Optum

Coding Companion

Plastics/ Dermatology

A comprehensive illustrated guide to coding and reimbursement

SAMPLE

2025

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Getting Started with Coding Companion

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

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

CPT/HCPCS Codes

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

Resequencing of CPT Codes

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

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

ICD-10-CM

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

Detailed Code Information

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

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT/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:

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

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

Brow Ptosis
  Repair, 67900

or **Eyebrow**
  Repair
    Ptosis, 67900

or **Repair**
  Eyebrow
    Ptosis, 67900

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page 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

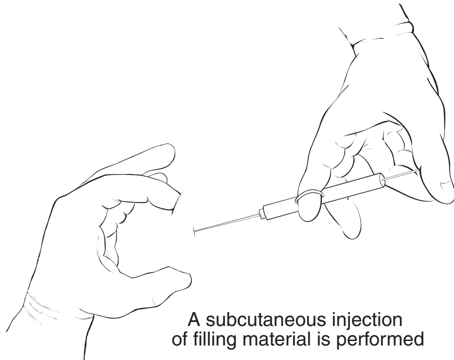
The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

SAMPLE

11950-11954 **1**

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

2



A subcutaneous injection of filling material is performed

Explanation **3**

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

Coding Tips **4**

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

ICD-10-CM Diagnostic Codes **5**

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

Associated HCPCS Codes **6**

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

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

Relative Value Units/Medicare Edits **8**

Non-Facility RVU	Work	PE	MP	Total
11950	0.84	1.44	0.17	2.45
11951	1.19	1.83	0.22	3.24
11952	1.69	2.34	0.3	4.33
11954	1.85	2.58	0.34	4.77
Facility RVU	**Work**	**PE**	**MP**	**Total**
11950	0.84	0.55	0.17	1.56
11951	1.19	0.76	0.22	2.17
11952	1.69	1.05	0.3	3.04
11954	1.85	1.14	0.34	3.33

	FUD	Status	MUE	Modifiers				IOM Reference
11950	0	R	1(2)	51	N/A	N/A	80*	100-02,16,10; 100-02,16,120; 100-02,16,180; 100-03,230.10
11951	0	R	1(2)	51	N/A	N/A	80*	
11952	0	R	1(2)	51	N/A	N/A	80*	
11954	0	R	1(3)	51	N/A	N/A	80*	

* with documentation

Terms To Know **9**

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

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

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

cosmetic. Superficial or external, having no medical necessity.

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

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

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

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

microcheilia. Congenital condition of abnormally small lips.

soft tissue. Nonepithelial tissues outside of the skeleton.

subcutaneous. Below the skin.

SAMPLE

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,

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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.

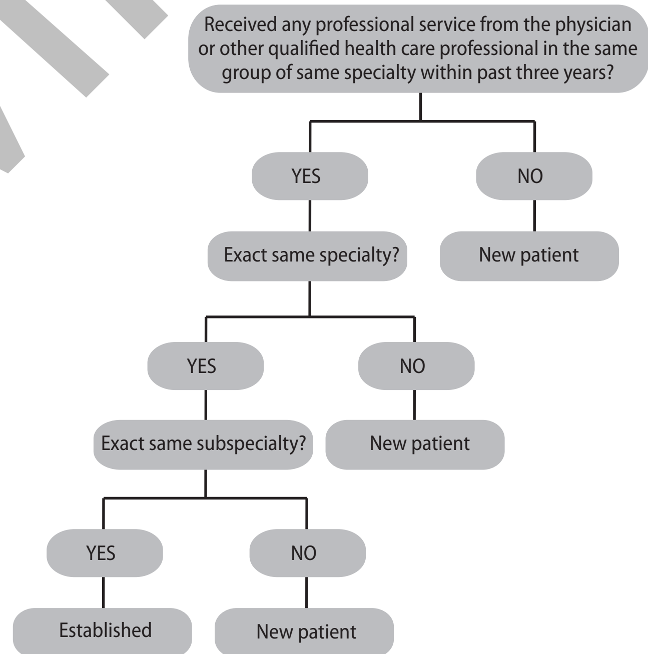
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the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

