Optum

Coding Companion

General Surgery/ Gastroenterology

A comprehensive illustrated guide to coding and reimbursement

2024

optumcoding.com

Contents

Getting Started with Coding Companion

Coding Companion for General Surgery/Gastroenterology is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to general surgery/gastroenterology are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT/HCPCS code is followed by its official CPT code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum *Coding Companion* series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the pages following the sample.

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT code description, followed by an easy-to-understand explanation.

The codes in the appendix are presented in the following order:

- E/M Services
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 28.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2023 edition password is: **23SPECIALTY.** Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

47600 Cholecystectomy;

could be found in the index under the following main terms:

Cholecystectomy
Open Approach, 47600-47762

or **Excision**
Gallbladder
Open, 47600-47620

or **Gallbladder**
Cholecystectomy, 47600

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xiv of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

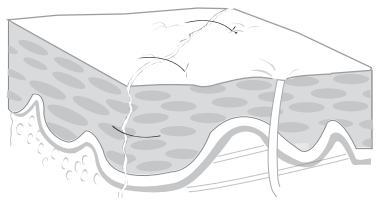
Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

12001-12007

12001 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
12002 2.6 cm to 7.5 cm
12004 7.6 cm to 12.5 cm
12005 12.6 cm to 20.0 cm
12006 20.1 cm to 30.0 cm
12007 over 30.0 cm



Example of a simple closure involving only one skin layer, the epidermis

Explanation

The physician performs wound closure of superficial lacerations of the scalp, neck, axillae, external genitalia, trunk, or extremities using sutures, staples, tissue adhesives, or a combination of these materials. A local anesthetic is injected around the wound and it is cleansed, explored, and often irrigated with a saline solution. The physician performs a simple, one-layer repair of the epidermis, dermis, or subcutaneous tissues. For multiple wounds of the same complexity and in the same anatomical area, the length of all wounds sutured is summed and reported as one total length. Report 12001 for a total length of 2.5 cm or less; 12002 for 2.6 cm to 7.5 cm; 12004 for 7.6 cm to 12.5 cm; 12005 for 12.6 cm to 20 cm; 12006 for 20.1 cm to 30 cm; and 12007 if the total length is greater than 30 cm.

Coding Tips

Wounds treated with tissue glue or staples qualify as a simple repair even if they are not closed with sutures. When chemical cauterization, electrocauterization, or adhesive strips are the only material used for wound closure, the service is included in the appropriate E/M code. Anesthesia (local or topical) and hemostasis are not reported separately. Intermediate repair is used when layered closure of one or more of the deeper layers of subcutaneous tissue and superficial fascia are required in addition to limited undermining. Single-layer closure of a wound requiring extensive cleaning or removal of contaminated foreign matter or damaged tissue is classified as an intermediate repair. For extensive debridement of soft tissue and/or bone, not associated with open fractures and/or dislocations, resulting from penetrating and/or blunt trauma, see 11042–11047. For wound care closure by tissue adhesive(s) only, see HCPCS Level II code G0168. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

S01.01XA Laceration without foreign body of scalp, initial encounter
S01.03XA Puncture wound without foreign body of scalp, initial encounter
S01.05XA Open bite of scalp, initial encounter
S21.011A Laceration without foreign body of right breast, initial encounter ☑
S21.032A Puncture wound without foreign body of left breast, initial encounter ☑
S91.154A Open bite of right lesser toe(s) without damage to nail, initial encounter ☑
S91.214A Laceration without foreign body of right lesser toe(s) with damage to nail, initial encounter ☑
S91.231A Puncture wound without foreign body of right great toe with damage to nail, initial encounter ☑
S91.235A Puncture wound without foreign body of left lesser toe(s) with damage to nail, initial encounter ☑
S91.251A Open bite of right great toe with damage to nail, initial encounter ☑
S91.255A Open bite of left lesser toe(s) with damage to nail, initial encounter ☑
S91.311A Laceration without foreign body, right foot, initial encounter ☑

