Procedural Coding Guidelines Utilizing CPT, HCPCS and CDT

I. INTRODUCTION

This paper discusses procedure coding, using the Current Procedural Terminology (CPT), Health Care Common Procedural Coding System (HCPCS), and Current Dental Terminology (CDT) systems. Subsequent papers of this series address diagnostic coding and coding for specific areas of OMS (e.g., TMJ surgery, implants, dentoalveolar surgery, etc.)

These coding guidelines have been developed by the AAOMS Committee on Health Care and Advocacy (CHCA) to assist you in your use of these coding systems. In no way are the guidelines a substitute for a working knowledge of the coding books and systems.

The American Medical Association (AMA) CPT codes are a listing of descriptive terms and numeric codes for reporting medical services and procedures. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and thereby provide an effective means for reliable nationwide communication among doctors, patients, and third parties.

Both CPT procedural and ICD-9-CM (International Classification of Diseases Ninth Revision Clinical Modification) diagnostic coding involve transforming verbal descriptors of patient care into code numbers for reporting to insurance companies. The more familiar you become with the terminology and the guidelines of the various coding systems, the easier it will become to file accurate and complete claims.

CHCA serves in an advisory capacity to the American Medical Association (AMA) CPT Editorial Panel and the American Dental Association (ADA) Code Maintenance Committee (CMC), striving for more appropriate language and treatment codes for the practice of the specialty. In addition, CHCA consults with the National Center for Health Statistics ICD-9-CM Coordination and Maintenance Committee to obtain better clarification of diagnostic codes.

AMA revises and publishes CPT codes biannually. Each new edition is made available in mid-November for the following year, with mid-year updates available on the AMA website. Currently CPT contains over 7,000 codes. It is imperative that you purchase an updated copy of the CPT codes each year to assure that you are reporting the procedures accurately. Using deleted codes will unnecessarily delay your reimbursement. CDT is revised and published by the American Dental Association (ADA) every year. The most current publication of CDT is CDT 2013, which became available December 2012 and effective January 1, 2013. CPT became effective January 1, 2013 and must be used for claims submitted commencing January 1, 2013.

II. USING CPT TO CODE OMS PROCEDURES

It is essential that you also understand CPT coding guidelines, symbols, instructions, and format in order to accurately reflect the level of service of the procedure being reported.

CPT BOOK INTRODUCTION

The “introduction” to the AMA CPT book provides the basis for CPT coding and basic instruction in the use of the book, its sections, and CPT in general.

SECTION GUIDELINES

In addition to the general guidelines that appear in the “Introduction,” section-specific guidelines also appear at the beginning of each of the six sections listed below. To understand this more clearly, open your CPT book to the beginning of the Surgery Section (codes ranging from 10021 to 69990) and note that the guidelines addressed here are applicable to only the surgery codes. The information here relates to issues such as the surgical package and what it includes: follow-up care, materials over and above those usually included in the service, multiple procedures, and modifiers.
CPT CONTAINS SIX SECTIONS

CPT is composed of six separate sections. The section numbers and their sequence are as follows:

<table>
<thead>
<tr>
<th>Sections</th>
<th>Code Ranges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and Management</td>
<td>99201 to 99499</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>00100 to 01999</td>
</tr>
<tr>
<td>Surgery</td>
<td>99143 to 99150</td>
</tr>
<tr>
<td>Radiology (including Nuclear Medicine &amp; Diagnostic Ultrasound)</td>
<td>70010 to 79999</td>
</tr>
<tr>
<td>Pathology and Laboratory</td>
<td>80048 to 89356</td>
</tr>
<tr>
<td>Medicine (except Anesthesiology)</td>
<td>90281 to 99602</td>
</tr>
</tbody>
</table>

In addition to the six major sections, surgery in particular is divided into subsections related to specific body systems: integumentary, musculoskeletal, respiratory, cardiovascular, hemic and lymphatic systems, mediastinum and diaphragm, digestive, urinary, male genital, female genital, maternity care and delivery, endocrine, nervous, eye and ocular adnexa, and auditory.

