Optum

Coding Companion

Family Practice/ Pediatrics

A comprehensive illustrated guide to coding and reimbursement

2024

optumcoding.com

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/HCPCS Codes

For ease of use, evaluation and management codes related to family practice/pediatrics 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/HCPCS 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

The most current ICD-10-CM codes are provided, each listed with their full official description. 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.

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT code description, followed by an easy-to-understand explanation.

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, RVUs, HCPCS, 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 website address is http://www.optumcoding.com/ProductUpdates/. The 2024 edition password is: **XXXXX** 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.

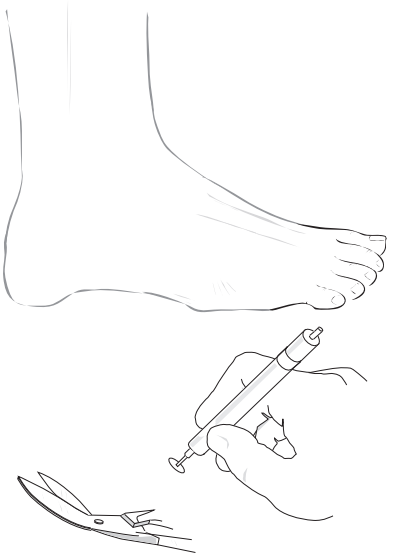
Sample Page and Key

The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

11720-11721

11720 Debridement of nail(s) by any method(s); 1 to 5
11721 6 or more

Nails are debrided using a number of methods



Explanation

The physician debrides fingernails or toenails, including tops and exposed undersides, by any method. The cleaning is performed manually with cleaning solutions, abrasive materials, and tools. The nails are shortened and shaped. Report 11720 for one to five nails and 11721 for six or more.

Coding Tips

For trimming of nondystrophic nails, see 11719. These codes are reported only once regardless of the number of nails that are trimmed. For the trimming of dystrophic nails, see G0127. 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. For diabetic patients with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), see G0247. 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 a podiatrist providing foot care, such as nail debridement or trimming, that would usually be considered routine and for which benefits would not be provided. 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

B35.1	Tinea unguium
B37.2	Candidiasis of skin and nail
L03.011	Cellulitis of right finger ☑
L03.012	Cellulitis of left finger ☑
L03.031	Cellulitis of right toe ☑
L03.032	Cellulitis of left toe ☑
L60.0	Ingrowing nail
L60.1	Onycholysis
L60.2	Onychogryphosis
L60.3	Nail dystrophy
L60.8	Other nail disorders
Q84.6	Other congenital malformations of nails

Associated HCPCS Codes

G0127	Trimming of dystrophic nails, any number

AMA: **11720** 2022,Feb; 2021,Aug **11721** 2022,Feb; 2021,Aug

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11720	0.32	0.6	0.04	0.96
11721	0.54	0.72	0.04	1.3
Facility RVU	**Work**	**PE**	**MP**	**Total**
11720	0.32	0.07	0.04	0.43
11721	0.54	0.12	0.04	0.7

	FUD	Status	MUE	Modifiers				IOM Reference
11720	0	A	1(2)	N/A	N/A	N/A	N/A	100-03,70.2.1
11721	0	A	1(2)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

candidiasis. Yeast infection caused by the fungus Candida albicans. It commonly occurs in the vagina, but affects any moist skin or mucus membrane.

debridement. Removal of dead or contaminated tissue and foreign matter from a wound.

onychia. Inflammation or infection of the nail matrix leading to a loss of the nail.

paronychia. Infection or cellulitis of nail structures.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS 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 audio-visual 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 93 or 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.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services, when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96160	96161	97802	97803	97804
99406	99407	99408	99409	99497	99498	

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.

The 2023 Medicare edits were not available at the time this book went to press. Updated 2023 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2023 edition password is **23SPECIALTY**.

