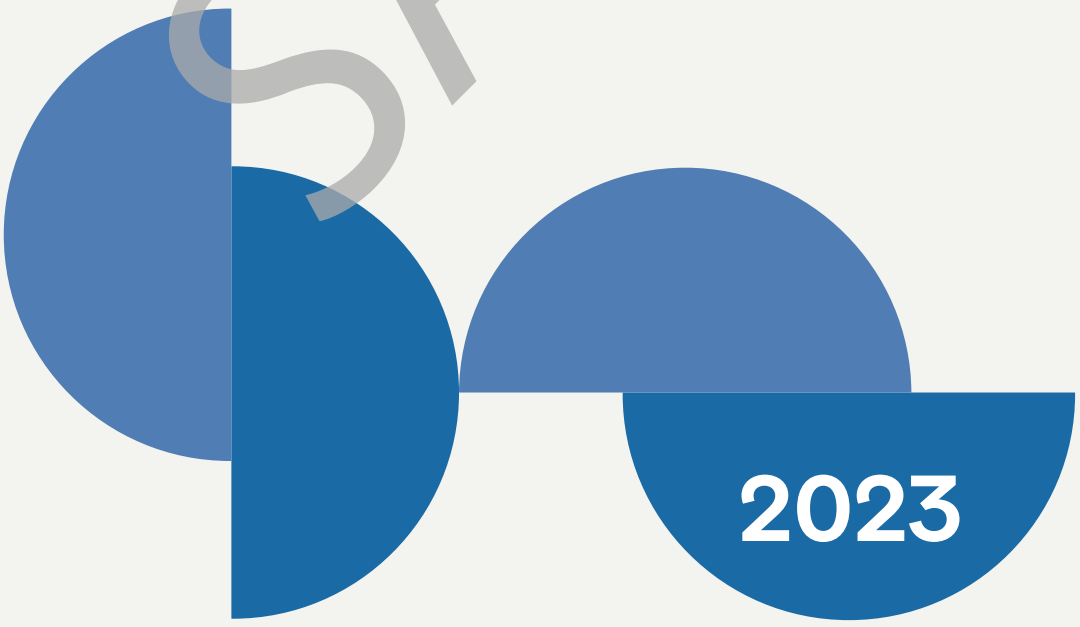
Optum

Coding Companion

Internal Medicine/ Endocrinology/ Rheumatology

A comprehensive illustrated guide to coding and reimbursement



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Contents

Getting Started with Coding Companion

Coding Companion for Internal Medicine/Endocrinology/Rheumatology 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

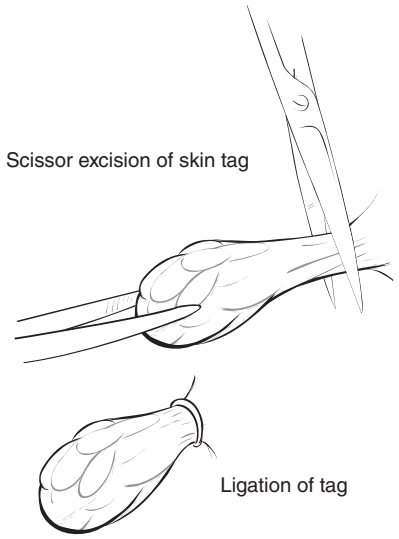
Terms To Know

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.

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

G0101

G0101 Cervical or vaginal cancer screening; pelvic and clinical breast examination

Explanation

This code reports a cervical or vaginal cancer screening and a pelvic and clinical breast examination. The specimen for cancer screening is collected by cervical, endocervical, or vaginal scrapings or by aspiration of vaginal fluid and cells. The pelvic and breast exams are done manually by the physician to check for abnormalities, pain, and/or any palpable lumps or masses.

Coding Tips

If a separately identifiable service is performed in addition to this procedure, an E/M service may be reported with modifier 25 appended. Some payers may require this service to be reported using CPT preventive medicine service codes: new patient, see 99384-99387; established patient, see 99394-99397. Check with specific payers to determine coverage.

ICD-10-CM Diagnostic Codes

Z01.411 Encounter for gynecological examination (general) (routine) with abnormal findings ♀

Z01.419 Encounter for gynecological examination (general) (routine) without abnormal findings ♀

Z12.39 Encounter for other screening for malignant neoplasm of breast

Z12.4 Encounter for screening for malignant neoplasm of cervix ♀

Z12.72 Encounter for screening for malignant neoplasm of vagina ♀

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0101	0.45	0.63	0.06	1.14
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0101	0.45	0.29	0.06	0.8

	FUD	Status	MUE	Modifiers				IOM Reference
G0101	N/A	A	1(2)	N/A	N/A	N/A	80*	None

* with documentation

Terms To Know

endocervix. Region of the cervix uteri that opens into the uterus or the mucous membrane lining the cervical canal.

exocervix. Region of the cervix uteri that protrudes into the vagina.

introitus. Entrance into the vagina.

