, 99215, 99223, 99233, 99245, 99255, etc.

-22 Unusual Services

The *Unusual Services* modifier has conceptually distinct uses in CPT. Its primary purpose is to denote circumstances for which a procedure or service required an "unusual" amount of time or effort to perform. As such, a higher fee is charged. A word of caution regarding the use of the unusual service modifier -- its use implies that the procedure or service was distinctly more time-consuming or difficult to perform. When using the modifier you <u>must</u> also send a special report to the insurance carrier that describes the unusual nature of the service and justifies the additional charge. Even when justified, it may be difficult at best to obtain higher than normal reimbursement from the majority of payers.

> Consider a surgical procedure that typically requires one to two hours to perform. Reimbursement from payers will be the same whether the procedure takes one or two hours. Why? Reimbursement averages out across patients over time. The use of the unusual services modifier would be inappropriate if the procedure took two hours, just as use of the reduced service modifier would not be appropriate if the procedure took one hour.
>
> However, use of the unusual services modifier would be more appropriate with the above hypothetical surgery if the operation was very difficult and required three hours to perform because the patient was obese.

The -22 modifier has other specific uses in CPT

> For example, in the Psychiatry section, the unusual services modifier is sometimes used to communicate that the patient was seen for a period greater than is customary.

-23 Unusual Anesthesia

Under some circumstances general anesthesia is given when normally either a local or no anesthesia is provided.

> For example, performing a cystoscopy on a three-year-old child would likely require a general anesthesia, whereas the same procedure on an adult would not. Thus, use of a general anesthetic when performing a cystoscopy is an example of unusual anesthesia.

Insurance companies will want to know why the anesthesia was required. Therefore, when submitting the unusual anesthesia modifier be sure to include a report that focuses on the circumstances which required that the patient receive a general anesthetic. The use of this modifier is generally restricted to anesthesiologists.

-24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period

This modifier allows the physician to report that a service was performed during a postoperative or global period for a reason(s) unrelated to the original procedure. Modifier –24 should be billed with an E/M code. Do not use this modifier with a surgical code. The diagnosis code used must support the service.

> For example, a patient who is being followed by her gynecologist during a pregnancy comes in for an additional visit because she has developed acute bronchitis. The bronchitis is unrelated to the pregnancy and necessitated an additional visit over and above her regular pregnancy check-ups. The E/M code for the visit is billed to the insurance carrier with a –24 modifier and the diagnosis code used is 466.0 for Acute Bronchitis.

-25 Significant Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

This modifier indicates that on a day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. Assign the proper E/M code and amount as appropriate for the service rendered.

The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding the modifier –25 to the appropriate level of E/M service. Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery.

Modifier –25 should be appended only to E&M service codes within the range of 92002-92014, 99201-99499, and with HCPCS codes G0101 and G0175

-26 Professional Components

Many listed procedures consist of both technical and professional components. Technical components include such things as equipment, technician time, and supplies that are used in the performance of a procedure. The professional component refers to the physician's time, skill, and judgment in interpreting the results of tests and procedures.

> For example, consider the simple chest X-ray described in code 71010. If the radiograph of the patient's chest is taken in the physician's office utilizing both the physician's equipment and staff, the charge for the chest X-ray will include the use of the equipment, film, chemicals, and staff time as well as the physician's time to interpret the X-ray itself. As such, the charge for code 71010 will include both the technical and professional components.

In contrast to the above example, suppose that the physician does not have X-ray equipment, and refers the patient to a local hospital where the "picture" will be taken. The hospital, in turn, sends the X-ray to a radiologist who interprets the chest X-ray The radiologist would bill the patient for interpreting the radiograph only and use the "-26" professional component modifier as shown below.

71010-26 Interpretation, single view chest X-ray

By the use of this modifier, the radiologist can restrict his or her charge to the professional component -- the interpretation.

-27 Multiple Outpatient Hospital E/M Encounters on the Same Date

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and district E&M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding the modifier –27 to each appropriate level outpatient and/or emergency department E/M code(s). This modifier provides a means of reporting circumstances involving evaluation and management services provided by physician(s) in more than one (multiple) outpatient hospital settings(s).

Modifier –27 should be appended only to E/M service codes within the range of 92002-92014, 99201-99499, and with HCPCS coded G0101 and G0175.

-32 Mandated Services

Mandated services are those requested by an insurance carrier, peer review organization, utilization review panel, HMO, PPO or other entity. Typically, the request is for a second or third opinion regarding a patient's illness or treatment. When mandated services are requested, the physician performing the service is usually required to accept assignment from the payer, and in turn, the payer reimburses the doctor 100 percent of the payer's allowable for the service.

An example of a mandated service would be an extended additional opinion consultation. This would be reported as: 99274-32

The -32 modifier is used to alert the payer's claim processors that the service was mandated and should receive special handling.

-47 Anesthesia by Surgeon

When the surgeon is required to provide the general anesthesia services normally handled by an anesthesiologist, the circumstance should be noted by adding the -47 or 09947 modifier to the surgery codes(s). This modifier is often used by surgeons working in rural areas where the services of anesthesiologists or nurse anesthetists are not always available. To report the modifier, list the surgery code(s) a second time, and place the modifier on the second code.

For example, suppose the surgeon removed a ruptured appendix from a patient and also provided a general anesthetic. The surgeon would code as follows:

44960	Appendectomy, ruptured appendix
44960-47	Anesthesia for appendectomy

Listing separate charges for each of the services would be appropriate.

-50 Bilateral Procedures

The bilateral modifier is restricted to surgical procedures only (CPT codes 10040 – 69990). It is not required for radiology procedure codes or diagnostic procedure codes.

