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CPT® Guidelines and Proper Use of Them – Tips & Tools to Get Your Deserved Reimbursements

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Agenda

- Common CPT® guidelines and how to ensure proper payments
- Difficult CPT® coding scenarios – and how to overcome them:
  - Incomplete Colonoscopy
  - Pan Metatarsal Head Resection
  - Maloney Esophageal Dilation with EGD Procedure
  - Hysteroscopic D&C and Excision of Leiomyoma, Uterus
  - CMC Joint Interposition Arthroplasty
- Proper use of modifiers – whether modifiers are billable with a particular code
- Coding scenarios in which modifiers play important part in getting CPT®s paid
- Useful tools that help to master CPT® guidelines

Get Proper Pay for Services Rendered

In today's regulatory environment, it can be a real challenge to obtain reimbursement for procedures and services rendered. Accurate coding is the most crucial step in the reimbursement process.

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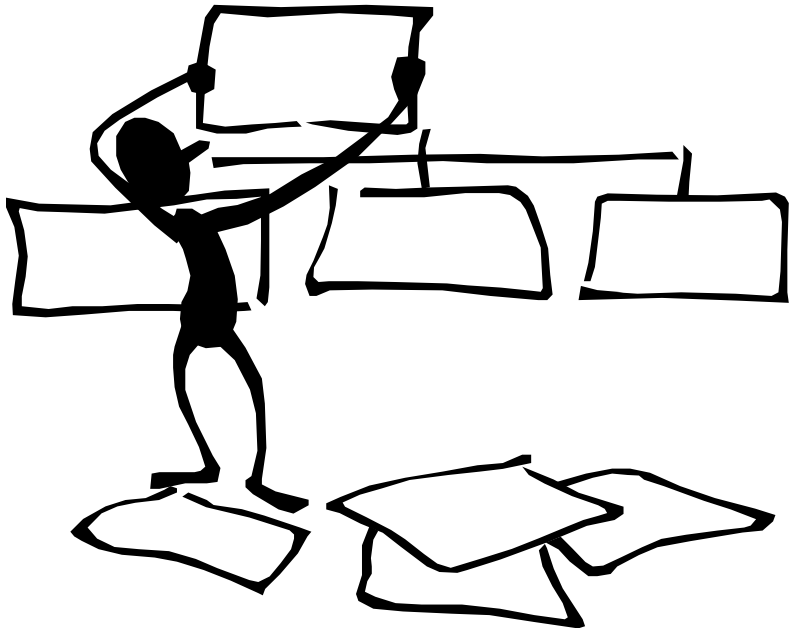
Understanding CPT® Guidelines

A major part of coding from CPT® is about understanding the parentheticals and other instructions that the AMA has added in the CPT® manual as guidelines in choosing the appropriate CPT® code for a procedure or service.

Better Understanding of CPT® Guidelines And Proper Use of Them Will Ensure The Reimbursement You Rightfully Deserve!



CPT® Guidelines

- As you are aware, each of the six sections of the AMA CPT® codebook covers specific guidelines for reporting procedures and services.
- These guidelines provide information that's important to appropriately interpret and report the procedures and services with the CPT® codes found in that specific section.
- For instance, the Medicine Section guidelines cover specific instructions for handling unlisted services or procedures, special reports, and supplies and materials provided.

Understanding CPT® Guidelines

- One of the best ways to reduce CPT® coding errors is to read all CPT® coding guidelines and notes very carefully.
- BUT the CPT® book is extremely detailed.
- Sometimes if a coder does not read the special notes that are included under codes or section headings, she may miss key reporting rules.
- Some codes will contain exclusion notes listing conditions or procedures that shouldn't be billed in a certain way or in addition to another code.
- So sometimes it's helpful to have an online tool to help you with the CPT® guidelines!

Today we'll talk about CPT® guidelines, proper use of the guidelines to secure proper pay, correct use of modifiers, some challenging CPT® coding scenarios coders/billers face on a daily basis, and how having an online tool can ease your work!

Overcome Tough CPT® Coding Challenges

To help you navigate the often-confusing world of CPT® coding, let's walk you through some tough coding scenarios and provide advice on the correct way to code these procedures.

Challenging Scenarios

Question: I am trying to code for angioplasty of peroneal and tibioperoneal, and angioplasty with stent of the anterior tibial. How would I code this?

Answer: For your case, you should report 37230 (*Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal stent placement[s], includes angioplasty within the same vessel, when performed*) for the angioplasty and stent placement in the anterior tibial.

