Optum

Coding Companion

Family Practice/ Pediatrics

A comprehensive illustrated guide to coding and reimbursement

2025

optumcoding.com

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Getting Started with Coding Companion

Coding Companion for Family Practice/Pediatrics 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 family practice/pediatrics 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:

65205 Removal of foreign body, external eye; conjunctival superficial

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

Conjunctiva
Foreign Body Removal, 65205-65210

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

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

General Guidelines

Providers

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

Supplies

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

Professional and Technical Component

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

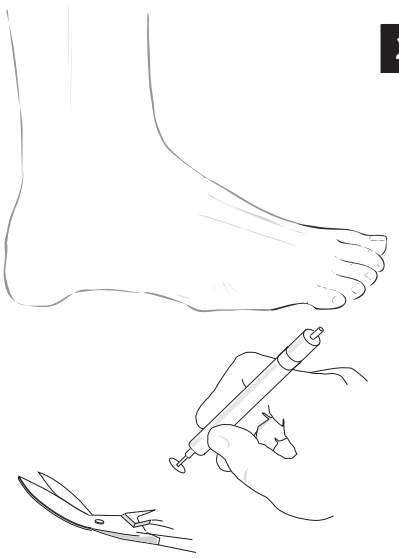
Sample Page and Key

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

11720-11721

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

Nails are debrided using a number of methods



Explanation

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

Coding Tips

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

ICD-10-CM Diagnostic Codes

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

Associated HCPCS Codes

G0127	Trimming of dystrophic nails, any number

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

Relative Value Units/Medicare Edits

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

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

* with documentation

Terms To Know

candidiasis. Yeast infection caused by the fungus Candida albicans. It commonly occurs in the vagina, but affects any moist skin or mucus membran

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

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

paronychia. Infection or cellulitis of nail structures.

1. CPT/HCPCS Codes and Descriptions

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

The following icons are used in *Coding Companion:*

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

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

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

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

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

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

2. Illustrations

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

3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes the most common method of performing each procedure.

4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

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

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

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

6. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

7. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2023.

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

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

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

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

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

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

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

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

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

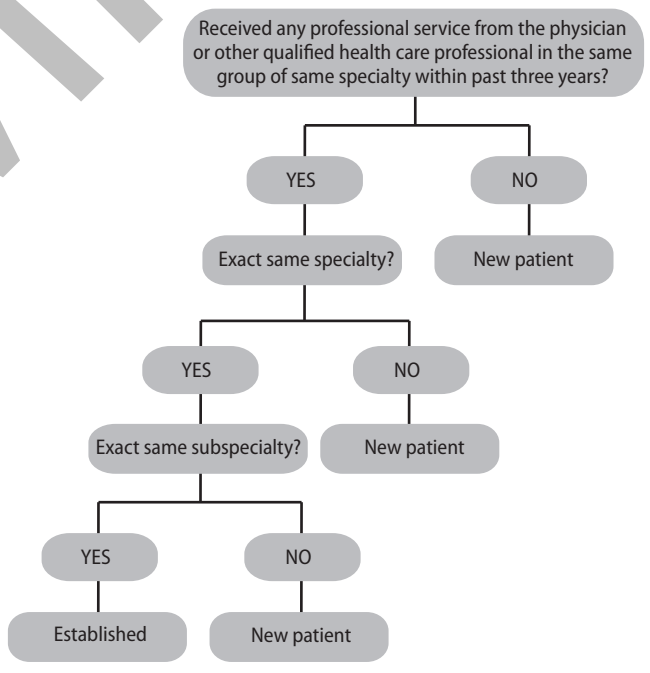
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the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

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



Initial and Subsequent Services

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

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

▶ ◀ = Contains new or revised text

99202-99205

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

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

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

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

Explanation

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

Coding Tips

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

ICD-10-CM Diagnostic Codes

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

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

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.14	0.08	2.15
99203	1.6	1.56	0.17	3.33
99204	2.6	2.11	0.23	4.94
99205	3.5	2.71	0.31	6.52
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.08	1.42
99203	1.6	0.68	0.17	2.45
99204	2.6	1.11	0.23	3.94
99205	3.5	1.54	0.31	5.35

