



CARE
RESEARCH
PREVENTION
REHABILITATION
TEACHING

Coding and Reimbursement Primer

2018 EDITION

American Burn Association
311 South Wacker Drive, Suite 4150
Chicago, IL 60606
(312) 642-9260
www.ameriburn.org

**American Burn Association
311 N. Wacker Dr., Suite 4150
Chicago, IL 60606
(312) 642-9260**

Copyright © American Burn Association 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2017, 2018 All Rights Reserved.

CPT codes, descriptions and material only are copyright 2000-2017 American Medical Association. All Rights Reserved. No fee schedules, basic units, relative values or related listings are included in CPT. The AMA assumes no liability for the data contained herein.

Disclaimer: Although the American Burn Association has taken reasonable steps to ensure the accuracy of the information presented in this Primer, this publication should not be construed as providing professional advice or consultation. Readers are encouraged to consult with knowledgeable coding consultants on specific issues affecting them. The American Burn Association assumes no legal liability for the information contained herein.



**This publication was made possible in part through an
unrestricted educational grant from the Integra Foundation.**

CPT codes, descriptions and material only © 2017 American Medical Association. All Rights Reserved
CPT® is a registered trademark of the American Medical Association

Burn surgeons are involved in exciting and truly changing times. The advent of tissue engineering, coupled with the expanding role of government in health care, including the Centers for Medicare and Medicaid Services (CMS), third party payers, HMOs, ACO's, and case management agencies, poses challenges involving not only the physician's responsibility to the burn patient but also how to address the socioeconomic issues of burn care. Case management and payers in general have introduced their own models of quality assurance. In addition, CMS has developed active programs to detect potential fraud and abuse in the delivery of health care for its Medicare and Medicaid programs.

It is evident that the clinical and surgical knowledge and skills of a burn surgeon are not enough to ensure success. It is also necessary to learn to properly code burn diagnoses and to appropriately code medical services and procedures performed on the burn patient. The burn surgeon cannot be content allocating this task to coding personnel. Correct coding is the responsibility of the burn physician. It is dependent upon appropriate documentation and a daily reporting mechanism for the medical and surgical services rendered to the burn patient.

To address this challenge, burn surgeons must become familiar with a group of acronyms: ICD-10-CM, ICD-10-PCS, CPT, E/M, MS-DRGs, RBRVS, HCPCS and others. This manual is designed to address the most important coding and reimbursement issues affecting burn surgeons and to provide relevant information to help avoid liability for fraud or abuse.

The content of this coding manual is based on current (as of this publication) CPT and Medicare/CMS coding and reporting guidelines, where applicable. In cases where the two sources diverge significantly (e.g., designation of burn wound excision as global vs. minor surgery), the policy distinction is explained.

CPT and Medicare/CMS are generally recognized as setting the national standard for coding and reporting. However, coding and reporting guidelines can and often do vary from community to community and state to state. Any non-Medicare payer may elect to adopt some or all of the national standards or deviate from them in whole or in part. Therefore, this manual does not attempt to address coding and reporting that is unique to a specific geographic region or given payer. Burn surgeons and coding staff are encouraged to utilize the manual as a standard coding reference while following any local payer coding and reporting guidelines that may vary from the national standard.

ACKNOWLEDGMENTS

The 2018 ABA Coding Primer represents the Association's continued commitment to providing burn centers and ABA members with pertinent information to enhance documentation and coding for the care of patients treated in burn center hospitals. It would not have been possible without the ongoing contributions of a number of dedicated and knowledgeable individuals: William Hickerson, MD, FACS (Chair of the ABA Coding Committee) and the following staff in the ABA Central Office: Kimberly A. Hoarle, MBA, CAE, Executive Director and Maureen T. Kiley, BA, Senior Program Director. The Association thanks Donna J. Cartwright, MPA, RHIA, CCS, RAC, FAHIMA, for serving as project consultant and, in that capacity, sharing her dedication, enthusiasm and extensive coding expertise. Special thanks and appreciation are also extended to the Foundation of Integra Lifesciences Corporation for their support of the Primer.

Table of Contents

Introduction & Purpose of Manual3

Acknowledgments4

CODING FOR PHYSICIAN SERVICES

Key Concepts.....11

 What is Coding? 11

 Coding Systems for Physician Claims 11
 Procedures, Services and Supplies Furnished by Physicians • Diseases, Conditions Evaluated /Treated by Physician • Coding Systems—Effective Dates of Annual Updates • Recent CPT Changes Affecting Burn Surgery for 2018

 Relative Value Update Process (RUC)..... 16

 Claim Forms for Physician Services 16

 What Makes a Claim Payable? 17

 Defensible Documentation..... 17

 Establishing Medical Necessity19

 Unbundling and Bundling 20

 MUEs—Medically Unlikely Edits (Medicare) 22

 Global Periods 28
 Global Surgery Package, CPT Surgical Package • Medicare Global Surgery Package • Medicare Coding Case Studies (1.0 & 2.0) for Single or Multiple Physicians, Same Group, Caring for Same Patient • CPT “Add-on” Codes

 Modifiers 53
 Modifier Essentials • Modifiers Most Commonly Used by Burn Surgeons • Surgical Modifiers Frequently Used by Burn Surgeons • Evaluation and Management Modifiers Used Frequently by Burn Surgeons

 Multiple Surgical Procedures 63
 Reduced Payment • What is a Secondary Procedure? • Reduced Payment Not Applicable to Add-on Codes & Modifier 51 Exempt Codes • Ranking Procedures on the Claim

 Assistant at Surgery: Medicare 66

Fraud and Abuse..... 67
Physician Claims for Services Must Be Performed or Provided Directly by the Physician • Two Situations Where the Physician Can Bill for Services Performed by a Different Clinician • Underlying Regulations and Guidelines • Summary of Key Points • Medicare Fraud, Waste & Abuse Training Required for Physicians

Evaluation & Management (E/M) Services.....70

Documentation: Key Concepts..... 70
CPT & Medicare Definitions of New & Established Patient • Categories of E/M Codes • Types of Problem-oriented E/M Codes • Selecting the Correct E/M Code for Level of Service—Determined by Documentation • CMS Requirements/ Selecting E/M Codes • CPT & CMS Documentation Requirements • Documentation for Separate E/M & Minor Surgical Procedure, Same Date of Service

Basic E/M Reporting Guidelines..... 73
1 E/M per day • Unbundling and Bundling E/M Services • E/M Services and the Surgical Package

Shared E/M Services: Physician and Non-Physician Practitioner..... 79
Unique Medicare-Only Concept • Medicare Payment Differential • Place of Service Requirements • Physician & NPP in Same Employer Group • Physician & NPP with Different Employers

Typical Burn E/M Services 89
Emergency Department Service (99281–99285) • Consultations (99241–99255, 99251-99255) • Admit H&P Only (99221–99223) • Critical Care (Hourly) (99291–99292) • Inpatient Pediatric Critical Care (99271-99276) • Inpatient Neonatal Critical Care (99468-99469) • Inpatient Daily Visits (99231–99233) • Multidisciplinary Rounds (99366–99368) • Discharge Day Management (99238–99239) • Office /Outpatient Hospital Clinic Visits (99201–99215, New or Established Patient)

Surgical Procedures: Surgery & Bedside 123

Basic Reporting Concepts & Documentation..... 123

Conscious Sedation/Moderate Sedation126
Definition of Moderate (Conscious) Sedation • Services Included in Conscious Sedation • Reporting Guidelines for Office-based and Hospital-based Physicians

Procedural Services 129
Abdominal Decompression • Amputation • Application Bilaminate Skin Substitute • Arterial Line Insertion • Biopsy of Skin • Bronchoscopy • Central Venous Access • Compartment Pressure Measurement • Contracture Release / Scar Revision • Debridement, Surgical (16020–16030) (11000–11001, & 11040–11044) • Burn Wound Debridement vs. Excision • Non-burn Wound Debridement • Debridement, Non-Surgical (97597-97598, 97602) • Dressing

Change • Escharotomy • Excision Burn & Non-burn Wounds (15002-15005) • Fasciotomy • Fasciotomy Code Table • GI Tubes • Skin Replacement Surgery and Skin Substitutes: Grafts • Table of Skin Replacements and Skin Substitutes • Intraosseous Needle Placement for Infusion • K-wire Insertion • Overlay Grafting • Splints, Custom Construction in OR • Sub eschar Clysis • Swan Ganz • Tracheostomy • Vacuum Assisted Wound Closure (VAC)

Diagnosis Coding for Physician Services201

Official Coding Guidelines for Physician Services: Excerpts 201
 Burn Diagnosis Coding for Physician Services 203

Coding for Non-Burn Conditions221

Coding for Professional Services/Procedures Performed in Conjunction with Non-Burn Conditions 221
 Pathophysiology and Diagnosis Coding for Non-Burn Conditions..... 221
Calciphylaxis • DE gloving Injuries • Fournier’s Gangrene, Fournier’s Disease • Hidradenitis Suppurativa • Necrotizing Fasciitis • Purpura Fulminans • Toxic Epidermal Necrolysis (TEN)

Teaching Physician Guidelines230

Documentation Guidelines for Evaluation and Management Services: “Key Components’ Codes” 231
 Documentation Guidelines for Evaluation and Management Services: Time-Based Codes234
 Documentation Guidelines for Procedures 235
 Assistants at Surgery in Teaching Institutions 237

Non-Physician Practitioners239

Coding and Payer Issues 239
 General CPT Coding Guidelines for Professional Services..... 243
E/M Services • Global Periods • Surgical Procedures • Diagnosis Coding for NPP Services

The Appeal Process: Physician Claims.....251

Medicare Appeals.....251
Where to File Appeals • Effect of Assignment on Physician Appeals • Attention to Detail-Appeals Process • Overview of Steps in Process • First Level Appeal • Second Level Appeal • Third Level Appeal • Fourth and Fifth Levels of Appeal
 Appeal Response256

CODING FOR FACILITY (HOSPITAL) SERVICES

Key Concepts.....	257
What is Coding?	258
Coding Systems Used by Hospitals	258
Coding Systems for Hospital Claims	259
<i>Procedure Coding Systems, Inpatient & Outpatient Hospital •</i>	
<i>Diagnosis Coding System, Inpatient and Outpatient Hospital • Coding</i>	
<i>Systems Effective Dates of Annual Updates</i>	
CMS Official Inpatient & Outpatient Coding Guidelines	262
<i>Mandated by Law</i>	
Inpatient Hospital Coding.....	264
Inpatient Hospital Reimbursement under DRGs/MS-DRGs	264
<i>DRG Background Summary • Major Diagnostic Category (MDC 22)</i>	
<i>Burns • Table of FY 2018 Burn & Related MS-DRGs (weights &</i>	
<i>length of stay) • Hospital-Acquired Conditions Rule & Effect on MS-</i>	
<i>DRG Payment</i>	
Inpatient Hospital Coding for Burn MS-DRGs.....	274
<i>General Inpatient Coding Guidelines Excerpted from 2018</i>	
<i>ICD-10-CM Official Guidelines for Coding and Reporting • Burn-</i>	
<i>Specific Coding: Excerpted from Official Guidelines for Coding and</i>	
<i>Reporting • Discussion: Inpatient Coding of Burn Diagnoses &</i>	
<i>Procedures • Tips for Inpatient Code Abstraction • Coding for</i>	
<i>Specific Burn MS-DRGs 928 & 929 • Present on Admission (POA)</i>	
<i>Official Reporting Guidelines</i>	
Outpatient Hospital Department Coding	292
Reimbursement under Medicare’s Hospital Outpatient Prospective	
Payment System (HOPPS/OPPS): Ambulatory Payment Classifications.	293
<i>Transitional Pass-Through Payments</i>	
Coding for Medicare’s Outpatient Hospital APCs.....	294
<i>Coding Systems Used for Reporting Outpatient Hospital Services</i>	
Coding Burn Procedures and Services	295
<i>Coding Systems for Reporting Procedures, Services, Supplies •</i>	
<i>Packaging of APCs • Unbundling and Bundling • Global Period for</i>	
<i>Outpatient Hospital Services • CPT “Add-on” Codes</i>	
Reporting Evaluation and Management (E/M) Services (Medicare).....	301
<i>Definition: New or Established Patient • CMS Criteria for Code</i>	
<i>Selection in Outpatient Hospital • E/M Service & Procedure, Same</i>	
<i>Date • General E/M Coding Guidelines • Emergency Department</i>	
<i>Services, Type A & Type B ED Visits • Hospital Observation Services</i>	
<i>• Clinic Visit • Critical Care</i>	

Reporting Outpatient Procedures (Medicare) 307
Reporting of Service Units • Procedural Services • Biopsy of Skin • Contracture Release/ Scar Revision • Debridement, Surgical (16020–16030) (11000–11001, & 11040–11044 • Debridement vs Excision • Debridement, Non-Surgical (97597-97598, 97602) • Dressing Change • Escharotomy • Excision Burn & Non-burn Wounds • Debridement vs Excision • Fasciotomy • Fasciotomy Code Table • Skin Replacement Surgery and Skin Substitutes: Grafts • K-Wire Insertion • Splints/ Custom Construction/ OR • VAC

Burn Diagnosis Coding for Outpatient Hospital Services 343
General Outpatient Diagnosis Coding Guidelines Excerpted from 2018 ICD-10 -CM Official Guidelines for Coding and Reporting • Burn-Specific Coding Excerpted from 2018 Official Guidelines • Discussion: Outpatient Coding of Burn Diagnoses • Diagnosis Coding Summary Table • Coding of Non-Burn Conditions

CMS-Approved Modifiers for Outpatient Hospital Reporting (CPT & HCPCS)350
General Guidelines • When to Use a Modifier • Special Guidelines for Using Modifiers with Radiology Services • HCPCS Level II Modifiers, General Guidelines • Table of Level II Modifiers Approved for Reporting Outpatient Hospital Services • Table of All Modifiers Approved for Outpatient Hospital Reporting

References363

APPENDICES

Appendix I: CMS 1500 Claim Form.....365

Appendix II: CPT Global Surgery Package 366

Appendix III: Medicare Global Surgical Package, Major & Minor Procedures 367

Appendix IV: Modifiers (CPT & HCPCS Level III): Physician Services 368

Appendix V: E/M Levels of Service: Code Selection and Audit Tables 384

Appendix VI: Burn Diagnosis Codes..... 393

Appendix VII: 2018 Medicare Physician Fee Schedule Relative Values...460

Index462

Coding for Physician Services

- **Key Concepts**
- **Evaluation & Management Services**
- **Surgical Procedures: Surgery & Bedside**
- **Diagnosis Coding for Physician Services**
- **Coding for Non-Burn Conditions**
- **Teaching Physician Guidelines**
- **Non-Physician Practitioners**
- **The Appeal Process**

Key Concepts

WHAT IS CODING?

KEY POINT

Codes represent documented information that substantiates the billed services on your claim.

Coding is the process of transforming *documented* medical information into a condensed form by substituting numeric or alphanumeric codes and descriptions for the actual individual procedures and services performed and the diagnoses treated.¹

Codes are the *sole* source of information that an insurance company or third party payer uses to determine what was done for a patient, why it was done, and whether and how to pay a claim.

Codes are obtained from several national standard *coding systems* that provide not only the codes with their descriptions, but also the guidelines for using them.

CODING SYSTEMS FOR PHYSICIAN SERVICES

Coding systems used for inpatient hospital services differ from those for physicians. Please refer to Part II of this manual, “Coding for Facility (Hospital) Services” for specific details. Coding systems for outpatient hospital services are also explained in Part II.

Procedures, Services and Supplies Furnished by Physicians

These sources provide codes that, when placed on a claim, identify *what* the physician provided or did for the patient:

¹ Kotoski, GM. CPT Coding Made Easy: A Technical Guide: Gaithersburg: Aspen Publishers, Inc., 1992–2005. Reprinted with permission

KEY POINT

Purchase CPT and HCPCS annually, in early fall. See References page for contact information.

- CPT-4 (*Current Procedural Terminology*), is published and updated annually by the AMA. CPT is designated as Level I of the two-level HCPCS (**H**ealthcare **C**ommon **P**rocedure **C**oding **S**ystem) by CMS². All of the more than 10,155 codes in CPT are 5-digit numeric codes. CPT also includes *modifiers* which are 2-digit numeric identifiers that can be appended to the codes under specific circumstances.

CPT codes describe the procedures and services provided by physicians.

- HCPCS National Level II codes, updated annually by CMS and published by CMS and commercial publishers. Level II also includes Level II national modifiers. HCPCS Level II codes are 5-character alpha-numeric (e.g. Q1234). Level II modifiers are 2-character alpha or alpha-numeric.

HCPCS codes describe the supplies (e.g., drugs, dressings) and some services provided by physicians and suppliers.

HCPCS Level II

The HCPCS coding system of Level II codes includes no formal guidelines for assigning and reporting them on claims other than those inherent in the code nomenclature of each code (e.g., one code may specify 50 mg. and another 100 mg. of the same medication) and the CMS coverage and reporting guidelines for claims published in periodic transmittals and its internet-only manuals.

CPT

Where applicable, the coding guidelines for CPT codes relevant to burns are listed in each chapter of Part I of this manual, “Coding for Physician Services.” Basic guidelines for CPT coding for burn surgery services are described in the chapters “Evaluation and Management” and “Surgical Procedures: Surgery and Bedside.” The complete set of CPT guidelines for all CPT codes is included in the most current volume of CPT, published and copyrighted by the American Medical Association.

²CMS: Centers for Medicare and Medicaid Services, agency under the U.S. Department of Health and Human Services

CPT is utilized for the purpose of identifying medical services and operative procedures performed by the physician. The purpose of the terminology is to ensure a uniform language that will accurately describe medical, surgical and diagnostic services for burn and other patients.

CPT terms and associated codes serve an important role for the burn patient. This terminology system is the most widely accepted nomenclature for reporting burn physician procedures and services for government (Medicare/Medicaid) and private health insurance programs. The coding process has evolved over the past thirty years from an initial effort by the American Medical Association to identify surgical procedures for nomenclature and reimbursement.

The CPT Advisory Committee, composed of more than 90 physicians and a small group of allied health care professionals, recommends proposed CPT changes to the CPT Editorial Panel which is responsible for the current edition of CPT. The ultimate decision for nomenclature and inclusion of a procedure resides with the sixteen-member physician CPT Editorial Panel. The procedures include evaluation and management services (E/M), surgical procedures and other services. E/M services are coded by the service provided, by the locale of the service (clinic, outpatient, inpatient) and by the intensity of service. The intensity of service may vary from a problem-focused service, to an expanded focus involving moderate medical decision-making, to a high complexity service. Consultation services are also coded based on the severity of the patient illness and intensity of the evaluation. Critical care in the E/M context is reimbursable for the burn patient with associated preoperative or postoperative care.

Procedural services are coded and identified by body system in the CPT book. For example, burn procedural codes and harvest of tissue for culture are listed in the integumentary system subsection of the CPT codes. In another example, other procedures such as bronchoscopy and central venous catheterization are found in the respiratory and cardiovascular subsections, respectively.

KEY POINT

Purchase ICD-10-CM annually, before October 1, its effective date. See References page for contact information.

Diseases, Conditions Evaluated/Treated by Physician

ICD-10-CM contain diagnosis codes that, when placed on a claim, indicate the reason why the services were provided and establish the medical necessity for them. That is, it provides codes for the patient’s diagnosis. This coding system includes guidelines for using the listed codes.

- ICD-10-CM, (International Classification of Diseases, 10th Revision, Clinical Modification)
- See Appendix VI of this manual for the complete list of burn diagnosis codes.

Coding diagnoses documented in the patient record for a given date of service is a two-part function; it begins with looking up the diagnosis in the Alphabetical Index and validating it in the Tabular listing. After assigning the appropriate diagnosis code that indicates the reason for the service, the procedure code(s) for the service are assigned from CPT (or HCPCS Level II). For the purpose of assigning diagnosis codes, the ICD-10-CM diagnosis codes are required for use in all clinical settings. It is required for reporting diagnoses and diseases by CMS, Blue Cross-Blue Shield, third party payers, HMOs and worker’s compensation insurers.

Coding guidelines for ICD-10-CM Diagnosis Codes are listed in the Chapter “Diagnosis Coding for Physician Services” which also includes web links to the complete Official ICD-10-CM Coding Guidelines for your reference. The ICD-10-CM is not copyrighted and both codes and guidelines are available free of charge on the web.

Coding Systems for Physician Services—Effective Dates of Annual Updates

Coding System Update	Effective Date As of January 1, 2005, Federal HIPAA legislation requires use of codes as of their effective date. Use of discontinued codes will result in claim denial.	Source / Publisher
CPT-4	January 1 of each year.	AMA
ICD-10-CM/PCS	October 1 of current year through September 30 of following year.	National Center For Health Statistics & CMS
HCPCS Level II	January 1 of each year.	CMS

Recent CPT Changes Affecting Burn Surgery

CPT code changes for previous years are not retained in order to avoid errors in coding and misinterpretation of guidelines that could result from using this section as a sole source for coding and billing reference. Users are strongly advised to reference the appropriate sections in this manual and in related original sources to properly code and bill burn surgery services.

This section will contain CPT changes affecting burn surgery for 2019 going forward as 2018 changes are represented in this year's manual.

RELATIVE VALUE UPDATE PROCESS (RUC)

KEY POINT

Find current national relative values for the procedures you perform in Appendix VII

All reimbursement for Medicare and for most carriers is guided by the Resource Based Relative Value Scale (RBRVS). This relative value scale was established by the American Medical Association (AMA) and is updated through the AMA's Relative Value Update Committee (RUC). The American Burn Association is represented on the RUC along with every major medical specialty. There are approximately 10,155 CPT codes that have been assigned relative work values. Every new CPT code is eligible to be presented to the RUC for assignment of a relative value. As an example, the American Burn Association presented codes 16035 and 16036 to the RUC and relative work values were assigned.

CMS ultimately publishes a decision in the Federal Register on the values established by the RUC committee. The effect of CMS's decision in terms of relative values is indisputable; many insurers adopt the Medicare Physician Fee Schedule (MPFS) or utilize their own fee schedule based upon CMS's MPFS.

Refer to Appendix VII "Medicare Physician Fee Schedule Relative Values" for a list of the current year's Medicare relative values for procedures performed by burn surgeons.

CLAIM FORMS FOR PHYSICIAN SERVICES

KEY POINTS

Find instructions for filling out the paper claim form at <http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf>

Paper and electronic claim forms (software-based) are available with the majority of claims submitted electronically.

The CMS-1500 paper claim form and its electronic equivalent are used universally by CMS/Medicare and by most insurers for reporting *physician services*. (See Appendix I for a copy of paper claim form.) Each of the elements on the form should be completed in conformity with the requirements of the payer to which it will be submitted.

It was effective January 1, 2007 and mandated for use beginning July 2, 2007. For instructions for filling out the new claim form, go to <http://www.cms.hhs.gov/manuals/downloads/clm104c26.pdf>

Claims submitted via *electronic* claim form must meet the requirements of the national standards set by federal HIPAA legislation. Details can be obtained from each Medicare contractor or commercial payers. For an overview, see the CMS web site at http://www.cms.hhs.gov/ElectronicBillingEDITrans/08_HealthCareClaims.asp#TopOfPage

WHAT MAKES A CLAIM PAYABLE?

Assuming all other required items are in place, claims are payable when codes are up to date, correctly reported and, most importantly, supported by physician documentation that corresponds to each code. This is often referred to as a “clean claim.” Payers cannot legally pay for services that were not provided. **Payers consider *undocumented services equivalent to services that have not been rendered.*** Hence, payers cannot pay for undocumented services.

KEY POINTS

Burn Surgeons:
Check your documentation to be certain it corresponds to the service or procedure descriptions in the codes on the charge ticket you submit for billing. Ideally, codes should be abstracted directly from the medical record. Every code must be supported by documentation.

DEFENSIBLE DOCUMENTATION

Defensible documentation is audit and reimbursement protection. It fully supports the codes submitted on the claim. *It means there are no codes on the claim that are unprotected by backup documentation.*

Document

- What was done during the encounter (CPT/HCPCS codes)
- Why it was done (ICD-10-CM codes)

Code

- Only what was documented

Your goal is congruency, which means that documentation and codes are equivalent, both in kind and substance. Think of it as:

Encounter = Documentation = Codes on Claim

E.g., the Procedure Performed statement and procedure narrative in an operative report match the code(s) used to report the

procedure(s). To enhance this match, whenever possible use the concept or actual wording from the CPT code description in the procedure performed statement and in the narrative of the operative report.

The result? Greatly reduced audit liability and more accurate, efficient code assignment.

Burn Documentation

The importance of documentation should be obvious; it is a means of recording illness, treatments and outcomes. It is also a legal document.

Documentation in the medical record:

- Enables the burn team to plan and evaluate the patient's treatment and develop continuity of care.
- Facilitates utilization review and continuing quality improvement (CQI).
- Describes the quality of care provided.
- Facilitates claim review and payment.

Payers utilize documentation to assure that they are receiving accurate information for the health care dollars they remit and because payers have a contractual obligation to enrollees to pay claims appropriately and accurately. Payers look at the medical record to determine:

- Appropriate treatment for the burn patient;
- That the care is medically necessary; and
- That the service is coded correctly.

Take a moment to reflect upon your documentation. Does your medical record provide the following?

- The reason for the patient's encounter in an outpatient or inpatient setting.
- Services provided are well documented.
- Ancillary services (*i.e.*, pulmonary, dietary, occupational and physical therapy, and social service) are documented and demonstrate necessity and the service provided.
- Adequate documentation of the assessment of the burn patient.
- Progress notes and results of treatment.
- Consistency, in that the medical record provides reasonable medical rationale for the services and care in the burn center.

ESTABLISHING MEDICAL NECESSITY

KEY POINTS

Medicare defines medical necessity as that which is “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

Medically necessary services have never been *specifically* defined by Medicare or other payers. Usually “medically necessary” services are considered to be those **services and supplies that are reasonable and necessary for the diagnosis and treatment of an illness or injury.**

Medicare and other payers have never defined “reasonable.” It is generally understood to be those services that are considered appropriate for the patient’s diagnosis or condition and provided at the level of intensity appropriate to achieve the desired clinical outcome.

Most insurance plans limit coverage to medically necessary services only.

On claims, presence or absence of medical necessity is established by the *diagnosis* for which a service was rendered.

KEY POINTS

The diagnosis code that is the main reason for the procedure or service should be entered in the appropriate field of the electronic claim or in block 21E on the same line of the paper claim where the code for the procedure is listed.

Link Diagnoses and Related Procedures/Services

- The appropriate diagnosis-(es) must be linked to each procedure or service on the claim form to establish its medical necessity.
- The diagnosis must *relate* to the procedure or service. The linked diagnosis explains why the procedure or service was provided and substantiates its medical necessity
- Burn surgeons can demonstrate this concept by linking, where possible, the treatment to the diagnosis in dictation. For example, “[procedure or service] was performed/provided to treat [diagnosis/condition].” This accomplishes the linking function for coders and protects against audit liability if audited.
- Claims can be rejected for illogical, non-specific, or vague diagnoses that do not substantiate the billed procedures or services.

For example, a burn patient develops abdominal compartment syndrome (ACS) accompanied by anuria and ascites. Listed diagnoses on the claim are extent of burn, and anuria. A laparotomy is performed for the ACS. Diagnoses linked to the laparotomy code on the claim are

extent of burn and anuria. Ascites is omitted. The payer may question the claim because the medical necessity for the laparotomy is not evident from the linked information on the claim. In particular, the anuria diagnosis alone can be illogical when a computer edit checks it against a laparotomy code.

UNBUNDLING AND BUNDLING

Definitions

- Unbundling is the *inappropriate* reporting of multiple codes (multiple procedures or services) that are actually parts of a single, comprehensive code that describes the total procedure which should have been reported instead.
- Unbundling is also used to describe inappropriate billing of two codes, each of which is mutually exclusive to the other. One or the other can be billed, but not both.
- Bundling is the process a payer uses to identify unbundled codes, disallow them, and allow payment for a single, correct code instead. Bundling is accomplished by screening every code on a claim against computer edits for the purpose of identifying all unbundled codes.

How Payer Edits Detect Unbundling

- Virtually every third party payer uses computer software edits to identify unbundled services and reject them. Non-government payers use commercial products for this purpose.
- Medicare (CMS) uses its National Correct Coding Initiative (“CCI”) software edits to identify and reject bundled services. The edits for physician claims are posted on the cms.hhs.gov web site and are updated quarterly.
- Sometimes an otherwise bundled procedure can be billed separately when it is provided at a different session on the same day, performed on a different anatomic site or organ system, injury, or lesion, or for other reasons. When used appropriately and added to the code, modifier 59 can allow the claim to bypass the edits. To learn when this modifier can be used, refer to Appendix IV “Modifiers.” See also specific surgical procedures in this Manual to find clinical examples showing the use of this modifier (e.g., Escharotomy).

Avoiding Unbundling

- A procedure code describes or names a clinical surgical or medical procedure. The named procedure/code includes all the component parts of the procedure, such as the surgical approach (e.g., incision), the surgical procedure itself, and, usually, wound closure, etc., despite the fact that there may be individual CPT codes that describe each of those parts of the procedure. For example, a carpal tunnel release includes a wrist arthrotomy (incision into a joint), a synovectomy (removal of synovium), release of the median nerve at the carpal tunnel, and closure of the wound. There are individual CPT codes for the wrist arthrotomy, synovectomy, and release of the median nerve (the carpal tunnel release). The arthrotomy and synovectomy may be performed alone in other situations, however when carpal tunnel release is performed, they are an integral part of and included in the carpal tunnel release code and are not separately billable.
- Check Medicare’s National Correct Coding Initiative (“CCI”) to avoid unbundling when assigning codes. These CCI edits may be included in vendor practice management software used for billing physician services.
- The NCCI edits for physician services are updated quarterly and are available for download, at no charge, from the CMS web site:
<http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCI/EP/list.asp#TopOfPage>

KEY POINT

To find a complete, updated list of Medicare’s edits for unbundled services for physician claims, refer to the NCCI, National Correct Coding Initiative for physician services at:

<http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCI/EP/list.asp#TopOfPage>

Examples of Unbundling and Coding Errors

Example 1. Unbundling and Double Billing

Removal of 6 cm scar on upper left abdomen followed by coverage of defect with advancement flap. Codes submitted are:

- | | |
|--------------|--|
| 11406 | Excision of benign lesion [unbundled, component code] |
| 14000 | Adjacent tissue transfer, defect 10 sq cm or less [comprehensive code] |

A single comprehensive code should have been reported instead. CPT guidelines state that excision of lesion is included in any adjacent tissue transfer procedure (e.g., advancement flap, Z-plasty, rotation flap, etc.). Code 11406 is therefore a component of 14000 and should not have been reported. By reporting both

KEY POINT

When otherwise bundled procedures are performed at different sites or encounters, modifier -59 can be used to indicate that fact.

Payer re-bundling edits will be bypassed.

Modifiers’ section of this chapter and Appendix IV give details.

codes, the service is unbundled and the excision of lesion is double billed.

Example 2. Mutually Exclusive Payer Edits and Incorrect Coding

Amputation of right index finger and amputation of left forearm, erroneously reported without modifiers to indicate different extremities or right and left sides.

4/25	25900	Amputation, forearm
4/25	26951	Amputation, finger

Payer edits assume both procedures were performed on the same extremity at the same operative session in the absence of coding information (*i.e.*, modifiers) to the contrary. Under that assumption, these procedures are mutually exclusive. Amputation of the forearm assumes amputation of the finger on the same extremity. Correct coding would have included one or more modifiers to indicate that each procedure was performed on a different site, on a different side of the body.

Example 3. An Unbundled E/M Service that Violates the 1 E/M per Day Rule Inherent in E/M Coding Guidelines

Emergency department visit and initial inpatient admission by same physician, same date of service. Patient admitted from emergency department.

9928x	Emergency department visit [component code]
9922x	Initial inpatient admission [comprehensive code]

In this case, CPT guidelines indicate that all related E/M services provided on the same day are included in the initial inpatient admission code.

MUEs—MEDICALLY UNLIKELY EDITS (MEDICARE)

Medically Unlikely Edits (MUEs) were established by CMS Medicare beginning January 1, 2007 to “lower paid claims error rates” based on the number of units of service (UOS) billed on a claim.

Definition

Medicare defines an MUE as an edit that tests claim lines for the same patient, CPT or HCPCS Level II code, date of service, and billing provider against a set number of units of service [established by CMS].

Overview

The NCCI (National Correct Coding Initiative contractor) develops and produces, with CMS Central Office approval, a table of MUEs. MUEs are developed for some, but not all, CPT and HCPCS Level II codes. The MUEs are applied to claims from physicians, suppliers and providers (e.g., outpatient hospital claims) who bill Medicare fiscal intermediaries (FIs), carriers, Part A/B Medicare Administrative Contractors, and other Medicare contractors that administer other Medicare benefits' claims (e.g., durable medical equipment).

How the Edits Work

Basically, the MUE edits are applied to each individual code **for the same date of service** on a claim. Each of those codes must have a date of service listed next to it (e.g., 5/12/17). The automated MUE edits scan each individual line of a claim, identify the code, then look for the maximum number of units that code is allowed **per day**.

For example, the maximum number of units for a hysterectomy is 1, based on the fact that only 1 hysterectomy can be performed. If the unit column adjacent to the hysterectomy code showed the number 2, that line would be denied by Medicare or the claim for that line would be returned to the provider unpaid. Any other payable services on the same claim would be paid.

It is important to note that the MUEs are not cumulative over different dates of service. In the case of burn surgery, regardless of the number of grafts performed or total cm² of grafts over a period of days or weeks, the MUEs would never be cumulative. **Instead, the MUEs are limited to one date of service; with another date of service, the MUEs start over again.**

MUE Example: Application of Skin Substitute

For application of a skin substitute, a hypothetical claim might list 5/2/17 15273 with a Unit of 1 for up to 100 cm² of skin substitute. For more than 100 cm², a second code of 15274 with Units of "x" cm² would be required. The same date of service, same physician, and same patient would be listed on the claim.

In this case, the edits would be applied to 15273, which would allow no more than 1 unit of service for that code, and then applied to 15274 which would allow for perhaps 10 units of service (for a graft of each additional 100 cm² up to 10). If the units did not exceed those actually set in the MUEs, the claim would be paid.

Note: Code 15273 is a primary code; code 15274 is its "add-on" code. 15273 reports the cm² after the first 100 cm² reported using code 15274. A separate MUE is set for each code.

FAQs

CMS has published several FAQs on the MUEs. In an ABA inquiry to the CMS MUE Contractor, the ABA referenced FAQ ID 8736, November 6, 2007, which provides a list of modifiers that will bypass MUE edits.

These modifiers are discussed further under the heading, **“Exceptions,”** below.

The CMS FAQ provides information for submitting claims in which the units of service (UOS) for a given code are exceeded on the same date of service. While the information is useful in that it identifies modifiers that will bypass MUE edits, it is important to understand that CMS does not publish the numeric values assigned to each CPT code. If one does not know the maximum number of units assigned to a code in the edit, one would not know if the UOS had been exceeded for that date. It may be difficult, therefore, to determine how to submit the codes on a claim as explained in the FAQ.

Nevertheless, the disclosure of the list of modifiers that will bypass the edits is useful and does allow consideration and use of one of the modifiers when appropriate. See **“Exceptions”** below.

Text of the CMS FAQ:

“How do I report medically reasonable and necessary units of service in excess of a Medically Unlikely Edit (MUE) value?”

CMS Answer:

Since each line of a claim is adjudicated separately against the MUE value for the code on that line, the appropriate use of Current Procedural Terminology (CPT) modifiers to report the same code on separate lines of a claim will enable a provider/supplier to report medically reasonable and necessary units of service in excess of an MUE value. CPT

modifiers such as:

-76 (repeat procedure by same physician), -77 (repeat procedure by another physician), anatomic modifiers (e.g., RT, LT, F1, F2), -91 (repeat clinical diagnostic laboratory test), and -59 (distinct procedural service) will accomplish this purpose. Modifier -59 should be utilized only if no other modifier describes the service.”

For CMS FAQs on MUEs, see:

<https://questions.cms.gov/faq.php?isDept=0&search=MUE+edits&searchType=keyword&submitSearch=1&id=5005>

Exceptions

If the units of service (UOS) for a given code are exceeded **on a given date of service**, that line will be denied unless one of the following modifiers applies:

76--repeat procedure by the same physician. This modifier may be used to report a repeat procedure on the same day or on a day subsequent to the date the initial procedure was performed. In the absence of guidelines to the contrary, the modifier may be used to report repeat surgical procedures, diagnostic procedures, etc.

77--repeat procedure by another physician. The same rules that apply to modifier 76 also apply to modifier 77.

Anatomic modifiers such as RT (right side), LT (left side), FI (left hand, second digit), F2 (left hand, third digit) and so on. Because the skin substitute codes already state multiple anatomic sites within each code, it is not appropriate to use one of these modifiers with them. (E.g., 15271 states "...trunk, arms, legs")

59--distinct procedural service. This modifier is used to indicate that a procedure that would otherwise be *included/bundled* into another procedure if performed at the same time, was separately reportable on the same date of service. The procedures may be performed at the same session or different sessions on the same day. If, for example, a graft is performed in the am and the same graft/code is performed again later the same day at a different encounter, the modifier could be used. The sum of the total units of service for both procedures may or may not exceed the total units of service allowed for the billed code on the same date of service. Modifier 59 and/or 76/77 would be submitted with the second procedure in this example, showing that it was performed at a different session and it was a repeat procedure. This “second” procedure should be submitted on a different line of the claim to avoid the possible excess units of service that could result if both procedures’ units were combined and entered on the same line on a claim submitted with the debridement because debridement is bundled.

In another example, assume a graft is performed on one body area (e.g., the back) and debridement only is performed on an arm (e.g., code 16025), modifier 59 would be submitted with the debridement code because debridement is bundled/included in graft codes. Modifier 59 provides the information that the debridement was performed on a different site. *It is important to read the full CPT definition of modifier 59 to identify the list of other instances in which it may be reported (see Appendix IV).* By definition, the use of modifier 59 is confined to the same date of service. Modifier 59 should be used only if no other modifier (e.g., 76 or 77) describes the service.

A Word About MUE for Commercial Payers

It is important to note that MUE's can also be found in commercial carrier policies. For example, some commercial carriers may use edits to identify units of services. Some commercial carriers have been known to limit how many units can be billed for a particular procedure date. In burns, this may be related to the use of certain Cellular and Tissue Based Products (CTP'). Others may have caps on the number of implantables that can be utilized during a procedure on the same date of services. Please check with the patient's insurance carrier prior to the procedure to understand if there are any limitations on use or coverage of a procedure, product, or services.

Appeals

Appeals are allowed for denied claims but no appeal is allowed or required for claims that are “returned to provider” unpaid. Instead, providers (e.g., outpatient hospital departments) should resubmit corrected claims.

Excess charges due to units of service greater than the MUE may not be billed to the Medicare beneficiary (this is considered a “provider liability”), and this provision can neither be waived nor subject to an Advanced Beneficiary Notice (ABN).

Global Periods

Global Surgery Package

Note: The Physician Services “Surgical Procedures” section, in another part of this chapter, includes applicable CPT Surgical Package guidelines and Medicare Global Surgery guidelines where relevant under each topic. In each case, it is important to note that payers that adopt the CPT surgical package guidelines usually revise or expand them and always assign their own postoperative follow up periods. Hence, wide variances can exist among payers’ “CPT” surgical package guidelines and postoperative follow up periods.

The global surgery package concept applies to surgical procedures and varies by payer. Generally, it is a package of services that are covered by the surgeon’s fee for the surgery and the payer’s reimbursement. The package usually includes care over a period of time after the surgery. **The time period is called the global surgery period or, alternatively, the postoperative follow-up period.**

Payers typically assign a specific number of days of postoperative care for each surgical procedure. Depending on the payer, the number of days can range from 0–120. *E.g.*, the global period for a “0” day procedure is the day of the procedure, whereas the global period for a “90” day procedure is 90 days immediately following the surgery.

The CPT Surgical Package

The CPT Surgical Package applies to all codes in the Surgery section that *are not* add-on codes. Refer to Appendix II for a complete table that summarizes the CPT Surgical Package. For a discussion of “CPT Add-on Codes,” see that topic in another section of this chapter.

CPT Surgical package always includes the following:

- The surgical procedure itself
- Local, topical or digital/metacarpal/metatarsal block anesthetic
- Subsequent to the decision for surgery, one related Evaluation and Management (E/M) visit on the day

before or the day of procedure (includes history and physical)

- Immediate postoperative care, including dictation of operative notes, discussion with the family and other physicians
- Writing orders
- Evaluation of the patient in postoperative recovery area
- Typical postoperative follow-up care

For procedures assigned a postoperative period (e.g., 90 days):

- Preoperative visits are not included in the surgical package unless, subsequent to the decision for surgery, one related E/M visit is provided on the day before or the day of the procedure (includes history and physical). Then, the related E/M visit is included in the global surgery package. The visit in which the decision was made to perform surgery may need to be submitted with a modifier if that visit occurs on the day before or the day of surgery. (See Appendix IV, modifier 57.)
- Typical, uncomplicated postoperative follow-up hospital visits, hospital discharge visit, and office visits are included in the global surgery package fee for procedures assigned a postoperative period.
- Postoperative visits for or operations to treat complications are usually separately reportable in addition to the fee for the surgical package.
- Necessary postoperative care/visits *after* the designated follow-up period are also separately reportable.

For procedures assigned a “0” day postoperative period (e.g., the “postoperative period” is the day of the procedure):

- Only the operation itself is included in the fee.
- An E/M service *on the day of the procedure* that is significant and separately identifiable (*i.e.*, documentation meets the CPT defined criteria for the E/M code and is over and above the routine preoperative care for the procedure) may be reported separately with modifier 25.
- E/M *postoperative* services in follow up to the procedure that are provided on dates of service after the procedure may be reported on a service by service basis.

Medicare Global Surgery Package

The Medicare global period for major and minor burn and other procedures refers to a period of days that include preoperative visits, intraoperative service (the surgery itself), and a postoperative period. Medicare’s global surgery periods for minor procedures are either 0 or 10 days and, for major procedures, 90 days.

Medicare’s global surgery package includes all of the following physician services/work during the global period:

- Preoperative visits on the day before or the day of *major* procedures (90-day global period), except for the encounter where the decision is made to perform surgery. When the decision to perform surgery is made at an encounter on either day, it is separately reportable. Add modifier 57 to the appropriate E/M code for the encounter.
- Preoperative visit on the day of *minor* procedures (0 or 10 day global) except a documented E/M visit that is significant, separately identifiable, and is beyond the usual preoperative and postoperative care associated with the procedure. When these conditions are met, add modifier 25 to the appropriate E/M code. (Do not use modifier 57 for this E/M service when provided in conjunction with procedures assigned 0 or 10 day global periods because Medicare will deny it. Source: (Internet Only Manual) Medicare Claims Processing Manual, Chapter 12, Section 30.6.6, B. & C.)

(Refer to Appendix IV, Modifiers, for applicable guidelines for use of modifiers when reporting major and minor procedures. See Modifier 25 for an E/M on the same day as a minor procedure and modifier 57 for an E/M the day before or day of a major procedure in which the decision to perform surgery was made.)

- Hospital admission evaluation and management (See also foregoing discussion of preoperative visits.)
- The operative procedure
- Immediate postoperative care including communication with family and referring physicians and dictation of the operative procedure
- Writing orders
- Post-anesthesia care and postoperative follow-up on the day of surgery

- Postoperative inpatient hospital and office visits *related* to care for the global surgery for the extent of the global period. (Please see “Unrelated Inpatient Postoperative Visits: Alert” immediately below this bulleted list.)

Other postoperative services by the surgeon also included in the global period are:

- Dressing change for the surgical wound
- Treatment (e.g., surgical procedures) for complications *that do not require a return to the OR*

For treatment of **related** conditions or complications that *do* require a return to the OR (e.g., debridement of part of grafted wound where graft does not take or an infected graft), add modifier 78 (Unplanned Return to Operating/Procedure Room for a related procedure during the postoperative period) to the surgery code to bypass Medicare denial edits. Documentation must support use of this modifier.

Medicare reduces payment for procedures submitted with modifier 78, allowing only the intraoperative percent of payment for the procedure. Refer to Appendix IV Modifiers, for complete details. See Appendix VII, Medicare Physician Fee Schedule, for pre-op, intra-op, and post-op percentages allocated to payment for burn surgery codes.

- Graft care
- Suture removal, removal of staples, tubes, and *non-tunneled* central venous lines
- Management of urinary catheters
- Placement/management of peripheral intravenous lines
- Tracheostomy tube management and removal

Unrelated Inpatient Postoperative Visits: Alert

In the past, **Medicare Carriers disallowed *unrelated inpatient*** E/M visits (e.g., for diagnosis unrelated to original surgery such as cellulitis of graft donor site), based on the following, now deleted, section of the CMS paper-based Medicare Carriers Manual.

“15501.1 Payment For Evaluation and Management Services Provided During Global Period Of Surgery.--
 CPT Modifier 24-Unrelated Evaluation and Management Service By Same Physician During Post-operative Period.--Pay for an evaluation and management service other than inpatient hospital care before discharge from the hospital following surgery (CPT codes 99221-99238) which was provided during the post-operative period of a surgical

procedure when it is furnished by the same physician who performed the procedure if it was billed with CPT modifier 24 and is accompanied by documentation that supports that the service is not related to the postoperative care of the procedure. Do not pay for inpatient hospital care that is furnished during the hospital stay in which the surgery occurred. All care provided during the inpatient stay in which the surgery occurred is compensated through the global surgical payment.” (Source: [CMS Paper-based Manual] Medicare Carriers Manual, Part 3 Claims Process, Section 15501.1) **Note: This section of the paper-based manual was deleted by CMS Transmittal 1832, October 31, 2003. The related instructions were issued in the manual, CMS Pub 100-4 Medicare Internet-only Claims Processing Manual, Chapter 12, Section 30.6.6. See relevant quote immediately below.**

The now-deleted policy has been revised in the CMS Internet-only claims processing manual and now indicates that carriers pay for “treating another medical condition that is unrelated to the surgery” during the inpatient hospital stay for the same surgery. See verbatim excerpt below.

KEY POINT

Unrelated inpatient visits during the postoperative period of a global surgery are *not* included in Medicare’s global surgical package according to clarification published in new (online) manual 100-4 which specifically allows payment for medical conditions unrelated to the previous global surgery. See details and excerpt at right.

“30.6.6 – Payment for Evaluation and Management Services Provided During Global Period of Surgery (Rev. 954, Issued: 05-19-06, Effective: 06-01-06, Implementation: 08-20-06

A. CPT Modifier "-24" - Unrelated Evaluation and Management Service by Same Physician During Postoperative Period

Carriers pay for an evaluation and management service other than inpatient hospital care before discharge from the hospital following surgery (CPT codes 99221-99238) if it was provided during the postoperative period of a surgical procedure, furnished by the same physician who performed the procedure, billed with CPT modifier "-24," and accompanied by documentation that supports that the service is not related to the postoperative care of the procedure. They do not pay for inpatient hospital care that is furnished during the hospital stay in which the surgery occurred **unless the doctor is also treating another medical condition that is unrelated to the surgery**. All care provided during the inpatient stay in which the surgery occurred is compensated through the global surgical payment.”

Written confirmation of the foregoing policy was received from Stephen Phillips, CMS Director of Hospital and Ambulatory Policy, Baltimore, MD, February 11, 2005. “...we will only pay for an E/M when it is unrelated to the surgical service which is dictating the global period.”

Possible Examples of Unrelated E/M Services & Required Documentation

- Cellulitis of graft donor site
- Second degree burn of leg in patient with third degree burn of arm which is treated with excision and grafting. Separate, unrelated E/M visit(s) for care of the leg burn are provided. (Assumes care of leg burn is non-surgical and is not subject to a global period on the day of the E/M service.)

- E/M visit solely to manage diabetes mellitus requiring insulin.
- E/M visit for unrelated (to the surgery) hypertension requiring PO or IV medication.

Documentation for the E/M service should be limited to care of the unrelated condition and the E/M code must be reported with modifier 24 to indicate an unrelated E/M service during the postoperative period. The E/M code and the code for the unrelated diagnosis should be linked on the claim.

However, some Medicare Contractors continue to deny unrelated inpatient postoperative visits. You may need to challenge their decision based on the foregoing CMS Manual provision and provide the carrier with evidence as to why the E/M services are unrelated to the postoperative care for the previous surgery.

Medicare contractors are empowered to make these decisions by CMS Central Office Policy. Per written communication with CMS, if there is no National Coverage Decision for a given service, then coverage is at the individual contractor's discretion. Your appeal will need to show why the contractor's decision does not apply to your claim.

Separately Billable Procedures/Services during the Global Surgery Period and Correct Use of Modifiers for Medicare Payment

- Certain services and procedures are not included in the global surgery period and are separately billable under the appropriate circumstances.
- Burn surgeons often perform multiple, different surgical procedures during the course of treatment for patients with burns or non-burn conditions (e.g., necrotizing fasciitis). Some are global surgeries and others are not. After the first global surgery, such as a graft, is performed, Medicare will deny all subsequent surgical procedures performed during the global surgery period as “included in previous global surgery,” *unless* they are submitted with the appropriate modifier: 58 (Staged or Related Procedure), 78 (Unplanned Return to Operating/Procedure Room for related procedure), or 79 (unrelated procedure).
- **Hence, the first global surgery period in the course of treatment governs claims for all subsequent surgeries performed during that time.**
- Subsequent global surgeries (e.g., grafts) during the global period of the previous global surgery must be submitted with the appropriate modifier to obtain payment. A new

global period begins with each, subsequent global surgery, runs concurrently with previous global period(s), and extends beyond them for the assigned number of days.

- Furthermore, the first global surgery period governs all Evaluation and Management services provided during that time. Unrelated E/M services and critical care services are the only separately billable inpatient E/M services allowed during the postoperative period; however, Medicare will deny these services unless submitted with the appropriate modifier (modifier 24) and supported by documentation (unrelated diagnosis code and supporting medical record documentation). See the Critical Care section for complete coding details.
- Unrelated outpatient E/M services provided during the rest of the global period following hospital discharge are allowed for payment when submitted with modifier 24 and a diagnosis that indicates the E/M service was unrelated to the previous global surgery. See Appendix IV, Modifiers, for guidelines.
- Separate payment is allowed for the surgeon’s *preoperative* medical visits (E/M services) that are *unrelated* to the operative procedure. When provided on a day prior to the surgery, this E/M service/code does not require a modifier.

Example: Following admission, a burn patient may require preoperative E/M visits related to fluid resuscitation and/or stabilization of comorbid conditions.

CMS has emphasized that Medicare carriers carefully scrutinize preoperative billings for medical necessity.)

Note: For a summary of the services included in the Medicare Global Surgery Package, services that are separately billable, and the specific modifiers required for payment, refer to the table in Appendix III, Medicare Global Surgical Package, Major & Minor Procedures. For a current list of Medicare RVUs (Relative Value Units) and global surgery periods for typical burn surgical procedures, see Appendix VII.

Medicare’s Unique Global Surgery Billing Requirements for Physicians in Group Practice

These requirements are unique to Medicare and are not required by other payers unless they have adopted Medicare’s global surgery payment policy. Few commercial or worker’s comp payers have done so to date.

KEY POINT

Unrelated medical visits **before** the global surgery procedure are not included in the global surgical package.

“When different physicians in a group practice participate in the care of the patient, the group bills for the entire global package if the physicians reassign benefits to the group. The physician who performs the surgery is shown as the performing physician.” (Source: CMS Pub 100-4 Medicare Internet-only Claims Processing Manual, Chapter 12, Section 40.2, A, 2)

For services provided to Medicare beneficiaries, Medicare requires all physicians in a group practice who bill under the same provider number to report services and procedures for the same patient *during the global period* as though they are the original performing surgeon. To obtain payment, each physician in the group who provides services to the patient, including the original performing surgeon, should submit claims for surgical procedures or critical care using the appropriate modifier (24 for critical care; 58, 78 or 79 for surgical procedures) to bypass Medicare’s global surgery denial edits.

Note: A postoperative daily hospital visit during the global surgery period, which is provided by a group physician *covering* for a surgeon in the same group who performed a global surgery on the patient, is typically not reported. This policy follows customary convention within the national medical community. Such visits are considered occasional “reciprocal” visits by Medicare and are not reported. Critical care services are an exception and may be reported by the covering physician using the applicable CPT code(s) with modifier 24 (Unrelated E/M service by same physician during postoperative period) care before or the day of procedure (includes history and physical) before or the day of procedure (includes history and physical)

- Immediate postoperative care, including dictation of operative notes, discussion with the family and other physicians
- Writing orders
- Evaluation of the patient in postoperative recovery area
- Typical postoperative follow-up care

For procedures assigned a postoperative period (e.g., 90 days):

- Preoperative visits are not included in the surgical package unless, subsequent to the decision for surgery, one related E/M visit is provided on the day before or the day of the procedure (includes history and physical). Then, the related E/M visit is included in the global surgery package. The visit in which the decision was made to perform surgery may need to be submitted with a modifier if that visit occurs on the day before or the day of surgery. (See Appendix IV, modifier 57.)
- Typical, uncomplicated postoperative follow-up hospital visits, hospital discharge visit, and office visits are included in the global surgery package fee for procedures assigned a postoperative period.
- Postoperative visits for or operations to treat complications are usually separately reportable in addition to the fee for the surgical package.
- Necessary postoperative care/visits *after* the designated follow-up period are also separately reportable.

- For procedures assigned a “0” day postoperative period (e.g., the “postoperative period” is the day of the procedure). Only the operation itself is included in the fee. An E/M service *on the day of the procedure* that is significant and separately identifiable (*i.e.*, documentation meets the CPT defined criteria for the E/M code and is over and above the routine preoperative care for the procedure) may be reported separately with modifier 25.
- Documentation for the E/M service should be limited to care of the unrelated condition and the E/M code must be reported with modifier 24 to indicate an unrelated E/M service during the postoperative period. The E/M code and the code for the unrelated diagnosis should be linked on the claim.
- E/M *postoperative* services in follow up to the procedure that are provided on dates of service after the procedure may be reported on a service by service basis.

Medicare Coding Case Studies---Single or Multiple Physicians in the Same Group Providing Care for the Same Patient *How to Use Codes and Modifiers Correctly*

The following cases are hypothetical.

A patient admitted to the burn unit with 40% burn, 20% of which is full thickness burn of back, chest, face/neck and both arms. Patient sustained inhalation injury.

Timeline is compressed to illustrate essential, key concepts only. It does not include all possible services that may be provided in similar cases.

If multiple physicians in the same group provide one or more of the following procedures for the same patient, services are coded as if only one physician provided all services. The individual performing physician’s NPI (National Provider Identifier) is submitted on the claim for each service he/she provided or rendered.

Two case studies are presented for the same patient, each illustrating alternative treatment scenarios and coding.

MEDICARE CODING CASE STUDY 1.0

Notes:

1. Escharotomy (16035) was assigned a “0” day global period in the Medicare fee schedule.
2. When critical care is provided on the same day as a second or subsequent surgical procedure performed during the global period of a previous procedure, add *both* modifiers 24 and 25 to the critical care code to bypass Medicare edits. The edits for each of these modifiers is *separate*. One edit for the critical care code takes into account the postoperative period of the earlier procedure and the other edit takes into account the preoperative global period of the procedure to be performed that day.

DATE	SERVICE OR PROCEDURE	NOTES & PRIMER REFERENCES
2/1/18	<p>9925x-25 Inpatient consultation*</p> <p>Medicare no longer allows payment for CPT consultation codes but does allow payment for consultations when submitted using inpatient hospital codes or office/outpatient codes. Refer to “Consultations” in the Evaluation and Management Chapter for complete instructions.</p>	<p>Modifier 25 is added to E/M code to indicate a significant E/M service on same date as a minor procedure (A-line insertion, CVP insertion)</p> <p>Without modifier, E/M service (consultation) will be denied.</p> <p>If procedure performed on same day is a major procedure & decision to perform surgery is made at the E/M day before or day of procedure, add modifier 57 instead.</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Medicare Global Surgery Package • Modifiers • Consultations • Appendix III (Medicare Global Surgery), Appendix IV (Modifiers)
2/1	36620 Arterial line insertion	<p>Minor procedure, 0-day global period</p> <p>No modifier is required because no global surgery procedure has yet been performed on this patient.</p> <p>Primer reference topics:</p>

DATE	SERVICE OR PROCEDURE	NOTES & PRIMER REFERENCES
		<ul style="list-style-type: none"> • Arterial Line Insertion • Medicare Global Surgery Package • Modifiers • Appendix III (Medicare Global Surgery) • Appendix IV (Modifiers) • Appendix VII (2018 Medicare Physician Fee Schedule) for global period
2/1	36556 Centrally inserted central line, age 5 years or older (R femoral vein)	<p>Minor procedure, 0-day global period</p> <p>No modifier is required because no global surgery procedure has been performed on this patient yet.</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Central venous access • Medicare Global Surgery Package • Modifiers • Appendix III (Medicare Global Surgery) • Appendix IV (Modifiers) • Appendix VII (2018 Medicare Physician Fee Schedule) for global period
2/2	99291 Critical care, 1 hour (traumatic shock, hypovolemia, etc.)	<p>No modifier is required for this critical care service because no major procedure (90 days global) was performed this day as would otherwise be required per Medicare guidelines.</p> <p>Critical care is billed because at least 30 minutes of separate, critical care, over and above the time for Swan-Ganz insertion, was provided and documented by the burn surgeon this day.</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Critical Care • Modifiers • Appendix III (Medicare Global Surgery) • Appendix IV (Modifiers)
2/2	93503 Insert Swan-Ganz (Patient not responding to resuscitation. Arrhythmia, EKG ST changes, reduced cardiac output, ischemia, elevated troponin. . .)	<p>0-day global period</p> <p>(Swan is not a surgical procedure but Medicare does assign a zero day global period to 93503.)</p> <p>Swan is separately billable because it</p>

DATE	SERVICE OR PROCEDURE	NOTES & PRIMER REFERENCES
		<p>is not included in separately provided critical care of at least 30 minutes, same day.</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Critical Care • Swan-Ganz
2/2	31500 Endotracheal intubation	<p>0-day global period</p> <p>Endotracheal intubation is separately billable because it is not included in separately provided critical care of at least 30 minutes, same day.</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Critical Care
2/3	99291 Critical care	<p>No modifier is required for this critical care service because no major procedure (90 day global) was performed this day as would otherwise be required per Medicare guidelines.</p> <p>Critical care is billed because at least 30 minutes of separate, critical care was provided and documented this day.</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Critical Care • Modifiers • Appendix III (Medicare Global Surgery) • Appendix IV (Modifiers)
2/4	99291-25 Critical care	<p>Modifier 25 (Significant E/M service on the day of the procedure) is added to indicate critical care provided preoperatively on the day of the first major surgery procedure (90 day global) during the inpatient stay or course of care, per Medicare guidelines.</p> <p>Without modifier, critical care will be denied.</p> <p>Any critical care provided <i>after</i> this date during the remainder of the global period should be reported with modifier 24 (Unrelated E/M during postoperative period) per Medicare guidelines.</p> <p>Note: Modifier 57 (Decision for surgery) may be listed as a <i>second</i> modifier for information only but is not</p>

DATE	SERVICE OR PROCEDURE	NOTES & PRIMER REFERENCES
		<p>necessary as 25 is the only modifier that can generate payment for critical care on this day.</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Critical Care • Modifiers • Appendix III (Medicare Global Surgery) • Appendix IV (Modifiers)
2/4	<p>15002-51 Excision burn wound, trunk, 1st 100 sq cm (Units=1) (3rd degree burn, back)</p>	<p>0 day global period</p> <p>Modifier 51 is optional if carrier does not require it.</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Excision Burn & Non-burn Wounds • Appendix VII (2018 Medicare Physician Fee Schedule)
2/4	<p>15003 Excision burn wound, trunk, ea. additional 100 sq cm (Units = 11)</p>	<p>Global period does not apply; when performed, 15003 is subject to global period for 15002, the primary procedure.</p> <p>15003 is an “add-on” code w/ reduced relative value as a secondary procedure. Do not reduce fee. Payer, unless otherwise required by benefit plan, should not utilize multiple procedure reduction (e.g., 50%) for add-on codes.</p> <p>Unless otherwise required by payer, do not add modifiers to add-on codes.</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Add-on Codes
2/4	<p>15100 split thickness autograft back 1st 100 sq cm (Units = 1)</p>	<p>90-day global period</p> <p>90-day global period begins & extends through April 24. Governs reporting and requires specific modifiers for payment of all billable procedures and services through April 24. Without appropriate modifier, claims will be denied.</p> <p>Dressing changes for graft are included in global.</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Grafting • Medicare Global Surgery Package

DATE	SERVICE OR PROCEDURE	NOTES & PRIMER REFERENCES
		<ul style="list-style-type: none"> • Modifiers • Appendix VII (2018 Medicare Physician Fee Schedule)
2/4	15101 Split-thickness autograft, back, ea. additional 100 sq cm (Units = 10)	<p>Global period does not apply; when performed, 15101 is subject to global period for 15100, the primary procedure.</p> <p>15101 is an “add-on” code w/ reduced relative value as a secondary procedure. Do not reduce fee. Payer, unless otherwise required by benefit plan, should not utilize multiple procedure reduction (e.g., 50%) for add-on codes.</p> <p>Unless otherwise required by payer, do not add modifiers to add-on codes.</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Add-on Codes
2/5	99291-24 Critical care (manage post op complications, vent management, monitor fluids, order enteral feeding. . .)	<p>Modifier 24 added to indicate unrelated critical care provided during 90-day global period of previous surgery per Medicare guidelines.</p> <p>Without modifier, critical care will be denied.</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Critical Care • Modifiers • Appendix III (Medicare Global Surgery) • Appendix IV (Modifiers)
2/6	99291-24 Critical care	<p>Modifier 24 added to indicate unrelated critical care provided during 90-day global period) per Medicare guidelines.</p> <p>Without modifier, claim will be denied.</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Critical Care • Modifiers • Appendix III (Medicare Global Surgery) • Appendix IV (Modifiers)
<p><i>Alternate Clinical Scenario</i></p> <p>2/7</p>	<p><i>Alternate Clinical Scenario</i></p> <p>93503-79 Insert Swan-Ganz (Patient not responding to resuscitation. Arrhythmia, EKG ST changes, reduced cardiac output,</p>	<p><i>Alternate Clinical Scenario</i></p> <p>Modifier 79 (Unrelated procedure during postoperative period) added to indicate that this procedure, while non-surgical, is unrelated to the previous global surgery site.</p>

DATE	SERVICE OR PROCEDURE	NOTES & PRIMER REFERENCES
	<i>ischemia, elevated troponin . . .)</i>	<p><i>Primer reference topics:</i></p> <ul style="list-style-type: none"> • <i>Critical Care</i> • <i>Swan-Ganz</i> • <i>Appendix III (Medicare Global Surgery)</i> • <i>Appendix IV (Modifiers)</i>
2/9	<p>15002-79/51 Excision burn wound, arms, 1st 100 sq cm (Units = 1)</p> <p>Both arms excised.</p> <p>(3rd degree burn, both arms)</p>	<p>0-day global period</p> <p>Modifier 79 added to indicate procedure was unrelated to previous global surgery on back on 2/4</p> <p>Modifier 51 is placed <i>after</i> 79 because 79 determines <i>whether</i> payment is made at all while 51 merely indicates multiple procedures, same operative session.</p> <p>Modifier 51 is added to 15002 because it is not the major procedure performed this day. Its relative value is lower than 15100; therefore, it is a secondary procedure.</p> <p>Modifier 51 is optional if carrier does not require it.</p> <p>Modifier 50 (Bilateral procedure) is not necessary because codes 15002-15005 are surface-area dependent. Total area of all excisions for a given code family (e.g., 15002-15003 or 15004-15005) at that operative intervention is used irrespective of laterality issues.</p> <p><i>Primer reference topics:</i></p> <ul style="list-style-type: none"> • <i>Excision Burn & Non-burn Wounds</i> • <i>Medicare Global Surgery Package</i> • <i>Modifiers</i> • <i>Appendix III (Medicare Global Surgery)</i> • <i>Appendix IV (Modifiers)</i>
2/9	<p>15003 Excision burn wound, arms, ea. additional 100 sq cm (Units = 9)</p> <p>Both arms excised.</p> <p>(3rd degree burn, both arms)</p>	<p>Global period does not apply; when performed, 15003 is subject to global period for 15002, the primary procedure.</p> <p>15003 is an “add-on” code w/ reduced relative value as a secondary procedure. Do not reduce fee. Payer, unless otherwise required by benefit</p>

DATE	SERVICE OR PROCEDURE	NOTES & PRIMER REFERENCES
		<p>plan, should not utilize multiple procedure reduction (e.g., 50%) for add-on codes.</p> <p>Unless otherwise required by payer, do not add modifiers to add-on codes.</p> <p>Primer reference topics: Add-on Codes</p>
2/9	<p>15100--79 Split-thickness autograft, arm, 1st 100 sq cm (Units = 1) Both arms grafted.</p>	<p>90-day global period</p> <p><u>This global period runs concurrent with previous global surgery period and extends beyond it for 5 days.</u></p> <p>Modifier 79 added to indicate procedure was unrelated to previous global surgery on back on 2/4</p> <p>Dressing changes for graft are included in global.</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Grafting • Medicare Global Surgery Package • Modifiers • Appendix VII (2018 Medicare Physician Fee Schedule)
2/9	<p>15101 Split-thickness autograft, arm, ea. additional 100 sq cm (Units = 9) Both arms grafted.</p>	<p>Global period does not apply; when performed, 15101 is subject to global period for 15100, the primary procedure.</p> <p>15101 is an “add-on” code w/ reduced relative value as a secondary procedure. Do not reduce fee. Payer, unless otherwise required by benefit plan, should not utilize multiple procedure reduction (e.g., 50%) for add-on codes.</p> <p>Unless otherwise required by payer, do not add modifiers to add-on codes.</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Add-on Codes
2/10	<p>15004-79/51 Excision burn wound, face, up to 100 sq cm</p>	<p>0 global days</p> <p>Modifier 79 added to indicate excision</p>

DATE	SERVICE OR PROCEDURE	NOTES & PRIMER REFERENCES
	(Units = 1) 3 rd degree burn, face	was unrelated to previous global surgeries. Modifier 51 is placed <i>after</i> 79 because 79 determines <i>whether</i> payment is made at all while 51 merely indicates multiple procedures, same operative session. Modifier 51 is added to 15004 because it is not the major procedure performed this day. Its relative value is lower than 15320; therefore, it is a secondary procedure. Modifier 51 is optional if carrier does not require it.
2/10	15275-79 Allograft skin for temporary wound closure, face, 100 sq cm or less (Units – 1)	0-day global period .
2/11-20	9923x Subsequent hospital visit	Included in previous global surgery; not billable. Primer reference topics: <ul style="list-style-type: none"> • Medicare Global Surgery Package • E/M Services & the Surgical Package • Appendix III (Medicare Global Surgery)
2/12	Return to OR: significant bleeding under cadaver graft, face. Control of	90-day global period Governs reporting and requires

DATE	SERVICE OR PROCEDURE	NOTES & PRIMER REFERENCES
	<p>bleeding using cautery, thrombin & topical epinephrine. Cadaver graft removed. Split-thickness autograft applied.</p> <p>15120-78 Split-thickness autograft, face, 100sq cm or less (Units –1)</p>	<p>specific modifiers for payment of all billable procedures and services through May 2. Without appropriate modifier, claims will be denied.</p> <p>This global period runs concurrent with previous global surgery period and extends beyond it for 2 days.</p> <p>Modifier 78 added to indicate procedure was performed for complication of previous global surgery on face.</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Grafting • Medicare Global Surgery Package • Modifiers • Appendix VII (2018 Medicare Physician Fee Schedule)
<p><i>Alternate Clinical Scenario</i> 2/12-16</p>	<p><i>Alternate Clinical Scenario</i> 99233-24 Subsequent hospital visit Cellulitis of donor site IV antibiotics 3 days</p>	<p><i>Alternate Clinical Scenario</i> Modifier 24 added to indicate E/M service was provided for problem unrelated to previous global surgeries.</p> <p><i>Primer reference topics:</i></p> <ul style="list-style-type: none"> • Medicare Global Surgery Package (See postoperative inpatient hospital and office visits under this topic, “Key Point” in left margin and new information in text adjacent.) • Inpatient Daily Visits
<p>2/21</p>	<p>99238 Discharge day management</p>	<p>Included in previous global surgeries</p> <p>Primer reference topics:</p> <ul style="list-style-type: none"> • Medicare Global Surgery Package • E/M Services & the Surgical Package • Discharge Day Management • Appendix III (Medicare Global Surgery)

MEDICARE CODING CASE STUDY 2.0

DATE	SERVICE OR PROCEDURE	NOTES & PRIMER REFERENCES
2/1	9925x-25 Inpatient consultation* Medicare no longer allows payment for CPT consultation codes but does allow payment for consultations when submitted using inpatient hospital codes or office/outpatient codes. Refer to “Consultations” in the Evaluation and Management Chapter for complete instructions.	Modifier 25 is added to E/M code to indicate a significant E/M service on same date as a minor procedure, (A-line insertion) Without modifier, claim will be denied. If procedure performed on same day is a major procedure & decision to perform surgery is made at the E/M day before or day of procedure, add modifier 57 instead. Primer sections: Medicare Global Surgery Package, Modifiers, Consultations, Appendix III (Medicare Global Surgery), Appendix IV (Modifiers)
2/1	36620 A-line	Minor procedure, 0-day global period Primer section: Appendix VII (2018 Medicare Physician Fee Schedule)
2/2	99291 Critical care, 1 hour (traumatic shock, hypovolemia, etc.)	No modifier is required for this critical care service because no major procedure (90 day global) was performed this day as would otherwise be required per Medicare guidelines. Primer sections: Critical Care, Modifiers, Appendix III (Medicare Global Surgery), Appendix IV (Modifiers)
2/2	93503 Insert Swan-Ganz (traumatic shock, hypovolemia, etc.)	Swan is separately billable because it is not included in critical care, same day Primer sections: Critical Care
2/3	99291 Critical care	No modifier is required for this critical care service because no major procedure (90 -

DATE	SERVICE OR PROCEDURE	NOTES & PRIMER REFERENCES
		<p>global) was performed this day as would otherwise be required per Medicare guidelines.</p> <p>Primer sections: Critical Care, Modifiers, Appendix III (Medicare Global Surgery), Appendix IV (Modifiers)</p>
2/3	1602x Dressing change (3 rd degree burn, back)	<p>Minor procedure, 0-day global period</p> <p>Primer section: Appendix VII (2018 Medicare Physician Fee Schedule)</p>
2/4	99291 Critical care	<p>No modifier is required for this critical care service because no major procedure (90 day global) was performed this day as would otherwise be required per Medicare guidelines.</p> <p>Primer sections: Critical Care, Modifiers, Appendix III (Medicare Global Surgery), Appendix IV (Modifiers)</p>
2/4	1602x Dressing change (3 rd degree burn, arms)	<p>Minor procedure, 0-day global period</p> <p>Primer section: Appendix VII (2018 Medicare Physician Fee Schedule)</p>
2/5	99291-25 Critical care	<p>Modifier 25 added to indicate critical care provided preoperatively (prior to any 90-day global surgery procedure during the hospital stay) per Medicare guidelines.</p> <p>Without modifier, claim will be denied.</p> <p>Primer sections: Critical Care, Modifiers, Appendix III (Medicare Global Surgery), Appendix IV (Modifiers)</p>
2/5	15002-51 Excision burn wound, trunk, 1 st 100 sq cm (Units=1) (3 rd degree burn wound, back)	<p>Minor procedure, 0-day global period</p> <p>Modifier 51 is optional if carrier does not require it.</p> <p>Primer section: Appendix VII</p>

DATE	SERVICE OR PROCEDURE	NOTES & PRIMER REFERENCES
		(2018 Medicare Physician Fee Schedule)
2/5	15003 Excision burn wound, trunk, ea. additional 100 sq cm (Units = 11)	Global period does not apply; when performed, 15003 is subject to global period for 15002, the primary procedure.
2/5	15100 Split-thickness autograft, back, 1 st 100 sq cm (Units = 1)	90-day global period begins and ends on April 24. Primer section: Appendix VII (2018 Medicare Physician Fee Schedule)
2/5/05	15101 Split-thickness autograft, back, ea. additional 100 sq cm (Units = 10)	Global period does not apply; when performed, 15101 is subject to global period for 15100, the primary procedure.
2/6/05	99291-24 Critical care	<p>Modifier 24 added to indicate unrelated critical care provided during 90-day global period) per Medicare guidelines.</p> <p>Without modifier, claim will be denied.</p> <p>Primer sections: Critical Care, Modifiers, Appendix III (Medicare Global Surgery), Appendix IV (Modifiers)</p>
2/7	99291-24 Critical care	<p>Modifier 24 added to indicate unrelated critical care provided during 90-day global period) per Medicare guidelines.</p> <p>Without modifier, claim will be denied.</p> <p>Primer sections: Critical Care, Modifiers, Appendix III (Medicare Global Surgery), Appendix IV (Modifiers)</p>
2/8	Dressing change, graft, back	<p>Included in STSG global surgery</p> <p>Primer sections: Medicare Global Surgery Package, Appendix III (Medicare Global Surgery)</p>

DATE	SERVICE OR PROCEDURE	NOTES & PRIMER REFERENCES
2/8	1602x-79 Dressing change, burn wound, arm	<p>Modifier 79 added to indicate procedure unrelated to previous global surgery on 2/5</p> <p>Primer sections: Medicare Global Surgery Package, Modifiers, Appendix III (Medicare Global Surgery), Appendix IV (Modifiers)</p>
2/9	<p>15002-79/51 Excision burn wound, arms, 1st 100 sq cm (Units = 1)</p> <p>3rd degree burn wound, arm)</p>	<p>Minor procedure, 0-day global period</p> <p>Modifier 79 added to indicate procedure was unrelated to previous global surgery on back on 2/5</p> <p>Modifier 51 is placed <i>after</i> 79 because 79 determines <i>whether</i> payment is made at all while 51 merely indicates multiple procedures, same operative session.</p> <p>Modifier 51 is added to 15002 because it is not the major procedure performed this day. Its relative value is lower than 15100; therefore, it is a secondary procedure.</p> <p>Modifier 51 is optional if carrier does not require it.</p> <p>Primer sections: Medicare Global Surgery Package, Modifiers, Appendix III (Medicare Global Surgery), Appendix IV (Modifiers)</p>
2/9	15003 Excision burn wound, arms, ea. additional 100 sq cm (Units = 4)	Global period does not apply; when performed, 15003 is subject to global period for 15002, the primary procedure.
2/9	15100 –79 Split-thickness autograft arm, 1 st 100 sq cm (Units = 1)	<p>90 Day global period begins and ends on April 28. Runs concurrent with previous global surgery period.</p> <p>Primer section: Appendix VII (2018 Medicare Physician Fee Schedule)</p>

DATE	SERVICE OR PROCEDURE	NOTES & PRIMER REFERENCES
2/9	15101 Split-thickness autograft, arm, ea. additional 100 sq cm (Units = 3)	Global period does not apply; when performed, 15101 is subject to global period for 15100, the primary procedure.
2/9-20	9923x Subsequent hospital visit	Included in previous global surgery whether related or unrelated to previous global surgery Primer sections: Medicare Global Surgery Package, E/M Services & the Surgical Package, Appendix III (Medicare Global Surgery)
2/21	99238 Discharge day management	Included in previous global surgery Primer sections: Medicare Global Surgery Package, E/M Services & the Surgical Package, Appendix III (Medicare Global Surgery)

KEY POINTS

An add-on code can only be used when it is performed at the same session as the primary code. The add-on code can never be reported alone.

Coding starts over again if another operative session occurs on the same date.

CPT “Add-on” Codes

CPT add-on codes, such as 16036 (Escharotomy; each additional incision), describe each additional portion of work performed after the first **at the same encounter**.

CPT procedures that state “each additional lesion,” “each additional level,” or “each additional procedure,” or “List separately in addition to code for primary procedure” are always secondary procedures **performed at the same operative session as the primary procedure by the same physician** and, therefore, can never be reported alone. When an add-on code is reported alone, the claim will be denied because it cannot be paid unless the primary code is reported at the same time.

When the same type of procedure, such as an escharotomy, is performed at a different encounter or session on the same day, coding starts over using the primary procedure code and, if applicable, the add-on code. Add modifier 59 (Distinct Procedure) to the code for the second session, to indicate the same procedure was performed but at a different session on the same day. The modifier avoids potential denial or re-coding by the payer. For more detailed information about modifiers, see the next section, Modifiers, and Appendix IV.

In addition, never report add-on codes with modifier 51. Their relative values are already set for the secondary procedure reduction in service and fee. Neither fee nor payment should be reduced for add-on procedures.

Burn surgery examples of add-on procedures are codes 15101, 15003, 15121, and 16036.

Add-on codes can be identified in CPT by a “+” sign in front of the code.

Note: CPT “Modifier 51 exempt procedures” listed in CPT Appendix F are not add-on codes but are always valued as secondary procedures in standard relative value studies. However, the AMA’s CPT provides no explicit guidance as to which of these procedures are primary or secondary for relative value purposes.

KEY POINTS

50% of claims require modifiers. Before billing, always check to be sure that modifiers have been added, where necessary, to codes on the claim.

Absence of modifiers often causes claim rejection.

KEY POINT

Do not use a modifier unless there is documentation in the medical record that supports it

KEY POINT

See **Appendix IV** for the complete list of CPT modifiers for physician burn services (including modifiers for co-surgeons or two surgeons, split global care, decision for surgery, and multiple procedures) as well as a selected list of HCPCS Level II modifiers most likely to be used by burn surgeons, non-physician practitioners & non-physician professionals.

MODIFIERS

Modifiers are used to indicate that a burn procedure or service was altered by one or more factors (*e.g.*, modifier 58, Staged or Related Procedure) and/or to provide needed information about the procedure (modifier 22, Increased Procedural Services) while the base code remains the same.

Two sets of modifiers, each from a different coding system, are currently in use:

- CPT modifiers are two-digit numeric, *e.g.*, 47 (Anesthesia by surgeon).
- HCPCS modifiers are two-character alphabetic or alphanumeric, (*e.g.*, LT [left] or E1 [upper left eyelid]). Medicare, other government programs and some non-government payers accept these modifiers on claims. HCPCS modifiers are published annually by CMS and commercial publishers as part of CMS’s HCPCS National Level II Codes.

Note: Refer to the table below for modifiers most commonly used by burn surgeons and to Appendix IV for more detailed information and a comprehensive list of CPT and HCPCS modifiers used by all physicians. CPT modifiers created originally for Medicare are identified in Appendix IV. The current volume of CPT lists all CPT modifiers in its Appendix A.

Modifier Essentials

- One or more modifiers can be added to a billed code when appropriate. List first the modifier that most directly affects payment unless the payer directs otherwise.
- Modifiers can allow some claims to pass payer automated edits that would otherwise legitimately deny the procedure or service. It is appropriate to use a modifier for this purpose when circumstances justify doing so.
- Note that some payers may interpret or reimburse modified procedures in ways that are inconsistent with standard

payment policies. Part of the HIPAA law—Administrative Simplification—requires all health plans to accept CPT codes and modifiers. In general, follow individual payer guidelines for modifier submission. Study written statements and action codes on the Explanation of Benefits and/or remittance advice from each payer to determine their modifier payment policies.

- Certain CPT modifiers were created for Medicare claim processing and payment. Those modifiers are also used by some payers that have elected to follow Medicare payment policies. Most commercial and worker's compensation payers do not follow the complex coding guidelines and payment restrictions in Medicare's global surgery payment policy but do accept all modifiers as a result of federal HIPAA mandates.

Modifiers Commonly Used by Burn Surgeons

Among other reasons, burn surgeons most often use modifiers to indicate that:

- A service or procedure was performed with unusual events or complications.
- A series of operations is anticipated or planned to treat the burn wound.

Modifiers commonly applicable to burn services include the following:

- 22 Increased Procedural Services: when the work required to provide a service is substantially greater than typically required for the specific code
- 24 Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period.
- 25 Significant, Separately Identifiable Evaluation and Management Service by the Same physician on the Same Day of the Procedure or Other Service.
- 57 Decision for Surgery.
- 58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period.
- 59 Distinct Procedural Service
- 62 Two Surgeons (Co-surgeons)

- 78 Unplanned Return to Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period
- 79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period
- 80 Assistant Surgeon
- 82 Assistant Surgeon (when qualified resident surgeon not available)

30.6.6 - Payment for Evaluation and Management Services Provided During Global Period of Surgery

(Rev. 954, Issued: 05-19-06, Effective: 06-01-06, Implementation: 08-20-06)

A. CPT Modifier “-24” - Unrelated Evaluation and Management Service by Same Physician During Postoperative Period

A/B MACs (B) pay for an evaluation and management service other than inpatient hospital care before discharge from the hospital following surgery (CPT codes 99221-99238) if it was provided during the postoperative period of a surgical procedure, furnished by the same physician who performed the procedure, billed with CPT modifier “-24,” and accompanied by documentation that supports that the service is not related to the postoperative care of the procedure. They do not pay for inpatient hospital care that is furnished during the hospital stay in which the surgery occurred unless the doctor is also treating another medical condition that is unrelated to the surgery. All care provided during the inpatient stay in which the surgery occurred is compensated through the global surgical payment.

