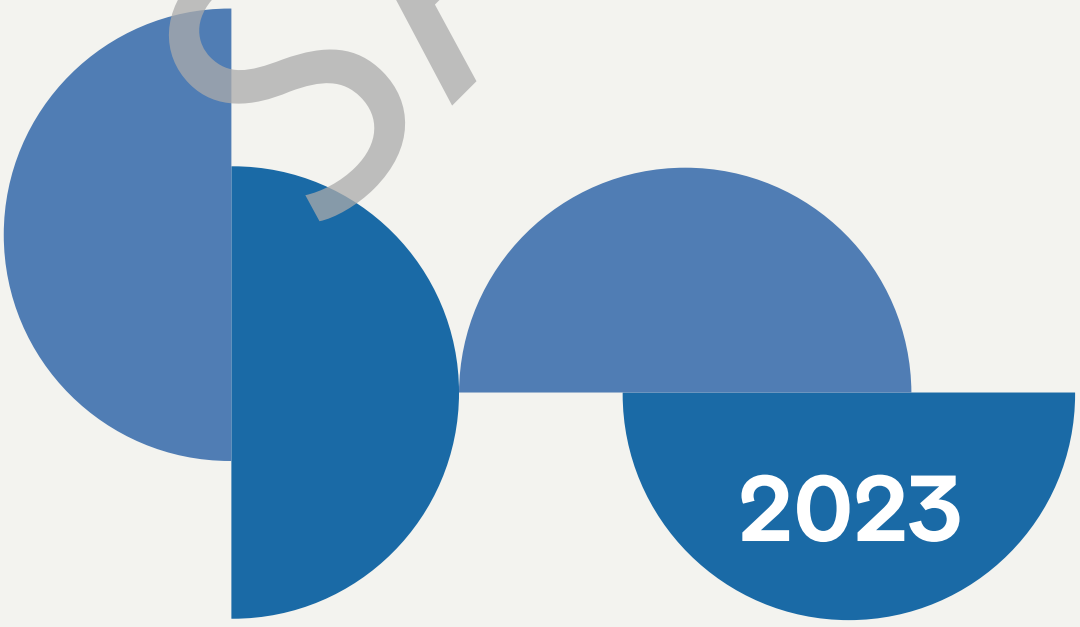
Optum

Coding Companion

Plastics/Dermatology

A comprehensive illustrated guide to coding and reimbursement



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Contents

Getting Started with Coding Companion

Coding Companion for Plastics/Dermatology 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 Plastics/Dermatology 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, in the 10th revision of the ICD-10-CM codes, conditions are grouped with general epidemiological purposes and the evaluation of health care in mind. Features include icons to identify newborn, pediatric, adult, male only, female only, and laterality. 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. A sample is shown on page ii. The black boxes with numbers in them correspond to the information on the page 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 Edits 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 XX.X 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 CCI edits are located in a section at the back of the book. As other CPT (including COVID-related vaccine and administration codes) and ICD-10-CM codes relevant to your specialty are released, updates will be posted to the Optum360 website. The website address is http://www.optum360coding.com/ProductUpdates/. The 2023 edition password is: **XXXXXX.** 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:

67900 Repair of brow ptosis (supraciliary, mid-forehead or coronal approach)

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

Brow Ptosis
Repair, 67900
OR

Eyebrow
Repair
Ptosis, 67900
OR

Repair
Eyebrow
Ptosis, 67900

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

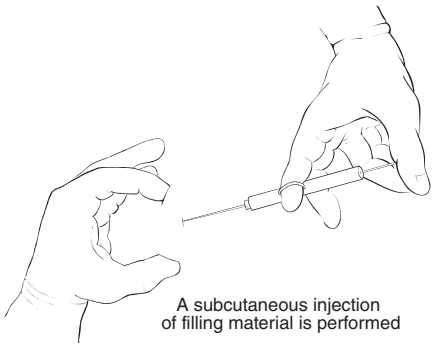
Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

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.

11950-11954

11950 Subcutaneous injection of filling material (eg, collagen); 1 cc or less
11951 1.1 to 5.0 cc
11952 5.1 to 10.0 cc
11954 over 10.0 cc



A subcutaneous injection of filling material is performed

Explanation

The physician uses an injectable dermal implant to correct small soft tissue deformities. This technique is used to treat facial wrinkles, post-surgical defects, and acne scars. The injectable filling material can be autologous fat, synthetic surgical compound, or a commercially produced collagen preparation. The physician uses a syringe to inject the selected material into the subcutaneous tissue. The injection will augment the dermal layer and alleviate the soft tissue depression. Report 11950 for an injection of 1 cc or less; 11951 for 1.1 cc to 5 cc; 11952 for 5.1 cc to 10 cc; and 11954 for an injection of more than 10 cc.

