Optum

Coding Companion

Emergency Medicine/ Critical Care/ Infectious Disease

A comprehensive illustrated guide to coding and reimbursement

2024

optumcoding.com

Contents

Getting Started with Coding Companion

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

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

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to emergency medicine/critical care/infectious disease 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/HCPCS 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.

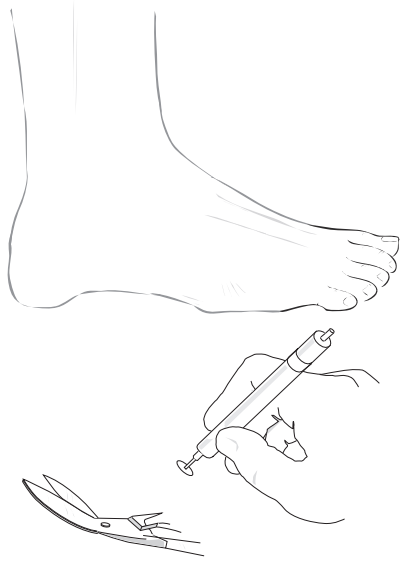
Sample Page and Key

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. 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

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

cellulitis. Infection of the skin and subcutaneous tissues, most often caused by *Staphylococcus* or *Streptococcus* bacteria secondary to a cutaneous lesion. Progression of the inflammation may lead to abscess and tissue death, or even systemic infection-like bacteremia.

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

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.

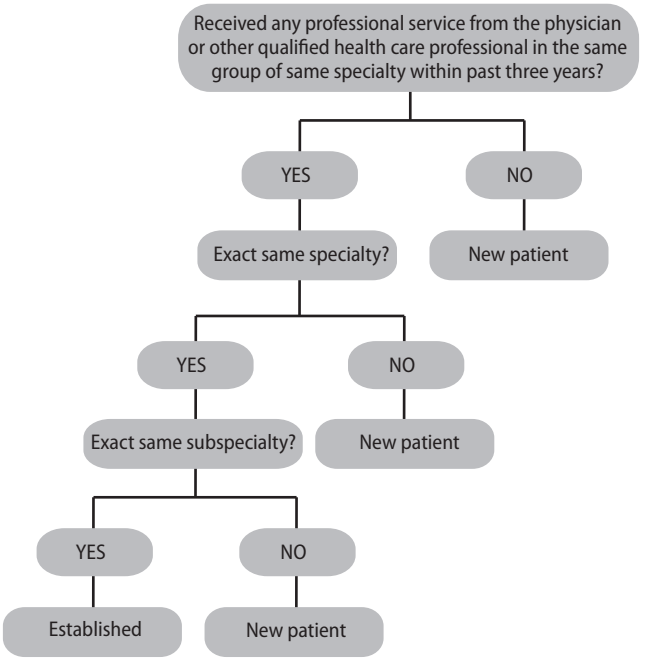
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the 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

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 not considered 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 patients admitted and discharged from inpatient or observation care on the same date, see 99234-99236. For prolonged services with 99205, see 99417; for Medicare, see G2212. Medicare has identified these codes as telehealth/telemedicine services. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

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

AMA: **99202** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99203** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99204** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99205** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.12	0.09	2.14
99203	1.6	1.52	0.17	3.29
99204	2.6	2.06	0.24	4.9
99205	3.5	2.66	0.32	6.48
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.17	2.44
99204	2.6	1.11	0.24	3.95
99205	3.5	1.54	0.32	5.36

	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 physician or other 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.

99288

99288 Physician or other qualified health care professional direction of emergency medical systems (EMS) emergency care, advanced life support

Explanation

This code is used to report qualified clinician direction of emergency medical systems (EMS) emergency care or advanced life support in the emergency department (ED). This can involve the clinician communicating via a two-way voice system with emergency medical technicians in an ambulance or with other rescue personnel who are outside of the hospital emergency department. Clinician direction of the performance of medically necessary procedures includes, but is not limited to, telemetry of cardiac rhythm; cardiac and/or pulmonary resuscitation; endotracheal or esophageal obturator airway intubation; administration of intravenous (IV) fluids and/or intramuscular (IM), intra-tracheal, or subcutaneous drugs; and/or electrical conversion of cardiac arrhythmia.