B. CPT Modifier “-25” - Significant Evaluation and Management Service by Same Physician on Date of Global Procedure

Medicare requires that Current Procedural Terminology (CPT) modifier -25 should only be used on claims for evaluation and management (E/M) services, and only when these services are provided by the same physician (or same qualified non-physician practitioner) to the same patient on the same day as another procedure or other service. A/B MACs (B) pay for an E/M service provided on the day of a procedure with a global fee period if the physician indicates that the service is for a significant, separately identifiable E/M service that is above and beyond the usual pre- and post-operative work of the procedure. Different diagnoses are not required for reporting the E/M service on the same date as the procedure or other service. Modifier -25 is added to the E/M code on the claim.

Both the medically necessary E/M service and the procedure must be appropriately and sufficiently documented by the physician or qualified non-physician practitioner in the patient’s medical record to support the claim for these services, even though the documentation is not required to be submitted with the claim.

If the physician bills the service with the CPT modifier “-25,” A/B MACs (B) pay for the service in addition to the global fee without any other requirement for documentation unless one of the following conditions is met:

- When inpatient dialysis services are billed (CPT codes 90935, 90945, 90947, and 93937), the physician must document that the service was unrelated to the dialysis and could not be performed during the dialysis procedure;
- When preoperative critical care codes are being billed on the date of the procedure, the diagnosis must support that the service is unrelated to the performance of the procedure; or
- When an A/B MAC (B) has conducted a specific medical review process and determined, after reviewing the data, that an individual or a group has high use of

modifier “-25” compared to other physicians, has done a case-by-case review of the records to verify that the use of modifier was inappropriate, and has educated the individual or group, the A/B MAC (B) may impose prepayment screens or documentation requirements for that provider or group. When an A/B MAC (B) has completed a review and determined that a high usage rate of modifier “-57,” the A/B MAC (B) must complete a case-by-case review of the records. Based upon this review, the A/B MAC (B) will educate providers regarding the appropriate use of modifier “-57.” If high usage rates continue, the A/B MAC (B) may impose prepayment screens or documentation requirements for that provider or group.

A/B MACs (B) may not permit the use of CPT modifier “-25” to generate payment for multiple evaluation and management services on the same day by the same physician, notwithstanding the CPT definition of the modifier.

Surgical Modifiers Frequently Used by Burn Surgeons

(*Note:* See Appendix IV for a more extensive list of CPT modifiers for physician services and selected HCPCS Level II modifiers most likely to be used by burn surgeons.)

MODIFIER	DESCRIPTION	USE
22	Increased procedural services	<p>Indicates that the work required is substantially greater than typically required for the specific code. Modifier 22 is used to communicate that a procedure required much greater work at that encounter only. Supporting documentation (e.g., in the operative report) is always required. The report must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient’s condition, physical and mental effort required).</p> <p>May be used with surgical and other procedure codes. Do not use with E/M codes.</p>

<p>58</p>	<p>Staged or related procedure or service by same physician during postoperative period (Modifier created originally for Medicare.)</p>	<p>Procedures that are</p> <ul style="list-style-type: none"> a) Planned or anticipated (staged); or, b) More extensive than the original procedure; or, c) For therapy following a surgical procedure <p>and are performed by the same physician during the postoperative period of a previous global surgery on the same patient.</p> <p>By definition, a staged surgical procedure is an operation performed in two or more phases. The modifier allows staging to be indicated for a subsequent related procedure that could not be predicted in advance but whose potential could reasonably be anticipated by the surgeon after or at the time of the original surgery. It is important that the burn surgeon document in the progress notes and in the operative note that the operation is a staged surgical procedure for a burn patient with ___% total body surface burn and ___% of total body surface full thickness burn.</p> <p><i>Examples</i></p> <ul style="list-style-type: none"> • Second and subsequent application of grafts on the same wound, such as an STSG following earlier allograft
------------------	--	--

MODIFIER	DESCRIPTION	USE
		<ul style="list-style-type: none"> • Closure of laparotomy incision days after decompression laparotomy <p><i>Medicare will deny claims for these services when submitted without the modifier.</i></p> <p>Contrast to modifier 78 which is to be used to identify a return to the operating or procedure room for an <i>unanticipated</i> clinical condition during the postoperative period.</p>
<p>59</p>	<p>Distinct procedural service</p>	<p>Indicates that an otherwise bundled procedure was performed on a different anatomic site, on a different injury/wound, at a different session, etc. on the same day by the same provider.</p> <p><i>Example:</i> Removal of small scar on arm with simple suture closure (included in removal) and removal of 6 cm scar on abdomen with coverage of defect with adjacent tissue transfer.</p> <p>1140x-59 Excise benign lesion 1 unit 14001 Adjacent tissue transfer, defect 10.1-30.0 sqcm</p> <p>Add the modifier to the code that would otherwise be bundled. Adjacent tissue transfer includes removal of the 6 cm scar. The payer's automated system would normally deny the 1140x code, assuming it represents the 6 cm scar removal. By adding modifier 59 to the 1140x code, you are indicating the lesion was removed from a <i>different</i> anatomic site, not the site of the adjacent tissue transfer.</p> <p>Modifier 59 is solely to be used by the same provider on the same day for the same patient.</p> <p>Modifier 59 is not to be used with E/M codes.</p>

<p>62</p>	<p>Two Surgeons (Co-Surgeons)</p>	<p>Indicates that two surgeons work together as primary surgeons performing distinct part(s) of a procedure.</p> <p>Each surgeon reports his/her distinct operative work by adding modifier “62” to the appropriate procedure code and any associated add-on code(s) for the procedure as long as both surgeons continue to work together as primary surgeons.</p> <p>Both surgeons report the same procedure code once with modifier 62. Additional procedures (secondary and add-on) performed as co-surgeons at the same session may also be reported with modifier 62. A co-surgeon who acts as an assistant surgeon for other procedures performed at the same time can report the services with the appropriate code(s) and modifier 80 or 81, whichever is applicable. Modifier 62 may be used by surgeons of the same or differing specialties. (See Medicare exception below.) Modifier 62 is not to be used for procedures where 3 or more surgeons participate in the same operative session. See modifier 66 (Surgical Team).</p> <p>Modifier 62 is used to report the services of two surgeons, each of whom is acting as an equal to the other while performing a surgical procedure. It is important to note that one physician is not assisting the other; instead each surgeon performs</p>
------------------	--	---

MODIFIER	DESCRIPTION	USE
		<p>essential part(s) of the same procedure. It is also important to note that the “two surgeons” concept is not the same as “primary/primary” surgeons, where each is performing a procedure independently of the other. See “primary/primary” explanatory section below.</p> <p>Co-surgeons elect to act in that capacity, usually in advance of the procedure. One surgeon generally requests another surgeon to act as a co-surgeon for the procedure in contrast to asking that same surgeon to act as his/her assistant surgeon for it. As a result, coding and reporting guidelines as well as payment are based on the surgeons’ choice to conduct the procedure as co-surgeons.</p> <p>One or the other surgeon may evaluate the patient pre-operatively, and/or admit the patient, and provide postoperative care.</p> <p>General Guidelines for Two Surgeons/Co-Surgeons (See separate Medicare Guidelines below.)</p> <p>Each surgeon must dictate his or her own operative report. The operative report for each surgeon’s work is required to support the billed services on the claim. If only one of the surgeons dictates an operative report, even though it includes mention of the work performed by the other surgeon, it does not constitute documentation that supports the claim submitted by the other surgeon because the other surgeon did not dictate his/her own operative report of the work he/she performed. A claim submitted by any physician without supporting documentation is considered a false claim and is an audit liability.</p> <p>Payers may require a copy of both operative reports for claim payment because these claims are paid manually. The reports with or without an accompanying brief note should display the medical necessity for two surgeons in the case.</p> <p>Many payers, including Medicare, allow a total of 125% of the allowable fee for the definitive procedure. Payment is divided between the two surgeons, 62.5% of the total allowable for each surgeon.</p> <p>Medicare Guidelines for Two Surgeons/Co-Surgeons <i>Surgeons must be of differing specialties as recognized by Medicare. The skills of two surgeons must be medically necessary to perform the procedure.</i></p> <p>Medicare claims for co-surgery are screened against three “medical necessity lists” in the Medicare Physician Fee Schedule database. When submitted with modifier 62:</p> <ul style="list-style-type: none"> -The claim can be paid without further scrutiny when the claim is

MODIFIER	DESCRIPTION	USE
		<p>on the approved list and the two-specialty requirement is met.</p> <p>-The claim is pended if the procedure falls in the category requiring manual review of the operative reports. When the reports demonstrate the medical necessity for two surgeons, the claim can be paid.</p> <p>For the remaining procedures, the first claim that is received is paid based on the lower of the billed amount or 100 percent of the fee schedule amount unless other payment adjustment rules apply. Bills received subsequently from another surgeon are denied for lack of medical necessity.</p> <p>“Primary/Primary” Surgeons vs. Two Surgeons/Co-Surgeons <i>Modifier 62 should not be used for operations where each surgeon performs a separate, primary procedure, usually in different anatomic locations. Each surgeon acts as an independent primary surgeon and dictates his/her own operative report. Payers generally allow the full allowable for each procedure, assuming all coverage and other requirements are in place.</i></p> <p>Coding Example of Primary/Primary Surgeon A performs wound excision on the right arm while Surgeon B performs wound excision on the left arm.</p> <p>Surgeon A 1/12 15002-RT Tangential excision, first 100 sq cm 1 unit</p> <p>Surgeon B 1/12 15002-LT Tangential excision, first 100 sq cm 1 unit</p>

Surgical Modifiers Frequently Used by Burn Surgeons (cont.)

(**Note:** See Appendix IV for a more extensive list of CPT modifiers for physician services and selected HCPCS Level II modifiers most likely to be used by burn surgeons.)

MODIFIER	DESCRIPTION	USE
78	<p>Unplanned return to the operating / procedure room by the same physician following initial procedure for a related procedure during the postoperative period</p>	<p>Indicates an unplanned procedure performed in the operating or procedure room during the postoperative period of a previous global surgery.</p> <p>Often, the procedure is required to treat a surgical complication such as hemorrhage, infection, etc. of the original procedure., Another example where modifier 78 would be used is the situation where a <i>replacement</i> free skin graft is applied to a wound during the postoperative period of a previous skin graft on the same wound (e.g., graft re-application).</p>

MODIFIER	DESCRIPTION	USE
		<p>Modifier 78 essentially allows reporting of procedures that were not foreseen in advance or are unplanned. Contrast to <i>staged</i> procedures which are <i>anticipated</i> or planned and involve some level of planning or anticipation, which procedures would be reported with modifier 58 instead.</p> <p>Modifier 78 is added to the code(s) for the related procedure(s). Secondary procedures performed at the same time should not be identified with modifier 51.</p>
79	<p>Unrelated Procedure or Service by the Same Physician During the Postoperative Period</p>	<p>Used to report a surgical procedure, performed during the assigned postoperative period of a different surgical procedure, but unrelated to it. The term “unrelated” means that the procedure is unrelated to recovery from the earlier procedure or due to a complication of the earlier procedure. Typically, unrelated procedures are performed on different wounds or anatomic sites.</p> <p>The modifier is added to the code for the unrelated surgical procedure.</p>
80	<p>Assistant surgeon</p>	<p>For assistant surgeon</p> <p>Add to the code(s) for the surgical procedure(s) on which the surgeon acted as a surgical assistant</p>
82	<p>Assistant surgeon when qualified resident is not available</p>	<p>Used for assistant surgeon in teaching institutions when</p> <ul style="list-style-type: none"> • Qualified* resident is not available, or • Attending has across-the-board policy never to involve residents in preoperative, operative, and postoperative care of his/her patients. <p>Add modifier to applicable code(s) for which assistant at surgery services were provided.</p> <p>*(Per Medicare, determination of a “qualified” resident is based on each teaching hospital’s own policy regarding qualifications for assisting at specific operations and type of operations that may be performed by the resident.)</p>

Evaluation and Management Modifiers Used Frequently by Burn Surgeons

(**Note:** See Appendix IV for a more extensive list of CPT modifiers for physician services and selected HCPCS Level II modifiers most likely to be used by burn surgeons.)

MODIFIER	DESCRIPTION	USE
24	<p>Unrelated E/M service by the same physician during postoperative period (Modifier created originally for</p>	<p>Evaluation and Management service provided by same physician but unrelated to routine postoperative follow-up care of or treatment for a complication of the previous surgery. <i>Examples</i></p> <ul style="list-style-type: none"> • Critical care for burn patient during postoperative period of previous global surgery (e.g., escharotomy, skin graft, laparotomy)

MODIFIER	DESCRIPTION	USE
	<p>Medicare)</p>	<ul style="list-style-type: none"> • Inpatient visit for problem unrelated to the previous global surgery (e.g., urinary tract infection or pneumonia) • Outpatient clinic visit for problem unrelated to the previous surgery (e.g., scar contracture of a different wound) during the postoperative period of previous global surgery on another wound. <p>Add to the applicable E/M code.</p> <p><i>Medicare will deny claims for these services when submitted without the modifier.</i></p>
<p>25</p>	<p>Significant, Separately Identifiable E/M Service by the same physician on the same day of the procedure or other service</p>	<p>(Modifier 25 can only be used with E/M codes.)</p> <p>TWO USES FOR THIS MODIFIER:</p> <p>1. To identify a separately reportable E/M service that would otherwise be bundled into Medicare or other payer payment for a minor surgical procedure performed at the same encounter or on the same date for the same patient.</p> <p>Criteria:</p> <ul style="list-style-type: none"> • E/M service is provided on the same day as a minor surgical or endoscopic procedure (0 or 10-day follow-up period), • The E/M visit is above and beyond the usual preoperative and postoperative care associated with the procedure, and • The E/M clinical note meets CPT and CMS criteria for the billed E/M code. <p><i>Examples:</i></p> <ul style="list-style-type: none"> • Hospital admission and debridement on the same date • Critical care and debridement on the same date when no previous global surgery period is in place • Outpatient clinic visit and debridement/dressing on the same date when no previous global surgery period is in place <p><i>Important Medicare Exception for Critical Care and Major Surgery:</i> Critical care provided on the day before or day of major surgery (90 days) can be paid only if modifier 25 is added to the critical care code(s) billed on those days.</p> <p>2. To identify a separately reportable E/M service that would otherwise be bundled into another E/M service provided on the same day for the same patient.</p> <p>Usually added to the less clinically intense of two E/M services on the same date to indicate that it also was a significant, separately identifiable visit. Specifically, the modifier is added to the E/M code that would be re-bundled by Medicare under CPT guidelines. (CPT guidelines allow only one E/M visit code per day per patient per physician; modifier 25 is used in those</p>

MODIFIER	DESCRIPTION	USE
		<p>situations that are exceptions to the CPT guidelines.)</p> <p><i>Examples of exceptions are:</i></p> <ul style="list-style-type: none"> • Office visit (25) and unrelated emergency department visit later on the same day • Emergency department visit (25) and critical care services later on the same day • Subsequent hospital visit (25) and critical care services later on the same day when no previous global surgery period is in place • Inpatient admission (25) and critical care services later on the same day <p>The examples assume the less clinically intense service was provided routinely but the patient required unanticipated emergent or critical care services later on the same day. In many instances, the diagnosis for each encounter is expected to differ in kind or acuity/severity. Medicare will deny claims for these services when submitted without the modifier.</p>
57	Decision for Surgery	<p>Indicates an evaluation and management service that resulted in the initial decision to perform surgery.</p> <p>Modifier 57 was created originally for Medicare to allow payment for the E/M service that resulted in the initial decision to perform major surgery when the service occurs on the day before or the day of surgery. The decision must be documented in the medical record. The modifier allows the claim to bypass Medicare global surgery edits that would otherwise bundle the E/M service into the global package and deny payment for it. Modifier 57 indicates that the E/M service is not a part of the global surgical service and, as such, is separately reportable and payable.</p> <p>Under Medicare, all major surgical procedures are assigned a 90-day global surgery follow-up period.</p>

MULTIPLE SURGICAL PROCEDURES

Reduced Payment

When multiple surgical procedures are reported on the same date of service, Medicare and other payers typically allow payment up to 100% of the allowable for the major procedure and then reduce each secondary procedure by a specific percent.

The major surgical procedure is the procedure that is assigned the highest relative value of the multiple procedures being submitted on the claim.

For example, Medicare and most payers allow payment at the percentages of 100, 50, 50, 50, and so on for non-endoscopic surgical procedures.

What is a “Secondary” Procedure?

Medicare and other payers assign a numeric relative value to each code listed in CPT. The Medicare relative values assigned to codes frequently used by burn surgeons are listed in Appendix VII Medicare Physician Fee Schedule Relative Values.

When multiple surgical procedures are performed at the same operative session, the procedure assigned the highest relative value is designated as the major procedure. Each lesser-valued procedure then becomes a secondary procedure for that operative intervention. This concept does not apply to add-on codes (see Add-on Codes in this chapter).

Reduced Payment Not Applicable to Add-on Codes and Modifier 51 Exempt Codes

Add-on Codes

The multiple procedures payment reduction does not apply to add-on codes. Add-on codes are already reduced in value because they are always secondary procedures; therefore, the payment reduction does not apply. (See Add-on Codes in this chapter.)

Modifier 51 Exempt Codes

A list of codes that are exempt from modifier 51 is listed in Appendix E of the CPT book. Modifier 51 should not be added to these codes when submitted on a claim. In theory, no payment reduction should be made for these codes; however, many payers do not recognize the “modifier 51 exempt” policy and do apply the payment reduction.

None of the codes listed in Appendix E are used by burn surgeons. Therefore, this issue is not discussed further in the Primer.

Ranking Procedures on the Claim

It is wise to list each surgical procedure in descending value order on each claim, listing the major procedure first followed by each secondary procedure in descending value order.

Modifier 51 may be added to each secondary procedure to indicate that fact. It is not added to the major procedure because no payment reduction applies to the major procedure.

Please note that payers do not generally mandate the use of modifier 51 when their claims' systems automatically make the major procedure/secondary procedures determination during the claims adjudication process; however, some payers may still require modifier 51. Check with your payers to determine their policy in this regard.

Medicare carriers in most states do not require the procedures to be ranked on the claim and do not require modifier 51. Several Medicare carriers have indicated they prefer claims to be submitted without modifier 51. In all states, Medicare's payment system automatically arrays all procedures on the claim and ranks them for payment regardless of how the procedures are ranked on the claim.

Sample Claim Showing Ranked Procedures

A burn surgeon grafts the torso, right arm and left leg. Split thickness autograft is applied. Documentation correctly lists the total surface area of each recipient site grafted.

Torso:	700 sq cm
R arm:	500 sq cm
R hand:	150 sq cm

The total surface area of recipient sites grafted is 1500 sq cm.

However, two of the anatomic sites are listed in one code category (torso, right arm) while the third site (right hand) is listed in another code category. The total surface area of the recipient sites on the torso and right arm is 1200 sq cm. Total surface area of the right hand recipient site is 150 sq cm.

Coding is as follows:

For torso and right arm, 1200 sq cm.

15100 Split-thickness autograft, first 100 sq cm or less
Units: 1

15101 Split-thickness autograft, each additional 100 sq cm
Units: 12

For right hand, 150 sq cm.

15120-51 Split-thickness autograft, first 100 sq cm or less
Units: 1

15121 Split-thickness autograft, each additional 100 sq cm
Units: 1

Note: Code 15100 is the major procedure in this example because its relative value is higher than that for 15120. Therefore, Modifier 51 is optionally added to code 15120, indicating it is a secondary procedure. Reimbursement will be reduced for 15120 because of this fact. The procedures shown above are ranked on the claim accordingly, with the major procedure listed first and secondary listed next.

ASSISTANT AT SURGERY: MEDICARE

An assistant at surgery is a physician (or, if allowed under state law, a nurse practitioner, physician assistant, or clinical nurse specialist) who actively assists the physician in charge of a case in performing a surgical procedure

When one of the following conditions exists, Medicare allows payment for an Assistant Surgeon only for those procedures where it has determined that assistant surgeon services are medically necessary and, therefore, warrant payment. **Medicare identifies these procedures in its Physician Fee Schedule, a burn-surgeon specific excerpt of which can be found in Appendix VII. To determine how to identify whether an assistant surgeon is allowed for a particular burn procedure, read the *first page* of Appendix VII, referring specifically to the definition in Column 10, “Assistant Surgeon.”**

Assistant at Surgery: Teaching Institutions

For Medicare guidelines for reporting assistant at surgery services in teaching institutions, please refer to the chapter entitled “Teaching Physician Guidelines” and the relevant section “Assistant at Surgery in Teaching Institutions.”

FRAUD AND ABUSE

All members of the burn team have a responsibility to address and prevent fraud and abuse, including claims for services that were not rendered. Although the vast majority of health providers are honest and well-intended, the Office of Inspector General (OIG) does not accept “honest mistakes” in billing and in interpretation of Medicare rules. Some payers have followed this trend by issuing the following statement on explanation of benefits forms:

“TO REPORT SUSPECTED FRAUD, CALL 1-800-HHS-TIPS (1-800-447-8477) AND ASK FOR THE SPECIAL INVESTIGATIONS DEPARTMENT.”

Abuse involves actions that are inconsistent with sound medical, business, or fiscal practices. Abuse directly or indirectly results in higher costs to Medicare programs through improper payments that are not medically necessary. The primary difference between fraud and abuse is a person’s intent. Both, however, can have very negative ramifications for burn centers and burn surgeons. For this reason, it is critical to have a solid understanding of burn care coding principles, *all of which are detailed in this manual.*

One special fraud issue, not addressed elsewhere in the manual, is explained in the following paragraphs.

Physician Claims for Services Must Be Performed or Provided Directly by the Physician

A surgeon may bill for professional services such as a graft or debridement when he/she personally performs/provides the procedure. Hence, the physician bills the professional component using the appropriate CPT code for the procedure.

A surgeon may not bill for the procedure or service when he/she supervises a procedure or service performed by a staff nurse who is salaried or employed by a hospital. The hospital bills for the technical component of this service, provided by its nursing staff. Because no professional component has been performed/provided by the surgeon in this circumstance, it is not billed or billable. In order to bill for the procedure, the surgeon must *personally perform/provide* the procedure.

Two Situations Where the Physician Can Bill for Services Performed by a Different Clinician

One situation occurs under Medicare’s Teaching Physician provisions, in which a teaching physician may bill for his/her professional services of supervising a resident who performs the procedure or service when certain Medicare requirements are met. The requirements are detailed in CMS Internet-only manual, CMS Pub 100-4, chapter 12, section 100 at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

A second situation involves procedures or services provided in the physician office setting when they are performed *by an employee of the physician* (e.g., nurse or non-physician practitioner) and meet Medicare’s “incident to” requirements.

Other than these two exceptions, a *physician* claim for a procedure that was not provided by the surgeon himself/herself would be considered a false claim, subject to fines and sanctions.

Underlying Regulations and Guidelines

A.

When claims for professional services are submitted on the universal claim form, the CMS 1500 or the electronic equivalent, the physician’s signature (or facsimile thereof) certifies the following:

“(I certify that the statements on the reverse [side of the claim form] apply to this bill and are made a part thereof.)”

The reverse side of the CMS 1500 includes the following statement, which, by signing the claim, the physician certifies is true:

“SIGNATURE OF PHYSICIAN OR SUPPLIER (Medicare, CHAMPUS, FECA and Black Lung)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations. See Appendix I.

For services to be considered as “incident” to a physician’s professional service, 1) they must be rendered under the

physician’s immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician’s service, 3) they must be of kinds commonly furnished in physician’s offices, and 4) the services of non-physicians must be included on the physician’s bills.”

The above certification is recognized by non-government payers as well.

B.

The hospital staff nurse’s professional services provided in the hospital are reimbursed by the payer under its usual inpatient or outpatient payment methodology for the technical component, which component is inclusive of the services provided by hospital nursing staff.

When a physician bills for that same service as though he or she personally performed or provided it (i.e., the professional component), the payer is billed twice for the same service. Thus, a service that would otherwise be billed only once is double-billed, causing the payer to make an unwarranted overpayment. Such claims can be considered fraudulent.

Summary of Key Points

A physician may not bill for supervision of a procedure performed by a staff nurse employed by the hospital because the physician did not personally provide the service/procedure.

A physician can bill for a) procedures or services he/she personally performs/provides; b) teaching physician supervision of residents for services provided to Medicare beneficiaries when Medicare’s regulations are met; and c) procedures or services provided in the physician office setting when they are performed by an employee of the physician and meet the “incident to” requirements.

Evaluation & Management (E/M) Services

DOCUMENTATION: KEY CONCEPTS

CPT Definitions

New patient: Patient has not received professional services from the physician or another physician of the same specialty in the group *within the past three years*.

Established patient: Patient has received professional services from the physician or another physician of the same specialty in the group *within the past three years*.

Face-to-face time, office/outpatient: Time spent face-to-face with the patient and/or family.

Floor/unit time, hospital/inpatient: Time spent on the patient's unit, with the patient, conducting chart review, writing progress notes, or communicating with other professionals and the patient's family.

Medicare Definition: New Patient

New patient: A patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3-year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

KEY POINT

CPT new & established patient definitions apply only to coding for physician professional services.

Categories of E/M Codes

Two broad categories of E/M codes are listed in CPT:

- Problem-Oriented: Codes for problem-oriented visits
- Preventive: Codes for preventive/well visits

Coding guidelines for problem-oriented visits only are discussed in this manual.

Types of Problem-oriented E/M Codes

- **Level of service**—defined by clinical intensity of history, exam, medical decision making (*e.g.*, consultation). A Time option is included in some categories.
- **Time-defined**—based on time spent providing care (*e.g.*, critical care).
- **Other**—defined by other criteria (*e.g.*, neonatal intensive care).

Selecting the Correct E/M Code for Level of Service—Determined by Documentation

Each level of service is selected based on the clinical intensity of 3 key components *documented* in the record—history, examination and/or medical decision-making.

Four additional components contribute to the level of service:

- Counseling
- Coordination of care
- Nature of presenting problem
- Time (see Time Option)

Time Option for Counseling and/or Coordination of Care

When counseling and/or coordination of care requires more than 50 percent of the face-to-face time in the office/outpatient area or 50% of the floor/unit time in the hospital, the code can be selected solely on time. The time option can only be used with codes that include “average time” in the code description, *e.g.*, 99201–99205, which list average times of 10, 20, 30, 45, and 60 minutes, respectively.

For example, assume a new patient clinic visit where counseling time was 20 minutes and total face-to-face time was 30 minutes.

The correct code is 99203, which specifies a 30-minute average time.

When counseling and/or coordination of care consume 100% of the time, the code can be selected on the basis of total time for the encounter. In this situation, a history and/or physical are not required.

It is important to document the total time of the encounter, time *devoted to counseling* and/or coordinating care, and the content of the encounter.

CMS Requirements for Selecting E/M Codes

CMS’s level of service requirements includes CPT guidelines *but go beyond* them to specify numeric documentation requirements for each key component of a level of service.

By following CMS guidelines, both CPT and CMS rules can be satisfied for selecting a level of service. These guidelines are called the AMA/CMS Evaluation and Management Documentation Guidelines. Two sets of guidelines were published, one in 1995 and the other in 1997. Physicians may choose either set of guidelines for documenting their E/M services.

CPT & CMS Documentation Requirements

CPT Documentation Summary

CPT has set 4 levels of clinical intensity or complexity for each key component:

- **History:** problem focused, expanded problem focused, detailed, comprehensive
- **Examination:** problem focused, expanded problem focused, detailed, comprehensive
- **Medical Decision-Making (MDM):** straightforward, low, moderate, high.

CMS Documentation Summary

CMS has established a specific number of items that must be documented for each level of history and examination. There are no numeric requirements for MDM. But other, unofficial, numeric criteria options and data). The third measure, risk, is determined using CMS’s Table of Risk.

KEY POINT

Find AMA/CMS E/M Documentation Guidelines at ama-assn.org or on CMS’ web site at: <http://www.cms.hhs.gov/MLNProducts/Downloads/1995dg.pdf> for 1995 guidelines) or <http://www.cms.hhs.gov/MLNProducts/Downloads/MASTER1.pdf> for 1997 guidelines)

Note: Refer to the CMS websites noted in the Key Point for the set of guidelines desired and then to Appendix V which provides a set of directions based on the guidelines that can be used to select the correct level of E/M service.

KEY POINT

Separate your E/M documentation from procedural documentation in your progress note.

Documentation for Separate E/M & Minor Surgical Procedure, Same Date of Service

- To illustrate the separate nature of each service provided, *physically* separate the documentation for the E/M service from that for the procedure. Each may appear on the same page, separated by several line spaces, or on separate pages.
- The “separation” technique is important when an E/M and a *minor* surgical procedure are performed on the same date to support appeal of any E/M claim denials that may result from payer bundling the E/M into the procedure. See Modifier 25 for specific reporting instructions.
- E/M documentation must meet CPT/CMS criteria for the billed level of service to meet the “significant, separately identifiable” requirement for separate billing.
- **Never “blend” the procedure into the E/M documentation, as it cannot immediately be distinguished from the E/M service itself.**

Avoid stating the procedure only as “Plan” without also documenting the full procedure itself.

BASIC E/M REPORTING GUIDELINES

Specific reporting guidelines apply to each E/M code category and to some codes within categories. An essential rule for reporting levels of service is that multiple, *related* E/M services on the same day are reported with a single E/M code, generally the most clinically intense level of service.

1 E/M per day unless...

Only 1 E/M per day is allowed per CPT guidelines, with certain exceptions. As you can see, the exceptions often occur when a level of service code is provided on the same day as a time-based code.

Medicare does not allow payment for more than one E/M service per day “billed by a physician or physician of the same specialty from the same group practice for the same beneficiary” unless each is provided for a different diagnosis.

(Source: CMS Transmittal 731, CMS Internet-only manual 100-04 Medicare Claims Processing)

Examples of Exceptions

1. Routine office/clinic visit in the a.m. and emergency department service later in the day for a different problem.
2. Critical care provided in the emergency department followed by admission history and physical after the patient no longer requires constant attendance. (Medicare does not allow billing for admission in this situation.)
3. Initial inpatient admission, then critical care later in the day
4. Inpatient consultation, then critical care later in the day
5. E/M services that are specifically exempted from the above rule.

Modifier 25 (Significant, separately identifiable E/M service by the same physician on the same day of the procedure or *other service*) must be used to identify the otherwise bundled E/M as a separate service on the same day. (Refer to Modifier 25 in Appendix IV for specific instructions.)

KEY POINTS

Always add the applicable modifier to the code that would otherwise be bundled when one of the listed situations occurs.

Unbundling and Bundling E/M Services

Unbundling is an audit liability!

Unbundling can occur when the physician reports:

- More than one related E/M service for the same patient on the same date instead of a single E/M code. For example, two subsequent hospital visits (99231–99233) on the same date of service. Because they are *per day codes*, only one may be billed per day.
- **A postoperative follow-up E/M service that is included in a global surgical package, such as the 90-day period following a skin graft. For example, discharge day management (99238–99239). Discharge day management should be dictated but not billed.**

Unbundling Example

Emergency department visit and initial inpatient admission by same physician, same date of service. Patient admitted from emergency department.

9928x Emergency department visit [component code]

9922x Initial inpatient admission [comprehensive code]

This example illustrates an unbundled E/M service that violates the “1 E/M per day” rule inherent in E/M coding guidelines. In this case, CPT guidelines indicate that all related E/M services provided on the same day are included in the initial inpatient admission code.

E/M Services and the Surgical Package

Preoperative E/M Service

CPT Guidelines

- **CPT Surgical Package**

(Global period, follow-up days, and guidelines can vary by payer)

Applies to CPT codes that are not add-on codes. Add-on codes are identified in CPT by a “+” sign before the code number.

Preoperative E/M services are not included in the global surgery package unless, subsequent to the decision for surgery, one related E/M visit is provided on the day before or the day of procedure (includes history and physical). Then, the related E/M visit is included in the global surgery package.

Examples: Burn surgery examples of global surgeries can include autografts, allografts, xenografts and laparotomy, but these may vary by payer.

Medicare Guidelines

Note: *Please refer to Critical Care section for special Medicare billing instructions when critical care is provided to burn patients preoperatively in conjunction with a major or minor procedure.*

- **Major surgery (90 days)**

An E/M service provided on the day before or the day of a major surgical procedure is included in the global surgical package unless the decision to perform the surgery was made at the E/M encounter on either day. In this situation,

KEY POINT

Modifier 57 informs Medicare that the decision for global surgery was made this day, allowing separate payment for the E/M service.

modifier 57 (Decision for Surgery) must be added to the E/M code to bypass Medicare’s global surgery bundling edit.

Burn surgery examples of Medicare major surgeries are skin grafts and decompression fasciotomy of the hand.

- **Minor Surgery (0 or 10 days)**

Note: CMS considers procedures to which it assigns “0” or “10” day follow-up periods as “minor” procedures.

An E/M service on the day of a minor surgical procedure (0 or 10 postoperative follow-up days) is separately reportable when it is:

- a) not part of the routine preoperative care included in the procedure;
- b) documented and meets the CPT/CMS criteria for the billed level of service;
- c) significant, and separately identifiable (see b).

Modifier 25 must be added to the E/M code to identify this situation and bypass re-bundling edits.

Burn surgery examples of Medicare minor surgeries are burn wound excision (15002-15005), dressings/debridement (16020–16030), escharotomy (16035-16036), insertion of central venous line (e.g., 36555–36556, 36568–36569), endotracheal intubation (31500), and tracheostomy (31600–31605).

Postoperative E/M Services

CPT Guidelines

- CPT Surgical Package

(Global period, follow-up days, and guidelines can vary by payer)

- Applies to CPT codes that are not add-on (+ sign before code number in CPT) codes.
- E/M services for *typical, uncomplicated* care during the assigned postoperative period are included in the global surgical package.
- E/M services *to treat a complication or unrelated conditions* during the assigned postoperative period are not included in the global surgical package and are separately reportable.
- Burn surgery examples of global surgeries can include certain skin grafts, laparotomy, decompression

fasciotomy of hand and others, but these can vary by payer.

Medicare Guidelines

Note: Please refer to Critical Care section for special Medicare billing instructions when critical care is provided to burn patients during the postoperative period of a major or minor procedure.

- **Major surgery (90 days)**

Follow-up visits during the postoperative period of the surgery that are related a) to recovery from the surgery or b) for complications related to the surgery are *included* in the global surgical package.

E/M services to treat unrelated conditions are not included in the global surgical package and are separately payable when submitted with the diagnosis for the unrelated condition and supported by documentation in the medical record. Modifier 24 must be added to the E/M code to identify the unrelated E/M service and bypass re-bundling edits.

Despite the fact that this policy is explicitly stated in the CMS/Medicare Claims Processing Manual, some Carriers continue to deny unrelated E/M visits during the postoperative period. You may need to challenge such denials on appeal, demonstrating why the E/M service was unrelated to the postoperative care of the previous surgery. See detailed discussion under “Global Periods,” “Medicare Global Surgery Package,” presented earlier in the *Key Concepts* section.

Burn surgery examples of Medicare major surgeries are certain skin grafts, laparotomy and decompression fasciotomy of hand.

- **Minor surgery (0–10 days)**

Note: CMS considers procedures to which it assigns “0” or “10” day follow-up periods as “minor” procedures.

- a) For procedures assigned 0 follow-up days, E/M follow-up services on the day after and subsequent days are separately reportable.
- b) For procedures assigned 10 follow-up days, E/M services related to recovery or complications from the minor surgery are *included* in the surgery.

KEY POINT

Unrelated inpatient visits during the postoperative period of a global surgery are *not* included in Medicare’s global surgical package according to clarification published in its internet only manual 100-4 which specifically allows payment for a medical condition unrelated to the previous global surgery.

Burn surgery examples of Medicare minor surgeries are burn wound excision (15002-15005), dressings/debridement (16020–16030), escharotomy (16035-16036), insertion of central venous line (e.g., 36555–36556, 36568–36569), endotracheal intubation (31500), tracheostomy (31600–31605), application of skin substitutes (O day global).

SHARED E/M SERVICES: PHYSICIAN AND NON- PHYSICIAN PRACTITIONER (NPP)

Selection of E/M Levels

30.6.1 - Selection of Level of Evaluation and Management Service (Rev. 3315, Issued: 08-06-15, Effective: 01-01-16, Implementation: 01-04-16)

A. Use of CPT Codes

Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Medicare will pay for E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM)) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice. Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

The complete reference for this topic is: CMS Internet Only Manual (IOM) Pub 100-4 Medicare Claims Processing Manual, Chapter 12 Physician/Practitioner Billing, section 30.6.1.B Selection of Level of E/M Service.

20.4.2 - Site of Service Payment Differential

(Rev. 3586, Issued: 08-12-16, Effective: 01-01-17, Implementation: 01-03-

17)

Under the Medicare Physician Fee schedule (MPFS), some procedures have separate rates for physicians’ services when provided in facility and non-facility settings. The CMS furnishes both rates in the MPFSDB update.

The rate, facility or non-facility, that a physician service is paid under the MPFS is determined by the Place of service (POS) code that is used to identify the setting where the beneficiary received the face-to-face encounter with the physician, non-physician practitioner (NPP) or other supplier. In general, the POS code reflects the actual place where the beneficiary receives the face-to-face service and determines whether the facility or non-facility payment rate is paid. However, for a service rendered to a patient who is an inpatient of a hospital (POS code 21) or an outpatient of a hospital (POS codes 19 or 22), the facility rate is paid, regardless of where the face-to-face encounter with the beneficiary occurred. For the professional component (PC) of diagnostic tests, the facility and non-facility payment rates are the same – irrespective of the POS code on the claim.

Place of Service Codes on Professional Claims (CMS 1500 Claim Form) Govern Reporting Guidelines for Office or Outpatient Visits

Place of Service codes on claims indicate the location where the service was rendered. Because CMS/Medicare based its coverage and payment guidelines on the place of service, coding and reporting should correspond to the place of service entered on the claim.

While CMS has created many different place of service codes, the key place of service codes related to shared E/M services are as follows:

- 11** Office
- 21** Hospital Inpatient
- 22** Hospital Outpatient (e.g., outpatient clinic)
- 23** Hospital Emergency Department

Because Office and Outpatient E/M services are reported using the same code categories (99201-99215), the key criteria for application of the guidelines is based on the *billed place of service code*. Local Medicare Carriers establish which place of service code should be used on professional claims. Place of service 11 is typically required for physician-owned office or clinic. Place of service 22 is usually required for professional services provided in the hospital outpatient department or clinic (e.g., wound or burn clinic).

Physician and NPP: Same Employer/Group

Medicare no longer allows payment for consultation codes but continues to allow payment for consultation services when billed using the appropriate office or other outpatient visit code or inpatient hospital code. Refer to “Consultations” in another part of this section for complete details of this Medicare payment policy.

Note: Regardless of place of service, Medicare does not allow payment for a “shared E/M” **consultation** service provided by both a physician and a non-physician practitioner (NPP). If a physician and an NPP provide a shared consultation service, it must be billed using the NPP’s NPI number, not the physician’s NPI number. A physician may bill a consultation under his NPI number only when all 3 key components have been performed and documented by the physician.

Hospital Inpatient/Outpatient (e.g., clinic)/Emergency Department (Places of Service: 21/22/23)

On October 25, 2002, Medicare’s payment policy for shared E/M services in a hospital setting was revised to allow billing under the physician’s provider number (NPI) so long as the physician provides any face-to-face portion of the E/M encounter with the patient.

- When a hospital E/M is shared between a physician and a non-physician practitioner (NPP) from the same employer/group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service

may be billed under either the physician’s or the NPP’s NPI number. **Separate documentation by each professional is crucial** for appropriate billing. Please refer to the “Documentation” section of this chapter for important tips to avoid audit liability.

- If there is no face-to-face encounter *or evidence of it* between the physician and patient, then the service must be billed under the NPP’s NPI.

Office (Place of Service 11)

- When an E/M service is a shared/split encounter provided by a physician and NPP, the service is considered to be rendered “incident to” if the requirements for an “incident to” service are met and the patient is an established patient (for “incident to” requirements, refer to CMS Pub. 100-2, Chapter 15, sections 60.1, 60.2, 60.3 Incident to Physicians Professional Services at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>).
- If the “incident to” requirements are met, the physician reports the E/M service. If the “incident to” requirements are not met, the service is reported using the NPP’s NPI.

60.1 - Incident to Physician’s Professional Services (Rev. 1, 10-01-03) B3-2050.1

Incident to a physician’s professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician’s personal professional services in the course of diagnosis or treatment of an injury or illness.

A - Commonly Furnished in Physicians’ Offices

Services and supplies commonly furnished in physicians’ offices are covered under the incident to provision. Where supplies are clearly of a type a physician is not expected to have on hand in his/her office or where services are of a type not considered medically appropriate to provide in the office setting, they would not be covered under the incident to provision.

Supplies usually furnished by the physician in the course of performing his/her services, e.g., gauze, ointments, bandages, and oxygen, are also covered. Charges for such services and supplies must be included in the physicians’ bills. (See §50 regarding coverage of drugs and biologicals under this provision.) To be covered, supplies, including drugs and biologicals, must represent an expense to the physician or legal entity billing for the services or supplies. For example, where a patient purchases a drug and the physician administers it, the cost of the drug is not covered. However, the administration of the drug, regardless of the source, is a service that represents an expense to the physician. Therefore, administration of the drug is payable if the drug would have been covered if the physician purchased it.

B - Direct Personal Supervision Coverage of services and supplies incident to the professional services of a physician in private practice is limited to situations in which there is direct physician supervision of auxiliary personnel.

Auxiliary personnel means any individual who is acting under the supervision of a physician, regardless of whether the individual is an employee, leased employee, or independent contractor of the physician, or of the legal entity that employs or contracts with the physician. Likewise, the supervising physician may be an employee, leased employee or independent contractor of the legal entity billing and receiving payment for the services or supplies.

However, the physician personally furnishing the services or supplies or supervising the auxiliary personnel furnishing the services or supplies must have a relationship with the legal entity billing and receiving payment for the services or supplies that satisfies the requirements for valid reassignment. As with the physician's personal professional services, the patient's financial liability for the incident to services or supplies is to the physician or other legal entity billing and receiving payment for the services or supplies. Therefore, the incident to services or supplies must represent an expense incurred by the physician or legal entity billing for the services or supplies.

Thus, where a physician supervises auxiliary personnel to assist him/her in rendering services to patients and includes the charges for their services in his/her own bills, the services of such personnel are considered incident to the physician's service if there is a physician's service rendered to which the services of such personnel are an incidental part and there is direct supervision by the physician.

This does not mean, however, that to be considered incident to, each occasion of service by auxiliary personnel (or the furnishing of a supply) need also always be the occasion of the actual rendition of a personal professional service by the physician. Such a service or supply could be considered to be incident to when furnished during a course of treatment where the physician performs an initial service and subsequent services of a frequency which reflect his/her active participation in and management of the course of treatment. (However, the direct supervision requirement must still be met with respect to every non-physician service.)

Direct supervision in the office setting does not mean that the physician must be present in the same room with his or her aide. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the aide is performing services.

If auxiliary personnel perform services outside the office setting, e.g., in a patient's home or in an institution (other than hospital or SNF), their services are covered incident to a physician's service only if there is direct supervision by the physician. For example, if a nurse

accompanied the physician on house calls and administered an injection, the nurse's services are covered. If the same nurse made the calls alone and administered the injection, the services are not covered (even when billed by the physician) since the physician is not providing direct supervision. Services provided by auxiliary personnel in an institution (e.g., nursing, or convalescent home) present a special problem in determining whether direct supervision exists.

The availability of the physician by telephone and the presence of the physician somewhere in the institution does not constitute direct supervision. (See §70.3 of the Medicare National Coverage Determinations Manual for instructions used if a physician maintains an office in an institution.) For hospital patients and for SNF patients who are in a Medicare covered stay, there is no Medicare Part B coverage of the services of physician-employed auxiliary personnel as services incident to physicians' services under §1861(s)(2)(A) §80 of the Act. Such services can be covered only under the hospital or SNF benefit and payment for such services can be made to only the hospital or SNF by an A/B MAC (A). (See concerning physician supervision of technicians performing diagnostic x-ray procedures in a physician's office.)

60.2 - Services of Non-Physician Personnel Furnished Incident to Physician's Services (Rev. 1, 10-01-03)

In addition to coverage being available for the services of such auxiliary personnel as nurses, technicians, and therapists when furnished incident to the professional services of a physician (as discussed in §60.1), a physician may also have the services of certain non-physician practitioners covered as services incident to a physician's professional services. These non-physician practitioners, who are being licensed by the States under various programs to assist or act in the place of the physician, include, for example, certified nurse midwives, clinical psychologists, clinical social workers, physician assistants, nurse practitioners, and clinical nurse specialists. (See §§150 through 200 for coverage instructions for various allied health/non-physician practitioners' services.)

Services performed by these non-physician practitioners incident to a physician's professional services include not only services ordinarily rendered by a physician's office staff person (e.g., medical services such as taking blood pressures and temperatures, giving injections, and changing dressings) but also services ordinarily performed by the physician such as minor surgery, setting casts or simple fractures, reading x-rays, and other activities that involve evaluation or treatment of a patient's condition.

Nonetheless, in order for services of a non-physician practitioner to be covered as incident to the services of a physician, the services must meet all of the requirements for coverage specified in §§60 through 60.1. For example, the services must be an integral, although incidental, part of the physician's personal professional services, and they must be performed under the physician's direct supervision.

A non-physician practitioner such as a physician assistant or a nurse practitioner may be licensed under State law to perform a specific medical procedure and may be able (see §§190 200 or, respectively) to perform the procedure without physician supervision and have the service separately covered and paid for by Medicare as a physician assistant's or nurse practitioner's service. However, in order to have that same service covered as incident to the services of a physician, it must be performed under the direct supervision of the physician as an integral part of the physician's personal in-office service. As explained in §60.1, this does not mean that each occasion of an incidental service performed by a non-physician practitioner must always be the occasion of a service actually rendered by the physician. It does mean that there must have been a direct, personal, professional service furnished by the physician to initiate the course of treatment of which the service being performed by the non-physician practitioner is an incidental part, and there must be subsequent services by the physician of a frequency that reflects the physician's continuing active participation in and management of the course of treatment. In addition, the physician must be physically present in the same office suite and be immediately available to render assistance if that becomes necessary.

Note also that a physician might render a physician's service that can be covered even though another service furnished by a non-physician practitioner as incident to the physician's service might not be covered. For example, an office visit during which the physician diagnoses a medical problem and establishes a course of treatment could be covered even if, during the same visit, a non-physician practitioner performs a non-covered service such as acupuncture.

Hospital Inpatient/Outpatient/Emergency Department (Places of Service are 21/22/23)

60.3 Billing for Shared & Non- shared E/M Services, Same Group

- Inpatient E/M service provided/documented by MD alone: Report under MD provider number.
- Inpatient E/M service provided/documented by NPP alone ***or not supported by MD documentation for shared visit***: Report under NPP provider number.
- Shared inpatient E/M service provided/documented by both the MD and NPP on same date of service: Report under MD provider number ***if*** MD documents and provides any portion of the face-to-face encounter. Documentation must support MD's portion of the E/M service (co-signing or initialing does not meet the requirement). The billed level of service should be based on the combined documentation but cannot be higher than warranted and medically necessary.
- Outpatient hospital (e.g., hospital outpatient clinic, burn clinic, wound clinic) (Place of service 22) including Emergency Room (Place of service 23) E/M service: Follow the same guidelines as listed above for Inpatient. The patient may be new or established.

Office (Place of Service is 11)

- E/M service provided/documented by MD alone: Report under MD provider number
- E/M service provided/documented by NPP alone: Report under MD provider number if “incident to” provisions are met and patient is established patient. If “incident to” provisions are not met or patient is new, report under NPP provider number
- Shared E/M provided/documented by both the MD and NPP: Report under MD number **if** “incident to” provisions are met **and** the patient is an established patient. The billed level of service should be based on the combined documentation but cannot be higher than warranted and medically necessary.

 KEY POINT

Do not select a level of service higher than that warranted by the severity and nature of the presenting problem.

Selecting the Level of Service

- The level of service should be selected based on the combined documentation of the physician and the non-physician practitioner (NPP), **subject to medical necessity for the E/M service and based on the severity of the presenting problem(s)**. CMS states, “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.”

Documentation should support the level of service billed.

Payment

Any physician or NPP authorized to bill Medicare services will be paid by the carrier at the appropriate physician fee schedule amount based on the rendering NPI on the claim.

Documentation

CMS has published no guidelines for physician documentation of his/her portion of the shared face-to-face encounter.

The burn surgeon should provide substantive documentation that provides evidence of the face-to-face encounter, supports medical necessity for the physician face-to-face activity and is appropriate to the patient’s presenting problem or status. Documentation of one or more of the key components (history, examination, medical decision making) may be sufficient to meet those criteria.

Documentation Crucial for Hospital Shared E/M Services Documentation by the burn surgeon must be present to establish his/her presence in the face-to-face hospital encounter.

Documentation must support the burn surgeon’s portion of the E/M service (co-signature or initial does not meet the requirement).

For handwritten or dictated progress notes, the burn surgeon should document his/her portion of the face-to-face encounter.

Documentation by the NPP only does not support billing for a shared E/M and should be billed under the NPP’s provider number.

Physician and NPP with Different Employers

Medicare no longer allows payment for consultation codes but continues to allow payment for consultation services when billed using the appropriate office or other outpatient visit code or inpatient hospital code. Refer to “Consultations” in another part of this section for complete details of this Medicare payment policy.

Note: Regardless of place of service, Medicare does not allow payment for a “shared E/M” **consultation** service provided by both a physician and a non-physician practitioner (NPP). If a physician and an NPP provide a shared consultation service, it must be billed using the NPP’s NPI number, not the physician’s NPI number. A physician may bill a consultation under his NPI number only when all 3 key components have been performed and documented by the physician.

When a physician and NPP, **each employed by a different entity,** provide a shared E/M service, **only 1 provider may report the E/M service.** One or the other, but not both may bill the service. The physician and NPP must decide which individual will bill the service.

KEY POINT

Only one provider may bill for a shared E/M service when the physician and NPP have different employers.

- **The billing provider must select the level of E/M service based solely on his/her documentation. The documentation by the other provider cannot be combined with that of the billing provider to select the level of service. The billing provider cannot use or refer to the other provider’s E/M notes in selecting the level of service.**
- The billing provider must demonstrate independent evaluation and medical decision-making in the documentation to qualify for billing the E/M service. That is, the billing provider’s documentation must stand alone as an E/M service consistent with CPT E/M code definitions and AMA/CMS documentation guidelines.

TYPICAL BURN E/M SERVICES

The following sections include coding for selected E/M services that are typically provided by burn surgeons.

Emergency Department Service (99281–99285)

Emergency Department Service with Discharge

*Codes 99281–99285 are generally utilized by ED attending staff. **Burn surgeons usually use an Office/Outpatient code from 99201–99215, or a Consultation code from 99241–99245, when an ED burn surgery consultation is requested. For Medicare, burn surgeons must use the appropriate ED code 99281–99285 instead.***

- The ED attending physician reports the appropriate ED level of service.

Emergency Department Service with Inpatient Admission

- Report the documented level of service for inpatient admission only. Do not code and report the ED service in addition.
- Code and report all minor and major surgical procedures performed on the same date. For Medicare, add modifier 25 to the E/M code when only minor procedures are performed on the same date. Add modifier 57 to the E/M code instead when major procedure(s) are performed on the same day or one day later.

Emergency Department Service and Critical Care

Either hourly critical care codes (e.g., 99191, 99192) or the appropriate level 4 or 5 ED code can be reported when critical care is provided in the ED to patients of *any age*. One or the other, but not both, may be billed. For critical care provided to a pediatric patient in both the outpatient and inpatient settings on the same day, report only the appropriate Neonatal or Pediatric Critical Care code for all such services on that day. Refer to the

KEY POINT

ED critical care can be coded when

1. Total critical care time is documented **and**
2. Illness or injury and treatment rendered meet CPT listed requirements.

See Critical Care section.

Critical Care section for Inpatient Pediatric Critical Care or Inpatient Neonatal Critical Care codes and guidelines.

Critical care in ED

- Report 99291 for first 30–74 minutes of documented critical care; 99292 for each additional 30 minutes of critical care.
- Report procedures excluded from (not bundled into) critical care codes separately and in addition. Time spent performing these separately reportable procedures should not be included in the time reported as critical care time for Medicare.
- Add modifier 25 to critical care code(s) when minor or major procedures that are not included in critical care codes are performed at the same encounter or on the same day. The modifier allows the claim to bypass Medicare re-bundling edits for critical care and same-day surgery.
- Refer to Critical Care section for detailed coding and reporting information.

Consultations (99241–99255, 99251-99255)

Medicare no longer allows payment for CPT consultation codes regardless of place of service. For consultations provided to Medicare patients, see “Rules for Medicare Coding & Payment of Consultations” below.

CPT Definition

A consultation is a type of evaluation and management service provided by a physician at the request of another physician or appropriate source to either

1. recommend care for a specific condition or problem or
2. to determine whether to accept responsibility for
 - ongoing management of the patient’s entire care or
 - for the care of a specific condition or problem.

CPT Requirements for a Consultation

- ***Must be requested by another physician or appropriate source.***
- ***The request is documented in the record by the consulting physician, requesting physician, or other appropriate source.***

KEY POINT

Consultation can be coded only when CPT stated requirements are met.

- Consultant’s opinion, advice and services ordered or performed are documented in the record and communicated to the requesting physician in a written report.

Consultant may initiate diagnostic or therapeutic services at the encounter.

Consultant may complete the E/M service and then initiate therapeutic services.

When a therapeutic service is provided at the consultative encounter, the E/M service is still considered a consultation if the definition of a consultation is met and all the above requirements are satisfied.

Once the consulting physician assumes care of the patient, the consultative mode ends. Subsequent visits should be reported with the appropriate E/M code (e.g., subsequent hospital visit, established patient office visit).

Diagnostic or therapeutic medical or surgical procedures performed at the same encounter may be reported separately and in addition.

When a “consultation” is **not** requested by a physician but is initiated by a patient and/or family instead, a consultation code is not reported. Use the appropriate office or outpatient visit codes when the service is provided in the office or outpatient clinic setting.

Note: Medicare does not allow payment for a “shared E/M” consultation service provided by both a physician and a non-physician practitioner (NPP). If a physician and an NPP provide a shared consultation service, it must be billed using the NPP’s NPI (National Provider Identifier) number, not the physician’s NPI number. A physician may bill a consultation under his NPI number only when all 3 key components have been performed and documented by the physician.

Concurrent Care, Transfer of Care, and Consultation

CPT definitions and guidelines:

“**Concurrent care** is the provision of similar services (e.g., hospital visits) to the same patient by more than one physician on the same day. When concurrent care is provided, no special reporting is required.

Transfer of care is the process whereby a physician who is providing management for some or all of a patient’s problems relinquishes this responsibility to another physician who explicitly agrees to accept this responsibility, and who, from the initial encounter, is not providing consultative services. The physician transferring care is then no longer providing care for these problems, though he or she may continue providing care for other condition(s) when appropriate. **Consultation codes should not** be reported by the physician who has agreed to accept transfer of care before an initial evaluation **but are appropriate** to report if the decision to accept transfer of care cannot be made until after the initial consultation evaluation, regardless of the site of service.” Source: CPT 2018 Professional Edition, page 5.

Note: The CPT coding guidelines that follow apply to use of consultation codes. In general, the guidelines may be used for Medicare patients as well; however, Medicare rules preclude use of the CPT consultation codes for these services. For example, the “Consultation in ED, Patient Discharged” reporting guidelines below remain the same for Medicare except that an ED code must be reported instead of a consultation code. See **“Rules for Medicare Coding & Payment of Consultations”** in another part of this section.

Consultation in ED, Patient Discharged

- When burn surgery consultation is requested and provided, report it with the appropriate code from 99241–99245 (Office or Other Outpatient Consultation).
- **For Medicare**, report the appropriate ED code 99281–99285 instead.
- Report any therapeutic procedures performed by the burn surgeon in the ED separately, and in addition.

Add modifier 25 to the consultation code when minor procedures are performed (e.g., debridement/dressings) at the encounter.

Consultation in ED, Patient Admitted as Inpatient, Same Date, Same Physician

- E/M reporting options are:
Consultation (Inpatient, 99251–99255)
or
Initial Inpatient Admission (99221–99223)
One or the other, but not both, may be reported.

- With minor procedures performed in the ED or after admission, same date:
 - a) Document separately and report each minor procedure performed (*e.g.*, debridement/dressing, escharotomy, insert central venous line, etc.)
 - b) Add modifier 25 to the E/M code

- With major procedure performed after admission, same day or 1 day later:
 - a) Document and report each major procedure performed (*e.g.*, escharotomy)
 - b) Add modifier 57 to the E/M code (for Medicare). Note: This guideline takes precedence over the modifier 25 requirement when both minor and major procedures are performed on the same day.

Note: See also critical care guidelines for specific Medicare coding/modifier exceptions.

Inpatient Consultation (99251–99255)

Inpatient consultation may be reported as provided when the requirements for a consultation are met. **Only one consultation should be reported by a consultant per admission (CPT guideline).** Subsequent E/M services during the same admission, whether consultative or not, are reported using the subsequent hospital visit codes (99231-99233)

For Medicare, report the appropriate initial inpatient hospital visit code (99221-99223) instead of a consultation code because Medicare no longer allows payment for consultation codes.

Rules for Medicare Coding & Payment of Consultations

Medicare will continue to allow payment for consultations; however, CPT consultation codes 99241-99245 and 99251-99255 will no longer be recognized for Medicare Part B payment.

This means that physicians who provide consultations are required to stop using CPT consultation codes and must begin using different codes to describe the consults they perform depending on the place of service where the service is rendered.

Documentation of Request for Consultation (“referral”)

CMS states the following:

“Conventional medical practice is that physicians making a referral and physicians accepting a referral would document the request to provide an evaluation for the patient. In order to promote proper coordination of care, these physicians should continue to follow appropriate medical documentation standards and communicate the results of an evaluation to the requesting physician. This is not to be confused with the specific documentation requirements that previously applied to the use of the consultation codes.” Source:

<http://www.cms.hhs.gov/MLNMattersArticles/downloads/MM6740.pdf>

Medicare Reporting Guidelines for Consultations

- Do not report consultation codes 99241-99245 and 99251-99255 for consultative services.
- For **office** consultations, report the appropriate office or outpatient visit code (99201-99215).
- For **initial inpatient** consults, report the appropriate initial hospital care code (99221-99223).
- For consultations provided to patients in outpatient **observation status**, report the appropriate office or outpatient visit code (99201-99215).
- For consultations provided in the **ED**, the consulting physician should bill the appropriate ED code. If the patient is admitted from the ED to the hospital by the consulting physician, the consulting physician should report an initial hospital care code and not an ED code.
- **All physicians** who perform an initial inpatient E/M service must bill the initial hospital care codes 99221-99223. This includes all physicians who provide consultative services. In

this scenario, multiple billings of initial hospital care codes could occur on the same day.

- The **admitting or attending physician** who oversees the patient's care in the hospital **should use modifier "AI"** ("Principal Physician of Record") with the initial inpatient care code to distinguish that service from the services of all other physicians who may be providing consultative or specialty hospital care on that day or subsequent days. The attending need not submit modifier AI on claims for subsequent hospital visits.
- **Follow-up hospital visits** by the attending physician or the consulting physician should be billed as subsequent hospital care visits.
- All physicians **must bill only the E/M code that meets the definition of the level of complexity performed and documented.**

How to Select the Correct Code for Office or Other Outpatient Services (99201-99215) By Level of Complexity

For **New Patients (99201-99205)**, there is a one-to-one correspondence between Office Consultation codes and Office New Patient codes. All of the 3 key components across the 5 levels of service in the two code sets are the same. For example, new patient code 99203 is equivalent to consultation code 99243. So a Medicare consultation previously billed with 99243 is now billed using code 99203 instead.

However, average times differ between the two code sets, with lower average times assigned to 99201-99205. As an example, if counseling and/or coordination of care dominates (more than 50% of) the new patient encounter and the physician chooses to select a code based on time only, the times assigned to new patient codes are 5-20 minutes less than those in the consultation codes. Thus, less time is required to bill these codes on the basis of time alone.

For **Established Patients (99211-99215)**, there is no one-to-one correspondence except for the key components of 99215 and 99245, which are the same. Also, average times differ between the two code sets, with much lower average times for 99211-99215, such as the time differential between 99214 (25 minutes) and 99244 (60 minutes). Therefore, established patient code selection for an established patient consultation must be based on the complexity of the level of service documented and provided to the patient.

How to Select the Correct Code for Initial Hospital Care Codes (99221-99223) By Level of Complexity

Caution: There is no direct correspondence between the 3 levels of initial hospital care and the 5 levels of inpatient consultation codes. If you formerly billed a level 1 or 2 inpatient consultation code, you will not be able to bill a level 1 or 2 initial inpatient hospital care code because the work that qualified for a level 1 or 2 inpatient consult is less than that set for a level 1 or 2 inpatient hospital care code. Thus, to report a 99221 or 99222, the documented level of complexity for the key components must meet the higher criteria for history, physical and medical decision making set for them.

A simpler way to select a code is to note that the key components for initial hospital care codes 99221, 99222 and 99223 are almost identical with those for consultation codes 99253, 99254, and 99255. The only distinction is as follows: Code 99221 requires *either* a detailed or comprehensive history and physical exam with *either* straightforward or low complexity medical decision making. Compare to code 99253 which requires a detailed history and physical exam and low complexity medical decision making.

Tips to Avoid Medicare Claim Denials

- Remember to submit the attending’s initial hospital care code (admit H&P) with modifier “AI” (“Principal Physician of Record”). The primary purpose of this modifier is to identify the principal physician of record on the initial hospital visit codes. It allows Medicare’s payment system to process payment for these services. It avoids denial of this claim and all other physicians’ claims (e.g., consulting physicians) for the same and subsequent days, assuming all other claim processing requirements have been met.
- For the consulting physician, no special Medicare modifier is necessary in reporting inpatient hospital consultations under the (new 2018) coding requirements. However, claims for the consulting physician will not be paid unless the attending’s claim for initial hospital care includes modifier “AI” and is in Medicare’s claim system prior to receipt of the consultant’s claim.
- **CMS has published “crosswalks”** between consultation codes and the office and initial inpatient hospital codes for budgetary purposes only. **Do not use these crosswalks to select the code for your services because some of the crosswalked codes are not equivalent in complexity of the key components required for their levels of service. Some large commercial publishers have recommended doing so;**

however, it is highly likely an audit liability will be incurred if that advice is followed.

Effective January 1, 2010, CPT consultation codes were no longer recognized for Medicare Part B payment. As explained in CR 6740, Transmittal 1875, Revisions to Consultation Services Payment Policy, issued on December 14, 2009, physicians shall code patient evaluation and management visits with E/M codes that represent where the visit occurs and that identify the complexity of the visit performed. CMS instructed providers billing under the PFS to use other applicable E/M codes to report the services that could be described by CPT consultation codes. CMS also provided that, in the inpatient hospital setting, physicians (and qualified non-physicians where permitted) who perform an initial E/M service may bill the initial hospital care codes (99221 – 99223).

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R147BP.pdf>

Admit H&P Only (99221–99223)

Admission

- Often used for transfers from another hospital, the appropriate admit code may be reported as provided.

Admit H&P with Surgical Procedure, Same Date

- With a minor surgical procedure on the same date, add modifier 25 (Separate, significant E/M service) to the E/M code when both services are provided by the same burn surgeon.
- With major surgical procedure provided by the same burn surgeon on the same date **and** when the decision for surgery occurred on the day before or day of surgery, add modifier 57 (Decision for surgery) to the E/M code to indicate that fact.

When the decision for surgery occurs prior to the day before surgery, do not add modifier 57 to the E/M code. Some payers, including Medicare, do not allow payment for an E/M service under these circumstances.

READMISSIONS

- For readmissions e.g. patient with previous burns, returning for grafting), report the admission code that reflects the service provided. Some payers, including Medicare, may not allow the readmission charge if it falls within the global surgery period assigned to an earlier surgical procedure and the readmission diagnosis indicates it is related to the previous surgery. Medicare may allow the charge for readmission if either of the foregoing conditions does not apply. For an unrelated readmission during the postoperative period of a previous surgery, modifier 24 (Unrelated E/M service) may be added to the admit code to indicate that fact.

Medicare: Modifier Required for Attending / Admitting Physician

The attending/admitting physician must submit the initial hospital care code with modifier “AI” (“Principal Physician of Record”) for Medicare claims. This modifier allows Medicare payment for the attending and all other physicians who may be providing consultative or specialty services on the same day or subsequent days during the same inpatient stay.

Without the modifier, claims from all physicians rendering inpatient hospital care services will be denied.

Documentation Optimizes Inpatient Burn Coding

Admission documentation is important for appropriate inpatient hospital burn code assignment, particularly when a patient is readmitted for non-take of graft. Include history of previous burns and relevant surgical procedures or other therapy in the admission note, as coders often do not have the old record for reference when coding.

Critical Care Code Categories

The CPT book provides 3 categories of critical care codes based on patient age. Burn surgeons should report the applicable critical care code when providing that service.

Each is explained in separate sections that follow.

Critical Care (Hourly) 99291–99292

Patients 6 years of age or older

Inpatient Pediatric Critical Care

99471–99472

29 days through 24 months of age

99475–99476

2 through 5 years of age

Inpatient Neonatal Critical Care 99468–99469

28 days of age or less

KEY POINT

Use 99291-99292 hourly critical care codes for inpatients 6 years of age or older.

Use 99291-99292 for critical care provided in the ED to patients of any age.

Critical Care, Hourly (99291–99292)

Because critical care services are of high importance to burn surgeons and because coding and reporting those services can be complex, the following detailed information is provided for complete reference.

Definitions

CPT defines *critical care* as direct physician medical care of a “critically ill or critically injured” patient. Such an illness or injury “. . . acutely impairs one or more vital organ systems such that there is high probability of imminent or life threatening deterioration in the patient’s condition.”

Content of Care

- High complexity medical decision making in imminent or actual life-threatening situations
- Evaluation, management and preservation of vital system functions in failure of one or more vital organ systems and/or prevention of additional life-threatening deterioration of the patient’s condition
- Possible interpretation of multiple physiologic values and/or application of advanced technology

Conditions for Reporting

- a. Both the illness/injury **and** the treatment must meet CPT stated definitions and content of care.
- b. Patient is critically ill or critically injured, is an inpatient, and is 6 years of age or older. *Exception: When critical care is provided in the ED, codes 99291-99292 may be reported for patients of any age.*
- c. Care is delivered directly by the physician
- d. High complexity medical decision-making is involved to “evaluate, manage, and support vital system function(s) to treat single or multiple vital organ system failure and/or to

prevent further life-threatening deterioration of the patient’s condition”³

- e. **Physician spends a total of 30 minutes or more on a given day providing critical care services to the patient**
- f. **Time spent and work directly related to the patient’s care is documented in the medical record by the physician.**

Time recording can be incremental (*e.g.*, 1100–1145 or 45 minutes followed by clinical note), contemporaneous (*e.g.*, 1100 followed by clinical note and 1145 at the end of the note), or totaled for the day (*e.g.*, 5/3/01 1.25h followed by clinical note detailing care provided that day).

- g. CPT and/or payer reporting guidelines are followed. See specifics under each topic below, including Medicare critical care guidelines.

What Can Be Reported

- a. Critical care services
- b. Separately reportable procedures

Place of Service

Any location qualifies. *For example:* emergency department, ICU, burn unit, CCU, respiratory care unit, or on the ward.

KEY POINTS

Do not bill any of the bundled procedures when billing critical care services. Time for bundled procedures can be counted toward total critical care time.

Note: Services for patients in a critical care unit who are not critically ill or injured are reported using the appropriate E/M code (*e.g.*, subsequent hospital visit 99231–99233, hospital consultation codes 99251–99263).

Bundled Procedures

Bundled procedures are not separately reportable in addition to critical care codes billed on the same date. Document each in the medical record, *remembering that the time spent in performing those procedures counts toward billable time for critical care.*

1. Interpretation of
 - cardiac output measurements (93561, 93562)
 - chest x-rays (71045, 71046)
 - pulse oximetry (94760, 94761, 94762)
 - blood gases
 - information data stored in computers (ECGs, blood pressures, hematologic data (99090))
2. Gastric intubation (43752, 43753)

³ American Medical Association. Current Procedural Terminology, CPT 2001. Chicago: American Medical Association, 2000.

3. Temporary transcutaneous pacing (92953)
4. Ventilation management (94002-94004, 94660, 94662)
5. Vascular access procedures (36000, 36410, 36415, 36591, 36600)

Separately Reportable Procedures

All other surgical or medical procedures performed and documented by the burn surgeon may be reported. **Time spent performing each of these procedures does not count toward billable critical care time.** However, each procedure itself is separately reportable in addition to the critical care codes billed on same date:

Examples—surgical procedures: debridement, insertion central venous catheter (36555 et seq.), insert arterial line (36620, 36625), insert needle for intraosseous infusion (36680), chest tube insertion, tracheostomy, bronchoscopy, escharotomy, and fasciotomy.

Examples—medical procedures: cardiopulmonary resuscitation, Swan-Ganz insertion.

Medicare Exception: When a surgical procedure is performed *at the bedside* during the global surgery postoperative period of a previous surgical procedure and it is performed to treat a problem or complication **related to** that previous global surgery, Medicare bundles it into the previous surgery and does not reimburse separately for it. When, however, the same procedure is performed in the operating or procedure room, it is billable with modifier 78.

Reporting Critical Care Time

Care may be provided at the bedside or elsewhere on the patient's floor or unit. The physician must devote full attention to the burn patient; services cannot be provided to other patients during the same time period. Full attention could include patient care, review of laboratory results, consultations, multidisciplinary conference, chart review, x-ray evaluation and similar patient-specific work.

Critical care time is reported using one or two codes:

99291 Critical care, evaluation and management of the critically ill or critically injured patient; first 30–74 minutes

99292 each additional 30 minutes (List separately in addition to code for primary service)

- 99291, first 30–74 minutes, is reported only once per day.

KEY POINT

Document separately reportable procedures in a separate paragraph. May be interspersed among critical care progress notes.

- 99292 is reported for each additional 30 minutes after the first 74 minutes. Enter the number of additional 30-minute increments in the unit’s field of the claim.
- 99292 can also be used to report the final 15-30 minutes of critical care time on a given day. Critical care time of less than 15 minutes after the final 30 minutes is not reportable.

Number of minutes/hours may be additive each day. For example, if a physician spent one hundred minutes intermittently throughout the day, the billing should be for a total of one hundred minutes. Code 99291 would be reported for the first 74 minutes, and 99292 for the final 26 minutes.

- Codes are reported based on total amount of time spent providing critical care on a given date.
- **Time need not be continuous on a given date.**
- Counting of critical care service time starts over again each day.
- **Less than 30 minutes of critical care on a given date is not reported.** The appropriate E/M service may be reported instead (*e.g.*, 99232, subsequent hospital visit) only when it does not fall within the global surgery postoperative period.
- Time spent for
 - “included” procedures **count** toward billable critical care time
 - separately reportable procedures or services **do not count toward** critical care time
 - conference with family members/surrogate decision makers a) when the patient is unable or clinically incompetent to participate in discussions *and* b) to obtain history, review prognosis or condition, discuss treatment or limits of treatment **can be counted as part of critical care time as long as discussion bears directly on management of the patient and it is documented.**

Critical care can be reported on multiple days, even when no changes are made in the treatment, as long as the patient continues to require the level of physician care specified in CPT as critical care.

Documenting Critical Care Services

Progress notes must include the following to support the claim for the burn surgeon's care. This documentation should clearly identify that the service rendered fulfills the definition of critical care:

- Time spent with the individual burn patient in providing that patient's care.
- Each "included" procedure performed by the physician (e.g., gastric intubation).
- Work directly related to the individual burn patient's care. (May be at bedside or on floor or unit.)

Examples of floor or unit activities:

- Reviewing test results or imaging studies
- Discussing the critically ill patient's care with other medical staff
- Documenting critical care services in the medical record
- **Time spent with family members or surrogate decision makers a) when the patient is unable or clinically incompetent to participate in discussions and b) to obtain medical history, review patient prognosis or condition, or discussing treatment or limitations of treatment as long as the discussion bears directly on the management of the patient and is documented.**

When counted toward critical care time, floor/unit activities must be recorded in the progress note(s).

Note: See Clinical Example at the end of this section.

Documenting Separately Reportable Procedures

Dictate or record a procedure note for each separately reportable procedure performed.

Critical Care add in

Critical care services provided during a global period for a seriously burned patient are not considered to be related to the surgical procedure and may be reimbursed separately under the following conditions:

1. **Preoperative** care may be reimbursed in addition to the surgical fee if the patient is critically ill and requires constant attention of the physician and the critical care is unrelated to the specific anatomic injury or general burn surgical

KEY POINT

Pre and postoperative critical care can be billed in addition to the global surgery using modifier 25 for preoperative critical care and modifier 24 for postoperative critical care.

procedure performed. Such patients are considered to be potentially unstable or to have conditions that pose a significant threat to life or risk of prolonged impairment. For critical care in the preoperative phase, two reporting requirements must be met: codes 99291/99292 and modifier 25 (Significant, separately identifiable E/M) must be used. The modifier identifies significant, separately identifiable evaluation and management services by the same physician on the day of the operation. For these patients, documentation with ICD-10 codes from the Burn by Anatomic site ICD-10 codes will indicate that the critical care was unrelated to the operation and should be accompanied by acceptable documentation. A progress note identifying the critical care service provided is mandatory.

2. **Postoperative** critical care is eligible for reimbursement under similar circumstances. Modifier 24 should be added to codes 99291/99292.
3. When critical care is provided on the same day as a second or subsequent surgical procedure performed during the global period of a previous procedure, your Medicare carrier may require that you add *both* modifiers 25 for preoperative and 24 for postoperative critical care to the critical care code to bypass Medicare edits.

Medicare Guidelines for Billing Pre and Postoperative Critical Care for Burns

Postoperative or preoperative critical care services for the burn patient may be reported when the criteria for critical care are met and treatment is for the underlying condition(s) or unrelated postoperative complication(s).

Medicare global surgery rules do not allow surgeons to bill for critical care or other evaluation and management services during the postoperative period of a previous global surgery when the service is required to treat problems related to that surgery.

Note: The preoperative portion of the Medicare global period includes the day before and the day of major surgical procedures assigned a 90-day postoperative global period.

Excerpt Medicare Internet-only Claims Processing Manual (CMS Pub. 100-4, Chapter 12, §30.6.12, L)

[Underline and boldface emphasis added.]

L. Critical Care Services Provided During Preoperative Portion and Postoperative Portion of Global Period of Procedure with 90 Day Global Period in Trauma and Burn Cases

Preoperative

Preoperative critical care may be paid in addition to a global fee if the patient is critically ill and requires the full attention of the physician, **and** the critical care is unrelated to the specific anatomic injury or general surgical procedure performed. Such patients may meet the definition of being critically ill and criteria for conditions where there is a high probability of imminent or life threatening deterioration in the patient's condition.

Preoperatively, in order for these services to be paid, two reporting requirements must be met. Codes 99291 - 99292 **and** modifier -25 (significant, separately identifiable evaluation and management services by the same physician on the day of the procedure) must be used, and documentation identifying that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed shall be submitted. An ICD-10-CM code which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

Postoperative

Postoperatively, in order for critical care services to be paid, two reporting requirements must be met. Codes 99291 - 99292 and modifier -24 (unrelated evaluation and management service by the same physician during a postoperative period) must be used, **and** documentation that the critical care was unrelated to the specific anatomic injury or general surgical procedure performed must be submitted. An ICD-10-CM code which clearly indicates that the critical care was unrelated to the surgery, is acceptable documentation.

Medicare policy allows separate payment to the surgeon for postoperative critical care services during the surgical global period when the patient has suffered trauma or burns. When the surgeon provides critical care services during the global period, for reasons unrelated to the surgery, these are separately payable as well.

[EDITORIAL NOTE: When critical care is provided on the same day as a second or subsequent surgical procedure performed during the global period of a previous procedure, add *both* modifiers 24 and 25 to the critical care code to bypass Medicare edits. The edits for each of these modifiers is *separate*. One edit for the critical care code takes into account the postoperative period of the earlier procedure and the other edit takes into account the preoperative global period of the procedure to be performed that day.]

Special Situations

Critical Care Provided but Time Not Documented

- Critical care codes cannot be billed.

- Procedures (*e.g.*, surgical) that are documented may be reported.
- If documentation meets criteria for an E/M service (*e.g.*, subsequent hospital visits 99231–99233), it may be reported unless it falls within the postoperative period of a previous global surgery.

Teaching Physician Presence

- The teaching physician must be present for the period of time for which the claim is made for critical care services.
- The teaching physician must personally document his/her presence and participation in the services in the medical record.

Diagnoses

- Sequence first the highest degree of burn.
- TBSA & 3RD degree burns
- Complications

Clinical Example:

CRITICAL CARE PROGRESS NOTE

Mr. Williams is currently post burn day #47 following 47% total body surface area full thickness burns. He was taken to the operating room today for excision and grafting of his anterior torso, right shoulder and unhealed wounds of his right upper extremity.

In the past 24 hours his maximum temperature has been 102.4°. His vital signs have been otherwise stable. Postoperatively, due to difficulty with oxygenation and ventilation he remains intubated and is currently on 50% FIO₂, with SIMV of 8 and pressure support of 15 over a PEEP of 5. On these settings, he is maintaining adequate oxygenation and ventilation and we will begin to wean his ventilatory rate tonight with the hope of being able to extubate him within the next 24 to 48 hours. He is tolerating his enteral feedings at their goal rate of 165 cc per hour of full-strength tube feedings, which is resulting in positive nitrogen balance. His total fluids are running at approximately 50 cc an hour above his calculated maintenance rate as his BUN had increased somewhat to 34 over the past few days and his urine output had been somewhat marginal. He has had an excellent response to increasing his fluids as well as intraoperative blood administration and administration of Pitkin intraoperatively for the purpose of harvesting his skin graft donor sites. He remains on a morphine infusion for pain control as well as renal dose dopamine.

Laboratory evaluation today prior to operation revealed his electrolytes to be within normal limits with BUN as stated above. His hematocrit was 28.6% preoperatively and is 30% postoperatively having received three units of blood intraoperatively. He remains on antibiotics and is in his eighth day of therapy and

we anticipate continuing him on this course until we have been able to assess graft take on postoperative day two. His wounds are being irrigated with Sulfamylon® solution per protocol every two hours and we plan to evaluate his wounds with postoperative day two dressing change per protocol. He continues to be evaluated by rehabilitation for range of motion of his left upper extremity as well as his lower extremities. His right arm remains at 90° abduction and rehabilitation of his right upper extremity is on hold per protocol.

Overall he remains stable and our goal is to maintain pulmonary toilet, wean his ventilator as tolerated and continue with nutritional and antibiotic support.

TOTAL TIME SPENT WITH PATIENT: Total time spent with the patient today providing critical care and discussing the treatment plan with the members of the multidisciplinary burn team, exclusive of pre, intra and postoperative time, was 40 minutes.

Coding Summary—Hourly Critical Care

Critical Care Emergency Department Services

Either critical care codes (99291, 99292) or the appropriate ED code (*e.g.*, 99284, 99285) can be reported. One or the other, but not both, may be reported. Codes can be used for patients of any age.

Critical care codes:

- Report 99291 for first 30–74 minutes of documented critical care; 99292 for each additional 30 minutes of critical care.
- Report procedures excluded from (not bundled into) critical care codes separately and in addition.
- Medicare

Add modifier 25 to critical care code(s) when minor or major procedures excluded from critical care codes are performed at the same encounter or on same day. The modifier allows the claim to bypass Medicare re-bundling edits for critical care and same-day surgery.

Critical Care in ED and Inpatient Admission

CPT guidelines indicate that all E/M services (including ED) “provided in conjunction with the inpatient admission are considered part of the initial hospital care when performed on the same date as the admission.”

Two situations involving these E/M services may occur. Each is explained in the following.

1. Critical Care in ED followed by Initial Inpatient care (E/M & dictation of the admission note), but on different days
2. Critical Care in ED followed by Inpatient Admission on the same day when the patient no longer requires constant attendance involved in critical care.

Regarding example 1: Medicare and other payers allow reporting of both services.

Regarding Example 2: At this time, there are no specific Medicare guidelines for this situation. Following CPT guidelines, the higher intensity service (critical care) would have to be included in the initial inpatient care service (admission), which would be the only billable service. Medicare and other payers may allow billing for the critical care service only; or, for both services. It is important to check with the relevant payer when this situation arises to determine the appropriate guideline for reporting them. (If a payer allows *both* services to be reported, append the -25 modifier to

both codes when submitting them, in the absence of payer instructions to the contrary.)

