

ULTRASOUND CODING AND REIMBURSEMENT DOCUMENT 2009

EMERGENCY ULTRASOUND SECTION

AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

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EMERGENCY ULTRASOUND CODING AND REIMBURSEMENT UPDATE – 2009

Introduction

The goal of this paper is to assist Emergency physicians in understanding correct and compliant coding, appropriate documentation, payer policy, and issues surrounding claims submission for Emergency physician ultrasound examinations they are currently performing or may anticipate performing. The codes included in this document are based on the “core” and “adjunct” ultrasound applications as described in the 2008 Emergency Ultrasound Guidelines.

The paper is organized into 5 sections:

1. Understanding CPT terminology
2. Emergency Ultrasound Coding
3. Understanding ICD-9 Coding
4. Ultrasound documentation
5. Reimbursement

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Finally, this paper addresses coding and reimbursement policy and regulation that are subject to change, vary by region and vary by payer. The reader is advised to confirm that the material addressed here is current for their specific location.

For a more in-depth understanding of emergency ultrasound procedures and guidelines please refer to the Emergency Ultrasound Section of Membership on the ACEP website: www.acep.org. Additional resources can be found at the end of this document.

I. CPT CODING

A. Current Procedural Terminology (CPT)

Physician's CPT is a system of descriptive terms and identifying codes for the reporting of medical, surgical, and diagnostic services. This system provides a communication tool for medical care and utilization review as well as a claim-processing tool utilized by both governmental and private payers.

CPT codes describe what services have been performed. The Evaluation and Management (E&M) codes 99281-99285 are the codes for cognitive services most commonly utilized by and familiar to Emergency Physicians. Procedure codes describe the performance of surgical or diagnostic procedures, for example, 12001 is the CPT code for the repair of a simple laceration < 2.5 cm. Multiple CPT codes may be used for the same patient, such as an E&M code plus a laceration repair procedure code for a patient that was evaluated for syncope and suffered a scalp laceration resulting from the fall.

Most ultrasound procedures performed by Emergency Physicians are accurately described by current CPT codes and generally may be coded in addition to Evaluation and Management codes. CPT codes commonly used by Emergency Physicians for ultrasound applications are catalogued below (see Appendix A). In some cases multiple ultrasound codes may be utilized for the same patient.

Finally, all physicians, regardless of specialty, utilize the same CPT codes. For example an Internist, Surgeon, Family Practitioner or Emergency Physician might utilize the critical care code 99291. A limited ultrasound of the pregnant uterus, performed by an Obstetrician-Gynecologist, a Family Practitioner, a Radiologist or an Emergency Physician would all be coded 76815.

B. Limited Vs Complete Ultrasound Studies

CPT codes for ultrasound examinations are considered to be "complete" studies unless specified as "limited" studies in their code definitions. A complete study, as defined by the CPT, is one in which an attempt is made to visualize and diagnostically evaluate all of the major structures within the anatomic description. CPT 2005 has further defined the elements required for a study to qualify as a "complete" examination. Specifically, this language is included in the Diagnostic Ultrasound instructions:

For those anatomic regions that have "complete" and "limited" ultrasound codes, note the elements that comprise a "complete" exam. The report should contain a description of these elements or the reason that an element could not be visualized (e.g. obscured by bowel gas, surgically absent etc.).

An example of what would constitute a complete examination can be found in the Abdomen and Retroperitoneum section of CPT 2005:

A complete ultrasound examination of the abdomen (76700) consists of real time scans of the liver, gall bladder, common bile duct, pancreas, spleen, kidneys, and

the upper abdominal aorta and inferior vena cava including any demonstrated abdominal abnormality.

A limited study would address only a single quadrant, a single diagnostic problem or might be a follow-up examination. In 2005 CPT modified the definition for a limited examination:

If less than the required elements for a “complete” exam are reported (e.g. limited number of organs or limited portion of region evaluated), the “limited” code for that anatomic region should be used once per patient exam session. A “limited” exam of an anatomic region should not be reported for the same exam session as a “complete” exam of that same region.

This indicates that an examination that fails to address all elements of a complete examination would qualify as a limited examination. Note: this approach adheres to the paradigm of emergency ultrasound and reflects our approach of focused examinations. The limited abdominal examination 76705 would be used to describe the ultrasound examination of a more focused diagnostic problem, e.g. the presence or absence of free intraperitoneal fluid in the clinical setting of blunt trauma.

Emergency Physicians may conduct complete examinations and code for them. It should be noted that a complete or limited examination would be expected to be substantially the same as that exam performed and reported by Radiologists or other imaging specialists though performed for a different purpose.

C. CPT Modifiers

Modifiers are additions to the CPT code designed to expand the information provided by the CPT code alone. Modifiers indicate that a service or procedure described by the code is being used other than as defined in CPT. Multiple modifiers may be applied to CPT codes. Failure to use appropriate modifiers may result in denial of payment, result in overpayment and/or trigger an audit of your billing and coding practices. One should be aware that the use of modifiers may draw attention to the claim by the payer and may prompt requests for additional information. Despite these complexities, coders must use the codes and modifiers that accurately describe the procedure performed or examination completed.

An exhaustive discussion of modifiers is beyond the scope of this review. However, the most common modifiers that may be utilized with ultrasound procedure codes are:

1) –26 Professional Component

Ultrasound CPT codes are combined, or “global” service codes. In this context a global code is a combined technical component and professional component of the examination. In the hospital setting the technical component, indicated by a –TC modifier, is typically reported by the facility (i.e. hospital) and includes reimbursement for the cost of equipment, supplies and technician salaries. The professional component, indicated by the –26 modifier, is typically reported by the physician for professional services and includes interpretation of diagnostic

tests/studies with preparation of a separate distinctly identifiable signed written report. An unmodified ultrasound CPT code describes a combination of professional and technical components as a global service. Unmodified codes are utilized by physician offices, clinics or free standing emergency facilities not operated by a hospital, that provide professional services as well as own and maintain the equipment. Hospital-based Emergency Physicians would report ultrasound CPT codes with the professional component modifier e.g. 76815-26 (Echography, pregnant uterus; limited; professional component). This modifier would be used whether the examination was reported by the hospital on behalf of an employed physician, under an agreement to reassign fees to the hospital, or submitted directly by a physician or a physician group. Reporting an unmodified, global CPT code by a hospital-based physician, when the equipment is owned and maintained by the hospital would be incorrect and inaccurately reflect the service provided. It should be noted that the fact that the Emergency Physician performs the scan as well as interprets the scan does not impact use of the -26 modifier under current CPT definition.

Finally, physicians contemplating arrangements such as equipment ownership in a hospital setting and the utilization of global codes are advised to seek competent specialized legal counsel. Financial relationships between physicians who utilize hospital services that entail using the physician's own equipment are subject to multiple fraud and abuse statutes and regulations.

2) -52 Reduced Services

Under certain circumstances a service is partially reduced or eliminated at the physician's discretion. The usual CPT code is used with the added -52 modifier indicating that the typical procedure was not performed as described, but rather at some reduced level of service. An example of this would be transvaginal ultrasound in a pregnant woman if a complete evaluation of the anatomic region is not performed (76817-26,-52)

3) -59 Distinct Procedural Service

This modifier is used to report procedures that are distinct but have the same CPT code. For example, if a patient had multiple foreign bodies in both the right upper and lower extremities, the 76880 code for ultrasound extremity, nonvascular, real time with image documentation, would be used twice, with a -59 modifier.

4) -76 Repeat Procedure by Same Physician

This modifier defines a repeat procedure by the "same physician" on the same date of service or patient session. Practitioners in the same specialty, same group and during the same encounter are viewed from a billing perspective as the "same physician". Payment is based on the group's Medicare provider number, not the unique physician identifier number. For example, if a patient with blunt abdominal trauma and a negative initial thoracoabdominal trauma study ("FAST" exam) then later becomes hemodynamically unstable, a repeat examination may be warranted. The -76 modifier would be appropriate if the repeat exam was performed by the same exact Emergency Physician or if the patient had been signed out to another

Emergency Physician and this second Emergency Physician repeated the study. This scenario would be similar to a patient developing recurring chest pain 30 minutes after an initial normal EKG requiring a repeat EKG. Again, as modified codes may draw attention based on pre-payment or post-payment edits (see III. C. Payment edits under Payer Policy), it would be prudent to include explanation of the medical necessity for repeated ultrasound examination in the study documentation.

5) -77 Repeat Procedure by Another Physician

This modifier defines a repeat procedure by another physician during the same patient encounter. When an ultrasound procedure is repeated by another physician, the first exam would not require a -77 modifier (i.e. indicating the exam was subsequently repeated). The second exam would require use of the -77 modifier and assumes that the second physician was aware that his/hers was a repeat examination. For example, if a patient with blunt abdominal trauma and a negative initial thoracoabdominal trauma study performed by the Emergency Physician requires a repeat ultrasound due to hemodynamic instability and the second physician is the Trauma Surgeon, the Trauma Surgeon should use the -77 modifier. The Trauma Surgeon's group Medicare provider number is different than the Emergency Physician's and warrants the -77 modifier instead of the -76 modifier. As always the medical necessity for repeating these procedures should be documented in the chart in addition to applying the modifier.

Note: A complete table of modifiers is available in *Current Procedural Terminology CPT™ 2009* (AMA Press).

II. CPT Codes for Emergency Ultrasound Procedures

Ultrasound usage by Emergency Physicians can be divided into two major categories as listed in the 2008 Emergency Ultrasound Guidelines: A) Core Emergency Ultrasound Applications and B) Adjunct Emergency Ultrasound Applications.

SEE APPENDIX A: EMERGENCY ULTRASOUND CODING SHEET

A. Core Emergency Ultrasound Applications

The core applications, described by the 2008 Emergency Ultrasound Guidelines, include :

1. Trauma
2. Intrauterine Pregnancy
3. AAA
4. Cardiac
5. Biliary
6. Urinary Tract
7. DVT
8. Soft Tissue/Musculoskeletal
9. Thoracic
10. Ocular
11. Procedural Guidance.

Each of these applications is addressed below.

1. Trauma Ultrasound

Clinical guidelines for performing a FAST examination have been defined by our College in the ACEP Ultrasound Imaging Criteria. These guidelines are also supported by the joint AIUM and ACEP Guideline for the Performance of the FAST Exam published in October 2007 (available at www.aium.org). The above documents outline the traditional four window examination (3 abdominal and 1 cardiac) and include evaluation of the anterior pleural windows for pneumothorax and additional cardiac windows to better evaluate for hemopericardium as well as IVC physiology.

There is no CPT code that specifically describes the emergency ultrasound trauma examination as this is not a single ultrasound procedure, but a clinical approach to the trauma patient that utilizes a group of distinct limited ultrasound examinations currently described by CPT. Coding for

elements contained within the FAST exam requires utilizing the same CPT and ICD-9 codes which are utilized by other medical professionals performing and coding for ultrasounds. Currently, there are three CPT codes which reflect separately identifiable elements of the FAST exam as described by the AIUM/ACEP documents: 1) cardiac 93308-26, 2) abdomen 76705-26, and 3) chest 76604-26.

These CPT codes must be used judiciously and must be supported by ICD-9 codes, which provide evidence of medical necessity for each ultrasound examination. It should be noted that the process of comparing CPT procedure codes with ICD-9 diagnosis codes are termed “edits” and are used by payers to make an initial determination of medical necessity. Further, screening ultrasound examinations, i.e. in the absence of abnormal signs, symptoms, laboratory tests or pathologic diagnosis, may not be reimbursable by many insurance carriers. Knowledge of which ICD-9 codes support use of the above CPT codes and are deemed to be reimbursable services requires communication with your local carriers.

The CMS website contains local coverage determinations (LCDs), which are documents prepared by regional Medicare Administrative Contractors (MACs). These LCDs list accepted ICD-9 codes that would support the medical necessity of corresponding ultrasound CPT codes. Regional MACs set standards adopted by other MACs as well as many private insurers. Some MAC websites are more user friendly than the CMS website. LCDs are not available for all CPT codes, for example, there is no LCD for chest ultrasound.

The LCD document ID number for transthoracic echocardiography is L6980 (see Appendix B). The following ICD-9 codes which are relevant to a traumatically injured patient are listed: 1. Traumatic shock (958.4), 2. Unspecified injury of heart with open wound into thorax—laceration of heart chambers and open wound into thorax (861.10-861.13), 3. Flail chest (807.4), 4. Precordial pain (786.51), 5. Shortness of breath (786.05). Other listed ICD-9 codes may also be deemed relevant. Despite the obvious logic, Injury to other and unspecified intrathoracic organs with open wound into cavity (862.9) is not listed as a reimbursable ICD-9 code and may result in a coding rejection on a first-pass edit. However, a first-pass edit rejection may be reimbursed after appeal when the service provider can demonstrate the medical necessity of the ultrasound procedure. Certainly the medical literature supports performing a focused cardiac exam and a focused chest exam on patients with a stab wound to the precordium who are intubated and who may have hemopericardium or a pneumothorax *prior* to developing traumatic shock.

The LCD document ID number for abdominal and pelvic ultrasound is L28539 (see Appendix C). The following ICD-9 codes related to traumatic injury are

listed: Hypotension unspecified (458.9), Abdominal pain (789.00-09), Abdominal rigidity (789.40-49), Contusion of abdominal wall (922.2), Abdominal tenderness (789.60-69), Internal injury to unspecified or ill-defined organs without open wound into cavity (869.0), Internal injury to unspecified or ill-defined organs with open wound into cavity (869.1). Other ICD-9 codes may also be deemed relevant.

We would emphasize again that despite the availability of 3 codes which accurately describe a full trauma torso ultrasound evaluation, physicians and coders should list only those appropriate for that patient.

2. Intrauterine Pregnancy

Evaluation of the female with abdominal pain or vaginal bleeding is a common scenario in the Emergency Department. In pregnancy these complaints are potentially life threatening. The Emergency Physician must differentiate between early intrauterine pregnancy, spontaneous abortion, ectopic pregnancy, ruptured ovarian cyst, ovarian torsion, as well as diseases that are neither gynecologic nor pregnancy-related. In this context, the primary goal of bedside ultrasound is to identify the presence or absence of an intrauterine pregnancy and presence or absence of free fluid in the pelvic peritoneum in order to support clinical decision-making.

The coding of ultrasound use in this setting is not always intuitive and depends primarily upon two conditions: 1) is the patient known to be pregnant when the ultrasound is performed and, 2) is the ultrasound performed to evaluate a non-obstetric condition. When the patient is known by any means to be pregnant, including a positive pregnancy test, and the physician is utilizing ultrasound to evaluate the pregnancy or a suspected complication of pregnancy, then the obstetric pelvic codes would be utilized (e.g. limited pelvic ultrasound in a woman known to be pregnant (76815-26) or complete transvaginal pelvic ultrasound in a woman known to be pregnant (76817-26 with or without -52 modifier for reduced level of service). When these criteria are met, the obstetric codes are utilized regardless of the study result. Thus, the obstetric pelvic codes would apply to the “known to be pregnant patient” even in the absence of an intrauterine pregnancy identified by the subsequent ultrasound and even if the patient was found to have an ectopic pregnancy, spontaneous abortion, molar pregnancy or a non-pregnancy related condition.

If pregnancy is documented to be absent prior to the ultrasound examination and ultrasound was utilized to evaluate pelvic pain, amenorrhea, vaginal bleeding or non-gynecologic pelvic pathology, then the non-obstetric pelvic codes would be utilized (e.g. limited transabdominal pelvic ultrasound in a woman known to be not pregnant (76857-26) or complete transvaginal ultrasound in a woman known to be not pregnant (76830-26 with or without -52 reduced service modifier). This would hold true even if the result of the subsequent ultrasound examination was an intrauterine or ectopic pregnancy.

The presence of a known pregnancy does not affect the application of abdominal, pelvic or retroperitoneal codes when ultrasound is utilized for non-obstetric indications. For example, an abdominal code (e.g. 76705-26) would be utilized to evaluate for gallstones in a pregnant patient; a non-obstetric pelvic code (76857-26) would be utilized to evaluate flank pain in a known pregnant patient. On the other hand, in trauma a known pregnant patient may require a limited ultrasound of the “pregnant uterus” to evaluate fetal activity. The proper code in this setting would be limited echography, pregnant uterus, transabdominal (76815-26) and would be coded in addition to an emergency trauma ultrasound examination if both were performed.

Transvaginal examination in pregnant and non-pregnant women may be utilized to gain a higher resolution view of pelvic anatomy and is appropriately coded with either 76817-26 (pregnant) or 76830-26 (non-pregnant). The transvaginal CPT codes are complete examination codes and there are no corresponding limited transvaginal codes. A thorough evaluation of the anatomic region with image documentation would be expected when using this complete code. If complete evaluation of the pelvic anatomy is not performed, the -52 modifier should be used. If both transabdominal and transvaginal examinations are medically necessary and performed, both can be coded. The planned sequencing for every transabdominal ultrasound to be followed by a transvaginal ultrasound would be inappropriate. Based on clinical requirements, the transvaginal examination may be the only ultrasound performed and coded.

3. AAA, and Urinary Tract/Postvoid-residual.

An emergency ultrasound of the abdominal aorta in a patient presenting with symptoms concerning for AAA or an emergency ultrasound of a patient with suspected hydronephrosis would be coded for by 76775-26, a limited retroperitoneal ultrasound. This study consists of fewer elements than a complete retroperitoneal ultrasound. A complete retroperitoneal ultrasound would require evaluation of kidneys, abdominal aorta, common iliac artery origins, and inferior vena cava. If history suggests urinary tract pathology, a complete retroperitoneal ultrasound may also consist of evaluation of the kidneys and urinary bladder.

If sectional views of the kidney were imaged in this same patient, the limited retroperitoneal code (76775-26) would still apply and would not be separately billable. One exception to using the limited retroperitoneal code for urinary tract pathology is when evaluating only for urinary bladder obstruction with a post-void residual. A specific code exists for measurement of post-void residual volume by ultrasound (51798-26). If post-void residual volume was measured as a part of a limited retroperitoneal exam that included focused views of the kidneys, the limited retroperitoneal code (76775-26) would be appropriate and 51798-26 would not be separately billable.

4. Cardiac

Transthoracic evaluation of the heart to evaluate for pericardial effusion, cardiac function in arrhythmia or etiology of hypotension would be coded by 93308-26, a limited transthoracic echocardiogram. This study consists of fewer elements than a complete transthoracic echocardiogram. A complete transthoracic echocardiogram would require 2-D and M-mode examination of all atria and ventricles, all valves, the pericardium, adjacent portions of the aorta, and a functional assessment of the heart. Additional structures that may be visualized including the inferior vena cava, are included in the complete study.

5. Biliary

Evaluation of the gallbladder for gallstones would be coded by 76705-26, a limited abdominal ultrasound. This study consists of fewer elements than a complete abdominal ultrasound. A complete ultrasound of the abdomen would include evaluation of the liver, gallbladder, common bile duct, pancreas, spleen, kidneys, and the upper abdominal aorta and inferior vena cava.

6. DVT

Two-point compression ultrasound of the lower extremity to evaluate for DVT would be coded by a limited duplex scan of the extremity veins (93971-26). This study consists of fewer elements than a complete duplex study of the extremity veins. A complete duplex scan of extremity veins would require integrating B-mode 2-D vascular structure with spectral and/or color flow Doppler mapping or imaging

7. Soft Tissue/Musculoskeletal

Soft tissue/musculoskeletal ultrasound is one of the rapidly growing areas of emergency ultrasound. The most common use for soft tissue ultrasound is to distinguish between cellulitis and abscess. Though no specific code exists for soft tissue ultrasound, the May 2009 CPT Assistant provides guidance on appropriate coding for these studies. These codes would also be used for evaluation of foreign body or other cutaneous mass.

Correct coding for evaluation of a palpable soft-tissue mass is based on the location of the subcutaneous abnormality. Reduced service modifier (-52) is not required for any of these codes.

Neck	76536-26
Upper extremity	76880-26
Axilla	76880-26
Chest Wall	76604-26
Breast*	76645-26

Upper Back	76604-26
Lower Back	76705-26
Abdominal Wall	76705-26
Pelvic Wall	76857-26
Lower Extremity	76880-26
Other Soft Tissue	76999-26

*May 2009 CPT Assistant did not include breast ultrasound on the list of soft tissue codes; however, it is included in this list as a complete reference for soft tissue codes used in the Emergency Department. Breast ultrasound has its own CPT code as above and would be appropriate for evaluating for a breast abscess.

Coding for musculoskeletal ultrasound is not well developed. The only codes that exist are extremity ultrasound, non-vascular, B-scan and/or real time with image documentation (76880-26), complete infant ultrasound hip, and limited infant ultrasound hip (76886-26). Ultrasound for miscellaneous musculoskeletal indications including fracture evaluation, tendon rupture, or muscle tear would all be coded by 76880-26.

8. Thoracic Ultrasound

Thoracic Ultrasound is a newer area for emergency ultrasound. Proper coding was recently addressed in the May 2009 CPT Assistant (Volume 19 Issue 5). Though the CPT description of chest ultrasound includes evaluation of the mediastinum, the May 2009 CPT assistant clarifies that an ultrasound of the chest for pleural fluid or pneumothorax does not require examination of the mediastinum in order to bill for a complete study. Evaluation of the chest for lung sliding in a patient with shortness of breath and a history of pneumothorax would be appropriately coded by 76604-26.

9. Ocular Ultrasound

Ocular ultrasound is used to detect posterior chamber and orbital pathology as well as evaluation of the optic nerve sheath diameter. All of these studies would be appropriately coded by 76512-26, ophthalmic ultrasound, diagnostic, B-scan (with or without superimposed non-quantitative A-scan). Ocular foreign body has a separate code (76529-26).

10. Ultrasound Guidance Procedures

For billing purposes, there are three main categories of ultrasound-guided procedures: 1. Ultrasound-guidance for needle placement (76942-26) 2.

Ultrasound-guidance for vascular access (76937-26) and 3. Ultrasound-guidance for pericardiocentesis (76930-26).

Ultrasound-guidance for needle placement (76942-26) continues to apply to virtually all localization and needle placement procedures performed by Emergency Physicians other than vascular access and pericardiocentesis. Examples would be the following procedures performed with ultrasound assistance: paracentesis, thoracentesis, suprapubic aspiration, lumbar puncture, foreign body removal. In 2005 CPT changed such that coding requirements for all procedure guidance codes required permanently recorded images. Currently, the 76942-26 code requires permanently recorded images of the site to be localized, but does not require a real-time image of the needle in the target.

Ultrasound-guidance for vascular access (76937-26) requires special real-time image documentation. The static technique, in which the operator identifies the vessel by location, depth and angle then marks the skin and sets the transducer aside for line placement, is not reimbursable. The 76937-26 code requires the following: “Ultrasound guidance for vascular access requiring ultrasound evaluation of potential access sites, documentation of selected vessel patency, *concurrent realtime ultrasound visualization of vascular needle entry*, with permanent recording and reporting (List separately in addition to code for primary procedure). An example of adequate image documentation for vascular access is a single thermal print of the angiocatheter needle in the vessel obtained while the procedure is occurring. A cineloop, foot pedal, DVD recorder, or an assistant is helpful in obtaining this image.

Ultrasound-guided pericardiocentesis (76930-26) has its own unique code.

Diagnostic and procedural ultrasounds may be billed on the same day during the same encounter as long as each one is not subsumed in the other. For example, ultrasound-guidance for vascular access (76937-26) specifically states that diagnosing potential sites is subsumed in the procedure. For other procedures, such as ultrasound-guided pericardiocentesis, if a focused cardiac ultrasound was performed to diagnose the tamponade, then a diagnostic code and a procedural code would be appropriate.

In addition to the ultrasound-guided procedural codes, the surgical code for the actual procedure being performed is applied. In the pericardiocentesis example, the surgical procedure itself (33010, pericardiocentesis; initial) and the ultrasound guidance procedure (76930-26, ultrasound guidance for pericardiocentesis) is coded. A more common example would be ultrasound-guided central venous access in which the surgical procedure (36556, Insertion of a non-tunneled central venous catheter, age > 5 yo) would be coded in addition to the ultrasound-guided vascular access procedure (76937-26). See Appendix A for a listing of procedural and separately billable surgical codes.

B. Adjunct Emergency Ultrasound Applications

Adjunct Emergency Ultrasound applications addressed in the 2008 Emergency Ultrasound Guidelines include Advanced Echo, Transesophageal Echo, Bowel,

Adnexal Pathology, Testicular, Transcranial Doppler, and Contrast Studies.
Codes for these studies, when available, are listed in Appendix A.

III-Payer Policy: ICD-9 Coding , Medical Necessity, and Payment Edits

Every payer, including Medicare, has its own rule sets regarding what services are covered, what constitutes a medically necessary service and what coding combinations are permissible.

A. ICD-9 Coding:

ICD-9, the International Classification of Diseases, 9th Revision, is a cataloging tool developed by the World Health Organization for the international comparison of morbidity and mortality data. ICD-9 codes may be driven by diagnosis, symptoms, signs, abnormal diagnostic tests, by external causes of injury (E codes) or factors influencing health status (V codes). ICD-9 codes are often used by payers to determine why you performed a procedure as opposed to CPT codes that explain what procedure(s) were performed. Carriers often look first at these ICD-9 codes as an indicator of medical necessity by developing, as a first-pass edit, lists of ICD-9 codes that support certain CPT codes.

Medicare carriers are required to publish bulletins that clarify their view of proper coding, including coding for ultrasound procedures. These bulletins often include lists of indications and limitations of coverage as well as lists of covered ICD-9 codes. These bulletins, previously termed Local Medical Review Policies or LMRPs, are now termed Local Coverage Determinations or LCDs. The bulletins may be searched through your local Medicare carrier under LCD for specific indications. For example, searching for ICD-9 codes on the CMS website

(<http://www.cms.hhs.gov/mcd/search.asp?clickon=search>) which support transvaginal ultrasound would yield the following document number: L28134. This LCD document provides information specific to Connecticut and New York on pelvic and transvaginal ultrasounds and appropriate ICD-9 codes. Unfortunately, these documents are challenging to find and are rarely published by non-governmental insurance carriers.

B. Medical Necessity

Medical necessity or medically necessary services are described as those that are felt by payers to be safe, effective and consistent with the symptoms or diagnosis of the illness or injury being treated. This determination may at times be subjective or may not reflect the most current application of medical technology. Services that are regarded as experimental or investigational are frequently deemed to be medically unnecessary.

The protocol-driven use of ultrasound for a class of patients, e.g. all those in motor vehicle accidents or all “trauma activations”, may be deemed medically unnecessary or a “screening examination” when not driven by patient-specific signs, symptoms or abnormal laboratory values. Screening examinations are generally not covered services by Medicare. Mammography and screening for AAA by ultrasound are specific exceptions to this rule. It should be noted that AAA ultrasound screening examinations require a family history of AAA or male and over 50 years old with a tobacco history and are performed in the context of a defined “Welcome to Medicare”

examination. These screening examinations are not an Emergency Department service.

C. Payment Edits

Edits are policy-driven computer programs or manual reviews that check information available on payment claim forms in an effort to identify the coding of services with a higher probability of being incorrect or medically unnecessary. Those identified as having a high probability of being unnecessary are denied payment. These edits cannot identify all circumstances that may warrant legitimate use of the code. Documentation of medical necessity for the study in the medical record will be essential in any effort to overcome a first-pass edit denial. Edit type examples include

1. Procedure to diagnosis (“diagnosis” or “payment” edits): Here the CPT code is compared to a list of previously approved ICD-9 codes. The procedures that are previously approved as compatible with the ICD-9 are automatically paid. All other CPT codes are denied, but may later be approved with additional information.

2. Procedure to procedure: The CPT code is compared to a second CPT code. The edit is designed to assure reporting a group of procedures with the most appropriate comprehensive code. For example, reporting a limited abdominal ultrasound (76705-26) during the same visit as a complete abdominal ultrasound (76700-26) would be rejected since the 76705-26 would be inclusive of the limited study. These correct coding initiatives for CMS (CCI edits) can be found at the following website: <http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEP/list.asp#TopOfPage>

3. Frequency to time: Multiple limited retroperitoneal examinations reported on the same date of service may be rejected unless there is an explanation to why the exam needed to be repeated. For example, it would be inappropriate to code for evaluation of the right and left kidneys as separate limited exams. It would be appropriate to code for repeat ultrasound of the abdomen in an unstable trauma patient in whom you are looking for hemoperitoneum over time (76705-26,76).

4. Site of Service: The CPT code is compared to the site where the service was rendered. A global ultrasound service (without using the -26 modifier) coded by a hospital-based physician would be rejected.

IV-Ultrasound Procedure Documentation

A. Procedure Specific Requirements:

There are three specific requirements for reporting procedures in the Emergency Department: 1. a written report, 2. test indication, and 3. interpretation. These requirements are also applicable to reporting ultrasound procedures.

1. “A written interpretation and report must be completed for each test performed and must be maintained in the patient’s medical record.” This written interpretation and report may take the form of a separately identifiable procedure note within the Emergency Department medical record, such as typically used for procedures like lumbar puncture. Alternatively, the report may take the form

of a separate note appended to the medical record, such as typically done for consultative radiology reports. The responsible physician must sign the report (see CMS memo regarding X-Ray/EKG Interpretations in the ED (<http://www.acep.org/practres.aspx?id=30322>)).

2. “Medical record documentation must indicate the medical necessity [of the diagnostic test]”. This would be the test indication.
3. “The report must describe the structures or organs studied and supply an interpretation of the findings”.

B. Image Documentation (archiving of images)

CPT requires that all diagnostic and procedure guidance ultrasounds have permanently recorded images in order to meet coding criteria. Previously the need for image retention has been a point of discussion however CPT has ended any debate. In short, when you code and bill any ultrasound study always archive an image. It is recognized that care of the emergency patient should not be delayed by the time consuming work of image archiving, however without an image these studies can be documented, but not coded or billed (note: there are several ophthalmic ultrasound biometric codes that are excluded from this requirement).

CPT does not indicate image documentation specifications, e.g. how many images, what views, what medium is utilized for storage or where images are stored. Image retention is subject to facility policy and may differ from department to department. A minimum of one image demonstrating relevant anatomy/pathology for each procedure coded should be retained and available for review. At some point in the future image retention requirements may be more clearly defined.

C. Additional Recommendations for Ultrasound Documentation

The following additional recommendations should assist in correct coding, though not specified by Medicare carriers:

1. The report should identify who performed the procedure. This will help avoid confusion as to whether the physician performed and interpreted the test, or simply reviewed the report of another provider.
2. To facilitate accurate coding, the scope of the study should be described. The performing physician should indicate whether the study was a limited or complete examination, if this was a repeat examination by the same physician, a repeat examination by a second physician, and/or a reduced level of service.

