AHIMA Distance Education

CPT® Surgery Coding Guidelines

Audio Seminar/Webinar

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Practical Tools for Seminar Learning

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Faculty

Margi Brown, RHIA, CCS, CCS-P, CPC

Margi Brown is Director of Coding Quality and Education for Community Health Systems in Brentwood, TN, concentrating on documentation and coding for billing accuracy. Ms. Brown has over 25 years of experience in the HIM field covering hospital outpatient, inpatient, surgical centers, physician office, clinic, law firms, consulting, and third-party carrier areas. She is also a frequent speaker on coding, documentation, and compliance topics.

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Notes/Comments/Questions

Objectives of this Seminar

- Review CPT surgery guidelines, modifier usage, CPT surgical package, and surgical follow up care
- Discuss documentation requirements for accurate CPT surgery coding
- Practice CPT surgery guidelines using case studies

1

Benefits from this Seminar

- Understand the CPT surgery guidelines in order to accurately report surgical procedures
- Practice assigning CPT codes through examples and scenarios
- Avoid reimbursement problems by getting a handle on the ground rules for coding CPT procedures and services.

2

CPT Includes:

- **Per the AMA, the CPT code set for 2008 includes:**
  - **8,661 codes**
    - **244 new codes**
    - **314 revised codes**
    - **52 deleted codes**
    - **Refer to next table from the AMA**
  - **Close numbers – Approximation**
  - **Refer to Appendix B – summary of additions, deletions, and revisions**

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Sections	Added	Deleted	Revised
Anesthesia	2	1	1
E/M	12	5	9
Surgery	***73***	***22***	***127***
Radiology	8	7	24
Path/Lab	11	1	11
Medicine	21	0	119
Category II	102	5	3
Category II/Modifier	1	0	0
Category III	13	11	13
Appendix A-Modifiers	1	0	8
Totals	244	52	314

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Notes/Comments/Questions

General Changes

- There were many changes made across the entire book.
  - Section, sub-section, headings
  - Results, testing, interpretation, and report
    - These instructions have been "moved" to the Introduction section - Instructions for Use of the CPT book, (from the individual sections)

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Change of Headings and Codes

- New and revised headings and subsections
- Old codes deleted with notation referring to new codes, which provides a simpler description
- Deleted codes and renumbered (new codes)
- Rearranged to make more sense
- Changed some of the wording

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Change Note Examples

- Instruction and usage notes
  - Many notes throughout to be coded in addition to primary procedure.
  - Cross reference notes are present to code in addition, when applicable
  - Notes present precluding separate reporting
  - New notes to explain use of codes
  - Notes to refer coder to correct new codes

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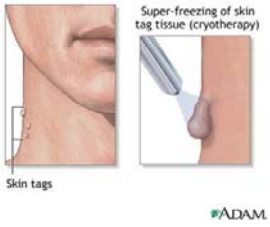
Change Guideline Examples

- Guideline revision
  - For more "grammatical clarification"
    - "Chemical destruction" added to removal of skin tags
  - Clarify intent
    - Excision and adjacent tissue transfer



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More Changes

- MS – Musculoskeletal section, 2xxxx - Largest group of changes within the surgical section
- Guideline revision and instruction changes or additions throughout chapter
- Revision of many codes for modifier 51 exempt changes
  - deletion of the modifier 51 exempt status symbol "⊘" is indicated by inclusion of a revision symbol "▲" on the revised codes.

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MS Change Example

- *Revision of many* codes clarifying external fixation is reported separately, when performed in addition to the listed procedures

▲26615 Open treatment of metacarpal fracture, single, with or ~~without~~ includes internal ~~or external~~ fixation, when performed, each bone

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Surgical Documentation Guidelines

- Accurate and complete coding should paint a picture of the patient's encounter
- Only documented services may be coded
- The physician documentation is key to correct code assignment and appropriate reimbursement
- Does the documentation support not only the code(s) assigned, but the medical necessity?

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Documentation = Code? And Documentation = Medical Necessity?

?

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Notes/Comments/Questions

Location of Surgical Guidelines

- Crucial to check for ***accurate*** coding:
  - CPT code guidelines are found as introductory notes at the beginning of a section or subsection, or as cross-references after specific codes or series of codes.
  - Surgical codes = 1xxxx – 69990
  - Also reference introduction section, front & back covers, and addendums.

