Optum

Coding Companion

General Surgery/ Gastroenterology

A comprehensive illustrated guide to coding and reimbursement

SAMPLE

2025

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Contents

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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/HCPCS 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/HCPCS 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 Optum *Coding Companion* series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

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/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT/HCPCS code description, followed by an easy-to-understand explanation.

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

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

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

CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* 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 version 29.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2025 edition password is: **XXXXXX.** Log in frequently to ensure you receive the most current updates.

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:

47600 Cholecystectomy;

could be found in the index under the following main terms:

Cholecystectomy
Open Approach, 47600-47620

or **Excision**
Gallbladder
Open, 47600-47620

or **Gallbladder**
Cholecystectomy, 47600

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 xv 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.

Sample Page and Key

The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

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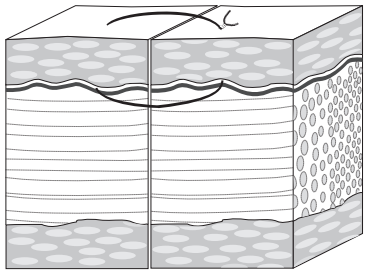
12011-12018

1

12011 Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12013 2.6 cm to 5.0 cm
12014 5.1 cm to 7.5 cm
12015 7.6 cm to 12.5 cm
12016 12.6 cm to 20.0 cm
12017 20.1 cm to 30.0 cm
12018 over 30.0 cm

2



Simple (single layer) repair

Explanation

3

Superficial wounds located on the face, ears, eyelids, nose, lips, and/or mucous membranes are repaired. A local anesthetic is injected around the laceration and the wound is cleansed, explored, and often irrigated with a saline solution. The physician performs a simple, one-layer repair of the epidermis, dermis, or subcutaneous tissue with sutures. With multiple wounds of the same complexity and in the same anatomical area, the length of all wounds sutured is summed and reported as one total length. Report 12011 for a total length of 2.5 cm or less; 12013 for 2.6 cm to 5 cm; 12014 for 5.1 cm to 7.5 cm; 12015 for 7.6 cm to 12.5 cm; 12016 for 12.6 cm to 20 cm; 12017 for 20.1 cm to 30 cm; and 12018 if the total length is greater than 30 cm.

Coding Tips

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Wounds treated with tissue glue or staples qualify as a simple repair even if they are not closed with sutures. When chemical cauterization, electrocauterization, or adhesive strips are the only material used for wound closure, the service is included in the appropriate E/M code. Anesthesia (local or topical) and hemostasis are not reported separately. Suture removal is included in these procedures. Intermediate repair is used when layered closure of one or more of the deeper layers of subcutaneous tissue and superficial fascia are required in addition to limited undermining. Single-layer closure of a wound requiring extensive cleaning or removal of contaminated foreign matter or damaged tissue is classified as an intermediate repair. For extensive debridement of soft tissue and/or bone, not associated with open fractures and/or dislocations, resulting from penetrating and/or blunt trauma, see 11042–11047. For wound closure by tissue adhesive(s) only, see HCPCS Level II code G0168. 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

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S00.471A Other superficial bite of right ear, initial encounter ☑
S00.511A Abrasion of lip, initial encounter
S00.512A Abrasion of oral cavity, initial encounter
S00.571A Other superficial bite of lip, initial encounter
S00.572A Other superficial bite of oral cavity, initial encounter
S01.111A Laceration without foreign body of right eyelid and periocular area, initial encounter ☑
S01.121A Laceration with foreign body of right eyelid and periocular area, initial encounter ☑

Associated HCPCS Codes

6

G0168 Wound closure utilizing tissue adhesive(s) only

AMA: 7
12011 2023,Aug; 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12013** 2023,Aug; 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12014** 2023,Aug; 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12015** 2023,Aug; 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12016** 2023,Aug; 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12017** 2023,Aug; 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12018** 2023,Aug; 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep

Relative Value Units/Medicare Edits

8

Non-Facility RVU	Work	PE	MP	Total
12011	1.07	2.11	0.2	3.38
12013	1.22	2.07	0.25	3.54
12014	1.57	2.43	0.3	4.3
12015	1.98	2.82	0.38	5.18
12016	2.68	3.41	0.51	6.6
12017	3.18	0.73	0.66	4.57
12018	3.61	0.8	0.75	5.16

Facility RVU	Work	PE	MP	Total
12011	1.07	0.37	0.2	1.64
12013	1.22	0.27	0.25	1.74
12014	1.57	0.35	0.3	2.22
12015	1.98	0.44	0.38	2.8
12016	2.68	0.61	0.51	3.8
12017	3.18	0.73	0.66	4.57
12018	3.61	0.8	0.75	5.16

	FUD	Status	MUE	Modifiers				IOM Reference
12011	0	A	1(2)	51	N/A	N/A	N/A	None
12013	0	A	1(2)	51	N/A	N/A	N/A	
12014	0	A	1(2)	51	N/A	N/A	N/A	
12015	0	A	1(2)	51	N/A	N/A	N/A	
12016	0	A	1(2)	51	N/A	N/A	N/A	
12017	0	A	1(2)	51	N/A	N/A	80*	
12018	0	A	1(2)	51	N/A	N/A	80	

* with documentation

Terms To Know

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dermis. Skin layer found under the epidermis that contains a papillary upper layer and the deep reticular layer of collagen, vascular bed, and nerves.

epidermis. Outermost, nonvascular layer of skin that contains four to five differentiated layers depending on its body location: stratum corneum, lucidum, granulosum, spinosum, and basale.

repair. Surgical closure of a wound. The wound may be a result of injury/trauma or it may be a surgically created defect. Repairs are divided into three categories: simple, intermediate, and complex.

subcutaneous. Below the skin.

superficial. On the skin surface or near the surface of any involved structure or field of interest.

wound. Injury to living tissue often involving a cut or break in the skin.

