Advanced CPT Coding for Surgeons & Staff

Current Procedural Terminology, CPT, is the coding basis for most medical and surgical services and procedures. Participants will learn how CPT is organized, how to properly determine a code from a brief description of the service and how to use the main sections of the book. Participants will learn key definitions of common services and situations. This program is an advanced course on CPT designed for surgeons and staff and there will be a particular emphasis on the use of case studies to fully demonstrate a process for defining and coding difficult CPT cases.

This Practice Management Teleconference is just $99 for ACS Fellows & their Practices:
♦ A 90-minute live teleconference including a formal presentation and time for Q&A
♦ The course is given once as a live teleconference, on Wednesday February 22, 2006 (convenient for your staff) and then via streaming Internet technologies shortly thereafter. Your $99 registration fee covers either one or both presentations and handout materials.
♦ The ability for ACS Fellows and practice managers to e-mail follow-up questions to Economedix Practice Management Advisors for personalized responses

Course Objectives - Completion of this Practice Management Course will provide:
1. An understanding of the proper use of the various sections of the CPT book
2. Participants will be able to identify and locate a procedure code from the index
3. An understanding of key terminology related to CPT definitions and descriptions
4. Participants with the knowledge to properly utilize modifiers to the procedure codes as well as ...
5. Utilize appropriate discriminators in determining proper codes with the use of case studies
6. Participants will properly code a procedure or service, including necessary modifiers, for submission to payers

Accreditation - The American College of Surgeons is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education to physicians.

CME Credit - The American College of Surgeons designates this educational activity for a maximum of 1.5 category 1 credits toward the AMA Physician’s Recognition Award. Each physician should claim only those credits that he/she actually spent in the educational activity. To earn the CME credit, participants must complete the combination Evaluation/CME Form, that is included in the course materials, and FAX this form back within seven days following the date of the teleconference.

Faculty - The faculty for the course is Mr. Tom Loughrey, MBA, CCS-P. Mr. Loughrey is CEO of Economedix and a noted practice management consultant to physicians, medical offices and medical societies. For over a decade, Mr. Loughrey has provided consulting services to the College as a part of the Consultant’s Corner at the annual ACS Clinical Congress and regularly is engaged by ACS to speak and teach at meetings and workshops throughout the country.

Registration & Information - This completed form can be Faxed Toll Free to 877-813-9784; or mailed to Economedix - 297 Valley Road # 200 - Wexford, PA 15090; For complete details and secure On-Line Registration simply go to: http://YourMedPractice.com/ACS

Thank you for your interest in this Program!

☐ Practice: ______________________________________________________
☐ Address: ______________________________________________________ Phone: __________________
☐ City: _____________________________________________ State: _____ Zip: __________
☐ Contact: _______________________________________ E-Mail: ____________________________

☐ [ X ] Yes, we want to participate in the **Advanced CPT Coding Course** … and will attend
[ ☐ ] Wednesday February 22, 2006 @ 3 PM Eastern, [ ☐ ] Web-based On-Demand … or [ ☐ ] Both Presentations.

☐ Form of Payment: [ ☐ ] Check Payable to Economedix, LLC & mailed to: 297 Valley Rd # 200 - Wexford, PA 15090 or [ ☐ ] Credit / Debit Card (MC, Visa, Discover or American Express)

☐ Card Number (15 or 16 digits): _________________________ Expiration Date: _____ / _________

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* Please use 4 Digit Code on front of AMX Card
NAME: _____________________________________________ Telephone #: ______________________
ACS Fellow #: _______________________ E-mail Address: ______________________________________

Please circle one number for each statement

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General Comments for this Course:

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Surgical Specialty

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Please FAX this Evaluation / CME Form Toll Free to: 877-813-9784 within 7 days following this Teleconference to receive CME recognition from the American College of Surgeons. Thank You!
Sign In Sheet

Educational Activity: **Advanced CPT Coding**

Dates: **Wednesday, February 22, 2006 @ 3:00 PM Eastern**

Faculty: **R. Thomas (Tom) Loughrey, MBA, CCS-P of Economedix, LLC**

Sponsor: **The American College of Surgeons**

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Welcome To The Digital Learning Center

