OPTUM360®

CODING COMPANION

General Surgery/ Gastroenterology

A comprehensive illustrated guide to coding and reimbursement

2022

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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 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 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 Optum360 *Coding Companion* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

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 codes are presented in a less comprehensive format in the appendix. The CPT codes appropriate to the specialty are included in the appendix with the official CPT code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

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 Edit Updates

The *Coding Companion* series 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 XX.X, the most current version available at press time. The CCI edits are located in a section at the back of the book. Optum360 maintains a website to accompany the Coding Companions series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is http://www.optum360coding.com/ProductUpdates/. The 2022 edition password is: XXXXXXX22. Please note that you should log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

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:

69501 Transmastoid antrotomy (simple mastoidectomy)

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

Antrotomy
Transmastoid, 69501

Excision
Mastoid
Simple, 69501

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.

99241-99245

★**99241** Office consultation for a new or established patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.

★**99242** Office consultation for a new or established patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.

★**99243** Office consultation for a new or established patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.

★**99244** Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.

★**99245** Office consultation for a new or established patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.

Explanation

Office and other outpatient consultation service codes describe encounters where another qualified clinician's advice or opinion regarding diagnosis and treatment or determination to accept transfer of care of a patient is rendered at the request of the primary treating provider. Consultations may also be requested by another appropriate source; for example, a third-party payer may request a second opinion. The request for a consultation must be documented in the medical record, as well as a written report of the consultation findings. During the course of a consultation, the physician consultant can initiate diagnostic or therapeutic services at the same encounter or at a follow-up visit. Other separately reportable procedures or services performed in conjunction with the consultation may be reported separately. Codes do not differentiate between new or established patients. Services are reported based on meeting all three key components (history, exam, and medical decision-making [MDM]) within each level of service. The most basic service, 99241, describes a problem-focused history and exam with straightforward medical decision-making encompassing approximately 15 minutes of face-to-face time with the patient and/or family discussing a minor or self-limiting complaint. The mid-level services describe problems involving an expanded problem focused history and exam or a detailed history and exam as represented by 99242 and 99243, respectively. Medical decision-making for 99242 is the same as for a level one visit (straightforward) and is designated as low complexity for the level three service (99243). At these levels of service, the encounter can involve face-to-face time of 30 (99242) to 40 (99243) minutes involving minimal to low severity concerns. The last two levels of service in this category represent moderate to high-severity problems and both services involve comprehensive history and examination components. The differentiating factor between the two levels is the medical decision-making; code 99244 involves moderate complexity MDM and approximately 60 minutes of face-to-face time with the patient and/or family, while the highest level of service in this category, 99245, involves MDM of high complexity and approximately 80 minutes of face-to-face time.

Coding Tips

These codes are used to report consultations in the office or outpatient setting. All three key components (history, exam, and medical decision making) must be met or exceeded for the level of service selected. Time may be used to select the level of service when counseling and coordination of care are documented as at least half of the time spent face-to-face with the patient. Codes may be selected based upon the 1995 or the 1997 Evaluation and Management Guidelines. Consultation codes are not covered by Medicare and some payers. Report new or established outpatient E/M codes for consultation services. Consultation services should not be reported when the care and management of a problem or condition is assumed prior to the initial examination of the patient. In these situations, the appropriate initial or subsequent evaluation and management service should be reported. For office or other outpatient services for a new patient, see 99202-99205; for an established patient, see 99211-99215. For inpatient consultation services, see 99251-99255.

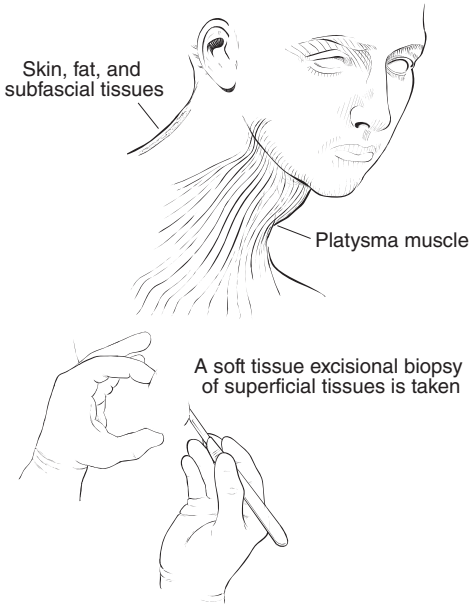
ICD-10-CM Diagnostic Codes

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: **99241** 2020,Sep,3; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Jan,16; 2015,Jan,12; 2014,Sep,13; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99242** 2020,Sep,3; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jun,8; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Jan,16; 2015,Jan,12; 2014,Sep,13; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99243** 2020,Sep,3; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Jan,12; 2015,Jan,16; 2014,Sep,13; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99244** 2020,Sep,3; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Jan,12; 2015,Jan,16; 2014,Sep,13; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99245** 2020,Sep,3; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Jan,16; 2015,Jan,12; 2014,Sep,13; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3

21550

21550 Biopsy, soft tissue of neck or thorax



Explanation

The physician performs a biopsy of the soft tissues of the neck or thorax. With proper anesthesia administered, the physician identifies the mass through palpation and x-ray (reported separately), if needed. An incision is made over the site and dissection is taken down to the subcutaneous fat or further into the fascia or muscle to reach the lesion. A portion of the tissue mass is excised and submitted for pathology. The area is irrigated and the incision is closed with layered sutures.

