

## **ABC Codes and the Mainstreaming of Oriental Medicine**

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ABC codes are essential to the advancement of integrative healthcare (IHC). They support the mainstreaming of cost-effective IHC practices - including Oriental medicine - by filling gaps in the Current Procedural Terminology (HCPCS Level I) and HCPCS Level II code sets.<sup>1</sup> Mainstreaming (i.e., making this type of care available on an insured basis, not just a cash pay basis) can occur when leading payors of health care decide that the cost-effectiveness of an unconventional approach to care equals or exceeds that of a conventional approach.

Cost-effectiveness, in turn, can be determined from data on the economic and health outcomes of care, as well as patterns in the financing, administration and delivery of care. If data are incomplete, inaccurate or imprecise, then researchers and health policymakers have difficulty substantiating progressive health policies such as reimbursing for acupuncture or licensing doctors of Oriental medicine.

One challenge with CPT® and HCPCS II codes is that these code sets do not support the collection, analysis and reporting of data across all health care settings, caregivers and approaches to care. These code sets focus on the practices of approximately 15.3 percent of the nation's caregivers and capture data on less than 43 percent of the nation's estimated 2.8 billion outpatient encounters - and even fewer inpatient encounters.<sup>2-4</sup>

Without data on the relative economic and health outcomes of conventional, complementary and alternative approaches to care (as well as MD and non-MD caregivers), researchers and policymakers cannot be certain which non-allopathic and non-MD interventions are cost-effective complements or alternatives to allopathic care delivered by MDs. ABC codes fill gaps in these older HIPAA code sets and help address the care delivered by as many as 84.7 percent of the nation's caregivers, in an estimated 1.6 billion outpatient encounters per year - and the vast majority of inpatient encounters. In doing so, ABC codes support scientific comparisons of the economic and health outcomes of competing sites of service, caregivers and approaches to care. They also improve efficiencies in the financing, administration and delivery of care.

That is, when used in conjunction with CPT and HCPCS II codes, ABC codes support the systematic identification of the nation's most cost-effective health care practices, so these practices can be supported by public and private health policymakers through more appropriate coverage and reimbursement policies.

To get a sense of how ABC codes fill gaps in the CPT and HCPCS II codes, Oriental medicine practitioners can compare the acupuncture-related services included in the *2005 CPT Coding Manual* to a broader range of Oriental medical practices included in the *2005 ABC Coding Manual for Integrative Healthcare*. An extensive list of ABC codes is included below. A noteworthy aspect of ABC codes is that they are designed to completely, accurately and precisely reflect the interventions they represent, so the codes can be used not only for billing, but also for practice-based research and clinical practice management. The granularity of ABC codes also helps ensure that the relative values assigned to varying types of care better reflect the resources that go into that care.<sup>5</sup> Proper reflection of the resources, processes and outcomes associated with individual IHC practices is essential to supporting favorable health policies because these very specific data elements are required by medical economists, policymakers and actuaries in pinpointing evidence-based and payment-worthy healthcare practices.

Many IHC practitioners and associations view medical billing codes as necessary only for getting paid by health plans. Others recognize the strategic implications of codes and are actively influencing national coverage and reimbursement policies.<sup>6,7</sup> To the degree the Oriental medicine profession as a whole understands that codes have much more far reaching uses and implications, the profession as a whole may advance more rapidly.<sup>8</sup>

Incomplete, inaccurate and imprecise codes can create far more significant impediments to IHC professions and practices than unfavorable, delayed or denied insurance payments on specific insurance claims. For example, among these potential impediments are 1) inadequate data to support broad-based inclusion of Oriental medicine in mainstream health insurance benefit plans, 2) insufficient information on legal scopes of practice (especially training/licensing and referral/supervision requirements) to support efficient managed care and provider contracting for IHCPs, 3) lack of cost-effectiveness evidence to support appropriate IHC utilization and clinical practice management, 4) costly workarounds for insurance claims management such as caps on annual IHC visits or expenditures or manual processing of insurance forms with requirements for written substantiation of delivered care, 5) substandard data for comparative outcomes research, and 6) misleading data for actuarial analyses.

