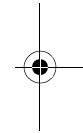
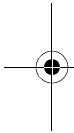


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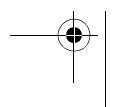
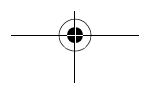
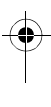
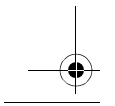
Specialty Expert

A procedural coding companion

Sample



2008



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Sample

Introduction

Specialty Expert is designed to be a guide to specialty procedures classified in the CPT book. It is structured to help coders understand specialty procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book will also allow 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 specialty procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of specialty procedures.

For ease of use, *Specialty Expert* lists the CPT codes in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine, and evaluation and management (E/M) codes pertinent to specialty. Each CPT code is followed by its official CPT code description.

CPT Codes and Descriptions

Indented Procedures

CPT descriptions have been developed to stand alone, but sometimes they appear to be incomplete. The format is employed to conserve space on the printed page. Some CPT codes that share a common procedure are grouped together and the common procedure is listed fully only with the first code. The codes that follow are indented to indicate that a portion of their description is found in a previous code.

For example:

53080 Drainage of perineal urinary extravasation; uncomplicated (separate procedure)
53085 complicated

The common portion of these codes precedes the semicolon (;) in the full description of 53080. The complete description of 53085 is:

53085 Drainage of perineal urinary extravasation; complicated

When the information for an indented code is the same as the information for the code with the full description, these codes will be grouped together in a range. When the information varies greatly, they will be listed separately.

Surgery Codes

A full page is dedicated to each surgical procedure or to a series of similar procedures. Following the specific CPT code and its narrative, you will find a combination of the following features:

Introduction

Specialty Expert

Illustrations

The illustrations that accompany the *Specialty Expert* 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. The depictions usually include a labeled view of the affected body area, and occasionally tools and devices pertinent to the referenced procedure. Since many codes within a given set are similar in nature, graphics have been developed to highlight differences for clearer code selection.

The illustrations are almost always simplified schematic representations, oftentimes of complex and delicate medical procedures. In many instances, proper anatomical detail is minimized to present a clearer picture of coding the procedure. As such, only a lay knowledge of a given medical procedure can be obtained from any depiction. All graphic material was computer generated by Ingenix staff. Valuable reference was drawn from a broad spectrum of surgical, clinical, and anatomic publications.

Explanation

Every surgical 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 *Specialty Expert*, you will find a step-by-step clinical description of the procedure, in simple terms. Technical language that might be used by the physician is included and defined.

Specialty Expert describes the most common method or methods for performing each procedure, using key words often found in operative reports. If our description varies too greatly from the operative report, another code might be more appropriate. If a satisfactory code description cannot be matched to the patient's record, consult the physician.

Coding Tips

Coding and reimbursement 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 technical editors at Ingenix and from the coding guidelines provided in the CPT book.

ICD-9-CM Diagnostic Codes

ICD-9-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to specialty.

Several conventions specific to *Specialty Expert* must be understood for effective use of this feature.

Specialty Expert

Integumentary

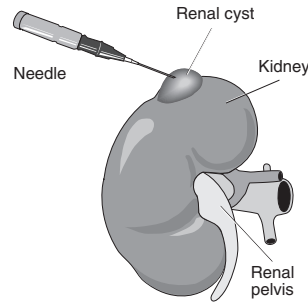
10021–10022

- 10021** Fine needle aspiration; without imaging guidance
- 10022** with imaging guidance