Associated HCPCS Codes

G0168 Wound closure utilizing tissue adhesive(s) only

AMA: **12001** 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep; 2017, 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12004** 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12005** 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12006** 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12007** 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
12001	0.84	1.79	0.17	2.8
12002	1.14	2.01	0.22	3.37
12004	1.44	2.2	0.27	3.91
12005	1.97	2.92	0.39	5.28
12006	2.39	3.31	0.47	6.17
12007	2.9	3.48	0.56	6.94
Facility RVU	**Work**	**PE**	**MP**	**Total**
12001	0.84	0.32	0.17	1.33
12002	1.14	0.38	0.22	1.74
12004	1.44	0.44	0.27	2.15
12005	1.97	0.45	0.39	2.81
12006	2.39	0.59	0.47	3.45
12007	2.9	0.84	0.56	4.3

	FUD	Status	MUE	Modifiers				IOM Reference
12001	0	A	1(2)	51	N/A	N/A	N/A	None
12002	0	A	1(2)	51	N/A	N/A	N/A	
12004	0	A	1(2)	51	N/A	N/A	N/A	
12005	0	A	1(2)	51	N/A	N/A	N/A	
12006	0	A	1(2)	51	N/A	N/A	N/A	
12007	0	A	1(2)	51	N/A	62*	N/A	

* with documentation

Terms To Know

simple repair. Surgical closure of a superficial wound requiring single layer suturing of the skin (epidermis, dermis, or subcutaneous tissue).

superficial. On the skin surface or near the surface of any involved structure or field of interest.

wound. Injury to living tissue often involving a cut or break in the skin.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2024.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2024.
- ▲ This CPT code description is revised for 2024.
- ✚ This CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.

The Centers for Medicare and Medicaid Services (CMS) have identified additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE), some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 93 or 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services, when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96160	96161	97802	97803	97804
99406	99407	99408	99409	99497	99498	

2. Illustrations

The illustrations that accompany the *Coding Companion* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most pages will have an illustration, there will be some pages that do not.

3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes the most common method of performing each procedure.

4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

6. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

7. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2022.

The 2024 Medicare edits were not available at the time this book went to press. Updated 2024 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2024 edition password is **23SPECIALTY**.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

▶The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service◀

Classification of Evaluation and Management (E/M) Services

▶The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.◀

New and Established Patients

▶Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

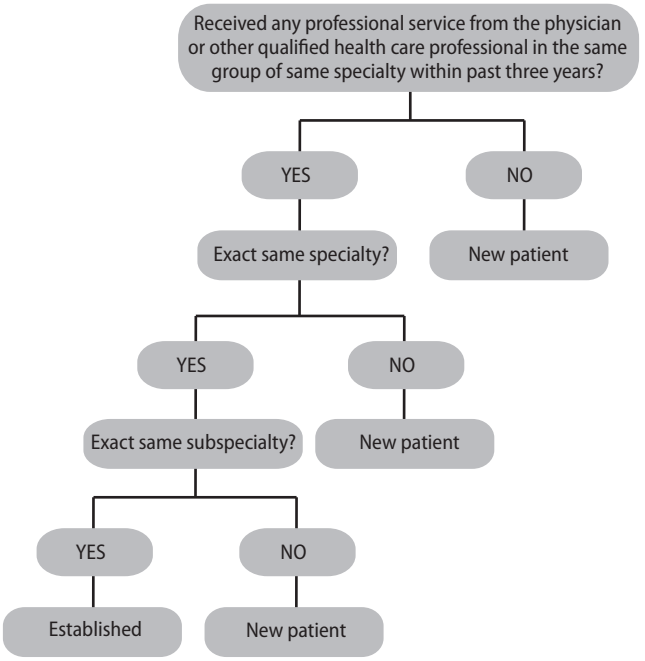
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.◀

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

▶◀ = Contains new or revised text

99202-99205

★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For patients admitted and discharged from inpatient or observation care on the same date, see 99234-99236. For prolonged services with 99205, see 99417; for Medicare, see G2212. Medicare has identified these codes as telehealth/telemedicine services. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99203** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99204** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99205** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.12	0.09	2.14
99203	1.6	1.52	0.17	3.29
99204	2.6	2.06	0.24	4.9
99205	3.5	2.66	0.32	6.48
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.17	2.44
99204	2.6	1.11	0.24	3.95
99205	3.5	1.54	0.32	5.36

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

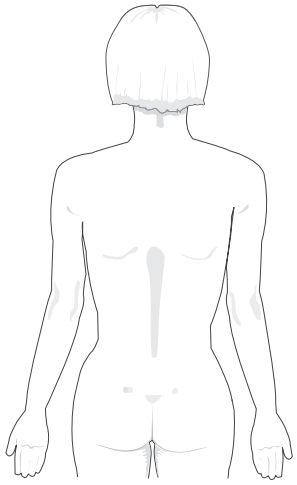
* with documentation

Terms To Know

new patient. Patient who is receiving face-to-face care from a physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice for the first time in three years. For OPPS hospitals, a patient who has not been registered as an inpatient or outpatient, including off-campus provider-based clinic or emergency department, within the past three years.