Coding Tips

A biopsy is not reported separately when followed by an excisional removal during the same operative session. When 21550 is 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. For a needle biopsy of muscle, see 20206. 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

C49.0	Malignant neoplasm of connective and soft tissue of head, face and neck
C49.3	Malignant neoplasm of connective and soft tissue of thorax
C76.0	Malignant neoplasm of head, face and neck
C76.1	Malignant neoplasm of thorax
C79.89	Secondary malignant neoplasm of other specified sites
D09.8	Carcinoma in situ of other specified sites
D21.0	Benign neoplasm of connective and other soft tissue of head, face and neck
D21.3	Benign neoplasm of connective and other soft tissue of thorax
D49.89	Neoplasm of unspecified behavior of other specified sites
L03.221	Cellulitis of neck
L03.313	Cellulitis of chest wall
R22.1	Localized swelling, mass and lump, neck
R22.2	Localized swelling, mass and lump, trunk

AMA: **21550** 2018,Sep,7

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21550	2.11	5.11	0.28	7.5
Facility RVU	**Work**	**PE**	**MP**	**Total**
21550	2.11	2.08	0.28	4.47

	FUD	Status	MUE	Modifiers				IOM Reference
21550	10	A	2(3)	51	N/A	N/A	N/A	None

* with documentation

Terms To Know

benign. Mild or nonmalignant in nature.

biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.

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.

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.

secondary. Second in order of occurrence or importance, or appearing during the course of another disease or condition.

soft tissue. Nonepithelial tissues outside of the skeleton that includes subcutaneous adipose tissue, fibrous tissue, fascia, muscles, blood and lymph vessels, and peripheral nervous system tissue.

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

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.

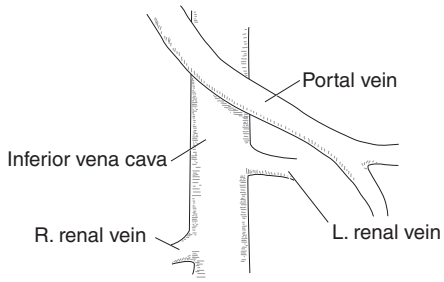
purse-string suture. Continuous suture placed around a tubular structure and tightened, to reduce or close the lumen.

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.

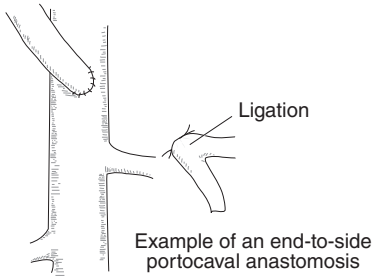
 N Newborn: 0 **P** Pediatric: 0-17 **M** Maternity: 9-64 **A** Adult: 15-124 ♂ Male Only ♀ Female Only

37140

37140 Venous anastomosis, open; portocaval



Schematic of portocaval anatomy



Example of an end-to-side portocaval anastomosis

Explanation

The physician performs portocaval venous anastomosis. The physician places a long right thoracoabdominal incision and exposes the liver. The physician exposes the inferior vena cava and portal vein through careful dissection. The physician places a plastic sling around the portal vein and ties it closed, just proximal to its bifurcation. The physician clamps and divides the portal vein. The physician applies a partial exclusion vascular clamp to the front of the vena cava and removes a small oval of tissue from the vena cava to allow end-to-side anastomosis of portal vein to the inferior vena cava. The physician removes the clamps and checks for appropriate flow without anastomotic leakage. The physician closes the incision, leaving a chest tube in place (but no abdominal drains, as this may lead to protein loss from postoperative drainage of ascites).

Coding Tips

When this code is 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 open venous anastomosis, renoportal, is reported with code 37145. For TIPS (percutaneous) procedure, see 37182. For peritoneal-venous shunt, see 49425.

