Optum

Coding Companion

Internal Medicine/ Endocrinology/ Rheumatology

A comprehensive illustrated guide to coding and reimbursement

2026

optumcoding.com

Contents

Getting Started with Coding Companion

Coding Companion for Internal Medicine/Endocrinology/ Rheumatology is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to internal medicine/endocrinology/rheumatology are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT/HCPCS code is followed by its official CPT code description.

Resequencing of CPT Codes

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

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

ICD-10-CM

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

Detailed Code Information

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

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT/HCPCS code description, followed by an easy-to-understand explanation, relative value units, and Medicare edits. The Relative Value Unit/Medicare Edits table will not be included with any CPT/HCPCS code with a "0" (zero) value.

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

- HCPCS
- E/M
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

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

CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 30.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2026 edition password is: **XXXXX.** Log in frequently to ensure you receive the most current updates.

Index

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

65205 Removal of foreign body, external eye; conjunctival superficial

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

Conjunctiva
Foreign Body Removal, 65205-65210

or **Eye**
Removal
Foreign Body
Superficial, 65205

or **Foreign Body**
Removal
External Eye, 65205

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xv of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

11055-11057

11055 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
11056 2 to 4 lesions
11057 more than 4 lesions

Depiction of a single corn-like lesion on a common location of the foot

Explanation

The physician removes a benign hyperkeratotic skin lesion such as a corn or callus by cutting, clipping, or paring. Report 11055 when one lesion is removed; 11056 when two to four lesions are removed; and 11057 when more than four lesions are removed.

Coding Tips

Routine foot care, which includes the paring or cutting of corns and calluses, is not covered by Medicare unless the patient suffers from a condition that puts him/her at risk when these services are performed by a nonprofessional. Medicare requires the use of specific HCPCS Level II modifiers Q7–Q9 to indicate clinical findings indicative of severe peripheral involvement warranting the medical necessity of providing foot care, such as nail debridement or trimming, that would usually be considered routine and for which benefits would not be provided. For destruction of a benign or a premalignant lesion, see 17000–17111. For a routine E/M service and foot care of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), see G0245–G0246. For diabetic foot care including debridement of corns and calluses, see G0247. Some non-Medicare payers may require that HCPCS Level II code S0390 be reported for this service when provided as routine foot care or as preventive maintenance in specific medical conditions. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

B07.0 Plantar wart
B07.8 Other viral warts
L11.0 Acquired keratosis follicularis
L84 Corns and callosities
L85.1 Acquired keratosis [keratoderma] palmaris et plantaris
L85.2 Keratosis punctata (palmaris et plantaris)
L86 Keratoderma in diseases classified elsewhere
L87.0 Keratosis follicularis et parafollicularis in cutem penetrans

Associated HCPCS Codes

G0247 Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include the local care of superficial wounds (i.e., superficial to muscle and fascia) and at least the following, if present: (1) local care of superficial wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails

AMA: **11055** 2022,Feb **11056** 2022,Feb **11057** 2022,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11055	0.35	1.76	0.03	2.14
11056	0.5	1.94	0.04	2.48
11057	0.65	2.01	0.05	2.71
Facility RVU	**Work**	**PE**	**MP**	**Total**
11055	0.35	0.08	0.03	0.46
11056	0.5	0.11	0.04	0.65
11057	0.65	0.15	0.05	0.85

	FUD	Status	MUE	Modifiers				IOM Reference
11055	0	R	1(2)	51	N/A	N/A	N/A	None
11056	0	R	1(2)	51	N/A	N/A	N/A	
11057	0	R	1(2)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

callosities. Localized, hardened patches of overgrowth on the epidermis caused by friction or pressure.

callus. Tissue formation at the site of a fracture that establishes continuity between the fractured ends of the bone. The initial provisional callus, which is comprised of fibrous tissue and cartilage, is eventually absorbed and replaced by osseous tissue (definitive callus).

diabetes mellitus. Endocrine disease manifested by high blood glucose levels and resulting in the inability to successfully metabolize carbohydrates, proteins, and fats, due to defects in insulin production and secretion, insulin action, or both.

hyperkeratosis. Thickening of the outer layer of the skin because of overproduction of the protein keratin.

keratoderma. Excessive growth of a horny, callous layer on the skin in three typical patterns: diffused over the palm and sole, focal with large keratin masses at points of friction, and punctate with tiny drops of keratin on the palmoplantar surface.

keratosis. Skin condition characterized by a wart-like or callus-type localized overgrowth, hardening, or thickening of the upper skin layer as a result of overproduction of the protein keratin.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2026.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2026.
- ▲ This CPT code description is revised for 2026.
- ✚ This CPT code is an add-on code.

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

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services. Note: This icon is not appended to the synchronous audio-video visit codes 98000-98007.

The Centers for Medicare and Medicaid Services (CMS) have identified services that may be performed via telehealth. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 93 or 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

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

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96041
96110	96116	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
97802	97803	97804	99406	99407	99408	99409
99497	99498					

2. Illustrations

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

3. Explanation

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

4. Coding Tips

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

5. ICD-10-CM Diagnostic Codes

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

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ☑ Laterality

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

6. Associated HCPCS Codes

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

7. AMA References

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

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2025.