Presented by …

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Today’s Presentation

Advanced CPT Coding

A Detailed Review of CPT Elements
Including … Modifiers, CCI Edits,
E&M Services & EOB Reviews

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Handout Materials

Click Here for the Course Overview … (PDF File)

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Course Faculty

R. Thomas (Tom) Loughrey, MBA, CCS-P

- Chairman, CEO & Co-Founder of Economedix
- Certified Coding Specialist
- BS Degree from Pennsylvania State University
- Earned an MBA in Health & Hospital Administration from the University of Florida
- Former Hospital Administrator
- Former Owner of a Medical Billing Company
- Consultant to Physician Practices & Medical Societies
- Member of Various Professional Organizations Dealing with Medical Practice Management
- Developed and Presented Thousands of Seminars & Workshops Dealing with Practice Management

ACCME Disclosure

R. Thomas (Tom) Loughrey, MBA, CCS-P

In accordance with the policies on disclosure of the Accreditation Council for Continuing Medical Education, presenters for this program, except for any noted below, have identified no personal relationships with a health care product company which, in the context of their topics, could be perceived as a real or apparent conflict of interest.

No conflicts were disclosed

Today’s Course

- The Global Surgery Package Concept
- Your Top 20
- Correct Coding Initiative Edits
- Modifier Usage
- E&M Coding
- EOB Review
- CPT Code Changes - Handouts
Global Surgical Package

The services provided by the physician to any patient by their very nature are variable. The CPT codes that represent a readily identifiable surgical procedure thereby include, on a procedure-by-procedure basis, a variety of services. On defining the specific service "included" in a given CPT surgical code, the following services are always included in addition to the operation per se:

- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
- Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure (including history and physical)

Other specific services "included" in a given CPT surgical code are:

- Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of the procedure (including history and physical)
- Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
- Writing orders
- Evaluation of the patient in post anesthesia recovery area
- Typical postoperative follow-up care.

Pre-Operative Period

- CPT is silent with regard to pre-op services being included or excluded in the surgical package
- Certain minor surgical procedures may have an E/M service reported separately if there is a separately identifiable reason for the service. The E/M code should be reported with modifier -25 and the reason usually requires a separate diagnosis
Global Surgical Package

Pre-Operative Period
- Medicare has numerous rules and exclusions for the pre-op period including:
  - A prohibition on pre-operative E/M services beginning the day before the surgery. The one exception to this is an E/M service for the purpose of determining a need for surgery (modifier -57) and is used only with major surgical procedures (90 day global period)
  - Diagnostic services are not included in the global concept pre-operatively
  - Any services to stabilize the patient’s condition pre-operatively are not included such as re-establishing an airway

Global Surgical Package

Post-Operative Period
- CPT does not specify any number of days in the post-op period. It only states that normal, uncomplicated post-operative care is included in the surgical package
  - The only follow-up care for diagnostic procedures is that which is required to recover from the diagnostic procedure itself
  - Complications, exacerbations, recurrence, etc., requiring additional services should be reported with the appropriate procedures coded
  - Medicare defines that all follow-up care is included in major surgeries for 90 days and minor surgeries for up to 10 days

- The only exclusion is if a complication results in a return to the operating room. Medicare limits reimbursement to no more than 50% of the allowed amount for the original surgery
  - The surgical procedure must be modified with −78
  - Surgical procedures unrelated to the original surgery during the post-op period of the original surgery may be reported with a −79 modifier
    - Appendectomy done in post-op period of a hernia repair
    - Unrelated E/M services during the post-op period may be reported with a −24 modifier
    - Consult for intestinal blockage done during post-op period of a chest wall tumor removal
What Are Your Top 20?

- It is very likely the 20 most frequently performed services and procedures in your practice account for 80% plus of your revenue
- Your job is to thoroughly understand everything about those top 20
- Use the 2006 RBRVS published by Medicare to help
- Thoroughly read the CPT description

Correct Coding Initiative

What are CCI edits?