Explanation

Fine needle aspiration (FNA) is a percutaneous procedure that uses a fine gauge needle (22 or 25 gauge) and a syringe to sample fluid from a cyst or remove clusters of cells from a solid mass. First, the skin is cleansed. If a lump can be felt, the radiologist or surgeon guides a needle into the area by palpating the lump. If the lump is nonpalpable, the FNA procedure is performed under image guidance using fluoroscopy, ultrasound, or computed tomography (CT), with the patient positioned according to the area of concern. In fluoroscopic guidance, intermittent fluoroscopy guides the advancement of the needle. Ultrasonography-guided aspiration biopsy involves inserting an aspiration catheter needle device through the accessory channel port of the echoendoscope; the needle is placed into the area to be sampled under endoscopic ultrasonographic guidance. After the needle is placed into the region of the lesion, a vacuum is created and multiple in and out needle motions are performed. Several needle insertions are usually required to ensure that an adequate tissue sample is taken. CAT image guidance allows computer-assisted targeting of the area to be sampled. At the completion of the procedure, the needle is withdrawn and a small bandage is placed over the area. Report 10021 if fine needle aspiration is performed without imaging guidance. Report 10022 if imaging guidance is used to assist in locating the lump.

Physician withdraws fluid from renal lesion



Coding Tips

For needle biopsy of testis, see 54500. For needle or punch biopsy of the prostate, see 55700. For needle biopsy of the epididymis, see 54800. For radiological supervision and interpretation, see 77002, 77012, and 76942. For evaluation of fine needle aspirate, see 88172 and 88173.

ICD-9-CM Diagnostic

- 185 Malignant neoplasm of prostate
- 187.5 Malignant neoplasm of epididymis
- 198.82 Secondary malignant neoplasm of genital organs
- 222.0 Benign neoplasm of testis — (Use additional code to identify any functional activity)
- 222.2 Benign neoplasm of prostate
- 600.3 Cyst of prostate

Integumentary

Specialty Expert

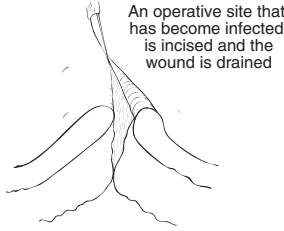
10180

10180 Incision and drainage, complex, postoperative wound infection

Integumentary

Explanation

This procedure treats an infected surgical site. An incision and drainage are necessary to remove the fluid to allow the surgical wound to heal. The physician either removes the surgical sutures or staples or makes additional incisions into the skin. The wound is drained of infected fluid. Necrotic tissue is removed from the surgical site. The wound is irrigated. The wound may either be sutured closed or packed open with sterile gauze to allow additional drainage. If closed, the surgical site may have suction or latex drains placed into the wound. If packed open, the wound may be sutured again during a later procedure.



The procedure is considered complex in nature

Coding Tips

Drain placement is included in this procedure and should not be reported separately. If drainage is of a hematoma, seroma, or fluid collection, see 10140. For simple secondary closure of a surgical wound, see 12020-12021. For extensive or complicated secondary closure of a surgical wound or dehiscence, see 13160.

ICD-9-CM Diagnostic

- 674.30 Other complication of obstetrical surgical wounds, unspecified as to episode of care
- 674.32 Other complication of obstetrical surgical wounds, with delivery, with mention of postpartum complication
- 674.34 Other complication of obstetrical surgical wounds, postpartum condition or complication
- 998.51 Infected postoperative seroma — (Use additional code to identify organism)
- 998.59 Other postoperative infection — (Use additional code to identify infection)

Specialty Expert

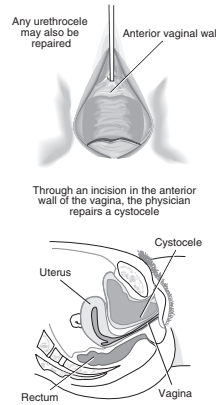
Vagina

57240

57240 Anterior colporrhaphy, repair of cystocele with or without repair of urethrocele

Explanation

The physician repairs a cystocele, which is a herniation of the bladder through its support tissues into the anterior vaginal wall causing it to bulge downward. The physician may also repair a urethrocele, which is a prolapse of the urethra. An incision is made from the apex of the vagina to within 1.0 cm of the urethral meatus. Plication sutures are placed along the urethral course from the meatus to the bladder neck. A suture is placed through the pubourethral ligament to the posterior symphysis pubis on each side of the urethra. The sutures are tied (ligated) and the posterior urethra is pulled upward to a retropubic position. If a cystocele is repaired, mattress sutures are placed in the mobilized paravesical tissue. The vaginal mucosa is closed.



