PHISC
Private Healthcare Information Standards Committee

BUSINESS CASE

Proposal from the PHISC Clinical Coding sub-committee's CCSA Technical Workgroup to Define Standards and Guidelines for the Interpretation of the CCSA / CPT® Coding Structure for Data Purposes

Date : 27 December 2012

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Revision History

Version	Date	By Whom	Changes
Draft 1 ver 3.00	2011/06/22	Izelle van Deventer (ID)	Document creation after meeting held 2011/03/17 and workshop held 2011/06/07.
Draft 2 ver 3.00	2011/07/15	Luisa Whitelaw (LW)	Document updated with inputs from stakeholders following distribution of Draft 1 ver 1.00 on 2001/06/28
Draft 3 ver 3.00	2011/07/20	ID	Document updated after meeting held 2011/07/20 at Momentum in Centurion.
Draft 4 ver 3.00	2011/09/16	ID	Document updated after meeting held 2011/09/16 at Discovery Health in Sandton.
Draft 5 ver 3.00	2012/01/13	LW	Document updated after PHISC Clinical Coding Subcommittee meeting 2011/10/27 at

			Medscheme in Woodstock, Cape Town.
Draft 6 ver 3.00	2012/02/10	LW	Document updated after CCSA Technical Work Group meeting 2012/01/25 at Discovery in Sandton, Johannesburg.
Draft 7 ver 3.00	2012/12/27	LW	Document updated to include inputs from Lyn Hanmer on the CCSA Standards and Guidelines Document, affecting the CCSA Business Case.

1. Introduction

1.1 Overview and Background

During the National ICD-10 Implementation Task Team (ICD-10 NTT) meeting held on 2 February 2011, the need to establish a CCSA Technical workgroup was identified. This request was brought to the Private Healthcare Information Standards Committee (PHISC) for consideration, following which, the workgroup was established on the 3rd of February 2011. The urgent request from the ICD-10 NTT to form the workgroup arose after the successful registration of the Coding Qualification [Higher Certificate: Diagnostic and Procedural Coding, SAQA ID 66389].

The Coding Qualification includes modules addressing diagnostic and procedural coding. Complete Current Procedural Terminology (CPT®) for South Africa (CCSA) has been recommended by the PHISC as the default procedure coding schema used in the private healthcare industry for data purposes.

PHISC is not recommending the use of CCSA as a national procedural coding standard and therefore this document and the workgroup will not address, discuss or make any recommendations towards the national procedural coding schema.

It was decided by the ICD-10 NTT that PHISC is the appropriate body to take ownership of this initiative after the Training sub-committee of the ICD-10 NTT has become dormant and as the mandate of the ICD-10 NTT has been ICD-10 diagnostic coding and not procedure coding.

However, in the absence of a final decision from the National Department of Health (NDoH) regarding the adoption and implementation of a national procedural coding schema, there is no clear alternative but to use CCSA as the procedural coding schema to best suit the training requirements for the national Coding Qualification. This decision is based on several factors, which include the following:-

- CCSA, based on CPT® is an international coding schema that conforms to international procedure coding requirements
- CCSA has built-in clinical and coding intelligence
- CCSA has well defined coding rules and conventions

In 1998 PHISC accepted CPT® as the de-facto standard for sharing data regarding procedures, surgeries and/or interventions between medical schemes, medical scheme administrators and health establishments i.e. hospitals in the private healthcare sector. CPT® came to be known as CCSA in South Africa as a result of changes that South African Medical Association (SAMA) has made to the structure of the books and electronic version of CPT®. It is no longer in its original format as released by the American Medical Association (AMA) hence the SAMA had to rename CPT® to CCSA. The codes and descriptions remain unchanged.

CCSA2010 is the latest version of CPT® in use in South Africa as released by SAMA. SAMA is the custodian for CPT® in SA under licence from the AMA. AMA CPT® 2009 is also utilised by certain stakeholders in the private healthcare sector. It must be clearly noted that it is incumbent on the users of the AMA CPT® versions to align the codes and descriptions with the current CCSA version in use in South Africa.

