2020

Medical Billing Training: Certified Professional Biller (CPB™)

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AAPC believes it is important in training and testing to reflect as accurate a setting as possible to students and examinees. All examples and case studies used in our study guides and exams are actual, redacted office visit and procedure notes donated by AAPC members. To preserve the real-world quality of these notes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes. The notes otherwise appear as one would find them in a coding setting.

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Chapter 5

CPT® Concepts

The American Medical Association (AMA) maintains the Current Procedural Terminology (CPT®) code set to describe services generally provided by healthcare professionals to individual patients. CPT® codes are intended to accurately describe those services, and to provide a convenient method of communicating this information between providers, payers, administrators, and regulators. The codes are shorthand notations that, when used properly, provide essential data to all those providing care, paying for that care, and overseeing the quality of care in the healthcare system. CPT® codes are part of the Healthcare Common Procedure Coding System (HCPCS) code set.

The medical biller must be familiar with the CPT® coding system and the information readily available in the CPT® code book. The CPT® code book includes three categories of codes. Category I codes are those codes that describe services generally acceptable in the current healthcare system and are performed by many providers in multiple clinical locations. These procedures are generally considered to be within standard medical practice, but the existence of a code does not indicate the conditions under which the use of the procedure would be considered the standard of care.

Category I codes are five-digit numerical codes (for example, 12345).

Category II codes are used primarily as performance measures. Medicare and other payers utilize these codes to document the quality of services provided to individual patients and to the patient population under the care of individual providers. Widespread use of these codes and changes to data systems may reduce the manual efforts currently necessary to document provider performance through chart reviews. CPT® Category II codes are four-digit numeric codes, followed by the letter F (for example, 1234F).

Category III codes are a set of temporary codes used to designate emerging technologies, services, and procedures. These codes may be used to document that many providers perform this service or procedure across the country, which is required for eventual inclusion as a Category I code. Category III codes are four-digit numeric codes, followed by the letter T (for example, 1234T).

The CPT® code book is organized by code sections, each of which designates a specific grouping of codes. Placement of a procedure within one code section does not reflect which providers may perform the service. Providers may perform services within the scope of their licenses regardless of the CPT® code that describes the service.

In general, CPT® codes are divided as follows:

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

Each of the sections may be further divided. For example, the surgery codes are generally divided as follows:

- Integumentary System
- Musculoskeletal System
- Respiratory System
- Cardiovascular System
    - Hemic and Lymphatic Systems
    - Mediastinum and Diaphragm
- Digestive System
- Urinary System
- Male Genital System
    - Reproductive System Procedures
    - Intersex Surgery
- Female Genital System
    - Maternity Care and Delivery
    - Endocrine System
- Nervous System
- Eye and Ocular Adnexa
- Auditory System

The CPT® code that most accurately describes the service provided should be used to designate that service. If a specific code accurately describes the actual services provided, it is improper to utilize a more general code or an unlisted procedure code.

An established set of conventions and symbols are used throughout the CPT® code book. They are designed to communicate information clearly and in an easily recognizable manner.

; Semicolon and Indented Procedure—The use of the semicolon was developed so that CPT® did not have to list full descriptions for every code in the publication. A CPT® procedure or service code that contains a semicolon is divided into two parts; the description before the semicolon and the description after the semicolon.

(a) The words before the semi-colon are considered the common procedure in the code descriptor.

(b) The indented descriptor is dependent on the preceding common procedure code descriptor.

(c) It is not necessary to report the main code (eg, 20100) when reporting the indented codes (eg, 20101, 20102 or 20103).

EXAMPLE

20100 Exploration of penetrating wound (separate procedure); neck

20101 chest

20102 abdomen/flank/back

20103 extremity

The full descriptor for CPT® code 20101, 20102 and 20103 includes the portion before the semicolon in 20100 to make the full description of the codes as follows:

20101 Exploration of penetrating wound (separate procedure); chest

20102 Exploration of penetrating wound (separate procedure); abdomen/flank/back

20103 Exploration of penetrating wound (separate procedure); extremity

One or more symbols may be attached to specific CPT® codes to designate information relevant to that code. These symbols include the following:

- New procedure or service: this symbol appears for only one year after a code is added to the CPT® code set.

EXAMPLE

- **33016** Pericardiocentesis, including imaging guidance, when performed

▲ Designates code descriptors that have been altered. Appendix B shows what has been altered in the description of the CPT® code.

EXAMPLE

The code as listed in the numeric section of the CPT® code book:

▲ 31292 Nasal/sinus endoscopy, surgical, with orbital decompression; medial or inferior wall

The code as listed in Appendix B indicating the specific changes made to the code:

▲31292 Nasal/sinus endoscopy, surgical, with orbital decompression; ~~with~~ medial or inferior ~~orbital~~ wall ~~decompression~~

►◄ Indicates new and revised text, such as parenthetical notes and guidelines. Revised text is in green.

EXAMPLE

11981 Insertion, non-biodegradable drug delivery implant

➲ CPT® Assistant Apr 11:12

► (For manual preparation and insertion of deep [eg, subfascial], intramedullary, or intra-articular drug-delivery device, see 20700, 20702, 20704)◄

► (Do not report 11981 in conjunction with 20700, 20702, 20704)◄

+ Designates add-on codes, which are also listed in Appendix D. Modifier 51 is never appended to an add-on code. An add-on code is never reported alone and is always reported with a parent code.

EXAMPLE

16035 Escharotomy; initial incision

+16036 each additional incision (List separately in addition to code for primary procedure)

(Use 16036 in conjunction with 16035)

In this example, the add-on code, 16036, should always be reported with its parent code 16035. Two parenthetical instructions guide the coding. First, in the description of 16036, it states to list separately in addition to the code for the primary procedure. This indicates another procedure code should also be reported. The second parenthetical note states to use 16036 in conjunction with 16035. This parenthetical instruction gives us the primary code to report with the add-on code.

⃠ Designates codes that are exempt from the use of modifier 51 but are not add-on codes. Add-on codes are inherently exempt from modifier 51. Modifier 51

indicates multiple procedures. Codes that are exempt from modifier 51 are procedures that are typically performed with other procedures. These are also listed in Appendix E.

EXAMPLE

⃠ 17004 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses),15 or more lesions.

When procedure code 17004 is reported with another procedure, modifier 51 is not appended to 17004.

↯ Designates vaccine codes pending approval from the Food and Drug Administration (FDA). Some vaccine products are assigned a CPT® Category I code in anticipation of future approval from the FDA. When the vaccine has been approved by the FDA, a revision notation will be provided on the AMA CPT® "Category I Vaccine Codes" website: www.ama-assn.org/ama/pub/category/10902.html (see Appendix K for Products Pending FDA Approval). These are also listed in Appendix K.

EXAMPLE

↯ **90668** Influenza virus vaccine (IIV), pandemic formulation, split virus, for intramuscular use

\# A pound sign indicates that the code has been sequenced out of order. The AMA began organizing codes out of order in 2010 to combat CPT®'s lack of flexibility and capacity for new code creation. Rather than deleting and renumbering, resequencing allows existing codes to be relocated to an appropriate location for the code concept, regardless of the numeric sequence. The pound sign appears next to the out-of-sequence code, and that code is reproduced in correct sequence in the code book with a notation of where to find the code with its description.

EXAMPLE

When you look for CPT® code 46947 you see:

46947 Code is out of numerical sequence. See 46760–46910.

This directs you to look at code range 46760–46910 to locate 46947. Code 46947 is found under CPT® code 46761.

\# 46947 Hemorrhoidopexy (eg, for prolapsing internal hemorrhoids) by stapling

The medical biller should be familiar with these symbols and how they affect coding and payment for services. For example, if an add-on code is included on a claim, the parent code must also be included. It is incorrect to submit an add-on code without the parent code. The symbols also designate proper payment guidelines. For example, codes designated as modifier 51 exempt are not subject to the usual multiple surgical reductions that are taken when more than one procedure is performed during the same setting.

The CPT® code book contains significant information beyond the codes and their descriptors. Being familiar with this additional information is critical to utilizing the CPT® code book to its fullest potential. Each section of the CPT® code book has an introduction that provides general guidelines to the use of those codes.