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1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2024.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2024.
- ▲ This CPT code description is revised for 2024.
- ✚ This CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.

The Centers for Medicare and Medicaid Services (CMS) have identified services that may be performed via telehealth. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 93 or 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services, when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
97802	97803	97804	99406	99407	99408	99409
99497	99498					

2. Illustrations

The illustrations that accompany the *Coding Companion* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most pages will have an illustration, there will be some pages that do not.

3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes the most common method of performing each procedure.

4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

6. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

7. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2023.

The 2024 Medicare edits were not available at the time this book went to press. Updated 2024 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2025 edition password is **XXXXXX**.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs

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Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

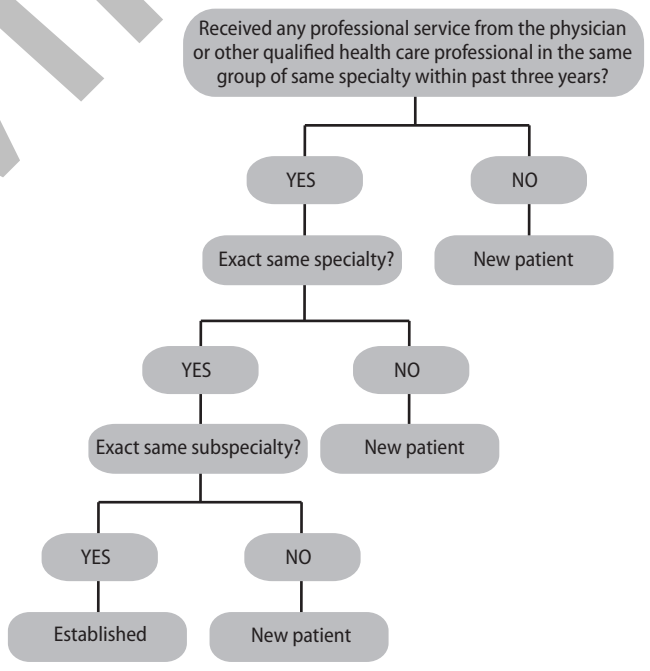
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or

AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

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▶ ◀ = Contains new or revised text

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99202-99205

▲★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

▲★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

▲★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

▲★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, a total time of 15 minutes must be met or exceeded on the day of the encounter. Report 99203 for a visit requiring a low level of MDM or meeting or exceeding 30 minutes of total time; 99204 for a visit requiring a moderate level of MDM or meeting or exceeding 45 minutes of total time; and 99205 for a visit requiring a high level of MDM or meeting or exceeding 60 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternatively, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. Medicare and the CPT codebook have identified these codes as telehealth/telemedicine services. Telemedicine services may be reported by the performing provider by adding modifier 95 to the procedure code and/or using the appropriate place of service (POS) indicator; POS 02 for telehealth when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. For prolonged services applicable to 99205, see 99417; for Medicare, see G2212. Medicare and commercial payers should be contacted regarding their coverage guidelines. For office or other outpatient services for an established patient, see 99211-99215.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99203** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99204** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99205** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.14	0.08	2.15
99203	1.6	1.56	0.17	3.33
99204	2.6	2.11	0.23	4.94
99205	3.5	2.71	0.31	6.52
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.08	1.42
99203	1.6	0.68	0.17	2.45
99204	2.6	1.11	0.23	3.94
99205	3.5	1.54	0.31	5.35

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	100-04,11,40.1.3; 100-04,12,30.6.4; 100-04,12,30.6.10; 100-04,12,190.7; 100-04,12,230; 100-04,12,230.1; 100-04,18,80.2; 100-04,32,12.1
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

SAMPLE

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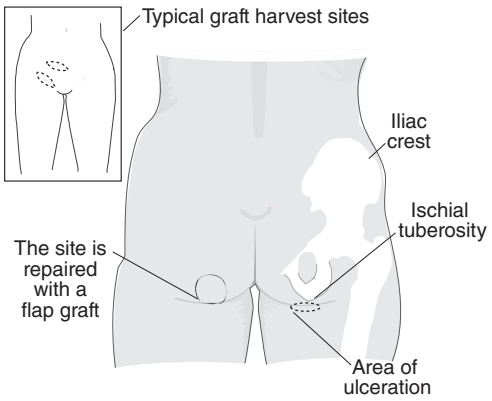
15944-15945

15944 Excision, ischial pressure ulcer, with skin flap closure;
15945 with ostectomy



A pressure ulcer caused by the ischial tuberosity is excised and repaired with a flap graft

Explanation

The physician excises an ischial pressure ulcer, with skin flap closure. An incision is made around the wound over the ischial tuberosity in order to remove the infected pressure sore. The infected tissue is removed; however, the wound is large enough to require a flap of skin from another part of the body, such as the groin area at the front of the hip, to completely close the area. The physician makes an appropriate size flap from the donor area and sutures it in place following the removal of the infected tissue. The donor site is sutured closed and soft dressings are used to cover the wounds. Report 15945 if a portion of bone from the ischium is removed before the wound is closed with the flap.

