



DESK REFERENCE

Coders` Desk Reference for Procedures

Answers to your toughest CPT®
coding questions

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optum360coding.com

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Introduction

Coding is a complicated business. It's not enough to have a current copy of a CPT® book. Medical coders also need dictionaries and specialty texts if they are to accurately translate physicians' operative reports or patient charts into CPT codes.

That's why Optum360 originally developed *Coders' Desk Reference*—now known as *Coders' Desk Reference for Procedures*—to provide a resource with answers to CPT coding questions. We polled the medical reimbursement community and our technical staff to determine the issues causing bottlenecks in a coder's workload.

We know that experienced coders are frustrated by limited definitions accompanying many CPT codes. Beginning coders need guidelines on the use of CPT codes and basic information about medical and reimbursement issues. Everyone requires up-to-date information about the anticipated changes in procedural coding.

Coders' Desk Reference for Procedures (CDR) answers the questions of both experienced and novice medical coders. Coders, physicians, registered nurses, physician assistants, and physical therapists contributed to the technical information contained in CDR. The result is a compendium of answers to a wide variety of CPT coding questions.

Since the first release of CDR in 1995, coders' corrections, suggestions, and tips have been incorporated into every printing, making this book as informative and useful as possible. Changes reflecting the dynamic world of coding are ongoing, and Optum360 encourages input for inclusion in future editions of the book. Information in CDR has been updated to reflect 2020 CPT codes.

Format

CDR is divided into convenient sections for easy use, with each section organized in alphabetic or numeric order. Simply access the section by thumbing through the convenient tabbing system to find the specific item of interest.

Using CPT Codes

For the new coder, and even for the veteran, this chapter provides an overview of the CPT book: what it is and how best to use this coding system for identifying procedures.

Using CPT Modifiers

Modifiers augment CPT codes to the satisfaction of private and government payers. Optum360 coding experts interpret CPT modifiers and identify their advantage in reimbursement.

Using E/M Codes

Although some of the most commonly used codes by physicians of all specialties, evaluation and management (E/M) codes are amongst the least understood. These codes, introduced in the 1992 CPT book, were designed to increase accuracy and consistency in the reporting of non-procedural encounters. This section contains a summary of E/M services and guidelines, along with information from the 1995 and 1997 documentation guidelines.

Reimbursement Terms

In order to get reimbursed in a timely manner, it is important to have a clear understanding of the terminology used by major insurers and the federal government. This section includes up-to-date terminology that will help coders have a better understanding of the complex reimbursement climate.

Clinical Abbreviations, Prefixes, Suffixes, and Acronyms

The medical profession has its own shorthand for documentation. Here, acronyms, abbreviations, and symbols commonly seen on operative reports or medical charts are listed for easy reference.

The uniquely efficient language of medicine is based on prefixes and suffixes attached to root words to modify the meaning. Medical prefixes and suffixes evolved from the Greek and Latin used by pioneering physicians.

Procedural Eponyms

What is the Mitrofanoff operation? What is the Binet test? Eponyms honor the developer of a procedure or test, but do little to clarify what the procedure is. Editors have researched the procedural eponyms found in the index of the CPT book and provide simplified explanations of what the procedures are, along with applicable CPT codes.

Surgical Terms

Operative reports contain words and phrases that not only communicate the importance and urgency of

Using CPT® Modifiers

Modifiers allow coders to indicate that a service was altered in some way from the stated CPT® description without actually changing the basic definition of the service. Modifiers are considered an essential component of accurate coding. Some modifiers impact reimbursement and others identify special circumstances. Modifiers can indicate the following:

- A service or procedure represents only a professional or technical component
- A service or procedure was performed by more than one physician
- Only part of a service was performed
- An adjunctive service was performed
- A bilateral procedure was performed
- A service or procedure was provided more than once
- Unusual events occurred
- A procedure or service was more difficult or took longer or was less involved or required less time

Physical status modifiers, P1-P6, specifically used for anesthesia services, are not discussed in this chapter. HCPCS modifiers, beginning with an alpha character, may be appended to CPT codes in specific circumstances and are also not discussed in this chapter.

