

**INGENIX®**

# Coding Companion for Plastics/OMS/Dermatology

*A comprehensive illustrated guide to coding and reimbursement*

# Contents

Getting Started with Coding Companion .....	i	Lips .....	372
Skin .....	1	Vestibule of Mouth .....	385
Nails .....	28	Tongue.....	398
Pilonidal Cyst.....	32	Dentoalveolar Structures .....	426
Repair .....	33	Palate/Uvula.....	439
Destruction .....	136	Abdomen .....	473
Breast .....	149	Extracranial Nerves.....	475
General Musculoskeletal .....	172	Ocular Adnexa .....	495
Head .....	187	External Ear .....	520
Neck/Thorax .....	302	Operating Microscope.....	521
Shoulder.....	307	Medicine Services.....	522
Humerus/Elbow.....	309	Appendix .....	527
Forearm/Wrist.....	312	CCI Edits .....	538
Hand/Fingers.....	327	Evaluation and Management .....	539
Endoscopy.....	359	Index.....	561
Nose .....	362		
Arteries/Veins.....	369		

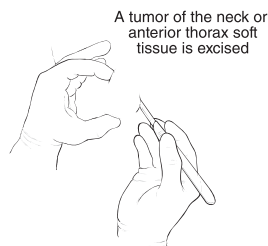
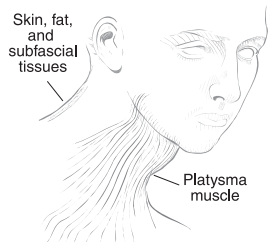
# 21555-21556 (21552, 21554)

**21555** Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm

**21552** 3 cm or greater

**21556** Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm

**21554** 5 cm or greater



## Explanation

The physician removes a tumor from the soft tissue of the neck or anterior thorax (chest) that is located in the subcutaneous tissue in 21552 or 21555 and in the deep soft tissue, below the fascial plane or within the muscle, in 21554 or 21556. With the proper anesthesia administered, the physician makes an incision in the skin overlying the mass and dissects down to the tumor. The extent of the tumor is identified and a dissection is undertaken all the way around the tumor. A portion of neighboring soft tissue may also be removed to ensure adequate removal of all tumor tissue. A drain may be inserted and the incision is repaired with layers of sutures, staples, or Steri-strips. Report 21555 for excision of subcutaneous tumors less than 3 cm and 21552 for excision of subcutaneous tumors 3 cm or greater. Report 21556 for excision of subfascial or intramuscular tumors less than 5 cm and 21554 for excision of subfascial or intramuscular tumors 5 cm or greater.

## Coding Tips

Codes 21552 and 21554 are new for 2010. These codes are resequenced codes and will not display in numeric order. Codes 21555 and 21556 have been revised for 2010 in the official CPT description. When any of these procedures are performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. 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. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

## ICD-9-CM Procedural

- 83.32 Excision of lesion of muscle
- 83.39 Excision of lesion of other soft tissue
- 83.49 Other excision of soft tissue
- 86.3 Other local excision or destruction of lesion or tissue of skin and subcutaneous tissue
- 86.4 Radical excision of skin lesion

## Anesthesia

- 21552** 00300, 00400
- 21554** 00300, 00400
- 21555** 00300
- 21556** 00300

## ICD-9-CM Diagnostic

- 171.0 Malignant neoplasm of connective and other soft tissue of head, face, and neck
- 171.4 Malignant neoplasm of connective and other soft tissue of thorax
- 171.8 Malignant neoplasm of other specified sites of connective and other soft tissue
- 195.0 Malignant neoplasm of head, face, and neck
- 195.1 Malignant neoplasm of thorax
- 199.0 Disseminated malignant neoplasm
- 199.1 Other malignant neoplasm of unspecified site
- 209.32 Merkel cell carcinoma of the scalp and neck
- 209.35 Merkel cell carcinoma of the trunk
- 214.1 Lipoma of other skin and subcutaneous tissue
- 214.8 Lipoma of other specified sites

- 215.0 Other benign neoplasm of connective and other soft tissue of head, face, and neck
- 215.4 Other benign neoplasm of connective and other soft tissue of thorax
- 229.8 Benign neoplasm of other specified sites
- 238.1 Neoplasm of uncertain behavior of connective and other soft tissue
- 784.2 Swelling, mass, or lump in head and neck

## Terms To Know

**dissection.** Separating by cutting tissue or body structures apart.

**subfascial.** Beneath the band of fibrous tissue that lies deep to the skin, encloses muscles, and separates their layers.