OMS PROCEDURES IN CPT

Most OMS procedures are listed in the Musculoskeletal System (20000-29999) and the Digestive System (40490-49999). Within the Musculoskeletal System, most OMS codes appear under “General” (20000-20999) and “Head” (21010-21499). In addition, applicable codes for OMS may be found in the integumentary, respiratory, and nervous system sections.

SYMBOLS IN CPT

Understanding the symbols that appear next to a code in CPT is necessary to identify additions, deletions, and revisions. New procedures added to that year’s edition are identified throughout the book with the “●” symbol appearing before the code number. The symbol “▲” is used to indicate that a code has been revised or there has been a substantial alteration to the procedure. Effective in 1999, two more symbols were added: “⁺” reflects an add-on code and the symbol “⊙” indicates the code is exempt to modifier –51. In CPT 2005, a symbol resembling a bulls-eye “⊙” was added to the book to identify procedures in which conscious sedation is considered an inherent component.

UNLISTED SERVICE CODES

Codes for unlisted services are also provided in the guidelines preceding some sections of CPT.

IDENTIFYING DELETED CODES

Deleted codes are identified in CPT by parenthetical notes in the location where the code had previously been located. Many times, the notation will also include a code or codes to use in its place (e.g., “99141, 99142 have been deleted. To report, see 99143-99145”). Occasionally, the deleted code will have the recommended notation that another medical encounter should be selected (e.g., “21493 and 21494 have been deleted. To report, use the applicable Evaluation and Management code”). The notation is removed the year following the year the deletion became effective.

STARRED PROCEDURES

Effective with CPT 2004, starred procedures were eliminated.

INDENTED PROCEDURES AND THE IMPORTANCE OF A SEMICOLON IN CPT CODING

Some of the codes in CPT are indented to avoid repeating a portion of a descriptor listed in a preceding code. It is important to note in these instances the location of the semicolon “;”. All portions of the descriptors up to the semicolon also apply to the portion of the selected descriptor that is indented.

Example:

12011 Simple repair of superficial wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 2.5 cm or less
12013 2.6 cm to 5.0 cm
12014 5.1 cm to 7.5 cm

Presume that we are coding for the above repair for lacerations of 3.5 cm. It would not be appropriate to code 12011 and 12013 together. The correct way to correctly report this procedure would be:

12013 Simple repair of superficial wounds of face, ears, eyelids, nose, lips, and/or mucous membranes; 2.6 cm to 5.0 cm
CPT INDEX
Unlike the ICD-9-CM Index, which encompasses the whole of Book 2, the CPT Index is located in the back of the CPT book.

There are four primary classes of entry:
1. Procedure or service (e.g., arthrocentesis, orthopantomogram)
2. Organ or other anatomic site (e.g., mandible, sinus, salivary gland)
3. Condition (e.g., abscess, fracture)
4. Synonyms, eponyms, and abbreviations (e.g., Abbe-Estlander Procedure, LeFort 1, EKG)

LOCATING PROCEDURAL CODES IN CPT
Open the CPT book to the Index in the back of the book. Carefully study the use of the Index, then find the principle procedure (e.g., “Temporomandibular Joint (TMJ) Arthroscopy”) relating to the principle diagnosis (“524.63 articular disc disorder”). As demonstrated in this example, the procedure codes for TMJ arthroscopy can be either 29800 or 29804, according to the Index. Without looking at the actual descriptors for CPT codes, 29800 and 29804, it would not be possible to identify from the CPT Index which arthroscopy code truly reflects the services provided. Just as you should never code from the ICD-9-CM diagnosis code index, you should never select a CPT code from the CPT Index without fully reviewing the complete descriptor. In CPT, as in ICD-9-CM, even if only one code is identified, you must refer to the actual code to assure accuracy.

