Optum

Coding Companion

Plastics/ Dermatology

A comprehensive illustrated guide to coding and reimbursement

2024

optumcoding.com

Contents

Getting Started with Coding Companion

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

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

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to plastics/dermatology are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT/HCPCS code is followed by its official CPT code description.

Resequencing of CPT Codes

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

CPT codes within the 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 code description, followed by an easy-to-understand explanation.

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

- HCPCS
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

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

CCI Edits, 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 28.3, 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 2024 edition password is: **XXXXX**. Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

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

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

Brow Ptosis
Repair, 67900

or **Eyebrow**
Repair
Ptosis, 67900

or **Repair**
Eyebrow
Ptosis, 67900

General Guidelines

Providers

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

Supplies

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

Professional and Technical Component

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

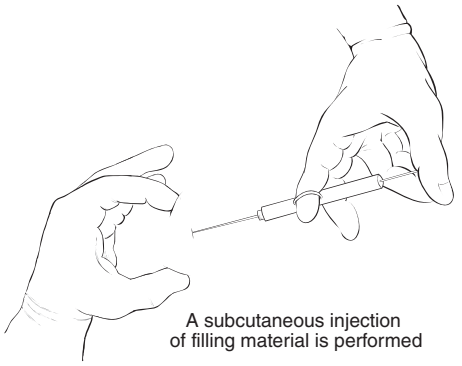
Sample Page and Key

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

11950-11954 1

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

2



A subcutaneous injection of filling material is performed

Explanation 3

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

Coding Tips 4

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

ICD-10-CM Diagnostic Codes 5

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

Associated HCPCS Codes 6

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

AMA: **11950** 2022,Feb; 2021,Aug; 2019,Aug **11951** 2022,Feb; 2021 2019,Aug **11952** 2022,Feb; 2021,Aug; 2019,Aug **11954** 2022,Feb; 2021,Aug; 2019,Aug 7

Relative Value Units/Medicare Edits 8

Non-Facility RVU	Work	PE	MP	Total
11950	0.84	1.39	0.14	2.37
11951	1.19	1.77	0.22	3.18
11952	1.69	2.25	0.31	4.25
11954	1.85	2.49	0.34	4.68
Facility RVU	**Work**	**PE**	**MP**	**Total**
11950	0.84	0.54	0.14	1.52
11951	1.19	0.74	0.22	2.15
11952	1.69	1.03	0.31	3.03
11954	1.85	1.12	0.34	3.31

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

* with documentation

Terms To Know 9

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

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

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

cosmetic. Superficial or external, having no medical necessity.

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

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

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

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

microcheilia. Congenital condition of abnormally small lips.

soft tissue. Nonepithelial tissues outside of the skeleton.

subcutaneous. Below the skin.

1. CPT/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 additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE), some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 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	96160	96161	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 2023 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 2023 edition password is **23SPECIALTY**.

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

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.

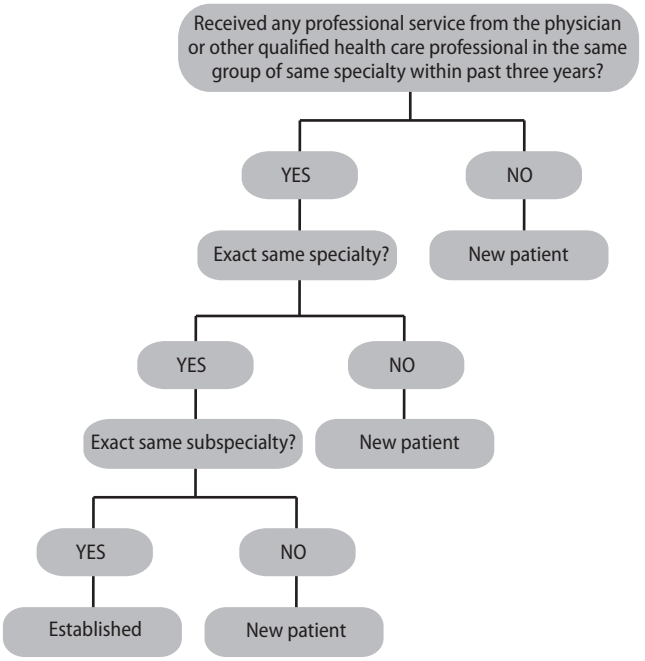
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the 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