A disclaimer will be added in the Guidelines document indicating that it is incumbent on users of the CPT® AMA versions to align the codes and descriptions with the current CCSA version in use in SA.

The PHISC document dated 10 July 1998 undersigned by the then chairperson of PHISC, John Heavens, titled 'SOUTH AFRICAN PHISC PROCEDURE CODE STANDARDS, Version 2.1' has been reviewed by the Workgroup. The Workgroup agreed that many of the standards contained herein seem to lean towards billing guidelines.

Thus, this 1998 document will be replaced by the suggested PHISC CCSA Standards and Guidelines for Data Purposes document (PHISC CCSA document), and the contents will be amended and updated to reflect the current needs and uses of CCSA for data purposes in the SA healthcare sector. It was further agreed that any errata issued by the AMA will not form part of the review process or the PHISC CCSA document. The published PHISC CCSA document must however clearly state that cognisance has been taken of any / all AMA errata up to the date of publication. This is critical for software development and potential software updates.

1.2 Objective(s)

The following matrix describes the main objectives of the PHISC CCSA Technical workgroup:-

O1.	Align the interpretation and usage of CCSA as the procedural coding schema for data purposes with the training requirements defined by the Coding Qualification.	
O2.	Formulate interpretation guidelines and standards for CCSA coding to be used in the SA healthcare sector solely for data purposes. (Applicable to medical schemes / medical scheme administrators and health establishments i.e. hospitals, relevant software only)	
	O2.1	The defined interpretation guidelines and standards will be published as a document on the PHISC web site (www.phisc.org.za).
	O2.2	No standards, guidelines and / or recommendations will be defined for the usage of CCSA as the national procedural coding schema.
	O2.3	No standards, guidelines and / or recommendations will be defined for the usage of any procedural coding schemas other than CCSA.
O3.	Develop related messaging content standards (data dictionary) for data purposes. The message content standard for CCSA could be used to support the development of electronic messages such as claim authorisation requests and hospital claims and could include, but is not limited to the specification of data element separator standards, and the inclusion or exclusion of procedural code descriptions.	
O4.	Align all interpretation guidelines and standards for CCSA usage as closely as possible to the existing AMA and CCSA rules.	

1.3 Definitions, Acronyms and Abbreviations

Abbreviation	Term / Definition
AMA	American Medical Association
CPT®	Current Procedural Terminology
CCSA	Complete CPT® for South Africa
COIDA	Compensation for Injuries and Diseases Act
HWSETA	The Health and Welfare Sector Education and Training Authority
ICD-9-CM	International Statistical Classification of Diseases and related Health Problems, 9th Revision, Clinical Modification (Volume 3 = Procedures)
ICD-10	International Statistical Classification of Diseases and Related Health Problems 10th Revision

Abbreviation	Term / Definition
ICD-10 NTT	National ICD-10 Implementation Task Team
IP	Intellectual Property
NDoH	National Department of Health
NHRPL	National Health Reference Price List
PHISC	Private Healthcare Information Standards Committee
RAF	Road Accident Fund
SAMA	South African Medical Association
SAQA	South African Qualifications Authority
UPFS	Uniform Patient Fee Schedule

1.4 Assumptions

It is assumed that any stakeholder using CPT® or CCSA has obtained the appropriate licensing agreements respectively with the AMA or SAMA.

The future of procedural coding for both data and billing purposes is unclear as there is no current national procedural coding standard approved / adopted / recommended by the NDoH. CCSA has been selected instead of any other procedural coding schema because:-

- of its coding structure;
- it has been the PHISC de-facto standard for sharing procedural coding data between medical schemes, administrators and/or health establishments; and
- can be used as the preferred procedural coding structure used for training purposes of the Coding Qualification.

1.5 Risks

Description of Risk	Impact on Initiative	Response to Risk
AMA / SAMA Copyright issues	Potential litigation should the standard contravene any of the copyright requirements.	SAMA has permission as the custodians of CPT® copyright in South Africa to adapt the coding structure for the South African healthcare environment. Leonie Maritz from the South African Medical Association (SAMA), on behalf of Elaine Sauls, former chairperson of the PHISC Clinical Coding sub-committee, contacted Paula Williams the CPT® licencing Manager for the AMA in Chicago (USA) and gained permission to use the CPT® coding structure for data training purposes.

