Learning Outcomes

After studying this chapter, you should be able to:

1. Discuss the purpose of the CPT code set.
2. Explain how to locate the periodic updates to CPT codes.
3. Describe the structure and content of the index and the main text in CPT.
4. Interpret the formats, conventions, and symbols used in CPT.
5. Describe the purpose and correct use of CPT modifiers.
6. List the three general steps for selecting correct CPT procedure codes.
7. Discuss the purpose, structure, and key guidelines for each of the six sections of CPT Category I codes.
8. Discuss the key components that are the basis for selection of CPT Evaluation and Management codes, and describe the steps for selecting correct codes.
9. Analyze procedural statements, apply appropriate physician practice coding guidelines, and assign correct CPT codes.

* All CPT 2007 codes are © 2006 American Medical Association.
Procedure codes, like diagnosis codes, are an important part of the medical billing process. Standard procedure codes are used by physicians to report the medical, surgical, and diagnostic services they provide. These reported codes are used by payers to determine payments. Accurate procedural coding ensures that providers receive the maximum appropriate reimbursement.

Procedure codes are also used to establish guidelines for the delivery of the best possible care for patients. Medical researchers track various treatment plans for patients with similar diagnoses and evaluate patients’ outcomes. The results are shared with physicians and payers so that best practices can be implemented. For example, this type of analysis has shown that a patient who has had a heart attack can reduce the risk of another attack by taking a class of drugs called beta blockers.

In the practice, physicians, medical coders, medical insurance specialists, or outside companies assign procedure codes. Medical insurance specialists verify the procedure codes and use them to report physicians’ services to payers. This chapter provides a fundamental understanding of how to assign procedure codes so that medical insurance specialists can work effectively with claims. Knowledge of procedural coding—and of how to stay up-to-date—is the baseline for compliant billing.

**CURRENT PROCEDURAL TERMINOLOGY, Fourth Edition (CPT)**

The procedure codes for physicians’ and other health care providers’ services are selected from the Current Procedural Terminology data set, called CPT, which is owned and maintained by the American Medical Association (AMA).

**History**

CPT was first produced by the AMA in 1966. Its wide use began in 1983 when the Health Care Financing Administration (now named the Centers for Medicare and Medicaid, or CMS) decided that the CPT codes would be the standard for physician procedures paid by Medicare, Medicaid, and other government medical insurance programs.

CPT lists the procedures and services that are commonly performed by physicians across the country. There is also a need for codes for items that are used in medical practices but are not listed in CPT, like supplies and equip-
ment. These codes are found in the Healthcare Common Procedure Coding System, referred to as HCPCS and pronounced hick-picks, which is covered in the next chapter of this text. Officially, CPT is the first part (called Level I) of HCPCS, and the supply codes are the second part (Level II). Most people, though, refer to the codes in the CPT book as CPT codes and the Level II codes as HCPCS codes.

Types of CPT Codes
There are three categories of CPT codes:

- Category I codes
- Category II codes
- Category III codes

Category I Codes
CPT Category I codes—which are the most numerous—have five digits (with no decimals). Each code has a descriptor, which is a brief explanation of the procedure:

- 99204 Office visit for evaluation and management of a new patient
- 00730 Anesthesia for procedures on upper posterior abdominal wall
- 24006 Arthrotomy of the elbow, with capsular excision for capsular release
- 70100 Radiologic examination of the mandible
- 80400 ACTH stimulation panel; for adrenal insufficiency
- 93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report

Although the codes are grouped into sections, such as Surgery, codes from all sections can be used by all types of physicians. For example, a family practitioner might use codes from the Surgery section to describe an office procedure such as the incision and drainage of an abscess.

Category II Codes
Category II codes are used to track performance measures for a medical goal such as reducing tobacco use. These codes are optional; they are not paid by insurance carriers. They help in the development of best practices for care and improve documentation. These codes have alphabetic characters for the fifth digit:

- 0002F Tobacco use, smoking, assessed
- 0004F Tobacco use cessation intervention, counseling

Category III Codes
Category III codes are temporary codes for emerging technology, services, and procedures. These codes also have alphabetic characters for the fifth digit:

- 0001T Endovascular repair of infrarenal abdominal aortic aneurysm or dissection
- 0041T Urinalysis infectious agent detection

A temporary code may become a permanent part of the regular codes if the service it identifies proves effective and is widely performed.
Organization and Format

The manual is made up of the main text—sections of codes—followed by appendixes and an index. The main text has the following six sections of Category I procedure codes:

- Evaluation and Management: Codes 99201–99499
- Anesthesia: Codes 00100–01999
- Surgery: Codes 10021–69990
- Radiology: Codes 70010–79999
- Pathology and Laboratory: Codes 80048–89356
- Medicine: Codes 90281–99602

Table 5.1 summarizes the types of codes, organization, and guidelines of these six main sections.

Updates

CPT is a proprietary code set, meaning that it is not available for free to the public. Instead, the information must be purchased, either in print or electronic format, from the AMA, which publishes the revised CPT codes.

During the year, practicing physicians, medical specialty societies, and state medical associations send their suggestions for revision to the AMA. This in-

<table>
<thead>
<tr>
<th>SECTION</th>
<th>DEFINITION OF CODES</th>
<th>STRUCTURE</th>
<th>KEY GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and Management</td>
<td>Physicians’ services that are performed to determine the best course for patient care</td>
<td>Organized by place and/or type of service</td>
<td>New/established patients; other definitions</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unlisted services, special reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Selecting an E/M service level</td>
</tr>
<tr>
<td>Anesthesia</td>
<td>Anesthesia services by or supervised by a physician; includes general, regional, and local anesthesia</td>
<td>Organized by body site</td>
<td>Time-based</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Services covered (bundled) in codes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unlisted services/special reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Qualifying circumstances codes</td>
</tr>
<tr>
<td>Surgery</td>
<td>Surgical procedures performed by physicians</td>
<td>Organized by body system and then body site, followed by procedural groups</td>
<td>Surgical package definition</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Follow-up care definition</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Add-on codes</td>
</tr>
<tr>
<td>Radiology</td>
<td>Radiology services by or supervised by a physician</td>
<td>Organized by type of procedure followed by body site</td>
<td>Unlisted services/special reports</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Supervision and interpretation (professional and technical components)</td>
</tr>
<tr>
<td>Pathology and Laboratory</td>
<td>Pathology and laboratory services by physicians or by physician-supervised technicians</td>
<td>Organized by type of procedure</td>
<td>Complete procedure</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Panels</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unlisted services/special reports</td>
</tr>
<tr>
<td>Medicine</td>
<td>Evaluation, therapeutic, and diagnostic procedures by or supervised by a physician</td>
<td>Organized by type of service or procedure</td>
<td>Subsection notes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Multiple procedures reported separately</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Add-on codes</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Separate procedures</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Unlisted services/special reports</td>
</tr>
</tbody>
</table>
put is reviewed by the AMA’s Editorial Panel, which includes physicians as well as representatives from the Health Insurance Association of America, CMS, the American Health Information Management Association (AHIMA), the American Hospital Association (AHA), and Blue Cross and Blue Shield. The panel decides what changes will be made in the annual revision of the printed reference book.

The annual changes for Category I codes are announced by the AMA on October 1 and are in effect for procedures and services provided after January 1 of the following year. The code books can be purchased in different formats, which range from a basic listing to an enhanced edition. The AMA also reports the new codes on its website.

Category II and III codes are prereleased on the AMA website and can be used on their implementation date even before they appear in the printed books.

The Index

The assignment of a correct procedure code begins by reviewing the physician’s statements in the patient’s medical record to determine the service, procedure, or treatment that was performed. Then the index entry is located, which provides a pointer to the correct code range in the main text. Using the CPT index makes the process of selecting procedure codes more efficient. The index contains the descriptive terms that are listed in the sections of codes in the CPT.

Main Terms and Modifying Terms

The main terms in the index are printed in boldface type. There are five types of main terms:

1. The name of the procedure or service, such as echocardiography, extraction, and cast
2. The name of the organ or other anatomical site, such as stomach, wrist, and salivary gland

Thinking It Through — 5.1

Would you expect to locate codes for the following services or procedures in CPT? What range or series of codes would you investigate?

Service or Procedure Range or Series

1. Routine obstetric care including antepartum care, cesarean delivery, and postpartum care
2. Echocardiography
3. Radiologic examination, nasal bones, complete
4. Home visit for evaluation and management of an established patient
5. Drug test for amphetamines
6. Anesthesia for cardiac catheterization

Billing Tip

Updating Vaccine Codes and Category III Codes

Both vaccine product codes and Category III codes are released twice a year and have a six-month period for implementation. Offices billing these services should check for updates at the CPT website.

HIPAA Tip

Using the Current Codes

Practices must use new CPT codes on the date they are effective. There is no “grace period” or overlapping use of old and new codes. Keep codes on encounter forms and practice management programs up to date.
3. The name of the condition, such as abscess, wound, and postpartum care
4. A synonym or an eponym for the term, such as Noble Procedure, Ramstedt operation, and Fowler-Stephens orchiopexy
5. The abbreviation for the term, such as CAT scan and ECMO

Many terms are listed more than one way. For example, the kidney biopsy procedure is listed both as a procedure—Biopsy, kidney—and by the site—Kidney, biopsy.

A main term may be followed by subterms that further describe the entry. These additional indented terms help in the selection process. For example, the procedure repair of tennis elbow is located beneath repair under the main term elbow (see Figure 5.1).
Code Ranges

A range of codes is shown when more than one code applies to an entry. Two codes, either sequential or not, are separated by a comma:

- Cervix
- Biopsy...57500, 57520

More than two sequential codes are separated by a hyphen:

- Dislocation
- Ankle
- Closed Treatment...27840–27842

Cross-References and Convention

There are two types of cross-references:

1. See is a mandatory instruction. It tells the coder to refer to the term that follows it to find the code. It is used mainly for synonyms, eponyms, and abbreviations. For example, the cross-reference “See Electrocardiogram” follows EKG (see Figure 5.1).

2. See also tells the coder to look under the term that follows if the procedure is not listed below. For example, under Elbow, the cross-reference “See also Humerus; Radius; Ulna” points to those main terms if the entry is not located under Elbow (see Figure 5.1).

To save space, some connecting words are left out and must be assumed by the reader. For example:

- Ear Cartilage
- Graft
- to face...21235

should be read “graft of ear cartilage to face.” The reader supplies the word of.

The Main Text

After the index is used to point to a possible code, the main text is read to verify the selection of the code (see Figure 5.2).

Each of the six sections of the main text lists procedure codes and descriptions under subsection headings. These headings group procedures or services, such as Therapeutic or Diagnostic Injections or Psychoanalysis; body systems, such as Digestive System; anatomical sites, such as Abdomen; and tests and examinations, such as Complete Blood Count (CBC). Following these headings are additional subgroups of procedures, systems, or sites. For example, Figure 5.2 illustrates the following structure, in which the body system appears as the subsection followed by a procedure subgroup:

- Surgery Section <The Section>
- Musculoskeletal System <The Subsection>
  - Endoscopy/Arthroscopy <The Procedure Subgroup>

The section, subsection, and code number range on a page are shown at the top of the page, making it easier to locate a code.
Guidelines

Each section begins with section guidelines for the use of its codes. The guidelines cover definitions and items unique to the section. They also include special notes about the structure of the section or the rules for its use. The guidelines must be carefully studied and followed in order to correctly use the codes in the section. Some notes apply only to specific subsections. The guidelines list the subsections in which these notes occur, and the notes themselves begin those subsections (see Figure 5.2).
Unlisted Procedures

Most sections’ guidelines give codes for **unlisted procedures**—those not completely described by any code in the section. For example, in the Evaluation and Management section, two unlisted codes are provided:

99429  Unlisted preventive medicine service
99499  Unlisted evaluation and management service

Unlisted procedure codes are used for new services or procedures that have not yet been assigned either Category I or III codes in CPT. When an unlisted code is reported to a payer, documentation of the procedure should accompany the claim. Often the operative report or a letter from the physician describing the procedure meets this need.