Coding Tips

These procedures are usually not done out of medical necessity, the patient may be responsible for charges. Verify with the insurance carrier for coverage. For intralesional injection of steroids, anesthetic, or other pharmacologic agent, see 11900–11901.

ICD-10-CM Diagnostic Codes

E88.1	Lipodystrophy, not elsewhere classified
H61.111	Acquired deformity of pinna, right ear ☑
L57.2	Cutis rhomboidalis nuchae
L57.4	Cutis laxa senilis
L90.3	Atrophoderma of Pasini and Pierini
L90.8	Other atrophic disorders of skin
N65.0	Deformity of reconstructed breast 🅰
N65.1	Disproportion of reconstructed breast 🅰
Q10.3	Other congenital malformations of eyelid
Z41.1	Encounter for cosmetic surgery
Z42.1	Encounter for breast reconstruction following mastectomy 🅰
Z42.8	Encounter for other plastic and reconstructive surgery following medical procedure or healed injury

Associated HCPCS Codes

G0429	Dermal filler injection(s) for the treatment of facial lipodystrophy syndrome (LDS) (e.g., as a result of highly active antiretroviral therapy)

AMA: **11950** 2019,Aug,10; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16
11951 2019,Aug,10; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **11952** 2019,Aug,10; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **11954** 2019,Aug,10; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11950	0.84	1.36	0.15	2.35
11951	1.19	1.74	0.21	3.14
11952	1.69	2.22	0.3	4.21
11954	1.85	2.45	0.33	4.63
Facility RVU	**Work**	**PE**	**MP**	**Total**
11950	0.84	0.54	0.15	1.53
11951	1.19	0.74	0.21	2.14
11952	1.69	1.03	0.3	3.02
11954	1.85	1.13	0.33	3.31

	FUD	Status	MUE	Modifiers				IOM Reference
11950	0	R	1(2)	51	N/A	N/A	80*	100-03,230.10
11951	0	R	1(2)	51	N/A	N/A	80*	
11952	0	R	1(2)	51	N/A	N/A	80*	
11954	0	R	1(3)	51	N/A	N/A	80*	

* with documentation

Terms To Know

anomaly. Irregularity in the structure or position of an organ or tissue.

autologous. Tissue, cells, or structure obtained from the same individual.

collagen. Protein based substance of strength and flexibility that is the major component of connective tissue, found in cartilage, bone, tendons, and skin.

cosmetic. Superficial or external, having no medical necessity.

dermis. Skin layer found under the epidermis that contains a papillary upper layer and the deep reticular layer of collagen, vascular bed, and nerves.

fibrosis. Formation of fibrous tissue as part of the restorative process.

implant. Material or device inserted or placed within the body for therapeutic, reconstructive, or diagnostic purposes.

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

microcheilia. Congenital condition of abnormally small lips.

soft tissue. Nonepithelial tissues outside of the skeleton.

subcutaneous. Below the skin.

1. CPT Codes and Descriptions

This edition of *Coding Companion* is updated with CPT codes for year 2023.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2023.
- ▲ This CPT code description is revised for 2023.
- ✚ 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 telemedicine services.

The Centers for Medicare and Medicaid Services (CMS) have identified additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE), some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. 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 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.

- [ ] CPT codes enclosed in brackets are resequenced and may not appear in numerical order.

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 the most 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 Optum360 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
- ♂ Male only
- ♀ Female Only
- ☑ 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 2022.

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 (modifier26) component of a procedure is provided.

Evaluation and Management Guidelines Common to All E/M Services

Information unique to this section is defined or identified below.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided following the Decision Tree for New vs Established Patients.)

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians and other qualified health care professionals. The definitions in the E/M section are provided solely for the basis of code selection.

Some definitions are common to all categories of services, and others are specific to one or more categories only.

New and Established Patient

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report E/M services with a specific CPT® code or codes. A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See the decision tree on the following page.