The 2026 Medicare edits were not available at the time this book went to press. Updated 2026 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2026 edition password is **XXXXX**.

Relative Value Units

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

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

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs when the technical (modifier TC) or professional (modifier 26) component of a procedure is provided.

99202-99205

99202 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

99203 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

99204 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

99205 Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, a total time of 15 minutes must be met or exceeded on the day of the encounter. Report 99203 for a visit requiring a low level of MDM or meeting or exceeding 30 minutes of total time; 99204 for a visit requiring a moderate level of MDM or meeting or exceeding 45 minutes of total time; and 99205 for a visit requiring a high level of MDM or meeting or exceeding 60 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternatively, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. Medicare has identified these codes as telehealth/telemedicine services. CMS requires the use of a place of service (POS) indicator: POS 02 for telehealth services when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. For prolonged services applicable to 99205, see 99417; for Medicare, see G2212. Medicare and commercial payers should be contacted regarding their coverage guidelines. For office or other outpatient services for an established patient, see 99211-99215.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99203** 2024,Oct; 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99204** 2024,Oct; 2024,Sep; 2024,Jun; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar **99205** 2024,Oct; 2024,Sep; 2024,Mar; 2024,Jan; 2023,Dec; 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.16	0.08	2.17
99203	1.6	1.59	0.16	3.35
99204	2.6	2.18	0.24	5.02
99205	3.5	2.79	0.33	6.62
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.4	0.08	1.41
99203	1.6	0.68	0.16	2.44
99204	2.6	1.13	0.24	3.97
99205	3.5	1.57	0.33	5.4

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

● New ▲ Revised + Add On ★ Telemedicine [Resequenced] ☑ Laterality

99374-99380

99374 Supervision of a patient under care of home health agency (patient not present) in home, domiciliary or equivalent environment (eg, Alzheimer's facility) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

99375 30 minutes or more

99377 Supervision of a hospice patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

99378 30 minutes or more

99379 Supervision of a nursing facility patient (patient not present) requiring complex and multidisciplinary care modalities involving regular development and/or revision of care plans by that individual, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes

99380 30 minutes or more

Explanation

Care plan oversight (CPO) services are reported for the primary supervising health care provider's time in reviewing and adjusting treatment plans. These services may include review of multiple modalities; patient status relevant laboratory tests; communication with other health care team members, family members, and/or patient advocates; and developing a new course of action or any adjustments to the current plan. Codes are reported within one calendar month and are classified according to the place of service. The initial service for each location is approximately 15 to 29 minutes in duration; each additional 30 minutes is reported separately. Report 99374-99375 for patients in a home health setting; 99377-99378 for hospice patients; and 99379-99380 for patients residing in a nursing facility. Note that only one clinician is eligible to report CPO services for a specific time period in order to demonstrate the singular or lead role the clinician has with a particular patient.

Coding Tips

Codes 99374-99380 are used to report care plan oversight (CPO) services of the physicians' supervision of patients in nursing facilities, under the care of home health agencies, or hospice benefits that require complex or multidisciplinary care modalities requiring ongoing provider involvement in the plan of care. These are time-based codes and time spent involved in care plan activities must be documented in the medical record. Total time for care plan oversight provided within a 30-day period determines code selection. Only one clinician is eligible to report CPO services for a specific time period in order to demonstrate the singular or lead role the clinician has with a particular patient. CPO services should not be reported until after the end of the month in which the services are performed. Coverage of these services varies by payer. Check with the payer for specific coverage guidelines. These codes may be reported separately from other E/M services provided in these settings. Do not report 99374-99378 with complex chronic care coordination services 99487-99489 for the same month. Do not report these codes for time reported with 98012-98016, 98966-98968, or 99421-99423.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99374** 2023,Nov; 2022,Nov; 2022,Jul; 2022,Jan; 2021,Jan; 2020,Mar; 2019,Jul; 2019,Jan **99375** 2023,Nov; 2022,Nov; 2022,Jul; 2022,Jan; 2021,Jan; 2020,Mar; 2019,Jul; 2019,Jan **99377** 2023,Nov; 2022,Nov; 2022,Jul; 2022,Jan; 2021,Jan; 2020,Mar; 2019,Jul; 2019,Jan **99378** 2023,Nov; 2022,Nov; 2022,Jul; 2022,Jan; 2021,Jan; 2020,Mar; 2019,Jul; 2019,Jan **99379** 2023,Nov; 2022,Nov; 2022,Jul; 2022,Jan; 2021,Jan; 2020,Mar; 2019,Jul; 2019,Jan **99380** 2023,Nov; 2022,Nov; 2022,Jul; 2022,Jan; 2021,Jan; 2020,Mar; 2019,Jul; 2019,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99374	1.1	0.87	0.07	2.04
99375	1.73	1.2	0.1	3.03
99377	1.1	0.87	0.07	2.04
99378	1.73	1.2	0.1	3.03
99379	1.1	0.87	0.07	2.04
99380	1.73	1.2	0.1	3.03
Facility RVU	**Work**	**PE**	**MP**	**Total**
99374	1.1	0.43	0.07	1.6
99375	1.73	0.67	0.1	2.5
99377	1.1	0.43	0.07	1.6
99378	1.73	0.67	0.1	2.5
99379	1.1	0.43	0.07	1.6
99380	1.73	0.67	0.1	2.5

