Coding Terminology
Getting Back To The Basics

ASCRS – ASOA Symposium & Congress
Administrator Program
Boston, Massachusetts
April 25-29, 2014

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Financial Interest

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Getting Back To The Basics

• Course includes coding basics typically used in ophthalmology & optometry
  – Documentation presumed complete
Coding Resources

- International Classification of Diseases (ICD)
  - ICD-9-CM (Clinical Modification)
  - ICD-10-CM (Clinical Modification)
- Healthcare Common Procedure Coding System (HCPCS)

Coding Resources

- Center for Medicare & Medicaid Services (CMS) – www.cms.gov
  - National Coverage Determinations (NCDs)
- Medicare Administrative Contractors (MACs) – Regional
  - Local Coverage Determinations (LCDs)

CPT Coding Book

  - American Medical Association (AMA)
    - 5 Digit Numbers 00100-99499
  - Covers all medical procedures
    - Main Categories
      - Anesthesia
      - Surgery by Bodily System
      - Radiology
      - Pathology & Laboratory
      - Specialty Specific Codes
      - Examination, Evaluation & Management
      - Category II & Category III
### CPT Organization

- Introduction, Guidelines & Explanations
- Evaluation & Management Codes
  - Clinic, Hospital, SNF, ER, etc.
  - Documentation required for each LOS
- Anesthesia
  - Subcategorized by Surgery Site
- Surgery by Bodily System
  - Subcategorized by Complexity, Site, Method, Material or Disease/Injury

### CPT Book

- Additional Information
  - Modifiers
  - Place of Service Codes
  - Guidelines & Explanations
  - Code Additions & Deletions
  - Clinical Examples
  - Anatomical Illustrations (Professional Edition)

### Using CPT

- Determine Primary Procedure Performed
  - Exam, Surgery, Test, Site, Tissues, Closure
- Use Introduction to Sections First
  - If it fits: consider one of the codes in the set
  - If it doesn’t fit: move to next Code Set
- Primary Word or Phrase (not indented)
  - Semi-colon leads to additional explanation
  - Next entry begins with the previous semi-colon
CPT Example

- 67036 Vitrectomy, mechanical, pars plana approach;
  - 67039....with focal endolaser photocoagulation
  - 67040....with endolaser pan retinal photocoagulation
  - 67041....with removal of preretinal cellular membrane
  - 67042....with removal of internal limiting membrane of retina
  - 67043....with removal of subretinal membrane includes, if performed, intraocular tamponade and laser photocoagulation

Ophthalmology Codes

- Most Exam Codes
  - 92002, 92012, 92004, 92014
    - Found in Medicine/Ophthalmology Section
  - 99201, 99202, 99203, 99204, 99205
  - 99211, 99212, 99213, 99214, 99215
  - 99xxx for Hospital, ER, SNF, etc.
    - Found in E&M coding section
- Most Surgery Codes 65091 – 68899

Ophthalmology Codes

- Integumentary Surgery
  - 10021-19499
- Musculoskeletal Surgery
  - 20005-29999
- Nervous System Surgery
  - 61000-64999
- Radiology/Diagnostic Ultrasound
  - 70010-77022
- Pathology & Laboratory/Chemistry
  - 82000-84999
- Category III Codes – Emerging Technology
Intermediate Eye Exam

- CPT Codes 92002 & 92012
  - Requirements from CPT are usually found verbatim in Medicare Local Coverage Determinations (LCDs)
    - History
    - General Medical Observation
    - External & Adnexal Exam
    - Other Procedures as Necessary

Comprehensive Eye Exam

- CPT Codes 92004 & 92014
  - Requirements from CPT are usually found verbatim in Medicare Local Coverage Determinations (LCDs)
    - History
    - Evaluation of the complete visual system
    - General Medical Observation
    - External & Adnexal Exam
    - Gross Visual Fields
    - Basic Sensorimotor exam

Comprehensive Eye Exam

- “It often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry. It always includes an initiation of diagnostic and treatment programs.”
**E&M Codes**

- Evaluation & Management Codes (E&M)
  - History
    - History of Present Illness (HPI)
    - Review of Systems (ROS)
    - Past, Family & Social History (PSFH)
  - Exam
  - Medical Decision Making
    - Diagnosis & Management Options
    - Amount & Complexity of Data Reviewed
    - Level of Risk