When a physician/qualified health care professional is on call or covering for another physician/qualified health care professional, the patient's encounter is classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The decision tree on the following page is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Time

The inclusion of time in the definitions of levels of E/M services has been implicit in prior editions of the CPT codebook. The inclusion of time as an explicit factor beginning in CPT 1992 was done to assist in selecting the most appropriate level of E/M services. Beginning with CPT 2021, except for 99211, time alone may be used to select the appropriate code level for the office or other outpatient E/M services codes (99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215). Different categories of services use time differently. It is important to review the instructions for each category.

Time is **not** a descriptive component for the emergency department levels of E/M services because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time. Therefore, it is often difficult to provide accurate estimates of the time spent face-to-face with the patient.

Time may be used to select a code level in office or other outpatient services whether or not counseling and/or coordination of care dominates the service. Time may only be used for selecting the level of the **other** E/M services when counseling and/or coordination of care dominates the service.

When time is used for reporting E/M services codes, the time defined in the service descriptors is used for selecting the appropriate level of services. The E/M services for which these guidelines apply require a face-to-face encounter with the physician or other qualified health care professional. For office or other outpatient services, if the physician's or other qualified health care professional's time is spent in the supervision of clinical staff who perform the face-to-face services of the encounter, use 99211.

A shared or split visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physician and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for shared or split visits (ie, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).

When prolonged time occurs, the appropriate prolonged services code may be reported. The appropriate time should be documented in the medical record when it is used as the basis for code selection.

Face-to-face time (outpatient consultations [99241, 99242, 99243, 99244, 99245], domiciliary, rest home, or custodial services [99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337], home services [99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350], cognitive assessment and care plan services [99483]): For coding purposes, face-to-face time for these services is defined as only that time spent face-to-face with the patient and/or family. This includes the time spent performing such tasks as obtaining a history, examination, and counseling the patient.

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 time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**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 time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**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 time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**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 time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

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, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 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 no longer used when determining the level of service. Codes should be selected based upon the current CPT 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. For office or other outpatient services for an established patient, see 99211-99215. For observation care services, see 99217-99226. For patients admitted and discharged from observation or inpatient status on the same date, see 99234-99236. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. 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: **99202** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,3; 2020,May,3; 2020,Jun,3; 2020,Jan,3; 2020,Feb,3; 2020,Dec,11; 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,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3 **99203** 2020,Sep,3; 2020,Sep,14; 2020,Oct,14; 2020,Nov,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,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 **99204** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,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,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,16; 2015,Jan,12; 2015,Dec,3 **99205** 2020,Sep,14; 2020,Sep,3; 2020,Oct,14; 2020,Nov,12; 2020,Nov,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,7; 2016,Jan,13; 2016,Dec,11; 2015,Oct,3; 2015,Jan,12; 2015,Jan,16; 2015,Dec,3

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.1	0.09	2.12
99203	1.6	1.51	0.15	3.26
99204	2.6	2.04	0.23	4.87
99205	3.5	2.62	0.31	6.43
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.15	2.42
99204	2.6	1.11	0.23	3.94
99205	3.5	1.54	0.31	5.35

	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*	

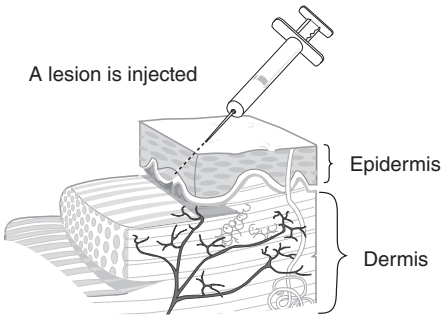
* with documentation

Terms To Know

new patient. Patient who is receiving face-to-face care from a provider/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice for the first time in three years. For OPPS hospitals, a patient who has not been registered as an inpatient or outpatient, including off-campus provider based clinic or emergency department, within the past three years.

11900-11901

11900 Injection, intralesional; up to and including 7 lesions
11901 more than 7 lesions



Schematic of layers of the skin

Explanation

The physician uses a syringe to inject a pharmacologic agent underneath or into any diagnosed skin lesion. Steroids, anesthetics (excluding preoperative local anesthesia), or any non-chemotherapy pharmacological agent may be injected. Report 11900 for injection of seven or fewer lesions. Report 11901 when more than seven lesions are treated.

Coding Tips

When 11900 or 11901 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. These codes should not be used to report preoperative local anesthetic injection. Local anesthesia is included in these services. The drug or other substance may be reported separately, see HCPCS Level II J codes. For injection of a therapeutic, prophylactic, or diagnostic substance, see 96372–96373. Report injection for veins with 36470-36471. For intralesional chemotherapy administration, see 96405 or 96406.