SAMPLE

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*	

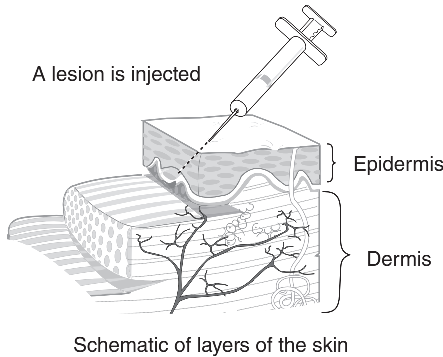
* with documentation

E/M Services

CPT © 2024 American Medical Association. All Rights Reserved. ● New ▲ Revised + Add On ★ Telemedicine AMA: CPT Assist [Resequenced] ☑ Laterality © 2024 Optum360, LLC

11900-11901

11900 Injection, intralesional; up to and including 7 lesions
11901 more than 7 lesions



Schematic of layers of the skin

Explanation

The physician uses a syringe to inject a pharmacologic agent underneath or into any diagnosed skin lesion. Steroids, anesthetics (excluding preoperative local anesthesia), or any non-chemotherapy pharmacological agent may be injected. Report 11900 for injection of seven or fewer lesions. Report 11901 when more than seven lesions are treated.

Coding Tips

When 11900 or 11901 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. These codes should not be used to report preoperative local anesthetic injection. Local anesthesia is included in these services. The drug or other substance may be reported separately, see HCPCS Level II J codes. For injection of a therapeutic, prophylactic, or diagnostic substance, see 96372–96373. Report injection for veins with 36470-36471. For intralesional chemotherapy administration, see 96405 or 96406.

ICD-10-CM Diagnostic Codes

A63.0	Anogenital (venereal) warts
B07.0	Plantar wart
B07.8	Other viral warts
H00.021	Hordeolum internum right upper eyelid ☑
H00.022	Hordeolum internum right lower eyelid ☑
H00.11	Chalazion right upper eyelid ☑
H00.12	Chalazion right lower eyelid ☑
H02.881	Meibomian gland dysfunction right upper eyelid ☑
H02.882	Meibomian gland dysfunction right lower eyelid ☑
H02.88A	Meibomian gland dysfunction right eye, upper and lower eyelids ☑
L28.0	Lichen simplex chronicus
L28.1	Prurigo nodularis
L30.0	Nummular dermatitis
L30.8	Other specified dermatitis
L40.0	Psoriasis vulgaris
L40.1	Generalized pustular psoriasis
L40.2	Acrodermatitis continua
L40.3	Pustulosis palmaris et plantaris
L40.4	Guttate psoriasis
L40.8	Other psoriasis
L43.0	Hypertrophic lichen planus
L43.1	Bullous lichen planus
L43.2	Lichenoid drug reaction
L43.3	Subacute (active) lichen planus
L43.8	Other lichen planus
L52	Erythema nodosum
L63.2	Ophiasis
L63.8	Other alopecia areata
L66.1	Lichen planopilaris
L70.0	Acne vulgaris
L70.1	Acne conglobata
L70.3	Acne tropica
L70.5	Acne excoriee
L70.8	Other acne
L73.0	Acne keloid
L91.0	Hypertrophic scar
L92.0	Granuloma annulare
L92.1	Necrobiosis lipoidica, not elsewhere classified
L92.2	Granuloma faciale [eosinophilic granuloma of skin]
L93.0	Discoid lupus erythematosus
L93.1	Subacute cutaneous lupus erythematosus
L93.2	Other local lupus erythematosus

AMA: **11900** 2022,Aug; 2022,Feb; 2021,Aug **11901** 2022,Feb; 2021,Aug

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11900	0.52	1.13	0.06	1.71
11901	0.8	1.21	0.08	2.09
Facility RVU	**Work**	**PE**	**MP**	**Total**
11900	0.52	0.31	0.06	0.89
11901	0.8	0.47	0.08	1.35

	FUD	Status	MUE	Modifiers				IOM Reference
11900	0	A	1(2)	51	N/A	N/A	N/A	None
11901	0	A	1(2)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

intra. Within.

