The Business of Healthcare for Nurse Practitioners

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Leesa A. Israel, BA, CPC, CUC, CEMC, CPPM, CMBS, AAPC
Fellow, AAPC MACRA Proficient
Vice President | TCI Content & Online Tools
Coding Institute, LLC

My Career

- Degree in Communication/Journalism with English and Economics minors from St. John Fisher College in Rochester
- Worked for newspapers and trade publications from high school, through college, and just out of college
- Been with Coding Institute, LLC for 18.5 years – started as an editor on the newsletter side; have worked in many departments including marketing, books, auditing, etc.
- Currently the VP of Content & Online Tools, overseeing our coding, billing & compliance newsletters as well as our online coding & billing products.
- Summary: I'm a writer, coder, biller, educator, speaker, auditor, and consultant.

My Professional Credentials

Certified Professional Coder (CPC), American Academy of Professional Coders (AAPC) July 2006 – Present
Certified Medical Billing Specialist (CMBS), Medical Association of Billers (MAB), September 2006 – Present
Certified Urology Coder (CUC), AAPC, October 2008 – Present
Certified Physician Practice Manager (CPPM), AAPC, June 2013 – Present
Certified Evaluation & Management Coder (CEMC), AAPC, March 2015 – Present
ICD-10 Proficient, AAPC, June 2014
AAPC Fellow Designation, December 2016
AAPC MACRA Proficient, May 2017
I am a writer, a coder, a consultant, and an auditor, not an attorney. Although the information has been carefully researched and checked for accuracy and completeness, the presenter and TCI carry no responsibility or liability with regards to errors, omissions, misuse, or misinterpretation.

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Agenda
1. Healthcare System 101
2. Revenue Cycle Management
3. Medical Billing
4. CMS NP Guidelines
5. Incident To Services
6. Documentation
7. Medical Necessity
8. Medical Coding
   a. CPT®
      i. E/M Coding
   b. ICD-10
   c. HCPCS
9. Resources

Healthcare System 101
First Piece of the Puzzle

Where do we go for healthcare?

HOSPITALS

Hospital Inpatient Care:
This is what we normally think of as hospital care. This takes place when you are very sick and need to stay at the hospital overnight.

Hospital Outpatient Visits
When you don’t need to stay overnight

Emergency Room Care
When you don’t need to spend the night, but you need to be seen immediately, you get emergency room care. This is at the hospital, but is not considered a hospital inpatient stay.

Outpatient Surgery
For simple surgeries such as tonsil removal or lesion removal you can go to an outpatient surgical center. These are sometimes part of a hospital and sometimes not. However, they are never considered a hospital inpatient stay because you do not spend the night.
Long-Term Care

- Nursing Homes
- Assisted Living
- Rehabilitation Centers

This is where people go when they can’t take care of themselves at home. They don’t need the intensive care that a hospital can provide. While most people in nursing homes are old and can’t take care of themselves at home, some are just there recovering from a traumatic injury.

Home Care

When people need medical care but are unable to get to regular doctor visits, they can get care in their homes. Nurses will visit and provide wound care, injections, etc.

Who Pays for Health Care?

- Medicare
- Medicaid
- Private Insurance
- Other Government Offices
- Individuals
### Medicare Part A

Medicare Part A is a hospitalization benefit. Medicare Part A covers:

- Hospital care
- Skilled nursing facility care
- Hospice care
- Home health services

It does not pay for doctor's visits or other outpatient services.

### Medicare Part B

Medicare Part B pays for physician services and other related outpatient services. Part B covers 2 types of services:

- Medically necessary services: Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice.
- Preventive services: Health care to prevent illness (like the flu) or detect it at an early stage, when treatment is most likely to work best.

### Medicare Part C

Medicare Part C (also called Medicare Advantage, MA) is a type of Medicare health plan offered by a private company that contracts with Medicare. MA combines Part A (hospital insurance) and Part B (medical insurance) together in one plan. They can also be combined with Part D.

Medicare Advantage Plans include:

- Health Maintenance Organizations
- Preferred Provider Organizations
- Private Fee-for-Service Plans
- Special Needs Plans
- Medicare Medical Savings Account Plans

### Medicare Part D

A Medicare Part D Prescription Drug Plan (PDP) can be a stand-alone plan (not joined with other insurance) or it may be combined with a Medicare Advantage Plan, also called a Medicare Advantage Prescription Drug (MA-PD) Plan.

Part D adds prescription drug coverage to:

- Original Medicare
- Some Medicare Cost Plans
- Some Medicare Private Fee-for-Service Plans
- Medicare Medical Savings Account Plans

These plans are offered by insurance companies and other private companies approved by Medicare.

### Medicaid

Medicaid is a jointly funded program by the federal government and by individual states. It provides care for poor people regardless of their age. More than half of all nursing home costs are paid by Medicaid.
Private Insurance

Most private insurance in the U.S. is employer sponsored. Employers pay part of the monthly premium and employees pay the rest. In exchange for the monthly premiums, the insurance company pays for most inpatient, outpatient and physician care.

Other Government Programs

The federal and state governments also provide other healthcare programs that provide funding for particular groups such as children and veterans.

And Many More

They Communicate Through

Medical Coding

Coding is the method of applying a series of numbers to represent the actions, reasoning and supplies provided by a healthcare practitioner to a patient.

In other words it is how the health care provider tells the government or other payer what they did and what they deserve to get paid.

Instead of submitting written descriptions of services, procedures, and diagnoses to request reimbursement, healthcare providers, insurance companies, and government agencies rely on standardized codes that always mean the same thing and are universally understood. Accurate coding is vital to the success of a practice.
Revenue Cycle Management

The revenue cycle begins the moment the patient makes the appointment and then walks through the door. It ends when the patient’s bill is paid in full, either by the patient or by insurance.

Revenue Cycle Management – The Beach Ball

Team Communication is key to effective RCM.

Think of your office like a beach ball. Each team has its own color, and often members of one team will only see things the way the others on their "color team" see them. No one can see the whole beach ball without stepping back and seeing all the colors.

The money doesn’t roll in unless all the color teams do their part. The practice manager negotiates contracts, the front desk registers the patient and collects insurance info, clinicians document the services they provide, coders translate the documentation into codes, billers submit the codes on a claim and appeal denials, etc.
Say I have a broken leg ... ouch.
I go to the emergency room.
The break is bad enough that I need to go under sedation while they set the bone.
I receive excellent care.
I also receive 3 bills:
1. The first bill is from the Orthopedist for her services.
2. The second is from the hospital for facility use and nursing services.
3. The third is from the anesthesiologist.

Let's Follow a Patient - Billing

Step 1
1. Patient appointment
2. Verification of benefits
3. Preauthorize non-routine services
4. Patient registration
5. Co-pay and deductible collection

Step 2
6. History – taken by medical assistant or physician
7. Exam – by physician
8. Complete superbill
9. Patient check out

Step 3
10. Insurance claim preparation
11. EOB submission

Step 4
12. Bill the patient
13. Bill the secondary insurance
14. Write off contractual adjustments.

Received EOB in 60 days?

Yes
No

Do you agree with the payer’s decision?

Yes
No

Appeal the claim

Does the patient have secondary insurance?

Yes
No

Bill the secondary insurance

Lifecycle of an Insurance Claim
CMS NP Guidelines

The Centers for Medicare & Medicaid Services (CMS)

- CMS Publication 100-02 Medicare Benefit Policy Manual
  - Chapter 15 – Covered Medical and Other Health Services
    - Section 200 - Nurse Practitioner (NP) Services
      - Includes Advanced Nurse Practitioners
      - Physician Assistant, Certified Nurse Specialists (CNS) and other types of non-physician practitioner guidelines are found in following sections
- CMS Publication 100-04 Medicare Claims Processing Manual
  - Chapter 12 - Physicians/Nonphysician Practitioners
    - Section 120 - Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) Services Payment Methodology
      - 120.1 - Limitations for Assistant-at-Surgery Services Furnished by Nurse Practitioners and Clinical Nurse Specialists
      - 120.2 - Outpatient Mental Health Treatment Limitation
      - 120.3 - NP and CNS Billing to the Contractor

Note: For other payer(s)
- Work with payer
- Know and understand their benefit/medical policy rules
CMS Nurse Practitioner Overview

"... registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law; ... certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; and
Possess a master's degree in nursing."

CMS Guidelines: Certifying Bodies & Part B Covered Conditions

Utilizes specific national certifying bodies
- List can be found in CMS manuals

Services will be covered under Part B if all of the following conditions are met:
- "They are the type that are considered physician's services if furnished by a doctor of medicine or osteopathy (MD/DO);
- They are performed by a person who meets the definition of an NP (see subsection A);
- The NP is legally authorized to perform the services in the State in which they are performed;
- They are performed in collaboration with an MD/DO (see subsection D); and
- They are not otherwise precluded from coverage because of one of the statutory exclusions. (See subsection C.2.)"