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	100-04,11,40.1.3; 100-04,12,30.6.4; 100-04,12,30.6.10; 100-04,12,190.7; 100-04,12,230; 100-04,12,230.1; 100-04,18,80.2; 100-04,32,12.1
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

[99417, 99418]

+ ★**99417** Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)
+ ★**99418** Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service)

Explanation

Prolonged time (with and without direct patient contact combined) that is provided by the physician or other qualified health care professional on the date of an evaluation and management service can be reported with 99417 (outpatient) or 99418 (inpatient or observation). These codes are assigned only when the code for the primary E/M service has been selected based solely on total time, and only after exceeding the required time to report the highest-level of service by at least 15 minutes. For example, when reporting an E/M service for an established patient (99215), code 99417 would not be reported until at least 15 minutes of time beyond 40 minutes has been accumulated (55 minutes) on the day of the encounter. Time spent on procedures that can be reported separately are not included in the prolonged time.

Coding Tips

These codes are used to report prolonged service time by the physician or other qualified health care professional provided on the same date as the highest level of service of the associated E/M service. The prolonged time may be with or without direct patient contact. This service is reported only when time was the criteria used to select the code for the primary E/M service and the time exceeds the minimum time required to report these levels of service by at least 15 minutes. Code 99417 may be reported once for each additional 15 minutes spent providing prolonged services. Time spent on procedures that can be reported separately are not included in the prolonged time. Report 99417 for prolonged time for an outpatient evaluation and management service for the combination of time with and without direct patient contact that goes beyond the required time of codes 99205, 99215, 99245, 99345, 99350, or 99483. Report 99418 for prolonged time for an inpatient or observation evaluation and management service for the combination of time with and without direct patient contact that goes beyond the required time of codes 99223, 99233, 99236, 99255, 99306, or 99310. Each code can be reported for each 15 minutes of prolonged time. Prolonged services provided on a date other than the date of the face-to-face encounter may be reported with 99358-99359. Prolonged services provided by clinical staff are reported with 99415-99416. Do not report 99417-99418 with 90833, 90836, 90838, or 99358-99359; do not report 99417 with 99415-99416 or G0318; do not report 99418 with G0316 or G0317.

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: **99417** 2023,Mar; 2022,Dec; 2022,Nov; 2022,Aug; 2022,Jul; 2022,May; 2021,Jan; 2020,Nov; 2020,Sep **99418** 2023,Mar; 2023,Jan; 2022,Nov; 2022,Oct

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99417	0.61	0.27	0.04	0.92
99418	0.81	0.31	0.04	1.16
Facility RVU	**Work**	**PE**	**MP**	**Total**
99417	0.61	0.24	0.04	0.89
99418	0.81	0.31	0.04	1.16

	FUD	Status	MUE	Modifiers				IOM Reference
99417	N/A	I	6(3)	N/A	N/A	N/A	N/A	100-04,12,30.6.4
99418	N/A	I	4(3)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

evaluation and management. Assessment, counseling, and other services provided to a patient reported through CPT codes.

face to face. Interaction between two parties, usually provider and patient, that occurs in the physical presence of each other.

other qualified health care professional. Individual who is qualified by education, training, licensure/regulation, and facility privileging to perform a professional service within his or her scope of practice and independently (or as incident-to) report the professional service without requiring physician supervision. Payers may state exemptions in writing or state and local regulations may not follow this definition for performance of some services. Always refer to any relevant plan policies and federal and/or state laws to determine who may perform and report services.

