Current Procedural Coding Expert
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32097  Thoracotomy, with diagnostic biopsy(es) of lung node(s) or mass(es) (eg, wedge, incisional), unilateral
Code also appropriate add-on code for the more extensive procedure in the same location if diagnostic wedge resection results in the need for further surgery (32597, 32668)
Do not report more than one time per lung
Do not report with (32440-32445, 32488)
  3233    23.33  23.33  FUD 090

32098  Thoracotomy, with biopsy(ies) of pleura
  22.02    22.02  FUD 090

### 32100-32160 Open Procedures: Chest

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>CPT Not Covered</th>
<th>Days Reserved</th>
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<tbody>
<tr>
<td>32100</td>
<td>Thoracotomy; with exploration</td>
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<tr>
<td></td>
<td>Do not report with (19260, 19271-19272, 32503-32504, 33955-33957, 33963, 33964)</td>
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<tr>
<td>32110</td>
<td>with control of traumatic hemorrhage and/or repair of lung tear</td>
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<tr>
<td>32120</td>
<td>for postoperative complications</td>
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<tr>
<td>32140</td>
<td>with open intrapleural pneumonolysis</td>
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<tr>
<td>32141</td>
<td>with cyst(s) removal, includes pleural procedure when performed</td>
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<tr>
<td>32150</td>
<td>with removal of intrapleural foreign body or fibrin deposit</td>
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<tr>
<td>32151</td>
<td>with removal of intrapulmonary foreign body</td>
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<tr>
<td>32160</td>
<td>with cardiac massage</td>
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### 32200-32320 Open Procedures: Lung

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<tbody>
<tr>
<td>32200</td>
<td>Pneumonostomy, with open drainage of abscess or cyst</td>
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<tr>
<td>32215</td>
<td>Pleural scarification for repeat pneumothorax</td>
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<tr>
<td>32220</td>
<td>Decortication, pulmonary (separate procedure); total</td>
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<td></td>
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<tr>
<td>32225</td>
<td>partial</td>
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<tr>
<td>32310</td>
<td>Pleurectomy, parietal (separate procedure)</td>
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<tr>
<td>32320</td>
<td>Decortication and parietal pleurectomy</td>
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### 32400-32405 Lung Biopsy

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>CPT Not Covered</th>
<th>Days Reserved</th>
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<tbody>
<tr>
<td>32400</td>
<td>Biopsy, pleura: percutaneous needle</td>
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<td></td>
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<tr>
<td>32404</td>
<td>Fine needle aspiration (10021-10022)</td>
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<tr>
<td>32405</td>
<td>Biopsy, lung or mediastinum, percutaneous needle</td>
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<tr>
<td>32406</td>
<td>Fine needle aspiration (10022)</td>
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### 32440-32501 Lung Resection

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<th>Days Reserved</th>
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<tbody>
<tr>
<td>32440</td>
<td>Removal of lung, pneumonectomy; Code also excision of chest wall tumor</td>
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<tr>
<td>32442</td>
<td>with resection of segment of trachea followed by broncho-tracheal anastomosis (sleeve pneumonectomy)</td>
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<td></td>
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<tr>
<td>32445</td>
<td>extrapleural</td>
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<tr>
<td>32480</td>
<td>Removal of lung, other than pneumonectomy; single lobe (lobectomy)</td>
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<tr>
<td>32488</td>
<td>2 lobes (bilobectomy)</td>
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<td></td>
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<tr>
<td>32484</td>
<td>single segment (segmentectomy)</td>
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<tr>
<td>32486</td>
<td>with circumferential resection of segment of bronchus followed by broncho-bronchial anastomosis (sleeve lobectomy)</td>
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Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the Introduction, several other items unique to this section are defined or identified here.

CLASSIFICATION OF EVALUATION AND MANAGEMENT (E/M) SERVICES

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient); and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes. This classification is important because the nature of work varies by type of service, place of service, and the patient's status.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined, eg, comprehensive history and comprehensive examination. (See “Levels of E/M Services” for details on the content of E/M services.) Fourth, the nature of the presenting problem(s) usually associated with a given level is described, eg, the time typically required to provide the service is specified. (A detailed discussion of time is provided separately.)

DEFINITIONS OF COMMONLY USED TERMS

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians in different specialties. E/M services may also be reported by other qualified health care professionals who are authorized to perform such services within the scope of their practice.

New and Established Patient

Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report E/M services with a specific CPT® code or codes. A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

When a physician/qualified health care professional is on call or covering for another physician/qualified health care professional, the patient’s encounter is classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The decision tree in the next column is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Chief Complaint

A chief complaint is a concise statement describing the symptom, problem, complaint, diagnosis, or other factor that is the reason for the encounter, usually stated in the patient’s words.

Concurrent Care and Transfer of Care

Concurrent care is the provision of similar services (e.g., hospital visits) to the same patient by more than one physician or other qualified health care professional on the same day. When concurrent care is provided, no special reporting is required. Transfer of care is the process whereby a physician or other qualified health care professional who is managing some or all of a patient’s problems relinquishes this responsibility to another physician or other qualified health care professional who explicitly agrees to accept this responsibility and who, from the initial encounter, is not providing consultative services. The physician or other qualified health care professional transferring care is then no longer providing care for these problems though he or she may continue providing care for other conditions when appropriate. Consultation codes should not be reported by the physician or other qualified health care professional who has agreed to accept transfer of care before an initial evaluation, but they are appropriate to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of site of service.

