



COMMUNITY HEALTH PLAN
of Washington

Committed to your health.®



Provider Education Webinars

Course 5:

**Conquering CPT Coding
(Current Procedural Terminology)**

Housekeeping Items

Technical Difficulties

If you experience technical difficulties, please

- utilize the “Chat” feature of the GoToWebinar application to let us know what kind of problem you’re having
- exit the application and try re-establishing your internet and phone connections
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Webinar Questions

For questions concerning the content of this webinar, CHP has a dedicated email address: providereducation@chpw.org.

Questions about Specific Coding Scenarios

If you have questions about particular documentation and coding questions (specific coding scenarios) please email it to us at providereducation@chpw.org.

Questions about Claims

If you have questions about specific coding/claims processing issues, please use your usual route for claims queries (the webinar project isn’t set up to be the best forum to access claims information).

Continuing Education Credit

At the end of each webinar, there are instructions detailing how to request Continuing Medical Education and/or Continuing Education Units, by using the dedicated email address that CHP has established for this activity: providereducation@chpw.org.

Welcome

Welcome to this presentation of Community Health Plan's Provider Education Webinar, Course 5: Conquering CPT Coding

This webinar series is designed specifically for Community Health Plan's Physicians, Healthcare Professionals, and Administrative Staff who want to broaden their understanding and use of documentation and coding skills.

This webinar series consists of 10 one-hour courses.

Attendees may earn

- Continuing Medical Education (CME) through the AAFP*, and/or
- Continuing Education Units (CEU) through AAPC** and AHIMA***

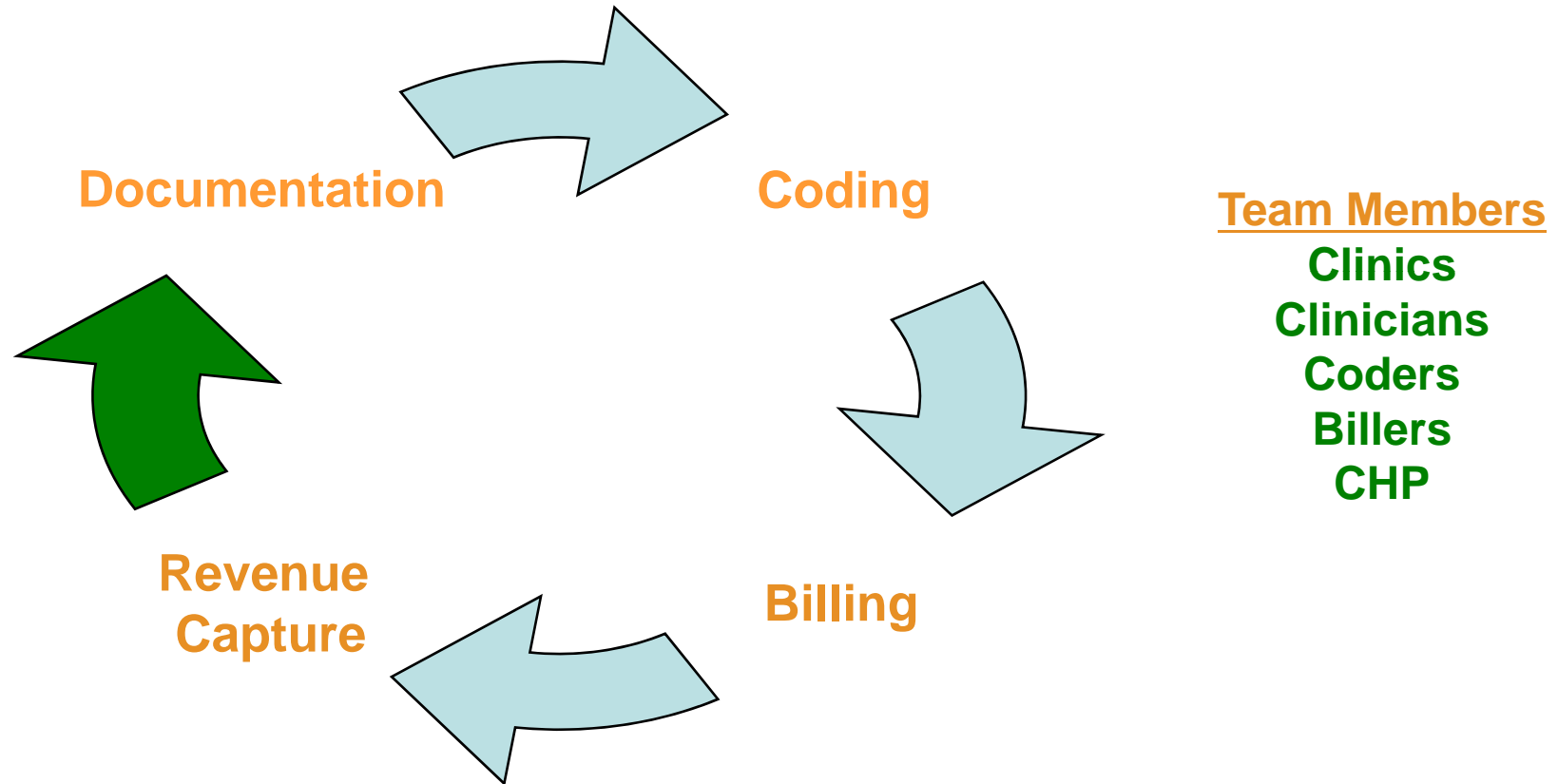
Courses and Self-Assessments must be completed to earn the CME/CEU credit.