Coding Tips

For a Marshall-Marchetti-Krantz urethral suspension, abdominal approach, see 51840 and 51841. For plastic repair of a urethrocele, see 57230.

ICD-9-CM Diagnostic

- 618.01 Cystocele without mention of uterine prolapse, midline — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)
- 618.02 Cystocele without mention of uterine prolapse, lateral — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)
- 618.03 Urethrocele without mention of uterine prolapse — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)
- 618.09 Other prolapse of vaginal walls without mention of uterine prolapse — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)
- 618.2 Uterovaginal prolapse, incomplete — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)
- 618.3 Uterovaginal prolapse, complete — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)
- 618.4 Uterovaginal prolapse, unspecified — (Use additional code to identify urinary incontinence: 625.6, 788.31, 788.33-788.39)
- 625.6 Female stress incontinence

Vagina

Specialty Expert

Radiology

Radiology

74425

74425 Urography, antegrade, (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation

Explanation

A radiographic exam of the urinary tract is performed with injection or instillation of a contrast medium. This test is done to follow the normal flow of urine through the tract (antegrade) and may identify obstructions, abnormalities in the urinary tract, or assess function following surgery. Contrast medium is introduced percutaneously with a needle or through an existing tube, catheter, or stoma. For percutaneous needle injection, the skin is anesthetized and the needle inserted under fluoroscopic guidance into a calyx of the kidney. Contrast medium is injected and radiographs are taken. This code reports the radiological supervision and interpretation. Use a separately reportable code for the surgical procedure.

74430

74430 Cystography, minimum of three views, radiological supervision and interpretation

Explanation

A radiographic exam of the bladder with a minimum of three views is performed using contrast material to diagnose rupture, injury, or stress incontinence. A catheter is inserted into the bladder and contrast medium is then instilled using mild pressure injection. The catheter is clamped after the contrast medium has filled the bladder and the bladder is fully expanded. Films are then taken to observe any medium that is outside the bladder. The bladder is next drained and

more films may be taken to look for other evidence of rupture following the flow of contrast outside the bladder. This code reports the radiological supervision and interpretation. Use a separately reportable code for the surgical procedure.

74440

74440 Vasography, vesiculography, or epididymography, radiological supervision and interpretation

Explanation

A radiographic exam is done to determine obstruction in the epididymis, seminal vesicle duct, or vas deferens. Methylene blue is injected into the vas to test for obstruction of the ejaculatory duct. If during cystoscopy, dye is seen, the ducts are patent and vesiculography may be obtained to further determine obstruction. The vas is approached through an incision in the scrotum. The testis is freed and the vas separated. After a catheter is threaded into the vas, saline or lactated Ringers are instilled to determine patency or blockage. Flow resistance may require more formal vasography, with water-soluble contrast media instilled through a ureteral catheter fed to the seminal vesicles through a dilated vas. Epididymography requires taking images of the coiled tube connecting the testis to the vas deferens. This code reports the radiological supervision and interpretation for epididymography, vesiculography, or vasography.

74445

74445 Corpora cavernosography, radiological supervision and interpretation

Explanation

Corpora cavernosography is performed to determine the area and degree of a venous

Radiology Appendix

Specialty Expert

Pathology and Laboratory

Pathology and Laboratory

80048

80048 Basic metabolic panel (Calcium, total). This panel must include the following: Calcium (82310) Carbon dioxide (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Potassium (84132) Sodium (84295) Urea nitrogen (BUN) (84520)

Explanation

A basic metabolic panel includes the following tests: calcium (82310), carbon dioxide (82374), chloride (82435), creatinine (82565), glucose (82947), potassium (84132), sodium (84295), and urea nitrogen (BUN) (84520). Blood specimen is obtained by venipuncture. See the specific codes for additional information about the listed tests.

