 Billing and Coding: Webinar #3

**NOTE:** Make sure your computer speakers are turned **ON**. Audio will be streaming through your speakers.

*If you do not have computer speakers, call the ACCMA at 510-654-5383 for alternatives.*

We will begin shortly after 10:00 am.
About This Manual

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CPT codes used in this manual are excerpts from the current edition of the CPT (Current Procedural Terminology) book, are not intended to be used to code from and are for instructional purposes only. It is strongly advised that all providers purchase and maintain up to date copies of CPT. CPT is copyrighted property of the American Medical Association.

Today’s Agenda

• Medicine Procedures & Services
  – Coding & Billing of Diagnostic Procedures & Services
• Category II CPT Codes
  – Quality Reporting – Are You Participating?
• Category III CPT Codes
  – Emerging Technology – Do You Know When to Use These?
• Understanding & Using Modifiers
  – CPT – documentation needed
  – HCPCS
Medicine

- Immune Globulins, Serum or Recombinant Products
- Vaccines, Toxoids
- Psychiatry
- Biofeedback
- Dialysis
- Gastroenterology
- Ophthalmology
- Special Otorhinolaryngologic Services

Medicine . . . . .

- Cardiovascular
- Noninvasive Vascular Diagnostic Studies
- Pulmonary
- Allergy & Clinical Immunology
- Endocrinology
- Neurology and Neuromuscular Procedures
- Medical Genetics & Genetic Counseling
Medicine . . . . .

- Central Nervous System Assessments/Tests
- Health & Behavior Assessment/Intervention
- Hydration, Therapeutic, Prophylactic, Diagnostic Injections & Infusions, and Chemotherapy & Other Highly Complex Drug or Highly Complex Biologic Agent Administration

Medicine . . . . .

- Photodynamic Therapy
- Special Dermatological Procedures
- Physical Medicine & Rehabilitation
- Medical Nutrition Therapy
- Acupuncture
- Osteopathic Manipulative Treatment
- Chiropractic Manipulative Treatment
Medicine . . . . .

- Education & Training for Patient Self-Management
- Non-Face-to-Face Nonphysician Services
- Special Services, Procedures & Reports
- Qualifying Circumstances for Anesthesia
- Moderate Sedation
- Other services, Procedures & Reports

Medicine . . . . .

- Home Health Procedures / Services
- Medication Therapy Management Services
Immune Globulins, Serum or Recombinant Products (CPT 90281 – 90399)

- Serum globulins
  - Extracted from human blood
- Recombinant Immune Globulin Products
  - Created in laboratory through genetic modification of human and/or animal proteins
- Both are reported in addition to administration codes
  - 96365 - 96368, 96372, 96374 - 96375

Immunization Administration for Vaccines/Toxoids (CPT 90465 – 90474)

- Report in addition to code for vaccine and/or toxoid
- 90460 – 90461
  - Report only when the physician or qualified health professional provides face-to-face counseling of the patient and family at the time of administration
  - Patients thru age 18
  - By number of vaccine/toxoid components, not by number of administrations
Immunization Administration for Vaccines/Toxoids (CPT 90465 – 90474)

- 90471 – 90474
  - Report when no face-to-face physician counseling
  - By number of administrations (not necessarily vaccines)
  - By route of administration
    - Subcutaneous or Intramuscular
    - Intranasal or oral
  - Do not report a “nurse visit” - 99211 - when reporting an administration service

Vaccines & Toxoids (CPT 90476 – 90749)

- Indicates FDA approval is pending for the vaccine/toxoid
- Codes Identify Vaccine Product only
  - Administration billed separately
  - Multiple codes for a particular vaccine are provided when the schedule (number of doses or timing) differ for two or more products of the same vaccine type or the vaccine product is available in more than one chemical formulation, dosage or route of administration
- Separate codes available for combination vaccines
Testing Your Knowledge

Poll Questions

Immunization services consist of two services; they are:
Poll Questions

It is appropriate to report a nurse only service (CPT 99211) instead of an administration service when giving an injection or vaccination.

Poll Questions

The symbol used to identify FDA approval pending for vaccine/toxoid is:
Psychiatry (CPT 90785 - 90899)

- Codes are frequently used by Psychologists and Social Workers, as well as Physicians
  - Nonphysician providers are *sometimes* paid less
- Psychiatry codes include:
  - Interactive Complexity (add-on)
  - Psychiatric Diagnostic Procedures
    - Psychotherapy
      - With and Without E/M Service
    - Psychotherapy for Crisis
      - First 60 minutes
      - Each additional 30 minutes
    - Other Psychiatric Services or Procedures

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Psychiatric diagnostic evaluation includes:

- History
- Mental Status
- Recommendations
- *May include communication with family or other sources*
- *May include ordering/interpretation of diagnostic studies*
### Individual Psychotherapy

- Face-to-Face Time
  - 30 minutes
  - 45 minutes
  - 60 minutes
- With Evaluation and Management Service
- Without Evaluation and management Service

### Other Psychiatric Codes/Services

- Family & Group Psychotherapy
- Medication Management
- Electroconvulsive Therapy
- Hypnotherapy
Dialysis

- Hemodialysis
- Miscellaneous Dialysis Procedures
- End-Stage Renal Disease
- Other Dialysis Procedures

Hemodialysis

- 90935, 90937 - Hemodialysis procedure with all E/M services related to patient’s renal disease on day of hemodialysis procedure
  - 90935 – one evaluation
  - 90937 – re-evaluation required
- 90940 – Hemodialysis access flow study to determine blood flow in grafts and arteriovenous fistulae by an indicator method