CCI edits are pairs of CPT or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same beneficiary on the same date of service. All claims are processed against the CCI tables.
The tables contain more than 140,000 edits
**Correct Coding Initiative**

What does it mean when a code is considered a "comprehensive code" in CCI?

A "comprehensive code" represents the major procedure or service when reported with another code. The "comprehensive code" represents greater work, effort, and time as compared to the other code reported.

**Correct Coding Initiative**

What does it mean when a code is considered a "component code" in CCI?

A "component code" represents the lesser procedure or service when reported with another code. The "component code" is part of a major procedure or service, and is often represented by a lower work relative value unit (RVU) under the Medicare Physician Fee Schedule as compared to the other code reported.

**Correct Coding Initiative**

What does it mean when codes are considered "mutually exclusive" of each other?

"Mutually exclusive" codes represent procedures or services that could not reasonably be performed at the same session by the same provider on the same beneficiary.
Correct Coding Initiative

What does "column 1" mean in the comprehensive/component (correct coding) edits table and in the mutually exclusive edits table?

Also known as the "comprehensive code" within the comprehensive/component (correct coding) edits table, this code represents the major procedure or service when reported with another code. When reported with another code, "column 1" generally represents the code with the greater payment of the two codes.

However, within the mutually exclusive edits table, "column 1" code generally represents the procedure or service with the lowest work RVU, and is the payable procedure or service when reported with another code.

Correct Coding Initiative

What does "column 2" mean in the comprehensive/component (correct coding) edits table and in the mutually exclusive edits table?

Also known as the "component code" within the comprehensive/component (correct coding) edits table, this code represents the lesser procedure or service when reported with another code. When reported with another code, "column 2" generally represents the code with the lower payment of the two codes.

However, within the mutually exclusive edits table, "column 2" represents the procedure or service with the highest work RVU, and is the non-payable procedure or service when reported with another code.
Correct Coding Initiative

How do I obtain the CCI Edits Manual?

http://www.cms.hhs.gov/physicians/cciedits/default.asp

or

The CCI Edits Manual may be obtained by purchasing the manual from the National Technical Information Service (NTIS) website at...

National Correct Coding Initiative
AdminStar Federal, Inc.
P.O. Box 50469
Indianapolis, IN 46250-0469

http://www.ntis.gov/products/families/cci

or by contacting NTIS at 1-800-363-2068 or 703-605-6060.

Modifiers

Use of Modifiers

- Modifiers provide new information which may alter payment, affect the global period or determine to whom a payment should be properly directed
- Modifiers reduce the need for additional CPT codes that would only describe the modifying circumstances
- Modifiers are listed as two digit suffixes to the code being modified
- Third party payers may treat the modifiers differently than intended by CPT
  - For example, a payer may want bilateral procedures reported on separate lines with modifier –50 on the second listed item. CPT simply states that the code for the procedure should be modified with modifier–50 indicating it was performed bilaterally

A complete list of modifiers can be found in Appendix A of CPT
A complete list of available modifiers for Ambulatory Surgery Center reporting of procedures is also included in Appendix A
A partial list of Level II HCPCS modifiers is included at the end of Appendix A
- Contact your carrier for a complete list of Level II modifiers. The AMA catalog has three separate publications on HCPCS which contain the list of modifiers. It is available at www.amapress.com or 800 621-8335
**Modifier -22**

-22 Unusual Procedural Services

When the service provided is greater than that usually required for the listed service

- Many insurers will simply ignore modifier -22
- Medicare rules allow consideration of unusual circumstances but the need for the unusual service must be documented and accompany the claim
  - Medicare will pass a claim with modifier -22 to medical review for pricing and adjudication but only if the claim is accompanied by a concise statement about how the service differs from the usual and an operative report
  - If either are missing the claim is processed as though there was no modifier

**Modifier -52**

-52 Reduced Services

Services which are significantly less than usually required may be reported with modifier -52

- The procedure is reduced or elements are eliminated at the discretion of the physician
- Although not often used it is appropriate when the code description indicates a significant amount of work but only the minimum was provided
- Examples include performing the technical component only of a diagnostic service (non-Medicare)
- The procedure has taken much less time or the surgeon will only have minimal follow-up care

