

INGENIX®

Coding Companion for Emergency Medicine

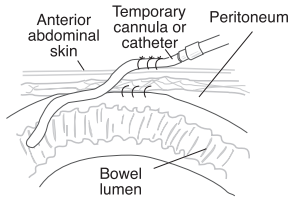
A comprehensive illustrated guide to coding and reimbursement

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49420

49420 Insertion of intraperitoneal cannula or catheter for drainage or dialysis; temporary



An intraperitoneal cannula or catheter is placed for drainage or dialysis

Explanation

The physician places a temporary intraperitoneal catheter for drainage or dialysis. The physician makes a small abdominal incision, opens the peritoneum, the double-layered sac covering the internal organs and lining the abdominopelvic walls, and inserts the catheter into the cavity. The proximal end of the catheter is tunneled subcutaneously away from the initial incision and brought out through the skin. The incision is closed. Alternately, the physician may percutaneously insert the catheter over a wire placed through a needle inserted into the peritoneal cavity.

Coding Tips

For peritoneal dialysis, see 90945 and 90947.

ICD-9-CM Procedural

54.91 Percutaneous abdominal drainage

Anesthesia

49420 00840

ICD-9-CM Diagnostic

- 250.40 Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled — (Use additional code to identify manifestation: 581.81, 583.81, 585.1-585.9)
- 250.41 Diabetes with renal manifestations, type I [juvenile type], not stated as uncontrolled — (Use additional code

to identify manifestation: 581.81, 583.81, 585.1-585.9)

- 250.42 Diabetes with renal manifestations, type II or unspecified type, uncontrolled — (Use additional code to identify manifestation: 581.81, 583.81, 585.1-585.9)
- 250.43 Diabetes with renal manifestations, type I [juvenile type], uncontrolled — (Use additional code to identify manifestation: 581.81, 583.81, 585.1-585.9)
- 577.0 Acute pancreatitis
- 581.81 Nephrotic syndrome with other specified pathological lesion in kidney in diseases classified elsewhere — (Code first underlying disease: 084.9, 249.4, 250.4, 277.30-277.39, 446.0, 710.0)
- 583.81 Nephritis and nephropathy, not specified as acute or chronic, with other specified pathological lesion in kidney, in diseases classified elsewhere — (Code first underlying disease: 016.0, 098.19, 249.4, 250.4, 277.30-277.39, 446.21, 710.0)
- 584.5 Acute kidney failure with lesion of tubular necrosis
- 584.6 Acute kidney failure with lesion of renal cortical necrosis
- 584.7 Acute kidney failure with lesion of medullary [papillary] necrosis
- 584.8 Acute kidney failure with other specified pathological lesion in kidney
- 584.9 Acute kidney failure, unspecified
- 585.1 Chronic kidney disease, Stage I — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic kidney disease, if applicable: 403.00-403.91, 404.00-404.93)
- 585.2 Chronic kidney disease, Stage II (mild) — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic kidney disease, if applicable: 403.00-403.91, 404.00-404.93)
- 585.3 Chronic kidney disease, Stage III (moderate) — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic

kidney disease, if applicable: 403.00-403.91, 404.00-404.93)

- 585.4 Chronic kidney disease, Stage IV (severe) — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic kidney disease, if applicable: 403.00-403.91, 404.00-404.93)
- 585.5 Chronic kidney disease, Stage V — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic kidney disease, if applicable: 403.00-403.91, 404.00-404.93)
- 585.6 End stage renal disease — (Use additional code to identify kidney transplant status, if applicable: V42.0. Use additional code to identify manifestation: 357.4, 420.0. Code first hypertensive chronic kidney disease, if applicable: 403.00-403.91, 404.00-404.93)
- 586 Unspecified renal failure
- 728.88 Rhabdomyolysis
- 753.12 Congenital polycystic kidney, unspecified type
- 789.51 Malignant ascites
- 789.59 Other ascites
- 998.59 Other postoperative infection — (Use additional code to identify infection)

CCI Version 15.3

36000, 36410, 37202, 43752, 44005, 44180, 44850, 49000-49010, 49255, 49400, 49402, 49423, 49436, 49570, 51701-51703, 62318-62319, 64415-64417, 64450, 64470, 64475, 69990, 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	Non-Fac		
	RVU	RVU	FUD	Assist
49420	3.65	3.65	0	N/A

Medicare References: 100-2,15,260; 100-4,12,30; 100-4,12,90.3; 100-4,14,10

70030

70030 Radiologic examination, eye, for detection of foreign body

Explanation

X-rays of the eyes are obtained to determine the location of a foreign body in the eye. After positioning the patient, either a one or two view x-ray is obtained. Transparent objects such as glass may not be good candidates for x-ray visualization. The physician supervises the procedure and interprets and reports the findings.

