Optum

Coding Companion

ENT/Allergy/ Pulmonology

A comprehensive illustrated guide to coding and reimbursement

SAMPLE

2025

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Getting Started with Coding Companion

Coding Companion for ENT/Allergy/Pulmonology 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 ENT/allergy/pulmonology 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/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:

69501 Transmastoid antrotomy (simple mastoidectomy)

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

Antrotomy
Transmastoid, 69501

or **Excision**
Mastoid
Simple, 69501

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.

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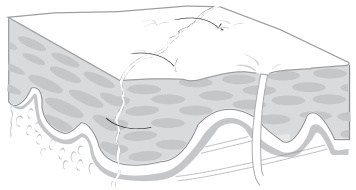
12001-12007

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, or trunk 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. Intermediate repair is used when layered closure of one or more of the deeper layers of subcutaneous tissue and superficial fascia, in addition to the skin, require closure. Intermediate repair is also reported for single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter. 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. 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. For wound closure by tissue adhesive(s) only, see HCPCS Level II code G0168.

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
S11.81XA Laceration without foreign body of other specified part of neck, initial encounter
S11.83XA Puncture wound without foreign body of other specified part of neck, initial encounter
S11.89XA Other open wound of other specified part of neck, initial encounter

Associated HCPCS Codes

G0168 Wound closure utilizing tissue adhesive(s) only

AMA: **12001** 2023,Aug; 2023,Mar; 2022,Aug; 2022,Feb; 2021,Aug; 2018, 2017,Dec **12002** 2023,Aug; 2023,Jul; 2022,Aug; 2022,Feb; 2021,Aug; 2018, **12004** 2023,Aug; 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12005** 2023,Aug; 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12006** 2023,Aug; 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep **12007** 2023,Aug; 2022,Aug; 2022,Feb; 2021,Aug; 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
12001	0.84	1.82	0.17	2.83
12002	1.14	2.06	0.22	3.42
12004	1.44	2.26	0.27	3.97
12005	1.97	2.97	0.37	5.31
12006	2.39	3.32	0.46	6.17
12007	2.9	3.49	0.56	6.95
Facility RVU	**Work**	**PE**	**MP**	**Total**
12001	0.84	0.33	0.17	1.34
12002	1.14	0.39	0.22	1.75
12004	1.44	0.46	0.27	2.17
12005	1.97	0.47	0.37	2.81
12006	2.39	0.61	0.46	3.46
12007	2.9	0.84	0.56	4.3

	FUD	Status	MUE	Modifiers				IOM Reference
12001	0	A	1(2)	51	N/A	N/A	N/A	None
12002	0	A	1(2)	51	N/A	N/A	N/A	
12004	0	A	1(2)	51	N/A	N/A	N/A	
12005	0	A	1(2)	51	N/A	N/A	N/A	
12006	0	A	1(2)	51	N/A	N/A	N/A	
12007	0	A	1(2)	51	N/A	62*	N/A	

* with documentation

Terms To Know

closure. Repairing an incision or wound by suture or other means.

epidermis. Outermost, nonvascular layer of skin that contains four to five differentiated layers depending on its body location: stratum corneum, lucidum, granulosum, spinosum, and basale.

injury. Harm or damage sustained by the body.

laceration. Tearing injury; a torn, ragged-edged wound.

superficial. On the skin surface or near the surface of any involved structure or field of interest.

suture. Numerous stitching techniques employed in wound closure.

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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

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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.

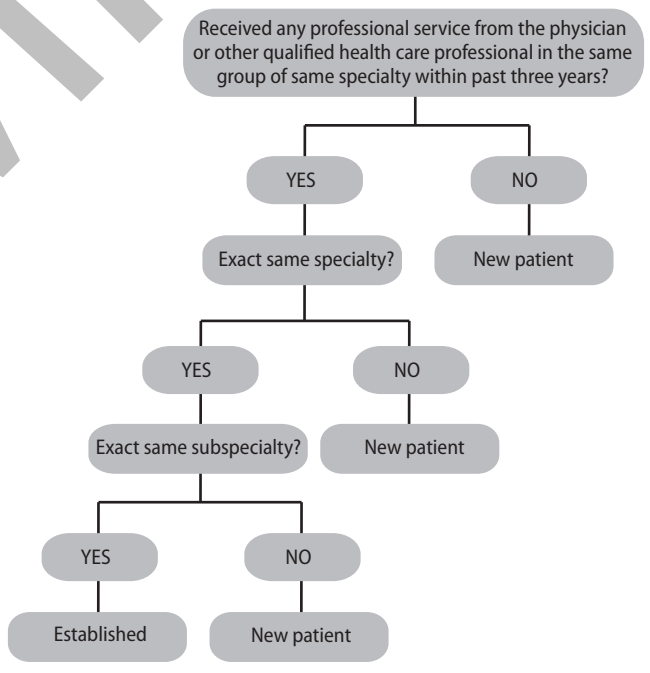
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the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

