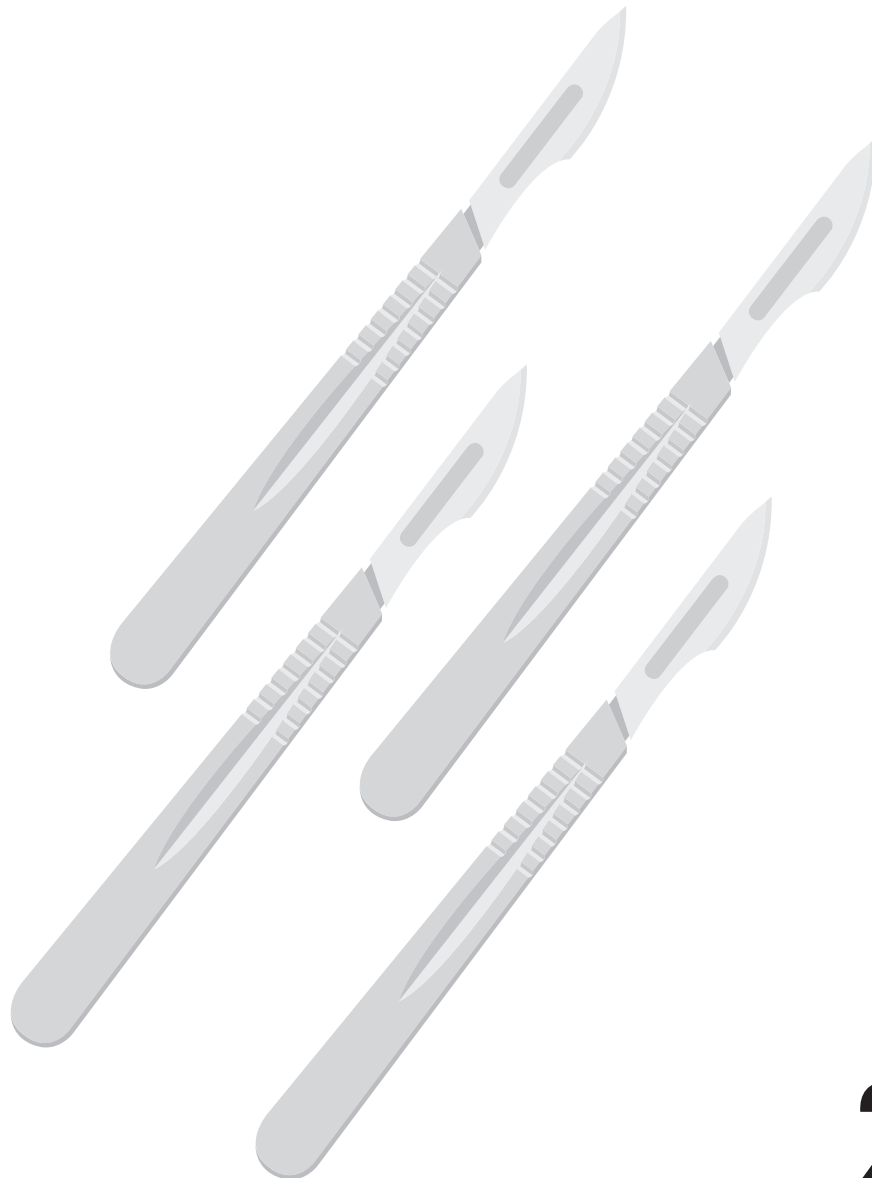


Coding and Billing for
**Plastic Surgery/
Dermatology**

A Comprehensive and Illustrative Specialty Guide



2011

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Vesicle – A circumscribed fluid-filled lesion less than 1.0 cm in diameter that is usually elevated above the surrounding skin. May be described as solitary, grouped, umbilicated, dyshidrotic, spongiotic, multi-locular or uni-locular.

Vesicular – Relating to a vesicle; characterized by or containing vesicles.

Vitiligo – A usually progressive, chronic pigmentary anomaly of the skin manifested by depigmented white patches that may be surrounded by a hyperpigmented border; it is associated with a dominantly inherited predisposition, and it has been speculated that autoimmune mechanisms are involved in the etiology. Cf. leukoderma and piebaldism. A disorder consisting of areas of macular depigmentation, commonly on extensor aspects of extremities, on the face or neck, and in skin folds. Age of onset is often in young adulthood and the condition tends to progress gradually with lesions enlarging and extending until a quiescent state is reached.

Wheal, Welt – A circumscribed, evanescent area of edema of the skin, appearing as an urticarial lesion, slightly redened, often changing in size and shape and extending to adjacent areas, and usually accompanied by intense itching.

Xerosis – Dry skin.

Zirconium – A rather rare metallic element; symbol Zr; atomic number, 40; atomic weight, 91.22; chiefly obtained from a mineral called zircon.

Abbreviations

The following definitions are medical terms commonly seen while coding for Plastic Surgery and Dermatology:

a	before meals
A	without, lack of, apathy; apnea; aphasia; anemia
A & P	anterior and posterior; auscultation and percussion
ABG	arterial blood gas
AC	before meals
Ad	to, toward, near to, adductor; adhesion, ; adnexia; adrenal
ADL	activities of daily living
Ad Lib	at pleasure, as needed or desired
ADP	abductor pollicis
AK	actinic keratosis
AM	anteromedial
AMA	against medical advice
AMB	ambulatory
Ambi	both, ambidextrous; ambilaterally
ANTE	before
Anti	against, opposed to, reversed antiperistalsis; antiseptis
A & O	alert and oriented
APB	abductor pollicis brevis (also ABPB)
APL	abductor pollicis longus (also ABPL)
Apo	from, away from aponeurosis; apochromatic
AT	achilles tendon (also TA)

Bi	twice, double biarticulate; bifocal; bifurcation
BID	twice a day
BILAT	bilateral
BP	blood pressure
BRP	bathroom privileges
bx	biopsy
C	Celsius (centigrade)
C	with
Ca	calcium, cancer, carcinoma
CAT	computerized tomography scan
Cata	down, according to, complete catabolism; catalepsia; catarrh
CBC	complete blood count
CBR	complete bed rest
cc	chief complaint
Circum	around, about circumflex; circumference; circumarticular
CMS	circulation, motion, sensation
CN (2-12)	cranial nerves (2 to 12)
CNS	central nervous system
C/O	complaint of
Com	with, together, commissure
Con	with, together, conductor; concrescence; concentric
Contra	against, opposite contralateral; contraception; contraindicated
CRT	capillary refill time
CSF	cerebrospinal fluid
CVA	costovertebral angle, cerebrovascular accident
CX	circumflex
CXR	chest x-ray
D	disc
D5W	Dextrose 5% in water
D5LR	Dextrose 5% with lactated ringers
DAT	diet as tolerated
DBP	diastolic blood pressure
D/C	discontinue
De	away from, dehydrate; dedentition; decompensation
Di	twice, double, diplopia; dichromatic; digastric
Dia	through, apart, across, completely diaphragm; diapedesis; diagnosis
DIP	distal interphalangeal
Dis	reversal, apart from, separation disinfection; disparity; dissec
DNR	do not resuscitate
Dx	diagnosis
Dys	bad, difficult, disordered, dyspepsia; dyspnea; dystopia
E, ex	out, away from, enucleate; eviscerate; exostosis
Ec	out from, ectopic; eccentric; ectasia
ECRB	extensor carpi radialis brevis
ECRL	extensor carpi radialis longus

of Diseases, 10th Edition (ICD-10). To view these Mappings, refer to the following link:

http://www.contextodata.com/2010ICD10CMMappings/2010_I9Gem.txt
http://www.contextodata.com/2010ICD10CMMappings/2010_I10Gem.txt

ICD-10-CM Code Set Improvements

The clinical modification of ICD-10 represents a significant improvement over ICD-9-CM. Some of the specific organizational improvements that provide greater specificity in code assignment include:

- The addition of information relevant to ambulatory and managed care encounters
- Expanded injury codes, grouped by anatomical site rather than injury category
- The creation of combination diagnosis/symptom or manifestation codes to reduce the number of codes needed to fully describe a condition as well as combination codes for poisonings and external causes
- The addition of 6th and 7th characters with the seventh digit extensions representing visit encounter or sequelae for injuries and external causes
- Added laterality
- Full code titles for all codes with the incorporation of common 4th and 5th digit subclassifications (no more referring back to common fourth and fifth digits to understand the full code)
- V and E codes are no longer supplemental classifications
- Postoperative complications have been grouped within a procedure-specific body system chapter

Official Coding Guideline Differences

In order to code more effectively, the Official Guidelines for Coding and Reporting should be reviewed. Below are examples of the ICD-9-CM and ICD-10-CM Guidelines placed side-by-side and the differences between the two become readily apparent. Because the format and structure of ICD-10-CM has undergone a number of changes, there is additional information as well as the changes.

ICD-9-CM General Coding Guidelines	ICD-10-CM General Coding Guidelines
Locating a Code in ICD-9-CM	Locating a Code in ICD-10-CM
Locate each term in the Alphabetic Index and verify the code selected in the Tabular List. Read and be guided by instructional notations that appear in both the Alphabetic Index and the Tabular List.	To select a code in the classification that corresponds to a diagnosis or reason for visit documented in a medical record, first locate the term in the Index, and then verify the code in the Tabular List. Read and be guided by instructional notations that appear in both the Index and the Tabular List. It is essential to use both the Index and Tabular List when locating and assigning a code. The Index does not always provide the full code. Selection of the full code, including laterality and any applicable 7th character can only be done in the Tabular List. A dash (-) at the end of an Index entry indicates that additional characters are required. Even if a dash is not included at the Index entry, it is necessary to refer to the Tabular List to verify that no 7th character is required.

