



5 Commonly Asked Coding Questions

Q. What are CPT codes?

The American Medical Association (AMA) publishes the Current Procedural Terminology, Fourth Edition (CPT-4) as a listing of descriptive terms and identifying codes for reporting medical services and procedures. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and as a result provides an effective means for communication among physicians, patients, and third parties.

CPT serves a wide variety of functions in the field of medical nomenclature, not the least of which is to describe most of what we do in noninvasive vascular technology. Changes that appear in CPT are prepared by the CPT Editorial Panel with the assistance of representatives from specialties of medicine, the Health Care Professionals Advisory Committee (HCPAC) and with important contributions from many third-party payers and governmental agencies.

Given the CPT manual is revised annually, access to a current version is critical for coding purposes.

Q. What are HCPCS codes?

The Centers for Medicare and Medicaid Services (CMS) maintains the Healthcare Common Procedure Coding System (HCPCS). The HCPCS is divided into two principle subsystems, referred to as level I and level II of the HCPCS.

HCPCS Level I consists of the AMA CPT-4 codes.

HCPCS Level II is a coding system used primarily to identify products, supplies and services not included in CPT-4. Further included in HCPCS Level II are several procedures of interest in noninvasive vascular testing including ultrasound screening for abdominal aortic aneurysm and preoperative mapping of vessels for autogenous dialysis access sites. These codes are considered temporary procedures and the codes serve a CMS interest specific to these procedures and they are not in the CPT-4 at the time of CMS's interest. However, both are considered covered services under the Medicare program.

Q. What is Medicare?

Medicare is a health insurance program for people age 65 or older, people under age 65 with certain disabilities and people of all ages with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Medicare program includes:

- Part A Hospital Insurance
 - Most beneficiaries do not pay a premium for Part A given they or a spouse paid it in the form of payroll taxes while working. Part A provides partial coverage for inpatient care in hospitals, skilled nursing facilities (not custodial or long-term care) and also helps cover hospice care and some home health care.
- Part B Medical Insurance
 - Most beneficiaries pay a monthly premium for Part B Medicare. This helps cover doctors' services and outpatient care. It also assists with some other medical services that Part A doesn't cover, such as some of the services of physical and occupational therapists, and some home health care.
- Prescription Drug Coverage
 - Most beneficiaries pay a monthly premium for this coverage and it is available to everyone that is eligible as a Medicare beneficiary. This is a form of insurance that is provided by a variety of private companies and programs.

Q. What are ICD codes?

The World Health Organization (WHO) publishes the International Classification of Diseases (ICD) as a standard diagnostic tool for epidemiology, health management and clinical purposes. This includes the analysis of the general health situation of population groups and is used to monitor the incidence and prevalence of diseases and other health problems.

ICD-10 was endorsed by the Forty-third World Health Assembly in May 1990 and came into use in WHO Member States as from 1994. The 11th revision of the classification has started and will continue until 2017.

The International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) is based on WHO's ICD-9. ICD-9-CM is the official system of assigning codes to diagnoses, signs, symptoms, procedures and related issues associated with utilization in the United States.

ICD-9-CM consists of a numeric list of disease code numbers, an alphabetical index to disease entries and a classification system for surgical, diagnostic and therapeutic procedures (alphabetic index and tabular list).

The National Center for Health Statistics (NCHS) and CMS are the U.S. governmental agencies responsible for overseeing all changes and modifications to the ICD-9-CM.

Q. What is the NCCI?

CMS developed the National Correct Coding Initiative (NCCI) edits, implementing them in 1996, to promote coding methodologies and control improper coding that results in inappropriate payments. The CMS coding policies are developed using coding conventions defined the AMA CPT Manual, national and local policies and edits, coding guidelines developed by national professional associations, analysis of standard practices in medicine and surgery and a review of current coding practices.

Medically Unlikely Edits (MUE) were added in 2007 and are used to adjudicate claims at Carriers, Fiscal Intermediaries and Durable Medical Equipment (DME) Medicare Administrative Contractors (MAC). The MUE includes edits where two procedures could not be performed at the same patient encounter because the two procedures were mutually exclusive based on anatomic, temporal, or gender considerations (e.g., a claim for child birth in male patient?).

The NCCI procedure and MUE edits are assigned to a Column One / Column Two file where, when submitted on the same date of service by the same provider, the code in Column One will be processed while the code in Column Two is stripped from the claim unless it is associated with acceptable NCCI and CPT Modifiers.

Two versions of NCCI edits exist; Practitioner NCCI and Outpatient NCCI, with the most significant difference being a one quarter lag in implementation between the Practitioner and Outpatient versions. Otherwise they function similarly.

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