

General Surgery/ Gastroenterology

A comprehensive illustrated guide to coding
and reimbursement

2021

optum360coding.com

Contents

Getting Started with Coding Companion	i
CPT Codes	i
ICD-10-CM.....	i
Detailed Code Information	i
Appendix Codes and Descriptions.....	i
CCI Edit Updates	i
Index.....	i
General Guidelines	i

General Surgery and Gastroenterology Procedures and Services	1
E/M Services	1
Skin	22
Pilonidal Cyst.....	56
Introduction	57
Repair	64
Destruction	110
Breast	115
General Musculoskeletal	141
Neck.....	155
Thorax	159
Back	160
Spine	163
Abdomen/Musculoskeletal	164
Humerus.....	166
Forearm/Wrist	170
Hands/Fingers.....	174
Pelvis/Hip	176
Femur/Knee.....	184
Leg/Ankle.....	187

Foot/Toes	192
Endoscopy	194
Respiratory	195
Arteries and Veins.....	204
Spleen.....	271
Lymph Nodes.....	275
Diaphragm	303
Esophagus	306
Stomach	402
Intestines	452
Meckel's Diverticulum	553
Appendix	556
Rectum.....	559
Anus	633
Liver	671
Biliary Tract.....	689
Pancreas.....	725
Abdomen/Digestive	742
Reproductive	809
Thyroid	810
Parathyroid.....	820
Extracranial Nerves	825
Medicine	831
HCPCS.....	845
Appendix.....	854
Correct Coding Initiative Update 25.3	871
Index.....	891

Getting Started with Coding Companion

Coding Companion for General Surgery/Gastroenterology is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT Codes

For ease of use, evaluation and management codes related to General Surgery/Gastroenterology are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT code is followed by its official CPT code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum360 *Coding Companion* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the pages following the sample.

Appendix Codes and Descriptions

Some CPT codes are presented in a less comprehensive format in the appendix. The CPT codes appropriate to the specialty are included in the appendix with the official CPT code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

The codes in the appendix are presented in the following order:

- E/M Services
- Pathology and Laboratory
- Surgery
- Medicine Services
- Radiology
- Category III

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edit Updates

The *Coding Companion* series includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from the most current version available at press time. The CCI edits are located in a section at the back of the book. Optum360 maintains a website to accompany the Coding Companions series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is <http://www.optum360coding.com/ProductUpdates/>. The 2021 edition password is: XXXXXX. Please note that you should log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

69501 Transmastoid antrotomy (simple mastoidectomy)
could be found in the index under the following main terms:

Antrotomy

Transmastoid, 69501

Excision

Mastoid

Simple, 69501

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xiii 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). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

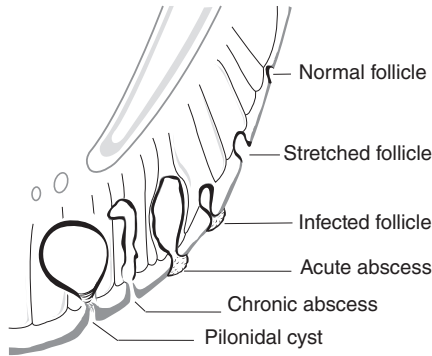
Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

11770-11772

- 11770** Excision of pilonidal cyst or sinus; simple
- 11771** extensive
- 11772** complicated



Pilonidal disorders

A pilonidal cyst is excised

Explanation

A pilonidal cyst or sinus is entrapped epithelial tissue located in the sacrococcygeal region above the buttocks. These lesions are usually associated with ingrown hair. A sinus cavity is present and may have a fluid-producing cystic lining. With a small or simple sinus in 11770, the physician uses a scalpel to completely excise the involved tissue. The wound is sutured in a single layer. In 11771, an extensive sinus is present superficial to the fascia overlying the sacrum but with subcutaneous extensions. The physician uses a scalpel to completely excise the cystic tissue. The wound may be sutured in several layers. In 11772, the sinus involves many subcutaneous extensions superficial to the fascia overlying the sacrum. The physician uses a scalpel to completely excise the cystic tissue. Local soft tissue flaps (i.e., Z-plasty, Y-V plasty, myofasciocutaneous flap) may be required for closure of a large defect or the wound may be left open to heal by granulation.

Coding Tips

Closure of the defect is included in this code and should not be reported separately. For incision and drainage of a pilonidal cyst, simple, see 10080; complicated, see 10081. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

- L05.01 Pilonidal cyst with abscess
- L05.02 Pilonidal sinus with abscess
- L05.91 Pilonidal cyst without abscess
- L05.92 Pilonidal sinus without abscess

AMA: 11772 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Sep,12

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11770	2.66	5.7	0.56	8.92
11771	6.09	9.84	1.36	17.29
11772	7.35	11.99	1.61	20.95
Facility RVU	Work	PE	MP	Total
11770	2.66	2.12	0.56	5.34
11771	6.09	5.29	1.36	12.74
11772	7.35	7.72	1.61	16.68

	FUD	Status	MUE	Modifiers			IOM Reference	
11770	10	A	1(3)	51	N/A	N/A	N/A	None
11771	90	A	1(3)	51	N/A	N/A	N/A	
11772	90	A	1(3)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.

epithelial tissue. Cells arranged in sheets that cover internal and external body surfaces that can absorb, protect, and/or secrete and includes the protective covering for external surfaces (skin), absorptive linings for internal surfaces such as the intestine, and secreting structures such as salivary or sweat glands.

fascia. Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.

lesion. Area of damaged tissue that has lost continuity or function, due to disease or trauma.

pilonidal cyst. Sac or sinus cavity of trapped epithelial tissues in the sacrococcygeal region, usually associated with ingrown hair.

pilonidal sinus. Fistula, tract, or channel that extends from an infected area of ingrown hair to another site within the skin or out to the skin surface.

