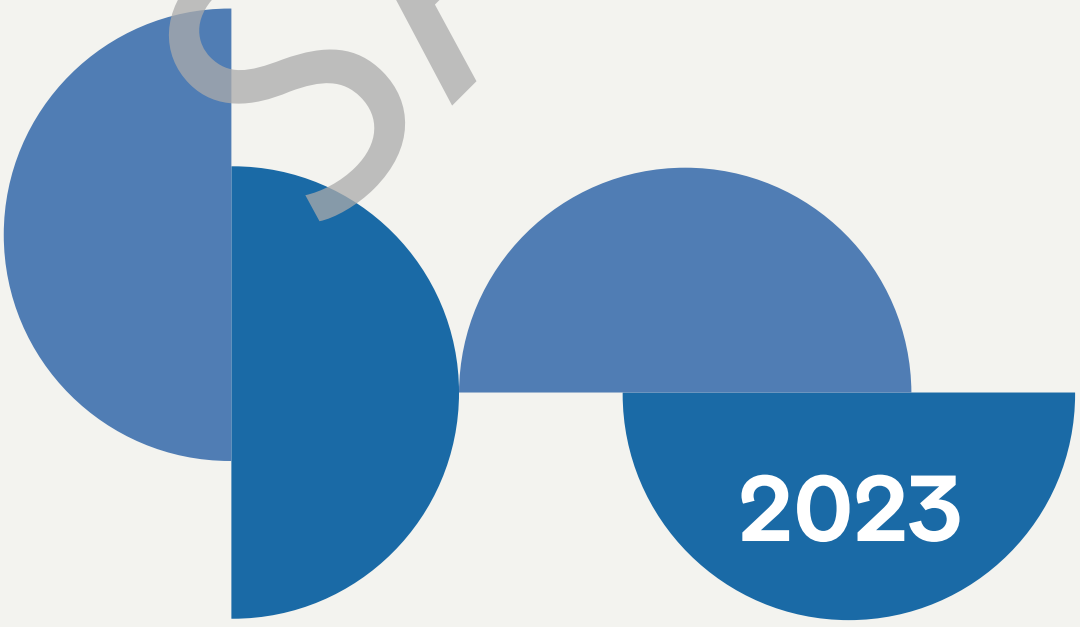
Optum

Coding Companion

Emergency Medicine/ Critical Care/ Infectious Disease

A comprehensive illustrated guide to coding and reimbursement



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Contents

Getting Started with Coding Companion

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

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

CPT Codes

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

Resequencing of CPT Codes

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

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

ICD-10-CM

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

Detailed Code Information

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

Appendix Codes and Descriptions

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

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

- HCPCS
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

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

CCI Edits and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 28.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The CCI edits are located in a section at the back of the book. As other CPT (including COVID-related vaccine and administration codes) and ICD-10-CM codes relevant to your specialty are released, updates will be posted to the Optum website. The website address is http://www.optumcoding.com/ProductUpdates/. The 2023 edition password is: **XXXXXX.** Log in frequently to ensure you receive the most current updates.

Index

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

65205 Removal of foreign body, external eye; conjunctival superficial

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

Conjunctiva
  Foreign Body Removal, 65205-65210
OR
Eye
  Removal
    Foreign Body
      Superficial, 65205
OR
Foreign Body
  Removal
    External Eye, 65205