22 Increased Procedural Services

Modifier 22 is not appropriate for CPT codes with the term “simple” as part of the code description, nor should it be appended to a code for an E/M service. Rather, modifier 22 is used to indicate that a procedure was complicated, complex, difficult, or took significantly more time than usually required by the provider to complete the procedure. Documentation, including notations to the amount of time involved, should be provided with the billing and kept in the medical record when this modifier is used. Time notations in the documentation should include start and stop times, as well as the total amount of additional time required to complete the procedure. The provider should clearly state *specifically*, and in detail, what issues made the procedure more complex rather than simply using vague statements such as, “The patient had a lot of adhesions.” When modifier 22 is used, an operative report should always be attached to the claim.

The fee reported for modifier 22 should be the usual and customary amount for the procedure plus an additional amount for the unusual circumstances. If

modifier 22 is appended to a code that is not the primary code, and modifier 51 has been appended, modifier 22 should be paid in addition to the cut contract rate paid for the code.

Modifier 22 often produces an automatic review or audit by payers. If the operative report attached to the claim does not indicate appropriate use of the modifier, the increase in payment will be denied. Periodic training for all involved in the coding process is important from both a legal and reimbursement perspective.

Because modifier 22 is often used when complications are encountered during surgical procedures, medical necessity is substantiated by additional diagnostic codes that identify the complication. These diagnostic codes should reflect the operative condition and the complication(s) encountered during the surgery.

23 Unusual Anesthesia

This modifier is used by anesthesiologists to indicate that this procedure is normally performed under local anesthesia or regional block but due to unusual circumstances, general anesthesia is needed. This modifier is not appropriate for use with codes that include the term “without anesthesia” in the descriptor, or for procedures normally performed under general anesthesia.

24 Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

This modifier reports that an unrelated E/M service was provided by the surgeon within the global period. Use of this modifier needs to be correlated to a diagnosis code that is unrelated to the surgical diagnosis code.

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

This modifier indicates that on the same day a procedure or service identified by a CPT code is performed, the patient’s condition required a significant, separately identifiable E/M code beyond the usual level of service required for the procedure. In addition, the modifier denotes that the patient’s condition required services that were over and above

Reimbursement Terms

An increasingly complex reimbursement climate means new terminology develops every year. The following glossary includes terms not only used when coding, it includes terms used by major insurers and the federal government.

AAPA. American Academy of Physician Assistants.

AAPC. American Academy of Professional Coders. National organization for coders and billers offering certification examinations based on physician-, facility-, payer-specific guidelines, or coding documentation. Upon successful completion of the selected examination, the credential for that examination is obtained.

AAPCC. Adjusted average per capita cost. Estimated average cost of Medicare benefits for an individual based upon criteria such as age, sex, institutional status, Medicaid, disability, and end-stage renal failure.

abstractor. Person who selects and extracts specific data from the medical record and enters the information into computer files.

accountable care organization. Recognized legal entity under state law comprised of providers of services and suppliers with an established mechanism for shared governance who work together to coordinate care for Medicare fee-for-service beneficiaries. Section 3022 of the Affordable Care Act required CMS to develop a shared savings program to promote coordination and cooperation among providers for the purposes of improving the quality of care for Medicare fee-for-service beneficiaries and minimize costs.

accreditation. Evaluative process in which a health care organization undergoes an examination of its policies, procedures, and performance by an external organization to ensure it is meeting predetermined criteria. It usually involves both on- and off-site surveys.

Accredited Standards Committee. Organization accredited by the American National Standards Institute (ANSI) for the development of American national standards.

accrual. Amount of money set aside to cover a health care benefit plan's expenses based upon estimates using a combination of data, including the claims system and the plan's prior history. In facility accounting, accrual accounting records the expenses as they are incurred and the revenue as it is generated. This contrasts with cash accounting where expenses

are recorded only when payment is made or revenues are recorded only when payment is received.

ACH. Automated clearinghouse. Entity that processes or facilitates the processing of information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction, or that receives a standard transaction from another entity and processes or facilitates the processing of that information into nonstandard format or nonstandard data content for a receiving entity.

ACLS. Advanced cardiac life support. Certification for health care professionals who have achieved proficiency in providing emergent care of cardiac and respiratory systems and medication management.

ACO. Accountable Care Organization.