Decision Tree for New vs Established Patients

- Received any professional service from the physician or another physician in group of same specialty within last three years?
  - Yes
  - New patient
  - No
  - Established patient

Counseling

Counseling is a discussion with a patient and/or family concerning one or more of the following areas:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of management (treatment) options
- Instructions for management (treatment) and/or follow-up
- Importance of compliance with chosen management (treatment) options
- Risk factor reduction
- Patient and family education

Family History

A review of medical events in the patient’s family that includes significant information about:

- The health status or cause of death of parents, siblings, and children
- Specific diseases related to problems identified in the Chief Complaint or History of the Present Illness, and/or System Review
Appendix F — Pub 100 References

The Centers for Medicare and Medicaid Services restructured its paper-based manual system as a web-based system on October 1, 2003. Called the online CMS manual system, it combines all of the various program instructions into internet-only manuals (IOMs), which are used by all CMS programs and contractors. In many instances, the references from the online manuals in appendix E contain a mention of the old paper manuals from which the current information was obtained when the manuals were converted. This information is shown in the header of the text, in the following format, when applicable, as A3-3101, HO-210, and B3-2494. Complete versions of all of the manuals can be found at http://www.cms.gov/manuals.

Effective with implementation of the IOMs, the former method of publishing program memoranda (PMs) to communicate program instructions was replaced by the following four templates:

- One-time notification
- Manual revisions
- Business requirements
- Confidential requirements

The web-based system has been organized by functional area (e.g., eligibility, entitlement, claims processing, benefit policy, program integrity) in an effort to eliminate redundancy within the manuals, simply updating, and make CMS program instructions available more quickly. The web-based system contains the functional areas included below:

- Introduction
- Medicare General Information, Eligibility, and Entitlement Manual
- Medicare Benefit Policy Manual
- Medicare Claims Processing Manual
- Medicare Secondary Payer Manual
- State Operations Manual
- Medicare Program Integrity Manual
- Medicare Contractor Beneficiary and Provider Communications Manual
- Quality Improvement Organization Manual
- Programs of All-Inclusive Care for the Elderly (PACE) Manual
- State Medicaid Manual (under development)
- Medicare State Children's Health Insurance Program (CHIP) Manual
- Medicare ESRD Network Organizations Manual
- Medicare Integrity Program (MPI)
- Medicare Managed Care Manual
- Medicare Prescription Drug Benefit Manual
- Demonstrations
- One-Time Notification
- Recurring Update Notification
- Medicare Quality Reporting Incentive Programs Manual
- State Buy-In Manual

A brief description of the Medicare manuals primarily used for CPC Expert follow:

The National Coverage Determinations Manual (NCD), is organized according to categories such as diagnostic services, supplies, and medical procedures. The table of contents lists each category and subject within that category. Revision transmittals identify any new or background material, recap the changes, and provide an effective date for the change.

When complete, the manual will contain two chapters. Chapter 1 currently includes a description of NCDs and NCCI Edits. As a general rule, in the past these instructions have been found in chapter II of the Medicare Carriers Manual, the Medicare Intermediary Manual, other provider manuals, and program memoranda. The Medicare Claims Processing Manual contains instructions for processing claims for contractors and providers.

The Medicare Program Integrity Manual communicates the priorities and standards for the Medicare integrity programs.

Medicare IOM references

100-1, 3, 20.5 Blood Deductibles (Part A and Part B)

Program payment may not be made for the first 3 pints of whole blood or equivalent units of packed red cells received under Part A and Part B combined in a calendar year. However, blood processing (e.g., administration, storage) is not subject to the deductible.

The blood deductible are in addition to any other applicable deductible and coinsurance amounts for which the patient is responsible. The deductible applies only to the first 3 pints of blood furnished in a calendar year, even if more than one provider furnished blood.

100-1, 3, 20.5.2 Part B Blood Deductible

Blood is furnished on an outpatient basis or is subject to the Part B blood deductible and is counted toward the combined limit. It should be noted that payment for blood may be made to the hospital under Part B only for blood furnished in an outpatient setting. Blood is not covered for inpatient Part B services.

100-1, 3, 20.5.3 Items Subject to Blood Deductibles

The blood deductible apply only to whole blood and packed red cells. The term whole blood means human blood from which none of the liquid or cellular components have been removed. Packed red cells are subjected to the blood deductible. Other components of blood such as platelets, fibrinogen, plasma, gamma globulin, and serum albumin are not subject to the blood deductible. However, these components of blood are covered as biologicals.

Refer to Pub. 100-1, Medicare Claims Processing Manual, chapter 4, sec. 231 regarding medical blood and biological products under the Hospital Outpatient Prospective Payment System (OPPS).

100-1, 3, 30 Outpatient Mental Health Treatment Limitation

Regardless of the actual diagnosis, a beneficiary's stay in connection with the treatment of mental, psychoneurotic, and personality disorders while the beneficiary is not an inpatient of a hospital at the time such expenses are incurred, the amount of those expenses that may be recognized for Part B deductible and payment purposes is limited to 62.5 percent of the Medicare approved amount for those services. The limitation is called the outpatient mental health treatment limitation (the limitation).

The 62.5 percent limitation has been in place since the inception of the Medicare Part B program and it will remain effective at this percentage amount until January 1, 2012. However, effective January 1, 2013, the limitation will be phased out as follows:

- January 1, 2010—December 31, 2011, the limitation percentage is 68.75% (Medicare pays 60% and the patient pays 40%).
- January 1, 2012—December 31, 2012, the limitation percentage is 75% (Medicare pays 75% and the patient pays 25%).