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

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▶ ◀ = Contains new or revised text

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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

SAMPLE

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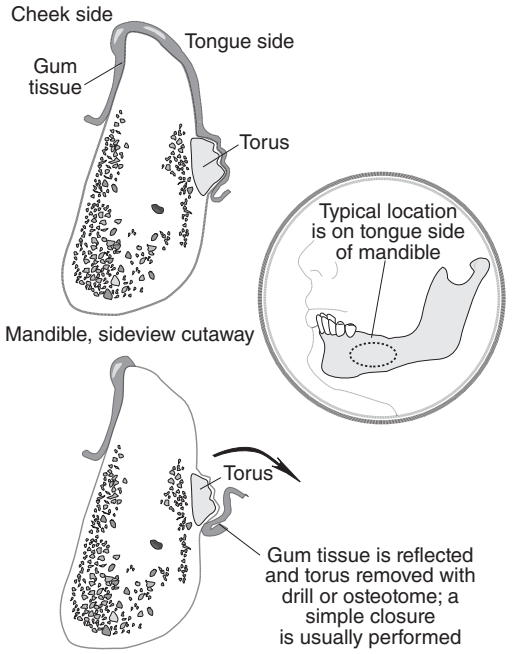
21031

21031 Excision of torus mandibularis



Explanation

The physician removes a benign outgrowth of bone (torus mandibularis), most commonly from the lingual (tongue) side of the mandible. Using an intraoral approach, the physician makes an incision in the mucosa overlying the outgrowth of bone and reflects the tissue. The excess bone is removed with a drill or osteotome. The mucosal incision is closed with sutures.

Coding Tips

This is a unilateral procedure. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). If specimen is transported to an outside laboratory, report 99000 for handling or conveyance. For excision of maxillary torus palatinus, see 21032.

ICD-10-CM Diagnostic Codes

M27.0 Developmental disorders of jaws

Relative Value Units/Medicare Edits

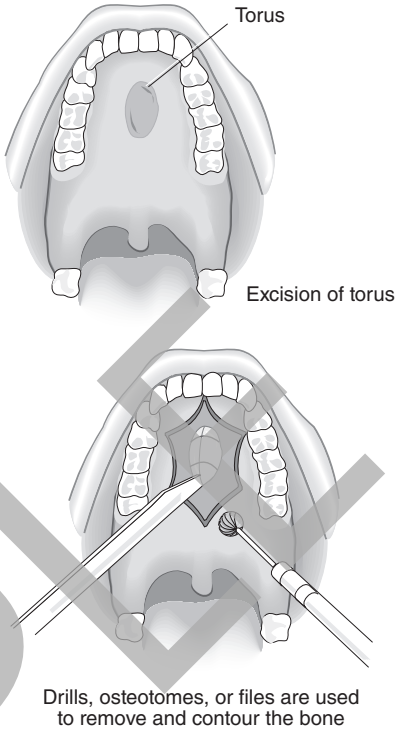
Non-Facility RVU	Work	PE	MP	Total
21031	3.3	7.85	0.34	11.49
Facility RVU	**Work**	**PE**	**MP**	**Total**
21031	3.3	4.49	0.34	8.13

	FUD	Status	MUE	Modifiers				IOM Reference
21031	90	A	2(3)	51	50	N/A	N/A	None

* with documentation

21032

21032 Excision of maxillary torus palatinus



Explanation

The physician excises a torus palatinus (a bony protuberance), usually found at the junction of the intermaxillary and transverse palatine structures, by making an incision through the mucosa overlying the protuberance. The torus is exposed. Drills, osteotomes, or files are used to remove and contour the bone. The tissue is sutured directly over the bone. Some soft tissue may be excised prior to closure for adaptation over the newly contoured bone.