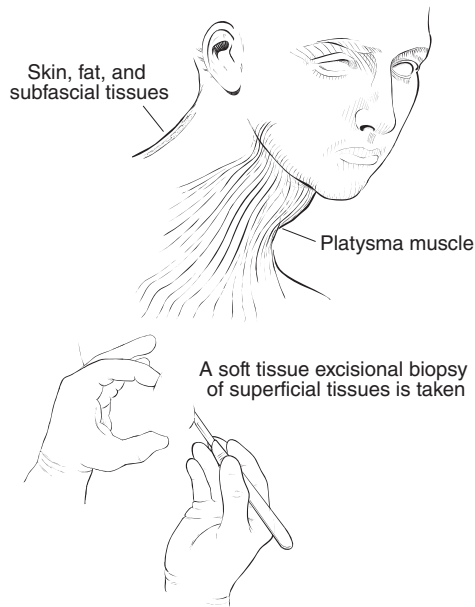
subcutaneous tissue. Sheet or wide band of adipose (fat) and areolar connective tissue in two layers attached to the dermis.

wound repair. Surgical closure of a wound is divided into three categories: simple, intermediate, and complex. **simple repair:** Surgical closure of a superficial wound, requiring single layer suturing of the skin epidermis, dermis, or subcutaneous tissue. **intermediate repair:** Surgical closure of a wound requiring closure of one or more of the deeper subcutaneous tissue and non-muscle fascia layers in addition to suturing the skin; contaminated wounds with single layer closure that need extensive cleaning or foreign body removal. **complex repair:** Repair of wounds requiring more than layered closure (debridement, scar revision, stents, retention sutures).

z-plasty. Plastic surgery technique used primarily to release tension or elongate contracted scar tissue in which a Z-shaped incision is made with the middle line of the Z crossing the area of greatest tension. The triangular flaps are then rotated so that they cross the incision line in the opposite direction, creating a reversed Z.

21550

21550 Biopsy, soft tissue of neck or thorax



Explanation

The physician performs a biopsy of the soft tissues of the neck or thorax. With proper anesthesia administered, the physician identifies the mass through palpation and x-ray (reported separately), if needed. An incision is made over the site and dissection is taken down to the subcutaneous fat or further into the fascia or muscle to reach the lesion. A portion of the tissue mass is excised and submitted for pathology. The area is irrigated and the incision is closed with layered sutures.

Coding Tips

A biopsy is not reported separately when followed by an excisional removal during the same operative session. When 21550 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure, and subsequent procedures are appended with modifier 51. For a needle biopsy of muscle, see 20206. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

- C49.0 Malignant neoplasm of connective and soft tissue of head, face and neck
- C49.3 Malignant neoplasm of connective and soft tissue of thorax
- C76.0 Malignant neoplasm of head, face and neck
- C76.1 Malignant neoplasm of thorax
- C79.89 Secondary malignant neoplasm of other specified sites
- D09.8 Carcinoma in situ of other specified sites
- D21.0 Benign neoplasm of connective and other soft tissue of head, face and neck
- D21.3 Benign neoplasm of connective and other soft tissue of thorax
- D49.89 Neoplasm of unspecified behavior of other specified sites
- L03.221 Cellulitis of neck
- L03.313 Cellulitis of chest wall
- R22.1 Localized swelling, mass and lump, neck

R22.2 Localized swelling, mass and lump, trunk

AMA: 21550 2018, Sep, 7

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21550	2.11	5.11	0.28	7.5
Facility RVU	Work	PE	MP	Total
21550	2.11	2.08	0.28	4.47

	FUD	Status	MUE	Modifiers			IOM Reference	
21550	10	A	2(3)	51	N/A	N/A	N/A	None

* with documentation

Terms To Know

benign. Mild or nonmalignant in nature.

biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.

carcinoma in situ. Malignancy that arises from the cells of the vessel, gland, or organ of origin that remains confined to that site or has not invaded neighboring tissue.

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 body areas.

neoplasm. New abnormal growth, tumor.

secondary. Second in order of occurrence or importance, or appearing during the course of another disease or condition.

soft tissue. Nonepithelial tissues outside of the skeleton that includes subcutaneous adipose tissue, fibrous tissue, fascia, muscles, blood and lymph vessels, and peripheral nervous system tissue.

subcutaneous tissue. Sheet or wide band of adipose (fat) and areolar connective tissue in two layers attached to the dermis.

suture. Numerous stitching techniques employed in wound closure.

buried suture. Continuous or interrupted suture placed under the skin for a layered closure.

continuous suture. Running stitch with tension evenly distributed across a single strand to provide a leakproof closure line.

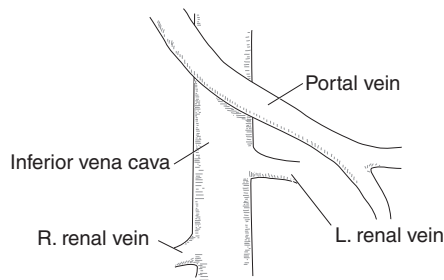
interrupted suture. Series of single stitches with tension isolated at each stitch, in which all stitches are not affected if one becomes loose, and the isolated sutures cannot act as a wick to transport an infection.

purse-string suture. Continuous suture placed around a tubular structure and tightened, to reduce or close the lumen.

