OPTUM360®

CODING COMPANION

Orthopaedics: Upper-Spine & Above

A comprehensive illustrated guide to coding and reimbursement

2022

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Contents

Getting Started with Coding Companion

Coding Companion for Orthopaedics — Upper: Spine and Above 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 Orthopaedics — Upper: Spine and Above 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: **XXXXXXX22**. 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:

24138 Sequestrectomy (eg, for osteomyelitis or bone abscess), olecranon process

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

Abscess
Excision
Olecranon Process, 24138

Excision
Abscess
Olecranon Process, 24138

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.

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/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 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. 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. 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,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,7; 2016,Jan,13; 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 **99203** 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 **99204** 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,Jan,16; 2015,Dec,3; 2014,Oct,3; 2014,Oct,8; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3 **99205** 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,8; 2014,Oct,3; 2014,Nov,14; 2014,Jan,11; 2014,Aug,3

Relative Value Units/Medicare Edits

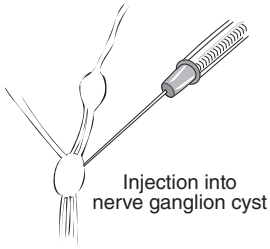
Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.12	0.09	2.14
99203	1.42	1.48	0.13	3.03
99204	2.43	1.98	0.22	4.63
99205	3.17	2.4	0.28	5.85
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.42	0.59	0.13	2.14
99204	2.43	1.01	0.22	3.66
99205	3.17	1.33	0.28	4.78

	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*	

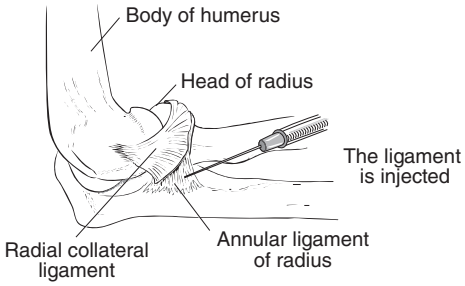
* with documentation

20550

20550 Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")



Lateral view of right elbow joint



Explanation

The physician injects a therapeutic agent into a single tendon sheath, or ligament, aponeurosis such as the plantar fascia. The physician identifies the injection site by palpation or radiographs (reported separately) and marks the injection site. The needle is inserted and the medicine is injected. After withdrawing the needle, the patient is monitored for reactions to the therapeutic agent.

Coding Tips

When multiple, separate tendon sheaths are injected in the same encounter, each injection is reported separately. Report 20550 and append modifier 59 or an X{EPSU} modifier for the second and subsequent sites. For injection or aspiration of a ganglion cyst, see 20612. For injection of trigger points, see 20552 and 20553. If imaging guidance is performed, see 76942, 77002, or 77021. Do not report 20550 with 0232T. Supplies used when providing this procedure may be reported with the appropriate HCPCS Level II J code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