Coding Tips

For excision of an ischial pressure ulcer with primary suture repair, see 15940–15941. For excision of an ischial pressure ulcer in preparation for muscle or myocutaneous flap or skin graft closure, see 15946. For excision of a sacral pressure ulcer with primary suture, see 15931; with skin flap closure, see 15934. For excision of a coccygeal pressure ulcer, with flap closure, see 15922.

ICD-10-CM Diagnostic Codes

L89.310 Pressure ulcer of right buttock, unstageable ☑
L89.313 Pressure ulcer of right buttock, stage 3 ☑
L89.314 Pressure ulcer of right buttock, stage 4 ☑
L89.316 Pressure-induced deep tissue damage of right buttock ☑
L89.320 Pressure ulcer of left buttock, unstageable ☑
L89.323 Pressure ulcer of left buttock, stage 3 ☑
L89.324 Pressure ulcer of left buttock, stage 4 ☑
L89.326 Pressure-induced deep tissue damage of left buttock ☑
L89.43 Pressure ulcer of contiguous site of back, buttock and hip, stage 3
L89.44 Pressure ulcer of contiguous site of back, buttock and hip, stage 4
L89.45 Pressure ulcer of contiguous site of back, buttock and hip, unstageable
L89.46 Pressure-induced deep tissue damage of contiguous site of back, buttock and hip

AMA: **15944** 2022,Feb; 2021,Aug **15945** 2022,Feb; 2021,Aug

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
15944	12.44	13.33	2.25	28.02
15945	13.75	14.33	2.48	30.56
Facility RVU	**Work**	**PE**	**MP**	**Total**
15944	12.44	13.33	2.25	28.02
15945	13.75	14.33	2.48	30.56

	FUD	Status	MUE	Modifiers				IOM Reference
15944	90	A	2(3)	51	N/A	N/A	80*	None
15945	90	A	2(3)	51	N/A	N/A	80*	

* with documentation

Terms To Know

chronic. Persistent, continuing, or recurring.

decubitus ulcer. Progressively eroding skin lesion produced by inflamed necrotic tissue as it sloughs off caused by continual pressure to a localized area, especially over bony areas, where blood circulation is cut off when a patient lies still for too long without changing position.

excision. Surgical removal of an organ or tissue.

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

incision. Act of cutting into tissue or an organ.

infection. Presence of microorganisms in body tissues that may result in cellular damage.

ischial tuberosity. Bony projection of the lower end of the ischium easily identified as the weight-bearing point in a sitting position.

ostectomy. Excision of bone.

pressure ulcers. Progressively eroding skin lesion produced by inflamed necrotic tissue as it sloughs off, caused by continual pressure impeding blood circulation, especially over bony areas, when a patient lies still for too long without changing position.

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

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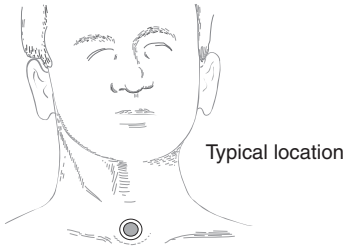
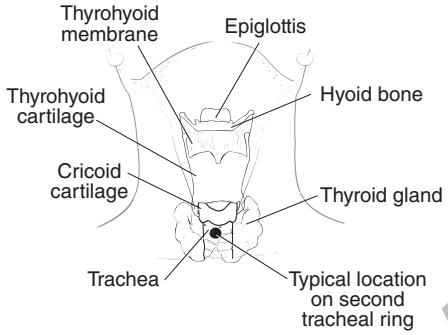
31600-31610

31600 Tracheostomy, planned (separate procedure);
31601 younger than 2 years
31603 Tracheostomy, emergency procedure; transtracheal
31605 cricothyroid membrane
31610 Tracheostomy, fenestration procedure with skin flaps



An emergency tracheostomy is performed



Explanation

The physician creates a tracheostomy. The physician makes a horizontal neck incision and dissects the muscles to expose the trachea. The thyroid isthmus is cut if necessary. The trachea is incised and an airway is inserted. After bleeding is controlled, a stoma is created by suturing the skin to the tissue layers. In 31600, the tracheostomy is a planned procedure. In 31601, it is a planned procedure performed on patients younger than 2 years of age. In 31603, it is performed under emergency conditions by puncturing the trachea and inserting a cannula. In 31605, it is performed under emergency conditions by puncturing the cricothyroid membrane located just above the cricoid and inserting a cannula. This is not a true tracheostomy and is usually converted to a tracheostomy once the situation is no longer emergent. In 31610, skin flaps are used to create a more permanent stoma.

Coding Tips

Note that 31600 and 31601, separate procedures by definition, are usually a component of a more complex service and are not identified separately. When performed alone or with other unrelated procedures/services they may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append modifier 59 or an X{EPSU} modifier. For endotracheal intubation, see 31500. For direct laryngoscopy with or without tracheoscopy, for aspiration under direct vision, see 31515. Tracheostoma revision, simple, without flap rotation, is reported with 31613; complex, with flap rotation, see 31614. For surgical closure of a tracheostomy or fistula, without plastic repair, see 31820; with plastic repair, see 31825. Revision of a tracheostomy scar is reported with 31830.