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Format of Surgical Section

- Introduction/Surgery
  - Guidelines before section – p 47-50
  - Subsection info with coding ranges
  - Unlisted procedure coding ranges
- Each section
  - With subsections by anatomical site(s), then type of procedure/surgery
  - Each section has similar format, but different

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Watch the "Wording"

- **Quantity**
  - Each; each separate/each additional;
  - single; multiple; any number
- **Severity**
  - Simple; complicated; extensive
- **Inclusive**
  - With; without
- **Site(s)**
- **Size**
  - Small, medium, large
- **Depth**
  - Deep, skin, sub-Q, …
- **Method**
  - Incision, excision, biopsy, …

Integumentary system – 1xxxx

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Many Choices for One Little Lesion

Paring/cutting benign hyperkeratotic lesion	11055-11057
Biopsy	11100-11101
Removal of skin tags	11200-11201
Shaving	11300-11313
Excision benign skin lesions	
Trunk, arms, legs	11400-11406
Scalp, neck, hands, feet, genitalia	11420-11426
Face, ears, eyelids, nose, lips, mucous membrane	11440-11446
Excision skin, and subcutaneous tissue, hidradenitis	
Axillary	11450-11451
Inguinal	11462-11463
Perianal, perineal, umbilical	11470-11471
Excision malignant skin lesions	
Trunk, arms, legs	11600-11606
Scalp, neck, hands, feet, genitalia	11620-11626
Face, ears, eyelids, nose, lips	11640-11646
Destruction	
benign or premalignant lesions	17000-17250
malignant lesions	17260-17286

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Lesions, lump…

- What is it? Where is it? What exactly was done?
- Documentation is crucial!
- Abscess, lesion, cyst….?
- Bone cyst or spur…? Plantar neuroma or wart, …..?
- Depth - Skin, sub-Q, muscle, ?..
- Excision lesion eyelid - more than skin?
- Type of repair?
- Review the diagnosis and the procedure

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Debridement Type Codes

- Of extensive eczematous/infected skin
  - 11000 - up to 10% body surface
  - 11001 (+) each addt'l 10%
- With fractures/dislocations:11010 – 11012
  - Skin and sub-Q
  - Skin, sub-Q, muscle fascia, and muscle
  - Skin, sub-Q, muscle fascia, muscle, and bone
- "Regular" also by depth: 11040 – 11044
  - Skin-partial thickness
  - Skin-full thickness
  - Skin and sub-Q
  - Skin, sub-Q, and muscle
  - Skin, sub-Q, muscle, and bone

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Repair (Closure)

- Classifications
  - Simple
  - Intermediate
  - Complex
- Instructions
  - Measure and record in cm
  - Add lengths in same classification & anatomic sites grouped together

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Conversion Table

Millimeters/Inches
Centimeters/Sq.Centimeters

1 mm	*= 0.1 cm*
10 mm	*= 1 cm*
0.3937 in	*= 1 cm*
1 in	*= 2.54 cm*
0.16 sq in	*= 1 sq cm*
1 sq in	*= 6.452 sq cm*

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Notes/Comments/Questions

Polling Question #1

- Patient presented with multiple lacerations on both legs with simple repairs done in the ER.
- X2 on the right leg (2.0 and 2.6), x 1 (2.6) in the left leg, and x 1 in the left foot (2.6) – all cm measurements
- Is the code 12004 correct?
  - 1 YES
  - 2 NO

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Code Structure

- All different through each chapter
- Some procedure codes are very specific defining a single service
  - Cholecystectomy – 47600
- Others may have many other qualifiers
  - Range of sites
    - Excision lesion codes – 114xxx …
  - Single/pleural
    - Colonoscopy with removal polyp(s), tumor(s), or other lesion(s)…. 453xx
  - With/without imaging
  - Inclusive of other services
    - vaginal hysterectomy, 250 grams or less, with removal of tube(s) and ovary(s) and repair of enterocele - 58263

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Code Structure - Approach

- Multiple approaches to various procedures, are often clusters of CPT codes describing the various approaches
  - (e.g., vaginal hysterectomy as opposed to abdominal hysterectomy)
- If the procedure is "scopic" and there is NOT an accurate code available, an unlisted "scopic" code must be used.
  - Cannot automatically use an open.