CPT AND ICD-9-CM CODES MUST CORRESPOND
After determining the diagnosis or diagnoses, use the principle diagnosis and demonstrate what was done to treat the problem and then relate the treatment procedures to the diagnosis. The ICD-9-CM diagnosis code must be appropriate for procedures performed as reflected by the CPT codes. Recent work by Medicare as well as the “Correct Coding Initiative” attempts to directly link CPT and ICD-9-CM codes. Codes that do not match will result in denial of the claim.

ACCURATE INFORMATION ASSURES ACCURATE CODING
In the example cited, based upon the information in the operative report, 29804 accurately identifies the surgical arthroscopic procedure performed. (Note that 29800 describes TMJ arthroscopy performed for diagnostic purposes with or without a synovial biopsy, and 29804 represents a TMJ arthroscopy performed for surgical purposes—i.e., lysis of adhesions, cartilage manipulation, lavage, etc.). It should be noted that when a diagnostic arthroscopy is performed and surgical treatment is carried out after the problem has been located, a separate code for a diagnostic arthroscopy cannot be submitted. CPT guidelines at the beginning of the arthroscopy section clearly state a surgical arthroscopy always includes a diagnostic arthroscopy; 29800 is only to be used when no surgical services are provided other than the diagnostic arthroscopy, with or without synovial biopsy.

MODIFIERS
Modifiers are additional two-digit numbers added to a code to indicate special circumstances not otherwise apparent when reporting the procedural code(s) alone. After the procedural codes have been obtained, attention should turn to the possible need for modifiers to make the carrier aware of services or procedures performed that may vary from the basic code because of a specific circumstance (e.g., reporting of bilateral procedures, indicating a procedure was performed more than once, reporting the assistant surgeon for the reported procedure, etc.). It may be necessary to support the modified code by submitting additional documentation to clarify the modification being reported.

Modifers may be added to any CPT code. A general description of modifiers appears in the front of the CPT book as part of the “Introduction” section. A complete listing of modifiers is contained in Appendix A (before the “Index” in the rear of the book). The listings of modifiers pertinent to evaluation and management services, medicine, anesthesia, surgery, radiology, and pathology are located in the guidelines for each of these sections.
Although many procedures are considered to be inherently bilateral (e.g., 21193-21196), it may be necessary with others to specify bilaterality by utilizing the “-50” modifier. The correct method of reporting the modifier is to add the hyphenated two-digit modifier to the five-digit procedural code for the second procedure (e.g., 29804-50). The first procedure should be identified only by the 29804 code. Note that the alternative five-digit modifier codes (i.e., 09950) were eliminated from CPT in 2003.

If you need to use more than one modifier for a procedure, add “99” to the procedural code to indicate that multiple modifiers will be utilized, and then list the additional modifiers (e.g., 21453-99 52/51).

When more than one procedure (other than E/M services) is performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) would be reported for reimbursement, with the “-51” modifier added to indicate multiple surgical procedures at the same operative session.

It is acceptable to use CPT modifiers with HCPCS codes. Likewise, HCPCS modifiers can be used on CPT codes. However, the American Dental Association presently does not approve the use of any modifiers with CDT codes submitted to dental carriers.

UNBUNDLING OF SURGICAL PROCEDURES

Unbundling of services refers to the practice whereby one essentially maintains the usual fee for a specific procedure, but one or more components of that procedure are segregated from the surgical package and given a separate fee. Unquestionably, some surgeons have successfully increased their income under this guise, which they refer to as “creative billing.” However, it is more appropriate to describe this practice as unethical or fraudulent billing.