*Early detection and treatment of stenosis and access flow reduction of hemodialysis reduces the frequency of thrombosis and reduces access replacement rates. This study is not considered to be a part of routine dialysis.*
Miscellaneous Dialysis Procedures

• Other than hemodialysis
  – Peritoneal
  – Hemofiltration
  – Continuous Renal Replacement therapies
• Includes all E/M on day of procedure
  – 90945 – one evaluation
  – 90947 – re-evaluation required
• If E/M for non-related dialysis or renal failure needed; add modifier -25 to E/M

End Stage Renal Disease Services (Outpatient Dialysis Center and Home)

• CPT 90951 – 90963 - Outpatient
• Reported **once** per month
• Age-specific services related to patient’s end-stage renal disease treated in outpatient setting
  – Establishment of dialyzing cycle
  – Outpatient E/M
  – Telephone calls
  – Patient management during dialysis

*****Do not use if hospitalization occurs anytime during the month!!!!
### ESRD - Outpatient

- **By Age**
  - < 2 years
  - 2-11 years
  - 12-19 years
  - 20+ years
- **By number of face-to-face visits**
  - 4 or more
  - 2-3
  - 1

### ESRD – Home

- **CPT 90963 – 90966**
  - Full Month
- **CPT 90967 - 90970**
  - Less Than Full Month
  - Bill *Per Day*
- **By Age**
  - < 2 years
  - 2-11 years
  - 12-19 years
  - 20+ years
Gastroenterology

• Diagnostic Testing
  – Motility Studies
    • Esophageal
    • Gastric
    • Duodenal
  – Reflux Studies
  – Capsule Endoscopy

• Gastric Intubation and Aspiration or Lavage
  – “Stomach Pumping” – for ingested poisons

Ophthalmology

Ophthalmologists have a unique set of codes (CPT 92002 – 92014) to describe their medical services. The codes are divided into new and established patient categories, and the three-year rule of determining the category applies. Unlike E/M codes, there is no reference to the key components, and these code descriptions do not include counseling or coordination of care.
Intermediate Services

• Describe evaluation of a new or existing condition that has been complicated by a new diagnostic or management problem. The new complaint may or may not relate to the primary diagnosis

• Includes
  – History
  – General medical observation
  – External ocular and adnexal examination
  – Other diagnostic procedures as indicated
  – Mydriasis [dilation] (optional)

Comprehensive Services

• Describe the evaluation of the complete visual system. This service is a single entity, but it need not be performed at one session.

• Includes
  – Complete medical and ocular history
  – External and ophthalmoscopic examination
  – Gross visual fields
  – Basic sensory motor examination

• Also often includes
  – Biomicroscopy
  – Dilation
  – Tonometry
Bilateral vs. Unilateral in Ophthalmology

According to the Federal Register, the relative value units for ophthalmology services “are based on the assumptions that the codes describe bilateral services.” When the diagnostic service is performed on only one eye, use modifier -52 to identify a reduced service.

Special Ophthalmologic Services

• Refractions
  – CPT 92015 – determination of refractive state
    • Many private insurers allow this service as covered benefit
    • Medicare DOES NOT – considers it “non-covered”
      – Bill the patient directly for this service

Example
  92014 Ophthalmological service comprehensive, established patient, one or more visits
  92015-GY Determination of refractive state
Special Ophthalmologic Services

• Visual Fields
  – A visual field examination is performed to document either peripheral loss or blind spots in the patient's visual field.
  – Three coding levels (CPT 92081 – 92083)
    • Limited
    • Intermediate
    • Extended
      – Described as unilateral or bilateral
      – Includes medical diagnostic evaluation and vary in extent of exam performed
  – Gross visual field testing considered integral to general ophthalmic services and is not billed separately

Special Ophthalmologic Services

• Ophthalmoscopy
  – Routine – is part of general and special ophthalmologic services whenever indicated and is a non-itemized service; not reported separately
  – Extended
    • CPT 92225 – with retinal drawing with interpretation & report; initial
    • CPT 92226 - above; subsequent

• Fluorescein angioscopy & angiography
• Indocyanine-green angiography
• Fundus photography
Other Ophthalmology Services

• Contact Lens Service
  – Prescription
  – Modification
  – Replacement

• Spectacle Services
  – Fitting
  – Repair & Fitting

MCR and Ophthalmology Services

• Multiple Procedure Payment Reduction (MPPR)
  – Effective 1/1/23012
  – Reduction to Technical Component (TC)
    • Same physician, or multiple physicians in same group
    • Full TC payment with highest value
      – Subsequent TC paid at 80%
### Payment Reduction (Example)

#### Sample Ophthalmology Payment Reduction

<table>
<thead>
<tr>
<th></th>
<th>Code 92235</th>
<th>Code 92250</th>
<th>Total Current</th>
<th>Total 2013 Payment</th>
<th>Payment Calculation</th>
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<tbody>
<tr>
<td>PC</td>
<td>$46.00</td>
<td>$23.00</td>
<td>$69.00</td>
<td>$69.00</td>
<td>No reduction</td>
</tr>
<tr>
<td>TC</td>
<td>$92.00</td>
<td>$53.00</td>
<td>$145.00</td>
<td>$134.40</td>
<td>$92 + (.80 \times $53)</td>
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<tr>
<td>Global</td>
<td>$138.00</td>
<td>$76.00</td>
<td>$214.00</td>
<td>$203.40</td>
<td>$69 + 92 + (.80 \times $53)</td>
</tr>
</tbody>
</table>