You should report +37232 (*Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty [List separately in addition to code for primary procedure]*) once to cover the work in both the peroneal and tibioperoneal.

Here's Why:

CPT® guidelines indicate that the "tibial/peroneal territory is divided into 3 vessels: anterior tibial, posterior tibial, and peroneal arteries."

When you compare the instruction to your case (interventions in the anterior tibial, peroneal, and tibioperoneal), you see the anterior tibial counts as one vessel and the peroneal counts as a separate vessel. CPT® does not count the tibioperoneal as a distinct vessel under this definition of the tibial/peroneal territory.

Apply the Rules:

You should choose a primary code for the vessel that had the most extensive procedure(s). In this case, you should report:

- 37230 for the angioplasty and stent in the anterior tibial.

Next, consider the guideline that "If other tibial/peroneal vessels are also treated in the same leg, these interventions are reported with the appropriate add-on code."

In your case, you should assign:

- +37232 for the angioplasty in the peroneal and include the tibioperoneal service here, as well.

Rationale:

If you continue reading the guidelines, you'll learn that you should not code the tibioperoneal work separately.

The guidelines state: "The common tibio–peroneal trunk is considered part of the tibial/peroneal territory, but is not considered a separate, fourth segment of vessel in the tibioperoneal family for CPT® reporting of endovascular lower extremity interventions … For instance, if lesions in the common tibio–peroneal trunk are treated in conjunction with lesions in the posterior tibial artery, a single code would be reported for treatment of this segment."

How to Code

Question: Can I charge for nitroglycerin injections x 2 when performing a right posterior tibial angioplasty and right peroneal angioplasty? If so, which codes do I use for the full service?

Answer: You should not code separately for nitroglycerin injections during catheter services. The injections are a usual part of the procedure and should not be reported with their own codes.

For the right posterior tibial and right peroneal angioplasty, report:

- **37228** (Revascularization, endovascular, open or percutaneous, tibial, peroneal artery, unilateral, initial vessel; with transluminal angioplasty) for one vessel
- **+37232** (Revascularization, endovascular, open or percutaneous, tibial/peroneal artery, unilateral, each additional vessel; with transluminal angioplasty [List separately in addition to code for primary procedure]) for the second vessel.

How to Bill for Splinter Removal in Foot?

What code would you use if the physician used fluoroscopy to assist removal?

The removal codes (10120, 10121, 28190, etc.) does not usually require fluoroscopy. In case fluoroscopy is required, reporting shall depend on several items:

According to **CPT® Assistant:**

"From a **CPT®** coding perspective, reporting a radiologic guidance procedure code, including codes 76000 and 77003, requires a separate distinctly identifiable report, or documentation within the report for the procedure where guidance was used, and should be signed by the interpreting physician, as indicated in the Radiology Guidelines."

Fluoroscopy

"Since fluoroscopic imaging requires personal supervision, if the physician is not present in the operating room during a procedure that uses fluoroscopy or fluoroscopic guidance, that physician should not submit a code for fluoroscopy."

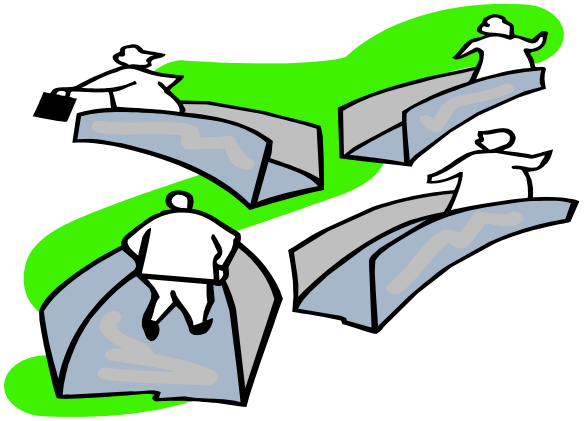
If there is adequate documentation of the physician interpreting the fluoroscopy report, then code 76000 with modifier 26. Ensure that the documentation contains the medical necessity for performing fluoroscopy. There is no CCI bundling between 76000 and procedure codes such as 28190/12020-12021 etc.

Watch Out

But remember, if fluoroscopy is a regular service used by this physician for every removal operation just to ensure the FB location, then billing a fluoroscopy code every time would attract audit attention and possible denial from payers for not meeting medical necessity requirements.

Know How to Avoid Confusing CPT® Scenarios

Here're some more examples of some confusing scenarios coders often face and trip up on, resulting in improper payments.



