

## 3. Coding Guidelines

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## 3.1 Guidelines for Selecting Codes

### 3.1.1 Do's

When selecting codes,

- Do submit a diagnosis code for the chief complaint. If a diagnosis cannot yet be made, submit a diagnosis code for symptoms and signs, if that is the highest level of certainty that can be reached at the time of visit.
- Do use a diagnosis code for a chronic condition treated on an ongoing basis as many times as the patient receives treatment and care for the condition.

For example, when treating rheumatoid arthritis, use the same diagnosis code for each visit for that condition, regardless of the frequency of visits.

- Do code all conditions that exist at the time of the visit and that affect patient care treatment and management, but not past problems that have been resolved.
- Do document medical necessity for a preoperative evaluation. Bill a diagnosis code for the chronic condition requiring preoperative clearance first, followed by the diagnosis code specifically for preoperative evaluation.
- Do document medical necessity, in general. The following information must be apparent from the medical record:
  - the severity of the patient's complaint or condition
  - the emergent nature of the condition, if it is emergent
  - a description of the reason for the care – signs, symptoms, complaints, or background facts, such as required for follow-up care
- Do have each patient sign a general release – before care is initiated – authorizing the clinician to provide a copy of the medical record documentation to the insurer.
- If more than fifty percent of the visit time was spent counseling a patient, bill on the basis of time spent and document the time spent and the matters counseled. Examples of counseling include:
  - Giving diagnostic results, impressions, and/or recommended diagnostic studies
  - Discussing prognosis
  - Discussing risks and benefits of treatment options
  - Giving instructions for treatment and/or follow-up

- Discussing the importance of compliance with chosen treatment options
- Discussing how to reduce risk factors
- Educating patients and families

### **3.1.2 Don'ts**

When selecting codes,

- Do not submit a complicated diagnosis when that diagnosis is not well supported in documentation.
- Do not submit only three or four digits of an ICD-9 code that has five or six digits. Important information is conveyed in these last digits as shown in the following:
  - Diabetes has 5-digit ICD-9 code; the fifth digit notates controlled or uncontrolled.
  - Non-traumatic rupture of the tendon has five digits; the fifth digit identifies which tendon has ruptured.
- Do not submit the diagnosis codes out of appropriate order. The rule is: List the diagnosis code first for the condition chiefly responsible for the services provided.
- Do not submit a “rule out” diagnosis as a definitive diagnosis. Instead, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.
- Do not submit a diagnosis for a problem that has been resolved. The rule is: Do not code a diagnosis that is no longer applicable.

## **3.2 Selecting the Appropriate Code for Provider Services**

These are the steps for selecting the appropriate code for provider services:

1. Did counseling and/or coordination of care require more than fifty percent of the face-to-face time of the total service?
  - If yes, select a code on the basis of total face-to-face time.
  - If no, continue with steps 2-5.

2. Look at the complexity of the physician's medical decision-making, based on information and data from the examination and history.

Select the level of medical decision-making, recalling that two of three elements must be met or exceeded for the selection.

3. Evaluate and determine the level of examination and history.
4. Determine the level of service according to whether two or three of the three key components are required in the code description.

Determine whether the required number of key components is met and/or exceeded for the category of codes.

Validate the physician's code selection by referring to the "nature of presenting problems list". Compare the nature of the patient's problem with this list, select the type of problem, and then match it to the type of problem noted in the physician's medical decision-making and to the description of the type of problem in the code that was tentatively selected.

5. Review documentation in the patient record. It should support the tentative evaluation and management code selection.

If the documentation is incomplete and does not support the code level selected, have the physician complete the documentation before making a final code selection. This is a critical step. You cannot select an evaluation and management code without documentation that supports it and demonstrates its key components as described for the code you have chosen.

Key components must be documented in the patient record along with other contributory factors to qualify for payment and to protect against audit liability.

