

Coding and Billing for

General Surgery/ Gastroenterology

A Comprehensive and Illustrated Specialty Guide



2011

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hemi-	half
hept-	seven
hetero-	different
hex-	six
homo-	same
hyper-	above, excessive
hypo-	below, deficient
im-, in-	not
in-	into, to
infra-	below, underneath
inter-	among, between
intra-	within, inside, during
intro-	inward, during
iso-	equal, same
juxta-	adjacent to
kata-	down, down from
macro-	large
magno-	large
medi-	middle
mega-	large
megalo-	very large
meso-	middle
meta-	beyond, between
micro-	small
neo-	new
non-	not
ob-	before, against
octa-	eight
octo-	eight
oligo-	few
pachy-	thick
pan-	all
para-	beside, to the side of, wrong
pent-	five
per-	by, through, throughout
peri-	around, round-about
pleo-	more than usual
poly-	many
post-	behind, after
pre-	before, in front, very
pros-	besides
prox-	besides
pseudo-	false, fake
quar(r)-	four
re, red-	back, again
retro-	backwards, behind
semi-	half
sex-	six
sept-	seven
sub-	under, beneath
super-	above, in addition, over
supra-	above, on the upper side
syn-	together, with
sys-	together, with
tetra-	four
thio-	sulfur

trans-	across, beyond
tri-	three
uni-	one
ultra-	beyond, besides, over

Suffixes

-ase	fermenter
-ate	do
-cide	killer
-c(o)ele	cavity, hollow
-ectomy	removal of, cut out
-form	shaped like
-ia	got
-iasis	full of
-ile	little version
-illa	little version
-illus	little version
-in	stuff
-ism	theory, characteristic of
-itis	inflammation
-ity	makes a noun of quality
-ium	thing
-ize	do
-logy	study of, reasoning about
-megaly	large
-noid	mind, spirit
-oid	resembling, image of
-ogen	precursor
-ol(e)	alcohol
-ole	little version
-oma	tumor (usually)
-osis	full of
-ostomy	“mouth-cut”
-pathy	disease of, suffering
-penia	lack
-pexy	fix in place
-plasty	re-shaping
-philia	affection for
-rhage	burst out
-rhea	discharge, flowing out
-rhexis	shredding
-pagus	Siamese twins
-sis	idea (makes a noun, typically abstract)
-thrix	hair
-tomy	cut
-ule	little version
-um	thing (makes a noun, typically abstract)

General Surgery/Gastroenterology Terms

The following definitions are medical terms commonly seen while coding/billing for General Surgery/Gastroenterology:

Abdominal – Pertaining to the abdomen.

Abdominoplasty – A surgical procedure which tightens a lax anterior abdominal wall and removes excess abdominal skin. It may be reconstructive or cosmetic.

Abduct – To move away from the body.

of Diseases, 10th Edition (ICD-10). To view these Mappings, refer to the following link:

http://www.contextodata.com/2010ICD10CMMappings/2010_I9Gem.txt
http://www.contextodata.com/2010ICD10CMMappings/2010_I10Gem.txt

ICD-10-CM Code Set Improvements

The clinical modification of ICD-10 represents a significant improvement over ICD-9-CM. Some of the specific organizational improvements that provide greater specificity in code assignment include:

- The addition of information relevant to ambulatory and managed care encounters
- Expanded injury codes, grouped by anatomical site rather than injury category
- The creation of combination diagnosis/symptom or manifestation codes to reduce the number of codes needed to fully describe a condition as well as combination codes for poisonings and external causes
- The addition of 6th and 7th characters with the seventh digit extensions representing visit encounter or sequelae for injuries and external causes
- Added laterality
- Full code titles for all codes with the incorporation of common 4th and 5th digit subclassifications (no more referring back to common fourth and fifth digits to understand the full code)
- V and E codes are no longer supplemental classifications
- Postoperative complications have been grouped within a procedure-specific body system chapter

Official Coding Guideline Differences

In order to code more effectively, the Official Guidelines for Coding and Reporting should be reviewed. Below are examples of the ICD-9-CM and ICD-10-CM Guidelines placed side-by-side and the differences between the two become readily apparent. Because the format and structure of ICD-10-CM has undergone a number of changes, there is additional information as well as the changes.

ICD-9-CM General Coding Guidelines	ICD-10-CM General Coding Guidelines
Locating a Code in ICD-9-CM	Locating a Code in ICD-10-CM
Locate each term in the Alphabetic Index and verify the code selected in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.	To select a code in the classification that corresponds to a diagnosis or reason for visit documented in a medical record, first locate the term in the Index, and then verify the code in the Tabular List. Read and be guided by instructional notations that appear in both the Index and the Tabular List. It is essential to use both the Index and Tabular List when locating and assigning a code. The Index does not always provide the full code. Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular List. A dash (-) at the end of an Index entry indicates that additional characters are required. Even if a dash is not included at the Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required.

ICD-9-CM General Coding Guidelines	ICD-10-CM General Coding Guidelines
Level of Detail in Coding	Level of Detail in Coding
ICD-9-CM diagnosis codes are composed of codes with 3, 4, or 5 digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater detail.	ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6, or 7 digits. Codes with three digits are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater detail.
A three digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code.	A three-digit code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.
Codes from 001.0 through V91.99	Codes from A00.0 through T88.9, Z00-Z99.89
The appropriate code or codes from 001.0 through V91.99 must be used to identify problems, complaints or other reason(s) for the encounter/visit.	The appropriate code or codes from A00.0 through T88.9, Z00-Z99.89 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.
Signs and Symptoms	Signs and Symptoms
Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0-799.9) contains many, but not all codes for symptoms.	Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0-R99) contains many, but not all codes for symptoms.

General Surgery Specific ICD-10-CM Coding Information

Although there are currently no special guidelines for coding particular circumstances related to the digestive system in the official guidelines, ICD-10-CM does present some differences in documentation requirements related to coding diseases of the digestive system. Some of these new, key documentation elements include the following:

Gastric ulcers, gastritis, and duodenitis are no longer classified as with or without mention of obstruction.

Hernias are no longer grouped together based on the presence of absence of obstruction or gangrene but all are grouped by site, not just inguinal hernias.

Diverticulosis and diverticulitis must be reported as with or without perforation or abscess as well as with or without bleeding.

Crohn's disease, ulcerative colitis, and inflammatory polyps (pseudopolypoid) must be reported as with or without complications. The complications must be further documented as:

- Rectal bleeding
- Intestinal obstruction
- Fistula
- Abscess
- Other specified complication
- Unspecified complication

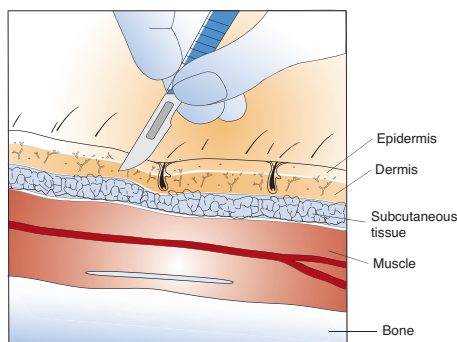
11042-11047

- ▲ **11042** Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); first 20 sq cm or less
- ▲ **11043** Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); first 20 sq cm or less
- ▲ **11044** Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); first 20 sq cm or less
- **11045** Debridement, subcutaneous tissue (includes epidermis and dermis, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
- **11046** Debridement, muscle and/or fascia (includes epidermis, dermis, and subcutaneous tissue, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)
- **11047** Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Plain English Description

Debridement of skin, subcutaneous tissue, muscle, and/or bone is performed and foreign material is removed. In 11042 and 11045, subcutaneous tissue, including epidermis and dermis, is debrided. Devascularized, necrotic skin is removed. Using sharp excision, nonviable epidermis, dermis, and subcutaneous tissue is removed until viable tissue is encountered as evidenced by bleeding. Foreign material is also removed. The physician may close the wound or cover the wound with gauze. Use 11042 for the first 20 sq cm debrided and 11045 for each additional 20 sq cm or part thereof. In 11043 and 11046, skin, subcutaneous tissue, and muscle are debrided. The wound is irrigated and skin and subcutaneous tissue are removed as described above. Muscle tissue is inspected for viability by checking color, consistency, contraction, and circulation. The fascia is incised parallel to the muscle fibers. Nonviable muscle tissue is identified and excised. Any foreign material is removed. When all nonviable tissue has been removed as indicated by bleeding in the exposed surfaces, the wound may be closed or packed with gauze, or a drain placed. Use 11043 for the first 20 sq cm debrided and 11046 for each additional 20 sq cm or part thereof. In 11044 and 11047, skin, subcutaneous tissue, muscle, and bone are debrided. Nonviable skin, subcutaneous tissue, muscle fascia, and muscle are removed as described above. All devascularized bone is removed until viable bone is encountered as evidenced by bleeding. The physician may close the wound, place a drain, or pack the wound with gauze. Use 11044 for the first 20 sq cm debrided and 11047 for each additional 20 sq cm or part thereof.

