Chapter Ten

MEDICINE SECTION

The medicine section contains a variety of codes describing therapeutic and diagnostic services for all specialty areas that are not reportable within radiology and laboratory/pathology services. Procedures in the medicine section are considered noninvasive or minimally invasive (percutaneous access) procedures and are services not listed in surgery or evaluation and management sections of CPT.

The medicine section includes coding for services such as immunizations, injections, dialysis, infusions, vascular studies, EKGs, Holter monitors, pacemaker procedures, cardiac catheterizations, occupational, physical and speech therapies, allergy services, psychiatry, optometry and chiropractic services, etc.

The medicine section also includes codes that consist primarily of **evaluation and management** services. These codes would be reported in place of visit codes listed in the E/M section of CPT. Examples of these codes include ophthalmology (92002-92004) and psychiatric services (90801-90802). E/M visits should never be reported with these codes.

E/M services may only be reported with diagnostic and therapeutic services in the medicine section when the E/M service is deemed a distinct and separate, identifiable service from the diagnostic or therapeutic service (i.e. an evaluation is performed of a patient complaining of pain and the diagnostic or therapeutic procedure is performed on the same date as part of treatment provided as a result of the condition revealed in the evaluation of the patient).

The same rules apply for **add-on** procedures and **separate** procedures as previously discussed for other sections of CPT.

Supplies are used when performing procedures that are not normally used to perform the procedure would be reported separately with the specific HCPCS supply code or code 99070 where a specific supply code is not available.

The medicine section is broken down into the following subsections:

90281-90399 Immune Globulins, Serum or Recombinant Products

90460-90474 Immunization Administration for Vaccines/Toxoids

90476-90749 Vaccines/Toxoid (Substances)

90785-90899 Psychiatry

90901-90911 Biofeedback

90935-90999 Dialysis

91010-91299 Gastroenterology

92002-92499 Ophthalmology

92502-92700 Otorhinolaryngology

92920-93799 Cardiovascular

93880-93998 Non-Invasive Vascular Diagnostic Studies

94002-94799 Pulmonary

95004-95199 Allergy and Clinical Immunology

95250-95251 Endocrinology

95782-96020 Neurology and Neuromuscular Procedures

96040 Medical Genetics and Genetic Counseling Services

96101-96127 Central Nervous System Assessments/Tests

96150-96161 Health and Behavior Assessment/Intervention

96360-96549 Hydration, Therapeutic, Prophylactic, Diagnostic Injections and Infusions, and Chemotherapy and Other Highly Complex Drug or Biologic Agent Administration

96567-96574 Photodynamic Therapy

96900-96999 Special Dermatological Procedures

97161-97799 Physical Medicine and Rehab

97802-97804 Medical Nutrition Therapy

97810-97814 Acupuncture

98925-98929 Osteopathic Manipulative Treatment

98940-98943 Chiropractic Manipulative Treatment

98960-98962 Education and Training for Patient Self-Management

98966-98969 Non-Face-to-Face Nonphysician Services (i.e. Telephone calls)

99000-99091 Special Services and Reports

99100-99140 Qualifying Circumstances for Anesthesia

99151-99157 Moderate Conscious Sedation

99170-99199 Other Services and Procedures

99500-99602 Home Health Procedures and Services

99605-99607 Medication Therapy Management Services

Immunization administration codes (90460-90474) and **vaccine/toxoid** codes (90476-90749) should be reported together. If a separate identifiable visit is performed when reporting immunization codes, report the appropriate visit code from the E/M section in addition to these codes.

When reporting vaccine and toxoid codes several factors are considered in the code description to ensure accurate reporting of vaccine codes. The **type** of vaccine, **patient age** and the **entry point** (intramuscular, intranasal, oral, intravesical, intradermal, percutaneous and subcutaneous) are included in the description of the codes.

Vaccination codes with the symbol ϟ represent codes that are pending FDA approval.

