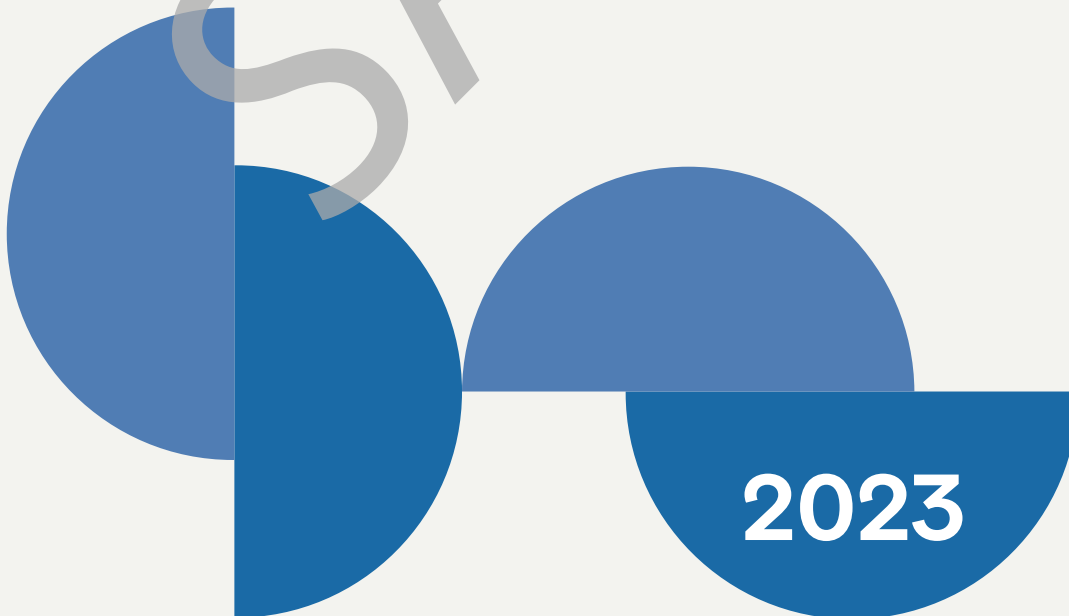


General Surgery/ Gastroenterology

A comprehensive illustrated guide to
coding and reimbursement

SAMPLE



2023

Contents

| | |
|--|----------|
| Getting Started with Coding Companion | i |
| CPT Codes | i |
| ICD-10-CM..... | i |
| Detailed Code Information | i |
| Appendix Codes and Descriptions..... | i |
| CCI Edits and Other Coding Updates..... | i |
| Index..... | i |
| General Guidelines | i |
| Sample Page and Key | ii |
| Evaluation and Management Guidelines | v |

| | |
|---|----------|
| General Surgery and Gastroenterology Procedures and Services | 1 |
| E/M Services | 1 |
| Skin | 23 |
| Pilonidal Cyst..... | 57 |
| Introduction | 58 |
| Repair | 65 |
| Destruction | 111 |
| Breast | 116 |
| General Musculoskeletal | 143 |
| Neck..... | 156 |
| Thorax | 160 |
| Back | 161 |
| Spine | 164 |
| Abdomen/Musculoskeletal | 165 |
| Humerus..... | 167 |
| Forearm/Wrist..... | 171 |
| Hands/Fingers..... | 175 |
| Pelvis/Hip | 177 |
| Femur/Knee..... | 185 |
| Leg/Ankle..... | 188 |

| | |
|---|------------|
| Foot/Toes | 193 |
| Endoscopy | 195 |
| Respiratory | 196 |
| Arteries and Veins..... | 205 |
| Spleen..... | 272 |
| Lymph Nodes..... | 276 |
| Diaphragm | 304 |
| Esophagus | 307 |
| Stomach | 403 |
| Intestines | 449 |
| Meckel's Diverticulum..... | 548 |
| Appendix | 551 |
| Rectum..... | 554 |
| Anus | 628 |
| Liver | 666 |
| Biliary Tract..... | 684 |
| Pancreas..... | 720 |
| Abdomen/Digestive | 737 |
| Reproductive | 802 |
| Thyroid | 803 |
| Parathyroid..... | 813 |
| Extracranial Nerves | 818 |
| Medicine | 824 |
| HCPCS..... | 839 |
| Appendix..... | 848 |
| Correct Coding Initiative Update | 867 |
| Index..... | 887 |

Getting Started with Coding Companion

Coding Companion for General Surgery/Gastroenterology is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT Codes

For ease of use, evaluation and management codes related to General Surgery/Gastroenterology are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT code is followed by its official CPT code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum360 *Coding Companion* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, in the 10th revision of the ICD-10-CM codes, conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. Features include icons to identify newborn, pediatric, adult, male only, female only, and laterality. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the pages following the sample.