In either case:

- *Separate* documentation is required for each service.
- Report procedures excluded from (not bundled into) critical care codes separately and in addition.

Critical Care in Unit

Report according to guidelines listed in the Critical Care section, above.

Critical Care, Inpatient Pediatric (99471–99476)

Code Ranges by Patient Age

99471-99472: 29 days through 24 months of age

99475-99476: 2 through 5 years of age

Definitions and Content of Care

Definitions of critical care and the content of care are the same as those for hourly critical care.

Conditions for Reporting

- a. Both the illness/injury and the treatment must meet CPT stated definitions and content of care.
- b. Patient is 29 days through 5 years of age.
- c. Patient is critically ill or critically injured
- d. Care is delivered directly by the physician
- e. High complexity medical decision-making is involved to “evaluate, manage, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient’s condition.”

What Can Be Reported

- a. Inpatient pediatric critical care service
- b. Separately reportable procedures

Bundled Procedures

Certain procedures are included into codes 99471-99476 and are not separately reportable in addition to a pediatric critical care

KEY POINTS

Pediatric critical care codes are used for inpatient patients in 2 age ranges: 29 days through 24 months of age; or 2 through 5 years of age.

Codes are for per day services. Only one code per day may be reported.

Codes are not time-based.

medical record. The bundled procedures are:

1. Interpretation of
 - cardiac output measurements (93562)
 - chest x-rays (71045, 71046)
 - pulse oximetry (94760, 94761, 94762)
 - blood gases
 - information stored in computers (ECGs, blood pressures, hematologic data (99090))
2. Gastric intubation (43752, 43753)
3. Temporary transcutaneous pacing (92953)
4. Ventilation management (94002-94004, 94660, 94662)
5. Vascular access and central line procedures (36000, 36140, 36400, 36405, 36406, 36420, 36510, 36555, 36591, 36420, 36600, 36601, 36620)
6. Umbilical venous (36510) and arterial (36660) catheterization
7. Other arterial catheters (36140, 36620)
8. Suprapubic bladder aspiration (51000)
9. Bladder catheterization (51701, 51702)
10. Endotracheal intubation (31500)
11. CPAP (94660)
12. Bedside pulmonary function testing (94375)

13. Ventilatory management (94002-94004)
14. Surfactant administration (94610)
15. Blood transfusion (36430, 36440)
16. Lumbar puncture (62270)
17. Interpretation of blood gases and oxygen saturation (99090)
18. Invasive or non-invasive monitoring of vital signs (99090)

Separately Reportable Procedures

All other surgical or medical procedures performed *and documented* by the burn surgeon may be reported. Each procedure may be reported *in addition to* the critical care codes billed on the same date:

Examples—surgical procedures: debridement, insert needle for intraosseous infusion (36680), chest tube insertion, tracheostomy, bronchoscopy, escharotomy, and fasciotomy

Examples—medical procedures: cardiopulmonary resuscitation, elective cardioversion, and Swan-Ganz insertion.

Medicare Exception: When a surgical procedure is performed *at the bedside* during the global surgery postoperative period of a previous surgical procedure and it is performed to treat a problem or complication related to that previous global surgery, Medicare bundles it into the previous surgery and does not reimburse separately for it. When, however, the same procedure is performed in the operating room, it is billable with modifier 78.

Reporting Inpatient Pediatric Critical Care

- Use these codes for critically ill or critically injured pediatric patients who are 29 days through 5 years of age.
- These are **per day** codes. They are not based on time as are the hourly critical care codes. Only 1 code per day, per patient may be reported. Select the appropriate code based on patient age.
 - 99471** Initial inpatient pediatric critical care, per day (admission), 29 days through 24 months of age
 - 99472** Subsequent inpatient pediatric critical care, per day, 29 days through 24 months of age
 - 99475** Initial inpatient pediatric critical care, per day (admission), 2 through 5 years of age
 - 99476** Subsequent inpatient pediatric critical care, per day, 2 through 5 years of age
- When the same physician provides both inpatient and outpatient critical care to the pediatric patient on the same day, report only the appropriate inpatient pediatric critical care code.

Critical Care, Inpatient Neonatal (99468–99469)

Definitions and Content of Care

Definitions of critical care and the content of care are the same as those for hourly critical care.

Conditions for Reporting

- a. Both the illness/injury **and** the treatment must meet CPT stated definitions and content of care.

KEY POINTS

Neonatal critical care codes are used for patients 28 days of age or less.

If patient reaches 29 days of age and still qualifies for critical care, switch to pediatric critical care code 99472. Subsequent Inpatient Pediatric Critical Care.

Codes are for per day services. Only one code per day may be reported and only by a single physician.

Codes are not time-based.

- b. Patient is 28 days of age or less.
- c. Patient is critically ill or critically injured
- d. Care is delivered directly by the physician
- e. High complexity medical decision-making is involved to “evaluate, manage, and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient’s condition.”

What Can Be Reported

- a. Inpatient neonatal critical care service
- b. Separately reportable procedures

Bundled Procedures

Certain procedures are included in codes 99295-99296 and are not separately reportable in addition to neonatal critical care codes billed on the same date. Document each in the medical record.

- 4. Interpretation of
 - cardiac output measurements (93562)
 - chest x-rays (71045, 71046)
 - pulse oximetry (94760, 94761, 94762)
 - blood gases
 - information stored in computers (ECGs, blood pressures, hematologic data (99090))
- 5. Gastric intubation (43752, 43753)
- 6. Temporary transcutaneous pacing (92953)
- 4. Ventilation management (94002-94004, 94660, 94662)
- 11. Vascular access and central line procedures (36000, 36140, 36400, 36405, 36406, 36420, 36510, 36555, 36591, 36420, 36600, 36601, 36620)
- 12. Umbilical venous (36510) and arterial (36660) catheterization
- 13. Other arterial catheters (36140, 36620)
- 14. Suprapubic bladder aspiration (51000)
- 15. Bladder catheterization (51701, 51702)
- 16. Endotracheal intubation (31500)
- 11. CPAP (94660)
- 19. Bedside pulmonary function testing (94375)

- 20. Ventilatory management (94002-94004)
- 21. Surfactant administration (94610)
- 22. Blood transfusion (36430, 36440)
- 23. Lumbar puncture (62270)
- 24. Interpretation of blood gases and oxygen saturation (99090)
- 25. Invasive or non-invasive monitoring of vital signs (99090)

Separately Reportable Procedures

All other surgical or medical procedures performed *and documented* by the burn surgeon may be reported. Each procedure itself is separately reportable *in addition to* the neonatal critical care codes billed on the same date:

Examples—surgical procedures: debridement, insert needle for intraosseous infusion (36680), chest tube insertion (32551), tracheostomy (31600), bronchoscopy, escharotomy, and fasciotomy.

Examples—medical procedures: cardiopulmonary resuscitation, elective cardioversion, and Swan-Ganz insertion.

Medicare Exception: When a surgical procedure is performed *at the bedside* during the global surgery postoperative period of a previous surgical procedure and it is performed to treat a problem or complication related to that previous global surgery, Medicare bundles it into the previous surgery and does not reimburse separately for it. When, however, the same procedure is performed in the operating room, it is billable with modifier 78.

Reporting Inpatient Neonatal Critical Care

- Use these codes for critically ill or critically injured patients whose age is 28 days of age or less.
- These are **per day** codes. They are not based on time, as are the hourly critical care codes. Only 1 code per day, per patient may be reported.
 - 99468** Initial neonatal critical care, per day (admission)
 - 99469** Subsequent neonatal critical care, per day
- When the neonate reaches 29 days of age and continues to qualify for critical care, use subsequent **Inpatient Pediatric** critical care codes as long as the patient qualifies for critical care services through 24 months of age.
- When the same physician provides both inpatient and outpatient critical care to the neonate on the same day, report only the appropriate inpatient neonatal critical care code.

- When the neonate is no longer critically ill, use subsequent hospital visit codes if current body weight is more than 2500 grams and the visits are not within the global period of a previous surgery. If the neonate’s current weight is 2500 grams **or less**, use Initial and Continuing Intensive Care Services codes 99477-99480, as appropriate.

Inpatient Daily Visits (99231–99233)

Preoperative Medical Visits

Unrelated medical visits before surgery may be reported separately. For example, inpatient visits for care provided for the underlying condition(s) and/or to stabilize the patient in advance of surgery.

Example: A burn patient admitted with an extensive body surface area burn accompanied by an inhalation burn and treated with fluid resuscitation and pulmonary care.

When the visit is provided on the same day as a minor surgical procedure, add modifier 25 (Significant, separately identifiable E/M on the same day of the procedure) to the E/M code, as appropriate.

Postoperative

Routine postoperative inpatient visits are included in the global surgery package for procedures assigned a postoperative follow-up period, *e.g.*, 90 days. Postoperative visits on the day of the procedure are included in procedures assigned “0” follow-up days.

Postoperative inpatient visits provided by the performing surgeon **for an unrelated problem** (problem unrelated to the previous global surgery) during the postoperative period of a previous global surgery may be separately reportable and payable, depending on payer guidelines. Add modifier -24 (Unrelated E/M service by the same physician during postoperative period) to the appropriate E/M code. Refer to Appendix IV for complete modifier guidelines.

Multidisciplinary Rounds (99367–99368)

Specific guidelines apply when using these codes. See below.

99366 Medical team conference with interdisciplinary team of health care professional, face- to- face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional

KEY POINT

Unrelated medical visits in advance of the initial global surgery are not included in the global surgical package.

- 99367** Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more, participation by physician
- 99368** participation by non-physician qualified health care professional

The attending burn surgeon may conduct multidisciplinary rounds daily. Clinical areas that may be represented are:

- Physical therapy
- Occupational therapy
- Respiratory therapy
- Nutrition
- Social services
- Psychology
- Nursing

Reporting Guidelines

- Medical team conferences **include face-to-face, in person, participation by a minimum of three qualified health care professionals** from different specialties or disciplines (each of whom provide direct care to the patient) with or without the presence of the patient, family members, or others as listed in CPT. The health care professionals meet as a group face-to-face; telephone conferencing does not qualify.
- Health care professionals who report these services must have performed face-to-face evaluations or treatments of the patient within the last 60 days.
- Codes are segmented as follows
 1. Team conference **with** direct face-to-face contact with patient and/or family (code 99366). Note that only a single code is available for non-physician services.
 2. Team conference **without** direct face-to-face contact with patient and/or family (codes 99367-99368). Note there are two codes available: 99367 for physician services and 99368 for non-physician services.
- Only one code, 99366, is provided for face-to-face team conferences for non-physician services **because physicians can report their time spent in a team conference with the patient and/or family using E/M codes (and time as**

the key factor when counseling and/or coordination of care predominates).

- **Code 99366 is used to report the services of a non-physician** qualified health care professional providing these services. The team conference services are provided face-to-face with the patient and/or family and the rest of the team.
- Codes 99367 and 99368 are used to report team conferences without face-to-face contact with the patient and/or family. Code 99367 is used to report physician team conference services and code 99368 is used to report non-physician team conference services. The group of health care professionals meets face-to-face in these conferences.
- Documentation must support all services reported.
- No more than one individual from the same specialty may report 99366-99368 at the same encounter.
- Team conferences of less than 30 minutes are not reportable.
- Physician services involved in participating in routine postoperative multidisciplinary rounds—rounds involving postoperative care related to the surgical procedure(s) performed—are included in the global surgical package.
- When the multidisciplinary rounds are unrelated to the postoperative care related to the surgical procedures performed, they are not included in the services that are part of the global surgical package as defined by CPT or Medicare.
- AMA provides limited guidance for the use of these codes, simply indicating that “these are “medical” (i.e., non-surgical) team conferences for established patients “who present with chronic and multiple health conditions or with congenital anomalies.” The AMA also states “The interdisciplinary team conference ... is far more comprehensive and complex than the conversations that may occur between physicians and/or other qualified health care professionals encompassed in other E/M or **global code** services.”
- See additional, detailed guidelines in the current volume of CPT.

KEY POINTS

Medicare does not allow payment for codes 99366-99368.

Routine postoperative multidisciplinary rounds (patient not critical) are included in the global surgery package.

Clinical Example: BURN CRITICAL CARE MULTIDISCIPLINARY CONFERENCE

Patient is a 27 y.o. female who sustained 42% total body surface area burns with 22% full thickness burns on September 10. She is now post-burn day 34 and postoperative day number 9 from grafting to her upper extremities and bilateral flank areas and thighs. She has good graft take. Approximately 8% of her burns are not covered.

Respiratory: She remains on minimal settings. We changed her to a tracheostomy collar since she will have one more major surgery probably the end of next week.

Nutrition: She is in positive nitrogen balance at 9 grams and we will leave her there. She has had some diarrhea, thus we will decrease Reglan, mineral oil, and Colace.

Physical Therapy: She has increased tone over her extremities, thus has decreased range of motion of her right ankle. This is true of her upper extremity as well.

Occupational Therapy: She has only 90% range of motion in her shoulder and once again has increased tone, presumably from neurological problems.

Neurological: She does respond to pain; however, does not respond to questions and appears to be waking up from cerebral hypoxia.

Overall, patient is reasonably stable and will continue with the same modality with probable surgery at the end of next week. We will D/C her IVs.

Total time: 15 minutes

Signature: L. Smith, MD

Coding: The time for this conference cannot be added to other documented critical care time or any other E/M service on the same day, October 14.

Discharge Day Management (99238–99239)

CPT Definition

99238 Hospital discharge day management; 30 minutes or less

99239 more than 30 minutes

Codes are used to report the total amount of time spent for final hospital discharge *on the day of discharge only*. Codes include, when appropriate, final exam, discussion of hospital stay, instructions for aftercare, and preparation of the discharge summary.

Time spent need not be continuous on that day.

KEY POINTS

Discharge may be billed for non-surgical, medical admission of a burn patient or when no global surgery period is in place on date of discharge.

Document total time for discharge day management and select code on basis of time.

Discharge day management may be reported when discharge occurs in an admission where a) no global surgery has been performed, or b) after the global surgery period has ended. Otherwise, it is included in the global surgery package and is not separately reportable.

Document all components of the service and the total time spent in providing the service.

- Report either 99238 or 99239.
- If time is not documented, only 99238 may be reported.

Discharge Planning and Summary

Discharge planning is identified in the course of the discharge summary. It is critical that the discharge summary be completed within 48 hours and include as a minimum the following:

- Dates of admission and discharge
- Name of attending physician
- Name of referring physician
- Name of resident physician(s)
- Final diagnoses, including all conditions that affected treatment and length of stay
- Procedures performed during the hospital stay
- The reason for admission, including history and pertinent physical findings
- The hospital course, identifying significant complications and comorbidities and the patient's condition on discharge.
- Discharge instructions, including instructions on physical activity, medications, diet and follow-up care. See Exhibit B (Patient Dismissal).

Discharge Day Management in Postoperative Period

- This service is included in the global surgical package and not separately reportable.
- **Possible exceptions:** For burn patients, a few payers may provide exceptions to the global surgery rule. Because the discharge day management must often cover extensive discussion of many topics, including aftercare required for underlying problems, residual effects, and other rehabilitation over and above that attendant to the previous surgical procedure(s), these payers may allow separate reporting for the service. Check with your payers to determine their payment policies for this service

If such an exception is allowed, report the applicable code and modifier (if required) based on the total time spent. Document all components of the service and the total time spent in providing the service.

Office/Outpatient Hospital Clinic Visits (99201–99215, New or Established Patient)

The appropriate level of service may be reported as provided, subject to the following.

Office/Clinic Visit, Preoperative

- **CPT Surgical Package & Modifier Guidelines**

New patient—the appropriate code may be reported. Modifier 25 may need to be added to the E/M code when the E/M service and a minor procedure are provided at the same encounter, same date.

New patient—the appropriate code may be reported. If the decision for major surgery is made at the encounter, modifier 57 may need to be added to the E/M code.

Established patient—If the E/M service is significant, separately identifiable, modifier 25 may need to be added to the E/M code when the E/M service and a minor procedure are provided at the same encounter, same date.

Established patient—if the decision for major surgery is made at the encounter, modifier 57 may need to be added to the E/M code.

- **Medicare Global Surgery-Modifier Guidelines**

Minor procedure—Add modifier 25 to the E/M code when both are provided at the same encounter, same date. Report separately documented procedure in addition.

Major procedure—Add modifier 57 to the E/M code if the decision to perform surgery was made at the encounter *and* surgery is performed that same day or the day after. Office visit in advance of that time (*e.g.*, 1 week in advance of surgery) may be reported separately without modifier 57.

Office/Clinic Visit in Postoperative Period

- Routine postoperative visits are included in the global surgical package and not separately reportable.
- Visit for complication related to the previous surgery:

CPT Surgical Package—report the appropriate level of service

Medicare Global Surgery—included in the global surgery package

Visit for unrelated problem, i.e., a problem unrelated to the surgery or the postoperative care for the surgery:

CPT Surgical Package—report the appropriate level of service

Medicare Global Surgery—report the appropriate level of service and add modifier 24 (Unrelated E/M Service in Postoperative Period).

Despite the fact that this policy is explicitly stated in the CMS/Medicare Claims Processing Manual, some Carriers continue to deny unrelated E/M visits during the postoperative period. You may need to challenge such denials on appeal, demonstrating why the E/M service was unrelated to the postoperative care of the previous surgery. See detailed discussion under “Global Periods,” “Medicare Global Surgery Package,” presented earlier in the *Key Concepts* section.

99211 Nurse Visit

- 99211 is a minimal, established patient visit generally provided by nursing staff and does not require the presence of or face-to-face encounter with the physician. (Under these circumstances, 99211 *is not* billable as a professional service in institutions where nursing staff is employed by the hospital.) A physician must be present on the premises. Generally used for nurse assessment, suture removal or surgical wound dressing change following a minor surgical procedure with 0 follow up days, BP check, patient teaching, test results and so on. Nursing documentation is required.

Surgical Procedures: Surgery & Bedside

BASIC REPORTING CONCEPTS & DOCUMENTATION

Refer to the *Key Concepts* chapter at the beginning of Part I of this manual (Coding for Physician Services) for basic concepts regarding global surgery, medical necessity, and other related topics.

NOTE: All codes in the CPT Surgery section that include the phrases “with anesthesia,” “requiring anesthesia” or “under anesthesia” indicate that the work involved in performing the procedure requires anesthesia, whether it is general anesthesia, regional anesthesia, or monitored anesthesia care. Moderate (conscious) sedation is not an anesthesia service.

Operative Report Documentation

Used for clinical record keeping, the operative report also serves as a source document for code assignment. As well, payers use it to determine whether the billed codes are matched by the content of the report and for payment and coverage determinations.

Documentation Tips

Identification of Surgeon(s)

1. Identify the surgeon(s), whether primary, co-surgeons, or team surgeons.
2. Identify assistant surgeon and resident surgeon, if any.

Preoperative diagnosis

1. Illustrates medical necessity.
2. Identifies the reason(s) for the procedure(s).
3. Include the following
 - Burn degree of site(s)

KEY POINTS

Always dictate the date of the surgery. Surgery cannot be billed without date of service. Date is also crucial for modifiers that may be potentially necessary for services on the same date.

- % Body surface area burned
- % Body surface 3rd degree burns
- Cause
- Specify site(s) that are to be operated on at that encounter. (This identifies the *surgical* diagnosis.)

Example: 50% TBSA burns, 42% full thickness burns to hands, forearms, and arms, sustained when clothing ignited.

4. Mention late effects, if any, which relate to the surgical diagnosis.
5. If they relate to the treatment, mention “history of” conditions.
6. If the procedure is to be performed for a complication related to the previous surgery (e.g., hemorrhage or infection), list the condition as the preoperative diagnosis.

Procedure Performed Statement

This entry identifies *what was done* during the operation. Ideally, each procedure listed here **should include the concept or actual wording from the CPT code description of the procedure**. This CPT-oriented “list” promotes accurate, easier and more efficient code assignment.

1. **Always identify any staged procedures as such.** For Medicare purposes, this identification is crucial for reimbursement.
Note: Medical necessity and reimbursement for staged procedures can be established in the initial operative report by indicating that the initial procedure is the first in an anticipated series of staged operations.
2. For grafts, indicate the type (autograft, homograft, etc.), thickness (if applicable), whether meshed (if meshed, give ratio), recipient site and **total area of each recipient site**.
3. Include location of the donor site and repair or closure, if any.
4. Adjacent tissue transfer: specify type of “plasty” or flap and size of defect.
5. For **escharotomy**, indicate number of incisions and locations.

6. **Excision of burn wound:** indicate total area excised in square centimeters or, for children under age 10, total percent of body surface area excised.
7. **Amputation:** specify site, laterality, technique, whether initial or second amputation, and associated closure procedures.
8. **Debridement:** indicate anatomic location of each wound debrided. (See Burn Wound Debridement and Excision sections.)

Clinical Indications

This paragraph is optional but can be crucial in cases where medical necessity may be questioned. Composed of a few key sentences, this section explains the clinical reasons why the procedure(s) are medically necessary. Reiterate any staging information, state the goal of the procedure, illustrate extenuating circumstances, explain the need for co-surgeons (if any), and include any other key justifying information in this paragraph.

Procedure Narrative

Describe each step in each of the procedures performed, supporting those listed in the “procedure performed” statement.

This section of the report substantiates the codes billed on the claim. If a code is not supported by corresponding language in the procedure narrative, it is not payable.

For co-surgeons, mention the portions of work the co-surgeon performed and **note that he or she will dictate a separate report for that portion of the procedure.**

Increased difficulty or work, if any, should be explained in this section.

Avoid unexplained acronyms, buzzwords, and jargon. Define briefly all eponyms used.

Date of Dictation, Physician Signature

Always review and sign your operative notes, whether dictated by you or a resident.

CONSCIOUS SEDATION/MODERATE SEDATION

Definition of Moderate (Conscious) Sedation

As defined in CPT, “moderate (conscious) sedation is a drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.”

Moderate sedation does not include minimal sedation (anxiolysis), deep sedation or monitored anesthesia care (anesthesia codes 00100-01999)

Services Included in Conscious Sedation

The following services are included in conscious sedation and are not separately reportable. When provided, these services should be documented in the patient record.

- Assessment of the patient (not included in intraservice time*)
- Establishment of IV access and fluids to maintain patency
- Administration of agent(s)
- Maintenance of sedation
- Monitoring of oxygen saturation, heart rate and blood pressure
- Recovery (not included in intra-service time)

Reporting Guidelines

Conscious sedation codes are time-based. *Intra-service time is reported and is defined as time that begins with administration of agent(s), requires continuous face-to-face attendance, and ends at the conclusion of personal contact by the physician providing the sedation.

Do not report pulse oximetry codes in conjunction with conscious sedation codes.

Office-based Physicians

Certain CPT Codes Include Conscious Sedation

A number of CPT codes include conscious sedation when *provided* by the performing surgeon, i.e., provided by the surgeon who also performs a procedure listed in the Surgical, Radiological or Medicine section of CPT. Those codes can be identified in CPT by a target symbol to the left of the code. A complete list of codes that include conscious sedation, together with relevant guidelines, can be found in Appendix G of the CPT book.

- These guidelines typically apply to physicians in office practice who provide conscious sedation for certain procedures performed in the office setting.
- When one of the procedures listed in Appendix G or identified by a target symbol before the code number is performed without conscious sedation, it is not considered a “reduced” procedure and need not be reported with modifier 52 (Reduced services).
- When another physician (e.g., anesthesiologist) or a qualified anesthesia care provider (e.g., CRNA) provides anesthesia services in conjunction with conscious sedation (e.g., MAC/monitored anesthesia care), that provider may report his/her services using the applicable anesthesia code from the Anesthesia section of CPT, as appropriate.
- For all other procedures *not listed* in Appendix G, a conscious sedation service provided by the performing surgeon (i.e., provided at a monetary cost to the performing surgeon) may be reported using the appropriate conscious sedation code 99151-99157. CPT indicates that the use of codes 99151-99157 requires the presence of an independent trained observer to assist the physician in monitoring the patient’s level of consciousness and physiological status.

Hospital Services

- When office-based burn surgeons personally provide documented conscious sedation services, e.g., at the hospital bedside during dressing change or debridement performed by a hospital staff nurse, the conscious sedation service may be reported using the applicable conscious sedation code from 99151-99157, as appropriate.

- If the burn surgeon does not personally provide the conscious sedation service and limits his/her professional service to supervision of a hospital staff nurse performing a procedure (e.g., dressing or debridement), the conscious sedation service is not separately billable. Please refer to the topic “Physician Claims for Services Must Be Performed or Provided Directly by the Physician” in the chapter entitled “Fraud and Abuse” for additional details.

Hospital-based Physicians

- Burn surgeons who are hospital-based would not report conscious sedation services unless the service was personally rendered by the burn surgeon himself or herself.
- When burn surgeons personally provide documented conscious sedation services, e.g., at the hospital bedside during dressing change or debridement performed by a hospital staff nurse, the conscious sedation service may be reported using the applicable conscious sedation code from 99151–99157, as appropriate.
- If the burn surgeon does not personally provide the conscious sedation service and limits his/her professional service to supervision of a hospital staff nurse performing a procedure (e.g., dressing or debridement), the conscious sedation service is not separately billable. Please refer to the topic “Physician Claims for Services Must Be Performed or Provided Directly by the Physician” in the chapter entitled “Fraud and Abuse” for additional details.

PROCEDURAL SERVICES

Abdominal Decompression

Abdominal decompression may be required to treat Abdominal Compartment Syndrome (ACS), a condition characterized by increased intra-abdominal pressure caused by massive fluid accumulation in the abdomen and retroperitoneum. A decompression laparotomy is performed to treat this condition.

Reporting Guidelines

- For decompression laparotomy, report code 49000 (Exploratory laparotomy, exploratory celiotomy, with or without biopsy[s]).
- Documentation of planned second or subsequent stage: In the laparotomy operative note, document the fact that closure of the wound is anticipated or planned for a subsequent (possibly undetermined) date postoperatively and, if the wound is not able to be closed by conventional suturing at that time, mesh may have to be utilized for the incisional hernia defect.
- For **definitive closure**, days or weeks later, report code 49900 (Suture, secondary, of abdominal wall for evisceration or dehiscence). Add modifier 58 (Staged Procedure).
- For cases where **definitive closure is not possible**, the wound is unable to be closed, and mesh is inserted, the incisional hernia and mesh insertion codes may be reported. Add modifier 58 to each code.
 - 49560** Repair initial incisional hernia; reducible
 - 49568** Implantation of mesh or other prosthesis for incisional or ventral hernia repair (List separately in addition to code for incisional or ventral hernia repair)
- Two distinct diagnosis codes are available for abdominal compartment syndrome. The code is assigned based on whether the syndrome is caused by trauma (e.g., burns) or by non-traumatic conditions. The ICD-10 index references the following two entries.

KEY POINT

The diagnosis code for abdominal compartment syndrome depends on whether the *cause* is traumatic or non-traumatic. Traumatic abdominal compartment syndrome caused by burns is coded to T79.A3.

Syndrome, compartment, traumatic, abdomen:

T79.83 Traumatic compartment syndrome of abdomen

Syndrome, compartment, non-traumatic, abdomen:

M79.83 Non-traumatic compartment syndrome of abdomen

For the burn patient, abdominal compartment syndrome is coded to T79.83, Traumatic compartment syndrome of abdomen.

Amputation

Amputation is surgical removal of a part or all of an extremity or body part.

Reporting Guidelines

- Amputations are coded by
 - a) Specific site
 - b) Technique
 - c) Initial; secondary closure of stump; or re-amputation
- Code also any flap closures, skin grafts or associated procedures that are not already specified in the amputation code.
- Bilateral amputations (*e.g.*, both feet; bilateral below the knee amputations)

Add modifier 50 (Bilateral Procedure) to the appropriate code for Medicare and payers that require single-line reporting:

27889–50	Amputation, both feet	(number of required units varies by payer)
-----------------	-----------------------	--

For payers that require two-line reporting, designate as follows:

27889	Amputation, foot (left)	1 unit
--------------	-------------------------	--------

27889–50 Amputation, foot (right) 1 unit

- Unilateral amputations (*e.g.*, left foot)
Add modifier LT or RT (left or right) for Medicare and payers that can accept these modifiers. Otherwise, report the code only.

27889-LT Amputation, foot (left) 1 unit

- Finger or Toe Amputations
For Medicare, add the appropriate finger (FA-F9) or toe (TA-T9) modifier to the appropriate amputation code. See Appendix IV, HCPCS Modifiers, for details.

Arterial Line Insertion

An arterial line is a catheter that is placed in an artery for one or more purposes. Often inserted into the radial or brachial artery in the arm, an arterial line can be used to continuously monitor arterial blood pressure, allow access for withdrawal of blood specimens, and direct delivery of certain drugs.

The catheter may be inserted using either the percutaneous or cut down method. In the former method, the physician inserts the catheter through the skin and into the artery. A cut down method requires incision over the artery and exposure of the artery followed by catheter insertion.

Reporting Guidelines

- Report the appropriate arterial line insertion code based on type of access (*e.g.*, percutaneous or cut down).

36620 Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

36625 cut down

- Removal is included in the insertion procedure.

Medicare Guidelines

- Medicare assigns “0” postoperative follow-up days to these minor procedures.
- When an arterial line is inserted during the global period of a previous major surgery (*e.g.*, skin grafting), add modifier 79 (Unrelated Procedure During Postoperative Period) to the appropriate code for arterial line insertion to bypass Medicare edits and allow payment for the claim.

Biopsy of Skin

A skin biopsy involves excision or removal of a small area of skin or part or all of a lesion with the intent of submitting the specimen for pathological examination to establish or rule out a diagnosis. The intent of a biopsy differs from that for excision of a skin lesion in that excision of a lesion involves intentional removal of the lesion along with a margin of normal tissue around its periphery.

Burn surgeons may perform a skin biopsy for suspected infection or for other purposes (e.g., for calciphylaxis).

Reporting Guidelines

11100 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

11101 each separate/additional lesion (List separately in addition to code for primary procedure)

- Biopsy may be performed on skin, subcutaneous tissue and/or mucous membrane.
- Report code 11100 for the first lesion or biopsy performed at the operative intervention. If additional biopsies are obtained at the same operative session, report code 11101 for each additional biopsy obtained after the first.
- Code 11101 is an add-on code and can only be submitted when code 11100 also is submitted at the same time. Do not add modifier 51 (Multiple procedures) to code 11101 because it is a secondary procedure and its relative value is already reduced.
- Example: Three skin biopsies are obtained.

11100 Skin biopsy (1st biopsy) Units = 1

11101 Skin biopsy (2nd and 3rd biopsies) Units = 2

Bronchoscopy

A bronchoscopy is the examination of the bronchi of the lung with a bronchoscope. It may be accompanied by surgical procedures performed through the scope.

Diagnostic Bronchoscopy (31622)

- When performed alone, report as performed.

- When a surgical bronchoscopy (31623–31656) is performed at the same time, report only the surgical bronchoscopy. The diagnostic bronchoscopy is included in the surgical bronchoscopy and is not separately reportable.
- Repeat diagnostic bronchoscopies, performed at separate encounters on subsequent days, may be reported as performed.
- Fluoroscopic guidance and cell washing are included when performed and are not separately reportable.

Surgical Bronchoscopy (31623–31654)

- When a surgical bronchoscopy (31623–31654) immediately follows a diagnostic bronchoscopy at the same session, report only the surgical bronchoscopy. The diagnostic bronchoscopy is included in the surgical bronchoscopy and is not separately reportable.
- Multiple surgical bronchoscopies from the above code range may be reported separately, subject to CPT guidelines.
- For therapeutic bronchoscopic aspiration of tracheobronchial tree, use code 31645 for initial aspiration and 31646 for each subsequent aspiration after the first session. These codes *include* conscious sedation when provided by the performing surgeon.
- Fluoroscopic guidance is included when performed and is not separately reportable.

KEY POINTS

Central line insertion may be coded and billed when performed by a physician or non-physician practitioner licensed to do so. Insertion by auxiliary hospital nursing staff is not a billable professional service.

Removal of a non-tunneled central venous catheter is included in the insertion procedure.

Central Venous Access

This section is divided into these main topics:

Overview:

Definition and Uses

Procedure Descriptions-Central or Peripheral

Central Venous Access CPT Code Categories

Reporting Guidelines:

Insertion of Central Venous Access Catheter or Device

Complete Exchange/Replacement of Central Venous Access Catheter or Device, Same Access Site

Removal of Existing *Tunneled* Central Venous Access Device w/ Insertion of New Device, Different Access Site

Removal Non-Tunneled Central Venous Access Device

Repositioning Previously Placed Central Venous Catheter under Fluoroscopic Guidance

Imaging Guidance for Central Venous Access

Medicare Global Surgery Issues: Bedside Procedures and Central Venous Line Insertion

Overview: Definition and Uses

A central venous line is a special catheter that is inserted into a specific vein or location as defined by the CPT book. “To qualify as a central venous access catheter or device, the tip of the catheter/device must terminate in the subclavian, brachiocephalic (innominate) or iliac veins, the superior or inferior vena cava, or the right atrium.”⁴ The central venous access catheter or device may be either *centrally inserted* (placed directly into the jugular, subclavian, or femoral vein, or the inferior vena cava) or *peripherally inserted* (placed directly into a peripheral vein such as the basilic or cephalic vein of the arm).

The catheter can be used for measurement of central venous pressure, administration of nutritional or medicinal substances, hyperalimentation, hemodialysis or chemotherapy.

In burn patients, a central venous line may be inserted for

- central venous pressure measurement to monitor adequacy of fluid resuscitation and blood volume,
- total or supplemental parenteral nutrition,
- administration of IV fluids,
- hemodialysis, and/or
- access for aspiration of blood samples for diagnostic tests.

Procedure Description: Central Insertion Method

Typically inserted into a large vein in the neck or groin area, a central venous line can also be inserted into a vein in the arm. The external portion of a catheter may have one end or it may be split into multiple ends, each of which has a port or “hub” at the end(s). The desired medical intervention is performed through the end(s) of the catheter (e.g., an infusion setup is attached to the end of the catheter to deliver resuscitative fluids).

Fluoroscopic or ultrasound imaging may be used to locate and access the vein. In some cases, fluoroscopic guidance may be used throughout the procedure for catheter manipulation and final placement.

The insertion procedure is most frequently performed using the percutaneous method, in which the physician inserts a needle

⁴American Medical Association. CPT 2017

into the skin and then into the selected vein (*e.g.*, jugular, subclavian, or femoral vein). Once in the vein, a long, thin guidewire is passed through the needle to the desired location, the needle is removed over the guidewire and then the catheter is passed over the guidewire and advanced to its destination. An alternative method, cut down, is performed by making an incision over the vein, exposing and incising it, and then proceeding as just described.

Procedure Description: Peripheral Insertion Method

The catheter is typically inserted percutaneously through a vein in the *arm* and advanced as described above. It may also be inserted into a vein in the upper leg or other peripheral locations.

Central Venous Access CPT Code Categories

CPT provides multiple code categories for procedures involving these devices. They are listed below along with new companion imaging codes. **Reporting Guidelines for insertion, replacement, removal, repositioning, and imaging procedures follow this list of code categories.**

Insertion 36555-36571

Used for placement of a catheter through a newly established venous access, these codes are used in two situations: Insertion of the initial central venous access catheter *or* insertion of a central venous access catheter *into a new site* following removal of an existing central venous catheter from a *different* site.

Repair of Central Venous Access Device 36575-36576

Repair of the device without replacing the catheter or subcutaneous port or pump.

Partial Replacement of Central Venous Access Device (Catheter Only) 36578

This procedure involves replacement of *only* the catheter portion of a central venous access device that includes a subcutaneous port or pump.

Complete Replacement of Entire Device through the Same Venous Access Site 36580-36585

Complete exchange of the central venous access catheter or device with a new one. The new catheter is inserted through the *same* venous access site.

***Removal of Tunneled Central Venous Access Device
36589-36590***

Removal of an entire, *tunneled* central venous access device.

Other Central Venous Access Procedures 36591-36598

***Collection of Blood Specimen (36591-36592) or
DE clotting by Thrombolytic Agent (36593)***

For collection of blood specimen from a completely implantable venous access device, see code 36591 For collection of blood specimen from an established central or peripheral venous catheter, see code 36592. For DE clotting of an implanted vascular access device or catheter using a thrombolytic agent, see code 36593.

***Mechanical Removal of Obstructive Material
36595-36596***

Removal of obstructing material from around or within the central venous catheter using mechanical, not pharmacological, techniques.

***Repositioning Previously Placed Central Venous
Catheter under Fluoroscopic Guidance 36597***

Repositioning an existing catheter under fluoroscopic guidance at an encounter subsequent to the catheter's insertion.

***Imaging Guidance 75820,75825, 75827 (Ultrasonic
guidance) 76000 (Fluoroscopic guidance),***

This code is used to report ultrasonic guidance for locating *and accessing* the vein. Code may be used by the physician who provides *both* services (ultrasonic guidance and the procedure of accessing the vein).

Fluoroscopic guidance for locating and accessing the vein, and/or catheter manipulations, contrast injections, venography, and confirmation of final catheter position.

Both modalities require permanent recording of radiographic and/or ultrasonic images and a written interpretation and report. For reporting guidelines, see "Imaging Guidance" below.

***Reporting Guidelines: Insertion of Central Venous
Access Catheter or Device***

Central venous access catheters or devices may be *centrally inserted* (inserted into the jugular, subclavian, or femoral vein, or into the inferior vena cava) or *peripherally inserted* (e.g., inserted

into the basilic or cephalic vein of the arm). These latter procedures are commonly called “PICC” lines (peripherally inserted central catheter).

Reporting Guidelines

- Codes 36555-36558 are segmented by central or peripheral insertion. Within those categories, there are further specifications that must be considered when selecting a code: non-tunneled or tunneled catheters/devices; without or with a subcutaneous port or pump; and patient age (under 5 years of age or age 5 years or older). Burn surgeons typically insert *non-tunneled* central venous catheters without an implantable port or pump. Insertion codes that are likely to be used by burn surgeons are:

36555 Insertion of non-tunneled centrally inserted central venous catheter; younger than 5 years of age

36556 age 5 years or older

36557 Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump; younger than 5 years of age

36558 age 5 years or older

Refer to the CPT book for codes for insertion of tunneled catheters/devices without or with ports or pumps.

Note: When a central venous catheter is inserted in neonates and infants up to a present body weight of 4 kg, add modifier 63 (Procedure performed on infants less than 4 kg) to indicate the additional work and complexity attendant to these procedures.

- Insertion codes 36555-36568 are used for placement in a *newly established* venous access site. The codes can be used in 2 instances:
 - 1) For the initial insertion
 - 2) For insertion of a central venous catheter/device into a *new* access site immediately after a previously placed central venous catheter/device in a *different* site is removed.
- A physician, a non-physician practitioner (acting within the scope of licensure) or hospital auxiliary *nursing staff* may insert a central venous line in a procedure called “peripherally inserted central catheter” or PICC. *When this procedure is performed by auxiliary hospital nursing staff, it is not reportable as a physician/professional service as it is considered a routine nursing service included in the charge for inpatient hospital services. When a non-physician practitioner (NPP), acting under his/her scope of licensure,*

inserts a PICC, it may be reported as a physician/professional service when all criteria for billing by the NPP are met.

- **Removal of a non-tunneled** central venous catheter is not separately reportable as it is included in the Evaluation and Management visit in which it is performed. Please refer to that topic below.

Reporting Guidelines: Complete Exchange/Replacement of Central Venous Access Catheter or Device, Same Access Site

Central venous catheters may be exchanged during the course of treatment. The catheter portion of the exchange typically involves insertion of a guidewire over the current catheter, removal of the catheter while the guidewire remains in place, and then insertion of the new catheter over the guidewire. If a subcutaneous port or pump is in place, it is removed and replaced as well in this procedure.

Coding guidelines for catheter exchange in the *same venous access site* differ from those for removal of a catheter from one access site and insertion (of a new catheter) into a different site at the same encounter. Guidelines for the former follow immediately below under Reporting Guidelines. For guidelines for the latter scenario, refer to “Removal of Existing *Tunneled* Central Venous Access Device with Insertion New Device at a Different Access Site.”

Reporting Guidelines

- When a central venous access catheter/device is replaced with a new catheter inserted *through the same venous access site*, the applicable complete replacement code may be used to report it. Codes are available for catheters *without* a port or pump *or with* a port or pump. Refer to replacement codes 36580-36585 in the CPT book.
- When *only* the tunneled catheter component of a central venous access device with a subcutaneous port or pump is removed and replaced, code 36578 may be used to report it.

Reporting Guidelines: Removal of Existing *Tunneled* Central Venous Access Device with Insertion of New Device at a Different Access Site

Reporting Guidelines

- **Two** codes may be reported when an existing *tunneled* central venous access device is removed and completely replaced with a new central venous access catheter/device *inserted into a different access site*.
 - a) The applicable removal code from 36589-36590 may be reported for removal of the existing tunneled device; and
 - b) The applicable insertion code from 36555-36571 may be reported for insertion of the new catheter/device into a different access site.

Reporting Guidelines: Removal Non-Tunneled Central Venous Access Device

Reporting Guidelines

- When a *non-tunneled* central venous access catheter is removed, it is not separately reportable as it is included in the Evaluation and Management visit in which it is performed.

Reporting Guidelines: Repositioning a Previously Placed Central Venous Catheter under Fluoroscopic Guidance

Reporting Guidelines

- Use code 36597 (Repositioning of previously placed central venous catheter under fluoroscopic guidance) to report the repositioning procedure.

Reporting Guidelines: Imaging Guidance for Central Venous Access

Ultrasonic guidance may be used for locating *and accessing* the vein. Fluoroscopic guidance may be used for locating and accessing the vein, and/or catheter manipulations, contrast injections, venography, confirmation of final catheter position.

Both modalities may be used in some cases. Ultrasonic guidance may be used for locating and puncturing the vein. Once the vein has been accessed, fluoroscopic guidance may be used for visualization throughout the remainder of the catheter insertion, manipulation, and positioning process, and for confirmation of final placement.

Reporting Guidelines

- Use code 76000 for fluoroscopic guidance when provided and documented according to the requirements in the code descriptor.
- Both modalities require permanent recording of radiographic and/or ultrasonic images and a written interpretation and report.

Medicare Global Surgery Issues: Bedside Procedures and Central Venous Line Insertion

- Under Medicare’s major surgery global package, a bedside procedure is included in Medicare’s payment for the global surgery when performed during the 90-day postoperative period of a previous global surgery and it is performed to treat a problem or complication *related to* that previous global surgery. For example, surgical treatment of an infected surgical wound performed at the bedside.

If, instead, the related problem or complication is treated in the operating or procedure room, it is separately reportable using modifier 78.

If the procedure is unrelated to the previous global surgery, it is separately reportable using modifier 79.

- For central venous catheter insertion or complete replacement through the same venous access (36556 and/or 36580), these procedures are usually, but not always, unrelated to the previous global surgery. When unrelated to the previous global surgery, these procedures may be reported using modifier 79 whether performed at the bedside or in the operating room. In those few instances when these procedures are related to the previous global surgery and are performed at the bedside, they are not separately reportable.

Compartment Pressure Measurement

Compartment pressure measurement is used to identify the pressure of fluid within a closed fascial compartment, a group of skeletal muscles completely enclosed by a thin sheet of fascia. When fluid accumulates within the compartment, it generates high pressure on the structures within it (*e.g.*, muscles, nerves, blood vessels, and bone).

KEY POINTS

Look for compartment pressure measurement in progress notes or operative report documentation.

Pressure measurement using a hand-held device **is not** separately reportable. Pressure measurement using needle, catheter or other device inserted into the compartment **is** separately reportable.

Compartment syndrome most frequently affects the lower arms or legs but can occur in the hand, foot, shoulder, thigh, upper arm, or buttocks.

Pressure measurement can be accomplished using a hand held device passed over the surface of the body part or using a needle or similar device inserted into the suspect compartment and connected to a pressure-measurement instrument.

Reporting Guidelines

- Pressure measurement using a hand-held device is not separately reportable.
- Pressure measurement using a needle, catheter or other device inserted into the compartment may be reported using code

20950 Monitoring of interstitial fluid pressure (includes insertion of device, *e.g.*, wick catheter technique, needle manometer technique) in detection of muscle compartment syndrome

Medicare

- Medicare assigns “0” postoperative follow-up days to this minor procedure.
- When measurement of compartment pressure is performed during the global period of a previous major surgery, add modifier 79 (Unrelated Procedure During Postoperative Period) to code 20950.

Contracture Release / Scar Revision

Burn wounds can develop contractures and hypertrophic scarring during and as a result of the healing process. A contracture is an area of fibrosed or hardened tissue, usually scar tissue that shrinks and prevents normal movement of the tissue or joint where it forms.

Contracture release and scar revision may be accomplished by any one of several treatment methods. Each is described below along with their respective coding and reporting guidelines. Select **carefully** the appropriate option based on the documentation in the operative report and the applicable reporting guidelines. These methods are:

1. Excision of the lesion and primary closure;
2. Excision of the lesion and closure using adjacent tissue transfer;
3. Excision of the lesion resulting in an open wound requiring a skin graft; and
4. Incisional release of the scar resulting in an open wound requiring a skin graft.

Excision with Primary Closure

Reporting Guidelines

Excision of Benign Lesions codes (114xx), typically used for small scar excision or scar revision, may be used to report excision and primary closure.

Use the Excision of Benign Lesions (114xx) codes to report removal of scar and/or contracted tissue. Use the Repair codes (12031–13153) to report intermediate or complex closure of the remaining defect.

- **Code by the anatomic location and the largest dimension, length or width, of the lesion plus margins. Do not code by the size of the excision.**

Margins are defined as the narrowest margin required to adequately excise the lesion, based on the physician’s judgment.

Measure the “greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the narrowest margins required equals the excised diameter).”

Measurement of the lesion is to be made prior to excision. Excision is defined as “full thickness (through the dermis).”

- The lesion excision codes include simple (one layer) repair. For example, excision of a 2 cm (including margins) benign trunk lesion closed with skin sutures would be coded 11402.
- When a lesion is excised and then closed with an intermediate (layer) or complex repair, code for both the excision of the lesion and the repair/closure. Code the repair by the total length of closure. Using the above

KEY POINTS

For small scar excision or scar revision:

Size of the lesion should be measured in advance of the procedure. Add margins on either side for total excision size.

“Lesion diameter + the narrowest margins required = excised diameter.”

example, a 2 cm benign trunk lesion closed in layers would be coded 11402 (for the excision) and 12032 (for the layer closure), assuming the length of the closure/repair is 4 cm.

Removal with Adjacent Tissue Transfer

Reporting Guidelines

Use adjacent tissue transfer codes 14000–14302 for excision of the lesion with Z-plasty, Y-plasty, rotation flap, advancement flap, or other local skin flaps.

KEY POINT

Refer to code(s) 15002-15005 for excisional or incisional release of a scar resulting in an open wound requiring a skin graft.

Removal of the lesion is included in these codes and is not separately reportable.

- Code by the anatomic location and **total** surface area of the defect (in sq cm). Calculate the total surface area of the defect by measuring the combined area of the primary and secondary defects. See next bullet. Do not code by the size of the lesion.
- The term “defect” includes the primary and secondary “defects.” The primary defect is the wound resulting from excision of the lesion. The secondary defect is the wound resulting from elevating and moving the flap to its new location (to cover the primary defect).
- Report only the applicable adjacent tissue transfer code, whether the lesion is benign or malignant.
- When the transferred skin leaves a defect that must be covered with a skin graft, report both the applicable adjacent tissue transfer code and the skin graft code. For example, a hypertrophic scar contracture on the back is released by excising it, creating a primary defect of 10 sq cm. A 60 sq cm rotation flap is raised and placed on the primary defect. The area from which the rotation flap is taken is the secondary defect; its area is 60 sq cm. When added together, the combined area of the primary and secondary defects is 70 sq cm. The adjacent tissue transfer code is selected based on a 70 sq cm defect.
- Code 14301 is used to report the first 60 sq cm. Code 14302 is used to report the remaining 10 sq cm as shown below.

The flap donor site is closed with a 10 sq cm split thickness skin graft.

14301	Adjacent tissue transfer (rotation flap)	
	defect 30.1 sq cm to 60.0 sq cm	1 unit
14302	each additional 30.0 sq cm	1 unit
15100–51	Split-thickness autograft	1 unit

Payer re-bundling edit caution. Because adjacent tissue transfer (14xxx) codes include excision of the lesion prior to closure with the local or advancement flap that the 14xxx codes represent, payer re-bundling edits automatically re-bundle lesion excision codes (*e.g.*, 114xx or 116xx) into adjacent tissue transfer codes. The edits assume that the lesion was removed and closed with the adjacent tissue transfer. However, when an adjacent tissue transfer is performed on one site and a lesion is excised from a different site, both procedures may be reported for separate reimbursement. To illustrate this situation on the claim and bypass payer edits, be certain to add modifier 59 (Distinct Procedure) to the lesion excision code.

Removal and Closure with Skin Graft (Resurfacing)

Reporting Guidelines

For excisional release of scar contracture, use codes 15002-15005 Surgical preparation or creation of recipient site by excision of ...scar, as appropriate. List the appropriate skin graft code in addition. Refer to the Skin Replacement Surgery and Skin Substitute section for coding guidelines for grafts.

- Code for excision of the burn wound scar/contracture and for the skin graft used to cover it. For example, assume a large hypertrophic burn scar of the back is excised and covered with a split-thickness autograft. The applicable code(s) would be selected from each of the following code ranges.

15002-15003	Excision of burn wound/scar
15100-15101	Split-thickness autograft

Incisional Release and Closure with Skin Graft (Resurfacing)

Reporting Guidelines

For incisional release of scar contracture, use codes 15002-15005 Surgical preparation or creation of recipient site by incisional release of scar contracture, as appropriate. List the appropriate skin graft code in addition. Refer to the Skin Replacement Surgery and Skin Substitute section for coding guidelines for grafts.

- Code for incisional release of the burn wound scar/contracture and for the skin graft used to cover it. For example, assume incisional release of a hypertrophic burn

scar of the back, which is then covered with a split-thickness autograft. The applicable code(s) would be selected from each of the following code ranges.

15002-15003	Excision of burn wound/scar
15100-15101	Split-thickness autograft

Hand Scar Contracture Release

For hand and/or finger scar contracture release, see the applicable method in this section (e.g., excision and primary closure, removal with adjacent tissue transfer, resurfacing).

See also:

26123	Fasciectomy, partial palmar, with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft);
26125	each additional digit
26508	Release of thenar muscles (<i>eg</i> , thumb contracture)

Debridement, Surgical (16020–16030) (11000–11001, 11004–11008, & 11042–11047)

This section applies only to surgical debridement by physicians or non-physician practitioners (NPPs). It is divided into the following main topics.

- Coding Differs by Type of Debridement and Performing Clinician
- Definition of Debridement
- Cautionary Note Regarding Physician Billing for Debridement by Hospital Staff Nurse Supervised by Physician
- Burn Wounds—Debridement by Physician or Non-Physician Practitioner (NPP) Within Scope of Licensure (16020-16030)
- Non-Burn Wounds—Debridement by Physician or Non-Physician Practitioner (NPP) Within Scope of Licensure (11000-11001, 11004-11008, 11040-11047)

For coding **non-surgical** debridement as performed **by non-physician professionals (PT, OT)**, refer to the section entitled

Debridement, Non-Surgical (97597-97602), which follows in sequence immediately after this section on surgical debridement.

Coding Differs by Type of Debridement and Performing Clinician

Any code in CPT can be utilized to describe a clinical procedure or service rendered by any provider whose scope of practice includes that service.

Debridement is reported based on the type of debridement performed, surgical versus non-surgical, and the clinical professional who performs the procedure.⁵

Codes for surgical debridement are used only by physicians and non-physician practitioners (e.g., NP or PA) acting within their scope of licensure.

KEY POINT

For burn wound debridement, burn surgeons & non-physician practitioners acting within scope of license should use debridement codes 16020-16030.

Codes for non-surgical debridement, 97597–97602 (Active Wound Care), are typically used by non-physician professionals such as physical therapists and occupational therapists. Physicians (and non-physician practitioners who are qualified to do so) generally use a surgical debridement code instead.

This section provides coding instructions for surgical debridement of burn wounds and non-burn wounds by physicians or non-physician practitioners (NPPs) **only**.

(Dressings are discussed in a separate discussion entitled “Dressing Change” in another part of this section.)

Debridement may be reported for a burn wound or for a different condition⁶ using the code(s) that most accurately describes the procedure performed.

Definition of Debridement

Debridement is the removal of loose, devitalized, necrotic, and/or contaminated tissue, foreign bodies, and other debris on the wound using mechanical or sharp techniques (e.g., copious irrigation, washing, removal of loose and necrotic tissue using sharp instruments and/or forceps, etc.).

Cautionary Note Regarding Physician Billing for Debridement Performed by Hospital Staff Nurse and Supervised by Physician

Please refer to the section entitled “Physician Claims for Services Must Be Performed or Provided Directly by the Physician” in the chapter on Fraud and Abuse. That section explains the prohibitions involved and the two circumstances when a physician can bill for supervision/provision of services performed by a different clinician.

See also, “Conscious Sedation” in this chapter for information relating to conscious sedation provided by the burn surgeon for procedures (e.g., debridement/dressing change) performed by hospital staff nurse.

Burn Wounds—Debridement by Physician or Non-Physician Practitioner (NPP) Within Scope of Licensure

Physician (e.g., burn surgeon) or non-physician practitioner (NPP) acting within his/her scope of licensure performs debridement of burn wound and documents it in a separate procedure note.

Burn wound debridement is reported using codes listed in CPT under the subheading “Burns, Local Treatment.” The relevant excerpt is shown below.

Burns, Local Treatment

16020	Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)
16025	medium (e.g., whole face or whole extremity, or 5% to 10% total body surface area)
16030	large (e.g., more than one extremity, or greater than 10% total body surface area)

Codes 16020–16030 include:

- a) removal and application of materials, dressings (e.g., Biobrane®, other dressings) and/or
- b) burn wound debridement. They may be used to report initial or subsequent burn wound debridement.

Codes are surface-area dependent and segmented by percent of total body surface area (TBSA) debrided.

Codes 16020–16030 may be used to report debridement or dressing change when one or the other is performed at an

encounter, or to report both a debridement and a dressing change when both are performed at the same encounter.

Debridement vs. Excision

It is important to distinguish burn wound *debridement* from burn wound *excision*. Each is a distinctly different procedure based on the technique used by the burn surgeon.

Debridement is the removal of loose, devitalized, necrotic and/or contaminated tissue, foreign bodies, and other debris on the wound, using mechanical or sharp techniques.

In contrast, burn wound excision is a surgical procedure that is usually performed to prepare the wound for immediate or later grafting. It is frequently performed in stages, where part of the burn wound is excised initially and the remainder is removed in one or more subsequent operations. The excisional technique may vary but is typically performed in one of two ways: tangential excision usually performed on deep partial thickness burns, and full thickness excision. Tangential excision involves a specific surgical technique in which successive layers of burn wound are removed down to viable dermis. Full thickness excision involves removal of the burn wound down to viable subcutaneous tissue or to fascia. Either process results in a large open area, i.e., *defect*, that must be covered.⁷ As an example, electrical burns may be initially excised followed by several additional staged excisions required to remove the additional, progressive necrosis (depth and width) that is characteristic of such burns.

Coding for burn wound debridement or burn wound excision must be based on documentation in the medical or operative record. If burn wound debridement is documented, the applicable code from 16020-16030 should be assigned. If burn wound excision is documented, the applicable code(s) from 15002-15005 should be assigned.

Coding is not based on the instrument used for the procedure because a scalpel, knives, or other instruments (e.g., Versajet) may be used to accomplish, alone or in combination, either burn wound excision or debridement.

Reporting Guidelines

See also Medicare Global Surgery Package Issues below.

- A single code is reported for all work to dress and/or debride burn wounds at a given encounter.
For example, debridement and/or dressing of a 15% TBSA burn wound would be reported using the single code 16030.
- When debridement is performed again on subsequent days, it may be reported according to the foregoing guideline.
- When debridement is performed at a second, *different* session on the same day, the appropriate code for the second session is reported with the addition of modifier 59 (Distinct Procedure) to indicate that fact. Two codes would

⁷ Gillespie, R.W., Burn Surgery Tab 10, 1–12: CPT 1999 Coding Symposium. Chicago: American Medical Association, 1999.

be reported for the same date, the first without and the second with modifier 59 added.

16030 (1 Unit)

16030–59 (1 Unit)

- Escharotomy and debridement, on the same site or different sites, may be reported separately when performed at the same session or at different sessions on the same day.
- List location of wounds, depth of burn, and percentage of body surface involved.
- Document anatomic location of each wound that is debrided.
- **Note:** Code 16000 is used for first degree burns and specifies “local treatment,” referring to treatment performed to provide symptomatic relief for the patient.⁸
- **Do not use other CPT debridement codes to report debridement of burn wounds.** (E.g., 11000-11001, 11004–11008 Debridement for necrotizing soft tissue infection, or 11040–11044 Debridement of skin, subcutaneous tissue, muscle, and bone)⁹

Medicare Global Surgery Package Issues

When burn wound debridement is *performed during the postoperative period* of a previous global surgery on a burn wound, it is important to follow Medicare coding and reporting guidelines.

- Debridement of different burn wound, performed at bedside: Report the appropriate debridement code with modifier 79 (Unrelated Procedure During the Postoperative Period of Previous Surgery) or 58 (Staged Procedure), whichever is applicable.
- Debridement of same burn wound/operative site, performed at bedside: If debridement is related to the previous surgical procedure (*e.g.*, for a complication), it is included in the previous global surgery when performed at bedside, and is not separately reportable.
- Planned or anticipated (staged) debridement of same burn wound/operative site performed in the OR during the postoperative period of a previous global surgery: Report

⁸ Ibid.
⁹ Ibid.

the appropriate debridement code with modifier 58 (Staged Procedure).

- Debridement of same burn wound/operative site, performed in the operating or procedure room: If debridement is related to the previous global surgical procedure (*e.g.*, for a complication or unanticipated clinical condition), report the appropriate debridement code with modifier 78 (Unplanned Return to Operating/Procedure Room for Related Procedure During the Postoperative Period of a Previous Surgery).
- ***Burn wound debridement by a different physician, same group practice***, during postoperative period of global surgery (on same patient) by another physician in the same group may be reported separately by the performing physician. Medicare’s unique guidelines require the group to bill for the entire global package if the physicians reassign benefits to the group. Hence, each physician in the group who provides services to the patient during the global period, including the original performing surgeon, should submit claims for surgical procedures using the appropriate global surgery modifier (58, 78, or 79) to bypass Medicare’s global surgery denial edits.

The surgical procedure, performed by a different group physician, should be reported under the group provider number. The performing physician’s NPI (National Provider Identifier) should be entered in the appropriate field on the claim.

- **Note:** A postoperative daily hospital visit during the global surgery period, which is provided by a group physician *covering* for a surgeon in the same group who performed a global surgery on the patient, is typically not reported. This policy follows customary convention within the national medical community. Such visits are considered occasional “reciprocal” visits by Medicare and are not reported. Critical care services are an exception and may be reported by the covering physician using the applicable CPT code(s) with modifier 24 (Unrelated E/M service by same physician during postoperative period).

CPT Surgical Package Issues

When burn wound debridement is *performed during the postoperative period* of a previous global surgery on a burn wound, it may be reported as performed subject to payer-specific coding guidelines.

It is appropriate to indicate whether the procedure is staged and/or unrelated to the previous surgery.

- Debridement of different burn wound, performed at bedside: Report the appropriate debridement code with modifier 79 (Unrelated Procedure During the Postoperative Period of Previous Surgery) or 58 (Staged Procedure), whichever is applicable.
- Debridement of same burn wound/operative site, performed at bedside or in the OR: Report the appropriate debridement code with modifier 58 (Staged Procedure).
- At this time, payers generally do not follow Medicare payment reduction policy for related procedures in the postoperative period. Workers Compensation carriers may vary; check with your W/C payer for specific information.
- ***Burn wound debridement by a different physician, same group practice***, during postoperative period of global surgery (on same patient) by another physician in the same group may be reported separately by the performing physician. No modifier is necessary or required *in the absence of payer guidelines to the contrary*.

The surgical procedure, performed by a different group physician, should be reported under the appropriate provider number. The performing physician's PIN number should be entered in the appropriate field on the claim. The NPI number (National Provider Identifier) is required in addition.

- **Note:** A postoperative daily hospital visit during the global surgery period, which is provided by a group physician *covering* for a surgeon in the same group who performed a global surgery on the patient, is typically not reported. This policy follows customary convention within the national medical community. Such visits are considered occasional "reciprocal" visits and are not reported. Critical care services are an exception and may be reported by the covering physician using the applicable CPT code(s) with modifier 24 (Unrelated E/M service by same physician during postoperative period).

Non-Burn Wounds/Conditions—Debridement Performed by Physician or Non-Physician Practitioner (NPP) Within Scope of Licensure

Physician (e.g., burn surgeon) or non-physician practitioner (NPP) acting within his/her scope of licensure performs debridement of a wound, infected tissues (i.e., necrotizing fasciitis), or eczematous skin.

Debridement code categories for these surgical services are:

- 11000** Debridement of extensive eczematous or infected skin; up to 10% of body surface
- 11001** each additional 10% of the body surface (List separately in addition to code for primary procedure)
- 11004** Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum
- 11005** abdominal wall, with or without fascial closure
- 11006** external genitalia, perineum and abdominal wall, with or without fascial closure
- 11008** Removal of prosthetic material or mesh, abdominal wall for infection (e.g., for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)
- 11042** Debridement; subcutaneous tissue; first 20 sq cm or less
- 11045** each additional 20 sq cm, or part thereof (use 11045 in conjunction with 11042)
- 11043** Debridement, muscle and or fascia; first 20 sq cm or less
- 11046** each additional 20 sq cm, or part thereof (use 11046 in conjunction with 11043)
- 11044** Debridement; bone; first 20 sq cm or less
- 11047** each additional 20 sq cm, or part thereof (use 11047 in conjunction with 11044)

Reporting Guidelines

- Debridement, initial or subsequent, may be reported as performed in the absence of payer guidelines to the contrary. An exception applies when debridement (or another procedure) **is performed for a complication of a previous surgery on a Medicare beneficiary** and the procedure **does not require** a return to the operating or procedure room. E.g., the procedure is performed at bedside. In this case, the debridement is included in Medicare’s payment for the previous global surgery.
- Wound closure (e.g., skin graft) at the time of debridement or at a subsequent operative intervention is separately reportable.

Codes 11000–11001 are surface area dependent and are reported by percent of body area *skin* that is debrided. Document the *total* percent of body area that is debrided in the operative record. Code 11000 is used to report the first 10% of body surface area of skin debrided. For each additional 10% of body surface area debrided thereafter, list code 11001 on one line and enter the total number of remaining units in the units field of the claim. *For example*, assume 60% of body surface area skin is debrided,

11000	(for first 10%)	Units = 1
11001	(for next 50%)	Units = 5

Codes 11004–11008 are anatomic-site and diagnosis- specific codes. They are utilized for debridement of necrotizing soft tissue infections such as necrotizing fasciitis, Fournier’s gangrene, and other rapidly progressing (fulminating) soft tissue infections that affect certain anatomic sites.

Codes 11004–11006 include debridement/removal of skin, subcutaneous tissue, fascia and muscle. If orchiectomy (54520) or testicular transplantation (54680) is performed in addition, each is separately reportable.

Only **one** code from 11004–11006 may be reported per operative intervention.

Repeat debridement, performed at subsequent sessions, may be reported separately. If performed during the postoperative period of a previous global surgery, add the appropriate global surgery modifier 58, 78, or 79. If there is no previous global surgery period in place, subsequent debridement may be submitted without a modifier because these codes have a “0” day global surgery period.

Code 11004 is used to report debridement of the external genitalia and perineum. Use code 11005 to report debridement of the abdominal wall. When debridement of external genitalia, perineum and the abdominal wall is performed, use the single code 11006. Closure of fascia, if performed, is included in codes 11005 and 11006.

When **prosthetic material or mesh**, previously placed in the abdominal wall (e.g., for repair of ventral hernia), **is removed** to treat chronic or recurrent mesh infection or necrotizing soft tissue infection, report code 11008. This code is an add-on code and can only be reported when one of the codes from 11004–11006 is also reported at the same encounter.

When prosthetic material or mesh *is inserted for closure or repair associated with necrotizing soft tissue infection*, code 49568 Implantation of mesh or other prosthesis for incisional or ventral hernia repair may be used to report it. This code is an add-on code.

For extensive debridement/excision of necrotizing soft tissue infection from other anatomic areas, refer to codes 15002–15005.

Codes 11042–11047 are depth-dependent codes and are reported on the basis of the deepest layer of tissue removed. These codes *should not* be used to describe debridement of burn wounds.¹⁰ The codes are often used for debridement of smaller chronic wounds such as vascular ulcerations. For larger areas that involve an excisional procedure such as tangential excision, refer to codes 15002–15005.

When performing debridement of multiple wounds, sum up the surface area of those wounds that are at the same depth, but do combine sums from different depths. Codes for the subsequent sites with different depths are each reported with modifier 59 (Distinct procedure) to indicate the procedure was performed at a different anatomic site/depth in each instance.

For each site debrided, document the deepest layer of tissue removed.

Medicare Global Surgery Package Issues

When non-burn wound debridement is *performed during the postoperative period* of a previous global surgery, it is important to follow Medicare coding and reporting guidelines.

- Debridement of different wound, performed at bedside: Report the appropriate debridement code with modifier 58 (Staged Procedure) or 79 (Unrelated Procedure During the Postoperative Period of Previous Surgery), whichever is applicable.
- Debridement of same non-burn wound/operative site, performed at bedside: If debridement is related to the previous surgical procedure (*e.g.*, for a complication), it is included in the previous global surgery when performed at bedside, and is not separately reportable.
- Debridement of same non-burn wound/operative site, performed in the operating or procedure room: If debridement is related to the previous global surgical procedure (*e.g.*, for a complication), report the appropriate

¹⁰ Ibid.

debridement code with modifier 78 (Unplanned Return to Operating/Procedure Room for Related Procedure Performed During the Postoperative Period of a Previous Surgery).

- **Non-burn wound debridement by a different physician, same group practice**, during postoperative period of global surgery (on same patient) by another physician in the same group may be reported separately by the performing physician. Medicare’s unique guidelines require the group to bill for the entire global package if the physicians reassign benefits to the group. Hence, each physician in the group who provides services to the patient during the global period, including the original performing surgeon, should submit claims for surgical procedures using the appropriate global surgery modifier (58, 78, or 79) to bypass Medicare’s global surgery denial edits.

The surgical procedure, performed by a different group physician, should be reported under the group provider number. The performing physician’s NPI (National Provider Identifier) should be entered in the appropriate field on the claim.

- **Note:** A postoperative daily hospital visit during the global surgery period, which is provided by a group physician *covering* for a surgeon in the same group who performed a global surgery on the patient, is typically not reported. This policy follows customary convention within the national medical community. Such visits are considered occasional “reciprocal” visits by Medicare and are not reported. Critical care services are an exception and may be reported by the covering physician using the applicable CPT code(s) with modifier 24 (Unrelated E/M service by same physician during postoperative period).

CPT Surgical Package Issues

When non-burn wound debridement is *performed during the postoperative period* of a previous global surgery, it may be reported as performed subject to payer-specific coding guidelines.

It is appropriate to indicate whether the procedure is staged and/or unrelated to the previous surgery.

- Debridement of different non-burn wound, performed at bedside: Report the appropriate debridement code with modifier 58 (Staged Procedure), or 79 (Unrelated Procedure During the Postoperative Period of Previous Surgery), whichever is applicable.

- Debridement of same non-burn wound/operative site, performed at bedside or in the OR: Report the appropriate debridement code with modifier 58 (Staged Procedure).
- At this time, payers generally do not follow Medicare payment reduction policy for related procedures in the postoperative period. Workers Compensation carriers may vary; check with your W/C payer for specific information.
- **Non-burn wound debridement by a different physician, same group practice**, during postoperative period of global surgery (on same patient) by another physician in the same group may be reported separately by the performing physician. No modifier is necessary or required *in the absence of payer guidelines to the contrary*.

The surgical procedure, performed by a different group physician, should be reported under the appropriate provider number. The performing physician’s NPI (National Provider Identifier) should be entered in the appropriate field on the claim.

- **Note:** A postoperative daily hospital visit during the global surgery period, which is provided by a group physician *covering* for a surgeon in the same group who performed a global surgery on the patient, is typically not reported. This policy follows customary convention within the national medical community. Such visits are considered occasional “reciprocal” visits and are not reported. Critical care services are an exception and may be reported by the covering physician using the applicable CPT code(s) with modifier 24 (Unrelated E/M service by same physician during postoperative period).

Debridement, Non-Surgical (97597-97598, 97602)

KEY POINT

Non-physician professionals (e.g., PT, OT), licensed to perform non-surgical debridement, should use Active Wound care codes 97597–97602 for burn wound debridement.

The following section is divided into these topics:

- Burn Wounds—Debridement, Non-Surgical, by Non-Physician Professionals (PT, OT)
- Non-Burn Wounds/Conditions—Debridement, Non-Surgical, by Non-Physician Professionals (PT, OT)

Burn Wounds—Debridement by Non-Physician Professional (PT, OT)

Non-physician professional, such as a physical or occupational therapist, performs selective or non-selective debridement of burn wound.

Burn wound debridement is reported using codes listed under “Active Wound Care Management” which represent *non-surgical* debridement and are performed without anesthesia. Codes are shown below.

- | | |
|--------------|---|
| 97597 | Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters |
| 97598 | total wound(s) surface area greater than 20 square centimeters |
| 97602 | Removal of devitalized tissue from wound(s); non-selective debridement, without anesthesia (e.g., wet- to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session |

Non-physician professionals may report selective or non-selective burn wound debridement (non-surgical debridement), subject to payer reporting and coverage guidelines. Subject to state and federal requirements, the services of non-physician professionals may be billed independently or by an organization with which they have a contractual or employee relationship. Refer to the section “Non-Physician Services” for additional information.

- CPT codes 97597–97602 are used to report these active wound care services as provided by physical therapists, occupational therapists, and enterostomal therapy nurses.
- Surgical debridement codes 11042–11047 may not be reported in addition to 97597–97602 by the non-physician professional. Wound debridement performed by physicians or non-physician practitioners acting within scope of licensure is reported using 11000–11001, 11004–11008 or 11042–11047 and, for burn wounds, 16020–16035.
- Application and removal of any protective or bulk dressings are included in codes 97597–97602.
- At this time, Medicare does not consider non-selective debridement (97602) a skilled service and bundles it into

other services provided on the same day. Other government programs may follow Medicare’s payment guidelines.

- Other payers may allow reporting and payment for both services.

KEY POINT

Non-physician professionals (e.g., PT, OT), licensed to perform non-surgical debridement, should use Active Wound care codes 97597–97602 for non-burn wound debridement.

Non-Burn Wounds/Conditions—Debridement, Non-Surgical, By Non-Physician Professional (PT, OT)

Non-physician professional, such as a physical or occupational therapist, performs selective or non-selective debridement of non-burn wound.

Non-burn wound debridement is reported using codes listed under “Active Wound Care Management,” which represent *non-surgical* debridement, and are performed without anesthesia. Codes are shown below.

- 97597** Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters
- 97598** total wound(s) surface area greater than 20 square centimeters
- 97602** Removal of devitalized tissue from wound(s); non-selective debridement, without anesthesia (e.g., wet- to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session

Non-physician professionals may report selective or non-selective non-burn wound debridement (non-surgical debridement), subject to payer reporting and coverage guidelines. Subject to state and federal requirements, the services of non-physician professionals may be billed independently or by an organization with which they have a contractual or employee relationship. Refer to the section “Non-Physician Services” for additional information.

- CPT codes 97597–97602 are used to report these active wound care services as provided by physical therapists, occupational therapists, and enterostomal therapy nurses.
- Surgical debridement codes 11042–11047 may not be reported in addition to 97597–97602 by the non-physician

professional. Wound debridement performed by physicians or non-physician practitioners acting within scope of licensure is reported using 11004–11008 or 11040–11044 and, for burn wounds, 16020–16035.

- Application and removal of any protective or bulk dressings are included in codes 97597–97602.
- At this time, Medicare does not consider non-selective debridement (97602) a skilled service and bundles it into other services provided on the same day. Other government programs may follow Medicare’s payment guidelines.
- Other payers may allow reporting and payment for both services.

Dressing Change

(See also Debridement, Burn Wounds.)

This discussion covers the following topics. Note that guidelines for Dressings are segmented into three distinct categories, each of which is discussed separately:

- Overview
- Cautionary Note Regarding Physician Billing for Dressing Change by Hospital Staff Nurse Supervised by Physician
- Dressings—Burn Wounds
- Dressings—Grafts
- Dressings—Non-burn Wounds.

Overview

Dressings may be applied to burn wounds, non-burn wounds, and grafts.

For burn wounds, dressings may be applied in initial and/or subsequent sessions at the bedside, in the operating room or in the treatment room.

For non-burn wounds, dressings may be applied in initial and/or subsequent sessions at the bedside, in the operating room or in the treatment room.

Dressing change may be performed on dates subsequent to debridement or excision.

KEY POINTS

Coding guidelines for burn wound dressing change differ from dressing change for grafts.

For skin grafts, dressings may be applied immediately following application of the graft and/or in subsequent sessions at the bedside or in the operating room.

Cautionary Note Regarding Physician Billing for Dressing Change by Hospital Staff Nurse Supervised by Physician

Please refer to the section entitled “Physician Claims for Services Must Be Performed or Provided Directly by the Physician” in the chapter on Fraud and Abuse. This section explains the prohibitions involved and the two circumstances when a physician can bill for supervision/provision of services performed by a different clinician.

Dressings—Burn Wounds

When performed by the physician, dressing changes are reported using the applicable “Burns, Local Treatment” codes: 16020–16030.

Medicare assigns “0” postoperative follow-up days to these codes; therefore, only postoperative care on the day of surgery is included. Other payers may or may not conform to Medicare’s policy.

- Codes are surface-area dependent and segmented by percent of total body surface area (TBSA).
- Codes 16020–16030 may be used for initial or subsequent burn wound dressings.
- Codes 16020–16030 may be used to report debridement or dressing change when one or the other is performed at an encounter, or to report both a debridement and a dressing change when both are performed at the same encounter.

Reporting Dressing and Dressing Changes

- A single code is reported for all work to dress and/or debride burn wounds at a given encounter.¹¹ *For example*, debridement and/or dressing of a 15% TBSA burn wound would be reported using the single code 16030.
- When, however, burn wound dressing is performed at a second, *different* session on the same day, the appropriate code for the second session is reported with the addition of modifier 59 (Distinct procedure). Two codes would be

¹¹ Ibid.

reported for the same date, the first without and the second with modifier 59 added.

- When burn wound dressing(s) are performed again on subsequent days, the appropriate code may be reported again according to the foregoing guidelines.
- Codes 16000-16030 are used to report local treatment of burn wounds.
- Document location of wounds, depth of burn, and percentage of body surface involved for diagnostic coding purposes.
- Document anatomic location of each wound that is dressed.
- **Note:** Code 16000 is used for first degree burn and specifies “local treatment,” which refers to treatment performed to provide symptomatic relief for the patient.¹²

Medicare Global Surgery Package Issues

When burn wound dressing is performed during the postoperative period of a previous global surgery on a burn wound (*e.g.*, escharotomy), it is important to follow specific Medicare coding and reporting guidelines. (For graft dressing change, refer to the next section “Dressings—Grafts.”)

- Dressing change for the previous global surgery site is included in Medicare’s global surgery package when performed at the bedside.
- Dressing change for the same burn wound, performed *in the operating or procedure room* for a complication of the previous global surgical procedure: Report the appropriate burn wound dressing code with modifier 78 (Unplanned Return to Operating/Procedure Room for Related Procedure or Service Performed During the Postoperative Period of a Previous Surgery).
- Dressing change performed in the OR for the same burn wound, but unrelated to the previous global surgery: May be reported as performed. Add modifier 79 (Unrelated Procedure or Service During Postoperative Period) to the appropriate dressing code.
- Dressing change for different burn wound, performed at bedside or in the OR: Report the appropriate burn wound dressing code with modifier 58 (Staged Procedure) or 79 (Unrelated Procedure or Service Performed During the

¹² *Ibid.*

Postoperative Period of Previous Surgery), whichever is applicable.

- Dressing change for a burn wound, **after** the postoperative period of a previous global surgery on the burn wound, may be reported as provided.
- ***Burn wound dressing change by a different physician, same group practice***, during postoperative period of global surgery (on same patient) by another physician in the same group may be reported separately by the performing physician, subject to the guidelines listed immediately above. Medicare’s unique guidelines require the group to bill for the entire global package if the physicians reassign benefits to the group. Hence, each physician in the group who provides services to the patient during the global period, including the original performing surgeon, would submit claims for billable surgical procedures using the appropriate global surgery modifier (58, 78, or 79) to bypass Medicare’s global surgery denial edits.

The surgical procedure, performed by a different group physician, should be reported under the group provider number. The performing physician’s NPI (National Provider Identifier) should be entered in the appropriate field on the claim.

- **Note:** A postoperative daily hospital visit during the global surgery period, which is provided by a group physician *covering* for a surgeon in the same group who performed a global surgery on the patient, is typically not reported. This policy follows customary convention within the national medical community. Such visits are considered occasional “reciprocal” visits by Medicare and are not reported. Critical care services are an exception and may be reported by the covering physician using the applicable CPT code(s) with modifier 24 (Unrelated E/M service by same physician during postoperative period).

CPT Surgical Package Issues

When burn wound dressing is performed during the postoperative period of a previous global surgery on a burn wound, payers that follow CPT surgical package rules may use the guidelines listed below. It is important to check with each payer for any variances that may apply. (For graft dressing change, refer to the next section “Dressings—Grafts.”)

- Routine dressing change for a previous global surgery site is included in the global surgical package.
- Dressing change for same burn wound may be reported with the appropriate burn wound dressing code. Some payers may require a specific modifier, *e.g.*, modifier 79 (Unrelated Procedure) for payment.
- Dressing change for different burn wound, performed at bedside or in the operating room: Report the appropriate burn wound dressing code with modifier 58 (Staged Procedure) or 79 (Unrelated Procedure During the Postoperative Period of Previous Surgery), whichever is applicable.

Dressing change for a burn wound, **after** the postoperative period of a previous global surgery on the burn wound, may be reported as provided.

Burn wound dressing change by a different physician, same group practice, during postoperative period of global surgery (on same patient) by another physician in the same group may be reported separately by the performing physician. No modifier is necessary or required in the absence of payer guidelines to the contrary.

- The surgical procedure, performed by a different group physician, should be reported under the appropriate provider number. The performing physician's NPI (National Provider Identifier) should be entered in the appropriate field on the claim.
- **Note:** A postoperative daily hospital visit during the global surgery period, which is provided by a group physician *covering* for a surgeon in the same group who performed a global surgery on the patient, is typically not reported. This policy follows customary convention within the national medical community. Such visits are considered occasional "reciprocal" visits and are not reported. Critical care services are an exception and may be reported by the covering physician using the applicable CPT code(s) with modifier 24 (Unrelated E/M service by same physician during postoperative period).

Dressings—Grafts

Not all graft codes are global surgery package procedures. (See Skin Replacement Surgery and Skin Substitutes Section for specific details.) Application of the initial dressing after certain graft procedures and routine dressing changes are included in the package if applicable. This guideline applies whether the original performing surgeon or another surgeon from the same group

practice changes the dressing on the graft during the postoperative period assigned to the graft procedure.

*Few, if any, payers allow separate payment for routine dressing changes for grafts on burn wounds during the postoperative period (e.g., 90-day postoperative period). In the unusual event that such coverage is allowed, the service may be reported separately, subject to applicable payer coverage and reporting guidelines. See **specific guidelines under Medicare Global Surgery Package Issues and CPT Surgical Package Issues below.***

Medicare Global Surgery Package Issues

When graft dressing change is performed during the postoperative period of the previous graft application procedure, it is important to follow specific Medicare coding and reporting guidelines.

- Routine graft dressing change is included in Medicare’s global surgery package when performed at the bedside.
- When the physician anticipates the need to perform graft dressing change in the operating room under anesthesia or conscious sedation because of extent of the graft and/or need for pain management during the procedure, the appropriate code for dressing change may be reported with modifier 58.
- Graft dressing change performed *in the operating or procedure room* for a complication or unanticipated clinical condition (e.g., hematoma, seroma, infection, etc.): Report the appropriate dressing code with modifier 78 (Unplanned Return to Operating/Procedure Room for Related Procedure Performed During the Postoperative Period of a Previous Surgery).
- Graft dressing change performed at the bedside for a complication is included in Medicare’s global surgery package and is not separately reportable.

CPT Surgical Package Issues

When dressing change is performed during the postoperative period of the previous graft application procedure, payers that follow CPT surgical package rules may use the guidelines listed below. It is important to check with each payer for any variances that may apply.

