CPC® Review Tool

2011
Presented by:

Introduction to CPT®

• AMA
• Unit of Service
  – 5 digit numeric
• CMS
• HCPCS
  – Three levels of codes
  – 5 digit alpha-numeric

CPT® Organization

• Evaluation and Management
• Anesthesia
  – ASA Guide
• Surgery
  – By system
  • Anatomic division
• Radiology
• Laboratory
• Medicine
How to Read CPT®

- Symbols
- Indented Codes
- Semicolon usage

Symbols

Ø Modifier –51 exempt
- New procedure code
+ Add-on
▲ Revised code
◄► New or revised text
# Out of numeric sequence

CPT® Index

- Alphabetic order
- Main terms
- Modifying terms
  – Single code
  – Range of codes
### CPT® Index

- **Main Terms**
  - Procedure or service, e.g., cast, neurorraphy
  - Organ or anatomic site, e.g., femur or heart
  - Condition, e.g., vascular malformation
  - Synonym, eponym, and abbreviation, e.g. Abbe-Estlander procedure or ECG

### CPT® Modifiers

- Located in Appendix A
- Change the meaning of a CPT® code
- Change the fee for a CPT® code

### CPT® Conventions

- Surgical Package
- Subsection Guidelines
- Add-on procedure codes
- Modifier -51 Exempt status
- Separate Procedures
Subsection Guidelines

• Read at the beginning of each subsection
  – Look up guidelines for suture/repair codes
    • Above code 12001
  – Look up guidelines for OB care
    • Above code 59000
  – Look up guidelines for Pathology services
    • Above code 88300

Surgical Package

• Pre-operative work-up traditionally 24 hrs prior to surgery
• Intra-operative
• Post-operative (normal/uncomplicated)
  – Major procedures = 90 days*
  – Minor procedures = 10 days*
• Local, digital or topical anesthesia

*Post-operative days may vary by payer and/or contract.

Global Surgical Package

• Preoperative care subsequent to the decision to perform surgery
  – One related E/M encounter on the day immediately prior to the day of surgery or
  – One encounter on the same day as surgery
Global Surgical Package

• Intraoperative – In OR, “operation per se”
• Includes local anesthesia
• Operative access and
• Uncomplicated closure

Global Surgical Package

• Postoperative –
  – 90 days global - major procedure
  – 10 day global – minor procedure
  – Uncomplicated follow-up
  – Immediate post operative care
  – Dictation of operative notes
  – Talking with family or other physicians
  – Writing orders
  – Evaluating the patient in the PACU

Add - On Codes

• Exempt from multiple surgical reduction
• Exempt from use of modifier -51
• Cannot stand alone
• Take on the global postoperative period of the principal service
Add - On Codes

• Identified by “each additional” or “list separately in addition to”
• Lower value is built in
• The add-on code concept in CPT® applies only to add-on procedures/services performed by the same physician.

Modifier -51 Exempt

• Exempt from the use of modifier -51
• Have not been designated as CPT® add-on procedures/services

Separate Procedures

• Commonly carried out as an integral component of a total service or procedure
• Identified by including the term "separate procedure” in ()
• Do not report in addition to the code for the total procedure or service for which it is considered an integral component.
Modifiers

- Indicate that a procedure has been changed in some way
- Indicate special circumstances
- Tell the whole story
- Can affect the fee

Modifiers may be used to indicate:
- A service or procedure has both a professional and technical component.
- A service or procedure was performed by more than one physician and/or in more than one location.
- A service or procedure has been enhanced or reduced.

Modifiers may be used to indicate:
- Only part of a service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.
Choosing Modifiers

• Triage modifiers
  – Identify primary procedure
  – Identify modifier “-51 exempt” and “add-on” services.

Choosing Modifiers (continued)

• Triage modifiers
  – Identify laterality issues (modifier -50, HCPCS Level II modifiers for digits)
  – Identify services subject to multiple procedure reductions (modifier -51).
  – Identify bundled services (modifier -59)

Multiple Procedure Reduction

• Third Party Payer
  – Reimbursement policy
  – Pays first procedure at 100% and each subsequent procedure at 50-25%
  – Use a modifier –51 to identify which one gets reduced.
Choosing Modifiers

- Bilateral - 50 versus LT and RT
  - 50 Same procedure both sides
  - LT and RT different procedure on different sides,
    - Without LT and RT the procedures might be bundled if done on the same side
  - HCPCS Level II
    - E1 – E4 Eyes
    - F1 – F9, FA Fingers
    - T1 – T9, TA Toes

Choosing Modifiers

- Triage modifiers (continued)
  - Identify global surgery issues
    - Repeat procedure by same provider (-76)
    - Planned or staged procedure (-58)
    - Unplanned Return to OR for related procedure (-78)
    - Return to OR for un-related surgery (-79)
    - Incomplete global package (-54, -55, -56)

Choosing Modifiers

- Triage modifiers (continued)
  - Identify special circumstances
    - Unusual or difficult procedures (-22 modifier)
    - Reduced services (-52 modifier)
    - Discontinued services (-53 modifier)
Choosing Modifiers

• Triage modifiers (continued)
  – Identify multiple providers
    • Assistant at surgery (-80, -81, -82)
    • Co-surgery (-62)
    • Surgical team (-66)

Modifiers

• Assistant at surgery –80, -81, -82
  – Assistant at surgery
  – Minimal assistant at surgery
  – Assistant at surgery (when a qualified resident surgeon is not available)

Co-Surgery

• Single shared approach (e.g. Anterior Spine)
• Same Code used by ENT Surgeon and other surgeon, e.g. Neurosurgeon
• Fee is Split 62.5% each MD
Surgery Documentation Modifiers

• Need to state
  – Unusual circumstances (modifier –22)
    • Document amount of prolonged operative time from normal to achieve dissection due to abnormal anatomy.
    • Abnormal due to:
      – Irradiation
      – Infection
      – Scarring or adhesions
      – Prior surgery
      – Trauma
      – VLBW
      – Congenital anomaly
    • Drop to paper claim

Surgery Documentation Modifiers

• Need to state if procedure has been discontinued and why (Modifier -53)
  – Must have started procedure and anesthesia.
  – Usually there are adverse indications to the patient for procedure to continue, e.g. patient is too hypotensive to continue.
  – Reduction of fee is at provider discretion.

Surgery Documentation Modifiers

• Need to state if procedure or service was reduced, note what was reduced and why. (Modifier –52)
  – Part of procedure reduced or eliminated at discretion of physician, e.g. can not do full surgery because the part you planned to work on had been previously removed.
  – Reduction of fee at physician discretion.
Surgery Documentation Modifiers

• Need to state if return to the OR for prior surgery
  – Related Condition/Complication (modifier –78)
  – Unrelated condition (modifier –79)
  – Staged procedure at time of original surgery (modifier –58)

Surgery Documentation Modifiers

• Need to state – Circumstances for Distinct Procedure or Service (Modifier –59)
  – CPT® codes identified with parenthetical statement “(Separate Procedure)”
  – Denied when billed with another surgery performed by same surgeon in same session in
    same surgical site.
    • e.g. CPT® 69310 – Reconstruction of external auditory canal (meatoplasty) (eg, for stenosis
      due to injury, infection) (Separate Procedure)

Evaluation and Management Modifiers

• Modifier -25 versus –57

• Modifier –57 decision to perform surgery
  – Only for surgery with global components

• Modifier – 25 identifies “Unrelated” E/M encounter on same day as surgery.
Evaluation and Management Modifiers

• Modifier –32
  – Use when insurance mandates the service such as confirmatory consultation

Technical and Professional Splits

• Professional –26 Modifier
  – Provider does not have fiscal responsibility for overhead e.g. x-ray film, machine and technician paid by the hospital
• Technical Portion – Billed by the hospital to account for overhead.
  – Use HCPCS modifier -TC

Laboratory Modifiers

• Modifier 92
  – Alternative laboratory platform testing
  – for use with disposable tests for HIV
• Modifier 91
  – Multiple or repeat clinical laboratory tests
  – Do not use with Evocative suppression tests
  – Do not use for tests re-run to confirm results
## Evaluation and Management Basics

- **Who** –
  - Patient – New Versus Established
  - Provider – Same specialty, Same Practice
- **What** – Type of service
  - Consult versus New Patient
  - Outpatient Observation versus Same Day Admit and D/C
- **Where** –
  - Emergency Room
  - Nursing Home

## Levels of Service

- **3 Key Components**
  - History
  - Exam
  - Medical Decision Making

## Levels of Patient History

- **Four types of history**
  - Problem Focused (PF)
  - Expanded Problem Focused (EPF)
  - Detailed (D)
  - Comprehensive (C)
Levels of Patient Examination

• Four Types of Patient Examination
  – Problem Focused
  – Expanded Problem Focused
  – Detailed
  – Comprehensive

Levels of Medical Decision Making

• Four Types of Medical Decision Making
  – Straightforward
  – Low Complexity
  – Moderate Complexity
  – High Complexity

E/M Coding Conventions

• Key Components
  – 3 of 3 met and/or exceeded
  – 2 of 3 met and/or exceeded
Rule Number 1

- If the key component requirement is 3 of 3 and the key components do not line up e.g.
  - EPF History
  - Detailed Exam
  - MDM of low complexity
- Drop down to the lowest key component and match on that

Rule Number 2

- If the key component requirement is 2 of 3 and the key components do not line up e.g.
  - EPF History
  - Detailed Exam
  - MDM of low complexity
- Drop the lowest key component
- Then drop down to the lowest remaining key component and match on that

The GRID

<table>
<thead>
<tr>
<th>History</th>
<th>Exam</th>
<th>MDM</th>
</tr>
</thead>
<tbody>
<tr>
<td>PF</td>
<td>PF</td>
<td>STFWD</td>
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<tr>
<td>EPF</td>
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<td>Detailed</td>
<td>MOD</td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Comprehensive</td>
<td>High</td>
</tr>
</tbody>
</table>
Requires ALL THREE key components

- Office or Outpatient New Patients
- Hospital Observation Services
- Initial Hospital Care
- Office Consultations
- Initial Inpatient Consultations
- Emergency Department Services
- Comprehensive Nursing Facility Services
- Domiciliary Care New Patients
- Home Care New Patients

E/M Coding Conventions

- Time Based Services
  - Inherent in Codes
  - Floor time vs Face to Face Time
  - 50% or More Counseling and Coordination of Care
Encounters Dominated by Counseling or Coordination of Care

- Rule Number 3
- When counseling and Coordination of care dominate greater than 50% of the visit
- Time becomes the key or controlling factor

Subsection Specific Coding for E/M

- Office visits 99201-99215
  - MD office or hospital outpatient
  - New if not seen for 3 years by provider, provider of same specialty in group practice
  - 99211 – Can be billed by MD, not required to be present, e.g. nurse code

Subsection Specific Coding for E/M

- Hospital Observation visits 99217-99220
  - Hospital outpatient
  - Stay over night
  - Bundle all other E/M services for date of service into admission
  - Bill discharge next day
Standard Criteria for Consultations
• Three R’s of consultation:
  – Request
    An opinion or advice regarding evaluation and/or management of a specific problem is requested by another physician or appropriate source (unless patient-generated confirmatory consultation).

Standard Criteria for Consultations
• Three R’s of consultation:
  – Request (Continued)
    • A request from an appropriate requestor.
    • Medical necessity for consultation must be documented in the patient’s medical record.

Standard Criteria for Consultations
• Three R’s of consultation:
  – Render opinion
    • After evaluation of the patient in question the consulting physician writes a progress note rendering his or her opinion.
Standard Criteria for Consultations

• Three R’s of consultation:
  – Response to requestor
  • After the consultation is provided, the consultant prepares a written report of his/her findings, which is provided to the referring physician.

Subsection Specific Coding for E/M

• Consultations
  – Outpatient – 99241-99245
  – Inpatient – 99251-99255
Consultations and Medicare

- No longer recognized
- Utilize other appropriate E/M codes
- For hospital patients admitting physician must use modifier A1 on the initial admission code

When to use Inpatient Consultation Codes

- The patient has been admitted to one of the following:
  - A hospital
  - A skilled nursing facility
  - A partial hospitalization setting

Emergency Care

99281-99285

- 24 hour availability
- Hospital based
- No time assigned
- No distinction new vs. established
Critical Care
99291 - 99292

• Patient requires constant attendance
• Time based – services provided in the vicinity of the patient
• Bundled services
• Can be provided anywhere
• Can bill in addition to other E/M services

Preventive Medicine

• Use in absence of “disease”
• Well Check up
• No documentation parameters
• Select based on age
• Select based on new or established
• Set of counseling codes
  – Individual
  – Group
• Other
• No chief complaint

Anesthesia Global
Per AMA CPT

• Usual Pre-operative and Post-operative visits
• Administration of the anesthetic agent
• Intra-anesthesia care
• Usual monitoring, e.g. BP, ECG, Temp, Pulse, Oximetry, Capnography, and Spectrometry
Anesthesia Time