Psychiatric services include therapeutic and diagnostic treatments for psychiatric conditions. These services are reported using codes 90785-90899.

Psychiatric **interactive complexity** code 90785 is reported as a separate procedure when performed in same session as psychiatric evaluations (90791 and 90792), psychotherapy (90832, 90834 and 90837), psychotherapy visits (90833, 90836, 90838, 99201-99255, 99304-99337, and 99341-99350) and group psychotherapy (90853) codes.

Interactive complexity factors make communicating with the patient more difficult and therefore the interaction and treatment more complex. Generally, the following factors are present when reporting interactive complexity:

- The patient has other individuals legally responsible for their care (child or adult guardian).
- Patient requests that others be present when they are being treated.
- Other third-party entities are required to be present during patient visits and treatment. Examples include child welfare agencies probation officers or school administrators or staff.

Ophthalmology services are reported using codes 92002-92287. Services are categorized under three service types as follows:

- Intermediate ophthalmological services are defined as evaluation of new or existing condition not necessarily related to the original diagnosis of the patient.
- Comprehensive ophthalmological services are defined as a general exam of the entire visual system. Services provided as part of a comprehensive service are not reported separately (slit lamp exam, keratometry, routine ophthalmoscopy, retinoscopy, tonometry, motor evaluation).
- Special ophthalmological services are reported when a special evaluation of part of the visual system is performed beyond a general exam. Special ophthalmological services can be reported with E/M or general ophthalmological services.

Contact lens and eyeglass services also are reported within the ophthalmology services code series.

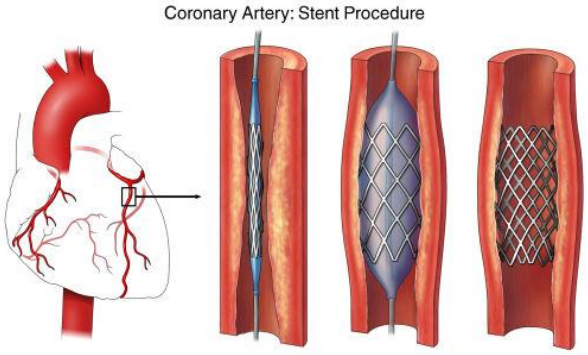
Coronary Therapeutic Services and Procedures are reported in code series 92920-92979 and are used to report **cardiovascular** angioplasty, intracoronary stent atherectomy, revascularization and thrombectomy procedures.

Diagnostic angiography procedures may be reported separately from the coronary interventional procedure when performed at the same session when:

- No other coronary angiography catheter study is available for review and a full study is performed and intervention is required.
- A prior study is available, however, documentation regarding patients condition concludes:
    1. The patient's condition has changed since prior study,
    2. Anatomy and/or pathology are not adequately visualized in previous study, or
    3. There is a clinical change during the procedure that requires evaluation outside of the original targeted area.

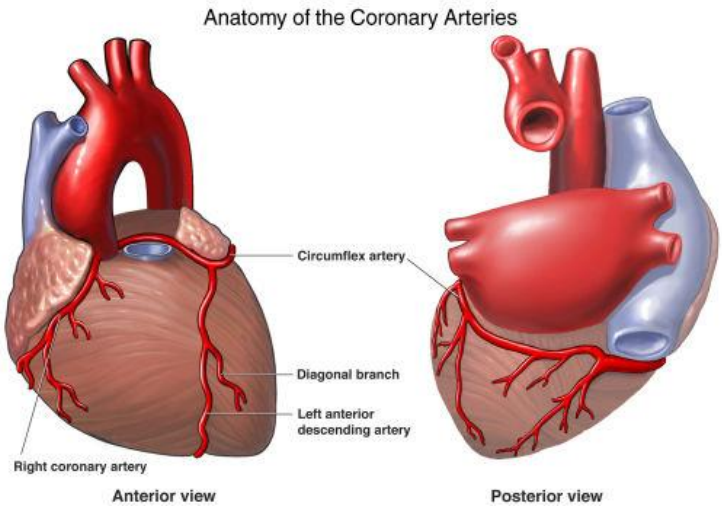
Diagnostic and interventional coronary angiographies are reported separately.