CMS Guidelines: Types of NP Services That May Be Covered

"State law or regulation governing an NP's scope of practice in the State in which the services are performed applies.
- Develop list of covered services based on the State scope of practice.
- Examples of the types of services that NPs may furnish include
  - Services traditionally reserved to physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting x-rays, and other activities that involve an independent evaluation or treatment of the patient's condition.
- If authorized under the scope of State license, NPs may furnish services billed under all levels of evaluation and management codes and diagnostic tests if furnished in collaboration with a physician.
See §60.2 for coverage of services performed by NPs incident to the services of physicians."
CMS Guidelines: Services Otherwise Excluded From Coverage

Services may not be covered if excluded from coverage
- Even if NP is authorized by State law to perform them

Example
- Medicare law excludes from coverage things such as but not limited to
  - Routine foot care, routine physical checkups, and services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member
- Services precluded from coverage even though they may be within an NP's scope of practice under State law

CMS Guidelines: Collaboration

"...process in which an NP works with one or more physicians (MD/DO) to deliver health care services, with medical direction and appropriate supervision as required by the law of the State in which the services are furnished.

...absence of State law governing collaboration, collaboration is to be evidenced by NPs documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice.

...collaborating physician does not need to be present with the NP when the services are furnished or to make an independent evaluation of each patient who is seen by the NP."

Incident To Services
Direct Billing

NP stand alone services
- Bills payer under own National Provider Identifier (NPI)
- Unique 10-digit identification number issued to health care providers in the United States by the Centers for Medicare and Medicaid Services (CMS).
- NPI replaced unique provider identification number (UPIN) as required identifier for Medicare services,
- May be allowed by other payers, including commercial healthcare insurers
- Always check with payer for specific rules

CMS Incident to Billing

In a nutshell, incident-to billing is when an advanced practice provider [APP], like an NP, sees an established patient in the office for an established problem with an established course of treatment outlined by one of the physicians within the practice.

Note: Remember that incident-to billing is a Medicare convention; third-party payers have no similar universal policy that applies to all its carriers. Third-party payers might have their own incident-to rules that emulate - or even duplicate - Medicare's rules. If you have any doubt as to whether a third party allows incident-to, check with the payer.

Incident to Versus Direct Billing Reimbursement

“Incident To” paid to physician/facility at 100%

“Direct Billing” paid to independent Nurse Practitioner at 85%
CMS Guidelines
Incident To Criteria

- Must be part of patient’s normal course of treatment
- Physician personally performed initial service, remains actively involved in the course of treatment
- Physician doesn’t have to be physically present in patient’s treatment room when services provided
- Must be present in the immediate office suite to render assistance, if necessary
- Solo practitioner - Must directly supervise care
- Group practitioner - Any physician member of group may be present in office to supervise
- Patient’s medical record must document essential requirements for incident to service
- Qualifying “incident to” services must be
  - Provided by a professional directly supervised by the physician
  - Who represents a direct financial expense to physician/practice/facility
  - Such as a “W-2” or leased employee, or an independent contractor

INCIDENT TO

- No “new” patients
- No new problems
- Physician in suite, not hospital/Skilled Nursing Facility
- Physician directs patient care
- Reimbursed as physician at 100%

DIRECT BILLING

- Any patient seen
- Any patient problem
- Physician location not applicable
- NP directs patient care
- Reimbursed at 85% of physician fee

CMS Guidelines
Incident To Types of Service

Services include but are not strictly limited to:
- Cardiac rehabilitation
- Providing non-self-administrable drugs and other biologicals, and
- Supplies usually furnished by the physician in the course of performing his/her services, e.g., gauze, ointments, bandages, and oxygen
- Follow-up office visits
CMS Guidelines
Inpatient or outpatient hospital services and residents in a Part A covered stay in SNF

- Unbundling provision (1862 (a)(14) provides payment for all services made to the hospital or SNF by a Medicare intermediary (except for certain professional services personally performed by physicians and other allied health professionals).
- "Therefore, incident to services are not separately billable to the carrier or payable under the physician fee schedule."

CMS Guidelines
Incident To — Office in Institutions

Institutions including SNF:
- Office must be confined to a separately identifiable part of the facility
- Cannot be construed to extend throughout the entire facility.
- Staff may provide service incident to your service in
- Office to outpatients
- Patients who are not in a Medicare covered stay or
- In a Medicare certified part of a SNF
- If your employee (or contractor) provides services outside of your "office" area,
  - Services would not qualify as "incident to" unless you are physically present where the service is being provided
- Exception
  - Certain chemotherapy "incident to" services are excluded from the bundled SNF payments and may be separately billable to the carrier

CMS Guidelines
Incident To — Patient’s Home

Must be present in the patient’s home for service to qualify as an “incident to” service

- Homebound patients in medically underserved areas where no available home health services
- Only for certain limited services found in Pub 100-02, Chapter 15 Section 60A-4 (S)
- Provider need not be physically present in the home when service is performed, although general supervision of the service is required. Related Change Request #: N/A
- You must order the services, maintain contact with the nurse or other employee, and retain professional responsibility for the service.
- All other incident to requirements must be met.
- Second exception
  - Service at home is an individual or intermittent service performed by personnel meeting pertinent state requirements (e.g., nurse, technician, or physician extender), and is an integral part of the physician's services to the patient."
CMS Guidelines
Incident To – Ambulance

"...Neither ambulance services nor EMT services performed under your telephone supervision are billable as “incident to” services."

Documentation

The Importance of Documentation

Documentation is the provider’s best weapon to maximize both patient care and professional reimbursement.

Providers are mandated by law and regulatory bodies to capture some form of record about an encounter with each patient. These notes provide a baseline from which the provider can build, review, and follow up on the treatment plan.

Additionally, a fully documented patient record is the provider’s best chance of receiving complete reimbursement for services rendered to the patient.
The Importance of Documentation

Get to Know That Proper Documentation Assures:

- **Patient care** – Good documentation = good patient care; bad documentation = poor quality care
- **Communication enhancements** – between providers, hospitals, ancillary staff, and patients
- **Billing accuracy** – reducing denials and reduced revenue
- **Quality measures are documented** – for quality and efficiency improvements to processes
- **Increased accountability and accuracy** – enhances reliability of everything that builds and relies upon that documentation (billing, coding, and future patient record)
- **Healthcare analytics** – allows practices to easily access, identify, and address patient care trends, enhance treatment decisions, and work toward process improvements

"If it isn’t documented, it didn’t happen."

Regardless of what services or procedures a provider performs, if it isn’t fully documented, it won’t be reimbursed.

Therefore, to maximize reimbursement, you need to ensure your documentation accurately and meticulously reflects the full picture of the patient encounter.

Malpractice Warning

Poor record keeping can mean the difference between an indefensible lawsuit and one that can be substantiated in court.

Exercise #1:

- **Complaint**: Cough.
- **A two-year-old male, an established patient of XYZ clinic, is brought to the clinic by mother.**
- **Presents with complaints of cough.**
- **Associated symptoms**: headache.
- **Associated with**: Fever, myalgia, nausea, vomiting, poor appetite, diarrhea, chills, chest congestion.
- **Denies**: Allergies, chest tightness, sore throat, wheezing, shortness of breath, ear or eye symptoms.

Question: Does this documentation support a diagnosis of cough?

**Answer:** No. This documentation is almost incoherent. Record says ‘associated symptoms’ and then ‘associated with.’ How are these different? There is little information in this documentation to support the complaint of a cough.
Documentation –
General Guidelines

- Medical record documentation must be completed for each patient seen
- Entries should be in ink, not pencil, or electronic
- Document as quickly as possible (during or after visit)
  - Do not wait a several days to document
- If utilizing:
  - Check-off sheet, only check off what you actually did
  - Electronic record, only document was what done
1. Authentication

Every medical record must have authentication. Every service you provide or order should be authenticated by the author. All notes should be dated, preferably timed, and signed by the author.

Authentication must be either a handwritten or an electronic signature. Note that signature stamps are not acceptable for Medicare and many other payers. In the office setting, initials are acceptable as long as they clearly identify the author.

Handwritten signature will be considered a "mark or sign." If the signature is illegible, Medicare shall consider evidence in a signature log. Lack of such supporting documentation will result in claims denial.
2. Timing Requirements

When your providers actually complete their documentation matters, it is important that documentation be generated at the time of service or, as Medicare puts it, “shortly thereafter.”

Delayed entries within a “reasonable” period of time are acceptable for the purposes of:
- Clarification
- Error correction
- Addition of information initially not available
- Unusual circumstances prevented generation of note at time of service (for example, if your EMR system is not working).

**Rule of thumb:** Payers don’t typically give a set timeframe on what qualifies as “shortly thereafter.” The rule is usually that you are in good shape as long as the documentation is in the chart and documented in the time that the author has “total recall” of the patient encounter or service.

3. Be Careful Making Alterations

The medical record cannot and should not be altered. Errors must be legibly corrected so that the reviewer can draw an inference to its origin. If you make a correction, you should include the date and (preferably) the time of the amended. Then, legibly sign or initial the entry.

Delayed written additions/explanations serve for clarification only and cannot be used to add and authenticate services billed and not documented at the time of service or to retrospectively substantiate medical necessity. For example, if your practice did an audit and found that one of your providers was billing based on time but never included the total time spent with the patient in the chart notes, you cannot go back later on and add the time to support the billing.

