Optum

Coding Companion

ENT/Allergy/ Pulmonology

A comprehensive illustrated guide to coding and reimbursement

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2024

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Contents

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Getting Started with Coding Companion

Coding Companion for ENT/Allergy/Pulmonology 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 ENT/allergy/pulmonology are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT/HCPCS code is followed by its official CPT code description.

Resequencing of CPT Codes

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

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

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features.

Appendix Codes and Descriptions

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

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

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

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

CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 28.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2024 edition password is: **XXXXX.** Log in frequently to ensure you receive the most current updates.

Index

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

69501 Transmastoid antrotomy (simple mastoidectomy)

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

Antrotomy
Transmastoid, 69501

or

Excision
Mastoid
Simple, 69501

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.

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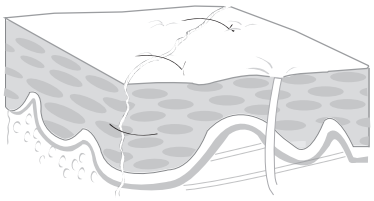
12001-12007

12001 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
12002 2.6 cm to 7.5 cm
12004 7.6 cm to 12.5 cm
12005 12.6 cm to 20.0 cm
12006 20.1 cm to 30.0 cm
12007 over 30.0 cm



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

Explanation

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

Coding Tips

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

ICD-10-CM Diagnostic Codes

S01.01XA Laceration without foreign body of scalp, initial encounter
S01.03XA Puncture wound without foreign body of scalp, initial encounter
S01.05XA Open bite of scalp, initial encounter
S11.81XA Laceration without foreign body of other specified part of neck, initial encounter
S11.83XA Puncture wound without foreign body of other specified part of neck, initial encounter
S11.89XA Other open wound of other specified part of neck, initial encounter

Associated HCPCS Codes

G0168 Wound closure utilizing tissue adhesive(s) only

AMA: **12001** 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep; 2017,De 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12004** 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12005** 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12006** 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12007** 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
12001	0.84	1.79	0.17	2.8
12002	1.14	2.01	0.22	3.37
12004	1.44	2.2	0.27	3.91
12005	1.97	2.92	0.39	5.28
12006	2.39	3.31	0.47	6.17
12007	2.9	3.48	0.56	6.94
Facility RVU	**Work**	**PE**	**MP**	**Total**
12001	0.84	0.32	0.17	1.33
12002	1.14	0.38	0.22	1.74
12004	1.44	0.44	0.27	2.15
12005	1.97	0.45	0.39	2.81
12006	2.39	0.59	0.47	3.45
12007	2.9	0.84	0.56	4.3

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

* with documentation

Terms To Know

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

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

injury. Harm or damage sustained by the body.

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

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

suture. Numerous stitching techniques employed in wound closure.

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1. CPT/HCPCS Codes and Descriptions

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

The following icons are used in *Coding Companion:*

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

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

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

The Centers for Medicare and Medicaid Services (CMS) have identified additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE), some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 93 or 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

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

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

2. Illustrations

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

3. Explanation

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

4. Coding Tips

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

5. ICD-10-CM Diagnostic Codes

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

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

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

6. Associated HCPCS Codes

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

7. AMA References

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

8. Relative Value Units/Medicare Edits

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

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

Relative Value Units

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

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

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled

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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.◀

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.

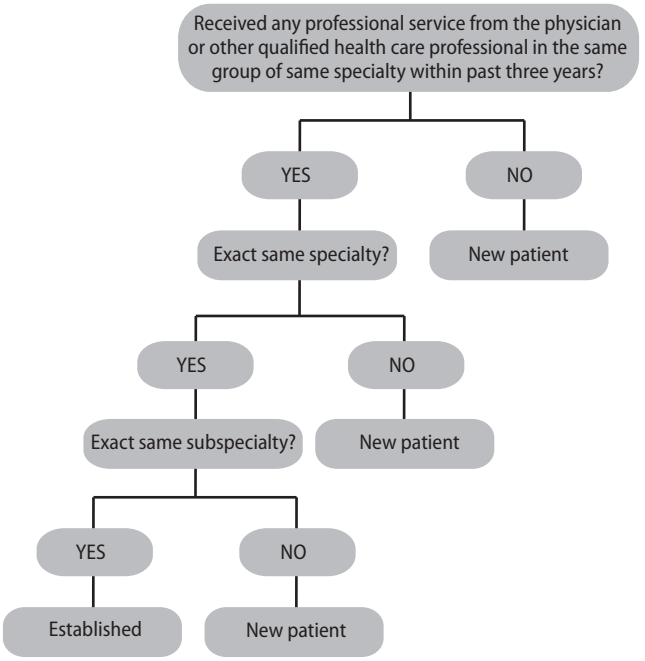
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the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



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▶◀ = Contains new or revised text

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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.

outpatient visit. Encounter in a recognized outpatient facility.