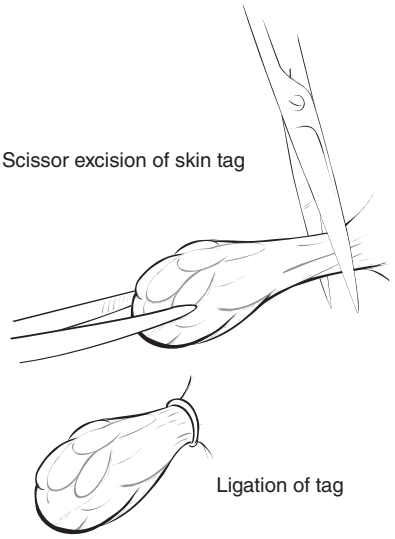
outpatient visit. Encounter in a recognized outpatient facility.

prolonged physician services. Extended pre- or post-service care provided to a patient whose condition requires services beyond the usual.

11200-11201

11200 Removal of skin tags, multiple fibrocutaneous tags, any area; up to and including 15 lesions

\+ **11201** each additional 10 lesions, or part thereof (List separately in addition to code for primary procedure)



Explanation

The physician removes skin tag lesions. Skin tags are common benign tumors found on many body regions, most frequently around the axillae, inguinal area, head, and neck. The physician uses sharp excision with scissors or scalpel, chemical cautery, electrical cautery, ligature strangulation, or any combination of these methods. Report 11200 for up to 15 lesions and 11201 for each additional 10 lesions, or part thereof, beyond the initial 15.

Coding Tips

Report 11201 in addition to 11200. For excision of benign lesions, other than skin tags, see 11400–11446. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

L91.8 Other hypertrophic disorders of the skin

N90.89 Other specified noninflammatory disorders of vulva and perineum ♀

AMA: **11200** 2022,Feb **11201** 2022,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11200	0.82	1.82	0.1	2.74
11201	0.29	0.22	0.04	0.55
Facility RVU	**Work**	**PE**	**MP**	**Total**
11200	0.82	1.36	0.1	2.28
11201	0.29	0.16	0.04	0.49

	FUD	Status	MUE	Modifiers				IOM Reference
11200	10	A	1(2)	51	N/A	N/A	N/A	None
11201	N/A	A	1(3)	N/A	N/A	N/A	N/A	

* with documentation

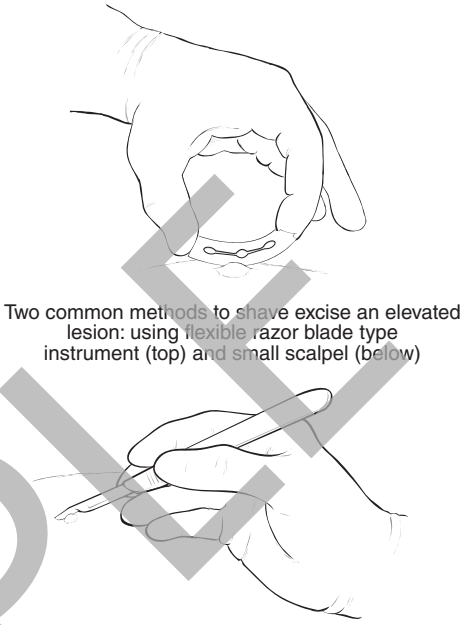
11300-11303

11300 Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less

11301 lesion diameter 0.6 to 1.0 cm

11302 lesion diameter 1.1 to 2.0 cm

11303 lesion diameter over 2.0 cm



Two common methods to shave excise an elevated lesion: using flexible razor blade type instrument (top) and small scalpel (below)

Explanation

The physician removes a single, elevated epidermal or dermal lesion from the trunk, arm, or legs by shave excision. Local anesthesia is injected beneath the lesion. A scalpel blade is placed against the skin adjacent to the lesion and the physician uses a horizontal slicing motion to excise the lesion from its base. The wound does not require suturing and bleeding is controlled by chemical or electrical cauterization. Report 11300 for a lesion diameter 0.5 cm or less; 11301 for 0.6 cm to 1 cm; 11302 for 1.1 cm to 2 cm; and 11303 for lesions greater than 2 cm.