An example of an Emergency Medicine ultrasound report for a patient with right upper quadrant pain and intractable vomiting follows:

Emergency Ultrasound Report (identifying header or separate note)

"I performed a limited abdominal ultrasound exam of the gallbladder to evaluate for gallstones. Indication: right upper quadrant pain and intractable vomiting. Findings: No gallstones were seen. The anterior gallbladder wall measured 2

mm. The patient had a negative sonographic Murphy's sign. The common bile duct was 4 mm in diameter. Pertinent images are attached to the chart.

Impression: no evidence of gallstones or cholecystitis.

V. Technical Charges

Technical charges cover hospital overhead involved in performing ultrasounds in the Emergency Department. Billing technical charges separately from professional charges again assumes the ultrasound machine is owned by the hospital, not the physician. CPT codes for technical charges should be identical to the physician charges except that there is a technical component (-TC) modifier instead of a professional component (-26) modifier. An ultrasound image and report must be in the patient's medical record in order for a technical charge to be billed. Medicare Outpatient Prospective Payment System considers the technical component of ultrasound-guided procedures to be a packaged service which is paid for through reimbursement for the procedure being performed. Of note, Medicare reimbursement for technical charges is often more robust than the professional charges.

References: For additional information regarding emergency ultrasound procedures and the coding of these procedures the reader is referred to the following publications:

1. ACEP Emergency Ultrasound Guidelines – 2001 (www.acep.org)
2. Use of Ultrasound Imaging by Emergency Physicians (Policy number 400121; www.acep.org)
3. Current Procedural Terminology CPT™ 2009 (AMA Press; www.ama-assn.org)
4. CPT™ Changes – An Insider's View 2009 (AMA Press; www.ama-assn.org)
5. Physician ICD-9-CM (Medicode; www.ingenix.com)
6. Principles of CPT™ Coding (AMA Press; www.ama-assn.org)
7. Healthcare Fraud and Abuse: A Physicians Guide to Compliance (AMA Press; www.ama-assn.org)
8. Medicare Correct Coding and Payment Manual for Procedures and Services (St. Anthony Publishing; www.ingenix.com)
9. Medicare RBRVS: The Physicians Guide 2009 (AMA Press; www.ama-assn.org)
10. Ultrasound Coders User's Guide (American College of Radiology; www.acr.org)
11. MedLearn 2009 Ultrasound Coder
12. CPT Assistant May 2009 Volume 19, Issue 5

APPENDIX A: EMERGENCY ULTRASOUND (US) CODING GUIDE

CORE EMERGENCY ULTRASOUND CODES			
US STUDY	CPT CODE	CPT Description	NOTES
FAST: SCAN FOR HEMOPERICARDIUM AND HEMOPERITONEUM, MAY INCLUDE LUNG US FOR PNEUMOTHORAX	93308	Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-Mode recording; follow-up or limited	
	76705	Echography, abdominal, B-scan and/or real time with image documentation, limited (eg, single organ, quadrant, follow-up)	
	76604	Ultrasound, chest, B-scan (includes mediastinum) and/or real time with image documentation	
INTRAUTERINE PREGNANCY			
PREGNANT TRANSABDOMINAL (TA)	76815	Ultrasound, pregnant uterus, real time with image documentation, limited (eg fetal heart beat, placental location, fetal position and/or qualitative amniotic fluid volume), one or more fetuses	
PREGNANT TRANSVAGINAL (TV)	76817	Ultrasound, pregnant uterus, real time with image documentation, transvaginal	NO LIMITED CODE EXISTS
AAA	76775	Echography, retroperitoneal (eg renal, aorta, nodes); B-scan and/or real time with image documentation; limited	
CARDIAC	93308	Echocardiography, transthoracic, real-time with image documentation (2D), with or without M-Mode recording; follow-up or limited	
BILIARY	76705	Echography, abdominal, B-scan and/or real time with image documentation, limited (eg, single organ, quadrant, follow-up)	
URINARY TRACT	76775	Echography, retroperitoneal (eg renal, aorta, nodes); B-scan and/or real time with image documentation; limited	
POST-VOID RESIDUAL	51798	Measurement of post-voiding residual urine and/or bladder capacity by ultrasound, nonimaging	
FOCUSED DVT STUDY	93971	Duplex scan of extremity veins including responses to compression and other maneuvers; unilateral or limited study.	

CORE EMERGENCY ULTRASOUND CODES

US STUDY	CPT CODE	CPT Description	NOTES
SOFT TISSUE ULTRASOUND			
NECK	76536	Ultrasound, soft tissues of head and neck (eg, thyroid, parathyroid, parotid), B-scan and/or real time with image documentation	
AXILLA	76880	Ultrasound, extremity, non-vascular, B-scan and/or real time with image documentation	
CHEST WALL	76604	Ultrasound, chest, B-scan (includes mediastinum) and/or real time with image documentation	
BREAST	76645	Ultrasound, breast, B-scan and/or real time with image documentation	
UPPER BACK	76604	Ultrasound, chest, B-scan (includes mediastinum) and/or real time with image documentation	
LOWER BACK	76705	Echography, abdominal, B-scan and/or real time with image documentation, limited (eg, single organ, quadrant, follow-up)	
ABDOMINAL WALL	76705	Echography, abdominal, B-scan and/or real time with image documentation, limited (eg, single organ, quadrant, follow-up)	
PELVIC WALL	76857	Ultrasound, pelvic (nonobstetric), B-scan and/or real time with image documentation, limited or follow-up	APPROPRIATE FOR MALE OR FEMALE PELVIC ULTRASOUND
LOWER EXTREMITY	76880	Ultrasound, extremity, non-vascular, B-scan and/or real time with image documentation	
MUSCULOSKELETAL (EXTREMITY, NON-VASCULAR)	76880	Ultrasound, extremity, non-vascular, B-scan and/or real time with image documentation	
INFANT HIP, STATIC	76886	Ultrasound, infant hips, real time with imaging documentation; limited, static (not requiring physician manipulation)	
THORACIC	76604	Ultrasound, chest, B-scan (includes mediastinum) and/or real time with image documentation	TO EVALUATE FOR PNEUMOTHORAX
OCULAR	76512	Ophthalmic ultrasound, diagnostic; B-scan (with or without superimposed non-quantitative A-scan)	
OCULAR FB	76529	Ophthalmic ultrasonic foreign body localization	
MISCELLANEOUS ULTRASOUND	76999	Unlisted ultrasound procedure (ex, diagnostic, interventional)	

ULTRASOUND-GUIDED PROCEDURE CODES

US-GUIDED PROCEDURE	CPT CODE	NOTES	ADDITIONAL CPT CODE
US-GUIDED PROCEDURES (US GUIDANCE FOR NEEDLE PLACEMENT EXCEPT FOR PERICARDIOCENTESIS and VASCULAR)	76942	REQUIRE IMAGE OF SITE TO BE LOCALIZED BUT DOES NOT REQUIRE IMAGE OF NEEDLE IN SITE	SEE BELOW
THORACOABDOMINAL US-GUIDED PROCEDURES			
US-GUIDED THORACENTESIS	76942		32421
US-GUIDED SUPRAPUBIC ASPIRATION	76942		51100
US-GUIDED PARACENTESIS	76942		49080
MUSCULOSKELETAL/SOFT TISSUE US-GUIDED PROCEDURES			
US-GUIDED ABSCESS DRAINAGE	76942		10160 OR 10161
US-GUIDED PERITONSILLAR ABSCESS DRAINAGE	76942		42700
US-GUIDED FB REMOVAL	76942		10120 OR 10121
US-GUIDED LUMBAR PUNCTURE	76942		62270
US-GUIDED JOINT ASPIRATION	76942		20600, 20605, OR 20610
US-GUIDED PERICARDIOCENTESIS	76930	REQUIRES IMAGE OF SITE TO BE LOCALIZED BUT DOES NOT REQUIRE IMAGE OF NEEDLE IN SITE	33010
US GUIDED VASCULAR ACCESS PLACEMENT	76937	REQUIRES IMAGE OF NEEDLE IN TARGET VESSEL	36400, 36410, 36555, 36556, 36568, 36569

SEPARATELY BILLABLE CPT CODES FOR ULTRASOUND GUIDED PROCEDURES (in numerical order)

CPT CODE	DESCRIPTION
10120	INCISION AND REMOVAL FOREIGN BODY SIMPLE
10121	INCISION AND REMOVAL FOREIGN BODY COMPLICATED
10160	INCISION AND DRAINAGE OF ABSCESS SIMPLE
10061	INCISION AND DRAINAGE OF ABSCESS COMPLICATED
20600	ARTHROCENTESIS SMALL JOINT
20605	ARTHROCENTESIS MEDIUM JOINT
20610	ARTHROCENTESIS LARGE JOINT
32421	THORACENTESIS, PUNCTURE OF PLEURAL CAVITY FOR ASPIRATION, INITIAL OR SUBSEQUENT
33010	PERICARDIOCENTESIS, INITIAL
36400	VENIPUNCTURE REQUIRING PHYSICIAN SKILL AGE < 3 YO
36410	VENIPUNCTURE REQUIRING PHYSICIAN SKILL AGE >3 YO
36555	INSERTION OF NON-TUNNELED CENTRAL VENOUS CATHETER AGE < 5 YO
36556	INSERTION OF A NON-TUNNELED CENTRAL VENOUS CATHETER AGE > 5 YO
36557	INSERTION OF A PERIPHERALLY INSERTED NON-TUNNELED CENTRAL VENOUS CATHETER AGE <5 YO
36558	INSERTION OF A PERIPHERALLY INSERTED NON-TUNNELED CENTRAL VENOUS CATHETER AGE > 5YO
49080	ABDOMINAL PARACENTESIS
51100	ASPIRATION OF BLADDER BY NEEDLE

LCD for Transthoracic Echocardiography (L6980)

Contractor Information

Contractor Name

Palmetto GBA

Contractor Number

00883

Contractor Type

Carrier

LCD Information

LCD ID Number

L6980

LCD Title

Transthoracic Echocardiography

Contractor's Determination Number

2001-14LR15

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CMS National Coverage Policy

· Internet-Only Manual (IOM) Publication 100-3, *Medicare National Coverage Determinations*, Chapter 1, Section 220.5.

Primary Geographic Jurisdiction

Ohio

Oversight Region

Region V

Original Determination Effective Date

For services performed on or after 11/01/1999

Original Determination Ending Date

Revision Effective Date

For services performed on or after 06/01/2009

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

The clinical use of contrast echocardiography is appropriate in selected patients to:

- Evaluate myocardial ischemia
- Quantify myocardial perfusion during stress
- Identify the “area at risk” during acute myocardial infarction
- Determine the success of reperfusion interventions
- Assess myocardial viability

The plethora of structural and functional information provided by TTE is unique among diagnostic testing modalities. The rapid and noninvasive acquisition of this information has contributed to exponential application, and to potential over utilization. This policy addresses the medically necessary and appropriate application of TTE.

Transesophageal echocardiography (TEE) is the subject of a separate policy statement.

A. Ventricular Function and Cardiomyopathies

Changes in myocardial thickness (hypertrophy and thinning) in derived parameters of contractility, and in chamber volume and morphology, can be quantitated and charted over time by TTE. Cardiac responses to volume perturbations, chronic pressure excess and therapeutic interventions can be monitored. Recognition of the relative contributions of myocardial and valvular functional perturbations to a clinical presentation is facilitated. TTE aids in the recognition of myopathies and their classification into hypertrophic, dilated and restrictive types. Without clinically documented, discrete (abrupt change in signs and symptoms) episodes of deterioration, it is not generally medically necessary to repeat TTE assessments more frequently than annually, unless done to evaluate the response to therapeutic intervention.

Although TTE is used in the assessment of ventricular diastolic function, reproducible pathognomonic findings are not well established. In individuals with signs and/or symptoms suggestive of ventricular dysfunction, the demonstration by TTE of normal systolic function and/or ventricular hypertrophy may suggest the presence of diastolic functional abnormalities. Because the TTE findings suggesting diastolic dysfunction are less well established, when this application of TTE is the primary indication for the test, it will be expected to be performed by examiners recognized as experts in assessment and treatment of ventricular diastolic dysfunction.

Evaluation of diastolic filling parameters by Doppler echocardiography is being used to help establish the prognosis in patients with congestive heart failure and systolic dysfunction as well as to evaluate appropriate parameters of medical treatment.

B. Hypertensive Cardiovascular Disease

When there are no signs or symptoms of heart disease, the use of TTE is not covered for hypertension. Hypertension with clinical evidence of heart disease is a Medicare-covered indication for TTE evaluation. Left ventricular hypertrophy (LVH) correlates with prognosis in hypertensive cardiovascular disease. Certain anti-hypertensive medications have been reported to stabilize and possibly contribute to the regression of LVH. The decision to commit certain individuals with insidiously progressive borderline hypertension to long-term anti-hypertensive therapy may be determined by the presence of LVH. TTE may assist in the decision to treat through the formulation and analysis of a treatment program. Baseline TTE and serial annual assessments may be medically appropriate. More frequent assessments should have explicit contemporaneous medical necessity documentation.

C. Acute Myocardial Infarction and Coronary Insufficiency

TTE can detect ischemic and infarcted myocardium. Regional motion, systolic thickening perturbations and mural thinning can be quantitated and global functional adaptation assessed. The relative contributions of right ventricular ischemia and/or infarction can be evaluated. Complications of acute infarction (e.g., mural thrombi, papillary muscle dysfunction and rupture, septal defects, true or false aneurysm and myocardial rupture) can be diagnosed and their contribution to the overall clinical status placed in perspective. In the setting of acute infarction, repeat study will typically be dictated by the clinical course. If available, the use of contrast agents may improve diagnostic efficiency, and eliminate the need for additional radionuclide testing. Without clinical deterioration or unclear examination findings, repeat assessment is typically performed at discharge. The medical record must document the medical necessity of more frequent TTE assessments.

The role of TTE in the emergency room assessment of individuals presenting with chest pain is not defined at this time. This use is not accepted as a standard-of-care. For TTE to be allowed, clinical findings supporting myocardial dysfunction must be present. When these findings are not present, this use is not covered.

D. Exposure to Cardiotoxic Agents (chemotherapeutic and external)

Measures of myocardial contractility, thinning and dilatation are important in the titration of therapeutic agents with known myocardial toxicity. Baseline assessment, bimonthly during and at six (6) months following therapy, is generally considered medically appropriate for exposure to many cardiotoxic agents. Following accidental exposure to known myocardial toxic agents, without abrupt change in clinical signs and/or symptoms, and when cardiac damage has been identified, annual assessment may be considered reasonable and necessary.

E. Cardiac Transplant and Rejection Monitoring

TTE is an integral part of the cardiac donor-selection and donor-recipient matching process. Evaluation focuses on analysis of ventricular function and valvular integrity. TTE is also incorporated into the management of allograft recipients. Myocardial thickness, refractile properties, contractile patterns and indices, restrictive hemodynamics, and the late development of pericardial fluid may alert the clinician to a rejection episode. None of these findings has achieved diagnostic sensitivity or specificity. Typically, TTE is performed weekly for the first four to eight (4-8) weeks following transplant, with decreasing frequency over time. Without acute rejection episodes, approximately two (2) TTE examinations are typically performed yearly in chronic transplant recipients. TTE of cardiac allografts is appropriately performed serially at transplant centers by examiners with expertise in the management of cardiac allograft recipients. Uses in excess of the generally accepted frequency will be expected to have appropriate medical necessity documentation provided.

F. Native Valvular Heart Disease

Detection of mitral stenosis was among the first practical clinical applications of TTE. TTE is well established as the technique of choice for the evaluation of valvular pathology and its effect upon global myocardial function. The relative severity of multi-valve pathologies can be quantified. Visualization of the valve and valvular apparatus facilitates therapeutic decisions when competing therapeutic options exist, especially interventions for mitral stenosis. Absent acute intervention, or a discrete change in otherwise stable clinical signs and symptoms, TTE is used annually in follow-up of chronic valvular disease to document the course over time. Generally, it is not medically necessary to repeat these examinations more frequently than annually. When the patient's plan of care includes imminent valvular surgery, more frequent exams may be necessary.

G. Prosthetic Heart Valves (Mechanical & Bio-prostheses)

TTE assessment soon after prosthetic valve implant is important in establishing a baseline structural and hemodynamic profile unique to the individual and the prosthesis. Size, position, underlying ventricular function and concomitant valve pathologies all impact this unique profile. Reassessment following convalescence (3-6 months) is appropriate. Thereafter, absent discretely defined clinical events or obvious change in physical examination findings, annual stability assessment is considered medically reasonable and appropriate. For certain indications, transesophageal echocardiography (TEE) may be the preferred modality for evaluation. (Please refer to separate TEE policy)

H. Acute Endocarditis

Transesophageal echocardiography (TEE) has a high degree of sensitivity for endocarditis evaluation, and is typically the diagnostic test of choice. TTE can provide diagnostic information; larger vegetations may be directly visualized; and valvular anatomy and ventricular function directly assessed. The complications or sequelae of acute infective endocarditis can be detected and monitored over time. Acutely, examination frequency is dictated by the individual clinical course. When the acute process has been stabilized, the frequency of serial TTE evaluation will be dictated by the residual pathophysiology and discrete clinical events, analogous to the serial assessment of chronic valvular dysfunction and/or normally functioning prosthetic valves.

I. Pericardial Disease

Detection and quantitation of the amount of pericardial effusion were among the first, and remain important, applications of TTE. Pericardial fluid accumulations as small as twenty (20) milliliters have been reliably diagnosed by TTE. Cardiac motion and blood flow patterns demonstrated by TTE characterize the hemodynamic consequences of pericardial fluid accumulation. A collage of TTE findings has been found to be a reliable indication of cardiac tamponade. TTE can be a valuable adjunct during the removal of pericardial fluid and creation of pericardial windows by balloon techniques. Acutely, clinical status will dictate examination frequency. Absent acute pathophysiology, serial assessment of chronic stable pericardial effusion by TTE is not usually medically necessary. In a patient with evolving pericardial pathology, a limited focused TTE exam may be appropriate. TTE/Doppler findings have moderate specificity and sensitivity and can be useful in the differential diagnosis of chronic pericardial constriction.

J. Aortic Pathology

TTE can provide valuable information when acute or chronic aortic pathology is present; however, the posterior window of TEE, coupled with the more posterior position of the thoracic aorta, has rendered TEE a more determinative study. Noninvasive TTE remains the study of choice for chronic aortic pathology when images suitable for serial quantitation can be obtained. Frequency of repeat study should be guided by the pathophysiology. In some individuals, such as those with Marfan's disease or atherosclerotic aneurysms, a focused limited follow-up exam to serially measure aortic diameters and arch diameters may be appropriate.

K. Congenital Heart Disease

In children and small adults TTE provides accurate anatomic definition of most congenital heart diseases. Coupled with Doppler hemodynamic measurements, TTE usually provides accurate diagnosis and noninvasive serial assessment. A technically adequate TTE can obviate the need for preoperative catheterization in selected individuals. When the disease process and therapy are stable, serial assessment by TTE requires medical necessity documentation, if the frequency exceeds an annual evaluation.

L. Suspected Cardiac Thrombi and Embolic Sources

TTE is sensitive in the detection of ventricular thrombi and potentially embolic material. Limited visualization of atrial interstices and the more peripheral and superior portions of the atria render TTE less sensitive than TEE in the detection of atrial thrombus and potentially embolic material. In individuals with cardiac pathology associated with a high incidence of thromboemboli (valvular heart disease, arrhythmias - especially atrial fibrillation, cardiomyopathies and ventricular dysfunction), TTE usually provides adequate supplemental data for therapeutic decision making. It merits emphasis that a negative examination (TTE or TEE) does not exclude a cardiac embolus and the findings of thrombus or vegetation does not establish a cardiac embolic source. Repeat examinations are not generally medically required in the absence of finding potentially embolic material.

M. Cardiac Tumors and Masses

Infiltrative and ventricular tumors and masses can be visualized, their extent quantitated, and their hemodynamic consequences assessed by TTE. Right atrial space-occupying masses are usually well visualized by TTE. TEE provides a more detailed view of the left atrium and is more sensitive in quantifying mass characteristics (solid, cystic, etc.), extensions and attachments. These acute pathologies are not typically followed serially. In specific situations, such as when a tumor is not removed at surgery, and when the patient has had cardiac myxoma removed serial TTEs may be medically necessary to monitor for tumor size or recurrence.

N. Critically Ill and Trauma Patients

There is a role for echocardiography in the management of critically ill patients and trauma victims. The diagnosis of suspect aortic or central pulmonary pathology, cardiac contusion, or a pericardial effusion may be confirmed. Perturbations of volume status may be more completely defined and management strategies modified. The frequency of these typically acute studies will be dictated by the clinical situation.

O. Arrhythmias and Palpitations

TTE is useful in defining cardiac function in which Arrhythmias occur, and may be useful in the management of cardiac arrhythmias. Some arrhythmias are frequently associated with underlying organic heart disease or may predispose the patient to hemodynamic deterioration. Atrial fibrillation and atrial flutter are examples of arrhythmias in which echocardiography may be appropriate to assess the underlying disorder.

Echocardiographic studies are appropriate only when there is evidence of heart disease. Palpitations without clinical suspicion of arrhythmia, or evidence of heart disease, is not a covered indication for transthoracic echocardiography.

P. Syncope

Determination of the etiology of syncopal episodes can be a difficult clinical problem. The origin may be cardiac, neurological, or due to other causes. Syncope due to cardiac origin is most commonly related to vasodepressor reflexes, bradyarrhythmias, or tachyarrhythmias. Syncope is less commonly caused by cardiac structural disorders. Patients with structurally normal hearts generally have a much more benign prognosis than those with underlying structural coronary artery disease or cardiomyopathic disease. Echocardiography is only appropriate as the initial evaluation, when other findings are suggestive of valvular heart disease or obstructive cardiomyopathy.

Q. Pulmonary

Right heart failure manifesting as edema or ascites may be due to pulmonary hypertension. Pulmonary heart disease may result from acute changes in the pulmonary circulation (e.g., pulmonary embolus) or chronic changes produced by chronic hypoxia that may cause significant right ventricular dysfunction and hypertrophy. Echocardiography may assess right ventricular size and performance, and quantify the severity of pulmonary hypertension using Doppler interrogation of valvular flow signals. Indications include unexplained pulmonary hypertension and pulmonary emboli with suspected clots in the right atrium or ventricle.

R. Follow-up Studies or Limited Studies

A complete study includes a full evaluation of all aspects of the heart, including the cardiac chambers, valves, blood flow, and great vessels. The images are reviewed, measured, analyzed and interpreted by the physician. A report is prepared for the patient's record. When a less than complete examination is performed for the purpose of evaluation of one specific cardiac problem, or region of the heart, the service is described by CPT codes **93308** and 93321, follow-up or limited studies. When a limited service is performed, or the patient's condition requires only a limited examination, these codes must be used to indicate the appropriate service.

Examples of appropriate use of CPT code **93308**: a follow-up study of a patient with pericardial effusion following heart surgery, to evaluate progression or resolution of the effusion, or a serial evaluation of left ventricular function during antineoplastic chemotherapy.

Examples of appropriate use of CPT Code 93321: recording tricuspid regurgitant velocity in order to estimate pulmonary artery systolic pressure; or sequential evaluation of the transmitral velocity profile in a patient with mitral stenosis, in order to evaluate for a change in gradient or valve area.

S. Doppler Color Flow Velocity Mapping (CPT code 93325)

Doppler color flow-velocity mapping is an appropriate addition to an echocardiogram when the examination is expected to contribute significant information relative to the patient's condition or treatment plan. Typically, color flow-velocity mapping is indicated in the evaluation of the symptoms of syncope and dyspnea, some heart murmurs, valvular problems, suspected congenital heart disease, complications of myocardial infarction, or cardiomyopathy. Medicare does not cover this service when performed routinely with all echocardiographic exams (i.e., without a clinical indication). This is true even when the results of the test reveal abnormalities. If an unsuspected finding on TTE indicates medical necessity for additional study with Doppler color flow velocity mapping, it can be covered. When the test is performed without a specific indication, it is considered routine screening, and must be billed with a screening ICD-9 code to indicate the reason for the test.

T. Stress Echocardiography (CPT code 93350)

Stress Echocardiography may be necessary when the evaluation could contribute significant information to the patient's condition or treatment plan. Typically, one stress imaging study (stress echocardiography or nuclear imaging) is adequate to accomplish the assessment. When two (or more) imaging studies are routinely billed (i.e., without a supporting clinical indication), only one of the services will be allowed and the other(s) will be denied as not medically necessary. Pharmacologically induced stress testing is also subject to medical necessity.

Indications and limitations for stress echocardiography:

1. Acute Myocardial Infarction

Stress echocardiography is not typically performed during the acute phase of a MI when a diagnosis has been established by other methods. In selected patients, stress echocardiography may be necessary when the evaluation could contribute significant information to the patient's condition or treatment plan.

2. Unstable Angina

Stress echocardiography may be useful as an adjunct to other tests in the diagnosis or treatment of unstable angina only when the combination of history and other tests are not diagnostic. In selected patients, stress echocardiography may be necessary when the evaluation could contribute significant information (e.g. assessment of LV function) to the patient's condition or treatment plan.

3. Chronic Ischemic Heart Disease

Stress echocardiography may be useful as an adjunct to other tests in the diagnosis or treatment of chronic ischemic heart disease only when the combination of history and other tests are not contributory. In selected patients (e.g. assessment of post-CABG symptoms for ischemia, follow-up of patients with symptomatic ischemic heart disease, or asymptomatic patients requiring follow-up that is customized to their condition and disease process) stress echocardiography may be necessary when the evaluation is expected to contribute significant additional information relating to the patient's condition or treatment plan.

4. Dilated Cardiomyopathies or Hypertrophic Cardiomyopathy

Stress echocardiography may be useful in the evaluation of cardiomyopathy when the evaluation could reasonably be expected to contribute significant information to the patient's condition or treatment plan.

5. Post-Transplant Cardiac Disease

Stress echocardiography may be useful in the evaluation of ventricular dysfunction with post-transplant rejection when the evaluation could reasonably be expected to contribute significant information to the patient's condition or treatment plan.

Pharmacological Stress Agents (HCPCS codes A9700, J0152, J0280, J0460, J1245, J1250)

For those patients who are unable to obtain 75-100% of their age-predicted maximum heart rate through physiologic exercise, vasodilation can be achieved with the use of either dipyridamole or adenosine. Dobutamine may be used to effect myocardial stress via its inotropic effect.

1. Dipyridamole is administered intravenously at 0.56 mg/Kg over a 4-minute period.

The maximum dose should not exceed 60 mg. Since the dilation effect persists, its effect typically is reversed with intravenous aminophylline, which must be available to reverse ischemia when it occurs.

Dipyridamole is relatively contraindicated in patients with:

- Known bronchospastic lung disease (asthma)
- Systemic hypotension (systolic BP below 100 mm Hg)
- Acute MI (less than 48 hours)
- Unstable angina

2. Adenosine is administered intravenously at 140 mcg/Kg/min over six minutes (total of 0.84 mg/Kg). The vasodilation effect of adenosine is short-lived. Adenosine is contraindicated in patients with:

- Second- or third degree AV block
- Sinus node disease except in patients with a functioning artificial pacemaker
- Known or suspected bronchoconstrictive or bronchospastic lung disease
- Known hypersensitivity to adenosine

3. Dobutamine is administered intravenously starting with 5 or 10 mcg/Kg/min) and titrated to reach the maximum heart rate for 2-5 minutes. The maximum dose administered is up to 50 mcg/Kg. Atropine may be added in appropriate doses IV. Dobutamine is contraindicated in patients with:

- Idiopathic hypertrophic subaortic stenosis
- Acute myocardial infarction

U. Physician Supervision Requirements

The technical component of TTE must be done under the general supervision of a qualified physician, appropriately trained and skilled in the performance and interpretation of echocardiography. Stress echocardiography is Medicare-covered only when performed under the direct supervision of a qualified physician who provides:

- Medical expertise required for the performance of the test;

- Medical treatment for complications and side effects of the test;
- Medical services required as part of the test, for example, injections or the administration of medications;
- Medical expertise in the interpretation of the test, some of which has to be provided during the test and before the patient is discharged from the testing suite.

V. Noncovered

Medicare does not cover echocardiograms performed with equipment that provides limited evaluations. Such evaluations typically do not provide a permanent image and complete interpretation is not performed. These tests have demonstrated value in screening-type evaluations, although they are then considered part of the physician's exam, similar to a blood-pressure measurement.

Echocardiography performed for screening purposes is not covered. Screening includes testing performed on patients who present with risk factors (including the risk factor as having a positive family history, e.g., familial history of Marfan's disease). Screening service for high-risk patients is considered good medical practice but is not covered by Medicare. When a screening test is performed, use the appropriate screening ICD -9 code to indicate the test is being done for screening purposes. When the result of the test is abnormal, subsequent services may be billed with the test-result diagnosis; however, the initial screening test must be listed as screening, even though the result of the screening test may be a covered condition. Symptoms or an existing condition must be present to meet medical necessity.

Diagnostic injection services are an integral part of a contrast procedure and are not separately payable.

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

99999

Not Applicable

CPT/HCPCS Codes

Applicable to CPT Codes

93303

Echo transthoracic

93304	Echo transthoracic
93306	Tte w/doppler, complete
93307	Tte w/o doppler, complete
93308	Tte, f-up or lmtd
93320	Doppler echo exam, heart
93321	Doppler echo exam, heart
93325	Doppler color flow add-on
93350	Stress tte only
93351	Stress tte complete
93352	Admin ecg contrast agent

Applicable to CPT code 93350

HCPCS codes

A9700	Echocardiography Contrast
J0152	Adenosine injection
J0280	Aminophyllin 250 MG inj
J0460	Atropine sulfate injection
J1245	Dipyridamole injection
J1250	Inj dobutamine HCL/250 mg

ICD-9 Codes that Support Medical Necessity

Use of these codes does not guarantee reimbursement. The patient's medical record must document that the coverage criteria in this policy have been met.

