



Coding Companion for General Surgery/ Gastroenterology

A comprehensive illustrated guide to coding and reimbursement

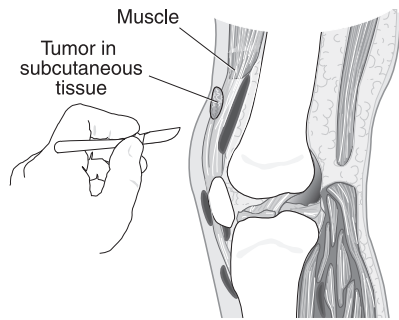
2016

Contents

Getting Started with Coding Companion	i	Stomach.....	307
Skin	1	Intestines.....	351
Pilonidal Cyst.....	24	Meckel’s Diverticulum.....	439
Introduction	25	Appendix.....	442
Repair	29	Rectum.....	446
Destruction.....	61	Anus.....	516
Breast	64	Liver	561
General Musculoskeletal	86	Biliary Tract.....	579
Neck.....	94	Pancreas	606
Back	98	Abdomen/Digestive.....	626
Spine	101	Testis	695
Abdomen/Musculoskeletal.....	102	Tunica Vaginalis	699
Humerus.....	104	Vas Deferens.....	702
Forearm/Wrist.....	108	Spermatic Cord/Seminal Vesicles	704
Hands/Fingers.....	112	Reproductive	709
Pelvis/Hip	114	Vagina	710
Femur/Knee.....	122	Thyroid.....	711
Leg/Ankle	125	Parathyroid.....	722
Foot/Toes.....	129	Extracranial Nerves	727
Endoscopy	131	Medicine	733
Respiratory	132	HCPCS	746
Arteries and Veins	139	Appendix.....	764
Spleen	191	Correct Coding Initiative Update 20.3	806
Lymph Nodes	194	Evaluation and Management	921
Diaphragm	215	Index.....	941
Esophagus	220		

27327-27328 [27337, 27339]

- 27327** Excision, tumor, soft tissue of thigh or knee area, subcutaneous; less than 3 cm
- 27337** 3 cm or greater
- 27328** Excision, tumor, soft tissue of thigh or knee area, subfascial (eg, intramuscular); less than 5 cm
- 27339** 5 cm or greater



Report 27327 or 27337 for subcutaneous excision and 27328 or 27339 for subfascial excision of a soft tissue tumor of the thigh or knee area

Explanation

The physician removes a tumor from the soft tissue of the thigh or knee area that is located in the subcutaneous tissue in 27327 and 27337 and in the deep soft tissue, below the fascial plane, or within the muscle in 27328 and 27339. With the proper anesthesia administered, the physician makes an incision in the skin overlying the mass and dissects 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 27327 for excision of a subcutaneous tumor whose resected area is less than 3 cm, and 27337 for excision of a subcutaneous tumor that is 3 cm or greater. Report 27328 for excision of a subfascial or intramuscular tumor whose resected area is less than 5 cm, and 27339 for excision of a subfascial or intramuscular tumor that is 5 cm or greater.

Coding Tips

Codes 27337–27339 are resequenced codes and will not display in numeric order. An excisional biopsy is not reported separately when a therapeutic excision is performed during the same surgical session. Radical resection of soft tissue tumor, thigh or knee area, is reported with resequenced codes 27329–27364; femur or knee tumor, see 27365. For excision of cutaneous, benign lesions, see 11400–11406.

ICD-9-CM Diagnostic

- 171.3 Malignant neoplasm of connective and other soft tissue of lower limb, including hip

- 173.71 Basal cell carcinoma of skin of lower limb, including hip
- 173.72 Squamous cell carcinoma of skin of lower limb, including hip
- 195.5 Malignant neoplasm of lower limb
- 198.89 Secondary malignant neoplasm of other specified sites
- 209.34 Merkel cell carcinoma of the lower limb
- 209.75 Secondary Merkel cell carcinoma
- 214.1 Lipoma of other skin and subcutaneous tissue
- 214.8 Lipoma of other specified sites
- 215.3 Other benign neoplasm of connective and other soft tissue of lower limb, including hip
- 228.1 Lymphangioma, any site
- 238.1 Neoplasm of uncertain behavior of connective and other soft tissue
- 239.2 Neoplasms of unspecified nature of bone, soft tissue, and skin
- 782.2 Localized superficial swelling, mass, or lump

HPCS Equivalent Codes

N/A

Terms To Know

deep fascia. Sheet of dense, fibrous tissue holding muscle groups together below the hypodermis layer or subcutaneous fat layer that lines the extremities and trunk.

intramuscular. Within a muscle.

ligament. Band or sheet of fibrous tissue that connects the articular surfaces of bones or supports visceral organs.

subfascial. Beneath the band of fibrous tissue that lies deep to the skin, encloses muscles, and separates their layers.