Angioplasties (also called **balloon angioplasty**) are performed when arteries are blocked or contracted usually by plaque (coronary artery disease). The procedure involves threading a thin tube through a blood vessel in the arm or groin up to the blocked area in the artery. The tube has a tiny balloon on the end. When the tube is in place, the balloon is inflated in order to push the plaque outward against the wall of the artery widening the artery and restoring the flow of blood.

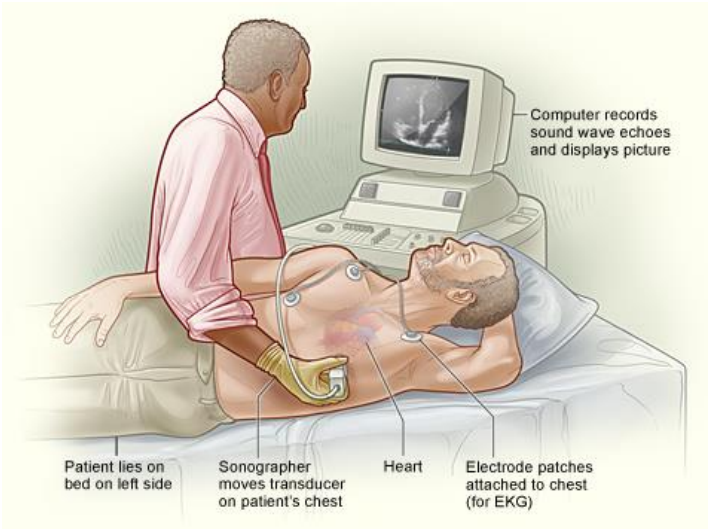


Coronary arteries are categorized as follows:

- **Major coronary artery** includes left main, left anterior descending, left circumflex, right, and ramus intermedius arteries.
- **Coronary artery branches** include up to two coronary artery branches of the left anterior descending (diagonals), left circumflex (marginals/obtuse artery) and right (posterior descending and posterolateral) coronary arteries.
- **Coronary artery bypass grafts** – each coronary artery bypass graft represents a coronary vessel. Sequential bypass graft represents only one bypass graft when more than one distal anastomosis (cross section of vessel) is performed.



Echocardiography uses ultrasound to provide an image of the heart. Transesophageal (TEE) and stress echoes are reported in this category of codes using code series 93303-93355.



Cardiac catheterizations are performed for the purpose of diagnosing problems with the heart. Cardiac catheter procedures are reported using code series 93451-93533.

A cardiac catheterization procedure begins with the provider inserting an intravenous line (IV) into a vein in the arm, neck or groin. A large plastic thin tube called a sheath is placed into a vein or artery in the leg or arm.

Catheters are carefully moved up into the heart using live x-rays as a guide.

The catheter allows physicians to:

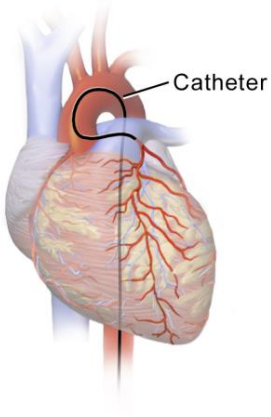
- Collect blood samples from the heart

- Measure pressure and blood flow in the heart's chambers and in the large arteries around the heart
- Measure the oxygen in different parts of your heart
- Examine the arteries of the heart
- Perform a biopsy on the heart muscle

If a blockage is discovered, an angioplasty and a stent placement can be performed during the procedure. A stent is a tube that is utilized to re-enforce an artery that has been narrowed or weakened so that the artery can be salvaged. The cardiac catheterization and stent placement procedures are shown in the illustration below.