Applicable to CPT codes 93303 and 93304

745.0	COMMON TRUNCUS
745.10	COMPLETE TRANSPOSITION OF GREAT VESSELS
745.11	DOUBLE OUTLET RIGHT VENTRICLE
745.12	CORRECTED TRANSPOSITION OF GREAT VESSELS
745.19	OTHER TRANSPOSITION OF GREAT VESSELS
745.2	TETRALOGY OF FALLOT
745.3	COMMON VENTRICLE
745.4	VENTRICULAR SEPTAL DEFECT
745.5	OSTIUM SECUNDUM TYPE ATRIAL SEPTAL DEFECT
745.60	

	ENDOCARDIAL CUSHION DEFECT UNSPECIFIED TYPE
745.61	OSTIUM PRIMUM DEFECT
745.69	OTHER ENDOCARDIAL CUSHION DEFECTS
745.7	COR BILOCULARE
745.8	OTHER BULBUS CORDIS ANOMALIES AND ANOMALIES OF CARDIAC SEPTAL CLOSURE
745.9	UNSPECIFIED DEFECT OF SEPTAL CLOSURE
746.00	CONGENITAL PULMONARY VALVE ANOMALY UNSPECIFIED
746.01	ATRESIA OF PULMONARY VALVE CONGENITAL
746.02	STENOSIS OF PULMONARY VALVE CONGENITAL
746.09	OTHER CONGENITAL ANOMALIES OF PULMONARY VALVE
746.1	TRICUSPID ATRESIA AND STENOSIS CONGENITAL
746.2	EBSTEIN'S ANOMALY
746.3	CONGENITAL STENOSIS OF AORTIC VALVE
746.4	CONGENITAL INSUFFICIENCY OF AORTIC VALVE
746.5	CONGENITAL MITRAL STENOSIS
746.6	CONGENITAL MITRAL INSUFFICIENCY
746.7	HYPOPLASTIC LEFT HEART SYNDROME
746.81	SUBAORTIC STENOSIS CONGENITAL
746.82	COR TRIATRIATUM
746.83	INFUNDIBULAR PULMONIC STENOSIS CONGENITAL
746.84	CONGENITAL OBSTRUCTIVE ANOMALIES OF HEART NOT ELSEWHERE CLASSIFIED
746.85	CORONARY ARTERY ANOMALY CONGENITAL
746.87	MALPOSITION OF HEART AND CARDIAC APEX
746.89	OTHER SPECIFIED CONGENITAL ANOMALIES OF HEART
747.0	PATENT DUCTUS ARTERIOSUS
747.10	COARCTATION OF AORTA (PREDUCTAL) (POSTDUCTAL)
747.11	INTERRUPTION OF AORTIC ARCH

747.20	CONGENITAL ANOMALY OF AORTA UNSPECIFIED
747.21	CONGENITAL ANOMALIES OF AORTIC ARCH
747.22	CONGENITAL ATRESIA AND STENOSIS OF AORTA
747.29	OTHER CONGENITAL ANOMALIES OF AORTA
747.3	CONGENITAL ANOMALIES OF PULMONARY ARTERY
747.40	CONGENITAL ANOMALY OF GREAT VEINS UNSPECIFIED
747.41	TOTAL ANOMALOUS PULMONARY VENOUS CONNECTION
747.42	PARTIAL ANOMALOUS PULMONARY VENOUS CONNECTION
747.49	OTHER ANOMALIES OF GREAT VEINS
759.3	SITUS INVERSUS
759.82	MARFAN SYNDROME

Applicable to CPT codes 93306, 93307, 93308, 93320, 93321

074.20	COXSACKIE CARDITIS UNSPECIFIED
074.21	COXSACKIE PERICARDITIS
074.22	COXSACKIE ENDOCARDITIS
074.23	COXSACKIE MYOCARDITIS
086.0	CHAGAS' DISEASE WITH HEART INVOLVEMENT
088.81	LYME DISEASE
093.0	ANEURYSM OF AORTA SPECIFIED AS SYPHILITIC
093.1	SYPHILITIC AORTITIS
093.21 - 093.24	SYPHILITIC ENDOCARDITIS OF MITRAL VALVE - SYPHILITIC ENDOCARDITIS OF PULMONARY VALVE
093.81	SYPHILITIC PERICARDITIS
093.82	SYPHILITIC MYOCARDITIS
098.83	GONOCOCCAL PERICARDITIS
098.84	GONOCOCCAL ENDOCARDITIS
112.81	CANDIDAL ENDOCARDITIS
115.03	HISTOPLASMA CAPSULATUM PERICARDITIS
115.04	HISTOPLASMA CAPSULATUM ENDOCARDITIS
115.13	HISTOPLASMA DUBOISII PERICARDITIS
115.14	HISTOPLASMA DUBOISII ENDOCARDITIS
130.3	MYOCARDITIS DUE TO TOXOPLASMOSIS

135	SARCOIDOSIS
164.1	MALIGNANT NEOPLASM OF HEART
164.8	MALIGNANT NEOPLASM OF OTHER PARTS OF MEDIASTINUM
198.89	SECONDARY MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES
212.7	BENIGN NEOPLASM OF HEART
238.8	NEOPLASM OF UNCERTAIN BEHAVIOR OF OTHER SPECIFIED SITES
239.8	NEOPLASM OF UNSPECIFIED NATURE OF OTHER SPECIFIED SITES
275.0	DISORDERS OF IRON METABOLISM
276.50	VOLUME DEPLETION, UNSPECIFIED
276.51	DEHYDRATION
276.52	HYPOVOLEMIA
276.6	FLUID OVERLOAD DISORDER
277.30	AMYLOIDOSIS, UNSPECIFIED
277.31	FAMILIAL MEDITERRANEAN FEVER
277.39	OTHER AMYLOIDOSIS
362.30 - 362.37	RETINAL VASCULAR OCCLUSION UNSPECIFIED - VENOUS ENGORGEMENT OF RETINA
391.0	ACUTE RHEUMATIC PERICARDITIS
391.1	ACUTE RHEUMATIC ENDOCARDITIS
391.2	ACUTE RHEUMATIC MYOCARDITIS
391.8	OTHER ACUTE RHEUMATIC HEART DISEASE
392.0	RHEUMATIC CHOREA WITH HEART INVOLVEMENT
393	CHRONIC RHEUMATIC PERICARDITIS
394.0 - 394.2	MITRAL STENOSIS - MITRAL STENOSIS WITH INSUFFICIENCY
394.9	OTHER AND UNSPECIFIED MITRAL VALVE DISEASES
395.0	RHEUMATIC AORTIC STENOSIS
395.1	RHEUMATIC AORTIC INSUFFICIENCY
395.2	RHEUMATIC AORTIC STENOSIS WITH INSUFFICIENCY
395.9	OTHER AND UNSPECIFIED RHEUMATIC AORTIC DISEASES
396.0 - 396.8	MITRAL VALVE STENOSIS AND AORTIC VALVE STENOSIS - MULTIPLE INVOLVEMENT OF MITRAL AND AORTIC VALVES

396.9	MITRAL AND AORTIC VALVE DISEASES UNSPECIFIED
397.0	DISEASES OF TRICUSPID VALVE
397.1	RHEUMATIC DISEASES OF PULMONARY VALVE
397.9	RHEUMATIC DISEASES OF ENDOCARDIUM VALVE UNSPECIFIED
398.0	RHEUMATIC MYOCARDITIS
398.90	RHEUMATIC HEART DISEASE UNSPECIFIED
398.91	RHEUMATIC HEART FAILURE (CONGESTIVE)
401.0	MALIGNANT ESSENTIAL HYPERTENSION
402.00 - 402.91	MALIGNANT HYPERTENSIVE HEART DISEASE WITHOUT HEART FAILURE - UNSPECIFIED HYPERTENSIVE HEART DISEASE WITH HEART FAILURE
403.00 - 403.91	HYPERTENSIVE CHRONIC KIDNEY DISEASE, MALIGNANT, WITH CHRONIC KIDNEY DISEASE STAGE I THROUGH STAGE IV, OR UNSPECIFIED - HYPERTENSIVE CHRONIC KIDNEY DISEASE, UNSPECIFIED, WITH CHRONIC KIDNEY DISEASE STAGE V OR END STAGE RENAL DISEASE
404.00 - 404.93	HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE, MALIGNANT, WITHOUT HEART FAILURE AND WITH CHRONIC KIDNEY DISEASE STAGE I THROUGH STAGE IV, OR UNSPECIFIED - HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE, UNSPECIFIED, WITH HEART FAILURE AND CHRONIC KIDNEY DISEASE STAGE V OR END STAGE RENAL DISEASE
405.01 - 405.99	MALIGNANT RENOVASCULAR HYPERTENSION - OTHER UNSPECIFIED SECONDARY HYPERTENSION
410.00 - 410.82	ACUTE MYOCARDIAL INFARCTION OF ANTEROLATERAL WALL EPISODE OF CARE UNSPECIFIED - ACUTE MYOCARDIAL INFARCTION OF OTHER SPECIFIED SITES SUBSEQUENT EPISODE OF CARE
410.92	ACUTE MYOCARDIAL INFARCTION OF UNSPECIFIED SITE SUBSEQUENT EPISODE OF CARE
411.0 - 411.89	POSTMYOCARDIAL INFARCTION SYNDROME - OTHER ACUTE AND SUBACUTE FORMS OF ISCHEMIC HEART DISEASE OTHER
412	OLD MYOCARDIAL INFARCTION
413.0	ANGINA DECUBITUS
413.1	PRINZMETAL ANGINA
413.9	OTHER AND UNSPECIFIED ANGINA PECTORIS

414.00 - 414.07	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED TYPE OF VESSEL NATIVE OR GRAFT - CORONARY ATHEROSCLEROSIS OF BYPASS GRAFT (ARTERY) (VEIN) OF TRANSPLANTED HEART
414.10	ANEURYSM OF HEART (WALL)
414.11	ANEURYSM OF CORONARY VESSELS
414.12	DISSECTION OF CORONARY ARTERY
414.19	OTHER ANEURYSM OF HEART
414.8	OTHER SPECIFIED FORMS OF CHRONIC ISCHEMIC HEART DISEASE
415.0	ACUTE COR PULMONALE
415.11	IATROGENIC PULMONARY EMBOLISM AND INFARCTION
415.12	SEPTIC PULMONARY EMBOLISM
416.0	PRIMARY PULMONARY HYPERTENSION
416.8	OTHER CHRONIC PULMONARY HEART DISEASES
417.0	ARTERIOVENOUS FISTULA OF PULMONARY VESSELS
417.1	ANEURYSM OF PULMONARY ARTERY
420.0 - 420.99	ACUTE PERICARDITIS IN DISEASES CLASSIFIED ELSEWHERE - OTHER ACUTE PERICARDITIS
421.0 - 421.9	ACUTE AND SUBACUTE BACTERIAL ENDOCARDITIS - ACUTE ENDOCARDITIS UNSPECIFIED
422.0	ACUTE MYOCARDITIS IN DISEASES CLASSIFIED ELSEWHERE
422.91 - 422.93	IDIOPATHIC MYOCARDITIS - TOXIC MYOCARDITIS
423.0 - 423.9	HEMOPERICARDIUM - UNSPECIFIED DISEASE OF PERICARDIUM
424.0 - 424.3	MITRAL VALVE DISORDERS - PULMONARY VALVE DISORDERS
424.90 - 424.99	ENDOCARDITIS VALVE UNSPECIFIED UNSPECIFIED CAUSE - OTHER ENDOCARDITIS VALVE UNSPECIFIED
425.0 - 425.8	ENDOMYOCARDIAL FIBROSIS - CARDIOMYOPATHY IN OTHER DISEASES CLASSIFIED ELSEWHERE
425.9	SECONDARY CARDIOMYOPATHY UNSPECIFIED
426.0	ATRIOVENTRICULAR BLOCK COMPLETE
426.10	ATRIOVENTRICULAR BLOCK UNSPECIFIED
426.11	FIRST DEGREE ATRIOVENTRICULAR BLOCK
426.12	MOBITZ (TYPE) II ATRIOVENTRICULAR BLOCK

426.2	LEFT BUNDLE BRANCH HEMIBLOCK
426.3	OTHER LEFT BUNDLE BRANCH BLOCK
426.4	RIGHT BUNDLE BRANCH BLOCK
427.0	PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA
427.1	PAROXYSMAL VENTRICULAR TACHYCARDIA
427.31	ATRIAL FIBRILLATION
427.32	ATRIAL FLUTTER
427.41	VENTRICULAR FIBRILLATION
427.42	VENTRICULAR FLUTTER
427.5	CARDIAC ARREST
427.81	SINOATRIAL NODE DYSFUNCTION
428.0 - 428.33	CONGESTIVE HEART FAILURE UNSPECIFIED - ACUTE ON CHRONIC DIASTOLIC HEART FAILURE
428.40 - 428.43	UNSPECIFIED COMBINED SYSTOLIC AND DIASTOLIC HEART FAILURE - ACUTE ON CHRONIC COMBINED SYSTOLIC AND DIASTOLIC HEART FAILURE
429.0 - 429.6	MYOCARDITIS UNSPECIFIED - RUPTURE OF PAPILLARY MUSCLE
429.71	CERTAIN SEQUELAE OF MYOCARDIAL INFARCTION NOT ELSEWHERE CLASSIFIED ACQUIRED CARDIAC SEPTAL DEFECT
429.79	CERTAIN SEQUELAE OF MYOCARDIAL INFARCTION NOT ELSEWHERE CLASSIFIED OTHER
429.81	OTHER DISORDERS OF PAPILLARY MUSCLE
429.83	TAKOTSUBO SYNDROME
429.89	OTHER ILL-DEFINED HEART DISEASES
429.9	HEART DISEASE UNSPECIFIED
434.10	CEREBRAL EMBOLISM WITHOUT CEREBRAL INFARCTION
434.11	CEREBRAL EMBOLISM WITH CEREBRAL INFARCTION
434.90	CEREBRAL ARTERY OCCLUSION UNSPECIFIED WITHOUT CEREBRAL INFARCTION
434.91	CEREBRAL ARTERY OCCLUSION UNSPECIFIED WITH CEREBRAL INFARCTION
435.8	OTHER SPECIFIED TRANSIENT CEREBRAL ISCHEMIAS
435.9	UNSPECIFIED TRANSIENT CEREBRAL ISCHEMIA
436	

ACUTE BUT ILL-DEFINED CEREBROVASCULAR
DISEASE

440.0	ATHEROSCLEROSIS OF AORTA
440.20	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES UNSPECIFIED
441.00 - 446.1	DISSECTION OF AORTA ANEURYSM UNSPECIFIED SITE - ACUTE FEBRILE MUCOCUTANEOUS LYMPH NODE SYNDROME (MCLS)
446.7	TAKAYASU'S DISEASE
458.0	ORTHOSTATIC HYPOTENSION
458.8	OTHER SPECIFIED HYPOTENSION
458.9	HYPOTENSION UNSPECIFIED
459.2	COMPRESSION OF VEIN
518.4	ACUTE EDEMA OF LUNG UNSPECIFIED
518.5	PULMONARY INSUFFICIENCY FOLLOWING TRAUMA AND SURGERY
518.6	ALLERGIC BRONCHOPULMONARY ASPERGILLIOSIS
518.7	TRANSFUSION RELATED ACUTE LUNG INJURY (TRALI)
518.82	OTHER PULMONARY INSUFFICIENCY NOT ELSEWHERE CLASSIFIED
584.9	ACUTE RENAL FAILURE UNSPECIFIED
674.82	OTHER COMPLICATIONS OF PUERPERIUM WITH DELIVERY WITH POSTPARTUM COMPLICATION
674.84	OTHER COMPLICATIONS OF PUERPERIUM
710.0	SYSTEMIC LUPUS ERYTHEMATOSUS
710.1	SYSTEMIC SCLEROSIS
745.0 - 745.9	COMMON TRUNCUS - UNSPECIFIED DEFECT OF SEPTAL CLOSURE
746.00 - 746.89	CONGENITAL PULMONARY VALVE ANOMALY UNSPECIFIED - OTHER SPECIFIED CONGENITAL ANOMALIES OF HEART
747.0 - 747.49	PATENT DUCTUS ARTERIOSUS - OTHER ANOMALIES OF GREAT VEINS
759.3	SITUS INVERSUS
759.82	MARFAN SYNDROME
780.2	SYNCOPE AND COLLAPSE
780.60	FEVER, UNSPECIFIED
780.61	FEVER PRESENTING WITH CONDITIONS CLASSIFIED ELSEWHERE

782.3	EDEMA
785.2	UNDIAGNOSED CARDIAC MURMURS
785.3	OTHER ABNORMAL HEART SOUNDS
785.50 - 785.59	SHOCK UNSPECIFIED - OTHER SHOCK WITHOUT TRAUMA
786.00	RESPIRATORY ABNORMALITY UNSPECIFIED
786.02	ORTHOPNEA
786.03	APNEA
786.04	CHEYNE-STOKES RESPIRATION
786.05	SHORTNESS OF BREATH
786.06	TACHYPNEA
786.07	WHEEZING
786.09	RESPIRATORY ABNORMALITY OTHER
786.50	UNSPECIFIED CHEST PAIN
786.51	PRECORDIAL PAIN
786.59	OTHER CHEST PAIN
786.6	SWELLING MASS OR LUMP IN CHEST
790.7	BACTEREMIA
794.31	NONSPECIFIC ABNORMAL ELECTROCARDIOGRAM (ECG) (EKG)
807.4	FLAIL CHEST
861.00	UNSPECIFIED INJURY OF HEART WITHOUT OPEN WOUND INTO THORAX
861.01 - 861.13	CONTUSION OF HEART WITHOUT OPEN WOUND INTO THORAX - LACERATION OF HEART WITH PENETRATION OF HEART CHAMBERS AND OPEN WOUND INTO THORAX
875.0	OPEN WOUND OF CHEST (WALL) WITHOUT COMPLICATION
875.1	OPEN WOUND OF CHEST (WALL) COMPLICATED
901.0	INJURY TO THORACIC AORTA
901.2	INJURY TO SUPERIOR VENA CAVA
901.41	INJURY TO PULMONARY ARTERY
901.42	INJURY TO PULMONARY VEIN
958.0	AIR EMBOLISM AS AN EARLY COMPLICATION OF TRAUMA
958.1	FAT EMBOLISM AS AN EARLY COMPLICATION OF TRAUMA
958.4	TRAUMATIC SHOCK
959.11	OTHER INJURY OF CHEST WALL

960.7	POISONING BY ANTINEOPLASTIC ANTIBIOTICS
962.0	POISONING BY ADRENAL CORTICAL STEROIDS
963.1	POISONING BY ANTINEOPLASTIC AND IMMUNOSUPPRESSIVE DRUGS
965.09	POISONING BY OTHER OPIATES AND RELATED NARCOTICS
980.3	TOXIC EFFECT OF FUSEL OIL
986	TOXIC EFFECT OF CARBON MONOXIDE
990	EFFECTS OF RADIATION UNSPECIFIED
993.3	CAISSON DISEASE
994.0	EFFECTS OF LIGHTNING
994.8	ELECTROCUTION AND NONFATAL EFFECTS OF ELECTRIC CURRENT
995.1	ANGIONEUROTIC EDEMA NOT ELSEWHERE CLASSIFIED
995.20	UNSPECIFIED ADVERSE EFFECT OF UNSPECIFIED DRUG, MEDICINAL AND BIOLOGICAL SUBSTANCE
995.29	UNSPECIFIED ADVERSE EFFECT OF OTHER DRUG, MEDICINAL AND BIOLOGICAL SUBSTANCE
996.01	MECHANICAL COMPLICATION DUE TO CARDIAC PACEMAKER (ELECTRODE)
996.02	MECHANICAL COMPLICATION DUE TO HEART VALVE PROSTHESIS
996.04	MECHANICAL COMPLICATION OF AUTOMATIC IMPLANTABLE CARDIAC DEFIBRILLATOR
996.61	INFECTION AND INFLAMMATORY REACTION DUE TO CARDIAC DEVICE IMPLANT AND GRAFT
996.71	OTHER COMPLICATIONS DUE TO HEART VALVE PROSTHESIS
996.72	OTHER COMPLICATIONS DUE TO OTHER CARDIAC DEVICE IMPLANT AND GRAFT
996.83	COMPLICATIONS OF TRANSPLANTED HEART
997.1	CARDIAC COMPLICATIONS NOT ELSEWHERE CLASSIFIED
998.0	POSTOPERATIVE SHOCK NOT ELSEWHERE CLASSIFIED
998.51	INFECTED POSTOPERATIVE SEROMA
998.59	OTHER POSTOPERATIVE INFECTION
999.1	AIR EMBOLISM AS A COMPLICATION OF MEDICAL CARE NOT ELSEWHERE CLASSIFIED
999.31	INFECTION DUE TO CENTRAL VENOUS CATHETER

999.39	INFECTION FOLLOWING OTHER INFUSION, INJECTION, TRANSFUSION, OR VACCINATION
999.4	ANAPHYLACTIC SHOCK DUE TO SERUM NOT ELSEWHERE CLASSIFIED
V15.1	PERSONAL HISTORY OF SURGERY TO HEART AND GREAT VESSELS PRESENTING HAZARDS TO HEALTH
V42.1	HEART REPLACED BY TRANSPLANT
V42.2	HEART VALVE REPLACED BY TRANSPLANT
V42.6	LUNG REPLACED BY TRANSPLANT
V43.3	HEART VALVE REPLACED BY OTHER MEANS
V47.2	OTHER CARDIORESPIRATORY PROBLEMS
V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
V58.83	ENCOUNTER FOR THERAPEUTIC DRUG MONITORING
V59.8	DONORS OF OTHER SPECIFIED ORGAN OR TISSUE
V67.2	FOLLOW-UP EXAMINATION FOLLOWING CHEMOTHERAPY
V72.85	OTHER SPECIFIED EXAMINATION

Applicable to CPT code 93325

074.20	COXSACKIE CARDITIS UNSPECIFIED
074.21	COXSACKIE PERICARDITIS
074.22	COXSACKIE ENDOCARDITIS
074.23	COXSACKIE MYOCARDITIS
086.0	CHAGAS' DISEASE WITH HEART INVOLVEMENT
088.81	LYME DISEASE
093.0	ANEURYSM OF AORTA SPECIFIED AS SYPHILITIC
093.1	SYPHILITIC AORTITIS
093.21	SYPHILITIC ENDOCARDITIS OF MITRAL VALVE
093.22	SYPHILITIC ENDOCARDITIS OF AORTIC VALVE
093.23	SYPHILITIC ENDOCARDITIS OF TRICUSPID VALVE
093.24	SYPHILITIC ENDOCARDITIS OF PULMONARY VALVE
093.81	SYPHILITIC PERICARDITIS
093.82	SYPHILITIC MYOCARDITIS
098.83	GONOCOCCAL PERICARDITIS
098.84	GONOCOCCAL ENDOCARDITIS
112.81	CANDIDAL ENDOCARDITIS

115.03	HISTOPLASMA CAPSULATUM PERICARDITIS
115.04	HISTOPLASMA CAPSULATUM ENDOCARDITIS
115.13	HISTOPLASMA DUBOISII PERICARDITIS
115.14	HISTOPLASMA DUBOISII ENDOCARDITIS
130.3	MYOCARDITIS DUE TO TOXOPLASMOSIS
164.1	MALIGNANT NEOPLASM OF HEART
164.8	MALIGNANT NEOPLASM OF OTHER PARTS OF MEDIASTINUM
198.89	SECONDARY MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES
212.7	BENIGN NEOPLASM OF HEART
238.8	NEOPLASM OF UNCERTAIN BEHAVIOR OF OTHER SPECIFIED SITES
239.8	NEOPLASM OF UNSPECIFIED NATURE OF OTHER SPECIFIED SITES
275.0	DISORDERS OF IRON METABOLISM
276.6	FLUID OVERLOAD DISORDER
277.30	AMYLOIDOSIS, UNSPECIFIED
277.31	FAMILIAL MEDITERRANEAN FEVER
277.39	OTHER AMYLOIDOSIS
362.34	TRANSIENT RETINAL ARTERIAL OCCLUSION
391.0	ACUTE RHEUMATIC PERICARDITIS
391.1	ACUTE RHEUMATIC ENDOCARDITIS
391.2	ACUTE RHEUMATIC MYOCARDITIS
391.8	OTHER ACUTE RHEUMATIC HEART DISEASE
392.0	RHEUMATIC CHOREA WITH HEART INVOLVEMENT
393	CHRONIC RHEUMATIC PERICARDITIS
394.0 - 394.9	MITRAL STENOSIS - OTHER AND UNSPECIFIED MITRAL VALVE DISEASES
395.0 - 395.9	RHEUMATIC AORTIC STENOSIS - OTHER AND UNSPECIFIED RHEUMATIC AORTIC DISEASES
396.0 - 396.9	MITRAL VALVE STENOSIS AND AORTIC VALVE STENOSIS - MITRAL AND AORTIC VALVE DISEASES UNSPECIFIED
397.0	DISEASES OF TRICUSPID VALVE
397.1	RHEUMATIC DISEASES OF PULMONARY VALVE
397.9	RHEUMATIC DISEASES OF ENDOCARDIUM VALVE UNSPECIFIED
398.0	RHEUMATIC MYOCARDITIS

398.90	RHEUMATIC HEART DISEASE UNSPECIFIED
398.91	RHEUMATIC HEART FAILURE (CONGESTIVE)
401.0	MALIGNANT ESSENTIAL HYPERTENSION
402.00 - 402.01	MALIGNANT HYPERTENSIVE HEART DISEASE WITHOUT HEART FAILURE - MALIGNANT HYPERTENSIVE HEART DISEASE WITH HEART FAILURE
402.11	BENIGN HYPERTENSIVE HEART DISEASE WITH HEART FAILURE
402.91	UNSPECIFIED HYPERTENSIVE HEART DISEASE WITH HEART FAILURE
403.00 - 403.01	HYPERTENSIVE CHRONIC KIDNEY DISEASE, MALIGNANT, WITH CHRONIC KIDNEY DISEASE STAGE I THROUGH STAGE IV, OR UNSPECIFIED - HYPERTENSIVE CHRONIC KIDNEY DISEASE, MALIGNANT, WITH CHRONIC KIDNEY DISEASE STAGE V OR END STAGE RENAL DISEASE
404.00 - 405.91	HYPERTENSIVE HEART AND CHRONIC KIDNEY DISEASE, MALIGNANT, WITHOUT HEART FAILURE AND WITH CHRONIC KIDNEY DISEASE STAGE I THROUGH STAGE IV, OR UNSPECIFIED - UNSPECIFIED RENOVASCULAR HYPERTENSION
410.00 - 410.92	ACUTE MYOCARDIAL INFARCTION OF ANTEROLATERAL WALL EPISODE OF CARE UNSPECIFIED - ACUTE MYOCARDIAL INFARCTION OF UNSPECIFIED SITE SUBSEQUENT EPISODE OF CARE
411.0	POSTMYOCARDIAL INFARCTION SYNDROME
411.1	INTERMEDIATE CORONARY SYNDROME
411.81	ACUTE CORONARY OCCLUSION WITHOUT MYOCARDIAL INFARCTION
411.89	OTHER ACUTE AND SUBACUTE FORMS OF ISCHEMIC HEART DISEASE OTHER
412	OLD MYOCARDIAL INFARCTION
413.0	ANGINA DECUBITUS
413.1	PRINZMETAL ANGINA
413.9	OTHER AND UNSPECIFIED ANGINA PECTORIS
414.00 - 414.07	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED TYPE OF VESSEL NATIVE OR GRAFT - CORONARY ATHEROSCLEROSIS OF BYPASS GRAFT (ARTERY) (VEIN) OF TRANSPLANTED HEART
414.10	ANEURYSM OF HEART (WALL)
414.11	ANEURYSM OF CORONARY VESSELS
414.12	DISSECTION OF CORONARY ARTERY
414.19	OTHER ANEURYSM OF HEART

414.2	CHRONIC TOTAL OCCLUSION OF CORONARY ARTERY
414.8	OTHER SPECIFIED FORMS OF CHRONIC ISCHEMIC HEART DISEASE
415.0	ACUTE COR PULMONALE
415.11	IATROGENIC PULMONARY EMBOLISM AND INFARCTION
415.12	SEPTIC PULMONARY EMBOLISM
416.0	PRIMARY PULMONARY HYPERTENSION
416.8	OTHER CHRONIC PULMONARY HEART DISEASES
417.0	ARTERIOVENOUS FISTULA OF PULMONARY VESSELS
417.1	ANEURYSM OF PULMONARY ARTERY
420.0 - 420.99	ACUTE PERICARDITIS IN DISEASES CLASSIFIED ELSEWHERE - OTHER ACUTE PERICARDITIS
421.0 - 421.9	ACUTE AND SUBACUTE BACTERIAL ENDOCARDITIS - ACUTE ENDOCARDITIS UNSPECIFIED
422.0	ACUTE MYOCARDITIS IN DISEASES CLASSIFIED ELSEWHERE
422.91	IDIOPATHIC MYOCARDITIS
422.92	SEPTIC MYOCARDITIS
422.93	TOXIC MYOCARDITIS
423.0	HEMOPERICARDIUM
423.1	ADHESIVE PERICARDITIS
423.2	CONSTRUCTIVE PERICARDITIS
423.3	CARDIAC TAMPONADE
423.8	OTHER SPECIFIED DISEASES OF PERICARDIUM
423.9	UNSPECIFIED DISEASE OF PERICARDIUM
424.0	MITRAL VALVE DISORDERS
424.1	AORTIC VALVE DISORDERS
424.2	TRICUSPID VALVE DISORDERS SPECIFIED AS NONRHEUMATIC
424.3	PULMONARY VALVE DISORDERS
424.90	ENDOCARDITIS VALVE UNSPECIFIED UNSPECIFIED CAUSE
424.91	ENDOCARDITIS IN DISEASES CLASSIFIED ELSEWHERE
424.99	OTHER ENDOCARDITIS VALVE UNSPECIFIED
425.0	ENDOMYOCARDIAL FIBROSIS