Coding Tips

This code is used by a facility-based practitioner (emergency department, critical care unit) who is directing remote emergency care or advanced life support in the urgent care of the patient. Time is not a factor when selecting this E/M service. This service may be reported in addition to other E/M services on the same date when documented in the patient record.

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: 99288 2022,Nov; 2022,Aug; 2022,Jul; 2022,May; 2021,Jan; 2019,Jul; 2017,Aug; 2017,Jun; 2016,Nov

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99288	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
99288	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
99288	N/A	B	0(3)	N/A	N/A	N/A	N/A	100-04,12,100

* with documentation

Terms To Know

cardioversion. Measured electric shock administered with a defibrillator chest paddle to the heart to convert the heartbeat to a regular rhythm. This procedure can be performed externally or internally.

intubation. Insertion of a tube into a hollow organ, canal, or cavity within the body.

resuscitation. Restoration to life or consciousness of one apparently dead, it includes such measures as artificial respiration and cardiac massage or electrical shock.

99291-99292

99291 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

+ 99292 each additional 30 minutes (List separately in addition to code for primary service)

Explanation

Critical care services are reported by a physician or other qualified health care provider for critically ill or injured patients. Critical illnesses or injuries are defined as those with impairment to one or more vital organ systems with an increased risk of rapid or imminent health deterioration. Critical care services require direct patient/provider involvement with highly complex decision making in order to evaluate, control, and support vital systems functions to treat one or more vital organ system failures and/or to avoid further decline of the patient's condition. Vital organ system failure includes, but is not limited to, failure of the central nervous, circulatory, or respiratory systems; kidneys; liver; shock; and other metabolic processes. Generally, critical care services necessitate the interpretation of many physiologic parameters and/or other applications of advanced technology as available in a critical care unit, pediatric intensive care unit, respiratory care unit, in an emergency facility, patient room or other hospital department; however, in emergent situations, critical care may be provided where these elements are not available. Critical care may be provided so long as the patient's condition continues to warrant the level of care according to the criteria described. Care provided to patients residing in a critical care unit but not fitting the criteria for critical care is reported using other E/M codes, as appropriate. These codes are time based codes, meaning the total time spent must be documented and includes direct patient care bedside or time spent on the patient's floor or unit (reviewing laboratory results or imaging studies and discussing the patient's care with medical staff, time spent with family members, caregivers, or other surrogate decision makers to gather information on the patient's medical history, reviewing the patient's condition or prognosis, and discussing various treatment options or limitations of treatment), as long as the clinician is immediately available and not providing services to any other patient during the same time period. Time spent outside of the patient's unit or floor, including telephone calls, caregiver discussions, or time spent in actions that do not directly contribute to the patient's care rendered in the critical unit are not reported as critical care. Report these codes for attendance of the patient during transport for patients 24 months of age or older to or from a facility. Code 99291 represents the first 30 to 74 minutes of critical care and is reported once per day. Additional time beyond the first 74 minutes is reported in 30 minute increments with 99292.

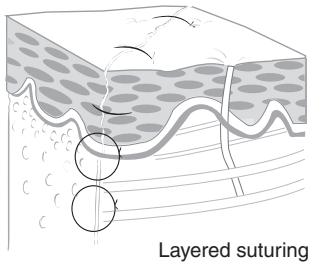
Coding Tips

These codes are used to report critical care services. These are time-based services and the total time spent providing critical care must be documented in the medical record. All time spent providing critical care on the same date of service is added together and does not need to be contiguous. Time is reported for practitioner time spent in care of the critically ill or injured patient at the patient's bedside and on the floor/unit. Time spent off the patient unit, even if related to patient care, is not counted. Do not report critical care for patients who may be in the critical care unit but are not currently critically ill. The following services are considered inclusive to the critical care codes when reported by the clinician: interpretation of cardiac output measurements, chest x-rays, pulse oximetry, blood gases, collection and interpretation of physiologic data, computer data such as ECGs, gastric intubation, vascular access, and ventilation management. Code 99291 is reported once per day. Code 99292 is reported in addition to code 99291. Medicare and some other payers may allow 99292 to be reported alone when critical care is reported by another physician of the same group and specialty the same date as another provider reporting 99291. For care of the critically ill neonate, see 99468-99469;

