Military Health System Coding Guidance:

Professional Services and Specialty Coding Guidelines

Version 3.6

Unified Biostatistical Utility

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Please note the following

A thorough search of the document may be required to determine location of specific coding rules. Utilize the find feature (Ctrl+F) to expedite locating specific references.
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This document provides guidance for Department of Defense (DOD) coding for professional services. MHS systems capture professional encounters in both outpatient and inpatient settings.

Updating Guidelines—MHS Coding Guidance is reviewed and updated annually, or more frequently as needed, by the Unified Biostatistical Utility (UBU) Working Group. To suggest updates, contact the Service point of contact listed in section 1.7.

Updates to coding guidance are on the UBU website, at the URL:

Guidelines effective for MTF’s and External Audits, as indicated on title sheet of MHS Coding Guidance: Professional Services and Specialty Coding Guidelines.

When delays to code table updates/system limitations occur, use applicable sections of the most current version of MHS coding guidelines until limitations are resolved.

1.1. Purpose
In the simplest sense, coding is the numeric or alphanumeric representation of written descriptions. It allows standardized, efficient data gathering for a variety of purposes. This document provides MHS-specific guidance for coding ambulatory and professional service encounters. These guidelines are derived from the following source documents, but take precedence over them:

- International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM);
- Centers for Medicare and Medicaid Services (CMS) Documentation Guidelines for Evaluation and Management (E&M) Services;
- Healthcare Common Procedure Coding System (HCPCS);
- The American Hospital Association (AHA) Coding Clinic;
- The American Medical Association (AMA) CPT Assistant;
- The Coding Clinic for HCPCS.

This document is not intended to be an all-inclusive reference for MHS coding guidance. In the absence of specific MHS coding guidance, refer to the appropriate industry standard coding conventions. For specific workload issues not covered in this document, refer to service specific workload guidance.

Coding serves a variety of purposes. While it can provide a detailed clinical picture of a patient population, it can also be useful in overseeing population health, anticipating demand, assessing quality outcomes and standards of care, managing business activities, and receiving reimbursements for services.

When coding for DoD healthcare services, substitute the term privileged providers where the CPT manual description uses the term physicians. Privileges are granted by individual military treatment facilities (MTFs). Common examples of privileged providers are licensed physicians, advanced
practice nurses, physician assistants, Independent Duty Corpsman (IDC), oral surgeons,
optometrists, residents (other than post-graduate year one [PGY-1]), and physical and occupational
therapists.

1.1. Other Qualified Healthcare Providers
An “other qualified healthcare professional,” as described in the Instructions for Use section of
the CPT® manual, “is an individual who is qualified by education, training, licensure/regulation
(when applicable), and faculty privileging (when applicable) who performs a professional service
within his/her scope of practice and independently reports that professional service. A clinical
staff member is a person who works under the supervision of a physician or other qualified
healthcare professional and who is allowed by law, regulation, and facility policy to perform or
assist in the performance of a specified professional service, but who does not individually report
that professional service.” When coding for DoD healthcare services, other qualified healthcare
professionals may report CPT codes, except as restricted by CPT descriptions or MHS Coding
Guidelines. For example, an MHS restriction can be found in 6.8.3.3.

1.2. Diagnostic Coding
Diagnostic coding began as a means of gathering statistical information to track mortality and
morbidity. Subsequent changes to add clinical information resulted in a coding structure that
describes the clinical picture of a patient, as well as non-medical reasons for seeking care and causes
of injury. Diagnosis codes are listed in the International Classification of Diseases, 9th revision,
Clinical Modifications or, ICD-9-CM.

1.3. Procedural Coding
Healthcare Common Procedure Coding System (HCPCS) codes are grouped in two levels:

   Level I HCPCS are commonly referred to as Current Procedural Terminology (CPT). They
form the major portion of the HCPCS coding system, covering most services and procedures.
CPT codes supersede Level II codes when the verbiage is identical.

   Level II codes supersede level I codes for similar encounters, when the verbiage of the level
II code is more specific as supported by the documentation. HCPCS includes evaluation and
management services, other procedures, supplies, materials, injectables, and dental codes.
Having a code number listed in a specific section of HCPCS does not usually restrict its use
to a specific profession or specialty.

Other Specifics Regarding HCPCS Level II Codes
Coding supplies/durable medical supplies/equipment. Code supplies/durable medical
supplies/equipment if specifically directed to do so in this document. Otherwise, do not code
clinic supplies or durable medical supplies/equipment funded by a different clinic or
organization. To code durable medical supply/equipment, it must meet all of the following.

   a. Can withstand repeated use (e.g., not consumed in use such as a syringe, suction bulb or suture
removal kit);
   b. Is primarily and customarily used to serve a medical purpose;
c. Generally is not useful to a person in the absence of an illness or injury;

d. Is appropriate for use in the home;

e. There is a specific HCPCS code for the item (e.g., not otherwise specified [NOS] codes should be used only when the value of the information collected exceeds the resources to collect/process/store/analyze/use the data); and

f. There is no anticipation of the item being returned. For instance, a TENS unit loaned to a patient to see if the TENS unit will work for that patient would not be coded as the TENS unit will be returned.

**Pharmaceuticals and Injectables**
HCPCS Level II codes will only be used when the pharmaceutical or injectable is paid for directly from the clinic’s funds, and is not a routine supply item. If a drug is issued by the pharmacy to the patient, and the patient brings the drug to the clinic for administration, the drug will not be coded, as the pharmacy was the service issuing the drug. Inpatient ward stock will not be coded, as it is part of the institutional component and part of the diagnosis-related group (DRG).

**C Codes**
These codes are commonly referred to as *pass-through* codes. They are usually only available for a few years at which time the item is included in a procedure or no longer used. These tend to be for high-cost items. The item must be coded if it is paid for out of clinic funds. As with other drugs, do not code it if the pharmacy issued it to the patient. Frequently, coders will need to query the provider or the clinic supply custodian on the method of acquisition.

**1.3.1. Performance Quality Reporting System (PQRS)**
Performance Quality Reporting System (PQRI) codes are not required to be reported within the MHS unless otherwise required within this document.

**1.4. Evaluation and Management (E&M) Coding**
In the DoD, the term *evaluation and management codes* refers to the CPT codes inclusive of 99201–99499. These codes describe the non-procedural portion of services furnished during a healthcare encounter. They classify services provided by a healthcare provider and indicate the level of service. E&M codes are a subset of CPT codes (Level I HCPCS), yet are referred to as an E&M instead of as a CPT code to distinguish between E&M services and procedural coding. See Section 3 for details about E&M coding.

**1.5. Coding Table Updates**
ICD-9-CM diagnosis codes are updated annually in the Composite Health Care System (CHCS). These updates, which usually affect a portion of the codes, should be effective on or about 1 October of each year. Implementation by DoD MTFs is tied to release and distribution of CHCS file updates. Actual activation at a specific CHCS host and its client sites requires coordination among coders and CHCS administrators at their facilities. Mechanisms should be in place to ensure record completion by fiscal year end. Corrections may be needed to complete records once the new codes are available.

CPT and HCPCS codes are updated annually about 1 January. Like the ICD-9-CM codes, implementation in DoD MTFs depends on a release of CHCS file updates and may therefore be
later than in the private sector. There may be table updates performed as needed in addition to the 
annual releases. Even when a table update is required, records will need to be completed within the 
normal 3 working days for clinic encounters and observation, and fifteen days for same-day surgery, 
and 25 days after discharge for inpatient records. Failure to have all prior year professional services 
CAPER coding complete before the tables update may result in situations where old codes are no 
longer available. Health Insurance Portability and Accountability Act (HIPAA) compliant billing 
requires use of the existing CPT or HCPCS code available at the time of the clinical service.

1.6. Legal Reference

The medical record is the legal record of care. When there is a difference between what is coded in 
the Ambulatory Data Module (ADM) and what is documented in the medical record, a coder may 
change a code to more accurately reflect the documentation. When this occurs, the coder must 
notify the provider. The provider is ultimately responsible for coding and documentation.

While the data from the CHCS record can be used to create third-party claims, the medical record 
must support the coding in the claim.

1.7. Getting Help on Coding Questions

For questions on coding issues, please contact the Service Representative, as follows:

Army http://pasba3.amedd.army.mil
Air Force AFMOA/Coding@us.af.mil or 1-800-298-0230

These Service sites can only be accessed from specific service domains (af.mil, navy.mil, 
army.mil) and must be CAC card enabled.

System issues: For ADM functional software and technical support, contact the MHS Help Desk.

MHS HELP DESK

CONUS 1-800-600-9332
OCONUS 866-637-8725

This information is also available from www.mhs-helpdesk.com.

1.8. Use of the Term CAPER

The Comprehensive Ambulatory Professional Encounter Record or CAPER is a subset of 
outpatient data collected in the ambulatory data module (ADM) in the CHCS. Data collected for 
professional services in the MHS is referred to as coding a CAPER.

The CAPER provides two electronic file transmissions. One is exported daily from ADM and 
sent to a central MHS database. A second file is transmitted to the Third-Party Outpatient 
Collection System (TPOCS).
ALL CODING MUST BE SUPPORTED BY THE DOCUMENTATION IN THE MEDICAL RECORD.

This section provides ICD-9-CM coding guidelines for data collection in the DoD. The following guidelines pertain to professional services coding, which includes outpatient clinic, observation, APVs (same-day surgeries), and inpatient.

2.1. Code Taxonomy (Structure)
ICD-9-CM codes are 3- to 5-digit numeric and alphanumeric codes. These codes are used to describe diseases, conditions, symptoms, and other reasons for seeking healthcare services. Some codes are modified for special use in the DoD. The first three digits usually represent a single disease entity, or a group of similar or closely related conditions. The fourth digit subcategory provides more specificity on the etiology, site, or manifestation. In some cases, fourth-digit subcategories have been expanded to the fifth-digit level to provide even greater specificity.

2.1.1. Factors Influencing Health Status and Contact with Health Services
ICD-9-CM codes beginning with the letter V are used when the patient seeks healthcare for reasons other than illness or injury. Examples include a well-baby exam or a physical. See section 2.2.8 in this chapter for more guidance.

2.1.2. External Causes of Injury
ICD-9-CM codes beginning with the letter E describe external causes of injury, poisoning and adverse reactions. They are used to describe where, why, and how an injury occurred. See section 2.2.9 in this chapter for more guidance.

2.1.3. Not Otherwise Specified (NOS)
Only use NOS codes when the documentation is insufficient to use a more specific code. This is synonymous with unspecified.

Example: A provider note indicates the patient has otitis media. Code 382.9, unspecified otitis media, is the appropriate code if the diagnostic statement or record lacks additional information, such as purulent or serous.

2.1.4. Not Elsewhere Classifiable (NEC)
Use NEC codes when there is no specific code in the classification system for the condition, even though the diagnosis may be very specific.

Example: 008.67 Enteritis due to Enterovirus NEC (Coxsackie virus, echovirus; excludes poliovirus). In this example, this code would be reported even if a specific enterovirus, such as echovirus, had been identified, because ICD-9-CM does not provide a specific code for echovirus.
2.2. Specific Diagnostic Guidelines

The following guidelines are to be followed when reporting diagnoses. The ICD-9-CM diagnostic codes are used for professional services furnished in both the inpatient and ambulatory setting. ICD-9-CM procedure codes are only used for inpatient institutional MHS coding and not professional services MHS coding.

2.2.1. Prioritized Diagnoses

The primary diagnosis is the reason for the encounter, as determined by the documentation. When a diagnosis has a manifestation, co-morbid condition, or etiology, the linked codes should be sequenced together whenever possible (e.g., diabetic skin ulcer of the ankle, coded with 250.8x and 707.13). For some cases, ICD-9-CM conventions indicate that the underlying cause should be coded first, before a manifestation. In these instances, manifestations cannot be coded as a primary diagnosis.

The chief complaint does not have to match the primary diagnosis.

2.2.2. Pre-Existing Conditions

Conditions or diseases that exist at the time of the encounter, but do not affect the current encounter are not coded. Documented conditions or diseases that affect the current encounter, are considered in decision making, and are treated or assessed, are coded. This guidance includes outpatient professional and rounds encounters.

2.2.3. Specificity in Coding Classification

Specificity in coding is assigning all the available digits for a code. Diagnostic codes should be assigned at the highest level of specificity. If a code has five digits, all five digits must be used.

- Assign three-digit codes only if there are no four-digit codes within that code category.
- Assign four-digit codes only if there is no fifth-digit sub-classification for that category.
- Assign the fifth-digit sub-classification code for those categories where it exists.
- Assign a DoD extender code if one exists (refer to the DoD Diagnosis Extender section in 2.2.6).

Example: A patient is seen for abdominal pain in the upper right quadrant; no specific cause has been determined. The appropriate diagnostic code would be the five-digit code 789.01—other symptoms involving abdomen and pelvis, right upper quadrant—as opposed to the four-digit code 789.0 (other symptoms involving abdomen and pelvis, unspecified site).

2.2.4. Selection of the Most Explicit Code

Coding should be as explicit as the documentation permits. For instance, when the provider documents acute serous OM, code 381.01 acute serous otitis media, not 382.9 unspecified OM.

2.2.4.1. Renewal/Replacement Prescription Refills
Code V68.1 is the primary diagnosis when documentation only supports a prescription refill. In most cases, this is an administrative encounter.

When a patient presents to a privileged provider and any assessment is made then the condition for which the assessment is being performed is your primary diagnosis and not the V code for prescription refill. The prescription refill V68.1 will not be used in this scenario.

2.2.5. Unconfirmed Diagnosis

When a provider is not certain of a diagnosis, capture the known manifestations, signs, symptoms, or abnormal test results.

**Example:** The diagnosis documented “rule out malignant neoplasm of the pancreas” cannot be coded, as the diagnosis is unconfirmed. The documentation indicates a mass on the pancreas. The terms *mass* and *neoplasm* are not synonymous. Therefore, the most appropriate code would be 577.9, unspecified disease of pancreas.

Although ADM permits designation of uncertain (unconfirmed) diagnoses with a *U* instead of a number, unconfirmed diagnoses are not traditionally coded. If a *U* designator is used for a diagnosis in ADM, those data are only available at the local server. The *U*-designated diagnosis cannot be the only diagnosis captured; there must be a primary diagnosis other than the *U* diagnosis. *Currently, Air Force is the only Service that permits use of a *U* designator in ADM.*

**Example:** A patient comes in with chest pain, and the provider wants to rule out myocardial infarction. The provider documents the specific symptom of chest pain as the primary diagnosis and documents the myocardial infarction code as an unconfirmed diagnosis. The provider could document the myocardial infarction code as an unconfirmed *U* diagnosis if that Service permits the designation.

**NOTE:** For inpatient professional services, see Chapter 9.

2.2.6. DoD Diagnosis Extender Codes

A number of ICD-9-CM codes have been modified to meet the needs of the Services. These codes are referred to as DoD extender codes. The one-character extender is paired with a specific ICD-9-CM code to acquire a unique meaning. The DoD established extender codes to address a number of specific reporting requirements, including physicals, asthma, hepatitis, abortion, bacterial disease, and Gulf War-related diagnoses. If an extender has been established in accordance with specificity guidelines, the root code is no longer valid for use without an extender code. See Appendix D for a complete list of DoD Extender codes. Many coders annotate the DoD extender codes in their ICD-9-CM books so they do not overlook them when looking up codes to develop superbills.

2.2.6.1. Acquired Absence of Body Part(s) or Organ(s)

For population health purposes, use V45.71 to V45.79 with the appropriate extender code to capture acquired absence of body part(s) or organ(s). The extender portion of these codes is not auditable;
as the codes are used for population health to exclude patients from preventive exams, such as mammograms.

2.2.6.2. Reaction to Vascular Devices
Codes for infection and inflammatory reactions to vascular devices and grafts, 996.62, are located in Appendix D.

2.2.6.3. Traumatic Brain Injury (TBI)
TBI extender codes are located in Appendix D; specific DoD guidelines for TBI coding are located in Appendix G.

2.2.7. Chronic Conditions
When a chronic disease is treated on an ongoing basis, it may be coded as often as treatment and care are provided to the patient for that condition.

Example: A patient is treated monthly with an epidural block and steroid injection for chronic low back pain (724.2). The code for low back pain would be reported each time the patient presented for care for this problem.

A chronic condition not addressed during the encounter that does not affect the care provided during the visit should not be coded with the encounter. Remind providers that medical decision making can be supported for higher levels of service if providers properly document.

Example: The same patient listed above also has hyperlipidemia. The patient is coming in for chronic low back pain, so unless hyperlipidemia is a factor in the care received for low back pain, it does not get coded.

2.2.7.1. Tobacco Use
For tobacco cessation see section 3.8.

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DoD Rule

When smoking is addressed (documentation of history of, or active tobacco use and referral for, or initiation of treatment) in the A&P section of the note by the privileged provider, assign “tobacco use” or “history of tobacco use” codes (305.1 or V15.82).
2.2.8. *V* Codes—Factors Influencing Health

DoD extender codes have been paired with selected *V* codes to further specify military unique services. The addition of DoD extender codes to the root code enables differentiation of the types of health assessments. The *V* codes are used to identify circumstances (diagnoses) other than disease, symptom, or injury that are the reason for an encounter, or that explain why a service or procedure was furnished. *V* codes are used to classify a patient in the following circumstances:

- **Examples:** *V04.2* would be used for the child receiving a measles vaccination in a pediatric clinic; *V65.3* would be used for the diabetic patient who receives dietary counseling.

- *V04.89* would be used for Human Papilloma virus (HPV) vaccination of girls and women 9-26 years old. Use procedure codes 90649 (HPV vaccine) and 90471 (administration).

- When a circumstance or problem influences the patient’s current illness or injury, but is not in itself a current illness or injury.

  - **Example:** A patient visits a provider’s office with a complaint of chest pain with an undetermined cause; patient status is post open-heart surgery for mitral valve replacement. Code *786.50* would be used to identify the chest pain, unspecified, and code *V43.3* would be used to identify the heart valve replaced by other means.

- When a person with a known disease or injury uses the healthcare system for specific treatment of that disease or injury:

  - **Example:** Encounter for occupational therapy for patient with cognitive deficits secondary to an old cerebral vascular accident (CVA) would be coded *V57.21, 438.0*.

2.2.8.1. DoD-Unique *V*-Code Guidance for Flyer Status

The annual flight physical or aviation exam is coded using *V70.5_1*. Flyers returning to active flight status who have an appointment to evaluate their condition should be coded using *V68.09* (medical certificate).

2.2.8.2. DoD-Unique *V*-Code Guidance for Assessments, Exams, Education, and Counseling

DoD extender codes have been paired with selected *V* codes to further specify military unique services. The addition of DoD extender codes to the root code enables differentiation of the types of health assessments. See section 6.17. for E&M coding guidance.

- **V70.5_0** Armed Forces medical exam: This is the initial general accession exam. For pre-enlistment, this initial qualifying exam is a “yes” test
that a person meets the requirements to join the military. Excludes exams covered under V70.5_8 Special Program Accession Exam.

V70.5_1 Aviation Exam: Initial qualifying and any recurring aviation exam.

V70.5_2 Periodic Health Assessments (PHA) or Prevention Assessment: Includes service member PHA documented on DD2766. Also use for a complete military physical exam which is not an accession, occupational, separation, termination or retirement exam.

V70.5_3 Occupational exam: Both initial qualifying and recurring exams because the individual works in a specific occupation or in support of occupational medicine programs (workers’ compensation). Examples include: diving, firefighter, Personal Reliability Program (PRP), protection of the president, crane operator and submariner. For return to duty following a non-aviation occupation-related condition, use V70.5_7.

V70.5_4 Pre-Deployment Related Encounter: Encounter related to a projected deployment. Could include family members experiencing a condition related to the projected deployment of the sponsor or other family member. Excludes V70.5_D which codes the encounter documented on the DD2795.

V70.5_5 Intra-Deployment encounter: Any deployment-related encounter performed while individual (active duty [AD], contractor, etc.) is deployed. Could include family members experiencing a condition related to the deployment of the sponsor or other family member.

V70.5_6 Post-deployment related encounter: Specifically performed because an individual was deployed. Could include family members experiencing a condition related to a prior deployment of the sponsor or other family member. Excludes V70.5_E and V70.5_F which code the encounters documented on the DD2796 and DD2900.

V70.5_7 Duty Status Determination encounter: Used for service members when the primary reason for being seen is to determine the ability to perform their duties. Includes re-enlistment exams determination or change in status of temporary or permanent duty limitations, deployment limiting conditions, temporary and permanent duty retirement list (TDRL/PDRL), medical evaluation board (MEB) assessments, and return to duty following pregnancy or surgery and treatment. See section 3.9.2. for MEB coding. Excludes return to flight/dive status (e.g., upchit) which is V68.09.
V70.5_8 Special Program Accession Encounter: A special medical examination on individuals being considered for special programs prior to Service entry. Exams are usually for officer candidates (Reserve Officer Training Corps [ROTC] programs, college graduates, professional schools, etc.) Other examples are DoD Medical Review Board exams, Health Professional School Program (HPSP) exams, and supplemental exams in support of Medical Examination Processing Stations.

V70.5_9 Separation/Termination/Retirement Exam: Examination performed at the end of employment and for retirement or separation.

V70.5_A Health Exam of defined subpopulations: Performed on a person in a specified group (refugees, prisoners, preschool children, etc.) other than exams identified above. Includes examinations related to the Exceptional Family Member Program (EFMP) and Overseas Screening. This is not the appropriate code for sport/school physicals, for such guidance see 6.14.1.2.1.

V70.5_B Abbreviated Separation/Termination/Retirement Exam: This code would be used when a partial examination is done within a defined period after a complete examination as an update. Guidance for abbreviated separation, termination or retirement exam will be provided by each Service.

V70.5_C Physical Readiness Test (PRT) Evaluation: Evaluation of Active duty/reserve/national guard member by a provider who is privileged to determine participation in Physical Fitness Assessment program (PFA) or physical conditioning.

V70.5_D Pre-Deployment Assessment: Documented on DD2795.

V70.5_E Initial Post-Deployment Assessment: Documented on DD2796.

V70.5_F Post Deployment Health Reassessment (PDHRA): Documented on DD2900.

V70.5_G Global War on Terrorism (GWOT)/Wounded Warriors (WW). To be used if the individual is designated a Wounded Warrior. For TBI coding, See Appendix G.

V70.5_H Other Exam Defined Population
2.2.8.3. Deployment Related Assessments

To proactively and reactively provide healthcare related to deployments, the DoD must be able to identify healthcare needs caused by deployments. Codes V70.5 4/5/6 may be used in the second, third, or fourth position to indicate some aspect or the encounter is deployment related. Codes V70.5_4/5/6/D/E/F are to be used as a primary diagnosis for an exam, assessment, or screening encounter when the purpose of the encounter is specifically deployment related.

Codes V70.5_4/5/6/D/E/F will be used in the subsequent diagnosis positions when the primary purpose of the encounter was not specifically deployment related, but “deployment related” concerns were found that should be coded as additional diagnoses.

Example: An AD member who recently returned from deployment presents to the clinic for an evaluation of a rash. The provider evaluates the patient and diagnoses the patient with cutaneous leishmaniasis related to his recent deployment to Iraq. The primary diagnosis in this scenario is 085.9 (unspecified cutaneous leishmaniasis) and the secondary code would be V70.5_6. If during this encounter the provider discovers that the patient has not completed his DD2976 and has the patient complete it, then V70.5_E should be added as an additional diagnosis. [Note: The ambulatory coding systems may not allow the use of the same code on the same record (V70.5_6 vs. V70.5_E), even as an extender code. Use the codes that best defines the services being provided.]

2.2.8.4. Reporting Scenarios for V70.5 Extender Codes.

PRT (V70.5_C)

Prior to doing Physical Readiness Testing all service members must complete a PRT screening questionnaire. If all answers are “no” the member is not referred for further follow up and completes the PRT. There is no medical encounter or coding. If any answers are “yes” the member comes in for a medical evaluation.

1. Service Member has a known medical problem, example post ACL repair. Provider does not do an exam of the Service Member. Service Member is issued a waiver from PRT. Use ICD-9 code V 70.5_C as the primary diagnosis and the medical problem(s) as secondary.

2. Service Member is referred for additional assessment face to face with privileged provider based upon answers on the PRT questionnaire. Provider reviews assessment and determines Service Member is cleared for PRT. Use E&M 99420 and ICD-9 code V70.5_C. For example, the member is referred based solely on age, but is otherwise healthy with no complaints, the provider finds the member fit to complete the PRT.

3. Service Member is referred for medical evaluation based upon answers on the PRT questionnaire. Provider reviews the assessment and finds the patient requires further evaluation and management. The encounter should be coded based on documentation and code V70.5_C as primary and other diagnoses as secondary.
Pre-deployment (DD Form 2795) (V70.5_D)
Collection of this information is for military readiness to ensure assessment is done prior to deployment.

1. The DD Form 2795 is determined to be a negative assessment and is reviewed only by a non-privileged provider, and the form is filed. Code the ICD-9 code V70.5_D under the technician’s name.

2. The privileged provider reviews the form in a face to face encounter and makes a final medical disposition. Code E&M 99420 and the ICD-9 code V70.5_D.

3. The provider identifies, addresses and documents a medical problem. The encounter should be coded based on documentation and code V70.5_D as primary and other diagnoses as additional.

Post Deployment Assessments (V70.5_E/F)
Exams will always be conducted by a face to face encounter with a privileged provider.

Initial Post Deployment (DD Form 2796) (V70.5_E)

1. If the purpose of the encounter is to complete the DD Form 2796 by the privileged provider and no medical conditions are found, code V70.5_E first and use 99420 for the E&M.

2. If the purpose of the encounter is to complete the DD Form 2796 and assessment and medical evaluation identifies medical conditions requiring treatment, code V70.5_E first and then code appropriate ICD9 codes. Use 99420 for the E&M code and additional E&M based on the documentation with modifier 25.

3. If during an encounter for other reasons, it is determined that a required DD Form 2796 has not been completed, code the appropriate ICD9 code for the principal reason for the visit and use code V70.5_E in the first four diagnosis codes. Use appropriate office visit E&M code based on the documentation.

Post Deployment Health Reassessment (PDHRA) (DD Form 2900) (V70.5_F)
Encounters involving completion of the DD Form 2900 should be coded in the same manner as specified for DD Form 2796 Initial Post-Deployment Assessment, substituting V70.5_F in place of V70.5_E.

Scenarios for coding primary complaints that are deployment related.

<table>
<thead>
<tr>
<th>Type of Patient</th>
<th>Example</th>
<th>Primary Diagnosis</th>
<th>2nd, 3rd or 4th Dx Code</th>
</tr>
</thead>
</table>

2-9
MHS Professional Services Coding Guidelines
March 2013
### Symptoms, Pre-Deployment-Related

<table>
<thead>
<tr>
<th>Description</th>
<th>Diagnosis Code</th>
<th>ICD Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>New onset bed wetting of 5-yr-old boy whose mother is about to leave on 12 month deployment.</td>
<td>788.36 (nocturnal enuresis)</td>
<td>V70.5_4</td>
</tr>
</tbody>
</table>

### Asymptomatic Concerned, Post-Deployment-Related

<table>
<thead>
<tr>
<th>Description</th>
<th>Diagnosis Code</th>
<th>ICD Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>AD soldier recently returned from deployment. Pregnant wife has concerns about depleted uranium exposure.</td>
<td>V65.5 (person with feared complaint)</td>
<td>V70.5_6</td>
</tr>
</tbody>
</table>

### Symptoms, Intra-Deployment-Related

<table>
<thead>
<tr>
<th>Description</th>
<th>Diagnosis Code</th>
<th>ICD Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>13-yr-old girl with significant weight loss. Mother suspects concern is related to father’s current deployment to Iraq.</td>
<td>783.21 (abnormal weight loss)</td>
<td>V70.5_5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>Diagnosis Code</th>
<th>ICD Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>23-yr-old Marine developed poison ivy rash while deployed.</td>
<td>692.6 (contact dermatitis caused by plants)</td>
<td>V70.5_5</td>
</tr>
</tbody>
</table>

### Medically Unexplained Physical Symptoms, Deployment-Related

<table>
<thead>
<tr>
<th>Description</th>
<th>Diagnosis Code</th>
<th>ICD Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>49-yr-old retired beneficiary has been evaluated over 3 months (5 visits) for intermittent joint pain, intermittent vertigo and severe fatigue. Patient says he believes he was exposed to something in Kuwait on mission two years ago. Work-up to date is complete, but negative.</td>
<td>799.89 (other ill-defined conditions and unknown causes of morbidity)</td>
<td>V70.5_6</td>
</tr>
</tbody>
</table>

This guidance is subject to change. More detailed information on program management is at [http://www.pdhealth.mil/](http://www.pdhealth.mil/).

### 2.2.8.5. V68.09 Issue of Medical Certificates

Medical certificates are frequently completed as part of an examination or physical. Use code V68.09 when there is no medical indication for the encounter, the patient’s reason for the encounter was solely to obtain a medical certificate; there is not another more appropriate code to reflect the primary reason for the encounter, and no symptoms, conditions, or diseases were evaluated or treated. See Section 6.6 Flight Medicine Services for an example involving flight medicine ground testing. The code V68.09 would not be used, for instance, when a student needs a sports physical, as there is a more appropriate code to reflect the reason for the visit, V70.3—other medical exam for administrative purpose.
2.2.8.6. Case Management Services
The Case Management coding and reporting framework can be found in Appendix E.

2.2.8.7. Body Mass Index (BMI)
Body Mass Index may be coded only when there has been a clinical correlation made by the physician/nurse practitioner/physician’s assistant. A diagnosis related to overweight, obesity, malnutrition, or other health (weight-related) problems must be documented. The BMI will then be coded as a secondary diagnosis. (See Coding Clinic, 2nd Qtr. 2010 for further clarification.)

2.2.9. Injuries, Poisonings, Adverse Effects, and E Codes

2.2.9.1 Injuries
Injuries are coded separately to ensure accurate capture of all data related to the type and extent of trauma. Use combination codes for multiple injuries when documentation in the record is insufficient to completely identify each injury. When coding multiple injuries the most severe injury is sequenced first. Where multiple sites of injury are specified in the titles, the word “with” indicates involvement of both sites, and the word “and” indicates involvement of either or both sites.

Do not code superficial injuries when they are associated with more severe injuries at the same site.


2.2.9.2 Poisoning
Poisoning due to drugs, medicinal substances, and biologicals is defined as conditions resulting from overdose of these substances or from the wrong substance given or taken in error.

To code a poisoning, select a code from the poisoning column of the Table of Drugs and Chemicals. If known, code the reaction/manifestation as an additional code. If a secondary code is used, the code for the poisoning must be sequenced first. Unlike coding an adverse effect, there is no code for an unknown reaction to a poisoning.

Physicians use various terms when describing poisoning such as: overdose, poisoning, toxic effect, wrong dosage given or taken, and wrong drug given or taken. Interactions between any drug and alcohol or between prescribed and over-the-counter drugs are classified as poisonings.

2.2.9.3. Adverse and Toxic Effects:

2.2.9.3.1. Adverse Effects of Drugs
An adverse drug reaction is defined as any response to a drug "which is noxious and unintended and which occurs at doses used in man for prophylaxis, diagnosis, or therapy."
Terms frequently used in diagnostic statements to identify adverse drug reaction to a correct substance properly administered are: accumulative effect, allergic reaction, idiosyncratic reaction, hypersensitivity, paradoxical reaction, side effects, synergistic reaction and antagonistic drug interactions.

For additional guidance and examples refer to ICD-9CM Official Coding Guidelines and MHS Inpatient Coding Guide Principle 13.2.

2.2.9.3.2. Adverse Effects of Surgery and Medical Care

For guidance and examples refer to ICD-9CM Official Coding Guidelines and MHS Inpatient Coding Guide Principle 15.

2.2.9.3.3. Toxic Effects

In general, exposure to harmful substances – contact with or ingestion -- is referred to as a Toxic Effect. These events are classified to categories 980-989, Toxic effects of substances chiefly non-medicinal as to source.

A toxic effect code is sequenced first. It is followed by code(s) to identify the conditions/symptoms present. External cause of injury code(s) are also used and selected from the following categories:

- E860-E869 for accidental exposure
- E950.6 or E950.7 for intentional self-harm
- E962 for assault
- E980-E982 for undetermined intent

Example:

Fisherman presents to a clinic complaining of a non-productive cough. Patient spent the last three weeks deploying booms to collect petroleum samples/reports. Provider attributes symptoms due to the toxic exposure, and documents final diagnosis as cough due to toxic effect of exposure to an oil spill. Code to:

First listed: 981 Toxic effect of petroleum product
Secondary: 786.2 Cough
Secondary: E862.1 Effect of petroleum fuel and cleaners
Secondary: Other relevant E-codes

2.2.9.4 E Codes

E codes should be used only for the first encounter at the MTF for treatment of an injury. If the patient was treated at a local civilian emergency department and received follow up or after care at the MTF, the first encounter at the MTF should have an E code. Providers should be taught always to document when initial care is received elsewhere. For follow-up care without documentation of the initial visit, assume the patient was initially treated at the MTF and do not use an E code.
An *E* code should be used with any diagnosis that indicates an injury, poisoning, or adverse effect with an external cause. In general, when the diagnosis code is in the range of 800–999, and V71.3–V71.6, at least one *E* code should be entered on the ADM record the first time the patient is seen for the condition. An example of when an *E* code would not be used for the codes listed above would be in conjunction with 917.2, blister without mention of infection, caused by walking in new shoes without wearing socks.

As many *E* codes should be assigned as necessary to fully explain each cause. All ICD-9-CM codes describing the reason for treatment must precede the *E* codes. If only one *E* code can be reported in ADM, assign the *E* code most related to the primary diagnosis or injury. Use the full range of *E* codes to completely describe the cause, the intent, and the place of occurrence, if applicable, for all injuries, poisoning, and adverse effects of drugs. Owing to limited number of reporting fields (currently four diagnoses) in the CAPER extract, the *E* codes may not be reported upward. The *E* codes should be assigned after the more critical injuries are listed. Only use *E* codes for external causes of injury. There is no additional code for most repetitive stress injuries and other injuries, such as knee pain owing to obesity or back pain caused by pregnancy.

### 2.2.10. Child and Adult Abuse Guidelines

Child and adult abuse codes may only be documented in ADM when substantiated.