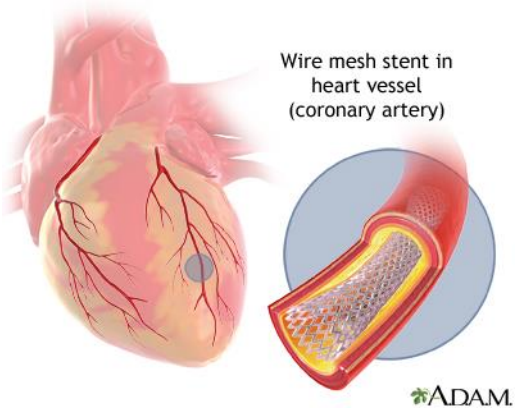
Injection procedures for cardiac catheterizations are reported separately using codes 93561-93572.

Cardiac catheterization



Catheter Entering Coronary Artery

Cardiac Stent Placement



Contrast injections, imaging supervisions, interpretation and report are bundled into the non-congenital cardiac catheter code series 93451–93461 and therefore are not reported separately.

The chart below provides a list of the main component cardiac catheterization code and the services that would be reported separately and would not be reported separately if performed during the same session as the cardiac catheterization.

Summary of Services Bundled & Separately Reported When Performed in Conjunction with Cardiac Catheterization

CPT Code	Non-Congenital Catheter Placement	Imaging Bundled (not separately reported)	Separately reportable-injection procedure (when performed)	Other separately reportable cardiac procedures (when performed)
93451	RHC	N/A	93566, 93567, 93568	93463, 93464
93452	LHC	93565	N/A	93462, 93463, 93464
93453	RHC & LHC	93565	93566, 93567, 93568	93462, 93463, 93464
93454	Coronary	93563	N/A	N/A
93455	Coronary w/Bypass Graft	93563, 93564	N/A	N/A
93456	Coronary w/ RHC	93563	96366, 93567, 93568	93463, 93464
93457	Coronary w/ RHC & w Bypass graft	93563, 93564	96366, 93567, 93568	93463, 93464
93458	Coronary w/ LHC	93563, 93565	N/A	93462, 93463, 93464
93459	Coronary w/ LHC & w Bypass graft	93563, 93564, 93565	N/A	93462, 93463, 93464
93460	Coronary w/RHC and LHC	93563, 93565	96366, 93567, 93568	93462, 93463, 93464
93461	Coronary/ w RHC, LHC, and w/Bypass graft	93563,93564, 93565	96366, 93567, 93568	93462, 93463, 93464

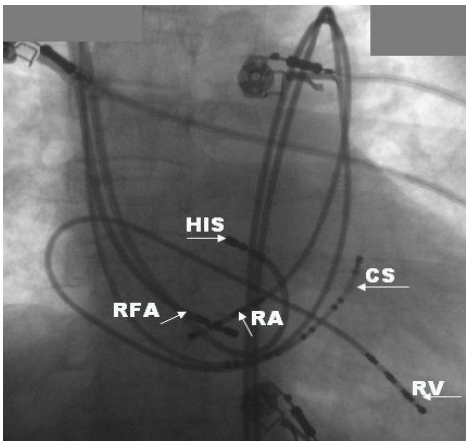
Electrophysiology procedures (EP) are performed to look at the electrical pulse function of the heart. Doctors are able to evaluate the patient heartbeat and heart rhythms to ensure there are no abnormalities. EP procedures are reported using codes in the 93600-93662 series.

When an EP procedure is done, IV's (sheaths) are placed in the neck or groin area. The sheaths are used to position wire electrodes in place on the patient's heart to measure the heart and muscle cell electrical activity. Moving x-ray images are utilized to assist the provider with finding the proper area(s) within the heart to position the electrodes for diagnosis and treatment of the affected site.

Treatments for cardiac arrhythmias are generally performed during the performance of the diagnostic service. There are processes that are performed when the test is performed and treatment provided.

