Welcome to
Coding Basics - Essentials You Must Know to Thrive
Brought to you by ACC's Cardiovascular Administrator Work Group
Presented by the ACC in conjunction with the MedAxiom Business Office and Coding Network (BOCN)
September 18, 2012
1-2 pm ET
Thank you for joining us this afternoon!

Speakers
Margie Amato, MBA, RHIA, ACS-CA, is the Director of the Business Office Coding Network of MedAxiom Inc. in Neptune Beach, Florida.

Debra Mariani, CPC, CGSC is a Senior Specialist in the Advocacy department of the American College of Cardiology in Washington, D.C.

What is Medical Coding?
Medical Coding – the process of applying nationally recognized codes to represent the clinical information that is documented in the patient’s chart. The codes are used to describe the diagnosis information related to a patient’s clinical condition as well as the services and supplies. In the United States we use three primary coding systems for billing purposes:
1. International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM**) (**ICD-10-CM on 10/1/14)
2. Healthcare Common Procedure Coding System (HCPCS) – Level II codes

Coding Flow Charts

![Coding Flow Chart Image]
ICD-9 Book – Break Down

1. Introduction
2. Volume 2 – Alphabetic Index
3. Volume 1 – Diseases: Tabular List
4. Volume 3 – Procedures (Hospital Billing)
5. Proposed Inpatient Procedures

Breaking Down the CPT Book by Tabs

1. Evaluation and Management (E/M) – 99201 - 99499
2. Anesthesia -00100 -01999
4. Musculoskeletal System – 20005 – 29999
5. Respiratory System –30000 –32999
6. Cardiovascular System – 33010 – 39599
7. Digestive System – 40490 – 49999
8. Urinary System – 50010 – 53899
9. Male/Female Genital System – 54000 – 58999
10. Nervous System – 61000 -64999
11. Eye/Ocular Adnexa – 65091 – 68899
12. Radiology Codes – 70010 – 79999
13. Pathology and Laboratory – 80047 – 89398
14. Category II Codes
15. Category III Codes
16. Appendices A – N
17. Index
Decision Tree for New vs. Established Patients

Received any Professional Service from the physician or another physician in group of same specialty with last three years?

No

New Patient

Yes

Exact Same Specialty

No

New Patient

Yes

Exam Same Specialty

No

Established

Yes

New Patient

Question 1

Does anyone recall the “Nike” slogan?

1. You can do it
2. I don’t have time to do it
3. I am not doing it
4. Just do it
5. I’ll do it tomorrow

NCCI EDITS

- The National Correct Coding Initiative (NCCI) – is a value tool to use in order to file a clean claim. This resource is available free on the CMS website:


Example of Edits

<table>
<thead>
<tr>
<th>Code</th>
<th>Code</th>
<th>Date</th>
<th>Edits</th>
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<tbody>
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Resources

- Current year ICD-9-CM book -
- Current year CPT book – Read all the guidelines, review your codes to see if they have been deleted, revised or you have new codes.
- Current year HCPCS book -
- CMS Website
- Know your local Medicare Administrative Contractor
- Place of Service Codes -
- CMS Website
- Place of Service Codes -
- CMS Website
- Place of Service Codes -
- CMS Website
- Place of Service Codes -

Helpful Websites

- [www.cms.hhs.gov](http://www.cms.hhs.gov/)

Websites

- [http://oig.hhs.gov/](http://oig.hhs.gov/)
- [http://oig.hhs.gov/compliance/](http://oig.hhs.gov/compliance/)
- [www.aapc.com](http://www.aapc.com)
- [www.ahima.org](http://www.ahima.org)
- [www.ama-assn.org](http://www.ama-assn.org)

The Rules – Evaluation & Management Codes

14

15

16
EM Coding - Decision Points

• Which Category
• What level within that category

Most Used Code Categories

• Office
  – New Patient
  – Established
  – Consult
• Hospital
  – Initial Visit (Admit)
  – Subsequent Visit
  – Consult

New vs. Established

• New Patient – Has not been seen by a physician of the same specialty, same group, within the past 3 years.