G0102

G0102 Prostate cancer screening; digital rectal examination

Explanation

This code reports a prostate cancer screening performed manually by the physician as a digital rectal exam in order to palpate the prostate and check for abnormalities.

Coding Tips

This service is covered by Medicare once every 12 months for men who have attained age fifty; at least 11 months must have passed following the month in which the last Medicare-covered screening digital rectal examination was performed.

ICD-10-CM Diagnostic Codes

Z12.5 Encounter for screening for malignant neoplasm of prostate ♂

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0102	0.18	0.47	0.01	0.66
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0102	0.18	0.07	0.01	0.26

	FUD	Status	MUE	Modifiers				IOM Reference
G0102	N/A	A	1(2)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

prostate. Male gland surrounding the bladder neck and urethra that secretes a substance into the seminal fluid.

screening test. Exam or study used by a physician to identify abnormalities, regardless of whether the patient exhibits symptoms.

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

G0108-G0109

G0108 Diabetes outpatient self-management training services, individual, per 30 minutes

G0109 Diabetes outpatient self-management training services, group session (two or more), per 30 minutes

Explanation

These codes are for diabetes self-management training services, either individually or in a group of two or more. Diabetes self-management training is done to teach the diabetic how to control and monitor blood glucose levels with the proper use of the monitoring device, dietary calculations and restrictions, and correct administration of diabetic medications. These codes are reported per 30 minute intervals.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0108	0.9	0.66	0.05	1.61
G0109	0.25	0.19	0.01	0.45
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0108	0.9	0.66	0.05	1.61
G0109	0.25	0.19	0.01	0.45

G0179-G0180

G0179 Physician or allowed practitioner re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians and allowed practitioners to affirm the initial implementation of the plan of care

G0180 Physician or allowed practitioner certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians or allowed practitioners to affirm the initial implementation of the plan of care

Explanation

These codes report one period of certification or recertification of a patient's qualifying status for Medicare-covered home health services under a home health plan of care by a physician, without the patient present. This includes all contacts made with the home health agency and reviewing of patient status reports required by physicians to affirm the initial implementation of the care plan designed to meet the patient's needs.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0179	0.45	0.7	0.04	1.19
G0180	0.67	0.81	0.05	1.53
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0179	0.45	0.7	0.04	1.19
G0180	0.67	0.81	0.05	1.53

G0181-G0182

G0181 Physician or allowed practitioner supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician or allowed practitioner development and/or revision of care plans

G0182 Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more

Explanation

These codes represent physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency or of a patient under a Medicare-approved hospice. This includes complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication with other health care professionals involved in the patient's care, including all telephone calls, and integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month. The patient is not present for the physician supervision.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0181	1.73	1.21	0.11	3.05
G0182	1.73	1.25	0.11	3.09
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0181	1.73	1.21	0.11	3.05
G0182	1.73	1.25	0.11	3.09

G0245-G0246

G0245 Initial physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) which must include: (1) the diagnosis of LOPS, (2) a patient history, (3) a physical examination that consists of at least the following elements: (a) visual inspection of the forefoot, hindfoot, and toe web spaces, (b) evaluation of a protective sensation, (c) evaluation of foot structure and biomechanics, (d) evaluation of vascular status and skin integrity, and (e) evaluation and recommendation of footwear, and (4) patient education

G0246 Follow-up physician evaluation and management of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include at least the following: (1) a patient history, (2) a physical examination that includes: (a) visual inspection of the forefoot, hindfoot, and toe web spaces, (b) evaluation of protective sensation, (c) evaluation of foot structure and biomechanics, (d) evaluation of vascular status and skin integrity, and (e) evaluation and recommendation of footwear, and (3) patient education

Explanation

Physician evaluation and management is given to a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation, including all of the following in addition to the initial diagnosis of lops: a patient history; patient education; and a physical examination consisting of at least visual inspection of

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

Relative Value Units/Medicare Edits

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

90732

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

Explanation

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

Relative Value Units/Medicare Edits

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

93000-93010

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

Explanation

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

Relative Value Units/Medicare Edits

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

93015-93018

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

Explanation

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

Relative Value Units/Medicare Edits

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

93024

93024 Ergonovine provocation test

Explanation

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

Relative Value Units/Medicare Edits

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

93025

93025 Microvolt T-wave alternans for assessment of ventricular arrhythmias

Explanation

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

CPT Index

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