General Guidelines

Providers

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

Supplies

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

Professional and Technical Component

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

12001-12007

12001 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less

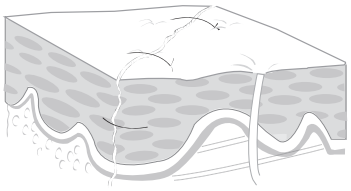
12002 2.6 cm to 7.5 cm

12004 7.6 cm to 12.5 cm

12005 12.6 cm to 20.0 cm

12006 20.1 cm to 30.0 cm

12007 over 30.0 cm



Example of a simple closure involving only one skin layer, the epidermis

Explanation

The physician performs wound closure of superficial lacerations of the scalp, neck, or trunk using sutures, staples, tissue adhesives, or a combination of these materials. A local anesthetic is injected around the wound and it is cleansed, explored, and often irrigated with a saline solution. The physician performs a simple, one-layer repair of the epidermis, dermis, or subcutaneous tissues. For multiple wounds of the same complexity and in the same anatomical area, the length of all wounds sutured is summed and reported as one total length. Report 12001 for a total length of 2.5 cm or less; 12002 for 2.6 cm to 7.5 cm; 12004 for 7.6 cm to 12.5 cm; 12005 for 12.6 cm to 20 cm; 12006 for 20.1 cm to 30 cm; and 12007 if the total length is greater than 30 cm.

Coding Tips

Wounds treated with tissue glue or staples qualify as a simple repair even if they are not closed with sutures. When chemical cauterization, electrocauterization, or adhesive strips are the only material used for wound closure, the service is included in the appropriate E/M code. Intermediate repair is used when layered closure of one or more of the deeper layers of subcutaneous tissue and superficial fascia, in addition to the skin, require closure. Intermediate repair is also reported for single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter. For extensive debridement of soft tissue and/or bone, not associated with open fractures and/or dislocations, resulting from penetrating and/or blunt trauma, see 11042–11047. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage. For wound closure by tissue adhesive(s) only, see HCPCS Level II code G0168.

ICD-10-CM Diagnostic Codes

S01.01XA Laceration without foreign body of scalp, initial encounter

S01.03XA Puncture wound without foreign body of scalp, initial encounter

S01.05XA Open bite of scalp, initial encounter

S11.81XA Laceration without foreign body of other specified part of neck, initial encounter

S11.83XA Puncture wound without foreign body of other specified part of neck, initial encounter

S11.89XA Other open wound of other specified part of neck, initial encounter

Associated HCPCS Codes

G0168 Wound closure utilizing tissue adhesive(s) only

AMA: **12001** 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2017,Dec,14; 2016, 2015,Jan,16 **12002** 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015, **12004** 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **12005** 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **12006** 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **12007** 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
12001	0.84	1.77	0.15	2.76
12002	1.14	1.99	0.21	3.34
12004	1.44	2.18	0.26	3.88
12005	1.97	2.84	0.38	5.19
12006	2.39	3.22	0.45	6.06
12007	2.9	3.42	0.58	6.9
Facility RVU	**Work**	**PE**	**MP**	**Total**
12001	0.84	0.31	0.15	1.3
12002	1.14	0.37	0.21	1.72
12004	1.44	0.44	0.26	2.14
12005	1.97	0.46	0.38	2.81
12006	2.39	0.59	0.45	3.43
12007	2.9	0.81	0.58	4.29

	FUD	Status	MUE	Modifiers				IOM Reference
12001	0	A	1(2)	51	N/A	N/A	N/A	None
12002	0	A	1(2)	51	N/A	N/A	N/A	
12004	0	A	1(2)	51	N/A	N/A	N/A	
12005	0	A	1(2)	51	N/A	N/A	N/A	
12006	0	A	1(2)	51	N/A	N/A	N/A	
12007	0	A	1(2)	51	N/A	62*	N/A	

* with documentation

Terms To Know

closure. Repairing an incision or wound by suture or other means.

epidermis. Outermost, nonvascular layer of skin that contains four to five differentiated layers depending on its body location: stratum corneum, lucidum, granulosum, spinosum, and basale.

injury. Harm or damage sustained by the body.

laceration. Tearing injury; a torn, ragged-edged wound.

superficial. On the skin surface or near the surface of any involved structure or field of interest.

suture. Numerous stitching techniques employed in wound closure.

1. CPT Codes and Descriptions

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

The following icons are used in *Coding Companion:*

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

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

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

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

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

2. Illustrations

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

3. Explanation

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

4. Coding Tips

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

5. ICD-10-CM Diagnostic Codes

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

- **N** Newborn: 0
- **P** Pediatric: 0-17
- **M** Maternity: 9-64
- **A** Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

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

6. Associated HCPCS Codes

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

7. AMA References

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

8. Relative Value Units/Medicare Edits

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

Relative Value Units

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

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

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs when the technical (modifier TC) or professional (modifier26) component of a procedure is provided.

