Documentation, Billing and Coding: Basic Concepts

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DISCLAIMER

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Publications: Over 200 articles and 3 books
No outside funding, no grants, no support from industry
Do No Harm

New Rule
Make No Mistake(s)

HIPPOCRATIC OATH

Myths and fears of coding

Demystifying the art of coding
Basic Concepts

♦ Documentation
  • Medical Necessity
  • Medical Record

♦ Billing and Coding
  • CPT
  • ICD
  • Coding Process
  • Specialty Decision
Medical Necessity

- Medical necessity requires appropriate diagnosis and coding by the ICD-9-CM to justify services rendered and indicates the severity of patients’ condition.
- The Balanced Budget Act (H.R. 2015, Section 4317) requires all physicians to provide diagnostic information for all Medicare/Medicaid patients starting from January 1, 1998.
- Failure to comply with this regulation can result in prosecution.
- Coding should be to the highest degree of certainty for each encounter.
  - Coding also should correlate with multiple components of the patient’s medical record, including initial evaluation or follow-up visits and the billing statement.
  - For chronic conditions treated on an ongoing basis, they may be reported as many times as the patient receives care for that condition.

AMA Definition

“IHalth care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is 1) in accordance with generally accepted standards of medical practice; 2) clinically appropriate in terms of type, frequency, extent, site and duration; and 3) not primarily for the convenience of the patient, physician, or other healthcare provider.”
Top Ten Consequences Of Inappropriate Documentation

1. PRISON

2. EXCLUSION
3. SANCTIONS
4. FINES
5. FALSE CLAIMS ACT
6. DENIED CLAIMS
7. TRIGGER REVIEW(S)
8. RETURNED CLAIMS
9. SUSPENDED CLAIMS
10. DOWN CODING

Who is Responsible?
Top Ten Regulations Requiring Appropriate Documentation

1. LOCAL COVERAGE DECISIONS
2. CMS’S GOAL TO REDUCE IMPROPER PAYMENT RATE TO 5%
3. COMPLEX FEDERAL REGULATIONS
4. SKY HIGH SETTLEMENTS
5. REGULATIONS TO CURB IMPROPER PAYMENTS
6. NATIONAL CORRECT CODING POLICY 1996
7. ANTI-KICKBACK STATUTE
8. BALANCED BUDGET ACT 1997
9. KENNEDY-KASSEBAUM REFORM BILL 1996
10. FEDERAL FALSE CLAIMS ACT

Documentation

◆ Purpose
  • To record information
  • To communicate information
  • To obtain proper reimbursement
  • To document level of service

◆ Types
  • Evaluation and management
  • Procedural Documentation
  • Discharge

◆ Location
  • Facility
    o ASC, Hospital, Rehab, Nursing Home, Mental Health
  • Non-facility
    o Office, home
Documentation:
Functions of Medical Record

1. Keeps practitioner out of slammer
2. Supports “medical necessity”
3. Reduces medical errors & professional liability exposure
4. Reduces audit exposure
5. Facilitates claims review
6. Supports insurance billing
7. Provides clinical data for education
8. Provides clinical data for research
9. Promotes continuity of care among physicians
10. Indicates quality of care

Documentation:
Proper Medical Record

♦ Why did the patient present for care?
♦ What was done?
♦ Where were the services rendered?
♦ When is the patient to return, or what is the plan of action?
♦ Will there be follow-up tests or procedures ordered?
Documentation

It's all about the documentation stupid!

Do it right!

If you “Make a mess, clean it up!”

Billing and Coding

*Current Procedural Terminology (CPT)*

*International Classification of Diseases (ICD-9-CM)*
What is the CPT nomenclature?
- A five-digit code.
- Accurately identifies procedures or services rendered by any qualified physician or other qualified health care professional.
- Simplifies reporting of a procedure or service.
- Represents any service or procedure rendered by any qualified physician or other qualified health care professional.

What is not?
- Does not imply any health insurance coverage or reimbursement policy.
- Does not restrict its use to a specific specialty group.