ICD-10-CM Diagnostic Codes

A80.0	Acute paralytic poliomyelitis, vaccine-associated
C01	Malignant neoplasm of base of tongue
C02.4	Malignant neoplasm of lingual tonsil
C09.0	Malignant neoplasm of tonsillar fossa
C09.1	Malignant neoplasm of tonsillar pillar (anterior) (posterior)
C09.8	Malignant neoplasm of overlapping sites of tonsil
C10.0	Malignant neoplasm of vallecula
C10.1	Malignant neoplasm of anterior surface of epiglottis
C10.2	Malignant neoplasm of lateral wall of oropharynx
C10.3	Malignant neoplasm of posterior wall of oropharynx
C10.4	Malignant neoplasm of branchial cleft
C10.8	Malignant neoplasm of overlapping sites of oropharynx
C12	Malignant neoplasm of pyriform sinus
C13.0	Malignant neoplasm of postcricoid region
C13.1	Malignant neoplasm of aryepiglottic fold, hypopharyngeal aspect
C13.2	Malignant neoplasm of posterior wall of hypopharynx
C13.8	Malignant neoplasm of overlapping sites of hypopharynx
C32.0	Malignant neoplasm of glottis
C32.1	Malignant neoplasm of supraglottis
C32.2	Malignant neoplasm of subglottis
C32.3	Malignant neoplasm of laryngeal cartilage
C32.8	Malignant neoplasm of overlapping sites of larynx
G12.0	Infantile spinal muscular atrophy, type I [Werdnig-Hoffman]
G12.1	Other inherited spinal muscular atrophy
G12.22	Progressive bulbar palsy
G46.3	Brain stem stroke syndrome
G80.0	Spastic quadriplegic cerebral palsy
G93.1	Anoxic brain damage, not elsewhere classified
J38.6	Stenosis of larynx
J44.81	Bronchiolitis obliterans and bronchiolitis obliterans syndrome
J44.89	Other specified chronic obstructive pulmonary disease
J4A.0	Restrictive allograft syndrome
J4A.8	Other chronic lung allograft dysfunction
J95.821	Acute postprocedural respiratory failure
J95.822	Acute and chronic postprocedural respiratory failure
J95.87	Transfusion-associated dyspnea (TAD)
J96.01	Acute respiratory failure with hypoxia
J96.02	Acute respiratory failure with hypercapnia
J96.11	Chronic respiratory failure with hypoxia
J96.12	Chronic respiratory failure with hypercapnia
J96.21	Acute and chronic respiratory failure with hypoxia
J96.22	Acute and chronic respiratory failure with hypercapnia
P07.01	Extremely low birth weight newborn, less than 500 grams N
P07.02	Extremely low birth weight newborn, 500-749 grams N
P07.03	Extremely low birth weight newborn, 750-999 grams N
P07.14	Other low birth weight newborn, 1000-1249 grams N
P07.15	Other low birth weight newborn, 1250-1499 grams N
P07.16	Other low birth weight newborn, 1500-1749 grams N
P07.21	Extreme immaturity of newborn, gestational age less than 23 completed weeks N
P07.22	Extreme immaturity of newborn, gestational age 23 completed weeks N
P07.23	Extreme immaturity of newborn, gestational age 24 completed weeks N
P07.24	Extreme immaturity of newborn, gestational age 25 completed weeks N

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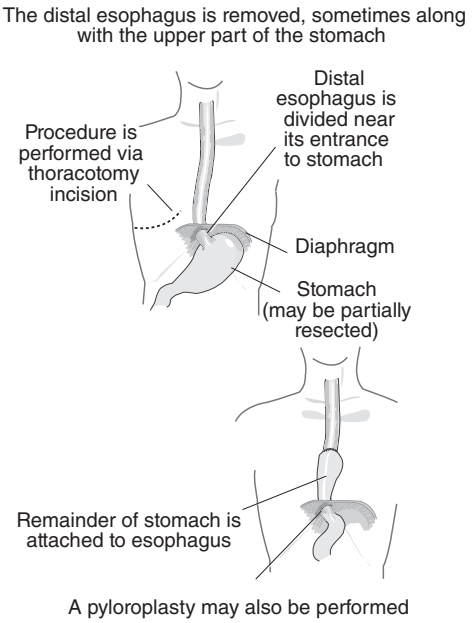
43121

43121 Partial esophagectomy, distal two-thirds, with thoracotomy only, with or without proximal gastrectomy, with thoracic esophagogastrostomy, with or without pyloroplasty



Explanation

The physician removes the affected part of the esophagus and proximal stomach and reattaches the remaining stomach to the esophageal stump. The physician accesses the esophagus through a right posterolateral thoracotomy; no abdominal incision is made. The physician resects the affected portion of the distal esophagus and sometimes a portion of the proximal stomach. The resected area is removed. The stomach or gastric remnant is pulled into the thorax and sutured to the esophageal stump. If the stomach is used as the esophageal conduit, a pyloroplasty may be performed to open the pyloric sphincter. The incision is sutured in layers.