- Start Time
  - Time begin to prepare the patient for the OR
- End Time
  - Turn patient over to the PACU staff
- Time spent performing billable procedures – e.g. placement of Swan-Ganz
  - Do not include in anesthesia time

Anesthesia – Surgery
Cross Walk

- A one to many relationship
- Cross walk based on the following
  - Type of procedure open versus scope
  - Anatomic site of procedure

Anesthesia Modifiers

- P1 ---- 0 units
  - A normal healthy patient
- P2 ---- 0 units
  - Patient with mild systemic disease
- P3 ---- 1 units
  - Patient with severe systemic disease
Anesthesia Modifiers

- **P4** ---- 2 units
  - Patient with severe systemic disease that is a constant threat to life
- **P5** ---- 3 units
  - Moribund patient that will die without the surgery
- **P6** ---- 0 units
  - Patient is brain dead, organ donor

Qualifying Circumstances

- **99100** - Anesthesia for patient of extreme age, under one year and over seventy (List separately in addition to code for primary anesthesia)

- **99116** – Anesthesia complicated for total body hypothermia (List separately in addition to code for primary anesthesia)

Qualifying Circumstances

- **99135** – Anesthesia complicated by utilization of controlled hypotension (List separately in addition to code for primary anesthesia)

- **99140** – Anesthesia complicated by emergency conditions (List separately in addition to code for primary anesthesia)
**Formula for Base Units**

Base units + Time Units + P modifier units + Qualifying Circumstances units = total base units

**Formula for reimbursement**

1) Convert hours to minutes and minutes to time to units (1 unit = 15 minutes.)
   - Note in some areas of the country 1 unit = 10 minutes.
2) Add up Units per equation in slide above.
3) Multiply total units times conversion factor.

**Code Selection for Multiple Surgical Procedures**

- Can only list one anesthesia code per session
- Cross walk all surgical codes to anesthesia codes
- Choose anesthesia code with highest base units
- Can list other procedure codes for things like central line placement
MAC

- ASA Definition
- The term “Monitored Anesthesia Care” refers to cases:
  - Where a request is made to the anesthesiologist for anesthesia services provided to a patient who is receiving local or no anesthesia at all.
  - In these cases the anesthesiologist is providing specific services for non-surgical or non-obstetrical medical management.
  - This includes responsibilities for VS and the ability to administer anesthetics and/or provide other medical management of the patient as necessary.

Rules for MAC

1) The procedure is to be requested by the attending and the patient is to be notified.

2) The service shall include:
   - a) Performance of pre-anesthetic examination and evaluation.
   - b) Prescription of the anesthesia care required.
   - c) Personal participation or medical direction of the plan of care.

Rules for MAC

d) Continuous physical presence of the anesthesiologist or, in the case of medical direction, of the resident or nurse anesthetist being medically directed.

e) Proximate—presence or (in the case of medical direction) availability of the anesthesiologist for diagnosis or treatment of emergencies.
Rules for MAC

3) All institutional regulations pertaining to anesthesia services shall be observed, and all the usual services performed by the anesthesiologist shall be furnished, including but not limited to:
   a) Usual non-invasive cardiocirculatory and respiratory monitoring.
   b) Oxygen administration, when indicated

Rules for MAC

c) Intravenous administration of sedatives, tranquilizers, antiemetics, narcotics, other analgesics, beta-blockers, vasopressors, bronchodilators, anti-hypertensives, or other pharmacologic therapy as may be required based on the medical judgment of the anesthesiologist.

HCPCS Level II Modifiers

- Supervision – A Medicare Rule
  – Be familiar with of these
    • AA
    • AD
    • G8
    • G9
    • GC
**HCPCS Level II Modifiers**

- Supervision – A Medicare Rule
  - Be familiar with these
    - QK
    - QS
    - QX
    - QY
    - QZ

**Integumentary System**

- The Integumentary System pertains to:
  - SKIN
  - HAIR
  - NAILS

**10000’s**

- Need to know what layer you are working in
- Excision of Benign Lesions
  - “Excision is considered full thickness through the dermis”
  - Includes non-layered closure
    - Layered = dermal layer and one other deeper layer
      e.g. superficial fascia
10000’s

- CPT® code 11042 = Epidermis+Dermis+Hypodermis
- Debridement of skin of epidermis and/or dermis only, refer to 97597, 97598

Integumentary Coding Conventions

- Simple versus Complex
  - At provider discretion
  - Placement of a drain or packing material in the wound
  - The presence of an infection
  - The size and depth of the wound
  - Hemorrhaging, requiring the ligation of blood vessels to stop the bleeding
  - Extensive time involved in treating the lesion(s).

Integumentary Coding Conventions

- Debridement
  - How deep
  - Why done
    - Infection – 11000-11006 (do not bill with 97597-97602)
    - Fracture – 11010-11012
    - All other – 11042-11045, 97597, 97598 (do not bill with 97597-97602)
  - Do not overuse
Integumentary Coding Conventions

• Lesions
  – Shaving
  – Paring
  – Cutting
  – Scissoring skin tags
  – Excision
    • Benign
    • Malignant

  No Repair

  Simple Repair Included

Integumentary Coding Conventions

• Lesion Size
  – Prior to anesthesia
  – Prior to removal
  – Prior to formaldehyde
  – In centimeters
  – Measure diameter lesions
    • Measure length for repairs

Integumentary Coding Conventions

• Lesion Type
  – Wait for Pathology
Integumentary Coding Conventions

• Repairs - Simple and Intermediate
  – Depth
  – Location
  – Sum of lengths of an anatomic area

Integumentary Coding Conventions

• Repairs - Complex
  – Location
  – Length of defect or recipient site
  – Can code repair of donor site in addition
  – Tissue rearrangements (14000s) include the excision

Integumentary Coding Conventions

• Destruction
  – Any Method
  – See 54050 - 54065
Integumentary Coding Conventions

- Mohs
  - Surgeon and Pathologist in one
  - Code repair separately if graft
  - Code per stage, each gets up to 5 specimens
  - Code 17315 if greater than 5 specimens in any stage

Helpful Anatomic Terms
Integumentary

- Primary wound closure – This is the immediate closure of a wound usually with sutures, staples or tissue adhesive
- Secondary wound closure – This is delayed healing from the bottom up.