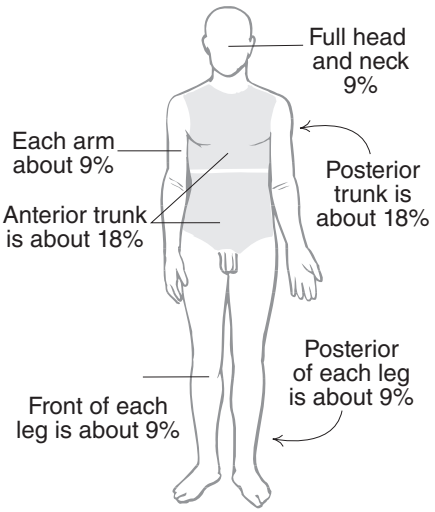
	FUD	Status	MUE	Modifiers				IOM Reference
99374	N/A	B	0(3)	N/A	N/A	N/A	N/A	None
99375	N/A	I	0(3)	N/A	N/A	N/A	N/A	
99377	N/A	B	0(3)	N/A	N/A	N/A	N/A	
99378	N/A	I	0(3)	N/A	N/A	N/A	N/A	
99379	N/A	B	0(3)	N/A	N/A	N/A	N/A	
99380	N/A	B	0(3)	N/A	N/A	N/A	N/A	

* with documentation

11000-11001

11000 Debridement of extensive eczematous or infected skin; up to 10% of body surface

\+ **11001** each additional 10% of the body surface, or part thereof (List separately in addition to code for primary procedure)



Extensive eczematous or infected skin is debrided

Explanation

The physician surgically removes extensive diseased or infected skin. The skin may be of an eczematous nature possessing erythema, vesicles, and scales. Bacteria or fungus may be causing the skin infection. Wet compresses are used initially to remove scaly skin. Abrasive techniques may be employed to remove remaining scales. A scalpel may be used to decompress vesicles and excise dead skin. After debridement, topical lubricants and antibiotic preparations are placed on the skin. Report 11000 for up to 10 percent of the body surface. Report 11001 once for each additional 10 percent of the body surface, or part thereof, in addition to the primary procedure.

Coding Tips

Report 11001 in addition to 11000. These codes report debridement of eczematous or infected skin not associated with open fractures or dislocations.

ICD-10-CM Diagnostic Codes

L01.01 Non-bullous impetigo
L01.02 Bockhart's impetigo
L01.03 Bullous impetigo
L01.09 Other impetigo
L01.1 Impetiginization of other dermatoses
L03.011 Cellulitis of right finger ☑
L03.113 Cellulitis of right upper limb ☑
L03.115 Cellulitis of right lower limb ☑
L03.121 Acute lymphangitis of right axilla ☑
L03.123 Acute lymphangitis of right upper limb ☑
L03.125 Acute lymphangitis of right lower limb ☑
L03.211 Cellulitis of face
L03.212 Acute lymphangitis of face
L03.213 Periorbital cellulitis
L03.221 Cellulitis of neck
L03.222 Acute lymphangitis of neck
L03.311 Cellulitis of abdominal wall
L03.312 Cellulitis of back [any part except buttock]
L03.313 Cellulitis of chest wall
L03.314 Cellulitis of groin
L03.315 Cellulitis of perineum
L03.316 Cellulitis of umbilicus
L03.317 Cellulitis of buttock
L03.321 Acute lymphangitis of abdominal wall
L03.322 Acute lymphangitis of back [any part except buttock]
L03.323 Acute lymphangitis of chest wall
L03.324 Acute lymphangitis of groin
L03.325 Acute lymphangitis of perineum
L03.326 Acute lymphangitis of umbilicus
L03.327 Acute lymphangitis of buttock
L03.811 Cellulitis of head [any part, except face]
L03.891 Acute lymphangitis of head [any part, except face]
L03.898 Acute lymphangitis of other sites

AMA: 11000 2023,Jun; 2022,Feb; 2018,Feb 11001 2023,Jun; 2022,Feb; 2018,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11000	0.6	1.13	0.05	1.78
11001	0.3	0.49	0.03	0.82
Facility RVU	**Work**	**PE**	**MP**	**Total**
11000	0.6	0.17	0.05	0.82
11001	0.3	0.11	0.03	0.44

	FUD	Status	MUE	Modifiers				IOM Reference
11000	0	A	1(2)	51	N/A	N/A	N/A	None
11001	N/A	A	1(3)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

cellulitis. Infection of the skin and subcutaneous tissues, most often caused by *Staphylococcus* or *Streptococcus* bacteria secondary to a cutaneous lesion. Progression of the inflammation may lead to abscess and tissue death, or even systemic infection-like bacteremia.

debridement. Removal of dead or contaminated tissue and foreign matter from a wound.

