Disclaimer

This material is designed to offer basic information for coding and billing. The information presented here is based on the experience, training, and interpretation of the author. Although the information has been carefully researched and checked for accuracy and completeness, the instructor does not accept any responsibility or liability with regard to errors, omissions, misuse, or misinterpretation. This handout is intended as an educational guide and should not be considered a legal/consulting opinion.

E & M Codes

- New patient
  - 3 year rule
  - Has not seen the physician personally
  - Or anyone in the group (same specialty)
  - Work comp & auto consider a new patient visit for each new injury
TIME

Two Kinds

CPT - Time

• When counseling and/or coordination of care constitute more than 50% of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or unit/floor time in the hospital or nursing facility) time may be considered the key or controlling factor to qualify for a particular level of E/M service.

PHYS - 001

• “The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.”
Office Services
Previously Consultations

• Consider Prolonged Care codes where appropriate
  – Bullet points determine code (i.e. 99213)
  – Time spent with patient exceeds “published time” for code
  – 30 minute threshold for use of prolonged care code
  – NOT same concept as “counseling & coordination of care”

Prolonged Physician Services
Office

• + 99354 – Prolonged physician service office or other outpatient setting: first hour
• + 99355 – each additional 30 minutes
  – Face to Face time (CPT & CMS)
  – List separately in addition to code for office or other outpatient Evaluation and Management service
  – RVU 2.69 and 2.65 respectively

45 Minute E&M Service

• If the dominate service has traditional elements of History, Exam and Medical Decision making.
  – 99213 (1.82) + prolonged service (2.69) = 4.51 RVU
• Bill If the dominant service is counseling and time is the basis of the code selection
  – 99215
  – TOTAL 3.68 RVU
• Based on Documentation
Prolonged Service
MCM 30.6.15.1 e

Threshold Time for Prolonged Visit Codes 99254 and/or 99255
Billed with Office/Outpatient and Consultation Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Typical Time for Code</th>
<th>Threshold Time to Bill Code 99254</th>
<th>Threshold Time to Bill Codes 99254 and 99255</th>
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<td>99210</td>
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VENTILATOR MANAGEMENT

- Physician documentation requirements:
  - Brief patient assessment
  - Initial or current vent settings
  - Changes to current vent settings
  - Any other orders/management related to vent settings
- Lower RVU than 99233 and 99232
- Medicare Fee schedule Status “B ”

Concurrent Care

- Multiple providers providing E&M services to the same patient on the same day
  - Use diagnosis code specific to care provided
  - Provider specialty
  - Verify specialty with carriers
Concurrent Care

- Type II Diabetes, uncontrolled
  - Internist
- Pneumonia
  - Pulmonary
- CHF
  - Cardiology
- Internist
  - Pneumonia
- Pulmonary
  - CHF
- Cardiology
  - Diabetes

TESTING

- Pulmonary Function Test
- Body Box
- Oximetry
- X-rays
- Stress Testing

PULMONARY FUNCTION TESTS

- 94010 – Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurement(s), with or without maximal voluntary ventilation
- 94060 – Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration
BODY BOX TESTING –
Common Code Groups *

- 94260 – Thoracic gas volume
- 94360 – Determination of resistance to airflow, oscillatory or plethysmographic methods
- 94720 – Carbon monoxide diffusing capacity (eg. single breath, steady state)
- 94060 – Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

*Verify actual tests with Ordering Physician and Technician

OXIMETRY

- Noninvasive ear or pulse oximetry for oxygen saturation;
  - 94760 - single determination
  - 94761 - multiple determinations (eg during exercise)
  \[O_2\ titration\].

CHEST X-RAYS

- 71010-Radiologic examination, chest; single view
- 71020-Radiologic examination, chest; two views, frontal and lateral

COMPONENT MODIFIERS
26 – Professional
TC - Technical
STRESS TESTING

- **94620 Pulmonary Stress Test; simple**
  - Allows quantification of work load and heart rate activity while measuring the degree of oxygen desaturation
  - Measures the degree of hypoxemia or desaturation that occurs with exertion
  - Also used to optimize titration of supplemental oxygen for the correction of hypoxemia
  - “6 minute walk”
- **94621 Pulmonary Stress Test; complex**
  - Involves the measurements of CO₂ production, O₂ uptake and electrocardiographic recording

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94620

- Editorially revised in 2007 to include a six minute walk test and oximetry in the descriptor.
- **CPT Assistant 2007**
  - The appropriate code to report the six-minute walk test to evaluate distance, dyspnea, oxyhemoglobin desaturation, and heart rate is 94620.
  - Most importantly heart rate, blood pressure, oxygen saturation, and liter flow of supplemental oxygen are to be reported at rest, during exercise, and during recovery.
  - Physician analysis of data and interpretation of the test are procedurally inclusive components of this code.
Nursing Home Patients