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

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

▶The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service◀

Classification of Evaluation and Management (E/M) Services

▶The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care 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 inpatient and observation care 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 codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.◀

AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

New and Established Patients

▶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 evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

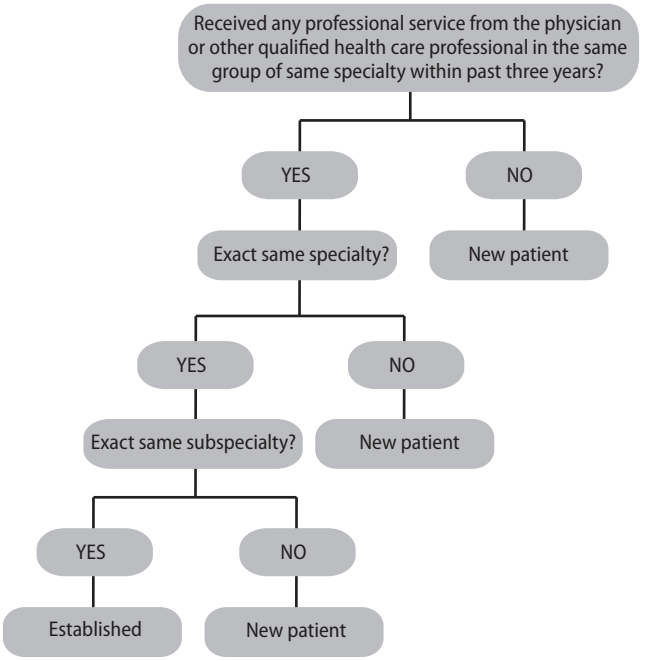
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other 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 subspecialty** 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 for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



▶ ◀ = Contains new or revised text

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 these E/M services. 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 vaccines including counseling when provided, 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 99384-99387.

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** 2022,Nov; 2022,Jul; 2021,Nov; 2021,Feb; 2021,Jan; 2019,Jul; 2016,Mar **99392** 2022,Nov; 2022,Jul; 2021,Nov; 2021,Feb; 2021,Jan; 2019,Jul; 2016,Mar **99393** 2022,Nov; 2022,Jul; 2021,Nov; 2021,Feb; 2021,Jan; 2019,Jul; 2016,Mar **99394** 2022,Nov; 2022,Jul; 2021,Nov; 2021,Feb; 2021,Jan; 2019,Jul; 2016,Mar **99395** 2022,Nov; 2022,Jul; 2021,Nov; 2021,Feb; 2021,Jan; 2019,Jul; 2016,Mar **99396** 2022,Nov; 2022,Jul; 2021,Nov; 2021,Feb; 2021,Jan; 2019,Jul; 2017,Sep; 2016,Mar **99397** 2022,Nov; 2022,Jul; 2021,Nov; 2021,Feb; 2021,Jan; 2019,Jul; 2016,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99391	1.37	1.42	0.11	2.9
99392	1.5	1.47	0.11	3.08
99393	1.5	1.46	0.11	3.07
99394	1.7	1.54	0.12	3.36
99395	1.75	1.56	0.12	3.43
99396	1.9	1.62	0.17	3.69
99397	2.0	1.79	0.18	3.97
Facility RVU	**Work**	**PE**	**MP**	**Total**
99391	1.37	0.53	0.11	2.01
99392	1.5	0.58	0.11	2.19
99393	1.5	0.58	0.11	2.19
99394	1.7	0.66	0.12	2.48
99395	1.75	0.68	0.12	2.55
99396	1.9	0.73	0.17	2.8
99397	2.0	0.77	0.18	2.95

	FUD	Status	MUE	Modifiers				IOM Reference
99391	N/A	N	0(3)	N/A	N/A	N/A	N/A	None
99392	N/A	N	0(3)	N/A	N/A	N/A	N/A	
99393	N/A	N	0(3)	N/A	N/A	N/A	N/A	
99394	N/A	N	0(3)	N/A	N/A	N/A	N/A	
99395	N/A	N	0(3)	N/A	N/A	N/A	N/A	
99396	N/A	N	0(3)	N/A	N/A	N/A	N/A	
99397	N/A	N	0(3)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

established patient. Patient who has received professional services in a face-to-face setting within the last three years from the same 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. If the patient is seen by a physician/qualified health care professional who is covering for another physician/qualified health care professional, the patient will be considered the same as if seen by the physician/qualified health care professional who is unavailable.

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.

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. 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. 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

B07.0 Plantar wart
B07.8 Other viral warts
L11.0 Acquired keratosis follicularis
L84 Corns and callosities
L85.1 Acquired keratosis [keratoderma] palmaris et plantaris
L85.2 Keratosis punctata (palmaris et plantaris)
L85.8 Other specified epidermal thickening
L85.9 Epidermal thickening, unspecified
L86 Keratoderma in diseases classified elsewhere
L87.0 Keratosis follicularis et parafollicularis in cutem penetrans
Q82.8 Other specified congenital malformations of skin

AMA: **11055** 2022,Feb **11056** 2022,Feb **11057** 2022,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11055	0.35	1.77	0.04	2.16
11056	0.5	1.93	0.04	2.47
11057	0.65	2.01	0.05	2.71
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.

callus. Tissue formation at the site of a fracture that establishes continuity between the fractured ends of the bone. The initial provisional callus, which is comprised of fibrous tissue and cartilage, is eventually absorbed and replaced by osseous tissue (definitive callus).