### Special Otorhinolaryngologic Services

**Diagnostic or treatment procedures that are reported as E/M services (eg, otoscopy, anterior rhinoscopy, tuning fork test, removal of non-impacted cerumen) are not reported separately.**

**Special otorhinolaryngologic services are those diagnostic and treatment services not included in an E/M service.**
ENT Services

• Vestibular Function Tests, without Electrical Recording
• Vestibular Function Tests, with Recording (eg ENG)
• Audiologic Function Tests
  – Tympanometry
  – Screening test
  – Pure Tone Audiometry
  – Speech Audiometry
  – Hearing Aid Exam
  – Hearing Aid check
  – Ear Protector Attenuation Measurements

Hearing Tests

• Hearing Tests are bilateral
  – If only one ear is tested, a reduced service must be reported using modifier -52

• Exception: codes 92590 - 92595 (hearing aid services) are identified specifically as monaural (one ear) or binaural (both ears)
• Evaluative and Therapeutic Services
  – Diagnostic analysis of cochlear implant
    • By patient age
    • Programming
    • Subsequent programming
  – Evaluation for other communication devices
  – Auditory Rehabilitation Codes
  – Special Diagnostic Procedures
    • Analysis w/programming auditory brainstem implant

Testing Your Knowledge
Poll Questions

Psychotherapy codes are based on which of the following:

ESRD services are reported once per month.
Poll Questions

For Ophthalmology services, the relative value units are based on an assumption the codes are unilateral services.

Cardiovascular

Cardiovascular services often involve complex anatomic and physiological terms and concepts. Use the Cardiovascular Surgery section of CPT for heart illustrations!
Cardiovascular Anatomy

- For coding purposes there are four main coronary vessels
  1. Right Coronary Artery
  2. Left Main Coronary Artery
  3. Left Anterior Descending Coronary Artery
  4. Left Circumflex Artery

Cardiovascular Services

- Diagnostic & Therapeutic Services
- Separate listings
  - Global
    - Technical & Professional
  - Technical
    - Tracing Only
  - Professional
    - Supervision of Procedure
    - Interpretation and Report
Categories of CV Codes

- **Therapeutic Services (CPT 92950 – 92998)**
  - Percutaneous Placement of Intracoronary Stents
  - Percutaneous Transluminal Coronary Angioplasty (PTCA)
  - Percutaneous Transluminal Coronary Athrectomy
- **Cardiography (CPT 93000 – 93042)**
  - Electrocardiogram (EKG)
  - Cardiovascular Stress Tests (Treadmills)
- **Cardiovascular Monitoring Services (93224 – 93278)**

CV Categories . . . .

- **Implantable & Wearable Cardiac Device Evaluations (CPT 93279 – 93299)**
  - Attended Surveillance
  - Devices
    - Pacemaker
      - Single Lead
      - Dual Lead
      - Multiple Lead
    - Implantable CV Monitor (ICM)
    - Implantable Cardioverter-defibrillator (ICD)
    - Implantable Loop Recorder (ILR)
CV Categories . . .

• Echocardiography (93303 – 93464)
  – Complete (initial) Studies
  – Follow-Up or Limited Studies
  – TEE (Transesophageal)
  – Doppler – sometimes reported in addition
  – Color Flow Mapping – sometimes reported in addition

CV Categories . . .

• Cardiac Catheterization (CPT 93451 – 93581)

  Table of Catheterization Codes is available as part of CPT

  Includes:
  – Intravenous pressure
  – Intracardiac pressure
  – Arterial blood sample for blood gas studies
  – Cardiac output
  – Ergometer (to exercise patient)
  – Electrode catheter (temporary pacemaker)
  – Swan-Ganz insertion
  – Arterial-venous cutdown
  – Placement or repositioning of catheters and use of automatic power injectors
CV Categories . . . .

• Intracardiac Electrophysiologic Procedures (EP) (CPT 93600 – 93662)
  – Diagnostic and/or Therapeutic
  – Includes inserting and repositioning catheters
  – Used to
    • Investigate patient’s sinus node function and atrioventricular (AV) conduction
    • Locate the origin of dangerous arrhythmias
    • Assess supraventricular tachycardia and ventricular tachycardia
    • Evaluation effectiveness of drug therapy or an automatic implantable cardioverter-defibrillator
    • Perform a radiofrequency ablation to destroy accessory condition pathways or other sites of abnormal electrical activity that causes tachycardias

CV Categories . . . .

• Peripheral Arterial Disease Rehabilitation (CPT 93668)
  – Per session
• Noninvasive Physiologic Studies & Procedures (CPT 93701 – 93790)
  – Interrogation of VAD
  – Determination of Venous Pressure
  – Ambulatory Blood Pressure Monitoring*

*Check with payers to see if these services are a benefit for the patient!
MCR and Ophthalmology Services

- Multiple Procedure Payment Reduction (MPPR)
  - Effective 1/1/23012
  - Reduction to Technical Component (TC)
    - Same physician, or multiple physicians in same group
    - Full TC payment with highest value
      - Subsequent TC paid at 75%

Payment Reduction (Example)

<table>
<thead>
<tr>
<th>Sample Cardiovascular Payment Reduction</th>
<th>Code 78452</th>
<th>Code 93306</th>
<th>Total Current</th>
<th>Total 2013 payment</th>
<th>Payment Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC</td>
<td>$77.00</td>
<td>$65.00</td>
<td>$142.00</td>
<td>$142.00</td>
<td>No reduction</td>
</tr>
<tr>
<td>TC</td>
<td>$427.00</td>
<td>$148.00</td>
<td>$575.00</td>
<td>$538.00</td>
<td>$427 + (.75 x $148)</td>
</tr>
<tr>
<td>Global</td>
<td>$504.00</td>
<td>$213.00</td>
<td>$717.00</td>
<td>$680.00</td>
<td>$142 + $427 + (.75 x $148)</td>
</tr>
</tbody>
</table>
Noninvasive Vascular Diagnostic Studies

1. Cerebrovascular Arterial Studies (CPT 93880 - 93893)
2. Extremity Arterial Studies (including digits) (CPT 93922 – 93931)
3. Extremity Venous Studies (including digits) (CPT 93965 – 93971)
5. Extremity Arterial-Venous Studies (CPT 93990)
6. Other Noninvasive Vascular Diagnostic Studies (93998)

Pulmonary

Pulmonary Codes (94002 – 94799) include both diagnostic and treatment services. Diagnostic procedures include the laboratory services, interpretation, and physician services, unless stated otherwise.

Carefully read definitions to determine correct codes!
Ventilation Management

• By site of service
  – Hospital inpatient/observation
  – Nursing Facility

• By session
  – Initial Day
  – Subsequent Day
  – Per Day (nursing facility)

• Home ventilator management care plan oversight
  – Home
  – Domiciliary or Rest Home (Assisted Living)
  – Calendar Month
  – 30 minutes or more

Spirometry – Codes 94010 – 94070 vary according to the extent of test performed

<table>
<thead>
<tr>
<th>Spirometry</th>
<th>Bronchospasm</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT 94010</td>
<td>CPT 94060 - Dilation</td>
</tr>
<tr>
<td>– Measurement of lung’s capacity and flow measurements with a spirometer</td>
<td></td>
</tr>
<tr>
<td>– Machine must produce a graphic copy or hard copy of the patient’s record</td>
<td></td>
</tr>
<tr>
<td>– Time necessary for exhaling total volume of inhaled air must be recorded</td>
<td></td>
</tr>
<tr>
<td>– Expiratory flow rate is calculated from these measurements in liters/second</td>
<td></td>
</tr>
<tr>
<td>– Maximal voluntary ventilation is included</td>
<td></td>
</tr>
<tr>
<td>– Spirometry before and after use of a bronchodilator</td>
<td></td>
</tr>
<tr>
<td>– Or after exercise</td>
<td></td>
</tr>
<tr>
<td>– CPT 94070 – Provocation</td>
<td></td>
</tr>
<tr>
<td>– Prolonged test – multiple spirometric determinations</td>
<td></td>
</tr>
</tbody>
</table>
Pulmonary . . . .

• Peak Flow Reading
  – There is NO CPT code for Peak Flow Reading
    • Inherent part of E/M exam – not separately billable
• Nebulizer Treatments
  – 94620 – inhalation treatment for acute airway obstruction
    • More than one hour – use 94644 and 94645 if appropriate
• Demonstration of Inhaler Use - 94664
• Pulse Ox (O₂ Saturation) – 94760
  – Often a bundled service

Allergy and Clinical Immunology

• Testing and treatment is performed according to patient’s history

• Many codes are defined by the number of tests performed

• Immunotherapy services are by number of injections and with or without provision of extract
Allergy Immunotherapy Guidelines

• All allergen immunotherapy codes (95115 – 95199) include the necessary professional services. Nursing services for observation and medical instruction are also included as an integral part of administering extracts or antigens. Use office visit codes in addition to an allergen immunotherapy code only if another identifiable services was provided at that time.

Immunotherapy Guidelines . . .

• Codes 95115 and 95117 are different from all other allergen immunotherapy codes in that they do not include the provision of allergenic extracts. Use these codes when the patient supplies the allergenic extract and the service performed is the injection only.

• Codes 95120 – 95134 describe both the provision of the allergenic extract and the professional service for the allergen immunotherapy. Each code specifies the number of antigens or venoms.
Immunotherapy Guidelines . . . .

- Codes 95145 – 95170 describe the supervision and provision of allergen immunotherapy using single or multiple-dose vials. These codes do not include the antigen injections.
  - Codes 95145 – 95149 used for insect venoms
  - Codes 95135, 95140, 95150, 95155 – used for antigens.
    - Specify the number of treatments
  - Code 95170 – whole body extracts of biting insects or other arthropods

Testing Your Knowledge
The technical only component of a cardiography service is the supervision and report.

Peak flow readings should be billed with CPT code 94150.
Poll Questions

Allergy testing is coded by:

Endocrinology

- Ambulatory Continuous Glucose Monitoring
  - 95250 – Sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording (technical)
  - 95251 – Interpretation and report (professional)

Check with payers for their guidelines on coverage for this service!
Neurology & Neuromuscular Procedures

- Sleep Testing
- Routine EEG
- Muscle & Range of Motion Testing
- EMG
- Guidance for Chemodenervation & Ischemic Muscle Testing
- Nerve Conduction Tests
- Intraoperative Neurophysiology
- Autonomic Function Tests

Neurology & Neuromuscular

- Evoked Potentials & Reflex Tests
- Special EEG
- Neurostimulators, Analysis-Programming
- Other Procedures
- Motion Analysis
- Functional Brain Mapping
Remember with Neuro . . . .

• Sleep Testing (95803 – 95811)
  – Lots of inclusions – read notes at beginning of subsection carefully

• EEG codes (95812 – 95827)
  – Both technical (tracing) & professional (interpretation & report) components
    • When only interpretation performed, indicate with modifier -26

• Muscle & Range of Motion
  – Anatomical site-specific
    • Excluding or including hand

Remember . . . . .