425.1	HYPERTROPHIC OBSTRUCTIVE CARDIOMYOPATHY
425.2	OBSCURE CARDIOMYOPATHY OF AFRICA
425.3	ENDOCARDIAL FIBROELASTOSIS
425.4	OTHER PRIMARY CARDIOMYOPATHIES
425.5	ALCOHOLIC CARDIOMYOPATHY
425.7	NUTRITIONAL AND METABOLIC CARDIOMYOPATHY
425.8	CARDIOMYOPATHY IN OTHER DISEASES CLASSIFIED ELSEWHERE
425.9	SECONDARY CARDIOMYOPATHY UNSPECIFIED
426.0	ATRIOVENTRICULAR BLOCK COMPLETE
426.10	ATRIOVENTRICULAR BLOCK UNSPECIFIED
426.11	FIRST DEGREE ATRIOVENTRICULAR BLOCK
426.12	MOBITZ (TYPE) II ATRIOVENTRICULAR BLOCK
426.2	LEFT BUNDLE BRANCH HEMIBLOCK
426.3	OTHER LEFT BUNDLE BRANCH BLOCK
426.4	RIGHT BUNDLE BRANCH BLOCK
427.0	PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA
427.1	PAROXYSMAL VENTRICULAR TACHYCARDIA
427.31	ATRIAL FIBRILLATION
427.32	ATRIAL FLUTTER
427.41	VENTRICULAR FIBRILLATION
427.42	VENTRICULAR FLUTTER
427.5	CARDIAC ARREST
427.81	SINOATRIAL NODE DYSFUNCTION
428.0	CONGESTIVE HEART FAILURE UNSPECIFIED
428.1	LEFT HEART FAILURE
428.20 - 428.23	UNSPECIFIED SYSTOLIC HEART FAILURE - ACUTE ON CHRONIC SYSTOLIC HEART FAILURE
428.30 - 428.33	UNSPECIFIED DIASTOLIC HEART FAILURE - ACUTE ON CHRONIC DIASTOLIC HEART FAILURE
428.40 - 428.43	UNSPECIFIED COMBINED SYSTOLIC AND DIASTOLIC HEART FAILURE - ACUTE ON CHRONIC COMBINED SYSTOLIC AND DIASTOLIC HEART FAILURE
429.0	MYOCARDITIS UNSPECIFIED
429.1	MYOCARDIAL DEGENERATION
429.2	CARDIOVASCULAR DISEASE UNSPECIFIED

429.3	CARDIOMEGALY
429.4	FUNCTIONAL DISTURBANCES FOLLOWING CARDIAC SURGERY
429.5	RUPTURE OF CHORDAE TENDINEAE
429.6	RUPTURE OF PAPILLARY MUSCLE
429.71	CERTAIN SEQUELAE OF MYOCARDIAL INFARCTION NOT ELSEWHERE CLASSIFIED ACQUIRED CARDIAC SEPTAL DEFECT
429.79	CERTAIN SEQUELAE OF MYOCARDIAL INFARCTION NOT ELSEWHERE CLASSIFIED OTHER
429.81	OTHER DISORDERS OF PAPILLARY MUSCLE
429.83	TAKOTSUBO SYNDROME
429.89	OTHER ILL-DEFINED HEART DISEASES
429.9	HEART DISEASE UNSPECIFIED
434.10	CEREBRAL EMBOLISM WITHOUT CEREBRAL INFARCTION
434.11	CEREBRAL EMBOLISM WITH CEREBRAL INFARCTION
434.90	CEREBRAL ARTERY OCCLUSION UNSPECIFIED WITHOUT CEREBRAL INFARCTION
434.91	CEREBRAL ARTERY OCCLUSION UNSPECIFIED WITH CEREBRAL INFARCTION
435.8	OTHER SPECIFIED TRANSIENT CEREBRAL ISCHEMIAS
435.9	UNSPECIFIED TRANSIENT CEREBRAL ISCHEMIA
436	ACUTE BUT ILL-DEFINED CEREBROVASCULAR DISEASE
440.0	ATHEROSCLEROSIS OF AORTA
440.20	ATHEROSCLEROSIS OF NATIVE ARTERIES OF THE EXTREMITIES UNSPECIFIED
441.00 - 441.9	DISSECTION OF AORTA ANEURYSM UNSPECIFIED SITE - AORTIC ANEURYSM OF UNSPECIFIED SITE WITHOUT RUPTURE
444.1	EMBOLISM AND THROMBOSIS OF THORACIC AORTA
444.21	ARTERIAL EMBOLISM AND THROMBOSIS OF UPPER EXTREMITY
444.22	ARTERIAL EMBOLISM AND THROMBOSIS OF LOWER EXTREMITY
446.1	ACUTE FEBRILE MUCOCUTANEOUS LYMPH NODE SYNDROME (MCLS)
446.7	TAKAYASU'S DISEASE

458.0	ORTHOSTATIC HYPOTENSION
458.8	OTHER SPECIFIED HYPOTENSION
458.9	HYPOTENSION UNSPECIFIED
459.2	COMPRESSION OF VEIN
518.4	ACUTE EDEMA OF LUNG UNSPECIFIED
518.5	PULMONARY INSUFFICIENCY FOLLOWING TRAUMA AND SURGERY
518.6	ALLERGIC BRONCHOPULMONARY ASPERGILLIOSIS
518.7	TRANSFUSION RELATED ACUTE LUNG INJURY (TRALI)
518.82	OTHER PULMONARY INSUFFICIENCY NOT ELSEWHERE CLASSIFIED
584.9	ACUTE RENAL FAILURE UNSPECIFIED
648.03	ANTEPARTUM DIABETES MELLITUS
674.82	OTHER COMPLICATIONS OF PUERPERIUM WITH DELIVERY WITH POSTPARTUM COMPLICATION
674.84	OTHER COMPLICATIONS OF PUERPERIUM
710.0	SYSTEMIC LUPUS ERYTHEMATOSUS
745.0 - 745.9	COMMON TRUNCUS - UNSPECIFIED DEFECT OF SEPTAL CLOSURE
746.00 - 746.89	CONGENITAL PULMONARY VALVE ANOMALY UNSPECIFIED - OTHER SPECIFIED CONGENITAL ANOMALIES OF HEART
747.0 - 747.49	PATENT DUCTUS ARTERIOSUS - OTHER ANOMALIES OF GREAT VEINS
759.3	SITUS INVERSUS
759.82	MARFAN SYNDROME
780.2	SYNCOPE AND COLLAPSE
780.60	FEVER, UNSPECIFIED
780.61	FEVER PRESENTING WITH CONDITIONS CLASSIFIED ELSEWHERE
785.2	UNDIAGNOSED CARDIAC MURMURS
785.3	OTHER ABNORMAL HEART SOUNDS
785.50 - 785.59	SHOCK UNSPECIFIED - OTHER SHOCK WITHOUT TRAUMA
786.00	RESPIRATORY ABNORMALITY UNSPECIFIED
786.02	ORTHOPNEA
786.05	SHORTNESS OF BREATH
786.50	UNSPECIFIED CHEST PAIN

786.51	PRECORDIAL PAIN
786.59	OTHER CHEST PAIN
786.6	SWELLING MASS OR LUMP IN CHEST
790.7	BACTEREMIA
794.31	NONSPECIFIC ABNORMAL ELECTROCARDIOGRAM (ECG) (EKG)
807.4	FLAIL CHEST
861.00	UNSPECIFIED INJURY OF HEART WITHOUT OPEN WOUND INTO THORAX
861.01	CONTUSION OF HEART WITHOUT OPEN WOUND INTO THORAX
861.02	LACERATION OF HEART WITHOUT PENETRATION OF HEART CHAMBERS OR OPEN WOUND INTO THORAX
861.03	LACERATION OF HEART WITH PENETRATION OF HEART CHAMBERS WITHOUT OPEN WOUND INTO THORAX
861.10	UNSPECIFIED INJURY OF HEART WITH OPEN WOUND INTO THORAX
861.11	CONTUSION OF HEART WITH OPEN WOUND INTO THORAX
861.12	LACERATION OF HEART WITHOUT PENETRATION OF HEART CHAMBERS WITH OPEN WOUND INTO THORAX
861.13	LACERATION OF HEART WITH PENETRATION OF HEART CHAMBERS AND OPEN WOUND INTO THORAX
901.0	INJURY TO THORACIC AORTA
901.2	INJURY TO SUPERIOR VENA CAVA
901.41	INJURY TO PULMONARY ARTERY
901.42	INJURY TO PULMONARY VEIN
958.0	AIR EMBOLISM AS AN EARLY COMPLICATION OF TRAUMA
958.1	FAT EMBOLISM AS AN EARLY COMPLICATION OF TRAUMA
958.4	TRAUMATIC SHOCK
995.1	ANGIONEUROTIC EDEMA NOT ELSEWHERE CLASSIFIED
996.01	MECHANICAL COMPLICATION DUE TO CARDIAC PACEMAKER (ELECTRODE)
996.02	MECHANICAL COMPLICATION DUE TO HEART VALVE PROSTHESIS
996.04	

MECHANICAL COMPLICATION OF AUTOMATIC
IMPLANTABLE CARDIAC DEFIBRILLATOR

996.61	INFECTION AND INFLAMMATORY REACTION DUE TO CARDIAC DEVICE IMPLANT AND GRAFT
996.71	OTHER COMPLICATIONS DUE TO HEART VALVE PROSTHESIS
996.72	OTHER COMPLICATIONS DUE TO OTHER CARDIAC DEVICE IMPLANT AND GRAFT
996.83	COMPLICATIONS OF TRANSPLANTED HEART
997.1	CARDIAC COMPLICATIONS NOT ELSEWHERE CLASSIFIED
998.0	POSTOPERATIVE SHOCK NOT ELSEWHERE CLASSIFIED
998.51	INFECTED POSTOPERATIVE SEROMA
998.59	OTHER POSTOPERATIVE INFECTION
999.1	AIR EMBOLISM AS A COMPLICATION OF MEDICAL CARE NOT ELSEWHERE CLASSIFIED
999.31	INFECTION DUE TO CENTRAL VENOUS CATHETER
999.39	INFECTION FOLLOWING OTHER INFUSION, INJECTION, TRANSFUSION, OR VACCINATION
999.4	ANAPHYLACTIC SHOCK DUE TO SERUM NOT ELSEWHERE CLASSIFIED
V15.1	PERSONAL HISTORY OF SURGERY TO HEART AND GREAT VESSELS PRESENTING HAZARDS TO HEALTH
V42.1	HEART REPLACED BY TRANSPLANT
V42.2	HEART VALVE REPLACED BY TRANSPLANT
V42.6	LUNG REPLACED BY TRANSPLANT
V43.3	HEART VALVE REPLACED BY OTHER MEANS
V47.2	OTHER CARDIORESPIRATORY PROBLEMS
V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
V58.83	ENCOUNTER FOR THERAPEUTIC DRUG MONITORING
V59.8	DONORS OF OTHER SPECIFIED ORGAN OR TISSUE
V67.2	FOLLOW-UP EXAMINATION FOLLOWING CHEMOTHERAPY

Applicable to CPT codes 93350, 93351, 93352

394.0	MITRAL STENOSIS
394.1	RHEUMATIC MITRAL INSUFFICIENCY
394.2	MITRAL STENOSIS WITH INSUFFICIENCY

394.9	OTHER AND UNSPECIFIED MITRAL VALVE DISEASES
395.0	RHEUMATIC AORTIC STENOSIS
395.1	RHEUMATIC AORTIC INSUFFICIENCY
395.2	RHEUMATIC AORTIC STENOSIS WITH INSUFFICIENCY
395.9	OTHER AND UNSPECIFIED RHEUMATIC AORTIC DISEASES
396.0	MITRAL VALVE STENOSIS AND AORTIC VALVE STENOSIS
396.1	MITRAL VALVE STENOSIS AND AORTIC VALVE INSUFFICIENCY
396.2	MITRAL VALVE INSUFFICIENCY AND AORTIC VALVE STENOSIS
396.3	MITRAL VALVE INSUFFICIENCY AND AORTIC VALVE INSUFFICIENCY
396.8	MULTIPLE INVOLVEMENT OF MITRAL AND AORTIC VALVES
396.9	MITRAL AND AORTIC VALVE DISEASES UNSPECIFIED
410.02	ACUTE MYOCARDIAL INFARCTION OF ANTEROLATERAL WALL SUBSEQUENT EPISODE OF CARE
410.12	ACUTE MYOCARDIAL INFARCTION OF OTHER ANTERIOR WALL SUBSEQUENT EPISODE OF CARE
410.22	ACUTE MYOCARDIAL INFARCTION OF INFEROLATERAL WALL SUBSEQUENT EPISODE OF CARE
410.32	ACUTE MYOCARDIAL INFARCTION OF INFEROPOSTERIOR WALL SUBSEQUENT EPISODE OF CARE
410.42	ACUTE MYOCARDIAL INFARCTION OF OTHER INFERIOR WALL SUBSEQUENT EPISODE OF CARE
410.52	ACUTE MYOCARDIAL INFARCTION OF OTHER LATERAL WALL SUBSEQUENT EPISODE OF CARE
410.62	TRUE POSTERIOR WALL INFARCTION SUBSEQUENT EPISODE OF CARE
410.72	SUBENDOCARDIAL INFARCTION SUBSEQUENT EPISODE OF CARE
411.1	INTERMEDIATE CORONARY SYNDROME
411.81	ACUTE CORONARY OCCLUSION WITHOUT MYOCARDIAL INFARCTION
411.89	OTHER ACUTE AND SUBACUTE FORMS OF ISCHEMIC HEART DISEASE OTHER

413.0	ANGINA DECUBITUS
413.1	PRINZMETAL ANGINA
413.9	OTHER AND UNSPECIFIED ANGINA PECTORIS
414.00 - 414.07	CORONARY ATHEROSCLEROSIS OF UNSPECIFIED TYPE OF VESSEL NATIVE OR GRAFT - CORONARY ATHEROSCLEROSIS OF BYPASS GRAFT (ARTERY) (VEIN) OF TRANSPLANTED HEART
414.10	ANEURYSM OF HEART (WALL)
414.11	ANEURYSM OF CORONARY VESSELS
414.12	DISSECTION OF CORONARY ARTERY
414.19	OTHER ANEURYSM OF HEART
414.2	CHRONIC TOTAL OCCLUSION OF CORONARY ARTERY
414.8	OTHER SPECIFIED FORMS OF CHRONIC ISCHEMIC HEART DISEASE
415.0	ACUTE COR PULMONALE
416.0	PRIMARY PULMONARY HYPERTENSION
416.8	OTHER CHRONIC PULMONARY HEART DISEASES
416.9	CHRONIC PULMONARY HEART DISEASE UNSPECIFIED
424.0	MITRAL VALVE DISORDERS
424.1	AORTIC VALVE DISORDERS
424.2	TRICUSPID VALVE DISORDERS SPECIFIED AS NONRHEUMATIC
424.3	PULMONARY VALVE DISORDERS
424.90	ENDOCARDITIS VALVE UNSPECIFIED UNSPECIFIED CAUSE
424.91	ENDOCARDITIS IN DISEASES CLASSIFIED ELSEWHERE
424.99	OTHER ENDOCARDITIS VALVE UNSPECIFIED
425.0	ENDOMYOCARDIAL FIBROSIS
425.1	HYPERTROPHIC OBSTRUCTIVE CARDIOMYOPATHY
425.2	OBSCURE CARDIOMYOPATHY OF AFRICA
425.3	ENDOCARDIAL FIBROELASTOSIS
425.4	OTHER PRIMARY CARDIOMYOPATHIES
425.5	ALCOHOLIC CARDIOMYOPATHY
425.7	NUTRITIONAL AND METABOLIC CARDIOMYOPATHY
425.8	CARDIOMYOPATHY IN OTHER DISEASES CLASSIFIED ELSEWHERE

425.9	SECONDARY CARDIOMYOPATHY UNSPECIFIED
426.10	ATRIOVENTRICULAR BLOCK UNSPECIFIED
426.11	FIRST DEGREE ATRIOVENTRICULAR BLOCK
426.2	LEFT BUNDLE BRANCH HEMIBLOCK
426.3	OTHER LEFT BUNDLE BRANCH BLOCK
426.4	RIGHT BUNDLE BRANCH BLOCK
427.0	PAROXYSMAL SUPRAVENTRICULAR TACHYCARDIA
427.2	PAROXYSMAL TACHYCARDIA UNSPECIFIED
427.31	ATRIAL FIBRILLATION
427.32	ATRIAL FLUTTER
427.60	PREMATURE BEATS UNSPECIFIED
427.61	SUPRAVENTRICULAR PREMATURE BEATS
427.69	OTHER PREMATURE BEATS
427.81	SINOATRIAL NODE DYSFUNCTION
427.89	OTHER SPECIFIED CARDIAC DYSRHYTHMIAS
428.0	CONGESTIVE HEART FAILURE UNSPECIFIED
428.1	LEFT HEART FAILURE
428.9	HEART FAILURE UNSPECIFIED
429.0	MYOCARDITIS UNSPECIFIED
429.1	MYOCARDIAL DEGENERATION
429.2	CARDIOVASCULAR DISEASE UNSPECIFIED
429.3	CARDIOMEGALY
429.4	FUNCTIONAL DISTURBANCES FOLLOWING CARDIAC SURGERY
429.5	RUPTURE OF CHORDAE TENDINEAE
429.6	RUPTURE OF PAPILLARY MUSCLE
429.71	CERTAIN SEQUELAE OF MYOCARDIAL INFARCTION NOT ELSEWHERE CLASSIFIED ACQUIRED CARDIAC SEPTAL DEFECT
780.2	SYNCOPE AND COLLAPSE
786.02	ORTHOPNEA
786.05	SHORTNESS OF BREATH
786.07	WHEEZING
786.50	UNSPECIFIED CHEST PAIN
786.51	PRECORDIAL PAIN
794.30	UNSPECIFIED ABNORMAL FUNCTION STUDY OF CARDIOVASCULAR SYSTEM

794.31	NONSPECIFIC ABNORMAL ELECTROCARDIOGRAM (ECG) (EKG)
794.39	OTHER NONSPECIFIC ABNORMAL FUNCTION STUDY OF CARDIOVASCULAR SYSTEM
995.20	UNSPECIFIED ADVERSE EFFECT OF UNSPECIFIED DRUG, MEDICINAL AND BIOLOGICAL SUBSTANCE
995.29	UNSPECIFIED ADVERSE EFFECT OF OTHER DRUG, MEDICINAL AND BIOLOGICAL SUBSTANCE
996.1	MECHANICAL COMPLICATION OF OTHER VASCULAR DEVICE IMPLANT AND GRAFT
996.61	INFECTION AND INFLAMMATORY REACTION DUE TO CARDIAC DEVICE IMPLANT AND GRAFT
996.72	OTHER COMPLICATIONS DUE TO OTHER CARDIAC DEVICE IMPLANT AND GRAFT
996.83	COMPLICATIONS OF TRANSPLANTED HEART
V45.81	POSTSURGICAL AORTOCORONARY BYPASS STATUS
V45.82	PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY STATUS
V72.81	PRE-OPERATIVE CARDIOVASCULAR EXAMINATION

Diagnoses that Support Medical Necessity

ICD-9 Codes that DO NOT Support Medical Necessity

All other ICD-9 codes not listed under “ICD-9 Codes that Support Medical Necessity” will be denied as not medically necessary.

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

General Information

Documentation Requirements

The patient's medical record must document the medical necessity of services performed for each date of service submitted on a claim, and documentation must be available to Medicare on request.

- When pharmacologic stress is used, the record must show clinical evidence supporting the reason exercise was not possible.
- The medical record must document when significant resting ECG abnormalities are present, or a medication that would interfere with interpretation of a stress ECG is being used and cannot be withdrawn, resulting in the selection of a stress echocardiogram.
- When TTE is performed in the emergency room assessment of a patient presenting with chest pain, clinical findings indicative of myocardial dysfunction must be present.
- When TTE is performed to assess exposure to a cardiotoxic agent, the name of the cardiotoxic agent must be indicated.
- When TTE is performed as the initial test to evaluate syncope, clinical findings indicative of valvular heart disease or obstructive cardiomyopathy must be documented.
- Services submitted for echocardiography with stress tests performed as preoperative evaluations of patients without symptoms of CAD who are deemed to be at moderate risk must document one of the following at-risk conditions in the medical record: Diabetes mellitus with complications, Peripheral vascular disease, Aortic aneurysm or Cerebrovascular disease.

Appendices

Utilization Guidelines

Services performed for excessive frequency are not medically necessary. Frequency is considered excessive when services are performed more frequently than generally accepted by peers and the reason for additional services is not justified by documentation.

Sources of Information and Basis for Decision

The development and coverage guidelines in this policy were based on a review of pertinent medical literature, policies from other Medicare contractors, and discussions with appropriate specialists.

Beller G, et al. ACC Revised Recommendations For Training in Adult Cardiovascular Medicine Core Cardiology Training II (COCATS2) (Revision of the 1995 COCATS Training Statement). *J Am Coll Cardiol* 2002; 39:1242-6.

Cheitlin M, et al. ACC/AHA Guidelines for the Clinical Application of Echocardiography. *J Am Coll Cardiol* 1997; 29:862-79.

Cheitlin M, et al. ACC/AHA/ASE 2003 Guideline Update for the Clinical Application of Echocardiography. *J Am Coll Cardiol* 2003; 42:954-70.

Fleisher L, Eagle K. Screening for Cardiac Disease in Patients Having Noncardiac Surgery. *Ann Intern Med* 1996; 124:767-72.

Miller L. et al. 24th Bethesda Conference: Cardiac Transplantation. Task force 5: Complications. *J Am Coll Cardiol* 1993; 22(1):41-54

O'Connell J, et al. Cardiac Transplantation: Recipient Selection, Donor Procurement, and Medical follow-up. A Statement for Health Professionals from the Committee on Cardiac Transplantation of the Council on Clinical Cardiology, American Heart Association. *Circulation* 1992; 86(3):1061-79.

Quinones M, et al. ACC/AHA Clinical Competence Statement on Echocardiography. *J Am Coll Cardiol* 2003; 41:687-708.

Advisory Committee Meeting Notes

Ohio Meeting: 06/16/1999

This policy does not reflect the sole opinion of the contractor or contractor medical director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from cardiology, internal medicine, and surgery.

Start Date of Comment Period

06/01/1999

End Date of Comment Period

Start Date of Notice Period

03/01/2000

Revision History Number

2001-14LR15

Revision History Explanation

Revision Policy Number: 2001-14LR15 (06/2009 Medicare Advisory)

Revision Effective Date: 06/01/2009

Revision Made: Addition of ICD-9 code 710.1 as supporting medical necessity for CPT codes 93306, 93307, 93308, 93320, and 93321.

Revision Policy Number: 2001-14LR14 (01/2009 Medicare Advisory)

Revision Effective Date: 01/01/2009

Revision Made: 2009 Annual CPT Update; Addition of CPT codes 93306, 93351, and 93352.

Revision Policy Number: 2001-14LR13 (10/2008 Medicare Advisory)

Revision Effective Date: 10/01/2008

Revision Made: 2009 Annual ICD-9 Update, deletion of ICD-9 code 780.6, addition of ICD-9 codes 780.60 and 780.61 as supporting medical necessity for CPT codes 93307, 93308, 93320, 93321, and 93325.

Revision Policy Number: 2001-14LR12 (10/2007 Medicare Advisory)

Revision Effective Date: Services performed on or after 10/01/2007

Revision Made: ICD-9 2008 Annual Update. Deletion of ICD-9 code 999.3 and addition of new ICD-9 codes 415.12, 423.3, 999.31 and 999.39 as supporting medical necessity for CPT codes 99307, 99308, 93320 and 93321. Deletion of ICD-9 code 999.3 and addition of new ICD-9 codes 414.2, 415.12, 423.3, 999.31 and 999.39 as supporting medical necessity for CPT code 93325. Addition of new ICD-9 code 414.2 as supporting medical necessity for CPT code 93350.

Revision Policy Number: 2001-14LR11 (11/2006 Medicare Advisory)

Revision Effective Date: Services performed on or after 10/01/2006

Revision Made: ICD-9 2007 Annual Update. Deletion of ICD-9 codes 277.3 and 995.2. Addition of ICD-9 codes 277.30, 277.31, 277.39, 429.83 and 518.7 as supporting medical necessity for CPT codes 99307, 99308, 99320, 93321 and 93325. Addition of ICD-9 codes 995.20 and 995.29 as supporting medical necessity for CPT codes 99307, 99308, 99320, 99321 and 93350.

Revision Policy Number: 2001-14LR10 (04/2006 Medicare Advisory)

Revision Effective Date: Services performed on or after 04/01/2006

Revision Made: Consolidate policy with South Carolina to provide consistency across all jurisdictions. Format changes, simplified CPT code list, and addition of ICD-9 codes including ICD-9 codes 434.90 and 434.91 as supporting medical necessity for CPT codes 99307, 99308, 93320, 93321, 93325.

Revision Policy Number: 2001-14LR9 (05/2005 Medicare Advisory)

Revision Effective Date: Services performed on or after 04/01/2005

Revision Made: Addition of ICD-9 code 794.30 as supporting medical necessity for CPT code 93350. Removal of HCPCS code A9700 from the policy. Correction of typographical error that deleted ICD-9 code 428.22 as supporting medical necessity for CPT codes 93307, 93308, 93320, 93321 and 93325.

Revision Policy Number: 2001-14LR8 (02/2005 Medicare Advisory)

Revision Effective Date: Services performed on or after 01/01/2005

Revision Made: Conversion to LCD. Template updated. 2005 CPT/HCPCS coding changes applied.

Revision Policy Number: 2001-14LR7 (05/2004 Medicare Advisory)

Revision Effective Date: Services performed on or after 05/01/2004

Revision Made: Addition of ICD-9 code 648.03 as supporting medical necessity for CPT code 93325 when used in conjunction with CPT codes 76825-76828. Clarification of Coding Guidelines and invoice requirements when HCPCS code A9700 is billed.

Revision Policy Number: 2001-14LR6 (02/2004 Medicare Advisory)

Revision Effective Date: Services performed on or after 01/01/2004

Revision Made: Deleted HCPCS code J0151 and replaced it with HCPCS code J0152 per 2004 HCPCS coding changes. LMRP reviewed.

Revision Policy Number: 2001-14LR5 (12/2003 Medicare Advisory)

Revision Effective Date: Services performed on or after 10/01/2003

Revision Made: Addition of 2004 ICD-9 coding changes. LMRP reviewed.

Revision Policy Number: 2001-14LR4 (06/2003 Medicare Advisory)

Revision Effective Date: Services performed on or after 06/01/2003

Revision Made: Removed documentation with the claim requirements and placed requirements in the Coding Guidelines or in the documentation required in the medical record, as appropriate. Removed references to deleted HCPCS code Q0188.

Revision Policy Number: 2001-14LR3 (10/2002 Medicare Advisory)

Revision Effective Date: Services performed on or after 10/01/2002

Revision Made: Addition of 2003 ICD-9 codes

Revision Policy Number: 2001-14LR2

Revision Effective Date: Claims processed on or after 06/01/2001

Revision Made: For CPT codes 93320, 93321, 93325 added ICD-9 codes 745.0-745.9, 746.00-746.85, 746.87, 746.89, 747.0-747.49, 759.3, and 759.82

Revision Effective Date: 04/01/2001

Revision Made: Added 362.30-362.37 to ICD-9 codes that support medical necessity

Revision Effective Date: 01/01/2001

Revision Made: Deleted HCPCS code Q0188 and added HCPCS code A9700

Revision Effective Date: 03/01/2000

Revision Made: Additional covered ICD-9 codes and clarified Coding Guidelines

Revision Effective Date: 10/01/2000

Revision Made: Additional procedure codes and clarified Coding Guidelines

Original Policy Number: Card-005.1

Original Policy Effective Date: Claims processed on or after 11/01/1999

Rev.10/99, 01/00, 03/00, 10/00, 11/00, 01/01, 04/01, 06/01, 10/02, 06/03, 12/03, 02/04, 05/04, 02/05, 05/05, 11/06, 10/07

11/07/2004 - The description for CPT/HCPCS code J0152 was changed in group 2

This LCD was converted from an LMRP on 12/29/2004

09/04/2005 - This policy was updated by the ICD-9 2005-2006 Annual Update.

09/04/2006 - This policy was updated by the ICD-9 2006-2007 Annual Update.

09/03/2007 - This policy was updated by the ICD-9 2007-2008 Annual Update.

08/10/2008 - This policy was updated by the ICD-9 2008-2009 Annual Update.

11/09/2008 - The description for CPT/HCPCS code 93307 was changed in group 1

11/09/2008 - The description for CPT/HCPCS code 93308 was changed in group 1

11/09/2008 - The description for CPT/HCPCS code 93350 was changed in group 1

Reason for Change

ICD9 Addition/Deletion

Last Reviewed On Date

05/13/2009

Related Documents

This LCD has no Related Documents.

LCD Attachments

There are no attachments for this LCD.

All Versions

Updated on 05/13/2009 with effective dates 06/01/2009 - N/A

Updated on 12/12/2008 with effective dates 01/01/2009 - 05/31/2009

Updated on 11/09/2008 with effective dates 10/01/2008 - 12/31/2008

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LCD for Abdominal and Pelvic Ultrasound (L28539)

Contractor Information

Contractor Name

National Government Services, Inc.

Contractor Number

00332

Contractor Type

FI

LCD Information

LCD ID Number

L28539

LCD Title

Abdominal and Pelvic Ultrasound

Contractor's Determination Number

L28539

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CMS National Coverage Policy

Language quoted from Centers for Medicare and Medicaid Services (CMS). National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

CMS Publications:

CMS Publication 100-02, *Medicare Benefit Policy*, Chapter 15:

20.1 Preoperative/Prenatal Services

CMS Publication 100-03, *Medicare National Coverage Determinations Manual*, Chapter 1:

220.5 Coverage of Diagnostic Ultrasound.

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 13:

20 Payment Conditions for Radiology Services

90 Services of Portable X-Ray Suppliers

CMS Publication 100-04, *Medicare Claims Processing Manual*, Chapter 23:

20.9 Standards of Medical/Surgical Practice and the Correct Coding Initiative (CCI)

Primary Geographic Jurisdiction

Ohio

Oversight Region

Region V

Original Determination Effective Date

For services performed on or after 01/01/2009

Original Determination Ending Date

Revision Effective Date

For services performed on or after 06/05/2009

Revision Ending Date

Indications and Limitations of Coverage and/or Medical Necessity

Abstract

Ultrasonography is a noninvasive procedure using high frequency sound waves to examine internal structures of the body.

Abdominal ultrasonography is noninvasive imaging of the abdominal contents.

Pelvic ultrasound refers to the ultrasonic investigation of pelvic structures. Traditional pelvic ultrasound uses external transducers. However, transvaginal probes often lead to superior resolution of reproductive organs.

A complete study is one in which an attempt is made to visualize all of the structures or organs within the anatomic description, with a majority of the included structures actually being diagnostically evaluated. The interpretation should include comments which are applicable to the visualized structures.

A limited study includes only a single quadrant or a possible single diagnostic problem (i.e., cholecystitis or cyst of the liver, ovarian disease, unilateral study). Limited studies may be used to reevaluate a problem after the initial interpretation has been completed to clarify a finding of the initial study.

