Coding Companion for Oncology/Hematology

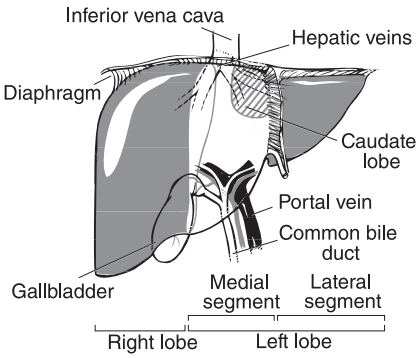
A comprehensive illustrated guide to coding and reimbursement

2016

Contents

47120-47130

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



A trisegmentectomy, reported by 47122, is the resection of an entire right or left lobe as well as a portion of the medial lobe (quadrate and caudate). This usually involves the right lobe and may be referred to as an extended 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 hemostases. 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

If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report.

ICD-9-CM Diagnostic

155.0 Malignant neoplasm of liver, primary
155.2 Malignant neoplasm of liver, not specified as primary or secondary
197.7 Secondary malignant neoplasm of liver
209.29 Malignant carcinoid tumor of other sites — (Code first any associated multiple endocrine neoplasia syndrome: 258.01-258.03)(Use additional code to identify associated endocrine syndrome, as: carcinoid syndrome: 259.2)
209.30 Malignant poorly differentiated neuroendocrine carcinoma, any site — (Code first any associated multiple endocrine neoplasia syndrome: 258.01-258.03)(Use additional code to identify associated endocrine syndrome, as: carcinoid syndrome: 259.2)
209.69 Benign carcinoid tumor of other sites — (Code first any associated multiple endocrine neoplasia syndrome: 258.01-258.03)(Use additional code to identify associated endocrine syndrome, as: carcinoid syndrome: 259.2)
209.72 Secondary neuroendocrine tumor of liver
211.5 Benign neoplasm of liver and biliary passages
230.8 Carcinoma in situ of liver and biliary system
235.3 Neoplasm of uncertain behavior of liver and biliary passages
239.0 Neoplasm of unspecified nature of digestive system
277.30 Amyloidosis, unspecified — (Use additional code to identify any associated intellectual disabilities)
277.31 Familial Mediterranean fever — (Use additional code to identify any associated intellectual disabilities)
277.39 Other amyloidosis — (Use additional code to identify any associated intellectual disabilities)
277.4 Disorders of bilirubin excretion — (Use additional code to identify any associated intellectual disabilities)
571.5 Cirrhosis of liver without mention of alcohol — (Code first, if applicable, viral hepatitis (acute) (chronic): 070.0-070.9)
571.6 Biliary cirrhosis
571.8 Other chronic nonalcoholic liver disease
572.0 Abscess of liver
573.8 Other specified disorders of liver
576.8 Other specified disorders of biliary tract
751.60 Unspecified congenital anomaly of gallbladder, bile ducts, and liver
751.62 Congenital cystic disease of liver
751.69 Other congenital anomaly of gallbladder, bile ducts, and liver
782.4 Jaundice, unspecified, not of newborn
789.1 Hepatomegaly

HCPCS Equivalent Codes

N/A

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Status	MUE
47120	67.15	67.15	90	A	2(3)
47122	98.94	98.94	90	A	1(2)
47125	88.55	88.55	90	A	1(2)
47130	95.16	95.16	90	A	1(2)

	Modifiers				Medicare Reference
47120	51	N/A	62*	80	None
47122	51	N/A	62*	80	
47125	51	N/A	62*	80	
47130	51	N/A	62*	80	

* with documentation

G0396-G0397

G0396 Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention 15 to 30 minutes

G0397 Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and intervention, greater than 30 minutes

Explanation

Alcohol and substance abuse may be assessed by several different methods, including a drug abuse screening test (DAST) and an alcohol use disorder identification test (AUDIT).

77014

77014 Computed tomography guidance for placement of radiation therapy fields

Explanation

Computed tomography (CT) is used in guiding the placement of radiation therapy fields. CT scanning directs multiple narrow beams of x-rays around the body structure being studied and uses computer imaging to produce thin cross-sectional views of various layers (or slices) of the body. It is able to visualize soft tissue, as well as bones. Patients are required to remain motionless during the study. Cross-sectional images of both normal and abnormal tissue structures are obtained and the treatment field area volume is determined. The normal tissues surrounding the treatment area are also defined. Acquiring this data is an important step in planning the patient's radiation treatment.