• EMG (95860 – 95887)
  – Coded according to number of extremities or areas evaluated
    • Includes related paraspinal areas

• Nerve Conduction Tests (95905 - 95913)
  – By Number of Studies
    • No Longer by Type of Nerve
    • No Longer each nerve

• Intra-operative Neurophysiology
  – Per Hour
Other Neurology & Neuromuscular

- Autonomic Function Tests
- Evoked Potentials and Reflex Tests
- Special EEG Tests
- Neurostimulators, Analysis-Programming
- Other Procedures
- Motion Analysis

Medical Genetics & Genetic Counseling

- One or More Sessions
- Review of Medical Data & Family Information
- Face-to-Face Interviews
- Counseling Services

*Check with payers for their coverage guidelines!*
### Central Nervous System Assessments/Tests

- Psychological Testing
- Assessment of Aphasia
- Developmental Testing
- Neurobehavioral Status Exam
- Neuropsychological Testing
- Cognitive Performance Testing

### Health & Behavior Assessment/Intervention

- Performed by Non-Physician
- Focus Not On Mental Health
- Code each 15 minutes of face-to-face
  - Individual
  - Group
  - Family (with patient)
  - Family (without patient)
- Code by Type
  - Initial Assessments
  - Re-Assessments
  - Intervention
Poll Questions

Ambulatory glucose monitoring is found in which Medicine section of CPT?
Poll Questions

Sleep Testing is found in which Medicine section of CPT?

Poll Questions

Services in the Health & Behavior Assessment/Intervention section are focused on Mental Health.
Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions

And Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration

Hydration

• Hydration IV Infusion
  – Pre-packaged fluid
  – Electrolytes
  – Do not use to report infusion of drugs or other substances
  – 96360 – 31min. – 1 hour
  – 96361 – each add’l hour

• Not reported by a physician in a facility setting
Therapeutic, Prophylactic, & Diagnostic Injections & Infusions

- IV Infusion (CPT 96365 – 96368)
  - Up to One Hour
  - Each Add’l Hour
  - Add’l sequential infusion – up to 1 hr
  - Concurrent Infusion (add-on code)
- SubQ infusion (CPT 96369 – 96371)
  - Initial, up to 1 hr
  - Each add’l hour
  - Add’l pump set-up

Injections . . . .

- Therapeutic, prophylactic, or diagnostic (96372 – 96379)
  - By route of administration
    - Subcutaneous or intramuscular
    - Intra-arterial
    - IV push, single or initial substance
    - Each add’l sequential push, new substance (add-on)
    - Each add’l sequential push of same substance (add-on)
- Non-chemotherapy
Chemotherapy, etc.

- Require direct physician supervision
- Not reported by physician in a facility setting
- Report separate code for each parenteral method of administration employed when chemotherapy is administered by different techniques
- Medications administered as supportive management of chemotherapy, separately reported using 96360 – 96379 as appropriate
- Report substances (medications) separately

Chemotherapy . . . . .

- Injections
  - Report by route of administration
    - Subcutaneous or intramuscular
      - Non-hormonal anti-neoplastic
      - Hormonal anti-neoplastic
    - Intrallesional (number of lesions)
    - IV Push
- IV Infusions
  - By Time
    - First Hour
    - Ea. Add'l Hr
    - 8 hours +
  - By Number of Substances/Drugs
Intra-Arterial Chemotherapy

- **By Technique**
  - Push
  - Infusion

- **By Time**
  - Up to 1 Hr.
  - Ea. Add’l Hr.
  - 8 Hrs. or More

- Bill refill and maintenance of pump separately

Other Injection & Infusion Services

- **Chemotherapy into**
  - Pleural Cavity
    - Includes thoracentesis
  - Peritoneal Cavity
    - Includes peritoneocentesis
  - Central Nervous System (CNS)
    - Includes spinal puncture

- Refilling & Maintenance of Pumps

- Irrigation of Venous Access Device
  - Bundled with E/M services (CPT 99211)
Photodynamic Therapy

• *Therapy by Light*
• External Application of Light (96567)
  – Premalignant or Malignant Lesions
  – Each Exposure Session
• Internal Application of Light (96570 – 96571)
  – First 30 minutes
  – Ea. Add'l 15 minutes
  – Code endoscopy or bronchoscopy service separately

Special Dermatology Procedures

• Actinotherapy (UV light)
• Micro exam of hair
• Whole body integumentary photography
• Photochemotherapy
• Laser Treatment for Inflammatory Skin Disease
  – By sq. cm of skin
Testing Your Knowledge

Poll Questions

Hydration & Therapeutic Infusion codes are selected by time.
Poll Questions

Injection codes are selected according to:

Poll Questions

Chemotherapy services require direct physician supervision:
Poll Questions

Chemotherapy medications are considered part of the administration service.

Poll Questions

Irrigation of a Venous Access Device can be billed in addition to a nurse only service (CPT 99211).
Poll Questions

Photodynamic Therapy is Therapy by Photography.