80050

80050 General health panel This panel must include the following: Comprehensive metabolic panel (80053) Blood count, complete (CBC), automated and automated differential WBC count (85025 or 85027 and 85004) OR Blood count, complete (CBC), automated (85027) and appropriate manual differential WBC count (85007 or 85009) Thyroid stimulating hormone (TSH) (84443)

Explanation

A general health panel includes the following tests: albumin (82040), total bilirubin (82247), calcium (82310), carbon dioxide (bicarbonate) (82374), chloride (82435), creatinine (82565), glucose (82947), alkaline phosphatase (84075), potassium (84132), total protein (84155), sodium

(84295), aspartate amino transferase (AST) (SGOT) (84450), urea nitrogen (BUN) (84520), and thyroid stimulating hormone (84443). In addition, this panel includes a hemogram as described by either 85022 or 85025. Blood specimen is obtained by venipuncture. See specific codes for additional information about the listed tests.

80051

80051 Electrolyte panel This panel must include the following: Carbon dioxide (82374) Chloride (82435) Potassium (84132) Sodium (84295)

Explanation

An electrolyte panel includes the following tests: carbon dioxide (82374), chloride (82435), potassium (84132), and sodium (84295). Blood specimen is obtained by venipuncture. See specific codes for additional information about the listed tests.

80053

80053 Comprehensive metabolic panel This panel must include the following: Albumin (82040) Bilirubin, total (82247) Calcium (82310) Carbon dioxide (bicarbonate) (82374) Chloride (82435) Creatinine (82565) Glucose (82947) Phosphatase, alkaline (84075) Potassium (84132) Protein, total (84155) Sodium (84295) Transferase, alanine amino (ALT) (SGPT) (84460) Transferase, aspartate amino (AST) (SGOT) (84450) Urea nitrogen (BUN) (84520)

Explanation

A comprehensive metabolic panel includes the following tests: albumin (82040), total bilirubin (82247), calcium (82310), carbon dioxide (bicarbonate) (82374), chloride

Pathology and Laboratory Appendix

Medicine

Specialty Expert

Medicine

90467-90468

90467 Immunization administration under age 8 years (includes intranasal or oral routes of administration) when the physician counsels the patient/family; first administration (single or combination vaccine/toxoid), per day

90468 each additional administration (single or combination vaccine/toxoid), per day (List separately in addition to code for primary procedure)

Explanation

The physician instructs the patient or family on the benefits and risks related to the vaccine or toxoid. The physician counsels the patient or family regarding signs and symptoms of adverse effects and when to seek medical care for any adverse effects. A physician, nurse, or medical assistant administers an immunization to a patient via an intranasal (e.g., nasal spray) or an oral route (e.g., a liquid that is swallowed). It may be a single vaccine or a combination vaccine/toxoid in one immunization administration (e.g., adenovirus, Rotavirus, typhoid, poliovirus). Report 90467 for one vaccine and 90468 for each additional vaccine (single or combination vaccine/toxoid) provided on the same day to a child younger than 8 years of age.

90473-90474

90473 Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)

90474 each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

Explanation

A physician, nurse, or medical assistant administers an immunization to a patient via intranasal route (e.g., a nasal spray) or via an oral route (e.g., a liquid that is swallowed). It may be a single or multiple vaccine or toxoid (e.g., adenovirus, Rotavirus, typhoid, poliovirus). Report 90473 for one vaccine. Report 90474 for each additional vaccine (single or combination vaccine/toxoid).

90760-90761

90760 Intravenous infusion, hydration; initial, 31 minutes to 1 hour

90761 each additional hour, (List separately in addition to code for primary procedure)

Explanation

A physician or an assistant under direct physician supervision infuses a hydration solution (pre-packaged fluid and electrolytes) for first 31 minutes to one hour through an intravenous catheter inserted by needle into a patient's vein or by infusion through an existing indwelling intravascular access catheter or port. Report 90761 for each additional hour beyond the first hour.

Medicine Appendix

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