Optum

Coding Companion

Emergency Medicine/ Critical Care/ Infectious Disease

A comprehensive illustrated guide to coding and reimbursement

2025

optumcoding.com

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Getting Started with Coding Companion

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

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

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to emergency medicine/critical care/infectious disease 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/HCPCS code description.

Resequencing of CPT Codes

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

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

ICD-10-CM

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

Detailed Code Information

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

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT/HCPCS code description, followed by an easy-to-understand explanation.

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

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

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

CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 29.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2025 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:

65205 Removal of foreign body, external eye; conjunctival superficial

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

Conjunctiva
Foreign Body Removal, 65205-65210

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

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

General Guidelines

Providers

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

Supplies

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

Professional and Technical Component

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

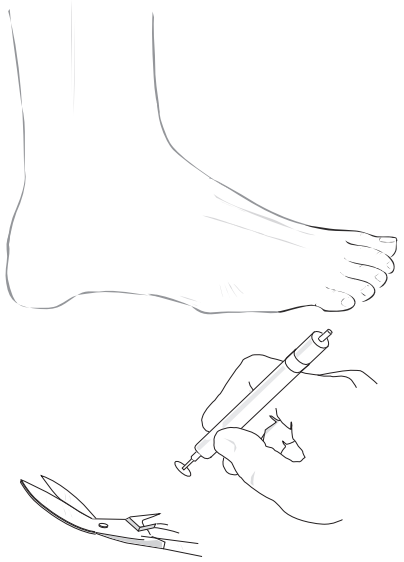
Sample Page and Key

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

11720-11721

11720 Debridement of nail(s) by any method(s); 1 to 5
11721 6 or more

Nails are debrided using a number of methods



Explanation

The physician debrides fingernails or toenails, including tops and exposed undersides, by any method. The cleaning is performed manually with cleaning solutions, abrasive materials, and tools. The nails are shortened and shaped. Report 11720 for one to five nails and 11721 for six or more.

Coding Tips

For trimming of nondystrophic nails, see 11719. These codes are reported only once regardless of the number of nails that are trimmed. For the trimming of dystrophic nails, see G0127. Some non-Medicare payers may require that HCPCS Level II code S0390 be reported for this service when provided as routine foot care or as preventive maintenance in specific medical conditions. For diabetic patients with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), see G0247. Medicare requires the use of specific HCPCS Level II modifiers Q7–Q9 to indicate clinical findings indicative of severe peripheral involvement, warranting the medical necessity of a podiatrist providing foot care, such as nail debridement or trimming, that would usually be considered routine and for which benefits would not be provided. It is inappropriate to report supplies when these services are performed in an emergency room. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

B35.1 Tinea unguium
B37.2 Candidiasis of skin and nail
L03.011 Cellulitis of right finger ☑
L03.012 Cellulitis of left finger ☑
L03.031 Cellulitis of right toe ☑
L03.032 Cellulitis of left toe ☑
L60.0 Ingrowing nail
L60.1 Onycholysis
L60.2 Onychogryphosis
L60.3 Nail dystrophy
L60.8 Other nail disorders
Q84.6 Other congenital malformations of nails

Associated HCPCS Codes

G0127 Trimming of dystrophic nails, any number

AMA: **11720** 2022,Feb; 2021,Aug **11721** 2022,Feb; 2021,Aug

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11720	0.32	0.62	0.04	0.98
11721	0.54	0.74	0.04	1.32
Facility RVU	**Work**	**PE**	**MP**	**Total**
11720	0.32	0.07	0.04	0.43
11721	0.54	0.12	0.04	0.7

	FUD	Status	MUE	Modifiers				IOM Reference
11720	0	A	1(2)	N/A	N/A	N/A	N/A	100-02,15,290; 100-03,70.2.1
11721	0	A	1(2)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

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

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

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

paronychia. Infection or cellulitis of nail structures.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2024.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2024.
- ▲ This CPT code description is revised for 2024.
- ✚ This CPT code is an add-on code.

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

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.

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

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

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
97802	97803	97804	99406	99407	99408	99409
99497	99498					

2. Illustrations

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

3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes 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 Optum and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

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

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ♂ 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 2023.

The 2024 Medicare edits were not available at the time this book went to press. Updated 2024 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2025 edition password is **XXXXXX**.

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

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care 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 inpatient and observation care 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 codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

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 evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