ICD-10-CM Diagnostic Codes

I81	Portal vein thrombosis
I82.0	Budd-Chiari syndrome
I85.11	Secondary esophageal varices with bleeding
I87.1	Compression of vein
K70.0	Alcoholic fatty liver A
K70.30	Alcoholic cirrhosis of liver without ascites A
K70.31	Alcoholic cirrhosis of liver with ascites A
K74.69	Other cirrhosis of liver
K75.1	Phlebitis of portal vein
K76.0	Fatty (change of) liver, not elsewhere classified
K76.1	Chronic passive congestion of liver
K76.3	Infarction of liver
K76.5	Hepatic veno-occlusive disease
K76.6	Portal hypertension
K76.89	Other specified diseases of liver

AMA: **37140** 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
37140	40.0	17.96	9.74	67.7
Facility RVU	**Work**	**PE**	**MP**	**Total**
37140	40.0	17.96	9.74	67.7

	FUD	Status	MUE	Modifiers				IOM Reference
37140	90	A	1(2)	51	N/A	62*	N/A	None

* with documentation

Terms To Know

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

ascites. Abnormal accumulation of free fluid in the abdominal cavity, causing distention and tightness in addition to shortness of breath as the fluid accumulates. Ascites is usually an underlying disorder and can be a manifestation of any number of diseases.

bifurcated. Having two branches or divisions, such as the left pulmonary veins that split off from the left atrium to carry oxygenated blood away from the heart.

Budd-Chiari syndrome. Thrombus or other obstruction of the hepatic vein, with an enlarged liver, intractable ascites, portal hypertension, and the growth of extensive collateral vessels.

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

inferior. Located toward the feet or lower part of the body.

ligation. Tying off a blood vessel or duct with a suture or a soft, thin wire.

portal hypertension. Abnormally high blood pressure in the portal vein.

thrombosis. Condition arising from the presence or formation of blood clots within a blood vessel that may cause vascular obstruction and insufficient oxygenation.

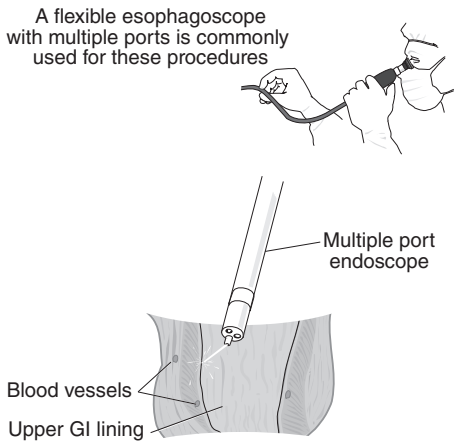
thrombus. Stationary blood clot inside a blood vessel.

varices. Enlarged, dilated, or twisted turning veins.

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.

43239

43239 Esophagogastroduodenoscopy, flexible, transoral; with biopsy, single or multiple



Schematic cross section of representativel upper GI tract (distal stomach shown)

Explanation

The physician examines the upper gastrointestinal tract for diagnostic purposes. The physician passes an endoscope through the patient's mouth into the esophagus. The esophagus, stomach, duodenum, and sometimes the jejunum are viewed to determine if bleeding, tumors, erosions, ulcers, or other abnormalities are present. Single or multiple tissue samples from the upper gastrointestinal tract are obtained for biopsy specimens using biopsy forceps through the endoscope.

Coding Tips

Report the appropriate endoscopy for each anatomic site examined. Surgical endoscopy includes a diagnostic endoscopy; however, diagnostic endoscopy can be identified separately when performed at the same surgical session as an open procedure. Supplies used when providing this procedure may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage. Do not report 43239 with 43197–43198, 43235, 44360–44361, 44363–44366, 44369–44370, 44372–44373, or 44376–44379. Do not report 43239 in addition to 43254 for the same lesion.