Coding Tips

This procedure includes the removal of tori, osseous tuberosities, and other osseous protuberances. If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report. An excisional biopsy is not reported separately if a therapeutic excision is performed during the same surgical session. Local anesthesia is included in the service. If specimen is transported to an outside laboratory, report 99000 for handling or conveyance.

ICD-10-CM Diagnostic Codes

M27.8 Other specified diseases of jaws

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21032	3.34	7.43	0.34	11.11
Facility RVU	**Work**	**PE**	**MP**	**Total**
21032	3.34	4.08	0.34	7.76

	FUD	Status	MUE	Modifiers				IOM Reference
21032	90	A	1(3)	51	N/A	N/A	N/A	None

* with documentation

SAMPLE

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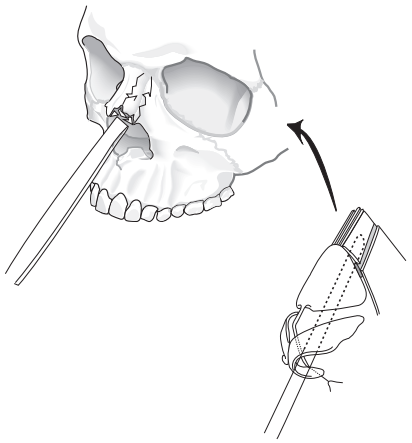
21315-21320

21315 Closed treatment of nasal bone fracture with manipulation; without stabilization

21320 with stabilization



Explanation

The physician treats a displaced nasal fracture by manipulating the fractured bones. The physician places nasal elevators or forceps into the nose and realigns the nasal bones. In 21315, after the bones are realigned, they are stable and require no additional stabilization with splints. In 21320, they remain slightly mobile and require additional stabilization with splints. External splinting may consist of a cast taped to the reduced nose. Internal splinting consists of supporting the nasal septum by splints or packing with gauze strips.

Coding Tips

For closed treatment of a nasal bone fracture without manipulation or stabilization, use an applicable E/M code. For open treatment, see 21325–21335.

ICD-10-CM Diagnostic Codes

S02.2XXA Fracture of nasal bones, initial encounter for closed fracture

AMA: 21315 2022,May; 2019,Nov; 2019,Sep; 2018,Jan **21320** 2022,May; 2019,Nov; 2019,Sep

Relative Value Units/Medicare Edits

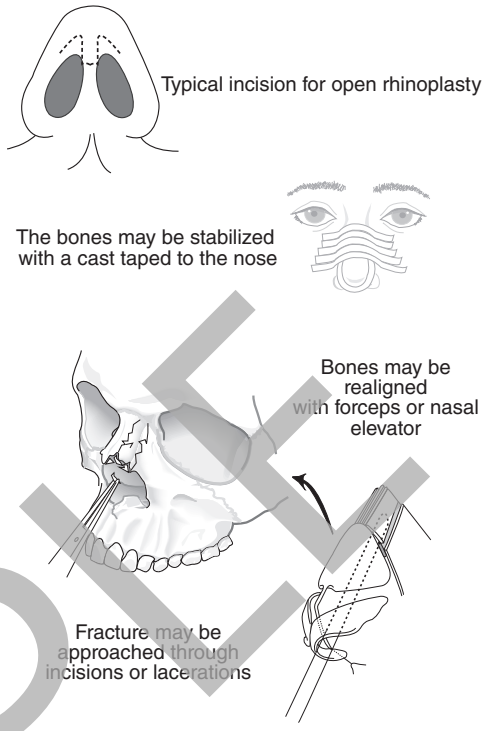
Non-Facility RVU	Work	PE	MP	Total
21315	0.96	3.43	0.17	4.56
21320	1.59	4.74	0.23	6.56
Facility RVU	**Work**	**PE**	**MP**	**Total**
21315	0.96	0.67	0.17	1.8
21320	1.59	1.01	0.23	2.83

	FUD	Status	MUE	Modifiers				IOM Reference
21315	0	A	1(2)	51	N/A	N/A	N/A	None
21320	0	A	1(2)	51	N/A	N/A	N/A	

