Coders' Dictionary & Reference Guide

A comprehensive resource for every medical coding and billing professional

SECOND EDITION
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Readers’ Questions and Answers ............................................. 757
We are pleased to offer you the **Coders’ Dictionary & Reference Guide**, a unique coding resource compiled by experts for your everyday use. We included in this comprehensive reference guide the most used and trusted resources that provide you with all the supporting information you need to tackle the complexities of medical coding.

Features you’ll benefit from page after page include:

- Comprehensive list of thousands of medical terms with definitions written in easy to understand language
- Billing, coding, and reimbursement terms and definitions so that you can become familiar with current regulations, requirements, processes, and regulatory agencies
- How-to guidance for coding procedures from the Surgery section, including explanations of common terms
- Evaluation and Management (E/M) Survival Guide that walks you through E/M services guidelines to make the right choice between the various E/M service levels
- Anesthesia primer to help you distinguish between various types of anesthesia
- Modifiers and lay descriptions for CPT® and HCPCS modifiers in simple-to-read language to clear up the confusion of when and how to apply modifiers
- Lists of prefixes, suffixes, abbreviations, and eponyms commonly used in coding
- Anatomical illustrations to guide you as you read descriptions of services and procedures
- Place of service (POS) and type of service (TOS) lists
SECTION I