Coding Tips

Local anesthesia is included in these services. Chemical or electrical cauterization of the wound is included in these services. For excision of a benign lesion, see 11400–11406. For excision of a malignant lesion, see 11600–11606. If specimen is transported to an outside laboratory, report 99000 for handling or conveyance. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

B07.0 Plantar wart

B07.8 Other viral warts

D22.5 Melanocytic nevi of trunk

D22.61 Melanocytic nevi of right upper limb, including shoulder ☑

D22.71 Melanocytic nevi of right lower limb, including hip ☑

D23.5 Other benign neoplasm of skin of trunk

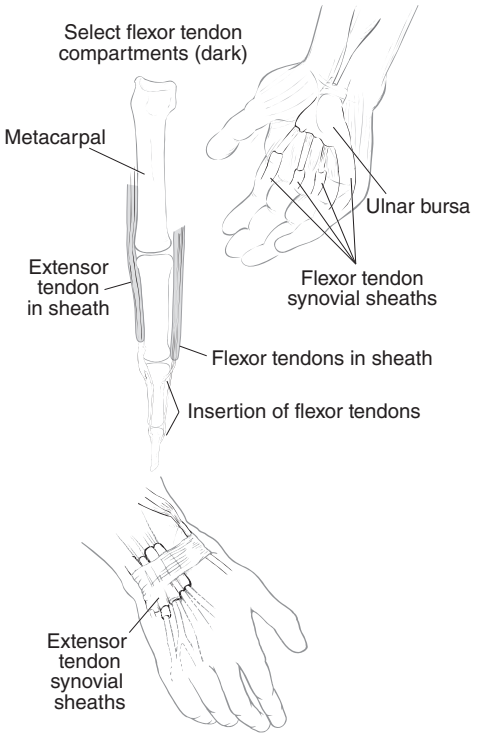
D23.61 Other benign neoplasm of skin of right upper limb, including shoulder ☑

D23.71 Other benign neoplasm of skin of right lower limb, including hip ☑

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

26020

26020 Drainage of tendon sheath, digit and/or palm, each



Explanation

The physician drains fluid located in a tendon sheath located in a finger or in the palm. The physician incises the skin above the affected sheath and dissects to the tendon sheath. The sheath is lanced and drained. An irrigation catheter may be placed and the wound is irrigated for up to 48 hours. The incision is sutured in layers.

Coding Tips

Local anesthesia is included in this service. For drainage of a finger abscess, simple, see 26010; complicated, see 26011. For drainage of a palmar bursa, single, see 26025; multiple, see 26030. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

M65.041 Abscess of tendon sheath, right hand ☑
M65.841 Other synovitis and tenosynovitis, right hand ☑
M67.843 Other specified disorders of tendon, right hand ☑

Relative Value Units/Medicare Edits

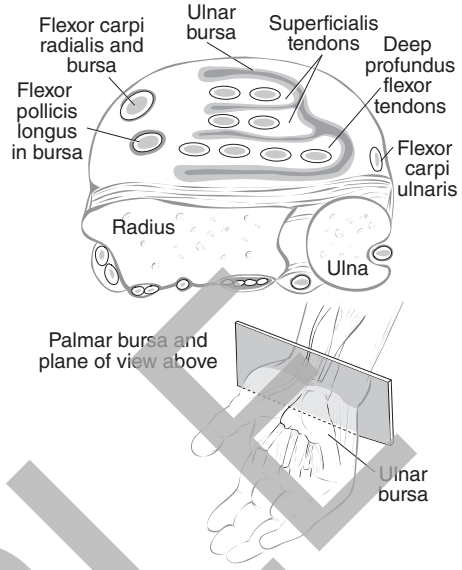
Non-Facility RVU	Work	PE	MP	Total
26020	6.84	8.73	1.28	16.85
Facility RVU	**Work**	**PE**	**MP**	**Total**
26020	6.84	8.73	1.28	16.85

	FUD	Status	MUE	Modifiers				IOM Reference
26020	90	A	4(3)	51	N/A	N/A	N/A	None

* with documentation

26025-26030

26025 Drainage of palmar bursa; single, bursa
26030 multiple bursa



Explanation

The physician drains a palmar bursa or multiple bursas located on the ulnar or radial side of the palm. The physician incises the skin over the bursa and dissects to the bursa. The bursa is lanced and irrigated with a catheter. The catheter is removed and the incision is sutured in layers. Report 26025 for a single bursa, report 26030 for multiple and/or complicated bursas.