Debridement



Subcutaneous tissue (11042, 11045); subcutaneous tissue, muscle and/or fascia (11043, 11046); subcutaneous tissue, muscle and/or fascia, bone (11044, 11047)

ICD-9-CM Diagnostic Codes (commonly used)

- 249.00** Secondary diabetes mellitus without mention of complication, not stated as uncontrolled, or unspecified
- 249.01** Secondary diabetes mellitus without mention of complication, uncontrolled
- 249.80** Secondary diabetes mellitus with other specified manifestations, not stated as uncontrolled, or unspecified
- 454.0** Varicose veins of lower extremities with ulcer
- 454.2** Varicose veins of lower extremities with ulcer and inflammation
- 675.14** Postpartum abscess of breast ♀
- 681.00** Unspecified cellulitis and abscess of finger

- 681.10** Unspecified cellulitis and abscess of toe
- 682.0** Cellulitis and abscess of face
- 682.1** Cellulitis and abscess of neck
- 682.2** Cellulitis and abscess of trunk
- 682.3** Cellulitis and abscess of upper arm and forearm
- 682.4** Cellulitis and abscess of hand, except fingers and thumb
- 682.5** Cellulitis and abscess of buttock
- 682.6** Cellulitis and abscess of leg, except foot
- 682.7** Cellulitis and abscess of foot, except toes
- 701.1** Keratoderma, acquired
- 707.02** Decubitus ulcer upper back
- 707.03** Decubitus ulcer lower back
- 707.04** Decubitus ulcer hip
- 707.05** Decubitus ulcer buttock
- 707.07** Decubitus ulcer heel
- 707.09** Decubitus ulcer, other site
- 707.11** Ulcer of thigh
- 707.12** Ulcer of calf
- 707.14** Ulcer of heel and midfoot
- 707.15** Ulcer of other part of foot
- 709.2** Scar conditions and fibrosis of skin
- 709.8** Other specified disorders of skin
- 730.07** Acute osteomyelitis involving ankle and foot
- 730.10** Chronic osteomyelitis, site unspecified
- 730.11** Chronic osteomyelitis involving shoulder region
- 730.12** Chronic osteomyelitis involving upper arm
- 730.13** Chronic osteomyelitis involving forearm
- 730.14** Chronic osteomyelitis involving hand
- 730.15** Chronic osteomyelitis involving pelvic region and thigh
- 730.16** Chronic osteomyelitis involving lower leg
- 730.17** Chronic osteomyelitis involving ankle and foot
- 730.21** Unspecified osteomyelitis involving shoulder region
- 730.22** Unspecified osteomyelitis involving upper arm
- 730.23** Unspecified osteomyelitis involving forearm
- 730.24** Unspecified osteomyelitis involving hand
- 730.25** Unspecified osteomyelitis involving pelvic region and thigh
- 730.26** Unspecified osteomyelitis involving lower leg
- 730.27** Unspecified osteomyelitis involving ankle and foot
- 785.4** Gangrene
- 873.0** Open wound of scalp, without complication

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
11042	0.80	0.50	1.66	0.10	1.40	2.56	000	A
11043	2.00	1.28	3.30	0.33	3.61	5.63	000	A
11044	3.60	2.03	4.34	0.62	6.25	8.56	000	A
11045	0.33	0.13	0.51	0.07	0.53	0.91	ZZZ	A
11046	0.70	0.31	0.77	0.12	1.13	1.59	ZZZ	A
11047	1.20	0.54	1.19	0.22	1.96	2.61	ZZZ	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
11042	0	2	0	0	1
11043	0	2	0	0	1
11044	0	2	0	0	1
11045	0	0	0	0	0
11046	0	0	0	0	0
11047	0	0	0	0	0

CCI

- 11042** There are too many associated CCI codes to list. Refer to Appendix A for complete list.
- 11043** There are too many associated CCI codes to list. Refer to Appendix A for complete list.
- 11044** There are too many associated CCI codes to list. Refer to Appendix A for complete list.
- 11045** No associated CCI edits apply to this code or code range.
- 11046** No associated CCI edits apply to this code or code range.
- 11047** No associated CCI edits apply to this code or code range.

Pub 100

No Pub 100 references apply to this code or code range.

** See Appendix for CCI information

* See Appendix for Modifier Rules

● New Code

▲ Revised Code

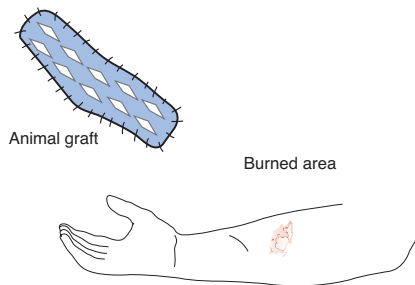
15430-15431

- 15430** Acellular xenograft implant; first 100 sq cm or less, or 1% of body area of infants and children
- 15431** Acellular xenograft implant; each additional 100 sq cm, or each additional 1% of body area of infants and children, or part thereof (List separately in addition to code for primary procedure)

Plain English Description

An acellular xenograft implant is used to cover a wound or skin defect. A skin xenograft, also referred to as a heterograft, refers to skin or other tissue obtained from another species usually a pig (porcine). An acellular xenograft is one in which the cells, cell debris, DNA and RNA have been removed to reduce the incidence of rejection which allows it to be used as a permanent skin or soft tissue implant. This type of implant is composed of acellular animal (porcine) collagen along with elastin fibers that have been treated using cross-linking so that the collagen will not be broken down and reabsorbed. The xenograft implant is removed from the packaging. The implant sheet is then cut to the size and shape of the wound, applied to the prepared wound bed, and secured with sutures. Use 15430 for the first 100 sq cm or less in adults or 1% of total body surface area (TBSA) in infants and children and 15431 for each additional 100 sq cm (adults) or 1% of TBSA (infants/children) or part thereof.

Acellular xenograft implant



The physician applies a graft of animal skin tissue

ICD-9-CM Diagnostic Codes (commonly used)

- 249.00** Secondary diabetes mellitus without mention of complication, not stated as uncontrolled, or unspecified
- 249.01** Secondary diabetes mellitus without mention of complication, uncontrolled
- 249.80** Secondary diabetes mellitus with other specified manifestations, not stated as uncontrolled, or unspecified
- 692.77** Sunburn of third degree
- 757.39** Other specified congenital anomalies of skin
- 906.5** Late effect of burn of eye, face, head, and neck
- 906.6** Late effect of burn of wrist and hand
- 906.7** Late effect of burn of other extremities
- 906.8** Late effect of burns of other specified sites
- 940.0** Chemical burn of eyelids and periocular area
- 940.1** Other burns of eyelids and periocular area
- 941.30** Full-thickness skin loss due to burn (third degree NOS) of unspecified site of face and head
- 941.31** Full-thickness skin loss due to burn (third degree NOS) of ear (any part)
- 941.32** Full-thickness skin loss due to burn (third degree NOS) of eye (with other parts of face, head, and neck)
- 941.33** Full-thickness skin loss due to burn (third degree NOS) of lip(s)
- 941.34** Full-thickness skin loss due to burn (third degree NOS) of chin
- 941.35** Full-thickness skin loss due to burn (third degree NOS) of nose (septum)
- 941.36** Full-thickness skin loss due to burn (third degree NOS) of scalp (any part)
- 941.37** Full-thickness skin loss due to burn (third degree NOS) of forehead and cheek
- 941.38** Full-thickness skin loss due to burn (third degree NOS) of neck
- 942.00** Burn of unspecified degree of unspecified site of trunk

