INTRODUCTION TO THE STANDARDS AND GUIDELINES OF CCHI BILLING SYSTEM

CCHI-BS

ABOUT

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TABLE OF CONTENTS

OUT-PATIENT SERVICES

These standards are for coding of procedures for ambulatory cases only. In some instances, they will contradict standards for coding inpatient procedures. Therefore, careful attention should be paid to how the standards differ for ambulatory versus inpatient coding.

As with the inpatient standards, the level of detail reflects the assumption that users of the document will have had training in abstracting relevant information from clinical records and in the use of ICD-10-AM and ACHI. It is assumed that clinical coders are aware of, and follow, ICD-10-AM and ACHI rules.

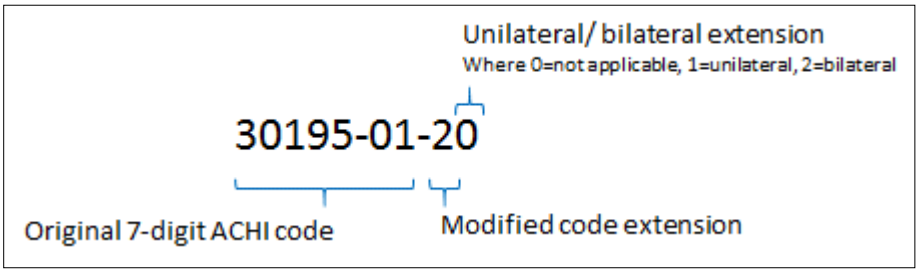
The clinical record should be the primary source for the coding of ambulatory cases, again as for inpatient cases. If a clinical record is inadequate for complete, accurate coding, the clinical coder should seek more information from the clinician. A joint effort between the clinician and clinical coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures.

Ambulatory ACHI Code Structure

ACHI codes' structure has been modified for use in ambulatory settings so to allow the inclusion of additional codes for better specificity, as well as further splits on unilateral/ bilateral procedures than what's available for inpatients. The ACHI system has been expanded as well to include new chapters that covers Laboratory & Pathology, Ambulance & Transport Services, and KSA Service codes

The ACHI ambulatory code set retains the same core 7-digit code as for inpatients, and includes extensions for additional codes and/ or unilateral/ bilateral procedures where applicable.

The ambulatory codes relate to the original ACHI 10th edition codes as follows:



Examples of new codes without a unilateral/ bilateral extension are as follows:

- 30195-01-10 Curettage of lesion of skin, 1 to 14 lesions
- 30195-01-20 Curettage of lesion of skin, 15 or more lesions

Examples of new codes with a unilateral/ bilateral extension are as follows:

- 55030-00-21 Ophthalmic biometry by ultrasound echography, with intraocular lens power calculation, unilateral
- 55030-00-22 Ophthalmic biometry by ultrasound echography, with intraocular lens power calculation, bilateral

General Guidelines for Ambulatory Procedures

For ambulatory settings, a 'procedure' means a medical service or a minor surgical intervention, and includes diagnostic imaging and laboratory tests. It excludes drugs and medical supplies such as walking aids or dressings.

A procedure for the purposes of coding in ambulatory settings is different from that for inpatients in that it includes interventions that would not normally be coded for inpatients. For example, the following procedures would be coded in the ambulatory setting in all circumstances:

- doppler recordings
- x-rays
- electromyography
- electrocardiography.

When coding procedures, select the procedure or service that accurately describes the service performed. All services or procedures should be adequately documented in the medical record.

The tabular listing of procedures sometimes contains inclusions and exclusions, and 'code also' instructions, as for inpatient coding. Ensure that you follow these, except where these standards overrule these instructions.

Bilateral Procedures

Bilateral procedures are those which involve the same organ/structure on different sides of the body at the same operative episode.

1. Procedures with separate unilateral/ bilateral codes

ACHI provides separate codes for unilateral/ bilateral procedures where the procedure may be performed on one or both organs/ structures. For example:

- probing of lacrimal passages
- ear toilet
- myringotomy

In addition to those procedures identified as unilateral/ bilateral for inpatients, the ambulatory modification of ACHI includes more extensive codes for unilateral/ bilateral procedures. For example:

- incision of eyelid, unilateral vs. bilateral
- magnetic resonance imaging of breast, with contrast medium, unilateral vs. bilateral
- radiography of clavicle, unilateral vs. bilateral
- removal of intraocular lens, unilateral vs. bilateral

Where a code is provided for a unilateral vs. a bilateral procedure, assign the appropriate code.

2. Inherently bilateral procedures

There are procedures that are inherently bilateral (i.e. there is an expectation that both organs/ structures would be attended to). An example is ophthalmological examination, where it is expected that both eyes would be examined although the pathology may be in one eye.

