Procedure Coding in Family Medicine

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As managed care organizations and government payers have focused on controlling medical costs, many family physicians have been "squeezed" by flat or declining revenue and increasing overhead. To maintain financial viability, family physicians and office managers must try to maximize revenue collected for the services they provide. Accurate coding of evaluation and management (E/M) services, billing for all services rendered, aggressive follow-up on claim denials and delinquent accounts, and correct coding of procedures are key areas where revenue enhancement can occur. Most family physicians perform some procedures in the office in order to provide convenient, cost-effective care, maintain skill levels, and as a source of revenue. The most frequent procedures done in family practice offices, according to HCFA data, are as follows:

- Removal of Impacted Ear Wax (CPT 69210)
- Arthrocentesis, Major Joint (CPT 20610*)
- Hot/Cold Pack (CPT 97010)
- Destruction Lesion, Benign (CPT 17000*)
- Spirometry (CPT 94010)
- Flexible Sigmoidoscopy (CPT 45330)
- Biopsy, Skin (CPT 11100)
- Injection Tendon Sheath/Ligament/Cyst (CPT 20550*)

This article provides some basic guidelines for proper procedure coding.

General Coding Guidelines:

1. The HCFA 1500 claim form requires both the appropriate CPT code to describe the procedure and a diagnosis code linked to it.

2. Use the correct CPT code, not just the first code that looks good. For example, a "bronchospasm evaluation" (spirometry pre- and post-bronchodilator, CPT 94060) is a more involved procedure than "spirometry" (CPT 94010). Incorrectly billing for "spirometry" forfeits the practice significant revenue.

3. The diagnosis code(s) **must support medical necessity** for performance of the procedure. For example, when billing for an anoscopy, a diagnosis such as "rectal pain" or "gastrointestinal bleeding" would be appropriate, while "diabetes" may not. Linking the diagnosis to the procedures **on the claim** clarifies medical necessity for the payer. If a significant, separately identifiable E/M service (i.e., CPT 99211—99215) is performed the same day, attach modifier —25 to the E/M code. For example, a diabetic patient presents with rectal bleeding. The doctor

performs an anoscopy, and on the same day reviews home glucose monitor results and changes the insulin dose. On the HCFA 1500 claim form, the coding would be as follows:

* For anoscopy, CPT 46600 (anoscopy) linked with ICD-9 569.3 (rectal bleeding)

*For diabetes visit, CPT 99212—25 linked with ICD-9 250.00. (diabetes).

Modifiers: An understanding of modifiers is critical to collect proper reimbursement. Modifiers are attached to CPT codes on a claim to provide additional explanation of the services. Typical modifiers used in family practice are as follows:

—25, used to indicate a significant, separately identifiable E/M service by the same physician **on the same day** as a procedure,

—24, used by a physician who performed a surgical procedure to bill a separately identifiable E/M service during a global post-surgical period, which is **unrelated** to the usual pre-and post-op care associated with the procedure,

—57, used to indicate that the initial decision to perform major surgery was made at that visit.

Some payers may not pay, even when use of a modifier supports the claim. Be prepared to assert your appeal rights. If specific payers deny payment for separate and identifiable

E/M services performed on the same day as a procedure, you will need to consider bringing those patients back on a different day in order to get paid properly for the procedure.

Global Periods: Many payers (including Medicare) utilize some type of "global payment policy" in paying for surgical procedures. This policy will define: **a)** whether or not a procedure falls under a global policy; **b)** if so, services included in the global package; and **c)** length of time the routine post-op care is included in the payment for the procedure (i.e., the "global period").

For **Medicare**, "minor surgeries" have a global period of either 0 or 10 days; "major surgeries" have a global period of 90 days. The defined "global period" for each procedure can be obtained from the local Medicare carrier, found in the Federal Register, or is published in many different "coding guidebooks." Not all private payers adhere to Medicare's global policy, but that is what we will discuss here since it is the most common (and usually the most restrictive).

"Starred" Procedures: This can be confusing, since the meaning of "stars" in the CPT book is different for most private payers versus Medicare. For most private payers, a CPT code with a "star"/asterisk next to it indicates that the code applies to the procedure only. Examples of "starred" procedures are arthrocentesis (20610*), destruction of benign lesion (17000*), tendon sheath injection (20550*), skin tag excision (11200*), avulsion of nail plate (11730*), and incision and drainage of simple cyst (10060*). For these procedures, all pre-op and post-op care may be charged using E/M visit codes without regard to global periods. Some payers may not pay regardless of this correct coding. Your office staff should identify those payers; develop a

policy regarding whether or not to charge for a non-reimbursed E/M visit the same day as the procedure.