Evaluation and Management Guidelines Common to All E/M Services

Information unique to this section is defined or identified below.

Classification of Evaluation and Management (E/M) Services

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

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

Definitions of Commonly Used Terms

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

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

New and Established Patient

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

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

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

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

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

Time

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

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

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

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

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

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

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

99202-99205

★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

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

Coding Tips

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

ICD-10-CM Diagnostic Codes

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

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

Relative Value Units/Medicare Edits

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

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

* with documentation

Terms To Know

new patient. Patient who is receiving face-to-face care from a provider/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice for the first time in three years. For OPPS hospitals, a patient who has not been registered as an inpatient or outpatient, including off-campus provider based clinic or emergency department, within the past three years.

99218-99220

99218 Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.

99219 Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.

99220 Initial observation care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.

Explanation

Initial hospital observation service codes describe the first visit of the patient's admission for hospital outpatient observation care by the supervising qualified clinician. Hospital outpatient observation status includes the supervision of the care plan for observation as well as periodic reassessments. The patient is not required to be physically located in a designated observation area within a hospital; however, if such an area is utilized, these codes should be reported. When a patient is admitted to observation status during the course of another encounter from a different site of service, such as the physician's office, a nursing home, or the emergency department, all of the E/M services rendered by the supervising clinician as part of the observation status are considered part of the initial observation care services when they are performed on the same day; the level of initial observation code reported by the clinician should incorporate the other services related to the hospital outpatient observation admission that were provided in any other sites of services as well as those provided in the actual observation setting. Codes are reported per day and do not differentiate between new or established patients. Under the initial observation care category, there are three levels represented by 99218, 99219, and 99220. These levels require all three key components to be documented. The lowest level of care within this category, 99218, requires a detailed or comprehensive history and exam as well as straightforward or low complexity medical decision making (MDM) with approximately 30 minutes time being spent at the patient's bedside and on the patient's floor or unit. For the mid-level and highest level observation care codes, a comprehensive history and examination are required. Medical decision making is the differentiating factor for these two levels. For moderate complexity, report 99219. For observation care requiring MDM of high complexity, report 99220. The clinician typically spends 50 (99219) to 70 (99220) minutes at the patient's bedside or on the unit accordingly.

Coding Tips

These codes are used to report initial hospital outpatient observation services. All three key components (history, exam, and medical decision making) must be met or exceeded for the level of service selected. Time may be used to select the level of service when counseling and coordination of care are documented as at least half of the time spent face-to-face with the patient. All evaluation and management services provided by the clinician leading up to the initiation of the observation status are part of the patient's initial observation care when performed on the same date of service. The designation of "observation status" refers to the initiation of observation care and not to a specific area of the facility. CPT guidelines indicate these services are reported only by the admitting/supervising provider; all other providers should report 99224-99226 or 99241-99245. Medicare and some payers may allow providers of different specialties to report initial hospital services and require the admitting/supervising provider to append modifier AI. For observation discharge on a different date of service than the admission, see 99217. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. Medicare has provisionally identified these codes as telehealth/telemedicine services. Current Medicare coverage guidelines, including place of service, should be reviewed. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

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

AMA: **99218** 2020,Sep,3; 2019,Jul,10; 2018,Jan,8; 2018,Dec,8; 2018,Dec,8; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Mar,3; 2015,Jul,3; 2015,Jan,16; 2015,Dec,3 **99219** 2020,Sep,3; 2019,Jul,10; 2018,Jan,8; 2018,Dec,8; 2018,Dec,8; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Jul,3; 2015,Jan,16; 2015,Dec,3 **99220** 2020,Sep,3; 2019,Jul,10; 2018,Jan,8; 2018,Dec,8; 2018,Dec,8; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Jul,3; 2015,Jan,16; 2015,Dec,3