Another group of 'pseudo-bilateral' procedures which are not explicitly described as bilateral in ACHI, include diagnostic or therapeutic interventions which have one entry point but affect bilateral structures, usually vessels, for example, coronary angiography or tonsillectomy.

Where a procedure is inherently bilateral, assign the code once.

3. Procedures with no code option for bilateral

Where no single code is provided for a procedure, and the procedure is performed bilaterally, assign the code twice.

Multiple Procedures

ACHI generally refers to organs, diseases and sites using the singular tense. This is done for consistency and ease of updating. For example, the code title intranasal removal of polyp from maxillary antrum includes where one, or more than one, polyp is removed. Thus polyp can be interpreted as polyp or polyps. Another example is biopsy/biopsies.

Procedures that have one entry point and are repeated during a single ambulatory visit should only be coded once. For example:

- cystoscopy with bladder biopsies
- intranasal removal of polyps from maxillary antrum

A procedure which is repeated during separate ambulatory visits should be coded as many times as performed. For example, exercise therapy or psychotherapy.

Anesthesia

Code any anaesthesia performed in the ambulatory setting in addition to the procedure.

For example, local anaesthetic may be commonly used for minor surgical procedures. The American Society of Anesthesiologists (ASA) Physical Status Classification also applies to anaesthesia performed in the ambulatory setting and the appropriate extensions should be assigned.

Allied Health Interventions

ACHI contains both general codes and specific codes for allied health interventions. The general codes are as follows:

95550-00-00	**Allied health intervention, dietetics**
95550-01-00	**Allied health intervention, social work**
95550-02-00	**Allied health intervention, occupational therapy**
95550-03-00	**Allied health intervention, physiotherapy**
95550-04-00	**Allied health intervention, podiatry**
95550-05-00	**Allied health intervention, speech pathology**
95550-06-00	**Allied health intervention, audiology**
95550-07-00	**Allied health intervention, orthoptics**
95550-08-00	**Allied health intervention, prosthetics and orthotics**
95550-09-00	**Allied health intervention, pharmacy**
95550-10-00	**Allied health intervention, psychology**
95550-12-00	**Allied health intervention, spiritual care**
95550-14-00	**Allied health intervention, diabetes education**
95550-11-00	**Allied health intervention, other**

Code *95550-11-00 Allied health intervention*, other should only be used when a service is provided by a registered professional in a recognised allied health discipline that is not listed under any of the other general allied health intervention codes.

The general codes should only be used where there is not a specific code for the assessment or intervention.

Specific codes are available in the following areas:

- diagnostic interventions (e.g. mental, behavioural and psychosocial assessments, block [1823]; developmental testing or ageing assessment, block [1824])
- other diagnostic tests (e.g. speech audiometry, block [1837])
- counselling/ educational interventions (blocks [1867] to [1869])
- nutritional support interventions (block [1871])
- mental, behavioural or psychosocial therapies skills training (blocks [1872] to [1879])
- other therapies (e.g. hydrotherapy, stimulation therapy [1880]).

These codes should be used in place of the general allied health interventions where available.

Procedures Distinguished on the Basis of Size, Time, Number of Lesions or Sites

The ambulatory ACHI classification further differentiates procedures based on size, time and number of lesions than that available for inpatients. For example:

- Administration of an agent into a joint or synovial cavity is based on small, intermediate and large joints or cavities. The tabular listing provides guidance on which joints/ cavities are considered small, intermediate and large. Examples are:
  - 50124-00-11 Aspiration of small joint or synovial cavity, unilateral
  - 50124-00-12 Aspiration of small joint or synovial cavity, bilateral
  - 50124-00-21 Aspiration of intermediate joint or synovial cavity, unilateral
  - 50124-00-22 Aspiration of intermediate joint or synovial cavity, bilateral
  - 50124-00-31 Aspiration of large joint or synovial cavity, unilateral
  - 50124-00-32 Aspiration of large joint or synovial cavity, bilateral

- As with administration of an agent, aspiration of joints or synovial cavities is based on small, intermediate and large joints or cavities.