How Is The CPT Nomenclature Used?
- CPT codes and descriptive terms currently serve a wide variety of important functions in the field of medical nomenclature.
- CPT coding is the most widely accepted medical nomenclature used to report medical procedures and services under government and private health insurance programs:
  - Over 10,000 codes in 2006
- CPT coding is also used for administrative management purposes such as:
  - Claims processing
  - Developing guidelines for medical review
- The uniform language is also applicable to medical education and research by providing a useful basis for utilization comparisons:
  - Local
  - Regional
  - National
How was the CPT nomenclature developed?

The AMA first developed and published the CPT nomenclature in 1966. The first edition helped to:

- Encourage the use of standard terms and descriptors to document procedures in the medical record.
- Communicate accurate information on procedures and services to agencies concerned with insurance claims.
- Provide the basis for a computer-oriented system to evaluate operative procedures (or surgical procedures).
- Contribute basic information for actuarial and statistical purposes.

The first edition of CPT contained primarily surgical procedures, with limited sections on medicine, radiology, and laboratory procedures.

In 1966, CPT coding used a 4-digit system.

How was the CPT nomenclature developed?

In 1970, the second edition of CPT was published by AMA.

- Presented and expanded systems of terms and codes to designate diagnostic and therapeutic procedures in surgery, medicine, and the specialties.
- 5-digit codes were introduced, replacing the former 4-digit system.
- A significant change to the book was to list procedures related to internal medicine.
How was the CPT nomenclature developed?

The third and fourth editions of CPT nomenclature were introduced in 1973 and 1977.

- The fourth edition, published in 1977, represented significant updates in medical technology.
- A system of periodic updating was introduced to keep pace with the rapidly changing medical environment.

How was the CPT nomenclature developed?

In 1983, CPT nomenclature was adopted as part of the Healthcare Common Procedure Coding System (HCPCS) developed by the Health Care Financing Administration (HCFA) – now the Centers for Medicare and Medicaid Services (CMS).

- With this adoption, the CMS mandated the use of HCPCS to report services for Part B of the Medicare program.
- In October 1986, CMS also required state Medicaid agencies to use HCPCS in the Medicaid management information system.
- In July 1987, as part of the Omnibus Budget Reconciliation Act, CMS mandated the use of CPT codes for reporting outpatient hospital surgical procedures.
How was the CPT nomenclature developed?

In 1983, CPT-editorial page and annual updates.

In 1988, AMA started publishing mini books.

In August 2000, the CPT code set was named as a national standard under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Who maintains the CPT nomenclature?

The AMA’s CPT Editorial Panel is responsible for maintaining the CPT nomenclature. This panel is authorized to revise, update, or modify the CPT codes. The panel is made up of 17 members:

- Eleven are nominated by the AMA
- Two are non-physician members representing the Health Care Professionals Advisory Committee (HCPAC)
- One is nominated by the Blue Cross and Blue Shield Association
- One is nominated by the Health Insurance Association of America
- One is nominated by CMS
- One is nominated by the American Hospital Association
Who maintains the CPT nomenclature?

♦ AMA’s Board of Trustees appoints the panel members. Of the 11 AMA seats on the panel, 7 are regular seats, having a maximum tenure of two 4-year terms, or a total of 8 years for any one individual.
♦ One of the seats is designated for a physician from Managed Care.
♦ The four seats are rotating seats, each have one 4-year term with input from various specialties.

Who maintains the CPT nomenclature?

♦ The CPT Executive Committee, maintained by five members of the Editorial Panel, includes the following:
  • Chairman
  • Vice Chairman
  • Three panel members at large

♦ The Editorial Panel is elected by the entire panel.

♦ One of the three members at large of the Executive Committee must be a third-party payor representative.

♦ AMA provides:
  • Staff support
  • Appoints a staff secretary
Who maintains the CPT nomenclature?