• Established Patient – Has been seen by a physician of the same specialty, same group in the past 3 years.
EM Coding Levels-Key Elements

1. History
   – History of Present Illness (HPI)
   – Review of Systems (ROS)
   – Past, Family, Social History (PFSH)

2. Exam

3. Medical Decision Making (MDM)
   – Diagnosis and Management Options (# Dx)
   – Data Reviewed
   – Table of Risk

All 3 Key Elements Required

Except:
- Hospital Subsequent Visits (99231-99233)
- Office/Outpt Established Visits (99212-15)

• These categories only require 2 of 3 key elements (usually exam and MDM)

Medical Decision Making

- Most Important Factor in Level
- Focus on Risk and good documentation
- Over Arching Criterion

Medicare Claims Processing Manual – 30.6.1

- “...Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed....”
1. Diagnosis and Management Options

- An auditor will evaluate:
  - Number of problems (dx)
  - New Problem more complex than existing condition
  - Problem requiring addl workup more complex
  - Established Problem getting worse is more complex than a stable problem
  - Only 2 self-limited problems can be counted

<table>
<thead>
<tr>
<th>Diagnosis and Treatment Options</th>
<th>freq</th>
<th>value</th>
<th>total</th>
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</thead>
<tbody>
<tr>
<td>Self-limited or minor (Max 2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Est. problem (stable or improved)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Est. problem (worsening)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem (no further work-up planned)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New problem (add’l work-up planned)</td>
<td></td>
<td></td>
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</tbody>
</table>

2. Data Reviewed

- Labs, XR, and Cardiology Diagnostics Count Separate (Medicine)
- Credit for discussing with performing doc
- Considers the decision to obtain old records, gather addl info from caregiver or other source than patient
- Credit for personal review of image vs. review of report

<table>
<thead>
<tr>
<th>Data Reviewed</th>
<th>Point</th>
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<tbody>
<tr>
<td>Review and/or order lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order radiology</td>
<td>1</td>
</tr>
<tr>
<td>Review and/or order medicine section</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of results with performing MD</td>
<td>1</td>
</tr>
<tr>
<td>Review and summary of old records, and/or obtaining hx from other than pt, and/or discuss case with health care professional</td>
<td>2</td>
</tr>
<tr>
<td>Independent visualization of image, tracing or specimen itself</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>
### Table of Risk

#### Medicare Learning Network - CMS

#### Risk - Straight Forward

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s)</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>One self-limited or minor problem (e.g., cold, insect bite, lacerations)</td>
<td>Laboratory tests requiring venipuncture, Chest x-rays, EKG, EEG, Urinalysis, Ultrasound (e.g., echocardiography), KCH prep</td>
<td>Rest, Gargles, Elastic bandages, Superficial dressings</td>
</tr>
<tr>
<td>Moderate</td>
<td>One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment</td>
<td>Physiologic tests under stress (e.g., cardiac stress test, total contraction stress test)</td>
<td>Minor surgery with identified risk factors, Elective major surgery (open, percutaneous or endoscopic) without identified risk factors, Prescription drug management, Therapeutic nuclear medicine</td>
</tr>
<tr>
<td>High</td>
<td>One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment</td>
<td>Diagnostic endoscopies with no identified risk factors, Deep needle or incision biopsy</td>
<td>Chest x-rays, EKG, EEG, Urinalysis, Ultrasound (e.g., echocardiography), KCH prep</td>
</tr>
</tbody>
</table>

### Risk - Low

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s)</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Two or more self-limited or minor problems</td>
<td>Physiologic tests not under stress (e.g., pulmonary function tests)</td>
<td>Over-the-counter drugs, Minor surgery with no identified risk factors, Physical therapy</td>
</tr>
<tr>
<td>Moderate</td>
<td>One or more stable chronic illnesses</td>
<td>Non-cardiovascular imaging studies with contrast (e.g., barium enema)</td>
<td>Occupational therapy, IV fluids without additives</td>
</tr>
<tr>
<td>High</td>
<td>Acute uncomplicated illness or injury (e.g., cysts, allergic rhinitis, simple sprain)</td>
<td>Non-cardiovascular imaging studies without contrast</td>
<td></td>
</tr>
</tbody>
</table>

### Risk - Moderate

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s)</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>Two or more self-limited or minor problems</td>
<td>Non-cardiovascular imaging studies with contrast (e.g., barium enema)</td>
<td>Over-the-counter drugs, Minor surgery with no identified risk factors, Physical therapy</td>
</tr>
<tr>
<td>Moderate</td>
<td>One or more stable chronic illnesses</td>
<td>Non-cardiovascular imaging studies with contrast and no identified risk factors (e.g., arteriogram, cardiac catheterization)</td>
<td>Deep needle or incision biopsy, Cardiovascular imaging studies with contrast and no identified risk factors</td>
</tr>
<tr>
<td>High</td>
<td>Acute uncomplicated illness or injury (e.g., cysts, allergic rhinitis, simple sprain)</td>
<td>Non-cardiovascular imaging studies without contrast</td>
<td></td>
</tr>
</tbody>
</table>
Exam – Body Areas