- Routine dressing change is included in the surgical package.
- Graft dressing change performed in the operating or procedure room, or at the bedside for a complication or unanticipated clinical condition (e.g., hematoma, seroma, infection, etc.): Report the applicable dressing code. Some

payers may accept or require the informational modifier 78 (Unplanned Return to Operating/Procedure Room for Related Procedure or Service Performed During the Postoperative Period of a Previous Surgery) to allow payment for this procedure.

- When the physician anticipates the need to perform graft dressing change in the operating room under anesthesia or conscious sedation because of extent of the graft and/or need for pain management during the procedure, the appropriate code for dressing change may be reported with modifier 58.

Dressings—Non-burn Wounds

When non-burn wound dressing change is performed under anesthesia, defined by the AMA’s *CPT Assistant* as general anesthesia, regional anesthesia, or monitored anesthesia care, it may be reported using code

15852 Dressing change (for other than burns) under anesthesia (other than local)

Medicare assigns “0” postoperative follow-up days to code 15852; therefore, only postoperative care on the day of surgery is included. Other payers may or may not conform to Medicare’s policy.

Code 15852 may be used for initial and subsequent dressing changes under anesthesia (general anesthesia, regional anesthesia, or monitored anesthesia care).

Escharotomy

Escharotomy (16035–16036)

Performed to relieve circulatory, pulmonary and/or neurological compromise resulting from the constricting effect of a full thickness burn, escharotomy is accomplished by making an axial incision (in a line parallel to the long axis of the body or body part) along the entire length of the burn eschar. The escharotomy incision is extended to a depth below the burned tissue, generally down to the subcutaneous fat.

One or more escharotomy incisions may be required to release constriction caused by leathery, inelastic burn eschar.

Documentation

Always dictate a procedure note for escharotomy(ies). Indicate anatomic location and extent of **each** escharotomy. This

KEY POINTS

Add-on codes can only be billed with the primary code when they are performed at the same operative session.

Coding starts over again when the same procedure is performed at another operative session on the same date.

information should be documented in addition to the facts routinely included in each operative procedure note. This level of documentation specificity is required because **each** escharotomy may be coded and reported separately.

Reporting Guidelines

- Code 16035 is used for the first escharotomy incision.
- Code 16036 is used for each escharotomy incision after the first incision **performed at the same operative session**.
- Codes are not limited by anatomic location. Each escharotomy incision may be reported, regardless of its anatomic location.

Example: Three escharotomy incisions are made on the chest to relieve pulmonary constriction. One horizontal incision is made below the rib cage. Two vertical incisions are made on the right and left sides of the chest. In addition, escharotomy incisions are made on the medial and lateral aspects of the right arm.

16035	First incision	1 unit
16036	[Second through fifth incisions]	4 units

- For multiple escharotomies on the same date **but performed at different encounters on that date**, code all escharotomies at each encounter using the primary code for the first incision at the encounter and the add-on code for each incision thereafter at the same encounter. Add modifier 59 (Distinct procedure) to code 16035 for the primary escharotomy performed at the second encounter to indicate that fact.

Example: Two escharotomy incisions are made on the chest at the initial encounter. At the second encounter on the same day, an additional incision is made on the chest and one on the upper arm.

First Encounter

16035	First incision	1 unit
16036	Second incision	1 unit

Second Encounter

16035-59	First incision	1 unit
16036	Second incision	1 unit

Excision Burn & Non-burn Wounds (15002–15005)

Burn wound excision is a surgical procedure that is performed to prepare the wound for immediate or later grafting, or for treatment with dressings or temporary wound covering. Depending on the size and clinical course of the wound, it may be performed in stages, where part of the burn wound is excised initially and the remainder is removed in one or more subsequent operations. **

Debridement vs. Excision

It is important to distinguish burn wound *debridement* from burn wound *excision*. Each is a distinctly different procedure based on the technique used by the burn surgeon.

Debridement is the removal of loose, devitalized, necrotic and/or contaminated tissue, foreign bodies, and other debris on the wound, using mechanical or sharp techniques.

In contrast, burn wound excision is a surgical procedure that is usually performed to prepare the wound for immediate or later grafting. It is frequently performed in stages, where part of the burn wound is excised initially and the remainder is removed in one or more subsequent operations. The excisional technique may vary but is typically performed in one of two ways: tangential excision usually performed on deep partial thickness burns, and full thickness excision. Tangential excision involves a specific surgical technique in which successive layers of burn wound are removed down to viable dermis. Full thickness excision involves removal of the burn wound down to viable subcutaneous tissue or to fascia. Either process results in a large open area, i.e., *defect*, that must be covered.¹³

Coding for burn wound debridement or burn wound excision must be based on documentation in the medical or operative record. If burn wound debridement is documented, the applicable code from 16020-16030 should be assigned. If burn wound excision is documented, the applicable code(s) from 15002-15005 should be assigned.

Coding is not based on the instrument used for the procedure because a scalpel, knives, or other instruments (e.g., Versajet) may be used to accomplish, alone or in combination, either burn wound excision or debridement.

Example, Burn Wound: Electrical burns may be initially excised followed by subsequent staged excisions to remove the additional, progressive necrosis (depth and width) that is characteristic of conversion of electrical burns.

¹³ Gillespie, R.W., Burn Surgery Tab 10, 1–12: CPT 1999 Coding Symposium. Chicago: American Medical Association, 1999.

Non-burn wounds, such as those involved in necrotizing fasciitis, may be excised using the same techniques as those described above for burn wounds.

****Note:** The CPT 2018 statement in the introduction to Skin Replacement Surgery and Skin Substitutes, “Use 15002-15005 for initial wound recipient site preparation,” is inconsistent with the fact that these codes may be used for subsequent procedures. It may be deleted in a future edition of CPT.

Overview

Codes 15002–15005 can be used to report excision of an open wound, burn eschar, or scar, or for incisional release of scar contracture. **The codes are reported based on the measurement of the surface area of the excised wounds located in the anatomic site(s) stated in the codes.**

Measurement of surface area is based on the size of the remaining defect or open wound(s). The unit of measurement used for measurement and reporting depends on the patient’s age: square centimeters (cm²) are used for persons 10 and older, while percent of body surface area is used for children under 10.

- | | |
|--------------|---|
| 15002 | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or 1% of body area of infants and children |
| 15003 | each additional 100 sq cm, or part thereof, or each additional 1% of body area of infants and children (List separately in addition to code for primary procedure) |
| 15004 | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or 1% of body area of infants and children |
| 15005 | each additional 100 sq cm, or part thereof, or each additional 1% of body area of |

infants and children (List separately in addition to code for primary procedure)

See Contracture Release/ Scar Revision section for coding guidelines for incisional and excisional release of scar contracture.

See Skin Replacement Surgery and Skin Substitutes for coding guidelines for skin grafts, replacements, and skin substitutes.

Reporting Guidelines

KEY POINTS

Document total area excised, by anatomic site, in sq cm for adults and children age 10 and over.

Document total area excised, by anatomic site, in percent total body surface area for children under 10 years of age.

- Codes 15002 and 15004 are used for excision of an area *up to and including* the first 100 sq cm in adults or 1% of surface area in infants and children. Thus, the codes can be used for wound excisions smaller than the areas listed in the code.
- Code 15003 is an add-on code and can only be used with code 15002 when both are provided at the same encounter. Code 15003 may be reported when the service described in 15003 is provided at the same encounter and documented accordingly.
- Code 15005 is an add-on code and can only be used with code 15004 when both are provided at the same encounter. Code 15005 may be reported when the service described in 15005 is provided at the same encounter and documented accordingly.
- Codes 15003 and 15005 are used for excision of additional wound area after the first 100 sq cm or 1% of surface area in infants and children has been removed *during the same operation*. These codes can be used to report *up to and including* each additional increment of 100 sq cm or 1% in infants and children. They cannot be reported alone and can only be reported when their primary codes, 15002 or 15004 respectively, are also reported for work performed at the same time. Codes 15003 and 15005 are **add-on codes and should not be reported with modifier 51 (Multiple Procedures)**. See example below.
- When excision is performed to prepare or create the recipient site, ***application of dressings or materials that are not described in codes 15040-15278 is not separately reportable***. Report code(s) 15002-15003

and/or 15004-15005 only, as appropriate. Examples of materials or dressings that are not separately reportable include but are not limited to Biobrane®, Xeroform®, Adaptic® and EXU-DRY®. **Example:** Excision of 450 sq cm burn wound on the back with application of dressing

15002	Tangential excision of first 100 sq cm	1 unit
15003	Tangential excision of each additional 100 sq cm, or part thereof, (Additional 350 sq cm after the first 100 sq cm = 4 units) Application of dressing is included and is not reported separately.	4 units

KEY POINTS

Document graft by type of graft, anatomic location, and total area of recipient site covered with graft.

In graft codes that specify 100 sq cm or one percent of body area of infants and children, use sq cm for adults and children 10 and over. Use percent total body surface area for children under 10.

- When excision is followed by immediate skin grafting, both the excision and appropriate skin graft procedure are reported.

Example: Excision of burn wound of chest with application of 450 sq cm split thickness skin grafts

15100	Split-thickness autograft, trunk, first 100 sq cm	1 unit
15101	Split-thickness autograft, trunk, each additional 100 sq cm	4 units
15002–51	Tangential excision of first 100 sq cm	1 unit
15003	Tangential excision of each additional 100 sq cm	4 units

- Modifier 51 (Multiple Procedures) is optional for Medicare. Other payers may require it. Modifier 51 is added to code 15002 in the above example because its relative value in the Medicare Physician Fee Schedule is lower than that for the skin graft. Modifier 51 would be added to either 15002 or 15100, whichever is the lesser-valued procedure according to the specific payer’s valuation.
- When wound excision is performed in stages, with each stage performed at a different operative encounter, each stage may be reported as performed. For example, wound excision performed on 3 separate dates would be reported with the appropriate code(s) for the excision performed on each date. Medicare and other payers assign “0” postoperative follow-up days to codes 15002 and 15004, hence **it is not necessary** to report the second and subsequent excisions/stages with modifier 58 (Staged Procedure) **unless a previous global surgery period is**

already in place. Then the modifier should be used to bypass Medicare or other payer global surgery denial edits.

- When excision is followed by immediate primary wound closure, do not report closure separately. Report the excision procedure only, using the applicable excision code(s) 15002-15003 and/or 15004-15005.
- Medicare does not allow an Assistant Surgeon for wound excision unless the claim is submitted with documentation supporting medical necessity.

Documentation Tips for Excision

Include the following in each operative report for wound excision:

- Total area of excision at the same operative session for **each** anatomic site, stated in square centimeters or percent of surface area, depending on patient age.

Documenting this measurement permits accurate code selection and reporting, and validates the information ultimately submitted on the claim.

- Alternatively, the total area of excision for each code family can be documented. For example, if excisions are performed on the chest and arms, the combined total area excised for both sites may be documented because these anatomic sites are listed in codes 15002-15003. Or, if excisions are performed on the face, neck, and hands, the combined total area excised for all three sites may be documented because these anatomic sites are listed in codes 15004-15005.
- Staged Excision: When staged excisions are anticipated, it may be helpful to document that fact in the operative report for the initial wound excision procedure. *For example:* “Patient has extensive burns of...This is the first in a series of staged procedures...” or, for a diabetic patient, “This is the first in a series of complicated wound excisions made necessary because of the patient’s diabetic condition and increased risk of complications.” Then, at subsequent excisions, reiterate any anticipated further stages and name the stage of the current operation.

Fasciotomy

Fourth degree burns involve organs beneath the skin, such as muscle and bone. Electrical burns to the extremities may also involve those structures. To relieve vascular compromise due to constriction caused by these burns, one or more fasciotomies may be performed. Fasciotomy for a burn is much deeper than an escharotomy. The incision extends through the fascia that covers muscle and, in some cases, through the muscle to bone. Often, it also requires debridement of muscle and/or bone.

Reporting Guidelines

- The applicable fasciotomy code is reported for each anatomic site. Refer to the Fasciotomy Code Table below.
- When there is no fasciotomy code available for the anatomic site (*e.g.*, upper arm), an unlisted procedure code may be used to report it. In the latter case, a copy of the operative report must be submitted with the claim in the absence of payer instructions to the contrary.
- When further muscle tissue must be excised on subsequent days to treat continued necrosis of muscle within the wound, it can be reported as performed, subject to payer guidelines. Report the appropriate excision code(s) (15002–15005). Refer to the Excision of Burn Wound section for additional information.

Closure of Fasciotomy

- When a delayed or secondary closure of the fasciotomy is performed on a subsequent date, it may be reported separately if no other surgical procedure, such as wound excision (15002-15005), is performed on the fasciotomy site at the same time as the closure. That is, the fasciotomy closure is the only procedure performed on the fasciotomy site at the operative encounter.
- The following codes are available for reporting the closure: Repair (Closure) of wounds, 12001-13153. Assign the appropriate code for simple, intermediate or complex closure based on the information documented in the patient record and the guidelines in CPT under the heading “Repair (Closure).”

If secondary closure is extensive or complicated, refer to code 13160.

If the closure is performed during the postoperative period of the fasciotomy and no other global period is in place, modifier 58 may be appended to the applicable repair code.

- If the closure is performed during the postoperative period of both the fasciotomy and another global surgery procedure, more than one of the postoperative modifiers may be required (e.g. 58, 79) when submitting the applicable repair code.

FASCIOTOMY CODE TABLE

Note: Some of the listed fasciotomy codes may not be used by burn surgeons but are included here for complete reference.

ANATOMIC LOCATION		CODE AND DESCRIPTION
Elbow	24357	Tenotomy, elbow, lateral or medial; percutaneous [replaces Fasciotomy, lateral or medial] (See other indented codes below 24357 also.)
Arm, lower	24495	Decompression fasciotomy, forearm, with brachial artery exploration
Arm, lower Wrist	25020	Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; without debridement of nonviable muscle and/or nerve
Arm, lower Wrist	25023	Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; with debridement of nonviable muscle and/or nerve
Arm, lower Wrist	25024	Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; without debridement of nonviable muscle and/or nerve
Arm, lower Wrist	25025	Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve
Hand	26037	Decompressive fasciotomy, hand (excludes 26035)
Palm	26040	Fasciotomy, palmar (e.g., Dupuytren's contracture); percutaneous
Palm	26045	Fasciotomy, palmar (e.g., Dupuytren's contracture); open, partial
Hip Thigh	27025	Fasciotomy, hip or thigh, any type
Thigh Knee	27496	Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor);
	27497	Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor); with debridement of nonviable muscle and/or nerve
	27498	Decompression fasciotomy, thigh and/or knee, multiple compartments;
	27499	Decompression fasciotomy, thigh and/or knee, multiple compartments; with debridement of nonviable muscle and/or nerve
Leg, lower	27600	Decompression fasciotomy, leg; anterior and/or lateral compartments only
	27601	Decompression fasciotomy, leg; posterior compartment(s) only

	27602	Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s)
Leg, lower	27892	Decompression fasciotomy, leg; anterior and/or lateral compartments only, with debridement of nonviable muscle and/or nerve
	27893	Decompression fasciotomy, leg; posterior compartment(s) only, with debridement of nonviable muscle and/or nerve
	27894	Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s), with debridement of nonviable muscle and/or nerve
Foot Toe	28008	Fasciotomy, foot and/or toe

GI Tubes

Feeding Tubes

A feeding tube is inserted to give nourishment to patients who are unable to eat or to provide supplemental feedings to patients who have very high nutritional requirements. The flexible tube is typically placed in the nose and advanced into the stomach or duodenum, the first portion of the small intestine. Or it may be inserted via the mouth in certain patients. In burn patients, feeding tubes are typically advanced to the duodenum.

Reporting Guidelines

Feeding tube insertion may be reported using one of the following codes *according to the guidelines listed below*:

- 43752** Naso- or oro-gastric tube placement, requiring physician’s skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)
or
- 44500** Introduction of long gastrointestinal tube (*e.g.*, Miller- Abbott)
- 43761** Repositioning of a naso- or oro-gastric feeding tube, through the duodenum for enteric nutrition

Feeding tubes may be inserted with or without imaging/fluoroscopic guidance. Special guidelines apply for reporting these services.

Naso- or oro-gastric tube insertion:

- When a naso- or oro-gastric tube is inserted using fluoroscopic guidance, it may be reported using code 43752. Documentation must include a permanent record of the images obtained during the procedure and a written report of the procedure. Fluoroscopic guidance is an

inherent part of code 43752; therefore, the radiologic service (e.g., 76000) is not separately reportable

- If the naso- or oro-gastric tube is inserted *without fluoroscopic guidance, it is not reportable.* (Source: AMA, *CPT Changes 2004*, p.72. “Naso- or oro-gastric tube placement in the absence of radiological guidance is not a separately reportable service.”)
- When a naso- or oro-gastric tube is repositioned (43761), it involves initial placement into the stomach. The patient is rotated to the right to allow it to fall into the duodenum by gravity. The process may take several days and include imaging at multiple times to determine placement and position. Other methods may be used to reposition the tube. For example, a tube with a magnet at the tip may be inserted and maneuvered into the duodenum by moving a magnet over the patient’s abdomen.

Gastrointestinal or enteric tube placement

- When a long gastrointestinal/enteric tube is inserted, it may be reported using code 44500.
- When the tube insertion is performed with fluoroscopic/radiologic imaging, both services may be reported. A record of the images and a written report are required.

Example:

- 44500** Introduction of long gastrointestinal tube (e.g., Miller- Abbott)
- 74340** Introduction of long gastrointestinal tube (e.g., Miller- Abbott), including multiple fluoroscopies and films, radiological supervision and interpretation

Gastrostomy/Jejunostomy Tube Placement

A tube gastrostomy or jejunostomy may be performed to provide a route for administration of nutrient solutions and/or medications and for other reasons. In a gastrostomy procedure, a tube is inserted into the stomach. A jejunostomy involves insertion of a tube into the jejunum, the second portion of the small intestine.

Gastrostomy Tube Placement

Gastrostomy tube placement may be accomplished using any one of several methods. It may be inserted via the percutaneous, endoscopic, laparoscopic or open methods. The following describes coding and reporting guidelines for each insertion method.

- **Percutaneous Method**

Reporting Guidelines

- Percutaneous insertion of a gastrostomy tube is coded

49440 Insertion of gastrostomy tube, under fluoroscopic guidance including contrast injection(s), image documentation and report

- Radiologic guidance for the insertion procedure is included in code 49440 and is not separately reportable.
- For change of gastrostomy tube, use code 43760.

For subsequent *replacement in a different percutaneous access site*, report 49440.

For subsequent percutaneous *replacement in the same site*, report 49450.

For percutaneous *change* of a gastrostomy tube *without* imaging or endoscopic guidance, use 43760 Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance.

- **Endoscopic Method (PEG)**

Percutaneous endoscopic gastrostomy (PEG) is usually performed using a flexible endoscope inserted into the stomach via the mouth. With the endoscope in the stomach, one end of a long suture is inserted through a small incision into the stomach. The suture is grasped by a snare that has been passed through the endoscope and pulled out along with the endoscope. That end of the suture is tied to the external end of a gastrostomy tube. The opposite end of the suture at the incision is pulled out, carrying the gastrostomy tube with it. When a sufficient portion of the gastrostomy tube exits the incision, the endoscope is reinserted to assess its position. If position is satisfactory, the gastrostomy tube is sutured to the external skin and the endoscope removed. The procedure may be performed under radiologic guidance.

Reporting Guidelines

- Use code 43246 for endoscopic insertion of a gastrostomy tube.

- **Laparoscopic Method**

The gastrostomy tube may be inserted in various ways during abdominal laparoscopy, but the essential method utilizes laparoscopic visualization and instruments to insert and secure the gastrostomy tube in place.

Code this procedure using code 43653 (Laparoscopy, surgical, gastrostomy, without construction of gastric tube).

- **Open Method**

The gastrostomy tube is inserted through an incision in the abdominal wall. Once inserted, the tube is sutured in place.

This procedure is reported using one of two codes, based on the age of the patient.

43830 Gastrostomy, open; without construction of gastric tube

43831 neonatal, for feeding

Jejunostomy Tube Placement

Jejunostomy tube placement may be accomplished using any one of several methods. It may be inserted percutaneously, intraoperatively during another intraabdominal procedure, laparoscopically, or via a separate, open procedure.

- Percutaneous

Percutaneous insertion of a jejunostomy tube is coded

49441 Insertion of duodenostomy or jejunostomy tube, percutaneous, under fluoroscopic guidance including contrast injection(s), image documentation and report

Radiologic guidance is not separately reportable.

For subsequent *replacement in a different percutaneous access site*, report 49441.

For subsequent *replacement in the same site*, report 49451.

- **Intraoperative Method**

This procedure is reported only when it is performed in conjunction with another, usually more major, intraabdominal procedure. It is reported with the following code. Note this code is an add-on code; modifier 51 (Multiple procedures) is not to be added to it.

44015 Tube or needle catheter jejunostomy for enteral alimentation, intraoperative, any method (List separately in addition to primary procedure)

- **Open Method**

The jejunostomy tube is inserted through an incision in the abdominal wall. Once inserted, the tube is sutured in place. It is reported using code

44300 Placement, enterostomy or cecostomy, tube open (*e.g.*, for feeding or decompression)

- **Laparoscopic Method**

The jejunostomy tube may be inserted in various ways during abdominal laparoscopy, but the essential method utilizes laparoscopic visualization and instruments to insert and secure the jejunostomy tube in place.

Code this procedure using code

44186 Laparoscopy, surgical; jejunostomy, (*e.g.*, for decompression or feeding).

Skin Replacement Surgery and Skin Substitutes—Grafts

Grafts (15100–15278)

Grafts are distinguished by their origin and, for autografts, by their anatomic source. Graft codes are arrayed in CPT accordingly.

Origin

- Autograft: tissue transplanted from one part of the body to another in the same individual
- Allograft (homograft): tissue transplanted from one individual to another of the same species
- Xenograft (heterograft): tissue transplanted from one species to an unlike species (*e.g.*, pig to human)

Autografts: Anatomic Source

- Epidermal grafts
- Dermal grafts
- Split-thickness skin grafts
- Full-thickness skin grafts

Additional Key Definitions

- Skin Replacement: a tissue or graft that permanently replaces lost skin with healthy skin
- Skin Substitute: a biomaterial, engineered tissue or combination of materials and cells or tissues that can be

substituted for skin autograft or allograft in a clinical procedure

- Temporary wound cover: a resurfacing material that provides coverage of the wound until the skin surface can be permanently replaced

The following table provides a partial listing of graft code ranges under the CPT subheading “Skin Replacement Surgery and Skin Substitutes.” Refer to CPT for a complete list of these codes.

Refer to this table for brief definitions and, where applicable, examples of products described by each type of graft within the given code ranges.

Table of Skin Replacements and Skin Substitutes

CODE RANGE	TYPE OF GRAFT	DEFINITION (AND PRODUCT SAMPLES)
15100-15101, 15120-15121	Split-thickness skin graft	Autologous skin graft
15110-15116	Epidermal autograft	Autologous skin graft
15130-15136	Dermal autograft	Autologous skin graft
15150-15157	Tissue Cultured Epidermal Autograft	Cultured autologous skin with only an epidermal layer (e.g., CEA, Epicel [®] , EpiDex [®])
15200-15261	Full Thickness Graft, Free	Autologous skin graft
15271-15278	Skin Substitute Grafts	Non-autologous human skin grafts, Non-human skin substitute grafts, and biological products that form a

KEY POINTS

Document graft by type of graft, anatomic location, and total area of recipient site covered with graft.

In graft codes that specify 100 sq cm or one percent of body area of infants and children, use sq cm for adults and children 10 and over. Use percent total body surface area for children under 10.

Reporting Guidelines

Clinical examples for using these graft codes correspond to the reporting guidelines for them.

Utilized to cover and/or close open wounds, grafts are coded according to specific rules.

- Grafts are identified by a) size and anatomic location of the defect or *recipient* site and b) type of graft applied.

For example, a 100 sq cm split-thickness autograft from the thigh applied to cover that same area of recipient site on the trunk would be coded 15100 because the recipient site location and size is specified in code 15100. Or, a split-thickness autograft applied to 80 sq cm total area on both hands and two fingers would be coded 15120 because the size and recipient sites are identified in code 15120.

- The foregoing rule applies whether or not a graft is meshed. For example, a 100 sq cm split thickness skin graft taken from the thigh, meshed 2:1 and placed on a 200 sq cm recipient site on the chest would be reported using the appropriate codes for

split thickness skin graft placed on 200 sq cm of recipient site on the trunk:

15100 Split-thickness autograft (first 100 sq cm) (1 unit)

15101 Split-thickness autograft (next 100 sq cm) (1 unit)

KEY POINTS

Application of dressings such as Biobrane, Xeroform, Adaptic, EXU-DRY®, etc. is not separately reportable.

- Report procedures by the size and location of the **recipient site. Do not code by the size of the graft.**
- When the *donor* site requires repair after harvest of the graft, the repair procedure for the donor site (*e.g.*, skin graft, advancement flap, etc.) may be coded and reported in addition.
- When excision (15002-15005) is performed to prepare or create the recipient site, **application of dressings or materials that are not described in codes 15040-15431 is not separately reportable and is included in code(s) 15002-15005.** Report code(s) 15002-15005 only, as appropriate. This means that application of dressings such as Biobrane®, Xeroform®, Adaptic®, EXU-DRY®, etc. are not separately reportable.
- In addition, CPT indicates that graft codes 15100-15278 are intended to be reported for application of skin substitutes/grafts using fixation such as sutures, staples, fibrin “glue” (*e.g.*, ARTISS Fibrin Sealant) and so on. Application of these materials without such fixation and using stabilization with dressings alone is not separately reportable.

CPT guidelines state: “These codes are not intended to be reported for simple graft application alone or application stabilized with dressings (*e.g.*, by simple gauze wrap). The skin substitute/graft is anchored using the surgeon’s choice of fixation.”

- **Simple debridement or scraping of granulation tissue or recent avulsions is included and not reported separately.**
- **Excision of granulation tissue for preparation of the recipient site is separately reportable. See codes 15002-15005.** (Do not use code 15002-15005 for simple *scraping* of granulation tissue.)

Example: Excision of 450 sq cm burn wound of the arm with application of a dressing material that is not surgically fixed to the wound and is not one of the materials named in 15100-15431. Three days later, split thickness skin graft is applied to the wound.

15002-51 Tangential excision of first 100 sq cm
1 unit

15003 Tangential excision of each additional
100 sq cm (Additional 350 sq cm after

the first 100 sq cm) 4 units

15100 Split-thickness autograft (first 100 sq cm) 1 unit

15101 Split-thickness autograft (each additional 100 sq cm) 4 units

- The foregoing guidelines apply whether the graft is applied immediately after wound excision or at a later date.
- When graft services are provided in the office setting and the skin substitute/graft material is provided by the physician, the supply of the material is separately reportable using the applicable HCPCS Level II code or the all-purpose CPT supply code 99070, whichever is required by the payer.
- ***Routine dressing supplies are not reported separately.***
- Codes for certain grafts utilize two different units of measurement for the recipient site: Square centimeters (sq cm) and percent of body surface. Where the codes specify “100 sq cm or one percent of body area of infants and children,” square centimeters are used for persons 10 and older while percent of body surface is used for children under 10.
- Where a code specifies a number of square centimeters, it refers to 1 sq cm *up to the stated amount*. Add-on codes begin with the next sq cm. Example: 140 sq cm would be coded using a code for the first 100 sq cm and an add-on code for the next 40 sq cm.

Each type of graft is described below and an explanation provided when different or additional coding guidelines apply.

Refer to the Table of Skin Replacements and Skin Substitutes in the introduction to this section for a description of product characteristics and common trade names applicable to each code category explained below.

Autograft/Tissue Cultured Autograft (15040-15157)

This category of codes includes split-thickness, epidermal, dermal, and tissue cultured autografts and other autografts.

For the full text of each CPT code, please refer to Appendix VII, Medicare Physician Fee Schedule.

Split-thickness Autograft

- Split-thickness autografts applied to the anatomic sites named in each primary code are reported using codes 15100-15101

and 15120-15121, as appropriate. Codes 15100 and 15120 are primary codes, while 15101 and 15121 are their respective add-on codes. The add-on codes can never be reported alone. They can only be reported when their primary code is also reported on the same date of service.

Epidermal Autograft

- Epidermal autografts applied to the anatomic sites named in each primary code are reported using codes 15110-15116, as appropriate. Codes 15110 and 15120 are primary codes. Codes 15111 and 15116 are their respective add-on codes and can never be reported alone. They can only be reported when their primary code is also reported on the same date of service.

Dermal Autograft

- Dermal autografts applied to the anatomic sites named in each primary code are reported using codes 15130-15136, as appropriate. Codes 15130 and 15135 are primary codes. Codes 15131 and 15136 are their respective add-on codes and can never be reported alone. They can only be reported when their primary code is also reported on the same date of service.

Tissue Cultured Epidermal Autograft

These grafts are composed of cultured skin cells taken from the patient and then grown over a period of weeks to form sheets of graft material. For example, CEA (cultured epidermal autograft).

- When skin is harvested or obtained for development of tissue cultured skin autograft, use code 15040. This code specifies harvest of skin in the amount of 100 sq cm or less.
- Tissue cultured epidermal autograft procedures (15150-15157) are performed when culture of the harvested skin is complete and the resulting autograft is ready to be applied. Tissue cultured epidermal autografts applied to the anatomic sites named in each primary code are reported using codes 15150-15157, as appropriate. Codes 15150 and 15155 are primary codes. Codes 15151-15152 and 15156-15157 are their respective add-on codes and can only be reported when their respective primary code is reported on the same date of service.
- Two code families are used to report the procedures, 15150-15152 and 15155-15157. Three codes in each family provide incremental units, listed below, for reporting the procedures.

First 25 sq cm or less

Additional 1 sq cm to 75 sq cm (add-on)

Each additional 100 sq cm (add-on)

Coding guidelines follow:

- Code 15150 is used to report the first 25 sq cm or less applied to the trunk, arms, and legs. Code 15151 is used to report the next 1 sq cm to 75 sq cm applied. For each additional 100 sq cm or 1% of body area of infants and children (or part thereof) applied thereafter, use code 15152.
- Code 15155 is used to report the first 25 sq cm or less applied to the named list of anatomic sites in the code descriptor. Code 15156 is used to report the next 1 sq cm to 75 sq cm applied. For each additional 100 sq cm or 1% of body area of infants and children (or part thereof) applied thereafter, use code 15157.
- Codes 15151 and 15156 cannot be reported more than once per operative session. Hence, the units reported for these codes will always be “1”.

Free Full Thickness Graft (15200-15261)

For the full text of each CPT code, please refer to Appendix VII, Medicare Physician Fee Schedule.

- Codes for full thickness skin grafts specify square centimeters only, using 20 sq cm increments as units of measurement. Therefore, the units of measurement in these codes apply to patients of all ages.
- All codes in this category include direct closure of the donor site, which is not to be reported separately. Full thickness grafts applied to the anatomic sites named in each primary code are reported using codes 15200-15261, as appropriate. Codes 15200, 15220, 15240, and 15260 are primary codes. Codes 15201, 15221, 15241 and 15261 are their respective add-on codes and can never be reported alone. They can only be reported when their companion primary code is also reported on the same date of service.

Operative Report Documentation for Grafts

The operative report should include the following facts for accurate, complete coding and reporting.

- Anatomic location of the recipient site(s)
- Type of graft
- Total surface area of each recipient site.
 - For codes/procedures that name anatomic sites, document the total surface area for **each** site. This information is necessary because the total area for all sites that fall under each code will be summed together for reporting purposes.
 - Once the anatomic locations in each code are committed to memory, the total surface area for all sites within a given code can be specified quickly.

Example 1.0:

A burn surgeon grafts the torso, right arm and left leg. Split thickness autograft is applied. Documentation correctly lists the total surface area of each recipient site grafted.

Torso:	700 sq cm
R arm:	500 sq cm
L leg:	300 sq cm

Because all anatomic sites grafted are listed in a single code family, 15100-15101, the total surface area of the recipient sites, 1500 sq cm, is reported using these codes.

15100 Split-thickness autograft, first 100 sq cm or less
Units: 1

15101 Split-thickness autograft, each additional 100 sq cm
Units: 14

Example 2.0

A burn surgeon grafts the torso, right arm and left leg. Split thickness autograft is applied. Documentation correctly lists the total surface area of each recipient site grafted.

Torso:	700 sq cm
R arm:	500 sq cm
R hand:	150 sq cm

The total surface area of recipient sites grafted is 1500 sq cm. **However, two of the anatomic sites are listed in one code category (torso, right arm) while the third site (right hand) is listed in another code category. The total surface area of the recipient sites on the torso and right arm is 1200 sq cm.**

Total surface area of the right hand recipient site is 150 sq cm.

Coding is as follows:

For torso and right arm, 1200 sq cm.

15100 Split-thickness autograft, first 100 sq cm or less
Units: 1

15101 Split-thickness autograft, each additional 100 sq cm
Units: 11

For right hand, 150 sq cm.

15120-51 Split-thickness autograft, first 100 sq cm or less
Units: 1

15121 Split-thickness autograft, each additional 100 sq cm
Units: 1

Note: Code 15100 is the major procedure in this example because its relative value is higher than that for 15120. Therefore, modifier 51 is added to code 15120, indicating it is a secondary procedure. Reimbursement will be reduced for 15120 because of this fact. The procedures shown above are ranked on the claim accordingly, with the major procedure listed first and secondary listed next. For details of reporting modifier 51 and ranking procedures on the claim and for payment, refer to Appendix IV, Modifiers.

Clinical Case Examples: Cellular and Tissue Based Products

Example 1.0

A 10-year-old boy was rescued from a burning building and assessed to have 80% total body surface area (TBSA) burns. Following initial stabilization at the local emergency room, he was transferred to the regional burn center for definitive management. Once hemodynamically stable, he was taken to the operating room for excision of his extensive full-thickness burns and wound coverage with cadaveric allograft and acellular dermal replacement. In addition, due to the extent of the burns and lack of sufficient donor sites, he had a split-thickness skin graft 0.012” in depth harvested for preparation of cultured autologous skin grafts that will be applied in 3-4 weeks (when available).

Procedure	CPT Codes
Application of skin substitute to bilateral hands (350 cm ²)	15277 x 1
Application of skin substitute to anterior torso (1000 cm ²)	15278 x 3 15273-51- x 1 15274 x 9
Harvest of skin for tissue-cultured skin autograft (50 cm ²)	15040-51
Surgical preparation or creation of recipient site by excision of open wounds, burn eschar ... (350 cm ² – hand) (1000 cm ² – torso)	1500X-51 x 1 1500X x 13* *Units assume all anatomic sites excised are in the same code family, e.g., 15002-15003 OR 15004-15005.

Example 1.1

It is now 4 weeks since the 10-year-old boy underwent his initial operative procedures. His donor sites are now healed, the acellular dermal replacement has vascularized, and an initial set of tissue cultured epidermal autografts are now available for application to the wounds. He is returned to the operating room for harvesting and application of epidermal autografts 0.006” in depth and application of multiple 25 cm² tissue cultured epidermal autografts.

Procedure	CPT Codes
Epidermal autograft, bilateral feet (300 cm ²)	15115 15116 x 2
Epidermal autograft, bilateral arms & legs (500 cm ²)	15110-51 15111 x 4
Tissue cultured epidermal autograft, bilateral hands (350 cm ²)	15155-51 15156 x 1, 15157 x 3
Tissue cultured epidermal autograft, anterior torso (1000 cm ²)	15150-51 15151 x 1, 15152 x 9

Example 2.0

A 62-year-old man has recurrent metastatic cancer of his left popliteal fossa. He has previously had radiation therapy to this area and undergoes surgical exploration. At operation, he is noted to have radiation injury to the popliteal artery. To protect the exposed vessel, a split-thickness skin graft is harvested but not removed from the underlying wound bed using a dermatome. A 2nd pass of the dermatome at 0.010” is made for the recovery of a dermal graft that measures 150 cm². The originally raised split-thickness skin graft is then reapplied to the wound bed, anchored with surgical staples and a dressing applied. The dermal graft is then sewn in place over the exposed popliteal artery using absorbable sutures and the wound is closed in layers utilizing non-absorbable sutures.

Procedure	CPT Codes
Dermal autograft, leg (150 cm ²)	15130 15131 x 1
<i>If the same procedure had been performed to cover the carotid artery:</i> Dermal autograft, neck (150 cm ²)	15135 15136 x 1

Example 3.0

A 20-year-old with a history of having been treated for extensive third degree burns presents with contractures of the axilla and hand. Because the patient has limited skin graft donor sites with little remaining dermal tissue due to multiple previous harvests, acellular dermal allograft is sutured into the skin defects created by the incisional release of the contractures. The acellular dermal allograft is then covered with a thin split-thickness skin autograft in order to prevent scarring and recurrence of the contracture. The axillary defect measures 250 cm² and the hand defect measures 125 cm².

Procedure	CPT Codes
Split-thickness skin autograft, hand (125 cm ²) Split-thickness skin autograft, axilla (250 cm ²)	15120 15121 x 1 15100-51 x 1
Application of skin substitute, hand (125 cm ²)	15277-51 x 1 15278 x 1
Application of skin substitute, axilla (250 cm ²)	15273-51 x 1 15274 x 2
Incisional release of scar contractures of hand and axilla (125 cm ² hand & axilla 250 cm ²)	15002-51 x 1 15003 x 2 15004 x 1

Example 4.0

A 68-year-old male with type II diabetes presents with an 8 x 10 non-infected, full-thickness venous stasis ulcer of the lower leg and ankle.

The wound is debrided and, after obtaining adequate hemostasis, 150 cm² of tissue cultured allogeneic skin substitute is grafted to the excised surface and secured with interrupted sutures.

skin substitute applied to leg (80 cm ²)	15271 x 1 15272 x 3
--	------------------------

Debridement or excision is not reported separately for these particular codes.

- Debridement of subcutaneous tissue (11042,11045) is typically considered inclusive in the application of skin substitute procedure and not separately reportable
- Surgical Preparation codes (15002-15003) are not for use in chronic wounds that have previously been debrided

Intraosseous Needle Placement for Infusion

Intraosseous needle placement is performed to permit infusion of fluids, medications or whole blood directly into the bone marrow. Often performed in infants and children, it is used in situations where access and infusion into a vein is not possible or would be quite difficult.

The needle may be placed in one of several sites (*e.g.*, anterior tibia [lower leg] or iliac crest). Using a special needle for that purpose, the physician inserts the needle through the skin and into the bone until it penetrates the bone marrow.

Reporting Guidelines

- Code 36680 (Placement of Needle for Intraosseous Infusion) is used to report this procedure. It may be reported as performed.
- Medicare assigns “0” postoperative follow-up days to this minor procedure.

K-wire Insertion

K-wires (Kirschner wires) are rigid metal wires available in varying thicknesses that are inserted across bone joints, bone fragments and other bony structures to hold them in a fixed position.

Application in Burn Surgery

During the acute phase of burn treatment, K-wires are typically inserted to immobilize one or more joints of the hand, fingers, foot, or toes to achieve the following:

- To limit motion, act as a splint and provide protection for a joint prior to skin grafting when the joint or tendons are exposed.
- To immobilize a joint in correct position after skin grafting until such time as it has become sufficiently attached to permit range of motion exercises.
- To prevent contractures that might develop if the body part is not maintained in correct position.

During the reconstructive phase of treatment, K-wires may be used in reconstructive surgery (*e.g.*, contracture release) to maintain the joint in proper alignment during the healing process.

Reporting Guidelines

K-wire insertion is reported using code

20650 Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)

- K-wire insertion is not included in acute burn therapeutic procedures, such as skin grafts and wound excision and may be reported separately and in addition.
- When performed alone, 20650 may be reported as performed.
- K-wire insertion is currently not included in reconstructive hand or finger surgery (26350–26596) according to Medicare’s National Correct Coding Policy Manual and edits. Therefore, it may be reported in addition to the appropriate hand surgery procedure performed at the same session. For foot and toe reconstructive surgery, check the payer’s guidelines and Medicare’s National Correct Coding Policy Manual before reporting 20650 separately.

Unbundling Caution: Because 20650 is designated a separate procedure, it may be reported when performed alone or when it is not an integral part of another, more major procedure.

Removal is included in the insertion procedure value; therefore, it is not separately reportable. K-wire insertion is *included* in a number of bone and joint procedures listed in the Musculoskeletal System subsection of CPT (2xxxx codes), generally in codes that state “with or without fixation.” Hence, K-wire insertion is not separately reportable with those codes.

Splints, Custom Construction in OR

Splints are devices used to support, stabilize alignment, and prevent deformity of body parts, usually extremities and/or their appendages. Splints can be made from a number of natural and synthetic materials. They may be prefabricated or manufactured in a fixed design or may be custom made for individual patients using one or a combination of a number of synthetic or other materials.

Reporting Guidelines

Distinguishing Between Routine Splint Application and Custom Splint Construction/Fabrication and Application for Burns

Routine Splint Application

- Routine splint application may be reported with the appropriate splint application code under Application of Casts and Strapping in the Musculoskeletal section of CPT, *unless the splint is applied for a fracture and/or dislocation in which case initial splint application is included in any CPT fracture care treatment code submitted on the claim.*
- Removal is included in the splint application procedure.

Custom Splint Construction/Fabrication and Application in OR

- Custom splint construction, fabrication and application in the OR is a separately reportable service **when and only when the physician personally prepares** and applies the custom splint for the patient.

- **Do not report custom splint construction by an Occupational or Physical Therapist. This service is not reportable.**

It is important to distinguish the “custom construction” aspect of the service from “application” of a prefabricated splint that is manufactured by an outside organization or laboratory. In the latter case, physician work is not extensive while custom construction implies extensive physician work and time to complete.

- Two coding options are available for reporting custom construction services.
 - (1) Select the appropriate CPT splint application code (*e.g.*, 29125—Application of Short Arm Splint; Static), and add modifier 22 (Increased Procedural Service). A copy of the operative report, including the splint construction and application procedure, must be submitted with the claim.

Or,

- (2) Report the unlisted code 29799 (Unlisted Procedure, Casting or Strapping) and submit a copy of the operative report, including the splint construction and application procedure, with the claim.

In either case, the claim will require manual review for payment.

- Professional judgment should be applied to each individual case to determine whether the service should be billed. If so, documentation of the service should clearly convey the steps, work and materials involved in the construction process.

For example, if a simple finger splint is fabricated and does not require significantly increased physician time and work, separate billing may not be appropriate for the minimal service.

Design and Fabrication of Oral or Maxillofacial Prostheses

When the burn surgeon personally designs and prepares (*i.e.*, not prepared by an outside laboratory) an oral or maxillofacial prosthesis, the appropriate code from 21076–21089 may be reported for the service.

Sub eschar Clysis

Overview

This procedure, which is performed infrequently, is used to treat invasive wound infections. A syringe is used to inject high dose antibiotics beneath the infected wound and into the subcutaneous fat or dermis.

Typically, multiple injections are required around the periphery of the wound during the session.

The procedure may be repeated every 12 hours on the same day.

Coding and Reporting

- CPT does not provide an appropriate unlisted code for this procedure as was the case prior to 2008). When sub eschar clysis involves injection into subcutaneous tissue, use the following code to report it.

96372 Therapeutic, prophylactic or diagnostic injection (specify substance or drug); subcutaneous or intramuscular

- 96372 is not a surgery code. It is a medical procedure.
- Code 96372 may be used to report sub eschar clysis **personally performed by the physician or when the procedure is performed under direct physician supervision. Otherwise, it is not separately reportable.**
- Dictate or write a descriptive procedure note or report in the patient's medical record. A copy of the procedure note must be sent in with the claim to explain the procedure performed and billed under the unlisted code.

- When 96372 is performed on multiple occasions on the same date, enter that number in the units field of the claim, on the same line as 96372. *For example*, assuming 96372 is performed 2 times in one day, then a “2” would be entered in the units field.

Swan Ganz

A Swan Ganz or pulmonary artery catheter is usually inserted to assess and monitor cardiac function in acutely or critically ill burn patients. Depending on its configuration, the catheter can be used to measure pulmonary artery pressure, pulmonary wedge pressure, cardiac output, and perform other functions.

The catheter is typically inserted by percutaneous introduction of a needle into a major vein, such as the subclavian, internal jugular, brachial, or femoral vein. A guidewire is passed through the needle, the needle is removed over the guidewire and then a sheath/dilator system is inserted over the guidewire to enlarge the opening in preparation for catheter insertion. The dilator and guidewire are removed, leaving the sheath behind. The catheter is inserted through the sheath, its external end(s) connected to a pressure measurement device and then advanced to the right heart under continuous pressure monitoring. The catheter is flow directed, advancing with the flow of venous blood from the right heart chambers into its usual terminal destination, the pulmonary artery.

The procedure may be performed at the bedside, in the cardiac catheterization lab or in another clinical setting.

Reporting Guidelines

- Swan Ganz catheter insertion is reported using code **93503** Insertion and placement of flow directed catheter (*e.g.*, Swan-Ganz) for monitoring purposes
- Removal is included in the insertion procedure.
- 93503 is not considered a surgical procedure. Therefore, there is no global surgical period assigned to it. Refer to Appendix VII for relative values assigned to this code.
- When other medical or surgical procedures are reported on the same date as 93503, **do not add** modifier 51 (*Multiple Procedures*) to code 93503. CPT designates it as a procedure that is exempt from modifier 51.

Tracheostomy

Tracheostomy is a surgical procedure in which an opening is created in the trachea (windpipe) via an incision in the skin over it. An indwelling tube is inserted into the trachea through the opening. The essential steps in the procedure are similar in each case, but can vary depending on whether the procedure is planned or emergent and whether an incisional or percutaneous method is used.

In some institutions, percutaneous dilatational tracheostomy is performed using a flexible bronchoscope for guidance purposes.

Burn patients with inhalation injury and/or other respiratory effects of burns may require tracheostomy to maintain an open airway, permit removal of tracheobronchial secretions, and provide access for mechanically-assisted ventilation. The procedure may be performed at the bedside or other clinical setting.

Reporting Guidelines

- Select the appropriate code from the range 31600–31610, 31612, or 31730 to report the procedure.

31600 Tracheostomy, planned (separate procedure)

31601 younger than two years

31603 Tracheostomy, emergency procedure;
trans tracheal

31605 cricothyroid membrane

31610 Tracheostomy, fenestration procedure with skin
flaps

31612 Tracheal puncture, percutaneous with
trans tracheal aspiration and/or
injection

31730 Trans tracheal (percutaneous) introduction of
needle wire dilator/stent or indwelling tube for
oxygen therapy

Note: Caution is advised when using code 31730 for Medicare claims because some carrier computer edits deny the procedure as non-covered, assuming it is being performed for home oxygen therapy.

- Medicare assigns “0” postoperative follow-up days to minor procedure codes 31600-31605, 31622, and 31730. “90” follow-up days are assigned to 31610, a major procedure.
- Report any accompanying E/M service with the appropriate modifier. (See modifiers under “Key Concepts” section and reporting guidance under the “Surgical Procedures” section for further details.)
- When tracheostomy is performed in conjunction with documented diagnostic and/or surgical bronchoscopy, both procedures may be reported.
- When a bronchoscope is used only for guidance to perform the tracheostomy, report the appropriate tracheostomy code instead. Currently, there is no CPT code to report the bronchoscopic-guided tracheostomy procedure.

Vacuum Assisted Wound Closure (VAC)

VAC involves application of a dressing (polyurethane foam) to the wound bed, which is sealed with an occlusive dressing. A tube is inserted into the foam and then its free end is attached to a negative pressure pump that removes fluid from the wound to promote healing by providing a clean environment and inhibiting infection. It may be used on chronic or acute wounds of all sizes as well as flaps and grafts.

Reporting Guidelines

Select the single appropriate code from either 97605 or 97606 to report VAC application.

97605	Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters
97606	total wound(s) surface area greater than 50 square centimeters

- The performing provider is required to have direct one-on-one contact with the patient for these procedures.
- Removal is included in these codes.
- When the VAC dressing is changed at subsequent intervals, it may be reported separately, as appropriate. For example, the VAC dressing may be changed 3 times per week. Each dressing change may be reported separately.

- **Note:** Medicare now allows separate payment for the professional service of VAC application. Refer to Appendix VII 2018 Medicare Physician Fee Schedule Relative Values for RVUs assigned to 97605 and 97606.

CPT Category III Codes-Fractional Ablative Lasers

Category III CPT codes are a temporary set of codes developed for emerging technologies, services, procedures, and service paradigms. These codes allow for data collection for services and procedures. The use of unlisted codes does not offer the opportunity to collect specific data. If a Category III code is available, the Category III code should be used instead of an unspecified Category I CPT code.

The inclusion of a service or procedure in this section does not constitute a finding of support, or lack thereof, with regard to clinical efficacy, safety, applicability to clinical practice, or payer coverage. The Category III codes do not conform to the normal requirements of a Category 1 CPT code established by the Editorial Panel as they may not be used yet in multiple locations by multiple professionals and that FDA approval has already been received.

Codes in this section may or may not eventually receive a Category 1 CPT code. In either case, in general, a given Category III code will be archived 5 years from the date of the initial publication or extension unless a modification of the archival date is specifically noted at the time a revision or change is made to the code. Services described by Category III codes which have been archived after 5 years without any conversion must be reported using the Category 1 Unlisted Code unless another specific cross reference is established at the time of archiving. These codes are released semi-annually.

CPT contains some Category III codes that may be used by Burn Surgeons. They are:

0479T Fractional ablative laser fenestration of burn and traumatic scars for functional improvement; first 100 sq cm or part thereof, or 1% of body surface area in infants and children

0480T each additional 100 sq cm, or each additional 1% of body surface area in infants and children, or part thereof (list separately in addition to code for primary procedure)

Please note: Use 0480T in conjunction with 0479T
Report 0479T, 0480T only once per day
Do not report 0479T, 0480T in conjunction with 0492T

These 2 codes sunset in January 2023.

HCPCS CODES FOR CELLULAR AND TISSUE BASED PRODUCTS

used in the physician’s office. These codes would be billed separately for Medicare contractor payment. Please be sure to utilize the correct number of units for the size product used in the case.

The table below shows the HCPCS codes for Skin Substitute

The following chart provides the HCPCS Q codes for all Cellular and Tissue Based Products. (CTP’s)

Q4100	Skin substitute, not otherwise specified
Q4101	Apligraf, per square centimeter
Q4102	Oasis wound matrix, per square centimeter
Q4103	Oasis burn matrix, per square centimeter
Q4104	Integra bilayer matrix wound dressing (bmwd), per square centimeter
Q4105	Integra dermal regeneration template (drt) or integra omnigraft dermal regeneration matrix, per square centimeter
Q4106	Dermagraft, per square centimeter
Q4107	Graftjacket, per square centimeter
Q4108	Integra matrix, per square centimeter
Q4110	Primatrix, per square centimeter
Q4111	Gammagraft, per square centimeter
Q4112	Cymetra, injectable, 1 cc
Q4113	Graftjacket xpress, injectable, 1 cc
Q4114	Integra flowable wound matrix, injectable, 1 cc
Q4115	Alloskin, per square centimeter
Q4116	Alloderm, per square centimeter
Q4117	Hyalomatrix, per square centimeter
Q4118	Matristem micromatrix, 1 mg
Q4119	Matristem wound matrix, per square centimeter
Q4120	Matristem burn matrix, per square centimeter
Q4121	Theraskin, per square centimeter
Q4122	Dermacell, per square centimeter
Q4123	Alloskin rt, per square centimeter
Q4124	Oasis ultra tri-layer wound matrix, per square centimeter
Q4125	Arthroflex, per square centimeter
Q4126	Memoderm, dermaspan, tranzgraft or integuply, per square centimeter
Q4127	Talymed, per square centimeter
Q4128	Flex hd, allopatch hd, or matrix hd, per square centimeter
Q4129	Unite biomatrix, per square centimeter
Q4130	Strattice tm, per square centimeter
Q4131	Epifix or epicord, per square centimeter
Q4132	Grafix core and grafixpl core, per square centimeter
Q4133	Grafix prime and grafixpl prime, per square centimeter
Q4134	Hmatrix, per square centimeter
Q4135	Mediskin, per square centimeter
Q4136	Ez-derm, per square centimeter
Q4137	Amnioexcel or biodexcel, per square centimeter
Q4138	Biodfence dryflex, per square centimeter
Q4139	Amniomatrix or biodmatrix, injectable, 1 cc
Q4140	Biodfence, per square centimeter

- Q4141 Alloskin ac, per square centimeter
- Q4142 Xcm biologic tissue matrix, per square centimeter
- Q4143 Repriza, per square centimeter
- Q4145 Epifix, injectable, 1 mg
- Q4146 Tensix, per square centimeter
- Q4147 Architect, architect px, or architect fx, extracellular matrix, per square centimeter
- Q4148 Neox cord 1k, neox cord rt, or clarix cord 1k, per square centimeter
- Q4149 Excellagen, 0.1 cc
- Q4150 Allowrap ds or dry, per square centimeter
- Q4151 Amnioband or guardian, per square centimeter
- Q4152 Dermapure, per square centimeter
- Q4153 Dermavest and plurivest, per square centimeter
- Q4154 Biovance, per square centimeter
- Q4155 Neoxflo or clarixflo, 1 mg
- Q4156 Neox 100 or clarix 100, per square centimeter
- Q4157 Revitalon, per square centimeter
- Q4158 Kerecis omega3, per square centimeter
- Q4159 Affinity, per square centimeter
- Q4160 Nushield, per square centimeter
- Q4161 Bio-connekt wound matrix, per square centimeter
- Q4162 Woundex flow, bioskin flow, 0.5 cc
- Q4163 Woundex, bioskin, per square centimeter
- Q4164 Helicoll, per square centimeter
- Q4165 Keramatrix, per square centimeter
- Q4166 Cytal, per square centimeter
- Q4167 Truskin, per square centimeter
- Q4168 Amnioband, 1 mg
- Q4169 Artacent wound, per square centimeter
- Q4170 Cygnus, per square centimeter
- Q4171 Interfyl, 1 mg
- Q4172 Puraply or puraply am, per square centimeter
- Q4173 Palingen or palingen xplus, per square centimeter
- Q4174 Palingen or promatrx, 0.36 mg per 0.25 cc
- Q4175 Miroderm, per square centimeter
- Q4176 Neopatch, per square centimeter
- Q4177 Floweramnioflo, 0.1 cc
- Q4178 Floweramniopatch, per square centimeter
- Q4179 Flowerderm, per square centimeter
- Q4180 Revita, per square centimeter
- Q4181 Amnio wound, per square centimeter
- Q4182 Transcyte, per square centimeter

Diagnosis Coding for Physician Services

The following information provides the essentials of diagnosis coding for convenient reference when coding diagnoses for burn surgery claims. It does not, however, include the basics of ICD-10-CM coding.

The novice coder is referred to basic texts published by professional organizations and commercial publishers. To foster accurate coding, coders are reminded that official coding steps and rules must be followed at all times when abstracting the medical record, searching the ICD-10-CM index, and assigning a code. Therefore, the following should be viewed as a guide and reference that can be used in support of appropriate coding activities.

Diagnosis CODING GUIDELINES FOR PHYSICIAN SERVICES EXCERPTED FROM 2018 *ICD-10-CM OFFICIAL GUIDELINES FOR CODING AND REPORTING*

KEY POINT

Check the new, revised guidelines on the CDC web site **quarterly**. They provide extensive, easy to understand information for diagnosis coding.

The most current, complete (full text), *ICD-10-CM Official Guidelines for Coding and Reporting* can be found at the CDC's National Center for Health Statistics web site:

https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf

According to the current introduction to the Official Guidelines:

“These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. **The instructions and conventions of the classification take precedence over guidelines.** These guidelines are based on the coding and sequencing instructions in ICD-10-CM, but provide additional instruction. Adherence to these guidelines when assigning ICD-10-CM or PCS diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes have been adopted under HIPAA for all healthcare settings. Procedure codes have been adopted for inpatient procedures reported by hospitals.”

And,

“The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient’s diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.”

Changes in the Official Guidelines appear in **BOLDFACE** in the online text.

“Diagnostic Coding and Reporting Guidelines for Outpatient Services” Excerpted from *ICD-10-CM Official Guidelines for Coding and Reporting*

The following are *verbatim* excerpts from the Official Guidelines from Section IV entitled, “Diagnostic Coding and Reporting Guidelines for Outpatient Services” and are to be followed when reporting/billing physician services, regardless of place of service. For the full text of the Official Guidelines, see https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf

BURN DIAGNOSIS CODING FOR PHYSICIAN SERVICES¹⁴

This section is divided into the following main topics:

Separate Coding of Burns

- Code Site of Burn
- Coding by Extent of Burn
 - Other Burn Code Categories
- Sequencing Codes
- Additional Coding Information for Burns and Related Conditions
- Table: Diagnosis Coding at a Glance
- Late Effect of Burns
- External Causes of Injury and Poisoning
- Physician Documentation
- Documentation Optimizes Inpatient Burn Coding and MS-DRG Assignment

(Refer to Appendix VI for a complete list of burn diagnosis codes.)

Burns are coded based on the diagnostic information in the record and require five -digit coding. With the exception of burns of the eye and internal organs, burns are generally coded:

1. By anatomic site, depth of burn and specific site using code categories T20-T25.
2. Burns and Corrosions to eye and internal organs T26-T28
3. By the *extent of body surface area burned*—Total Body Surface Area (TBSA) —using code category T31-T32.

Ideally, and if space on the claim form permits, a burn can be described using two codes: one for site and degree and the other for total body surface area burned. This type of reporting may not always be possible when there are multiple or extensive burn wounds and because of space limitations on claim forms.

¹⁴ American Hospital Association, Coding Clinic; Brown, Faye, IDC-9-CM Coding Handbook with Answers, American Hospital Associations, Chicago, 1997.

 KEY POINT

Look for documentation of loss of body part (e.g., finger, hand) with electrical burns or deep 3rd degree burns.

Separate Coding of Burns

Select first the code for burn site and depth using the appropriate code from categories T20-T25, or T26-T29. Code the extent of the burn next, using code category T31-T32.

Code Site of Burn (T20-T29)

Code the site of the burn first. Each burn is coded separately to the extent possible, using the appropriate code from T20-T29. When coding multiple burns, assign separate codes for each burn site.

Code Categories T20-T29

Identify the general anatomic location of each burn site by most severe to least severe depth of burn. If diagnostic information is available, identify the specific site of each burn.

Code burns of the same anatomic site to the highest degree recorded in the diagnosis.

Example: A full thickness burn of the face involving the forehead in a child would be coded to T20.36

Code Category T26-T29

This code category identifies burns of eyes and internal organs, including burns from ingested chemical agents

Coding of Burns and Corrosions

The ICD-10-CM makes a distinction between burns and corrosions. The burn codes are for thermal burns, except sunburns, that come from a heat source, such as a fire or hot appliance. The burn codes are also for burns resulting from electricity and radiation. Corrosions are burns due to chemicals. The guidelines are the same for burns and corrosions.

Current burns (T20-T25) are classified by depth, extent and by agent (X code). Burns are classified by depth as first degree (erythema), second degree (blistering), and third degree (full-thickness involvement). Burns of the eye and internal organs (T26-T28) are classified by site, but not by degree.

1) Sequencing of burn and related condition codes

Sequence first the code that reflects the highest degree of burn when more than one burn is present.

When a patient is admitted for burn injuries and other related conditions such as smoke inhalation and/or respiratory failure, the circumstances of admission govern the selection of the principal or first-listed diagnosis

- a. When the reason for the admission or encounter is for treatment of external multiple burns, sequence first the code that reflects the burn of the highest degree.
- b. When a patient has both internal and external burns, the circumstances of admission govern the selection of the principal diagnosis or first-listed diagnosis.
- c. When a patient is admitted for burn injuries and other related conditions such as smoke inhalation and/or respiratory failure, the circumstances of admission govern the selection of the principal or first-listed diagnosis.

2) Burns of the same local site

Classify burns of the same local site (three-character category level, T20-T28) but of different degrees to the subcategory identifying the highest degree recorded in the diagnosis.

3) Non-healing burns

Non-healing burns are coded as acute burns.

Necrosis of burned skin should be coded as a non-healed burn.

4) Infected Burn

For any documented infected burn site, use an additional code for the infection.

5) Assign separate codes for each burn site

When coding burns, assign separate codes for each burn site. Category T30, Burn and corrosion, body region unspecified is extremely vague and should rarely be used.

6) Burns and Corrosions Classified According to Extent of Body Surface Involved

Assign codes from category T31, Burns classified according to extent of body surface involved, or T32, Corrosions classified according to extent of body surface involved, when the site of the burn is not specified or when there is a need for additional data. It is advisable to use category T31 as additional coding when needed to provide data for evaluating burn mortality, such as that needed by burn units. It is also advisable to use category T31 as an additional code for reporting purposes when there is mention of a third-degree burn involving 20 percent or more of the body surface.

Categories T31 and T32 are based on the classic “rule of nines” in estimating body surface involved: head and neck are assigned nine percent, each arm nine percent, each leg 18 percent, the anterior trunk 18 percent, posterior trunk 18 percent, and genitalia one percent. Providers may change these percentage assignments where necessary to accommodate infants and children who have proportionately larger heads than adults, and patients who have large buttocks, thighs, or abdomen that involve burns.

7) Encounters for treatment of sequela of burns

Encounters for the treatment of the late effects of burns or corrosions (i.e., scars or joint contractures) should be coded with a burn or corrosion code with the 7th character “S” for sequela.

8) Sequelae with a late effect code and current burn

When appropriate, both a code for a current burn or corrosion with 7th character “A” or “D” and a burn or corrosion code with 7th character “S” may be assigned on the same record (when both a current burn and sequelae of an old burn exist). Burns and corrosions do not heal at the same rate and a current healing wound may still exist with sequela of a healed burn or corrosion.

See Section I.B.10 Sequela (Late Effects)

9) Use of an external cause code with burns and corrosions

An external cause code should be used with burns and corrosions to identify the source and intent of the burn, as well as the place where it occurred.

Other Burn Code Categories

Category T30 lists multiple burns of various sites; however, these codes should only be assigned when the anatomic location of the burn(s) is not documented.

Category T30 (Unspecified Burn) is vague; it should be used rarely.

Sequencing Codes

General Guideline: *List first the reason for the encounter/visit shown in the medical record to be chiefly responsible for the services provided.*

For Multiple Burns: *[Subject to the above General Guideline] When burns of multiple anatomic sites are present, the site with the highest degree burn is sequenced first. Codes for the other sites are listed next.*

Multiple diagnosis codes may be necessary to support medical services and surgical procedures.

Application of 7th Characters in Chapter 19

Most categories in chapter 19 have a 7th character requirement for each applicable code. Most categories in this chapter have three 7th character values (with the exception of fractures): A, initial encounter, D, subsequent encounter and S, sequela. Categories for traumatic fractures have additional 7th character values. While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

For complication codes, active treatment refers to treatment for the condition described by the code, even though it may be related to an earlier precipitating problem. For example, code T84.50XA, Infection and inflammatory reaction due to unspecified internal joint prosthesis, initial encounter, is used when active treatment is provided for the infection, even though the condition relates to the prosthetic device, implant or graft that was placed at a previous encounter. 7th character “A”, initial encounter is used for each encounter where the patient is receiving active treatment for the condition.

7th character “D” subsequent encounter is used for encounters after the patient has completed active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.

The aftercare Z codes should not be used for aftercare for conditions such as injuries or poisonings, where 7th characters are provided to identify subsequent care. For example, for aftercare of an injury, assign the acute injury code with the 7th character “D” (subsequent encounter).

7th character “S”, sequela, is for use for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn. The scars are sequelae of the burn. When using 7th character “S”, it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The “S” is added only to the injury code, not the sequela code. The 7th character “S” identifies the injury responsible for the sequela. The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code.

Nonhealing burns and necrosis of burned skin are coded as acute burns.

- Non-healing, surgically treated burn wound documented as “non-healing wound” should be coded to acute burn. Do not code to T81.89xA (Non-Healing Surgical Wound).

Any documented **infected** burn site requires two codes. The code for the burn is listed first. An additional code, **T79.8XXA** (Posttraumatic wound infection, not elsewhere classified), is sequenced for the infected burn. This guideline is not applicable to friction burns or sunburn.

Post burn scar and contracture are classified as “late effects.” Assign the code for the residual condition (*e.g.*, the burn scar or contracture) followed by the appropriate late effect code (appropriate burn code with S as 7th character).

For **complications related to artificial skin** and decellularized allodermis, use codes T85.613A, T85.623A, or T85.693A (Mechanical Complications Due to Artificial Skin Graft and Decellularized Allodermis).

For **failure or rejection of skin autograft** (*e.g.*, “lack of take”), use code T86.820, T86.821, T86.822, T86.828, or T86.829 (Mechanical Complications Due to Skin Graft Failure or Rejection.)

Smoke inhalation is coded to J70.5 (Toxic Effect of Unspecified gas, fume or vapor).

Burn of lung due to inhalation of flame is coded to T27.1.

Traumatic shock is coded to T79.4.4.

Pulmonary insufficiency following trauma and surgery (**ARDS**—Adult Respiratory Distress Syndrome) is coded to J80.

Respiratory failure or acute respiratory failure is coded to J96.00.

Routine graft dressing change after the expiration of the 90-day global surgery period is coded to Z48.01 (Attention to Surgical Dressings or Sutures, Change of Dressings). Note that Z48.01 must be listed in the first position; it can never be listed as a secondary code. If dressing change is for a different reason, the diagnosis code will vary depending on the reason for the service.

Sepsis, Severe Sepsis, and Septic Shock

1) Coding of Sepsis and Severe Sepsis

(a) Sepsis

For a diagnosis of sepsis, assign the appropriate code for the underlying systemic infection. If the type of infection or causal organism is not further specified, assign code A41.9, Sepsis, unspecified organism. A code from subcategory R65.2, Severe sepsis, should not be assigned unless severe sepsis or an associated acute organ dysfunction is documented.

(i) Negative or inconclusive blood cultures and sepsis

Negative or inconclusive blood cultures do not preclude a diagnosis of sepsis in patients with clinical evidence of the condition; however, the provider should be queried.

(ii) Urosepsis

The term urosepsis is a nonspecific term. It is not to be considered synonymous with sepsis. It has no default code in the Alphabetic Index. Should a provider use this term, he/she must be queried for clarification.

(iii) Sepsis with organ dysfunction

If a patient has sepsis and associated acute organ dysfunction or multiple organ dysfunction (MOD), follow the instructions for coding severe sepsis. (iv) Acute organ dysfunction that is not clearly associated with the sepsis

If a patient has sepsis and an acute organ dysfunction, but the medical record documentation indicates that the acute organ dysfunction is related to a medical condition other than the sepsis, do not assign a code from subcategory R65.2, Severe sepsis. An acute organ dysfunction must be associated with the sepsis in order to assign the severe sepsis code. If the documentation is not clear as to whether an acute organ dysfunction is related to the sepsis or another medical condition, query the provider.

(b) Severe sepsis

The coding of severe sepsis requires a minimum of 2 codes: first a code for the underlying systemic infection, followed by a code from subcategory R65.2, Severe sepsis. If the causal organism is not documented, assign code A41.9, Sepsis, unspecified organism, for the infection. Additional code(s) for the associated acute organ dysfunction are also required. Due to the complex nature of severe sepsis, some cases may require querying the provider prior to assignment of the codes.

2) Septic shock

(a) Septic shock generally refers to circulatory failure associated with severe sepsis, and therefore, it represents a type of acute organ dysfunction. For cases of septic shock, the code for the systemic infection should be sequenced first, followed by code R65.21, Severe sepsis with septic shock or code T81.12, Post procedural septic shock. Any additional codes for the other acute organ dysfunctions should also be assigned. As noted in the sequencing instructions in the Tabular List, the code for septic shock cannot be assigned as a principal diagnosis.

3) Sequencing of severe sepsis

If severe sepsis is present on admission, and meets the definition of principal diagnosis, the underlying systemic infection should be assigned as principal diagnosis followed by the appropriate code from subcategory R65.2 as required by the sequencing rules in the Tabular List. A code from subcategory R65.2 can never be assigned as a principal diagnosis. When severe sepsis develops during an encounter (it was not present on admission), the underlying systemic infection and the appropriate code from subcategory R65.2 should be assigned as secondary diagnoses. Severe sepsis may be present on admission, but the diagnosis may not be confirmed until sometime after admission. If the documentation is not clear whether severe sepsis was present on admission, the provider should be queried.

4) Sepsis and severe sepsis with a localized infection

If the reason for admission is both sepsis or severe sepsis and a localized infection, such as pneumonia or cellulitis, a code(s) for the underlying systemic infection should be assigned first and the code for the localized infection should be assigned as a secondary diagnosis. If the patient has severe sepsis, a code from subcategory R65.2 should also be assigned as a secondary diagnosis. If the patient is admitted with a localized infection, such as pneumonia, and sepsis/severe sepsis doesn't develop until after admission, the localized infection should be assigned first, followed by the appropriate sepsis/severe sepsis codes.

5) Sepsis due to a post procedural infection**(a) Documentation of causal relationship**

As with all post procedural complications, code assignment is based on the provider's documentation of the relationship between the infection and the procedure.

(b) Sepsis due to a post procedural infection

For such cases, the post procedural infection code, such as T80.2, Infections following infusion, transfusion, and therapeutic injection,

T81.4, Infection following a procedure, T88.0, Infection following immunization, or O86.0, Infection of obstetric surgical wound, should be coded first, followed by the code for the specific infection. If the patient has severe sepsis, the appropriate code from subcategory R65.2 should also be assigned with the additional code(s) for any acute organ dysfunction.

(c) Post procedural infection and post procedural septic shock

In cases where a post procedural infection has occurred and has resulted in severe sepsis the code for the precipitating complication such as code T81.4, Infection following a procedure, or O86.0, Infection of obstetrical surgical wound should be coded first followed by code R65.20, Severe sepsis without septic shock. A code for the systemic infection should also be assigned. If a post procedural infection has resulted in post procedural septic shock, the code for the precipitating complication such as code T81.4, Infection following a procedure, or O86.0, Infection of obstetrical surgical wound should be coded first followed by code T81.12-, Post procedural septic shock. A code for the systemic infection should also be assigned.

6) Sepsis and severe sepsis associated with a noninfectious process (condition)

In some cases, a noninfectious process (condition), such as trauma, may lead to an infection which can result in sepsis or severe sepsis. If sepsis or severe sepsis is documented as associated with a noninfectious condition, such as a burn or serious injury, and this condition meets the definition for principal diagnosis, the code for the noninfectious condition.

Methicillin Resistant Staphylococcus aureus (MRSA) Conditions

1) Selection and sequencing of MRSA codes

(a) Combination codes for MRSA infection

When a patient is diagnosed with an infection that is due to methicillin resistant *Staphylococcus aureus* (MRSA), and that infection has a combination code that includes the causal organism (e.g., sepsis, pneumonia) assign the appropriate combination code for the condition (e.g., code A41.02, Sepsis due to Methicillin Resistant Staphylococcus aureus or code J15.212, Pneumonia due to Methicillin Resistant Staphylococcus aureus). Do not assign code B95.62, Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere, as an additional code, because the combination code includes the type of infection and the MRSA organism. Do not assign a code from subcategory Z16.11, Resistance to penicillins, as an additional diagnosis.

See Section C.1. for instructions on coding and sequencing of sepsis and severe sepsis.

(b) Other codes for MRSA infection

When there is documentation of a current infection (e.g., wound infection, stitch abscess, urinary tract infection) due to MRSA, and that infection does not have a combination code that includes the causal organism,

assign the appropriate code to identify the condition along with code B95.62, Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere for the MRSA infection. Do not assign a code from subcategory Z16.11, Resistance to penicillins.

(c) Methicillin susceptible Staphylococcus aureus (MSSA) and MRSA colonization

The condition or state of being colonized or carrying MSSA or MRSA is called colonization or carriage, while an individual person is described as being colonized or being a carrier. Colonization means that MSSA or MRSA is present on or in the body without necessarily causing illness. A positive MRSA colonization test might be documented by the provider as “MRSA screen positive” or “MRSA nasal swab positive”. Assign code Z22.322, Carrier or suspected carrier of Methicillin Resistant Staphylococcus aureus, for patients documented as having MRSA colonization. Assign code Z22.321, Carrier or suspected carrier of Methicillin Susceptible Staphylococcus aureus, for patient documented as having MSSA colonization. Colonization is not necessarily indicative of a disease process or as the cause of a specific condition the patient may have unless documented as such by the provider.

(d) MRSA colonization and infection

If a patient is documented as having both MRSA colonization and infection during a hospital admission, code Z22.322, Carrier or suspected carrier of Methicillin Resistant Staphylococcus aureus, and a code for the MRSA infection may both be assigned.

Ventilator associated Pneumonia

1) Documentation of Ventilator associated Pneumonia

As with all procedural or post procedural complications, code assignment is based on the provider’s documentation of the relationship between the condition and the procedure. Code J95.851, Ventilator associated pneumonia, should be assigned only when the provider has documented ventilator associated pneumonia (VAP). An additional code to identify the organism (e.g., Pseudomonas aeruginosa, code B96.5) should also be assigned. Do not assign an additional code from categories J12-J18 to identify the type of pneumonia. Code J95.851 should not be assigned for cases where the patient has pneumonia and is on a mechanical ventilator and the provider has not specifically stated that the pneumonia is ventilator-associated pneumonia. If the documentation is unclear as to whether the patient has a pneumonia that is a complication attributable to the mechanical ventilator, query the provider.

2) Ventilator associated Pneumonia Develops after Admission

A patient may be admitted with one type of pneumonia (e.g., code J13, Pneumonia due to Streptococcus pneumonia) and subsequently develop VAP. In this instance, the principal diagnosis would be the appropriate code from categories J12-J18 for the pneumonia diagnosed at the time of admission. Code J95.851, Ventilator associated pneumonia, would be assigned as an additional diagnosis when the provider has also documented the presence of ventilator associated pneumonia.

3) Pain due to medical devices

Pain associated with devices, implants or grafts left in a surgical site (for example painful hip prosthesis) is assigned to the appropriate code(s) found in Chapter 19, Injury, poisoning, and certain other consequences of external causes. Specific codes for pain due to medical devices are found in the T code section of the ICD-10-CM. Use additional code(s) from category G89 to identify acute or chronic pain due to presence of the device, implant or graft (G89.18 or G89.28).

4). Encounters for treatment of sequela of burns

Encounters for the treatment of the late effects of burns or corrosions (i.e., scars or joint contractures) should be coded with a burn or corrosion code with the 7th character “S” for sequela.

5) Sequelae with a late effect code and current burn

When appropriate, both a code for a current burn or corrosion with 7th character “A” or “D” and a burn or corrosion code with 7th character “S” may be assigned on the same record (when both a current burn and sequelae of an old burn exist). Burns and corrosions do not heal at the same rate and a current healing wound may still exist with sequela of a healed burn or corrosion.

See Section I.B.10 Sequela (Late Effects)

6) Use of an external cause code with burns and corrosions

An external cause code should be used with burns and corrosions to identify the source and intent of the burn, as well as the place where it occurred.

External Causes of Morbidity (V00-Y99)

The external causes of morbidity codes should never be sequenced as the first-listed or principal diagnosis.

External cause codes are intended to provide data for injury research and evaluation of injury prevention strategies. These codes capture how the injury or health condition happened (cause), the intent (unintentional or accidental; or intentional, such as suicide or assault), the place where the event occurred the activity of the patient at the time of the event, and the person’s status (e.g., civilian, military).

There is no national requirement for mandatory ICD-10-CM external cause code reporting. Unless a provider is subject to a state-based external cause code reporting mandate or these codes are required by a particular payer, reporting of ICD-10-CM codes in Chapter 20, External Causes of Morbidity, is not required. In the absence of a mandatory reporting requirement, providers are encouraged to voluntarily report external cause codes, as they provide valuable data for injury research and evaluation of injury prevention strategies.

General External Cause Coding Guidelines

1) Used with any code in the range of A00.0-T88.9 Z00-Z99

An external cause code may be used with any code in the range of A00.0-T88.9, Z00-Z99, classification that **represents** a health condition due to an external cause. Though they are most applicable to injuries, they are also valid for use with such things as infections or diseases due to an external source, and other health conditions, such as a heart attack that occurs during strenuous physical activity.

2) External cause code used for length of treatment

Assign the external cause code, with the appropriate 7th character (initial encounter, subsequent encounter or sequela) for each encounter for which the injury or condition is being treated.

Most categories in chapter 20 have a 7th character requirement for each applicable code. Most categories in this chapter have three 7th character values: A, initial encounter, D, subsequent encounter and S, sequela. While the patient may be seen by a new or different provider over the course of treatment for an injury or condition, assignment of the 7th character for external cause should match the 7th character of the code assigned for the associated injury or condition for the encounter.

3) Use the full range of external cause codes

Use the full range of external cause codes to completely describe the cause, the intent, the place of occurrence, and if applicable, the activity of the patient at the time of the event, and the patient's status, for all injuries, and other health conditions due to an external cause.

4) Assign as many external cause codes as necessary

Assign as many external cause codes as necessary to fully explain each cause. If only one external code can be recorded, assign the code most related to the principal diagnosis.

5) The selection of the appropriate external cause code

The selection of the appropriate external cause code is guided by the Alphabetic Index of External Causes and by Inclusion and Exclusion notes in the Tabular List.

6) External cause code can never be a principal diagnosis

An external cause code can never be a principal (first-listed) diagnosis.

7) Combination external cause codes

Certain of the external cause codes are combination codes that identify sequential events that result in an injury, such as a fall which results in striking against an object. The injury may be due to either event or both. The combination external cause code used should correspond to the sequence of events regardless of which caused the most serious injury.

Place of Occurrence Guideline

Codes from category Y92, Place of occurrence of the external cause, are secondary codes for use after other external cause codes to identify the location of the patient at the time of injury or other condition.

Generally, a place of occurrence code is assigned only once, at the initial encounter for treatment. However, in the rare instance that a new injury occurs during hospitalization, an additional place of occurrence code may be assigned. No 7th characters are used for Y92.

Do not use place of occurrence code Y92.9 if the place is not stated or is not applicable.

c. Activity Code

Assign a code from category Y93, Activity code, to describe the activity of the patient at the time the injury or other health condition occurred.

An activity code is used only once, at the initial encounter for treatment.

Only one code from Y93 should be recorded on a medical record.

The activity codes are not applicable to poisonings, adverse effects, misadventures or sequela.

Do not assign Y93.9, Unspecified activity, if the activity is not stated.

A code from category Y93 is appropriate for use with external cause and intent codes if identifying the activity provides additional information about the event.

d. Place of Occurrence, Activity, and Status Codes Used with other External Cause Code

When applicable, place of occurrence, activity, and external cause status codes are sequenced after the main external cause code(s). Regardless of the number of external cause codes assigned, generally there should be only one place of occurrence code, one activity code, and one external cause status code assigned to an encounter. However, in the rare instance that a new injury occurs during hospitalization, an additional place of occurrence code may be assigned.

e. If the Reporting Format Limits the Number of External Cause Codes

If the reporting format limits the number of external cause codes that can be used in reporting clinical data, report the code for the cause/intent most related to the principal diagnosis. If the format permits capture of additional external cause codes, the cause/intent, including medical misadventures, of the additional events should be reported rather than the codes for place, activity, or external status.

f. Multiple External Cause Coding Guidelines

More than one external cause code is required to fully describe the external cause of an illness or injury. The assignment of external cause codes should be sequenced in the following priority:

If two or more events cause separate injuries, an external cause code should be assigned for each cause.

External Cause Status

A code from category Y99, External cause status, should be assigned whenever any other external cause code is assigned for an encounter, including an Activity code, except for the events noted below. Assign a code from category Y99, External cause status, to indicate the work status of the person at the time the event occurred. The status code indicates whether the event occurred during military activity, whether a non-military person was at work, whether an individual including a student or volunteer was involved in a non-work activity at the time of the causal event.

A code from Y99, External cause status, should be assigned, when applicable, with other external cause codes, such as transport accidents and falls. The external cause status codes are not applicable to poisonings, adverse effects, misadventures or late effects.

Do not assign a code from category Y99 if no other external cause codes (cause, activity) are applicable for the encounter.

An external cause status code is used only once, at the initial encounter for treatment. Only one code from Y99 should be recorded on a medical record.

Do not assign code Y99.9, Unspecified external cause status, if the status is not stated.

Status

Status codes indicate that a patient is either a carrier of a disease or has the sequelae or residual of a past disease or condition. This includes such things as the presence of prosthetic or mechanical devices resulting from past treatment. A status code is informative, because the status may affect the course of treatment and its outcome. A status code is distinct from a history code. The history code indicates that the patient no longer has the condition.

A status code should not be used with a diagnosis code from one of the body system chapters, if the diagnosis code includes the information provided by the status code. For example, code Z94.1, Heart transplant status, should not be used with a code from subcategory T86.2, Complications of heart transplant. The status code does not provide additional information. The complication code indicates that the patient is a heart transplant patient.

For encounters for weaning from a mechanical ventilator, assign a code from subcategory J96.1, Chronic respiratory failure, followed by code Z99.11, Dependence on respirator [ventilator] status.