CPT ADVISORY COMMITTEE

- A larger body of CPT advisors that supports the CPT Editorial Panel in its work.
- Members are primarily physicians nominated by the National Medical Specialty Societies represented in the AMA House of Delegates.
- Limited to:
  - National Medical Specialty Societies with a seat on the Delegates.
  - AMA-HCPAC
  - Organizations representing limited-licensed practitioners
  - Organizations representing other allied health professionals
- The Performance Measures Advisory Committee (PMAC) representing various organizations concerned with performance measures

Objectives of CPT Advisory Committee

- To serve as a resource to the CPT Editorial Panels by giving advice on procedure coding and appropriate nomenclature as relevant to the members’ specialty of practice
- Provide documentation to AMA staff and CPT Editorial Panel regarding the appropriateness of various medical and surgical procedures under consideration as CPT codes
- To suggest revisions to the CPT nomenclature
  - The Advisory Committee meets annually to discuss items of mutual concern and to keep informed on current issues in coding and nomenclature
- To assist in the review and further development of relevant coding issues and in the preparation of technical education material and articles pertaining to CPT coding.
- To promote and educate its membership on the use and benefits of CPT coding
Objectives of AMA Health Care Professionals Advisory Committee

- The current CPT nomenclature contains many codes that are used by physicians and other types of providers.
- HCPAC was established in 1992 by the AMA Board of Trustees for CPT Editorial Panel and Relative Value Scale Update Committee (RUC).

Organizations

- Physician Assistants
- Nurses
- Occupational and Physical Therapists
  - Optometrists
  - Podiatrists
  - Psychologists
  - Social workers
  - Audiologists
  - Speech pathologists
  - Chiropractors
  - Dietitians
  - Respiratory therapists
  - Naturopaths
  - Genetic counselors
Who can submit suggestions for changes to CPT nomenclature?

- Anyone
  - Changes to CPT coding
  - Updates to CPT coding
  - Changes in the nomenclature
  - Correspondence inquiries
  - Suggestions

CPT Process

Coding suggestion for Category I, II, or III codes

Staff Review

Panel Has Already Addressed the Issue
New Issue or Significant New Information Received
Category II code Proposal to PMAG
PMAG agrees code is not necessary

Letter to requestor informing him or her of correct coding interpretation
Specially Advisors
PMAG agrees code is necessary
Letter to requestor informing him or her of correct coding interpretation

Advise(say give consideration or two specialty advisors disagree on code assignment or nomenclature)
Editora Panel
Advise(say agree No New Code or Revision Needed)

Staff letter to requestor informing him or her of correct coding interpretation or action taken by the panel

Table for further study
Reject proposal change
Add new code Delete Existing Code or Rename Current Terminology
Published in CPT Books and on the Web
Categories of CPT Codes

- Category I CPT Codes reflect services or procedures performed by health care providers in clinical practice with FDA approval when necessary.
- Category II CPT Codes are for performance measurements.
- Category III CPT Codes are temporary codes for emerging technology, services and procedures that allow for data collection.
  - Category III CPT Codes must be used when available instead of a Category I Unlisted CPT Code.
HCPCS Terminology

◆ “Hick Picks”
◆ Health Care common Procedure Coding System
◆ Developed in 1983
◆ Uniform method to report Professional Services and Procedures
◆ Third Party, Medicaid, any Manufacturer or Supplier contribute to those codes
◆ CMS maintains HCPCS
  • A National Panel

CMS Intentions

◆ Meet the operational needs of Medicare/Medicaid
◆ Coordinate government programs by uniform application of CMS policies
◆ Allow providers and suppliers to communicate their services in a consistent manner
◆ Ensure the validity of profiles and fee schedules through standardized coding
◆ Enhance medical education and research by providing a vehicle for local, regional, and national utilization comparisons
HCPCS Codes

3 Levels:

♦ Level I-CPT
  

Level II- HCPCS National Codes (Over 5000 codes)

1. Required for reporting most medical services and supplies provided to Medicare and Medicaid patients and by most private payers.