EXAMPLE

A claim is billed with procedure codes 14020 and 11402. In the CPT® code book, the following guidelines are found for an adjacent tissue transfer:

Adjacent Tissue Transfer or Rearrangement

Codes 14000-14302 are used for excision (including lesion) and/or repair by adjacent tissue transfer or rearrangement (eg, Z-plasty, W-plasty, V-Y plasty, rotation flap, random island flap, advancement flap). When applied in repairing lacerations, the procedures listed must be performed by the surgeon to accomplish the repair. They do not apply to direct closure or rearrangement of traumatic wounds incidentally resulting in these configurations. Undermining alone of adjacent tissues to achieve closure, without additional incisions, does not constitute adjacent tissue transfer, see complex repair codes 13100–13160. The excision of a benign lesion 11400–11446 or a malignant lesion (11600–11646) is not separately reportable with codes 14000–14302.

In this example, subsection guidelines for Adjacent Tissue Transfer or Rearrangement indicates that a benign lesion removal is not reportable with the adjacent tissue transfer. Code 11402 should not be reported on the same claim as 14020, so this would be an error on the claim. The more inclusive code (14020) should be reported alone.

Be familiar with the use of parenthetical notes as directions that apply to specific codes or groups of codes. These notes direct the use of specific codes for services or prohibit the use of certain code combinations.

EXAMPLE

A claim is billed with procedure codes 15757, 69990. You can find the following parenthetical instructions under code 15757 in the CPT® code book:

15757 Free skin flap with microvascular anastomosis

(Do not report code 69990 in addition to code 15757)

In this example, there is a parenthetic instruction to give guidance on reporting of the add-on code 69990. The parenthetic instruction states not to report add-on code 69990 in addition to code 15757.

69990 is not reported on the same claim as 15757 and this would be an error on the claim.

Understand how to use the index effectively as a cross-reference to locate specific procedure codes based on anatomic locations, general procedural designations, acronyms, abbreviations, and other criteria that may assist the medical biller in identifying which code should be used to describe a procedure.

To assign appropriate CPT® codes, the documentation is thoroughly reviewed, and the procedure or service is selected to accurately describe the care provided. The CPT® alphabetic index is referenced for a CPT® code or code range. After locating the approximate CPT® code in the alphabetic index, the numeric section is used for code specifications. A code is not to be selected using only the alphabetic index.

The CPT® Index is alphabetized with main terms organized by condition, procedure, anatomic site, synonyms, eponyms, and abbreviations. For example:

1) A condition: for example, Impacted Cerumen, Cyst, Angle Deformity

2) The name of the procedure or medical service documented: for example, Removal, Suture, Fasciotomy

3) The name of the anatomic site or organ: for example, Neck, Skin, Femur

4) Synonyms, eponyms, and abbreviations: for example, Toe/Interphalangeal Joint, Watson-Jones Procedure, EEG

Information in the alphabetic index expands by subterms listed alphabetically below each main term. The subterms further clarify the main term by noting condition, procedure, or anatomic site. With each subterm is a listing of the CPT® code, codes, or code ranges located in the numeric section of the CPT® code book.

To clarify and ensure selection of the correct CPT® code, the code, codes, or code range from the alphabetic index are located in the CPT® numeric section.

EXAMPLE

Let's look for the CPT® code for a flexible diagnostic colonoscopy. Look in the CPT® alphabetic index for Colonoscopy/Flexible/Diagnostic.

Colonoscopy

Flexible

Diagnostic. 45378

When CPT® code 45378 is referenced in the numeric section, additional information for correct code assignment is defined. The defining information written in the numeric section for the CPT® code 45378 is:

Section: **Surgery**

Subsection: **Digestive System**

Subheading: **Colon and Rectum**

Category: **Endoscopy**

45378 Colonoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

➲ CPT® Changes: An Insider's View 2015, 2017

➲ CPT® Assistant Spring 94:9, Aug 99:3, Jan 02:12, Jan 04:4, May 05:3, Dec 10:3, Apr 11:12, Jan 13:11, Nov 14.3, Dec 14.3, Sep 15:12, Sep 17:14, Jan 18:7

(Do not report 45378 in conjunction with 45379-45393, 45398)

(For colonoscopy with decompression [pathologic distention], use 45393)

CPT® conventions, symbols, and references are taken under consideration to report the correct use of the code (as seen in the 45378 example). Important considerations found in the example's descriptor include:

1. Separate Procedure—When the service or procedure is designated as a "separate procedure" it is performed alone or is considered unrelated to another procedure/service provided during the same patient encounter.

   Modifier 59 may be appended to a "separate procedure" designated CPT® code if guidelines are met within the medical documentation. Modifier 59 guidelines and its uses will be discussed later.

2. This example cites two references:

   ➲ CPT® Assistant—the Spring 1994 issue, page 9; the August 1999 issue, page 3; the January 2002 issue, page 12; the January 2004 issue, page 4; the May 2005 issue, page 3; the December 2010 issue, page 3; the April 2011 issue, page 12; the January 2013 issue, page 11; the November 2014 issue, page 3; the December 2014 issue, page 3; the September 2015 issue, page 12; September 2017 issue, page 14, and the January 2018 issue, page 7.

   CPT® Changes: An Insider's View 2015. This indicates a change was made to the procedure description in the year 2015.

3. Parenthetic instructions—below code 45378, there are two parenthetic instructions. The first indicates not to report 45378 in conjunction with 45379-45393, and 45398. The second indicates that code 45393 should be reported for a colonoscopy with decompression.

   All information from the CPT® numeric section should be analyzed before assigning a CPT® code. Some health plans have specific billing instructions and coverage issue clarifications posted on their websites for review prior to code assignment. CMS publishes Internet Only Manuals (IOMs) and a Medicare Coverage Center that can help medical billers with billing and coverage instructions on their website. Online documents are not updated with every new Transmittal, Program Memorandum, or Medlearn Matters article, so pay particular attention to when these documents were last updated. Each Medicaid agency maintains its website and program requirements.

   Internet-Only Manuals (IOMs): https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html. Some of the main internet only manuals to review for information include:

Publication #	Title
100-01	Medicare General Information, Eligibility and Entitlement Manual
100-02	Medicare Benefit Policy Manual
100-03	Medicare National Coverage Determinations (NCD) Manual
100-04	Medicare Claims Processing Manual

   Medicare Coverage Center: https://www.cms.gov/Medicare/Coverage/CoverageGenInfo/index.html

Section Review 5.1

1. What does the icon indicate for procedure code 20974?

   A. Modifier 51 must be used with procedure code 20974.
   B. Use modifier 59 instead of 51 with procedure code 20974.
   C. Modifier 51 cannot be used with procedure code 20974.
   D. Use modifier 58 with procedure code 20974 since it was a planned procedure following the surgical procedure.

2. Which option shows the correct way to report procedure code 22515?

   A. 22515
   B. 22514, 22515
   C. 22514, 22515, 77012
   D. 22515, 77012

3. What is the full descriptor for CPT® code 35632?

   A. Ilio-celiac
   B. Aortoceliac, aortomesenteric, aortorenal, ilio-celiac
   C. Bypass graft, with other than vein; ilio-celiac
   D. Bypass graft, with other than vein; common carotid-ipsilateral internal carotid, ilio-celiac

4. What is/are the CPT® code(s) for removal of a pancreatic calculus?

   A. 48020
   B. 43264
   C. 43264, 48020
   D. 43265

5. What CPT® code(s) is/are reported for removal of two skin tags?

   A. 11200
   B. 11200 x 2
   C. 11200, 11201
   D. 11201 x 2

The appendices also provide information that is both useful and necessary for successful coding as a payer or provider. The medical biller should have general familiarity with these and will find the following appendices the most useful:

Appendices A through P are located in the CPT® code book after the Category III CPT® codes. The Appendix section references topics important for coding specificity and provides examples for the reader.

Appendix A

Modifiers—This appendix lists modifiers categorized as:

1. CPT® Level I Modifiers—lists all the modifiers applicable to CPT® codes
2. Anesthesia Physical Status Modifiers
3. CPT® Level I Modifiers approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use
4. Category II Modifiers – lists all the modifiers applicable to performance measurement codes
5. Level II (HCPCS/National) Modifiers

Appendix B

Summary of Additions, Deletions, and Revisions—Appendix B contains the actual changes and additions to the CPT® codes from the previous year to the current publication.