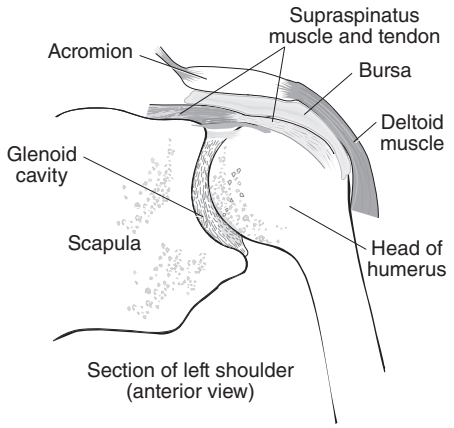
G89.0 Central pain syndrome
G89.11 Acute pain due to trauma
G89.12 Acute post-thoracotomy pain
G89.21 Chronic pain due to trauma
G89.22 Chronic post-thoracotomy pain
G89.28 Other chronic postprocedural pain
G89.29 Other chronic pain
G89.4 Chronic pain syndrome
M13.111 Monoarthritis, not elsewhere classified, right shoulder ☑
M13.112 Monoarthritis, not elsewhere classified, left shoulder ☑
M13.121 Monoarthritis, not elsewhere classified, right elbow ☑
M13.122 Monoarthritis, not elsewhere classified, left elbow ☑
M13.131 Monoarthritis, not elsewhere classified, right wrist ☑
M13.132 Monoarthritis, not elsewhere classified, left wrist ☑
M13.141 Monoarthritis, not elsewhere classified, right hand ☑
M13.142 Monoarthritis, not elsewhere classified, left hand ☑
M25.511 Pain in right shoulder ☑
M25.512 Pain in left shoulder ☑
M25.521 Pain in right elbow ☑
M25.522 Pain in left elbow ☑
M25.531 Pain in right wrist ☑
M25.532 Pain in left wrist ☑
M65.011 Abscess of tendon sheath, right shoulder ☑
M65.012 Abscess of tendon sheath, left shoulder ☑
M65.021 Abscess of tendon sheath, right upper arm ☑
M65.022 Abscess of tendon sheath, left upper arm ☑
M65.031 Abscess of tendon sheath, right forearm ☑
M65.032 Abscess of tendon sheath, left forearm ☑
M65.041 Abscess of tendon sheath, right hand ☑
M65.042 Abscess of tendon sheath, left hand ☑
M65.111 Other infective (teno)synovitis, right shoulder ☑
M65.112 Other infective (teno)synovitis, left shoulder ☑
M65.121 Other infective (teno)synovitis, right elbow ☑
M65.122 Other infective (teno)synovitis, left elbow ☑
M65.131 Other infective (teno)synovitis, right wrist ☑
M65.132 Other infective (teno)synovitis, left wrist ☑
M65.141 Other infective (teno)synovitis, right hand ☑
M65.142 Other infective (teno)synovitis, left hand ☑
M65.221 Calcific tendinitis, right upper arm ☑
M65.222 Calcific tendinitis, left upper arm ☑
M65.231 Calcific tendinitis, right forearm ☑
M65.232 Calcific tendinitis, left forearm ☑
M65.241 Calcific tendinitis, right hand ☑
M65.242 Calcific tendinitis, left hand ☑
M65.4 Radial styloid tenosynovitis [de Quervain]
M70.11 Bursitis, right hand ☑
M70.12 Bursitis, left hand ☑
M70.21 Olecranon bursitis, right elbow ☑
M70.22 Olecranon bursitis, left elbow ☑
M72.2 Plantar fascial fibromatosis
M75.21 Bicipital tendinitis, right shoulder ☑
M75.22 Bicipital tendinitis, left shoulder ☑
M75.31 Calcific tendinitis of right shoulder ☑
M75.32 Calcific tendinitis of left shoulder ☑
M75.41 Impingement syndrome of right shoulder ☑
M75.42 Impingement syndrome of left shoulder ☑
M75.51 Bursitis of right shoulder ☑
M75.52 Bursitis of left shoulder ☑
M77.11 Lateral epicondylitis, right elbow ☑
M77.12 Lateral epicondylitis, left elbow ☑

AMA: **20550** 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16; 2014,Oct,9; 2014,Jan,11

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

23000

23000 Removal of subdeltoid calcareous deposits, open



Inflammatory cells from wear and tear cause calcareous (calcium) deposits to form in the supraspinatus tendon and deltoid muscle. The deposits are removed from sites under the tendon or from beneath the deltoid in the shoulder

Explanation

The physician removes subdeltoid calcareous deposits by making a small incision over the deltoid muscle to expose the rotator cuff tendons. The raised area over the calcium deposits is incised in line with the axis of the fibers and the calcareous deposits are removed. A large cavity is made in the tendon with a curette to remove all damaged tissue. The opening is closed with side-to-side sutures. Once the tendon is repaired, the skin incision is closed and a soft dressing is applied.