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.

hyperkeratosis. Thickening of the outer layer of the skin because of overproduction of the protein keratin.

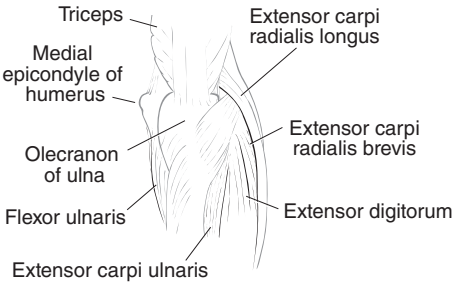
keratoderma. Excessive growth of a horny, callous layer on the skin in three typical patterns: diffused over the palm and sole, focal with large keratin masses at points of friction, and punctate with tiny drops of keratin on the palmoplantar surface.

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.

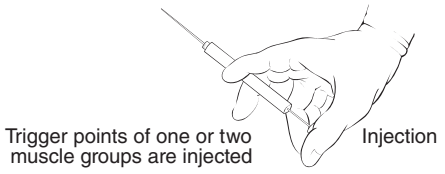
 N Newborn: 0 **P** Pediatric: 0-17 **M** Maternity: 9-64 **A** Adult: 15-124 ♂ Male Only ♀ Female Only

20552-20553

20552 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
20553 single or multiple trigger point(s), 3 or more muscles



Posterior view, right elbow, superficial dissection



Explanation

The physician injects a therapeutic agent into a single or multiple trigger point of one or two muscles in 20552 and into a single or multiple trigger point for three or more muscles in 20553. Trigger points are focal, discrete spots of hypersensitive irritability identified within bands of muscle. These points cause local or referred pain. Trigger points may be formed by acute or repetitive trauma to the muscle tissue, which puts too much stress on the fibers. The physician identifies the trigger point injection site by palpation or radiographic imaging and marks the injection site. The needle is inserted, and the medicine is injected into the trigger point. The injection may be done using image guidance, which is reported separately. After withdrawing the needle, the patient is monitored for reactions to the therapeutic agent. The injection procedure is repeated at the other trigger points for multiple sites.

Coding Tips

Local anesthesia is included in these services. If imaging guidance is performed, see 76942, 77002, and 77021. Do not report these codes in addition to 20560 or 20561 when the same muscles are being treated. 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

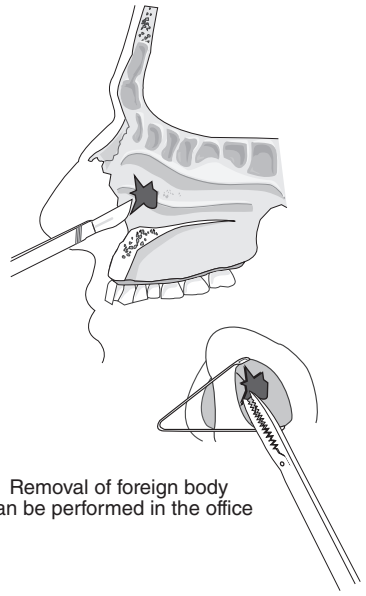
G44.211 Episodic tension-type headache, intractable
G44.219 Episodic tension-type headache, not intractable
G44.221 Chronic tension-type headache, intractable
G44.229 Chronic tension-type headache, not intractable
G89.0 Central pain syndrome
G89.11 Acute pain due to trauma
G89.12 Acute post-thoracotomy pain
G89.18 Other acute postprocedural pain
G89.21 Chronic pain due to trauma
G89.22 Chronic post-thoracotomy pain
G89.28 Other chronic postprocedural pain
G89.29 Other chronic pain
G89.4 Chronic pain syndrome
M25.511 Pain in right shoulder ☑
M25.521 Pain in right elbow ☑
M25.531 Pain in right wrist ☑
M25.541 Pain in joints of right hand ☑
M25.551 Pain in right hip ☑
M25.561 Pain in right knee ☑
M25.571 Pain in right ankle and joints of right foot ☑
M26.621 Arthralgia of right temporomandibular joint ☑
M54.2 Cervicalgia
M54.51 Vertebrogenic low back pain
M54.59 Other low back pain
M70.811 Other soft tissue disorders related to use, overuse and pressure, right shoulder ☑
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm ☑
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm ☑
M70.841 Other soft tissue disorders related to use, overuse and pressure, right hand ☑
M70.851 Other soft tissue disorders related to use, overuse and pressure, right thigh ☑
M70.861 Other soft tissue disorders related to use, overuse and pressure, right lower leg ☑
M70.871 Other soft tissue disorders related to use, overuse and pressure, right ankle and foot ☑
M72.2 Plantar fascial fibromatosis
M79.10 Myalgia, unspecified site
M79.11 Myalgia of mastication muscle
M79.12 Myalgia of auxiliary muscles, head and neck
M79.601 Pain in right arm ☑
M79.604 Pain in right leg ☑
M79.621 Pain in right upper arm ☑
M79.631 Pain in right forearm ☑
M79.641 Pain in right hand ☑
M79.644 Pain in right finger(s) ☑
M79.651 Pain in right thigh ☑
M79.661 Pain in right lower leg ☑
M79.671 Pain in right foot ☑
M79.674 Pain in right toe(s) ☑
M79.7 Fibromyalgia