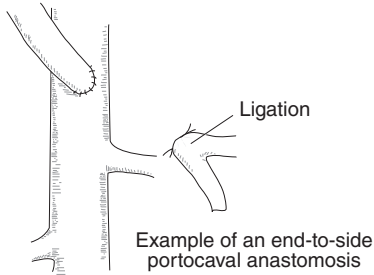
retention suture. Secondary stitching that bridges the primary suture, providing support for the primary repair; a plastic or rubber bolster may be placed over the primary repair and under the retention sutures.

37140

37140 Venous anastomosis, open; portocaval



Schematic of portocaval anatomy



Explanation

The physician performs portocaval venous anastomosis. The physician places a long right thoracoabdominal incision and exposes the liver. The physician exposes the inferior vena cava and portal vein through careful dissection. The physician places a plastic sling around the portal vein and ties it closed, just proximal to its bifurcation. The physician clamps and divides the portal vein. The physician applies a partial exclusion vascular clamp to the front of the vena cava and removes a small oval of tissue from the vena cava to allow end-to-side anastomosis of portal vein to the inferior vena cava. The physician removes the clamps and checks for appropriate flow without anastomotic leakage. The physician closes the incision, leaving a chest tube in place (but no abdominal drains, as this may lead to protein loss from postoperative drainage of ascites).

Coding Tips

When this code is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. An open venous anastomosis, reoportal, is reported with code 37145. For TIPS (percutaneous) procedure, see 37182. For peritoneal-venous shunt, see 49425.

ICD-10-CM Diagnostic Codes

- I81 Portal vein thrombosis
- I82.0 Budd-Chiari syndrome
- I85.11 Secondary esophageal varices with bleeding
- I87.1 Compression of vein
- K70.0 Alcoholic fatty liver
- K70.30 Alcoholic cirrhosis of liver without ascites
- K70.31 Alcoholic cirrhosis of liver with ascites
- K74.69 Other cirrhosis of liver
- K75.1 Phlebitis of portal vein
- K76.0 Fatty (change of) liver, not elsewhere classified
- K76.1 Chronic passive congestion of liver
- K76.3 Infarction of liver

- K76.5 Hepatic veno-occlusive disease
- K76.6 Portal hypertension
- K76.89 Other specified diseases of liver

AMA: 37140 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
37140	40.0	17.96	9.74	67.7
Facility RVU	Work	PE	MP	Total
37140	40.0	17.96	9.74	67.7

	FUD	Status	MUE	Modifiers			IOM Reference	
37140	90	A	1(2)	51	N/A	62*	N/A	None

* with documentation

Terms To Know

anastomosis. Surgically created connection between ducts, blood vessels, or bowel segments to allow flow from one to the other.

ascites. Abnormal accumulation of free fluid in the abdominal cavity, causing distention and tightness in addition to shortness of breath as the fluid accumulates. Ascites is usually an underlying disorder and can be a manifestation of any number of diseases.

bifurcated. Having two branches or divisions, such as the left pulmonary veins that split off from the left atrium to carry oxygenated blood away from the heart.

Budd-Chiari syndrome. Thrombus or other obstruction of the hepatic vein, with an enlarged liver, intractable ascites, portal hypertension, and the growth of extensive collateral vessels.

hepatic portal vein. Blood vessel that delivers unoxygenated blood from the gastrointestinal tract, spleen, pancreas, and gallbladder to the liver.

inferior. Located toward the feet or lower part of the body.

ligation. Tying off a blood vessel or duct with a suture or a soft, thin wire.

portal hypertension. Abnormally high blood pressure in the portal vein.

thrombosis. Condition arising from the presence or formation of blood clots within a blood vessel that may cause vascular obstruction and insufficient oxygenation.

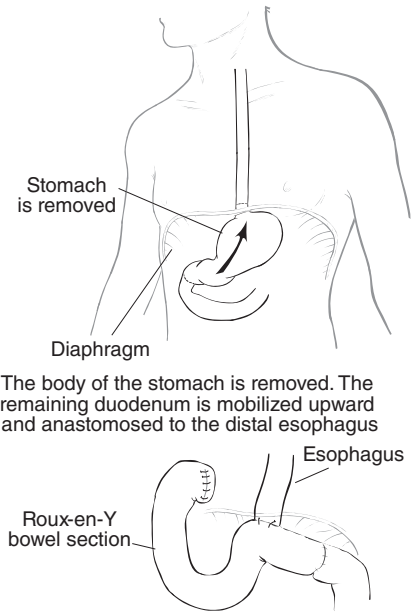
thrombus. Stationary blood clot inside a blood vessel.

varices. Enlarged, dilated, or twisted turning veins.

vena cava. Main venous trunk that empties into the right atrium from both the lower and upper regions, beginning at the junction of the common iliac veins inferiorly and the two brachiocephalic veins superiorly.