Appendix C

Clinical Examples—Limited to E/M services, the AMA has provided clinical examples for different specialties. These clinical examples do not encompass the entire scope of medical practice and guides medical billers to follow E/M patient encounter rules for level of service.

Appendix D

Summary of CPT® Add-on Codes—Lists codes not reported as a single or stand-alone code. The codes listed are identified throughout CPT® with the + symbol.

Appendix E

Summary of CPT® Codes Exempt from Modifier 51—This listing is a summary of CPT® codes that are exempt from the use of modifier 51. The codes are identified in the CPT® code book with the ⃠ symbol.

Appendix F

Summary of CPT® Codes Exempt from Modifier 63—This listing is a summary of CPT® codes that are exempt from the use of modifier 63. The listed codes will also be identified by the CPT® convention of parenthetical instruction "(Do not report modifier 63 in conjunction with…)."

Appendix G

Summary of CPT® Codes That Include Moderate (Conscious) Sedation—This has been removed from the CPT® code book, Moderate (Conscious) Sedation is now reported with codes 99151-99157.

Appendix H

Alphabetic Clinical Topics Listing (AKA—Alphabetical Listing)—This has been removed from the CPT® code book, because CPT® Category II codes, clinical conditions, and measure abstracts rapidly change and expand. This listing is now solely accessed on the AMA website https://www.ama-assn.org/practice-management/cpt/ama-cpt-licensing-overview.

Appendix I

Genetic Testing Code Modifiers—This appendix was removed with the deletion of the molecular pathology stacking codes (83890-83914). The genetic testing code modifiers were reported with the codes that were deleted. New codes for molecular pathology were created eliminating the need for the modifiers included in Appendix I.

Appendix J

Electrodiagnostic Medicine Listing of Sensory, Motor, and Mixed Nerves—This appendix provides a summary that assigns each sensory, motor, and mixed nerve with its appropriate nerve conduction study code to enhance accurate reporting of codes.

Appendix K

Product Pending Food and Drug Administration (FDA) Approval—Some vaccine products listed as CPT® Category I codes are still pending approval from the FDA and can be found in this appendix. The lightning bolt symbol identifies the pending codes throughout the CPT® code set. For updated vaccine approvals by the FDA, visit the AMA CPT® Category I Vaccine Code information on website https://www.ama-assn.org/practice-management/cpt/category-i-vaccine-codes.

Appendix L

Vascular Families—Based on the assumption that a vascular catheterization has a starting point of the aorta, Appendix L illustrates vascular "families" that emerge from the aorta using brackets to identify the order of vessels: First, Second, Third, and Beyond Third Order of vascular branches. The largest First Order Branch emerges from the aorta. The Second Order Branch emerges from the First Order Branch, and so on to include the vessel's Third Order Branch and Beyond Third Order Branches. If the starting point of the catheterization is other than the aorta, the orders might change.

Appendix M

Renumbered CPT® Codes-Citations Crosswalk—This listing is a summary of the crosswalks noting the deleted and renumbered CPT® codes and descriptors with the associated reference to CPT® *Assistant* 2007 to 2009.

Appendix N

Summary of Resequenced CPT® Codes—This listing is a summary of CPT® codes not appearing in numeric sequence. This allows existing codes to be relocated to an appropriate location.

Appendix O

Multianalyte Assays with Algorithmic Analyses—This is a listing of administrative codes for Multianalyte Assays with Algorithmic Analyses (MAAA) procedures. These are typically unique to a single clinical laboratory or manufacturer.

Appendix P

CPT® Codes That May Be Used for Synchronous Telemedicine Services – This listing is a summary of CPT® codes used for reporting synchronous (real-time) telemedicine services that involve electronic communication using equipment that includes, at a minimum, audio and video.

Evaluation and Management Codes

Entire books have been written regarding proper use of the Evaluation and Management (E/M) codes. Most E/M codes are based on the three key components of history, examination, and medical decision making along with contributing factors of counseling, coordination of care, the nature of the presenting problem, and time. Some E/M codes are based solely on time or age.

BILLING TIP

CMS provides E/M guidelines for selecting the correct level of E/M service. Providers who report E/M services may use either the 1995 Documentation Guidelines for Evaluation and Management Services or the 1997 Documentation Guidelines for Evaluation and Management Services. Both sets of guidelines can be found at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications-Items/CMS1243514.html.

In general, the following criteria must be considered when deciding which E/M code best describes the services provided:

Location of the service (eg, office, hospital, critical care unit, nursing home, etc.). Each location typically has guidelines for the use of these codes.

EXAMPLE

Office or Other Outpatient Services

The following codes are used to report evaluation and management services provided in the office or in an outpatient or other ambulatory facility. A patient is considered an outpatient until inpatient admission to a healthcare facility occurs.

To report services provided to a patient who is admitted to a hospital or nursing facility in the course of an encounter in the office or other ambulatory facility, see the notes for initial hospital care (page 16) or initial nursing facility care (page 26).

For services provided in the emergency department, see 99281-99285.

For observation care, see 99217-99226.

For observation or inpatient care services (including admission and discharge services), see 99234-99236.

New vs. established patient (a "new" patient is one who has not received face-to-face services from the same physician or another physician of the exact same specialty and subspecialty within the same group practice within the previous three years: See "Decision Tree for New vs. Established Patients" preceding the E/M Service Guidelines in the CPT® code book). If the patient has seen another provider, in the same group, of the same specialty and subspecialty, within the three years, the patient is established. In addition, when a provider is acting as on call, the visit is classified based on the provider who is not available.

The extent and complexity of the following key components:

Patient history—the history is used for the provider to troubleshoot the chief complaint based on an interview with the patient. History is divided into the history of present illness (HPI), review of systems (ROS), and past, family, and social history (PFSH).

Some categories of service only require an interval history, such as subsequent hospital care and subsequent nursing facility care. An interval history is the history during the period since the physician last performed an assessment of the patient. As such, the PFSH is not required for an interval history.

Physical examination—The physician's physical examination of the patient.

Medical decision-making (MDM)—the nature of the presenting problem and medical necessity of the encounter are the best MDM indicators. The overall MDM level is based on three factors; the number of diagnoses or management options, the amount and/or complexity of data to be reviewed and the risk of complications and morbidity or mortality.

Each E/M description identifies the level of key components required for that visit. In addition, the description identifies whether two or three key components are required.

EXAMPLE

99214 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:

- A detailed history;
- A detailed examination;
- Medical decision making of moderate complexity.

Counseling and/or coordination of care with other physicians, other qualified healthcare professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.

Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

In this example, only 2 of the 3 key components are required. If documentation shows a problem focused history, a detailed examination, and moderate medical decision making, 99214 is still applicable because the level of examination and medical decision making are met. If the code requires 3 of 3 key components to be met, all 3 key components would have to meet the level specified.

BILLING TIP

When referring to a level of E/M visit, it is sometimes stated as Office Visit—Level 3 or Office Consultation—Level 2. The level refers to the last digit in the code section. For example, an Office Visit—Level 3 for an established patient is reported with CPT® code 99213; an Office Consultation—Level 2 is reported with CPT® code 99242.

To qualify as a consultation, three requirements must be met: 1) the services must be *requested* by another provider; 2) the consulting provider must *render an opinion or recommendation or decide to accept responsibility for ongoing care;* and 3) the consulting provider must *respond* to the requesting provider with a written report. Medicare and some commercial payers do not reimburse for consultations. CMS recommends reporting new and established office/outpatient E/M codes or initial and subsequent hospital care codes. Check with individual payers for specific benefits.

Preventive medicine services are based on the age of the patient and whether it is a new vs. established patient.

For purposes of the CPB® exam, the extent and complexity of the key components will be given. The examinee will not be expected to determine those levels but should recognize which E/M code is associated with those given levels.

EXAMPLE

A patient visits her family provider with sinus congestion and a cough. The provider performs an expanded problem focused history, an expanded problem focused exam, and medical decision making of moderate complexity. For this scenario, the correct E/M level is 99213.

