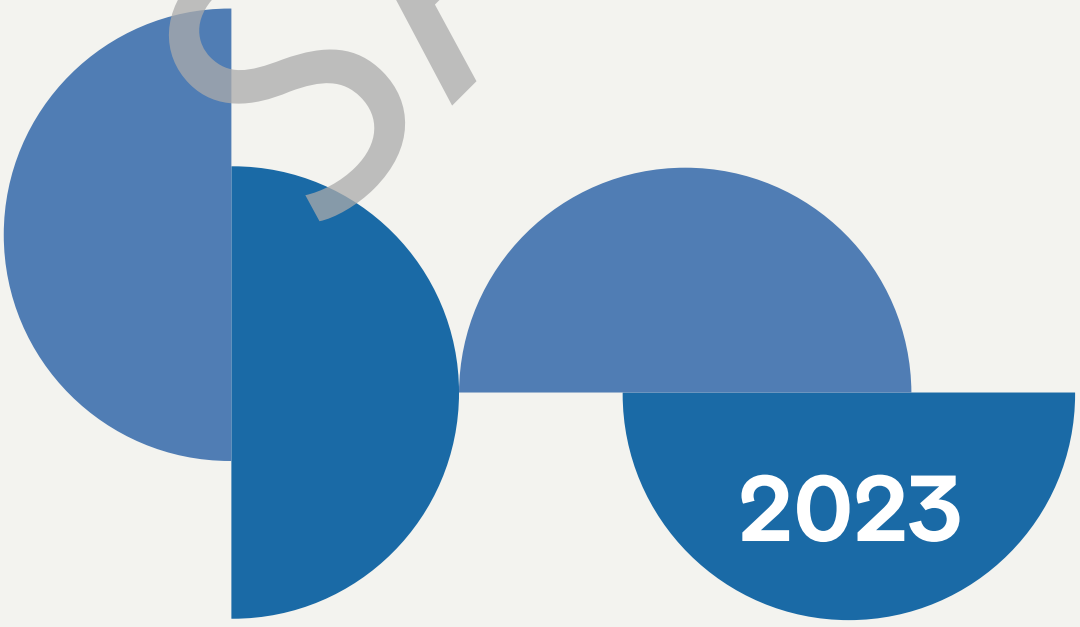
Optum

Coding Companion

Family Practice/ Pediatrics

A comprehensive illustrated guide to coding and reimbursement



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Contents

Getting Started with Coding Companion

Coding Companion for Family Practice/Pediatrics 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.

11055-11057

11055 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
11056 2 to 4 lesions
11057 more than 4 lesions

Depiction of a single corn-like lesion on a common location of the foot

Explanation

The physician removes a benign hyperkeratotic skin lesion such as a corn or callus by cutting, clipping, or paring. Report 11055 when one lesion is removed; 11056 when two to four lesions are removed; and 11057 when more than four lesions are removed.

Coding Tips

Routine foot care, which includes the paring or cutting of corns and calluses, is not covered by Medicare unless the patient suffers from a condition that puts him/her at risk when these services are performed by a nonprofessional. Medicare requires the use of specific HCPCS Level II modifiers Q7–Q9 to indicate clinical findings indicative of severe peripheral involvement warranting the medical necessity of providing foot care, such as nail debridement or trimming, that would usually be considered routine and for which benefits would not be provided. For destruction of a benign or a premalignant lesion, see 17000–17111. For a routine E/M service and foot care of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), see G0245–G0246. For diabetic foot care including debridement of corns and calluses, see G0247. Some non-Medicare payers may require that HCPCS Level II code S0390 be reported for this service when provided as routine foot care or as preventive maintenance in specific medical conditions. It is inappropriate to report supplies when these services are performed in an emergency room. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

L11.0 Acquired keratosis follicularis
L84 Corns and callosities
L85.1 Acquired keratosis [keratoderma] palmaris et plantaris
L85.2 Keratosis punctata (palmaris et plantaris)
L86 Keratoderma in diseases classified elsewhere
L87.0 Keratosis follicularis et parafollicularis in cutem penetrans
Q82.8 Other specified congenital malformations of skin