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

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For patients admitted and discharged from inpatient or observation care on the same date, see 99234-99236. For prolonged services with 99205, see 99417; for Medicare, see G2212. Medicare has identified these codes as telehealth/telemedicine services. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

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

AMA: **99202** 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; 2016,Dec; 2016,Mar; 2016,Jan **99203** 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; 2016,Dec; 2016,Mar; 2016,Jan **99204** 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; 2016,Dec; 2016,Mar; 2016,Jan **99205** 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; 2016,Dec; 2016,Mar; 2016,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.12	0.09	2.14
99203	1.6	1.52	0.17	3.29
99204	2.6	2.06	0.24	4.9
99205	3.5	2.66	0.32	6.48
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.17	2.44
99204	2.6	1.11	0.24	3.95
99205	3.5	1.54	0.32	5.36

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

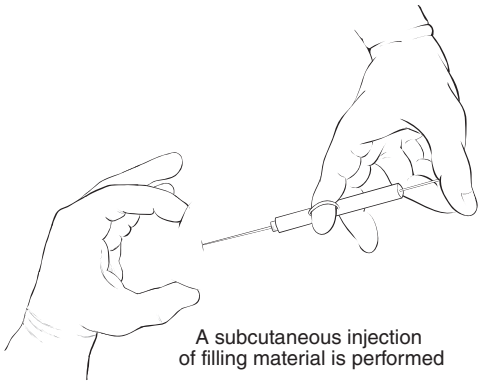
* with documentation

Terms To Know

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

11950-11954

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



A subcutaneous injection of filling material is performed

Explanation

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

Coding Tips

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

ICD-10-CM Diagnostic Codes

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

Associated HCPCS Codes

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

AMA: **11950** 2022,Feb; 2021,Aug; 2019,Aug **11951** 2022,Feb; 2021,Aug; 2019,Aug **11952** 2022,Feb; 2021,Aug; 2019,Aug **11954** 2022,Feb; 2021,Aug; 2019,Aug

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11950	0.84	1.39	0.14	2.37
11951	1.19	1.77	0.22	3.18
11952	1.69	2.25	0.31	4.25
11954	1.85	2.49	0.34	4.68
Facility RVU	**Work**	**PE**	**MP**	**Total**
11950	0.84	0.54	0.14	1.52
11951	1.19	0.74	0.22	2.15
11952	1.69	1.03	0.31	3.03
11954	1.85	1.12	0.34	3.31

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

* with documentation

Terms To Know

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

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

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

cosmetic. Superficial or external, having no medical necessity.

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

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

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

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

microcheilia. Congenital condition of abnormally small lips.

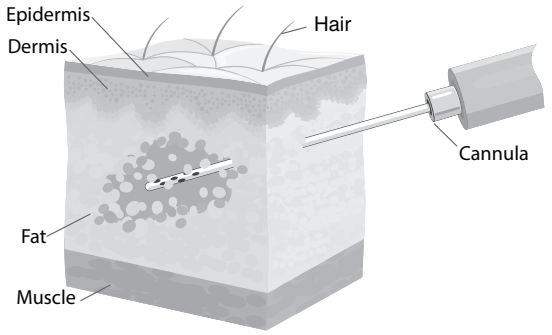
soft tissue. Nonepithelial tissues outside of the skeleton.

subcutaneous. Below the skin.

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

15876-15879

15876 Suction assisted lipectomy; head and neck
15877 trunk
15878 upper extremity
15879 lower extremity



Explanation

The physician performs a lipectomy. The physician makes small incisions in the skin overlying an area of fat deposits on the area being treated. A liposuction cannula is inserted through the incision. The physician moves the cannula through the fat deposits, creating tunnels and removing excess deposits. The incisions are closed with sutures. For lipectomy of the head and neck, see 15876; trunk, see 15877; upper extremity, see 15878; lower extremity, see 15879.