ICD-9-CM General Coding Guidelines	ICD-10-CM General Coding Guidelines
Level of Detail in Coding	Level of Detail in Coding
ICD-9-CM diagnosis codes are composed of codes with 3, 4, or 5 digits. Codes with three digits are included in ICD-9-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater detail.	ICD-10-CM diagnosis codes are composed of codes with 3, 4, 5, 6, or 7 digits. Codes with three digits are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth and/or fifth digits, which provide greater detail.
A three digit code is to be used only if it is not further subdivided. Where fourth-digit subcategories and/or fifth-digit subclassifications are provided, they must be assigned. A code is invalid if it has not been coded to the full number of digits required for that code.	A three-digit code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.
Codes from 001.0 through V91.99	Codes from A00.0 through T88.9, Z00-Z99.89
The appropriate code or codes from 001.0 through V91.99 must be used to identify problems, complaints or other reason(s) for the encounter/visit.	The appropriate code or codes from A00.0 through T88.9, Z00-Z99.89 must be used to identify diagnoses, symptoms, conditions, problems, complaints or other reason(s) for the encounter/visit.
Signs and Symptoms	Signs and Symptoms
Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 16 of ICD-9-CM, Symptoms, Signs, and Ill-defined conditions (codes 780.0-799.9) contains many, but not all codes for symptoms.	Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a related definitive diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified (codes R00.0-R99) contains many, but not all codes for symptoms.

Plastic Surgery/Dermatology Specific ICD-10-CM Coding Information

In ICD-9-CM, diseases of the genitourinary system are coded to Chapter 10. In ICD-10-CM, diseases of the genitourinary system are coded in Chapter 14. This chapter in ICD-10-CM also contains codes for many conditions that are considered symptoms related to the genitourinary system and reported in the Signs, Symptoms, and Ill-Defined Conditions chapter in ICD-9-CM.

The table below shows examples of conditions that have been moved from the signs and symptoms chapter to the genitourinary chapter in ICD-10-CM:

Condition	ICD-9-CM	ICD-10-CM
Skin abscess of top of left hand	682.4 Cellulitis and abscess of hand, except fingers and thumb	L02.512 Cutaneous abscess of left hand

Introduction to ICD-10-PCS

As new procedures are developed, the structure of ICD-10-PCS should allow them to be easily incorporated as unique codes.

Multiaxial

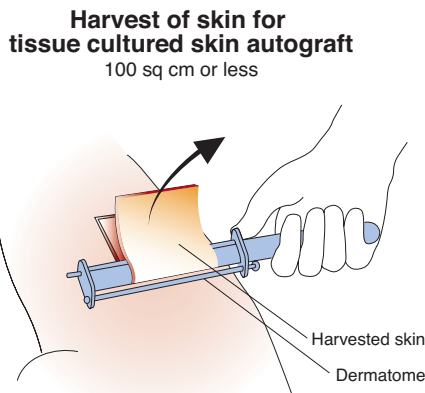
ICD-10-PCS codes should consist of independent characters, with each individual axis retaining its meaning across broad ranges of codes to the extent possible.

15040

15040 Harvest of skin for tissue cultured skin autograft, 100 sq cm or less

Plain English Description

Skin from the patient is harvested for tissue culture for a skin autograft. This procedure is typically performed on burn patients with burns covering 30% or more of total body surface area (TBSA). The subcutaneous tissue is infiltrated with a solution containing epinephrine to control bleeding. A dermatome is used to harvest a small piece, 100 sq cm or less, of the patient's skin. The harvested skin is then sent to a specialized laboratory where the epithelial cells are separated from dermal cells and placed in an incubator where they are provided with nutrients so that the cells will grow into sheets of skin that can be used as grafts over the burned regions. The dermal cells may also be cultured and the layers of cells combined prior to grafting.



ICD-9-CM Diagnostic Codes (commonly used)

- 701.4 Keloid scar
- 707.20 Pressure ulcer, unspecified stage
- 707.23 Pressure ulcer, stage III
- 709.2 Scar conditions and fibrosis of skin
- 906.0 Late effect of open wound of head, neck, and trunk
- 906.1 Late effect of open wound of extremities without tendon injury
- 906.5 Late effect of burn of eye, face, head, and neck
- 906.6 Late effect of burn of wrist and hand
- 906.7 Late effect of burn of other extremities
- 908.6 Late effect of certain complications of trauma
- 941.30 Full-thickness skin loss due to burn (third degree NOS) of unspecified site of face and head
- 941.38 Full-thickness skin loss due to burn (third degree NOS) of neck
- 941.48 Deep necrosis of underlying tissues due to burn (deep third degree) of neck, without loss of neck
- 942.01 Burn of unspecified degree of breast
- 942.02 Burn of unspecified degree of chest wall, excluding breast and nipple
- 942.03 Burn of unspecified degree of abdominal wall
- 942.04 Burn of unspecified degree of back (any part)
- 942.30 Full-thickness skin loss due to burn (third degree NOS) of unspecified site of trunk
- 942.31 Full-thickness skin loss due to burn (third degree NOS) of breast
- 942.32 Full-thickness skin loss due to burn (third degree NOS) of chest wall, excluding breast and nipple
- 942.33 Full-thickness skin loss due to burn (third degree NOS) of abdominal wall
- 942.34 Full-thickness skin loss due to burn (third degree NOS) of back (any part)
- 942.41 Deep necrosis of underlying tissues due to burn (deep third degree) of breast, without loss of breast
- 942.42 Deep necrosis of underlying tissues due to burn (deep third degree) of chest wall, excluding breast and nipple, without loss of chest wall
- 942.43 Deep necrosis of underlying tissues due to burn (deep third degree) of abdominal wall, without loss of abdominal wall
- 942.44 Deep necrosis of underlying tissues due to burn (deep third degree) of back (any part), without loss of back

- 943.30 Full-thickness skin loss due to burn (third degree NOS) of unspecified site of upper limb
- 943.31 Full-thickness skin loss due to burn (third degree NOS) of forearm
- 943.32 Full-thickness skin loss due to burn (third degree NOS) of elbow
- 943.33 Full-thickness skin loss due to burn (third degree NOS) of upper arm
- 943.35 Full-thickness skin loss due to burn (third degree NOS) of shoulder
- 943.36 Full-thickness skin loss due to burn (third degree NOS) of scapular region
- 943.41 Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, without loss of forearm
- 943.42 Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, without loss of elbow
- 943.43 Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, without loss of upper arm
- 943.45 Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, without loss of shoulder
- 943.46 Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, without loss of scapula
- 944.30 Full-thickness skin loss due to burn (third degree NOS) of unspecified site of hand
- 944.31 Full-thickness skin loss due to burn (third degree NOS) of single digit (finger (nail) other than thumb)
- 944.32 Full-thickness skin loss due to burn (third degree NOS) of thumb (nail)
- 944.33 Full-thickness skin loss due to burn (third degree NOS) of two or more digits of hand, not including thumb
- 944.34 Full-thickness skin loss due to burn (third degree NOS) of two or more digits of hand, including thumb
- 944.35 Full-thickness skin loss due to burn (third degree NOS) of palm of hand
- 944.36 Full-thickness skin loss due to burn (third degree NOS) of back of hand
- 944.37 Full-thickness skin loss due to burn (third degree NOS) of wrist
- 945.30 Full-thickness skin loss due to burn (third degree NOS) of unspecified site of lower limb
- 945.33 Full-thickness skin loss due to burn (third degree NOS) of ankle
- 945.34 Full-thickness skin loss due to burn (third degree NOS) of lower leg
- 945.35 Full-thickness skin loss due to burn (third degree NOS) of knee
- 945.36 Full-thickness skin loss due to burn (third degree NOS) of thigh (any part)
- 945.44 Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, without loss of lower leg
- 945.45 Deep necrosis of underlying tissues due to burn (deep third degree) of knee, without loss of knee
- 945.46 Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), without loss of thigh
- 998.30 Disruption of wound, unspecified
- 998.33 Disruption of traumatic injury wound repair

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
15040	2.00	1.38	5.01	0.37	3.75	7.38	000	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
15040	0	0	0	0	1

CCI

15040	0213T ⁰ , 0216T ⁰ , 0228T ⁰ , 0230T ⁰ , 36000 ¹ , 36400 ¹ , 36405 ¹ , 36406 ¹ , 36410 ¹ , 36420 ¹ , 36425 ¹ , 36430 ¹ , 36440 ¹ , 36600 ¹ , 36640 ¹ , 37202 ¹ , 43752 ¹ , 51701 ¹ , 51702 ¹ , 51703 ¹ , 62310 ⁰ , 62311 ⁰ , 62318 ⁰ , 62319 ⁰ , 64400 ⁰ , 64402 ⁰ , 64405 ⁰ , 64408 ⁰ , 64410 ⁰ , 64412 ⁰ , 64413 ⁰ , 64415 ⁰ , 64416 ⁰ , 64417 ⁰ , 64418 ⁰ , 64420 ⁰ , 64421 ⁰ , 64425 ⁰ , 64430 ⁰ , 64435 ⁰ , 64445 ⁰ , 64446 ⁰ , 64447 ⁰ , 64448 ⁰ , 64449 ⁰ , 64450 ⁰ , 64479 ⁰ , 64483 ⁰ , 64490 ⁰ , 64493 ⁰ , 64505 ⁰ , 64508 ⁰ , 64510 ⁰ , 64517 ⁰ , 64520 ⁰ , 64530 ⁰ , 69990 ⁰ , 93000 ¹ , 93005 ¹ , 93010 ¹ , 93040 ¹ , 93041 ¹ , 93042 ¹ , 93318 ¹ , 94002 ¹ , 94200 ¹ , 94250 ¹ , 94680 ¹ , 94681 ¹ , 94690 ¹ , 94770 ¹ , 95812 ¹ , 95813 ¹ , 95816 ¹ , 95819 ¹ , 95822 ¹ , 95829 ¹ , 95955 ¹ , 96360 ¹ , 96365 ¹ , 96372 ¹ , 96374 ¹ , 96375 ¹ , 96376 ¹ , 99148 ⁰ , 99149 ⁰ , 99150 ⁰ , J0670 ¹ , J2001 ¹
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Pub 100

No Pub 100 references apply to this code or code range.