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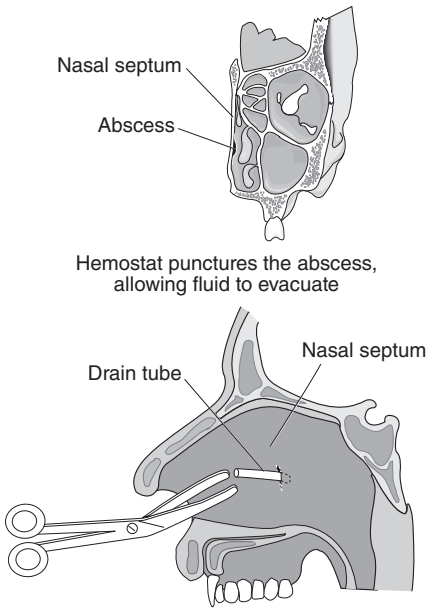
CPT © 2023 American Medical Association. All Rights Reserved. ● New ▲ Revised + Add On ★ Telemedicine AMA: CPT Assist [Resequenced] ☑ Laterality © 2023 Optum Inc.

30000-30020

30000 Drainage abscess or hematoma, nasal, internal approach
30020 Drainage abscess or hematoma, nasal septum



Explanation

The physician makes an incision to decompress and drain a collection of pus or blood in the nasal mucosa for 30000 or septal mucosa for 30020. A hemostat bluntly penetrates the pockets and allows the fluid to evacuate. Once decompressed, a small latex drain may be placed into the incision site. This allows an escape for any fluids that may continue to enter the pocket. If a drain is used, it is removed within 48 hours. The nasal cavity may be packed with gauze or Telfa to provide pressure against the mucosa and assist decompression after drainage. The incision may be closed primarily or may be left to granulate without closure.

Coding Tips

Hematomas can result from trauma or postoperative complications. Abscesses can result from hematomas or directly from trauma. These fluid-filled pockets can lead to permanent erosion of bone and/or cartilage. Removal of the drain is not reported separately. For external approach, see 10060 and 10140.

ICD-10-CM Diagnostic Codes

J34.0 Abscess, furuncle and carbuncle of nose
J34.89 Other specified disorders of nose and nasal sinuses
J95.830 Postprocedural hemorrhage of a respiratory system organ or structure following a respiratory system procedure
J95.831 Postprocedural hemorrhage of a respiratory system organ or structure following other procedure
J95.860 Postprocedural hematoma of a respiratory system organ or structure following a respiratory system procedure
J95.861 Postprocedural hematoma of a respiratory system organ or structure following other procedure
J95.862 Postprocedural seroma of a respiratory system organ or structure following a respiratory system procedure
J95.863 Postprocedural seroma of a respiratory system organ or structure following other procedure
J95.89 Other postprocedural complications and disorders of respiratory system, not elsewhere classified
S00.33XA Contusion of nose, 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
S02.2XXA Fracture of nasal bones, initial encounter for closed fracture
S02.2XXB Fracture of nasal bones, initial encounter for open fracture
T81.41XA Infection following a procedure, superficial incisional surgical site, initial encounter
T81.42XA Infection following a procedure, deep incisional surgical site, initial encounter
T81.43XA Infection following a procedure, organ and space surgical site, initial encounter
T81.44XA Sepsis following a procedure, initial encounter
T81.49XA Infection following a procedure, other surgical site, initial encounter

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
30000	1.48	6.44	0.21	8.13
30020	1.48	6.51	0.22	8.21
Facility RVU	**Work**	**PE**	**MP**	**Total**
30000	1.48	1.87	0.21	3.56
30020	1.48	1.9	0.22	3.6

	FUD	Status	MUE	Modifiers				IOM Reference
30000	10	A	1(3)	51	N/A	N/A	80*	None
30020	10	A	1(3)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

abscess. Circumscribed collection of pus resulting from bacteria, frequently associated with swelling and other signs of inflammation.

contusion. Superficial injury (bruising) produced by impact without a break in the skin.

fracture. Break in bone or cartilage.

hematoma. Tumor-like collection of blood in some part of the body caused by a break in a blood vessel wall, usually as a result of trauma.

incision and drainage. Cutting open body tissue for the removal of tissue fluids or infected discharge from a wound or cavity.

infected postoperative seroma. Infection within a pocket of serum following surgery.

nasal septum. Membrane made of cartilage, bone, and mucosa that partitions the two nostrils, or nasal cavities, down the middle.

rhinodynia. Pain in the nose.