* with documentation

21325

21325 Open treatment of nasal fracture; uncomplicated



Explanation

The physician treats a displaced nasal fracture. After unsatisfactory results with closed manipulation of the fractured bones, the physician performs open treatment. Open reduction allows the physician to visualize the fracture. Lacerations may be present, allowing direct visualization. Incisions are made inside the nose to expose the nasal septum and portions of the nasal bones. The physician realigns the fractured bones using nasal elevators and forceps. It may be necessary to remove small segments of bone for adequate realignment. Intranasal incisions are closed in a single layer. Any lacerated skin areas are closed in layers. After the bones are realigned, they remain slightly mobile and require additional stabilization with splints. External splinting may consist of a cast taped to the reduced nose. Internal splinting consists of supporting the nasal septum by splints or packing with gauze strips.

Coding Tips

This code should only be reported for open treatment of an acute, uncomplicated non-healed nasal fracture. For repair of a previous nasal fracture, following knitting of the bones/cartilage, see 30410. For open treatment of a nasal fracture, complicated, see 21330; with concomitant, open treatment, see 21335. For closed treatment, see 21315–21320. Supplies used when providing this procedure may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

S02.2XXA Fracture of nasal bones, initial encounter for closed fracture

S02.2XXB Fracture of nasal bones, initial encounter for open fracture

AMA: 21325 2022,May; 2021,Jan

SAMPLE

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J38.01	Paralysis of vocal cords and larynx, unilateral
J38.02	Paralysis of vocal cords and larynx, bilateral
J38.1	Polyp of vocal cord and larynx
J38.2	Nodules of vocal cords
J38.3	Other diseases of vocal cords
J38.5	Laryngeal spasm
J38.6	Stenosis of larynx
J38.7	Other diseases of larynx
J95.5	Postprocedural subglottic stenosis
Q31.0	Web of larynx
Q31.1	Congenital subglottic stenosis
Q31.2	Laryngeal hypoplasia
Q31.3	Laryngocele
Q31.5	Congenital laryngomalacia
Q32.0	Congenital tracheomalacia
R49.0	Dysphonia
R49.8	Other voice and resonance disorders
S10.0XXA	Contusion of throat, initial encounter
S10.15XA	Superficial foreign body of throat, initial encounter
S11.011A	Laceration without foreign body of larynx, initial encounter
S11.012A	Laceration with foreign body of larynx, initial encounter
S11.013A	Puncture wound without foreign body of larynx, initial encounter
S11.014A	Puncture wound with foreign body of larynx, initial encounter
S11.015A	Open bite of larynx, initial encounter
S11.032A	Laceration with foreign body of vocal cord, initial encounter
S11.034A	Puncture wound with foreign body of vocal cord, initial encounter
S17.0XXA	Crushing injury of larynx and trachea, initial encounter
T17.320A	Food in larynx causing asphyxiation, initial encounter
T27.0XXA	Burn of larynx and trachea, initial encounter
T27.1XXA	Burn involving larynx and trachea with lung, initial encounter
T27.4XXA	Corrosion of larynx and trachea, initial encounter
T27.5XXA	Corrosion involving larynx and trachea with lung, initial encounter

AMA: 31579 2017,Jul; 2017,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
31579	1.88	3.84	0.25	5.97
Facility RVU	**Work**	**PE**	**MP**	**Total**
31579	1.88	1.43	0.25	3.56

	FUD	Status	MUE	Modifiers				IOM Reference
31579	0	A	1(2)	51	N/A	N/A	N/A	None

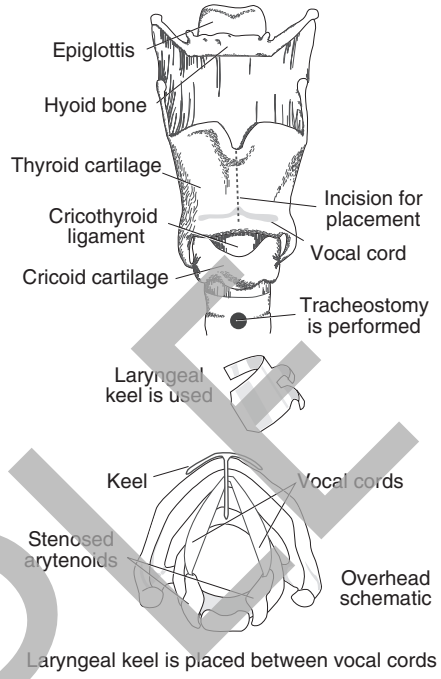
* with documentation

Terms To Know

stroboscope. Device that produces an interrupted light that, when projected on moving or vibrating objects, makes them appear to be stationary.