### 3.2.1 Coding Directly from the Record

When coding directly from the patient record or the electronic health record, take these steps:

1. Review the relevant portion(s) of the patient record, as necessary.
2. Return to that part of the record from which the service must be coded.
3. Identify what was done.
4. Jot down each procedure or service identified.
5. Select the main term and any modifying or descriptive terms for each procedure that must be coded.
6. Turn to the CPT index and locate the main term.
7. Scan any modifying terms listed below the main term.

Note the code or code range listed with the index entry you have located.

8. Turn back to the body of the text and find the code or code range referenced.
9. Locate the heading and subheading under which the code is listed.

Verify that this is the correct body part and the correct type of procedure (e.g., excision versus incision).

10. Read any applicable annotations under the heading, subheading, and codes.
11. Return to the referenced code.

If the code is part of a CPT code family, read the un-indented code and the indented codes below it. Look for the semicolon in the un-indented code first, and then go on to read the indented codes below it.

12. Apply all appropriate coding guidelines.
13. Select the code.

### 3.2.2 Coding from the PCC+ Form

When coding from the PCC+ form, follow these steps:

1. Check the procedure code selection to ensure that the codes correspond with the supporting documentation. Refer to the most current CPT coding guidelines for coding from the patient record.
2. If any services are not pre-coded, review the documentation and apply the appropriate code, based on the most current CPT coding guidelines.
3. If any of the codes appear to be incorrectly coded by the provider, either discuss your opinion directly with the provider or have the provider review the medical record. If he/she agrees with your comments, have the provider change the PCC+ and initial the change.

## 3.3 International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)

The **International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)**, Volumes 1, 2, and 3, is a coding system used to translate medical terminology for diseases and procedures into numeric codes. Maintenance and updates to ICD-9 is carried out collaboratively by the

- **American Hospital Association (AHA)**
- **National Center for Health Statistics (NCHS)**
- **Centers for Medicare and Medicaid Services (CMS)**
- **American Health Information Management Association (AHIMA)**

Originally ICD-9 was used as a means to track the morbidity and mortality of diseases to determine disease trends. These codes are now used to justify the medical necessity of the services provided. Information specifically related to ICD-9 codes includes the following:

- Diagnosis and procedure codes are assigned to the highest level of specificity (the fourth and fifth digits are mandatory when available), based on provider documentation.
- Outpatient diagnoses documented as *rule out*, *probable*, *questionable*, *suspected*, or *working diagnosis* should not be coded; instead, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

- If the diagnosis at the time of discharge is documented as *ruled out*, *probable*, *questionable*, *suspected*, *possible*, or *likely*, code the condition as if it existed or was established. The bases for these guidelines are the diagnostic workup, arrangements for further workup or observation, and initial therapeutic approach that correspond most closely with the established diagnosis.
- Acute and chronic conditions should be specified and differentiated. Chronic conditions that are still being treated should be referenced on the claim form.
- Code all documented conditions that coexist at the time of the encounter and that affect patient treatment or management.
- The acute nature of any emergency situation needs to be identified, such as hemorrhage, concussion, loss of consciousness, and such.
- Secondary diagnoses should also be referenced.
- The primary diagnosis codes should be listed first, followed by secondary, tertiary, and so on. The first diagnosis code should be the diagnosis, condition or problem that is the reason for the patient encounter for that day as documented in the medical record. Other diagnoses can be listed and sequenced in order of importance.
- For ancillary (lab, x-ray and pharmacy) only, a *V* code should be listed first, followed by the diagnosis of the ordering visit.
- Use *E* codes for identifying how injuries occur.
- Previous conditions, not being treated during the current clinic visit, should be coded as historical.
- When a patient encounter is only for a pre-op evaluation, list first the appropriate ICD-9 code that specifically describes the medical necessity for the pre-op evaluation. List second the *V* code that best describes the pre-op evaluation.
- When a patient undergoes surgery, code the diagnosis that necessitated the surgery. If the post-op diagnosis is known and confirmed to be different from the pre-op diagnosis, code for the confirmed post-op diagnosis, since it is more definitive than the pre-op diagnosis.
- Beware of the *Rules of Nines* – 9s usually, but not always, indicate “not specified elsewhere” or “unspecified condition.” Unspecific codes may not clearly identify the medical necessity and should not be used as the sole or primary diagnosis code unless there is no other diagnosis code to use to describe the patient encounter.