When the cause of an injury or neglect is intentional child or adult abuse, the first listed *E* code should be assigned from categories E960–E968 (*Homicide and Injury Purposely Inflicted by Other Persons*), except category E967. An *E* code from category E967 (*Child and Adult Battering and Other Maltreatment*), should be added as an additional code to identify the perpetrator, if known.

In cases of neglect, when the intent is determined to be accidental, *E* code E904.0 (*Abandonment or Neglect of Infant and Helpless Person*) should be the first listed *E* code (not the primary diagnosis).

### 2.2.11. M Codes: Morphology of Neoplasms

The morphology of neoplasm is not collected in the ADM.

### 2.2.12. Abortions

The number of legal—elective or therapeutic—and illegal abortions performed in DoD MTFs must be reported to Congress annually. **Use of the 635, 636, and 637 codes should be carefully scrutinized.** Coding personnel will not use 635–638 without authorization from their supervisor.

Some of the basic rules that apply include the following:

- Fifth-digit-1, **incomplete**, indicates that all of the products of conception have not been expelled from the uterus *prior to* the episode of care.
- Fifth-digit-2, **complete**, indicates that all of the products of conception have been expelled from the uterus.
• Code 635 requires additional code to identify the reason for the abortion. Codes from categories 640–648 and 651–657 (with fifth digits 3) may be used as additional codes with an abortion code to indicate the complication leading to the abortion.

• Codes from the 660–669 series are not to be used for complication leading to the abortion.

• Retained products of conception following an abortion: Subsequent encounters with the diagnosis of retained products of conception following a spontaneous or legally induced abortion are assigned the appropriate code from category 634, spontaneous abortion, or 635, legally induced abortion, with a fifth digit of 1 (incomplete). This advice is appropriate even when the patient was discharged previously with a diagnosis of complete abortion.

• A patient who has an abortion performed outside the MTF and presents for treatment without complications is assigned code V58x. To treat a complication following an abortion, code the complication using 639x codes. Category code 639 is to be used for all complications following complete abortions. Code 639 cannot be assigned in the presence of codes 634–638.

• Illegally induced abortion (636): Not performed within prescribed statutes, performed by an unqualified individual, or performed at an unauthorized location. Do not use in DoD.

• Unspecified abortion (637): No details about the abortion are available. Do not use in DoD.

• Failed abortion (638): The elective procedure failed to evacuate or expel the products of conception (fetus) and the patient is still pregnant.

• If a code from 636 or 637 must be used, supervisor approval must be obtained and the supervisor must contact his/her Service coding representative prior to assignment.

As with all coding, it is important to select the correct 3rd, 4th, and 5th digits, as applicable. Use DoD-unique code extenders 0 (elective), 1 (therapeutic), 2 (elective, terminated elsewhere), or 9 (unspecified) with abortion codes 635 and 638.

Do not use unspecified abortion codes in DoD.

When using the code for abortions incomplete with other specified complications, an additional code is required to describe the other specified complication.

If a patient has an abortion at the MTF or elsewhere and returns for care after the abortion, with no problems present, the code is V58.49, after care, following surgery.

2.2.13. Abortion with Live-Born Fetus

When an attempted termination of pregnancy results in a live-born fetus, assign code 644.21, Early Onset of Delivery, with an appropriate code from category V27, Outcome of Delivery. The procedure code for the attempted termination of pregnancy should also be assigned.
2.2.14. Administrative Close Out of Encounters

If there is no indication of an encounter taking place in an outpatient clinic, cancel the appointment in CHCS during end of day processing.

When there is an indicator that an encounter occurred (e.g., prior to ED triage, documented technician screening, a prescription, or laboratory test or radiology study associated with the encounter), but the provider’s documentation is not available, code as follows:

Dx: V68.89, Other specified administrative purpose
Disposition Type: Will vary depending on the circumstances and documentation available.

2.2.14.1. Patient Triaged in the Emergency Department

Patients who leave without being seen (LWBS) after being triaged by a nurse/technician will be coded as follows:

Dx: None
E&M: None
Disposition Type: LWBS

2.2.14.2. Patient leaves AMA after being seen by the Emergency Department provider

Patients who leave AMA after being seen by a privileged provider but prior to being released will be coded based upon the extent of the documentation contained within the record. When the documentation does not support a minimum code of 99281 then append modifier 52 to support services rendered by the provider.

Dx: Chief Complaint/diagnosis
E&M: 9928x-52
Disposition Type: Against Medical Advice (AMA)

2.2.15. HIV

Return visit for results of HIV serology test will be assigned to code V65.44, HIV counseling. For inconclusive findings, an additional code of 795.71, Nonspecific serologic evidence of human immunodeficiency virus (HIV) would be used.

2.2.16. Ordering Screening Exams
When ordering screening examinations in a clinical setting i.e. screening mammograms, it is recommended to place the ICD-9-CM code supporting the screening procedure in the last position.

2.2.17. Aftercare vs. Follow-up
Follow ICD-9-CM coding conventions.
Chapter 3 EVALUATION AND MANAGEMENT (E&M) CODING

ALL CODING WILL BE SUPPORTED BY THE DOCUMENTATION IN THE MEDICAL RECORD.

DoD Rule

AHLTA Documentation: Autocite information will not be considered when determining the appropriate ICD-9-CM, E&M, and/or CPT code to be assigned to the encounter, unless pertinent findings are acknowledged within the body of the providers’ notes.

NOTE: This section refers to coding collected in the second data collection screen of the ADM. Only E&M codes 99201–99499 may be entered in this screen. There are other E&M codes, most frequently used in mental health, optometry or ophthalmology, physical therapy, and occupational therapy. Refer to separate sections on E&M codes outside the 99201–99499 range.

Facilities must indicate in their Coding Compliance/Protocol Plan which set of CMS guidelines each clinical service will follow. Encounters will be audited using the set of guidelines that the facility selected for the clinical service.

NOTE: Chapter 3 is organized as follows: Section 3.1. gives general information on E&M coding in the MHS. Sections 3.2. to 3.8. cover categories of E&M codes. The paragraphs follow the numbering sequence in the CPT. For instance, paragraph 3.2. provides MHS information on codes 99201–99215; paragraph 3.3 gives MHS information on the next category in the CPT, codes 99217–99236.

3.1. Evaluation and Management Coding – 99201-99499

E&M codes, a subset of CPT codes, identify the location, type, and overall complexity of a patient encounter. Modifiers clarify the E&M services provided, but their use is limited by MHS systems.

3.1.1. Determination of Level of E&M Code

The three key elements in selecting the appropriate complexity of the E&M code are history, examination, and medical decision making. These components must meet or exceed the minimum requirements specified in the E&M guidance of CPT. Certain categories of encounters, such as new patient office visits, hospital observation services, and emergency department services, require that all three key E&M components are documented. From time to time, one of these categories of services is provided, but all three components might not be rendered to the patient (example: physical exam or history is deferred). In such instances, the lowest level E&M code of that category
3.1.1.1. Documentation of Key Components

The reason for the encounter, called the chief complaint, should always be noted in the encounter documentation. This requirement can be met by printing out the reason entered by the appointment clerk in the computer system. If the chief complaint is not what the appointment clerk entered, (e.g., patient told clerk the appointment was for abdominal pain, but when the patient met the provider, the patient expressed concerns about a sexually transmitted disease), the correct chief complaint must be documented. All parts of the history (review of systems (ROS), past-family-social history (PFSH) and the chief complaint may be documented by other staff members, medical students or the patient. In the case of history of present illness (HPI), staff documentation may only be counted towards E&M leveling if the provider’s documentation demonstrates he reviewed and expanded on the staff documentation. This could be accomplished in the electronic medical record by having the provider “edit” the nurse’s S/O section and add additional information in the HPI. Only those parts of the examination, and assessment/plan that are actually documented by the privileged provider may be used in calculating the level of the encounter. Any documentation, from provider, staff member, medical students or patient, may be used to calculate the level of the encounter for the ROS and PFSH.

To certify that the provider reviewed the information documented by others, there must be an expanded notation supplementing or confirming the review. Merely documenting “Reviewed and agree” is not sufficient documentation to demonstrate that the physician truly took ownership of the history.

3.1.1.2. Self-Limited/Minor Problems

A common error in E&M leveling is to assign a self-limited or minor problem in the “Number of Diagnoses or Treatment Options” component of medical decision-making to the level of a new problem, creating a tendency to overvalue the level of medical decision-making and increasing the risk of over coding. In order to address this type of error, the CPT definition of a self-limited or minor problem will be followed.

CPT defines a self-limited or minor problem as "a problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status, OR has a good prognosis with management/compliance."

In order to comply with this CPT definition, unless the provider documents risk factors specific to the patient (e.g., co-morbidities or other extenuating circumstances) that indicate a specific increased risk of altering the health status of the patient or of worsening his or her prognosis, any self-limited or minor problems should be considered "self-limited or minor" in determining the level for diagnoses/management options and level of risk in medical decision-making. Simply stating potential risk factors or circumstances common to all patients with the problem will not justify considering the problem beyond a self-limited/minor problem.
Example of self-limited/minor problem: 22 year old male (patient of Dr A, seen by Dr B) presents for 2 day history of cough and congestion. Patient is otherwise healthy, without any other positive findings noted in Review of Systems for ENT and Respiratory organ systems or past medical, family, or social history. Provider performed exam and diagnosed patient with a URI, and prescribed a 10 day course of antibiotics. The appropriate code for this scenario is 99212; the medical decision-making would be minimal since the problem would be self-limited/minor, even though the prescription of antibiotics would result in a moderate level of risk.

Example of problem beyond the “self-limited/minor problem”: 22 year old male (patient of Dr A, seen by Dr B presents for 2 day history of cough and congestion; positive family history of asthma documented; other positive findings noted in Review of Systems for ENT and Respiratory organ systems or past medical or social history. Provider performed exam and diagnosed patient with URI and prescribed a 10 day course of antibiotic, with instructions to follow-up and consider referral to Pulmonary to assess for asthma if no improvement. The appropriate code for this scenario is 99214; the medical decision-making would be moderate since the problem would be considered new to the provider and the prescription of antibiotics would result in a moderate level of risk.

3.1.2. Coding E&M

Up to three E&M codes may be entered. Modifiers should be assigned where appropriate.

3.1.3. Privileged Providers

A privileged provider may use any E&M code that accurately reflects the services rendered and documented. A privileged provider is an independent practitioner who is granted permission to provide medical, dental, and other patient care in the granting facility, within defined limits, based on the individual’s education, licensure, experience, competence, ability, health, and judgment. Resident physicians are not independent practitioners, although they are included in the scope of privileged providers for this document. Refer to MHS Guidelines 1.1.1 regarding the description of “other qualified healthcare professionals”.

NOTE: Navy coding guidance for Independent Duty Corpsman (IDCs) and Air Force coding guidance for Independent Duty Medical Technician (IDMTs) are in Appendix B.

3.1.4. Non-Privileged Providers (Nurses and Technicians)

Non-privileged providers are normally restricted to using E&M code 99211 to document face-to-face encounters in which no procedure is performed (e.g., education by a technician or offering a service or supply item that does not have a specific code).

The following clinic services are not considered code-able events:

- TB test reading
- Patient who presents for an order for pregnancy test only
- Blood pressure checks per patient request
- Patient who presents to pick up a prescription refill
- Pulse oximetry
3.1.4.1. 5 Day BP Checks
Nurses/technicians will use the vital signs module to collect the data for the 5 day blood pressure checks.

Create an encounter for each day. Enter the blood pressure into the vital signs module of AHLTA. Code 2000F to indicate the blood pressure check; do not enter an E&M code.

3.1.5. Encounter Duration

3.1.5.1. When Time Is Not a Dominant Factor
Time is not a dominant factor for assigning the appropriate E&M code in most scenarios. The time frames identified in E&M code descriptions represent a general range of time that will vary depending on actual clinical circumstances. The severity of illness as documented by history, examination, and medical decision making should determine the choice of office visit or consultation E&M code.

3.1.5.2. Counseling and Coordination Exception
Counseling and coordination are exceptions to the time factor in selecting the E&M code. Time is the determining factor when counseling or coordination of care consumes more than 50 percent of the time a provider spends face-to-face with the patient, the family, or both.

DoD Rule

AHLTA Documentation: When a provider selects greater than 50% of time spent “counseling and/or coordinating care” and also selects the appropriate amount of floor time (face to face) then time in and time out requirement has been met.

The AHLTA documentation area for documenting time-based E&M coding is NOT to be used to document time for non – E&M time-based CPT coding.

Detailed documentation must indicate specifics on the counseling or coordination of care, discussion of why the additional time was necessary, what occurred during the additional time, and how much time was spent. Note: “counseled on condition, diagnosis, or treatment alternatives” is not acceptable documentation in and of itself.

3.1.5.3. Other Specific Exceptions
Specific exceptions when time is always a factor are prolonged services, critical care, discharge services, and patient transport. Time plays a role in the extended duration of the encounter. Extended time may be identified with E&M codes 99354–99357 (Prolonged Services).

3.1.6. New and Established Patients

To recognize the different levels of service between a patient who has not received care in a practice (and therefore needs more explanations about the operation of the practice) and an established patient (who is aware of the practice’s routines), there are different coding categories.

3.1.6.1. New Patient

A new patient is one who has not received any professional services from the privileged provider or another privileged provider of the exact same specialty and subspecialty who belongs to the same group practice in the previous three years. The reason for the initial subspecialty encounter must be documented.

The following examples would NOT qualify as a new patient encounter:

- Privileged provider of any level filling in for another privileged provider (example: PA or NP covering for MD, or an IM provider covering for Peds provider)
- Specialist embedded/assigned to the same group practice (example: BH specialist assigned to PCMH)
- Patient sees same group of providers after group practice is reorganized (example: IM patient sees same providers after IM group changes to a PCMH)
- Patient from child clinic seen in parent MTF within the installation (NOTE: Geographically separated child DMISs may be considered as separate facilities for the purpose of new vs. established)
  - Example: Patient seen in Ft. Benning, GA and then seen at Eglin AFB, FL. Eglin is a child clinic of Ft. Benning but would be new since out of the Geographic area.
- Patient seen by same provider, regardless of location

A new patient may receive initial professional services as an inpatient or outpatient. Subsequent professional services would be coded as an established patient. The encounter that determines a new patient is the first encounter a patient has that meets the criteria above and meets the requirements of a visit. Occasions of service are not coded as a new patient encounter. A common error in the DoD is coding a newborn as a new patient at its first well-baby visit with the pediatrician involved with the delivery and initial hospitalization. The first well-baby visit would be as an established patient.

3.1.6.2. Established Patient

An established patient is one who has received professional services from the provider or another provider of the exact same specialty and subspecialty who belongs to the same group practice in
the previous three years. A common error in DoD is an optometrist new to the facility coding all
patients as new. The patients who had been seen in the clinic by the previous optometrists in the
prior three years are all established patients to that optometry clinic.

DoD Rule

DoD requires the utilization of medical decision making as a
mandatory component of an established patient E&M assignment. The
provider may choose between History and Physical Exam for the second
component to determine E&M code assignment for the encounter

3.1.6.3. Determining New versus Established based on Documentation

New and established patients are determined based on documentation. If the documentation does
not specifically indicate new or established and the record is not available to review for previous
encounters, verify prior encounters in ADM. If, after research, the status of the patient cannot be
determined, the encounter will be coded as an established patient.

3.2. Office Outpatient Services, 99201–99215

These codes are used when a privileged provider collects a medically related history, performs an
exam, and makes a medical decision in a DoD healthcare facility on a patient who is not admitted as
an inpatient to a healthcare facility.

3.2.1. Shared Medical Appointments (SMA)

SMAs are visits when multiple patients meet with the provider and a behaviorist at the same
encounter. A list of chief complaints is compiled. All patients are present for those parts of the
examination not requiring privacy. The provider examines each patient individually and addresses
the patient’s issues. Immediately after completing the encounter with each patient, the provider
documents the encounter while the behaviorist furnishes general education or counseling. When the
provider completes the documentation, the provider starts the next patient’s exam. This continues
until all patients are evaluated and treated. SMAs usually take 60–90 minutes to complete. SMAs
are coded based on documentation. Only one encounter per patient will be completed. The
appropriate E&M code will be assigned according to the documentation (i.e., prevention/office
visit). The modifier TT, indicating individualized services with multiple patients present, is used
when available in the ADM.

3.3. Hospital Observation Services

See Appendix H for Coding for Observation

3.4. Emergency Department

Code procedures performed by the emergency department staff, such as infusions, injections and
medications, EKG tracings, in addition to professional services. For consultation or referral
within the ED, see Chapter 4. Not all services provided in the ED constitute use of an ED E&M
EVALUATION AND MANAGEMENT (E&M) CODING

3.5. Consultations

THIS SECTION HAS CODING INFORMATION BASED ON THE SPECIALTY CLINIC THAT PROVIDES SERVICES.

3.5.1. Consultation Guidelines

The MHS no longer recognizes consultation codes (99241-99245 and 99251-99255). Providers will use either a new patient or established patient E&M service, depending upon the setting (inpatient or outpatient) and if the patient has previously been seen by a privileged provider of the same specialty at the same facility.

3.5.2. Outpatient Guidance

A privileged provider being consulted by another provider will use an established E&M code (99211-99215) for the initial encounter if the patient has been seen face-to-face by a privileged provider in the same specialty within 3 years of the date of service. A patient will be considered as a new patient if the patient has not received any face-to-face services by a privileged provider in the same specialty within 3 years of the date of service. Professional components of procedures previously performed, in the absence of a face-to-face service, are not to be used in designating a patient as established. A subspecialist may code a new patient visit (99201-99205) for the initial encounter if the patient has not been seen by a privileged provider of the same subspecialty within 3 years of the date of service, and the documentation of the encounter clearly demonstrates that the subspecialist is being consulted for a subspeciality issue. An example would be a cardiologist sending the patient to an EP or interventional cardiologist for evaluating a patient for a pacemaker/ICD implant. All follow-up face-to-face professional encounters after the initial encounter will be coded with the appropriate established E&M code (99211-99215). This guidance will also apply to observation services.

Example: A surgeon sees a patient in the office as a consultation for another provider at the MTF. The patient is either a new or established-depending on whether the patient had been seen at least once in the previous 36 months by that surgeon or by any other provider in that same clinic. If a new patient, the surgeon should report the consultation visit at the appropriate E&M level (1 through 5) using CPT codes 99201-99205. If the patient is an established patient, the surgeon should report the consultation visit as an established patient visit at the appropriate E&M level using CPT codes 99211-99215.

3.5.3 Consults in the Emergency Department

The emergency department provider requests the specialist take over care or a portion of care. The emergency department does not intend for the patient to receive follow-up care in the emergency department. To code emergency department services with separate specialist services, two ADM records will be created.
An appointment will be generated in the emergency department. The emergency department provider will document services provided. In the documented plan of care, the emergency department provider will indicate a portion or all of the care will be transferred to the specialist. The emergency department provider will generally use a code in the 99281–99285 series and collect the care in code BIAA of Medical Expense and Performance Reporting System (MEPRS).

The specialist will document services in a separate document. The specialist will have an appointment generated in the clinic, usually a walk-in. The appointment will be marked kept, which will generate a report to be completed in the ADM. This report will be separate from the ADM report generated in the emergency department. The specialist will usually code an office visit range of 99201–99215 in the specialist’s outpatient clinic MEPRS.

If the specialist admits the patient from the ED, there would not be a specialty clinic appointment generated. The specialist’s documentation would become part of the inpatient record and collected in the initial inpatient professional service rounds appointment.

3.5.4. Inpatient Guidance
A privileged provider being consulted by the attending provider on an inpatient case will code their initial face-to-face service using inpatient codes 99221-99223. This service will be differentiated from the attending provider’s initial service by the attending provider appending modifier “AI” to their initial service code (99221-99223). All subsequent face-to-face encounters by the consulting provider will be coded with the subsequent inpatient codes (99231-99233). Refer to 9.2.4 of the MHS Guidelines for further information.

3.6 Medical Evaluation Boards (MEB)

3.6.1. Board Participation Not Code-able
Participation on the board is an administrative service and is not code-able. Time spent participating on an MEB is not collected in the B*** MEPRS, but in the FED* MEPRS.

3.6.2. MEB Services (includes initial and follow-up)
The MEB may originate from different sources; the privileged providers performing evaluations for a specific condition will be coded as an office visit, based on the documentation. The MEB initiating provider will assess the patient and request necessary consults. The consults (e.g., mental health evaluations, neurology, and orthopedics) will be coded based on the documentation. The package development by the MEB initiating provider, which incorporates all the consults and other documentation, will be coded with the 99455 or 99456 codes. The package development codes 99455 or 99456 documentation will include the following:
- completion of a medical history, commensurate with patient’s condition; performance of an examination commensurate with the patient’s condition; formulation of a diagnosis, assessment of capabilities and stability and calculation of impairment; development of future medical treatment plan; and completion of necessary documentation/certificates or reports. When the MEB meets, the primary provider presents the case, and the board makes a recommendation. MEB services do not include ongoing treatment for any disability-related condition. If the
package development takes more than 90 minutes, use the appropriate prolonged services code.
Note: V70.5_7 will be used as the primary diagnosis when recording MEB package
development.

3.7. Tobacco Cessation Counseling
Use code 99406 for smoking and tobacco use cessation counseling visit, greater than 3 minutes up
to 10 minutes: and 99407 for smoking and tobacco use cessation counseling when greater than 10
minutes. These codes can be used by qualified MTF personnel as identified by MTF policy. For
smoking cessation classes by non-privileged providers, use appropriate HCPCS level II code.
All patient-to-provider communication will be documented within the patient’s medical record. For assessment, evaluation and management via electronic communications, such as emails, the patient’s consent is required. The telephone (T-con) module may be used to document both telephone and electronic communications. Each Service may have explicit policies concerning electronic communications.

Medical record documentation for telephone or electronic communication between patient and provider will follow medical record documentation standards.

Documentation guidelines for electronic communication between patient and provider include a physician’s timely response to the patient’s inquiry and must involve the permanent storage of this communication with either hard copy or electronic storage. It also encompasses the sum of communication including related telephone calls, prescription refills, or laboratory orders associated with the same on-line encounter.

### 4.1 Telephone and Online (Email) Encounters

#### 4.1.1. Privileged Provider

For privileged providers [to include IDC’s and residents beyond post-graduate year one (PGY1)] to use the following codes, communications via telephone or electronic media must be initiated by an **established patient**. Documentation must contain evidence of medical decision making by a licensed provider directly responsible for the management of the patient’s care.

- 99441 Telephone evaluation and management service provided by a privileged provider to an established patient, parent, or guardian not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
- 99442 ; 11-20 minutes of medical discussion
- 99443 ; 21-30 minutes of medical discussion

- 99444 Online evaluation and management provided by a privileged provider to an established patient, guardian, or health care provider not originating from a related E&M service provided within the previous 7 days, using the internet or similar electronic communications network.

#### 4.1.2. Non Privileged Provider

For nurses and technicians (including IDMTs) to use the following codes, communications via telephone or electronic media must be initiated by an **established patient**.

- 98966 Telephone assessment and management service provided by a non-privileged provider to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous seven days nor leading to an assessment
and management service or procedure within the next 24 hours or soonest available appointment;
5-10 minutes of medical discussion
98967 ; 11-20 minutes of medical discussion
98968 ; 21-30 minutes of medical discussion
98969 Online assessment and management provided by a non-privileged provider to an
established patient, guardian, or health care provider not originating from a related assessment
and management services provided within the previous 7 days, using the internet or similar
electronic communications network.

**Patient initiated situations applicable for telephone and electronic communications**

Examples include the following:

- A patient describes new symptoms and requests intervention or advice from the
  privileged provider.
- In response to a patient communication, a privileged provider makes a new diagnosis and
  prescribes new treatment.
- A patient describes ongoing symptoms from a recent acute problem or chronic health
  problem and requests intervention or advice from the privileged provider to treat ongoing
  acute problem or chronic health problem.
- In response to a patient communication, a privileged provider gives substantive medical
  advice, revises a treatment plan, prescribes or revises medication, recommending
  additional testing, or provides self-care or patient education information for new or
  chronic health problem.
- A patient requests interpretation of lab or test results with evidence that the privileged
  provider is giving substantive explanation and possibly making recommendations to
  modify treatment plan, revise medications, etc.
- In response to a patient communication, a privileged provider gives extended personal
  patient counseling that changes the course of treatment and affects the potential health
  outcome.

**DoD Rule**

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There may be patient initiated communications that do not meet the criteria above and should be coded with a 99499.

Administrative telephone calls, or encounters/episode of care that would have not previously been captured or coded in MHS will now be captured as non-count and coded with 99499 in the E&M field and appropriate administrative V Code as a diagnosis.

4.1.3. Provider (privileged and non-privileged) Initiated Telephone Calls

99499 is to be used for provider initiated telephone calls. Use 99499 as the E&M in the T-CON* module, and the diagnosis as the reason for the call.

The following list gives examples where you will not apply telephone and electronic communications codes (applies to privileged and non-privileged providers):

- Telephone services referring to an E&M service performed and reported by the same provider occurring within the past 7 days
- Telephone services ending with a decision to see the patient within 24 hours or next available urgent visit appointment
- Telephone services occurring within the post-operative period of the previously completed procedure
- New patient interaction
- Provider to provider interaction
- Provider to commander interaction
- Leaving messages on answering machines
- Scheduling/Billing/Administrative issues
- Communication of non-clinical information
- Telephone services completed by residents that are PGY-1’s
- Providing test results without any medical decision making

4.2 Telehealth Services

A subset of e-Health, telehealth is the use of electronic information and telecommunications technologies to provide or support clinical healthcare, patient and professional health-related education, public health, and health administration when distance separates participants. It embraces several related areas, including electronic consultation and e-mail. Coding of telephone encounters is covered under the E&M
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section. Coding for telehealth does not encompass provider-to-provider interaction (such as provider-to-provider e-mail).

NOTE: Provider-to-provider telephone calls, images transmitted via facsimile machines and text messages without visual images (e-mail) are not considered telehealth.

4.2.1. Providers must be privileged and credentialed per their Service’s requirements to perform Telehealth services.

* clinical social workers cannot code for psychotherapy services that include medical E&M services. These practitioners may not use the following CPT codes: 90833, 90836 and 90838.

4.2.2. Documentation of Telehealth
Coders should look for telehealth encounters to be documented on an SF513 (Consultation Sheet), an approved substitute form or in AHLTA. For tele-radiology, the SF 519 (Radiographic Report) or AHLTA are used. Telehealth encounters must meet the same documentation requirements as face-to-face encounters.

4.2.3. How to Report

4.2.3.1. Real-time Communications
Telehealth may be reported for interactive audio, video, or other electronic media telecommunications permitting real-time communication between the distant site provider and the patient.

4.2.3.2. Store and Forward Telecommunications
Telehealth may also be reported for store-and-forward telecommunication that permits asynchronous transmission of medical information to be reviewed later by a provider at the distant site. The type of telehealth is identified by a modifier (see section 8.5.5 Modifiers).

4.2.3.3. Hospital Inpatients
Telehealth encounters for hospital inpatients will be reported in ADM as outpatient encounters.

4.2.3.4. Photographs
Photographs, (e.g., of a skin lesion) must be specific to the patient’s condition and show enough
detail for interpretation or confirmation of a diagnosis or treatment regimen.

4.2.4. Definitions

4.2.4.1. Originating Site
The originating site is the location where the patient is at the time the service is furnished. The
originating site will not use an E&M code for the telehealth encounter unless a separately
identifiable E&M service is documented on the same day. For encounters involving patient-
provider interaction, the visit will be entered as an office visit (e.g., 99201 or 99211) The
originating site will report telehealth episodes with Q3014 Telehealth Originating Site Facility
Fee.

4.2.4.2 Remote (Distant) Site
The remote site is the location where the consultant is at the time the service is furnished.
Services at the receiving facility are coded based on the documentation of the encounter. In
general, the consultant will code the appropriate office visit E&M code for services. Mental
health consultants will use mental health intake and therapy codes as appropriate. A provider at
the originating site is not required to present the patient to a physician or practitioner at the
remote site unless medically necessary. This decision will be made by the physician or
practitioner located at the remote site. However, the provider must be in the facility and
available to take part in the teleconference if needed.

4.2.4.3. Asynchronous Encounters: No communication between the distant-site physician or
practitioner and the patient. Typically an interpretation of a diagnostic test by the distant-site
physician.

Example: A 35 year old female presented to her primary care provider (PCP) with an 11
year history of DM controlled with insulin. Her medical history includes known background
diabetic retinopathy. The PCP sends her to the optometrist, who notes some potential retinal
changes that are worrisome. Fundus photography is performed bilaterally, and the images are
scanned and sent to the retinal specialist (remote) for interpretation. At the remote site, the retinal
specialist documents that the interpretation is a telehealth encounter, reviews and interprets the
images and provides a report to the referring provider.

Coding guidance for this scenario:

1. Originating Site codes:
   a. Diagnosis: The appropriate ICD-9-CM diagnosis code(s)
   b. E/M: 99499
   c. CPT: 92250-TC for the fundus photographs taken; and Q3014 (Telehealth
      Originating Site)

2. Remote Site codes:
a. Diagnosis: The appropriate ICD-9-CM diagnosis code(s)
b. E/M: 99499
c. 92250-26, GQ for review and interpretation of images

4.2.4. Real-Time Encounters: Real-time communication between the distant-site physician or practitioner and the patient.

Example: 25 year old AD service member was referred by PCP for evaluation regarding restless sleep, poor concentration, hyper vigilance, and irritability. A real-time telehealth encounter is conducted between the patient and a clinical psychologist. At the remote site, the clinical psychologist documents that the encounter is a telehealth encounter and conducts a review of PCP documentation; interviews patient, obtains a complete psychiatric history, including present illness, past history, and family history; and performs a complete mental status exam. The clinical psychologist provides their opinion and treatment recommendations to the PCP.

Coding guidance for this scenario:

1. Originating Site codes:
   a. Diagnosis: The appropriate ICD-9-CM diagnosis code(s)
   b. E/M: 99499
   c. CPT: Q3014 (Telehealth Originating Site)

2. Remote Site codes:
   a. Diagnosis: The appropriate ICD-9-CM diagnosis code(s)
   b. E/M: 99499
   c. CPT: 90791-GT

4.2.5. Types of Remote Professional Services: Interpretations, Referrals, and Consults.

4.2.5.1 Interpretations
An interpretation is made on limited clinical data and the finding(s) documented. The data could be transmitted electronically, via e-mail or facsimile, or by mail. If an EKG is done at one facility and transmitted to another for interpretation, the facility where the EKG was done would code 93005 and the facility where the EKG was interpreted would code 93010. Another common example would be radiology. For radiology, one facility would code the 7xxxx-TC (technical component) and the other would code the 7xxxx-26 (professional component).

4.2.5.2. Referrals
When a provider at the remote site evaluates a patient for a specific problem or condition, this is called a referral. Please refer to 4.2.1.4 for an example of a referral.

4.2.5.3. Consulting Provider
When a provider at the remote site is asked for advice on a patient, this is called a consult. As with all consults, there must be a documented request and documented report. Documentation request can be from requesting or consulting provider. The request should specify the reason for the evaluation: the report should specify opinion and recommendations and any treatment initiated. The most common example is a family practice provider at the originating site e-mailing a request for consult along with EKG tracings and other documentation to the specialist at the remote MTF. The family practitioner then telephones or goes online and discusses the patient with the specialist. The consulted provider (specialist at remote MTF) then evaluates the patient through a real-time telemedicine encounter, arrives at a diagnosis, develops a treatment plan, documents the encounter, and sends the requesting provider the consult report. This would be coded by the remote, consulted provider as a new or established office visit with the appropriate modifier.

**Situations Applicable for Online Consultations (E-Mail)**

- Patient describes new symptoms and requests intervention or advice from the privileged provider.
- Patient describes ongoing symptoms from a recent acute problem or chronic health problem and requests intervention or advice from the privileged provider to treat ongoing acute problem or chronic health problem.
- Physician is giving substantive medical advice, revising treatment plan, prescribing or revising medication, recommending additional testing, or providing self-care or patient education information for a new or chronic health problem.
- Physician makes a new diagnosis and prescribes new treatment.
- Patient requests interpretation of lab or test results and privileged provider gives substantive explanation and possibly makes recommendations to modify treatment plan, revising medications, etc.
- Clinical psychologist gives extended personal patient counseling, changing the course of treatment and affecting the potential health outcome.

**4.3. E&M Coding**

**4.3.1. Documentation Needed**

When telemedicine is applied to conduct a professional office visit or consultation between provider and patient, the appropriate E&M codes for those services should be used. In general, the initial visit will be a consult and follow-up visits will be established office visits. Documentation must be filed in the patient’s permanent medical record and should include:

- Patient’s chief complaint
- Additional information from the patient to clarify his or her condition
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- Any medications (over the counter, herbal, or prescription) being taken
- Date and time a prescription was ordered (may be available in CHCS)
- Date and time the patient is to return for care
- Electronic signature of the individual who performed the service when the online consultation is placed into AHLTA

4.4. Diagnosis Coding
Official outpatient coding guidelines will be followed for reporting diagnoses for telehealth encounters.

4.5. Procedural Coding

4.5.1 Originating Site
The originating site will report telehealth episodes with Q3014 Telehealth Originating Site Facility Fee.

4.5.2 Distant Site
The distant site may report telehealth for many store-and-forward applications including but not limited to the interpretation of:

- Colposcopy
- Obstetric ultrasound
- Electrocardiography, fetal
- Echocardiography
- ESRD-related services
- Cardiography interpretation and report
- MRI
- Laboratory results
- Video clips

4.6. Modifiers

4.6.1. Asynchronous vs. Real-Time Encounters
Telehealth encounters will be identified with one of the following modifiers:
* GQ for asynchronous encounters, or
* GT for real-time interactive encounters.

Professional telehealth services are coded with the appropriate E/M level code and telehealth modifier appended.

4.6.1.1. GT Modifiers
This signifies real-time communication between the distant-site physician or practitioner has taken place with the patient present and participating in the telehealth visit.
4.6.1.2. GQ Modifiers
This signifies the distant site physician or practitioner certifies that the asynchronous medical file was collected and transmitted to him/her at his or her distant site from an eligible originating site when the telehealth service was furnished.

4.6.2. Modifier -26
When a provider at a distant site provides an interpretation and report of a diagnostic study (e.g. laboratory or radiology test), the service is reported with the -26 modifier for the professional component of the procedure. The originating site would report the procedure with the –TC modifier if no interpretation and report are rendered.
ALL CODING WILL BE SUPPORTED BY THE DOCUMENTATION IN THE MEDICAL RECORD. Specific uses of procedural coding are listed under specialty chapters in Section 7.