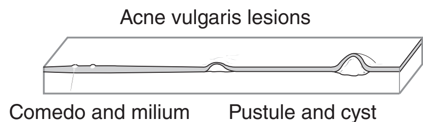
lesion. Area of damaged tissue that has lost continuity or function, due to disease or trauma.

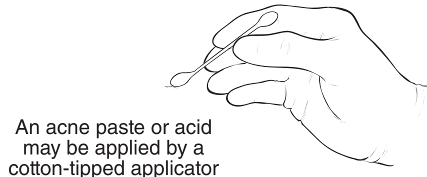
pharmacological agent. Drug used to produce a chemical effect.

SAMPLE

17360

17360 Chemical exfoliation for acne (eg, acne paste, acid)





Explanation

The physician destroys the area of acne with a chemical exfoliator such as acne paste or acid by touching a soaked cotton tip applicator to the lesion for a short period of time (commonly 30 seconds). This leads to formation of eschar and healing.

Coding Tips

Local anesthesia is included in this service. A benign lesion excision code (11400–11446) and chemical exfoliation for acne (17360) should not be reported on the same date of service with acne surgery (10040). For cryotherapy (CO2 slush, liquid N2 for acne), see 17340. Surgical trays, A4550, are not separately reimbursed by Medicare; however, other third-party payers may cover them. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

L70.0	Acne vulgaris
L70.1	Acne conglobata
L70.2	Acne varioliformis
L70.3	Acne tropica
L70.4	Infantile acne P
L70.5	Acne excoriee
L70.8	Other acne

AMA: 17360 2022,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
17360	1.46	2.09	0.17	3.72
Facility RVU	**Work**	**PE**	**MP**	**Total**
17360	1.46	1.14	0.17	2.77

	FUD	Status	MUE	Modifiers				IOM Reference
17360	10	A	1(2)	51	N/A	N/A	N/A	100-02,16,10; 100-02,16,120

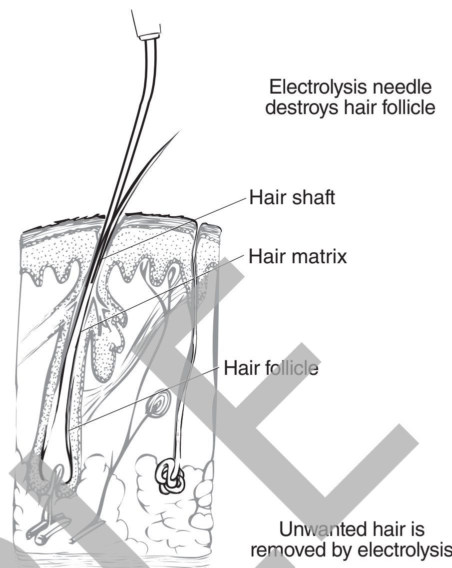
* with documentation

Terms To Know

eschar. Leathery slough produced by burns.

17380

17380 Electrolysis epilation, each 30 minutes



Explanation

The physician uses electrolysis to remove hair. This code is used to report a 30-minute session. The physician inserts the electroneedle into the hair follicle and applies electrical current, killing the follicle. The electroneedle is removed.

Coding Tips

Because this procedure is usually not done out of medical necessity, the patient may be responsible for charges. Verify with the insurance carrier for coverage. For actinotherapy, see 96900.

ICD-10-CM Diagnostic Codes

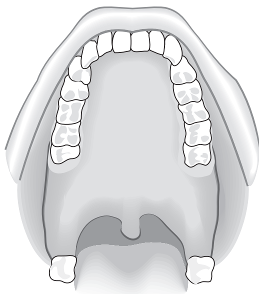
L68.0	Hirsutism
L68.1	Acquired hypertrichosis lanuginosa
L68.2	Localized hypertrichosis
L68.3	Polytrichia
L68.8	Other hypertrichosis
Q84.1	Congenital morphological disturbances of hair, not elsewhere classified
Q84.2	Other congenital malformations of hair
Z41.1	Encounter for cosmetic surgery