- The EP test **induces** an arrhythmia so that the damaged area is visible to the provider.
- When the area causing the arrhythmia is revealed, the site or electrical path is **mapped.** Mapping is the process by which multiple origin points are visualized and the catheter placed or repositioned at the origin where the arrhythmia is created.
- **Ablation** is performed to repair the arrhythmia origins producing the abnormalities. Ablation is treatment that delivers radiofrequency or cryo-energy to repair the damaged heart tissue.

EP Procedure Session **EP Image During Procedure**



Noninvasive diagnostic vascular studies are performed to check for blood flow in major arteries and veins and to assist with diagnosing blockages in these areas. The studies are performed using ultrasound (high-frequency sound waves).

The different types of ultrasounds used are listed and defined below (information from American College of Radiology).

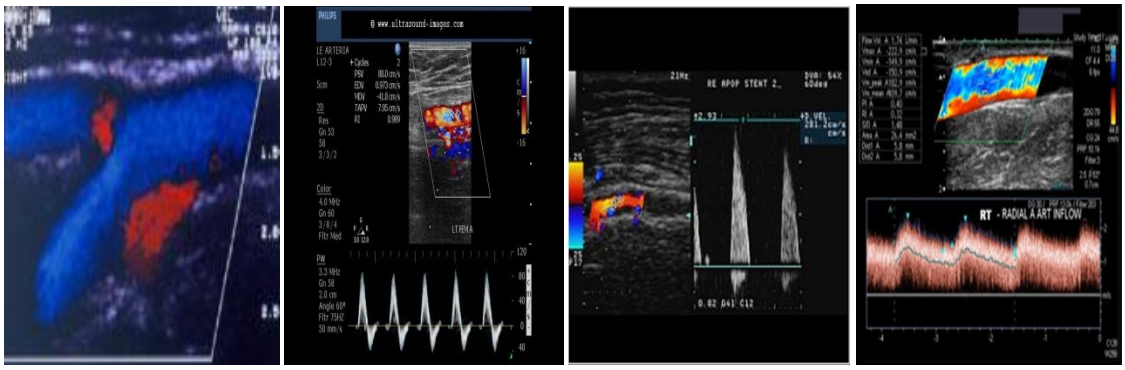
- **Conventional ultrasound** (reported in the 7xxxx series) refers to the use of high frequency sound waves which reflect off structures within the body. Real-time ultrasound is a 2-D scan that depicts structure and motion over time—like a "movie."
- **Doppler ultrasound** uses reflected sound waves to evaluate blood as it flows through a blood vessel. The sound waves bounce off blood cells in a motion that causes a change in the pitch of the sound, called the Doppler Effect. If there is no blood flow, the pitch does not change.
- **Duplex ultrasound** combines Doppler and conventional ultrasound, allowing the radiologist to see the structure of blood vessels, how the blood is flowing through the vessels, and whether there is any obstruction in the vessels. Color Doppler produces a picture of the blood vessel, and a computer converts the Doppler sounds into colors overlaid on the image, representing information about the speed and direction of blood flow. Using spectral Doppler analysis[1], the duplex scan images provide anatomic and hemodynamic information, identifying the presence of any stenosis or plaque in the vessels.
- **Physiologic studies** consist of functional measurement procedures, including ankle/brachial index measurement (ABI), blood pressure (BP) and physiologic waveforms, segmental pressure measurement, plethysmography, and stress testing.

  These studies do not involve imaging. Plethysmography is a measurement of the volume of an organ or limb section, or flow rate, in response to the inflation and deflation of a BP cuff.

CPT code series for **noninvasive vascular studies** are divided into the five different vascular sections.