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

12051-12057

12051 Repair, intermediate, wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
12052 2.6 cm to 5.0 cm
12053 5.1 cm to 7.5 cm
12054 7.6 cm to 12.5 cm
12055 12.6 cm to 20.0 cm
12056 20.1 cm to 30.0 cm
12057 over 30.0 cm



Layered suturing

Explanation

The physician performs a repair of a wound located on the face, ears, eyelids, nose, lips, and/or mucous membranes. A local anesthetic is injected around the laceration, and the wound is cleansed, explored, and often irrigated with a saline solution. Due to deeper or more complex lacerations, deep layered suturing techniques are required. The physician closes tissue layers under the skin with dissolvable sutures before suturing the skin. Extensive cleaning or removal of foreign matter from a heavily contaminated wound that is closed with a single layer may also be reported as an intermediate repair. With multiple wounds of the same complexity and in the same anatomical area, the length of all wounds sutured is summed and reported as one total length. Report 12051 for a total length of 2.5 cm or less; 12052 for 2.6 cm to 5 cm; 12053 for 5.1 cm to 7.5 cm; 12054 for 7.6 cm to 12.5 cm; 12055 for 12.6 cm to 20 cm; 12056 for 20.1 cm to 30 cm; and 12057 if the total length is greater than 30 cm.

Coding Tips

When multiple wounds are repaired, add together the lengths of those in the same classification and report as a single item. Intermediate repair is used when one or more of the deeper layers of subcutaneous tissue and superficial fascia, in addition to the skin, require closure including any limited undermining that may be required. Intermediate repair is also reported for single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter. For simple (non-layered) closure of the face, ears, eyelids, nose, lips, and/or mucous membranes, see 12011–12018. For complex repairs, see 13131–13153. 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

S01.121A Laceration with foreign body of right eyelid and periocular area, initial encounter ☑
S01.131A Puncture wound without foreign body of right eyelid and periocular area, initial encounter ☑
S01.141A Puncture wound with foreign body of right eyelid and periocular area, initial encounter ☑
S01.151A Open bite of right eyelid and periocular area, initial encounter ☑
S01.21XA Laceration without foreign body of nose, initial encounter
S01.22XA Laceration with foreign body of nose, initial encounter
S01.23XA Puncture wound without foreign body of nose, initial encounter
S01.24XA Puncture wound with foreign body of nose, initial encounter
S01.25XA Open bite of nose, initial encounter
S01.311A Laceration without foreign body of right ear, initial encounter ☑
S01.321A Laceration with foreign body of right ear, initial encounter ☑
S01.331A Puncture wound without foreign body of right ear, initial encounter ☑
S01.341A Puncture wound with foreign body of right ear, initial encounter ☑
S01.351A Open bite of right ear, initial encounter ☑
S01.411A Laceration without foreign body of right cheek and temporomandibular area, initial encounter ☑
S01.421A Laceration with foreign body of right cheek and temporomandibular area, initial encounter ☑
S01.431A Puncture wound without foreign body of right cheek and temporomandibular area, initial encounter ☑
S01.441A Puncture wound with foreign body of right cheek and temporomandibular area, initial encounter ☑
S01.451A Open bite of right cheek and temporomandibular area, initial encounter ☑
S01.511A Laceration without foreign body of lip, initial encounter
S01.521A Laceration with foreign body of lip, initial encounter
S01.522A Laceration with foreign body of oral cavity, initial encounter
S01.531A Puncture wound without foreign body of lip, initial encounter
S01.532A Puncture wound without foreign body of oral cavity, initial encounter
S01.541A Puncture wound with foreign body of lip, initial encounter
S01.542A Puncture wound with foreign body of oral cavity, initial encounter
S01.551A Open bite of lip, initial encounter
S01.552A Open bite of oral cavity, initial encounter
S08.121A Partial traumatic amputation of right ear, initial encounter ☑
S08.812A Partial traumatic amputation of nose, initial encounter