### 3.4 International Classification of Diseases Tenth Edition, Clinical Modification (ICD-10-CM) and Procedure Coding System (PCS)

The **International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) and Procedure Coding System (PCS)** is an updated version of ICD-9-CM. As stated, ICD-9 includes three volumes of diagnosis coding for operative, diagnostic, and therapeutic procedures. ICD-10 will accommodate more uses and users than ICD-9. ICD-10 is designed for every field in health care. A greater level of detail will be included.

There are four objectives with ICD-10 PCS:

- **Completeness** – a unique code for all substantially different procedures.
- **Expandability** – as new procedures are developed the new system will be able to more easily accommodate these unique codes.
- **Multi-axial** – each code character should have the same meaning within the specific procedure section and across procedure sections.
- **Standardized Terminology** – the update will include definitions of the terminology used.

ICD-10 - PCS uses seven-character alphanumeric code structures, with each character having up to 34 different values.

- The first character identifies what type of procedure is being reported.
- The second character identifies the body system affected by the service.
- The third character indicates the root operation which can include such procedures as alteration, bypass, or destruction.

#### 3.4.1 Comparison between ICD-9 - CM and ICD-10 - CM

- Addition of information relevant to ambulatory and managed care encounters
- Expanded injury codes
- The creation of combination diagnosis/symptom codes to reduce the number of codes needed to fully describe a condition
- Incorporation of common fourth and fifth digit classifications
- Laterality
- Alphanumeric categories rather than numeric categories

- Rearranged chapters
- Nearly twice as many categories

**Comparison Example – ICD-9 and ICD-10**

| ICD-9-CM |   | ICD-10-CM |   |
|----------|---|-----------|---|
| 892.     | Open wound of hand except finger(s) alone | 861.4     | Open wound of hand                                |
| 892.0    | without mention of complication           | 861.40    | unspecified open wound of hand                    |
| 892.2    | with tendon involvement                   | 861.401   | unspecified open wound, right hand                |
|          |   | 861.402   | unspecified open wound, left hand                 |
|          |   | 861.409   | unspecified open wound, unspecified hand          |
|          |   | 861.41    | laceration without foreign body of hand           |
|          |   | 861.411   | laceration without foreign body, right hand       |
|          |   |           | hand  |
|          |   | 861.402   | laceration without foreign body, left hand        |
|          |   | 861.412   | laceration without foreign body, left hand        |
|          |   | 861.419   | laceration without foreign body, unspecified hand |

**3.5 Healthcare Common Procedural Coding System (HCPCS)**

The **Healthcare Common Procedural Coding System (HCPCS)** is a three-level coding system consisting of five-character codes or four digits followed by a letter that standardizes the reporting of services, equipment, and supplies. HCPCS

- Ensures the validity of fee schedules because of the use of standard codes.
- Allows CMS to compare local, regional, and national utilization of services, procedures, and supplies.
- Makes it easier to coordinate the uniform application of CMS’s policies to all government health care organizations.

Most of the major insurers, Medicare, Medicaid, and most private insurers accept these codes; however, not all payers use these codes for reimbursement purposes.

There are three levels of HCPCS codes:

| Level            | Description  |
|------------------|--|
| <b>Level I</b>   | Current Procedural Terminology (CPT) five-digit codes and two-digit modifiers as developed by the AMA.   |
| <b>Level II</b>  | HCPCS codes beginning with letters A-S and V followed by four digits and two-character modifiers comprised of either two letters or a letter and a digit.                              |
| <b>Level III</b> | Local HCPCS five-character codes beginning with the letters W, X, Y or Z and two-character modifiers. These codes, being locally derived, must be approved by CMS prior to being used. |

### 3.6 Level I - Current Procedural Terminology (CPT)

Level 1 - Current Procedural Terminology (CPT), developed and updated by the American Medical Association, is a listing of descriptive terms and identifying codes for reporting medical services and procedures.