* American Academy of Family Physicians

** American Academy of Professional Coders

*** American Health Information Management Association

A Comprehensive Approach to Optimizing Documentation & Coding



Our Role – Clinical Components

- Deliver timely comprehensive care....
- Document the care you deliver....
- Code the care you document....
- Capture the codes you document...

Community Health Plan - Medicare Advantage
Member HCC Report



HEALTH CENTER - Clinic Name

Run Date: 10/27/2008

Patient Name: Doe, John
 Address: 1234 Main Street, Anytown, US 98765
 Phone: (555) 555-5555

Member ID: HP1000000000

How To Use This Report

Step 1: Please review the diagnoses (ICD9 codes) and conditions (Hierarchical Condition Categories (HCC Codes)) listed in Sections 1 and 2. If you believe that a diagnosis/condition listed here is not relevant to this patient, please circle the diagnosis/condition.

Step 2: After reviewing, please sign below and fax this form to our confidential fax: 206-652-7024, Attn: Member HCC Report.

Step 3: At your next visit with this patient, please check for the presence of these diagnoses/conditions and document each currently present diagnosis/condition accordingly in your visit note.

Section 1 - Conditions (HCCs) Reported in Current Year

(Reported diagnoses may come from multiple care settings, including primary care, specialty care and hospital providers. Only one HCC per patient is shown, with highest documented ICD9 code.)

ICD9 Code	ICD9 Description	HCC Code	HCC Description	Risk Score
250.00	Dmii Wo Cmp Nt St Uncntr	19	Diabetes without Complication	0.2

Section 2 - Additional Conditions (HCCs) Reported in Prior Years

ICD9 Code	ICD9 Description	HCC Code	HCC Description	Risk Score
291.81	Alcohol Withdrawal	51	Drug/Alcohol Psychosis	0.353
303.90	Alcoh Dep Nec/Nos-Unspec	52	Drug/Alcohol Dependence	0.265
780.39	Convulsions Nec	74	Seizure Disorders and Convulsions	0.269
428.0	Chf Nos	80	Congestive Heart Failure	0.417
		16	Diabetes with Neurologic or Other Specified Manifestation	0.552
		71	Polyneuropathy	0.268

I have reviewed the diagnoses/conditions listed on this page, along with the medical history of this patient. With the exception of those codes that are circled, I attest that these diagnoses/conditions are present in this patient's medical history as available to me beginning _____ (mm/yyyy).