2. The permanent national codes serve the important function of providing a standardized coding system that is managed jointly by private and public insurers.

3. National codes consist of one alphabetic character (a letter between A and V), followed by four digits.

4. They are grouped by the type of service or supply they represent and are updated annually by CMS with input from private insurance companies.

5. Also contain modifies, which are either alphanumeric or two letters in the range A1 to VP.
Level III – Local Codes

- The Health Insurance Portability and Accountability Act (HIPAA) required that there be standardized procedure coding.
- To meet this requirement, all unapproved HCPCS Level III codes/modifiers were eliminated on December 31, 2003, except in rare cases.
- To compensate for the loss in local reporting, a greater number of codes are available on the national level.
- For example, since 2000 there has been a 47 percent increase in the number of Level II codes, owing in part to the increasing number of codes.

Sections Current Procedural Terminology

- Evaluation and Management 99201-99499
- Anesthesiology 00100-01999
  99100-99140
- Surgery 10021-69990
- Radiology 70010-71999
- Pathology 80048-89356
- Medicine 90281-99199
  99500-99602
## Interventional Pain Management Coding

1. Evaluation and Management

2. Surgery
   - musculoskeletal
     - General
     - Pelvis and hip joint

   Nervous system
     - Spine and spinal cord
     - Extracranial nerves, peripheral nerves and autonomic nervous system

3. Radiology (needle placement, fluoroscopy)
   - Spine and pelvis
   - Lower extremities (SI joint)
   - Other procedures

4. Medicine
   - Physical medicine & Rehab.
   - Psychiatry

## Instructions for Using the CPT Nomenclature

- Select procedure or service that accurately identifies the service performed.
- Do not select a CPT code that merely approximates the service provided.
- If no such service or procedure exists, then report the service using the appropriate unlisted procedure or service.
- Also list additional pertinent services or procedures.
- When necessary, modifying or extenuating circumstances are added.
- Any service or procedure performed should be adequately documented in the medical record.
CPT Nomenclature

Nomenclature vs. Classification

- CPT codes must be considered on their own merits and not simply on the placement of the code in CPT nomenclature
- Listing of a service or procedure in a specific section of the CPT code book does not restrict its use to a specific specialty group.
- Any procedure or service in any section of the book may be used to designate services rendered by any qualified physician or other healthcare professional.

Confusion about Surgical Codes

- Surgery is defined as: “incision, excision, amputation, introduction, endoscopy, repair, destruction, suture, and manipulation”
- Some procedures that appear in sections other than those where they might ordinarily be classified, because CPT nomenclature is not a strict classification system
- CPT places procedures in general sections according to where physicians will most conveniently find them (e.g., interventional pain management codes, digestive system surgery codes, musculoskeletal surgery codes)
- Some insurers may not cover any type of surgical procedures
- Type of service – medical or surgical-may be defined by insurers differently
CPT Format of the Terminology

- The format of the terminology was originally developed as stand-alone descriptions of medical procedures.
- To conserve space and avoid having to repeat common terminology, some of the procedure descriptors in CPT coding are not printed in their entirety.
  - They are described to refer back to a common portion of the procedure descriptor listed in a preceding entry
    64470 – Injection, anesthetic agent and/or steroid, paravertebral facet joint or facet joint nerve; cervical or thoracic, single level
    64472 cervical or thoracic, each additional level
    64475 lumbar or sacral, single level
    64476 lumbar or sacral, each additional level

CPT Code Symbols

- New procedure codes are identified throughout the manual with the “bullet” symbol preceding the code number for one year.
- The triangle is used to designate codes with substantially altered descriptions.
- These sideways triangles are used throughout CPT coding to indicate new and revised text, such as new parenthetical notes and language added to guidelines. They do not apply to code descriptors (see ▲).
- Add-on codes are identified with the plus symbol preceding the codes. (since 1999)
- This symbol designates codes that are exempt from the use of modifier 51, but have not been designated as CPT add-on procedures/services. Appendix E lists these codes
- This symbol designates codes for vaccines that are pending approval from the FDA.
- A green arrow symbol identifies CPT Assistant feature articles and educational instruction related to new, revised, and deleted codes published annually in CPT Changes:
CPT Guidelines

- Guidelines are found at the beginning of each of the 6 sections of the CPT Code book.
- The guidelines provide information that is necessary to appropriately interpret and report the procedures and services found in that section.
- In addition to the guidelines that appear at the beginning of each section:
  - Several of the subheadings or subsections have special instructions unique to that section.
  - These guidelines endnotes are critical to using CPT coding correctly.