21930-21933

21930 Excision, tumor, soft tissue of back or flank, subcutaneous; less than 3 cm
21931 3 cm or greater
21932 Excision, tumor, soft tissue of back or flank, subfascial (eg, intramuscular); less than 5 cm
21933 5 cm or greater



Excision of a soft tissue tumor of the back or flank

Explanation

The physician removes a tumor from the soft tissue of the back or flank that is located in the subcutaneous tissue in 21930–21931 and in the deep soft tissue, below the fascial plane or within the muscle, in 21932–21933. The patient is positioned lying on the side or prone. With the proper anesthesia administered, the physician makes an incision in the skin overlying the mass and dissects down to the tumor. The extent of the tumor is identified and a dissection is undertaken all the way around the tumor. A portion of neighboring soft tissue may also be removed to ensure adequate removal of all tumor tissue. A drain may be inserted and the incision is repaired with layers of sutures, staples, or Steri-strips. Report 21930 for excision of subcutaneous tumors whose resected area is less than 3 cm and 21931 for excision of subcutaneous tumors 3 cm or greater. Report 21932 for excision of subfascial or intramuscular tumors whose resected area is less than 5 cm and 21933 for excision of subfascial or intramuscular tumors 5 cm or greater.

Coding Tips

When any of these procedures are performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. An excisional biopsy is not reported separately when a therapeutic excision is performed during the same surgical session. Report any free grafts or flaps separately. When medically necessary, report moderate (conscious) sedation provided by the performing physician with 99151–99153; another physician, see 99155–99157.

ICD-10-CM Diagnostic Codes

C43.59 Malignant melanoma of other part of trunk
C4A.59 Merkel cell carcinoma of other part of trunk
C76.8 Malignant neoplasm of other specified ill-defined sites
D03.59 Melanoma in situ of other part of trunk
D04.5 Carcinoma in situ of skin of trunk
D17.1 Benign lipomatous neoplasm of skin and subcutaneous tissue of trunk
D49.2 Neoplasm of unspecified behavior of bone, soft tissue, and skin
D49.89 Neoplasm of unspecified behavior of other specified sites
R22.2 Localized swelling, mass and lump, trunk

AMA: **21930** 2022,Oct; 2018,Sep **21931** 2022,Oct; 2018,Sep **21932** 2022,Oct; 2018,Sep **21933** 2022,Oct; 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21930	4.94	9.14	1.04	15.12
21931	6.88	5.53	1.61	14.02
21932	9.82	7.72	2.23	19.77
21933	11.13	8.3	2.6	22.03
Facility RVU	**Work**	**PE**	**MP**	**Total**
21930	4.94	4.84	1.04	10.82
21931	6.88	5.53	1.61	14.02
21932	9.82	7.72	2.23	19.77
21933	11.13	8.3	2.6	22.03

	FUD	Status	MUE	Modifiers				IOM Reference
21930	90	A	5(3)	51	N/A	N/A	N/A	None
21931	90	A	3(3)	51	N/A	N/A	80	
21932	90	A	2(3)	51	N/A	N/A	80	
21933	90	A	2(3)	51	N/A	N/A	80	

* with documentation

Terms To Know

dissection. Separating by cutting tissue or body structures apart.

drain. Device that creates a channel to allow fluid from a cavity, wound, or infected area to exit the body.

excision. Surgical removal of an organ or tissue.

subcutaneous tissue. Sheet or wide band of adipose (fat) and areolar connective tissue in two layers attached to the dermis.

