Basics of Procedural Coding
Consider the following while reading this chapter:

- What will the medical assistant find similar to ICD-9-CM as she or he performs procedural coding?
- What will help in selecting the most specific and accurate CPT code?
- What are the differences between coding for the **CPT** and coding for **HCPCS**?
- What will be learned about the legal and compliance implications of improper coding?
What is Procedural Coding (CPT coding) and HCPCS?

- There are two levels of procedural coding.
- Level I- Procedural or CPT coding is defined as the transformation of verbal descriptions of medical services and procedures into numeric or alphanumeric designations.
- This manual is published by the American Medical Association (AMA).
- The process for CPT coding is very similar to ICD-9-CM except that a different manual is used in most cases.
- Level II-HCPCS stands for Healthcare Common Procedural Coding System also known as “hix-pix” was created to supplement procedures and services not covered in the CPT manual.
- This manual is published by the Centers for Medicare and Medicaid Services (CMS).
Uses of CPT and HCPCS

- The medical assistant facilitates accurate medical recordkeeping and the **efficient processing of insurance claims** by using the CPT and HCPCS.
- These manuals help identify appropriate procedures and services common to the doctors office.
- CPT and HCPCS are used in the claims submission process to receive reimbursement from payors.
- Also tracks the doctors productivity in the office.
- Provides statistical data for research and other purposes.
The Purpose of CPT Coding

• Lists descriptive terms and identifying codes for reporting medical services and procedures performed by the doctors.

• This system provides standard language that accurately describes medical, surgical, and diagnostic services so that communication among doctors, patients, and third parties are consistent.

• Help communicate accurate information on procedures and services to agencies concerned with insurance claims.
What is CPT Procedural Code and Categories I, II, III, and Modifiers?

• The CPT code is a five-digit code also known as a **Category I** code.

• Category I codes are located in the **Tabular Index (Main Text)** of the CPT coding manual and are arranged by Section.

• Example: Codes beginning with 7 (eg. 70100- a radiographic exam of the mandible, partial, with less than four views) are found in the Radiology section of the coding manual.
Category II Codes

• **Category II** codes are *optional codes* used by providers to help assist in measuring performance and outcomes and track revenues and reimbursements.

• In Category II codes, the letter F serves as the fifth digit.

• They are listed in alphabetical (not numerically) order by condition in the CPT manual.
Category III Codes

• *Category III* codes are *temporary codes* assigned for emerging and new technology, services and procedures that have not been officially added to the Main Text of the CPT manual.

• The fifth digit of the Category III code is the letter T.

• Cat III codes are used for a new or experimental procedure or service.
Modifiers

• Modifiers are two character code additions that explain circumstances that alter a provided service. (Example of CPT Code Modifiers are -50 and -62 and are detailed on page 328 Table 19-1)
• Also provides additional clarification or detail about a procedure or service.
Arrangement (Format) of the CPT Coding Manual

• Each procedure or service is represented by a five-digit numeric code.
• This five-digit numeric code is a type of medical shorthand that saves enormous amounts of time and effort and helps to ensure the accuracy of information.
• In most cases the use of five-digit CPT codes eliminates the use of written descriptions because the codes are standard and are understood with every party involved.
4 Contents in the CPT Manual

1. Comprehensive instructions for use of the manual, including steps for coding
2. A complete Alphabetic Index
3. Main Text (Tabular Index)
   - Six sections
   - Guidelines and notes
   - Conventions
4. Thirteen appendixes
The Alphabetic Index

• The CPT Manual has 2 primary divisions, The Alphabetic Index and the Main Text (Tabular Index)

• The Alphabetic Index is a guide to finding data in the body of the manual. It is not in page numbers (like in a textbook) but in codes or code ranges found numerical order in each section of the Main Text.
The Main Text (Tabular Index)

• This Index includes definitions, guidelines, and notes to help the coder select the most specific code based on a procedure or service that is documented in the medical record. (Very similar to the ICD-9-CM Manual)

• The Main Text (Tabular Index) is divided into 6 sections, with codes listed in numeric or alphanumeric order within each section.

• The 6 sections are:
  1. Evaluation and Management (E&M)
  2. Anesthesia
  3. Surgery (all body systems)
  4. Radiology
  5. Pathology and Laboratory
  6. Medicine
Sections of the CPT Main Text

• A **section** is a broad (wide) category in the main text of the CPT manual.

• A **section** is one of the 6 main divisions if the CPT manual.

• Each of the 6 **sections** is divided by the general type of service.

• Here they are again:
  - Evaluation and Management (E&M)
  - Anesthesia
  - Surgery
  - Radiology
  - Pathology and Laboratory
  - Medicine
Sections of the CPT Main Text

- **subsection** of the CPT manual is indented two spaces below a section, and usually describes:
  - Anatomic Site
  - Organ System

- **Categories** are indented two additional spaces below the subsection, and generally refer to:
  - a specific procedure or service
  - can also be a more specific anatomical site

- The **subcategory** is indented two spaces below a category, and provides even more specificity about an anatomical site or the procedure or service performed.