SAMPLE

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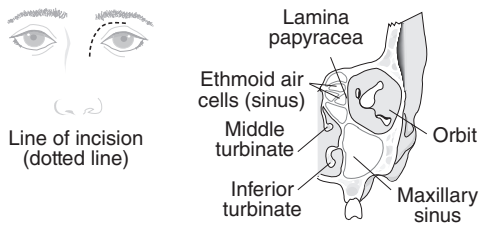
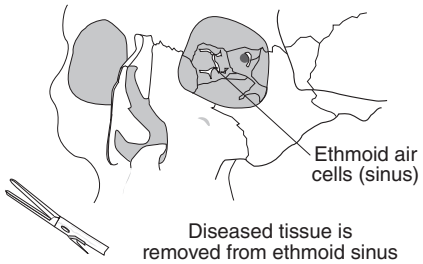
31205

31205 Ethmoidectomy; extranasal, total





Explanation

The physician removes diseased tissue of the ethmoid sinuses. A curvilinear incision is made between the nasal dorsum and the medial canthus of the eye. Dissection is carried to the medial orbital bone. A bony window is made through the lamina papyracea bone, exposing the lateral ethmoid sinus. The physician removes all diseased tissue. The nasal cavity is penetrated through the medial ethmoid region. Nasal gauze packing is placed through the extranasal incision. The external skin incision is repaired with a layered closure.

Coding Tips

This procedure is also called an external ethmoidectomy. For an anterior intranasal ethmoidectomy, see 31200. For a total intranasal ethmoidectomy, see 31201.

ICD-10-CM Diagnostic Codes

C31.1	Malignant neoplasm of ethmoidal sinus
C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
C78.39	Secondary malignant neoplasm of other respiratory organs
D02.3	Carcinoma in situ of other parts of respiratory system
D14.0	Benign neoplasm of middle ear, nasal cavity and accessory sinuses
D38.5	Neoplasm of uncertain behavior of other respiratory organs
D49.1	Neoplasm of unspecified behavior of respiratory system
J01.21	Acute recurrent ethmoidal sinusitis
J01.41	Acute recurrent pansinusitis
J33.1	Polypoid sinus degeneration
J33.8	Other polyp of sinus
J34.0	Abscess, furuncle and carbuncle of nose
J34.1	Cyst and mucocele of nose and nasal sinus
J34.89	Other specified disorders of nose and nasal sinuses

AMA: **31205** 2016,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
31205	10.58	16.51	0.9	27.99
Facility RVU	**Work**	**PE**	**MP**	**Total**
31205	10.58	16.51	0.9	27.99

	FUD	Status	MUE	Modifiers				IOM Reference
31205	90	A	1(2)	51	50	62*	80	None

* with documentation

Terms To Know

benign. Mild or nonmalignant in nature.

carcinoma in situ. Malignancy that arises from the cells of the vessel, gland, or organ of origin that remains confined to that site or has not invaded neighboring tissue.

chronic. Persistent, continuing, or recurring.

dissection. Separating by cutting tissue or body structures apart.

ethmoid bone. Cube-shaped bone located between the orbits.

extranasal approach. Incision from outside of the nose to gain access into the sinus cavity.

osteomyelitis. Inflammation of bone that may remain localized or spread to the marrow, cortex, or periosteum, in response to an infecting organism, usually bacterial and pyogenic.

secondary. Second in order of occurrence or importance, or appearing during the course of another disease or condition.

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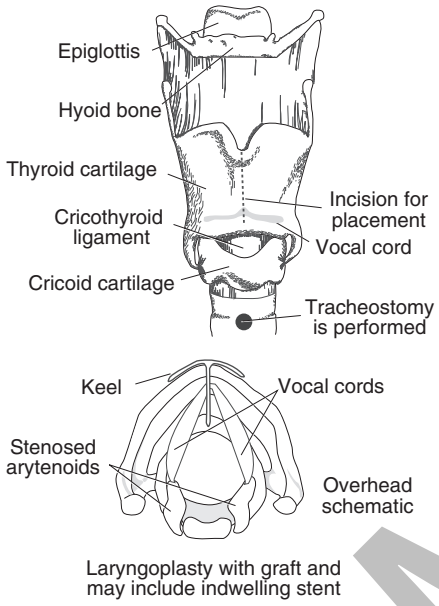
[31551, 31552, 31553, 31554]

31551 Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, younger than 12 years of age

31552 Laryngoplasty; for laryngeal stenosis, with graft, without indwelling stent placement, age 12 years or older

31553 Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, younger than 12 years of age

31554 Laryngoplasty; for laryngeal stenosis, with graft, with indwelling stent placement, age 12 years or older



Laryngoplasty with graft and may include indwelling stent

Explanation

The physician treats laryngeal stenosis. The physician performs a laryngotomy on the patient. Using a horizontal neck incision, the physician exposes the stenosis, in the affected area of the supraglottis, glottis, and/or subglottis. A cartilage graft is obtained and sewn to provide anterior and/or posterior stability to the larynx and adjacent trachea. The incision is sutured in layers. Report 31551 for procedures performed without placement of an indwelling stent on patients 12 years of age or younger and 31552 for patients older than age 12. Report 31553 for procedures that include placement of an indwelling stent on patients younger than 12 years of age and 31554 for patients over age 12.