ICD-10-CM Diagnostic Codes

A63.0	Anogenital (venereal) warts
B07.0	Plantar wart
B07.8	Other viral warts
H00.021	Hordeolum internum right upper eyelid ☑
H00.022	Hordeolum internum right lower eyelid ☑
H00.11	Chalazion right upper eyelid ☑
H00.12	Chalazion right lower eyelid ☑
H02.881	Meibomian gland dysfunction right upper eyelid ☑
H02.882	Meibomian gland dysfunction right lower eyelid ☑
H02.88A	Meibomian gland dysfunction right eye, upper and lower eyelids ☑
L28.0	Lichen simplex chronicus
L28.1	Prurigo nodularis
L30.0	Nummular dermatitis
L30.8	Other specified dermatitis
L40.0	Psoriasis vulgaris
L40.1	Generalized pustular psoriasis
L40.2	Acrodermatitis continua
L40.3	Pustulosis palmaris et plantaris
L40.4	Guttate psoriasis
L40.8	Other psoriasis
L43.0	Hypertrophic lichen planus
L43.1	Bullous lichen planus
L43.2	Lichenoid drug reaction
L43.3	Subacute (active) lichen planus
L43.8	Other lichen planus
L52	Erythema nodosum
L63.2	Ophiasis
L63.8	Other alopecia areata
L66.1	Lichen planopilaris
L70.0	Acne vulgaris
L70.1	Acne conglobata
L70.3	Acne tropica
L70.5	Acne excoriee
L70.8	Other acne
L73.0	Acne keloid
L91.0	Hypertrophic scar
L92.0	Granuloma annulare
L92.1	Necrobiosis lipoidica, not elsewhere classified
L92.2	Granuloma faciale [eosinophilic granuloma of skin]
L93.0	Discoid lupus erythematosus
L93.1	Subacute cutaneous lupus erythematosus
L93.2	Other local lupus erythematosus

AMA: **11900** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16 **11901** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11900	0.52	1.08	0.05	1.65
11901	0.8	1.17	0.09	2.06
Facility RVU	**Work**	**PE**	**MP**	**Total**
11900	0.52	0.3	0.05	0.87
11901	0.8	0.46	0.09	1.35

	FUD	Status	MUE	Modifiers				IOM Reference
11900	0	A	1(2)	51	N/A	N/A	N/A	None
11901	0	A	1(2)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

intra. Within.

lesion. Area of damaged tissue that has lost continuity or function, due to disease or trauma.

pharmacological agent. Drug used to produce a chemical effect.

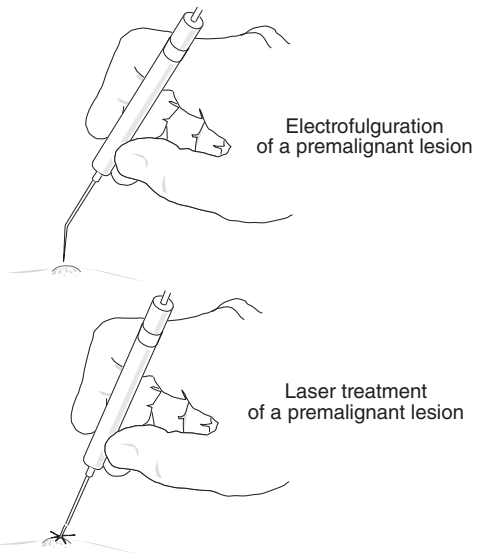
 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

17000-17004

17000 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses); first lesion

\+ **17003** second through 14 lesions, each (List separately in addition to code for first lesion)

17004 Destruction (eg, laser surgery, electrosurgery, cryosurgery, chemosurgery, surgical curettement), premalignant lesions (eg, actinic keratoses), 15 or more lesions



A premalignant lesion is treated by any of a number of methods

Explanation

The physician destroys or excises premalignant lesions using a laser, electrosurgery, cryosurgery, chemical treatment, or surgical curettement. Local anesthesia is included. Report 17000 when one lesion is destroyed and 17003 when two to 14 lesions are destroyed. Report 17004 for destruction of 15 or more lesions during the same surgical session.

Coding Tips

Report 17003 in addition to 17000. Local anesthesia is included in these services. 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. For destruction of cutaneous vascular proliferative lesions (e.g., laser technique), see 17106–17108. For destruction of benign lesions other than skin tags or cutaneous vascular lesions, see 17110–17111.

