Official CPC® Certification Study Guide

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Regarding HCPCS Level II

HCPCS Level II codes and guidelines discussed in this book are current as of press time.

Clinical Examples Used in this Book

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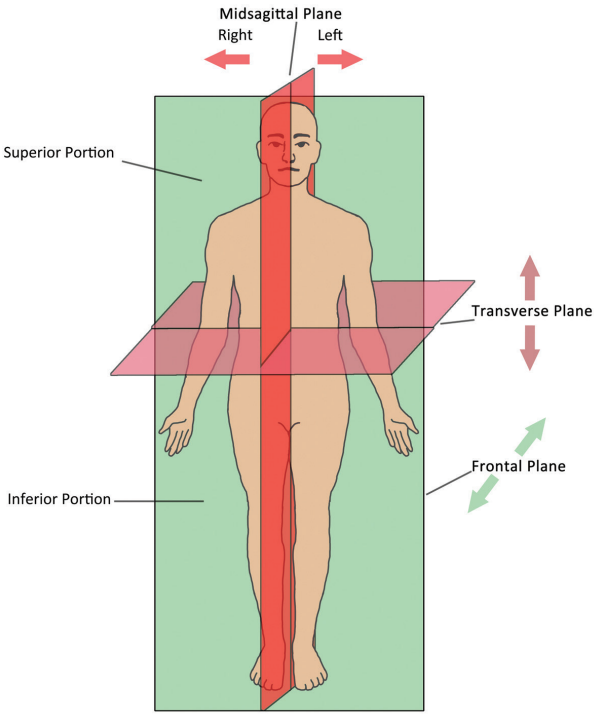
Anatomic Positions and Planes

The standard body position is considered the anatomic position. The anatomic position is an upright, face-forward position with the arms by the side and palms facing forward. The feet are parallel and slightly apart.

Anatomical Planes and Directions



Source: AAPC

Based on the anatomic position, the following directional terms are pertinent to understanding medical documentation:

Anterior (ventral)—Toward the front of the body.

Posterior (dorsal)—Toward the back of the body.

Medial—Toward the midline of the body.

Lateral—Toward the side of the body.

Proximal—Nearer to the point of attachment or to a given reference point.

Distal—Farther from the point of attachment or from a given reference point.

Superior (cranial)—Above; toward the head.

Inferior (caudal)—Below; toward the lower end of the spine.

Superficial (external)—Closer to the surface of the body.

Deep (internal)—Closer to the center of the body.

For radiological studies, the body is often virtually cut along a flat surface called a plane. The most frequently used planes include:

Sagittal—Cuts through the midline of the body from front to back, dividing the body into right and left sections.

Frontal (coronal)—Cuts at a right angle to the midline, from side to side, dividing the body into front (anterior) and back (posterior) sections.

Transverse (horizontal) (axial)—Cuts horizontally through the body, separating the body into upper (superior) and lower (inferior) sections.

Structure of the Human Body

The structure of the human body falls into four categories:

1. The cell is the basic unit of all living things. Human anatomy is composed of cells that vary in size and shape according to function.
2. Tissue is a group of similar cells performing a specific task; for instance, muscle tissue produces movement. Connective tissue is divided into four general groups: adipose tissue, cartilage, bone, and blood.
3. Organs are two or more kinds of tissue that together perform special body functions. As an example, the skin is an organ composed of epithelial, connective, and nerve tissue.
4. Systems are groups of organs that work together to perform complex body functions. For example, the nervous system is made up of the brain, spinal cord, and nerves. Its function is to coordinate and control other body parts.

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The pharynx is divided into three regions: nasopharynx (air passageway), oropharynx (air and food passageway), and laryngopharynx (air and food passageway).

The larynx is your voicebox. In addition to voice production, it also helps provide an open (patent) airway and to act as a switching mechanism to route air and food into the proper channels.

The trachea is in the mediastinal region and splits into two bronchi (at the carina) which enter the lungs. The lungs are divided into lobes; the right lung has three lobes and the left lung has two lobes.

At the smallest branch of the bronchial tree, the airways are called bronchioles. Each of these bronchioles narrow further until they end in a tiny pouch called an alveolar sac. Gases are exchanged across the single-cell layer of tissue comprising the alveolar sac into the pulmonary circulation. Capillaries from the pulmonary circulation form a bed around each alveoli; gas is exchanged between the alveoli and the capillaries via diffusion.