Coding Tips

When the graft is harvested through the laryngoplasty incision, the graft is not reported separately. Do not report these codes with 31580 or with each other. For a tracheostomy, see 31600-31610. For stent removal, see 31599.

ICD-10-CM Diagnostic Codes

A52.73	Symptomatic late syphilis of other respiratory organs
J38.6	Stenosis of larynx
J99	Respiratory disorders in diseases classified elsewhere
Q31.1	Congenital subglottic stenosis
Q31.8	Other congenital malformations of larynx

AMA: **31551** 2020,Dec; 2019,Sep; 2017,Jul; 2017,Apr; 2017,Mar **31552** 2020,Dec; 2019,Sep; 2017,Jul; 2017,Apr; 2017,Mar **31553** 2020,Dec; 2019,Sep; 2017,Jul; 2017,Apr; 2017,Mar **31554** 2020,Dec; 2019,Sep; 2017,Jul; 2017,Apr; 2017,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
31551	21.5	21.37	3.04	45.91
31552	20.5	20.94	2.92	44.36
31553	22.0	25.13	3.13	50.26
31554	22.0	25.16	3.13	50.29
Facility RVU	**Work**	**PE**	**MP**	**Total**
31551	21.5	21.37	3.04	45.91
31552	20.5	20.94	2.92	44.36
31553	22.0	25.13	3.13	50.26
31554	22.0	25.16	3.13	50.29

	FUD	Status	MUE	Modifiers				IOM Reference
31551	90	A	1(2)	51	N/A	62*	80*	None
31552	90	A	1(2)	51	N/A	62*	80*	
31553	90	A	1(2)	51	N/A	62*	80*	
31554	90	A	1(2)	51	N/A	62*	80*	

* with documentation

Terms To Know

larynx. Musculocartilaginous structure between the trachea and the pharynx that functions as the valve preventing food and other particles from entering the respiratory tract, as well as the voice mechanism.

stenosis. Narrowing or constriction of a passage.

trachea. Tube descending from the larynx and branching into the right and left main bronchi.

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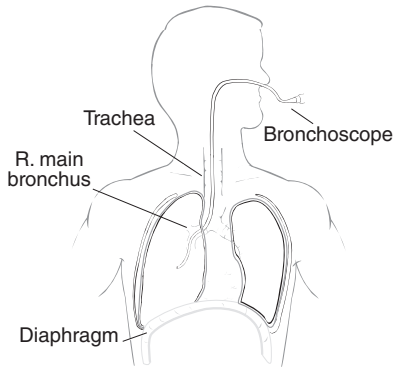
31652-31654

31652 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), one or two mediastinal and/or hilar lymph node stations or structures

31653 with endobronchial ultrasound (EBUS) guided transtracheal and/or transbronchial sampling (eg, aspiration[s]/biopsy[ies]), 3 or more mediastinal and/or hilar lymph node stations or structures

\+ **31654** with transendoscopic endobronchial ultrasound (EBUS) during bronchoscopic diagnostic or therapeutic intervention(s) for peripheral lesion(s) (List separately in addition to code for primary procedure[s])



Endobronchial ultrasound guided transbronchial sampling

Explanation

Endobronchial ultrasound (EBUS) is a minimally invasive technique utilizing ultrasound in conjunction with bronchoscopy to view the airway wall and adjacent structures. Utilizing appropriate anesthesia, the physician performs a transbronchial needle aspiration (TBNA) biopsy on lymph nodes via a thin flexible instrument (bronchoscope) fitted with an ultrasound processor, as well as a fine-gauge aspiration needle guided through the patient's mouth and trachea permitting real-time imaging of the airways, blood vessels, lungs, and lymph nodes. The physician can view hard to reach areas and gain greater access to biopsy smaller lymph nodes than would be possible via conventional mediastinoscopy. A pathologist in the operating room with the physician can immediately process the biopsy samples and/or request additional samples as necessary, leading to a quicker diagnosis of cancer, infections, or other inflammatory diseases of the lungs, as well as to assist in staging lung cancer. There are two types of EBUS: radial probe EBUS and linear probe EBUS. The radial probe EBUS has a rotating mechanical transducer with very good image quality that permits the airway layers to be identified but TBNA is not possible with this device. The linear probe EBUS is a fixed array of electronic transducer aligned in a curvilinear pattern and permits real-time guidance for mediastinal lesion sampling. EBUS procedures may be performed under general anesthesia or with moderate conscious sedation and typically allow for patients to go home the same day as the procedure. Report 31652 for EBUS-guided biopsy for one or two mediastinal and/or hilar lymph node stations or structures and 31653 for three or more. Report 31654 when EBUS using a radial ultrasound probe is performed during diagnostic or therapeutic bronchoscopy for peripheral lesions.

