OPTUM360®

CODING COMPANION

Primary Care/ Pediatrics/Emergency Medicine

A comprehensive illustrated guide to coding and reimbursement

2022

optum360coding.com

Contents

Getting Started with Coding Companion

Coding Companion for Primary Care/Pediatrics/Emergency Medicine 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 Codes

For ease of use, evaluation and management codes related to Primary Care/Pediatrics/Emergency Medicine 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 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 Optum360 *Coding Companion* series display in their resequenced order. Resequenced codes are enclosed in brackets for easy identification.

ICD-10-CM

Overall, the 10th revision goes into greater clinical detail than did ICD-9-CM and addresses information about previously classified diseases, as well as those diseases discovered since the last revision. Conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. New features have been added, and conditions have been reorganized, although the format and conventions of the classification remain unchanged for the most part.

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. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the pages following the sample.

Appendix Codes and Descriptions

Some CPT codes are presented in a less comprehensive format in the appendix. The CPT codes appropriate to the specialty are included in the appendix with the official CPT code description. The codes are presented in numeric order, and each code is followed by an easy-to-understand lay description of the procedure.

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

- HCPCS
- 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 Edit Updates

The *Coding Companion* series 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 XX.X, the most current version available at press time. The CCI edits are located in a section at the back of the book. Optum360 maintains a website to accompany the Coding Companions series and posts updated CCI edits on this website so that current information is available before the next edition. The website address is http://www.optum360coding.com/ProductUpdates/. The 2022 edition password is: **XXXXXXXX22**. Log in each quarter to ensure you receive the most current updates. An email reminder will also be sent to you to let you know when the updates are available.

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:

69501 Transmastoid antrotomy (simple mastoidectomy)

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

Antrotomy
Transmastoid, 69501

Excision
Mastoid
Simple, 69501

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 xiv 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.

99211-99215

▲ **99211** Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

▲★**99212** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

▲★**99213** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

▲★**99214** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

▲★**99215** Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for established 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 excluding the most basic service represented by 99211 that describes an encounter in which the presenting problems are typically minimal and may not require the presence of a physician or other qualified health care professional. For the remainder of codes within this range, 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/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. Report 99212 for a visit that entails straightforward MDM. If time is used for code selection, 10 to 19 minutes of total time is spent on the day of encounter. Report 99213 for a visit requiring a low level of MDM or 20 to 29 minutes of total time; 99214 for a moderate level of MDM or 30 to 39 minutes of total time; and 99215 for a high level of MDM or 40 to 54 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for an established 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 no longer used when determining the level of service. Codes should be selected based upon the CPT revised 2021 Medical Decision Making table. Alternately, 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. Code 99211 does not require the presence of a physician or other qualified health care professional. For office or other outpatient services for a new patient, see 99202-99205. For observation care services, see 99217-99226. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. Medicare has identified 99211 as a telehealth/telemedicine service. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes. Services at the origination site are reported with HCPCS Level II code Q3014.

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: **99211** 2020,Sep,14; 2020,Sep,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Mar,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Mar,13; 2014,Jan,11; 2014,Aug,3 **99212** 2020,Sep,14; 2020,Sep,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Oct,5; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99213** 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,10; 2018,Apr,9; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,3; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99214** 2020,Sep,14; 2020,Sep,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Dec,3; 2014,Oct,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99215** 2020,Sep,3; 2020,Sep,14; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2019,Oct,10; 2019,Jan,3; 2019,Feb,3; 2018,Sep,14; 2018,Mar,7; 2018,Jan,8; 2018,Apr,9; 2018,Apr,10; 2017,Jun,6; 2017,Jan,8; 2017,Aug,3; 2016,Sep,6; 2016,Mar,10; 2016,Jan,13; 2016,Jan,7; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3; 2014,Oct,3; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3

 N Newborn: 0 **P Pediatric: 0-17** **M Maternity: 9-64** **A Adult: 15-124** ♂ **Male Only** ♀ **Female Only**

17106-17108

17106 Destruction of cutaneous vascular proliferative lesions (eg, laser technique); less than 10 sq cm
17107 10.0 to 50.0 sq cm
17108 over 50.0 sq cm

Cutaneous vascular proliferative lesions are destroyed

Explanation

The physician destroys a collection of abnormal proliferative blood vessels within the skin. To complete this procedure, the physician usually applies a laser treatment in a technique similar to painting the skin. This destroys the vessels, creating scar tissue that eventually fades. No incision is made and no tissue is removed. Report 17106 if the treated area totals less than 10 sq cm; 17107 for 10 sq cm to 50 sq cm; and 17108 for more than 50 sq cm.