- The size of the body surface area debrided (by excision) or dressed in the case of burns is differentiated:
  - 30017-00-10 Excisional debridement of burn, small (< 5% of body surface area excised or debrided)

- 30017-00-20 Excisional debridement of burn, medium (5 to 10% of body surface area excised or debrided)
- 30020-00-00 Excisional debridement of burn, large (>= 10% of body surface area excised or debrided)

- Repairs of skin wounds are differentiated on the basis of small, medium and large wounds:

  - 30032-00-10 Repair of wound of skin and subcutaneous tissue of face or neck, superficial, small
  - 30032-00-20 Repair of wound of skin and subcutaneous tissue of face or neck, superficial, medium
  - 30032-00-30 Repair of wound of skin and subcutaneous tissue of face or neck, superficial, large

- Excision of skin lesions is based on the size of the lesion, i.e. small, medium or large:

  - 31235-02-10 Excision of lesion of skin and subcutaneous tissue of hand, small
  - 31235-02-20 Excision of lesion of skin and subcutaneous tissue of hand, medium
  - 31235-02-30 Excision of lesion of skin and subcutaneous tissue of hand, large

- Destruction of skin lesions is based on the number of lesions destroyed. For example:

  - 30195-05-10 Cryotherapy of lesion of skin, 1 to 14 lesions
  - 30195-05-20 Cryotherapy of lesion of skin, 15 or more lesions

- Radiography is based on the number of films, with different thresholds for different regions of the body being x-rayed, for example:

  - 57901-00-00 Radiography of skull, up to 4 views
  - 57901-00-10 Radiography of skull, 4 or more views

Procedures Normally Not Coded For Inpatients

Ambulatory coding differs significantly from inpatient coding in that most procedures not normally coded for inpatients should be coded for ambulatory patients. This includes the following:

- bladder washout via indwelling catheter
- cardiopulmonary resuscitation (mechanical or non-mechanical)
- cardiotocography (CTG)
- catheterisation – arterial or venous (e.g. Hickman's, PICC (peripherally inserted central catheter), CVC (central venous catheter), Swan Ganz), or urinary
- doppler recordings
- electrocardiography (ECG)
- electromyography (EMG)

- imaging services – codes in ACHI Chapter 20 Imaging services (blocks [1940]-[2016])
- monitoring: cardiac, electroencephalography (EEG), vascular pressure
- nasogastric intubation, aspiration and feeding
- primary suture of surgical and traumatic wounds
- stress test
- traction.

The exceptions are as follows:

- **Application of immobilisation or support devices** (e.g. plaster, brace, strapping). These should only be coded as a separate procedure when the application is not associated with a fracture, dislocation or sprain at the same visit. When it is, then the appropriate immobilisation or closed reduction procedure code should be selected instead of the application of the immobilisation/ support device.

  Application of devices or supports for correction/ strengthening of bones or ligaments not associated with an injury (e.g. due to arthritis) should be coded with the codes provided in block [1870].

- **Dressings** should only be coded when not associated with an excision, debridement or repair procedure at the same visit. Change of dressing at a separate visit should be coded.

- **Drug treatment/pharmacotherapy**. Chemotherapy should be coded. However, dispensing of drugs or other oral supplements should not be coded (e.g. provision of mixture for total parental nutrition (TPN)).

- **Orthotic devices**. The orthotic device itself is a supply item and should not be coded. However, the fitting of the device should be coded.

LABORATORY AND PATHOLOGY SERVICES

Introduction

Laboratory & Pathology Codes, are a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals, or entities. Each procedure or service is identified with a **Nine-digit code**. The use of codes simplifies the reporting of procedures and services. In the code set, the term "procedure" is used to describe services, including diagnostic tests.

Pathology and Laboratory

Pathology and laboratory Procedure codes describe services to evaluate specimens (e.g., blood, body fluid, tissue) obtained from patients in order to provide information to the treating physician.

Generally, pathology and laboratory specimens are prepared, screened, and/or tested by laboratory personnel with a pathologist assuming responsibility for the integrity of the results generated by the laboratory. Certain types of specimens and tests are reviewed or interpreted personally by the pathologist. Coding for this section includes few codes requiring patient contact or evaluation and management services rendered directly by the pathologist

Below are the subcategories under which all the sections of laboratory and Pathology codes are divided;

S.No	Subsection	Block	Min Range	Max Range
1	Essential Test Panels	3000	73000-00-00	73000-03-30
2	Chemistry & Microbiology	3050	73050-00-00	73050-61-60
3	Study of Blood Products & Antibodies	3100	73100-00-00	73100-29-70
4	Clinical Pathology & Urinalysis	3150	73150-00-00	73150-01-20
5	Cell Study - Disease Analysis & Genetics; Specimen Study	3200	73200-00-00	73200-10-60
6	Blood Screening & Transfusion related Procedures	3250	73250-00-00	73250-03-80
7	Drug Assays	3300	73300-00-00	73300-09-80
8	Molecular Pathology including Gene Sequencing	3350	73350-00-00	73350-07-20
9	Fertility Medicine, In Vivo and Other Lab Procedures	3400	73400-00-00	73400-05-10

Laboratory & Pathology Blocks

3000 Essential Test Panels (73000-00-00; 73000-03-30)

Laboratory Essential panels or chemistry panels are groups of tests that are ordered together.

The below points are important for consideration of the Panel Test (Code).