Description of Risk	Impact on Initiative	Response to Risk
Distribution of the standard to PHISC members only	Limit the adoption / buy-in of the standard.	PHISC documentation is not copyright restricted. PHISC guidelines and standards are de-facto industry standards and are never enforced.
Resistance to change	The resistance may come from parties who have not actively participated in setting the standards / guidelines. Existing methods / processes / systems that are in place might be sufficient for the organisation's existing requirements / needs.	PHISC has always endeavoured to encourage all interested parties to participate in various forums. All meetings are held as open forums and participation is voluntary. PHISC guidelines and standards are de-facto industry standards and are not enforced by PHISC; uptake of the standards is voluntary.
Cost of implementation	Each industry stakeholder will need to change to ensure a critical mass of compliance in order for everyone to reap the benefits. Initial cost for long term impact.	Each stakeholder will bear their own costs in order to comply with the standards.
Timing and actual roll-out of changes to guidelines and standards (as related to 2 yearly updates of the master/flat file)	Not all stakeholders that have adopted the PHISC standard are necessarily using the same version of the Standard. Not all companies have the same ability to implement changes timeously.	Ad hoc changes will be published as a version update. A six (6) month period for any system related changes, including a three (3) month period of any operational changes, will be allowed for the implementation.
Different interpretation / implementation of PHISC CCSA guidelines / standards. Development of different CCSA guidelines and / or standards.	PHISC guidelines and standards are adopted voluntarily and are never prescriptive.	Adhere to contractual agreements and appropriate training standards and guidelines. Communication to the Workgroup should any other CCSA guidelines / standards be identified. Minimise differences between AMA CPT® and what this Workgroup endeavours to accomplish with CCSA.

1.6 References

The following documents have been referenced in this document (including the author's name and the version number and date).

Document Name	Version	Publish Date	Author
National Health Act 2003 (Government Gazette 26595)	Act No. 23 of 2003	2004/07/23	South African Government

2. Business Drivers

The PHISC CCSA Technical Workgroup exists as an industry initiative to establish best practice guidelines and standards for the interpretation of CCSA codes used for data purposes.

Formalising CCSA coding guidelines and standards will promote uniformity and consistency of CCSA coding used in the SA healthcare environment for data and training purposes. Improved quality of healthcare intervention data will be ensured through the correct and appropriate interpretation of CCSA codes.

Standardising the interpretation of CCSA codes and aligning the PHISC CCSA standard with the Coding Qualification could enable the public to gain easy access to and potentially obtain this national qualification that uses a consistent, complete and correct course outline.

Potential ability to use the collected data to address Diagnosis Related Groupers (DRGs) issues, or be used during the data collection process of healthcare intervention information, and compilation of relevant statistics to support decision making.

Drive efficiencies and consistency for stakeholders throughout the SA healthcare industry.

3. Business Problems, Opportunities and Needs

Problem:
The disparate procedural coding schemas hinder the access to obtain the full Coding Qualification. A common understanding and interpretation of CCSA for data purposes is needed but have not yet been agreed to or been defined.

Adding to the private healthcare industry's frustration is the myriad of procedural coding schemas currently in use for data and billing purposes:-

Stakeholder	Billing Purposes	Data Purposes	Contractual Agreements
Private sector health service providers	NHRPL, COID, RAF, CCSA, Proprietary codes sets	NHRPL, COID, RAF, CCSA, Proprietary codes sets	NHRPL, COID, RAF, CCSA, Proprietary codes sets
Private sector health establishments	NHRPL, COID, RAF, CCSA / CPT®, Proprietary codes sets	NHRPL, COID, RAF, CCSA / CPT®, Proprietary codes sets	NHRPL, COID, RAF, CCSA / CPT®, Proprietary codes sets
Public sector health establishments	UPFS, COID, RAF, CCSA / CPT®, Proprietary codes sets	UPFS, COID, RAF, CCSA / CPT®, Proprietary codes sets	UPFS, COID, RAF, CCSA / CPT®, Proprietary codes sets
Military health establishments	UPFS, Proprietary codes sets	ICD9-CM Procedure Coding, Proprietary codes sets	UPFS, ICD-9-CM Procedure Coding, Proprietary codes sets

Need:
The urgent need to address the standards associated with procedural coding component of the Coding Qualification is apparent. There is thus a need for guidelines that should be used as the CCSA standard within the private sector.