Relative Value Units/Medicare Edits

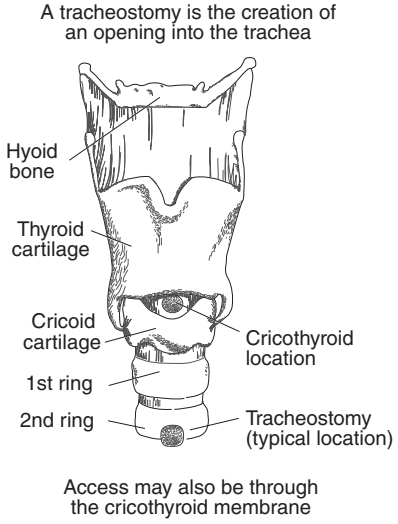
Non-Facility RVU	Work	PE	MP	Total
99218	1.92	0.74	0.16	2.82
99219	2.6	1.05	0.2	3.85
99220	3.56	1.4	0.25	5.21
Facility RVU	**Work**	**PE**	**MP**	**Total**
99218	1.92	0.74	0.16	2.82
99219	2.6	1.05	0.2	3.85
99220	3.56	1.4	0.25	5.21

	FUD	Status	MUE	Modifiers				IOM Reference
99218	N/A	A	1(2)	N/A	N/A	N/A	80*	100-04,12,100
99219	N/A	A	1(2)	N/A	N/A	N/A	80*	
99220	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

31603-31605

31603 Tracheostomy, emergency procedure; transtracheal
31605 cricothyroid membrane



Explanation

The physician creates a tracheostomy. The physician makes a horizontal neck incision and dissects the muscles to expose the trachea. The thyroid isthmus is cut if necessary. The trachea is incised and an airway is inserted. After bleeding is controlled, a stoma is created by suturing the skin to the tissue layers. In 31603, it is performed under emergency conditions by puncturing the trachea and inserting a cannula. In 31605, it is performed under emergency conditions by puncturing the cricothyroid membrane located just above the cricoid and inserting a cannula. This is not a true tracheostomy and is usually converted to a tracheostomy once the situation is no longer emergent.

Coding Tips

For endotracheal intubation, see 31500. For tracheal aspiration under direct vision, see 31515.

ICD-10-CM Diagnostic Codes

J80	Acute respiratory distress syndrome
J95.821	Acute postprocedural respiratory failure
J95.822	Acute and chronic postprocedural respiratory failure
J96.01	Acute respiratory failure with hypoxia
J96.02	Acute respiratory failure with hypercapnia
J96.21	Acute and chronic respiratory failure with hypoxia
J96.22	Acute and chronic respiratory failure with hypercapnia
P22.0	Respiratory distress syndrome of newborn N
P27.1	Bronchopulmonary dysplasia originating in the perinatal period
P28.5	Respiratory failure of newborn N
R06.03	Acute respiratory distress
S11.012A	Laceration with foreign body of larynx, initial encounter
S11.014A	Puncture wound with foreign body of larynx, initial encounter
S11.015A	Open bite of larynx, initial encounter
S11.032A	Laceration with foreign body of vocal cord, initial encounter
S17.0XXA	Crushing injury of larynx and trachea, initial encounter
T17.310A	Gastric contents in larynx causing asphyxiation, initial encounter
T17.320A	Food in larynx causing asphyxiation, initial encounter
T17.410A	Gastric contents in trachea causing asphyxiation, initial encounter
T17.420A	Food in trachea causing asphyxiation, initial encounter
T27.0XXA	Burn of larynx and trachea, initial encounter
T27.1XXA	Burn involving larynx and trachea with lung, initial encounter
T27.4XXA	Corrosion of larynx and trachea, initial encounter
T27.5XXA	Corrosion involving larynx and trachea with lung, initial encounter

AMA: **31603** 2020,Dec,11; 2017,Apr,5 **31605** 2017,Apr,5

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
31603	6.0	2.34	1.03	9.37
31605	6.45	2.02	1.26	9.73
Facility RVU	**Work**	**PE**	**MP**	**Total**
31603	6.0	2.34	1.03	9.37
31605	6.45	2.02	1.26	9.73

	FUD	Status	MUE	Modifiers				IOM Reference
31603	0	A	1(2)	51	N/A	N/A	N/A	None
31605	0	A	1(2)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

cricoid. Circular cartilage around the trachea.