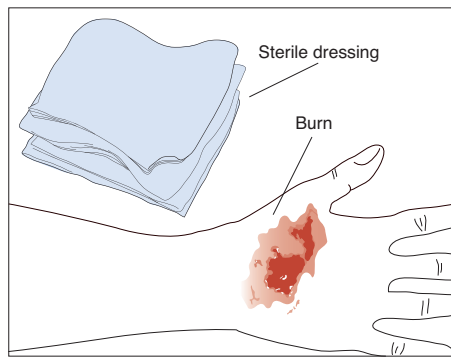
16000

16000 Initial treatment, first degree burn, when no more than local treatment is required

Plain English Description

The physician provides initial local treatment of a first degree burn. Burns are classified by degree. A first degree burn is the least serious type causing injury only to the epidermis, the top layer of skin. The burn area is examined and washed with an antiseptic cleanser. A soothing cream and a sterile dressing is applied as needed. The patient is instructed on the use of pain relievers such as acetaminophen, ibuprofen, or aspirin.

Initial first degree burn treatment



Cream and a sterile dressing is applied as needed.

ICD-9-CM Diagnostic Codes (commonly used)

- 941.10 Erythema due to burn (first degree) of unspecified site of face and head
- 941.11 Erythema due to burn (first degree) of ear (any part)
- 941.12 Erythema due to burn (first degree) of eye (with other parts face, head, and neck)
- 941.13 Erythema due to burn (first degree) of lip(s)
- 941.14 Erythema due to burn (first degree) of chin
- 941.15 Erythema due to burn (first degree) of nose (septum)
- 941.16 Erythema due to burn (first degree) of scalp (any part)
- 941.17 Erythema due to burn (first degree) of forehead and cheek
- 941.18 Erythema due to burn (first degree) of neck
- 941.19 Erythema due to burn (first degree) of multiple sites (except with eye) of face, head, and neck
- 942.10 Erythema due to burn (first degree) of unspecified site of trunk
- 942.11 Erythema due to burn (first degree) of breast
- 942.12 Erythema due to burn (first degree) of chest wall, excluding breast and nipple
- 942.13 Erythema due to burn (first degree) of abdominal wall
- 942.14 Erythema due to burn (first degree) of back (any part)
- 942.15 Erythema due to burn (first degree) of genitalia
- 942.19 Erythema due to burn (first degree) of other and multiple sites of trunk
- 942.22 Blisters with epidermal loss due to burn (second degree) of chest wall, excluding breast and nipple
- 943.10 Erythema due to burn (first degree) of unspecified site of upper limb
- 943.11 Erythema due to burn (first degree) of forearm
- 943.12 Erythema due to burn (first degree) of elbow
- 943.13 Erythema due to burn (first degree) of upper arm
- 943.14 Erythema due to burn (first degree) of axilla
- 943.15 Erythema due to burn (first degree) of shoulder
- 943.16 Erythema due to burn (first degree) of scapular region
- 943.19 Erythema due to burn (first degree) of multiple sites of upper limb, except wrist and hand
- 944.00 Burn of unspecified degree of unspecified site of hand
- 944.10 Erythema due to burn (first degree) of unspecified site of hand
- 944.11 Erythema due to burn (first degree) of single digit (finger (nail) other than thumb
- 944.12 Erythema due to burn (first degree) of thumb (nail)

- 944.13 Erythema due to burn (first degree) of two or more digits of hand, not including thumb
- 944.14 Erythema due to burn (first degree) of two or more digits of hand, including thumb
- 944.15 Erythema due to burn (first degree) of palm of hand
- 944.16 Erythema due to burn (first degree) of back of hand
- 944.17 Erythema due to burn (first degree) of wrist
- 944.18 Erythema due to burn (first degree) of multiple sites of wrist(s) and hand(s)
- 945.10 Erythema due to burn (first degree) of unspecified site of lower limb (leg)
- 945.11 Erythema due to burn (first degree) of toe(s) (nail)
- 945.12 Erythema due to burn (first degree) of foot
- 945.13 Erythema due to burn (first degree) of ankle
- 945.14 Erythema due to burn (first degree) of lower leg
- 945.15 Erythema due to burn (first degree) of knee
- 945.16 Erythema due to burn (first degree) of thigh (any part)

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
16000	0.89	0.34	0.98	0.12	1.35	1.99	000	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
16000	0	2	0	0	1

CCI

16000	0213T ⁰ , 0216T ⁰ , 0228T ⁰ , 0230T ⁰ , 11100 ¹ , 16025 ^{E1} , 16030 ^{E1} , 36000 ¹ , 36400 ¹ , 36405 ¹ , 36406 ¹ , 36410 ¹ , 36420 ¹ , 36425 ¹ , 36430 ¹ , 36440 ¹ , 36600 ¹ , 36640 ¹ , 37202 ¹ , 43752 ¹ , 51701 ¹ , 51702 ¹ , 51703 ¹ , 62310 ⁰ , 62311 ⁰ , 62318 ⁰ , 62319 ⁰ , 64400 ⁰ , 64402 ⁰ , 64405 ⁰ , 64408 ⁰ , 64410 ⁰ , 64412 ⁰ , 64413 ⁰ , 64415 ⁰ , 64416 ⁰ , 64417 ⁰ , 64418 ⁰ , 64420 ⁰ , 64421 ⁰ , 64425 ⁰ , 64430 ⁰ , 64435 ⁰ , 64445 ⁰ , 64446 ⁰ , 64447 ⁰ , 64448 ⁰ , 64449 ⁰ , 64450 ¹ , 64479 ⁰ , 64483 ⁰ , 64490 ⁰ , 64493 ⁰ , 64505 ⁰ , 64508 ⁰ , 64510 ⁰ , 64517 ⁰ , 64520 ⁰ , 64530 ⁰ , 69990 ⁰ , 93000 ¹ , 93005 ¹ , 93010 ¹ , 93040 ¹ , 93041 ¹ , 93042 ¹ , 93318 ¹ , 94002 ¹ , 94200 ¹ , 94250 ¹ , 94680 ¹ , 94681 ¹ , 94690 ¹ , 94770 ¹ , 95812 ¹ , 95813 ¹ , 95816 ¹ , 95819 ¹ , 95822 ¹ , 95829 ¹ , 95955 ¹ , 96360 ¹ , 96365 ¹ , 96372 ¹ , 96374 ¹ , 96375 ¹ , 96376 ¹ , 97022 ¹ , 97597 ^{E1} , 97598 ^{E1} , 97602 ^{E1} , 97605 ^{E1} , 97606 ^{E1} , 99148 ⁰ , 99149 ⁰ , 99150 ⁰ , J0670 ¹ , J2001 ¹
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Pub 100

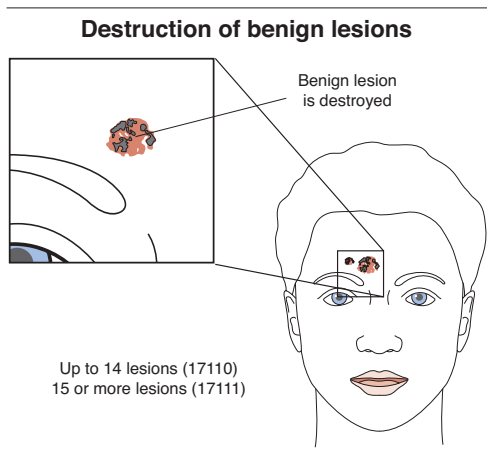
No Pub 100 references apply to this code or code range.

17110-17111

- 17110** Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; up to 14 lesions
- 17111** Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettage), of benign lesions other than skin tags or cutaneous vascular proliferative lesions; 15 or more lesions

Plain English Description

Benign lesions other than skin tags or cutaneous vascular proliferative lesions are destroyed by laser surgery, electrosurgery, cryosurgery, chemosurgery, or surgical curettage. A local anesthetic may be administered. The type of destruction depends on the lesion type and location and may include use of a laser, heat or thermal energy (electrosurgery), cold or freezing (cryosurgery), chemical destruction, or scraping (surgical curettage). Use 17110 to report destruction of up to 14 lesions and 17111 for destruction of 15 or more lesions.



