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office supplies. These Level II codes consist of one alphabetic character (A through Y) followed by four numbers. A complete list of the HCPCS Level II codes and the quarterly updates to this code set may be found at http://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS_Quarterly_Update.html.

Claim Forms
Institutional (facility) providers use the UB-04 claim form, also known as the CMS-1450, or the electronic 837P format to file a Medicare Part A claim to Medicare contractors. Noninstitutional providers and suppliers (private practice or other health care providers offices) use the CMS-1500 form or the 837P electronic format to submit claims to Medicare contractors for Medicare Part B covered services. Medicare Part A coverage includes inpatient hospital, skilled nursing facilities (SNF), hospice, and home health. Medicare Part B coverage provides payment for medical supplies, physician, and outpatient services. Not all services rendered by a facility are inpatient services. Providers working in facilities routinely render services on an outpatient basis. Outpatient services are provided in settings that include rehabilitation centers, certified outpatient rehabilitation facilities, SNFs, and hospitals. Outpatient and partial hospitalization facility claims might be submitted on either a CMS-1500 or UB-04, depending on the payer.

For professional component billing, most claims are filed using CPT codes to identify the service provided, and HCPCS Level II codes to report supplies on the CMS-1500 paper claim or the 837P electronic format.

Contents and Format of This Guide
The three chapters following this introduction provide information regarding the reimbursement process, documentation, and claim completion, respectively.

The fifth chapter, “Procedure Codes,” contains a numeric listing of procedure codes. Each page identifies the information associated with that procedure including an explanation of the service, coding tips, related terms, and associated diagnoses. Please note that this list of associated ICD-9-CM codes is not all inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

The procedure code page contains related terms and the CMS Manual System references that designate the official references to the service, which is identified by the procedure code and found in the online manual system. The full excerpt from the online CMS Manual System pertaining to the reference is provided in the Medicare official regulatory information appendix. The full text of all of the Internet-Only Manuals (IOM) may be found at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html. The procedure code pages also have a list of codes from the official Centers for Medicare and Medicaid Services National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive or mutually exclusive coding system and should not be reported separately. Please note that the CCI edits will be updated quarterly and posted on Optum’s website at www.optumcoding.com/cciedits.

Finally, all relative value information relevant to the code is listed at the bottom of the page. Following this chapter you will find a CPT procedure code index, an index of ICD-9-CM diagnosis codes for anesthesia services, and a glossary.

Medicare Official Regulatory Information
The full excerpts from the online online CMS Manual System pertaining to anesthesia are provided in this section. Since these excerpts often do not identify the guideline with corresponding CPT code, our experts have crosswalked the appropriate reference, wherever possible, to the applicable procedure or supply code. This crosswalk reference is listed under each applicable CPT code in the definitions, guidelines, and index section. The excerpts are listed in this section in numerical order.

Index and Appendixes
The final section consists of a comprehensive index that provides a list of pages on which each term is discussed, and a glossary of coding, billing, and clinical terms applicable to your specialty. Appendix A contains a list of base units for CPT codes.

How to Use This Guide
The chapters: “The Reimbursement Process,” “Documentation—An Overview,” and “Claims Processing” may be read in their entirety and/or used as references. When using this Coding and Payment Guide for code assignment, follow these important steps to improve accuracy and experience fewer overlooked diagnoses and services:

- **Step 1.** Carefully read the medical record documentation that describes the patient’s diagnosis and the service provided. Remember, more than one diagnosis or service may be documented.
- **Step 2.** Locate the main term for the procedure or service documented in the CPT index. This will identify the procedure code that may be used to report this service.
- **Step 3.** Locate the procedure code in the chapter titled “Procedure Codes.” Read the explanation and determine if that is the procedure performed and supported by the medical record documentation. The Terms to Know section may be used ensure appropriate code assignment.
- **Step 4.** At this time review the additional information pertinent to the specific code found in the coding tips, IOM reference, and CCI sections or the Medicare physician fee schedule references.
- **Step 5.** Peruse the list of ICD-9-CM codes to determine if the condition documented in the medical record is listed and the code identified.

Assessing the ICD-10-CM Code Crosswalks on October 1, 2015
Optum will include the ICD-9-CM to ICD-10-CM crosswalk in the web-based http://www.MedicalCodeExpert.com. This application will allow users of the Coding and Payment Guides.
00102
Anesthesia for procedures involving plastic repair of cleft lip

Coding Tips
Do not report code 00102 for procedures performed on the lip for conditions other than repair of cleft lip. For other, non-cleft-lip repairs, see code 00300. For cleft palate repairs, see 00172. The appropriate modifier indicating the type of provider (i.e., physician, CRNA) as well as the type of service being rendered (i.e., personally performed, medical direction) should be appended to the procedure code. Modifiers indicating the physical status of the patient should also be appended when required by the third-party payer. Note that Medicare does not recognize physical status modifiers.

Terms To Know
- **cleft lip**: Congenital fissure or opening in the upper lip due to failure of embryonic cells to fuse completely.
- **congenital**: Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.
- **fissure**: Deep furrow, groove, or cleft in tissue structures.

Surgical to Anesthesia Code Crosswalk
40700, 40701, 40702, 40720, 40761

ICD-9-CM Diagnostic Codes
- 749.10: Unspecified cleft lip
- 749.11: Unilateral cleft lip, complete
- 749.12: Unilateral cleft lip, incomplete
- 749.13: Bilateral cleft lip, complete
- 749.14: Bilateral cleft lip, incomplete
- 749.20: Unspecified cleft palate with cleft lip
- 749.21: Unilateral cleft palate with cleft lip, complete
- 749.22: Unilateral cleft palate with cleft lip, incomplete
- 749.23: Bilateral cleft palate with cleft lip, complete
- 749.24: Bilateral cleft palate with cleft lip, incomplete
- 749.25: Other combinations of cleft palate with cleft lip
- V13.69: Personal history of other (corrected) congenital malformations
- V51.8: Other aftercare involving the use of plastic surgery

Please note that this list of associated ICD-9-CM codes is not all-inclusive. The procedure may be performed for reasons other than those listed that support the medical necessity of the service. Only those conditions supported by the medical record documentation should be reported.

IOM References
100-4,4,10.4; 100-4,4,10.5; 100-4,4,250.3.2; 100-4,4,250.3.3.1; 100-4,12,140.1; 100-4,12,140.3; 100-4,12,140.3.3; 100-4,12,140.3.4; 100-4,12,140.4.1; 100-4,12,140.4.2; 100-4,12,140.4.3; 100-4,12,140.4.4

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Appendix A: CPT Base Units

As discussed in the reimbursement chapter of this manual, each anesthesia code is assigned a base unit by the American Society of Anesthesiologists (ASA) that reflects the difficulty of the procedure and inherent risks. Base units range from three to 20 units. It should be noted, however, that some payers may revise the base units of certain procedures. CMS also developed base units for anesthesia codes. Base units are used to help calculate payment and should not be included when determining the number of units to be indicated on the claim.

Both the CMS and ASA base unit values represent all usual anesthesia services, with the exception of the time actually spent in anesthesia care as well as any modifying factors that may occur.

The following table contains the 2014 base units assigned by CMS for anesthesia services, the most current at the time of printing.

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