CPT was designed to uniformly represent and report medical services with a 5-digit code. The medical necessity for a service reported with a CPT code is supported by a 3-to-5 digit ICD-9 code that is coded from the supporting documentation in the medical record.

Payers use claims management and editing software to review submitted CPT codes and compare them with ICD-9-CM codes reported as diagnoses and/or status codes specific to the patient's care or condition on the date of service. When the service performed for a patient meets a defined medical condition or other criteria associated with the specific procedure or service, the claim is paid. This relationship or linkage is often called "medical necessity". When the medical necessity linkage is not done appropriately, the claim is often denied.

The process of assigning a CPT code to a procedure or service is dependent on both the supporting documentation and the procedure recorded. The ICD-9 diagnosis code must be well documented in the medical record and must support the medical necessity of the claim. The medical record serves as a tool for patient care, medical research health care statistical measurements, and as a supporting tool for reimbursement. The patient chart is the legal document that should not be tampered with, falsified, or altered in any manner that would cause the loss of or suppression of data.

There are six sections to the CPT manual:

- 1) **Evaluation and Management** (99201-99499) – Codes that pertain to medical office services including medical management visits and consultations in the office, outpatient and inpatient setting
- 2) **Anesthesia** (00100-01999) – Codes specific to anesthesia services performed by physicians and certified registered nurse anesthetists (CRNAs) specific to surgical procedures
- 3) **Surgery** (10040-69990) – Codes that describe surgical procedures and diagnostic tests or procedures. The codes are organized according to body system, then according to anatomic site and procedure type.
- 4) **Radiology** (70010-7999) – Codes that describe radiological, diagnostic ultrasound, and nuclear medicine procedures and services. These codes may include procedures that specifically identify the supervision and interpretation of a service by the radiologist or physician.
- 5) **Pathology and Laboratory** (80048-89399) – Codes for reporting testing or clinical studies conducted on fluids, tissues, or other organic or non-organic material obtained from patients.
- 6) **Medicine** (90281-99199) – Examples of some miscellaneous services found in this section are ophthalmological, echocardiography, special services, and others. These codes represent primarily noninvasive services and procedures.

### 3.6.1 CPT Evaluation and Management Codes

Evaluation and Management (E&M) codes were established by the American Medical Association and became effective with 1992 dates of services.

Evaluation and Management services include all “visit” codes, such as, office visits, hospital visits, nursing home visits, emergency department services, and consultations. To ensure correct reimbursement, it is important that the correct code be submitted.

The current Evaluation and Management documentation guidelines were developed in 1995 and 1997 to supplement the definitions of E&M codes contained in the American Medical Association's (AMA) Current Procedural Terminology (CPT) coding system – the system used for coding physicians' services. The guidelines were developed with the active involvement of the AMA and specialty societies.

These guidelines were designed to assist physicians and medical reviewers to determine

- Which of five coding levels would be appropriate for an E&M service, and
- What documentation would be appropriate to document the level chosen.

In annual financial audits required by the Chief Financial Officers Act, CMS frequently has been criticized for inadequate documentation on claims Medicare paid for E&M visits by physicians. The guidelines attempted to strike a balance so that physicians could accurately report the services they furnish without undue burden.

The Health Information managers must choose either the 1995 or 1997 *Documentation Guidelines for Evaluation & Management Services*. To review the guidelines, go to this website:

[http://www.cms.hhs.gov/MLNEdWebGuide/25\\_EMDOC.asp](http://www.cms.hhs.gov/MLNEdWebGuide/25_EMDOC.asp)

Only the counseling, anesthesia, hospital discharge, prolonged services, care plan oversight services, standby services, or critical care visits use “time” as a discriminating factor. The following sections provide excerpts of these guidelines.

### **3.6.2 History Component of E&M**

The history component includes:

- **Chief Complaint (CC)**
- **History of Present Illness (HPI)**
- **Review of Systems (ROS)**
- **Past, Family, and Social History (PFSH)**

Four types of history are based on these components:

- Problem Focused
- Expanded Problem Focused
- Detailed
- Comprehensive

The paper-based or electronic health record needs to reflect a Chief Complaint (CC).

