Coders' Desk
Reference for Procedures

2013
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Discussion of contradictory or unexpected test results with the physician who performed or interpreted the test is an indication of the complexity of data being reviewed. On occasion the physician who ordered a test may personally review the image, tracing, or specimen to supplement information from the physician who prepared the test report or interpretation; this is another indication of the complexity of data being reviewed.

For additional information, review the section "Medical Decision Making."

Assessing Risk

The risk of significant complications, morbidity, and/or mortality is based on the risks associated with the presenting problem, the diagnostic procedure, and the possible management options:

- Comorbidities/underlying disease or other factors that increase the complexity of medical decision making by increasing the risk of complications, morbidity, and/or mortality should be documented.
- If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure (e.g., laparoscopy) should be documented.
- If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the specific procedure should be documented. The referral for or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

The accompanying table may be used to help determine whether the risk of significant complications, morbidity, and/or mortality is minimal, low, moderate, or high. Since risk is complex and not readily quantifiable, the table includes common clinical examples rather than absolute measures of risk. Keep in mind the following:

- The assessment of risk of the presenting problem is based on the risk related to the disease process anticipated between the present encounter and the next one.
- The assessment of risk of selecting diagnostic procedures and management options is based on the risk during and immediately following any procedures or treatment.
- The highest level of risk in any one category (presenting problem, diagnostic procedure, or management options) determines the overall risk.

<table>
<thead>
<tr>
<th>Level of Risk</th>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>One self-limited or minor problem, e.g., cold, insect bite, tinea corporis</td>
<td>Laboratory tests requiring venipuncture, Chest x-rays, EKG/EEG, Urinalysis, Ultrasound, e.g., echocardiography, KOH prep</td>
<td>Rest, Gargles, Elastic bandages, Superficial dressings</td>
</tr>
<tr>
<td>Low</td>
<td>Two or more self-limited or minor problems, One stable chronic illness, e.g., well controlled hypertension, Type II diabetes, cataract, BPH, Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain</td>
<td>Physiologic tests not under stress, e.g., pulmonary function tests, Non-cardiovascular imaging studies with contrast, e.g., barium enema, Superficial needle biopsies, Clinical laboratory tests requiring arterial puncture, Skin biopsies</td>
<td>Over-the-counter drugs, Minor surgery with no identified risk factors, Physical therapy, Occupational therapy, IV fluids without additives</td>
</tr>
</tbody>
</table>
### Using E/M Codes

**Level of Risk**

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>Diagnostic Procedure(s) Ordered</th>
<th>Management Options Selected</th>
</tr>
</thead>
</table>
| Moderate • One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment  
  • Two or more stable chronic illnesses 
  • Undiagnosed new problem with uncertain prognosis, e.g., lump in breast 
  • Acute illness with systemic symptoms, e.g., pyleonephritis, pneumonitis, colitis 
  • Acute complicated injury, e.g., head injury with brief loss of consciousness | Physiologic tests under stress, e.g., cardiac stress test, lethal contraction stress test 
  • Diagnostic endoscopies with no identified risk factors 
  • Deep needle or incisional biopsy 
  • Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization 
  • Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis 
  • Minor surgery with identified risk factors | Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors 
  • Prescription drug management 
  • Therapeutic nuclear medicine 
  • IV fluids with additives 
  • Closed treatment of fracture or dislocation without manipulation |
| High • One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment  
  • Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure  
  • An abrupt change in neurologic status, e.g., seizure, TIA, weakness, sensory loss | Cardiovascular imaging studies with contrast with identified risk factors 
  • Cardiac electrophysiological tests 
  • Diagnostic endoscopies with identified risk factors 
  • Discography | Elective major surgery (open, percutaneous or endoscopic) with identified risk factors 
  • Emergency major surgery (open, percutaneous or endoscopic) 
  • Parenteral controlled substances 
  • Drug therapy requiring intensive monitoring for toxicity 
  • Decision not to resuscitate or to de-escalate care because of poor prognosis |

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**Coders' Desk Reference for Procedures**
Circulatory System: Arterial
Arteries carry oxygen-rich blood from the lungs to the extremities.