Coding Tips

When the physician cannot complete the procedure through the arthroscope and an open procedure is performed, list the open procedure first, code the arthroscope as diagnostic, and append modifier 51. Medicare and some other third party payers do not allow a scope procedure when performed in conjunction with a related open procedure. Check with individual payers regarding their specific coding guidelines. For excisional biopsy of soft tissue of the shoulder, superficial, see 23065; deep, see 23066. For needle biopsy of muscle, see 20206.

ICD-10-CM Diagnostic Codes

M11.011 Hydroxyapatite deposition disease, right shoulder ☑
M11.012 Hydroxyapatite deposition disease, left shoulder ☑
M11.111 Familial chondrocalcinosis, right shoulder ☑
M11.112 Familial chondrocalcinosis, left shoulder ☑
M11.211 Other chondrocalcinosis, right shoulder ☑
M11.212 Other chondrocalcinosis, left shoulder ☑
M11.811 Other specified crystal arthropathies, right shoulder ☑
M11.812 Other specified crystal arthropathies, left shoulder ☑
M25.711 Osteophyte, right shoulder ☑
M25.712 Osteophyte, left shoulder ☑
M25.811 Other specified joint disorders, right shoulder ☑
M25.812 Other specified joint disorders, left shoulder ☑
M61.011 Myositis ossificans traumatica, right shoulder ☑
M61.012 Myositis ossificans traumatica, left shoulder ☑
M61.021 Myositis ossificans traumatica, right upper arm ☑
M61.022 Myositis ossificans traumatica, left upper arm ☑
M61.111 Myositis ossificans progressiva, right shoulder ☑
M61.112 Myositis ossificans progressiva, left shoulder ☑
M61.121 Myositis ossificans progressiva, right upper arm ☑
M61.122 Myositis ossificans progressiva, left upper arm ☑
M61.311 Calcification and ossification of muscles associated with burns, right shoulder ☑
M61.312 Calcification and ossification of muscles associated with burns, left shoulder ☑
M61.321 Calcification and ossification of muscles associated with burns, right upper arm ☑
M61.322 Calcification and ossification of muscles associated with burns, left upper arm ☑
M61.411 Other calcification of muscle, right shoulder ☑
M61.412 Other calcification of muscle, left shoulder ☑
M61.421 Other calcification of muscle, right upper arm ☑
M61.422 Other calcification of muscle, left upper arm ☑
M65.221 Calcific tendinitis, right upper arm ☑
M65.222 Calcific tendinitis, left upper arm ☑
M75.31 Calcific tendinitis of right shoulder ☑
M75.32 Calcific tendinitis of left shoulder ☑

AMA: **23000** 2018,Sep,7

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
23000	4.48	11.16	0.85	16.49
Facility RVU	**Work**	**PE**	**MP**	**Total**
23000	4.48	5.2	0.85	10.53

	FUD	Status	MUE	Modifiers				IOM Reference
23000	90	A	1(2)	51	50	62*	80	None

* with documentation

Terms To Know

bursa. Cavity or sac containing fluid that occurs between articulating surfaces and serves to reduce friction from moving parts. An anatomical structure frequently referenced in orthopedic notes as it may become diseased or need removal.

calcifying tendinitis. Inflammation and hardening of tissue due to calcium salt deposits, occurring in the tendons and areas of tendonomuscular attachment.

myositis ossificans. Inflammatory disease of muscles due to bony deposits or conversion of muscle tissue to bony tissue.

ossification. Formation of bony growth or hardening into bone-like substance.

tendon. Fibrous tissue that connects muscle to bone, consisting primarily of collagen and containing little vasculature.

M25.621 Stiffness of right elbow, not elsewhere classified ☑
M25.622 Stiffness of left elbow, not elsewhere classified ☑
M62.3 Immobility syndrome (paraplegic)

AMA: **24310** 2018,Sep,7

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
24310	6.12	6.35	1.12	13.59
Facility RVU	**Work**	**PE**	**MP**	**Total**
24310	6.12	6.35	1.12	13.59

	FUD	Status	MUE	Modifiers				IOM Reference
24310	90	A	2(3)	51	N/A	N/A	80*	None

* with documentation

Terms To Know

ankylosis. Abnormal union or fusion of bones in a joint, which is normally moveable.

anterior. Situated in the front area or toward the belly surface of the body; an anatomical reference point used to show the position and relationship of one body structure to another.

contracture. Shortening of muscle or connective tissue.

