

Thank you for attending

INTRODUCTION TO CPT CODING

*A CHAMPS webcast presented by
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on Tuesday, May 10th, 2005*

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CODING FOR PROFITABILITY, OR, "HOW TO SPEAK THEIR LANGUAGE"

Whenever one is presented with the task of learning a foreign language, two issues immediately come to mind: vocabulary and rules of grammar. Learning to use the CPT coding system is, in effect, learning to speak a foreign language. Therefore, you must learn the vocabulary and the rules of grammar.

RULES OF GRAMMAR

The rules of grammar are sometimes dependent upon the region of a country (field of medicine) you are visiting. This is due to the use of idiomatic language (different ground rules). The rules of grammar, for the language we will call CPT, are contained in several sections of the CPT language book: forward, introduction, and guidelines. Each section of the country (book) has its own rules of grammar. In our language manual (CPT) these are divided into Evaluation & Management (E&M), Medicine, Surgery, Anesthesia, Radiological Services, and Pathological Services. Everything contained in the forward and introduction applies to all areas of the country. Each area, however, contains its own idioms (ground rules for use of codes), and these must be familiar to the traveler, if the traveler hopes to make his/her needs known to the natives.

Consequently, if not familiar with the content of the forward, introduction, and rules of grammar of the area you will be visiting (ground rules), you will not speak the language with any degree of proficiency. Frequently, you will be conversing with individuals whom you believe to have expert knowledge of the language (clerks for insurance companies), but who, in fact, do not. When faced with this situation, you must be fluent in the language in order to aid them in understanding you, and to know (based on reimbursement levels) when they have misunderstood, or misinterpreted, what you have said.

PHRASING

You have probably had the opportunity to listen to people who use certain phrases with such frequency that you finally begin to "tune them out". When you are speaking CPT, you must be very careful of the way you phrase what it is you want to say. If you overuse or abuse the vocabulary (codes) that is/are available to you, those who are conversant in the language will soon begin to "tune you out" (reimburse at a lesser level).

OVERUSED AND ABUSED PHRASES (CODES)

There are certain codes that, when overused, can cause you a great deal of harm by way of altering your Fee Profile (or causing you problems with CMS or the OIG), and therefore, resulting in consistently lower reimbursement. Conduct an audit to determine which codes in your clinic are overused. The overuse and abuse of codes indicates that you are not taking the time to code properly, and frequently results in your being reimbursed at a lower level than deserved. Overuse and abuse of

codes can raise "red flags" in insurance company computers. Always code properly, and in compliance with CMS regulations.

MODIFIERS

Use modifiers whenever they are needed. They add validity to your claims, as long as you are not consistently modifying up. Modifiers are very much like adjectives and adverbs: they describe and qualify what you are saying. Don't be afraid to use them.

CODES THAT SHOULD BE USED, BUT FREQUENTLY AREN'T

For some strange reason, many practices fail to charge for all services that are rendered. The section entitled "Special Services and Reports" contains a myriad of codes for numerous activities that are routinely carried out in most medical offices. Become very familiar with these codes and use them whenever possible. They could make the difference of several thousands of dollars of income to your practice every year. Don't fail to include this section as a "MUST" on your reading list. Additionally, be aware that even if insurers don't reimburse for some of these services, they should still be coded. If you provided the service, document it on both the Encounter Form and in the Medical Record. The two should "match".

DOCUMENT THE NEED FOR YOUR CLINICAL SUPPORT STAFF (AND HELP THEM PAY FOR THEMSELVES)

Minimal levels of service, performed by clinical support staff, can (and should be) coded (even though these codes sometimes cannot be charged/reimbursed). If you code for every blood pressure check, every immunization, even though the provider does not see the patient, administration will understand what the support staff does, and you may realize an additional source of income.

SUPPLIES, BIOLOGICALS, ETC.

If you are not charging for sterile trays, biologicals, supplies, etc., you are going to be very happy to find yet another source of income. There are codes for all of these and they are there to be used (but be careful not to "unbundle" - become familiar with the "Correct Coding Initiative"). Supplies, drugs, etc. are not free to you and should not be free to the patient. The provider's fee is just that (a professional fee), and it comprises only the professional component of the total bill.