Special Reports

Some section guidelines suggest the use of **special reports** for rare or new procedures, especially unlisted procedures. These reports, which are mandatory, permit payers to assess the medical appropriateness of the procedures. The guidelines cover the information that should be in the report, such as a description of the nature, extent, and need for the procedure plus additional notes on the symptoms or findings.

Format

Semicolons and Indentions

To save space in the book, CPT uses a semicolon and indentions when a common part of a main entry applies to entries that follow. For example, in the entries listed below, the procedure **partial laryngectomy (hemilaryngectomy)** is the common descriptor. This same descriptor applies to the four unique descriptors after the semicolon—**horizontal**, **laterovertical**, **anterovertical**, and **antero-latero-vertical**. Note that the common descriptor begins with a capital letter, but the unique descriptors after the semicolon do not. Also note that after the first listing, the second, third, and fourth descriptors are indented. Indenting visually reinforces the relationship between the entries and the common descriptor.

31370  Partial laryngectomy (hemilaryngectomy); horizontal
31375  laterovertical
31380  anterovertical
31382  antero-latero-vertical

This method shows the relationships among the entries without repeating the common word or words. Follow this case example in Figure 5.2:

*Index Entry:* Arthroscopy, Surgical. . . . . . . .29834–29838
*Main Text:* 29838 Arthroscopy, elbow, surgical; with debridement, extensive

Cross-References

Some codes and descriptors are followed by indented **see** or **use** entries in parentheses, which refer the coder to other codes. For example:

82239  Bile acids; total
82240  cholylglycine

(For bile pigments, urine, see 81000–81005)
Examples
Descriptors often contain clarifying examples in parentheses, sometimes with the abbreviation e.g. (meaning for example). These provide further descriptions, such as synonyms or examples, but they are not essential to the selection of the code. Here are examples:

87040 Culture, bacterial; blood, with isolation and presumptive identification of isolates (includes anaerobic culture, if appropriate)

50400 Pyeloplasty (Foley Y-pyeloplasty), plastic operation on renal pelvis, with or without plastic operation on ureter, nephropexy, nephrostomy, pyelostomy, or ureteral splinting; simple

50405 complicated (congenital kidney abnormality, secondary pyeloplasty, solitary kidney, calyceoplasty)

Symbols for Changed Codes
These symbols have the following meanings when they appear next to CPT codes:

- A bullet (a black circle) indicates a new procedure code. The symbol appears next to the code only the year that it is added.
- A triangle indicates that the code’s descriptor has changed. It, too, appears in only the year the descriptor is revised.
- Facing triangles (two triangles that face each other) enclose new or revised text other than the code’s descriptor.

Symbol for Add-On Codes
A plus sign (+) next to a code in the main text indicates an add-on code. Add-on codes describe secondary procedures that are commonly carried out in addition to a primary procedure. Add-on codes usually use phrases such as each additional or list separately in addition to the primary procedure to show that they are never used as stand-alone codes. For example, the add-on code +15001 is used after the code for surgical preparation of a free skin graft site (15000) to provide a specific percentage or dimension of body area that was involved beyond the amount covered in the primary procedure.

Symbols for Conscious Sedation and for FDA Approval Pending
In CPT, the symbol • (a bullet inside a circle) next to a code means that conscious sedation is a part of the procedure that the surgeon performs. This means that for compliant coding, conscious sedation is not billed in addition to the code. Conscious sedation is a moderate, drug-induced depression of consciousness during which patients can respond to verbal commands. This type of sedation is typically used with procedures such as bronchoscopies.

Also used is the symbol ⚡ (a thunderbolt). This symbol is used with vaccine codes that have been submitted to the Federal Drug Administration (FDA) and are expected to be approved for use soon. The codes cannot be used until approved, at which point this symbol is removed.

CPT Modifiers
A CPT modifier is a two-digit number that may be attached to most five-digit procedure codes (see Table 5.2 on page 154). Modifiers are used to communi-
1. Find the following codes in the index of CPT. Underline the key term you used to find the code.
   A. Intracapsular lens extraction
   B. Coombs test
   C. X-ray of duodenum
   D. Unlisted procedure, maxillofacial prosthetics
   E. DTAP immunization

2. Identify the symbol used to indicate a new procedure code, and list five new codes that appear in CPT.

3. Identify the symbol used to indicate a procedure that is usually done in addition to a primary procedure. Locate code 92981, and describe the unit of measure that is involved with this add-on code.

4. Identify the symbol that indicates that the code’s description has been changed, and list five examples of codes with new or revised descriptors that appear in CPT.

5. Identify the symbols that enclose new or revised text other than the code’s descriptor, and list five examples of codes with new or revised text that appear in CPT.

6. Identify the symbol next to a code that means that conscious sedation is a part of the procedure that the surgeon performs, and list five examples from CPT.

7. Identify the symbol next to a code that means that FDA approval is pending, and list one example from CPT’s vaccines and toxoids code section (codes 90476–90749).

cate special circumstances involved with procedures that have been performed. A modifier tells private and government payers that the physician considers the procedure to have been altered in some way. A modifier usually affects the normal level of reimbursement for the code to which it is attached.

For example, the modifier –76, Repeat Procedure by Same Physician, is used when the reporting physician repeats a procedure or service after doing the first one. A situation requiring this modifier to show the extra procedure might be:

   **Procedural Statement:** Physician performed a chest X-ray before placing a chest tube and then, after the chest tube was placed, performed a second chest X-ray to verify its position.

   **Code:** 71020–76 Radiologic examination, chest, two views, frontal and lateral; repeat procedure or service by same physician

The modifiers are listed in Appendix A of CPT. However, not all modifiers are available for use with every section’s codes:

- Some modifiers apply only to certain sections. For example, the modifier –21, Prolonged Evaluation and Management Services, is used only with
### TABLE 5.2

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>E/M</th>
<th>Anesthesia</th>
<th>Surgery</th>
<th>Radiology</th>
<th>Pathology</th>
<th>Medicine</th>
</tr>
</thead>
<tbody>
<tr>
<td>–21</td>
<td>Prolonged E/M Service</td>
<td>Yes</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
</tr>
<tr>
<td>–22</td>
<td>Unusual Procedural Service</td>
<td>Never</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>–23</td>
<td>Unusual Anesthesia</td>
<td>Never</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>–24</td>
<td>Unrelated E/M Service by the Same Physician During a Postoperative Period</td>
<td>Yes</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
</tr>
<tr>
<td>–25</td>
<td>Significant, Separately Identifiable E/M Service by the Same Physician on the Same Day of the Procedure or Other Service</td>
<td>Yes</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
</tr>
<tr>
<td>–26</td>
<td>Professional Component</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>–27</td>
<td>Mandated Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>–47</td>
<td>Anesthesia by Surgeon</td>
<td>Never</td>
<td>Never</td>
<td>Yes</td>
<td>Never</td>
<td>Never</td>
<td>Never</td>
</tr>
<tr>
<td>–50</td>
<td>Bilateral Procedure</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>–51</td>
<td>Multiple Procedures</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Never</td>
</tr>
<tr>
<td>–52</td>
<td>Reduced Services</td>
<td>Yes</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>–53</td>
<td>Discontinued Procedure</td>
<td>Never</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>–54</td>
<td>Surgical Care Only</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>–55</td>
<td>Postoperative Management Only</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>–56</td>
<td>Preoperative Management Only</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>–57</td>
<td>Decision for Surgery</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>–58</td>
<td>Staged or Related Procedure/Service by the Same Physician During the Postoperative Period</td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>–59</td>
<td>Distinct Procedural Service</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>–62</td>
<td>Two Surgeons</td>
<td>Never</td>
<td>Never</td>
<td>Yes</td>
<td>Yes</td>
<td>Never</td>
<td>—</td>
</tr>
<tr>
<td>–63</td>
<td>Procedure Performed on Infants</td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>—</td>
<td></td>
</tr>
<tr>
<td>–66</td>
<td>Surgical Team</td>
<td>Never</td>
<td>Never</td>
<td>Yes</td>
<td>Yes</td>
<td>Never</td>
<td>—</td>
</tr>
<tr>
<td>–76</td>
<td>Repeat Procedure by Same Physician</td>
<td>—</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>–77</td>
<td>Repeat Procedure by Another Physician</td>
<td>—</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>–78</td>
<td>Return to the Operating Room for a Related Procedure During the Postoperative Period</td>
<td>—</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>–79</td>
<td>Unrelated Procedure/Service by the Same Physician During the Postoperative Period</td>
<td>—</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>–80</td>
<td>Assistant Surgeon</td>
<td>Never</td>
<td>—</td>
<td>Yes</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>–81</td>
<td>Minimum Assistant Surgeon</td>
<td>Never</td>
<td>—</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>–82</td>
<td>Assistant Surgeon (When Qualified Resident Surgeon Not Available)</td>
<td>Never</td>
<td>—</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
<td>—</td>
</tr>
<tr>
<td>–90</td>
<td>Reference (Outside) Laboratory</td>
<td>—</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>—</td>
</tr>
<tr>
<td>–91</td>
<td>Repeat Clinical Diagnostic Laboratory Test</td>
<td>—</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>—</td>
</tr>
<tr>
<td>–99</td>
<td>Multiple Modifiers</td>
<td>—</td>
<td></td>
<td>Yes</td>
<td>Yes</td>
<td>—</td>
<td>—</td>
</tr>
</tbody>
</table>

Source: CPT 2007

Key:
- *Yes* = commonly used
- *—* = not usually used with the codes in that section
- *Never* = not used with the codes in that section
codes that are located in the Evaluation and Management section, as its descriptor implies.

- Add-on codes cannot be modified with –51, Multiple Procedures, because the add-on code is used to add increments to a primary procedure, so the need for multiple procedures is replaced by procedures added on.
- Codes that begin with ⊗ (a circle with a backslash) also cannot be modified with –51, Multiple Procedures.

**What Do Modifiers Mean?**

The use of a modifier means that a procedure was different from the description in CPT, but not in a way that changed the definition or required a different code. Modifiers are used mainly when:

- A procedure has two parts—a technical component (TC) performed by a technician, such as a radiologist, and a professional component (PC) that the physician performs, usually the interpretation and reporting of the results.
- A service or procedure has been performed more than once, by more than one physician, and/or in more than one location
- A service or procedure has been increased or reduced
- Only part of a procedure has been done
- A bilateral or multiple procedure has been performed
- Unusual difficulties occurred during the procedure

**Assigning Modifiers**

Modifiers are shown by adding a hyphen and the two-digit code to the CPT code. For example, a physician providing therapeutic radiology services in a hospital would report the modifier –26, Professional Component, as follows:

73090–26

This format means professional component only for an X-ray of the forearm. (In effect, it means that the physician who performed the service did not own the equipment used, so the fee is split between the physician and the equipment owner.)