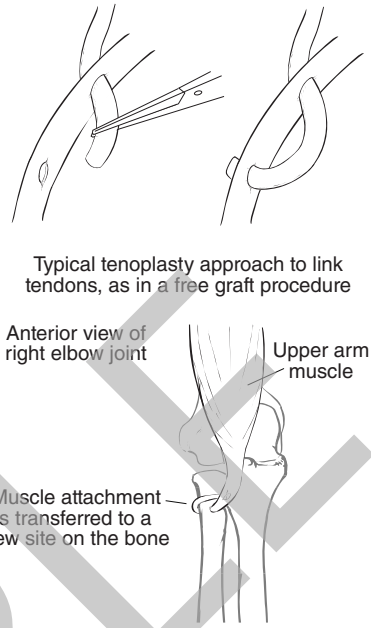
distal. Located farther away from a specified reference point or the trunk.

flexion. Act of bending or being bent causing a decreased angle of a joint.

tendon. Fibrous tissue that connects muscle to bone, consisting primarily of collagen and containing little vasculature.

24320

24320 Tenoplasty, with muscle transfer, with or without free graft, elbow to shoulder, single (Seddon-Brookes type procedure)



Typical tenoplasty approach to link tendons, as in a free graft procedure

Explanation

A Seddon-Brookes type upper arm tenoplasty with muscle transfer restores elbow flexion by prolonging the tendon of the pectoralis major muscle with the long head of the biceps brachii. The physician makes an incision from the deltopectoral groove to the midportion of the upper arm. The pectoralis major tendon is exposed through dissection, detached from its insertion, and mobilized from the chest wall toward the clavicle. The tendon of the long head of the biceps is exposed and severed from its origin and withdrawn into the wound. The long head of the biceps is dissected from the short head. An L-shaped incision is made over the anterior aspect of the elbow. The long head of the biceps is divided and freed distally to its attachment on the radius. The biceps tendon and muscle are withdrawn through the distal L-shaped incision. Through the proximal incision, the tendon and muscle belly of the long head of the biceps is passed through two slits in the tendon of the pectoralis major and looped on itself so that its proximal tendon is brought into the distal L-shaped incision. The end of the proximal tendon is sutured through a slit in the distal tendon and the tendon of the pectoralis major is sutured to the long head of the biceps at their junction. The incisions are repaired in layers using sutures, staples, and/or Steri-strips. A posterior plaster splint is applied with the elbow in flexion.

Coding Tips

Any tendon graft harvest is not reported separately. Code 24320 should be reported for each tenoplasty performed. When multiple tenoplasties are performed, report one tendon as the primary procedure and append modifier 51 to subsequent procedures. According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. See "Application of Casts and Strapping" in the CPT book in the Surgery Section, under the Musculoskeletal system.

