Coding for Office Procedures and Activities

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ABSTRACT

Accurate coding of diagnoses and procedures is the key to managing your reimbursement, limiting your write-offs, and avoiding fraudulent activity that could bring havoc to your practice. Proper ICD-9-CM coding (International Classifications of Disease, Clinical Modifications) and CPT coding (Current Procedural Terminology) should be documented for each patient encounter. This article provides basic information to aid physicians in expanding their knowledge of this critical component of a successful practice.

KEYWORDS: ICD-9-CM (International Classifications of Disease, Clinical Modifications), CPT (Current Procedural Terminology), encounter form

Objectives: Upon completion of this article, the reader should be able to define and justify proper coding techniques.

Accurate coding of diagnoses and procedures is the key to managing your reimbursement, limiting your write-offs, and avoiding fraudulent activity that could bring havoc to your practice. In this article we will analyze proper ICD-9-CM coding (International Classifications of Disease, Clinical Modifications) as well as CPT coding (Current Procedural Terminology). An encounter form (paper or electronic) should be completed for each patient at each office visit. Information on this form should include patient demographics (with a unique patient identifier number), a diagnostic code (ICD-9-CM) and a procedure code (CPT) for the visit. The encounter form should be checked by the physician for accuracy and correlation between the diagnosis and procedure performed prior to being submitted to the office personnel or electronically filed.

DIAGNOSIS CODING

The *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM)* has its basis in the World Health Organization's (WHO) official classification of diseases. The diagnosis codes are owned and updated by the WHO. There are hundreds of thousands of codes available which can be found in a book titled *ICD-9 Codes*, but fortunately as a colorectal specialist you can limit the ones you need for your practice to essentially 50 or 60. These should be included in your encounter form and checked for each patient visit.

ICD-9 codes are used to describe conditions, diseases, and symptoms. Because these codes cover symptoms as well as diagnoses, an individual patient can have one or more ICD-9 codes associated with his or her encounter. Let's consider several common scenarios as examples. A 28-year-old male presents with painful anal bleeding. After your history and examination, you determine that he has an anal fissure. You would select a diagnostic code of 565.0 (fissure-in-ano), 569.42 (anal pain), and/or 569.3 (anal bleeding). If this patient were also diabetic you could also include a code 250.03 (diabetes).

A second example is a 48-year-old female referred to you for colon cancer screening. She is otherwise

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Table 1 Office Diagnosis ICD-9-CM

789.06 Abdominal Pain, Epigastric
789.07 Abdominal Pain, Generalized
789.04 Abdominal Pain, Left Lower Quad
789.02 Abdominal Pain, Left Upper Quad
789.09 Abdominal Pain, Other Spec Site
789.05 Abdominal Pain, Periumbilic
789.03 Abdominal Pain, Rt Lower Quad
789.01 Abdominal Pain, Rt Upper Quad
789.00 Abdominal Pain, Unspecified
569.81 Abdominal Wall Fistula
998.59 Abdominal Wound Infection
569.5 Abscess, Intestinal
566 Abscess, Ischiorectal
566 Abscess, Perianal
042 AIDS/HIV
787.6 Anal Incontinence
569.2 Anal Stenosis
285.9 Anemia
578.1 Blood in Stool (Melena)
555.1 Colitis, Crohn's
008.45 Colitis, Fulminant
009.0 Colitis, Infectious
557.9 Colitis, Ischemic
008.45 Colitis, Pseudomembraneous
556.0 Colitis, Ulcerative, Enterocolitis
556.1 Colitis, Ulcerative, Ileocolitis
556.5 Colitis, Ulcerative, Left Sided
556.8 Colitis, Ulcerative, Other
556.2 Colitis, Ulcerative, Proctitis
556.3 Colitis, Ulcerative, Protosig
556.6 Colitis, Ulcerative, Universal
569.83 Colon Perforation
596.6 Colostomy, Enterostomy Mal
078.11 Condyloma Acuminata
564.00 Constipation, Functional
555.9 Crohn's Disease
564.5 Diarrhea, Functional
564.4 Diarrhea, Post Op
562.11 Diverticulitis
562.10 Diverticulosis
617.9 Endometriosis
617.5 Endometriosis, Rectum/Colon
V16.0 Family History of Colon Neoplasm
565.0 Fissure in Ano
565.1 Fistula in Ano (Simple, Complex)
619.1 Fistula, Recto Vaginal
455.4 Hemorrhoids, Thrombosed, Exter.
455.1 Hemorrhoids, Thrombosed, Inter.
455.2 Hemorrhoids, Intern. (Bleeding or Ulcerated)
455.5 Hemorrhoids, Exter. (Bleeding or Ulcerated)
455.0 Hemorrhoids, Internal
569.3 Hemorrhage of Rectum/Anus
553.21 Hernia, Incisional
569.69 Hernia, Parastomal
553.20 Hernia, Ventral
705.83 Hidradenitis Suppurative
751.3 Hirschsprung's Disease
569.49 Hypertrophied Anal Papilla
560.39 Impaction, Fecal
560.9 Obstruction, Small Bowel
706.2 Sebaceous Cyst
564.1 Irritable Bowel Syndrome
564.6 Levator Spasm/Proctalgia Fugax
564.7 Mega Colon
154.0 Neoplasm, Colorectal
V10.05 Neoplasm, Colon, History
V10.06 Neoplasm, Rectal, History
V76.51 Screen for Colon Cancer
879.9 Open Anal Wound
569.49 Perianal Irritation
685.0 Pilonidal Cyst/Sinus, Abscess
685.1 Pilonidal Cyst/Sinus, Infected
211.3 Polyps, Colon
V12.72 Polyps, Colon, History
211.3 Polyps, Familial Polyposis
569.0 Polyps, Rectal
556.4 Polyps, Pseudopolyposis
569.49 Pouchitis
569.49 Proctitis
698.0 Pruritis Ani
569.42 Rectal Pain
569.1 Rectal Procidentia
787.9 Rectal Swelling
569.41 Rectal Ulcer
618.0 Rectocele
455.9 Skin Tags, External
788.20 Urine, Retention of
569.82 Ulceration, Colon
958.3 Wound Infection