Appendix Codes and Descriptions

Some CPT codes are presented in a less comprehensive format in the appendix. The CPT codes appropriate to the specialty are included in the appendix with the official CPT code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

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

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

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

CCI Edits and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version XX.X, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The CCI edits are located in a section at the back of the book. As other CPT (including COVID-related vaccine and administration codes) and ICD-10-CM codes relevant to your specialty are released, updates will be posted to the Optum360 website. The website address is <http://www.optum360coding.com/ProductUpdates/>. The 2023 edition password is: XXXXXX. Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

47600 Cholecystectomy;

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

Cholecystectomy

Open Approach, 47600-47620

OR

Excision

Gallbladder
Open, 47600-47620

OR

Gallbladder

Cholecystectomy, 47600

General Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xiv of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

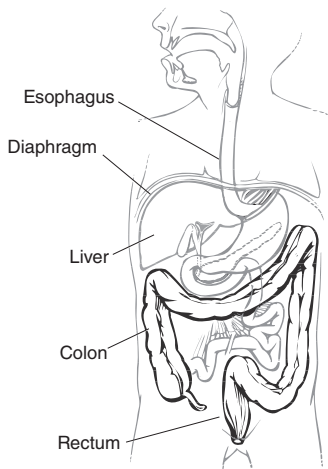
Professional and Technical Component

Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

44705

1

44705 Preparation of fecal microbiota for instillation, including assessment of donor specimen



2

Explanation

Fecal microbiota transplantation (FMT) is the process of instilling fecal matter from a donor to a patient to treat a *Clostridium difficile* (C. diff) infection, most commonly. The donor stool is thinned using a normal saline solution and filtered for use in a nasogastric tube or an enema application. This code includes the screening protocol of the donor specimen for C. diff and other enteric bacterial pathogens and any ova or parasites.

3

Coding Tips

Do not report 44705 with 74283. For fecal instillation via enema or oro- or nasogastric tube, see 44799. Medicare and some other payers may require G0455 be reported for this service.

4

ICD-10-CM Diagnostic Codes

- A04.71 Enterocolitis due to *Clostridium difficile*, recurrent
- A04.72 Enterocolitis due to *Clostridium difficile*, not specified as recurrent
- K50.011 Crohn's disease of small intestine with rectal bleeding
- K50.012 Crohn's disease of small intestine with intestinal obstruction
- K50.013 Crohn's disease of small intestine with fistula
- K50.014 Crohn's disease of small intestine with abscess
- K50.018 Crohn's disease of small intestine with other complication
- K50.111 Crohn's disease of large intestine with rectal bleeding
- K50.112 Crohn's disease of large intestine with intestinal obstruction
- K50.113 Crohn's disease of large intestine with fistula
- K50.114 Crohn's disease of large intestine with abscess
- K50.118 Crohn's disease of large intestine with other complication
- K51.00 Ulcerative (chronic) pancolitis without complications
- K51.011 Ulcerative (chronic) pancolitis with rectal bleeding
- K51.012 Ulcerative (chronic) pancolitis with intestinal obstruction
- K51.013 Ulcerative (chronic) pancolitis with fistula
- K51.014 Ulcerative (chronic) pancolitis with abscess
- K51.018 Ulcerative (chronic) pancolitis with other complication
- K51.80 Other ulcerative colitis without complications

5

- K51.811 Other ulcerative colitis with rectal bleeding
- K51.812 Other ulcerative colitis with intestinal obstruction
- K51.813 Other ulcerative colitis with fistula
- K51.814 Other ulcerative colitis with abscess
- K51.818 Other ulcerative colitis with other complication
- K55.021 Focal (segmental) acute infarction of small intestine
- K55.022 Diffuse acute infarction of small intestine
- K55.031 Focal (segmental) acute (reversible) ischemia of large intestine
- K55.032 Diffuse acute (reversible) ischemia of large intestine
- K55.041 Focal (segmental) acute infarction of large intestine
- K55.042 Diffuse acute infarction of large intestine
- K58.0 Irritable bowel syndrome with diarrhea
- K58.1 Irritable bowel syndrome with constipation
- K58.2 Mixed irritable bowel syndrome
- K58.8 Other irritable bowel syndrome
- K59.01 Slow transit constipation
- K59.02 Outlet dysfunction constipation
- K59.03 Drug induced constipation
- K59.04 Chronic idiopathic constipation
- K59.09 Other constipation

Associated HCPCS Codes

G0455 Preparation with instillation of fecal microbiota by any method, including assessment of donor specimen

AMA: 44705 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|------------------|------|------|------|-------|
| 44705 | 1.42 | 1.72 | 0.13 | 3.27 |
| Facility RVU | Work | PE | MP | Total |
| 44705 | 1.42 | 0.55 | 0.13 | 2.1 |

| | FUD | Status | MUE | Modifiers | IOM Reference |
|-------|-----|--------|------|-----------------|---------------|
| 44705 | N/A | I | 1(3) | N/A N/A N/A N/A | None |

* with documentation

Terms To Know

colitis. Inflammation of the colon, caused by an infection or external influences such as laxatives, radiation, or antibiotics.

instillation. Administering a liquid slowly over time, drop by drop.

nasogastric tube. Long, hollow, cylindrical catheter made of soft rubber or plastic that is inserted through the nose down into the stomach, and is used for feeding, instilling medication, or withdrawing gastric contents.

1. CPT Codes and Descriptions

This edition of *Coding Companion* is updated with CPT codes for year 2023.

The following icons are used in *Coding Companion*:

- This CPT code is new for 2023.
- ▲ This CPT code description is revised for 2023.
- + This CPT code is an add-on code.

