INGENIX®

Coding Companion for Emergency Medicine

A comprehensive illustrated guide to coding and reimbursement

2009

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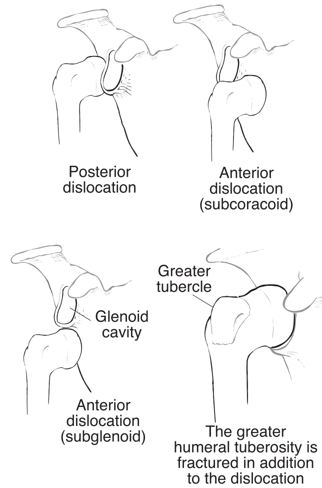
23665

23665 Closed treatment of shoulder dislocation, with fracture of greater humeral tuberosity, with manipulation



A shoulder dislocation with fracture of the greater humeral tuberosity is treated in a closed fashion with manipulation

Explanation

The physician performs closed reduction of a shoulder dislocation with greater humeral tuberosity fracture. With the patient positioned prone and the arm hanging toward the floor, manual distraction is attempted. If not successful, the physician may hang a five-pound weight from the arm in an attempt to reduce the shoulder into place. Once shoulder reduction is obtained, a neurovascular examination is performed and treatment of the humeral tuberosity fracture is addressed. The arm is immobilized for three to six weeks.

Coding Tips

According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. See "Application of Casts and Strapping" in the CPT book in the Surgery Section, under the Musculoskeletal system. Local anesthesia is included in this service. However, this procedure may be performed under general anesthesia, depending on the age and/or condition of the patient. For open treatment of a shoulder dislocation with a greater humeral tuberosity fracture, see 23670. For closed treatment of a shoulder dislocation alone, see 23650 and 23655. For open treatment of a shoulder dislocation alone, see 23660. Use caution when coding dislocations, especially in differentiating between the types of dislocation and the types of treatment. Closed dislocations may require either closed and/or open treatment, whereas open dislocations require open treatment. Make sure to identify the site of the dislocation, whether the dislocation is open or closed, whether the treatment is open or closed, if manipulation is part of the treatment, internal and external skeletal fixation of the dislocation, and the use of anesthesia.

ICD-9-CM Procedural

79.01 Closed reduction of fracture of humerus without internal fixation

79.71 Closed reduction of dislocation of shoulder

Anesthesia

23665 01620

ICD-9-CM Diagnostic

733.11 Pathologic fracture of humerus

812.03 Closed fracture of greater tuberosity of humerus

831.00 Closed dislocation of shoulder, unspecified site

Terms To Know

closed fracture. Break in a bone without a concomitant opening in the skin. A closed fracture is coded when the type of fracture is not specified.

closed reduction. Treatment of a fracture by manipulating it into proper alignment without opening the skin.

closed treatment. Realignment of a fracture or dislocation without surgically opening the skin to reach the site. Treatment methods employed include with or without manipulation, and with or without traction.

developmental dislocation. Displacement of a body part occurring in the developmental phase of childhood.

dislocation. Displacement of a bone in relation to its neighboring tissue, especially a joint.

manipulation. Skillful treatment by hand to reduce fractures and dislocations, or provide therapy through forceful passive movement of a joint beyond its active limit of motion.

pathologic fracture. Break in bone due to a disease process that weakens the bone structure, such as osteoporosis, osteomalacia, or neoplasia, and not traumatic injury.

prone. Lying face downward.

strapping. Application of overlapping strips of tape or bandaging to put pressure on the affected area.

CCI Version 14.3

01610, 23700, 29000-29065, 29105, 29240, 29700-29715, 36000, 36410, 37202, 51701-51703, 62318-62319, 64415-64417, 64450, 64470, 64475, 69990, 90760, 90765, 90772, 90774, 90775, 97597-97598, 97602-97606

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
23665	9.67	10.25	90	N/A

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

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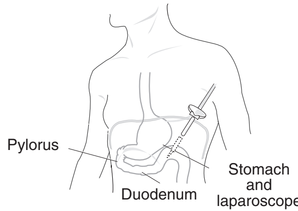
49440