Terms and Definitions
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<th>Billing/Coding/Reimbursement Term</th>
<th>Definition</th>
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<tr>
<td>ACTUARIAL BALANCE</td>
<td>The difference between the summarized income rate and the summarized cost rate over a given valuation period.</td>
</tr>
<tr>
<td>ACTUARIAL DEFICIT</td>
<td>A negative actuarial balance.</td>
</tr>
<tr>
<td>ACTUARIAL RATES</td>
<td>One half of the expected monthly cost of the SMI program for each aged enrollee (for the aged actuarial rate) and one half of the expected monthly cost for each disabled enrollee (for the disabled actuarial rate) for the duration the rate is in effect.</td>
</tr>
<tr>
<td>ACTUARIAL SOUNDNESS</td>
<td>A measure of the adequacy of Hospital Insurance and Supplementary Medical Insurance financing as determined by the difference between trust fund assets and liabilities for specified periods.</td>
</tr>
<tr>
<td>ACTUARIAL STATUS</td>
<td>A measure of the adequacy of the financing as determined by the difference between assets and liabilities at the end of the periods for which financing was established.</td>
</tr>
<tr>
<td>ADDITIONAL BENEFITS</td>
<td>Healthcare services not covered by Medicare and reductions in premiums or cost sharing for Medicare-covered services. Additional benefits are specified by the MA Organization and are offered to Medicare beneficiaries at no additional premium. Those benefits must be at least equal in value to the adjusted excess amount calculated in the ACR. An excess amount is created when the average payment rate exceeds the adjusted community rate (as reduced by the actuarial value of coinsurance, copayments, and deductibles under Parts A and B of Medicare). The excess amount is then adjusted for any contributions to a stabilization fund. The remainder is the adjusted excess, which will be used to pay for services not covered by Medicare and/or will be used to reduce charges otherwise allowed for Medicare-covered services. Additional benefits can be subject to cost sharing by plan enrollees. Additional benefits can also be different for each MA plan offered to Medicare beneficiaries.</td>
</tr>
<tr>
<td>ADJUSTED AVERAGE PER CAPITA COST (AAPCC)</td>
<td>An estimate of how much Medicare will spend in a year for an average beneficiary. (See &quot;Risk Adjustment.&quot;).</td>
</tr>
<tr>
<td>ADJUSTED COMMUNITY RATING (ACR)</td>
<td>How premium rates are decided based on members’ use of benefits and not their individual use of benefits.</td>
</tr>
<tr>
<td>ADMINISTRATIVE CODE SETS</td>
<td>Code sets that characterize a general business situation, rather than a medical condition or service. Under HIPAA, these are sometimes referred to as nonclinical or nonmedical code sets. Compare to medical code sets.</td>
</tr>
<tr>
<td>ADMINISTRATIVE COSTS</td>
<td>A general term that refers to Medicare and Medicaid administrative costs, as well as CMS administrative costs. Medicare administrative costs are comprised of the Medicare related outlays and non-CMS administrative outlays. Medicaid administrative costs refer to the federal share of the states’ expenditures for administration of the Medicaid program. CMS administrative costs are the costs of operating CMS (e.g., salaries and expenses, facilities, equipment, rent and utilities, etc.). These costs are reflected in the Program Management account.</td>
</tr>
<tr>
<td>ADMINISTRATIVE DATA</td>
<td>This refers to information that is collected, processed, and stored in automated information systems. Administrative data include enrollment or eligibility information, claims information, and managed care encounters. The claims and encounters may be for hospital and other facility services, professional services, prescription drug services, laboratory services, and so on.</td>
</tr>
<tr>
<td>ADMINISTRATIVE EXPENSES</td>
<td>Expenses incurred by the Department of HHS and the Department of the Treasury in administering the SMI program and the provisions of the Internal Revenue Code relating to the collection of contributions. Such administrative expenses, which are paid from the SMI trust fund, include expenditures for contractors to determine costs of, and make payments to, providers, as well as salaries and expenses of CMS.</td>
</tr>
<tr>
<td>ADMINISTRATIVE LAW JUDGE (ALJ)</td>
<td>A hearings officer who presides over appeal conflicts between providers of services, beneficiaries, and Medicare contractors.</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
<tr>
<td>--------------</td>
<td>-------------</td>
</tr>
<tr>
<td>AAA</td>
<td>abdominal aortic aneurysm</td>
</tr>
<tr>
<td>AAROM</td>
<td>active assistive range of motion</td>
</tr>
<tr>
<td>AB</td>
<td>abortion</td>
</tr>
<tr>
<td>ABE</td>
<td>acute bacterial endocarditis</td>
</tr>
<tr>
<td>ABG</td>
<td>arterial blood gases</td>
</tr>
<tr>
<td>ABN</td>
<td>abnormal, or advance beneficiary notice</td>
</tr>
<tr>
<td>a.c.</td>
<td>before eating</td>
</tr>
<tr>
<td>AC</td>
<td>acromioclavicular joint, or abdominal circumference</td>
</tr>
<tr>
<td>ACDF</td>
<td>anterior cervical disectomy with fusion</td>
</tr>
<tr>
<td>ACI</td>
<td>autologous chondrocyte implantation</td>
</tr>
<tr>
<td>ACL</td>
<td>anterior cruciate ligament</td>
</tr>
<tr>
<td>ACLS</td>
<td>advanced cardiac life support</td>
</tr>
<tr>
<td>Acq.</td>
<td>acquired</td>
</tr>
<tr>
<td>ACS</td>
<td>acute coronary syndromes</td>
</tr>
<tr>
<td>ACTH</td>
<td>adrenocorticotropic hormone</td>
</tr>
<tr>
<td>ACVD</td>
<td>acute cardiovascular disease</td>
</tr>
<tr>
<td>ADD</td>
<td>attention deficit disorder</td>
</tr>
<tr>
<td>ADH</td>
<td>antidiuretic hormone</td>
</tr>
<tr>
<td>ADHD</td>
<td>attention deficit hyperactivity disorder</td>
</tr>
<tr>
<td>ADL</td>
<td>activities of daily living</td>
</tr>
<tr>
<td>AF</td>
<td>atrial fibrillation</td>
</tr>
<tr>
<td>AFI</td>
<td>amniotic fluid index</td>
</tr>
<tr>
<td>A fib</td>
<td>atrial fibrillation</td>
</tr>
<tr>
<td>AFP</td>
<td>alpha-fetoprotein</td>
</tr>
<tr>
<td>AGA</td>
<td>appropriate for gestational age</td>
</tr>
<tr>
<td>AI</td>
<td>aortic insufficiency</td>
</tr>
<tr>
<td>AID</td>
<td>artificial insemination with donor sperm</td>
</tr>
<tr>
<td>AIDH</td>
<td>artificial insemination with husband’s sperm</td>
</tr>
<tr>
<td>AIDS</td>
<td>acquired immunodeficiency syndrome</td>
</tr>
<tr>
<td>AKA</td>
<td>above-knee amputation</td>
</tr>
<tr>
<td>AL</td>
<td>artificial larynx</td>
</tr>
<tr>
<td>ALA</td>
<td>aminolevulinic acid</td>
</tr>
<tr>
<td>ALL</td>
<td>acute lymphocytic leukemia</td>
</tr>
<tr>
<td>ALP</td>
<td>alkaline phosphatase</td>
</tr>
<tr>
<td>ALS</td>
<td>advanced life support</td>
</tr>
<tr>
<td>AMA</td>
<td>against medical advice, or advanced maternal age</td>
</tr>
<tr>
<td>AODM</td>
<td>adult-onset diabetes mellitus</td>
</tr>
</tbody>
</table>
Skeletal System — Skull