ACR. 1) American College of Radiology. 2) American College of Rheumatology. 3) Adjusted community rate, calculation of what premium the plan charges to provide Medicare-covered benefits for greater frequency of use by participants.

activities of daily living. Self-care activities often used to determine a patient's level of function, such as bathing, dressing, using a toilet, transferring in and out of bed or a chair, continence, eating, and walking.

actual charge. Charge a physician or supplier bills for a service rendered or a supply item.

actuarial assumptions. Characteristics used in calculating the risks and costs of a plan, including age, sex, and occupation of enrollees; location; utilization rates; and service costs.

acute care facility. Health care institution primarily engaged in providing treatment to inpatients and diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons who are in an acute phase of illness.

add-on code. Code representing a procedure performed in addition to the primary procedure and is represented with a + in the CPT book. Add-on codes are never reported for stand-alone services but are reported secondarily in addition to the primary procedure.

additional development request. Formal request from a Medicare contractor for additional information needed to determine if a claim is covered and/or payable.

Clinical Abbreviations, Prefixes, Suffixes, and Acronyms

The acronyms, abbreviations, prefixes, suffixes, and symbols used by health care providers speed communications. The following list includes the most often seen acronyms, abbreviations, and symbols. In some cases, abbreviations have more than one meaning. Multiple interpretations are separated by a slash (/). Abbreviations of Latin phrases are punctuated.

-agra	Severe pain.	-opathy	Relating to disease.
-algia	Pain.	-opexy	Surgical fixation.
-ase	Denoting an enzyme.	-oplasty	Surgical repair.
-asthenia	Weakness.	-orrhaphy	Suturing.
-atresia	Closure, occlusion.	-orrhagia	Hemorrhage.
-blast	Incomplete cellular development.	-orrhaphy	Suturing.
-centesis	Puncture.	-oscopy	To examine.
-cephal	Relating to the head.	-osis	Condition, process.
-cle	Small or little.	-ostomy	Indicates a surgically created artificial opening.
-cyte	Having to do with cells.	-otomy	Indicates a cutting.
-dactyl	Relating to the fingers or toes.	-otripsy	Crushing, destroying.
-desis	Binding or fusion.	-pagus	Indicates fixed or joined together.
-ectomy	Excision, removal.	-paraesis	Indicates weakness.
-emia	Blood.	-pathic	Indicates a feeling, diseased condition, or therapy.
-ferous	Produces, causes, or brings about.	-penia	Indicates a deficiency, less than normal.
-fuge	Drive out or expel.	-pexy	Fixation.
-genic	Production, causation, generation.	-philia	Inordinate love of or craving for something.
-gram	Drawn, written, and recorded.	-phobia	Abnormal fear of or aversion to.
-graphic	Written or drawn.	-plasia	Indicates growth, growing.
-ia	State of being, condition (abnormal).	-plasty	Indicates surgically formed or molded.
-iasis	Condition.	-plegia	Indicates a stroke or paralysis.
-itis	Inflammation.	-pnea	Relating to breath, breathing.
-lysis	Release, free, reduction of.	-poietic	Indicates producing or making.
-lytic	Destroy, breakdown.	-praxis	Indicates activity, action, condition, or use.
-metry	Scientific measurement.	-rhage	Indicates bleeding or other fluid discharge.
-odynia	Indicates pain or discomfort.	-rhaphy	Indicates a suture or seam joining two structures.
-oid	Indicates likeness or resemblance.	-rrhagia	Indicates an abnormal or excessive fluid discharge.
-ology	Study of.	-rrhaphy	Repair.
-oma	Tumor.	-rrhexis	Splitting or breaking.
		-sarcoma	Malignant tumor of flesh or connective tissue.
		-spasm	Contraction.

Procedural Eponyms

The medical custom of honoring a popular procedure's originator by name may prove to be problematic for the coder, who may have no trouble coding a Marshall-Marchetti but be faced with choosing one of the many Campbell procedures.

The following list includes many of the procedures described by eponym in the CPT® book.

Abbe-Estlander procedure

- 40527 Excision of lip; full thickness, reconstruction with cross lip flap (Abbe-Estlander)
- 40761 Plastic repair of cleft lip/nasal deformity; with cross lip pedicle flap (Abbe-Estlander type), including sectioning and inserting of pedicle

Surgical technique for a lip repair.

Addam operation

- 26040 Fasciotomy, palmar (eg, Dupuytren's contracture); percutaneous
- 26045 Fasciotomy, palmar (eg, Dupuytren's contracture); open, partial

Procedure releases a Dupuytren's contracture.