Two or more modifiers may be used with one code to give the most accurate description possible. The use of two or more modifiers is shown by reporting –99, Multiple Modifiers, followed by the other modifiers, with the most essential modifier listed first.

*Procedures:* Multitrauma patient's extremely difficult surgery after a car accident; team surgery by orthopedic surgeon and neurosurgeon. The first surgical procedure carries these modifiers:

27236–99, –66, –51, –22

**The Appendixes**

The twelve appendixes contain information helpful to the coding process:

1. **Appendix A—Modifiers:** A complete listing of all modifiers used in CPT with descriptions and, in some cases, examples of usage
2. **Appendix B—Summary of Additions, Deletions, and Revisions:** A summary of the codes added, revised, and deleted in the current version
Coding Steps

The correct process for reporting accurate procedure codes has three steps.

Step 1 Determine the Procedures and Services to Report

The first step is to review the documentation of the patient's visit and decide which procedures and/or services were performed. Then, based on knowledge of the CPT and of the payer's policies, a decision is made about which services can be charged and are to be reported.

Step 2 Identify the Correct Codes

The process for selecting correct codes is as follows:

1. The index is used to locate the main term for each procedure or service. If the term is not found, the organ or body site is looked up, and then the disease or injury. Further checking can be done to locate any synonyms, eponyms, or abbreviations associated with the main term. The entries under the main term are reviewed to see if any apply, and cross-references are checked.
2. If the main term cannot be located in the index, the medical insurance specialist reviews the main term selection with the physician for clarification. In some cases, there is a better or more common term that can be used.
3. The main text listing, including all section guidelines and notes for the particular subsection, is carefully reviewed to make the final code choice. Items that cannot be billed separately because they are covered under another, broader code are eliminated.
4. The codes to be reported for each day's services are ranked in order of highest to lowest rate of reimbursement. The actual order in which they were performed on a particular day is not important. For services on multiple dates, the earliest day is listed first, followed by subsequent dates of service. For example:

<table>
<thead>
<tr>
<th>Date</th>
<th>Procedure</th>
<th>Charge</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/17/2008</td>
<td>99204</td>
<td>$202</td>
</tr>
<tr>
<td>11/20/2008</td>
<td>43215</td>
<td>$355</td>
</tr>
<tr>
<td>11/20/2008</td>
<td>74235</td>
<td>$75</td>
</tr>
</tbody>
</table>
Thinking It Through — 5.3

1. In CPT, what is the meaning of the symbol in front of code 93501?

2. Based on Appendix A of CPT, what modifiers would you assign in each of the following cases? Why?

CASE 1
Patient has recurrent cancer; surgeon performed a colectomy, which took forty-five minutes longer than the normal procedure due to dense adhesions from the patient’s previous surgery.

CASE 2
Surgeon operating on an ingrown toenail administers a regional nerve block.

CASE 3
Patient was scheduled for a total diagnostic colonoscopy, but the patient went into respiratory distress during procedure; surgeon stopped the procedure.

CASE 4
Puncture aspiration of a cyst in the left breast and a cyst in the right breast.

CASE 5
A neurological surgeon and an orthopedic surgeon worked as cosurgeons.

Step 3 Determine the Need for Modifiers

The circumstances involved with the procedure or service may require the use of modifiers. The patient’s diagnosis may affect this determination.

Evaluation And Management Codes

The codes in the Evaluation and Management section (E/M codes) cover physicians’ services that are performed to determine the best course for patient care. The E/M codes are listed first in CPT because they are used so often by all types of physicians. Often called the cognitive codes, the E/M codes cover the complex process a physician uses to gather and analyze information about a patient’s illness and to make decisions about the patient’s condition and the best treatment or course of management. The actual treatments—such as surgical procedures and vaccines—are covered in the CPT sections that follow the E/M codes, such as the Surgery and Medicine sections.

Although CPT was first published in 1966, the Evaluation and Management section was not introduced until 1992. The E/M coding method came from a joint effort by CMS and the AMA to define ranges of services from simple to very complicated. Patients’ conditions require different levels of information gathering, analysis, and decision making by physicians. For example, on the low end of a range might be a patient with a mild case of poison ivy. On the opposite end is a patient with a life-threatening condition. The E/M codes reflect these different levels. There are five codes to choose from for an office visit with a new patient, for example, and another five for office visits with established
patients. A financial value (fee or prospective payment) is assigned by a payer to each code in a range. To justify the use of a higher-level code in the range—one that is tied to a higher value—the physician must perform and document specific clinical facts about the patient encounter.

**Structure**

Most codes in the E/M section are organized by the place of service, such as the office, the hospital, or a patient's home. A few (for example, consultations) are grouped by type of service. The subsections, detailed in Table 5.3, are as follows:

- Office or Other Outpatient Services
- Hospital Observation Services
- Hospital Inpatient Services
- Consultations
- Emergency Department Services
- Pediatric Patient Transport
- Critical Care Services
- Continuing Intensive Care Services
- Nursing Facility Services
- Domiciliary, Rest Home (e.g., Assisted Living Facility), or Home Care Plan Oversight Services
- Home Services
- Prolonged Services
- Standby Services
- Case Management Services
- Care Plan Oversight Services
- Preventive Medicine Service
- Special/Other E/M Services

**Table 5.3**

<table>
<thead>
<tr>
<th>Category/Subcategory</th>
<th>Code Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office or Other Outpatient Services</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>Hospital Observation Services</td>
<td></td>
</tr>
<tr>
<td>Hospital Observation Discharge Services</td>
<td>99217</td>
</tr>
<tr>
<td>Initial Hospital Observation Services</td>
<td>99218–99220</td>
</tr>
<tr>
<td>Hospital Observation or Inpatient Care Services (Including Admission and Discharge Services)</td>
<td>99234–99236</td>
</tr>
<tr>
<td>Hospital Inpatient Services</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>Hospital Discharge Services</td>
<td>99238–99239</td>
</tr>
</tbody>
</table>
### TABLE 5.3 E/M Code Organization by Type or Place of Service (continued)

<table>
<thead>
<tr>
<th>Category/Subcategory</th>
<th>Code Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultations</td>
<td></td>
</tr>
<tr>
<td>Office Consultations</td>
<td>99241–99245</td>
</tr>
<tr>
<td>Initial Inpatient Consultations</td>
<td>99251–99255</td>
</tr>
<tr>
<td>Emergency Department Services</td>
<td>99281–99288</td>
</tr>
<tr>
<td>Pediatric Patient Transport</td>
<td>99289–99290</td>
</tr>
<tr>
<td>Critical Care Services</td>
<td></td>
</tr>
<tr>
<td>Adult (over 24 months of age)</td>
<td>99291–99292</td>
</tr>
<tr>
<td>Pediatric</td>
<td>99293–99294</td>
</tr>
<tr>
<td>Neonatal</td>
<td>99295–99296</td>
</tr>
<tr>
<td>Continuing Intensive Services</td>
<td>99298–99300</td>
</tr>
<tr>
<td>Nursing Facility Services</td>
<td></td>
</tr>
<tr>
<td>Initial Nursing Facility Care</td>
<td>99304–99306</td>
</tr>
<tr>
<td>Subsequent Nursing Facility Care</td>
<td>99307–99310</td>
</tr>
<tr>
<td>Nursing Facility Discharge Services</td>
<td>99315–99316</td>
</tr>
<tr>
<td>Other Nursing Facility Services</td>
<td>99318</td>
</tr>
<tr>
<td>Domiciliary, Rest Home or Custodial Care Services</td>
<td></td>
</tr>
<tr>
<td>Established Patient</td>
<td>99334–99337</td>
</tr>
<tr>
<td>Domiciliary, Rest Home (e.g., Assisted Living Facility) or Home Care Plan Oversight Services</td>
<td>99339–99340</td>
</tr>
<tr>
<td>New Patient</td>
<td>99307–99310</td>
</tr>
<tr>
<td>Home Services</td>
<td></td>
</tr>
<tr>
<td>New Patient</td>
<td>99341–99345</td>
</tr>
<tr>
<td>Established Patient</td>
<td>99347–99350</td>
</tr>
<tr>
<td>Prolonged Services</td>
<td></td>
</tr>
<tr>
<td>With Direct Patient Contact</td>
<td>99354–99357</td>
</tr>
<tr>
<td>Without Direct Patient Contact</td>
<td>99358–99359</td>
</tr>
<tr>
<td>Standby Services</td>
<td>99360</td>
</tr>
<tr>
<td>Care Management Services</td>
<td></td>
</tr>
<tr>
<td>Team Conferences</td>
<td>99361–99362</td>
</tr>
<tr>
<td>Telephone Calls</td>
<td>99371–99373</td>
</tr>
<tr>
<td>Care Plan Oversight Services</td>
<td>99374–99380</td>
</tr>
<tr>
<td>Preventive Medicine Services</td>
<td></td>
</tr>
<tr>
<td>New Patient</td>
<td>99381–99387</td>
</tr>
<tr>
<td>Established Patient</td>
<td>99391–99397</td>
</tr>
<tr>
<td>Individual Counseling</td>
<td>99401–99404</td>
</tr>
<tr>
<td>Group Counseling</td>
<td>99411–99412</td>
</tr>
<tr>
<td>Other</td>
<td>99420–99429</td>
</tr>
<tr>
<td>Newborn Care</td>
<td>99431–99440</td>
</tr>
<tr>
<td>Special E/M Services</td>
<td>99450–99456</td>
</tr>
<tr>
<td>Other E/M Services</td>
<td>99499</td>
</tr>
</tbody>
</table>

**A New or Established Patient?**

Many subsections of E/M codes assign different code ranges for new patients and established patients. A new patient (NP) has not received any professional services from the physician (or from another physician of the same specialty in the same group practice) within the past three years. An established patient...
(EP) has received professional services under those conditions (see Chapter 3, Figure 3.1, for a decision tree for determining patient status as NP or EP). The distinction is important because new patients typically require more effort by the physician and practice staff, who should therefore be paid more.

The term any professional services in the definitions of new and established patients means that the established category is used for a patient who had a face-to-face encounter with a physician. The same rule applies to a patient of a physician who moves to another group practice. If the patient then sees the physician (or another of the same specialty) in the new practice, the patient is established. In other words, the patient is new to the practice, but established to the provider.

**A Consultation or A Referral?**

To understand the subsection of E/M codes on consultations, review the difference between a consultation and a referral in coding terminology. A **consultation** occurs when a second physician, at the request of the patient’s physician, examines the patient. The second physician usually focuses on a particular issue and reports a written opinion to the first physician. The physician providing a consultation (“consult”) may perform a service for the patient but does not independently start a full course of treatment (although the consulting physician may recommend one) or take charge of the patient’s care. Consultations require use of the E/M consultation codes (the range from 99241 to 99255).

On the other hand, when the patient is referred to another physician, either the total care or a specific portion of care is transferred to that provider (see Chapter 3, which describes the requirement by payers for referral authorization). The patient becomes a new patient of that doctor for the referred condition and may not return to the care of the referring physician until the completion of a course of treatment. Referrals require use of the regular office visit E/M service codes.

