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**ICD-9-CM Procedural**

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**

23071 00300, 00400

23073 01610

23075 00300, 00400

23076 01610

**ICD-9-CM Diagnostic**

171.2 Malignant neoplasm of connective and other soft tissue of upper limb, including shoulder

173.69 Other specified malignant neoplasm of skin of upper limb, including shoulder

195.4 Malignant neoplasm of upper limb

198.89 Secondary malignant neoplasm of other specified sites

214.1 Lipoma of other skin and subcutaneous tissue

215.2 Other benign neoplasm of connective and other soft tissue of upper limb, including shoulder

228.01 Hemangioma of skin and subcutaneous tissue

238.1 Neoplasm of uncertain behavior of connective and other soft tissue

239.2 Neoplasms of unspecified nature of bone, soft tissue, and skin

728.82 Foreign body granuloma of muscle — (Use additional code to identify foreign body [V90.01-V90.9])

782.2 Localized superficial swelling, mass, or lump

**Coding Tips**

Codes 23071 and 23073 are resequenced codes and will not display in numeric order. When these codes are 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 radical resection of a tumor of the soft tissue of the shoulder area, see 23077. When medically necessary, report moderate (conscious) sedation provided by the performing physician with 99143-99145. When provided by another physician, report 99148-99150.

**Terms To Know**

**malignant neoplasm.** Any cancerous tumor or lesion exhibiting uncontrolled tissue growth that can progressively invade other parts of the body with its disease-generating cells.

**melanoma.** Highly metastatic malignant neoplasm composed of melanocytes that occur most often on the skin from a preexisting mole or nevus but may also occur in the mouth, esophagus, anal canal, or vagina.

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

**CCI Version 17.3**

01610, 02287, 02301, 10021-10022, 10060, 10140, 10160, 11010-11012, 11042-11044, 12001-12007, 12020-12037, 13100-13101, 13120-13121, 21303-21301, 23400, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 38525, 38550-38555, 38740-38745, 43752, 51701-51703, 62310-62319, 64400-64435, 64445-64450, 64479, 64483, 64490, 64493, 64505-64530, 69990, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96376, 97597, 99148-99149, 99150

Also not with 23071: 02137, 02167, 13132, 23000, 23065-23066, 23075, 38500-38505, J2001

Also not with 23073: 02137, 02167, 23000, 23065-23071, 23075-23076, 38500-38505, J2001

Also not with 23075: 13132, 23065-23066, 38500-38505, J0670, J2001

Also not with 23076: 11400, 11406, 11600-11606, 23000, 23065-23071, 23075, 38505, 64718

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

**Medicare Edits**

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**MUE**

**Modifiers**

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* with documentation

**Medicare References:** None
43239
43239  Upper gastrointestinal endoscopy including esophagus, stomach, and either the duodenum and/or jejunum as appropriate; with biopsy, single or multiple

Explanation
The physician examines the upper gastrointestinal tract for diagnostic purposes. The physician passes an endoscope through the patient’s mouth into the esophagus. The esophagus, stomach, duodenum, and sometimes the jejunum are viewed to determine if bleeding, tumors, erosions, ulcers, or other abnormalities are present. In 43239, single or multiple tissue samples are obtained for biopsy specimens using bite forceps through the endoscope.

45380
45380  Colonoscopy, flexible, proximal to splenic flexure; with biopsy, single or multiple

Explanation
The physician performs a colonoscopy and obtains tissue samples. The physician inserts the colonoscope into the anus and advances the scope past the splenic flexure. The lumen of the colon and rectum is visualized and biopsies are obtained. The colonoscope is withdrawn at the completion of the procedure.

52351
52351  Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic

Explanation
The physician examines the urinary collecting system for diagnostic purposes with endoscopes passed through the urethra into the bladder (cystourethroscopy), ureter (ureteroscopy), and renal pelvis (pyeloscopy). After examination, the physician removes the endoscopes.

53600-53601
53600  Dilation of urethral stricture by passage of sound or urethral dilator, male; initial
53601  subsequent

Explanation
A soft, rubbery urethral catheter is passed to locate a stricture. If a stricture is noted, a dilator is used to widen the urethra. Report 53600 for the first visit and 53601 for subsequent visits.