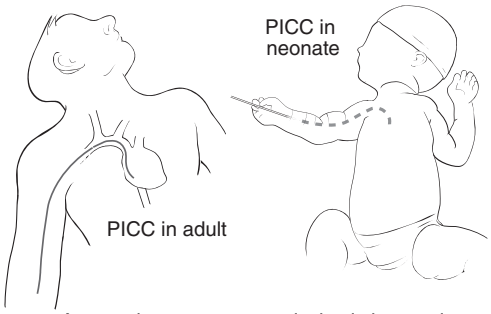
tumor. Pathological swelling or enlargement; a neoplastic growth of uncontrolled, abnormal multiplication of cells.

 N Newborn: 0 **P** Pediatric: 0-17 **M** Maternity: 9-64 **A** Adult: 15-124 ♂ Male Only ♀ Female Only

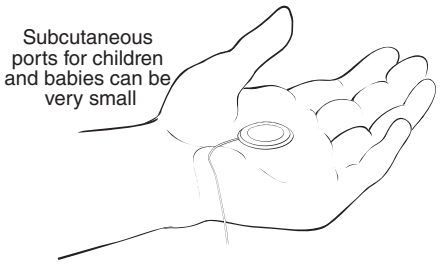
36570-36571

36570 Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age

36571 age 5 years or older



A central venous access device is inserted from a periphery, with use of a subcutaneous port



Explanation

A central venous access device or catheter is one in which the tip terminates in the subclavian, brachiocephalic, or iliac vein; the superior or inferior vena cava; or the right atrium. A peripherally inserted central venous catheter (PICC) has an entry site in the basilic or cephalic vein in the arm and is threaded into the superior vena cava above the right atrium. PICC lines are used for antibiotic therapy, chemotherapy, total parenteral nutrition, lab work, pain medications, blood transfusions, and hydration the same as a central line. For insertion of a peripherally inserted central venous catheter with a subcutaneous port, the site over the access vein (basilic or cephalic) is injected with local anesthesia and punctured with a needle. A guidewire is inserted. The central venous catheter is placed over the guidewire and fed through the vein in the arm into the superior vena cava. The port may be placed in the chest in a subcutaneous pocket created through an incision in the chest wall, or placed in the arm through a small incision just above or halfway between the elbow crease and the shoulder on the inside of the arm. The port is attached to the catheter and checked. Ultrasound guidance may be used to gain venous access and/or fluoroscopy to check the positioning of the catheter tip. The catheter and port are secured into position and incisions are closed and dressed. Report 36570 for insertion for children younger than 5 years of age and 36571 for a patient 5 years of age or older.

Coding Tips

For insertion of a tunneled, centrally inserted central venous access device, with subcutaneous port, younger than 5 years of age, see 36560; 5 years or older, see 36561. When imaging is used for gaining access to the venous entry site or for manipulating the catheter into final central position, see 76937 or 77001.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **36570** 2019,Mar **36571** 2019,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
36570	5.11	39.39	1.29	45.79
36571	5.09	33.75	1.01	39.85
Facility RVU	**Work**	**PE**	**MP**	**Total**
36570	5.11	3.48	1.29	9.88
36571	5.09	3.16	1.01	9.26

	FUD	Status	MUE	Modifiers				IOM Reference
36570	10	A	2(3)	51	50	N/A	80*	None
36571	10	A	2(3)	51	50	N/A	80*	

* with documentation

Terms To Know

central venous access device. Catheter or other device introduced through a large vein, such as the subclavian or femoral vein, terminating in the superior or inferior vena cava or the right atrium and used to measure venous pressure or administer medication or fluids.

chemotherapy. Treatment of disease, especially cancerous conditions, using chemical agents.

fluoroscopy. Radiology technique that allows visual examination of part of the body or a function of an organ using a device that projects an x-ray image on a fluorescent screen.

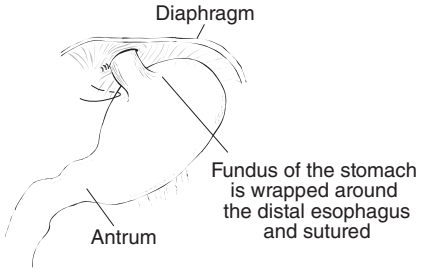
guidewire. Flexible metal instrument designed to lead another instrument in its proper course.

ultrasound. Imaging using ultra-high sound frequency bounced off body structures.

vena cava. Main venous trunk that empties into the right atrium from both the lower and upper regions, beginning at the junction of the common iliac veins inferiorly and the two brachiocephalic veins superiorly.