The status Z codes/categories are:

Z14 Genetic carrier Genetic carrier status indicates that a person carries a gene, associated with a particular disease, which may be passed to offspring who may develop that disease. The person does not have the disease and is not at risk of developing the disease.

Z15 Genetic susceptibility to disease

Genetic susceptibility indicates that a person has a gene that increases the risk of that person developing the disease. Codes from category Z15 should not be used as principal or first-listed codes. If the patient has the condition to which he/she is susceptible, and that condition is the reason for the encounter, the code for the current condition should be sequenced first. If the patient is being seen for follow-up after completed treatment for this condition, and the condition no longer exists, a follow-up code should be sequenced first, followed by the appropriate personal history and genetic susceptibility codes. If the purpose of the encounter is genetic counseling associated with procreative management, code Z31.5, Encounter for genetic counseling, should be assigned as the first-listed code, followed by a code from category Z15. Additional codes should be assigned for any applicable family or personal history.

Z16 Resistance to antimicrobial drugs

This code indicates that a patient has a condition that is resistant to antimicrobial drug treatment. Sequence the infection code first.

Z17 Estrogen receptor status

Z18 Retained foreign body fragments

Z19 Hormone sensitivity malignancy status

Z21 Asymptomatic HIV infection status

This code indicates that a patient has tested positive for HIV but has manifested no signs or symptoms of the disease.

Z22 Carrier of infectious disease

Carrier status indicates that a person harbors the specific organisms of a disease without manifest symptoms and is capable of transmitting the infection.

Z28.3 Underimmunization status

Z33.1 Pregnant state, incidental

This code is a secondary code only for use when the pregnancy is in no way complicating the reason for visit. Otherwise, a code from the obstetric chapter is required.

Z66 Do not resuscitate

This code may be used when it is documented by the provider that a patient is on do not resuscitate status at any time during the stay.

Z67 Blood type

Z68 Body mass index (BMI)

As with all other secondary diagnosis codes, the BMI codes should only be assigned when they meet the definition of a reportable diagnosis (see Section III, Reporting Additional Diagnoses).

Z74.01 Bed confinement status

Z76.82 Awaiting organ transplant status

Z78 Other specified health status

Code Z78.1, Physical restraint status, may be used when it is documented by the provider that a patient has been put in restraints during the current encounter. Please note that this code should not be reported when it is documented by the provider that a patient is temporarily restrained during a procedure.

Z79 Long-term (current) drug therapy

Codes from this category indicate a patient's continuous use of a prescribed drug (including such things as aspirin therapy) for the long-term treatment of a condition or for prophylactic use. It is not for use for patients who have addictions to drugs. This subcategory is not for use of medications for detoxification or maintenance programs to prevent withdrawal symptoms in patients with drug dependence

(e.g., methadonemaintenance for opiate dependence). Assign the appropriate code for the drug dependence instead. Assign a code from Z79 if the patient is receiving a medication for an extended period as a prophylactic measure (such as for the prevention of deep vein thrombosis) or as treatment of a chronic condition (such as arthritis) or a disease requiring a lengthy course of treatment (such as cancer). Do not assign a code from category Z79 for medication being administered for a brief period of time to treat an acute illness or injury (such as a course of antibiotics to treat acute bronchitis).

**Z88 Allergy status to drugs, medicaments and biological substances
Except: Z88.9, Allergy status to unspecified drugs, medicaments and biological substances status.**

Z89 Acquired absence of limb

Z90 Acquired absence of organs, not elsewhere classified

Z91.0- Allergy status, other than to drugs and biological substances

Z92.82 Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to a current facility.

Z93 Artificial opening status

Z94 Transplanted organ and tissue status

Z95 Presence of cardiac and vascular implants and grafts

Z96 Presence of other functional implants

Z97 Presence of other devices Z98 Other post procedural states

Z99 Dependence on enabling machines and devices, not elsewhere classified

Note: Categories Z89-Z90 and Z93-Z99 are for use only if there are no complications or malfunctions of the organ or tissue replaced, the amputation site or the equipment on which the patient is dependent.

History (of)

There are two types of history Z codes, personal and family. Personal history codes explain a patient's past medical condition that no longer exists and is not receiving any treatment, but that has the potential for recurrence, and therefore may require continued monitoring.

Family history codes are for use when a patient has a family member(s) who has had a particular disease that causes the patient to be at higher risk of also contracting the disease.

Personal history codes may be used in conjunction with follow-up codes and family history codes may be used in conjunction with screening codes to explain the need for a test or procedure. History codes are also acceptable on any medical record regardless of the reason for visit. A history of an illness, even if no longer present, is important information that may alter the type of treatment ordered.

The history Z code categories are:

Z80 Family history of primary malignant neoplasm

Z81 Family history of mental and behavioral disorders

Z82 Family history of certain disabilities and chronic diseases (leading to disablement)

Z83 Family history of other specific disorders

Z84 Family history of other conditions
Z85 Personal history of malignant neoplasm
Z86 Personal history of certain other diseases
Z87 Personal history of other diseases and conditions
Z91.4- Personal history of psychological trauma, not elsewhere classified
Z91.5 Personal history of self-harm
Z91.81 History of falling
Z91.82 Personal history of military deployment
Z92 Personal history of medical treatment
Except: Z92.0, Personal history of contraception
Except: Z92.82, Status post administration of tPA (rtPA) in a different facility within the last 24 hours prior to admission to a current facility

Aftercare

Aftercare visit codes cover situations when the initial treatment of a disease has been performed and the patient requires continued care during the healing or recovery phase, or for the long-term consequences of the disease. The aftercare Z code should not be used if treatment is directed at a current, acute disease. The diagnosis code is to be used in these cases. Exceptions to this rule are codes **Z51.0, Encounter for antineoplastic radiation therapy, and codes from subcategory Z51.1, Encounter for antineoplastic chemotherapy and immunotherapy**. These codes are to be first-listed, followed by the diagnosis code when a patient’s encounter is solely to receive radiation therapy, chemotherapy, or immunotherapy for the treatment of a neoplasm. If the reason for the encounter is more than one type of antineoplastic therapy, code Z51.0 and a code from subcategory Z51.1 may be assigned together, in which case one of these codes would be reported as a secondary diagnosis.

The aftercare Z codes should also not be used for aftercare for injuries. For aftercare of an injury, assign the acute injury code with the appropriate 7th character (for subsequent encounter).

The aftercare codes are generally first-listed to explain the specific reason for the encounter. An aftercare code may be used as an additional code when some type of aftercare is provided in addition to the reason for admission and no diagnosis code is applicable. An example of this would be the closure of a colostomy during an encounter for treatment of another condition.

Aftercare codes should be used in conjunction with other aftercare codes or diagnosis codes to provide better detail on the specifics of an aftercare encounter visit, unless otherwise directed by the classification. Should a patient receive multiple types of antineoplastic therapy during the same encounter, code Z51.0, Encounter for antineoplastic radiation therapy, and codes from subcategory Z51.1, Encounter for antineoplastic chemotherapy and immunotherapy, may be used together on a record. The sequencing of multiple aftercare codes depends on the circumstances of the encounter.

Certain aftercare Z code categories need a secondary diagnosis code to describe the resolving condition or sequelae. For others, the condition is included in the code title.

Additional Z code aftercare category terms include fitting and adjustment, and attention to artificial openings.

Status Z codes may be used with aftercare Z codes to indicate the nature of the aftercare. For example, code **Z95.1, Presence of aortocoronary bypass graft, may be used with code Z48.812**, Encounter for surgical aftercare following surgery on the circulatory system, to indicate the surgery for which the aftercare is being performed. A status code should not be used when the aftercare code indicates the type of status, such as using **Z43.0, Encounter for attention to tracheostomy, with Z93.0, Tracheostomy status**.

The aftercare Z category/codes:

Z42 Encounter for plastic and reconstructive surgery following medical procedure or healed injury
Z43 Encounter for attention to artificial openings
Z44 Encounter for fitting and adjustment of external prosthetic device
Z45 Encounter for adjustment and management of implanted device
Z46 Encounter for fitting and adjustment of other devices Z47 Orthopedic aftercare
Z48 Encounter for other post procedural aftercare
Z49 Encounter for care involving renal dialysis
Z51 Encounter for other aftercare and medical care

8) Follow-up

The follow-up codes are used to explain continuing surveillance following completed treatment of a disease, condition, or injury. They imply that the condition has been fully treated and no longer exists. They should not be confused with aftercare codes, or injury codes with a 7th character for subsequent encounter, that explain ongoing care of a healing condition or its sequelae. Follow-up codes may be used in conjunction with history codes to provide the full picture of the healed condition and its treatment. The follow-up code is sequenced first, followed by the history code. A follow-up code may be used to explain multiple visits. Should a condition be found to have recurred on the follow-up visit, then the diagnosis code for the condition should be assigned in place of the follow-up code. The follow-up Z code categories:

Z08 Encounter for follow-up examination after completed treatment for malignant neoplasm
Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm
Z39 Encounter for maternal postpartum care and examination

9) Donor

Codes in category Z52, Donors of organs and tissues, are used for living individuals who are donating blood or other body tissue. These codes are only for individuals donating for others, not for self-donations. They are not used to identify cadaveric donations.

Coding for Non-Burn Conditions

CODING FOR PROFESSIONAL SERVICES/PROCEDURES PERFORMED FOR NON-BURN CONDITIONS

- For **debridement** of non-burn tissue, refer to the Surgical Procedures section, Debridement, “Non-Burn Wounds/Conditions—Debridement Performed by Physician or Non-Physician Professional.”
- For **excision of non-burn wounds**, refer to the Surgical Procedures section, “Excision Burn and Non-Burn Wounds.” As the heading indicates, those coding guidelines also apply to coding for excision of non-burn wounds.
- Coding guidelines for all other procedures commonly performed by burn surgeons are found under the relevant topic in the Surgical Procedures section.

PATHOPHYSIOLOGY AND DIAGNOSIS CODING FOR NON- BURN CONDITIONS

Calciphylaxis

Pathophysiology

- Calciphylaxis is a rare, often fatal, condition that frequently occurs in patients with ESRD (End Stage Renal Disease)

undergoing hemodialysis or peritoneal dialysis and patients who are status-post renal transplantation. It may also be associated with other hypercalcemic conditions and can also occur in patients who are immunosuppressed, patients with advanced liver disease, Crohn's disease, and extensive bowel resections. By a 3:1 ratio, the condition affects more women than men. The actual cause of the disease is unknown.

- When it is a complication of ESRD and dialysis, calciphylaxis is linked to the development of secondary hyperparathyroidism with a parathyroid hormone level that is usually noticeably higher than found in other causes of metastatic calcification. Functional protein C deficiency is often present. However, calciphylaxis can occur in the absence of these clinical findings.
- The secondary hyperparathyroidism leads to elevated serum calcium and phosphorus levels, development of calcium deposits in blood vessels and soft tissues, and calcified, narrowed arteries. Ultimately, necrotic lesions develop in the affected tissues.
- Calciphylaxis is manifested by painful, exquisitely tender subcutaneous skin lesions that can present in 2 clinical variants that have been described as distal and proximal distributions of the lesions. The distal variant commonly occurs on the posterior calves, fingers, toes and glans penis. Patients with the proximal variant generally present with lesions on the abdomen, trunk, buttocks, and proximal extremities, notably on the proximal thighs. Lesions may also occur in internal organs.

Skin lesions may initially vary in type and form, presenting in a range of erythematous nodules to depressed plaques with telangiectasia and mottled hyperpigmentation. The lesions become calcified, develop central necrosis, and can progress to large areas of eschar as the lesions enlarge over time. It can further progress to skin ulcers that may extend to fascia. Infection and gangrene may occur. Sepsis may develop as a result. Differential diagnosis usually includes skin biopsy of necrotic lesions to confirm small-vessel calcification with endovascular fibrosis, fat necrosis and acute inflammation.

- Treatment involves aggressive wound care, surgical debridement or excision of the wound and grafting with autologous skin and/or tissue-engineered skin. Systemically, the goal of treatment is to normalize the serum calcium and phosphorus levels and prevent infection. For patients who are considered surgical candidates, possible subtotal or total parathyroidectomy may be performed and, in some patients, may be beneficial in causing regression of the lesions.
For patients on dialysis, treatment also consists of elimination of calcium containing phosphate binders (typically administered to ESRD patients on dialysis) and administration of low-calcium dialysate solutions.

Diagnosis Coding

- Calciphylaxis is coded to disorders of mineral metabolism, specifically:
E83.59 Other disorders of calcium metabolism
- When calciphylaxis and ESRD are documented, coding recommendations are as follows:
E83.59 Other disorders of calcium metabolism
N18.6 ESRD

If secondary hyperparathyroidism resulting from ESRD is also documented, code N25.81 (Other specified disorders resulting from impaired renal function) may also be assigned.

Refer to “calciphylaxis” in the ICD-10-CM Index for additional information.

Degloving Injuries

Pathophysiology

Degloving injuries involve traumatic stripping of the skin and underlying tissues from one or more body parts. The term “degloving” describes an action that is similar to peeling a glove from a hand. The arms, legs, hands, feet or fingers are usually involved in the injury. It often occurs as a result of jewelry or clothing being caught in operating machinery, pulling the patient into it.

Skin, soft tissue, and/or muscle may be stripped from the body part, in some cases leaving only exposed bone. Degloving can range from superficial skin and soft tissue

injuries to complete avulsion or tearing away of all soft tissue, including tendons, nerves, and arteries.

Treatment is based on the extent and depth of injury, body part affected, vascular and nerve damage, and patient condition. It may involve:

- Stabilization of the patient
- Assessment of the injured part for ischemia
- Necessary fasciotomy
- Neurologic assessment for nerve compromise which may involve neurologic examination or, if the patient is unable to communicate, actual nerve exploration within the wound
- Initial and subsequent serial debridement
- Autologous tissue rescue for potential free grafts
- Necessary fracture stabilization
- Wound coverage procedures: skin grafting, local flaps, free flaps/free tissue transfer with microvascular anastomosis

Diagnosis Coding

- For degloving injury, code based on type of injury and anatomic site. For example, for documented avulsion of skin and subcutaneous tissue on a limb, code to Wound, Open, By Site.
- When friction burns or abrasions are documented as “deep wounds” or deep abrasions (e.g., degloving injuries), code to Wound, Open, By Site.

Fournier’s Gangrene, Fournier’s Disease

Pathophysiology

- Fournier’s gangrene is variously described in the literature as a variant of cellulitis, necrotizing cellulitis, or necrotizing fasciitis. Typically caused by a polymicrobial bacterial infection, it affects the external genitalia (e.g., scrotum and/or penis) and perineum. It is more common in men.
- The disease is characterized by a fulminating (rapidly progressing) cellulitis that is potentially fatal. The infection can spread very rapidly along subcutaneous planes and result in tissue necrosis and gangrene. While usually confined to the scrotum and penis or perineum, it can advance up the abdominal wall and, in some cases, invade the retroperitoneum and thorax. It is considered a urologic/surgical emergency.
- Frequently associated with comorbidities (e.g., diabetes,

chronic renal and liver disease, immunosuppression, malignancy), this condition usually can be traced to a direct cause such as trauma, anal fistula, a urogenital surgical procedure, or soft tissue abscess.

- Patients present with fever, chills, local pain and swelling, and pruritus. Examination usually reveals intact overlying skin with extensive necrosis of the dermal and subcutaneous tissues.
- Treatment consists of immediate, aggressive surgical excision (usual) or surgical debridement of all diseased tissue down to viable tissue. Note that the lesions often require actual surgical excision (rather than debridement) in which tangential excision or similar techniques are used to remove a measurable surface area of skin and soft tissue down to viable tissue. (For procedure coding purposes, it is important to distinguish between surgical excision of the wound and debridement that does not involve excisional techniques and is a less extensive procedure. Burn surgeons typically document the size of the area that is surgically excised using square centimeters.)
Surgery is followed by dressing changes several times a day, administration of broad-spectrum antibiotics, and hemodynamic stabilization with fluid resuscitation. Repeat debridement may be required. Depending on the extent of disease, reconstruction may involve split thickness skin grafts, myocutaneous flaps, scrotal and/or penile reconstruction.

Diagnosis Coding

- Diagnosis coding will vary depending on specificity of physician documentation. This condition may be documented using one or more different diagnostic statements as indicated in the preceding discussion.
- Selection of the Principal diagnosis can be challenging in these cases. Coders must often select the Principal diagnosis from among a number of coded diagnoses abstracted from the medical record.
- Selected ICD-10 diagnosis codes that may apply, depending on documentation present in the record:
 - N49.2 Cellulitis, scrotum
 - L03.315 Cellulitis, perineum
 - M72.6 Necrotizing fasciitis
 - N49.3 Fournier’s disease with gangrene

Hidradenitis Suppurativa

Pathophysiology

- A chronic, usually longstanding, condition that affects the

apocrine (sweat) glands in various body locations, hidradenitis suppurativa may affect adjacent subcutaneous tissue and, possibly, fascia.

- The disease is characterized by swollen, painful, inflamed nodules in the axillae, groin, perineum, buttocks, scrotum, and other areas of the body where apocrine glands are located. The actual cause is unknown.
- In this condition, perspiration does not drain properly from the sweat glands and becomes trapped within them. Perspiration along with bacteria eventually spreads into adjacent tissues, resulting in localized inflammation and infection. Abscesses may form and drain pus with cellulitis in surrounding tissues. Nodules can heal and recur in a cyclical fashion over many years. As a result, the affected tissues may develop fibrotic cords and scarring that becomes painful and disfiguring.
- Treatment for minor cases may consist of incision and drainage with antibiotic administration. In cases with more extensive involvement, excision and skin grafting may be required.

Diagnosis Coding

- ICD-10 diagnosis code: L73.2 Hidradenitis suppurativa

Procedure Coding (Physician Services)

Excision of hidradenitis lesions may be reported using codes that describe excision of skin and subcutaneous tissue for hidradenitis by anatomic site, including repair.

11450	Excision of skin and subcutaneous tissue for hidradenitis, axillary; with simple or intermediate repair
11451	with complex repair
11462	Excision of skin and subcutaneous tissue for hidradenitis, inguinal; with simple or intermediate repair

- 11463 with complex repair
- 11470 Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal, or umbilical; with simple or intermediate repair
- 11471 with complex repair

Code skin grafts or flaps used for closure separately and in addition using the appropriate code for the specific type of skin graft applied and the anatomic location of the recipient site. When a flap is used for closure, refer to the applicable flap or adjacent tissue transfer code.

Do not use code 15002-15005 to report excision of hidradenitis lesions. Use the appropriate code from 11450-11471 instead.

Necrotizing Fasciitis

Pathophysiology

- Necrotizing fasciitis is an infection that affects the superficial and deep fascia, usually involving multiple microorganisms.
- Most common in the extremities but may occur at other sites.
- Produces severe toxicity, with a mortality rate of 40-50%.
- Skin is erythematous, swollen, and painful. Fluid filled blisters form on the skin. Gas formation can occur in subcutaneous tissues.
- Generally referred to burn center for intensive care, wound care, and burn-type surgery intervention.
- Antimicrobial therapy is administered for the infection.
- Diagnosis mandates immediate surgical excision of all affected tissue and beyond its border, leaving margins of normal tissue. Serial excisions may be required. Skin grafting may be performed at a later date.

Diagnosis Coding

- ICD-10 diagnosis code

M72.6 Necrotizing fasciitis

Use an additional code or codes to identify the infectious organism (B95-B97) and, if applicable, gangrene (N49.3)

Purpura Fulminans (Waterhouse-Friderichsen Syndrome)

Pathophysiology

- Typically, a complication of meningococcal sepsis (meningococcemia or invasion of the bloodstream with meningococcal organisms).
- Rapid onset of fever, muscle and joint pain, and rash on the trunk, extremities, palms and soles of feet.
- Rapidly progressive, often fatal disease with rapid enlargement of purpuric lesions and circulatory collapse. In some patients, lesions may not be detectable visually. Inflammation of the heart muscle (myocarditis) and disseminated intravascular coagulation are common. It is frequently accompanied by organ failure.
- Treatment involves management of infection, organ failure, and excision and grafting of wounds. May also require fasciotomies for decompression of compartment syndromes.

Diagnosis Coding

- ICD-10 diagnosis code
D65 Defibrination syndrome
Purpura fulminans

Toxic Epidermal Necrolysis (TEN)

Pathophysiology: Toxic Epidermal Necrolysis

- A severe skin reaction due to various causative factors, including drugs, infections, external exposure to chemicals, and other conditions.
- The skin injury is similar to partial thickness burn and involves a massive epidermal slough at the dermal-epidermal junction leading to a completely denuded dermis.
- TEN generally involves skin slough of over 30 percent of the total body surface area. The percent of body surface area involved is a significant clinical factor in the level of care required.
- Severe systemic reaction may occur as well, with sloughing of conjunctiva, the GI tract and respiratory tract.

- Patients are often referred to a burn center for fluid resuscitation, intensive wound care, respiratory support and any necessary surgical intervention.
- The condition may require surgical wound debridement and application of alloplastic dressing (e.g., Biobrane). Xenograft or allograft may be applied to promote re-epithelialization.
- **Stevens-Johnson syndrome (SJS)**, previously considered synonymous with erythema multiforme major, is now considered to be part of the same spectrum of disease as TEN, although it generally involves body surface area of less than 10 percent.
- **There is also an overlap condition** with an intermediate percent of body surface area affected (10-30 percent), which may be termed **SJS-TEN overlap syndrome**.
- Mucositis, related to SJS or TEN, is of clinical importance when present in these cases.
- TEN is similar to Staphylococcal scalded skin syndrome (SSSS), which is a reaction to Staphylococcal toxin that causes a separation at the granular layer of the epidermis. In contrast to TEN, the wound in SSSS is superficial and may heal rapidly if superinfection and desiccation are prevented. SSSS may be considered to be synonymous with Ritter's disease.
- Differential diagnosis may include skin biopsy to confirm the diagnosis and distinguish TEN from SSSS.

SJS-TEN overlap syndrome is coded to L51.3

TEN is coded to L51.2.

Diagnosis Coding for TEN

- ICD-10 diagnosis coding for TEN

L51.2 Toxic epidermal necrolysis

Use additional code to identify associated manifestations. Use additional code to identify percentage of skin exfoliation. For example, if documentation indicates 40-49 percent involvement:

L49.4 Exfoliation due to erythematous condition involving 40-49 percent of body surface

Use additional T code to identify drug, if drug-induced

For TEN *due to drug overdose or wrong substance given or taken*, review the Table of Drugs and Chemicals for Poisoning by other and unspecified drug or medicinal substances. (If drug is known use specific code for that drug. Use additional code to specify the effects of the poisoning.

For TEN *due to drug, correct substance properly administered*, see Table of Drugs and Chemicals by drug, adverse effect

Teaching Physician Guidelines

KEY POINTS

CMS' Teaching Physician "presence" guidelines apply to Evaluation and Management Services, Anesthesia, and Surgical Procedures, among others.

CMS issued significantly revised documentation requirements for supervising physicians in teaching settings in Medicare Carriers Manual

On January 13, 2006, CMS issued Transmittal 811, which added the 11/02 revisions and several new provisions to the CMS Medicare Internet-only Claims Processing Manual 100-4, Chapter 12, Section 100. The new provisions are not relevant to burn surgeons and are not discussed here.

Please refer to the above CMS Internet-only Manual for all CMS guidelines at:

<http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

The essential CMS documentation guidelines for teaching physicians, which are expressed as **the minimum required**, are summarized in the following sections.

To support billing for a teaching physician's services, the teaching physician must be present for the key or critical portion of the service. Specific documentation requirements must be met to bill the services and are summarized below.

DOCUMENTATION GUIDELINES FOR EVALUATION AND MANAGEMENT SERVICES: “KEY COMPONENTS’ CODES”

“Key Components” codes are those E/M services that require documentation of history, physical examination, and medical decision-making. Some examples are office visits, consultations, and hospital admission H&P. These codes are distinguished from E/M Time Based Codes, which are discussed in a subsequent section.

Medical Necessity

The combined entries into the medical record by the teaching physician and the resident constitute the documentation for the service and together must support the medical necessity of the service.

Medicare defines medical necessity as “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.”

Level of Service:

Selection of an E/M level of service should be based on:

1. The CPT code definitions for those services
2. Any applicable documentation guidelines (currently the 1995 or 1997 AMA/CMS E/M Documentation Guidelines)
3. The combination of the resident and teaching physician notes

Documentation

Mandatory Documentation

Teaching physicians **must personally document at least** the following:

- a. That they performed the service or were physically present during the key or critical portions of the service when performed by the resident; and
- b. The participation of the teaching physician in the management of the patient.

Resident documentation of teaching physician presence and participation is not sufficient to establish his/her presence and participation.

Examples of *Minimally* Acceptable Documentation

Teaching physician personally performs all required elements of an E/M service without or with a resident.

- Without a resident note, the teaching physician must document as if the service was performed in a non-teaching setting. That is, documentation should consist of the required key components—history, physical examination, and medical decision making—required to meet the billed level of service (e.g., 2 of 3 or 3 of 3 key components as specified in the CPT code definitions).
- With resident notes, the teaching physician may reference the note and must document that:
 - He/she performed the critical/key portion(s) of the service and
 - He/she was directly involved in the patient’s management.
- **Minimally** acceptable documentation:
 - Admission Note: “I performed a history and physical examination of the patient and discussed his management with the resident. I reviewed the resident’s note and agree with the documented findings and plan of care.”
 - Follow-up Visit: “Hospital Day #3. I saw and evaluated the patient. I agree with the findings and the plan of care as documented in the resident’s note.”
 - Follow-up Visit: “Hospital Day #5. I saw and examined the patient. I agree with the resident’s note except the heart murmur is louder, so I will obtain an echo to evaluate.”

Resident performs elements required for E/M service, in presence or together with, teaching physician. Resident documents the service.

- Teaching physician must document that:

He/she was present during the critical/key portion(s) of the service and

He/she was directly involved in the patient's management.

- **Minimally** acceptable documentation:

Initial or Follow-up Visit: "I was present with resident during the history and exam. I discussed the case with the resident and agree with the findings and plan as documented in the resident's note."

Follow-up Visit: "I saw the patient with the resident and agree with the resident's findings and plan."

Resident performs some or all elements required for E/M service without the teaching physician. Resident documents the service. Teaching physician independently performs the critical/key portion(s) of the service with or without the resident present.

- Teaching physician must document that:

He/she personally saw the patient,

Personally performed the critical/key portions and

Participated in the patient's management.

- The teaching physician's note should reference the resident's note.
- **Minimally** acceptable documentation:

Initial Visit: "I saw and evaluated the patient. I reviewed the resident's note and agree, except that picture is more consistent with pericarditis than myocardial ischemia. Will begin NSAIDs."

Initial or Follow-up Visit: "I saw and evaluated the patient. Discussed with resident and agree with resident's findings and plan as documented in the resident's note."

Follow-up Visit: "See resident's note for details. I saw and evaluated the patient and agree with the resident's finding and plans as written."

Follow-up Visit: "I saw and evaluated the patient. Agree with resident's note but lower extremities are weaker, now 3/5; MRI of L/S Spine today."

Unacceptable Documentation

The following examples **are unacceptable according to CMS** because it is not possible to determine whether the teaching physician was present, evaluated the patient, or had any involvement with the plan of care.

“Agree with above.” followed by legible countersignature or identity;

“Rounded, Reviewed, Agree.” followed by legible countersignature or identity;

“Discussed with resident. Agree.” followed by legible countersignature or identity;

“Seen and agree.” followed by legible countersignature or identity;

“Patient seen and evaluated.” followed by legible countersignature or identity; and

A legible countersignature or identity alone.

E/M Documentation by Students

Medicare does not pay for any service furnished by a student. Students may document E/M services in the medical record.

However,

- The teaching physician’s documentation may only refer to the student’s documentation of the review of systems and/or past/family/social history. He/she may not refer to the physical examination or medical decision-making.
- The teaching physician must verify and re-document the history of present illness, perform and re-document the physical examination and medical decision-making provided in the service.

DOCUMENTATION GUIDELINES FOR EVALUATION AND MANAGEMENT SERVICES: TIME-BASED CODES

Time-based codes are those E/M codes that require documentation of incremental and/or total time such as critical care codes, and discharge day management.

Calculating Time for Code Selection

The teaching physician must be present for the period of time for which the claim is made. For example, for a code that specifically describes a service of from 20 to 30 minutes, the teaching physician must be present for 20 to 30 minutes. Time spent by the resident in the absence of the teaching physician **cannot be added** to time spent by the resident and teaching physician with the patient or to time spent by the teaching physician alone with the patient.

Documentation

The teaching physician must document

- Total time for the service
- Content of the service

Time documentation may vary by the type of E/M service provided. For example:

- Hospital discharge day management (99238-99239) –Total time per day (of discharge) spent on the final examination, instructions for continuing care, and other elements specified in the code definition.
- Hourly Critical Care (99291–99292) –Total time per day (may be listed incrementally or as a single entry with daily summary).
- E/M key components' code/service where counseling and/or coordination of care dominates (more than 50%) of the encounter and **time** is considered the key or controlling factor to qualify for a given level of E/M service: Total time for entire encounter and total time for the segment involving counseling/coordination of care is documented.

DOCUMENTATION GUIDELINES FOR PROCEDURES

The teaching physician must be present during all critical and key portions of the procedure and be immediately available to furnish services during the entire procedure.

Surgery (Includes Endoscopic Surgical Procedures)

Presence

The teaching physician is not required to be present for opening and closing unless these are considered to be critical/key portions.

- The teaching physician determines which postoperative visits are critical/key and require his/her presence.
- When the teaching physician does not provide postoperative visits following patient discharge, the code for the operative procedure must be billed using the appropriate “split-care” modifier to indicate that less than the global service was provided. See modifier 54 (Surgical care only), Appendix IV.
- If the teaching physician is not present during non-critical/key portions of the procedure, he/she must be immediately available to return to the procedure, i.e., he or she cannot be performing another procedure. If circumstances prevent a teaching physician from being immediately available, then he/she must arrange for another qualified surgeon to be immediately available to assist with the procedure, if needed.

Documentation

Single Surgery

- There is no **required** information that the teaching surgeon must enter into the medical records.
- If present for the entire procedure, the teaching physician’s presence may be demonstrated by notes in the medical records made by the physician, resident, or operating room nurse.

Two Overlapping Surgeries

- The teaching physician must be present for the critical/key portions of **both** surgeries.
- The critical/key portions of both surgeries **cannot occur at the same time.**
- The teaching physician **must personally document** that he/she was physically present for the critical/key portions of both procedures.
- When the teaching physician is involved in **three concurrent surgeries**, it is considered a supervisory service rather than a physician service and is not payable by Medicare.

Minor Surgeries

For procedures that require 5 minutes or less to complete, the teaching surgeon must be present for the entire procedure in order to bill for the procedure.

Endoscopic Procedures

The teaching physician must be present during the entire viewing, which starts at the insertion of the endoscope and ends with removal of the endoscope. Viewing a monitor in another room does not qualify for teaching physician presence.

Medicare does not specify which endoscopic procedures are covered by this policy versus those endoscopic procedures covered under the general surgery policy.

ASSISTANTS AT SURGERY IN TEACHING INSTITUTIONS

An assistant at surgery is a physician (or, if allowed under state law, a nurse practitioner, physician assistant, or clinical nurse specialist) who actively assists the physician in charge of a case in performing a surgical procedure.

Payment Conditions

Medicare does not pay for assistant surgeon services provided in a teaching institution that has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service, unless certain requirements are met.

- If the primary surgeon is being assisted by a resident and his/her PA (Physician's Assistant), the services of the PA are not billable under Medicare guidelines stated above.
- When a qualified resident is not available and the PA assists, the services of the PA may be reported as described immediately below. The primary surgeon should include operative report dictation that supports these facts.

Qualified Resident Not Available

If a qualified resident is not available, the claim may be submitted with modifier 82 (Assistant at Surgery, Qualified Resident Not Available). Or the claim may be submitted with a certification containing specific language dictated by Medicare.

Exceptional Circumstances

Payment may be allowed for the services of assistants at surgery in teaching hospitals even though a qualified resident is available to furnish the services. There may be exceptional medical circumstances, e.g., emergency, life-threatening situations such as multiple traumatic injuries which require immediate treatment. There may be other situations in which the medical staff may find that exceptional medical circumstances justify the services of a physician assistant at surgery even though a qualified resident is available.

Physicians Who Do Not Involve Residents in Patient Care

Payment may be allowed for the services of assistants at surgery in teaching hospitals if the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients.

Generally, this exception is applied to community physicians who have no involvement in the hospital's GME program. In such situations, payment may be made for reasonable and necessary services on the same basis as in a non-teaching hospital.

However, if the assistant is not a physician primarily engaged in the field of surgery, **no payment may be made unless either of the criteria in the following section is met.**

Multiple Physician Specialties Involved in Surgery

- For complex surgeries that require a team of surgeons (e.g., transplant surgery), each physician acts as a primary member of the team and does not function as an assistant surgeon. Payment is made on the basis of a single claim for a single team fee and is determined using a by Report methodology. Claims are submitted using Modifier 66 Surgical Team.
- When, due to the presence of multiple medical conditions, the services of multiple physicians of differing specialties are required during an operative procedure, payment is allowed on that basis as the physicians are providing concurrent care and are not functioning at the level of an assistant surgeon. For example, a cardiologist whose presence is required because the patient's cardiac condition requires monitoring during abdominal or other surgery.

Non-Physician Practitioners (NPP)

The following information is relevant to **professional** services provided by Nurse Practitioners (NPs), Physician Assistants (PAs), and Clinical Nurse Specialists (CNS) only.

KEY POINTS

Non-physician practitioners include NPs, PAs, and CNSs.

This chapter summarizes essential Medicare guidelines for coding and billing services provided by NPPs.

This section contains general coding guidelines for services and procedures based on the American Medical Association’s CPT (Current Procedural Terminology) book. For diagnostic coding guidelines, the reader is referred to the chapter, “Diagnosis Coding for Physician Services.” Where relevant, Medicare guidelines are included for reference purposes and because Medicare is a national program with published guidelines that may be recognized or adopted by other payers in any given geographic locality.

It is not possible to include all state, federal, and payer requirements, guidelines, and reimbursement concepts in this Manual because of the hundreds of potential variables inherent in coding and billing for each type of NPP. See Recommended Actions below.

(This publication does not address coding and billing for NPPs working in Rural Health Centers (RHCs) or Federally Qualified Health Centers (FQHCs).)

CODING AND PAYER ISSUES

Complexity and Inconsistency among States and Payers

Coding for NPP professional services and procedures is complex. It can and does vary widely depending on the following, multiple variables:

- State licensing and level of certification required by the payer
- Scope of practice described in each of 50 different State practice acts (e.g., state nursing practice acts). In some states the law describing the scope of practice is highly detailed in terms of allowed duties and practices. In other states, the law may be vague or non-specific.

- Payer coverage of services and/or procedures provided by NPPs. Coverage may or may not be available at all, coverage may be available for certain NPPs and not others, coverage may be available for certain benefit categories or types of patients, and so on.
- Payer coding guidelines for NPPs. Some payers such as Medicare have relatively specific coding guidelines for NPPs' services while others may have some or none.

Medicare Regulations

Medicare regulations have been established for each type of NPP. These published regulations can be obtained from your local Medicare Carrier and on the web. See below.

Selected Regulations Pertinent to NPP Services

For qualifications, covered services, physician supervision, and other specific regulations affecting NPPs, see **CMS manual 100-2**, chapter 15, sections 190, 200, 210 which cover PAs, NPs, and CNS', respectively.

For billing and payment of NPP services, see **CMS manual 100-4**, chapter 12, section 110 for PAs, and section 120 for NPs and CNS'.

An overview of selected Medicare regulations follows.

- Medicare generally defers to states' laws authorizing the scope of practice for each type of NPP.
- Nurses who are not licensed to practice in one of the Medicare NPP designations are considered "auxiliary" personnel and are not allowed to bill Medicare directly for their professional services. Hospitals cannot bill separately for the professional services of nurses who are considered auxiliary personnel.
- Each type of NPP must meet specific Medicare professional qualifications to qualify for Medicare Part B coverage of his/her services (e.g., educational levels, experience, national specialty association certification, state licensure, etc.)
- The NPP or employing organization must accept assignment when billing the NPP's services to Medicare.
- Medicare may pay the NPP directly or may pay the organization with which the NPP has a legal business relationship based on the National Provider Identifier (NPI) on the claim. PAs, however, are not paid directly by Medicare; instead, Medicare pays only the PA's employer.

- Medicare payment for NPPs’ services is based on a percent of the Medicare Physician Fee Schedule allowable. Assistant at surgery services are allowed for NPPs and payment is based on a percent of the Medicare Physician Fee Schedule allowable.
- The Medicare allowed amount for a given service is 15% more for services billed under an MD NPI (National Provider Identifier) than those billed under an NPP NPI. For NPP reimbursement, Medicare allows 85% of 80% (i.e., 68%) of the Medicare Physician Fee Schedule amount.
- Services performed by the NPP must be considered “physician services” as defined in Medicare regulations in order to qualify for reimbursement. “Physician services” are diagnosis, therapy, surgery consultation, and care plan oversight. These services are covered by Medicare **to the extent the services are authorized by the NPP’s state scope of practice act.** Covered services in these categories are those that are described in the AMA’s CPT book and, to a lesser extent, in CMS’ HCPCS National Level II Code book. (Medicare does not cover or reimburse separately all physician services.)
- Services must be medically necessary as defined by Medicare.
- Billed services must be supported by documentation in the medical record. Codes on the claim must correspond to the billed service.
- The NPP must have a Medicare provider number (subject to specific requirements in Medicare regulations).
- Services must be billed under the provider number of the clinician providing the service.
- Services must be performed in collaboration with or, for a PA, under the general supervision of a physician.
- Medicare pays only certain parties, specified in the law. See Medicare reference documents below.
- Professional services provided by a hospital-based PA may be billed by a hospital when the PA is employed by the hospital. Hospitals may bill the Medicare Carrier for professional services of an NP or CNS furnished to hospital inpatients and outpatients when payment for their services has been reassigned to the hospital and when the hospital bills for these services under the NP’s or CNS’s NPI. Refer to CMS Manual 100-4 Medicare Claims Processing, Chapter 12, section 120.1 Direct Billing and Payment for Non-Physician Practitioner Services Furnished to Hospital Inpatients and Outpatients.

Medicare “Incident to” Services

Medicare “incident to” regulations are, in part, as follows. These regulations apply to services provided in the physician office place of service. They do not apply to services provided in the hospital place of service. See Medicare Benefit Policy Manual 100-2, Chapter 15, Section 60.1 for complete details.

“60.1 Incident to Physician's Professional Services. --Incident to a physician's professional services means that the services or supplies are furnished as an integral, although incidental, part of the physician's personal professional services in the course of diagnosis or treatment of an injury or illness.”

See also Section 60.2 of the same manual for “Services of Nonphysician Personnel Furnished Incident to Physician's Services” for important, additional information regarding these services.

Both sections provide extensive information on “incident to” services that should be reviewed. They can be found on the CMS web site at

<http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>

Recommended Actions

To determine **specific** coding, billing, and reimbursement for your NPP designation, the following list of steps is recommended. The list is not all-inclusive. Most of the recommended documents or contacts are readily available on the Web.

- Obtain a copy of your state practice act. Identify the scope of practice and list of duties and allowed services/procedures for your NPP certification.
- Determine whether you are allowed to practice independently or must be employed or contracted with a health care organization (e.g., physician group, hospital, SNF, other) to practice in your state. You may wish to contact your state board for this information and it may be included in the state practice act.
- If you are employed by a physician or hospital organization, the appropriate administrative department (e.g., Billing, Reimbursement, HR and/or other) may already have the information you need to determine coverage, coding and billing guidelines. Such organizations may have retained the services of NPPs in the past and may already have these processes in place.
- Contact each payer in your state/locality to obtain coverage information and, if available, coding guidelines. Generally, this

information is available from the Provider Services Department.

- Contact Provider Services at your local Medicare **Carrier** to obtain coverage, coding and billing information. Be certain to indicate whether you are in independent practice or are employed or have another arrangement with a healthcare organization. (Medicare Carriers pay claims for NPP professional services; Medicare Fiscal Intermediaries pay claims for technical/hospital services.)
- For Medicare regulations, go to www.cms.gov. Select in this sequence: “Regulations and Guidance; Manuals; Internet Only Manuals; Publication “100-04 Medicare Claims Processing Manual;” Chapter 12. At the chapter 12 screen use Ctrl-F (Find) and enter “nonphysician” which will bring up all instances of regulations that affect NPPs. See also section 120.1 of the same chapter which specifically focuses on NPPs.
- Contact your state Medicaid/Medical Assistance Department, requesting information on how to obtain coverage, coding and billing guidelines for your state’s Medicaid program. You may be referred to a state-contracted Fiscal Agent that administers and pays claims for the state program. Also, request the names, contact numbers, and or web site for any Medicaid MCOs (Managed Care Organizations) with whom the state has contracted. Obtain the same information from their Provider Services Departments.
- Contact the state Worker’s Compensation Board or equivalent entity to request coverage, billing, coding, and payment information. Request names and contact information for W/C contractors/payers and contact their offices for the foregoing information.

GENERAL CPT CODING GUIDELINES FOR PROFESSIONAL SERVICES PROVIDED BY A NON- PHYSICIAN PRACTITIONER

The following describes general CPT coding guidelines for reporting **professional** services provided by an NPP. Specific guidelines are not included because of the variability of requirements by licensure, state, payer, and practice relationships.

Please refer to the “Key Concepts,” “Evaluation and Management,” and “Surgical Procedures” chapters in the Coding for Physician Services part of this manual for detailed information regarding coding professional services and procedures.

Evaluation and Management (E/M) Services

CPT Definitions

New patient: Patient has not received professional services from the physician or another physician of the same specialty in the group *within the past three years.*

Established patient: Patient has received professional services from the physician or another physician of the same specialty in the group *within the past three years.*

Medicare Definition: New Patient

New patient: A patient who has not received any professional services, i.e., E/M service or other face-to-face service (e.g., surgical procedure) from the physician or physician group practice (same physician specialty) within the previous 3 years. For example, if a professional component of a previous procedure is billed in a 3-year time period, e.g., a lab interpretation is billed and no E/M service or other face-to-face service with the patient is performed, then this patient remains a new patient for the initial visit. An interpretation of a diagnostic test, reading an x-ray or EKG etc., in the absence of an E/M service or other face-to-face service with the patient does not affect the designation of a new patient.

1 E/M per Day

Only one E/M service is allowed per day, per patient. Exceptions are allowed in certain cases. See “1 E/M per day, unless” topic in the Evaluation and Management chapter under the Coding for Physician Services part of this manual.

Code Selection Guidelines

Please refer to the sections entitled “Selecting the Correct Level of Service—Determined by Documentation,” “CMS Requirements,” and “CPT and CMS Documentation Requirements” at the beginning of the Evaluation and Management chapter in the Coding for Physician Services part of this manual.

Code selection and documentation guidelines are mandatory and must be followed by the NPP for reporting/billing purposes.

Shared E/M Services—Physician and Non-Physician Practitioner

Medicare Policy and Coverage

The “Shared E/M” concept is a Medicare policy. At this time, few, if any, other payers have adopted this policy.

Only part of this policy is explained here. For additional details, see the Evaluation and Management chapter, “Shared E/M Services” section of the Coding for Physician Services, Part I, of this manual.

KEY POINTS

The “Shared E/M” concept is unique to Medicare. Few, if any, other payers have adopted this policy.

Guidelines for physician office/clinic, Place of Service (POS) 11, differ from those for hospital inpatient (POS 21), outpatient (POS 22), and ED (POS 23).

When an E/M service is shared in the physician office/clinic setting (Place of Service (POS) 11 *only*), it is considered to be an “incident to” service if the “incident to” requirements are met and the patient is an established patient. The service may be billed using the physician’s NPI number. If the “incident to” requirements are not met, the service must be billed under the NPP’s NPI.

In a hospital inpatient (POS 21), outpatient (POS 22) or emergency department (POS 23) setting, if an E/M service is shared between a physician and NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under **either** the physician’s or NPP’s NPI number. If there is no face-to-face encounter between the patient and physician, the service may only be billed under the NPP’s NPI number. Medicare payment will be based on the rendering NPI number on the claim.

Note: Regardless of place of service, Medicare does not allow payment for a “shared E/M” consultation service provided by both a physician and a non-physician practitioner (NPP). If a physician and an NPP provide a shared consultation service, it must be billed using the NPP’s NPI number, not the physician’s NPI number. A physician may bill a consultation under his NPI number only when all 3 key components have been performed and documented by the physician.

Office/Outpatient Clinic Visits (New Patient 99201-99205, Established Patient 99211-99215)

NPP Employed by or with Legal Business Relationship to Physician/Group Practice

- New and established patient visits may be allowed, subject to state scope of practice and payer guidelines.
- Under Medicare’s “incident to” provisions, E/M office visits are generally limited to established patient visits only (99211-99215) when billing for care of a Medicare beneficiary. Medicare requires the physician to provide the “initial” visit and provide “subsequent services of a frequency which reflect active participation in the management of the course of treatment” with supporting documentation. Medicare provides no further definition of “initial” and “subsequent services” requirements. Medicare “incident to” provisions apply to services provided in the physician office/clinic that are designated as Place of Service/POS 11.
- For complete Medicare “incident to” provisions, see the CMS manual 100-2 Medicare Benefit Policy Manual chapter 15, section 60, at <http://www.cms.hhs.gov/manuals/Downloads/bp102c15.pdf>
- See also “Medicare Regulations” under “Coding and Payer Issues” in the introductory material for this chapter.
- Other payers may follow Medicare guidelines or may allow both new and established patient visits by the NPP. Coverage varies by payer, by state.
- Level of service must be selected based on CPT code definition and AMA/CMS Documentation Guidelines for Evaluation and Management Services (1995 OR 1997 guidelines). See AMA or CMS web sites for exact description of these guidelines.
- Visits for postoperative follow up visits during the global surgery period of a previous surgical procedure performed by the practice physician or the NPP are not separately billable as they are included in the global fee/payment for the surgical procedure.

NPP Employed by or with Legal Business Relationship to Hospital

- The following applies to the NPP who provides E/M services in the outpatient hospital setting (Place of Service/POS 22).
- Subject to state scope of practice and billing regulations as well as payer guidelines, established patient visits may be allowed. New patient visits may or may not be allowed by the NPP.
- Medicare’s “incident to” provisions do not apply to E/M service provided in the outpatient hospital setting.
- Level of service must be selected based on CPT code definition and AMA/CMS Documentation Guidelines for Evaluation and

Management Services (1995 OR 1997 guidelines). See AMA or CMS web sites for exact text of guidelines.

- Postoperative follow up visits during the global surgery period of a previous surgical procedure performed by the NPP are not separately billable as they are included in the global fee/payment for the surgical procedure.
- Postoperative follow up visits **provided by the hospital-based NPP** during the global surgery period of a previous surgical procedure **performed by a surgeon** are subject to the following considerations:
 - a. If the global fee for the surgery is billed by the surgeon, postoperative care is **included** in the fee and payment to the surgeon. If the hospital-based NPP provides and bills postoperative care (e.g., visits) instead of the surgeon, the payer will be billed twice and pay twice for the same service. The issue of a surgeon false claim and duplicate billing occurs. Hence, careful coordination between the surgeon and hospital-based NPP must occur with respect to coding and billing for the respective services. In this situation, the surgeon should bill using the split care modifier -54 (Surgical care only) with corresponding fee reduction. The NPP should bill using modifier 55 (Postoperative care only), following payer guidelines for doing so. (Some payers allow separate billing of each visit code with the modifier. Medicare requires submission of the surgery code with the modifier. Rules for using modifiers when billing these services are listed in detail in Appendix IV “Modifiers: Physician Services.”)

Consultations (99241-99245)

- Please refer to Consultations in the Evaluation and Management chapter of the Coding for Physician Services, Part I, of this manual for definition and requirements for a consultation as well as coding and reporting guidelines. See also Shared E/M Services section in the same chapter.
- Medicare no longer allows payment for CPT consultation codes regardless of place of service. For consultations provided to Medicare patients, see also “**Rules for Medicare Coding & Payment of Consultations**” in the Consultations section of the Evaluation and Management chapter.
- Refer also to the Medicare policy for shared consultations under Shared E/M Services—Physician and Non-Physician Practitioner in preceding text of this section.

- When authorized by state scope of practice and payer guidelines, consultations may be coded and reported as long as the requirements for a consultation are met.

Inpatient Hospital Care

- Admission H&P (99221-99223) is generally performed by the physician.
- Federal law mandates that hospitals must require that “every patient must be under the care of a physician.”
- NPPs may provide care in the acute care hospital (as well as other non-acute hospitals) within the scope of practice authorized by state law or if specifically delegated by a physician.
- Subsequent hospital visits (99231-99233) may be reported when provided and documented consistent with code reporting requirements based on CPT code selection guidelines and CMS documentation guidelines. For NPPs employed by a physician/group, subsequent hospital visits provided during postoperative period of a previous surgical procedure performed by the practice physician or the NPP are not separately billable as they are included in the global fee/payment for the surgical procedure.
- Hospital discharge day management (99238-99239) may be reported when provided and documented under specific circumstances. Time must be documented for appropriate code selection. Refer to “Discharge Day Management” section in the Evaluation and Management chapter of the Coding for Physician Services part of this manual for specific coding and documentation guidelines.

For NPPs employed by a physician/group, hospital discharge day management **provided during postoperative period** of a previous surgical procedure performed by the practice physician or the NPP is not separately billable as the discharge is included in the global fee/payment for the surgical procedure. For a medical admission (global surgery not performed) or when the discharge day management occurs **after** the end of the global surgery period, the applicable discharge day management code may be reported as appropriate.

Global Periods

For a detailed discussion of guidelines for global surgery and postoperative follow up periods defined for the CPT surgical package and Medicare’s global surgery package, see the “Global

Periods” section in the Key Concepts chapter in the Coding for Physician Services part of this manual. That information is also summarized in table form in Appendices II and III.

Global Surgery Package

- Applies to surgical procedures and certain medical invasive procedures.
- Generally defined as a package of services included in the surgeon’s fee and payer’s reimbursement. The package includes postoperative care for a period of days (e.g., 0, 10, 90, other) following the surgery. Both CPT and Medicare have defined the global surgery package.
- CPT surgical package defines only the included services; it does not specify the number of days of postoperative care included in the package. A few workers’ compensation plans and a number of private payers may utilize this definition and set varying time periods for postoperative care that is included in the fee for the surgery.
- Medicare global surgery package differs from the CPT package in that it defines more specifically the included services and the global surgery time period. Medicare further defines services included in major and minor surgeries as well as preoperative, intraoperative, and postoperative included services. Other government payers as well as an increasing number of worker’s compensation and private payers have adopted Medicare’s global surgery package guidelines.
- See Appendices II and III for summary information and “Global Periods” in the Key Concepts chapter in the Coding for Physician Services part of this manual.

Surgical Procedures

NPPs may perform surgical procedures, typically minor procedures, within the scope of practice authorized by state law. Coverage, coding and billing are subject to individual payer requirements and vary by payer, by state.

Medicare allows “services that traditionally have been reserved to physicians, such as physical examinations, minor surgery, setting casts for simple fractures, interpreting X-rays, and other activities that involve an independent evaluation or treatment of the patient’s condition” subject to state scope of practice authorizing such services.

NPPs may also provide assistant at surgery services, consistent with state scope of practice and licensure requirements for the NPP.

Typical NPP Surgical Services

Among burn surgical procedures typically performed by NPPs are burn wound debridement and dressing changes. For specific coding guidelines for coding and reporting these procedures performed by a **Non-Physician Practitioner**, please refer to the sections on Debridement and Dressing Change in the Surgical Procedures: Surgery and Bedside chapter, Procedural Services subchapter.

Assistant at Surgery NPP Services

Medicare carriers pay covered PA assistant at surgery services at 85 percent of the 16 percent of the physician fee schedule amount (i.e., 10.4 percent). The “AS” modifier must be appended to the applicable CPT code on the claim to indicate the PA provided assistant surgery services.

Diagnosis Coding for NPP Services

Assignment of diagnosis codes for NPP professional services follows the same guidelines as those for physician professional services. For detailed information regarding coding burn and non-burn diagnoses, please refer to the Chapter “Diagnosis Coding for Physician Services” in the Coding for Physician Services part of this manual.

The Appeal Process

MEDICARE AND OTHER PAYER APPEALS

Burn surgeons are encouraged to make contact with the medical director of the CMS Medicare Contractor who has jurisdiction over their claims. A telephone conversation identifying the unusual medical issues involved in providing care for a critically burned patient will help in the interpretation of the codes and, in many instances, may abort a denial or, at the least, facilitate an appeal. Similarly, contact with the medical director of Blue Cross Blue Shield or other third party carriers will serve a similar purpose.

When appealing any issue, it is important to realize that decisions are frequently made by nonprofessional personnel and a phone call to the medical director of the agency responsible for reimbursement may resolve the issue. When this fails there is a defined methodology for appeal to Medicare and a similar process for other third party payers and insurers. Contact provider services at Blue Cross Blue Shield or other third party payers to obtain information regarding the appropriate steps for appealing a claim.

MEDICARE APPEALS

For current, detailed guidelines and instructions on the entire appeals process for institutional and physician provider claims, see CMS Internet-only Pub. 100-4 Medicare Claims Processing Manual, Chapter 29 at the CMS web site <http://www.cms.hhs.gov/manuals/downloads/clm104c29.pdf>

Essentially, the appeals process is the same for burn surgeons and burn center hospitals with the exception of where the initial appeal, the redetermination, is filed and, for physician claims, whether the claim is assigned or non-assigned.

Where to File an Appeal

LEVEL	PART A	PART B
Redetermination	MAC	MAC
Reconsideration	QIC	QIC
ALJ	DHHS OMHA Central Docket	DHHS OMHA Central Docket
Appeals Council Review	Appeals Council	Appeals Council

Effect of Assignment on Physician Appeals

The appeals process prescribed by Medicare is determined by whether the claim has already been assigned or is non-assigned. For the assigned claim, the provider, the patient, or the patient’s representative may request a review. Non-assigned claims are handled differently. When the claim is non-assigned, the provider may request a review only if the payment was denied or reduced due to medical necessity guidelines and the provider is liable for the denial or payment reduction. On the other hand, the provider may request a review if the beneficiary gives written authorization to request a review.

Attention to Detail in the Appeals Process

Caution: Always follow your Medicare contractor’s written instructions to the letter at each level of the appeals process. Deviating from those instructions can disqualify your appeal leaving you with, in most cases, no recourse. Also, should you anticipate an appeal beyond the first level, always review all the Medicare Manual references provided here before moving forward, keeping in mind the time deadlines for each step of appeal.

Overview of Steps in the Process

Contractors cannot accept an appeal for which no initial determination has been made. This means that the contractor must make an initial determination on the claim before the first level of an appeal can be filed.

There are 15 types of “initial determinations,” each of which is defined in CMS Pub. 100-4 Medicare Claims Processing Manual, Chapter 29, section 200.b. **In general, an initial determination is Medicare’s initial decision as to whether or not a claim is payable.** Because they vary significantly, it is strongly recommended that the definitions be reviewed when considering an appeal.

Each level must be completed for each claim at issue prior to proceeding to the next level of appeal.

“The appellant must begin the appeal at the first level after receiving an initial determination. Each level, after the initial determination, has procedural steps the appellant must take before appealing to the next level. If the appellant meets the procedural steps at a specific level, the appellant is then afforded the right to appeal any determination or decision to the next level in the process. The appellant may exercise the right to appeal any determination or decision to the next higher level, until appeal rights are exhausted. Although there are five distinct levels in the Medicare appeals process, the re-determination, level 1, is the only level in the appeals process that the contractor performs.”

The following table summarizes each level in the Medicare appeals process. An explanation of each level follows the table.

APPEAL LEVEL	TIME LIMIT FOR FILING REQUEST	MONETARY THRESHOLD TO BE MET
1. Redetermination	120 days from date of receipt of the notice initial determination	None
2. Reconsideration	180 days from date of receipt of the redetermination*	None
3. Administrative Law Judge (ALJ) Hearing	60 days from the date of receipt of the reconsideration	Current AIC requirements can be found on CMS.gov at: http://www.cms.gov/Medicare/ Appeals-and- Grievances/OrgMedFFSAppeal s/HearingsALJ.html . See §250 for additional information.
4. Departmental Appeals Board (DAB) Review/Appeals Council	60 days from the date of receipt of the ALJ hearing decision	None

5. Federal Court Review

60 days from date of receipt of the Appeals Council decision

Current AIC requirement can be found on CMS.gov at: [http://www.cms.gov/Medicare/ Appeals-and- Grievances/OrgMedFFSAppeal s/Review-Federal-District- Court.html](http://www.cms.gov/Medicare/Appeals-and-Grievances/OrgMedFFSAppeals/Review-Federal-District-Court.html). See §345 for

APPEAL LEVEL	TIME LIMIT FOR FILING REQUEST	MONETARY THRESHOLD TO BE MET
(DAB)		
5. Judicial review in U. S. District Court	Filed within 60 days of receipt of MAC/DAB decision or declination of review by MAC/DAB	At least \$1,220 remains in controversy**

*

First Level Appeal

Claim **redetermination**, formerly “claim review,” is the first level of appeal. A redetermination is an examination of the contractor’s initial claim decision. The request for redetermination must be made in writing.

(A telephone reopening of a claim may be permitted by some contractors for clerical omissions.)

A written request for redetermination can be filed in the following ways:

1. Highlighting on your remittance advice the services to be reviewed. A detailed letter should be included identifying specifically why the initial decision may be incorrect. A copy of the claim and any supporting documentation relating to the service should accompany the written review. The service to be reviewed should be specifically identified to ensure a timely and accurate reply to the review request.
2. Many carriers will provide a sample form for inquiry regarding a claim. Or, the form can be downloaded from <http://www.cms.hhs.gov/forms/>. The forms may also be obtained by requesting the CMS 1964 form. The form can be obtained by writing to:

Superintendent of Documents
 United States Government Printing Office
 Washington, D.C. 20402

Written appeals should then be mailed to the Medicare carrier.

CAUTION: A review/redetermination must be requested within four months from the date the claim was denied. Consideration will be given for review requests ***filed late only for “good cause.”*** Findings of good cause are generally limited to:

- Incorrect or incomplete information from the Medicare Part B carrier, Social Security Administration, or the Health Care Financing Administration.
- Damage to records as a result of fire, theft, etc.

Second Level Appeal

Reconsideration: If you are still dissatisfied after a redetermination decision has been made, you may request a reconsideration. This level of appeal is performed by a Qualified Independent Contractor (QIO).

The request for a reconsideration must be in writing such as a letter or similar written statement. Optionally, CMS form 20033 may be used instead to request the hearing.

Third Level Appeal

Administrative Law Judge Hearing: If you are dissatisfied with the result of the reconsideration and your case qualifies (amount in controversy is at least \$120 or more per CMS guidelines stated in the double-asterisked note below the table), you can request an ALJ hearing by writing to the entity specified in the QIC’s reconsideration. The QIC will specify the appropriate OMHA (Office of Medicare Hearings and Appeals) field office as the filing location for ALJ hearing requests. Filing must take place within 60 days after receiving the reconsideration decision.

The request for an ALJ hearing must be made in writing. The request must include all of the following:

1. The name, address, and Medicare health insurance claim number of the beneficiary whose claim is being appealed,
2. The name and address of the appellant, when the appellant is not the beneficiary,
3. The name and address of the designated representative, if any,
4. The document control number assigned to the appeal by the QIC, if any,

5. The dates of service,
6. The reasons the appellant disagrees with the QIC's reconsideration or other determination being appealed, and
7. A statement of any additional evidence to be submitted and the date it will be submitted.

For the convenience of parties, HHS provides a form that may be used to request a Medicare ALJ hearing. The contractor provides copies of the form to parties upon request. It is not necessary, however, that this form be used to make a written request.

See:

<http://new.cms.hhs.gov/cmsforms/downloads/cms20034ab.pdf> for the hearing request form used when the request follows a QIC reconsideration

and <http://new.cms.hhs.gov/cmsforms/downloads/cms5011a-b.pdf> for the hearing request form used when the request follows a carrier hearing officer hearing or FI reconsideration.

Refer to CMS Internet-only Pub. 100-4, Medicare Claims Processing Manual, Chapter 29, section 330 for additional requirements.

Fourth and Fifth Levels of Appeal

For subsequent steps in the appeal process, refer to your Medicare Contractor's instructions on its web site and to Chapter 29 of the internet only Medicare Claims Processing Manual 100-4. See sections 340 and 345 for the MAC/DAB and U. S. District Court appeals process. Follow the instructions *to the letter; do not deviate from them* or your appeal may be disqualified.

APPEAL RESPONSE

Once a review has been requested and is processed, the provider will receive a written response. The response varies with the action taken:

1. If the original decision is upheld, a detailed letter will be sent advising why additional payment cannot be allowed.
2. If the original decision can be changed and payment is due, a new remittance advice and a check will be issued.
3. If the original decision on the claim is changed, but no further payment is due, a letter will be sent which explains why no payment is forthcoming. A new remittance advice will be

issued indicating that a correction was made to the previously processed claim.

4. If a portion of the claim can be allowed, a check with a corrected remittance advice will be issued for the services allowed. A separate explanatory letter will be sent advising that an adjustment has been made.

Coding for Facility (Hospital) Services

- **Key Concepts**
- **Inpatient Hospital Coding**
- **Outpatient Hospital Department Coding**

Key Concepts

WHAT IS CODING?

KEY POINT

Codes represent documented information that substantiates services billed on the claim.

Coding is the process of transforming *documented* medical information into a condensed form by substituting numeric or alphanumeric codes and descriptions for the actual individual procedures and services performed and the diagnoses treated.¹⁵

Codes are the *sole* source of information that an insurance company or third party payer uses to determine what was done for a patient, why it was done, and whether and how to pay a claim.

Studies repeatedly confirm that 30% of all health care claims contain one or more coding errors. Careful attention to coding rules and insurer guidelines can prevent these errors.

Codes are published in several national standard *coding systems* that list the codes with their descriptions and, with the exception of HCPCS Level II codes, generally include guidelines for using the codes and the coding system itself.

CODING SYSTEMS USED BY HOSPITALS

Two types of coding systems are used by hospitals when submitting claims for their services.

An overview of each of the following coding systems is provided in this chapter.

- Procedure coding systems
- Diagnosis coding system

¹⁵ Kotoski, GM. CPT Coding Made Easy: A Technical Guide: Gaithersburg: Aspen Publishers, Inc., 1992–2000. Reprinted with permission

CODING SYSTEMS FOR HOSPITAL CLAIMS

Procedure Coding Systems

Inpatient Hospital

One coding system is used to report inpatient hospital procedures.

The procedure coding system used in the Inpatient Hospital setting is:

- ICD-10-PCS, the **I**nternational **C**lassification of **D**iseases, 10th Revision, Procedural Coding System

The Chapter, “Inpatient Hospital Coding,” includes

- a brief verbatim excerpt of general inpatient coding guidelines for procedures from the CMS/Medicare *ICD-10-PCS Official Guidelines for Coding and Reporting Procedures*; and
- a summary of specific coding guidelines for inpatient hospital procedures relevant to burns based on ICD-10-PCS

Outpatient Hospital

Two coding systems are used to report outpatient procedures, services or supplies provided by outpatient hospital facilities, ambulatory surgical centers, and other facilities.

The procedure coding systems used in the Outpatient Hospital setting are:

- CPT-4 (**C**urrent **P**rocedural **T**erminology, American Medical Association) CPT is designated as Level I of HCPCS by CMS (CMS Healthcare Common Procedure Coding System) CPT codes are 5 digit numeric and CPT modifiers are 2 digit numeric.
- HCPCS (**H**ealthcare **C**ommon **P**rocedure **C**oding **S**ystem) HCPCS is comprised of two levels of codes: Level I (CPT) and HCPCS National Level II codes. The latter is updated annually by CMS and published by CMS and commercial publishers. Level II codes also include Level II national modifiers. HCPCS Level II codes are 5-character alpha-

numeric codes (e.g., J1234). Level II modifiers are 2-character alpha or alpha-numeric.

Coding Guidelines for CPT and HCPCS

Coding guidelines for CPT codes relevant to burn services provided by the outpatient hospital department are listed under each topic where applicable in the chapter “Outpatient Hospital Department Coding for Medicare.” See each of the subchapters: “Evaluation and Management Services (Medicare)” and “Medicare: Reporting Outpatient Procedures.”

Coding guidelines for the HCPCS coding system are:

- those inherent in each code’s nomenclature and
- the coverage and reporting guidelines published by CMS in its Transmittals and other publications that discuss certain supplies and services reported using HCPCS Level II codes.

For example, one HCPCS Level II code may specify 50 mg. and another code may specify 100 mg. of the same medication. The correct code is selected on the basis of the particular strength of the medication administered.

Because of the size, extent, and frequent revisions that are published in CMS/Medicare Transmittals that cover HCPCS Level II codes and coding, HCPCS guidelines are generally not included in this manual.

Other than the above, the HCPCS coding system provides no single set of guidelines for reporting.

Diagnosis Coding System

Inpatient and Outpatient Hospital

The coding system used to report medical conditions or other reasons for health care encounters provided by facilities is

- ICD-10-CM (**I**nternational **C**lassification of **D**iseases, **10**th Revision, **C**linical **M**odification) The entire ICD-10-CM coding system is mandated by law for submission of health care claims for services in all settings.

Web links to the complete CMS/Medicare ICD-10-CM Official Guidelines for Coding and Reporting are included in both the Inpatient Hospital Coding and the Outpatient Hospital Department Coding chapters and Physician

Diagnosis coding for your reference.

The ICD-10-CM is not copyrighted and both codes and guidelines are free on the web.

The Chapter “Inpatient Hospital Coding,” includes

- a verbatim excerpt of inpatient coding guidelines for diagnoses, including coding for burns, from the CMS/Medicare *ICD-10-CM Official Guidelines for Coding and Reporting*
- a summary of coding guidelines for burns and related conditions for inpatient hospital services based on ICD-10-CM

The Chapter “Outpatient Hospital Department Coding,” includes

- a verbatim excerpt of outpatient coding guidelines for diagnoses, including coding for burns, from the CMS/Medicare *ICD-10-CM Official Guidelines for Coding and Reporting*; and
- a summary of coding guidelines for burns and related conditions for outpatient hospital services based on ICD-10- CM.

PLEASE NOTE: Full detail of the coding guidelines are contained in these 2 references so they are not repeated here.

Coding Systems—Effective Dates of Annual Updates

Coding System Or DRG Update	Effective Date As of January 1, 2005, Federal HIPAA legislation requires use of codes as of their effective date. Use of discontinued codes will result in claim denial.	Source / Publisher
CPT-4	January 1 of each year.	AMA
ICD-10	October 1 of current year through September 30 of following year.	National Center Vital & Health Statistics & CMS
HCPCS Level II	January 1 of each year.	CMS
MS-DRG (Medicare's Inpatient Prospective Payment System)	October 1 of current year through September 30 of following year.	CMS
APCs (Medicare's Outpatient Hospital)	January 1 of each year.	CMS

Coding System Or DRG Update	Effective Date As of January 1, 2005, Federal H I P A A legislation requires use of codes as of their effective date. Use of discontinued codes will result in claim denial.	Source / Publisher
Prospective Payment System)		

CMS OFFICIAL INPATIENT AND OUTPATIENT CODING GUIDELINES MANDATED BY LAW

The CMS/Medicare Official inpatient and outpatient coding guidelines for ICD-10-CM are mandated by federal law for use on health care claims in all settings.

- As noted in the preceding section, relevant verbatim excerpts from the *ICD-10-CM Official Guidelines for Coding and Reporting* are provided in the chapters that follow.

These verbatim excerpts provide the essentials of diagnosis and procedure [inpatient only] coding for convenient reference when coding burn services.

This manual does not, however, include the basics of ICD-10 coding. The novice coder is referred to basic texts published by professional organizations and commercial publishers. To foster accurate coding, coders are reminded that official coding steps and rules must be followed at all times when abstracting the medical record, searching the ICD-10-CM index, and assigning a code. Therefore, the information in succeeding chapters should be viewed as a guide and reference that can be used in support of appropriate coding activities.

The most current, complete (full text), *ICD-10-CM Official Guidelines for Coding and Reporting* can be found at the CDC's National Center for Health Statistics web site:

https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf

All entities that submit or accept health care claims must use, accept, and follow, as appropriate, these Guidelines. This requirement is based on federal HIPAA legislation (Administrative Simplification).

According to the current introduction to the Official Guidelines:

“These guidelines are a set of rules that have been developed to accompany and complement the official conventions and instructions provided within the ICD-10-CM itself. Adherence to these guidelines when assigning ICD-10-CM/PCS diagnosis and procedure codes is required under the Health Insurance Portability and Accountability Act (HIPAA). The diagnosis codes have been adopted under HIPAA for all healthcare settings. ICD-10-PCS procedure codes have been adopted for inpatient procedures reported by hospitals.”

“The term encounter is used for all settings, including hospital admissions. In the context of these guidelines, the term provider is used throughout the guidelines to mean physician or any qualified health care practitioner who is legally accountable for establishing the patient's diagnosis. Only this set of guidelines, approved by the Cooperating Parties, is official.”

Inpatient Hospital Coding

This chapter is divided into two sections:

- Inpatient Hospital Reimbursement under DRGs/MS-DRGs
- Inpatient Hospital Coding for Burn MS-DRGs

INPATIENT HOSPITAL REIMBURSEMENT UNDER DRGs/MS-DRGs (DIAGNOSIS RELATED GROUPS)

DRG Background Summary

Reimbursement from Medicare, certain Medicaid state plans and some non-government payers is based on DRGs. DRGs are a “prospective” payment system used by CMS for reimbursement of inpatient acute care hospital stays for Medicare beneficiaries.

Typically, acute care hospitals use software programs called encoders to evaluate various data elements, “group” them together, and, using the software grouping logic, assign each case to an appropriate DRG classification with a corresponding payment rate. Some of the key factors used to determine a DRG are principal and secondary diagnoses, significant surgical procedures, sex, and discharge status. The most current hospital encoders reflect the same “grouping” concepts used in CMS’s “Grouper” software utilized by its Fiscal Intermediaries.

Using the CMS/NCHS official inpatient coding guidelines and the medical record as a source document, Health Information Management (HIM) coders abstract specific demographic information from the record and select the code for the principal diagnosis, secondary diagnoses and surgical procedures performed during the inpatient stay. The information and codes are entered into the encoder system. The encoder selects the most appropriate DRG for the stay and reimbursement for the hospital.

Once the DRG has been established for the patient's inpatient stay and the claim submitted, the Medicare fiscal intermediary reimburses the hospital based on the relative weight assigned to the DRG multiplied by the individual hospital's specific reimbursement base rate.

Major Diagnostic Category 22 (MDC 22): Burns & MS-DRGs

A major diagnostic category (MDC) is a broad classification of principal diagnoses, typically grouped by body system. When DRGs were initially developed, all possible principal diagnoses were segmented into mutually exclusive groups that are now known as MDCs.

Under MS-DRGs, the diagnosis related groups for burns continue to be classified under MDC 22. Separate codes are utilized based upon the severity of the burn and are categorized by individual codes related to the extent of full thickness burn and the association with pulmonary inhalation injury or with associated complications and comorbidities with which the patient presents or develops during the stay. Although burn surgeons are not directly involved in the DRG categorization, burn center hospital coders and the hospital are dependent upon correct diagnoses so that reimbursement utilizing DRG's is equitable.

Hospital reimbursement is directly related to burn surgeons' documentation of the hospital course and the final discharge summary.

CC Exclusions List for MS- DRGs

CMS retained the CC exclusions list concept for MS-DRGs. The exclusions list is made up of certain MCCs and CCs that are excluded from consideration *as MCCs or CCs when submitted with a given principal diagnosis*. These MCCs and CCs are excluded because they are too closely related to the principal diagnoses and to ensure that cases are appropriately classified between the complicated and uncomplicated DRGs in a pair.

The complete CC Exclusions List is published on the CMS web site at

<http://www.cms.hhs.gov/AcuteInpatientPPS>

Look for “Acute Inpatient Files for Download” and go to the pages that list the current year’s Final Rule files. You will need to check each of the “Tables” files listed there by going to the web page for each. Then find the page that lists explanations for each of the CC Exclusions Lists. For example, a Table “x” (such as Table 6) may list the Additions; another may list the Deletions, still another may list the Complete list of CC exclusions for the MS-DRGs. The last is the Table you are looking for. See Description of Table 6 files below:

Tables 6A-6M and Tables 6P.1a-6P.4p (Final Rule and Correction Notice): Table 6A- New Diagnosis Codes; Table 6B-New Procedure Codes; Table 6C-Invalid Diagnosis Codes; Table 6D-Invalid Procedure Codes; Table 6E-Revised Diagnosis Code Titles; Table 6F- Revised Procedure Code Titles; Table 6G.1- Secondary Diagnosis Order Additions to the CC Exclusions List; Table 6G.2- Principal Diagnosis Order Additions to the CC Exclusions List; Table 6H.1- Secondary Diagnosis Order Deletions to the CC Exclusions List; Table 6H.2- Principal Diagnosis Order Deletions to the CC Exclusions List; Table 6I.- Complete MCC List; Table 6I.1- Additions to MCC List; Table 6I.2- Deletions to MCC List; Table 6J.- Complete CC List; Table 6J.1- Additions to CC List; Table 6J.2- Deletions to CC List; Table 6K.-Complete List of CC Exclusions; Table 6L.- Principal Diagnosis Is Its Own MCC List; Table 6M.- Principal Diagnosis Is Its Own CC List; **Tables 6P.1a-6P.4p (ICD-10-CM and ICD-10-PCS Code Designations, MCE and MS-DRG Changes):** See summary tab in excel spreadsheet called “CMS-1677-F TABLE 6P.1a-6P.4P.xlsx” for complete description of all tables.

Table: FY 2018 Burn & Related MS-DRGs (Relative Weights & Length of Stay)

MS-DRG	MS-DRG Title	Weights	Geometric mean LOS	Arithmetic mean LOS
901	WOUND DEBRIDEMENTS FOR INJURIES W MCC	4.1541	9	13.1
902	WOUND DEBRIDEMENTS FOR INJURIES W CC	1.998	5.1	6.8
903	WOUND DEBRIDEMENTS FOR INJURIES W/O CC/MCC	1.2477	3.1	3.9
904	SKIN GRAFTS FOR INJURIES W CC/MCC	3.2509	6.7	9.7
905	SKIN GRAFTS FOR INJURIES W/O CC/MCC	1.4619	3.5	4.4
906	HAND PROCEDURES FOR INJURIES	1.7443	2.9	4.5
907	OTHER O.R. PROCEDURES FOR INJURIES W MCC	4.1721	7.3	10.3
908	OTHER O.R. PROCEDURES FOR INJURIES W CC	2.0254	4	5.2
909	OTHER O.R. PROCEDURES FOR INJURIES W/O CC/MCC	1.4069	2.5	3.1
927	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W SKIN GRAFT	16.9378	23.7	30
928	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W CC/MCC	5.7034	10.7	14.6
929	FULL THICKNESS BURN W SKIN GRAFT OR INHAL INJ W/O CC/MCC	2.6348	5.6	7.5
933	EXTENSIVE BURNS OR FULL THICKNESS BURNS W MV >96 HRS W/O SKIN GRAFT	3.2557	2.8	5.9
934	FULL THICKNESS BURN W/O SKIN GRFT OR INHAL INJ	1.7432	4.3	6.4
935	NON-EXTENSIVE BURNS	1.6879	3.5	5
957	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W MCC	7.3033	9.7	13.8
958	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W CC	4.2558	7.1	8.8
959	OTHER O.R. PROCEDURES FOR MULTIPLE SIGNIFICANT TRAUMA W/O CC/MCC	2.6946	3.9	4.8

Hospital Acquired Conditions 2018 Overview

Section 3008 of the Patient Protection and Affordable Care Act (ACA) established the Hospital-Acquired Condition (HAC) Reduction Program to encourage eligible hospitals to reduce HACs.

Beginning in Fiscal Year (FY) 2015 (i.e., discharges beginning on October 1, 2014), the HAC Reduction Program requires the Secretary of the Department of Health and Human Services (HHS) to adjust payments to hospitals that rank in the worst-performing quartile of all subsection (d) non-Maryland hospitals with respect to risk-adjusted HAC quality measures. Hospitals with a Total HAC Score greater than the 75th percentile of all Total HAC Scores (i.e., the worst-performing quartile) will be subject to a 1 percent payment reduction.

FY 2018 Results

The cutoff for the 75th percentile of Total HAC Scores is 0.3687. The 75th percentile cutoff was 6.5700 in FY 2017. Hospitals cannot directly compare Total HAC Scores or the 75th percentile cutoff between FY 2018 and previous program years because these results are on different scales due to the Winsorized z-score method, which CMS adopted in FY 2018. Please refer to the Scoring Methodology section below for more information.

Public Reporting

CMS will report the following FY 2018 HAC Reduction Program information for each hospital on *Hospital Compare* in December 2017:

Recalibrated PSI 90 Composite measure score

Central Line-Associated Bloodstream Infection (CLABSI), Catheter-Associated Urinary Tract Infection (CAUTI), Surgical Site Infection (SSI), Methicillin-resistant Staphylococcus aureus (MRSA) bacteremia, and Clostridium Difficile Infection (CDI) measure scores

Domain 1 and Domain 2 scores, Total HAC Score, and Payment Reduction Indicator.

CMS refers to PSIs as “recalibrated” to differentiate from the all-payer population for AHRQ.

Measure Selection and Calculation

In the FY 2014 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule, CMS adopted the PSI 90 Composite and CDC CLABSI, CAUTI, SSI (Abdominal Hysterectomy and Colon Procedures), MRSA bacteremia, and CDI measures. In the FY 2017 Inpatient Prospective Payment System (IPPS)/Long-Term Care Hospital Prospective Payment System (LTCH PPS) Final Rule, CMS adopted the modified Recalibrated PSI 90 Composite for the FY 2018 HAC Reduction Program.

Recalibrated PSI 90 Composite

The Recalibrated PSI 90 Composite includes the following ten PSIs:

PSI 03 – Pressure Ulcer Rate

PSI 06 – Iatrogenic Pneumothorax Rate

PSI 08 – In-Hospital Fall with Hip Fracture Rate

PSI 09 – Perioperative Hemorrhage or Hematoma Rate

PSI 10 – Postoperative Acute Kidney Injury Requiring Dialysis Rate

PSI 11 – Postoperative Respiratory Failure Rate

PSI 12 – Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate

PSI 13 – Postoperative Sepsis Rate

PSI 14 – Postoperative Wound Dehiscence Rate

PSI 15 – Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate

Hospital Acquired Conditions (HAC) Rule & Effect on Burn MS-DRG Payment

Overview

A Medicare Only Payment Policy

MS/Medicare describes their HAC policy as follows:

Hospital Acquired Conditions (HAC) is the name given to certain conditions that are complicating conditions (CCs) or major complicating conditions (MCCs) that formerly caused an inpatient case to group to a higher paying MS-DRG when one of them was present as a secondary diagnosis on an inpatient claim.

Under the HAC payment provision, HAC is now used to identify certain CCs or MCCs that will trigger the claim to group to a lower paying MS-DRG instead when the claim indicates that the HAC condition was not present on admission, developed during the hospital stay, is coded as a secondary diagnosis and meets certain other requirements.

LINKS

The link to the 2018 Hospital Acquired Conditions Fact Sheet document is below:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2018-HAC-Reduction-Program-Fact-Sheet.pdf>

The link to the 2018 list for Hospital Acquired conditions can be found at:

https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/HospitalAcqCond/ICD-10_hacs.html.

Hospital Acquired Conditions: Assigning POA (Present on Admission) Indicators

The complete (full text) official guidelines for reporting POA indicators are published in the ICD-10-CM Official Guidelines for Coding and Reporting. Here are the guidelines for 2018:

Appendix I

Present on Admission Reporting Guidelines

Introduction

These guidelines are to be used as a supplement to the *ICD-10-CM Official Guidelines for Coding and Reporting* to facilitate the assignment of the Present on Admission (POA) indicator for each diagnosis and external cause of injury code reported on claim forms (UB-04 and 837 Institutional).

These guidelines are not intended to replace any guidelines in the main body of the *ICD-10-CM Official Guidelines for Coding and Reporting*. The POA guidelines are not intended to provide guidance on when a condition should be coded, but rather, how to apply the POA indicator to the final set of diagnosis codes that have been assigned in accordance with Sections I, II, and III of the official coding guidelines. Subsequent to the assignment of the ICD-10-CM codes, the POA indicator should then be assigned to those conditions that have been coded.

As stated in the Introduction to the ICD-10-CM Official Guidelines for Coding and Reporting, a joint effort between the healthcare provider and the coder is essential to achieve complete and accurate documentation, code assignment, and reporting of diagnoses and procedures. The importance of consistent, complete documentation in the medical record cannot be overemphasized. Medical record documentation from any provider involved in the care and treatment of the patient may be used to support the determination of whether a condition was present on admission or not. In the context of the official coding guidelines, the term “provider” means a physician or any qualified healthcare practitioner who is legally accountable for establishing the patient’s diagnosis.