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

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

The Centers for Medicare and Medicaid Services (CMS) have identified additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE), some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

- [] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

2. Illustrations

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

3. Explanation

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

4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum360 and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

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

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

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

6. Associated HCPCS Codes

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

7. AMA References

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

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2022.

Relative Value Units

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

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

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs when the technical (modifier TC) or professional (modifier 26) component of a procedure is provided.

Evaluation and Management Guidelines Common to All E/M Services

Information unique to this section is defined or identified below.

Classification of Evaluation and Management (E/M) Services

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

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians and other qualified health care professionals. The definitions in the E/M section are provided solely for the basis of code selection.

Some definitions are common to all categories of services, and others are specific to one or more categories only.

New and Established Patient

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

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact same specialty and subspecialty** who belongs to the same group practice, within the past three years. See the decision tree on the following page.

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

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

The decision tree on the following page is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the **other** E/M services when counseling and/or coordination of care dominates the service.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Face-to-face time (outpatient consultations [99241, 99242, 99243, 99244, 99245], domiciliary, rest home, or custodial services [99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337], home services [99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350], cognitive assessment and care plan services [99483]): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, examination, and counseling the patient.

99202-99205

- ★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
- ★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
- ★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
- ★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number/complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are no longer used when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For observation care services, see 99217-99226. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

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

AMA: 99202 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2020,Dec,11; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3
99203 2020,Sep,3; 2020,Sep,14; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3
99204 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3
99205 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3

Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|------------------|------|------|------|-------|
| 99202 | 0.93 | 1.1 | 0.09 | 2.12 |
| 99203 | 1.6 | 1.51 | 0.15 | 3.26 |
| 99204 | 2.6 | 2.04 | 0.23 | 4.87 |
| 99205 | 3.5 | 2.62 | 0.31 | 6.43 |
| Facility RVU | Work | PE | MP | Total |
| 99202 | 0.93 | 0.41 | 0.09 | 1.43 |
| 99203 | 1.6 | 0.67 | 0.15 | 2.42 |
| 99204 | 2.6 | 1.11 | 0.23 | 3.94 |
| 99205 | 3.5 | 1.54 | 0.31 | 5.35 |

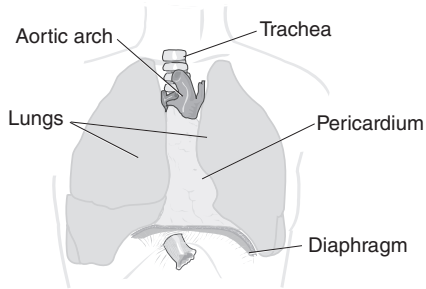
| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|-------|-----|--------|------|-----------|-----|-----|-----|---------------|
| 99202 | N/A | A | 1(2) | N/A | N/A | N/A | 80* | None |
| 99203 | N/A | A | 1(2) | N/A | N/A | N/A | 80* | |
| 99204 | N/A | A | 1(2) | N/A | N/A | N/A | 80* | |
| 99205 | N/A | A | 1(2) | N/A | N/A | N/A | 80* | |

* with documentation

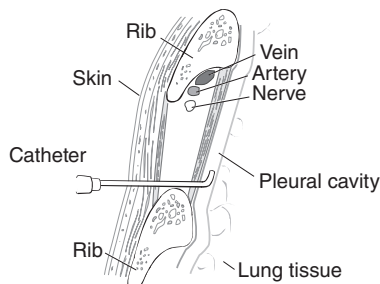
32554-32555

32554 Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance

32555 with imaging guidance



The pleural space is aspirated



Explanation

The physician removes fluid and/or air from the chest cavity by puncturing through the space between the ribs with a hollow needle (cannula) and entering the chest cavity. The fluid (blood or pus) is removed from the chest cavity by pulling back on the plunger of the syringe attached to the cannula. Report 32554 if the procedure is performed without imaging guidance. Report 32555 when imaging guidance is used during the procedure.

Coding Tips

These are unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). When medically necessary, report moderate (conscious) sedation provided by the performing physician with 99151–99153. When provided by another physician, report 99155–99157. Imaging guidance is included in 32555 and is not reported separately. Do not report 32554-32555 with 75989, 76942, 77002, 77012, or 77021. These codes should not be reported with 32550 and 32551 when procedures are performed on the same side of the chest. For percutaneous insertion of an indwelling pleural catheter, see 32556 and 33557. For insertion of an indwelling tunneled pleural catheter with cuff, see 32550.

ICD-10-CM Diagnostic Codes

| | |
|-------|---|
| A15.6 | Tuberculous pleurisy |
| J86.0 | Pyothorax with fistula |
| J86.9 | Pyothorax without fistula |
| J90 | Pleural effusion, not elsewhere classified |
| J91.0 | Malignant pleural effusion |
| J91.8 | Pleural effusion in other conditions classified elsewhere |
| J93.0 | Spontaneous tension pneumothorax |

| | |
|--------|--|
| J93.11 | Primary spontaneous pneumothorax |
| J94.0 | Chylous effusion |
| J94.2 | Hemothorax |
| J94.8 | Other specified pleural conditions |
| J95.4 | Chemical pneumonitis due to anesthesia |
| M32.13 | Lung involvement in systemic lupus erythematosus |
| M35.02 | Sjögren syndrome with lung involvement |