**History of Present Illness**

- History of Present Illness (HPI)
  - Location
  - Quality
  - Severity
  - Modifying Factors
  - Context
  - Duration
  - Associated Signs or Symptoms
  - Timing

**Review of Systems**

- Constitutional (fever, weight loss etc.)
- Eyes
- Ears, nose, mouth, throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Integumentary (skin and/or breast
- Neurological
- Psychiatric
- Endocrine
- Hematologic/lymphatic
- Allergic/immunologic
Past, Family, Social History

- **Past History**
  - Prior illnesses, injuries, surgeries, hospitalizations, current medications, allergies
- **Family History**
  - Presence or Absence of hereditary disease
- **Social History**
  - Mental status, living arrangements, occupation history, use of alcohol, drugs, tobacco

Exam

- **Visual Acuity**
- **Gross Visual Fields**
- **Ocular Motility**
- **Conjunctivae**
  - Bulbar & Palpebral
- **Pupils & Iris**
  - Shape, light response
- **Cornea**
  - Epithelium, stroma, endothelium & tear film
- **Intraocular pressure**
- **Anterior chamber**
  - Depth, cells, flare
- **Lenses**
  - Clarity, anterior/posterior capsule, cortex & nucleus
- **Optic discs**
  - C/D ratio, appearance
- **Posterior segment**
  - Retina & Vessels
- **Mental Status**
  - Oriented to person, place & time

* Must be dilated unless contraindicated

Medical Decision Making

- **Data to be Reviewed**
  - Old or New
  - Internal or External
    - Tests ordered
    - Review of records
  - Levels
    - Minimal (1)
    - Limited (2)
    - Moderate (3)
    - Extensive (4)
E&M Coding

- New Patient
  - 99201, 99202, 99203, 99204, 99205
  - Must meet or exceed all 3 parts of the service
    - History, exam, medical decision making
      - Lowest of any part determines the exam level
- Established Patient
  - 99211, 99212, 99213, 99214, 99215
  - Must meet or exceed all 2 parts of the service
    - History, exam, medical decision making
      - Lowest part is discarded
      - Lowest of remaining 2 determines the code

Modifiers

- Modifiers provide additional information to the payer
  - Only append to CPT codes
  - Make services payable when otherwise not
  - Specify location
  - Multiple modifiers may apply
    - Modifier that affects payment is appended first

Modifiers -RT & -LT

- Indicates laterality
  - Which side of the body the procedure or service occurred
- Two line entry may be required for bilateral procedures
  - As opposed to the bilateral modifier -50
- Always appears last in a string of modifiers
Modifiers -E1, -E2, -E3, -E4

- Eyelid modifiers
  - E1 – Left Upper Eyelid
  - E2 – Left Lower Eyelid
  - E3 – Right Upper Eyelid
  - E4 – Right Lower Eyelid
- Only applies if service is paid per eyelid (e.g., punctal occlusion)

Modifier -22

- Increased Procedure Services
  - Work required was substantially greater
  - Documentation must support the increased work
  - Doesn’t apply to exam codes
  - Requires medical record with claim
  - Contractor determines payment if any

Modifier -24

- Unrelated E&M Service by the Same Physician During Post-operative period
  - Applies to both minor and major procedures
  - Applies to:
    - Problems in the fellow eye
    - Problems un-related to the surgery (underlying disease)
    - Off-cycle visit
### Modifier -25

- Significant, Separately identifiable E&M Service by Same Physician on the same day as minor procedure (0-10 day post-op)
  - It is NOT the decision for surgery
  - Does not apply to diagnostic tests
  - Does not require a different diagnosis
  - The exam must be “above and beyond the usual pre-operative & post-operative care”
  - Audit target

### Modifier -TC

- Identifies the technical component of diagnostic tests
  - The performance of the test usually by allied personnel
  - Does not apply to tests performed only by the physician (e.g., gonioscopy, extended ophthalmoscopy)
  - Not routinely reported separately except for in-patients (e.g., skilled nursing facility SNF)