- Testing done in physician’s offices patients admitted to Nursing Home present problems
- Payment for Technical Portion of test not possible to physician office
  - Contract with Nursing Home for payment
- Payment for Professional portion of test is possible
  - Bill with 25 modifier

Thoracentesis

- 32421 aspiration only
  - Diagnostic or therapeutic in nature
  - AKA pleural tap
  - Needle aspiration of fluid from pleural space
- 32422 with tube insertion
  - Therapeutic, similar to chest tube (32551)
  - Small-bore catheter for drainage
  - Larger volume of fluid to be drained

Thoracentesis

- Aspiration vs insertion of “temporary” catheter tube
- Use modifier –50 if performed bilaterally
BRONCHOSCOPY CODING RULES

- Surgical bronchoscopy always includes diagnostic bronchoscopy when performed by same physician
- Fluoroscopy is bundled
- Bronchoscopies are inherently bilateral
- Multiple techniques?
  - How to bill
  - Modifier – 51 not required by CMS
  - Code in RVU order- highest goes first

MEDICARE Rules

- Multiple Procedures
  - #1 paid at 100%
  - #2 paid at 50%
  - #3 paid at 25%
  - #4 paid at 25%

PAYMENT METHODOLOGY

- Multiple surgical discounts are NOT used here
- Special rules for multiple endoscopic procedures
  - “If the procedure is billed with another endoscopy that has the same base procedure
  - Apply multiple endoscopy rules of a family before ranking the family with other procedures performed on the same day”
MULTIPLE ENDOSCOPY RULES

- Base Code? Family??
  - 31622 – Bronchoscopy, rigid or flexible, with or without fluoroscopic guidance;
    diagnostic, with or without cell washings (separate procedure)
  - 31623 with brushings or protected brushings
  - 31624 with bronchial alveolar lavage
  - 31625 with bronchial or endobronchial biopsy(s) single or multiple sites

PAYMENT METHODOLOGY

- Highest “value” procedure?
  - How do we know?
- What work is inherent to all codes in this family?
- What additional work is being done?

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MCM CHAPTER 12

• Section 40.6 - C.13

• Example

In the course of performing a fiber optic colonoscopy (CPT code 45378), a physician performs a biopsy on a lesion (code 45380) and removes a polyp (code 45385) from a different part of the colon. The physician bills for codes 45380 and 45385. The value of the diagnostic colonoscopy (code 45378) is built into the value of codes 45380 and 45385. Rather than paying 100 percent for the highest valued procedure (45385) and 50 percent for the next (45380), pay the full value of the higher valued endoscopy (45385), plus the difference between the next highest endoscopy (45380) and the base endoscopy (45378).

• Carriers assume the following fee schedule amounts for these codes:
  – 45378: $255.40
  – 45380: $285.98
  – 45385: $374.56

• Pay the full value of 45385 ($374.56), plus the difference between 45380 and 45378 ($30.58), for a total of $405.14.

COMPUTATION

45385 - Polyp removal (highest RVU code)
  – $374.56 pay @ 100%

45380 - Lesion biopsy (next highest RVU code)
45378 - Diagnostic (subtract base endo code fee)

45380 - $285.98
  -45378 - $255.40
  $30.58 (difference)

Add difference to 1st code fee for a total of $405.14.

Multiple Bronchoscopy
When is it worth it?

• 31625 – biopsy
  – $169.49

• 31623 – brush
  – $145.02

$314.51 (endo base)
$1.81

$169.49 + $1.81 = $171.30

• 31629 – tx bron fna
  – $201.52

• 31628 – tx bron bx
  – $188.56

$489.08

$201.52 + $45.35 = $246.83
DIAGNOSIS CODING

Snags, Snares and Specificity

ICD-9-CM Official Guidelines for Coding and Reporting

• A joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.
• These guidelines have been developed to assist both the healthcare provider and the coder in identifying those diagnoses and procedures that are to be reported.

ICD-9-CM Official Guidelines for Coding and Reporting

• The importance of consistent, complete documentation in the medical record cannot be overemphasized. Without such documentation accurate coding cannot be achieved.
• The entire record should be reviewed to determine the specific reason for the encounter and the conditions treated.
493 - ASTHMA

- Excludes wheezing NOS (786.07)
- Fifth digits
  - 0 - unspecified
  - 1 - with status asthmaticus
  - 2 - with (acute) exacerbation

493 - ASTHMA

- **DEF:** Status asthmaticus; severe intractable episode of asthma unresponsive to normal therapeutic measures
- **TIP:** If documentation indicates both exacerbation and status asthmaticus, assign only the code for status asthmaticus