ICD-10-CM Diagnostic Codes

D22.0 Melanocytic nevi of lip

D22.111 Melanocytic nevi of right upper eyelid, including canthus ☑

D22.112 Melanocytic nevi of right lower eyelid, including canthus ☑

D22.21 Melanocytic nevi of right ear and external auricular canal ☑

D22.4 Melanocytic nevi of scalp and neck

D22.5 Melanocytic nevi of trunk

D22.61 Melanocytic nevi of right upper limb, including shoulder ☑

D22.71 Melanocytic nevi of right lower limb, including hip ☑

D23.0 Other benign neoplasm of skin of lip

D23.111 Other benign neoplasm of skin of right upper eyelid, including canthus ☑

D23.112 Other benign neoplasm of skin of right lower eyelid, including canthus ☑

D23.121 Other benign neoplasm of skin of left upper eyelid, including canthus ☑

D23.122 Other benign neoplasm of skin of left lower eyelid, including canthus ☑

D23.21 Other benign neoplasm of skin of right ear and external auricular canal ☑

D23.22 Other benign neoplasm of skin of left ear and external auricular canal ☑

D23.39 Other benign neoplasm of skin of other parts of face

D23.4 Other benign neoplasm of skin of scalp and neck

D23.5 Other benign neoplasm of skin of trunk

D23.61 Other benign neoplasm of skin of right upper limb, including shoulder ☑

D23.62 Other benign neoplasm of skin of left upper limb, including shoulder ☑

D23.71 Other benign neoplasm of skin of right lower limb, including hip ☑

D23.72 Other benign neoplasm of skin of left lower limb, including hip ☑

L56.8 Other specified acute skin changes due to ultraviolet radiation

L57.0 Actinic keratosis

L85.8 Other specified epidermal thickening

AMA: **17000** 2018,Jan,8; 2017,Jan,8; 2017,Dec,14; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16 **17003** 2018,Jan,8; 2017,Jan,8; 2017,Dec,14; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16 **17004** 2018,Jan,8; 2017,Jan,8; 2017,Dec,14; 2016,Jan,13; 2016,Apr,3; 2015,Jan,16

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
17000	0.61	1.27	0.05	1.93
17003	0.04	0.15	0.0	0.19
17004	1.37	3.35	0.13	4.85
Facility RVU	**Work**	**PE**	**MP**	**Total**
17000	0.61	0.9	0.05	1.56
17003	0.04	0.02	0.0	0.06
17004	1.37	1.34	0.13	2.84

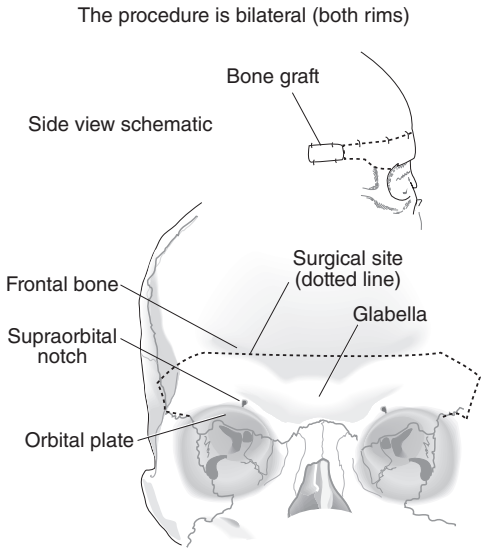
	FUD	Status	MUE	Modifiers				IOM Reference
17000	10	A	1(2)	51	N/A	N/A	N/A	100-03,140.5
17003	N/A	A	13(2)	N/A	N/A	N/A	N/A	
17004	10	A	1(2)	N/A	N/A	N/A	N/A	

* with documentation

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

21175

21175 Reconstruction, bifrontal, superior-lateral orbital rims and lower forehead, advancement or alteration (eg, plagiocephaly, trigonocephaly, brachycephaly), with or without grafts (includes obtaining autografts)



Reconstructive surgery is performed on the lower forehead and both orbital rims (upper lateral portions)

Explanation

The physician performs reconstructive surgery on the lower forehead and both superior lateral orbital rims to correct skeletal abnormalities of the cranium, with or without grafts. The physician utilizes a variety of incisions about the eyes, forehead, and scalp to gain access to these bones. The soft tissues are dissected as needed to expose the bones. Several osteotomies of the forehead and orbits are made so that the deformity can be corrected. The bones are manipulated, contoured, and shifted as needed to place them in the desired positions. The physician may obtain bone grafts from the patient's hip, rib, or skull that can be placed to augment the reconstruction. Various internal fixation devices are employed to hold the reduction rigidly in place, such as wires, pins, plates, or screws. The wounds are irrigated and closed in layers.