 Printed Name & Credentials

 Signature

 Date

Community Health Plan of Washington Provider Education Webinar

Course 5: Conquering CPT Coding (Current Procedural Terminology)

Marvel Gray, CPC, CCS-P, MCS-P, PCS, CCP, CCO, CMPM
Cost Reimbursement and Research Analyst

Kate Parman, CPC, CCS, CCS-P, MCS-P
Cost Recovery Analyst

Learning Objectives

Webinar Learning Objective:

Community Health Plan's goal is that our Providers will apply this career training and best practices information across their care spectrum, regardless of Patients' ability to pay or insurance type.

Course 5 CPT Coding Learning Objective:

Focus on proper use of CPT codes to meet various coding and descriptive requirements.

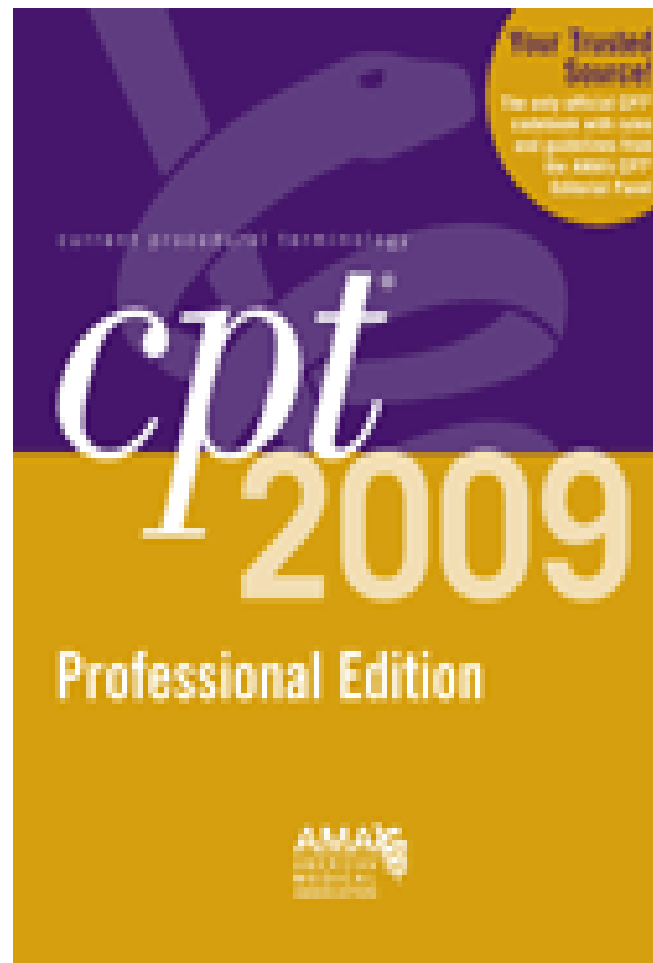
Participants' learning objectives for Course 5:

- Understand the purpose of the CPT code classification
- Learn that there are guidelines that drive accurate CPT coding
- Recognize how the proper use of CPT code set improves documentation quality, coding accuracy, and ethical revenue.

The Common Procedural Terminology (CPT) Code Set: Introduction and Purpose

What is the CPT code set and what purpose does it serve?

- Developed by the American medical Association (AMA) in 1966, and updated annually.
- Listing of descriptive terms and five-digit, numeric codes for reporting medical services and procedures performed by physicians and healthcare providers.
- Provide a universal language to accurately designate medical surgical and diagnostic services.
- Serves as an effective means of consistent nationwide communication between the Physicians, Patients, and Payers.
- Revised and published each year with the current changes which include deleted procedures, modified procedure descriptions, and the newly developed procedures.



CPT Manual Structure and Content

Configurations of sections can differ by publisher: best practice is to become familiar with publisher-specific nuances each time new manuals are obtained.

