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28043-28045 (28039, 28041)

**ICD-9-CM Procedural**

83.31 Excision of lesion of tendon sheath
83.32 Excision of lesion of muscle
83.49 Other excision of soft tissue
86.3 Other local excision or destruction of lesion or tissue of skin and subcutaneous tissue
86.4 Radical excision of skin lesion

**Anesthesia**

28039 00400
28041 01470
28043 00400
28045 01470

**ICD-9-CM Diagnostic**

171.3 Malignant neoplasm of connective and other soft tissue of lower limb, including hip
172.7 Malignant melanoma of skin of lower limb, including hip
195.5 Malignant neoplasm of lower limb
198.89 Secondary malignant neoplasm of other specified sites
209.34 Merkel cell carcinoma of the lower limb
209.75 Secondary Merkel cell carcinoma
214.1 Lipoma of other skin and subcutaneous tissue
215.3 Other benign neoplasm of connective and other soft tissue of lower limb, including hip
238.1 Neoplasm of uncertain behavior of connective and other soft tissue
239.2 Neoplasms of unspecified nature of bone, soft tissue, and skin

**Terms To Know**

benign. Mild or nonmalignant in nature.

fascia. Fibrous sheet or band of tissue that envelops organs, muscles, and groupings of muscles.

lipoma. Benign tumor containing fat cells and the most common of soft tissue lesions, which are usually painless and asymptomatic, with the exception of an angiolipoma.

malignant. Any condition tending to progress toward death, specifically an invasive tumor with a loss of cellular differentiation that has the ability to spread or metastasize to other areas in the body.

sebaceous cyst. Benign cyst of the skin or hair follicle filled with keratin and debris rich in lipids that may be treated by incision and drainage or puncture aspiration.

**CCI Version 17.3**


Also not with 28039: 0213T, 0216T, 28001

Also not with 28043: 0213T, 0216T, 28001, 28008-28011, 28043, 28060, 28080-28092, 28220, 28225-28226, 29515, 38500, J0670

Also not with 28043: 0213T, 0216T, 28001-28002, 28008, 28024, 28039, 28043-28045, 28054-28062, 28080-28092, 28220-28226, 28232-28234, 28272, 28315, 29405

Also not with 28043: 28001, 28010-28011, 28090-28092, 28220-28226, 29515, 38500, J0670

Also not with 28045: 28001-28002, 28008, 28024, 28039, 28043, 28054, 28060, 28080-28092, 28220-28226, 28232-28234, 28272, 28315, 29405, J0670

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

**Medicare Edits**

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* with documentation

**Medicare References:** None

**Coding Tips**

Codes 28039 and 28041 are resequenced codes and will not display in numeric order. Local anesthesia is included in these services.

However, these procedures may be performed under general anesthesia, depending on the age and/or condition of the patient. An excisional biopsy is not reported separately when a therapeutic excision is performed during the same surgical session. If specimen is transported to an outside laboratory, report 99900 for handling or conveyance. For radical resection of a tumor, soft tissue of foot, see 28046-28047.

**Explanation**

The physician removes a tumor from the soft tissue of the foot or toe that is located in the subcutaneous tissue in 28039 and 28043 and in the deep soft tissue, below the fascial plane, or within the muscle in 28041 and 28045.

With the proper anesthesia administered, the physician makes an incision in the skin overlying the mass and dissects down to the tumor. The extent of the tumor is identified and a dissection is undertaken all the way around the tumor. A portion of neighboring soft tissue may also be removed to ensure adequate removal of all tumor tissue. A drain may be inserted and the incision is repaired with layers of sutures, staples, or Steri-strips. Report 28045 for excision of a subfascial or intramuscular tumor whose resected area is less than 1.5 cm and 28039 for a resected area that is 1.5 cm or greater. Report 28045 for excision of a subfascial or intramuscular tumor whose resected area is less than 1.5 cm and 28041 for a resected area 1.5 cm or greater.

**Coding Tips**

Codes 28039 and 28041 are resequenced codes and will not display in numeric order. Local anesthesia is included in these services.

With the proper anesthesia administered, the physician makes an incision in the skin overlying the mass and dissects down to the tumor. The extent of the tumor is identified and a dissection is undertaken all the way around the tumor. A portion of neighboring soft tissue may also be removed to ensure adequate removal of all tumor tissue. A drain may be inserted and the incision is repaired with layers of sutures, staples, or Steri-strips. Report 28045 for excision of a subfascial or intramuscular tumor whose resected area is less than 1.5 cm and 28039 for a resected area that is 1.5 cm or greater. Report 28045 for excision of a subfascial or intramuscular tumor whose resected area is less than 1.5 cm and 28041 for a resected area 1.5 cm or greater.

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**Medicare References:** None
36415
36415 Collection of venous blood by venipuncture

**Explanation**
A needle is inserted into the skin over a vein to puncture the blood vessel and withdraw blood for venous collection. The blood is used for diagnostic study and no catheter is placed.

73590
73590 Radiologic examination; tibia and fibula, 2 views

**Explanation**
Two films of the lower leg bones are taken. The physician interprets and reports the findings.

73600-73610
73600 Radiologic examination, ankle; 2 views
73610 complete, minimum of 3 views

**Explanation**
Two films are taken of the ankle in 73600 and a complete radiologic exam of the ankle is performed in 73610 with three or more films taken. The codes do not specify that a specific view must be performed. The physician interprets and reports the findings.