Procedures are now assumed to be unilateral unless they are either always performed bilaterally or are otherwise noted in CPT. The most commonly accepted method of reporting bilateral procedures is to list the procedure twice and add the "-50" modifier to the second procedure.

For example, Otoplasty is performed one a patient's left and right ears:

69300-RT	Otoplasty, protruding ear RIGHT
69300-50-LT	Otoplasty, protruding ear LEFT

Note that the words "right" and "left" have been added to clarify that the procedures were indeed performed bilaterally. Also, it is common for physicians to report their full charge for each procedure and let the payer reduce the amount on the second, or bilateral, procedure.

Some payers accept an alternative method of billing bilateral procedures. This method involves listing the procedure once and adding the "-50" modifier as shown below:

69300-50	Otoplasty, protruding ear, bilateral

If this method is used, place a "2" in the UNITS column of the claim form so that the payer is aware that two procedures were performed. The charge reported on the claim for the procedures is typically twice that of what the physician charges for performing one of the procedures.

Bilateral procedures are identical procedures (i.e., you use the same CPT code) performed on the same anatomic site but on opposite sides of the body. Furthermore, in most instances, each procedure must be performed through its own separate incision to qualify for bilateral.

Note: Modifier –50 does not apply to radiology procedures.

-51 Multiple Procedures

This modifier has traditionally been used to identify multiple surgical procedures performed on a patient during the same operative session. It is applicable when unrelated procedures are performed during the same operative session or when multiple related procedures are performed and there is no single inclusive code available. List the major procedure or service (most revenue intensive) first on the HCFA-1500 claim form, than attach modifier –51 to each applicable secondary procedure code.

For example, the repair of a simple neck wound and the closed treatment of a clavicle fracture would be coded as:

23500	Treatment closed clavicle fracture without manipulation
12005-51	Simple closure neck wound

Note that the higher charge procedure (fracture treatment in this case) is listed first and the multiple procedure modifier is added to the lesser or secondary service. If three procedures had been performed, the services would be ranked from highest to lowest charge on the claim form and the "-51" modifier would be added to all but the first (highest charge) procedure.

-52 Reduced Service

Just as the unusual services modifier (-22) is used to denote abnormally difficult or time-consuming procedures, the reduced service modifier -52 or 09952 signifies the opposite: that a procedure was reduced or eliminated in part.

> For example, consider the physician who removes a coccygeal pressure ulcer and performs a coccygectomy but does not use a primary suture or skin flap closure. (The physician wants to continue cleansing the wound for a period of time before closing.) The proper way to report the procedure would be:
>
> 15920-52
>
> At a later date the physician would code for the appropriate wound closure procedure.

Many coders mistakenly use the "-52" modifier to reduce a charge for a patient who is indigent. The physician performed the procedure or service as described, but did not want to charge the patient the full amount. The "-52" modifier should NOT be used for this purpose.

Effective January 1, 1999, a new modifier –73 replaces modifier –52 for reporting discontinued services. Modifier –52 still applies to radiology services for "reduced" but not terminated procedures.

-53 Discontinued Procedure

This modifier indicates that the physician elected to terminate a surgical or diagnostic procedure. A surgical procedure may have been started, but because of extenuation or threatening circumstances was discontinued. Modifier –53 is not used to report elective cancellation of a procedure prior to the anesthesia induction and/or surgical preparation in the operating suite.

Effective January 1, 1999, a new modifier –74 replaces modifier –53 for reporting these discontinued services. Modifier –53 will not longer be an acceptable modifier for hospital reporting to include radiology procedures.

-54 Surgical Care Only

When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified.

-55 Postoperative Management Only

When one physician performs the postoperative care and evaluation and another physician performs the surgical procedure, the postoperative component may be identified by adding the modifier '-55' to the usual procedure number.

-56 Preoperative Management Only

When only one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by addition the modifier '-56' to the usual procedure number.

-57 Decision for Surgery

Modifier –57 identifies an evaluation and management service that results in the initial decision to perform surgery. Even though modifier –57 is included in the guidelines for evaluation and management, surgery, and medicine services, it should only be reported with E/M codes. It is to be used in circumstances where a major surgery is performed within less than 24 hours of the initial evaluation.

Medicare has said that practices should use –57 only with major surgical procedures. These are defined as procedures having a preoperative period one-day before the surgery and 90 days afterward in the postoperative period. Many commercial carriers have also adopted this ruling.

Example: A patient presents to the emergency department complaining of acute lower abdominal pain. She is evaluated by a general surgeon who determines that she has a ruptured appendix. He immediately transfers her to the operating suite and performs an appendectomy. The services would be coded as follows:

99284-57	Emergency room E/M service
44960	Appendectomy for ruptured appendix

-58 Staged or Related Procedure or Service by the Same Physician during the Postoperative Period

There are three ways to use modifier –58:

1. For a surgery result planned in stages – a staged procedure

   Example: 54308-58 would be used for "urethroplasty for second stage hypospadias repair; less than 3 cm" if this second stage was performed during the postoperative period of the first procedure.

2. To report a more extensive procedure performed during the postoperative period of a less extensive procedure.

   Example: 54352-58 would be used for "repair of hypospadias cripple requiring extensive dissection" if the procedure was performed during the postoperative period of 54308 above.

3. To report a therapy given after a diagnostic surgical procedure

   Example: 29870 "diagnostic knee arthroscopy", carries a 90-day global period. If a claim is reported under the same surgeon's name for physical therapy during the 90-day postoperative period, 97124-58 should be reported for the massage therapy.