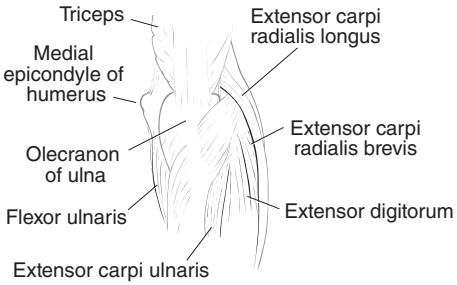
eczema. Inflammatory form of dermatitis with red, itchy breakouts of exudative vesicles that leads to crusting and scaling that occurs as a reaction to internal or external agents.

impetigo. Acute, superficial, highly contagious skin infection commonly occurring in children. Skin lesions usually appear on the face and consist of vesicles and bullae that burst and form yellow crusts.

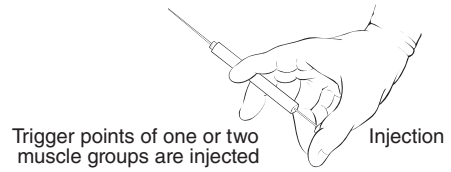
lymphangitis. Inflammation of the lymph channels most often caused by *Streptococcus*.

20552-20553

20552 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
20553 single or multiple trigger point(s), 3 or more muscles



Posterior view, right elbow, superficial dissection



Explanation

The physician injects a therapeutic agent into a single or multiple trigger point of one or two muscles in 20552 and into a single or multiple trigger point for three or more muscles in 20553. Trigger points are focal, discrete spots of hypersensitive irritability identified within bands of muscle. These points cause local or referred pain. Trigger points may be formed by acute or repetitive trauma to the muscle tissue, which puts too much stress on the fibers. The physician identifies the trigger point injection site by palpation or radiographic imaging and marks the injection site. The needle is inserted, and the medicine is injected into the trigger point. The injection may be done using image guidance, which is reported separately. After withdrawing the needle, the patient is monitored for reactions to the therapeutic agent. The injection procedure is repeated at the other trigger points for multiple sites.

Coding Tips

Local anesthesia is included in these services. If imaging guidance is performed, see 76942, 77002, and 77021. Supplies used when providing these procedures may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage. Do not report these codes with 20560 or 20561 for the same muscles.

ICD-10-CM Diagnostic Codes

G89.0 Central pain syndrome
G89.11 Acute pain due to trauma
G89.12 Acute post-thoracotomy pain
G89.18 Other acute postprocedural pain
G89.21 Chronic pain due to trauma
G89.22 Chronic post-thoracotomy pain
G89.28 Other chronic postprocedural pain
G89.29 Other chronic pain
G89.4 Chronic pain syndrome
M25.511 Pain in right shoulder ☑
M25.521 Pain in right elbow ☑
M25.531 Pain in right wrist ☑
M25.541 Pain in joints of right hand ☑
M25.551 Pain in right hip ☑
M25.561 Pain in right knee ☑
M25.571 Pain in right ankle and joints of right foot ☑
M26.621 Arthralgia of right temporomandibular joint ☑
M54.2 Cervicalgia
M54.51 Vertebrogenic low back pain
M54.59 Other low back pain
M72.2 Plantar fascial fibromatosis
M79.11 Myalgia of mastication muscle
M79.12 Myalgia of auxiliary muscles, head and neck
M79.18 Myalgia, other site
M79.601 Pain in right arm ☑
M79.604 Pain in right leg ☑
M79.621 Pain in right upper arm ☑
M79.631 Pain in right forearm ☑
M79.641 Pain in right hand ☑
M79.644 Pain in right finger(s) ☑
M79.651 Pain in right thigh ☑
M79.661 Pain in right lower leg ☑
M79.671 Pain in right foot ☑
M79.674 Pain in right toe(s) ☑
M79.7 Fibromyalgia

AMA: **20552** 2023,Jan; 2022,Jul; 2021,Oct; 2020,Feb; 2018,Dec **20553** 2024,May; 2023,Jan; 2021,Oct; 2020,Feb; 2018,Dec

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
20552	0.66	0.84	0.08	1.58
20553	0.75	0.98	0.09	1.82
Facility RVU	**Work**	**PE**	**MP**	**Total**
20552	0.66	0.36	0.08	1.1
20553	0.75	0.41	0.09	1.25

	FUD	Status	MUE	Modifiers				IOM Reference
20552	0	A	1(2)	51	N/A	N/A	N/A	None
20553	0	A	1(2)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

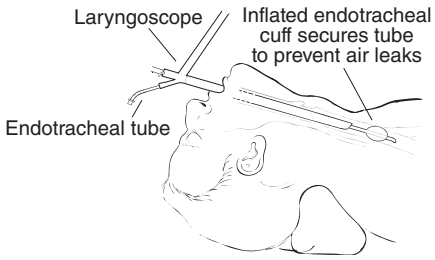
injection. Forcing a liquid substance into a body part such as a joint or muscle.

myalgia. Pain in the muscles.

trigger point. Focal, discrete spot of hypersensitivity identified within bands of muscle that causes local or referred pain. Trigger points may be formed by acute or repetitive trauma to the muscle tissue, which puts too much stress on the fibers.