Adson test

- 95870 Needle electromyography; limited study of muscles in 1 extremity or non-limb (axial) muscles (unilateral or bilateral), other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters

Physiological assessment for thoracic outlet syndrome.

Alexander's operation

- 58400 Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; (separate procedure)
- 58410 Uterine suspension, with or without shortening of round ligaments, with or without shortening of sacrouterine ligaments; with presacral sympathectomy

Uteral displacement is repaired by shortening round ligaments.

Altemeier procedure

- 45130 Excision of rectal procidentia, with anastomosis; perineal approach

Removal of a rectal prolapse through a perineal approach or through a combined abdominal and perineal approach.

Amussat's operation

- 44025 Colotomy, for exploration, biopsy(s), or foreign body removal

Long transverse incision made to expose the colon.

Anderson's method of tibial lengthening

- 27715 Osteoplasty, tibia and fibula, lengthening or shortening

Technique in which the tibia is severed and screws are affixed to plates supporting the bone across the gap to lengthen the patient's leg.

Aries-Pitanguy mammoplasty

- 19318 Reduction mammoplasty

Procedure to reduce breast size.

Babcock's operation

- 37700 Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions

Varicose veins are eliminated using a long probe and tying the end of the vein to it to draw out the vein by invagination.

Baker tube

- 44021 Enterotomy, small intestine, other than duodenum; for decompression (eg, Baker tube)

Tube placed into the jejunum or small bowel for decompression or extensive adhesions.

Baker's cannula

Flexible cannula used on the trachea.

Bankart procedure

- 23455 Capsulorrhaphy, anterior; with labral repair (eg, Bankart procedure)

Procedure used to treat recurrent dislocation of the shoulder requiring reconstruction of the avulsed capsule and labrum at the glenoid lip.

Barany's caloric test

- 92533 Caloric vestibular test, each irrigation (binaural, bithermal stimulation constitutes 4 tests)

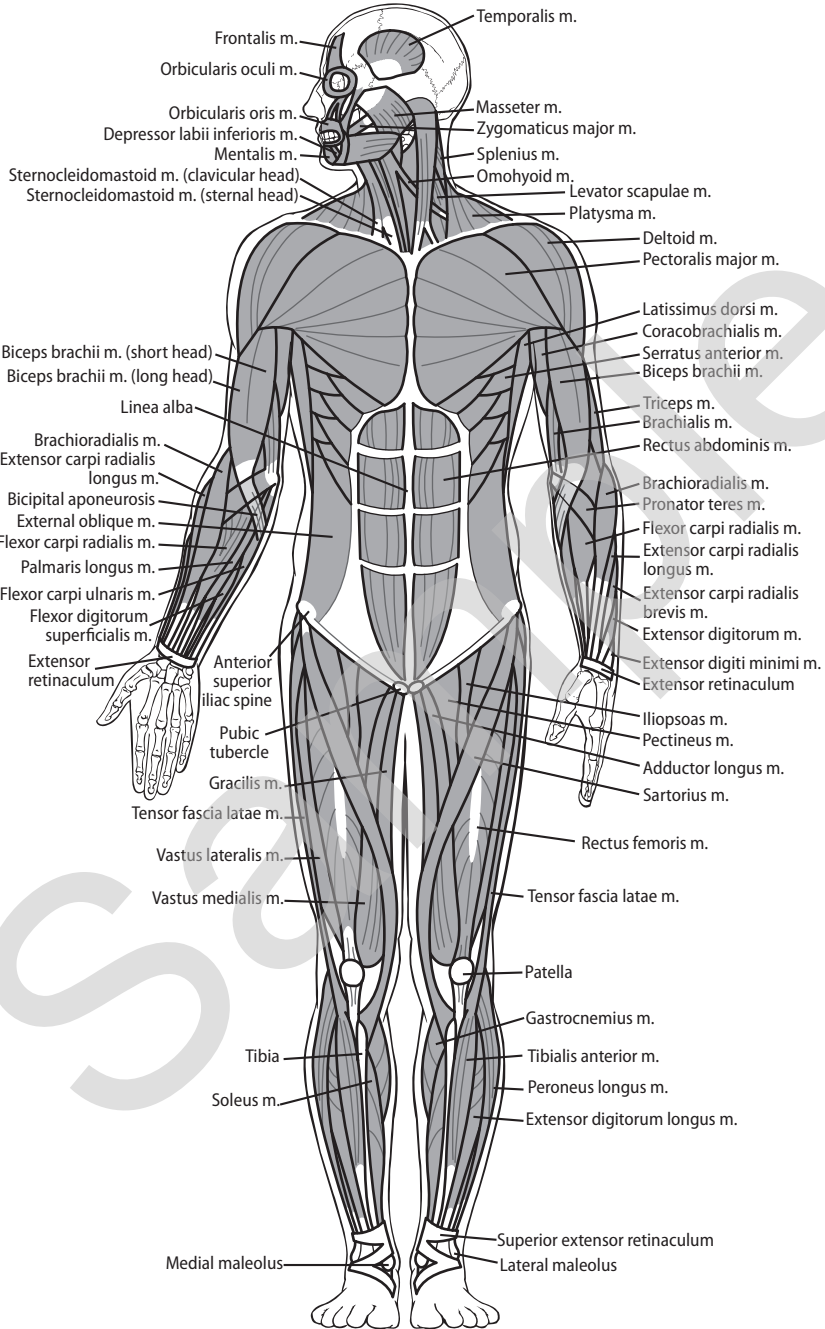
Extent of nystagmus is determined by irrigating the external auditory meatus with hot or cold water.