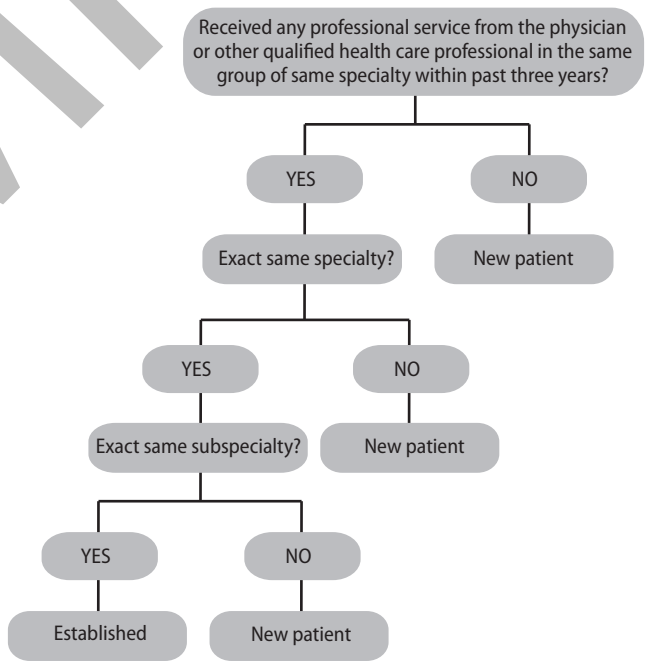
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other 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 subspecialty** 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 for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other

AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

▶ ◀ = Contains new or revised text

99202-99205

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

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

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

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

Explanation

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

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternatively, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. Medicare and the CPT codebook have identified these codes as telehealth/telemedicine services. Telemedicine services may be reported by the performing provider by adding modifier 95 to the procedure code and/or using the appropriate place of service (POS) indicator; POS 02 for telehealth when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. For prolonged services applicable to 99205, see 99417; for Medicare, see G2212. Medicare and commercial payers should be contacted regarding their coverage guidelines. For office or other outpatient services for an established patient, see 99211-99215.

ICD-10-CM Diagnostic Codes

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

AMA: **99202** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99203** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99204** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99205** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.14	0.08	2.15
99203	1.6	1.56	0.17	3.33
99204	2.6	2.11	0.23	4.94
99205	3.5	2.71	0.31	6.52
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.08	1.42
99203	1.6	0.68	0.17	2.45
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*	100-04,11,40.1.3; 100-04,12,30.6.4; 100-04,12,30.6.10; 100-04,12,190.7; 100-04,12,230; 100-04,12,230.1; 100-04,18,80.2; 100-04,32,12.1
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

99288

99288 Physician or other qualified health care professional direction of emergency medical systems (EMS) emergency care, advanced life support

Explanation

This code is used to report qualified clinician direction of emergency medical systems (EMS) emergency care or advanced life support in the emergency department (ED). This can involve the clinician communicating via a two-way voice system with emergency medical technicians in an ambulance or with other rescue personnel who are outside of the hospital emergency department. Clinician direction of the performance of medically necessary procedures includes, but is not limited to, telemetry of cardiac rhythm; cardiac and/or pulmonary resuscitation; endotracheal or esophageal obturator airway intubation; administration of intravenous (IV) fluids and/or intramuscular (IM), intra-tracheal, or subcutaneous drugs; and/or electrical conversion of cardiac arrhythmia.

Coding Tips

This code is used by a facility-based practitioner (emergency department, critical care unit) who is directing remote emergency care or advanced life support in the urgent care of the patient. Time is not a factor when selecting this E/M service. This service may be reported in addition to other E/M services on the same date when documented in the patient record.

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: 99288 2022,Nov; 2022,Aug; 2022,Jul; 2022,May; 2021,Jan; 2019,Jul; 2017,Aug; 2017,Jun

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99288	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
99288	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
99288	N/A	B	0(3)	N/A	N/A	N/A	N/A	100-04,4,160; 100-04,12,30.6.11; 100-04,12,100

* with documentation

Terms To Know

cardioversion. Measured electric shock administered with a defibrillator chest paddle to the heart to convert the heartbeat to a regular rhythm. This procedure can be performed externally or internally.

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

resuscitation. Restoration to life or consciousness of one apparently dead, it includes such measures as artificial respiration and cardiac massage or electrical shock.

99291-99292

99291 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

\+ **99292** each additional 30 minutes (List separately in addition to code for primary service)

Explanation

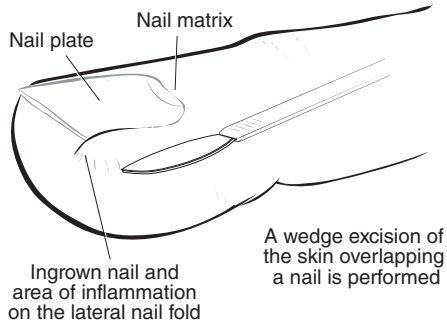
Critical care services are reported by a physician or other qualified health care provider for critically ill or injured patients. Critical illnesses or injuries are defined as those with impairment to one or more vital organ systems with an increased risk of rapid or imminent health deterioration. Critical care services require direct patient/provider involvement with highly complex decision making in order to evaluate, control, and support vital systems functions to treat one or more vital organ system failures and/or to avoid further decline of the patient's condition. Vital organ system failure includes, but is not limited to, failure of the central nervous, circulatory, or respiratory systems; kidneys; liver; shock; and other metabolic processes. Generally, critical care services necessitate the interpretation of many physiologic parameters and/or other applications of advanced technology as available in a critical care unit, pediatric intensive care unit, respiratory care unit, in an emergency facility, patient room or other hospital department; however, in emergent situations, critical care may be provided where these elements are not available. Critical care may be provided so long as the patient's condition continues to warrant the level of care according to the criteria described. Care provided to patients residing in a critical care unit but not fitting the criteria for critical care is reported using other E/M codes, as appropriate. These codes are time based codes, meaning the total time spent must be documented and includes direct patient care bedside or time spent on the patient's floor or unit (reviewing laboratory results or imaging studies and discussing the patient's care with medical staff, time spent with family members, caregivers, or other surrogate decision makers to gather information on the patient's medical history, reviewing the patient's condition or prognosis, and discussing various treatment options or limitations of treatment), as long as the clinician is immediately available and not providing services to any other patient during the same time period. Time spent outside of the patient's unit or floor, including telephone calls, caregiver discussions, or time spent in actions that do not directly contribute to the patient's care rendered in the critical unit are not reported as critical care. Report these codes for attendance of the patient during transport for patients 24 months of age or older to or from a facility. Code 99291 represents the first 30 to 74 minutes of critical care and is reported once per day. Additional time beyond the first 74 minutes is reported in 30 minute increments with 99292.