31500

31500 Intubation, endotracheal, emergency procedure



An emergency endotracheal intubation is performed

Explanation

The physician places an endotracheal tube to provide air passage in emergency situations. The patient is ventilated with a mask and bag and positioned by extending the neck anteriorly and the head posteriorly. The physician places the laryngoscope into the patient's mouth and advances the blade toward the epiglottis until the vocal cords are visible. An endotracheal tube is inserted between the vocal cords and advanced to the proper position. The cuff of the endotracheal tube is inflated.

Coding Tips

Emergency endotracheal intubation may be reported separately when performed in connection with critical care. See 99291, 99292, and notes for definitions of critical care and other procedures that may be reported. Do not report anesthesia services separately; intubation is included in these services. Do not report 31500 with neonatal (99468–99469) or pediatric (99471–99476) critical care services, as well as neonatal or pediatric intensive care services (99477–99480).

ICD-10-CM Diagnostic Codes

I11.0	Hypertensive heart disease with heart failure
I26.01	Septic pulmonary embolism with acute cor pulmonale
I26.02	Saddle embolus of pulmonary artery with acute cor pulmonale
I26.09	Other pulmonary embolism with acute cor pulmonale
I27.82	Chronic pulmonary embolism
I50.21	Acute systolic (congestive) heart failure
I50.22	Chronic systolic (congestive) heart failure
I50.23	Acute on chronic systolic (congestive) heart failure
I50.811	Acute right heart failure
I50.812	Chronic right heart failure
I97.131	Postprocedural heart failure following other surgery
J12.89	Other viral pneumonia
J13	Pneumonia due to Streptococcus pneumoniae
J14	Pneumonia due to Hemophilus influenzae
J15.0	Pneumonia due to Klebsiella pneumoniae
J15.1	Pneumonia due to Pseudomonas
J15.211	Pneumonia due to Methicillin susceptible Staphylococcus aureus
J15.212	Pneumonia due to Methicillin resistant Staphylococcus aureus
J15.29	Pneumonia due to other staphylococcus
J15.3	Pneumonia due to streptococcus, group B
J15.4	Pneumonia due to other streptococci
J15.5	Pneumonia due to Escherichia coli
J15.61	Pneumonia due to Acinetobacter baumannii
J15.69	Pneumonia due to other Gram-negative bacteria
J44.0	Chronic obstructive pulmonary disease with (acute) lower respiratory infection
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J45.22	Mild intermittent asthma with status asthmaticus
J45.32	Mild persistent asthma with status asthmaticus
J45.42	Moderate persistent asthma with status asthmaticus
J45.51	Severe persistent asthma with (acute) exacerbation
J45.52	Severe persistent asthma with status asthmaticus
J68.0	Bronchitis and pneumonitis due to chemicals, gases, fumes and vapors
J68.1	Pulmonary edema due to chemicals, gases, fumes and vapors
J68.4	Chronic respiratory conditions due to chemicals, gases, fumes and vapors
J80	Acute respiratory distress syndrome
J81.0	Acute pulmonary edema
J82.81	Chronic eosinophilic pneumonia
J82.82	Acute eosinophilic pneumonia
J82.83	Eosinophilic asthma
J84.114	Acute interstitial pneumonitis
J85.1	Abscess of lung with pneumonia
J95.821	Acute postprocedural respiratory failure
J95.822	Acute and chronic postprocedural respiratory failure
J96.01	Acute respiratory failure with hypoxia

AMA: 31500 2021,Jul; 2018,Jun

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
31500	3.0	0.74	0.43	4.17
Facility RVU	**Work**	**PE**	**MP**	**Total**
31500	3.0	0.74	0.43	4.17

	FUD	Status	MUE	Modifiers				IOM Reference
31500	0	A	2(3)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

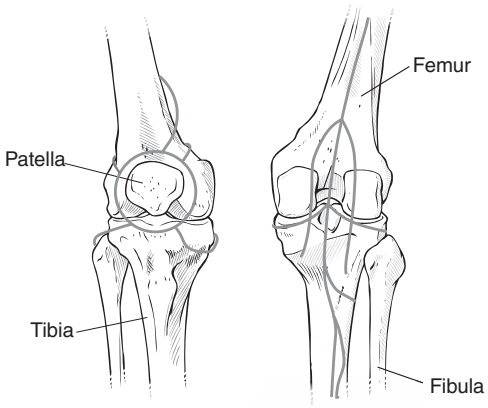
cor pulmonale. Heart-lung disease appearing in identifiable forms as chronic or acute. The chronic form of this heart-lung disease is marked by dilation and hypertrophy failure of the right ventricle due to a disease that has affected the function of the lungs, excluding congenital or left heart diseases and is also called chronic cardiopulmonary disease. The acute form is an overload of the right ventricle from a rapid onset of pulmonary hypertension, usually arising from a pulmonary embolism.

embolism. Obstruction of a blood vessel resulting from a clot or foreign substance.

intubation. Insertion of a tube into a hollow organ, canal, or cavity within the body.