AMA: 17380 2022,Feb

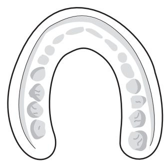
SAMPLE

21079-21080

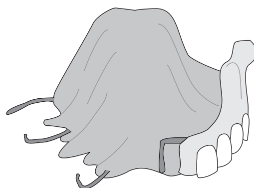
21079 Impression and custom preparation; interim obturator prosthesis
21080 definitive obturator prosthesis



An interim or definitive obturator prosthesis is customized



An impression is taken of the patient's tooth, gum, and jaw structure



The doctor fabricates an obturator prosthesis to augment the palate

Explanation

The physician or other qualified health care provider fabricates an obturator prosthesis to provide a separation between the mouth and the surgical site and/or protect the surgical site while assisting the patient's ability to talk and chew. Impressions are made of the mouth. The impressions are used to make models from which a custom obturator prosthesis is fabricated. The provider makes an interim or temporary obturator prosthesis in 21079 and a definitive obturator prosthesis in 21080, which separates the nasal and sinus complex from the mouth.

Coding Tips

Report 21079 and 21080 only when the physician or other qualified health care professional actually designs and prepares the prosthesis (e.g., not prepared by an outside laboratory). A temporary (interim) prosthesis is inserted during or immediately following surgical or traumatic loss of a portion of one or both maxillary bones and alveolar structures. Frequent revisions of surgical obturators during the healing phase (approximately six months) are not reported separately. Further surgical revisions may require fabrication of another surgical obturator (e.g., an initially planned small defect may be revised and greatly enlarged after the final pathologic report indicates margins are not free of tumor).

ICD-10-CM Diagnostic Codes

C05.0	Malignant neoplasm of hard palate
C05.1	Malignant neoplasm of soft palate
C41.0	Malignant neoplasm of bones of skull and face
Q35.1	Cleft hard palate
Q35.3	Cleft soft palate
Q35.5	Cleft hard palate with cleft soft palate
Q37.0	Cleft hard palate with bilateral cleft lip
Q37.1	Cleft hard palate with unilateral cleft lip
Q37.2	Cleft soft palate with bilateral cleft lip
Q37.3	Cleft soft palate with unilateral cleft lip
Q37.4	Cleft hard and soft palate with bilateral cleft lip
Q37.5	Cleft hard and soft palate with unilateral cleft lip
Q75.8	Other specified congenital malformations of skull and face bones
Q87.0	Congenital malformation syndromes predominantly affecting facial appearance
S01.512A	Laceration without foreign body of oral cavity, initial encounter
S01.522A	Laceration with foreign body of oral cavity, initial encounter
S01.532A	Puncture wound without foreign body of oral cavity, initial encounter
S01.542A	Puncture wound with foreign body of oral cavity, initial encounter
S01.552A	Open bite of oral cavity, initial encounter
S02.42XA	Fracture of alveolus of maxilla, initial encounter for closed fracture
S02.42XB	Fracture of alveolus of maxilla, initial encounter for open fracture
S02.81XA	Fracture of other specified skull and facial bones, right side, initial encounter for closed fracture ☑
S02.81XB	Fracture of other specified skull and facial bones, right side, initial encounter for open fracture ☑
S02.82XA	Fracture of other specified skull and facial bones, left side, initial encounter for closed fracture ☑
S02.82XB	Fracture of other specified skull and facial bones, left side, initial encounter for open fracture ☑
S07.0XXA	Crushing injury of face, initial encounter
Z44.8	Encounter for fitting and adjustment of other external prosthetic devices

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21079	22.31	18.67	2.09	43.07
21080	25.06	22.1	2.4	49.56
Facility RVU	**Work**	**PE**	**MP**	**Total**
21079	22.31	10.27	2.09	34.67
21080	25.06	11.93	2.4	39.39

	FUD	Status	MUE	Modifiers				IOM Reference
21079	90	A	1(2)	51	N/A	N/A	N/A	None
21080	90	A	1(2)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

cleft palate. Congenital fissure or defect of the roof of the mouth opening to the nasal cavity due to failure of embryonic cells to fuse completely.

obturator. Prosthesis used to close an acquired or congenital opening in the palate that aids in speech and chewing.