1. Arteries of the brain (cerebrovascular) – 93880-93895
2. Arteries of the extremities – 93922-93931
3. Veins of the extremities – 93970-93971
4. Visceral Arterial inflow and venous outflow imaging - 93975-93981
5. Hemodialysis access scanning - 93990

Cerebrovascular **Extremity arteries** **Extremity veins** **Hemodialysis**



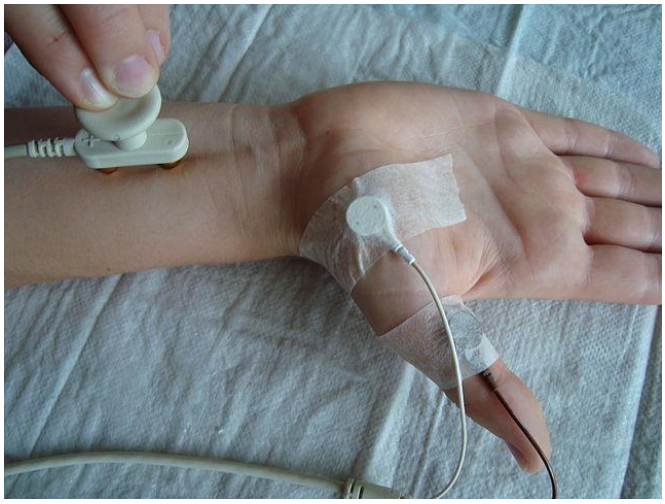
Pulmonary testing and therapies include ventilation management, spirometry, and pulmonary function testing procedures. These codes are reported using code series 94002-94799. These procedures focus on measuring and maintaining lung capacity and are commonly performed for diagnoses such as chronic obstructive pulmonary disease (COPD).

An **electromyogram (EMG)** measures the electrical activity of muscles at rest and during contraction. **Nerve conduction studies** measure how well and how fast the nerves can send electrical signals. These codes are reported in code series 95905-95913.

Nerves control the muscles in the body with electrical signals called impulses. These impulses make the muscles react in specific ways. Nerve and muscle problems cause the muscles to react in abnormal ways. These tests may be performed for a number of reasons including pain or numbness of the extremity. The tests are performed to determine if there are issues with the spinal cord, nerve roots, or nerves and muscles present in the arms and legs and whether the pain and or numbness is caused by a deficiency in these areas.

Nerve conduction study procedure codes are defined are reported by the number of studies performed within one session.

Nerve Conduction Study Test



The following CPT codes are used to report nerve conduction studies. Each type of nerve conduction study is counted only once on the same nerve.

- ✓ **95907** Nerve conduction studies; 1–2 studies
- ✓ **95908** 3–4 studies
- ✓ **95909** 5–6 studies
- ✓ **95910** 7–8 studies
- ✓ **95911** 9–10 studies
- ✓ **95912** 11–12 studies
- ✓ **95913** 13 or more studies

Tests must be performed with separate electrodes for stimulating, recording, and grounding on only those specific nerves needed for the diagnosis in question.

Waveforms must be reviewed on site in real time with reports by the examiner and interpretation by the physician or other qualified health care professionals.

Autonomic function testing is performed to check the function of the nerve connections between the brain, heart and other organs and is reported within code series 95921-95943. These nerve connections control automatic functions such as breathing, heart rate, bowl function and blood pressure. These tests may be performed to diagnose and treat the following conditions:

- ✓ Recurrent dizziness and/or fainting
- ✓ Rapid heart rate
- ✓ Autonomic failure
- ✓ Neurogenic orthostatic hypotension
- ✓ Orthostatic intolerance (symptoms caused by standing and sitting)
- ✓ Sweat disorders

Intraoperative Neurostimulators (IONM), Analysis-Programming procedures are reported in code series 95970-95982. These procedures are performed during surgery for the purpose of analyzing, programming and reprogramming of implanted neurostimulators.

The codes are categorized as to whether the code is initial intra-operative or subsequent event and whether the procedure is for analysis, programming, or reprogramming of the neurostimulator.

Billing note: *A physician should not bill if the service is performed entirely by, or under the direction of, a manufacturer representative. If the service is performed in part by a physician or physician-supervised personnel (in accordance with the Medicare incident to requirements) and in part by a manufacturer representative, the payer and/or a billing expert should be consulted before billing the service.*

The following codes are reported for IONM services that are performed on patients who have commercial insurance. The codes are time-based codes.