-59 Distinct Procedural Service

Modifier –59 allows the physician to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier –59 is appropriate for procedures or services that are not normally reported together, but are appropriate under the circumstances. CPT states that modifier –59 may represent a different session or patient encounter, different site or organ system, separate incision or excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same date by the same physician.

Example: On Monday, a dermatologist performs a biopsy on the face. On Thursday, following the results of the biopsy, he removes the 2 cm malignant lesion and does another biopsy of a different site on the face. The services performed on Thursday are reported as follows:

11642	Excision malignant lesion, face
11100-59	Biopsy

62 Two Surgeons

This modifier has two distinct uses.

First, it is reported when two physicians are acting as co-surgeons. That is, each surgeon is acting as a "primary" surgeon performing a different aspect of a complex procedure.

Example: a laminectomy is performed jointly by a neurosurgeon and an orthopedic surgeon. Each physician might list the following on his/her claim:

63045-62 Laminectomy, cervical

Third party payers often allow sixty percent of their prevailing to each surgeon in such cases.

Second, the two surgeons modifier may be used when two primary surgeons, usually in different specialties, perform different procedures on a patient during the same operative session.

Example: a general surgeon performs a windpipe incision on a trauma patient while another surgeon works to stop the patient's bleeding. Each surgeon could list his/her CPT code(s) with the addition of the "-62" modifier thus denoting that the services were performed during the same operative session.

Note that in the first example, each surgeon reported the same CPT code. Use of the two surgeons modifier is important in such circumstances: it helps ensure that the payer understands that two surgeons were involved in performing the procedure and that double billing is not taking place. In the second example, each surgeon reported different CPT codes. Use of the two surgeons modifier is not as important in this situation.

Due to increasing third party payment restrictions, it may be helpful to send a special report (KISS letter) with the claim that explains and justifies the need for two Primary surgeons. Some payers may assume that the procedure(s) can be performed by a primary surgeon and an assistant rather than by two primary surgeons.

-66 Surgical Team

Certain complex surgical procedures require the skills of more than two surgeons. A good example is the surgical team that implants an artificial heart. As with the "62" modifier, the physicians performing the surgery usually have different skills or specialties. Each member of the team would add the -66 or 09966 modifier to the procedures he/she performed as part of the surgical team.

As with the two surgeons situation, it may be necessary to communicate the need for the team of surgeons to the insurance company. This is especially true in cases where the need for the team may not be immediately obvious to the claims processor.

-73 Discontinued Out-Patient Hospital/Ambulatory Surgery Center Procedure Prior to the Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well being of the patient, the physician may cancel a surgical or diagnostic procedure subsequent to the patient's surgical preparation (including sedation when provided, and being taken to the room where the procedure is to be performed), but prior to the administration of anesthesia (local, regional block(s) or general). Under these circumstances, the intended service that is prepared for but canceled can be reported by its usual CPT procedure code with the addition of this modifier.

-74 Discontinued Out-Patient Hospital/Ambulatory Surgery Center Procedure after Administration of Anesthesia

Due to extenuating circumstances or those that threaten the well being of the patient, the physician may terminate a surgical or diagnostic procedure after the administration of anesthesia or after the procedure was started (incision made, intubation started, scope inserted, etc).

The elective cancellation of a service prior to the administration of anesthesia and/or surgical preparation of the patient should not be reported. For physician reporting of a discontinued procedure, see modifier -53.

-76 Repeat Procedure By Same Physician

-77 Repeat Procedure By Another Physician

These two modifiers are to be used when the procedure has been repeated subsequent to the original service. You need to submit these modifiers because, without them, the insurance company may think you accidentally double billed for the service.

Example: A patient is brought to the hospital with internal hemorrhaging that is repaired surgically. Three days after surgery, the patient begins hemorrhaging again and the surgeon must perform the same repair again. Would you use the repeat procedure modifier on the second repair? Yes, assuming that the same procedure code was being reported. If a different physician had performed the second repair, he/she would use the 77 modifier.

It may be necessary to send a special report with the claim explaining why the procedure needed to be repeated. This is appropriate in cases where the need for the repeat may not be clear to the carrier.

-78 Return to the Operating Room for a Related Procedure during the Postoperative Period

Modifier –78 reports related procedures performed in the operating room within the assigned postoperative period of a surgical. This modifier is often utilized when the patient develops a complication that requires a return trip to the operating room for intervention.

Example: A patient’s operative site bleeds after an initial surgery and requires a return to the operating room to stop the bleeding, the same procedure is not repeated. Thus a different code, 35860, exploration for postoperative hemorrhage, thrombosis or infection; extremity, would be reported with the -78 modifier appended. Since the same procedure is not repeated, modifier –76 would not be appropriate to use.

-79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

Modifier –79 notifies payers that the procedure was performed during the postoperative period of another procedure but is *not* related to that surgery. The diagnostic codes must document medical necessity of the service, so the ICD-9-CM codes are usually different for this service from those reported with the initial procedure.

Example: A patient has a femoral-popliteal graft (35556) and goes home. The incision and graft heal well. However, the patient develops acute renal failure a week after being home and is hospitalized. The patient does not respond to medical treatment of the renal failure. Hemodialysis is indicated, and a second physician inserts a cannula for hemodialysis (36810).

The services of the second surgeon are reported as 36810-79 because this service is unrelated to the femoral-popliteal bypass graft performed during the previous hospitalization.

If the –79 modifier is not appended to this procedure, the third-party payer may not know that this service is not related to the femoral-popliteal graft (i.e., the computer program used by the third-party payer may not be able to distinguish that this service is not related to the previous surgery and may automatically reject this claim).