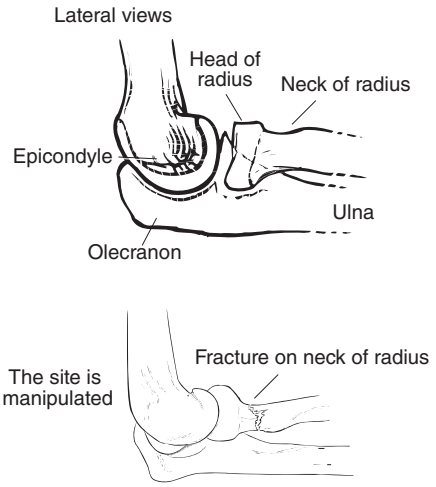
AMA: **12051** 2022,Aug; 2022,Jun; 2022,Feb; 2021,Aug; 2019,Nov; 2018,Sep **12052** 2022,Aug; 2022,Jun; 2022,Feb; 2021,Aug; 2019,Nov; 2018,Sep **12053** 2022,Aug; 2022,Jun; 2022,Feb; 2021,Aug; 2019,Nov; 2018,Sep **12054** 2022,Aug; 2022,Jun; 2022,Feb; 2021,Aug; 2019,Nov; 2018,Sep **12055** 2022,Aug; 2022,Feb; 2021,Aug; 2019,Nov; 2018,Sep **12056** 2022,Aug; 2022,Feb; 2021,Aug; 2019,Nov; 2018,Sep **12057** 2022,Aug; 2022,Feb; 2021,Aug; 2019,Nov; 2018,Sep

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

24650-24655

24650 Closed treatment of radial head or neck fracture; without manipulation

24655 with manipulation



Explanation

The physician performs closed treatment of a radial head or neck fracture without manipulation in 24650 and with manipulation in 24655. In 24650, the radial fracture is determined to be stable and nondisplaced and can be splinted or braced without requiring manipulation. In 24655, the physician performs manual manipulation to realign the fractured bone by applying pressure. No incisions are made. The arm is placed in a posterior elbow splint or brace.

Coding Tips

According to CPT guidelines, the application and removal of the first cast, splint, or traction device are included in the codes that appear in the Musculoskeletal System section of CPT. Supplies may be reported separately. Modifier 56 should not be reported for preoperative management of a fracture. Removal of a cast by a provider, other than the provider who applied the cast, can be reported with cast removal codes 29700, 29705, and 29710. Cast, splint, or strapping (29000-29750) and/or traction device (20690, 20692) replacement during or after the global period of a procedure may be reported separately. In 24655, local anesthesia is included. However, this procedure may be performed under conscious sedation or general anesthesia, depending on the age and/or condition of the patient. For radiology services, see 73070–73085. For radiology services, add modifier 26 to identify the professional component only; if the physician owns the equipment, both components may be reported.

ICD-10-CM Diagnostic Codes

M80.831A Other osteoporosis with current pathological fracture, right forearm, initial encounter for fracture ☑

M84.333A Stress fracture, right radius, initial encounter for fracture ☑

M84.433A Pathological fracture, right radius, initial encounter for fracture ☑

M84.533A Pathological fracture in neoplastic disease, right radius, initial encounter for fracture ☑

M84.633A Pathological fracture in other disease, right radius, initial encounter for fracture ☑

S52.121A Displaced fracture of head of right radius, initial encounter for closed fracture ☑

S52.124A Nondisplaced fracture of head of right radius, initial encounter for closed fracture ☑

S52.131A Displaced fracture of neck of right radius, initial encounter for closed fracture ☑

S52.134A Nondisplaced fracture of neck of right radius, initial encounter for closed fracture ☑

S59.111A Salter-Harris Type I physeal fracture of upper end of radius, right arm, initial encounter for closed fracture ☑