**Modifier -51**

-51 Multiple Procedures

When multiple procedures are performed at the same operative session by the same surgeon it is appropriate to list the first procedure and then report additional procedures with modifier -51

Third party payers have different rules for determining payments for multiple surgeries. The norm is for a decreasing percentage of the payer’s allowed amount for the surgery

- It is appropriate for the physician to report the modified procedures with his/her normal fees
- Medicare applies the use of modifier -51 to the surgeon and other members of the same surgical group for all surgeries on the same day
- Medicare reimburses for the most major procedure first and rank orders the procedures by RBRVS units
Modifier -51

-51 Multiple Procedures

- Medicare pays 100% of the allowed amount for the first procedure and 50% of the allowed amount for second through the fifth procedures
- Additional procedures must go to medical review for pricing
- Multiple endoscopies are paid at 100% for the highest valued endoscopy and then the difference in value between the next endoscopy and the lowest endoscopy
- If an endoscopy is reported with modifier -51 and the other procedures are not endoscopies then normal multiple surgery rules apply
- If bilateral procedures are also modified as multiple procedures the value is calculated at 150% and then reduced for multiple procedures

Modifier -50

-50 Bilateral Procedures

- Unless otherwise indicated in CPT bilateral procedures that are performed at the same operative session should be reported using modifier -50
- Medicare extends this definition to include surgeries on both sides on the same day as well as the same operative session and includes other surgeons in the group practice
- By definition some procedures are already described as bilateral and should not be modified. Examples include:
  - Cystourethroscopy (52290 et al)
  - Vasectomy (55250)

Modifier -50

-50 Bilateral Procedures

- Medicare and many other third party payers will value bilateral procedures at 150% of the allowed amount for the basic unilateral procedure
- Because most payers will pay the lesser of 150% of the allowed amount or the actual charge the physician should report the fee for two sides as opposed to the fee for a single side

Example:
Partial thyroid lobectomy, bilateral (left with isthmusectomy and right without isthmusectomy)
60210 –50 note: procedure is with or without isthmusectomy
Modifier -58

-58 Staged Procedure

A planned procedure performed by the same surgeon during the post-operative period of the first surgery is reported by the addition of modifier -58

* This may be the result of prospective planning at the time of the original surgery, or,
  * It is more extensive than the original surgery, or,
  * It is for therapy following a diagnostic procedure

Example:
Patient has received a partial thyroidectomy (unilateral)(60252) with limited neck dissection for malignancy (193). Following the surgery (within the global period) it is decided to do a more extensive procedure and remove the remainder of the thyroid.

60260-58 Thyroidectomy, removal of all remaining thyroid tissue following previous removal of partial thyroid

Modifier -78

-78 Return to Surgery During Post-Op Period

The physician may need to report that a return to the operating room is needed during the global follow-up period of another surgery. When this subsequent procedure is related to the first it is reported with modifier -78

* Do not modify the original surgery
  * This modifier is not limited to just complications of the original surgery
  * It is not used to describe planned subsequent surgery or staged surgeries
### Modifier -78

** Modifier -78

Return to Surgery During Post-Op Period

- Medicare limits reimbursement to the lesser of the allowed amount for the service or 50% of the original service
- The Medicare Carrier’s Manual indicates a failure to add modifier -78 to a related procedure performed during the global period may be an issue for the fraud unit of the carrier

**Example:**

A vascular surgeon has a patient with a failure of a surgically created fistula for a dialysis catheter (996.1) and must return the patient to surgery for correction of the fistula and removal of a thrombus.