- 942.01** Burn of unspecified degree of breast
- 942.02** Burn of unspecified degree of chest wall, excluding breast and nipple
- 942.03** Burn of unspecified degree of abdominal wall
- 942.04** Burn of unspecified degree of back (any part)
- 942.05** Burn of unspecified degree of genitalia
- 942.09** Burn of unspecified degree of other and multiple sites of trunk
- 942.10** Erythema due to burn (first degree) of unspecified site of trunk
- 942.11** Erythema due to burn (first degree) of breast
- 942.12** Erythema due to burn (first degree) of chest wall, excluding breast and nipple
- 942.13** Erythema due to burn (first degree) of abdominal wall
- 942.14** Erythema due to burn (first degree) of back (any part)
- 942.15** Erythema due to burn (first degree) of genitalia
- 943.31** Full-thickness skin loss due to burn (third degree NOS) of forearm
- 943.32** Full-thickness skin loss due to burn (third degree NOS) of elbow
- 943.33** Full-thickness skin loss due to burn (third degree NOS) of upper arm
- 943.34** Full-thickness skin loss due to burn (third degree NOS) of axilla
- 943.35** Full-thickness skin loss due to burn (third degree NOS) of shoulder
- 943.36** Full-thickness skin loss due to burn (third degree NOS) of scapular region
- 944.00** Burn of unspecified degree of unspecified site of hand
- 944.01** Burn of unspecified degree of single digit (finger (nail) other than thumb)
- 944.02** Burn of unspecified degree of thumb (nail)
- 944.03** Burn of unspecified degree of two or more digits of hand, not including thumb

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
15430	6.20	7.86	8.50	1.05	15.11	15.75	090	A
15431	4.13	2.62	2.62	0.14	6.89	6.89	ZZZ	C

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
15430	0	2	0	0	1
15431	0	0	0	0	0

CCI

- 15430** 01951⁰, 01952⁰, 02131⁰, 02161⁰, 02281⁰, 02301⁰, 11000¹, 11042¹, 12001¹, 12002¹, 12004¹, 12005¹, 12006¹, 12007¹, 12011¹, 12013¹, 12014¹, 12015¹, 12016¹, 12017¹, 12018¹, 12020¹, 12021¹, 12031¹, 12032¹, 12034¹, 12035¹, 12036¹, 12037¹, 12041¹, 12042¹, 12044¹, 12045¹, 12046¹, 12047¹, 12051¹, 12052¹, 12053¹, 12054¹, 12055¹, 12056¹, 12057¹, 13100¹, 13101¹, 13120¹, 13121¹, 13131¹, 13132¹, 13150¹, 13151¹, 13152¹, 15002¹, 15004¹, 15852¹, 16020¹, 16025¹, 16030¹, 29000¹, 29010¹, 29015¹, 29020¹, 29025¹, 29035¹, 29040¹, 29044¹, 29046¹, 29049¹, 29055¹, 29058¹, 29065¹, 29075¹, 29085¹, 29086¹, 29105¹, 29125¹, 29126¹, 29130¹, 29131¹, 29200¹, 29240¹, 29260¹, 29280¹, 29305¹, 29325¹, 29345¹, 29355¹, 29358¹, 29365¹, 29405¹, 29425¹, 29435¹, 29440¹, 29445¹, 29450¹, 29505¹, 29515¹, 29520¹, 29530¹, 29540¹, 29550¹, 29580¹, 29581¹, 29590¹, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36600¹, 36640¹, 37202¹, 43752¹, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450¹, 64479⁰, 64483⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 97597¹, 97598¹, 97602¹, 97605¹, 97606¹, 99148⁰, 99149⁰, 99150⁰, G0168¹, J2001¹

15431 No associated CCI edits apply to this code or code range.

Pub 100

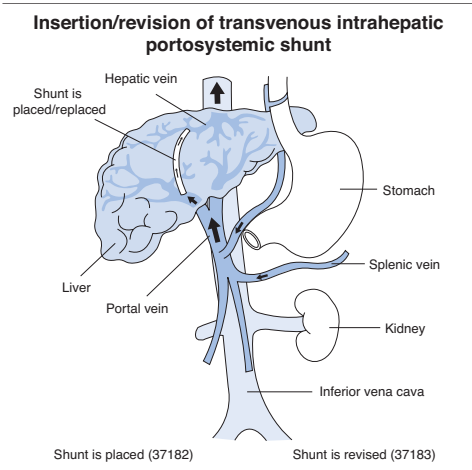
Pub 100-3, 1, 270.5

37182-37183

- 37182** Insertion of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract formation/dilatation, stent placement and all associated imaging guidance and documentation)
- 37183** Revision of transvenous intrahepatic portosystemic shunt(s) (TIPS) (includes venous access, hepatic and portal vein catheterization, portography with hemodynamic evaluation, intrahepatic tract recanalization/dilatation, stent placement and all associated imaging guidance and documentation)

Plain English Description

The physician inserts one or more transvenous intrahepatic portosystemic shunt(s) (TIPS). Venous access is typically via the right internal jugular vein. The jugular is punctured with a needle and a guidewire is introduced under fluoroscopic guidance. The needle is then exchanged for a vascular introducer and a catheter is advanced over the guidewire and into one of the hepatic veins. Contrast material is injected and portography performed to define and evaluate the portal system for optimal placement of the intrahepatic portosystemic shunt(s). Pressure gradients are obtained. The catheter is advanced into the selected hepatic vein. A needle is then guided through the catheter and advanced into the selected portal vein to create a path for the stent. A guidewire is then passed into the selected portal vein and the needle removed. A balloon tipped catheter is advanced over the guidewire and the tract between the hepatic and portal veins dilated. One or more stents are then placed over the balloon tipped catheter and positioned in the dilated tract. The balloon is inflated to expand the stent(s). Following placement of the stent(s), pressure gradients are again obtained to evaluate the effectiveness of the shunt. A post-procedure venography may also be performed. All guidewires, catheters, and the vascular introducer are removed and direct pressure applied to the puncture site to control bleeding. In 37183, a malfunctioning TIPS is evaluated and revised. Transvenous access to the hepatic and portal veins is accomplished as described in 37182. Contrast material is injected and portography performed to evaluate the stent. Pressure gradients are obtained. The stent is then revised as needed which may include recanalization or dilatation of the tract, revision of the stent by extending the stent or placing additional stents, or removal of the existing stent and replacing it with a new stent. Following the revision procedure, pressure gradients are obtained and venography performed to evaluate results of the revision.