53620-53621
53620  Dilation of urethral stricture by passage of dilator and follower, male; initial
53621  subsequent

Explanation
The physician uses fine tools to dilate the male urethra. A dilator (a small, silk-like instrument with woven spiral tips, to which followers made of a similar material can be attached by a screw-like mechanism) is used when a stricture cannot be passed. With a dilator as a guide, the follower is passed through the urethra. Increasing sizes of followers are introduced, dilating the stricture. The dilator is manipulated up a lubricated urethra to the stricture. The physician attaches a follower to the dilator and the stricture is widened. Report 53621 for subsequent procedures.

53660-53665
53660  Dilation of female urethra including suppository and/or instillation; initial
53661  subsequent
53665  Dilation of female urethra, general or conduction (spinal) anesthesia

Explanation
The physician uses dilators of increasing size to widen the female urethra. A suppository or instillation of a saline solution may be used. Report 53660 for initial dilation, and 53661 for subsequent dilation. Use 53665 if general or spinal anesthesia is administered for dilation of female urethral stricture.

54830
54830  Excision of local lesion of epididymis

Explanation
The physician removes a local lesion of the epididymis by direct incision. The procedure is done under local or regional anesthesia. While the testis is held firmly with the scrotal skin stretched tightly over the testis and epididymis positioned just under the skin, a small incision is made through the skin of the scrotum. The underlying tissues are incised and dissected to expose the epididymis and the area of concern. The epididymis may be stabilized by two sutures placed on each side of the lesion and an ellipse of tissue is removed from the epididymis containing the lesion between the two sutures. The stabilizing sutures are tied across the excision site to close it. The scrotal incision is closed by suturing.

57020
57020  Colposcentesis (separate procedure)

Explanation
Colposcentesis is the aspiration of fluid in the peritoneum through the wall of the vagina. Through a speculum inserted in the vagina, the physician grasps the posterior lip of the cervix with a toothed instrument called a tenaculum. The cervix is lifted, exposing the posterior vaginal pouch and deep back wall of the vagina. A long needle attached to a syringe is inserted through the exposed vaginal wall and the posterior pelvic cavity is entered. Fluid is aspirated through the needle into the syringe.

57100

57410
57410  Pelvic examination under anesthesia (other than local)

Explanation
The physician performs a manual examination of the vagina, including the cervix, uterus, tubes, and ovaries. During the examination, the patient is under anesthesia (other than local) because of the patient’s inability to tolerate the procedure while fully alert or awake.

57420-57421
57420  Colposcopy of the entire vagina, with cervix if present;
57421  with biopsy(s) of vagina/cervix

Explanation
The physician performs a colposcopy of the vagina and the cervix, if present. The patient is placed in the lithotomy position and a speculum is inserted into the vagina. The vagina is inspected through the colposcope, a binocular microscope providing direct, magnified visualization of the vagina and cervix. The physician examines the tissue for discharge, inflammation, ulceration, and lesions. The cervix is exposed, cleansed, and inspected for any ulceration or lesions. Acetic acid may be applied to help enhance visualization of the columnar villi and any lesions. In 57421, the area is examined and questionable tissue is removed from the vagina and/cervix under direct visualization. The number and size of the biopsy(ies) is variable; multiple biopsies may be taken. Pressure is applied with a cotton swab as silver nitrate or other solution is applied with another applicator directly onto the biopsy site(s) for hemostasis. The instruments are removed.

57452
57452  Colposcopy of the cervix including upper/adjacent vagina;

Explanation
The physician examines the cervix, including the upper/adjacent portion of the vagina, through a colposcope, a binocular microscope used for direct visualization of the vagina, ectocervix, and endocervix. The physician may insert a speculum into the vagina to fully expose the cervix as part of this procedure.

59025
59025  Fetal non-stress test

Explanation
The physician evaluates fetal heart rate response to its own activity. The patient reports fetal movements as an external monitor records fetal heart rate changes. The procedure is noninvasive and takes 20 to 40 minutes to perform. If the fetus is not active, an acoustic device may be used to stimulate activity.
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 a 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 99221-99236 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, 99221-99223, 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}