The terms real-time, B-scan and M-mode describe the imaging methods used in the performance of diagnostic ultrasound procedure. Current equipment for real-time may utilize either B-scan or M-mode.

- M-mode implies a one-dimensional ultrasonic measurement procedure with movement of the trace to record amplitude and velocity of moving echo-producing structures.
- B-scan implies a two-dimensional ultrasonic scanning procedure with a two-dimensional display.
- Real-time scan implies a two-dimensional ultrasonic scanning procedure with display of both two-dimensional structure and motion with time.

Note: this LCD does not address ultrasonography used during pregnancy.

Indications

Abdominal Ultrasound

- These tests are indicated when there is evidence of a disease process, trauma or a congenital condition involving the abdominal organs and related structures.

Pelvic Ultrasound

- Ultrasound of the pelvis is indicated to aid in the diagnosis and treatment of disorders of the anatomical pelvis. It is a covered procedure when used to evaluate abnormal physical findings, when used to evaluate a patient with genital cancer, or when the patient's condition makes bimanual examination inadequate to evaluate the pelvis. The ordering physician's records should include the results of the physical exam (e.g., lower abdomen, rectum and/or bimanual pelvic examination) that necessitated the test. Utilization without the above will be considered not medically necessary unless there are extenuating circumstances precluding these examinations.
- There is broad use of this modality in the diagnosis of pelvic pain. This is a covered indication after standard abdominal, pelvic and/or rectal examinations have failed to identify the source of the problem. Routine use in all patients with pelvic pain is not considered medically necessary. Ultrasound is considered of prime importance in the evaluation of pelvic masses. Routine use of ultrasound for cancer screening in asymptomatic patients is not a covered service, except for patients with a documented history of familial ovarian cancer (V16.41).

Transvaginal Ultrasound

- Transvaginal ultrasound adds important information in depicting abnormalities of the uterus or the adnexa and the surrounding spaces and tissues.

Non-Gestational Pelvic Ultrasound

- Uterus, tubes and ovaries - Ultrasound is considered of prime importance in diagnosing disorders of these organs when an adequate bimanual examination has not clearly defined the problem. The use of pelvic ultrasound in routine myomas is not medically necessary. Routine use when endocervical or endometrial biopsy is contemplated is also not indicated. Pelvic ultrasound for tumors and inflammatory masses of the tubes, ovaries, and broad ligaments are covered when routine physical examination is not adequate for diagnosis.
- Pelvic vascular structures - Ultrasound is valuable in diagnosing and measuring an aneurysm of the arterial system, and follow-up is considered medically necessary every six months.
- Anatomic cul-de-sac - Evaluation of masses or fluid collections of the cul-de-sac is covered.
- Prostate - Evaluation of the prostate is primarily done transrectally and should be billed with CPT code 76872. However in certain situations, a limited pelvic ultrasound to measure the size of the prostate may be indicated if the patient will be undergoing transurethral resection (TUR) of the prostate.

Bladder Ultrasound

- Ultrasound of the bladder is covered only when there is documented reason to suspect bladder tumors, diverticula or stones. Ultrasound for post-voiding residuals (PVR) should be billed using CPT code 51798.

Limitations

- Pelvic nodes - Pelvic nodal evaluations are done primarily by CT scans, and repeat ultrasound is of little value. Follow-up of prostatic nodal progression for staging has not been proven clinically effective and will not be considered medically necessary.
- Rectum - Rarely would ultrasound be indicated for rectal diseases with the exception of presacral or cul-de-sac abscesses, staging for rectal carcinoma, evaluation of sphincter integrity or for the evaluation of perirectal mass/abscess.
- Connective tissue or bony tumors - Ultrasound is not indicated in the routine diagnosis or follow-up of these diseases.

Other Comments:

LCD Category

Radiology/Nuclear Medicine

This draft Local Coverage Determination (LCD) (DL28539) is presented for comment to all National Government Services contracts, including all Jurisdiction 13 Medicare Administrative Contractor (J13 MAC) contracts. For J13 MAC Part A contracts, this document addresses the same topic as one which will take effect on 11/14/2008. The anticipated effective date of LCD #DL28539 is 01/01/2009 for all National Governments Services contracts.

This LCD consolidates and replaces all previous policies and publications on this subject by the carrier and fiscal intermediary predecessors of National Government Services (AdminaStar Federal, Anthem Health Plans of New Hampshire, Associated Hospital Service, Empire Medicare Services, and United Government Services).

For claims submitted to the fiscal intermediary: This coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated National Government Services to process their claims.

Bill type codes only apply to providers who bill these services to the fiscal intermediary. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier.

Limitation of liability and refund requirements apply when denials are based on medical necessity. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be considered medically necessary by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes. In these instances it is recommended, although not required, that the provider notify the beneficiary in writing with a Notice of Exclusion of Medicare Benefits (NEMB).

Notice to beneficiaries related to discharge and coverage notification, as described in CMS Publication 100-04, Medicare Claims Processing Manual, Chapter 2, Sections 80-80.2, applies.

Hospitals have been instructed to provide Hospital-Issued Notices of Noncoverage (HINNs) to beneficiaries prior to admission, at admission, or at any point during an inpatient stay if the hospital determines that the care the beneficiary is receiving, or is about to receive, is not covered because it is:

- Not medically necessary;
- Not delivered in the most appropriate setting; or
- Is custodial in nature.

For outpatient settings other than CORFs, references to "physicians" throughout this policy include non-physicians, such as nurse practitioners, clinical nurse specialists and physician assistants. Such non-physician practitioners, with certain exceptions, may certify, order and establish the plan of care for Abdominal and Pelvic Ultrasound services as authorized by State law. (See Sections 1861[s][2] and 1862[a][14] of Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.)

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

11x	Hospital-inpatient (including Part A)
12x	Hospital-inpatient or home health visits (Part B only)
13x	Hospital-outpatient (HHA-A also) (under OPPTS 13X must be used for ASC claims submitted for OPPTS payment -- eff. 7/00)
18x	Hospital-swing beds
21x	SNF-inpatient, Part A
22x	SNF-inpatient or home health visits (Part B only)
23x	SNF-outpatient (HHA-A also)
71x	Clinic-rural health
73x	Clinic-independent provider based FQHC (eff 10/91)
85x	Special facility or ASC surgery-rural primary care hospital (eff 10/94)

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory; unless specified in the policy services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the fiscal intermediary. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue

032X	Radiology diagnostic-general classification
0402	Other imaging services-ultrasound

CPT/HCPCS Codes

76700	ULTRASOUND, ABDOMINAL, REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE
76705	ULTRASOUND, ABDOMINAL, REAL TIME WITH IMAGE DOCUMENTATION; LIMITED (EG, SINGLE ORGAN, QUADRANT, FOLLOW-UP)
76830	ULTRASOUND, TRANSVAGINAL
76856	ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE DOCUMENTATION; COMPLETE
76857	ULTRASOUND, PELVIC (NONOBSTETRIC), REAL TIME WITH IMAGE DOCUMENTATION; LIMITED OR FOLLOW-UP (EG, FOR FOLLICLES)

ICD-9 Codes that Support Medical Necessity

It is the responsibility of the provider to code to the highest level specified in the ICD-9-CM (e.g., to the fourth or fifth digit). The correct use of an ICD-9-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

The following ICD-9 CM codes are payable indications for CPT codes 76700 and 76705:

006.3	AMEBIC LIVER ABSCESS
038.9	UNSPECIFIED SEPTICEMIA
070.0	VIRAL HEPATITIS A WITH HEPATIC COMA
070.1	VIRAL HEPATITIS A WITHOUT HEPATIC COMA
070.20 - 070.23	VIRAL HEPATITIS B WITH HEPATIC COMA ACUTE OR UNSPECIFIED WITHOUT HEPATITIS DELTA - CHRONIC VIRAL HEPATITIS B WITH HEPATIC COMA WITH HEPATITIS DELTA
070.30 - 070.33	VIRAL HEPATITIS B WITHOUT HEPATIC COMA ACUTE OR UNSPECIFIED WITHOUT HEPATITIS DELTA - CHRONIC VIRAL HEPATITIS B WITHOUT HEPATIC COMA WITH HEPATITIS DELTA
070.41 - 070.43	ACUTE HEPATITIS C WITH HEPATIC COMA - HEPATITIS E WITH HEPATIC COMA
070.44	CHRONIC HEPATITIS C WITH HEPATIC COMA
070.49	OTHER SPECIFIED VIRAL HEPATITIS WITH HEPATIC COMA
070.51 - 070.54	

	ACUTE HEPATITIS C WITHOUT MENTION OF HEPATIC COMA - CHRONIC HEPATITIS C WITHOUT HEPATIC COMA
070.59	OTHER SPECIFIED VIRAL HEPATITIS WITHOUT HEPATIC COMA
070.6	UNSPECIFIED VIRAL HEPATITIS WITH HEPATIC COMA
070.70	UNSPECIFIED VIRAL HEPATITIS C WITHOUT HEPATIC COMA
070.71	UNSPECIFIED VIRAL HEPATITIS C WITH HEPATIC COMA
070.9	UNSPECIFIED VIRAL HEPATITIS WITHOUT HEPATIC COMA
122.0	ECHINOCOCCUS GRANULOSUS INFECTION OF LIVER
122.1	ECHINOCOCCUS GRANULOSUS INFECTION OF LUNG
122.2	ECHINOCOCCUS GRANULOSUS INFECTION OF THYROID
122.3	ECHINOCOCCUS GRANULOSUS INFECTION OTHER
122.4	ECHINOCOCCUS GRANULOSUS INFECTION UNSPECIFIED
122.5	ECHINOCOCCUS MULTILOCULARIS INFECTION OF LIVER
122.8	ECHINOCOCCOSIS UNSPECIFIED OF LIVER
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
150.9	MALIGNANT NEOPLASM OF ESOPHAGUS UNSPECIFIED SITE
151.0	MALIGNANT NEOPLASM OF CARDIA
151.1	MALIGNANT NEOPLASM OF PYLORUS
151.2	MALIGNANT NEOPLASM OF PYLORIC ANTRUM
151.3	MALIGNANT NEOPLASM OF FUNDUS OF STOMACH
151.4	MALIGNANT NEOPLASM OF BODY OF STOMACH
151.5	MALIGNANT NEOPLASM OF LESSER CURVATURE OF STOMACH UNSPECIFIED
151.6	MALIGNANT NEOPLASM OF GREATER CURVATURE OF STOMACH UNSPECIFIED

151.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF STOMACH
151.9	MALIGNANT NEOPLASM OF STOMACH UNSPECIFIED SITE
152.0	MALIGNANT NEOPLASM OF DUODENUM
152.1	MALIGNANT NEOPLASM OF JEJUNUM
152.2	MALIGNANT NEOPLASM OF ILEUM
152.3	MALIGNANT NEOPLASM OF MECKEL'S DIVERTICULUM
152.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF SMALL INTESTINE
152.9	MALIGNANT NEOPLASM OF SMALL INTESTINE UNSPECIFIED SITE
153.0	MALIGNANT NEOPLASM OF HEPATIC FLEXURE
153.1	MALIGNANT NEOPLASM OF TRANSVERSE COLON
153.2	MALIGNANT NEOPLASM OF DESCENDING COLON
153.3	MALIGNANT NEOPLASM OF SIGMOID COLON
153.4	MALIGNANT NEOPLASM OF CECUM
153.5	MALIGNANT NEOPLASM OF APPENDIX VERMIFORMIS
153.6	MALIGNANT NEOPLASM OF ASCENDING COLON
153.7	MALIGNANT NEOPLASM OF SPLENIC FLEXURE
153.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF LARGE INTESTINE
153.9	MALIGNANT NEOPLASM OF COLON UNSPECIFIED SITE
154.0	MALIGNANT NEOPLASM OF RECTOSIGMOID JUNCTION
154.1	MALIGNANT NEOPLASM OF RECTUM
154.2	MALIGNANT NEOPLASM OF ANAL CANAL
154.3	MALIGNANT NEOPLASM OF ANUS UNSPECIFIED SITE
154.8	MALIGNANT NEOPLASM OF OTHER SITES OF RECTUM RECTOSIGMOID JUNCTION AND ANUS
155.0	MALIGNANT NEOPLASM OF LIVER PRIMARY
155.1	MALIGNANT NEOPLASM OF INTRAHEPATIC BILE DUCTS
155.2	MALIGNANT NEOPLASM OF LIVER NOT SPECIFIED AS PRIMARY OR SECONDARY
156.0	MALIGNANT NEOPLASM OF GALLBLADDER
156.1	MALIGNANT NEOPLASM OF EXTRAHEPATIC BILE DUCTS
156.2	MALIGNANT NEOPLASM OF AMPULLA OF VATER

156.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF GALLBLADDER AND EXTRAHEPATIC BILE DUCTS
156.9	MALIGNANT NEOPLASM OF BILIARY TRACT PART UNSPECIFIED SITE
157.0	MALIGNANT NEOPLASM OF HEAD OF PANCREAS
157.1	MALIGNANT NEOPLASM OF BODY OF PANCREAS
157.2	MALIGNANT NEOPLASM OF TAIL OF PANCREAS
157.3	MALIGNANT NEOPLASM OF PANCREATIC DUCT
157.4	MALIGNANT NEOPLASM OF ISLETS OF LANGERHANS
157.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF PANCREAS
157.9	MALIGNANT NEOPLASM OF PANCREAS PART UNSPECIFIED
158.0	MALIGNANT NEOPLASM OF RETROPERITONEUM
158.8	MALIGNANT NEOPLASM OF SPECIFIED PARTS OF PERITONEUM
158.9	MALIGNANT NEOPLASM OF PERITONEUM UNSPECIFIED
159.0	MALIGNANT NEOPLASM OF INTESTINAL TRACT PART UNSPECIFIED
159.1	MALIGNANT NEOPLASM OF SPLEEN NOT ELSEWHERE CLASSIFIED
159.8	MALIGNANT NEOPLASM OF OTHER SITES OF DIGESTIVE SYSTEM AND INTRA-ABDOMINAL ORGANS
159.9	MALIGNANT NEOPLASM OF ILL-DEFINED SITES WITHIN THE DIGESTIVE ORGANS AND PERITONEUM
171.5	MALIGNANT NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE OF ABDOMEN
172.5	MALIGNANT MELANOMA OF SKIN OF TRUNK EXCEPT SCROTUM
174.9	MALIGNANT NEOPLASM OF BREAST (FEMALE) UNSPECIFIED SITE
179	MALIGNANT NEOPLASM OF UTERUS-PART UNS
180.0 - 180.1	MALIGNANT NEOPLASM OF ENDOCERVIX - MALIGNANT NEOPLASM OF EXOCERVIX
180.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF CERVIX
180.9	MALIGNANT NEOPLASM OF CERVIX UTERI UNSPECIFIED SITE
181	MALIGNANT NEOPLASM OF PLACENTA
182.0 - 182.1	MALIGNANT NEOPLASM OF CORPUS UTERI EXCEPT ISTHMUS - MALIGNANT NEOPLASM OF ISTHMUS

182.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF BODY OF UTERUS
183.0	MALIGNANT NEOPLASM OF OVARY
183.2 - 183.5	MALIGNANT NEOPLASM OF FALLOPIAN TUBE - MALIGNANT NEOPLASM OF ROUND LIGAMENT OF UTERUS
183.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF UTERINE ADNEXA
183.9	MALIGNANT NEOPLASM OF UTERINE ADNEXA UNSPECIFIED SITE
185	MALIGNANT NEOPLASM OF PROSTATE
188.9	MALIGNANT NEOPLASM OF BLADDER PART UNSPECIFIED
195.2	MALIGNANT NEOPLASM OF ABDOMEN
195.3	MALIGNANT NEOPLASM OF PELVIS
196.2	SECONDARY AND UNSPECIFIED MALIGNANT NEOPLASM OF INTRA-ABDOMINAL LYMPH NODES
196.6	SECONDARY AND UNSPECIFIED MALIGNANT NEOPLASM OF INTRAPELVIC LYMPH NODES
197.4	SECONDARY MALIGNANT NEOPLASM OF SMALL INTESTINE INCLUDING DUODENUM
197.5	SECONDARY MALIGNANT NEOPLASM OF LARGE INTESTINE AND RECTUM
197.6	SECONDARY MALIGNANT NEOPLASM OF RETROPERITONEUM AND PERITONEUM
197.7	MALIGNANT NEOPLASM OF LIVER SECONDARY
197.8	SECONDARY MALIGNANT NEOPLASM OF OTHER DIGESTIVE ORGANS AND SPLEEN
200.00 - 200.08	RETICULOSARCOMA UNSPECIFIED SITE - RETICULOSARCOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
200.10 - 200.18	LYMPHOSARCOMA UNSPECIFIED SITE - LYMPHOSARCOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
200.20 - 200.28	BURKITT'S TUMOR OR LYMPHOMA UNSPECIFIED SITE - BURKITT'S TUMOR OR LYMPHOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
200.30	MARGINAL ZONE LYMPHOMA, UNSPECIFIED SITE, EXTRANODAL AND SOLID ORGAN SITES
200.33	MARGINAL ZONE LYMPHOMA, INTRAABDOMINAL LYMPH NODES
200.36	MARGINAL ZONE LYMPHOMA, INTRAPELVIC LYMPH NODES
200.37	MARGINAL ZONE LYMPHOMA, SPLEEN

200.38	MARGINAL ZONE LYMPHOMA, LYMPH NODES OF MULTIPLE SITES
200.40	MANTLE CELL LYMPHOMA, UNSPECIFIED SITE, EXTRANODAL AND SOLID ORGAN SITES
200.43	MANTLE CELL LYMPHOMA, INTRA-ABDOMINAL LYMPH NODES
200.46	MANTLE CELL LYMPHOMA, INTRAPELVIC LYMPH NODES
200.47	MANTLE CELL LYMPHOMA, SPLEEN
200.48	MANTLE CELL LYMPHOMA, LYMPH NODES OF MULTIPLE SITES
200.50	PRIMARY CENTRAL NERVOUS SYSTEM LYMPHOMA, UNSPECIFIED SITE, EXTRANODAL AND SOLID ORGAN SITES
200.53	PRIMARY CENTRAL NERVOUS SYSTEM LYMPHOMA, INTRA-ABDOMINAL LYMPH NODES
200.56	PRIMARY CENTRAL NERVOUS SYSTEM LYMPHOMA, INTRAPELVIC LYMPH NODES
200.57	PRIMARY CENTRAL NERVOUS SYSTEM LYMPHOMA, SPLEEN
200.58	PRIMARY CENTRAL NERVOUS SYSTEM LYMPHOMA, LYMPH NODES OF MULTIPLE SITES
200.60	ANAPLASTIC LARGE CELL LYMPHOMA, UNSPECIFIED SITE, EXTRANODAL AND SOLID ORGAN SITES
200.63	ANAPLASTIC LARGE CELL LYMPHOMA, INTRA-ABDOMINAL LYMPH NODES
200.66	ANAPLASTIC LARGE CELL LYMPHOMA, INTRAPELVIC LYMPH NODES
200.67	ANAPLASTIC LARGE CELL LYMPHOMA, SPLEEN
200.68	ANAPLASTIC LARGE CELL LYMPHOMA, LYMPH NODES OF MULTIPLE SITES
200.70	LARGE CELL LYMPHOMA, UNSPECIFIED SITE, EXTRANODAL AND SOLID ORGAN SITES
200.73	LARGE CELL LYMPHOMA, INTRA-ABDOMINAL LYMPH NODES
200.76	LARGE CELL LYMPHOMA, INTRAPELVIC LYMPH NODES
200.77	LARGE CELL LYMPHOMA, SPLEEN
200.78	LARGE CELL LYMPHOMA, LYMPH NODES OF MULTIPLE SITES
200.80 - 200.88	OTHER NAMED VARIANTS OF LYMPHOSARCOMA AND RETICULOSARCOMA UNSPECIFIED SITE - OTHER NAMED VARIANTS OF LYMPHOSARCOMA AND RETICULOSARCOMA INVOLVING LYMPH NODES OF MULTIPLE SITES

201.00 - 201.08	HODGKIN'S PARAGRANULOMA UNSPECIFIED SITE - HODGKIN'S PARAGRANULOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
201.10 - 201.18	HODGKIN'S GRANULOMA UNSPECIFIED SITE - HODGKIN'S GRANULOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
201.20 - 201.28	HODGKIN'S SARCOMA UNSPECIFIED SITE - HODGKIN'S SARCOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
201.40 - 201.48	HODGKIN'S DISEASE LYMPHOCYTIC-HISTIOCYTIC PREDOMINANCE UNSPECIFIED SITE - HODGKIN'S DISEASE LYMPHOCYTIC-HISTIOCYTIC PREDOMINANCE INVOLVING LYMPH NODES OF MULTIPLE SITES
201.50 - 201.58	HODGKIN'S DISEASE NODULAR SCLEROSIS UNSPECIFIED SITE - HODGKIN'S DISEASE NODULAR SCLEROSIS INVOLVING LYMPH NODES OF MULTIPLE SITES
201.60 - 201.68	HODGKIN'S DISEASE MIXED CELLULARITY UNSPECIFIED SITE - HODGKIN'S DISEASE MIXED CELLULARITY INVOLVING LYMPH NODES OF MULTIPLE SITES
201.70 - 201.78	HODGKIN'S DISEASE LYMPHOCYTIC DEPLETION UNSPECIFIED SITE - HODGKIN'S DISEASE LYMPHOCYTIC DEPLETION INVOLVING LYMPH NODES OF MULTIPLE SITES
201.90 - 201.98	HODGKIN'S DISEASE UNSPECIFIED TYPE UNSPECIFIED SITE - HODGKIN'S DISEASE UNSPECIFIED TYPE INVOLVING LYMPH NODES OF MULTIPLE SITES
202.00 - 202.08	NODULAR LYMPHOMA UNSPECIFIED SITE - NODULAR LYMPHOMA INVOLVING LYMPH NODES OF MULTIPLE SITES
202.10 - 202.18	MYCOSIS FUNGOIDES UNSPECIFIED SITE - MYCOSIS FUNGOIDES INVOLVING LYMPH NODES OF MULTIPLE SITES
202.20 - 202.28	SEZARY'S DISEASE UNSPECIFIED SITE - SEZARY'S DISEASE INVOLVING LYMPH NODES OF MULTIPLE SITES
202.30 - 202.38	MALIGNANT HISTIOCYTOSIS UNSPECIFIED SITE - MALIGNANT HISTIOCYTOSIS INVOLVING LYMPH NODES OF MULTIPLE SITES
202.40 - 202.48	LEUKEMIC RETICULOENDOTHELIOSIS UNSPECIFIED SITE - LEUKEMIC RETICULOENDOTHELIOSIS INVOLVING LYMPH NODES OF MULTIPLE SITES
202.50 - 202.58	LETTERER-SIWE DISEASE UNSPECIFIED SITE - LETTERER-SIWE DISEASE INVOLVING LYMPH NODES OF MULTIPLE SITES
202.60 - 202.68	

	MALIGNANT MAST CELL TUMORS UNSPECIFIED SITE - MALIGNANT MAST CELL TUMORS INVOLVING LYMPH NODES OF MULTIPLE SITES
202.70	PERIPHERAL T CELL LYMPHOMA, UNSPECIFIED SITE, EXTRANODAL AND SOLID ORGAN SITES
202.73	PERIPHERAL T CELL LYMPHOMA, INTRA-ABDOMINAL LYMPH NODES
202.76	PERIPHERAL T CELL LYMPHOMA, INTRAPELVIC LYMPH NODES
202.77	PERIPHERAL T CELL LYMPHOMA, SPLEEN
202.78	PERIPHERAL T CELL LYMPHOMA, LYMPH NODES OF MULTIPLE SITES
202.80 - 202.88	OTHER MALIGNANT LYMPHOMAS UNSPECIFIED SITE - OTHER MALIGNANT LYMPHOMAS INVOLVING LYMPH NODES OF MULTIPLE SITES
202.90 - 202.98	OTHER AND UNSPECIFIED MALIGNANT NEOPLASMS OF LYMPHOID AND HISTIOCYTIC TISSUE UNSPECIFIED SITE - OTHER AND UNSPECIFIED MALIGNANT NEOPLASMS OF LYMPHOID AND HISTIOCYTIC TISSUE INVOLVING LYMPH NODES OF MULTIPLE SITES
204.00 - 204.01	ACUTE LYMPHOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - LYMPHOID LEUKEMIA ACUTE IN REMISSION
204.02	ACUTE LYMPHOID LEUKEMIA, IN RELAPSE
204.10 - 204.11	CHRONIC LYMPHOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - LYMPHOID LEUKEMIA CHRONIC IN REMISSION
204.12	CHRONIC LYMPHOID LEUKEMIA, IN RELAPSE
204.20 - 204.21	SUBACUTE LYMPHOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - LYMPHOID LEUKEMIA SUBACUTE IN REMISSION
204.22	SUBACUTE LYMPHOID LEUKEMIA, IN RELAPSE
204.80 - 204.81	OTHER LYMPHOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - OTHER LYMPHOID LEUKEMIA IN REMISSION
204.82	OTHER LYMPHOID LEUKEMIA, IN RELAPSE
204.90 - 204.91	UNSPECIFIED LYMPHOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - UNSPECIFIED LYMPHOID LEUKEMIA IN REMISSION
204.92	UNSPECIFIED LYMPHOID LEUKEMIA, IN RELAPSE
205.00 - 205.01	ACUTE MYELOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - MYELOID LEUKEMIA ACUTE IN REMISSION
205.02	ACUTE MYELOID LEUKEMIA, IN RELAPSE
205.10 - 205.11	

	CHRONIC MYELOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - MYELOID LEUKEMIA CHRONIC IN REMISSION
205.12	CHRONIC MYELOID LEUKEMIA, IN RELAPSE
205.20 - 205.21	SUBACUTE MYELOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - MYELOID LEUKEMIA SUBACUTE IN REMISSION
205.22	SUBACUTE MYELOID LEUKEMIA, IN RELAPSE
205.30 - 205.31	MYELOID SARCOMA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - MYELOID SARCOMA IN REMISSION
205.32	MYELOID SARCOMA, IN RELAPSE
205.80 - 205.81	OTHER MYELOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - OTHER MYELOID LEUKEMIA IN REMISSION
205.82	OTHER MYELOID LEUKEMIA, IN RELAPSE
205.90 - 205.91	UNSPECIFIED MYELOID LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - UNSPECIFIED MYELOID LEUKEMIA IN REMISSION
205.92	UNSPECIFIED MYELOID LEUKEMIA, IN RELAPSE
206.00 - 206.01	ACUTE MONOCYTIC LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - MONOCYTIC LEUKEMIA ACUTE IN REMISSION
206.02	ACUTE MONOCYTIC LEUKEMIA, IN RELAPSE
206.10 - 206.11	CHRONIC MONOCYTIC LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - MONOCYTIC LEUKEMIA CHRONIC IN REMISSION
206.12	CHRONIC MONOCYTIC LEUKEMIA, IN RELAPSE
206.20 - 206.21	SUBACUTE MONOCYTIC LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - MONOCYTIC LEUKEMIA SUBACUTE IN REMISSION
206.22	SUBACUTE MONOCYTIC LEUKEMIA, IN RELAPSE
206.80 - 206.81	OTHER MONOCYTIC LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - OTHER MONOCYTIC LEUKEMIA IN REMISSION
206.82	OTHER MONOCYTIC LEUKEMIA, IN RELAPSE
206.90 - 206.91	UNSPECIFIED MONOCYTIC LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - UNSPECIFIED MONOCYTIC LEUKEMIA IN REMISSION
206.92	UNSPECIFIED MONOCYTIC LEUKEMIA, IN RELAPSE
207.00 - 207.01	ACUTE ERYTHREMIA AND ERYTHROLEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - ACUTE ERYTHREMIA AND ERYTHROLEUKEMIA IN REMISSION
207.02	

	ACUTE ERYTHREMIA AND ERYTHROLEUKEMIA, IN RELAPSE
207.10 - 207.11	CHRONIC ERYTHREMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - CHRONIC ERYTHREMIA IN REMISSION
207.12	CHRONIC ERYTHREMIA, IN RELAPSE
207.20 - 207.21	MEGAKARYOCYTIC LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - MEGAKARYOCYTIC LEUKEMIA IN REMISSION
207.22	MEGAKARYOCYTIC LEUKEMIA, IN RELAPSE
207.80 - 207.81	OTHER SPECIFIED LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - OTHER SPECIFIED LEUKEMIA IN REMISSION
207.82	OTHER SPECIFIED LEUKEMIA, IN RELAPSE
208.00 - 208.01	ACUTE LEUKEMIA OF UNSPECIFIED CELL TYPE, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - LEUKEMIA OF UNSPECIFIED CELL TYPE ACUTE IN REMISSION
208.02	ACUTE LEUKEMIA OF UNSPECIFIED CELL TYPE, IN RELAPSE
208.10 - 208.11	CHRONIC LEUKEMIA OF UNSPECIFIED CELL TYPE, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - LEUKEMIA OF UNSPECIFIED CELL TYPE CHRONIC IN REMISSION
208.12	CHRONIC LEUKEMIA OF UNSPECIFIED CELL TYPE, IN RELAPSE
208.20 - 208.21	SUBACUTE LEUKEMIA OF UNSPECIFIED CELL TYPE, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - LEUKEMIA OF UNSPECIFIED CELL TYPE SUBACUTE IN REMISSION
208.22	SUBACUTE LEUKEMIA OF UNSPECIFIED CELL TYPE, IN RELAPSE
208.80 - 208.81	OTHER LEUKEMIA OF UNSPECIFIED CELL TYPE, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - OTHER LEUKEMIA OF UNSPECIFIED CELL TYPE IN REMISSION
208.82	OTHER LEUKEMIA OF UNSPECIFIED CELL TYPE, IN RELAPSE
208.90 - 208.91	UNSPECIFIED LEUKEMIA, WITHOUT MENTION OF HAVING ACHIEVED REMISSION - UNSPECIFIED LEUKEMIA IN REMISSION
208.92	UNSPECIFIED LEUKEMIA, IN RELAPSE
209.00	MALIGNANT CARCINOID TUMOR OF THE SMALL INTESTINE, UNSPECIFIED PORTION
209.01	MALIGNANT CARCINOID TUMOR OF THE DUODENUM
209.02	MALIGNANT CARCINOID TUMOR OF THE JEJUNUM