99213 *Office or other outpatient visit for the evaluation and management of an established patient* which requires at least 2 of these 3 key components:

- An expanded problem focused history
- An expanded problem focused examination
- Medical decision making of low complexity

Although we have a medical decision making of moderate complexity, we need at least 2 of the 3 key components to qualify for the level of E/M. In this example, the requirements for the examination and the medical decision making are met for E/M code 99213.

BILLING TIP

In the Evaluation and Management Services section of your CPT® code book, highlight or underline the number of key components necessary for a code. In the example above, highlight or underline "requires at least 2 of these 3 components."

Time may be considered the controlling factor to qualify for an E/M service level, "when counseling and/or coordination of care dominates (more than 50 percent) the encounter," according to CPT® guidelines. The E/M category selected must include a time reference. As an example, the descriptor for level 5 established patient outpatient service 99215 specifies, "Typically, 40 minutes are spent face-to-face with the patient and/or family."

Time includes face-to-face time in the office or other outpatient setting, or floor/unit time in the hospital or nursing facility, and includes time spent with the patient and/or family members who have assumed responsibility for the care and/or decision making for the patient.

The time the physician or other qualified healthcare professional spends taking the patient's history or performing an examination does not count as counseling time. The provider must look at the entire patient encounter and decide if he or she spent the majority of time in counseling and/or coordinating care or if the key components of history, exam, and MDM should be the deciding factor when choosing an E/M level.

Counseling and coordination of care could include discussion with the patient (or his or her family) about one or more of the following, according to CPT® guidelines:

- Diagnostic results
- Impressions and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of treatment options
- Instructions for treatment and/or follow up
- Importance of compliance with chosen treatment options
- Risk-factor reduction
- Patient/family education

The provider's documentation should support the content and extent of the patient counseling. For example, Mary presents with a wrist injury. After history and exam are performed, she is counseled on care to prevent further damage of the weak wrist, including: no lifting of heavy objects and no gymnastic activities involving direct pressure on the wrist (such as hand springs, head stands, etc.). The provider spent 30 minutes with the patient and over 50 percent of that time was spent in counseling. In this case, time is the dominant factor of the E/M visit; not the E/M visit leveling of history, exam, and MDM.

It is important to note that a level of visit in one category does not directly correlate to another category. For example, the requirements to meet for a 99213 are not the same as what is required for 99203. See the chart below:

Code	99203 - New Patient Requires 3 of 3 Key Components	99213 - Established Patient Requires 2 of 3 Key Components
History	Detailed	Expanded Problem Focused
Examination	Detailed	Expanded Problem Focused
Medical Decision Making	Low	Low
Time (typical face-to-face time)	30 minutes	15 minutes

EXAMPLE

A patient is seen by the provider with pain in her knee. The provider performs an expanded problem focused history, an expanded problem focused exam, with low medical decision making. For an established patient, this is reported as 99213. However, for a new patient where all three key components must be met, this is reported as 99202.

BILLING TIP

When a provider selects a level of visit for a new patient and it is discovered the patient is established, do not select the same level of established patient visit. Review the documentation for the component levels and then select the correct level for an established patient.

The most important part of coding by time is complete and adequate documentation of the visit; this includes documentation of the total visit time and the total time the provider spends counseling.

Section Review 5.2

1. A patient is seen in the ED after having an auto accident. The patient is new to this provider. What subcategory of E/M is reported?

   A. Office or Other Outpatient Services; New Patient
   B. Initial Observation Care
   C. Initial Hospital Care
   D. Emergency Department Services

2. A patient is seen by his family provider at the provider's office. The patient last saw the provider four years prior. Which range of codes would a code be selected from?

   A. 99201–99215
   B. 99201–99205
   C. 99211–99215
   D. 99221–99233

3. A patient is admitted to the hospital for observation on date of service 01/02/XX and discharged from observation on date of service 01/03/XX. Which range of codes would the code(s) be selected from for the admit and discharge from observation?

   A. Admit 99221–99223; Discharge 99238–99239
   B. Admit and Discharge 99234–99236
   C. Admit 99218–99220; Discharge 99217
   D. Admit 99218–99220; Discharge 99224–99226

4. A patient is seen for a follow-up visit in the hospital. A problem focused interval history, an expanded problem focused exam, and MDM of low complexity. What E/M code is reported?

   A. 99213
   B. 99224
   C. 99231
   D. 99241

5. A 43-year-old established patient is seen for his annual preventive exam by the family physician. A comprehensive history, comprehensive exam, and medical decision making of low complexity is performed. What E/M code is reported?

   A. 99215
   B. 99396
   C. 99386
   D. 99402

Anesthesia

The CPT® codes describing anesthesia services (00100–01999) are used to describe the administration of anesthesia for the associated surgical procedure. To determine the proper anesthesia code, it is necessary to consider what surgical procedure is performed during anesthesia care services. The anesthesia CPT® codes are organized by anatomic regions.

There are three different types of anesthesia: General, Regional, and Monitored Anesthesia Care (MAC):

General Anesthesia—A drug-induced loss of consciousness

Regional Anesthesia—A loss of sensation in a region of the body, such as:

- **Spinal Anesthesia**—An anesthetic agent is injected in the subarachnoid space into the cerebral spinal fluid (CSF) in the patient's spinal canal for surgeries performed below the upper abdomen.
- **Epidural Anesthesia**—An anesthetic agent is injected in the epidural space. A small catheter may be placed for a continuous epidural. An epidural can also remain in place after surgery to assist with postoperative pain.
- **Nerve Block**—An anesthetic agent is injected directly into the area around a nerve to block sensation for the region the surgery is being performed. Commonly used for procedures on the arms or legs.

Monitored Anesthesia Care (MAC)—Anesthesia service where the patient is under light sedation or no sedation while undergoing surgery with local anesthesia provided by the surgeon. The patient can respond to purposeful stimulation and can maintain his airway. The service is monitored by an anesthesia provider who is prepared to convert MAC to general anesthesia if necessary.

Anesthesia services are typically reported using both the appropriate CPT® code and the time that the anesthesia services were provided. Time is reported in actual minutes. Payment for anesthesia services is calculated using the number of base anesthesia units associated with each anesthesia code, the time those services were provided (most payers calculate time units as 15 minutes for one unit) and modifying units (physical status and qualifying circumstances). The units are then multiplied by a conversion factor or dollar amount.

Selecting an anesthesia code follows the same basic steps as assigning procedure codes for other specialties. Billers either will use the CPT® Index under Anesthesia, in the back of the CPT® code book to locate the correct anatomic area or turn to the blue edged "Anesthesia 00100" pages with an index page at the beginning of the section and look under the appropriate anatomic heading.

EXAMPLE

To look for the anesthesia code for a percutaneous liver biopsy, you can look in the CPT® Index or in the Anesthesia section of the CPT® code book.

1. In the CPT® Index

– Anesthesia

Biopsy

Ear	00120
Liver	00702
Salivary Glands	00100

Refer to the code (00702) in the Anesthesia section to verify it is correct.

2. In the Anesthesia section table of contents, look for Upper Abdomen which directs you to code range 00700–00797.

00702 *Anesthesia for procedures on upper anterior abdominal wall; percutaneous liver biopsy*

Until the medical biller becomes familiar with anatomical codes, it is best to use the index found in the back of the book and look for the term Anesthesia. Keep in mind codes are not always found under the surgical description and the biller may need to default backward to find the most accurate description.

There are several modifiers that are specific to anesthesia codes. P1–P6 are physical status modifiers that designate the general health status of the patient. Some payers recognize these modifiers for payment purposes. There are also four add-on codes that are used to identify specific qualifying circumstances, including extreme age (99100), the use of total body hypothermia (99116), the use of controlled hypotension (99135), and emergency conditions (99140). If the qualifying circumstance is part of the CPT® code description, the qualifying circumstance is not reported. There is typically a parenthetic instruction stating not to use the qualifying circumstance code.

EXAMPLE

00834 Anesthesia for hernia repairs in the lower abdomen not otherwise specified, younger than 1 year of age.

(Do not report 00834 in conjunction with 99100).

99100 reports anesthesia for a patient who is younger than one or older than 70. The descriptor for 00834 indicates in the procedure description that it is for a patient younger than one. Therefore, the qualifying circumstance code 99100 is not reported.