Providing documentation to indicate the service is unrelated to the first procedure may be helpful compared to clearing up a problem retrospectively.

-80 Assistant Surgeon

One physician assists another physician in performing a procedure. If an assistant surgeon assists a primary surgeon and is present for the entire operation, or a substantial portion of the operation, then the assisting physician reports the same surgical procedure as the operating surgeon. The operating surgeon does not append a modifier to the procedure that he/she reports. The assistant surgeon reports the same CPT code as the operation physician, with modifier –80 appended.

Example: To report a closure of intestinal cutaneous fistula, the primary operating surgeon reports code 44640, and the assistant surgeon reports 44640-80. The individual operative report submitted by each surgeon should indicate the distinct service provided by each surgeon.

-81 Minimum Assistant Surgeon

At times, while a primary operating physician may plan to perform a surgical procedure alone, during an operation circumstances may arise that require the services of an assistant surgeon for a relatively short time. In this instance, the second surgeon provides minimal assistance, for which he/she reports the surgical procedure code with the –81 modifier appended.

-82 Assistant Surgeon (Where Qualified Resident Not Available)

The prerequisite for using the –82 modifier is the unavailability of a qualified resident surgeon. In certain programs (e.g., teaching hospitals), the physician acting as the assistant surgeon is usually a qualified resident surgeon. However, there may be times (e.g., during rotational changes) when a qualified resident surgeon is not available and another surgeon assists in the operation. In these instances, report the services of the nonresident-assistant surgeon with the –82 modifier appended to the appropriate code. This indicates another surgeon is assisting the operating surgeon instead of a qualified resident surgeon.

-90 Reference (Outside) Laboratory

When the physician bills the patient for lab work that was performed by an outside (or "reference") lab, add the -90 or 09990 modifier to the lab procedure codes. Physicians should never bill Medicare or Medicaid patients for lab work done outside their office.

Example: An internist performs an examination of a patient and, as part of the exam, orders a complete blood count. He does not perform in-office lab testing. He has an arrangement with a laboratory to bill him for the testing procedure, and, in turn, he bills the patient. The physician's staff performs the venipuncture. The physician reports the appropriate E/M code, the venipuncture (36415), and 85024-90 for the CBC performed by the outside lab.

-91 Repeat Clinical Diagnostic Laboratory Test

May be appended to a laboratory test code to indicate that a laboratory test was performed multiple times on the same day, for the same patient, and that it was necessary to obtain multiple results in the course of treatment. Modifier –91 is not intended to be used when
laboratory tests are rerun to confirm initial results due to testing problems encountered with specimens or equipment; or for any other reason when a normal, one-time, reportable results is all that is required. Modifier –91 may not be used when there are other code(s) to describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing).

-99 Multiple Modifiers

If two or more <u>different</u> modifiers are added to the same procedure, a third modifier, the -99 or 09999 can be added to alert the carrier to the fact that two or more modifiers are associated with the procedure.

For example, to report for the physician who assisted on a bilateral subcutaneous mastectomy (19182) you would code as shown below. Since the procedure is bilateral, you must list each procedure separately. In this case, each procedure will list the assistant surgeon modifier (-82), and the second, bilateral procedure requires the use of the -50 modifier. Since there are two modifiers on the second procedure, the -99 modifier is listed.

19182-82 (for the first procedure)

19182-99 (-99 for multiple modifiers on second procedure)
or
19182-50/82

Most carriers require that you have a charge for each line used on the claim form. Thus, you may want to string the modifiers together on the same line on the claim form. You can do this by putting the -99 modifier next to the code in the procedure column and listing the other modifiers in the procedure description column.

MODIFIERS - HCPCS

Generally, HCPCS Modifier codes are required to add specificity to the reporting of procedures performed on eyelids, fingers, toes, and arteries. They may be appended to CPT codes. If more than one level II modifier applies, repeat the HCPCS code on to another line with the appropriate level II modifier:

EXAMPLE: Code 26010 (drainage of finger abscess; simple) done on the left hand thumb and second finger would be codes:
26010FA
26010F1

LT	Left side (used to identify procedures on the left side of the body)
RT	Right side (used to identify procedures performed on the right side of the body)
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower left, eyelid
FA	Left hand, thumb
F1	Left hand, second digit
F2	Left hand, third digit
F3	Left hand, fourth digit
F4	Left hand, fifth digit
F5	Right hand, thumb
F6	Right hand, second digit
F7	Right hand, third digit
F8	Right hand, fourth digit
F9	Right hand, fifth digit
TA	Left foot, great toe
T1	Left foot, second digit
T2	Left foot, third digit
T3	Left foot, fourth digit
T4	Left foot, fifth digit
T5	Right foot, great toe
T6	Right foot, second digit
T7	Right foot, third digit
T8	Right foot, fourth digit
T9	Right foot, fifth digit
GC	This service has been performed in part by a resident under the direction of a teaching physician prior to January 1, 2006
GE	This service has been performed by a resident without the presence of a teaching physician under the primary care exception
GR	This service has been performed in part by a resident under the direction of a teaching physician after January 1, 2006 (specific code to VHA only)

LD Left anterior descending coronary artery (LAD)
LC Left circumflex coronary artery
RC Right coronary artery (RCA)

QM Ambulance service provided under arrangement by provider of services
QN Ambulance service furnished directly by provider of services

Anesthesia Modifiers (Physical Status)

P1-A A normal healthy patient.
P2-A A patient with mild systemic disease.
P3-A A patient with severe systemic disease.
P4-A A patient with severe systemic disease that is a constant threat to life.
P5-A A moribund patient who is not expected to survive without the operation.
P6-A A declared brain-dead patient whose organs are being removed for donor purposes.