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Code Structure - Diagnosis

- There are many surgeries/procedures that the procedure is for a certain diagnosis
  - Debridements
  - Drainage of abscess
    - 50020- perirenal/renal
  - Cystourethroscopy with dilation of bladder for *interstitial cystitis* (general or spinal anesthesia) - 52260
  - Removal of mesh for infection…. 11008 - narrative description changed for 2008

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Notes/Comments/Questions

Code Structure - Severity

- Code to the more severe on the same site
  - Complex – simple
  - Complicated - simple
  - Complete - limited
  - Deep – superficial
  - Complete – incomplete
  - Comprehensive - intermediate
  - .....

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Documentation Requirements - Operative Report

- Operative report – few components
  - Technique and approach
    - Open vs. closed, aspiration, percutaneous, etc.
  - Screening vs. diagnostic vs. therapeutic
  - Location/Site(s) –
    - Right, left, bilateral, distal, proximal, depth, single/pleural, ...
  - Severity/Risk
    - Complex/simple.....
- Provide complete roadmap of what was done

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Notes/Comments/Questions

Documentation Tips

- *Usual* format/heading of the surgery or procedure
  - Pre & post-op DX(s)
  - Procedure listing
  - Anesthesia
  - Physician(s) involved
  - Body of report
  - Surgical findings
  - Indications for surgery?

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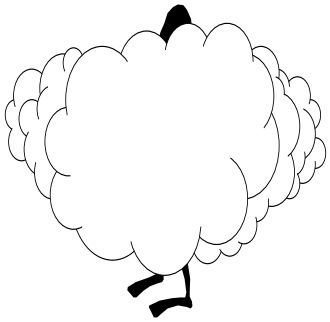
Procedure(s): Many questions

- ? Unbundled, inclusive mutually exclusive
- ? Co-surgeon vs. assistant surgeon
- ? Application of multiple guidelines
- ? Repeat,unrelated, staged?
- ? Site(s)?
- ? *Indications for surgery*



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Notes/Comments/Questions

Integral Surgery Services

- Some procedures have certain services included
  - Cleansing, shaving and prepping of skin
  - Draping and positioning of patient
  - Insertion of intravenous access
  - Moderate sedation administration by the physician performing a procedure
  - Local, topical or regional anesthesia administered by the physician performing the procedure

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Integral Surgical Approach

- Includes identification of anatomical landmarks
  - incision
  - evaluation of the surgical field
  - simple debridement of traumatized tissue
  - lysis of simple adhesions
  - isolation of structures such as bone, blood vessels, nerve, and muscles including stimulation for identification or monitoring
  - surgical cultures
  - wound irrigation

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Notes/Comments/Questions

Integral Surgical Approach Cont'd

- Insertion and removal of drains, suction devices, and pumps into same site
- Surgical closure and dressings
- Application, management, and removal of postoperative dressings including analgesic devices (peri-incisional TENS unit, institution of Patient Controlled Analgesia)
- Preoperative, intra-operative and postoperative documentation, including photographs, drawings, dictation, transcription as necessary to document the services provided

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Add-On Codes (+)

- Describes a service that can ***only*** be reported in addition to a primary procedure. (+)
- For other add-on codes, primary procedure code(s) is (are) not specified, and generally, these are identified with the statement: "List separately in addition to code for primary procedure."

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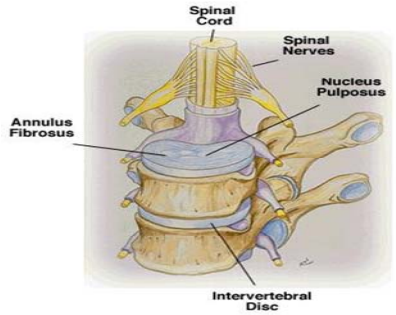
Add-On Codes (+)

- **Other types of procedures – example:** Spinal area instrumentation 22840-22851 codes



- **Mesh with hernia repairs**
- **Microsurgical technique requiring operating microscope – 69990**
- **"Each additional" something …**

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Separate Procedure

- **Key term = "integral component"**
- **If a HCPCS/CPT code descriptor includes the term "separate procedure," the HCPCS/CPT code may not be reported separately with a *related procedure.***
- **CMS interprets this designation to prohibit the separate reporting of a "separate procedure" when performed with another procedure in an anatomically related region through the same skin incision, orifice, or surgical approach.**