Temporomandibular joint arthroplasty is perhaps the most frequently cited example of unbundling in OMS. The basic question is what components of the procedure are inherent in its routine completion and what, if any, ancillary procedures would constitute separate procedures. Clearly, autografts and allografts are specifically addressed in the coding definitions of 21240 and 21242 of the CPT manual, but what about condylar shaves and/or meniscus surgery? Are these procedures germane to completion of the arthroplasty, or do they constitute procedures that should be charged for individually by utilizing CPT codes 21050 and 21060?

The CPT definitions for utilizing codes 21050 and 21060 specifically state “separate procedure” and therefore should not be used when arthroplasty codes 21240 and 21242 are used.

EVALUATION AND MANAGEMENT (E/M) CODES

Evaluation and Management Codes (visits and consultations) were extensively revised and redefined to conform to the new Medicare Payment Schedule in 1992. This change significantly affected coding and documentation of what was previously simple consultative or office visit services. The most current E/M Documentation Guidelines may be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads//MASTER1.pdf

The categories and subcategories of codes available for reporting E/M services are as follows:

<table>
<thead>
<tr>
<th>Category/Subcategory</th>
<th>Code Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office or Other Outpatient Services</strong></td>
<td></td>
</tr>
<tr>
<td>New Patient</td>
<td>99201-99205</td>
</tr>
<tr>
<td>Established Patient</td>
<td>99211-99215</td>
</tr>
<tr>
<td><strong>Hospital Observation Services</strong></td>
<td></td>
</tr>
<tr>
<td>Observation Care Discharge Services</td>
<td>99217</td>
</tr>
<tr>
<td>Initial Observation Care</td>
<td>99218-99220</td>
</tr>
<tr>
<td><strong>Hospital Inpatient Services</strong></td>
<td></td>
</tr>
<tr>
<td>Initial Hospital Care</td>
<td>99221-99223</td>
</tr>
<tr>
<td>Subsequent Hospital Care</td>
<td>99231-99233</td>
</tr>
<tr>
<td>Observation or Inpatient Care Services</td>
<td>99234-99236</td>
</tr>
<tr>
<td>Hospital Discharge Services</td>
<td>99238-99239</td>
</tr>
<tr>
<td><strong>Consultations</strong></td>
<td></td>
</tr>
<tr>
<td>Office Consultations</td>
<td>99241-99245</td>
</tr>
<tr>
<td>Inpatient Consultations</td>
<td>99251-99255</td>
</tr>
<tr>
<td><strong>Emergency Department Services</strong></td>
<td></td>
</tr>
<tr>
<td>New or Established Patient</td>
<td>99281-99285</td>
</tr>
</tbody>
</table>
Effective with CPT 2006, the Follow-Up Inpatient Consultation codes (99261-99263) and the Confirmatory Consultation codes (99271-99275) have been deleted. Follow-up visits to an initial consultation are now reported with Subsequent Hospital Care codes 99231-99233 when performed in the inpatient setting, and Office or Other Outpatient Established Patient codes 99212-99215 when performed in the office or other outpatient setting. Confirmatory (second opinion) Consultations performed in the facility setting, meeting consultation requirements, will be reported using Initial Inpatient Consultation codes 99251-99255, and those performed in the office or other outpatient setting will be reported with Office or Other Outpatient Services codes 99201-99205 for new patients and 99212-99215 for established patients. Note the above applies to the CPT manual in general and not any specific carrier or Medicare policy.

In addition to these standard E/M services, numerous other such services are added yearly to this category; Preventive Medicine, Critical Care Services, Nursing Facility Assessment and Care, Home Services, etc.

The evaluation and management codes define all visits (consultations, office and hospital visits) and delineate levels of service. The levels of evaluation and management services encompass the wide variations in skill, effort, time, responsibility, and knowledge required for the prevention, or diagnosis and treatment, of illness or injury. In making the revisions, the AMA placed primary emphasis on the content of the services provided in determining the appropriate level of service.