Examples of these sections are on page 329, Table 19-2.
Guidelines and Notes

• **Guidelines** are found at the beginning of each of the 6 sections and some subsections.

• They add definitions and descriptions necessary to interpret and report appropriately the procedures and services in that section or subsection.

• **Notes** provide additional information to aid the selection if specific codes.
12 Appendices

• A list of all the Appendices and their specifics are found on page 331.

• Appendixes found in the CPT are as follows:
  – Appendix A: Modifiers
  – Appendix B: Summary of Additions, Deletions, and Revisions
  – Appendix C: Clinical Examples
  – Appendix D: Summary of CPT Add-on Codes
  – Appendix E: Summary of CPT Codes Exempt from Modifier -51
  – Appendix F: Summary of CPT Codes Exempt from Modifier -63
Appendixes

– Appendix G: Summary of CPT Codes that Include Moderate (Conscious) Sedation
– Appendix H: Alphabetic Index of Performance Measures by Clinical Condition or Topic
– Appendix I: Genetic Testing Code Modifiers
– Appendix J: Electrodiagnostic Medicine Listing of Sensory, Motor, and Mixed Nerves
– Appendix K: Product Pending FDA Approval
– Appendix L: Vascular Families (Cardiology coding)
Beginning the Coding Process

• The steps for using the CPT manual actually begin with the medical documentation such as:
  – Encounter form (also known as a superbill, fee slip, or charge ticket)
  – History and physical report (H&P)
  – Discharge summary
  – Operative report
  – Pathology report
Beginning the Coding Process using 4 Basic Steps

• The 4 basic steps in medical coding are to:

1. Read, analyze, and abstract (create a summary of information) the procedure or service documented in the medical record.

Then you compare it with the encounter form, operative report, or other documentation to make sure all services and procedures have been recorded.
Beginning the Coding Process using 4 Basic Steps

2. The abstracted info is then broken down into main terms and modifying terms.

- A **Main term** usually is the primary procedure or service performed.

- A **Modifying term** further defines or adds information to a main term.
Beginning the Coding Process using 4 Basic Steps

3. The Main and Modifying terms are used to find the coed or code ranges in the Alphabetic Index.

4. The code selected is conformed by reviewing the guidelines, notes, and conventions in the main Text (Tabular Index) to verify that the most accurate code has been chosen.
Using the Alphabetic Index to Search

• Begin the search by using one or all of the four primary classifications (or types) of main and modifying term entries:
  – Procedure or service
  – Organ or anatomic site
  – Condition, illness, or injury
  – Eponym (a person after whom a discovery or invention is named after), synonym, abbreviation, or **acronym**.
8 Steps for Using the Alphabetic Index

1. Abstract the procedures and/or services performed from the medical documentation.

2. Determine the main and modifying terms from the abstracted information.

3. Select the most appropriate main term to begin the search in the Alphabetic Index.

4. Select modifying term(s), if needed, once the main term is located to narrow down the search.

5. If no main or modifying term produces an appropriate code or code range, repeat steps 2, 3, and 4, using a different main term.

6. Find code or code ranges that include all or most of the medical record procedure or service description.

7. Disregard any code or code range containing additional descriptions or modifying terms not found in the abstracted information or the medical documentation.

8. Write down the code or code ranges that best match the medical documentation.
7 Steps for Using the Main Text (Tabular Index)

1. Turn to the Main Text and find the first code or code range found while searching the Alphabetic Index.

2. Compare the description of the code with the medical documentation. Verify that all or most of the medical record documentation matches the code description and that there is no additional element or information in the code description that is not found in the documentation.

3. Read the guidelines and notes for the section, subsection, and code to ensure there are no contraindications to the use of the code.

4. Evaluate the conventions, especially add-on codes (+) and exemption from modifier -51.

5. Determine if there are special circumstances that require the use of a modifier.

6. Determine if a Special Report is required.

7. Record the CPT code selected in the medical record documentation next to the procedure or service performed and in the appropriate block of the insurance claim form.
Compliance and Legal Issues

• Medical assistants should also ensure that proper precautions are taken to avoid incorrect coding, data entry errors, and false claims submissions.
  – **Downcoding**, in which lower level codes are used even when the diagnostic statement indicates a higher level procedure or service, usually affects reimbursement only by lowering the amount received, but may have civil and criminal penalty implications if it is done to disregard insurance policy restrictions or preexisting condition clauses.
  – **Upcoding**, on the other hand, in which a procedure or service code is used that is of a higher level than is supported by the medical documentation, can result in civil and criminal penalties, including fines, loss of privileges as a participating provider, and even prison time.