EVALUATION & MANAGEMENT SERVICES	99201 – 99499
ANESTHESIOLOGY	00100 – 01999
SURGERY	10021 – 69990
RADIOLOGY	70010 – 79999
PATHOLOGY AND LABORATORY	80048 – 89356
MEDICINE	90281 – 99602
CATEGORY II CODES	0001F - 7025F
CATEGORY III CODES	0016T - 0196T

CPT Guidelines and Symbols

Section Guidelines

- Provide information necessary to interpret and report the procedures contained in that section
- Located at the beginning of each section
- Apply only to codes in that designated section

Symbols (located to the left of the CPT code)

- Bullet: New Procedures
 - Dual Horizontal Triangles: New or Revised Description
 - Single Triangle: Revisions
 - Bulls-Eye: Conscious Sedation
 - Plus Sign: Add-On Codes
 - Flash Bolt: FDA Approval Pending
 - Circle with a line through it: Exempt from -51 Modifier
-
- Example of a change: in 2009, CPT code 90772 Therapeutic Prophylactic and Diagnostic Injection Service was deleted, Healthcare Providers now should be reporting CPT code the new Code 99672 when appropriate

CPT Appendices

Configurations of appendices can differ by publisher, so Best Practice is to become familiar with publisher-specific nuances each time new manuals are obtained.

Appendix A:	Contains a list of modifiers applicable to the 2009 CPT codes
Appendix B:	Summary of Additions, Deletions, and Revisions
Appendix C:	Clinical Examples of Evaluation and Management Coding
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
Appendix G:	Summary of CPT codes that includes moderate conscious sedation
Appendix H:	Alphabetic Index of Performance Measures by Clinical Condition or Topic
Appendix I:	Contains genetic testing modifiers
Appendix J:	Electrodiagnostic Medicine Listing of Sensory, Motor, and Mixed Nerves
Appendix K:	Contains a list of products pending FDA approval
Appendix L:	Contains a list of Vascular Families
Appendix M:	Summary of cross-walked deleted CPT codes

- Example of a change: in 2009, Modifier - 21 Prolonged Evaluation and Management services was deleted, and that deletion is listed in Appendix A.

Understanding CPT Format & Unlisted Code Usage

Semicolon and Indentation:

Semicolon:

29834	Arthroscopy, elbow, surgical; with removal of loose body/ foreign body
29835	synovectomy, partial
29836	synovectomy, complete
29837	debridement , limited
29838	debridement, extensive

Indentation:

25100 Arthrotomy, wrist joint; with biopsy

25101 with synovectomy

Unlisted CPT Code Usage

- Unlisted codes should be rarely used
- Codes ending in 99 denote unlisted codes and are found throughout each section and subsection of the CPT manual
- Use unlisted codes only when you cannot find a code that describes the procedure performed (last resort)
- Don't select a CPT code that's for a service that is a close description of the service provided
- Always give a written description of the procedure when using unlisted codes

The Alphabetic Index Is The Starting Point

To locate a CPT code, find the alphabetic index first.

The alphabetic index is organized by main terms. There are four primary classes of main entries.

- Procedure or service
- Anatomic sites or organs
- Condition
- Synonyms, Eponyms, and Abbreviations

Principles & Requirements of Quality Chart Documentation

Below are some of the major components of complete and accurate chart documentation.

- Record is thorough and legible
- States the reason for the encounter (Chief Complaint)
- Relevant history
- Assessment/impression/diagnosis
- Details of the management of Patient's condition
- Date and legible identity of author
- Rationale for ordering diagnostic and other ancillary services
- Identify risk factors of the condition/s and treatment/s
- Document patient progress, response to and changes in treatment and revision of diagnosis
- Opinions of other Providers who have been consulted
- Report CPT and ICD-9 codes supported by the documentation in the medical record

Evaluation and Management (E/M) Guidelines

The Evaluation and Management (E/M) Section of CPT is usually located at the beginning of the CPT Manual (depending on publisher).