AMA: 32554 2019,Dec,4; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

32555 2019,Dec,4; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|------------------|------|------|------|-------|
| 32554 | 1.82 | 5.07 | 0.19 | 7.08 |
| 32555 | 2.27 | 7.14 | 0.2 | 9.61 |
| Facility RVU | Work | PE | MP | Total |
| 32554 | 1.82 | 0.6 | 0.19 | 2.61 |
| 32555 | 2.27 | 0.75 | 0.2 | 3.22 |

| | FUD | Status | MUE | Modifiers | | IOM Reference | | |
|--------------|-----|--------|------|-----------|----|---------------|-----|------|
| 32554 | 0 | A | 2(3) | 51 | 50 | N/A | N/A | None |
| 32555 | 0 | A | 2(3) | 51 | 50 | N/A | N/A | |

* with documentation

Terms To Know

hemothorax. Blood collecting in the pleural cavity.

malignant pleural effusion. Severe build-up of fluid in the pleural space from a disturbance of the normal processes that regulate fluid reabsorption. It is caused by an obstruction of the lymph that normally drains the parietal pleura or the transfer of a malignancy from a primary site to the lining of the lung, not to be confused with nonmalignant pleural effusion.

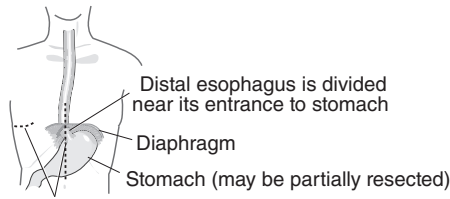
pleurisy. Inflammation of the serous membrane that lines the lungs and the thoracic cavity. Pleurisy may cause effusion within the cavity or have exudate in the pleural space or on the membrane surface.

pneumothorax. Collapsed lung due to air or gas trapped in the pleural space formed by the membrane that encloses the lungs and lines the thoracic cavity.

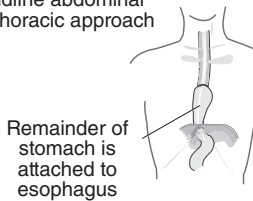
43122

43122 Partial esophagectomy, thoracoabdominal or abdominal approach, with or without proximal gastrectomy; with esophagogastrostomy, with or without pyloroplasty

The distal esophagus is removed, sometimes along with the upper part of the stomach



Midline abdominal or thoracic approach



A pyloroplasty may also be performed

Explanation

The physician removes the distal esophagus and possibly proximal stomach through a combined abdominal and chest incision and replaces the esophagus with the remaining stomach. The physician makes a midline abdominal incision. The stomach is dissected free of surrounding structures and the esophagus is mobilized as it passes through the diaphragm to the stomach. The esophagus is divided proximally above the diseased area and distally at its junction with the stomach or the middle portion of the stomach may be divided. The distal esophagus and attached proximal stomach are removed. The remaining stomach is connected to the stump of the esophagus. The incision is closed.

Coding Tips

Proximal gastrectomy, esophagogastrostomy, pyloroplasty, and thoracoabdominal or abdominal approach are included in this procedure and are not reported separately. If this procedure is performed with colon interposition or small intestine reconstruction, including intestine mobilization, preparation, and anastomosis(es), see 43123.

ICD-10-CM Diagnostic Codes

- C15.4 Malignant neoplasm of middle third of esophagus
- C15.5 Malignant neoplasm of lower third of esophagus
- C15.8 Malignant neoplasm of overlapping sites of esophagus
- C16.0 Malignant neoplasm of cardia
- C49.A1 Gastrointestinal stromal tumor of esophagus
- C7A.092 Malignant carcinoid tumor of the stomach
- D00.1 Carcinoma in situ of esophagus
- D3A.092 Benign carcinoid tumor of the stomach
- K21.9 Gastro-esophageal reflux disease without esophagitis
- K22.10 Ulcer of esophagus without bleeding
- K22.11 Ulcer of esophagus with bleeding
- K22.70 Barrett's esophagus without dysplasia
- K22.710 Barrett's esophagus with low grade dysplasia

- K22.711 Barrett's esophagus with high grade dysplasia
- K22.89 Other specified disease of esophagus
- K23 Disorders of esophagus in diseases classified elsewhere
- K25.0 Acute gastric ulcer with hemorrhage
- K25.2 Acute gastric ulcer with both hemorrhage and perforation
- K25.3 Acute gastric ulcer without hemorrhage or perforation
- K25.4 Chronic or unspecified gastric ulcer with hemorrhage
- K31.1 Adult hypertrophic pyloric stenosis **A**
- Q39.5 Congenital dilatation of esophagus
- Q39.6 Congenital diverticulum of esophagus
- Q39.8 Other congenital malformations of esophagus
- S27.812A Contusion of esophagus (thoracic part), initial encounter
- S27.813A Laceration of esophagus (thoracic part), initial encounter
- S27.818A Other injury of esophagus (thoracic part), initial encounter
- T28.1XXA Burn of esophagus, initial encounter
- T28.6XXA Corrosion of esophagus, initial encounter

AMA: 43122 2014, Jan, 11

Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|------------------|-------|-------|-------|-------|
| 43122 | 44.18 | 20.48 | 10.11 | 74.77 |
| Facility RVU | Work | PE | MP | Total |
| 43122 | 44.18 | 20.48 | 10.11 | 74.77 |

| | FUD | Status | MUE | Modifiers | | | IOM Reference | |
|-------|-----|--------|------|-----------|-----|-----|---------------|------|
| 43122 | 90 | A | 1(2) | 51 | N/A | 62* | 80 | None |

* with documentation

Terms To Know

approach. Method or anatomical location used to gain access to a body organ or specific area for procedures.