Physical Medicine & Rehabilitation

- Evaluation Services
- Modalities
- Therapeutic Procedures
- Active Wound Care Management
- Tests & Measurements
- Orthotic Mgmt  Prosthetic Mgmt
- Other Procedures
Evaluation Services

• New
• Re-Evaluation
• Physical Therapy
• Occupational Therapy
• Athletic Training
  – Check for payer coverage

Modalities

• Supervised
  – One-on-one practitioner/patient contact not required
• Constant Attendance
  – Requires one-on-one patient contact
• By Type of Modality
• Bill separately for all modalities used
Therapeutic Procedures

• Used to report application of clinical skills or services to improve function
• Require one-on-one patient contact
• Bill by each 15 minute increment
• Read descriptions of procedures carefully

Active Wound Care Management

• Direct provider – patient contact required
• Coding by surface area
• Some codes *per session*
Tests & Measurements

• Requires direct one-on-one patient contact
• Report in 15 minutes increments
• Written report required for each service

Orthotic or Prosthetic Management

• Orthotic Management & Training
  – Ea. 15 minutes

• Prosthetic Training
  – Ea. 15 minutes

• Checkout for orthotic/prosthetic use
  – Established patient
  – Ea. 15 minutes
Therapy Functional Reporting (G codes) (Medicare)

- Reporting of data by therapy providers and practitioners furnishing therapy services
- Non-payable G-codes and severity/complexity modifiers
  - Outset of therapy episode of care
  - Specified points during treatment
  - Time of discharge

(See additional handout)

Medical Nutrition Therapy

- MNT
  - Individual
    - Ea. 15 minutes
    - Initial Assessment & Intervention
    - Re-assessment & Intervention
  - Group
    - Ea. 30 minutes

*Check with Payers – some coverage is limited to certain diagnosis such as diabetes or ESRD*
Acupuncture

- With Electrical Stimulation
- Without Electrical Stimulation
- Each 15 minutes
- With personal one-on-one contact with patient

Check With Payers for Benefits/Coverage

Osteopathic Manipulative Treatment (OMT)

- By Number of Body Regions Involved
  - 98925 = 1-2 regions
  - 98926 = 3-4 regions
  - 98927 = 5-6 regions
  - 98928 = 7-8 regions
  - 98929 = 9-10 regions
OMT Regions

- Head
- Cervical
- Thoracic
- Lumbar
- Sacral
- Pelvic
- Lower Extremities
- Upper Extremities
- Rib Cage
- Abdomen
- Viscera

Chiropractic Manipulative Treatment (CMT)

- Five spinal regions
  - Cervical
  - Thoracic
  - Lumbar
  - Sacral
  - Pelvic
- Five Extraspinal regions
  - Head
  - Lower Extremities
  - Upper Extremities
  - Rib Cage
  - Abdomen
CMT

- Code by Region
  - 98940 = spinal, 1-2 regions
  - 98941 = spinal, 3-4 regions
  - 98942 = spinal, 5 regions
  - 98943 = extraspinal, 1 region

Education & Training for Patient Self-Management

- For Individuals & Groups
- Use Standardized Curriculum
- Physician or Nonphysician Provider
- By 30 minutes increment
- By number of patients
  - 1 patient
  - 2-4 patients
  - 5-8 patients
- For treatment of established illness/disease
  - Or to delay comorbidity
Non-Face-to-Face Nonphysician Services

- Non-Physician
  - PA
  - NP
  - CNS
  - CNM

- Telephone Services
  - By time

- On-Line Medical Evaluation

Special Services, Procedures & Reports

- Handling Fee – often not separately payable
  - CPT 99000 – 99002

- Post-operative Follow Up Visit (99024)
  - Zero dollar value
  - Should use for reporting/tracking

- Emergency Services in office which disrupts other scheduled office services (99058)
  - Add-on

- Supplies & Materials (99070)
Special Services, etc. . . .

- Medical Testimony (99075)
  - Establish hourly and each add’l 30 min. fee
- Physician services rendered in a group setting (99078)
  - Check payers for coverage
- Special Reports
  - Insurance Forms
  - Establish Fee Schedule
  - Collect before form is completed

Qualifying Circumstances for Anesthesia

- These are all ADD-ON codes for anesthesia services
  - General Anesthesia
  - Use in addition to codes that begin with 00###
Moderate (Conscious) Sedation

- Does not include minimal sedation, deep sedation or monitored anesthesia care
- Includes
  - Assessment of patient
  - Establishment of IV access & fluids to maintain patency
  - Administration of agent(s)
  - Maintenance of sedation
  - Monitoring of oxygen saturation, heart rate and blood pressure
  - Recovery

Moderate Sedation

- Coded by
  - Physician performing the diagnostic or therapeutic service requiring the sedation vs. provided by physician other an health are professional performing the diagnostic or therapeutic service that sedation supports
  - Patient age
    - Under 5 years
    - 5 years and older
  - Time
    - First 30 minutes
    - Ea. Add'l 15 minutes
Other

• Screening, visual acuity (Snellen Chart)
  – 99173

• Ipecac administration
  – 99175

• Therapeutic Phlebotomy
  – 99195

Finishing The Medicine Section of CPT

• Home Health Procedures/Services
  – Non-physician home health professional

• Home Infusion Procedures/Services

• Medication Therapy Management Services
  – Face-to-Face Assessment and Intervention
    – By Pharmacist
Testing Your Knowledge

Poll Questions

Physicians may perform either a PT evaluation or an OT evaluation.
Poll Questions

Physical Therapists are allowed to provide Active Wound Care Management.

