



CPT-4 Coding for Facilities

Computer Based Training on

Evaluation and Management Coding
The Surgical Package
Unlisted Codes

Objectives

- **Provide an overview of the use of the CPT manual and codes**
 - **Identify the purposes of CPT coding in Facilities**
- **Define the rules for use of Evaluation and Management (E/M) codes in facilities**
- **Define the CPT surgical package for facilities**
- **Identify appropriate use of unlisted codes**

CPT For Physicians vs Facilities

- **Physician**

- Knowledge and skill
- Training and experience
- Time
- Risk (malpractice)

- **Facility**

- Space
- Supplies
- Clinical personnel
- Equipment
- Support personnel
- Utilities, physical plant

Format of the Manual

6 Chapters

- **Chapter 1 - E/M**
- **Chapter 2 - Anesthesia** (not used in facilities)
- **Chapter 3 - Surgery**
 - **10000 - Integument and Breast**
 - **20000 - Musculoskeletal**
 - **30000 - Respiratory, Cardiovascular, Lymphatic**

Format of the Manual

- **Chapter 3 - Surgery (con't)**
 - **40000 - Digestive**
 - **50000 - Renal, Male & Female
Genitalia, Maternity Care & Delivery**
 - **60000 - Endocrine, Nervous system, Eye,
Ocular adnexa, & Auditory**

Format of the Manual

**Chapter 4 - Radiology, Radiation
Oncology, Nuclear Medicine**

Chapter 5 - Pathology and Laboratory

Chapter 6 - Medicine

Format of the Manual (Continued)

- **Category II Codes**
- **Category III Codes**
- **Appendices**
- **Index**

Using the Index

- **Look codes up four ways**
 - **Procedure**
 - **Condition or Disease**
 - **Organ or Organ System**
 - **Synonym, Eponym, Abbreviation**
- **Better to go directly to the correct chapter and subdivision**

CPT Conventions and Symbols

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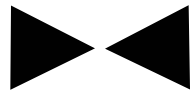
- Separates common and unique portions of codes



- New code



- Revised code text

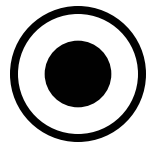


- Other revised text

More CPT Conventions and Symbols

+

- Add on code



- Conscious sedation bundled



- Modifier 51 exempt



Evaluation and Management Codes

Evaluation and Management Codes

- **Describe use of space**
- **Describe use of supplies**
- **Describe involvement of hospital employees**
- **Can't Be Used If...**
 - **Patient admitted within 72 hours**
 - **Patient taken to surgery**
 - **Patient receives other global service**
 - **Example: Dialysis**

Codes with Status V

- **Only codes used in outpatient settings**
 - **Outpatient clinic**
 - **Office or Other Outpatient Service (99201 – 99215)**
 - **Office or Other Outpatient Consults (99241 – 99245)**
 - **Confirmatory Consults (99271 – 99275)**
 - **HCPCS exams (G0101, G0175, G0245, G0246, G0264, G0344)**
 - **Ophthalmology codes for appropriate exams (92002 – 92014)**
 - **Emergency Room**
 - **Emergency Department Services (99281 – 299285)**
 - **Normal Newborn Care**
 - **Only the outpatient code 99431**

Office or Outpatient Services

- **Used primarily in clinics**
- **May be used in any outpatient location**
 - **New patients 99201 - 99205**
 - **Established patients 99211 - 99215**
 - **May be based on time**

Consults

- **Outpatient consults 99241 – 99245**
 - Requires documentation of request and reply
 - May be performed in any outpatient location
 - May be based on time
- **Confirmatory consults 99271 – 99275**
 - 2nd opinions
 - Discontinued in 2006

Emergency Department Services

- **Must be performed in the ER**
 - **Can't be used in Urgent Care or for emergent services performed in other locations**
- **Must be unscheduled episodic care**
- **Use 99281 for screening services in the ER when no treatment is furnished**

Ophthalmology

- **General ophthalmologic services**
 - New patients 92002 - 92004
 - Established patients 92012 – 92014
- **Use when patient receives preventive or periodic ophthalmologic services**
 - Not usually used for treatment of disease processes

CMS on Level of E/M Service

- **Hospitals identify and follow a method for choosing the level of service**
 - **"As long as the services furnished are documented and medically necessary and the facility is following its own system, which reasonably relates the intensity of hospital resources to the different levels of HCPCS codes, CMS will assume that it is in compliance with these reporting requirements."**

Choosing the Level of Service

- **Systems for choosing the level of E/M are developed by each facility**
 - **Facilities must follow their own systems**
 - **Nursing acuity levels are often used**
 - **Facility codes would not often match providers**
 - **"New" and "established" pertain to whether the patient already has a medical record**

E/M Documentation

- **Draft documentation guidelines state that the medical record must support codes**
- **Certain documentation should be included for each patient encounter**
 - **Chief complaint (reason for encounter)**
 - **Relevant history, physical examination findings and prior test results**
 - **Assessment, clinical impression or diagnosis**
 - **Plan of care**
 - **Rationale for ordering tests and other services**
 - **The date and legal signature of the provider**

Documentation

- **When counseling or coordination of care is more than 50% of the service, time is the key component.**
- **Documentation should include**
 - **Total length of time of the encounter**
 - **Description of counseling or coordination of care activities**
 - **Substantiation of medical decision making associated with the encounter**