Coding Tips

When 15876–15879 are performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. For the harvesting of adipose fat grafting via a liposuction technique, see 15771-15774. For the harvesting of adipose tissue for autologous adipose-derived regenerative cell therapy, see 0489T. Do not report 15876–15879 with 15771-15774 or 0489T–0490T. Because these procedures may be performed for cosmetic purposes, verify with the insurance carrier for coverage.

ICD-10-CM Diagnostic Codes

E65	Localized adiposity
E66.01	Morbid (severe) obesity due to excess calories
E66.09	Other obesity due to excess calories
E66.1	Drug-induced obesity
E66.2	Morbid (severe) obesity with alveolar hypoventilation
E66.3	Overweight
E66.8	Other obesity
Z41.1	Encounter for cosmetic surgery

AMA: 15876 2022,May; 2022,Feb; 2021,Aug; 2019,Oct; 2019,Aug; 2018,Sep **15877** 2022,May; 2022,Feb; 2021,Aug; 2021,Apr; 2019,Oct; 2019,Aug; 2018,Sep **15878** 2022,May; 2022,Feb; 2021,Aug; 2019,Oct; 2019,Aug; 2018,Sep **15879** 2022,May; 2022,Feb; 2021,Aug; 2019,Oct; 2019,Aug; 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
15876	0.0	0.0	0.0	0.0
15877	0.0	0.0	0.0	0.0
15878	0.0	0.0	0.0	0.0
15879	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
15876	0.0	0.0	0.0	0.0
15877	0.0	0.0	0.0	0.0
15878	0.0	0.0	0.0	0.0
15879	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
15876	0	R	1(2)	51	N/A	N/A	80*	100-02,16,10; 100-02,16,120; 100-02,16,180; 100-03,140.4
15877	0	R	1(2)	51	N/A	N/A	80*	
15878	0	R	1(2)	51	50	N/A	80*	
15879	0	R	1(2)	51	50	N/A	80*	

* with documentation

Terms To Know

adiposity. Site or organ that is fatty in nature.

cannula. Tube inserted into a blood vessel, duct, or body cavity to facilitate passage.

cosmetic. Superficial or external, having no medical necessity.

incision. Act of cutting into tissue or an organ.

lipectomy. Surgical excision of fatty tissue that may be performed with or without suction-assistance.

lipodystrophy. Loss of fatty tissue in areas of the body due to a disturbance of metabolism.

lipoma. Benign tumor containing fat cells and the most common of soft tissue lesions, which are usually painless and asymptomatic, with the exception of an angiolipoma.

suture. Numerous stitching techniques employed in wound closure.

buried suture. Continuous or interrupted suture placed under the skin for a layered closure.

continuous suture. Running stitch with tension evenly distributed across a single strand to provide a leakproof closure line.

interrupted suture. Series of single stitches with tension isolated at each stitch, in which all stitches are not affected if one becomes loose, and the isolated sutures cannot act as a wick to transport an infection.

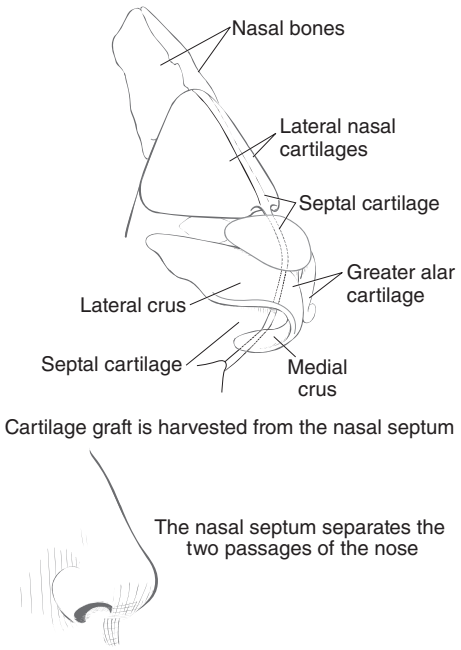
purse-string suture. Continuous suture placed around a tubular structure and tightened, to reduce or close the lumen.

retention suture. Secondary stitching that bridges the primary suture, providing support for the primary repair; a plastic or rubber bolster may be placed over the primary repair and under the retention sutures.