49440 Insertion of gastrostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report



Duodenostomy or jejunostomy tube is inserted percutaneously

Explanation

The physician inserts a gastrostomy tube via percutaneous (under the skin) approach using fluoroscopic guidance. Percutaneous image-guided gastrostomy or enterostomy procedures may be indicated for patients who have an impaired swallowing mechanism, mechanical obstruction of the upper GI tract due to malignancy, or those with aberrant upper GI anatomy. Following administration of any necessary sedation, nasogastric or orogastric intubation is performed under fluoroscopic guidance and the stomach is insufflated. The skin and subcutaneous tissues overlying the stomach are anesthetized with lidocaine. Using a subcostal (below the ribs) approach and fluoroscopic guidance, the physician inserts a 7 cm, 18-gauge needle in the area of the horizontal portion of the greater curvature. A guidewire is then passed through the needle and the needle is withdrawn. A dilator is introduced over the wire and the tract is dilated. The physician places a self-retaining loop catheter into the stomach and injects a small amount of contrast material in order to confirm placement. A loop-locking suture is tied and nasogastric or orogastric tubes are removed. Antiseptic ointment and sterile dressings are applied. This code includes image documentation and report.

Coding Tips

For conversion to a gastro-jejunostomy tube at the time of initial gastrostomy tube placement, use 49440 in conjunction with 49446. If an existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube is removed and a new tube is placed via a separate percutaneous access site, the placement of the new tube is not considered a replacement and would be reported using the appropriate initial placement codes 49440–49442.

ICD-9-CM Procedural

43.11 Percutaneous (endoscopic) gastrostomy (PEG)

Anesthesia

49440 00700

ICD-9-CM Diagnostic

141.9 Malignant neoplasm of tongue, unspecified site
149.0 Malignant neoplasm of pharynx, unspecified
149.8 Malignant neoplasm of other sites within the lip and oral cavity
150.0 Malignant neoplasm of cervical esophagus
150.1 Malignant neoplasm of thoracic esophagus
150.2 Malignant neoplasm of abdominal esophagus
150.3 Malignant neoplasm of upper third of esophagus
150.4 Malignant neoplasm of middle third of esophagus
150.5 Malignant neoplasm of lower third of esophagus
150.8 Malignant neoplasm of other specified part of esophagus
151.9 Malignant neoplasm of stomach, unspecified site
161.9 Malignant neoplasm of larynx, unspecified site
203.00 Multiple myeloma, without mention of having achieved remission
250.31 Diabetes with other coma, type I [juvenile type], not stated as uncontrolled
250.32 Diabetes with other coma, type II or unspecified type, uncontrolled
250.33 Diabetes with other coma, type I [juvenile type], uncontrolled
261 Nutritional marasmus
262 Other severe protein-calorie malnutrition
330.8 Other specified cerebral degenerations in childhood — (Use additional code to identify associated mental retardation)
335.20 Amyotrophic lateral sclerosis
436 Acute, but ill-defined, cerebrovascular disease — (Use additional code to identify presence of hypertension)
530.4 Perforation of esophagus
530.5 Dyskinesia of esophagus
530.84 Tracheoesophageal fistula
780.01 Coma
787.20 Dysphagia, unspecified
787.29 Other dysphagia
V10.01 Personal history of malignant neoplasm of tongue — (Code first any continuing functional activity: 259.2)
V10.02 Personal history of malignant neoplasm of other and unspecified parts of oral cavity and pharynx — (Code first any continuing functional activity: 259.2)
V10.03 Personal history of malignant neoplasm of esophagus — (Code first any continuing functional activity: 259.2)
V10.21 Personal history of malignant neoplasm of larynx — (Code first any continuing functional activity: 259.2)

CCI Version 14.3

36000, 36410, 37202, 43200, 43234, 43246❖, 43752-43761, 49450, 49452-49465, 62318-62319, 64415-64417, 64450, 64470, 64475, 69990, 75984, 76000-76001, 77002, 90760, 90765, 90772, 90774, 90775, 93000-93010, 93040-93042, 94770, 99143-99144, 99148-99149

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
49440	6.58	29.09	10	80

Medicare References: None

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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 for 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 and instructions and

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