Coding Tips

These codes are used to report critical care services. These are time-based services and the total time spent providing critical care must be documented in the medical record. All time spent providing critical care on the same date of service is added together and does not need to be contiguous. Time is reported for practitioner time spent in care of the critically ill or injured patient at the patient's bedside and on the floor/unit. Time spent off the patient unit, even if related to patient care, is not counted. Do not report critical care for patients who may be in the critical care unit but are not currently critically ill. The following services are considered inclusive to the critical care codes when reported by the clinician: interpretation of cardiac output measurements, chest x-rays, pulse oximetry, blood gases, collection and interpretation of physiologic data, computer data such as ECGs, gastric intubation, vascular access, and ventilation management. Code 99291 is reported once per day. Code 99292 is reported in addition to code 99291. Medicare and some other payers may allow 99292 to be reported alone when critical care is reported by another physician of the same group and specialty the same date as another provider reporting 99291. Medicare has identified these codes as

11765

11765 Wedge excision of skin of nail fold (eg, for ingrown toenail)



Explanation

The physician excises a wedge of restrictive skin in the nail fold to free an ingrown nail. The physician performs a wedge excision of the skin overlapping the lateral nail. The nail is examined and trimmed to encourage straight growth. The wound is dressed.

Coding Tips

Local anesthesia is included in this service. However, this procedure may be performed under general anesthesia, depending on the age and/or condition of the patient. For excision of a nail and nail matrix, partial or complete, for permanent removal, see 11750. For avulsion of a nail plate, see 11730–11732. Some payers may require the use of HCPCS Level II modifiers FA–F9 or TA–T9 to identify the specific nail involved. If specimen is transported to an outside laboratory, report 99000 for handling or conveyance. It is inappropriate to report supplies when these services are performed in an emergency room. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

L60.0 Ingrowing nail

AMA: 11765 2022,Feb; 2021,Aug

Relative Value Units/Medicare Edits

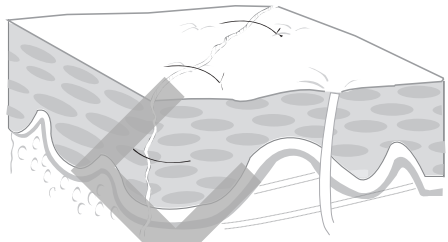
Non-Facility RVU	Work	PE	MP	Total
11765	1.22	3.63	0.1	4.95
Facility RVU	**Work**	**PE**	**MP**	**Total**
11765	1.22	1.42	0.1	2.74

	FUD	Status	MUE	Modifiers				IOM Reference
11765	10	A	4(3)	51	N/A	N/A	N/A	100-02,15,290

* with documentation

12001-12007

12001 Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less
12002 2.6 cm to 7.5 cm
12004 7.6 cm to 12.5 cm
12005 12.6 cm to 20.0 cm
12006 20.1 cm to 30.0 cm
12007 over 30.0 cm



Example of a simple closure involving only one skin layer, the epidermis

Explanation

The physician performs wound closure of superficial lacerations of the scalp, neck, axillae, external genitalia, trunk, or extremities using sutures, staples, tissue adhesives, or a combination of these materials. A local anesthetic is injected around the wound and it is cleansed, explored, and often irrigated with a saline solution. The physician performs a simple, one-layer repair of the epidermis, dermis, or subcutaneous tissues. For multiple wounds of the same complexity and in the same anatomical area, the length of all wounds sutured is summed and reported as one total length. Report 12001 for a total length of 2.5 cm or less; 12002 for 2.6 cm to 7.5 cm; 12004 for 7.6 cm to 12.5 cm; 12005 for 12.6 cm to 20 cm; 12006 for 20.1 cm to 30 cm; and 12007 if the total length is greater than 30 cm.