AMA: **20552** 2022,Jul; 2021,Oct; 2020,Feb; 2018,Dec; 2017,Dec; 2017,Jun; 2017,May **20553** 2021,Oct; 2020,Feb; 2018,Dec; 2017,Jun; 2017,May

 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 the inside of 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. 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

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

Relative Value Units/Medicare Edits

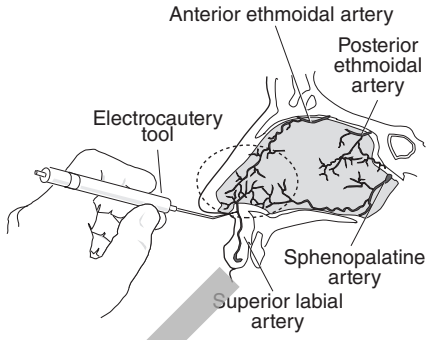
Non-Facility RVU	Work	PE	MP	Total
30300	1.09	5.11	0.14	6.34
Facility RVU	**Work**	**PE**	**MP**	**Total**
30300	1.09	2.47	0.14	3.7

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

* with documentation

30901

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



Cautery and packing applied to anterior area

Explanation

To control a less serious nosebleed, 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.

Coding Tips

This is a unilateral procedure. 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 this service. 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

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; 2020,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
30901	1.1	3.47	0.19	4.76
Facility RVU	**Work**	**PE**	**MP**	**Total**
30901	1.1	0.38	0.19	1.67

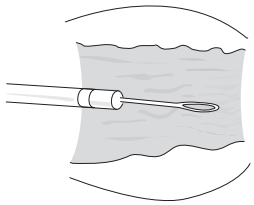
	FUD	Status	MUE	Modifiers				IOM Reference
30901	0	A	1(3)	51	50	N/A	N/A	None

* with documentation

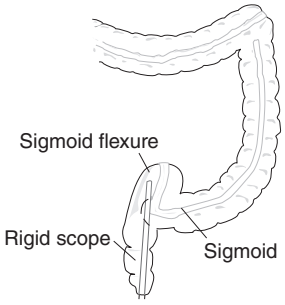
N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

45317

45317 Proctosigmoidoscopy, rigid; with control of bleeding (eg, injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, plasma coagulator)



Bleeding in the sigmoid and/or rectum is controlled using any of a variety of techniques



Explanation

The physician performs rigid proctosigmoidoscopy and controls an area of bleeding. The physician inserts the rigid proctosigmoidoscope into the anus and advances the scope. The sigmoid colon and rectal lumen are visualized and the area of bleeding is identified and controlled. A variety of methods can be used to control bleeding, including injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler, or plasma coagulator. The proctosigmoidoscope is removed at the completion of the procedure.

Coding Tips

Report the appropriate endoscopy for each anatomic site examined. Surgical endoscopy includes a diagnostic endoscopy; however, diagnostic endoscopy can be identified separately when performed at the same surgical session as an open procedure. For sigmoidoscopy, flexible, with control of bleeding, see 45334. For colonoscopy, flexible, with control of bleeding, see 45382. For anoscopy, with control of bleeding, see 46614. Bleeding that occurs as the result of an endoscopic procedure, and controlled during the same operative session, is not reported separately.