**Example:** You accidentally copy and paste a sentence from one patient’s record into another patient’s record. Someone in your practice catches the error later on. Even if you realize that you put it on the wrong patient’s record, it should not be taken out of the record, but corrected using an appropriate method such as lining through it and initializing above it and adding the date and a statement to say that was an error.

4. Know Scribe Rules

If you or another non-physician practitioner (NPP), such as a physician assistant or nurse practitioner, act as a “scribe” for another provider, the individual writing the note or entry in the record should note “written by (name of NPP), acting as a scribe for Dr. (Physician Name).”

The physician should then co-sign and date the record, and also indicate that the note accurately reflects work and decisions he made during the encounter.

**Note:** It would be inappropriate for you, as an employee of the physician, to make rounds or see patients at one time and make entries in the record and then the provider make rounds later and notes “agree with above,” unless you are billing for services under your own name/number.
5. Beware EMR Pitfalls

Templates and electronic medical records (EMRs) were designed to help you increase productivity, organization, and workflow; however, they can lead to over-documenting or other documentation issues.

Remember that only medically necessary information is considered when you are deciding on the code to bill based on supporting documentation. Copy and paste, cloning, and the act of carrying information forward from another record or another portion of the record has the same effect on the integrity of the medical record. Eventually, there will be contradictions in a patient’s record. Payers obviously frown on this type of documentation.

Bottom line: Cloning of documentation is considered a misrepresentation of medical necessity requirement for coverage of services. Credibility of the record is compromised and an auditor will be unable to determine what is accurate and how much work was done on one visit versus another.

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Documentation – CMS’s Watch List

CMS has shortlisted these top errors in documentation:

- Incomplete progress notes: They are either unsigned, undated, or have insufficient details.
- Unauthenticated medical record: The medical record bears no provider signature, initials, supervising signature, or a legitimate signature.
- No documentation to support the service or procedure: Incomplete or missing signed order or progress note describing intent for service/procedure/test.

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Medical Necessity
Define Medical Necessity

The first key to supporting your coding, is understanding what medical necessity really is.

Official wording: The American Medical Association defines medical necessity as "Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider."

Medicare defines medical necessity in the Social Security Act (Title XVIII of the Social Security Act, Section 1862 [a] [1] [a]) as follows: "No payment may be made under Part A or Part B for expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Why it matters: On the back of the CMS-1500 or the electronic equivalent, you are attesting that "I certify that the services shown on this form were medically indicated and necessary for the health of the patient."

There are two possibilities when you receive a denial based on medical necessity:

1. Covered, but not medically necessary in this case — You may perform a service, that the payer normally covers, but for some reason the payer does not feel the encounter is medically necessary for the claim you are submitting. These are the denials you should appeal, using your documentation.

2. Not covered, regardless of your determination of medical necessity — There are some services your payer may never reimburse you for, regardless of your determination that the encounter was medically necessary for that patient at that time.

E/M and Medical Necessity

With EMRs, you may see that your documentation is more detailed and your levels of history and examination seem higher much of the time. That means you need to be careful coding services, such as established patient visits, that only require two out of three key components for a code level.

Your payer can easily determine if you rendered an E/M service when you bill for it, but determining whether medical necessity supports the level of service you coded is the next step. A payer can make the medical necessity judgment and either deny or adjust your E/M levels based on their medical necessity determination.
Medical Necessity Practice Exercise

Review the following documentation example to determine if the service the provider rendered was medically necessary:

A patient presents with a swollen and painful right knee. He complains that the pain started three days ago but denies any specific injury or accident. His pain is aggravated by motion and relieved with rest. Ibuprofen and icing offers little relief and no resolution of pain.

The provider performs a Review of Systems (ROS) for 10 systems, carries out an external exam of ears and documents that there is no hearing loss noted, the temporomandibular joints are clear, no lesions, the lips and gums are normal. The provider reports 99214. Office or other outpatient visit for the evaluation and management of an established patient, with a detailed history and exam and MDM of a moderate complexity.

Question: Was this service medically necessary?

Answer: No. As the OIG would look at it, this is a case of over-documenting and possible fraud to obtain a higher level of reimbursement because the inclusion of an examination of ears has nothing to do with assessing the cause for the swollen right knee. A full 10 system ROS was not necessary.

Caution: Providers should not quickly check off boxes in the EMR or in the record without carefully reviewing the accuracy of the documentation. Checkboxes lend themselves to quick completion of documentation that may be inaccurate.

Lesson: Physicians who get paid for an over-documented service do not necessarily get to keep the money. Auditors on the payers' side look for evidence-based documentation to prove medical necessity, and if they don't find it, the payers ask for their money back. Physicians must be able to substantiate their claims of medical necessity with accurate documentation.

Medical Coding
The Code Sets

- **CPT**
  - Current Procedural Terminology
  - "What the doctor did"

- **ICD-10**
  - International Classification of Diseases
  - "Why he did it"

- **HCPCS**
  - Health Care Common Procedure Coding System
  - "Stuff that he used in order to do it"

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The Code Sets

- **DRG**
  - Diagnostic Related Group
  - For inpatient coding

- **APC**
  - Ambulatory Payment Classification
  - For outpatient coding

- **OAISIS**
  - Organisation for the Advancement of Structured Information Standards
  - Outcome & Assessment Information Set

- **MDS**
  - Minimum Data Set
  - For nursing home use

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**CPT®**

Current Procedural Terminology (CPT®) codes, 4th edition, are used to describe the services provided by physicians, advanced practice providers, and ancillary staff in any given practice (regardless of size or specialty). These services can include visits, tests, injections, therapies, or procedures. These codes are also referred to as HCPCS Level II codes.

CPT® codes are developed and maintained by the American Medical Association (AMA). Each year various specialists, societies, colleges, clinicians, and the like, make requests to the AMA for additions, deletions, and updates to the codes to keep up with technology, medical breakthroughs, public health, and many other reasons. The AMA also looks at the codes to make them more appropriate, user-friendly, timely, accurate, and consistent. They have developed codes to illustrate the types of visits clinicians have with their patients. They look at how procedures are performed by surgeons and update the descriptions of each of the codes to accurately capture the focus of the operations. They add various lab and pathology services to reflect the specimens being studied. They also add injections, tests, studies, and some supplies to the code set based on the needs of the current clinical arena.
**CPT®**

**Categories**
The CPT® code set includes Category I, Category II, and Category III codes.

- Category I codes consist of 5 digits, make up the bulk of the code set, and represent the most common services and procedures.
- Category II codes contain 4 digits followed by an F and represent statistical or tracking codes.
- Category III codes contain 4 digits followed by a T and are created as temporary codes for emerging technologies and services.

**Modifiers:** CPT® modifiers are made up of two numbers that can be added to the end of a CPT® or HCPCS code to provide more information about the service performed.

Updated annually, with changes taking effect on January 1 every year.

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**CPT®**

**Category I (00100–99607)**

Category I codes, the largest category in CPT®-4, are five digits long and are separated into six sections, starting at the beginning of the coding manual. In order for a service or procedure to be listed under Category I, many providers have to perform it, it has to be proven to be effective, and the Food and Drug Administration (FDA) has to approve it (when appropriate). Refer to your CPT®-4 coding manual or electronic version of the code set to find each of the following six sections, or chapters, in Category I, beginning with the first section located at the beginning of the coding manual:

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**CPT®**

1. **Evaluation and Management (E/M) (99201–99499)**—face-to-face services between a physician and patient that typically involve the following three components:
   a. Obtaining the patient’s personal, family, and social histories
   b. Examining the patient
   c. Determining the patient’s diagnosis and developing a treatment plan, if appropriate

   There are exceptions where physicians perform E/M services that do not include the three components, or physicians do not meet with the patient face-to-face during an encounter.
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2. **Anesthesia** (00100–01999)—services that represent various types of anesthesia administered to a patient during a procedure, monitoring a patient during and after anesthesia administration, and other related services.

3. **Surgery** (10021–69999)—surgical procedures arranged by body systems.

4. **Radiology** (70010–79999)—radiology procedures, such as X-rays, CT scans, and ultrasounds.

5. **Pathology and Laboratory** (80047–89998)—laboratory tests including biopsies and tests on various body fluids.

6. **Medicine** (90281–99607)—This section contains a variety of other services and procedures that are not classified to any of the other five sections.

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**Category II (0001F–9007F)**

**Category II codes** (four numbers and the letter F) are supplemental tracking and performance measurement codes, which providers can assign in addition to Category I codes. Providers may want to track specific criteria about patients, such as whether they use tobacco, which is represented by code 1000F. You can find Category II codes listed directly after the last Category I code in the Medicine section.

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**Category III (0042T–0478T)**

**Category III codes** (four numbers and the letter T) follow Category II codes in the coding manual. They are temporary codes that represent new technology, services, and procedures. Codes remain in Category III for up to five years and can become Category I codes if they meet Category I criteria, including approval from the FDA, evidence that many providers perform the service or procedure, and it is proven to be effective.