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Coding/Billing Edits

- ✓ Mutually exclusive
- ✓ Component
- ✓ Unbundling
- ✓ Diagnosis to procedure
- ✓ Age/gender
- ✓ Status codes
- ✓ Duplicate procedures per date of service date
- ✓ Modifier processing
- ✓ Code validation
- ✓ Frequency
- ✓ Medical necessity

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Edits

- National Correct Coding Initiative (NCCI)
  - Set of edits used by Medicare Part B carriers to identify coding patterns resulting in overpayment to providers
  - Policy on what procedures and services can't be billed at the same time when they are furnished for the same patient on the same day
  - Generally part of hospital's encoder system; incorporated into the outpatient code editor (OCE)
  - Updates are provided on a quarterly basis

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Notes/Comments/Questions

Surgical Guidelines

- Report procedures with the HCPCS/CPT codes that most comprehensively describe services performed
- Beware of unbundling
  - Unintentional unbundling
  - Intentional unbundling
- Correct coding requires that we report a group of procedures with the appropriate comprehensive code

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Types of Surgical Unbundling

- Fragmented unbundling
- Unbundling for related services
- Break out unbundling
- Unbundling Surgeries

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Notes/Comments/Questions

Unbundling Explained

- Fragmented: one service into component parts and coding each component part as if it were a separate service.
- Related: reporting separate codes for related services when one combined code includes all related services
- Breakout: Breaking out bilateral procedures when one code is appropriate.

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Sequential Procedure

- Initial approach vs. second procedure
  - Second procedure performed due to the initial procedure being unsuccessful
  - Most invasive service should be reported

Example:

Failed laparoscopic cholecystectomy followed by an open cholecystectomy at the same session

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Notes/Comments/Questions

Mutually Exclusive Procedure

- "Mutually exclusive procedures cannot reasonably be performed at the same anatomic site or same patient encounter".
  - Repair of an organ that can be performed by two different methods. Only one method can be chosen to repair the organ.
  - Service that can be reported as an "initial" service or a "subsequent" service.
  - Number involved - Code 15775 graft for hair transplant 1 to 15 punches, would not be reported with code 15776 more than 15 punch grafts

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Some CCI Guidelines

- When an initial attempt to remove a lesion is followed by a more invasive lesion removal-only report the most invasive procedure.
- When a biopsy is done as part of a lesion excision, only the excision is coded.
- If the decision to perform the more comprehensive procedure is based on the biopsy result, the biopsy can be separately reported.

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Notes/Comments/Questions

Global Surgery Package

- Global Surgery
  - What's included or not
- Timeframes
- Postoperative complications
- Minor versus major surgeries
- Follow-up care

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Global Surgery Concept

- Reimbursement for surgery includes pre-, intra-, and post-op care
- Major surgery = 1 day pre-op + 90 days post-op
- Minor surgery has either 0 or 10 days post-op
- Global surgery modifiers: 24, 25, 58, 78, 79
- Note: Global for hospitals is the same calendar date.

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Notes/Comments/Questions

Included in Global Surgery

- Pre-operative visits – not including the visit that included the "decision for surgery"
- immediate postoperative care, including dictating operative notes, talking with the family and other physicians
- writing orders
- evaluating the patient in the post-anesthesia recovery area
- typical postoperative follow-up care
- complications following surgery
- post-operative visits

45

Not Included in Global Surgery

- ✓ Initial consultation or evaluation
- ✓ Services of other physicians
- ✓ Visits unrelated to the surgery after the initial hospitalization
- ✓ Added courses of treatment
- ✓ Diagnostic tests

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Notes/Comments/Questions

Not Included in Global Surgery

- ✓ Distinct procedural services
- ✓ Return trips to the operating room
- ✓ More extensive procedures
- ✓ Immunotherapy management
- ✓ Unrelated critical care for burn and/or trauma patients

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A Modifier is:

- A two character code attached to a CPT/HCPCS code to add additional information
- An explanation of unusual circumstances
- Used to capture payment data
- Sometimes a requirement for proper claim processing.
- Supported by documentation (should be) Sometimes a target of a focused review and is benchmarked for compliance purposes
- Is benchmarked by CMS for compliance purposes. (See OIG work plan)

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Purpose of Modifiers

To indicate:

- A portion of the service was performed
- Performed by more than one physician
- Service was increased or decreased
- Unusual events occurred

- To add more information regarding the anatomic site of the procedure
- To eliminate the appearance of duplicate billing
- When needed to eliminate appearance of unbundling

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More Modifier info

- All modifiers are not created equal
- Modifiers are required for hospitals and physicians.
- The time frame in the global period for modifiers are different for the hospital and the physician.
- For the hospital, the global period = the same calendar date as the procedure.
- For the physician, the global period is 0, 10, or 90 days.
- There are different modifiers for the same/similar situation. (ex: 73/74, 53)

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Notes/Comments/Questions

Modifier Format

- Refer to CPT Appendix A and HCPCS
- Appendix A is not intended to be a comprehensive list
- Two modifiers allowed per code
- Formats are different depending on the modifier and payer
- Medicare has specific reporting guidelines
  - Five digit modifiers are not accepted by Medicare
- Review FI and payer information - interpretations may vary.

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Modifiers and Appendices 2008

- Defined modifiers
- Service performed has been "altered by some specific circumstance but not changed in definition or code"
  - Allows response to payment policy requirements and specifications
  - Revised descriptions of commonly used modifiers to clarify intent

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Notes/Comments/Questions

Modifier Meanings

- Lateral – side(s)
  - 50, LT/RT
- Separate site
  - Eyelids, digits, 59
- Separate sessions
  - 58, 78, 79, 59
- Separately identifiable services
  - 25, 59
- Reduced/discontinued
  - 52, 53, 73, 74
- Anesthesia
  - 47, 23
- Multiple
  - 51, 99
- Repeat
  - 76, 77
- Role in surgery
  - >1: 62, 66
  - Assisting: 80, 81, 82
- Split care
  - 54, 55, 56
- Decision for surgery
  - 25, 57
- Unusual
  - 22, 23, 63-infants < 4kg

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Site Specific Modifiers

- Coronary artery
  - LC-Left Circumflex
  - LD-Left anterior descending
  - RC-Right coronary artery
  - Only valid on certain CPT codes
- Eyelids
  - E1 Upper left
  - E2 Lower left
  - E3 Upper right
  - E4 Lower right
- Separate site
  - Eyelids, digits, 59
- Left/Right
  - LT Left side
  - RT Right side
- Bilateral
  - 50

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Coronary Artery Modifiers

Coronary artery modifiers: LC, RC, & LD add to procedures:

- **92980 & 92981 – transcatheter placement of intracoronary stent(s); percutaneous**
- **92982, 92984 - PTCA**
- **92995-92996 – Percutaneous transluminal coronary athterectomy, ….**

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Modifier 50

Bilateral Procedure

- **Do *NOT* report 50:**
  - **Code definition contains the term "bilateral" or "unilateral or bilateral"**
- ***Do* report 50:**
  - **Can be performed on both sides, paired organs..**
- **Report unit of service as 1**
- **Medicare allows 150% of the MPFSDB for bilateral surgeries and 200% for radiology procedures**

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Notes/Comments/Questions

Modifier 50 to Check

- Is code a unilateral or bilateral code?
- Are there multiple sites listed in the code narrative?
- Is there a note or parenthetical statement indicating allowed usage of -50 modifier?
- Units of measure – MUE's

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Bilateral Examples

- Examples of bilateral surgeries – so would NOT need modifier 50:
  - Transurethral insertion bilateral J-stents
  - Bilateral removal impacted cerumen
  - Bilateral adult inguinal hernia repair
  - Bilateral sinus endoscopic surgeries: Right maxillary antrostomy; left total ethmoidectomy
  - Cysto with bilateral ureteral meatotomy

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Bilateral Procedures and Unit Instruction

- 66984-RT Cataract surgery, right eye
  66984-LT Cataract surgery, left eye
  or
- 66984-50 Bilateral
- enter ""1"" in the number of service/quantity billed field

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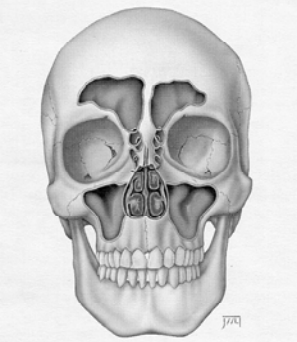
Modifiers RT & LT