CPT Coding

- Modifiers
- Add-on codes
- Bilateral codes
- Unlisted Procedures
- Correct coding policies
  - Comprehensive
  - Component
  - Mutually exclusive
CPT Modifiers

- CPT nomenclature uses modifiers as an integral part of its structure. Modifiers are used to indicate that a performed service or procedures has been altered by some specific circumstance but not changed in its definition.

- Modifiers may be used in many instances. Some examples are:
  - To report only the professional component of a procedure or service
  - To report a service mandated by a third-party payer
  - To indicate that a procedure was performed bilaterally
  - To report multiple procedures performed at the same session by the same provider
  - To report that a portion of a service or procedure is reduced or eliminated at the physician’s discretion.
  - To report assistant surgeon services

21 - prolonged E & M services
22 – unusual procedural services
23 – unusual anesthesia
24 – unrelated E & M service by same physician during post-op period
25 - significant, separately identifiable E & M service by the same physician on the same day of procedure or other service
26 – professional component
32 - mandated services
47 – anesthesia by surgeon
50 - bilateral procedure
51 - multiple procedures
52 - reduced services
53 - discontinued procedure
54 - surgical care only
55 - postoperative management only
56 - postoperative management only
57 - decision for surgery
58 - staged or related procedure or service by the same physician during the postop period
59 - distinct procedural service
62 - two surgeons
63 - procedure performed on infants less than 4 kg
66 - surgical terms
76 - repeat procedure by same physician
77 – repeat procedure by another physician
78 – return to the operating room for a related procedure during postop period
79 – unrelated procedure or service by the same physician during the postop period
80 – assistant surgeon
81 – minimum assistant surgeon
82 – assistant surgeon (when qualified resident surgeon not available)
90 – reference (outside) laboratory
91 – repeat clinical diagnostic laboratory test
99 – multiple modifiers
**CPT Add-On Codes**

- Never used by themselves
- The modifier 51 (additional procedure) is not used
- No payment adjustments
- Examples:
  - Facet joint injections
  - Facet neurolysis
  - Transforaminal epidurals
- Not Add-On Codes:
  - Epidurography
  - Fluoroscopy
  - Discocography-interpretation

**CPT Bilateral Codes**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transforaminal Facet Joint Blocks Facet Neurolysis SI Joint Injections</td>
<td>Intercostal Nerve Blocks Sympathetic Blocks Occipital Nerve Blocks Interlaminar Epidurals</td>
</tr>
</tbody>
</table>
National Correct Coding Policies

Now online from CMS
http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp

Interventional Correct Coding Policies
www.asipp.org
Correct Coding Policies

◆ Comprehensive
Comprehensive codes include certain services that are separately identified by other component codes.

◆ Component
Component codes are considered members of a code family and included in a comprehensive code.

◆ Mutually Exclusive
Mutually exclusive codes are codes for procedures that cannot be reasonably performed in the same session.