Coding Tips

Report 31654 in addition to 31622–31626, 31628, 31629, 31640, 31643, 31645, and 31646. When medically necessary, report moderate (conscious) sedation provided by the performing physician with 99151-99153. When provided by another physician, report 99155-99157. Codes 31652 and 31653 represent complete services and are reported separately when a bronchoscopy procedure includes endobronchial ultrasound (EBUS) guided transbronchial or transtracheal sampling of mediastinal/hilar lymph nodes or surrounding structures. Report 31652–31654 once per encounter.

ICD-10-CM Diagnostic Codes

A15.4	Tuberculosis of intrathoracic lymph nodes
C46.3	Kaposi's sarcoma of lymph nodes
C77.1	Secondary and unspecified malignant neoplasm of intrathoracic lymph nodes
C81.02	Nodular lymphocyte predominant Hodgkin lymphoma, intrathoracic lymph nodes
C81.12	Nodular sclerosis Hodgkin lymphoma, intrathoracic lymph nodes
C81.22	Mixed cellularity Hodgkin lymphoma, intrathoracic lymph nodes
C81.32	Lymphocyte depleted Hodgkin lymphoma, intrathoracic lymph nodes
C81.42	Lymphocyte-rich Hodgkin lymphoma, intrathoracic lymph nodes
C81.72	Other Hodgkin lymphoma, intrathoracic lymph nodes
C82.02	Follicular lymphoma grade I, intrathoracic lymph nodes
C82.12	Follicular lymphoma grade II, intrathoracic lymph nodes
C82.32	Follicular lymphoma grade IIIa, intrathoracic lymph nodes
C82.42	Follicular lymphoma grade IIIb, intrathoracic lymph nodes
C82.52	Diffuse follicle center lymphoma, intrathoracic lymph nodes
C82.62	Cutaneous follicle center lymphoma, intrathoracic lymph nodes
C82.82	Other types of follicular lymphoma, intrathoracic lymph nodes
C83.02	Small cell B-cell lymphoma, intrathoracic lymph nodes
C83.12	Mantle cell lymphoma, intrathoracic lymph nodes
C83.32	Diffuse large B-cell lymphoma, intrathoracic lymph nodes
C83.52	Lymphoblastic (diffuse) lymphoma, intrathoracic lymph nodes
C83.72	Burkitt lymphoma, intrathoracic lymph nodes
C83.82	Other non-follicular lymphoma, intrathoracic lymph nodes
C84.02	Mycosis fungoides, intrathoracic lymph nodes
C84.12	Sezary disease, intrathoracic lymph nodes
C84.42	Peripheral T-cell lymphoma, not elsewhere classified, intrathoracic lymph nodes
C84.62	Anaplastic large cell lymphoma, ALK-positive, intrathoracic lymph nodes
C84.72	Anaplastic large cell lymphoma, ALK-negative, intrathoracic lymph nodes
C84.Z2	Other mature T/NK-cell lymphomas, intrathoracic lymph nodes
C85.22	Mediastinal (thymic) large B-cell lymphoma, intrathoracic lymph nodes
C85.82	Other specified types of non-Hodgkin lymphoma, intrathoracic lymph nodes
D86.1	Sarcoidosis of lymph nodes
D86.2	Sarcoidosis of lung with sarcoidosis of lymph nodes

AMA: **31652** 2021,Sep; 2021,Apr; 2016,Apr **31653** 2021,Sep; 2021,Apr; 2016,Apr **31654** 2021,Sep; 2021,Apr; 2016,Apr

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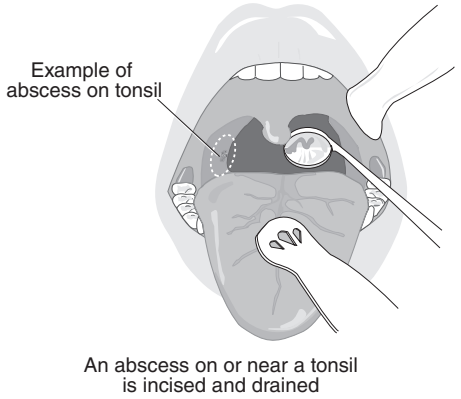
42700

42700 Incision and drainage abscess; peritonsillar



An abscess on or near a tonsil is incised and drained

Explanation

The physician drains an abscess near or on a tonsil. The patient is given a topical anesthetic or placed under general anesthesia. Using an intraoral approach with a mouth gag, the physician incises the mucus membrane of the abscess. The abscess cavity is opened with angulated closed forceps or hemostat. The wound is irrigated and left open.

