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# Complete Healthcare Compliance Manual
# Health Information Management: Coding with ICD-10 Current Procedural Terminology/Healthcare Common Procedure Coding System (ICD-10-CPT/HCPCS)

By Nancy L. Freeman,[1] RHIA, CHC, CRC

## What Is the Current Procedural Terminology/Healthcare Common Procedure Coding System?

The Healthcare Common Procedure Coding System (HCPCS) is a standardized coding system for describing and identifying healthcare services and supplies. It is designed to allow for the efficient processing of claims from Medicare as well as other payers. There are three recognized levels of this coding system:

- **Level I**: *Current Procedural Terminology* (CPT) is maintained and published by the American Medical Association (AMA). The Health Insurance Portability and Accountability Act (HIPAA) mandates the use of CPT reporting of outpatient services and procedures.
- **Level II**: HCPCS is published and maintained by the Centers for Medicare & Medicaid Services (CMS). HCPCS Level II codes were developed to provide a mechanism for suppliers other than physicians to bill for products and services that are not identified in CPT. Use is mandated by HIPAA for standardized billing of healthcare equipment and supplies as well as services not covered by CPT.
- **Level III**: HCPCS codes are utilized by local carriers and payers.

## Level 1: HCPCS/CPT

Level I HCPCS/CPT is a set of codes, descriptions, and guidelines that describe procedures and services performed by physicians, other medical professionals, and facilities. The code set is updated annually and published in the fall. Updates generally are based upon input from practicing physicians, other healthcare providers, specialty associations, state medical associations, and others who use the CPT code set. The new code application process can be found at https://www.ama-assn.org/practice-management/cpt. The new codes are effective with encounters on or after January 1 of the following year.

General instructions for using CPT that apply across the entire code set are provided in the introduction to the code set. More specific guidance is presented within the body of the code set and may apply to one or more chapters. For example, the Anesthesia Guidelines only apply to the Anesthesia section of the CPT; however, the Surgery Guidelines apply to all surgical services. Section guidance applies to an even more limited part of the code set.

There are three categories of CPT codes. Category I codes are 5-digit numeric codes representing procedures and services that are consistent with contemporary medical practice and are performed by many practitioners in clinical practice in many locations. This category is the standard used to bill most professional and outpatient-facility services. Category II codes are supplemental codes used for tracking and performance measurement. Category II codes are alphanumeric, and their use is optional. Category III codes are temporary codes used for emerging technology, services, procedures, and service paradigms. They are alphanumeric and should be used in

lieu of an unlisted Category I code.

The Category I codes are subdivided into six distinct sections:

1. Evaluation and Management (E&M) Services
2. Anesthesia Services
3. Surgery
4. Radiology Services
5. Pathology and Laboratory Services
6. Medical Services and Procedures

The E&M codes depict a variety of provider visits: office visits, hospital visits, emergency department visit, critical care, etc. This area of CPT has recently changed significantly beginning in 2021.

Prior to January 1, 2021 most E&M codes were based upon documentation of history, physical examination, and Medical Decision Making (MDM). For most E&M services time was a factor for selecting the correct code only when greater than 50% of the visit is spent counseling and coordinating care. The two exceptions are instances in which:

1. The code is a time-based code, such as critical care management or discharge day management.
2. The service was a telehealth service performed during the COVID-19 Public Health Emergency.

CPT provides the definition for the codes; however, CMS provided guidelines in 1995 and 1997 that further refined the requirements for code assignment (such as what documentation is required for a comprehensive history or physical examination).[2][3] These guidelines are required for government payors but are adopted by most commercial payers as well. Of note, each Medicare Administrative Contractor (MAC) as well as Medicaid programs and private payers have interpreted the guidelines differently—some are more restrictive than others—and this has led to inconsistent application.

In January 2021, the basis for code selection in the office and outpatient settings (CPT codes 99202–99215) changed to total time of the visit or MDM. When determining total time for code selection, the amount should include both face-to-face and non-face-to-face time. If an advanced practice professional (e.g., nurse practitioner or physician assistant) participates in the visit, the time spent by both the physician and the advanced practice professional can be included, *except for time jointly spent* with the patient (this would represent double billing). Additionally, a prolonged service code was created. The CPT states that the prolonged service code 99417 is used when the *minimum* time associated with 99205 or 99215 is reached. This code may be used for commercial payers. CMS created a new code, G2212, to be used for prolonged visits for time-based services for federal beneficiaries (e.g. Medicare patients). The CMS guidance, however, is that the *maximum* time associated with 99205 or 99215 is reached before the prolonged service code G2212 can be used. If using MDM rather than time for code selection, a new MDM grid was developed that is similar in appearance to the Risk Table used in determining MDM prior to January 1, 2021. However, it is designed to be less complicated and the AMA published definitions for terms used in the new MDM to promote consistency in application.