70140-70150

70140 Radiologic examination, facial bones; less than 3 views

70150 complete, minimum of 3 views

Explanation

X-rays of the facial bones are obtained to determine an injury, fracture, or neoplasm. After positioning the patient, x-rays are taken of the facial bones. The physician supervises the procedure and interprets and reports the findings. When less than three facial x-rays are taken, report 70140. When three or more views are taken, report 70150.

70160

70160 Radiologic examination, nasal bones, complete, minimum of 3 views

Explanation

Films are taken of the nasal bones to include a complete exam, or minimum of three views. Typically, this exam would consist of both right and left lateral (side to side) for comparison, as well as a tangential projection in which the x-ray beam is directed from a position above the patient's head down through the nose. This view is primarily used to demonstrate the medial or lateral (side to side) displacement of nasal fractures.

70200

70200 Radiologic examination; orbits, complete, minimum of 4 views

Explanation

Radiological examination of the orbits is useful in the evaluation of trauma, tumors, or foreign bodies. After positioning the patient, the radiologist obtains a minimum of four x-rays views of the orbits. Standard methods include posteroanterior (PA) exposures from two different positions, lateral views, optic canal projections, and oblique views of each side for comparison. The physician supervises the procedure and interprets and reports the findings.

70250-70260

70250 Radiologic examination, skull; less than 4 views

70260 complete, minimum of 4 views

Explanation

Films are taken of the skull bones. In 70250, three or less views are taken, and in 70260, a complete exam with a four view minimum is performed. The most common projections for routine skull series are AP axial (front to back), lateral, and PA axial (back to front). X-rays may be taken with the patient placed erect, prone, or supine and either code may include stereoradiography, which is a technique that produces three-dimensional images.

70360

70360 Radiologic examination; neck, soft tissue

Explanation

The technologist uses x-rays to obtain soft tissue images of the patient's neck rather than bone. The radiologist obtains two views, typically front to back (AP), and side to side (lateral). This procedure is performed to visualize abnormal air patterns or suspected foreign bodies or obstructions within the throat or neck.

71010

71010 Radiologic examination, chest; single view, frontal

Explanation

A radiograph is taken of the patient's chest from front to back (AP). Typically, this is done when the patient is too ill to stand or be turned to the prone position. The key element of this code is that it reports a single, frontal view.

71020

71020 Radiologic examination, chest, 2 views, frontal and lateral;

Explanation

Films are taken of the patient's chest to include a frontal and side to side (lateral) view. This code specifically reports these two views.

71021

71021 Radiologic examination, chest, 2 views, frontal and lateral; with apical lordotic procedure

Explanation

Films are taken of the patient's chest with the patient placed in a side to side (lateral) position, as well as a standard front to back position (AP). Another front to back (AP) film is also taken with the patient leaning back resting shoulders against the wall/film tray in a lordotic (arched back) position. This

projection produces x-rays that demonstrate the top, or apices, of the lungs.

71022

71022 Radiologic examination, chest, 2 views, frontal and lateral; with oblique projections

Explanation

Radiographs are taken of the patient's chest with the patient in a standard front to back (AP) position, as well as side to side (laterally). In addition, right and left obliques, or angled views, are taken. The key element of this code is that it reports specifically frontal, lateral, and oblique views.

71030

71030 Radiologic examination, chest, complete, minimum of 4 views;

Explanation

Films are taken of the patient's chest, specifically a complete exam, with a minimum of four views. Typically, this would include a back to front (PA), side to side (lateral), and right and left obliques, but may include any number of specialized projections, e.g., axial (angulated) views or lateral decubitus views for fluid levels.

71130

71130 Radiologic examination; sternoclavicular joint or joints, minimum of 3 views

Explanation

Films are taken of the sternoclavicular joint or joint with a minimum of three views from posteroanterior and oblique projections.

72020

72020 Radiologic examination, spine, single view, specify level

Explanation

One film is taken of the spine that requires specification of the level examined.

72040-72052

72040 Radiologic examination, spine, cervical; 2 or 3 views

72050 minimum of 4 views

72052 complete, including oblique and flexion and/or extension studies

Explanation

A radiologic examination of the cervical spine is performed that includes a minimum of two views in 72040, a minimum of four views in 72050, and a complete study in 72052. The complete study

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.

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