### Modifier -26

- Identifies the professional component of diagnostic tests
  - The separate interpretation & report for a diagnostic test
  - Does not apply to test performed only by the physician (e.g., gonioscopy, extended ophthalmoscopy)
  - Routinely reported on second eye axial length measurements & SNF patients
Modifier -50

- Bilateral Procedure- Indicates when a procedure was performed bilaterally
  - Does not apply to inherently “unilateral or bilateral” services (e.g., visual fields)
  - May be subject to 50% reduction on the second eye (e.g., epilation by forceps)
  - May result in 100% payment for each eye (e.g., fluorescein angiography)
  - Some payers may require two line entry

Modifier -51

- Multiple Procedures (surgical)
  - When multiple procedures are performed by the same physician, same session the additional procedures are paid at 50%
    - No longer required by Medicare
  - Does not apply to “add-on codes” (e.g., +66990 Use of ophthalmic endoscope)
  - Apply to lesser valued codes

Modifier -53

- Discontinued Procedure
  - Applies to surgical procedures that are partially completed but had to be discontinued
    - Typically after surgery has been started
    - If used, must fax copy of operative report when electronic claim filed
  - Subject to payer discretion
Modifier -54

- Surgical Care Only
  - Applies to Co-Managed Cases
  - Indicates the surgical portion of the procedure only
    - Typically 80% of the allowable reimbursement
  - Requires very specific documentation

Modifier -55

- Post-operative Management Only
  - Applies to Co-Managed Cases
  - Indicates the post-operative portion of the procedure only
    - Typically 20% of the allowable
  - Requires very specific documentation

Modifier -57

- Decision for Major Surgery
  - The exam resulting in the decision for major surgery occurred within 24 hours
  - Typically applies to more urgent cases
  - Not to be confused with Modifier -25
### Modifier -58

- Staged or Related Procedure or Service by same physician within the post-operative period for the same site
  - Planned or anticipated
  - More extensive than original procedure
  - An additive method of treatment
- Restarts the global period

### Modifier -59

- Distinct procedural service
  - A procedure typically included with a larger service is billed separately
    - Separate site or organ system
    - Separate incision/excision
    - Separate injury
  - Does not apply to exams or tests
  - Audit target

### Modifier -78

- Unplanned return to the OR/Procedure room by same physician during the post-operative period for the same site
  - Usually management of complication
  - Must be an OR, ASC, laser suite or dedicated procedure room
    - Not an exam lane or multi-purpose room
  - Does not restart the global period
    - Results in a reduction in reimbursement
### Modifier -79

- Unrelated Procedure or Service by the same physician during the post-operative period
  - Typically applies to the fellow eye
    - Starts the global period for that eye
  - Does not alter reimbursement
  - Applies to major & minor surgeries

### Modifier -GA

- Indicates a properly executed Advanced Beneficiary Notice (ABN) is on file for a specific service or drug
- Medicare only
  - Service normally covered by Medicare but may not be covered in a specific case (e.g., increased frequency of service, diagnosis code not found in covered list)
    - Allows you to balance bill the patient for service

### ICD-9-CM

- There are 3 sections
  - Section 1 – Index to Diseases & Injuries
    - Alphabetical
  - Section 2 – Table of Drugs & Chemicals
    - External causes such as injury or poisoning
  - Section 3 – Tabular List
    - Numerical
    - Alpha-numerical
ICD-9-CM

- Steps to use
  - Look up disease in Section 1
    - Find "mother code" – first 3 digits (e.g. 366.xx for cataract)
      - Do not code from alphabetical section
  - Turn to Section 3 – go to 366.xx
    - Find most descriptive code to highest specificity up to 7 digits
      - Avoid codes described as "unspecified" or ending in 00 – NOS – not otherwise specified

- V-Codes – circumstances other than disease or injury
  - Status after surgery
- E-Codes – external causes of injury
  - Poisoning
  - Accidents
  - Late Effects

HCPCS Codes

- Medication codes – "J" codes
  - e.g., J2778 – injection, ranibizumab – Lucentis
- Temporary codes for private payers – “S” codes
  - e.g., S0620 – Routine ophthalmological examination including refraction; new patient
- Supply codes – “V” codes
  - e.g., V2020 – Frames (DME)