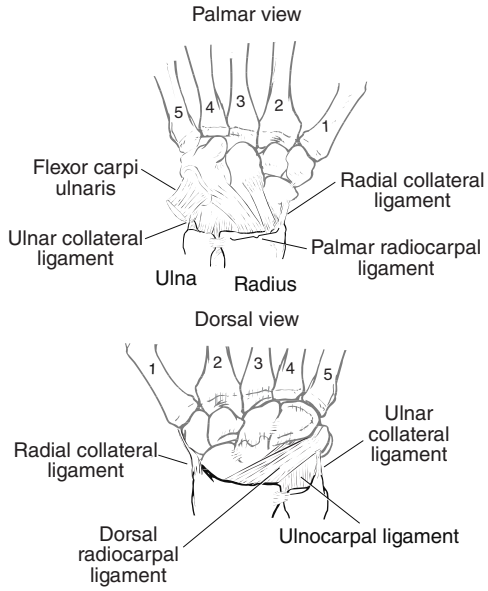
ICD-10-CM Diagnostic Codes

M21.221 Flexion deformity, right elbow ☑

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

25085

25085 Capsulotomy, wrist (eg, contracture)



A capsulotomy of the wrist is performed

Explanation

The physician performs a capsulotomy of the wrist. The physician makes an incision overlying the wrist joint. The tissues are dissected to the joint capsule. The physician makes an incision in the capsule, allowing better joint movement. The incision is closed in layers with sutures.

Coding Tips

Capsulotomy is not reported separately when performed as part of a more complex procedure requiring incision into the joint capsule. According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. See "Application of Casts and Strapping" in the CPT book in the Surgery Section, under the Musculoskeletal system.

ICD-10-CM Diagnostic Codes

M24.531 Contracture, right wrist ☑

M24.532 Contracture, left wrist ☑

AMA: **25085** 2018,Sep,7

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
25085	5.64	6.26	1.03	12.93
Facility RVU	**Work**	**PE**	**MP**	**Total**
25085	5.64	6.26	1.03	12.93

	FUD	Status	MUE	Modifiers				IOM Reference
25085	90	A	1(2)	51	50	N/A	80	None

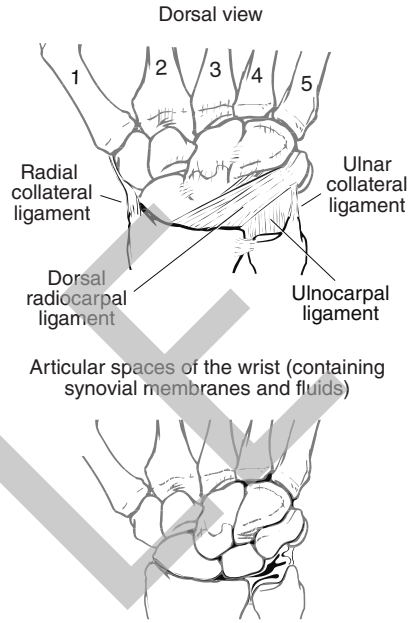
* with documentation

25100-25105

25100 Arthrotomy, wrist joint; with biopsy

25101 with joint exploration, with or without biopsy, with or without removal of loose or foreign body

25105 with synovectomy



Explanation

The physician makes a longitudinal incision over the part of the wrist to be exposed (e.g., anterior, posterior, medial, or lateral aspect) to access the wrist joint and perform an arthrotomy. The soft tissues are dissected away to expose the joint capsule, which is incised to expose the synovium lying within the capsule. A small portion of the synovium is excised for biopsy in 25100. In 25101, additional dissection is carried out to further explore the joint cavity. Any loose or foreign bodies (e.g., free cartilage, bone chips, gravel) are removed and a biopsy may be taken. The physician irrigates the joint. In 25105, the joint capsule is incised to expose the synovium, the inner membrane of the articular capsule that lines the joint cavity. The inflamed or enlarged synovium is dissected away from the capsule and the bones and removed. The physician may leave the wound packed open with daily dressing changes to allow for further drainage and secondary healing by granulation. A drain tube may be placed and the incision repaired in layers with sutures, staples, and/or Steri-strips. A splint may be applied to limit wrist movement.

Coding Tips

According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. See "Application of Casts and Strapping" in the CPT book in the Surgery Section, under the Musculoskeletal system. For wrist arthroscopy, diagnostic with or without synovial biopsy, see 29840. For arthroscopy of the wrist with synovectomy, see 29844 and 29845.