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

20912

20912 Cartilage graft; nasal septum



Explanation

The physician takes a cartilage graft from the nasal septum for later use in an autologous reconstructive procedure. For instance, harvested nasal cartilage is often used as a spreader graft or as a nasal alar batten graft to repair a dysfunctional or collapsed internal nasal valve. Usually under local anesthesia and through a small internal incision (6-8 mm), the physician harvests a piece of septal cartilage from within the nose for later grafting. Graft sizes vary and can be 1-3 mm thick, from 4-8 mm wide, and up to 35 mm in length. A generous amount of cartilage must be maintained to continue functioning as nasal support.

Coding Tips

The harvest of autogenous bone, cartilage, tendon, fascia lata grafts, or other tissues through separate incisions is to be reported only when a graft is not already listed as part of the basic procedure. Local anesthesia is included in this service. For a cartilage graft harvested from the ear, see 21235. Do not append modifier 62 with 20912.

ICD-10-CM Diagnostic Codes

C30.0	Malignant neoplasm of nasal cavity
C41.0	Malignant neoplasm of bones of skull and face
C43.31	Malignant melanoma of nose
C44.311	Basal cell carcinoma of skin of nose
C44.321	Squamous cell carcinoma of skin of nose
C44.391	Other specified malignant neoplasm of skin of nose
C4A.31	Merkel cell carcinoma of nose
C76.0	Malignant neoplasm of head, face and neck
D14.0	Benign neoplasm of middle ear, nasal cavity and accessory sinuses
D16.4	Benign neoplasm of bones of skull and face
D22.39	Melanocytic nevi of other parts of face
D23.39	Other benign neoplasm of skin of other parts of face
D36.7	Benign neoplasm of other specified sites
J34.0	Abscess, furuncle and carbuncle of nose
J34.1	Cyst and mucocele of nose and nasal sinus
J34.81	Nasal mucositis (ulcerative)
M95.0	Acquired deformity of nose
Q30.0	Choanal atresia
Q30.1	Agenesis and underdevelopment of nose
Q30.2	Fissured, notched and cleft nose
Q30.3	Congenital perforated nasal septum
Q30.8	Other congenital malformations of nose
S01.21XA	Laceration without foreign body of nose, initial encounter
S01.22XA	Laceration with foreign body of nose, initial encounter
S01.23XA	Puncture wound without foreign body of nose, initial encounter
S01.24XA	Puncture wound with foreign body of nose, initial encounter
S01.25XA	Open bite of nose, initial encounter
S08.811A	Complete traumatic amputation of nose, initial encounter
S08.812A	Partial traumatic amputation of nose, initial encounter
T17.0XXA	Foreign body in nasal sinus, initial encounter
T20.34XA	Burn of third degree of nose (septum), initial encounter
T20.74XA	Corrosion of third degree of nose (septum), initial encounter
Z41.1	Encounter for cosmetic surgery
Z42.8	Encounter for other plastic and reconstructive surgery following medical procedure or healed injury

AMA: 20912 2021,Dec; 2021,Jul; 2020,May; 2018,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
20912	6.54	6.73	0.99	14.26
Facility RVU	**Work**	**PE**	**MP**	**Total**
20912	6.54	6.73	0.99	14.26

	FUD	Status	MUE	Modifiers				IOM Reference
20912	90	A	1(3)	51	N/A	N/A	80*	None

* with documentation

Terms To Know

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

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

nasal septum. Membrane made of cartilage, bone, and mucosa that partitions the two nostrils, or nasal cavities, down the middle.