SAMPLE

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N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only
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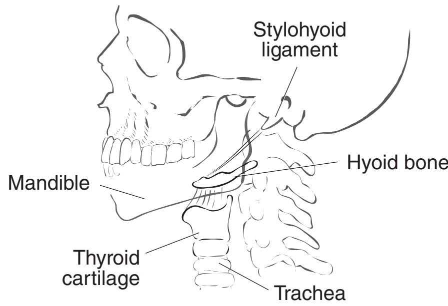
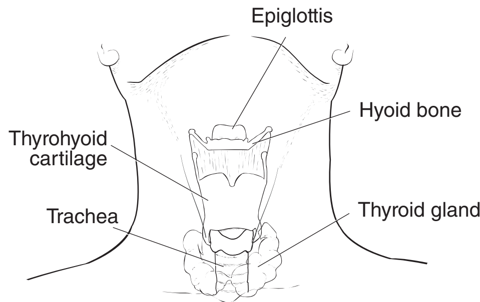
21685

21685 Hyoid myotomy and suspension



The hyoid bone is surgically exposed by a neck incision



Explanation

The hyoid bone is a small C-shaped bone in the neck above the Adam's apple, or thyroid cartilage, with muscles of the tongue and throat attached to it. Hyoid myotomy and suspension is done to open the oro-hypopharyngeal airway for correcting breathing in sleep apnea. It involves repositioning and fixating the hyoid bone to improve the airway. A submental incision is made to expose the hyoid bone in the neck. The muscles below the hyoid are transected and separated to expose a small, isolated, mid-portion of the hyoid bone. Strips of fascia lata (bands of fibrous tissue), nonresorbable suture, or other strong materials are wrapped around the body of the hyoid and used to pull it forward and secure it to the inferior mandibular border. An alternative method pulls the hyoid downward to the voicebox cartilage for thyro-hyoid suspension, and secures it there.

Coding Tips

When 21685 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. Report any free grafts or flaps separately.

ICD-10-CM Diagnostic Codes

G47.33	Obstructive sleep apnea (adult) (pediatric)
G47.39	Other sleep apnea
G47.8	Other sleep disorders

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21685	15.26	12.06	2.16	29.48
Facility RVU	**Work**	**PE**	**MP**	**Total**
21685	15.26	12.06	2.16	29.48

	FUD	Status	MUE	Modifiers				IOM Reference
21685	90	A	1(2)	51	N/A	62*	80	None

* with documentation

Terms To Know

fascia lata. Fibrous sheet or band of tissue that envelops the deep muscles of the thigh.

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

hyoid bone. Single, U-shaped bone palpable in the neck above the larynx and below the mandible (lower jaw) with various muscles attached but not articulating with any other bone.

hypersomnia. Disorder identified by the need for excessive sleep.

insomnia. Inability to sleep.

myotomy. Surgical cutting of a muscle to gain access to underlying tissues or for therapeutic reasons.

reposition. Placement of an organ or structure into another position or return of an organ or structure to its original position.

sleep apnea. Intermittent cessation of breathing during sleep that may cause hypoxemia and pulmonary arterial hypertension.

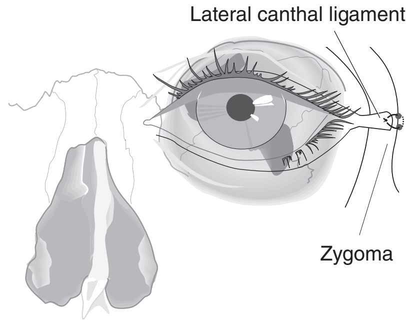
suspension. Fixation of an organ for support; temporary state of cessation of an activity, process, or experience.

transection. Transverse dissection; to cut across a long axis; cross section.