Scenario 1: Incomplete Colonoscopy

A 62-year-old Medicare male patient presented to the clinic for screening colonoscopy.

- The patient has history of colonic polyp removed 5 years ago.
- Currently he does not have any complaint.
- He was taken to the operative room, prepped and draped for the colonoscopy procedure. Conscious sedation was achieved.
- The procedure was started. Colonoscope was inserted through the rectum, but due to poor prep the physician was unable to advance the scope beyond sigmoid colon.
- During the procedure, the patient complained of shortness of breath and became hypertensive.
- The physician cancelled the procedure as the patient's conditions were life threatening.

Correct Coding for Incomplete Colonoscopy

During incomplete colonoscopy procedures, if the patient was scheduled and prepped for colonoscopy, always use colonoscopy codes.

- Do not down code the procedure to sigmoidoscopy.
- Also do not append modifier 52 to report incompleteness of the procedure.
- Instead, use modifier 53 when reporting for physician with adequate documentation and use modifiers 73 or 74 whichever is applicable if reporting for facility outpatient/ ASC.

If we report the incomplete service using modifier 52, the beneficiary will only get 50% of the payment for this procedure. Since the first colonoscopy was incomplete, the physician will definitely undergo second colonoscopy. If we report the first incomplete colonoscopy with modifier 52, the second visit will be denied by the insurance carrier as it will fall under frequency trap.

Incomplete Colonoscopy

CPT® Guidelines Read: "When performing an endoscopy on a patient who is scheduled and prepared for a total colonoscopy, if the physician is unable to advance the colonoscope beyond the splenic flexure, due to unforeseen circumstances, report the colonoscopy code with modifier 53 and appropriate documentation."

Second Scenario: Pan Metatarsal Head Resection: 1st through 5th

A 52 year-old male patient presented to the hospital with chief complaint of chronic metatarsalgia. Conservative management failed to provide relief. Pan metatarsal head resection of 2nd through 5th metatarsal was planned. The patient's foot was prepped and draped for the procedure and pan metatarsal head resection of 2nd through 5th metatarsal was performed.

Correct Coding for Pan Metatarsal Head Resection

We have specific codes for resection of first (28111), second through fourth (28112) and fifth metatarsal (28113). Many coders get confused and report the procedure with code 28114:

- Ostectomy, complete excision,
- All metatarsal head with partial proximal phalangectomy
- Excluding first metatarsal (e.g., Clayton type procedure).

But this is incorrect!

Proximal phalanx phalangectomy is also required to qualify for 28114. Reporting 28114 for pan-metatarsal head resection procedure may lead to denial. The ideal coding should be 28112 three times for 2^{nd}, 3^{rd} and 4^{th} metatarsal head excision and 28113 for metarsectomy performed on 5^{th} metatarsal.

Third Scenario: Maloney Esophageal Dilation with EGD Procedure

A gastroenterologist performed an upper GI endoscopy. After introducing the scope through the mouth, he advanced the scope to the second part of the duodenum. He accomplished the upper GI endoscopy without difficulty. He found a mild Schatzki ring (acquired) in the gastro esophageal junction. He successfully dilated it with a 50Fr Maloney dilator. He also found a small hiatus hernia. He examined the stomach and found it normal.

Correct coding for Maloney Esophageal Dilation with EGD Procedure

In such a scenario, for the Maloney dilation, report:

- **43450** (Dilation of esophagus, by unguided sound or bougie, single or multiple passes).
- Also, do not forget to report the endoscopy performed along with Maloney dilation as there is no bundling issue between codes **43235** and **43450**.
- Don't append modifier 59 if you are reporting these two codes.

Scenario 4: Hysteroscopic D&C and Excision of Leiomyoma, Uterus

A physician performed hysteroscopy for abnormal uterine bleeding. During the procedure, he noted a submucosal uterine fibroid in the fundal portion of the uterus. The physician performed D&C of the uterus. He also removed the uterine fibroid in the same operative session.

Correct coding tip: Code both the procedures - 58561, +58558 - separately as there is no bundling issue between these two codes.