Associated HCPCS Codes

G0247 Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include the local care of superficial wounds (i.e., superficial to muscle and fascia) and at least the following, if present: (1) local care of superficial wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails

AMA: **11055** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **11056** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **11057** 2018,Jan,8; 2017 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11055	0.35	1.66	0.04	2.05
11056	0.5	1.81	0.04	2.35
11057	0.65	1.88	0.05	2.58
Facility RVU	**Work**	**PE**	**MP**	**Total**
11055	0.35	0.08	0.04	0.47
11056	0.5	0.11	0.04	0.65
11057	0.65	0.14	0.05	0.84

	FUD	Status	MUE	Modifiers				IOM Reference
11055	0	R	1(2)	51	N/A	N/A	N/A	None
11056	0	R	1(2)	51	N/A	N/A	N/A	
11057	0	R	1(2)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

benign. Mild or nonmalignant in nature.

callosities. Localized, hardened patches of overgrowth on the epidermis caused by friction or pressure.

diabetes mellitus. Endocrine disease manifested by high blood glucose levels and resulting in the inability to successfully metabolize carbohydrates, proteins, and fats, due to defects in insulin production and secretion, insulin action, or both.

keratoderma. Excessive growth of a horny, callous layer on the skin in three typical patterns: diffused over the palm and sole, focal with large keratin masses at points of friction, and punctate with tiny drops of keratin on the palmoplantar surface.

keratosis. Skin condition characterized by a wart-like or callus-type localized overgrowth, hardening, or thickening of the upper skin layer as a result of overproduction of the protein keratin.

noncovered procedure. Health care treatment not reimbursable according to provisions of a given insurance policy, or in the case of Medicare, in accordance with Medicare laws and regulations.

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.

 ● New ▲ Revised + Add On ★ Telemedicine AMA: CPT Assist [Resequenced] ☑ Laterality

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: **99366** 2018,Jan,8; 2018,Apr,9; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **99367** 2019,Dec,14; 2018,Jan,8; 2018,Apr,9; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **99368** 2018,Jan,8; 2018,Apr,9; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99366	0.82	0.35	0.06	1.23
99367	1.1	0.43	0.09	1.62
99368	0.72	0.28	0.05	1.05
Facility RVU	**Work**	**PE**	**MP**	**Total**
99366	0.82	0.32	0.06	1.2
99367	1.1	0.43	0.09	1.62
99368	0.72	0.28	0.05	1.05

	FUD	Status	MUE	Modifiers				IOM Reference
99366	N/A	B	0(3)	N/A	N/A	N/A	N/A	100-02,15,230.4; 100-04,11,40.1.3
99367	N/A	B	0(3)	N/A	N/A	N/A	N/A	
99368	N/A	B	0(3)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

interdisciplinary care. Two or more health care professions working in a collaborative manner for the benefit of the patient.

other qualified health care professional. Individual who is qualified by education, training, licensure/regulation, and facility privileging to perform a professional service within his or her scope of practice and independently (or as incident-to) report the professional service without requiring physician supervision. Payers may state exemptions in writing or state and local regulations may not follow this definition for performance of some services. Always refer to any relevant plan policies and federal and/or state laws to determine who may perform and report services.

99381-99387

99381 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; infant (age younger than 1 year)
99382 early childhood (age 1 through 4 years)
99383 late childhood (age 5 through 11 years)
99384 adolescent (age 12 through 17 years)
99385 18-39 years
99386 40-64 years
99387 65 years and older

Explanation

Initial preventive medicine services are typically well-patient examinations for new patients with code selection dependent upon the patient's age. These services include applicable patient history and examination, guidance/recommendation regarding personal risk factors, and any laboratory and/or diagnostic procedures ordered. Clinicians are not required to report minor or self-limiting problems or complaints noted during the course of the preventive examination when those problems do not require any additional work or necessitate performing the key components of a problem oriented E/M service. Report 99381 for infants younger than 1 year of age; 99382 for children 1 to 4 years of age; 99383 for children 5 to 11 years of age; 99384 for adolescents12 to 17 years of age; 99385 for adult patients 18 to 39 years of age; 99386 for patients 40 to 64 years of age; and 99387 for patients 65 years of age and older.