healthy but has an uncle who has had colon cancer. She has no symptoms. You would then code "V76.51" which is a special screening for malignant neoplasms. The "V" prescript signifies a history of a problem. Next, you consider a patient who has a personal history of polyps or cancer, and the code is "V12.72" or "V10.05," respectively.

There are numerous codes to use as your diagnosis code and they are all virtually self-explanatory. For instance, abdominal pain is coded 789.00, and other types of abdominal pain are subtyped according to location. The code for "left lower quadrant pain" is 789.04. Table 1 provides the more common ICD-9-CM codes for colorectal diagnoses. The codes you select should be supported by documentation in your encounter note.

CPT CODES

For the office, CPT codes will be limited to two categories: evaluation and management (E&M) and minor office procedures. Procedures performed in the operating room or ambulatory surgery center also have CPT codes and some of these are similar to the office codes. CPT codes have been developed by the American Medical Association and groups associated with the federal government. New codes are developed and older codes are updated by these groups. The E&M codes (Table 2) are those beginning with "99," and these codes are based on three types of visits: (1) new patient, (2) consultation, and (3) established patient. A new patient is an individual who has not received any professional service from you within the past 3 years. A consultation is defined by a patient seeking your opinion or advice at the request of another physician and is documented in the patient record as such. Established patients have received professional services from you or your group in the past 3 years. Once a category of E&M coding has been determined, you must then determine the level of service.

The level of service depends on three documented components: (1) history, (2) physical examination, and (3) medical decision-making. History is defined by three areas which are the chief complaint, the history of present illness, and the past, family, and social history. The chief complaint should be a brief concise statement that explains the symptom, problem, condition, or current diagnosis. Next, the history of present illness (HPI) will consist of a description of the signs/symptoms of the patient. The number of signs and symptoms documented in the patient record determines the level of service you will be able to code. The following are the elements of an HPI:

Location
Quality
Severity
Context
Modifying factors
Associated signs and symptoms
Timing
Duration

The past, family, and social history is the third part of the history. Most practices develop a history form that the patient fills out at the initial visit and that can be incorporated into the office note. It is important to sign and date the history form every time a patient comes into the office to document that this review of the past, family, and social history was covered. Also, during the history portion, the number of reviews of systems (ROS) documented will also help in determining the level of service for which you will be able to charge. There are 14 ROS groups as described below:

Constitutional symptoms
Eyes
Ears, nose, mouth, throat
Cardiovascular
Respiratory
Gastrointestinal
Genitourinary
Musculoskeletal
Integumentary
Neurological
Psychiatric
Endocrine
Hematologic/lymphatic
Allergic/immunologic

In general, by including a review of systems, you can increase your level of E&M coding to increase your reimbursement. This does not apply, however, to a preoperative history and physical (99999) for established patients. These are coded and reimbursed as part of the global surgical fee which includes the history and physical visit and subsequent postoperative visits for the 90-day global period after surgery for procedures performed in the operating room, and for 30 days following office procedures (i.e., incision and drainage of an abscess). The actual global period can be confirmed by contacting your local Medicare chapter or referring to the Health Care Finance Act (HCFA).

Table 2 Office Evaluation and Management Codes (CPT)

NEW PATIENT	
Problem Focused	99201
Expanded Problem Focused	99202
Detailed	99203
Comprehensive—Moderate	99204
Comprehensive—High	99205
ESTABLISHED PATIENT	
Problem Focused	99212
Expanded Problem Focused	99213
Detailed	99214
Comprehensive	99215
Post Op Exam	99024
CONSULTATIONS	
Problem Focused	99241
Expanded Problem Focused	99242
Detailed	99243
Comprehensive–Moderate	99244
Comprehensive–High	99275
CONFIRMATORY CONSULTATIONS	
Limited Confirmatory Consultation	99271
Intermediate Confirmatory Consultation	99272
Extended Confirmatory Consultation	99273
Comprehensive Confirmatory Consultation	99274
Complex Confirmatory Consultation	99275

The level of exam is defined by the elements identified by each system, according to the following guidelines.