Coding Tips

Local anesthesia is included in these services. However, these procedures may be performed under conscious sedation or general anesthesia, depending on the age and/or condition of the patient. For drainage of a tendon sheath, palm or digit, see 26020. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

M70.11 Bursitis, right hand ☑
M71.041 Abscess of bursa, right hand ☑
M71.141 Other infective bursitis, right hand ☑
M71.341 Other bursal cyst, right hand ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
26025	5.08	6.68	0.96	12.72
26030	6.25	7.46	1.17	14.88
Facility RVU	**Work**	**PE**	**MP**	**Total**
26025	5.08	6.68	0.96	12.72
26030	6.25	7.46	1.17	14.88

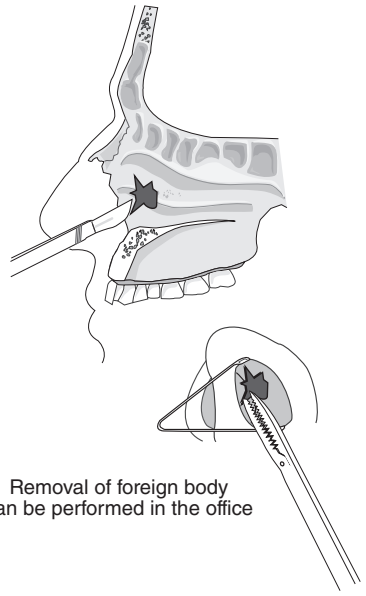
	FUD	Status	MUE	Modifiers				IOM Reference
26025	90	A	1(2)	51	50	N/A	80*	None
26030	90	A	1(2)	51	50	N/A	80*	

* with documentation

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

30300

30300 Removal foreign body, intranasal; office type procedure



Removal of foreign body can be performed in the office

Explanation

The physician removes a foreign body from the inside of the nasal cavity in the office setting. Foreign bodies are defined as objects not normally found in the body. An object may be embedded in normal tissue as a result of some type of trauma. Topical vasoconstrictive agents and local anesthesia are applied to the nasal mucosa. A small incision may be necessary to access the foreign body. Blunt dissection and retrieval of the object is performed with hemostats or forceps. Sutures may close the mucosa in a single layer if the size of the dissection requires.

Coding Tips

Topical vasoconstrictive agents and local anesthesia are not reported separately. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

S01.22XA Laceration with foreign body of nose, initial encounter

S01.24XA Puncture wound with foreign body of nose, initial encounter

T17.1XXA Foreign body in nostril, initial encounter

Relative Value Units/Medicare Edits

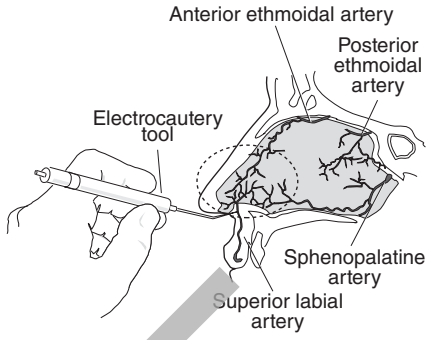
Non-Facility RVU	Work	PE	MP	Total
30300	1.09	5.11	0.17	6.37
Facility RVU	**Work**	**PE**	**MP**	**Total**
30300	1.09	2.49	0.17	3.75

	FUD	Status	MUE	Modifiers				IOM Reference
30300	10	A	1(3)	51	N/A	N/A	N/A	None

* with documentation

30901

30901 Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method



Cautery and packing applied to anterior area

Explanation

To control a less serious nosebleed, the physician applies electrical or chemical coagulation or packing materials to the anterior (front) section of the nose. Only limited electrical or chemical coagulation is used.

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). Local anesthesia is included in this service. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

J95.71 Accidental puncture and laceration of a respiratory system organ or structure during a respiratory system procedure

J95.72 Accidental puncture and laceration of a respiratory system organ or structure during other procedure

J95.830 Postprocedural hemorrhage of a respiratory system organ or structure following a respiratory system procedure

J95.831 Postprocedural hemorrhage of a respiratory system organ or structure following other procedure

R04.0 Epistaxis

AMA: **30901** 2020,Oct; 2020,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
30901	1.1	3.46	0.19	4.75
Facility RVU	**Work**	**PE**	**MP**	**Total**
30901	1.1	0.4	0.19	1.69

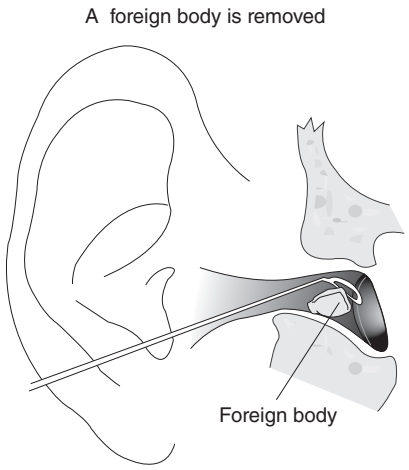
	FUD	Status	MUE	Modifiers				IOM Reference
30901	0	A	1(3)	51	50	N/A	N/A	None

* with documentation

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

69200

69200 Removal foreign body from external auditory canal; without 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.

Coding Tips

For removal of impacted cerumen, see 69210. For debridement of the mastoid cavity, see 69220 or 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
Facility RVU	**Work**	**PE**	**MP**	**Total**
69200	0.77	0.53	0.11	1.41

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

* with documentation

Terms To Know

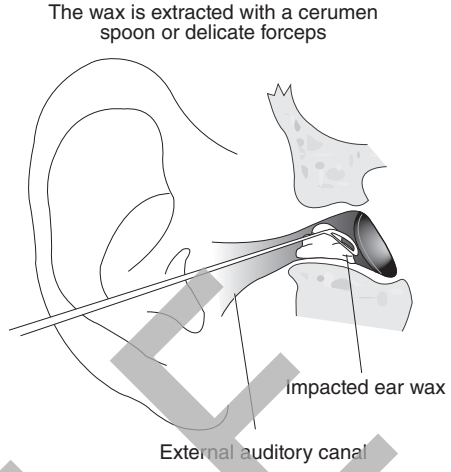
external auditory canal/meatus. External channel that leads from the opening in the external ear to the tympanic membrane (eardrum).

forceps. Tool used for grasping or compressing tissue.

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 codes describe removal of cerumen impaction. Report unimpacted cerumen removal with the appropriate E/M service code. Do not report 69209 and 69210 together when performed on the same ear. These codes describe 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). Medicare allows only one unit of this code to be billed even if both ears are treated. Medicare and some other payers may require that HCPCS Level II code G0268 be reported for removal of impacted cerumen (one or both ears) by a physician on the same date of service as audiologic function testing. The removal of ventilating tubes is included in the charge for insertion, regardless of how long afterwards removal occurs. Code 69210 should not be reported for removal of PE tubes. For removal of a foreign body from the external auditory canal, without general anesthesia, see 69200; under general anesthesia, see 69205.

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

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

90647

90647 Haemophilus influenzae type b vaccine (Hib), PRP-OMP conjugate, 3 dose schedule, for intramuscular use

Explanation

A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of the antibody production pattern for long-term protection. A *Haemophilus influenzae* type b vaccine (Hib), PRP-OMP conjugate, is prepared for intramuscular use in a three-dose schedule. It immunizes the patient against influenza that is caused by the bacteria species *Haemophilus influenzae*. Report this code with the appropriate administration code.