❖ Essential Test Panel

- ❑ Providers may bill either a panel code or an individual code.
- ❑ Each panel code comprises multiple tests.
- ❑ The panel code should be reported when all individual components in the panel have been performed.
- ❑ The code or codes to describe the individual tests performed should be reported if any test defined as part of the panel is not performed.
- ❑ Two or more panel codes that include any of the same constituent tests performed from the same patient collection should not be reported.
- ❑ If a group of tests overlaps two or more panels, the panel that incorporates the greater number of tests to fulfill the code definition should be reported and the remaining tests should be reported using individual test codes.
- ❑ Each test billed under the panel must be reasonable and necessary.

- **Testing Panels (Evocative/Suppression)**

  Evocative/suppression testing refers to a class of tests performed where one substance is measured both before and after the administration of another substance to determine if the levels are stimulated ("evocative") or suppressed.

  They are most commonly performed in the evaluation of possible endocrine disorders.

3050 Chemistry and Microbiology (73050-00-00; 73050-61-60)

- **Chemistry** panels are groups of tests that are routinely ordered to determine a person's general health status. They help evaluate, for example, the body's electrolyte balance and/or the status of several major body organs.

  The tests are performed on a blood sample, usually drawn from a vein. Codes describes microbiological culture studies.

  This area typically includes automated analysis of blood

  - Test are Quantitative OR Qualitative unless specified otherwise
  - Same analyte in multiple specimens
  - Molecular diagnostics

  Coded by procedure not analyte

- **Microbiology** is the study of microscopic organisms, such as bacteria, viruses, archaea, fungi and protozoa. This discipline includes fundamental research on the biochemistry, physiology, cell biology, ecology, evolution and clinical aspects of microorganisms, including the host response to these agents.

Definitions

A **urine culture** is a test to find germs (such as bacteria) in the urine that can cause an infection. Urine in the bladder is normally sterile. This means it does not contain any bacteria or other organisms (such as fungi). But bacteria can enter the urethra and cause a urinary tract infection (UTI).

Susceptible means they can't grow if the drug is present. This means the antibiotic is effective against the bacteria. Resistant means the bacteria can grow even if the drug is present. Intermediate means a higher dose of the antibiotic is needed to prevent growth.

3100 Study of Blood Products and Antibodies (73100-00-00; 73100-29-70)

- **Blood Products**

It involves treating diseases that affect the production of blood and its components, such as blood cells, hemoglobin, blood proteins, bone marrow, platelets, blood vessels, spleen, and the mechanism of coagulation.

- **Antibodies**

Antibody and **Antigen Tests. Antibodies** are part of the body's defence (immune) system. Antigens are the particles that cause the body to create an antibody.

Tests to detect antibodies and antigens help to identify certain infections and some other medical conditions

3150 Clinical Pathology and Urinalysis (73150-00-00; 73150-01-20)

A clinical pathology consultation is a service performed by a physician (pathologist) in response to a request from the attending physician regarding test results requiring additional medical interpretive judgment.

Pharmacokinetic consultations regarding therapeutic drug levels may be reported with this code. Code 80500 reports a limited consultation not requiring review of the patient's history and medical records.

Code 80502 reports a comprehensive consultation related to more complex diagnostic problems and requires review of the patient's history and medical records.

- **Urinalysis**

A **urinalysis** is used to detect and manage a wide range of disorders, such as urinary tract infections, kidney disease and diabetes. A **urinalysis** involves checking the appearance, concentration and content of urine. The tests can be done for Routine quantitative or Qualitative analysis, with or without microscopy or for screening the bacterial growth etc.

3200 Cell Study for Disease and Genetic Analysis and Surgical Specimen Study (73200-00-00; 73200-10-60)

- **Cell Study - Disease Analysis**

Cell Study is the study of individual cells and **cytopathology** is the study of individual cells in disease. ... Cytology is most often used as a screening tool to look for disease and to decide whether or not more tests need to be performed. An example of screening would be the investigation of a breast lump

- Obtained by several methods
  - Washing or brushing
  - Smears
  - Fine needle aspiration

- **Genetic Analysis**

Cytogenetics is a field of study that deals with chromosomes and related abnormalities. Chromosome **analysis** is also known as karyotyping and involves the pairing of homologous chromosomes. **Cytogenetic analysis** is very crucial in the diagnosis of oncologic and hematologic disorders.

❖ **Surgical Specimen (s)**

Surgical pathology is the study of tissues removed from living patients during surgery to help diagnose a disease and determine a treatment plan. Often, the surgical pathologist provides consultation services in a wide variety of organ systems and medical subspecialties.