Bardenheuer operation

- 37616 Ligation, major artery (eg, post-traumatic, rupture); chest

Arterial fistula in the chest is repaired by ligation and sutures.

Muscles



21600

The physician removes part of one rib. With the patient under anesthesia, the physician makes an incision in the skin of the chest overlying the rib. The tissues are dissected deep to the rib itself. The rib is identified. The physician removes the desired part of the rib using a saw and other instruments. The remaining pieces of the rib and the wound itself are irrigated and debrided. The incision is sutured in layers.

21601

The physician excises a chest wall tumor, including ribs. An incision in the skin of the chest overlying the site of the tumor is made. The tumor and surrounding tissue are excised. The tissue removed includes at least one adjacent rib above or below the tumor site and any associated intercostal muscles. It may also include rib cage resection and/or an en bloc resection of muscles, including the pectoralis minor or major, the serratus anterior, or the latissimus dorsi. The physician ligates or cauterizes bleeding vessels. A chest tube may be placed to re-expand the lung. The incision is repaired with layered closure and a pressure dressing is applied to the wound.

21602-21603

The physician excises a chest wall tumor, involving ribs, with plastic reconstruction. The physician makes an incision in the skin of the chest overlying the tumor. The tumor and surrounding tissue are excised and includes at least one adjacent rib above and below the tumor site and all intervening intercostal muscles. It may also include an en bloc resection of muscles, including the pectoralis minor or major, the serratus anterior, or the latissimus dorsi. In 21603, lymphatic tissue lying within the mediastinum is also removed. The physician ligates or cauterizes bleeding vessels. A chest tube may be placed to re-expand the lung. Plastic reconstruction is done and may involve rib grafts and/or a myocutaneous flap. A pressure dressing is applied to the wound.

21610

The physician resects the costovertebral joint. The physician makes a posterior incision overlying the joint. The tissues are dissected from the joint and the transverse process is cut from the vertebral body. The physician removes all or a portion of the adjacent rib. The incision is sutured in layers.

21615-21616

The physician performs surgery to remove the first rib and/or an extraneous cervical rib. With the patient under anesthesia, an incision is made in the skin just above the clavicle on the affected side and carried deep to the rib. The rib is identified and the attached soft tissues are dissected from the bone. The physician excises the rib using a saw and other surgical instruments. The rib is freed from its articulation and removed. The wound is irrigated and closed in layers.

A dressing is applied. Report 21616 if a sympathetic nerve pathway is cut during the procedure.

21620

The physician removes a portion of the sternum from the chest. With the patient under anesthesia, the physician makes an incision in the skin overlying the sternum. This is carried deep through the subcutaneous tissues to the bone. The sternum is identified and the attached soft tissues are dissected from the bone. The physician marks the portion of the sternum to be removed. The bone is cut in the appropriate places using a saw and other surgical instruments. The remaining portion of the bone is irrigated and smoothed as needed. The wound is closed in layers and a dressing is applied.

21627

The physician performs a debridement of the sternum. With the patient under anesthesia, the physician makes an incision in the skin overlying the sternum. The incision is carried deep to the bone. The sternum is debrided as warranted using any of a variety of hand or powered surgical instruments. Irrigation is used so that debridement can be completed as extensively as indicated. The wound may be loosely packed and a dressing applied or it may be closed in layers and a dressing applied.