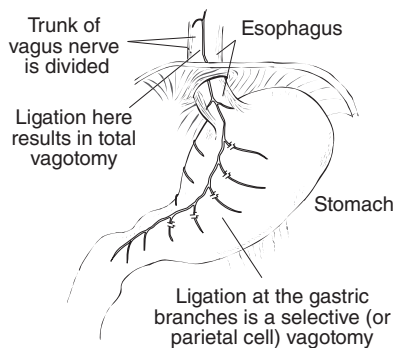
dissect. Cut apart or separate tissue for surgical purposes or for visual or microscopic study.

distal. Located farther away from a specified reference point or the trunk.

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

43635

+ **43635** Vagotomy when performed with partial distal gastrectomy (List separately in addition to code[s] for primary procedure)



Two main trunks of the vagus nerve run down the esophagus. They branch onto the stomach and govern gastric acid secretion

Explanation

The physician performs this with a separately reportable partial distal gastrectomy and repairs the stomach and severs vagus nerves. The physician uses a midline abdominal approach. The distal stomach (antrum) is dissected free and the blood supply to the antrum divided. The distal stomach is removed and the proximal stomach is sutured to the duodenum. Truncal vagotomy is performed by severing both right and left vagus nerves just below the diaphragm.

Coding Tips

Report 43635 in addition to 43631, 43632, 43633, and 43634.

ICD-10-CM Diagnostic Codes

- C16.0 Malignant neoplasm of cardia
- C16.1 Malignant neoplasm of fundus of stomach
- C16.2 Malignant neoplasm of body of stomach
- C16.3 Malignant neoplasm of pyloric antrum
- C16.4 Malignant neoplasm of pylorus
- C16.8 Malignant neoplasm of overlapping sites of stomach
- C7A.092 Malignant carcinoid tumor of the stomach
- D13.1 Benign neoplasm of stomach
- D37.1 Neoplasm of uncertain behavior of stomach
- D3A.092 Benign carcinoid tumor of the stomach
- K25.0 Acute gastric ulcer with hemorrhage
- K25.1 Acute gastric ulcer with perforation
- K25.2 Acute gastric ulcer with both hemorrhage and perforation
- K25.4 Chronic or unspecified gastric ulcer with hemorrhage
- K25.5 Chronic or unspecified gastric ulcer with perforation
- K25.6 Chronic or unspecified gastric ulcer with both hemorrhage and perforation
- K25.7 Chronic gastric ulcer without hemorrhage or perforation
- K27.0 Acute peptic ulcer, site unspecified, with hemorrhage
- K27.1 Acute peptic ulcer, site unspecified, with perforation
- K27.2 Acute peptic ulcer, site unspecified, with both hemorrhage and perforation

- K27.3 Acute peptic ulcer, site unspecified, without hemorrhage or perforation
- K27.4 Chronic or unspecified peptic ulcer, site unspecified, with hemorrhage
- K27.5 Chronic or unspecified peptic ulcer, site unspecified, with perforation
- K27.6 Chronic or unspecified peptic ulcer, site unspecified, with both hemorrhage and perforation
- K27.7 Chronic peptic ulcer, site unspecified, without hemorrhage or perforation
- K31.1 Adult hypertrophic pyloric stenosis
- K31.2 Hourglass stricture and stenosis of stomach
- K31.3 Pylorospasm, not elsewhere classified
- K31.5 Obstruction of duodenum
- K31.811 Angiodysplasia of stomach and duodenum with bleeding
- K31.819 Angiodysplasia of stomach and duodenum without bleeding
- K31.82 Dieulafoy lesion (hemorrhagic) of stomach and duodenum
- K31.89 Other diseases of stomach and duodenum
- K91.81 Other intraoperative complications of digestive system
- S36.33XA Laceration of stomach, initial encounter
- S36.39XA Other injury of stomach, initial encounter

AMA: 43635 2014, Jan, 11

Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|------------------|------|------|------|-------|
| 43635 | 2.06 | 0.76 | 0.48 | 3.3 |
| Facility RVU | Work | PE | MP | Total |
| 43635 | 2.06 | 0.76 | 0.48 | 3.3 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|-------|-----|--------|------|-----------|-----|-----|----|---------------|
| 43635 | N/A | A | 1(2) | N/A | N/A | 62* | 80 | None |

* with documentation

Terms To Know

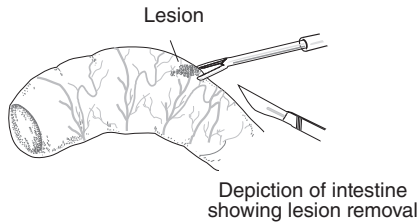
gastrectomy. Surgical excision of all or part of the stomach.

vagotomy. Division of the vagus nerves, interrupting impulses resulting in lower gastric acid production and hastening gastric emptying. Used in the treatment of chronic gastric, pyloric, and duodenal ulcers that can cause severe pain and difficulties in eating and sleeping.