S59.121A Salter-Harris Type II physeal fracture of upper end of radius, right arm, initial encounter for closed fracture ☑

S59.131A Salter-Harris Type III physeal fracture of upper end of radius, right arm, initial encounter for closed fracture ☑

S59.141A Salter-Harris Type IV physeal fracture of upper end of radius, right arm, initial encounter for closed fracture ☑

S59.191A Other physeal fracture of upper end of radius, right arm, initial encounter for closed fracture ☑

AMA: **24650** 2022,May **24655** 2022,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
24650	2.31	5.19	0.43	7.93
24655	4.62	7.9	0.93	13.45
Facility RVU	**Work**	**PE**	**MP**	**Total**
24650	2.31	4.63	0.43	7.37
24655	4.62	6.58	0.93	12.13

	FUD	Status	MUE	Modifiers				IOM Reference
24650	90	A	1(2)	51	50	N/A	N/A	None
24655	90	A	1(2)	51	50	N/A	N/A	

* with documentation

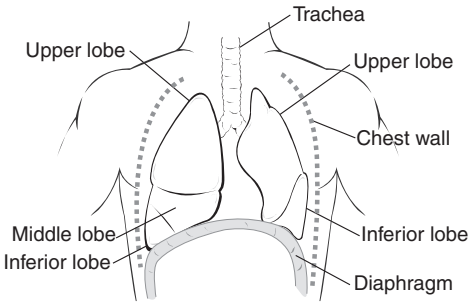
Terms To Know

closed treatment. Realignment of a fracture or dislocation without surgically opening the skin to reach the site. Treatment methods employed include with or without manipulation and with or without traction.

manipulation. Skillful treatment by hand to reduce fractures and dislocations or provide therapy through forceful passive movement of a joint beyond its active limit of motion.

32552

32552 Removal of indwelling tunneled pleural catheter with cuff



Explanation

The physician removes a previously placed, indwelling tunneled pleural catheter with cuff. Following administration of local anesthesia along the subcutaneous catheter tunnel, blunt dissection is used to release the cuff and the catheter is meticulously withdrawn. Conscious sedation may be required.

Coding Tips

For insertion of an indwelling tunneled pleural catheter with cuff, see 32550. For insertion of a chest tube, see 32551.

ICD-10-CM Diagnostic Codes

Z48.03 Encounter for change or removal of drains

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
32552	2.53	2.54	0.35	5.42
Facility RVU	**Work**	**PE**	**MP**	**Total**
32552	2.53	1.74	0.35	4.62

	FUD	Status	MUE	Modifiers				IOM Reference
32552	10	A	2(2)	51	N/A	N/A	80*	None

* with documentation

Terms To Know

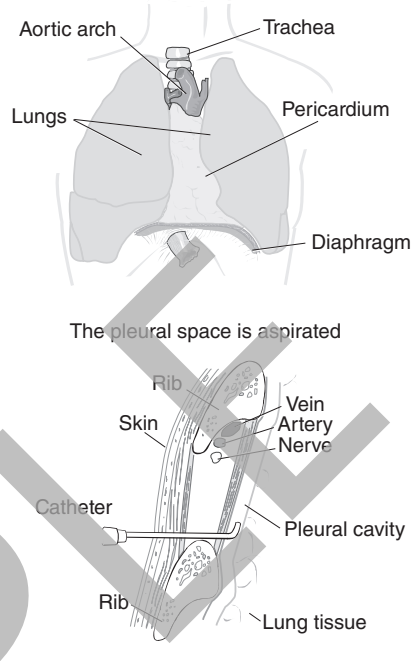
dissection. (dis. apart; -section, act of cutting) Separating by cutting tissue or body structures apart.

subcutaneous. Below the skin.

32554-32555

32554 Thoracentesis, needle or catheter, aspiration of the pleural space; without imaging guidance

32555 with imaging guidance



Explanation

The physician removes fluid and/or air from the chest cavity by puncturing through the space between the ribs with a hollow needle (cannula) and entering the chest cavity. The fluid (blood or pus) is removed from the chest cavity by pulling back on the plunger of the syringe attached to the cannula. Report 32554 if the procedure is performed without imaging guidance. Report 32555 when imaging guidance is used during the procedure.