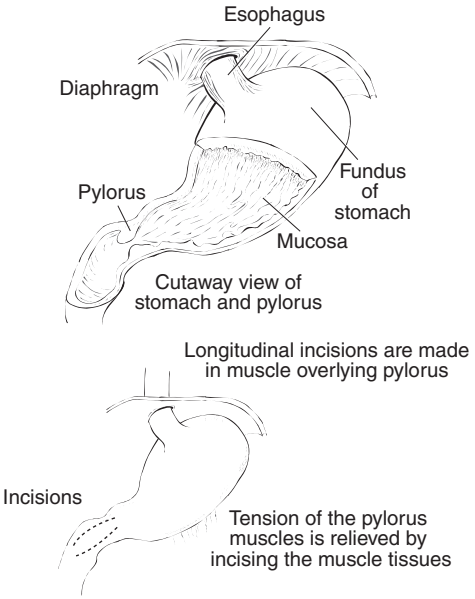
ICD-10-CM Diagnostic Codes

C15.3	Malignant neoplasm of upper third of esophagus
C15.4	Malignant neoplasm of middle third of esophagus
C15.5	Malignant neoplasm of lower third of esophagus
C16.0	Malignant neoplasm of cardia
C16.1	Malignant neoplasm of fundus of stomach
C16.2	Malignant neoplasm of body of stomach
C16.3	Malignant neoplasm of pyloric antrum
C16.4	Malignant neoplasm of pylorus
C17.0	Malignant neoplasm of duodenum
C17.1	Malignant neoplasm of jejunum
C49.A1	Gastrointestinal stromal tumor of esophagus
C49.A2	Gastrointestinal stromal tumor of stomach
C49.A3	Gastrointestinal stromal tumor of small intestine
C78.4	Secondary malignant neoplasm of small intestine
C78.89	Secondary malignant neoplasm of other digestive organs
C7A.010	Malignant carcinoid tumor of the duodenum
C7A.011	Malignant carcinoid tumor of the jejunum
C7A.092	Malignant carcinoid tumor of the stomach
D00.1	Carcinoma in situ of esophagus
D00.2	Carcinoma in situ of stomach
D13.0	Benign neoplasm of esophagus
D13.1	Benign neoplasm of stomach
D13.2	Benign neoplasm of duodenum
D37.1	Neoplasm of uncertain behavior of stomach
D37.2	Neoplasm of uncertain behavior of small intestine
D3A.010	Benign carcinoid tumor of the duodenum
D3A.011	Benign carcinoid tumor of the jejunum
D3A.092	Benign carcinoid tumor of the stomach
I85.01	Esophageal varices with bleeding
I85.11	Secondary esophageal varices with bleeding
K20.0	Eosinophilic esophagitis
K20.80	Other esophagitis without bleeding
K20.81	Other esophagitis with bleeding
K21.00	Gastro-esophageal reflux disease with esophagitis, without bleeding
K21.01	Gastro-esophageal reflux disease with esophagitis, with bleeding
K22.0	Achalasia of cardia
K22.10	Ulcer of esophagus without bleeding
K22.11	Ulcer of esophagus with bleeding
K22.2	Esophageal obstruction
K22.4	Dyskinesia of esophagus
K22.5	Diverticulum of esophagus, acquired
K22.6	Gastro-esophageal laceration-hemorrhage syndrome
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
K25.0	Acute gastric ulcer with hemorrhage
K25.2	Acute gastric ulcer with both hemorrhage and perforation
K25.5	Chronic or unspecified gastric ulcer with perforation
K25.6	Chronic or unspecified gastric ulcer with both hemorrhage and perforation
K26.0	Acute duodenal ulcer with hemorrhage
K26.1	Acute duodenal ulcer with perforation
K26.3	Acute duodenal ulcer without hemorrhage or perforation
K26.4	Chronic or unspecified duodenal ulcer with hemorrhage
K26.6	Chronic or unspecified duodenal ulcer with both hemorrhage and perforation
K26.7	Chronic duodenal ulcer without hemorrhage or perforation
K27.5	Chronic or unspecified peptic ulcer, site unspecified, with perforation
K27.6	Chronic or unspecified peptic ulcer, site unspecified, with both hemorrhage and perforation
K28.0	Acute gastrojejunal ulcer with hemorrhage
K28.2	Acute gastrojejunal ulcer with both hemorrhage and perforation
K28.5	Chronic or unspecified gastrojejunal ulcer with perforation
K28.6	Chronic or unspecified gastrojejunal ulcer with both hemorrhage and perforation
K29.01	Acute gastritis with bleeding
K29.21	Alcoholic gastritis with bleeding

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

43520

43520 Pyloromyotomy, cutting of pyloric muscle (Fredet-Ramstedt type operation)



Explanation

The physician incises the pyloric muscle. The physician makes a small subcostal incision over the pyloric olive. The peritoneum is incised, the tissues are retracted, and the pylorus is identified. The serosa is incised and the tension of the pyloric muscle is released with longitudinal incisions. The peritoneum is sutured closed and the operative site is sutured in layers.

Coding Tips

For vagotomy, including pyloroplasty, with or without gastrostomy, truncal or selective, see 43640; parietal cell, see 43641. For pyloroplasty, see 43800. Do not append modifier 63 to 43520 as the description or nature of the procedure includes infants up to 4 kg.

ICD-10-CM Diagnostic Codes

C16.3	Malignant neoplasm of pyloric antrum
C16.4	Malignant neoplasm of pylorus
C7A.092	Malignant carcinoid tumor of the stomach
K31.1	Adult hypertrophic pyloric stenosis A
K31.3	Pylorospasm, not elsewhere classified
K31.811	Angiodysplasia of stomach and duodenum with bleeding
K31.819	Angiodysplasia of stomach and duodenum without bleeding
K31.89	Other diseases of stomach and duodenum
Q40.0	Congenital hypertrophic pyloric stenosis
R11.11	Vomiting without nausea
R11.12	Projectile vomiting

AMA: **43520** 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
43520	11.29	6.17	2.47	19.93
Facility RVU	**Work**	**PE**	**MP**	**Total**
43520	11.29	6.17	2.47	19.93

	FUD	Status	MUE	Modifiers				IOM Reference
43520	90	A	1(2)	51	N/A	62*	80	None

* with documentation

Terms To Know

angiodysplasia. Vascular abnormalities, with or without bleeding.

closure. Repairing an incision or wound by suture or other means.

congenital. Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.

diaphragm. Muscular wall separating the thorax and its structures from the abdomen.

duodenum. First portion of the small intestine connected to the stomach at the pylorus and extending to the jejunum.

hypertrophy. Overgrowth or enlargement of normal cells in tissue.

incision. Act of cutting into tissue or an organ.