Coding Tips

For sharp removal, ligature strangulation, electrosurgical destruction, or combination of treatment modalities, including chemical or electrocauterization of wound of skin tags and fibrocutaneous lesions, see 11200 and 11201. For destruction of malignant skin lesions, see 17260–17286. These procedures include local anesthesia. For destruction of premalignant lesions, see 17000–17004. It is inappropriate to report supplies when these services are performed in an emergency room. 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

D18.01 Hemangioma of skin and subcutaneous tissue
D18.09 Hemangioma of other sites
I78.0 Hereditary hemorrhagic telangiectasia
I78.1 Nevus, non-neoplastic
I78.8 Other diseases of capillaries
Q82.5 Congenital non-neoplastic nevus
Q85.8 Other phakomatoses, not elsewhere classified

AMA: **17106** 2019,Sep,10; 2018,Jan,8; 2017,Jan,8; 2017,Dec,14; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16; 2014,Jan,11 **17107** 2018,Jan,8; 2017,Jan,8; 2017,Dec,14; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16; 2014,Jan,11 **17108** 2018,Jan,8; 2017,Jan,8; 2017,Dec,14; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16; 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
17106	3.69	5.63	0.4	9.72
17107	4.79	7.34	0.6	12.73
17108	7.49	9.79	0.86	18.14
Facility RVU	**Work**	**PE**	**MP**	**Total**
17106	3.69	3.75	0.4	7.84
17107	4.79	4.78	0.6	10.17
17108	7.49	6.66	0.86	15.01

	FUD	Status	MUE	Modifiers				IOM Reference
17106	90	A	1(2)	51	N/A	N/A	N/A	100-02,16,10; 100-02,16,120; 100-02,16,180; 100-03,140.5
17107	90	A	1(2)	51	N/A	N/A	N/A	
17108	90	A	1(2)	51	N/A	N/A	80*	

* with documentation

Terms To Know

benign. Mild or nonmalignant in nature.

cautery. Destruction or burning of tissue by means of a hot instrument, an electric current, or a caustic chemical, such as silver nitrate.

chemosurgery. Application of chemical agents to destroy tissue, originally referring to the in situ chemical fixation of premalignant or malignant lesions to facilitate surgical excision.

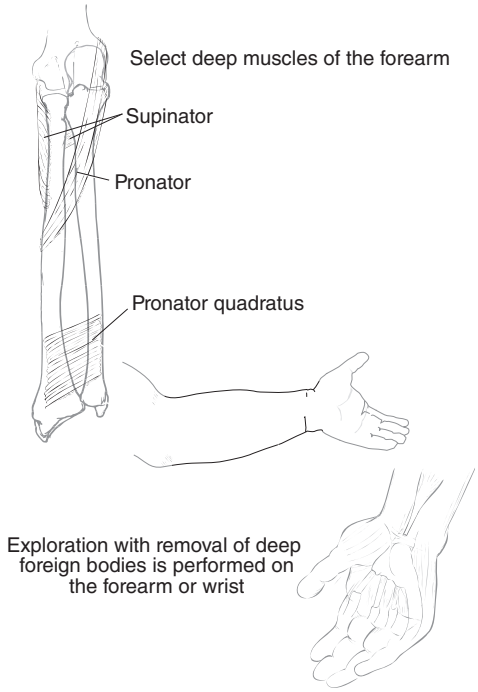
hemangioma. Benign neoplasm arising from vascular tissue or malformations of vascular structures. It is most commonly seen in children and infants as a tumor of newly formed blood vessels due to malformed fetal angioblastic tissues.

incision. Act of cutting into tissue or an organ.

nevus. Benign, pigmented skin lesion that includes congenital lesions of the skin such as birthmarks, telangiectasias (permanent dilations of small blood vessels), vascular spider veins, hemangiomas, and moles.