Coding Tips

For incision and drainage of an abscess, retropharyngeal or parapharyngeal, intraoral approach, see 42720; external approach, see 42725.

ICD-10-CM Diagnostic Codes

J02.0	Streptococcal pharyngitis
J02.8	Acute pharyngitis due to other specified organisms
J03.01	Acute recurrent streptococcal tonsillitis
J03.80	Acute tonsillitis due to other specified organisms
J03.81	Acute recurrent tonsillitis due to other specified organisms
J31.1	Chronic nasopharyngitis
J31.2	Chronic pharyngitis
J35.01	Chronic tonsillitis
J35.03	Chronic tonsillitis and adenoiditis
J35.1	Hypertrophy of tonsils
J35.3	Hypertrophy of tonsils with hypertrophy of adenoids
J35.8	Other chronic diseases of tonsils and adenoids
J36	Peritonsillar abscess

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
42700	1.67	3.84	0.25	5.76
Facility RVU	**Work**	**PE**	**MP**	**Total**
42700	1.67	2.08	0.25	4.0

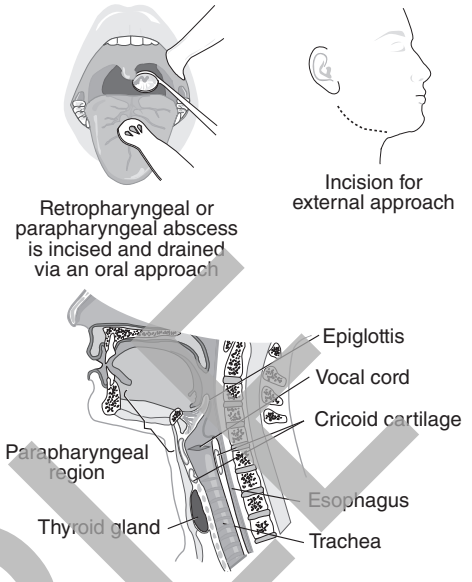
	FUD	Status	MUE	Modifiers				IOM Reference
42700	10	A	2(3)	51	N/A	N/A	N/A	None

* with documentation

42720-42725

42720 Incision and drainage abscess; retropharyngeal or parapharyngeal, intraoral approach

42725 retropharyngeal or parapharyngeal, external approach



Explanation

The physician drains an abscess located on or near the pharynx. Retropharyngeal indicates the abscess is located on the back of the pharynx; parapharyngeal indicates the abscess is near the pharynx. The patient is given a topical anesthetic or placed under general anesthesia. In 42720, through an intraoral approach, the physician locates the abscess using a diagnostic needle puncture and aspiration at the point of maximal fluctuation on the pharynx. The physician incises the mucus membrane to open the abscess. The pus is evacuated using suction and sponging. In 42725, the patient is placed under general anesthesia. The physician makes an incision beneath the angle of the jaw and carries out a blunt dissection to locate and isolate the abscess. The physician incises the mucous membrane of the abscess. The pus is evacuated and a gauze or rubber drain may be inserted into the abscess cavity. The incision is repaired in sutured layers.

Coding Tips

If a culture is transported to an outside laboratory, report 99000 for handling or conveyance. For peritonsillar incision and drainage, see 42700.

ICD-10-CM Diagnostic Codes

J02.0	Streptococcal pharyngitis
J03.01	Acute recurrent streptococcal tonsillitis
J03.80	Acute tonsillitis due to other specified organisms
J03.81	Acute recurrent tonsillitis due to other specified organisms
J39.0	Retropharyngeal and parapharyngeal abscess
J39.1	Other abscess of pharynx
J39.2	Other diseases of pharynx

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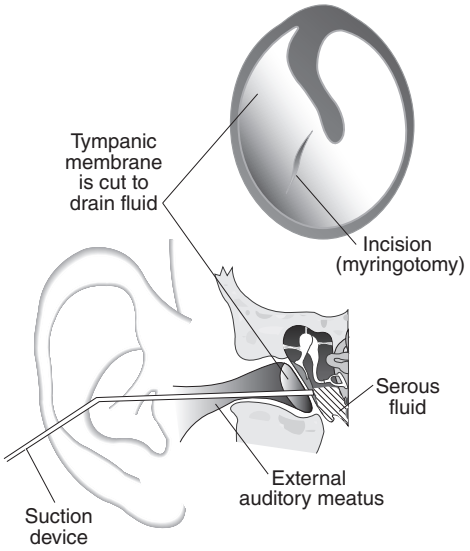
69420-69421

69420 Myringotomy including aspiration and/or eustachian tube inflation
69421 Myringotomy including aspiration and/or eustachian tube inflation requiring general anesthesia



Explanation

After the application of a local anesthetic (e.g., for 69420) or a general anesthetic (e.g., for 69421) and using a microscope for guidance, the physician makes an incision in the patient's tympanic membrane. Fluid is suctioned from the middle ear space and may be reserved for analysis. The Eustachian tube may be inflated. No closure is required.