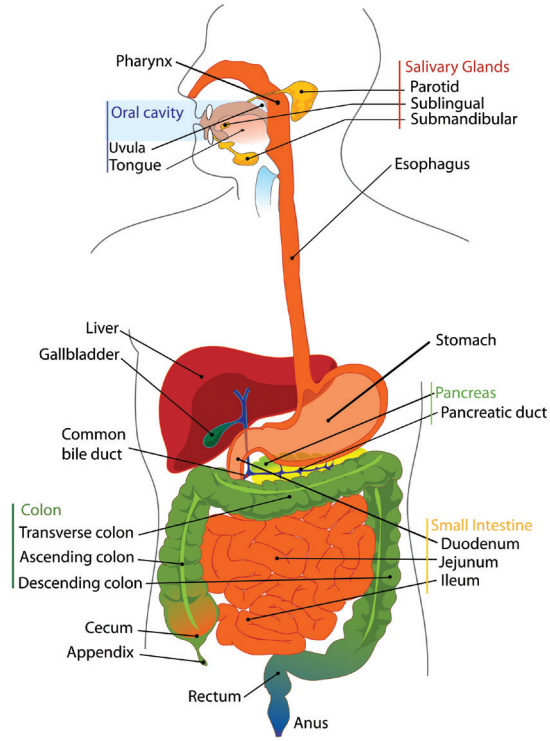
Application to Documentation

TECHNIQUE: After induction of satisfactory general anesthesia, flexible fiberoptic bronchoscopy was performed. Airways were essentially normal with minimal secretions. No endobronchial lesions. The patient was kept supine and the neck was prepared with DuraPrep and draped in the sterile fashion. A transverse incision was used and deepened with cautery. The pretracheal fascial plane was entered and the mediastinoscope easily passed. Samples of nodes from three different stations were taken from the **subcarinal area**, the **right tracheobronchial angle area**, and the **low pretracheal area**. All were negative for neoplasm. The wound was irrigated, checked for hemostasis, closed with absorbable sutures, and a dry sterile dressing was placed. A double-lumen lube was placed and its proper position confirmed bronchoscopically.

In the sample documentation above, it is important to understand anatomy to determine from where the biopsies were taken.

Digestive System

Digestive System



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The feeding tube begins in the mouth and ends at the anus. The system mechanically and chemically breaks down food into minuscule or molecular size for absorption into the blood stream and use at the cellular level.

Food enters the digestive system via the mouth. The teeth and tongue mechanically break food into small particles to provide greater exposure/surface area for the chemical processes that follow. The salivary glands that surround the mouth secrete saliva, which aids in early phases of chemical digestion and liquefaction of the food. The food is swallowed and peristalsis in the esophagus moves food down through the upper thoracic cavity into the stomach.

The opening is the cardiac orifice. The fundus is the rounded upper portion of the stomach. The main portion of the stomach is considered the body. The lower portion of the stomach is the pyloric antrum.

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Establishing medical necessity is the first step in third-party reimbursement. Payers require the following information to determine the need for care:

1. Knowledge of the emergent nature or severity of the patient's complaint or condition.
2. All signs, symptoms, complaints, or background facts describing the reason for care, such as required follow-up care. These facts must be substantiated by the patient's medical record, which must be available to payers on request.

ICD-10-PCS includes procedure codes and is typically used by facilities for inpatient services. Hospitals use ICD-10-PCS in the outpatient facility for tracking purposes only and do not submit claims using ICD-10-PCS.

We will focus on the proper use of ICD-10-CM in this chapter.

Tabular List

The Tabular List is a numerical listing of disease and injury. There are 21 chapters for the classification of diseases and injury, grouped by etiology (cause) or anatomical (body) site. The Tabular List is organized in three-character codes and their titles, called category codes. Some three-character codes are very specific and are not subdivided. These three-character codes can stand alone to describe the condition being coded. Most three-character categories (rubrics) have been subdivided with the addition of a decimal point, followed by up to four additional characters.

Each character for all categories, subcategories, and codes may be either a letter or a number. Codes can be three, four, five, six, or seven characters. The first character of a category is a letter. The second and third characters may be either numbers or alpha characters. Subcategories are either four or five characters and may be either letters or numbers. Codes are three, four, five, or six characters and the final character in a code may be either a letter or number. Certain categories have a seventh character extension (discussed later in this chapter). The fourth character in an ICD-10-CM code further defines the site, etiology, and manifestation or state of the disease or condition. The four character subcategory includes the three character category plus a decimal with an additional character to further identify the condition to the highest level of specificity. The fifth or sixth character subclassifications represent the most accurate level of specificity regarding the patient's condition or diagnosis. Certain ICD-10-CM categories have applicable seven characters. The applicable seventh character is required for all codes within the category, or as the notes in the Tabular List instruct. The seventh character must always be in the seventh position. If a code is three, four, or five characters, but requires a seventh character extension, a placeholder X must be used to fill the empty characters. There are symbols throughout the Tabular List to identify when a code requires an additional character.

Examples:

√ 4th F01 Vascular Dementia

√ 5th H21.4 Pupillary membranes

√ 6th I87.00 Postthrombotic syndrome without complications

√ 7th O32.0 Maternal care for unstable lie

Index to Diseases and Injuries

Main terms in the Index to Diseases and Injuries usually reference the disease, condition, or symptom. Subterms modify the main term to describe differences in site, etiology, or clinical type. Subterms add further modification to the main term.

Example:

Look in the Index to Diseases and Injuries for Pain(s) (*see also* Painful) R52

abdominal R10.9
colic R10.83
generalized R10.84
with acute abdomen R10.0
lower R10.30

In this example, the subterms further define the location of pain and type of pain.

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aftercare of an injury, assign the acute injury code with the appropriate seventh character. The aftercare Z code categories are listed in Section Guideline I.C.21.c.7.

Follow Up

Codes from this category are used to indicate the surveillance of a condition that has healed fully and no longer exists. Do not confuse follow-up care with aftercare. Aftercare codes are reported for encounters required during the healing phase of a condition. Follow up is reported when the condition has fully healed. A provider may require a patient to come to the office following treatment to make sure the patient responded. For example, a patient with chronic tonsillitis is seen to make sure the condition is fully resolved following a six month course of antibiotics. When the patient is seen, the provider documents the tonsillitis is resolved. The follow-up Z code categories are listed in Section Guidelines I.C.21.c.8.

Donor

Category Z52 is reported for a patient who donates tissue or blood to another patient. This code is not used for organs harvested from cadavers or for self donations. For example, prior to surgery a patient may donate his or her own blood in case he or she needs a blood transfusion as a result of surgery. In this example, do not report a code from category Z52. Instead, report the code for the reason for the surgery.

Counseling

Z codes are reported when a patient or family member receives counseling following an illness or injury, or when support is required in coping with family or social problems. There are counseling codes for genetic counseling, contraception, family problems (eg, marital, substance abuse in the family, and victims of child abuse), and dietary counseling. The counseling Z code categories are listed in Section Guideline I.C.21.c.10.

Routine and Administrative Examinations

Z codes are reported when a patient presents for a routine exam. Examples include well child preventative visits, routine gynecological exams, and preoperative clearance. Some of the codes for routine health examinations have an option for with or without abnormal findings. The code is selected based on the information known at the time of coding. If the provider orders a test during the examination, but results are not back, and no abnormal findings are mentioned, the option for without abnormal findings is reported. An abnormal finding is a condition the provider finds during that visit when examining the patient or an abnormal result from a test at that visit. When the option for with abnormal findings is reported, additional codes are reported for the condition. The Z code categories for routine and administrative examinations are listed in Section Guideline I.C.21.c.13.

Diagnosis Coding Guidelines for Outpatient Reporting

Diagnostic Coding and Reporting Guidelines for Outpatient Services is described in section IV of the *ICD-10-CM Official Guidelines for Coding and Reporting.* These coding guidelines for outpatient diagnoses have been approved for use by hospitals/physicians in coding and reporting hospital based outpatient services and physician office visits. Review the following guideline sections for coding and reporting outpatient services.