SAMPLE

21282

21282 Lateral canthopexy



Ligament and wire are passed through drilled hole and ligated to bone

Explanation

The physician reattaches the lateral canthal ligament to correct soft tissue structures of the lateral aspect of the eye and eyelids. The lateral canthal ligament is attached laterally to the orbital aspect of the zygoma and medially to the orbital fascia, the upper eyelid, and the lower eyelid. The ligament is isolated through a horizontal skin incision placed beside the ligament. After locating the ligament, the physician places stainless steel suture or wire through the ligament. A hole is made in the zygoma with a drill. The physician passes the suture or wire through the bony hole. The suture or wire is ligated to the bone. Skin incisions are repaired with a layered closure.

Coding Tips

Detachment of the lateral canthal ligament usually results from fractures of the zygomaticomaxillary or orbital regions or from laceration of the ligament. For medial canthopexy, see 21280. For lateral or medial canthoplasty, see 67950.

ICD-10-CM Diagnostic Codes

Q10.3 Other congenital malformations of eyelid
Q15.8 Other specified congenital malformations of eye
S00.211A Abrasion of right eyelid and periocular area, initial encounter ☑
S00.212A Abrasion of left eyelid and periocular area, initial encounter ☑
S00.221A Blister (nonthermal) of right eyelid and periocular area, initial encounter ☑
S00.222A Blister (nonthermal) of left eyelid and periocular area, initial encounter ☑
S00.271A Other superficial bite of right eyelid and periocular area, initial encounter ☑
S00.272A Other superficial bite of left eyelid and periocular area, initial encounter ☑
S01.111A Laceration without foreign body of right eyelid and periocular area, initial encounter ☑
S01.112A Laceration without foreign body of left eyelid and periocular area, initial encounter ☑
S01.121A Laceration with foreign body of right eyelid and periocular area, initial encounter ☑
S01.122A Laceration with foreign body of left eyelid and periocular area, initial encounter ☑
S01.131A Puncture wound without foreign body of right eyelid and periocular area, initial encounter ☑
S01.132A Puncture wound without foreign body of left eyelid and periocular area, initial encounter ☑
S01.141A Puncture wound with foreign body of right eyelid and periocular area, initial encounter ☑
S01.142A Puncture wound with foreign body of left eyelid and periocular area, initial encounter ☑
S01.151A Open bite of right eyelid and periocular area, initial encounter ☑
S01.152A Open bite of left eyelid and periocular area, initial encounter ☑
S05.21XA Ocular laceration and rupture with prolapse or loss of intraocular tissue, right eye, initial encounter ☑
S05.22XA Ocular laceration and rupture with prolapse or loss of intraocular tissue, left eye, initial encounter ☑
S05.31XA Ocular laceration without prolapse or loss of intraocular tissue, right eye, initial encounter ☑
S05.32XA Ocular laceration without prolapse or loss of intraocular tissue, left eye, initial encounter ☑
S05.41XA Penetrating wound of orbit with or without foreign body, right eye, initial encounter ☑
S05.42XA Penetrating wound of orbit with or without foreign body, left eye, initial encounter ☑
S05.51XA Penetrating wound with foreign body of right eyeball, initial encounter ☑
S05.52XA Penetrating wound with foreign body of left eyeball, initial encounter ☑
S05.61XA Penetrating wound without foreign body of right eyeball, initial encounter ☑
S05.62XA Penetrating wound without foreign body of left eyeball, initial encounter ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
21282	4.27	7.11	0.53	11.91
Facility RVU	**Work**	**PE**	**MP**	**Total**
21282	4.27	7.11	0.53	11.91

	FUD	Status	MUE	Modifiers				IOM Reference
21282	90	A	1(2)	51	50	N/A	N/A	None

* with documentation

Terms To Know

canthopexy. Procedure performed to stabilize the eyelid by reattaching the medial or lateral canthal ligament by placing a wire or suture through the nasal orbital or cheekbones.

lateral. Located away from the medial plane or farther away from the middle of the body.