These guidelines are not a substitute for the provider’s clinical judgment as to the determination of whether a condition was/was not present on admission. The provider should be queried regarding issues related to the linking of signs/symptoms, timing of test results, and the timing of findings.

Please see the CDC website for the detailed list of ICD-10-CM codes that do not require the use of a POA indicator (<https://www.cdc.gov/nchs/icd/icd10cm.htm>) (<https://www.cms.gov/Medicare/Coding/ICD10/2018-ICD-10-CM-and-GEMs.htm> healthcare encounter or factors influencing health status that do not represent a current disease or injury or **that describe conditions that** are always present on admission.

General Reporting Requirements

All claims involving inpatient admissions to general acute care hospitals or other facilities that are subject to a law or regulation mandating collection of present on admission information.

Present on admission is defined as present at the time the order for inpatient admission occurs -- conditions that develop during an outpatient encounter, including emergency department, observation, or outpatient surgery, are considered as present on admission.

POA indicator is assigned to principal and secondary diagnoses (as defined in Section II of the Official Guidelines for Coding and Reporting) and the external cause of injury codes. Issues related to inconsistent, missing, conflicting or unclear documentation must still be resolved by the provider. If a condition would not be coded and reported based on UHDDS definitions and current official coding guidelines, then the POA indicator would not be reported.

Reporting Options

Y - Yes

N - No

U - Unknown

W – Clinically undetermined

Unreported/Not used – (Exempt from POA reporting)

Reporting Definitions

Y = present at the time of inpatient admission

N = not present at the time of inpatient admission

U = documentation is insufficient to determine if condition is present on admission

W = provider is unable to clinically determine whether condition was present on admission or not

Timeframe for POA Identification and Documentation

There is no required timeframe as to when a provider (per the definition of “provider” used in these guidelines) must identify or document a condition to be present on admission. In some clinical situations, it may not be possible for a provider to make a definitive diagnosis (or a condition may not be recognized or reported by the patient) for a period of time after admission. In some cases, it may be several days before the provider arrives at a definitive diagnosis. This does not mean that the condition was not present on admission. Determination of whether the condition was present on admission or not will be based on the applicable POA guideline as identified in this document, or on the provider’s best clinical judgment.

If at the time of code assignment, the documentation is unclear as to whether a condition was present on admission or not, it is appropriate to query the provider for clarification.

Assigning the POA Indicator

Condition is on the “Exempt from Reporting” list

Leave the “present on admission” field blank if the condition is on the list of ICD-10-CM codes for which this field is not applicable. This is the only circumstance in which the field may be left blank.

POA Explicitly Documented

Assign Y for any condition the provider explicitly documents as being present on admission.

Assign N for any condition the provider explicitly documents as not present at the time of admission.

Conditions diagnosed prior to inpatient admission

Assign “Y” for conditions that were diagnosed prior to admission (example: hypertension, diabetes mellitus, asthma)

Conditions diagnosed during the admission but clearly present before admission

Assign “Y” for conditions diagnosed during the admission that were clearly present but not diagnosed until after admission occurred.

Conditions diagnosed prior to inpatient admission

Assign “Y” for conditions that were diagnosed prior to admission (example: hypertension, diabetes mellitus, asthma)

Conditions diagnosed during the admission but clearly present before admission

Assign “Y” for conditions diagnosed during the admission that were clearly present but not diagnosed until after admission occurred.

Diagnoses subsequently confirmed after admission are considered present on admission if at the time of admission, they are documented as suspected, possible, rule out, differential diagnosis, or constitute an underlying cause of a symptom that is present at the time of admission.

Condition develops during outpatient encounter prior to inpatient admission

Assign Y for any condition that develops during an outpatient encounter prior to a written order for inpatient admission.

Documentation does not indicate whether condition was present on admission

Assign “U” when the medical record documentation is unclear as to whether the condition was present on admission. “U” should not be routinely assigned and used only in very limited circumstances. Coders are encouraged to query the providers when the documentation is unclear.

Documentation states that it cannot be determined whether the condition was or was not present on admission

Assign “W” when the medical record documentation indicates that it cannot be clinically determined whether or not the condition was present on admission.

Chronic condition with acute exacerbation during the admission.

If a single code identifies both the chronic condition and the acute exacerbation, see POA guidelines pertaining to codes that contain multiple clinical concepts.

If a single code only identifies the chronic condition and not the acute exacerbation (e.g., acute exacerbation of chronic leukemia), assign “Y.”

Conditions documented as possible, probable, suspected, or rule out at the time of discharge

If the final diagnosis contains a possible, probable, suspected, or rule out diagnosis, and this diagnosis was based on signs, symptoms or clinical findings suspected at the time of inpatient admission, assign “Y.”

If the final diagnosis contains a possible, probable, suspected, or rule out diagnosis, and this diagnosis was based on signs, symptoms or clinical findings that were not present on admission, assign “N”.

Conditions documented as impending or threatened at the time of discharge

If the final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were present on admission, assign “Y”.

If the final diagnosis contains an impending or threatened diagnosis, and this diagnosis is based on symptoms or clinical findings that were not present on admission, assign “N”.

Acute and Chronic Conditions

Assign “Y” for acute conditions that are present at time of admission and N for acute conditions that are not present at time of admission.

Assign “Y” for chronic conditions, even though the condition may not be diagnosed until after admission.

If a single code identifies both an acute and chronic condition, see the POA guidelines for codes that contain multiple clinical concepts.

Codes That Contain Multiple Clinical Concepts

Assign “N” if at least one of the clinical concepts included in the code was not present on admission (e.g., COPD with acute exacerbation and the exacerbation was not present on admission; gastric ulcer that does not start bleeding until after admission; asthma patient develops status asthmaticus after admission).

Assign “Y” if all of the clinical concepts included in the code were present on admission (e.g., duodenal ulcer that perforates prior to admission).

For infection codes that include the causal organism, assign “Y” if the infection (or signs of the infection) were present on admission, even though the culture results may not be known until after admission (e.g., patient is admitted with pneumonia and the provider documents *Pseudomonas* as the causal organism a few days later).

Same Diagnosis Code for Two or More Conditions

When the same ICD-10-CM diagnosis code applies to two or more conditions during the same encounter (e.g. two separate conditions classified to the same ICD-10-CM diagnosis code): Assign “Y” if all conditions represented by the single ICD-10-CM code were present on admission (e.g. bilateral unspecified age-related cataracts).

Assign “N” if any of the conditions represented by the single ICD-10-CM code was not present on admission (e.g. traumatic secondary and recurrent hemorrhage and seroma is assigned to a single code T79.2, but only one of the conditions was present on admission).

External cause of injury codes

Assign “Y” for any external cause code representing an external cause of morbidity that occurred prior to inpatient admission (e.g., patient fell out of bed at home, patient fell out of bed in emergency room prior to admission)

Assign “N” for any external cause code representing an external cause of morbidity that occurred during inpatient hospitalization (e.g., patient fell out of hospital bed during hospital stay, patient experienced an adverse reaction to a medication administered after inpatient admission).

INPATIENT HOSPITAL CODING FOR BURN MS-DRGs

The following section is divided into these main topics:

- General Inpatient Coding Guidelines Excerpted from CMS/Medicare 2018 *ICD-10-CM Official Guidelines for Coding and Reporting* inpatient diagnoses and procedures
- Burn-Specific Coding: Excerpted from 2018 *ICD-10-CM Official Guidelines for Coding and Reporting*
- Discussion: Inpatient Coding of Burn Diagnoses and Procedures
 - ◊ Burn Diagnosis Coding
 - ◊ Sequencing Codes
 - ◊ Additional Coding Information for Burns and Related Conditions
 - ◊ Table: Diagnosis Coding at a Glance
 - ◊ Late Effect of Burns
 - ◊ External Causes of Injury and Poisoning (E Codes)
- PLEASE NOTE: These guidelines for General Coding Guidelines as well as Burn Specific Coding excerpts are under the Physicians Diagnosis Coding Section of this manual. It is not repeated here.
- Procedure Coding (ICD-10-PCS)

- Tips for Inpatient Code Abstraction
- Coding for Specific Burn MS-DRGs 928 & 929

**General Inpatient Coding Guidelines:
Excerpted from *ICD-10-CM Official
Guidelines for Coding and Reporting***

The following links are for the 2018 ICD-10-CM Official Guidelines for Coding and Reporting. See the full text at

https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf

Procedure Coding (ICD-10-PCS)

Definitions

Principal Procedure

The principal procedure is one that was performed for definitive treatment, rather than one performed for diagnostic or exploratory purposes, or was necessary to take care of a complication. If there appear to be two procedures that are principal, then the one most related to the principal diagnosis should be selected as the principal procedure.

Significant Procedure

A significant procedure is a procedure that meets one of the following criteria:

- is surgical in nature
- carries an anesthetic risk
- carries a procedural risk
- requires specialized training

The Actual ICD-10-PCS Reference Manual Can be found by using the following link:
https://www.cms.gov/Medicare/Coding/ICD10/downloads/pcs_refman.pdf

ICD-10-PCS Coding Guidelines

<https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2018-PCS-Guidelines.pdf>

Conventions

A1

ICD-10-PCS codes are composed of seven characters. Each character is an axis of classification that specifies information about the procedure performed. Within a defined code range, a character specifies the same type of information in that axis of classification.

Example: The fifth axis of classification specifies the approach in sections 0 through 4 and 7 through 9 of the system.

A2

One of 34 possible values can be assigned to each axis of classification in the seven-character code: they are the numbers 0 through 9 and the alphabet (except I and O because they are easily confused with the numbers 1 and 0). The number of unique values used in an axis of classification differs as needed.

Example: Where the fifth axis of classification specifies the approach, seven different approach values are currently used to specify the approach.

A3

The valid values for an axis of classification can be added to as needed.

Example: If a significantly distinct type of device is used in a new procedure, a new device value can be added to the system.

A4

As with words in their context, the meaning of any single value is a combination of its axis of classification and any preceding values on which it may be dependent.

Example: The meaning of a body part value in the Medical and Surgical section is always dependent on the body system value. The body part value 0 in the Central Nervous body system specifies Brain and the body part value 0 in the Peripheral Nervous body system specifies Cervical Plexus.

A5

As the system is expanded to become increasingly detailed, over time more values will depend on preceding values for their meaning.

Example: In the Lower Joints body system, the device value 3 in the root operation Insertion specifies Infusion Device and the device value 3 in the root operation Replacement specifies Ceramic Synthetic Substitute.

A6

The purpose of the alphabetic index is to locate the appropriate table that contains all information necessary to construct a procedure code. The PCS Tables should always be consulted to find the most appropriate valid code.

A7

It is not required to consult the index first before proceeding to the tables to complete the code. A valid code may be chosen directly from the tables.

A8

All seven characters must be specified to be a valid code. If the documentation is incomplete for coding purposes, the physician should be queried for the necessary information.

A9

Within a PCS table, valid codes include all combinations of choices in characters 4 through 7 contained in the same row of the table. In the example below, 0JHT3VZ is a valid code, and 0JHW3VZ is not a valid code.

Body Part	Approach	Device	Qualifier
S Subcutaneous Tissue and Fascia, Head and Neck	0 Open	1 Radioactive Element	Z No Qualifier
V Subcutaneous Tissue and Fascia, Upper Extremity	3 Percutaneous	3 Infusion Device	
W Subcutaneous Tissue and Fascia, Lower Extremity			
T Subcutaneous Tissue and Fascia, Trunk	0 Open	1 Radioactive Element	Z No Qualifier
	3 Percutaneous	3 Infusion Device	
		V Infusion Pump	

Section: 0 Medical and Surgical

Body System: J Subcutaneous Tissue and Fascia

Operation: H Insertion: Putting in a nonbiological appliance that monitors, assists

Z No Qualifier

A10

“And,” when used in a code description, means “and/or.”

Example: Lower Arm and Wrist Muscle means lower arm and/or wrist muscle.

A11

Many of the terms used to construct PCS codes are defined within the system. It is the coder’s responsibility to determine what the documentation in the medical record equates to in the PCS definitions. The physician is not expected to use the terms used in PCS code descriptions, nor is the coder required to query the physician when the correlation between the documentation and the defined PCS terms is clear.

Example: When the physician documents “partial resection” the coder can independently correlate “partial resection” to the root operation Excision without querying the physician for clarification.

Medical and Surgical Section Guidelines (section 0)

B2. Body System

General guidelines

B2.1a

The procedure codes in the general anatomical regions body systems can be used when the procedure is performed on an anatomical region rather than a specific body part (e.g., root operations Control and Detachment, Drainage of a body cavity) or on the rare occasion when no information is available to support assignment of a code to a specific body part.

Examples: Control of postoperative hemorrhage is coded to the root operation Control found in the general anatomical regions body systems.

Chest tube drainage of the pleural cavity is coded to the root operation Drainage found in the general anatomical regions body systems. Suture repair of the abdominal wall is coded to the root operation Repair in the general anatomical regions body system.

B2.1b

Where the general body part values “upper” and “lower” are provided as an option in the Upper Arteries, Lower Arteries, Upper Veins, Lower Veins, Muscles and Tendons body systems, “upper” or “lower” specifies body parts located above or below the diaphragm respectively.

Example: Vein body parts above the diaphragm are found in the Upper Veins body system; vein body parts below the diaphragm are found in the Lower Veins body system.

B3. Root Operation

General guidelines

B3.1a

In order to determine the appropriate root operation, the full definition of the root operation as contained in the PCS Tables must be applied.

B3.1b

Components of a procedure specified in the root operation definition and explanation are not coded separately. Procedural steps necessary to reach the operative site and close the operative site, including anastomosis of a tubular body part, are also not coded separately.

Examples: Resection of a joint as part of a joint replacement procedure is included in the root operation definition of Replacement and is not coded separately.

Laparotomy performed to reach the site of an open liver biopsy is not coded separately.

In a resection of sigmoid colon with anastomosis of descending colon to rectum, the anastomosis is not coded separately.

Multiple procedures

B3.2

During the same operative episode, multiple procedures are coded if: 5 the same root operation is performed on different body parts as defined by distinct values of the body part character.

Examples: Diagnostic excision of liver and pancreas are coded separately. Excision of lesion in the ascending colon and excision of lesion in the transverse colon are coded separately.

b. The same root operation is repeated in multiple body parts, and those body parts are separate and distinct body parts classified to a single ICD-10-PCS body part value.

Examples: Excision of the sartorius muscle and excision of the gracilis muscle are both included in the upper leg muscle body part value, and multiple procedures are coded.

Extraction of multiple toenails are coded separately.

c. Multiple root operations with distinct objectives are performed on the same body part.

Example: Destruction of sigmoid lesion and bypass of sigmoid colon are coded separately.

d. The intended root operation is attempted using one approach, but is converted to a different approach.

Example: Laparoscopic cholecystectomy converted to an open cholecystectomy is coded as percutaneous endoscopic Inspection and open Resection.

Discontinued or incomplete procedures

B3.3

If the intended procedure is discontinued or otherwise not completed, code the procedure to the root operation performed. If a procedure is discontinued before any other root operation is performed, code the root operation Inspection of the body part or anatomical region inspected.

Example: A planned aortic valve replacement procedure is discontinued after the initial thoracotomy and before any incision is made in the heart muscle, when the patient becomes hemodynamically unstable. This procedure is coded as an open Inspection of the mediastinum.

Biopsy procedures

B3.4a

Biopsy procedures are coded using the root operations Excision, Extraction, or Drainage and the qualifier Diagnostic.

Examples: Fine needle aspiration biopsy of fluid in the lung is coded to the root operation Drainage with the qualifier Diagnostic.

Biopsy of bone marrow is coded to the root operation Extraction with the qualifier Diagnostic.

Lymph node sampling for biopsy is coded to the root operation Excision with the qualifier Diagnostic.

Biopsy followed by more definitive treatment

B3.4b

If a diagnostic Excision, Extraction, or Drainage procedure (biopsy) is followed by a more definitive procedure, such as Destruction, Excision or Resection at the same procedure site, both the biopsy and the more definitive treatment are coded.

Example: Biopsy of breast followed by partial mastectomy at the same procedure site, both the biopsy and the partial mastectomy procedure are coded.

Overlapping body layers

B3.5

If the root operations Excision, Repair or Inspection are performed on overlapping layers of the musculoskeletal system, the body part specifying the deepest layer is coded.

Example: Excisional debridement that includes skin and subcutaneous tissue and muscle is coded to the muscle body part.

Bypass procedures

B3.6a

Bypass procedures are coded by identifying the body part bypassed “from” and the body part bypassed “to.” The fourth character body part specifies the body part bypassed from, and the qualifier specifies the body part bypassed to.

Example: Bypass from stomach to jejunum, stomach is the body part and jejunum is the qualifier.

B3.6b

Coronary artery bypass procedures are coded differently than other bypass procedures as described in the previous guideline. Rather than identifying the body part bypassed from, the body part identifies the number of coronary arteries bypassed to, and the qualifier specifies the vessel bypassed from.

Example: Aortocoronary artery bypass of the left anterior descending coronary artery and the obtuse marginal coronary artery is classified in the body part axis of classification as two coronary arteries, and the qualifier specifies the aorta as the body part bypassed from.

B3.6c

If multiple coronary arteries are bypassed, a separate procedure is coded for each coronary artery that uses a different device and/or qualifier.

Example: Aortocoronary artery bypass and internal mammary coronary artery bypass are coded separately.

Control vs. more definitive root operations

B3.7

The root operation Control is defined as, “Stopping, or attempting to stop, post procedural or other acute bleeding.” If an attempt to stop post procedural or other acute bleeding is initially unsuccessful, and to stop the bleeding requires performing a more definitive root operation, such as Bypass, Detachment, Excision, Extraction, Reposition, Replacement, or Resection, then the more definitive root operation is coded instead of Control.

Example: Resection of spleen to stop bleeding is coded to Resection instead of Control.

Excision vs. Resection

B3.8

PCS contains specific body parts for anatomical subdivisions of a body part, such as lobes of the lungs or liver and regions of the intestine. Resection of the specific body part is coded whenever all of the body part is cut out or off, rather than coding Excision of a less specific body part.

Example: Left upper lung lobectomy is coded to Resection of Upper Lung Lobe, left rather than Excision of Lung, Left.

Excision for graft

B3.9

If an autograft is obtained from a different procedure site in order to complete the objective of the procedure, a separate procedure is coded.

Example: Coronary bypass with excision of saphenous vein graft, excision of saphenous vein is coded separately.

Fusion procedures of the spine

B3.10a

The body part coded for a spinal vertebral joint(s) rendered immobile by a spinal fusion procedure is classified by the level of the spine (e.g. thoracic). There are distinct body part values for a single vertebral joint and for multiple vertebral joints at each spinal level.

Example: Body part values specify Lumbar Vertebral Joint, Lumbar Vertebral Joints, 2 or More and Lumbosacral Vertebral Joint.

B3.10b

If multiple vertebral joints are fused, a separate procedure is coded for each vertebral joint that uses a different device and/or qualifier.

Example: Fusion of lumbar vertebral joint, posterior approach, anterior column and fusion of lumbar vertebral joint, posterior approach, posterior column are coded separately.

B3.10c

Combinations of devices and materials are often used on a vertebral joint to render the joint immobile. When combinations of devices are used on the same vertebral joint, the device value coded for the procedure is as follows:

- If an interbody fusion device is used to render the joint immobile (alone or containing other material like bone graft), the procedure is coded with the device value Interbody Fusion Device
- If bone graft is the *only* device used to render the joint immobile, the procedure is coded with the device value Nonautologous Tissue Substitute or Autologous Tissue Substitute. □ If a mixture of autologous and nonautologous bone graft (with or without biological or synthetic extenders or binders) is used to render the joint immobile, code the procedure with the device value Autologous Tissue Substitute *Examples:* Fusion of a vertebral joint using a cage style interbody fusion device containing morsellized bone graft is coded to the device Interbody Fusion Device.

Fusion of a vertebral joint using a bone dowel interbody fusion device made of cadaver bone and packed with a mixture of local morsellized bone and demineralized bone matrix is coded to the device Interbody Fusion Device.

Fusion of a vertebral joint using both autologous bone graft and bone bank bone graft is coded to the device Autologous Tissue Substitute.

Inspection procedures

B3.11a

Inspection of a body part(s) performed in order to achieve the objective of a procedure is not coded separately.

Example: Fiberoptic bronchoscopy performed for irrigation of bronchus, only the irrigation procedure is coded.

B3.11b

If multiple tubular body parts are inspected, the most distal body part (the body part furthest from the starting point of the inspection) is coded. If multiple non-tubular body parts in a region are inspected, the body part that specifies the entire area inspected is coded.

Examples: Cystoureteroscopy with inspection of bladder and ureters is coded to the ureter body part value.

Exploratory laparotomy with general inspection of abdominal contents is coded to the peritoneal cavity body part value.

B3.11c

When both an Inspection procedure and another procedure are performed on the same body part during the same episode, if the Inspection procedure is performed using a different approach than the other procedure, the Inspection procedure is coded separately.

Example: Endoscopic Inspection of the duodenum is coded separately when open Excision of the duodenum is performed during the same procedural episode.

Occlusion vs. Restriction for vessel embolization procedures

B3.12

If the objective of an embolization procedure is to completely close a vessel, the root operation Occlusion is coded. If the objective of an embolization procedure is to narrow the lumen of a vessel, the root operation Restriction is coded.

Examples: Tumor embolization is coded to the root operation Occlusion, because the objective of the procedure is to cut off the blood supply to the vessel.

Embolization of a cerebral aneurysm is coded to the root operation Restriction, because the objective of the procedure is not to close off the vessel entirely, but to narrow the lumen of the vessel at the site of the aneurysm where it is abnormally wide.

B3.13 9 In the root operation Release, the body part value coded is the body part being freed and not the tissue being manipulated or cut to free the body part.

Example: Lysis of intestinal adhesions is coded to the specific intestine body part value.

Release vs. Division

B3.14

If the sole objective of the procedure is freeing a body part without cutting the body part, the root operation is Release. If the sole objective of the procedure is separating or transecting a body part, the root operation is Division.

Examples: Freeing a nerve root from surrounding scar tissue to relieve pain is coded to the root operation Release.

Severing a nerve root to relieve pain is coded to the root operation Division.

Reposition for fracture treatment

B3.15

Reduction of a displaced fracture is coded to the root operation Reposition and the application of a cast or splint in conjunction with the Reposition procedure is not coded separately. Treatment of a nondisplaced fracture is coded to the procedure performed.

Examples: Casting of a nondisplaced fracture is coded to the root operation Immobilization in the Placement section.

Putting a pin in a nondisplaced fracture is coded to the root operation Insertion.

Transplantation vs. Administration

B3.16

Putting in a mature and functioning living body part taken from another individual or animal is coded to the root operation Transplantation. Putting in autologous or nonautologous cells is coded to the Administration section.

Example: Putting in autologous or nonautologous bone marrow, pancreatic islet cells or stem cells is coded to the Administration section.

B4. Body Part

General guidelines

B4.1a

If a procedure is performed on a portion of a body part that does not have a separate body part value, code the body part value corresponding to the whole body part.

Example: A procedure performed on the alveolar process of the mandible is coded to the mandible body part.

B4.1b

If the prefix “peri” is combined with a body part to identify the site of the procedure, and the site of the procedure is not further specified, then the procedure is coded to the body part named. This guideline applies only when a more specific body part value is not available.

Examples: A procedure site identified as perirenal is coded to the kidney body part when the site of the procedure is not further specified.

A procedure site described in the documentation as peri-urethral, and the documentation also indicates that it is the vulvar tissue and not the urethral tissue that is the site of the procedure, then the procedure is coded to the vulva body part.

B4.1c

If a procedure is performed on a continuous section of a tubular body part, code the body part value corresponding to the furthest anatomical site from the point of entry.

Example: A procedure performed on a continuous section of artery from the femoral artery to the external iliac artery with the point of entry at the femoral artery is coded to the external iliac body part.

Branches of body parts

B4.2

Where a specific branch of a body part does not have its own body part value in PCS, the body part is typically coded to the closest proximal branch that has a specific body part value. In the cardiovascular body systems, if a general body part is available in the correct root operation table, and coding to a proximal branch would require assigning a code in a different body system, the procedure is coded using the general body part value.

Examples: A procedure performed on the mandibular branch of the trigeminal nerve is coded to the trigeminal nerve body part value.

Occlusion of the bronchial artery is coded to the body part value Upper Artery in the body system Upper Arteries, and not to the body part value Thoracic Aorta, Descending in the body system Heart and Great Vessels.

Bilateral body part values

B4.3

Bilateral body part values are available for a limited number of body parts. If the identical procedure is performed on contralateral body parts, and a bilateral body part value exists for that body part, a single procedure is coded using the bilateral body part value. If no bilateral body part value exists, each procedure is coded separately using the appropriate body part value.

Examples: The identical procedure performed on both fallopian tubes is coded once using the body part value Fallopian Tube, Bilateral.

The identical procedure performed on both knee joints is coded twice using the body part values Knee Joint, Right and Knee Joint, Left.

Coronary arteries

B4.4

The coronary arteries are classified as a single body part that is further specified by number of arteries treated. One procedure code specifying multiple arteries is used when the same procedure is performed, including the same device and qualifier values.

Examples: Angioplasty of two distinct coronary arteries with placement of two stents is coded as Dilation of Coronary Artery, Two Arteries with Two Intraluminal Devices. 11

Angioplasty of two distinct coronary arteries, one with stent placed and one without, is coded separately as Dilation of Coronary Artery, One Artery with Intraluminal Device, and Dilation of Coronary Artery, One Artery with no device.

Tendons, ligaments, bursae and fascia near a joint

B4.5

Procedures performed on tendons, ligaments, bursae and fascia supporting a joint are coded to the body part in the respective body system that is the focus of the procedure. Procedures performed on joint structures themselves are coded to the body part in the joint body systems.

Examples: Repair of the anterior cruciate ligament of the knee is coded to the knee bursa and ligament body part in the bursae and ligaments body system.

Knee arthroscopy with shaving of articular cartilage is coded to the knee joint body part in the Lower Joints body system.

Skin, subcutaneous tissue and fascia overlying a joint

B4.6

If a procedure is performed on the skin, subcutaneous tissue or fascia overlying a joint, the procedure is coded to the following body part:

- Shoulder is coded to Upper Arm
- Elbow is coded to Lower Arm
- Wrist is coded to Lower Arm
- Hip is coded to Upper Leg
- Knee is coded to Lower Leg
- Ankle is coded to Foot

Fingers and toes

B4.7

If a body system does not contain a separate body part value for fingers, procedures performed on the fingers are coded to the body part value for the hand. If a body system does not contain a separate body part value for toes, procedures performed on the toes are coded to the body part value for the foot.

Example: Excision of finger muscle is coded to one of the hand muscle body part values in the Muscles body system.

Upper and lower intestinal tract

B4.8

In the Gastrointestinal body system, the general body part values Upper Intestinal Tract and Lower Intestinal Tract are provided as an option for the root operations Change, Inspection, Removal and Revision. Upper Intestinal Tract includes the portion of the gastrointestinal tract from the esophagus down to and including the duodenum, and Lower Intestinal Tract includes the portion of the gastrointestinal tract from the jejunum down to and including the rectum and anus.

Example: In the root operation Change table, change of a device in the jejunum is coded using the body part Lower Intestinal Tract. 12

B5. Approach

Open approach with percutaneous endoscopic assistance

B5.2

Procedures performed using the open approach with percutaneous endoscopic assistance are coded to the approach Open.

Example: Laparoscopic-assisted sigmoidectomy is coded to the approach Open.

External approach

B5.3a

Procedures performed within an orifice on structures that are visible without the aid of any instrumentation are coded to the approach External.

Example: Resection of tonsils is coded to the approach External.

B5.3b

Procedures performed indirectly by the application of external force through the intervening body layers are coded to the approach External.

Example: Closed reduction of fracture is coded to the approach External.

Percutaneous procedure via device

B5.4

Procedures performed percutaneously via a device placed for the procedure are coded to the approach Percutaneous.

Example: Fragmentation of kidney stone performed via percutaneous nephrostomy is coded to the approach Percutaneous.

B6. Device

General guidelines

B6.1a

A device is coded only if a device remains after the procedure is completed. If no device remains, the device value No Device is coded. In limited root operations, the classification provides the qualifier values Temporary and Intraoperative, for specific procedures involving clinically significant devices, where the purpose of the device is to be utilized for a brief duration during the procedure or current inpatient stay.

B6.1b

Materials such as sutures, ligatures, radiological markers and temporary post-operative wound drains are considered integral to the performance of a procedure and are not coded as devices.

B6.1c

Procedures performed on a device only and not on a body part are specified in the root operations Change, Irrigation, Removal and Revision, and are coded to the procedure performed.

Example: Irrigation of percutaneous nephrostomy tube is coded to the root operation Irrigation of indwelling device in the Administration section.

Drainage device

B6.2

A separate procedure to put in a drainage device is coded to the root operation Drainage with the device value Drainage Device

Below are the categories under the Medical Surgical Section for Skin and Breast:

Skin and Breast

- 0H0 Alteration
- 0H2 Change
- 0H5 Destruction
- 0H8 Division
- 0H9 Drainage
- 0HB Excision
- 0HC Extirpation
- 0HD Extraction
- 0HH Insertion
- 0HJ Inspection
- 0HM Reattachment
- 0HN Release
- 0HP Removal
- 0HQ Repair
- 0HR Replacement
- 0HS Reposition
- 0HT Resection
- 0HU Supplement
- 0HW Revision
- 0HX Transfer

Below are examples of the categories for the root procedure Replacement

Replacement Categories

- 0HR0 Skin, Scalp
- 0HR1 Skin, Face
- 0HR2 Skin, Right Ear
- 0HR3 Skin, Left Ear
- 0HR4 Skin, Neck
- 0HR5 Skin, Chest

- 0HR6 Skin, Back
- 0HR7 Skin, Abdomen
- 0HR8 Skin, Buttock
- 0HR9 Skin, Perineum
- 0HRA Skin, Inguinal
- 0HRB Skin, Right Upper Arm
- 0HRC Skin, Left Upper Arm
- 0HRD Skin, Right Lower Arm
- 0HRE Skin, Left Lower Arm
- 0HRF Skin, Right Hand
- 0HRG Skin, Left Hand
- 0HRH Skin, Right Upper Leg
- 0HRJ Skin, Left Upper Leg
- 0HRK Skin, Right Lower Leg
- 0HRL Skin, Left Lower Leg
- 0HRM Skin, Right Foot
- 0HRN Skin, Left Foot
- 0HRQ Finger Nail
- 0HRR Toe Nail
- 0HRS Hair
- 0HRT Breast, Right
- 0HRU Breast, Left
- 0HRV Breast, Bilateral
- 0HRW Nipple, Right
- 0HRX Nipple, Left

Mechanical Ventilation Codes

- 5A09 Respiratory
 - 5A092 Continuous
 - 5A0920 Filtration
 - 5A0920Z Assistance with Respiratory Filtration, Continuous
 - 5A093 Less than 24 Consecutive Hours
 - 5A0935 Ventilation
 - 5A09357 Assistance with Respiratory Ventilation, Less than 24 Consecutive Hours, Continuous Positive Airway Pressure
 - 5A09358 Assistance with Respiratory Ventilation, Less than 24 Consecutive Hours, Intermittent Positive Airway Pressure
 - 5A09359 Assistance with Respiratory Ventilation, Less than 24 Consecutive Hours, Continuous Negative Airway Pressure
 - 5A0935B Assistance with Respiratory Ventilation, Less than 24 Consecutive Hours, Intermittent Negative Airway Pressure
 - 5A0935Z Assistance with Respiratory Ventilation, Less than 24 Consecutive Hours
 - 5A094 24-96 Consecutive Hours
 - 5A0945 Ventilation
 - 5A09457 Assistance with Respiratory Ventilation, 24-96 Consecutive Hours, Continuous Positive Airway Pressure
 - 5A09458 Assistance with Respiratory Ventilation, 24-96 Consecutive Hours, Intermittent Positive Airway Pressure
 - 5A09459 Assistance with Respiratory Ventilation, 24-96 Consecutive Hours, Continuous Negative Airway Pressure
 - 5A0945B Assistance with Respiratory Ventilation, 24-96 Consecutive Hours, Intermittent Negative Airway Pressure
 - 5A0945Z Assistance with Respiratory Ventilation, 24-96 Consecutive Hours
 - 5A095 Greater than 96 Consecutive Hours
 - 5A0955 Ventilation
 - 5A09557 Assistance with Respiratory Ventilation, Greater than 96 Consecutive Hours, Continuous Positive Airway Pressure
 - 5A09558 Assistance with Respiratory Ventilation, Greater than 96 Consecutive Hours, Intermittent Positive Airway Pressure
 - 5A09559 Assistance with Respiratory Ventilation, Greater than 96 Consecutive Hours, Continuous Negative Airway Pressure
 - 5A0955B Assistance with Respiratory Ventilation, Greater than 96 Consecutive Hours, Intermittent Negative Airway Pressure
 - 5A0955Z Assistance with Respiratory Ventilation, Greater than 96 Consecutive Hours

Mouth and Throat (Tracheostomy)

- OCHY Mouth and Throat
 - OCHY0 Open
 - OCHY0Y Other Device
 - OCHY0YZ Insertion of Other Device into Mouth and Throat, Open Approach
 - OCHY3 Percutaneous
 - OCHY3Y Other Device
 - OCHY3YZ Insertion of Other Device into Mouth and Throat, Percutaneous Approach
 - OCHY7 Via Natural or Artificial Opening
 - OCHY7B Intraluminal Device, Airway
 - OCHY7BZ Insertion of Airway into Mouth and Throat, Via Natural or Artificial Opening
 - OCHY7Y Other Device
 - OCHY7YZ Insertion of Other Device into Mouth and Throat, Via Natural or Artificial Opening

- OCHY8 Via Natural or Artificial Opening Endoscopic
 - OCHY8B Intraluminal Device, Airway
 - OCHY8BZ Insertion of Airway into Mouth and Throat, Via Natural or Artificial Opening Endoscopic
 - OCHY8Y Other Device
 - OCHY8YZ Insertion of Other Device into Mouth and Throat, Via Natural or Artificial Opening Endoscopic

Release Category (Fasciotomy)

- 0HN0 Skin, Scalp
- 0HN1 Skin, Face
- 0HN2 Skin, Right Ear
- 0HN3 Skin, Left Ear
- 0HN4 Skin, Neck
- 0HN5 Skin, Chest
- 0HN6 Skin, Back
- 0HN7 Skin, Abdomen
- 0HN8 Skin, Buttock
- 0HN9 Skin, Perineum
- 0HNA Skin, Inguinal
- 0HNB Skin, Right Upper Arm
- 0HNC Skin, Left Upper Arm
- 0HND Skin, Right Lower Arm
- 0HNE Skin, Left Lower Arm
- 0HNF Skin, Right Hand
- 0HNG Skin, Left Hand
- 0HNH Skin, Right Upper Leg
- 0HNJ Skin, Left Upper Leg
- 0HNK Skin, Right Lower Leg
- 0HNL Skin, Left Lower Leg
- 0HNM Skin, Right Foot
- 0HNN Skin, Left Foot
- 0HNQ Finger Nail
- 0HNR Toe Nail
- 0HNT Breast, Right

- 0HNU Breast, Left
- 0HNV Breast, Bilateral
- 0HNW Nipple, Right
- 0HNX Nipple, Left

Endotracheal Intubation

- To calculate the number of hours (duration) of continuous mechanical ventilation during a hospitalization, begin the count from the start of the (endotracheal) intubation. The duration ends with (endotracheal) extubation.
- If the patient is intubated prior to admission, begin counting the duration from the time of admission. If a patient transferred (discharged) while intubated, the duration would end at the time of transfer (discharge).
- For patients who begin on (endotracheal) intubation and subsequently have a tracheostomy performed for mechanical ventilation, the duration begins with the (endotracheal) intubation and ends when the mechanical ventilation is turned off (after the weaning period).

Tracheostomy

- To calculate the number of hours of continuous mechanical ventilation during a hospitalization, begin counting the duration when mechanical ventilation is started. The duration ends when the mechanical ventilator is turned off (after the weaning period).
- If a patient has received a tracheostomy prior to admission and is on mechanical ventilation at the time of admission, begin counting the duration from the time of admission. If a patient is transferred (discharged) while still on mechanical ventilation via tracheostomy, the duration would end at the time of the transfer (discharge).

Tips for Inpatient Code Abstraction

To accurately code an inpatient admission and capture all of the codeable diagnoses and procedures, the following steps are recommended. The end result will be an accurate database, correct DRG assignment and optimum reimbursement.

- Read the admission like a book. Never begin with the discharge summary; instead review the entire record to obtain all necessary data for coding.

- Take notes during the chart review.
 - Begin with the admission history and physical. Note the current reason for admission as well as any other condition for which the patient received medication and/or treatment.
 - Review any consult reports and the reason for the consultation in each case.
 - Read all progress notes, from admission through discharge.
 - If any surgical procedures were performed, read the operative report for each. Note any complications that occurred as a result of the surgery.
 - If surgery was performed, note whether a specimen was obtained. If so, review the pathology report findings on the specimen.
 - Check radiology reports for findings. Note any interventional radiology procedures performed.
 - Check clinical laboratory reports, looking for positive cultures, organisms identified, and for physician acknowledgment of the results in the documentation. If not, question the physician as to the significance of the organism.
 - Finally read the Discharge Summary and review the face sheet.
- Assign codes.
- **Remember**—Accurate coding results from a careful, thorough review of the entire medical record, not the discharge summary and the face sheet alone.

Documentation Optimizes Inpatient Burn Coding

To optimize DRG assignment for the burn center, medical record documentation (e.g., admission H&P, operative reports, discharge summary) should **always** include anatomic site(s) of the burn and burn depth of each in addition to % TBSA burned and % TBSA 3rd degree.

Burn center coders may assign codes **only** for documented findings. If TBSA only is documented, then a code from the appropriate codes must be assigned as principal diagnosis.

Outpatient Hospital Department Coding

Reimbursement for outpatient hospital procedures and services varies by payer. Payments may be based on any one of a number of methodologies: prospective payment system, per diem, per episode of care, cost plus, fee-for-service and many other variations and combinations of these methods. Medicare reimbursement for outpatient hospital services is based on a prospective payment system that was implemented on August 1, 2000.

Most major payers, including Medicare, accept the CPT and HCPCS coding systems for procedural services and the ICD-10-CM coding system for diagnoses on claims for outpatient services.

This chapter is divided into the following sections.

- Reimbursement under Medicare’s Hospital Outpatient Prospective Payment System (HOPPS/OPPS): Ambulatory Payment Classifications (APCs)
- Coding for Medicare’s Outpatient Hospital APCs
 - ◇Note: Outpatient Hospital Coding Systems
- Coding Burn Procedures and Services
- Reporting Outpatient Hospital Evaluation & Management Services
- Reporting Outpatient Hospital Procedures
- Burn Diagnosis Coding for Outpatient Hospital Services
 - ◇General Outpatient Diagnosis Coding Guidelines Excerpted from *ICD-10-CM Official Guidelines for Coding and Reporting*
 - ◇Burn-Specific Coding Excerpted from *ICD-10-CM Official Guidelines for Coding and Reporting*
 - ◇Discussion: Outpatient Coding of Burn Diagnoses
 - ◇Coding Non-Burn Conditions
- CMS-Approved Modifiers for Outpatient Hospital Reporting

REIMBURSEMENT UNDER MEDICARE'S HOSPITAL OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (HOPPS/OPPS): AMBULATORY PAYMENT CLASSIFICATIONS (APCs)

Medicare reimbursement for outpatient hospital procedures and certain services is based on a prospective payment system called Ambulatory Payment Classifications (APCs). Services in each APC are similar clinically and in terms of the resources they require. The APC payment methodology also applies to other outpatient facilities and some services provided by comprehensive outpatient rehabilitation facilities (CORF), home health agencies (HHA), and hospice patients for a non-terminal illness.

Generally, each APC is assigned a relative payment weight by CMS. APC payment rates are calculated on a national basis and adjusted annually. The national rates are then adjusted by geographic area, depending on the area's wage level. Using each hospital's wage index value, the labor-related portion of the payment rate (60 percent) is wage adjusted to account for wage differences across different geographic areas. That product is added to the remaining 40% of the national payment amount and the sum is the final, locality-specific reimbursement amount for the hospital.

Under this system, the hospital may furnish a number of procedures and/or services to a patient on the same day and receive an APC payment for each. Each APC is a fixed payment amount that includes a number of packaged items or services, none of which is separately payable even though each may occupy a separate line item on the claim. The line item level of granularity allows Medicare to acquire the data for resource utilization and cost collection purposes. Some procedures, although separately payable through an APC, are discounted when provided on the same day as other procedures.

Beginning in 2008, CMS developed encounter based “composite APCs” that allow a single APC payment for certain common combinations of services/procedures that are typically performed on the same date of service. An example is the composite APC Cardiac Electro physiologic Evaluation and Ablation, which consists of multiple cardiac electrophysiological evaluation, mapping and ablation services.

Transitional Pass-Through Payments

Medicare will make supplemental payments (based on costs, subject to limitations) for the following: current orphan drugs; current drugs biologics and brachytherapy devices used in the treatment of cancer; current radiopharmaceutical drugs and biologics; and new devices, drugs and biologic agents. These additional payments are known as transitional pass-through payments. A transitional pass-through payment will be available for a given item for between two and three years after which the supplemental payment will be retired and standard APC payment will be in place for the item. Products eligible for a transitional pass-through payment will be designated by a unique, CMS assigned, HCPCS Level II “C” code.

CODING FOR MEDICARE’S OUTPATIENT HOSPITAL APCs

Note on Outpatient Hospital Coding Systems

(For detailed information on coding systems used for facility services, see the chapter, “Key Concepts” at the beginning of Part II, Coding for Facility (Hospital) Services.)

Medicare requires facilities to code outpatient hospital procedures and services and procedures using HCPCS codes, a system comprised of CPT (HCPCS Level I) and HCPCS Level II codes and modifiers.

Diagnoses, problems, conditions and other reasons for the health encounter must be coded using ICD-10-CM diagnosis codes.

CODING BURN PROCEDURES & SERVICES

This section includes the following topics.

- Coding Systems for Reporting Procedures, Services and Supplies
- Packaging of APCs
- Unbundling and Bundling
- Global Period for Outpatient Hospital Services
- CPT “Add-on” Codes

Coding Systems for Reporting Procedures, Services and Supplies

These sources provide codes that, when placed on a claim, identify *what* was provided for the patient:

- CPT-4 (*Current Procedural Terminology*), published and updated annually by the AMA. CPT is designated as Level I of HCPCS by CMS (CMS **H**ealthcare **C**ommon **P**rocedure **C**oding **S**ystem). All of the more than 10,155 codes in CPT are 5-digit numeric codes. CPT also includes *modifiers* which are 2-digit numeric identifiers that can be appended to the codes under specific circumstances. Medicare accepts only certain CPT modifiers for payment of outpatient hospital claims.

CPT codes describe the procedures and services provided by the outpatient hospital department.

- HCPCS National Level II codes, updated annually by CMS and published by CMS and commercial publishers. Level II also includes Level II national modifiers. HCPCS Level II codes are 5-character alpha-numeric (e.g., J1234). Level II modifiers are 2-character alpha or alpha-numeric.

HCPCS codes typically describe the supplies (e.g., drugs, dressings) provided by the outpatient hospital department.

Basic guidelines for CPT coding for burn surgery are described in the subchapters “Evaluation and Management” and “Surgical Procedures: Surgery and Bedside” in Part I of this

manual. These guidelines reflect those stated in the current volume of CPT.

However, Medicare has modified certain CPT guidelines for outpatient hospital claims submitted on behalf of Medicare beneficiaries. Further, the nature of the prospective payment system for Outpatient Hospital services (OPPS) has necessitated other modifications in coding. Where a Medicare modification has been made, it governs coding for the outpatient services provided and is the guideline stated in this Chapter of the manual. The CPT guideline is therefore omitted in that instance.

(Note that CPT is published and copyrighted by the American Medical Association and is used with permission by CMS for reporting services for outpatient hospital services.)

There are no formal guidelines for reporting HCPCS Level II codes other than a) those inherent in the code nomenclature itself (e.g., one drug code may specify 50 mg. and another 100 mg. of the same medication) and b) the coverage and reporting guidelines published by CMS for Medicare claims. Medicare guidelines that pertain to any HCPCS Level II codes listed in this chapter are included where relevant to the care of burns and the topic discussed.

KEY POINTS

Distinguish “packaged” services from “bundled” procedures.

APC “packaged” services may be itemized on the claim. Medicare will allow payment only for the applicable APC(s).

However, a procedural service (e.g., excision of scar with primary repair) may not be unbundled on the claim. E.g., excision of scar should be billed using a single code. Single layer closure of the wound is included and cannot be billed separately.

Packaging of APCs

Packaging is a term that Medicare uses to describe its practice of paying a single dollar amount for a “package” of items that typically includes a specific procedure or service plus supplies and other items used when providing the procedure or service. Each “package” is assigned to a separate APC for Medicare reimbursement under its Hospital Outpatient Prospective Payment System (HOPPS).

Packaging should be clearly distinguished from “bundling.” Refer to the next section where the two concepts are compared and contrasted to help you understand the key distinctions between them.

Unbundling and Bundling

Definitions

- Unbundling is the *inappropriate* reporting of multiple codes (multiple procedures or services) that are actually parts of a

single, comprehensive code, which should have been reported instead.

- Unbundling is also used to describe inappropriate billing of two codes, each of which is mutually exclusive to the other. One or the other can be billed, but not both.
- Bundling is the process a payer uses to identify unbundled codes, disallow them, and allow payment for a single, correct code instead. Bundling is accomplished by screening every code on a claim against computer edits for the purpose of identifying all unbundled codes.
- For Medicare Outpatient Hospital coding, **it is important to distinguish between a procedure code that should not be unbundled and a “Packaged” service** under Medicare’s Outpatient Prospective Payment System (OPPS) which makes a single payment for an APC, as explained in the preceding section.

A **“Package”** is a group of items that include a procedure and/or a service and supplies packaged together by Medicare and reimbursed under a single APC and at a single amount. For example, an appendectomy includes a package of services that includes the procedure itself, anesthesia/supplies, use of the operating room, routine drugs and IVs, among other items.

Procedures that should not be unbundled: A procedure code describes or names a clinical surgical or medical procedure. The named procedure/code includes all of the component parts of the procedure, such as the surgical approach (e.g., incision), the surgical procedure itself, usually wound closure, etc., despite the fact that there may be individual CPT codes that describe each of those parts of the procedure. For example, a carpal tunnel release includes a wrist arthrotomy (incision into a joint), a synovectomy (removal of synovium), release of the median nerve at the carpal tunnel, and closure of the wound. There are individual CPT codes for the wrist arthrotomy, synovectomy, and release of the median nerve (the carpal tunnel release). The arthrotomy and synovectomy may be performed alone in other situations. But when carpal tunnel release is performed, they are an integral part of and included in the carpal tunnel release and are not separately billable.

Medicare Edits Detect Unbundling

- Medicare (CMS) uses its National Correct Coding Initiative (“CCI”) software edits to identify and reject bundled services.

- Sometimes an otherwise bundled procedure can be billed separately when it is provided at a different session on the same day, performed on a different anatomic site or organ system, injury, or lesion, or for other reasons. When used appropriately and added to the code, modifier 59 allows the claim to bypass the edits. To learn when this modifier can be used, refer to “CMS-Approved Modifiers for Outpatient Hospital Reporting” at the end of this chapter. See also specific surgical procedures in this Manual to find clinical examples showing the use of this modifier (e.g., Escharotomy).

Check Medicare’s Correct Coding Initiative (CCI) for APCs to avoid unbundling when assigning codes. These CCI edits are generally included in vendor encoder software that most hospitals have purchased for outpatient hospital coding.

The most current CCI edits for outpatient hospital are available for download, at no charge, from the CMS web site:

<http://www.cms.hhs.gov/NationalCorrectCodInitEd/NCCIEHOPPS/list.asp#TopOfPage>

Examples of Unbundling and Coding Errors

Example 1. Unbundling and Double Billing

Removal of 6 cm scar on upper left abdomen followed by coverage of defect with advancement flap. Codes submitted are:

11406 Excision of benign lesion [unbundled, component code]

14001 Adjacent tissue transfer, defect 10.1 to 30.0 sq cm [comprehensive code]

A single comprehensive code should have been reported instead. CPT guidelines state that excision of lesion is included in any adjacent tissue transfer procedure (e.g., advancement flap, Z-plasty, rotation flap, etc.). Code 11406 is therefore a component of 14001 and should not have been reported. By reporting both codes, the service is unbundled and the excision of lesion is double billed.

Example 2. Mutually Exclusive Payer Edits and Incorrect Coding

Amputation of right index finger and amputation of left forearm, erroneously reported without modifiers to indicate different extremities or right and left sides.

4/25 **25900** Amputation, forearm

4/25 **26951** Amputation, finger

Payer edits assume both procedures were performed on the same extremity in the absence of coding information (*i.e.*, modifiers) to the contrary. Under that assumption, these procedures are mutually exclusive. Amputation of the forearm assumes amputation of the finger on the same extremity. Correct coding would have included one or more modifiers to indicate that each procedure was performed on a different site, on a different side of the body.

Global Period for Outpatient Hospital Services

Definition

The **Medicare** global period for procedures provided by the outpatient hospital facility is *the day of the procedure*. For example, the global period for a scar revision procedure, performed in the outpatient hospital department/same-day surgery, is the day of the procedure. This concept is important for coding, reporting and other reasons:

- Other procedures or services provided on the same day, but not necessarily at the same session, may require addition of specific modifiers for appropriate payment and/or to pass certain Medicare payment edits.
- CPT and HCPCS Level II codes that bundle “multiple sessions” or similar concepts into a single code are instead reported individually and as provided on subsequent days.

KEY POINTS

Add-on codes can only be used with the primary code when they are performed at the same operative session.

Coding starts over again when the same procedure is performed at another operative session on the same date.

CPT “Add-on” Codes

CPT add-on codes, such as 16036 (Escharotomy; each additional incision List separately in addition to code for primary procedure)], describe each additional portion of work performed after the first **at the same encounter**.

CPT procedures that state “each additional lesion,” “each additional level,” or “each additional procedure,” or “List separately in addition to code for primary procedure” are always secondary procedures **performed at the same operative session as the primary procedure** and, therefore, can never be reported alone. When an add-on code is reported alone, the claim will be denied because it cannot be paid unless the primary code is reported at the same time.

When the same type of procedure, such as an escharotomy, is performed at a subsequent encounter or session on the same day, coding starts over using the primary procedure code and, if applicable, the add-on code. Add modifier 59 (Distinct procedure) to the primary code for the second session, to indicate the same procedure was performed but at a different session on the same day. The modifier avoids potential denial or re-coding by the payer. For more on Modifiers, see “CMS Approved Modifiers for Outpatient Hospital Reporting” at the end of this chapter.

Burn surgery examples of add-on procedures are codes 15101, 15001, 15121, and 16036.

Add-on codes can be identified in CPT by a “+” sign in front of the code.

REPORTING OUTPATIENT HOSPITAL EVALUATION AND MANAGEMENT (E/M) SERVICES (MEDICARE)

Definition: New or Established Patient

- **New:** Patient who has not been registered as an inpatient or outpatient of the hospital within the 3 years prior to the visit is considered a new patient for that visit.
- **Established:** Patient who has been registered as an inpatient or outpatient of the hospital within the 3 years prior to the visit is considered an established patient for that visit.

CMS Criteria for E/M Code Selection in Outpatient Hospital

CMS Outpatient Hospital Prospective Payment System guidelines require each hospital to choose E/M codes based on the following:

CMS requires hospitals to report facility resources for clinic and emergency department hospital outpatient visits using the CPT E/M codes and to develop internal guidelines for reporting the appropriate visit level based on criteria published by CMS as follows. (Source: FR November 27, 2007 Hospital Outpatient Department Prospective Payment System, Final rule.)

- “(1) The coding guidelines should follow the intent of the CPT code descriptor in that the guidelines should be designed to reasonably relate the intensity of hospital resources to the different levels of effort represented by the code (65 FR 18451).
- (2) The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources (67 FR 66792).
- (3) The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits (67 FR 66792).
- (4) The coding guidelines should meet the HIPAA requirements (67 FR 66792).

KEY POINT

Beginning in 2000, hospitals should have established compliance criteria specifying the basis for selecting E/M codes for its outpatient services.

- (5) The coding guidelines should only require documentation that is clinically necessary for patient care (67 FR 66792).
- (6) The coding guidelines should not facilitate up coding or gaming (67 FR 66792). We also proposed the following five additional principles for application to hospital-specific guidelines, based on our evolving understanding of the important issues addressed by many hospitals in developing their internal guidelines that now have been used for a number of years. We believed that it was reasonable to elaborate upon the standards for hospitals' internal guidelines that we proposed to apply in CY 2008, based on our knowledge of hospitals' experiences to date with guidelines for visits.
- (7) The coding guidelines should be written or recorded, well-documented, and provide the basis for selection of a specific code.
- (8) The coding guidelines should be applied consistently across patients in the clinic or emergency department to which they apply.
- (9) The coding guidelines should not change with great frequency.
- (10) The coding guidelines should be readily available for fiscal intermediary (or, if applicable, MAC) review.
- (11) The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.”

E/M Service and Procedure, Same Date

Note: When a visit and procedure are provided and documented on the same date, whether each is provided in the same or different outpatient hospital sites, modifier 25 (Significant, Separate E/M on the Day of the Procedure) must be added to the E/M code to bypass Medicare's Outpatient Code Editor.

General E/M Coding Guidelines

- Multiple visits, each in a different clinic, on the same day may be reported separately. When the same level code is provided at more than one clinic, enter the number of such visits in the units field of the claim. Otherwise, list each visit separately with a “1” in the units field.
- When three or more physicians (or a combination of at least one physician and other interdisciplinary team members, excluding patient care nursing staff) see a patient concurrently in the same clinic for the same reason, report a single clinic visit using code G0175 (Scheduled Interdisciplinary Team Conference (minimum of three, exclusive of patient care nursing staff) with Patient Present).

Emergency Department Services (99281–99285 Type A ED Visits) and (G0380-G0384 Type B ED Visits)

Type A ED Visits

The following guidelines apply to Type A Emergency Department visits

“A Type A provider-based emergency department must meet at least one of the following requirements: (1) It is licensed by the state in which it is located under applicable state law as an emergency room or emergency department and be open 24 hours a day, seven days a week; or (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment and be open 24 hours a day, seven days a week.”

- Report the appropriate Emergency Department CPT code, 99281-99285, that most appropriately reflects the hospital’s utilization of resources, based on an assessment of the differing levels of resources required for each level. Refer to the Criteria for E/M Code Selection, above.
- Documentation of the services provided should support the billed level of service, consistent with the hospital’s guidelines for code assignment.
- Critical care code 99291 may be reported **in lieu** of the ED codes for documented treatment of a critically ill or injured patient.
- For ED service with outpatient surgical procedure, same day of service: Add modifier 25 to ED code.
- Report surgical procedure separately and in addition.
- Other services such as diagnostic testing, x-rays, administration of medication infusions, therapeutic procedures, and high cost drugs may be reported in addition.

Type B ED Visits

For Type B hospital emergency departments, CMS provides the following definition:

“A Type B provider-based emergency department must meet at least one of the following requirements: (1) It is licensed by the state in which it is located under applicable state law as an emergency room or emergency department and open less than 24

hours a day, seven days a week; or (2) it is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment and open less than 24 hours a day, seven days a week; or during the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during that calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment, regardless of its hours of operation.”

CMS requires ED visits for Type B emergency department visits to be reported using 5 HCPCS Level II codes, G0380-G0384.

KEY POINTS

Medicare allows payment for outpatient observation services in two, narrowly defined circumstances.

Hospital Observation Services (99218–99220)

- Billing for observation stay for recovery from outpatient surgery is currently not allowed and will not be allowed under OPPS.

0760 General Classification Category

0762 Observation Room

- Complete, detailed requirements must be met for payment. Refer to (Medicare Pub 100-4 Medicare Claims Processing, Chapter 4, Section 290.5.1 – General Billing Requirements for Observation Services.

Clinic Visit: Office or Other Outpatient Services (99201–99215)

- Report the clinic visit CPT code that most appropriately reflects utilization of resources, based on assessment of the differing levels of resources required for each level. Refer to the Criteria for E/M Code Selection, above.
- Documentation of the services provided should support the billed level of service, consistent with the hospital's system for code assignment.
- For clinic visit with outpatient surgical procedure, same day of service: Add modifier 25 to visit code.
- Report surgical procedure separately and in addition.

Critical Care (99291–99292)

- Effective 1/1/09, Hospitals should separately report all HCPCS codes in accordance with correct coding principles, CPT code descriptions, and any additional CMS guidance, when available. Specifically, with respect to CPT code 99291 (Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes), hospitals must follow the CPT instructions related to reporting that CPT code. Any services that CPT indicates are included in the reporting of CPT code 99291 (including those services that would otherwise be reported by and paid to hospitals using any of the CPT codes specified by CPT) should not be billed separately by the hospital. Instead, hospitals should report charges for any services provided as part of the critical care services.
- Only code 99291 may be reported by facilities when provided on an outpatient basis (*e.g.*, in ED). Code 99292 is packaged and is not reportable.
- Critical care codes are time-based codes; however, hospitals need not report on the basis of time. However, hospitals that provide less than 30 minutes of critical care should bill for a

visit, as CPT guidelines indicate. This is typically an emergency department visit, and should be reported at a level consistent with the hospital's own internal guidelines.

- With separately reportable outpatient surgical procedure, same date of service, add modifier 25 to critical care code.
- Critical care services are paid at two levels, depending on the presence or absence of trauma activation. For reporting details, please refer to CMS Pub. 100-4 Medicare Claims Processing Manual, Chapter 4 Part B Hospital Including Inpatient Hospital Part B and OPPS, section 160.1 Critical Care Services at <http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf>

REPORTING OUTPATIENT HOSPITAL PROCEDURES (MEDICARE)

In general, report each procedure as performed but check first Medicare’s Correct Coding Initiative (CCI) for APCs to avoid unbundling when assigning codes. These CCI edits are generally included in vendor encoder software that most hospitals have purchased for outpatient hospital coding.

The most current CCI edits for outpatient hospital are available for download, at no charge, from the CMS web site:

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>

Reporting of Service Units

A unit is defined as the “number of times the service or procedure being reported was performed according to the HCPCS code definition.”

Example: Excision of burn wound, trunk, 300 sq cm

15002	Excision, burn wound, first 100 sq cm	1 unit
15003	each additional 100 sq cm	2 units

Procedural Services

The following lists selected procedures that may be provided for treatment of burn or non-burn wounds in the outpatient hospital setting. There are important, sometimes subtle, differences between CPT coding for outpatient hospital services and coding for physician services. For that reason and to avoid confusion, read each of the following guidelines carefully before coding any of the listed services for outpatient hospital billing.

Biopsy of Skin

A skin biopsy involves excision or removal of a small area of skin or part or all of a lesion with the intent of submitting the specimen for pathological examination to establish or rule out a diagnosis. The intent of a biopsy differs from that for excision of a skin lesion in that excision of a lesion involves intentional removal of the lesion along with a margin of normal tissue around its periphery.

Burn surgeons may perform a skin biopsy for suspected infection or for other purposes (e.g., for calciphylaxis).

11100 Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed; single lesion

11101 each separate/additional lesion (List separately in addition to code for primary procedure)

Reporting Guidelines

- Biopsy may be performed on skin, subcutaneous tissue and/or mucous membrane.
- Report code 11100 for the first lesion or biopsy performed at the operative intervention. If additional biopsies are obtained at the same operative session, report code 11101 for each additional biopsy obtained after the first.
- Code 11101 is an add-on code and can only be submitted when code 11100 also is submitted at the same time.
- Example: Three skin biopsies are obtained.

11100	Skin biopsy (1 st biopsy)	Units = 1
--------------	--------------------------------------	-----------

11101	Skin biopsy (2 nd and 3 rd biopsies)	Units = 2
--------------	--	-----------

Contracture Release/Scar Revision

Burn wounds can develop contractures and hypertrophic scarring during and as a result of the healing process. A contracture is an area of fibrosed or hardened tissue, usually scar tissue that shrinks and prevents normal movement of the tissue or joint where it forms.

Contracture release and scar revision may be accomplished by any one of several treatment methods. Each is described below along with their respective coding and reporting guidelines. Select

carefully the appropriate option based on the documentation in the operative report and the applicable reporting guidelines. These methods are:

1. Excision of the lesion and primary closure;
2. Excision and closure using adjacent tissue transfer;
3. Excision of the lesion resulting in an open wound requiring a skin graft; and
4. Incisional release of the scar, resulting in an open wound requiring a skin graft.

Excision with Primary Closure

Reporting Guidelines

Excision of Benign Lesions codes (114xx), typically used for small scar excision or scar revision, may be used to report excision and primary closure.

Use the Excision of Benign Lesions (114xx) codes to report removal of scar and/or contracted tissue. Use the Repair codes (12031–13153) to report intermediate or complex closure of the remaining defect.

- **Code by the anatomic location and the largest dimension, length or width, of the lesion plus margins. Do not code by the size of the excision.**

Margins are defined as the most narrow margin required to adequately excise the lesion, based on the physician’s judgment.

Measure the “greatest clinical diameter of the apparent lesion plus that margin required for complete excision (lesion diameter plus the most narrow margins required equals the excised diameter).”

Measurement of the lesion is to be made prior to excision. Excision is defined as “full thickness (through the dermis).”

- The lesion excision codes include simple (one layer) repair. For example, excision of a 2 cm benign trunk lesion closed with skin sutures would be coded 11403.
- When a lesion is excised and then closed with an intermediate (layer) or complex repair, code for both the excision of the lesion and the repair/closure. Code the repair by the total length of closure. Using the above example, a 2 cm benign trunk lesion closed in layers would be coded 11403 (for the excision) and 12032 (for the layer closure), assuming the length of the closure/repair is 4 cm.

KEY POINTS

For small scar excision or scar revision:

Size of the lesion should be measured in advance of the procedure. Add margins on either side for total excision size.

“Lesion diameter + the most narrow margins required = excised diameter.”

KEY POINT

Refer to code(s) 15002-15005 for excisional or incisional release of a scar resulting in an open wound requiring a skin graft.

Removal with Adjacent Tissue Transfer

Reporting Guidelines

Use adjacent tissue transfer codes 14000-14300 for excision of the lesion with Z-plasty, Y-plasty, rotation flap, advancement flap, or other local skin flaps.

Removal of the lesion is included in these codes and is not separately reportable.

- Code by the anatomic location and **total** surface area of the defect (in sq cm). Calculate the total surface area of the defect by measuring the combined area of the primary and secondary defects. See next bullet. Do not code by the size of the lesion.
- The term “defect” includes the primary and secondary “defects.” The primary defect is the wound resulting from excision of the lesion. The secondary defect is the wound resulting from elevating and moving the flap to its new location (to cover the primary defect).
- Report only the applicable adjacent tissue transfer code, whether the lesion is benign or malignant.
- When the transferred skin leaves a defect that must be covered with a skin graft, report both the applicable adjacent tissue transfer code and the skin graft code. For example, a hypertrophic scar contracture on the back is released by excising it, creating a primary defect of 10 sq cm. A 60 sq cm rotation flap is raised and placed on the primary defect. The area from which the rotation flap is taken is the secondary defect; its area is 60 sq cm. When added together, the combined area of the primary and secondary defects is 70 sq cm. The adjacent tissue transfer code is selected based on a 70 sq cm defect.
- Code 14301 is used to report the first 60 sq cm. Code 14302 is used to report the remaining 10 sq cm as shown below.

The flap donor site is closed with a 10 sq cm split thickness skin graft.

14301	Adjacent tissue transfer (rotation flap)	1 unit
14302	each additional 30.0 sq cm	1 unit
15100	Split-thickness autograft	1 unit

Payer re-bundling edit caution. Because adjacent tissue transfer (14xxx) codes include excision of the lesion prior to closure with the local or advancement flap that the 14xxx codes represent, payer re-bundling edits automatically rebundle lesion excision

codes (e.g., 114xx or 116xx) into adjacent tissue transfer codes. The edits assume that the lesion was removed and closed with the adjacent tissue transfer. However, when an adjacent tissue transfer is performed on one site and a lesion is excised from a different site, both procedures may be reported for separate reimbursement. To illustrate this situation on the claim and bypass payer edits, be certain to add modifier 59 (Distinct Procedure) to the lesion excision code.

Removal and Closure with Skin Graft (Resurfacing)

Reporting Guidelines

For excisional release of scar contracture, use codes 15002-15005 Surgical preparation or creation of recipient site by excision of scar, as appropriate. List the appropriate skin graft code in addition. Refer to the Skin Replacement Surgery and Skin Substitute section for coding guidelines for grafts.

- Code for excision of the burn wound/scar contracture and for the skin graft used to cover it. For example, assume a large hypertrophic burn scar of the back is excised and covered with a split-thickness autograft. The applicable code(s) would be selected from each of the following code ranges.

15002-15003	Excision of burn wound/scar
15100-15101	Split-thickness autograft

Incisional Release and Closure with Skin Graft (Resurfacing)

Reporting Guidelines

For incisional release of scar contracture, use codes 15002-15005 Surgical preparation or creation of recipient site by incisional release of scar contracture, as appropriate. List the appropriate skin graft code in addition. Refer to the Skin Replacement Surgery and Skin Substitute section for coding guidelines for grafts.

- Code for incisional release of the burn wound scar/contracture and for the skin graft used to cover it. For example, assume incisional release of a hypertrophic burn scar of the back and then covered with a split-thickness autograft. The applicable code(s) would be selected from each of the following code ranges.

15002-15005	Excision of burn wound/scar
15100-15101	Split-thickness autograft

KEY POINT

Use code(s) 15002-15005 for excision of scar contracture. Code the applicable skin graft in addition.

Hand Scar Contracture Release

For hand and/or finger scar contracture release, see the applicable method in this section (e.g., excision and primary closure, removal with adjacent tissue transfer, resurfacing)

See also:

- 26123** Fasciectomy, partial palmar with release of single digit including proximal interphalangeal joint, with or without Z-plasty, other local tissue rearrangement, or skin grafting (includes obtaining graft);
- 26125** Each additional digit
- 26508** Release of thenar muscles (e.g., thumb contracture)

Debridement, Surgical, (16020-16030) (11000-11001, 11004–11008, & 11042-11047)

This discussion of debridement procedures is divided into the following main topics and covers only surgical debridement performed by physicians or non-physician practitioners (NPPs):

- Coding Differs by Type of Debridement and Performing Clinician
- Definition of Debridement
- Burn Wounds—Debridement by Physician or Non-Physician Practitioner (NPP) Within Scope of Licensure (16020-16030)
- Non-Burn Wounds—Debridement by Physician or Non-Physician Practitioner (NPP) Within Scope of Licensure (11000-11001, 11004-11008, 11042-11047)

For coding **non-surgical** debridement as performed **by non-physician professionals (PT, OT)**, refer to the section entitled **Debridement, Non-Surgical (97597-97602)**, which follows in sequence immediately after this discussion on surgical debridement.

KEY POINT

For burn wound debridement, burn surgeons & non-physician practitioners acting within scope of license should use debridement codes 16020-16030.

Coding Differs by Type of Debridement and Performing Clinician

Any code in CPT can be utilized to describe a clinical procedure or service rendered by any provider whose scope of practice includes that service.

Debridement is reported by the hospital based on the type of debridement performed, surgical versus non-surgical, and the clinical professional who performs the procedure.¹⁶

Codes for surgical debridement are used only by physicians and non-physician practitioners (e.g., NP or PA) acting within their scope of licensure.

Codes for non-surgical debridement, 97597–97602 (Active Wound Care), are typically used by non-physician professionals such as physical therapists and occupational therapists. Physicians (and non-physician practitioners who are qualified to do so) generally use a surgical debridement code instead.

This section provides coding instructions for surgical debridement of burn wounds and non-burn wounds by physicians or non-physician practitioners (NPPs) **only**.

(Dressings are discussed in a discussion entitled “Dressing Change” in another part of this section.)

Debridement may be reported for a burn wound or for a different condition¹⁷ using the code(s) that most accurately describe the procedure performed.

Definition of Debridement

Debridement is the removal of loose, devitalized, necrotic, and/or contaminated tissue, foreign bodies, and other debris on the wound using mechanical or sharp techniques (e.g., copious irrigation, washing, removal of loose and necrotic tissue using sharp instruments and/or forceps, etc.).

Burn Wounds—Debridement by Physician or Non-Physician Practitioner (NPP) Within Scope of Licensure

KEY POINT

For burn wound debridement by physician or non-physician practitioner acting within scope of licensure, use debridement codes 16020-16030.

Physician (e.g., burn surgeon) or **non-physician practitioner (NPP) acting within his/her scope of licensure** performs debridement of burn wound and documents it in a separate procedure note.

Burn wound debridement is reported using the codes listed in CPT under the CPT subheading “Burns, Local Treatment.” The relevant excerpt is shown below.

¹⁶ American Medical Association. CPT Changes 2001. Chicago: American Medical Association, 2001.

¹⁷ American Medical Association. CPT Assistant. Vol. 7. Chicago: American Medical Association, 1997.

Burns, Local Treatment

- 16020** Dressings and/or debridement of partial-thickness burns, initial or subsequent; small (less than 5% total body surface area)
- 16025** *under anesthesia*, medium or large, or with major debridement
- 16030** large (e.g., more than one extremity, or greater than 10% total body surface area)

Codes 16020–16030 include:

- a) removal and application of materials, dressings (e.g., Biobrane®, other dressings) and/or
- b) burn wound debridement. They may be used to report initial or subsequent burn wound debridement.

Codes are surface-area dependent and segmented by percent of total body surface area (TBSA) debrided.

Evaluation & Management Services (e.g., clinic visit, Emergency Department visit) are not included and are separately reportable with supporting documentation and when medically necessary.

Codes 16020–16030 may be used to report debridement or dressing change when one or the other is performed at an encounter, or to report both a debridement and a dressing change when both are performed at the same encounter.

Debridement vs. Excision

It is important to distinguish burn wound debridement from burn wound *excision*. Each is a distinctly different procedure based on the technique used by the burn surgeon.

Debridement is the removal of loose, devitalized, necrotic and/or contaminated tissue, foreign bodies, and other debris on the wound, using mechanical or sharp techniques.

In contrast, burn wound excision is a surgical procedure that is usually performed to prepare the wound for immediate or later grafting. It is frequently performed in stages where part of the burn wound is excised initially and the remainder is removed in one or more subsequent operations. The excisional technique may vary but is typically performed in one of two ways: tangential excision usually performed on deep partial thickness burns, and full thickness excision. Tangential excision involves a specific surgical technique in which successive layers of burn wound are removed down to viable dermis. Full thickness excision involves removal of the burn wound down to viable subcutaneous tissue or to fascia. Either process results in a large open area, i.e., *defect*, that must be covered.¹⁸ As an example, electrical burns may be initially excised followed by several additional staged excisions required to remove the additional, progressive necrosis (depth and width) that is characteristic of electrical burns.

Coding for burn wound debridement or burn wound excision must be based on documentation in the medical or operative record. If burn wound debridement is documented, the applicable code from 16020-16030 should be assigned. If burn wound excision is documented, the applicable code(s) from 15002-15005 should be assigned.

Coding is not based on the instrument used for the procedure because a scalpel, knives, or other instruments (e.g., Versajet) may be used to accomplish, alone or in combination, either burn wound excision or debridement.

Reporting Guidelines

- A single code is reported for all work to dress and/or debride burn wounds at a given encounter.
- For example, debridement and/or dressing of a 15% TBSA burn wound would be reported using the single code 16030.
- When debridement is performed again on subsequent days, it may be reported according to the foregoing guideline.
- When debridement is performed at a second, *different* session on the same day, the appropriate code for the second session is reported with the addition of modifier 59 to indicate that fact. Two codes would be reported for the same date, the first without and the second with modifier 59 added.

16030 (1 Unit)

18 Gillespie, R.W., Burn Surgery Tab 10, 1–12: CPT 1999 Coding Symposium. Chicago: American Medical Association, 1999.

16030-59 (1 Unit)

- **Note:** Code 16000 is used for first degree burn and specifies “local treatment,” referring to treatment performed to provide symptomatic relief for the patient.
- **Do not use other CPT debridement codes should not be used to report debridement of burn wounds** (E.g., 11000-11001, 11004–11008 Debridement for necrotizing soft tissue infection, or 11040-11047 Debridement of skin, subcutaneous tissue, muscle, and bone).

Non-Burn Wounds/Conditions—Debridement Performed by Physician or Non-Physician Practitioner (NPP) Within Scope of Licensure

Physician (e.g., burn surgeon) or **non-physician practitioner (NPP) acting within his/her scope of licensure** performs debridement of a wound, infected tissues (e.g., necrotizing fasciitis), or eczematous skin.

Debridement code categories for these surgical services are:

- 11000** Debridement of extensive eczematous or infected skin; up to 10% of body surface
- 11001** each additional 10% of the body surface (List separately in addition to code for primary procedure)
- 11004** Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum
- 11005** abdominal wall, with or without fascial closure
- 11006** external genitalia, perineum and abdominal wall, with or without fascial closure
- 11008** Removal of prosthetic material or mesh, abdominal wall for infection (e.g., for chronic or recurrent mesh infection or necrotizing soft tissue infection) (List separately in addition to code for primary procedure)
- 11042** Debridement; subcutaneous tissue; first 20 sq cm or less
- 11045** each additional 20 sq cm, or part thereof (use 11045 in conjunction with 11042)
- 11043** Debridement, muscle and or fascia; first 20 sq cm or less
- 11046** each additional 20 sq cm, or part thereof (use 11046 in conjunction with 11043)
- 11044** Debridement; bone; first 20 sq cm or less
- 11047** each additional 20 sq cm, or part thereof (use 11047 in

Reporting Guidelines

- Debridement, initial or subsequent, may be reported as performed.
- Wound closure (e.g., skin graft) at the time of debridement or at a subsequent operative intervention is separately reportable.
- **Codes 11000-11001** are surface area dependent are reported by percent of body area *skin* that is debrided.
- Code 11000 is used to report the first 10% of body surface area of skin debrided. For each additional 10% of body surface area debrided thereafter, list code 11001 on one line and enter the total number of remaining units in the units field of the claim, unless otherwise directed by the payer. For example, assume 60% of body surface area is debrided

11000 (for first 10%) Units = 1

11001 (for next 50%) Units = 5

- **Codes 11004–11008** are anatomic-site and diagnosis-specific codes. They are utilized for debridement of necrotizing soft tissue infections such as necrotizing fasciitis, Fournier’s gangrene, and other rapidly progressing (fulminating) soft tissue infections that affect certain anatomic sites.

Codes 11004–11006 include debridement/removal of skin, subcutaneous tissue, fascia and muscle. If orchiectomy (54520) or testicular transplantation (54680) is performed in addition, each is separately reportable.

Only **one** code from 11004–11006 may be reported per operative intervention.

Code 11004 is used to report debridement of the external genitalia and perineum. Use code 11005 to report debridement of the abdominal wall. When debridement of external genitalia, perineum and the abdominal wall is performed, use the single code 11006. Closure of fascia, if performed, is included in codes 11005 and 11006.

When **prosthetic material or mesh**, previously placed in the abdominal wall (e.g., for repair of ventral hernia), **is removed** to treat chronic or recurrent mesh infection or necrotizing soft tissue infection, report code 11008. This code is an add-on code and can only be reported when one of the codes from 11004–11006 is also reported at the same encounter.

When prosthetic material or mesh is inserted for closure or repair associated with necrotizing soft tissue infection, code 49568 Implantation of mesh or other prosthesis for incisional or ventral hernia repair may be used to report it. This code is an add-on code

For extensive debridement/excision of necrotizing soft tissue infection from other anatomic areas, refer to codes 15002–15005.

- Codes 11042-11047 are depth-dependent codes and are reported on the basis of the deepest layer of tissue removed. **These codes should not be used to describe debridement of burn wounds.**¹⁹ The codes are often used for debridement of smaller chronic wounds such as vascular ulcerations. For larger areas that involve an excisional procedure such as tangential excision, refer to codes 15002–15005.
- **When multiple anatomic sites are debrided at the same session, debridement of each noncontiguous site may be reported separately.** Codes for the second and subsequent sites are each reported with modifier 59 to indicate the procedure was performed at a different anatomic site in each instance.

Debridement, Non-Surgical (97597-97598, 97602)

The following discussion covers these topics:

- Burn Wounds—Debridement, Non-Surgical, by Non-Physician Professionals (PT, OT)
- Non-Burn Wounds/Conditions—Debridement, Non-Surgical, by Non-Physician Professionals (PT, OT)

KEY POINT

Burn wound debridement by non-physician professionals (e.g., PT, OT), licensed to perform non-surgical debridement, is reported using Active Wound care codes 97597-97602.

Burn Wounds—Debridement by Non-Physician Professional

Non-physician professional, such as a physical or occupational therapist, performs selective or non-selective debridement of burn wound.

Burn wound debridement is reported using codes listed under “Active Wound Care Management” which represent *non-surgical* debridement and are performed without anesthesia. Codes are shown below.

¹⁹ American Medical Association. CPT Assistant Vol. 7, Issue 8. Chicago: American Medical Association, 1997.

- 97597** Removal of devitalized tissue from wound(s); selective debridement, without anesthesia (e.g., high pressure waterjet, with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters
- 97598** total wound(s) surface area greater than 20 square centimeters
- 97602** Removal of devitalized tissue from wound(s); non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session

Reporting Guidelines

Outpatient selective or non-selective burn wound debridement (non-surgical debridement) performed by a non-physician professional may be reported subject to payer reporting and coverage guidelines.

- CPT codes 97597–97602 are used to report these active wound care services as provided by physical therapists, occupational therapists, enterostomal therapy nurses, and other non-physician professionals, as appropriate.
- Surgical debridement codes 11042–11047 may not be reported in addition to 97597–97602 when performed by a non-physician professional. Wound debridement performed by physicians or non-physician practitioners licensed to do so is reported using 11004–11008 or 11040–11047 and, for burn wounds, 16020–16035.
- Application and removal of any protective or bulk dressings is included in codes 97597–97602.
- At this time, Medicare considers codes 97597–97602 therapy services and allows payment for them as follows: When provided under a certified therapy plan of care by a qualified therapist, the services are paid under the Medicare Physician Fee Schedule. When provided independent of a therapy plan of care, the services are paid under the OPPS.
- When these services are provided independent of a therapy plan of care, a modifier is not required for payment purposes.
- However, when these services are provided under a certified therapy plan of care, they must be reported using the appropriate modifier that designates which type of therapy

provider rendered the service. Use modifier GP for physical therapy or modifier GO for occupational therapy.

Non-Burn Wounds—Debridement by Non-Physician Professional (PT, OT)

Non-physician professional, such as a physical or occupational therapist, performs selective or non-selective debridement of a non-burn wound.

Non-burn wound debridement is reported using codes listed under “Active Wound Care Management,” which represent *non-surgical* debridement, and are performed without anesthesia. Codes are shown below.

- | | |
|--------------|---|
| 97597 | Removal of devitalized tissue from wound(s), selective debridement, without anesthesia (e.g., high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), with or without topical application(s), wound assessment, and instruction(s) for ongoing care, may include use of a whirlpool, per session; total wound(s) surface area less than or equal to 20 square centimeters |
| 97598 | total wound(s) surface area greater than 20 square centimeters |
| 97602 | Removal of devitalized tissue from wound(s); non-selective debridement, without anesthesia (e.g., wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session |

Outpatient hospital selective or non-selective wound debridement performed by a non-physician professional may be reported, subject to payer reporting and coverage guidelines.

- CPT codes 97597–97602 are used to report these active wound care services as provided by physical therapists, occupational therapists, enterostomal therapy nurses, and other non-physician professionals, as appropriate.
- Surgical debridement codes 11042–11047 may not be reported in addition to 97597–97602 by the non-physician professional. Wound debridement performed by physicians or non-physician practitioners licensed to do so is reported using 11004–11008 or 11042–11047 and, for burn wounds, 16020–16035.
- Application and removal of any protective or bulk dressings are included in codes 97597–97602.

- At this time, Medicare considers code 97597–97602 therapy services and allows payment for them as follows: When provided under a certified therapy plan of care by a qualified therapist, the services are paid under the Medicare Physician Fee Schedule. When provided independent of a therapy plan of care, the services are paid under the OPPS.
- When these services are provided independent of a therapy plan of care, a modifier is not required for payment purposes.
- However, when these services are provided under a certified therapy plan of care, they must be reported using the appropriate modifier that designates which type of therapy provider rendered the service. Use modifier GP for physical therapy or modifier GO for occupational therapy.

Dressing Change

This discussion covers the following topics. Note that guidelines for Dressings are segmented into three distinct categories, each of which is discussed separately.

- Overview
- Dressings—Burn Wounds
- Dressings—Grafts
- Dressings—Non-burn Wounds.

Dressings may be applied to burn wounds, non-burn wounds, and grafts.