64454

64454 Injection(s), anesthetic agent(s) and/or steroid; genicular nerve branches, including imaging guidance, when performed



Genicular nerve branches are injected

Explanation

Articular branches of various nerves (common peroneal, femoral, obturator, saphenous, and tibial) innervate the knee joint. These branches around the knee joint are known as genicular nerves. The physician injects one or more anesthetic agents and/or steroids near the genicular nerve branches to control pain and inflammation of the knee. The physician determines the target area using anatomic landmarks or image guidance, draws an anesthetic agent and/or steroid into a syringe, and injects it into the targeted area near the genicular nerves.

Coding Tips

Do not report 64454 with 64624. Code 64454 requires injection of all genicular nerve branches: superolateral, superomedial, and inferomedial. If all branches are not injected, report 64454 with modifier 52.

ICD-10-CM Diagnostic Codes

M25.561 Pain in right knee ☑
Z96.651 Presence of right artificial knee joint ☑
Z96.653 Presence of artificial knee joint, bilateral ☑

AMA: 64454 2023,Jan; 2022,Dec; 2022,Jul; 2021,Feb; 2020,Dec; 2019,Dec

Relative Value Units/Medicare Edits

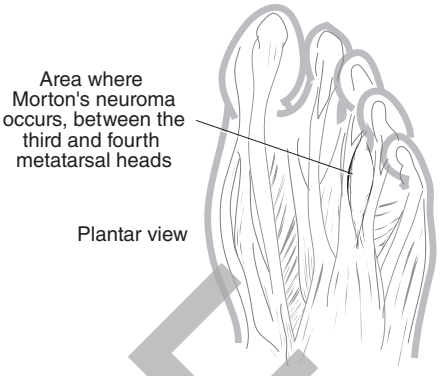
Non-Facility RVU	Work	PE	MP	Total
64454	1.52	5.0	0.14	6.66
Facility RVU	**Work**	**PE**	**MP**	**Total**
64454	1.52	0.79	0.14	2.45

	FUD	Status	MUE	Modifiers				IOM Reference
64454	0	A	1(2)	51	50	N/A	N/A	None

* with documentation

64455

64455 Injection(s), anesthetic agent(s) and/or steroid; plantar common digital nerve(s) (eg, Morton's neuroma)



Anesthetic and steroid is injected into the plantar common digital nerve or Morton's neuroma

Explanation

The physician injects a local anesthetic agent and/or steroid into a plantar common digital nerve from the dorsal direction. This procedure is often performed to treat Morton's neuroma, a frequently occurring injury of the forefoot that affects the third web space of the toes. This code reports single or multiple injections.

Coding Tips

For destruction of the plantar common digital nerve by neurolytic agent, see 64632. Do not report 64455 with 64632.

ICD-10-CM Diagnostic Codes

G57.61 Lesion of plantar nerve, right lower limb ☑
G57.62 Lesion of plantar nerve, left lower limb ☑
G57.63 Lesion of plantar nerve, bilateral lower limbs ☑

AMA: 64455 2023,Jan; 2022,Dec; 2021,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
64455	0.75	0.69	0.06	1.5
Facility RVU	**Work**	**PE**	**MP**	**Total**
64455	0.75	0.18	0.06	0.99

	FUD	Status	MUE	Modifiers				IOM Reference
64455	0	A	1(2)	51	50	N/A	80*	None

* with documentation

90732

90732 Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older, for subcutaneous or intramuscular use

Explanation

This code reports supply of a vaccine only. A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of these antibody production patterns for long-term protection. This code reports a pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, for subcutaneous or intramuscular administration to patients 2 years of age or older. Report this code with the appropriate administration code.

Coding Tips

Report this code with the appropriate administration code. Administration codes should only be reported when the clinician renders face-to-face counseling to the patient and/or family at the time the immunization is being administered. For administration of a vaccine without the face-to-face clinician counseling service for patients 18 years of age and older, see 90471–90474. Separately identifiable E/M services may be reported in addition to the vaccine and toxoid administration codes.

ICD-10-CM Diagnostic Codes

Z23 Encounter for immunization

Z29.89 Encounter for other specified prophylactic measures

AMA: **90732** 2024,Jan; 2023,Aug; 2023,Jan; 2021,Jun; 2021,May; 2021,Apr; 2020,Nov

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90732	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90732	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
90732	N/A	X	1(2)	N/A	N/A	N/A	N/A	None

* with documentation

93000-93010

93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report

93005 tracing only, without interpretation and report

93010 interpretation and report only

Explanation

Multiple electrodes are placed on a patient's chest to record the electrical activity of the heart. A physician interprets the findings. Report 93000 for the combined technical and professional components of an ECG; 93005 for the technical component only; and 93010 for the professional component only.