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.

myotomy. Surgical cutting of a muscle to gain access to underlying tissues or for therapeutic reasons.

neoplasm. New abnormal growth, tumor.

peritoneum. Strong, continuous membrane that forms the lining of the abdominal and pelvic cavity. The parietal peritoneum, or outer layer, is attached to the abdominopelvic walls and the visceral peritoneum, or inner layer, surrounds the organs inside the abdominal cavity.

pylorus. Lower portion of the stomach, which opens into the duodenum.

release. Disconnection of a tendon or ligament.

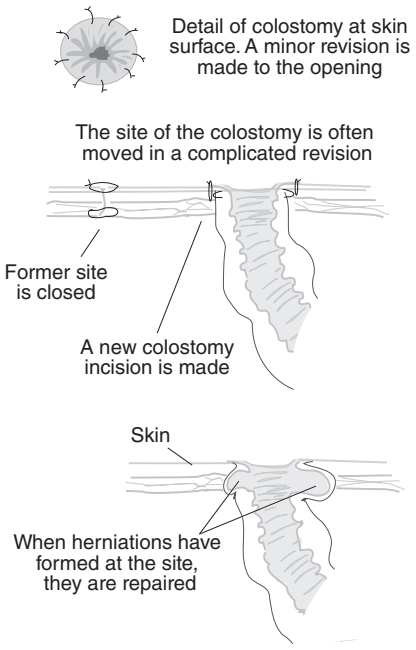
retraction. Act of holding tissue or a structure back away from its normal position or the field of interest.

stenosis. Narrowing or constriction of a passage.

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

44340-44346

44340 Revision of colostomy; simple (release of superficial scar) (separate procedure)
44345 complicated (reconstruction in-depth) (separate procedure)
44346 with repair of paracolostomy hernia (separate procedure)



Explanation

The physician revises a colostomy through an incision around the stoma site. In 44340, a release of scar tissue is performed. The physician makes an incision around the stoma site. The stoma is dissected free of the surrounding abdominal wall and constricting scar tissue is released. The stoma is reapproximated to the skin or the distal stoma is transected and additional colon pulled through the abdominal wall and approximated to the skin as a revised colostomy. In 44345, a new stoma site is formed. The previous colostomy is completely taken down. The distal end of colon is brought through a separate incision on the abdominal wall onto the skin at a new site as a revised colostomy. The initial incision and previous stoma site are closed. In 44346, the physician repairs a paracolostomy hernia. The previous colostomy site is taken down. The hernia at the former colostomy site is repaired. The end of colon is brought through a separate incision on the abdominal wall at a new site and onto the skin as a revised colostomy. The initial incision and previous stoma site are closed.

Coding Tips

These separate procedures by definition are usually a component of a more complex service and are not identified separately. When performed alone or with other unrelated procedures/services it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59 or an X{EPSU} modifier.

ICD-10-CM Diagnostic Codes

K43.3 Parastomal hernia with obstruction, without gangrene
K43.4 Parastomal hernia with gangrene
K43.5 Parastomal hernia without obstruction or gangrene
K91.89 Other postprocedural complications and disorders of digestive system
K94.01 Colostomy hemorrhage
K94.02 Colostomy infection
K94.03 Colostomy malfunction
K94.09 Other complications of colostomy
T81.31XA Disruption of external operation (surgical) wound, not elsewhere classified, initial encounter
Z43.3 Encounter for attention to colostomy

AMA: **44340** 2014,Jan,11 **44345** 2014,Jan,11 **44346** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
44340	9.28	6.82	1.96	18.06
44345	17.22	9.71	3.55	30.48
44346	19.63	10.58	4.15	34.36
Facility RVU	**Work**	**PE**	**MP**	**Total**
44340	9.28	6.82	1.96	18.06
44345	17.22	9.71	3.55	30.48
44346	19.63	10.58	4.15	34.36

	FUD	Status	MUE	Modifiers				IOM Reference
44340	90	A	1(2)	51	N/A	62*	N/A	None
44345	90	A	1(2)	51	N/A	62*	80	
44346	90	A	1(2)	51	N/A	62*	80	

* with documentation

Terms To Know

colostomy. Artificial surgical opening anywhere along the length of the colon to the skin surface for the diversion of feces.

complication. Condition arising after the beginning of observation and treatment that modifies the course of the patient's illness or the medical care required, or an undesired result or misadventure in medical care.

dissection. Separating by cutting tissue or body structures apart.

infection. Presence of microorganisms in body tissues that may result in cellular damage.

intestinal or peritoneal adhesions with obstruction. Abnormal fibrous band growths joining separate tissues in the peritoneum or intestine, causing blockage.