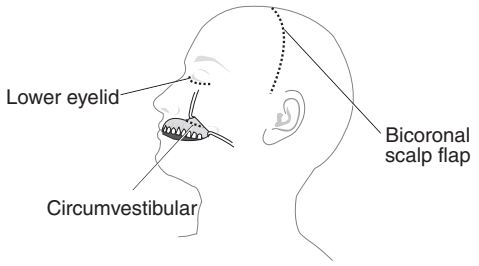
reconstruction. Recreating, restoring, or rebuilding a body part or organ.

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

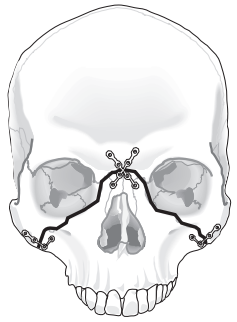
21347-21348

21347 Open treatment of nasomaxillary complex fracture (LeFort II type); requiring multiple open approaches

21348 with bone grafting (includes obtaining graft)



Typical transcutaneous and transoral incisions



Fracture is reduced with wires, plates, and/or screws

Explanation

In 21347, the physician realigns a complex pyramidal (LeFort II type) midface fracture of the nasomaxillary complex using more than one site of open access. Multiple incisions are made to expose the fracture sites. These incisions include the bicoronal scalp flap, lower eyelid, and transoral incisions. The nasomaxillary complex is manipulated, realigning the fractured bones. The fracture is stabilized with wires, plates, and/or screws. In 21348, the physician realigns a complex pyramidal (LeFort II type) midface fracture of the nasomaxillary complex with bone grafting. Access incisions may include the bicoronal scalp flap, lower eyelid, and/or transoral incisions. The pyramidal fracture is exposed and the complex is manipulated, realigning the fractured bones. Comminution of bone (e.g., nasofrontal region, orbital floors) requires bone grafting of these areas. The physician uses wires, plates, and/or screws to stabilize the fracture. Through a separate incision, the physician may harvest a bone graft from the patient's hip, rib, or skull and close the surgically created wound. The physician reconstructs areas of bony defect. In both procedures, the transoral incision is then closed in a single layer. The scalp and lower eyelid incisions are repaired with a layered closure. Intermaxillary fixation may be used to additionally stabilize the fracture.

Coding Tips

This procedure includes obtaining the graft. For radiology services, see 70140–70170.

ICD-10-CM Diagnostic Codes

S02.412A LeFort II fracture, initial encounter for closed fracture

S02.412B LeFort II fracture, initial encounter for open fracture

AMA: **21347** 2022,May **21348** 2022,May

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21347	13.53	15.57	1.94	31.04
21348	17.52	12.35	2.49	32.36
Facility RVU	**Work**	**PE**	**MP**	**Total**
21347	13.53	15.57	1.94	31.04
21348	17.52	12.35	2.49	32.36

	FUD	Status	MUE	Modifiers				IOM Reference
21347	90	A	1(2)	51	N/A	62*	80	None
21348	90	A	1(2)	51	N/A	62	80	

* with documentation

Terms To Know

approach. Method or anatomical location used to gain access to a body organ or specific area for procedures.

bone graft. Bone that is removed from one part of the body and placed into another bone site without direct re-establishment of blood supply.

comminuted fracture. Any type of fracture in which the bone is splintered or crushed, resulting in multiple bone fragments.

fixation. Act or condition of being attached, secured, fastened, or held in position.

incision. Act of cutting into tissue or an organ.

