Overview of Coding Systems

Physicians are required to use a variety of coding systems to obtain reimbursement for services rendered. This chapter provides critical care practitioners with an overview of these coding systems; their use is explained in more detail in subsequent chapters.

CURRENT PROCEDURAL TERMINOLOGY

The American Medical Association (AMA) established Current Procedural Terminology (CPT®) coding as a uniform method of describing services performed by physicians and other clinicians. Because of the ongoing changes in healthcare, CPT® codes are updated annually, with new codes added and old codes revised or deleted. Table 1-1 provides an example of code frequency according to the most current data from the Centers for Medicare and Medicaid Services (CMS) Medicare Utilization for Part B.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>2015 Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>99233</td>
<td>22,189,676</td>
</tr>
<tr>
<td>99291</td>
<td>5,330,015</td>
</tr>
<tr>
<td>99292</td>
<td>474,663</td>
</tr>
</tbody>
</table>

Use of a CPT® code is mandated when physicians file claims seeking reimbursement from payers for services provided, although its use does not guarantee reimbursement of all services by all payers. Most codes cannot be used multiple times by the same physician for the same patient on the same day. Furthermore, certain codes in the same section have specific restrictions. For example, although critical care codes are included in the Evaluation and Management (E/M) section of CPT® codes, critical care codes are unique in that they include a specific time element. The other E/M codes provide for “typical” time involved but, unlike the critical care codes, do not require coding based on time.

Also included with the CPT® codes are modifiers that can be used to alter individual codes in certain prescribed circumstances. For example, modifiers can be used to indicate the need for specialized or prolonged services or can be used to denote unusual clinical circumstances. However, not all payers recognize CPT® code modifiers. See Chapter 15 for a complete description and examples.
Distinctions exist between coding rules and payment rules. Coding rules typically are defined by the various coding systems discussed in this chapter. Payment rules are linked to these coding systems but are distinct. Payment rules determine whether a particular service (usually identified by a code from one of the coding systems discussed in this chapter) will be reimbursed. Payment rules are determined by the CMS and third-party payers and focus on what providers must do to ensure payment rather than what they must do to code the service properly. A common statement from Medicare is that "just because it is a valid code does not mean it is a covered service."

HEALTHCARE COMMON PROCEDURE CODING SYSTEM

Level I of the Healthcare Common Procedure Coding System (HCPCS) consists of CPT® codes, a numeric coding system maintained by the AMA and updated annually. The fourth edition of CPT® (CPT®-4) is a uniform coding system consisting of descriptive terms and identifying codes that are used primarily to identify medical services and procedures furnished by physicians and other healthcare professionals. These healthcare professionals use the CPT®-4 codes to identify services and procedures for which they bill public or private health insurance programs. Level I of the HCPCS, the CPT®-4 codes, does not include codes needed to separately report medical items or services that are regularly billed by suppliers other than physicians.

Level II of the HCPCS is a standardized coding system that is used primarily to identify products, supplies, and services not included in the CPT®-4 codes, such as ambulance services and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) when used outside a physician’s office. This coding system is updated annually. Because Medicare and other insurers cover a variety of services, supplies, and equipment that are not identified by CPT®-4 codes, the level II HCPCS codes were established for submitting claims for these items. As with CPT® codes, the HCPCS includes modifiers for coding under specific circumstances.

RESOURCE-BASED RELATIVE VALUE SYSTEM

The Resource-Based Relative Value System (RBRVS) is the most widely used of numerous scaling systems and is the system used by Medicare. The system is designed to address the time, skill, overhead, and malpractice expense involved when determining the relative value of a specific service compared with other services. Relative value units (RVUs) are assigned to 3 components for every service:

1. Physician work
2. Practice expense (overhead)
3. Malpractice (also known as physician liability insurance)

The practice expense component is further divided by site of service: facility (eg, hospital, nursing home) or nonfacility (eg, physician office). Multipliers or conversion
factors are used with the total RVUs to determine the payment amount. Application of geographic adjustments is based on where in the United States the service was provided. The Medicare conversion factor for 2017 is $35.8887. Many managed care organizations use relative value scales such as the RBRVS to set the maximum allowable professional fees for clinicians.