21630-21632

The physician removes most or all of the sternum from the chest. With the patient under anesthesia, the physician makes a long incision overlying the sternum and anterior chest. This is carried deep to the bone. Dissection is performed around the sternum. Ribs are disarticulated as needed and thorough debridement is accomplished. Using saws and other surgical instruments, the physician removes the bone. Internal fixation devices (reported separately) are often needed to support the ribs and chest wall. The wound is irrigated and closed in layers. Report 21632 if a mediastinal lymphadenectomy is performed during the procedure.

21685

The hyoid bone is a small C-shaped bone in the neck above the Adam's apple, or thyroid cartilage, with muscles of the tongue and throat attached to it. Hyoid myotomy and suspension is done to open the oropharyngeal airway for correcting breathing in sleep apnea. It involves repositioning and fixating the hyoid bone to improve the airway. A submental incision is made to expose the hyoid bone in the neck. The muscles below the hyoid are transected and separated to expose a small, isolated, mid-portion of the hyoid bone. Strips of fascia lata (bands of fibrous tissue), nonresorbable suture, or other strong materials are wrapped around the body of the hyoid and used to pull it forward and secure it to the inferior mandibular border. An alternative method pulls the

Respiratory

30000-30020

The physician makes an incision to decompress and drain a collection of pus or blood in the nasal mucosa for 30000 or septal mucosa for 30020. A hemostat bluntly penetrates the pockets and allows the fluid to evacuate. Once decompressed, a small latex drain may be placed into the incision site. This allows an escape for any fluids that may continue to enter the pocket. If a drain is used, it is removed within 48 hours. The nasal cavity may be packed with gauze or Telfa to provide pressure against the mucosa and assist decompression after drainage. The incision may be closed primarily or may be left to granulate without closure.

30100

The physician removes mucosa from inside the nose for biopsy. This biopsy is performed when the mucosa is suspicious for disease. Some normal tissue adjacent to the diseased mucosa is also removed during the biopsy. This allows the pathologist to compare diseased versus nondiseased tissues. The excision site may be closed primarily with sutures or may be allowed to granulate without closure.

30110

The physician removes a polyp from inside the nose. Nasal polyps may obstruct both the airway passages and sinus drainage ducts in the nose. The area is approached intranasally. Topical vasoconstrictive agents are applied to the nasal mucosa. Local anesthesia is injected underneath and around the polyp. A scalpel or biting forceps excise the polyp. Small polyps may leave mucosal defects that do not require closure. With larger defects, the mucosa is closed with sutures in a single layer. The physician may place Telfa to pack the nasal cavity during the first 24 hours.

30115

The physician removes complicated nasal polyps in a hospital setting. Nasal polyps may obstruct both the airway passages and sinus drainage ducts in the nose. The area is approached intranasally. Topical vasoconstrictive agents are applied to the nasal mucosa. Local anesthesia is injected underneath and around the polyp. Large polyps are removed with a wire snare stretching the polyp base; the snare or a scalpel can be used to detach the polyp from its mucosal base. A scalpel or biting forceps excise smaller polyps. Small polyps may leave mucosal defects that do not require closure. With larger defects, the mucosa is closed with sutures in a single layer. The physician may place Telfa to pack the nasal cavity during the first 24 hours.

30117-30118

The physician removes or destroys intranasal soft tissue lesions using techniques such as surgical excision,

cryosurgery, chemical application, or laser surgery. The lesion is approached intranasally in 30117. The physician performs a lateral rhinotomy by retracting the lateral ala to expose the internal nose in 30118. Surgical excision can be utilized to remove the lesion. Cryosurgery freezes and kills soft tissue lesions. Laser surgery vaporizes and emulsifies the lesions. Chemical application of topical vasoconstrictive agents and local anesthesia cauterizes vessels and limits postsurgical hemorrhage. Postoperative wound closure or intranasal packing may not be necessary.