Although people sometimes use these terms to mean the same thing, a referral and a consultation are different. This distinction is important to medical insurance specialists because the amounts that can be charged for the two types of service are different. Under a referral, the PCP or other provider is sending the patient to another physician for specialized care. If the sending provider requests a consultation, this is asking for the opinion of another physician regarding the patient’s care. The patient will be returned to the care of the original provider with the specialist’s written consultation report containing an evaluation of the patient’s condition and/or care.

**Modifiers**

A number of modifiers are commonly used with evaluation and management services:

- **21 Prolonged Evaluation and Management service**: Used when the services are greater than the highest level described for the code range.

- **24 Unrelated Evaluation and Management service by the same physician during a postoperative period**: Used when an E/M service that is not related to the reason for the surgery is provided within the postoperative time period included in the payer’s reimbursement.

- **25 Significant, separately identifiable Evaluation and Management service by the same physician on the same day of the procedure or other service**: Used when the physician provides an E/M service in addition to another E/M
service or a procedure on the same day. The E/M service to which the modifier is appended must be significant enough to report.

-32 Mandated services: Used when the procedure is required by a payer.
-52 Reduced services: Used when an E/M service is less extensive than the descriptor indicates.
-57 Decision for surgery: Used to indicate the visit at which the decision for surgery was made and the patient was counseled about risks and outcomes.

**E/M Code Selection**

To select the correct E/M code, eight steps are followed (see Figure 5.3).

**Step 1. Determine the Category and Subcategory of Service**
**Based on the Place of Service and the Patient’s Status**

The list of E/M categories—such as office visits, hospital services, and preventive medicine services—is used to locate the appropriate place or type of service in the index. In the main text of the selected category, the subcategory, such as new or established patient, is then chosen.

- **Documentation:** initial hospital visit to established patient
- **Index:** Hospital Services
  - Inpatient Services
    - Initial Care, New or Established Patient
- **Code Ranges:** 99221–99223

For most types of service, from three to five codes are listed. To select an appropriate code from this range, consider three key components: (1) the history the

---

**STEP 1** Determine the category and subcategory of service based on the place of service and the patient’s status

**STEP 2** Determine the extent of the history that is documented

**STEP 3** Determine the extent of the examination that is documented

**STEP 4** Determine the complexity of medical decision making that is documented

**STEP 5** Analyze the requirements to report the service level

**STEP 6** Verify the service level based on the nature of the presenting problem, time, counseling, and care coordination

**STEP 7** Verify that the documentation is complete

**STEP 8** Assign the code

---

**FIGURE 5.3** Selecting an Evaluation and Management Code
physician documented, (2) the examination that was documented, and (3) the medical decisions the physician documented. (The exception to this guideline is selecting a code for counseling or coordination of care, where in some situations the amount of time the physician spends may be the only key component.)

**Step 2. Determine the Extent of the History That Is Documented**

History is the information the physician received by questioning the patient about the chief complaint and other signs or symptoms, about all or selected body systems, and about pertinent past history, family background, and other personal factors. (See Chapter 2, Figure 2.2, as an example of this documentation.)

The history is documented in the patient medical record as follows.

**History of present illness (HPI)** The history of the illness is a description of the development of the illness from the first sign or symptom that the patient experienced to the present time. These points about the illness or condition may be documented:

- Location (body area of the pain or symptom)
- Quality (type of pain or symptom, such as sudden or dull)
- Severity (degree of pain or symptom)
- Duration (how long the pain or symptom lasts and when it began)
- Timing (time of day the pain or symptom occurs)
- Context (any situation related to the pain or symptom, such as occurs after eating)
- Modifying factors (any factors that alter the pain or symptom)
- Associated signs and symptoms (things that also happen when the pain or symptom occurs)

**Review of systems (ROS)** The review of systems is an inventory of body systems. These systems are:

- Constitutional symptoms (such as fever or weight loss)
- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular (CV)
- Respiratory
- Gastrointestinal (GI)
- Genitourinary (GU)
- Musculoskeletal
- Integumentary
- Neurological
- Psychiatric
- Endocrine
- Hematologic/lymphatic
- Allergic/immunologic

**Past medical history (PMH)** The past history of the patient's experiences with illnesses, injuries, and treatments contains data about other major illnesses and injuries, operations, and hospitalizations. It also covers current medications the patient is taking, allergies, immunization status, and diet.

**Family history (FH)** The family history reviews the medical events in the patient's family. It includes the health status or cause of death of parents, brothers and sisters, and children; specific diseases that are related to the patient's
chief complaint or the patient's diagnosis; and the presence of any known hereditary diseases.

**Social history (SH)** The facts gathered in the social history, which depend on the patient's age, include marital status, employment, and other factors.

The histories documented after the HPI are sometimes referred to as PFSH, for past, family, and social history. This history is then categorized as one of four types on a scale from lesser to greater extent of amount of history obtained:

1. **Problem-focused:** Determining the patient's chief complaint and obtaining a brief history of the present illness
2. **Expanded problem-focused:** Determining the patient's chief complaint and obtaining a brief history of the present illness, plus a problem-pertinent system review of the particular body system that is involved
3. **Detailed:** Determining the chief complaint; obtaining an extended history of the present illness; reviewing both the problem-pertinent system and additional systems; and taking pertinent past, family, and/or social history
4. **Comprehensive:** Determining the chief complaint and taking an extended history of the present illness, a complete review of systems, and a complete past, family, and social history

**Step 3. Determine the Extent of the Examination That Is Documented**

The physician may examine a particular body area or organ system or may conduct a multisystem examination. The body areas are divided into the head and face; chest, including breasts and axilla; abdomen; genitalia, groin, and buttocks; back; and each extremity.

The organ systems that may be examined are the eyes; the ears, nose, mouth, and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; skin; neurologic; psychiatric; and hematologic/lymphatic/immunologic.

The examination that the physician documents is categorized as one of four types on a scale from lesser to greater extent:

1. **Problem-focused:** A limited examination of the affected body area or system
2. **Expanded problem-focused:** A limited examination of the affected body area or system and other related areas
3. **Detailed:** An extended examination of the affected body area or system and other related areas
4. **Comprehensive:** A general multisystem examination or a complete examination of a single organ system

**Step 4. Determine the Complexity of Medical Decision Making That Is Documented**

The complexity of the medical decisions that the physician makes involves how many possible diagnoses or treatment options were considered; how much information (such as test results or previous records) was considered in analyzing the patient's problem; and how serious the illness is, meaning how much risk there is for significant complications, advanced illness, or death.

The decision-making process that the physician documents is categorized as one of four types on a scale from lesser to greater complexity:

1. **Straightforward:** Minimal diagnoses options, a minimal amount of data, and minimum risk
2. **Low complexity:** Limited diagnoses options, a low amount of data, and low risk
3. Moderate complexity: Multiple diagnoses options, a moderate amount of data, and moderate risk
4. High complexity: Extensive diagnoses options, an extensive amount of data, and high risk

Step 5. Analyze the Requirements to Report the Service Level

The descriptor for each E/M code explains the standards for its selection. For office visits and most other services to new patients and for initial care visits, all three of the key components must be documented. If there are two at a higher level and a third below that level, the standard is not met. This is stated in CPT as follows:

99203 Office or other outpatient visit for the evaluation and management of a new patient, which require these three key components:
- a detailed history
- a detailed examination
- medical decision making of low complexity

For most services for established patients and for subsequent care visits, two out of three of the key components must be met. For example:

99213 Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components:
- an expanded problem-focused history
- an expanded problem-focused examination
- medical decision making of low complexity

Table 5.4 shows the type of decision tool many medical coders use to assign the correct E/M code for office visits with new and established patients.

Step 6. Verify the Service Level Based on the Nature of the Presenting Problem, Time, Counseling, and Care Coordination

Nature of the Presenting Problem      Many descriptors mention two additional components: (1) how severe the patient’s condition is, referred to as the nature of the presenting problem, and (2) how much time the physician typically spends directly treating the patient. These factors, while not key components, help in selecting the correct E/M level. For example, the following wording appears in CPT after the 99214 code (office visit for the evaluation and management of an established patient):

Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family.

The severity of the presenting problem helps determine medical necessity. Even if a physician documented comprehensive history and exam, with complex decision making, treating a minor problem like removal of uncomplicated sutures would not warrant a high E/M level.

Counseling      Counseling is a discussion with a patient regarding areas such as diagnostic results, instructions for follow-up treatment, and patient education. It is mentioned as a typical part of each E/M service in the descriptor, but it is not required to be documented as a key component.

Care Coordination      Coordination of care with other providers or agencies is also mentioned. When coordination of care is provided but the patient is not
present, codes from the case management and care plan oversight services subsections are reported.

**Step 7. Verify That the Documentation Is Complete**

The documentation must contain the record of the physician’s work in enough detail to support the selected E/M code. The history, examination, and medical decision making must be sufficiently documented so that the medical necessity and appropriateness of the service could be determined by an independent auditor (see Chapter 7).

**Step 8. Assign the Code**

The code that has been selected is assigned. The need for any modifiers, based on the documentation of special circumstances, is also reviewed.

**Reporting E/M Codes on Claims**

**Documentation Guidelines for Evaluation and Management**

Two sets of guidelines for documenting evaluation and management codes have been published by CMS and the AMA: the 1995 Documentation Guidelines for Evaluation and Management Services and a 1997 version. CMS and most payers permit providers to use either the 1995 or the 1997 E/M guidelines. Table 5.5 on pages 166–167 shows the items that can be documented to satisfy the general multisystem examination requirements under the 1997 Documentation Guidelines, which are most commonly used. There are similar guidelines to Table 5.5 for each major medical specialty.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>99201 NP Level 1</th>
<th>99202 NP Level 2</th>
<th>99203 NP Level 3</th>
<th>99204 NP Level 4</th>
<th>99205 NP Level 5</th>
<th>99211 EP Level 1</th>
<th>99212 EP Level 2</th>
<th>99213 EP Level 3</th>
<th>99214 EP Level 4</th>
<th>99215 EP Level 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Components</td>
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<tr>
<td>Detailed</td>
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<tr>
<td>Comprehensive</td>
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<td>Examination:</td>
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<td>Problem-focused</td>
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<tr>
<td>Expanded Problem-focused</td>
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<td>Detailed</td>
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<tr>
<td>Comprehensive</td>
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<td>Medical Decision Making:</td>
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<td>Straightforward</td>
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<td>Moderate complexity</td>
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<tr>
<td>NUMBER OF KEY COMPONENTS REQUIRED</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
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<td>2</td>
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</tr>
</tbody>
</table>
### TABLE 5.5  General Multi-System Examination