Opportunity
CCSA was selected from the above mentioned procedural coding schemas by the PHISC Clinical Coding sub-committee as the procedural coding schema of choice because it is already an accepted de-facto standard between private healthcare establishments and medical scheme funders and it is accepted as part of contractual agreements. CCSA has the most readily available and acceptable supporting documentation.

4. Scope of Project

4.1 In Scope

The PHISC CCSA Technical Workgroup will deliver the following:-

- Update the existing PHISC CCSA Guideline and Standards document.
- Set guidelines and standards on the usage of CCSA codes for data purposes.
- Develop a data dictionary to ensure consistent interpretation of unclear terminologies.
- Align our guidelines and standards as closely as possible to the AMA and CCSA rules and guidelines and ensure that we support and understand existing CCSA / CPT® rules and conventions.

4.2 Out of Scope

The PHISC CCSA Technical Workgroup will NOT:-

- Promote and / or recommend a national procedural coding structure.
- Discuss any NHRPL tariff and / or billing and / or monetary issues related or not related to CCSA.
- Review or compare any other AMA CPT® and / or CCSA versions.
- Regulate any contractual agreements.
- Embark on a formal marketing strategy to promote the usage of this PHISC standard / guideline.
- Manage the implementation of multiple electronic versions of CPT® / CCSA respectively in stakeholders' systems. This remains the stakeholder organisations' responsibility and / or intellectual property (IP).
- Rewrite the rules of AMA CPT® or CCSA, as those set by the AMA are already very specific.
- Address the maintenance and/or update of the CCSA flat file, since these activities are not within the mandate of this workgroup.

5. Requirements

The Workgroup has identified a number of issues that need discussion:-

Review existing PHISC standards pertaining to CCSA, with the following 5 items as priority:

1. CCSA Modifiers
    - Presenting and storing modifiers as a five-digit code (099xx) or as a suffix to the procedural code (xxxxx-xx)
    - Review the adopted PHISC Standardised Claim: Modifier Standard.
    - Sequencing of modifiers.
    - Modifier 99
    - Out of scope:
        - Physical status modifiers (applies mainly to anaesthetic billing)
        - Level II modifiers
        - Discipline code indicators
        - POS (Place Of Service) codes in AMA CPT® 2009 book
2. Unlisted procedure codes
3. Definition for primary / principal procedure (A PHISC definition does exist-needs to be relooked at)
    - Sequencing of codes to be included in this discussion
4. Quantity of codes
5. Radiology codes

Other issues (in no particular order)

6. Category 2 codes
7. Category 3 codes
8. Default codes
9. Evaluation and Management codes
10. Anaesthetic codes
11. Surgery codes
    - Microsurgery
    - Obstetric codes
    - Spinal and cardiac codes
12. Medicine codes
13. Over-coding i.e. drips, oxygen
14. Definition for event, episode and encounter
15. CCSA codes out of sequence
16. Reuse of previous codes

6. Outline of Proposed Solution

The PHISC CCSA Technical Workgroup was established with the objective of defining standards that could address inefficiencies in the usage of CCSA codes for data purposes. To this end, the Workgroup actively recruited various parties in the industry to ensure the following:-

- Sufficient involvement and representation from medical scheme funders, service providers, Practice Management Application (PMA) vendors, switching intermediaries and other 3rd parties.
- Relevance and sufficient coverage when considering the diversity of software systems and business rules in the industry.
- The change impact of the standard in the industry is reasonable and sufficiently motivated by its expected benefits.
- The standard fairly balances the need for simplicity and low cost of implementation with the needs for strategic flexibility.