The new coding system differs significantly from previous coding practices. The definitions of evaluation and management (visit) codes now vary among subcategories. As indicated previously, the new codes are divided into categories such as location of service delivery, and subcategories to indicate whether the patient is new or established. (A new patient is one who has not received any professional services from the physician/qualified health care professional, or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the physician/qualified health care professional, or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.) When an oral and maxillofacial surgeon is on call or covering for another doctor, the patient’s encounter would be classified as it would have been by the doctor who is not available. There is no distinction between new and established patients treated in the emergency room.

Under this E/M coding system, codes in each subcategory are identified by number only and are defined in terms of seven components: history, examination, medical decision-making, counseling, coordination of care, nature of presenting problem, and time. The first three components, history, examination, and medical decision-making, are considered the key components in selecting a level of evaluation and management services. An exception to this would be cases in which the patient visit consists predominantly of counseling and/or coordination of care. In those instances, if time involved in “face to face” discussion with the patient and/or family constitutes more than 50% of the total time spent with the patient, time can be the sole factor in determining level of service. However, it is essential that the time is documented in the patient record.

Medical decision-making refers to the complexity of establishing a diagnosis and/or selecting a management option. Four types of medical decision-making are recognized. These include: straight forward, low complexity, moderate complexity, and high complexity. The type of decision-making is determined by the number of diagnoses or management options, amount and/or complexity of data to be reviewed, and the risk of complications and/or morbidity and mortality.

When reporting the E/M code, refer to the complete set of guidelines that precedes all of the evaluation and management codes in the CPT book and the specific instructions in each category or subcategory. In addition, examples pertinent to specific specialties are provided in the E/M section, as well as in Appendix C – Clinical Examples Supplement, located in the back of the CPT book.

Under the new Medicare Payment Schedule, “cognitive skill” is weighted more heavily, thus the value of E/M services is greater. It is important that oral and maxillofacial surgeons familiarize themselves with and correctly utilize the new codes to ensure they receive proper reimbursement. If the correct codes are not used, carriers are not obligated to pay claims.
III. HCPCS

The Health Care Common Procedure Coding System (HCPCS), commonly pronounced “hicks-picks,” is sometimes required by CMS and Medicaid carriers for the reporting of OMS procedures. As the administrator of both Medicare and Medicaid, HCFA’s (now CMS) intent in 1974, was to establish HCPCS to allow uniform reporting of physician and non-physician services. This system, updated annually, also was designed to provide accurate and more detailed reporting of supplies and equipment, drugs, and other services not currently specified in CPT.

There are two levels of HCPCS Codes:

Level 1 contains the same codes and modifiers that appear in the current CPT Coding System, with the exception of specific anesthesiology codes. When you are reporting anesthesia procedures to CMS or Medicaid carriers with HCPCS codes, you should use the surgical procedure code with the appropriate anesthesiology code modifiers. However, CMS does not recognize general anesthesia or deep sedation by the surgeon and will deny payment for this service. Separate payment for moderate conscious sedation by the surgeon can vary by carrier. Medicaid policy for all levels of anesthesia may also vary from state to state. Head and neck anesthesia codes (00100-00352) are to be used only when a second doctor actually provides the anesthetic management. The Level 1 codes are five-digit numeric codes exactly as they are in CPT.

Level II contains codes for physician and non-physician services that are not contained in CPT. The Level II codes are alpha-numeric (e.g., D7111, D7220, D7250). The modifiers for Level II codes are mostly double alpha (e.g., “-CC” procedure code change). Use “-CC” when the procedure code was filed by your office and you are resubmitting the procedure(s) correctly.