ICD-9-CM Diagnostic Codes (commonly used)

- 070.54** Chronic hepatitis C without hepatic coma
- 070.70** Unspecified viral hepatitis C without hepatic coma
- 155.0** Malignant neoplasm of liver primary
- 275.1** Disorders of copper metabolism
- 401.9** Unspecified essential hypertension
- 452** Portal vein thrombosis
- 456.0** Esophageal varices with bleeding
- 456.1** Esophageal varices without bleeding
- 456.20** Esophageal varices in diseases classified elsewhere, with bleeding
- 456.21** Esophageal varices in diseases classified elsewhere, without bleeding

- 456.8** Varices of other sites
- 511.9** Unspecified pleural effusion
- 569.3** Hemorrhage of rectum and anus
- 571.2** Alcoholic cirrhosis of liver
- 571.3** Alcoholic liver damage, unspecified
- 571.5** Cirrhosis of liver without alcohol
- 571.6** Biliary cirrhosis
- 571.8** Other chronic nonalcoholic liver disease
- 572.3** Portal hypertension
- 572.8** Other sequelae of chronic liver disease
- 573.8** Other specified disorders of liver
- 573.9** Unspecified disorder of liver
- 576.2** Obstruction of bile duct
- 578.9** Hemorrhage of gastrointestinal tract, unspecified
- 789.00** Abdominal pain, unspecified site
- 996.1** Mechanical complication of other vascular device, implant, and graft
- 996.59** Mechanical complication of other implant and internal device, not elsewhere classified
- 996.62** Infection and inflammatory reaction due to other vascular device, implant, and graft
- 996.74** Other complications due to other vascular device, implant, and graft

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
37182	16.97	7.34	7.34	1.62	25.93	25.93	000	A
37183	7.99	3.53	152.24	0.73	12.25	160.96	000	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
37182	0	2	0	0	0
37183	0	2	0	0	0

CCI

- 37182** 0075T¹, 0213T⁰, 0216T⁰, 0228T⁰, 0230T⁰, 36000¹, 36010¹, 36011¹, 36012¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36481¹, 36500¹, 36600¹, 36640¹, 37140⁰⁰, 37183^{E1}, 37202¹, 37205¹, 37207¹, 43752¹, 47010¹, 47011¹, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64479⁰, 64483⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 75885⁰, 75887⁰, 75896¹, 76000¹, 76001¹, 76942¹, 76998¹, 77001¹, 77002¹, 77012¹, 77021¹, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 99148⁰, 99149⁰, 99150⁰
- 37183** 0075T¹, 0213T⁰, 0216T⁰, 0228T⁰, 0230T⁰, 36000¹, 36010¹, 36011¹, 36012¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36481¹, 36500¹, 36600¹, 36640¹, 37140⁰⁰, 37202¹, 37205¹, 37207¹, 43752¹, 47010¹, 47011¹, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64479⁰, 64483⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 75885⁰, 75887⁰, 75896¹, 76000¹, 76001¹, 76942¹, 76998¹, 77001¹, 77002¹, 77012¹, 77021¹, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 99143⁰, 99144⁰, 99145⁰, 99148⁰, 99149⁰, 99150⁰, J0670¹, J1644¹, J2001¹

Pub 100

No Pub 100 references apply to this code or code range.

** See Appendix for CCI information

* See Appendix for Modifier Rules

● New Code

▲ Revised Code

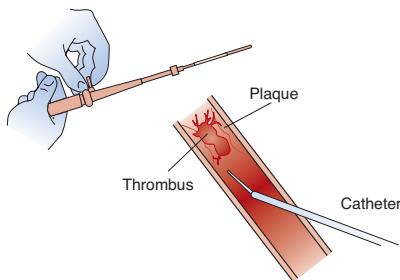
37184-37186

- 37184** Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); initial vessel
- 37185** Primary percutaneous transluminal mechanical thrombectomy, noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injection(s); second and all subsequent vessel(s) within the same vascular family (List separately in addition to code for primary mechanical thrombectomy procedure)
- 37186** Secondary percutaneous transluminal thrombectomy (eg, nonprimary mechanical, snare basket, suction technique), noncoronary, arterial or arterial bypass graft, including fluoroscopic guidance and intraprocedural pharmacological thrombolytic injections, provided in conjunction with another percutaneous intervention other than primary mechanical thrombectomy (List separately in addition to code for primary procedure)

Plain English Description

The physician performs primary or secondary percutaneous transluminal mechanical thrombectomy on a noncoronary artery or arterial bypass graft including fluoroscopic guidance and intraprocedural injection of thrombolytic agent. Percutaneous transluminal mechanical thrombectomy is performed using an arterial catheter and a mechanical device that either breaks up the thrombus (blood clot), breaks up and removes the thrombus, or snares and retrieves the thrombus. Devices that break up the thrombus include rotating wires or brushes. Devices that break up and retrieve the thrombus include those that deliver a rapid stream of fluid and use hydrodynamic forces to break up the clot in conjunction with aspiration to remove the clot. Retriever type devices such as a microsnares, snare basket, or other retriever device allow the physician to grasp and remove the thrombus. The technique varies slightly depending on the type of mechanical device used and the location of the thrombus. The skin over the artery that will be used to approach the thrombus is prepped, the artery punctured, and a sheath placed. A guiding catheter is introduced under fluoroscopic guidance. A microcatheter is then advanced over a microguidewire and passed through the thrombus. The guidewire is then removed and the mechanical thrombectomy device advanced through the microcatheter to the thrombus. If a rotating wire or brush device is used, it is activated and the thrombus fragmented. If hydrodynamic forces are used, a stream of fluid is delivered to break up the thrombus which is then aspirated. If a retriever device is used, it is passed beyond the level of the clot, deployed, and the clot captured by the device. The retriever device is then retracted along with the microcatheter. Several passes of the mechanical device may be required to break up and remove the clot. A thrombolytic agent may be injected during to the procedure to help dissolve the clot. Once the procedure is complete, the mechanical device, microcatheter, and guiding catheter are removed. Use code 37184 for primary percutaneous transluminal mechanical thrombectomy on the initial noncoronary artery or arterial bypass graft and 37185 for the second and subsequent vessels within the same vascular family. Use code 37186 for a secondary percutaneous transluminal thrombectomy provided in conjunction with another percutaneous intervention other than a primary mechanical thrombectomy.

Primary percutaneous transluminal mechanical thrombectomy



Use 37184 for primary clot removal of the initial vessel and 37185 for second/ subsequent vessel(s). For secondary clot removal, use 37186

ICD-9-CM Diagnostic Codes (commonly used)

- 325 Phlebitis and thrombophlebitis of intracranial venous sinuses
- 336.1 Vascular myelopathies
- 362.35 Central retinal vein occlusion
- 362.36 Venous tributary (branch) occlusion of retina
- 415.19 Other pulmonary embolism and infarction
- 437.6 Nonpoyogenic thrombosis of intracranial venous sinus
- 444.0 Embolism and thrombosis of abdominal aorta
- 444.21 Arterial embolism and thrombosis of upper extremity
- 444.22 Arterial embolism and thrombosis of lower extremity
- 444.81 Embolism and thrombosis of iliac artery
- 444.89 Embolism and thrombosis of other artery
- 444.9 Embolism and thrombosis of unspecified artery
- 445.01 Atheroembolism of upper extremity
- 445.02 Atheroembolism of lower extremity
- 445.81 Atheroembolism of kidney
- 445.89 Atheroembolism of other site
- 453.0 Budd-Chiari syndrome
- 453.2 Other embolism and thrombosis of inferior vena cava
- 453.40 Venous embolism and thrombosis of deep vessels of unspecified lower extremity
- 453.41 Acute venous embolism and thrombosis of deep vessels of proximal lower extremity
- 453.42 Acute venous embolism and thrombosis of deep vessels of distal lower extremity

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
37184	8.66	3.91	61.25	1.51	14.08	71.42	000	A
37185	3.28	1.32	19.69	0.61	5.21	23.58	ZZZ	A
37186	4.92	2.09	40.61	0.95	7.96	46.48	ZZZ	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
37184	1	2	2	0	1
37185	2	0	2	0	1
37186	2	0	2	0	1