The Workgroup agreed that in keeping with the good practice of providing motivation for all new and revised PHISC initiatives, a business case document will be developed to support the efforts of this

Workgroup. The technical work requirements already identified will continue in parallel with this process.

Workshops have been and will be held as open forum sessions with voluntary participation by interested parties. Formal feedback will be provided at the broader PHISC committee meetings held quarterly under the auspices of the Clinical Coding sub-committee.

At these quarterly meetings the following key principles and assumptions have been reiterated and have served to govern the design of the standard:

- The efficiencies which accrue this standard are dependent on broad based adoption and therefore cannot be viewed as a long term sustainable basis for competitive advantage by any single adopter. However, it is critical that all stakeholders should derive benefit from the standard in order for adoption to be meaningful.

The CCSA Technical Guidelines and Standards document will be reviewed in parallel with the publication of the CCSA version which is set to occur every two (2) years with the implementation of the next update being effective from 01 January 2012. The CCSA Technical Guidelines and Standards document will be version controlled and will be published on the PHISC web site. A six (6) month period for any system related changes, including a three (3) month period of any operational changes, will be allowed for the implementation.

7. Expected Benefits and Beneficiaries

The Workgroup expects the following benefits from completing this initiative:-

#	Benefit	Result of Benefit
1.	Improved quality, uniformity and consistency of healthcare intervention data.	Sound auditing, assist planning, resource allocation, budget allocation, quality of care presented to patients, burden of disease profiling, sustainable healthcare intervention information, basis for potential improved alternative reimbursement, reliable and uniform statistics.
2.	Obtaining / accessing a national qualification in Diagnostic and Procedural Coding.	Skills development, career opportunities, job creation, promotion of coding as a profession.
3.	Standard field definitions and descriptions in electronic messages.	Ensures consistency in interpretation and avoids misinterpretation.
4.	Industry co-operation and sharing of information to design the best possible solution.	Achieved through participation in the Workgroup as well as making it specific to the South African healthcare industry.
5.	Centralised point for change management.	PHISC will maintain the standard and guidelines and changes will be agreed to and communicated to all PHISC stakeholders.

8. Budget, Resourcing and Cost Justification

The standardisation of the interpretation of CCSA codes used for data purposes is an industry initiative to establish best practice guidelines, standards and principles for the South African healthcare industry.

PHISC is a non-profit organisation established as a private healthcare industry initiative in order to drive industry partnerships and address industry issues. It is not a legislative body and is empowered to make recommendations only, if required.

The cost of implementation will be the responsibility of each stakeholder and there will be no subsidisation. It should be noted that each stakeholder will need to perform their own analysis to determine costs, resource requirements, system changes and training.

It is the responsibility of each stakeholder to provide an estimated time line for implementation and the intention is to publish the first version of the "PHISC Technical CCSA Guidelines and Standards" document on the 1st of June 2012.

9. Conclusion / Recommendation

It is imperative that the work of this Workgroup continues to ensure that coding standards are in place in order for the Coding Qualification to be fully achievable. Failing to do so could make the recognition of the Coding Qualification by the SAQA null and void.

10. Appendix A: List of Invitees (as per PHISC mailing 'company' list)

Representing Company
Africode Consulting
Agility Tech (Agility Global Health)
AHPCSA
Board of Healthcare Funders (BHF)
Bytes Healthcare Solutions: Medd-e-Mass
Bytes Healthcare Solutions: Switch
Care Gauge
Chiropractic Association of SA
Clicks Direct Medicines
Community Pharmacist Sector of the PSSA
Council for Medical Schemes
Discovery Health
DOH Pharmaceutical Planning and Management
Electronic Patient Records (EPR)
e-MD Technologies
Goodex Software
Healthbridge
Hospital Association of SA
Independent Clinical Coding Consultant
Lancet
Liberty
Life Healthcare
Lifechoice
Lifepoint Integrated Healthcare Services
Managed Healthcare Systems (MHS)
Medcode Training and Consulting
Medcodelink (Pty) Ltd
Medi Charge
Medical EDI Services
Medical Research Council
Mediclinic
Medihelp
MediKredit Integrated Healthcare Solutions
Medscheme
Metropolitan Health Group (MHG)
Momentum Medical Schemes Administrator
National Hospital Network
National Pathology Group
Neil Harvey Associates
Nelson Mandela Metropolitan University (NMMU)
Netcare Management
NHA (IT arm of Liberty)
Occupational Therapy Association of SA
Prime Cure
Radiology Society of SA
SA Acute Hospital Association (Medsac)
SA Bureau of Standards
SA Dental Association
SA Medical Association
SA Physiotherapy Society
SA Private Practitioner's Forum
SA Tibb Association
Strategic Business Solutions