Coding Tips

For partial esophagectomy by thoracoabdominal or abdominal approach with esophagogastrostomy, with or without pyloroplasty, see 43122.

ICD-10-CM Diagnostic Codes

C15.4	Malignant neoplasm of middle third of esophagus
C15.5	Malignant neoplasm of lower third of esophagus
C15.8	Malignant neoplasm of overlapping sites of esophagus
C16.0	Malignant neoplasm of cardia
C49.A1	Gastrointestinal stromal tumor of esophagus
C7A.092	Malignant carcinoid tumor of the stomach
D3A.092	Benign carcinoid tumor of the stomach
K22.10	Ulcer of esophagus without bleeding
K22.11	Ulcer of esophagus with bleeding
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
K22.89	Other specified disease of esophagus
K23	Disorders of esophagus in diseases classified elsewhere
K25.0	Acute gastric ulcer with hemorrhage
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
K31.1	Adult hypertrophic pyloric stenosis A
Q39.5	Congenital dilatation of esophagus
Q39.6	Congenital diverticulum of esophagus
Q39.8	Other congenital malformations of esophagus
S27.812A	Contusion of esophagus (thoracic part), initial encounter
S27.813A	Laceration of esophagus (thoracic part), initial encounter
S27.818A	Other injury of esophagus (thoracic part), initial encounter
T28.1XXA	Burn of esophagus, initial encounter
T28.6XXA	Corrosion of esophagus, initial encounter

AMA: **43121** 2018,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
43121	51.43	20.2	12.38	84.01
Facility RVU	**Work**	**PE**	**MP**	**Total**
43121	51.43	20.2	12.38	84.01

	FUD	Status	MUE	Modifiers				IOM Reference
43121	90	A	1(2)	51	N/A	62	80	None

* with documentation

Terms To Know

distal. *1)* Located farther away from a specified reference point or the trunk. *2)* Pertaining to the area farthest from the center of the body or the point of origin.

gastrectomy. Surgical excision of all or part of the stomach.

proximal. Located closest to a specified reference point, usually the midline or trunk.

pyloroplasty. Enlargement and reconstruction of the lower portion of the stomach opening into the duodenum performed after vagotomy to speed gastric emptying and treat duodenal ulcers.

thoracotomy. Surgical procedure for opening the chest wall in order to access the lungs, esophagus, trachea, aorta, heart, and diaphragm.

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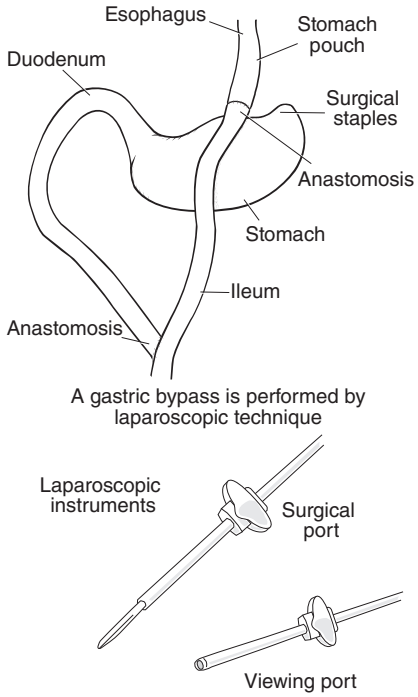
43644

43644 Laparoscopy, surgical, gastric restrictive procedure; with gastric bypass and Roux-en-Y gastroenterostomy (roux limb 150 cm or less)



Explanation

The physician performs a laparoscopic gastric bypass for morbid obesity by partitioning the stomach and performing a small bowel division with anastomosis to the proximal stomach (Roux-en-Y gastroenterostomy). This bypasses the majority of the stomach. The physician places a trocar though an incision above the umbilicus and insufflates the abdominal cavity. The laparoscope and additional trocars are placed through small portal incisions. The stomach is mobilized and the proximal stomach is divided with a stapling device along the lesser curvature, leaving only a small proximal pouch in continuity with the esophagus. A short limb of the proximal small bowel (150 cm or less) is divided and the distal end of the short intestinal limb is brought up and anastomosed to the proximal gastric pouch. The other end of the divided bowel is connected back into the small bowel distal to the short limb's gastric anastomosis to restore intestinal continuity. The instruments are removed.

Coding Tips

Surgical laparoscopy always includes diagnostic laparoscopy. Do not report 43644 with 43846 or 49320. Esophagogastroduodenoscopy (EGD) performed for a separate condition should be reported with modifier 59 or an X{EPSU} modifier. A gastric restrictive procedure with a roux limb greater than 150 cm is reported with 43645. For an open procedure, see 43846.