CCI

37184	01924 ⁰	01925 ⁰	01926 ⁰	0213T ⁰	0216T ⁰	0228T ⁰	0230T ⁰	35201 ¹	35206 ¹	35226 ¹	35231 ¹	35236 ¹	35256 ¹	35261 ¹	35266 ¹	35286 ¹	36000 ¹	36400 ¹	36405 ¹	36406 ¹	36410 ¹	36420 ¹	36425 ¹	36430 ¹	36440 ¹	36600 ¹	36640 ¹	36860 ^{1E1}	36861 ^{1E1}	36870 ^{1E1}	37186 ⁰	37201 ¹	37202 ¹	43752 ¹	51701 ¹	51702 ¹	51703 ¹	62310 ⁰	62311 ⁰	62318 ⁰	62319 ⁰	64400 ⁰	64402 ⁰	64405 ⁰	64408 ⁰	64410 ⁰	64412 ⁰	64413 ⁰	64415 ⁰	64416 ⁰	64417 ⁰	64418 ⁰	64420 ⁰	64421 ⁰	64425 ⁰	64430 ⁰	64435 ⁰	64445 ⁰	64446 ⁰	64447 ⁰	64448 ⁰	64449 ⁰	64450 ⁰	64479 ⁰	64483 ⁰	64490 ⁰	64493 ⁰	64505 ⁰	64508 ⁰	64510 ⁰	64517 ⁰	64520 ⁰	64530 ⁰	69990 ⁰	75896 ¹	76000 ¹	76001 ¹	77001 ¹	77002 ¹	93000 ¹	93005 ¹	93010 ¹	93040 ¹	93041 ¹	93042 ¹	93318 ¹	94002 ¹	94200 ¹	94250 ¹	94680 ¹	94681 ¹	94690 ¹	94770 ¹	95812 ¹	95813 ¹	95816 ¹	95819 ¹	95822 ¹	95829 ¹	95955 ¹	96360 ¹	96365 ¹	96372 ¹	96374 ¹	96375 ¹	96376 ¹	99143 ⁰	99144 ⁰	99145 ⁰	99148 ⁰	99149 ⁰	99150 ⁰
37185	0213T ¹	0216T ¹	36000 ¹	36410 ¹	37202 ¹	43752 ¹	62318 ¹	62319 ¹	64415 ¹	64416 ¹	64417 ¹	64450 ¹	64490 ¹	64493 ¹	69990 ⁰	76000 ¹	77001 ¹	77002 ¹	93000 ¹	93005 ¹	93010 ¹	93040 ¹	93041 ¹	93042 ¹	94770 ¹	96360 ¹	96365 ¹	96372 ¹	96374 ¹	96375 ¹	96376 ¹	99143 ⁰	99144 ⁰	99145 ⁰	99148 ⁰	99149 ⁰	99150 ⁰																																																																											
37186	01924 ⁰	01925 ⁰	01926 ⁰	0213T ¹	0216T ¹	35201 ¹	35206 ¹	35226 ¹	35231 ¹	35236 ¹	35256 ¹	35261 ¹	35266 ¹	36000 ¹	36410 ¹	37201 ¹	37202 ¹	43752 ¹	62318 ¹	62319 ¹	64415 ¹	64416 ¹	64417 ¹	64450 ¹	64490 ¹	64493 ¹	69990 ⁰	75896 ¹	76000 ¹	76001 ¹	77001 ¹	77002 ¹	93000 ¹	93005 ¹	93010 ¹	93040 ¹	93041 ¹	93042 ¹	94770 ¹	96360 ¹	96365 ¹	96372 ¹	96374 ¹	96375 ¹	96376 ¹	99143 ⁰	99144 ⁰	99145 ⁰	99148 ⁰	99149 ⁰	99150 ⁰																																																													

Pub 100

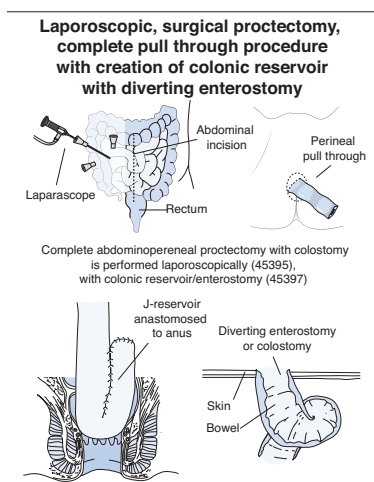
No Pub 100 references apply to this code or code range.

45395-45397

- 45395** Laparoscopy, surgical; proctectomy, complete, combined abdominoperineal, with colostomy
- 45397** Laparoscopy, surgical; proctectomy, combined abdominoperineal pull-through procedure (eg, colo-anal anastomosis), with creation of colonic reservoir (eg, J-pouch), with diverting enterostomy, when performed

Plain English Description

A small portal incision is made near the umbilicus, a trocar inserted, and pneumoperitoneum established. Additional portal incisions are made and trocars placed in the upper and lower quadrants of the abdomen. The abdominal cavity is inspected. In 45395, a complete proctectomy with colostomy is performed. The sigmoid colon is retracted medially and mobilized along the line of Toldt to the splenic flexure. The sigmoid colon is then retracted laterally. The left ureter is identified and protected. The sigmoid mesentery is incised at the pelvic brim and dissected and the inferior mesenteric artery and vein are isolated, ligated, and transected. The rectum and surrounding mesentery are freed from pelvic and abdominal attachments. The colon is clamped and divided at the level of the sigmoid junction. The perineum is incised in a circular fashion around the rectum. The rectum and surrounding mesentery are delivered en bloc through the perineal incision. The perineal incision is closed. The stoma site is prepared around one of the previously placed trocars. Gas is released from the abdomen and the proximal segment of colon exteriorized through the stoma incision. The colon is folded back on itself (everted) and sutured to the skin and subcutaneous tissue. Drains are placed in the abdomen and the portal incisions closed. A stoma appliance is placed. In 45397, a proctectomy is performed using pull-through procedure with creation of a colonic reservoir such as a J-pouch with a diverting enterostomy when performed. The proctectomy is performed as described above. The segment of colon to be used as the reservoir is identified and the colon is mobilized. Folding the colon back on itself creates a colonic reservoir. The colon is then sutured together and the antimesenteric border incised parallel to the suture line to open the pouch and expose the mucosa. The previously placed suture lines in the colon wall are reinforced by suturing the mucosal layer to create a two-layer closure. The pouch is closed and positioned in the pelvis. The anastomosis site in the anus is prepared by placing sutures around the circumference of the anus. The anal mucosa and the colon are sutured together (anastomosed). If a diverting enterostomy is required, the enterostomy site is selected and the abdomen incised. The intestinal segment is mobilized and transected. The distal segment is closed and the proximal segment brought out through the stoma incision. The intestine is folded back on itself (everted) and sutured to the skin and subcutaneous tissue. The procedure is completed as described above.



ICD-9-CM Diagnostic Codes (commonly used)

- 153.0** Malignant neoplasm of hepatic flexure
- 153.1** Malignant neoplasm of transverse colon
- 153.2** Malignant neoplasm of descending colon
- 153.3** Malignant neoplasm of sigmoid colon
- 153.4** Malignant neoplasm of cecum
- 153.5** Malignant neoplasm of appendix vermiformis

- 153.6** Malignant neoplasm of ascending colon
- 153.7** Malignant neoplasm of splenic flexure
- 153.9** Malignant neoplasm of colon, unspecified site
- 154.0** Malignant neoplasm of rectosigmoid junction
- 154.1** Malignant neoplasm of rectum
- 154.2** Malignant neoplasm of anal canal
- 154.3** Malignant neoplasm of anus, unspecified site
- 154.8** Malignant neoplasm of other sites of rectum, rectosigmoid junction, and anus
- 197.5** Secondary malignant neoplasm of large intestine and rectum
- 211.3** Benign neoplasm of colon
- 230.3** Carcinoma in situ of colon
- 230.4** Carcinoma in situ of rectum
- 235.2** Neoplasm of uncertain behavior of stomach, intestines, and rectum
- 555.1** Regional enteritis of large intestine
- 556.0** Ulcerative (chronic) enterocolitis
- 556.1** Ulcerative (chronic) ileocolitis
- 556.2** Ulcerative (chronic) proctitis
- 556.3** Ulcerative (chronic) proctosigmoiditis
- 556.5** Left-sided ulcerative (chronic) colitis
- 557.0** Acute vascular insufficiency of intestine
- 557.1** Chronic vascular insufficiency of intestine
- 557.9** Unspecified vascular insufficiency of intestine
- 569.1** Rectal prolapse
- 569.43** Anal sphincter tear (healed) (old)
- 751.3** Hirschsprung's disease and other congenital functional disorders of colon

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
45395	33.00	18.73	18.73	5.98	57.71	57.71	090	A
45397	36.50	19.73	19.73	6.00	62.23	62.23	090	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
45395	0	2	1	0	2
45397	0	2	1	0	2

CCI

- 45395** 0213T⁰, 0216T⁰, 0226T¹, 0228T⁰, 0230T⁰, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36600¹, 36640¹, 37202¹, 43653⁰, 43752¹, 44005⁰, 44156¹, 44180¹, 44188¹, 44206^{E1}, 44207^{E1}, 44210¹, 44211¹, 44212¹, 44320¹, 44602¹, 44603¹, 44604¹, 44605¹, 44970¹, 45990¹, 46600¹, 49320⁰, 50715¹, 51701¹, 51702¹, 51703¹, 58660¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64479⁰, 64483⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 76000¹, 76001¹, 77001¹, 77002¹, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 99148⁰, 99149⁰, 99150⁰
- 45397** 0213T⁰, 0216T⁰, 0226T¹, 0228T⁰, 0230T⁰, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36600¹, 36640¹, 37202¹, 43653⁰, 43752¹, 44005⁰, 44180¹, 44187¹, 44188¹, 44206^{E1}, 44207^{E1}, 44208^{E1}, 44210^{E1}, 44211¹, 44212¹, 44310¹, 44320¹, 44602¹, 44603¹, 44604¹, 44605¹, 44970¹, 45395^{E0}, 45990¹, 46600¹, 49320⁰, 50715¹, 51701¹, 51702¹, 51703¹, 58660¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64479⁰, 64483⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 76000¹, 76001¹, 77001¹, 77002¹, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 99148⁰, 99149⁰, 99150⁰

Pub 100

No Pub 100 references apply to this code or code range.

** See Appendix for CCI information

* See Appendix for Modifier Rules

● New Code

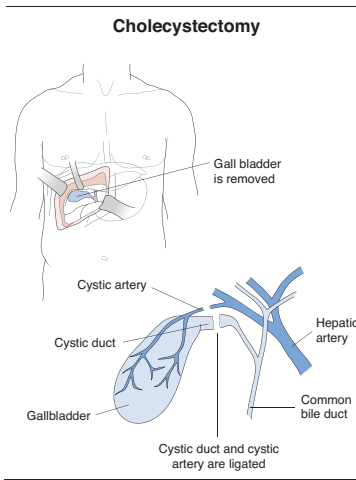
▲ Revised Code

47600-47605

- 47600** Cholecystectomy
- 47605** Cholecystectomy; with cholangiography

Plain English Description

The gallbladder is removed by open surgical technique. An incision is made in the upper abdomen, typically in the right subcostal region. Retractors are inserted and the hepatoduodenal ligament, gallbladder, and triangle of Calot are visualized. Tissue is carefully dissected down to the level of the cystic duct at its junction with the common duct. Dissection continues to the level of the cystic artery. The gallbladder is then dissected from hepatic bed and the cystic duct ligated. The cystic artery is dissected, doubly ligated, and divided. The gallbladder is removed. Drains may be placed and the incision closed. Use 47605 if intraoperative cholangiography is also performed by placing a small catheter into the cystic duct, instilling 10-20 ml of contrast, and then visualizing the ducts using fluoroscopy.



ICD-9-CM Diagnostic Codes (commonly used)

- 156.0** Malignant neoplasm of gallbladder
- 156.9** Malignant neoplasm of biliary tract, part unspecified site
- 197.8** Secondary malignant neoplasm of other digestive organs and spleen
- 211.5** Benign neoplasm of liver and biliary passages
- 230.8** Carcinoma in situ of liver and biliary system
- 560.31** Gallstone ileus
- 571.6** Biliary cirrhosis
- 574.00** Calculus of gallbladder with acute cholecystitis, without obstruction
- 574.01** Calculus of gallbladder with acute cholecystitis, with obstruction
- 574.10** Calculus of gallbladder with other cholecystitis, without obstruction
- 574.11** Calculus of gallbladder with other cholecystitis, with obstruction
- 574.20** Calculus of gallbladder without cholecystitis, without obstruction
- 574.21** Calculus of gallbladder without cholecystitis, with obstruction
- 574.30** Calculus of bile duct with acute cholecystitis, without obstruction
- 574.31** Calculus of bile duct with acute cholecystitis, with obstruction
- 574.40** Calculus of bile duct with other cholecystitis, without obstruction
- 574.41** Calculus of bile duct with other cholecystitis, with obstruction
- 574.50** Calculus of bile duct without cholecystitis, without obstruction
- 574.51** Calculus of bile duct without cholecystitis, with obstruction
- 574.60** Calculus of gallbladder and bile duct with acute cholecystitis, without obstruction
- 574.61** Calculus of gallbladder and bile duct with acute cholecystitis, with obstruction
- 574.70** Calculus of gallbladder and bile duct with other cholecystitis, without obstruction
- 574.71** Calculus of gallbladder and bile duct with other cholecystitis, with obstruction
- 574.80** Calculus of gallbladder and bile duct with acute and chronic cholecystitis, without obstruction
- 574.81** Calculus of gallbladder and bile duct with acute and chronic cholecystitis, with obstruction

- 574.90** Calculus of gallbladder and bile duct without cholecystitis, without obstruction
- 574.91** Calculus of gallbladder and bile duct without cholecystitis, with obstruction
- 575.0** Acute cholecystitis
- 575.10** Cholecystitis, unspecified
- 575.11** Chronic cholecystitis
- 575.12** Acute and chronic cholecystitis
- 575.2** Obstruction of gallbladder
- 575.3** Hydrops of gallbladder
- 575.4** Perforation of gallbladder
- 575.5** Fistula of gallbladder
- 575.6** Cholesterosis of gallbladder
- 575.8** Other specified disorders of gallbladder
- 576.1** Cholangitis
- 576.8** Other specified disorders of biliary tract
- 868.02** Injury to bile duct and gallbladder without open wound into cavity
- V64.1** Laparoscopic surgical procedure converted to open procedure

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
47600	17.48	9.98	9.98	3.69	31.15	31.15	090	A
47605	15.98	9.02	9.02	3.40	28.40	28.40	090	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
47600	0	2	1	0	2
47605	0	2	1	0	2

CCI

- 47600** 0213T⁰, 0216T⁰, 0228T⁰, 0230T⁰, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36600¹, 36640¹, 37202¹, 38500¹, 43752¹, 44005⁰, 44180⁰, 44602¹, 44603¹, 44604¹, 44605¹, 44820⁰, 44850⁰, 44950⁰, 47420¹, 47480¹, 47562⁰, 47563⁰, 47564⁰, 47570E¹, 49000⁰, 49002¹, 49010¹, 49020¹, 49040¹, 49255⁰, 49320⁰, 49560¹, 49561¹, 49565¹, 49566¹, 49570⁰, 49572¹, 49580¹, 49582¹, 49585¹, 49587¹, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64479⁰, 64483⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 99148⁰, 99149⁰, 99150⁰
- 47605** 0213T⁰, 0216T⁰, 0228T⁰, 0230T⁰, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36600¹, 36640¹, 37202¹, 38500¹, 43752¹, 44005⁰, 44180⁰, 44602¹, 44603¹, 44604¹, 44605¹, 44820⁰, 44850⁰, 44950⁰, 47420¹, 47480¹, 47550¹, 47562⁰, 47563⁰, 47564⁰, 47570E¹, 47600⁰, 49000⁰, 49002¹, 49010⁰, 49020¹, 49040¹, 49255¹, 49320⁰, 49507¹, 49560¹, 49561¹, 49565¹, 49566¹, 49570⁰, 49572¹, 49580¹, 49582¹, 49585¹, 49587¹, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64479⁰, 64483⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 99148⁰, 99149⁰, 99150⁰

Pub 100

No Pub 100 references apply to this code or code range.

Volume 2 – Alphabetic Index

The Alphabetic Index also makes use of certain instructional conventions to help guide the user in appropriate code selection and sequencing.

Special Instruction Notes

The “*see*” instruction directs the user to another main term to find the correct code.

Example:**Crisis**

Vascular – *see* Disease, cerebrovascular, acute

The “*see also*” instruction directs the user to also refer to the suggested main term for additional information on the condition or disease.

Example:

Crohn’s disease (*see also* Enteritis, regional) 555.9

Punctuation

[/] Slanted brackets identify situations when more than one code is needed to correctly code the condition. The index lists the codes in sequencing order with the secondary code in brackets.

Example:

Mononeuropathy (*see also* Mononeuritis) 355.9
diabetic NEC 250.6x [355.9]

() Parentheses enclose nonessential modifiers which may or may not be used with the diagnosis or condition listed in the index. These nonessential modifiers may help in clarifying the documentation, but the presence or absence of any of them does not change the code number selection.

Example:

Cyst (mucus) (retention) (serous) (simple)

ICD-9-CM Coding

ICD-9-CM diagnostic coding is a necessity when submitting claims to payers for reimbursement. It also identifies the reason for the patient’s visit to the provider and will indicate the medical necessity of the services rendered by the provider. The following are guidelines that instruct on ICD-9-CM diagnostic coding:

1. Consult Volume 2, Alphabetic Index to ICD-9-CM, first. Locate the main entry term. The Alphabetic Index is arranged by condition.
2. Refer to Volume 1 of the ICD-9-CM, locating the selected code in the Tabular List. Review any exclusion notes or other instructions for proper coding before final selection of codes. Also, refer to the addenda for any new diagnostic codes or corrections.
3. Read and apply all other conventions used in the Tabular List and Alphabetic Index.
4. Code only confirmed diagnoses. Do not code “suspected,” “rule out” or “probable” diagnoses. If there is not a confirmed diagnosis for outpatient service, code the symptom(s). For inpatient, short-term, acute care, and long term care coding, if only a “suspected,” “rule-out,” or “probable” diagnosis is listed, it should be coded as if it existed or was established.
5. Code only the confirmed diagnoses if both the diagnoses and symptoms are documented in the medical record, except

when the diagnoses and symptoms are not related, then code both.

6. Code to the level of highest specificity. Check to see if the diagnostic code consists of three, four, or five numbers. Truncated codes will be denied if a claim is submitted without all of the digits.
7. Chronic diseases and conditions treated on an ongoing basis may be coded as many times as the patient receives treatment and care for the condition(s).
8. Code all documented conditions that coexist at the time of the patient encounter that require or affect patient care, treatment, or management.

2011 General General Surgery/Gastroenterology Diagnostic Code Index**Abnormal, abnormality**

arterial blood gases 790.91
bowel sounds 787.5
chemistry, blood, other 790.6
coagulation profile 790.92
feces 787.7
findings, exam, blood 790.99
reaction/later complication
 formation external stoma E878.3
 insertion of gastric/duodenal sound E879.5
red blood cells, other 790.09
serum enzyme levels, nonspecific, other 790.5
tumor markers 795.89
weight gain 783.1

Abscess

anal, rectal 566
intestine 569.5
liver 572.0
lung 513.0
mediastinum 513.1
peritoneal 567.22
peritonsillar 475
prostate 601.2
psoas muscle 567.31
renal, perinephric 590.2
retroperitoneal, other 567.38
urethral 597.0

Absence, acquired

intestine, large/small V45.72
pancreas
 partial V88.12
 total V88.11

Acetonuria 791.6**Achalasia, cardiospasm** 530.0**Achlorhydria** 536.0**Adhesions, postoperative/postinfection**

peritoneal, intestinal
 with obstruction 560.81
 without obstruction 568.0

Allergy, drug, other 995.27**Amebiasis, intestinal, chronic, without abscess** 006.1

Jurisdiction D Information

Claims, Correspondence, Redetermination Requests, Refunds, FOIA, etc.

Noridian Administrative Services

PO Box 6727
Fargo ND 58108-6727
Electronic Funds Transfer (EFT) Forms

Noridian Administrative Services

PO Box 6728
Fargo ND 58108-6728

Benefit Protection**Noridian Administrative Services**

PO Box 6736
Fargo ND 58108-6736

Advance Determination of Medicare Coverage (ADMC)**IntegriGuard, LLC**

2301 N 117 Ave Suite 200
Omaha NE 68164
Fax: 1-402-498-2306

Reconsiderations/Administrative Law Judge (ALJ) Hearing Requests**RiverTrust Solutions**

PO Box 180208
Chattanooga, TN 37401-7208

ALJ Status Inquiries**Office of Medicare Hearings and Appeals (OMHA)**

BP Tower & Garage
200 Public Square Suite 1300
Cleveland OH 44114-2316

Jurisdiction D Durable Medical Equipment**Benefit Integrity Support Center (DME-BISC)**

Richard Kensic, Benefit Integrity Manager
DME-BISC
PO Box 51152
Los Angeles CA 90051-5452
www.integriguard.org/gov/psc/dme-bisc.html

Additional Resources**Supplier Enrollment/Inquiries**

National Supplier Clearinghouse
PO Box 100142
Columbia SC 29202-3142

Overnight Mailing Address**National Supplier Clearinghouse**

2300 Springdale Drive Bldg 1
Camden SC 29020
Phone: 1-866-238-9652
www.palmettogba.com/nsc

The supplier enrollment form, CMS 855S, is available at www.cms.gov/cmsforms/downloads/cms855S.pdf

Coding Assistance**Statistical Analysis Durable Medical Equipment Regional Contractor (SADMERC)**

Palmetto Government Benefits Administrators
Medicare SADMERC Operations
PO Box 100143
Columbia SC 29202-3143
Phone: 1-877-735-1326
www.palmettogba.com/sadmerc

2011 General Surgery/Gastroenterology HCPCS Level II Code Index

Additive, enteral formula B4104

Adhesive

disk A5126
foam pad A5126
liquid or equal A4364
remover, wipes, each A4456
remover/solvent A4455

Alprostadil urethral suppository J0275

Appliance cleaner, incontinence and ostomy appliances, per 16 oz A5131

Azathioprine

oral, 50 mg J7500
parenteral, 100 mg J7501

Bedside drainage bottle, rigid/expandable A5102

Bottle, drainage, bedside, rigid/expandable A5102

Brachytherapy, endorectal intracavitary applicator placement C9725

Breast reconstruction

deep inferior epigastric perforator (diep) flap S2068
gluteal artery perforator (gap) flap S2066-S2067

Breast reconstruction

stacked deep inferior epigastric perforator (diep) flap(s) S2067
superficial inferior epigastric artery (sisa) flap S2068

Camisole, post-mastectomy S8460

Catheter

Foley, indwelling
two-way, all silicone A4344
three way for continuous irrigation A4346
two-way latex with coating A4338

Catheter – continued

hemodialysis/peritoneal
long-term C1750
short-term C1752
infusion, peripherally inserted C1751
specialty A4340

Cholangiopancreatography, magnetic resonance (MRCP) S8037

Closure device, vascular C1760

Colonoscope, implantable, retrograde imaging C1749

Colorectal cancer screening

alternative to
G0104, screening sigmoidoscopy, barium enema G0106
G0105, screening colonoscopy, barium enema G0120
barium enema G0122

- ❶ Procedures reported with modifier 52 are typically billed at a reduced amount. Most payers do not require documentation to support the use of modifier 52 and will reimburse the procedure at a reduced level.

53 Discontinued Procedure

Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding the modifier 53 to the code reported by the physician for the discontinued procedure.

Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite.

Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use in the CPT book).

Split Care

When more than one physician provides care for a procedure, the care is split between the physicians. The physicians will use the same CPT code, but attach a modifier to the end of the code. The modifiers that indicate split care has taken place are:

- 54 Surgical care only
- 55 Postoperative management only
- 56 Preoperative management only

- ❶ The global payment of the surgery is distributed among the physicians according to the procedure percentages as determined by CMS and most payers follow the same rules. Workers Compensation carriers may use different percentage amounts for split care reimbursement. Medicare payment for postoperative care by more than one physician will be apportioned according to the number of days each doctor renders care during the 90 day follow-up period. In most cases, the surgeon will perform the in-hospital care, but may turn over the out-of-hospital or postoperative care to another physician.

54 Surgical Care Only

When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding the modifier 54 to the usual procedure number.

- ❶ Both claims submitted by the surgeon and the other physician must report the date patient care was assumed and relinquished in block 19 of the CMS-1500 or electronic equivalent. Both the surgeon and the other physician must keep a copy of the written transfer agreement in the patient's medical record. Both physicians will use the same CPT code, but they will use different modifiers that identify which portion of care they provided.

55 Postoperative Management Only

When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier 55 to the usual procedure number.

- ❶ Both physicians will use the same CPT code, but they will use different modifiers that identify which portion of care they provided.

56 Preoperative Management Only

When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding the modifier 56 to the usual procedure number.

- ❶ Both physicians will use the same CPT code, but will they will use different modifiers that identify which portion of care they provided. Some payers do not allow modifier 56 as by their definition the pre-operative care is included in the surgical component.

57 Decision for Surgery

An evaluation and management (E/M) service that resulted in the initial decision to perform the surgery may be identified by adding the modifier 57 to the appropriate level of E/M service.

❶ Major Surgical Procedures

Major Surgery with a global period of 90 days (as defined by Medicare) include the day before and the day of surgery. For example, a visit the day before or the same day could be properly billed in addition to a cholecystectomy if the need for the surgery was found during the encounter. Modifier 57 should be added to the E/M code. Billing for a visit would not be appropriate if the physician was only discussing the upcoming surgical procedure.

Procedures with a 90 day global period are considered to be major surgery, as categorized by CMS. The RBRVS Resource-Based Relative Value Scale) manual or Federal Register lists the global period for all procedure codes eligible for payment by Medicare.

❶ Minor Surgical Procedures

Procedures with a 0 or 10 day global period are considered to be minor or endoscopic surgeries, as categorized by CMS. E/M visits by the same physician on the same day as a minor surgery or endoscopy are included in the payment for the procedure, unless a significant, separately identifiable service is also performed.

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned or anticipated (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure.

Note: For treatment of a problem that requires a return to the operating/procedure room (e.g., unanticipated clinical condition), see modifier 78.

- ❶ Modifier 58 must be used for purposes of identifying procedures performed by the original physician during the postoperative period of the original procedure, within the constraints of the modifier's definition. These procedures cannot be repeat operations (unless the procedures are more extensive than the original procedure) and cannot be for the treatment of complications requiring a return trip to the operating room.

The existence of modifier 58 does not negate the global fee concept. Services that are included in CPT as multiple sessions or are defined as including multiple services or events may not be billed with this modifier. This modifier is designed to allow a method of reporting additional, related surgeries that are due to a progression of the disease and are not to be used to avoid global surgery edits applicable to staged procedures.

Modifier 58 should be used on surgical codes only and has no effect on the payment amount. It should not be used with the following codes because the codes are defined as "one or more sessions or stages":

65855	67031	67108	67145	67220
66762	67101	67110	67208	67227
66821	67105	67112	67210	67228
66840	67107	67141	67218	67229

- gastric intubation—43752, 46753
- temporary transcutaneous pacing —92953
- ventilatory management —94002-94004, 94660,94662
- vascular access procedures —36000, 36410, 36415, 36591, 36600

Any services performed that are not listed above should be reported separately.

Codes 99291 and 99292 report the total duration of time spent by a physician providing critical care services to a patient who is critically ill or injured. The time spent by the physician providing critical care services does not have to be continuous. For any given period of time reported using critical care codes for the patient, the physician must devote his/her full attention to the patient and for this reason cannot provide services to another patient during the same period of time.

Time spent with the patient should be documented in the patient's medical record. Time reported as critical care time must have the physician occupied in work directly related to the critical patient's care. This time does not need to be spent at the immediate bedside, but can be elsewhere on the floor or unit, as long as all care provided was for that patient (e.g., review of diagnostic tests). In addition, the physician needs to be immediately available to the patient during the time period for which the critical care services are reported.

Code 99291 is used to report the first 30-74 minutes of critical care on one date of service; the time does not have to be continuous. Critical care of less than 30 minutes on a one date of service should be reported with the appropriate E/M code. Code 99292 is used to report each additional 30 minutes beyond the first 74 minutes. It also may be used to report the final 15-30 minutes of critical care on a given date. Any critical care service(s) of less than 15 minutes outside of the first 74 minutes or less than 15 minutes beyond the final 30 minutes is not reported separately.

Total Duration of Critical Care	Code(s)
Less than 30 minutes	Appropriate E/M codes
30-74 minutes	99291 x 1
75-104 minutes	99291 x 1 and 99292 x 1
105-134 minutes	99291 x 1 and 99292 x 2
135-164 minutes	99291 x 1 and 99292 x 3
165-194 minutes	99291 x 1 and 99292 x 4

Nursing Facility Services (99304-99318)

These codes identify E/M services provided to patients in Nursing Facilities (formerly called Skilled Nursing Facilities (SNFs)), Intermediate Care Facilities (ICFs), or Long-Term Care Facilities (LTCFs). These codes are also used to report E/M services provided in a psychiatric residential treatment center. Any medical psychotherapy provided in addition to E/M services are reported separately.

Initial Nursing Facility Care: New or Established Patient (99304-99306)

If the patient is admitted to the nursing facility during the course of an encounter at another site of service (e.g., physician's office), all E/M services provided by that physician that coincide with that admission are part of initial nursing facility care if on the same date as the admission. The level of service used by the admitting physician should include all services related to the admission in

the other sites of service, as well as in the nursing facility setting. The only exception are the Hospital discharge services which may be reported separately. More than one comprehensive assessment may be necessary during a resident stay.

Subsequent Nursing Facility Care: New or Established Patient (99307-99310)

Subsequent Nursing Facility codes are used to report the services provided to residents of nursing facilities who have not had a major, permanent change of status. All levels include reviewing the medical record, noting changes in the resident's status since the last visit, and reviewing and signing orders.

Nursing Facility Discharge Services: (99315-99316)

Based on time, codes 99315 and 99316 are used to report the total duration of time spent by a physician for the final nursing facility discharge of a patient. The codes include a final examination of the patient and a discussion regarding the patient's stay at the facility. The time spent for review of the patient and any pertinent information related to their care does not have to be continuous.

Other Nursing Facility Services (99318)

This code is used once per year to report an annual patient assessment performed at a nursing facility defined as a SNF, ICF, or LTCF.

Preventive Medicine Services (99381-99397)

Preventative Medicine services report the preventive medicine care provided to infants, children, adolescents, and adults. The codes are divided into different age categories, based on areas of focus needed for that age group. If the physician identifies a condition or a preexisting problem is addressed in the process of performing a preventive medicine E/M service and additional work is required, then the appropriate Office/Outpatient code should also be reported, along with Modifier 25 (see the Modifier chapter for more information on Modifier 25). Codes 99381-99397 include counseling/anticipatory guidance/risk factor reduction interventions which are provided at the time of the initial or periodic, comprehensive preventive medicine examination. See codes 99401-99412 for reporting those counseling/ anticipatory guidance/risk factor reduction interventions that are provided at an encounter separate from the preventive medicine examination. Any immunizations or diagnostic studies involving laboratory or other procedures are reported separately.

Preventive Medicine Services: New Patient (99381-99387)

These codes are comprised of initial comprehensive preventive medicine codes. They are assigned based on the age of the patient and should include an age and gender appropriate history, physical examination, any counseling, guidance, or risk factor (e.g., stop smoking, exercising) information the patient may need, along with any immunizations, laboratory or diagnostic procedures.

Preventive Medicine Services: Established Patient (99391-99397)

To report a periodic comprehensive preventative medicine examination, it should include reassessment and supervision of a patient that would include an age appropriate history, physical examination, any counseling, guidance, or risk factor (e.g., stop smoking, exercising) information the patient may need, along with any immunizations, laboratory or diagnostic procedures. These codes are also assigned based on age of the patient.