31580

31580 Laryngoplasty; for laryngeal web, with indwelling keel or stent insertion



Explanation

The physician excises a laryngeal web, a congenital malformation of the larynx. The physician performs a laryngotomy on the patient. Using a horizontal neck incision, the physician exposes the laryngeal web. The web lies between the vocal cords. The physician excises the web and inserts a laryngeal indwelling keel, or stent, between the vocal cords. The laryngotomy incision is closed.

Coding Tips

Do not report 31580 with 31551-31554. For tracheostomy, see 31600-31610. For removal of keel or stent, see 31599. For laryngoplasty with open reduction of a fracture, see 31584.

ICD-10-CM Diagnostic Codes

Q31.0 Web of larynx

AMA: 31580 2017,Apr; 2017,Mar

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
31580	14.6	22.05	2.08	38.73
Facility RVU	**Work**	**PE**	**MP**	**Total**
31580	14.6	22.05	2.08	38.73

	FUD	Status	MUE	Modifiers				IOM Reference
31580	90	A	1(2)	51	N/A	62*	80*	None

* with documentation

Terms To Know

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

SAMPLE

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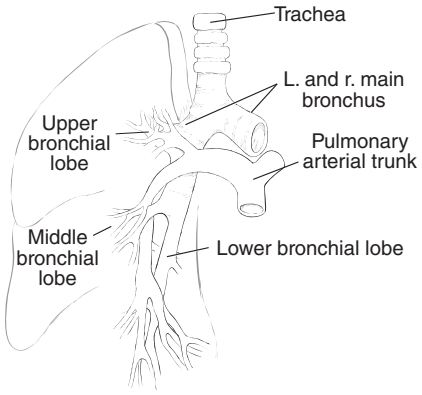
31648-31649

31648 Bronchoscopy, rigid or flexible, including fluoroscopic guidance, when performed; with removal of bronchial valve(s), initial lobe

\+ **31649** with removal of bronchial valve(s), each additional lobe (List separately in addition to code for primary procedure)



Bronchial valves are removed

Explanation

The physician removes one or more previously placed bronchial valves using a bronchoscopic approach. Under appropriate anesthesia, the physician introduces a flexible fiberoptic or rigid bronchoscope through the nasal or oral cavity and advances it past the larynx and into the bronchus. The bronchial valve is visualized by fluoroscopy, if utilized, grasped with biopsy forceps, and removed.

Coding Tips

Report 31649 in addition to 31648. When medically necessary, report moderate (conscious) sedation provided by the performing physician with 99151-99153. When provided by another physician, report 99155-99157. For removal and insertion of a bronchial valve during the same operative session, see 31647, 31648, and 31651.

ICD-10-CM Diagnostic Codes

T85.618A Breakdown (mechanical) of other specified internal prosthetic devices, implants and grafts, initial encounter

T85.638A Leakage of other specified internal prosthetic devices, implants and grafts, initial encounter

T85.698A Other mechanical complication of other specified internal prosthetic devices, implants and grafts, initial encounter

T85.79XA Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, initial encounter

T85.818A Embolism due to other internal prosthetic devices, implants and grafts, initial encounter

T85.828A Fibrosis due to other internal prosthetic devices, implants and grafts, initial encounter

T85.838A Hemorrhage due to other internal prosthetic devices, implants and grafts, initial encounter

T85.848A Pain due to other internal prosthetic devices, implants and grafts, initial encounter

T85.858A Stenosis due to other internal prosthetic devices, implants and grafts, initial encounter

T85.868A Thrombosis due to other internal prosthetic devices, implants and grafts, initial encounter

T85.898A Other specified complication of other internal prosthetic devices, implants and grafts, initial encounter

Z45.89 Encounter for adjustment and management of other implanted devices

AMA: **31648** 2023,Jun; 2018,Sep **31649** 2023,Jun; 2018,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
31648	3.95	1.41	0.37	5.73
31649	1.44	0.4	0.11	1.95
Facility RVU	**Work**	**PE**	**MP**	**Total**
31648	3.95	1.41	0.37	5.73
31649	1.44	0.4	0.11	1.95