The CC, Review of Systems (ROS) and Past, Family, and/or Social History (PFSH) may be listed as separate elements of the history or may be included in the description of the History of Present Illness (HPI).

An ROS and/or PFSH obtained during an earlier encounter need not be re-recorded, if there is evidence that the physician reviewed and updated previous information.

If the physician is unable to obtain a history, the record should describe the patient's condition or circumstances.

Each element of the patient history can only be counted once.

### **History of Present Illness**

The **History of Present Illness (HPI)** uses eight elements to identify the patient's present illness, signs, and/or symptoms:

1. **Location** - the area of the body where the problem, pain, or discomfort is located.
2. **Quality** - the quality can be related by the patient's sensation of what he/she is experiencing.
3. **Severity** - the level or magnitude of the presenting problem.
4. **Duration** - when the symptoms first occurred up to the present encounter.
5. **Timing** - whether the sign or symptom occurs intermittently or at a specific time during the day.
6. **Context** - the situation surrounding the problem, episode, or condition. Sometimes this is referred to as the "big picture."
7. **Modifying Factors** - include remedies or interventions that the patient has used for the specific problem or symptom to relieve discomfort.
8. **Associated Signs and Symptoms** - Additional signs and symptoms presented by the patient.

A brief HPI would include 1-3 elements and an extended HPI would describe 4-8 elements.

## Review of Systems

The **Review of Systems (ROS)** is often the most poorly documented portion of the patient history; however, it is essential. Several of the higher levels of E&M cannot be documented without this information.

Review of Systems include eyes; ears, nose, mouth, and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; integumentary (skin and/or breast); neurological; psychiatric; endocrine; hematologic/lymphatic; and allergic/immunologic systems.

### Categories

There are three categories of ROS:

| Category                 | Description  |
|--------------------------|--|
| <b>Problem Pertinent</b> | Positive and negative responses for at least one system. |
| <b>Extended</b>          | Positive and/or negative responses for 2-9 systems.      |
| <b>Complete</b>          | Positive and/or negative responses for all systems.      |

### Past, Family, and/or Social History (PFSH)

The **Past, Family, and/or Social History (PFSH)** are described in two levels:

| Level            | Description                                 |
|------------------|---|
| <b>Pertinent</b> | Describes one of the three PFSH components. |
| <b>Complete</b>  | Describes all the components.               |

### 3.6.3 Examination Component of E&M

The examination component describes the extent of the examination performed. The guidelines are based on the number of body areas and organ systems examined and documented.

A notation of “abnormal” without elaboration is insufficient. Any abnormal or unexpected finding of the examination, or any asymptomatic body area(s) or organ system(s) should be described.

A brief statement or notation indicating “negative” or “normal” is sufficient to document normal findings related to unaffected area(s).

### Types of Examinations

There are four types of examinations:

| Type                            | Description   |
|---------------------------------|---|
| <b>Problem Focused</b>          | A limited examination of the affected body area or organ system, one area or system.  |
| <b>Expanded Problem Focused</b> | A limited examination of the affected body area or organ system that includes 2-7 areas or systems.   |
| <b>Detailed</b>                 | An extended examination of the affected body area or organ system that includes 2-7 areas or systems.   |
| <b>Comprehensive</b>            | A general multi-system examination or complete examination of a single organ system that includes an exam of 8 or more systems or a complete single system examination. |

#### Body areas are:

- Head, including the face
- Neck
- Chest, including the breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

#### Organ systems are

- Eyes
- Ears, Nose, Mouth, and Throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin

- Neurologic
- Psychiatric
- Hematologic/Lymphatic/immunologic

### 3.6.4 Medical Decision-Making Component of E&M

Medical decision-making should be considered the thought process of the physician. For each encounter, an assessment, clinical impression, or diagnosis should be documented.

| For a presenting problem . . .    | the . . .  |
|-----------------------------------|--|
| with an established diagnosis,    | record should reflect <ul style="list-style-type: none"> <li>• improvement,</li> <li>• well controlled,</li> <li>• resolving or resolved, or</li> <li>• inadequately controlled, worsening, or failing.</li> </ul> |
| without an established diagnosis, | assessment of clinical impression may be stated <ul style="list-style-type: none"> <li>• in the form of a differential diagnoses or</li> <li>• as a “possible,” “probable,” or “rule out.”</li> </ul>              |

The initiation or changes in treatment should be documented.