44110-44111

44110 Excision of 1 or more lesions of small or large intestine not requiring anastomosis, exteriorization, or fistulization; single enterotomy

44111 multiple enterotomies



One or more bowel lesions are excised without anastomosis, exteriorization, or fistulization

Explanation

The physician removes one or more lesions in the small or large intestine through an incision in the colon (colotomy) or small intestine (enterotomy) without bowel resection. The physician makes an abdominal incision. Next, the segment of small intestine or colon containing the lesions is mobilized. An incision is made in the small intestine or colon and the lesions are removed. The enterotomy or colotomy is closed with staples or sutures. The abdominal incision is closed. Report 44111 when multiple enterotomies are performed.

Coding Tips

If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report. When these codes are performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. Excision of the stomach for ulcer or benign tumor, see 43610; malignant, see 43611.

ICD-10-CM Diagnostic Codes

- C17.1 Malignant neoplasm of jejunum
- C17.2 Malignant neoplasm of ileum
- C17.3 Meckel's diverticulum, malignant
- C18.0 Malignant neoplasm of cecum
- C18.1 Malignant neoplasm of appendix
- C18.2 Malignant neoplasm of ascending colon
- C18.3 Malignant neoplasm of hepatic flexure
- C18.4 Malignant neoplasm of transverse colon
- C18.5 Malignant neoplasm of splenic flexure
- C18.6 Malignant neoplasm of descending colon
- C18.7 Malignant neoplasm of sigmoid colon
- C18.8 Malignant neoplasm of overlapping sites of colon
- C49.A3 Gastrointestinal stromal tumor of small intestine
- C49.A4 Gastrointestinal stromal tumor of large intestine
- C7A.010 Malignant carcinoid tumor of the duodenum
- C7A.011 Malignant carcinoid tumor of the jejunum
- C7A.012 Malignant carcinoid tumor of the ileum
- C7A.021 Malignant carcinoid tumor of the cecum
- C7A.023 Malignant carcinoid tumor of the transverse colon
- C7A.024 Malignant carcinoid tumor of the descending colon
- C7A.025 Malignant carcinoid tumor of the sigmoid colon
- D01.0 Carcinoma in situ of colon

- D01.1 Carcinoma in situ of rectosigmoid junction
- D01.2 Carcinoma in situ of rectum
- D12.0 Benign neoplasm of cecum
- D12.1 Benign neoplasm of appendix
- D12.2 Benign neoplasm of ascending colon
- D12.3 Benign neoplasm of transverse colon
- D12.4 Benign neoplasm of descending colon
- D12.5 Benign neoplasm of sigmoid colon
- D13.2 Benign neoplasm of duodenum
- D37.2 Neoplasm of uncertain behavior of small intestine
- D37.3 Neoplasm of uncertain behavior of appendix
- D37.4 Neoplasm of uncertain behavior of colon
- D37.5 Neoplasm of uncertain behavior of rectum
- D3A.010 Benign carcinoid tumor of the duodenum
- D3A.011 Benign carcinoid tumor of the jejunum
- D3A.012 Benign carcinoid tumor of the ileum
- D3A.021 Benign carcinoid tumor of the cecum
- D3A.022 Benign carcinoid tumor of the ascending colon
- D3A.023 Benign carcinoid tumor of the transverse colon
- D3A.024 Benign carcinoid tumor of the descending colon
- D3A.025 Benign carcinoid tumor of the sigmoid colon
- K56.51 Intestinal adhesions [bands], with partial obstruction
- K56.52 Intestinal adhesions [bands] with complete obstruction
- K63.5 Polyp of colon
- N80.5 Endometriosis of intestine ♀
- Q43.1 Hirschsprung's disease
- Q43.2 Other congenital functional disorders of colon

AMA: 44110 2014,Jan,11 44111 2014,Jan,11

Relative Value Units/Medicare Edits

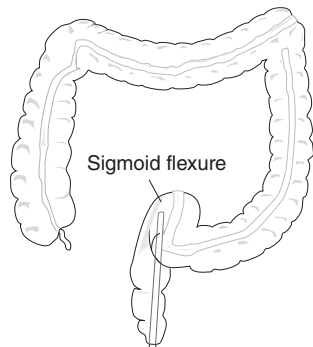
| Non-Facility RVU | Work | PE | MP | Total |
|------------------|-------|------|------|-------|
| 44110 | 14.04 | 8.1 | 2.88 | 25.02 |
| 44111 | 16.52 | 8.98 | 3.27 | 28.77 |
| Facility RVU | Work | PE | MP | Total |
| 44110 | 14.04 | 8.1 | 2.88 | 25.02 |
| 44111 | 16.52 | 8.98 | 3.27 | 28.77 |

| | FUD | Status | MUE | Modifiers | | | | IOM Reference |
|--------------|-----|--------|------|-----------|-----|-----|----|---------------|
| 44110 | 90 | A | 1(2) | 51 | N/A | 62* | 80 | None |
| 44111 | 90 | A | 1(2) | 51 | N/A | 62* | 80 | |

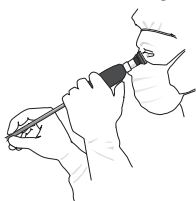
* with documentation

45307

45307 Proctosigmoidoscopy, rigid; with removal of foreign body



A rigid proctosigmoid examination is performed. Usually access beyond the sigmoid flexure is limited due to the rigidity of the scope.