- ❑ The unit of service is the SPECIMEN.
- ❑ Specimen – tissue sample
  - ➢ Has to be separately identifiable
- ❑ Divided into levels of progressive complexity
  - ➢ Level I – gross
  - ➢ Level II-IV gross and microscopic
- ❑ Additional codes for special stains

3250 Blood Screening and Transfusion related Procedures (73250-00-00; 73250-03-80)

Transfusion medicine is the field of medicine that encompasses blood banking (the collection, preparation, testing, and storage of blood components and plasma derivatives) as well as the therapeutic uses of blood components, plasma derivatives, and apheresis technology. It also includes the collection, storage, and use of hematopoietic and other blood-derived cells.

3300 Drug Assays (73300-00-00; 73300-09-80)

❖ **Drug Assay** (Active Ingredients and Dosage Forms) An assay is an investigative (analytic) procedure for qualitatively assessing or quantitatively measuring the presence, amount, or functional activity of a target entity (the analyte).

❖ **Therapeutic drug** monitoring (TDM) is a branch of clinical chemistry and clinical pharmacology that specializes in the measurement of medication levels in blood. Its main focus is on drugs with a narrow therapeutic range, i.e. drugs that can easily be under- or overdosed.

3350 Molecular Pathology including Gene Sequencing (73350-00-00; 73350-07-20)

This category is further subdivided into Molecular pathology, genotyping, Genome sequencing and Multianalyte Assays with Algorithm Analyses

- **Molecular** topographic **genotyping**, also called molecular anatomic pathology, combines advanced molecular genetics with current pathology practices for a definitive diagnosis from existing specimens, which is focused in the study and diagnosis of disease through the examination of molecules within organs, tissues or bodily fluids.

- **Genome sequencing** is figuring out the order of DNA nucleotides, or bases, in a genome—the order of As, Cs, Gs, and Ts that make up an organism's DNA. ... Today, DNA sequencing on a large scale—the scale necessary for ambitious projects such as sequencing an entire genome—is mostly done by high-tech machines

- ***Multianalyte Assays with Algorithmic Analyses*** (MAAAs) are procedures that utilize multiple results derived from panels of *analyses* of various types, including molecular pathology *assays*, fluorescent in situ hybridization *assays*, and non-nucleic acid-based *assays* (e.g., proteins, polypeptides, lipids, carbohydrates).

3400 Fertility Medicine, In Vivo and Other Lab Procedures (73400-00-00; 73400-05-10)

- **Fertility testing** is the process by which fertility is assessed, both generally and also to find the fertile window. General health affects fertility, and STI testing is an important related field.

- **In Vivo**

  In Vivo -The term in vivo refers to a medical test, experiment or procedure that is done on (or in) a living organism, such as a laboratory animal or human.

  In Vitro -The term in **vitro**, in contrast to in vivo, refers to a medical study or experiment which is done in the laboratory within the confines of a test tube or laboratory dish.

AMBULANCE & TRANSPORTATION SERVICES

Introduction to Ambulance services:

Ambulance services are those provided by an ambulance land or Air vehicle, whether it is listed as an emergency or non- emergency service.

The call received by the Ambulance Call Center will determined the nature of the case reported depending on the patient condition where the below factors are to be validated:

- The patient condition is what determines whether it is an Emergency or non-Emergency case

- identify whether the patient is in Stable or not stable condition.

- Decide Whether the patient condition requires a Paramedic or Physician intervention.

- Based on the Patient Condition the intervention is categorized to one of the following:

  - Basic Life support which is the set of intervention protocols given to a patient with a life-threatening illnesses or injuries until they can be given full medical care at a hospital.

  - Acute life support which is a set of intervention protocols given to a patient with a life-threatening illnesses or injuries on site. An example would be providing an open airway and adequate ventilation (breathing).

- scheduled transports fall under non-emergency categories, and include routine transports.

Below are a list of codes reflecting the different ambulance & transportation services:

83500-00-00 Emergency Ambulance Assistance for a Patient in need for Oxygen life Support Services:

Where Life Support services are provided including Oxygen and provision of any procedural intervention for a patient with requirement for advanced/acute life support and involving transport to the Medical Facility. The ambulance must have at least one individual who is qualified as an emergency EMT.

83530-00-00 Non Emergency Ambulance Service for the transportation of a patient on Advanced Life Support:

Includes the request for an ambulance vehicle for a scheduled transport with the equipment of Advanced Life Support Services including any procedural intervention for a patient with requirement for advanced/acute life support. which involves the transport of patient to the point of care

83500-00-10 Emergency Ambulance Service for the transportation of a patient on Acute Life Support:

Assistance by an ambulance vehicle and the provision of Acute Life Support Services. for a patient with requirement for acute life support in addition to transport to the point of care. The ambulance must be staffed by at least one individual who is qualified as an emergency EMT.