5.1. Procedures

The term procedures include E&Ms not in the 99201–99499 range, such as mental health, physical therapy, occupational therapy and optometry or ophthalmology evaluations. Procedures also include supplies and durable equipment. Procedure codes are entered in the CPT/HCPCS Description position on the ADM screen. CPT procedure codes (00100–99199 and 99500+, Category II and Category III) and all of the HCPCS Level II codes are entered in the CPT/HCPCS Description position. All procedure codes will be entered before the anesthesia code for APVs. The last code listed for the institutional component of the APV will always be 99199.

ICD-9-CM procedure codes are not used when coding professional services. The ICD-9-CM diagnosis that shows the medical necessity for a procedure must be linked to the procedure. The codes for diagnostic radiology and laboratory procedures (other than those done and interpreted in the clinic such as obstetric ultrasounds and KOH tests) should only be added to the encounter when performed in the clinical setting.

Example: A child presents with ear pain. Because the tympanic membrane cannot be seen because cerumen is impacted, cerumen is removed with magnification and instrumentation. The primary diagnosis is otitis media (1). The secondary diagnosis is impacted cerumen (2). The procedure for removal of impacted cerumen, one or both ears, is coded with the CPT code 69210 and matched to impacted cerumen secondary diagnosis.

5.1.1. Minimize Use of Unlisted Procedure Codes

Efforts should be made to minimize use of unlisted procedure codes. In CPT, unlisted codes usually end in 99. In HCPCS, unlisted codes are less consistent in their numbering and may have any numbering convention (e.g., Q4050 Unlisted Cast Supplies), though the terminal digit is frequently a 9.

5.1.2. Non-Privileged Provider Procedures

When a non-privileged provider is granted permission by the MTF to do a procedure, the procedure code may be used to reflect nurse or technician services. Common examples are physical therapy technicians performing physical therapy procedures and technicians removing warts. In these cases, the technicians may only furnish the service if working under the written orders of a privileged provider.

5.1.3. Documentation Requirements for All Procedural Interpretation and Report

The documentation of the procedure and its interpretation does not have to be a separate page. The summary of the findings must contain sufficient detail that a conclusion can be made.

Simply clicking the procedure in AHLTA is not adequate documentation to support coding of a
5.2. Modifiers

Modifiers are used to indicate a service or procedure has been performed, but was altered by some specific circumstance. Modifiers are two-character codes added to the E&M or CPT/HCPCS procedures. They are alpha, numeric, or alphanumeric codes. Modifiers and their associated nomenclature are derived from two sources—CPT and HCPCS. Common modifiers can be located in Appendix C of the MHS Coding Guidelines. Not all modifiers are currently available at this time in ADM and AHLTA.

5.2.1. CPT Modifiers Approved for Ambulatory Surgery Hospital Outpatient Use

The MHS does not utilize the modifiers associated with the institutional component of an ambulatory surgery center (modifiers 27, 73, and 74). Utilize modifier 52 or 53 for procedures which have been reduced or cancelled.

5.2.2. Modifier -32 Mandated Services

The intent of this modifier is to define when another entity has a mandate, not when an entity is following its own regulations. Therefore, it is inappropriate to use this code for encounters such as flight physicals, hearing conservation screenings or newborn hearing screenings and premarital laboratory testing.

5.3. Bundled Procedures and Global Procedures

5.3.1. Bundled Procedure

Bundled procedure codes should be used whenever possible. Bundled services are a set of medical or surgical services wrapped in a group package. The components listed in a particular service are considered integral to the procedure and should not be billed separately. An example of this is a sigmoidoscopy with removal of foreign body. The code 45332 captures both procedures.

5.3.2. Global Procedures

Global procedures are similar to bundled procedures. Global surgical packages have one code for all three parts: preoperative services, the procedure, and uncomplicated postoperative care—a package deal. The global package includes low-level patient monitoring and topical anesthesia.

The encounter when a decision for surgery is made is coded as an E&M. If the decision for surgery is made within 24 hours of a procedure with a 90-day postoperative period, the E&M is appended with the -57 modifier. If the decision for surgery is made at the same encounter as a procedure with a 0-or 10-day postoperative period, the E&M is appended with a -25 modifier in accordance with guidance in 5.3.2.1.

When one provider performs the surgery, and postoperative care will be provided at a different MTF, the surgeon will code the procedure followed by modifier -54 to indicate only performance of intraoperative care. The provider at a different MTF performing the first episode of postoperative care codes the encounter using modifier -55, postoperative. Additional
uncomplicated follow-up care for this service is coded with 99024, indicating subsequent visits within the 90-day global period.

The provider may be entitled to code additional services performed in the evaluation of a new patient in accordance with procedural coding rules. When providing postoperative care, the date of procedure is included in the documentation.

5.3.2.1. E&M Services Bundled Into Procedures.

Preoperative and postoperative care protocols associated with a procedure are included in the CPT code for a minor procedure (0-10 day global period); an E&M code would not be reported in addition to the procedure. In some instances, the physician may need to indicate that on the day a procedure is identified with a CPT code as being performed, the patient’s condition required a significant, separately identifiable evaluation and management service above and beyond the usual preoperative and postoperative care associated with the procedure. For these instances, an E&M code with a 25 modifier would be reported in addition to the CPT code; the provider’s documentation must demonstrate an important, notable, distinct correlation with signs and symptoms to make a diagnostic classification or demonstrate a distinct problem causing the provider to work beyond the usual preoperative and postoperative work included in the procedure. A common error is using an E&M to code uncomplicated postoperative services already included in a global procedure. Also, an E&M code is typically not utilized on an encounter when a decision is made to perform a minor procedure (0 – 10 day global period) immediately prior to performing the procedure.

Example of E&M service bundled into the CPT code:

69 year old black female presents with complaint of soreness in her knee. The provider evaluates the knee and determines it would be beneficial for the patient to undergo an arthrocentesis. The physician performed the arthrocentesis and instructed the patient to schedule a follow up visit in two weeks. The encounter is coded 20610 for the arthrocentesis. The provider does not code an evaluation and management code since the focus of the encounter is related only to the knee pain, which resulted in the performance of the arthrocentesis.

5.3.2.1.2. MHS specific RVUs have been developed to support utilization of code 99024. Exceptions to the global surgical package are as follows:

A. The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery. This encounter would be coded with the appropriate E&M office code (99201-99215) or initial inpatient code (99221-99223) for consultation encounters. Please note that this policy only applies to major surgical procedures. The initial evaluation is always included in the allowance for a minor surgical procedure.

B. Visits unrelated to the diagnosis for which the surgical procedure is performed, unless the visits occur due to complications of the surgery.
C. Treatment for the underlying condition or an added course of treatment which is not part of normal recovery from surgery.

D. Diagnostic tests and procedures, including diagnostic radiological procedures.

E. Clearly distinct surgical procedures during the postoperative period which are not re-operations or treatment for complications. (A new postoperative period begins with the subsequent procedure.) This includes procedures done in two or more parts for which the decision to stage the procedure is made prospectively or at the time of the first procedure. Examples of this are procedures to diagnose and treat epilepsy (codes 61533, 61534-61536, 61539, 61541, and 61543) which may be performed in succession within 90 days of each other.

F. Treatment for postoperative complications which requires a return trip to the operating room (OR). An OR for this purpose is defined as a place of service specifically equipped and staffed for the sole purpose of performing procedures. The term includes a cardiac catheterization suite, a laser suite, and an endoscopy suite. It does not include a patient’s room, a minor treatment room, a recovery room, or an intensive care unit (unless the patient’s condition was so critical there would be insufficient time for transportation to an OR).

G. If a less extensive procedure fails, and a more extensive procedure is required, the second procedure is coded separately.

H. Immunosuppressive therapy for organ transplants.

I. Critical care services (codes 99291 and 99292) unrelated to the surgery where a seriously injured or burned patient is critically ill and requires constant attendance of the physician.

5.3.2.2. Services of other physicians (except where the surgeon and the other physician(s) agree on the transfer of care) are not covered under the global surgical package and thus may be coded separately. The transfer of care agreement may be in the form of a letter or an annotation in the discharge summary, hospital record, or Ambulatory Surgical Center (ASC) record.

5.3.2.3. When a patient has surgery at one clinical service/facility, the first follow-up at a different clinical service/facility will be coded with the surgical procedure code and modifier -55 (postoperative care only). Code 99024 is for all subsequent uncomplicated encounters until resolution.

5.3.2.4. Obstetrical Coding.

See section 6.10

5.4. Clinical Pharmacists
Anticoagulation INR lab tests review may be reported with appropriate diagnosis code. E&M codes are reported only once at the end of the 90 day time frame. Pharmacists will code 99363 or 99364 once the 90 day time frame has elapsed. If the services performed occur for less than 60 days each encounter must be coded using 99211.

INR lab test will be reported on each encounter if performed in the B MEPRS clinic.

Clinical pharmacists are privileged to provide patient care independently outside the pharmacy environment. These providers are usually doctors of pharmacy or pharmacists with extensive training that covers a particular range of disease processes for which they are credentialed to manage pharmacologically in a clinical setting. See Service-specific guidance for privileging procedures. Pharmacists will use Medication Therapy Management CPT codes (99605–99607) for patient treatment other than coagulation therapy. These are face-to-face timed codes that must include the following documented elements: review of the pertinent patient history; medication profile; recommendations for improving health outcomes and treatment compliance.

5.5. Chaplains and Pastoral Counselor

Chaplain and pastoral counselor services will always be non-count. On occasion, chaplains document in the hard copy medical record to communicate with medical providers. In this case, it is inappropriate to code in ADM as only Defense Health Program (DHP) funded visits should be collected in CHCS or AHLTA. To document in AHLTA as a communication tool, the documenter must be able to enter the provider (usually with nurse or technician permission). Use the provider specialty code 530 Pastoral Counselor. No workload will be credited for pastoral care. The usual diagnosis would be V62.89, Other, religious or spiritual problem or V62.6, Refusal of treatment for reasons of religion or conscience.

5.6. Electrocardiogram (ECG or EKG) Services 93000–93042

ECG/EKG has a global code (93000, 93040) when the tracing, interpretation, and report are completed in the same clinic. When the tracing (technical component) is performed in the cardiopulmonary lab or other clinic, code 93005 or 93041 for the tracing only. The provider privileged to interpret and report the ECG/EKG uses 93010 or 93042 after a report is completed to code the professional component. Interpretation only without a report is not a code-able event. An example of an interpretation would be an emergency department physician interpreting, but not creating a report for ECG tracing performed in the ED. This should be included in the medical decision-making portion of the E&M code.

NOTE: Although the interpretation does not have to be on a separate page, the summary of findings must contain sufficient detail that a conclusion of the significance of the findings can be made without the tracing itself being available. Documentation must include descriptive or tabular summary including information such as PR, QRS, QT intervals, rate, rhythm, axis, ST segment changes, along with an interpretation of these findings. Simple notations in the E&M visit notes, such as "EKG-neg" or "EKG-acute MI," are not adequate documentation.
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Example: ECG/EKG ordered and read by the same provider in conjunction with a visit. The provider would capture the tracing, as well as the interpretation and report for the ECG along with the visit and code 93000 or 93040, as appropriate. The technician performing the test could be included as an additional provider in ADM.

Example: ECG/EKG performed in a central cardiopulmonary lab and interpreted by a provider. Currently there is no module to capture and code these procedures. **NOTE:** For ADM reporting, the MTF may establish a non-count clinic, non-count appointment type in CHCS using DDA and capture the CPT tracing only code. The interpretation and report will be captured by the provider doing the initial interpretation in their B MEPRS clinic.

5.7. Laser Tattoo and Hair Removal
For laser removal of tattoos code to ICD-9-CM 709.09, use procedure code 17999. For laser hair removal of pseudofolliculitis barbae (shaving bumps) code to ICD-9-CM 704.8 and procedure code 96999.

5.8. On Call
On call codes will not be used. To enter an encounter in the ADM, a patient must be associated with the procedure code. On call is not for a specific patient.

5.9. Records Review
Records review for peer review and the Medical Record Review Committee are administrative activities. There are no CPT/HCPCS codes for administrative records review.

5.10. Injections and Infusions
To capture the immunization administration for vaccines or toxoids, for individuals younger than 19, report 90460-90461 in cases where the physician provides face-to-face counseling of the patient or family during administration of the vaccine. These two codes are not like the other administration codes as 90460 is for the first vaccine/toxoid component and 90461 is for each additional vaccine/toxoid component. For instance, if 90710 Measles, mumps, rubella, and varicella vaccine (MMRV) is administered, 90460 quantity 1 and 90461 quantity 3 would be coded.

For services provided by technicians or nurses, and services provided by providers without counseling for patients of any age, use the code range 90471–90474 and the immunization product code 90476–90479.

If a significantly identifiable E&M service is performed with a vaccine or toxoid procedure, the appropriate E&M service code should be reported in addition to the vaccine or toxoid administration.

For injections/immunization administration, documentation must include at a minimum, method of administration, unit(s), and substance.
For infusions, documentation must include at a minimum, start and stop times, method of administration, unit(s) and substance.

It is insufficient to simply select corresponding CPT codes in AP section of AHLTA note. Although this information may be reported in a different system, documentation must be contained in the AHLTA note.

5.11. Cast or Splint Application

All casts, casting supplies, and splints applied will be coded when not bundled with another procedure on the ordering privileged provider’s CAPER, with the technician listed as a secondary provider. When applying other than the initial cast or splint, also use the casting and splint supply codes Q4001–Q4051.

5.12. Dry Needling

Dry needling (also known as Intramuscular Manual Therapy (IMT)) pertains to the insertion of small, fine, solid needles into specific muscle locations or trigger points for the purpose of relieving pain caused by muscle contraction and spasm. This procedure differs from traditional acupuncture techniques. Dry needling may be performed by privileged providers within their scope of practice as defined by their service. HCPCS code S8990 will be used to code the dry needling procedure.
6.1. Anesthesia

6.1.1. Basic Tenets of Professional Services Anesthesia Coding

Anesthesia procedures are coded when local anesthesia is supplemented, or when regional, monitored anesthesia care or general anesthesia is performed by a person other than the provider performing the surgical procedure.

- Regional anesthesia is the use of anesthetic agents with or without sedation to provide pain relief or the loss of sensation to a specific area of the body, such as epidural anesthesia or a brachial plexus block.
- General anesthesia is the total loss of consciousness and reflexes caused by the administration of drugs and inhalation agents.
- Monitored anesthesia care (MAC) is intra-operative monitoring by an anesthesiologist or CRNA of the patient’s vital signs, in anticipation of possible need to transition to general anesthesia. The patient maintains an airway and responds to verbal stimuli, except possibly for brief periods of time (e.g., fewer than 60 seconds).

6.1.2. Reporting B MEPRS for Anesthesia Services

The professional component of anesthesia services will be captured on the lead surgeon’s ADM encounter. The anesthesia code will be sequenced after all procedures performed by any surgeons and before the 99199 code for the institutional component of the APV. Procedures performed by the surgeon should be linked to the surgeon. Procedures performed by the anesthesia provider should be linked to the anesthesia provider.

DoD Rule

Anesthesia services will be reported in MTFs when performed by a provider other than the surgeon using anesthesia procedure CPT codes: 00100–01999.

MTFs will list anesthesiologists or CRNAs as additional providers on the surgeon’s record in the ADM.

6.1.3. Providers
6.1. Anesthesia

6.1.3.1. Anesthesia Performed by a Provider Other than the Surgeon
When the provider administering and monitoring the anesthesia is a provider other than the
surgeon (e.g., another physician, anesthesiologist, or CRNA), the anesthesia services will be
reported using anesthesia procedure CPT codes: 00100–01999.

6.1.3.2. Anesthesia Performed by Provider Also Performing Surgical Procedure
When the provider performing the surgical procedure also administers and monitors the
anesthesia, a surgical CPT procedure(s) code and not an anesthesia code is applied. Append
modifier -47 to the surgical procedure code.

6.1.4. Gathering Documentation
Medical records will be reviewed for the anesthesia provider’s documentation supporting
the use of regional, MAC, or general anesthesia. Generally, these anesthesia services can
be found on DA Form 7389 for the Army or OF 517 for the Navy and Air Force.

6.1.4.1. When Not to Code for Anesthesia Services

6.1.4.1.1. Types
Anesthesia services are NOT coded when the procedure is performed using the following types
of anesthesia:

- topical;
- local infiltration of anesthetic agents to a limited area, such as those used for minor
  procedures like biopsies, and the excision of skin tumors and lesions; or
- metacarpal, metatarsal, or digital block.

6.1.4.1.2. Procedures
Anesthesia guidelines in the CPT coding manual and the National Correct Coding Initiatives
(NCCI) provide guidance on the services that are inclusive to the provision of anesthesia, and
therefore are not coded separately. They are:

- normal pre- and post-anesthesia visits;
- provision of fluids or blood;
- normal monitoring of vital signs, EKG, pulse oximetry, capnography (blood carbon
dioxide concentration), and mass spectrometry;
- laryngoscopy for placement of airway and placement; and
- nerve stimulation to determine level of consciousness.

6.1.4.1.3. Moderate Sedation (Previously Termed Conscious Sedation)
Clinicians use moderate sedation to achieve a medically controlled state of depressed
consciousness while maintaining the patient’s airway, protective reflexes, and ability to respond
to stimulation or verbal commands. Review CPT code descriptions to avoid unbundling as some
procedures (e.g., some endoscopies) include moderate sedation. Moderate sedation is reported
when the physician performing the surgical procedure also provides the moderate sedation.

MHS Professional Services Coding Guidelines
March 2013
Moderate sedation requires an independent observer be present to assist the physician in monitoring the patient’s level of consciousness and physiologic status. Report moderate sedation on the surgeon’s ADM entry in the appropriate MEPRS code.

6.1.5. Additional Anesthesia Procedures

Other forms of monitoring by anesthesia personnel will be coded on the surgeon’s ADM encounter when they are done by an anesthesia provider. These codes should be linked to the anesthesia provider. For example:

- Central venous puncture (CVP) line insertion,
- Intra-arterial lines,
- Swan–Ganz catheters,
- Emergency intubation,
- Critical care visits and
- Transesophageal echocardiography.

6.1.6. Coding Anesthesia

6.1.6.1. Coding with a Crosswalk

Anesthesia can be coded in a number of ways. A crosswalk between surgical procedures and anesthesia is available from a variety of sources, including the American Society of Anesthesiologists (www.asahq.org) or the Coding Compliance Editor (CCE). When a crosswalk is not available, follow the steps below.

6.1.6.2. Coding without Crosswalk:

1. Identify all surgical procedures performed.
2. Refer to the main term, anesthesia, in the CPT index.
3. Search for a sub-term to indicate the anatomic site of the procedure or the actual procedure performed.
4. Reference the code or codes noted in the index’s tabular portion of the CPT codebook.
5. Read and apply any notes in the index or in the tabular portion of the CPT codebook.
6. If multiple anesthesia services are performed in the same session, the anesthesia procedure with the highest base unit will be determined (see the “Relative Value Guide,” published by the American Society of Anesthesiologists).
7. To calculate the base units for multiple anesthesia services, see section 6.1.8 Base Unit in this document.
8. At this time the MHS cannot accommodate modifiers for anesthesia. Therefore, the MHS does not report medical direction or supervision.
6.1. Anesthesia

6.1.7. Base Unit

A base unit reflects the difficulty (or level of acuity) of the anesthesia service. The base unit includes the initial anesthesia assessment to determine if the patient is an anesthesia candidate. It also includes the following services, usually provided on the day of surgery:

- preoperative visit,
- postoperative visit, and
- administration of fluids or blood products incident to the anesthesia care and interpretation of non-invasive monitoring.

Each anesthesiology CPT code is assigned a base unit value in the Medicare Relative Value Guide. It is available at the CMS Website: [http://www.cms.hhs.gov/center/anesth.asp](http://www.cms.hhs.gov/center/anesth.asp) in Appendix A, Chapter 8, Medicare Carriers Manual, Part 3.

6.1.8. Single Code Exceptions for Anesthesia

There are exceptions to the inclusion of all anesthesia procedures performed during the same surgical session under one code. The exceptions are the anesthesia add-on codes for the excision or debridement of burns (that accommodates percentage of body surface) and obstetrical anesthesia (that allows for time). The anesthesia add-on codes have separate base units. All add-on codes are reported in addition to the principal procedure code(s). They are never used as the first-reported or solo code.

6.1.9. Identifying Type of Provider

When available in the MHS systems, an HCPCS level II modifier identifies the provider as an anesthesiologist or CRNA. The modifier indicates whether the CRNA provider is or is not under the medical direction or supervision of an anesthesiologist. Additionally the modifier indicates the number of cases directed or supervised by a provider. The physician or anesthesiologist and the anesthetist both report their services with the appropriate modifier.

6.1.10. Coding Anesthesia for Cancelled Procedure

If the procedure is cancelled or terminated prior to the induction of anesthesia or the administration of drugs or medication, but there has been a pre-surgical anesthesia assessment, then code the anesthesia with the appropriate low level E&M.

If the surgical procedure is cancelled or terminated after preparation of the patient for anesthesia, assign the anesthesia code for the anticipated surgical procedure, along with the appropriate modifier -53 for discontinued procedure.

6.1.11. Aborted Procedure

If the surgical procedure is cancelled or terminated (not patient elective) after the surgical procedure has started, assign the appropriate anesthesia code for the procedure in the routine manner, based on the actual procedure performed. Do not use modifier -53 on anesthesia codes. Modifier -53 would be used on the surgical procedure code.
6.1.1. Monitored Anesthesia Care (MAC)
MAC entails intra-operative monitoring of the patient’s vital physiological signs in anticipation of the need for administration of general anesthesia or in the event the patient develops physical complications from the surgical procedure. To report MAC, the anesthesia provider must:

- provide a pre-anesthesia evaluation and examination;
- prescribe the anesthesia plan;
- dispense any oral or parenteral anesthesia drugs to the patient;
- provide intra-procedural monitoring of patient’s vital signs, maintenance of the patient’s airway, and continual evaluation of vital functions;
- conduct any postoperative care needed; and
- maintain adequate medication and ensure pharmacological equipment is readily available at all times.

Because MAC requires at least the same level of monitoring as that of general anesthesia, it is treated the same as general anesthesia except that the appropriate modifiers should be coded when they become available in the DoD system. Medical necessity must be documented to support the need for MAC.

6.1.1.3. Reporting Qualifying Circumstances
Additional codes are needed to report unusually difficult circumstances for anesthesia administration. The qualifying circumstances codes are in the Medicine Section of the CPT. They are also listed in the beginning of the Anesthesia Section of the CPT coding manual. These codes are not stand-alone codes. More than one qualifying circumstance code can be used if applicable.

<table>
<thead>
<tr>
<th>Qualifying Circumstances</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>+99100</td>
<td>Anesthesia for patient of extreme age, under 1 year and over 70 (List separately in addition to code for primary anesthesia procedure).</td>
</tr>
<tr>
<td>+99116</td>
<td>Anesthesia complicated by use of total body hypothermia (List separately in addition to code for primary anesthesia procedure).</td>
</tr>
<tr>
<td>+99135</td>
<td>Anesthesia complicated by use of controlled hypotension (List separately in addition to code for primary anesthesia procedure).</td>
</tr>
<tr>
<td>+99140</td>
<td>Anesthesia complicated by emergency conditions (specify) (List separately in addition to code for primary anesthesia procedure).</td>
</tr>
</tbody>
</table>

6.1.1.4. Postoperative Pain Management

6.1.1.4.1. Overview
The most common techniques for postoperative pain control are patient-controlled analgesia (PCA), epidural analgesia, and nerve blocks. Postoperative pain management is only reported
when the attending surgeon requests, in writing, that the anesthesia provider performs significant, separately identifiable services, such as ongoing critical care services, postoperative pain management services, or extensive unrelated ventilator management.

6.1.14.2. Patient Controlled Analgesia
PCA therapy is a technique for pain management that involves self-administration of intravenous drugs through an infusion device. When PCA is initiated in the recovery room by an anesthesiologist as part of the anesthesia time, the initial set-up time for PCA may be incorporated into the total number of anesthesia time units reported.

6.1.14.3. Epidural
Epidural analgesia involves the administration of a narcotics drug through an epidural catheter. Insertion of an epidural catheter should be reported as a separate procedure code. Management of epidural or subarachnoid drug administration (CPT code 01996) is reported on dates of service after the date of the surgery. Management of epidural or subarachnoid drug administration is limited to one unit of service per postoperative day, regardless of the number of visits necessary to control the catheter per postoperative day. Postoperative pain management services are generally provided by the surgeon, who is reimbursed under a global payment policy related to the procedure and is reported by the anesthesia provider only when separate, medically necessary services are required that cannot be rendered by the surgeon. The surgeon is responsible for documenting in the medical record the reason care is being referred to the anesthesia provider.

6.1.14.4. Nerve Block
A nerve block injection involves injection of an anesthetic agent into or around a given nerve. When an injection or block is administered postoperatively by an anesthesia provider in the recovery room as part of the anesthesia time, any additional time required for the injection may be included in the total number of anesthesia minutes reported.

6.1.15. Physical status modifiers are used in the civilian sector but not currently used in DoD.

6.1.16. Anesthetic Agents
Anesthetic agents, as well as other medications (e.g., anti-emetics, antibiotics) are part of the institutional component of the surgery. They are not coded separately.
6.2. Audiology

6.2.1. Evaluation & Management (E&M) Rules

E&M codes are not appropriate for routine audiology encounters for procedures. The medical E&M components of an outpatient office visit are already included in the special procedures codes listed in the Special Otorhinolaryngologic Services subsection.

Encounters with patients for whom no procedure is done are reported with an E&M code (99201–99205 or 99211–99215) based on the chief complaint, history, exam, and decision making documented in the medical record.

6.2.2. Diagnosis Coding Rules

6.2.2.1. Extender Codes

See Appendix D for a complete list of all extender codes.

V72.1 Examination of Ears and Hearing
- V72.11* 0 Encounter for Hearing Examination Following Failed Hearing Screening.
- V72.11* 1 Encounter for Hearing Examination Following Failed Hearing Screening, Otoscopic Exam Done
- V72.11* 2 Encounter for Hearing Examination Following Failed Hearing Screening, Otoscopic Exam Not Performed
- V72.19* 0 Other Examination of Ears and Hearing
- V72.19* 1 Other Examination of Ears and Hearing, Otoscopic Exam Done
- V72.19* 2 Other Examination of Ears and Hearing, Otoscopic Exam Not Performed

6.2.2.2. Hearing Conservation Program (HCP)

HCP guidelines in DA Pam 40–501 or other Service guidelines require all military and civilian personnel who routinely work in noise-hazardous areas to have reference (base line), annual, and terminal audiograms.
Hearing Conservation Program services are coded in a Special Program service in an F MEPRS clinic (FBN*). Please refer to your Service MEPRS Office for workload reporting.

Hearing tests performed in other than an audiology clinic or for HCP are reported in the clinic where the test or procedure is performed. These examination encounters are coded according to the table below. The table includes only codes for HCP encounters leading to referral to an audiology clinic.

Official ICD-9-CM coding guidelines state that both V70.5 and V72 codes are only listed first. Code V72 excludes V70.5. However, for the DoD to identify the specific type of HCP exam, particularly those with an identified significant threshold shift (STS), or permanent threshold shift (PTS), both codes are reported in the order shown for HCP exams.

HEARING CONSERVATION PROGRAM (HCP) TABLE
### SPECIALTY CODING

6.2. Audiology

<table>
<thead>
<tr>
<th>Encounter Type</th>
<th>ICD-9-CM Diagnosis Codes</th>
<th>E&amp;M Codes</th>
<th>CPT Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accession exam in basic training with no abnormalities</td>
<td>V70.5_8 and V72.1*</td>
<td>N/A</td>
<td>92552 (Individual), 92559**(Group)</td>
</tr>
<tr>
<td>Accession exam in basic training with abnormalities</td>
<td>V70.5_8 and V72.1*, plus 794.15***</td>
<td>N/A</td>
<td>92552 (Individual), 92559**(Group)</td>
</tr>
<tr>
<td>Exam at start of routine employment involving hazardous noise with no abnormalities</td>
<td>V70.5_3 and V72.1*</td>
<td>N/A</td>
<td>92552 (Individual), 92559**(Group)</td>
</tr>
<tr>
<td>Exam at start of routine employment involving hazardous noise with abnormalities</td>
<td>V70.5_3 and V72.1*, plus 794.15***</td>
<td>N/A</td>
<td>92552 (Individual), 92559**(Group)</td>
</tr>
<tr>
<td>Annual exam with no identified STS</td>
<td>V70.5_3 and V72.1*</td>
<td>N/A</td>
<td>92552 (Individual), 92559**(Group)</td>
</tr>
<tr>
<td>Annual exam with an initial STS identification</td>
<td>V70.5_3 and V72.1* plus 794.15***</td>
<td>N/A</td>
<td>92552 (Individual), 92559**(Group)</td>
</tr>
<tr>
<td>Annual exam with a previously confirmed PTS</td>
<td>V70.5_3 and 388.1X* or 389.XX*</td>
<td>N/A</td>
<td>92552 (Individual), 92559**(Group)</td>
</tr>
<tr>
<td>Follow-up 1 or 2 for STS identified during current annual or follow-up 1 exam</td>
<td>794.15***</td>
<td>N/A</td>
<td>92552 (Individual), 92559**(Group)</td>
</tr>
<tr>
<td>Termination exam at end of employment or separation from active duty</td>
<td>V70.5_9 and V72.1*</td>
<td>N/A</td>
<td>92552 (Individual), 92559**(Group)</td>
</tr>
</tbody>
</table>

* Indicates there are various 4th and 5th digits or extender codes that may be assigned to indicate a specific condition or encounter

** For patients tested using Defense Occupational and Environmental Health Readiness System-Hearing Conservation (DOEHRS-HC).

*** Code to be used by non-professionals (e.g., technicians, nurses, volunteers). Only physicians or audiologists may diagnose noise-induced hearing loss.

**NOTE:** 99078 may be used as an additional code if physician education services are provided in a group setting.

### 6.2.2.3. Hearing Loss Caused by Injury

Initial encounters for hearing loss acquired from performance of duties, but not associated with physical trauma to the head will be identified with the appropriate E code as a secondary diagnosis. E codes are only used for the first encounter for the condition that was caused by the...
situation described by the *E* code. There is an injury or accident field in the ADM that should be answered *yes* each time the patient is seen for a condition caused by an accident or injury.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E923.8</td>
<td>Other Explosive Material—explosions not a result of war operations</td>
</tr>
<tr>
<td>E928.1</td>
<td>Exposure to Noise</td>
</tr>
<tr>
<td>E993</td>
<td>Injury Caused by War Operations by Other Explosion—including accidental explosion of own weapon</td>
</tr>
<tr>
<td>E995</td>
<td>Injury Caused by War Operations by Other and Unspecified Forms of Conventional Warfare—for hearing losses caused by exposure to other noises during war operations</td>
</tr>
</tbody>
</table>

### 6.2.2.4. Early Hearing Detection and Intervention (EHDI)

EHDI will not be coded on the SIDR. EHDI screening exams and interventions are coded according to the table below. The table includes only codes for EHDI encounters.

#### NEWBORN EARLY HEARING DETECTION AND INTERVENTION

<table>
<thead>
<tr>
<th>Encounter Type</th>
<th>ICD-9-CM Diagnosis Codes</th>
<th>CPT E&amp;M Codes</th>
<th>CPT Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn hearing screening with no abnormalities performed in audiology clinic***</td>
<td>V72.1**</td>
<td>If applicable, 99xxx</td>
<td>92586 or 92587</td>
</tr>
<tr>
<td>Newborn hearing screening with abnormalities performed in audiology clinic***</td>
<td>V72.1** and 794.15* or 389.XX**</td>
<td>N/A</td>
<td>92586 or 92587</td>
</tr>
<tr>
<td>Follow-up with no abnormalities</td>
<td>794.15</td>
<td>N/A</td>
<td>92585 and 92588</td>
</tr>
<tr>
<td>Follow-up with abnormalities</td>
<td>389.XX*</td>
<td>N/A</td>
<td>92585 and 92588</td>
</tr>
<tr>
<td>Intervention 1</td>
<td>389.XX*</td>
<td>N/A</td>
<td>92590, 92591, or 92700</td>
</tr>
<tr>
<td>Intervention 2</td>
<td>389.XX*</td>
<td>N/A</td>
<td>92590, 92591, or 99002</td>
</tr>
<tr>
<td>1st follow-up to intervention</td>
<td>389.XX*</td>
<td>N/A</td>
<td>92590, 92591, 92594 or 92595</td>
</tr>
</tbody>
</table>

* Code to be used by non-professionals (e.g., technicians, nurses, volunteers).

** Indicates there are various 4th and 5th digits that may be assigned to indicate a specific condition or encounter.

*** Initial screening exam for patients not tested in the hospital prior to discharge from birth episode.

### 6.2.3. Procedural Coding Rules

#### 6.2.3.1. CPT procedure Codes for Audiology

These services are in the Special Otorhinolaryngologic Services subsection of the Medicine section (92502–92700). Codes in the 92500 series do not require the supervision of a physician. Tests in this series can be performed by a qualified audiologist, but diagnostic procedures must be ordered by a physician.
6.2. Audiology

6.2.3.2. Cerumen Removal
Removal of cerumen is considered integral to audiology services. Instillation of drops, minor scraping, or simple irrigation is bundled into the evaluation portion of audiology service. If a physician removes impacted cerumen before audiology testing, the physician should use code G0268. In all other circumstances, use 69210 for removal of impacted cerumen. Removal of cerumen to see the tympanic membrane is included in the E&M component. The physician or audiologist may report separate E&M service with modifier -25.

6.2.3.3. Tinnitus
Audiologists are qualified to evaluate, diagnose, develop management strategies, and provide treatment and rehabilitation for tinnitus patients. Diagnostic audiologic testing for tinnitus is reported with CPT code 92625.

6.2.3.4. Hearing Equipment Services
Services related to fitting, providing or repairing hearing supplies and equipment, excluding implantable bone conduction devices, are reported with HCPCS Level II codes V5008–V5299.

