Procedural and Diagnostic Coding

- A quick easy breakdown for MA students

Accurate and precise coding not only helps optimize reimbursement, it is essential for insurance carrier acceptance of the claim. The providers reimbursement is based on the codes that are submitted

The Healthcare Common Procedure Coding System (HCPCS) is comprised of two levels (subsystems):

- Level 1: Current procedural terminology (CPT codes)
- Level 2: Codes that identify products, supplies and services not included in CPT

The term procedural code refers to a code that represents a medical procedure such as surgery or a diagnostic tests and medical services. The term is interchangeable w/ CPT

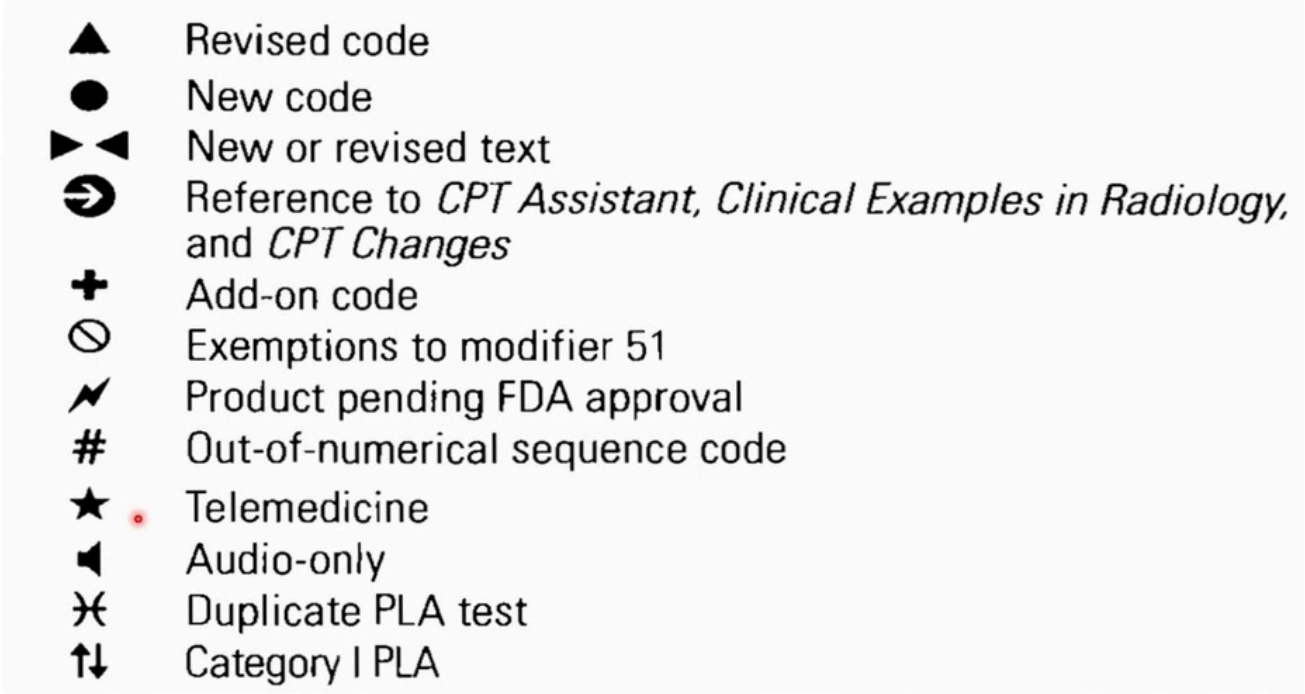
Each procedure or service is identified w/ a 5 digit code. The main body of the material is listed in 6 sections

1. Evaluation and management (E/M)	99202*-99499
1. Anesthesiology	00100-01999, 99100-99140
1. Surgery	10021-69990
1. Radiology (including nuclear medicine and diagnostic ultrasound)	70010-79999
1. Pathology and laboratory	80047-89398
1. Medicine (except anesthesiology)	90281-99199, 99500-99607

Within each section are subsections w/ anatomic, procedure, condition, or descriptor subheadings. The procedures and services w/ their identifying codes are presented in numeric order w/ one exception: the entire evaluation and management system is placed at the beginning of the listed procedures