43620-43621

43620 Gastrectomy, total; with esophagoenterostomy
43621 with Roux-en-Y reconstruction



Explanation

The physician removes the stomach and approximates a limb of small bowel to the esophagus by performing an esophagoenterostomy in 43620 or a Roux-en-Y esophagojejunostomy in 43621. The physician makes a midline abdominal incision. The stomach is dissected free of surrounding structures and its blood supply is divided. The stomach is divided at the gastroesophageal junction and at the gastroduodenal junction and removed. In 43620, the remaining duodenal end of the intestine is simply mobilized to the end of the esophagus and connected. In 43621, a measured limb of Roux, or limb of small intestine, is created by dividing the upper jejunum. The distal part of the now divided upper jejunum, the limb in continuity with the ileum, is brought up and anastomosed to the esophagus. The proximal end of the divided jejunum, the segment containing the duodenum, must be connected back into the limb of small bowel farther down from the esophageal anastomosis. This maintains continuity for the duodenal section, which was sealed upon removal of the stomach, but which is also receiving bile from the liver and gallbladder as well as pancreatic juice.

Coding Tips

For total gastrectomy with formation of an intestinal pouch, any type, see 43622. For partial distal gastrectomy, with gastroduodenostomy, see 43631; with gastrojejunostomy, see 43632; with Roux-en-Y reconstruction, see 43633; with formation of a gastrointestinal pouch, see 43634.

ICD-10-CM Diagnostic Codes

- C16.0 Malignant neoplasm of cardia
- C16.1 Malignant neoplasm of fundus of stomach
- C16.2 Malignant neoplasm of body of stomach
- C16.3 Malignant neoplasm of pyloric antrum
- C16.4 Malignant neoplasm of pylorus
- C16.8 Malignant neoplasm of overlapping sites of stomach
- C78.89 Secondary malignant neoplasm of other digestive organs

- C7A.092 Malignant carcinoid tumor of the stomach
- D13.1 Benign neoplasm of stomach
- D37.1 Neoplasm of uncertain behavior of stomach
- D3A.092 Benign carcinoid tumor of the stomach
- D49.0 Neoplasm of unspecified behavior of digestive system
- K25.0 Acute gastric ulcer with hemorrhage
- K25.1 Acute gastric ulcer with perforation
- K25.2 Acute gastric ulcer with both hemorrhage and perforation
- K25.3 Acute gastric ulcer without hemorrhage or perforation
- K25.4 Chronic or unspecified gastric ulcer with hemorrhage
- K25.5 Chronic or unspecified gastric ulcer with perforation
- K25.6 Chronic or unspecified gastric ulcer with both hemorrhage and perforation
- K25.7 Chronic gastric ulcer without hemorrhage or perforation
- K27.0 Acute peptic ulcer, site unspecified, with hemorrhage
- K27.1 Acute peptic ulcer, site unspecified, with perforation
- K27.2 Acute peptic ulcer, site unspecified, with both hemorrhage and perforation
- K27.3 Acute peptic ulcer, site unspecified, without hemorrhage or perforation
- K27.4 Chronic or unspecified peptic ulcer, site unspecified, with hemorrhage
- K27.5 Chronic or unspecified peptic ulcer, site unspecified, with perforation
- K27.6 Chronic or unspecified peptic ulcer, site unspecified, with both hemorrhage and perforation
- K27.7 Chronic peptic ulcer, site unspecified, without hemorrhage or perforation
- K31.7 Polyp of stomach and duodenum
- S36.32XA Contusion of stomach, initial encounter
- S36.33XA Laceration of stomach, initial encounter
- S36.39XA Other injury of stomach, initial encounter

AMA: 43620 2014,Jan,11;2013,Jan,11-12 43621 2014,Jan,11;2013,Jan,11-12

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
43620	34.04	15.6	8.25	57.89
43621	39.53	17.32	9.37	66.22
Facility RVU	Work	PE	MP	Total
43620	34.04	15.6	8.25	57.89
43621	39.53	17.32	9.37	66.22

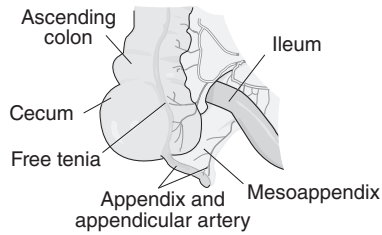
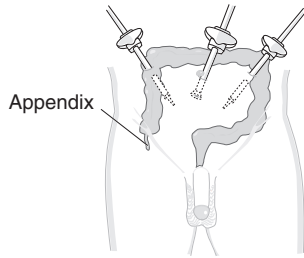
	FUD	Status	MUE	Modifiers			IOM Reference	
43620	90	A	1(2)	51	N/A	62*	80	None
43621	90	A	1(2)	51	N/A	62*	80	

* with documentation

44970

44970 Laparoscopy, surgical, appendectomy

Trocars deliver surgical instruments Laparoscope is inserted near the umbilicus



Explanation

The physician performs a laparoscopic appendectomy. The physician places a trocar at the umbilicus and insufflates the abdomen. The laparoscope is placed through the umbilical port and additional trocars are placed into the abdominal cavity. The appendix is identified, dissected from surrounding structures, and its blood supply divided. The appendix is transected with staples or suture and removed. The trocars are removed and the incisions are closed.

Coding Tips

Surgical laparoscopy always includes diagnostic laparoscopy. To report a diagnostic laparoscopy (peritoneoscopy) (separate procedure) only, see 49320. For open appendectomy, see 44950; when performed for an indicated purpose at the time of another major procedure (not as a separate procedure), see 44955; for a ruptured appendix with abscess or generalized peritonitis, see 44960.