ICD-9-CM Diagnostic Codes (commonly used)

- 078.0** Molluscum contagiosum
- 078.10** Viral warts, unspecified
- 078.11** Condyloma acuminatum
- 078.12** Plantar wart
- 078.19** Other specified viral warts
- 214.0** Lipoma of skin and subcutaneous tissue of face
- 214.1** Lipoma of other skin and subcutaneous tissue
- 216.0** Benign neoplasm of skin of lip
- 216.1** Benign neoplasm of eyelid, including canthus
- 216.2** Benign neoplasm of ear and external auditory canal
- 216.3** Benign neoplasm of skin of other and unspecified parts of face
- 216.4** Benign neoplasm of scalp and skin of neck
- 216.5** Benign neoplasm of skin of trunk, except scrotum
- 216.6** Benign neoplasm of skin of upper limb, including shoulder
- 216.7** Benign neoplasm of skin of lower limb, including hip
- 216.8** Benign neoplasm of other specified sites of skin
- 216.9** Benign neoplasm of skin, site unspecified
- 701.9** Unspecified hypertrophic and atrophic conditions of skin
- 702.11** Inflamed seborrheic keratosis
- 702.19** Other seborrheic keratosis
- 706.2** Sebaceous cyst
- 709.2** Scar conditions and fibrosis of skin
- 709.3** Degenerative skin disorders
- 709.8** Other specified disorders of skin
- 709.9** Unspecified disorder of skin and subcutaneous tissue
- 757.39** Other specified congenital anomalies of skin

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
17110	0.70	1.24	2.42	0.08	2.02	3.20	010	A
17111	0.97	1.42	2.72	0.12	2.51	3.81	010	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
17110	0	2	0	0	1
17111	0	2	0	0	1

CCI

17110 0213T⁰, 0216T⁰, 0228T⁰, 0230T⁰, 11056E¹, 11057E¹, 11100¹, 11200E¹, 11301E¹, 11302E¹, 11303E¹, 11305E¹, 11306E¹, 11308E¹, 11310E¹, 11311E¹, 11400E¹, 11401E¹, 11402E¹, 11403E¹, 11404E¹, 11420E¹, 11421E¹, 11423E¹, 11424E¹, 11440E¹, 11441E¹, 11443E¹, 11603E¹, 11641E¹, 11642E¹, 11719¹, 11900¹, 11901¹, 17000E¹, 17261E¹, 17262E¹, 17272E¹, 17280E¹, 17281E¹, 17282E¹, 17283E¹, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36600¹, 36640¹, 37202¹, 43752¹, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64479⁰, 64483⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 97597¹, 97598¹, 97602¹, 97605¹, 97606¹, 99148⁰, 99149⁰, 99150⁰, G0127¹, J0670¹, J2001¹

17111 0213T⁰, 0216T⁰, 0228T⁰, 0230T⁰, 11057¹, 11100¹, 11302E¹, 11306E¹, 11311E¹, 11312E¹, 11403E¹, 11440E¹, 11441E¹, 11601E¹, 11900¹, 11901¹, 17000E¹, 17110⁰, 17262E¹, 17270E¹, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36600¹, 36640¹, 37202¹, 43752¹, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64479⁰, 64483⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 99148⁰, 99149⁰, 99150⁰, J0670¹, J2001¹

Pub 100

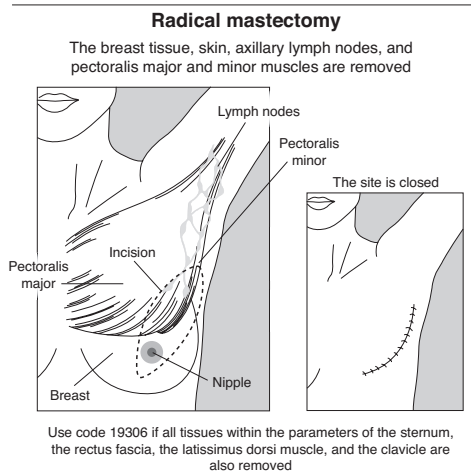
Pub 100-3, 1, 140.5

19305-19306

- 19305** Mastectomy, radical, including pectoral muscles, axillary lymph nodes
- 19306** Mastectomy, radical, including pectoral muscles, axillary and internal mammary lymph nodes (Urban type operation)

Plain English Description

Radical mastectomy includes removal of the entire breast, nipple, and areola with excision of pectoralis major and minor muscles and axillary lymph nodes. Sometimes a more extensive procedure, referred to as an Urban-type radical mastectomy is performed which in addition to the procedures listed above includes excision of internal mammary lymph nodes. An elliptical incision is made to include the breast and the tissue that extends into the axilla referred to as the tail of Spence. The breast tissue, skin, areola, and nipple are removed en bloc along with the underlying pectoral muscles of the chest. Axillary lymph nodes are dissected from the underlying axillary vein along the neighboring nerves and muscles and removed. If an Urban-type procedure is performed, the internal mammary nodes are dissected free of surrounding tissue and removed as is tissue connected to the sternum, portions of the rectus fascia, latissimus dorsi muscle, and clavicle. The skin is closed or a separately reportable myocutaneous graft placed for closure when there is not have enough remaining skin to close the surgical site. Alternatively, a separately reportable breast reconstruction procedure or prosthesis placement may be performed prior to closure. Surgical wounds are closed around a suction catheter or drainage tube. Use 19305 for radical mastectomy with excision of pectoral muscles and axillary lymph nodes or 19306 for a more extensive Urban-type procedure that also includes removal of internal mammary lymph nodes and surrounding tissue.



ICD-9-CM Diagnostic Codes (commonly used)

- 174.0** Malignant neoplasm of nipple and areola of female breast ♀
- 174.1** Malignant neoplasm of central portion of female breast ♀
- 174.2** Malignant neoplasm of upper-inner quadrant of female breast ♀
- 174.3** Malignant neoplasm of lower-inner quadrant of female breast ♀
- 174.4** Malignant neoplasm of upper-outer quadrant of female breast ♀
- 174.5** Malignant neoplasm of lower-outer quadrant of female breast ♀
- 174.8** Malignant neoplasm of other specified sites of female breast ♀
- 174.9** Malignant neoplasm of breast (female), unspecified site ♀
- 196.3** Secondary and unspecified malignant neoplasm of lymph nodes of axilla and upper limb
- 217** Benign neoplasm of breast
- 233.0** Carcinoma in situ of breast
- 611.1** Hypertrophy of breast
- 611.3** Fat necrosis of breast
- 611.4** Atrophy of breast
- 611.72** Lump or mass in breast
- V10.3** Personal history of malignant neoplasm of breast
- V16.3** Family history of malignant neoplasm of breast
- V84.01** Genetic susceptibility to malignant neoplasm of breast

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
19305	17.46	11.23	11.23	3.72	32.41	32.41	090	A
19306	18.13	12.16	12.16	3.86	34.15	34.15	090	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
19305	1	2	1	0	2
19306	1	2	1	0	2

CCI

- 19305** 00400⁰, 0213T⁰, 0216T⁰, 0228T⁰, 0230T⁰, 10021¹, 10022¹, 19100¹, 19102¹, 19103¹, 19110¹, 19112¹, 19120¹, 19125¹, 19300^{E1}, 19301^{E1}, 19302^{E1}, 19303^{E1}, 19304^{E1}, 19318¹, 19328^{E1}, 19330^{E1}, 19342^{E1}, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36600¹, 36640¹, 37202¹, 38500¹, 38525¹, 38740¹, 38745¹, 43752¹, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450¹, 64479⁰, 64483⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 99148⁰, 99149⁰, 99150⁰, J0670¹, J2001¹
- 19306** 00400⁰, 0213T⁰, 0216T⁰, 0228T⁰, 0230T⁰, 10021¹, 10022¹, 19100¹, 19102¹, 19103¹, 19110¹, 19112¹, 19120¹, 19125¹, 19300^{E1}, 19301^{E1}, 19302^{E1}, 19303^{E1}, 19304^{E1}, 19305^{E1}, 19318¹, 19328^{E1}, 19330^{E1}, 19342^{E1}, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36600¹, 36640¹, 37202¹, 38500¹, 38525¹, 38530¹, 38740¹, 38745¹, 43752¹, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450¹, 64479⁰, 64483⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 99148⁰, 99149⁰, 99150⁰, J0670¹, J2001¹

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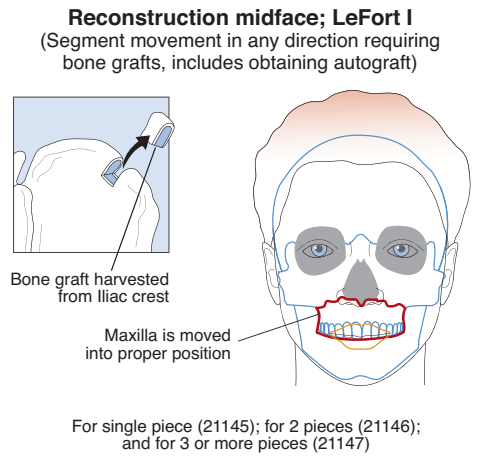
No Pub 100 references apply to this code or code range.

21145-21147

- 21145** Reconstruction midface, LeFort I; single piece, segment movement in any direction, requiring bone grafts (includes obtaining autografts)
- 21146** Reconstruction midface, LeFort I; 2 pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted unilateral alveolar cleft)
- 21147** Reconstruction midface, LeFort I; 3 or more pieces, segment movement in any direction, requiring bone grafts (includes obtaining autografts) (eg, ungrafted bilateral alveolar cleft or multiple osteotomies)

Plain English Description

The physician repairs a congenital facial bone deformity with the use of bone grafts. Under general anesthesia, the physician performs a LeFort I osteotomy in order to achieve this. The physician obtains bone autografts and then proceeds with the facial surgery. Through intraoral incisions, the maxilla is moved into the proper position. Bone grafts, commonly harvested from the iliac or cranial bones are placed in the appropriate sites. The maxilla is then wired to the mandible for fixation. Plates and wires are also used for fixation. An antibiotic solution is used and then the incisions are closed. Code 21146 if the physician repositions a single segment; code 21145 if the physician repositions two segments; and code 21147 if the physician repositions three or more segments.