Helpful Anatomic Terms
Integumentary

- Necrotic – Refers to dead non-viable tissues
- Eschar – Refers to the thick dried crust that forms from the exudate that comes from a burn
- Hidradenitis = infection of the sweat gland
- Sebaceous cyst – A cyst filled with sebum and keratin. Sebum is the secretion of the oil gland at the base of a hair follicle
Musculoskeletal System

- Bones – Rigid connective tissue
  - Forms the skeleton
  - Provides chief means of support for the body
  - Provide the mechanism for motion
  - Protect vital organs
  - Factory for blood cells (Marrow)
  - Storage for calcium, phosphorus and magnesium salts

Bone Classification

- Long bones - femur
- Short bones – carpals, tarsals
- Flat bones - skull
- Sesamoid – protect tendons - patella
- Irregular - Zygoma

Musculoskeletal System

- Cartilage – Flexible connective tissue –
  - Non-vascular
  - Matrix comprised of:
    - Chondrocytes
    - Collagen
    - Proteoglycans
Musculoskeletal System

- Joints
  - A connection between two parts of the skeleton
  - Three types: Classified by the type of connective tissues at the articulating surfaces
    - Fibrous
    - Cartilaginous
    - Synovial

Musculoskeletal System

- Joints
  - Synovial - Most common
    - Articular cartilage covers the bone ends
    - Joint cavity lined with synovial membrane
    - Surrounded by a joint capsule of fibrous connective tissue
    - Usually reinforced by accessory ligaments

2000’s

- Divided by anatomical area
- Divided by bony, muscle and tendon work
- Divided by the area of a bone where the work is done e.g. shaft versus condyle
- Divided by intra-articular versus extra-articular
20000’s

• For each anatomical Area
  – Incision
  – Excision
  – Introduction or Removal
  – Repair Revision and/or Reconstruction
  – Fracture and/or Dislocation
  – Manipulation
  – Arthrodesis
  – Amputation
  – Other

Choosing CPT® Procedural Codes

• Determine Anatomical Site
• Determine Type of Surgical Access
• Determine what was done (see previous analysis of procedure note)
• Choose and apply the CPT® code that is most appropriate for what was done.

Choosing CPT® Procedural Codes

• Fracture reduction
  – Closed
  – Closed with manipulation
  – Percutaneous Fixation
  – ORIF – Open reduction internal fixation
  • Independent of the fracture type!
Miscellaneous Issues

• First Cast Included in Fracture Care
• Insertion and/or Application of external fixation generally includes removal by same surgeon with exception:
  • Removed under anesthesia
    – can be billed by separate provider.

Anatomical Locators

• Tendon - Teno
• Ligament - Dislocation
• Muscle – Myo
• Bone - Osteo

Helpful Anatomic Terms

Musculoskeletal

• Flexor tendon – A tendon that moves a body part by decreasing the angle between body parts.
• Extensor tendon – A tendon the straightens a body part.
• Proximal – Close to the point of origin or close to the trunk.
• Distal – Far from the point of origin or trunk.
Helpful Anatomic Terms
Musculoskeletal

• Superior – Close to the top or the head. Also referred to as cranial.
• Inferior – Closer to the bottom or the feet. Also referred to caudal.
• Lateral – To the outside, away from the middle.
• Medial – To the center or median plane that runs down the center of the body.

Bones of the Cranium

• What are they?
  1. Ethmoid
  2. Sphenoid
  3. Frontal
  4. Parietal (2)
  5. Occipital
  6. Temporal (2)

Flat Bones of the Skull

- Ethmoid
- Parietal Bone
- Sphenoid
- Temporal Bone
- Zygoma
- Occipital Bone
- Maxilla
- Mandible
Le Fort Fractures

- Le Fort Fractures (Mid Face Fractures) - Result from severe frontal blows. Frequently associated with intracranial damage, CSF leak.

Le Fort Fractures

- Types of Le Fort fractures
  - Le Fort I - tooth bearing portion separated from upper maxilla
  - Le Fort II - fracture across orbital floor and nasal bridge (pyramidal fracture)
  - Le Fort III - fracture across frontozygomatic suture line, entire orbit and nasal bridge (craniofacial separation)
Spine Surgery

- Know where the surgery is performed, e.g. vertebral body versus interspace
  - Work on the vertebral body = 22100-22226
  - Work at the interspace = 22548-22632

Vertebral Segment Versus Interspace

- “A vertebral segment describes the basic constituent part into which the spine may be divided. It represents a single complete vertebral bone with its associated articular processes and laminae.”

AMA CPT® Assistant, November 1999 page 11

Vertebral Segment Versus Interspace

- “A vertebral interspace is the non-bony compartment between two adjacent vertebral bodies which contains the intervertebral disk, and includes the nucleus pulposus, annulus fibrosus, and two cartilagenous endplates.”

AMA CPT® Assistant, November 1999 page 11
Spine Surgery

• Know what level
  – Cervical – 7
  – Thoracic – 12
  – Lumbar – 5
  – Sacrum – Fused

Component Billing for Spinal Surgery

• Identify anatomical approach (anterior vs. posterior)
• Identify number of levels on the spinal column that were treated.
  • Intervertebral versus vertebral body work
• Was anything removed (laminectomy, disectomy, old hardware)

Component Billing for Spinal Surgery

• Was a fracture treated?
• Was an arthrodesis performed?
  – How many levels?
  – What type of graft material?
  – Where was it placed?
• Was hardware provided, at how many levels, why and what kind?
### Spine Surgery

- Know your approach
  - Posterior – 22590-22632
  - Anterior – 22548-22585
    - Always includes surgical dissection from either the abdomen or the chest to the back
    - Often this is done by another surgeon = -modifier 62

### Spine Surgery

- Anterior Spine
  - RUC included surgical access in RVU
  - Corpectomy includes removing disk above and below
  - Codes are valued by RUC to include microdissection (63075-63078)
  - Approach is critical –
    - Thoracolumbar approach is separated in CPT® to account for extra work to take down the diaphragm (63087, 63088)

### Respiratory System

- Sinus Surgery
  - Scope Versus Open
  - Where is the “Canine Fossa”?  
  - Bilateral Versus Unilateral
  - Beware of the Turbinates
Respiratory System

• Larynx and Trachea
• Pharynx versus Larynx
  – Pharynx – Upper portion of the digestive tract between the nasal cavity and mouth from above and the esophagus from below
  – Larynx - Upper portion of the respiratory tract, the area where voice is produced between the pharynx and the trachea
  – Hypopharynx – Laryngopharynx – Lies below opening to larynx, extends to the esophagus
  – Trachea – Tube from larynx to thorax - divides into the left and right main stem bronchi

Respiratory System

• Larynx and Trachea
  – Open Versus Scope
  – What is the rule with diagnostic and therapeutic scopes performed in the same operative session?