ICD-10-CM Diagnostic Codes

- C18.1 Malignant neoplasm of appendix
- C78.5 Secondary malignant neoplasm of large intestine and rectum
- C7A.020 Malignant carcinoid tumor of the appendix
- D12.1 Benign neoplasm of appendix
- D37.3 Neoplasm of uncertain behavior of appendix
- K35.20 Acute appendicitis with generalized peritonitis, without abscess
- K35.21 Acute appendicitis with generalized peritonitis, with abscess
- K35.30 Acute appendicitis with localized peritonitis, without perforation or gangrene
- K35.31 Acute appendicitis with localized peritonitis and gangrene, without perforation
- K35.32 Acute appendicitis with perforation and localized peritonitis, without abscess
- K35.33 Acute appendicitis with perforation and localized peritonitis, with abscess
- K35.890 Other acute appendicitis without perforation or gangrene

- K35.891 Other acute appendicitis without perforation, with gangrene
- K36 Other appendicitis
- K38.0 Hyperplasia of appendix
- K38.1 Appendicular concretions
- K38.2 Diverticulum of appendix
- K38.3 Fistula of appendix
- K38.8 Other specified diseases of appendix
- R10.813 Right lower quadrant abdominal tenderness
- R10.823 Right lower quadrant rebound abdominal tenderness

AMA: 44970 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Mar,3; 2015,Jan,16; 2014,Jan,11; 2013,Jan,11-12; 2013,Dec,3

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
44970	9.45	5.82	2.22	17.49
Facility RVU	Work	PE	MP	Total
44970	9.45	5.82	2.22	17.49

	FUD	Status	MUE	Modifiers			IOM Reference	
44970	90	A	1(2)	51	N/A	62	80	None

* with documentation

Terms To Know

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation. Abscesses may be punctured or aspirated or the physician may perform an incision and drainage.

acute. Sudden, severe. Documentation and reporting of an acute condition is important to establishing medical necessity.

appendicitis. Inflammation and infection of the appendix. In the acute stage of the disease, common symptoms include severe pain in the right lower quadrant of the abdomen, nausea, and vomiting.

dissect. Cut apart or separate tissue for surgical purposes or for visual or microscopic study.

gangrene. Death of tissue, usually resulting from a loss of vascular supply, followed by a bacterial attack or onset of disease.

hyperplasia of appendix. Increase in the size and number of cells in the appendix.

insufflation. Blowing air or gas into a body cavity.

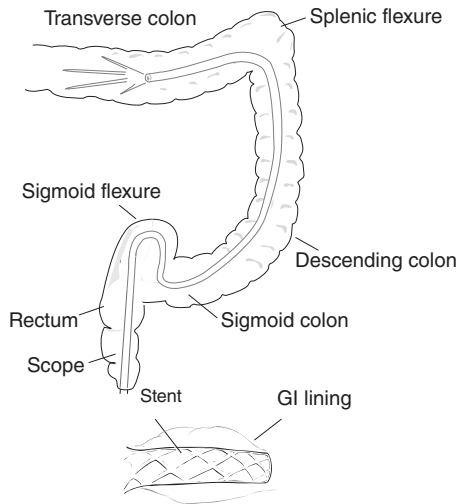
laparoscopy. Direct visualization of the peritoneal cavity, outer fallopian tubes, uterus, and ovaries utilizing a laparoscope, a thin, flexible fiberoptic tube.

neoplasm. New abnormal growth, tumor.

transection. Transverse dissection; to cut across a long axis; cross section.

45389

45389 Colonoscopy, flexible; with endoscopic stent placement (includes pre- and post-dilation and guide wire passage, when performed)



A colonoscopy session is performed with endoscopic stent placement, including pre- and postdilation

Explanation

The physician uses a colonoscope to examine the colon and place an endoscopic stent. The physician inserts the flexible endoscope into the anus and advances the scope through the colon to the cecum. The lumen of the colon is visualized. The endoscope is placed at the site of an obstruction or stricture and the necessary stent length is determined. If the area is partially occluded or obstructed, a balloon-tipped catheter is inserted through the scope and the balloon is inflated to dilate the area before stent placement. The stent (endoprosthesis) is introduced to the site of the lesion by a stent-carrying catheter inserted through the scope. The plastic covering over the stent is removed and the stent self-deploys, shoring-up the walls at the target site in the colon. When necessary, a balloon catheter is placed into the stent and gently inflated to more fully deploy the stent. The delivery system and endoscope are removed at the completion of the procedure. This code reports dilation before and after the procedure and utilization of a guidewire, if employed.

Coding Tips

Surgical endoscopy includes diagnostic endoscopy; however, diagnostic endoscopy can be identified separately when performed at the same surgical session as an open procedure. If fluoroscopic guidance is used, see 74360. Bleeding that occurs as the result of an endoscopic procedure, and controlled during the same operative session, is not reported separately. Do not report 45389 with 45378 or 45386.