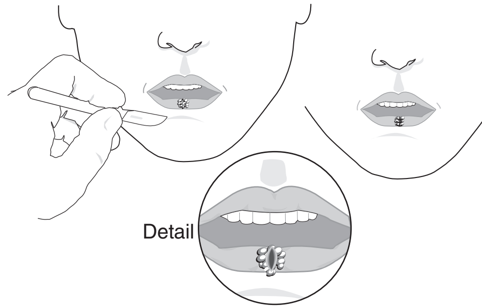
soft tissue. Nonepithelial tissues outside of the skeleton.

zygoma. Zygomatic process of the temporal bone that creates the cheekbone.

SAMPLE

40490

40490 Biopsy of lip



Portion of lesion is removed with a scalpel

Explanation

The physician performs a biopsy of a lesion on the lip. An incision is made in the lip and a portion of the lesion together with some normal tissue is removed. The surgical wound is closed directly.

Coding Tips

This procedure is for a biopsy of the lip. If an entire lesion is removed, use the appropriate excision code. If multiple areas are biopsied, report 40490 for each site taken and append modifier 51 to additional codes. For resection of more than one-fourth of the lip, see 40530. Local anesthesia is included in this service. For handling or conveyance of a specimen transported to an outside laboratory, see 99000. For procedures on the skin of the lips, see the Integumentary section of CPT. For excision of a lesion of the lip, benign, see 11440–11446; malignant, see 11640–11646. For vermilionectomy (lip shave) with mucosal advancement, see 40500. For excision of the lip, see 40510–40527.

ICD-10-CM Diagnostic Codes

A18.83	Tuberculosis of digestive tract organs, not elsewhere classified
A51.2	Primary syphilis of other sites
A51.39	Other secondary syphilis of skin
B00.1	Herpesviral vesicular dermatitis
C00.0	Malignant neoplasm of external upper lip
C00.1	Malignant neoplasm of external lower lip
C00.3	Malignant neoplasm of upper lip, inner aspect
C00.4	Malignant neoplasm of lower lip, inner aspect
C00.8	Malignant neoplasm of overlapping sites of lip
C14.8	Malignant neoplasm of overlapping sites of lip, oral cavity and pharynx
C43.0	Malignant melanoma of lip
C44.01	Basal cell carcinoma of skin of lip
C44.02	Squamous cell carcinoma of skin of lip
C44.09	Other specified malignant neoplasm of skin of lip
C4A.0	Merkel cell carcinoma of lip
D00.01	Carcinoma in situ of labial mucosa and vermilion border
D03.0	Melanoma in situ of lip
D04.0	Carcinoma in situ of skin of lip
D10.0	Benign neoplasm of lip
D22.0	Melanocytic nevi of lip
D23.0	Other benign neoplasm of skin of lip
D37.01	Neoplasm of uncertain behavior of lip
K13.0	Diseases of lips
K13.21	Leukoplakia of oral mucosa, including tongue

AMA: 40490 2019,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
40490	1.22	2.34	0.12	3.68
Facility RVU	**Work**	**PE**	**MP**	**Total**
40490	1.22	0.71	0.12	2.05

	FUD	Status	MUE	Modifiers				IOM Reference
40490	0	A	2(3)	51	N/A	N/A	N/A	None

* with documentation

Terms To Know

biopsy. Tissue or fluid removed for diagnostic purposes through analysis of the cells in the biopsy material.

carcinoma in situ. Malignancy that arises from the cells of the vessel, gland, or organ of origin that remains confined to that site or has not invaded neighboring tissue.

lesion. Area of damaged tissue that has lost continuity or function, due to disease or trauma.

malignant. Any condition tending to progress toward death, specifically an invasive tumor with a loss of cellular differentiation that has the ability to spread or metastasize to other body areas.

surgical wound. Surgical wounds fall into four categories that determine treatment methods and outcomes: ***clean wound*** No inflammation or contamination; treatment performed with no break in sterile technique; no alimentary, respiratory, or genitourinary tracts involved in the surgery. Infection rate: up to 5 percent. ***clean-contaminated wound*** No inflammation; treatment performed with minor break in surgical technique; no unusual contamination resulting when alimentary, respiratory, genitourinary, or oropharyngeal cavity is entered. Infection rate: up to 11 percent. ***contaminated wound*** Less than four hours old with acute, nonpurulent inflammation; treatment performed with major break in surgical technique; gross contamination resulting from the gastrointestinal tract. Infection rate: up to 20 percent. ***dirty and infected wound*** More than four hours old with existing infection, inflammation, abscess, and nonsterile conditions due to perforated viscus, fecal contamination, necrotic tissue, or foreign body. Infection rate: up to 40 percent. A complicated open wound is defined as a wound that has delayed healing, delayed treatment, foreign body (including debris), or infection.