ICD
International Classification of Diseases

◆ 1937 – London Bills of Mortality – evolved into International Classification of Causes of Death
◆ 1948 - Based upon World Health Organization International Classification of Diseases.
◆ Need for more efficient storage and retrieval of diagnostic data.
◆ 1950 U.S. Public Health Service and VA testing of ICD for Hospital indexing of records by disease and operations for data storage and retrieval.
◆ U.S. National Committee on Vital & Health Statistics proposed uniform changes to ICD for hospital indexing.
◆ 1956 American Hospital Association and American Medical Record Association sponsored a study that demonstrated ICD provided a suitable means for indexing hospital records.
<table>
<thead>
<tr>
<th>ICD</th>
<th>International Classification of Diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basis for coding diagnostic data for morbidity and mortality statistics in the United States.</td>
<td></td>
</tr>
<tr>
<td>1968 Commission on Professional and Hospital Activities (CPHA) published Hospital adaptation of ICDA (H-ICDA) based on ICD-8 and ICDA-8.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD</th>
<th>International Classification of Diseases</th>
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<tbody>
<tr>
<td>1993 WHO published newest version of ICD.</td>
<td></td>
</tr>
<tr>
<td>ICD-10 5500 more codes than ICD-9.</td>
<td></td>
</tr>
<tr>
<td>ICD-10 currently used in some European countries.</td>
<td></td>
</tr>
</tbody>
</table>
Purpose of ICD

- ICD coding is used to substantiate the need for patient care or treatment and provide statistics for morbidity and mortality rates.
- ICD coding serves the following purposes:
  - Establishes medical necessity
  - Translates written terminology or descriptions into a universal, common language
  - Provides data for statistical analysis

Benefits of ICD-9-CM

- The systematic arrangement of ICD-9-CM makes it possible to encode, computerize, store, and retrieve large volumes of information from the patient’s medical record.
- Hospitals, physician offices, and other healthcare providers use ICD-9 to code and report clinical information required for participation in various government programs.
- Diagnostic coding is crucial for reimbursement process
- Diagnostic coding is equally important for tracking disease and compiling statistical data
ICD 9
International Classification of Diseases

SECTIONS

- Infectious and Parasitic Diseases (001-139.8)
- Neoplasms (140-239.9)
- Endocrine, Nutritional, Metabolic, Immunity (240-279.9)
- Blood and Blood-Forming Organs (280-289.9)
- Mental Disorders (290-319)
- Nervous System and Sense Organs (320-389.9)
- Circulatory System (390-459.9)
- Respiratory System (460-519.9)
- Digestive System (520-579.9)
- Genitourinary System (580-629.9)

ICD
International Classification of Diseases

SECTIONS

- Complications of Pregnancy, Childbirth & Puerperium (630-677)
- Skin and Subcutaneous Tissue (680-709.9)
- Musculoskeletal System and Connective Tissue (710-739.9)
- Congenital Anomalies (740-759.9)
- Conditions in the Perinatal Period (760-779.9)
- Symptoms, Signs, and Ill Defined Conditions (780-799.9)
- Injury and Poisoning (800-999.9)
- V Codes = Supplemental Classification
- E Codes = Environmental events leading to injury
Updates of ICD-9-CM
♦ The US National Center for Health Statistics and the Centers for Medicare and Medicaid are responsible for the annual update of ICD-9-CM each October 1, 2006.
♦ The changes are published in three publications:
  - Coding clinic published by the American Hospital Association
  - American Health Information Management Association Journal published by the American Health Information Management Association
  - Federal Register published by the US Government Printing Office

Official Guidelines of ICD-9-CM
♦ The Official Coding and Reporting Guidelines were developed and approved by the cooperating parties for ICD-9-CM:
  - American Hospital Association
  - American Health Information Management Association
  - Centers for Medicare and Medicaid Systems
  - National Center for Health Statistics
♦ The guidelines have been developed to assist the user in coding and reporting in situations where the ICD-9-CM manual does not provide direction
  - However, coding and subsequent instructions in the three ICD-9-CM volumes take precedence over any guidelines
♦ Guidelines appear in the text and in the appendices
Official Guidelines of ICD-9-CM

Publishing
- ICD-9-CM manuals are produced by a variety of publishers
  - All of the editions in publications today are based on the official government version of ICD-9-CM and contain the same basic content
- Variations may occur in the way the volumes are organized and cross-referenced
- Differences in publishers
  - Some publishers look at the index in the front of the manual for easy access or the back of the manual.
- Color Coding
- Mechanical alerts (circles, squares, and triangles)
- Anatomical drawings