Two categories are identified under this service:

- ❑ Acute Life Support Assessment
- ❑ An Acute life support intervention

83530-00-10 Non Emergency Ambulance Assistance for a Non - Acute patient in need for Basic Support Services:

Assistance by an ambulance vehicle and the provision of Basic Support Services without any procedural intervention for a non-acute patient with transport to the point of care The ambulance must be staffed by an individual who is qualified as an emergency EMT.

83500-00-20 Emergency Ambulance Assistance for a Non - Acute patient in need for Basic Support Services:

Assistance by a ground ambulance vehicle and the provision of Non-Acute Basic Support Services without any procedural intervention for a non-acute patient with transport to the point of care. The ambulance must be staffed by an individual who is qualified as an emergency EMT.

83500-00-30 Emergency ambulance Services for a Patient with high level Of Complicative Risks.

Assistance by ground ambulance vehicle, involving transport to the point of care with the provision of Acute Life Support Services and supplies including:

- ❑ At least three separate administrations of one or more medications by intravenous push/bolus or by continuous infusion
- ❑ Ground ambulance transport.

83530-00-20 Mileage Fee for Transportation of the Patient from One Zone to another KM

Assistance by ambulance vehicle for transport of the patient from one Zone to another Zone charged per KM

Zone Definition: either from one City to another, or from one region to another.

83500-00-40 Emergency Ambulance Assistance for a Neonatal Patient in need for life Support Services.

Ambulance vehicle service, involving transport of a Neonate (age 0-22 days) to the point of care with the provision of Acute Life Support Services and supplies including:

83500-01-00 Acute Life Support Routine Disposable Supplies

All routine consumables that are used when responding to an ambulatory service under Acute Life Support Scenario, billed as a package

83500-00-50 Ambulance waiting time per 30 Minutes Intervals.

Ambulance vehicle on an emergency or non - emergency situation where the ambulance is made to wait due to delay in preparing the patient by the calling facility.
1 unit = 30 min

83500-00-60 Additional trained Support person for Special Need Scenario.

Emergency ambulatory services where an extra ambulance attendant, ground (ALS or BLS) or air (fixed or rotary winged). Requires medical review.

83510-00-00 Emergency Air Lift of the Patient in need of aeronautics - Fixed Wing.

Emergency Assistance by a fixed wing(aircraft) ambulance, involving transport of a critically ill patient to the point of care with the provision of Acute Life Support Services and supplies including:

83510-00-10 Emergency Air Lift of the Patient in need of aeronautics – Rotary Wing.

Assistance by a rotary air ambulance(helicopter), involving transport of a critically ill patient to the point of care with the provision of Acute Life Support Services and supplies:

83530-00-30 Noncovered ambulance mileage, per KM (e.g for distances traveled beyond closest appropriate facility).

Ambulance vehicle for transport of the patient beyond the closest available facility, charged per KM.

83500-00-70 Ambulance Auxiliary Attention without Supplying Transport Patient Services:

Response to a medical emergency and the provision of medically necessary supplies and services without provision of any patient transport services. The ambulance must be staffed by an individual who is qualified as an emergency EMT

83540-00-00 Non-emergency transportation; taxi.

Assistance by a non-ambulance vehicle i.e, taxi for transport of the patient charged per KM. E.g., Transported to client

83540-00-10 Transport Bus - non Emergency.

Assistance by a non-ambulance vehicle i.e, bus to perform scheduled transport

83540-00-20 Van Transportation for a patient with a wheel chair.

Assistance by a non-ambulance vehicle i.e, van for transport of the patients who is using a wheelchair, charged per KM

83500-00-90 Specialty Need Transport:

Used when transporting patient at a level of service beyond the scope of the EMT-Paramedic designed for individuals who need advanced life support and continuous monitoring by a critical care nurse/resident physician.

83520-00-00 Basic Life Support Ambulance Charge per KM.

Assistance by a ground ambulance vehicle and the provision of Basic Life Support Services for transport of the patient to the destiny, charged per KM.

83520-00-10 Advanced Life Support Ambulance Charge Per KM

Assistance by a ground ambulance vehicle and the provision of Advanced life Support Services for transport of the patient to the destiny, charged per KM.

83510-00-20 Fixed wing air mileage, per statute mile.

Emergency Assistance by a fixed wing(aircraft) ambulance vehicle, for transport of the patient charged per statute mile.

83510-00-30 Rotary wing air mileage, per statute mile.

Emergency Assistance by a rotary air ambulance(helicopter), ambulance vehicle, for transport of the patient charged per statute mile

Ambulance minimum documenters' requirements:

Documentation is key for the coding of ambulance services to the highest accuracy, and to ensure adequate level of reimbursement. Paramedics should be trained to document properly to support the coding of the service provided, as well as capture all relevant identification documents. Below is a high level guideline on the same:

a) Assessment and Triaging paper with the below details:

- Reason for calling Ambulance.
- Ambulance arriving time.
- Findings.
- Treatment plan.
- Diagnosis on arrival at the place of transfer (in transferred case).
- Ambulance leaving time.

b) Patient Identifications document.

c) Patient insurance (if its available).

