Coding Companion for Oncology/Hematology

A comprehensive illustrated guide to coding and reimbursement

2013
Contents

Getting Started with Coding Companion ...........................................i
General/Integumentary ....................................................................1
Musculoskeletal ............................................................................36
Respiratory ..................................................................................110
Cardiovascular .............................................................................140
Hemic/Lymphatic .........................................................................164
Mediastinum ................................................................................195
Digestive ......................................................................................199
Urinary .........................................................................................292
Male Genital ................................................................................316
Reproductive ..................................................................................331
Female Genital .............................................................................332
Endocrine ....................................................................................368
Nervous .......................................................................................373
Radiation Oncology .....................................................................378
Nuclear Medicine .........................................................................414
Chemotherapy ..............................................................................417
Appendix .......................................................................................427
Evaluation and Management Codes ...........................................453
Index ............................................................................................473
**48100-48102**

**48100** Biopsy of pancreas, open (eg, fine needle aspiration, needle core biopsy, wedge biopsy)

**48102** Biopsy of pancreas, percutaneous needle

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**Explanation**

In 48100, the physician obtains a biopsy of the pancreas. The physician makes a midline epigastric incision and retracts the skin and underlying tissues laterally. The physician approaches the pancreas through the lesser sac of the omental bursa. The pancreas is palpated, the lesion is identified, and a biopsy is obtained by various methods, such as fine needle aspiration or needle core or wedge biopsy. Bleeding is controlled and the lesser sac is closed. Tissues are reaproximated to the anatomical position and the incision is sutured in layers. In 48102, the physician percutaneously biopsies tissue from the pancreas. The physician passes the biopsy needle through the skin of the upper abdomen under separately reportable computerized tomography guidance. The pancreatic lesion is removed and the specimen is sent for pathology for examination (reported separately).

**Coding Tips**

An excisional biopsy is not reported separately when a therapeutic excision is performed during the same surgical session.

**ICD-9-CM Procedural**

52.11 Closed (aspiration) (needle) (percutaneous) biopsy of pancreas

52.12 Open biopsy of pancreas

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**Anesthesia**

48100 00790

48102 00700

**ICD-9-CM Diagnostic**

157.0 Malignant neoplasm of head of pancreas

157.1 Malignant neoplasm of body of pancreas

157.2 Malignant neoplasm of tail of pancreas

157.3 Malignant neoplasm of pancreatic duct

157.4 Malignant neoplasm of islets of Langerhans — (Use additional code to identify any functional activity)

157.8 Malignant neoplasm of other specified sites of pancreas

157.9 Malignant neoplasm of pancreas, part unspecified

179.5 Secondary malignant neoplasm of liver

197.8 Secondary malignant neoplasm of other digestive organs and spleen

197.9 Malignant carcioid tumor of other sites — (Use additional code to identify associated endocrine neoplasia syndrome. Use of a knife or needle to pierce a fluid-filled cavity and then withdraw the fluid using a syringe or suction device.

**Medicare Edits**

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**MUE**

Medicare References: None
77014

Computed tomography guidance for placement of radiation therapy fields

Explanation
Computed tomography (CT) is used to guide 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 asymptomatic 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 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
Radionabeled 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.
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.

### 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 the 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 99234-99236 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, 99221-99233, 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