- Add to sinus endoscopic procedures when performed on one side
  - Be especially careful to append modifier 50 when these procedures are performed bilaterally



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Modifiers LT/RT

- Examples *to* add:
- Procedures on "dual" or "paired" organs or structures
  - Limbs for fracture care, strapping, other…
  - Eyes, ears
  - Nosebleeds—which nostril?
- Examples to *delete*-not required:
  - Codes with ranges of sites such as wound repairs
  - Ear wax removal—this code includes "one or both ears"

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Digit Modifiers

HAND

Left

FA thumb
F1 2nd
F2 3rd
F3 4th
F4 5th

Right

F5 thumb
F6 2nd
F7 3rd
F8 4th
F9 5th

TOES

Left

TA great toe
T1 2nd
T2 3rd
T3 4th
T4 5th

Right

T5 great toe
T6 2nd
T7 3rd
T8 4th
T9 5th

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Polling Question #2

- Choose the code(s) with the ***incorrect modifier:***

A ORIF right great toe – 28505 – T5
B Amputation right foot, midtarsal – 28800 - RT
C Arthrocentesis (major joint or bursa) left knee – 20610 – LT
D Simple repair right arm 2.5 cm wound – 12001 – RT

* 1 A
* 2 A & B
* 3 C & D
* 4 None of the above

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Modifier 51

- Modifier 51
  - Development of new exempt criteria by the CPT editorial panel with RUC information
  - Refer to Appendix E
  - Also refer to Appendix D – add-on codes
  - Deletion of the symbol "⊘" is indicated by inclusion of a revision symbol "▲" on the revised codes for modifier 51 exempt status

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Appendix E, Modifier 51 Exempt

- Criteria established to allow codes to be on exempt list
  - Procedure typically performed with another procedure but not add on because could be performed independently
  - Not on CMS multiple procedure reduction list
  - Minimal amount of pre- and post- service time
  - No add on codes selected
  - Payments shouldn't be reduced when performed with another procedure
  - Performed with many other procedures so impractical to list all if on add on list
- Many codes removed from list

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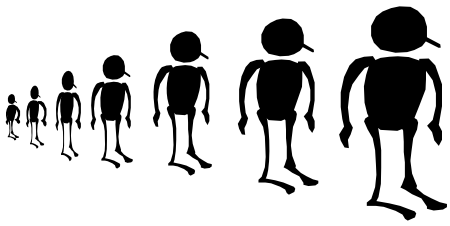
Modifier 99

= Multiple Modifiers

- When more than two modifiers are necessary
- Waiting for Common Working File to be expanded



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Multiple Providers

- Surgical package
- Multiple surgeons and/or assistants
- Split care
- Role of surgeon(s) and assistant(s)

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Multiple Surgeons

Modifier 62-Two surgeons – Co-surgery

- Requires skills of two surgeons both acting as primary surgeons performing distinct part(s) of a procedure
- Reported with same code(s)
- For multiple procedures – role has to be clearly defined

Modifier 66 – Surgical Team

- Requires skills of more than two surgeons
- Each bills procedure with modifier 66
- Document medical necessity

Both apply to professional billing only

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Notes/Comments/Questions

Assistant at Surgery

- 80 - Assistant surgeon
- 81 - Minimal assistant surgeon
- 82 - Assistant surgeon when a qualified resident is not available
- AS - Physician Assistant, Nurse Practioner, or Clinical Nurse specialist services for the assistant at surgery
- Check if surgery is covered for an assistant
- All of the above apply to professional billing only

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Assistant at Surgery Modifier 80 vs. 82

80 – Assistant Surgeon

- Performed in non-teaching setting

- or -

- Teaching setting when resident available but not used

82 – Assistant surgeon when qualified resident not available

- Know when documentation needs to be submitted

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Notes/Comments/Questions

Split Care Guidelines

- When transfer of postoperative care is performed, Medicare regulations require a written transfer of care agreement between the operating surgeon and the physician who will do the postoperative care.
- Both the surgeon and the physician providing the postoperative care must keep a copy of the written transfer agreement in the beneficiary's medical record

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Split Care Guidelines

- The first date of service reported should be the date the physician assumes care of the patient.
- The last date should be the day care is relinquished.
- Report this date range in Item 19 of the CMS-1500 claim form or in the narrative field of the electronic claim screen.