Category III codes also may be dropped from the Category III if providers do not use them. The AMA updates Category III codes twice a year. When providers assign Category III codes and bill insurers, they have to send medical documentation (special reports) with insurance claims to justify the Category III procedure and further explain why the provider performed it.
CPT®

Providers Who Assign CPT® Codes

The CPT® code set is for physician services and services that other qualified healthcare professionals render, like physician assistants, physical therapists, and psychologists. The CPT® code set is also the designated code set for organizational or facility providers, such as hospitals, ambulatory surgery centers (ASCs), outpatient clinics, urgent care centers, and offices of other healthcare practitioners. The CPT® coding manual uses the term nonfacility to describe services that a facility cannot code and bill.

Many times, physicians or other qualified healthcare professionals provide services within facilities, like hospitals. When this happens, both the physician or other qualified healthcare professional and the facility can each bill the patient’s insurance for the same service. The facility wants to be paid for the service because the physician performed it there and used the facility’s equipment and resources, and the physician also wants to be paid for performing the service.

CPT®

CAUTION

The AMA includes many different coding guidelines and instructions for sections, subsections, subheadings, categories, subcategories, and many individual codes. Guidelines and instructions provide specific information about when and how to assign codes, how providers perform procedures, which codes can and cannot be reported together, and other details related to coding.

Think of the guidelines and instructions as the Dos and Don’ts road signs as you navigate the CPT® coding manual. You could not operate a vehicle effectively without road signs to guide you, and CPT® coding works the same way. Just as you should not ignore road signs while driving, you should not ignore CPT®’s additional guidelines that help you along your way to choosing the correct code.

CPT® - Evaluation & Management

E/M codes are popular Evaluation and Management (E/M) services are the most-used codes of the entire CPT® code set as they are used by nearly every specialty. As a result, there is a lot of data available about those codes that can be beneficial to practices. CMS keeps track of the distribution of E/M codes by specialty that can be used when performing internal audits and physician productivity standards, just to name a few activities.

The E/M code range is from 99201-99499. They are then broken down by location and patient type (new, established, child, adult, initial, subsequent, etc.). Most groups of E/M codes describe five levels of services ranging from problem-focused or straightforward to high complexity or comprehensive. There are several exemptions to the five levels and those include follow-up visits having only three levels, critical care services having only two time-based codes, and preventive or annual visits that have seven levels of services based on the age of the patient.

Even though the five digit E/M codes begin with the numbers “99,” they appear at the beginning of the CPT® manual because they are so heavily used.
What Are E/M Services?

Office and other outpatient services
- New patient: 99201-99205 – require 3 of 3 key components
- Established patient: 99211-99215 – require 2 of 3 key components

Hospital observation services
- Observation Care Discharge: 99217
- Initial Observation Care: 99218-99220 – require 3 of 3 key components
- Subsequent Observation Care: 99224-99226 – require 2 of 3 key components

Hospital inpatient services
- Initial Hospital Inpatient Care: 99221-99223 – require 3 of 3 key components
- Subsequent Hospital Care: 99231-99233 – require 2 of 3 key components
- Observation or inpatient care services: 99234-99236 – require 3 of 3 key components
- Hospital Discharge: 99238-99239 – time-based codes

What Are E/M Services?

Consultations
- Office or other outpatient: 99241-99245 – require 3 of 3 key components
- Inpatient: 99251-99255 – require 3 of 3 key components

Emergency department services

Critical care services

Nursing facility services

Domiciliary/rest home care services

Home services

And others …

What Are E/M Services?

For E/M services, the nature and amount of physician work and documentation varies by type of service, place of service, and the patient’s status.

Place of Service - Explains the setting service was provided in
- Office
- Inpatient Hospital
- Nursing Home

Type of Service - Explains the reason the service was requested or performed
- Consultation
- Admission
- Newborn care
- Office visit

Patient Status - What is the status of the provider to the patient
- New patient
- Established patient
- Inpatient
- Outpatient

Bird’s eye view: The E/M code set is categorized into 21 broad types of services, which are further classified based on factors such as a service for a new or established patient, observation or inpatient services, initial or subsequent services, and more.
What Are E/M Services?

Documentation for every patient encounter must include the reason for the visit. E/M documentation must include a Chief Complaint.

Chief Complaint
- Reason the patient is being seen

Describes:
- Symptoms
- Problem
- Condition
- Diagnosis
- Usually stated in patient’s own words

What Are E/M Services?

E/M services consist of seven components which are used in defining the levels of E/M services:
1. * History
2. * Examination
3. * Medical decision making
4. Counseling
5. Coordination of care
6. Nature of presenting problem
7. Time.

CPT® - Evaluation & Management: Consultations

- Provided at request of another physician and/or appropriate provider type
- Three “R’s” apply:
  - Request – Provider A requests Provider B to see their patient and provide feedback
  - Review – Provider B reviews patient, documents findings and/or procedures performed during visit
  - Report – Provider B provides Provider A report on visit findings

Example: Dr. A requests Dr. B to see Mrs. Parker for a foot ulcer consultation. Dr. B evaluates the patient’s ulcerative foot and documents in his patient files findings. Dr. B provides a written report to Dr. A with recommendations. Can bill a consultation code.

Note: Medicare does not allow consultations codes. Many other payers follow this as well. Instead, you just use new and established patient codes.
CPT® - Evaluation & Management:
Transfer of Care

Transfer of Care
• Provider of care transfers responsibility of care to another provider

Example: Family Practice provider treats patient for diabetic ulcers of foot. Transfers only care of foot care to podiatrist. Family Practice provider continues to treat patient for all other diagnosis, including diabetes. The podiatrist takes over care of the patient's foot problems. This is a transfer of care, not a consultation.

Key Component #1: History

E/M services include some or all of these elements:
• Chief complaint (CC)
• History of present illness (HPI)
• Review of systems (ROS)
• Past medical, family, and/or social history (PMFSH)

Hint: This is the “S” in a SOAP note.

Key Component #1: History

Tips on History:
- There MUST be a documented CC in every chart.
- You don’t have to have separate sections for CC, ROS, and PMFSH. They can all be included in the HPI section.
- Previously recorded ROS and PMFSH can be counted as long as you note that you reviewed that past history during the current encounter.
- Provider does not have to capture the CC, ROS, or PMFSH – these can be documented by ancillary staff, or even by the patient. Provider must indicate he reviewed the information.
- If you are unable to obtain history from patient, there must be a note as to why in order to get credit for history in calculating the level of service.
Key Component #1: History

There are four types of history:
- Problem focused
- Expanded problem focused
- Detailed
- Comprehensive

Key Component #1: History -
- HPI

HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present.

There are two types of HPI: brief or extended.

The type of HPI is determined by either the number of chronic conditions addressed in the history, or by the number of HPI elements noted in the HPI:

- **HPI Elements:**
  - **Location** is the place on the patient’s body where the symptoms exist (e.g., lower back or right arm).
  - **Context** is what the patient was doing when the problem occurred (e.g., “patient has pain after sitting all day at work.”).
  - **Quality** represents the chief complaint or signs or symptoms. For instance, if a patient reports a sharp pain in her abdomen, “sharp” is the quality.
  - **Timing** is the time of day the patient experienced the signs and symptoms. If the notes say, “Pain while urinating, last two weeks,” “while urinating” is the timing.
  - **Severity** shows just how serious the patient’s condition is. Physicians often show severity in their notes with a scale of 1 (least painful) to 10 (most painful).
Key Component #1: History - HPI

**HPI Elements (continued):**

**Duration** is how long the patient’s signs and symptoms have been present (for instance, “Patient has had pain during exercise, last three weeks”). Three weeks is the duration.

**Modifying factors** are what the patient did herself to alleviate pain – or exacerbate the symptoms (for example, “Patient’s headache is worse after consuming caffeine” or “Pain improved when patient took TYLENOL”).

**Associated signs and symptoms** are any other problems the patient has in addition to the chief complaint (such as fever, other areas of pain).

*Pointer:* CPT® only lists seven HPI elements, with duration not making the list. Therefore, for Medicare payers, you should consider duration and timing separately. With payers that follow CPT®, however, be aware of this distinction.

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Key Component #1: History - ROS

**ROS** is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms that the patient may be experiencing or has experienced.

There are four types of ROS: none, problem pertinent, extended, or complete.

The type of ROS is determined by the number of systems addressed:

<table>
<thead>
<tr>
<th>ROS categories of systems</th>
<th>All body systems</th>
<th>None</th>
<th>Problem pertinent</th>
<th>Extended</th>
<th>Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>All body systems</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>None</td>
<td></td>
<td>✔️</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Problem pertinent</td>
<td></td>
<td></td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Extended</td>
<td></td>
<td></td>
<td></td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Complete</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✔️</td>
</tr>
</tbody>
</table>

*Tip:* Both positive and negative responses count toward ROS, and a notation of “all other systems negative” allows for complete ROS.

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Key Component #1: History -- PMFSH

**PMFSH** is review of the patient’s past personal medical history, family history, and/or social history.

There are three types of PMFSH: none, pertinent, or complete.