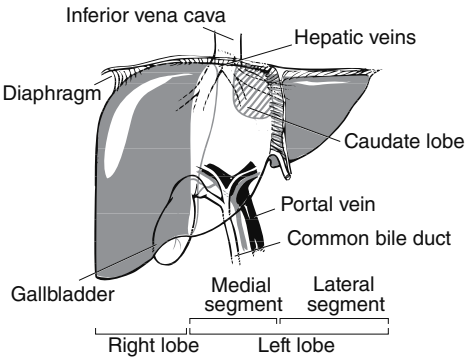
revision. Reordering or rearrangement of tissue to suit a particular need or function.

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

transection. Transverse dissection; to cut across a long axis; cross section.

47120-47130

47120 Hepatectomy, resection of liver; partial lobectomy
47122 trisegmentectomy
47125 total left lobectomy
47130 total right lobectomy



Explanation

The physician removes a section of liver, or lobectomy. The physician exposes the liver via an upper midline incision through skin, fascia, and muscle. The fibrous connections of the liver to the diaphragm are divided and the portal structures are controlled. The portal and hepatic vessels associated with the affected lobe are divided. The portal structures are clamped. The liver parenchyma is divided by pressure or coagulation hemostasis. The portal clamp is removed and hemostasis is assured before the abdomen is closed with sutures. Report 47120 if a partial lobectomy is performed; report 47122 if a trisegmentectomy is performed; report 47125 if a total left lobectomy is performed; and report 47130 if a total right lobectomy is performed.

Coding Tips

For donor hepatectomy, see 47133 and 47140–47142. For liver allotransplantation, see 47135.

ICD-10-CM Diagnostic Codes

C22.0 Liver cell carcinoma
C22.1 Intrahepatic bile duct carcinoma
C22.2 Hepatoblastoma
C22.3 Angiosarcoma of liver
C78.7 Secondary malignant neoplasm of liver and intrahepatic bile duct
C7B.02 Secondary carcinoid tumors of liver
C80.2 Malignant neoplasm associated with transplanted organ
D01.5 Carcinoma in situ of liver, gallbladder and bile ducts
D13.4 Benign neoplasm of liver
D13.5 Benign neoplasm of extrahepatic bile ducts
D37.6 Neoplasm of uncertain behavior of liver, gallbladder and bile ducts
D3A.098 Benign carcinoid tumors of other sites
D47.Z2 Castleman disease
E80.5 Crigler-Najjar syndrome
E85.81 Light chain (AL) amyloidosis
E85.82 Wild-type transthyretin-related (ATTR) amyloidosis
E85.89 Other amyloidosis
K70.0 Alcoholic fatty liver A
K70.10 Alcoholic hepatitis without ascites A
K70.11 Alcoholic hepatitis with ascites A
K70.2 Alcoholic fibrosis and sclerosis of liver A
K70.30 Alcoholic cirrhosis of liver without ascites A
K70.31 Alcoholic cirrhosis of liver with ascites A
K70.40 Alcoholic hepatic failure without coma A
K70.41 Alcoholic hepatic failure with coma A
K71.0 Toxic liver disease with cholestasis
K71.10 Toxic liver disease with hepatic necrosis, without coma
K71.11 Toxic liver disease with hepatic necrosis, with coma
K71.2 Toxic liver disease with acute hepatitis
K71.3 Toxic liver disease with chronic persistent hepatitis
K71.4 Toxic liver disease with chronic lobular hepatitis
K71.50 Toxic liver disease with chronic active hepatitis without ascites
K71.51 Toxic liver disease with chronic active hepatitis with ascites
K71.6 Toxic liver disease with hepatitis, not elsewhere classified
K71.7 Toxic liver disease with fibrosis and cirrhosis of liver
K72.00 Acute and subacute hepatic failure without coma
K72.01 Acute and subacute hepatic failure with coma
K72.10 Chronic hepatic failure without coma
K72.11 Chronic hepatic failure with coma
K73.0 Chronic persistent hepatitis, not elsewhere classified
K73.1 Chronic lobular hepatitis, not elsewhere classified
K73.2 Chronic active hepatitis, not elsewhere classified
K74.1 Hepatic sclerosis
K74.2 Hepatic fibrosis with hepatic sclerosis
K74.3 Primary biliary cirrhosis
K74.4 Secondary biliary cirrhosis
K76.1 Chronic passive congestion of liver
K76.2 Central hemorrhagic necrosis of liver
K76.3 Infarction of liver
K76.4 Peliosis hepatis
K76.5 Hepatic veno-occlusive disease
K76.6 Portal hypertension
K83.5 Biliary cyst
P78.81 Congenital cirrhosis (of liver) N
P78.84 Gestational alloimmune liver disease
Q44.6 Cystic disease of liver
R16.0 Hepatomegaly, not elsewhere classified
R16.2 Hepatomegaly with splenomegaly, not elsewhere classified
S36.112A Contusion of liver, initial encounter
S36.114A Minor laceration of liver, initial encounter
S36.115A Moderate laceration of liver, initial encounter
S36.116A Major laceration of liver, initial encounter