ICD-10-CM Diagnostic Codes

E27.8	Other specified disorders of adrenal gland
E35	Disorders of endocrine glands in diseases classified elsewhere
E66.01	Morbid (severe) obesity due to excess calories
E66.09	Other obesity due to excess calories
E66.1	Drug-induced obesity
E66.2	Morbid (severe) obesity with alveolar hypoventilation
E66.3	Overweight
E66.8	Other obesity

AMA: **43644** 2022,Nov; 2021,Jul; 2020,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
43644	29.4	15.1	7.33	51.83
Facility RVU	**Work**	**PE**	**MP**	**Total**
43644	29.4	15.1	7.33	51.83

	FUD	Status	MUE	Modifiers				IOM Reference
43644	90	A	1(2)	51	N/A	62*	80	None

* with documentation

Terms To Know

BMI. Body mass index. Tool for calculating weight appropriateness in adults and may be a factor in determining medical necessity for bariatric procedures.

bypass. Auxiliary or diverted route to maintain continuous flow.

class III obesity (formerly known as morbid obesity). Accumulation of excess fat in the subcutaneous connective tissue with increased weight. Class III, or severe, obesity is defined as a body mass index (BMI) of 40 or greater in adults. It is often associated with serious conditions that can become life threatening, such as diabetes, hypertension, and arteriosclerosis. An adult who has one of these obesity-related conditions and a BMI of 35 or higher, or one who is more than 100 pounds over the recommended weight for their sex and height, is included in the Class III category.

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

proximal. Located closest to a specified reference point, usually the midline or trunk.

Roux-en-Y anastomosis. Y-shaped attachment of the distal end of a divided small intestine segment to the stomach, esophagus, biliary tract, or other structure with anastomosis of the proximal end to the side of the small intestine further down for reflux-free drainage.

trocar. Cannula or a sharp pointed instrument used to puncture and aspirate fluid from cavities.

SAMPLE

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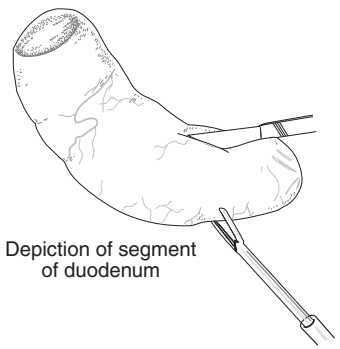
44010

44010 Duodenotomy, for exploration, biopsy(s), or foreign body removal



Depiction of segment of duodenum

A foreign body may be removed or a biopsy specimen taken

Explanation

The physician opens the duodenum, explores the segment, collects tissue samples for biopsy, or removes a foreign body. The physician exposes the proximal duodenum via a midline upper abdominal incision through skin, fascia, and muscles. The duodenum is incised in a longitudinal fashion and the area of concern is exposed. The physician may choose during exploration to excise tissues, biopsy, or remove foreign bodies. The duodenum is closed with transverse interrupted sutures. The abdominal incision is closed.

Coding Tips

For esophagogastroduodenoscopy, with biopsy, single or multiple, see 43239; with removal of foreign body, see 43247. For small intestinal endoscopy, with biopsy, single or multiple, see 44361; with removal of foreign body, see 44363. For biopsy of the intestine by capsule, tube or peroral (one or more specimens), see 44100. For small intestine enterotomy, other than duodenum, with biopsy or foreign body removal, see 44020. For colotomy, with biopsy or foreign body removal, see 44025.

ICD-10-CM Diagnostic Codes

B78.0	Intestinal strongyloidiasis
C17.0	Malignant neoplasm of duodenum
C7A.010	Malignant carcinoid tumor of the duodenum
D01.49	Carcinoma in situ of other parts of intestine
D13.2	Benign neoplasm of duodenum
D37.2	Neoplasm of uncertain behavior of small intestine
D3A.010	Benign carcinoid tumor of the duodenum
D49.0	Neoplasm of unspecified behavior of digestive system
K31.5	Obstruction of duodenum
K31.7	Polyp of stomach and duodenum
K31.811	Angiodysplasia of stomach and duodenum with bleeding
K31.819	Angiodysplasia of stomach and duodenum without bleeding
K31.82	Dieulafoy lesion (hemorrhagic) of stomach and duodenum
K31.89	Other diseases of stomach and duodenum
K90.0	Celiac disease
T18.3XXA	Foreign body in small intestine, initial encounter
T18.8XXA	Foreign body in other parts of alimentary tract, initial encounter

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
44010	14.26	8.44	2.62	25.32
Facility RVU	**Work**	**PE**	**MP**	**Total**
44010	14.26	8.44	2.62	25.32

	FUD	Status	MUE	Modifiers				IOM Reference
44010	90	A	1(2)	51	N/A	62*	80	None

* with documentation

Terms To Know

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.

duodenum. First portion of the small intestine connected to the stomach at the pylorus and extending to the jejunum.

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

foreign body. Any object or substance found in an organ and tissue that does not belong under normal circumstances.

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.

proximal. Located closest to a specified reference point, usually the midline or trunk.

skin. Outer protective covering of the body composed of the epidermis and dermis, situated above the subcutaneous tissues.

transverse. Crosswise at right angles to the long axis of a structure or part.

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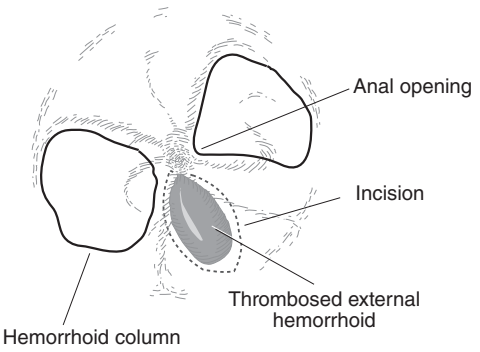
46250

46250 Hemorrhoidectomy, external, 2 or more columns/groups



Explanation

The physician performs an excision of external hemorrhoids. The physician identifies the external hemorrhoids. Incisions are made around the hemorrhoids and the lesions are dissected from the underlying sphincter muscle and removed. The incisions are closed with sutures.