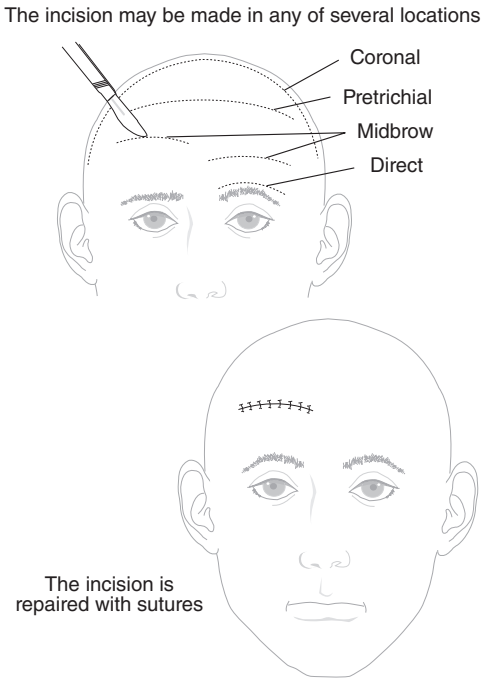
LeFort II type fracture. Unilateral or bilateral fracture of the maxilla in which it is separated from the facial skeleton in a pyramid shape. The fracture can extend through the maxilla and hard palate, through the orbit floor, and into the nasal cavity.

nonunion. Failure of two ends of a fracture to mend or completely heal.

stabilization. Fixed, firm state that is resistant to change.

67900

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



Explanation

Ptosis refers to a droop or displacement resulting from paralysis. The physician makes an incision directly above the brow (supraciliary), through the mid-forehead or near the hairline (coronal). A dissection is carried down to the area of the brow. The skin is pulled superiorly and the brow approximated to its proper position above the supraorbital rim. The incision is repaired with sutures.

Coding Tips

For blepharoptosis repair, see 67901–67908. For forehead rhytidectomy, see 15824. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

H02.411	Mechanical ptosis of right eyelid ☑
H02.412	Mechanical ptosis of left eyelid ☑
H02.421	Myogenic ptosis of right eyelid ☑
H02.422	Myogenic ptosis of left eyelid ☑
H02.431	Paralytic ptosis of right eyelid ☑
H02.432	Paralytic ptosis of left eyelid ☑
H53.451	Other localized visual field defect, right eye ☑
H53.452	Other localized visual field defect, left eye ☑
H57.811	Brow ptosis, right ☑
H57.812	Brow ptosis, left ☑
Z41.1	Encounter for cosmetic surgery

AMA: **67900** 2016,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
67900	6.82	11.69	0.61	19.12
Facility RVU	**Work**	**PE**	**MP**	**Total**
67900	6.82	7.21	0.61	14.64

	FUD	Status	MUE	Modifiers				IOM Reference
67900	90	A	1(2)	51	50	N/A	N/A	100-02,16,120

* with documentation

Terms To Know

blepharochalasis. Loss of elasticity and relaxation of skin of the eyelid, thickened or indurated skin on the eyelid associated with recurrent episodes of edema, and intracellular atrophy.

dissection. Separating by cutting tissue or body structures apart.

exophthalmos. Abnormal bulging or protrusion of the eyeballs, seen in cases of hyperthyroidism, like Grave's disease and toxic diffuse goiter, or as a congenital condition.

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

paralytic lagophthalmos. Palsy of the seventh cranial nerve, which prevents full closure of the eyelids.

ptosis. Drooping or displacement of the upper eyelid, caused by paralysis, muscle problems, or outside mechanical forces.

suture. Numerous stitching techniques employed in wound closure.

buried suture. Continuous or interrupted suture placed under the skin for a layered closure.

continuous suture. Running stitch with tension evenly distributed across a single strand to provide a leakproof closure line.

interrupted suture. Series of single stitches with tension isolated at each stitch, in which all stitches are not affected if one becomes loose, and the isolated sutures cannot act as a wick to transport an infection.

purse-string suture. Continuous suture placed around a tubular structure and tightened, to reduce or close the lumen.

retention suture. Secondary stitching that bridges the primary suture, providing support for the primary repair; a plastic or rubber bolster may be placed over the primary repair and under the retention sutures.