The formula for calculating a national average payment in the Medicare fee schedule is as follows:

\[(\text{Work RVU} + \text{Practice Expense RVU} + \text{Physician Liability Insurance RVU}) \times \text{Conversion Factor} = \text{Payment}.\]

Geographic adjustment factors are not used in this formula, as they make only minor differences.

The following is an example of how to calculate a national average payment for a specific service under the Medicare fee schedule using CPT® code 36556 (ie, placement of central venous catheter, percutaneous, patient older than 5 years):

\[([\text{Work RVU} (2.50) + \text{Practice Expense RVU} (0.69) + \text{Malpractice RVU} (0.29)] \times 2017 \text{Conversion Factor} ($35.8887) = $124.89.\]

**INTERNATIONAL CLASSIFICATION OF DISEASES**

The World Health Organization established an international classification system to aid in collecting morbidity statistics. Medicare and many other payers have adopted the system, thereby requiring clinicians to use the codes from the *International Classification of Diseases, Tenth Revision* (ICD-10), in addition to the CPT® codes, in claims submitted for reimbursement. The ICD-10 codes refer to specific diagnoses or the reason that the patient is being seen, and these must be linked appropriately to the CPT® code to determine the medical necessity for the service provided and whether the service will be reimbursed.

Although not always required of critical care providers, the use of diagnoses different from those used by other providers (eg, surgeons, emergency physicians, cardiologists) when treating a patient can often prevent problems with critical care claims. Because critically ill and injured patients typically qualify for multiple diagnoses, it is often easier, ultimately, to use an ICD-10 code different from that which other physicians use, because it keeps critical care services separate from other patient services. Assuming the diagnosis is applicable, it is perfectly appropriate to select a code that makes billing easier. Although duplicating another physician’s diagnosis is permissible in some instances, oftentimes it is easier to avoid initial rejections and appeals by selecting from available options that distinguish between the services of each provider.

Thus, it is useful to be cognizant of the diagnosis (ICD-10) codes that apply to your patient and keep track of those used by other physicians and nonphysician
practitioners (ie, midlevel practitioners) who treat your patient. This practice is especially useful for physicians of different specialties who provide critical care to the same patient at the same time, or for physicians in different tax groups, each of whom needs to bill for critical care on the same day. As long as different diagnoses are used and the criteria for critical care are met (as discussed in Chapter 3), each provider’s claim is valid.

If multiple providers use the same diagnosis to support separate services, the provider whose claim comes in second or last is sure to be rejected by the processing computer and probably denied, even in appeal. Even in instances in which the claim is upheld during the appeals process, it is often easier to avoid the appeal entirely by using a different, applicable ICD-10 code for the second claim. The current coding system, presented in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), went in effect October 1, 2015, replacing ICD-9-CM.

5-YEAR REVIEW

By federal statute, all CPT® codes must be reviewed to account for changes in work associated with the relevant service. These reappraisals occur at 5-year review meetings of the Relative Scale Update Committee and result in recommendations to CMS, the federal agency responsible for managing Medicare. Because CMS accepts more than 90% of the Relative Update Committee’s recommendations, the Relative Update Committee’s 5-year review process is extremely influential in determining the values of all CPT® codes, including those typically used by providers of critical care services. Because regulations require that CMS accept public comments on changes, proposed rules are published in the Federal Register (typically in the spring). After changes based on public comments are incorporated, a final rule is published 60 days before the new rule becomes effective. Typically, that results in a final rule that is published in the fall before the new rule takes effect in January. Many E/M codes, including the adult critical care codes, are included in a 5-year review. As a result, the work RVU for critical care code 99291 increased from 3.99 in 2006 to 4.50 in 2014 and remains the same in 2017. https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx

SUMMARY

Critical care physicians must understand coding rules to obtain appropriate reimbursement. The ICD-10 (diagnosis) code should link appropriately to the CPT® code. Documentation in the medical record should support all CPT® and ICD-10-CM codes reported on the health insurance claim form. If clinical circumstances warrant, appropriate modifiers should be added to the code, and the codes used should be compared against the National Correct Coding Initiative edits to ensure that they are neither mutually exclusive nor part of a comprehensive or component coding pair.
SUGGESTED READING


