



Coding Companion for Primary Care

A comprehensive illustrated guide to coding and reimbursement

2016

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24075-24076 [24071, 24073]

- 24075** Excision, tumor, soft tissue of upper arm or elbow area, subcutaneous; less than 3 cm
- 24071** 3 cm or greater
- 24076** Excision, tumor, soft tissue of upper arm or elbow area, subfascial (eg, intramuscular); less than 5 cm
- 24073** 5 cm or greater



Report 24075 or 24071 for subcutaneous excision and 24076 or 24073 for subfascial excision of a soft tissue tumor of the upper arm or elbow area

Medial view of select upper arm musculature

Explanation

The physician removes a tumor from the soft tissue of the upper arm or elbow area that is located in the subcutaneous tissue in 24071 and 24075 and in the deep soft tissue, below the fascial plane or within the muscle, in 24073 and 24076. With the proper anesthesia administered, the physician makes an incision in the skin overlying the mass and dissects down to the tumor. The extent of the tumor is identified and a dissection is undertaken all the way around the tumor. A portion of neighboring soft tissue may also be removed to ensure adequate removal of all tumor tissue. A drain may be inserted and the incision is repaired with layers of sutures, staples, or Steri-strips. Report 24075 for excision of subcutaneous tumors whose resected area is less than 3 cm and 24071 for excision of subcutaneous tumors 3 cm or greater. Report 24076 for excision of subfascial or intramuscular tumors whose resected area is less than 5 cm and 24073 for excision of subfascial or intramuscular tumors 5 cm or greater.

Coding Tips

Codes 24071 and 24073 are resequenced codes and will not display in numeric order. For an excision of soft tissues of other sites, see the specific anatomical section. An excisional biopsy is not reported separately when a therapeutic excision is performed during the same surgical session. Local anesthesia is included in these services. However, these procedures may be performed under general anesthesia, depending on the age and/or condition of the patient. For excision of cutaneous, benign lesions, see 11400–11406. It is inappropriate to report supplies when these services are performed in an emergency room. For physician office, supplies may be reported with the

appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-9-CM Diagnostic

- 171.2 Malignant neoplasm of connective and other soft tissue of upper limb, including shoulder
- 195.4 Malignant neoplasm of upper limb
- 209.33 Merkel cell carcinoma of the upper limb
- 209.75 Secondary Merkel cell carcinoma
- 214.1 Lipoma of other skin and subcutaneous tissue
- 214.8 Lipoma of other specified sites
- 215.2 Other benign neoplasm of connective and other soft tissue of upper limb, including shoulder
- 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

HCPCS Equivalent Codes

N/A

Terms To Know

intramuscular. Within a muscle.

subcutaneous. Below the skin.

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

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

Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Status	MUE
24071	11.63	11.63	90	A	3(1)
24073	19.93	19.93	90	A	3(1)
24075	9.43	13.97	90	A	-
24076	15.53	15.53	90	A	-

	Modifiers				Medicare Reference
24071	51	50	N/A	80	None
24073	51	50	N/A	80	
24075	51	50	N/A	N/A	
24076	51	50	N/A	N/A	

* with documentation

G0108-G0109

- G0108** Diabetes outpatient self-management training services, individual, per 30 minutes
- G0109** Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes

Explanation

These codes are for diabetes self-management training services, either individually or in a group of two or more. Diabetes self-management training is done to teach the diabetic how to control and monitor blood glucose levels with the proper use of the monitoring device, dietary calculations and restrictions, and correct administration of diabetic medications. These codes are reported per 30 minute intervals.

G0123-G0124

- G0123** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, screening by cytotechnologist under physician supervision
- G0124** Screening cytopathology, cervical or vaginal (any reporting system), collected in preservative fluid, automated thin layer preparation, requiring interpretation by physician

Explanation

These cervical or vaginal cytopathology screenings (any reporting system) of specimens collected in preservative fluid may be identified as "thin prep." The specimen is collected by cervical, endocervical, or vaginal scrapings or by aspiration of vaginal fluid and cells. This method saves time by eliminating the need for the physician to prepare a smear; the specimen is placed in a preservative suspension instead. At the laboratory, special instruments take the cells in the preservative suspension and "plate-out" a monolayer for screening, which will carefully review the specimen for abnormal cells.

G0130

- G0130** Single energy x-ray absorptiometry (SEXA) bone density study, one or more sites; appendicular skeleton (peripheral) (e.g., radius, wrist, heel)

Explanation

Bone mineral density studies are used to evaluate diseases of bone and/or the responses of bone disease to treatment. Densities are measured at the wrist, radius, hip, pelvis, spine, or heel. The studies assess bone mass or density associated with such diseases as osteoporosis, osteomalacia, and renal osteodystrophy. Single energy x-ray absorptiometry (SEXA) utilizes an x-ray tube as the radiation source that is pulsed at a certain energy level. SEXA is used to scan bone that is in a superficial location with little adjacent soft tissue, such as the wrist or heel. There is a differential attenuation between bone and soft tissue for the energy beam. Excessive soft tissue renders the measurement incorrect. An attenuation profile of the bony components is calculated and the results are given in two scores, which are reported as standard deviations from the normal bone density of a person the same sex, 30 years old, which is the age of peak bone mass, and from the normal bone density of an "age matched" that compares the patient's bone density to what is expected in someone the same age, sex, and size.

G0141

- G0141** Screening cytopathology smears, cervical or vaginal, performed by automated system, with manual rescreening, requiring interpretation by physician

Explanation

This cervical or vaginal cytopathology screening is done on specimens prepared in a smear. The specimen is collected by cervical, endocervical, or vaginal scrapings or by aspiration of vaginal fluid and cells. The screening method is microscopy examination of a spray or liquid fixated smear prepared by the physician collecting the specimen. Screening, defined as the careful review of the specimen for abnormal cells, may then be accomplished by different methods that involve the use of automated systems.

G0179-G0180

- G0179** Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period
- G0180** Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period

Explanation

These codes report one period of certification or recertification of a patient's qualifying status for Medicare-covered home health services under a home health plan of care by a physician, without the patient present. This includes all contacts made with the home health agency and reviewing of patient status reports required by physicians to affirm the initial implementation of the care plan designed to meet the patient's needs.

G0181-G0182

- G0181** Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more
- G0182** Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more

Explanation

These codes represent physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency or of a patient under a Medicare-approved hospice. This includes complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication with other health care professionals involved in the patient's care, including all telephone calls, and integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month. The patient is not present for the physician supervision.

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).” In addition, CPT guidelines indicate that the advanced practice nurses and physician assistant who work with

physicians should practice in “the exact same specialty and exact same subspecialty as the physician.” 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, guidance, or payer policies 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