73615
73615 Radiologic examination, ankle, arthrography, radiological supervision and interpretation

**Explanation**
The physician injects radiopaque fluid into the ankle for arthrography. The physician inserts a needle into the joint and aspirates if necessary. Opaque contrast solution is injected into the ankle and the needle is removed. Films are then taken of the ankle. This code reports the radiological supervision and interpretation only. Use a separately reportable code for the injection.

73620-73630
73620 Radiologic examination, foot; 2 views
73630 complete, minimum of 3 views

**Explanation**
Two films are taken of the foot in 73620 and a complete radiologic exam of the foot is performed in 73630 with three or more films taken. The codes do not specify that a specific view must be performed. The physician interprets and reports the findings.

73650
73650 Radiologic examination; calcaneus, minimum of 2 views

**Explanation**
Two or more films are taken of the calcaneous or heel bone. The physician interprets and reports the findings.

73660
73660 Radiologic examination; toe(s), minimum of 2 views

**Explanation**
Two or more films are taken of the toes. The physician interprets and reports the findings.

73700-73702
73700 Computed tomography, lower extremity; without contrast material
73701 with contrast material(s)
73702 without contrast material(s) and further sections

**Explanation**
Computed tomography (CT) directs multiple narrow beams of x-rays around the body structure being studied and uses computer imaging to produce thin cross-sectional views of various layers (or slices) of the body. CT is useful for the evaluation of trauma, tumor, and foreign bodies as CT is able to visualize soft tissue as well as bones. Patients are required to remain motionless during the study and sedation may need to be administered as well as a contrast medium for image enhancement. These codes report an exam of the lower extremity. Report 73700 if no contrast is used. Report 73701 if performed with contrast and 73702 if performed first without contrast and again following the injection of contrast.

73718-73720
73718 Magnetic resonance angiography, lower extremity; without contrast material(s)
73719 with contrast material(s)
73720 without contrast material(s), followed by contrast material(s) and further sequences

**Explanation**
Magnetic resonance angiography (MRA) is magnetic resonance imaging (MRI) that specifically visualizes blood vessels and blood flow to evaluate vascular disorders within the structure being studied. Unlike CT, it does not rely on the absorption of x-ray energy. Magnetic resonance imaging uses the natural magnetic properties of the hydrogen atoms in our bodies that emit radiofrequency signals when exposed to radio waves within a strong electro-magnetic field. These signals are then processed and converted by the computer into high-resolution, three-dimensional, tomographic images. Patients with metallic or electronic implants or foreign bodies cannot be exposed to MRI. The patient must remain still while lying on a motorized table within the large, circular MRI tunnel. A sedative may be administered as well as contrast material for image enhancement. This code reports an exam of any joint of the lower extremity, with or without contrast material.

73725
73725 Magnetic resonance angiography, lower extremity, with or without contrast material(s)

**Explanation**
Magnetic resonance angiography (MRA) is magnetic resonance imaging (MRI) that specifically visualizes blood vessels and blood flow to evaluate vascular disorders within the structure being studied. Unlike CT, it does not rely on the absorption of x-ray energy. Magnetic resonance imaging uses the natural magnetic properties of the hydrogen atoms in our bodies that emit radiofrequency signals when exposed to radio waves within a strong electro-magnetic field. These signals are then processed and converted by the computer into high-resolution, three-dimensional, tomographic images. Patients with metallic or electronic implants or foreign bodies cannot be exposed to MRI. The patient must remain still while lying on a motorized table within the large, circular MRI tunnel. A sedative may be administered as well as contrast material for image enhancement. For any joint of the lower extremity, report 73721 if no contrast is used; 73722 if performed with contrast and 73723 if performed first without contrast and then again following the injection of contrast.

73730
73730 Magnetic resonance angiography, lower extremity, with or without contrast material(s)

**Explanation**
Magnetic resonance angiography (MRA) is magnetic resonance imaging (MRI) that specifically visualizes blood vessels and blood flow to evaluate vascular disorders within the structure being studied. Unlike CT, it does not rely on the absorption of x-ray energy. Magnetic resonance imaging uses the natural magnetic properties of the hydrogen atoms in our bodies that emit radiofrequency signals when exposed to radio waves within a strong electro-magnetic field. These signals are then processed and converted by the computer into high-resolution, three-dimensional, tomographic images. Patients with metallic or electronic implants or foreign bodies cannot be exposed to MRI. The patient must remain still while lying on a motorized table within the large, circular MRI tunnel. A sedative may be administered as well as contrast material for image enhancement. For any joint of the lower extremity, report 73730 if no contrast is used; 73731 if performed with contrast and 73732 if performed first without contrast and then again following the injection of contrast.
This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately $32 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient, the system of coding clinical visits may be mastered once the knowledge that a provider may bring to bear on a given patient is recognized without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

### Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:
- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Hospital inpatient services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician’s office, the outpatient area, or other ambulatory facility.

Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a patient is on call or covering for another physician, the patient’s encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient’s attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as “observation status” in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician “admitting” the patient for observation.

Codes 99224-99226 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and preparation of the discharge records. It should not be used when admission and discharge are on the same date of service. As mentioned above, report codes 99234-99236 to appropriately describe same day observation services.

If a patient is in observation longer than one day, subsequent observation care codes 99224-99226 should be reported if the patient is discharged on the second day, observation discharge code 99217 should be reported. If the patient status is changed to inpatient on a subsequent date, the appropriate inpatient code, 99221-99223, should be reported.

Initial hospital care is defined as E/M services provided during the first hospital inpatient encounter with the patient by the admitting physician. (If a physician other than the admitting physician