36833 -78 Revision, open, arteriovenous fistula, with thrombectomy

### Modifier -79

** Modifier -79

Unrelated Procedure During Post-Op Period

A patient may need a procedure unrelated to another procedure during the post-op period of the first surgery. The unrelated procedure should be reported with modifier -79

- Generally, the second, unrelated procedure will be documented with a different diagnosis
- If the latest procedure also involved an E/M service, such as a consultation, the consult would be modified with ~24 (unrelated E/M during post-op period)
- It could be additionally modified with ~57 (decision for surgery)

### Modifier -79

** Modifier -79

Unrelated Procedure During Post-Op Period

- Use of the -79 modifier is only by the surgeon performing the original procedure

**Example:**

A patient with a bilateral inguinal hernia (550.9) had a procedure to correct the hernia. Within the global follow-up period the surgeon was asked to see the same patient for possible cholecystitis. The patient was diagnosed with cholelithiasis with acute cholecystitis (574.00)

The patient had a laparoscopic cholecystectomy with cholangiography

47563 -79 Laparoscopic cholecystectomy with cholangiography

99214 – 24 Established patient office visit
Modifier -62

62 Two Surgeons

In this case each surgeon is working as a primary surgeon and performing distinct parts of a single procedure. Neither is assisting the other on the particular procedure. Each surgeon reports the same procedure code with modifier –62

• Additional surgeries may be reported with modifier – 51 (if required) and may be reported as an assistant at surgery as well
• The medical necessity must be documented for two surgeons
• Medicare will increase the allowed amount for the procedure to 125% and split the payment between the two surgeons
• The procedure must be one that Medicare has determined is eligible for co-surgeons

Modifier -66

66 Team Surgery

• Highly complex surgeries requiring services of multiple physicians each reporting the procedure codes with modifier –66
• Medicare requires documentation of the need for a team and each physician must provide sufficient information to pay the procedure by report
• Medicare requires the team to each agree on the percentage each physician will receive
• If multiple surgeons are performing different procedures the modifier rules for team or co-surgeons does not apply

Modifiers –80, –81, –82

–80, –81, –82 Assistant Surgeon

The assistant in surgery reports the surgical procedure with the modifier for the appropriate type of assist
–80 is for an assistant at surgery
–81 is for a minimum assist
–82 is for an assistant in a teaching hospital when the services of a qualified resident are not available
Modifiers –80, –81, –82

–80, –81, –82 Assistant Surgeon

• Third party payers will have different rules about payment for the services of an assistant
  • The surgeon acting as an assistant should be aware of exactly what procedures and codes have been reported by the primary surgeon.
  • Medicare bases the payment on 16.5% of the allowed amount for the primary procedure.
  • The procedure must be one that qualifies for an assistant to begin with or no additional payment will be made.
  • All rules for other modifiers (multiple procedures, bilateral procedures, etc.) apply to the assistant.

Tips for the Assistant at Surgery
1. Get a copy of the primary surgeon’s operative report and charge documents prior to reporting.
2. Establish fees specifically for the surgical procedures for the assistant.
3. Work with the primary surgeon’s staff. Any problems they have will filter down to the assistant.

Modifier -24

–24 Unrelated E/M Service During Post-Op Period

A patient may require an E/M service unrelated to a procedure during the post-op period for the procedure. The E/M service should be reported with a –24 modifier.

• The ICD-9-CM code becomes extremely important in the documentation of the need for the service and the fact that the service is unrelated to the procedure.

• If there is any confusion in the reporter’s mind, attach additional documentation to the claim.

• A physician providing only post-op care for the surgery and using modifier –55 should also use –24 for any unrelated E/M services during the post-op period.

Example:

A thoracic surgeon performed a Coronary Artery By-pass Graft (X3) on a patient. During the post-op period the patient’s pulmonologist asks the surgeon to consult on a suspected tracheomalacia. The patient was seen for the consultation and a diagnosis of tracheomalacia (S91.1) was made. The surgeon recommended an aortic suspension to decompress the trachea but wants to wait another month for the recuperation from the CABG.