ICD-10-CM Diagnostic Codes

C18.7	Malignant neoplasm of sigmoid colon
C18.8	Malignant neoplasm of overlapping sites of colon
C19	Malignant neoplasm of rectosigmoid junction
C20	Malignant neoplasm of rectum
C21.8	Malignant neoplasm of overlapping sites of rectum, anus and anal canal
C7A.025	Malignant carcinoid tumor of the sigmoid colon
C7A.026	Malignant carcinoid tumor of the rectum
D01.0	Carcinoma in situ of colon
D01.1	Carcinoma in situ of rectosigmoid junction
D01.2	Carcinoma in situ of rectum
D01.3	Carcinoma in situ of anus and anal canal
D12.5	Benign neoplasm of sigmoid colon
D12.7	Benign neoplasm of rectosigmoid junction
D12.8	Benign neoplasm of rectum
D12.9	Benign neoplasm of anus and anal canal
D37.4	Neoplasm of uncertain behavior of colon
D37.5	Neoplasm of uncertain behavior of rectum
D3A.025	Benign carcinoid tumor of the sigmoid colon
D3A.026	Benign carcinoid tumor of the rectum
K50.111	Crohn's disease of large intestine with rectal bleeding
K50.811	Crohn's disease of both small and large intestine with rectal bleeding
K51.011	Ulcerative (chronic) pancolitis with rectal bleeding
K51.211	Ulcerative (chronic) proctitis with rectal bleeding
K51.311	Ulcerative (chronic) rectosigmoiditis with rectal bleeding
K51.411	Inflammatory polyps of colon with rectal bleeding
K51.511	Left sided colitis with rectal bleeding
K51.811	Other ulcerative colitis with rectal bleeding
K55.1	Chronic vascular disorders of intestine
K55.21	Angiodysplasia of colon with hemorrhage
K55.8	Other vascular disorders of intestine
K57.31	Diverticulosis of large intestine without perforation or abscess with bleeding
K57.33	Diverticulitis of large intestine without perforation or abscess with bleeding
K57.41	Diverticulitis of both small and large intestine with perforation and abscess with bleeding
K57.51	Diverticulosis of both small and large intestine without perforation or abscess with bleeding
K57.53	Diverticulitis of both small and large intestine without perforation or abscess with bleeding
K62.5	Hemorrhage of anus and rectum
K64.0	First degree hemorrhoids
K64.1	Second degree hemorrhoids
K64.2	Third degree hemorrhoids
K64.3	Fourth degree hemorrhoids
K64.8	Other hemorrhoids
K92.1	Melena
S31.831A	Laceration without foreign body of anus, initial encounter
S31.832A	Laceration with foreign body of anus, initial encounter
S31.833A	Puncture wound without foreign body of anus, initial encounter
S31.834A	Puncture wound with foreign body of anus, initial encounter
S36.63XA	Laceration of rectum, initial encounter

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
45317	1.9	4.53	0.27	6.7
Facility RVU	**Work**	**PE**	**MP**	**Total**
45317	1.9	1.07	0.27	3.24

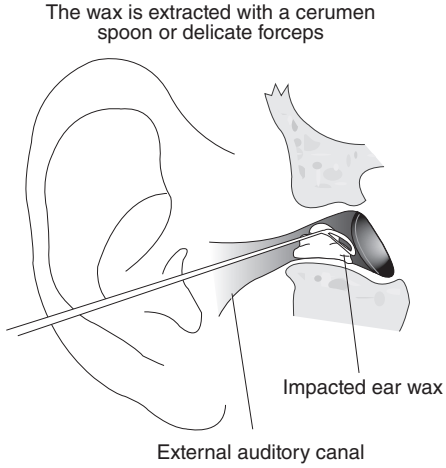
	FUD	Status	MUE	Modifiers				IOM Reference
45317	0	A	1(3)	51	N/A	N/A	N/A	None

* with documentation

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

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

AMA: **69209** 2016,Mar; 2016,Feb; 2016,Jan **69210** 2016,Mar; 2016,Feb; 2016,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
69209	0.0	0.44	0.01	0.45
69210	0.61	0.7	0.09	1.4
Facility RVU	**Work**	**PE**	**MP**	**Total**
69209	0.0	0.44	0.01	0.45
69210	0.61	0.27	0.09	0.97

	FUD	Status	MUE	Modifiers				IOM Reference
69209	0	A	1(2)	51	50	N/A	N/A	None
69210	0	A	1(2)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

cerumen. Wax-like substance secreted by the ceruminous glands in the external ear canal. If it becomes firm and blocks the ear canal it may interfere with hearing and require removal.