Coding Tips

These codes are used to report preventive medicine services for a new patient. Time is not a factor when selecting this E/M service. Code selection is determined based on whether the patient is new or established and the age of the patient. When documentation supports that a significant, separately identifiable problem-oriented evaluation and management (E/M) service is rendered, the appropriate code for the E/M service may be reported separately. Append modifier 25 to the service code selected to indicate that a separately identifiable E/M service was provided on the same date of service as the preventive medicine service. Immunizations and ancillary services, including laboratory, radiology, or screening tests, performed at the time of the preventive service may be reported separately. Preventive medicine services are not covered by Medicare. For preventive services provided to an established patient, see 99391-99397.

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: **99381** 2018,Jan,8; 2017,Jan,8; 2016,Mar,8; 2016,Jan,13; 2015,Jan,16 **99382** 2018,Jan,8; 2017,Jan,8; 2016,Mar,8; 2016,Jan,13; 2015,Jan,16 **99383** 2018,Jan,8; 2017,Jan,8; 2016,Mar,8; 2016,Jan,13; 2015,Jan,16 **99384** 2018,Jan,8; 2017,Jan,8; 2016,Mar,8; 2016,Jan,13; 2015,Jan,12; 2015,Jan,16 **99385** 2018,Jan,8; 2017,Jan,8; 2016,Mar,8; 2016,Jan,13; 2015,Jan,12; 2015,Jan,16 **99386** 2018,Jan,8; 2017,Jan,8; 2016,Mar,8; 2016,Jan,13; 2015,Jan,12; 2015,Jan,16 **99387** 2018,Jan,8; 2017,Jan,8; 2016,Mar,8; 2016,Jan,13; 2015,Jan,16

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

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99381	1.5	1.59	0.13	3.22
99382	1.6	1.63	0.13	3.36
99383	1.7	1.65	0.14	3.49
99384	2.0	1.76	0.16	3.92
99385	1.92	1.74	0.15	3.81
99386	2.33	1.89	0.19	4.41
99387	2.5	2.07	0.21	4.78
Facility RVU	**Work**	**PE**	**MP**	**Total**
99381	1.5	0.58	0.13	2.21
99382	1.6	0.62	0.13	2.35
99383	1.7	0.66	0.14	2.5
99384	2.0	0.77	0.16	2.93
99385	1.92	0.74	0.15	2.81
99386	2.33	0.9	0.19	3.42
99387	2.5	0.97	0.21	3.68

	FUD	Status	MUE	Modifiers				IOM Reference
99381	N/A	N	0(3)	N/A	N/A	N/A	N/A	100-04,12,30.6.2; 100-04,12,30.6.4
99382	N/A	N	0(3)	N/A	N/A	N/A	N/A	
99383	N/A	N	0(3)	N/A	N/A	N/A	N/A	
99384	N/A	N	0(3)	N/A	N/A	N/A	N/A	
99385	N/A	N	0(3)	N/A	N/A	N/A	N/A	
99386	N/A	N	0(3)	N/A	N/A	N/A	N/A	
99387	N/A	N	0(3)	N/A	N/A	N/A	N/A	

* 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.

preventive medicine service. Evaluation and management service provided as a periodic health screening and/or prophylactic service that does not typically include management of new or existing diagnoses or problems.

99391-99397

99391 Periodic comprehensive preventive medicine reevaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient; infant (age younger than 1 year)
99392 early childhood (age 1 through 4 years)
99393 late childhood (age 5 through 11 years)
99394 adolescent (age 12 through 17 years)
99395 18-39 years
99396 40-64 years
99397 65 years and older

Explanation

Periodic comprehensive preventive medicine services are typically well-patient examinations for established patients presenting for reevaluations and/or management of overall health condition with code selection dependent upon the patient's age. These services include applicable patient history and examination, guidance/recommendation regarding personal risk factors, and any laboratory and/or diagnostic procedures ordered. Clinicians are not required to report minor or self-limiting problems or complaints noted during the course of the preventive examination when those problems do not require any additional work or necessitate performing the key components of a problem oriented E/M service. Report 99391 for infants younger than 1 year of age; 99392 for children 1 to 4 years of age; 99393 for children 5 to 11 years of age; 99394 for adolescents12 to 17 years of age; 99395 for adult patients 18 to 39 years of age; 99396 for patients 40 to 64 years of age; and 99397 for patients 65 years of age and older.