- Frontal bone
- Parietal bone
- Temporal bone
- Orbital process of palatine bone
- Lacrimal bone
- Perpendicular plate of ethmoid bone
- Middle nasal concha of ethmoid bone
- Inferior nasal concha
- Vomer
- Nasal bone
- Zygomatic bone
- Maxilla
- Teeth
- Mandible

- Parietal bone
- Frontal bone
- Superior temporal linea
- Inferior temporal linea
- Occipital bone
- Superior nuchal line
- External occipital protuberance
- External occipital crest
- Squamous part of temporal bone
- Mastoid part of temporal bone
- External acoustic meatus
- Styloid process of temporal bone
- Zygomatic arch
- Zygomatic bone
- Nasal bone
- Maxilla
- Teeth
- Mandible
SECTION IV

Surgery
Chapter 1

E/M Guidelines

Evaluation and management (E/M) services refer to patient visits and consultations provided by physicians or residents under their supervision, as well as nonphysician providers both under a physician’s supervision in an incident-to situation and operating without supervision when billing under their own provider identification. The AMA has assigned each of these services a CPT® code, the Health Care Financing Administration (HCFA) — now the Centers for Medicare and Medicaid Services (CMS) — implemented them in 1992 as part of the resource-based Medicare fee schedule payment system.

Like all CPT® codes, E/M codes are universal payers for processing claims and used by Medicare, Medicaid, and most other physician's professional services. You should also use E/M service codes for billing facility services on an outpatient basis.

Because evaluation and management services are high-volume provider activities, the E/M codes are the most frequently used by physicians and nonphysician providers in daily practice.

Know Your Guidelines

The following guidance applies to E/M codes except 99202-99215. The new 2021 guidelines will be explained in Chapter 34 of this guide. To help providers distinguish between the various E/M service levels, CMS issued E/M documentation guidelines in 1995 and again in 1997, with the section on examinations being the main difference between the two sets.

The 1995 guidelines allow physicians to conduct either a general multisystem or single-system exam and defined the levels of examination based on body areas and organ systems. The guidelines neglect, however, to specifically define what constitutes a single-system comprehensive exam.

In addition, the 1995 guidelines created confusion by describing both an expanded problem-focused exam and a detailed exam as encompassing two to seven body areas or organ systems — although the guidelines state that an expanded problem-focused exam includes a limited exam of the areas, while a detailed exam includes an expanded exam of at least one area.

The CMS-issued 1997 guidelines create more specific audit criteria by including the number of examination elements that a provider must perform and document at each level and by outlining the elements of the multisystem general exam and 10 single-organ system exams: cardiovascular, ear/nose/throat, eye, genitourinary, hematologic/lymphatic/immunologic, musculoskeletal, neurological, psychiatric, respiratory, and skin.