The type of ROS is determined by the number of elements addressed:

<table>
<thead>
<tr>
<th>PMFSH (past medical, family, social history) areas</th>
<th>None</th>
<th>Pertinent</th>
<th>Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>Past medical</td>
<td>✔️</td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>Family</td>
<td>✔️</td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>Social</td>
<td>✔️</td>
<td></td>
<td>✔️</td>
</tr>
</tbody>
</table>

*Tip:* For the categories of subsequent hospital care, follow-up inpatient consultations and subsequent nursing facility care, CPT® requires only an “interval” history. It is not necessary to record information about the PMFSH.
Key Component #1: History -- PMFSH

**Complete PMFSH**

Note that there is a difference in complete PMFSH depending on the type of E/M service:

- At least one specific item from **two of the three history areas** must be documented for a complete PMFSH for the following categories of E/M services: office or other outpatient services, established patient; emergency department; subsequent nursing facility care; domiciliary care, established patient; and home care, established patient.

- At least one specific item from **each of the three history areas** must be documented for a complete PMFSH for the following categories of E/M services: office or other outpatient services, new patient; hospital observation services; hospital inpatient services, initial care; consultations; comprehensive nursing facility assessments; domiciliary care, new patient; and home care, new patient.

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**Key Component #1: History -- Putting it all together**

So how do HPI, ROS, and PMFSH combine to reach a level of history?

If one column contains three circles, draw a line down that column to the bottom row to identify the type of history. If no column contains three circles, the column containing a circle farthest to the left identifies the type of history.

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**Example**

From Provider Notes: Patient is an 38-year-old female established patient. She presents today with ankle pain and swelling for the past four days. There is some bruising around the left ankle and walking is painful. Patient states she fell during soccer practice and her ankle has hurt since then. She has not had any fever or additional muscle pain. She has sprained this ankle twice before.

- **CC:** ankle pain
- **HPI:**
  - Location: left ankle
  - Associated signs and symptoms: bruising, swelling
  - Duration: four days ago
  - Context: playing soccer
  - Quality: painful
- **ROS:**
  - Constitutional: no fever
  - MS: no other muscle pain
- **PMFSH:**
  - Personal history: past ankle sprains
Key Component #1: History – Putting it all together: Example

There are four types of exam:

**Problem Focused** – a limited examination of the affected body area or organ system.

**Expanded Problem Focused** – a limited examination of the affected body area or organ system 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.

Hint: This is the “O” in a SOAP note.
**Key Component #2: Exam**

### Tips on Exam:
- You must first decide whether you are using 1995 or 1997 exam guidelines. You can use either set of guidelines as long as you use one set per encounter.
- A statement of "negative" or "normal" is sufficient to count the system/body area toward exam level.
- Abnormal or unexpected findings of the examination should be described. A notation of "abnormal" without elaboration is insufficient.
- Critical: Medical necessity must guide the exam regardless of which guidelines you use. Performing (or documenting) comprehensive exams when medical necessity doesn’t support the need for a comp exam, does not help your coding.

### 1995 and 1997 Guidelines define the exam levels differently:

**1997:** The 1997 guidelines include specific physical exam elements that the provider must address in the documentation. If you address elements other than those specified in the guidelines, you won’t necessarily receive credit for that element in the level of service.

**1995:** The 1995 guidelines are much less restrictive. They allow you to comment on any of the designated body areas and/or organ systems you examine. What you examine within the areas and systems and the wording you choose to document are ultimately decided by you.

### Levels of the Physical Exam Components

<table>
<thead>
<tr>
<th>Problem-Focused Exam</th>
<th>1995 Guidelines</th>
<th>1997 Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 body area and/or organ system</td>
<td>1+ body areas and/or organ systems, 5-11 elements</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expanded Problem-Focused Exam</th>
<th>1995 Guidelines</th>
<th>1997 Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-7 body areas and/or organ systems</td>
<td>3+ body areas and/or organ systems, 6-11 elements</td>
<td></td>
</tr>
</tbody>
</table>
Key Component #2: Exam

Levels of the Physical Exam Components

Detailed Exam

<table>
<thead>
<tr>
<th>1995 Guidelines</th>
<th>1997 Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-7 body areas and/or organ systems with at least 1 being of a detailed nature</td>
<td></td>
</tr>
</tbody>
</table>

Comprehensive Exam

<table>
<thead>
<tr>
<th>1995 Guidelines</th>
<th>1997 Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 or more organ systems</td>
<td></td>
</tr>
</tbody>
</table>

* Note: Different payers have different rules regarding what constitutes a detailed visit, so check with your local payers.

Key Component #2: Exam

1995 GUIDELINES:

Body areas:
- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

Organ systems:
- Constitutional (e.g., vital signs, general appearance)
- Ears, nose, mouth and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurological
- Psychiatric
- Hematologic/Lymphatic/Immunologic

Key Component #2: Exam

1997 Guidelines:
This set of guidelines has defined the four exam levels for a general multi-system exam and the following single organ system exams:

- Cardiovascular
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin

Key Component #2: Exam

1997 Guidelines:
This set of guidelines has defined the four exam levels for a general multi-system exam and the following single organ system exams:

- Cardiovascular
- Musculoskeletal
- Neurological
- Psychiatric
- Respiratory
- Skin
Key Component #2: Exam

1997 Guidelines
Key Component #2: Exam

1997 Guidelines: Musculoskeletal

From Provider Notes:

Patient is an 38-year-old female established patient. She presents today with left ankle pain and swelling for the past four days. There is some bruising around the ankle and walking is painful.

Vitals: Temp 98.5, Wt. 120 lbs, Pulse 72, Resp 16

Patient is well-developed, well-nourished, in no acute distress. Oriented x 3. Normal mood and affect. Neck supple, no swollen lymph nodes. Respiratory effort normal. Lungs clear to auscultation. Cardio: regular rate, no murmurs, gallops. Musculoskeletal: Patient limping, favoring left ankle; left ankle tender to touch; limited range of motion in left ankle; area around left ankle swollen; no open sores on skin or ankle, but there is bruising.
Key Component #2: Exam—Example

Under 1995 Guidelines:
Less than 8 systems, none in complete detail, leads to Expanded Problem Focused exam:
- Constitutional
- Respiratory
- Cardiovascular
- Musculoskeletal

Under 1997 Guidelines: At least 12 bullets in the general multi-system exam leads to a Detailed exam:
1. Constitutional – vitals
2. Constitutional – general appearance
3. Neck – general appearance
4. Respiratory – respiratory effort
5. Respiratory – auscultation
6. Cardiovascular – auscultation
7. Cardiovascular – swelling
8. Lymphatic – lymph nodes
9. MS – gait
10. MS – inspection, palpation
11. MS – range of motion
12. Skin – inspection
13. Psychiatric – orientation
14. Psychiatric – mood/affect

Key Component #3: MDM

To determine the level of medical decision making for an encounter, you should assign points to each of the three MDM components that your provider performs.

The three components are:
1. Number of diagnoses/management options
2. Amount and/or complexity of data ordered or reviewed
3. Risk of complications and/or morbidity/mortality

Hint: This is the “A&P” in a SOAP note.
Key Component #3: MDM

Diagnoses/treatment options:

Ask yourself: “What is wrong with the patient?” and “What is the total number of medical diagnoses that the patient has that you addressed during the encounter?”

Then, for each diagnosis, you will assign a point and score the diagnosis level as follows:

<table>
<thead>
<tr>
<th>Number of Diagnoses or Treatment Options</th>
<th>Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>1</td>
</tr>
<tr>
<td>B</td>
<td>2</td>
</tr>
<tr>
<td>C</td>
<td>3</td>
</tr>
<tr>
<td>D</td>
<td>4</td>
</tr>
</tbody>
</table>

Key Component #3: MDM

Amount and complexity of data:

For this piece of the MDM puzzle, you need to determine if your work included the following classes of data:

- Review/order of clinical lab services such as WBC tests (80000 codes)
- Review/order of radiology services such as x-rays (70000 codes)
- Review/order of medicine services such as an EKG (90000 codes)
- Discuss results with test-performing physician
- Independent review of image, tracing or specimen, such as such as reading a sonogram or CT scan brought in by the patient to the office visit
- Decision to obtain old records/obtain history from someone other than patient
- Review and summarize old patient records from an outside source.

Key Component #3: MDM

Amount and complexity of data:

You will assign points as follows:

<table>
<thead>
<tr>
<th>Amount and Complexity of Data Reviewed</th>
<th>Point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review and order of clinical lab tests</td>
<td>1</td>
</tr>
<tr>
<td>Review and order of tests in the radiology section of OPT</td>
<td>1</td>
</tr>
<tr>
<td>Review and order of tests in the medicine section of OPT</td>
<td>1</td>
</tr>
<tr>
<td>Discussion of test results with physician</td>
<td>1</td>
</tr>
<tr>
<td>Decision to obtain old records/obtain history from someone other than patient</td>
<td>1</td>
</tr>
<tr>
<td>Review and summarization of old records and/obtain history</td>
<td>1</td>
</tr>
<tr>
<td>Independent review of image, tracing or specimen itself</td>
<td>2</td>
</tr>
<tr>
<td>Summary review of report</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>2</td>
</tr>
</tbody>
</table>

Pointer: No matter how many x-rays or labs you order, you can only assign one point for ordering and reviewing all of the data in each of those two classes.
Key Component #3: MDM

Level of Risk:
Level of risk involves three subcategories:
- Presenting problem
- Diagnostic procedures ordered
- Management options.