Coding Tips

This procedure includes obtaining autografts. For bifrontal craniotomy performed for craniosynostosis, see 61557. For reduction forehead, contouring only, see 21137; contouring and application of prosthetic material or bone graft, see 21138; contouring and setback or anterior frontal sinus wall, see 21139. For reconstruction midface, LeFort III (extra and intracranial) with forehead advancement (e.g., mono bloc), see 21159; with LeFort I, see 21160. For reconstruction superior-lateral orbital rim and lower forehead, advancement or alteration, see 21172. For frontal or parietal craniotomy performed for craniosynostosis, see 61556. For reconstruction, entire or majority of the forehead or supraorbital rims, see 21179–21180.

ICD-10-CM Diagnostic Codes

C41.0	Malignant neoplasm of bones of skull and face
D49.2	Neoplasm of unspecified behavior of bone, soft tissue, and skin
H05.311	Atrophy of right orbit ☑
H05.321	Deformity of right orbit due to bone disease ☑
H05.331	Deformity of right orbit due to trauma or surgery ☑
H05.341	Enlargement of right orbit ☑
H05.351	Exostosis of right orbit ☑
H05.89	Other disorders of orbit
M95.2	Other acquired deformity of head
M99.80	Other biomechanical lesions of head region
Q75.0	Craniosynostosis
Q75.1	Craniofacial dysostosis
Q75.2	Hypertelorism
Q75.3	Macrocephaly
Q75.4	Mandibulofacial dysostosis
Q75.5	Oculomandibular dysostosis
Q75.8	Other specified congenital malformations of skull and face bones
Q87.0	Congenital malformation syndromes predominantly affecting facial appearance
S02.121A	Fracture of orbital roof, right side, initial encounter for closed fracture ☑
S02.121B	Fracture of orbital roof, right side, initial encounter for open fracture ☑
S02.31XA	Fracture of orbital floor, right side, initial encounter for closed fracture ☑
S02.31XB	Fracture of orbital floor, right side, initial encounter for open fracture ☑
S02.40AA	Malar fracture, right side, initial encounter for closed fracture ☑
S02.40AB	Malar fracture, right side, initial encounter for open fracture ☑
S02.81XA	Fracture of other specified skull and facial bones, right side, initial encounter for closed fracture ☑
S02.81XB	Fracture of other specified skull and facial bones, right side, initial encounter for open fracture ☑
S07.0XXA	Crushing injury of face, initial encounter
S07.1XXA	Crushing injury of skull, initial encounter

AMA: **21175** 2018,Sep,7

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21175	33.56	25.61	5.95	65.12
Facility RVU	**Work**	**PE**	**MP**	**Total**
21175	33.56	25.61	5.95	65.12

	FUD	Status	MUE	Modifiers				IOM Reference
21175	90	A	1(2)	51	N/A	N/A	80	None

* with documentation

Terms To Know

anomaly. Irregularity in the structure or position of an organ or tissue.

atrophy. Reduction in size or activity in an anatomic structure, due to wasting away from disease or other factors.

deformity. Irregularity or malformation of the body.

fracture. Break in bone or cartilage.

graft. Tissue implant from another part of the body or another person.

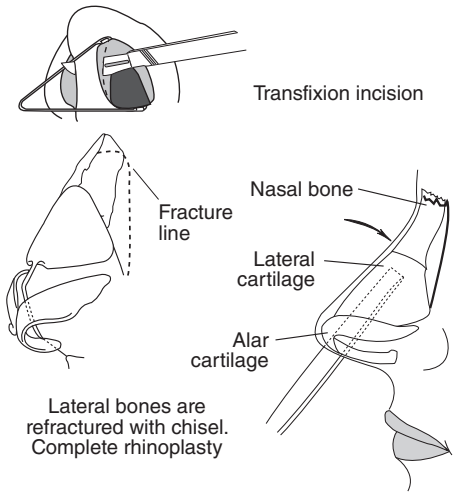
incision. Act of cutting into tissue or an organ.

osteotomy. Surgical cutting of a bone.