Important: Providers can use either the 1995 or the 1997 guidelines.

Commonly Used E/M Terms

When you're reviewing E/M rules and regulations, there are certain terms that you'll see frequently, including the following:

Provider — A provider is a physician or licensed nonphysician provider who may provide services incident to the physician or independently under his or her own provider number (PIN or NPI).
Follow-up Hospital Care

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
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</thead>
<tbody>
<tr>
<td>99231</td>
<td>45 min.</td>
</tr>
<tr>
<td>99232</td>
<td>55 min.</td>
</tr>
<tr>
<td>99233</td>
<td>65 min.</td>
</tr>
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</table>

Inpatient Consults

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
</tr>
</thead>
<tbody>
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<td>99251</td>
<td>50 min.</td>
</tr>
<tr>
<td>99252</td>
<td>70 min.</td>
</tr>
<tr>
<td>99253</td>
<td>85 min.</td>
</tr>
<tr>
<td>99254</td>
<td>110 min.</td>
</tr>
<tr>
<td>99255</td>
<td>140 min.</td>
</tr>
</tbody>
</table>

Discharges

<table>
<thead>
<tr>
<th>Code</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99238</td>
<td>Up to 30 min.</td>
</tr>
<tr>
<td>99239</td>
<td>Over 30 min.</td>
</tr>
</tbody>
</table>

**NOTES**

**Emergency E/M codes**

You may not use prolonged services codes (99354-99357) with emergency E/M codes (99281-99285). If an admission follows an ER E/M, attach the prolonged service code to the admission.

For example, if you select an E/M service with a reference time of 15 minutes (such as 99231, *Subsequent hospital care, per day... Counseling and/or coordination of care with other physicians, other qualified healthcare professionals...Typically 15 minutes are spent at the bedside and on the patient’s hospital floor or unit*), the physician must document a minimum of 45 minutes of face-to-face time before you can report an initial prolonged service code.

**Document Time With Care**

To gain reimbursement for prolonged services, you must document all time the physician spends face-to-face with the patient for outpatient coding, and all the unit/floor time the physician spends treating the patient in the inpatient setting. Without an actual minute value stated in the physician notes, prolonged service codes are not valid no matter how much time the physician actually spent.

Time needn’t be uninterrupted: The time you count toward prolonged services need not be continuous, although it should occur on the same date of service. The physician may consult with a patient in the hospital, spend 30 minutes discussing his condition, leave to perform regular rounds, and return to the original patient for another 40 minutes of counseling. The time spent with the patient both before and after the physician made rounds can contribute toward prolonged services.

**Give a reason:** You must explain why the physician provided prolonged services, according to Medicare Claims Processing Manual instructions (Publication 100-04, Chapter 12, Section 30.6.15.1 C), which state, to support billing for prolonged services, the medical record must document the duration and content of the E/M code billed.

Simply noting that the physician spent an extra 42 minutes with the patient, for instance, is not adequate. You must prove, in the medical record, the medical necessity for the extra time spent.

**NOTES**
Ensure that the following three factors are documented in the hospital record if you select 99233 based on time:

1. The total time spent during the inpatient encounter (which should be at least 35 minutes for 99233)
2. The time spent counseling/coordinating care (which must exceed 50 percent of the total visit time)
3. A description or summary of the counseling/coordination of care provided.

Keep in mind that the total time for an inpatient is considered as the face-to-face time plus the unit/floor time spent in care directly related to the patient.

For instance, the documentation would say something like: “Total visit time was 35 minutes; 20 minutes of that visit was spent counseling the patient and her husband about potential treatment options and management techniques for colitis, as well as prognosis. Answered multiple questions and provided them with educational information.”