Poll Questions

Acupuncture is always billed with Electrical Stimulation.
Poll Questions

Both OMT and CMT are coded by number of treatment:

Poll Questions

The completion of Special Forms is always part of any office visit and should not be billed separately.
Category II CPT

Reporting Performance Measurements

The Basics

- Four numeric digits followed by an alpha digit (F)
- Have no dollar value – used for reporting only
- Modifiers
  - 1P – Performance Measure Exclusion due to Medical Reason
  - 2P – Performance Measure Exclusion due to Patient Reason
  - 3P – Performance Measure Exclusion due to System Reason
  - 8P – Performance Measure Reporting Modifier – action not performed, reason not otherwise specified
Types

- Composite Codes
- Patient Management
- Patient History
- Diagnostic/Screening Processes or Results
- Therapeutic, Preventive, or Other Interventions
- Follow-Up or Other Outcomes
- Patient Safety
- Structural Measures

Category II

Additions and Deletions to these code sets annually!
Category III CPT

Emerging Technology

Category III (Emerging Technology)

- May or may not eventually receive a Category I code
- Archived after five years if not converted to Category I code
  - Use Category I unlisted code
  - Released semi-annually
    - www.ama-assn.org/go/cpt
  - Not assigned RVUs
- Coverage and payment dependent upon individual insurance carrier(s)
MODIFIERS

Use Effectively
To
Get Paid For What You Do

MODIFIERS

• **Modifier -22:** Unusual Services *(extra payment not guaranteed)*
  
  – Physician **Work** Increased = Physician Fee Increased (30%-50% increase justifies)
  
  – Submit Documentation (manual review)
    - Op-note(s); clear and definitive
    - Statement by Physician [clearly outlining how the work by the physician was "unusual"]
MODIFIERS

• **Modifier -23: Unusual Anesthesia**
  
  – General Anesthesia is used for procedure when usually no anesthesia or local anesthesia is used

MODIFIERS

• **Modifier -24: Unrelated E/M During Postoperative Period**
  
  – Physician must have billed for surgery or postoperative care
  – Must be during global period
  – Cannot be same day as surgery
  – Must be E/M service
  – Must have unique ICD-9-CM code
MODIFIERS

• **Modifier -25: Significant, Separately Identifiable E/M Service/Same Day**
  
  - Should have different diagnosis code (if possible)
  
  - Record must support unique situation
  
  - Goes on E/M service; NOT procedure

MODIFIERS

• **Modifier -26: Professional Component**
  
  - Five digit CPT is combination of physician component & technical component
  
  - Adjust fee accordingly
MODIFIERS

- **Modifier -32: Mandated Services**
  - List organization (3rd party payer or PRO) requesting service

MODIFIERS

- **Modifier -33: Preventive Services**
  - Assists in identifying preventive services in payer-processing systems
    - Indicates when it is appropriate to waive deductible associated with copayment or coinsurance
  - Do not use if the service described by a CPT code is specifically identified as preventive
    - i.e. well care, immunizations, screenings
MODIFIERS

• **Modifier -47: Anesthesia performed by Surgeon**
  
  – Service not currently payable by Medicare, but other carriers pay

MODIFIERS

• **Modifier -50: Bilateral Procedures**
  
  – Usually Paid At 150% Of The Global Fee For The Unilateral Procedure
  
  – Place The -50 Modifier Beside the CPT Procedure Code (One Line Item), With A Quantity Of 1 In The Units Box
  
  Or
  
  – Bill One Line Item with -50 Modifier and Double Fee
MODIFIERS

- **Modifier -51: Multiple Procedures (same session/day)**
  - Will by Ranked Based on the Allowed Amount, but the Billed Amount
  - Multiple Endoscopies Reimbursed Differently than Traditional Multiple Discount

MODIFIERS

- **Modifier -52: Reduced Service**
  - Not To Be Used To Signify A Fee Reduction Unless The Service Was Reduced
  - A Bilateral Code By Description And Only One Side Is Carved Out

- **Modifier -53: Discontinued Service**
  - Do not use with elective cancellation (patient elects to cancel before anesthesia induction begins)
  - Hospital Outpatient/ASC has own modifier
 MODIFIERS

• Modifier -54: Surgical Care Only
  – Used When a Different Physician Will Perform the Post-operative Management
  – Payment Will be Reduced to the Surgeon
  – Bill the Surgery Code with the -54 and the Date of Surgery
  – Allowance is Based on the Pre-op and Intra-op Percentages of the Global Allowances

 MODIFIERS

• Modifier -55: Postoperative Management Only
  – One Physician Performs The Postoperative Management And Another Physician Has Performed The Surgical Procedure
  – Add -55 To The Surgery Code, With The Date The Surgery Was Performed
  – Allowance Is Based On The Postoperative Percentage
MODIFIERS

• **Modifier –56: Preoperative Management Only**
  - One Physician Performs the Preoperative Care and Evaluation, Another Physician Performs the Surgical Procedure
  - Add to Usual Procedure Number
  - Not to be Used for Preoperative Clearance

MODIFIERS

• **Modifier -57: Decision for Surgery**
  - Add to E/M service
  - Use when "major" surgery performed
  - E/M service performed day of or day before surgery
  - Not appropriate to use with "elective" surgery
**MODIFIERS**

- **Modifier - 58:** Staged or Related Procedure or Service by the Same Physician During Post-operative Period
  - A Procedure Is "Staged" When It is Known Going Into The First Procedure That Subsequent Staged Procedure(s) Will Be Performed
  - The Physician May Be Required To Submit Documentation To Show The "Staged" Procedures:
    - Were Planned Prospectively Prior To The Original Surgery
    - More Extensive Than The Original Procedure
    - For Therapy Following A Diagnostic Surgical Procedure

**MODIFIERS**

- **Modifier - 59:** Distinct Procedure Service
  - Used to Identify Procedures/Services not Normally Reported Together
  - Different session or patient encounter, different procedure or surgery, different site, separate lesion, or separate injury (or area of injury)
  - Added to secondary, additional or lesser procedure(s)
MODIFIERS