77055-77057

77055 Mammography; unilateral

77056 bilateral

77057 Screening mammography, bilateral (2-view film study of each breast)

Explanation

Mammography is a radiographic technique used to diagnose breast cysts or tumors in women with symptoms of breast disease or to detect them before they are palpable in women who are asymptomatic. Mammography is done using a different type of x-ray than is used for routine exams that do not penetrate tissue as easily. The breast is compressed firmly between two planes and pictures are taken. This spreads the tissue and allows for a lower x-ray dose. Use 77055 for a single breast and 77056 for both breasts. Report 77057 for both breasts done in an asymptomatic screening with two views taken of each breast.

77058-77059

77058 Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral

77059 bilateral

Explanation

Magnetic resonance imaging (MRI) is a radiation-free, noninvasive technique to produce high-quality sectional images of the inside of the body in multiple planes. MRI uses the natural magnetic properties of the hydrogen atoms in our bodies that emit radiofrequency signals when exposed to radio waves within a strong electromagnetic field. These signals are processed and converted by the computer into high-resolution, three-dimensional, tomographic images. Patients with metallic or electronic implants or foreign bodies cannot be exposed to MRI. The patient must remain still while lying on a motorized table within the large, circular MRI tunnel. A sedative may be administered, as well as an IV injected contrast material for image enhancement. Report 77058 for magnetic resonance imaging of the left or right breast and 77059 for both breasts.

77074-77075

77074 Radiologic examination, osseous survey; limited (eg, for metastases)

77075 complete (axial and appendicular skeleton)

Explanation

Various bones in the body are x-rayed. A limited study is reported (77074) when specific symptomatic sites are examined. This procedure is rarely performed to determine any spread of cancer, having been replaced by nuclear bone scanning, a more precise study for diagnosing metastases. A complete study (77075) is when the axial (head and trunk) and appendicular (extremities) skeleton is surveyed for evidence of metastatic disease. It may also be performed on children to identify current and/or old healed fractures in the case of suspected child abuse. This procedure is rarely performed for metastatic disease, having been replaced by nuclear bone scanning, a more precise study for diagnosing metastases.

[77387]

77387 Guidance for localization of target volume for delivery of radiation treatment delivery, includes intrafraction tracking, when performed

Explanation

Radiation treatment delivery involves the transfer of a beam of radioactive electromagnetic energy from a treatment machine distanced from the treatment area. Stereotactic body radiation therapy is a radiation therapy technique designed to deliver a large radiation dose to discrete tumor sites in the lungs, liver, brain, or elsewhere while minimizing damage to healthy tissue. Stereoscopic x-ray guidance utilizes infrared and/or camera technology to precisely localize targets in conjunction with intensity modulated radiation therapy and stereotactic radiotherapy. This code reports the guidance for localization of target volume for treatment delivery and includes intrafraction tracking, when performed.

Coding Tips

This code is new for 2015. It replaces 77421 which has been deleted.

77422-77423

77422 High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking

77423 1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s)

Explanation

External beam radiotherapy is radiation delivered from a distant source outside the body and directed at the patient's cancer site. High-energy neutron radiotherapy destroys the cells ability to divide and grow by damaging the cells through nuclear interactions, which decreases the damaged cells chances of repairing themselves. Since high-energy neutron radiotherapy works in the absence of oxygen, unlike conventional radiation therapy, it is used to treat larger tumors and is particularly effective in treating inoperable salivary gland tumors, bone cancers, and certain types of advanced malignancies of the pancreas, bladder, lung, prostate, and uterus. Due to the high potency of neutron radiation, the required dose is much less than with conventional radiotherapy, and a full course may be delivered in 10 to 12 treatments rather than the usual 30 to 40. Report 77422 for a single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking. Report 77423 for

Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $33.5 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group (see paragraphs 2 and 3 under "Instructions for Use of the CPT Codebook" on page xii 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).

The use of the phrase "physician or other qualified health care professional" (OQHCP) was adopted to identify a health care provider other than a physician. This type of provider is further described in CPT as an individual "qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable)." State licensure guidelines determine the scope of practice and a qualified health care professional must practice within these guidelines, even if more restrictive than the CPT guidelines. The qualified health care professional may report services independently or under incident-to guidelines. The professionals within this definition are separate from "clinical staff" and are able to practice independently. CPT defines clinical staff as "a person who works under the supervision of a physician or other qualified health care professional and who is allowed, by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service." Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Hospital inpatient services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician or other qualified health care provider's office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician or other qualified health care provider within the past three years. An established patient is a patient who has received face-to-face professional services from the physician or other qualified health care provider within the past three years. In the case of group practices, if a physician or other qualified health care provider of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a physician or other qualified health care provider is on call or covering for another physician or other qualified health care provider, the patient's encounter is classified as it would have been by the physician or other qualified health care provider who is not available. Thus, a locum tenens physician or other qualified health care provider who sees a patient on behalf of the patient's attending