The CPT 2023 incorporates massive changes to the E&M section intended to reduce the administrative burden for providers. The following families of E&M are affected:

- Hospital Inpatient – revised
- Hospital Observation – deleted (incorporated into inpatient)
- Consultation – deleted and reviewed
- Emergency Department - revised
- Nursing Facility – deleted and revised
- Domiciliary, Rest Home, Custodial Care– deleted
- Home or Residential Services – deleted and revised
- Deletion of Prolonged Services – added, deleted and revised

While the changes to CPT have been adopted by the CPT Editorial Board, the changes have not yet completed the process for acceptance for Medicare. As of 10/31/2022 the Medicare Physician Fee Schedule (MPFS) CY 2023 Final Rule has not yet been published. However, the MPFS Proposed Rule published 07/07/22 stated the following:

> "As part of the ongoing updates to E/M visits and related coding guidelines that are intended to reduce administrative burden, the AMA CPT Editorial Panel approved revised coding and updated guidelines for Other E/M visits, effective January 1, 2023. Similar to the approach we finalized in the CY 2021 PFS final rule for office/outpatient E/M visit coding and documentation, we are proposing to adopt most of these changes in coding and documentation for Other E/M visits (which include hospital inpatient, hospital observation, emergency department, nursing facility, home or residence services, and cognitive impairment assessment) effective January 1, 2023. This revised coding and documentation framework would include CPT code definition changes (revisions to the Other E/M code descriptors), including:
>
> New descriptor times (where relevant).
>
> Revised interpretive guidelines for levels of medical decision making.
>
> Choice of medical decision making or time to select code level (except for a few families like emergency department visits and cognitive impairment assessment, which are not timed services).
>
> Eliminated use of history and exam to determine code level (instead there would be a requirement for a medically appropriate history and exam).
>
> We are proposing to maintain the current billing policies that apply to the E/Ms while we consider potential revisions that might be necessary in future rulemaking. We are also proposing to create Medicare-specific coding for payment of Other E/M prolonged services, similar to what CMS adopted in CY 2021 for payment of Office/Outpatient prolonged services."

While Medicare may not adopt all of the proposed changes – or may create Medicare specific codes for certain services such as the prolonged services – it is expected that most of the suggested changes will be accepted by

the Medicare Program as well as commercial payers.

The Anesthesia codes are used for reporting the administration of anesthesia and include all routine services, such as pre- and post-operative visits, intra-operative care, and fluid administration. Nonroutine services are billed separately. Additionally, physical status modifiers are reported with the anesthesia codes and reflect the severity/complexity of the anesthesia service. The anesthesia codes start with the numeral 0.

The largest section of CPT, Surgery, is organized into sections by body system. The range of codes per sections are as follows.

| Codes | Section |
|---|---|
| 10004–19499 | Integumentary System |
| 20100–29999 | Musculoskeletal System |
| 30000–32999 | Respiratory System |
| 33016–39599 | Cardiovascular System |
| 40490–49999 | Digestive System |
| 50010–53899 | Urinary System |
| 54000–55899 | Male Genital System |
| 55920 | Reproductive System Procedures |
| 55970–55980 | Intersex Surgery |
| 56405–58999 | Female Genital System |
| 59000–59899 | Maternity Care and Delivery |

| | |
|---|---|
| 60000–60699 | Endocrine System |
| 61000–64999 | Nervous System |
| 65091–68899 | Eye and Ocular Adnexa |
| 69000–69979 | Auditory System |
| 69990 | Microsurgical Techniques |

**Table 1. CPT Surgery Codes**

The Surgery guidelines are found at the beginning of the Surgery section. They provide guidance and definitions unique to surgery (i.e., separate procedures or the global surgical package). Additionally, chapter-specific and subchapter-specific guidance is covered throughout. The Surgery section provides codes for commonly performed surgical procedures. In the event that no code accurately defines the surgical procedure performed, Unlisted Procedure codes within most chapters and subchapters should be used.

The codes for Radiology Services are found in the 70000 series. In addition to the introductory CPT guidelines, this section has radiology-specific guidance applicable to the entire chapter as well as subsection guidance that provides special instruction for complex and unique areas, such as vascular procedures.

The main sections are Diagnostic Radiology, Diagnostic Ultrasound, Radiologic Guidance, Breast Mammography, Bone and Joint Studies, Radiation Oncology, Nuclear Medicine, and Therapeutic Procedures.