ICD-9-CM Diagnostic Codes (commonly used)

- 195.0** Malignant neoplasm of head, face, and neck
- 327.20** Organic sleep apnea, unspecified
- 327.23** Obstructive sleep apnea (adult) (pediatric)
- 327.29** Other organic sleep apnea
- 524.00** Major anomalies of jaw size, unspecified anomaly
- 524.01** Major anomalies of jaw size, maxillary hyperplasia
- 524.02** Major anomalies of jaw size, mandibular hyperplasia
- 524.03** Major anomalies of jaw size, maxillary hypoplasia
- 524.04** Major anomalies of jaw size, mandibular hypoplasia
- 524.06** Major anomalies of jaw size, microgenia
- 524.07** Major anomalies of jaw size, excessive tuberosity of jaw
- 524.09** Major anomalies of jaw size, other specified anomaly
- 524.10** Anomalies of relationship of jaw to cranial base, unspecified anomaly
- 524.11** Anomalies of relationship of jaw to cranial base, maxillary asymmetry
- 524.12** Anomalies of relationship of jaw to cranial base, other jaw asymmetry
- 524.19** Anomalies of relationship of jaw to cranial base, other specified anomaly
- 524.70** Dental alveolar anomalies, unspecified alveolar anomaly
- 524.71** Dental alveolar anomalies, alveolar maxillary hyperplasia
- 524.73** Dental alveolar anomalies, alveolar maxillary hypoplasia
- 524.79** Dental alveolar anomalies, other specified alveolar anomaly
- 524.89** Other specified dentofacial anomalies
- 526.4** Inflammatory conditions of jaw
- 526.5** Alveolitis of jaw
- 526.81** Exostosis of jaw
- 733.81** Malunion of fracture
- 738.19** Other acquired deformity of head other specified deformity
- 754.0** Congenital musculoskeletal deformities of skull, face, and jaw

- 756.0** Congenital anomalies of skull and face bones
- 802.4** Closed fracture of malar and maxillary bones
- 802.9** Open fracture of other facial bones
- 905.0** Late effect of fracture of skull and face bones

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
21145	23.94	18.35	18.35	1.68	43.97	43.97	090	A
21146	24.87	20.73	20.73	4.89	50.49	50.49	090	A
21147	26.47	19.86	19.86	1.87	48.20	48.20	090	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
21145	0	2	0	0	2
21146	0	2	1	0	2
21147	0	2	0	0	2

CCI

21145	0213T ⁰ , 0216T ⁰ , 0228T ⁰ , 0230T ⁰ , 20900 ¹ , 20902 ¹ , 21141 ¹ , 21142 ¹ , 21143 ¹ , 36000 ¹ , 36400 ¹ , 36405 ¹ , 36406 ¹ , 36410 ¹ , 36420 ¹ , 36425 ¹ , 36430 ¹ , 36440 ¹ , 36600 ¹ , 36640 ¹ , 37202 ¹ , 43752 ¹ , 51701 ¹ , 51702 ¹ , 51703 ¹ , 62310 ⁰ , 62311 ⁰ , 62318 ⁰ , 62319 ⁰ , 64400 ⁰ , 64402 ⁰ , 64405 ⁰ , 64408 ⁰ , 64410 ⁰ , 64412 ⁰ , 64413 ⁰ , 64415 ⁰ , 64416 ⁰ , 64417 ⁰ , 64418 ⁰ , 64420 ⁰ , 64421 ⁰ , 64425 ⁰ , 64430 ⁰ , 64435 ⁰ , 64445 ⁰ , 64446 ⁰ , 64447 ⁰ , 64448 ⁰ , 64449 ⁰ , 64450 ⁰ , 64479 ⁰ , 64483 ⁰ , 64490 ⁰ , 64493 ⁰ , 64505 ⁰ , 64508 ⁰ , 64510 ⁰ , 64517 ⁰ , 64520 ⁰ , 64530 ⁰ , 69990 ⁰ , 93000 ¹ , 93005 ¹ , 93010 ¹ , 93040 ¹ , 93041 ¹ , 93042 ¹ , 93318 ¹ , 94002 ¹ , 94200 ¹ , 94250 ¹ , 94680 ¹ , 94681 ¹ , 94690 ¹ , 94770 ¹ , 95812 ¹ , 95813 ¹ , 95816 ¹ , 95819 ¹ , 95822 ¹ , 95829 ¹ , 95955 ¹ , 96360 ¹ , 96365 ¹ , 96372 ¹ , 96374 ¹ , 96375 ¹ , 96376 ¹ , 99148 ⁰ , 99149 ⁰ , 99150 ⁰
21146	0213T ⁰ , 0216T ⁰ , 0228T ⁰ , 0230T ⁰ , 20900 ¹ , 20902 ¹ , 21141 ¹ , 21142 ¹ , 36000 ¹ , 36400 ¹ , 36405 ¹ , 36406 ¹ , 36410 ¹ , 36420 ¹ , 36425 ¹ , 36430 ¹ , 36440 ¹ , 36600 ¹ , 36640 ¹ , 37202 ¹ , 43752 ¹ , 51701 ¹ , 51702 ¹ , 51703 ¹ , 62310 ⁰ , 62311 ⁰ , 62318 ⁰ , 62319 ⁰ , 64400 ⁰ , 64402 ⁰ , 64405 ⁰ , 64408 ⁰ , 64410 ⁰ , 64412 ⁰ , 64413 ⁰ , 64415 ⁰ , 64416 ⁰ , 64417 ⁰ , 64418 ⁰ , 64420 ⁰ , 64421 ⁰ , 64425 ⁰ , 64430 ⁰ , 64435 ⁰ , 64445 ⁰ , 64446 ⁰ , 64447 ⁰ , 64448 ⁰ , 64449 ⁰ , 64450 ⁰ , 64479 ⁰ , 64483 ⁰ , 64490 ⁰ , 64493 ⁰ , 64505 ⁰ , 64508 ⁰ , 64510 ⁰ , 64517 ⁰ , 64520 ⁰ , 64530 ⁰ , 69990 ⁰ , 93000 ¹ , 93005 ¹ , 93010 ¹ , 93040 ¹ , 93041 ¹ , 93042 ¹ , 93318 ¹ , 94002 ¹ , 94200 ¹ , 94250 ¹ , 94680 ¹ , 94681 ¹ , 94690 ¹ , 94770 ¹ , 95812 ¹ , 95813 ¹ , 95816 ¹ , 95819 ¹ , 95822 ¹ , 95829 ¹ , 95955 ¹ , 96360 ¹ , 96365 ¹ , 96372 ¹ , 96374 ¹ , 96375 ¹ , 96376 ¹ , 99148 ⁰ , 99149 ⁰ , 99150 ⁰
21147	0213T ⁰ , 0216T ⁰ , 0228T ⁰ , 0230T ⁰ , 20900 ¹ , 20902 ¹ , 21141 ¹ , 21142 ¹ , 21143 ¹ , 36000 ¹ , 36400 ¹ , 36405 ¹ , 36406 ¹ , 36410 ¹ , 36420 ¹ , 36425 ¹ , 36430 ¹ , 36440 ¹ , 36600 ¹ , 36640 ¹ , 37202 ¹ , 43752 ¹ , 51701 ¹ , 51702 ¹ , 51703 ¹ , 62310 ⁰ , 62311 ⁰ , 62318 ⁰ , 62319 ⁰ , 64400 ⁰ , 64402 ⁰ , 64405 ⁰ , 64408 ⁰ , 64410 ⁰ , 64412 ⁰ , 64413 ⁰ , 64415 ⁰ , 64416 ⁰ , 64417 ⁰ , 64418 ⁰ , 64420 ⁰ , 64421 ⁰ , 64425 ⁰ , 64430 ⁰ , 64435 ⁰ , 64445 ⁰ , 64446 ⁰ , 64447 ⁰ , 64448 ⁰ , 64449 ⁰ , 64450 ⁰ , 64479 ⁰ , 64483 ⁰ , 64490 ⁰ , 64493 ⁰ , 64505 ⁰ , 64508 ⁰ , 64510 ⁰ , 64517 ⁰ , 64520 ⁰ , 64530 ⁰ , 69990 ⁰ , 93000 ¹ , 93005 ¹ , 93010 ¹ , 93040 ¹ , 93041 ¹ , 93042 ¹ , 93318 ¹ , 94002 ¹ , 94200 ¹ , 94250 ¹ , 94680 ¹ , 94681 ¹ , 94690 ¹ , 94770 ¹ , 95812 ¹ , 95813 ¹ , 95816 ¹ , 95819 ¹ , 95822 ¹ , 95829 ¹ , 95955 ¹ , 96360 ¹ , 96365 ¹ , 96372 ¹ , 96374 ¹ , 96375 ¹ , 96376 ¹ , 99148 ⁰ , 99149 ⁰ , 99150 ⁰

Pub 100

No Pub 100 references apply to this code or code range.

** See Appendix for CCI information

* See Appendix for Modifier Rules

● New Code

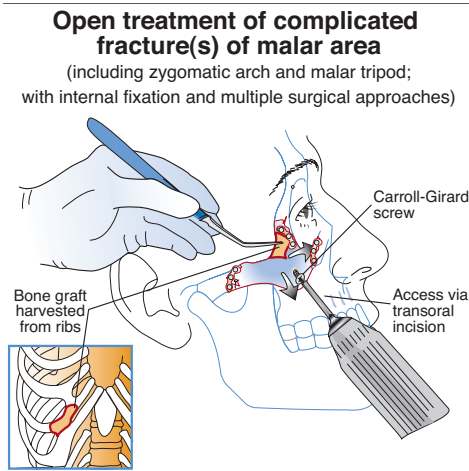
▲ Revised Code

21366

21366 Open treatment of complicated (eg, comminuted or involving cranial nerve foramina) fracture(s) of malar area, including zygomatic arch and malar tripod; with bone grafting (includes obtaining graft)

Plain English Description

The physician repairs a complicated fracture of the malar area in an open environment. Multiple surgical approaches are used to gain access to the fracture site(s), including a transoral incision through the maxillary buccal vestibule. The fracture is reduced to its correct anatomical placement via the use of Carroll-Girard screw or other instrument which lifts the fractured bones into position. Through another incision, the physician obtains a bone graft from the patient's hip, rib, or skull. Bone grafts are placed in the defect areas. The physician utilizes screws, wires, and/or plates to stabilize the fracture site. All incisions are closed.



ICD-9-CM Diagnostic Codes (commonly used)

- 802.4 Closed fracture of malar and maxillary bones
- 802.5 Open fracture of malar and maxillary bones
- 802.8 Closed fracture of other facial bones
- 802.9 Open fracture of other facial bones

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
21366	18.60	15.13	15.13	3.67	37.40	37.40	090	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
21366	0	2	2	0	2

CCI

21366 0213T⁰, 0216T⁰, 0228T⁰, 0230T⁰, 20900¹, 20902¹, 21355¹, 21356¹, 21360¹, 21365¹, 21390¹, 21395¹, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36600¹, 36640¹, 37202¹, 43752¹, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64419⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64479⁰, 64483⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 97597¹, 97598¹, 97602¹, 97605¹, 97606¹, 99148⁰, 99149⁰, 99150⁰

Pub 100

No Pub 100 references apply to this code or code range.

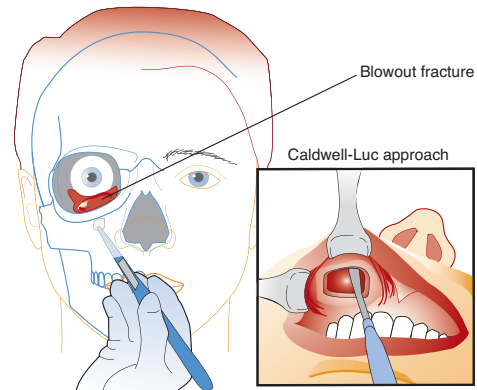
21385

21385 Open treatment of orbital floor blowout fracture; transanal approach (Caldwell-Luc type operation)

Plain English Description

The physician treats a blowout fracture of the orbital floor in an open environment. The physician uses a Caldwell-Luc approach, which is an intraoral procedure for opening the maxillary antrum through the canine fossa above the maxillary premolar teeth. The physician creates an incision through the maxilla so the orbital floor fracture can be viewed. A ballooned catheter or gauze is used to reposition the fractured bones. The gauze or catheter is secured to the mucosa. The incisions are closed, with the exception of the protruding gauze or catheter, which will be removed after the fracture heals.

Open treatment of orbital floor blowout fracture; transanal approach



ICD-9-CM Diagnostic Codes (commonly used)

- 802.6 Closed fracture of orbital floor (blow-out)
- 802.7 Open fracture of orbital floor (blow-out)

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
21385	9.57	9.79	9.79	1.22	20.58	20.58	090	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
21385	0	2	1	0	2

CCI

21385 0213T⁰, 0216T⁰, 0228T⁰, 0230T⁰, 21400⁰, 21401⁰, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36600¹, 36640¹, 37202¹, 43752¹, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64479⁰, 64483⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 67400¹, 67405¹, 67413¹, 67414¹, 67430¹, 67440¹, 67445¹, 67450¹, 69990⁰, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 97597¹, 97598¹, 97602¹, 97605¹, 97606¹, 99148⁰, 99149⁰, 99150⁰

Pub 100

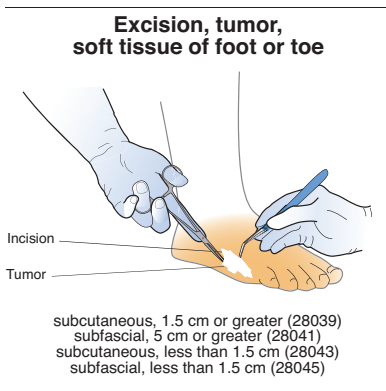
No Pub 100 references apply to this code or code range.

28039-28045

- 28039** Excision, tumor, soft tissue of foot or toe, subcutaneous; 1.5 cm or greater
- 28041** Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); 1.5 cm or greater
- 28043** Excision, tumor, soft tissue of foot or toe, subcutaneous; less than 1.5 cm
- 28045** Excision, tumor, soft tissue of foot or toe, subfascial (eg, intramuscular); less than 1.5 cm

Plain English Description

Soft tissues include subcutaneous fat and connective tissue, fascia, muscles, tendons, blood vessels, lymph vessels, nerves, and tissues surrounding the joints. Soft tissue tumors may be benign or malignant. Benign tumors are typically treated by excision, although small malignant or indeterminate tumors may be excised if the margins are well defined. Depending on the location of the tumor in the soft tissue of the foot or toe, the skin over the tumor may be incised or a skin flap created and elevated. Overlying tissue is dissected and the soft tissue mass exposed. The tumor is then excised along with a margin of healthy tissue. Separately reportable frozen section may be performed to ensure that all margins are free of tumor cells. Drains are placed as needed and the surgical wound is closed in layers. For tumors in the subcutaneous fat or connective tissue, use 28043 for excision of less than 1.5 cm and 28039 for excision of 1.5 cm or greater. For tumors that lie below the fascia, use 28045 for excision of less than 1.5 cm and 28041 for excision of 1.5 cm or greater. Subfascial soft tissue tumors include those within muscle tissue.



ICD-9-CM Diagnostic Codes (commonly used)

- 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
- 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
- 216.7** Benign neoplasm of skin of lower limb, including hip
- 232.7** Carcinoma in situ of skin of lower limb, including hip
- 238.1** Neoplasm of uncertain behavior of connective and other soft tissue
- 239.2** Neoplasm of unspecified nature of bone, soft tissue, and skin
- 728.71** Plantar fascial fibromatosis
- 782.2** Localized superficial swelling, mass, or lump

RVU(s)

Code	Work	PE Facility	PE Non-Facility	MP	Total Facility	Total Non-Facility	Global	Status
28039	5.42	4.05	8.38	0.54	10.01	14.34	090	A
28041	7.13	5.30	5.30	0.73	13.16	13.16	090	A
28043	3.96	3.49	6.52	0.39	7.84	10.87	090	A
28045	5.45	4.32	8.45	0.56	10.33	14.46	090	A

Modifiers*

Code	Mod 50 PAR	Mod 51 PAR	Mod 62 PAR	Mod 66 PAR	Mod 80 PAR
28039	1	2	0	0	2
28041	1	2	0	0	0
28043	1	2	0	0	1
28045	1	2	0	0	0

CCI

28039 01470⁰, 02137⁰, 02167⁰, 02287⁰, 02307⁰, 10060¹, 10140¹, 10160¹, 11010^{E1}, 11011^{E1}, 11012^{E1}, 11042¹, 11043¹, 11044¹, 12001¹, 12002¹, 12004¹, 12005¹, 12006¹, 12007¹, 12020¹, 12021¹, 12041¹, 12042¹, 12044¹, 12045¹, 12046¹, 12047¹, 13131¹, 13132¹, 20550¹, 20551¹, 20552¹, 20553¹, 28001¹, 28008¹, 28010¹, 28011¹, 28043¹, 28060¹, 28080¹, 28086¹, 28088¹, 28090¹, 28092¹, 28190¹, 28192¹, 28193¹, 28220¹, 28225¹, 28226¹, 29130¹, 29131¹, 29515¹, 29540¹, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36600¹, 36640¹, 37202¹, 38500¹, 43752¹, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450¹, 64455¹, 64479⁰, 64483⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 97597¹, 99148⁰, 99149⁰, 99150⁰, J0670¹, J2001¹

28041 01470⁰, 02137⁰, 02167⁰, 02287⁰, 02307⁰, 10060¹, 10140¹, 10160¹, 11010^{E1}, 11011^{E1}, 11012^{E1}, 11042¹, 11043¹, 11044¹, 12001¹, 12002¹, 12004¹, 12005¹, 12006¹, 12007¹, 12020¹, 12021¹, 12041¹, 12042¹, 12044¹, 12045¹, 12046¹, 12047¹, 13131¹, 13132¹, 20550¹, 20551¹, 20552¹, 20553¹, 28001¹, 28002¹, 28008¹, 28024¹, 28039¹, 28043¹, 28045¹, 28054¹, 28055¹, 28060¹, 28062¹, 28080¹, 28086¹, 28088¹, 28090¹, 28092¹, 28190¹, 28192¹, 28193¹, 28220¹, 28222¹, 28225¹, 28226¹, 28232¹, 28234¹, 28272¹, 28315¹, 29130¹, 29131¹, 29405¹, 29540¹, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36600¹, 36640¹, 37202¹, 43752¹, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450¹, 64455¹, 64479⁰, 64483⁰, 64490⁰, 64493⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 97597¹, 99148⁰, 99149⁰, 99150⁰, J2001¹

28043 01470⁰, 02287⁰, 02307⁰, 10060¹, 10140¹, 10160¹, 11010^{E1}, 11011^{E1}, 11012^{E1}, 11042¹, 11043¹, 11044¹, 12001¹, 12002¹, 12004¹, 12005¹, 12006¹, 12007¹, 12020¹, 12021¹, 12041¹, 12042¹, 12044¹, 12045¹, 12046¹, 12047¹, 13131¹, 13132¹, 20550¹, 20551¹, 20552¹, 20553¹, 28001¹, 28010¹, 28011¹, 28090¹, 28092¹, 28190¹, 28192¹, 28193¹, 28220¹, 28222¹, 28225¹, 28226¹, 29130¹, 29131¹, 29515¹, 29540¹, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36600¹, 36640¹, 37202¹, 38500¹, 43752¹, 51701¹, 51702¹, 51703¹, 62310⁰, 62311⁰, 62318⁰, 62319⁰, 64400⁰, 64402⁰, 64405⁰, 64408⁰, 64410⁰, 64412⁰, 64413⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450¹, 64455¹, 64479⁰, 64483⁰, 64505⁰, 64508⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 94002¹, 94200¹, 94250¹, 94680¹, 94681¹, 94690¹, 94770¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 97597¹, 99148⁰, 99149⁰, 99150⁰, J0670¹, J2001¹

28045 *There are too many associated CCI codes to list. Refer to Appendix A for complete list.*

Pub 100

No Pub 100 references apply to this code or code range.

Volume 2 – Alphabetic Index

The Alphabetic Index also makes use of certain instructional conventions to help guide the user in appropriate code selection and sequencing.

Special Instruction Notes

The “*see*” instruction directs the user to another main term to find the correct code.