6.2.4. Other Audiology Guidance

6.2.4.1. Documentation of Hearing Conservation
The results of administering all aspects of monitoring audiometry with the DOEHRS HC equipment is documented by completion of the following:

- DD Form 2215 Reference Audiogram
- DD Form 2216 Hearing Conservation Data

6.2.4.2. Dispositions or Referrals
DOEHRS HC software will automatically determine if an Occupational Safety and Health Administration (OSHA)-reportable hearing loss (RHL) is present and will provide disposition instructions.

6.2.5. Modifiers
TC Technical Component is used by technicians who perform tests in a different clinic than the one used by the audiologist who interprets the test and renders a report.
26 Professional Component is used by the audiologist who only interprets tests performed elsewhere and provides a report.
52 Reduced Service is used when audiologic function tests (except 92559) are performed on one ear only.
6.3. Chiropractic Services

6.3.1. E&M Rules

6.3.1.2. Initial Encounter for a Problem
If chiropractic manipulative treatment (CMT) was furnished during the initial encounter, indicating the chiropractor accepted the patient for treatment of the problem, and a separately identifiable chiropractic evaluation was conducted, use an E&M code, usually in the new or established office visit codes (9920x/9921x) with a modifier -25, along with the CMT procedure code (98940–98943).

6.3.1.3. Referrals
If there is a request for the chiropractor to evaluate and treat the patient, this is a referral. CMT covers pre- and post-services, including an assessment specific to CMT. The documentation must reflect a history, exam or decision of something not related to the CMT to use a separate E&M code.

6.3.1.4. Consult When CMT Not Appropriate
If there is a request for evaluation and advice, and the chiropractor determines that CMT is not appropriate for the patient, and sends advice back to the provider who requested the consult, and all other requirements are met, the appropriate office visit code should be used.

6.3.1.5. Consult When CMT Is Appropriate
When there is a request for evaluation and advice; the chiropractor determines that CMT would be appropriate but has not yet begun it; the chiropractor sends advice back to the consulting provider and meets all other requirements, the appropriate office visit code should be used.

6.3.1.6. CMT
When an encounter is for CMT and the evaluation is limited to reviewing data to ensure CMT is still appropriate, there is no separately identifiable E&M and only the CMT code should be used.

6.3.1.7. Reevaluation
When there are separately identifiable E&M services beyond those needed for CMT, such as when the chiropractor re-exams the patient to obtain objective measures of progress, and the treatment plan is modified as necessary, a separate E&M coded (usually from the established office visit range, 9921x) should be coded.

6.3.1.8. The AT Modifier
Use the AT modifier when the treatment is for active or corrective treatment, when the documentation shows that treatment is medically reasonable or necessary under Medicare rules. The AT modifier is not used for maintenance therapy, such as services that seek to prevent disease, promote health, maintain or prevent deterioration of a chronic condition, or enhance the quality of life.
6.3.2. Procedural Coding Rules

**DoD Rule**

The CMT procedure codes are 98940–98943. Use only one code per session unless both spinal and extra spinal are performed.

6.3.2.1. Manual Therapy Techniques

Manual therapy techniques are coded 97140. The provider uses his/her hands to perform soft tissue massage and joint mobilization, manipulation, manual traction, or manual lymphatic drainage to one or more areas. The code requires direct one-on-one contact with the patient.

6.3.3. Modifiers

- **25** Separate or distinct E&M services
- **51** Multiple procedures (when unrelated procedures are done at the same encounter)
- **59** Distinct procedural service (when one code is usually included in another but for an unusual reason both were done separately).
6.4. Dialysis

6.4.1. E&M Rules
E&M services associated with or related to the performance of dialysis, performed on the same day as the dialysis, are included in the dialysis procedure; therefore, no separate E&M code is reported. If there is a separately identifiable E&M, unrelated to the dialysis, that E&M shall be coded based on documentation and appended with modifier 25.

6.4.2. Procedural Coding Rules. See 6.5.5 for a sample list of dialysis procedures.

6.4.2.1. Individual Dialysis Therapy Encounters
In the MHS, each encounter is coded. Therefore, except for the first encounter of the month, each encounter is coded using an unlisted code of 90999 in the CPT/Procedure field.

6.4.2.2. Monthly Dialysis Codes
The monthly dialysis codes will always be used for the first dialysis of the new month to reflect the previous month’s treatment. For instance, it will reflect 31 days for January and 30 days for April.

6.4.2.3. Dialysis for Less than an Entire Month
Dialysis does not always begin the first day of the month. On the first dialysis of the month following initial treatment, instead of the monthly code, use the per day codes to reflect services from the start of care through the end of the prior month. Code 90967-90970 should be reported for each day outside of inpatient hospitalization.
Example: A 10 yr. old patient is admitted to the hospital on the 11\textsuperscript{th} of the month and discharged on the 27\textsuperscript{th}. On the first dialysis visit in the next month, code 90968 with a quantity of 13 for the days the patient was not an inpatient the prior month. (30 days in the month minus 17 days of hospitalization = 13 days). Report inpatient E&M services as appropriate. Dialysis procedures rendered during hospitalization are coded as part of the hospitalization.

6.4.2.4. Dialysis for Entire Month
To code dialysis, the first visit of the month will be used to record the appropriate monthly or per day code for services the previous month. All other visits will use the unlisted dialysis code of 90999 for the procedure. If any of the encounters of the prior month were conducted by a non-privileged provider, the first encounter of the new month must be collected in the DGB or DGD MEPRS, with the individual performing the service that day listed as the provider.

6.4.2.5. Privileged Provider
If a privileged provider performs the dialysis, the provider’s name should be listed as the primary provider. If a separately identifiable E&M service is performed, use the appropriate E&M code with modifier -25. When a privileged provider furnishes a dialysis service, the encounter will usually be collected in the BAJ MEPRS as a count encounter.

6.4.2.6. Non-Privileged Provider
Dialysis procedures should only be conducted by a non-privileged provider following a written treatment plan of a privileged provider. When a non-privileged provider performs the dialysis, the non-privileged provider should be listed as the primary provider.

6.4.2.6.1. Dialysis treatment is usually done by non-privileged providers whose time is collected in the DGB or DGD MEPRS. Therefore, a “clinic” must be created in the DGB or DGD MEPRS where appointments will be created and marked as kept and ADM reports will be collected. When a non-privileged provider performs the service, the encounter must be entered as a non-count encounter.

6.4.3. Diagnosis Coding
The first listed diagnosis, when the patient is only being seen for ongoing dialysis treatment, is in the V56 category. A secondary diagnosis will be used to explain why the dialysis is necessary, such as chronic kidney disease.
6.5. End Stage Renal Disease Services (ESRD) (90951–90970)

6.5.1. Included Services
ESRD-related physician services include establishment of a dialyzing cycle, outpatient evaluation and management of the dialysis visits, telephone calls and patient management during the dialysis, provided during a full month. These codes are not used if a hospitalization occurred during the month.

6.5.2. E&M Rules
The E&M services associated with or related to performance of dialysis for ESRD services, when performed on the same day as the dialysis, are included in the ESRD procedure. Therefore no separate E&M code is reported. If there is a separately identifiable E&M, unrelated to the dialysis procedure, that E&M shall be coded based on documentation and appended with modifier -25.

6.5.3. Procedural Coding Rules
In general, using ESRD codes is similar to using the dialysis codes in section 6.4. Because ESRD is a Medicare-covered benefit there are specific HCPCS codes. These codes (90951–90970) are more detailed and are used when the code requirements are met. The HCPCS Level II codes are used in the same manner as the dialysis CPT (HCPCS Level I) codes. ESRD services are usually captured in the BAJ* MEPRS (Nephrology).

DoD Rule

When ESRD service is performed, no procedure codes will be reported, except for the first encounter of the month, to reflect the previous month’s services.

Hint: To determine the number of ESRD encounters during the month, use the patient appointment history in AHLTA/CHCS.

6.5.4. ESRD Diagnosis Coding
Use ESRD 585.6. Use V42.0 as an additional code to identify kidney transplant status if applicable.

6.5.5. Dialysis and ESRD Procedure Code List.
End Stage Renal Disease Services (90935-90970)

90951 ESRD-related services during the course of treatment, for patients under 2 years of age, including monitoring for adequacy of nutrition, assessment of growth and development and counseling of parents; with four or more face-to-face physician visits per month.
SPECIALTY CODING

6.5. End Stage Renal Disease Services (ESRD) (90951–90970)

90952 ESRD-related services during the course of treatment for patients under 2 years of age, including monitoring for adequacy of nutrition, assessment of growth and development and counseling of parents; with two or three face-to-face physician visits per month.

90953 ESRD-related services during the course of treatment, for patients under 2 years of age including monitoring for adequacy of nutrition, assessment of growth and development, and counseling of parents; with one face-to-face physician visit per month.

90954 ESRD-related services during the course of treatment, for patients between 2 and 11 years of age, including monitoring for adequacy of nutrition, assessment of growth and development and counseling of parents; with four or more face-to-face physician visits per month.

90955 ESRD-related services during the course of treatment, for patients 2 to 11 years of age, including monitoring for adequacy of nutrition, assessment of growth and development and counseling of parents; with two or three face-to-face physician visits per month.

90956 ESRD-related services during the course of treatment, for patients 2 to 11 years of age, including monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with one face-to-face physician visit per month.

90957 ESRD-related services, during the course of treatment, for patients between 12 and 19 years of age, including monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with four or more face-to-face physician visits per month.

90958 ESRD-related services during the course of treatment, for patients between 12 and 19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with two or three face-to-face physician visits per month.

90959 ESRD-related services during the course of treatment, for patients between 12 and 19 years of age, including monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with one face-to-face physician visit per month.

90960 ESRD-related services during the course of treatment, for patients 20 years of age and older; with 4 or more face-to-face physician visits per month.

90961 ESRD-related services during the course of treatment, for patients 20 years of age and over; with two or three face-to-face physician visits per month.

90962 ESRD-related services during the course of treatment, for patients 20 years of age and over; with one face-to-face physician visit per month.
SPECIALTY CODING
6.5. End Stage Renal Disease Services (ESRD) (90951–90970)

90963 ESRD-related services for home dialysis patients per full month; for patients less than two years of age including monitoring for adequacy of nutrition, assessment of growth and development and counseling of parents.

90964 ESRD-related services for home dialysis patients per full month; for patients two to eleven years of age including monitoring for adequacy of nutrition, assessment of growth and development and counseling of parents.

90965 ESRD-related services for home dialysis patients per full month; for patients 12 to 19 years of age, including monitoring for adequacy of nutrition, assessment of growth and development and counseling of parents.

90966 ESRD-related services for home dialysis patients per full month; for patients 20 years of age and older

90967 ESRD-related services less than full month, per day; for patients under 2 years of age.

90968 ESRD-related services less than full month, per day; for patients 2 to 11 years of age.

90969 ESRD-related services less than full month, per day; for patients 12 to 19 years of age.

90970 ESRD-related services less than full month, per day; for patients 20 years of age and older.
6.6. Flight Medicine Services

NOTE: Referral to flying status includes air traffic control duty. Reference to air crew member includes air traffic controller.

6.6.1. E&M Rules

DoD Rule

Annual/periodic flight exams are reported as comprehensive preventive medicine encounters (99384–99397). Treatment of conditions identified, regardless of whether they are pre-existing or identified in the course of the preventive medicine encounter, are coded separately per the instructions in the Preventive Medicine Services subsection of the CPT manual. To use the code range 99384–99397, an examination must be performed.

6.6.1.1. Encounters for Approval for Flying Status

Encounters that do not meet the requirements of a comprehensive preventive medicine service are reported as either individual counseling preventive medicine services (no medical problems and meets the requirements of preventive medicine counseling, use codes 99401–99404) or as office visit or other outpatient services (for a medical issue, use codes 99201–99215). When documentation supports only the use of a 99211, it is appropriate for providers to use the 99211 code.

6.6.2. Diagnosis Coding Rules

DoD Rule

Annual flight exams are reported with V70.5_1 as the first listed diagnosis. Any pre-existing or newly diagnosed conditions are listed as additional diagnoses.

Encounters for post-deployment conditions (confirmed or suspected) will have the reason for the encounter listed in the primary diagnosis field with V70.5_6 listed as a secondary code. *This rule takes precedence over any other diagnosis coding rule.*

6.6.2.1. The following information provides guidance on coding flight physicals:

6-19
MHS Professional Services Coding Guidelines
March 2013
1. Initial flight exam, no symptoms
   a. Diagnosis code: V70.5 1 Aviation exam
   b. E&M: 993xx Age-appropriate prevention exam
   c. CPT procedures *: 92551/2/3 Pure tone audiometry tests (specify if air, bone, etc.)
   93000** EKG, interpretation & report
   93005 EKG, tracing only
   93010 EKG, interpretation & report only
   d. Visual Screening 99172/3 Visual Acuity Screen
   * Procedures are coded if performed and properly documented in flight medicine clinic note(s).
   ** Choose appropriate EKG test performed in flight medicine clinic

2. Annual flight exam, normal, no symptoms
   a. Diagnosis code: V70.5 1 Aviation exam
   b. E&M: 993xx Age-appropriate prevention exam
   c. CPT procedures *: 92551/2/3 Pure tone audiometry tests (specify if air, bone, etc.)
   93000** EKG, interpretation & report
   93005 EKG, tracing only
   93010 EKG, interpretation & report only
   d. Visual Screening 99172/3 Visual Acuity Screen
   * Procedures are coded if performed and properly documented in Flight Medicine Clinic note(s).
   ** Choose appropriate EKG test performed in Flight Medicine Clinic

3. Annual flight exam with symptoms, disease found, or acute exacerbation of chronic condition
   a. Diagnosis codes: V70.5 1 Aviation exam
      xxxx Code the symptom/disease found on examination
   b. E&M: 993xx Age-appropriate prevention exam.
      992xx Appropriate office encounter. Add modifier -25 to show a separate E&M service was provided.
   c. CPT Procedure: xxxx List any procedures performed for the flight exam as outlined in Item 1. List any additional procedures performed that relate to the symptom or disease found on examination.

4. Flight exam, chronic condition (not active or influencing flight status)
   a. Diagnosis code: V70.5 1 Aviation exam
      xxx.xx Code chronic condition (e.g. hypertension)
   b. E&M: 993xx Age-appropriate prevention exam
SPECIALTY CODING
6.6. Flight Medicine Services

5. Flight exam, active condition or disease influencing flight status
   a. Diagnosis code: xxx.xx  Code active condition of symptom/disease that removed individual from flight status
   b. E&M: 992xx  Appropriate office encounter
   c. CPT procedures: xxxxx  List any procedures performed during office visit

6. Return-to-flight status, (after illness/injury) currently no symptoms
   a. Diagnosis code: V68.09  Medical certificate
   b. E&M: 9921x  Appropriate E&M office visit

7. Flight Exam, waiver renewal (face-to-face)
   a. Diagnosis code: V68.09  Medical certificate (waiver)
   b. E&M: 992xx  Appropriate office visit code
   c. CPT procedure: 99080  Special reports (service specific waiver report)

   * Prolonged services code would be assigned when the provider reviews records, tests and communications with professionals and family. This would be in addition to time spent with the patient—99358-first hour of review of tests and communication with other professionals and family. Code 99359 identifies any additional 30 minutes.

8. Ground testing, no adverse effects of drugs
   a. Diagnosis code: V70.5 1  Aviation exam
   b. E&M code: 992xx  Appropriate office visit (new/established)
   c. CPT procedure: None

9. Ground testing, with adverse effects of drugs
   a. Diagnosis code: 995.2  Adverse effect of correct drug properly administered
   b. E&M code: 780-789.xx  Symptom code or appropriate ICD code to describe the drug interaction
   c. CPT procedure: E930-E949.x  Cause of injury code to identify the drug reaction

10. Incentive Flight/Chamber/Survival Training clearance encounters
    a. Diagnosis code: V70.5_1  Aviation exam
### SPECIALTY CODING

6.6. Flight Medicine Services

<table>
<thead>
<tr>
<th></th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2648</td>
<td>V65.43</td>
<td>Counseling on injury prevention (survival training)</td>
</tr>
<tr>
<td>2649</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2650</td>
<td>b. E&amp;M code:</td>
<td>99384/86 New patient preventive exam, OR</td>
</tr>
<tr>
<td>2651</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2652</td>
<td></td>
<td>99394/96 Established patient prevention exam</td>
</tr>
<tr>
<td>2653</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
6.7. Gynecology

6.7.1. E&M Rules

6.7.1.1. Office Visit
The most common type of E&M is the office visit for a symptom, condition, or disease. Office visits are coded 99201–99215.

6.7.1.2. Well Woman Exam
If a complete general physical exam is performed, use preventive medicine E&M codes 99384–99387 for new patients and 99394–99397 for established patients. When a patient is seen for a physical and has a separately identifiable symptom, condition, or disease that requires significant time or resources, it should be documented and coded separately. Append the modifier -25 to the appropriate office E&M. When a patient is seen for a physical and a screening Pap smear is collected at the time, code the E&M and collect Q0091 in the CPT/HCPCS field.

6.7.1.3. Counseling
Visits specifically for initial contraceptive management are coded to preventive medicine. Should the encounter not include an exam, counseling is reported as 99401–99404. Subsequent visits for contraceptive management are reported as established patient office visits.

6.7.2. Diagnosis Coding Rules

DoD Rule

Well-Woman Exams

V72.31 Is reported for a complete physical exam with a gynecology component.

Use these codes in addition to V72.31 when appropriate:

V76.47 Special screening for malignant neoplasms, vagina (For post-hysterectomy patients)

V88.01-.03 Acquired absence of the cervix and uterus

Report the code(s) for any problem(s) also addressed during the encounter.

6.7.2.1. Screening Pap
When a screening Pap smear is done, one of the following diagnosis codes is reported and linked to the HCPCS codes for the exam.

V67.01 Vaginal Pap Smear s/p hysterectomy for malignant condition

(use additional codes for acquired absence of genital organs V88.01-.03)

V76.2 Cervical Pap Smear (Routine)
6.7. Gynecology

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V76.47</td>
<td>Vaginal Pap Smear s/p hysterectomy for non-malignant condition</td>
</tr>
<tr>
<td></td>
<td>(use additional codes for acquired absence of genital organs V88.01-.03)</td>
</tr>
<tr>
<td>V76.49</td>
<td>Special screening for malignant neoplasm, other sites.</td>
</tr>
<tr>
<td>V15.89</td>
<td>Other specified personal history presenting hazards to health.</td>
</tr>
<tr>
<td></td>
<td>(Used for women considered to be at high-risk for cervical cancer. Examples</td>
</tr>
<tr>
<td></td>
<td>were screenings for patients with early onset of sexual activity, patients</td>
</tr>
<tr>
<td></td>
<td>exposed to DES in the womb, patients with more than five sexual partners in</td>
</tr>
<tr>
<td></td>
<td>a lifetime, and patients who have had a sexually transmitted disease.)</td>
</tr>
</tbody>
</table>

**NOTE:** If the original pap smear did not contain an adequate sample, and the patient returns to obtain a new smear, code 795.08 nonspecific abnormal Pap smear of cervix, unsatisfactory smear.

An additional diagnosis code may be used to identify the high-risk factor, such as V69.2 “High-Risk Sexual Behavior.”

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**DoD Rule**

Use Q0091 to code the collection of screening Pap smear. In the MHS, it is appropriate to code the V76 screening code when using the Q0091, including when this occurs during a well-woman visit, coded V72.31.

The collection of a diagnostic Pap is part of the exam component of an office visit and is not coded separately.

When a patient receives a breast and pelvic exam only and not enough of the health/preventive requirements to satisfy a physical, the G0101 continues to be the most appropriate code.

**6.7.2. Diagnostic Pap**

Pap smears completed on women who have had previous cancer of the female genital tract are diagnostic, not screening, Pap smears. They are for a medically necessary reason, regardless of the presence or absence of symptoms. The appropriate personal history diagnosis code is reported.

**Example:** V67.01 would be used for diagnostic vaginal pap smear s/p hysterectomy for malignant condition (use additional codes for acquired absence of genital organs V88.01-.03).

**6.7.2.3. Abnormal Followed by Normal Pap**
If a woman has an abnormal Pap smear and then a follow-up Pap smear is normal, two more Pap smears are usually done to confirm the normal result. These encounters will be coded V72.32.

6.7.2.4. Contraceptive Management
A code from V25 is used when a contraceptive management procedure or counseling is done during an encounter.

6.7.2.5. Pregnancy Testing
Encounters for the purpose of pregnancy testing are to be coded as follows, based on the results of the test or exam known at the time of the encounter.

<table>
<thead>
<tr>
<th>Results of Test and/or Exam</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>V72.42</td>
</tr>
<tr>
<td>Negative without any related symptoms or diagnoses</td>
<td>V72.41</td>
</tr>
<tr>
<td>Negative with any related symptoms or diagnoses</td>
<td>Codes for symptoms or conditions and V72.41</td>
</tr>
<tr>
<td>Unconfirmed exam or test</td>
<td>V72.40</td>
</tr>
</tbody>
</table>

6.7.3. Procedural Coding Rules

6.7.3.1. No Coding for Contraceptives
Contraceptive supplies or medications dispensed through the pharmacy are not coded.

6.7.3.2. Procedures for Implantable Contraceptive Capsules
These are coded in the Integumentary subsection (e.g., 11980, 11981, 11982, and 11983) of the CPT manual. If the patient is coming in with an implanted contraceptive capsule (e.g., Norplant) and wants it removed, use code 11976. Non-implantable devices are in the Female Genital System subsection (e.g., 58300).

6.7.3.3. Pelvic Exam under Anesthesia
This (57410) is commonly miscoded in the clinic setting. A pelvic is part of the exam component of an office visit and the preventive medicine service (e.g., physical). There is no separate code for a pelvic exam.

6.7.4. Modifiers
A -25 modifier is appended to the E&M code when a procedure is performed as well as a separately identifiable E&M. Do not use the -25 modifier with E&Ms done at the same time as laboratory tests (e.g., KOH, wet prep).
6.8. Mental Health

6.8.1. Evaluation & Management (E&M) Rule

DoD Rule

Air Force will follow guidance in the Mental Health Coding Handbook.

6.8.1.1. Mental Health Screenings
When a patient presents for a pre-deployment, post-deployment, security clearance, in and out processing, etc., these are considered screenings and not Diagnostic Evaluations. These visits will be coded with a HCPCS code of H0031 (Mental Health Assessment) or H0046 (Mental Health Services) if performed by a Social Worker. When performed by a psychiatrist, behavioral health Nurse Practitioner, Physician Assistant or psychologist with prescribing privileges will use an E/M service code (99201-99215).

NOTE: Screenings are when the patient presents without signs or symptoms of a mental health condition or existing mental health diagnosis. If a patient is seeking help for a physical condition, see the guidelines for Health and Behavioral Assessment and Intervention codes.

6.8.1.2. Inpatient Treatment without Therapy
See section 9 for other coding guidance on inpatient services.

6.8.2. Diagnosis Coding Rules

6.8.2.1. Diagnostic and Statistical Manual (DSM)
Mental health diagnoses are based on terminology and codes in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV). Although the terminology in ICD-9-CM or CHCS does not always match the terminology in DSM IV, use the mental health codes in the 290–320 range in ICD-9-CM.

NOTE: Do not use the “Axis” in AHLTA when selecting an ICD9 code.

6.8.2.2. Patients without Mental Disorder Diagnosis
Some encounters are with patients or clients who do not have a mental disorder diagnosis. Use the appropriate sign/symptom code, or there are V codes that can be used to describe these encounters, such as:
SPECIALTY CODING

6.9. Nutritional Medicine Encounters

- 799.21 Nervousness
- 799.22 Irritability
- 799.23 Impulsiveness
- 799.24 Emotional liability
- 799.25 Demoralization and apathy
- 799.29 Other signs and symptoms involving emotional state
- 799.3 Dehility, unspecified
- 799.51 Attention or concentration deficit
- 799.52 Cognitive communication deficit
- 799.59 Other signs and symptoms involving cognition
- V40 Mental and behavioral problems
- V60.2 Financial problems
- V61 Other family circumstances, including
  - V61.10 Counseling for marital and partner problems
  - V61.49 Presence of sick or handicapped person in family or household
  - V62.82 Bereavement
- V71.09 Observation for other suspected mental condition

DoD Mental Health Extender Codes

Mental health diagnosis extender codes are a group of ICD-9 codes that have been modified to meet the needs of the Services. The extender is paired with an ICD code to acquire a unique meaning. Use the appropriate extender for the type of service provided. DOD mental health diagnoses extender codes can be used in any clinical setting.

6.8.2.3. DOD Mental Health Diagnoses with Extender Codes

- V65.42_0 Alcohol education
- V65.42_1 Substance abuse counseling
- V65.49_1 Medication education
- V65.49_7 Occupational stress education
- V65.49_8 Mental health education
- V65.49_9 Other specified counseling
- V65.49_A Stress education
- V65.49_B Suicide education
NOTE: Counseling codes are not necessary to capture when the counseling pertains to an existing diagnosis being treated. Example: V65.49 A is not needed if the patient has a diagnosis of Stress Reaction.

6.8.3. Procedural Coding Rules

6.8.3.1. Four Code Groups for Mental Health

There are four major groups of procedure codes commonly used by mental health and life skills providers. They are the psychiatry and biofeedback CPT codes 90785–90899; the central nervous system assessments/tests CPT codes 96101 - 96125; health and behavior assessment/intervention CPT codes 96150–96155; and the HCPCS H codes for mental health and alcohol/drug abuse treatment services.

6.8.3.2. 90785 Interactive Complexity

CPT code 90785 is an add-on code which is used to describe an encounter in which specific communication factors complicate the delivery of a psychiatric procedure. Examples of communication factors include:

- Use of play equipment, other physical devices, interpreter, or translator to communicate with the patient to overcome barriers
- Maladaptive communication problems (related to high anxiety, high reactivity, repeated questions, disagreement) that complicate delivery of care
- Caregiver emotions or behavior interfering with understanding and ability to assist in plan of care
- Evidence or disclosure of a sentinel event and mandated report to third party (abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other vital participants

CPT 90785 may be reported in conjunction with codes for diagnostic psychiatric evaluation, psychotherapy, psychotherapy with an E/M service, and group psychotherapy.

6.8.3.3. Psychiatric Diagnostic Evaluation

The Psychiatric diagnostic evaluation code, 90791 are used by all privileged mental health providers (e.g., social workers, psychologists, psychiatrists). If the privileged mental health provider was unable to complete the psychiatric diagnostic evaluation at the initial encounter, a code would be selected for the initial encounter specifically on the basis of what services/procedures were performed. If an established patient presents with a new mental health condition, a re-assessment of a current condition, or presents for a second opinion, a new psychiatric diagnostic evaluation may be required.
6.9. Nutritional Medicine Encounters

Psychiatric Diagnostic Evaluation with E/M service is used only by providers that are privileged to use an E/M service, such as psychiatrist, BH Nurse Practitioners, BH Physician Assistants.

Refer to CPT® guidelines for the description of psychiatric diagnostic evaluation with medical services (90792). The psychiatric diagnostic evaluation codes may not be reported more than once per day, and not on the same day as an E/M service performed by the same provider for the same patient.

6.8.3.3. Therapy with E&M

The therapy with E&M codes are usually used only by psychiatrists and psychologists, or other qualified healthcare providers with prescriptive privileges. The E&M component must be documented separately and include the history, exam, and decision making. For therapy, the actual start and stop time or the total amount of time spent with a patient should be documented, because the therapy codes are time based. Time spent conducting the E&M component is not included in the therapy time. A separate diagnosis is not required for the reporting of E/M and psychotherapy on the same date of service. To report therapy with E/M services, the appropriate E/M code and psychotherapy code would be reported.

6.8.3.4 Psychotherapy for Crisis (90839, 90840)

Psychotherapy for crisis is an urgent assessment and history of a crisis state, a mental status exam, and a disposition. It includes psychotherapy and use of resources and psychotherapeutic interventions to help mitigate the crisis and potential for psychological trauma. The presenting problem is typically life threatening or complex and requires immediate attention to a patient in high distress. Face-to-face time does not have to be continuous, but the total face-to-face time must be documented. As with critical codes, the provider must devote his or her full attention to the patient for the time reported. The psychiatric diagnostic interview codes are not reported with codes 90839 and 90840.

6.8.3.5. 90885 Psychiatric Evaluation of Records

This is a non-face-to-face code and is included in the initial diagnostic interview and therapy codes and is not used if codes 90791-90853 are used. Evaluation of all available applicable data is always part of treatment. This code is for a paper review of the patient, without seeing or treating the patient, to make a diagnosis. The documentation should reflect a review of the patients past medical and psychological history, current medications and treatments, and test results to gain an insight into the patient’s present condition and possible medical diagnosis and recommendations for further treatments.

6.8.3.6. 90887 Advising Family and Others How to Assist Patient

This code is used when a provider summarizes results to the family when the patient is unable to communicate. It is not used in conjunction with 90791–90853. NOTE: this code is not used with multi-disciplinary meeting with other providers or medical staff members.

6.8.4. Documentation
When both therapy and an E&M are provided in the same encounter, the E&M documentation should be noted separately, after the end of the therapy note or on a separate page.

6.9. Nutritional Medicine Encounters

6.9.1. Evaluation & Management (E&M) Rules
Nutritional medicine does not generate E&M services.

6.9.2. Privileged Providers, Dieticians

6.9.2.1. Physicians and Other Privileged Providers Not Registered Dieticians.
Privileged providers other than registered dieticians should use an office E&M (e.g., 99201–99215) when consulting on nutritional therapy or intervention. These privileged providers (not Registered Dieticians) should use the preventive medicine codes (e.g., 99401–99412) when counseling individuals or groups on nutritional topics when the patients do not have symptoms, conditions, or diagnoses related to the topics being addressed. These privileged providers should...
use the group education code (99078) when educating groups with symptoms, conditions or diagnoses related to the education topic.

6.9.2.2. Registered Dieticians

6.9.2.2.1. Preventive Medicine
Registered dieticians may use the preventive medicine codes (99401–99412) when providing counseling or risk-factor reduction interventions. To use these codes, the patient should not have a symptom, condition, or diagnosis related to the topics covered. For example, registered dieticians may teach a Healthy Heart eating group.

6.9.2.2.2. Telephone Consultation
Registered dieticians may use the appropriate telephone consultation code, as long as the documentation reflects the encounter was for a new issue, providing additional information on a nutrition-related topic. Telephone consults are not to be used for administrative encounters, such as reminding patients of appointments. Telephone consults are not to be used for continuations of previous encounters, such as providing websites for help groups when information was not available at the previous encounter.

6.9.2.2.3. Outpatient Consultation
Both referrals and consults are requested using Standard Form (SF) 513. It is very infrequent when a provider requests advice (a consult) from a registered dietitian on management of a medical condition (e.g., for this 211-pound male, which diet should I use to treat him?). Usually, the provider refers (a referral) the medical nutritional management of the patient to the registered dietician. The registered dietician’s medical nutritional therapy should be coded using the 97802–97804 codes.

6.9.2.3. Non-Privileged Providers or Diet Technicians
All diet technician visits are coded with the procedure code. If the technician is involved in the patient appointment conducted by a dietitian (e.g. assesses the food diaries prior to the group encounter, which the dietitian will conduct), the technician is considered an additional provider in ADM and the dietician is credited with the visit(s). Merely checking a patient in does not meet the requirement of an additional provider.

6.9.3. Diagnosis Coding Rules
An outpatient visit to a nutrition clinic is coded with the ICD-9-CM code V65.3, Dietary Surveillance and Counseling. Other existing conditions would be coded as a secondary or additional diagnostic code. With ADM version 3.0, up to four diagnosis codes may be entered.

Examples of codes include the following:
- Colitis—558.9
- Diabetes mellitus—250.0_ (5th digit sub-classification 0–3)
6.9. Nutritional Medicine Encounters

- Requires an additional code for diabetic manifestations (e.g., acute angle-closure glaucoma, 365.22; peripheral neuropathy, 355.8; skin ulcer of lower extremity, 707.10)
- Dermatitis caused by food (allergies)—693.1
- Pure hypercholesterolemia—272.0

When a patient is seen for the cause of his weight gain (thyroid, etc.), use code V77.8 special screening for obesity in addition to the overweight/obese ICD codes.

Refer to 2.2.8.7. for BMI guidance

6.9.4. Procedural Coding Rules

6.9.4.1. Medical Nutritional Therapy (MNT) CPT codes

6.9.4.1.1. MNT; Initial Assessment and Intervention

97802 is to be used only once each year, for initial assessment of a new patient, unless the patient is seen for a different condition with different therapy requirements than the prior initial assessment. Documentation must reflect the amount of face-to-face time with the patient. Enter the number of units (each 15 minutes) in the unit field.

6.9.4.1.2. MNT, Reassessment, and Intervention

97803 should be used when there is a change in the patient’s medical condition that affects the nutritional status of the patient. Documentation must reflect the amount of face-to-face time with the patient. Enter the number of units (e.g., if the reassessment took 45 minutes, code a quantity of 3) in the unit field.

NOTE: MNT CPT codes (97802–97804) cannot be used in conjunction with the preventive medicine E&M codes (99401–99412). If the patient is receiving medical nutritional therapy and risk-factor reduction nutritional guidance (e.g., being briefed on low-sodium diet, but also receives counseling on general nutritional topics), the entire time would be coded for the MNT.

6.9.4.1.3. Registered Dieticians

These individuals should use the appropriate medical nutritional therapy code (97802–97804) when conducting nutritional assessments and specific diet training. As these codes are time sensitive, the documentation must reflect the amount of time spent face-to-face with the patient. Time spent reviewing the food diary with the patient would be coded as part of the MNT encounter.

6.9.4.1.4. Certified Diet Technicians

These individuals should use the nutritional medicine codes 97802–97804 for MNT. Diet technicians are authorized to provide instruction on those diets on which they have been certified.
6.9.4.2. Education and Training for Patient Self-Management

Services prescribed by a physician and provided by a qualified non-physician healthcare professional designed to teach patients how to effectively self-manage illness (es) or disease(s) including asthma and diabetes may be coded as follows when a standardized curriculum is used:

98960  Face-to-face with patient each 30 minutes; individual patient
98961  2-4 patients
98962  5-8 patients

6.9.4.3. Group Counseling Performed by a Non-Privileged Provider

Documentation of group counseling, per session, is required in each individual’s medical record, along with topics addressed and any specific patient-related issues.