1. Head
2. Neck
3. Chest, including breasts and axilla
4. Abdomen
5. Genitalia, groin, buttocks
6. Back, including spine
7. Each extremity

1995 Exam Elements

The levels of E/M services are based on four types of examination that are defined as follows:

- **Problem Focused** -- a limited examination of the affected body area or organ system.
- **Expanded Problem Focused** -- a limited examination of the affected body area(s) and other symptomatic or related organ system(s).
- **Detailed** -- an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- **Comprehensive** -- a general multi-system examination or complete examination of a single organ system.

Exam – Organ Systems

1. Constitutional (3 vital signs)
2. Eyes
3. Ears, nose, throat
4. Respiratory
5. Genitourinary
6. Skin
7. Psychiatric
8. Cardiovascular
9. Gastrointestinal
10. Musculoskeletal
11. Neurologic
12. Hematologic/Lymphatic/Immunologic
1997 – General Multi-system Exam

- Problem Focused Examination—should include performance and documentation of one to five elements identified by a bullet (•) in one or more organ system(s) or body area(s).
- Expanded Problem Focused Examination—should include performance and documentation of at least six elements identified by a bullet (•) in one or more organ system(s) or body area(s).
- Detailed Examination—should include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet (•) is expected. Alternatively, a detailed examination may include performance and documentation of at least twelve elements identified by a bullet (•) in two or more organ systems or body areas.
- Comprehensive Examination—should include at least nine organ systems or body areas. For each system/area selected, documentation of at least two elements identified by a bullet is expected.

1997 – Single Organ System Exam

- Problem Focused Examination—should include performance and documentation of one to five elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
- Expanded Problem Focused Examination—should include performance and documentation of at least six elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
- Detailed Examination—examinations other than the eye and psychiatric examinations should include performance and documentation of at least twelve elements identified by a bullet (•), whether in box with a shaded or unshaded border.
- Eye and psychiatric examinations should include the performance and documentation of at least nine elements identified by a bullet (•), whether in a box with a shaded or unshaded border.
- Comprehensive Examination—should include performance of all elements identified by a bullet (•), whether in a shaded or unshaded box. Documentation of every element in each box with a shaded border and at least one element in each box with an unshaded border is expected.

History

1. History of Present Illness (HPI)
2. Review of Systems (ROS)
3. Past, Family, Social History (PFSH)

HPI - Complaint or Condition Description

- Location
- Severity
- Timing
- Modifying Factors
- Quality
- Duration
- Context
- Associated Signs and Symptoms

- Brief = 1-3 HPI elements
- Extended
  - 1995 – Should describe four or more elements of the present HPI or associated comorbidities.
  - 1997– Should describe at least four elements of the present HPI or the status of at least three chronic or inactive conditions.
HPI – Can be one sentence

Describe the presenting problem 4 ways...

– Example: The patient complains of severe substernal chest pain, nonradiating which is not relieved by rest.

Review of Systems (ROS)

1. Constitutional
2. Eyes
3. Ears, Nose, Mouth, Throat
4. Cardiovascular
5. Respiratory
6. Gastrointestinal
7. Genitourinary
8. Musculoskeletal
9. Integumentary
10. Neurological
11. Psychiatric
12. Endocrine
13. Hematologic/lymphatic
14. Allergic/Immunologic

Counting Elements

Most Used Examples:
➢ Detailed is 2-9 systems
➢ Comprehensive is 10+

To meet the requirements for a complete ROS....
• Those systems with positive or pertinent negative responses must be individually documented.
• For the remaining systems, a notation indicating all other systems are negative is permissible (except for certain MAC Carriers).
• In the absence of such a notation, at least ten systems must be individually documented.
• If you can not obtain a ROS (from patient/other source) – note that and describe the pt’s condition or other circumstance to receive credit for a comprehensive ROS

For ROS and PFSH Only:

• You can refer to a patient completed sheet
• You can use the ROS/PFSH completed by ancillary personnel
• To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others.
• You can refer to a previous document – must note date and location of the ROS/PFSH
Past, Family, Social History (PFSH)

- One item needed from each category for comprehensive

Past History

- Includes a review of:
  - Prior major illness and injuries
  - Prior hospitalizations
  - Current medications
  - Prior operations
  - Allergies