25248

25248 Exploration with removal of deep foreign body, forearm or wrist



Explanation

The physician removes a deeply implanted foreign body from the forearm or wrist. The physician incises the site and dissects down to reach the area where the foreign object is embedded. Exploration of the site is done. Separately reportable x-rays may be taken to locate the object. All parts of the object are removed. The wound is sutured in layers.

Coding Tips

Local anesthesia is included in this service. However, this procedure may be performed under general anesthesia, depending on the age and/or condition of the patient. For radiology services, see 73090–73115. For removal of a superficial foreign body, see 20520. Arthrotomy with removal of a foreign body in the wrist joint is reported with 25101. For removal of hardware (K-wire, pin, or rod), see 20670 or 20680. It is inappropriate to report supplies when these services are performed in an emergency room. For physician office, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

M60.231 Foreign body granuloma of soft tissue, not elsewhere classified, right forearm ☑

M60.232 Foreign body granuloma of soft tissue, not elsewhere classified, left forearm ☑

M79.5 Residual foreign body in soft tissue

S51.821A Laceration with foreign body of right forearm, initial encounter ☑

S51.822A Laceration with foreign body of left forearm, initial encounter ☑

S51.841A Puncture wound with foreign body of right forearm, initial encounter ☑

S51.842A Puncture wound with foreign body of left forearm, initial encounter ☑

S61.521A Laceration with foreign body of right wrist, initial encounter ☑

S61.522A Laceration with foreign body of left wrist, initial encounter ☑

S61.541A Puncture wound with foreign body of right wrist, initial encounter ☑

S61.542A Puncture wound with foreign body of left wrist, initial encounter ☑

AMA: **25248** 2018,Sep,7

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
25248	5.31	5.61	1.05	11.97
Facility RVU	**Work**	**PE**	**MP**	**Total**
25248	5.31	5.61	1.05	11.97

	FUD	Status	MUE	Modifiers				IOM Reference
25248	90	A	3(3)	51	50	N/A	N/A	None

* with documentation

Terms To Know

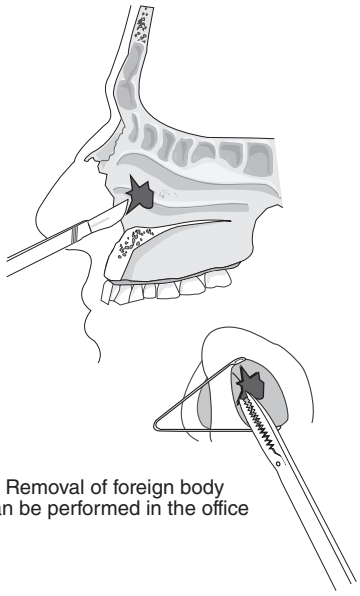
dissection. Separating by cutting tissue or body structures apart.

exploration. Examination for diagnostic purposes.

foreign body. Any object or substance found in an organ and tissue that does not belong under normal circumstances.

30300

30300 Removal foreign body, intranasal; office type procedure



Removal of foreign body can be performed in the office

Explanation

The physician removes a foreign body from inside the nasal cavity in the office setting. Foreign bodies are defined as objects not normally found in the body. An object may be embedded in normal tissue as a result of some type of trauma. Topical vasoconstrictive agents and local anesthesia are applied to the nasal mucosa. A small incision may be necessary to access the foreign body. Blunt dissection and retrieval of the object is performed with hemostats or forceps. Sutures may close the mucosa in a single layer if the size of the dissection requires.