Representing Company
Sub-Acute Hospital Association
Universal Care (Pty) Ltd (Previously QA Care Plus)
Vmed/Liberty
Waymark Infotech (Pty) Ltd

11. Appendix B: List of Attendees (names and company)

Name	Representing Company
Amanda du Plessis	Medi-Clinic - Tshwane Regional
Antoinette Iglauer	Aromatherapy Association of SA
Antoinette Ueckermann	Momentum
Brenda Gous	Medihelp
Chris Cockett	Medscheme
Christa Trichard	Spesnet
Claudine Muller	Medcode Training & Consulting
Conita van Rensburg	Prime Cure
Corne Vaughn	Medscheme
Crystal Wahid	Discovery Health
Dershnee Devan	Occupational Therapy Association of SA
Elaine Sauls	Medcode Training & Consulting
Erica Manuel	Liberty
Erna Van Rooyen	Netcare
Faith Barter	Life Healthcare
Fiona Wade	Medscheme
Fundiswa Maqula	Discovery Health
Gary Behenna	Bytes Healthcare Solutions: Switch
George Sole	National Pathology Group
Glenda De Beer	SA Medical Association
Hazel Mitchell	Clicks Direct Medicines
Heather Pereira	Managed Healthcare Systems (MHS)
Ilse Spaarwater	National Pathology Group - Ampath
Izelle van Deventer	e-MD Technologies
Johan Bothma	CPS
Karen vd Westhuizen	Independent
Lelanie Agenbag	Vmed / Liberty
Leonie Maritz	SA Medical Association
Leonie von Möllendorff	Netcare
Lorna Smargiasso	SA Reflexology Society
Luisa Whitelaw	Discovery Health
Lyn Hanmer	Medical Research Council
Lynet Clarke	Medcode Training & Consulting
Manono Mdoda	Momentum Medical Schemes Administrator
Mari McLeod	Medihelp
Maria van der Walt	Medikredit
Marianne Prinsloo	Discovery Health
Maryna Meyer	NHA
Melanie Smith	Discovery Health
Monica Raju	NHA
Nicolene Dessels	Medi Charge
Penny Mekgwe	Discovery Health
Rianda Horn	Prime Cure
San-Mari Matthee	Medi-Clinic
Sheryl Mulder	Discovery Health
Silvia Grobbelaar	Discovery Health
Sithara Satiyadev	Africode
Stefan Snyders	Bytes Healthcare Solutions: Med-e-Mass
Sunelle Lubbe	Mediclinic
Wendy Hanan	Medikredit

12. Appendix C: Copy of PHISC Procedure Code Standards v 2.1, July 1998

Private Health Information Standards Committee

PHISC

10 July 1998

TO ALL MEMBERS OF: THE DIAGNOSTIC AND PROCEDURES WORK GROUP
THE PHISC COMMITTEE

Herewith the draft SA Procedure Code Standards version 2.1 with suggested modifications from the Coding Network Committee for ratification at the next Diagnosis & Procedure Codes Work Group and PHISC meetings, 21st July 1998:

If you have any comments, queries or concerns please contact Dr. John Heavens prior to the meetings at :

Cell	082 449-7568
Fax	(011) 789-2342
E-mail	johnheav@ medscheme.co.za'

Many thanks

John Heavens

c/o RAMS Secretariat P 0 Box 2324 PARKLANDS, 2121. P (011) 880-8900 ;F (011) 880-8798 e-mail: rams@cis.co.za

