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Part B Insider (Multispecialty) Coding Alert

Part B Coding Coach: Dust Off Category II & III Codes And Put Them To Use

We'll help you unveil the mystery of the back of your coding book.

Don't ignore those funny alphanumeric codes that are listed after your general CPTs. We'll tell you why reporting them is important if you want to increase your reimbursement in the long run; plus, we'll introduce you to some of these new Category II and III codes.

The Problem: Your natural instinct is to leave these codes alone since Medicare won't reimburse Category IIs or reimburse many Category IIIs as they would unlisted codes. But if you choose to stick only with the tried-and-true Category I codes, you're cheating yourself out of future reimbursement.

What they are: Among the upgrades to CPT, the **American Medical Association** (AMA) developed CPT II codes for performance measures and CPT III codes for new and emerging technologies, explains **Dr. Franz Ritucci, MD, DABAM, FAEP**, director of the **American Academy of Ambulatory Care** in Orlando, FL. And reporting these could help support payor negotiations and contribute to creating future codes that are reimbursable.

Use Category IIs To Support Outcomes

Put to use: Category II codes help better describe E/Ms and can correlate a patient's disease to the treatment rendered, points out **Denae M. Merrill, CPC**, coder for **Covenant MSO** in Saginaw, MI. For example, you could code 1000F (Tobacco use assessment) with an E/M for a patient seeing a cardiologist.

Although Category IIs are not required, the AMA's intent is to help data mining by coding certain services and/or test results found to be contributing factors to positive health outcomes and quality patient care, Ritucci explains. Also, Pay for Performance is around the corner, and there is a good chance that Category II information could be contributory.

Bonus: The AMA hopes that using these codes will decrease the need for typical record abstractions and chart review--which would minimize administrative burdens on physicians and data collection and cut the cost of surveys administered by various health plans, Ritucci adds. So, in the long run, using category IIs will save money and contribute to quality care.

Helpful: For a more immediate benefit of Category IIs, use them to help negotiate with private payors. The codes can easily help pull out outcomes information, experts say. The information these codes generate may also be beneficial with the increasing managed care/Medicare negotiations.

Even better: Because many Category IIs are specific components of E/Ms, these codes help qualify your E/M or preventative care to specific diagnostic conditions.

But don't get too coding happy with this good news: Category II codes may not be used as a substitute for Category I codes, asserts CPT 2006.

The right way: You should always code Category IIs as secondary to the primary procedure code, emphasizes **Rebecca Massey, CPC, CHC,** senior consultant for **Gates, Moore & Co**. in Atlanta, GA. Think of them as you would V codes or E codes (since most of them are not primary).

Example: A Medicare patient comes to a pulmonologist for a preventative medicine visit, and the physician assesses the

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patient's smoking history. You would bill a 99397 and then a 1000F (Tobacco use, smoking assessed).

Heads up: The 2006 Category II codes are relatively straightforward, but the new "composite measures" codes could create some confusion because they already include several Category II.

For example, 0001F (Heart failure assessment) includes blood pressure measurement (2000F), level of activity assessment (1003F), clinical symptoms assessment (1004F), weight measurement (2001F) and an auscultation of the heart (2003F), Merrill points out. "However, patient education (4003F) for the patient's heart failure can be separately reported," she says.

Likewise, the other composite measures code, 0005F (Osteoarthritis assessed) includes assessment of osteoarthritis symptoms (1006F), assessment of OTC anti-inflammatory medication use for symptom relief (1007F) and an initial examination of the involved joint (2004F).

Important: You shouldn't use these composite measures codes unless all the individual component measures for that specific composite measure are met, states CPT 2006 guidelines. If you can only report a few, then report them as the individual Category IIs.

Finally, believe it or not, Category II codes just received their own special modifiers in CPT 2006--and they're not to be reported with Category I or III codes unless noted in special guidelines, says CPT Changes 2006. Modifiers 1P (Performance Measure Exclusion Modifier due to Medical Reasons) and 2P (Performance Measure Exclusion Modifier due to Patient Choice) help show that the physician considered the associate measures but did not provide them due to medical or patient circumstances.

For instance, if a physician prescribes aspirin, and the patient refuses due to religious reasons, you would still report 4011F (Oral antiplatelet therapy prescribed...), but you would append a Modifier 2P.

Use Category IIIs For Future Reimbursement Possibilities

Similar to Category II codes, Category IIIs are important tracking mechanisms that also have the ability to become regular CPTs. They exist to report certain emerging technology, services and procedures that aren't yet listed under Category I and would normally be reported as unlisted codes.

You should report a Category III code that accurately describes the service when there is no option under the Category I codes.

Example: An otolaryngologist does a radiofrequency reduction of the tongue for a sleep apnea patient. The coder should bill Category III code 0088T (Submucosal radiofrequency tissue volume reduction of tongue base...) to Medicare. However, for most private payors you would probably have to bill 41599 (Unlisted procedure, tongue, floor of mouth).

Important: CPT instructions specifically say not to use a Category I unlisted code if there's a Category III available. Category IIIs only span a few pages in your coding book, so if you get familiar with them, you'll have a better feel of when not to use an unlisted code. You can also chat with your physicians to see what kinds of emerging technology they might be using.

Also, make sure you read the entire text of the code explanation, as there are many details, Merrill advises. For instance, the new codes for Medication Therapy Manage-ment (0115T-0140T) are for pharmacists to use when they spend at least 15 minutes reviewing patient history, medication profile and recommendation. You cannot report these codes for describing product-specific information and other routine dispensing-related activities.

Payoff: When coders begin reporting Category III codes, they will continue to be available, but CPT will archive the unused Category IIIs after five years, Merrill says. However, if they are proven to be useful, Category III codes have the possibility of becoming Category I codes.

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Proof: Check out the Category IIIs that have recently converted to Category I:

• 28890 (Extracorporeal shock wave, high energy, performed by a physician, requiring anesthesia other than local, including ultrasound guidance, involving plantar fascia)

• 33880-33891--These are seven codes that represent new procedures associated with "endovascular repair of descending thoracic aorta."

• 86480 (Tuberculosis test, cell mediated immunity measurement of gamma interferon antigen response)

• 87900 (Infectious agent drug susceptibility phenotype prediction using regularly updated genotypic bioinformatics)

Downside: Unfortunately there is no guarantee of reimbursement with Category IIIs. For instance, the new Category III codes for spinal surgery (0090T-0098T) are paid by workers' comp only, Merrill points out.

If your payor won't reimburse, determine an appropriate charge by discussing with the physician and assigning a fee that corresponds to the complexity of the procedure, Massey suggests.

Good idea: If you report a Category III code to Medicare or other payors, "drop the claim to paper, and send a copy of the documentation to the payor for reimbursement," Massey adds.

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