43279

43279 Laparoscopy, surgical, esophagomyotomy (Heller type), with fundoplasty, when performed



Explanation

The physician performs laparoscopic esophagomyotomy (Heller myotomy), often for treatment of achalasia. Achalasia (a motility disorder of the esophagus) is caused by degeneration of the nerves in the esophageal wall and results in an absence of the typical wave-like motion of the esophagus and lack of relaxation of the lower esophagus. The physician makes several small incisions in the abdominal wall through which a video camera and laparoscopic instruments are inserted. An incision of the esophageal muscle is made using specialized laparoscopic instruments. To prevent reflux, a part of the upper stomach is then wrapped around the lower portion of the esophagus. Laparoscopic instruments are removed, and the small incisions are sutured. A swallowing study is typically obtained prior to discharge.

Coding Tips

A surgical laparoscopy always includes a diagnostic laparoscopy. Do not report 43279 with 43280. For an open approach, see 43330–43331.

ICD-10-CM Diagnostic Codes

C15.5	Malignant neoplasm of lower third of esophagus
C15.8	Malignant neoplasm of overlapping sites of esophagus
C16.0	Malignant neoplasm of cardia
K21.00	Gastro-esophageal reflux disease with esophagitis, without bleeding
K21.01	Gastro-esophageal reflux disease with esophagitis, with bleeding
K21.9	Gastro-esophageal reflux disease without esophagitis
K22.0	Achalasia of cardia
K22.10	Ulcer of esophagus without bleeding
K22.11	Ulcer of esophagus with bleeding
K22.2	Esophageal obstruction
K22.70	Barrett's esophagus without dysplasia
K22.710	Barrett's esophagus with low grade dysplasia
K22.711	Barrett's esophagus with high grade dysplasia
K22.89	Other specified disease of esophagus
Q39.0	Atresia of esophagus without fistula
Q39.1	Atresia of esophagus with tracheo-esophageal fistula
Q39.2	Congenital tracheo-esophageal fistula without atresia
Q39.3	Congenital stenosis and stricture of esophagus
Q39.4	Esophageal web
Q39.5	Congenital dilatation of esophagus
Q39.6	Congenital diverticulum of esophagus
Q39.8	Other congenital malformations of esophagus
R13.0	Aphagia
R13.11	Dysphagia, oral phase
R13.12	Dysphagia, oropharyngeal phase
R13.13	Dysphagia, pharyngeal phase
R13.14	Dysphagia, pharyngoesophageal phase
R13.19	Other dysphagia
R63.32	Pediatric feeding disorder, chronic P
R63.39	Other feeding difficulties

AMA: **43279** 2021,Jul; 2020,Jan; 2017,Aug

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
43279	22.1	10.73	5.39	38.22
Facility RVU	**Work**	**PE**	**MP**	**Total**
43279	22.1	10.73	5.39	38.22

	FUD	Status	MUE	Modifiers				IOM Reference
43279	90	A	1(2)	51	N/A	62*	80	None

* with documentation

Terms To Know

achalasia. Failure of the smooth muscles within the gastrointestinal tract to relax at points of junction; most commonly referring to the esophagogastric sphincter's failure to relax when swallowing.

degeneration. Deterioration of an anatomic structure due to disease or other factors.

Heller myotomy. Longitudinal division of the distal esophageal muscle down to the submucosal layer. Cardia muscle fibers may also be divided. This procedure is used to treat achalasia.

laparoscopy. Direct visualization utilizing a thin, flexible, fiberoptic tube.

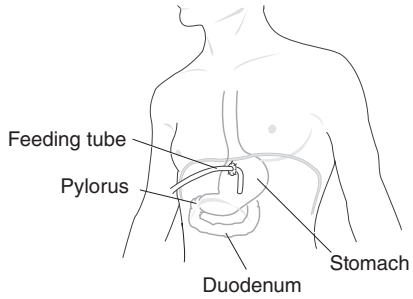
reflux. Return or backward flow.