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.

impaction. State of being tightly wedged or lodged into or between something.

irrigation. To wash out or cleanse a body cavity, wound, or tissue with water or other fluid.

lavage. Washing.

suction. Vacuum evacuation of fluid or tissue.

[99421, 99422, 99423]

99421 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

99422 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes

99423 Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes

Explanation

Online medical evaluation services are non-face-to-face encounters originating from the established patient to the physician or other qualified health care professional for evaluation or management of a problem utilizing internet resources. The service includes all communication, prescription, and laboratory orders with permanent storage in the patient's medical record. The service may include more than one provider responding to the same patient and is only reportable once during seven days for the same encounter. Do not report these codes if the online patient request is related to an E/M service that occurred within the previous seven days or within the global period following a procedure. Report 99421 if the cumulative time during the seven-day period is five to 10 minutes; 99422 for 11 to 20 minutes; and 99423 for 21 or more minutes.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99421	0.25	0.17	0.02	0.44
99422	0.5	0.32	0.04	0.86
99423	0.8	0.53	0.07	1.4
Facility RVU	**Work**	**PE**	**MP**	**Total**
99421	0.25	0.11	0.02	0.38
99422	0.5	0.21	0.04	0.75
99423	0.8	0.34	0.07	1.21

[99453, 99454]

99453 Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment

99454 Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days

Explanation

A physician or other qualified health care professional orders an FDA-defined remote patient monitoring (RPM) device that is used by a patient for the purposes of collecting, monitoring, and reporting health-related data to the provider, including, but not limited to, weight, blood pressure, or pulse oximetry. This technology allows for the gathering of health data from the patient in one location and the electronic transmission of that data to a provider in a different location for review and subsequent recommendations, particularly in patients with ongoing and/or chronic disease processes. Code 99453 reports the work involved with orienting the patient to the RPM process, the initial device set-up, and patient instruction and training for each episode of care. An episode of care is described as starting at the time the RPM device service begins and is complete when the established treatment goal has been reached. Code 99454 reports the supply of the actual device including the daily recordings and program alert transmissions for a 30-day period. These codes should not be reported for monitoring if the duration is less than 16 days.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99453	0.0	0.54	0.01	0.55
99454	0.0	1.6	0.01	1.61
Facility RVU	**Work**	**PE**	**MP**	**Total**
99453	0.0	0.54	0.01	0.55
99454	0.0	1.6	0.01	1.61

[99091]

99091 Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days

Explanation

A physician or other qualified health care professional collects and interprets physiologic data. The data (e.g., blood pressure) is stored digitally and may be transmitted by the patient and/or the caregiver to the provider. The report should contain the time it took the provider to acquire the physiologic data, review and interpret the data, and modify any care plan due to the additional data acquisition. A minimum of 30 minutes every 30 days must be spent in the collection and interpretation of data to report this service.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99091	1.1	0.44	0.09	1.63
Facility RVU	**Work**	**PE**	**MP**	**Total**
99091	1.1	0.44	0.09	1.63

[99473, 99474]

99473 Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration

99474 Self-measured blood pressure using a device validated for clinical accuracy; separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient

Explanation

Self-measured blood pressure monitoring (SMBP) has been shown to be an effective approach to lowering blood pressure (BP), improving control in patients with hypertension, and increasing patient compliance with antihypertensive therapy. Also known as out-of-office BP measurement or home BP monitoring, the practice involves the use of devices that have been validated for clinical accuracy. Devices that measure blood pressure over the upper arm remain the most accurate choice compared to other available options, and remain the standard for proper BP measurement over finger, wrist, mobile health, and wearable devices. Report 99473 for patient education/training and device calibration. Report 99474 for separate self-measurements of two readings, one minute apart, twice daily over a 30-day period with a minimum of 12 readings. This includes collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with a report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient.

Correct Coding Initiative Update 28.3

❖Indicates Mutually Exclusive Edit

0732T No CCI edits apply to this code.

0740T No CCI edits apply to this code.