tissue. Group of similar cells with a similar function that form definite structures and organs. Tissue types include epithelial tissue, muscle tissue, connective tissue, and nervous tissue.

SAMPLE

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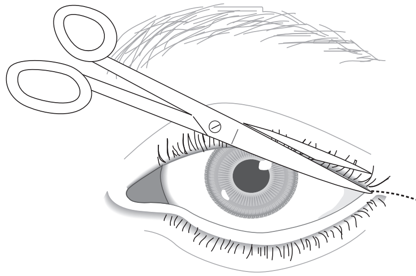
67715

67715 Canthotomy (separate procedure)



Scissors cut the lateral canthus to further divide the upper and lower lid to extend the eye opening

Explanation

Under local anesthesia, the face and eyelids are draped and prepped. Scissors cut the lateral canthus to further divide the upper and lower lid to extend the division.

Coding Tips

This separate procedure by definition is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported. If performed alone, list the code; if performed with other procedures/services, list the code and append 59 or an X{EPSU} modifier. For canthoplasty, see 67950. For division of symblepharon, see 68340.

ICD-10-CM Diagnostic Codes

H05.211 Displacement (lateral) of globe, right eye ☑
H05.221 Edema of right orbit ☑
H05.231 Hemorrhage of right orbit ☑
H05.241 Constant exophthalmos, right eye ☑
H05.261 Pulsating exophthalmos, right eye ☑
H40.051 Ocular hypertension, right eye ☑

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
67715	1.27	6.5	0.18	7.95
Facility RVU	**Work**	**PE**	**MP**	**Total**
67715	1.27	1.76	0.18	3.21

	FUD	Status	MUE	Modifiers				IOM Reference
67715	10	A	1(3)	51	50	N/A	N/A	None

* with documentation

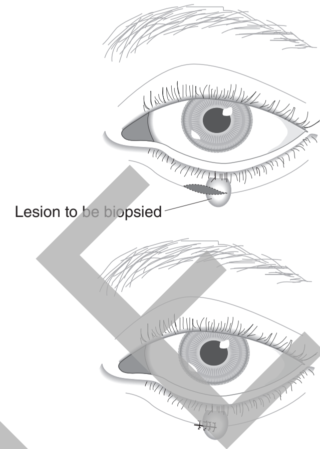
Terms To Know

canthotomy. Horizontal incision at the canthus (junction of upper and lower eyelids) to divide the outer canthus and enlarge lid margin separation.

division. Separating into two or more parts.

[67810]

67810 Incisional biopsy of eyelid skin including lid margin



Explanation

A local anesthetic is applied and the face and eyelid are prepped and draped. A small amount of tissue is excised from the suspect portion of the eyelid, which may include the lid margin. Sutures may be required to repair the incision.

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). When 67810 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 multiple areas are biopsied, report 67810 for each site taken and append modifier 59 or an X{EPSU} modifier to additional codes. 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 biopsy of the eyelid skin, see 11102–11107.

ICD-10-CM Diagnostic Codes

C43.111 Malignant melanoma of right upper eyelid, including canthus ☑
C43.112 Malignant melanoma of right lower eyelid, including canthus ☑
C43.121 Malignant melanoma of left upper eyelid, including canthus ☑
C43.122 Malignant melanoma of left lower eyelid, including canthus ☑
C44.1121 Basal cell carcinoma of skin of right upper eyelid, including canthus ☑
C44.1122 Basal cell carcinoma of skin of right lower eyelid, including canthus ☑

SAMPLE

Correct Coding Initiative Update 29.3

❖Indicates Mutually Exclusive Edit

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