209.03	MALIGNANT CARCINOID TUMOR OF THE ILEUM
209.10	MALIGNANT CARCINOID TUMOR OF THE LARGE INTESTINE, UNSPECIFIED PORTION
209.11	MALIGNANT CARCINOID TUMOR OF THE APPENDIX
209.12	MALIGNANT CARCINOID TUMOR OF THE CECUM
209.13	MALIGNANT CARCINOID TUMOR OF THE ASCENDING COLON
209.14	MALIGNANT CARCINOID TUMOR OF THE TRANSVERSE COLON
209.15	MALIGNANT CARCINOID TUMOR OF THE DESCENDING COLON
209.16	MALIGNANT CARCINOID TUMOR OF THE SIGMOID COLON
209.17	MALIGNANT CARCINOID TUMOR OF THE RECTUM
209.20	MALIGNANT CARCINOID TUMOR OF UNKNOWN PRIMARY SITE
209.21	MALIGNANT CARCINOID TUMOR OF THE BRONCHUS AND LUNG
209.22	MALIGNANT CARCINOID TUMOR OF THE THYMUS
209.23	MALIGNANT CARCINOID TUMOR OF THE STOMACH
209.24	MALIGNANT CARCINOID TUMOR OF THE KIDNEY
209.25	MALIGNANT CARCINOID TUMOR OF FOREGUT, NOT OTHERWISE SPECIFIED
209.26	MALIGNANT CARCINOID TUMOR OF MIDGUT, NOT OTHERWISE SPECIFIED
209.27	MALIGNANT CARCINOID TUMOR OF HINDGUT, NOT OTHERWISE SPECIFIED
209.29	MALIGNANT CARCINOID TUMOR OF OTHER SITES
209.30	MALIGNANT POORLY DIFFERENTIATED NEUROENDOCRINE CARCINOMA, ANY SITE
209.40	BENIGN CARCINOID TUMOR OF THE SMALL INTESTINE, UNSPECIFIED PORTION
209.41	BENIGN CARCINOID TUMOR OF THE DUODENUM
209.42	BENIGN CARCINOID TUMOR OF THE JEJUNUM
209.43	BENIGN CARCINOID TUMOR OF THE ILEUM
209.50	BENIGN CARCINOID TUMOR OF THE LARGE INTESTINE, UNSPECIFIED PORTION
209.51	BENIGN CARCINOID TUMOR OF THE APPENDIX
209.52	BENIGN CARCINOID TUMOR OF THE CECUM
209.53	BENIGN CARCINOID TUMOR OF THE ASCENDING COLON

209.54	BENIGN CARCINOID TUMOR OF THE TRANSVERSE COLON
209.55	BENIGN CARCINOID TUMOR OF THE DESCENDING COLON
209.56	BENIGN CARCINOID TUMOR OF THE SIGMOID COLON
209.57	BENIGN CARCINOID TUMOR OF THE RECTUM
209.60	BENIGN CARCINOID TUMOR OF UNKNOWN PRIMARY SITE
209.61	BENIGN CARCINOID TUMOR OF THE BRONCHUS AND LUNG
209.62	BENIGN CARCINOID TUMOR OF THE THYMUS
209.63	BENIGN CARCINOID TUMOR OF THE STOMACH
209.64	BENIGN CARCINOID TUMOR OF THE KIDNEY
209.65	BENIGN CARCINOID TUMOR OF FOREGUT, NOT OTHERWISE SPECIFIED
209.66	BENIGN CARCINOID TUMOR OF MIDGUT, NOT OTHERWISE SPECIFIED
209.67	BENIGN CARCINOID TUMOR OF HINDGUT, NOT OTHERWISE SPECIFIED
209.69	BENIGN CARCINOID TUMOR OF OTHER SITES
211.1	BENIGN NEOPLASM OF STOMACH
211.2	BENIGN NEOPLASM OF DUODENUM JEJUNUM AND ILEUM
211.3	BENIGN NEOPLASM OF COLON
211.4	BENIGN NEOPLASM OF RECTUM AND ANAL CANAL
211.5	BENIGN NEOPLASM OF LIVER AND BILIARY PASSAGES
211.6	BENIGN NEOPLASM OF PANCREAS EXCEPT ISLETS OF LANGERHANS
211.7	BENIGN NEOPLASM OF ISLETS OF LANGERHANS
211.8	BENIGN NEOPLASM OF RETROPERITONEUM AND PERITONEUM
211.9	BENIGN NEOPLASM OF OTHER AND UNSPECIFIED SITE IN THE DIGESTIVE SYSTEM
228.04	HEMANGIOMA OF INTRA-ABDOMINAL STRUCTURES
235.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF STOMACH INTESTINES AND RECTUM
235.3	NEOPLASM OF UNCERTAIN BEHAVIOR OF LIVER AND BILIARY PASSAGES
235.4	NEOPLASM OF UNCERTAIN BEHAVIOR OF RETROPERITONEUM AND PERITONEUM
235.5	NEOPLASM OF UNCERTAIN BEHAVIOR OF OTHER AND UNSPECIFIED DIGESTIVE ORGANS

277.4	DISORDERS OF BILIRUBIN EXCRETION
285.9	ANEMIA UNSPECIFIED
289.50	DISEASE OF SPLEEN UNSPECIFIED
289.51	CHRONIC CONGESTIVE SPLENOMEGALY
289.53	NEUTROPENIC SPLENOMEGALY
289.59	OTHER DISEASES OF SPLEEN
441.00	DISSECTION OF AORTA ANEURYSM UNSPECIFIED SITE
441.01	DISSECTION OF AORTA THORACIC
441.02	DISSECTION OF AORTA ABDOMINAL
441.03	DISSECTION OF AORTA THORACOABDOMINAL
441.3	ABDOMINAL ANEURYSM RUPTURED
441.4	ABDOMINAL ANEURYSM WITHOUT RUPTURE
442.83	ANEURYSM OF SPLENIC ARTERY
442.84	ANEURYSM OF OTHER VISCERAL ARTERY
452	PORTAL VEIN THROMBOSIS
458.9	HYPOTENSION UNSPECIFIED
530.0	ACHALASIA AND CARDIOSPASM
530.10	ESOPHAGITIS UNSPECIFIED
530.11	REFLUX ESOPHAGITIS
530.12	ACUTE ESOPHAGITIS
530.13	EOSINOPHILIC ESOPHAGITIS
530.19	OTHER ESOPHAGITIS
530.20	ULCER OF ESOPHAGUS WITHOUT BLEEDING
530.21	ULCER OF ESOPHAGUS WITH BLEEDING
530.3	STRICTURE AND STENOSIS OF ESOPHAGUS
530.4	PERFORATION OF ESOPHAGUS
530.5	DYSKINESIA OF ESOPHAGUS
530.6	DIVERTICULUM OF ESOPHAGUS ACQUIRED
530.7	GASTROESOPHAGEAL LACERATION-HEMORRHAGE SYNDROME
530.81	ESOPHAGEAL REFLUX
530.82	ESOPHAGEAL HEMORRHAGE
530.83	ESOPHAGEAL LEUKOPLAKIA
530.84	TRACHEOESOPHAGEAL FISTULA
530.85	BARRETT'S ESOPHAGUS
530.86	INFECTION OF ESOPHAGOSTOMY

530.87	MECHANICAL COMPLICATION OF ESOPHAGOSTOMY
530.89	OTHER DISEASES OF ESOPHAGUS
530.9	UNSPECIFIED DISORDER OF ESOPHAGUS
531.00	ACUTE GASTRIC ULCER WITH HEMORRHAGE WITHOUT OBSTRUCTION
531.01	ACUTE GASTRIC ULCER WITH HEMORRHAGE WITH OBSTRUCTION
531.10	ACUTE GASTRIC ULCER WITH PERFORATION WITHOUT OBSTRUCTION
531.11	ACUTE GASTRIC ULCER WITH PERFORATION WITH OBSTRUCTION
531.20	ACUTE GASTRIC ULCER WITH HEMORRHAGE AND PERFORATION WITHOUT OBSTRUCTION
531.21	ACUTE GASTRIC ULCER WITH HEMORRHAGE AND PERFORATION WITH OBSTRUCTION
531.30	ACUTE GASTRIC ULCER WITHOUT HEMORRHAGE OR PERFORATION WITHOUT OBSTRUCTION
531.31	ACUTE GASTRIC ULCER WITHOUT HEMORRHAGE OR PERFORATION WITH OBSTRUCTION
531.40	CHRONIC OR UNSPECIFIED GASTRIC ULCER WITH HEMORRHAGE WITHOUT OBSTRUCTION
531.41	CHRONIC OR UNSPECIFIED GASTRIC ULCER WITH HEMORRHAGE WITH OBSTRUCTION
531.50	CHRONIC OR UNSPECIFIED GASTRIC ULCER WITH PERFORATION WITHOUT OBSTRUCTION
531.51	CHRONIC OR UNSPECIFIED GASTRIC ULCER WITH PERFORATION WITH OBSTRUCTION
531.60	CHRONIC OR UNSPECIFIED GASTRIC ULCER WITH HEMORRHAGE AND PERFORATION WITHOUT OBSTRUCTION
531.61	CHRONIC OR UNSPECIFIED GASTRIC ULCER WITH HEMORRHAGE AND PERFORATION WITH OBSTRUCTION
531.70	CHRONIC GASTRIC ULCER WITHOUT HEMORRHAGE OR PERFORATION WITHOUT OBSTRUCTION
531.71	CHRONIC GASTRIC ULCER WITHOUT HEMORRHAGE OR PERFORATION WITH OBSTRUCTION
531.90	GASTRIC ULCER UNSPECIFIED AS ACUTE OR CHRONIC WITHOUT HEMORRHAGE OR PERFORATION WITHOUT OBSTRUCTION
531.91	GASTRIC ULCER UNSPECIFIED AS ACUTE OR CHRONIC WITHOUT HEMORRHAGE OR PERFORATION WITH OBSTRUCTION
532.00	ACUTE DUODENAL ULCER WITH HEMORRHAGE WITHOUT OBSTRUCTION

532.01	ACUTE DUODENAL ULCER WITH HEMORRHAGE WITH OBSTRUCTION
532.10	ACUTE DUODENAL ULCER WITH PERFORATION WITHOUT OBSTRUCTION
532.11	ACUTE DUODENAL ULCER WITH PERFORATION WITH OBSTRUCTION
532.20	ACUTE DUODENAL ULCER WITH HEMORRHAGE AND PERFORATION WITHOUT OBSTRUCTION
532.21	ACUTE DUODENAL ULCER WITH HEMORRHAGE AND PERFORATION WITH OBSTRUCTION
532.30	ACUTE DUODENAL ULCER WITHOUT HEMORRHAGE OR PERFORATION WITHOUT OBSTRUCTION
532.31	ACUTE DUODENAL ULCER WITHOUT HEMORRHAGE OR PERFORATION WITH OBSTRUCTION
532.40	CHRONIC OR UNSPECIFIED DUODENAL ULCER WITH HEMORRHAGE WITHOUT OBSTRUCTION
532.41	CHRONIC OR UNSPECIFIED DUODENAL ULCER WITH HEMORRHAGE WITH OBSTRUCTION
532.50	CHRONIC OR UNSPECIFIED DUODENAL ULCER WITH PERFORATION WITHOUT OBSTRUCTION
532.51	CHRONIC OR UNSPECIFIED DUODENAL ULCER WITH PERFORATION WITH OBSTRUCTION
532.60	CHRONIC OR UNSPECIFIED DUODENAL ULCER WITH HEMORRHAGE AND PERFORATION WITHOUT OBSTRUCTION
532.61	CHRONIC OR UNSPECIFIED DUODENAL ULCER WITH HEMORRHAGE AND PERFORATION WITH OBSTRUCTION
532.70	CHRONIC DUODENAL ULCER WITHOUT HEMORRHAGE OR PERFORATION WITHOUT OBSTRUCTION
532.71	CHRONIC DUODENAL ULCER WITHOUT HEMORRHAGE OR PERFORATION WITH OBSTRUCTION
532.90	DUODENAL ULCER UNSPECIFIED AS ACUTE OR CHRONIC WITHOUT HEMORRHAGE OR PERFORATION WITHOUT OBSTRUCTION
532.91	DUODENAL ULCER UNSPECIFIED AS ACUTE OR CHRONIC WITHOUT HEMORRHAGE OR PERFORATION WITH OBSTRUCTION
533.00	ACUTE PEPTIC ULCER OF UNSPECIFIED SITE WITH HEMORRHAGE WITHOUT OBSTRUCTION
533.01	ACUTE PEPTIC ULCER OF UNSPECIFIED SITE WITH HEMORRHAGE WITH OBSTRUCTION
533.10	ACUTE PEPTIC ULCER OF UNSPECIFIED SITE WITH PERFORATION WITHOUT OBSTRUCTION
533.11	

	ACUTE PEPTIC ULCER OF UNSPECIFIED SITE WITH PERFORATION WITH OBSTRUCTION
533.20	ACUTE PEPTIC ULCER OF UNSPECIFIED SITE WITH HEMORRHAGE AND PERFORATION WITHOUT OBSTRUCTION
533.21	ACUTE PEPTIC ULCER OF UNSPECIFIED SITE WITH HEMORRHAGE AND PERFORATION WITH OBSTRUCTION
533.30	ACUTE PEPTIC ULCER OF UNSPECIFIED SITE WITHOUT HEMORRHAGE AND PERFORATION WITHOUT OBSTRUCTION
533.31	ACUTE PEPTIC ULCER OF UNSPECIFIED SITE WITHOUT HEMORRHAGE AND PERFORATION WITH OBSTRUCTION
533.40	CHRONIC OR UNSPECIFIED PEPTIC ULCER OF UNSPECIFIED SITE WITH HEMORRHAGE WITHOUT OBSTRUCTION
533.41	CHRONIC OR UNSPECIFIED PEPTIC ULCER OF UNSPECIFIED SITE WITH HEMORRHAGE WITH OBSTRUCTION
533.50	CHRONIC OR UNSPECIFIED PEPTIC ULCER OF UNSPECIFIED SITE WITH PERFORATION WITHOUT OBSTRUCTION
533.51	CHRONIC OR UNSPECIFIED PEPTIC ULCER OF UNSPECIFIED SITE WITH PERFORATION WITH OBSTRUCTION
533.60	CHRONIC OR UNSPECIFIED PEPTIC ULCER OF UNSPECIFIED SITE WITH HEMORRHAGE AND PERFORATION WITHOUT OBSTRUCTION
533.61	CHRONIC OR UNSPECIFIED PEPTIC ULCER OF UNSPECIFIED SITE WITH HEMORRHAGE AND PERFORATION WITH OBSTRUCTION
533.70	CHRONIC PEPTIC ULCER OF UNSPECIFIED SITE WITHOUT HEMORRHAGE OR PERFORATION WITHOUT OBSTRUCTION
533.71	CHRONIC PEPTIC ULCER OF UNSPECIFIED SITE WITHOUT HEMORRHAGE OR PERFORATION WITH OBSTRUCTION
533.90	PEPTIC ULCER OF UNSPECIFIED SITE UNSPECIFIED AS ACUTE OR CHRONIC WITHOUT HEMORRHAGE OR PERFORATION WITHOUT OBSTRUCTION
533.91	PEPTIC ULCER OF UNSPECIFIED SITE UNSPECIFIED AS ACUTE OR CHRONIC WITHOUT HEMORRHAGE OR PERFORATION WITH OBSTRUCTION
534.00	ACUTE GASTROJEJUNAL ULCER WITH HEMORRHAGE WITHOUT OBSTRUCTION
534.01	ACUTE GASTROJEJUNAL ULCER WITH HEMORRHAGE WITH OBSTRUCTION

534.10 ACUTE GASTROJEJUNAL ULCER WITH PERFORATION WITHOUT OBSTRUCTION

534.11 ACUTE GASTROJEJUNAL ULCER WITH PERFORATION WITH OBSTRUCTION

534.20 ACUTE GASTROJEJUNAL ULCER WITH HEMORRHAGE AND PERFORATION WITHOUT OBSTRUCTION

534.21 ACUTE GASTROJEJUNAL ULCER WITH HEMORRHAGE AND PERFORATION WITH OBSTRUCTION

534.30 ACUTE GASTROJEJUNAL ULCER WITHOUT HEMORRHAGE OR PERFORATION WITHOUT OBSTRUCTION

534.31 ACUTE GASTROJEJUNAL ULCER WITHOUT HEMORRHAGE OR PERFORATION WITH OBSTRUCTION

534.40 CHRONIC OR UNSPECIFIED GASTROJEJUNAL ULCER WITH HEMORRHAGE WITHOUT OBSTRUCTION

534.41 CHRONIC OR UNSPECIFIED GASTROJEJUNAL ULCER WITH HEMORRHAGE WITH OBSTRUCTION

534.50 CHRONIC OR UNSPECIFIED GASTROJEJUNAL ULCER WITH PERFORATION WITHOUT OBSTRUCTION

534.51 CHRONIC OR UNSPECIFIED GASTROJEJUNAL ULCER WITH PERFORATION WITH OBSTRUCTION

534.60 CHRONIC OR UNSPECIFIED GASTROJEJUNAL ULCER WITH HEMORRHAGE AND PERFORATION WITHOUT OBSTRUCTION

534.61 CHRONIC OR UNSPECIFIED GASTROJEJUNAL ULCER WITH HEMORRHAGE AND PERFORATION WITH OBSTRUCTION

534.70 CHRONIC GASTROJEJUNAL ULCER WITHOUT HEMORRHAGE OR PERFORATION WITHOUT OBSTRUCTION

534.71 CHRONIC GASTROJEJUNAL ULCER WITHOUT HEMORRHAGE OR PERFORATION WITH OBSTRUCTION

534.90 GASTROJEJUNAL ULCER UNSPECIFIED AS ACUTE OR CHRONIC WITHOUT HEMORRHAGE OR PERFORATION WITHOUT OBSTRUCTION

534.91 GASTROJEJUNAL ULCER UNSPECIFIED AS ACUTE OR CHRONIC WITHOUT HEMORRHAGE OR PERFORATION WITH OBSTRUCTION

535.00 ACUTE GASTRITIS (WITHOUT HEMORRHAGE)

535.01 ACUTE GASTRITIS WITH HEMORRHAGE

535.10 ATROPHIC GASTRITIS (WITHOUT HEMORRHAGE)

535.11 ATROPHIC GASTRITIS WITH HEMORRHAGE

535.20 GASTRIC MUCOSAL HYPERTROPHY (WITHOUT HEMORRHAGE)

535.21	GASTRIC MUCOSAL HYPERTROPHY WITH HEMORRHAGE
535.30	ALCOHOLIC GASTRITIS (WITHOUT HEMORRHAGE)
535.31	ALCOHOLIC GASTRITIS WITH HEMORRHAGE
535.40	OTHER SPECIFIED GASTRITIS (WITHOUT HEMORRHAGE)
535.41	OTHER SPECIFIED GASTRITIS WITH HEMORRHAGE
535.50	UNSPECIFIED GASTRITIS AND GASTRODUODENITIS (WITHOUT HEMORRHAGE)
535.51	UNSPECIFIED GASTRITIS AND GASTRODUODENITIS WITH HEMORRHAGE
535.60	DUODENITIS (WITHOUT HEMORRHAGE)
535.61	DUODENITIS WITH HEMORRHAGE
536.0	ACHLORHYDRIA
536.1	ACUTE DILATATION OF STOMACH
536.2	PERSISTENT VOMITING
536.3	GASTROPARESIS
536.40	GASTROSTOMY COMPLICATION UNSPECIFIED
536.41	INFECTION OF GASTROSTOMY
536.42	MECHANICAL COMPLICATION OF GASTROSTOMY
536.49	OTHER GASTROSTOMY COMPLICATIONS
536.8	DYSPEPSIA AND OTHER SPECIFIED DISORDERS OF FUNCTION OF STOMACH
536.9	UNSPECIFIED FUNCTIONAL DISORDER OF STOMACH
537.0	ACQUIRED HYPERTROPHIC PYLORIC STENOSIS
537.1	GASTRIC DIVERTICULUM
537.2	CHRONIC DUODENAL ILEUS
537.3	OTHER OBSTRUCTION OF DUODENUM
537.4	FISTULA OF STOMACH OR DUODENUM
537.5	GASTROPTOSIS
537.6	HOURGLASS STRICTURE OR STENOSIS OF STOMACH
537.81	PYLOROSPASM
537.82	ANGIODYSPLASIA OF STOMACH AND DUODENUM (WITHOUT HEMORRHAGE)
537.83	ANGIODYSPLASIA OF STOMACH AND DUODENUM WITH HEMORRHAGE
537.84	DIEULAFOY LESION (HEMORRHAGIC) OF STOMACH AND DUODENUM
537.89	OTHER SPECIFIED DISORDERS OF STOMACH AND DUODENUM

537.9	UNSPECIFIED DISORDER OF STOMACH AND DUODENUM
540.0	ACUTE APPENDICITIS WITH GENERALIZED PERITONITIS
540.1	ACUTE APPENDICITIS WITH PERITONEAL ABSCESS
540.9	ACUTE APPENDICITIS WITHOUT PERITONITIS
541	APPENDICITIS UNQUALIFIED
542	OTHER APPENDICITIS
543.0	HYPERPLASIA OF APPENDIX (LYMPHOID)
543.9	OTHER AND UNSPECIFIED DISEASES OF APPENDIX
550.00	UNILATERAL OR UNSPECIFIED INGUINAL HERNIA WITH GANGRENE
550.01	RECURRENT UNILATERAL OR UNSPECIFIED INGUINAL HERNIA WITH GANGRENE
550.02	BILATERAL INGUINAL HERNIA WITH GANGRENE
550.03	RECURRENT BILATERAL INGUINAL HERNIA WITH GANGRENE
550.10	UNILATERAL OR UNSPECIFIED INGUINAL HERNIA WITH OBSTRUCTION WITHOUT GANGRENE
550.11	RECURRENT UNILATERAL OR UNSPECIFIED INGUINAL HERNIA WITH OBSTRUCTION WITHOUT GANGRENE
550.12	BILATERAL INGUINAL HERNIA WITH OBSTRUCTION WITHOUT GANGRENE
550.13	RECURRENT BILATERAL INGUINAL HERNIA WITH OBSTRUCTION WITHOUT GANGRENE
550.90	UNILATERAL OR UNSPECIFIED INGUINAL HERNIA WITHOUT OBSTRUCTION OR GANGRENE
550.91	RECURRENT UNILATERAL OR UNSPECIFIED INGUINAL HERNIA WITHOUT OBSTRUCTION OR GANGRENE
550.92	BILATERAL INGUINAL HERNIA WITHOUT OBSTRUCTION OR GANGRENE
550.93	RECURRENT BILATERAL INGUINAL HERNIA WITHOUT OBSTRUCTION OR GANGRENE
551.00	UNILATERAL OR UNSPECIFIED FEMORAL HERNIA WITH GANGRENE
551.01	RECURRENT UNILATERAL OR UNSPECIFIED FEMORAL HERNIA WITH GANGRENE
551.02	BILATERAL FEMORAL HERNIA WITH GANGRENE
551.03	RECURRENT BILATERAL FEMORAL HERNIA WITH GANGRENE
551.1	UMBILICAL HERNIA WITH GANGRENE
551.20	UNSPECIFIED VENTRAL HERNIA WITH GANGRENE

551.21	INCISIONAL VENTRAL HERNIA WITH GANGRENE
551.29	OTHER VENTRAL HERNIA WITH GANGRENE
551.3	DIAPHRAGMATIC HERNIA WITH GANGRENE
551.8	HERNIA OF OTHER SPECIFIED SITES WITH GANGRENE
551.9	HERNIA OF UNSPECIFIED SITE WITH GANGRENE
552.00	UNILATERAL OR UNSPECIFIED FEMORAL HERNIA WITH OBSTRUCTION
552.01	RECURRENT UNILATERAL OR UNSPECIFIED FEMORAL HERNIA WITH OBSTRUCTION
552.02	BILATERAL FEMORAL HERNIA WITH OBSTRUCTION
552.03	RECURRENT BILATERAL FEMORAL HERNIA WITH OBSTRUCTION
552.1	UMBILICAL HERNIA WITH OBSTRUCTION
552.20	UNSPECIFIED VENTRAL HERNIA WITH OBSTRUCTION
552.21	INCISIONAL HERNIA WITH OBSTRUCTION
552.29	OTHER VENTRAL HERNIA WITH OBSTRUCTION
552.3	DIAPHRAGMATIC HERNIA WITH OBSTRUCTION
553.1	UMBILICAL HERNIA WITHOUT OBSTRUCTION OR GANGRENE
553.20	UNSPECIFIED VENTRAL HERNIA WITHOUT OBSTRUCTION OR GANGRENE
553.21	INCISIONAL HERNIA WITHOUT OBSTRUCTION OR GANGRENE
553.9	HERNIA OF UNSPECIFIED SITE WITHOUT OBSTRUCTION OR GANGRENE
557.9	UNSPECIFIED VASCULAR INSUFFICIENCY OF INTESTINE
560.0	INTUSSUSCEPTION
560.1	PARALYTIC ILEUS
560.2	VOLVULUS
560.30	IMPACTION OF INTESTINE UNSPECIFIED
560.31	GALLSTONE ILEUS
560.39	OTHER IMPACTION OF INTESTINE
560.81	INTESTINAL OR PERITONEAL ADHESIONS WITH OBSTRUCTION (POSTOPERATIVE) (POSTINFECTION)
560.89	OTHER SPECIFIED INTESTINAL OBSTRUCTION
560.9	UNSPECIFIED INTESTINAL OBSTRUCTION
562.00	DIVERTICULOSIS OF SMALL INTESTINE (WITHOUT HEMORRHAGE)
562.01	

	DIVERTICULITIS OF SMALL INTESTINE (WITHOUT HEMORRHAGE)
562.02	DIVERTICULOSIS OF SMALL INTESTINE WITH HEMORRHAGE
562.03	DIVERTICULITIS OF SMALL INTESTINE WITH HEMORRHAGE
562.10	DIVERTICULOSIS OF COLON (WITHOUT HEMORRHAGE)
562.11	DIVERTICULITIS OF COLON (WITHOUT HEMORRHAGE)
562.12	DIVERTICULOSIS OF COLON WITH HEMORRHAGE
562.13	DIVERTICULITIS OF COLON WITH HEMORRHAGE
564.00	UNSPECIFIED CONSTIPATION
564.01	SLOW TRANSIT CONSTIPATION
564.02	OUTLET DYSFUNCTION CONSTIPATION
564.09	OTHER CONSTIPATION
564.1	IRRITABLE BOWEL SYNDROME
564.2	POSTGASTRIC SURGERY SYNDROMES
564.3	VOMITING FOLLOWING GASTROINTESTINAL SURGERY
564.4	OTHER POSTOPERATIVE FUNCTIONAL DISORDERS
564.5	FUNCTIONAL DIARRHEA
564.6	ANAL SPASM
564.7	MEGACOLON OTHER THAN HIRSCHSPRUNG'S
564.81	NEUROGENIC BOWEL
564.89	OTHER FUNCTIONAL DISORDERS OF INTESTINE
564.9	UNSPECIFIED FUNCTIONAL DISORDER OF INTESTINE
565.0	ANAL FISSURE
565.1	ANAL FISTULA
566	ABSCESS OF ANAL AND RECTAL REGIONS
567.0	PERITONITIS IN INFECTIOUS DISEASES CLASSIFIED ELSEWHERE
567.1	PNEUMOCOCCAL PERITONITIS
567.21	PERITONITIS (ACUTE) GENERALIZED
567.22	PERITONEAL ABSCESS
567.23	SPONTANEOUS BACTERIAL PERITONITIS
567.29	OTHER SUPPURATIVE PERITONITIS
567.31	PSOAS MUSCLE ABSCESS
567.38	OTHER RETROPERITONEAL ABSCESS
567.39	OTHER RETROPERITONEAL INFECTIONS

567.81	CHOLEPERITONITIS
567.82	SCLEROSING MESENTERITIS
567.89	OTHER SPECIFIED PERITONITIS
567.9	UNSPECIFIED PERITONITIS
568.0	PERITONEAL ADHESIONS (POSTOPERATIVE) (POSTINFECTION)
568.81	HEMOPERITONEUM (NONTRAUMATIC)
568.82	PERITONEAL EFFUSION (CHRONIC)
568.89	OTHER SPECIFIED DISORDERS OF PERITONEUM
568.9	UNSPECIFIED DISORDER OF PERITONEUM
569.0	ANAL AND RECTAL POLYP
569.1	RECTAL PROLAPSE
569.2	STENOSIS OF RECTUM AND ANUS
569.3	HEMORRHAGE OF RECTUM AND ANUS
569.41	ULCER OF ANUS AND RECTUM
569.42	ANAL OR RECTAL PAIN
569.44	DYSPLASIA OF ANUS
569.49	OTHER SPECIFIED DISORDERS OF RECTUM AND ANUS
569.5	ABSCESS OF INTESTINE
569.60	COLOSTOMY AND ENTEROSTOMY COMPLICATION UNSPECIFIED
569.61	INFECTION OF COLOSTOMY OR ENTEROSTOMY
569.62	MECHANICAL COMPLICATION OF COLOSTOMY AND ENTEROSTOMY
569.69	OTHER COLOSTOMY AND ENTEROSTOMY COMPLICATION
569.81	FISTULA OF INTESTINE EXCLUDING RECTUM AND ANUS
569.82	ULCERATION OF INTESTINE
569.83	PERFORATION OF INTESTINE
569.84	ANGIODYSPLASIA OF INTESTINE (WITHOUT HEMORRHAGE)
569.85	ANGIODYSPLASIA OF INTESTINE WITH HEMORRHAGE
569.86	DIEULAFOY LESION (HEMORRHAGIC) OF INTESTINE
569.89	OTHER SPECIFIED DISORDERS OF INTESTINES
569.9	UNSPECIFIED DISORDER OF INTESTINE
570	ACUTE AND SUBACUTE NECROSIS OF LIVER
571.0	ALCOHOLIC FATTY LIVER