HCPCS Level II modifiers are applied to report the circumstances surrounding the various methods of anesthesia delivery. These modifiers report if the anesthesiologist personally performed the anesthesia, provided medical supervision of the anesthesia, or provided medical direction of the anesthesia. To apply the provider modifiers correctly, the types of providers must be understood.

The anesthesiologist is a physician licensed to practice medicine and has completed an accredited anesthesiology program. These physicians may personally perform, medically direct, or medically supervise members of an anesthesia care team.

A certified registered nurse anesthetist (CRNA) is a registered nurse who has completed an accredited nurse anesthesia training program. The CRNA may be either medically directed by an anesthesiologist or non-medically directed.

An anesthesiologist assistant is a health professional who has completed an accredited anesthesia assistant training program. The anesthesiologist assistant may only be medically directed by an anesthesiologist. Anesthesiologist assistant should be spelled out because the abbreviation AA will be confused with the HCPCS Level II modifier containing the same letters.

An anesthesia resident is a physician who has completed his medical degree and is in a residency program specifically for anesthesiology training.

A student registered nurse anesthetist (SRNA) is a registered nurse who is training in an accredited nurse anesthesia program.

These modifiers are reported only with anesthesia CPT® codes:

- AA—Anesthesia services performed personally by anesthesiologist
- AD—Medical supervision by a physician: more than four concurrent anesthesia procedures

Note: "Concurrency" refers to all current ongoing anesthesia cases during the same time under the direction or supervision of an anesthesiologist.

- QK—Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals
- QY—Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist
- GC—This service has been performed in part by a resident under the direction of a teaching physician

The following medical supervision/direction modifiers are reported with CRNA or anesthesiologist assistant services:

- QX—CRNA service: with medical direction by a physician
- QZ—CRNA service: without medical direction by a physician

Note: State scope of practice may prohibit an Anesthesiologist Assistant from reporting claims with a non-medical direction modifier. If a provider moves from QK—Medical direction of 2, 3, or 4 concurrent anesthesia procedures involving qualified individuals to AD—Medical supervision by a physician: more than 4 concurrent anesthesia procedures, the CRNA still reports QX as the CRNA would not necessarily know the number of cases the anesthesiologist is overseeing.

Medical Direction modifiers are associated with specific providers and are reported in the first position after the anesthesia CPT® code because payment often is related to the modifier reported.

Additional anesthesia-related modifiers usually are reported in the second position after any related medical direction modifiers, as they are considered informational or statistical. Modifiers affecting payment always should be reported in the position before information/statistical modifiers.

If more than one surgical procedure is performed during a single anesthetic, the anesthesia code that describes the most complex procedure (highest unit value) is reported. The remaining procedures are reflected in the increased time that the anesthesia services were provided.

EXAMPLE

A patient has two surgical procedures at one time:

01220 Anesthesia for all closed procedures involving upper two-thirds of femur

01380 Anesthesia for all closed procedures on knee joint

The closed procedure involving the upper two-thirds of the femur has 4 base units and the closed procedure on the knee joint has 3 base units. Only the code for the femur (01220) is reported because it is more complex and has a higher base value than the closed procedure on the knee.

Surgery

CPT® codes describing surgical procedures describe a package of services that may include:

- Local anesthesia (including digital nerve blocks)
- One E/M encounter on the day of, or immediately preceding the date of, surgery (unless the decision for surgery was made at that visit, in which case it may be claimed separately)

- Immediate postoperative care in the recovery area, including writing orders and dictating operative notes
- Talking with the family and other physicians
- Typical postoperative follow-up care

Follow-up services provided during the postoperative global period are typically included in the fee; however, there is no single definition of "global period" for all payers. Medicare designates either a 0-day, 10-day (minor surgery) or 90-day (major surgery) global period for each surgical code. Many payers adopt the Medicare global period, and these will be used for purposes on the CPB® exam.

BILLING TIP

Mark the global days in the surgical section of your CPT® code book:

10-day—minor surgery

90-day—major surgery

To determine the global period, the Medicare Physician Fee Schedule can be referenced:

HCPCS	MOD	DESCRIPTION	GLOB DAYS
11740		Drain blood from under nail	000
11750		Removal of nail bed	010
11755		Biopsy nail unit	000
11760		Repair of nail bed	010
11762		Reconstruction of nail bed	010
11765		Excision of nail fold toe	010
11770		Remove pilonidal cyst simple	010
11771		Remove pilonidal cyst exten	090

Global Days Status Indicators

000 Endoscopies or minor procedures with preoperative and postoperative relative values on the day of the procedure only are reimbursable. Evaluation and management services on the same day of the procedure are generally not payable. (eg, CPT® 43255, 53020, 67346).

010 Minor procedures with preoperative relative values on the day of the procedure and postoperative relative values during a 10-day postoperative period are reimbursable services. Evaluation and management services on the day of the procedure and during the 10-day postoperative period are also generally not reimbursable. (eg, CPT® 17261, 40800, 64612).

090 Major procedures with one day preoperative period and 90-days postoperative period are considered to be a component of global package of the major procedure. Evaluation and management services on the day prior to the procedure, the day of the procedure, and during the 90-day postoperative period are not reimbursable. (eg, CPT® 21048, 32664, 49582).

MMM Maternity codes; the usual global period concept does not apply. (eg, CPT® 59400, 59612).

XXX The global concept does not apply to this code. (eg, Evaluation and Management services, Anesthesia, Laboratory and Radiology procedures) (eg, CPT® 10021, 36593, 38220, 44720).

YYY These are unlisted codes, and subject to individual pricing. (eg, CPT® 19499, 20999, 44979).

ZZZ These represent add-on codes. They are related to another service and are always included in the global period of the primary service. (eg, CPT® 27358, 44955, 67335).

Follow-up care for diagnostic procedures includes care related to recovery from the procedure. Care related to the underlying condition for which the diagnostic procedure was performed is not included. Any such care performed during the recovery period may be separately reported. Follow-up care for therapeutic procedures includes those services that are typically included as part of the surgical procedure. Care required due to complications, exacerbations, recurrences, or other diseases may be separately reported. Medicare will only reimburse separately for postoperative complications that result in a return to the operating room. Postoperative complications treated during an office visit during the postoperative period are included with the global payment and should not be listed separately.

When multiple procedures are performed during a single surgical episode, the major (or most complex) procedure is reported with the appropriate CPT® code. The additional procedures are reported with modifier 51 attached to the CPT® codes that describe those additional procedures. The use of modifiers is discussed more fully in the section on Modifiers.

BILLING TIP

Some payers request modifier 51 not be appended as the payers processing system is programmed to automatically append modifier 51 to subsequent procedures. It is necessary for a medical biller to know the policies of their payers.

Some codes are designated with the plus sign symbol as add-on codes. These codes usually designate additional lesions, levels, locations, or procedures performed in addition to the primary procedure. Add-on codes should never be reported without a parent code with which it is associated. Because these codes are already designated as add-on codes and can only be reported with a parent code, it is not necessary to attach modifier 51 to these codes.

EXAMPLE

15260 Full thickness graft, free, including direct closure of donor site, nose, ears, eyelids, and/or lips; 20 sq cm or less

+15261 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

The proper reporting for a full thickness graft of the nose that is 30 sq cm is 15260, 15261. Modifier 51 is not appended to 15261 because it is an add-on code.

Numerous codes include the term "separate procedure" in the code descriptor. This is often misunderstood to mean that these codes may be billed separately no matter what other procedures are performed during the same setting. That is an incorrect interpretation. These codes are used when the procedure described by the code is performed alone as a "separate procedure." If the procedure is performed as part of another procedure that typically includes the "separate procedure," then separate reporting of the "separate procedure" code is incorrect.

EXAMPLE

CPT® codes 45330 *Sigmoidoscopy, flexible; diagnostic, including collection of specimen(s) by brushing or washing when performed (separate procedure)* and 45331 *Sigmoidoscopy, flexible; with biopsy, single or multiple* cannot be reported together. Even though CPT® code 45330 is designated as a separate procedure, that procedure is inherent within the description of CPT® code 45331. If only the procedure described by CPT® code 45330 is performed, then that code may be reported separately.

Surgical procedures are often found in the CPT® Index under the anatomic location or under the procedure being performed.