MORE ALPHABET SOUP

The ICD.9.CM codes comprise supporting documentation for your CPT codes. As an example, suppose you code a patient's visit, indicating that a lavage of the external otic canal was carried out. You bill for the lavage. This patient has seen

you in the past for hypertension. For this visit, you code the diagnosis as hypertension. If the insurance clerk on the other end is on "his/her toes", he/she will deny this claim (actually, these days, "edits" built into insurance computers do the work). Yes, the patient is hypertensive. This has nothing whatsoever to do, however, with today's visit. The CPT codes explain what you did and the ICD.9.CM codes explain why you did what you did. The two codes MUST support one another.

IN CONCLUSION

In today's competitive marketplace, we are all well-advised to maximize what resources are available to us. We should deliver the highest quality care possible, make the care we give (and all activity surrounding it) as pleasant an experience as possible for the patient, and charge in a manner that is consistent with good business techniques. It has been our experience, when conducting random audits, that most practices fail to charge for approximately 32% of the services rendered. This converts to a great deal of lost income. If your practice is experiencing decreased revenues, and frantically searching for palatable marketing techniques, first look at what you are currently doing. Until you are certain that you are appropriately charging for every service being rendered, and collecting in a timely manner, don't look for solutions beyond your front door.

TO OBTAIN THE 2005 EDITION OF THE CPT

If you do not have the 2005 edition of the CPT, it is available from many sources. If you are close to a university, the bookstore will probably have it. Several organizations sell it. However, you can also order it from the AMA, Ingenix, or online from Barnes & Noble or Amazon. The CPT is also available on computer disks and CD-ROMs.

For the "ultimate" coding experience, try using Encoder Pro from Ingenix Corporation (sample disks are available), either disk-based or web-based. It's expensive but, in my opinion, well worth it. By the time you add the costs of CPT, HCPCS and ICD.9.CM books, you've approached the cost of Encoder Pro. Among other "fabulous" features, Encoder Pro runs compliance and medical necessity edits. You can search by any code, by a medical term or in plain English.....a wonderful tool for a busy practice.

CODING SYSTEMS

Level I

CPT

- Current Procedural Terminology
- Used by All Insuring Organizations
- Consists of a 5 digit code and, sometimes, a 2 digit modifier
- Use new codes each January (available in October each year)

Level II

HCPCS - National

- Healthcare Common Procedure Coding System
- Used by Medicare, Medicaid and Most Other Insurers
- Usually consists of one alpha character and 4 digits, plus some modifiers
- Use new codes each January (available in October each year)

DIAGNOSTICS

ICD.9.CM

- Used by All Insuring Organizations
- Supportive of the CPT and HCPCS procedure codes, indicating why you did what you did to/for the patient
- Updated Periodically

EVALUATION & MANAGEMENT SERVICE CODES

- **Secondary to implementation of Medicare Payment Schedule (MPS) required by Amendment to OBRA of 1990**
- **New codes & coding rules took effect 1/1/92**
- **All specialties use all codes (including consultation codes for FPs)**
- **"New Patient" specifically defined as one who has not received professional services at this clinic within past 3 years**
- **Office-based providers use Emergency Department E&M codes**
- **Using Time as a Factor in Determining LOS**
 1. When Counseling and/or Coordination of Care Comprises More Than 50% of the Face-to-Face Physician/Patient Encounter (Must Be Documented As Such)
 2. When Determining LOS for Inpatient Care (Unit/Floor Time)
- **Definition of Counseling**
 1. Diagnostic Results, Impressions, and/or Recommended Diagnostic Studies
 2. Prognosis
 3. Risks and Benefits of Treatment Options
 4. Instructions for Treatments and/or Follow-Up
 5. Importance of Compliance With Chosen Treatment Option
 6. Risk Factor Reduction
 7. Patient and Family Education
- **Three Key Components in Selecting Correct Level of Service (LOS)**
 1. History
 2. Examination
 3. Medical Decision-Making
- **Four Contributing Components**
 1. Counseling
 2. Coordination of Care
 3. Nature of Presenting Problem
 4. Time (Only In Relation to Patient Counseling/Coordination of Care and Inpatient Care)
- **Documentation Required**
 1. Indication That Service Was Performed by Physician or Under Supervision of Physician
 2. Chief Complaint
 3. History of Present Illness/Problem
 4. Examination of Affected Body Area or Organ System