Problem Focused Evaluate one to five elements within a system (i.e., rectal bleeding).

Expanded Problem Focus Evaluate at least six elements within a system or six systems (i.e., rectal pain, rectal bleeding, weight loss, diarrhea, pruritis, fever).

Detailed Evaluate at least two elements within six systems or at least 12 elements within two or more systems.

Comprehensive Evaluate the entire ROS and identify one or two elements per system.

The last component of the level of service is "medical decision-making." This refers to the complexity of the diagnosis or management option and is measured by three areas: (1) the amount and complexity of data reviewed which include referring physician's notes, laboratory data, x-rays, etc.; (2) the number of diagnoses or management options; and (3) the level of risk. The levels of decision-making are low, moderate, and high complexity based on the three areas of medical decision-making. The guidelines for the levels can be found in the HCFA/CPT documentation guidelines, and you should document these levels in your office notes or dictation to justify the level of complexity of the visit.

Office procedures should be coded as described in the CPT handbook A yearly updated copy of this handbook can be purchased from the American Medical Association. Please refer to Table 3 for the most common office procedure in a colon and rectal practice. Remember that the CPT code should correlate with the ICD-9-CM code. For instance, if you see a patient with a diagnosis of perianal abscess (566) and you drain the abscess in the office, you should code for an incision and drainage of a perianal abscess (46050), not a sphincterotomy (46080).

An important thing to consider when performing an office procedure is whether it is performed on the same day as an E&M visit. If an E&M service and an office procedure are performed on the same day, a modifier must be used to be reimbursed for both services. For example, if a new patient is seen in consultation for constipation (564.00), and in your workup you find that he or she has also had rectal bleeding (569.3), and you perform a flexible sigmoidoscopy with a biopsy (45331) to evaluate the rectal bleeding on the same day, a number 25 modifier must be used with the E&M service (99242). The following are two modifiers that are commonly used in office settings:

Table 3 Office Procedures-CPT

Anoscopy	46600
Anoscopy/Dilation	46604
Anoscopy/Biopsy	46606
Anoscopy Removal of Foreign Body	46608
Anoscopy/Removal of Single (Polyp-Lesion, Hot Biopsy)	46610
Anoscopy/Removal of Single (Polyp-Lesion, Snare)	46611
Anoscopy/Removal of Multi (Polyps-Lesions)	46612
Anoscopy/Control of Bleeding	44614
Cauterization of Anal Fissure	17250
Destruction of Lesion, simple, chemical	46900
Destruction of Lesion, simple, electrodesiccation	46910
Destruction of Lesion, extensive, any method	46924
Excision, Pilonidal Cyst	11772
Excision of Thrombosed Hemorrhoid	46320
Flex Sig Diagnostic	45330
Flex PS with Biopsy	45531
Flex PS w/Polypectomy, Hot Biopsy	45333
Flex PS, Rem. Polyp or Lesion, Snare	45338
Flex PS, Control of Bleeding	45334
Ileoscopy, via Stoma	44380
Flex Sig of SB Pouch, Diag.	44385
Flex Sig of SB Pouch w/Biopsy	44386
Ileoscopy via Stoma w/Biopsy	44388
I&D of Perianal Abscess, Superficial	46050
I&D of Perirectal/Ischiorectal Abscess	46040
I&D of Pilonidal Cyst	10081
Injection of Internal Hemorrhoids	46500
Ligation of Internal Hemorrhoids (Single or Multi)	46221
Mult. Ligation of Hemorrhoids	46946
Ultrasound Intrepretation	76872
PS	45300
PS with Hot Biopsy	45308
PS with Biopsy	45305
PS with Rem. of Foreign Body	45307
PS with Rem. of Polyp, Snare	45309
PS with Rem. of Polyp, Snare, Multiple	45315
PS to Control Bleeding	45317
PS with Dilitation	45303
PS Cauterization of Polyps	45320
Removal of Fecal Impaction or Foreign Body	45915
Removal of Seton	46030
Skin Tag/Papillectomy	46220
Sphincterotomy	46080
Skin Tag/Papillectomy, Multiple	46230
Wound Care	11000

24 Unrelated E&M visit during postoperative period by the same physician/group.

25 Significant, separate, identifiable E&M service on the same day of a procedure.

Unfortunately, some procedures that are performed on the same day along with an E&M visit may

not be reimbursed by your carrier. However, you should document what you have done and attempt to be compensated for your time. You should check with your insurance contracts to see what is considered inclusive and regularly review your collections to identify whether your carrier has changed its policy.

Accurate documentation and coding are critical to a successful practice. This process can be complex and many of the "rules" can have various interpretations. Unfortunately, several organizations have input into those rules (federal government, insurance carriers, American Medical Association, etc.) and the rules can be changed. Therefore, physicians must constantly expand their knowledge and review the process on a regular basis to strive for accuracy and appropriate reimbursement.