Add-on codes are always performed in addition to the primary procedure of service; add-on codes are designated w/ the + symbol and are never reported as stand-alone codes. Conventions are a list of abbreviations, punctuations, symbols, typefaces, and instructional notes. Conventions provide guidelines for using the code set

CPT Symbols:



Modifiers inform third-party payers that circumstances for that particular code have been altered. Some examples would be if unusual events occurred, a service was done by more than 1 provider, or if only the professional or technical component of a radiologic procedure is being billed

Unlisted procedure codes

- When one is reported, a copy of the operative note must also be sent so that the payer can determine what was performed and then determine the appropriate reimbursement

Coding terminology:

- Bundled codes: any code that includes more than 1 procedure in its description is a bundled code. It can be considered fraudulent coding to unbundle codes
- Unbundling: unbundling codes refers to using several CPT codes for a service when one inclusive code is available
- Upcoding: when a facility coder assigns a procedure code that does not match pt documentation, w/ the intention of increasing reimbursement to the facility or practice, serious penalties and fines will be levied against the facility/practice for submitting fraudulent claims
- Downcoding: another practice in which a reported evaluation and management service is reduced to a lower level based strictly on the diagnosis code reported. Downcoding is practiced by third party carriers but also performed when a physician codes a lesser service than what was performed
- Concurrent care: when similar care is being provided to a pt by more than 1 provider
- Critical care: when constant bedside attention is required to a pt who is critically ill or unstable, it is defined as critical care. The key factors for coding critical care are the elements of constant bedside attention, as well as documented time (min requirement of at least 30 mins), and the documentation must be explicit

- Consultations: a pt visit w/ another provider at the request of a health care provider. CPT defines a consultation as “a type of evaluation and management service provided at the request of another physician or appropriate source to either recommend care for a specific condition or problem to determine whether to accept responsibility for ongoing management of the pts entire care or for care of a specific condition or problem”. Outpatient CPT codes for consultations include 99241-99245. The inpatients codes range from 99251-99255
- Counseling: considered a part of E/M services. The AMA defines counseling as a “discussion w/ a pt and/or family concerning one or more of the following areas:

    - Diagnostic results, impressions, and/or recommended diagnostic studies

    - Prognosis

    - Risks and benefits of management (treatment) options

    - Instructions for management (treatment) and/or follow up

    - Importance of compliance w/ chosen management (treatment) options

    - Risk factor reduction

    - Pt and family education

Evaluation and management services guidelines:

- The E/M codes are related to medical services as opposed to surgical services. Another key factor that affects code descriptions is whether the pt is considered “new” or “established”. New vs established pt is whether they have received services within the past 3 years

Key components

- Each code description identifies the key components as well as contributory factors that must be met to report that code

Pt history: Per CPT, E/M levels of service include the following 4 types of history that determine the chief complaint (CC):

- Problem focused: brief history of the illness of the problem
- Expanded problem focused: brief history of the illness; problem-pertinent system review
- Detailed: extended history of the present illness; problem-pertinent system review extended to include a review of a limited number of additional systems
- Comprehensive: extended history of present illness; review of systems directly related to the problem(s) identified in the history of the present illness plus a review of all additional body systems; complete past, family, and social history

Physical Exam

- Problem-focused: a limited examination of the affected body area or organ system
- Extended 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 or organ system and other symptomatic or related organ system(s)

- Comprehensive: general multisystem examination or a complete examination of a single organ system

    - The physical exam has 2 elements, (1) body areas, and (2) organ systems

Contributory factors include the amt of time the provider spends w/ the pt, counseling, coordination of care, and the nature of the presenting problem

- Counseling: only considered when 50% of more of the time is spent on counseling and/or coordination of the care of the pt
- Coordination of care: defined as the time a licensed provider spends coordinating pt care w/ other health care agencies
- Nature of presenting problem: 5 types of presenting problems

1. Minimal
2. Self-limited or minor
3. Low severity
4. Moderate severity
5. High severity

A surgical package generally includes:

- Preoperative exam and testing
- Surgical procedure itself (including local or regional anesthesia if used)
- Routine follow-up care for a set period of time