Coding Tips

These are unilateral procedures. If performed bilaterally, some payers will require that the service be reported twice with modifier 50 appended to the second code while others will require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). If a specimen is transported to an outside laboratory, report 99000 for handling or conveyance.

ICD-10-CM Diagnostic Codes

H65.01 Acute serous otitis media, right ear ☑
H65.04 Acute serous otitis media, recurrent, right ear ☑
H65.111 Acute and subacute allergic otitis media (mucoid) (sanguinous) (serous), right ear ☑
H65.114 Acute and subacute allergic otitis media (mucoid) (sanguinous) (serous), recurrent, right ear ☑
H65.191 Other acute nonsuppurative otitis media, right ear ☑
H65.194 Other acute nonsuppurative otitis media, recurrent, right ear ☑
H65.21 Chronic serous otitis media, right ear ☑
H65.31 Chronic mucoid otitis media, right ear ☑
H65.411 Chronic allergic otitis media, right ear ☑
H65.491 Other chronic nonsuppurative otitis media, right ear ☑
H66.001 Acute suppurative otitis media without spontaneous rupture of ear drum, right ear ☑
H66.004 Acute suppurative otitis media without spontaneous rupture of ear drum, recurrent, right ear ☑
H66.3X1 Other chronic suppurative otitis media, right ear ☑
H69.81 Other specified disorders of Eustachian tube, right ear ☑
H70.001 Acute mastoiditis without complications, right ear ☑
H70.011 Subperiosteal abscess of mastoid, right ear ☑
H70.091 Acute mastoiditis with other complications, right ear ☑
H74.8X1 Other specified disorders of right middle ear and mastoid ☑
H90.11 Conductive hearing loss, unilateral, right ear, with unrestricted hearing on the contralateral side ☑
H90.A11 Conductive hearing loss, unilateral, right ear with restricted hearing on the contralateral side ☑
H90.A21 Sensorineural hearing loss, unilateral, right ear, with restricted hearing on the contralateral side ☑
H90.A31 Mixed conductive and sensorineural hearing loss, unilateral, right ear with restricted hearing on the contralateral side ☑

AMA: **69420** 2021,Apr **69421** 2021,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
69420	1.38	4.14	0.2	5.72
69421	1.78	2.47	0.25	4.5
Facility RVU	**Work**	**PE**	**MP**	**Total**
69420	1.38	1.97	0.2	3.55
69421	1.78	2.47	0.25	4.5

	FUD	Status	MUE	Modifiers				IOM Reference
69420	10	A	1(2)	51	50	N/A	N/A	None
69421	10	A	1(2)	51	50	N/A	N/A	

* with documentation

Terms To Know

aspiration. Drawing fluid out by suction.

chronic. Persistent, continuing, or recurring.

eustachian tube. Internal channel between the tympanic cavity and the nasopharynx that equalizes internal pressure to the outside pressure and drains mucous production from the middle ear.

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

myringotomy. Incision in the eardrum done to prevent spontaneous rupture precipitated by fluid pressure build-up behind the tympanic membrane and to prevent stagnant infection and erosion of the ossicles.

tympanic membrane. Thin, sensitive membrane across the entrance to the middle ear that vibrates in response to sound waves, allowing the waves to be transmitted via the ossicular chain to the internal ear.

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Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
92568	0.29	0.15	0.02	0.46
Facility RVU	**Work**	**PE**	**MP**	**Total**
92568	0.29	0.14	0.02	0.45

92570

92570 Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing

Explanation

The audiologist performs acoustic immittance testing. Using an ear probe, the eardrum's resistance to sound transmission is measured in response to pressure changes. Tympanometry varies the pressure in the external ear canal and identifies the pressure at which maximum sound transmission occurs. This corresponds to current middle ear pressure status. The pressures are recorded and compared to normal values. To measure acoustic reflex threshold testing, the audiologist places a probe in one ear (ipsilateral ear) to measure the impedance of the middle ear and places an earphone on the patient's opposite ear (contralateral ear). A loud sound is presented in the contralateral or ipsilateral ear and the change in impedance caused by the contraction of the stapedius muscle is measured. The acoustic stapedial reflex threshold test (ASRT) measures response to acoustic stimuli (threshold) using the lowest intensity stimulus to obtain a reliable positive stapedial reflex with an acoustic meter. Among other applications, these measurements are used to diagnose neuro-otological conditions and/or determine the appropriate treatment or rehabilitation modalities. In the acoustic reflex decay test, the audiologist again places a probe to measure impedance in one ear and places an earphone on the other ear. A loud tone is presented to one of the ears and maintained for 10 seconds. The impedance change (acoustic reflex) is measured by the probe. In a normal ear, the reflex persists for 10 seconds. In an abnormal ear, the reflex diminishes at least 50 percent in the first five seconds. The presence or absence of this reflex is important in the diagnosis of middle ear dysfunctions. In neural hearing loss, this reflex adapts or decays. Determining whether it adapts or decays aids in differential diagnosis of sensory and neural hearing loss.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
92570	0.55	0.38	0.04	0.97
Facility RVU	**Work**	**PE**	**MP**	**Total**
92570	0.55	0.28	0.04	0.87

