OptumInsight Learning:
Facilities and Ancillary Services

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INTRODUCTION
The medicine section of the CPT book contains codes for diagnostic and therapeutic services such as immunizations, injections, dialysis, specialty specific codes, and special services.

Within the medicine section of the CPT book are a number of subsections for either the type of service provided (e.g., chemotherapy administration) or for the specialty providing the service (i.e., cardiovascular).

Medicare requires HCPCS Level II codes in place of CPT Level I codes for some services listed in the medicine section. See the current ambulatory payment classification (APC) code list with status indicators to determine appropriate code reporting.

Coders are instructed in the medicine codes section of the CPT book to report each procedure separately. The word procedure may also describe a medical or evaluation and management (E/M) service.

BUNDLED MEDICINE CODES
The process of coding integral services separately from a procedure or bundled service is called unbundling or fragmenting. If the component is considered part of the package or bundled service, do not code it individually. For example, 93015 is a bundled code that includes all the components of a stress test and should be reported as such when the complete procedure is performed. If the components 93016 and 93018 are reported instead of the complete test (93015), the payer will probably rebundle the two codes into 93015. The reimbursement is usually greater when the codes are unbundled than when they are reported appropriately, and Medicare and private payers have become adept at isolating and rejecting claims in which procedures have been unbundled. The facility providing the technical component would report services representing only the technical portion and not the professional portion of the procedure.

Do not confuse bundling with the OPPS term packaging. Packaging has a different connotation that does not apply to payment systems other than OPPS. Medicare sets OPPS payment rates based on procedures reported with CPT and HCPCS Level II codes. The term packaged means that Medicare has already incorporated the costs of the packaged service, procedure, or item into the payment rate that they have established. It does not mean that the service should be bundled, not billed, or not paid.

For example, CPT code 92504 Binocular microscopy (separate diagnostic procedure), is a packaged service. This does not mean that it should not be billed or reported. It means that Medicare has already included the cost of this procedure in their payment rates for the procedures where the binocular microscope is usually used. Another example is the implantable breast prosthesis, silicone or equal, HCPCS code L8600. The cost for this prosthesis is included in the payment rate paid for the

OBJECTIVES
In this chapter you will learn:
- The code categories for the medicine section of the CPT book
- The difference between administration of vaccines/toxoids, therapeutic or diagnostic injection codes, and surgical injection codes
- How to identify the psychiatry services section codes
- When dialysis codes are reported and what services are included in a procedure code
- The difference between the intermediate and comprehensive levels of services for ophthalmology services
1. Vaccines and toxoids are reported with a code for the ________ and a code for the ________________.

2. Infusion therapy is reported per ________ and may be performed in the ________________ setting.

3. Psychiatry services are divided into ________ ______________ and ________________.

4. True or False. Psychotherapy is the treatment of behavior problems such as smoking cessation. _____

5. Dialysis services are divided into three categories:  
   a. ____________________________  
   b. ____________________________  
   c. ____________________________

6. Ophthalmology services are defined as ________ and ________ and include exam of the visual system, history and general medical observation in addition to more specific examinations of the eye.

7. The cardiovascular section includes ________ and ________ services.

8. Placement of stents, angioplasty, and atherectomy services are considered ________ in nature.

9. Cardiac catheterization services report the placement of the ________, ________, and imaging as well as other services.

10. Bronchospasm includes ________ before and after the use of a ________.

11. Allergy sensitivity tests are selective ________ and __________________ tests.

12. Polysomnography is a minimum of six hours of sleep study and includes the following sleep staging modalities:  
   a. ____________________________  
   b. ____________________________  
   c. ____________________________

13. True or False. EMG testing is reported per nerve and not per muscle. _____

14. Health and behavior assessment is used to report treatment of ________ and ________ affecting the patient’s health.

15. Chemotherapy codes are used to report the administration of the chemotherapy agent. The agent is reported using ________ found in ____________.

16. Physical therapy modalities are categorized as requiring ________ versus ________.

17. True or False. Active wound care services cannot be reported with debridement codes 11000–11047. _____

18. True or False. Osteopathic manipulative treatment and chiropractic manipulative treatment are interchangeable. _____

19. Conscious sedation includes:
   a. ____________________________  
   b. ____________________________  
   c. ____________________________

20. Home infusion is reported according to the ________ of the infusion.