	FUD	Status	MUE	Modifiers				IOM Reference
31648	0	A	1(2)	51	N/A	N/A	N/A	None
31649	N/A	A	2(3)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

approach. Method or anatomical location used to gain access to a body organ or specific area for procedures. The approach is not coded separately although it may be a specified component of the procedure, such as laparoscopic versus incisional, or spinal procedures in which the amount of dissection required to expose the spine significantly alters with the site of approach.

larynx. Musculocartilaginous structure between the trachea and the pharynx that functions as the valve preventing food and other particles from entering the respiratory tract, as well as the voice mechanism.

SAMPLE

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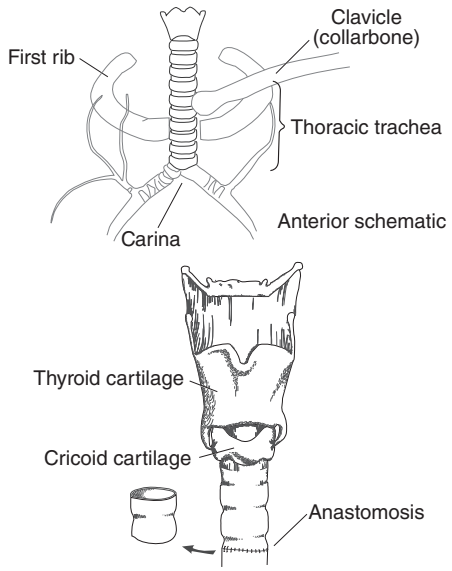
31781

31781 Excision tracheal stenosis and anastomosis; cervicothoracic



Explanation

The physician excises a tracheal stenosis and re-anastomoses the trachea. The physician makes a cervicothoracic incision to access the stenosis. The trachea is incised and the stenosis is resected. The proximal and distal portions of the trachea are brought together and closed with sutures. The wound is sutured in layers.

Coding Tips

If significant additional time and effort are documented, append modifier 22 and submit a cover letter and operative report. When 31781 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure, and subsequent procedures are appended with modifier 51.

ICD-10-CM Diagnostic Codes

J39.8	Other specified diseases of upper respiratory tract
J95.03	Malfunction of tracheostomy stoma
Q32.1	Other congenital malformations of trachea
Z85.12	Personal history of malignant neoplasm of trachea

AMA: **31781** 2017,Apr; 2017,Feb

Relative Value Units/Medicare Edits

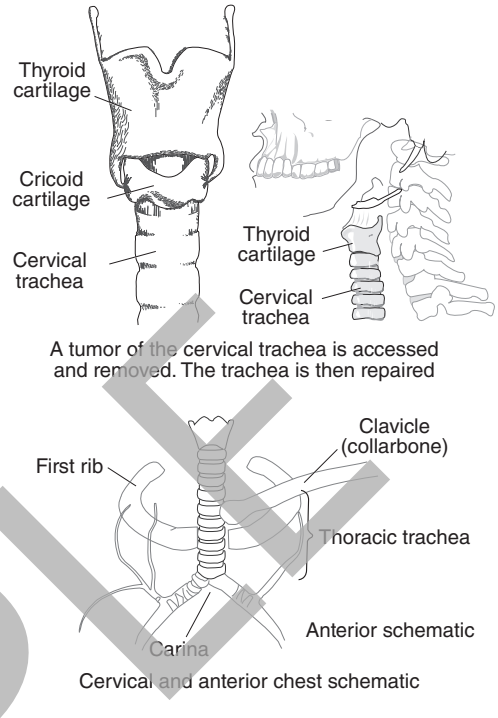
Non-Facility RVU	Work	PE	MP	Total
31781	24.85	14.6	3.53	42.98
Facility RVU	**Work**	**PE**	**MP**	**Total**
31781	24.85	14.6	3.53	42.98

	FUD	Status	MUE	Modifiers				IOM Reference
31781	90	A	1(2)	51	N/A	62*	80	None

* with documentation

31785

31785 Excision of tracheal tumor or carcinoma; cervical



Explanation

The physician excises a tracheal tumor or carcinoma. The physician makes a horizontal neck incision to access the mass. The trachea is incised and the mass is resected. If necessary, the proximal and distal portions of the trachea are brought together and closed with sutures. The wound is sutured in layers.