ICD-10-CM Diagnostic Codes

- C17.2 Malignant neoplasm of ileum
- C18.0 Malignant neoplasm of cecum
- C18.1 Malignant neoplasm of appendix
- C18.2 Malignant neoplasm of ascending colon
- C18.3 Malignant neoplasm of hepatic flexure
- C18.4 Malignant neoplasm of transverse colon
- C18.5 Malignant neoplasm of splenic flexure
- C18.6 Malignant neoplasm of descending colon

- C18.7 Malignant neoplasm of sigmoid colon
- C18.8 Malignant neoplasm of overlapping sites of colon
- C19 Malignant neoplasm of rectosigmoid junction
- C20 Malignant neoplasm of rectum
- C78.4 Secondary malignant neoplasm of small intestine
- C7A.012 Malignant carcinoid tumor of the ileum
- C7A.020 Malignant carcinoid tumor of the appendix
- C7A.021 Malignant carcinoid tumor of the cecum
- C7A.022 Malignant carcinoid tumor of the ascending colon
- C7A.023 Malignant carcinoid tumor of the transverse colon
- C7A.024 Malignant carcinoid tumor of the descending colon
- C7A.025 Malignant carcinoid tumor of the sigmoid colon
- D49.0 Neoplasm of unspecified behavior of digestive system
- K50.012 Crohn's disease of small intestine with intestinal obstruction
- K50.112 Crohn's disease of large intestine with intestinal obstruction
- K50.812 Crohn's disease of both small and large intestine with intestinal obstruction
- K51.012 Ulcerative (chronic) pancolitis with intestinal obstruction
- K51.212 Ulcerative (chronic) proctitis with intestinal obstruction
- K51.312 Ulcerative (chronic) rectosigmoiditis with intestinal obstruction
- K51.412 Inflammatory polyps of colon with intestinal obstruction
- K51.512 Left sided colitis with intestinal obstruction
- K56.51 Intestinal adhesions [bands], with partial obstruction
- K56.52 Intestinal adhesions [bands] with complete obstruction
- K56.690 Other partial intestinal obstruction
- K56.691 Other complete intestinal obstruction
- K91.31 Postprocedural partial intestinal obstruction
- K91.32 Postprocedural complete intestinal obstruction
- Q42.0 Congenital absence, atresia and stenosis of rectum with fistula
- Q42.1 Congenital absence, atresia and stenosis of rectum without fistula

AMA: 45389 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Dec,3

Relative Value Units/Medicare Edits

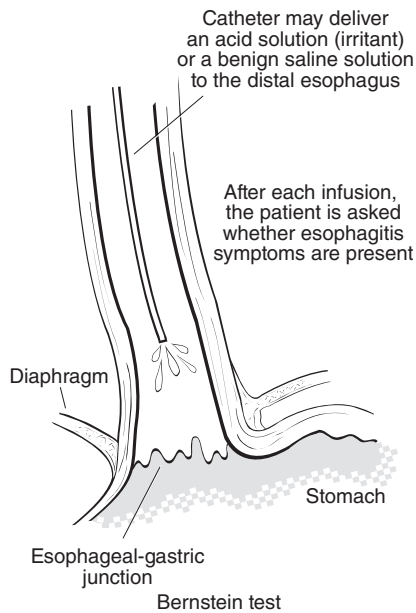
Non-Facility RVU	Work	PE	MP	Total
45389	5.24	2.53	0.6	8.37
Facility RVU	Work	PE	MP	Total
45389	5.24	2.53	0.6	8.37

	FUD	Status	MUE	Modifiers				IOM Reference
45389	0	A	1(3)	51	N/A	N/A	N/A	None

* with documentation

91030

91030 Esophagus, acid perfusion (Bernstein) test for esophagitis



Explanation

This code reports a provocative acid perfusion study, also called a Bernstein test, performed on the esophagus, not in conjunction with a motility test. The acid perfusion test is done to try and replicate atypical chest pain the patient has been experiencing and aid in diagnosing the pain as non-cardiac, or due to esophageal reflux/esophagitis. Both hydrochloric acid and an alternate saline control solution are infused one after the other via a nasogastric tube, without the patient being aware of the identity of the solution. The symptoms of chest pain are recorded as the patient identifies them.

Coding Tips

For esophagoscopy, see 43180 and 43191–43232. For an esophagogastroduodenoscopy, see 43210, 43233, 43235–43259, 43266, and 43270.

ICD-10-CM Diagnostic Codes

- K20.8 Other esophagitis
- K21.0 Gastro-esophageal reflux disease with esophagitis
- K21.9 Gastro-esophageal reflux disease without esophagitis
- K22.0 Achalasia of cardia
- K22.4 Dyskinesia of esophagus
- K22.5 Diverticulum of esophagus, acquired
- K22.70 Barrett's esophagus without dysplasia
- K22.710 Barrett's esophagus with low grade dysplasia
- K22.711 Barrett's esophagus with high grade dysplasia
- K22.8 Other specified diseases of esophagus
- R07.89 Other chest pain
- R12 Heartburn
- R13.11 Dysphagia, oral phase
- R13.12 Dysphagia, oropharyngeal phase
- R13.13 Dysphagia, pharyngeal phase
- R13.14 Dysphagia, pharyngoesophageal phase

R13.19 Other dysphagia

AMA: 91030 2018, Feb, 11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
91030	0.91	2.98	0.05	3.94
Facility RVU	Work	PE	MP	Total
91030	0.91	2.98	0.05	3.94

	FUD	Status	MUE	Modifiers				IOM Reference
91030	0	A	1(2)	N/A	N/A	N/A	80*	None

* with documentation

Terms To Know

achalasia. Failure of the smooth muscles within the gastrointestinal tract to relax at points of junction; most commonly referring to the esophagogastric sphincter's failure to relax when swallowing.

acute. Sudden, severe. Documentation and reporting of an acute condition is important to establishing medical necessity.

Barrett's esophagus. Complication of gastroesophageal reflux disease causing peptic ulcer and stricture in the lower part of the esophagus due to columnar epithelial cells from the lining of the stomach and intestine replacing the natural esophageal lining made of normal squamous cell epithelium. Barrett's esophagus is linked to an elevated risk of esophageal cancer, and is sometimes followed by esophageal adenocarcinoma.