Respiratory System

• Thoracic Cavity
  – Two lateral compartments each with the pleura and lungs
  – One central cavity called the mediastinum
• Parietal Pleura – Adherent to the thoracic wall, mediastinum and the diaphragm
• Visceral Pleura – The outer covering of the lung parenchyma
• The Vacuum – Pleural Cavity – Potential space between the Parietal and Visceral Pleura
**Coding for Intracardiac Procedures**

- Always enter the thorax for open procedures
- Loose negative vacuum that allows the lungs to expand
- Chest tube is always required and as such not separately billed
  - See tube thoracotomy 32551

**Cardiac Procedures**

- Know where the valves are all the CPT® codes are divided accordingly:
  - 33400-33417 = Aortic valve
  - 33420-33430 = Mitral Valve
  - 33460-33468 = Tricuspid valve
  - 33470-33478 = Pulmonary valve
Blood Flow Through the Heart

Cardiac Procedures

- Know what side of the heart you are starting on right versus left for Heart Catheterizations
  - Swan Gantz Cath = Right Heart - 93503
  - Retrograde Left heart cath indicates coming back towards the heart from the brachial, axillary or femoral artery - 93531
- All blood flow through these arteries is usually away from the heart

Cardiac Procedures

- Can’t get from right to left with normal anatomy
  - 93530 is for right heart cath for congenital anomalies
  - +93462 is for a left heart catheterization, punching a hole in the atrial septum
CABG
• CPT® codes are separate for
  – Vein graft only (33511 – 33516)
  – Mixed arterial (33533 – 33536) and venous
    grafting combined (33517 – 33523)
• What is + 33530 used for?

Vascular Surgery
• Includes
  – Establishing Inflow and Outflow
  – Sympathectomy when done
• Direct repair (35001 – forward) versus
  Endovascular Repair (34800 – 34832)
• Arterial Versus Venous
• Ruptured versus non-ruptured

Vascular Surgery
• Aneurysm
  – Ruptured versus non-ruptured
  – Thoracic see 33860-33863
  – Intracranial see 61700
  – Procedures include preparation for anastomosis
Vascular Surgery

- By-pass Surgery
  - Harvest
    - Single segment 33500
    - > One segment see 35682 – 35683
    - Add-on codes
  - Need to know two points of bypass from what point to what point e.g. Fem-Pop
  - Know type of graft material

Hemic and Lymph

- Spleen
- Bone Marrow
- Lymph Nodes
  - Take care not to unbundle

The Digestive System

- Esophagus
- Liver
- Stomach
- Gall Bladder
- Pancreas
- Transverse Colon
- Small Intestines
- Ascending Colon
- Descending Colon
- Sigmoid Colon
Digestive System

- Feeding tube from mouth to anus
- Smooth muscle
- Involuntary movement = peristalsis
- Processes food and fluids for use by the body
- Secretes digestive fluids
- Absorption of nutrients
- Expel solid waste

40000s

- Listed from mouth to anus
- Laparoscopic versus open procedures
  - These are not interchangeable
  - Know the point and method of access
- Includes secretory organs of digestion
  - Liver/gallbladder – Bile
  - Pancreas – Enzymes for proteolysis

40000s

- With endoscopy need to know where the MD started and where he/she ended up to choose the correct code.
  - What is the difference between 43250 and 44365?
  - What is the difference between 45308 and 45383?
**40000s**

- **Location, location, location!**
- CPT code 43250 enter through the mouth and biopsy can be done in the esophagus, stomach, duodenum and/or first part of the jejunum.
- CPT code 44365 – Enter through a stoma and all work at level beyond the second portion of the duodenum.

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**40000s**

- **Location, location, location!**
- CPT code 45308 enter through the rectum and biopsy can be done in the sigmoid colon.
- CPT code 45383 – Enter through rectum and all work at level above the sigmoid portion of the rectum. Colonoscopy usually takes place past the splenic flexure.

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**Multiple Procedures via the Scope**

- If remove multiple lesions of the colon by distinct techniques can bill per technique, NOT per lesion
  - 45308
  - 45309 -51
  - 45320 -51
**Endoscopy**
- Proctosigmoidoscopy
- Sigmoidoscopy
- Colonoscopy

**Sialography**
- Injection Procedure
  - 42550
- Radiology Procedure
  - 70390

**Helpful Vocabulary Digestive**
- Vermilion Border – The dark area of the lips between the intraoral labial mucosa and the extra oral junction with the skin.
- Buccal – Pertains to the cheek
- Vestibule – Small cavity or space at the entrance (applies to mouth, ear and vagina)
Helpful Vocabulary Digestive

• Frenum – Folds of mucous membrane extending from gums to lips
• Palate
  – Hard – The anterior bony portion of the palate comprising the floor of the nasal cavity and the roof of the mouth
  – Soft – Refers to the posterior part of the palate, a muscular partition between the naso and oropharynx. Also forms an incomplete septum between the mouth and the oropharynx.

Helpful Vocabulary Digestive

• ERCP – Endoscopic Retrograde cholangiopancreatography
• Retrograde – Going against the flow
• Roux en Y anastamosis – A connection of the lower end of the jejunum to the stomach with a second connection of the upper jejunum back on itself a distance from the first connection, forms a Y.

Hernia Repair

• Patient Age
• Location of the Hernia
• Incarcerated - Trapped
• Strangulated – A hernia that is trapped and can’t be reduced. As a result the circulation has been cut off and gangrene will result if not repaired
• Reducible – Hernia can be placed back through the connective tissues it protruded through.
• Unilateral in nature – need –50 modifier if do both sides
Hernia Repair

- Unilateral in nature – need –50 modifier if do both sides
- Only report mesh if incisional hernia repair otherwise included
- Need to know if initial or recurrent

Renal Transplantation

- Renal autotransplantation includes reimplantation of autograft as primary procedure
  - Also with secondary extra-corporeal procedures reported with modifier -51
  - See 50380 and applicable secondary

Ureter and Pelvis

- Insertion and removal of temporary ureteral catheter (52005) during diagnostic or therapeutic cystourethroscopic with ureteroscopy and or pylescopy is included in 52320-52355 and should not be reported separately.
Renal Allotransplantation

- Involves three distinct components
  - Cadaver donor nephrectomy, unilateral or bilateral
  - Backbench work
  - Recipient renal allotransplantation

Urodynamics

- Multiple procedures use modifier -51
- Most procedures in section imply services are provided by or under the direct supervision of a physician and all supplies and equipment are provided by physician
- Check your guidelines
- Use modifier -26 when physician interprets the results, operates equipment only

Vulva, Perineum, Introitus

- Simple
  - Removal of skin and superficial subq tissues
- Radical
  - Removal of skin and deep subq tissues
- Partial
  - Removal of less than 80% of the vulvar area
- Complete
  - Removal of greater than 80% of the vulvar area
Maternity Care and Delivery