Coding Tips

These codes are used to report preventive medicine services for an established patient. Time is not a factor when selecting this E/M service. Code selection is determined based on whether the patient is new or established and the age of the patient. When documentation supports that a significant, separately identifiable problem-oriented evaluation and management (E/M) service is rendered, the appropriate code for the E/M service may be reported separately. Append modifier 25 to the service code selected to indicate that a separately identifiable E/M service was provided on the same date of service as the preventive medicine service. Immunizations and ancillary services, including laboratory, radiology, or screening tests, performed at the time of the preventive service may be reported separately. Preventive medicine services are not covered by Medicare. For preventive services provided to a new patient, see 99381-99387.

ICD-10-CM Diagnostic Codes

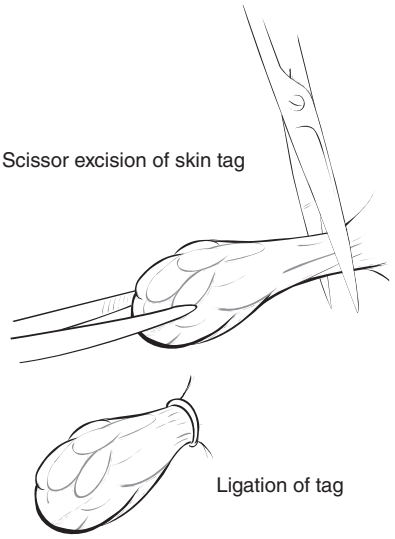
The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99391** 2018,Jan,8; 2017,Jan,8; 2016,Mar,8; 2016,Jan,13; 2015,Jan,16 **99392** 2018,Jan,8; 2017,Jan,8; 2016,Mar,8; 2016,Jan,13; 2015,Jan,16 **99393** 2018,Jan,8; 2017,Jan,8; 2016,Mar,8; 2016,Jan,13; 2015,Jan,16 **99394** 2018,Jan,8; 2017,Jan,8; 2016,Mar,8; 2016,Jan,13; 2015,Jan,12; 2015,Jan,16 **99395** 2018,Jan,8; 2017,Jan,8; 2016,Mar,8; 2016,Jan,13; 2015,Jan,16; 2015,Jan,12 **99396** 2018,Jan,8; 2017,Sep,11; 2017,Jan,8; 2016,Mar,8; 2016,Jan,13; 2015,Jan,16; 2015,Jan,12 **99397** 2018,Jan,8; 2017,Jan,8; 2016,Mar,8; 2016,Jan,13; 2015,Jan,16

11200-11201

11200 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

\+ **11201** each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)



Explanation

The physician removes skin tag lesions. Skin tags are common benign tumors found on many body regions, most frequently around the axillae, inguinal area, head, and neck. The physician uses sharp excision with scissors or scalpel, chemical cautery, electrical cautery, ligature strangulation, or any combination of these methods. Report 11200 for up to 15 lesions and 11201 for each additional 10 lesions, or part thereof, beyond the initial 15.

Coding Tips

Report 11201 in addition to 11200. For excision of benign lesions, other than skin tags, see 11400–11446. It is inappropriate to report supplies when these services are performed in an emergency room. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

L91.8	Other hypertrophic disorders of the skin
L91.9	Hypertrophic disorder of the skin, unspecified
N90.89	Other specified noninflammatory disorders of vulva and perineum ♀
Q17.0	Accessory auricle
Q82.6	Congenital sacral dimple
Q82.8	Other specified congenital malformations of skin

AMA: **11200** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **11201** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11200	0.82	1.72	0.09	2.63
11201	0.29	0.21	0.04	0.54
Facility RVU	**Work**	**PE**	**MP**	**Total**
11200	0.82	1.27	0.09	2.18
11201	0.29	0.15	0.04	0.48

	FUD	Status	MUE	Modifiers				IOM Reference
11200	10	A	1(2)	51	N/A	N/A	N/A	None
11201	N/A	A	1(3)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

anomaly. Irregularity in the structure or position of an organ or tissue.

atrophy. Reduction in size or activity in an anatomic structure, due to wasting away from disease or other factors.

benign. Mild or nonmalignant in nature.

cauterization. Tissue destruction by means of a hot instrument, an electric current, or a caustic chemical.

cautery. Destruction or burning of tissue by means of a hot instrument, an electric current, or a caustic chemical, such as silver nitrate.

congenital. Present at birth, occurring through heredity or an influence during gestation up to the moment of birth.

excision. Surgical removal of an organ or tissue.

hypertrophic. Enlarged or overgrown from an increase in cell size of the affected tissue.

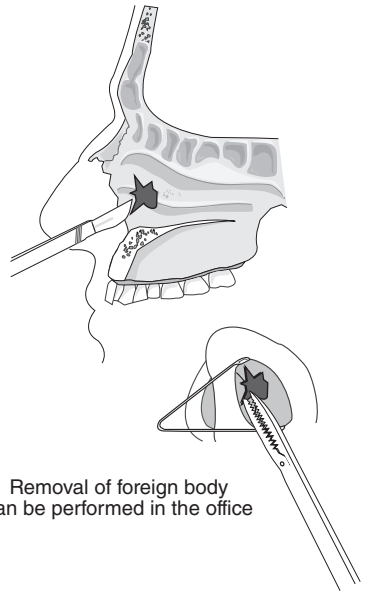
lesion. Area of damaged tissue that has lost continuity or function, due to disease or trauma. Lesions may be located on internal structures such as the brain, nerves, or kidneys, or visible on the skin.

ligation. Tying off a blood vessel or duct with a suture or a soft, thin wire.

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

30300

30300 Removal foreign body, intranasal; office type procedure



Explanation

The physician removes a foreign body from inside the nasal cavity in the office setting. Foreign bodies are defined as objects not normally found in the body. An object may be embedded in normal tissue as a result of some type of trauma. Topical vasoconstrictive agents and local anesthesia are applied to the nasal mucosa. A small incision may be necessary to access the foreign body. Blunt dissection and retrieval of the object is performed with hemostats or forceps. Sutures may close the mucosa in a single layer if the size of the dissection requires.

Coding Tips

Topical vasoconstrictive agents and local anesthesia are not reported separately. It is inappropriate to report supplies when these services are performed in an emergency room. For physician office, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

S01.22XA Laceration with foreign body of nose, initial encounter
S01.24XA Puncture wound with foreign body of nose, initial encounter
T17.0XXA Foreign body in nasal sinus, initial encounter
T17.1XXA Foreign body in nostril, initial encounter

AMA: **30300** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
30300	1.09	4.82	0.15	6.06
Facility RVU	**Work**	**PE**	**MP**	**Total**
30300	1.09	2.3	0.15	3.54

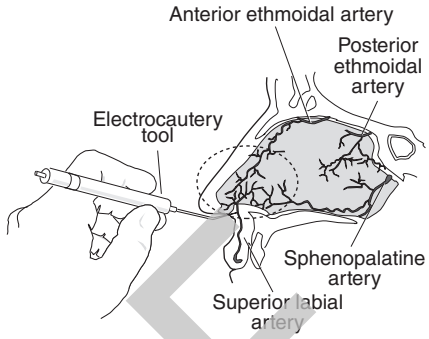
	FUD	Status	MUE	Modifiers				IOM Reference
30300	10	A	1(3)	51	N/A	N/A	N/A	None

* with documentation

30901-30903

30901 Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method

30903 Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method



Cautery and packing applied to anterior area

Explanation

To control a less serious nosebleed in 30901, the physician applies electrical or chemical coagulation or packing materials to the anterior (front) section of the nose. Only limited electrical or chemical coagulation is used. To control a less responsive nosebleed in 30903, the physician uses extensive electrical coagulation or extensive packing in the anterior (front) section of the nose.