0741T No CCI edits apply to this code.

0743T No CCI edits apply to this code.

0749T No CCI edits apply to this code.

0750T No CCI edits apply to this code.

0001A 0591T-0593T, 36591-36592, 96160-96161, 96523, 99202-99215, 99241-99245, 99281-99285, 99381-99412, 99483, 99497, G0442-G0445, G0463

0002A 0591T-0593T, 36591-36592, 96160-96161, 96523, 99202-99215, 99241-99245, 99281-99285, 99381-99412, 99483, 99497, G0442-G0445, G0463

0003A No CCI edits apply to this code.

0004A No CCI edits apply to this code.

0011A No CCI edits apply to this code.

0012A No CCI edits apply to this code.

0013A No CCI edits apply to this code.

0021A 0591T-0593T, 36591-36592, 96160-96161, 96523, 99202-99215, 99241-99245, 99281-99285, 99381-99412, 99483, 99497, G0442-G0445, G0463

0022A 0591T-0593T, 36591-36592, 96160-96161, 96523, 99202-99215, 99241-99245, 99281-99285, 99381-99412, 99483, 99497, G0442-G0445, G0463

0031A 0591T-0593T, 36591-36592, 96160-96161, 96523, 99202-99215, 99241-99245, 99281-99285, 99381-99412, 99483, 99497, G0442-G0445, G0463

0034A No CCI edits apply to this code.

0041A 0591T-0593T, 36591-36592, 96160-96161, 96523, 99202-99215, 99241-99245, 99281-99285, 99381-99412, 99483, 99497, G0442-G0445, G0463

0042A 0591T-0593T, 36591-36592, 96160-96161, 96523, 99202-99215, 99241-99245, 99281-99285, 99381-99412, 99483, 99497, G0442-G0445, G0463

0044A No CCI edits apply to this code.

0051A No CCI edits apply to this code.

0052A No CCI edits apply to this code.

0053A No CCI edits apply to this code.

0054A No CCI edits apply to this code.

0064A No CCI edits apply to this code.

0071A No CCI edits apply to this code.

0072A No CCI edits apply to this code.

0073A No CCI edits apply to this code.

0074A No CCI edits apply to this code.

0081A No CCI edits apply to this code.

0082A No CCI edits apply to this code.

0083A No CCI edits apply to this code.

0091A No CCI edits apply to this code.

0092A No CCI edits apply to this code.

0093A No CCI edits apply to this code.

0094A No CCI edits apply to this code.

0104A No CCI edits apply to this code.

0111A No CCI edits apply to this code.

0112A No CCI edits apply to this code.

0113A No CCI edits apply to this code.

0124A No CCI edits apply to this code.

0134A No CCI edits apply to this code.

0144A No CCI edits apply to this code.

0154A No CCI edits apply to this code.

10004 0213T, 0216T, 10012, 10035, 19281, 19283, 19285, 19287, 36000, 36410, 36591-36592, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 76000, 76380❖, 76942, 76998, 77001-77002, 77012, 77021, 96360, 96365, 96372, 96374-96377, 96523, J2001

10005 0213T, 0216T, 10004, 10008, 10010-10012, 10021, 10035, 11102-11107, 19281, 19283, 19285, 19287, 36000, 36410, 36591-36592, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 76000, 76380❖, 76942, 76998, 77001-77002, 77012, 77021, 96360, 96365, 96372, 96374-96377, 96523, J2001

10006 0213T, 0216T, 10004, 10035, 19281, 19283, 19285, 19287, 36000, 36410, 36591-36592, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 76000, 76380❖, 76942, 76998, 77001-77002, 77012, 77021, 96360, 96365, 96372, 96374-96377, 96523, J2001

10007 0213T, 0216T, 10004-10006, 10010-10012, 10021, 10035, 11102-11107, 19281, 19283, 19285, 19287, 36000, 36410, 36591-36592, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 76000, 76380❖, 76942, 76998, 77001-77002, 77012, 77021, 96360, 96365, 96372, 96374-96377, 96523, J2001

10008 0213T, 0216T, 10004, 10021, 10035, 19281, 19283, 19285, 19287, 36000, 36410, 36591-36592, 61650, 62324-62327, 64415-64417, 64450, 64454, 64486-64490, 64493, 76000, 76380❖, 76942, 76998, 77001-77002, 77012, 77021, 96360, 96365, 96372, 96374-96377, 96523, J2001

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