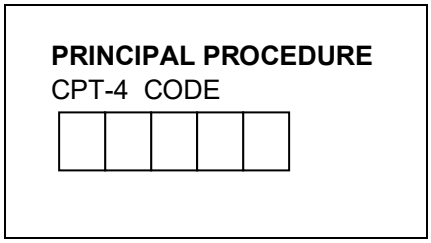
PRINCIPAL PROCEDURE — Section 97262

The patient's principal procedure is one that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk. The procedure related to the principal diagnosis, as the chief reason for the encounter, shall be selected as the principal procedure. The procedure shall be coded according to the Current Procedural Terminology, Fourth Edition (CPT-4).

DISCUSSION

Specifications for reporting this data element with the Record Entry Form for online web entry of individual records or online data file transmission:



Reporting Requirements:

Ambulatory surgery procedures means those procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or a freestanding ambulatory surgery clinic. (Section 128700 of California Health and Safety Code)

- A Principal Procedure must be reported on each Ambulatory Surgery record.
- Fill from the left-most position and do not skip fields.
- The full range of CPT-4 codes should be used to report ambulatory surgery procedures performed. Category II CPT-4 codes are not accepted by HCAI. Modifiers are not accepted by HCAI.

Healthcare Common Procedure Coding System (HCPCS)			
Level I	**Terminology**	**Codes**	**For HCAI**
	"CPT"		
	Category I	00001-99999	Report
	Category II	0001F-9999F	See below*
	Category III	0001T-9999T	Report
	Modifiers	-00 thru -99	See below*
Level II	**Terminology**	**Codes**	**For HCAI**
	"National Codes" or "HCPCS"	A0000-V9999	See below*
	Modifiers	-AA thru -ZZ, -A thru -Z, and -A1 thru -Z9	See below*

*Codes in this category will cause an error if reported to HCAI. Please convert to a Category I or Category III code when applicable to report procedure to HCAI.

Three categories within HCPCS Level 1 CPT-4 codes are:

1. Category I CPT-4 codes, established by the CPT Editorial panel, are required for reporting services and procedures performed to HCAI.

2. Category II CPT-4 codes are a set of supplemental tracking codes for performance measurements and are **not accepted** by HCAI.

3. Category III CPT-4 codes are a set of temporary codes for emerging technology, services and procedures and are required to be used instead of Category I unlisted codes when reporting to HCAI.

The following procedural codes are **not accepted** by HCAI for reporting ED and AS records:

- CPT-4 codes, Category II

- ICD-10-PCS

Criteria for Reporting

For Ambulatory Surgery Data:

Two criteria must be met:

1. Procedure is performed on an outpatient basis, and

2. Procedure is performed in one of these areas of a hospital or freestanding ambulatory surgery clinic: general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories.

If both criteria are met, then determine if the procedure is surgical in nature, carries a procedural risk, or carries an anesthetic risk. See **Determining Surgery, Procedural Risk, Anesthetic Risk** section below.

For Emergency Department Data:

Report the procedure if it is performed in the Emergency Department and if the procedure is surgical in nature, carries a procedural risk, or carries an anesthetic risk.

Note: Not all ED records will have a procedure. All ED records are to be reported to HCAI regardless of whether a procedure was performed when an encounter occurred (face-to-face contact between an outpatient and a provider). A provider is the person who has primary responsibility for assessing and treating the condition of the patient at a given contact and exercises independent judgement in the care of the patient.

For ED and AS:
Determining Surgery, Procedural Risk, Anesthetic Risk

The definition of a significant procedure is one that is surgical in nature, or carries a procedural risk or carries an anesthetic risk.

(1) **Surgery** includes incision, excision, amputation, introduction, endoscopy repair, destruction, suture and manipulation.

(2) **Procedural risk** – This term refers to a professionally recognized risk that a given procedure may induce some functional impairment, injury, morbidity, or even death. This risk may arise from direct trauma, physiologic disturbances,

interference with natural defense mechanisms, or exposure of the body to infection or other harmful agents.

Traumatic procedures are those that are invasive, including nonsurgical procedures that utilize cutdowns; cause tissue damage (e.g., irradiation); or introduce some toxic or noxious substance (e.g., caustic test reagents).

Physiologic risk is associated with the use of virtually any pharmacologic or physical agent that can affect homeostasis (e.g., those that alter fluid distribution, electrolyte balance, blood pressure levels, and stress or tolerance tests).

Any procedure in which it is obligatory (or usual) to utilize pre- or postmedications that are associated with physiologic or pharmacologic risk may be considered as having a "procedural risk," for example, those that require heavy sedation or drugs selected for their systemic effects such as alteration of metabolism, blood pressure or cardiac function. Some of the procedures that include harmful exposures are those that can introduce bacteria into the bloodstream (e.g., cardiac catheterization), those capable of suppressing the immune system, those that can precipitate idiosyncratic reactions such as anaphylaxia after the use of contrast materials, and those involving substances with known systemic toxicity.

Long-life radioisotopes pose a special kind of exposure risk to other persons as well as to the patient. Thus, these substances require special precautionary measures and the procedures using them carry procedural risk.

(3) **Anesthetic risk** – Any procedure that either requires or is regularly performed under general anesthesia carries anesthetic risk, as do procedures under local, regional, or other forms of anesthesia that induce sufficient functional impairment necessitating special precautions to protect the patient from harm.

Cancelled Procedures:

If a procedure is begun but cannot be completed (similar to the description in CPT modifier 74), report the record to HCAI showing the CPT procedure code. Code one of the Z codes (Z53) as Other Diagnosis to explain the reason for the incomplete procedure. If a procedure has not begun (similar to the description in CPT modifier 73), do not report the record to HCAI.