30120

Rhinophyma describes a chronic skin disorder categorized under part of an advanced staged rosacea called phymatous rosacea, identified with significant disfigurement from severe redness and a bulbous nose caused by hypertrophy and hyperplasia of the sebaceous nasal glands. The condition can also seriously impact the function of the nose and without surgery may produce a functional airway compromise (airway obstruction). The physician surgically removes diseased tissue caused by rhinophyma from the external nasal tip. Local anesthesia is injected into the nasal tip. The excess tissue is removed by carving and recontouring hyperplastic tissue from the area. Scalpels, dermabrasion (planing with fine sandpaper or wire brushes), and lasers are common methods of removing this excess tissue. A thin layer of epithelium is maintained over the nasal cartilages to ensure adequate healing. Separately reportable skin grafting may be necessary for very large lesions.

30124-30125

The physician removes a dermoid (developmental) cyst of the nose that may be associated with the soft tissue only in 30124 or may extend into bone and/or cartilage in 30125. If associated with the nasal bone, the usual location is at the bone-cartilage junction. Dependent on the size and location, the cyst may be removed using skin or intranasal incisions. A fistula opening may be present and its tract would be excised. Commonly, an incision is made overlying the cyst in the nasal skin. The cyst is removed from its cavity using curettes. The defect size dictates post-removal cavity packing and/or separately reportable reconstruction. Incisions may be closed in single and layers.

30130

The physician removes a part of or the entire inferior nasal turbinate located on the lateral wall of the nose. The turbinate is primarily removed in cases of hypertrophy that obstruct the nasal airway. The physician places topical vasoconstrictive drugs on the turbinate to shrink the blood vessels. A mucosal incision is made around the base of the turbinate. The physician fractures the bony turbinate from the lateral nasal wall with a chisel or drill. The turbinate is excised. Electrocautery may control bleeding. The nasal mucosa is sutured in single layers. The nasal cavity may be packed with gauze.

Eye and Ocular Adnexa

65091-65093

The physician removes the contents of the eyeball: the vitreous, retina, choroid, lens, iris, and ciliary muscles. Retained is the tough, white outer shell (the sclera). After an ocular speculum has been inserted, the physician dissects the conjunctiva free from the sclera. An elliptical incision is made in the sclera surrounding the cornea, and the contents of the anterior chamber are removed. The physician uses a spoon to remove the contents of the posterior chamber, and scrapes the inside of the sclera with gauze on a curette. Only the scleral shell remains. The conjunctiva may be removed. A temporary (e.g., for 65091) or permanent (e.g., for 65093) implant is inserted into the scleral shell at this time. The sclera is attached to the implant, usually with sutures.

65101-65105

The physician severs the eyeball from the extraorbital muscles and optic nerve and removes it. After an ocular speculum has been inserted, the physician dissects the conjunctiva free at the corneal-scleral juncture (the limbus). The physician cuts each extraocular muscle at its juncture to the eyeball and severs the optic nerve. The eyeball, and sometimes the conjunctiva, is removed but the extraocular muscles remain attached at the back of the eye socket. A spherical implant is placed in the eye socket. This implant, if unattached to the extraocular muscles, may be temporary (e.g., 65101) or permanent (e.g., 65103). The extraocular muscles may be attached to the permanent implant to allow normal movement of the prosthesis (e.g., 65105).

65110-65112

The physician sutures the eyelids closed. An elliptical incision is cut through the skin, subcutaneous tissue, muscle and periosteum to the bone beginning at the upper nasal orbital rim and is carried below the brow to the lateral canthus. The incision is extended from the upper nasal quadrant along the nasal and inferior orbit rim to the lateral canthus, terminating in a wide canthotomy. The periosteum is freed around the orbital rim with a periosteum elevator, beginning in the upper temporal quadrant. The trochlea is detached with a sharp dissection. In the upper temporal quadrant, the lacrimal gland is removed. The lacrimal sac is separated from its attachments and removed. The medial and lateral canthal ligaments are cut with a blunt dissection. A blunt dissection is also used to separate the periorbital to the apex, and the firm attachment of the periosteum is cut from the bone with scissors. The orbital contents are removed. Pieces of orbital bone may be excised (e.g., for 65112). The orbit is packed with dry gauze and pressure is applied to control bleeding.