- S9449  Weight management classes, non-physician
- S9451  Exercise class, non-physicians
- S9452  Nutrition class, non-physician
- S9455  Diabetic management program, group session
- S9460  Diabetic management program, nurse visit
- S9465  Diabetic management program, dietician visit
- S9470  Nutrition counseling, dietician visit

6.9.5. Units of Service

6.9.5.1. Time Spent as Unit of Service

By marking the quantity column on the superbill, indicate the time spent with the patient as units of service for CPT code assignment. Example: One 30-minute reassessment visit equates to two units of service.

6.9.5.1.1. Dietitian Outpatient Examples:

1. A dietitian teaches a 45 minute nutrition segment of a multidisciplinary team diabetes education program (following the American Diabetes Association standardized curriculum). The dietitian reviews the patient diet history questionnaire which
includes meds, labs, and exercise history. An individualized meal plan is provided to each patient and explained during the class. All patients are scheduled to return for two more follow-up visits to complete the series of classes. Once the class is completed, the RD documents the patient condition/diagnosis, initial assessment, diagnosis, counseling provided, and goals/action plan.

Codes for example:

2. A dietitian spends 45 minutes reading about an uncommon medical condition and then develops a handout for a patient. The RD spends 30 minutes face-to-face with the patient, discussing the information on the handout and providing detailed diet instruction. After the appointment, the RD takes 15 minutes to input the note into AHLTA. Codes for example:

3. A physician sends a request for assessment to the RD to see an obese patient for weight loss and consideration for bariatric surgery. The RD conducts a 60 minute in-depth assessment for the patient’s readiness for behavior change, usual diet and exercise habits, measures current height and weight, and provides diet education and written materials. Codes for example:

4. A dietitian teaches a 90 minute class on sports nutrition to a group of eight. The patients’ height, weight, and BMI are calculated. The dietitian works with each patient to determine estimated energy, protein, fluid, and carbohydrate needs. Individualized documentation for each patient is entered into AHLTA. Codes for example:
SPECIALTY CODING
6.9. Nutritional Medicine Encounters

- CPT: no NMT CPT codes are used with a preventive medicine E&M code

6.9.5.1.2. Diet Technician Outpatient Examples

1. A diet technician teaches a one-hour group cholesterol class. The technician has each patient fill out an information sheet, reviews each patient’s laboratory values, and documents the visit by assessing the patient condition, describing the education provided and educational materials, and the follow-up plan. Codes for example:

   - ICD9-CM: V65.3, dietary surveillance and counseling
   - E&M: N/A
   - CPT: 97804 with 2 units of service

2. The diet technician has a 30-minute follow-up visit with a patient who attended the cholesterol class described above. The technician analyzes the patient’s food diary, reviews any new relevant labs, provides specific recommendations on dietary changes, and documents the visit. ICD9-CM code V65.3, dietary surveillance and counseling. Codes for example:

   - ICD-9: V65.3, dietary surveillance and counseling
   - E&M: N/A
   - CPT: 97803, reassessment and intervention, with 2 units of service

NOTE: 99078 may be used as an additional code if physician education services are provided in a group setting.

3. A diet technician teaches the 30-minute nutrition segment of an obstetrics orientation. The diet tech assesses self-reported data on an SF 600 overprint for each attendee includes: current pregnancy weight, week’s gestation, total weight gain compared to expected weight gain, and usual diet intake or food frequently. The diet technician meets with each patient individually to ensure her understanding of the assessment and nutritional recommendations. Codes for example:

   - ICD-9: V65.3 and applicable pregnancy code (e.g., V22.0, supervision of normal first pregnancy or V22.1, supervision of subsequent pregnancy)
   - E&M: N/A
   - CPT: 97804 with 1 unit of service

6.9.6. Inpatient Therapy Examples:
SPECIALTY CODING
6.9. Nutritional Medicine Encounters

DoD Rule

Inpatient nutrition consultation encounters are reported in ADM. When the screen prompts, *Are you from the attending service?* select *no*. This will create the encounter in ADM and will be reported in the B MEPRS. Nutritional screenings are not code-able services and will not be brought back as workload to the B MEPRS clinic.

6.9.6.1. A physician consults an RD to assess an ICU patient with COPD with acute exacerbation for alternate nutrition sources e.g. TPN (total parenteral nutrition). The RD reviews the patient medical record, conducts a brief interview with the patient and spouse, talks with the nursing staff about the patient’s usual oral intake, and then make a detailed recommendation for TPN in the medical chart. The RD completes the assessment in 45 minutes. Codes for this example:

- ICD-9-CM: V65.3, additional diagnosis code for current medical condition COPD 491.21
- E&M: N/A
- CPT: 97802 with 3 units of service

6.9.6.2. The diet technician screens a cardiac patient and indicates the patient is high nutrition risk due to post-CABG surgical procedure, recent weight loss and poor appetite/intake. The diet tech refers the patient to the dietitian for further assessment and intervention. The dietitian interviews the patient and family, reviews the medical record, assesses the patient current condition and calorie needs, and makes recommendations to the physician for a liberal diet. The nutrition screening and assessment process are integral to the inpatient stay and are considered an institutional component of care, therefore are not separately code-able.
SPECIALTY CODING
6.10. Obstetrics Services

6.10. Obstetrics Services

**NOTE: When a patient's pregnancy is incidental:**

Code the pregnant state with V22.2 diagnosis code. An incidental pregnancy cannot be the reason for the encounter, so V22.2 will not be the first listed diagnosis. Do not use the V22.2 code with obstetrical diagnostic codes from 630–677. Do not code the encounters with the 0500F or 0502F obstetrical procedure codes.

For instance, a three-months-pregnant patient breaks her wrist. This would be coded with an office visit E&M; a diagnosis code for the fracture, an E code for the injury, the V22.2 code for the incidental pregnancy and a procedure code for treatment of the fracture.

6.10.1. E&M Rules

DoD Rule

**UNCOMPLICATED obstetric encounters do not have an E&M component in the 99201–99499 series.**

Most obstetric encounters involving complications of pregnancy do have an appropriate E&M in the 99201–99499 series and the appropriate E&M should be entered in the E&M field.

DoD Rule

**As policy, global OB codes that represent work in two different MEPRS codes and the bundled ante partum visit codes (59425 and 59426) are not coded in the ADM.**

To account for workload, the MHS cannot use the global codes.

6.10.1. Do not use the following codes:
### SPECIALTY CODING
#### 6.10. Obstetrics Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>59400</td>
<td>Routine obstetric care including ante partum care, vaginal delivery (includes services in both the outpatient and inpatient MEPRS codes)</td>
</tr>
<tr>
<td>59410</td>
<td>Routine obstetric care including postpartum care (includes services in both outpatient and inpatient MEPRS codes)</td>
</tr>
<tr>
<td>59425</td>
<td>Ante partum care only, 4–6 visits (use 0500F, initial prenatal care visit, and 0502F subsequent prenatal care, for ante partum encounters)</td>
</tr>
<tr>
<td>59426</td>
<td>Ante partum care, 7 or more visits (use 0500F, initial prenatal care visit, and 0502F, subsequent prenatal care, for ante partum encounters)</td>
</tr>
<tr>
<td>59510</td>
<td>Routine obstetric care including ante partum care—Cesarean delivery (includes services in both outpatient and inpatient MEPRS codes)</td>
</tr>
<tr>
<td>59515</td>
<td>Cesarean delivery—postpartum care (includes services in both outpatient and inpatient MEPRS codes)</td>
</tr>
<tr>
<td>59610</td>
<td>Vaginal birth after a previous C-section (VBAC) delivery including ante partum, delivery, and post-partum (includes services in both outpatient and inpatient MEPRS codes)</td>
</tr>
<tr>
<td>59614</td>
<td>VBAC delivery and postpartum care (includes services in both the outpatient and inpatient MEPRS codes)</td>
</tr>
<tr>
<td>59618</td>
<td>Attempted VBAC ante partum, delivery and postpartum care (includes services in both outpatient and inpatient MEPRS codes)</td>
</tr>
<tr>
<td>59622</td>
<td>Attempted VBAC delivery and postpartum care (includes services in both outpatient and inpatient MEPRS codes)</td>
</tr>
</tbody>
</table>

---

#### 6.10.1. Billing vs. Data Collection Codes

The codes listed above are a billing convention, as insurance companies do not want 13 separate bills for the professional services associated with a full-term pregnancy. The codes listed above cannot be used for data collection when each encounter reflects services provided. By using the new category II CPT obstetrical codes, obstetrical encounters will be collected without unbundling the obstetrical global codes.

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**DoD Rule**

*Use the appropriate E&M for office visits/hospital when something other than uncomplicated, routine obstetrical care is furnished.*

*For first visit with nurse for screening, vaccinations and counseling, code services as appropriate. Code 99211 for face to face visit with no procedures.*

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#### 6.10.2. Diagnosis Coding Rules

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#### 6.10.2.1. Fifth Digit Requirement for Obstetric Diagnoses
The range of diagnosis codes 640–648, complications mainly related to pregnancy, requires a fifth digit. Follow ICD-9-CM coding guidance for reporting obstetric diagnoses.

Fifth Digits
- 0: Unspecified episode of care
- 1: Delivered this episode, may or may not have had ante partum condition
- 2: Delivered the episode of care, had postpartum complication
- 3: Ante partum care (patient still pregnant at end of this episode of care)
- 4: Postpartum care (patient delivered during previous episode of care)

6.10.2.2. Co-morbidities
Some obstetric cases have co-morbidities that influence the pregnancy. Ensure that the pregnancy and manifestation codes are listed.

6.10.2.2.1. Example: A pregnant patient presents to the clinic with a diagnosis of Type I diabetes, which complicates the pregnancy. This encounter is coded in the following manner:

Fifth Digits
- 648.03: Current conditions in the mother classifiable elsewhere, but complicating pregnancy, childbirth, or the puerperium, diabetes mellitus
- 250.01: Type I diabetes, without mention of complication

6.10.2.3. Diagnosis codes 647–649
Coders unfamiliar with obstetrical coding should review the codes in the 647–649 range and understand their application. If a patient 3 months pregnant sprains her ankle while jogging, but it does not affect the pregnancy and the pregnancy does not affect the care, the code 648.7X would not be appropriate. However, smoking is a systemic issue with decreased oxygenation that will affect the pregnancy. A pregnant patient with tobacco use disorder would usually be coded with 649.0X.

6.10.2.4. Congenital Anomalies
When the infant has a congenital anomaly, it is coded on the infant’s record, not the mother’s. Be careful with the codes 740–759. For the mother’s record, consider 655, known or suspected fetal abnormality affecting management of mother.

6.10.2.5. Outcome of Delivery Codes V27
These codes are used on the mother’s record at delivery, which is usually an inpatient event. Therefore, the V27 codes would be in the A MEPRS CAPER if delivered at an MTF. This would be coded in ADM and will appear on the inpatient rounds encounter at delivery.
6.10. Obstetrics Services

6.10.2.6. Live-born Infants According to Type of Birth, Codes V30–V39

These codes are not used on the mother’s record. They are used in the infant’s record.

6.10.2.7. Pregnancy Testing

Encounters for the purpose of pregnancy testing are to be coded as follows, based on the results of the test or exam that are known at the time of the encounter.

<table>
<thead>
<tr>
<th>Results of Test and/or Exam</th>
<th>Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>V72.42</td>
</tr>
<tr>
<td>Negative without any related symptoms or diagnoses</td>
<td>V72.41</td>
</tr>
<tr>
<td>Negative with any related symptoms or diagnoses</td>
<td>Codes for symptoms or conditions and V72.41</td>
</tr>
<tr>
<td>Unconfirmed exam or test</td>
<td>V72.40</td>
</tr>
</tbody>
</table>

6.10.3. Procedural Coding Rules

Category II CPT obstetric coded 0500F, 0502F, 0503F and Level I CPT code 59430.

0500F Initial prenatal care visit. Reported for those portions of the first prenatal encounter that are routine for that point in the pregnancy, with health care professional providing obstetrical care.

0501F Prenatal flow sheet documented. Do not use, because the DoD will use 0500F, initial prenatal care visit, when the prenatal flow sheet is initiated and 0502F for each subsequent obstetrical encounter.

0502F Subsequent prenatal visits (continuing care). Use for subsequent obstetrical visits that are routine for that point in the pregnancy. This code does not include complications or issues not related to the pregnancy.

Use 0503F for one uncomplicated postpartum care encounter (usually done six to eight weeks after delivery), signifying the end of the global period. Code all other postpartum complications or unrelated problems addressed with the appropriate established patient office visit E&M code. Use this code if the delivery and postpartum visit are performed by the same group practice.

Use 59430 if postpartum care is provided by a different group practice other than the group practice that performed the ante partum care or delivery.

6.10.3.1. Obstetrical Services
SPECIALTY CODING
6.10. Obstetrics Services

Included are: obstetric care (routine and non-routine), ante partum care, vaginal delivery (with or without episiotomy or forceps) and postpartum care uses 0500F, 0501F, 0502F, 0503F, and 59430.

6.10.3.2. Ante Partum Services

To document ante partum services, indicate the following when given:

- Pap Smear
- Monthly visit up to 28 weeks’ gestation, biweekly visit to 36 weeks’ gestation and weekly visits until delivery
- Initial history and physical exam (code 0500F) and subsequent history and physical examinations (code 0502F)
- Recording of weight, blood pressures, and fetal heart tones. When routine chemical urinalysis is done and interpreted in the clinic and is not bundled with routine obstetrical care, it may be coded using a laboratory code (e.g., 81000 or 81002).
- For first visit with nurse for screening, vaccinations and counseling, code services as appropriate. Code 99211 for face-to-face visit with no procedures.
- 0500F, initial prenatal care visit reported for the first prenatal encounter with healthcare professional providing obstetrical care. After confirmation of pregnancy, the 0500F code is the trigger code to indicate the start of the pregnancy episode. The code is not appropriate when the only prenatal service during an office visit is pregnancy test.
- 0501F, prenatal flow sheet documented. Do not use.
- 0502F, subsequent prenatal visits (continuing care)
- 0503F, uncomplicated outpatient visit by the same group practice that performed the delivery until six weeks postpartum. The AMA uses this code to define the number of women who receive care on or between 21 and 56 days after delivery.
- 59430, uncomplicated outpatient postpartum follow-up by a group practice other than the group practice that performed the delivery.

6.10.3.3. The following is a list of services that reflect routine, uncomplicated care and are included in the routine codes.

Procedures outlined below, will not be coded separately. Positive findings during screening will be coded.

- Prenatal risk assessment checklist—administering and history taking, ordering applicable tests
  - Auscultation of fetal heart tones
  - Screening fundal height
  - Screening for hypertension (HTN) disorders
  - Assessing inappropriate weight gain
  - Educate about symptoms of preterm labor
  - Review for development of contraindications
  - Assessment of fetal kick counts
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6.10. Obstetrics Services

3398
3399
3400
3401
3402
3403
3404

- Interventions at all visits
  - Screening for HTN disorders
  - Breast feeding education
  - Exercise during pregnancy
  - Influenza vaccine (season-related, 6–20 weeks)

3405

- First visit with nurse (6–8 weeks)
  - Screening for
    - Tobacco use, alcohol use, drug abuse
    - Domestic abuse
    - Anti-D/non-anti-D antibodies
    - Rubella, varicella, hepatitis B, syphilis (RPR), asymptomatic bacteriuria
    - HIV counseling
    - Immunization–TB booster (1st trimester), hepatitis B (1st trimester)

3412

- First visit with provider (10–12 weeks)
  - Assessing weight gain (inappropriate)
  - Auscultation fetal heart tones
  - Screening fundal height
  - Screening for gonorrhea and chlamydia
  - Counseling for cystic fibrosis screening

3419

- Weeks 16–24
  - Assessing weight gain (inappropriate)
  - Auscultation fetal heart tones
  - Screening fundal height
  - Screen for domestic abuse
  - Maternal serum analyte screening
  - Counseling for family planning
  - Educate regarding preterm labor

3428

- Weeks 28–37
  - Assessing weight gain (inappropriate)
  - Auscultation fetal heart tones
  - Screening fundal height
  - Screen for domestic abuse (week 32)
  - Assess for preterm labor
  - Daily fetal movement counts
  - Screening for gestational diabetes
  - Iron supplementation
  - Anti-D prophylaxis for Rh-negative women
  - Screening for group B streptococcal (week 36)
  - Assessment of fetal presentation (week 36)
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- Weeks 38–41
  - Assessing weight gain (inappropriate)
  - Auscultation fetal heart tones
  - Screening fundal height
  - Weekly cervical check (stripping)
  - Post-dates antenatal fetal testing

6.10.3.4. Codes for Medical Problems Complicating Pregnancy

All encounters for OB care will have a code from the 0500F series coded. Significant separately identifiable medical conditions complicating obstetric management may require additional resources and should be identified by using the E&M codes in addition to those codes for maternity. Modifier -25 will not be assigned to an E&M in this chapter only. These significant separately identifiable medical conditions will be coded when documented in the medical record. Documentation must meet minimal requirements. Procedures other than those routine procedures listed above should also be coded.

Examples of complicating conditions are:

- Pre-existing diabetes
- Gestational diabetes mellitus (GDM)
- Pregnancy-induced hypertension or pre-eclampsia
- Fetal anomaly or abnormal presentation (older than or equal to 36 weeks)
- Multiples
- Placenta previa
- Chronic hypertension
- Systemic disease that requires ongoing care (e.g., severe asthma, lupus, inflammatory bowel disease)
- Drug abuse
- HIV (or abnormal screen)
- Age (<16 or >40 years at delivery)
- Past complicated pregnancy
- Prior preterm delivery (<37 weeks)
- Prior preterm labor requiring admission (e.g., early cervical change)
- Intrauterine fetal demise—10 weeks after cardiac activity was first noted
- Prior cervical or uterine surgery
- Fetal anatomic abnormality (e.g., open neural tube defects in prior child or first-degree relative)
- Abnormal fetal growth
- Preterm labor requiring admission (i.e., regular uterine contractions and cervical change)
- Abnormal amniotic fluid
- 2nd or 3rd trimester bleeding
- Relative BMI <16.5
- Hematologic disorders
- Severe anemia (<24 percent hematocrit)
- Cancer
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Seizure disorders
Recurrent urinary tract infections or stones
Substance use disorders (alcohol or tobacco)
Eating disorders
Surgery
Abnormal screen—antibody, hepatitis, syphilis, and Pap
Abnormal maternal triple screen
Current mental illness requiring medical therapy

Examples of separately reportable services:
All routine ultrasound
Additional non-routine Ultrasound
Echocardiography
Fetal biophysical profile
Amniocentesis, cordocentesis
Chorionic villus sampling
Fetal contraction stress test
Fetal non-stress test
Hospital admission and observation for preterm labor, except within 24 hours of delivery
Management of surgical problems arising during pregnancy (e.g., appendicitis, incompetent cervix, ruptured uterus)
Insertion of cervical dilator by physician
External cephalic version, if done in the clinic
Administration of Rh immune globulin
Cerclage of cervix, during pregnancy—vaginal or abdominal

6.10.3.5. Postpartum Care

6.10.3.5.1. Routine Postpartum Care
For postpartum encounters code 0503F/59430 in the CPT/HCPCS field code. Following is a list of services that reflect routine, uncomplicated postpartum care and are included in the routine codes. They will not be coded separately.

Postnatal tests—administering and history taking, ordering applicable tests
  o Pelvic exam
  o Breast exam

Topics addressed:
  o Contraception
  o Postpartum depression, screening for
  o Sexual activity
  o Weight
  o Exercise
  o Woman’s assessment of her adaptation to motherhood
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6.10.3.5.2. Non-routine Postpartum Care

Collection of Pap smears is not included and should be documented and coded separately and appropriately with reason (e.g., high risk or not). Additional services may be provided during a postpartum visit.

Patients who present with a history of an abnormal Pap smear and are being seen for a diagnostic Pap will require an added E&M code. If the obstetric follow up code 59430 is used, then a modifier -25 will be required on the E&M code.

Code non-routine postpartum issues separately. Treatment of these would be coded using an E&M. A few examples:

- Disruption of wounds
- Infections of breast and nipples
- Disorders of lactation

6.10.4. Inpatient Obstetric Coding.

For more guidance on inpatient coding, see section 9. This section addresses inpatient professional services, including OB rounds and appointments that generate automatically in the name of the attending provider.

6.10.4.1. Recording in MEPRS

To record the delivery, code inpatient professional services in the ACxx, AGxx or AHxx MEPRS. After a patient is admitted, an inpatient rounds ADM record is generated each inpatient day under the name of the attending physician.

6.10.4.1.1. Hospital Days prior to Delivery

6.10.4.1.1.1. OB Observation Status

Pre-term labor/Labor Observation

(See also Appendix H for Coding for Observation)

Patient is seen in the OB-GYN clinic or Emergency Department. The provider writes an order to place the patient in observation status. Changing the patient from observation status is a decision of the privileged provider.

For normal, uncomplicated pre-natal care (which could include some labor) use procedure code 0502F for encounters leading up to delivery.

For problems other than normal pre-natal and labor care:

IF THERE IS NO ORDER FOR OBSERVATION:

- For clinic services, use E&M code 9921X based on documentation. For Emergency department services, use E&M 9928x based on documentation. In those instances when
a non-emergency service is provided by a non-emergency provider (e.g., obstetrician
treats patient in the Emergency Department on a weekend when the OB clinic is closed),

code the services as clinic services.

- If more than 70 minutes (99215= 40 minutes, modifier 21 = 30 minutes) is spent face-to-
face with the patient AND THE TOTAL TIME AND PROVIDER’S ACTIVITIES
DURING THAT TIME ARE DOCUMENTED in the medical record, code 99215 and
99354-99355 for clinic OR 99285 only for Emergency Department.

- Code for fetal stress/non-stress/monitoring in addition to the E&M code.

**IF THERE IS AN ORDER FOR OBSERVATION:**

- Provider documents written order for observation, no delivery on same date of service
(99218-99220). Diagnosis will reflect medical necessity. Observation services are
outpatient services. Therefore, if the patient is observed for a condition not verified, code
the symptoms. Do not use the V71 Observation for Condition not found.

- To generate a code-able encounter, an appointment must be created manually for each
day of observation. Contact your Service Representative for guidance on manual
creation of code-able observation encounters.

- Provider documents written order for observation, no delivery on subsequent date of
service, use E&M 99218-99220.

- Provider documents written order for observation, no delivery, discharged same date of
service; use E&M 99234-99236.

- Provider documents written order for observation, no delivery, discharged on subsequent
date of service; use E&M 99217 for the last day of observation.

**Scenarios:**

**Admit from observation/trial labor**

- Patient is in observation, is admitted and delivers the same date.

  1. Observation: close out the observation using the 0502F for routine prenatal and
     labor. Complications are coded based on documentation.

  2. Admission: the round (RND) encounter for this day may have an E&M based
     on documentation and the procedure will be the delivery (vaginal 59409; cesarean
     section 59514). This is an MHS deviation from civilian standards of coding. Refer
     to DoD Rule for E&M in section 6.10.1.2.

- Patient is in observation and is admitted and does not deliver during this admission.

  1. Observation: close out the observation using the 0502F for routine prenatal
care and labor. Complications are coded based on documentation.
2. Admission: the RNDs encounter will be based on the documentation from the time of admission.

Patient delivers on the second date of observation status.

1. Observation: code the observation encounter for day 1 using the 0502F for routine prenatal care and labor. Complications are coded based on documentation.

2. Code the observation encounter for day 2 using the 0502F for routine prenatal care and labor.

3. Admission: the RNDs encounter will be based on the documentation from the time of admission. Use appropriate delivery codes based on documentation.

6.10.4.1.2. Preterm Admission/Bed-Rest Admission

For problem pregnancies that need inpatient monitoring (pre-mature labor, diabetic patient, toxemic, high blood pressure), the attending service will code one RNDs per day for admission until date of delivery or discharge as follows: admission date (99221-99223) subsequent days (9923X), date of delivery (59XXX).

6.10.4.1.3. Labor

All E&M services prior to labor are considered ante partum care. If the delivery does not take place until after the initial day of admission, delete the rounds encounter for the initial day. For example, when a healthy-term, uncomplicated singleton female is admitted at 1800 and delivers vaginally 12 hours later, the following codes are used: delete the automatically generated rounds appointment for the day of admission and code the delivery 59409 on the rounds appointment for the day of delivery.

6.10.4.1.4. Complicated

For complicated inpatient ante partum care, use the appropriate initial hospitalization and subsequent hospitalization codes.

6.10.4.1.2. Delivery

On the day of delivery, use

- 59409 for vaginal delivery
- 59514 for C-section
- 59612 for successful vaginal delivery after previous C-section
- 59620 for an attempted vaginal delivery after a previous C-section when ultimately the newborn is delivered C-section

The delivery codes include:
6.10. Obstetrics Services

- Management of uncomplicated labor, including fetal monitoring
- Placement of internal fetal or uterine monitors
- Catheterization or catheter insertion
- Preparation of perineum with antiseptic solution
- Forceps or vacuum extraction
- Delivery of placenta, any method
- Injection of local anesthesia
- Administration of intravenous oxytocin

Code any other appropriate procedures done.

For complicated deliveries, use the appropriate procedure codes, e.g., surgical fixation for prolapsed uterus. For medical complications, e.g., asthma, the provider would use the appropriate E&M code.

6.10.4.1.2.1 Multiple Births

- For all newborns born vaginally, code 59409 (or 59612) for a vaginal birth after a previous C-section (VBAC) with a unit of the number of newborns. For instance, vaginally delivered twins would be coded 59409, unit of service 2.
- All newborns delivered C-section, code 59514 (or 59620 for a VBAC that results in a C-section), with a unit of service of 1. There is only one C-section.
- Multiple births with at least one vaginal and one C-section are coded with the appropriate type of vaginal birth code and the number of vaginal births using the unit’s field. Code the appropriate C-section code with a unit of service of 1 for all the infants delivered by the one C-section.

6.10.4.1.3. Associated C-section Procedures

Code both the C-section and the associated procedure (e.g., hysterectomy, tubal ligation).

6.10.4.1.4. Routine Post-Partum Days

Code CPT 99024. For complications, code the appropriate procedure and E&M. Add diagnosis for post-partum condition. (V24.x).
6.11. Occupational Therapy (OT)

6.11.1. E&M Rules
E&M codes are not appropriate for occupational therapy. The evaluation and management components of routine outpatient office E&Ms are included in special occupational therapy evaluation (97003) and reevaluation (97004) procedural codes as indicated below.

6.11.2. Diagnosis Coding Rules

6.11.2.1. Outpatient Occupational Therapy
All outpatient occupational therapy encounters for the purpose of receiving therapy are always coded with the V57.21 as the first listed diagnosis unless the need for therapy is related to a deployment. In that case, abide by the MHS Coding Guidance for deployment related issues.

6.11.2.2. Occupational Therapy Evaluation
Occupational therapy encounters for the purpose of evaluation only or group educational classes (no therapy done during the encounter) are not identified by V57.21.

NOTE: When a patient presents for evaluation and therapy is initiated on the same day, do not use V57.21. Code the condition as primary diagnosis.

6.11.2.3. E Codes for Occupational Therapy
Occupational therapy encounters should not report E codes, as the occupational therapy encounter will not be the initial medical encounter at the MTF for the injury. If it is documented that the patient was initially seen for the injury at another MTF without occupational therapy, and this is the initial encounter at this MTF, then the E code(s) should be used. Most therapy encounters will not be for an acute injury (e.g., fracture). In rare instances, treatment will be to address the immediate resulting limitations from the injury (e.g., reduced movement of fingers following hand fracture).

6.11.3. Procedural Coding Rules
CPT codes for occupational therapy procedures are in the Physical Medicine and Rehabilitation subsection of the Medicine Section (97003–97799). Activities of daily living (ADL) mock-ups...
SPECIALTY CODING

6.11. Occupational Therapy (OT)

for self-care home living are coded 97535 (and should not be used for education activities, like
Osteopathic Manipulative Treatment codes may be used by Physical Therapist if authorized
under their scope of practice (98925-98929).

6.11.4. Evaluations and Reevaluations

6.11.4.1. New vs. Established Patients

There is no distinction for new or established patients. Code either an: evaluation 97003 or
reevaluation 97004 with or without modalities, or code just the modalities performed. The initial
assessment of the problem is used to determine the appropriate therapy and prognosis. Various
movements required for ADL are examined. Dexterity, range of motion, and other elements may
also be studied. Reevaluations are for subsequent assessments to determine treatment success
and make modifications as needed.

6.11.4.2. Reevaluation Is Part of Normal Service

Reevaluation is part of the normal pre- and post-service. As with an E&M service, these
evaluations should only be separately reported if the patient's condition requires significant,
separately identifiable E&M services.

6.11.5. Modalities

6.11.5.1. Modalities Included in Evaluation, Reevaluation

Certain modalities (e.g., injection of anesthetic agents, range of motion measurements) are
included in the evaluation and reevaluation procedural codes. For a list of these modalities refer
to the National Correct Coding Initiative (NCCI) at the CMS Web.

6.11.5.2. One-on-One Contact

Therapeutic procedures (97110–97546) require direct (one-on-one) patient contact by the
provider. Basically, this means the provider must maintain visual, verbal, or manual contact with
the patient throughout the procedure. For a technician to code an encounter, the technician must
be working under a privileged provider’s plan of care. When the occupational therapist is
actively involved in the therapy and assisted by a technician, the technician should be listed as an
additional provider when coding the encounter.

6.11.6. Modifiers

The HCPCS modifier GO is used in the civilian sector by occupational therapy to indicate that
the therapy is being performed under an outpatient occupational therapy plan of care. It does not
specify a therapist furnished the care. The GO modifier is not used in the DoD system.

6.11.7. Documentation of Occupational Therapy

6.11.7.1. Requirements for CPT Code
To support a CPT code, at a minimum each occupational therapy note needs to include therapist name, date, modality, treatment assessment (patient tolerated treatment), and adjustment to the therapy plan. Documentation based on a checklist alone is not sufficient for coding.

6.11.7.2. Required Elements

The following elements need to be recorded by the therapist (or technician),
- The specific modalities or procedures (supervised or attended),
- The body area involved, and
- The start and stop times or total time for each treatment.

6.11.7.3. Coding for Pregnant Patients

When a patient is pregnant, and the pregnancy affects the services provided (e.g., not pregnancy incidental, coded V22.2), the patient’s last menstrual period and estimated date of delivery need to be documented so they can be recorded in ADM.

6.11.8. Units of Service

6.11.8.1. Unit of Service Is 8-15 Minutes

Constant attendance modalities and therapeutic modalities include “each 15 minutes” in the code descriptions. Therefore, one unit of service is reported for each 15 minutes (or major portion thereof) of therapy rendered per date of service. The table below is used to calculate units of service. A minimum of eight minutes must be performed to qualify for 1 unit of service.

6.11.8.2. Reporting Time Intervals

For any single CPT procedure where unit of service is a factor, report time intervals for units of service as follows:

<table>
<thead>
<tr>
<th>Unit of Service</th>
<th>Greater than or equal to</th>
<th>And fewer than</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>08 minutes</td>
<td>23 minutes total for all time-based modalities</td>
</tr>
<tr>
<td>2</td>
<td>23 minutes</td>
<td>38 minutes total for all time-based modalities</td>
</tr>
<tr>
<td>3</td>
<td>38 minutes</td>
<td>53 minutes total for all time-based modalities</td>
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<tr>
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<td>53 minutes</td>
<td>68 minutes total for all time-based modalities</td>
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<td>5</td>
<td>68 minutes</td>
<td>83 minutes total for all time-based modalities</td>
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<td>6</td>
<td>83 minutes</td>
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</tr>
<tr>
<td>7</td>
<td>98 minutes</td>
<td>113 minutes total for all time-based modalities</td>
</tr>
<tr>
<td>8</td>
<td>113 minutes</td>
<td>128 minutes total for all time-based modalities</td>
</tr>
</tbody>
</table>
Units are calculated in the same manner for therapy that exceeds two hours.

6.11.8.3. Multiple CPT Procedures
For multiple CPT procedures performed on the same calendar day, the total number of units does not equal the individual units of service for each service; rather, it equals the units of service for the total treatment time.

6.11.8.4. Group Therapy
Multiple patients being given modalities or procedures during the same time are reported as group therapy. (See 97150)

6.11.9. Inpatient Therapy

DoD Rule

Inpatient therapy consults will be reported in ADM. When the screen prompts *Are you from the attending service?* select *NO*. This will create the encounter in ADM. Therapy related to the patient’s reason for admission is not coded in the B MEPRS.
6.12. Ophthalmology/Optometry

**DoD Rule**

Optometry clinic services are coded in an ambulatory service BHCx MEPRS clinic. Ophthalmology clinic services, including services for pay patients are coded in the ambulatory service BBDx MEPRS.

6.12.1. E&M Rules

6.12.1.1. Optometrists

An optometrist seldom uses an E&M office visit code in the 99201–99215 range.

6.12.1.2. Ophthalmologists

Depending on the patient population and the number of associated optometrists, ophthalmologists commonly have 30 percent to 40 percent of their visits coded with E&M codes in the 99201–99499 range. Referrals and consults are coded 99201-99215.

6.12.1.3. An E&M code may be used when a patient is seen for a medical reason that does not require any eye examination procedures. The most common instances when an E&M code is used are:

- Limited exams that do not meet the exam elements of an intermediate eye exam, but do meet the elements of a low-level E&M code (e.g., follow-up contact lens visit).
- Highly complex or risk-prone exams that meet the documentation elements of a 99204/14 or 99215 E&M encounter.
- Examinations for medical reasons when no eye procedures are performed (e.g., an acute care visit for a subconjunctival hemorrhage).

6.12.2. Diagnosis Coding Rules

6.12.2.1. Routine Exams (DoD Unique Visits)

Encounters for DoD unique visits, such as aviation, military school screening, periodic, or termination exams, are reported using V70.5 with the appropriate extender (e.g., Aviation exam V70.5_1). Any condition diagnosed during the examination is listed as an additional diagnosis.

<table>
<thead>
<tr>
<th>V CODES</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>V70.5</td>
<td>Armed Forces Medical Examination</td>
</tr>
</tbody>
</table>
6.12.2. Routine Exams

6.12.2.2.1. Diagnosis Coding Based on Documentation

Other than the DoD-required first-listed codes, diagnosis coding in optometry and ophthalmology is based on documentation. If the patient’s reason for the encounter is vision problems (e.g., myopia, presbyopia), that will be the first listed code. If the patient’s reason for the encounter is “here for annual exam,” the most appropriate V code would be used.