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Split Care

- Medicare will pay no more than the total fee schedule approved amount for the surgical procedure regardless of the number of physicians involved.
  - 54 Surgical care only (69%)
  - 55 Post-op management only (21%)
  - 56 Pre-op management only (10%)
- Professional fee

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Modifiers 52, 53, 73, and 74

- 52-reduced - both
- Discontinued
  - 53 – MD
  - Circumstances exist that threaten patient's well-being
  - 73 - hosp
  - 74 - hosp

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Modifier 52

= Reduced Services

- A bilateral procedure is only performed on one side
- May need to include documentation
- Medicare does not recognize with an E/M code

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Modifier 52 Reduced Services

- Hospitals: Change in guideline—TR 442
- Modifier 52 is used to indicate partial reduction or discontinuation of a *RADIOLOGY* procedure and *other services* that do *NOT* require anesthesia.
- This modifier provides a means for reporting reduced services without disturbing the ID of the basic service.
- The TR "clarifies that discontinued radiology procedures that do not require anesthesia may not be reported using 73 and 74"

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Notes/Comments/Questions

Modifiers 73 and 74 Reduced or Discontinued Services

- Modifier 73 and 74 are used to indicate partial reduction or discontinuation of certain diagnostic and surgical procedures that DO require anesthesia.
- This modifier provides a means for reporting reduced services without disturbing the ID of the basic service.
- "Clarifies that discontinued radiology procedures that do not require anesthesia may *not* be reported using 73 and 74"
- "Due to extenuating circumstances or those that threaten the well-being of the patient …"
- 73 and 74 are for the hospital use only (facility)
  - The physician arena uses modifier 53. (not for hospitals)

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Modifier 73 Discontinued Service PRIOR to Administration of Anesthesia

- "Due to extenuating circumstances or those that threaten the well-being of the patient *after* the patient had been prepared for the procedure…, *taken to the room where the procedure was to be performed*, but *PRIOR* to administration of anesthesia".
- Anesthesia in the hospital outpatient departments = local, regional block, general, and now including conscious sedation.

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Modifier 74
Discontinued Service AFTER Anesthesia Administration

- … a surgical or diagnostic procedure requiring anesthesia was terminated AFTER the induction of anesthesia or after the procedure was started due to extenuating circumstances or those that threaten the well-being of the patient …
  - (incision made, intubation started, scope inserted, etc).
- Anesthesia in the hospital outpatient departments = local, regional block, general, and now including conscious sedation
- May receive 100% of the OPPS payment for costs/resources expended in the procedure & recovery room….

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Discontinued Services

- If procedures planned are completed, report as usual.
- The other(s) that were were planned, but not started are not reported.
- When none of the procedures were planned, but not completed, AND meet the criteria for 73 or 74, report only one procedure with the appropriate modifier.
- No procedure room—no procedure.
- Elective cancellation—no procedure.

80

Something Different

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Modifier 58

= Staged or Related Procedure or Service by Same Physician During the Post-op Period

- Planned or anticipated prospectively
- More extensive than the original procedure
- Therapy following diagnostic surgical
- CPT notes: "unanticipated clinical condition with return to OP/procedure room" = 78
- Note: Narrative changed for 2008

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Modifier 59

- Distinct procedural service
- Used to indicate a procedure was distinct or independent from other (non-E/M) procedures on the same date
  - Procedures that are not normally reported together but are appropriate under the circumstances
  - Different session, different site or organ system, separate incision/excision, separate lesion, organ, injury, ...

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Modifier 59 Guidelines

- Accuracy and clarity in the documentation is necessary to explain how the procedures are distinctly different or separate.
- Modifier 59 stated on the 2nd (component) code.
- Report when second service is done:
  - During a different session, site, lesion, excisions ..
- Use 25, 58, 78 and 79 instead if applicable
- Example: Patient has a 4.0 cm lesion biopsied and a 3.0 cm lesion excised, both on the same arm, both benign.
  - Codes are:
    - 11403 Excision benign lesion arm-3.0 cm
    - 11100*59* Biopsy single lesion

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Notes/Comments/Questions

Modifier 59 Tips

- Do not use on different procedures that are self-explanatory or not required.
- This modifier should only be used when one of the anatomical modifiers does not apply.
- If the code pair has an "o" indicator, payment will not be made for the column 2 code even if an anatomical or modifier 59 is used.
- Problems
  - Can bypass CCI edits, sometimes incorrectly
  - High frequency of usage errors