AMA: **47120** 2018,Jan,8; 2017,Jan,8; 2016,Oct,11; 2016,Jan,13; 2015,Jan,16; 2014,Sep,13; 2014,Jan,11 **47122** 2014,Jan,11 **47125** 2014,Jan,11 **47130** 2014,Jan,11

G0341-G0343

G0341 Percutaneous islet cell transplant, includes portal vein catheterization and infusion

G0342 Laparoscopy for islet cell transplant, includes portal vein catheterization and infusion

G0343 Laparotomy for islet cell transplant, includes portal vein catheterization and infusion

Explanation

Islets cells are found in clusters throughout the pancreas and can be taken from an organ donor and transferred into the pancreas of the patient. Once transplanted, the cells can take over the task of destroyed cells. For example, diabetic Type I patients have a pancreas that no longer makes insulin and must take insulin daily. Once implanted, the islet cells, which contain beta cells, begin to make insulin. Each approach requires access to the portal vein, commonly via a transhepatic approach.

Coding Tips

Medicare covers transplantation of pancreatic islet cells, the insulin producing cells of the pancreas. Coverage includes the costs of acquisition and delivery of the pancreatic islet cells, as well as clinically necessary inpatient and outpatient medical care and immunosuppressants. Partial pancreatic tissue transplantation or islet cell transplantation performed outside the context of a clinical trial is not covered by Medicare. Third-party payers may not reimburse this code and may require the use of the appropriate CPT procedure code. Check with the payer for specific guidelines.

ICD-10-CM Diagnostic Codes

E10.10 Type 1 diabetes mellitus with ketoacidosis without coma

E10.11 Type 1 diabetes mellitus with ketoacidosis with coma

E10.21 Type 1 diabetes mellitus with diabetic nephropathy

E10.22 Type 1 diabetes mellitus with diabetic chronic kidney disease

E10.29 Type 1 diabetes mellitus with other diabetic kidney complication

E10.311 Type 1 diabetes mellitus with unspecified diabetic retinopathy with macular edema

E10.319 Type 1 diabetes mellitus with unspecified diabetic retinopathy without macular edema

E10.36 Type 1 diabetes mellitus with diabetic cataract

E10.39 Type 1 diabetes mellitus with other diabetic ophthalmic complication

E10.41 Type 1 diabetes mellitus with diabetic mononeuropathy

E10.42 Type 1 diabetes mellitus with diabetic polyneuropathy

E10.43 Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy

E10.44 Type 1 diabetes mellitus with diabetic amyotrophy

E10.49 Type 1 diabetes mellitus with other diabetic neurological complication

E10.51 Type 1 diabetes mellitus with diabetic peripheral angiopathy without gangrene

E10.52 Type 1 diabetes mellitus with diabetic peripheral angiopathy with gangrene

E10.59 Type 1 diabetes mellitus with other circulatory complications

E10.610 Type 1 diabetes mellitus with diabetic neuropathic arthropathy

E10.618 Type 1 diabetes mellitus with other diabetic arthropathy

E10.620 Type 1 diabetes mellitus with diabetic dermatitis

E10.621 Type 1 diabetes mellitus with foot ulcer

E10.622 Type 1 diabetes mellitus with other skin ulcer

E10.628 Type 1 diabetes mellitus with other skin complications

E10.630 Type 1 diabetes mellitus with periodontal disease

E10.638 Type 1 diabetes mellitus with other oral complications

E10.641 Type 1 diabetes mellitus with hypoglycemia with coma

E10.649 Type 1 diabetes mellitus with hypoglycemia without coma

E10.65 Type 1 diabetes mellitus with hyperglycemia

E10.69 Type 1 diabetes mellitus with other specified complication

E10.9 Type 1 diabetes mellitus without complications

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0341	6.98	52.23	0.56	59.77
G0342	11.92	6.71	0.93	19.56
G0343	19.85	10.86	1.58	32.29
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0341	6.98	2.84	0.56	10.38
G0342	11.92	6.71	0.93	19.56
G0343	19.85	10.86	1.58	32.29

	FUD	Status	MUE	Modifiers				IOM Reference
G0341	0	A	1(2)	51	N/A	62*	80*	100-04,32,70
G0342	90	A	1(2)	51	N/A	62*	80	
G0343	90	A	1(2)	51	N/A	62*	80	

* with documentation

Terms To Know

catheterization. Use or insertion of a tubular device into a duct, blood vessel, hollow organ, or body cavity for injecting or withdrawing fluids for diagnostic or therapeutic purposes.

infusion. Introduction of a therapeutic fluid, other than blood, into the bloodstream.

islet cell. Islet of Langerhans, hormone producing pancreatic cells.

laparotomy. Incision through the flank or abdomen for therapeutic or diagnostic purposes.