Coding Tips

Wounds treated with tissue glue or staples qualify as a simple repair even if they are not closed with sutures. When chemical cauterization, electrocauterization, or adhesive strips are the only material used for wound closure, the service is included in the appropriate E/M code. Anesthesia (local or topical) and hemostasis are not reported separately. Intermediate repair is used when layered closure of one or more of the deeper layers of subcutaneous tissue and superficial fascia are required in addition to limited undermining. Single-layer closure of a wound requiring extensive cleaning or removal of contaminated foreign matter or damaged tissue is classified as an intermediate repair. For extensive debridement of soft tissue and/or bone, not associated with open fractures and/or dislocations, resulting from penetrating and/or blunt trauma, see 11042–11047. For wound care closure by tissue adhesive(s) only, see HCPCS Level II code G0168. It is inappropriate to report supplies when these services are performed in an emergency room. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

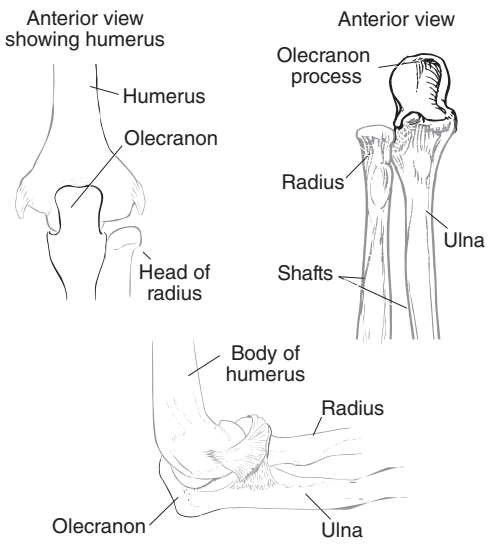
S01.01XA Laceration without foreign body of scalp, initial encounter
S01.03XA Puncture wound without foreign body of scalp, initial encounter
S01.05XA Open bite of scalp, initial encounter
S20.151A Superficial foreign body of breast, right breast, initial encounter ☑

24670-24675

24670 Closed treatment of ulnar fracture, proximal end (eg, olecranon or coronoid process[es]); without manipulation

24675 with manipulation

A fracture of the olecranon process is treated



Explanation

The physician performs closed treatment of an olecranon or coronoid process fracture. No manipulation is required in 24670. In 24675, mild or slight separation of the fragments requires manipulation. The physician manually manipulates the area, reducing the proximal end ulnar fracture. No incisions are made. The arm may be placed in a posterior elbow splint at 90 degrees of flexion.

Coding Tips

According to CPT guidelines, the application and removal of the first cast, splint, or traction device are included in the codes that appear in the Musculoskeletal System section of CPT. Supplies may be reported separately. Modifier 56 should not be reported for preoperative management of a fracture. Removal of a cast by a provider, other than the provider who applied the cast, can be reported with cast removal codes 29700, 29705, and 29710. Cast, splint, or strapping (29000-29750) and/or traction device (20690, 20692) replacement during or after the global period of a procedure may be reported separately. In 24675, local anesthesia is included. However, this procedure may be performed under conscious sedation or general anesthesia, depending on the age and/or condition of the patient. For radiology services, see 73070–73085. For radiology services, add modifier 26 to identify the professional component only; if the physician owns the equipment, both components may be reported.

ICD-10-CM Diagnostic Codes

M80.831A Other osteoporosis with current pathological fracture, right forearm, initial encounter for fracture ☑

M84.331A Stress fracture, right ulna, initial encounter for fracture ☑

M84.431A Pathological fracture, right ulna, initial encounter for fracture ☑

M84.531A Pathological fracture in neoplastic disease, right ulna, initial encounter for fracture ☑

M84.631A Pathological fracture in other disease, right ulna, initial encounter for fracture ☑

S52.011A Torus fracture of upper end of right ulna, initial encounter for closed fracture ☑

S52.021A Displaced fracture of olecranon process without intraarticular extension of right ulna, initial encounter for closed fracture ☑

S52.024A Nondisplaced fracture of olecranon process without intraarticular extension of right ulna, initial encounter for closed fracture ☑

S52.031A Displaced fracture of olecranon process with intraarticular extension of right ulna, initial encounter for closed fracture ☑

S52.034A Nondisplaced fracture of olecranon process with intraarticular extension of right ulna, initial encounter for closed fracture ☑

S52.041A Displaced fracture of coronoid process of right ulna, initial encounter for closed fracture ☑

S52.044A Nondisplaced fracture of coronoid process of right ulna, initial encounter for closed fracture ☑

S52.091A Other fracture of upper end of right ulna, initial encounter for closed fracture ☑

AMA: **24670** 2022,May **24675** 2022,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
24670	2.69	5.81	0.53	9.03
24675	4.91	8.27	0.94	14.12
Facility RVU	**Work**	**PE**	**MP**	**Total**
24670	2.69	5.04	0.53	8.26
24675	4.91	6.93	0.94	12.78

	FUD	Status	MUE	Modifiers				IOM Reference
24670	90	A	1(2)	51	50	N/A	N/A	None
24675	90	A	1(2)	51	50	N/A	N/A	

* with documentation

Terms To Know

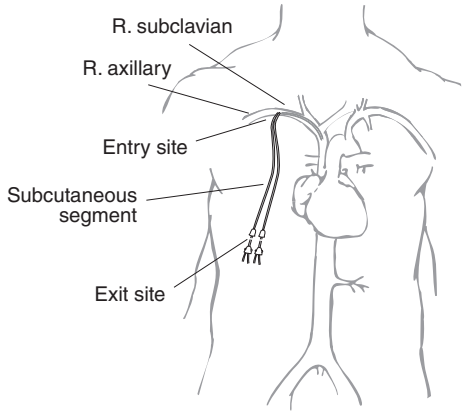
closed fracture. Break in a bone without a concomitant opening in the skin.

closed treatment. Realignment of a fracture or dislocation without surgically opening the skin to reach the site. Treatment methods employed include with or without manipulation and with or without traction.

fragment. Small piece broken off a larger whole; to divide into pieces.