Coding Tips

Topical vasoconstrictive agents and local anesthesia are not reported separately. It is inappropriate to report supplies when these services are performed in an emergency room. For physician office, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

S01.22XA Laceration with foreign body of nose, initial encounter
S01.24XA Puncture wound with foreign body of nose, initial encounter
T17.0XXA Foreign body in nasal sinus, initial encounter
T17.1XXA Foreign body in nostril, initial encounter

AMA: **30300** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11

Relative Value Units/Medicare Edits

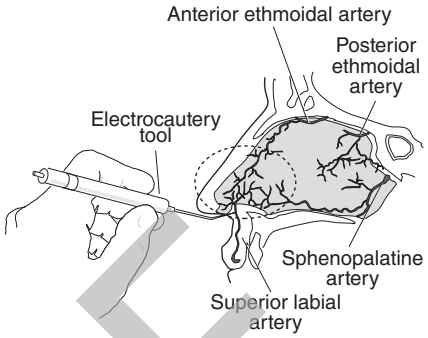
Non-Facility RVU	Work	PE	MP	Total
30300	1.09	4.18	0.13	5.4
Facility RVU	**Work**	**PE**	**MP**	**Total**
30300	1.09	2.01	0.13	3.23

	FUD	Status	MUE	Modifiers				IOM Reference
30300	10	A	1(3)	51	N/A	N/A	N/A	None

* with documentation

30901-30903

30901 Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method
30903 Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method



Cautery and packing applied to anterior area

Explanation

To control a less serious nosebleed in 30901, the physician applies electrical or chemical coagulation or packing materials to the anterior (front) section of the nose. Only limited electrical or chemical coagulation is used. To control a less responsive nosebleed in 30903, the physician uses extensive electrical coagulation or extensive packing in the anterior (front) section of the nose.

Coding Tips

These are unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). Local anesthesia is included in these services. It is inappropriate to report supplies when these services are performed in an emergency room. For physician office, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

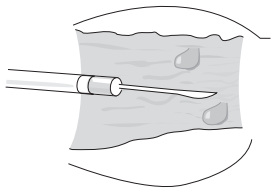
ICD-10-CM Diagnostic Codes

J95.61 Intraoperative hemorrhage and hematoma of a respiratory system organ or structure complicating a respiratory system procedure
J95.62 Intraoperative hemorrhage and hematoma of a respiratory system organ or structure complicating other procedure
J95.71 Accidental puncture and laceration of a respiratory system organ or structure during a respiratory system procedure
J95.72 Accidental puncture and laceration of a respiratory system organ or structure during other procedure
J95.830 Postprocedural hemorrhage of a respiratory system organ or structure following a respiratory system procedure
J95.831 Postprocedural hemorrhage of a respiratory system organ or structure following other procedure
R04.0 Epistaxis

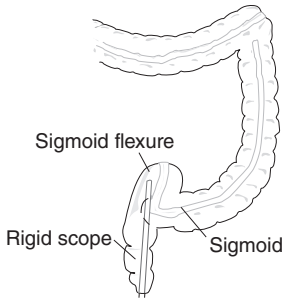
AMA: **30901** 2020,Jul,13

45320

45320 Proctosigmoidoscopy, rigid; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique (eg, laser)



Tumor(s), polyp(s), or other lesion(s) are ablated from the rectum/sigmoid region of the colon



Explanation

The physician performs rigid proctosigmoidoscopy and ablation of a tumor polyp or other lesion. The physician inserts the proctosigmoidoscope into the anus and advances the scope. The lumen of the sigmoid colon and rectum is visualized and the tumor, polyp or other lesion is identified and ablation performed. The proctosigmoidoscope is removed at the completion of the procedure.

Coding Tips

Report the appropriate endoscopy for each anatomic site examined. Surgical endoscopy includes a diagnostic endoscopy; however, diagnostic endoscopy can be identified separately when performed at the same surgical session as an open procedure. For flexible sigmoidoscopy with ablation of tumors, polyps, or other lesions, see 45346. For colonoscopy, flexible, with ablation of tumors, polyps, or other lesions, see 45388. For anoscopy, with ablation of tumors, polyps, or other lesions not amenable to removal by hot biopsy forceps, bipolar cautery, or snare technique, see 46615.