If referrals are made, consults requested or advice sought, the record should indicate this information.

There are four levels of medical decision-making:

- 1) Straightforward
- 2) Low Complexity
- 3) Moderate Complexity
- 4) High complexity

In determining the level of medical necessity, the following three elements are considered:

1. The number of diagnoses or management options
  - Documentation should include all established problems pertinent to the visit whether they are stable, improved, worsening or resolved
  - Management options should include changes or initiations of new treatment plans and medications

- The number of diagnosis or management options is defined as:
  - Minimal - self-limited or minor problem
  - Limited - one or two established problems
  - Multiple - two or three problems worsening or exacerbated
  - Extensive - three or more diagnoses or new problems
- 2. The amount and/or complexity of the data, diagnostic tests, and/or other information that must be obtained and reviewed
  - The amount or complexity of data is based on the types of diagnostic testing ordered and reviewed. Discussion of tests results should be documented.
  - A decision to review old medical records should be noted. Relevant findings from old records should be documented. A notation that “old records reviewed” is insufficient without further documentation.
  - Data is defined as none or minimal, limited, moderate, or extensive
- 3. The risk of significant complications, morbidity, and/or mortality as well as co-morbidities associated with the presenting problems diagnostic procedures and/or possible management options.
  - Risk is related to the presenting problem to the disease process anticipated between the present encounter and the next one.
  - The highest level of risk in any one category determines the overall level of risk.
  - If a surgical or invasive diagnostic procedure is performed during the encounter, it should be documented
  - The referral for a procedure to be performed should be documented.

### 3.7 Level II - HCPCS Codes

Level II - Healthcare Common Procedural Coding System (HCPCS) codes were created to report supplies, materials, injections, and certain procedures and services that are not defined in the CPT. These codes are updated annually and are recognized as a national set of standard alphanumeric codes and modifiers.

Level II HCPCS codes are 5-character codes, beginning with a single letter - A through S, and V - and followed by four digits. They are grouped according to type of service or supply within a section of HCPCS that begins with a specific letter.

| Code Group | Type of Service or Supply   |
|------------|---|
| A          | Transportation codes, medical and surgical supplies and administrative miscellaneous and investigational                              |
| B          | Enteral and parenteral therapy  |
| C          | Temporary codes for use with outpatient Prospective Payment System (PPS)  |
| D          | Dental procedures, orthodontics, adjunctive general services.   |
| E          | Durable medical equipment   |
| F          | <i>Not Used</i>   |
| G          | Procedures/professional services (temporary)  |
| H          | Temporary national codes for government entities other than Medicare and Medicaid   |
| I          | <i>Not Used</i>   |
| J          | Drugs administered other than oral method, chemotherapy drugs.  |
| K          | Assigned to jurisdiction of durable medical equipment regional carriers (DMERC), temporary codes                                      |
| L          | Orthotic procedures, prosthetic procedures  |
| M          | Medical services  |
| N          | <i>Not Used</i>   |
| O          | <i>Not Used</i>   |
| P          | Pathology and laboratory services   |
| Q          | Procedures, services, and supplies on a temporary basis   |
| R          | Diagnostic radiology services   |
| S          | Temporary national codes, non-covered by Medicare   |
| V          | Vision, hearing, and speech-language pathology services, under the jurisdiction of Durable Medical Equipment Regional Carrier (DMERC) |

## 3.8 Level III - HCPCS Codes

Level III - Healthcare Common Procedural Coding System (HCPCS) codes were originally designed for “state only” use, allowing local carriers the privilege of assigning W-through-Z codes to local procedures, supplies, and services for which no Level I or Level II code existed. Now CMS requires that all Level II codes must be sent to them - not the state carrier - for approval before implementing the codes.