ICD-10-CM Diagnostic Codes

C40.11 Malignant neoplasm of short bones of right upper limb ☑

C40.12 Malignant neoplasm of short bones of left upper limb ☑

D16.11 Benign neoplasm of short bones of right upper limb ☑

D16.12 Benign neoplasm of short bones of left upper limb ☑

D21.12 Benign neoplasm of connective and other soft tissue of left upper limb, including shoulder ☑

D48.1 Neoplasm of uncertain behavior of connective and other soft tissue

D49.2 Neoplasm of unspecified behavior of bone, soft tissue, and skin

M60.241 Foreign body granuloma of soft tissue, not elsewhere classified, right hand ☑

M60.242 Foreign body granuloma of soft tissue, not elsewhere classified, left hand ☑

Q27.31 Arteriovenous malformation of vessel of upper limb

Q27.8 Other specified congenital malformations of peripheral vascular system

AMA: **26117** 2018,Sep,7 **26118** 2018,Sep,7

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
26117	10.13	9.41	1.91	21.45
26118	14.81	12.78	2.8	30.39
Facility RVU	**Work**	**PE**	**MP**	**Total**
26117	10.13	9.41	1.91	21.45
26118	14.81	12.78	2.8	30.39

	FUD	Status	MUE	Modifiers				IOM Reference
26117	90	A	2(3)	51	N/A	N/A	N/A	None
26118	90	A	1(3)	51	N/A	N/A	80	

* with documentation

Terms To Know

radical resection. Removal of an entire tumor (e.g., malignant neoplasm) along with a large area of surrounding tissue, including adjacent lymph nodes that may have been infiltrated.

sarcoma. Malignant tumor arising in connective tissue, bone, cartilage, or striated muscle that spreads to neighboring tissue through the bloodstream.

soft tissue. Nonepithelial tissues outside of the skeleton that includes subcutaneous adipose tissue, fibrous tissue, fascia, muscles, blood and lymph vessels, and peripheral nervous system tissue.

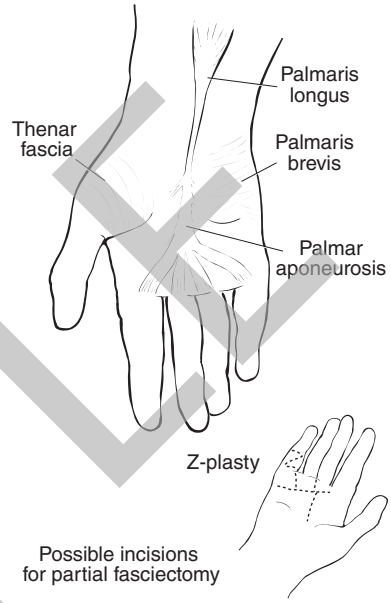
tumor. Pathological swelling or enlargement; a neoplastic growth of uncontrolled, abnormal multiplication of cells.

26121-26125

26121 Fasciectomy, palm only, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft)

26123 Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft);

\+ **26125** each additional digit (List separately in addition to code for primary procedure)



A palmar fasciectomy is performed

Explanation

The physician removes the palmar fascia. The physician incises the overlying skin and subcutaneous tissue. The palmar fascia is exposed and resected. Tendon sheaths are freed. The incision is sutured in layers if possible. Z-plasties are performed or skin grafts are obtained to close the wound if necessary. In 26121, the palmar fascia is removed. In 26123, part of the palmar fascia is removed and flexor tendons at proximal interphalangeal joints are released. Use 26125 to report additional digits.

Coding Tips

Report 26125 in addition to 26123. For palmar fasciotomy, see 26040 or 26045. For palmar fasciotomy by enzyme injection, see 20527 and 26341.