ICD-10-CM Diagnostic Codes

C18.7	Malignant neoplasm of sigmoid colon
C18.8	Malignant neoplasm of overlapping sites of colon
C19	Malignant neoplasm of rectosigmoid junction
C20	Malignant neoplasm of rectum
C21.8	Malignant neoplasm of overlapping sites of rectum, anus and anal canal
C49.A4	Gastrointestinal stromal tumor of large intestine
C49.A5	Gastrointestinal stromal tumor of rectum
C78.5	Secondary malignant neoplasm of large intestine and rectum
C7A.025	Malignant carcinoid tumor of the sigmoid colon
C7A.026	Malignant carcinoid tumor of the rectum
D01.0	Carcinoma in situ of colon
D01.1	Carcinoma in situ of rectosigmoid junction
D01.2	Carcinoma in situ of rectum
D01.3	Carcinoma in situ of anus and anal canal
D12.5	Benign neoplasm of sigmoid colon
D12.7	Benign neoplasm of rectosigmoid junction
D12.8	Benign neoplasm of rectum
D12.9	Benign neoplasm of anus and anal canal
D37.4	Neoplasm of uncertain behavior of colon
D37.5	Neoplasm of uncertain behavior of rectum
D3A.025	Benign carcinoid tumor of the sigmoid colon
D3A.026	Benign carcinoid tumor of the rectum
K51.013	Ulcerative (chronic) pancolitis with fistula
K51.014	Ulcerative (chronic) pancolitis with abscess
K51.311	Ulcerative (chronic) rectosigmoiditis with rectal bleeding
K51.312	Ulcerative (chronic) rectosigmoiditis with intestinal obstruction
K62.1	Rectal polyp
K63.5	Polyp of colon

AMA: **45320** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Jan,11

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
45320	1.68	3.69	0.41	5.78
Facility RVU	**Work**	**PE**	**MP**	**Total**
45320	1.68	0.96	0.41	3.05

	FUD	Status	MUE	Modifiers				IOM Reference
45320	0	A	1(2)	51	N/A	N/A	N/A	None

* with documentation

Terms To Know

ablation. Removal or destruction of tissue by cutting, electrical energy, chemical substances, or excessive heat application.

hemorrhage. Internal or external bleeding with loss of significant amounts of blood.

polyp. Small growth on a stalk-like attachment projecting from a mucous membrane.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

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

These codes are 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
L03.011	Cellulitis of right finger ☑
L03.012	Cellulitis of left finger ☑
L03.021	Acute lymphangitis of right finger ☑
L03.022	Acute lymphangitis of left finger ☑
L03.031	Cellulitis of right toe ☑
L03.032	Cellulitis of left toe ☑
L03.041	Acute lymphangitis of right toe ☑
L03.042	Acute lymphangitis of left toe ☑
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
R68.3	Clubbing of fingers

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0127	0.17	0.49	0.01	0.67
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

Terms To Know

onychia. Inflammation or infection of the nail matrix leading to a loss of the nail.

paronychia. Infection or cellulitis of nail structures.

G0166

G0166 External counterpulsation, per treatment session

Explanation

External counterpulsation is a therapy for relieving angina and is also beneficial for congestive heart failure patients. The treatment increases blood flow into the arteries and decreases the work load of the heart. The therapy is believed to work by stimulating the growth of new blood vessels around the arteries in the heart that are blocked. The patient has compressive cuffs wrapped around his/her calves and upper and lower thighs. The cuffs inflate when the heart is filling with blood and deflate when the heart is ejecting blood. Treatment sessions last one hour and are usually for a period of five times a week for seven weeks. This code reports one treatment session.

Coding Tips

Per Medicare, a full course of treatment usually consists of 35 one-hour sessions, which may be offered once or twice daily, lasting four to seven weeks.