36565

36565 Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; without subcutaneous port or pump (eg, Tesio type catheter)



Tesio type catheters are double lumen devices. They are typically inserted into the superior vena cava and positioned before tunneling to an exit site or connecting to a subcutaneous port

Explanation

For insertion of a tunneled, centrally inserted CVAD, requiring two catheters via two separate venous access sites, without subcutaneous port/pump, the sites of access (e.g., subclavian, jugular vein) for each catheter are injected with local anesthesia and two punctures are made with a needle or cutdown approach. Guidewires are inserted. Two subcutaneous tunnels are created using a blunt pair of forceps or sharp tunneling tools, over the clavicle, from the anterior chest wall to the venotomy sites, which are dilated to the right size. The catheters are each passed through their tunnel, over the guidewires, and into their venotomy sites. Ultrasound guidance may be used to gain venous access and/or fluoroscopy to check the positioning of the catheter tip. The catheters are secured into position and any incisions are sutured.

Coding Tips

When medically necessary, report moderate (conscious) sedation provided by the performing physician with 99151-99153. When provided by another physician, report 99155-99157. If imaging guidance is used, for obtaining access to the venous access site or for manipulating the catheter into its end position, see 76937 and 77001.

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.

Relative Value Units/Medicare Edits

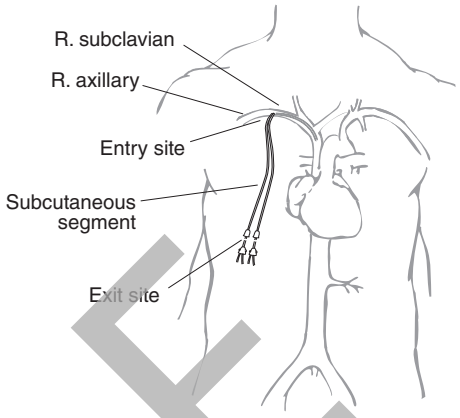
Non-Facility RVU	Work	PE	MP	Total
36565	5.79	17.74	1.25	24.78
Facility RVU	**Work**	**PE**	**MP**	**Total**
36565	5.79	2.87	1.25	9.91

	FUD	Status	MUE	Modifiers				IOM Reference
36565	10	A	1(3)	51	50	N/A	80*	None

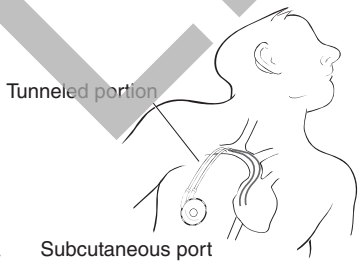
* with documentation

36566

36566 Insertion of tunneled centrally inserted central venous access device, requiring 2 catheters via 2 separate venous access sites; with subcutaneous port(s)



Tesio type catheters are double lumen devices. They are typically inserted into the superior vena cava and positioned before tunneling to an exit site or connecting to a subcutaneous port



Explanation

For insertion of a tunneled, centrally inserted CVAD, requiring two catheters via two separate venous access sites, with subcutaneous ports, the sites of access (e.g., subclavian, jugular vein) for each catheter are injected with local anesthesia and two punctures are made with a needle or cutdown approach. Guidewires are inserted. Two subcutaneous tunnels are created using a blunt pair of forceps or sharp tunneling tools, over the clavicle, from the anterior chest wall to the venotomy sites, which are dilated to the right size. The catheters are each passed through their tunnel over the guidewires and into their venotomy sites. Two subcutaneous pockets for the ports are created with incisions through the skin in the chest wall, a few centimeters from the midline. Blunt dissection and cautery are used to create the pockets in the chest wall and the ports are placed. The catheters are connected to their respective ports and checked by injection. Ultrasound guidance may be used to gain venous access and/or fluoroscopy to check the positioning of the catheter tip. The catheters and ports are secured into position and any incisions are sutured.

Coding Tips

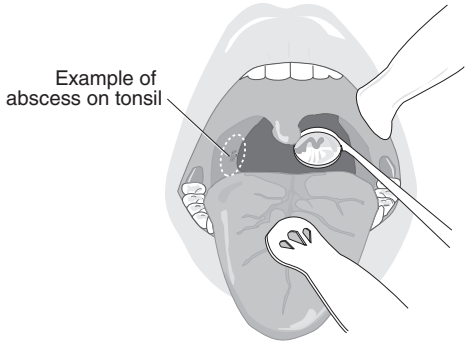
When medically necessary, report moderate (conscious) sedation provided by the performing physician with 99151-99153. When provided by another physician, report 99155-99157. If imaging guidance is used, for obtaining access to the venous access site or for manipulating the catheter into its end position, see 76937 and 77001.