Coding Tips

These are unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). Local anesthesia is included in these services. It is inappropriate to report supplies when these services are performed in an emergency room. For physician office, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

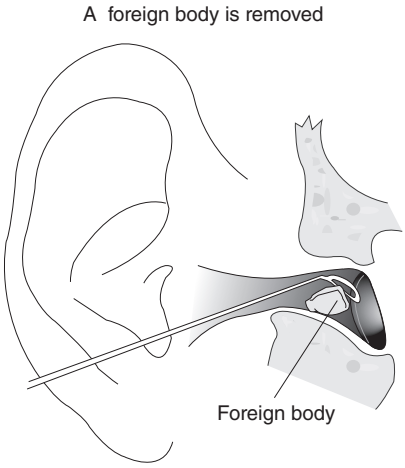
J95.61 Intraoperative hemorrhage and hematoma of a respiratory system organ or structure complicating a respiratory system procedure
J95.62 Intraoperative hemorrhage and hematoma of a respiratory system organ or structure complicating other procedure
J95.71 Accidental puncture and laceration of a respiratory system organ or structure during a respiratory system procedure
J95.72 Accidental puncture and laceration of a respiratory system organ or structure during other procedure
J95.830 Postprocedural hemorrhage of a respiratory system organ or structure following a respiratory system procedure
J95.831 Postprocedural hemorrhage of a respiratory system organ or structure following other procedure
R04.0 Epistaxis

AMA: **30901** 2020,Oct,13; 2020,Jul,13

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

69200

69200 Removal foreign body from external auditory canal; without general anesthesia



Explanation

Under direct visualization, the physician or technician removes a foreign body from the external auditory canal using delicate forceps, a cerumen spoon, or suction. In the case of a live insect, oil is dropped into the ear to immobilize it before it is removed. No local anesthetic is used.

Coding Tips

For removal of impacted cerumen, see 69210. For debridement of the mastoid cavity, see 69220 or 69222. Do not report these codes for removal of PE tubes. The removal of ventilating tubes is included in the charge for insertion, regardless of how long afterwards removal occurs. If ventilating tubes were removed by another physician, see 69424.

ICD-10-CM Diagnostic Codes

T16.1XXA Foreign body in right ear, initial encounter ☑

T16.2XXA Foreign body in left ear, initial encounter ☑

AMA: **69200** 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
69200	0.77	1.51	0.11	2.39
Facility RVU	**Work**	**PE**	**MP**	**Total**
69200	0.77	0.49	0.11	1.37

	FUD	Status	MUE	Modifiers				IOM Reference
69200	0	A	1(2)	51	50	N/A	N/A	None

* with documentation

Terms To Know

external auditory canal/meatus. External channel that leads from the opening in the external ear to the tympanic membrane (eardrum).

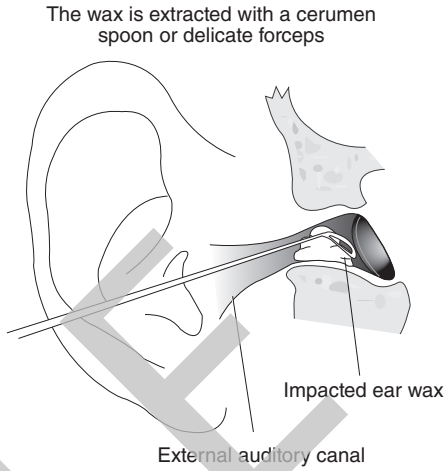
forceps. Tool used for grasping or compressing tissue.

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

69209-69210

69209 Removal impacted cerumen using irrigation/lavage, unilateral

69210 Removal impacted cerumen requiring instrumentation, unilateral



Explanation

Under direct visualization, the physician removes impacted cerumen (ear wax) using irrigation or lavage (69209), or via suction, a cerumen spoon, or delicate forceps (69210). A typical solution used for lavage is water and saline, warmed to body temperature to avoid causing dizziness, placed in the ear approximately 15 to 30 minutes prior to removal. When instrumentation is used and no infection is present, the ear canal may also be irrigated.