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Modifier 51 vs. 59

51 Multiple surgery

- Applies for professional billing only
- Apply to secondary codes, but not to the add-on codes (+)

59 Distinct procedural service

- Separate encounters or sites when affected by CCI
- Modifier of last resort
- Applies to both professional and institutional billing

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Notes/Comments/Questions

Modifiers 76 & 77
Repeat Procedures

- Repeat procedure by:
  - Or service - Same physician - 76
  - Different physician - 77
- Example:
  - Patient's esophageal varices continue to bleed following an endoscopic cautery earlier that day (43227), so the same procedure was repeated later in the day
  - Same procedure (same code) performed later that day.
- With the use of these modifiers, the question of duplicate billing should be answered.
- Note – apply to the 2nd procedure

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Modifiers 78 & 79
Another Surgery-Procedure with Same Doc

- Same physician during the post-op period
  - 78 ***UNPLANNED*** return to OR/procedure room for *related* procedure
  - 79 Unrelated procedure/service
  - Document the clinical details of how second procedure relates to the 1st procedure

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Notes/Comments/Questions

Modifier 78 Example

- Colectomy partial with anastamois - 44140 performed May 23rd
  - 90 day post-op period
- Today, June 19, the pt returned to OR for suture of abdominal wall due to dehiscence
- Report as 49900-78

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Modifier 79

Unrelated Procedure or Service by Same Physician During Post-op Period

Example: Repair of femoral hernia (49550)

- 90 days post-op procedure
- Six weeks later an appendectomy is done
- Report appendectomy as 44950-79

90

References

- ***AMA***
  - ***CPT 2008 Professional Edition,***
  - ***CPT 2008 Changes; An Insider's View***
  - ***CPT Assistant***
- **National Correct Coding Initiative Policy Manual for Medicare Services http://www.cms.hhs.gov/NationalCorrectCodInitEd/**
- **Medicare Claims Processing (PUB. 100-04)**
- Break Through the Modifier Maze, Nancy Maguire
- Coding with Modifiers, Deborah J. Grider

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Web Bibles

Just a few…with lots of links…..

- **www.cms.hhs.gov**
- **www.cms.hhs.gov/medlearn**
- **www.cms.hhs.gov/QuarterlyProviderUpdates/02_WhatsNew.asp**
- **www.dhhs.gov**
- **www.trailblazerhealth.com**
- **www.Ahima.org**
- **www.ama-assn.org**
- **www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guidelines**
- **www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp/**
- **www.ntis.gov/**

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Notes/Comments/Questions

More Specific CMS links

- 59: http://www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf
- MD: http://www.cms.hhs.gov/center/physician.asp
- Hospital:
  - http://www.cms.hhs.gov/center/hospital.asp
  - http://www.cms.hhs.gov/HospitalOutpatientPPS/01_overview.asp
  - http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp

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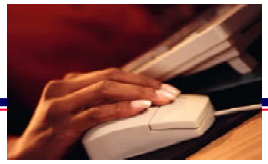
On-Line Resources



- AHIMA Online Training:

E&M Coding for Professional Services

http://campus.ahima.org/campus/course_info/CATS/CATS_newtraining.html#em

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Appendix

Appendix

Resource/Reference List

AMA

- *CPT 2008 Professional Edition*,
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- *CPT Assistant*

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www.cms.hhs.gov/QuarterlyProviderUpdates/02_WhatsNew.asp
www.dhhs.gov
www.trailblazerhealth.com
www.Ahima.org
www.ama-assn.org
www.cdc.gov/nchs/datawh/ftpserv/ftpicd9/ftpicd9.htm#guidelines
www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp/
www.ntis.gov/

59:

http://www.cms.hhs.gov/NationalCorrectCodInitEd/Downloads/modifier59.pdf

MD:

http://www.cms.hhs.gov/center/physician.asp

Hospital:

http://www.cms.hhs.gov/center/hospital.asp
http://www.cms.hhs.gov/HospitalOutpatientPPS/01_overview.asp
http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp

AHIMA Online Training:

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http://campus.ahima.org/campus/course_info/CATS/CATS_newtraining.html#em

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