For Medicare, the meaning of the "stars" in the CPT book is not as clear (see below). In general, procedures can be broken down into three basic categories: minor surgical, major surgical and non-surgical. Each category has characteristics that affect the way the procedures are coded, so we deal with each separately.

Minor Surgeries: This category includes most "starred" procedures, as well as some others that Medicare has defined as "non-global." Under Medicare, these minor procedures have a global period of either 0 or 10 days. For those procedures with a 0-dayglobal period, all pre-op and post-op visits should be billed using office E/M codes (99201-99215). For procedures with a global period of 10 days, pre-op care can still be charged using E/M codes. However, you should not bill for post-operative services related to normal recovery from the surgery during the 10-day post-op period. Treatment of complications is always a billable service, using the standard office visit E/M codes linked to a diagnosis describing the complication.

Examples of minor surgery (non-starred) procedures are: skin biopsy (11000), flexible sigmoidoscopy (45330), removal of impacted cerumen (69210), anoscopy (46600) and LEEP (57460). E/M visit codes may be charged the same day of a minor surgery or during the global post-op period if a significant, separately identifiable service is furnished. Use modifier –24 or –25, and document diagnosis carefully. Again, it is best to use a different diagnosis to clarify that the E/M service was unrelated to procedure.

Major Surgeries: These are surgical procedures that are paid for as a "global package" and are designated to have a "global period" of 90 days. They are not common in family medicine; however, most fracture cases would be included in this category. The CPT codes for major surgeries include the total work required for the physician to complete the service once the decision for surgery is made. Thus, the pre-op visit, the procedure itself and uncomplicated post-op care (both in the hospital and office) are included in the global fee. The "global period" begins 24 hours pre-op and continues for 90 days post-op. During the global period, E/M services billed with the same diagnosis as the surgical procedure usually will not be paid.

As a family physician, your main concern is to collect for separately identifiable and non-related E/M services during the global time period. Use of a different diagnosis than that used for the surgery and modifier -24 added to the E/M CPT code helps to secure payment.

Non-Surgical Procedures: Procedures that are found in the "Medicine" section of CPT (located at the back of the book) are simply coded in addition to E/M services. Because they are not "surgical" procedures, modifiers and global periods do not apply. Some examples of "non-surgical" procedures are spirometry (94010) and application of hot/cold pack (97010).

Injections: The following chart adapted from *Family Practice Management* summarizes when a drug or vaccine injection will be paid and the proper code to use. The rule of thumb is that you can always bill for what is in the syringe using either an HCPCS code (if it is a drug/biological) or a CPT code (if it is a vaccine). For Medicare, whether you charge additionally for the

administration of the injection or charge an E/M visit depends on whether the injection is the sole purpose of the visit or is incidental to the visit. Some private payers will allow a low-level E/M visit (e.g., 99211) even when the sole purpose of the visit is the injection. (See Figure 1)

Physicians are challenged with the responsibility to verify that services are billed as provided. A clear understanding of the coding requirements can help practices to ensure fair payment for all services rendered. Since payer policies vary, close attention to the requirements of the payers coupled with an internal commitment to assessing denied claims, identifying areas that need improvement, and developing strategies for meeting these requirements will help a practice maximize revenues.

Figure 1

a) When the injection is the *sole purpose* of the visit, submit as follows:

	Injection	**Administration**	**Office Visit (E/M)**
Drug or Biological	HCPCS code	CPT code	Medicare - No Private Payer - Maybe
Vaccine*	CPT code	CPT code 90471 (1st); 90472 (each additional)	Medicare - No Private Payer - Maybe

b) When the injection is *incidental* to the visit, submit as follows:

	Injection	**Administration**	**Office Visit (E/M)**
Drug or Biological	HCPCS code	Medicare - No Private Payer - Maybe	CPT code**
Vaccine	CPT code	CPT code 90471 (1st) 90472 (each additional)	CPT code**

For example, a child is given DTaP, IPV and varicella vaccines at a well-care visit. In addition to the visit code, the immunizations are coded as follows:

Vaccine	**CPT**	**Administrative**
DtaP	90700	90471
IVP	90713	90472
varicella	90716	90472

Also note that many private payers also recognize the HCPCS codes for injectables.

* Applies only to pneumococcal, hepatitis B and influenza vaccines. Medicare excludes other vaccinations as "immunizations" unless they are directly related to the treatment of an injury or direct exposure to a disease or condition (e.g., rabies vaccine or tetanus booster).

** The —25 modifier is not needed. (Modified from *Family Practice Management*, May 1995.)