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Constitutional</td>
<td>• Measurement of any three of the following seven vital signs: 1) sitting or standing</td>
</tr>
<tr>
<td></td>
<td>blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4)</td>
</tr>
<tr>
<td></td>
<td>respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded</td>
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<tr>
<td></td>
<td>by ancillary staff)</td>
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<td></td>
<td>• General appearance of patient (eg, development, nutrition, body habitus, deformities,</td>
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<td></td>
<td>attention to grooming)</td>
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<tr>
<td>Eyes</td>
<td>• Inspection of conjunctivae and lids</td>
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<tr>
<td></td>
<td>• Examination of pupils and itises (eg, reaction to light and accommodation, size and</td>
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<tr>
<td></td>
<td>symmetry)</td>
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<tr>
<td></td>
<td>• Ophthalmoscopic examination of optic discs (eg, size, C/D ratio, appearance) and</td>
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<tr>
<td></td>
<td>posterior segments (eg, vessel changes, exudates, hemorrhages)</td>
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<tr>
<td>Ears, Nose, Mouth and Throat</td>
<td>• External inspection of ears and nose (eg, overall appearance, scars, lesions, masses)</td>
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<tr>
<td></td>
<td>• Otoscopic examination of external auditory canals and tympanic membranes</td>
</tr>
<tr>
<td></td>
<td>• Assessment of hearing (eg, whispered voice, finger rub, tuning fork)</td>
</tr>
<tr>
<td></td>
<td>• Inspection of nasal mucosa, septum and turbinates</td>
</tr>
<tr>
<td></td>
<td>• Inspection of lips, teeth and gums</td>
</tr>
<tr>
<td></td>
<td>• Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates,</td>
</tr>
<tr>
<td></td>
<td>tongue, tonsils and posterior pharynx</td>
</tr>
<tr>
<td>Neck</td>
<td>• Examination of neck (eg, masses, overall appearance, symmetry, tracheal position,</td>
</tr>
<tr>
<td></td>
<td>crepitus)</td>
</tr>
<tr>
<td></td>
<td>• Examination of thyroid (eg, enlargement, tenderness, mass)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>• Assessment of respiratory effort (eg, intercostal retractions, use of accessory</td>
</tr>
<tr>
<td></td>
<td>muscles, diaphragmatic movement)</td>
</tr>
<tr>
<td></td>
<td>• Percussion of chest (eg, dullness, flatness, hyperresonance)</td>
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<tr>
<td></td>
<td>• Palpation of chest (eg, tactile fremitus)</td>
</tr>
<tr>
<td></td>
<td>• Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>• Palpation of heart (eg, location, size, thrills)</td>
</tr>
<tr>
<td></td>
<td>• Auscultation of heart with notation of abnormal sounds and murmurs</td>
</tr>
<tr>
<td></td>
<td>Examination of:</td>
</tr>
<tr>
<td></td>
<td>• carotid arteries (eg, pulse, amplitude, bruits)</td>
</tr>
<tr>
<td></td>
<td>• abdominal aorta (eg, size, bruits)</td>
</tr>
<tr>
<td></td>
<td>• femoral arteries (eg, pulse, amplitude, bruits)</td>
</tr>
<tr>
<td></td>
<td>• pedal pulses (eg, pulse amplitude)</td>
</tr>
<tr>
<td></td>
<td>• extremities for edema and/or varicities</td>
</tr>
<tr>
<td>Chest (Breasts)</td>
<td>• Inspection of breasts (eg, symmetry, nipple discharge)</td>
</tr>
<tr>
<td></td>
<td>• Palpation of breasts and axillae (eg, masses or lumps, tenderness)</td>
</tr>
<tr>
<td>Gastrointestinal (Abdomen)</td>
<td>• Examination of abdomen with notation of presence of masses or tenderness</td>
</tr>
<tr>
<td></td>
<td>• Examination of liver and spleen</td>
</tr>
<tr>
<td></td>
<td>• Examination for presence or absence of hernia</td>
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<tr>
<td></td>
<td>• Examination (when indicated) of anus, perineum and rectum, including sphincter tone,</td>
</tr>
<tr>
<td></td>
<td>presence of hemorrhoids, rectal masses</td>
</tr>
<tr>
<td></td>
<td>• Obtain stool sample for occult blood text when indicated</td>
</tr>
<tr>
<td>Genitourinary</td>
<td>Male:</td>
</tr>
<tr>
<td></td>
<td>• Examination of the scrotal contents (eg, hydrocele, spermatocele, tenderness of cord,</td>
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<tr>
<td></td>
<td>testicular mass)</td>
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<tr>
<td></td>
<td>• Examination of the penis</td>
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<tr>
<td></td>
<td>• Digital rectal examination of prostate gland (eg, size, symmetry, nodularity, tenderness)</td>
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<tr>
<td></td>
<td>Female:</td>
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<tr>
<td></td>
<td>Pelvic examination (with or without specimen collection for smears and cultures)</td>
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<td></td>
<td>including</td>
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<tr>
<td></td>
<td>• Examination of external genitalia (eg, general appearance, hair distribution, lesions)</td>
</tr>
<tr>
<td></td>
<td>• Examination of urethra (eg, masses, tenderness, scoring)</td>
</tr>
<tr>
<td></td>
<td>• Examination of bladder (eg, fullness, masses, tenderness)</td>
</tr>
<tr>
<td></td>
<td>• Cervix (eg, general appearance, lesions, discharge)</td>
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<tr>
<td></td>
<td>• Uterus (eg, size, contour, position, mobility, tenderness, consistency, descent or</td>
</tr>
<tr>
<td></td>
<td>support)</td>
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<tr>
<td></td>
<td>• Adnexa/parametria (eg, masses, tenderness, organomegaly, nodularity)</td>
</tr>
</tbody>
</table>
### General Multi-System Examination (continued)

<table>
<thead>
<tr>
<th>System/Body Area</th>
<th>Elements of Examination</th>
</tr>
</thead>
</table>
| **Lymphatic**    | Palpation of lymph nodes in **two or more** areas:  
  • Neck  
  • Axillae  
  • Groin  
  • Other |
| **Musculoskeletal** |  
  • Examination of gait and station  
  • Inspection and/or palpation of digits and nails (eg, clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes)  
  Examination of joints, bones and muscles of **one or more of the following six** areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes:  
  • Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions  
  • Assessment of range of motion with notation of any pain, crepitation or contracture  
  • Assessment of stability with notation of any dislocation (luxation), subluxation or laxity  
  • Assessment of muscle strength and tone (eg, flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements |
| **Skin** |  
  • Inspection of skin and subcutaneous tissue (eg, rashes, lesions, ulcers)  
  • Palpation of skin and subcutaneous tissue (eg, induration, subcutaneous nodules, tightening) |
| **Neurologic** |  
  • Test cranial nerves with notation of any deficits  
  • Examination of deep tendon reflexes with notation of pathological reflexes (eg, Babinski)  
  • Examination of sensation (eg, by touch, pin, vibration, proprioception) |
| **Psychiatric** |  
  • Description of patient’s judgment and insight  
  Brief assessment of mental status, including:  
  • Orientation to time, place and person  
  • Recent and remote memory  
  • Mood and affect (eg, depression, anxiety, agitation) |

### Content and Documentation Requirements

Perform General Multi-System Examination

<table>
<thead>
<tr>
<th>Level of Exam</th>
<th>Perform and Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem Focused</td>
<td><strong>One to five</strong> elements identified by a bullet.</td>
</tr>
<tr>
<td>Expanded Problem Focused</td>
<td><strong>At least six</strong> elements identified by a bullet</td>
</tr>
<tr>
<td>Detailed</td>
<td><strong>At least two</strong> elements identified by a bullet from each of <strong>six areas/systems</strong> or at least <strong>12</strong> elements identified by a bullet in two or more areas/systems.</td>
</tr>
<tr>
<td>Comprehensive</td>
<td><strong>At least two</strong> elements identified by a bullet from each of <strong>nine areas/systems</strong>.</td>
</tr>
</tbody>
</table>
Thinking It Through — 5.4

1. In which category—problem-focused, expanded problem-focused, detailed, or comprehensive—would you place these statements concerning patient history? Why?

CASE A
Patient seen for follow-up of persistent sinus problems including pain, stuffiness, and greenish drainage over the past twenty days. She continues to have left-sided pain in the forehead and maxillary areas and feels that her symptoms are worse around dust. She gets drainage into her throat, which causes her to cough. Review of systems reveals no history of diabetes or asthma. She has thyroid problems for which she takes Synthroid®.

CASE B
Patient presents with a mild case of poison ivy on face and both hands contracted four days ago while gardening; has never been bothered by poison ivy before.

2. Using the office visit E/M codes, which code would you select for each of these cases?

CASE A
Chart note for established patient:
S: Patient returns for removal of stitches I placed about seven days ago. Reports normal itching around the wound area, but no pain or swelling. _______________________________________________
O: Wound at lateral aspect of the left eye looks well healed. Decision made to remove the 5-0 nylon sutures, which was done without difficulty. _________________________________________
A: Laceration, healed. _____________________________________
P: Patient advised to use vitamin E for scar prophylaxis. ____________________________________________

CASE B
Initial office evaluation by oncologist of a sixty-five-year-old female with sudden unexplained twenty-pound weight loss. Comprehensive history and examination performed.

CASE C
Office visit by established patient for regularly scheduled blood test to monitor long-term effects of Coumadin; nurse spends five minutes, reviews the test, confirms that the patient is feeling well, and states that no change in the dosage is necessary.

3. If a physician sees a patient in the hospital and the patient comes to the office for a follow-up visit, is the follow-up encounter coded for a new or established patient?
Office and Hospital Services

Office and other outpatient services are the most often reported E/M services. A patient is an outpatient unless admitted to a health care facility, such as a hospital or nursing home, for a twenty-four-hour period or longer.

- When a patient is evaluated and then admitted to a health care facility, the service is reported using the codes for initial hospital care (the range 99221–99223).
- The admitting physician uses the initial hospital care services codes. Only one provider can report these services; other physicians involved in the patient's care, such as a surgeon or radiologist, use other E/M service codes or other codes from appropriate sections.
- Codes for initial hospital observation case (99218–99220), initial hospital case (99221–99223), and initial inpatient consultations (99251–99255) should be reported by a physician only once for a patient admission.

Emergency Department Services

An emergency department is hospital-based and available to patients twenty-four hours a day. When emergency services are reported, whether the patient is new or established is not applicable. Time is not a factor in selecting the E/M service code. The code ranges are 99281 to 99288.

Preventive Medicine Services

Preventive medicine services are used to report routine physical examinations in the absence of a patient complaint. These codes, in the range 99381 to 99429, are divided according to the age of the patient. Immunizations and other services, such as lab tests that are normal parts of an annual physical, are reported using the appropriate codes from the Medicine and the Pathology and Laboratory sections (see pages 177 through 180).

Anesthesia Codes

The codes in the Anesthesia section are used to report anesthesia services performed or supervised by a physician. These services include general and regional anesthesia as well as supplementation of local anesthesia. Anesthesia codes each include the complete usual services of an anesthesiologist:

- Usual preoperative visits for evaluation and planning
- Care during the procedure, such as administering fluid or blood, placing monitoring devices or IV lines, laryngoscopy, interpreting lab data, and nerve stimulation
- Routine postoperative care

EXAMPLE

Anesthesiologist Report: Initial meeting with seven-year-old patient in good health, determined good candidate for required general anesthesia for tonsillectomy. Surgical procedure conducted April 4, 2008; patient in the supine position; administered general anesthesia via endotracheal tube. Routine monitoring during procedure. Following successful removal of the right and left tonsils, the patient was awakened and taken to the recovery room in satisfactory condition.
00170–P1  Anesthesia for intraoral procedures, including biopsy; not otherwise specified

(The modifier -P1 is discussed below.)

Postoperative critical care and pain management requested by the surgeon are not included and can be billed in addition to the main anesthesia code by the anesthesiologist.