Examination using rigid proctosigmoidoscope

Explanation

The physician performs rigid proctosigmoidoscopy and removes a foreign body. The physician inserts the rigid proctosigmoidoscope into the anus and advances the scope. The sigmoid colon and rectal lumen are visualized and the foreign body is identified. The foreign body is removed by a snare or forceps inserted through the scope. The proctosigmoidoscope is removed at the completion of the procedure.

Coding Tips

Report the appropriate endoscopy for each anatomic site examined. Surgical endoscopy includes diagnostic endoscopy; however, diagnostic endoscopy can be identified separately when performed at the same surgical session as an open procedure. Proctosigmoidoscopy codes are reported only when a rigid proctoscope (stiff hollow tube-like instrument) is used. If a flexible instrument is used, flexible sigmoidoscopy codes should be reported. For sigmoidoscopy, flexible, with removal of a foreign body, see 45332. For colonoscopy, flexible, with removal of a foreign body, see 45379. For anoscopy, with removal of a foreign body, see 46608.

ICD-10-CM Diagnostic Codes

- K62.5 Hemorrhage of anus and rectum
- K62.89 Other specified diseases of anus and rectum
- K92.1 Melena
- T18.4XXA Foreign body in colon, initial encounter
- T18.5XXA Foreign body in anus and rectum, initial encounter

AMA: 45307 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|------------------|------|------|------|-------|
| 45307 | 1.6 | 4.26 | 0.21 | 6.07 |
| Facility RVU | Work | PE | MP | Total |
| 45307 | 1.6 | 0.98 | 0.21 | 2.79 |

| | FUD | Status | MUE | Modifiers | | | IOM Reference | |
|--------------|-----|--------|------|-----------|-----|-----|---------------|------|
| 45307 | 0 | A | 1(3) | 51 | N/A | N/A | 80* | None |

* with documentation

Terms To Know

endoscopy. Visual inspection of the body using a fiberoptic scope.

forceps. Tool used for grasping or compressing tissue.

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

hemorrhage. Internal or external bleeding with loss of significant amounts of blood.

lumen. Space inside an intestine, artery, vein, duct, or tube.

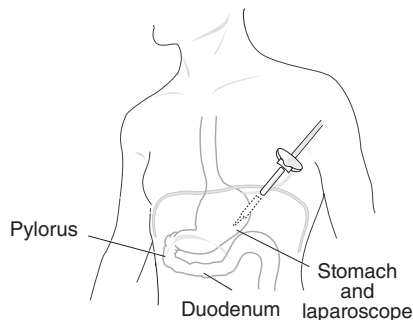
proctosigmoidoscope. Instrument used for examination of the sigmoid colon and rectum.

sigmoidoscopy. Endoscopic examination of the entire rectum and sigmoid colon, often including a portion of the descending colon and usually performed with a flexible fiberoptic scope in conjunction with a surgical procedure.

snare. Wire used as a loop to excise a polyp or lesion.

49460

49460 Mechanical removal of obstructive material from gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, any method, under fluoroscopic guidance including contrast injection(s), if performed, image documentation and report



Obstructions are mechanically removed

Explanation

The physician mechanically removes obstructive material from an existing tube (gastrostomy, duodenostomy, jejunostomy, gastrojejunostomy, or cecostomy) by any method. Fluoroscopic guidance and contrast imaging may be utilized. This procedure includes image documentation and report.

Coding Tips

Do not report 49460 with 49450–49452 and 49465.

ICD-10-CM Diagnostic Codes

- K31.89 Other diseases of stomach and duodenum
- K94.01 Colostomy hemorrhage
- K94.09 Other complications of colostomy
- K94.11 Enterostomy hemorrhage
- K94.19 Other complications of enterostomy
- K94.21 Gastrostomy hemorrhage
- K94.22 Gastrostomy infection
- K94.23 Gastrostomy malfunction
- K94.29 Other complications of gastrostomy
- L02.211 Cutaneous abscess of abdominal wall
- L02.212 Cutaneous abscess of back [any part, except buttock]
- L02.213 Cutaneous abscess of chest wall
- L02.215 Cutaneous abscess of perineum
- L02.216 Cutaneous abscess of umbilicus
- L03.311 Cellulitis of abdominal wall
- L03.313 Cellulitis of chest wall
- L03.315 Cellulitis of perineum
- L03.316 Cellulitis of umbilicus
- L03.321 Acute lymphangitis of abdominal wall
- L03.322 Acute lymphangitis of back [any part except buttock]
- L03.323 Acute lymphangitis of chest wall
- L03.324 Acute lymphangitis of groin
- L03.325 Acute lymphangitis of perineum
- L03.326 Acute lymphangitis of umbilicus
- T85.510A Breakdown (mechanical) of bile duct prosthesis, initial encounter