Coding Tips

Report these codes with the appropriate administration code. Administration codes 90460-90461 should only be reported when the clinician renders face-to-face counseling to the patient and/or family at the time the immunization is being administered. For administration of a vaccine without the face-to-face clinician counseling service for patients 18 years of age and older, see 90471-90474. Separately identifiable E/M services may be reported in addition to the vaccine and toxoid administration codes.

ICD-10-CM Diagnostic Codes

Z23 Encounter for immunization

Z29.89 Encounter for other specified prophylactic measures

AMA: **90647** 2023,Aug; 2023,Jan; 2021,Jun; 2021,May; 2021,Apr; 2020,Nov

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90647	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90647	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
90647	N/A	E	1(2)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

influenza. Contagious respiratory infection caused by the inhalation of an influenza virus causing inflammation of the mucous membranes. There are three types of influenza viruses: type A, which is constantly mutating and producing hundreds of different strains; type B, which has only two strains; and type C.

vaccine. Preparation formed by microorganisms or viruses that have been altered to reduce their virulence but retain their ability to trigger the immune response.

90648

90648 Haemophilus influenzae type b vaccine (Hib), PRP-T conjugate, 4 dose schedule, for intramuscular use

Explanation

A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of the antibody production pattern for long-term protection. A *Haemophilus influenzae* type b vaccine (Hib), PRP-T conjugate, is prepared for intramuscular use in a four-dose schedule. It immunizes a patient against influenza that is caused by the bacteria species *Haemophilus influenzae*. Report this code with the appropriate administration code.

Coding Tips

Report these codes with the appropriate administration code. Administration codes 90460-90461 should only be reported when the clinician renders face-to-face counseling to the patient and/or family at the time the immunization is being administered. For administration of a vaccine without the face-to-face clinician counseling service for patients 18 years of age and older, see 90471-90474. Separately identifiable E/M services may be reported in addition to the vaccine and toxoid administration codes.

ICD-10-CM Diagnostic Codes

Z23 Encounter for immunization

Z29.89 Encounter for other specified prophylactic measures

AMA: **90648** 2023,Aug; 2023,Jan; 2021,Jun; 2021,May; 2021,Apr; 2020,Nov

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90648	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90648	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
90648	N/A	E	1(2)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

influenza. Contagious respiratory infection caused by the inhalation of an influenza virus causing inflammation of the mucous membranes. There are three types of influenza viruses: type A, which is constantly mutating and producing hundreds of different strains; type B, which has only two strains; and type C.

vaccine. Preparation formed by microorganisms or viruses that have been altered to reduce their virulence but retain their ability to trigger the immune response.

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

G0101

G0101 Cervical or vaginal cancer screening; pelvic and clinical breast examination

Explanation

This code reports a cervical or vaginal cancer screening and a pelvic and clinical breast examination. The specimen for cancer screening is collected by cervical, endocervical, or vaginal scrapings or by aspiration of vaginal fluid and cells. The pelvic and breast exams are done manually by the physician to check for abnormalities, pain, and/or any palpable lumps or masses.

Coding Tips

If a separately identifiable service is performed in addition to this procedure, an E/M service may be reported with modifier 25 appended. Some payers may require this service to be reported using CPT preventive medicine service codes: new patient, see 99384-99387; established patient, see 99394-99397. Check with specific payers to determine coverage.

ICD-10-CM Diagnostic Codes

Z01.411 Encounter for gynecological examination (general) (routine) with abnormal findings ♀

Z01.419 Encounter for gynecological examination (general) (routine) without abnormal findings ♀

Z12.39 Encounter for other screening for malignant neoplasm of breast

Z12.4 Encounter for screening for malignant neoplasm of cervix ♀

Z12.72 Encounter for screening for malignant neoplasm of vagina ♀

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0101	0.45	0.65	0.07	1.17
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0101	0.45	0.3	0.07	0.82

	FUD	Status	MUE	Modifiers				IOM Reference
G0101	N/A	A	1(2)	N/A	N/A	N/A	80*	None

* with documentation

Terms To Know

screening test. Exam or study used by a physician to identify abnormalities, regardless of whether the patient exhibits symptoms.