Coding Tips

Do not report 32554-32555 with 75989, 76942, 77002, 77012, or 77021. In addition, these codes should not be reported with 32550 and 32551 when procedures are performed on the same side of the chest.

ICD-10-CM Diagnostic Codes

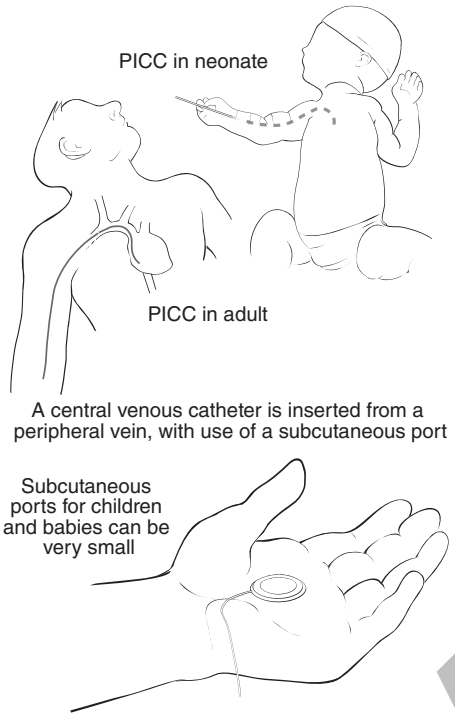
A15.6	Tuberculous pleurisy
J86.0	Pyothorax with fistula
J86.9	Pyothorax without fistula
J90	Pleural effusion, not elsewhere classified
J91.0	Malignant pleural effusion
J91.8	Pleural effusion in other conditions classified elsewhere
J93.0	Spontaneous tension pneumothorax
J93.11	Primary spontaneous pneumothorax
J94.0	Chylous effusion
J94.2	Hemothorax
J94.8	Other specified pleural conditions
J95.4	Chemical pneumonitis due to anesthesia
M32.13	Lung involvement in systemic lupus erythematosus
M35.02	Sjögren syndrome with lung involvement
N80.B1	Endometriosis of pleura ♀
N80.B5	Endometriosis of the mediastinal space ♀

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

36570-36571

36570 Insertion of peripherally inserted central venous access device, with subcutaneous port; younger than 5 years of age

36571 age 5 years or older



Explanation

A central venous access device or catheter is one in which the tip terminates in the subclavian, brachiocephalic, or iliac vein; the superior or inferior vena cava; or the right atrium. A peripherally inserted central venous catheter (PICC) has an entry site in the basilic or cephalic vein in the arm and is threaded into the superior vena cava above the right atrium. PICC lines are used for antibiotic therapy, chemotherapy, total parenteral nutrition, lab work, pain medications, blood transfusions, and hydration the same as a central line. For insertion of a peripherally inserted central venous catheter with a subcutaneous port, the site over the access vein (basilic or cephalic) is injected with local anesthesia and punctured with a needle. A guidewire is inserted. The central venous catheter is placed over the guidewire and fed through the vein in the arm into the superior vena cava. The port may be placed in the chest in a subcutaneous pocket created through an incision in the chest wall, or placed in the arm through a small incision just above or halfway between the elbow crease and the shoulder on the inside of the arm. The port is attached to the catheter and checked. Ultrasound guidance may be used to gain venous access and/or fluoroscopy to check the positioning of the catheter tip. The catheter and port are secured into position and incisions are closed and dressed. Report 36570 for insertion for children younger than 5 years of age and 36571 for a patient 5 years of age or older.

Coding Tips

When medically necessary, report moderate (conscious) sedation provided by the performing physician with 99151-99153. When provided by another physician, report 99155-99157. For insertion of a tunneled, centrally inserted central venous access device, with subcutaneous port, younger than 5 years of age, see 36560; 5 years of age or older, see 36561. If imaging guidance is used, for obtaining access to the venous access site or for manipulating the catheter into its end position, see 76937 and 77001.