Coding Tips

Selection of codes for hemorrhoid treatment depends on the site of the hemorrhoid (internal or external) and the nature of the surgical procedure (injection, destruction, incision, ligation, or excision). For hemorrhoidectomy, external, single column/group, see 46999. For incision of an external thrombosed hemorrhoid, see 46083; for excision, see 46320. For excision of an external anal papilla or tag, single, see 46220; multiple, see 46230. For internal hemorrhoidectomy by rubber band(s) ligation, see 46221. For injection of a hemorrhoidal sclerosing agent, see 46500. Do not report 46250 with 46948.

ICD-10-CM Diagnostic Codes

K64.0	First degree hemorrhoids
K64.1	Second degree hemorrhoids
K64.2	Third degree hemorrhoids
K64.3	Fourth degree hemorrhoids
K64.4	Residual hemorrhoidal skin tags
K64.5	Perianal venous thrombosis
K64.8	Other hemorrhoids

AMA: **46250** 2022,May

Relative Value Units/Medicare Edits

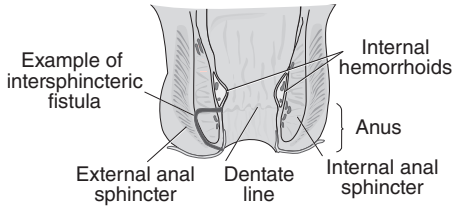
Non-Facility RVU	Work	PE	MP	Total
46250	4.25	9.37	0.79	14.41
Facility RVU	**Work**	**PE**	**MP**	**Total**
46250	4.25	4.54	0.79	9.58

	FUD	Status	MUE	Modifiers				IOM Reference
46250	90	A	1(2)	51	N/A	N/A	N/A	None

* with documentation

46255-46258

46255 Hemorrhoidectomy, internal and external, single column/group;
46257 with fissurectomy
46258 with fistulectomy, including fissurectomy, when performed



Removal of hemorrhoids. A fissurectomy or fistulectomy may also be performed

Explanation

The physician performs excision of a single column or group of internal and external hemorrhoids. The physician explores the anal canal and identifies the hemorrhoid column. An incision is made in the rectal mucosa around the hemorrhoids and the lesions are dissected from the underlying sphincter muscles and removed. The incisions are closed with sutures. In 46257, hemorrhoidectomy with an associated fissure is performed. An incision is made around the fissure and the fissure is dissected from the underlying sphincter muscles and excised. In 46258, hemorrhoidectomy with associated fistulectomy and a possible fissurectomy is performed. If the fistula is in the same plane as the hemorrhoid, a single incision is made in the mucosa around the lesions and the lesions are dissected from the underlying sphincter muscles and removed. If the lesions are in different planes, separate incisions are used to excise the lesions. If a fissure is present it may be excised in a similar manner. The incisions are closed with sutures.

Coding Tips

Selection of codes for hemorrhoid treatment depends on the site of the hemorrhoid (internal or external) and the nature of the surgical procedure (injection, destruction, incision, ligation, or excision). For hemorrhoidectomy, internal/external, two or more columns/groups, see 46260; with fissurectomy, see 46261; with fistulectomy, including fissurectomy, when performed, see 46262. For excision of a single external anal papilla or tag, see 46220; multiple, see 46230. For incision of an external thrombosed hemorrhoid, see 46083; excision, see 46320. For internal hemorrhoidectomy by rubber band(s) ligation, see 46221. For injection of a hemorrhoidal sclerosing agent, see 46500. Do not report 46255–46258 with 46948.

ICD-10-CM Diagnostic Codes

K60.0	Acute anal fissure
K60.1	Chronic anal fissure
K60.3	Anal fistula
K60.4	Rectal fistula
K60.5	Anorectal fistula
K62.5	Hemorrhage of anus and rectum
K62.82	Dysplasia of anus
K62.89	Other specified diseases of anus and rectum
K64.0	First degree hemorrhoids
K64.1	Second degree hemorrhoids
K64.2	Third degree hemorrhoids
K64.3	Fourth degree hemorrhoids
K64.4	Residual hemorrhoidal skin tags

SAMPLE

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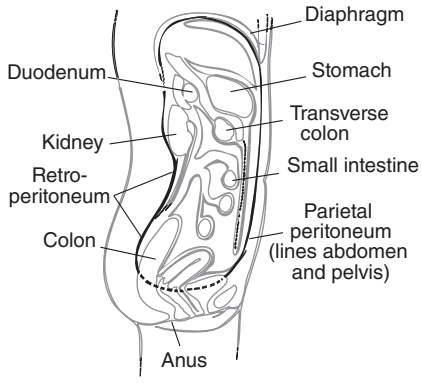
49406

49406 Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst); peritoneal or retroperitoneal, percutaneous



Percutaneous drainage of peritoneal or retroperitoneal abscess, hematoma, seroma, or lymphocele using image guidance

Explanation

A fluid collection in the peritoneum or retroperitoneum, such as a hematoma, a seroma, an abscess, a lymphocele, or a cyst, is drained using a catheter. The area over the affected site is cleansed and local anesthesia is administered. Imaging is performed to assist in the insertion of a needle or guidewire into the fluid collection. Small tissue samples may be collected from the site for pathological examination. A catheter is inserted to drain and collect the fluid for analysis and is then removed. More imaging may be performed to ensure hemostasis. A bandage is applied. In some cases, the catheter may be attached to a bag to allow for further drainage over the course of days.