Bernstein test. Acid perfusion test used to differentiate substernal chest pain due to gastroesophageal reflux disease (GERD).

dyskinesia of esophagus. Difficult or impaired voluntary muscle movement of the esophagus.

dysphagia. Difficulty and pain upon swallowing.

esophagitis. Inflammation of the esophagus.

esophagus. Muscular tube that carries swallowed liquids and foods from the pharynx to the stomach.

fistula. Abnormal tube-like passage between two body cavities or organs or from an organ to the outside surface.

reflux. Return or backward flow.

tracheoesophageal fistula. Abnormal opening between the trachea and the esophagus. There are three types of tracheoesophageal fistulas; congenital, formed from a previous tracheostomy, and fistula not caused by previous surgery.

tube. Long, hollow cylindrical instrument or body structure.

G0105, G0120-G0121

- G0105** Colorectal cancer screening; colonoscopy on individual at high risk
G0120 Colorectal cancer screening; alternative to G0105, screening colonoscopy, barium enema
G0121 Colorectal cancer screening; colonoscopy on individual not meeting criteria for high risk

Explanation

In G0105, a colonoscopy is performed on a high-risk patient for colorectal cancer screening. A high-risk patient is one with ulcerative enteritis or a history of malignant neoplasm of the lower gastrointestinal tract. After the patient's bowel has been prepped, the physician inserts the colonoscope through the anus and advances the scope through the colon past the splenic flexure. The lumen of the colon and rectum is visualized. Brushings or washings may be obtained. The colonoscope is withdrawn. In G0120, a colorectal screening for cancer is performed via barium enema as an alternative to a screening colonoscopy on a high-risk individual (G0105). This is a radiological exam of the large intestine carried out after the administration of a barium enema to instill the contrast medium into the colon. Fluoroscopy and x-rays are used to observe the images as the contrast fills the colon and helps the physician to diagnose cancer, even colitis, and other diseases. After the patient has emptied the colon, more films are taken. In G0121, a colonoscopy is performed for colorectal cancer screening on a patient who does not meet high-risk criteria. This would be a patient without a diagnosis of ulcerative enteritis or without a history of malignant neoplasm of the lower gastrointestinal tract.

Coding Tips

Medicare covers a screening colonoscopy for patients at average risk for colorectal cancer every 10 years, or for patients at high risk for colorectal cancer every three years. A high-risk patient is identified as a patient with a personal or family history of colorectal cancer or certain types of polyps, family history of hereditary colorectal cancer, or personal history of inflammatory bowel disease.

ICD-10-CM Diagnostic Codes

- K51.00 Ulcerative (chronic) pancolitis without complications
- K51.011 Ulcerative (chronic) pancolitis with rectal bleeding
- K51.012 Ulcerative (chronic) pancolitis with intestinal obstruction
- K51.013 Ulcerative (chronic) pancolitis with fistula
- K51.014 Ulcerative (chronic) pancolitis with abscess
- K51.018 Ulcerative (chronic) pancolitis with other complication
- K51.20 Ulcerative (chronic) proctitis without complications
- K51.211 Ulcerative (chronic) proctitis with rectal bleeding
- K51.212 Ulcerative (chronic) proctitis with intestinal obstruction
- K51.213 Ulcerative (chronic) proctitis with fistula
- K51.214 Ulcerative (chronic) proctitis with abscess
- K51.218 Ulcerative (chronic) proctitis with other complication
- K51.30 Ulcerative (chronic) rectosigmoiditis without complications
- K51.311 Ulcerative (chronic) rectosigmoiditis with rectal bleeding
- K51.312 Ulcerative (chronic) rectosigmoiditis with intestinal obstruction
- K51.313 Ulcerative (chronic) rectosigmoiditis with fistula
- K51.314 Ulcerative (chronic) rectosigmoiditis with abscess
- K51.318 Ulcerative (chronic) rectosigmoiditis with other complication
- K51.40 Inflammatory polyps of colon without complications
- K51.411 Inflammatory polyps of colon with rectal bleeding
- K51.412 Inflammatory polyps of colon with intestinal obstruction

- K51.413 Inflammatory polyps of colon with fistula
- K51.414 Inflammatory polyps of colon with abscess
- K51.418 Inflammatory polyps of colon with other complication
- K51.50 Left sided colitis without complications
- K51.511 Left sided colitis with rectal bleeding
- K51.512 Left sided colitis with intestinal obstruction
- K51.513 Left sided colitis with fistula
- K51.514 Left sided colitis with abscess
- K51.518 Left sided colitis with other complication
- K51.80 Other ulcerative colitis without complications
- K51.811 Other ulcerative colitis with rectal bleeding
- K51.812 Other ulcerative colitis with intestinal obstruction
- K51.813 Other ulcerative colitis with fistula
- K51.814 Other ulcerative colitis with abscess
- K51.818 Other ulcerative colitis with other complication
- K52.0 Gastroenteritis and colitis due to radiation
- K52.1 Toxic gastroenteritis and colitis
- K52.21 Food protein-induced enterocolitis syndrome
- K52.22 Food protein-induced enteropathy
- K52.29 Other allergic and dietetic gastroenteritis and colitis
- K52.3 Indeterminate colitis
- K52.81 Eosinophilic gastritis or gastroenteritis
- K52.82 Eosinophilic colitis
- K52.831 Collagenous colitis
- K52.832 Lymphocytic colitis
- K52.838 Other microscopic colitis
- K52.89 Other specified noninfective gastroenteritis and colitis
- K55.031 Focal (segmental) acute (reversible) ischemia of large intestine
- K55.032 Diffuse acute (reversible) ischemia of large intestine
- K55.039 Acute (reversible) ischemia of large intestine, extent unspecified
- K55.041 Focal (segmental) acute infarction of large intestine
- K55.042 Diffuse acute infarction of large intestine
- K55.1 Chronic vascular disorders of intestine
- Z12.11 Encounter for screening for malignant neoplasm of colon
- Z12.12 Encounter for screening for malignant neoplasm of rectum
- Z80.0 Family history of malignant neoplasm of digestive organs
- Z83.71 Family history of colonic polyps
- Z86.010 Personal history of colonic polyps