CMS on Documentation

- **Facilities that use documentation to determine the level of E/M have little problem supporting the codes.**
 - **If physicians, nurses, or clerical staff assign codes without reference to documentation, routine periodic audits should be performed to ensure that documentation supports the level of service**
- **This includes facilities that crosswalk to link their acuity levels to E/M codes.**
 - **Documentation is the final arbiter of the level of service**
 - **Inappropriate assignment of E/M codes is viewed as a compliance issue**

More on E/M Coding

- **Use the unit field for multiple E/M at the same level**
 - **If several physicians see a patient in the same clinic for the same reason bill one visit only**
 - **Do not bill a medical visit simply because a patient has presented for a service**
- **Bill for limited surgery follow-up using an appropriate medical visit code**

Critical Care

- **Critical care is classified as a "significant procedure" (APC 0620) under the OPPTS.**
 - **Hospitals use code 99291 to report outpatient critical care services**
 - **Used in place of a code for a medical visit or emergency department service.**
- **Use CPT definition of "critical care" and coding guidelines**
 - **Exceptions**
 - **Facilities only paid for one period time with code 99291**
 - **Facilities paid separately for services bundled by CPT**
- **If services such as surgery, x-rays, or CPR are furnished on the same day they may be billed separately.**



The Facility Surgical Package

CPT Surgical Package

- **Found in the Surgery Guidelines**
 - **Operation per se;**
 - **Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia;**
 - **Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including History and Physical);**
 - **Immediate postoperative care, including dictating operative notes, talking with the family and other physicians;**
 - **Writing orders;**
 - **Evaluating the patient in the postanesthesia recovery area;**
 - **Typical postoperative care**

The Facility Surgical Package

- **Operation per se;**
- **All anesthesia**
- **Observation care**
- **Use of the rooms (Preop area, OR, PACU, etc)**
- **Surgical supplies, drugs, and materials except pass-throughs**
- **Surgical personnel (nurses, technicians)**
- **Facility overhead expenses**

Other Included Elements

- **Opening (incision) or Approach;**
- **Exploration (looking around);**
- **Destruction (lysis);**
- **Debridement (removing dead or damaged tissues and/or foreign material);**
- **Lavage (washing out);**
- **Control of bleeding;**
- **Diagnostic procedures;**
- **Closure;**
- **Dressings**

Often Included Elements

- **Separate procedures**
- **Harvesting of autografts**
- **Less extensive with more extensive procedures**
- **Use of operating microscope**
 - **Loops are always included**

Other Factors in Surgery Coding

- **Approach is definitive in CPT**
 - **Must code open procedures with open codes**
 - **Endoscopic, thoracoscopic, laparoscopic, etc. procedures must use codes specific to those approaches**
 - **If no code available, use unlisted**

Modifiers

- **Modifiers indicate that a service or procedure has been altered by some specific circumstance but not changed in its definition or code**
 - **Use modifiers to identify minor changes in the procedure that don't change the coding**
 - **13 modifiers available for facilities**

Unlisted Procedure Codes

- **“It is recognized that there may be services or procedures performed by physicians that are not found in the CPT book.”**
- **“Do not select a CPT code that merely approximates the service provided.”**
 - **“If no such procedure or service exists, then report the service using the appropriate unlisted procedure or service code”**

This program is presented for informational purposes only.

- **The current Medicare regulations will prevail**

**Thank you, you have completed
the CBT.**

**Would you like to take a 10 question
knowledge check?**

Yes, let's get started.

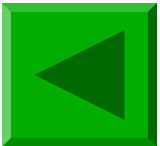
No, please take me back to
WPS Medicare's Provider
Homepage.

A patient presents to her OB/Gyn with a yeast infection. The patient was last seen by this physician in his private clinic 2 years ago but she has never been seen in this facility. This patient is a new patient (99201 – 99205).

True

False

**That is not correct, please try
again.**



**That's correct, the answer is
true.**

A patient presents to the ER with a head injury and brief loss of consciousness. He is discharged home but is told to return the next day for a follow up. The patient does return for a follow up visit and sees a different physician at that time. This second service should be coded as an ED service (99281- 99285).

True

False

**That's correct, the answer is
false.**

The codes in the Anesthesia chapter of CPT are not used in facility coding.

True

False

**That's correct, the answer is
true.**

Codes for outpatient consultations (99241 – 99245) may be based on the time the physician counseled the patient.

True

False

**That's correct, the answer is
true.**

Facilities may have a policy that allows them to simply code the same E/M code that the physician who saw the patient on that date is coding.

True

False

**That's correct, the answer is
false.**

If a patient presents for any service, an E/M code may also automatically be billed on that date.

True

False

**That's correct, the answer is
false.**

A woman with bilateral lower extremity varicosities presents for phlebectomy. She has 17 stab incisions on her right leg and 8 stab incisions on her left leg. This would be coded 37765-RT, 37799-LT

True

False

**That's correct, the answer is
true.**

If a patient presents for outpatient knee surgery including exploratory arthroscopy (29870) and arthroscopic meniscectomy (29881), both services may be coded.

True

False

**That's correct, the answer is
false.**

Since there is no code for laparoscopic ventral hernia repair, coders should use the unlisted code (49659) to describe this service.

True

False

**That's correct, the answer is
true.**

Unlisted procedure codes can be used instead of a listed code when the encoding software will not allow unbundling of the services.

True

False

**That's correct, the answer is
false.**

Thank you, you have completed the Knowledge Check.

Would you like to take another CBT?

Yes, let's get started.

No, please take me back to
WPS Medicare's Provider
Homepage.