Example:**Crisis**

Vascular – *see* Disease, cerebrovascular, acute

The “*see also*” instruction directs the user to also refer to the suggested main term for additional information on the condition or disease.

Example:

Crohn’s disease (*see also* Enteritis, regional) 555.9

Punctuation

[] Slanted brackets identify situations when more than one code is needed to correctly code the condition. The index lists the codes in sequencing order with the secondary code in brackets.

Example:

Mononeuropathy (*see also* Mononeuritis) 355.9

diabetic NEC 250.6x [355.9]

() Parentheses enclose nonessential modifiers which may or may not be used with the diagnosis or condition listed in the index. These nonessential modifiers may help in clarifying the documentation, but the presence or absence of any of them does not change the code number selection.

Example:

Cyst (mucus) (retention) (serous) (simple)

ICD-9-CM Coding

ICD-9-CM diagnostic coding is a necessity when submitting claims to payers for reimbursement. It also identifies the reason for the patient’s visit to the provider and will indicate the medical necessity of the services rendered by the provider. The following are guidelines that instruct on ICD-9-CM diagnostic coding:

1. Consult Volume 2, Alphabetic Index to ICD-9-CM, first. Locate the main entry term. The Alphabetic Index is arranged by condition.
2. Refer to Volume 1 of the ICD-9-CM, locating the selected code in the Tabular List. Review any exclusion notes or other instructions for proper coding before final selection of codes. Also, refer to the addenda for any new diagnostic codes or corrections.
3. Read and apply all other conventions used in the Tabular List and Alphabetic Index.
4. Code only confirmed diagnoses. Do not code “suspected,” “rule out” or “probable” diagnoses. If there is not a confirmed diagnosis for outpatient service, code the symptom(s). For inpatient, short-term, acute care, and long term care coding, if only a “suspected,” “rule-out,” or “probable” diagnosis is listed, it should be coded as if it existed or was established.
5. Code only the confirmed diagnoses if both the diagnoses and symptoms are documented in the medical record, except

when the diagnoses and symptoms are not related, then code both.

6. Code to the level of highest specificity. Check to see if the diagnostic code consists of three, four, or five numbers. Truncated codes will be denied if a claim is submitted without all of the digits.
7. Chronic diseases and conditions treated on an ongoing basis may be coded as many times as the patient receives treatment and care for the condition(s).
8. Code all documented conditions that coexist at the time of the patient encounter that require or affect patient care, treatment, or management.

2011 Plastic Surgery/Dermatology Diagnostic Code Index**Abnormal/Abnormality**

dentofacial, functional, NOS 524.50

granulation tissue, other 701.5

hair 704.2

jaw closure 524.51

Abrasion/friction burn

ankle

infected 916.1

without infection 916.0

elbow

infected 913.1

without infection 913.0

face, except eye

infected 910.1

without infection 910.0

fingers

infected 915.1

without infection 915.0

foot

infected 917.1

without infection 917.0

forearm

infected 913.1

without infection 913.0

hand(s) except finger(s) alone

infected 914.1

without infection 914.0

hip/thigh

infected 916.1

without infection 916.0

leg

infected 916.1

without infection 916.0

multiple/unspecified sites

infected 919.1

without infection 919.0

neck

infected 910.1

without infection 910.0

scalp

infected 910.1

without infection 910.0

Unlisted Codes

The terminology used in the descriptions for unlisted codes varies within HCPCS Level II codes. For example:

J3490	Unclassified biologics
J7599	Immunosuppressive drug, not otherwise classified
E1699	Dialysis equipment, not otherwise specified

Do not use an unlisted code if a code exists that identifies the supply, service, or procedure provided better.

HCPCS Level II Update

Many of the new HCPCS codes found at the end of this chapter were part of the CMS Physician Voluntary Reporting Program (PVRP). These codes fall in the range of G codes.

Under the voluntary reporting program, physicians who chose to participate helped capture data about the quality of care provided to Medicare beneficiaries in order to identify the most effective ways to use the quality measures in routine practice and to support physicians in their efforts to improve quality of care. Voluntary reporting of quality data through the PVRP began January 1, 2006, and ended December 31, 2006.

PVRP was implemented as the first step toward pay for performance for physician practice and has been replaced with the Physician Quality Reporting Initiative (PQRI).

The PQRI was built on CMS and provider experience with the PVRP and was established pursuant to the Tax Relief and Health Care Act of 2006. The PQRI provides an incentive payment to eligible professionals who successfully submit data for a designated set of quality measures for services paid under the Medicare Physician Fee Schedule.

The PVRP measures have been incorporated into the PQRI, which consists of quality measures and their final specifications. CPT Category II codes and specified G codes are to be used in reporting the data on Medicare claims and are identified in the measure specifications. For more information on PQRI, see the CMS website <http://www.cms.hhs.gov/PQRI/>.

Durable Medical Equipment

Durable medical equipment (DME) consists of prosthetics, orthotics, and other supplies. Some supplies can be billed to the local Medicare carrier; others cannot. For supplies that cannot be billed to a local carrier, the only other method of reimbursement is through a durable medical equipment Medicare administrative contractor (DME MAC). In order to receive reimbursement from a DME MAC, the provider must be a certified durable medical equipment supplier.

Under Section 911 of the Medicare Prescription Drug, Improvement and Modernization Act (MMA), Congress mandated that the Secretary of Health and Human Services replace the current contracting authority under Title XVIII of the Social Security Act with the Medicare Administrative Contractor (MAC) authority. Contracting reform requires that CMS use competitive procedures to replace its current fiscal intermediaries (FIs) and carriers with a uniform type of administrative entity, referred to as Medicare Administrative Contractors (MACs) and that MACs must re-compete every five years. The FIs handled claims processing and benefit payment functions for institutional providers under Part A and Part B of the Medicare

program, while carriers performed the same functions for professional providers under Part B of the program.

The following is a listing of the current DME MACs and their contact information.

Durable Medical Equipment Medicare Administrative Contractors (DME MACs)***Jurisdiction A***

Connecticut, Delaware, District of Columbia, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont

NHIC (National Heritage Insurance Corp.)

PO Box 9146
Hingham MA 02043-9146
Supplier Customer Service: 1-866-419-9458
IVR: 1-866-419-9458
EDI Help Desk: 1-866-563-0049
www.medicarenhic.com/dme

Jurisdiction B

Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, Wisconsin

National Government Services

PO Box 240
Indianapolis IN 46207-0240
Supplier Customer Service/IVR: 1-877-299-7900
EDI Contact Center: 1-877-273-4334
www.adminastar.com

Jurisdiction C

Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, Virgin Islands, Virginia, West Virginia

CIGNA Government Services

PO Box 20010
Nashville TN 37202
Supplier Customer Services: 1-866-270-4909
IVR: 1-866-238-9650
www.cignagovernmentservices.com
EDI Contact Center: 1-888-613-9271 or www.palmettogba.com/jcedi

Jurisdiction D

Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, N. Mariana Islands, Missouri, Montana, Nebraska, Nevada, North Dakota, Oregon, South Dakota, Utah, Washington, Wyoming

Noridian Administrative Services

901 40th Avenue South Suite 1
Fargo ND 58103-2146
IVR: 1-877-320-0390
Supplier Contact Center: 1-866-243-7272
www.noridianmedicare.com

EDI

Jurisdiction D EDI
PO Box 690
Nashville TN 37202
Telephone: 1-866-224-3094

- ❶ In some hospitals with residency programs, Medicare pays through the medical program or graduate medical education (GME) program. Because of this, they will not reimburse for a resident when they are used as an assistant surgeon. Although under special circumstances, payment may be made if there is a emergent situation that is life-threatening.

90 Reference (Outside) Laboratory

When laboratory procedures are performed by a party other than the treating or reporting physician, the procedure may be identified by adding modifier 90 to the usual procedure number.

- ❶ Check with payers to determine if the provider may bill for the laboratory procedure if not performed by the provider.

91 Repeat Clinical Diagnostic Laboratory Test

In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of the modifier 91.

Note: This modifier may not be used when tests are rerun to confirm initial results due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (e.g., glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

92 Alternative Laboratory Platform Testing

When laboratory testing is performed using a kit or transportable instrument that wholly or in part consists of a single use, disposable analytical chamber, the service may be identified by adding modifier 92 to the laboratory procedure code (HIV testing 86701-86703). The test does not require permanent dedicated space, hence by its design may be hand carried or transported to the vicinity of the patient for immediate testing at that site, although location of testing is not in itself determinative of the use of this modifier.

99 Multiple Modifiers

Under certain circumstances, two or more modifiers may be necessary to completely delineate a service. In such situations, modifier 99 should be added to the basic procedure, and other applicable modifiers may be listed as part of the description of the service.

- ❶ Check with payers to determine if this modifier is necessary when reporting multiple modifiers.

Approved Modifiers For Ambulatory Surgery Center (ASC) Hospital Outpatient Use

There are some differences in modifiers for professional and ASC hospital use. The following list consists of the only approved modifiers that can be used in an ASC/hospital setting:

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or Other Service

It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M

service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This service may be reported by adding modifier 25 to the appropriate level of E/M service.

Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

- ❶ According to Medicare, modifier 25 may be appended to an Emergency Department Services E/M code (99281-99285) if provided on the same day as a diagnostic or therapeutic procedure.

27 Multiple Outpatient Hospital E/M Encounters on the Same Date

For hospital outpatient reporting purposes, utilization of hospital resources related to separate and distinct E/M encounters performed in multiple outpatient hospital settings on the same date may be reported by adding the modifier 27 to each appropriate level outpatient and/or emergency department code(s). This modifier provides a means of reporting circumstances involving E/M services provided by physician(s) in more than one (multiple) outpatient hospital setting(s) (e.g., hospital emergency department, clinic).