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

30410

30410 Rhinoplasty, primary; complete, external parts including bony pyramid, lateral and alar cartilages, and/or elevation of nasal tip



Explanation

The physician performs surgery to reshape the external nose. No surgery to the nasal septum is necessary. This surgery can be performed open (external skin incisions) or closed (intranasal incisions). Topical vasoconstrictive agents are applied to shrink the blood vessels and local anesthesia is injected in the nasal mucosa. After incisions are made, dissections expose the external nasal cartilaginous and bony skeleton. The cartilages may be reshaped by trimming or may be augmented by grafting. Local grafts from adjacent nasal bones and cartilage are not reported separately. The physician may reshape the dorsum with files. The physician fractures the lateral nasal bones with chisels. Fat may be removed from the subcutaneous regions. Incisions are closed in single layers. Steri-strip tape is used to support cartilaginous surgery of the nasal tip. An external splint or cast supports changes in bone position.

Coding Tips

Topical vasoconstrictive agents and local anesthesia are not reported separately. The patient may desire surgery because of a hereditary condition or trauma, producing an unacceptable function and/or appearance. Presurgical treatment planning defines the functional and cosmetic goals of the nasal corrective surgery. Because this procedure may not be done out of medical necessity, the patient may be responsible for charges. Verify with the insurance carrier for coverage. When tissues are obtained from distant sites for graft, see 20900–20924 and 21210. For columellar reconstruction, see 13151–13153. For rhinoplasty, including major septal repair, see 30420.

ICD-10-CM Diagnostic Codes

C30.0	Malignant neoplasm of nasal cavity
C43.31	Malignant melanoma of nose
C44.311	Basal cell carcinoma of skin of nose
C44.321	Squamous cell carcinoma of skin of nose
C44.391	Other specified malignant neoplasm of skin of nose
C76.0	Malignant neoplasm of head, face and neck
D03.39	Melanoma in situ of other parts of face
D04.39	Carcinoma in situ of skin of other parts of face
D14.0	Benign neoplasm of middle ear, nasal cavity and accessory sinuses
D16.4	Benign neoplasm of bones of skull and face
D22.39	Melanocytic nevi of other parts of face
D23.39	Other benign neoplasm of skin of other parts of face
D38.5	Neoplasm of uncertain behavior of other respiratory organs
J34.0	Abscess, furuncle and carbuncle of nose
J34.1	Cyst and mucocele of nose and nasal sinus
J34.89	Other specified disorders of nose and nasal sinuses
M95.0	Acquired deformity of nose
Q30.1	Agenesis and underdevelopment of nose
Q30.2	Fissured, notched and cleft nose
Q30.8	Other congenital malformations of nose
S01.21XA	Laceration without foreign body of nose, initial encounter
S01.22XA	Laceration with foreign body of nose, initial encounter
S01.23XA	Puncture wound without foreign body of nose, initial encounter
S01.24XA	Puncture wound with foreign body of nose, initial encounter
S01.25XA	Open bite of nose, initial encounter
S02.2XXA	Fracture of nasal bones, initial encounter for closed fracture
S02.2XXB	Fracture of nasal bones, initial encounter for open fracture
S07.0XXA	Crushing injury of face, initial encounter
S08.812A	Partial traumatic amputation of nose, initial encounter
T20.34XA	Burn of third degree of nose (septum), initial encounter
T20.74XA	Corrosion of third degree of nose (septum), initial encounter
T34.02XA	Frostbite with tissue necrosis of nose, initial encounter
Z41.1	Encounter for cosmetic surgery
Z42.8	Encounter for other plastic and reconstructive surgery following medical procedure or healed injury

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
30410	14.0	25.9	2.47	42.37
Facility RVU	**Work**	**PE**	**MP**	**Total**
30410	14.0	25.9	2.47	42.37

	FUD	Status	MUE	Modifiers				IOM Reference
30410	90	R	1(2)	51	N/A	N/A	80	None

* with documentation

Terms To Know

augment. Add to or increase.

carcinoma in situ. Malignancy that arises from the cells of the vessel, gland, or organ of origin that remains confined to that site or has not invaded neighboring tissue.

cartilage. Variety of fibrous connective tissue that is inherently nonvascular. Usually found in the joints, it aids in movement and provides a cushion to absorb jolts and shocks.

dissection. Separating by cutting tissue or body structures apart.