Anesthesia codes are reimbursed according to time. The American Society of Anesthesiologists assigns a base unit value to each code. The anesthesiologist also records the amount of time spent with the patient during the procedure and adds this to the base value. Difficulties, such as a patient with severe systemic disease, also add to the value of the anesthesiologist’s services.

Structure

The Anesthesia section’s subsections are organized by body site. Under each subsection, the codes are arranged by procedures. For example, under the heading Neck, codes for procedures performed on various parts of the neck (the integumentary system; the esophagus, thyroid, larynx, trachea; and lymphatic system; and the major vessels) are listed. The body-site subsections are followed by two other subsections: (1) radiological procedures—that is, anesthesia services for patients receiving diagnostic or therapeutic radiology—and (2) other or unlisted procedures.

Modifiers

Two types of modifiers are used with anesthesia codes: (1) a modifier that describes the patient’s health status and (2) the standard modifiers.

Physical Status Modifiers

Because the patient’s health has a large effect on the level of difficulty of anesthesia services, anesthesia codes are assigned a physical status modifier. This modifier is added to the code. The patient’s physical status is selected from this list:

- P1  Normal, healthy patient
- P2  Patient with mild systemic disease
- P3  Patient with severe systemic disease
- P4  Patient with severe systemic disease that is a constant threat to life
- P5  Moribund patient who is not expected to survive without the operation
- P6  Declared brain-dead patient whose organs are being removed for donation purposes

For example:
00320–P3  Anesthesia services provided to patient with severe diabetes for procedure on larynx

Modifiers

The following standard modifiers are also commonly used with anesthesia codes:

-22 Unusual procedural service: Used with rare, unusual, or variable anesthesia services.

-23 Unusual anesthesia service: Used when the procedure normally requires either no anesthesia or local anesthesia but, because of unusual circumstances, general anesthesia is administered.
–32 **Mandated service:** Used when the procedure is required by a payer. For example, a PPO may require an independent evaluation of a patient before procedures are performed.

–51 **Multiple procedures:** Used to identify a second procedure or multiple procedures during the same operation.

–53 **Discontinued:** Used when the procedure is canceled after induction of anesthesia but before the incision is made. If the surgery is canceled after the evaluation of the patient, an E/M code is used rather than this modifier.

–59 **Distinct procedural service:** Used for a different encounter or procedure for the same patient on the same day; also used to describe the requirement for critical care and nonroutine pain management.

Note that modifier –37, Anesthesia by Surgeon, is used only during surgical procedures, not for services performed by anesthesiologists or anesthetists or supervised by surgeons.

For example, an anesthesia code with both types of modifiers appears as:

00320–P3–53 Anesthesia services provided to patient with severe diabetes for procedure on larynx; procedure discontinued because patient experienced a sudden drop in blood pressure

### Add-On Codes for Qualifying Circumstances

Four add-on codes are used to indicate that the administration of the anesthesia involved important circumstances that had an effect on how it was performed. As add-on codes, these do not stand alone but always appear in addition to the primary procedure code. These four codes apply only to anesthesia and are described in the notes for the Anesthesia Section.

*+99100 Anesthesia for patient of extreme age (under one year or over age seventy)*

*+99116 Anesthesia complicated by utilization of total body hypothermia*

*+99135 Anesthesia complicated by utilization of controlled hypotension*

*+99140 Anesthesia complicated by specified emergency conditions*

### Reporting Anesthesia Codes

Anesthesia services for Medicare patients and most other patients are reported using codes from the Anesthesia section. However, medical insurance specialists should be aware that some private payers require anesthesia services to be reported by procedure codes from the Surgery section rather than by codes from the Anesthesia section. The anesthesia modifier is added to the procedure code.

### Surgery Codes

The codes in the Surgery section are used for the many hundreds of surgical procedures performed by physicians. This is the largest procedure code section, with codes ranging from 10021 to 69990.

### Surgical Package

Most surgical codes include all the usual services in addition to the operation itself:
• After the decision for surgery, one related E/M encounter on the date immediately before or on the date of the procedure
• The operation: preparing the patient for surgery, including injection of anesthesia by the surgeon (local infiltration, metacarpal/metatarsal/digital block, or topical anesthesia), and performing the operation, including normal additional procedures, such as debridement
• Immediate postoperative care, including dictating operative notes and talking with the family and other physicians
• Writing orders
• Evaluating the patient in the postanesthesia recovery area
• Typical postoperative follow-up care

A complete procedure includes the operation, the use of a local anesthetic, and postoperative care, all covered under a single code.

EXAMPLE

Procedural Statement: Procedure conducted two weeks ago in office to correct hallux valgus (bunions) on both feet; local nerve block administered, correction by simple exostectomy. Saw patient in office today for routine follow-up; complete healing.

Code: 28290–50 Bunion correction on both feet

In the Surgery section, the grouping of related work under a single procedure code is called a surgical package or global surgery rule. Government and private payers assign a fee to a surgical package code that reimburses all the services provided under it. The period of time that is covered for follow-up care is referred to as the global period. After the global period ends, additional services that are provided can be reported separately for additional payment. For most payers, there are two possible global preoperative periods—zero days and one day. Usually, there are three possible postoperative global periods: zero days, ten days, and ninety days.

Two types of services are not included in surgical package codes. These services are billed separately and are reimbursed in addition to the surgical package fee:

• Complications or recurrences that arise after therapeutic surgical procedures.
• Care for the condition for which a diagnostic surgical procedure is performed. Routine follow-up care included in the code refers only to care related to recovery from the diagnostic procedure itself, not the condition. For example, a diagnostic colonoscopy is performed to examine a growth in the patient’s colon. An office visit after the surgery to evaluate the patient for chemotherapy because the tumor is cancerous is billed separately, not with code 99024 for a postoperative follow-up visit included in global service.

Separate Procedures

Some procedural code descriptors in the Surgery section are followed by the words separate procedure in parentheses. Separate procedure means that the procedure is usually done as an integral part of a surgical package—usually a larger procedure—but that in some situations it is not. If a separate procedure is performed alone or along with other procedures but for a separate purpose, it may be reported separately. For example:

42870 Excision or destruction lingual tonsil, any method (separate procedure)
Lingual tonsil excision is a separate procedure. It is usually a part of a routine tonsillectomy and so cannot be reported separately when a tonsillectomy is performed. When it is done independently, however, this code can be reported.

**Structure**

Most of the Surgery section's subsections are organized by body system and then divided by body site. Procedures are grouped next, under headings followed by specific procedures. For example:

<table>
<thead>
<tr>
<th>Subsection:</th>
<th>DIGESTIVE SYSTEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Site:</td>
<td>Lips</td>
</tr>
<tr>
<td>Heading—type of procedure:</td>
<td>Excision</td>
</tr>
<tr>
<td>Description—specific procedure:</td>
<td>40490 Biopsy of lip</td>
</tr>
</tbody>
</table>

The exceptions to the usual subsection structure are the Laparoscopy/Hysteroscopy subsection, which groups those operative procedures, and the Maternity Care and Delivery subsection, organized by type of service, such as postpartum care.

**Modifiers**

A number of modifiers are commonly used to indicate special circumstances involved with surgical procedures.

- **–22 Unusual procedural service:** Used with rare, unusual, or variable surgery services; requires documentation.

- **–26 Professional component:** Used to report the professional components when a procedure has both professional and technical components.

- **–32 Mandated service:** Used when the procedure is required by a payer or is a government, legislative, or regulatory requirement.

- **–47 Anesthesia by surgeon:** Used when the surgeon (rather than an anesthesiologist) administers regional or general anesthesia (local/topical anesthesia is bundled in the surgical code).

- **–50 Bilateral procedure:** Used when identical bilateral procedures were performed during the same operation, either through the same incision or on separate body parts, such as left and right bunion correction. Attach the bilateral modifier to the code for the first procedure to indicate that the procedure was done bilaterally. For example, to report a puncture aspiration of one cyst in each breast:

  19100–50  Puncture aspiration of cyst of breast

- **–51 Multiple procedures:** Used to identify a second procedure or multiple procedures during the same operation. The additional procedures are the same type and done to the same body system. Attach the modifier to the second procedure code. For example, to report two procedures, a bunionectomy on the great toe and, in the same session, correction of a hammertoe on the fourth toe:

  28290  Hallux valgus (bunions) correction
  28285–51  Hammertoe operation, one
–52 Reduced services: Used when a procedure is less extensive than described. The modifier is attached to the procedure code. It is not used to identify a reduced or a discounted fee. Instead, usually, the normal fee is listed, and the payer determines the amount of the reduction.

–53 Discontinued procedure: Used when the procedure is discontinued due to circumstances that threaten the patient’s well-being—for example, surgery discontinued because the patient went into shock during the operation.

–54 Surgical care only: Added to the surgery code when the surgeon performs only the surgery itself, without preoperative or postoperative services. The fee will be reduced by the payer to reflect only that part of the surgical package.

–55 Postoperative management only: Added to the surgery code when the physician provides only the follow-up care in the global period after another physician has done the surgery. The fee will be reduced by the payer to reflect only that part of the surgical package.

–56 Preoperative management only: Added to the surgery code when the physician provides only preoperative care. The fee will be reduced by the payer to reflect only that part of the surgical package.

–58 Staged or related procedure or service by the same physician during the postoperative period: Used when the physician performs a postoperative procedure (1) as planned during the surgery to be done later, (2) that is more extensive than the original procedure, or (3) for therapy after diagnostic surgery.

–59 Distinct procedural service: Used for a different encounter or procedure for the same patient on the same day. A different patient encounter, an unrelated procedure, a different body site or system, or a separate incision or injury must be involved. The modifier may also be used to describe the requirement for critical care and nonroutine pain management. If a separate procedure is performed with other procedures, the –59 modifier is added to the separate code to show that it is a distinct, independent procedure, not part of a surgical package.

–62 Two surgeons: Used when a specific surgical procedure requires two surgeons, usually of different specialties; each appends the modifier to the surgical code. Usually each surgeon performs a distinct part of the procedure and dictates a separate operative report. If each surgeon reports different surgical procedure codes, the modifier is not used.

–63 Procedure performed on infants: Used when the patient is under twenty-four months of age.

–66 Surgical team: Used in very complex procedures that usually require the simultaneous services of physicians of different specialties. Usually used to report transplant-type procedures only.

–76 Repeat procedure by same physician: Used when a physician repeats a procedure performed earlier.

–77 Repeat procedure by another physician: Used when a physician repeats a procedure done by another physician.

–78 Return to the operating room for a related procedure during the postoperative period: Used when the patient develops a complication during the postoperative period that requires an additional procedure by the same physician.
79 Unrelated procedure or service by the same physician during the postoperative period: Used when a second, unrelated surgical procedure is performed by the same physician during the postoperative period.

80 Assistant surgeon: Used when a physician assists another during a surgical procedure. Each physician reports the services using the same code, but the assistant surgeon appends the modifier to the code.

81 Minimum assistant surgeon: Used when an assistant surgeon assists another during only part of a surgical procedure.

82 Assistant surgeon (when qualified resident surgeon not available): Used in teaching hospitals where residents usually assist with surgery but none was available during the reported procedure, so a surgeon performed the assistant’s work.

90 Reference (outside) laboratory: Used when laboratory procedures are done by someone other than the reporting physician.