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.

42700

42700 Incision and drainage abscess; peritonsillar



An abscess on or near a tonsil is incised and drained

Explanation

The physician drains an abscess near or on a tonsil. The patient is given a topical anesthetic or placed under general anesthesia. Using an intraoral approach with a mouth gag, the physician incises the mucus membrane of the abscess. The abscess cavity is opened with angulated closed forceps or hemostat. The wound is irrigated and left open.

Coding Tips

For drainage of an abscess, a cyst, or a hematoma in the vestibule of the mouth, see 40800–40801. For incision and drainage of an abscess, a cyst, or a hematoma of the tongue or floor of the mouth, lingual or sublingual, see 41000–41005. It is inappropriate to report supplies when this service is performed in an emergency room. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

J02.0	Streptococcal pharyngitis
J03.01	Acute recurrent streptococcal tonsillitis
J03.80	Acute tonsillitis due to other specified organisms
J03.81	Acute recurrent tonsillitis due to other specified organisms
J35.01	Chronic tonsillitis
J35.03	Chronic tonsillitis and adenoiditis
J35.8	Other chronic diseases of tonsils and adenoids
J36	Peritonsillar abscess

Relative Value Units/Medicare Edits

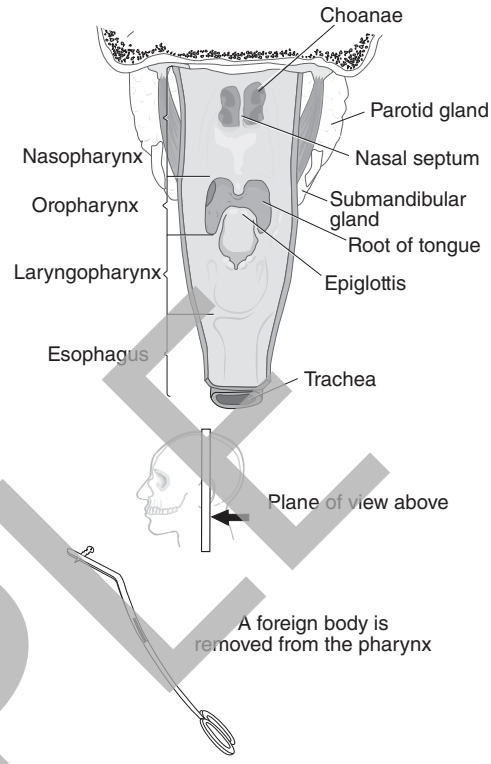
Non-Facility RVU	Work	PE	MP	Total
42700	1.67	3.91	0.25	5.83
Facility RVU	**Work**	**PE**	**MP**	**Total**
42700	1.67	2.17	0.25	4.09

	FUD	Status	MUE	Modifiers				IOM Reference
42700	10	A	2(3)	51	N/A	N/A	N/A	None

* with documentation

42809

42809 Removal of foreign body from pharynx



Explanation

The physician removes a foreign body from the pharynx. The physician uses an intraoral approach with the aid of a tongue blade to visualize the foreign body. The foreign body is grasped with forceps and removed.

Coding Tips

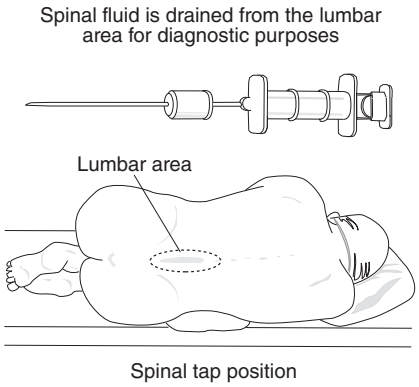
Removal of a foreign body of the pharynx may be reported separately when performed in connection with critical care, see 99291, 99292, and CPT notes for definitions of critical care and other procedures that may be reported. When medically necessary, report moderate (conscious) sedation provided by the performing physician with 99151-99153. When provided by another physician, report 99155-99157. It is inappropriate to report supplies when these services are performed in an emergency room. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

T17.220A	Food in pharynx causing asphyxiation, initial encounter
T17.228A	Food in pharynx causing other injury, initial encounter
T17.290A	Other foreign object in pharynx causing asphyxiation, initial encounter
T17.298A	Other foreign object in pharynx causing other injury, initial encounter

62270 [62328]

62270 Spinal puncture, lumbar, diagnostic;
62328 Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance



Explanation

A diagnostic lumbar puncture, also known as a spinal tap, is performed using anatomical landmarks in 62270 and under fluoroscopic or CT guidance in 62328. The patient is placed in a spinal tap position, either lying on one side or in an upright position. The skin is sterilized and a local anesthetic may be administered. The biopsy needle is inserted and cerebrospinal fluid (CSF) is withdrawn for diagnostic testing. Upon completion of the procedure, the needle is removed and a small sterile dressing is applied to the wound.