Scenario 5: CMC Joint Interposition Arthroplasty

A CMC joint arthroplasty of the thumb is a commonly performed procedure. The base procedure described by 25447 is as follows:

- A curvilinear incision is made over the radial aspect of the proximal first metacarpal extending proximally over the trapezium and trapezioscaphoid joint.
- The interval between the slips of the abductor pollicis longus is developed and the periosteum over the base of the first metacarpal and trapezium is elevated along with dorsal and palmar flaps of the first CMC and scaphotrapezial capsules

CMC Joint Interposition Arthroplasty

- The trapezium is carefully removed, taking care not to injure the adjacent radial artery and flexor carpi radialis. (Some surgeons will remove the base of the first metacarpal.)
- The interposition material chosen by the surgeon is placed in the defect created by removal of the trapezium.
- Usually an autologous tendon is used though other tissues such as fascial lata and allografts have been used. The interposition material is secured in the trapezial defect. A temporary Kirschner wire is often used to stabilize the arthroplasty. The capsule is closed and a splint applied.

Correct Coding for CMC Joint Interposition Arthroplasty

Many times physicians perform tendon transfer procedure along with interposition arthroplasty to provide more stability to the joint. This transfer of tendon (generally FCR) to the base of the first metacarpal is not a part of the basic first CMC arthroplasty procedure and must be coded in addition to 25447.

- This can be reported by either 26480, Transfer or transplant of tendon, carpometacarpal area or dorsum of hand; without free graft, each tendon, or 25310, Tendon transplantation or transfer, flexor or extensor, forearm and/or wrist, single; each tendon, as appropriate depending upon the documentation.

- Modifier 51 would be appended to the secondary procedure in either the 25447 + 26480 or 25310 code pairs.

Proper Use of Modifiers

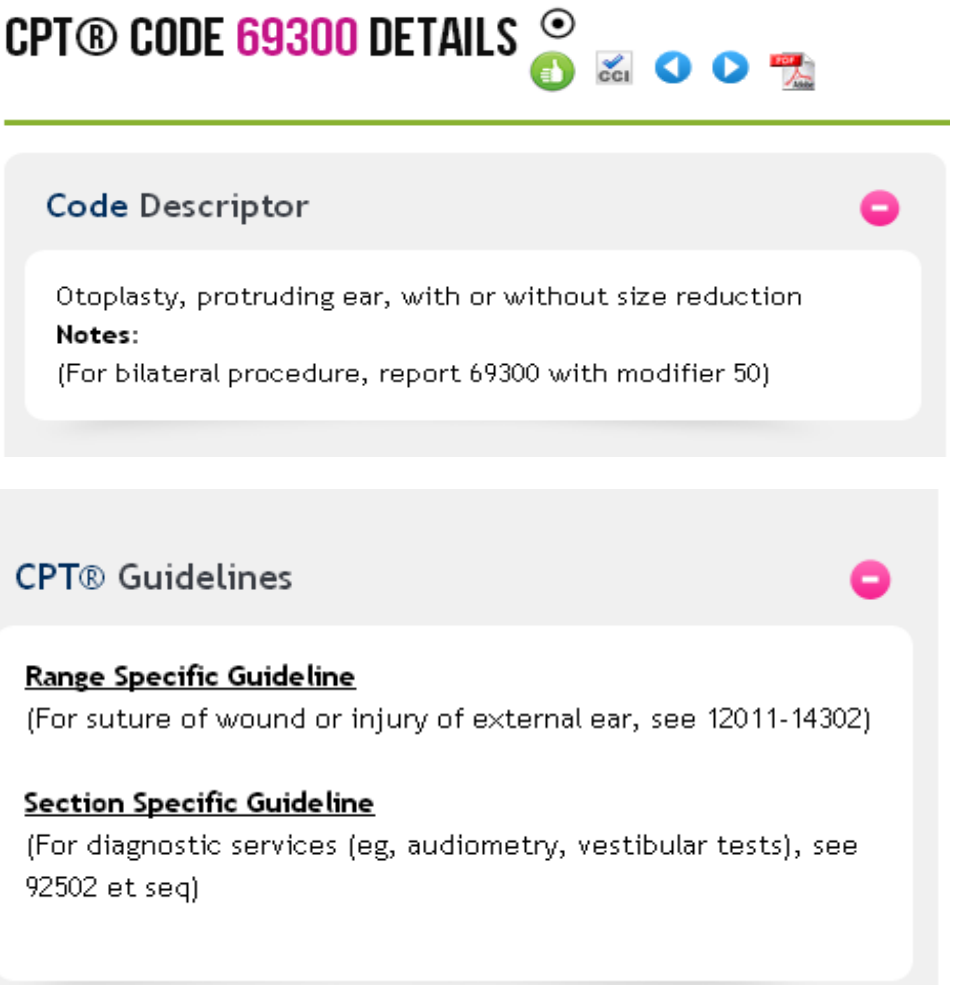
In the AMA CPT® manual, you can find many "parenthetical notes" just below a code. Not every code has a note, but many do. These notes may suggest whether a modifier can be appended to a code, whether a code can be bundled with another and any other code-specific instruction that is very important for a coder.