91 Repeat clinical diagnostic laboratory test: Used when laboratory procedures are repeated.

99 Multiple modifiers: Used when more than one modifier is required; the –99 modifier is appended to the basic procedure, followed by the other modifiers in descending order.

Reporting Surgical Codes
Surgical package codes often are “bundled” by payers. Bundling is using a single payment for two or more related procedure codes. Bundled payment combinations are based on payers’ judgment of the correct value for the physician’s work. As an example of a bundled code, CPT 27370 codes an injection procedure for knee arthrography. If this code is billed, payers will not also pay for any of these codes on the same day of service:

20610 Injection of major joint
76000 Fluoroscopy (separate procedure)
76003 Fluoroscopic guidance

Because 27370 is bundled, neither 20610, 76000, nor 76003 should be billed with it; payment for each of these codes is already included in the payment rate.

When such services are billed, physicians must report the bundled code and not each of the other codes separately. Reporting anything that is included in the bundled code is considered unbundling, or fragmented billing. Doing so causes denied claims and may result in an audit.

Reporting Sequence
When payers reimburse multiple surgical procedures performed on the same day for the same patient, they pay the full amount of the first listed surgical procedure, but they often pay reduced percentages of the subsequent procedures. For maximum payment when multiple procedures are reported, the most complex or highest-level code—the procedure with the highest reimbursement value—should be listed first. The subsequent procedures are listed with the modifier –51 (indicating multiple procedures).

When warranted, to avoid reduced payment for multiple procedures, the modifier –59 is used to indicate distinct procedures rather than multiple procedures. This is usually done when the surgeon performs procedures on two different body parts.
Lesion Excision
The choice of the correct code for the surgical removal of a lesion depends on the pathology report. There are different code ranges for benign lesions and malignant lesions. Coders should wait for a pathology report before coding lesion excisions from the benign or malignant code ranges.

Billing Tip

Profession Component Requirement
Billing the professional component of a radiologic procedure requires a written interpretation from the physician. This documentation contains the patient’s identifying information, the clinical indications for the procedure, the process followed, and the physician’s impressions of the findings.

Bilateral Modifier
The bilateral modifier (–50) is attached to unilateral procedures that are done bilaterally. However, there are a few codes that are defined as bilateral procedures. For example:

32853  Lung transplant, double (bilateral sequential or en bloc)

The trend in annual updates is to replace bilateral codes with unilateral codes to which the –50 modifier is attached if needed.

Radiology Codes
The codes in the Radiology section are used to report radiological services performed by or supervised by a physician. Radiology procedures have two parts:

1. The technical component: The technologist, the equipment, and processing, including preinjection and postinjection services such as local anesthesia, placement of needle or catheter, and injection of contrast material
2. The professional component: The reading of the radiological examination and the written report of interpretation by the physician

Radiology codes follow the same types of guidelines as noted in the Surgery section. For example, some radiology codes are identified as separate procedure codes. These codes are usually part of a larger, more complex procedure and should not be reported as separate codes unless the procedure was done independently. Also, some codes are add-on codes, such as those covering additional vessels that are studied after the basic examination. These codes are used with the primary codes, not alone.

Unlisted Procedures and Special Reports
New procedures are common in the area of radiology services. There are codes for nearly twenty unlisted code areas, such as:

78299  Unlisted gastrointestinal procedure, diagnostic nuclear medicine
When unlisted codes are reported, a special report must be attached that defines the nature, extent, and need for the procedure and describes the time, effort, and equipment necessary to provide it.

**Contrast Material**

For some radiological procedures, the physician decides whether it is best to perform the procedure with or without contrast material, a substance administered in the patient's blood vessels that helps highlight the area under study. For example, computerized tomography (CT) and magnetic resonance imaging (MRI) provide different types of information about body parts and may be performed with or without contrast material. The term *with contrast* means only contrast materials given in the patient's veins or arteries. Contrast materials administered orally or rectally are coded as without contrast.

**Structure and Modifiers**

The diagnostic radiology, diagnostic ultrasound, and nuclear medicine subsections of the Radiology section are structured by type of procedure, followed by body sites and then specific procedures. For example:

- **Type**: Diagnostic Ultrasound
- **Body site**: Chest
- **Procedure**: Echography, chest, B-scan and/or real time with image documentation

The radiation oncology subsection is organized somewhat differently. The first group of codes covers the planning services oncologists perform to set up a patient's radiation therapy treatment for cancer.


**Reporting Radiology Codes**

Most radiology services are performed and billed by radiologists working in hospital or clinic settings. Medical practices usually do not have radiology equipment and instead refer patients to these specialists. In many cases, the radiologist performs both the technical and the professional components. Codes are selected based on body part, and the number/type of views.

**Pathology and Laboratory Codes**

The codes in the Pathology and Laboratory section cover services provided by physicians or by technicians under the supervision of physicians. A complete procedure includes:

- Ordering the test
- Taking and handling the sample
- Performing the actual test
- Analyzing and reporting on the test results.

**Panels**

Certain tests are customarily ordered together to detect particular diseases or malfunctioning organs. These related tests are grouped under laboratory
Billing Tip

Laboratory Work
Medicare does not permit a physician who does not perform the lab work to bill for it. However, other payers allow it. When the physician orders the lab test and then pays the lab (called the reference lab) for the service, the physician may then report that test. The modifier –90 is attached to the code for the lab test.

Panels for reporting convenience. When a panel code is reported, all the listed tests must have been performed (otherwise, just the individual tests are billed). For example, the electrolyte panel requires these tests:

80051 Electrolyte panel
This panel must include the following:
Carbon dioxide (82374)
Chloride (82435)
Potassium (84132)
Sodium (84295)

Panels are bundled codes, so when a panel code is reported, no individual test within it may be additionally billed. Other tests that were performed outside that panel may be billed, of course.

Unlisted Procedures and Special Reports

New developments are frequent in pathology and laboratory services. There are codes for twelve unlisted code areas, such as:

86586 Unlisted antigen, each

Any unlisted code must be submitted with a special report that defines the nature, extent, and need for the procedure and describes the time, effort, and equipment necessary to provide it.

Structure and Modifiers

Procedures and services are listed in the Index under the following types of main terms:

- Name of the test, such as urinalysis, HIV, skin test
- Procedure, such as hormone assay
- Abbreviation, such as TLC screen
- Panel of tests, such as Complete Blood Count

The following modifiers are commonly used with pathology and laboratory codes: –22, –26, –32, –52, –53, –59, –90, and –91. Table 5.2 on page 154 has a brief description of each modifier.

Reporting Pathology and Laboratory Codes

Some medical practices have laboratory equipment and perform their own testing. In-office labs are guided by federal safety regulations from OSHA (the Occupational Safety and Health Administration), and the tests that can be performed are regulated by CLIA (the Clinical Laboratory Improvement Amendment of 1988). The CLIA certification program awards one of two levels of certification: (1) waived tests and provider-performed microscopy (PPM) procedures and (2) moderate- or high-complexity testing. The in-office lab with the first level can perform common tests, such as dipstick urinalysis and urine pregnancy, and PPM procedures such as nasal smears for eosinophils and pinworm exams.

If the medical practice does not have an in-office lab, the physician may either take the specimen, reporting this service only (for example, using code 36415 for venipuncture to obtain a blood sample), and send it to an outside lab for processing or refer the patient to an outside lab for the complete procedure.
Medicine Codes

The Medicine section contains the codes for the many types of evaluation, therapeutic, and diagnostic procedures that physicians perform. (Codes for the Evaluation and Management section described earlier in the chapter, 99201 to 99499, fall numerically at the end of this section, but they appear first in CPT because they are the most frequently used codes.) Medicine codes may be used for procedures and services done or supervised by a physician of any specialty. They include many procedures and services provided by family practice physicians, such as immunizations and injections. The services of many specialists, such as allergists, cardiologists, and psychiatrists, are also covered in the Medicine section. Some Medicine section codes are for ancillary services that are used to support diagnosis and treatment, like rehabilitation, occupational therapy, and nutrition therapy.

Codes from the Medicine section may be used with codes from any other section. Add-on codes and separate procedure codes are included in the Medicine section. Their use follows the guidelines described for previous sections. Unlisted procedure codes are provided for new procedures; a special report is required with unlisted codes.

Structure and Modifiers

The subsections are organized by type of service. Many subsections have notes containing usage guidelines and definitions. Some services, for example, have subcategories for new and established patients.


Reporting Medicine Codes

- Some of the services in the Medicine section are considered Evaluation and Management services, even though they are not listed in the E/M section. For these codes, the –51 modifier, Multiple Procedures, may not be used. For example, if a physician makes a second, brief visit to a patient in the hospital and also provides psychoanalysis, these services are reported separately:

  99231  Subsequent hospital care, problem focused/straightforward or low complexity decision making
  90845  Psychoanalysis

- Immunizations require two codes, one for administering the immunization and the other for the particular vaccine or toxoid that is given. For example, when a patient receives a MMRV vaccine, these two codes are used:

  90471  Immunization administration
  90710  Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use

- The descriptors for injection codes also require two codes, one for the injection and one for the substance that is injected (the exception is allergy shots, which have their own codes in the Allergy and Clinical Immunology subsection). For example, to report the intravenous administration of an anti-emetic:

  90774  Therapeutic, prophylactic or diagnostic injection (specify substance or drug); intravenous push, single or initial substance/drug
Thinking It Through — 5.6

1. If a test for ferritin and a comprehensive metabolic panel are both performed, can both be reported?

2. Is it correct to report a comprehensive metabolic panel and an electrolyte panel for the same patient on the same day?

3. Which of these codes, 93000, 93005, or 93010, is used to report the technical component only of a routine ECG? Defend your decision.

Some commercial payers and Medicare use a HCPCS code, instead of CPT 99070, for the material that is injected, as covered in Chapter 6.

**Category II and III Codes**

The Category II code set contains supplemental tracking codes to help collect data regarding services, such as prenatal care and tobacco use cessation counseling, that are known to contribute to good patient care. Having codes available reduces the amount of administrative time needed to gather this data from documentation.

The use of these codes is optional and does not affect reimbursement. The codes are not required for correct coding and are not a substitute for Category I codes.

Category II codes are four digits followed by an alphabetical character. They are arranged according to the following categories:

- Composite Measures
- Patient Management
- Patient History
- Physical Examination
- Diagnostic Screening Processes or Results
- Therapeutic, Preventive or Other Interventions
- Follow-up or Other Outcomes
- Patient Safety

The Category III code set contains temporary codes for emerging technology, services, and procedures. If a Category III code is available for a new procedure, this code must be reported instead of a Category I unlisted code.

The codes in this section are not like CPT Category I codes, which require that the service or procedure be performed by many health care professionals in clinical practice in multiple locations and that FDA approval, as appropriate, has already been received. For these reasons, temporary codes for emerging technology, services, and procedures have been placed in a separate section of the CPT book. When a temporary service or procedure does meet these requirements, it is listed as a Category I code in the appropriate section of the main text.

Category III codes are four digits followed by an alphabetical character.

Note that modifiers can be used with Category III codes, but not with Category II codes.
Review

II. Claim Coding
5. Procedural Coding: Introduction to CPT
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Steps to Success

☐ Read this chapter and review the Key Terms and the Chapter Summary.
☐ Answer the Review Questions and Applying Your Knowledge in the Chapter Review.
☐ Access the chapter’s websites and complete the Internet Activities to learn more about available professional resources.