For burn wounds, dressings may be applied in initial and/or subsequent sessions in the outpatient department.

For non-burn wounds, dressings may be applied in initial and/or subsequent sessions in the outpatient department.

For skin grafts, dressings may be applied immediately following application of the graft and, as necessary, in subsequent sessions.

The following guidelines are divided into three distinct categories:

- Dressings—Burn Wounds
- Dressings—Grafts, and
- Dressings—Non-burn Wounds.

Dressings—Burn Wounds

When performed by the physician, dressing changes are reported using the applicable “Burns, Local Treatment” codes 16020-16030.

- Codes are surface-area dependent and segmented by percent of total body surface area (TBSA).
- Codes 16020-16030 may be used for initial or subsequent burn wound dressings.
- Codes 16020–16030 may be used to report debridement or dressing change when one or the other is performed at an encounter, or to report both a debridement and a dressing change when both are performed at the same encounter.

Reporting Dressing and Dressing Changes

- A single code is reported for all work to dress and/or debride burn wounds at a given encounter.²⁰ *For example*, debridement and/or dressing of a 15% TBSA burn wound would be reported using the single code 16030.
- When, however, burn wound dressing is performed at a second, *different* session on the same date, the appropriate code for the second session is reported with the addition of modifier 59. Two codes would be reported for the same date, the first without and the second with modifier 59 added.
- When burn wound dressing(s) are performed again on a later date, the appropriate code may be reported again according to the foregoing guidelines.
- Codes 16000-16030 are used to report local treatment of burn wounds. Evaluation and Management services (e.g., visit or consultation) are not included and are separately reportable with supporting documentation and when medically necessary.
- **Note:** Code 16000 is used for first degree burn and specifies “local treatment” which refers to treatment performed to provide symptomatic relief for the patient.⁴

Dressings—Grafts

- Codes 16020-16030 are surface-area dependent and segmented by percent of total body surface area (TBSA).
- Codes include removal and application of dressing.

Reporting Dressing and Dressing Changes

²⁰ American Medical Association. CPT Assistant. Vol. 7. Chicago: American Medical Association, 1997.

- A single code is reported for all work to dress the wound at a given encounter. For example, debridement and/or dressing of a 15% TBSA burn wound would be reported using the single code 16030.
- When, however, dressing change is performed at a second, *different* session on the same date, the appropriate code for the second session is reported with the addition of modifier 59 (Distinct procedure). Two codes would be reported for the same date, the first without and the second with modifier 59 added.
- When dressing(s) are performed again on a later date, the appropriate code may be reported again according to the foregoing guidelines.

Dressings—Non-burn Wounds

When non-burn wound dressing change is performed under anesthesia defined by the AMA's *CPT Assistant* as general anesthesia, regional anesthesia, or monitored anesthesia care, it may be reported using code

15852 Dressing change (for other than burns) under anesthesia (other than local)

Code 15852 may be used for initial and subsequent dressing changes under anesthesia (general anesthesia, regional anesthesia, or monitored anesthesia care).

Escharotomy (16035–16036)

Performed to relieve circulatory, pulmonary and/or neurological compromise resulting from the constricting effect of a full thickness burn, escharotomy is accomplished by making an axial incision (in a line parallel to the long axis of the body or body part) along the entire length of the burn eschar. The escharotomy incision is extended to a depth below the burned tissue, generally down to the subcutaneous fat.

One or more escharotomy incisions may be required to release constriction caused by leathery, inelastic burn eschar.

Reporting Guidelines

- Code 16035 is used for the first escharotomy incision.

- Code 16036 is used for each escharotomy incision after the first incision **performed at the same operative session**.
- Codes are not limited by anatomic location. Each escharotomy incision may be reported, regardless of its anatomic location.

Example: Three escharotomy incisions are made on the chest to relieve pulmonary constriction. One horizontal incision is made below the rib cage. Two vertical incisions are made on the right and left sides of the chest. In addition, escharotomy incisions are made on the medial and lateral aspects of the right arm.

16035	First incision	1 unit
16036	[Second through fifth incisions]	4 units

KEY POINTS

Add-on codes can only be used with the primary code when they are performed at the same operative session.

Coding starts over again when the same procedure is performed at another operative session on the same date.

- For multiple escharotomies on the same date **but performed at different encounters on that date**, code all escharotomies at each encounter using the primary code for the first incision at the encounter and the add-on code for each incision thereafter **at the same encounter**. Add modifier 59 (Distinct procedure) to code 16035 for the primary escharotomy performed at the second encounter to indicate that fact.

Example: Two escharotomy incisions are made on the chest at the initial encounter. At the second encounter on the same day, an additional incision is made on the chest and one on the upper arm.

First Encounter

16035	First incision	1 unit
16036	Second incision	1 unit

Second Encounter

16035-59	First incision	1 unit
16036	Second incision	1 unit

Excision Burn & Non-burn Wounds (15002-15005)

Burn wound excision is a surgical procedure that is usually, but not always, performed to prepare the wound for immediate or later grafting, or for treatment with dressings or temporary wound covering.

Depending on the size and clinical course of the wound, it may be performed in stages where part of the burn wound is excised initially and the remainder is removed in one or more subsequent operations. **

Debridement vs. Excision

It is important to distinguish burn wound *debridement* from burn wound *excision*. Each is a distinctly different procedure based on the technique used by the burn surgeon.

Debridement is the removal of loose, devitalized, necrotic and/or contaminated tissue, foreign bodies, and other debris on the wound, using mechanical or sharp techniques.

In contrast, burn wound excision is a surgical procedure that is usually performed to prepare the wound for immediate or later grafting. It is frequently performed in stages, where part of the burn wound is excised initially and the remainder is removed in one or more subsequent operations. The excisional technique may vary but is typically performed in one of two ways: tangential excision usually performed on deep partial thickness burns, and full thickness excision. Tangential excision involves a specific surgical technique in which successive layers of burn wound are removed down to viable dermis. Full thickness excision involves removal of the burn wound down to viable subcutaneous tissue or to fascia. Either process results in a large open area, i.e., *defect*, that must be covered.²¹

Coding for burn wound debridement or burn wound excision must be based on documentation in the medical or operative record. If burn wound debridement is documented, the applicable code from 16020-16030 should be assigned. If burn wound excision is documented, the applicable code(s) from 15002-15005 should be assigned.

Coding is not based on the instrument used for the procedure because a scalpel, knives, or other instruments (e.g., Versajet) may be used to accomplish, alone or in combination, either burn wound excision or debridement.

Example: Electrical burns may be initially excised followed by several additional staged excisions required to remove the additional, progressive necrosis (depth and width) that is characteristic of electrical burns.

Non-burn wounds, such as those involved in necrotizing fasciitis, may be excised using the same techniques as those described above for burn wounds.

²¹ Gillespie, R.W., Burn Surgery Tab 10, 1–12: CPT 1999 Coding Symposium. Chicago: American Medical Association, 1999.

Overview

Codes 15002-15005 can be used to report excision of an open wound, burn eschar, or scar, or for incisional release of scar contracture. **The codes are reported based on the measurement of the surface area of the excised wounds located in the listed anatomic site(s) stated in the codes. Measurement of surface area is based on** the size of the remaining defect or open wound. The unit of measurement used for measurement and reporting depends on the patient's age: square centimeters (cm²) are used for persons 10 and older, while percent of body surface area is used for children under 10.

KEY POINTS

Measurement of area is based on patient age:

Total area excised in sq cm **by anatomic site** for adults and children age 10 and over.

Total area excised in percent total body surface area **by anatomic site** for children under 10 years of age.

Codes 15002 and 15004 are stand-alone codes. Codes 15003 and 15004 are their respective add-on codes. Each add-on code is reported only when its companion primary code is reported at the same time and the service it describes is provided at the same encounter and documented accordingly.

- | | |
|--------------|--|
| 15002 | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, trunk, arms, legs; first 100 sq cm or one percent of body area of infants and children |
| 15003 | each additional 100 sq cm, or part thereof, or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure) |
| 15004 | Surgical preparation or creation of recipient site by excision of open wounds, burn eschar, or scar (including subcutaneous tissues), or incisional release of scar contracture, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet and/or multiple digits; first 100 sq cm or one percent of body area of infants and children |
| 15005 | each additional 100 sq cm, or part thereof, or each additional one percent of body area of infants and children (List separately in addition to code for primary procedure) |

See Contracture Release/ Scar Revision section for coding guidelines for incisional and excisional release of scar contracture.

See Skin Replacement Surgery and Skin Substitutes for coding guidelines for skin grafts, replacements, and skin substitutes.

Reporting Guidelines

- Codes 15002 and 15004 are used for excision of an area *up to and including* the first 100 sq cm in adults or one percent of surface area in infants and children. Thus, the codes can be used for wound excisions smaller than the areas listed in the code.
- Code 15003 is an add-on code and can only be used with code 15002 when both are provided at the same encounter. Code 15003 may be reported when the service described in 15003 is provided at the same encounter and documented accordingly.
- Code 15005 is an add-on code and can only be used with code 15004 when both are provided at the same encounter. Code 15005 may be reported when the service described in 15005 is provided at the same encounter and documented accordingly.

KEY POINTS

Application of dressings such as Biobrane, Xeroform, Adaptic, Exudry, etc. is not separately reportable.

- Codes 15003 and 15005 are used for excision of additional wound area after the first 100 sq cm or one percent of surface area in infants and children has been removed *during the same operation*. These codes can be used to report *up to and including* each additional increment of 100 sq cm or 1 percent in infants and children. They cannot be reported alone and can only be reported when their primary codes, 15002 or 15004, respectively, are also reported for work performed at the same time. See example below.

KEY POINTS

Skin graft must be documented by type of graft, anatomic location, and total area of recipient site covered with graft.

In graft codes that specify 100 sq cm or one percent of body area of infants and children, use sq cm for adults and children 10 and over. Use percent total body surface area for children under 10.

- When excision is performed to prepare or create the recipient site, **application of dressings or materials that are not described in codes 15040-15431 is not separately reportable**. Report code(s) 15002-15003 and/or 15004-15005 only, as appropriate. Examples of materials or dressings that are not separately reportable include but are not limited to Biobrane®, Xeroform®, Adaptic® and Exudry®

However, **the supply** of dressing materials may be reported, as appropriate and consistent with payer guidelines.

Example: Excision of 450 sq cm burn wound on the back with application of dressing

15002	Tangential excision of first 100 sq cm 1 unit
15003	Tangential excision of each additional 100 sq cm, or part thereof, 4 units
	(Additional 350 sq cm after the first 100 sq cm = 4 units)

- When excision is followed by immediate skin grafting, both the excision and appropriate skin graft procedure are reported.

Example: Excision of burn wound of chest with application of 450 sq cm split thickness skin grafts

15100 Split-thickness autograft, trunk, first 100 sq cm (1 unit)

15101 Split-thickness autograft, trunk, each additional 100 sq cm (4 units)

15002 Tangential excision of first 100 sq cm (1 unit)

15003 Tangential excision of each additional 100 sq cm (4 units)

- When wound excision is performed in stages, with each stage performed at a different operative encounter, each stage may be reported as performed. For example, wound excision performed on 3 separate dates would be reported with the appropriate code(s) for the excision performed on each date.
- When excision is followed by immediate primary wound closure, do not report closure separately. Report the excision procedure only, using the applicable excision code(s) 15002-15003 and/or 15004-15005.

Fasciotomy

Fourth degree burns involve organs beneath the skin such as muscle and bone. Electrical burns to the extremities may also involve those structures. To relieve vascular compromise due to constriction caused by these burns, one or more fasciotomies may be performed. Fasciotomy for a burn is much deeper than an escharotomy. The incision extends through the fascia that covers muscle and, in some cases, through the muscle to bone. Often, it also requires debridement of muscle and/or bone.

Reporting Guidelines

- The applicable fasciotomy code is reported for each anatomic site. Refer to the Fasciotomy table below.
- When there is no fasciotomy code available for the anatomic site (e.g., upper arm) an unlisted procedure code may be used to report it.

- When further muscle tissue must be excised on subsequent days to treat continued necrosis of muscle within the wound, it can be reported as performed, subject to payer guidelines. Report the appropriate excision code(s) (15002-15005). Refer to the Excision of Burn Wound section for additional information.

Closure of Fasciotomy

- When a delayed or secondary closure of the fasciotomy is performed on a subsequent date, it may be reported separately if no other surgical procedure, such as wound excision (15002-15005), is performed on the fasciotomy site at the same time as the closure. That is, the fasciotomy closure is the only procedure performed on the fasciotomy site at the operative encounter.
- The following codes are available for reporting the closure:
Repair (Closure) of wounds, 12001-13153. Assign the appropriate code for simple, intermediate or complex closure based on the information documented in the patient record and the guidelines in CPT under the heading “Repair (Closure).”
- If secondary closure is extensive or complicated, refer to code 13160.

FASCIOTOMY CODE TABLE

Note: Some of the listed fasciotomy codes may not be used for burns but are included here for complete reference.

ANATOMIC LOCATION	CODE AND DESCRIPTION
Elbow	24357 Tenotomy, elbow, lateral or medial; percutaneous [replaces Fasciotomy, lateral or medial (See other indented codes below 24357 also)
Arm, lower	24495 Decompression fasciotomy, forearm, with brachial artery exploration
Arm, lower Wrist	25020 Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; without debridement of nonviable muscle and/or nerve
Arm, lower Wrist	25023 Decompression fasciotomy, forearm and/or wrist, flexor OR extensor compartment; with debridement of nonviable muscle and/or nerve
Arm, lower Wrist	25024 Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; without debridement of nonviable muscle and/or nerve
Arm, lower Wrist	25025 Decompression fasciotomy, forearm and/or wrist, flexor AND extensor compartment; with debridement of nonviable muscle and/or nerve
Hand	26037 Decompressive fasciotomy, hand (excludes 26035)
Palm	26040 Fasciotomy, palmar (e.g., Dupuytren's contracture); percutaneous
Palm	26045 Fasciotomy, palmar (e.g., Dupuytren's contracture); open, partial
Hip Thigh	27025 Fasciotomy, hip or thigh, any type
Thigh Knee	27496 Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor);
	27497 Decompression fasciotomy, thigh and/or knee, one compartment (flexor or extensor or adductor); with debridement of nonviable muscle and/or nerve
	27498 Decompression fasciotomy, thigh and/or knee, multiple compartments;
	27499 Decompression fasciotomy, thigh and/or knee, multiple compartments; with debridement of nonviable muscle and/or nerve
Leg, lower	27600 Decompression fasciotomy, leg; anterior and/or lateral compartments only
	27601 Decompression fasciotomy, leg; posterior compartment(s) only
	27602 Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s)
Leg, lower	27892 Decompression fasciotomy, leg; anterior and/or lateral compartments only, with debridement of nonviable muscle and/or nerve
	27893 Decompression fasciotomy, leg; posterior compartment(s) only, with debridement of nonviable muscle and/or nerve
	27894 Decompression fasciotomy, leg; anterior and/or lateral, and posterior compartment(s), with debridement of nonviable muscle and/or nerve
Foot Toe	28008 Fasciotomy, foot and/or toe

Skin Replacement Surgery and Skin Substitutes—Grafts

Origin

- Autograft: tissue transplanted from one part of the body to another in the same individual
- Allograft (homograft): tissue transplanted from one individual to another of the same species
- Xenograft (heterograft): tissue transplanted from one species to an unlike species (e.g., pig to human)

Autografts: Anatomic Source

- Epidermal grafts
- Dermal grafts
- Split-thickness skin grafts
- Full-thickness skin grafts

Additional Key Definitions

- Skin Replacement: a tissue or graft that permanently replaces lost skin with healthy skin
- Skin Substitute: a biomaterial, engineered tissue or combination of materials and cells or tissues that can be substituted for skin autograft or allograft in a clinical procedure
- Temporary wound cover: a resurfacing material that provides coverage of the wound until the skin surface can be permanently replaced

The following table provides a partial listing of graft code ranges under the CPT subheading “Skin Replacement Surgery and Skin Substitutes.” Refer to CPT for a complete list of these codes.

Refer to this table for brief definitions and, where applicable, examples of products described by each type of graft within the given code ranges.

Table of Skin Replacements and Skin Substitutes

Table of Skin Replacements and Skin Substitutes

CODE RANGE	TYPE OF GRAFT	DEFINITION
15100-15101, 15120-15121	Split-thickness skin graft	Autologous skin graft
15110-15116	Epidermal autograft	Autologous skin graft
15130-15136	Dermal autograft	Autologous skin graft
15150-15157	Tissue Cultured Epidermal Autograft	Cultured autologous skin with only an epidermal layer (e.g., CEA, Epicel [®] , EpiDex [®])
15200-15261	Full Thickness Graft, Free	Autologous skin graft
15271-15278	Skin Substitute Grafts	Non-autologous human skin grafts, Non-human skin substitute grafts, and biological products that form a sheet scaffolding for skin growth

Reporting Guidelines

Clinical examples for using these graft codes correspond to the reporting guidelines for them.

Utilized to cover and/or close open wounds, free skin grafts are coded according to specific rules.

- Grafts are identified by a) size and anatomic location of the defect or *recipient site* and b) type of graft applied.

For example, a 100 sq cm split-thickness autograft from the thigh applied to cover that same area of recipient site on the trunk would be coded 15100 because the recipient site location and size is specified in code 15100. Or, a split- thickness autograft applied to 80 sq cm total area on both hands and two fingers would be coded 15120 because the size and recipient sites are identified in code 15120.

KEY POINTS

Skin graft must be documented by type of graft, anatomic location, and total area of recipient site covered with graft. In graft codes 15100, 15001, 15120, and 15121 sq cm is used for adults and children 10 and over. Percent total body surface area is used for children under 10.

- The foregoing rule applies whether or not a graft is meshed. For example, a 100 sq cm split thickness skin graft taken from the thigh, meshed 2:1 and placed on a 200 sq cm recipient site on the chest would be reported using the appropriate codes for split thickness skin graft placed on 200 sq cm of recipient site on the trunk:

15100 Split-thickness autograft (first 100 sq cm) (1 unit)
15101 Split-thickness autograft (next 100 sq cm) (1 unit)

- Report procedures by the size and location of the **recipient site. Do not code by the size of the graft.**
- When the *donor* site requires repair after harvest of the graft, the repair procedure for the donor site (*e.g.*, skin graft, advancement flap, etc.) may be coded and reported in addition.
- When excision (15002-15005) is performed to prepare or create the recipient site, **application of dressings or materials that are not described in codes 15040-15431 is not separately reportable and is included in code(s) 15002-15005.** Report code(s) 15002-15005 only, as appropriate. This means that application of dressings such as Biobrane®, Xeroform®, Adaptic®, EXU-DRY®, etc. are not separately reportable.
- In addition, CPT indicates that graft codes 15100-15431 are intended to be reported for application of skin substitutes/grafts using fixation such as sutures, staples, fibrin “glue” (*e.g.*, ARTISS Fibrin Sealant) and so on. Application of these materials without such fixation and using stabilization with dressings alone is not separately reportable.

CPT guidelines state: “These codes are not intended to be reported for simple graft application alone or application stabilized with dressings (*e.g.*, by simple gauze wrap). The skin substitute/graft is anchored using the surgeon’s choice of fixation.”

- **Simple debridement or scraping of granulation tissue or recent avulsions is included and not reported separately.**

KEY POINTS

Application of dressings such as Biobrane, Xeroform, Adaptic, EXU-DRY, etc. are not separately reportable.

- **Excision of granulation tissue for preparation of the recipient site is separately reportable. See codes 15002- 15005.** (Do not use code 15002-15005 for simple scraping of granulation tissue.)

Example: Excision of 450 sq cm burn wound of the arm with application of a dressing material that is not surgically fixed to the wound and is not one of the materials named in 15100-15431. Three days later, split thickness skin graft is applied to the wound.

3/1	15002	Tangential excision of first 100 sq cm	1 unit
3/1	15003	Tangential excision of each additional 100 sq cm (Additional 350 sq cm after the first 100 sq cm)	4 units
3/4	15100	Split-thickness autograft (first 100 sq cm)	1 unit
3/4	15101	Split-thickness autograft (each additional 100 sq cm)	4 units

The foregoing guidelines apply whether the graft is applied immediately after wound excision or at a later date.

- Codes for certain grafts utilize two different units of measurement for the recipient site: Square centimeters (sq cm) and percent of body surface. Where the codes specify “100 sq cm or one percent of body area of infants and children,” square centimeters are used for persons 10 and older while percent of body surface is used for children under 10.
- Where a code specifies a number of square centimeters, it refers to 1 sq cm *up to the stated amount*. Add-on codes begin with the next sq cm. Example: 140 sq cm would be coded using a code for the first 100 sq cm and an add-on code for the next 40 sq cm.

Each type of graft is described below and an explanation provided, when different or additional coding guidelines apply.

Refer to the Table of Skin Replacements and Skin Substitutes in the introduction to this section for a description of product characteristics and common trade names applicable to each code category explained below.

Autograft/Tissue Cultured Autograft (15040-15157)

This category of codes includes split-thickness, epidermal, dermal, and tissue cultured autografts and other autografts.

For the full text of each CPT code, please refer to Appendix VII, Medicare Physician Fee Schedule.

Split-thickness Autograft

- Split-thickness autografts applied to the anatomic sites named in each primary code are reported using codes 15100-15101 and 15120-15121, as appropriate. Codes 15100 and 15120 are primary codes, while 15101 and 15121 are their respective add-on codes. The add-on codes can never be reported alone. They can only be reported when their primary code is also reported on the same date of service.

Epidermal Autograft

- Epidermal autografts applied to the anatomic sites named in each primary code are reported using codes 15110-15116, as appropriate. Codes 15110 and 15120 are primary codes. Codes 15111 and 15116 are their respective add-on codes and can never be reported alone. They can only be reported when their primary code is also reported on the same date of service.

Dermal Autograft

- Dermal autografts applied to the anatomic sites named in each primary code are reported using codes 15130-15136, as appropriate. Codes 15130 and 15135 are primary codes. Codes 15131 and 15136 are their respective add-on codes and can never be reported alone. They can only be reported when their primary code is also reported on the same date of service.

Tissue Cultured Epidermal Autograft

These grafts are composed of cultured skin cells taken from the patient and then grown over a period of weeks to form sheets of graft material. For example, CEA (cultured epidermal autograft).

- When skin is harvested or obtained for development of tissue cultured skin autograft, use code 15040. This code specifies harvest of skin in the amount of 100 sq cm or less.
- Tissue cultured epidermal autograft procedures (15150-15157) are performed when culture of the harvested skin is complete and the resulting autograft is ready to be applied. Tissue cultured epidermal autografts applied to the anatomic sites named in each primary code are reported using codes 15150-15157, as appropriate. Codes 15150 and 15155 are primary codes. Codes 15151-15152 and 15156-15157 are their respective add-on codes and can only be reported when their respective primary code is reported on the same date of service.
- Two code families are used to report the procedures, 15150-15152 and 15155-15157. Three codes in each family provide incremental units, listed below, for reporting the procedures.

First 25 sq cm or less

Additional 1 sq cm to 75 sq cm (add-on)

Each additional 100 sq cm (add-on)

Coding guidelines follow.

- Code 15150 is used to report the first 25 sq cm or less applied to the trunk, arms, and legs. Code 15151 is used to report the next 1 sq cm to 75 sq cm applied. For each additional 100 sq cm or 1% of body area of infants and children (or part thereof) applied thereafter, use code 15152.
- Code 15155 is used to report the first 25 sq cm or less applied to the named list of anatomic sites in the code descriptor. Code 15156 is used to report the next 1 sq cm to 75 sq cm applied. For each additional 100 sq cm or 1% of body area of infants and children (or part thereof) applied thereafter, use code 15157.
- **Codes 15151 and 15156 cannot be reported more than once per operative session. Hence, the units reported for these codes will always be “1”.**

Free Full Thickness Graft (15200-15261)

For the full text of each CPT code, please refer to Appendix VII, Medicare Physician Fee Schedule.

- Codes for full thickness skin grafts specify square centimeters only, using 20 sq cm increments as units of measurement. Therefore, the units of measurement in these codes apply to patients of all ages.
- All codes in this category include direct closure of the donor site, which is not to be reported separately. Full thickness grafts applied to the anatomic sites named in each primary code are reported using codes 15200-15261, as appropriate. Codes 15200, 15220, 15240, and 15260 are primary codes. Codes 15201, 15221, 15241 and 15261 are their respective add-on codes and can never be reported alone. They can only be reported when their companion primary code is also reported on the same date of service.

Clinical Case Examples: Cellular and Tissue Based Products

Example 1.0

A 10-year-old boy was rescued from a burning building and assessed to have 80% total body surface area (TBSA) burns. Following initial stabilization at the local emergency room, he was transferred to the regional burn center for definitive management. Once hemodynamically stable, he was taken to the operating room for excision of his extensive full-thickness burns and wound coverage with cadaveric allograft and acellular dermal replacement. In addition, due to the extent of the burns and lack of sufficient donor sites, he had a split-thickness skin graft 0.012” in depth harvested for preparation of cultured autologous skin grafts that will be applied in 3-4 weeks (when available).

Procedure	CPT Codes
Application of skin substitute to bilateral hands (350 cm ²)	15277 x 1
Application of skin substitute to anterior torso (1000 cm ²)	15278 x 3
	15273-51- x 1
	15274 x 9
Harvest of skin for tissue-cultured skin autograft (50 cm ²)	15040-51
Surgical preparation or creation of recipient site by excision of open wounds, burn eschar ... (350 cm ² – hand)	1500X-51 x 1
(1000 cm ² – torso)	1500X x 13*
	*Units assume all anatomic sites excised are in the same code family, e.g., 15002-15003 OR 15004-15005.

Example 1.1

It is now 4 weeks since the 10-year-old boy underwent his initial operative procedures. His donor sites are now healed, the acellular dermal replacement has vascularized, and an initial set of tissue cultured epidermal autografts are now available for application to the wounds. He is returned to the operating room for harvesting and application of epidermal autografts 0.006” in depth and application of multiple 25 cm² tissue cultured epidermal autografts.

Procedure	CPT Codes
Epidermal autograft, bilateral feet (300 cm ²)	15115 15116 x 2
Epidermal autograft, bilateral arms & legs (500 cm ²)	15110-51 15111 x 4
Tissue cultured epidermal autograft, bilateral hands (350 cm ²)	15155-51 15156 x 1, 15157 x 3
Tissue cultured epidermal autograft, anterior torso (1000 cm ²)	15150-51 15151 x 1, 15152 x 9

Example 2.0

A 62-year-old man has recurrent metastatic cancer of his left popliteal fossa. He has previously had radiation therapy to this area and undergoes surgical exploration. At operation, he is noted to have radiation injury to the popliteal artery. To protect the exposed vessel, a split-thickness skin graft is harvested but not removed from the underlying wound bed using a dermatome. A 2nd pass of the dermatome at 0.010” is made for the recovery of a dermal graft that measures 150 cm². The originally raised split-thickness skin graft is then reapplied to the wound bed, anchored with surgical staples and a dressing applied. The dermal graft is then sewn in place over the exposed popliteal artery using absorbable sutures and the wound is closed in layers utilizing non-absorbable sutures.

Procedure	CPT Codes
Dermal autograft, leg (150 cm ²)	15130 15131 x 1
<i>If the same procedure had been performed to cover the carotid artery:</i> Dermal autograft, neck (150 cm ²)	15135 15136 x 1

Example 3.0

A 20-year-old with a history of having been treated for extensive third degree burns presents with contractures of the axilla and hand. Because the patient has limited skin graft donor sites with little remaining dermal tissue due to multiple previous harvests, acellular dermal allograft is sutured into the skin defects created by the incisional release of the contractures. The acellular dermal allograft is then covered with a thin split-thickness skin autograft in order to prevent scarring and recurrence of the contracture. The axillary defect measures 250 cm² and the hand defect measures 125 cm².

Procedure	CPT Codes
Split-thickness skin autograft, hand (125 cm ²) Split-thickness skin autograft, axilla (250 cm ²)	15120 15121 x 1 15100-51 x 1
Application of skin substitute, hand (125 cm ²)	15277-51 x 1 15278 x 1
Application of skin substitute, axilla (250 cm ²)	15273-51 x 1 15274 x 2
Incisional release of scar contractures of hand and axilla (125 cm ² hand & axilla 250 cm ²)	15002-51 x 1 15003 x 2 15004 x 1

Example 4.0

A 68-year-old male with type II diabetes presents with an 8 x 10 non-infected, full-thickness venous stasis ulcer of the lower leg and ankle.

The wound is debrided and, after obtaining adequate hemostasis, 150 cm² of tissue cultured allogeneic skin substitute is grafted to the excised surface and secured with interrupted sutures.

skin substitute applied to leg (80 cm ²)	15271 x 1 15272 x 3
Debridement or excision is <u>not</u> reported separately for these particular codes.	
<ul style="list-style-type: none"> • Debridement of subcutaneous tissue (11042,11045) is typically considered inclusive in the application of skin substitute procedure and not separately reportable • Surgical Preparation codes (15002-15003) are not for use in chronic wounds that have previously been debrided 	

K-wire Insertion

K-wires (Kirschner wires) are rigid metal wires available in varying thicknesses that are inserted across bone joints, bone fragments and other bony structures to hold them in a fixed position.

Application in Burn Surgery

During the acute phase of burn treatment, K-wires are typically inserted to immobilize one or more joints of the hand, fingers, foot, or toes to achieve the following:

- To limit motion, act as a splint and provide protection for a joint prior to skin grafting when the joint or tendons are exposed.
- To immobilize a joint in correct position after skin grafting until such time as it has become sufficiently attached to permit range of motion exercises.
- To prevent contractures that might develop if the body part is not maintained in correct position.

During the reconstructive phase of treatment, K-wires may be used in reconstructive surgery, e.g., contracture release, to maintain the joint in proper alignment during the healing process.

Reporting Guidelines

K-wire insertion is reported using code

20650 Insertion of wire or pin with application of skeletal traction, including removal (separate procedure)

- K-wire insertion is not included in acute burn therapeutic procedures, such as skin grafts and wound excision and may be reported separately and in addition.
- When performed alone, 20650 may be reported as performed.
- K-wire insertion is currently not included in reconstructive hand or finger surgery (26350-26596) according to Medicare's National Correct Coding Initiative (NCCI). Therefore, it may be reported in addition to the appropriate hand surgery procedure performed at the same session.
- For foot and toe reconstructive surgery, check the payer's guidelines and Medicare's National Correct Coding Initiative (NCCI) before reporting 20650 separately.

- Because 20650 is designated a separate procedure, it may be reported when performed alone or when it is not an integral part of another, more major procedure.
- When removal is performed in the outpatient hospital setting, the hospital may report this service using code 20670 Removal of Implant; Superficial (e.g., buried wire, pin or rod).
- K-wire insertion is *included* in a number of bone and joint procedures listed in the Musculoskeletal system subsection of CPT (2xxxx codes), generally in codes that state “with or without . . . fixation.” Hence, K-wire insertion is not separately reportable with those codes.

Splints, Custom Construction in OR

Splints are devices used to support, stabilize alignment, and prevent deformity of body parts, usually extremities and/or their appendages. Splints can be made from a number of natural and synthetic materials. They may be prefabricated or manufactured in a fixed design or may be custom made for individual patients using one or a combination of a number of synthetic or other materials.

Reporting Guidelines

Distinguishing Between Routine Splint Application and Custom Splint Construction/Fabrication and Application for Burns

Routine Splint Application

- Routine splint application may be reported with the appropriate splint application code under Application of Casts and Strapping in the Musculoskeletal section of CPT. For Medicare purposes and before billing, hospital coding and billing personnel should always check (a) the Fiscal Intermediary’s Local Medical Review Policies (LMRPs) to determine coding and coverage guidelines and/or (b) check with the Fiscal Intermediary to determine whether splint/cast application is separately reportable.
- Removal on a different date is separately reportable, in the absence of Fiscal Intermediary policy guidelines to the contrary.

Custom Splint Construction/Fabrication and Application in OR

- Custom splint construction, fabrication and application in the OR may be separately reported as provided.
- It is important to distinguish the “custom construction” aspect of the service from “application” of a prefabricated splint that is manufactured by an outside organization or laboratory. In the latter case, hospital resource utilization is not extensive while

custom construction implies extensive hospital utilization of resources to complete.

- Report the unlisted code 29799 Unlisted Procedure, Casting or Strapping. There are no CPT codes for the custom splints fabricated for each patient in these circumstances.

Vacuum Assisted Wound Closure (VAC)

VAC involves application of a dressing (polyurethane foam) to the wound bed, which is sealed with an occlusive dressing. A tube is inserted into the foam and then its free end is attached to a negative pressure pump that removes fluid from the wound to promote healing by providing a clean environment and inhibiting infection. It may be used on chronic or acute wounds of all sizes as well as flaps and grafts.

Reporting Guidelines

Select the single appropriate code from either 97605 or 97606 to report VAC application.

- | | |
|-------|--|
| 97605 | Negative pressure wound therapy (e.g., vacuum assisted drainage collection), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters |
| 97606 | total wound(s) surface area greater than 50 square centimeters |

- The performing provider is required to have direct one-on-one contact with the patient for these procedures.
- When the VAC dressing is changed at subsequent intervals, it may be reported separately, as appropriate. For example, the VAC dressing may be changed 3 times per week. Each dressing change may be reported separately.
- **Note:** Medicare allows separate payment for VAC under OPPS.

BURN DIAGNOSIS CODING FOR OUTPATIENT HOSPITAL SERVICES

This section is divided into several parts:

- General Outpatient Diagnosis Coding Guidelines, excerpted from the 2018 *ICD-10-CM Official Guidelines for Coding and Reporting*
- “Coding of Burns,” Excerpted from the 2018 *ICD-10-CM Official Guidelines for Coding and Reporting*. **Please see Diagnosis coding for Physician Services Chapter for details**
- Burn Diagnosis Coding (summary of specific diagnosis coding guidelines for **outpatient** hospital reporting relevant to burns based on ICD-10-CM the Official Guidelines, and the American Hospital Association’s *Coding Clinic*)

The most current, complete (full text), *2018 ICD-10-CM Official Guidelines for Coding and Reporting* can be found at the CDC’s National Center for Health Statistics web site:

https://www.cdc.gov/nchs/data/icd/10cmguidelines_fy2018_final.pdf

Changes in the guidelines appear in **BOLDFACE** in the text.

General Outpatient Diagnosis Coding Guidelines, Excerpted from the 2018 ICD-10-CM Official Guidelines for Coding and Reporting

The following *are verbatim excerpts* from the Official Guidelines and restates the list of guidelines from Section IV of the Official Guidelines entitled “Diagnostic Coding and Reporting Guidelines for Outpatient Services.”

- A. Selection of **first-listed** condition

In the outpatient setting, the term first-listed diagnosis is used in lieu of principal diagnosis. In determining the first-listed diagnosis the coding conventions of ICD-10-CM, as well as the general and disease specific guidelines take precedence over the outpatient guidelines. Diagnoses often are not established at the time of the initial encounter/visit. It may take two or more visits before the diagnosis is confirmed.

The most critical rule involves beginning the search for the correct code assignment through the Alphabetic Index. Never begin searching initially in the Tabular List as this will lead to coding errors.

1. Outpatient Surgery

When a patient presents for outpatient surgery, code the reason for the surgery as the first-listed diagnosis (reason for the encounter), even if the surgery is not performed due to a contraindication.

2. Observation Stay

When a patient is admitted for observation for a medical condition, assign a code for the medical condition as the first-listed diagnosis.

When a patient presents for outpatient surgery and develops complications requiring admission to observation, code the reason for the surgery as the first reported diagnosis (reason for the encounter), followed by codes for the complications as secondary diagnoses.

Codes from A00.0 through T88.9, Z00-Z99

The appropriate code(s) from A00.0 through T88.9, Z00-Z99 must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reason(s) for the encounter/visit.

Accurate reporting of ICD-10-CM diagnosis codes

For accurate reporting of ICD-10-CM diagnosis codes, the documentation should describe the patient's condition, using terminology which includes specific diagnoses as well as symptoms, problems, or reasons for the encounter. There are ICD-10-CM codes to describe all of these.

Codes that describe symptoms and signs

Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when a diagnosis has not been established (confirmed) by the provider. Chapter 18 of ICD-10-CM, Symptoms, Signs, and Abnormal Clinical and Laboratory Findings Not Elsewhere Classified (codes R00-R99) contain many, but not all codes for symptoms.

Encounters for circumstances other than a disease or injury

ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury. The Factors Influencing Health Status and Contact with Health Services codes (Z00-Z99) are provided to deal with occasions when circumstances other than a disease or injury are recorded as diagnosis or problems.

F. Level of Detail in Coding**1. ICD-10-CM codes with 3, 4, 5, 6 or 7 characters**

ICD-10-CM is composed of codes with 3, 4, 5, 6 or 7 characters. Codes with three characters are included in ICD-10-CM as the heading of a category of codes that may be further subdivided by the use of fourth, fifth, sixth or seventh characters to provide greater specificity.

2. Use of full number of characters required for a code

A three-character code is to be used only if it is not further subdivided. A code is invalid if it has not been coded to the full number of characters required for that code, including the 7th character, if applicable.

G. ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit

List first the ICD-10-CM code for the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the services provided. List additional codes that describe any coexisting conditions. In some cases, the first-listed diagnosis may be a symptom when a diagnosis has not been established (confirmed) by the physician.

H. Uncertain diagnosis

Do not code diagnoses documented as “probable”, “suspected”, “questionable”, “rule out,” or “working diagnosis” or other similar terms indicating uncertainty. Rather, code the condition(s) to the highest degree of certainty for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Please note: This differs from the coding practices used by short-term, acute care, long-term care and psychiatric hospitals.

I. Chronic diseases

Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s)

J. Code all documented conditions that coexist

Code all documented conditions that coexist at the time of the encounter/visit, and require or affect patient care treatment or management. Do not code conditions that were previously treated and no longer exist. However, history codes (categories Z80-Z87) may be used as

secondary codes if the historical condition or family history has an impact on current care or influences treatment.

K. Patients receiving diagnostic services only

For patients receiving diagnostic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

For encounters for routine laboratory/radiology testing in the absence of any signs, symptoms, or associated diagnosis, assign Z01.89, Encounter for other specified special examinations. If routine testing is performed during the same encounter as a test to evaluate a sign, symptom, or diagnosis, it is appropriate to assign both the Z code and the code describing the reason for the non-routine test.

For outpatient encounters for diagnostic tests that have been interpreted by a physician, and the final report is available at the time of coding, code any confirmed or definitive diagnosis(es) documented in the interpretation. Do not code related signs and symptoms as additional diagnoses.

Please note: This differs from the coding practice in the hospital inpatient setting regarding abnormal findings on test results.

L. Patients receiving therapeutic services only

For patients receiving therapeutic services only during an encounter/visit, sequence first the diagnosis, condition, problem, or other reason for encounter/visit shown in the medical record to be chiefly responsible for the outpatient services provided during the encounter/visit. Codes for other diagnoses (e.g., chronic conditions) may be sequenced as additional diagnoses.

The only exception to this rule is that when the primary reason for the admission/encounter is chemotherapy or radiation therapy, the appropriate Z code for the service is listed first, and the diagnosis or problem for which the service is being performed listed second.

M. Patients receiving preoperative evaluations only

For patients receiving preoperative evaluations only, sequence first a code from subcategory Z01.81, Encounter for pre-procedural examinations, to describe the pre-op consultations. Assign a code for the condition to describe the reason for the surgery as an additional diagnosis. Code also any findings related to the pre-op evaluation.

N. Ambulatory surgery

For ambulatory surgery, code the diagnosis for which the surgery was performed. If the postoperative diagnosis is known to be different from the preoperative diagnosis at the time the diagnosis is confirmed, select the postoperative diagnosis for coding, since it is the most definitive.

O. Routine outpatient prenatal visits

See Section I.C.15. Routine outpatient prenatal visits.

P. Encounters for general medical examinations with abnormal findings

The subcategories for encounters for general medical examinations, Z00.0- and encounter for routine child health examination, Z00.12-, provide codes for with and without abnormal findings. Should a general medical examination result in an abnormal finding, the code for general medical examination with abnormal finding should be assigned as the first-listed diagnosis. An examination with abnormal findings refers to a condition/diagnosis that is newly identified or a change in severity of a chronic condition (such as uncontrolled hypertension, or an acute exacerbation of chronic obstructive pulmonary disease) during a routine physical examination. A secondary code for the abnormal finding should also be coded.

Burn-Specific Coding: Excerpted from the 2018 ICD-10-CM Official Guidelines for Coding and Reporting

Chapter 19: Injury, poisoning, and certain other consequences of external causes (S00-T88)

a. Application of 7th Characters in Chapter 19

Most categories in chapter 19 have a 7th character requirement for each applicable code. Most categories in this chapter have three 7th character values (with the exception of fractures): A, initial encounter, D, subsequent encounter and S, sequela. Categories for traumatic fractures have additional 7th character values. While the patient may be seen by a new or different provider over the course of treatment for an injury, assignment of the 7th character is based on whether the patient is undergoing active treatment and not whether the provider is seeing the patient for the first time.

For complication codes, active treatment refers to treatment for the condition described by the code, even though it may be related to an earlier precipitating problem. For example, code T84.50XA, Infection and inflammatory reaction due to unspecified internal joint prosthesis, initial encounter, is used when active treatment is provided for the infection, even though the condition relates to the prosthetic device, implant or graft that was placed at a previous encounter.

7th character “A”, initial encounter is used for each encounter where the patient is receiving active treatment for the condition.

7th character “D” subsequent encounter is used for encounters after the patient has completed active treatment of the condition and is receiving routine care for the condition during the healing or recovery phase.

The aftercare Z codes should not be used for aftercare for conditions such as injuries or poisonings, where 7th characters are provided to identify subsequent care. For example, for aftercare of an injury, assign the acute injury code with the 7th character “D” (subsequent encounter).

7th character “S”, sequela, is for use for complications or conditions that arise as a direct result of a condition, such as scar formation after a burn. The scars are sequelae of the burn. When using 7th character “S”, it is necessary to use both the injury code that precipitated the sequela and the code for the sequela itself. The “S” is added only to the injury code, not the sequela code. The 7th character “S” identifies the injury responsible for the sequela. The specific type of sequela (e.g. scar) is sequenced first, followed by the injury code.

See Section I.B.10 Sequelae, (Late Effects)

b. Coding of Injuries

When coding injuries, assign separate codes for each injury unless a combination code is provided, in which case the combination code is assigned. **Codes from category** T07, Unspecified multiple injuries should not be assigned in the inpatient setting unless information for a more specific code is not available. Traumatic injury codes (S00-T14.9) are not to be used for normal, healing surgical wounds or to identify complications of surgical wounds.

The code for the most serious injury, as determined by the provider and the focus of treatment, is sequenced first.

1) Superficial injuries

Superficial injuries such as abrasions or contusions are not coded when associated with more severe injuries of the same site.

2) Primary injury with damage to nerves/blood vessels

When a primary injury results in minor damage to peripheral nerves or blood vessels, the primary injury is sequenced first with additional code(s) for injuries to nerves and spinal cord (such as category S04), and/or injury to blood vessels (such as category S15). When the primary injury is to the blood vessels or nerves, that injury should be sequenced first.

Coding of Burns and Corrosions

The ICD-10-CM makes a distinction between burns and corrosions. The burn codes are for thermal burns, except sunburns, that come from a heat source, such as a fire or hot appliance. The burn codes are also for burns resulting from electricity and radiation. Corrosions are burns due to chemicals. The guidelines are the same for burns and corrosions.

Current burns (T20-T25) are classified by depth, extent and by agent (X code). Burns are classified by depth as first degree (erythema), second degree (blistering), and third degree (full-thickness involvement). Burns of the eye and internal organs (T26-T28) are classified by site, but not by degree.

1) Sequencing of burn and related condition codes

Sequence first the code that reflects the highest degree of burn when more than one burn is present.

- a. When the reason for the admission or encounter is for treatment of external multiple burns, sequence first the code that reflects the burn of the highest degree.
- b. When a patient has both internal and external burns, the circumstances of admission govern the selection of the principal diagnosis or first-listed diagnosis.
- c. When a patient is admitted for burn injuries and other related conditions such as smoke inhalation and/or respiratory failure, the circumstances of admission govern the selection of the principal or first-listed diagnosis.

2) Burns of the same local site

Classify burns of the same local site (three-character category level, T20-T28) but of different degrees to the subcategory identifying the highest degree recorded in the diagnosis.

3) Non-healing burns

Non-healing burns are coded as acute burns.

Necrosis of burned skin should be coded as a non-healed burn.

4) Infected Burn

For any documented infected burn site, use an additional code for the infection.

5) Assign separate codes for each burn site

When coding burns, assign separate codes for each burn site. Category T30, Burn and corrosion, body region unspecified is extremely vague and should rarely be used.

6) Burns and Corrosions Classified According to Extent of Body Surface Involved

Assign codes from category T31, Burns classified according to extent of body surface involved, or T32, Corrosions classified according to extent of body surface involved, when the site of the burn is not specified or when there is a need for additional data. It is advisable to use category T31 as additional coding when needed to provide data for evaluating burn mortality, such as that needed by burn units. It is also advisable to use category T31 as an additional code for reporting purposes when there is mention of a third-degree burn involving 20 percent or more of the body surface

Outpatient Coding of Non-Burn Conditions

For a complete discussion of the pathophysiology of these conditions and diagnosis coding guidelines, please refer to “Coding for Non-Burn Conditions” in Part I of the manual.

- For **debridement** of non-burn conditions, refer to the Reporting Outpatient Hospital Procedures section, “Debridement, Non-Burn Wounds/Conditions—Debridement Performed by Physician or Non-Physician Professional” in the chapter “Outpatient Hospital Department Coding.”
- For **excision of non-burn wounds**, refer to the Reporting Outpatient Hospital Procedures section, “Excision Burn and Non- Burn Wounds” in the chapter “Outpatient Hospital Department Coding.”
- Coding guidelines for all other procedures commonly performed in the Outpatient Hospital Department are found under the relevant topic in the Reporting Outpatient Hospital Procedures section.

CMS-APPROVED MODIFIERS FOR OUTPATIENT HOSPITAL REPORTING (CPT & HCPCS)

Modifiers are two-character numeric, alphabetic or alphanumeric symbols that are added to HCPCS codes to further explain the services reported on the claim.

Modifiers provide a method to report needed information about a

service without having to actually change the procedure code. The additional facts foster correct payment and, when used appropriately,

permit the claim to legitimately bypass Medicare re-bundling and other edits.

Specific HCPCS (CPT-4 and HCPCS Level II) modifiers are approved for reporting Medicare outpatient hospital services.

Use the modifiers in the following tables for surgical procedures (HCPCS codes 10000–69999), radiology (HCPCS codes 70010–79999), other diagnostic procedures (HCPCS codes 90700–99199), and evaluation and management services (HCPCS codes 99201–99215, 99241–99245 99281–99285), when appropriate

General Guidelines

It is important to note that **Medicare guidelines for reporting modifiers for facility services vary from guidelines for reporting modifiers for physician services**. The guidelines below apply to reporting outpatient facility services **only**.

The global surgical period is **the day of the procedure** for outpatient hospital services. Hence, application of modifiers applies to procedures performed on the **same calendar date**. Some HCPCS codes will not require modifiers.

- Do not use a modifier to indicate the location or anatomical site on the body (*e.g.*, modifier 50 for bilateral procedure or Level II modifiers) if the narrative definition of a code indicates multiple occurrences.

For example, the code definition indicates two to four lesions:

11056—Paring or cutting hyperkeratotic lesion, leg (*e.g.*, corn or callous); two or four lesions. The code description indicates multiple lesions.

Or, the code description already indicates the specific, bilateral sites:

73565—Radiologic examination; both knees, standing, anteroposterior.

- Do not use a modifier to indicate an anatomic site (*e.g.*, modifier 50 for bilateral procedure or Level II modifiers) if the narrative description of a code indicates the procedure applies to more than two sites.

For example, code 11600 (Excision, malignant lesion, trunk, arms, or legs; lesion diameter 0.5 cm or less)

When to Use a Modifier

- To provide additional information regarding the anatomic site of the procedure. *For example*,

Below the knee amputation, right side.

Addition of the RT (right side) modifier specifies the anatomic location.

- To prevent rejection as a duplicate claim. *For example*,

Debridement of wound performed twice on the same day, but at different sessions.

Addition of modifier 76 or -77 (Repeat procedure/same physician, repeat procedure/different physician) indicates the repeat procedure on the same day.

- To prevent rejection as unbundled service. *For example*,

Split skin graft to right arm and allograft to back at the same session.

Addition of modifier 59 (Distinct procedure) indicates that each procedure was performed on a different body site; therefore, allograft should not be rebundled into the skin graft for payment.

Special Guidelines for Using Modifiers with Radiology Services

- Use modifiers 50, 52, 59, 76, 77, and Level II modifiers.
- Do not report a radiology procedure that was canceled.

HCPSC Level II Modifiers, General Guidelines

- When a modifier is needed, the most specific modifier should be used first.

For example, use modifier E1 for the upper left eyelid, instead of modifier LT.

- If more than one Level II modifier applies, repeat the HCPCS code on another line of the UB-92 claim form with the appropriate Level II modifier.

For example, code 26010 (drainage of finger abscess; simple) performed on the left thumb and second finger would be billed: 26010FA (one line) and 26010F1 (separate line).

Modifiers LT and RT

1. Apply to codes that identify procedures which can be performed on paired anatomic sites (joints, bones), paired extremities, and paired organs (*e.g.*, ears, eyes, nasal passages, kidneys, lungs, ureters and ovaries).
2. Are required when the procedure is performed on only one side (unilaterally), to identify the side operated on.
3. Do not use modifiers LT and RT to report bilateral surgical procedures; use modifier 50 (Bilateral Procedure).

The following HCPCS Level II modifiers are added, as appropriate, to codes for procedures performed on paired organs such as eyelids, fingers, toes, or arteries. The modifiers are used to prevent incorrect denials when duplicate HCPCS codes are billed to report separate procedures performed on different anatomical sites or different sides of the body.

Level II Modifiers (Selected) Approved for Reporting Outpatient Hospital Services

E1	Upper left, eyelid	on	LT	Left side (used to identify procedures performed on the left side of the body)
E2	Lower left, eyelid		RC	Right coronary artery (Use with codes 92980–92982, 92995, and 92996.)
E3	Upper right, eyelid	performed on body)	RT	Right side (used to identify procedures performed on the right side of the
E4	Lower right, eyelid		TA	Left foot, great toe
FA	Left hand, thumb		T1	Left foot, second digit
F1	Left hand, second digit		T2	Left foot, third digit
F2	Left hand, third digit		T3	Left foot, fourth digit
F3	Left hand, fourth digit		T4	Left foot, fifth digit
F4	Left hand, fifth digit		T5	Right foot, great toe
F5	Right hand, thumb		T6	Right foot, second digit
F6	Right hand, second digit		T7	Right foot, third digit
F7	Right hand, third digit		T8	Right foot, fourth digit
F8	Right hand, fourth digit		T9	Right foot, fifth digit
F9	Right hand, fifth digit			
LC	Left circumflex coronary artery (Hospitals use with codes 92980–92982, 92995, and 92996)			
LD	Left anterior descending coronary artery (Hospitals use with codes 92980–92982, 92995, and 92996)			

All CPT Modifiers Approved for Outpatient Hospital Reporting

Medicare has modified the guidelines for certain CPT modifiers for use under its OPSS payment methodology. Where applicable, the modification is included under the “Guidelines” without identifying it as a deviation from CPT.

Table includes selected HCPCS Level II modifiers approved for Outpatient Hospital Reporting. For a complete list of all CPT and HCPCS modifiers approved for OPSS use, refer to CMS Pub. 100-4 Medicare Claims Processing Manual, Chapter 4 Part B Hospital, Including Inpatient Hospital Part B and OPSS, section 20.6 Use of Modifiers. See <http://www.cms.hhs.gov/manuals/downloads/clm104c04.pdf>

Service & HCPCS Code Range	Modifier	Description	Guidelines
Surgery Codes 10000–69999	50	Bilateral Procedure	<p>Indicates the same procedure was performed on both sides at the same operative session.</p> <p>Use only for paired organs/body parts.</p> <p>Submit on one line with modifier appended to procedure code.</p> <p>Units = 1</p> <p>Do not submit two line items to report a bilateral procedure.</p> <p>Do not use if code indicates multiple occurrences.</p> <p>Do not use if the code indicates the procedure applies to different body parts.</p> <p>Do not use if code description included “bilateral” or “unilateral or bilateral.”</p> <p>Do not submit with modifiers RT and LT when modifier 50 applies.</p> <p>Payment follows rules for multiple procedures.</p>
	58	Staged or Related Procedure or Service by the Same Physician during the Postoperative Period	<p>Indicates the following type of procedure was performed during the post-operative period; that is, it was performed on the same calendar day on the same patient. The procedure was:</p> <ul style="list-style-type: none"> • Planned or anticipated (staged); or • More extensive than the original procedure; or • For therapy following a surgical procedure <p>Do not use to report the treatment of a problem (e.g., unanticipated clinical condition) that requires a return to the operating or procedure room (see modifier 78).</p>
	59	Distinct Procedural Service	<p>Indicates procedures, other than E/M services, that are not normally reported together but able to be reported separately under the circumstances.</p> <p>Indicates a procedure distinct or independent from</p>

Service & HCPCS Code Range	Modifier	Description	Guidelines
			<p>other procedures <i>performed on the same day</i>.</p> <p>Modifier represents: Different session Different procedure or surgery Different site or organ system Separate incision or excision Separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.</p> <p>Add the modifier to the code that would otherwise be bundled/denied. Do not use if a Level II modifier can be used instead</p>
	73	Discontinued Outpatient Hospital Procedure Prior to the Administration of Anesthesia	<p>Indicates an outpatient surgical or other procedure requiring anesthesia was discontinued/terminated due to extenuating circumstances or to circumstances that threatened the well- being of the patient</p> <ul style="list-style-type: none"> • after the patient had been prepared for the procedure (including procedural pre-medication when provided), and had been taken to the room where the procedure was to be performed, • but prior to administration of anesthesia (e.g., local, regional block, moderate sedation/analgesia (“conscious sedation”), deep sedation/analgesia, or general anesthesia) <p>When more than one procedure was planned, report only the procedure that was discontinued with the 73 modifier.</p>
	74	Discontinued Outpatient Hospital/Ambulatory Center (ASC) Procedure after the Administration of Anesthesia	<p>Indicates an outpatient surgical or other procedure requiring anesthesia was discontinued/terminated due to extenuating circumstances or to circumstances that threatened the well- being of the patient</p> <ul style="list-style-type: none"> • after induction of anesthesia (e.g., local, regional block, moderate sedation/analgesia (“conscious sedation”), deep sedation/analgesia, or general anesthesia) • or after the procedure was started (e.g., incision made, intubation started, scope inserted) <p>When more than one procedure was planned, report only the procedure that was discontinued with the 74 modifier. Any other completed procedures are reported as usual. .</p>
	76	Repeat Procedure by Same Physician	<p>Indicates a procedure repeated:</p> <ul style="list-style-type: none"> • In a separate session • On the same day

Service & HCPCS Code	Modifier	Description	Guidelines
			<ul style="list-style-type: none"> • By the same physician <p>The repeated procedure must be the same procedure (same HCPCS code).</p> <p>It is not to be used for planned or anticipated subsequent or staged procedures (see modifier 58) or related unplanned procedures (e.g., for complications) (see modifier 78).</p> <p>Report the HCPCS code without the modifier to indicate the initial procedure. For each additional time the procedure was repeated, list the HCPCS code on another</p>
	77	Repeat Procedure by Another Physician	<p>Use when a procedure is repeated:</p> <ul style="list-style-type: none"> • In a separate session • On the same day • By a different physician <p>The repeated procedure must be the same procedure (same HCPCS code)</p> <p>Report the HCPCS code without the modifier to indicate the initial procedure. For each additional time the procedure was repeated, list the HCPCS code on another line with the 77 modifier added. Units = 1 for</p>
	78	Unplanned Return to the Operating/Procedure Room by the Same Physician for a Related Procedure During the Postoperative Period	<p>Indicates another procedure was performed during the postoperative period of the initial procedure on the same day.</p> <p>Modifier 78 applies when the subsequent procedure:</p> <ul style="list-style-type: none"> • Is an <i>unplanned</i> procedure • <i>Relates</i> to the first procedure; and • Requires the use of an operating or procedure room. <p>Modifier 78 essentially allows reporting of procedures that were not foreseen in advance or are unplanned. Contrast to <i>staged</i> procedures which are <i>anticipated</i> or planned and involve some level of planning</p>
	79	Unrelated Procedure or Service by the Same Physician during the	<p>Indicates that a procedure was performed:</p> <ul style="list-style-type: none"> • During the post-operative period on the same day • By the same physician, and

Service & HCPCS Code Range	Modifier	Description	Guidelines
		Postoperative Period	the same day.
	RT/LT	Right Side/Left Side	Identifies procedures performed on the right or left side of a paired organ or contralateral anatomic sites (e.g., bones, joints). Applicable modifier should be used <i>only</i> when the procedure is performed unilaterally, (i.e., on only one side) to identify the specific side operated on. Do not use if code indicates multiple occurrences. Do not use if the code indicates the procedure applies to different body sites or anatomic structures. Do not use RT/LT if a more specific modifier is available. Do not use RT and LT when modifier 50 is appropriate.
	E1 – E4	Eyelids	Identifies specific anatomic sites.
	FA – F9	Fingers	Use the most specific modifier available
	TA – T9	Toes	If more than one Level II modifier applies, repeat the HCPCS code on another line with the appropriate Level II modifiers. Do not use if the code indicates multiple occurrences. Do not use if the code indicates the procedure applies to different body parts.

Service & HCPCS Code Range	Modifier	Description	Guidelines
Radiology Codes 70010–79999	52	Reduced Services	Indicates a service that was: <ul style="list-style-type: none"> • Begun • Partially completed, and • No available HCPCS code describes the <i>portion</i> of the intended procedure that was completed. If a radiology code exists for the portion of the procedure that was completed, <i>do not use modifier 52</i> . Instead, use the code that identifies the completed portion of the procedure. Do not report a radiology procedure that was canceled.
	59	Distinct Procedural Service	Indicates procedures, other than E/M services, that are not normally reported together but able to be reported separately under the circumstances. Indicates a procedure distinct or independent from other procedures <i>performed on the same day</i> . Modifier represents: Different session

Service & HCPCS Code Range	Modifier	Description	Guidelines
			<p>Different procedure or surgery Different site or organ system Separate incision or excision Separate injury (or area of injury in extensive injuries) Not ordinarily encountered or performed on the same day by the same physician.</p> <p>Add the modifier to the code that would otherwise be bundled/denied. Do not use if a Level II modifier can be used instead.</p>
	76	Repeat Procedure by Same Physician	<p>Indicates a procedure repeated:</p> <ul style="list-style-type: none"> • In a separate session • On the same day • By the same physician <p>The repeated procedure must be the same procedure (same HCPCS code).</p> <p>It is not to be used for planned or anticipated subsequent or staged procedures (see modifier 58) or related unplanned procedures (e.g., for complications) (see modifier 78).</p> <p>Report the HCPCS code without the modifier to indicate the initial procedure. For each additional time the procedure was repeated, list the HCPCS code on another line with the 76 modifier added. Units = 1 for each line.</p>
	77	Repeat Procedure by Another Physician	<p>Use when a procedure is repeated:</p> <ul style="list-style-type: none"> • In a separate session • On the same day • By a different physician <p>The repeated procedure must be the same procedure (same HCPCS code)</p> <p>Report the HCPCS code without the modifier to indicate the initial procedure. For each additional time the procedure was repeated, list the HCPCS code on another line with the 77 modifier added. Units = 1 for each line</p>
	RT/LT	Right Side/Left Side	<p>Identifies procedures performed on the right or left side of a paired organ or contralateral anatomic sites (e.g., bones, joints).</p> <p>–Applicable modifier should be used <i>only</i> when the procedure is performed unilaterally (i.e., on only one side) to identify the specific side operated on. –Do not use if code indicates multiple occurrences. –Do not use if the code indicates the procedure applies to different body sites or anatomic structures. –Do not use RT/LT if a more specific modifier is available. –Do not use RT and LT when modifier 50 is appropriate.</p>

Service & HCPCS Code Range	Modifier	Description	Guidelines
Other Diagnostic Codes 90700–99199	59	Distinct Procedural Service	<p>Indicates procedures, other than E/M services, that are not normally reported together but able to be reported separately under the circumstances. Indicates a procedure distinct or independent from other procedures <i>performed on the same day</i>.</p> <p>Modifier represents: Different session Different procedure or surgery Different site or organ system Separate incision or excision Separate injury (or area of injury in extensive injuries) Not ordinarily encountered or performed on the same day by the same physician.</p> <p>Add the modifier to the code that would otherwise be bundled/denied. Do not use if a Level II modifier can be used instead.</p>
	76	Repeat Procedure by Same Physician	<p>Indicates a procedure repeated:</p> <ul style="list-style-type: none"> • In a separate session • On the same day • By the same physician <p>The repeated procedure must be the same procedure (same HCPCS code).</p> <p>It is not to be used for planned or anticipated subsequent or staged procedures (see modifier 58) or related unplanned procedures (e.g., for complications) (see modifier 78).</p> <p>Report the HCPCS code without the modifier to indicate the initial procedure. For each additional time the procedure was repeated, list the HCPCS code on another line with the 76 modifier added. Units = 1 for each line.</p>
	77	Repeat Procedure by Another Physician	<p>Use when a procedure is repeated:</p> <ul style="list-style-type: none"> • In a separate session • On the same day • By a different physician <p>The repeated procedure must be the same procedure (same HCPCS code)</p> <p>Report the HCPCS code without the modifier to indicate the initial procedure. For each additional time the procedure was repeated, list the HCPCS code on another line with the 77 modifier added. Units = 1 for each line</p>
	79	Unrelated Procedure or Service by the	<p>Use to indicate that a service/procedure performed earlier in the day</p> <ul style="list-style-type: none"> • During the post-operative period

Service & HCPCS Code Range	Modifier	Description	Guidelines
		Same Physician during the Postoperative Period	<ul style="list-style-type: none"> • By the same physician • Is unrelated to the original procedure
	RT/LT	Right Side/Left Side	<p>Identifies procedures performed on the right or left side of a paired organ or contralateral anatomic sites (e.g., bones, joints).</p> <p>Applicable modifier should be used only when the procedure is performed unilaterally (i.e., on <i>only</i> one side), to identify the specific side operated on.</p> <ul style="list-style-type: none"> • Do not use if code indicates multiple occurrences. • Do not use if the code indicates the procedure applies to different body sites or anatomic structures. • Do not use RT/LT if a more specific modifier is available. • Do not use RT and LT when modifier 50 is appropriate.
	GP	Services Delivered Under An Outpatient Physical Therapy Plan of Care	<p>Used to report outpatient physical therapy services performed by a qualified therapist provided under a certified outpatient physical therapy plan of care. Add the modifier to the applicable active wound care code 97597-97602.</p> <p>Do not use this modifier for reporting PT services provided independent of a therapy plan of care</p>
	GO	Services Delivered Under An Outpatient Occupational Therapy Plan of Care	<p>Used to report outpatient occupational therapy services performed by a qualified therapist provided under a certified outpatient occupational therapy plan of care. Add the modifier to the applicable active wound care code 97597-97602 or other applicable therapy code.</p> <p>Do not use this modifier for reporting OT services provided independent of a therapy plan of care</p>
	GN	Services Delivered Under An Outpatient Speech Language Pathology Plan Of Care	<p>Used to report outpatient speech therapy services performed by a qualified therapist provided under a certified outpatient speech therapy plan of care. Add the modifier to the applicable therapy code.</p> <p>Do not use this modifier for reporting speech therapy services provided independent of a therapy plan of care</p>

Service & HCPCS Code Range	Modifier	Description	Guidelines
Evaluation and Management Codes 99201-99499	25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of a Procedure or Other Service	<p>Indicates that the patient required a significant, separately identifiable E/M service on the same day a procedure was performed.</p> <p>Modifier is used for an E/M service that:</p> <ul style="list-style-type: none"> • Is beyond the usual pre-operative care associated with the procedure. • Key components of the E/M service were performed and documented (e.g., a separate history obtained, physical examination performed, and medical decision making completed). <p><i>Modifier 25 must always be appended to the emergency department code (99281–99285) when provided on the same date as a diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s).</i></p> <p>It is appropriate to append modifier 25 to an ED code when these services lead to a decision to perform diagnostic medical/surgical and/or therapeutic medical/surgical procedure(s).</p> <p>Diagnosis associated with the E/M services need not be different from that for the procedure that was provided on the same day.</p>

References

**Current Procedural Terminology, cptTM*

American Medical Association

Customer Service

800-621-8335

www.ama-assn.org/catalog

**International Classification of Diseases, Tenth Revision,
Clinical Modification and International Classification of*

Diseases-Procedural Coding System 2018

Various commercial publishers & the AMA

**HCPCS Level II National Codes*

Various commercial publishers & the AMA

CPT Assistant

American Medical Association

Customer Service

800-621-8335

www.ama-assn.org/catalog

Medicare Administrative Contractors

available on line at www.CMS.gov

Coding Clinic

American Hospital Association

National Center for Health Statistics (NCHS)

2018 ICD-10-CM Coding Guidelines

NCHS.gov

Appendices

Appendix I

Sample CMS Claim Form 1500

HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 0812

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN VERA OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
 3. PATIENT'S BIRTH DATE (MM/YY) SEX (M/F)
 4. INSURED'S NAME (Last Name, First Name, Middle Initial)
 5. PATIENT RELATIONSHIP TO INSURED (Spouse/Child/Other)
 6. RESERVED FOR MAAC USE

7. PATIENT'S ADDRESS (No. Street)
 8. RESERVED FOR MAAC USE
 9. PATIENT'S CONDITION RELATED TO: (Employment/Auto/Other)
 10. INSURED'S ADDRESS (No. Street)
 11. INSURED'S POLICY GROUP OR FDGA NUMBER
 12. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
 13. OTHER INSURED'S POLICY OR GROUP NUMBER
 14. RESERVED FOR MAAC USE
 15. RESERVED FOR MAAC USE
 16. INSURANCE PLAN NAME OR PROGRAM NAME
 17. CLAIM CODES (Designated by NACC)
 18. IS THERE ANOTHER HEALTH BENEFIT PLAN? (Yes/No)

19. READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. AUTHORIZES THE RELEASE OF ANY MEDICAL OR OTHER INFORMATION NECESSARY TO PROCESS THIS CLAIM. (For request payment of government claims.)
 20. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (authorizes payment of medical benefits to the undersigned physician or supplier for services described below.)

21. DATE OF CLINICAL SERVICE (DATE, TIME, or PREGNANCY)
 22. DATE PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM/TO)
 23. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (NAME)
 24. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE (FROM/TO)
 25. ADDITIONAL CLAIM INFORMATION (Designated by NACC)
 26. OUTSIDE LAB? (Yes/No) \$ CHARGES
 27. DISEASE OR NATURE OF LESION OR INJURY (Ref: ICD-9-CM)
 28. REQUIREMENT CODE ORIGINAL COPY NO.
 29. FEE OR CHARGE

30. DATE OF SERVICE (MM/YY) PLACE OF SERVICE (ICD-9-CM) PROCEDURE, SERVICE, OR SUPPLY (ICD-9-CM) HICPCS CODE (ICD-9-CM) UNITS PROVIDED (UNIT)
 31. FEDERAL TAX ID NUMBER (SSN/EIN) 32. PATIENT'S ACCOUNT NO. 33. SECURITY AGREEMENT? (Yes/No) 34. TOTAL CHARGE \$ 35. AMOUNT PAID \$ 36. Paid for MAAC Use \$

37. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING ADDRESS OR CREDENTIALS) 38. SERVICE FACILITY LOCATION INFORMATION 39. BILLING PROVIDER INFO & PI # ()

39a. NPI 39b. NPI

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED CMS-0936-1197 FORM 1500 (02-12)

Item 19 – Enter Product Name, NDC, WAC, WAC per sq cm, source of WAC

Item 21 – Enter Diagnosis code(s)

Item 21 B – Enter Place of Service

Item 24D/1 – Enter Product HCPCS Code and modifier(s)

Item 24D/2 – Enter CPT Code for Application

Item 24 F – Enter Charges

Item 24 G – Enter Units (cm²)

Appendix II: CPT Surgical Package

CPT Surgical Package

SURGICAL PACKAGE	INCLUDES	SEPARATELY REPORTABLE
<p>Follow-up days vary by procedure/payer</p>	<ul style="list-style-type: none"> ·Surgical procedure(s) ·Local, topical, or metacarpal/digital block anesthesia ·After decision for surgery, 1 related E/M visit the day before or day of surgery (includes H&P) ·Immediate postop care* ·Typical, uncomplicated follow-up to include: <ul style="list-style-type: none"> –Care during assigned post op period –Dressings –Dressing changes <p>*Can vary by payer, procedure, and whether “0” or a specific number of postoperative follow up days is assigned to a given procedure.</p>	<ul style="list-style-type: none"> · E/M services prior to surgery (varies by payer & contract) · Surgical trays · X-rays · Lab ·Diagnostic testing ·Surgery during post op period ·Additional visits for complications or different problem during post op period (varies by payer) ·Visits after post op period

Appendix III: Medicare Global Surgery Package, Major & Minor Procedures

MEDICARE MINOR AND MAJOR SURGERY	INCLUDES (Applicable modifiers in parentheses)	SEPARATELY REPORTABLE (Applicable modifiers in parentheses)
0 Follow-up days, Minor Surgery	Visit, same day unless: ·Visit is for significant, separately identifiable E/M service (Modifier 25) Postoperative care on the day of the procedure only Local anesthesia Surgical Supplies Dressings	Follow-up visits after the day of surgery
10 Follow-up days, Minor Surgery	Visit, same day unless: ·Visit is for significant, separately identifiable E/M service (Modifier 25) Local anesthesia Surgical supplies 10 days follow-up Dressing changes	Unrelated surgical procedure during post op period (Modifier 79) Staged surgical procedure during post op period (Modifier 58) X-rays Lab work Diagnostic testing Unrelated (to original surgery) E/M visits during post op period (Modifier 24)
90 Follow-up days, Major Surgery	Visit day before or day of surgery unless: ·Need & decision for surgery is determined during E/M day before or day of surgery (Modifier 57) Local anesthesia 90 days follow-up to include: ·Post op inpatient or outpatient visits related to the global surgery ·Dressings ·Dressing changes ·Treatment of complications that do not require a return to the operating room	Unrelated surgical procedure during post op period (Modifier 79) Second or subsequent staged procedures (Modifier 58) Surgery in OR for related procedure, e.g., surgical complications such as hemorrhage, wound disruption, etc. (Modifier 78) X-rays Lab Diagnostic testing Critical care for burn/trauma (preoperative: add Modifier 25; postoperative: add Modifier 24) See Critical Care section for details. Unrelated E/M visits for unrelated condition or underlying problem (Modifier 24)

Appendix IV: Modifiers (CPT & HCPCS Level II): Physician Services

CPT Modifiers

The following is a list of selected CPT modifiers, criteria for use, and relevant reporting comments for physician services only. For a complete list of CPT modifiers, refer to the CPT book, Appendix A. Guidelines for use of CPT modifiers for facility/technical reporting vary by payer; CMS guidelines can be found in “CMS-Approved Modifiers for Outpatient Hospital Reporting” under Coding for Facility Services.

Effective October 2003 and as a result of HIPAA legislation, all payers throughout the nation must accept all CPT codes and modifiers.

22 Increased Procedural Services

“When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier ‘22’ to the usual procedure code.”

Modifier 22 is used to communicate that a procedure required much greater work at that encounter only. Supporting documentation (e.g., in the operative report) is always required. The report must support the substantial additional work and the reason for the additional work (i.e., increased intensity, time, technical difficulty of procedure, severity of patient’s condition, physical and mental effort required).

May be used with surgical and other procedure codes. Do not use with E/M codes.

24 Unrelated Evaluation and Management Service by Same Physician During a Postoperative Period

“The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure.”

Modifier 24 was created originally for Medicare to identify one of the services that Medicare may pay for in addition to its global surgery package payment. **For Medicare claims**, this modifier is used to report an E/M service by the surgeon during the assigned postoperative period of a previous global surgery he/she performed on the same patient, but for reasons unrelated to the previous surgery. “Unrelated,” as defined by Medicare, means that the E/M service was not provided for routine postoperative follow-up care or for treatment of a complication of the previous surgery.

For example, an E/M service provided for the *underlying* condition or unrelated conditions would be reported with modifier 24. Documentation in the clinical note

should demonstrate that the visit was for the underlying condition or unrelated condition(s). Further, that the reason for the visit was not for routine postoperative follow-up care or for treatment of a complication of the previous surgery (e.g., an infected skin graft).

The modifier is added to the appropriate E/M visit code when it is unrelated to the previous global surgery. If the E/M code is submitted without modifier 24, Medicare will bundle it into the previous global surgery and deny it.

For non-Medicare claims and in the absence of payer guidelines to the contrary, modifier 24 may be used to report an E/M service (inpatient or outpatient) by the surgeon during the assigned postoperative period of a previous global surgery he/she performed on the same patient when provided for reasons /conditions unrelated to the previous surgery.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician on the Same Day of the Procedure or other Service.

“It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported. The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date.”

“Note: This modifier is not used to report an E/M service that resulted in a decision [the initial decision] to perform surgery. See modifier 57.”

Modifier 25 was created originally for Medicare to identify two situations where a separate Medicare payment is allowed.

It is used to identify a separately reportable E/M service that would otherwise be bundled into Medicare or other payer payment for a minor surgical procedure performed at the same encounter or on the same date for the same patient.

Modifier 25 is added to the appropriate E/M code when the E/M service is provided on the same day as a minor surgical or endoscopic procedure (0 or 10-day follow-up period), the E/M visit is above and beyond the usual preoperative and postoperative care associated with the procedure, and the E/M clinical note *meets CPT and CMS criteria for the billed E/M code*.

Examples are: hospital admission and debridement on the same date; critical care and debridement on the same date when no previous global surgery period is in place; outpatient clinic visit and Modifier 25 is usually added to the less clinically intense of two E/M services on debridement/dressing on the same date when no previous global surgery period is in place.

It is also used to identify a separately reportable E/M service that would otherwise be bundled into another E/M service provided on the same day for the same patient the same date to indicate that it also was a significant, separately identifiable visit. Specifically, it is added to the E/M code that would be rebundled by Medicare under CPT guidelines. Because CPT guidelines allow only one E/M visit code per day per patient per physician, this modifier is used in those situations that are exceptions to the CPT guidelines. Examples of some exceptions are:

- Office visit (25) and unrelated emergency department visit later on the same day
- Emergency department visit (25) and critical care services later on the same day
- Subsequent hospital visit (25) and critical care services later on the same day when no previous global surgery period is in place
- Inpatient admission (25) and critical care services later on the same day

The above examples assume that the less clinically intense service was provided routinely but the patient required unanticipated emergent or critical care services later on the same day. In many instances, the diagnosis for each encounter is expected to differ in kind or acuity/severity.

50 Bilateral Procedure

“Unless otherwise identified in the listings, bilateral procedures that are performed at the same operative session should be identified by adding the modifier ‘50’ to the appropriate five-digit code.”

Most CPT codes are considered inherently unilateral unless a procedure is commonly performed bilaterally (e.g., hearing test) or the procedure description states “bilateral” or “unilateral or bilateral.” The 50 modifier is not added to “bilateral” codes because the value for the procedure already includes the second side.

Modifier 50 is used when the same procedure is performed on paired body parts or organs at the same session. It can be used with surgical, radiological, and some diagnostic procedures (e.g., median nerve testing).

Bilateral procedures can be reported in one of two ways.

The CPT-recommended method, also required by Medicare, lists the code once with modifier 50.

64721–50 Carpal tunnel release [right & left] (number of units varies by payer)

The second method, required by some payers, lists the code on two lines with the –50 modifier added to the code on the second line.

64721 Carpal tunnel release 1 unit
64721–50 Carpal tunnel release 1 unit

51 Multiple Procedures

“When multiple procedures, other than Evaluation and Management Services, are performed at the same session by the same provider, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending the modifier ‘51’ to the additional procedure or service code(s).

Note: This modifier should not be appended to designated “add-on” codes (see the CPT book, Appendix D).”

The major or highest valued procedure is listed first without a modifier; the secondary procedures are listed in descending value order thereafter, each with modifier 51. In the following example, code 15100 is the major or primary procedure while code 15002 is an additional, secondary procedure based on their relative values in the Medicare fee schedule. Hence, modifier 51 is added to code 15002.

Note: Many, if not all, Medicare Carriers are now using a standardized, automated regional claims payment system which automatically prices and ranks each line item on the claim. As a result, Carriers have instructed physician billers to discontinue use of modifier 51 as the system automatically identifies codes that qualify for the modifier 51 reduction.

Example of Use of 51 Modifier

3/1	15100	STSG (first 100 sq cm)	1 unit
3/1	*15101	STSG (each additional 100 sq cm)	4 units
3/1	15002–51	Tangential excision of first 100 sq cm	1 unit
3/1	*15003	Tangential excision of each additional 100 sq cm	4 units
		(Additional 350 sq cm after the first 100 sq cm = 4 units)	

Modifier 51 is generally reported with surgical procedure codes.

***Add-On Code Exception:**

Procedures that state “each additional lesion,” “each additional level,” or “each additional procedure,” or “List separately in addition to code for primary procedure” should not be reported with the –51 modifier since their relative values already reflect the reduction in the service. They are always secondary procedures and, therefore, cannot be reported alone. Neither fee nor payment should be reduced for add-on procedures. In the above example, codes 15101 and 15001 are add-on codes.

Note: CPT “Modifier 51 exempt procedures” listed in CPT Appendix E are not always valued as secondary procedures in standard relative value studies. However, the AMA’s CPT provides no explicit guidance as to which of these procedures are primary or secondary for relative value purposes.

52 Reduced Services

“Under certain circumstances a service or procedure is partially reduced or eliminated at the physician’s discretion. Under these circumstances the service provided can be identified by its usual procedure number and the addition of the modifier ‘52’, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

Modifier 52 can be used to report a situation in which part of a service or procedure, as described in CPT, is eliminated or reduced at the discretion of the physician.

Corresponding fee/payment reduction applies. Medicare carriers require a copy of the operative report with claims for reduced services.

Modifier 52 can be used with surgical, diagnostic and non-surgical therapeutic procedures. Never use modifier 52 with E/M codes.

53 Discontinued Procedure

“Under certain circumstances, the physician may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding the modifier ‘53’ to the code reported by the physician for the discontinued procedure.

Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient’s anesthesia induction and/or surgical preparation in the operating suite.”

Modifier 53 can be used in situations where a surgical or diagnostic procedure is terminated by the physician after it has begun because of extenuating circumstances or those that threaten the well-being of the patient. **For example, excision of a large burn wound in an obese patient is abruptly terminated because of massive blood loss.**

Split Global Surgical Package Modifiers

54 Surgical care only

“When one physician performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding the modifier ‘54’ to the usual procedure number.”

55 Postoperative care only

“When one physician performs the postoperative management and another physician has performed the surgical procedure, the postoperative component may be identified by adding the modifier ‘55’ to the usual procedure number.”

56 Preoperative care only

“When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding the modifier ‘56’ to the usual procedure number.”

The above split surgical care modifiers are used to report those instances when the global surgical service is split between different physicians. In these cases, the surgeon usually provides the preoperative care (e.g., E/M service such as a consultation) and surgery while another physician provides the postoperative care. This situation can occur when a burn patient from a distant location is treated in a burn center, returns home and follow-up care is furnished by his local physician. For example, [code 12345 is hypothetical code],

Dr. A (the surgeon)

1/15	992xx-56/57	E/M visit, preoperative care only
1/16	12345-54	Surgery only

(Note: In actual practice, few surgeons use modifier 56 in this situation because it can be assumed from the context of the claim that the E/M service was provided for pre-operative purposes. Modifier 57 is included for accuracy in this example and demonstrates that the decision for surgery was made at this encounter. (See modifier 57 for additional detail.)

Dr. B (physician who provides postoperative care)

12345-55	Postoperative care only
----------	-------------------------

Note: Modifier 56 is used on an infrequent basis because few payers recognize it and it seldom affects global surgery claim payment.

Medicare Guidelines for Split Global Surgical Package

Medicare guidelines require physicians who have not established a reciprocal billing arrangement to report split surgical care using the split care modifiers. More specifically, Modifiers 54 and 55 are required for proper allocation of the applicable portion of the global surgery payment for each physician. The combined amount paid to each surgeon cannot exceed the Medicare fee schedule allowable for the global surgical package.

Under a reciprocal billing arrangement, another physician generally provides the postoperative care instead of the surgeon of record. The “stand in” physician does not submit a claim for the surgery. Instead, the surgeon bills as usual for the complete global surgical package, adding the Q5 modifier (Service furnished by a substitute physician under a reciprocal billing arrangement) to the surgical code.