N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

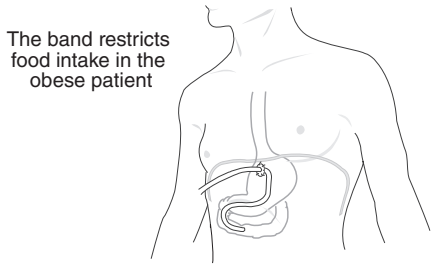
43887-43888

43887 Gastric restrictive procedure, open; removal of subcutaneous port component only

43888 removal and replacement of subcutaneous port component only



Gastric band is placed in laparoscopic approach



Explanation

The physician performs an open removal or a removal and replacement of the subcutaneous port component used in a gastric restrictive procedure for the treatment of morbid obesity. The subcutaneous port is the access point for infusing saline into the gastric band to adjust the band for optimal performance. The physician makes an incision through the old scar near the original port. Dissection is carried down to the port and the sutures adhering the port to the fascia are removed. The physician severs the tubing connected to the port. In 43887, the subcutaneous port is removed. In 43888, the original subcutaneous port is removed and replaced with a new port to which the tubing is reattached. The replacement port is secured to the fascia with sutures. The incision is closed with sutures.

Coding Tips

Do not report 43888 with 43774 or 43887. For revision of the subcutaneous port component only, see 43886; via laparoscopy, see 43771. For removal only, see 43887; via laparoscopy, see 43772. For removal and replacement through a laparoscope, see 43773. For removal and replacement of the gastric band device and subcutaneous port components, see 43659.

ICD-10-CM Diagnostic Codes

E66.01	Morbid (severe) obesity due to excess calories
E66.09	Other obesity due to excess calories
E66.1	Drug-induced obesity
E66.2	Morbid (severe) obesity with alveolar hypoventilation
E66.3	Overweight
E66.8	Other obesity
K91.1	Postgastric surgery syndromes
K95.01	Infection due to gastric band procedure
K95.09	Other complications of gastric band procedure
K95.81	Infection due to other bariatric procedure
K95.89	Other complications of other bariatric procedure
T85.518A	Breakdown (mechanical) of other gastrointestinal prosthetic devices, implants and grafts, initial encounter
T85.528A	Displacement of other gastrointestinal prosthetic devices, implants and grafts, initial encounter
T85.598A	Other mechanical complication of other gastrointestinal prosthetic devices, implants and grafts, initial encounter
Z46.51	Encounter for fitting and adjustment of gastric lap band

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
43887	4.32	4.52	1.09	9.93
43888	6.44	5.9	1.63	13.97
Facility RVU	**Work**	**PE**	**MP**	**Total**
43887	4.32	4.52	1.09	9.93
43888	6.44	5.9	1.63	13.97

	FUD	Status	MUE	Modifiers				IOM Reference
43887	90	A	1(2)	51	N/A	62*	80	None
43888	90	A	1(2)	51	N/A	62*	80	

* with documentation

Terms To Know

BMI. Body mass index. Tool for calculating weight appropriateness in adults and may be a factor in determining medical necessity for bariatric procedures.

fascia. Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.

incision. Act of cutting into tissue or an organ.

morbid obesity. Accumulation of excess fat in the subcutaneous connective tissue with increased weight beyond the limits of skeletal requirements, defined as 125 percent or more over the ideal body weight. It is often associated with serious conditions that can become life threatening, such as diabetes, hypertension, and arteriosclerosis.

suture. Numerous stitching techniques employed in wound closure.

buried suture. Continuous or interrupted suture placed under the skin for a layered closure.

continuous suture. Running stitch with tension evenly distributed across a single strand to provide a leakproof closure line.

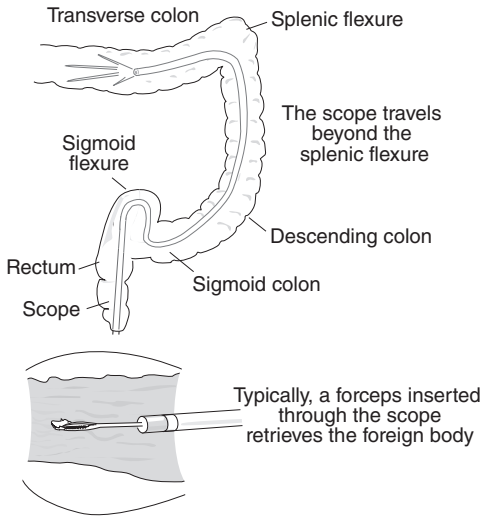
interrupted suture. Series of single stitches with tension isolated at each stitch, in which all stitches are not affected if one becomes loose, and the isolated sutures cannot act as a wick to transport an infection.

purse-string suture. Continuous suture placed around a tubular structure and tightened, to reduce or close the lumen.

retention suture. Secondary stitching that bridges the primary suture, providing support for the primary repair; a plastic or rubber bolster may be placed over the primary repair and under the retention sutures.