ICD-10-CM Diagnostic Codes

I20.0	Unstable angina
I20.1	Angina pectoris with documented spasm
I20.8	Other forms of angina pectoris
I50.1	Left ventricular failure, unspecified
I50.21	Acute systolic (congestive) heart failure
I50.22	Chronic systolic (congestive) heart failure
I50.23	Acute on chronic systolic (congestive) heart failure
I50.31	Acute diastolic (congestive) heart failure
I50.32	Chronic diastolic (congestive) heart failure
I50.33	Acute on chronic diastolic (congestive) heart failure
I50.41	Acute combined systolic (congestive) and diastolic (congestive) heart failure
I50.42	Chronic combined systolic (congestive) and diastolic (congestive) heart failure
I50.43	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0166	0.0	2.86	0.03	2.89
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0166	0.0	2.86	0.03	2.89

	FUD	Status	MUE	Modifiers				IOM Reference
G0166	N/A	A	2(3)	N/A	N/A	N/A	N/A	None

* with documentation

with alternate right and left flexion. These images are taken to detect any curvature of the spine when scoliosis or other pathology may be present. Report 72081 for one view; 72082 for two or three views; 72083 for four or five views; and 72084 for a minimum of six views.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
72081	0.26	0.89	0.02	1.17
72082	0.31	1.56	0.03	1.9
72083	0.35	1.83	0.03	2.21
72084	0.41	2.18	0.03	2.62
Facility RVU	**Work**	**PE**	**MP**	**Total**
72081	0.26	0.89	0.02	1.17
72082	0.31	1.56	0.03	1.9
72083	0.35	1.83	0.03	2.21
72084	0.41	2.18	0.03	2.62

72100-72110

72100 Radiologic examination, spine, lumbosacral; 2 or 3 views
72110 minimum of 4 views

Explanation

A radiologic examination of the lumbosacral spine is performed that includes two or three views in 72100, and a minimum of four views in 72110. These procedures do not specify that a certain view must be performed.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
72100	0.22	0.83	0.02	1.07
72110	0.26	1.08	0.02	1.36
Facility RVU	**Work**	**PE**	**MP**	**Total**
72100	0.22	0.83	0.02	1.07
72110	0.26	1.08	0.02	1.36

72220

72220 Radiologic examination, sacrum and coccyx, minimum of 2 views

Explanation

Films are taken (minimum of two views) of the sacrum and the coccyx. The sacrum is a triangular bone located between the fifth lumbar vertebra and the coccyx. It is formed by five connected vertebrae and is wedged between the two innominate bones. The coccyx is the small bone at the very base of the spinal column, and is formed by the fusion of four vertebrae. The sacrum and the coccyx form the posterior (back) boundary of the pelvis. While anteroposterior (AP; front to back) and lateral (side) views are the most common views taken, this procedure is used for any two or more views reported.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
72220	0.17	0.69	0.02	0.88
Facility RVU	**Work**	**PE**	**MP**	**Total**
72220	0.17	0.69	0.02	0.88

73000-73010

73000 Radiologic examination; clavicle, complete
73010 scapula, complete

Explanation

In 73000, films are taken of the clavicle for a complete radiologic examination. The patient is placed supine for a front to back (AP) view and the x-ray is directed to the midpoint and perpendicular to the clavicle. In 73010, films are taken of the scapula for a complete examination. Anteroposterior (AP) and lateral views may be taken. The patient is placed supine for a front to back (AP) view and may be erect or recumbent for a lateral view. The arm is abducted to make a 90-degree angle to the body with the elbow flexed. In both cases, the number of films is not specified.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
73000	0.16	0.7	0.02	0.88
73010	0.17	0.59	0.02	0.78
Facility RVU	**Work**	**PE**	**MP**	**Total**
73000	0.16	0.7	0.02	0.88
73010	0.17	0.59	0.02	0.78

73020-73030

73020 Radiologic examination, shoulder; 1 view
73030 complete, minimum of 2 views

Explanation

Films are taken of the shoulder. The patient is supine with the arm extended to a 90 degree angle from the body and externally rotated while the head is turned to face opposite the affected side. Code 73020 is for reporting one view only and 73030 specifies a minimum of two views.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
73020	0.15	0.43	0.02	0.6
73030	0.18	0.73	0.02	0.93
Facility RVU	**Work**	**PE**	**MP**	**Total**
73020	0.15	0.43	0.02	0.6
73030	0.18	0.73	0.02	0.93