Classification of Diseases and Injuries

<table>
<thead>
<tr>
<th>Divisions</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter:</td>
<td>A main division to the ICD-9-CM manual. Volume 1 consists of 17 chapters with codes from 001 to 999.</td>
</tr>
<tr>
<td>Section:</td>
<td>A group of three-digit categories (rubrics) that represents a group of conditions or related conditions.</td>
</tr>
<tr>
<td>Category:</td>
<td>A three-digit code that represents a single condition or disease; also referred to as a rubric.</td>
</tr>
<tr>
<td>Subcategory:</td>
<td>A four-digit code that provides a higher level of specificity, as compared to a three-digit code. The fourth digit can further define site, manifestation of the condition. A fourth digit must available.</td>
</tr>
<tr>
<td>Subclassification:</td>
<td>A five-digit code that adds additional information and specificity to the description. The fifth digit must be used, when available.</td>
</tr>
</tbody>
</table>

Example: Low back pain

722 Intervertebral disc disorders
722.5 Degeneration of thoracic or lumbar intervertebral disc
722.51 Thoracic or thoracolumbar intervertebral disc
722.52 Lumbar or lumbosacral intervertebral disc
Supplementary Codes

V and E Codes

V codes

♦ V codes are a supplementary classification of factors influencing health status and contact with health services:
  • Used when a person who is not currently sick uses health services for some specific purposes, such as to act as a donor of an organ or tissue, to receive vaccinations, to discuss a problem, or
  • When a person has a disease or injury and is in need of a specific treatment for that problem such as dialysis or chemotherapy

E codes

♦ E codes are a supplementary classification of codes that are used to clarify external circumstances that have causes an injury but not a disease:
  • These codes are never used alone
  • They always modify the main diagnosis code

Appendixes

The five appendixes:

♦ Provide additional information about the patient’s clinical picture
♦ Classify new drugs
♦ Reference three-digit categories
♦ Further define a diagnosis

Appendix Names  Description
Appendix A:  Morphology of Neoplasms
Appendix B:  (Note: The Glossary of Mental Disorders was deleted from the appendixes in 2005.)
Appendix C:  Classification of Drugs by the American Hospital Formulary Services
Appendix D:  Classification of Industrial Accidents
Appendix E:  List of Three-Digit Categories
Conventions and Terminology

**Includes** – An “includes” note further defines or clarifies the content of the chapter, subchapter, category, subcategory, or subclassification.

**Excludes** – Terms following “excludes” are not classified to the chapter, subchapter, category, subcategory, or classification.

**Use Additional Code** – This instruction indicates that an additional code should be used (when the information is available) to provide a more complete description of the diagnosis.

**Code First the Underlying Disease** – This instruction is used in those categories not intended for use as a principal diagnosis for the disease. These codes, called manifestation codes, may never be used alone or as the principal diagnosis (sequenced first). They must always be preceded by another ICD-9-CM code.

**Omit Code** – The term “omit code” is used to indicate that no code is to be assigned. When this instruction is found in the Alphabetic Index to Diseases, the medical term should not be coded as the diagnosis. This instruction is also italicized.

**Inclusion Terms** – A list of terms are included under certain fourth- and fifth-digit codes. These terms are the conditions for which that code number is to be used.

**And** – The word “and” should be interpreted to mean either “and” or “or” when it appears in the title.

**See** – The instruction “see” acts as a cross-reference and directs the coder to look elsewhere.

**See Also** – “See also” is a reference instructional note to refer to a specific category, subcategory, or subclassification before making a code selection if you cannot find the diagnosis listed under a term in Volume 2.

**NEC** – “Not elsewhere classifiable”; use this code assignment when the information at hand specifies a condition but no separate code for that condition is provided. When a specific code is not available for a condition, the Alphabetic index directs the coder to the “other specified” code in the Tabular list.