Arteries (left) are usually accompanied by at least one vein.

Schematic of a capillary bed containing arterioles, the smallest type of artery.

Arteries (right) are usually accompanied by at least one vein.

Major arteries of the head and neck

Major arteries of the arm

Major arteries of the leg

The great vessels
35612
Through incisions in the skin at the base of the neck, the physician isolates and dissects the subclavian arteries, separating them from adjacent critical structures. The physician creates a bypass around a section of subclavian artery that is damaged or blocked, using a synthetic vein and one of two methods of repair. Once vessel clamps have been affixed above and below the defect, the ends of the synthetic vein graft are sutured into the sides of the walls of the two subclavian arteries, resulting in a bypass of the damaged area. In the second method, the subclavian artery may be cut through beyond the damaged area and sutured to one end of a synthetic vein, which is sutured to the subclavian artery on the opposite side of the neck. In either case, the blocked or damaged portion of the artery is not removed. When the clamps are removed, the section of synthetic vein graft forms a new path through which blood can easily bypass the blocked area. After the graft is complete, the skin incisions are repaired with a layered closure.

35616
Through an incision in the skin at the base of the neck and axilla, the physician isolates and dissects the subclavian and axillary arteries, separating them from adjacent critical structures. The physician creates a bypass around a section of subclavian artery that is damaged or blocked, using a synthetic vein and one of two methods of repair. Once vessel clamps have been affixed above and below the defect, the ends of the synthetic vein are sutured into the sides of the subclavian and axillary arterial walls resulting in a bypass of the damaged area (end-to-side). In the second method, the subclavian artery may be cut through before the damaged area and sutured to one end of a synthetic vein, which is sutured to the axillary artery (end-to-end). The blocked or damaged portion of the subclavian artery is not removed. When the clamps are removed, the section of synthetic vein graft forms a new path through which blood can easily bypass the blocked area. After the graft is complete, the skin incisions are repaired with a layered closure.

35621
The physician makes incisions in the skin of the axilla and upper thigh. The artery is isolated and dissected from adjacent critical structures. The physician creates a bypass around a section of lower aorta or iliac artery that is damaged or blocked using a synthetic vein and one of two methods of repair. Once vessel clamps have been affixed above and below the areas of anastomosis, the synthetic vein is sutured to an incision in the side of the axillary artery and passed through a subcutaneous tunnel on the side of the body and behind the knee or upper thigh. The synthetic vein is sutured to the popliteal or tibial artery in an end-to-side or end-to-end fashion. The blocked or damaged portion of lower aorta or iliac artery is not removed. When the clamps are removed, the section of synthetic vein graft forms a new path through which blood can easily bypass the blocked area. After the graft is complete, the skin incisions are repaired with layered closures.

35626
The physician exposes the aorta by median sternotomy and exposes the aortocoronary, aortoinnominate, or aortosubclavian artery, extending this incision in the appropriate direction. The physician clamps the middle part of the right anterolateral aspect of the anterior ascending aorta with a J clamp. The physician makes a 2 cm to 3 cm longitudinal incision in the clamped portion of the aorta and sews the arterial or synthetic graft to the aortic incision. The physician clamps the graft and releases the aortic clamp to assess the anastomosis for leaks. The physician clamps the distal end of the diseased artery. The physician makes a longitudinal incision in the diseased artery, distal to the blockage, and sews the graft to the arterial incision. The physician may also use graft material to enlarge the arterial lumen (patch graft). The physician removes the clamp from the graft. The physician may perform arteriography or use a Doppler probe to establish patency of the graft. The physician closes the sternotomy or thoracotomy, leaving a chest tube in place.

35631
The physician exposes the involved mesenteric or celiac artery using an upper midline abdominal incision, retracting and dissecting past large and small bowel. The physician exposes the distal thoracic aorta, administers heparin for anticoagulation, and clamps the aorta both proximal and distal to the celiac axis origin. The physician cuts out an elliptical disk of aortic wall from the anterior surface of the aorta. The physician exposes the involved vessel (mesenteric or celiac artery) and divides it proximal to the occlusion,