45379

45379 Colonoscopy, flexible; with removal of foreign body(s)



A flexible scope is inserted for foreign body removal

Explanation

The physician performs flexible colonoscopy and removes a foreign body(s). The physician inserts the colonoscope into the anus and advances the scope through the colon to the cecum. The lumen of the colon and rectum are visualized. The foreign body(s) is identified and removed by forceps or snare placed through the colonoscope. The colonoscope is withdrawn at the completion of the procedure.

Coding Tips

Report the appropriate endoscopy for each anatomic site examined. Surgical endoscopy includes diagnostic endoscopy; however, diagnostic endoscopy can be identified separately when performed at the same surgical session as an open procedure. Colonoscopy involves examination of the entire colon, from the rectum to the cecum, and may also include the terminal ileum. An incomplete colonoscopy with full colonoscopy preparation is reported with the colonoscopy code and modifier 52. For colonoscopy through stoma, with removal of a foreign body, see 44390. For proctosigmoidoscopy, rigid, with removal of a foreign body, see 45307. For sigmoidoscopy, flexible, with removal of a foreign body, see 45332. If fluoroscopic guidance is performed, see 76000. Bleeding that occurs as the result of an endoscopic procedure, and controlled during the same operative session, is not reported separately. Do not report 45379 with 45378.

ICD-10-CM Diagnostic Codes

T18.4XXA Foreign body in colon, initial encounter

T18.8XXA Foreign body in other parts of alimentary tract, initial encounter

AMA: **45379** 2021,Aug

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
45379	4.28	8.45	0.52	13.25
Facility RVU	**Work**	**PE**	**MP**	**Total**
45379	4.28	2.2	0.52	7.0

	FUD	Status	MUE	Modifiers				IOM Reference
45379	0	A	1(3)	51	N/A	N/A	N/A	None

* with documentation

Terms To Know

endoscopy. Visual inspection of the body using a fiberoptic scope.

forceps. Tool used for grasping or compressing tissue.

foreign body. Any object or substance found in an organ and tissue that does not belong under normal circumstances.

lumen. Space inside an intestine, artery, vein, duct, or tube.

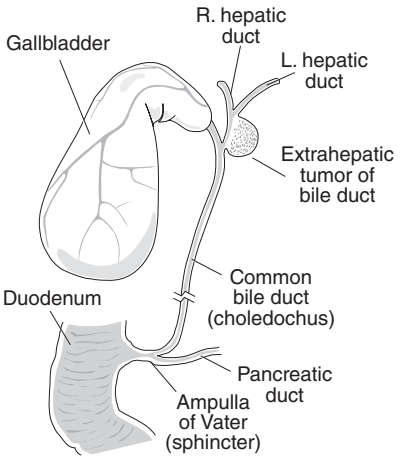
snare. Wire used as a loop to excise a polyp or lesion.

stoma. Opening created in the abdominal wall from an internal organ or structure for diversion of waste elimination, drainage, and access.

47711-47712

47711 Excision of bile duct tumor, with or without primary repair of bile duct; extrahepatic

47712 intrahepatic



Explanation

The physician performs excision of an extrahepatic bile duct tumor and reconstructs bile duct drainage. The physician makes an abdominal incision and explores the abdomen. The bile duct is dissected from surrounding structures and the tumor is identified and mobilized. The tumor is excised with a margin of normal bile duct tissue proximal and distal to the tumor. An anastomosis is usually created between the proximal end of the bile duct and a loop of small bowel to allow biliary drainage. The distal end of the bile duct is oversewn. The incision is closed. In 44712, an intrahepatic bile duct tumor is excised and reconstruction of the bile duct drainage is performed. Through an abdominal excision, the physician isolates the distal bile duct. The tumor is identified and dissection is continued proximally along the bile duct into the parenchyma of the liver beyond the tumor onto the left and right hepatic ducts. The tumor is excised with a normal margin of bile duct or hepatic duct proximal and distal to the tumor. An anastomosis is created between the proximal bile duct or left and right hepatic ducts and a limb of small bowel to allow biliary drainage. The distal end of the bile duct is oversewn. The incision is closed.