ASTHMA

- 493.0 √ - Extrinsic asthma
- 493.1 √ - Intrinsic asthma
- 493.2 √ - Chronic obstructive asthma
- 493.8 √ - Other forms of asthma
- 493.9 √ - Asthma, unspecified
COPD

• **496** Chronic airway obstruction, not elsewhere classified
  – **NOTE:** This code is not to be used with any code from categories 491-493
  – **EXCLUDED:** chronic obstructive lung disease specified: ---
  – **TIP:** COPD is a nonspecific term that encompasses many different respiratory conditions; review medical record and query physician for more specific documentation of emphysema, bronchitis, asthma, etc

BRONCHITIS

- **491.2√** - Obstructive chronic bronchitis
  - **491.20** Without exacerbation
  - **491.21** With (acute) exacerbation
  - **491.22** With acute bronchitis
- **466√** - Acute bronchitis and bronchiolitis
  - **466.0** Acute or subacute

PNEUMONIA

• **486** Pneumonia
  (acute)[benign](bilateral)[brain][cerebral]
  (circumscribed)[congestive][creeping][delayed resolution][double][epidemic][fever][flash]
  (fulminant)[fungoid][granulomatous]
  (hemorrhagic)[incipient][infantile][infectious][infiltration][insular][intermittent][latent][lobar][migratory][newborn][organized][overwhelming][primary][progressive][pseudolobar][purulent][resolve d][secondary][senile][septic][supportive][terminal][true][unresolved][vesicular]
PNEUMONIA

- 486 Pneumonia, organism unspecified
  - TIP: Never assume a causal organism based on laboratory or radiology findings alone
- 480. ✓ Viral pneumonia
- 481. ✓ Pneumococcal pneumonia
- 482. ✓ Other bacterial pneumonia
- 483. ✓ Pneumonia due to other specified organism
- 484. ✓ Pneumonia in infectious diseases classified elsewhere*
- 485 - Bronchopneumonia, organism unspecified

SIGNS & SYMPTOMS

- 786 - Symptoms Involving Respiratory System and Other Chest Symptoms
  - 786.05 Shortness of Breath (SOB)
  - 786.09 Other
    - Dyspnea
    - Snoring
SLEEP DISORDERS

• 327.20 - Organic sleep apnea, unspecified
• 327.21 - Primary central sleep apnea
• 327.23 - Obstructive sleep apnea (adult) (pediatric)
• 327.27 - Central sleep apnea in conditions classified elsewhere
• 327.51 - Periodic limb movement disorder
• 333.94 - Restless legs syndrome (RLS)
• 780.57 - Apnea, sleep unspecified

NEW IN 2011

• 278.03  Obesity hypoventilation syndrome

• 786.30  Hemoptysis, unspecified
• 786.31  Acute idiopathic pulmonary hemorrhage in infants [AIPHI]

NEW IN 2011

• V85.41  Body Mass Index 40.0-44.9, adult
• V85.42  Body Mass Index 45.0-49.9, adult
• V85.43  Body Mass Index 50.0-59.9, adult
• V85.44  Body Mass Index 60.0-69.9, adult
• V85.45  Body Mass Index 70 and over, adult
MODIFIER 22
Increased Procedural Service

• When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (i.e. increased intensity, time, technical difficulty of procedure, severity of patient’s condition, and mental effort required.)

— NOTES: This modifier should not be appended to an E/M service.

MODIFIER 25

Significant, Separately Identifiable Evaluation and Management Service Provided by the Same Physician 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 that was performed.

• A significantly, 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 Services Guidelines for instructions on determining level of E/M service).
MODIFIER 25
• For significant, separately identifiable non-E/M services, use modifier 59
• Does not require different diagnosis
• Documentation must support separate additional work
• Monitored for high utilization

Why All The Fuss?
• OIG Report issued 2006
  – 35% of claims submitted with modifier 25 in 2002 were incorrectly paid
  – $538 million in improper payments

Questions for Use of Modifier 25
• Was the procedure previously scheduled?
• Was the patient prepped in any way?
• Did the physician have to do all the work on the E&M to get to the decision to do the procedure?
• Did a new sign or symptom require an evaluation before being treated?
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 services 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

Modifier 59
Distinct Procedural Service

• Documentation must support
  – Different session
  – Different procedure or surgery
  – Different site or organ system
  – Separate incision/excision
  – Separate lesion
  – Separate injury (or area of injury in extensive injuries) encountered or performed on the same day on the same individual.
• However, when another already established modifier is appropriate, it should be used rather than modifier 59 best explains the circumstances should modifier 59 be used.
  – NOTE: Modifier 59 should NOT be appended to an E&M service.

Questions for Use of Modifier 59

• Are the procedures separate and distinct?

• Does the documentation clearly show the distinction?

• Is there a better, more descriptive modifier available?
Questions?

Questions are guaranteed in life; Answers aren't.

Youngmedconsult@aol.com