Coding Tips

This code should be reported for each individual collection drained using a separate catheter. To report percutaneous insertion of a tunneled intraperitoneal catheter without a subcutaneous port, see 49418. For percutaneous paracentesis, see 49082–49083. For open drainage of an abscess, appendiceal, see 44900; peritoneal, see 49020; subdiaphragmatic or subphrenic, see 49040; retroperitoneal, see 49060; extraperitoneal to peritoneal cavity, see 49062; peritoneal lavage, see 49084; perirenal or renal, see 50020; and ovarian, see 58805 or 58822. For transvaginal or transrectal image-guided drainage of a peritoneal or retroperitoneal abscess, see 49407; transrectal drainage of a pelvic abscess, see 45000. Do not report 49406 with 75989, 76942, 77002–77003, 77012, or 77021.

ICD-10-CM Diagnostic Codes

K35.210	Acute appendicitis with generalized peritonitis, without perforation, with abscess
K35.211	Acute appendicitis with generalized peritonitis, with perforation and abscess
K35.219	Acute appendicitis with generalized peritonitis, with abscess, unspecified as to perforation
K35.33	Acute appendicitis with perforation, localized peritonitis, and gangrene, with abscess
K65.1	Peritoneal abscess
K68.11	Postprocedural retroperitoneal abscess
K68.19	Other retroperitoneal abscess
K68.3	Retroperitoneal hematoma

AMA: **49406** 2020,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
49406	4.0	22.46	0.38	26.84
Facility RVU	**Work**	**PE**	**MP**	**Total**
49406	4.0	1.3	0.38	5.68

	FUD	Status	MUE	Modifiers				IOM Reference
49406	0	A	2(3)	51	N/A	N/A	N/A	None

* with documentation

Terms To Know

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

cyst. Elevated encapsulated mass containing fluid, semisolid, or solid material with a membranous lining.

drainage. Releasing, taking, or letting out fluids and/or gases from a body part.

hematoma. Tumor-like collection of blood in some part of the body caused by a break in a blood vessel wall, usually as a result of trauma.

imaging. Radiologic means of producing pictures for clinical study of the internal structures and functions of the body, such as x-ray, ultrasound, magnetic resonance, or positron emission tomography.

lymphocele. Cyst that contains lymph.

percutaneous. Through the skin.

seroma. Swelling caused by the collection of serum, or clear fluid, in the tissues.

SAMPLE

© 2024 Optum360, LLC **N** Newborn: 0 **P** Pediatric: 0-17 **M** Maternity: 9-64 **A** Adult: 15-124 ♂ Male Only ♀ Female Only CPT © 2024 American Medical Association. All Rights Reserved.

G0104, G0106, G0122

G0104 Colorectal cancer screening; flexible sigmoidoscopy
G0106 Colorectal cancer screening; alternative to G0104, screening sigmoidoscopy, barium enema
G0122 Colorectal cancer screening; barium enema

Explanation

In G0104, a flexible sigmoidoscopy is performed for colorectal cancer screening. After the patient's bowel has been prepped, the physician inserts the flexible sigmoidoscope through the anus and advances the scope into the sigmoid colon. The lumen of the sigmoid colon and rectum are visualized and brushings or washings may be obtained. The sigmoidoscope is withdrawn. In G0106, a colorectal screening for cancer is performed via barium enema as an alternative to a screening sigmoidoscopy (G0104). Both G0106 and G0122 are 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.

Coding Tips

Medicare covers a flexible sigmoidoscopy for screening of colorectal cancer once every four years for patients 50 years of age or older. Some payers may require 45330 be reported for colorectal cancer screening via sigmoidoscopy. For a screening sigmoidoscopy that results in a biopsy or removal of a growth, see the appropriate sigmoidoscopy CPT code for the diagnostic procedure. Medicare and some payers may require modifier PT appended to the diagnostic code to indicate the screening sigmoidoscopy turned into a diagnostic procedure.

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
K55.041 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

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0104	0.84	4.64	0.11	5.59
G0106	1.26	5.38	0.09	6.73
G0122	0.99	8.73	0.04	9.76
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0104	0.84	0.7	0.11	1.65
G0106	1.26	5.38	0.09	6.73
G0122	0.99	8.73	0.04	9.76

	FUD	Status	MUE	Modifiers				IOM Reference
G0104	0	A	1(2)	51	N/A	N/A	N/A	None
G0106	N/A	A	1(2)	N/A	N/A	N/A	80*	
G0122	N/A	N	0(3)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

barium enema. Radiology exam for viewing the intestine that utilizes a suspension of barium sulfate, a chalk-like substance that appears white on x-ray, to delineate the lining of the colon and rectum. The barium is administered via the rectum and held inside the colon while x-rays are taken. Barium enema may also be performed therapeutically in order to relieve intussusception or intestinal obstructions.

SAMPLE

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