The payer assigns a fee to each of the surgical packages. The global period refers to the period of time that is covered for follow-up care

- Integumentary system: Read the description very carefully as many of the codes are based on size and location
- Musculoskeletal system: The most common codes in this section are related to fractures. General rules regarding coding for fractures include the following: (1) the fracture is considered closed unless otherwise indicated, (2) coding cast and strapping codes can be tricky, as the fracture repair assumes the application of the cast, and (3) carefully review any therapeutic procedure
- Respiratory system: Extremely important to code to the furthest extent possible, be alert for incision vs excision, and also carefully review the suffix
- Cardiovascular system: Carefully read the entire chart notes. Use as many codes are necessary
- Hemic / Lymphatic systems and mediastinum and diaphragm
- Digestive System: Surgical procedures include the upper and lower digestive system. You will find procedures on the pancreas, liver, abdomen, peritoneum, and biliary tract
- Urinary system: can be challenging and detailed. Carefully read the notes and code descriptions
- Male genital system
- Female genital system / maternity and delivery: Best to seek training from an experienced OB-GYN coder
- Endocrine system
- Nervous system: the anatomical site creates the subheadings
- Eye and ocular adnexa: Many highly specialized codes in this section, which requires careful attention to detail
- Auditory system: Because an operating microscope is often involved, be careful not to unbundle where indicated
- Radiology: Many of the procedures in this section will use modifier 26 (professional component only) and modifier TC (technical component only). Read all the includes and excludes notes

carefully
- Laboratory Procedures: If you were to code each lab test or procedure separately when a panel has been ordered, it would be considered unbundling. To correctly code a panel, all the tests listed within the panel must have been performed and there must be a need for each one
- Medicine: The two codes are (1) the code for administering the injection and (2) the code for the actual vaccine or toxoid that is given

The actual performance of any diagnostic test or study requires separate and specific coding in addition to the appropriate E/M code

Codes have to be sequenced in relation to intensity and level of service provided. Order of importance, primary reason for visit on top in order

General rules for coding:

- Analyze the providers statement or description for the service provided and isolate the main term
- Identify the main term in the index
- Check for any relevant subterms under the main term. Verify the meaning of any unfamiliar terms or abbreviations
- Note the code(s) found in the index for the main term or subterm(s)
- After locating the term and the code in the index, verify each code in the respective section of the manual to be sure the description matches the procedure or service performed
- Never code directly from the index. Always cross reference the code found in the index w/ the actual code descriptions
- Many times, 1 specific code is provided. Other times, there will be several codes or code ranges. They all need to be reviewed and verified
- In all cases, it is necessary to review all descriptions of codes listed for main terms and subterms to be sure the correct code is selected

HCPCS Level II codes were developed to identify products and supplies for which there are no CPT codes. They are codes composed of 5 characters (alphanumeric) and published annually. The HCPCS Level II manual has 2 selections, the Index and the Tabular List of Codes. The search for the correct HCPCS code begins in the index which has services and supplies listed in alphabetic order. When the description is found, the code or codes should be verified by looking in the Tabular List (numerical order)

ICD-10-CM codes describe the disease or condition presented by the pt. ICD-10-CM requires all claims to report morbidity and mortality of the pt. Morbidity is defined as the frequency of the appearance of complications following a surgical procedure or other treatment. Mortality is defined as a fatal outcome

ICD-10-CM codes vary from 3-7 characters. The first 3 characters designate the category of the diagnosis. The next 3 correspond to the related etiology, anatomic site, severity, or other vital clinical details. The 7th character applies to certain categories noted w/ the Tabular List of Codes. Use placeholder X if a code has fewer than 7 characters

Format of the ICD-10-CM manual. It is divided into 2 parts: Alphabetic index and Tabular List

- Index - the Alphabetic Index contains the Index to Diseases and Injuries, and the index to external causes of injury. It also includes the Neoplasm Table and a table of Drugs and Chemicals

- Tabular List - contains categories, subcategories, and valid codes

Punctuation:

- Brackets [ ] - in the Tabular List, [ ] are used to enclose synonyms, alternative wording, or explanatory phrases. In the index, [ ] are used to identify manifestation codes
- Parentheses ( ) - in both the Tabular List and the index, ( ) are used to enclose nonessential modifiers and supplementary words (present or absent) in the statement of a disease or procedure w/o affecting the # assigned
- Colons : - in the Tabular List : are used after an incomplete term that needs one or more of the modifiers following the colon to make it assignable to a given category

Abbreviations: The abbreviations NEC and NOS fall into this category. The NEC abbreviation directs the coder to an “other specified” code. NOS stands for “not otherwise specified” and may be interpreted as "unspecified"

General ICD-10-CM coding rules are:

1. Code correctly and completely any diagnosis or procedure that affects the care, influences the health status, or is a reason for treatment on that visit
2. Code the minimum # of diagnoses that fully describe the pts care received on that visit. The diagnosis must reflect the pts need for treatment, x-rays, diagnostic procedures, or modifications
3. Code each problem to the highest level of specificity (4th to the 7th character) available in the classification sequence codes correctly so that it is possible to understand the chronology of events
4. The main rule to remember is that the reason for the pt visit is coded first (primary diagnosis); any other issue the pt presents w/ (comorbidity) are coded next, in order of importance

Acute vs chronic conditions:

A combination code is a single code used to classify:

- Two diagnoses, or
- A diagnosis w/ an associated complication

Multiple coding:

Some ICD-10-CM codes indicate laterality, specifying whether the condition occurs on the left, right, or bilaterally. If a bilateral code is not provided, use separate codes for both left and right side. If it's not specified, use unspecified codes

Diagnosis-related group (DRG)

ICD-10-CM chapters

1. Certain infectious and parasite diseases (A00-B99)
2. Neoplasm (C00-D49)
3. Diseases of the blood and blood forming organs and certain disorders involving the immune mechanism (D50-D89)
4. Endocrine, nutritional, and metabolic diseases (E00-E89)
5. Mental, behavioral, and neurodevelopmental disorders (F01-F99)
6. Diseases of the nervous system (G00-G990
7. Diseases of the eye and adnexa (H00-H59)

8. Diseases of the ear and mastoid process (H60-H95)
9. Diseases of the circulatory system (I00-I99)
10. Diseases of the respiratory system (J00-J99)
11. Diseases of the digestive system (K00-K95)
12. Diseases of the skin and subcutaneous tissue (L00-L99)
13. Diseases of the musculoskeletal system and connective tissue (M00-M99)
14. Diseases of the genitourinary system (N00-N99)
15. Pregnancy, childbirth and the puerperium (O00-O94)
16. Certain conditions originating in the perinatal period (P00-P96)
17. Congenital malformations, deformations, and chromosomal abnormalities (Q00-Q99)
18. Symptoms, signs, and abnormal clinical and laboratory findings, not elsewhere classified (R00-R99)
19. Injury, poisoning, and certain other consequences of external causes (S00-T88)
20. External causes of morbidity (V00-Y99)
21. Factors influencing health status and contact w/ health services (Z00-Z99)
22. Codes for special purposes (U00-U085)

ICD-10-PCS is used only for inpatient facility hospital settings. More than 87000 codes

Summary

- Providers use 2 coding systems to report their services in order to be paid by commercial and government payers: (1) HCPCS and (2) ICD-10-CM
- CPT consists of 6 sections. HCPCS Level II codes are used to report supplies and services for which there are no current CPT codes
- Modifiers are used w/ CPt and HCPCS codes to indicate something different about the way the service or procedure was performed
- Symbols within the CPT manual either call attention to or provide additional info for the coder to accurately assign the code
- Most outpatient clinical providers use evaluation and management (E/M) services, which is listed at the front of the CPT manual
- The key components of (E/M) service are history, examination, and medical decision making. Other factors are nature of the presenting problem, counseling, coordination of pt care, and time spent w/ the pt
- Providers use encounter forms. Electronic ones are found in the EMR
- ICD-10-CM codes are required on all claims to report morbidity and mortality of the pt
- ICD-10-CM manual is divided into 2 sections: the Alphabetic Index and the Tabular List
- The primary reason the pt is being seen should be listed as the primary diagnosis