6.12.2.2.2. Routine Eye Exams

For patients without any complaints or previously diagnosed ophthalmologic conditions, routine exams are coded V72.0, and any condition identified during the exam is an additional diagnoses.

| V70.5 1 | Aviation Examination |
| V70.5 2 | Periodic Prevention Examination |
| V70.5 3 | Occupational Examination |
| V70.5 4 | Pre-Deployment Examination |
| V70.5 5 | During Deployment Examination |
| V70.5 6 | Post-Deployment Examination |
| V70.5 7 | Fitness for Duty Examination |
| V70.5 8 | Accession Examination |
| V70.5 9 | Termination Examination |

6.12.2.2.3. Routine Exams with Complaints

For routine exams (reason for encounter), with complaints or ophthalmologic conditions, the most appropriate V code would be the first-listed code with the applicable codes for the complaints or conditions listed as additional codes.

| 367.1 | Myopia |
| 367.21 | Astigmatism, regular |
| 367.4 | Presbyopia |
| 379.90 | Disorder of the Eye—Unspecified |
| 379.91 | Pain in or Around Eyes |
| 379.99 | Other Ill-Defined Disorder of Eyes |

6.12.2.4. Non-Routine Encounters

Diagnostic codes are to be used at their highest level of specificity (fourth and fifth digits) and explicitness (e.g., chronic, acute, regular, irregular) to support medical necessity for procedures such as extended ophthalmology. Fourth and fifth digits should be used when available.

6.12.2.5. Special Screening for Glaucoma
See glaucoma screening below for documentation requirements.

6.12.2.2.6. Diabetic Retinopathy

Code 250.5x first, then use one of the following codes:

- 362.01 Background diabetic retinopathy
- 362.02 Proliferative diabetic retinopathy (NOS)
- 362.03 Non-proliferative diabetic retinopathy (NOS)
- 362.04 Mild non-proliferative diabetic retinopathy
- 362.05 Moderate non-proliferative diabetic retinopathy
- 362.06 Severe non-proliferative diabetic retinopathy
- 362.07 Diabetic macular edema

6.12.3. Procedural Coding Rules

6.12.3.1. Optometrists

Optometrists usually use the ophthalmology codes in the 92002–92396 range (e.g., diagnosis and treatment) as well as the HCPCS codes V2020–V2799 and various other HCPCS codes. The most commonly used codes by optometrists are 92002–92014 for eye exams and 92015 for refractions. Optometrists associated with a refractive surgery program who do postoperative assessments will also frequently use 99024, postoperative follow-up visit.

6.12.3.2. Ophthalmologists

Ophthalmologists also code a number of visits using the 92002–92499 ophthalmologic services codes, the diagnosis and treatment codes 92015–92396, and surgical eye and ocular adnexa codes 65091–68899. Ophthalmologists also frequently perform refractive surgery, coded S0800–S0830. Refractive surgery procedures tend not to have RVUs assigned by the CMS as they are not a CMS-covered benefit. It is very important that these services be coded correctly as they are specifically evaluated to determine the effectiveness of various refractive surgery programs.

6.12.3.3. Use of 92002–92499 Codes

Usually optometrists and ophthalmologists use the 92002–92499 codes. When a technician does a simple acuity or visual function, the procedure codes 99172 and 99173 are appropriate. Dispensing glasses is a continuation of the visit when the glasses were prescribed or ordered and is not coded separately.

6.12.4. Eye Exams

6.12.4.1. CPT Codes for New and Established Patients

CPT codes 92002, 92004, 92012, and 92014 for new and established ophthalmology or optometry patients include an evaluation and management of a patient. These codes are appropriate when the level of service includes several routine optometric or ophthalmologic examination techniques, such as slit lamp examination, keratometry, ophthalmoscopy,
retinoscopy, tonometry, and sensorimotor evaluation that are integrated with and cannot be separated from the diagnostic evaluation.

6.12.4.2. Documentation Guidelines for 92 Series Eye Exam and Treatment Codes:

There is no specific history or medical decision-making guidelines for these codes.

There are 13 exam elements that must be documented to validate a coding level:

- Testing visual acuity
- Gross visual fields
- Eyelids and adnexae
- Ocular motility
- Pupils
- Iris
- Conjunctiva
- Cornea
- Anterior chamber
- Lens
- Intra-ocular pressure
- Retina
- Optic disc

If three to eight of these elements are documented, an intermediate exam (92012 or 92002) should be coded. If nine or more of these elements are documented, a comprehensive exam (92014 or 92004) should be coded.

If fewer than three of these elements are documented, the lowest level E&M code (based on the documentation) should be coded along with the primary diagnosis (reason for visit or chief complaint).

Note that some procedures are bundled-included as part of / the 92 series exam codes. This means you would NOT put a separate CPT code for these procedures if done as part of the exam using a 92 series exam code.

The bundled procedures are:

- Amsler grid
- Brightness acuity test (BAT)
- Corneal sensation
- Exophthalmometry
- General medical observation
- Glare test
- History
- Keratometry
- Laser interferometry
SPECIALTY CODING
6.12. Ophthalmology

- Pachymetry
- Potential acuity meter (PAM)
- Schirmer test
- Slit lamp tear film evaluation and transillumination

NOTE: Corneal Pachymetry (76514) is separately reportable if a thorough evaluation of the cornea is performed along with image documentation, interpretation and report; no technical or professional modifiers should be reported. Code 76514 is reported only once, since it is considered a bilateral service. Therefore, if corneal pachymetry is performed on both eyes, modifier 50 would not be used.

If medically indicated other services, tests, or procedures performed can be added as additional CPT codes, e.g., contact lens fitting, photography, foreign body removal, or refraction. It is inappropriate to code for a limited visual field examination when performed as part of a routine screening examination.

6.12.4.3. Refraction Code
Any time refraction is performed, it is reported as an additional code. 92015 Refraction can only be use once, no multiple units. This is not reported with routine postoperative care or reported by auto refraction.

6.12.4.4. Dilated Retinal Exams for Diabetics, S3000
Diabetic indicator, retinal eye exam, dilated, bilateral. Diabetic patient exam encounters with a dilated, bilateral retinal eye exam as part of the comprehensive exam should be coded with additional code S3000 for the diabetic indicator.

6.12.4.5. Visual Acuity Screening
When doing an occupational health screening use 99172 or 99173 (screening codes) for optometry. These codes should not be used with 92002, 92004, 92012, and 92014 (General Ophthalmologic Services). In addition 99172 cannot be used with any E&M code and 99173 cannot be used with any E&M service of the eye code.

6.12.4.6. Fitting of Spectacles
Minimal documentation requirements for optometrist or technician for the use of codes 92340-92342 include: measurements of anatomical facial characteristics, records the laboratory specifications and performs the final adjustment of the spectacles to the visual axes and anatomical topography. If the final adjustment is performed on a later date, use V53.1. The supporting documentation must be contained within the medical record.

6.12.5. Glaucoma Screening (both military and nonmilitary)

6.12.5.1. Patients without a Primary Glaucoma Diagnosis
For patients without a primary diagnosis of glaucoma, glaucoma screening is reported separately as V80.1. If this is part of an annual exam, list the annual examination V code of V70.5__2 followed by V80.1 as the secondary diagnosis.

6.12.5.2. Patients at High Risk for Glaucoma
Charting documentation is specifically streamlined for the patient at high risk for glaucoma. The history will include the obvious risk factors for glaucoma (e.g., age, race, family history, trauma, corticosteroid use, and diabetes). Elements of the exam must be clearly documented if glaucoma screening is the only ophthalmologic or optometric service reported for high-risk patient’s code.

- G0117 Glaucoma screening for high-risk patients, furnished by an optometrist or ophthalmologist
- G0118 Glaucoma screening for high-risk patients, furnished under the direct supervision of an optometrist or ophthalmologist

6.12.5.3. Screening for Glaucoma
Glaucoma screening is defined to include:
- A dilate and eye examination with an intraocular pressure measurement; and
- A direct ophthalmoscopy examination, or slit-lamp biomicroscopic examination

6.12.5.4. Glaucoma Screening for Diabetics
Glaucoma screening performed on diabetics during a general ophthalmologic exam is identified with an additional HCPCS Level II code, S3000, diabetic indicator, retinal eye exam, dilated, bilateral. This is for population health data collection purposes only, not for reimbursement.

6.12.6. Coding for the Optometric or Ophthalmology Technician

6.12.6.1. When the technician provides services for a patient in conjunction with an optometrist or ophthalmologist, the technician is reported in ADM as an additional provider using the designation paraprofessional. Additional codes for any procedures the technician performs (e.g., spectacle ordering, visual field) are to be reported.

Example: Patient seen by technician for vision exam portion of routine physical

- V70.5_2 Routine annual physical
- 99173 Screening test of visual acuity

If a technician performs one of these procedures (99172 or 99173) at a separate encounter no E&M level is assigned and one of these codes is assigned. (See section 6.12.4.5.)

6.12.7. Refractive Surgery
SPECIALTY CODING
6.12. Ophthalmology

DoD Rule

S0800 will be used for both LASIK and LASEK procedures until a code is created for LASEK procedures.

Use modifier -54 and -55 with S0800 and S0810 codes.

Examples for lasik/lasek:

Pre-op:

Diagnosis 1: V72.83 Other Specified Pre-Op Exam
E&M N/A
Procedure Code(s) as applicable:
   92004 Comprehensive New
   92014 Comprehensive Established
   92015 Refraction (can only use once, no multiple units)
   S0820 Computerized Corneal Topography (Has been replaced with 92025 and should be used if available.)
   76514 Pachymetry (no 50 modifier, code is automatically bilat.)

Diagnosis 2: Hypermetropia 367.0, Myopia 367.1, Astigmatism 376.2, etc.

Procedure:

Diagnosis: Hypermetropia 367.0, Myopia 367.1, Astigmatism 376.2, etc.
E&M N/A
Procedure Code(s) as applicable:
   S0800 LASIK
   S0810 PRK
   Use 50 modifier for bilateral, use 54 modifier if all f/u at another MTF
   Cannot use 65760 Keratomileusis or 92071 Fitting of contact lens for treatment of ocular surface disease

Post-op:

At same MTF:
Diagnosis 1: V58.71 Aftercare Following Surgery of the Sense Organs, NEC
E&M: N/A
Procedure Code: 99024 (Exception: post-op complication, code diagnosis first and code as 92014 Comprehensive Established)

Diagnosis 2: V45.69 Postsurgical State of the Eye and Adnexa
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At different MTF:

Diagnosis 1: V58.71 Aftercare Following Surgery of the Sense Organs, NEC

Procedure Code: S0800 or S0810 with 55 modifier for first f/u encounter, subsequent encounters 99024 (Exception: post-op complication, code diagnosis first and code as 92014 Comprehensive Established)

Diagnosis 2: V45.69 Postsurgical State of the Eye and Adnexa

**Pre-op Exams:**

- The primary Dx code should be V72.83 “other specified pre-op exam”. Secondary are things like myopia, etc. The referral exam should be coded as a comprehensive eye exam (92004 for new patient or 92014 for prior patient).
- Corneal Topography: CPT code 92025- “Computerized corneal topography, unilateral or bilateral, with interpretation and report” is reported when topography is not performed in conjunction with keratoplasty procedures (65710, 65730, 65750 and 65755).
- Pachymetry: When this is documented with interpretation it can be coded as 76514. The requirement does not specify the exact instrument used, and “permanently recorded images are not required”.

**6.12.7.1. V72.83 Other Specified Preoperative Exam**

This code will be the first listed. The diagnosis that is the reason for the surgery will be a secondary code, followed by any conditions that may affect treatment.

**6.12.7.2. Postoperative Care**

Postoperative care following eye surgery may be performed or shared between providers (e.g., when the surgery is done at another facility). When one provider performs the surgery, and postoperative care will be provided at a different MTF, the surgeon will code the procedure followed by modifier -54 to indicate only performance of intraoperative care, (e.g., S0810–54). The provider at a different MTF performing the first episode of postoperative care codes the encounter using modifier -55, (e.g., S0810–55) postoperative. Additional uncomplicated follow-up care for this service is coded with 99024, indicating subsequent visits within the 90-day global period. The provider may be entitled to code additional services performed in the evaluation of a new patient in accordance with procedural coding rules. When providing postoperative care, the date of procedure is included in the documentation. Utilize ICD-9-CM code V58.71 for aftercare provided within the global period.

**6.12.8. Extended Ophthalmoscopy with Retinal Drawing**

**6.12.8.1. Ophthalmoscopy**

Extended (92225) and subsequent (92226) ophthalmoscopy are considered reasonable and necessary services for evaluation of tumors of the retina and choroid (the tumor may be too peripheral for an accurate photograph), retinal tears, detachments, hemorrhages, exudative
detachments, and retinal defects without detachment, as well as other ocular defects when the
patient’s medical record meets the documentation requirements set forth in this policy. These
codes are reserved for the meticulous evaluation of the eye and detailed documentation of a
severe ophthalmologic problem when photography is not adequate or appropriate.

6.12.8.2. Frequency of Service
Frequency for providing these services depends on the medical necessity of each patient and this,
of course, relates to the diagnosis. A serious retinal condition must exist or be suspected, based
on routine ophthalmoscopy, which requires further detailed study.

6.12.8.3. Medical Necessity
In all instances, extended ophthalmoscopy must be medically necessary. It must add information
not available from the standard evaluation services or information that will demonstrably affect
the treatment plan. It is not medically necessary, for example, to confirm information already
available by other means.

6.12.8.4. Major Criteria
These criteria must be met:

- A serious retinal condition is present based on ophthalmoscopy, which requires
  further study, such as the detailed study of pre-retinal membrane, a retinal tear
detachment, a suspected retinal tear with sudden onset of symptomatic floaters or
vitreous hemorrhage.
- Another diagnostic technique in addition to routine direct and indirect
  ophthalmoscopy is necessary and documented; for example 360° scleral depressions,
  fundus contact lens, or 90-diopter lens.
- The technique and findings of the extended ophthalmoscopy must be documented,
  including a three-dimensional representation or an extended colored retinal drawing.
  Sketches and templates are not acceptable. The documentation of follow-up services
  (92226) must include an assessment of the change from previous examinations.
- Documentation supporting the medical necessity of this item, such as ICD-9 codes,
  must be submitted with each encounter.

6.12.9. Modifiers
The most commonly used modifiers (and most frequently found to be missing in audits) in
optometry or ophthalmology are the LT for left and the RT for right when unilateral codes are
used; such as removal of foreign body. Many of the procedures for the eye are inherently
bilateral. When one of these procedures is done on only one eye, add modifier -52, reduced
services, as well as the modifier RT for right or LT for left.
6.13. Physical Therapy (PT)—Coding for Physical Therapist or Technician

6.13.1. E&M Coding Rules
E&M codes are not appropriate for routine physical therapy (PT). The evaluation and management components of an outpatient office E&M are already included in special physical therapy evaluation and reevaluation procedural codes, as indicated below.

6.13.2. Diagnosis Coding Rules

6.13.2.1. Outpatient Physical Therapy
Outpatient PT encounters for the purpose of receiving therapy are always coded with V57.1 as the first listed diagnosis.

NOTE: When a patient presents for evaluation and therapy is initiated on the same day, do not use V57.1. Code the condition as primary diagnosis.

6.13.2.2. Evaluative PT
PT encounters for evaluation only, or for attending runner’s clinics, or group educational classes, would not be identified by V57.1. Exercise counseling (e.g., runner’s clinic) is an education V code, V65.41. If the purpose of the encounter is evaluation, use the appropriate ICD-9-CM diagnosis or symptom code in the first CAPER position.

6.13.2.3. Injuries
When functioning in the role of physician extender, physical therapists may render a diagnosis. If this is the first time the patient has been seen at the facility for the current injury, use the appropriate injury code followed by the appropriate E code. You must also document date of injury. PT services are only coded with aftercare, follow-up care, and pain-, muscle-, or joint-related diagnoses.

Example: A patient comes in with back pain that is the result of lifting a heavy item. The patient has not been seen in the ED or by any other provider for this pain. Physical therapist examines the back and determines there is a strained muscle. PT evaluation was done and therapy was not started that day.
SPECIALTY CODING
6.13. Physical Therapy (PT)

Codes: ICD-9 847.1 (thoracic back strain), E927 (lifting injury)
  E&M  N/A
  CPT  97001 (evaluation)

Example: Patient encounter for first PT session for a previously treated thoracic back sprain.
PT evaluation was conducted at the previous visit. Modalities provided to the patient on this day were electrical stimulation and hot packs.

Codes: ICD-9 V57.1, (physical therapy)
  847.1 (thoracic back strain)
  E&M  N/A
  CPT  97014 (electrical stimulation)
  97010 (hot pack)

6.13.3. Procedural Coding Rules
CPT codes for rehabilitation procedures are in the Physical Medicine and Rehabilitation subsection of the Medicine Section (97001—97799). A clinic visit for evaluation only with no therapy is given a CPT code of 97001. For education by a non-privileged provider (PT technician) the appropriate HCPCS S codes are S9451 exercise and S9454 stress management. A clinic encounter for education and/or counseling of an established problem by a physical therapist, where no evaluation and management services were provided, will be coded as a 98960.

6.13.4. Evaluations and Reevaluations
There is no distinction for new or established patients. Code an evaluation, 97001 or reevaluation, 97002 with or without modalities, or code just the modalities performed. The initial assessment of the problem is to determine the appropriate therapy, the increments, frequency, duration, and other factors necessary to enhance healing. Reevaluations are for subsequent assessments to determine the success of the treatment and make modifications as needed.

6.13.5. Modalities
Certain modalities are inclusive of the evaluation and reevaluation procedural codes. For a list of these modalities you may refer to the NCCI. NCCI edits are at:

Constant attendance modalities (97032–97039) and therapeutic procedures (97110–97546) require direct, one-on-one patient contact by the provider. Basically, this direct one-on-one contact requires that the provider maintain visual, verbal, or manual contact with the patient throughout the procedure. For a technician to code an encounter, the technician must be working under a privileged provider’s plan of care. When the physical therapist is actively involved in the therapy and assisted by a technician, the technician should be listed as an additional provider when coding the encounter.
6.13.6. Units of Service

6.13.6.1. Time as Unit of Service
Constant attendance modalities and therapeutic modalities are each 15 minutes in the code descriptions. Therefore, one unit of service is reported for each 15 minutes of therapy rendered per date of service. The table below is used to calculate units of service. A minimum of 8 minutes must be performed to qualify for 1 unit of service.

6.13.6.2. Reporting Time Intervals
For each CPT procedure where unit of service is a factor, report time intervals for units of service as follows:

<table>
<thead>
<tr>
<th>Unit of Service</th>
<th>Greater than or equal to</th>
<th>Less than</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>8</td>
<td>113 minutes</td>
<td>128 minutes</td>
</tr>
</tbody>
</table>

Units are calculated in the same manner for therapy that exceeds two hours.

6.13.6.3. Treatment Time for Multiple Procedures
For multiple CPT procedures performed on the same calendar day, the total amount of treatment time determines the number of units for the day. Each modality and amount of time needs to be documented, not a total time given for all modalities. A minimum of 8 minutes for each modality provided is needed in order to report time.

6.13.6.4. Group Therapy Procedures
Group therapy involves constant attendance by the physician or therapist, but by definition does not require one-on-one patient contact by the physician or therapist. Report code 97150 for each member of the group and provide documentation for the therapies the patients received, including minutes of activity.

6.13.7. Modifiers
The HCPCS modifier GP is used in the civilian sector by physical therapy to indicate that the therapy is being performed under an outpatient physical therapy plan of care. It does not specify a therapist furnished the care. The GP modifier is not used in the DoD system.

6.13.8. Documentation of Physical Therapy

6.13.8.1. Note Requirements
To support a CPT or HCPCS code, at a minimum each physical therapy note needs to include therapist’s name, modality, treatment assessment (patient tolerated treatment), and adjustment to the therapy plan. Documentation based on a checklist alone is insufficient.

6.13.8.2. Required Elements

The following elements need to be recorded by the therapist or technician:

- The specific modalities or procedures (supervised or attended),
- The body area involved,
- The start and stop times or total time for each modality,
- Access to a plan of care for reference to modalities and therapies being provided by the technician.

6.13.8.3. For pregnant patients, the date of the patient’s last menstrual period and estimated date of delivery must be recorded in ADM.

6.13.9. Inpatient Therapy

Evaluations and Re-evaluations for physical therapy are coded in the B MEPRS. Physical therapy modalities related to the admission are not coded.
6.14. Preventive Medicine Services

There are two basic types of preventive medicine services, physicals or well-baby visits and counseling or risk-factor reduction intervention. Section 6.14.1 is about physicals and well-baby visits. Section 6.14.2 is about counseling and risk factor reduction intervention.

**DoD Rule**

If an additional problem or issue is identified and treated, an additional office E&M code may be warranted.

If the encounter intent is preventive (e.g., a physical), code the preventive E&M encounter (e.g., 99384–7, 99394–7) first, even though problems or issues addressed constitute an additional problem-oriented E&M code (e.g., 99212) based on the separate problem-oriented documentation. Append modifier -25 to the problem-oriented E&M (e.g., 99212-25).

6.14.1. Physicals and Well-Baby Visits


Preventive medicine E&M services, such as physicals and well-baby checks, are categorized by patient age and status. It is the privileged provider’s clinical judgment as to what constitutes age and gender appropriate history and exam. The history obtained as part of the preventive medicine service is not problem-oriented and does not involve a chief complaint or present illness.

6.14.1.1.2. Visit Comparisons

The following table provides preventive medicine visit comparisons:

<table>
<thead>
<tr>
<th>Preventive Medicine Visit</th>
<th>Problem Oriented Visit</th>
<th>Preventive Medicine Visit with Problem 993xx and 992xx with modifier -25</th>
</tr>
</thead>
<tbody>
<tr>
<td>99381–99397</td>
<td>99201–99215</td>
<td></td>
</tr>
<tr>
<td>Chief complaint</td>
<td>Healthy patient, absence of complaints. Insignificant or trivial problem</td>
<td>Chief complaint specified</td>
</tr>
<tr>
<td>History</td>
<td>Not problem oriented. No description of present illness. Assessment of pertinent risk factors</td>
<td>Description of the history of present illness as appropriate for the presenting problem</td>
</tr>
</tbody>
</table>
SPECIALTY CODING
6.14 Preventive Medicine Services

<table>
<thead>
<tr>
<th>Review of systems—past, family, social history</th>
<th>Comprehensive system review. *Comprehensive past, family, and social history</th>
<th>To the extent appropriate for the presenting problem</th>
<th>Combine system review and presenting problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examination</td>
<td>Extent of the examination is based on the age of the patient and risk factors identified</td>
<td>Level of exam as appropriate to evaluate the presenting problem</td>
<td>Level of exam as appropriate to evaluate the presenting problem 1) related to age/gender and 2) present illness</td>
</tr>
<tr>
<td>Assessment and plan</td>
<td>Screening for ancillary services without complaint. Typically related to counseling, anticipatory guidance, risk factor reduction</td>
<td>Ancillary services ordered for specific medical problem(s). Medical decision-making reflected</td>
<td>Combination of screening and medical decision making</td>
</tr>
</tbody>
</table>

*For preventative medicine services, the term “Comprehensive” reflects an age and gender appropriate history/exam and is not synonymous with the “comprehensive” examination required in Office E&M codes.

6.14.1.3. Determining Proper Code Category
The issue is not how healthy the patient is, but rather how much work the provider does. Use problem-oriented office visit codes when the documentation shows significant medical decision making.

Documentation points to preventive medicine codes when a patient presents for routine services (annual exam) and documentation does not show that a significant problem is addressed.

Documentation points to preventive medicine codes when there are no patient complaints, no symptoms, and no significant problem or abnormality is recorded.

6.14.1.4. A Physical and a Condition
Frequently, a patient will schedule an appointment but identify other issues at the encounter that require medical intervention. When the condition requires significant time and resources, it should be documented separately from the physical. There is usually a second SOAP (Subjective, Objective, Assessment, and Plan) note after the physical documentation. Code the physical E&M (i.e., 99381–99397) linking the physical diagnosis to the physical E&M. Then code an office visit E&M (e.g., 99212) with a modifier -25, linking the medical condition to the office visit E&M.

Example: Well-baby visit with a second diagnosis of acute otitis media. The first E&M code, 993xx, would be linked to the well-baby visit (V20.2), while the 992xx-25 would be linked to the acute otitis media diagnosis (382.9).
6.14.2. Counseling and Risk Factor Reduction Interventions

The second basic type of preventive medicine services is counseling or risk factor reduction intervention.

One of the more common coding errors in the DoD is using a preventive medicine, individual, or group counseling code, when an education code should have been used. Use
6.14 Preventive Medicine Services

A counseling or risk factor reduction intervention code when there is no condition, symptom, or disease.

For instance, a couple is considering having a child and the woman’s nephew has Tay-Sachs. The couple does not have a child with Tay-Sachs, but there is a risk they could since a nephew has it. This is therefore a counseling session. If the couple had already had a child with Tay-Sachs and was seeing a provider to learn more about the disease and how to manage their child, it would be education.

Another example: Discussion about having a prophylactic mastectomy because a woman’s mother and sister both had breast cancer is counseling. Discussion on treatment options for a woman diagnosed with breast cancer is an office visit. Occupational therapy to improve ADL after the mastectomy is occupational therapy. Classes addressing post-mastectomy issues are education. Prenatal, obesity, and diabetes classes are education.

NOTE: When an applicable education class code is not available in HCPCS (many are around S9436), use the 99078 CPT code, if applicable. These are procedure codes and would be coded in the procedure field of the ADM.

6.14.2.1. E&M

The appropriate E&M codes should be assigned based on the documentation of the services performed: Counseling or risk factor reduction E&M codes include 99401–99404 and 99411–99412. To determine if the counseling or risk factor reduction codes are appropriate, ask: Was the encounter for an examination, education, or counseling?

If the provider sees the patient for a problem, reviews the patient’s health assessment form as part of the visit, and does risk factor reduction intervention (e.g., noticed on health assessment form that the patient does not wear sunscreen and has been sunburned a number of times), assign the office-outpatient codes 99201–99215. If the counseling (e.g., about protection from the sun) takes more than 50 percent of the time of the encounter, and it is documented, the encounter may be coded based on time instead of the history, exam and decision making.

Office visits not documented as a new visit should be coded for established patients.

Diagnosis coding is based on the provider’s assessment of problems or illnesses and any counseling provided. It is also based on the type of exam or counseling performed and any problems or illnesses assessed as part of the examination.

If the provider is conducting preventive medicine counseling or risk factor reduction counseling, (e.g., counseling on safe sex) the 99401–99404 codes should be assigned.

NOTE: These codes are not to be used to report counseling and risk factor reduction interventions provided to patients with symptoms or established illness. The code selection is based on time. Documentation must support the reason for the amount of time used.
For instance: *Counseled on safe sex, 30 minutes* would not adequately explain the amount of time involved.

**Example:** The 99411–99412 codes are appropriate for all students when the provider is teaching a healthy heart class for a general audience, even if one of the participants is diabetic, another is hypertensive, and a third is obese.

### 6.14.2.2. Diagnosis Coding for Preventive Encounters

Diagnosis coding is based on the type of counseling provided. When counseling is provided, frequently used ICD-9-CM codes include:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V16.X</td>
<td>Family history of malignant neoplasm</td>
</tr>
<tr>
<td>V17.X</td>
<td>Family history of certain chronic disabling diseases</td>
</tr>
<tr>
<td>V25.09</td>
<td>Family planning (counseling for contraceptive mgt)</td>
</tr>
<tr>
<td>V65.3</td>
<td>Dietary surveillance and counseling</td>
</tr>
<tr>
<td>V65.40</td>
<td>Other counseling, no other symptoms</td>
</tr>
<tr>
<td>V65.41</td>
<td>Exercise counseling</td>
</tr>
<tr>
<td>V65.42</td>
<td>Counseling on substance use and abuse (this is a root code, use the appropriate DoD extender code)</td>
</tr>
<tr>
<td>V65.43</td>
<td>Counseling on injury prevention</td>
</tr>
<tr>
<td>V65.44</td>
<td>HIV counseling</td>
</tr>
<tr>
<td>V65.45</td>
<td>Counseling on other sexually transmitted diseases</td>
</tr>
<tr>
<td>V65.46</td>
<td>Encounter for insulin pump training</td>
</tr>
<tr>
<td>V65.49_x</td>
<td>Other specified counseling (this is a root code, use the appropriate DoD extender code)</td>
</tr>
<tr>
<td>V69.0</td>
<td>Lack of physical exercise</td>
</tr>
<tr>
<td>V69.1</td>
<td>Inappropriate diet and eating habits</td>
</tr>
<tr>
<td>V69.2</td>
<td>High-risk sexual behavior</td>
</tr>
<tr>
<td>V69.3</td>
<td>Gambling and betting</td>
</tr>
<tr>
<td>V69.8</td>
<td>Other lifestyle-related problems</td>
</tr>
<tr>
<td>V69.9</td>
<td>Problem related to lifestyle, unspecified</td>
</tr>
</tbody>
</table>

### 6.14.2.3. Procedures

Separate procedures for counseling or risk factor reduction are rarely done during an encounter.

### 6.14.3. Modifiers

-25 Append to any separate office visit E&M services provided. Reported in addition to the preventive medicine service codes.

### 6.14.4. Documentation

For counseling, the amount of time spent with the patient as well as the time counseling the patient must be included in the documentation in addition to the date (e.g., 12 Oct 04, 0900–0930, counseling 20 minutes). Additional documentation guidelines are:
• Patient presents for annual physical when using preventive medicine codes.
• Patient presents for multiple concerns as well as health maintenance when using both a low-level office visit and a preventive medicine code.
• When reporting preventive medicine counseling codes, document the nature of the counseling and any education provided during the encounter.
• Do not document patient presents for yearly exam when using a problem-oriented visit code.
6.15. Radiation Oncology Services

6.15.1. E&M Coding Rules
E&M codes are used in radiation oncology for services such as consultation, pre-treatment evaluations, and non-routine follow-up visits. Select the appropriate code from the documentation in the E&M section. For example, an inpatient might be evaluated by the therapeutic radiologist to determine treatment options before a decision for treatment is made. This visit would be coded as an initial inpatient consultation or subsequent hospital care, as appropriate.

6.15.2. Diagnosis
Code the reason for the encounter. For instance, if the patient is being seen for radiation therapy, the first code will be:
V58.0 Radiotherapy. However, coding convention holds that this therapy is conducted if the malignancy still exists. Therefore, the malignancy should also be coded. The neoplasm table in the ICD-9-CM book is simple to use and codes may be taken directly from it without referring to the tabular.

6.15.3. Procedural Treatment Planning Rules

6.15.3.1. Radiation Oncology
This treatment is used to destroy tumors and has professional and technical components. Procedure codes are for initial consultation through patient management of the entire course of treatment.

6.15.3.2. Treatment and Planning Codes
Privileged providers document treatment and planning using codes 77261, 77262 and 77263. These codes include the initial consultation, so there is no separate E&M.

6.15.3.3. Clinical Treatment, Planning, and Tumor Mapping
This is used to identify the location, extent, volume of tumor(s) to be treated, and all critical structures surrounding them. The privileged provider plans an individualized course of radiation therapy that allows maximum benefit while protecting surrounding tissues and structures. These codes include clinical treatment planning, which may involve interpreting special tests. These professional services are usually provided once during the course of treatment and include a follow-up period of up to three months after treatment, unless a separate plan is implemented.

6.15.3.4. Simulation (77280–77295)

6.15.3.4.1. Simulation
The purpose of simulation is to determine treatment options and the placement of ports for radiation treatment. It does not include the administration of radiation. The complexity of a
6.15. Radiation Oncology Services

Simulation is based on the number of ports, volumes of interest, inclusion and type of treatment devices.

6.15.3.4.2. Simulations Not Reported Separately
Simulations that are not to be reported separately are: (1) portal changes based on unsatisfactory initial simulations, (2) minor changes in port size without changes in beam and simulation set up. The simulation set up is part of a period of treatment management, usually in units of five.

6.15.3.4.3. Additional Simulations
These may be necessary during treatment to account for changes in port size, boost dose, or tumor volume. Simulations need to be ordered by the privileged provider and documentation should be completed and signed with the results. Documentation should include the date, reason (initial, block check, subsequent, etc.), and a summary of the procedure.

6.15.3.4.4. Teletherapy Isodose
If the documentation of the simulation supports CPT 77295, then teletherapy isodose (77305–77315) plans are also reported.

6.15.3.4.5. Level of Complexity of Treatment Planning and Simulation Services
The levels of complexity for these services are clearly identified in the CPT code. All criteria do not have to be met to establish the level of complexity. For example, three or more separate treatment areas with simple blocking or no blocking would qualify as a complex service.

6.15.4. Medical Radiation Physics

6.15.4.1. Basic Dosimetry 77300
The calculation of the radiation dose and placement is called dosimetry. The radiation oncologist must order these services as part of the treatment plan. These are reported once per port and may be repeated if documentation supports the reason for the new calculation.

6.15.4.2. IMRT-Intensity Modulated Treatment Delivery
IMRT Planning—77301

6.15.4.3. Teletherapy Isodose Plans 77305–77315
Teletherapy Isodose plans are coded once for a specific treatment area. An additional plan maybe coded if documentation supports that it was medically necessary to change fields or equipment, or if clinical variations are made during the course of treatment.

6.15.4.4. Special Therapy Port Plan 77321
This should be coded only once per treatment area (volume of interest) and not in conjunction with 77300.
6.15. Radiation Oncology Services

6.15.4.5. Special Dosimetry 77331
This service is the measurement of the actual amount of radiation a patient has received at any
given point. The radiation oncologist must order this service. This code may be used more than
once per day per treatment course.

6.15.4.6. Treatment Devices 77332–77334
Multiple devices may be coded if documentation substantiates. If two devices of separate levels of
complexity are documented, code only the one of the higher level.

6.15.5. Radiation Physics Consultations

6.15.5.1. Continuing Medical Physics Consultation 77336
CPT clearly identifies the documentation requirements. This code may be reported weekly.

6.15.5.2. Special Medical Radiation Physics Consultation 77370
This code may only be reported once per course of treatment. This is used when a problem or
situation arises during treatment. It requires a written analysis or report of the course of
treatment, and is done at the direct request of the radiation oncologist.