Coding Tips

When 31785 is performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. If significant additional time and effort is documented, append modifier 22 and submit a cover letter and operative report. An excisional biopsy is not reported separately when a therapeutic excision is performed during the same surgical session. Report any free grafts or flaps separately. For excision of a tracheal tumor or carcinoma, thoracic, see 31786.

ICD-10-CM Diagnostic Codes

C33	Malignant neoplasm of trachea
C78.39	Secondary malignant neoplasm of other respiratory organs
D02.1	Carcinoma in situ of trachea
D38.1	Neoplasm of uncertain behavior of trachea, bronchus and lung
D3A.090	Benign carcinoid tumor of the bronchus and lung

SAMPLE

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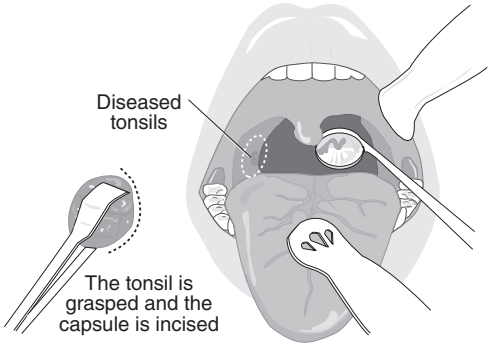
42825-42826

42825 Tonsillectomy, primary or secondary; younger than age 12
42826 age 12 or over



Diseased tonsils are removed or destroyed

Explanation

The physician removes the tonsils. The tonsillectomy can be the first the patient has undergone, or a secondary procedure to remove tonsil regrowth since the primary procedure. The physician accesses the tonsils in an intraoral approach. First, the physician removes the tonsils by grasping the tonsil with a tonsil clamp and dissecting the capsule of the tonsil. The tonsil is removed. Bleeding vessels are clamped and tied. Bleeding may also be controlled using silver nitrate and gauze packing. Alternate surgical techniques for a tonsillectomy include electrocautery, laser surgery, and cryogenic surgery. Report 42825 if the patient is under 12 years. For patients 12 years or older, report 42826.

Coding Tips

Payer protocols may require that documentation be submitted showing repeated strep or other infections before this procedure will be preauthorized. If preauthorization is obtained, include the preauthorization number on the claim submission and on any correspondence relating to the claim. If the condition is pre-existing, this procedure may not be covered or may only be partially covered until the pre-existing condition period of the plan benefit is met. Most payers consider tonsillectomy codes to be bilateral. Postoperative complications (e.g., control of postoperative hemorrhage) are reported separately. These procedures report tonsillectomy and include primary (first time) or secondary (regrowth of tonsil tissue) excision. For tonsillectomy and adenoidectomy, see 42820 and 42821. For adenoidectomy, primary, see 42830 and 43831; secondary, see 42835 and 42836.

ICD-10-CM Diagnostic Codes

C09.8	Malignant neoplasm of overlapping sites of tonsil
D10.4	Benign neoplasm of tonsil
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
J35.1	Hypertrophy of tonsils
J35.8	Other chronic diseases of tonsils and adenoids
J36	Peritonsillar abscess

AMA: **42825** 2021,Jun **42826** 2021,Sep

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
42825	3.51	4.09	0.5	8.1
42826	3.45	3.76	0.5	7.71
Facility RVU	**Work**	**PE**	**MP**	**Total**
42825	3.51	4.09	0.5	8.1
42826	3.45	3.76	0.5	7.71

	FUD	Status	MUE	Modifiers				IOM Reference
42825	90	A	1(2)	51	N/A	N/A	80*	None
42826	90	A	1(2)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

clamp. Tool used to grip, compress, join, or fasten body parts.

excision. Surgical removal of an organ or tissue.

general anesthesia. State of unconsciousness produced by an anesthetic agent or agents, inducing amnesia by blocking the awareness center in the brain, and rendering the patient unable to control protective reflexes, such as breathing.

hypertrophy. Overgrowth or enlargement of normal cells in tissue.

silver nitrate. Topical antiinfective or germicide used as antiseptic and astringent.