SERVICE CODES

Introduction

Are the code set that are used to translate physician/ancillary staff encounters with the patient into a desired codes set so as to facilitate billing of these services.

These service codes can be used to describe various types of encounters in Outpatient and Inpatient Settings which can be used to identify the Evaluation and Management services such as consultations, teleconsultations, room charges etc.

Consultation

The below list of consultation codes has been created to reflect the service:

83600-00-00	**Consultation – GP (General Practitioner)**
83600-00-10	**Consultation – Specialist**
83600-00-20	**Consultation - Consultant**
83600-00-30	**Free secondary treatment for same condition**
83600-00-60	**Repeat Consultation for same condition/Procedure**
83600-00-90	**Emergency Consultation**
83600-01-00	**Dietician Consultation**
83600-01-10	**Physiotherapist Consultation**
83600-01-20	**Cardiopulmonary Consultation**
83600-01-30	**Audiologist Consultation**
83600-01-40	**Occupational therapist**
83600-01-50	**Speech therapist**
83600-01-60	**Radiologist**

83600-01-70	**Specialist Psychiatrist (Adult)**
83600-01-80	**Specialist Psychiatrist (Child)**
83600-01-90	**Alternative Medicine**

- **Health Screening**

Can be provided by either registered nurse or Physician; this service includes all services related to Vital signs, weight, family history, and the early detection of heart disease and other conditions. And general Life style assessment.

- **Community Based Doctor (CBD)**

Defined as physicians who work in ambulatory care facilities and refers patients that needs surgery to secondary or tertiary care facilities due to their facility not having the capacity to perform the needed services. The surgery shall be done by the doctor himself.

In such case, the surgeon's fee will be claimed by the doctor directly and the treating facility charges shall be claimed by the them directly. It is also possible that the treating facility could claim for the whole service and then pay the CBD directly either a percentage, or a pre-agreed surgeon fees.

- **Rounding fees :**

This is only applicable to In- Patient cases where the physician will have a daily visit to the admitted patients. This includes, GP, Specialist, intensivist and consultant visit whether it is in Ward, ICU, NICU, or PICU.

The below codes have been created to reflect the service:

83600-02-90	**Rounding Fee (Specialist Physician) – Ward, ICU, NICU, PICU**
83600-03-10	**Rounding Fee (Consultant) – Ward or ICU**
83600-02-30	**Rounding Fee (Intensivist) – Ward, ICU, NICU, PICU**

- **Surgeon Assistant fees**

When the support of another physician is sourced and utilized. This is usually applicable to GP's and Specialists

The below codes have been created to reflect the service

83600-02-40	**(Specialist)**
83600-02-50	**Surgery Assistance Fee (General Practitioner)**

- **In- Patient Consultations:**

In the case of two or more Interrelated Conditions, each potentially meeting the definition for principal diagnosis. - charge ratio will be one only for any of the two conditions considered as primary reason for consultation. This includes Consultations for GP, Specialist, and Consultant.

83600-02-60	**Specialist Consultation (Specialist)**
83600-02-70	**Consultant Consultation (Consultant)**

❖ **Other Types Of Consultations:**

Specific Specialties falls under this category such as Dietician, Physiotherapist, and the consultations that are related to the same condition report previously:

The below list of codes has been created to reflect the service

83600-00-40	**Free secondary treatment for same condition**
83600-00-70	**Repeat Consultation for same condition/Procedure**
83600-00-90	**Emergency Consultation**
83600-01-00	**Dietician Consultation**
83600-01-10	**Physiotherapist Consultation**
83600-01-20	**Cardiopulmonary Consultation**
83600-01-30	**Audiologist Consultation**
83600-01-40	**Occupational therapist**
83600-01-50	**Speech therapist**

83600-01-60 **Radiologist.**

83600-01-70 **Specialist Psychiatrist (Adult)**

83600-01-80 **Specialist Psychiatrist (Child)**

83600-01-90 **Alternative Medicine**

Homecare Services

All service provided to a Patient while he is staying at home where no hospitalization is required

The below codes have been created to identify the medical personnel performing the service. All other services performed during the home visit will be coded as normal.

83620-00-50 **Home Care GP Consultation**

83620-00-60 **Home Care Specialist Consultation**

83620-00-70 **Home Care Specialist Consultant**

83620-00-00 **Home Care nurse Visit**

83620-00-10 **Home Care Physio Therapy**

83620-00-20 **Home Care Respiratory Therapy**

83620-00-40 **Occupational therapy**

Telemedicine

Assessment for diagnosis treatment and counselling a new or established patient by General Practitioner, specialist, consultant, or any allied health; which takes place through phone, or any other communication tool such as Video calls.