The codes for Laboratory and Pathology Services are found in the 80000 series. This chapter begins with an extensive table of molecular-pathology gene tables with information about genes, related diseases, and CPT codes. Most of the remaining specific guidance relating to laboratory and pathology lies at the section and subsection level, due to the varying modalities. Also included in this chapter are the Proprietary Laboratory Analysis codes (PLA). These codes are alphanumeric and are specific to manufacturers and laboratories to identify their tests, including codes for multianalyte assays with algorithmic analysis and genomic sequencing procedures. An area of recent focus is the appropriate billing of drug assays and molecular/genomic testing.

The codes for Medicine Services are found in the 90000 series. This chapter includes a variety of nonsurgical services that may be performed by and under the supervision of a physician. It includes the following sections.

**Medicine Services (Nonsurgical):**

- Immune globulins, serum or recombinant products
- Immunization Administration for Vaccine/Toxoids
- Vaccines, Toxoids

- Psychiatry
- Biofeedback
- Dialysis
- Gastroenterology Services
- Ophthalmology Services
- Special Otorhinolaryngologic Services
- Cardiovascular Services
- Noninvasive Vascular Diagnostic Services
- Pulmonary Services
- Allergy and Clinical Immunology Services
- Endocrinology Services
- Neurology and Neuromuscular Procedures
- Medical Genetics and Genetic Counseling Services
- Adaptive Behavior Services
- Central Nervous Systems Assessment/Testing
- Health Behavior Assessment and Intervention
- Hydration/Therapeutic Prophylactic, Diagnostic Injections and Infusions and Chemotherapy and Other Highly Complex Drug or Highly Complex Biologic Agent Administration
- Photodynamic Therapy
- Special Dermatological Procedures
- Physical Medicine and Rehabilitation
- Medical Nutrition Therapy
- Acupuncture
- Osteopathic Manipulative Treatment
- Chiropractic Manipulative Treatment
- Education and Training for Patient Self-Management
- Non-Face-to-Face Nonphysician Services
- Special Services, Procedures and Reports
- Qualifying Circumstances for Anesthesia

- Moderate (Conscious) Sedation
- Other Services and Procedures
- Home Health Procedures/Services
- Medication Therapy Management Services

Because of the lack of commonality between the various subchapters, the chapter guidance is limited. However, most subchapters do have code-specific guidance.

## Level II: HCPCS

Level II of the HCPCS is a standardized coding system that is used to identify products, supplies, and services not included in the CPT® code set, such as ambulance services and durable medical equipment (DME), drugs, prosthetics, orthotics, and supplies when used outside a physician's office. They are also often used as temporary codes prior to a code being assigned by the CPT. HCPCS Level II provides a mechanism for providers and suppliers to bill for items covered by Medicare and by other payers, but for which there is no CPT code. For example, when the COVID-19 public health emergency began, CMS was able to quickly create HCPCS codes for laboratory testing specific to the virus that causes COVID-19. It was selected as a part of HIPAA as the standardized coding system for reporting items and services not identified by CPT.[4]

Level II HCPCS has several types of codes:

- **Permanent National Codes**: Maintained by the CMS HCPCS Workgroup, which includes representatives from private and public insurers, and updated annually.
- **Dental Codes**: Maintained and published by the American Dental Association (ADA) and used for billing dental procedures and supplies.
- **Miscellaneous Codes**: A category of codes used for billing for items or services with no existing national code. These codes allow suppliers to begin billing as soon as U.S. Food and Drug Administration (FDA) approval is received. Claims are manually reviewed, and documentation describing the item and pricing must be provided.
- **Temporary National Codes**: Temporary codes maintained by the CMS HCPCS Workgroup and used to address national program operational needs. Temporary codes are provided quarterly, while permanent codes are updated only once per year, effective January 1. There is no expiration date for a temporary code, and the codes may be replaced with a permanent code if they receive Workgroup approval. There are several types of temporary codes:
    - **C codes**: Established to report drugs, biologicals, magnetic resonance angiography (MRA), and devices used by OPPS hospitals. C codes are reported for device categories, new technology procedures, and drugs, biologicals, and radiopharmaceuticals that do not have existing HCPCS codes.
    - **G codes**: Used to report professional healthcare procedures and services that would otherwise be coded in CPT but have no existing code.
    - **H codes**: Used by state Medicaid agencies for identifying mental health services.
    - **K codes**: Used by the DME MACs when there is not a permanent code and the DME MAC needs a code

for purposes of medical review policy.

- **Q codes**: Used for items that will not have a CPT code and do not currently have a permanent Level II code.
- **S codes**: Used by private insurers to report products or services for which there is no national code.

## Level III: HCPCS

Level III HCPCS are codes developed and utilized at the state or local level. Published guidance is available only at the state level.

## Modifiers

Both CPT (numeric) and HCPCS (alphanumeric or two letters) have two-character modifiers that are required to supplement the code definition or identify special circumstances. Some modifiers affect payment while others do not. Failure to apply a modifier when needed or applying a modifier when not appropriate can result in overpayments or underpayments.