E/M Service Documentation Requirements (CPT):

- Listed in the beginning of the E/M Section
- Exact documentation requirements necessary to determine the level of the E/M service to report

E/M Service Documentation Guidelines-1995 & 1997 (AMA):

- Listed on CMS Website
- Official, Approved, Adopted by Medicare and Medicaid
- Answer many frequently asked questions
- Requirements to meet documentation minimums for general, multi-system as well as specialty examinations

http://www.cms.hhs.gov/MLNEdwebGuide/25_EMDOC.asp

E/M Services Key Components

The descriptions of the levels of E/M services comprise seven components which are used in defining the levels of E/M services.

- Extent of history
- Extent of examination
- Complexity of medical decision making
- Counseling
- Coordination of care
- Nature of presenting problem
- Time

History Of Present Illness (HPI)

The HPI is a chronological description of the development of the patient's present illness from the first sign and/or symptom or from the previous encounter to the present. It includes the following elements:

Elements included in the HPI are:

- Location
- Duration
- Modifying Factors
- Quality
- Associated Signs & Symptoms
- Context
- Timing
- Severity

Brief HPI consists of one to three elements of the HPI

Extended HPI consists of four or more elements of the HPI

Review Of Systems (ROS)

Review of systems (ROS) is an inventory of body systems obtained through a series of questions seeking to identify signs and/or symptoms which the Patient may be experiencing or has experienced.

- None
- Pertinent
- Extended
- Complete

Past, Family, and/or Social History (PFSH)

The PFSH consists of a review of three areas:

Past History

Family History

Social History

Pertinent PFSH is a review of the history directly related to the problem.

Complete PFSH is a review of two or all three of the history areas.

Documentation of Examination

Physical examination is an assessment of the Patient's organ and body system(s).

Four Categories of Examination Detail:

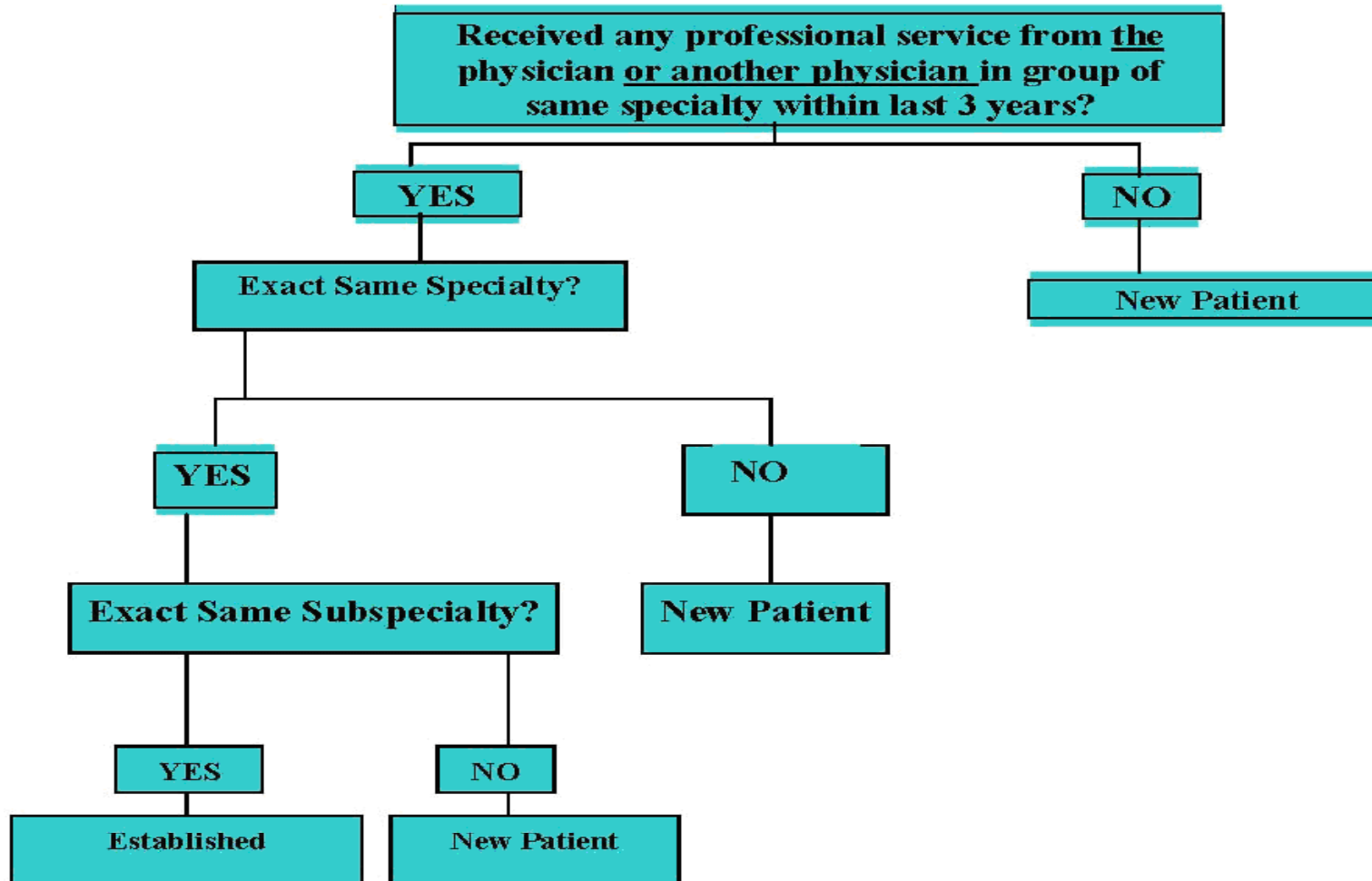
- Problem focused
- Expanded problem focused
- Detailed
- Comprehensive