ICD-10-CM Diagnostic Codes

M20.091 Other deformity of right finger(s) ☑

M20.092 Other deformity of left finger(s) ☑

M24.541 Contracture, right hand ☑

M24.542 Contracture, left hand ☑

M65.311 Trigger thumb, right thumb ☑

M65.312 Trigger thumb, left thumb ☑

M65.321 Trigger finger, right index finger ☑

M65.322 Trigger finger, left index finger ☑

M65.331 Trigger finger, right middle finger ☑

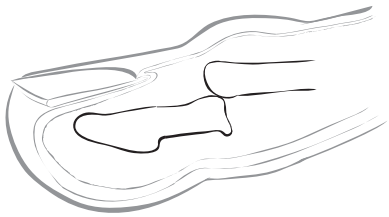
M65.332 Trigger finger, left middle finger ☑

M65.341 Trigger finger, right ring finger ☑

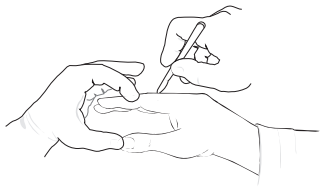
M65.342 Trigger finger, left ring finger ☑

26785

26785 Open treatment of interphalangeal joint dislocation, includes internal fixation, when performed, single



A dislocation of an interphalangeal joint is treated in an open surgical session, with or without internal or external fixation



Open surgery

Explanation

The physician performs open correction of an interphalangeal joint dislocation. The physician uses an x-ray to determine the position and severity of the defect. An incision is made on the overlying skin to expose the dislocated joint and the bones are reapproximated. A wire may be placed for internal fixation. The incision is sutured in layers and the hand is splinted.

Coding Tips

When multiple fractures are treated, report one fracture treatment as the primary procedure and append modifier 51 to subsequent procedures. Some payers may require the use of HCPCS Level II modifiers FA–F9 to identify the specific finger involved. According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. See "Application of Casts and Strapping" in the CPT book in the Surgery Section, under the Musculoskeletal system. For radiology services, see 73140. For closed treatment of an interphalangeal joint dislocation, without anesthesia, see 26770; with anesthesia, see 26775. For percutaneous skeletal fixation of an interphalangeal joint dislocation, see 26776.

ICD-10-CM Diagnostic Codes

S63.230A Subluxation of proximal interphalangeal joint of right index finger, initial encounter ☑

S63.231A Subluxation of proximal interphalangeal joint of left index finger, initial encounter ☑

S63.232A Subluxation of proximal interphalangeal joint of right middle finger, initial encounter ☑

S63.233A Subluxation of proximal interphalangeal joint of left middle finger, initial encounter ☑

S63.234A Subluxation of proximal interphalangeal joint of right ring finger, initial encounter ☑

S63.235A Subluxation of proximal interphalangeal joint of left ring finger, initial encounter ☑

S63.236A Subluxation of proximal interphalangeal joint of right little finger, initial encounter ☑

S63.237A Subluxation of proximal interphalangeal joint of left little finger, initial encounter ☑

S63.240A Subluxation of distal interphalangeal joint of right index finger, initial encounter ☑

S63.241A Subluxation of distal interphalangeal joint of left index finger, initial encounter ☑

S63.242A Subluxation of distal interphalangeal joint of right middle finger, initial encounter ☑

S63.243A Subluxation of distal interphalangeal joint of left middle finger, initial encounter ☑

S63.244A Subluxation of distal interphalangeal joint of right ring finger, initial encounter ☑

S63.245A Subluxation of distal interphalangeal joint of left ring finger, initial encounter ☑

S63.246A Subluxation of distal interphalangeal joint of right little finger, initial encounter ☑

S63.247A Subluxation of distal interphalangeal joint of left little finger, initial encounter ☑

S63.280A Dislocation of proximal interphalangeal joint of right index finger, initial encounter ☑

S63.281A Dislocation of proximal interphalangeal joint of left index finger, initial encounter ☑

S63.282A Dislocation of proximal interphalangeal joint of right middle finger, initial encounter ☑

S63.283A Dislocation of proximal interphalangeal joint of left middle finger, initial encounter ☑

S63.284A Dislocation of proximal interphalangeal joint of right ring finger, initial encounter ☑

S63.285A Dislocation of proximal interphalangeal joint of left ring finger, initial encounter ☑

S63.286A Dislocation of proximal interphalangeal joint of right little finger, initial encounter ☑