83600-03-40	**Telemedicine – GP**
83600-03-50	**Telemedicine – Specialist**
83600-03-60	**Telemedicine – Consultant**
83600-03-70	**Telemedicine – Allied Health**
83600-03-80	**Telemedicine – Psychotherapy**
83600-03-90	**Telemedicine – Emergency**
83600-04-00	**Telemedicine – for Refill of Chronic Prescription**

Room and Board

Includes all In Patient Room and board services.

83610-00-10	**Day Stay Room charges**
83610-00-20	**Day Stay Room charges NOT including Laboratory and Radiology**

83610-00-30	**Day Stay Room charges including Laboratory and Radiology**
83610-00-40	**Day Procedure Room charges including Laboratory and Radiology**
83610-00-50	**Short Stay Room - Hourly Rate**
83610-00-60	**Short Stay Room - Hourly Rate**
83610-00-90	**Room and Board Isolation Room or Negative pressure room**
83610-00-70	**Room and Board: Ward**
83610-00-80	**Room and Board: Semi -Private (Shared Room)**
83610-01-20	**Room and Board- First Class Pediatric Room**
83610-01-30	**Room and Board: Private Room Deluxe**
83610-01-50	**Room and Board: Suite**
83610-01-70	**Room and Board: Royal Suite**
83610-01-10	**Room Rate difference - Daily Rate (Day 1 and more) – First Class Room**

83610-01-60	**Room Rate difference - Daily Rate (Day 1 and more) – Suite**
83610-01-80	**Room Rate difference - Daily Rate (Day 1 and more) – Royal Suit**
83610-02-00	**Room Rate difference - Daily Rate (Day 1 and more) – VIP Room**
83610-02-10	**Room and Board SCU including Consumables**
83610-02-20	**Room and Board SCU excluding Consumables**
83610-02-30	**Adult Special-Care Unit (ASCU).**
83610-02-40	**Room and Board Special care Nursery excluding Consumables.**
83610-02-50	**Room and Board Nursery including Consumables**
83610-02-60	**Room and Board Nursery excluding consumables**
83610-02-80	**Room and Board SCBU including Consumables**
83610-02-90	**Room and Board SCBU excluding Consumables**
83610-03-10	**Room and Board PICU including Consumables.**
83610-03-20	**Room and Board PICU excluding Consumables**

83610-03-40	**Room and Board NICU including Consumables**
83610-03-50	**Room and Board NICU excluding Consumables**
83610-03-60	**NICU OBSERVATION.**
83610-03-70	**Room and Board ICU including Consumables**
83610-03-80	**Room and Board ICU excluding Consumables**
83610-03-90	**Room and Board VIP- ICU excluding Consumables.**
83610-04-10	**Coronary Care Unit (CCU)**
83610-04-20	**Emergency Room - Hourly Rate including Consumables**
83610-04-30	**Emergency Room - Hourly Rate excluding Consumables**
83610-04-40	**Companion Accommodation**
83610-04-50	**Medical Escort accommodation - Daily Rate**
83630-00-00	**Delivery Room excluding Consumables**
83630-00-10	**Delivery Room including Consumables**

83640-00-00	**Cath Lab Charges - Excluding Consumables - every 30 mins**
83640-00-10	**Cath Lab Charges - Including Consumables - every 30 mins.**
83670-00-00	**Pre-Operating Room Services**
83670-00-10	**Procedure Room/Minor Operating Room Excluding Consumables**
83670-00-20	**Procedure Room/Minor Operating Room Including Consumables**
83670-00-30	**Operating Room Services - First 30 minutes**
83670-00-40	**Operating Room Services - Every Additional 30 Minutes**
83670-00-50	**Recovery Room - Hourly Rate**
83670-00-60	**Anesthesia Services Per Unit**
83680-00-00	**Hemodialysis on outpatient basis per session**

COVID 19 Cases

COVID-19 codes below are proposed as packages that includes all IP Services.

83690-00-00	**Per Diem - IP Care COVID- 19 Suspected.**
83690-00-10	**Per Diem - IP Care COVID - 19 Asymptomatic**
83690-00-20	**Per Diem - IP Care COVID - 19 Mild**
83690-00-30	**Per Diem - IP Care COVID - 19 Moderate**
83690-00-40	**Per Diem - IP Care COVID - 19 Severe**
83690-00-50	**Per Diem - IP Care COVID - 19 Critical**

Unlisted Code

This Code use is restricted to be only used for the services that are not mentioned in this list. However, on submission the service specification and details should be mentioned.