Documentation Of The Complexity of Medical Decision Making (MDM)

The levels of E/M services recognize four types of medical decision making (MDM).

- Straight-forward
- Low complexity
- Moderate complexity
- High complexity

Decision Tree for New vs. Established Patients



Evaluation and Management New Patient 99203

CC: Nasal congestion and swollen eyelids.

HPI: 58 year old female new to my practice comes in today with increased nasal congestion about two weeks ago. She states the problem is sometimes quite severe and is worse when she goes outside. She is concerned she may be developing seasonal allergies. She says the congestion is often associated with swollen eyelids and watery eyes and can last for several hours at a time.

Medications: HCTZ 12.5 mg po qd.

PMH: Hypertension non smoker

ROS:

Ears, Nose, Mouth and Throat - Negative for epistaxis, sore throat or decreased hearing

Pulmonary - Negative for cough, hemoptysis, SOB

Physical Exam:

General: NAD, conversant; looks younger than her stated age

Vitals: 130/72, 88, 98.6

Head: NC/AT, no sinus tenderness or submandibular lymphadenopathy

Neck: Supple without lymphadenopathy; trachea midline

Eyes: anicteric sclerae with moist, pale conjunctiva

Nose: normal non-injected nasal mucosa, with normal septum and turbinates

Oropharynx: No mucosal ulcerations, normal hard and soft palate. No pharyngeal erythema

Ears: Patent external auditory canals with pearly TMs and normal hearing acuity

Lungs: CTA

CV: RRR

Extremities: no edema

Assessment:

Allergic rhinitis 477.9

Controlled HTN 401.9

Plan:

OTC acetaminophen and diphenhydramine

Saline nasal flushes

Patient was instructed to avoid decongestants with phenylpropanolamine due to the risk of exacerbating her hypertension.

Time Based Evaluation and Management Example

Established Office Visit 99213

CHIEF COMPLAINT: Muscle Weakness

INTERVAL HISTORY: The patient is here today to discuss the risks and benefits of statin medication for dyslipidemia with LDL of 160. She states she has muscle weakness and she wants to know if she really needs to continue this medication.