## CCI Version 15.3

Also not with 21555: 10021-10022, 10060, 10140, 10160, 11010-11012, 12001-12007, 12020-12047, 13100-13101, 13131-13132, 21550, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 38500, 43752, 51701-51703, 62310-62319, 64400-64435, 64445-64450, 64470, 64475, 64479, 64483, 64505-64530, 69990, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150, J2001

Also not with 21556: 10021-10022, 10060, 10140, 10160, 11012, 12001-12007, 12020-12047, 13100-13101, 13131-13132, 21550, 21555, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 43752, 51701-51703, 62310-62319, 64400-64435, 64445-64450, 64470, 64475, 64479, 64483, 64505-64530, 69990, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150

Note: These CCI edits are used for Medicare. Other payers may reimburse on codes listed above.

## Medicare Edits

	Fac	Non-Fac	FUD	Assist
	RVU	RVU		
<b>21552</b>	12.14	12.14	90	80
<b>21554</b>	19.94	19.94	90	80
<b>21555</b>	8.36	10.89	90	N/A
<b>21556</b>	14.2	14.2	90	N/A

**Medicare References:** 100-2,15,260; 100-4,12,30; 100-4,12,90.3; 100-4,14,10

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## 0168T

**0168T** Rhinophototherapy, intranasal application of ultraviolet and visible light, bilateral

### Explanation

The physician treats allergic rhinitis by exposing nasal tissue to ultraviolet and visible light. A light wand connected to a specialized light source is fitted with a disposable nasal tip and inserted into the nasal cavity of the patient for three minutes or less. During the treatment, the physician rotates the light source to continually pan the nasal cavity to ensure the treatment reaches all nasal tissue. The light inhibits histamine release from mast cells and induces apoptosis in T cells and eosinophils. The process is repeated in the contralateral nostril. The patient is instructed to use vitamin B oil as a salve after the treatment. This code reports one treatment course of rhinophototherapy.

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## 0183T

**0183T** Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day

### Explanation

The physician performs wound treatment utilizing a device that produces low-frequency, ultrasound-generated mist. This non-contact, non-thermal modality promotes wound healing through cellular stimulation. Indicated for acute, chronic, and colonized wounds, as well as burns and ulcers, it provides wound cleansing, bacteria removal, and maintenance debridement of fibrin and tissue exudates. The device uses ultrasound technology to atomize saline, delivering a continuous mist to the treatment site. Multiple passes over the wound are made with the treatment head of the device for a predetermined treatment session. This code includes assessment of the wound, topical applications when performed, and ongoing care instructions. Report this code once per day for the duration of treatment.

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## 70100-70110

**70100** Radiologic examination, mandible; partial, less than 4 views

**70110** complete, minimum of 4 views

### Explanation

The lower jaw bone is x-rayed. In 70100, three or less projections are taken for a partial view of the bone structure and in 70110, four or more

projections are taken for a complete view of the bone structure.

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## 70140

**70140** Radiologic examination, facial bones; less than 3 views

### Explanation

X-rays of the facial bones are obtained to determine an injury, fracture, or neoplasm. After positioning the patient, less than three views of the facial bones are obtained. The physician supervises the procedure and interprets and reports the findings.

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## 70150

**70150** Radiologic examination, facial bones; complete, minimum of 3 views

### Explanation

X-rays of the facial bones are obtained to determine an injury, fracture, or neoplasm. After positioning the patient, a complete series of x-rays of the facial bones, with a minimum of three views, is obtained. The physician supervises the procedure and interprets and reports the findings.

