Coding Companion for General Surgery/Gastroenterology

A comprehensive illustrated guide to coding and reimbursement
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**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  

**Coding Tips**

Codes 27337–27339 are resequenced codes and will not display in numeric order. An excisional biopsy is noted 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.

**ICD-9-CM Procedural**

83.31 Excision of lesion of tendon sheath
83.32 Excision of lesion of muscle
83.39 Excision of lesion of other soft tissue
83.49 Other excision of soft tissue
86.3 Other local excision or destruction of lesion or tissue of skin and subcutaneous tissue
86.4 Radical excision of skin lesion

**Anesthesia**

27327 00400
27328 01320
27337 00400
27339 01320

**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

**Terms To Know**

**deep fascia.** Sheet of dense, fibrous tissue lying beneath the subcutaneous fat layer that lines extremities and the trunk and holds groups of muscles together.  

**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.

**CCI Version 17.3**


Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

**Medicare Edits**

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<tr>
<th>Fac</th>
<th>RVU</th>
<th>Non-Fac</th>
<th>RVU</th>
<th>FUD</th>
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<td>27327</td>
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<td>22.15</td>
<td>22.15</td>
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</tr>
</tbody>
</table>

**MUE**

Modifiers

| 27327 | S1 | 50 | N/A | N/A |
| 27328 | S1 | 50 | N/A | N/A |
| 27337 | S1 | 50 | N/A | 80 |
| 27339 | S1 | 50 | N/A | 80 | * with documentation |

**Medicare References:** None
Appendix

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>71010</td>
<td>Radiologic examination, chest; single view, frontal</td>
<td>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.</td>
</tr>
<tr>
<td>71020</td>
<td>Radiologic examination, chest, 2 views, frontal and lateral;</td>
<td>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.</td>
</tr>
<tr>
<td>71021</td>
<td>Radiologic examination, chest, 2 views, frontal and lateral;</td>
<td>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.</td>
</tr>
<tr>
<td>71022</td>
<td>Radiologic examination, chest, 2 views, frontal and lateral;</td>
<td>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.</td>
</tr>
<tr>
<td>71030</td>
<td>Radiologic examination, chest, complete, minimum of 4 views;</td>
<td>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.</td>
</tr>
<tr>
<td>71035</td>
<td>Radiologic examination, chest, special views (eg, lateral decubitus, Bucky studies)</td>
<td>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.</td>
</tr>
<tr>
<td>74000</td>
<td>Radiologic examination, abdomen; single anteroposterior view</td>
<td>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.</td>
</tr>
<tr>
<td>74010</td>
<td>Radiologic examination, abdomen; anteroposterior and additional oblique and cone views</td>
<td>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.</td>
</tr>
<tr>
<td>74020</td>
<td>Radiologic examination, abdomen; complete, including decubitus and/or erect views</td>
<td>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.</td>
</tr>
<tr>
<td>74022</td>
<td>Radiologic examination, abdomen; complete acute abdomen series, including supine, erect, and/or decubitus views, single view chest</td>
<td>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.</td>
</tr>
</tbody>
</table>

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 1 or both body regions, followed by contrast material(s) and further sections in 1 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, cross-sectional views of various layers (or slices) of the body. It is useful for the evaluation of trauma, tumor, and foreign bodies as CT is able to visualize soft tissue as well as bones. Patients are required to remain motionless during the study and sedation may need to be administered, as well as a contrast medium for image enhancement. These codes report an exam of the abdomen and pelvis. Report 74176 if no contrast is used; 74177 if performed with contrast; and 74178 if performed first without contrast in one or both body regions followed by the injection of contrast and further sections in one or both body regions.

74220  Radiologic examination; esophagus

Explanation

Films are taken of the esophagus, which is the muscular tube, about nine inches long, that carries swallowed foods and liquids from the pharynx to the stomach. Films are taken both before and after introduction of a contrast material consisting of barium sulfate. Hence, this study is also commonly referred to as a "barium swallow." Structural abnormalities of the esophagus and vessels, such as esophageal varices, may be diagnosed by use of this study. There are no number or type of views associated with this procedure.

74235  Removal of foreign body(s), esophageal, with use of balloon catheter, radiological supervision and interpretation

Explanation

The physician uses an esophagoscopy to locate and remove a foreign body from the esophagus. The physician passes a rigid or flexible esophagoscopy through the patient’s mouth and into the esophagus. The foreign body is located. It may be
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 $32 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.

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’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 within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a physician is on call or covering for another physician, the patient’s encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient’s attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as “observation status” in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician “admitting” the patient for observation.

Codes 99224-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and preparation of the discharge records. It should not be used when admission and discharge are on the same date of service. As mentioned above, report codes 99234-99236 to appropriately describe same day observation services.

If a patient is in observation longer than one day, subsequent observation care codes 99224-99226 should be reported. If the patient is discharged on the second day, observation discharge code 99217 should be reported. If the patient status is changed to inpatient on a subsequent date, the appropriate inpatient code, 99221-99233, should be reported.

Initial hospital care is defined as E/M services provided during the first hospital inpatient encounter with the patient by the admitting physician. (If a physician other than the admitting physician