PHYSICAL EXAMINATION: GENERAL: NAD, conversant; looks younger than stated age. VITAL SIGNS: BP 124/72, HR 84, RR 18. LUNGS: CTA. CARDIOVASCULAR: RRR. EXTREMITIES: No peripheral edema.

LABORATORY INFORMATION: LDL 92

IMPRESSION:

Controlled dyslipidemia 272.4

PLAN:

Continue PRAVASTATIN 20 mg PO QD.
RTC in six months with LFTs and lipid panel.

Time: I spent 20 minutes face-to-face with this patient over 50 % of the time was devoted to counseling and/or coordination of care. We discussed the side effect and risks of statin medications in primary prevention of cardiovascular events. All questions were answered and the patient understands the risks involved.

Consultation vs. Referral

- A **consultation** is a request by a physician for the advice or opinion of another physician regarding the evaluation and/or management of a specific problem.
- Document the 4 R's to report Consultation codes:
Request Reason Render Report
- A **referral** is the transfer of care from one physician to a second physician when the second physician assumes responsibility for treatment of the patient.

Consultation vs. Referral

CRITERIA	CONSULT	REFERRAL
Request	<p>"Please see patient for a consult." "Consulting services requested." Request must be in writing</p>	"Patient has been referred by..."
Problem	<p>Suspected or known diagnosis Consulting physician unsure of condition or assumption of management</p>	Identified problem
Treatment	Undetermined or possibly known	Known
Requesting Physician	<p>Decides which physician will administer care Uncertain at time of consult</p>	Oversees and manages care
Report	Written report to requesting physician	Written report to requesting physician is not necessary
CPT Code	Consult	New or established patient

Consultation Services That Meet Criteria

The Four R's

Meet these criteria and you'll be meeting CMS and Stark (Anti-Kickback) requirements.

- **Reason:** A family practice physician examines a female patient who has been under his care for some time and diagnoses a breast mass.
- **Request:** The family practitioner sends the patient to a general surgeon for advice and management of the mass and related patient care.
- **Render:** The general surgeon examines the patient and recommends a breast biopsy, which he schedules.
- **Report:** The general surgeon then sends a written report to the requesting physician. The general surgeon subsequently performs a biopsy and then periodically sees the patient once a year as follow-up.

Note: Subsequent visits provided by the surgeon should be billed as an established patient visit in the office or other outpatient setting, as appropriate. Following the advice and intervention by the surgeon the family practice physician resumes the general medical care of the patient.

Surgery Section and Medicine Sections

Surgery Section:

- is the largest section of the CPT book
- contains code range 10021 – 69990
- is divided into 19 subsections and are defined by anatomic site
- Guidelines are located in the front of each CPT section

Medicine Section:

- is for coding diagnostic and therapeutic services
- contains code range 90281 – 99607
- has approximately 30 subsections
- begins with the guidelines

Clarifying Skin Tag Removal 11200 & 11201

Example: Chief Complaint: Removal of inflamed skin tags

Mrs. Jones presents for removal of multiple skin tags which are inflamed, occasionally bleeding, catching on her undergarments. Complains of severe itching, irritation, and somewhat painful.

28 skin tags were documented as excised

Surgery/Integumentary System Removal of Skin Tags

- 11200** Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions
- +11201** each additional 10 lesions, or part thereof
(List separately in addition to code for primary procedure)

Report CPT 11200 ("parent" code) once for the first 15 skin tags

Report 11201 twice:

once to report an additional 10 skin tags, plus

once more to report an additional 3 skin tags

First fifteen: 11200

Next ten: 11201

Next three: 11201

(15+10+3=28)

When chart documentation is specific in stating how many skin tags were removed, the service meets quality of care, coding, compliance, and reimbursement criteria.

Wart Destruction

CPT Code 17110 & 17111

Example:

When the physician **destroys one to fourteen warts** Report code CPT code **17110**. Only code 17100 once, even if the physician has destroyed fourteen lesions.