6.15.6. Radiation Treatment Delivery Codes 77401–77416
Radiation treatment delivery codes are used for the actual delivery of the radiation and consist of
the technical component only. This code is chosen by level of service and energy used. Multiple
sessions on the same day may be coded when there is a break in sessions. The record
should document a distinct break in therapy.

6.15.7. Radiation Treatment Management 77427–77499

6.15.7.1. Radiation treatment management codes consist of the professional component only.
CPT identifies documentation requirements for these services. This includes review of port films
and dosimetry, dose delivery, and treatment parameters, review of treatment set up, and
examination of patient for medical evaluation and management. The documentation must clearly
identify that the radiation oncologist examined the patient. Nursing notes that the doctor adds,
agree or patient doing well will not qualify as the examination of the patient for this
management.

6.15.7.2. 77427 Reporting
This is done every five treatments. For the first, second, third, and fourth treatment, use diagnosis
V58.0 and the code for the neoplasm. Do not code 77427 until the fifth treatment. 77431 is
reported if the course of treatment consists of one or two fractions.

6.15.8. Final Note
Some radiation oncology services may be bundled and may be modified under Correct Coding
Initiative, as discussed previously.
References:
SPECIALTY CODING
6.15. Radiation Oncology Services

CPT 2004 Professional Edition
"Cancer Care Network—A User’s Guide For Radiation Oncology Management & Billing Procedures.”
Coding Strategies, Inc.
The Medical Management Institute—CUB All-In-One Coding Utility Book—Coding and Medicare for Radiation Oncology
”AETC Radiation Oncology Training Modules,” by Patricia Bridges RHIT, CCS, CCS-P and Victoria Flisk BHA, CPC

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MHS Professional Services Coding Guidelines
March 2013
6.16. Radiology, Interventional

Interventional radiology is used to describe the use of cross-sectional imaging techniques, such as ultrasound, CT and MRI, and digital processing of fluoroscopy. These techniques are used not only for diagnostic but also therapeutic applications.

6.16.1. E&M Coding Rules

6.16.1.1. No Separate E&M Codes

Usually there is no separately identifiable E&M associated with an interventional radiology encounter.

6.16.1.1.2. Coding E&M Separately

To code an E&M separately from a procedure, there must be a separately identifiable reason. For instance, a provider determines the need for a procedure. At that encounter, there would be a discussion of risks and benefits, informed consent would be obtained, and there would be an evaluation to determine contraindications and other issues affecting the procedure (such as allergies, previous adverse issue, or review of lab tests). If it is a major procedure (usually with a global post-operative period of 90 days), there would be a preoperative physical. In this case, there would be an E&M code. For minor procedures (usually with a global postoperative period of 0–10 days), the pre-procedural assessment is a component of the procedure. The postoperative encounter, usually for a suture removal, does not have an E&M, but is coded with 99024 in the CPT field.

6.16.2. Diagnosis

6.16.2.1. First-Listed Diagnosis

The first-listed diagnosis is the reason the patient is having the procedure. If a definitive diagnosis is not available by the end of the encounter and there will not be a pathology report, code what is known. Do not code rule out. Code any additional diagnoses that affect the encounter, such as diabetes, pregnancy, or a history of carcinoma.

6.16.2.2. Diagnosis Contingent on Pathology Report

When the diagnosis is contingent on a pathology report, wait to code the encounter until the pathology report is available. For example, if the provider’s pre-procedure diagnosis is mass and after the procedure, it is the provider’s assessment that the mass is benign, it would be coded as a benign neoplasm. If after the procedure, the provider suspects the mass may be malignant, the provider should wait to code the diagnosis and procedure until the pathology results are available. For instance, if a patient presents for rule out neoplasm of breast, but all that is known is that there is a mass in the breast, code a mass, not a neoplasm.

6.16.3. Procedures

6.16.3.1. Interventional radiology usually involves two components: the imaging procedural component and the therapeutic or diagnostic procedural component. In this section, the term
imaging guidance usually indicates a procedure in the 7xxxx range of CPT codes. The term procedural component usually indicates a procedure from the 10000–69999 or 9xxxx CPT codes.

6.16.3.2. When performing the procedural component, (e.g., 19102, biopsy of breast; percutaneous, needle core, using imaging guidance), collect the procedural component in ADM. Collect the imaging guidance used in conjunction with the procedure (e.g., 76095, stereotactic localization guidance for breast biopsy or needle placement, each lesion, radiological supervision and interpretation) in the radiology module.

6.16.4. Modifiers

6.16.4.1. Modifier -26
Most procedures in the 10000–69999 and 9xxxx ranges do not have a professional and technical component. Usually, the procedures are performed by a privileged provider in one setting. Therefore, it is not necessary to use the modifier -26 for the professional component.

6.16.4.2. Technical Component Modifier
Most procedures in the 10000–69999 range do not have a separate technical component. There are a few in urology, but these would not usually be involved with interventional radiology. In those cases when there is a technical component, the appropriate modifier would be TC. The urology procedures may be performed by a urology technologist or nurse but the data must be interpreted by the urologist. A radiology imaging exam performed by a radiological technologist (imaging of the patient) must also have the data interpreted by the radiologist.

6.16.4.3. MEPRS
Collect the procedural component of interventional radiology for procedures that do not require medically supervised recovery (e.g., patient is able to respond to verbal stimulus for the entire procedure and is able to depart upon termination of the procedure), in the BBMA MERPS account. Collect the procedural component of interventional radiology, for procedures requiring medically supervised recovery (e.g., patient needs to be supervised in the post-anesthesia care unit), in the BBM5 MEPRS account when the radiologist is AD or civil service.
6.17. Health Exams of Defined Subpopulations, V 70.5_x

6.17.1. E&M Guidance

<table>
<thead>
<tr>
<th>ENCOUNTER TYPE</th>
<th>E&amp;M</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounter with exam, &lt;1 years</td>
<td>99391</td>
</tr>
<tr>
<td>Encounter with exam, 1-4 years</td>
<td>99392</td>
</tr>
<tr>
<td>Encounter with exam, 5-11</td>
<td>99393</td>
</tr>
<tr>
<td>Encounter with exam, 12-17</td>
<td>99394</td>
</tr>
<tr>
<td>Encounter with exam, 18-39</td>
<td>99395</td>
</tr>
<tr>
<td>Encounter with exam, 40-64 years</td>
<td>99396</td>
</tr>
<tr>
<td>Encounter with exam, 65 years or older</td>
<td>99397</td>
</tr>
<tr>
<td>Encounter no exam, counseling provided to an individual, 15 minutes (with provider)</td>
<td>99401</td>
</tr>
<tr>
<td>Encounter no exam, counseling provided to an individual, 30 minutes (with provider)</td>
<td>99402</td>
</tr>
<tr>
<td>Encounter no exam, counseling provided to a group, 30 minutes (with provider)</td>
<td>99411</td>
</tr>
<tr>
<td>Encounter no exam, counseling provided to a group, 60 minutes (with provider)</td>
<td>99412</td>
</tr>
<tr>
<td>Encounter record review only (face to face), no exam, no Counseling, reviewed by provider (physicians, NPs, PAs or IDCs)</td>
<td>99420</td>
</tr>
<tr>
<td>Encounter record review, no exam, no Counseling, reviewed by provider (physicians, NPs, PAs or IDCs)</td>
<td>Do Not Code *</td>
</tr>
<tr>
<td>Encounter Office Consultation</td>
<td>99201</td>
</tr>
<tr>
<td>Encounter Tech Visit, face to face, no privileged provider contact</td>
<td>99211</td>
</tr>
</tbody>
</table>

*Air Force, see your service representative.

6.17.1.1. Privileged Provider Performs Assessment

The appropriate E&M codes should be assigned based on the documentation. Was the encounter for a DoD evaluation of the patient’s ability to perform his mission? Was the encounter for counseling or an examination? The definition of counseling is a dialogue with patient or family on one or more of the subsequent areas:

- diagnostic results, impressions, or recommended diagnostic studies
- prognosis
- risks and benefits of management (treatment) options
- instructions for management (treatment) or follow-up
- risk factor reduction
- patient and family education (CPT Assistant, January 1998, p. 6)

For annual mission specific exams (e.g. Personnel Reliability Program (PRP)), medical decision making might not be the determining factor for the E&M assignment.

6.17.1.2. Prevention Counseling

If the provider is conducting preventive medicine counseling or risk factor reduction counseling, (e.g., counseling on safe sex so long as the patient is not doing anything that could be considered unsafe sex) use codes 99401–99404.

NOTE: These codes are not to be used to report counseling and risk factor reduction interventions given to patients with symptoms or established illness. The code selection is based on provider counseling time. Time spent on risk-factor reduction must be
6.17. Health Exams of Defined Subpopulations, V 70.5_x

Documented. Time spent evaluating the patient for ability to perform the mission or educating the patient is not included in the time used to determine a preventive medical counseling or risk factor reduction.

- Preventive medical counseling or risk factor reduction intervention(s) given to an individual (separate procedure): 15 minutes
- Preventive medical counseling or risk factor reduction intervention(s) given to an individual (separate procedure): 30 minutes
- Preventive medical counseling or risk factor reduction intervention(s) given to an individual (separate procedure): 45 minutes
- Preventive medical counseling or risk factor reduction intervention(s) given to an individual (separate procedure): 60 minutes

Example: The privileged provider is rendering individual counseling on lifestyle modifications for risky behavior, preventive counseling based on family history and occupational exposure. The duration of this visit is 60 minutes with 15 for evaluation to perform the mission (do not include this time), 15 minutes discussing why the patient should stop smoking, exercise, and lose weight (education, do not include this time), and 30 minutes for counseling or risk-factor reduction. Code this as 99402—counseling.

If the provider is conducting a wellness or screening exam (e.g., pelvic examination for women or prostate examination for men) during the PHA, the preventive medicine codes are to be used. A pelvic exam or prostate examination by itself does not justify use of these codes. The appropriate comprehensive history, comprehensive exam and risk factor reduction must be completed.

<table>
<thead>
<tr>
<th>Patient Age (Years)</th>
<th>New Patient</th>
<th>Established Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td>18–39</td>
<td>99385</td>
<td>99395</td>
</tr>
<tr>
<td>40–64</td>
<td>99386</td>
<td>99396</td>
</tr>
</tbody>
</table>

If the provider sees the patient for a problem (e.g., patella femoral syndrome for physical fitness waiver or profile), and reviews the patient’s medical record (e.g. DD Form 2766) as part of the visit, assign the office or outpatient codes 99201–99215.

NOTE: Code selection is based on documentation and new vs. established patient status.

6.17.2. Non-privileged Provider Performs the Assessment

Code selection is based on what takes place during the encounter.

If a review of the medical record and DD Form 2766 results in preventive medicine or risk factor reduction counseling, assign E&M code 99211. Diagnosis coding is based on the type of counseling provided. (See the ICD-9-CM counseling code listing below.)
If a review of the medical record and DD Form 2766 does not result in preventive medicine or risk-factor reduction counseling, assign code V68.89 for the diagnosis.

6.17.3. Diagnosis Coding Rules

6.17.3.1. Use of V70.5 is located in Section 2.2.8.

6.17.3.2. Diagnosis coding is based on the type of counseling given. When counseling is provided, refer to the following series of ICD-9-CM codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V25.09</td>
<td>Family planning (counseling for contraceptive management)</td>
</tr>
<tr>
<td>V65.3</td>
<td>Dietary surveillance and counseling</td>
</tr>
<tr>
<td>V65.40</td>
<td>Other counseling, no other symptoms (NOS)</td>
</tr>
<tr>
<td>V65.41</td>
<td>Exercise counseling</td>
</tr>
<tr>
<td>V65.42</td>
<td>Counseling on substance use and abuse (this is a root code; use the appropriate DoD extender code)</td>
</tr>
<tr>
<td>V65.43</td>
<td>Counseling on injury prevention</td>
</tr>
<tr>
<td>V65.44</td>
<td>HIV counseling</td>
</tr>
<tr>
<td>V65.45</td>
<td>Counseling on other sexually transmitted diseases</td>
</tr>
<tr>
<td>V65.49_x</td>
<td>Other specified counseling (this is a root code, use the appropriate DoD extender code)</td>
</tr>
<tr>
<td>V69.0</td>
<td>Lack of physical exercise</td>
</tr>
<tr>
<td>V69.1</td>
<td>Inappropriate diet and eating habits</td>
</tr>
<tr>
<td>V69.2</td>
<td>High-risk sexual behavior</td>
</tr>
<tr>
<td>V69.3</td>
<td>Gambling and betting</td>
</tr>
<tr>
<td>V69.8</td>
<td>Other problems related to lifestyle</td>
</tr>
<tr>
<td>V69.9</td>
<td>Problem related to lifestyle, unspecified</td>
</tr>
</tbody>
</table>

6.17.3.3. Hearing Conservation and Hearing Loss

DoD unique extender tracking codes:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V41.2_1</td>
<td>Hearing Conservation (HC), PH-1</td>
</tr>
<tr>
<td>V41.2_2</td>
<td>HC, PH-2</td>
</tr>
<tr>
<td>V41.2_3</td>
<td>HC, PH-3</td>
</tr>
<tr>
<td>V41.2_4</td>
<td>HC, PH-4</td>
</tr>
<tr>
<td>V41.2_0</td>
<td>Other and Unspecified problems with hearing</td>
</tr>
</tbody>
</table>

Hearing loss caused by injury:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>E923.8</td>
<td>Other Explosive Materials</td>
</tr>
<tr>
<td>E928.1</td>
<td>Exposure to Noise</td>
</tr>
</tbody>
</table>

6.17.4. Documentation—What to Document

For counseling, the amount of time spent with a patient must be included in the documentation, with the date (e.g., 12 Oct 04, 0900–0930).
6.17. Health Exams of Defined Subpopulations, V 70.5

- Patient presents for annual physical: use preventive medicine codes.
- Patient presents for multiple concerns as well as health maintenance: use both a low-level office visit and a preventive medicine code.
- When reporting preventive medicine counseling codes, document the nature of the counseling and any education provided during the encounter.

6.17.5. Procedural Coding

6.17.5.1. Education and Training for Patient Self-Management

Services prescribed by a physician and provided by a qualified non-physician healthcare professional designed to teach patients how to self-manage illness(es) or disease(s) effectively. The following codes may be reported when a standardized curriculum is used:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>98960</td>
<td>Face-to-face with patient each 30 minutes; individual patient</td>
</tr>
<tr>
<td>98961</td>
<td>2–4 patient</td>
</tr>
<tr>
<td>98962</td>
<td>5–8 patients</td>
</tr>
</tbody>
</table>

6.17.5.2. Procedures in Conjunction with Readiness Encounter

<table>
<thead>
<tr>
<th>Procedures</th>
<th>Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunizations, 90465–90749</td>
<td>Prostate cancer screening, G0102</td>
</tr>
<tr>
<td>Venipuncture, 36415</td>
<td>Pap smear collection, Q0091</td>
</tr>
<tr>
<td>Audiometry:</td>
<td></td>
</tr>
<tr>
<td>Pure tone (threshold), 92252</td>
<td>KOH, 87210, 87220</td>
</tr>
<tr>
<td>Testing of groups, 92559</td>
<td></td>
</tr>
<tr>
<td>Tympanometry, 92567</td>
<td>Guaiac Test, 82270</td>
</tr>
<tr>
<td>Visual acuity and color vision screening, 99172–99173</td>
<td>Dip Stick US, 81002</td>
</tr>
<tr>
<td>EKG, 93000, 93010</td>
<td>Pulmonary Function Test (PFT), 94010–60</td>
</tr>
</tbody>
</table>
6.18. Reconstructive and Cosmetic Surgery

Cosmetic procedures improve the patient’s appearance by plastic restoration, correction, and removal of blemishes. Many cosmetic procedures are coded with the same procedure codes as a reconstructive procedure. Reconstructive procedures are not cosmetic. Reconstructive procedures are performed on abnormal structures, generally to improve function and to approximate normal appearance. Reconstructive procedures are coded using codes in CPT.

**DoD Rule.** Regardless of training or skills maintenance for the provider, the patient must pay for all cosmetic procedures through the Medical Services Accounts (MSA) office and present a paid bill for the services prior to receiving services.

6.18.1. Diagnosis Coding Rules

6.18.1.1. Cosmetic Procedure

The provider determines if a procedure is reconstructive (e.g., to improve function) or cosmetic (e.g., to improve the patient’s appearance or self-esteem). When a provider documents that a procedure is cosmetic, use codes:

- V50.0 Hair transplant
- V50.1 Other plastic surgery for unacceptable cosmetic appearance
- V50.3 Ear piercing
- V50.8 Other. This includes piercing other than the ear.
- V50.9 Unspecified

6.18.1.2. Post-Procedure Services

For routine follow up for cosmetic procedures, use the appropriate V codes, such as V58.30, attention to surgical dressings and sutures, V67.9, follow-up exam following other surgery, and V67.59, follow-up exam following other treatment—other.

6.18.2. Procedural Coding Rules

6.18.2.1. Many procedures can be reconstructive or cosmetic, such as blepharoplasty. Others are only cosmetic, such as hair transplant or lipectomy. When there is a CPT or HCPCS code that accurately reflects the service provided, use the CPT or HCPCS code.

6.18.2.2. Post-Procedure Services
Routine post-procedure services are coded with 99024 for each visit within global period in the CPT/HCPCS field. Complications are coded based on the documented complication and procedures.

NOTE: See section 5.3.2. for a detailed explanation of global period.

6.18.2.3. Botox for Cosmetic Surgery
Code J0585. The number of injections involved is not considered in coding. The physician is required to document the number of units administered to the patient. The number of units is entered in the unit’s field. Units feed to TPOCS and reside on the local server. Units are not a field in the CAPER and are not transmitted to a central database— injection codes are not used in coding Botox used for cosmetic reasons. There is an injection code for therapeutic use of Botox.

Social workers in the mental health and life skills clinic should refer to section 6.8, Mental Health.

6.19.1. E&M Coding Rules

Social work providers **do not** use outpatient office E&M codes in addition to their procedural services. When social work providers furnish diagnostic interviews, psychotherapy, assessments, counseling, and other social work services, the services should be coded as procedures.

6.19.2. Diagnosis Coding Rules

**DoD Rule**

Encounters for post-deployment related conditions will have V70.5_6 as the second code and the patient’s mental health condition listed first.

6.19.2.1. Diagnostic and Statistical Manual (DSM IV)

Mental health diagnoses are based on terminology and codes found in the *Diagnostic and Statistical Manual of Mental Disorders (DSM IV)*. Although the terminology in ICD-9-CM or CHCS does not always match the terminology in DSM IV, the majority of the codes are the same.

6.19.2.2. Coding for Clients Without Mental Disorder Diagnosis

Use V codes for encounters with patients or clients who do not have a mental disorder diagnosis. For example:

- V60.2 Financial problems
- V61.10 Counseling for marital and partner problems
- V61.49 Presence of sick or handicapped person in family or household
- V62.82 Bereavement

Any conditions that may contribute to the patient’s mental condition, affect treatment (e.g., depression, anxiety) are coded as additional diagnoses.

6.19.2.3. Suspected Conditions

Encounters for suspected conditions, including abuse or neglect, that do **not** have any reportable physical signs, symptoms, or conditions when the suspected condition is **ruled out** are to be coded:

- V71 Observation and Evaluation for Suspected Conditions **not found**.
**SPECIALTY CODING**


**6.19.2.4. HIV-Related Conditions**

Patients who have been diagnosed with HIV or AIDS may be evaluated to determine if they are experiencing depression or anxiety that needs the services of a psychiatrist (e.g., pharmacological management of the mental problem). HIV will be reported as the reason for the encounter, then the mental condition, because the mental condition being evaluated is related to the HIV.

**6.19.2.5. Family Advocacy Encounters**

NOTE: For Air Force, AD and Defense Health Program-funded civilians, report family advocacy program (FAP) encounters. Refer to “Behavioral Health Coding Handbook.”

Initial domestic violence encounters for crisis intervention are reported with a code from 995.5 Child Maltreatment Syndrome or 995.8 Other Specified Adverse Effects, not elsewhere classifiable (NEC). The code(s) for any physical injuries sustained, plus the appropriate E codes for external cause of injury, will be additional codes. Subsequent encounters for counseling will be reported with a V code such as:

- V61.10 Counseling for marital and partner problems
- V61.12 Counseling of perpetrator of spousal and partner abuse
- V61.21 Counseling of victim or child abuse
- V61.22 Counseling for perpetrator of parent or child abuse
- V62.83 Counseling for perpetrator of physical or sexual abuse (used for a perpetrator who is not a parent, spouse, or partner of the victim)

**6.19.3. Procedural Coding Rules**

**6.19.3.1. Social workers will use 90791, the CPT psychiatric diagnostic interview examination codes for many initial encounters.**

<table>
<thead>
<tr>
<th>Description</th>
<th>ICD-9-CM</th>
<th>E&amp;M</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial FAP assessment; no evidence or allegation</td>
<td>V71.9</td>
<td>N/A</td>
<td>90791</td>
</tr>
<tr>
<td>Initial FAP assessment; evidence or allegation present; adult maltreatment</td>
<td>995.80</td>
<td>N/A</td>
<td>90791</td>
</tr>
<tr>
<td>Initial FAP assessment; evidence or allegation present; child maltreatment</td>
<td>995.50</td>
<td>N/A</td>
<td>90791</td>
</tr>
<tr>
<td>Individual follow-up for maltreatment</td>
<td>995.80or 995.50 and V61.10</td>
<td>N/A</td>
<td>90832-30 min 90834-45 min 90837-60 min</td>
</tr>
<tr>
<td>Group treatment</td>
<td>995.80 or 995.50 and V61.20 or V61.22</td>
<td>N/A</td>
<td>90853</td>
</tr>
<tr>
<td>Marital or family treatment</td>
<td>995.80 or 995.50 &amp; V61.20 or V61.22</td>
<td>N/A</td>
<td>90847</td>
</tr>
</tbody>
</table>
## 6.19. Social Work and Family Advocacy Services

### 6.19.3.2. Use of HCPCS Level II Codes

Social workers will also use HCPCS Level II codes. For example, an initial encounter for domestic violence is coded S9484, crisis intervention mental health services, per hour.

### 6.19.3.3. Health and Behavior Assessment/Intervention (96150–96155)

Health and behavior assessment or intervention codes are to be used by social workers and other non-physicians. These codes are not intended for use by physicians. Non-physician providers assess patients with acute or chronic medical illnesses who might benefit from counseling. Patients have psychiatric issues that may affect their illness or hinder treatment. Patients treated for psychiatric diagnoses are not coded using the Health and Behavior Assessment/Intervention.

### 6.19.3.4. Modifiers

The following modifiers are used to identify the type of provider or to provide more specificity about a service than is listed in the CPT or HCPCS Level II coding manuals.

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
<th>PROVIDER</th>
<th>APPEND TO</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Increased procedural service</td>
<td>Mental/behavioral health provider</td>
<td>CPT &amp; HCPCS codes</td>
<td>Indicates the service was more than is normally provided for the reported procedure (usually at least 25% more work involved).</td>
</tr>
<tr>
<td>32</td>
<td>Mandated services</td>
<td>Mental/behavioral health provider</td>
<td>CPT &amp; HCPCS codes</td>
<td>Services mandated by law or regulation other than DoD regulations.</td>
</tr>
<tr>
<td>AJ</td>
<td>Clinical social worker</td>
<td>Clinical social worker</td>
<td>HCPCS codes</td>
<td>Indicates type of provider.</td>
</tr>
<tr>
<td>H9</td>
<td>Court-ordered</td>
<td>Mental/behavioral health provider</td>
<td>HCPCS codes</td>
<td>Indicates the service was ordered by a court, a probation officer, or a parole officer.</td>
</tr>
<tr>
<td>HE</td>
<td>Mental health program</td>
<td>Mental/behavioral health provider</td>
<td>HCPCS codes</td>
<td>Designates that a procedure is associated with a program specifically designed to provide mental health services.</td>
</tr>
<tr>
<td>HO</td>
<td>Master’s degree level</td>
<td>Mental/behavioral health provider</td>
<td>HCPCS codes</td>
<td>Provider’s education is master’s degree level</td>
</tr>
<tr>
<td>HP</td>
<td>Doctoral level</td>
<td>Mental/behavioral health provider</td>
<td>HCPCS codes</td>
<td>Provider’s education is doctoral level</td>
</tr>
</tbody>
</table>
### SPECIALTY CODING


<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
<th>PROVIDER</th>
<th>APPEND TO</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>HQ</td>
<td>Group setting</td>
<td>Mental/behavioral</td>
<td>HCPCS codes</td>
<td>Reported services are provided to two or more clients who have no definite relationship during a single treatment encounter.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>health provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HR</td>
<td>Family/couple</td>
<td>Mental/behavioral</td>
<td>HCPCS codes</td>
<td>Reported services are provided to two or more clients who have a familial or significant other relationship, during a single tx encounter.</td>
</tr>
<tr>
<td></td>
<td>with client present</td>
<td>health provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HS</td>
<td>Family/couple</td>
<td>Mental/behavioral</td>
<td>HCPCS Codes</td>
<td>Reported services are provided to two or more clients who have a familial or significant other relationship, during a single treatment encounter.</td>
</tr>
<tr>
<td></td>
<td>without client</td>
<td>health provider</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>present</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* HCPCS II modifiers are not available in AHLTA.

### 6.19.4. Documentation of Time-Based Encounters

The actual start and stop time or the total amount of time spent with a patient must be documented to support coding for encounters based on time.

### 6.19.5. Case Management Services

The Case Management coding and reporting framework can be found in Appendix E.
6.20. Substance Abuse Program Services

6.20.1. E&M Coding Rules

### 6.20.1.1. HCPCS H Codes

Generally, behavioral health evaluation services related to substance abuse programs should not be reported with E&M codes. HCPCS Level II codes will be used to report these encounters.

### 6.20.1.2. Lab Results

An encounter solely for the purpose of reviewing laboratory results will be reported with an E&M code.

### 6.20.1.3. Structured Screening Tools

These E&M codes are used when structured screening tools or brief intervention services are used with individuals who are not currently enrolled in a substance abuse program.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99408</td>
<td>Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15-30 minutes</td>
</tr>
<tr>
<td>99409</td>
<td>; greater than 30 minutes</td>
</tr>
</tbody>
</table>

---

Workload performed by Non-Defense Health Program-funded personnel is NOT captured in ADM.

**Air Force Rule**

Air Force substance abuse rehabilitation services provided by AD and Defense Health program-funded civilians will begin coding for ambulatory services provided. See “Mental Health Coding Handbook.”

**Navy and Army Rule**

Navy Substance Abuse and Rehabilitation Program (SARP) and Army Substance Abuse Program (SAP) encounters will be reported in an ambulatory service B MEPRS clinic in the ADM. Workload performance is measured in visits for this service.

*Army, contact the Service representative for specific guidance on use of HCPCS II and CPT codes.*
6.20. Substance Abuse Program Services

6.20.2. Diagnosis Coding Rules

6.20.2.1. Reporting Substance Abuse Disorders

Substance abuse disorders are never to be reported as dependence without specific documentation of the dependence. Licensed chemical dependency counselors (LCDC) or certified alcohol drug abuse counselors (CADAC) can diagnose a substance abuse problem, but a privileged provider must evaluate the patient for a diagnosis of dependence to be established.

6.20.2.2. Coding for Patients Without Substance Abuse Diagnosis

Patients who present to the clinic seeking program information or advice without a diagnosed substance abuse problem are coded V65.42—a root code—with the appropriate DoD extender. Encounters with a person seeking information or advice for someone else (e.g., for a family member) are coded V65.19, person consulting on behalf of another.

6.20.2.3. Medical Treatment for Physical Condition

Medical treatment for an acute physical condition caused by substance abuse or dependence is coded and sequenced as a poisoning, with the E code for the substance and circumstance. The abuse will be an additional diagnosis.

6.20.3. Procedural Coding Rules

Most encounters by CADAC, including evaluation for eligibility for a SAP, will be reported using H codes from the HCPCS Level II coding manual.

<table>
<thead>
<tr>
<th>CPT Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>82075  Breath analyzer</td>
</tr>
<tr>
<td>99082  Transportation</td>
</tr>
<tr>
<td>90885  Psychiatric evaluation of records, tests, etc.</td>
</tr>
<tr>
<td>90887  Fitness for evaluation</td>
</tr>
<tr>
<td>90889  Prepare reports for agencies</td>
</tr>
</tbody>
</table>

6.20.4. Modifiers Used in Substance Abuse Programs

The following modifiers are used to identify the type of provider or to provide more specificity to a service than is listed in the CPT or HCPCS Level II coding manuals.

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
<th>PROVIDER</th>
<th>APPEND TO</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Increased procedural service</td>
<td>Mental/behavioral health provider</td>
<td>CPT &amp; HCPCS codes</td>
<td>Indicates service was more than is normally provided for the reported procedure (usually at least 25% more work involved).</td>
</tr>
<tr>
<td>32</td>
<td>Mandated service</td>
<td>Mental/behavioral health provider</td>
<td>CPT &amp; HCPCS codes</td>
<td>Services mandated by law or regulation other than DoD.</td>
</tr>
</tbody>
</table>
## SPECIALTY CODING
### 6.20. Substance Abuse Program Services

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
<th>PROVIDER</th>
<th>APPEND TO</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>AH</td>
<td>Clinical psychologist</td>
<td>Clinical psychologist</td>
<td>HCPCS codes</td>
<td>Indicates type of provider.</td>
</tr>
<tr>
<td>AJ</td>
<td>Clinical social worker</td>
<td>Clinical social Worker</td>
<td>HCPCS codes</td>
<td>Indicates type of provider.</td>
</tr>
<tr>
<td>H9</td>
<td>Court ordered</td>
<td>Mental/behavioral health provider</td>
<td>HCPCS codes</td>
<td>Indicates the service was ordered by a court, probation officer, or parole officer.</td>
</tr>
<tr>
<td>HE</td>
<td>Mental health program</td>
<td>Mental/behavioral health provider</td>
<td>HCPCS codes</td>
<td>Designates a procedure is associated with a program specifically designed to provide mental health services.</td>
</tr>
<tr>
<td>HF</td>
<td>Substance abuse program</td>
<td>Mental/behavioral health provider</td>
<td>HCPCS codes</td>
<td>Designates a procedure is associated with a program specifically designed to provide substance abuse services.</td>
</tr>
<tr>
<td>HG</td>
<td>Opioid addiction treatment program</td>
<td>Mental/behavioral health provider</td>
<td>HCPCS codes</td>
<td>Designates a procedure is associated with a program specifically designed to provide opioid treatment services, including but not limited to the provision of methadone and levo-alpha-acetylmethadol (LAAM).</td>
</tr>
<tr>
<td>HO</td>
<td>Master’s degree level</td>
<td>Mental/behavioral health provider</td>
<td>HCPCS codes</td>
<td>Provider’s education level is a master’s degree</td>
</tr>
<tr>
<td>HP</td>
<td>Doctoral level</td>
<td>Mental/behavioral health provider</td>
<td>HCPCS codes</td>
<td>Provider’s education level is a doctorate</td>
</tr>
<tr>
<td>HQ</td>
<td>Group setting</td>
<td>Mental/behavioral health provider</td>
<td>HCPCS codes</td>
<td>Reported services are provided to two or more clients who have <strong>no definite</strong> relationship during a single treatment encounter.</td>
</tr>
<tr>
<td>HR</td>
<td>Family/couple with client present</td>
<td>Mental/behavioral health provider</td>
<td>HCPCS codes</td>
<td>Reported services are provided to two or more clients who <strong>have</strong> a familial or significant other relationships during a single treatment encounter</td>
</tr>
<tr>
<td>HS</td>
<td>Family/couple without client present</td>
<td>Mental/behavioral health provider</td>
<td>HCPCS codes</td>
<td>Reported services are provided to two or more clients who <strong>have</strong> a familial or significant other</td>
</tr>
</tbody>
</table>
6.20. Substance Abuse Program Services

<table>
<thead>
<tr>
<th>MODIFIER</th>
<th>DESCRIPTION</th>
<th>PROVIDER</th>
<th>APPEND TO</th>
<th>EXPLANATION</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>relationships during a single treatment encounter</td>
</tr>
</tbody>
</table>

Examples: A master’s level LCDC conducts substance abuse counseling with an AD patient and his wife as part of the soldier’s treatment program.

A patient in the SAP who is being treated by a psychiatrist with Antabuse is seen for management of the medication. 90863 Pharmacological management modifier HF indicates this is being done for a patient in an SAP.

6.20.5. Documentation of SAP Treatment

Documentation of SARP treatment is governed by Navy regulations. Referral of patients to the SARP or SAP through medical channels is documented on an SF 513. Military health records (HREC) and outpatient treatment records (OTR) will only contain the following notation for outpatient mental health treatment: “Patient seen, refer to file number 40-216k1” for adults or “Patient seen, refer to file number 40-216k2” for minors. The referenced file will contain the actual documentation of any mental health treatment.

6.20.6. Documentation of Time-Based Encounters

The actual start and stop time or the total amount of time spent with a patient must be documented to support coding for encounters based on time.
Chapter 7 CODING AMBULATORY PROCEDURE VISIT (APV) ENCOUNTERS

Coding audits indicate that the DoD needs to improve coding of APV procedures in five areas: procedure or service not coded, code(s) not supported by documentation, appropriate use of modifiers, appropriate use of quantity, and future focus on coding improvement (codes not matched to correct diagnosis, sequencing, and application of ancillary services). APV procedures can occur in the ambulatory procedure unit, emergency department, clinic, or outpatient activities on a ward. Diagnostic radiology and laboratory procedure codes should not be coded in the ADM, since that workload is reported in other MHS systems. Administration of local anesthesia is not reported separately because it is considered part of the procedure.

7.1. Definitions

The definition of APV per Department of Defense Instruction (DoDI) 6025.8, Subject: APV, dated September 23, 1996, was modified by the UBU effective 01 Oct 2004. The complete list of CMS-approved ambulatory surgical center (ASC) procedures is at http://www.cms.hhs.gov/ASCPayment/.

7.1.1. Ambulatory Procedure Visit

APVs are defined as procedures or surgical interventions that require pre-procedure care, a procedure, and immediate post-procedure care, directed by a qualified healthcare provider. Minor procedures performed in an outpatient clinic that do not require post-procedure care by a medical professional are not considered APVs. The nature of the procedure and the medical status of the patient combine to require short-term, but not inpatient care. These procedures are appropriate for all types of patients (obstetrical, surgical, and non-surgical) who, by virtue of the procedure or anesthesia, require post-procedure care or monitoring by medical personnel. Requiring an individual to remain in the area for a period of time, such as 20 minutes after an injection, is not post-procedure care.