Coding Tips

These codes describe removal of cerumen impaction. Report unimpacted cerumen removal with the appropriate E/M service code. Do not report 69209 and 69210 together when performed on the same ear. These codes describe unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). Medicare allows only one unit of this code to be billed even if both ears are treated. Medicare and some other payers may require that HCPCS Level II code G0268 be reported for removal of impacted cerumen (one or both ears) by a physician on the same date of service as audiologic function testing. The removal of ventilating tubes is included in the charge for insertion, regardless of how long afterwards removal occurs. Code 69210 should not be reported for removal of PE tubes. For removal of a foreign body from the external auditory canal, without general anesthesia, see 69200; under general anesthesia, see 69205.

ICD-10-CM Diagnostic Codes

H61.21 Impacted cerumen, right ear ☑

H61.22 Impacted cerumen, left ear ☑

H61.23 Impacted cerumen, bilateral ☑

Associated HCPCS Codes

G0268 Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing

90284

90284 Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each

Explanation

This code identifies the human immune globulin for use in subcutaneous infusions (SCIg). An immune globulin is a passive immunization agent obtained from donated pooled human plasma. Passive immunity is achieved for a short period as the antibodies received through the immune globulin are circulated through the body. The recipient's immune system is not stimulated to build its own antibodies. Some patients have insufficient venous access or adverse reactions to intravenous treatments, making them unsuitable candidates for traditional IVIg therapy. Controlled doses of immune globulin are administered over a period of several hours through a small needle placed just under the skin. Report this code with the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90284	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90284	0.0	0.0	0.0	0.0

90296

90296 Diphtheria antitoxin, equine, any route

Explanation

This code identifies the diphtheria antitoxin, equine, administered by any route. The antitoxin is a passive immunizing agent derived from purified serum from previously immunized horses. The antibodies received through the antiserum are circulated through the body and neutralize toxins produced by Corynebacterium diphtheriae. Report this code with the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90296	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90296	0.0	0.0	0.0	0.0

90371

90371 Hepatitis B immune globulin (HBIg), human, for intramuscular use

Explanation

This code identifies the hepatitis B immune globulin (HBIg), human, for intramuscular use. This immune globulin is a passive immunization agent that gives protection against Hepatitis B and is obtained from donated, pooled human plasma. Passive immunity is achieved for a short period as the antibodies received through the immune globulin are circulated through the body. The recipient's immune system is not stimulated to build its own antibodies. Report this code with the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90371	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90371	0.0	0.0	0.0	0.0

90378

90378 Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each

Explanation

Code 90378 identifies the respiratory syncytial virus (RSV) recombinant monoclonal antibody for intramuscular use, 50 mg, each. This humanized monoclonal antibody (IgG) gives protection against the respiratory syncytial virus and is injected once a month during the RSV season. Passive immunity is achieved for a short period as the antibodies received are circulated through the body. The recipient's immune system is not stimulated to build its own antibodies. Report this code with the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90378	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90378	0.0	0.0	0.0	0.0

90384-90386

90384 Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use

90385 Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use

90386 Rho(D) immune globulin (RhIgIV), human, for intravenous use

Explanation

Code 90384 identifies the human Rho(D) immune globulin (RhIg) for intramuscular use, full-dose; 90385 is for a mini-dose. Code 90386 identifies the human Rho(D) immune globulin (RhIgIV) for intravenous use. This immune globulin is a passive immunization agent that gives protection against reactions between blood that is negative for the presence of Rh antigens on the surface of red blood cells to blood that is positive for the presence of Rh antigens on the RBC. Report these codes with the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90384	0.0	0.0	0.0	0.0
90385	0.0	0.0	0.0	0.0
90386	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90384	0.0	0.0	0.0	0.0
90385	0.0	0.0	0.0	0.0
90386	0.0	0.0	0.0	0.0

90389

90389 Tetanus immune globulin (TIg), human, for intramuscular use

Explanation

This code identifies a tetanus immune globulin (TIg), human, for intramuscular use. This immune globulin is a passive immunization agent that gives protection against tetanus and is obtained from donated, pooled human plasma. Passive immunity is achieved for a short period as the antibodies received through the immune globulin are circulated through the body. The recipient's immune system is not stimulated to build its own antibodies. Report this code with the appropriate administration code.

CPT Index

A

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