Note: P1-P6 will be used when VHA begins to bill for unit-based components for anesthesia.

Other

AA Anesthesia services performed personally by anesthesiologist
AD Medically supervised by a physician for more than four concurrent procedures
QK Medically directed by a physician: two, three, or four concurrent procedures
QX CRNA with medical direction by a physician
QY Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist
QZ CRNA without medical direction by a physician

Monitored Anesthesia Care

The QS modifier is reported in addition to one of the above modifiers to indicate monitored anesthesia care was provided. The QS modifier should always be reported in the second position.

QS Monitored anesthesia care service (MAC)
MAC involves the intraoperative monitoring of the patient's vital physiological signs in anticipation of the need for administration of general anesthesia or of the development of adverse physiological patient reaction to the surgical procedures.

G8 Monitored anesthesia care (MAC) for deep, complex, complicated, or markedly invasive surgical procedure. (Applicable to CPT 00100, 00400, 00160, 00300, 00532, 00920)
Note: The G8 modifier should not be reported in conjunction with a "QS" modifier, but it must be reported with the pertinent anesthesia payment modifier for personally performed anesthesia or medical direction.

G9 Monitored anesthesia care (MAC) for patient who has history of severe cardio-pulmonary condition. *(Reference: HCFA Transmittal No. B-99-17 Date April 1999 and HCFA Transmittal No. B-99-38 Date November 1999)*

Therapists Modifiers

GN Speech language therapy
GO Occupational therapy
GP Physical therapy

EVALUATION AND MANAGEMENT SERVICES TABLE

	Office or Other Outpatient Services				**Key**
Type of Patient	**History**	**Examination**	**Medical Decision**	**Code**	**Component**
New Patient	Problem Focused	Problem Focused	Straightforward	99201	3 of 3
	Expanded Problem	Expanded Problem	Straightforward	99202	3 of 3
	Detailed	Detailed	Low Complexity	99203	3 of 3
	Comprehensive	Comprehensive	Moderate Complexity	99204	3 of 3
	Comprehensive	Comprehensive	High Complexity	99205	3 of 3
Established Patient	Chief Complaint and Description of Service			99211	Time
	Problem Focused	Problem Focused	Straightforward	99212	2 of 3
	Expanded Problem	Expanded Problem	Low Complexity	99213	2 of 3
	Detailed	Detailed	Moderate Complexity	99214	2 of 3
	Comprehensive	Comprehensive	High Complexity	99215	2 of 3
	Hospital Observation Services				**Key**
Type of Patient	**History**	**Examination**	**Medical Decision**	**Code**	**Component**
Observation Care d/c	Final Exam, Discussion of Hosp. Stay, Instruction for Care			99217	
Initial observation Care	Detailed or Comp.	Detailed or Comp.	Straightforward/Low	99218	3 of 3
New or Established	Comprehensive	Comprehensive	Moderate Complexity	99219	3 of 3
	Comprehensive	Comprehensive	High Complexity	99220	3 of 3
	Hospital Inpatient Services				**Key**
Type of Patient	**History**	**Examination**	**Medical Decision**	**Code**	**Component**
Initial Hospital Care	Detailed or Comp.	Detailed or Comp.	Straightforward/Low	99221	3 of 3
New or Established	Comprehensive	Comprehensive	Moderate Complexity	99222	3 of 3
	Comprehensive	Comprehensive	High Complexity	99223	3 of 3
Subsequent Hospital Care	Problem Focused	Problem Focused	Straightforward/Low	99231	2 of 3
	Expanded Problem	Expanded Problem	Moderate Complexity	99232	2 of 3
	Detailed	Detailed	High Complexity	99233	2 of 3
Observation or Inpatient Care Services	Detailed or Comp.	Detailed or Comp.	Straightforward/Low	99234	3 of 3
	Comprehensive	Comprehensive	Moderate Complexity	99235	3 of 3
	Comprehensive	Comprehensive	High Complexity	99236	3 of 3
Hospital d/c Service (<30 min)	Final Exam, Discussion of Hosp. Stay, Instruction for Care			99238	Time
Hospital d/c Service (> 30 min)	Final Exam, Discussion of Hosp. Stay, Instruction for Care			99239	Time
	Consultations				**Key**
Type of Patient	**History**	**Examination**	**Medical Decision**	**Code**	**Component**
Office or Other Out-Patient Consults	Problem Focused	Problem Focused	Straightforward	99241	3 of 3
New or Established Pt	Expanded Problem	Expanded Problem	Straightforward	99242	3 of 3
	Detailed	Detailed	Low Complexity	99243	3 of 3
	Comprehensive	Comprehensive	Moderate Complexity	99244	3 of 3
	Comprehensive	Comprehensive	High Complexity	99245	3 of 3
Initial Inpatient Consultation					
New or Established Pt	Problem Focused	Problem Focused	Straightforward	99251	3 of 3
	Expanded Problem	Expanded Problem	Straightforward	99252	3 of 3
	Detailed	Detailed	Low Complexity	99253	3 of 3
	Comprehensive	Comprehensive	Moderate Complexity	99254	3 of 3
	Comprehensive	Comprehensive	High Complexity	99255	3 of 3
Follow-Up Inpatient Consults	Problem Focused	Problem Focused	Straightforward	99261	2 of 3
Established Patient	Expanded Problem	Expanded Problem	Moderate Complexity	99262	2 of 3
	Detailed	Detailed	High Complexity	99263	2 of 3
Confirmatory Consultation	Problem Focused	Problem Focused	Straightforward	99271	3 of 3
New or Established Pt	Expanded Problem	Expanded Problem	Straightforward	99272	3 of 3
In or Out Patient	Detailed	Detailed	Low Complexity	99273	3 of 3
	Comprehensive	Comprehensive	Moderate Complexity	99274	3 of 3
	Comprehensive	Comprehensive	High Complexity	99275	3 of 3