The highest score from only one of the three categories (not from each category) determines the patient’s risk level:
- Minimal
- Low
- Moderate
- High


Key Component #3: MDM

Level of Risk

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem(s)</th>
<th>Diagnostic Procedure(s)</th>
<th>Management Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

So how do diagnoses, data, and risk all come together to reach an MDM level?

Draw a line down any column with 2 or 3 circles to identify the level of medical decision making. If no column has 2 or 3 circles, draw a line down the column with the second circle from the left.
Key Component #3: MDM

Tips on Medical Decision Making:

- For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

- Details about the review and/or order of tests should be documented. An entry in a progress note such as "WBC elevated" or "abdominal x-ray ordered" may suffice, but documentation should also be documented by initialing and dating the report containing the test results.

- A decision to obtain old records or decision to obtain additional history from the family, caretaker or other source to supplement that obtained from the patient should be documented. A notation of "old records reviewed" or "additional history obtained from family" without elaboration is insufficient.

- If a surgical or invasive diagnostic procedure is ordered, planned or scheduled at the time of the E/M encounter, the type of procedure, e.g., laparoscopy, should be documented.

Key Component #3: MDM—Putting it all together:

Example

From Provider Notes:

Patient is an 38-year-old female established patient. She presents today with left ankle pain and swelling for the past four days. There is some bruising around the ankle and walking is painful.

Diagnosis: Acute ankle sprain. X-ray ordered, shows no fracture per radiology interpretation. Rx of pain killer and anti-inflammatory x 10 days ordered. Wrap with bandage to stabilize and ice for 10 minutes three times per day. No soccer until re-evaluation. RTC if symptoms worsen.

MDM—Putting it all together: Example

Diagnosis: Acute ankle sprain. X-ray ordered, shows no fracture per radiology interpretation. Rx of pain killer and anti-inflammatory x 10 days ordered. Wrap with bandage to stabilize and ice for 10 minutes three times per day. No soccer until re-evaluation. RTC if symptoms worsen.

Diagnosis/treatment options: 1 new diagnosis, with additional workup = 4 points
MDM—Putting it all together: Example

Diagnosis: Acute ankle sprain. X-ray ordered, shows no fracture per radiology interpretation. Rx of pain killer and anti-inflammatory x 10 days ordered. Wrap with bandage to stabilize and ice for 10 minutes three times per day. No soccer until re-evaluation. RTC if symptoms worsen.

Data: X-ray order = 1 point

MDM—Putting it all together: Example

Risk: Acute uncomplicated injury (low risk) with x-ray (minimal risk) order, prescription drug management (moderate risk), rest, ice, and bandage (minimal risk).

Moderate risk overall (highest level determines overall level).

MDM—Putting it all together: Example

Diagnosis/treatment options: 1 new diagnosis, with additional workup = 4 points

Data: X-ray order = 1 point

Risk: Acute uncomplicated illness (low risk) with prescription drug management (moderate risk) and x-ray (minimal risk) = moderate risk overall.

Overall MDM complexity: Moderate

Remember: Draw a line down any column with 2 or 3 circles to identify the level of medical decision making. If no column has 2 or 3 circles, draw a line down the columns with the second circle from the left.
**Reaching a Level**

Putting the three components together: in our example of a 38-year-old female established patient with ankle sprain, we got:

<table>
<thead>
<tr>
<th>History: Detailed</th>
<th>Exam: Detailed</th>
<th>MDM: Moderate</th>
<th>Overall level of service: 99214</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>New Office/Consult/ER</th>
<th>Established Office</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
<td>Exam</td>
</tr>
<tr>
<td>DR: L</td>
<td>ER: L</td>
</tr>
<tr>
<td>ER: L</td>
<td>ER: L</td>
</tr>
<tr>
<td>ER: E</td>
<td>ER: E</td>
</tr>
<tr>
<td>ER: C</td>
<td>ER: C</td>
</tr>
<tr>
<td>MDM</td>
<td></td>
</tr>
<tr>
<td>PP</td>
<td>APP</td>
</tr>
<tr>
<td>LV</td>
<td>V</td>
</tr>
<tr>
<td>Overall Level of Service:</td>
<td>99214</td>
</tr>
</tbody>
</table>

**Reaching a Level**

If you find that you are lacking a key component for an encounter that requires 3 of 3 elements (such as a new patient office visit), that doesn’t necessarily mean you can’t bill an E/M service.

Best bet: You can bill the unlisted E/M code:

99499 – Unlisted evaluation and management service

**Time-Based Coding**

Time is ONLY a factor for E/M coding if you documented that counseling and coordination of care documented took at least 50 percent of the total time with patient.

The diagnosis you document (and you code) does not affect the level of service.
Time-Based Coding

The documentation must contain the following three elements:

1. Notation of the total time spent on the encounter
2. Notation of the total time spent on counseling and/or coordination of care or the percentage of the visit spent on counseling/CoC
3. The reason for/topic of the counseling/CoC

Example: Document "Total encounter: 55 minutes with more than 50% spent on coordination of care for patient's prostate cancer diagnosis and treatment decisions." For an established patient office visit you could report 99215 based on time for this encounter.

Time-Based Coding:

Face-to-Face time
- Applies to office, other outpatient visits, and office consultations
- Defined as "Only time spent face-to-face with patient and/or family"
- Includes time spent obtaining history, exam and counseling patient

Unit/floor time
- Applies to hospital observation, inpatient hospital care, initial inpatient hospital consultations, or nursing facilities
- Includes time present on patient's hospital unit and at bedside rendering care, establishing, reviewing or updating chart and time spent off patient's floor reviewing labs, x-rays, etc.

New vs. Established Rules

For codes with new or established differentiation:

CPT® rule: The chief factor in determining whether a patient is new or established is time.
You must decide whether you have seen the patient in the past, and if you have, how long ago.

CPT® clearly defines what qualifies as an established patient: "An established patient is one who has received professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years."
New vs. Established Rules

Ask yourself
“Has the patient seen the provider in the past three years?”

Here's how to code based on your answer:

◦ Yes: If you (or your physician) have billed for a professional service in the past three years for a patient, you’ll report the visit using established patient E/M codes (such as 99211-99215).

◦ No: If you (or your physician) have not seen the patient within the past three years and neither has another provider of the same specialty and subspecialty in your group, you can report a new patient E/M code (such as 99201-99205).

Tips on New vs. Established:

 You should not use place of service (POS) as an indication of new versus established patient. Based on CPT®’s established patient definition, new versus established refers to the patient’s relationship to the physician, not his relationship to the practice or its location.

 New problem doesn’t mean new patient.

 If two specialists are of the same specialty and billing under the same group number, the three-year rule applies. If they work under different specialties or bill under different provider numbers, the second specialist may be able to report the patient as “new,” as long as she hadn’t seen that patient within the previous 36 months.

 If a new provider in your practice has provided professional services to a patient elsewhere, such as in a hospital or other practice, within the last 36 months, the patient is an established patient even if this is his first visit to your practice.

Evaluation & Management – New vs. Established Patient Example

A & B Orthopedic Practice

- Dr. A – Orthopedic specialty
- Nurse Practitioner – Orthopedic specialty
- Patient has never been seen at this practice or by these providers before these encounters

07/01 Dr. A
- Patient seen first time for fractured ulna (forearm), right
  New patient for this visit

08/01 NP
- Patient seen fractured ulna (forearm), right, follow-up
  Established patient for this visit

Note: This could be billed incident-to the physician for 100% reimbursement.

Is this a new patient or established patient?
Evaluation & Management – New vs. Established Patient Example

A & B Orthopedic Practice
- Dr. A – Orthopedic specialty, Fairport office location
- Nurse Practitioner – Orthopedic specialty, Irondequoit office location
- Patient has never been seen at this practice or by these providers before these encounters

07/01 Dr. A
- Patient seen first time for fractured ulna (forearm), right

08/01 NP
- Patient seen fractured ulna (forearm), right, follow-up

Established patient for this visit

Note: This could be billed incident-to the physician for 100% reimbursement.

Is this a new patient or established patient?

Evaluation & Management – New vs. Established Patient Example

A & B Orthopedic Practice
- Dr. A – Orthopedic specialty
- Dr. B – Orthopedic specialty, sports medicine subspecialty
- Patient has never been seen at this practice or by these providers before these encounters

07/01 Dr. A
- New patient for this visit
- Patient seen first time for fractured ulna (forearm), right

08/01 Dr. B
- Patient seen for torn ACL, left

New patient for this visit
Dr. B is a sub-specialist in a different sub-specialty, so this is a new patient.

Is this a new patient or established patient?