SAMPLE

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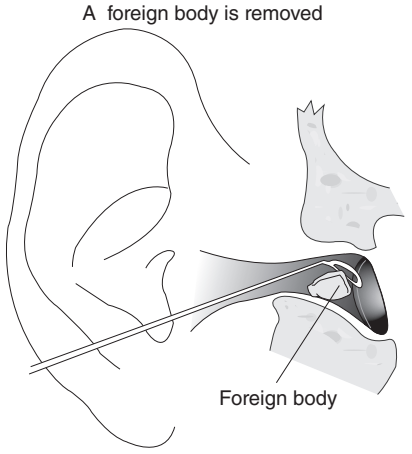
69200-69205

69200 Removal foreign body from external auditory canal; without general anesthesia

69205 with general anesthesia



Explanation

Under direct visualization, the physician or technician removes a foreign body from the external auditory canal using delicate forceps, a cerumen spoon, or suction. In the case of a live insect, oil is dropped into the ear to immobilize it before it is removed. No anesthetic or local anesthetic is used in 69200. If a child or an adult cannot tolerate the procedure while awake, it is performed under general anesthesia in 69205. Code 69205 is also reported in cases where the foreign body is so large, an incision is made in the external meatus to enlarge the opening before the foreign body can be extracted.

Coding Tips

For removal of impacted cerumen, see 69210. For debridement of the mastoid cavity, see 69220 and 69222. Do not report these codes for removal of PE tubes. The removal of ventilating tubes is included in the charge for insertion, regardless of how long afterwards removal occurs. If ventilating tubes were removed by another physician, see 69424.

ICD-10-CM Diagnostic Codes

T16.1XXA Foreign body in right ear, initial encounter ☑

T16.2XXA Foreign body in left ear, initial encounter ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
69200	0.77	1.53	0.11	2.41
69205	1.21	1.49	0.18	2.88
Facility RVU	**Work**	**PE**	**MP**	**Total**
69200	0.77	0.53	0.11	1.41
69205	1.21	1.49	0.18	2.88

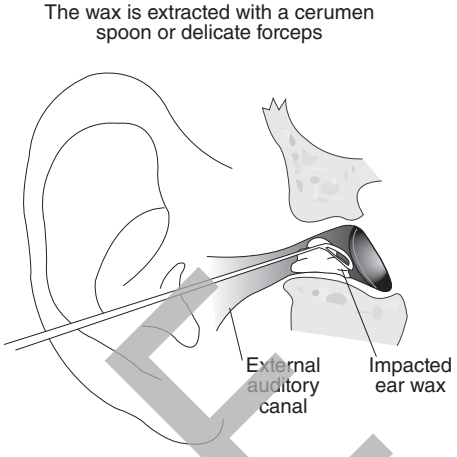
	FUD	Status	MUE	Modifiers				IOM Reference
69200	0	A	1(2)	51	50	N/A	N/A	None
69205	10	A	1(3)	51	50	N/A	N/A	

* with documentation

69209-69210

69209 Removal impacted cerumen using irrigation/lavage, unilateral

69210 Removal impacted cerumen requiring instrumentation, unilateral



Explanation

Under direct visualization, the physician removes impacted cerumen (ear wax) using irrigation or lavage (69209), or via suction, a cerumen spoon, or delicate forceps (69210). A typical solution used for lavage is water and saline, warmed to body temperature to avoid causing dizziness, placed in the ear approximately 15 to 30 minutes prior to removal. When instrumentation is used and no infection is present, the ear canal may also be irrigated.

Coding Tips

These are unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Modifier 50 identifies a procedure performed identically on the opposite side of the body (mirror image). For removal of nonimpacted cerumen, report the appropriate E/M or other outpatient service code. Medicare allows only one unit of this code to be billed even if both ears are treated. Do not report these codes together when both procedures are performed on the same ear.

ICD-10-CM Diagnostic Codes

H61.21 Impacted cerumen, right ear ☑

H61.22 Impacted cerumen, left ear ☑

H61.23 Impacted cerumen, bilateral ☑

Associated HCPCS Codes

G0268 Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing

SAMPLE

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Correct Coding Initiative Update 29.3

❖Indicates Mutually Exclusive Edit

0208T 36591-36592, 69209-69210, 96523

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