571.1	ACUTE ALCOHOLIC HEPATITIS
571.2	ALCOHOLIC CIRRHOSIS OF LIVER
571.3	ALCOHOLIC LIVER DAMAGE UNSPECIFIED
571.40	CHRONIC HEPATITIS UNSPECIFIED
571.41	CHRONIC PERSISTENT HEPATITIS
571.42	AUTOIMMUNE HEPATITIS
571.49	OTHER CHRONIC HEPATITIS
571.5	CIRRHOSIS OF LIVER WITHOUT ALCOHOL
571.6	BILIARY CIRRHOSIS
571.8	OTHER CHRONIC NONALCOHOLIC LIVER DISEASE
571.9	UNSPECIFIED CHRONIC LIVER DISEASE WITHOUT ALCOHOL
572.0	ABSCESS OF LIVER
572.1	PORTAL PYEMIA
572.2	HEPATIC COMA
572.3	PORTAL HYPERTENSION
572.4	HEPATORENAL SYNDROME
572.8	OTHER SEQUELAE OF CHRONIC LIVER DISEASE
573.0	CHRONIC PASSIVE CONGESTION OF LIVER
573.1	HEPATITIS IN VIRAL DISEASES CLASSIFIED ELSEWHERE
573.2	HEPATITIS IN OTHER INFECTIOUS DISEASES CLASSIFIED ELSEWHERE
573.3	HEPATITIS UNSPECIFIED
573.4	HEPATIC INFARCTION
573.8	OTHER SPECIFIED DISORDERS OF LIVER
573.9	UNSPECIFIED DISORDER OF LIVER
574.00	CALCULUS OF GALLBLADDER WITH ACUTE CHOLECYSTITIS WITHOUT OBSTRUCTION
574.01	CALCULUS OF GALLBLADDER WITH ACUTE CHOLECYSTITIS WITH OBSTRUCTION
574.10	CALCULUS OF GALLBLADDER WITH OTHER CHOLECYSTITIS WITHOUT OBSTRUCTION
574.11	CALCULUS OF GALLBLADDER WITH OTHER CHOLECYSTITIS WITH OBSTRUCTION
574.20	CALCULUS OF GALLBLADDER WITHOUT CHOLECYSTITIS WITHOUT OBSTRUCTION
574.21	CALCULUS OF GALLBLADDER WITHOUT CHOLECYSTITIS WITH OBSTRUCTION
574.30	

	CALCULUS OF BILE DUCT WITH ACUTE CHOLECYSTITIS WITHOUT OBSTRUCTION
574.31	CALCULUS OF BILE DUCT WITH ACUTE CHOLECYSTITIS WITH OBSTRUCTION
574.40	CALCULUS OF BILE DUCT WITH OTHER CHOLECYSTITIS WITHOUT OBSTRUCTION
574.41	CALCULUS OF BILE DUCT WITH OTHER CHOLECYSTITIS WITH OBSTRUCTION
574.50	CALCULUS OF BILE DUCT WITHOUT CHOLECYSTITIS WITHOUT OBSTRUCTION
574.51	CALCULUS OF BILE DUCT WITHOUT CHOLECYSTITIS WITH OBSTRUCTION
574.60	CALCULUS OF GALLBLADDER AND BILE DUCT WITH ACUTE CHOLECYSTITIS WITHOUT OBSTRUCTION
574.61	CALCULUS OF GALLBLADDER AND BILE DUCT WITH ACUTE CHOLECYSTITIS WITH OBSTRUCTION
574.70	CALCULUS OF GALLBLADDER AND BILE DUCT WITH OTHER CHOLECYSTITIS WITHOUT OBSTRUCTION
574.71	CALCULUS OF GALLBLADDER AND BILE DUCT WITH OTHER CHOLECYSTITIS WITH OBSTRUCTION
574.80	CALCULUS OF GALLBLADDER AND BILE DUCT WITH ACUTE AND CHRONIC CHOLECYSTITIS WITHOUT OBSTRUCTION
574.81	CALCULUS OF GALLBLADDER AND BILE DUCT WITH ACUTE AND CHRONIC CHOLECYSTITIS WITH OBSTRUCTION
574.90	CALCULUS OF GALLBLADDER AND BILE DUCT WITHOUT CHOLECYSTITIS WITHOUT OBSTRUCTION
574.91	CALCULUS OF GALLBLADDER AND BILE DUCT WITHOUT CHOLECYSTITIS WITH OBSTRUCTION
575.0	ACUTE CHOLECYSTITIS
575.10	CHOLECYSTITIS UNSPECIFIED
575.11	CHRONIC CHOLECYSTITIS
575.12	ACUTE AND CHRONIC CHOLECYSTITIS
575.2	OBSTRUCTION OF GALLBLADDER
575.3	HYDROPS OF GALLBLADDER
575.4	PERFORATION OF GALLBLADDER
575.5	FISTULA OF GALLBLADDER
575.6	CHOLESTEROLOSIS OF GALLBLADDER
575.8	OTHER SPECIFIED DISORDERS OF GALLBLADDER
575.9	UNSPECIFIED DISORDER OF GALLBLADDER
576.0	POSTCHOLECYSTECTOMY SYNDROME

576.1	CHOLANGITIS
576.2	OBSTRUCTION OF BILE DUCT
576.3	PERFORATION OF BILE DUCT
576.4	FISTULA OF BILE DUCT
576.5	SPASM OF SPHINCTER OF ODDI
576.8	OTHER SPECIFIED DISORDERS OF BILIARY TRACT
576.9	UNSPECIFIED DISORDER OF BILIARY TRACT
577.0	ACUTE PANCREATITIS
577.1	CHRONIC PANCREATITIS
577.2	CYST AND PSEUDOCYST OF PANCREAS
577.8	OTHER SPECIFIED DISEASES OF PANCREAS
577.9	UNSPECIFIED DISEASE OF PANCREAS
578.0	HEMATEMESIS
578.1	BLOOD IN STOOL
578.9	HEMORRHAGE OF GASTROINTESTINAL TRACT UNSPECIFIED
579.0	CELIAC DISEASE
579.1	TROPICAL SPRUE
579.2	BLIND LOOP SYNDROME
579.3	OTHER AND UNSPECIFIED POSTSURGICAL NONABSORPTION
579.4	PANCREATIC STEATORRHEA
579.8	OTHER SPECIFIED INTESTINAL MALABSORPTION
579.9	UNSPECIFIED INTESTINAL MALABSORPTION
590.9	INFECTION OF KIDNEY UNSPECIFIED
724.5	BACKACHE UNSPECIFIED
751.2	CONGENITAL ATRESIA AND STENOSIS OF LARGE INTESTINE RECTUM AND ANAL CANAL
751.60	UNSPECIFIED CONGENITAL ANOMALY OF GALLBLADDER BILE DUCTS AND LIVER
751.61	BILIARY ATRESIA CONGENITAL
751.62	CONGENITAL CYSTIC DISEASE OF LIVER
751.69	OTHER CONGENITAL ANOMALIES OF GALLBLADDER BILE DUCTS AND LIVER
759.0	ANOMALIES OF SPLEEN CONGENITAL
771.81	SEPTICEMIA [SEPSIS] OF NEWBORN
780.60	FEVER, UNSPECIFIED
780.61	FEVER PRESENTING WITH CONDITIONS CLASSIFIED ELSEWHERE

780.62	POSTPROCEDURAL FEVER
780.63	POSTVACCINATION FEVER
780.64	CHILLS (WITHOUT FEVER)
782.4	JAUNDICE UNSPECIFIED NOT OF NEWBORN
783.0	ANOREXIA
783.21	LOSS OF WEIGHT
783.22	UNDERWEIGHT
783.7	ADULT FAILURE TO THRIVE
785.9	OTHER SYMPTOMS INVOLVING CARDIOVASCULAR SYSTEM
786.50	UNSPECIFIED CHEST PAIN
786.8	HICCOUGH
787.01 - 787.03	NAUSEA WITH VOMITING - VOMITING ALONE
787.1	HEARTBURN
789.00	ABDOMINAL PAIN UNSPECIFIED SITE
789.01	ABDOMINAL PAIN RIGHT UPPER QUADRANT
789.02	ABDOMINAL PAIN LEFT UPPER QUADRANT
789.03	ABDOMINAL PAIN RIGHT LOWER QUADRANT
789.04	ABDOMINAL PAIN LEFT LOWER QUADRANT
789.05	ABDOMINAL PAIN PERIUMBILIC
789.06	ABDOMINAL PAIN EPIGASTRIC
789.07	ABDOMINAL PAIN GENERALIZED
789.09	ABDOMINAL PAIN OTHER SPECIFIED SITE
789.1	HEPATOMEGALY
789.2	SPLENOMEGALY
789.30	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP UNSPECIFIED SITE
789.31	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP RIGHT UPPER QUADRANT
789.32	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP LEFT UPPER QUADRANT
789.33	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP RIGHT LOWER QUADRANT
789.34	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP LEFT LOWER QUADRANT
789.35	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP PERIUMBILIC
789.36	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP EPIGASTRIC

789.37	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP GENERALIZED
789.39	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP OTHER SPECIFIED SITE
789.40	ABDOMINAL RIGIDITY UNSPECIFIED SITE
789.41	ABDOMINAL RIGIDITY RIGHT UPPER QUADRANT
789.42	ABDOMINAL RIGIDITY LEFT UPPER QUADRANT
789.43	ABDOMINAL RIGIDITY RIGHT LOWER QUADRANT
789.44	ABDOMINAL RIGIDITY LEFT LOWER QUADRANT
789.45	ABDOMINAL RIGIDITY PERIUMBILIC
789.46	ABDOMINAL RIGIDITY EPIGASTRIC
789.47	ABDOMINAL RIGIDITY GENERALIZED
789.49	ABDOMINAL RIGIDITY OTHER SPECIFIED SITE
789.51	MALIGNANT ASCITES
789.59	OTHER ASCITES
789.60	ABDOMINAL TENDERNESS UNSPECIFIED SITE
789.61	ABDOMINAL TENDERNESS RIGHT UPPER QUADRANT
789.62	ABDOMINAL TENDERNESS LEFT UPPER QUADRANT
789.63	ABDOMINAL TENDERNESS RIGHT LOWER QUADRANT
789.64	ABDOMINAL TENDERNESS LEFT LOWER QUADRANT
789.65	ABDOMINAL TENDERNESS PERIUMBILIC
789.66	ABDOMINAL TENDERNESS EPIGASTRIC
789.67	ABDOMINAL TENDERNESS GENERALIZED
789.69	ABDOMINAL TENDERNESS OTHER SPECIFIED SITE
789.9	OTHER SYMPTOMS INVOLVING ABDOMEN AND PELVIS
790.4	NONSPECIFIC ELEVATION OF LEVELS OF TRANSAMINASE OR LACTIC ACID DEHYDROGENASE (LDH)
790.5	OTHER NONSPECIFIC ABNORMAL SERUM ENZYME LEVELS
793.3	NONSPECIFIC ABNORMAL FINDINGS ON RADIOLOGICAL AND OTHER EXAMINATION OF BILIARY TRACT
793.4	NONSPECIFIC ABNORMAL FINDINGS ON RADIOLOGICAL AND OTHER EXAMINATION OF GASTROINTESTINAL TRACT
793.6	NONSPECIFIC ABNORMAL FINDINGS ON RADIOLOGICAL AND OTHER EXAMINATION OF ABDOMINAL AREA INCLUDING RETROPERITONEUM
794.8	

NONSPECIFIC ABNORMAL RESULTS OF FUNCTION
STUDY OF LIVER

- 863.0 INJURY TO STOMACH WITHOUT OPEN WOUND INTO CAVITY
- 863.1 INJURY TO STOMACH WITH OPEN WOUND INTO CAVITY
- 863.20 INJURY TO SMALL INTESTINE UNSPECIFIED SITE WITHOUT OPEN WOUND INTO CAVITY
- 863.21 INJURY TO DUODENUM WITHOUT OPEN WOUND INTO CAVITY
- 863.29 OTHER INJURY TO SMALL INTESTINE WITHOUT OPEN WOUND INTO CAVITY
- 863.30 INJURY TO SMALL INTESTINE UNSPECIFIED SITE WITH OPEN WOUND INTO CAVITY
- 863.31 INJURY TO DUODENUM WITH OPEN WOUND INTO CAVITY
- 863.39 OTHER INJURY TO SMALL INTESTINE WITH OPEN WOUND INTO CAVITY
- 863.41 - 863.44 INJURY TO ASCENDING (RIGHT) COLON WITHOUT OPEN WOUND INTO CAVITY - INJURY TO SIGMOID COLON WITHOUT OPEN WOUND INTO CAVITY
- 863.51 - 863.55 INJURY TO ASCENDING (RIGHT) COLON WITH OPEN WOUND INTO CAVITY - INJURY TO RECTUM WITH OPEN WOUND INTO CAVITY
- 863.80 INJURY TO GASTROINTESTINAL TRACT UNSPECIFIED SITE WITHOUT OPEN WOUND INTO CAVITY
- 863.81 INJURY TO PANCREAS HEAD WITHOUT OPEN WOUND INTO CAVITY
- 863.82 INJURY TO PANCREAS BODY WITHOUT OPEN WOUND INTO CAVITY
- 863.83 INJURY TO PANCREAS TAIL WITHOUT OPEN WOUND INTO CAVITY
- 863.84 INJURY TO PANCREAS MULTIPLE AND UNSPECIFIED SITES WITHOUT OPEN WOUND INTO CAVITY
- 863.85 INJURY TO APPENDIX WITHOUT OPEN WOUND INTO CAVITY
- 863.89 INJURY TO OTHER AND UNSPECIFIED GASTROINTESTINAL SITES WITHOUT OPEN WOUND INTO CAVITY
- 863.90 INJURY TO GASTROINTESTINAL TRACT UNSPECIFIED SITE WITH OPEN WOUND INTO CAVITY
- 863.91 INJURY TO PANCREAS HEAD WITH OPEN WOUND INTO CAVITY
- 863.92 INJURY TO PANCREAS BODY WITH OPEN WOUND INTO CAVITY

863.93 INJURY TO PANCREAS TAIL WITH OPEN WOUND INTO CAVITY

863.94 INJURY TO PANCREAS MULTIPLE AND UNSPECIFIED SITES WITH OPEN WOUND INTO CAVITY

863.95 INJURY TO APPENDIX WITH OPEN WOUND INTO CAVITY

863.99 INJURY TO OTHER AND UNSPECIFIED GASTROINTESTINAL SITES WITH OPEN WOUND INTO CAVITY

864.00 UNSPECIFIED INJURY TO LIVER WITHOUT OPEN WOUND INTO CAVITY

864.01 HEMATOMA AND CONTUSION OF LIVER WITHOUT OPEN WOUND INTO CAVITY

864.02 LACERATION OF LIVER MINOR WITHOUT OPEN WOUND INTO CAVITY

864.03 LACERATION OF LIVER MODERATE WITHOUT OPEN WOUND INTO CAVITY

864.04 LACERATION OF LIVER MAJOR WITHOUT OPEN WOUND INTO CAVITY

864.05 LACERATION OF LIVER UNSPECIFIED WITHOUT OPEN WOUND INTO CAVITY

864.09 OTHER INJURY TO LIVER WITHOUT OPEN WOUND INTO CAVITY

864.10 UNSPECIFIED INJURY TO LIVER WITH OPEN WOUND INTO CAVITY

864.11 HEMATOMA AND CONTUSION OF LIVER WITH OPEN WOUND INTO CAVITY

864.12 LACERATION OF LIVER MINOR WITH OPEN WOUND INTO CAVITY

864.13 LACERATION OF LIVER MODERATE WITH OPEN WOUND INTO CAVITY

864.14 LACERATION OF LIVER MAJOR WITH OPEN WOUND INTO CAVITY

864.15 LACERATION OF LIVER UNSPECIFIED WITH OPEN WOUND INTO CAVITY

864.19 OTHER INJURY TO LIVER WITH OPEN WOUND INTO CAVITY

865.00 UNSPECIFIED INJURY TO SPLEEN WITHOUT OPEN WOUND INTO CAVITY

865.01 HEMATOMA OF SPLEEN WITHOUT RUPTURE OF CAPSULE WITHOUT OPEN WOUND INTO CAVITY

865.02 CAPSULAR TEARS TO SPLEEN WITHOUT MAJOR DISRUPTION OF PARENCHYMA WITHOUT OPEN WOUND INTO CAVITY

865.03

	LACERATION OF SPLEEN EXTENDING INTO PARENCHYMA WITHOUT OPEN WOUND INTO CAVITY
865.04	MASSIVE PARENCHYMAL DISRUPTION OF SPLEEN WITHOUT OPEN WOUND INTO CAVITY
865.09	OTHER INJURY INTO SPLEEN WITHOUT OPEN WOUND INTO CAVITY
865.10	UNSPECIFIED INJURY TO SPLEEN WITH OPEN WOUND INTO CAVITY
865.11	HEMATOMA OF SPLEEN WITHOUT RUPTURE OF CAPSULE WITH OPEN WOUND INTO CAVITY
865.12	CAPSULAR TEARS TO SPLEEN WITHOUT MAJOR DISRUPTION OF PARENCHYMA WITH OPEN WOUND INTO CAVITY
865.13	LACERATION OF SPLEEN EXTENDING INTO PARENCHYMA WITH OPEN WOUND INTO CAVITY
865.14	MASSIVE PARENCHYMA DISRUPTION OF SPLEEN WITH OPEN WOUND INTO CAVITY
865.19	OTHER INJURY TO SPLEEN WITH OPEN WOUND INTO CAVITY
866.00	UNSPECIFIED INJURY TO KIDNEY WITHOUT OPEN WOUND INTO CAVITY
866.01	HEMATOMA OF KIDNEY WITHOUT RUPTURE OF CAPSULE WITHOUT OPEN WOUND INTO CAVITY
866.02	LACERATION OF KIDNEY WITHOUT OPEN WOUND INTO CAVITY
866.03	COMPLETE DISRUPTION OF KIDNEY PARENCHYMA WITHOUT OPEN WOUND INTO CAVITY
866.10	UNSPECIFIED INJURY TO KIDNEY WITH OPEN WOUND INTO CAVITY
866.11	HEMATOMA OF KIDNEY WITHOUT RUPTURE OF CAPSULE WITH OPEN WOUND INTO CAVITY
866.12	LACERATION OF KIDNEY WITH OPEN WOUND INTO CAVITY
866.13	COMPLETE DISRUPTION OF KIDNEY PARENCHYMA WITH OPEN WOUND INTO CAVITY
868.00	INJURY TO UNSPECIFIED INTRA-ABDOMINAL ORGAN WITHOUT OPEN WOUND INTO CAVITY
868.01	INJURY TO ADRENAL GLAND WITHOUT OPEN WOUND INTO CAVITY
868.02	INJURY TO BILE DUCT AND GALLBLADDER WITHOUT OPEN WOUND INTO CAVITY
868.03	INJURY TO PERITONEUM WITHOUT OPEN WOUND INTO CAVITY
868.04	INJURY TO RETROPERITONEUM WITHOUT OPEN WOUND INTO CAVITY

868.09 INJURY TO OTHER AND MULTIPLE INTRA-
ABDOMINAL ORGANS WITHOUT OPEN WOUND INTO
CAVITY

868.10 INJURY TO UNSPECIFIED INTRA-ABDOMINAL ORGAN
WITH OPEN WOUND INTO CAVITY

868.11 INJURY TO ADRENAL GLAND WITH OPEN WOUND
INTO CAVITY

868.12 INJURY TO BILE DUCT AND GALLBLADDER WITH
OPEN WOUND INTO CAVITY

868.13 INJURY TO PERITONEUM WITH OPEN WOUND INTO
CAVITY

868.14 INJURY TO RETROPERITONEUM WITH OPEN WOUND
INTO CAVITY

868.19 INJURY TO OTHER AND MULTIPLE INTRA-
ABDOMINAL ORGANS WITH OPEN WOUND INTO
CAVITY

869.0 INTERNAL INJURY TO UNSPECIFIED OR ILL-DEFINED
ORGANS WITHOUT OPEN WOUND INTO CAVITY

869.1 INTERNAL INJURY TO UNSPECIFIED OR ILL-DEFINED
ORGANS WITH OPEN WOUND INTO CAVITY

902.11 INJURY TO HEPATIC VEINS

902.19 INJURY TO OTHER SPECIFIED BRANCHES OF INFERIOR
VENA CAVA

902.20 INJURY TO CELIAC AND MESENTERIC ARTERIES
UNSPECIFIED

902.22 INJURY TO HEPATIC ARTERY

902.23 INJURY TO SPLENIC ARTERY

902.24 INJURY TO OTHER SPECIFIED BRANCHES OF CELIAC
AXIS

902.27 INJURY TO INFERIOR MESENTERIC ARTERY

902.29 INJURY TO OTHER CELIAC AND MESENTERIC
ARTERIES

902.31 - 902.33 INJURY TO SUPERIOR MESENTERIC VEIN AND
PRIMARY SUBDIVISIONS - INJURY TO PORTAL VEIN

902.34 INJURY TO SPLENIC VEIN

902.39 INJURY TO OTHER PORTAL AND SPLENIC VEINS

922.2 CONTUSION OF ABDOMINAL WALL

959.12 OTHER INJURY OF ABDOMEN

996.1 MECHANICAL COMPLICATION OF OTHER VASCULAR
DEVICE IMPLANT AND GRAFT

996.82 COMPLICATIONS OF TRANSPLANTED LIVER

996.86 COMPLICATIONS OF TRANSPLANTED PANCREAS

996.87 COMPLICATIONS OF TRANSPLANTED ORGAN

996.89	COMPLICATIONS OF OTHER SPECIFIED TRANSPLANTED ORGAN
998.51	INFECTED POSTOPERATIVE SEROMA
998.59	OTHER POSTOPERATIVE INFECTION
V10.00	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF UNSPECIFIED SITE IN GASTROINTESTINAL TRACT
V10.04	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF STOMACH
V10.05	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF LARGE INTESTINE
V10.06	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF RECTUM RECTOSIGMOID JUNCTION AND ANUS
V10.07	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF LIVER
V10.09	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF OTHER SITES IN GASTROINTESTINAL TRACT
V10.3	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF BREAST
V10.40 - V10.49	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF UNSPECIFIED FEMALE GENITAL ORGAN - PERSONAL HISTORY OF MALIGNANT NEOPLASM OF OTHER MALE GENITAL ORGANS
V10.50 - V10.53	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF UNSPECIFIED URINARY ORGAN - PERSONAL HISTORY OF MALIGNANT NEOPLASM OF RENAL PELVIS
V10.59	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF OTHER URINARY ORGANS
V10.60 - V10.63	PERSONAL HISTORY OF UNSPECIFIED LEUKEMIA - PERSONAL HISTORY OF MONOCYTIC LEUKEMIA
V10.69	PERSONAL HISTORY OF OTHER LEUKEMIA
V10.71 - V10.72	PERSONAL HISTORY OF LYMPHOSARCOMA AND RETICULOSARCOMA - PERSONAL HISTORY OF HODGKIN'S DISEASE
V10.79	PERSONAL HISTORY OF OTHER LYMPHATIC AND HEMATOPOIETIC NEOPLASMS
V42.7	LIVER REPLACED BY TRANSPLANT
V42.83	PANCREAS REPLACED BY TRANSPLANT
V42.84	ORGAN OR TISSUE REPLACED BY TRANSPLANT INTESTINES

The following ICD-9 CM codes are payable indications for CPT codes 76830, 76856, and 76857):

158.0	MALIGNANT NEOPLASM OF RETROPERITONEUM
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158.8	MALIGNANT NEOPLASM OF SPECIFIED PARTS OF PERITONEUM
158.9	MALIGNANT NEOPLASM OF PERITONEUM UNSPECIFIED
179	MALIGNANT NEOPLASM OF UTERUS-PART UNS
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
181	MALIGNANT NEOPLASM OF PLACENTA
182.0	MALIGNANT NEOPLASM OF CORPUS UTERI EXCEPT ISTHMUS
182.1	MALIGNANT NEOPLASM OF ISTHMUS
182.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF BODY OF UTERUS
183.0	MALIGNANT NEOPLASM OF OVARY
183.2	MALIGNANT NEOPLASM OF FALLOPIAN TUBE
183.3	MALIGNANT NEOPLASM OF BROAD LIGAMENT OF UTERUS
183.4	MALIGNANT NEOPLASM OF PARAMETRIUM
183.5	MALIGNANT NEOPLASM OF ROUND LIGAMENT OF UTERUS
183.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF UTERINE ADNEXA
183.9	MALIGNANT NEOPLASM OF UTERINE ADNEXA UNSPECIFIED SITE
184.0	MALIGNANT NEOPLASM OF VAGINA
184.9	MALIGNANT NEOPLASM OF FEMALE GENITAL ORGAN SITE UNSPECIFIED
188.0	MALIGNANT NEOPLASM OF TRIGONE OF URINARY BLADDER
188.1	MALIGNANT NEOPLASM OF DOME OF URINARY BLADDER
188.2	MALIGNANT NEOPLASM OF LATERAL WALL OF URINARY BLADDER
188.3	MALIGNANT NEOPLASM OF ANTERIOR WALL OF URINARY BLADDER
188.4	MALIGNANT NEOPLASM OF POSTERIOR WALL OF URINARY BLADDER
188.5	MALIGNANT NEOPLASM OF BLADDER NECK

188.6	MALIGNANT NEOPLASM OF URETERIC ORIFICE
188.7	MALIGNANT NEOPLASM OF URACHUS
188.8	MALIGNANT NEOPLASM OF OTHER SPECIFIED SITES OF BLADDER
188.9	MALIGNANT NEOPLASM OF BLADDER PART UNSPECIFIED
195.3	MALIGNANT NEOPLASM OF PELVIS
198.1	SECONDARY MALIGNANT NEOPLASM OF OTHER URINARY ORGANS
218.0	SUBMUCOUS LEIOMYOMA OF UTERUS
218.1	INTRAMURAL LEIOMYOMA OF UTERUS
218.2	SUBSEROUS LEIOMYOMA OF UTERUS
218.9	LEIOMYOMA OF UTERUS UNSPECIFIED
219.0	BENIGN NEOPLASM OF CERVIX UTERI
219.1	BENIGN NEOPLASM OF CORPUS UTERI
219.8	BENIGN NEOPLASM OF OTHER SPECIFIED PARTS OF UTERUS
219.9	BENIGN NEOPLASM OF UTERUS PART UNSPECIFIED
220	BENIGN NEOPLASM OF OVARY
221.0	BENIGN NEOPLASM OF FALLOPIAN TUBE AND UTERINE LIGAMENTS
221.1	BENIGN NEOPLASM OF VAGINA
221.9	BENIGN NEOPLASM OF FEMALE GENITAL ORGAN SITE UNSPECIFIED
223.3	BENIGN NEOPLASM OF BLADDER
233.1	CARCINOMA IN SITU OF CERVIX UTERI
236.0	NEOPLASM OF UNCERTAIN BEHAVIOR OF UTERUS
236.1	NEOPLASM OF UNCERTAIN BEHAVIOR OF PLACENTA
236.2	NEOPLASM OF UNCERTAIN BEHAVIOR OF OVARY
236.3	NEOPLASM OF UNCERTAIN BEHAVIOR OF OTHER AND UNSPECIFIED FEMALE GENITAL ORGANS
236.4	NEOPLASM OF UNCERTAIN BEHAVIOR OF TESTIS
236.5	NEOPLASM OF UNCERTAIN BEHAVIOR OF PROSTATE
236.7	NEOPLASM OF UNCERTAIN BEHAVIOR OF BLADDER
236.90	NEOPLASM OF UNCERTAIN BEHAVIOR OF URINARY ORGAN UNSPECIFIED
236.91	NEOPLASM OF UNCERTAIN BEHAVIOR OF KIDNEY AND URETER
236.99	NEOPLASM OF UNCERTAIN BEHAVIOR OF OTHER AND UNSPECIFIED URINARY ORGANS

239.4	NEOPLASM OF UNSPECIFIED NATURE OF BLADDER
256.0	HYPERESTROGENISM
256.1	OTHER OVARIAN HYPERFUNCTION
256.2	POSTABLATIVE OVARIAN FAILURE
256.31	PREMATURE MENOPAUSE
256.39	OTHER OVARIAN FAILURE
256.4	POLYCYSTIC OVARIES
256.8	OTHER OVARIAN DYSFUNCTION
256.9	UNSPECIFIED OVARIAN DYSFUNCTION
442.2	ANEURYSM OF ILIAC ARTERY
451.81	PHLEBITIS AND THROMBOPHLEBITIS OF ILIAC VEIN
568.81	HEMOPERITONEUM (NONTRAUMATIC)
568.89	OTHER SPECIFIED DISORDERS OF PERITONEUM
594.0	CALCULUS IN DIVERTICULUM OF BLADDER
594.1	OTHER CALCULUS IN BLADDER
596.3	DIVERTICULUM OF BLADDER
599.60	URINARY OBSTRUCTION, UNSPECIFIED
599.69	URINARY OBSTRUCTION, NOT ELSEWHERE CLASSIFIED
599.70	HEMATURIA, UNSPECIFIED
599.71	GROSS HEMATURIA
614.0	ACUTE SALPINGITIS AND OOPHORITIS
614.1	CHRONIC SALPINGITIS AND OOPHORITIS
614.2	SALPINGITIS AND OOPHORITIS NOT SPECIFIED AS ACUTE SUBACUTE OR CHRONIC
614.3	ACUTE PARAMETRITIS AND PELVIC CELLULITIS
614.4	CHRONIC OR UNSPECIFIED PARAMETRITIS AND PELVIC CELLULITIS
614.5	ACUTE OR UNSPECIFIED PELVIC PERITONITIS FEMALE
614.6	PELVIC PERITONEAL ADHESIONS FEMALE (POSTOPERATIVE) (POSTINFECTION)
614.7	OTHER CHRONIC PELVIC PERITONITIS FEMALE
614.8	OTHER SPECIFIED INFLAMMATORY DISEASE OF FEMALE PELVIC ORGANS AND TISSUES
614.9	UNSPECIFIED INFLAMMATORY DISEASE OF FEMALE PELVIC ORGANS AND TISSUES
615.0	ACUTE INFLAMMATORY DISEASES OF UTERUS EXCEPT CERVIX
615.1	