For example, CPT®code 69300 has parenthetical notes that state: "For bilateral procedure, report 69300 with modifier 50".

Proper Use of Modifiers

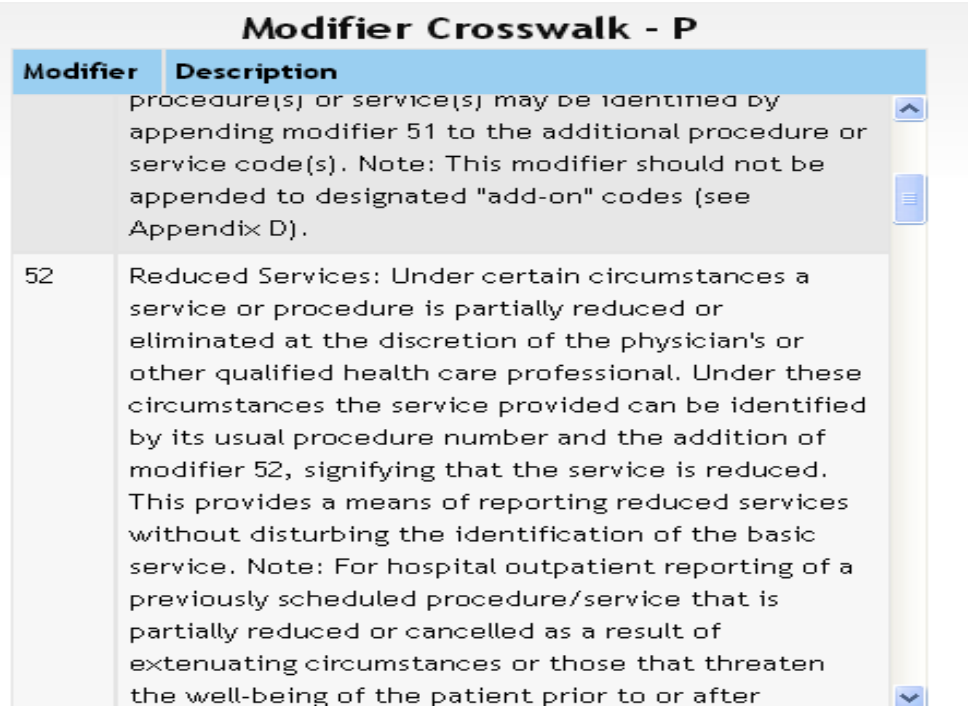
This information can be verified and used in coding using an online resource like SuperCoder; you can find the information from multiple locations on SuperCoder (see Code Details Page next slide). The "parenthetical notes" are visible on the CPT® Code Details Page, just below the official descriptor.

CPT® Guidelines



Know Whether Modifiers are Billable with a Particular Code

On the **Modifier-P** tab (available with Fast Coder and higher products) under the green "Crosswalks" bar, the notes will say whether the modifiers are billable for that particular code.



Modifier Crosswalk - P

Modifier	Description
	procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s). Note: This modifier should not be appended to designated "add-on" codes (see Appendix D).
52	Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician's or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after

CPT® Guidelines

In the CPT® manual, the guidelines for the range 62263-62319 under the header "Injection, Drainage, or Aspiration" reads:

"Injection of contrast during fluoroscopic guidance and localization is an inclusive component of 62263, 62264, 62267, 62270-62273, 62280-62282, 62310-62319. Fluoroscopic guidance and localization is reported with 77003, unless a formal contrast study (myelography, epidurography, or arthrography) is performed, in which case the use of fluoroscopy is included in the supervision and interpretation codes."

You can tally or check this with the help of a CCI tool on SuperCoder – **CCI Edits Checker**.

The tool will show a bundling with modifier indicator "1" that can be seen with column II code 77003 (fluoro guidance), suggesting that this code should not be billed separately with the codes falling in range 62263-62319.

The tool will help you check any type of CCI bundling (physician/hospital) existing between two codes, and this tallies with the AMA guidelines.

Where can I get one?

The CCI tool is found on SuperCoder's Fast Coder and all higher products.