EXAMPLE

The code for a liver biopsy can be found in the CPT® Index under Biopsy/Liver which directs you to 47000, 47001, 47100, 47700.

Biopsy

Liver 47000, 47001, 47100, 47700

You can also look under Liver/Biopsy, which directs you to more options. Looking under Liver/Biopsy gives you options that narrows down the code selection:

Liver	
Biopsy	47700
Needle	47000, 47001
Wedge	47100
with Staging Laparotomy	49220

It is very important to read the section guidelines and parenthetical instructions in the surgical section as they give guidance on correct coding for procedures. Some guidance that can be found in the surgical section guidelines and parenthetical instructions includes:

1. Each lesion excision is reported separately while the length of multiple repairs performed within the same anatomic section and complexity are added together to report the correct code.

EXAMPLE

A 7.5 cm intermediate repair is performed on a wound on the right leg and a 2.5 cm intermediate repair is performed on a wound on the right arm. Because both wounds are classified to the extremities and are both intermediate repairs, the length of the repairs are added together (7.5 cm + 2.5 cm = 10 cm) to report 12034.

12034 Repair, intermediate, wounds of scalp, axillae, trunk and/or extremities (excluding hands and feet); 7.6 cm to 12.5 cm

2. A diagnostic endoscopy or arthroscopy is always included when performed with a surgical endoscopy or arthroscopy respectively.

EXAMPLE

29800 Arthroscopy, temporomandibular joint, diagnostic, with or without synovial biopsy (separate procedure)

29804 Arthroscopy, temporomandibular joint, surgical

CPT® code 29800 is inclusive to CPT® code 29804 and is not reported separately.

3. Some interventional codes have supervision and interpretation included in the procedure. The imaging codes are not reported in addition to the procedure code. There are often instructions for this in both the section guidelines and in parenthetical instructions.

EXAMPLE

Transluminal Angioplasty

Percutaneous

Codes for the radiologic supervision and interpretation should not be reported in addition to the code(s) for the therapeutic aspect of the procedure. Codes for catheter placement can be billed separately

37246 Transluminal balloon angioplasty (except lower extremity artery(ies) for occlusive disease, intracranial, coronary, pulmonary, or dialysis circuit), open or percutaneous, including all imaging and radiological supervision and interpretation necessary to perform the angioplasty within the same artery; initial artery

4. Sometimes, the use of modifiers in certain circumstances is included in the section guidelines.

EXAMPLE

Digestive System

Colon and Rectum

Endoscopy

When performing a diagnostic or screening endoscopic procedure on a patient who is scheduled and prepared for a total colonoscopy, if the physician is unable to advance the colonoscope to the cecum or colon-small intestine anastomosis due to unforeseen circumstances, report 45378 (colonoscopy) or 44388 (colonoscopy through stoma) with modifier 53 and provide appropriate documentation.

5. Coding guidance may also be found in parenthetic instructions.

EXAMPLE

58672 Laparoscopy, surgical; with fimbrioplasty

58673 Laparoscopy, surgical; with salpingostomy (salpingoneostomy)

(Codes 58672 and 58673 are used to report unilateral procedures. For bilateral procedure, use modifier 50)

EXAMPLE

63620 Stereotactic radiosurgery (particle beam, gamma ray, or linear accelerator); 1 spinal lesion

(Do not report 63620 more than once per course of treatment)

Section Review 5.3

1. What is the CPT® code for anesthesia performed for surgical arthroscopy on the ankle?

   A. 29891
   B. 01464
   C. 00400
   D. 01522

2. Anesthesia procedures 00830 (4 base units) and 00832 (6 base units) are both performed. How are these reported on the claim form?

   A. 00830, 00832 with the time units per procedure
   B. 00830, 00832-51 with the time units per procedure
   C. 00830 with the time units for both procedures
   D. 00832 with the time units for both procedures

3. What CPT® code is reported for a diagnostic proctosigmoidoscopy?

   A. 45300
   B. 45305
   C. 45317
   D. 45320

4. What guidance is found under CPT® code 64492?

   A. Report modifier 50 when the procedure is performed bilaterally
   B. Do not report 64492 in conjunction with 64490
   C. Do not report 64492 in conjunction with 64491
   D. Do not report 64492 more than once per day

5. Which reporting option below is correct for CPT® code 69424?

   A. 69424-50
   B. 69424-50, 69420
   C. 69433, 69424
   D. 69801, 69424

Radiology

CPT® codes in the 70000 range describe radiological services. Often these services are performed as part of an interventional procedure and are designated as "radiological supervision and interpretation." In those cases, where a single provider performs both the interventional procedure and the radiological services, that provider may submit both codes to describe the total services provided.

Most radiology codes can be divided into technical and professional components, designated with modifier TC for the technical component and modifier 26 for the professional component. The entity that owns the equipment used to perform the service usually files a claim for the technical component, while the professional interpreting the image claims the professional component. If the same provider owns the equipment and provides the interpretation, the global service is reported without a modifier.

EXAMPLE

You can see how the payment is distributed based on the modifier by looking at the Physician Fee Schedule for 72020:

HCPCS CODE	MODIFIER	SHORT DESCRIPTION	NON-FACILITY PRICE
72020		Radiologic examination, spine; single view, specify level	$23.43
72020	26	Radiologic examination, spine; single view, specify level	$7.93
72020	TC	Radiologic examination, spine; single view, specify level	$15.50

If the provider owns the equipment and provides the interpretation and report, 72020 is reported.

If the X-ray is taken at the hospital and the provider only provides the interpretation and report, 72020-26 is reported by the provider.

In the CPT® Index, some imaging can be found under the location being imaged. Other entries in the index where imaging may be found include X-Ray, CT Scan for computed tomography, Magnetic Resonance Imaging (MRI), etc.

EXAMPLE

Chest

Diagnostic Imaging	
Angiography	71275
CT Angiography	71275
CT Scan	71250, 71260, 71270
Magnetic Resonance Angiography	71555
Magnetic Resonance Imaging (MRI)	71550-71552
PET Imaging	78811, 78814
Ultrasound	76604
X-Ray	
See X-Ray, Chest	

When coding radiology services, it is important to know which views and how many views are taken. Many codes in this section are based on the views taken.

EXAMPLE

72114	Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views

It is also important to note when contrast is used for imaging. Code selection for some radiologic procedures will have code options for with contrast, without contrast, and without contrast followed by with contrast. According to the CPT® guidelines, the term "with contrast" is used when the contrast is administered intravascularly, intra-articularly, or intrathecally. An intravascular injection is one that is given within the vessel (artery or vein). An intra-articular injection is given into the joint. An intrathecal injection is given into the subarachnoid space of the spinal cord. Oral and rectal contrast do not qualify as a study "with contrast."

Laboratory

CPT® codes in the 80000 range are for reporting specific laboratory tests or specific groups of tests, commonly known as panels. These codes do not include the collection of the specimen on which the tests are performed. The appropriate codes describing various specimen collections may be claimed in addition to the codes for the laboratory tests. Sometimes, the insurance carrier will consider the collection of the specimen inclusive to an office visit and is considered a write off by the provider.

EXAMPLE

99213 Office or other outpatient visit

36415 Collection of venous blood by venipuncture

Some insurance carriers will pay for the office visit and deny the collection of blood as inclusive to the office visit.

The CPT® contains approximately 10 panels that contain specific combinations of tests. These codes are not used unless every test in the panel is performed. When a combination of tests is performed that does not exactly match one of the standard panels, the code for the panel that contains the greatest number of tests performed is listed and the additional tests are reported individually.

EXAMPLE

A physician performs a battery of tests that includes sodium, potassium, chloride, carbon dioxide, urea nitrogen, creatinine, and glucose. This almost matches the basic metabolic panel (80047), but the basic metabolic panel also includes ionized calcium. The physician cannot claim 80047. She can, however, use 80051 (electrolyte panel) to describe the sodium, potassium, chloride and carbon dioxide measurements and separately claim the urea nitrogen (84520), creatinine (82565), and glucose (82947) tests.

Codes describing anatomic, cytological, and surgical pathology services may be divided into technical and professional components. Similar to radiological procedures, the entity that owns the laboratory equipment claims the technical component, while the provider interpreting the results of the test claims the professional component.