Coding Tips

Injection of contrast is included in these procedures and should not be reported separately. Do not report these codes with 77003 or 77012. For ultrasound or MRI guidance, see 76942 and 77021.

ICD-10-CM Diagnostic Codes

A52.19 Other symptomatic neurosyphilis
A52.2 Asymptomatic neurosyphilis
B00.82 Herpes simplex myelitis
B01.12 Varicella myelitis
B02.24 Postherpetic myelitis
B45.1 Cerebral cryptococcosis
C41.2 Malignant neoplasm of vertebral column
C70.1 Malignant neoplasm of spinal meninges
C71.5 Malignant neoplasm of cerebral ventricle
C71.8 Malignant neoplasm of overlapping sites of brain
C72.0 Malignant neoplasm of spinal cord
C72.1 Malignant neoplasm of cauda equina
C79.31 Secondary malignant neoplasm of brain
C79.32 Secondary malignant neoplasm of cerebral meninges
D32.0 Benign neoplasm of cerebral meninges
D32.1 Benign neoplasm of spinal meninges
D33.0 Benign neoplasm of brain, supratentorial
D33.1 Benign neoplasm of brain, infratentorial
D33.4 Benign neoplasm of spinal cord
D33.7 Benign neoplasm of other specified parts of central nervous system
D42.0 Neoplasm of uncertain behavior of cerebral meninges
D42.1 Neoplasm of uncertain behavior of spinal meninges
D43.0 Neoplasm of uncertain behavior of brain, supratentorial
D43.1 Neoplasm of uncertain behavior of brain, infratentorial
D43.4 Neoplasm of uncertain behavior of spinal cord
E74.810 Glucose transporter protein type 1 deficiency
E74.818 Other disorders of glucose transport
E74.89 Other specified disorders of carbohydrate metabolism
G00.0 Hemophilus meningitis
G00.1 Pneumococcal meningitis
G00.2 Streptococcal meningitis
G00.3 Staphylococcal meningitis
G00.8 Other bacterial meningitis
G03.0 Nonpyogenic meningitis
G03.1 Chronic meningitis
G03.8 Meningitis due to other specified causes
G04.01 Postinfectious acute disseminated encephalitis and encephalomyelitis (postinfectious ADEM)
G04.02 Postimmunization acute disseminated encephalitis, myelitis and encephalomyelitis
G04.2 Bacterial meningoencephalitis and meningomyelitis, not elsewhere classified
G04.31 Postinfectious acute necrotizing hemorrhagic encephalopathy
G04.32 Postimmunization acute necrotizing hemorrhagic encephalopathy
G04.39 Other acute necrotizing hemorrhagic encephalopathy
G04.81 Other encephalitis and encephalomyelitis
G04.82 Acute flaccid myelitis
G04.89 Other myelitis
G06.1 Intraspinal abscess and granuloma
G35 Multiple sclerosis
G61.0 Guillain-Barre syndrome
G61.81 Chronic inflammatory demyelinating polyneuritis
G61.89 Other inflammatory polyneuropathies
G91.2 (Idiopathic) normal pressure hydrocephalus
G93.2 Benign intracranial hypertension
G93.7 Reye's syndrome P
G95.0 Syringomyelia and syringobulbia
G95.11 Acute infarction of spinal cord (embolic) (nonembolic)
G95.89 Other specified diseases of spinal cord
G96.12 Meningeal adhesions (cerebral) (spinal)
I60.01 Nontraumatic subarachnoid hemorrhage from right carotid siphon and bifurcation ☑
I60.02 Nontraumatic subarachnoid hemorrhage from left carotid siphon and bifurcation ☑
I60.11 Nontraumatic subarachnoid hemorrhage from right middle cerebral artery ☑
I60.12 Nontraumatic subarachnoid hemorrhage from left middle cerebral artery ☑
I60.31 Nontraumatic subarachnoid hemorrhage from right posterior communicating artery ☑
I60.32 Nontraumatic subarachnoid hemorrhage from left posterior communicating artery ☑
I60.4 Nontraumatic subarachnoid hemorrhage from basilar artery
I60.51 Nontraumatic subarachnoid hemorrhage from right vertebral artery ☑
I60.52 Nontraumatic subarachnoid hemorrhage from left vertebral artery ☑

93000-93010

93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93005 tracing only, without interpretation and report
93010 interpretation and report only

Explanation

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

Coding Tips

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

ICD-10-CM Diagnostic Codes

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

Associated HCPCS Codes

G0403 Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report

G0404 Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination

G0405 Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination

AMA: **93000** 2020,Dec; 2017,Oct **93005** 2020,Dec; 2017,Oct **93010** 2021,May; 2020,Dec

Relative Value Units/Medicare Edits

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

	FUD	Status	MUE	Modifiers				IOM Reference
93000	N/A	A	3(3)	N/A	N/A	N/A	80*	100-03,160.17; 100-04,18,80.2
93005	N/A	A	3(3)	N/A	N/A	N/A	80*	
93010	N/A	A	5(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

EKG. Electrocardiogram. Graphic recording of the changes in electrical voltage and polarity caused by the heart muscle's electrical excitation. The tracing follows atrial and ventricular activity over time, captured through electrodes placed on the skin.