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

96910

96910 Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B

Explanation

The physician uses photosensitive chemicals and light rays to treat skin ailments. This code applies to tar and ultraviolet B rays (Goeckerman treatment) or petrolatum and ultraviolet B rays.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
96910	0.0	3.48	0.02	3.5
Facility RVU	**Work**	**PE**	**MP**	**Total**
96910	0.0	3.48	0.02	3.5

96912

96912 Photochemotherapy; psoralens and ultraviolet A (PUVA)

Explanation

The physician uses photosensitive chemicals and light rays to treat skin ailments. This code applies to psoralens and ultraviolet A rays (PUVA).

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
96912	0.0	3.0	0.01	3.01
Facility RVU	**Work**	**PE**	**MP**	**Total**
96912	0.0	3.0	0.01	3.01

96913

96913 Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)

Explanation

The physician uses photosensitive chemicals and light rays to treat skin ailments. This code applies to tar and ultraviolet B rays (Goeckerman treatment) and/or psoralens and ultraviolet A rays (PUVA) used for severe skin problems requiring between four to eight hours of care under a physician's direct supervision.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
96913	0.0	4.42	0.02	4.44
Facility RVU	**Work**	**PE**	**MP**	**Total**
96913	0.0	4.42	0.02	4.44

97597-97598

97597 Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less

+ 97598 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

Explanation

A health care provider performs wound care management by using selective debridement techniques to remove devitalized or necrotic tissue from an open wound. Selective techniques are those in which the provider has complete control over which tissue is removed and which is left behind, and include high-pressure waterjet with or without suction and sharp debridement using scissors, a scalpel, or forceps. Wound assessment, topical applications, instructions regarding ongoing care of the wound, and the possible use of a whirlpool for treatment are included in these codes. Report 97597 for a total wound surface area less than or equal to 20 sq cm and 97598 for each additional 20 sq cm or part thereof.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
97597	0.77	2.12	0.05	2.94
97598	0.5	0.79	0.05	1.34
Facility RVU	**Work**	**PE**	**MP**	**Total**
97597	0.77	0.22	0.05	1.04
97598	0.5	0.18	0.05	0.73

97605-97606

97605 Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters

97606 total wound(s) surface area greater than 50 square centimeters

Explanation

Negative pressure wound therapy (NPWT) is a widely used advanced wound treatment technique. The health care provider performs NPWT via the use of durable medical equipment (DME), such as vacuum assisted drainage collection, to promote healing of a chronic nonhealing wound, including diabetic or pressure (decubitus) ulcers. This procedure includes topical applications to the wound, wound assessment, and patient or caregiver instruction related to ongoing care per session. Negative pressure wound therapy uses controlled application of subatmospheric pressure to a wound. The subatmospheric pressure is generated using an electrical pump. The electrical pump conveys intermittent or continuous subatmospheric pressure by connecting tubing to a specialized wound dressing. The specialized wound dressing includes a porous foam dressing that covers the wound surface and an airtight adhesive dressing that seals the wound and contains the subatmospheric pressure at the wound site. Negative pressure wound therapy promotes healing by increasing local vascularity and oxygenation of the wound bed, evacuating wound fluid thereby reducing edema, and removing exudates and bacteria. Drainage from the wound is collected in a canister. Report 97605 for a wound(s) with a total surface area less than or equal to 50 sq. cm. Report 97606 for a wound(s) with a total surface area greater than 50 sq. cm.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
97605	0.55	0.67	0.02	1.24
97606	0.6	0.85	0.02	1.47
Facility RVU	**Work**	**PE**	**MP**	**Total**
97605	0.55	0.16	0.02	0.73
97606	0.6	0.18	0.02	0.8

Correct Coding Initiative Update

❖Indicates Mutually Exclusive Edit

0419T 0213T, 0216T, 0596T-0597T, 11057, 11102, 11104, 11106, 11900-11901, 12001-12007, 12011-12057, 13100-13133, 13151-13153, 17110-17111, 36000, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 43752, 51701-51703, 61650, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 92012-92014, 93000-93010, 93040-93042, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96377, 96523, 99155, 99156, 99157, 99211-99223, 99231-99255, 99291-99292, 99304-99310, 99315-99316, 99334-99337, 99347-99350, 99374-99375, 99377-99378, 99446-99449, 99451-99452, 99495-99496, G0463, G0471, J0670, J2001

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0471T 36591-36592, 76000, 76942, 76998, 96523

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