Coding Tips

For anastomosis of the biliary ducts and the gastrointestinal tract, see 47760–47785. Reconstruction of the extrahepatic ducts with end-to-end anastomosis is reported with 47800.

ICD-10-CM Diagnostic Codes

C22.1 Intrahepatic bile duct carcinoma

C24.0 Malignant neoplasm of extrahepatic bile duct

C24.1 Malignant neoplasm of ampulla of Vater

C24.8 Malignant neoplasm of overlapping sites of biliary tract

C78.7 Secondary malignant neoplasm of liver and intrahepatic bile duct

C78.89 Secondary malignant neoplasm of other digestive organs

C7A.1 Malignant poorly differentiated neuroendocrine tumors

D01.5 Carcinoma in situ of liver, gallbladder and bile ducts

D13.5 Benign neoplasm of extrahepatic bile ducts

D37.6 Neoplasm of uncertain behavior of liver, gallbladder and bile ducts

K83.5 Biliary cyst

K83.8 Other specified diseases of biliary tract

K87 Disorders of gallbladder, biliary tract and pancreas in diseases classified elsewhere

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
47711	25.9	14.21	6.34	46.45
47712	33.72	17.39	8.53	59.64
Facility RVU	**Work**	**PE**	**MP**	**Total**
47711	25.9	14.21	6.34	46.45
47712	33.72	17.39	8.53	59.64

	FUD	Status	MUE	Modifiers				IOM Reference
47711	90	A	1(2)	51	N/A	62*	80	None
47712	90	A	1(2)	51	N/A	62*	80	

* with documentation

Terms To Know

ampulla of Vater. Tubular structure with flask-like dilation where the common bile and pancreatic ducts join before emptying into the duodenum.

anastomosis. Surgically created connection between ducts, blood vessels, or bowel segments to allow flow from one to the other.

carcinoma in situ. Malignancy that arises from the cells of the vessel, gland, or organ of origin that remains confined to that site or has not invaded neighboring tissue.

exploration. Examination for diagnostic purposes.

hepatic portal vein. Blood vessel that delivers unoxygenated blood from the gastrointestinal tract, spleen, pancreas, and gallbladder to the liver.

malignant. Any condition tending to progress toward death, specifically an invasive tumor with a loss of cellular differentiation that has the ability to spread or metastasize to other body areas.

neoplasm. New abnormal growth, tumor.

proximal. Located closest to a specified reference point, usually the midline or trunk.

reconstruction. Recreating, restoring, or rebuilding a body part or organ.

 N Newborn: 0 **P** Pediatric: 0-17 **M** Maternity: 9-64 **A** Adult: 15-124 ♂ Male Only ♀ Female Only

Correct Coding Initiative Update 28.3

❖Indicates Mutually Exclusive Edit

0184T 00731-00732, 00811-00813, 0213T, 0216T, 0596T-0597T, 0708T-0709T, 11000-11006, 11042-11047, 36000, 36410, 36591-36592, 44701, 45900-45990, 46040, 46080, 46220, 46600-46601, 46604-46615, 46940-46942, 51701-51703, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 69990, 94760-94761, 96360, 96365, 96372, 96374-96377, 96523, 97597-97598, 97602, 99151, 99152, 99153, 99446-99449, 99451-99452, G0471, G0500

0234T 01924-01926, 0213T, 0216T, 0596T-0597T, 11000-11006, 11042-11047, 34713-34716, 34812, 34820, 34833-34834, 35201-35206, 35226-35236, 35256-35266, 35286, 36000, 36002-36005, 36400-36410, 36420-36430, 36440, 36500, 36591-36592, 36600-36640, 37184, 43752, 49000-49002, 51701-51703, 61645-61650, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 75893, 76000, 76942, 76998, 77002, 93000-93010, 93040-93042, 93050, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96377, 96523, 97597-97598, 97602, 99155, 99156, 99157, 99446-99449, 99451-99452, G0471

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