73050

73050 Radiologic examination; acromioclavicular joints, bilateral, with or without weighted distraction

Explanation

A radiologic examination is made of the acromioclavicular joints bilaterally, with no specified amount of views. The patient is placed in a sitting or standing upright position with arms at the side for an anteroposterior view. The patient may also be given weights to hold in each hand for weighted distraction radiographs of each joint.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
73050	0.18	0.68	0.02	0.88
Facility RVU	**Work**	**PE**	**MP**	**Total**
73050	0.18	0.68	0.02	0.88

73060

73060 Radiologic examination; humerus, minimum of 2 views

syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), influenza virus types A and B, and respiratory syncytial virus, multiplex amplified probe technique.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
87635	0.0	0.0	0.0	0.0
87636				
87637				
Facility RVU	**Work**	**PE**	**MP**	**Total**
87635	0.0	0.0	0.0	0.0
87636				
87637				

87807

▲ **87807** Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; respiratory syncytial virus

Explanation

This test may be requested as a rapid antigen test for respiratory syncytial virus (RSV). Specimen collection is typically by nasal swab, nasopharyngeal aspirate, or nasal wash. In one method, a nasal swab is dipped into a solution provided with a proprietary test kit and a measured sample from the swab solution is pipetted onto the rapid test. Results are ready in approximately 15 minutes and are interpreted as negative or positive. Detection is by immunoassay with direct optical (i.e., visual) observation. When referring to primary source infectious disease codes, direct optical observation is a testing platform that produces a signal, such as a colored band, on the reaction chamber that can be interpreted visually.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
87807	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
87807	0.0	0.0	0.0	0.0

87808

▲ **87808** Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Trichomonas vaginalis

Explanation

This test may be requested as a rapid antigen test for trichomonas. Sample is vaginal swab; detection is by immunoassay with direct optical observation. When referring to primary source infectious disease codes, direct optical observation is a testing platform that produces a signal, such as a colored band, on the reaction chamber that can be interpreted visually. In one proprietary method, a swab is collected from the vaginal cavity and mixed in sample buffer to make the trichomonas proteins more soluble. The test stick is placed into the sample mixture, which migrates along the membrane surface. Within approximately 10 minutes, the results are available. Positivity is indicated by the appearance of a visible blue test line along with the red control line.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
87808	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
87808	0.0	0.0	0.0	0.0

87880

▲ **87880** Infectious agent antigen detection by immunoassay with direct optical (ie, visual) observation; Streptococcus, group A

Explanation

This test may be requested as a rapid antigen test for Strep A. *Streptococcus* A is a form of beta hemolytic *Streptococcus*, which causes pharyngitis. Untreated infection can cause rheumatic fever or glomerulonephritis. Sample is throat swab; detection is by immunoassay with direct optical observation. When referring to primary source infectious disease codes, direct optical observation is a testing platform that produces a signal, such as a colored band, on the reaction chamber that can be interpreted visually. In one test method, a throat swab specimen is collected, and antigen is extracted from the specimen with reagents. A dipstick is added to the extracted sample. If the sample contains Strep A antigen, a positive result is indicated by the appearance of a pink to red test line along with a blue control line on the dipstick.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
87880	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
87880	0.0	0.0	0.0	0.0

90281

90281 Immune globulin (Ig), human, for intramuscular use

Explanation

This code identifies the immune globulin (Ig), human, for intramuscular use. An immune globulin is a passive immunization agent obtained from donated, pooled human plasma. Passive immunity is achieved for a short period as the antibodies received through the immune globulin are circulated through the body. The recipient's immune system is not stimulated to build its own antibodies. Report this code with the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90281	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90281	0.0	0.0	0.0	0.0

90283

90283 Immune globulin (IgIV), human, for intravenous use

Explanation

This code identifies the immune globulin (IgIV), human, for intravenous administration. An immune globulin is a passive immunization agent obtained from donated, pooled human plasma. Passive immunity is achieved for a short period as the antibodies received through the immune globulin are circulated through the body. The recipient's immune system is not stimulated to build its own antibodies. Report this code with the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90283	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90283	0.0	0.0	0.0	0.0

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