Note: This modifier is not to be used for physician reporting of multiple E/M services performed by the same physician on the same date. For physician reporting of all outpatient E/M services provided by the same physician on the same date and performed in multiple outpatient setting(s) (e.g., hospital emergency department, clinic), see Evaluation and Management, Emergency Department, or Preventive Medicine services codes.

50 Bilateral Procedure

Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding the modifier 50 to the appropriate 5-digit code.

- ❶ Reported on procedures performed at the same operative session, this modifier should be reported only once as a one-line item for Medicare, with the modifier appended to the end of the code.
- ❶ Some payers may accept the bilateral procedures as two-line items, with HCPCS Level II modifiers LT and RT appended to the end of the codes.

52 Reduced Services

Under certain circumstances, a service or procedure is partially reduced or eliminated at the physician's discretion. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of the modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstance or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74.

- ❶ Procedures reported with modifier 52 are typically billed at a reduced amount. Most payers do not require documentation to support the use of modifier 52 and will reimburse the procedure at a reduced level.

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned or anticipated (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure.

Note: For treatment of a problem that requires a return to the operating/procedure room (e.g., unanticipated clinical condition), see modifier 78.

- Constitutional symptoms (i.e., fever, weight loss, etc.)
- Ears, Nose, Mouth, Throat
- Respiratory
- Genitourinary
- Integumentary (skin and/or breast)
- Psychiatric
- Hematologic/Lymphatic
- Eyes
- Cardiovascular
- Gastrointestinal
- Musculoskeletal
- Neurological
- Endocrine
- Allergic/Immunologic

A problem pertinent ROS inquires about the system directly related to the problem(s) identified in the HPI.

An extended ROS inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems.

A complete ROS inquires about the system(s) directly related to the problem(s) identified in the HPI, plus all additional body systems.

Past, Family, and/or Social History

The Past, Family, and/or Social History (PFSH) consists of a review of three areas:

- Past history (the patient's past experiences with illnesses, operations, injuries and treatments)
- Family history (a review of medical events in the patient's family, including diseases which may be hereditary or place the patient at risk)
- Social history (an age appropriate review of past and current activities)

For certain categories of E/M services that include only an interval history, it is not necessary to record information about the PFSH. Those categories are subsequent hospital care, follow-up inpatient consultations, and subsequent nursing facility care.

A pertinent PFSH is a review of the history area(s) directly related to the problem(s) identified in the HPI.

A complete PFSH is of a review of two or all three of the PFSH history areas, depending on the category of the E/M service. A review of all three history areas is required for services that include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.

Specific Definitions and Guidance for Exam Elements

Documentation of Examination

In the CPT book, the levels of E/M services are based on four types of examination:

- **Problem Focused** – a limited examination of the affected body area or organ system
- **Expanded Problem Focused** – a limited examination of the affected body area or organ system and any other symptomatic or related body area(s) or organ system(s)
- **Detailed** – an extended examination of the affected body area(s) organ system(s) and any other symptomatic or related body area(s) or organ system(s)
- **Comprehensive** – a general multi-system examination, or complete examination of a single organ system and other symptomatic or related body area(s) or organ system(s)

These types of examinations have been defined for general multi-system and the following single organ systems:

- Cardiovascular
- Eyes
- Ears, Nose, Mouth and Throat
- Genitourinary (Female)

- Genitourinary (Male)
- Musculoskeletal
- Psychiatric
- Skin
- Hematologic/Lymphatic/Immunologic
- Neurological
- Respiratory

The documentation guidelines for E/M services reflect the needs of the typical adult population. For certain groups of patients, the recorded information may vary slightly from that described here. Specifically, the medical records of infants, children, adolescents and pregnant women may have additional or modified information recorded in each history and examination area.

For example, the content of a pediatric examination will vary with the age and development of the child. Although not specifically defined in these documentation guidelines, these variations on history and examination are generally recognized as appropriate.

1995 Federal Guidance

Current CMS guidance indicates that providers may use either the 1995 or 1997 E/M documentation guidelines. Find below the 1995 CMS guidance pertaining to the physical exam:

Documentation of Examination

The levels of E/M services are based on four types of examination that are defined as follows:

- **Problem Focused** – a limited examination of the affected body area or organ system.
- **Expanded Problem Focused** – a limited examination of the affected body area or organ system and other symptomatic or related organ system(s).
- **Detailed** – an extended examination of the affected body area(s) and other symptomatic or related organ system(s).
- **Comprehensive** – a general multi-system examination or complete examination of a single organ system.

For purposes of examination, the following body areas are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axillae
- Abdomen
- Genitalia, groin, buttocks
- Back, including spine
- Each extremity

For purposes of examination, the following organ systems are recognized:

- Constitutional
- Ears, nose, mouth and throat
- Respiratory
- Genitourinary
- Skin
- Hematologic/Lymphatic/Immunologic
- Eyes
- Cardiovascular
- Gastrointestinal
- Musculoskeletal
- Neurologic
- Psychiatric

The extent of examinations performed and documented is dependent upon clinical judgment and the nature of the presenting problem(s). They range from limited examinations of single body areas to general multi-system examinations.

1997 Federal Guidance

In 1997, CMS introduced physical exam criteria that was intended to allow specialists to perform higher level services while staying closer to those organ systems pertinent to their specialty or area of concern. The original 1995 guidelines seemed to be too

oriented towards primary care and unfair to specialists. A series of alternative exams was devised which used an “elemental” or “bullet-point” approach to the exam. These guidelines were developed jointly by the AMA and CMS.

The following are the 1997 CMS guidance pertaining to the general multi-system physical exam:

General Multi-System Examination

General multi-system examinations are described in detail. To qualify for a given level of multi-system examination, the following content and documentation requirements should be met:

- **Problem Focused Examination** – should include performance and documentation of one to five elements identified by a bullet (•) in one or more organ system(s) or body area(s).

- **Expanded Problem Focused Examination** – should include performance and documentation of at least six elements identified by a bullet (•) in one or more organ system(s) or body area(s).
- **Detailed Examination** – should include at least six organ systems or body areas. For each system/area selected, performance and documentation of at least two elements identified by a bullet (•) is expected. Alternatively, a detailed examination may include performance and documentation of at least twelve elements identified by a bullet (•) in two or more organ systems or body areas.
- **Comprehensive Examination** – should include at least nine organ systems or body areas. For each system/area selected, all elements of the examination identified by a bullet (•) should be performed, unless specific directions limit the content of the examination. For each area/system, documentation of at least two elements identified by a bullet is expected.

Skin Examination

System/Body Area	Elements of Examination												
Constitutional	<ul style="list-style-type: none"> • Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming) 												
Head and Face													
Eyes	<ul style="list-style-type: none"> • Inspection of conjunctivae and lids 												
Ears, Nose, Mouth and Throat	<ul style="list-style-type: none"> • Inspection of lips, teeth and gums • Examination of oropharynx (e.g., oral mucosa, hard and soft palates, tongue, tonsils, posterior pharynx) 												
Neck	<ul style="list-style-type: none"> • Examination of thyroid (e.g., enlargement, tenderness, mass) 												
Respiratory													
Cardiovascular	<ul style="list-style-type: none"> • Examination of peripheral vascular system by observation (e.g., swelling, varicosities) and palpation (e.g., pulses, temperature, edema, tenderness) 												
Chest (Breasts)													
Gastrointestinal (Abdomen)	<ul style="list-style-type: none"> • Examination of liver and spleen • Examination of anus for condyloma and other lesions 												
Genitourinary													
Lymphatic	<ul style="list-style-type: none"> • Palpation of lymph nodes in neck, axillae, groin and/or other location 												
Musculoskeletal													
Extremities	<ul style="list-style-type: none"> • Inspection and palpation of digits and nails (e.g., clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes) 												
Skin	<ul style="list-style-type: none"> • Palpation of scalp and inspection of hair of scalp, eyebrows, face, chest, pubic area (when indicated) and extremities • Inspection and/or palpation of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers, susceptibility to and presence of photo damage) in eight of the following ten areas: <table border="0" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%;">– Head, including the face</td> <td style="width: 25%;">– Neck</td> <td style="width: 25%;">– Chest, including breasts and axillae</td> <td style="width: 25%;">– Abdomen</td> </tr> <tr> <td>– Genitalia, groin, buttocks</td> <td>– Back</td> <td>– Right upper extremity</td> <td>– Left upper extremity</td> </tr> <tr> <td>– Right lower extremity</td> <td>– Left lower extremity</td> <td></td> <td></td> </tr> </table> <p>NOTE: For the comprehensive level, the examination of at least eight anatomic areas must be performed and documented. For the three lower levels of examination, each body area is counted separately. For example, inspection and/or palpation of the skin and subcutaneous tissue of the right upper extremity and the left upper extremity constitutes two elements.</p> <ul style="list-style-type: none"> • Inspection of eccrine and apocrine glands of skin and subcutaneous tissue with identification and location of any hyperhidrosis, chromhidroses or bromhidrosis 	– Head, including the face	– Neck	– Chest, including breasts and axillae	– Abdomen	– Genitalia, groin, buttocks	– Back	– Right upper extremity	– Left upper extremity	– Right lower extremity	– Left lower extremity		
– Head, including the face	– Neck	– Chest, including breasts and axillae	– Abdomen										
– Genitalia, groin, buttocks	– Back	– Right upper extremity	– Left upper extremity										
– Right lower extremity	– Left lower extremity												
Neurological/ Psychiatric	<ul style="list-style-type: none"> • Brief assessment of mental status including <ul style="list-style-type: none"> – Orientation to time, place and person – Mood and affect (e.g., depression, anxiety, agitation) 												

Content and Documentation Requirements

Level of Exam	Perform and Document:
Problem Focused	One to five elements identified by a bullet.
Expanded Problem Focused	At least six elements identified by a bullet.
Detailed	At least twelve elements identified by a bullet.
Comprehensive	Perform all elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.