Recognition of the need for more complete, accurate and precise health-related data standards was documented as early as 1993 by the National Committee on Vital and Health Statistics. This need has been the topic of numerous initiatives from the U.S. Department of Health and Human Services in the last decade and, especially, over the past two years. The need gained Presidential attention in the past 18 months and was addressed by an Executive Order in April 2004. The Executive Order resulted in HHS establishing aggressive consumer-centric and interoperability requirements for a national health information infrastructure or network (NHII or NHIN). According to HHS, the NHII (and its health-related data standards) must 1) inform clinical practice, 2) interconnect all clinicians, 3) personalize care and 4) improve population health.<sup>9</sup> These endpoints cannot be achieved using CPT and HCPCS II codes alone because these do not address all areas of clinical practice, all types of clinicians, all approaches to care sought by consumers or all subpopulations (e.g., medically underserved populations that rely on rural or ethnic care). ABC codes are thus a missing and essential building block of the NHII.<sup>10</sup>

In summary, ABC codes fill gaps in the CPT and HCPCS II code sets. ABC codes reflect care delivered by allied and public health, nursing, CAM and other IHC practitioners. The codes work side-by-side with other HIPAA-compliant and NHII code sets and fit into the same insurance forms, data fields, software applications, databases, information systems and business processes. Other data elements essential to the NHII are available and link to ABC codes.<sup>11</sup> Used in conjunction with other code sets, ABC codes and these data elements 1) provide the backbone for insurance underwriting and 2) improve healthcare research, management and commerce. Over time, ABC codes will support improvements in healthcare access, quality and cost-management through favorable changes in 1) health benefit plan design, 2) managed care and provider contracting, 3) utilization and clinical practice management, 4) billing and claims management, 5) outcomes research and 6) a variety of actuarial analyses.

ABC codes support comparisons of the economic and health outcomes of conventional, complementary and alternative approaches to care, as well as MD and non-MD caregivers. They help give employers and public payors a way to reduce health benefit costs and generate greater employee and beneficiary accountability for health-related choices. They help give health policymakers a more complete, accurate and precise picture of the financing, administration and delivery of care. This is resulting in the identification of best practices across settings, caregivers and care philosophies to support cost-effective, evidence-based care that ensures more Americans gain access to the right care in the right place and time, at a rational cost.<sup>12</sup>

<b>ABC code</b>	<b>ABC code short description</b>	<b>ABC code expanded definition</b>	<b>RVU - relative values for physicians methodology</b>	<b>RBRVS methodology</b>
ACAAE	Simple new 10 minutes in-office Oriental medicine intake	Using Oriental diagnostic methods in a simple, 10-minute, in-office meeting to assess the health status of a new client and develop an Oriental medicine treatment plan. This code should only be used for client/patient assessment and/or history. For all other acupuncture and Oriental procedures or supplies, use more specific codes.	6.50	1.02
ACAAF	Using new 20 minutes in-office Oriental medicine intake	Using Oriental diagnostic methods in a usual, 20-minute, in-office meeting to assess the health status of a new client and develop an Oriental medicine treatment plan. This code should only be used for client/patient assessment and/or history. For all other acupuncture and Oriental procedures or supplies, use more specific codes.	9.50	1.49
ACAAG	Detailed new 30 minutes in-office Oriental medicine intake	Using Oriental diagnostic methods in a detailed, 30-minute, in-office meeting to assess the health status of a new client and develop an Oriental medicine treatment plan. This code should only be used for client/patient assessment and/or history. For all other acupuncture and Oriental procedures or supplies, use more specific codes.	14.00	2.20
ACBAE	Simple subsequent 10 minutes in-office Oriental medicine intake	Using Oriental diagnostic methods in a simple, subsequent, 10-minute, in-office meeting to assess the health status of an existing client and develop an Oriental medicine treatment plan. This code should only be used for client/patient assessment and/or history. For all other acupuncture and Oriental procedures or supplies, use more specific codes.	6.00	.94

ACBAF	Usual subsequent 20 minutes in-office Oriental medicine intake	Using Oriental diagnostic methods in a usual, subsequent, 20-minute, in-office meeting to assess the health status of an existing client and develop an Oriental medicine treatment plan. This code should only be used for client/patient assessment and/or history. For all other acupuncture and Oriental procedures or supplies, use more specific codes.	9.00	1.41
ACBAG	Detailed subsequent 30 minutes in-office Oriental medicine intake	Using Oriental diagnostic methods in a detailed, subsequent, 30-minute, in-office meeting to assess the health status of an existing client and develop an Oriental medicine treatment plan. This code should only be used for client/patient assessment and/or history. For all other acupuncture and Oriental procedures or supplies, use more specific codes.	13.50	2.11
ACCAG	Simple new 10 minutes out-of-office Oriental medicine intake	Using Oriental diagnostic methods in a simple, 10-minute, out-of-office meeting to assess the health status of a new client and develop an Oriental medicine treatment plan. This code should only be used for client/patient assessment and/or history. For all other acupuncture and Oriental procedures or supplies, use more specific codes.	8.50	1.33
ACCAH	Usual new 20 minutes out-of-office Oriental medicine intake	Using Oriental diagnostic methods in a usual 20-minute, out-of-office meeting to assess the health status of a new client and develop an Oriental medicine treatment plan. This code should only be used for client/patient assessment and/or history. For all other acupuncture and Oriental procedures or supplies, use more specific codes.	11.50	1.80

