Coding Companion for Oncology/Hematology

A comprehensive illustrated guide to coding and reimbursement
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one or more liver tumors, see 47380–47381.
If significant additional time and effort is
documented, append modifier 22 and submit
a cover letter and operative report.

ICD-9-CM Procedural
50.25 Laparoscopic ablation of liver lesion
or tissue

Anesthesia
00790

ICD-9-CM Diagnostic
155.0 Malignant neoplasm of liver, primary
155.2 Malignant neoplasm of liver, not
specified as primary or secondary
197.7 Secondary malignant neoplasm of liver

209.29 Malignant carcinoid tumor of other
sites — (Code first any associated
multiple endocrine neoplasia
syndrome: 258.01-258.03)(Use
additional code to identify associated
docrine syndrome, as: carcinoid
syndrome: 259.2)

209.30 Malignant poorly differentiated
neuroendocrine carcinoma, any site —
(Code first any associated multiple
endocrine neoplasia syndrome:
258.01-258.03)(Use additional code
to identify associated endocrine
syndrome, as: carcinoid syndrome:
259.2)

209.69 Benign carcinoid tumor of other sites —
(Code first any associated multiple
endocrine neoplasia syndrome:
258.01-258.03)(Use additional code
to identify associated endocrine
syndrome, as: carcinoid syndrome:
259.2)

209.72 Secondary neuroendocrine tumor of
liver

211.5 Benign neoplasm of liver and biliary
passages
230.8 Carcinoma in situ of liver and biliary
system
235.3 Neoplasm of uncertain behavior of
liver and biliary passages
239.0 Neoplasm of unspecified nature of
digestive system

Terms To Know
ablation. Removal or destruction of tissue
by cutting, electrical energy, chemical
substances, or excessive heat application.

adhesion. Abnormal fibrous connection
between two structures, soft tissue or bony
structures, that may occur as the result of
surgery, infection, or trauma.
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.
lesion. Area of damaged tissue that has lost
continuity or function, due to disease or
trauma.
omentum. Fold of peritoneal tissue
suspended between the stomach and
neighboring visceral organs of the abdominal
cavity.
viscera. Large interior organs enclosed
within a cavity, generally referring to the
abdominal organs.

CCI Version 18.3
0213T, 0216T, 0228T, 0230T, 12001-12007,
12011-12057, 13100-13153, 36000,
36400-36410, 36420-36430, 36440, 36600,
36640, 37202, 43653, 43752, 44005, 44180,
44450, 44970, 49203*, 49320, 50715,
51701-51703, 62310-62319, 64400-64435,
64445-64450, 64479, 64483, 64490, 64493,
64505-64530, 69990, 76000-76001, 76942,
76998, 77001-77002, 77012-77013,
77021-77022, 93000-93010, 93040-93042,
93318, 94002, 94200, 94250, 94680-94690,
94770, 95812-95816, 95819, 95822, 95829,
95955, 96360, 96365, 96372, 96374-96376,
99148-99149, 99150
Also not with 47370: 44602-44605
Also not with 47371: 47370*

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

Medicare Edits

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<th>Fac</th>
<th>RVU</th>
<th>Non-Fac</th>
<th>RUVE</th>
<th>FUD</th>
<th>Status</th>
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CCI Modifiers

| 47370 | 1 | 51 | N/A | 62* | 80 |
| 47371 | 1 | 51 | N/A | 62* | 80 |

* with documentation

Medicare References: None
Appendix

77014
77014  Computed tomography guidance for placement of radiation therapy fields

Explanation
Computed tomography (CT) is used in guiding the placement of radiation therapy fields. CT scanning directs multiple narrow beams of x-rays around 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 able to visualize soft tissue, as well as bones. Patients are required to remain motionless during the study. Cross-sectional images of both normal and abnormal tissue structures are obtained and the treatment field area volume is determined. The normal tissues surrounding the treatment area are also defined. Acquiring this data is an important step in planning the patient’s radiation treatment.

77055-77057
77055  Mammography; unilateral
77056  bilateral
77057  Screening mammography, bilateral (2-view film study of each breast)

Explanation
Mammography is a radiographic technique used to diagnose breast cysts or tumors in women with symptoms of breast disease or to detect them before they are palpable in women who are asymptomatic. Mammography is done using a different type of x-ray than is used for routine exams that do not penetrate tissue as easily. The breast is compressed firmly between two planes and pictures are taken. This spreads the tissue and allows for a lower x-ray dose. Use 77055 for a single breast and 77056 for both breasts. Report 77057 for both breasts done in an asymmetric screening with two views taken of each breast.