**NOS** – “Not otherwise specified”; use the “NOS” code assignment when the information at hand does not permit either a more specific or other code assignment. Also called “unspecified.”

**“Other” Codes** – Codes titled “other” or “other specified” (usually with a fourth-digit “8” or fifth-digit “9” for diagnosis codes) are for use when the information in the medical record provides detail for which a specific code does not exist.

**“Unspecified” Codes** – Codes (usually with a fourth-digit “0” or a fifth-digit “0” for diagnosis codes) titled “unspecified” are for use when information in the medical record is insufficient to assign a more specific code.

{} – Braces enclose a set of terms, each of which is modified by the statement appearing at the right of the brace.

[ ] – Brackets enclose synonyms, alternate wording, or explanatory phrases and identify manifestation codes.

( ) – Parentheses enclose supplementary words (modifiers) that may be present or absent in the statement of a disease or procedure, without affecting the code number to which it is assigned.

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The Future of Diagnosis Coding

1992 – the WHO finished its 10th revision to the ICD

◆ The National Center for Health Statistics has developed a clinical modification with a classification for morbidity purposes.

◆ ICD-10-CM is planned as the replacement for ICD-9-CM, volumes I and II.

◆ ICD-9-CM remains the diagnostic coding standard by government and private payors across the country until the implementation of ICD-10-CM.

◆ The projected implementation of ICD-9-CM is currently scheduled for October 2007.
Ten steps to ICD-9

1. Identify the reason for the visit
2. Consult the alphabetic index
3. Locate the main entry term
4. Read and interpret any new notes listed with the main term
5. Review entries for modifiers
6. Interpret abbreviations, cross references, and brackets
7. Choose a tentative code and locate it in the tabular list
8. Determine whether the code is at the highest level of specificity
9. Refer to the front of the book for definitions of colors and symbols
10. Assign the code

Coding Process

◆ Coding is not rocket science
  • But, it is Complex requires skill and effort.

◆ Coding is not black and white
  • May be several ways to code procedures

◆ Physician must be involved in Coding
  • Physician is the only individual who knows what was done
  • An informed MD coder is always better than a non-MD coder
Coding Tips

◆ Use CPT and ICD language
◆ Each document should stand alone
◆ List diagnosis in ICD language
◆ List procedures in CPT language
◆ Document medical necessity and indications
◆ Link diagnosis and procedure(s)

Coding Tips

◆ Preapproval
  • Precertification
  • Approval for performing the procedure (number)
  • Approval for coding and charge, in writing
◆ Who is watching your coding?
  • Physician should see every EOB in which there is a denial
◆ Three reasons for denial:
  • They misinterpreted your coding
  • They unilaterally denied payment
  • You coded it wrong

Repeated incorrect coding / denials leads to auditing
**Coding Tips**

Medicare decisions are made at two levels:

- CMS
  - Local carriers must abide by CMS rulings
- Local carrier
  - Have leeway on regional decisions

**Resources:**
- Federal Register
- CMS Memoranda

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**Specialties**

- 05 - Anesthesiology
- 72 - Pain Medicine (formerly Pain Management)
- 09 - Interventional Pain Management
- 25 – Physical Medicine & Rehabilitation
- 13 - Neurology
- 14 - Neurosurgery
If you practice ≥ 50% Interventional Pain Management
You should register as
O9 – Interventional Pain Management

You can download CMS Application form ASIPP home page

www.asipp.org
### TEN STEPS TO SAFETY

1. **LIVE HAPPILY EVER AFTER**
2. **COLLECT WHAT YOU BILLED**
3. **BILL WHAT YOU DOCUMENTED**
4. **STAY AWAY FROM CREATIVE BILLING**
5. **FOLLOW BILLING & CODING GUIDELINES**
6. **UNDERSTAND THE REGULATIONS**
7. **DOCUMENT MEDICAL NECESSITY**
8. **DOCUMENT THE PROCEDURE**
9. **DOCUMENT THE VISIT**
10. **PERFORM THE SERVICE**
Thank you

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