ACCAI	Detailed new 30 or more minutes out-of-office Oriental medicine intake	Using Oriental diagnostic methods in a detailed, 30-minute or more out-of-office meeting to assess the health status of a new client and develop an Oriental medicine treatment plan. This code should only be used for client/patient assessment and/or history. For all other acupuncture and Oriental procedures or supplies, use more specific codes.	16.00	2.50
ACDAG	Simple subsequent 10 minutes out-of-office Oriental medicine intake	Using Oriental diagnostic methods in a simple subsequent, 10-minute, out-of-office meeting to assess the health status of an existing client and develop an Oriental medicine treatment plan. This code should only be used for client/patient assessment and/or history. For all other acupuncture and Oriental procedures or supplies, use more specific codes.	8.00	1.25
ACDAH	Usual subsequent 20 minutes out-of-office Oriental medicine intake	Using Oriental diagnostic methods in a usual, subsequent 20-minute, out-of-office meeting to assess the health status of an existing client and develop an Oriental medicine treatment plan. This code should only be used for client/patient assessment and/or history. For all other acupuncture and Oriental procedures or supplies, use more specific codes.	11.00	1.73
ACDAI	Detailed subsequent 30 or more minutes out-of-office Oriental medicine intake	Using Oriental diagnostic methods in a detailed, subsequent, 30-minute or more, out-of-office meeting to assess the health status of an existing client and develop an Oriental medicine treatment plan. This code should only be used for client/patient assessment and/or history. For all other acupuncture and Oriental procedures or supplies, use more specific codes.	15.50	2.43

CACAB	Cupping each 15 minutes	Applying a suction device to a client's skin to induce and/or correct an ecchymosal condition(s) (for example, to drain blood-blisters). Service is billed in 15-minute increments.	4.20	.66
CACAC	Ear seeds or pellets each 15 minutes	Placing and/or removing ear seeds or pellets in the pinna of a client's ear to treat and/or prevent disease, disorder and/or to relieve his or her pain. Service is billed in 15-minute increments.	3.00	0.47
CACAD	Electrical acupuncture each 15 minutes	Applying an electrical current to acupuncture needles in situ on a client's body part, region or full body to facilitate a transdermal current between two or more acupoints. Service is billed in 15+minute increments.	9.10	1.43
CACAE	Moxibustion each 15 minutes	Using moxa to heat acupoints on a client's body. Service is billed in 15-minute increments.	4.10	0.64
CACAG	Laser acupuncture noncauterizing each 15 minutes	Using a noncauterizing laser on one or more acupoints of a client's body. Service is billed in 15-minute increments.	9.20	1.44
CACAH	Auricular tacks or microneedles each 15 minutes	Applying ear tacks or microneedles to acupoints on a client's ear(s). Service is billed in 15-minute increments.	(I) 3.6	0.56
CACAI	Auricular therapy each 15 minutes	Applying acupuncture needles to acupoints on a client's outer ear that relate to various areas of his or her body. Service is billed in 15-minute increments.	N/A	N/A
CACZZ	Undefined Oriental modality narrative required	Any elsewhere undefined Oriental modality, narrative required. To help develop more comprehensive coding, please submit an ABC Terminology and Code Request Form, which is available in the back of all ABC coding publications and at <a href="http://www.AlternativeLink.com">www.AlternativeLink.com</a> .	BR	0.00
CADAA	Point injection aquapuncture each 5 minutes	Injecting a solution(s) into one or more acupoints of a client's body. Service is billed in 5-minute increments.	5.60	0.88