77058-77059
77058  Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral
77059  bilateral

Explanation
Magnetic resonance imaging (MRI) is a radiation-free, noninvasive technique to produce high-quality sectional images of the inside of the body in multiple planes. MRI uses the natural magnetic properties of the hydrogen atoms in our bodies that emit radiofrequency signals when exposed to radio waves within a strong electromagnetic field. These signals are processed and converted by the computer into high-resolution, three-dimensional, tomographic images. Patients with metallic or electronic implants or foreign bodies cannot be exposed to MRI. The patient must remain still while lying on a motorized table within the large, circular MRI tunnel. A sedative may be administered, as well as an IV injected contrast material for image enhancement. Report 77058 for magnetic resonance imaging of the left or right breast and 77059 for both breasts.

77074-77075
77074  Radiologic examination, osseous survey; limited (eg, for metastases)
77075  complete (axial and appendicular skeleton)

Explanation
Various bones in the body are x-rayed. A limited study is reported (77074) when specific symptomatic sites are examined. This procedure is rarely performed to determine any spread of cancer, having been replaced by nuclear bone scanning, a more precise study for diagnosing metastases. A complete study (77075) is when the axial (head and trunk) and appendicular (extremities) skeleton is surveyed for evidence of metastatic disease. It may also be performed on children to identify current and/or old healed fractures in the case of suspected child abuse. This procedure is rarely performed for metastatic disease, having been replaced by nuclear bone scanning, a more precise study for diagnosing metastases.

77421
77421  Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy

Explanation
Radiation treatment delivery involves the transfer of a beam of radioactive electromagnetic energy from a treatment machine distanced from the treatment area. Stereotactic body radiation therapy is a radiation therapy technique designed to deliver a large radiation dose to discrete tumor sites in the lungs, liver, brain, or elsewhere while minimizing damage to healthy tissue. Stereoscopic x-ray guidance utilizes infrared and/or camera technology to precisely localize targets in conjunction with intensity modulated radiation therapy and stereotactic radiotherapy. This code reports the stereoscopic x-ray guidance only.

77422-77423
77422  High energy neutron radiation treatment delivery; single treatment area using a single port or parallel-opposed ports with or no blocks or simple blocking
77423  1 or more isocenter(s) with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s).

Explanation
External beam radiotherapy is radiation delivered from a distant source outside the body and directed at the patient’s cancer site. High-energy neutron radiotherapy destroys the cells ability to divide and grow by damaging the cells through nuclear interactions, which decreases the damaged cells chances of repairing themselves. Since high-energy neutron radiotherapy works in the absence of oxygen, unlike conventional radiation therapy, it is used to treat larger tumors and is particularly effective in treating inoperable salivary gland tumors, bone cancers, and certain types of advanced malignancies of the pancreas, bladder, lung, prostate, and uterus. Due to the high potency of neutron radiation, the required dose is much less than with conventional radiotherapy, and a full course may be delivered in 10 to 12 treatments rather than the usual 30 to 40. Report 77422 for a single treatment area using a single port or parallel-opposed ports with no blocks or simple blocking. Report 77423 for treatment of one or more isocenters with coplanar or non-coplanar geometry with blocking and/or wedge, and/or compensator(s).

78102-78104
78102  Bone marrow imaging; limited area
78103  multiple areas
78104  whole body

Explanation
Radiolabeled sulphur colloid is the most commonly used radiopharmaceutical for bone marrow imaging. The radiotracer is injected into the patient and images are obtained after a two- or three-hour delay for optimal evaluation. A special camera, called a scintillation or gamma camera, takes planar images of the study area on computer screen or film by detecting the gamma radiation from the radionuclide that has traveled to the bone marrow as it "scintillates" or gives off energy in a flash of light when coming in contact with the camera's detector. The bone marrow scan provides information about the distribution of functioning bone marrow and any irregular pattern of marrow tissue expansion occurring in different clinical states such as malignancy or infection. Report 78102 for bone marrow imaging of a limited area; 78103 for multiple areas; and 78104 for whole body imaging.

78191
78191  Platelet survival study

Explanation
Once released from the bone marrow, platelets normally circulate in the blood for eight to 10 days. In patients with certain types of chronic disease such as immune thrombocytopenic purpura (chronic ITP), an autoimmune disorder in which patients produce platelet autoantibodies that destroy blood platelets, the platelet survival time is shortened due to their destruction by the autoantibodies. The patient develops a low platelet count (thrombocytopenia). For the procedure, blood is withdrawn from the patient, the platelets are separated and labeled with Indium-111, and reinjected intravenously. Samples are withdrawn at intervals and the platelet levels recorded until a certain level of tagged platelets are left in circulation.
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 $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.

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group (see paragraphs 2 and 3 under “Instructions for Use of the CPT Codebook” on page x 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).

The use of the phrase “physician or other qualified health care professional” (QHCP) was adopted to identify a health care provider other than a physician. This type of provider is further described in CPT as an individual “qualified by education, training, licensure/registration (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 specific 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:

- 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 covering for another physician or other qualified health care provider, the patient's encounter is classified as it would have been 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 physician or other qualified health care provider may not bill a new