SOUTH AFRICAN PHISC PROCEDURE CODE STANDARDS

DRAFT PHISC VERSION 2.1, July 1998

PROCEDURE CODES :

PHISC AGREED CODES FOR NATIONAL USE :

- Tariff
- CPT

CODES BEING INVESTIGATED BY PHISC:

- CDT
- Optometry

LEVEL IN CLAIM (if appropriate) :

- Claim line item level

CPT CODING STANDARDS

For national use from 1 July, 1998. No changes, additions or deletions of the following standards or usage rules are permitted unless these have been fully motivated, agreed by consensus in the appropriate PHISC work group and formally approved by PHISC.

CPT CODE STRUCTURE :

- 5 digit CPT procedure code, '-', and a 2 digit modifier as a suffix, when appropriate

Code:		**Description** :	
Length	8	Length	70 (short descriptions), 130 (long descriptions)
Type	AN	Type	AN
Justification	L	Justification	L
Initial	Spaces	Initial	Spaces
Format	NNNNN-NN		

CPT USAGE RULES :

1 More than one modifier per procedure :
- 1.1 Repeat the same CPT code with each additional modifier
- 1.2 Each CPT code + modifier to appear as a separate claim line item
- 1.3 Recommended practice- to sequence the CPT codes in order from highest to lowest modifier
- 1.4 **Modifier '99'** (use of multiple modifiers)- **NOT TO BE USED** as it adds no value and could cause data collection problems

2 **Unlisted procedure codes** - the code to be followed by a description of what was done

3 **Dental procedures-** code 41899 (unlisted dental procedure) to be specified by using the DASA codes until the implementation of COT

4 **Starred procedures** - to be used as per instructions in the CPT book

5 **Obstetric codes:**
- 5.1 first visit to the obstetrician/gynaecologist to be a code from the evaluation and management section
- 5.2 visits 2 - 6 to be coded as CPT code 59425 and billed on a visit per visit basis
- 5.3 visits 7 - 13 to be coded as CPT code 59426 and billed on a visit per visit basis.
- 5.4 If the same Ob/Gyn who delivers the baby will be providing the post-partum care:
  - 5.4.1 code 59410 to be used for vaginal delivery
  - 5.4.2 code 59515 to be used for caesarean delivery
- 5.5 If another doctor will be providing the postpartum care, the doctor who delivers the baby will report:
  - 5.5.1 a vaginal delivery as 59409
  - 5.5.2 a caesarean delivery as 59514.
- 5.6 Hospitals code vaginal deliveries as 59409
- 5.7 Hospitals code caesarean deliveries as 59514.
- 5.8 Coding of twin deliveries: add modifier -22 (unusual procedure) to the delivery code.

6 **The Evaluation and Management codes** :
- 6.1 are to be used as per CPT instructions
- 6.2 Modifier 21 (prolonged evaluation and management)- use:

To indicate that the face to face service was prolonged or greater than usually required

If the prolonged time is continuous

With the evaluation and management codes of the highest level- i.e.: 99205 99215,99223,99233,99245,99255,99263,99303,99313,99323,99333, 99343

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Version 2.10 Date 10 July, 1998

6.3 Use of codes 99354-99357:
Report in addition to other physician services
May be reported at any level of E/M code
Time spent on patient does not need to be continuous
Should only be used once per day

7 **Microsurgery:**
7.1 Code 61712 is to be used as per instructions in CPT only.
7.2 Modifier 20 is to be used for those procedures which are typically done without a microscope
7.3 modifier 20 **not** used if a procedure is typically done with a microscope

8 **Maximum number** of codes for reporting will not be set.

9 **Use of modifier 22-** should be used:
9.1 if the work effort of the procedure is increased by at least 20%
9.2 If a complication occurs during a procedure, which requires the procedure to be longer, or more work intensive than normal.

10 **Use of modifier 90:**
10.1 to be used by the pathologist only when a specimen is not analyses at the specific laboratory but referred to an outside laboratory for analysis. The outside laboratory will bill for the service.