G0316

- **G0316** Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (Do not report G0316 on the same date of service as other prolonged services for evaluation and management codes 99358, 99359, 99418, 99415, 99416). (Do not report G0316 for any time unit less than 15 minutes)

Explanation

The physician or qualified health care professional provides prolonged hospital inpatient or observation care (including partial hospitalization) evaluation and management (E/M) services, with or without direct patient contact. Report G0316 as an add-on code to represent each additional 15 minutes of services provided beyond the greatest amount of allowed time of the highest-level primary E/M service. These primary services include initial or subsequent inpatient or observation care, as well as that for patients whose admission and discharge occur on the same day, and do not differentiate between new or established patients. Note: G0316 has been added to the Medicare telehealth services list, effective through the end of calendar year 2023.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0316				
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0316				

G0317

- **G0317** Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99306, 99310 for nursing facility evaluation and management services). (Do not report G0317 on the same date of service as other prolonged services for evaluation and management codes 99358, 99359, 99418). (Do not report G0317 for any time unit less than 15 minutes)

Explanation

The physician or qualified health care professional provides prolonged nursing facility evaluation and management (E/M) services, with or without direct patient contact. Report G0317 as an add-on code to represent each additional 15 minutes of services provided beyond the greatest amount of allowed time of the highest-level primary E/M service. These primary services include initial or subsequent nursing facility care that may be provided in nursing facilities and skilled nursing facilities, or for services in psychiatric residential treatment centers or immediate care facilities for patients with intellectual disabilities. They do not differentiate between new or established patients. Note: G0317 has been added to the Medicare telehealth services list, effective through the end of calendar year 2023.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0317				
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0317				

G0318

- **G0318** Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99345, 99350 for home or residence evaluation and management services). (Do not report G0318 on the same date of service as other prolonged services for evaluation and management codes 99358, 99359, 99417). (Do not report G0318 for any time unit less than 15 minutes)

Explanation

The physician or qualified health care professional provides prolonged evaluation and management (E/M) services, with or without direct patient contact, in a home or residence. Report G0318 as an add-on code to represent each additional 15 minutes of services provided beyond the greatest amount of allowed time of the highest-level primary E/M service. These primary services include the evaluation and management of a new or an established patient in a private residence or temporary lodging. Short-term accommodations such as a hotel, campground, hostel, or cruise ship are included, along with assisted living facility, group home, custodial care facility, or residential substance abuse treatment facility. Note: G0318 has been added to the Medicare telehealth services list, effective through the end of calendar year 2023.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0318				
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0318				

G0429

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

Explanation

Facial lipodystrophy syndrome (LDS) is a condition that is characterized by localized loss of fat in the face. This loss of fat results in a facial abnormality, such as severely sunken cheeks. Patients with HIV can suffer from this condition due to antiviral treatment or the disease itself. Due to appearance, patients with LDS may discontinue treatment and feel depressed and stigmatized. Dermal filler injection gradually increases the fullness in the face to provide a more normal appearance. The treatment area is sterilely prepped and a series of injections are administered into the deep dermal, subcutaneous areas, or by depot technique. The areas are massaged periodically during the treatment to distribute the medication evenly. The patient may need additional injection sessions to obtain the desired result. This code includes the medication.

Correct Coding Initiative Update 28.3

❖Indicates Mutually Exclusive Edit

0419T 0213T, 0216T, 0596T-0597T, 0708T-0709T, 11057, 11102, 11104, 11106, 11900-11901, 12001-12007, 12011-12057, 13100-13133, 13151-13153, 17110-17111, 36000, 36400-36410, 36420-36430, 36440, 36591-36592, 36600, 36640, 43752, 51701-51703, 61650, 62320-62327, 64400, 64405-64408, 64415-64435, 64445-64454, 64461, 64463, 64479, 64483, 64486-64490, 64493, 64505, 64510-64530, 69990, 92012-92014, 93000-93010, 93040-93042, 93318, 93355, 94002, 94200, 94680-94690, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96377, 96523, 99155, 99156, 99157, 99211-99223, 99231-99255, 99291-99292, 99304-99310, 99315-99316, 99334-99337, 99347-99350, 99374-99375, 99377-99378, 99446-99449, 99451-99452, 99495-99496, G0463, G0471, J0670, J2001

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