In some cases, carriers may attempt to change all submitted procedures received from oral and maxillofacial surgeons from CPT codes to HCPCS because of their dental degree. AAOMS considers this practice in violation of the Medicare Federal Regulation relating to the degree of the provider. A copy of the Medicare regulation to which you address this issue can be obtained from AAOMS. Section 2020.3 of the Medicare Regulation states, “Dentists – a dentist qualifies as a “physician” if he/she is a doctor of dental surgery or dental medicine who is acting within the scope of his/her license when he/she performs such functions. Such services include any otherwise covered service that may legally and alternatively be performed by doctors of medicine, osteopathy and dentistry; e.g., dental examinations to detect infections prior to certain surgical procedures, treatment of oral infections and interpretations of diagnostic X-ray examinations in connection with covered services. Because the general exclusion of payment for dental services has not been withdrawn, payment for the services of dentists is also limited to those procedures that are not primarily provided for the care, treatment, removal or replacement of teeth or structures directly supporting the teeth. The coverage or exclusion of any given dental service is not affected by the professional designation of “physician” rendering the services; i.e., an excluded dental service remains excluded, and a covered dental service is still covered whether furnished by a dentist or a doctor of medicine or osteopathy.”

Medicare regulations prohibit such discrimination under the Medicaid Overlap Law enacted in 1987 as part of the Federal Budget Reconciliation Act. AAOMS recommends that you continue to report the procedure using the most accurate reporting system (CPT or HCPCS). When the most accurate reporting of that procedure is CPT, that should be the code by which your services are reported, unless that procedure is also changed for all Medicare physicians performing the same services. AAOMS considers it illegal to change the code for only an oral and maxillofacial surgeon. The following are examples of procedures more accurately reported by CPT: excisions of lesions (both benign and malignant); fractures; and reconstructive surgery.

IV. ADA CDT 2013 CODES

The American Dental Association (ADA) has revised the Code on Dental Procedures and Nomenclature (the Code) several times since the original code was developed and published in 1969. The latest revision to the Code, referred to as CDT 2013, is the result of work by the Code Maintenance Committee (CMC), representing interests between the ADA and the Payer sector of the dental community. Unlike CDT-2, beginning with CDT-3 in 2000, the codes now start with “D” instead of “0”. All of the ADA codes are contained in CDT 2013, which also provides assistance to accurately report dental treatment to the carriers.
Dental codes are now divided into 12 categories, which include:

I. Diagnostic D0100-D0999
II. Preventive D1000-D1999
III. Restorative D2000-D2999
IV. Endodontics D3000-D3999
V. Periodontics D4000-D4999
VI. Prosthodontics, removable D5000-D5899
VII. Maxillofacial Prosthetics D5900-D5999
VIII. Implant Services D6000-D6199
IX. Prosthodontics, fixed D6200-D6999
X. Oral and Maxillofacial Surgery D7000-D7999
XI. Orthodontics D8000-D8999
XII. Adjunctive General Services D9000-D9999

While the categories appear to be titled by dental specialty, use of the codes is not restricted to any specific specialty. Any dental practitioner can use any code found in CDT.

SYMBOLS FOR ADA CODES
Symbols designating new or revised ADA codes are the same as those used to denote additional or revised CPT codes (see Section II-Symbols in CPT).

UNBUNDLING SURGICAL PROCEDURES REPORTED WITH DENTAL CODES
When surgical procedures are reported under the dental coding system, as in CPT medical reporting, oral and maxillofacial surgeons are expected to use the same guidelines regarding which components of the procedure are inherent in that procedure’s routine completion, and which, if any, ancillary procedures would constitute separate procedures. For example, ADA code D7840 (condylectomy) would not be listed in addition to D7865 (arthroplasty) as an additional procedure. The condylectomy would only be reported separately if it were the only procedure performed. Reporting the arthroplasty and the condylectomy as two separate procedures constitutes classic “unbundling” since the condylectomy is a component of a temporomandibular joint arthroplasty and therefore does not warrant a separate charge.

In many instances in CDT, multiple codes may be indicated for use in a procedure. CDT will indicate that a code should be reported “in addition to” other procedure codes. An example of this would be D7290 (surgical repositioning of teeth), which states in the descriptor, “Grafting procedure(s) is / are additional.”