Selection of First-Listed Condition

- In the outpatient setting, the first-listed diagnosis is used in lieu of principal diagnosis.
- In determining the first-listed diagnosis, the coding conventions of ICD-10-CM, as well as the general and disease specific guidelines, take precedence over the outpatient guidelines.

Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The most critical rule involves beginning the search for the correct code assignment through the Index to Diseases. Never begin searching initially in the Tabular List because this will lead to coding errors.

Example

A middle-aged male presents with a complaint of constant facial pain. The physician orders diagnostic tests to determine the source of the pain. The initial

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Chapter 4

Introduction to CPT®, Surgery Guidelines, HCPCS Level II, and Modifiers

Introduction to CPT®

The Current Procedural Terminology (CPT®) codebook is a compilation of guidelines, codes, and descriptions used to report healthcare services. The CPT® code set, Healthcare Common Procedure Coding System (HCPCS) Level I, is copyrighted and maintained by the American Medical Association (AMA). In 1983, the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services (CMS)) adopted CPT®, and its own HCPCS Level II, mandating these code sets be used for billing Medicare. In August 2000, the Transactions and Code Sets Final Rule (45 CFR 160.103) additionally named CPT®, HCPCS Level II, and their respective modifiers as standard code sets for national use.

The CPT® code set includes three categories of medical nomenclature and descriptors:

- Category I CPT® codes utilize a five-digit numerical code (eg, 12345). The codes are reviewed and updated annually by an AMA panel. It is mandatory to use Category I CPT® codes for reporting and reimbursement. For Medicare, a HCPCS Level II code may be used instead of HCPCS Level I CPT® code if available.
- Category II CPT® codes are optional "performance measurement" tracking codes. They are used for the Physician Quality Reporting System (PQRS), an incentive-based program developed by CMS to record evidence-based measures, discussed later in this chapter. The format for Category II codes is alphanumeric, with the letter F in the last position (eg, 0001F).

Category II codes may be reported in addition to evaluation and management (E/M) services or clinical services CPT® Category I codes.

Example

A physician examines a patient currently taking Statin therapy for coronary artery disease during an E/M visit. Report 4013F **Statin therapy, prescribed or currently being taken (CAD)** and an appropriate-level office visit code (99201–99215).

- Category III CPT® codes are temporary codes assigned by the AMA for emerging technology, services, and procedures. Category III codes are alphanumeric, with the letter T in the last position, eg, 0075T. Unlike the Category II CPT® codes, Category III codes can be reported alone, without an additional Category I code.

The AMA updates the CPT® codebook annually.

The Organization of the CPT® Codebook

The CPT® codebook is organized by:

- CPT® sections—Category I has six sections that include services and surgical procedures separated into subsections.
- Section Guidelines
- Section Table of Contents
- Notes
- Category II Codes (0001F–9007F)
- Category III Codes (0019T–0407T)
- Appendices A–O
- Alphabetized Index

The CPT® subsections also include:

- Indicator icons
- Boldfaced type
- Italicized type
- Cross-referenced terms
- Anatomy illustrations

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Glossary

Add-on Code—CPT® code used to report a supplemental or additional procedure appended to a primary procedure (stand-alone) code. Add-on codes are recognized by the CPT® symbol "+" used throughout the CPT® codebook.

The Centers for Medicare & Medicaid Services (CMS)—The agency within the U.S. Department of Health & Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid and state Children's Health Insurance Programs (CHIP).

Current Procedural Terminology (CPT®)—A code set copyrighted and maintained by the AMA.

Global Package—The period (0–10 days, or 0–90 days as determined by the health plan) and services provided for a surgery inclusive of preoperative visits, intraoperative services, post-surgical complications, postoperative visits, post-surgical pain management by the surgeon, and several miscellaneous services as defined by the health plan, regardless of setting (eg, in a hospital, an ASC, or physician office).

Global Surgery Status Indicator—An assigned payment indicator, which determines classification for a minor or major surgery, based on RVU calculations.

Healthcare Common Procedure Coding System (HCPCS) Level II—HCPCS Level II is the national procedure code set for healthcare practitioners, providers, and medical equipment suppliers when filing insurance claims for medical devices, medications, transportation services, and other items and services.

Locum Tenens—Substitute physicians who takes over the professional practice of a physician who is absent for reasons such as illness, pregnancy, vacation, or continuing medical education. When a locum tenens fills in, the regular physician submits the claim with modifier Q6 appended to the services.