92582

92582 Conditioning play audiometry

Explanation

Often physicians or technicians can diagnose a cause of hearing loss through tests using an audiometer. Many causes of hearing loss have characteristic threshold curves. Conditioning play audiometry tests pure tone air and bone conduction and speech thresholds in children. Test sounds can be presented with earphones or sound field testing (pure tone air conduction only). The child is conditioned to perform a simple task (i.e., drop a block in a bucket) when the test sound is heard.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
92582	0.0	2.26	0.02	2.28
Facility RVU	**Work**	**PE**	**MP**	**Total**
92582	0.0	2.26	0.02	2.28

[92650, 92651, 92652, 92653]

92650 Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis

92651 Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report

92652 Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report

92653 Auditory evoked potentials; neurodiagnostic, with interpretation and report

Explanation

In testing auditory evoked potentials (AEPs), electrodes are placed in various locations on the scalp and electrical recordings are made in response to auditory stimulations delivered through earphones. The origin of the electrical response is believed to be from the auditory nerve and brainstem. In 92650, an automated screening is performed with broadband (i.e., frequency nonspecific) stimuli, such as amplitude modulated noise, chirps, or clicks. Broadband stimuli are also used in 92651, which reports a hearing status determination with interpretation and report. Report 92652 for threshold estimation testing using multiple frequencies; this also includes interpretation and report. Code 92653 reports testing to evaluate neural conduction; interpretation and report are included.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
92650	0.25	0.58	0.02	0.85
92651	1.0	1.56	0.05	2.61
92652	1.5	1.83	0.09	3.42
92653	1.05	1.42	0.07	2.54
Facility RVU	**Work**	**PE**	**MP**	**Total**
92650	0.25	0.58	0.02	0.85
92651	1.0	1.56	0.05	2.61
92652	1.5	1.83	0.09	3.42
92653	1.05	1.42	0.07	2.54

92590-92591

92590 Hearing aid examination and selection; monaural

92591 binaural

Explanation

The physician takes a history of hearing loss. The patient's ears are examined. Medical or surgical treatment is offered if possible. The appropriate type of hearing aid is selected to fit the patient's pattern of hearing loss. Report 92590 if one ear is fitted with a hearing aid and 92591 if both ears receive aids.

SAMPLE

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Correct Coding Initiative Update 28.3

❖Indicates Mutually Exclusive Edit

0208T 36591-36592, 69209-69210, 96523

0209T 0208T, 0211T, 36591-36592, 69209-69210, 92552, 96523

0210T 36591-36592, 69209-69210, 96523

0211T 0210T, 36591-36592, 69209-69210, 96523

0212T 0208T, 0209T, 0210T, 0211T, 36591-36592, 69209-69210, 92555-92556, 96523

0485T 36591-36592, 69209-69210, 92567-92568, 96523

0486T 0485T, 36591-36592, 69209-69210, 92567-92568, 96523

0559T 0694T, 76376-76377

0560T 0694T, 76376-76377

0561T 0694T, 76376-76377

0562T 0694T, 76376-76377

0673T 0213T, 0216T, 10005, 10007, 10009, 10011, 10021, 12001-12007, 12011-12057, 13100-13133, 13151-13153, 36000, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 43752, 51701-51703, 60100, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461-64463, 64479-64505, 64510-64530, 69990, 76000, 76940, 76942, 76998, 77001-77002, 77012-77013, 77021-77022, 92012-92014, 93000-93010, 93040-93042, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360-96368, 96372, 96374-96377, 96523, 99155, 99156, 99157, 99211-99223, 99231-99255, 99291-99292, 99304-99310, 99315-99316, 99334-99337, 99347-99350, 99374-99375, 99377-99378, 99446-99449, 99451-99452, 99495-99496, G0463, J0670, J2001

0725T No CCI edits apply to this code.

0726T No CCI edits apply to this code.

0727T No CCI edits apply to this code.

0728T No CCI edits apply to this code.

0729T No CCI edits apply to this code.

0781T No CCI edits apply to this code.

0782T No CCI edits apply to this code.

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0004A No CCI edits apply to this code.

0011A No CCI edits apply to this code.

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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.

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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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