Codes for this section can be found in the CPT® Index under Pathology and Laboratory.

Medicine

The Medicine section includes codes describing numerous diverse medical services, including immunization services, psychiatric services, dialysis, cardiovascular services (including catheterization, angioplasties, stent placement, and various implantable cardiac devices), allergy treatments, neurological testing, intravenous infusions, physical medicine,

rehabilitation services, and more. As with other sections in the CPT® code book, pay close attention to the guidance found in the section guidelines and in parenthetic instructions.

Modifiers

Modifiers are appended to CPT® and HCPCS Level II codes to report specific circumstances or alterations to a procedure, service, or medical equipment without changing the definition of the code. Both CPT® and HCPCS Level II code books list modifiers and their descriptions.

CPT® modifiers are two-digit codes. Appendix A lists CPT® modifiers, and includes a wide range of modifiers, including those used for anesthesia and modifiers reported by ASCs and hospital outpatient facilities. HCPCS Level II modifiers are in Appendix B of the HCPCS Level II code book.

When reporting codes with more than one modifier, always list functional, or pricing modifiers in the first position. Payers consider functional modifiers when determining reimbursement. Next, report the informational modifiers; these modifiers clarify certain aspects of the procedure or service provided for the payer (procedures performed on the left or right side of the patient's body).

Modifiers affecting payment include those that identify the following:

- Procedures with both professional and technical components, but only one component is included on the claim
- When more than one provider performed all or part of the procedures
- Procedures that were increased or decreased from the usual procedure definition, but no other procedure code correctly identifies the modified procedure
- When multiple different procedures were performed during the same session
- When a single procedure was performed more than once during the same session
- When a single procedure was performed bilaterally

Modifier 22

Increased Procedural Services: When the service provided is greater than that usually required for the listed procedure, it may be identified by adding modifier 22 to the usual procedure code number. Documentation must support the substantial additional work and the reason for the additional work. Modifier 22 is not appended to E/M codes.

(Append modifier 22 to a procedure code when the provider describes "above and beyond" circumstances within his operative report, and there is no other procedure code to describe the extensive services.)

Appropriate Uses:

- Excessive blood loss during the procedure
- Excessively large surgical specimen
- Trauma extensive enough to complicate the procedure and not billed as additional procedure codes
- Other pathologies, tumors, malformations (genetic, traumatic, surgical) that interfere directly with the procedure but are not billed separately

Inappropriate Uses:

- Increased time to perform a procedure due to provider variation in practice or minor anatomical variation
- Another code exists that describes the increased work

Keywords: extended time, took longer than normal, extenuating circumstances, etc.

Modifier 24

Unrelated E/M by the Same Physician or Other Qualified Healthcare Professional During a Postoperative Period: The physician or other qualified healthcare professional may need to indicate an E/M service was performed during a postoperative period for reasons unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

Appropriate Uses:

- Added to CPT® codes 99201-99499 and 92012-92014 to indicate the evaluation is unrelated to the surgical procedure.
- Some insurance carriers allow the use of modifier 24 when the E/M is due to a complication of the surgical procedure. This is carrier specific.

Inappropriate Uses:

- Adding modifier 24 for hospital visits during the initial postoperative period, unless the physician is providing one of the following services:
  - Immunosuppressive therapy
  - Chemotherapy
  - Critical care services unrelated to the original surgery
- Office visit during the global period when the major purpose of the visit is to follow up on the original surgery.

Keywords: unrelated, outside of, not related to, etc.

Modifier 25

Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Healthcare Professional on the Same Day of the Procedure or Other Service: It may be necessary to indicate that on the 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 other service provided or beyond the usual preoperative and postoperative care associated with the procedure performed. It is not required that the E/M service have a different diagnosis than the other procedure.

Appropriate Uses:

- With E/M codes describing initial hospital visits (99221-99223), initial hospital consult (99251-99255), or hospital discharge (99238 or 99239) on the same day as a separate inpatient hospital service, such as dialysis, that would not typically require such E/M services.
- When a significant, separately identifiable E/M service is performed on the same day as a preventive care visit. The E/M service must be performed for a non-preventive reason and must be clearly documented.

Inappropriate Uses

- Used to indicate the E/M service resulted in the decision to perform a major surgery (see Modifier 57).
- On a surgical procedure code (10021-69990). It is added to the E/M code when both are performed together.
- On an office visit E/M code when the primary purpose of the visit is to perform a minor surgical procedure. In this instance, only the minor surgical procedure should be billed.

Keywords: unrelated, outside of, not related to, etc.

BILLING TIP

Modifier 25 is commonly misused. To use modifier 25, work with your coder to determine if the documentation supports an E/M visit separate from the surgical procedure performed at the same time. This modifier is under constant evaluation by payers.

Modifier 26

Professional Component: Certain procedures are a combination of a professional component and a technical component. When the professional component is reported separately, identify it as such by adding modifier 26 to the usual procedure code.

Appropriate Uses:

- An imaging study is performed in a hospital and interpreted by a physician. The physician appends modifier 26 to the code and the hospital submits a claim for the technical component of the test using modifier TC.
- The physician should only submit a claim for professional services in those instances where he or she interprets the test and prepares a written report of that interpretation for use by others.

Inappropriate Uses:

- Using both modifier 26 and modifier TC to report the professional and technical components by a single provider. If the same provider performs both the professional and technical components, it is considered global and no modifier is appended.
- Using the modifier when re-reading a study originally interpreted by another provider. Many insurance carriers, including Medicare, will only pay for a single interpretation of a study, regardless of how many professionals review the study for their own decision-making purposes.

Keywords: independent radiologist, performed in a hospital, etc.

Modifier 50

Bilateral Procedure: Bilateral procedures performed at the same operative session code. For most insurance carriers, bilateral services are reported with a single use of the appropriate code with modifier 50 appended. Some insurance carriers require the code be reported twice with modifier 50 added to one of the codes.

Not all procedures can be reported with modifier 50. Some code definitions include the statement "unilateral or bilateral" or similar language, indicating that the code is used only once even if the procedure is performed on both sides.

Instructions for use of modifier 50 are often found in the CPT® guidelines and parenthetic instructions.

Appropriate Uses:

- When the exact same service is performed bilaterally.
- Medicare indicates which CPT® codes can be reported with modifier 50 on the Medicare Physician Fee Schedule (MPFS). Other insurance carriers also determine when they will accept the modifier 50.
- Medicare recognizes the modifier 50 appended to radiology codes when the same study is performed on each side. Not all insurance carriers allow this modifier combination.

Inappropriate Uses:

- Bilateral procedures performed on different areas of the right and left sides of the body.
- Appending the modifier 50 to a code identified as a bilateral procedure in the description of the code (for example, 40843 Vestibuloplasty; posterior, bilateral).
- Appending the modifier 50 to a code identified as a unilateral or bilateral procedure in the description of the code (for example, 31231 Nasal endoscopy, diagnostic, unilateral or bilateral).

Keywords: bilateral, both sides, left and right, etc.

Modifier 51

Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services, or provision of supplies are performed at the same session by the same provider.

Appropriate Uses:

- Append modifier 51 to additional procedures (that are not modifier 51 exempt) performed during the same operative session.
- Multiple instances of the same service if each service is listed on a separate line and does not require modifier 59.

Inappropriate Uses:

- Separating or unbundling a procedure into its components and appending modifier 51 to one or more components.
- Appending modifier 51 to add-on codes or to codes listed as modifier 51 exempt.
- Appending to an E/M code.

Keywords: a different procedure, separate from, etc.

Modifier 52

Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the physician's or other qualified healthcare professional's discretion. Under these circumstances, the service provided can be identified by its usual procedure code and the addition of modifier 52.

Appropriate Uses:

- Indicate the provider reduced or eliminated some services usually associated with the code to which the modifier is appended.

Inappropriate Uses:

- Indicate terminated procedures (refer to modifier 53).
- Appended to E/M services.
- Appended to time-based services, such as psychotherapy, anesthesia, or critical care services.

Keywords: partially, to be reduced, part of procedure not completed, etc.

Modifier 53

Discontinued Procedure: Under certain circumstances, the physician or other qualified healthcare professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances, or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued.