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Status	MUE
27327	8.99	13.09	90	A	-
27328	17.82	17.82	90	A	-
27337	11.99	11.99	90	A	-
27339	21.63	21.63	90	A	-

	Modifiers				Medicare Reference
27327	51	50	N/A	N/A	None
27328	51	50	N/A	N/A	
27337	51	50	N/A	80	
27339	51	50	N/A	80	

* with documentation

71010

71010 Radiologic examination, chest; single view, frontal

Explanation

A radiograph is taken of the patient's chest from front to back (AP). Typically, this is done when the patient is too ill to stand or be turned to the prone position. The key element of this code is that it reports a single, frontal view.

71020

71020 Radiologic examination, chest, 2 views, frontal and lateral;

Explanation

Films are taken of the patient's chest to include a frontal and side to side (lateral) view. This code specifically reports these two views.

71021

71021 Radiologic examination, chest, 2 views, frontal and lateral; with apical lordotic procedure

Explanation

Films are taken of the patient's chest with the patient placed in a side to side (lateral) position, as well as a standard front to back position (AP). Another front to back (AP) film is also taken with the patient leaning back resting shoulders against the wall/film tray in a lordotic (arched back) position. This projection produces x-rays that demonstrate the top, or apices, of the lungs.

71022

71022 Radiologic examination, chest, 2 views, frontal and lateral; with oblique projections

Explanation

Radiographs are taken of the patient's chest with the patient in a standard front to back (AP) position, as well as side to side (laterally). In addition, right and left obliques, or angled views, are taken. The key element of this code is that it reports specifically frontal, lateral, and oblique views.

71030

71030 Radiologic examination, chest, complete, minimum of 4 views;

Explanation

Films are taken of the patient's chest, specifically a complete exam, with a minimum of four views. Typically, this would include a back to front (PA), side to side (lateral), and right and left obliques, but may include any number of specialized projections, e.g., axial (angulated) views or lateral decubitus views for fluid levels.

71035

71035 Radiologic examination, chest, special views (eg, lateral decubitus, Bucky studies)

Explanation

Radiographs are taken of the patient's chest. This code reports special views, but does not specify number of films allowed. Specific examples may include Bucky studies and/or lateral decubitus studies, wherein the patient is prone or supine and the x-ray beam is directed through the side of the chest. This lateral projection shows change in position of fluid and reveals areas that are obscured by the fluid in standard, upright projections.

74000

74000 Radiologic examination, abdomen; single anteroposterior view

Explanation

Films are taken of the abdominal cavity in one view from front to back. Because an abdominal x-ray usually precedes another diagnostic imaging procedure, it is not coded separately unless performed as a separately identifiable examination.

74010

74010 Radiologic examination, abdomen; anteroposterior and additional oblique and cone views

Explanation

Films are taken of the abdominal cavity from front to back, with an oblique view and a focused (coned down or spot) view. Because an abdominal x-ray usually precedes another diagnostic imaging procedure, it is not coded separately unless performed as a separately identifiable examination.

74020

74020 Radiologic examination, abdomen; complete, including decubitus and/or erect views

Explanation

Films are taken of the abdominal cavity from front to back, back to front, or front to back with the patient lying on the side and/or standing. Because an abdominal x-ray usually precedes another diagnostic imaging procedure, it is not coded separately unless performed as a separately identifiable examination.

74022

74022 Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest

Explanation

Films are taken of the abdominal cavity with the patient lying flat, standing, and/or lying on the side. This procedure includes an upright chest x-ray. Because an abdominal x-ray usually precedes another diagnostic imaging procedure, it is not coded separately unless performed as a separately identifiable examination.

74176-74178

74176 Computed tomography, abdomen and pelvis; without contrast material
74177 with contrast material(s)
74178 without contrast material in one or both body regions, followed by contrast material(s) and further sections in one or both body regions

Explanation

Computed tomography directs multiple thin beams of x-rays at the body structure being studied and uses computer imaging to produce thin,

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