## 3.9 Modifiers

Modifiers are two-digit indicators used to describe a service or procedure, which has been altered from the baseline description in the CPT book. Modifiers can change the meaning or degree of difficulty, and can ultimately affect reimbursement for a particular service.

The medical record must reflect that the modifier is being used appropriately to describe separate services. The documentation should be maintained in the patient’s medical record and must be made available to any insurer on request.

For the most current list of modifiers, refer to the current CPT or HCPCS Code book.

For the modifiers related to Medicare billable services, refer to Medicare Billing Guidelines provided by your fiscal intermediary.

### 3.9.1 Prolonged Service Modifier

For monitoring and treatment services done in the clinic, consider adding a prolonged service modifier.

- When a clinician spends prolonged time (more than 30 minutes beyond the time spent for the usual service) talking with family, reviewing complex medical records, completing a comprehensive treatment plan, or coordinating plans with a home health agency or dietitian, bill the procedure code for a prolonged service without direct patient contact, in addition to the procedure code for the office visit.
- Provide a diagnosis code for each service, procedure, or supply billed.
- If the visit is for other than a disease or injury, such as follow-up for therapy, use one of the ICD V-codes.

### 3.10 Dental Codes

Accurate recording and reporting dental treatment is supported by a set of codes that:

- 1) Have a standard format,
- 2) Are at the appropriate level of specificity,
- 3) Can be applied uniformly, and
- 4) Are used to report dental procedures provided under public and private dental insurance benefit plans.

In addition, the code set should contain the appropriate number of procedure codes that adequately encompass commonly accepted dental procedures.

These needs prompted development of the **Code on Dental Procedures and Nomenclature** (the “Code”). Individual dental procedure codes, as currently defined, are 5-character alphanumeric codes, beginning with the “D” and followed by four digits. Each code identifies a specific dental procedure.

On August 17, 2000 the Code was named as a HIPAA standard code set. Any claim submitted on a HIPAA standard electronic dental claim must use dental procedure codes from the version of the Code in effect on the date of service.

The Code is also used on dental claims submitted on paper. The ADA maintains a paper claim form whose data content reflects the HIPAA standard electronic dental claim.

The Code is periodically reviewed and revised to reflect the dynamic changes in dental procedures that are recognized by organized dentistry and the dental community as a whole. Revisions to the Code are published and effective biannually, at the start of odd-numbered years. The current version became effective January 1, 2005 and can be found in the ADA publication titled *CDT-2005*.

### 3.11 Requirements for Clinical Reporting

The Government Performance and Results Act (GPRA) requires Federal agencies to report annually on how the agency measured against the performance targets set in the plan. IHS GPRA+ indicators include measures for:

- **Clinical**, such as various diabetes measures, cancer screening or others
- **Quality of care**, such as percent of hospitals accredited
- **Prevention**, such as immunizations and injury prevention
- **Infrastructure**
- **Administrative efficiency** functions

The purpose of the GPRA+ reporting system is to eliminate the need for manual chart audits for evaluating and reporting clinical GPRA indicators, based on RPMS data. The system will:

- Identify potential data issues in the RPMS, such as missing or incorrect data.
- Identify specific areas where the site is not meeting the indicator in order to initiate business process or other changes.
- Quickly measure impact of process changes on indicators.
- Identify areas meeting or exceeding indicators to provide lessons learned.

Taxonomies are groupings of functionally related data elements that contain codes, code ranges, or terms, such as diagnoses or procedures or site-specific terms. For other types of data elements, including medications and lab tests, taxonomies are used to mitigate the variations in terminology that exist in RPMS tables from one facility to another.

GPRA+ uses pre-defined taxonomies to find data items in PCC to determine if

- a patient meets the indicator criteria
- an item was done for the patient

The primary focus for coders is to accurately report, code, and enter all procedures and services data into RPMS so that the GPRA+ reports can accurately display data results, not only one facility but also comparable data across every facility.

Since GPRA+ is designed to monitor how allocated funds are effectively being used towards meeting the missions of the facility and the Area, it is very important that measurements and upward trends in data analysis occur.