E/M 2019 Updates

As of Jan. 1, 2019 providers no longer have to:
- Document medical necessity for a home visit instead of an office visit.
- Re-record a defined list of required elements in the medical record if there is evidence that the provider reviewed the previous information and updated it as needed; instead, the provider must just document what has changed since the last visit, or pertinent items that have not changed.
- Document the patient’s chief complaint and history if it has already been entered by ancillary staff or the beneficiary — again, the provider may simply indicate in the medical record that he or she reviewed and verified this information.
- Duplicate notations that may have previously been included in medical records by residents or other members of the medical team for E/M visits furnished by teaching physicians.
ICD-10

International Classification of Diseases (ICD)
The International Classification of Diseases (ICD) was established by the World Health Organization (WHO) for statistical reporting of symptoms, diseases, diagnoses, and health trends. Each country in the world can use the ICD code set and tweak it to meet their needs. The U.S. started using these codes for statistical mortality reporting in 1940. Although it was first created in the early 1900s, the WHO wasn’t formally organized until 1946, at which point they began to publish the code set. Shortly thereafter, the U.S. began using these codes for indexing of hospital patients. The code set was updated each year, resulting in editions ICD-1, ICD-2, up through ICD-4 and then ICD-9. The Centers for Medicare and Medicaid Services (CMS) updated the ninth revision every year since its original publication in 1974. Healthcare providers used ICD-9-CM (9th revision) codes Volumes 1 and 2 to represent diagnoses on claims for services up to and including 9/30/15. In 1990, the WHO determined they needed to update the entire code set to ICD-10. This was created and adopted by most countries shortly thereafter. The U.S. adopted the ICD-10-CM (10th revision) code set for services beginning on 10/1/15.

Clinical Modification vs. Procedural Coding System. The ICD code set in the U.S. also includes the International Classification of Diseases, 10th revision, Procedural Coding System (ICD-10-PCS) codes, which health care providers use to bill payers for inpatient procedures.

Updated annually, with changes taking effect on October 1 every year.

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ICD-10-CM – Chapter Classifications

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Code Span</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>A00–B99</td>
<td>Certain infectious and parasitic diseases</td>
</tr>
<tr>
<td>2</td>
<td>C00–D489</td>
<td>Neoplasms</td>
</tr>
<tr>
<td>3</td>
<td>D50–D89</td>
<td>Diseases of the blood and blood-forming organs and certain disorders involving the immune mechanism</td>
</tr>
<tr>
<td>4</td>
<td>E00–E89</td>
<td>Endocrine, nutritional and metabolic diseases</td>
</tr>
<tr>
<td>5</td>
<td>F00–F99</td>
<td>Mental and behavioral disorders</td>
</tr>
<tr>
<td>6</td>
<td>G00–G99</td>
<td>Diseases of the nervous system</td>
</tr>
<tr>
<td>7</td>
<td>H00–H59</td>
<td>Diseases of the eye and adnexa</td>
</tr>
<tr>
<td>8</td>
<td>I00–I99</td>
<td>Diseases of the ear and mastoid process</td>
</tr>
<tr>
<td>9</td>
<td>J00–J99</td>
<td>Diseases of the circulatory system</td>
</tr>
<tr>
<td>10</td>
<td>K00–K93</td>
<td>Diseases of the respiratory system</td>
</tr>
<tr>
<td>11</td>
<td>L00–L99</td>
<td>Diseases of the digestive system</td>
</tr>
<tr>
<td>12</td>
<td>M00–M99</td>
<td>Diseases of the skin and subcutaneous tissue</td>
</tr>
</tbody>
</table>
ICD-10-CM – Chapter Classifications

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Code Space</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>13</td>
<td>N00-N99</td>
<td>Diseases of the musculoskeletal system and connective tissue</td>
</tr>
<tr>
<td>14</td>
<td>N90-N99</td>
<td>Diseases of the genitourinary system</td>
</tr>
<tr>
<td>15</td>
<td>O00-O99</td>
<td>Pregnancy, childbirth and the puerperium</td>
</tr>
<tr>
<td>16</td>
<td>P00-P96</td>
<td>Certain conditions originating in the perinatal period</td>
</tr>
<tr>
<td>17</td>
<td>Q00-Q99</td>
<td>Congenital malformations, deformations and chromosomal abnormalities</td>
</tr>
<tr>
<td>18</td>
<td>R00-R99</td>
<td>Symptoms, signs and abnormal clinical and laboratory findings, not elsewhere classified</td>
</tr>
<tr>
<td>19</td>
<td>S00-T98</td>
<td>Injury, poisoning and certain other consequences of external causes</td>
</tr>
<tr>
<td>20</td>
<td>Y00-Y99</td>
<td>External causes of morbidity and mortality</td>
</tr>
<tr>
<td>21</td>
<td>Z00-Z99</td>
<td>Factors influencing health status and contact with health services</td>
</tr>
</tbody>
</table>

ICD-10-CM – Code Structure

ICD-10-CM – min. of 3, max of 7, alpha or numeric

ICD-10-CM Structure:
- Category: 3 characters (if adding more characters) OR code (if complete)
- Subcategory: 4-6 characters OR code (if complete)
- Code: 7 characters, OR 3-6 characters (if complete)
ICD-10-CM – Code Structure

<table>
<thead>
<tr>
<th>Character Detail</th>
<th>ICD-10-CM - S88.011A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Alpha (Capital letter A-Z, except U, not used)</td>
</tr>
<tr>
<td>2</td>
<td>Numeric</td>
</tr>
<tr>
<td>3</td>
<td>Numeric</td>
</tr>
<tr>
<td>4</td>
<td>Numeric or Alpha</td>
</tr>
<tr>
<td>5</td>
<td>Numeric or Alpha</td>
</tr>
<tr>
<td>6</td>
<td>Numeric or Alpha</td>
</tr>
<tr>
<td>7</td>
<td>Numeric or Alpha</td>
</tr>
</tbody>
</table>

- **7th character extension:**
  - Encounter
  - Sequela
  - External cause
  - Birth order
  - “fetus 1”

**Examples:**
- S88.011A, Complete traumatic amputation at knee level, right lower leg (A=initial encounter)
- 035.0XX1, Maternal care for (suspected) CNS malformation in fetus (1= fetus 1 in a multiple birth situation)
ICD-10-CM – Code Structure

Example:
- S88 = Traumatic amputation of the lower leg
- S88.0 = Knee level
- S88.01 = Complete amputation
- S88.011 = Right lower leg

ICD-10-CM – Coding Conventions

Excludes Notes
- Two types with different, but similar, definitions
- Indicate that codes excluded from each other are independent of each other

Excludes1
- NOT coded here - indicates that the code excluded should never be used at the same time as the code above the Excludes1 note. An Excludes1 is used when two conditions cannot occur together, such as a congenital form versus an acquired form of the same condition.

Excludes2
- Not included here - indicates that the condition excluded is not part of the condition represented by the code, but a patient may have both conditions at the same time. When an Excludes2 note appears under a code, it is acceptable to use both the code and the excluded code together, if supported in medical record and both conditions exist.

ICD-10-CM – Coding Conventions

Excludes1 Example
- I10 Essential (primary) Hypertension Includes:
  - High blood pressure hypertension (arterial) (benign) (essential) (malignant) (primary) (systemic)

Excludes1: hypertensive disease complicating pregnancy, childbirth and the puerperium (O10-O11, O13-O16)

Excludes2 Example
- J03 Acute tonsillitis
  - Excludes2: chronic tonsillitis (J35.0)
ICD-10-CM – Coding Conventions

Proper Sequencing

• Condition may have:
  ◦ Underlying etiology
  ◦ Associated condition

• Pay attention to: Instructional notes
  ◦ “Code first”
  ◦ “Use additional code”
  ◦ “Code if applicable, any causal condition first”

• Underlying condition = Primary diagnosis
• Associated manifestation = Secondary diagnosis
  ◦ NEVER Primary

ICD-10-CM – Coding Conventions

Acute vs Chronic Conditions

• Both acute and chronic = Code both
• Code first: Acute

Example: Acute thyroiditis (E06.0) and Chronic thyroiditis with transient thyrotoxicosis (E06.2)
  ◦ Report both codes
  ◦ E06.0 listed first

ICD-10-CM – Coding Conventions

Combination code

• Two diagnoses
• Associated manifestation
• Associated complication

• Use combination code:
  ◦ Diagnostic conditions documented or
  ◦ Alphabetic Index instructions

• Avoid multiple codes if combination code exists.
ICD-10-CM – Coding Conventions

Late effects

- Residual effect after acute phase has ended.
- No time limit on when you can use a sequela code.
- Multiple codes – generally requires two codes.
- Condition of sequela coded first. Late effect code secondary.

Exceptions to the above sequencing guidelines:
- Late effect followed by manifestation. See Tabular notes.
- Late effect code expanded to reflect the manifestation.
- Never report: Acute phase of illness or injury in addition to the late effect.

Example:
- A patient in an acute phase of viral encephalitis also has mental retardation due to a previous bout with encephalitis
- Acute phase of the viral encephalitis = primary diagnosis

ICD-10-CM – Coding Conventions

Late effects

- You must code the active or presenting condition.
- Late effect will be secondary diagnosis in this case.

