INGENIX

Coding Companion for Plastics/OMS/Dermatology

A comprehensive illustrated guide to coding and reimbursement

2011
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21025-21026
21025 Excision of bone (e.g., for osteomyelitis or bone abscess); mandible
21026 facial bone(s)

21025 or 21026 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report. Antibiotic-impregnated beads are not reported separately. An excisional biopsy is not reported separately when a therapeutic excision is performed during the same surgical session. Local anesthesia is included in the service. If specimen is transported to an outside laboratory, report 99000 for handling or conveyance. For biopsy of bone, see 20220 and 20240. For excision of a benign cyst or tumor of the mandible, simple, see 21040; complex, see 21041. For excision of a malignant tumor of the mandible, see 21044 and 21045. If harvest of bone is required, see 21025.

ICD-9-CM Procedural
76.31 Partial mandibulectomy
76.39 Partial ostectomy of other facial bone
76.41 Total mandibulectomy with synchronous reconstruction
76.42 Other total mandibulectomy
76.44 Total ostectomy of other facial bone with synchronous reconstruction
76.45 Other total ostectomy of other facial bone

Anesthesia
00190

ICD-9-CM Diagnostic
015.56 Tuberculosis of mandible, confirmation unspecified — (Use additional code to identify manifestation: 711.4, 727.01, 730.8)
383.01 Subperiosteal abscess of maxilla
383.02 Acute mastoiditis with other complications
383.1 Chronic mastoiditis
383.21 Acute petrositis
383.22 Chronic petrositis
526.2 Other cysts of jaws
526.4 Inflammatory conditions of jaw
526.89 Other specified disease of the jaws
730.08 Acute osteomyelitis, other specified site — (Use additional code to identify organism: 041.1. Use additional code to identify major osseous defect, if applicable: 731.3)
730.88 Other infections involving bone diseases classified elsewhere, other specified sites — (Use additional code to identify organism: 041.1. Code first underlying disease: 002.0, 015.0-015.9)
996.66 Infection and inflammatory reaction due to internal joint prosthesis — (Use additional code to identify specified infections. Use additional code to identify infected prosthetic joint: V43.60-V43.69)

Terms To Know
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.

petrositis. Inflammation occurring in the petrous portion of the lateral region (temporal bone) of the skull.
saucerization. Creation of a shallow, saucer-like depression in the bone to facilitate drainage of infected areas.

CCI Version 16.3
0213T, 0216T, 0228T, 0230T, 21050, 21060, 21070, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 51701-51703, 62310-62319, 64400-64435, 64445-64450, 64479, 64483, 64490, 64493, 64505-64530, 69990, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150, J0670, 9201
Also not with 21025: 00170, 21073
Also not with 21026: 11011-11012

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

Medicare Edits

Medicare References: 100-2,15,260; 100-4,12,30; 100-4,12,90.3; 100-4,14,10

Explanation
The physician removes infected or dead bone tissue from the mandible in 21025. This procedure can be performed intraorally through the mucosa or extraorally through a skin incision. If only a small amount of bone is affected, the physician may saucervize the area by grinding the dead bone away with drills or osteotomes. Healthy bone and the continuity of the mandible are left intact. Antibiotic-impregnated acrylic beads may be implanted into the surgical site to stop infection after the removal of bone. These beads are removed at a later time. Extensive bone removal in large sections or blocks may require a separate bone harvesting/extensive procedure to repair continuity defects. The incisions are closed simply. In 21026, the physician removes dead or infected bone from facial bones. A transoral incision in the maxillary buccal vestibule is the most frequent approach. Facial incisions would only be used for large lesions or for additional surgical access. The physician reflects the overlying mucosa, exposing the dead bone. Drills, saws, and osteotomes are used to remove the bone. The transoral incisions are closed in a single layer. Any cutaneous incision is closed in multiple layers.

Coding Tips
The bone death is secondary to infection (e.g., osteomyelitis) or loss of vascularity (e.g., radiation therapy for malignancy). When

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Radiologic examination, mandible; partial, less than 4 views

Explanation

The lower jaw bone is x-rayed. In 70100, three or less projections are taken for a partial view of the mandible in 70110, four or more projections are taken for a complete view of the bone structure.

Radiologic examination, facial bones; less than 3 views

Explanation

X-rays of the facial bones are obtained to determine an injury, fracture, or neoplasm. After positioning the patient, less than three views of the facial bones are obtained. The physician supervises the procedure and interprets the findings.

Radiologic examination, facial bones; complete, minimum of 3 views

Explanation

X-rays of the facial bones are obtained to determine an injury, fracture, or neoplasm. After positioning the patient, a complete series of x-rays of the facial bones, with a minimum of three views, is obtained. The physician supervises the procedure and interprets the findings.

Radiologic examination, nasal bones; complete, minimum of 3 views

Explanation

Films are taken of the nasal bones to include a complete exam, or minimum of three views. Typically, this exam would consist of both right and left lateral (side to side) for comparison, as well as a tangential projection in which the x-ray beam is directed from a position above the patient’s head down through the nose. This view is primarily used to demonstrate the medial or lateral (side to side) displacement of nasal fractures.

Radiologic examination, skull; less than 4 views

Explanation

Films are taken of the skull bones. In 70250, three or less views are taken, and in 70260, a complete exam with a four view minimum is performed. The most common projections for routine skull series are AP axial (front to back), lateral, and PA axial (back to front). X-rays may be taken with the patient placed erect, prone, or supine and either code may include stereoradiography, which is a technique that produces three-dimensional images.

Radiologic examination, teeth; single view

Explanation

Films are taken of the mouth to show teeth and/or surrounding bone. In dental radiography, the film may be placed either inside or outside the mouth. Code 70300 reports a single view only, 73010 reports a partial examination, and 70320 reports a complete full mouth exam.

Radiologic examination, temporomandibular joint, open and closed mouth; unilateral

Explanation

The temporomandibular joint is x-rayed in two projections on one side only in 70328 and in two projections on both sides in 70330. One film is taken with the mouth open and one with the mouth closed.

Radiologic examination, temporomandibular joint(s)

Explanation

A radiographic contrast study is performed on the temporomandibular joint. A contrast material is injected into the joint spaces, followed by x-ray examination of the joint. This allows the physician to see the position of the structures not normally seen on conventional x-rays.

Magnetic resonance imaging (MRI) is a radiation-free, noninvasive technique to produce high quality sectional images of the inside of the body in multiple planes. MRI 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 the temporomandibular joint(s).

Computed tomography, head or brain; without contrast material

Explanation

Computed axial tomography 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. It 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 head or brain. Report 70450 if no contrast is used. Report 70460 if performed with contrast and 70470 if performed first without contrast and then again following the injection of contrast.

Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material

Explanation

Computed axial tomography 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
Evaluation and Management

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 few 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 $29 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 presentation, the true indications of the level of this work may be difficult to recognize 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.

If a physician 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.

If a patient is discharged from observation status or hospital inpatient 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