- T85.511A Breakdown (mechanical) of esophageal anti-reflux device, initial encounter
- T85.518A Breakdown (mechanical) of other gastrointestinal prosthetic devices, implants and grafts, initial encounter
- T85.520A Displacement of bile duct prosthesis, initial encounter
- T85.521A Displacement of esophageal anti-reflux device, initial encounter
- T85.528A Displacement of other gastrointestinal prosthetic devices, implants and grafts, initial encounter
- T85.590A Other mechanical complication of bile duct prosthesis, initial encounter
- T85.591A Other mechanical complication of esophageal anti-reflux device, initial encounter
- T85.598A Other mechanical complication of other gastrointestinal prosthetic devices, implants and grafts, initial encounter
- T85.618A Breakdown (mechanical) of other specified internal prosthetic devices, implants and grafts, initial encounter
- T85.692A Other mechanical complication of permanent sutures, initial encounter
- T85.698A Other mechanical complication of other specified internal prosthetic devices, implants and grafts, initial encounter
- Z43.1 Encounter for attention to gastrostomy
- Z43.2 Encounter for attention to ileostomy

AMA: 49460 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

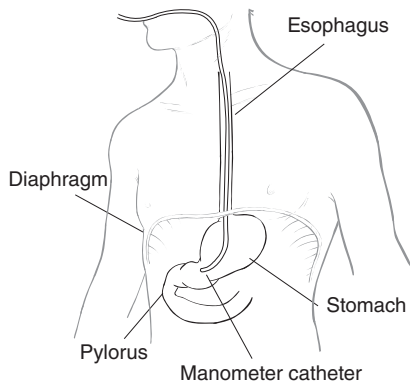
| Non-Facility RVU | Work | PE | MP | Total |
|------------------|------|-------|------|-------|
| 49460 | 0.96 | 20.74 | 0.11 | 21.81 |
| Facility RVU | Work | PE | MP | Total |
| 49460 | 0.96 | 0.35 | 0.11 | 1.42 |

| | FUD | Status | MUE | Modifiers | | | IOM Reference | |
|--------------|-----|--------|------|-----------|-----|-----|---------------|------|
| 49460 | 0 | A | 1(3) | 51 | N/A | N/A | 80* | None |

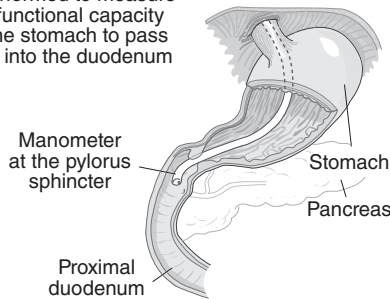
* with documentation

91022

91022 Duodenal motility (manometric) study



A manometric study is performed to measure the functional capacity of the stomach to pass food into the duodenum



Explanation

The physician inserts a tube with sensors into the patient's nose or mouth and down into the duodenum to perform a duodenal motility study. The muscles of the duodenum and the gastroduodenal junction, which propel food and water into the first part of the small intestines, are studied to measure the pressure of the contraction waves and diagnose abnormalities in the muscle that affect digestion. Sensors on the tube measure the amount of pressure generated by the duodenal muscles as food is moved into the small intestine. The tighter the muscles contract around the tube, the greater pressure that is sensed. The data is recorded for computer analysis.

Coding Tips

For a gastric motility study, see 91020. Fluoroscopy is reported with 76000, when performed. For diagnostic esophagogastroduodenoscopy, see 43235. Do not report 91022 with 91112.

ICD-10-CM Diagnostic Codes

- K30 Functional dyspepsia
- K31.0 Acute dilatation of stomach
- K31.1 Adult hypertrophic pyloric stenosis **A**
- K31.2 Hourglass stricture and stenosis of stomach
- K31.3 Pylorospasm, not elsewhere classified
- K31.4 Gastric diverticulum
- K31.5 Obstruction of duodenum
- K31.84 Gastroparesis
- K31.89 Other diseases of stomach and duodenum
- K59.01 Slow transit constipation
- K59.02 Outlet dysfunction constipation

- K59.04 Chronic idiopathic constipation
- K59.09 Other constipation
- K92.81 Gastrointestinal mucositis (ulcerative)
- R11.0 Nausea
- R11.11 Vomiting without nausea
- R11.12 Projectile vomiting

AMA: 91022 2018,Jan,8; 2018,Feb,11; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

| Non-Facility RVU | Work | PE | MP | Total |
|------------------|------|------|------|-------|
| 91022 | 1.44 | 3.64 | 0.06 | 5.14 |
| Facility RVU | Work | PE | MP | Total |
| 91022 | 1.44 | 3.64 | 0.06 | 5.14 |

| | FUD | Status | MUE | Modifiers | IOM Reference |
|--------------|-----|--------|------|-----------------|---------------|
| 91022 | 0 | A | 1(2) | N/A N/A N/A 80* | None |

* with documentation

Terms To Know

achalasia. Failure of the smooth muscles within the gastrointestinal tract to relax at points of junction; most commonly referring to the esophagogastric sphincter's failure to relax when swallowing.

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

dyskinesia of esophagus. Difficult or impaired voluntary muscle movement of the esophagus.

dyspepsia. Epigastric discomfort after eating, due to impaired digestive function.

ileus. Persistent obstruction of the intestines.

manometric. Pertaining to pressure, as measured in a meter.

motility. Capability of independent, spontaneous movement.