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: **36570** 2019,Mar **36571** 2019,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
36570	5.11	39.39	1.29	45.79
36571	5.09	33.75	1.01	39.85
Facility RVU	**Work**	**PE**	**MP**	**Total**
36570	5.11	3.48	1.29	9.88
36571	5.09	3.16	1.01	9.26

	FUD	Status	MUE	Modifiers				IOM Reference
36570	10	A	2(3)	51	50	N/A	80*	None
36571	10	A	2(3)	51	50	N/A	80*	

* with documentation

Terms To Know

central venous access device. Catheter or other device introduced through a large vein, such as the subclavian or femoral vein, terminating in the superior or inferior vena cava or the right atrium and used to measure venous pressure or administer medication or fluids.

chemotherapy. Treatment of disease, especially cancerous conditions, using chemical agents.

guidewire. Flexible metal instrument designed to lead another instrument in its proper course.

parenteral nutrition. Nutrients provided subcutaneously, intravenously, intramuscularly, or intradermally for patients during the postoperative period and in other conditions, such as shock, coma, and renal failure.

peripheral. Outside of a structure or organ.

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.

Coding Tips

Do not report these codes with Category III codes 0525T-0532T.

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.

Associated HCPCS Codes

G0403 Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report

G0404 Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination

G0405 Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination

AMA: **93000** 2020,Dec; 2017,Oct **93005** 2020,Dec; 2017,Oct **93010** 2021,May; 2020,Dec; 2016,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
93000	0.17	0.23	0.02	0.42
93005	0.0	0.17	0.01	0.18
93010	0.17	0.06	0.01	0.24
Facility RVU	**Work**	**PE**	**MP**	**Total**
93000	0.17	0.23	0.02	0.42
93005	0.0	0.17	0.01	0.18
93010	0.17	0.06	0.01	0.24

	FUD	Status	MUE	Modifiers				IOM Reference
93000	N/A	A	3(3)	N/A	N/A	N/A	80*	100-03,160.17; 100-04,18,80.2
93005	N/A	A	3(3)	N/A	N/A	N/A	80*	
93010	N/A	A	5(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

EKG. Electrocardiogram. Graphic recording of the changes in electrical voltage and polarity caused by the heart muscle's electrical excitation. The tracing follows atrial and ventricular activity over time, captured through electrodes placed on the skin.

interpretation. Professional health care provider's review of data with a written or verbal opinion.

93040-93042

93040 Rhythm ECG, 1-3 leads; with interpretation and report
93041 tracing only without interpretation and report
93042 interpretation and report only

Explanation

An assistant records the electrical activity of the heart by placing one to three electrodes on a patient's chest in a predetermined pattern. Report 93040 when the physician interprets the report. Report 93041 when only the tracing is performed. Report 93042 when a physician interprets a previously acquired report.

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: **93040** 2020,Dec; 2020,Sep; 2017,Oct **93041** 2020,Dec; 2017,Oct **93042** 2020,Dec; 2017,Oct

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
93040	0.15	0.2	0.02	0.37
93041	0.0	0.16	0.01	0.17
93042	0.15	0.04	0.01	0.2
Facility RVU	**Work**	**PE**	**MP**	**Total**
93040	0.15	0.2	0.02	0.37
93041	0.0	0.16	0.01	0.17
93042	0.15	0.04	0.01	0.2

	FUD	Status	MUE	Modifiers				IOM Reference
93040	N/A	A	3(3)	N/A	N/A	N/A	80*	100-04,32,130.1
93041	N/A	A	2(3)	N/A	N/A	N/A	80*	
93042	N/A	A	3(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

EKG. Electrocardiogram. Graphic recording of the changes in electrical voltage and polarity caused by the heart muscle's electrical excitation. The tracing follows atrial and ventricular activity over time, captured through electrodes placed on the skin.

electrode. Electric terminal specialized for a particular electrochemical reaction that acts as a medium between a body surface and another instrument, commonly termed a lead.

Correct Coding Initiative Update 28.3

❖Indicates Mutually Exclusive Edit

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.

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