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58960 Laparotomy, for staging or restaging of ovarian, tubal, or primary peritoneal malignancy (second look), with or without omentectomy, peritoneal washing, biopsy of abdominal and pelvic peritoneum, diaphragmatic assessment with pelvic and limited para-aortic lymphadenectomy

Explanation
This procedure is the second operation to check for a recurrence of the ovarian malignancy. Through a full abdominal incision extending from just above the pubic hairline to the rib cage, the physician may elect to remove the omentum, a membrane of lymph, blood vessels, and fat that forms a protective layer that extends from the stomach to the transverse colon. The physician may flush the lining of the abdominal cavity (peritoneum) and remove the liquid to check for cancerous cells. A tissue sample of the abdominal and pelvic peritoneum may be taken. The physician also may examine and take tissue samples of the diaphragm. The pelvic lymph nodes are removed and a portion of the lymph nodes that surrounds the lower aorta within the pelvis is removed. The abdominal incision is closed with layered sutures.

Coding Tips
A prior surgery for ovarian malignancy should be documented. For initial treatment and guidelines, see 58950–58952.

ICD-9-CM Diagnostic
183.0 Malignant neoplasm of ovary — (Use additional code to identify any functional activity)
183.8 Malignant neoplasm of other specified sites of uterine adnexa
196.6 Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
197.6 Secondary malignant neoplasm of retroperitoneum and peritoneum
198.6 Secondary malignant neoplasm of ovary
198.89 Secondary malignant neoplasm of other specified sites
209.71 Secondary neuroendocrine tumor of distant lymph nodes
209.74 Secondary neuroendocrine tumor of peritoneum
209.79 Secondary neuroendocrine tumor of other sites

236.2 Neoplasm of uncertain behavior of ovary — (Use additional code to identify any functional activity)
V10.43 Personal history of malignant neoplasm of ovary
V84.02 Genetic susceptibility to malignant neoplasm of ovary — (Use additional code, if applicable, for any associated family history of the disease: V16-V19. Code first, if applicable, any current malignant neoplasms: 140.0-195.8, 200.0-208.9, 230.0-234.9. Use additional code, if applicable, for any personal history of malignant neoplasm: V10.0-V10.9)
V84.04 Genetic susceptibility to malignant neoplasm of endometrium — (Use additional code, if applicable, for any associated family history of the disease: V16-V19. Code first, if applicable, any current malignant neoplasms: 140.0-195.8, 200.0-208.9, 230.0-234.9. Use additional code, if applicable, for any personal history of malignant neoplasm: V10.0-V10.9)
V84.09 Genetic susceptibility to other malignant neoplasm — (Use additional code, if applicable, for any associated family history of the disease: V16-V19. Code first, if applicable, any current malignant neoplasms: 140.0-195.8, 200.0-208.9, 230.0-234.9. Use additional code, if applicable, for any personal history of malignant neoplasm: V10.0-V10.9)

HCPCS Equivalent Codes
N/A

Terms To Know
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 areas in the body.
omentum. Fold of peritoneal tissue suspended between the stomach and neighboring visceral organs of the abdominal cavity.
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.

Medicare Edits

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* with documentation
Initial annual wellness visit (AWV) includes taking the patient's history; counseling and coordination of patient care with the other providers.

**G0426**
G0426 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 preserved 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 a microscopy examination of a spray or liquid fixed 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.

**G0447**
G0447 Face-to-face behavioral counseling for obesity, 15 minutes

**Explanation**
Behavioral counseling for obesity is reported with this code. The United States Preventive Services Task Force (USPSTF) considers body mass index (BMI) a good indicator of morbidity and mortality as a result of being overweight or obesity. BMI is calculated using the following formula: BMI = (weight in pounds / (height in inches x height in inches)) x 703. Obese adults are considered those that have a BMI >=30 kg/m2. Behavioral counseling and behavior modification can be an effective combination to produce moderate, sustainable weight loss. The patients should have the following services: screening for obesity using BMI, assessment of food and nutritional intake, and counseling to include diet and exercise. Behavioral counseling interventions should include the following Five A’s approach that has been developed by the United States Preventive Services Task Force (USPSTF): Assess: Ask about/assess behavioral health risk(s) and factors affecting choice of behavior and change goals/methods; Advise: Give clear, specific, and personalized behavior change advice, including information about personal health harms and benefits; Agree: collaboratively select appropriate treatment goals and methods based on the patient’s interest in and willingness to change the behavior; Assist: Using behavior change techniques (self-help and/or counseling), aid the patient in achieving agreed-upon goals by acquiring the skills, confidence, and social/environmental supports for behavior change, supplemented with adjunctive medical treatments when appropriate; Arrange: Schedule follow-up contacts (in person or by telephone) to provide ongoing assistance/support and to adjust the treatment plan as needed, including referral to more intensive or specialized treatment.
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 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 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 providers must make is what type of code to use. The following tables outline the E/M codes for different levels of care for: