

**INGENIX®**

# Coding Companion for Oncology/Hematology

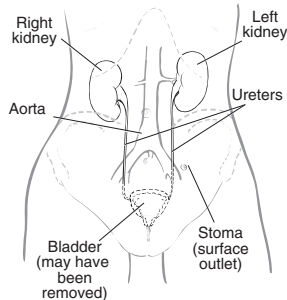
*A comprehensive illustrated guide to coding and reimbursement*

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# 55920

**55920** Placement of needles or catheters into pelvic organs and/or genitalia (except prostate) for subsequent interstitial radioelement application



Needles or catheters are placed in the genitalia or pelvic organs

## Explanation

The physician places needles or catheters into the pelvic organs and/or genitalia, excluding the prostate, for subsequent interstitial radioelement application. The radioactive isotopes that are introduced subsequently, such as iodine-125 or palladium-103, are contained within tiny seeds that are left in place to deliver radiation over a period of months. They do not cause any harm after becoming inert. This method provides radiation to the prescribed body area while minimizing exposure to normal tissue.

## Coding Tips

For placement of needles or catheters into prostate, report 55875 For insertion of uterine tandems and/or vaginal ovoids for clinical brachytherapy, report 57155 For insertion of Heyman capsules for clinical brachytherapy, report 58346

## ICD-9-CM Procedural

- 54.12 Reopening of recent laparotomy site
- 54.19 Other laparotomy
- 62.0 Incision of testis
- 65.09 Other oophorotomy
- 68.0 Hysterotomy
- 69.95 Incision of cervix
- 70.12 Culdotomy
- 70.14 Other vaginotomy
- 71.09 Other incision of vulva and perineum

- 92.27 Implantation or insertion of radioactive elements

## Anesthesia

**55920** 00902, 00920, 00940

## ICD-9-CM Diagnostic

- 158.8 Malignant neoplasm of specified parts of peritoneum
- 158.9 Malignant neoplasm of peritoneum, unspecified
- 180.0 Malignant neoplasm of endocervix
- 180.1 Malignant neoplasm of exocervix
- 180.8 Malignant neoplasm of other specified sites of cervix
- 180.9 Malignant neoplasm of cervix uteri, unspecified site
- 183.0 Malignant neoplasm of ovary — (Use additional code to identify any functional activity)
- 183.8 Malignant neoplasm of other specified sites of uterine adnexa
- 186.0 Malignant neoplasm of undescended testis — (Use additional code to identify any functional activity)
- 186.9 Malignant neoplasm of other and unspecified testis — (Use additional code to identify any functional activity)
- 196.6 Secondary and unspecified malignant neoplasm of intrapelvic lymph nodes
- 197.6 Secondary malignant neoplasm of retroperitoneum and peritoneum
- 198.6 Secondary malignant neoplasm of ovary
- 198.89 Secondary malignant neoplasm of other specified sites
- 201.50 Hodgkin's disease, nodular sclerosis, unspecified site, extranodal and solid organ sites
- 201.60 Hodgkin's disease, mixed cellularity, unspecified site, extranodal and solid organ sites
- 201.70 Hodgkin's disease, lymphocytic depletion, unspecified site, extranodal and solid organ sites
- 209.74 Secondary neuroendocrine tumor of peritoneum
- 236.2 Neoplasm of uncertain behavior of ovary — (Use additional code to identify any functional activity)
- 785.6 Enlargement of lymph nodes
- V10.43 Personal history of malignant neoplasm of ovary
- V84.02 Genetic susceptibility to malignant neoplasm of ovary — (Use additional code, if applicable, for any associated

family history of the disease: V16-V19. Code first, if applicable, any current malignant neoplasms: 140.0-195.8, 200.0-208.9, 230.0-234.9. Use additional code, if applicable, for any personal history of malignant neoplasm: V10.0-V10.9)

- V84.04 Genetic susceptibility to malignant neoplasm of endometrium — (Use additional code, if applicable, for any associated family history of the disease: V16-V19. Code first, if applicable, any current malignant neoplasms: 140.0-195.8, 200.0-208.9, 230.0-234.9. Use additional code, if applicable, for any personal history of malignant neoplasm: V10.0-V10.9)
- V84.09 Genetic susceptibility to other malignant neoplasm — (Use additional code, if applicable, for any associated family history of the disease: V16-V19. Code first, if applicable, any current malignant neoplasms: 140.0-195.8, 200.0-208.9, 230.0-234.9. Use additional code, if applicable, for any personal history of malignant neoplasm: V10.0-V10.9)

## CCI Version 15.3

20555❖, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 57155, 58346, 62310-62319, 64400-64435, 64445-64450, 64470, 64475, 64479, 64483, 64505-64530, 69990, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150

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

## Medicare Edits

	Fac RVU	Non-Fac RVU	FUD	Assist
<b>55920</b>	12.59	12.59	0	Ⓜ

**Medicare References:** None

**0073T**

**0073T** Compensator-based beam modulation treatment delivery of inverse planned treatment using 3 or more high resolution (milled or cast) compensator convergent beam modulated fields, per treatment session

**Explanation**

Compensator-based beam modulation treatment delivery of inverted planned treatment using three or more high-resolution (milled or cast) compensator convergent beam modulated fields is a method of delivering intensity modulated radiation therapy (IMRT). Prior to treatment delivery, a computerized planning system is used to calculate dose by inverse treatment planning method for IMRT optimization. The planner chooses beam angles and writes a prescription for targets identifying critical structures. The computerized planning system optimizes beam weights and modulation patterns and generates files for milling or casting of the required high resolution compensators that are then fabricated as prescribed and planned. During treatment delivery solid filters modulate the beams. Code 0073T reports only the treatment delivery component and is reported for each treatment session.

**0111T**

**0111T** Long-chain (C20-22) omega-3 fatty acids in red blood cell (RBC) membranes

**Explanation**

Long chain (C20-22) omega-3 fatty acids in red blood cell (RBC) membranes are measured. Long chain fatty acid levels have been associated with insulin resistance, coronary heart disease, and cardiac risk factors. A blood sample is obtained by venipuncture. Method is chromatography.

**0130T**

**0130T** Validated, statistically reliable, randomized, controlled, single-patient clinical investigation of FDA approved chronic care drugs, provided by a pharmacist, interpretation and report to the prescribing health care professional

**Explanation**

The pharmacist performs a validated, statistically reliable, randomized, controlled, single-patient clinical investigational review of FDA approved drugs used to treat chronic conditions and supplies interpretation and report to the prescribing professional. These single-patient trials compare medications that may be prescribed for the same condition, to help determine the optimal treatment and promote compliance and cost-effective drug use. In this trial design, the patient normally receives two treatments, one at a time, in random order. The patient receives each treatment for at least two multiple-day periods so that replication can be

achieved. In the majority of single-patient trials, the consecutive periods are paired and the treatment order is independently randomized for each pair so that variability due to temporal trends can be reduced. The physician sends a prescription to a properly equipped and trained pharmacist. A standard test protocol is specified, as well as the two test agents to be utilized. In the majority of cases, the pharmacist will manage patient registration and eligibility screening. A trial test kit is prepared to capture data on effectiveness and adverse effects from the patient in diary form. Various methods are utilized for daily data capture, including Web-based data entry screens, interactive voice recognition systems, and mark-sense readable paper diaries. Upon completion of the trial, a statistical analysis is performed and the physician is provided a summary, as well as a detailed report of the results, which is used to direct the patient's ongoing therapy.

**0159T**

**0159T** Computer-aided detection, including computer algorithm analysis of MRI image data for lesion detection/characterization, pharmacokinetic analysis, with further physician review for interpretation, breast MRI (List separately in addition to code for primary procedure)

**Explanation**

The physician uses dynamic contrast-enhanced MRI (DCE-MRI) to evaluate lesions of the breast. Pharmacokinetic analysis describes a process in which the data is calibrated by a computer to the patient's specific physiology. The physician reviews for interpretation the test results. This procedure is performed secondary to the primary MRI procedure.

**0160T-0161T**

**0160T** Therapeutic repetitive transcranial magnetic stimulation treatment planning  
**0161T** Therapeutic repetitive transcranial magnetic stimulation treatment delivery and management, per session

**Explanation**

Transcranial magnetic stimulation (TMS) is a technique to stimulate the brain by electromagnetic induction with a coil placed on the scalp. For direct stimulation to cortical neurons, a strong magnetic field pulse is generated over the patient's scalp to activate cortical neurons in the brain. This procedure has been applied to activate neuronal processes and to disturb the normal operation of the brain. Treatment planning is reported with 0160T and each TMS session is reported with 0161T.

**0169T**

**0169T** Stereotactic placement of infusion catheter(s) in the brain for delivery of therapeutic agent(s), including

computerized stereotactic planning and burr hole(s)

**Explanation**

An infusion catheter is implanted in the brain for convection enhanced delivery of an antineoplastic drug. Following a computerized stereotactic plan, the physician creates a burr hole in the patient's skull. Using stereotactic guidance, the physician places a catheter system into the area of the brain in which a tumor has been resected. This area will be treated with cintredakin besudotox to stop or slow the growth of the malignancy. The drug infusion typically occurs slowly over several days. When the infusion is completed, the catheter is withdrawn.

**0182T**

**0182T** High dose rate electronic brachytherapy, per fraction

**Explanation**

The physician delivers high dose rate electronic brachytherapy, a type of radiation therapy indicated for the treatment of early stage breast cancer following breast-conserving surgery. A form of accelerated partial breast irradiation (APBI), it is designed to precisely target the portion of the tissue surrounding the tumor as opposed to the entire breast. This form of brachytherapy is delivered in fewer fractions and at larger doses per fraction, resulting in a treatment duration of four to five days as opposed to the standard five to seven weeks of whole-breast irradiation. Under local anesthesia and utilizing ultrasound guidance, the surgeon makes a small incision in the skin over the lumpectomy cavity and inserts a trocar through which a balloon applicator is inserted. The balloon is inflated with sterile water until ultrasound reveals that the cavity is filled and the surgical margin conforms to the applicator. The surgeon dresses the entrance wound and tapes the applicator shaft to the patient's skin. Details of the treatment plan, formulated using standard treatment planning software, are downloaded into a controller. The x-ray source, which is encased in a sheath, is inserted into the applicator shaft and connected to the controller. The source travels to the distant point of the shaft inside the saline-filled balloon and stops. Radiation treatment is delivered according to the preset treatment plan. Treatments are typically broken down into two fractions per day for five days, for a total of 10 fractions. Following each treatment, the source is removed. The applicator remains inside the breast until the entire treatment regimen is complete, after which it is removed.

**0184T**

**0184T** Excision of rectal tumor, transanal endoscopic microsurgical approach (ie, TEMS)

**Explanation**

The physician excises a rectal tumor utilizing the transanal endoscopic microsurgical (TEMS) approach. Following administration of appropriate

# Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately \$29 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

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## Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services
- Hospital inpatient services—initial care

- Hospital inpatient services—subsequent care
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician's office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the same specialty has seen the patient within three years, the patient is considered established.

If a physician is on call or covering for another physician, the patient's encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient's attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as "observation status" in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician "admitting" the patient for observation.

Codes 99234-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and