Major Surgery—Surgeries classified as major have a global surgical period that includes the day before the surgery, the day of surgery, and any related follow-up visits with the provider 90 days after the procedure.

Minor Surgery—Surgeries classified as minor have a global surgical period that includes the preoperative service the day of surgery, surgery, and any related follow-up visits with the provider 0–10 days after the surgery.

Resource-Based Relative Value Scale (RBRVS)—The physician payment schedule established by Medicare.

Relative Value Units (RVU)—CMS reimburses physicians for Medicare services using a national payment schedule based on the resources used in furnishing physician services. RVUs are configured using work based on specialties, practice expense, and physician liability insurance.

National Correct Coding Initiative (NCCI)—Used by professional coders to determine codes considered by CMS to be bundled codes for procedures and services deemed necessary to accomplish a major procedure. This is to promote correct coding methodologies and to control improper assignment of codes that results in inappropriate reimbursement.

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9. Operative Note #1.

Procedure(s) Performed: Excision with layered closure right lower leg;
Excision of a melanoma in situ on left dorsal forearm

Preoperative Diagnosis: Basal cell carcinoma right lower leg and melanoma in situ, left dorsal forearm.

Postoperative Diagnosis: Basal cell carcinoma right lower leg and melanoma in situ, left dorsal forearm.

Indications: Well-marginated, erythematous, slightly scaly, plaque(s): posterior right lower leg.

Biopsy revealed a superficial BCC (basal cell carcinoma). The patient is allergic to Codeine. The patient takes the following medication(s): Hydroxyurea, alegralide, Boniva. Informed consent was obtained from the patient. Risks of the procedure including, bleeding, infection, scarring, and recurrence were explained, and the patient acknowledged understanding of these potential complications.

Procedure: The preoperative measurement of the lesion on the right lower leg was 0.9 cm. The proposed excision lines were drawn. Anesthesia was delivered locally with 12.0 cc of 1% Xylocaine with epinephrine buffered 1:10. The site was cleansed with Betadine. The site was prepped and draped in the usual sterile fashion. An incision was performed with a number 15 blade 0.5 cm outside the margin of the identified neoplasm extending deep, through the dermis and into the subcutaneous fat. The excised diameter (total pre-operative dimensions including margins) measured 1.9 cm. The specimen was tagged at the superior tip. This tissue was dissected from the patient with care to preserve histologic features. The surgical site was undermined to a distance of 2.0 cm. Hemostasis was obtained by electrocautery and vessels ligated as necessary. The specimen was placed in a bottle of Formalin labeled with the patient's identifying information. The specimen was sent for pathologic and/or margin analysis. In order to prevent dehiscence due to wound tension, an intermediate layered closure was performed. Seven 4-0 Polysorb™ sutures were placed subcuticularly utilizing a simple inverted interrupted stitch. Seven 4-0 nylon sutures were placed cutaneously utilizing a simple interrupted stitch. The final length of the surgical repair was 2.5 cm. The surgical site was cleansed with saline. A sterile dressing was applied utilizing the following: sterile petrolatum, gauze, and taped into place to form a pressure bandage. The patient tolerated the procedure well. Postoperative instructions were given to the patient. The patient was instructed to return in nine days for suture removal.

Lesion Treatment: The lesion on the left dorsal forearm was cleansed with alcohol and anesthetized with lidocaine with epinephrine. Electrodesiccated and curetted x 3. Appropriate dressing was applied and post-op instructions were given. The final defect measures 0.9 cm in size.

The patient tolerated both procedures well. Recommend routine skin examination in three months. The patient was released in good condition.

What are the CPT® and ICD-10-CM codes for this procedure?

10. Operative Note #2

Indications: The patient has an excision of a painful cyst on midline upper back. The lesion has previously ruptured and has significant scarring. The patient also has a painful cyst on the left upper back. The patient is allergic to penicillin and takes aspirin and Micardis for blood pressure. Informed consent was obtained from the patient. Risks of the procedure, including bleeding, infection, scarring and recurrence, were explained, and the patient acknowledged understanding of these potential complications.

Procedure 1-Excision cyst midline upper back:

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