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## 70160

**70160** Radiologic examination, nasal bones, complete, minimum of 3 views

### Explanation

Films are taken of the nasal bones to include a complete exam, or minimum of three views. Typically, this exam would consist of both right and left lateral (side to side) for comparison, as well as a tangential projection in which the x-ray beam is directed from a position above the patient's head down through the nose. This view is primarily used to demonstrate the medial or lateral (side to side) displacement of nasal fractures.

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## 70250-70260

**70250** Radiologic examination, skull; less than 4 views

**70260** complete, minimum of 4 views

### Explanation

Films are taken of the skull bones. In 70250, three or less views are taken, and in 70260, a complete exam with a four view minimum is performed. The most common projections for routine skull series are AP axial (front to back), lateral, and PA axial (back to front). X-rays may be taken with the patient placed erect, prone, or supine and either code may include stereoradiography, which is a technique that produces three-dimensional images.

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## 70300-70320

**70300** Radiologic examination, teeth; single view

**70310** partial examination, less than full mouth

**70320** complete, full mouth

### Explanation

Films are taken of the mouth to show teeth and/or surrounding bone. In dental radiography, the film may be placed either inside or outside the mouth. Code 70300 reports a single view only, 73010 reports a partial examination, and 70320 reports a complete full mouth exam.

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## 70328-70330

**70328** Radiologic examination, temporomandibular joint, open and closed mouth; unilateral

**70330** bilateral

### Explanation

The temporomandibular joint is x-rayed in two projections on one side only in 70328 and in two projections on both sides in 70330. One film is taken with the mouth open and one with the mouth closed.

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## 70332

**70332** Temporomandibular joint arthrography, radiological supervision and interpretation

### Explanation

A radiographic contrast study is performed on the temporomandibular joint. A contrast material is injected into the joint spaces, followed by x-ray examination of the joint. This allows the physician to see the position of the structures not normally seen on conventional x-rays.

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## 70336

**70336** Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)

### Explanation

Magnetic resonance imaging (MRI) is a radiation-free, noninvasive, technique to produce high quality sectional images of the inside of the body in multiple planes. MRI uses the natural magnetic properties of the hydrogen atoms in our bodies that emit radiofrequency signals when exposed to radio waves within a strong electro-magnetic field. These signals are then processed and converted by the computer into high-resolution, three-dimensional, tomographic images. Patients with metallic or electronic implants or foreign bodies cannot be exposed to MRI. The patient must remain still while lying on a motorized table within the large, circular MRI tunnel. A sedative may be administered as well as contrast material for

# Evaluation and Management

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represent the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

Although some of the most commonly used codes by physicians of all specialties, the E/M service codes are among the least understood. These codes, introduced in the 1992 CPT® manual, were designed to increase accuracy and consistency of use in the reporting of levels of non-procedural encounters. This was accomplished by defining the E/M codes based on the degree that certain common elements are addressed or performed and reflected in the medical documentation.

The Office of the Inspector General (OIG) Work Plan for physicians consistently lists these codes as an area of continued investigative review. This is primarily because Medicare payments for these services total approximately \$29 billion per year and are responsible for close to half of Medicare payments for physician services.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may bring to bear on a given patient presentation, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

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## Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services
- Hospital inpatient services—initial care

- Hospital inpatient services—subsequent care
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

Office or other outpatient services are E/M services provided in the physician's office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient.

A new patient is a patient who has not received any face-to-face professional services from the physician within the past three years. An established patient is a patient who has received face-to-face professional services from the physician within the past three years. In the case of group practices, if a physician of the same specialty has seen the patient within three years, the patient is considered established.

If a physician is on call or covering for another physician, the patient's encounter is classified as it would have been by the physician who is not available. Thus, a locum tenens physician who sees a patient on behalf of the patient's attending physician may not bill a new patient code unless the attending physician has not seen the patient for any problem within three years.

Hospital observation services are E/M services provided to patients who are designated or admitted as "observation status" in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the physician "admitting" the patient for observation.

Codes 99234-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and