CADAB	Oriental stress reduction technique each 15 minutes	Using Oriental medicine techniques to reduce a client's stress. Service is billed in 15-minute increments.	3.40	0.53
CADAD	Moxibustion scar therapy each 15 minutes	Using moxibustion to reduce and/or affect scarring on a client's body part or region. Service is billed in 15-minute increments.	(I) 4.8	0.75
CADAF	Oriental injection therapy each injection	Injecting an herb(s), homeopathic remedy or remedies and/or other nutritional supplement(s), in sterile substance form, into one or more acupoints of a client's body for therapeutic effect(s) (for example, to manage pain). Any practitioner using this code must document training and/or certification. Service is billed per injection.		
CADZZ	Undefined Oriental therapy narrative required	Any elsewhere undefined Oriental therapy, narrative required. To help develop more comprehensive coding, please submit an ABC Terminology and Code Request Form, which is available in the back of all ABC coding publications and at <a href="http://www.AlternativeLink.com">www.AlternativeLink.com</a> .		
CAEAM	Acupuncture anesthesia dental initial 60 minutes	Using acupuncture to provide anesthesia and/or analgesia to a client/patient for one or more dental procedures on a single occasion. When using CAEAM, no other acupuncture services may be billed. For additional time, use CAEAQ. Any practitioner using this code must document training and/or certification. Service is billed in 60-minute increments.		
CAEAO	Acupuncture anesthesia labor and post-delivery initial 60 minutes	Using acupuncture to provide anesthesia and/or analgesia to a client/patient to reduce labor and/or post-delivery pain and/or stress. When using CAEAO, no other acupuncture services may be billed. For additional time, use CAEAQ. Any practitioner using this code must document training and/or certification. Service is billed in 60-minute increments.	26.00	4.07

CAEAP	Acupuncture anesthesia Caesarean-section delivery initial 60 minutes	Using acupuncture to provide anesthesia and/or analgesia to a client/patient during a Caesarean-section delivery. When using CAEAP, no other acupuncture services may be billed. For additional time, use CAEAQ. Any practitioner using this code must document training and/or certification. Service is billed in 60-minute increments.	26.00	4.07
CAEAQ	Acupuncture anesthesia each additional 15 minutes	Using acupuncture to provide anesthesia and/or analgesia to a client/patient. Use CAEAQ in conjunction with CAEAM, CAEAN, CAEAO or CAEAP. Service is billed in 15-minute increments.	14.00	2.20
CAEZY	Undefined acupuncture anesthesia narrative required	Any elsewhere undefined acupuncture anesthesia, narrative required. To help develop more comprehensive coding, please submit an ABC Terminology and Code Request Form, which is available in the back of all ABC coding publications and at <a href="http://www.AlternativeLink.com">www.AlternativeLink.com</a>	BR	0.00
CBGAA	Acupressure each 15 minutes	Applying firm, sustained pressure using fingers and palms to stimulate a client's energy flow along acupuncture meridian points of his or her body. Any practitioner using this code, other than an acupuncturist or an Oriental medicine practitioner, must document training and/or certification Service is billed in 15-minute increments.	4.20	.66
CBGAB	Amma therapy each 15 minutes	Applying deep rhythmic tissue manipulation using fingers, elbows and/or feet on a client's vital points or tsubos. Any practitioner using this code must document training and/or certification. Service is billed in 15-minute increments.	3.00	0.47

CBGAI	Shiatsu each 15 minutes	Performing a Japanese technique that uses pressure applied by the thumbs to a client's meridian(s). Any practitioner using this code, other than an acupuncturist or an Oriental medicine practitioner, must document training and/or certification Service is billed in 15-minute increments.	3.00	0.47
CBGAK	Tuina each 15 minutes	Using Chinese massage techniques to manipulate a client's soft tissue of his or her musculoskeletal and ligamentous systems to realign their relationships within the body. Any practitioner using this code, other than an acupuncturist or an Oriental medicine practitioner, must document training and/or certification Service is billed in 15-minute increments.	3.00	0.47
CBGAL	Gua Sha each 15 minutes	Promoting blood circulation and/or lymph drainage in a client by scraping his or her skin with a flat tool to facilitate pain relief. Any practitioner using this code, other than an acupuncturist or an Oriental medicine practitioner, must document training and/or certification Service is billed in 15-minute increments.	4.60	.072
CBGZZ	Undefined Oriental massage practice narrative required	Any elsewhere undefined Oriental massage practice, narrative required. To help develop more comprehensive coding, please submit an ABC Terminology and Code Request Form, which is available in the back of all ABC coding publications and at <a href="http://www.AlternativeLink.com">www.AlternativeLink.com</a> .	BR	0.00

### References

1. HCPCS includes Level I and II codes. The AMA ([www.ama-assn.org](http://www.ama-assn.org)) maintains Level I (CPT) codes. According to CMS ([www.cms.hhs.gov](http://www.cms.hhs.gov)), these codes do not support "medical items or services that are

regularly billed by suppliers other than physicians." Level II codes are maintained by CMS, AHIP ([www.ahip.org](http://www.ahip.org)), and BCBSA ([www.bluecares.org](http://www.bluecares.org)) and "identify products, supplies, and services... used outside a physician's office." Level III local codes were developed and used by Medicaid, Medicare contractors, and private insurers in their specific programs or local areas. CMS eliminated local codes because the codes "do not support the objectives of the HIPAA legislation, which calls for ... uniform standards and requirements."