7.1.2. Ambulatory Surgery Program

A facility program for the performance of elective surgical procedures is defined as an APV in DODI 6025.8. APV care is not to exceed 23 hours and 59 minutes; measured from the time patient care begins in the MTF to the time the patient no longer requires medical supervision. Being checked in CHCS does not begin patient care. Frequently, care begins a significant amount of time after the nurse activates the encounter in CHCS. An APV patient who stays beyond 24 hours past actual patient care start time must be admitted to a hospital as an inpatient, if medically necessary. APV patients staying beyond 24 hours after start of care are not automatically admitted. As with any admission, there must be a written order from a provider to change an APV to an admission.

Observation is not an APV.

7.1.3. Ambulatory Procedure Units (APUs)

APUs are designated MTF-approved locations or areas that are specially equipped and staffed to perform the level of care associated with APV services. APUs provide a coordinated program of care for patients usually requiring care that lasts less than 24 hours.
7.2. Coding Pre- and Post-Procedure APV Encounters

7.2.1. Global Surgery Coding

Refer to Section 5.3.2

7.2.2. Uncomplicated Post-Operative Encounters

Code these with a 99024 procedure code

7.2.3. History and Physical

Usually a preoperative history and physical is done a few days prior to the scheduled surgery to ensure the patient is a candidate for surgery. The history and physical is coded based on documentation. It becomes part of the APV record. If a pre-op is done within 24 hours of a major operation (having a 90-day global postoperative period), it is not coded unless the decision for surgery was made at that time. In that case, use modifier -57 to indicate the decision for surgery was made during that E&M. Preoperative encounters to check that there have been no significant changes in the patient’s condition are not coded. If there is a significant change that requires medical intervention or a completely different issue is addressed, the encounter should be coded.

7.2.4. Complications

Unlike some civilian coding guidance, all complications (conditions not expected at that time after the surgery) must be documented and coded with an E&M based on the complication documentation.

7.2.5. Postoperative Visits

Visits during the postoperative period that are unrelated to the surgery should be coded and appended with the modifier -24.

7.2.6. Preoperative Appointments

If visits the day before major surgery involve a nurse, but no independent medical judgment (although perhaps following medical staff-approved decision tables), they are usually performed outside the clinic visit and are not collected in the ADM.

7.2.7. Chronic Conditions

Refer to section 2.2.7. Chronic Conditions

7.3. Patient Admitted from APV

If a patient is admitted from an APV, the ADM record should be coded and closed out with disposition type *admitted*. The procedure codes associated with the APV will not be included in the inpatient stay.

7.4. Consultation for APV

When an APV patient requires a consultation, the consulted provider will code the appropriate office visit code in his or her specialty clinic.
7.5. Assistant at Surgery
When coding an APV, capture the additional providers (assistant surgeons) in the Provider field of the ADM screen. The assistant surgeon should be linked to the same CPT code as the operating physician. Code the anesthesia provider on the same ambulatory data record as the surgeon. For anesthesia coding, see section 6.1.

7.5.1. Co-Surgeon
The individual operative report submitted by each surgeon should indicate the distinct service each surgeon provided.

7.6. Code 99199: Institutional Component of an APV

7.6.1. Coding APV’s Institutional Component
There is no CPT or HCPCS code for the institutional component of an APV. To bill, the MHS will use the CPT code 99199 to indicate the institutional component of an APV.

7.6.2. Discontinuance of Code 99199
All MTFs discontinued using the CPT code 99199 as an unlisted code by 30 September 2004. CPT defines 99199 as “unlisted special service, procedure or report.” Most MTFs do not use the CPT code 99199. A few have used it to track unlisted services that currently do not have a code, such as a pediatrician sedating a patient so a radiologist can do a diagnostic imaging procedure.

7.6.3. No RVU with Code 99199
As of 1 October 2004, to ensure correct billing, the MHS only uses the CPT code 99199 for APV data collection and billing. As the code is only for billing, no RVU is associated with it. Using the CPT code 99199 in the MHS now means Institutional Component, APV. Code 99199 will be reported as the last procedure on the lead surgeon’s CAPER.

7.7. Cancelled APVs

7.7.1. Coding Cancelled APVs
A patient may present for an APV, but the procedure is cancelled because:
- Patient develops a condition that contra-indicates surgery (V64.1). For example, patient experiences arrhythmia that causes the procedure to be terminated.
- Patient decides not to have the planned surgery (V64.2).
- The provider is unavailable to perform the APV, or
- Supplies or necessary resources are not available to support the APV (V64.3).

7.7.1.2. Additional Coding
Mark the appointment or encounter as kept. Code 2000F (blood pressure, measure) as a placeholder.

7.7.1.3. Coding Presenting Medical Conditions
It may also be necessary to code presenting medical conditions (e.g., fever, elevated hypertension) that prevented the procedure from being carried out. The first diagnosis coded should be the preoperative diagnosis, secondary diagnosis should be the conditions that prevented the procedure to be performed, then the appropriate V64*.

7.7.1.4. Incomplete Procedures
If a scheduled procedure was started but not completed, use the appropriate surgical CPT code with appropriate modifier;
-52 Reduced Services: Service or procedure partially reduced or eliminated at provider’s discretion.
-53 Discontinued Procedure: Anesthesia has been started or the patient has been prepped in the operating room suite.

7.7.1.5. Anesthesia Cancellations
See Anesthesia section 6.1.11 for coding anesthesia procedures that are cancelled.

7.8. Procedures Not Performed in the APU
Since DoD only reports four procedures in the CAPER, the highest risk or most resource-intensive procedure needs to be listed first. Examples of procedures that are not APVs are services associated with a magnetic resonance imaging (MRI), suturing a laceration, wart removal, removal of wisdom teeth, or unlisted dental procedures. The list of office procedures excludes the DoD ambulatory surgical procedures.
Chapter 8 OTHER FUNCTIONAL ISSUES RELATED TO CHCS/AHLTA OR CLINICAL SCENARIOS

This section provides coding guidance for specific functions and situations.

8.1. Use of the MAIL Function
In the menu across the bottom of the ADM entry screen, mail permits providers with coding questions to forward them to the MTF. The coder who receives this mail determines the most appropriate code for the condition or encounter and replies in a timely manner. This relieves providers from spending excessive amounts of time determining appropriate codes. The provider may also elect to have the coder complete the ADM encounter documentation, according to the policies of the clinic or facility.

8.2. For Clinic Use Only, an ADM function
This function permits each clinic to collect data unique to that clinic. These data are not part of the CAPER and remain at the facility level.

8.3. Additional Providers
This function permits data collection of names and categories of personnel who assist with an encounter. It is especially useful to indicate when a second provider assists in performing a procedure. The second privileged provider may bill a percentage of the procedure in which he/she assists. For nurses and paraprofessional personnel, this function should be used when the data collected justify the time and effort involved in data collection. The categories for additional providers are:
- Attending
- Assisting
- Supervising
- Nurse
- Paraprofessional
- Operating provider #1 (will only appear if APV field is YES)
- Surgeon
- Anesthesia
- GME (resident)

8.4. Resident/GME Services

8.4.1. Definitions for Staff and Providers
For DoD purposes, the following definitions are applicable for staff or providers in a GME program.

Chief Resident. An individual who has completed an accredited residency program, then engaged in an additional year of training and responsibility. Chief residents are board-eligible or board-certified and are able to be privileged in the discipline of their completed specialty training
OTHER FUNCTIONAL ISSUES RELATED TO CHCS/AHLTA OR CLINICAL SCENARIOS

program. Chief residents are frequently licensed independent practitioners. This model is common in internal medicine programs.

**Fellow.** A physician or dentist, who has enrolled in a special fellowship program for additional training, primarily in research.

**Resident.** An individual engaged in a graduate training program in medicine (including all specialties, e.g., internal medicine, surgery, psychiatry, radiology, nuclear medicine, dentistry, podiatry or optometry), who participates in patient care under the direction of supervising practitioners. Such programs must be accredited or certified as appropriate.

**NOTE:** The term *resident* includes individuals in a recognized ACGME (Accreditation Council for Graduate Medical Education) program and individuals in approved subspecialty graduate medical education programs who historically have also been referred to as *fellows* by some sponsoring institutions.

**Intern.** A physician typically in the first year of training after medical school, often described as PGY1. Interns typically do not have a license.

8.4.2. GME Documentation Requirements

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**DoD Rule**

**Physicians at Teaching Hospitals (PATH)/Primary Care Exception.** PATH, which includes the Primary Care exception, does not apply to the MHS, because the MHS funds its own GME programs. GME participants, except for PGY1, are permitted to use any code based on the documentation.

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**DoD Rule**

**Providers who participate in a residency program for GME usually do so with the oversight of an attending or teaching provider.** Licensed physicians have the full range of E&M and procedure codes available. For unlicensed physicians (typically interns or PGY1), coding is limited to lower or mid-range E&M codes and office visit procedure codes.
OTHER FUNCTIONAL ISSUES RELATED TO CHCS/AHLTA OR CLINICAL SCENARIOS

When an attending and resident are both involved in a procedure, the primary provider must be identified in the documentation. The record is coded under the primary and the other individual is assigned the role of either supervising (staff) or GME (resident). The primary provider is the individual who performs critical and key portions of the procedure.

8.4.2.1. Medical Student Documentation

All students, including medical students, may document in the medical record; for appropriate E&M on encounters that involve medical student documentation, refer to 3.1.1.1.

8.4.2.2. Supervision Documentation

Documentation of supervision must be entered into the medical record by the supervising practitioner or reflected in the resident progress notes or other appropriate entries in the medical record (e.g., procedure reports, consultations, discharge summaries). Pathology and radiology reports must be verified by a supervising practitioner.

NOTE: Co-signatures for coding purposes are required unless the notes meet the documentation standards outlined in 1 (d).

(1) Allowable documentation:
(a) SF 600/Progress note or other entry into the medical record by the supervising practitioner, or
(b) Addendum to the resident SF 600 or progress note by the supervising practitioner, or
(c) Co-signature of the SF 600 or progress note or other medical record entry by the supervising practitioner, or
(d) Resident SF 600 or progress note or other medical record entry documenting the name of the supervising practitioner with whom the case was discussed, a summary of the discussion, and a statement of the supervising practitioner’s oversight responsibility for the assessment, diagnosis, plan for evaluation, or treatment.

NOTE: Statements such as the following are acceptable to demonstrate the supervising practitioner’s oversight responsibility. “I have seen and discussed the patient with my supervising practitioner, Dr. X, and Dr. X agrees with my assessment and plan.” “I have discussed the patient with my supervising practitioner, Dr. X, and Dr. X agrees with my assessment and plan.” The supervising practitioner of record for this patient care encounter is Dr. X.

(2) Allowable documentation varies by clinical setting and kind of patient encounter. In all cases, the responsible supervising practitioner must be clearly identifiable in the documentation of the patient encounter or report of reviews of patient material.
Chapter 9 PROFESSIONAL CODING FOR INPATIENT PROFESSIONAL SERVICES

9.1. Background
The MHS captures inpatient workload with professional and institutional data. All CAPERs generated have a flag that indicates if the patient is inpatient or outpatient. The flag can be used to identify all inpatient professional services.

9.2. Definitions

9.2.1. Attending Service
The attending service is the medical or surgical unit to which the patient is officially admitted via admission or transfer orders.

9.2.2. House Staff
House staff consists of medical students, interns (PGY1), and residents working under approved GME program guidelines.

9.2.3. Diagnosis
The documentation records the progression of the workup and treatments leading to the final diagnosis. The coding will reflect what is addressed each day; except for the discharge day when non-surgical admissions coding reflects the discharge diagnoses as outlined in the discharge progress note or narrative summary.

9.2.4. Inpatient Consult
A privileged provider being consulted by the attending provider on an inpatient case will code their initial face-to-face service using inpatient codes 99221-99223. This service will be differentiated from the attending provider’s initial service by the attending provider appending modifier “AI” to their initial service code (99221-99223). This initial service will only be used once per service per admission. All subsequent face-to-face encounters by the consulting provider will be coded with the subsequent inpatient codes (99231-99233). Follow-up inpatient care from that service are coded with subsequent E&M hospital day codes and will also be captured in the consultant’s B clinic.

9.2.5. Institutional Services
Healthcare services provided by interns, residents, fellows, technicians, and some physician extenders and non-privileged providers. It includes resources used or consumed during a patient’s encounter with the healthcare system (e.g., equipment, facilities, utilities, and supplies) including cardiac care units and intensive care units.

9.2.6. Interservice Transfers
If an inpatient is transferred from one clinical service to another for care and the transfer is noted in CHCS, an inpatient CAPER may be generated for both the losing and gaining clinical services for that day.
9.2.7. Professional Services
Healthcare services provided directly to the patient by a privileged provider or GME personnel with appropriate documentation. This excludes ancillary services.

9.2.8. Rounds (RNDS)
An appointment type in DoD information systems (CHCS/AHLTA) is designed to capture professional services delivered in the inpatient environment by the service of the attending provider of record.

9.3. Business Rules

9.3.1. Institutional Service or Cost
Inpatient services provided by nurses, technicians, allied health providers, some physician extenders, and non-privileged providers are counted as a part of institutional service/cost and will not produce an inpatient professional service round in CHCS. Documentation by interns, residents, and physician assistants in and of itself is insufficient to support coding of a rounds encounter.

NOTE: To utilize hospital discharge day management code 99239, time must be documented.

9.3.2. ADT Module in CHCS
Inpatient professional services rely on appropriate use of the ADT Module. The correct specialty service is designated by the MEPRS code. The attending physician’s name and MEPRS code must be associated with the patient to accurately identify and allocate professional services and costs. This is especially important when patients are transferred from one service to another.

9.3.3. MTFs with GME Program
MTFs that operate a GME program are particularly affected by this effort. For example, MTF medical staff bylaws typically permit the attending (teaching) physician to place documentation in the inpatient record once every three days. If the house staff or attending work is to be captured using the rounds (RNDS) process, the attending provider is required to provide more frequent and detailed documentation. Residents will document the involvement of the staff attending provider’s management of the patient. Residents may be included as the secondary provider on the rounds encounter.

Documentation of supervision must be entered into the medical record by the supervising practitioner or reflected in the resident progress notes or other appropriate entries in the medical record (e.g., procedure reports, consultations, discharge summaries). Pathology and radiology reports must be verified by a supervising practitioner.

NOTE: Co-signatures for coding purposes are required unless the notes meet the documentation standards outlined in 1 (d).
(1) Allowable documentation:
   (a) Progress note or other entry into the medical record by the supervising practitioner, or
   (b) Addendum to the resident progress note by the supervising practitioner, or
   (c) Co-signature of the progress note or other medical record entry by the supervising practitioner, or
   (d) Resident progress note or other medical record entry documenting the name of the supervising practitioner with whom the case was discussed, a summary of the discussion, and a statement of the supervising practitioner’s oversight responsibility for the assessment, diagnosis, plan for evaluation, or treatment.

NOTE: Statements such as the following are acceptable to demonstrate the supervising practitioner’s oversight responsibility. “I have seen and discussed the patient with my supervising practitioner, Dr. X, and Dr. X agrees with my assessment and plan.” “I have discussed the patient with my supervising practitioner, Dr. X, and Dr. X agrees with my assessment and plan.” The supervising practitioner of record for this patient care encounter is Dr. X.

(2) Allowable documentation varies by clinical setting and kind of patient encounter. In all cases, the responsible supervising practitioner must be clearly identifiable in the documentation of the patient encounter or report of reviews of patient material.

9.3.4. Inpatient Professional Services for Surgery
See surgical services guidelines 9.5.

9.3.5. Ancillary Services
For the purposes of the MHS and these guidelines, ancillary services include radiology, laboratory, pharmacy post-operative pain management, and anesthesiology. These services are not coded in rounds.

9.4. Inpatient Professional Services Data Capture
There are two methods for capturing this workload in ADM/AHLTA/P-GUI.

9.4.1 Auto Generation
The RNDS appointment type will automatically be generated upon admission and each night at the census hour in the MEPRS code of the inpatient service to which the patient is admitted. (Example: A nephrologist admits a patient to internal medicine. The MEPRS code will be AAA based on the service to which the patient is admitted; ADT determines both the attending provider and the service.

Example: When a surgical consult is performed on an internal medicine patient who is subsequently transferred to the surgical service on the same day, the surgeon cannot get credit for the consultation and the RNDS on the same patient on the same day.
**PROFESSIONAL CODING FOR INPATIENT PROFESSIONAL SERVICES**

9.4.1.1 Default to Admitting Provider

If the attending provider field is not filled in, the default will be the admitting provider. In a GME program, this is extremely important since the ambulatory data record-generated IBWA round will default to the house staff, if the house staff is listed as *admitting provider*. Per MHS policy, house staff do not have admitting privileges. If a house staff officer receives an inpatient RNDS, the record needs to be redirected to the attending provider and the ADT module must be updated appropriately.

9.4.1.2. Appointment Status Default to Kept

CHCS automatically sets the appointment status to *kept*. This will generate an encounter to be completed by the physician/provider.

9.4.2. Manual Creation

Use the RNDS Appointment Processing option to create new RNDS appointments. There are two common reasons for creating a RNDS manually.

1. Interservice transfers at the same facility: When a transfer is not precipitated by a consult, or the consult was done on a day preceding the transfer, a RNDS encounter will be initiated using the manual creation feature in DoD systems.

2. Transfer precipitated by the consult module on the same day. Instead of collecting the inpatient consult in the B MEPRS, use the Data Entry Menu/Rounds Appointment Processing to generate a RNDS visit in the A MEPRS.

**NOTE:** The inpatient admission E&M is collected by the admitting clinical service and is appended with modifier AI; an E&M is not collected in the clinic (or *B* MEPRS). The workload for an inpatient consult that results in the transfer to a new service is collected in the RNDS E&M for the new service for that day.

9.4.2.1. Inter-service Transfer at Same Facility Without Referral Initiated in the Consult Module.

When an inpatient is transferred from one clinical service to another for care and the transfer is noted in CHCS, an inpatient E&M may be generated for both the losing and the gaining clinical service for that day.

**NOTE:** The gaining clinical service will have to manually generate a new encounter. The E&M will be based on the rounds documentation for that service for that day.

**Example:** A patient changes services (e.g., a surgical patient with a post-surgical embolism is transferred to internal medicine). One E&M may be coded in the initial service (surgery) and one E&M may be coded in the new service for that day (internal medicine).
Example: When a patient is transferred from service A to service B and the attending
on service B sees the patient and had completed an inpatient consult earlier that day,
an RNDS record for the attending on service B will need to be manually generated
and completed.

9.4.2.2. Recording a Procedure by another Provider at the Same Clinical Service

Example: Dr. A makes rounds on patient X in the morning. Dr. A documents
sufficiently for E&M code 99232 for the rounds with appropriate diagnoses. Dr. B
(same clinic service, covering for Dr. A) is called to see patient X that same calendar
day. Dr. B documents patient’s fever, headache, and stiff neck and wants to rule out
meningitis. Dr. B performs a lumbar puncture. Additional diagnosis codes would be
added to Dr A’s ADM RNDS encounter. Enter Dr. B as an additional provider on Dr.
A’s ADM record for the total E&M services.

9.4.2.3. A separate RNDS encounter would be created for Dr B with diagnosis codes for fever,
headache and stiff neck. These diagnosis codes support the medical necessity for the procedure
(lumbar puncture). The lumbar puncture code (62270) would be coded on Dr B’s ambulatory
data record. Dr B’s E&M was included in Dr A’s CAPER.

9.4.3. RNDS Record Completion

Complete the RNDS encounter based on the patient interaction and the documentation in the
inpatient record. The physician or provider is responsible for documenting all patient encounters
in the medical record in accordance with hospital and Service policies. Codes will be assigned
based on documentation.

9.4.3.1. Dates for RNDS Documentation

RNDS encounters will be completed for the dates the attending physician sees and documents
the encounter with the patient. If house staff sees the patient and the attending provider is not
physically present during the portion of the service that determines the level of service and the
attending does not document the key components of those services, no RNDS encounter will be
completed. The RNDS appointment for that date should be cancelled by the physician or
provider (or by the coder upon completion of the inpatient stay), although it will automatically
disappear after 30 days. Once cancelled or after 30 days, the RNDS appointment cannot be re-
created.

NOTE: Even though the rounds appointment is canceled, patients may appear on other
reports as “kept” appointments.

9.4.4. E&M Coding

9.4.4.1. Services Recorded Once Daily

E&M services may only be recorded once per patient per clinical specialty day. The correct
codes are based on the sum of the documentation of all E&M services.
NOTE: If the admission E&M is not documented within 24 hours by the attending, then only the E&M code for a subsequent day of care can be used. The attending provider must append modifier “AI” to their E&M admission (99221-99223). Once the initial hospital care visit is completed and fully documented, only two of the three components for an E&M are required to be documented on subsequent visits. Multiple E&M codes can be reported in a cost center but they must all be recorded on one RNDS encounter. Generally, one E&M code is sufficient.

9.4.4.2. Coding for Multiple Providers
When multiple providers from the same clinical specialty cover for the attending provider, and the attending provider does not see the patient at all that day, the E&M services will be coded under the name of the last provider who documents services on that calendar day. This will require the default provider on the ADM to be changed to the last provider of the day. All other providers may be listed as additional providers on the encounter record.

9.4.4.3. Providers Covering for Attendings
Providers covering for the attending are considered to be in the same specialty as the attending, even if the provider is from a different specialty. For example, if it is an internal medicine patient, then it is internal medicine work, even if the provider covering is a family practice provider.

9.4.4.4. Inter-Service Transfer.
When an inpatient is transferred from one clinical specialty to another for care, and the transfer is noted in CHCS, an inpatient ambulatory data record may be generated for both the losing and gaining clinical specialty for that day. NOTE: The gaining clinical specialty will have to manually generate a new RNDS encounter if the patient is not transferred through a consult.

Example: Patient is transferred from one clinical service to another for care and the transfer is noted in CHCS, an inpatient round will be auto generated for the losing clinical service and the gaining clinical service will have a manually created round for that day.

<table>
<thead>
<tr>
<th>E&amp;M</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1 99221-23</td>
<td>1 Round Medicine</td>
</tr>
<tr>
<td>Day 2 99231-33</td>
<td>1 Round Medicine</td>
</tr>
<tr>
<td>Day 3 99231-33</td>
<td>1st Round Medicine</td>
</tr>
<tr>
<td></td>
<td>2nd Round (Receiving provider gets the created round) Orthopedic Service</td>
</tr>
<tr>
<td>Day 4 99231-33</td>
<td>1 Round Orthopedic Service</td>
</tr>
<tr>
<td>Day 5 99238-39</td>
<td>Discharge Orthopedic Service</td>
</tr>
</tbody>
</table>
9.4.4.5. Transfer on Day of Consult

If the patient is transferred to a new specialty on the day of the consult, **no RNDS appointment** is completed. As noted in the example below, the consultation is attributed to the Psychiatry B Clinic. **NOTE: A consult must be in the chart.**

**Example:** A patient who has taken an overdose as a suicide attempt is admitted to the internal medicine service. The internist requests a psychiatry consult. The psychiatrist sees the patient and recommends the patient be transferred to the psychiatry service when medically stable. The next day, the patient is deemed medically stable and the transfer occurs.

<table>
<thead>
<tr>
<th>Day</th>
<th>E&amp;M</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>99221-23</td>
<td>1 Round Medicine</td>
</tr>
<tr>
<td>Day 2</td>
<td>99231-33</td>
<td>1 Round Medicine</td>
</tr>
<tr>
<td>Day 3</td>
<td>99231-33</td>
<td>1st Round (Transferring Attending) Medicine</td>
</tr>
<tr>
<td></td>
<td>99251-55</td>
<td>Consult to B Clinic Psychiatry</td>
</tr>
<tr>
<td>Day 4</td>
<td>99231-33</td>
<td>1 Round Psychiatry</td>
</tr>
<tr>
<td>Day 5</td>
<td>99238-39</td>
<td>Discharge Psychiatry</td>
</tr>
</tbody>
</table>

9.5. Surgical Services

9.5.1. Elective Surgery

When elective/non-elective surgery is determined to be necessary, assign appropriate E&M code with modifier -57 in addition to any surgical procedure codes performed by the same provider.

9.5.2. Surgery More Than Two Days after Admission

If surgery is not the day of or the day after admission, use inpatient hospital care E&M codes.

Review rules for modifiers if care involves a separately identifiable E&M service on the day of procedure (-25) or an unrelated E&M service during the post-op period (-24).

9.5.3. Assigning CPT Codes

Assign CPT codes for any operating room or bedside procedures.

9.5.4. Post-Surgical Codes

Assign code 99024 for routine postoperative follow-up visits.

9.5.5. Surgical Specialty

Following are scenarios that surgical specialists may encounter. The following codes are reported by surgical specialists:

<table>
<thead>
<tr>
<th>SCENARIO</th>
<th>E&amp;M</th>
<th>CPT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective surgical admission: scheduled total knee replacement</td>
<td>N/A</td>
<td>27447</td>
</tr>
</tbody>
</table>
Non-elective surgical admission: patient presents to ED with abdominal pain; admitted for appendectomy | 9922-57 | 44950

Medical admission for pneumonia; patient develops pulmonary embolism and requires embolectomy with cardiopulmonary bypass | If applicable, E&M code with modifier -57 if decision for surgery is made that day or within 24 hours of surgery | 33910

### 9.5.6. Professional Services Scenarios for Inpatient Encounters

#### GYN Example:
Patient with menorrhagia is admitted to GYN for planned hysterectomy. Hysterectomy was performed the day of admission. It was determined that uterine fibroids were the cause of menorrhagia.

<table>
<thead>
<tr>
<th>Planned admission w/out complication</th>
<th>ICD-9</th>
<th>E&amp;M</th>
<th>CPT</th>
<th>Responsible Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>Uterine fibroids</td>
<td>N/A</td>
<td>Hysterectomy</td>
<td>GYN</td>
</tr>
<tr>
<td>Day 2</td>
<td>Aftercare</td>
<td>N/A</td>
<td>99024</td>
<td>GYN</td>
</tr>
<tr>
<td>Day 3</td>
<td>Aftercare</td>
<td>N/A</td>
<td>99024</td>
<td>GYN</td>
</tr>
<tr>
<td>Discharge</td>
<td>Uterine fibroids</td>
<td>N/A</td>
<td>99024</td>
<td>GYN</td>
</tr>
</tbody>
</table>

#### Family Practice Transfer of Care to General Surgery Example:
Patient was admitted to family practice with abdominal pain. General surgery consulted on day 3 of admission and determined a diagnosis of appendicitis. Care was transferred to general surgery. On day 3, an appendectomy was performed. General surgery consulted prior to transfer of care so the consult with -57 modifier is entered in the B MEPRS for general surgery since it was not the attending practice at the time.

<table>
<thead>
<tr>
<th>Medical condition w/global event</th>
<th>ICD-9</th>
<th>E&amp;M</th>
<th>CPT</th>
<th>Responsible Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>Abdominal Pain</td>
<td>99221–99223</td>
<td>~</td>
<td>Family Practice</td>
</tr>
<tr>
<td>Day 2</td>
<td>Abdominal Pain</td>
<td>99231–99233</td>
<td>~</td>
<td>Family Practice</td>
</tr>
<tr>
<td>Day 3</td>
<td>Appendicitis</td>
<td>992xx-57</td>
<td>Appendectomy</td>
<td>General Surgery</td>
</tr>
<tr>
<td>Discharge</td>
<td>Appendicitis</td>
<td>N/A</td>
<td>99024</td>
<td>General Surgery</td>
</tr>
</tbody>
</table>

#### OB Care Example:
Patient admitted for planned C-section. There were no complications during delivery or admission.

<table>
<thead>
<tr>
<th>OB with planned C-section</th>
<th>ICD-9</th>
<th>E&amp;M</th>
<th>CPT</th>
<th>Responsible Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAY 1</td>
<td>Delivery codes</td>
<td>N/A</td>
<td>5XXXX</td>
<td>OB</td>
</tr>
<tr>
<td>DAY 2</td>
<td>Post-partum aftercare</td>
<td>N/A</td>
<td>99024</td>
<td>OB</td>
</tr>
<tr>
<td>DAY 3</td>
<td>Post-partum aftercare</td>
<td>N/A</td>
<td>99024</td>
<td>OB</td>
</tr>
<tr>
<td>Discharge</td>
<td>Per discharge summary/progress note</td>
<td>N/A</td>
<td>99024</td>
<td>OB</td>
</tr>
</tbody>
</table>
PROFESSIONAL CODING FOR INPATIENT PROFESSIONAL SERVICES

**OB Care Example:**
Patient admitted in labor. Baby was delivered the following day. There were no complications during delivery or during admission. See 6.10.4.1.1.3 for Day 1 guidance.

<table>
<thead>
<tr>
<th>OB with normal delivery</th>
<th>ICD-9</th>
<th>E&amp;M</th>
<th>CPT</th>
<th>Responsible Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAY 1</td>
<td>Pregnancy</td>
<td>Delete rounds</td>
<td></td>
<td>OB</td>
</tr>
<tr>
<td>DAY 2</td>
<td>Delivery codes</td>
<td>N/A</td>
<td>59XXX</td>
<td>OB</td>
</tr>
<tr>
<td>DAY 3</td>
<td>Post-partum aftercare</td>
<td>N/A</td>
<td>99024</td>
<td>OB</td>
</tr>
<tr>
<td>Discharge</td>
<td>Per discharge summary/progress note</td>
<td>N/A</td>
<td>99024</td>
<td>OB</td>
</tr>
</tbody>
</table>

**Surgery Example:**
Orthopedist sees patient in clinic and decision is made to admit patient for reduction of fracture.

<table>
<thead>
<tr>
<th>Traumatic Fracture</th>
<th>ICD-9</th>
<th>E&amp;M</th>
<th>CPT</th>
<th>Responsible Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day 1</td>
<td>Fracture code w/ E code 992xx-57</td>
<td>Reduction of Fracture</td>
<td>Ortho</td>
<td></td>
</tr>
<tr>
<td>Day 2</td>
<td>Aftercare</td>
<td>N/A</td>
<td>99024</td>
<td>Ortho</td>
</tr>
<tr>
<td>Day 3</td>
<td>Aftercare</td>
<td>N/A</td>
<td>99024</td>
<td>Ortho</td>
</tr>
<tr>
<td>Discharge</td>
<td>Fracture code w/ E code N/A</td>
<td>99024</td>
<td></td>
<td>Ortho</td>
</tr>
</tbody>
</table>

**Illness with No Complication Example:**
Patient admitted from clinic with a diagnosis of gastritis. On day two, patient developed hyponatremia. No surgical procedure was performed during this stay.

<table>
<thead>
<tr>
<th>Gastritis</th>
<th>ICD-9</th>
<th>E&amp;M</th>
<th>CPT</th>
<th>Responsible Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td>Gastritis</td>
<td>99221–99223</td>
<td>~</td>
<td>Gastro</td>
</tr>
<tr>
<td>DAY 2</td>
<td>Gastritis w/ hyponatremia</td>
<td>99231–99233</td>
<td>~</td>
<td>Gastro</td>
</tr>
<tr>
<td>DAY 3</td>
<td>Gastritis</td>
<td>99231–99233</td>
<td>~</td>
<td>Gastro</td>
</tr>
<tr>
<td>Discharge</td>
<td>Gastritis w/ hyponatremia</td>
<td>99238–99239</td>
<td>~</td>
<td>Gastro</td>
</tr>
</tbody>
</table>

**9.6. Inpatient Consults**

**9.6.1. Outpatient Appointment Type**

Follow current procedures for capturing consults to inpatients, using the outpatient appointment type *walk-in*. When prompted, “Is this clinic visit related to the inpatient stay?” answer *No*. This will ensure credit is given to the appropriate *B* MEPRS code for services rendered.

Inpatient consults are collected using the appropriate E&M code along with the appropriate diagnoses and procedure codes. Example: Dr Orthopedics, an orthopedic surgeon, requests a pulmonary consult on a high-risk surgical patient. In this case, Dr. Pulmonary did not recommend the patient be transferred to his service. The inpatient consult performed by Dr. Pulmonary, the consulting physician, will be entered in CHCS under the *B* MEPRS code along with the appropriate diagnosis and procedures.

9-9

MHS Professional Services Coding Guidelines
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9.7. Subsequent Hospital Care
Use the 99231–99233, 99294, 99296, 99298–99299 codes when an initial consult is completed and the consultant assumes some (both attending and consultant responsible for different aspects of care) or all (patient transferred to consultant) inpatient care.

9.7.1. Same Specialty: Additional Provider
A request for a consult from a physician or provider in the same specialty would be listed as an additional provider on the attending’s inpatient E&M encounter.

**Example:** An internist seeing another internist’s patient would be listed as the additional provider.

**Example:** A cardiologist seeing an internal medicine patient will generate a separate inpatient consultation (B MEPRS). The document will be maintained in the inpatient record and not the clinic.

9.8. Observation Status
This is an outpatient status. Patients may not be discharged from inpatient status to observation status. Patients may be admitted directly from observation. Once admitted, all E&M services, both the observation and inpatient, for a specific condition provided that calendar day (for clinic or observation status) shall be collected in the E&M code for inpatient services. (See also Appendix H for Coding for Observation)

9.8.1. Inpatient Record
All professional services given to the patient are documented in the inpatient record. Ambulatory clinic services for the inpatient are also recorded in the inpatient record.

9.9. Newborn Early Hearing Detection and Intervention (EHDI)
EHDI while the newborn is in the hospital should be documented in the RNDS if done by the attending provider.

**NEWBORN EARLY HEARING DETECTION AND INTERVENTION**

<table>
<thead>
<tr>
<th>Encounter Type</th>
<th>ICD-9-CM Diagnosis Codes</th>
<th>CPT E&amp;M Codes</th>
<th>CPT Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn hearing screening with no abnormalities performed in newborn nursery or neonatal ICU (Inpatient rounds CAPER)</td>
<td>V72.1**</td>
<td>If applicable, 992XX*</td>
<td>92586 or 92587</td>
</tr>
</tbody>
</table>

If a newborn hearing test is performed by the pediatrician, then the service is reported as a "Rounds" encounters.

If a newborn hearing test is performed by the audiologist (a consult), then report to the appropriate "B" MEPRS.