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

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
91035	1.59	12.0	0.12	13.71
Facility RVU	**Work**	**PE**	**MP**	**Total**
91035	1.59	12.0	0.12	13.71

91037-91038

91037 Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;

91038 prolonged (greater than 1 hour, up to 24 hours)

Explanation

The physician performs an esophageal function test with gastroesophageal reflux testing using nasal catheter intraluminal impedance electrode placement and recording. The patient fasts for a minimum of six hours. An impedance probe affixed to flexible nasal catheter tubing is inserted through the nose down to the lower esophageal sphincter following location of the lower sphincter by manometry. The impedance probe contains several electrodes that make up multiple measuring segments each 2 cm in length. The measuring segments are located at intervals above the proximal border of the lower esophageal sphincter. The patient is given a liquid or solid bolus to swallow. As the bolus passes through the esophagus, the average electrical resistance between two adjacent electrodes (impedance) is measured. The electrodes detect esophageal contraction and expansion and movement of the bolus through the esophagus in real time, as well as any gastroesophageal reflux. Esophageal function is evaluated by calculating the bolus transport time (BTT), which is the time it takes the bolus to pass from the proximal measuring segment and exit through the distal measuring segment. Contraction wave velocity (CWV), which is the speed of the contraction wave from the proximal measuring segment to the distal measuring segment, is also evaluated. This test is also referred to as multichannel intraluminal impedance testing or MII. Report 91037 for a recording of one hour or less. Report 91038 for prolonged recording of greater than one hour, up to 24 hours.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
91037	0.97	3.68	0.06	4.71
91038	1.1	11.29	0.06	12.45
Facility RVU	**Work**	**PE**	**MP**	**Total**
91037	0.97	3.68	0.06	4.71
91038	1.1	11.29	0.06	12.45

91040

91040 Esophageal balloon distension study, diagnostic, with provocation when performed

Explanation

The physician performs a diagnostic esophageal balloon distension study, including provocation, when performed, to evaluate chest pain of undetermined etiology that is suspected to be noncardiac in origin. The patient fasts for a minimum of six hours. A local anesthetic is sprayed into the patient's throat. With the patient in an upright position, a probe is passed through the mouth into the esophagus. The subject is placed supine with the head of the exam table elevated approximately 30 degrees. Manometric pressure recordings are obtained to identify the upper and lower esophageal sphincters. The probe is removed and the physician inserts a balloon into the esophagus. The balloon is moved along the esophagus and inflated multiple times to increasing diameters at selected sites in the esophagus in an attempt to provoke chest pain in the patient. Pain is measured by conscious perception or objective responses to the stimuli. Perception of moderate to severe chest pain with low levels of balloon distension is considered to be positive for noncardiac chest pain.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
91040	0.97	13.34	0.09	14.4
Facility RVU	**Work**	**PE**	**MP**	**Total**
91040	0.97	13.34	0.09	14.4

92950

92950 Cardiopulmonary resuscitation (eg, in cardiac arrest)

Explanation

Cardiopulmonary arrest occurs when the patient's heart and lungs suddenly stop. In a clinical setting, cardiopulmonary resuscitation, the attempt at restarting the heart and lungs, is usually directed by a physician or another health care provider who is certified in Advanced Cardiac Life Support (ACLS). The patient's lungs are ventilated by mouth-to-mouth breathing or by a bag and mask. The patient's circulation is assisted using external chest compression. An electronic defibrillator may be used to shock the heart into restarting. Medications used to restart the heart include epinephrine and lidocaine.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
92950	4.0	4.77	0.39	9.16
Facility RVU	**Work**	**PE**	**MP**	**Total**
92950	4.0	0.97	0.39	5.36

93000-93010

93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report

93005 tracing only, without interpretation and report

93010 interpretation and report only

Explanation

Multiple electrodes are placed on a patient's chest to record the electrical activity of the heart. A physician interprets the findings. Report 93000 for the combined technical and professional components of an ECG; 93005 for the technical component only; and 93010 for the professional component only.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
93000	0.17	0.29	0.02	0.48
93005	0.0	0.23	0.01	0.24
93010	0.17	0.06	0.01	0.24
Facility RVU	**Work**	**PE**	**MP**	**Total**
93000	0.17	0.29	0.02	0.48
93005	0.0	0.23	0.01	0.24
93010	0.17	0.06	0.01	0.24

93040

93040 Rhythm ECG, 1-3 leads; with interpretation and report

Explanation

One to three electrodes placed on a patient's chest are used to record electrical activity of the heart. The physician interprets the report.

CPT Index

A