Coding Tips

Do not report these codes with Category III codes 0525T-0532T.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **93000** 2020,Dec **93005** 2020,Dec **93010** 2024,Sep; 2021,May; 2020,Dec

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
93000	0.17	0.24	0.02	0.43
93005	0.0	0.18	0.01	0.19
93010	0.17	0.06	0.01	0.24
Facility RVU	**Work**	**PE**	**MP**	**Total**
93000	0.17	0.24	0.02	0.43
93005	0.0	0.18	0.01	0.19
93010	0.17	0.06	0.01	0.24

	FUD	Status	MUE	Modifiers				IOM Reference
93000	N/A	A	3(3)	N/A	N/A	N/A	80*	None
93005	N/A	A	3(3)	N/A	N/A	N/A	80*	
93010	N/A	A	5(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

interpretation. Professional health care provider's review of data with a written or verbal opinion.

professional component. Portion of a charge for health care services that represents the physician's (or other practitioner's) work in providing the service, including interpretation and report of the procedure. This component of the service usually is charged for and billed separately from the inpatient hospital charges.

technical component. Portion of a health care service that identifies the provision of the equipment, supplies, technical personnel, and costs attendant to the performance of the procedure other than the professional services.

G0127

G0127 Trimming of dystrophic nails, any number

Explanation

A physician trims fingernails or toenails usually with scissors, nail cutters, or other instruments when the nails are defective and dystrophic from nutritional or metabolic abnormalities. Report this code for any number of nails trimmed.

Coding Tips

This code is reported only once regardless of the number of nails that are trimmed. Medicare requires the use of specific HCPCS Level II modifiers Q7–Q9 to indicate clinical findings indicative of severe peripheral involvement, warranting the medical necessity of a podiatrist providing foot care, such as nail debridement or trimming, that would usually be considered routine and for which benefits would not be provided.

ICD-10-CM Diagnostic Codes

B35.1	Tinea unguium
B37.2	Candidiasis of skin and nail
L60.0	Ingrowing nail
L60.1	Onycholysis
L60.2	Onychogryphosis
L60.3	Nail dystrophy
L60.4	Beau's lines
L60.5	Yellow nail syndrome
L60.8	Other nail disorders
L60.9	Nail disorder, unspecified
L62	Nail disorders in diseases classified elsewhere
R68.3	Clubbing of fingers

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0127	0.17	0.54	0.01	0.72
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0127	0.17	0.04	0.01	0.22

	FUD	Status	MUE	Modifiers				IOM Reference
G0127	0	R	1(2)	51	N/A	N/A	N/A	None

* with documentation

G0136

G0136 Administration of a standardized, evidence-based social determinants of health risk assessment tool, 5 to 15 minutes

Explanation

A physician or other qualified health care professional administers an assessment of an individual's social determinants of health (SDOH) or identified social risk factors that may influence the diagnosis and treatment of medical conditions. SDOH can limit the provider's ability to diagnose or treat a condition and the patient's ability to follow the prescribed treatment plan. This service is reported in addition to an E/M service or the annual wellness visit (AWV). This service may only be reported once every six months. This service is approved by Medicare as a telehealth service and may be performed by staff under incident-to guidelines.

Coding Tips

Medicare has identified this code as a telehealth/telemedicine service. Telemedicine services may be reported by the performing provider by using the appropriate place-of-service (POS) indicator. This service may be provided in addition to an annual wellness visit (AWV), outpatient E/M service 99202-99205, 99212-99215; psychiatric diagnostic evaluation 90791; health behavior assessment and intervention service 96156, 96158, 96159, 96164, 96165, 96167, and 96168; or hospital discharge service.

ICD-10-CM Diagnostic Codes

Z56.82	Military deployment status
Z59.01	Sheltered homelessness
Z59.02	Unsheltered homelessness
Z59.11	Inadequate housing environmental temperature
Z59.12	Inadequate housing utilities
Z59.19	Other inadequate housing
Z59.3	Problems related to living in residential institution
Z59.41	Food insecurity
Z59.48	Other specified lack of adequate food
Z59.5	Extreme poverty
Z59.6	Low income
Z59.71	Insufficient health insurance coverage
Z59.811	Housing instability, housed, with risk of homelessness
Z59.812	Housing instability, housed, homelessness in past 12 months
Z59.82	Transportation insecurity
Z59.86	Financial insecurity
Z59.87	Material hardship due to limited financial resources, not elsewhere classified
Z59.89	Other problems related to housing and economic circumstances

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0136	0.18	0.38	0.01	0.57
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0136	0.18	0.08	0.01	0.27

	FUD	Status	MUE	Modifiers				IOM Reference
G0136	N/A	A	-	N/A	N/A	N/A	80*	None

* with documentation

mechanically. The strip is exposed to the urine sample and is mechanically fed through a processor that reads the colors emitted by the reaction. The unit will be calibrated according to international standards and readings have a high degree of accuracy. The result may be displayed on a monitor, but is always printed or recorded in some form. Code 81003 does not include a microscopic examination of the urine sample or its components.

81007

81007 Urinalysis; bacteriuria screen, except by culture or dipstick

Explanation

This type of test may be ordered by the brand name of the commercial kit used and the bacteria that the kit screens for. Human urine is normally free of bacteria. However, bacteria can easily be introduced upon voiding. In addition, specimens containing any amount of pathological bacteria can have the organisms rapidly multiply after collection. For this reason, specimens are often examined shortly after collection. Method includes any method except culture or dipstick. The test is often performed by commercial kit. The type of kit used should be specified in the report.