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

stoma. Opening created in the abdominal wall from an internal organ or structure for diversion of waste elimination, drainage, and access.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

A suspension of the prevalent strain of influenza virus that has been derived from cell cultures is prepared for intramuscular use. Cell culture-derived vaccines are those in which the virus is grown in mammalian cells rather than egg-derived. The vaccine provides active immunity to the highly contagious infection of the respiratory tract caused by a myxovirus and transmitted by airborne droplet infection. This vaccine (ccIIV4) is preservative and antibiotic-free. This code reports a subunit in a .50 mL dose and should be reported with the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90674	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90674	0.0	0.0	0.0	0.0

90732

90732 Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use

Explanation

This code reports supply of a vaccine only. A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of these antibody production patterns for long-term protection. This code reports a pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, for subcutaneous or intramuscular administration to patients 2 years of age or older. Report this code with the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90732	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90732	0.0	0.0	0.0	0.0

93000-93010

93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93005 tracing only, without interpretation and report
93010 interpretation and report only

Explanation

Multiple electrodes are placed on a patient's chest to record the electrical activity of the heart. A physician interprets the findings. Report 93000 for the combined technical and professional components of an ECG; 93005 for the technical component only; and 93010 for the professional component only.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
93000	0.17	0.24	0.02	0.43
93005	0.0	0.18	0.01	0.19
93010	0.17	0.06	0.01	0.24
Facility RVU	**Work**	**PE**	**MP**	**Total**
93000	0.17	0.24	0.02	0.43
93005	0.0	0.18	0.01	0.19
93010	0.17	0.06	0.01	0.24

93015-93018

93015 Cardiovascular stress test using maximal or submaximal treadmill or bicycle exercise, continuous electrocardiographic monitoring, and/or pharmacological stress; with supervision, interpretation and report
93016 supervision only, without interpretation and report
93017 tracing only, without interpretation and report
93018 interpretation and report only

Explanation

A continuous recording of electrical activity of the heart is acquired by an assistant supervised by a qualified health care professional while the patient is exercising on a treadmill or bicycle and/or given medicines. The stress on the heart during the test is monitored. Code 93015 includes the test, supervision, and interpretation of the report; 93016 includes only the supervision of the test; 93017 includes performing the test only; and 93018 is reported for the interpretation of a previously performed test.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
93015	0.75	1.26	0.05	2.06
93016	0.45	0.16	0.02	0.63
93017	0.0	0.99	0.02	1.01
93018	0.3	0.11	0.01	0.42
Facility RVU	**Work**	**PE**	**MP**	**Total**
93015	0.75	1.26	0.05	2.06
93016	0.45	0.16	0.02	0.63
93017	0.0	0.99	0.02	1.01
93018	0.3	0.11	0.01	0.42

93024

93024 Ergonovine provocation test

Explanation

The purpose of the study is to evaluate for coronary artery spasm. If ergonovine is not available, certain other ergot medications may be infused for the same purpose. Following baseline coronary angiography (coded elsewhere), the physician infuses gradually escalating doses of ergonovine into a peripheral vein, while monitoring for chest discomfort and electrocardiographic changes. Repeat angiography is performed during ergonovine infusion to assess the size of the coronary lumen. If the patient develops symptomatic coronary spasm, the physician may directly infuse vasodilating medications through the intracoronary catheter to relieve the problem.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
93024	1.17	1.93	0.06	3.16
Facility RVU	**Work**	**PE**	**MP**	**Total**
93024	1.17	1.93	0.06	3.16

93025

93025 Microvolt T-wave alternans for assessment of ventricular arrhythmias

Explanation

T-Wave Alternans testing is an electrocardiographic method of measuring the alternating electrical amplitude from beat to beat on an electrocardiogram and is used as a method of evaluating ventricular arrhythmia risk. Microvolt T-wave alternans can be measured during exercise or pharmacologic stress, or during cardiac pacing, using a spectral analytic method with equipment that is able to

CPT Index

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● New ▲ Revised + Add On AMA: CPT Assist [Resequenced]