99243 –24 Office Consultation
Modifier -25

-25 Significant, Separately Identifiable E/M Service on Same Day As Procedure

This modifier has been on the OIG’s list for focused audits since 2004

Used to report an E/M service on the same day as a procedure

- Must be significant and separately identifiable above and beyond the procedure or the usual pre-operative service
- May be prompted by the symptom or condition for which the procedure is being done
- May be documented with the same diagnosis as the procedure

Example:
A general surgeon is seeing a patient for a scalp wound (5,0cm, Intermediate) (974.0). The surgeon also does a neurological exam of the patient for the head injury and concussion (990.0).
12032 Layer closure scalp wound
99212 -25 Office visit for head injury (462)

Modifier -57

-57 Decision for Surgery

An E/M service that resulted in the initial decision to perform surgery is reported by the appropriate code for the E/M service modified with -57

- Medicare rules state that an E/M service provided the day before or the day of the surgery that results in a decision to perform surgery is not included in the global surgical package
- The E/M service should be modified with -57
- Modifier -25 should not be used with -57
Modifier -57

-57 Decision for Surgery

-57 should not be used for minor surgeries (10 days or less in the global period) when the E/M service is provided the day before surgery.

• The global period for minor surgeries starts the day of surgery. The global period for major surgeries starts the day before surgery.

Example:
A urologist has been asked to do an initial inpatient consultation on a 68 year old male with a bladder neck obstruction (596.0)
A decision is made for an endoscopic procedure which results in the removal of calculus. The procedure is done that same afternoon. 50980 Ureteral endoscopy with removal of foreign body 99251 –57 Inpatient Initial Consultation

What if the consult was done the previous day?

Modifier -54

-54 Surgical Care Only

When one surgeon provides the intra-operative service and another physician provides the post-operative or pre-operative care, the surgeon reports the surgery only with the -54 modifier

Note: Medicare does not recognize the pre-operative care being separate from the intra-operative service

Modifier -55

-55 Post-Operative Management Only

When one surgeon has performed the the post-op management and
another has performed the surgery, the physician providing the post-op care reports the surgical procedure identified by -55

• The reporting of the post-op care should be reported one time using the same procedure code as the surgery and the same date of service.

• Medicare requires that the date of transfer from the surgeon to the post-op physician be documented on the claim and,

• Both physicians must keep a copy of the written transfer agreement in the medical record

• Medicare requires that the physician managing the post-op care may not report the service until it actually commences
Modifier -56

-56 Pre-Operative Management Only

When one physician performs the pre-operative care and another performs the surgery, the physician managing the pre-operative service reports the surgical procedure with modifier -56

• Medicare has no specific rules on modifier –56
• This may occur when another physician does the E/M service prior to the surgery. If done the day before or the same day as the surgery it is included in the Global service

Example:

Puncture aspiration of cyst of right breast, during post-op period of surgery on other breast. Procedure discontinued. 19000-99-RT-79-53

Modifier -99

-99 Multiple Modifiers

Most payers will be able to recognize multiple modifiers on the claim and do not need to have you report modifier -99

• Most payment systems can handle no more than three modifiers. Additional modifiers may have to be added "by report"
• Many third party payers will have difficulty determining allowed amounts for procedures with multiple modifiers. This requires the physician to pay particular attention to the explanation of benefits that is returned to the practice. The claim may need to be appealed

Example:

Consultations

• A service provided by a physician whose advice or opinion has been requested
• The consultant may initiate therapeutic and diagnostic procedures at the same or a subsequent encounter
• A written or verbal request for the consultation must be made in the patient's medical record along with the need for a consultation
• The advice or opinion along with any other services must be documented in the medical record
• Medicare requires documentation that the advice or opinion was communicated to the requesting physician. This may be evidenced by a letter or documentation of other communication
E&M Services

Common Consultation Errors

- A “referral” is not necessarily a request for a consult
- Standing orders for the ED physician to call a trauma surgeon (or any surgeon) are not a consult request
- Once a consultant assumes responsibility for care of the patient, the consult codes are no longer appropriate – use visit codes
- Follow-up I/P Consultation Codes and Confirmatory Consult Codes have been eliminated for 2006
- Users are instructed to use visitation codes instead

E&M Services

Critical Care

- The direct delivery by the physician of services to critically ill patients
- Involves high complexity decision making to patients with imminent or life threatening deterioration of their condition
- Critical care is usually provided in critical care areas of hospitals but may occur in any location of the hospital
- Services provided in critical care units are not necessarily critical care services