- Antepartum includes initial and subsequent history, exam, recording of wt, bp, fetal heart tones, routine UA and monthly visits up to 28 weeks, biweekly visits to 36 weeks and weekly visits until delivery.
- Additional visits within this time period can be coded separately

Delivery services include admission to hospital, H&P, mgmt of uncomplicated labor, vaginal delivery, or cesarean delivery.
- Medical problems complicating labor and delivery mgmt may require additional resources in the Medicine and E/M sections

Postpartum care includes hospital and office visits following delivery
- Medical complications of pregnancy should be coded in the Medicine and E/M services section (eg, cardiac problems, diabetes, hypertension, toxemia, hyperemesis, per-term labor etc)
Skull Base Surgery

• Surgical mgmt of lesions involving the skull base often requires skills of several surgeons of different surgical specialties working together or in tandem. Usually not staged because of the need for definitive closure of the dura, subcutaneous tissues and skin to avoid infections.

Categorizations

• Approach Procedure
  – Described according to anatomical area involved (anterior, cranial fossa, middle cranial fossa, posterior cranial fossa, and brain stem or upper spinal cord
• Definitive Procedure
  – Describes the repair, biopsy, resection, or excision of various lesions and when appropriate primary closure of dura, mucous membranes and skin
• Repair/reconstruction
  – Reported separately if extensive dural grafting, cranioplasty, local or regional myocutaneous pedicle flaps or extensive skin grafts

Radiology

• Supervision and Interpretation
  – When procedure is performed by two physicians the radiologic portion of the procedure is designated as “radiologic supervision and interpretation”
  – When physician performs both the procedure and provides imaging supervisions and interpretation a combination of procedure codes outside the 70000 series and imaging supervision and interpretation codes are to be used
Administration of Contrast

- “with contrast” represents contrast material administered intravascularly, intra-articularly or intrathecally
- Intra-articular injections use appropriate joint injections
- Injection of intravascular contrast material is part of the “with contrast” CT, CTA, MRI and MRA procedures
- Oral and/or rectal contrast administration alone does not qualify as a study “with contrast”

Written Report

- A written report signed by the interpreting physician should be considered an integral part of a radiologic procedure or interpretation

Vascular Procedures

- Aorta and Arteries
  - Selective vascular catheterizations should be coded to include introduction and all lesser order selective catheterizations used in the approach
  - Additional second and/or third order arterial catheterization within the same family of arteries supplied by a single first artery should be expressed by 36218 or 36248
• Additional first order or higher catherizations in the vascular families supplied by a first order vessel different from a previously selected and coded family should be coded separately coded using the conventions described above

• Angiography performed in conjunction with therapeutic trascatheter radiologic supervision and interpretation services see the Radiology Transcatheter Procedures guidelines

• Diagnostic angiography codes should NOT be used with interventional procedures for:
  – Contrast injections, angiography, roadmapping and/or fluoroscopic guidance for the intervention
  – Vessel Measurement
  – Post-angioplasty/stent angiography
  – This work is captured in the radiologic supervision and interpretation codes

• Diagnostic angiography performed at the time of an interventional procedure is separately reportable if:
  – No prior catheter-based angiographic study is available and a full diagnostic study is performed, and the decision to intervene is based on the diagnostic study OR
  – A prior study is available but as documented in the medical record:
    • The patient’s condition with respect to the clinical indication has changed since prior study OR
    • There is inadequate visualization of the anatomy and/or pathology OR
    • There is clinical change during the procedure that requires new evaluation outside the target area of intervention
Diagnostic Ultrasound

- Examinations require permanently recorded images with measurements when measurements are clinically indicated
- Evaluation of vascular structures using both color and spectral Doppler is separately reportable.
  - Color doppler alone when performed for anatomic structure identification in conjunction with a real-time ultrasound examination is not reported separately.

Laboratory Panels

- All or nothing
  - Code to panel if have all the components
  - If fall short of required components bill each test individually
  - Code components in excess of panel separately
  - No professional component

Drug Testing

- Drug Screen (80100 – 80103)
- Therapeutic Drug Level (80150 – 80299)
- Evocative Suppression Testing
  - Includes serial blood draws (drug x 3)
  - Can code drugs separately
  - Can code administration separately
Pathology Consultation

• Per Medicare Carriers Manual, Chapter 12, Section 60.D.
  – Requested by patient’s attending
  – Relate to test result
    • Clinically abnormal in view of patient’s condition
  – Written report in patient medical record
  – Requires exercise of medical judgment by the consultant physician.

Encounters NOT Considered Pathology Consultations

• Routine conversations laboratory director has with attending physicians re-test results (when 4 criteria are not met)
• Pathologists contact attending to recommend additional tests.
• Attending calls Pathologist to inquire about need for further testing.

Coding Pathology Consultations

• 80500 Limited
  – Does not require a medical records review
• 80502 Comprehensive
  – Requires a review of patient history and medical records
Intraoperative Pathology Consultations

- At request of another physician
- Determine presence or absence of diseased tissue
- During surgery
- With frozen section versus without
- Help surgeon determine surgical course

Coding Intraoperative Pathology Consultations

- **88329 Without Frozen Section**
  - Gross examination without concurrent microscopic exam

Coding Intraoperative Pathology Consultations

- **88331-88332 With Frozen Section**
  - Gross examination performed
  - Freeze specimen to -20 to -70 C
  - Make slices with microtome
  - Stain if appropriate
  - Examine microscopically
Can a Pathologist Use E/M codes for a Consultation

- Not unless the key components are met
  - Most Pathology consultations do not have face to face patient contact.
- Highly unlikely this would happen
- Not usually medically necessary

Urinalysis

- Automated
- Manual
- With microscopy
- Without microscopy

Laboratory Vocabulary

- Analyte – Substance for analysis can be chemical or bodily substance
- Qualitative – Is it there?
- Quantitative – How much is there?
Laboratory Vocabulary

• **Chromatography** - The separation of chemical substances and particles by differential movement through a two-phase system.
  - The substances least absorbed are least retarded and emerge the earliest; those more strongly absorbed emerge later.

Chemistry

• Test is based on the analyte under review
• Automated
• Calculated
• Methodology versus Analyte
• Can be any bodily substance if not specified

DNA Analysis

83890 - 83913

• Analysis of nucleic acids
• Building blocks for DNA
• Code each procedure performed
• This set does not code based on analyte
Hematology and Coagulation

• Measure blood cells and clotting factors
• Automated versus manual
• Depends on what was counted
• Transfusion codes separate

Immunology

• Antigens – A substance that provokes an immune response, that can be demonstrated after a period of latency
• Antibodies – The specific immune globulins produced in response to a specific antigen

Non-Specific Immunology Codes

• If specific analyte is not listed look to method
  — 86171 Complement Fixation test
  — 86255 Florescent Antibody
  — 86317 Immunoassay, quantitative
  — 86318 Immunoassay, qualitative
  — 86320 Immunelectrophoresis
  — 86329 Immunodiffusion
  — 86403 Particle Agglutination, screen
  — 86406 Particle Agglutination, titer
Microbiology
- Bacteriology
- Mycology
- Parasitology
- Virology

Microbiology
- Based on source of specimen
- Based on type of culture
  - Anaerobic
  - Aerobic
- Susceptibility studies 87181 – 87190

Microbiology
- Antigen detection Immunofluorescent technique 87260-87299
- Infectious agent antigen by enzyme immunoassay 87301 – 87451
- Infectious agent by nucleic acid 87470 - 87801
Cytopathology

- Study of disease changes in individual cells or a specific cell line
  - Pap smear
  - Check various methodologies prior to selecting a code

Surgical Pathology

- Gross
- Microscopic
- TC/PC Split
- Unit of service is the specimen
- Special Stains
  - Add on codes

Other Laboratory Procedures

- Transcutaneous Bilirubin
- Gastric studies
- Fertility studies
**Immune Globulins**

- Identify Immune Globulin only
- Code injection separately

**Vaccines and Toxoids**

- Must report injection in addition to the vaccine
- If a combination vaccine given must bill combination code

**Therapeutic and Diagnostic Injections**

- IV infusion includes IV start
- IV – Intravenous
- IA – Intra-arterial
- IM – Intra-muscular
Therapeutic and Diagnostic Injections

Hydration

Therapeutic, Prophylactic and Diagnostic Injections and Infusions Injections

Psychiatry

- Time based
- Place of service specific
- Type of service
  - Interactive
  - Insight oriented
  - Psychoanalysis

Dialysis

- ESRD
  - Monthly Capitation
    - Age dependent
  - Less than a full month
    - Age dependant
    - Pro – rate the monthly
  - Hemodialysis versus Peritoneal
Gastroenterology

- Gastric intubation without the scope
- A variety of GI studies
  - Acid perfusion
  - Saline Load test
  - Gastric intubation

Ophthalmology

- Visits
  - New versus Established
  - Intermediate versus Comprehensive
    - Pay attention to descriptions
  - Special Services
    - Refraction not included in the general exam
    - Visual fields test for cupping of optic nerve in glaucoma
    - Tonometry – measures intraocular pressures

Special Otorhinolaryngologic Services

- Vestibular Tests
  - Tests movement and balance
    - In vestibular testing nystagmus results from physiological stimuli to the labyrinth e.g. rotatory, caloric, compressive, or galvanic
  - Audiologic Function tests
    - Tests hearing
Cardiology

- Invasive
  - Cardiac Catheterization
  - EPS
  - Pacemakers

Diagnostic

- Medical Necessity
  - Chest Pain
  - MI (410.XX)
  - Abnormal ECG
  - Abnormal Stress ECG
  - Abnormal Stress Echo

Therapeutic

- Medical Necessity
  - Native Coronary Artery Disease
  - Autologous Vein Graft
  - Donor vein graft
  - Autologous arterial graft
Component Billing

- Access
  - One per side per session
- Injection
  - Multiples possible
- Supervision and Interpretation
  - Once each per session

Access

- Left Heart
  - Femoral
  - Brachial
  - Axillary
- Right Heart
  - Subclavian Vein
  - Internal Jugular Vein

Pulmonary

- Function Testing
- Breathing Treatments
- Vent settings
Allergy and Immunology

• Testing
  – Route – Intra-dermal versus percutaneous scratch tests
  – Methodology – Photo tests
• Provision of allergenic extract
  – 95120 - 95134
• Provision of injection only
  – 95115 - 95117

Sleep Testing

• Sleep Studies VS Polysomnography
  – Polysomnography includes sleep staging, includes
    • 1-4 lead EEG
    • EOG – electro-oculogram
    • EMG – Submental electromyogram
  – Check subsection guidelines for additional parameters

The Basics

• What does ICD-9-CM Stand for?
  – International Classification of Diseases 9th revision, Clinical Modifications
• Who writes ICD-9?
  – WHO
• Who puts on the fourth and fifth digits?
  – National Institute for Health Statistics
ICD-9-CM Book Organization

• What is in Volume I?
  – Tabular list of diseases, conditions and situations

• What is in Volume II?
  – Alphabetic Index

• What is in Volume III?
  – ICD-9-CM Procedure Codes

The Tabular List

• There are 17 chapters
  – Chapter 1 - Infectious and Parasitic Diseases (001-139)
  – Chapter 2 – Neoplasms (140 – 239)
  – Chapter 3 – Endocrine, Nutritional and Metabolic Diseases, and Immunity disorders (240-279)

The Tabular List

• There are 17 chapters
  – Chapter 4 –Disease of Blood and Blood -forming Organs (280 – 289)
  – Chapter 5 – Mental Disorders (290-319)
  – Chapter 6 – Diseases of the Nervous System and Sense organs (320-389)
### The Tabular List

- There are 17 chapters
  - Chapter 7 – Diseases of the Circulatory System (390 – 459)
  - Chapter 8 – Diseases of the Respiratory System (460 – 519)
  - Chapter 9 – Diseases of the Digestive System (520 - 579)

### The Tabular List

- There are 17 chapters
  - Chapter 10 – Diseases of the Genitourinary System (580 -629)
  - Chapter 11 – Complications of Pregnancy, Childbirth and the Puerperium (630-679)
  - Chapter 12 – Diseases of Skin and Subcutaneous Tissue (680 - 709)

### The Tabular List

- There are 17 chapters
  - Chapter 13 – Diseases of the Musculoskeletal System and Connective Tissues (710 - 739)
  - Chapter 14 – Congenital Anomalies (740-759)
  - Chapter 15 – Certain Conditions Originating in the Perinatal Period (760-779)
The Tabular List

- There are 17 chapters
  - Chapter 16 – Symptoms, Signs, and Ill-Defined Conditions (780 - 799)
  - Chapter 17 – Injury and Poisoning (800 – 999)

The Tabular List

- There are 2 Supplementary Classifications
  - V Codes – Supplementary Classification of Factors Influencing Health Status and Contact with Health Services.
  - E Codes – Supplementary Classification of External Causes of Injury and Poisoning

Appendices to Volume 1

- Appendix A – Morphology of Neoplasms
- Appendix C – Drugs Classified by the AHFS and the ICD-9-CM equivalents
- Appendix D – Classification of Accidents According to Agency
- Appendix E – List of Three Digit Categories
Volume II The Alphabetic Index

Is it ever okay to code from the Index?