	Emergency Department Services				Key
Type of Patient	**History**	**Examination**	**Medical Decision**	**Code**	**Component**
New or Established Patient	Problem Focused	Problem Focused	Straightforward	99281	3 of 3
	Expanded Problem	Expanded Problem	Low Complexity	99282	3 of 3
	Expanded Problem	Expanded Problem	Moderate Complexity	99283	3 of 3
	Detailed	Detailed	Moderate Complexity	99284	3 of 3
	Comprehensive	Comprehensive	High Complexity	99285	3 of 3
Other Emergency Services	Physician directed emergency care via two-way voice communication			99288	
	Critical Care Services				**Key**
Type of Patient				**Code**	**Component**
Unstable Pt (1/2hr – 1 hr 14 min.)	Total duration of time continuous or not on one date			99291	Time
Unstable Pt (each additional 30 min.)*	Total duration of time continuous or not on one date			99292	Time
*Critical care of less than 15 min. beyond the first hour or less than 15 min. beyond the final 30 min. is not reported separately.					
	Home Services				**Key**
Type of Patient	**History**	**Examination**	**Medical Decision**	**Code**	**Component**
New Patient	Problem Focused	Problem Focused	Straightforward	99341	3 of 3
	Expanded Problem	Expanded Problem	Low Complexity	99342	3 of 3
	Detailed	Detailed	Moderate Complexity	99343	3 of 3
	Comprehensive	Comprehensive	Moderate Complexity	99344	3 of 3
	Comprehensive	Comprehensive	High Complexity	99345	3 of 3
Established Patient	Problem Focused	Problem Focused	Straightforward	99347	2 of 3
	Expanded Problem	Expanded Problem	Low Complexity	99348	2 of 3
	Detailed	Detailed	Moderate Complexity	99349	3 of 3
	Comprehensive	Comprehensive	High Complexity	99350	3 of 3
	Prolonged Services				**Key**
Type of Patient				**Code**	**Component**
Outpatient or Office Setting	Patient Contact , 1 hour			99354	Time
	Patient Contact each additional 30 min.			99355	Time
Inpatient Setting	Patient Contact , 1 hour			99356	Time
	Patient Contact each additional 30 min			99357	Time
Without Direct Face to Face Pt Contact					
Out Pt or Office Setting	Before or after direct face to face patient care, , 1 hour			99358	Time
	Before or after direct face to face pt care, each additional 30 min			99359	Time
Physician Standby Services	Each full 30 minute unit of standby services provided			99360	Time
	Case Management Services				**Key**
Type of Patient				**Code**	**Component**
Team Conferences	Medical conference approximately 30 min			99361	Time
	Medical conference approximately 60 min			99362	Time
Telephone calls	Consulting, Medical Management, Coordinating Medical Management			99371	
	Intermediate			99372	
	Complex or lengthy			99373	
	Preventive Medicine Services				**Key**
Type of Patient				**Code**	**Component**
New Patient	18-39 years			99385	Age
	40-64 years			99386	Age
	65 years and older			99387	Age
Established Patient	18-39 years			99395	Age
	40-64 years			99396	Age
	65 years and over			99397	Age

	Preventive Medicine Services		**Key**
Type of Patient		**Code**	**Component**
Counseling and/or Risk Factor Reduction			
Preventive Med, Individual	Approximately 15 min	99401	
	Approximately 30 min	99402	
	Approximately 45 min	99403	
	Approximately 60 min	99404	
Preventive Med, Group	Approximately 30 min	99411	Time
	Approximately 60 min	99412	
Other Preventive Medicine Services			
Administration & Interpretation		99420	
Unlisted Preventive		99429	
	Special Evaluation and Management Services		
Type of Patient		**Code**	
Basic Life and/or Disability Evaluation		99450	
Work Related or Medical	Exam by treating physician	99455	
Disability Evaluation	Exam by someone other than treating physician	99456	

NOTE: 1995 and 1997 E&M documentation guidelines can be referenced at website: www.cms.hhs.gov/medlearn/emdoc.asp

HPI DEFINITIONS:

Location: Described where on the body the symptom is occurring, i.e., Chest pain, abdominal pain, sore throat, knee swelling. Diffuse or localized? Unilateral or bilateral? Fixed or migratory? Not every history gives location.

Severity: Is a rank of the symptom/pain on a scale from 1-10. Severity can also be described with terms like severe, slightly, worst I've never had, mild, moderate, 0 pain (must be ranked; can't just say "pain in my leg), increasing, decreasing, progressive, well, etc.

Duration: Describes how long the symptom/pain has been present or how long it lasts when the patient has it, i.e., 20 minutes, onset 3 years ago, since last Friday, for approximately 2 months, yesterday.

Assoc. Signs and Symptoms: A clinician's impressions formulated during the interview may lead to questioning about additional sensations or feeling. Describes the symptom/pain and other things that happen when this symptom/pain occurs, i.e., chest pain leads to shortness of breath, nausea, vomiting or sweating; headache leads to vision disturbances, diaphoresis associated with indigestion or chest pain tremulousness, weakness and hunger pangs in patients with diabetes. A clinician may ask patients directly about "pertinent positives and negatives".

Quality: Describes the character of the symptom/pain, i.e., sharp, dull, burning, gnawing, stabbing, fullness, color of sputum, non-productive, asymptomatic, etc. Describes a laceration as jagged or straight. Describes a sore throat as scratchy.