Example:
- A patient in an acute phase of viral encephalitis also has mental retardation due to a previous bout with encephalitis
- Acute phase of the viral encephalitis = primary diagnosis

ICD-10-CM – Coding Conventions

Impending or threatened conditions

- If it did occur, code as confirmed diagnosis.
- If it did not occur, reference the Alphabetic Index to determine if the condition has a subentry term for “impending” or “threatened” and also reference main term entries for “Impending” and for “Threatened.”
  - If the subterms are listed, assign the given code.
  - If the subterms are not listed, code the existing underlying condition(s) and not the condition described as impending or threatened.
ICD-10-CM – Coding Conventions

Reporting the same code more than once
• Avoid! You can’t report the same diagnosis code more than once.
• Report a combination code - If a patient has two different conditions that a single combination code describes, then you should only report that single combination code once.
• This rule applies to bilateral conditions when you don’t have any distinct codes describing laterality.
  ◦ Left and right side - use bilateral code once.

ICD-10-CM – Coding Conventions

Documentation of complications of care
• Documentation must reflect the diagnosis.
• NO assumptions – coders cannot infer or assume anything that isn’t documented.
• When it isn’t clear if the patient’s condition resulted from a complication of care, then the coder must query you for clarification.

ICD-10-CM – Coding Conventions

Borderline diagnosis
• Borderline diagnosis = Confirmed diagnosis
• Index may include borderline diagnoses.
  ◦ Borderline diabetes mellitus (E73.09)
• Borderline IS NOT uncertain
ICD-10-CM – Coding Conventions

Laterality
- Right – usually uses 1
- Left – usually uses 2
- Bilateral – usually uses 3
- Unspecified – usually 0 or 9

Examples:
- H57.11-Ocular pain, right eye
- H57.12-Ocular pain, left eye
- H57.13-Ocular pain, bilateral

Providers should always document laterality!

ICD-10-CM – Coding Conventions

Laterality
- No bilateral option: Left and right side - use both codes.
- Example:
  - H50.21, Vertical strabismus, right eye
  - H50.22, Vertical strabismus, left eye

Documentation issue:
- Laterality not documented – coder will have to query you.
- Unspecified code - Last resort.

ICD-10-CM – Coding Conventions

Use of Sign/Symptom/Unspecified Codes
- Can only code based on level of certainty in the documentation.
- Coder may query.
- Do not report signs and symptoms with confirmed diagnosis if symptom is integral to diagnosis.
- Symptom code can be used with confirmed diagnosis only when symptom is not associated with confirmed diagnosis.

Don’t Land in Hot Water:
- Code based on documentation.
- Do not conduct unnecessary tests.
ICD-10-PCS
• Utilized by inpatient facilities only
  ◦ Hospital
  ◦ Skilled Nursing Facility
• Outpatient coders (i.e., physicians, non-physician practitioners, DME, etc.) utilize CPT® and/or HCPCS codes to provide payers information on procedures, encounters, diagnostic tests, etc.

ICD-10-PCS - Guidelines

Three sections of Guidelines
A. General  B. Med/Surg Section  C. Other Med/Surg Related

ICD-10-PCS – Code Structure
• Each character represents an aspect of the procedure.
• Meanings change by Section.
• I and O (letters) are not used in PCS (procedures) but are used in CM (diagnosis).
ICD-10-PCS - Code Structure

<table>
<thead>
<tr>
<th>Section</th>
<th>Body System</th>
<th>Root Operation</th>
<th>Body Part</th>
<th>Approach</th>
<th>Device</th>
<th>Qualifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>These could be numbers or letters</td>
<td>These could be numbers or letters</td>
<td>These could be numbers or letters</td>
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<td>These could be numbers or letters</td>
<td>These could be numbers or letters</td>
<td>These could be numbers or letters</td>
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</tbody>
</table>

HCPCS

Healthcare Common Procedure Coding System (HCPCS) Level II

In order to bill supplies, medications, dental procedures, and a variety of other services and equipment to Medicare and Medicaid, and sometimes other payers, the code set most preferred is created by the Centers for Medicare and Medicaid Services (CMS) in the Healthcare Common Procedure Coding System (HCPCS) codes. These codes are also referred to as HCPCS Level II codes. Also covered in this code set are durable medical equipment (DME), medical supplies, such as gauze, tape and ostomy dressing; ambulance service that includes care as well as miles; and many other services. These codes, which consist of a single alpha character followed by 4 numbers are usually updated quarterly, with the bulk of the changes becoming effective January 1 of each year.

HCPCS - Code Levels

The HCPCS code set includes Level I, Level II, and Level III codes.

- Level I codes are the CPT codes created by AMA.
- Level II codes are codes within the HCPCS manual, developed by CMS, that describe supplies and services.
- Level III codes are created at the local level by Medicare, state Medicaid, and private payers. These codes are no longer in effect.

Modifiers: HCPCS modifiers are made up of two alphanumeric characters that can be added to the end of a CPT® or HCPCS code to provide more information about the service performed.

Updated annually, with changes taking effect on January 1 every year.
HCPCS – Code Structure

- Codes start with a letter, followed by 4 numbers
- Broken into chapters based on the starting letter

HCPCS - Chapters

<table>
<thead>
<tr>
<th>Code</th>
<th>Repsented Service</th>
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</thead>
<tbody>
<tr>
<td>A</td>
<td>A6031-A6099</td>
</tr>
<tr>
<td>A</td>
<td>A2066-A8004</td>
</tr>
<tr>
<td>A</td>
<td>B0150-B0999</td>
</tr>
<tr>
<td>B</td>
<td>84210-8999</td>
</tr>
<tr>
<td>C</td>
<td>C140-C4899</td>
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<tr>
<td>C</td>
<td>D0166-D8662</td>
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<td>G</td>
<td>G0000-G4517</td>
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<tr>
<td>H</td>
<td>H0001-H2037</td>
</tr>
<tr>
<td>J</td>
<td>J0121-J0699</td>
</tr>
<tr>
<td>J</td>
<td>J0600-J9999</td>
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<td>K</td>
<td>K0001-K4999</td>
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<td>L</td>
<td>L0100-L8399</td>
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<td>L</td>
<td>L9500-L9999</td>
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<td>M8900-M9999</td>
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<td>T1990-T9999</td>
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<td>V</td>
<td>V0000-V2799</td>
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<td>V</td>
<td>V3500-V5004</td>
</tr>
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</table>

Resources

<table>
<thead>
<tr>
<th>Name of Coding Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD-10-CM Official Guidelines for Coding and Reporting</td>
<td>The ICD-10-CM manual contains these guidelines to help you understand the rules for assigning correct codes.</td>
</tr>
<tr>
<td>CPT® Assistant</td>
<td>The AMA publishes the CPT® Assistant, a monthly newsletter with updates on coding and billing regulations and guidance on how to assign specific codes. The CPT® manual contains coding references to specific issues of the CPT® Assistant that codes can review for additional information.</td>
</tr>
<tr>
<td>Coding guidelines in the CPT®-4® manual</td>
<td>The CPT® manual contains many guidelines for coding specialty areas of medicine and specific services and procedures.</td>
</tr>
</tbody>
</table>
Resources

<table>
<thead>
<tr>
<th>Name of Coding Reference</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centers for Medicare and Medicaid (CMS)</td>
<td>Manages local coverage determinations (LCDs) and program transmittals for Medicare coding, billing, and reimbursement. CMS publishes these documents, and providers can access the versions on the CMS website intended for their specific provider types. CMS publishes national regulations for providers across the country. These are also local regulations that apply to hospitals and other providers in certain geographic areas.</td>
</tr>
<tr>
<td>Ambulatory Surgery</td>
<td>The federal government produces the daily publication, which includes codes for the 19th and 19th supplemental pay codes, and codes for the 19th supplemental pay codes. The codes include those that provide information on how to use codes for the codes they are intended for.</td>
</tr>
<tr>
<td>National Correct Coding Initiative (NCCI edits)</td>
<td>CMS publishes lists of practice tips that providers cannot report on the same claim. Providers typically use software that removes claims before auditing them for reimbursement codes that the provider needs to correct.</td>
</tr>
<tr>
<td>American Academy of Professional Coders (AAPC) and the American Medical Records Association (AMRA)</td>
<td>The AAPC and the AMRA publish updates. The AHA publishes national guidelines and codes for the codes they are intended for.</td>
</tr>
<tr>
<td>Resources – Government Sites</td>
<td></td>
</tr>
</tbody>
</table>

Centers for Disease Control and Prevention (CDC)
www.cdc.gov
A federal agency that conducts and supports health promotion, prevention, and preparedness activities in the U.S. with the goal of improving overall public health. CDC is responsible for maintaining the ICD-10-CM code set.

Centers for Medicare and Medicaid Services (CMS)
www.cms.gov
The federal agency administers Medicare and Medicaid programs and oversees HIPAA. CMS maintains the ICD-10-PCS code set and the HCPCS code set.

National Institutes of Health (NIH)
www.nih.gov
The primary agency of the U.S. government responsible for biomedical and health-related research. It maintains the National Library of Medicine and makes numerous medical publications available online.

Questions?
Additional Questions – Contact Me

Contact info:
• Email: leesaisrael@gmail.com
• Phone: 866-458-2973

Thank You!