NO!

- Name the 2 main tables found in the Alphabetic Index.
  - Neoplasms
  - Hypertension

Vocabulary for the Neoplasm Table

- Neoplasm
- Benign
- Malignant
- Primary
- Secondary
- In Situ
- Uncertain Behavior
- Unspecified

Vocabulary for the Hypertension Table

- Malignant
- Benign
- Unspecified
### Hypertension – Other Places in ICD-9-CM

- Elevated BP –
- Pregnancy –

### Vocabulary for Table of Drugs and Chemicals

- Accidental
- Therapeutic Use
- Suicide
- Assault
- Undetermined

### Neoplasms

- Distinguish the type of Neoplasm
- Determine reason for the encounter
  - If for treatment of malignancy e.g. surgery then code malignancy as primary.
  - If for radiation or chemotherapy then code those as primary and cancer as secondary*  
  
* When chemotherapy or radiation are administered in same admission as initial diagnosis and/or surgery the malignancy is primary.
Neoplasms...continued
• In absence of tumor code from the V10 set for “history of.”
• Treatment of complications for the malignancy or associated therapy are coded as primary and malignancy secondary.

Neoplasms...continued
• When treatment is aimed at the secondary site this is coded as primary.*
  * This is true even if the primary malignancy still exists.
• Patients returning for a wide excision of a previously removed malignancy should have the malignancy as primary (even in the absence of finding for further malignancy).

Absent Organs and Other Body Parts...acquired
• New Sub-Category of Codes in 1997.
• V45.71...Acquired Absence of Breast
• Surgical Follow-up post mastectomy
Burns

• First - Degree – Superficial burns through only the epidermis are referred to as first degree. The area of the burn is usually red, very painful and blanches to touch.

• First - degree burns are not included in the estimates of TBSA burned.

Burns

• Second - Degree – A partial thickness burn involving the epidermis and the dermis.

• Usually blister immediately and fill with a fluid/serous exudate.

• The nerve endings are exposed making the extreme pain a characteristic hallmark of their presentation.

Burns

• Third - Degree – Full thickness burns involves the epidermis, dermis and varying levels of the subcutaneous and underlying structures.
Burns

• Some systems that classify burns actually classify burns involving the muscles, tendons and bones as fourth degree.

• In some burn centers fourth degree burn designation is reserved for burns stemming from an electrical injury.

• ICD-9-CM does not currently have this designation.

• There are two sub-classifications of burns beyond full thickness involving deep necrosis with or without loss of a body part.

• “Classify Burns of the same local site but of varying degrees to the subcategory identifying the highest degree recorded in the diagnosis”

(AHA Coding Clinic, March-April 1986 page 9-10)
Rule of Nines

- Used to determine percent of body surface area (BSA) burned.
  - Head and Neck = 9%
  - Each arm = 9%
  - Each leg = 18%
  - Anterior trunk = 18%
  - Posterior trunk = 18%
  - Genitalia = 1%

AHA Coding Clinic, March - April 1986 page 9-10

Burns...continued

- Assign codes from category 948 when:
  - The site of the burn is not known
  - Data is needed to evaluate mortality statistics
  - When greater than 20% of BSA has burns classified as third-degree

Burns...continued

- Assignment of a fourth digit to a 948.XX code indicates the total BSA involved in a burn.

- Assignment of a 5th digit to a 948.XX code will indicate what portion of the total BSA burned sustained a third degree burn.
Burns...continued

- Late Effects of Burns (906.5-906.9)
  - Code effect first...e.g. keloid scarring (701.4)
  - Code the late effect relating the problem back to the burn (e.g. 906.6 Late effect of burn to wrist or hand)
  - Code external cause of injury (e.g. E929.4 Late effects of accident caused by fire)

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Burns...continued

- Use a late effect E code with a late effect burn code.
- Use a current external cause of injury code with a current injury.
- Can have both in same encounter as burns can heal at different rates based on locale and depth.

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Late Effects

- Late effects should be coded according to the nature of the residual condition or late effect.
- Two codes are usually required when coding late effects.
- The residual condition is coded first.
**Late Effects**

- The codes for the cause of the late effect (905-909) are coded as secondary.
- Reference the appropriate late effect of an external cause with an E code.
- Coders should be aware that there are no late effect E codes for infectious conditions.

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**Adverse Effects**

- Adverse effects are coded with the manifestation of the drug reaction first.
- The appropriate E code from the E930-E949 series.
- The E930-E949 series are not optional; one of these must be coded to accurately depict the substance responsible for the adverse effect. *(AHA Coding Clinic, November-December 1984, pages 14-15.)*

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**External Causes of Injury and Poisoning**

- The “E” codes are used to describe external causes of injury, poisonings or other untoward effects.
- E Codes are categorized by the type of external cause of injury or poisoning.
External Causes of Injury and Poisoning

The major categories of E codes are listed below in the same order as ICD-9-CM.

- Transport Accidents
- Accidental Poisoning
- Misadventures during surgical and medical care
- Medical and surgical procedures as the cause of an abnormal reaction or later complication without mention of initial misadventure
- Accidental falls
- Accidents caused by fire and flames
- Accidents due to natural and environmental factors.
- Accidents caused by submersion, suffocation and foreign bodies
- Late effects of accidental injury

External Causes of Injury and Poisoning

The major categories of E codes...continued.

- Drugs, medicinal, and biological substances causing adverse effects in therapeutic use.
- Suicide and self-inflicted injury
- Homicide and injury purposely inflicted by other persons.
- Legal intervention
- Injury undetermined whether accidentally or purposely inflicted.
- Injury resulting from the operations of war

E Codes

- Never primary
- Never alone
Trauma

• Use External Cause of Injury Code when applicable.
  – Alerts coder to look at auto or workers’ comp claim versus submitting to medical and getting denied.
  – Alerts third party to need for multiple services and multiple provider scenario.

GOLDEN RULE

ICD-9-CM Coding

Code to the highest level of specificity

General Rules

• Code to appropriate fourth or fifth digit
• Do not code from “Probable,” “Suspected,” or “Rule Out” diagnoses.
• Avoid NOS and NEC
• Keep Superbill updated
• Documentation and Claim must support each other
What to Do Without a Definitive Diagnosis?

- Code to symptoms or administrative reason for visit.
- Answer the question “Why Now” for each encounter.