☑ Complete the related chapter in the Medical Insurance Workbook to reinforce your understanding of medical coding for procedures.

Chapter Summary

1. CPT, a publication of the American Medical Association, contains the most widely used system of codes for physicians’ medical, diagnostic, and procedural services. CPT codes are required for reporting physician practice services on insurance claims and encounter forms. The codes have five digits and a description. Updated versions are released annually. Medical practices must use the current codes for proper billing and reimbursement.

2. Each year’s CPT codes must be purchased from the American Medical Association, which also publishes changes online.

3. CPT contains six sections of Category I codes, Evaluation and Management, Anesthesia, Surgery, Radiology, Pathology and Laboratory, and Medicine, followed by the Category II and Category III codes, nine appendixes, and an index. The index is used first in the process of selecting a code; it contains alphabetic descriptive main terms and subterms for the procedures and services contained in the main text. The codes themselves are listed in the main text and are generally grouped by body system or site or by type of procedure.

4. Each coding section begins with section guidelines, which discuss definitions and rules for the use of codes, such as for unlisted codes, special reports, and notes for specific subsections. When a main entry has more than one code, a semicolon follows the common part of a descriptor in the main entry, and the unique descriptors that are related to the common description are indented below it. Seven symbols are used in the main text: (a) ● (a bullet or black circle) indicates a new procedure code; (b) ▲ (a triangle) indicates that the code’s descriptor has changed; (c) ◼ ◽ (facing triangles) enclose new or revised text other than the code’s descriptor; (d) + (a plus sign) before a code indicates an add-on code that is used only along with other codes for primary procedures; (e) the symbol θ next to a code means that conscious sedation is a part of the procedure the surgeon performs; (f) a ◼ indicates that the code cannot be modified with a −51 modifier; and (g) a ‖ is used for codes for vaccines that are pending FDA approval.

5. A CPT modifier is a two-digit number that may be attached to most five-digit procedure codes to indicate that the procedure is different from the listed descriptor, but not in a way that changes the definition or requires a different code. Two or more modifiers may be used with one code to give the most accurate description possible.

6. The first step in selecting a procedure code is to determine the procedures and services to report by reviewing the documentation of the patient’s visit. Next, after checking the coding system to use, CPT codes are located by finding the procedure in the index and verifying the code in the main text. The reporting order for the procedure codes places the code with the highest rate of reimbursement first. The final step is to determine whether modifiers are needed.
7. A summary of the six sections of Category I codes appears in Table 5.1 on page 146.

8. The key components for selecting Evaluation and Management codes are the extent of the history documented, the extent of the examination documented, and the complexity of the medical decision making. The steps for selecting correct E/M codes are to (a) determine the category and subcategory of service, (b) determine the extent of the history, (c) determine the extent of the examination, (d) determine the complexity of medical decision making, (e) analyze the requirements to report the service level, (f) verify the service level based on the nature of the presenting problem, time, counseling, and care coordination, (g) verify that the documentation is complete, and (h) assign the code.

Review Questions

Match the key terms with their definitions.

A. panel
B. professional component
C. separate procedure
D. Category III codes
E. global period
F. bundled code
G. Category II codes
H. add-on code
I. unlisted procedure
J. modifier

1. The physician’s skill, time, and expertise used in performing a procedure
2. Temporary codes for emerging technology, services, and procedures
3. Procedure code that groups related procedures under a single code
4. A service that is not listed in CPT and requires a special report
5. The inclusion of pre- and postoperative care for a specified period in the charges for a surgical procedure
6. CPT codes that are used to track performance measures
7. In CPT, a single code that groups laboratory tests that are frequently done together
8. A procedure performed in addition to a primary procedure
9. A secondary procedure that is performed with a primary procedure and that is indicated in CPT by a plus sign (+) next to the code
10. A two-digit number indicating that special circumstances were involved with a procedure, such as a reduced service or a discontinued procedure

Decide whether each statement is true or false.

1. In selecting correct procedure codes, the main text sections are first searched, and the code is then verified in the index.
2. Category II codes are not reported for payment.
3. In the CPT index, a see cross-reference must be followed.
4. The section guidelines summarize the unlisted codes for the section.
5. The phrases before the semicolon in a code descriptor define the unique entries; those after the semicolon are common.
6. Descriptive entries in parentheses are not essential to code selection.
8. Procedure codes are reported in order of increasing financial value for services performed on the same day.
9. For new patients, two of the three key factors that are listed must be met.
10. Because it is an evaluation of a patient, a consultation is coded using Evaluation and Management office services codes.
Select the letter that best completes the statement or answers the question.

___ 1. A new patient has not received services from the physician or from another physician of the same specialty in the same group practice for:
   A. ninety days
   B. one year
   C. two years
   D. three years

___ 2. When a physician asks a patient questions to obtain an inventory of constitutional symptoms and of the various body systems, the results are documented as the:
   A. past medical history
   B. family history
   C. review of systems
   D. comprehensive examination

___ 3. The abbreviation PFSH stands for:
   A. past, family, and/or social history
   B. patient, family, and/or systems history
   C. past, family, and systems history
   D. none of the above

___ 4. The examination that the physician conducts is categorized as:
   A. straightforward, low complexity, moderate complexity, or high complexity
   B. problem-focused, expanded problem-focused, detailed, or comprehensive
   C. straightforward, problem-focused, detailed, or highly complex
   D. low risk, moderate risk, or high risk

___ 5. The three key factors in selecting an Evaluation and Management code are:
   A. time, severity of presenting problem, and history
   B. history, examination, and time
   C. past history, history of present illness, and chief complaint
   D. history, examination, and medical decision making

___ 6. CPT code 99382 is an example of:
   A. an emergency department service code
   B. a preventive medicine service code
   C. a consultation service code
   D. a hospital observation code

___ 7. Anesthesia codes generally include:
   A. preoperative evaluation and planning, normal care during the procedure, and routine care after the procedure
   B. preparing the patient for the anesthetic, care during the procedure, postoperative care, and pain management as required by the surgeon
   C. preoperative evaluation and planning, routine postoperative care, but not the administration of the anesthetic itself
   D. all procedures that are ordered by the surgeon

___ 8. Surgery codes generally include:
   A. all procedures done during the global period that comes before the surgery
   B. preoperative evaluation and planning, the operation and normal additional procedures, and routine care after the procedure
   C. all aspects of the operation, including preparing the patient for the surgery, performing the operation and normal additional procedures, as well as normal, uncomplicated follow-up
   D. preoperative evaluation and planning, routine postoperative care, but not the operation itself
9. When a Surgery section code has a star next to it, the code descriptor covers:
   A. all procedures done during the global period that follows the surgery
   B. preoperative evaluation and planning, the operation and normal additional procedures, and routine care
      after the procedure
   C. the surgical procedure
   D. preoperative evaluation and planning, routine postoperative care, but not the surgical procedure

10. When a panel code from the Pathology and Laboratory section is reported:
    A. all the listed tests must have been performed
    B. 90 percent of the listed tests must have been performed
    C. 50 percent of the listed tests must have been performed
    D. all the listed tests must have been performed on the same day

Answer the following questions.

1. List the three steps in the procedural coding process.
2. List the three key components used to select E/M codes and the four levels each component has.

Applying Your Knowledge

Case 5.1 Coding Evaluation and Management Services

Supply the correct E/M CPT codes for the following procedures and services.

A. Office visit, new patient; detailed history and examination, low complexity medical decision
   making

B. Hospital visit, new patient; comprehensive history and examination, highly complex case

C. Office consultation for established patient; comprehensive history and examination, moderately
   complex medical decision making

D. Annual comprehensive physical examination for sixty-four-year-old new patient

E. Medical disability examination by treating physician

F. Hospital visit to previously admitted patient; expanded problem-focused history and examination,
   twenty-five minutes spent at bedside

G. Hospital emergency department call for established patient with cardiac infarction; detailed
   history and examination, moderately complex decision making

H. Third visit to established, stable patient in nursing facility, medical record and patient’s status
   reviewed, no change made to medical plan

I. Home visit for new patient, straightforward case, problem-focused history and examination

J. Short telephone call to patient to report laboratory test results
Case 5.2  Coding Anesthesia and Surgery Procedures

Supply the correct CPT codes for the following procedures and services.

A. Anesthesia for vaginal delivery only

B. Anesthesia services for patient age seventy-six, healthy, for open procedure on wrist

C. Incision and drainage of infected wound after surgery

D. Destruction of flat wart

E. Closed treatment of acromioclavicular dislocation with manipulation

F. Complicated drainage of finger abscess

G. Paring of three skin lesions

H. Postpartum D & C

I. Excision of chest wall tumor including ribs

J. Transurethral electrosurgical resection of the prostate (TURP); patient has mild systemic disease; payer requires surgery codes

K. Amniocentesis, diagnostic

L. Ureterolithotomy on lower third of ureter

M. Tonsillectomy and adenoidectomy, patient age fifteen

N. Flexible sigmoidoscopy with specimen collection, separate procedure.

O. Kidner type procedure

P. Application of short leg splint

Q. Unilateral transorbital frontal sinusotomy

R. Puncture aspiration of three cysts in breast

S. Posterior arthrodesis for scoliosis patient, eleven vertebral segments

T. Routine obstetrical care, vaginal delivery
Case 5.3  Coding Radiology, Pathology and Laboratory, or Medicine Procedures

Supply the correct CPT codes for the following procedures and services.

A. Subcutaneous chemotherapy administration

B. Material (sterile tray) supplied by physician

C. Routine ECG with fifteen leads, with the physician providing only the interpretation and report of the test

D. CRH stimulation panel

E. Automated urinalysis for glucose, without microscopy

F. Aortography, thoracic, without serialography, radiological supervision and interpretation

G. Bone marrow smear interpretation

H. Physical therapy evaluation

I. Ingestion challenge test

J. Electroencephalogram at surgery, separate procedure

Case 5.4  Assigning Modifiers

A. What is the meaning of each of the modifiers used in the following case example? A multi-trauma patient had a bilateral knee procedure as part of team surgery following a motorcycle crash. The orthopedic surgeon also reconstructed the patient's pelvis and left wrist.

1. –99
2. –66
3. –51
4. –50

Supply the correct codes and modifiers for these cases.

B. A surgeon administers a regional Bier block and then monitors the patient and the block while repairing the flexor tendon of the forearm.

C. Primary care provider performs a frontal and lateral chest X-ray and observes a mass. The patient is sent to a pulmonologist, who, on the same day, repeats the frontal and lateral chest X-ray. How should the pulmonologist report the X-ray service?

D. A day after surgery for a knee replacement, the patient develops an infection in the surgical area and is returned to the operating room for debridement. Which modifier is attached to the second procedure?
Internet Activities

1. The American Academy of Professional Coders (AAPC) is a coding association that certifies medical coders and provides information on coding issues. Visit http://www.aapc.com, and list the specialty coding certifications that are available. Also review the online publication *The Added Edge* (under the More banner), and research recent coding articles.

2. Visit the website of the American Medical Association: http://www.ama-assn.org. Under the banner CPT Codes and Resources, read the information on the CPT process, and report on how new CPT codes are approved.

3. Medical societies such as the American Academy of Family Physicians also offer Internet tools to support their coding. Research this site at http://www.aafp.org, and locate this year’s CPT code updates. Prepare a report on other information that you consider valuable from this website.