81015

81015 Urinalysis; microscopic only

Explanation

This test may be ordered as a microscopic analysis. Human urine is normally free of bacteria. However, bacteria can easily be introduced upon voiding. In addition, specimens containing any amount of pathological bacteria can have the organisms rapidly multiply after collection. For this reason, specimens are often examined shortly after collection. The sample may first be centrifuged into a graduated tube to concentrate the sediments, or solid matter, held in suspension. The concentration of bacteria as well as cell types, crystals, and other elements seen is reported.

81025

81025 Urine pregnancy test, by visual color comparison methods

Explanation

This test may be ordered by any of the brand name kits available. The tests typically involve a dipstick impregnated with reagents that chemically react upon contact with urine. A change in color indicates positive or negative for the presence of hormones found in the urine of women in early pregnancy.

82270

82270 Blood, occult, by peroxidase activity (eg, guaiac), qualitative; feces, consecutive collected specimens with single determination, for colorectal neoplasm screening (ie, patient was provided 3 cards or single triple card for consecutive collection)

Explanation

This test may be requested as a screening guaiac, screening stool guaiac, or by a variety of brand names. The patient is instructed to obtain three consecutive stool specimens and send the kit to a lab or physician office for performance of the test. The method is peroxidase activity. This test reports the presence (qualitative analysis) of blood in the stool, but does not quantify the amount. This code is used to report the service when performed as colorectal neoplasm screening.

82272

82272 Blood, occult, by peroxidase activity (eg, guaiac), qualitative, feces, 1-3 simultaneous determinations, performed for other than colorectal neoplasm screening

Explanation

This test may be requested as a screening guaiac or screening stool guaiac, or by a variety of brand names. The patient is instructed to obtain one to three consecutive stool specimens and send the kit to a lab or physician office for test performance. The method is peroxidase activity. This test detects the presence (qualitative analysis) of blood in the stool, but does not quantify the amount. This code is used to report the service when performed for reasons other than colorectal neoplasm screening. If more than one sample is required, each must be obtained from a separate bowel movement.

82274

82274 Blood, occult, by fecal hemoglobin determination by immunoassay, qualitative, feces, 1-3 simultaneous determinations

Explanation

Fecal sample is dispersed in a diluent with antibodies for hemoglobin antigen to form a complex of antibody and antigen. A complex of antibody and antigen is separated from the specimen and exposed to a second antibody for the hemoglobin antigen. A sample from the first complex is bound to a solid carrier, and a sample from the second antibody exposure is labeled with a detection agent to determine the presence of hemoglobin antigen in the original fecal specimen. This code requires one to three consecutive stool samples, which must be obtained from separate bowel movements, and each sample must be placed in a sterile, leakproof container with a screw-cap lid for transport to the laboratory.

82565

82565 Creatinine; blood

Explanation

Serum creatinine is the most common laboratory test for evaluating renal function. Method is enzymatic or colorimetry.

82570

82570 Creatinine; other source

Explanation

Urine creatinine levels are not normally used to evaluate disease processes except as part of a creatinine clearance test, but they are a good indicator of the adequacy of timed urine specimens. Amniotic fluid creatinine is used to evaluate fetal maturity. For amniotic fluid specimen, a separately reportable amniocentesis is performed. Method is enzymatic, Jaffe reaction, or manual.

82947-82950

82947 Glucose; quantitative, blood (except reagent strip)
82948 blood, reagent strip
82950 post glucose dose (includes glucose)

Explanation

These tests are used to monitor disorders of carbohydrate metabolism. The quantitative test reported with code 82947 may be requested as a fasting blood sugar (FBS). The patient has ordinarily fasted for eight hours. Method is enzymatic. In 82948, the blood specimen is obtained by finger stick. A drop of blood is placed on the reagent strip for a specified amount of time. When the prescribed amount of time has elapsed, the strip is blotted and the reagent strip is compared to a color chart. Method is reagent strip with visual comparison. A postglucose test, 82950, may also be requested as glucose, postprandial (PP). The patient consumes a high carbohydrate meal or an oral glucose solution. Blood glucose levels are checked two hours after the meal or glucose solution. A one-hour postprandial screen may be used to evaluate pregnant women for gestational diabetes mellitus. Method of testing varies.

Correct Coding Initiative Update 30.3

❖Indicates Mutually Exclusive Edit

0732T 0213T, 0216T, 12001-12007, 12011-12057, 13100-13133, 13151-13153, 36000, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 43752, 51701-51703, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64450, 64461-64463, 64479-64505, 64510-64530, 69990, 92012-92014, 93000-93010, 93040-93042, 93318, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360-96368, 96372, 96374-96377, 96523, 99155, 99156, 99157, 99211-99215, 99221-99223, 99231-99239, 99242-99245, 99252-99255, 99291-99292, 99315-99316, 99347-99350, 99374-99375, 99377-99378

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0770T No CCI edits apply to this code.

0771T 36591-36592, 96523

0772T No CCI edits apply to this code.

0773T 36591-36592, 96523

0774T No CCI edits apply to this code.

0815T 36591-36592, 96523

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