CHRONIC INFLAMMATORY DISEASES OF UTERUS
EXCEPT CERVIX

615.9	UNSPECIFIED INFLAMMATORY DISEASE OF UTERUS
616.0	CERVICITIS AND ENDOCERVICITIS
617.0	ENDOMETRIOSIS OF UTERUS
617.1	ENDOMETRIOSIS OF OVARY
617.2	ENDOMETRIOSIS OF FALLOPIAN TUBE
617.3	ENDOMETRIOSIS OF PELVIC PERITONEUM
617.4	ENDOMETRIOSIS OF RECTOVAGINAL SEPTUM AND VAGINA
617.5	ENDOMETRIOSIS OF INTESTINE
617.6	ENDOMETRIOSIS IN SCAR OF SKIN
617.8	ENDOMETRIOSIS OF OTHER SPECIFIED SITES
617.9	ENDOMETRIOSIS SITE UNSPECIFIED
620.0	FOLLICULAR CYST OF OVARY
620.1	CORPUS LUTEUM CYST OR HEMATOMA
620.2	OTHER AND UNSPECIFIED OVARIAN CYST
620.3	ACQUIRED ATROPHY OF OVARY AND FALLOPIAN TUBE
620.4	PROLAPSE OR HERNIA OF OVARY AND FALLOPIAN TUBE
620.5	TORSION OF OVARY OVARIAN PEDICLE OR FALLOPIAN TUBE
620.6	BROAD LIGAMENT LACERATION SYNDROME
620.7	HEMATOMA OF BROAD LIGAMENT
620.8	OTHER NONINFLAMMATORY DISORDERS OF OVARY FALLOPIAN TUBE AND BROAD LIGAMENT
620.9	UNSPECIFIED NONINFLAMMATORY DISORDER OF OVARY FALLOPIAN TUBE AND BROAD LIGAMENT
621.0	POLYP OF CORPUS UTERI
621.1	CHRONIC SUBINVOLUTION OF UTERUS
621.2	HYPERTROPHY OF UTERUS
621.30	ENDOMETRIAL HYPERPLASIA, UNSPECIFIED
621.31	SIMPLE ENDOMETRIAL HYPERPLASIA WITHOUT ATYPIA
621.32	COMPLEX ENDOMETRIAL HYPERPLASIA WITHOUT ATYPIA
621.33	ENDOMETRIAL HYPERPLASIA WITH ATYPIA
621.4	HEMATOMETRA
621.5	INTRAUTERINE SYNECHIAE

621.6	MALPOSITION OF UTERUS
621.7	CHRONIC INVERSION OF UTERUS
621.8	OTHER SPECIFIED DISORDERS OF UTERUS NOT ELSEWHERE CLASSIFIED
621.9	UNSPECIFIED DISORDER OF UTERUS
623.8	OTHER SPECIFIED NONINFLAMMATORY DISORDERS OF VAGINA
625.0	DYSPAREUNIA
625.2	MITTELSCHMERZ
625.3	DYSMENORRHEA
625.5	PELVIC CONGESTION SYNDROME
625.6	STRESS INCONTINENCE FEMALE
625.70	VULVODYNIA, UNSPECIFIED
625.71	VULVAR VESTIBULITIS
625.79	OTHER VULVODYNIA
625.8	OTHER SPECIFIED SYMPTOMS ASSOCIATED WITH FEMALE GENITAL ORGANS
625.9	UNSPECIFIED SYMPTOM ASSOCIATED WITH FEMALE GENITAL ORGANS
626.0	ABSENCE OF MENSTRUATION
626.1	SCANTY OR INFREQUENT MENSTRUATION
626.2	EXCESSIVE OR FREQUENT MENSTRUATION
626.3	PUBERTY BLEEDING
626.4	IRREGULAR MENSTRUAL CYCLE
626.5	OVULATION BLEEDING
626.6	METRORRHAGIA
626.7	POSTCOITAL BLEEDING
626.8	OTHER DISORDERS OF MENSTRUATION AND OTHER ABNORMAL BLEEDING FROM FEMALE GENITAL TRACT
626.9	UNSPECIFIED DISORDERS OF MENSTRUATION AND OTHER ABNORMAL BLEEDING FROM FEMALE GENITAL TRACT
627.0	PREMENOPAUSAL MENORRHAGIA
627.1	POSTMENOPAUSAL BLEEDING
752.0	CONGENITAL ANOMALIES OF OVARIES
752.10	UNSPECIFIED CONGENITAL ANOMALY OF FALLOPIAN TUBES AND BROAD LIGAMENTS
752.11	EMBRYONIC CYST OF FALLOPIAN TUBES AND BROAD LIGAMENTS

752.19 OTHER CONGENITAL ANOMALIES OF FALLOPIAN TUBES AND BROAD LIGAMENTS

752.2 DOUBLING OF UTERUS

752.3 OTHER CONGENITAL ANOMALIES OF UTERUS

752.40 UNSPECIFIED CONGENITAL ANOMALY OF CERVIX VAGINA AND EXTERNAL FEMALE GENITALIA

752.41 EMBRYONIC CYST OF CERVIX VAGINA AND EXTERNAL FEMALE GENITALIA

752.42 IMPERFORATE HYMEN

752.49 OTHER CONGENITAL ANOMALIES OF CERVIX VAGINA AND EXTERNAL FEMALE GENITALIA

752.7 INDETERMINATE SEX AND PSEUDOHERMAPHRODITISM

752.9 UNSPECIFIED CONGENITAL ANOMALY OF GENITAL ORGANS

753.8 OTHER SPECIFIED CONGENITAL ANOMALIES OF BLADDER AND URETHRA

787.3 FLATULENCE ERUCTATION AND GAS PAIN

788.0 RENAL COLIC

788.20 RETENTION OF URINE UNSPECIFIED

788.30 URINARY INCONTINENCE UNSPECIFIED

788.38 OVERFLOW INCONTINENCE

788.8 EXTRAVASATION OF URINE

788.91 FUNCTIONAL URINARY INCONTINENCE

788.99 OTHER SYMPTOMS INVOLVING URINARY SYSTEM

789.03 ABDOMINAL PAIN RIGHT LOWER QUADRANT

789.04 ABDOMINAL PAIN LEFT LOWER QUADRANT

789.05 ABDOMINAL PAIN PERIUMBILIC

789.30 ABDOMINAL OR PELVIC SWELLING MASS OR LUMP UNSPECIFIED SITE

789.31 ABDOMINAL OR PELVIC SWELLING MASS OR LUMP RIGHT UPPER QUADRANT

789.32 ABDOMINAL OR PELVIC SWELLING MASS OR LUMP LEFT UPPER QUADRANT

789.33 ABDOMINAL OR PELVIC SWELLING MASS OR LUMP RIGHT LOWER QUADRANT

789.34 ABDOMINAL OR PELVIC SWELLING MASS OR LUMP LEFT LOWER QUADRANT

789.35 ABDOMINAL OR PELVIC SWELLING MASS OR LUMP PERIUMBILIC

789.36

	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP EPIGASTRIC
789.37	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP GENERALIZED
789.39	ABDOMINAL OR PELVIC SWELLING MASS OR LUMP OTHER SPECIFIED SITE
789.43	ABDOMINAL RIGIDITY RIGHT LOWER QUADRANT
789.44	ABDOMINAL RIGIDITY LEFT LOWER QUADRANT
789.51	MALIGNANT ASCITES
789.59	OTHER ASCITES
789.63	ABDOMINAL TENDERNESS RIGHT LOWER QUADRANT
789.64	ABDOMINAL TENDERNESS LEFT LOWER QUADRANT
998.11	HEMORRHAGE COMPLICATING A PROCEDURE
998.12	HEMATOMA COMPLICATING A PROCEDURE
998.13	SEROMA COMPLICATING A PROCEDURE
998.51	INFECTED POSTOPERATIVE SEROMA
998.59	OTHER POSTOPERATIVE INFECTION
V10.41	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF CERVIX UTERI
V10.43	PERSONAL HISTORY OF MALIGNANT NEOPLASM OF OVARY
V13.29	PERSONAL HISTORY OF OTHER GENITAL SYSTEM AND OBSTETRIC DISORDERS
V16.41	FAMILY HISTORY OF MALIGNANT NEOPLASM OF OVARY
V58.69	LONG-TERM (CURRENT) USE OF OTHER MEDICATIONS
V71.1	OBSERVATION FOR SUSPECTED MALIGNANT NEOPLASM

The following ICD-9 CM codes are payable indications for CPT codes 76856 and 76857 only.

185	MALIGNANT NEOPLASM OF PROSTATE
186.0	MALIGNANT NEOPLASM OF UNDESCENDED TESTIS
186.9	MALIGNANT NEOPLASM OF OTHER AND UNSPECIFIED TESTIS
187.9	MALIGNANT NEOPLASM OF MALE GENITAL ORGAN SITE UNSPECIFIED
222.9	BENIGN NEOPLASM OF MALE GENITAL ORGAN SITE UNSPECIFIED
600.00	HYPERTROPHY (BENIGN) OF PROSTATE WITHOUT URINARY OBSTRUCTION AND OTHER LOWER URINARY TRACT (LUTS)

600.01	HYPERTROPHY (BENIGN) OF PROSTATE WITH URINARY OBSTRUCTION AND OTHER LOWER URINARY TRACT SYMPTOMS (LUTS)
600.10	NODULAR PROSTATE WITHOUT URINARY OBSTRUCTION
600.11	NODULAR PROSTATE WITH URINARY OBSTRUCTION
600.20	BENIGN LOCALIZED HYPERPLASIA OF PROSTATE WITHOUT URINARY OBSTRUCTION AND OTHER LOWER URINARY TRACT SYMPTOMS (LUTS)
600.21	BENIGN LOCALIZED HYPERPLASIA OF PROSTATE WITH URINARY OBSTRUCTION AND OTHER LOWER URINARY TRACT SYMPTOMS (LUTS)
600.3	CYST OF PROSTATE
600.90	HYPERPLASIA OF PROSTATE, UNSPECIFIED, WITHOUT URINARY OBSTRUCTION AND OTHER LOWER URINARY SYMPTOMS (LUTS)
600.91	HYPERPLASIA OF PROSTATE, UNSPECIFIED, WITH URINARY OBSTRUCTION AND OTHER LOWER URINARY SYMPTOMS (LUTS)
601.0	ACUTE PROSTATITIS
601.1	CHRONIC PROSTATITIS
601.2	ABSCCESS OF PROSTATE
601.3	PROSTATOCYSTITIS
601.4	PROSTATITIS IN DISEASES CLASSIFIED ELSEWHERE
601.8	OTHER SPECIFIED INFLAMMATORY DISEASES OF PROSTATE
601.9	PROSTATITIS UNSPECIFIED
602.3	DYSPLASIA OF PROSTATE
603.0	ENCYSTED HYDROCELE
603.1	INFECTED HYDROCELE
603.8	OTHER SPECIFIED TYPES OF HYDROCELE
603.9	HYDROCELE UNSPECIFIED
604.0	ORCHITIS EPIDIDYMITIS AND EPIDIDYMO-ORCHITIS WITH ABSCESS
604.90	ORCHITIS AND EPIDIDYMITIS UNSPECIFIED
604.91	ORCHITIS AND EPIDIDYMITIS IN DISEASES CLASSIFIED ELSEWHERE
604.99	OTHER ORCHITIS EPIDIDYMITIS AND EPIDIDYMO-ORCHITIS WITHOUT ABSCESS

608.0	SEMINAL VESICULITIS
608.1	SPERMATOCELE
608.20	TORSION OF TESTIS, UNSPECIFIED
608.21	EXTRAVAGINAL TORSION OF SPERMATIC CORD
608.22	INTRAVAGINAL TORSION OF SPERMATIC CORD
608.23	TORSION OF APPENDIX TESTIS
608.24	TORSION OF APPENDIX EPIDIDYMIS
608.3	ATROPHY OF TESTIS
608.4	OTHER INFLAMMATORY DISORDERS OF MALE GENITAL ORGANS
608.81	DISORDERS OF MALE GENITAL ORGANS IN DISEASES CLASSIFIED ELSEWHERE
608.82	HEMATOSPERMIA
608.83	VASCULAR DISORDERS OF MALE GENITAL ORGANS
608.84	CHYLOCELE OF TUNICA VAGINALIS
608.85	STRICTURE OF MALE GENITAL ORGANS
608.86	EDEMA OF MALE GENITAL ORGANS
608.87	RETROGRADE EJACULATION
608.89	OTHER SPECIFIED DISORDERS OF MALE GENITAL ORGANS
608.9	UNSPECIFIED DISORDER OF MALE GENITAL ORGANS
752.51	UNDESCENDED TESTIS
752.52	RETRACTILE TESTIS
752.61	HYPOSPADIAS
752.62	EPISPADIAS
752.63	CONGENITAL CHORDEE
752.64	MICROPENIS
752.65	HIDDEN PENIS
752.69	OTHER PENILE ANOMALIES
752.81	SCROTAL TRANSPOSITION
752.89	OTHER SPECIFIED ANOMALIES OF GENITAL ORGANS
788.30	URINARY INCONTINENCE UNSPECIFIED
788.31	URGE INCONTINENCE
788.32	STRESS INCONTINENCE MALE
788.33	MIXED INCONTINENCE (MALE) (FEMALE)
788.34	

INCONTINENCE WITHOUT SENSORY
AWARENESS

788.35

POST-VOID DRIBBLING

788.36

NOCTURNAL ENURESIS

788.37

CONTINUOUS LEAKAGE

788.39

OTHER URINARY INCONTINENCE

788.41

URINARY FREQUENCY

788.42

POLYURIA

788.43

NOCTURIA

Diagnoses that Support Medical Necessity

Not applicable

ICD-9 Codes that DO NOT Support Medical Necessity

Not applicable

ICD-9 Codes that DO NOT Support Medical Necessity Asterisk Explanation

Diagnoses that DO NOT Support Medical Necessity

Not applicable

General Information

Documentation Requirements

The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.

Each claim must be submitted with ICD-9-CM codes that reflect the condition of the patient, and indicate the reason(s) for which the service was performed. Claims submitted without ICD-9-CM codes will be returned.

Medical record documentation maintained by the ordering/referring physician must indicate the medical necessity for the abdominal ultrasonography procedure covered by the Medicare program. The procedure results/report must be included in the patient's medical record. If the ordering/referring physician is also the performing provider, a hard copy documentation of the procedure results/report must be available for review.

If the provider of the abdominal ultrasonography is other than the ordering/referring physician, the provider of the service must be able to produce hard copy documentation of the procedure results/report along with copies of the ordering/referring physician's order for the procedure.

Documentation must be available to Medicare upon request.

Appendices

Not applicable

Utilization Guidelines

Ultrasound is valuable in diagnosing and measuring an aneurysm of the arterial system, and follow-up should be considered medically necessary every six months.

Sources of Information and Basis for Decision

This bibliography presents those sources that were obtained during the development of this policy. National Government Services is not responsible for the continuing viability of Web site addresses listed below.

Current Medical Diagnosis and Treatment. Edited by Tierney et al, Appleton Lange, 1993

Harrison's Principles of Internal Medicine, 13th Edition. Editors Isselbacher et al, McGraw Hill Publishing, 1994

Nasri, M.N.; Shepherd, J.H.; Setchell, M.E.; Lowe, D.G.; Chard, T. "Transvaginal Ultrasound: A Reliable Basis for Clinical Management?" *British Journal of Obstetrics and Gynecology*, May 1991, 98 (5): 485-486.

Schwartz et al, editor, *Principles of Surgery*, 6th Edition. McGraw Hill, 1994

Teisala, K.; Heinonen, P.K.; Punnonen, R. Transvaginal Ultrasound in the Diagnosis and Treatment of Tubo-Ovarian Abscess. *British Journal of Obstetrics and Gynecology*, February 1990, 97 (2): 178-180.

Advisory Committee Meeting Notes

Carrier Advisory Committee Meeting Date(s):

Connecticut: 09/16/2008

Indiana: 09/22/2008

Kentucky: 09/25/2008

New York: 09/10/2008

This coverage determination does not reflect the sole opinion of the contractor or contractor Medical Director. Although the final decision rests with the contractor, this determination was developed in consultation with representatives from Advisory Committee members and/or from various state and local provider organizations.

Start Date of Comment Period

09/02/2008

End Date of Comment Period

10/16/2008

Start Date of Notice Period

11/17/2008

Revision History Number

Not applicable

Revision History Explanation

Not applicable

05/15/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary numbers 00180 and 00181 were removed from this LCD as the claims processing for Maine and Massachusetts was transitioned to NHIC, the Part A/Part B MAC contractor in these states.

06/05/2009 - In accordance with Section 911 of the Medicare Modernization Act of 2003, fiscal intermediary number 00270 was removed from this LCD as the claims processing for New Hampshire and Vermont was transitioned to NHIC, the Part A/Part B MAC contractor in these states.

Reason for Change**Last Reviewed On Date**

11/17/2008

Related Documents**Article(s)**

A48013 - Abdominal and Pelvic Ultrasound - Supplemental Instructions Article

LCD Attachments

There are no attachments for this LCD.

All Versions

Updated on 05/28/2009 with effective dates 06/05/2009 - N/A

Updated on 05/27/2009 with effective dates 05/15/2009 - 06/04/2009

Updated on 05/07/2009 with effective dates 05/15/2009 - N/A

Updated on 01/23/2009 with effective dates 01/01/2009 - 05/14/2009

Updated on 01/23/2009 with effective dates 01/01/2009 - N/A

Updated on 01/23/2009 with effective dates 01/01/2009 - N/A

Updated on 11/19/2008 with effective dates 01/01/2009 - N/A

Updated on 11/04/2008 with effective dates 01/01/2009 - N/A

FREQUENTLY ASKED QUESTIONS

1. What documentation is necessary for the coding of Emergency Department ultrasounds?

Proper documentation of ultrasound studies performed in the Emergency Department should include or indicate the following: (ref IV. A)

- A separately identifiable written report for each test performed. This may be an independent report or may be incorporated within the patient treatment record.
- Who performed the study
- Scope of the examination (limited vs. complete, including any modifiers)
- The indication (medical necessity) for the examination
- A description of the structures or organs studied and an interpretation of the findings.
- Signed by physician

2. Do I have to meet American College of Radiology standards for documentation in order to code for an ultrasound interpretation?

No, there are no CMS (agency formerly known as HCFA) requirements that documentation adhere to any specialty society guidelines. CMS opinion has primarily addressed X-ray and EKG interpretation and can be reviewed in the “HCFA Final Rule on X-ray/EKG Interpretations” and “HCFA memo regarding X-ray/EKG Interpretations in the ED” (both found at www.acep.org). While these documents do not directly address ultrasound interpretation and reports, our opinion is that general principles of X-ray interpretation by Emergency Physicians would be similar to ultrasound examination and interpretation by Emergency Physicians.

Reports must be complete and similar to that usually prepared by a specialist in the field. Reports need not specifically follow the American College of Radiology guidelines.

When multiple bills are submitted for the same report, CMS will pay for the interpretation and report that directly contributed to the diagnosis and treatment of the individual patient. The interpretation and report paid will usually be that provided contemporaneous with the patient’s visit and without consideration of the reporting physician’s specialty. (IV. A).

3. What code should I use for the FAST exam?

The FAST examination is not a single ultrasound procedure, but a clinical approach to the traumatically injured or hypotensive patient that utilizes two

distinct limited examinations currently described by CPT. The components of this clinical approach have been outlined by both ACEP publications as well as the joint AIUM and ACEP document: Guideline for the Performance of the FAST exam. The CPT codes are (1) limited transthoracic echocardiogram (93308-26) and (2) limited abdominal ultrasound (76705-26). If one performs a focused chest ultrasound, the CPT for a limited chest ultrasound may be added (76604-26) (ref II.A.1).

4. If I perform a diagnostic ultrasound and a related ultrasound-guided procedure during a single patient encounter, how do I code?

As long as the diagnostic code is not subsumed in the procedural code, the diagnostic and procedural codes can be billed separately. If one performs a limited cardiac ultrasound and diagnoses pericardial tamponade, then performs an ultrasound-guided pericardiocentesis, the codes would be: 1. diagnostic transthoracic echocardiogram (93308-26) 2. ultrasound-guided pericardiocentesis (76930-26), and 3. the surgical procedure for pericardiocentesis (33010, pericardiocentesis; initial). (ref. II.A.7).

5. Do I have to include an ultrasound image in the chart to code for an ultrasound that I perform?

Yes. CPT requires that all diagnostic and procedure guidance ultrasounds have permanently recorded images in order to meet coding criteria. The only exception to this requirement is a post-void residual volume measurement which does not require an image. Currently, there are no specific guidelines regarding the medium on which the image is stored (e.g. hard copy vs. digital) or the number of images which must be recorded. Emergency Physicians are encouraged to review local payer policies (IV. B).

6. If the Emergency Physician and a Trauma Surgeon both perform a FAST exam, can both physicians code and bill for their respective examinations?

Physicians with the same group Medicare provider number are considered to be the same physician from a billing perspective. If the “same physician” repeats an examination, then the -76 modifier is utilized (I.C.4,5).

A second physician with a different group Medicare provider number may code and bill a repeat examination for the same patient on the same date. However, the second physician should utilize the -77 CPT code modifier. Both physicians must document the medical necessity for each examination performed. The indications for a repeat FAST examination during the same patient encounter might include such factors as the development of hemodynamic instability, a falling hematocrit, or development of increased abdominal pain/tenderness in a patient who had a negative initial FAST examination. Repeating a FAST examination to simply

confirm the finding of another provider may be clinically reasonable, but would not warrant the coding of a separate study.

7. Can an Emergency Physician code a limited examination and a Radiologist code a complete examination on the same patient encounter?

Two physicians can code a limited examination and a complete examination, of the same anatomic description, on the same date of service, if two separate procedures are performed and are medically necessary. On some occasions, an initial limited examination by an Emergency Physician will be inconclusive or demonstrate an unexpected finding requiring a complete examination or follow-up examination by a consulting Radiologist. What is required is that each examination, limited or complete, stand on its own merit as a medically necessary study. A repeat examination of the exact same type by a second physician with a different group Medicare provider number would require a -77 modifier.

The planned sequencing of a limited examination by one provider (Emergency Physician) followed by a complete examination by a second provider (Radiologist), both coding for the procedure, would not constitute proper or compliant coding.

A single provider would not code a limited exam followed by a complete examination of the same anatomic description, as the initial limited exam would be included in the more comprehensive complete code.

8. If I use ultrasound to diagnose pregnancy, how do I code for the study?

If the pregnancy status of a patient is unknown prior to the sonographic examination, and ultrasonography was utilized to evaluate amenorrhea, pelvic pain, vaginal bleeding or non-gynecologic pelvic pathology, then the non-obstetric pelvic CPT code (76857-26) would be used. This would be true even if the result of the examination was the diagnosis of an intrauterine or ectopic pregnancy (ref. II. A. 2).

9. Can I code for both a transabdominal and transvaginal pelvic ultrasound during the same exam session?

Yes. If transabdominal and transvaginal examinations are medically necessary and performed, both can be coded. The planned sequencing of a transabdominal and transvaginal ultrasound for every patient, regardless of the information obtained on transabdominal ultrasound would not be appropriate. As stated earlier, the medical indication for each exam should be documented (II. A. 2).

10. If I use ultrasound to evaluate a pregnancy or a possible complication of pregnancy, how should I code the study?

When the patient is (1) known to be pregnant, including knowledge of a positive pregnancy test and (2) the physician is utilizing ultrasound to evaluate the pregnancy or a suspected complication of pregnancy, then the obstetric pelvic codes would be utilized (e.g. 76815-26). When these two criteria are met, the obstetric codes are utilized regardless of the study result. Thus the obstetric pelvic codes would apply to the “known pregnant patient” even in the absence of an identified intrauterine pregnancy and if the patient was found to have an ectopic pregnancy, spontaneous abortion, molar pregnancy, ovarian torsion or a non-pregnancy related condition (ref. II. A. 2).

11. How do I code for a study in which there is an unexpected ultrasonographic finding?

Code for the studies indicated and performed. In many circumstances, the examination indicated and the corresponding CPT code will be unchanged even when an unexpected finding occurs, e.g. gallstones seen when performing a FAST examination. The gallstones would be recorded as an incidental finding in the abdominal portion of the FAST exam and would not require that an additional code or even a more comprehensive code be applied.

In other circumstances, a finding during the initial examination may necessitate a second examination indicated by the unexpected finding. For example, the abdominal portion of the FAST examination is being performed on a patient who was in a motor vehicle collision and is hypotensive. When scanning the pelvic window, no peritoneal fluid is seen; however, an abdominal aortic aneurysm is seen. This finding would justify coding both a limited abdominal ultrasound (76705-26) as well as a limited retroperitoneal ultrasound (76775-26).

12. If an Emergency Physician images two organ systems which utilize the same CPT code (eg aorta and renal in an elderly patient with flank pain), should two separate bills be submitted?

No. An ultrasound of the abdominal aorta in a patient presenting with symptoms concerning for AAA would be coded for by 76775-26. If sectional views of the kidney were imaged in this same patient, the limited retroperitoneal code (76775-26) would still apply and would not be separately billable (ref II. A. 3).

13. Does the introduction of APCs (ambulatory patient classification groups) change the CPT coding of Emergency Department ultrasounds?

Currently, physician services are excluded from APCs and are billed separately. APC codes apply to the technical component of ultrasound charges.

14. How does the hospital bill for the technical component of ultrasounds performed in the Emergency Department?

The technical component covers reimbursement for the cost of equipment, service and maintenance, supplies, and technician salaries. Medicare has a specific program called Ambulatory Payment Classifications (APC) that assigns payment categories to the technical components of ultrasound exams. Private insurers have not adopted APCs and therefore reimbursement of the technical component varies by payer.

If a Medicare patient is admitted to the hospital within 72 hours of performance of an Emergency Department ultrasound, the technical component of the ultrasound charge should be rolled into the hospital inpatient DRG and must be backed out of the outpatient bill (“72 hour rule”). Recognition of these necessary charge adjustments is technically difficult and requires internal oversight to ensure compliance.

15. What impact does ICD-9 coding have on claims submission for emergency ultrasound examinations?

Payers frequently develop lists of pre-approved ICD-9 codes they feel are compatible with, support, or verify the ultrasound CPT procedures listed on claim forms. This screening of CPT procedures by comparison to ICD-9 codes is designed to detect claims with a higher probability of being incorrect or unnecessary and are termed diagnosis or payment edits. The ICD-9 codes that are previously approved as compatible with the CPT codes receive a first pass edit green light. Other claims are often denied, but may later be approved when supplemented with additional information. As this screening process is often based on a payer’s concept of accepted professional medical standards, such determinations may at times be subjective or may not reflect the most current application of medical technology (ref III. A).

16. Can hospital based Emergency Physicians own the US machine and code a global CPT based on ownership of the equipment?

No. In the hospital setting, ultrasound charges are divided between the professional component and the technical component instead of having a global fee assigned. The professional component of the ultrasound service, indicated by the -26 modifier, is reported by the physician for professional services that include interpretation and report of the study results. The technical component, designated by a -TC modifier, is charged by the facility (i.e. hospital) and includes reimbursement for the cost of equipment, service and maintenance, supplies, and technician salaries.

If physicians are hospital employees and the hospital owns the ultrasound machine, the hospital must still separate the ultrasound billing into professional and technical charges. The physician service is submitted on the HCFA form 1500 and the technical component is submitted to the Medicare fiscal intermediary on a form UB 92.

Equipment purchase is not typically a cost sustained by hospital-based physicians, and hospital Emergency Physician groups do not typically receive revenue from equipment ownership. Financial relationship between physicians who utilize hospital services that entail using the physicians' own equipment are addressed by multiple fraud and abuse statutes and regulations. Physicians contemplating such arrangement are advised to seek competent specialized legal counsel (ref I. C. 1).

17. Can an Emergency Physician ever bill the global fee for ultrasound?

The global fee, when billed by a physician, should reflect a non-hospital location as a site of service and not a hospital site of service such as the ED. One would expect a coding edit to result in a payment denial or possible payer inquiry when a global CPT is submitted with a hospital site of service. Physicians including Emergency Physicians, may utilize global or unmodified ultrasound CPT codes in physician offices, clinics or free standing emergency facilities (not operated by a hospital), that provide professional services as well as own and maintain the equipment.

18. Are midlevel providers allowed to perform Emergency Department ultrasounds?

Midlevel providers (ie. PAs and NPs) are subject to state defined scope of practice. Depending on how the state-guidelines above are interpreted, the midlevel providers would also have to be credentialed by the hospital to be performing the ultrasound procedure. Their credentialing process would be expected to meet the same requirements as an Emergency Physician.

The following resources are available for more specific information:

PA scope of practice

<http://www.aapa.org/gandp/statelaw.html>

NP scope of practice

<http://www.aanp.org/Publications/AANP+Position+Statements/Position+Statements+and+Papers.asp>

ACEP's FAQs link for mid-level providers

<http://www.acep.org/practres.aspx?id=30478>

If the scope of practice criteria is met and the hospital credentials the midlevel provider, the PA or NP is able to bill for procedures. Medicare typically pays

85% of what they would pay for a physician performing the same procedure if a physician is not involved in a mid-level provider case. Non-Medicare payers have different contractual agreements for fee schedules.

Mid-level providers are not inclusive of registered nurses. Nurses are not billing for "professional" services found in the professional CPT guidelines.

19. How does the July 2009 Office of the Inspector General report affect emergency ultrasound?

The OIG report addresses excessive ultrasound procedures billed under Medicare part B. Ultrasounds performed in the Emergency Department are billed in part to Medicare part B for the professional component and also to Medicare part A for the technical component. The OIG analyzed ultrasounds performed exclusively in non-hospital outpatient settings (ie not emergency ultrasounds).

The most common problems the report found were:

1. The physician ordering the study had never billed a prior claim for the patient.
2. The claim involved a combination of questionable procedures billed for the same beneficiary on the same day by the same provider.
3. Instances of more than 5 ultrasound procedures billed to the same patient on the same date of service.
4. More than five different providers billed for ultrasounds for a single beneficiary in one year.

The second and third problems highlight the importance of documenting medical necessity for each of your ultrasounds. It is not proper for a physician to be coding for a limited and a comprehensive study of the same area during the same encounter (ex. limited abdominal ultrasound 76705-26 and comprehensive abdominal ultrasound 76700-26). The report highlighted another combination of CPT codes for complete transabominal pelvic ultrasound (76856-26) and a transvaginal ultrasound (76817-26) for nonpregnant women. In the emergency setting, it is frequently medically necessary to code for both a transabdominal ultrasound and a transvaginal ultrasound on the same patient. For example, a pregnant woman with a positive pregnancy test and abdominal pain may have an indeterminate transabdominal ultrasound (76815-26) and may require a transvaginal ultrasound (76817-26) to determine the location of her pregnancy. The planned sequencing for every transabdominal ultrasound to be followed by a transvaginal ultrasound regardless of findings on the first study would not be appropriate. Again, every case has to be justified by medical necessity.

Although coding five ultrasound procedures would not be a common occurrence in the ED, it is feasible that it could occur. For example, a patient in traumatic shock may have five ultrasound procedures coded in one encounter: an extended FAST with three codes, a repeat focused abdominal scan for ongoing hypotension, and an ultrasound guided procedure such as vascular access. As stated throughout this document and the accompanying Coding and Reimbursement document, ultrasound codes need to be used judiciously and each code requires justification of medical necessity.