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
91035	1.59	12.0	0.12	13.71
Facility RVU	Work	PE	MP	Total
91035	1.59	12.0	0.12	13.71

91037-91038

91037 Esophageal function test, gastroesophageal reflux test with nasal catheter intraluminal impedance electrode(s) placement, recording, analysis and interpretation;

91038 prolonged (greater than 1 hour, up to 24 hours)

Explanation

The physician performs an esophageal function test with gastroesophageal reflux testing using nasal catheter intraluminal impedance electrode placement and recording. The patient fasts for a minimum of six hours. An impedance probe affixed to flexible nasal catheter tubing is inserted through the nose down to the lower esophageal sphincter following location of the lower sphincter by manometry. The impedance probe contains several electrodes that make up multiple measuring segments each 2 cm in length. The measuring segments are located at intervals above the proximal border of the lower esophageal sphincter. The patient is given a liquid or solid bolus to swallow. As the bolus passes through the esophagus, the average electrical resistance between two adjacent electrodes (impedance) is measured. The electrodes detect esophageal contraction and expansion and movement of the bolus through the esophagus in real time, as well as any gastroesophageal reflux. Esophageal function is evaluated by calculating the bolus transport time (BTT), which is the time it takes the bolus to pass from the proximal measuring segment and exit through the distal measuring segment. Contraction wave velocity (CWV), which is the speed of the contraction wave from the proximal measuring segment to the distal measuring segment, is also evaluated. This test is also referred to as multichannel intraluminal impedance testing or MII. Report 91037 for a recording of one hour or less. Report 91038 for prolonged recording of greater than one hour, up to 24 hours.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
91037	0.97	3.68	0.06	4.71
91038	1.1	11.29	0.06	12.45
Facility RVU	Work	PE	MP	Total
91037	0.97	3.68	0.06	4.71
91038	1.1	11.29	0.06	12.45

91040

91040 Esophageal balloon distension study, diagnostic, with provocation when performed

Explanation

The physician performs a diagnostic esophageal balloon distension study, including provocation, when performed, to evaluate chest pain of undetermined etiology that is suspected to be noncardiac in origin. The patient fasts for a minimum of six hours. A local anesthetic is sprayed into the patient's throat. With the patient in an upright position, a probe is passed through the mouth into the esophagus. The subject is placed supine with the head of the exam table elevated approximately 30 degrees. Manometric pressure recordings are obtained to identify the upper and lower esophageal sphincters. The probe is removed and the physician inserts a balloon into the esophagus. The balloon is moved along the esophagus and inflated multiple times to increasing diameters at selected sites in the esophagus in an attempt to provoke chest pain in the patient. Pain is measured by conscious perception or objective responses to the

stimuli. Perception of moderate to severe chest pain with low levels of balloon distension is considered to be positive for noncardiac chest pain.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
91040	0.97	13.34	0.09	14.4
Facility RVU	Work	PE	MP	Total
91040	0.97	13.34	0.09	14.4

92950

92950 Cardiopulmonary resuscitation (eg, in cardiac arrest)

Explanation

Cardiopulmonary arrest occurs when the patient's heart and lungs suddenly stop. In a clinical setting, cardiopulmonary resuscitation, the attempt at restarting the heart and lungs, is usually directed by a physician or another health care provider who is certified in Advanced Cardiac Life Support (ACLS). The patient's lungs are ventilated by mouth-to-mouth breathing or by a bag and mask. The patient's circulation is assisted using external chest compression. An electronic defibrillator may be used to shock the heart into restarting. Medications used to restart the heart include epinephrine and lidocaine.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
92950	4.0	4.77	0.39	9.16
Facility RVU	Work	PE	MP	Total
92950	4.0	0.97	0.39	5.36

93000-93010

93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report

93005 tracing only, without interpretation and report

93010 interpretation and report only

Explanation

Multiple electrodes are placed on a patient's chest to record the electrical activity of the heart. A physician interprets the findings. Report 93000 for the combined technical and professional components of an ECG; 93005 for the technical component only; and 93010 for the professional component only.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
93000	0.17	0.29	0.02	0.48
93005	0.0	0.23	0.01	0.24
93010	0.17	0.06	0.01	0.24
Facility RVU	Work	PE	MP	Total
93000	0.17	0.29	0.02	0.48
93005	0.0	0.23	0.01	0.24
93010	0.17	0.06	0.01	0.24

93040

93040 Rhythm ECG, 1-3 leads; with interpretation and report

Explanation

One to three electrodes placed on a patient's chest are used to record electrical activity of the heart. The physician interprets the report.