Context: Is the situation associated with the pain/symptom, i.e. exercise, big meals, dairy products, etc. Look for statements that describe how a complaint occurred such as: injuries incurred in a MVA, running down the steps, sitting in a chair, playing sports, etc.

Timing: Describes when the pain/symptom occurs or establishes the onset for each symptom (why or when), and a rough chronology of the development of the problem, i.e., onset 10am, night, day, both or is it continuous, occasional, episodic, AM, PM, constant, intermittent, recurrent, seldom or frequently, etc.

Modifying Factors: What has the patient attempted to do to obtain relief or make himself/herself better? Are things done to make the symptom/pain better or worse, i.e., improved with rest or eating, affected by spicy foods, a migraine headache responding to an ice pack and a quiet room, coughing irritates the pain, over-the counter or prescribed medications have been attempted, etc. What were the results?

REVIEW OF SYSTEMS:

Constitutional
chills
unusual symptoms/problems
fever
weakness
exercise intolerance
tiredness
weight change
sleep habits
appetite (changes)
fatigue
good general health lately
impaired ability to function
syncope
sweats
nightmares
hot flashes

Integumentary
bruising
changes in moles
changes in hair texture
changes in nail texture/color
extreme dryness
changes in skin/lesion color
eczema
hives
breast pain/lumps
rash
history of breast feeding
infections
itching
nipple discharge/changes
presence of scars/moles
skin reactions to hot/cold
sores
swelling
tenderness
tumor
varicose veins
skin diseases/history of
date/result last mammo/exam
pattern of self exam

Musculoskeletal
back pain/injury
arthritis
gout
joint aches/hot joint
redness of any joint
joint stiffness/swelling
muscle aches/pain
muscle stiffness/cramps
pain down back of legs
weakness
atrophy
cold extremities
fracture/history of
kyphosis
twitching
lordosis
noise w/ joint movement
sciatica
scoliosis
spinal deformity
limitations on walking/ running/in sports
interference with ADL's

Psychiatric
anxiety
depression
forgetfulness
loss of sleep
nervousness
aggressiveness
confusion
delusions
emotion unstable
fear
h/o psych conditions
h/o psych treatment
hallucinations
loss of labido
memory loss
panic
paranoia
sleep disturbance
suicidal thoughts
tension

Genitourinary
urine output/frequency
hesitancy starting stream
dribbling/changes in stream
kidney/bladder infections
blood in urine/hematuria
night time urination/patterns
pain/burning w/urination
urgency
polyuria
incontinence
renal stones/h/o stones
flank pain
sexual difficulty
male: testicle pain
female: pain with periods
irregular periods
vaginal discharge
# of pregnancies
# of miscarriages
date of last pap smear
children: toilet training
bed wetting

Respiratory
asthma/history of
wheezing/noisy respiration
bronchitis/history of
pneumonia/history of
dry/chronic/frequent cough
cough up phlegm
cough up blood/hemoptysis
SOB
chest pain/pain with cough
snoring
cyanosis
dyspnea
exposure to TB
tachypnea
pleurisy
recurrent infection
cyanosis
sputum (color, frequency)
breathing problems w/ exercise

Endocrine
excessive hunger
polydipsia/excess thirst
polyuria/excess urination
heat/cold intolerance
unexplained weakness
thyroid/adrenal dz/h/o
high sugar
low sugar
diabetes
adrenal problems
brittle nails
dry skin
excessive sweating
goiter/history of
hair change/loss
heavy/lighter menses
height changes
hormone therapy/h/o
increased appetite
infertility
missed periods
pigmentation changes
voice change
weight change

Neurologic
headache
dizziness
fainting/unconsciousness
blackouts
speaking/language problem
loss of balance
coordination
loss of sensation/dysesthesia
numbness
seizures/on anticonvulsants
ataxia
blindness
convulsions
diplopia
drowsiness
inability to concentrate
hallucination/disorientation
head injury
memory loss/history of
pain
paralysis/paresis
slurred speech
stroke
h/o sensory/motor problems
tics
tremor
vertigo

Cardiovascular
palpitations
irregular heart beat/murmur
chest pain
color change in fingers/toes
wake up at night SOB/paroxysmal nocturnal dyspnea
high blood pressure/hypertension
low blood pressure
poor circulation/cold/numb ext.
swelling/edema ankles/legs/hands
varicose veins
angina
dyspnea on exertion
electrocardiogram results
h/o rheumatic fever
hair loss on legs
heart trouble
irregular pulse/skipped beats
leg pain when walking
preferred position to breathe
orthopnea
sleep with 2/more pillows
phlebitis
SOB with walking or lying flat
syncope
varicosities
racing heart

Allergic/Immunologic
hay fever
hives
itching
medication allergies
multiple colds/infecitons
slow healer
frequent sneezing
history of allergies/eczema
chronic clear nasal discharge
conjunctivitis
allergies that interfere with ADL's

Gastrointestinal
loss of appetite
indigestion/heartburn
abdominal pain/swelling
nausea/vomiting
vomiting blood/hematemesis
constipation
bloating
hemorrhoids
black stools
change in stool characteristics
change in bowel habits
rectal bleeding/melena
diarrhea
laxative/digestive aids/enema use
excessive belching
weight gain or loss
ascites
flatulance
burning in esophagus
dysphagia
food intolerance
gallbladder disease/history of
liver disease/history of
ulcers/history of
data/results last hemoccult exam
hematochezia
hernia
hiccups
jaundice