- **Modifier -62: Co-surgery (Two Surgeons)**
  
  - Two Surgeons, Usually of Different Specialties, Performing A Singe Procedure
  
  - 125% of Global Fee Divided Between the Two Surgeons

MODIFIERS

- **Modifier -63: Procedure Performed on Infants less than 4 kg**

  - Add to the surgical procedure
  
  - Use with surgical CPT 20000-69999

  - Some CPT exempt by CPT definitions
MODIFIERS

• **Modifier -66: Team Surgery**
  
  – More Than Two Surgeons Working as a Team, Such as Transplants
  
  – Carriers’ Medical Directors Will Determine Payment Amount
  
  – Physicians of Different Specialties Each Report the CPT Code With the -66 Modifier
  
  – Documentation Required

MODIFIERS

• **Modifier -73:** Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to Administration of Anesthesia
  
  – Not to be used by Physician; only Hospital or ASC

• **Modifier -74:** Discontinued Outpatient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia
  
  – To Be Used Only by Hospital or ASC
MODIFIERS

• **Modifier - 76:** Repeat Procedure by Same Physician
  – Same Day or During Post Op Period

• **Modifier – 77:** Repeat Procedure by Another Physician
  – Same Day or During Post Op Period, but by Different Physician

MODIFIERS

• **Modifier -78:** Return To O.R. For A Related Procedure By The Same Physician During The Post-operative Period
  – Includes Post-operative Complications Requiring A Return To The O.R.
  – Procedure Paid At A Reduced Rate (Intra-Operative Portion)
  – Same Global Period As The Original Surgery
MODIFIERS

• **Modifier -79:** Unrelated Procedure By The Same Physician During A Post-operative Period
  
  – Used With The Surgical Procedure To Show The Procedure Was Performed During A Post-operative Period And Is Unrelated To The Original Surgical Procedure
  
  – Allows Full Allowable Fee Schedule Amount
  
  – New "Global Period" Begins

MODIFIERS

• **Modifier -80:** Assistant-At-Surgery
  
  – A Physician Who Actively Assists The Physician In Charge Of The Case In Performing A Surgical Procedure (Some Payers Cover PA Services)
  
  – Reimbursed A Percentage Of The Fee Schedule Amount For The Surgical Procedure (Medicare 16%; Others Vary)

• **Modifier –81:** Minimum Assist. Surgeon
  
  – Second Surgical Assistant
• **Modifier –82**: Assistant Surgeon (when qualified resident surgeon not available)
  - Use in teaching facilities

• **Modifier –90**: Reference (Outside) Laboratory
  - Identify use of outside lab on claim
  - Disclose amount paid to outside lab for service

• **Modifier –91**: Repeat Clinical Diagnostic Laboratory Test
  - Same test; Same day; Same Patient
  - Not to be used to confirm initial results
  - Not to be used for testing problems with specimen or equipment
Modifiers

• **Modifier 92**: Alternative Laboratory Platform Testing
  - Laboratory kit or transportable instrument
    - Single use
    - Disposable analytical chamber

MODIFIERS

• **Modifier –99**: Multiple Modifiers
  - Identify modifiers being used
    (eg. 99 = -80, -51, -LT)
Anesthesia Physical Status Modifiers

- P1 – Normal healthy patient
- P2 – Patient with mild systemic disease
- P3 – Patient with severe systemic disease
- P4 – Patient with severe systemic disease that is a constant threat to life
- P5 – Moribund patient who is not expected to survive without the operation
- P6 – Declared brain-dead patient whose organs are being removed for donor purposes

Level II HCPCS

Modifiers
Eyes & Hands

- E1 – Upper left, eyelid
- E2 – Lower left, eyelid
- E3 – Upper right, eyelid
- E4 – Lower right, eyelid
- F1 – Left hand, second digit
- F2 – Left hand, third digit
- F3 – Left hand, fourth digit
- F4 – Left hand, fifth digit
- F5 – Right hand, thumb
- F6 – Right hand, second digit
- F7 – Right hand, third digit
- F8 – Right hand, fourth digit
- F9 – Right hand, fifth digit
- FA – Left hand, thumb

HCPCS Modifiers

- GA – Waiver of Liability Statement (ABN) on file
- GN – Services delivered under outpatient speech language pathology plan of care
- GO – Services delivered under outpatient occupational therapy plan of care
- GP – Services delivered under outpatient physical therapy plan of care
HCPCS Modifiers

• GV – Attending physician not employed or paid under arrangement by patient’s hospice provider

• GW – Services not related to the hospice patient’s terminal condition

• GY – Item or service statutorily excluded, does not meet the definition of any Medicare benefit or for non-Medicare insurers, is not a contract benefit

• LT – Left Side

• RT – Right Side

HCPCS Modifiers

• PT - Colorectal cancer screening test; converted to diagnostic test or other procedure

• Q5 - Service furnished by a substitute physician under a reciprocal billing arrangement

• Q6 – Service furnished by a locum tenens physician

• QW – CLIA-waived test
Toes

- T1 – Left foot, second digit
- T2 – Left foot, third digit
- T3 – Left foot, fourth digit
- T4 – Left foot, fifth digit
- T5 – Right foot, great toe
- T6 – Right foot, second digit
- T7 – Right foot, third digit
- T8 – Right foot, fourth digit
- T9 – Right foot, fifth digit
- TA – Left foot, great toe

HCPCS Modifiers for Non-Physician Providers

Use these for Medi-Cal ONLY!!!

- SA = Nurse Practitioner
- SB = Certified Nurse Midwife
- U7 = Physicians Assistant