Although this question indicates that the gastroenterologist documented the total time spent and what was discussed, there’s no indication that the physician spent at least half of that time on counseling/coordinating care. In these situations, you may not be able to bill based on time unless you have a record of how much time was spent counseling/coordinating care.

**ICD-10-CM Encounter Code**

**Question:** How would you assign a 7th character (A, D, S) for a procedure that isn’t due to an injury? A shunt is put in and later the patient returns to have the shunt removed due to a mechanical failure. What 7th character would be used in this case?

**Please give the 7th character for both of these scenarios:**

**Scenario 1:** The physician who puts in the shunt is the same physician who takes the shunt out.

**Scenario 2:** The physician who put in the shunt is another physician but from the same specialty.

**Answer:** The seventh character identifies the encounter as Initial, Subsequent, or Sequela due to injury and external cause also. Initial encounter (seventh character A) is used when the patient is receiving active treatment of the condition. Subsequent encounter (seventh character D) is used for encounters after the patient has received active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase. Sequela (seventh character S) is used for complications or conditions that arise as a direct result of a condition.

Mechanical failure can be a breakdown, displacement, leakage, or other mechanical complication. In the given scenarios, the same and different physician (but from the same specialty) performing the procedure will have to code with Sequela (complication) with seventh character S.
cauterized. The central portion of the volar flap was sewn to the dorsal skin. Triangles were taken out of the volar flap so that it contoured nicely to the dorsal flap.

Is the debridement included in the amputation? Would we code 26952 only? Can we bill any of the debridement codes (11720/11042) also with modifier 59?

Answer: When a physician removes sutures while the patient is under anesthesia, you could report either 15850 Removal of sutures under anesthesia (other than local), same surgeon or 15851 Removal of sutures under anesthesia (other than local), other surgeon. However, if the suture is infected and no longer serves the purpose for which it was initially placed (medical necessity), then it should be treated as foreign body and (complication) and its removal should be coded with foreign body removal code from the appropriate body part CPT® section.

Degenerative Joint Disease

Question: How would I code the following?

The diagnoses are right foot second tarsometatarsal joint DJD and fifth metatarsal cuboid DJD. The procedures performed are as follows: (1) Fusion of second tarsometatarsal joint, right. (2) Fifth metatarsal cuboid resectional arthroplasty, right. (3) Harvest of calcaneal autograft through a separate incision. (4) Aspiration of bone marrow for use in fusion, right hip.

Answer: The appropriate codes are 28740-RT, 28122-59-RT, 20900-RT or 20902 based on the size of the graft. Aspiration of bone marrow is not separately codable as bundles in graft procedure.

Delayed Primary Closure

Question: The diagnosis provided was an abscess, dorsal right middle finger at MCP level, with early septic arthritis. The procedure performed was a delayed primary closure of right middle finger dorsal wound (1.5 cm). The procedure report states: The patient had a laceration that became infected with a subcutaneous abscess-type formation and early septic arthritis. This was treated with an incision and drainage, packed open, with leaving the portion of the wound open. How should I bill this service?

Answer: The correct CPT® code for this procedure is 10060 Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia), simple or single.

Dialysis

Question: My provider is removing and replacing a peritoneal dialysis catheter, but I cannot locate a code for the removal. Code 49324 is for the placement, is there a removal code like the open procedure has or is it included with the placement of the new catheter?

Answer: Use CPT® code 49325 Laparoscopy, surgical; with revision of previously placed intraperitoneal cannula or catheter, with removal of intraluminal obstructive material if performed for laparoscopic revision of PD cath.
Question: When coding 99212 with 93281, should we use modifier 25 on the 99212 or should we also use modifier 26?

Answer: You should not use a modifier 26 on any E/M code. Modifier 26 is only used for services that have both a technical and professional component, such as an X-ray. An E/M code does not meet the requirements for a code with technical and professional components. Modifier 25 would be the proper modifier to append to the 99212 in this case; however, there are certain requirements that must be met to use modifier 25. You must be sure that the E/M visit is a significant, separately identifiable service and your documentation should be able to support this.