Ear, Nose, Throat
date/results last hear test
deafness
ear discharge/drainage
ear pain
ear wax abnormality
h/o ear infections
hearing loss/ringing
noise sensitivity
tinnitus
vertigo
stuffy/runny nose
post-nasal drip/drainage
sinusitis/sinus problems
hay fever
sneezing
decreased sense of smell
difficulty breathing
nasal discharge
nasal dryness
nosebleeds
nasal obstruction
impaired ability to smell
hoarseness
pain/sore throat
swallowing problems
bad breath
bad taste
bleeding gums
blisters
canker sores
infection
lip/mouth lesions/or h/o
sore tongue
swollen glands in neck
teeth
tonsillitis
ulcers
voice change
update last dental exam
describe dental health

Eyes
blurred/double vision
contact lenses/glasses
date/results last eye exam
discharge
dryness
eye disease/injury
eye pain
excessive tearing
glaucoma/checked for
h/o retinal detachment
infection
itch
light sensitivity
redness
scotoma
spots
twitching
watery
tunnel vision
blindness
floaters/spots/light flashes
swelling eyelid

Hematologic/Lymphatic
anemia/history of
bleeding tendencies
easy bruising
enlarged glands
fatigue
low platelet count
lymphadenopathy
malignancy
nose bleeds
past/current transfusions
phlebitis
slow healing after cut(s)
swollen nodes
tender nodes
granular swelling
h/o systemic infections

ESSENTIAL CODING RESOURCES

References/Resources
Anatomy and Physiology texts
Coder's Desk Reference
Coding Classification Update Newsletter/ASC Newsletter
Coding Clinic
Coding Answer Book
CPT Assistant
Current Procedural Terminology (CPT-4)
Disease process manual (i.e. Merck Manual)
DRG Guidebook and Optimizer
Drug reference tools
Grouper/software coding reference
CMS Current Procedural Classification System (HCPCS) Level II National codes and Level III
ICD-9-CM Coding Handbook with Answers
International Classification of Diseases 9th Edition, Clinical Modification (ICD-9-CM)
Local codes, if applicable
Medical Acronyms and Abbreviation list
Medical dictionary
Memoranda/SOP re coding and claims processing

CODING WEBSITES

American Academy of Professional Coders (AAPC)	www.aapc.com
American Health Information Management Assoc (AHIMA)	www.ahima.org
American Medical Association (AMA) Compliance Plan	www.ama-assn.org/ama/pub/category/4541.html
American Medical Association (AMA) CPT Coding	www.ama-assn.org/ama/pub/category/3884.html
American Medical Association (AMA) Home Page	www.ama-assn.org
Classification of Diseases (NCHS)	http://www.cdc.gov/nchs/icd9.htm
CMS Coding Education Resources	www.cms.hhs.gov/medlearn
CMS Local Medicare Review Policies/Coverage Database	www.cms.hhs.gov/mcd
CMS Physician Fee Schedule	www.cms.hhs.gov/physicians/pfs/default.asp
CMS Program Manuals, Transmittals & Memos	www.cms.hhs.gov/manuals
Coding and Reimbursement Network (CRN)	www.codingandreimbursement.net
E&M Specialty Exam Score Sheets	http://www.hgsa.com/professionals/scoresheets.shtml
eMRA – Medicare Remittance Advice Project	http://vaww.vistau.med.va.gov/VistaU/e-bp/e-mra.htm
EPRP Coding Accuracy Review	http://vaww.vhaco.va.gov/cbi/audeprpcoding.htm
ICD-9-CM Codes Crosswalk (Old Codes)	www.cdc.gov/nchs
ICD9-CM Searchable Database (FREE)	www.eicd.com/EICDMain.htm
JustCoding	www.justcoding.com
National Drug Code Directory (NDC)	www.fda.gov/cder/ndc/
Office of Inspector General (OIG)	www.oig.hhs.gov/
Part B News	http://www.partbnews.com/pbnweb/index.htm
QuadraMed	http://www.quadramed.com/web/customers/government/
Trailblazer (VHA's Fiscal Intermediary)	www.trailblazerhealth.com
VHA HIM Coding Question & Answer	vaww.appc1.va.gov/codequest/index.cfm
VHA HIM Home Page	http://vaww.vhaco.va.gov/him/
VHA Revenue Office	http://vaww1.va.gov/cbo
VHA Social Work Information	vaww.va.gov/socialwork
VHA WebInservice Coding Training (Educode)	www.educode.com/VAEES

QUICK REFERENCE CHART: Consult vs Referral

CONSULTATION	REFERRAL VISIT
Suspected problem	Known problem.
Undetermined course of treatment.	Prescribed and known course of treatment.
Only opinion or advice sought. Subsequent to the opinion, treatment may be initiated – even during the same encounter.	Transfer of total patient care for management of the specified condition.
Request for opinion or advice received from attending physician (e.g., separate written request or documentation in the medical record indicating that a consult was requested by phone, including the specific reason the consultation is requested).	Patient appointment made for the purpose of providing treatment or management or other diagnostic or therapeutic services.
Written opinion or findings in medical record for an inpatient, returned to attending physician (if a telephone call is made, there must be documentation of the call by both physicians in the patient record).	No further communication (or limited contact) with referring physician is required.
Patient advised to follow up with attending physician.	Patient advised to return for additional discussion, testing, treatment or continuation of treatment and management.
Diagnosis is probably unknown, and patient presents with specific signs and symptoms at the time of the consult service.	Final diagnosis is typically known at the time of referral.
Recommended request language: "Please examine patient and provide me with your opinion and recommendation on his/her condition.	Typical verbiage: "Patient is referred to your office for treatment or management of his/her condition".
Source: Compiled by Coding Pro from information in MCM 15506.	