5. Type of Medical Decision-Making
 - a. Nature of Diagnosis
 - b. Management Options
 - c. Amount/Complexity of Data Reviewed
 - d. Risk of Complications
 - e. Morbidity/Mortality Risks
- **Definition of Chief Complaint (Nature of Presenting Problem)**
 - Minimal: problem may not require the presence of the physician, but for which service is provided under the physician's supervision
 - Self-Limited: problem runs a definite and prescribed course, is transient, and either is not likely to alter health status permanently or has a good prognosis with management and compliance
 - Low Severity: problem in which the risk of morbidity without treatment is low, there is little to no risk of mortality without treatment, and full recovery without functional impairment is expected
 - Moderate Severity: problem in which the risk of morbidity without treatment is moderate, there is moderate risk of mortality without treatment, and there is uncertain prognosis or increased probability of prolonged functional impairment
 - High Severity: problem in which the risk of morbidity without treatment is high to extreme; there is a moderate to high risk of mortality without treatment; or there is high probability of severe, prolonged functional impairment
- **Types of History**
 1. Problem Focused (PF): targets the chief complaint - brief history of present illness or problem
 2. Expanded Problem Focused (EPF): combines PF with problem - pertinent system review
 3. Detailed (D): combines EPF with extended history of present illness; extended system review; and pertinent past, family and/or social history
 4. Comprehensive (C): combines elements of D with complete system review and complete past, family and social history
- **Types of Examination**
 1. Problem Focused (PF) is limited to the affected body area or organ system
 2. Expanded Problem Focused (EPF) combines PF with examination of other symptomatic or related organ systems
 3. Detailed (D) is an extended examination of the affected body area(s) and other symptomatic or related system(s)
 4. Comprehensive (C) is a complete single-system specialty exam or a complete multi-system examination

GENERAL INFORMATION ABOUT ICD.9.CM
(International Classification of Diseases - 9th Clinical Modification)

1. 3 volume set
2. Volume 3 not used by physicians
3. Purchase volumes 1 and 2 only
4. Used internationally
5. Revisions made periodically
6. Volume 1 - tabular list (diagnoses by number)
7. Volume 2 - alphabetical index (diagnoses by name)
8. In addition to diagnoses, multiple appendices
9. Primary diagnoses are 001.0 - 999.9
10. Supplementary Classifications: (a) Factors influencing health status and contact with health services - "V" codes; and (b) External causes of injury and poisoning - "E" codes
11. Incomplete/incorrect coding can result in denied claims or reduced payment of claims
12. CMS regulations demands that claims be coded using fifth digits, wherever possible (other insurers have followed suit)
13. Medicolegal purposes
14. Accurate epidemiological profiles of the patients you're serving
15. Management decision-making

PRESENTATION SLIDE TEXT

Learning Objectives

At the end of this session, participants will:

- Be able to identify the 3 major coding systems used in ambulatory care, and determine when each should be employed;
- Understand the importance of coding correctly, even when being reimbursed under a cost-based system of care, such as FOHCs and RHCs; and,
- Know how to use the Current Procedural Terminology (CPT) book.