Modifier 50

Question: I billed 99203-25, 20526-RT, J3301 with two units, and 20526-LT. Blue Cross denied the second 20526-LT stating that only one unit is allowed per day. Is this correct or am I missing something?

Answer: You can use modifier 50 with 20526 Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel to identify a bilateral procedure. Since you are receiving a denial for this code, your payer probably prefers receiving this code with modifier 50 instead of RT and LT. You should bill this code as single line item with modifier 50.

Modifier 51

Question: I am new to urology coding and was informed that they use modifier 51 and 59 in combination to get paid. I have never heard of this. Could you please explain when this is necessary to do so?

Answer: Modifier 51 would be used when more than one procedure is performed on the same day with the same physician and modifier 59 is used to identify that the procedure is separately identifiable from the other procedure(s) performed, usually procedures that are bundled. Using modifier 51 notifies the payer that more than one procedure was performed. Adding modifier 59 to an additional code, lets the payer know that there was another procedure done but maybe another site/location, and it should be reimbursed. When using these modifiers together it is important to send in supporting documentation with the claim.

Question: If an X-ray of the skull is done prior to an MRI for brain shunt valve setting and then another skull X-ray is done after the MRI for brain shunt valve setting, should a modifier 51 be appended to the second skull X-ray?

Answer: You should use modifier 76 in this circumstance.

Modifier 57

Question: When billing an E/M code along with 66821 to Medicare, is modifier 57 required?

Answer: You would append modifier 57 to an E/M service if the provider decides to perform surgery the day of the E/M service. The selection of a modifier will depend on whether the provider has decided to do the surgery at the time of the office visit or if the E/M is separately identifiable from the surgery. Other modifiers...
Answer: Use modifier XS. This represents a service that is distinct because it was performed on a separate organ/structure. This is applicable if the biopsy performed on a lesion is different from the polyp or tumor treated by snare.

Modifier XU

Question: I need help with billing a left heart cath with stent. I would normally use 92928 and 93458-26 and I added 59 to the 93458. Should I use XS or XU?

Answer: Using modifier XU would be most appropriate in this scenario. This represents the use of a service that is distinct because it does not overlap usual components of the main service.

Ophthalmology Modifiers

Question: Can you modify eye codes just like E/M codes?

Answer: Adding modifiers to eye codes would depend on the eye code that you are billing and what codes you are billing out with the eye code. It is not appropriate to say that you can add modifiers on all ophthalmology codes.

Suffixes

Question: Can a modifier be a suffix to a CPT® code?

Answer: Yes, a modifier is a two-character suffix for procedure codes. They can be alpha and or numeric and are used to indicate that the procedure code has been altered in some way.

2 Surgeons

Question: Our provider performed a removal of a cecal tumor. While the abdomen was still open, they also performed a cystoscopy, bilateral retrograde pyelography, and placement of a double-J stent. Which modifier, if any, would we use? Will reimbursement be reduced because of it?

Answer: Different procedures require no modifier if surgeons of different specialties are each performing a different procedure with different CPT® codes. Neither co-surgery nor multiple surgeon rules apply, even if the procedures are performed through the same incision. If one of the surgeons performs multiple procedures, the multiple procedure rules apply to that surgeon’s services.

Wound Care

Question: I billed 99214 with modifier 25 and diagnoses J30.9, H66.009, and J06.9; 94060 with modifier TC and diagnosis code J45.20; 94060 with modifier 26 and diagnosis code J45.20; and 87880 with modifier 59 and diagnosis code J02.9. If the pediatrician also did wound cleaning and dressing with gauze for an abscess, diagnosis code L02.91, what CPT® code would I choose for the wound cleaning and dressing for the abscess and what modifier should I append?

Answer: The wound cleaning and dressing are not separately billable. This is included under the billed E/M visit code.
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