Family History

- Health status or cause of death of parents, siblings and children
- Specific diseases related to problems identified in the chief complaint or history of present illness and system review
- Diseases of family members which may be hereditary or place the patient at risk

Social History

- Age appropriate review of:
  - Marital status and/or living arrangements
  - Occupational history
  - Other relevant social factors
  - Current employment
  - Use of drugs, alcohol, tobacco
Billing Based On Time

- You can also bill based on time and not use the key elements in some circumstances:
  - Consider this option when you have recently seen the patient – already completed your history and examination, and now the primary focus of your visit is counseling
  - It’s rarely to the providers advantage to try to find ways to use this on your typical visits
  - This should be used only when it is counseling/coordination of care that dominates (greater than half) of your visit

Time-Based Billing - Medicare

- In the case where counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter…time is considered the key or controlling factor to qualify for a particular level of E/M services.
  - DG: If the physician elects to report the level of service based on counseling and/or coordination of care, the total length of time of the encounter should be documented and the record should describe the counseling and/or activities to coordinate care
  - Don’t forget to clearly document medical necessity

Time Values

- New Patient Visits
  - 99201 – 10 minutes
  - 99202 – 20 minutes
  - 99203 – 30 minutes
  - 99204 – 45 minutes
  - 99205 – 60 minutes
- Established Patient Visits
  - 99212 – 10 minutes
  - 99213 – 15 minutes
  - 99214 – 25 minutes
  - 99215 – 40 minutes
- Each CPT code has its own time allowance

MODIFIERS
Modifier 25

**Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Services:**

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 that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Service Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Modifier 59

**Distinct Procedural Service:**

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M service performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service.

Modifier 26

**Professional Component:**

Certain procedures are a combination of a physician component and a technical component. When the physician component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

Modifier 51

**Multiple Procedures:**

When multiple procedures, other than E/M services. Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). **Note:** This modifier should not be appended to designated “add-on” codes.
A Few Honorable Mentions

Modifier 22 – Increased Procedural Services
Modifier 24 – Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period.
Modifier 57 – Decision for Surgery
Modifier 76 – Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
Modifier 77 – Repeat Procedure by Another Physician or Other Qualified Health Care Professional
Modifier 78 – Unplanned Return to the Operating/Procedure Room by the same Physician or Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
Modifier 79 – Unrelated Procedure or Service by the Same Physician During the Postoperative Period

Physician Fee Schedule

The Medicare Physician Fee Schedule (MPFS) provides a list of over 10,000 services. You can find the associated relative value units (RVUs) for each of these services as well as various payment policy indicators:

- Payment of assistant at surgery
- Team surgery
- Bilateral surgery
- Technical component (TC)
- Professional Component (PC)
- Bilateral surgery
- Technical component (TC)
- Professional Component (PC)

You can search for a specific CPT code for the national payment amount, a specific Carrier/Medicare Administrative Contractor (MAC), GPCIs. You can locate a single code or you can locate a range of procedures codes.

http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html?redirect=/PhysicianFeeSched/

Calculating Payment Amounts

The formula for calculating 2012 physician fee schedule payment amount is as follows:

2012 Non-Facility Pricing Amount =
\[(\text{Work RVU} * \text{Work GPCI}) +
\text{(Transitioned Non-Facility PE RVU} * \text{PE GPCI}) +
\text{(MP RVU} * \text{MP GPCI})\] * Conversion Factor (CF)

2012 Facility Pricing Amount =
\[(\text{Work RVU} * \text{Work GPCI}) +
\text{(Transitioned Facility PE RVU} * \text{PE GPCI}) +
\text{(MP RVU} * \text{MP GPCI})\] * CF

The conversion factor for CY 2012 is $34.0376.
<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>PROC STAT</th>
<th>PCTC</th>
<th>GLOBAL</th>
<th>MULT SURG</th>
<th>BLT SURG</th>
<th>ASST SURG</th>
<th>CO SURG</th>
<th>TEAM SURG</th>
<th>PHYS SURV</th>
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</tbody>
</table>

Question & Answer Session

General Coding Questions
American College of Cardiology
Coding@acc.org

Contact Information
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Post-webinar Evaluation Survey
Each participant on today’s webinar presentation will receive a short evaluation form and CEU information by email within a few days. You can also access it here: http://www.surveymonkey.com/s/ZXBGHP5

We want to hear from you!

AAPC CEU’s

Index #
MA0822120420A

Medical Specialty Coding and Compliance

SM92012