- ✓ **95940** Continuous intraoperative neurophysiology monitoring in the operating room, one on one monitoring requiring personal attendance, each 15 minutes (List separately in addition to code for primary procedure)
- ✓ **95941** Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby) or for monitoring of more than one case while in the operating room, per hour (List separately in addition to code for primary procedure)

For Medicare patients, report the following HCPCS code for IONM services.

- ✓ **G0453** Continuous intraoperative neurophysiology monitoring, from outside the operating room (remote or nearby), per patient, (attention directed exclusively to one patient) each 15 minutes (list in addition to primary procedure).

Hydration infusion codes are reported using codes 96360 (31 minutes to 1 hour) and 96361 (each additional hour).

Diagnostic and therapeutic injections and infusions are reported in code series 96365-96379. These codes are used to report the administration of drugs and substances other than chemotherapy. The drug being administered should be reported separately.

Chemotherapy and other complex drug infusion/administration codes are reported within code series 96401-96549. The codes are reported by administration technique, number of lesions injected or time of infusion.

Physical therapy and rehab codes are reported using code series 97161-97546. Codes describe all services provided in PT environment including evaluation (evaluation and re-evaluation), application of modalities (supervised and constant attendance) and therapeutic procedures (i.e. gait training and aquatic therapy).

PT related **wound care management** (97597-97610) and **orthotic and prosthetic management** (97760-97763) codes are also included within the PT series of codes.

Osteopathic manipulative treatment is hands-on manual medical system of treatment which utilizes the distinct osteopathic philosophy, structural diagnosis, and use of osteopathic manipulative techniques in the diagnosis and management of the patient. Doctors of Osteopathy (DO) medicine apply the following principles, as documented by the American Osteopathic Association, to diagnose and treat patients under their care.

1. The body is an integrated unit of mind, body, and spirit.
2. The body possesses self-regulatory mechanisms, having the inherent capacity to defend, repair, and remodel itself.
3. Structure and function are reciprocally interrelated.
4. Rational therapy is based on consideration of the first three principles.

The codes are defined and reported based on the number of body areas that are manipulated.

Chiropractic manipulative treatment is an approach to healing concerned with the diagnosis, treatment and prevention of disorders of the neuromusculoskeletal system and the effects of these disorders on overall general health.

Chiropractic treatment focuses on manual therapy including joint adjustment and manipulation with particular focus on joint dysfunction/subluxations (misalignments).

The chiropractic treatments are defined and reported based on the number of spinal regions manipulated.

Conscious sedation, according to the Encyclopedia of Surgery, is defined as an altered level of consciousness that still allows a patient to respond to physical stimulation and verbal commands, and to maintain an unassisted airway. These codes are reported within code series 99151-99157.

Depending on the procedure being performed, conscious sedation may be bundled into the surgery procedure code or reported separately. A list of CPT codes that include moderate conscious sedation see Appendix G in the CPT book.

The following services are included and not reported separately when patient is administered conscious sedation:

- ✓ Patient assessment
- ✓ IV procedure
- ✓ Administration of conscious sedation materials
- ✓ Maintaining and monitoring of patient under conscious sedation
- ✓ Recovery

These codes are time-based codes. The time begins with the administration of the sedative and ends with the physician contact with the patient under conscious sedation.

Cardiac catheterizations, endoscopic procedures and biopsies are all types of medicine procedures performed using moderate conscious sedation.

Home Health procedures and services performed by non-physician providers are reported using codes 99500-99602. For physician services, E/M codes 99431-99350 should be reported.

Modifiers utilized in the Medicine section are 26, 32, 51, 52, 53, 58, 59, 76, 77, 78, 79, and 99.

 For more information on Psychiatry services visit the American Psychiatric Association website at http://www.psychiatry.org/.

More information on coding for cardiac catheterizations can be found at the American College of Cardiology website at http://www.cardiosource.org/.