Results

Validation Results Office

Code	Description	TOTAL RVU
62263	percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days **CCI Validation Results:** No CCI edit; Check CPT® coding guidelines to make sure code is allowed. **CPT® Assistant** **Lay Terms** **My Specialty Coding Alert Related Articles**	21.30
62319	injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal) **CCI Validation Results:** Code 62319 is a column 2 code for 62263, These codes cannot be billed together in any circumstances. Code 62319 is bundled into code 62263 Code 62319 cannot be billed with 62263. **CCI edit Rule:** **Standards of medical / surgical practice**	5.17

CPT® Scenario: Modifiers Help Distinguish 92928 Services

Can you bill multiple stents to different arteries of the heart? For example, if the doctor does a stent to the RC and LC, and angioplasty to the LD, should you bill 92928-RC, 92928-LC, and 92920-LD?

Answer: For your scenario, you may report one intervention code per major coronary artery.

As you describe, the codes and modifiers are:

- 92928-RC, *Percutaneous transcatheter placement of intracoronary stent(s), with coronary angioplasty when performed; single major coronary artery or branch; Right coronary artery*
- 92928-LC, … *Left circumflex coronary artery*
- 92920-LD, *Percutaneous transluminal coronary angioplasty; single major coronary artery or branch; Left anterior descending coronary artery*.

Percutaneous Coronary Intervention

According to CPT® guidelines, you should use one base code per major coronary artery for percutaneous coronary intervention (PCI) procedures performed during the same session. The term base code lets you know not to use one of the add-on codes CPT® includes for coronary branches (more on that on the next slide).

Tip: If a case involves branches of the major arteries, you need to check your payer's rules for reimbursement information. CPT® now includes separate add-on "additional branch" codes, but Medicare bundles payment for those branch codes into the major artery codes.

Watch Out for Special Cases Outlined in the Guidelines

For instance, if the physician uses a single intervention to treat a lesion that takes up space in two different vessels, you should report just one code rather than reporting each vessel separately.

Alternatively, if the physician uses the kissing balloon technique on a bifurcation lesion of a major artery and branch, the guidelines state you may report a base code and an "additional branch" code when warranted, depending on the documentation provided.

Knowing CPT® Guidelines Properly Can Help You Avoid Many Procedure Coding Mistakes!

And with a good online resource like **Fast Coder**, you can sidestep most procedure coding mistakes effortlessly.

This online resource can help you:

- **Get CPT® code details instantly** – including new, revised and deleted codes.
- **Get official guidelines shown per code:** No need to flip from a code to the start of a section to locate applicable guidelines. Essential instructions from CPT® coding guidelines are shown with each code.
- **Master CPT® guidelines**: Shows all instances of the searched code(s) and/or keyword(s) appearing in the searched codeset's official guidelines, such as when 69210 appears in guidelines of CPT® codes.

How Can It Help You?

- Code new and past changes for the **CPT® code(s) and/or keyword(s) entered**
- Compare guidelines, lay terms and even historical data in a snap
- Get all personal notes for the **CPT®** code entered and all personal notes containing the **code(s) and/or keyword(s) entered**.
- Quickly spot CPT® guideline changes by looking for green **SuperCoder** Text
- See the code's allowed physician modifiers by clicking on the **Modifiers – P** button

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Other Key Features on Fast Coder

Anatomic Modifiers: Anatomic modifiers are now available for orthopedic, integumentary, respiratory, cardiovascular, digestive, and urinary system CPT® codes!

To see the top modifiers associated with a CPT® code, simply open the code's details page, look under Crosswalks, and select a Modifiers tab.

Other key Features on Fast Coder

- ✓ CCI Edits Checker
- ✓ LCD Lookup

Helpful Online Tools & Resources

Features	Code Search	Fast Coder	Physician Coder	Outpatient Facility Coder	DRG Coder
CPT® Codes Index & Search:	✓	✓	✓	✓	✓
Modifier Pack:	✗	✓	✓	✓	✓
CPT® ↔ HCPCS:	✗	✓	✓	✓	✓
CCI Edits Checker:	✗	✓	✓	✓	✓
LCD Lookup:	✗	✓	✓	✓	✓
Fee Schedules:	✗	✗	✓	✓	✓
CPT ↔ICD-9 Crossref:	✗	✗	✓	✓	✓
Coding Newsletter:	✗	✗	✓	✓	✓
Survival Guides:	✗	✗	✓	✓	✓
OPPS (Outpatient Prospective Payment System):	✗	✗	✗	✓	✗
DRG (Diagnosis-Related Grouper):	✗	✗	✗	✗	✓
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