S63.287A Dislocation of proximal interphalangeal joint of left little finger, initial encounter ☑

S63.290A Dislocation of distal interphalangeal joint of right index finger, initial encounter ☑

S63.291A Dislocation of distal interphalangeal joint of left index finger, initial encounter ☑

S63.292A Dislocation of distal interphalangeal joint of right middle finger, initial encounter ☑

S63.293A Dislocation of distal interphalangeal joint of left middle finger, initial encounter ☑

S63.294A Dislocation of distal interphalangeal joint of right ring finger, initial encounter ☑

S63.295A Dislocation of distal interphalangeal joint of left ring finger, initial encounter ☑

S63.296A Dislocation of distal interphalangeal joint of right little finger, initial encounter ☑

S63.297A Dislocation of distal interphalangeal joint of left little finger, initial encounter ☑

AMA: **26785** 2018,Sep,7

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

70360

70360 Radiologic examination; neck, soft tissue

Explanation

The technologist uses x-rays to obtain soft tissue images of the patient's neck rather than bone. The radiologist obtains two views, typically front to back (AP), and side to side (lateral). This procedure is performed to visualize abnormal air patterns or suspected foreign bodies or obstructions within the throat or neck.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
70360	0.18	0.66	0.02	0.86
Facility RVU	**Work**	**PE**	**MP**	**Total**
70360	0.18	0.66	0.02	0.86

72020

72020 Radiologic examination, spine, single view, specify level

Explanation

One film is taken of the spine that requires specification of the level examined.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
72020	0.16	0.5	0.02	0.68
Facility RVU	**Work**	**PE**	**MP**	**Total**
72020	0.16	0.5	0.02	0.68

72040-72052

72040 Radiologic examination, spine, cervical; 2 or 3 views
72050 4 or 5 views
72052 6 or more views

Explanation

A radiologic examination of the cervical spine is performed. Report 72040 for two or three views, 72050 for four or five views, and 72052 for a complete study (six or more views). The complete study includes films taken in oblique (angled) positions and in flexion and/or extension positioning.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
72040	0.22	0.83	0.02	1.07
72050	0.27	1.13	0.02	1.42
72052	0.3	1.35	0.02	1.67
Facility RVU	**Work**	**PE**	**MP**	**Total**
72040	0.22	0.83	0.02	1.07
72050	0.27	1.13	0.02	1.42
72052	0.3	1.35	0.02	1.67

72070-72074

72070 Radiologic examination, spine; thoracic, 2 views
72072 thoracic, 3 views
72074 thoracic, minimum of 4 views

Explanation

A radiologic examination of the thoracic spine is performed that includes two views in 72070, three views in 72072, and a minimum of four views in 72074. These procedures do not specify that a certain view must be performed.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
72070	0.2	0.67	0.02	0.89
72072	0.23	0.83	0.02	1.08
72074	0.25	0.94	0.02	1.21
Facility RVU	**Work**	**PE**	**MP**	**Total**
72070	0.2	0.67	0.02	0.89
72072	0.23	0.83	0.02	1.08
72074	0.25	0.94	0.02	1.21

72080

72080 Radiologic examination, spine; thoracolumbar junction, minimum of 2 views

Explanation

Films are taken of the thoracolumbar junction of the spine with a minimum of two views.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
72080	0.21	0.73	0.02	0.96
Facility RVU	**Work**	**PE**	**MP**	**Total**
72080	0.21	0.73	0.02	0.96

72081-72084

72081 Radiologic examination, spine, entire thoracic and lumbar, including skull, cervical and sacral spine if performed (eg, scoliosis evaluation); one view
72082 2 or 3 views
72083 4 or 5 views
72084 minimum of 6 views

Explanation

A scoliosis series consists of images taken of the entire thoracic and lumbar spine and may include the skull, cervical, and sacral spine. Typical views including standing from front to back (AP), supine or lying down AP, and supine views 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

CPT Index

A

● New ▲ Revised + Add On AMA: CPT Assist[Resequenced]