G0102

G0102 Prostate cancer screening; digital rectal examination

Explanation

This code reports a prostate cancer screening performed manually by the physician as a digital rectal exam in order to palpate the prostate and check for abnormalities.

Coding Tips

This service is covered by Medicare once every 12 months for men who have attained age 50; at least 11 months must have passed following the month in which the last Medicare-covered screening digital rectal examination was performed.

ICD-10-CM Diagnostic Codes

Z12.5 Encounter for screening for malignant neoplasm of prostate ♂

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0102	0.18	0.5	0.01	0.69
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0102	0.18	0.07	0.01	0.26

	FUD	Status	MUE	Modifiers				IOM Reference
G0102	N/A	A	1(2)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

prostate. Male gland surrounding the bladder neck and urethra that secretes a substance into the seminal fluid.

screening test. Exam or study used by a physician to identify abnormalities, regardless of whether the patient exhibits symptoms.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90696	0.0	0.0	0.0	0.0
90697	0.0	0.0	0.0	0.0
90698	0.0	0.0	0.0	0.0
90700	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90696	0.0	0.0	0.0	0.0
90697	0.0	0.0	0.0	0.0
90698	0.0	0.0	0.0	0.0
90700	0.0	0.0	0.0	0.0

90702

90702 Diphtheria and tetanus toxoids adsorbed (DT) when administered to individuals younger than 7 years, for intramuscular use

Explanation

This code reports supply of the toxoid only. A toxoid stimulates the body's own immune system to produce specific antitoxin antibodies that destroy the toxins secreted by bacteria. This provides immunity that is effective and long lasting. This code reports toxoids against diphtheria and tetanus (DT), adsorbed for intramuscular use, for administration to individuals younger than age 7. Report this code with the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90702	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90702	0.0	0.0	0.0	0.0

90707

90707 Measles, mumps and rubella virus vaccine (MMR), live, for subcutaneous use

Explanation

A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of these antibody production patterns for long-term protection. Code 90707 reports the combined measles, mumps, and rubella (MMR) vaccine, live, for subcutaneous use. A live vaccine contains the actual pathogens. Report this code with the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90707	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90707	0.0	0.0	0.0	0.0

90710

90710 Measles, mumps, rubella, and varicella vaccine (MMRV), live, for subcutaneous use

Explanation

A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of these antibody production patterns for long-term protection. This vaccine combines measles, mumps, rubella, and varicella (MMRV) for subcutaneous use. This live vaccine contains the actual pathogens. Report this code with the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90710	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90710	0.0	0.0	0.0	0.0

90713

90713 Poliovirus vaccine, inactivated (IPV), for subcutaneous or intramuscular use

Explanation

A vaccine produces active immunization by inducing the immune system to manufacture its own antibodies against specific microorganisms/viruses. The body retains memory of these antibody production patterns for long-term protection. This code describes the inactivated poliovirus vaccine (IPV) for subcutaneous or intramuscular use. Report this code with the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90713	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90713	0.0	0.0	0.0	0.0

90714

90714 Tetanus and diphtheria toxoids adsorbed (Td), preservative free, when administered to individuals 7 years or older, for intramuscular use

Explanation

This code reports supply of the toxoid only. A toxoid stimulates the body's own immune system to produce specific antitoxin antibodies that destroy the toxins secreted by bacteria. This provides immunity that is effective and long lasting. This code reports the immunization supply of tetanus and diphtheria toxoids (Td), adsorbed, preservative free, for intramuscular administration to patients 7 years of age or older. Report this code with the appropriate administration code.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90714	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90714	0.0	0.0	0.0	0.0

90715

90715 Tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap), when administered to individuals 7 years or older, for intramuscular use

Explanation

This code reports the vaccine/toxoid product supply only. A toxoid stimulates the body's own immune system to produce specific antitoxin antibodies that destroy the toxins secreted by bacteria. This provides immunity that is effective and long lasting. A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of these antibody production