E&M Services

Critical Care

The following professional component services are included in the codes for critical care. Any other services should be reported separately:

- Interpretation of cardiac output measures (93561 & 93562);
- Chest x-rays (71010, 71015 & 71020);
- Pulse oximetry (94760, 94761 & 94762);
- Blood gases (99090);
- Gastric intubation (43752 & 91105);
- Temporary transcutaneous pacing (92953);
- Ventilatory management (94556, 94557, 94660 & 94662);
- Vascular access procedures (36500, 36410, 36415, 36540 & 36600)
E&M Services

Critical Care

Time is an essential element of critical care

- Less than 30 minutes = report an E/M code plus procedures
- 30 – 74 minutes = report 99291
- Only once per day
- Additional 30 minute time periods = report 99292
  Must provide at least 15 minutes of time in final unit

E&M Services

Critical Care – Medicare Rules

- Critical care can be reimbursed separately within the global period provided:
  - The patient is critically ill requiring the constant attendance of the physician, and;
  - The critical care is above and beyond, and, in most instances unrelated to the specific anatomic injury or general surgical procedure performed

E&M Services

Critical Care – Medicare Rules

- Two reporting requirements must be met in claim submission:
  1. Codes 99291, 99292 and modifier –25 (preoperative care) or –24 (post-operative care) must be used, and
  2. Documentation that the critical care was unrelated to the specific anatomic injury or surgical procedure must be submitted with the claim
    - An ICD-9-CM code between 800.0 and 999.9 (excluding 930-939, foreign bodies) must be used to indicate critical care unrelated to the surgery. This will suffice for adequate documentation.
E&M Services

Prolonged Services

- Occurs when the physician provides direct face-to-face patient contact beyond the usual service
- May occur in inpatient or outpatient settings
- Prolonged services are reported in addition to other physician services including E/M services
- Prolonged services are time dependent for the date of service
  - First 30 minutes of prolonged service is not separately reported from the basic service
  - First hour is reported with 99354 (outpatient) or 99356 (inpatient)
  - Additional thirty minute increments are reported with 99355 (outpatient) or 99357 (inpatient)

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E&M Services

Prolonged Services

Example:

Surgeon is consulting on trauma patient with significant injuries suffered in automobile crash. Patient has significant spinal cord damage. In consultation with the patient and family reviewing medical records, imaging, and discussing options, education and expectations the inpatient consultation has gone 85 minutes beyond the initial consult.

Coding:

99254 Inpatient consultation
99356 Prolonged service (first hour)
99357 Prolonged service (additional 30 minutes)

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EOB Review

- Key Information
- Patient Identification
- Dates of service
- Procedure codes
- Charge amount
- Payer allowable amount
- Benefits applied to:
  - Deductible
  - Physician Payment
- Denial codes & reasons
EOB Review

What to watch for:

- Zero payments – what is the reason?
- Previously considered? Previously paid?
- Medical necessity? Missing information?
- Incorrect payment – less than allowed?
- Payer bundling of codes – appropriate?
- Proper fee schedule? Use your computer system
- Allowable exceeds charge?
- Consider re-pricing if you have not updated fees

EOB Review

What to watch for:

- Practice system problems
  - Slow claims submittal – look at dates of service
  - Incorrect patient identification
  - Repeated errors
  - Failure to collect co-payments and deductibles
- Payer system problems
  - Slow pay
  - Missing, incomplete or unclear information
  - Inappropriate claims edits

Summary

- Know your “Top 20” like the back of your hand
- Review your Charge Tickets for accuracy
- Pay close attention to the EOB’s
- Understand when and how to use modifiers
- Use Medicare’s Physician Fee Schedule to help you code it right the first time
### Table 1: CPT Code Descriptions

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
<th>Effective Date</th>
<th>Deletion Date</th>
<th>Modifier</th>
</tr>
</thead>
<tbody>
<tr>
<td>1089 1100</td>
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**Example:**

Billed 11100 - Biopsy of skin when billed with 36000 - introduction of needle, vein or intracatheter may not be separately billed. If billed together, 36000 will be denied as being included in the Biopsy procedure.