When the physician **destroys fifteen or more warts** report code **17111**. Even if the physician destroys thirty-five warts, it is appropriate to only use the code 17111 a single time.

CPT Procedure Punch Biopsy 11100

Example:

Chief Complaint: 58 year old female who is well known to me complains of nevus of the left forearm that recently changed in appearance.

Plan: Punch Biopsy

Informed Consent: The risks and benefits of the procedure were explained to the patient . The patient elected to proceed with the procedure.

Procedure: The area was prepped with betadine. A local anesthetic was injected around the area. A 4 mm skin punch was inserted into nevus, and piece of the nevus was removed and sent to pathology . Minor bleeding was stopped by placing a 4 x4 dressing over the site and applying pressure to the area . Once hemostasis was achieved the area was cleaned with normal saline, and a bandaid was applied.

Pathology Report: Benign neoplasm skin upper limb.

CPT Code: 11100 Punch Biopsy

ICD-9 Code: 216.6 Benign neoplasm skin upper limb

Therapeutic Prophylactic or Diagnostic Injection CPT Code 96372

The Medicine section contains the New 2009 CPT Code 96372 for therapeutic prophylactic, or diagnostic injection subcutaneous or intramuscular

CPT code 96372 has been renumbered. (deleted code 90772)

Building a Bridge, and Using it

Ethical Responsibility

Guessing about where to find rules that apply to documentation and coding questions is not necessary, is unethical, and wastes your valuable time and energy.

CHP is here to help you build a foundation for understanding this valuable career skill, and to assist you with official references when questions about proper documentation and coding arise.

Feedback about the Webinar

Community Health Plan chose this enterprise-wide, long-term approach of online training to serve our Providers, achieve our training objectives, and optimize the delivery of this information (which ultimately benefits the Patients, the Providers, and the Plan).

To that end, CHP has created a dedicated email address for our Providers and their Staff to send questions and comments about this training: please email us at: providereducation@chpw.org. CHP encourages our Providers to give us feedback about this educational webinar, so that it may be continuously improved.

Continuing Education Credit Requirements

CHP has arranged to award CMEs (through AAFP) and CEUs (through AAPC and AHIMA) for Participants who:

- attend this webinar
- are counted as present
- complete a brief Self-Assessment and Quality Survey at the end of the webinar
- request the continuing, education credit in the manner described in the steps in the next slide.

Obtaining Continuing Education Credits

1. Send an email to providereducation@chpw.org with “Continuing Education Credit Request” in the subject line.
2. Be sure to let us know which organization/s you’re requesting continuing education credit from, and
3. Include your contact information in the body of the email.
4. A *brief* Self-Assessment will be emailed to requesters. The brief Self-Assessment is evidence of learning objectives met (and is a requirement of the continuing education granting organizations), and
5. Upon completion of your Self-Assessment, email it back to CHP at the above email address.
6. CHP will process and send the continuing education certificates to the Participants at the contact information provided in Step 3 (above).
7. As always, it’s the responsibility of the Participant to submit and/or make available proof of continuing education credit earned (CME/CEU certificates) to the AAFP, AAPC, and AHIMA on demand. CHP doesn’t submit certificates to these organizations on behalf of webinar Attendees.

Additional Resources: much of the information in the Webinar is available in a more comprehensive form at CMS’s website: <http://www.cms.hhs.gov/MLNGenInfo/> and click on the Web-Based Training Modules. There are additional CMS web-based training courses there as well.

Thank You for Participating

Community Health Plan would like to thank you for taking time out of your busy schedule to participate in today's Provider Education Course 5 Webinar: Conquering CPT Coding.

Community Health Plan has arranged for documentation and coding resources to be made available to you by email for questions about the materials covered in this webinar series. We cannot address specific, individual claims processing queries. There are other resources available for reimbursement questions, and the usual route for claims questions should be used for them.

The Provider Education Team is looking forward to delivering the next course in this webinar series, and it will reinforce the concepts and complement the content of this course.