Appropriate Uses:

- When a provider begins a procedure, but decides to discontinue due to:
  - Uncontrollable bleeding, hypotension, or physiologic changes
  - Unexpected findings during surgery making continuing surgery unnecessary or ill-advised
  - Anesthesia complication
- Modifier 53 may be used to report terminated procedures in the office.

Inappropriate Uses:

- Elective cancellation of a procedure prior to anesthesia induction and/or surgical preparation in the surgical suite.

Keywords: procedure stopped before completion, aborted the procedure, etc.

Modifiers 54, 55, and 56

Modifiers 54, 55, and 56 are appended to procedures to indicate different providers provided the **preoperative** (modifier 56), **intraoperative** (modifier 54) and **postoperative services** (modifier 55). These modifiers are only appended to codes that have a global period. For procedures without a global period (global period of zero days), pre- and postoperative services are reported separately without using modifiers.

Insurance carriers usually establish the percentage of the global fee attributable to each partial service. For Medicare, the surgeon performing the procedure must see the patient at least once before transferring care to the provider assuming postoperative management.

Appropriate Uses:

- Modifier 54 is appended to indicate the provider performed only the surgical procedure.

- If a single provider provides surgical and postoperative care, but not the preoperative care, modifiers 54 and 55 are appended.

Inappropriate Uses:

- Appending modifier 54 to surgical codes without a global period.
- Appending modifier 55 to inpatient postoperative visits by a provider of a different specialty; those visits should be identified by hospital visit E/M codes (99231-99233).
- Appending modifier 54, 55, or 56 to an E/M code.

Modifier 54 Keywords: only performed the surgical procedure, no pre or post-op management, etc.

Modifier 55 Keywords: post-op follow-up only, postoperative care turned over to, transfer of care, etc.

Modifier 56 Keywords: pre-op evaluation only, covering for surgeon, etc.

Modifier 57

Decision for Surgery: When an E/M service provided the day before or the day of a surgery results in the decision to perform surgery, append modifier 57 to the appropriate level of E/M service. Most insurance carriers, including Medicare, only recognize this modifier when appended to an E/M service performed on the day of or day before a major surgical procedure, which is identified as having a 90-day global period. Some insurance carriers recognize the use of this modifier for minor procedures.

Appropriate Uses:

- For a Medicare claim, append modifier 57 to the E/M service during which the decision was made, if that E/M visit occurred the day before or the day of a surgical procedure with a 90-day global period.
- When the decision for a subsequent surgery occurs during the global period of a previous surgery, append both modifier 24 and modifier 57 to the E/M code.

Inappropriate Uses:

- Do not use on a Medicare claim for the decision to perform a minor procedure.
- Do not use on an E/M code on the day of surgery when the actual decision for surgery was made in advance.
- Do not append to a surgical procedure.

Keywords: decision to perform surgery, will need to go to OR, etc.

Modifier 58

Staged or Related Procedure or Service by the Same Physician or Other Qualified Healthcare Professional During the Postoperative Period: It may be necessary to indicate the performance of a procedure or service during the postoperative period was:

a) planned prospectively at the time of the original procedure (staged);

b) more extensive than the original procedure; or

c) for therapy following a diagnostic surgical procedure

Report the circumstance by adding modifier 58 to the staged or related procedure.

Appropriate Uses:

- When a patient is planned to have the second procedure (eg, daily debridement of a burn).
- When the procedure is more extensive than the original procedure (eg, a lumpectomy followed by a complete mastectomy on the same breast).

Inappropriate Uses:

- When a patient is returned to the operating room for a complication.

Keywords: return to OR, will proceed with additional services in next procedure, etc.

Modifier 59

Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify services not normally reported together but are appropriate under the reported circumstances. CMS NCCI documentation has specific examples for the correct use of modifier 59.

Appropriate Uses:

- Used with code pairs listed in the National Correct Coding Initiative (NCCI) edits when supported in the documentation as a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or a separate lesion and allowed by the NCCI edit.
- Modifier 59 is appended to the column 2 code if circumstances permit both services to be reported separately.
- Modifier is considered the modifier of last resort and is only used when there is no other appropriate modifier.

Inappropriate Uses:

- Depending on carrier policy, do not use with codes that are not listed in the NCCI edits.
- Do not use with E/M codes.
- For Medicare claims, do not use with a code pair that has a correct coding modifier (CCM) indicator restricting the use of a modifier or if one of the X-[ESPU] modifiers is more appropriate. The abbreviation represents the separate Encounter, Structure, Practitioner, and Unusual service. These will be discussed in more detail in Chapter 7.
- Documentation does not support the services were separate and distinct.
- If another modifier exists to describe the service.
- Do not append with modifier 51 on the same procedure code.

Keywords: separate procedure, needed additional services, etc.

Modifier 79

Unrelated Procedure or Service by the Same Physician or Other Qualified Healthcare Professional During the Post-operative Period: The physician or other qualified healthcare professional may need to indicate the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using modifier 79.

Appropriate Uses:

- The second procedure must be unrelated to the original procedure, must be performed by the same provider, and must be performed during the global period of the first procedure.

Inappropriate Uses:

- Do not use modifier 79 when the second procedure is related to the first.

Keywords: not related to previous care, etc.

Modifier 80

Assistant Surgeon: Surgical surgeon assistant services may be identified by adding modifier 80 to the usual procedure code(s).

Appropriate Uses:

- The provider assisted the surgeon during the procedure.
- An assistant surgeon is appropriate for the procedure. The MPFS Relative Value Files containing this information can be found on the CMS website.

Inappropriate Uses:

- Use by a provider not qualified to assist in surgery.
- Use with a procedure that is not eligible for an assistant surgeon.

Keywords: assisted, surgeon called in to help, etc.

Section Review 5.4

1. What CPT® code is reported for an MRI of the brain without contrast?

   A. 70350
   B. 70551
   C. 70552
   D. 70553

2. A provider orders a lipid panel. According to the practice standards, this includes a complete blood count (85027), total cholesterol (82465), HDL cholesterol (83718), and triglycerides (84478). What is reported on the claim form?

   A. 80061
   B. 80061, 85027
   C. 80053, 82465, 83718, 84478
   D. 85027, 82465, 83718, 84478

3. Which reporting option below is correct for immunization administration for vaccines or toxoids?

   A. 90460, 90474
   B. 90471, 90473
   C. 90461, 90474
   D. 90472, 90474

4. Which reporting option below is correct use of the modifier 50?

   A. 19318-50
   B. 36251-50
   C. 36252-50
   D. 69801-50

5. Which reporting option below is correct use of a modifier with an E/M code?

   A. 99213-22
   B. 99213-25
   C. 99213-59
   D. 99213-54, 55, 56

Glossary

Add-on Code—CPT® code used to report a supplemental or additional procedure appended to a primary procedure (stand-alone) code. Add-on codes are recognized by the CPT® symbol +used throughout the CPT® code book.

Centers for Medicare & Medicaid Services (CMS)—Agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid and State Children's Health Insurance Programs (CHIP).

Current Procedural Terminology (CPT®)—A code set copyrighted and maintained by the American Medical Association (AMA).

Global Package—The period (0–90 days as determined by the health plan) and services provided for a surgery inclusive of preoperative visits, intraoperative services, post-surgical complications not requiring a return trip to the operating room, postoperative visits, post-surgical pain management by the surgeon, and several miscellaneous services as defined by the health plan, regardless of setting (for example, in a hospital, an ambulatory surgical center (ASC), or physician office).

Global Surgery Status Indicator—An assigned indicator, which determines classification for a minor or major surgery, based on relative value unit (RVU) calculations.

Major Surgery—Surgeries classified as major have a global surgical period that includes the day before the surgery, the day of surgery, and any related follow-up visits with/by the physician 90 days after the procedure.

Minor Surgery—Surgeries classified as minor have a global surgical period that includes the preoperative service the day of surgery, the surgery, and any related follow-up visits with/by the physician 0–10 days after the surgery.

National Correct Coding Initiative (NCCI)—Used by professional billers to determine codes considered by CMS to be bundled codes for procedures and services deemed necessary to accomplish a major procedure. This is to promote correct coding methodologies and to control improper assignment of codes that results in inappropriate reimbursement.