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

93040-93042

93040 Rhythm ECG, 1-3 leads; with interpretation and report
93041 tracing only without interpretation and report
93042 interpretation and report only

Explanation

An assistant records the electrical activity of the heart by placing one to three electrodes on a patient's chest in a predetermined pattern. Report 93040 when the physician interprets the report. Report 93041 when only the tracing is performed. Report 93042 when a physician interprets a previously acquired report.

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: **93040** 2020,Dec; 2020,Sep; 2017,Oct **93041** 2020,Dec; 2017,Oct **93042** 2020,Dec; 2017,Oct

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
93040	0.15	0.21	0.02	0.38
93041	0.0	0.17	0.01	0.18
93042	0.15	0.04	0.01	0.2
Facility RVU	**Work**	**PE**	**MP**	**Total**
93040	0.15	0.21	0.02	0.38
93041	0.0	0.17	0.01	0.18
93042	0.15	0.04	0.01	0.2

	FUD	Status	MUE	Modifiers				IOM Reference
93040	N/A	A	3(3)	N/A	N/A	N/A	80*	100-04,32,130.1
93041	N/A	A	2(3)	N/A	N/A	N/A	80*	
93042	N/A	A	3(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

EKG. Electrocardiogram. Graphic recording of the changes in electrical voltage and polarity caused by the heart muscle's electrical excitation. The tracing follows atrial and ventricular activity over time, captured through electrodes placed on the skin.

electrode. Electric terminal specialized for a particular electrochemical reaction that acts as a medium between a body surface and another instrument, commonly termed a lead.

90654 [90630]

90654 Influenza virus vaccine, trivalent (IIV3), split virus, preservative-free, for intradermal use

90630 Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, for intradermal use

Explanation

A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of the antibody production pattern for long-term protection. A trivalent (IIV3) or quadrivalent (IIV4), split virus suspension, preservative free vaccine of the prevalent strains of influenza is prepared for intradermal injection. Report 90654 for the trivalent vaccine and 90630 for the quadrivalent vaccine. Report these codes in addition to the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90630	0.0	0.0	0.0	0.0
90654	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90630	0.0	0.0	0.0	0.0
90654	0.0	0.0	0.0	0.0

90655-90656

90655 Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.25 mL dosage, for intramuscular use

90656 Influenza virus vaccine, trivalent (IIV3), split virus, preservative free, 0.5 mL dosage, for intramuscular use

Explanation

These codes report the supply of the vaccine only. A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of the antibody production pattern for long-term protection. A split virus suspension of three (two influenza A and one influenza B) (IIV3) of the most prevalent strains of influenza is prepared for intramuscular injection. Report 90655 for a 0.25 mL dose of preservative free, split virus influenza vaccine and 90656 for a 0.50 mL dose. Report these codes with the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90655	0.0	0.0	0.0	0.0
90656	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90655	0.0	0.0	0.0	0.0
90656	0.0	0.0	0.0	0.0

90657-90658

90657 Influenza virus vaccine, trivalent (IIV3), split virus, 0.25 mL dosage, for intramuscular use

90658 Influenza virus vaccine, trivalent (IIV3), split virus, 0.5 mL dosage, for intramuscular use

Explanation

These codes report the supply of the vaccine only. A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of the antibody production pattern for long-term protection. A split virus suspension of three (two influenza A and one influenza B) (IIV3) of the most prevalent strains of influenza is prepared for intramuscular use. Report 90657 for a 0.25 mL dose and 90658 for a 0.5 mL dose. The vaccine induces active immunity to the highly contagious infection of the respiratory tract caused by a myxovirus and transmitted by airborne droplet infection. Report these codes with the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90657	0.0	0.0	0.0	0.0
90658	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90657	0.0	0.0	0.0	0.0
90658	0.0	0.0	0.0	0.0

90660 [90672]

90660 Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use

90672 Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use

Explanation

A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of the antibody production pattern for long-term protection. A suspension of the prevalent strains of influenza virus is prepared for intranasal use. This live vaccination (LAIV3, LAIV4) contains the actual pathogen that has been weakened. Report these codes with the appropriate administration code. Report 90660 when the vaccine contains three strains. Report 90672 if the vaccine is comprised of four strains.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90660	0.0	0.0	0.0	0.0
90672	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90660	0.0	0.0	0.0	0.0
90672	0.0	0.0	0.0	0.0

90661

90661 Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use

Explanation

A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of the antibody production pattern for long-term protection. A suspension of the prevalent strain of influenza virus that has been derived from cell cultures is prepared for intramuscular use. Cell culture-derived vaccines are those in which the virus is grown in mammalian cells rather than egg-derived. The vaccine provides active immunity to the highly contagious infection of the respiratory tract caused by a myxovirus and transmitted by airborne droplet infection. This vaccine (ccIIV3) is preservative and antibiotic-free. This code reports a subunit in a 0.5 mL dose and should be reported with the appropriate administration code.