2. Alternative Link. 45 CFR 162.940: *The Commercial Use and Cost-Benefit of ABC Codes in HIPAA Transactions and the NHII*. Submitted on October 11, 2004 to the Office of the Secretary, U.S. Department of Health and Human Services (HHS) ([www.hhs.gov](http://www.hhs.gov)).
3. Imagine the inefficiencies that would result if only 15.3% of food products in grocery stores had UPCs or bar codes. Medical billing codes are supposed to function much like UPCs by supporting electronic recordkeeping and business processes automation.
4. Among the underserved sites of service are wellness, palliative, rehabilitative, faith-based, obesity management, disease management, culturally competent and other IHC clinics and settings. Among the underserved caregivers are acupuncturists, advanced nurse practitioners, behavioral health professionals, chiropractors, clinical nurse specialists, culturally competent caregivers, dental hygienists, homeopaths, massage therapists, midwives, naturopaths, nutritionists, pharmacists, physical therapists, physician assistants, reflexologies, registered nurses, social workers, spiritual care practitioners and others. Among the underserved approaches to care are allied and public health, nursing, complementary and alternative medicine (CAM) and other IHC practices.
5. ABC codes are supported by relative values based on the 1) Relative Values for Physicians, Dentists and Therapists methodologies described at [www.rvsdata.com](http://www.rvsdata.com), and 2) RBRVS methodologies supported by CMS.
6. Virtually every participant in the U.S. health care system uses codes for some critical purpose. Incomplete, inaccurate and imprecise codes give caregivers, administrators and health policymakers incorrect information about the kind of care American consumers demand and can lead to care, business and policy decisions that do not support what is best for these consumers.
7. For example, some noteworthy strategic initiatives are listed at [www.aomnc.com](http://www.aomnc.com). AOMNC has motivated insurance companies to request ABC codes be supported by software developers in the automotive injury arena.
8. ABC codes improve business processes and health industry efficiencies in the same manner that UPCs

improved retail operations and retail industry efficiencies. In healthcare, the combination of ABC, CPT and HCPCS II codes not only supports business process automation, but also helps digitize information to simplify data collection, analysis, and reporting. This improves data quality and leads to more timely conclusions about what works in U.S. health care and why. By offering health industry participants more complete, accurate, and precise information on best practices, ABC codes can help demonstrate that Oriental medicine practitioners generate favorable economic and health outcomes.

9. Tommy G. Thompson and David J. Brailer. *The Decade of Health Information Technology: Delivering Consumer-centric and Information-Rich Health Care*. HHS Office of the National Coordinator for Health Information Technology, July 21, 2004.
  10. The aforementioned report to HHS revealed deployment of ABC codes would lead to \$51 billion in annual savings - the majority of this derived from eliminating coding anomalies and supporting direct insurance billing by IHCPs. HHS is considering redesignating ABC codes as a mandatory rather than an optional HIPAA and NHII standard. The code set is expected to lead to highly favorable changes in coverage and reimbursement policies for cost-effective IHC practices over the next several years.
  11. These data elements include 1) descriptions that reduce the need for lengthy explanations of care and claims attachments; 2) relative value units that support pricing and payment decisions; 3) two-character practitioner identifiers, used as code modifiers, that characterize caregivers; 4) legal practice guidelines on per intervention, per practitioner and per state-specific basis; and 5) training/licensing and referral/supervision requirements to support credentialing and other mechanisms for establishing caregiver qualifications. Companies such as Natural Standard ([www.naturalstandard.com](http://www.naturalstandard.com)) can help provide corresponding IHC clinical efficacy and cost-effectiveness guidelines.
  12. Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule for Calendar Year 2005 (CMS-1429-FC) Retrieved from the Internet on January 24, 2005 from [www.cms.hhs.gov/regulations/pfs/2005/1429fc.asp](http://www.cms.hhs.gov/regulations/pfs/2005/1429fc.asp).
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