Terms to Understand

- **CPT** (Current Procedural Terminology)
- **HCPCS** (Healthcare Common Procedural Coding System)
- **ICD.9.CM** (Int'l Classification of Diseases, 9th Clinical Modification)
- **RRVS** (Resource Based Relative Value System)
- **RVU** (Relative Value Unit)

ICD.9.CM

- Used to code diagnosis(es) - WHY you did what you did
- MUST accurately support the services rendered

HCPCS

- Medicare & Medicaid specific codes
- Changes annually
- Used for services not usually coded by outpatient care physicians
- Generally, codes are used for drugs & supplies
- Also used for some specific services
- Example: G0344 (IPPE), "Welcome to Medicare Physical" - Initial Preventive Physical Exam and G0366, the accompanying EKG

CPT

- Primary system for coding services rendered to patients
- Changes annually
- Book is divided into 6 PRIMARY sections
 - Evaluation & Management with code range of 99201 - 99499
 - most common codes in primary care, referred to as "E&M"
 - Anesthesiology with code range of 00100 - 99140
 - Surgery with code range of 10021 - 69990
 - organ system is usually identifiable by first digit of code
 - Radiology with code range of 70010 - 79999
 - Pathology and laboratory with code range of 80048 - 89356
 - Medicine with code range of 90281 - 99602

Using the CPT Book

- Guidelines - specific to each section
- Symbols - at the bottom of each page
- Colon & semi-colons - within definitions
- Modifiers - not all apply to all codes
- Appendices - very useful
- Indices - question? check alphabetically
- Examples - contained in some guidelines

RBRVS & RVU

- Codes have associated "resource based" relative value units
- Insurance entities reimburse based upon these values
- Fee schedules SHOULD be based upon these values
- Fee schedules based upon RVUs are simple to handle
 - "multipliers", rather than "fees" are used
 - for medical codes, e.g., \$7;
 - for surgical codes, e.g., \$100;
 - for laboratory codes, e.g., \$8;
 - for radiology codes, e.g., \$11
- Instead of changing "fees" annually, update the \$ multiplier and update the RVUs; do the math; and the entire fee schedule is automatically updated
- An E&M example
 - 99213 @ 9.0 RVUs with a multiplier of \$7 = \$63
 - 99214 @ 13.5 RVUs with a multiplier of \$7 = \$94.50

Why to Code Correctly

- Encounter Form Should Corroborate the Medical Record
- Epidemiological Purposes
- Management Decision-Making Purposes
- Development of Meaningful Health Care Plans
- Risk Management Tool
- If Fee Schedule is RVU-Based, It's IMPERATIVE or You'll Skew Your Next Fee Schedule
- Might as Well Do It Right the First Time
- Medicolegal Purposes
- Possible Insurance Payer Audits
- It's the Law!!!

?? Questions ??

- Can you use the -25 modifier when you address an acute issue at a well woman exam, or well child check?
- When is the -25 modifier appropriate?
- Some intermediate/advanced questions:
 - How do we code group visits? For the work a provider does in the visit according to the usual CPT, or a special group visit code?
 - Also, is there a better way to gauge the level of CPT coding of a visit? We've been using a form from Family Practice Management, others use the Stat E&M coder on their Palms, but is there another way? Although usually the forms/programs work, sometimes they don't-especially if you spend time in the visit dealing with several difficult problems.
 - Also, what counts as reviewing a system? How complete does that review or exam (in the physical) have to be to be valid as reviewed for coding purposes?
- **Excellent Group Visit Resource:**
<http://www.aafp.org/fpm/20000600/33plan.html>
- When coding for neoplasm's, should one always use the code under "skin", for the site and unspecified instead of the other choices if still not known whether benign or uncertain behavior rather than coding directly from the site?

Biography of Maureen A. Hong, PA, FNP, MHA

Maureen Hong is a consultant with Hong & Associates, providing practice management consulting services to clinics, physicians, hospitals, and other health care organizations (in both the public and private sectors). She is a licensed Family Nurse Practitioner, Physician Assistant, and Registered Nurse, with additional degrees in Community Medicine and Health Care Administration. Her career has taken her through multiple health-related fields, as a practitioner in primary care practices, a clinical instructor at the University of Colorado, and past Executive Director of the Colorado Community Health Network (CCHN) and the Community Health Association of Mountain/Plains States (CHAMPS). Maureen's current consulting involves workshop/seminar development and presentation; activities in medical billing advocacy; grant reviews; and contract work for HRSA (Health Resources and Services Administration).