65114

The physician splits the upper and lower eyelids at the gray line throughout their length, leaving the cilia and the skin anteriorly, and the tarsus, the orbicularis muscle, the conjunctiva, the palpebral muscle and the fascial planes posteriorly. The margins of the posterior halves of the lids are sutured together. The lateral bony wall and the temporal fossa are exposed by lateral canthotomy and dissection of the skin, continuous with both lids. The orbital septum is incised. The trochlea is detached with a sharp dissection. The lacrimal gland and lacrimal sac are removed. The medial and lateral canthal ligaments are cut with a blunt dissection. A blunt dissection is also used to separate the periorbital to the apex. The firm attachment of the periosteum is cut from the bone with scissors. The orbital contents are removed. An incision is made in the fascia at the origin of the temporalis muscle. Fascia and muscle are reflected from the temporal fossa. Adherent fascia is excised from the upper margin of the zygomatic process. The muscle is dissected beneath the process. The temporalis muscle and its fascia are taken through the opening into the orbit. After the muscle and the fascia are spread to fill the orbit, they are sutured to the periosteum.

65125

The physician modifies an ocular implant that has been created elsewhere. The modifications may include the addition of screws or other prosthetic appendages to alter the shape of the prosthesis so that it better fits the patient's eye. The physician may drill holes to accommodate the screws.

65130-65140

The physician inserts a permanent ocular prosthesis into a patient's orbit. In each case, an ocular speculum is placed in the eye, any conjunctiva is retracted, and any temporary prosthesis is removed. In a patient whose eye has been eviscerated, the implant is attached to the remaining sclera (e.g., 65130). In a patient following enucleation, the implant is otherwise secured (e.g., 65135). In some cases, eye muscles are attached to corresponding niches in the prosthesis to provide for more natural movement of the artificial eye following enucleation (e.g., 65140).

65150-65155

The physician returns an ocular prosthesis to the patient's eye socket. After an ocular speculum is inserted, the physician places the ocular prosthesis back into an eye from which it had been previously removed. The prosthesis is attached to the sclera in an eviscerated eye, or otherwise secured in an enucleated eye (e.g., 65150). In 65155, foreign material may be required to better secure the prosthesis and/or the prosthesis may be reattached to extraocular muscles. In either procedure, conjunctival tissue may be grafted over the prosthesis once it is secured.

Medicine

90281

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

90283

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

90284

This code identifies the human immune globulin for use in subcutaneous infusions (SCIG). An immune globulin is a passive immunization agent obtained from donated pooled human plasma. Passive immunity is achieved for a short period as the antibodies received through the immune globulin are circulated through the body. The recipient's immune system is not stimulated to build its own antibodies. Some patients have insufficient venous access or adverse reactions to intravenous treatments, making them unsuitable candidates for traditional IVIG therapy. Controlled doses of immune globulin are administered over a period of several hours through a small needle placed just under the skin. Report this code with the appropriate administration code.

90287

This code identifies the botulinum antitoxin, equine, administered by any route. The antitoxin is a passive immunizing agent derived from purified serum from previously immunized horses. The antibodies received through the antiserum are circulated through the body and neutralize toxins produced by strains of the botulinum bacteria. Report this code with the appropriate administration code.

90288

This code identifies the botulism immune globulin, human, for intravenous use. This immune globulin is a passive immunization agent that gives protection against Botulism and is obtained from donated, pooled human plasma. Passive immunity is achieved for a short period as the antibodies received through the immune globulin are circulated through the body. The recipient's immune system is not stimulated to build

its own antibodies. Report this code with the appropriate administration code.

90291

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

90296

This code identifies the diphtheria antitoxin, equine, administered by any route. The antitoxin is a passive immunizing agent derived from purified serum from previously immunized horses. The antibodies received through the antiserum are circulated through the body and neutralize toxins produced by *Corynebacterium diphtheriae*. Report this code with the appropriate administration code.

90371

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

90375-90376

Code 90375 identifies the rabies immune globulin (RIG), human, for intramuscular and/or subcutaneous use and 90376 identifies the heat-treated Rabies immune globulin (RIG-HT), also for intramuscular and/or subcutaneous use. This immune globulin is a passive immunization agent that gives protection against Rabies and is obtained from donated, pooled human plasma. Passive immunity is achieved for a short period as the antibodies received through the immune globulin are circulated through the body. The recipient's immune system is not stimulated to build its own antibodies. Report these codes with the appropriate administration code.

90378

Code 90378 identifies the respiratory syncytial virus (RSV) recombinant monoclonal antibody for intramuscular use, 50 mg, each. This humanized monoclonal antibody (IgG) gives protection against the respiratory syncytial virus and is injected once a month during the RSV season. Passive immunity is achieved for a short period as the antibodies received are circulated through the body. The recipient's