Coding Companion for Plastics/Dermatology

A comprehensive illustrated guide to coding and reimbursement

2013
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17280-17286
17280 Destruction, malignant lesion (eg, laser surgery, electrosurgery, cryosurgery, chemo surgery, surgical curettage), face, ears, eyelids, nose, lips, mucous membrane; lesion diameter 0.5 cm or less
17281 lesion diameter 0.6 to 1.0 cm
17282 lesion diameter 1.1 to 2.0 cm
17283 lesion diameter 2.1 to 3.0 cm
17284 lesion diameter 3.1 to 4.0 cm
17286 lesion diameter over 4.0 cm

Explanation
The physician destroys a malignant lesion of the face, ears, eyelids, nose, lips, or mucous membranes. Destruction may be accomplished by using a laser or electrocautery to burn the lesion, cryotherapy to freeze the lesion, chemicals to destroy the lesion, or surgical curettage to remove the lesion. Report 17280 for a lesion diameter 0.5 cm or less; 17281 for 0.6 cm to 1 cm; 17282 for 1.1 cm to 2 cm; 17283 for 2.1 cm to 3 cm; 17284 for 3.1 cm to 4 cm; and 17286 if the lesion diameter is greater than 4 cm.

Coding Tips
A biopsy is not identified separately when followed by destruction during the same operative session. For destruction of premalignant lesions, see 17000–17011. For intralesional injection to limit scarring, see 11900.

ICD-9-CM Procedural
08.25 Destruction of lesion of eyelid
18.29 Excision or destruction of other lesion of external ear
21.32 Local excision or destruction of other lesion of nose
86.24 Chemosurgery of skin
86.3 Other local excision or destruction of lesion or tissue of skin and subcutaneous tissue

Anesthesia
00300

ICD-9-CM Diagnostic
140.0 Malignant neoplasm of upper lip, vermilion border
140.1 Malignant neoplasm of lower lip, vermilion border
140.3 Malignant neoplasm of upper lip, inner aspect
140.4 Malignant neoplasm of lower lip, inner aspect
140.5 Malignant neoplasm of lip, inner aspect, unspecified as to upper or lower
140.6 Malignant neoplasm of commissure of lip
140.8 Malignant neoplasm of other sites of lip
143.0 Malignant neoplasm of upper gum
143.1 Malignant neoplasm of lower gum
144.0 Malignant neoplasm of anterior portion of floor of mouth
144.1 Malignant neoplasm of lateral portion of floor of mouth
145.0 Malignant neoplasm of cheek mucosa
145.1 Malignant neoplasm of vestibule of mouth
145.6 Malignant neoplasm of retromolar area
171.0 Malignant neoplasm of connective and other soft tissue of head, face, and neck
172.0 Malignant melanoma of skin of lip
172.1 Malignant melanoma of skin of eyelid, including canthus
172.2 Malignant melanoma of skin of ear and external auditory canal
172.3 Malignant melanoma of skin of other and unspecified parts of face
173.01 Basal cell carcinoma of skin of lip
173.02 Squamous cell carcinoma of skin of lip
173.21 Basal cell carcinoma of skin of ear and external auditory canal
173.22 Squamous cell carcinoma of skin of ear and external auditory canal
173.31 Basal cell carcinoma of skin of other and unspecified parts of face
173.32 Squamous cell carcinoma of skin of other and unspecified parts of face
209.31 Merkel cell carcinoma of the face
230.2 Carcinoma in situ of skin of lip
230.1 Carcinoma in situ of eyelid, including canthus
230.2 Carcinoma in situ of skin of ear and external auditory canal
230.3 Carcinoma in situ of skin of other and unspecified parts of face

CCI Version 17.3
0213T, 0216T, 0228T, 0230T, 1100, 11900-11901, 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, 10670, J2001 Also not with 17280: 11600#, 11602-11606#, 11620-11646# Also not with 17281: 11601-11606#, 11621-11626#, 11641-11646# Also not with 17282: 11602-11606#, 11622-11626#, 11641-11646# Also not with 17283: 11606#, 11623-11626#, 11642-11646# Also not with 17284: 11606#, 11624-11626#, 11643-11646# Also not with 17286: 11644-11646# Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

Medicare Edits

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MUE Modifiers

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Medicare References: 100-3,140.5
Films
Explanation
The lower jaw bone is x-rayed. In 70100, three or less projections are taken for a partial view of the bone structure and in 70110, four or more projections are taken for a complete view of the bone structure.

70140
70140 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 and reports the findings.

70150
70150 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 and reports the findings.

70160
70160 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.

70250-70260
70250 Radiologic examination, skull; less than 4 views
70260 complete, minimum of 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.

70300-70320
70300 Radiologic examination, teeth; single view
70310 partial examination, less than full mouth
70320 complete, full mouth
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.

70328-70330
70328 Radiologic examination, temporomandibular joint, open and closed mouth; unilateral
70330 bilateral
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.

70332
70332 Temporomandibular joint arthrography, radiological supervision and interpretation
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.

70336
70336 Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)
Explanation
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).

70350
70350 Cephalogram, orthodontic
Explanation
A lateral or frontal x-ray projection is taken to examine the entire skull, jaw, and related tooth positions. The machine holds the patient’s head in the same position each time so that a series of cephalograms can be directly compared for growth and development over time.

70355
70355 Orthopantomogram (eg, panoramic x-ray)
Explanation
A panoramic radiographic study is performed on the mandibular arch and its supporting structures. A single image is produced of the mandible for diagnostic purposes. The physician evaluates trauma, third molar, and other unique disease conditions. Tooth development and anomalies may also be studied.

Coding Tips
This code has been revised for 2012 in the official CPT description.

70450-70470
70450 Computed tomography, head or brain; without contrast material
70460 with contrast material(s)
70470 without contrast material, followed by contrast material(s) and further sections
Explanation
Computerized 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.
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.

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 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.

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 99224-99236 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 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, 99221-99233, 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