The Medicare Physician Fee Schedule Database provides a comprehensive listing of all preoperative, intraoperative, and postoperative percentages for surgical procedures. These percentages are used to allocate payment to physicians who bill using the split care modifiers. For Medicare allocations for burn surgery, see Appendix VII, 2018 Medicare Physician Fee Schedule Relative Values.

Medicare guidelines specify additional reporting details for these situations. Refer to the online Medicare Internet-only Claims Processing Manual 100-4, Chapter 12 Section 40.2A3 Billing Requirements for Global Surgery; Physicians Who Furnish Part of a Global Surgical Package. See the CMS web page at <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

57 Decision for Surgery

“An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding the modifier ‘57’ to the appropriate level of E/M service.”

Modifier 57 was created originally for Medicare to allow payment for the E/M service that resulted in the initial decision to perform major surgery when the service occurs on the day before or the day of surgery. The decision must be documented in the medical record. The modifier allows the claim to bypass Medicare global surgery edits that would otherwise bundle the E/M service into the global package and deny payment for it. Modifier 57 indicates that the E/M service is not a part of the global surgical service and, as such, is separately reportable and payable.

Under Medicare, all major surgical procedures are assigned a 90-day global surgery follow-up period.

58 Staged or Related Procedure or Service by the Same Physician During the Postoperative Period

“It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: a) planned or anticipated (staged); b) more extensive than the original procedure; or c) for therapy following a diagnostic surgical procedure. This circumstance may be reported by adding the modifier ‘58’ to the staged or related procedure.

Note: For treatment of a problem that requires a return to the operating or procedure room (e.g., unanticipated clinical condition, see modifier 78.” *

Modifier 58 was developed originally for Medicare to allow separate payment for a surgical procedure, performed *by the same physician* on the same patient during the assigned postoperative period of a previous global procedure that was:

- planned or anticipated (staged); or,
- more extensive than the original procedure; or,
- for therapy following a surgical procedure.

By definition, a staged surgical procedure is an operation performed in two or more phases. The modifier allows staging to be indicated for a subsequent related procedure that could not be predicted in advance but whose potential could reasonably be anticipated by the surgeon after or at the time of the original surgery. It is important that the burn surgeon document in the progress notes and in the operative note that the operation is a staged surgical procedure for a burn patient with ___% total body surface burn and ___% of total body surface full thickness burn.

These types of procedures are performed frequently in the course of treatment for the burn patient.

Examples are:

- **Second and subsequent application of grafts on the same wound such as an STSG following earlier allograft**
- **Closure of laparotomy incision days after decompression laparotomy**

Medicare will deny claims for these services when submitted without the modifier.

For return to the operating or procedure room during the postoperative period for an *unanticipated* clinical condition, refer to modifier 78 instead.

59 Distinct Procedural Service

“Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier ‘59’ is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a

- different session,
- different procedure or surgery,
- different site or organ system,
- separate incision or excision,
- separate lesion, or
- separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same physician.

However, when another already established modifier is appropriate it should be used rather than modifier ‘59.’ Only if no more descriptive modifier is available and the use of modifier ‘59’ best explains the circumstances, should modifier ‘59’ be used.”

Modifier 59 is an important modifier that was established to allow physicians to inform payers that an otherwise bundled procedure was performed separately at the same session or on the same day, can be legitimately submitted for payment,

and should be paid separately. Essentially, it allows the claim to bypass payer re-bundling software edits that bundle any procedures that are components of more comprehensive procedures into the respective comprehensive procedure.

Modifier 59 is solely to be used by the same provider on the same day for the same patient.

Modifier 59 is not to be used with E/M codes.

Example for Modifier 59:

Medicare and other payer edits bundle skin substitute codes into split thickness skin graft codes when billed on the same date of service. The edit assumes that both grafts are placed on the same site (e.g., overlay graft). However, when each type of graft is applied to a different site, modifier 59 must be added to the potentially bundled code—the Skin Substitute code—to obtain reimbursement for it.

100 sq cm skin substitute is applied to the foot and an 80 sq cm split thickness graft is applied to the right arm at same operative session

15100	STSG first 100 sq cm	1 unit
15275–59	Skin Substitute, first 100	1 unit

In the example, modifier 59 demonstrates that the skin substitute was applied to a different anatomic site.

62 Two Surgeons (Co-Surgeons)

“When two surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding the modifier ‘62’ to procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons.

Both surgeons report the same procedure code once with modifier 62. Additional procedures (secondary and add-on) performed as co-surgeons at the same session may also be reported with modifier 62. A co-surgeon who acts as an assistant surgeon for other procedures performed at the same time can report the services with the appropriate code(s) and modifier 80 or 81, whichever is applicable. Modifier 62 may be used by surgeons of the same or differing specialties. (See Medicare exception.) Modifier 62 is not to be used for procedures where 3 or more surgeons participate in the same operative session. See modifier 66 (Surgical Team).

Modifier 62 is used to report the services of two surgeons, each of whom is acting as an equal to the other **while performing a surgical procedure**. It is important to note that one physician is *not* assisting the other; instead each surgeon performs essential part(s) of the same procedure. **It is also important to note that the “two surgeons” concept is not the same as**

“primary/primary surgeons,” each performing a procedure independently of the other. See “primary/primary” explanatory section below.

Co-surgeons elect to act in that capacity, usually in advance of the procedure. One surgeon generally requests another surgeon to act as a co-surgeon for the procedure in contrast to asking that same surgeon to act as his/her assistant surgeon for it. As a result, coding and reporting guidelines as well as payment are based on the surgeons' choice to conduct the procedure as co-surgeons.

One or the other surgeon may evaluate the patient pre-operatively, and/or admit the patient, and provide postoperative care.

General Guidelines for Two Surgeons/Co-Surgeons (See separate Medicare Guidelines below.)

Each surgeon must dictate his or her own operative report. The operative report for each surgeon's work is **required** to support the billed services on the claim. If only one of the surgeons dictates an operative report, even though it includes mention of the work performed by the other surgeon, it does not constitute documentation that supports the claim submitted by the other surgeon because the other surgeon did not dictate his/her own operative report of the work he/she performed. A claim submitted by any physician without supporting documentation is considered a false claim and is an audit liability.

Payers may require a copy of both reports for claim payment because these claims are paid manually. The reports with or without an accompanying brief note should display the medical necessity for two surgeons in the case.

Many payers, including Medicare, allow a total of 125% of the allowable fee for the definitive procedure. Payment is divided between the two surgeons, 62.5% of the total allowable for each surgeon.

Medicare Guidelines for Two Surgeons/Co-Surgeons

Surgeons must be of differing specialties as recognized by Medicare. The skills of two surgeons must be medically necessary to perform the procedure.

Medicare claims for co-surgery are screened against three “medical necessity lists” in the Medicare Physician Fee Schedule database. When submitted with modifier 62:

- The claim can be paid without further scrutiny when the claim is on the approved list and the two-specialty requirement is met.
- The claim is pended if the procedure falls in the category requiring manual review of the operative reports. When the reports demonstrate the medical necessity for two surgeons, the claim can be paid.

For the remaining procedures, the first claim that is received is paid based on the lower of the billed amount or 100 percent of the fee schedule amount unless other payment adjustment rules apply. Bills received subsequently from another surgeon are denied for lack of medical necessity.

“Primary/Primary “Surgeons vs. Two Surgeons/Co-Surgeons

Modifier 62 should not be used for operations where each surgeon performs a separate, primary procedure, usually in different anatomic locations. Each surgeon acts as an independent primary surgeon and dictates his/her own operative report. Payers generally allow the full allowable for each procedure, assuming all coverage and other requirements are in place.

Coding Example of “Primary/Primary”

Surgeon A performs wound excision on the right arm while Surgeon B performs wound excision on the left arm.

Surgeon A			
1/12	15002-RT	Tangential excision, first 100 sq cm	1 unit
Surgeon B			
1/12	15002-LT	Tangential excision, first 100 sq cm	1 unit

63 Procedure Performed on Infants less than 4 kg

“Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work commonly associated with these patients.”

“Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20000-69999 code series. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections.”

Procedures performed on these patients involve a significant increase in the intensity of work required to accomplish the procedure.

Certain surgical procedures cannot be reported with modifier 63 and are identified in the CPT book by a parenthetical notation stating “(Do not report modifier 63 in conjunction with _____[code]).” The relative values for these modifier 63 exempt codes already includes the increased physician work and intensity for such procedures.

66 Surgical Team

“Under some circumstances, highly complex procedures (requiring the concomitant services of several physicians, often of different specialties, plus other highly skilled, specially trained personnel, various types of complex equipment) are carried out under the “surgical team” concept. Such circumstances may be identified by each participating physician with the addition of the modifier ‘66’ to the basic procedure number used for reporting services.”

Modifier 66 is used for procedures performed by a team of 3 or more surgeons. Each surgeon should report his/her services with modifier 66.

Medicare Guidelines

Each team surgery claim is paid on a “By Report” basis with the exception of a few procedures for which Medicare has set team surgery RVUs and payment amounts.

Two categories of claims are reviewed for payment. One category of procedures is reviewed for medical necessity for team surgeons. If Medicare determines that team surgeons were medically necessary, the claims are paid on an individual basis. The second category of claims is assumed to be medically necessary and are paid on an individual basis.

In the cases where Medicare has established RVUs and payment amounts, all physicians on the team must agree on the percentage of the Medicare payment amount each is to receive. That information should be submitted with the claims for Medicare payment.

76 Repeat Procedure by Same Physician

“It may be necessary to indicate that a procedure or service was repeated subsequent to the original procedure or service.”

Modifier 76 is not restricted to procedures or services performed on the same date. **It is not to be used for planned or anticipated subsequent or staged procedures (see modifier 58) or related unplanned procedures (e.g., for complications) (see modifier 78).**

Modifier 76 indicates to the payer that the claim is not a duplicate. It does not function to allow a claim to bypass payer re-bundling or coding edits; therefore, it should not be used in lieu of another modifier when the other modifier more appropriately communicates a separate encounter where the same procedure was performed. Instead, modifier 76 may be used in addition to the other modifier. For claims where payer edits are not a consideration, modifier 76 may be used alone.

77 Repeat Procedure by Another Physician

“The physician may need to indicate that a basic procedure or service performed by another physician had to be repeated.”

Use this modifier when the same procedure is repeated but performed by a different physician. This modifier indicates to the payer that the claim is not a duplicate.

78 Unplanned Return to the Operating/Procedure Room by the Same Physician Following Initial Procedure for a Related Procedure During the Postoperative Period

“It may be necessary to indicate that another procedure was performed during the postoperative period of the initial procedure (unplanned procedure following initial procedure). When this procedure is related to the first and requires the use

of the operating or procedure room, it may be reported by adding the modifier '78' to the related procedure."

Created for Medicare, modifier 78 is used to bypass Medicare edits that would otherwise deny a surgical procedure performed in the operating or procedure room to treat a postoperative complication when that complication occurs during the postoperative period.

In most cases, the reoperation is required to treat a surgical complication such as hemorrhage, infection, etc. Another example where modifier 78 would be used is the situation where a *replacement* free skin graft is applied to a wound during the postoperative period of a previous skin graft on the same wound (e.g., graft re-application).

Modifier 78 essentially allows reporting of procedures that were not foreseen in advance or are unplanned. Contrast to *staged* procedures which are *anticipated* or planned and involve some level of planning or anticipation, which procedures would be reported with modifier 58 instead.

Modifier 78 is added to the code(s) for the related procedure(s). Secondary procedures performed at the same time should not be identified with modifier 51 for Medicare or other payers that follow the Medicare-specific payment reduction policy for modifier 78.

79 Unrelated Procedure or Service by the Same Physician During the Postoperative Period

"The physician may need to indicate that the performance of a procedure or service during the postoperative period was unrelated to the original procedure. This circumstance may be reported by using the modifier '79'"

Modifier 79 was developed for Medicare and is used to report a surgical procedure, performed during the assigned postoperative period for another, different surgical procedure, but unrelated to it. The term "unrelated" means that the procedure is unrelated to recovery from the earlier procedure or due to a complication of the earlier procedure.

The modifier is added to the code for the unrelated surgical procedure.

Assistant Surgeon Modifiers

80 Assistant Surgeon

"Surgical assistant services may be identified by adding the modifier '80' to the usual procedure number(s)"

This modifier is used to identify the services of a first assistant surgeon and is added to the code(s) for the surgical procedure(s) on which the surgeon acted as a surgical assistant.

Payment is based on a percent of the allowed amount of the surgeon's fee. In most of the US, 20% is allowed for reimbursement of assistant surgeon's services. Medicare's allowance is 16%.

81 Minimum Assistant Surgeon

"Minimum surgical assistant services are identified by adding the modifier '81' to the usual procedure number"

The services of non-physician assistants may occasionally be reported with this modifier.

82 Assistant Surgeon (when qualified resident surgeon not available)

"The unavailability of a qualified resident surgeon is a prerequisite for use of modifier '82' appended to the usual procedure code number(s)"

Modifier 82 Used to report the services of an assistant at surgery in an institution where a qualified residency program is available, where such a resident usually assists at surgery, but is not available on this occasion.

Medicare Guidelines

"Qualified resident: No payment may be made for the services of assistants at surgery furnished in a teaching hospital which has a training program related to the medical specialty required for the surgical procedure and has a qualified resident available to perform the service unless the requirements of Sec. 5038.2, 5038.3 or 5038.4 are met. **Each teaching hospital will have a different situation concerning numbers of residents, qualifications of residents, duties of residents and types of surgeries performed.** Contact those affected by these instructions to learn the circumstances in individual teaching hospitals."

When a qualified resident is available and the physician assists in lieu of the resident, the physician's services are not payable unless the primary surgeon has an across-the-board policy of never involving residents in the preoperative, operative, or postoperative care of his or her patients.

Exceptional Circumstances—Payment may be made for the services of assistants at surgery in teaching hospitals notwithstanding the availability of a qualified resident to furnish the services. There may be exceptional medical circumstances, (e.g., emergency, life-threatening situations such as multiple traumatic injuries) which require immediate treatment. There may be other situations in which carrier medical staff may find that exceptional medical circumstances justify the services of a physician assistant at surgery even though a qualified resident is available.

HCPCS Modifiers

The following is a *selected* list of HCPCS modifiers, criteria for use, and relevant reporting comments *for physician services only*. For a complete list of HCPCS modifiers, refer to HCPCS Level II code publications from CMS and commercial publishers. Guidelines for use of CPT and HCPCS modifiers for facility/technical reporting vary by payer; CMS guidelines can be found in “CMS-Approved Modifiers for Outpatient Hospital Reporting” under Coding for Facility Services.

Selected HCPCS National Level II modifiers that may be used in submitting claims by burn surgeons. See also “AI,” “AS,” and “GC,” in Table, next page.

E1	Upper left eyelid	F7	Right hand, third digit
E2	Lower left eyelid	F8	Right hand, fourth digit
E3	Upper right eyelid	F9	Right hand, fifth digit
E4	Lower right eyelid	TA	Left foot, great toe
RT	Right side	T1	Left foot, second digit
LT	Left side	T2	Left foot, third digit
FA	Left hand, thumb	T3	Left foot, fourth digit
F1	Left hand, second digit	T4	Left foot, fifth digit
F2	Left hand, third digit	T5	Right foot, great toe
F3	Left hand, fourth digit	T6	Right foot, second digit
F4	Left hand, fifth digit	T7	Right foot, third digit
F5	Right hand, thumb	T8	Right foot, fourth digit
F6	Right hand, second digit	T9	Right foot, fifth digit

E1–E4	<p>The eyelid modifiers allow claims for procedures performed on one or more eyelids to bypass Medicare re-bundling edits that apply to some “eye-specific” procedure codes listed in the Eye and other sections of CPT.</p>
F1–F9	<p>The finger modifiers are used to identify procedures on individual fingers and allow claims for these procedures to bypass Medicare re-bundling edits for procedure codes listed in the Musculoskeletal system and other sections of CPT.</p> <p>These modifiers should be added to the appropriate code(s) when reporting fasciotomies or amputations on one or multiple fingers.</p>
TA–T9	<p>The toe modifiers are used to identify procedures on individual toes and allow claims for these procedures to bypass Medicare re-bundling edits for procedure codes listed in the Musculoskeletal system and other sections of CPT.</p> <p>These modifiers should be added to the appropriate code(s) when reporting</p>
RT and LT	<p>Medicare utilizes these modifiers to identify unilateral procedures performed on one of the body’s paired organs (e.g., ears, arms, legs) to track unlikely duplicate procedures. These modifiers must be used with caution for burn surgery procedures. Because many identically coded, staged procedures are performed on the external paired organs, use of these modifiers may result in inappropriate Medicare claim denials.</p> <p>Modifier RT or LT may be used appropriately for one-time unilateral procedures such as amputation of an extremity, foot, or hand.</p>
AI	<p>“Principal physician of record”</p> <p>The admitting or attending physician who oversees the patient’s care in the hospital should use modifier “AI” with the initial inpatient care code (admission H&P) to distinguish that service from the services of all other physician who may be providing consultative or specialty hospital care on that day or subsequent days. This modifier allows the attending’s and consultative physicians’ claims for initial hospital care codes (required by Medicare in lieu of consultation codes) to be paid.</p>
AS	<p>“Physician assistant, nurse practitioner or clinical nurse specialist services for assistant at surgery”</p> <p>Medicare requires this modifier when billing assistant surgery for one of the above non-physician practitioners. Add the modifier to the applicable code for which the assistant at surgery services were provided.</p>
GC	<p>“This service has been performed in part by a resident under the direction of a teaching physician.”</p> <p>Medicare requires this modifier when billing for a teaching physician’s service performed in conjunction with a resident. It indicates the teaching physician was present for the critical or key portion of the billed service and that documentation supports that fact.</p>

Appendix V: E/M Levels of Service: Code Selection and Audit Tables

E/M Levels of Service Code Selection and Audit Tables

The following code selection/audit tables summarize the combined CPT and CMS documentation requirements for each of the key components, leading to selection of a level of service.

History: CPT and CMS Combined Guidelines

History

Note: Chief complaint is required for all history types. Numeric values are CMS requirements.

TYPE OF HISTORY	HPI GUIDELINES See HPI table below	ROS GUIDELINES See ROS table below	PFSH GUIDELINES See PFSH table below
Problem focused	Brief (1-3)	None	None
Expanded problem focused	Brief (1-3)	Problem pertinent (1)	None
Detailed	Extended (4 or more)	Extended (2-9)	Pertinent (1)
Comprehensive	Extended (4 or more)	Complete (10 or more or individual systems' responses documented w/ notation for remaining systems "all others negative")	Complete 1 item each area (See PFSH table below) OR 1 item from 2 of the 3 areas (See PFSH table below)

Tally scores on HPI, ROS, and PFSH tables below. Circle score for each item on table above. If all 3 in a row are not circled, item closest to top of table determines type of history.

Detailed CMS Guidelines for HPI, ROS, and PFSH

Circle number of elements documented and total.

HPI—HISTORY OF PRESENT ILLNESS	ROS—REVIEW OF SYSTEMS	PFSH—PAST, FAMILY, SOCIAL HISTORY
(elements) Location Quality Severity Duration Timing Context Modifying factors	(elements) Constitutional Eyes ENT/mouth Cardiovascular Respiratory GI GU Musculoskeletal Skin or breast Neurologic Psychiatric Endocrine Heme/lymph Allergy/immune	(areas) Medical history Family history Social history
GUIDELINES	GUIDELINES	GUIDELINES
Brief = 1-3 elements Extended = 4 or more elements OR status of 3 chronic or inactive conditions	Problem pertinent = 1 element Extended = 2-9 elements Complete = 10 or more elements or notation "all others negative" Option: Or review /update of an earlier ROS	Pertinent = 1 Complete = 1 item, each area (For levels of service requiring all 3 key components, except ED) Complete = 1 item from 2 of the 3 areas (For ED & levels of service requiring 2 of 3 key components)

Examination: CPT and CMS Combined Guidelines
Two sets of CMS official guidelines: 1995 and 1997.
Physicians may choose whichever is optimal for their practice.

Physical Examination—1995 Guidelines
Note: Numeric values are CMS requirements.

TYPE OF EXAMINATION		GUIDELINES
# Organ Systems or Body Areas (BA/OS)		
Problem focused	1	Limited exam of affected BA/OS
Expanded problem focused symptomatic /	2-4	Limited exam of affected BA/OS + other related organ systems
Detailed	5-7	Extended exam of affected BA/OS + other symptomatic / related organ systems
Comprehensive	8 or more	Or, complete single organ system exam, undefined by CPT or CMS

Tally the total number of OS/BA examined/documented from Examination table below. Circle total score in table above for type of examination.

ORGAN SYSTEMS

- Constitutional
- Eyes
- ENT/mouth
- Cardiovascular
- Respiratory
- GI
- GU
- Musculoskeletal
- Skin or breast
- Neurologic
- Psychiatric
- Endocrine
- Heme/lymph
- Allergy/immune

BODY AREAS

- Head (including face)
- Neck
- Chest (including breasts, axillae)
- Abdomen
- Genitalia, groin, buttocks
- Back (including spine)
- Each extremity

Physical Examination—1997 Guidelines

CMS Guidelines—General Multi-System Physical Examination

TYPE OF EXAMINATION	GUIDELINES
Problem focused	1-5 bullets
Expanded problem focused	6 or more bullets
Detailed	6 OS/BA, 2 bullets each (12) OR 12 bullets in 2 or more OS/BA
Comprehensive	9 or more OS/BA, 2 bullets each (18)

CMS General Multi-System Physical Examination

Check each bullet documented. Total all bullets in table below. Circle total number in table above to determine type of examination.

System/Body

Area	Elements of Examination
Constitutional	<ul style="list-style-type: none"> • Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (e.g., development, nutrition, body habitus, deformities, attention to grooming)
Eyes	<ul style="list-style-type: none"> • Inspection of conjunctivae and lids • Examination of pupils and irises (e.g., reaction to light and accommodation, size and symmetry) • Ophthalmoscopic examination of optic discs (e.g., size, C/D ratio, appearance) and posterior segments (e.g., vessel changes, exudates, hemorrhages)
Ears, Nose, Mouth and Throat	<ul style="list-style-type: none"> • External inspection of ears and nose (e.g., overall appearance, scars, lesions, masses) • Otoscopic examination of external auditory canals and tympanic membranes • Assessment of hearing (e.g., whispered voice, finger rub, tuning fork) • Inspection of nasal mucosa, septum and turbinates • Inspection of lips, teeth and gums • Examination of oropharynx: oral mucosa, salivary glands, hard and soft palates, tongue, tonsils and posterior pharynx
Neck	<ul style="list-style-type: none"> • Examination of neck (e.g., masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (e.g., enlargement, tenderness, mass)
Respiratory	<ul style="list-style-type: none"> • Assessment of respiratory effort (e.g., intercostal retractions, use of accessory muscles, diaphragmatic movement) • Percussion of chest (e.g., dullness, flatness, hyperresonance) • Palpation of chest (e.g., tactile fremitus) • Auscultation of lungs (e.g., breath sounds, adventitious sounds, rurs)
Cardiovascular	<ul style="list-style-type: none"> • Palpation of heart (e.g., location, size, thrills) • Auscultation of heart with notation of abnormal sounds and murmurs Examination of: <ul style="list-style-type: none"> • carotid arteries (e.g., pulse amplitude, bruits) • abdominal aorta (e.g., size, bruits) • femoral arteries (e.g., pulse amplitude, bruits) • pedal pulses (e.g., pulse amplitude) • extremities for edema and/or varicosities
Chest (Breasts)	<ul style="list-style-type: none"> • Inspection of breasts (e.g., symmetry, nipple discharge) • Palpation of breasts and axillae (e.g., masses or lumps, tenderness)
Gastrointestinal (Abdomen)	<ul style="list-style-type: none"> • Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen • Examination for presence or absence of hernia

- Examination (when indicated) of anus, perineum and rectum, including sphincter tone, presence of hemorrhoids, rectal masses
- Obtain stool sample for occult blood test when indicated

Genitourinary

MALE: Examination of the scrotal contents (e.g., hydrocele, spermatocele, tenderness of cord, testicular mass)

- Examination of the penis
- Digital rectal examination of prostate gland (e.g., size, symmetry, nodularity,

tenderness)

FEMALE:

Pelvic examination (with or without specimen collection for smears and cultures),

including

- Examination of external genitalia (e.g., general appearance, hair distribution, lesions) and vagina (e.g., general appearance, estrogen effect, discharge, lesions, pelvic support, cystocele, rectocele)
- Examination of urethra (e.g., masses, tenderness, scarring)
- Examination of bladder (e.g., fullness, masses, tenderness)
- Cervix (e.g., general appearance, lesions, discharge)
- Uterus (e.g., size, contour, position, mobility, tenderness, consistency, descent

or support)

- Adnexa/parametria (e.g., masses, tenderness, organomegaly, nodularity)

Lymphatic

Palpation of lymph nodes in **two or more** areas:

- Neck
- Axillae
- Groin
- Other

Musculoskeletal

- Examination of gait and station

- Inspection and/or palpation of digits and nails (e.g., clubbing, cyanosis, inflammatory conditions, petechiae, ischemia, infections, nodes)

Examination of joints, bones and muscles of one or more of the following six areas: 1) head and neck; 2) spine, ribs and pelvis; 3) right upper extremity; 4) left upper extremity; 5) right lower extremity; and 6) left lower extremity. The examination of a given area includes:

- Inspection and/or palpation with notation of presence of any misalignment, asymmetry, crepitation, defects, tenderness, masses, effusions
- Assessment of range of motion with notation of any pain, crepitation or

contracture

- Assessment of stability with notation of any dislocation (luxation), subluxation or

laxity

- Assessment of muscle strength and tone (e.g., flaccid, cog wheel, spastic) with notation of any atrophy or abnormal movements

Skin

- Inspection of skin and subcutaneous tissue (e.g., rashes, lesions, ulcers)
- Palpation of skin and subcutaneous tissue (e.g., induration, subcutaneous

nodules, tightening)

Neurologic

- Test cranial nerves with notation of any deficits
- Examination of deep tendon reflexes with notation of pathological reflexes (e.g.,

Babinski)

- Examination of sensation (e.g., by touch, pin, vibration, proprioception)

Psychiatric

- Description of patient's judgment and insight

Brief assessment of mental status including:

- orientation to time, place and person
- recent and remote memory
 - mood and affect (e.g., depression, anxiety, agitation)

Medical Decision Making: CPT and CMS Combined Guidelines

Complexity of medical decision-making is measured by

- a) the number of possible diagnoses and/or management options established,
- b) the amount and/or complexity of data obtained, reviewed or analyzed, and
- c) the risk associated with the presenting problems, diagnostic procedures, and/or possible management options.

Medical Decision Making—1995 and 1997

Type of Medical Decision Risk	Diagnoses &/or Mgt. Options	Amount of Data	
Making			
Straightforward Minimal	1 Minimal	1 Minimal / None	1
Low	2 Limited	2 Limited	2 Low
Moderate	3 Multiple	3 Moderate	3 Moderate
High	4 Extensive	4 Extensive	4 High

Notes: Diagnoses/Management Options and Data elements are unofficial but used by CMS for 1991 medical director training and auditors throughout U.S. Table of Risk is official CMS document.

Tally the scores from the three tables (Diagnoses, Data, CMS Table of Risk) below. Circle score for each item on table above.

DIAGNOSES/MANAGEMENT OPTIONS		DATA	
	# Problems	Points	Points
Self ltd or minor (stable, improved or worsening)	(2 max)	1	Review &/or order clinical lab tests
Est. problem; stable, improved		1	Review &/or order radiology tests
Est. problem; worsening		2	Review &/or order tests in Medicine section
New problem, no additional workup Planned	(1 max)	3	Discuss test results with performing physician
New problem, additional workup planned		4	Independent review of image, tracing or specimen
			Decision to obtain old records &/or obtain history from person other than patient
			Review & summary of old records &/or obtain history from person other than patient
TOTAL POINTS TOTAL			

SCORING

- Find each problem in record. Enter # in each category. Multiply Problems times Points, enter score on each line and total all points.
- When counseling/cc dominates & time is not noted, enter 3 for total.

CMS Table of Risk (Common examples; not absolute risk measures.) (Highest level item in any category determines overall risk.)

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
Minimal	<ul style="list-style-type: none"> – One self-limited or minor problem, e.g., cold, insect bite, tinea corporis 	<ul style="list-style-type: none"> – Laboratory tests requiring venipuncture – Chest x-rays – EKG/EEG – Urinalysis – Ultrasound, e.g., echocardiography – KOH prep 	<ul style="list-style-type: none"> – Rest – Gargles – Elastic bandages – Superficial dressing
Low	<ul style="list-style-type: none"> – Two or more self-limited or minor problems – One stable chronic illness, e.g., well controlled hypertension, non-insulin dependent diabetes, cataract, BPH – Acute uncomplicated illness or injury, e.g., cystitis, allergic rhinitis, simple sprain 	<ul style="list-style-type: none"> – Physiologic tests not under stress, e.g., pulmonary function tests – Non-cardiovascular imaging studies with contrast, e.g., barium enema – Superficial needle biopsies – Clinical laboratory tests requiring arterial puncture – Skin biopsies 	<ul style="list-style-type: none"> – Over-the-counter drugs – Minor surgery with no identified risk factors – Physical therapy – Occupational therapy – IV fluids without additives
Moderate	<ul style="list-style-type: none"> – One or more chronic illnesses mild exacerbation, progression, or side effects of treatment – Two or more stable chronic illnesses – Undiagnosed new problem with uncertain prognosis, e.g., lump in breast – Acute illness with systemic symptoms, e.g., pyelonephritis, pneumonitis, colitis – Acute complicated injury, e.g., head injury with brief loss of consciousness 	<ul style="list-style-type: none"> – Physiologic tests under stress, e.g., cardiac stress test, fetal contraction stress test – Diagnostic endoscopies with no identified risk factors – Deep needle or incisional biopsy – Cardiovascular imaging studies with contrast and no identified risk factors, e.g., arteriogram, cardiac catheterization – Obtain fluid from body cavity, e.g., lumbar puncture, thoracentesis, culdocentesis 	<ul style="list-style-type: none"> – Minor surgery with identified risk factors – Elective major surgery (open, percutaneous or endoscopic) with no identified risk factors – Prescription drug management – Therapeutic nuclear medicine – IV fluids with additives – Closed treatment of fracture or dislocation without manipulation

Level of Risk	Presenting Problem(s)	Diagnostic Procedure(s) Ordered	Management Options Selected
High	<ul style="list-style-type: none"> – One or more chronic illnesses with severe exacerbation, progression, or side effects of treatment – Acute or chronic illnesses or injuries that pose a threat to life or bodily function, e.g., multiple trauma, acute MI, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure – An abrupt change in neurologic status, e.g., seizure, TIA, weakness, sensory loss 	<ul style="list-style-type: none"> – Cardiovascular imaging studies with contrast with identified risk factors – Cardiac electrophysiological tests – Diagnostic Endoscopies with identified risk factors – Discography 	<ul style="list-style-type: none"> – Elective major surgery (open, percutaneous or endoscopic) with identified risk factors – Emergency major surgery (open, percutaneous or endoscopic) – Parenteral controlled substances – Drug therapy requiring intensive monitoring for toxicity – Decision not to resuscitate or to de-escalate care because of poor prognosis

Selecting the Code

After determining the level of history, physical examination and medical decision-making, refer to the CPT definitions of levels of service in the applicable code category (e.g., new patient office service). Then determine the code that is equivalent to your documentation.

Example

Assume the documented history is expanded problem focused, examination is detailed and medical decision-making is low complexity. Circle the applicable key components. Find the circle farthest to the left and draw a line down to the level of service.

Office or Outpatient Service, New Patient

3 of 3 key components required

HISTORY	Problem focused	Expanded problem focused	Detailed	Comprehensive	Detailed
EXAMINATION	Problem focused	Expanded problem focused		Comprehensive	Comprehensive

MEDICAL

	Straightforward	Straightforward	Low	Moderate	High
DECISION MAKING	99201	99202	99203	99204	99205

Correct level of service: 99202

Continuing the above example, circle the applicable key components. Find the column with two or three circles and draw a line down to the level of service. If no column has at least two circles, fine the column with the second circle from the left and draw a line down to the level of service.

**Office or Outpatient Service, Established
Patient 2 of 3 key components required**

HISTORY	N/A	Problem focused	Expanded problem-focused	Detailed	Comprehensive
EXAMINATION	N/A	Problem focused	Expanded problem focused	Detailed	Comprehensive
MEDICAL DECISION MAKING	N/A	Straightforward	Low	Moderate	High
	99211	99212	99213	99214	99215

Correct level of service: 99213

Appendix VI Common Burn ICD-10-CM Diagnosis Codes

Complications, Skin Graft

- T86.82 Complications of skin graft (allograft) (autograft)
- T86.820 Skin graft (allograft) rejection
- T86.821 Skin graft (allograft) (autograft) failure
- T86.822 Skin graft (allograft) (autograft) infection
- T86.828 Other complications of skin graft (allograft) (autograft)
- T86.829 Unspecified complication of skin graft (allograft) (autograft)

Burn by Site

- T20 Burn and corrosion of head, face, and neck
- T20.0 Burn of unspecified degree of head, face, and neck
- T20.00 Burn of unspecified degree of head, face, and neck, unspecified site
 - T20.00XA initial encounter
 - T20.00XD subsequent encounter
 - T20.00XS sequela
- T20.01 Burn of unspecified degree of ear [any part, except ear drum]
 - T20.011 Burn of unspecified degree of right ear [any part, except ear drum]
 - T20.011A initial encounter
 - T20.011D subsequent encounter
 - T20.011S sequela
 - T20.012 Burn of unspecified degree of left ear [any part, except ear drum]
 - T20.012A initial encounter
 - T20.012D subsequent encounter
 - T20.012S sequela
 - T20.019 Burn of unspecified degree of unspecified ear [any part, except ear drum]
 - T20.019A initial encounter
 - T20.019D subsequent encounter
 - T20.019S sequela
- T20.02 Burn of unspecified degree of lip(s)
 - T20.02XA initial encounter

- T20.02XD subsequent encounter
- T20.02XS sequela
- T20.03 Burn of unspecified degree of chin
 - T20.03XA initial encounter
 - T20.03XD subsequent encounter
 - T20.03XS sequela
- T20.04 Burn of unspecified degree of nose (septum)
 - T20.04XA initial encounter
 - T20.04XD subsequent encounter
 - T20.04XS sequela
- T20.05 Burn of unspecified degree of scalp [any part]
 - T20.05XA initial encounter
 - T20.05XD subsequent encounter
 - T20.05XS sequela
- T20.06 Burn of unspecified degree of forehead and cheek
 - T20.06XA initial encounter
 - T20.06XD subsequent encounter
 - T20.06XS sequela
- T20.07 Burn of unspecified degree of neck
 - T20.07XA initial encounter
 - T20.07XD subsequent encounter
 - T20.07XS sequela
- T20.09 Burn of unspecified degree of multiple sites of head, face, and neck
 - T20.09XA initial encounter
 - T20.09XD subsequent encounter
 - T20.09XS sequela
- T20.1 Burn of first degree of head, face, and neck
 - T20.10 Burn of first degree of head, face, and neck, unspecified site
 - T20.10XA initial encounter
 - T20.10XD subsequent encounter
 - T20.10XS sequela
 - T20.11 Burn of first degree of ear [any part, except ear drum]

- T20.111 Burn of first degree of right ear [any part, except ear drum]
 - T20.111A initial encounter
 - T20.111D subsequent encounter
 - T20.111S sequela
- T20.112 Burn of first degree of left ear [any part, except ear drum]
 - T20.112A initial encounter
 - T20.112D subsequent encounter
 - T20.112S sequela
- T20.119 Burn of first degree of unspecified ear [any part, except ear drum]
 - T20.119A initial encounter
 - T20.119D subsequent encounter
 - T20.119S sequela
- T20.12 Burn of first degree of lip(s)
 - T20.12XA initial encounter
 - T20.12XD subsequent encounter
 - T20.12XS sequela
- T20.13 Burn of first degree of chin
 - T20.13XA initial encounter
 - T20.13XD subsequent encounter
 - T20.13XS sequela
- T20.14 Burn of first degree of nose (septum)
 - T20.14XA initial encounter
 - T20.14XD subsequent encounter
 - T20.14XS sequela
- T20.15 Burn of first degree of scalp [any part]
 - T20.15XA initial encounter
 - T20.15XD subsequent encounter
 - T20.15XS sequela
- T20.16 Burn of first degree of forehead and cheek
 - T20.16XA initial encounter
 - T20.16XD subsequent encounter
 - T20.16XS sequela

- T20.17 Burn of first degree of neck
 - T20.17XA initial encounter
 - T20.17XD subsequent encounter
 - T20.17XS sequela
- T20.19 Burn of first degree of multiple sites of head, face, and neck
 - T20.19XA initial encounter
 - T20.19XD subsequent encounter
 - T20.19XS sequela
- T20.2 Burn of second degree of head, face, and neck
 - T20.20 Burn of second degree of head, face, and neck, unspecified site
 - T20.20XA initial encounter
 - T20.20XD subsequent encounter
 - T20.20XS sequela
 - T20.21 Burn of second degree of ear [any part, except ear drum]
 - T20.211 Burn of second degree of right ear [any part, except ear drum]
 - T20.211A initial encounter
 - T20.211D subsequent encounter
 - T20.211S sequela
 - T20.212 Burn of second degree of left ear [any part, except ear drum]
 - T20.212A initial encounter
 - T20.212D subsequent encounter
 - T20.212S sequela
 - T20.219 Burn of second degree of unspecified ear [any part, except ear drum]
 - T20.219A initial encounter
 - T20.219D subsequent encounter
 - T20.219S sequela
- T20.22 Burn of second degree of lip(s)
 - T20.22XA initial encounter
 - T20.22XD subsequent encounter
 - T20.22XS sequela
- T20.23 Burn of second degree of chin
 - T20.23XA initial encounter

- T20.23XD subsequent encounter
- T20.23XS sequela
- T20.24 Burn of second degree of nose (septum)
 - T20.24XA initial encounter
 - T20.24XD subsequent encounter
 - T20.24XS sequela
- T20.25 Burn of second degree of scalp [any part]
 - T20.25XA initial encounter
 - T20.25XD subsequent encounter
 - T20.25XS sequela
- T20.26 Burn of second degree of forehead and cheek
 - T20.26XA initial encounter
 - T20.26XD subsequent encounter
 - T20.26XS sequela
- T20.27 Burn of second degree of neck
 - T20.27XA initial encounter
 - T20.27XD subsequent encounter
 - T20.27XS sequela
- T20.29 Burn of second degree of multiple sites of head, face, and neck
 - T20.29XA initial encounter
 - T20.29XD subsequent encounter
 - T20.29XS sequela
- T20.3 Burn of third degree of head, face, and neck
 - T20.30 Burn of third degree of head, face, and neck, unspecified site
 - T20.30XA initial encounter
 - T20.30XD subsequent encounter
 - T20.30XS sequela
 - T20.31 Burn of third degree of ear [any part, except ear drum]
 - T20.311 Burn of third degree of right ear [any part, except ear drum]
 - T20.311A initial encounter
 - T20.311D subsequent encounter
 - T20.311S sequela

- T20.312 Burn of third degree of left ear [any part, except ear drum]
 - T20.312A initial encounter
 - T20.312D subsequent encounter
 - T20.312S sequela
- T20.319 Burn of third degree of unspecified ear [any part, except ear drum]
 - T20.319A initial encounter
 - T20.319D subsequent encounter
 - T20.319S sequela
- T20.32 Burn of third degree of lip(s)
 - T20.32XA initial encounter
 - T20.32XD subsequent encounter
 - T20.32XS sequela
- T20.33 Burn of third degree of chin
 - T20.33XA initial encounter
 - T20.33XD subsequent encounter
 - T20.33XS sequela
- T20.34 Burn of third degree of nose (septum)
 - T20.34XA initial encounter
 - T20.34XD subsequent encounter
 - T20.34XS sequela
- T20.35 Burn of third degree of scalp [any part]
 - T20.35XA initial encounter
 - T20.35XD subsequent encounter
 - T20.35XS sequela
- T20.36 Burn of third degree of forehead and cheek
 - T20.36XA initial encounter
 - T20.36XD subsequent encounter
 - T20.36XS sequela
- T20.37 Burn of third degree of neck
 - T20.37XA initial encounter
 - T20.37XD subsequent encounter
 - T20.37XS sequela

- T20.39 Burn of third degree of multiple sites of head, face, and neck
 - T20.39XA initial encounter
 - T20.39XD subsequent encounter
 - T20.39XS sequela
- T20.4 Corrosion of unspecified degree of head, face, and neck
 - T20.40 Corrosion of unspecified degree of head, face, and neck, unspecified site
 - T20.40XA initial encounter
 - T20.40XD subsequent encounter
 - T20.40XS sequela
 - T20.41 Corrosion of unspecified degree of ear [any part, except ear drum]
 - T20.411 Corrosion of unspecified degree of right ear [any part, except ear drum]
 - T20.411A initial encounter
 - T20.411D subsequent encounter
 - T20.411S sequela
 - T20.412 Corrosion of unspecified degree of left ear [any part, except ear drum]
 - T20.412A initial encounter
 - T20.412D subsequent encounter
 - T20.412S sequela
 - T20.419 Corrosion of unspecified degree of unspecified ear [any part, except ear drum]
 - T20.419A initial encounter
 - T20.419D subsequent encounter
 - T20.419S sequela
- T20.42 Corrosion of unspecified degree of lip(s)
 - T20.42XA initial encounter
 - T20.42XD subsequent encounter
 - T20.42XS sequela
- T20.43 Corrosion of unspecified degree of chin
 - T20.43XA initial encounter
 - T20.43XD subsequent encounter
 - T20.43XS sequela
- T20.44 Corrosion of unspecified degree of nose (septum)
 - T20.44XA initial encounter

- T20.44XD subsequent encounter
- T20.44XS sequela
- T20.45 Corrosion of unspecified degree of scalp [any part]
 - T20.45XA initial encounter
 - T20.45XD subsequent encounter
 - T20.45XS sequela
- T20.46 Corrosion of unspecified degree of forehead and cheek
 - T20.46XA initial encounter
 - T20.46XD subsequent encounter
 - T20.46XS sequela
- T20.47 Corrosion of unspecified degree of neck
 - T20.47XA initial encounter
 - T20.47XD subsequent encounter
 - T20.47XS sequela
- T20.49 Corrosion of unspecified degree of multiple sites of head, face, and neck
 - T20.49XA initial encounter
 - T20.49XD subsequent encounter
 - T20.49XS sequela
- T20.5 Corrosion of first degree of head, face, and neck
 - T20.50 Corrosion of first degree of head, face, and neck, unspecified site
 - T20.50XA initial encounter
 - T20.50XD subsequent encounter
 - T20.50XS sequela
 - T20.51 Corrosion of first degree of ear [any part, except ear drum]
 - T20.511 Corrosion of first degree of right ear [any part, except ear drum]
 - T20.511A initial encounter
 - T20.511D subsequent encounter
 - T20.511S sequela
 - T20.512 Corrosion of first degree of left ear [any part, except ear drum]
 - T20.512A initial encounter
 - T20.512D subsequent encounter
 - T20.512S sequela

- T20.519 Corrosion of first degree of unspecified ear [any part, except ear drum]
 - T20.519A initial encounter
 - T20.519D subsequent encounter
 - T20.519S sequela
- T20.52 Corrosion of first degree of lip(s)
 - T20.52XA initial encounter
 - T20.52XD subsequent encounter
 - T20.52XS sequela
- T20.53 Corrosion of first degree of chin
 - T20.53XA initial encounter
 - T20.53XD subsequent encounter
 - T20.53XS sequela
- T20.54 Corrosion of first degree of nose (septum)
 - T20.54XA initial encounter
 - T20.54XD subsequent encounter
 - T20.54XS sequela
- T20.55 Corrosion of first degree of scalp [any part]
 - T20.55XA initial encounter
 - T20.55XD subsequent encounter
 - T20.55XS sequela
- T20.56 Corrosion of first degree of forehead and cheek
 - T20.56XA initial encounter
 - T20.56XD subsequent encounter
 - T20.56XS sequela
- T20.57 Corrosion of first degree of neck
 - T20.57XA initial encounter
 - T20.57XD subsequent encounter
 - T20.57XS sequela
- T20.59 Corrosion of first degree of multiple sites of head, face, and neck
 - T20.59XA initial encounter
 - T20.59XD subsequent encounter
 - T20.59XS sequela

- T20.6 Corrosion of second degree of head, face, and neck
 - T20.60 Corrosion of second degree of head, face, and neck, unspecified site
 - T20.60XA initial encounter
 - T20.60XD subsequent encounter
 - T20.60XS sequela
 - T20.61 Corrosion of second degree of ear [any part, except ear drum]
 - T20.611 Corrosion of second degree of right ear [any part, except ear drum]
 - T20.611A initial encounter
 - T20.611D subsequent encounter
 - T20.611S sequela
 - T20.612 Corrosion of second degree of left ear [any part, except ear drum]
 - T20.612A initial encounter
 - T20.612D subsequent encounter
 - T20.612S sequela
 - T20.619 Corrosion of second degree of unspecified ear [any part, except ear drum]
 - T20.619A initial encounter
 - T20.619D subsequent encounter
 - T20.619S sequela
 - T20.62 Corrosion of second degree of lip(s)
 - T20.62XA initial encounter
 - T20.62XD subsequent encounter
 - T20.62XS sequela
 - T20.63 Corrosion of second degree of chin
 - T20.63XA initial encounter
 - T20.63XD subsequent encounter
 - T20.63XS sequela
 - T20.64 Corrosion of second degree of nose (septum)
 - T20.64XA initial encounter
 - T20.64XD subsequent encounter
 - T20.64XS sequela
 - T20.65 Corrosion of second degree of scalp [any part]
 - T20.65XA initial encounter

- T20.65XD subsequent encounter
- T20.65XS sequela
- T20.66 Corrosion of second degree of forehead and cheek
 - T20.66XA initial encounter
 - T20.66XD subsequent encounter
 - T20.66XS sequela
- T20.67 Corrosion of second degree of neck
 - T20.67XA initial encounter
 - T20.67XD subsequent encounter
 - T20.67XS sequela
- T20.69 Corrosion of second degree of multiple sites of head, face, and neck
 - T20.69XA initial encounter
 - T20.69XD subsequent encounter
 - T20.69XS sequela
- T20.7 Corrosion of third degree of head, face, and neck
 - T20.70 Corrosion of third degree of head, face, and neck, unspecified site
 - T20.70XA initial encounter
 - T20.70XD subsequent encounter
 - T20.70XS sequela
 - T20.71 Corrosion of third degree of ear [any part, except ear drum]
 - T20.711 Corrosion of third degree of right ear [any part, except ear drum]
 - T20.711A initial encounter
 - T20.711D subsequent encounter
 - T20.711S sequela
 - T20.712 Corrosion of third degree of left ear [any part, except ear drum]
 - T20.712A initial encounter
 - T20.712D subsequent encounter
 - T20.712S sequela
 - T20.719 Corrosion of third degree of unspecified ear [any part, except ear drum]
 - T20.719A initial encounter
 - T20.719D subsequent encounter
 - T20.719S sequela

- T20.72 Corrosion of third degree of lip(s)
 - T20.72XA initial encounter
 - T20.72XD subsequent encounter
 - T20.72XS sequela
- T20.73 Corrosion of third degree of chin
 - T20.73XA initial encounter
 - T20.73XD subsequent encounter
 - T20.73XS sequela
- T20.74 Corrosion of third degree of nose (septum)
 - T20.74XA initial encounter
 - T20.74XD subsequent encounter
 - T20.74XS sequela
- T20.75 Corrosion of third degree of scalp [any part]
 - T20.75XA initial encounter
 - T20.75XD subsequent encounter
 - T20.75XS sequela
- T20.76 Corrosion of third degree of forehead and cheek
 - T20.76XA initial encounter
 - T20.76XD subsequent encounter
 - T20.76XS sequela
- T20.77 Corrosion of third degree of neck
 - T20.77XA initial encounter
 - T20.77XD subsequent encounter
 - T20.77XS sequela
- T20.79 Corrosion of third degree of multiple sites of head, face, and neck
 - T20.79XA initial encounter
 - T20.79XD subsequent encounter
 - T20.79XS sequela

- T21 Burn and corrosion of trunk
 - T21.0 Burn of unspecified degree of trunk

- T21.00 Burn of unspecified degree of trunk, unspecified site
 - T21.00XA initial encounter
 - T21.00XD subsequent encounter
 - T21.00XS sequela
- T21.01 Burn of unspecified degree of chest wall
 - T21.01XA initial encounter
 - T21.01XD subsequent encounter
 - T21.01XS sequela
- T21.02 Burn of unspecified degree of abdominal wall
 - T21.02XA initial encounter
 - T21.02XD subsequent encounter
 - T21.02XS sequela
- T21.03 Burn of unspecified degree of upper back
 - T21.03XA initial encounter
 - T21.03XD subsequent encounter
 - T21.03XS sequela
- T21.04 Burn of unspecified degree of lower back
 - T21.04XA initial encounter
 - T21.04XD subsequent encounter
 - T21.04XS sequela
- T21.05 Burn of unspecified degree of buttock
 - T21.05XA initial encounter
 - T21.05XD subsequent encounter
 - T21.05XS sequela
- T21.06 Burn of unspecified degree of male genital region
 - T21.06XA initial encounter
 - T21.06XD subsequent encounter
 - T21.06XS sequela
- T21.07 Burn of unspecified degree of female genital region
 - T21.07XA initial encounter
 - T21.07XD subsequent encounter
 - T21.07XS sequela

- T21.09 Burn of unspecified degree of other site of trunk
 - T21.09XA initial encounter
 - T21.09XD subsequent encounter
 - T21.09XS sequela
- T21.1 Burn of first degree of trunk
 - T21.10 Burn of first degree of trunk, unspecified site
 - T21.10XA initial encounter
 - T21.10XD subsequent encounter
 - T21.10XS sequela
 - T21.11 Burn of first degree of chest wall
 - T21.11XA initial encounter
 - T21.11XD subsequent encounter
 - T21.11XS sequela
 - T21.12 Burn of first degree of abdominal wall
 - T21.12XA initial encounter
 - T21.12XD subsequent encounter
 - T21.12XS sequela
 - T21.13 Burn of first degree of upper back
 - T21.13XA initial encounter
 - T21.13XD subsequent encounter
 - T21.13XS sequela
 - T21.14 Burn of first degree of lower back
 - T21.14XA initial encounter
 - T21.14XD subsequent encounter
 - T21.14XS sequela
 - T21.15 Burn of first degree of buttock
 - T21.15XA initial encounter
 - T21.15XD subsequent encounter
 - T21.15XS sequela
 - T21.16 Burn of first degree of male genital region
 - T21.16XA initial encounter
 - T21.16XD subsequent encounter

- T21.16XS sequela
- T21.17 Burn of first degree of female genital region
 - T21.17XA initial encounter
 - T21.17XD subsequent encounter
 - T21.17XS sequela
- T21.19 Burn of first degree of other site of trunk
 - T21.19XA initial encounter
 - T21.19XD subsequent encounter
 - T21.19XS sequela
- T21.2 Burn of second degree of trunk
 - T21.20 Burn of second degree of trunk, unspecified site
 - T21.20XA initial encounter
 - T21.20XD subsequent encounter
 - T21.20XS sequela
 - T21.21 Burn of second degree of chest wall
 - T21.21XA initial encounter
 - T21.21XD subsequent encounter
 - T21.21XS sequela
 - T21.22 Burn of second degree of abdominal wall
 - T21.22XA initial encounter
 - T21.22XD subsequent encounter
 - T21.22XS sequela
 - T21.23 Burn of second degree of upper back
 - T21.23XA initial encounter
 - T21.23XD subsequent encounter
 - T21.23XS sequela
 - T21.24 Burn of second degree of lower back
 - T21.24XA initial encounter
 - T21.24XD subsequent encounter
 - T21.24XS sequela
 - T21.25 Burn of second degree of buttock
 - T21.25XA initial encounter

- T21.25XD subsequent encounter
- T21.25XS sequela
- T21.26 Burn of second degree of male genital region
 - T21.26XA initial encounter
 - T21.26XD subsequent encounter
 - T21.26XS sequela
- T21.27 Burn of second degree of female genital region
 - T21.27XA initial encounter
 - T21.27XD subsequent encounter
 - T21.27XS sequela
- T21.29 Burn of second degree of other site of trunk
 - T21.29XA initial encounter
 - T21.29XD subsequent encounter
 - T21.29XS sequela
- T21.3 Burn of third degree of trunk
 - T21.30 Burn of third degree of trunk, unspecified site
 - T21.30XA initial encounter
 - T21.30XD subsequent encounter
 - T21.30XS sequela
 - T21.31 Burn of third degree of chest wall
 - T21.31XA initial encounter
 - T21.31XD subsequent encounter
 - T21.31XS sequela
 - T21.32 Burn of third degree of abdominal wall
 - T21.32XA initial encounter
 - T21.32XD subsequent encounter
 - T21.32XS sequela
 - T21.33 Burn of third degree of upper back
 - T21.33XA initial encounter
 - T21.33XD subsequent encounter
 - T21.33XS sequela
 - T21.34 Burn of third degree of lower back

- T21.34XA initial encounter
- T21.34XD subsequent encounter
- T21.34XS sequela
- T21.35 Burn of third degree of buttock
 - T21.35XA initial encounter
 - T21.35XD subsequent encounter
 - T21.35XS sequela
- T21.36 Burn of third degree of male genital region
 - T21.36XA initial encounter
 - T21.36XD subsequent encounter
 - T21.36XS sequela
- T21.37 Burn of third degree of female genital region
 - T21.37XA initial encounter
 - T21.37XD subsequent encounter
 - T21.37XS sequela
- T21.39 Burn of third degree of other site of trunk
 - T21.39XA initial encounter
 - T21.39XD subsequent encounter
 - T21.39XS sequela
- T21.4 Corrosion of unspecified degree of trunk
 - T21.40 Corrosion of unspecified degree of trunk, unspecified site
 - T21.40XA initial encounter
 - T21.40XD subsequent encounter
 - T21.40XS sequela
 - T21.41 Corrosion of unspecified degree of chest wall
 - T21.41XA initial encounter
 - T21.41XD subsequent encounter
 - T21.41XS sequela
 - T21.42 Corrosion of unspecified degree of abdominal wall
 - T21.42XA initial encounter
 - T21.42XD subsequent encounter
 - T21.42XS sequela

- T21.43 Corrosion of unspecified degree of upper back
 - T21.43XA initial encounter
 - T21.43XD subsequent encounter
 - T21.43XS sequela
- T21.44 Corrosion of unspecified degree of lower back
 - T21.44XA initial encounter
 - T21.44XD subsequent encounter
 - T21.44XS sequela
- T21.45 Corrosion of unspecified degree of buttock
 - T21.45XA initial encounter
 - T21.45XD subsequent encounter
 - T21.45XS sequela
- T21.46 Corrosion of unspecified degree of male genital region
 - T21.46XA initial encounter
 - T21.46XD subsequent encounter
 - T21.46XS sequela
- T21.47 Corrosion of unspecified degree of female genital region
 - T21.47XA initial encounter
 - T21.47XD subsequent encounter
 - T21.47XS sequela
- T21.49 Corrosion of unspecified degree of other site of trunk
 - T21.49XA initial encounter
 - T21.49XD subsequent encounter
 - T21.49XS sequela
- T21.5 Corrosion of first degree of trunk
 - T21.50 Corrosion of first degree of trunk, unspecified site
 - T21.50XA initial encounter
 - T21.50XD subsequent encounter
 - T21.50XS sequela
 - T21.51 Corrosion of first degree of chest wall
 - T21.51XA initial encounter
 - T21.51XD subsequent encounter

- T21.51XS sequela
- T21.52 Corrosion of first degree of abdominal wall
 - T21.52XA initial encounter
 - T21.52XD subsequent encounter
 - T21.52XS sequela
- T21.53 Corrosion of first degree of upper back
 - T21.53XA initial encounter
 - T21.53XD subsequent encounter
 - T21.53XS sequela
- T21.54 Corrosion of first degree of lower back
 - T21.54XA initial encounter
 - T21.54XD subsequent encounter
 - T21.54XS sequela
- T21.55 Corrosion of first degree of buttock
 - T21.55XA initial encounter
 - T21.55XD subsequent encounter
 - T21.55XS sequela
- T21.56 Corrosion of first degree of male genital region
 - T21.56XA initial encounter
 - T21.56XD subsequent encounter
 - T21.56XS sequela
- T21.57 Corrosion of first degree of female genital region
 - T21.57XA initial encounter
 - T21.57XD subsequent encounter
 - T21.57XS sequela
- T21.59 Corrosion of first degree of other site of trunk
 - T21.59XA initial encounter
 - T21.59XD subsequent encounter
 - T21.59XS sequela
- T21.6 Corrosion of second degree of trunk
 - T21.60 Corrosion of second degree of trunk, unspecified site
 - T21.60XA initial encounter

- T21.60XD subsequent encounter
- T21.60XS sequela
- T21.61 Corrosion of second degree of chest wall
 - T21.61XA initial encounter
 - T21.61XD subsequent encounter
 - T21.61XS sequela
- T21.62 Corrosion of second degree of abdominal wall
 - T21.62XA initial encounter
 - T21.62XD subsequent encounter
 - T21.62XS sequela
- T21.63 Corrosion of second degree of upper back
 - T21.63XA initial encounter
 - T21.63XD subsequent encounter
 - T21.63XS sequela
- T21.64 Corrosion of second degree of lower back
 - T21.64XA initial encounter
 - T21.64XD subsequent encounter
 - T21.64XS sequela
- T21.65 Corrosion of second degree of buttock
 - T21.65XA initial encounter
 - T21.65XD subsequent encounter
 - T21.65XS sequela
- T21.66 Corrosion of second degree of male genital region
 - T21.66XA initial encounter
 - T21.66XD subsequent encounter
 - T21.66XS sequela
- T21.67 Corrosion of second degree of female genital region
 - T21.67XA initial encounter
 - T21.67XD subsequent encounter
 - T21.67XS sequela
- T21.69 Corrosion of second degree of other site of trunk
 - T21.69XA initial encounter

- T21.69XD subsequent encounter
- T21.69XS sequela
- T21.7 Corrosion of third degree of trunk
 - T21.70 Corrosion of third degree of trunk, unspecified site
 - T21.70XA initial encounter
 - T21.70XD subsequent encounter
 - T21.70XS sequela
 - T21.71 Corrosion of third degree of chest wall
 - T21.71XA initial encounter
 - T21.71XD subsequent encounter
 - T21.71XS sequela
 - T21.72 Corrosion of third degree of abdominal wall
 - T21.72XA initial encounter
 - T21.72XD subsequent encounter
 - T21.72XS sequela
 - T21.73 Corrosion of third degree of upper back
 - T21.73XA initial encounter
 - T21.73XD subsequent encounter
 - T21.73XS sequela
 - T21.74 Corrosion of third degree of lower back
 - T21.74XA initial encounter
 - T21.74XD subsequent encounter
 - T21.74XS sequela
 - T21.75 Corrosion of third degree of buttock
 - T21.75XA initial encounter
 - T21.75XD subsequent encounter
 - T21.75XS sequela
 - T21.76 Corrosion of third degree of male genital region
 - T21.76XA initial encounter
 - T21.76XD subsequent encounter
 - T21.76XS sequela
 - T21.77 Corrosion of third degree of female genital region

- T21.77XA initial encounter
- T21.77XD subsequent encounter
- T21.77XS sequela
- T21.79 Corrosion of third degree of other site of trunk
- T21.79XA initial encounter
- T21.79XD subsequent encounter
- T21.79XS sequela

- T22.0 Burn of unspecified degree of shoulder and upper limb, except wrist and hand
 - T22.00 Burn of unspecified degree of shoulder and upper limb, except wrist and hand, unspecified site
 - T22.00XA initial encounter
 - T22.00XD subsequent encounter
 - T22.00XS sequela
 - T22.01 Burn of unspecified degree of forearm
 - T22.011 Burn of unspecified degree of right forearm
 - T22.011A initial encounter
 - T22.011D subsequent encounter
 - T22.011S sequela
 - T22.012 Burn of unspecified degree of left forearm
 - T22.012A initial encounter
 - T22.012D subsequent encounter
 - T22.012S sequela
 - T22.019 Burn of unspecified degree of unspecified forearm
 - T22.019A initial encounter
 - T22.019D subsequent encounter
 - T22.019S sequela
 - T22.02 Burn of unspecified degree of elbow
 - T22.021 Burn of unspecified degree of right elbow
 - T22.021A initial encounter
 - T22.021D subsequent encounter
 - T22.021S sequela
 - T22.022 Burn of unspecified degree of left elbow

- T22.022A initial encounter
- T22.022D subsequent encounter
- T22.022S sequela
- T22.029 Burn of unspecified degree of unspecified elbow
- T22.029A initial encounter
- T22.029D subsequent encounter
- T22.029S sequela
- T22.03 Burn of unspecified degree of upper arm
 - T22.031 Burn of unspecified degree of right upper arm
 - T22.031A initial encounter
 - T22.031D subsequent encounter
 - T22.031S sequela
 - T22.032 Burn of unspecified degree of left upper arm
 - T22.032A initial encounter
 - T22.032D subsequent encounter
 - T22.032S sequela
 - T22.039 Burn of unspecified degree of unspecified upper arm
 - T22.039A initial encounter
 - T22.039D subsequent encounter
 - T22.039S sequela
- T22.04 Burn of unspecified degree of axilla
 - T22.041 Burn of unspecified degree of right axilla
 - T22.041A initial encounter
 - T22.041D subsequent encounter
 - T22.041S sequela
 - T22.042 Burn of unspecified degree of left axilla
 - T22.042A initial encounter
 - T22.042D subsequent encounter
 - T22.042S sequela
 - T22.049 Burn of unspecified degree of unspecified axilla
 - T22.049A initial encounter
 - T22.049D subsequent encounter

- T22.049S sequela
- T22.05 Burn of unspecified degree of shoulder
 - T22.051 Burn of unspecified degree of right shoulder
 - T22.051A initial encounter
 - T22.051D subsequent encounter
 - T22.051S sequela
 - T22.052 Burn of unspecified degree of left shoulder
 - T22.052A initial encounter
 - T22.052D subsequent encounter
 - T22.052S sequela
 - T22.059 Burn of unspecified degree of unspecified shoulder
 - T22.059A initial encounter
 - T22.059D subsequent encounter
 - T22.059S sequela
- T22.06 Burn of unspecified degree of scapular region
 - T22.061 Burn of unspecified degree of right scapular region
 - T22.061A initial encounter
 - T22.061D subsequent encounter
 - T22.061S sequela
 - T22.062 Burn of unspecified degree of left scapular region
 - T22.062A initial encounter
 - T22.062D subsequent encounter
 - T22.062S sequela
 - T22.069 Burn of unspecified degree of unspecified scapular region
 - T22.069A initial encounter
 - T22.069D subsequent encounter
 - T22.069S sequela
- T22.09 Burn of unspecified degree of multiple sites of shoulder and upper limb, except wrist and hand
 - T22.091 Burn of unspecified degree of multiple sites of right shoulder and upper limb, except wrist and hand
 - T22.091A initial encounter
 - T22.091D subsequent encounter

- T22.091S sequela
- T22.092 Burn of unspecified degree of multiple sites of left shoulder and upper limb, except wrist and hand
- T22.092A initial encounter
- T22.092D subsequent encounter
- T22.092S sequela
- T22.099 Burn of unspecified degree of multiple sites of unspecified shoulder and upper limb, except wrist and hand
- T22.099A initial encounter
- T22.099D subsequent encounter
- T22.099S sequela

- T22.1 Burn of first degree of shoulder and upper limb, except wrist and hand
 - T22.10 Burn of first degree of shoulder and upper limb, except wrist and hand, unspecified site
 - T22.10XA initial encounter
 - T22.10XD subsequent encounter
 - T22.10XS sequela
 - T22.11 Burn of first degree of forearm
 - T22.111 Burn of first degree of right forearm
 - T22.111A initial encounter
 - T22.111D subsequent encounter
 - T22.111S sequela
 - T22.112 Burn of first degree of left forearm
 - T22.112A initial encounter
 - T22.112D subsequent encounter
 - T22.112S sequela
 - T22.119 Burn of first degree of unspecified forearm
 - T22.119A initial encounter
 - T22.119D subsequent encounter
 - T22.119S sequela
 - T22.12 Burn of first degree of elbow
 - T22.121 Burn of first degree of right elbow

- T22.121A initial encounter
- T22.121D subsequent encounter
- T22.121S sequela
- T22.122 Burn of first degree of left elbow
 - T22.122A initial encounter
 - T22.122D subsequent encounter
 - T22.122S sequela
- T22.129 Burn of first degree of unspecified elbow
 - T22.129A initial encounter
 - T22.129D subsequent encounter
 - T22.129S sequela
- T22.13 Burn of first degree of upper arm
 - T22.131 Burn of first degree of right upper arm
 - T22.131A initial encounter
 - T22.131D subsequent encounter
 - T22.131S sequela
 - T22.132 Burn of first degree of left upper arm
 - T22.132A initial encounter
 - T22.132D subsequent encounter
 - T22.132S sequela
 - T22.139 Burn of first degree of unspecified upper arm
 - T22.139A initial encounter
 - T22.139D subsequent encounter
 - T22.139S sequela
- T22.14 Burn of first degree of axilla
 - T22.141 Burn of first degree of right axilla
 - T22.141A initial encounter
 - T22.141D subsequent encounter
 - T22.141S sequela
 - T22.142 Burn of first degree of left axilla
 - T22.142A initial encounter
 - T22.142D subsequent encounter

- T22.142S sequela
- T22.149 Burn of first degree of unspecified axilla
- T22.149A initial encounter
- T22.149D subsequent encounter
- T22.149S sequela
- T22.15 Burn of first degree of shoulder
 - T22.151 Burn of first degree of right shoulder
 - T22.151A initial encounter
 - T22.151D subsequent encounter
 - T22.151S sequela
 - T22.152 Burn of first degree of left shoulder
 - T22.152A initial encounter
 - T22.152D subsequent encounter
 - T22.152S sequela
 - T22.159 Burn of first degree of unspecified shoulder
 - T22.159A initial encounter
 - T22.159D subsequent encounter
 - T22.159S sequela
- T22.16 Burn of first degree of scapular region
 - T22.161 Burn of first degree of right scapular region
 - T22.161A initial encounter
 - T22.161D subsequent encounter
 - T22.161S sequela
 - T22.162 Burn of first degree of left scapular region
 - T22.162A initial encounter
 - T22.162D subsequent encounter
 - T22.162S sequela
 - T22.169 Burn of first degree of unspecified scapular region
 - T22.169A initial encounter
 - T22.169D subsequent encounter
 - T22.169S sequela
- T22.19 Burn of first degree of multiple sites of shoulder and upper limb, except wrist and hand

- T22.191 Burn of first degree of multiple sites of right shoulder and upper limb, except wrist and hand
 - T22.191A initial encounter
 - T22.191D subsequent encounter
 - T22.191S sequela
- T22.192 Burn of first degree of multiple sites of left shoulder and upper limb, except wrist and hand
 - T22.192A initial encounter
 - T22.192D subsequent encounter
 - T22.192S sequela
- T22.199 Burn of first degree of multiple sites of unspecified shoulder and upper limb, except wrist and hand
 - T22.199A initial encounter
 - T22.199D subsequent encounter
 - T22.199S sequela
- T22.2 Burn of second degree of shoulder and upper limb, except wrist and hand
 - T22.20 Burn of second degree of shoulder and upper limb, except wrist and hand, unspecified site
 - T22.20XA initial encounter
 - T22.20XD subsequent encounter
 - T22.20XS sequela
 - T22.21 Burn of second degree of forearm
 - T22.211 Burn of second degree of right forearm
 - T22.211A initial encounter
 - T22.211D subsequent encounter
 - T22.211S sequela
 - T22.212 Burn of second degree of left forearm
 - T22.212A initial encounter
 - T22.212D subsequent encounter
 - T22.212S sequela
 - T22.219 Burn of second degree of unspecified forearm
 - T22.219A initial encounter
 - T22.219D subsequent encounter

- T22.219S sequela
- T22.22 Burn of second degree of elbow
 - T22.221 Burn of second degree of right elbow
 - T22.221A initial encounter
 - T22.221D subsequent encounter
 - T22.221S sequela
 - T22.222 Burn of second degree of left elbow
 - T22.222A initial encounter
 - T22.222D subsequent encounter
 - T22.222S sequela
 - T22.229 Burn of second degree of unspecified elbow
 - T22.229A initial encounter
 - T22.229D subsequent encounter
 - T22.229S sequela
- T22.23 Burn of second degree of upper arm
 - T22.231 Burn of second degree of right upper arm
 - T22.231A initial encounter
 - T22.231D subsequent encounter
 - T22.231S sequela
 - T22.232 Burn of second degree of left upper arm
 - T22.232A initial encounter
 - T22.232D subsequent encounter
 - T22.232S sequela
 - T22.239 Burn of second degree of unspecified upper arm
 - T22.239A initial encounter
 - T22.239D subsequent encounter
 - T22.239S sequela
- T22.24 Burn of second degree of axilla
 - T22.241 Burn of second degree of right axilla
 - T22.241A initial encounter
 - T22.241D subsequent encounter
 - T22.241S sequela

- T22.242 Burn of second degree of left axilla
 - T22.242A initial encounter
 - T22.242D subsequent encounter
 - T22.242S sequela
- T22.249 Burn of second degree of unspecified axilla
 - T22.249A initial encounter
 - T22.249D subsequent encounter
 - T22.249S sequela
- T22.25 Burn of second degree of shoulder
 - T22.251 Burn of second degree of right shoulder
 - T22.251A initial encounter
 - T22.251D subsequent encounter
 - T22.251S sequela
 - T22.252 Burn of second degree of left shoulder
 - T22.252A initial encounter
 - T22.252D subsequent encounter
 - T22.252S sequela
 - T22.259 Burn of second degree of unspecified shoulder
 - T22.259A initial encounter
 - T22.259D subsequent encounter
 - T22.259S sequela
- T22.26 Burn of second degree of scapular region
 - T22.261 Burn of second degree of right scapular region
 - T22.261A initial encounter
 - T22.261D subsequent encounter
 - T22.261S sequela
 - T22.262 Burn of second degree of left scapular region
 - T22.262A initial encounter
 - T22.262D subsequent encounter
 - T22.262S sequela
 - T22.269 Burn of second degree of unspecified scapular region
 - T22.269A initial encounter

- T22.269D subsequent encounter
- T22.269S sequela
- T22.29 Burn of second degree of multiple sites of shoulder and upper limb, except wrist and hand
 - T22.291 Burn of second degree of multiple sites of right shoulder and upper limb, except wrist and hand
 - T22.291A initial encounter
 - T22.291D subsequent encounter
 - T22.291S sequela
 - T22.292 Burn of second degree of multiple sites of left shoulder and upper limb, except wrist and hand
 - T22.292A initial encounter
 - T22.292D subsequent encounter
 - T22.292S sequela
 - T22.299 Burn of second degree of multiple sites of unspecified shoulder and upper limb, except wrist and hand
 - T22.299A initial encounter
 - T22.299D subsequent encounter
 - T22.299S sequela
- T22.3 Burn of third degree of shoulder and upper limb, except wrist and hand
 - T22.30 Burn of third degree of shoulder and upper limb, except wrist and hand, unspecified site
 - T22.30XA initial encounter
 - T22.30XD subsequent encounter
 - T22.30XS sequela
 - T22.31 Burn of third degree of forearm
 - T22.311 Burn of third degree of right forearm
 - T22.311A initial encounter
 - T22.311D subsequent encounter
 - T22.311S sequela
 - T22.312 Burn of third degree of left forearm
 - T22.312A initial encounter
 - T22.312D subsequent encounter

- T22.312S sequela
- T22.319 Burn of third degree of unspecified forearm
- T22.319A initial encounter
- T22.319D subsequent encounter
- T22.319S sequela
- T22.32 Burn of third degree of elbow
 - T22.321 Burn of third degree of right elbow
 - T22.321A initial encounter
 - T22.321D subsequent encounter
 - T22.321S sequela
 - T22.322 Burn of third degree of left elbow
 - T22.322A initial encounter
 - T22.322D subsequent encounter
 - T22.322S sequela
 - T22.329 Burn of third degree of unspecified elbow
 - T22.329A initial encounter
 - T22.329D subsequent encounter
 - T22.329S sequela
- T22.33 Burn of third degree of upper arm
 - T22.331 Burn of third degree of right upper arm
 - T22.331A initial encounter
 - T22.331D subsequent encounter
 - T22.331S sequela
 - T22.332 Burn of third degree of left upper arm
 - T22.332A initial encounter
 - T22.332D subsequent encounter
 - T22.332S sequela
 - T22.339 Burn of third degree of unspecified upper arm
 - T22.339A initial encounter
 - T22.339D subsequent encounter
 - T22.339S sequela
- T22.34 Burn of third degree of axilla

- T22.341 Burn of third degree of right axilla
 - T22.341A initial encounter
 - T22.341D subsequent encounter
 - T22.341S sequela
- T22.342 Burn of third degree of left axilla
 - T22.342A initial encounter
 - T22.342D subsequent encounter
 - T22.342S sequela
- T22.349 Burn of third degree of unspecified axilla
 - T22.349A initial encounter
 - T22.349D subsequent encounter
 - T22.349S sequela
- T22.35 Burn of third degree of shoulder
 - T22.351 Burn of third degree of right shoulder
 - T22.351A initial encounter
 - T22.351D subsequent encounter
 - T22.351S sequela
 - T22.352 Burn of third degree of left shoulder
 - T22.352A initial encounter
 - T22.352D subsequent encounter
 - T22.352S sequela
 - T22.359 Burn of third degree of unspecified shoulder
 - T22.359A initial encounter
 - T22.359D subsequent encounter
 - T22.359S sequela
- T22.36 Burn of third degree of scapular region
 - T22.361 Burn of third degree of right scapular region
 - T22.361A initial encounter
 - T22.361D subsequent encounter
 - T22.361S sequela
 - T22.362 Burn of third degree of left scapular region
 - T22.362A initial encounter

- T22.362D subsequent encounter
- T22.362S sequela
- T22.369 Burn of third degree of unspecified scapular region
 - T22.369A initial encounter
 - T22.369D subsequent encounter
 - T22.369S sequela
- T22.39 Burn of third degree of multiple sites of shoulder and upper limb, except wrist and hand
 - T22.391 Burn of third degree of multiple sites of right shoulder and upper limb, except wrist and hand
 - T22.391A initial encounter
 - T22.391D subsequent encounter
 - T22.391S sequela
 - T22.392 Burn of third degree of multiple sites of left shoulder and upper limb, except wrist and hand
 - T22.392A initial encounter
 - T22.392D subsequent encounter
 - T22.392S sequela
 - T22.399 Burn of third degree of multiple sites of unspecified shoulder and upper limb, except wrist and hand
 - T22.399A initial encounter
 - T22.399D subsequent encounter
 - T22.399S sequela
- T22.4 Corrosion of unspecified degree of shoulder and upper limb, except wrist and hand
 - T22.40 Corrosion of unspecified degree of shoulder and upper limb, except wrist and hand, unspecified site
 - T22.40XA initial encounter
 - T22.40XD subsequent encounter
 - T22.40XS sequela
 - T22.41 Corrosion of unspecified degree of forearm
 - T22.411 Corrosion of unspecified degree of right forearm
 - T22.411A initial encounter
 - T22.411D subsequent encounter

- T22.411S sequela
- T22.412 Corrosion of unspecified degree of left forearm
 - T22.412A initial encounter
 - T22.412D subsequent encounter
 - T22.412S sequela
- T22.419 Corrosion of unspecified degree of unspecified forearm
 - T22.419A initial encounter
 - T22.419D subsequent encounter
 - T22.419S sequela
- T22.42 Corrosion of unspecified degree of elbow
 - T22.421 Corrosion of unspecified degree of right elbow
 - T22.421A initial encounter
 - T22.421D subsequent encounter
 - T22.421S sequela
 - T22.422 Corrosion of unspecified degree of left elbow
 - T22.422A initial encounter
 - T22.422D subsequent encounter
 - T22.422S sequela
 - T22.429 Corrosion of unspecified degree of unspecified elbow
 - T22.429A initial encounter
 - T22.429D subsequent encounter
 - T22.429S sequela
- T22.43 Corrosion of unspecified degree of upper arm
 - T22.431 Corrosion of unspecified degree of right upper arm
 - T22.431A initial encounter
 - T22.431D subsequent encounter
 - T22.431S sequela
 - T22.432 Corrosion of unspecified degree of left upper arm
 - T22.432A initial encounter
 - T22.432D subsequent encounter
 - T22.432S sequela
 - T22.439 Corrosion of unspecified degree of unspecified upper arm

- T22.439A initial encounter
- T22.439D subsequent encounter
- T22.439S sequela
- T22.44 Corrosion of unspecified degree of axilla
 - T22.441 Corrosion of unspecified degree of right axilla
 - T22.441A initial encounter
 - T22.441D subsequent encounter
 - T22.441S sequela
 - T22.442 Corrosion of unspecified degree of left axilla
 - T22.442A initial encounter
 - T22.442D subsequent encounter
 - T22.442S sequela
 - T22.449 Corrosion of unspecified degree of unspecified axilla
 - T22.449A initial encounter
 - T22.449D subsequent encounter
 - T22.449S sequela
- T22.45 Corrosion of unspecified degree of shoulder
 - T22.451 Corrosion of unspecified degree of right shoulder
 - T22.451A initial encounter
 - T22.451D subsequent encounter
 - T22.451S sequela
 - T22.452 Corrosion of unspecified degree of left shoulder
 - T22.452A initial encounter
 - T22.452D subsequent encounter
 - T22.452S sequela
 - T22.459 Corrosion of unspecified degree of unspecified shoulder
 - T22.459A initial encounter
 - T22.459D subsequent encounter
 - T22.459S sequela
- T22.46 Corrosion of unspecified degree of scapular region
 - T22.461 Corrosion of unspecified degree of right scapular region
 - T22.461A initial encounter

- T22.461D subsequent encounter
- T22.461S sequela
- T22.462 Corrosion of unspecified degree of left scapular region
 - T22.462A initial encounter
 - T22.462D subsequent encounter
 - T22.462S sequela
- T22.469 Corrosion of unspecified degree of unspecified scapular region
 - T22.469A initial encounter
 - T22.469D subsequent encounter
 - T22.469S sequela
- T22.49 Corrosion of unspecified degree of multiple sites of shoulder and upper limb, except wrist and hand
 - T22.491 Corrosion of unspecified degree of multiple sites of right shoulder and upper limb, except wrist and hand
 - T22.491A initial encounter
 - T22.491D subsequent encounter
 - T22.491S sequela
 - T22.492 Corrosion of unspecified degree of multiple sites of left shoulder and upper limb, except wrist and hand
 - T22.492A initial encounter
 - T22.492D subsequent encounter
 - T22.492S sequela
 - T22.499 Corrosion of unspecified degree of multiple sites of unspecified shoulder and upper limb, except wrist and hand
 - T22.499A initial encounter
 - T22.499D subsequent encounter
 - T22.499S sequela
- T22.5 Corrosion of first degree of shoulder and upper limb, except wrist and hand
 - T22.50 Corrosion of first degree of shoulder and upper limb, except wrist and hand unspecified site
 - T22.50XA initial encounter
 - T22.50XD subsequent encounter
 - T22.50XS sequela

- T22.51 Corrosion of first degree of forearm
 - T22.511 Corrosion of first degree of right forearm
 - T22.511A initial encounter
 - T22.511D subsequent encounter
 - T22.511S sequela
 - T22.512 Corrosion of first degree of left forearm
 - T22.512A initial encounter
 - T22.512D subsequent encounter
 - T22.512S sequela
 - T22.519 Corrosion of first degree of unspecified forearm
 - T22.519A initial encounter
 - T22.519D subsequent encounter
 - T22.519S sequela
- T22.52 Corrosion of first degree of elbow
 - T22.521 Corrosion of first degree of right elbow
 - T22.521A initial encounter
 - T22.521D subsequent encounter
 - T22.521S sequela
 - T22.522 Corrosion of first degree of left elbow
 - T22.522A initial encounter
 - T22.522D subsequent encounter
 - T22.522S sequela
 - T22.529 Corrosion of first degree of unspecified elbow
 - T22.529A initial encounter
 - T22.529D subsequent encounter
 - T22.529S sequela
- T22.53 Corrosion of first degree of upper arm
 - T22.531 Corrosion of first degree of right upper arm
 - T22.531A initial encounter
 - T22.531D subsequent encounter
 - T22.531S sequela
 - T22.532 Corrosion of first degree of left upper arm

- T22.532A initial encounter
- T22.532D subsequent encounter
- T22.532S sequela
- T22.539 Corrosion of first degree of unspecified upper arm
- T22.539A initial encounter
- T22.539D subsequent encounter
- T22.539S sequela
- T22.54 Corrosion of first degree of axilla
 - T22.541 Corrosion of first degree of right axilla
 - T22.541A initial encounter
 - T22.541D subsequent encounter
 - T22.541S sequela
 - T22.542 Corrosion of first degree of left axilla
 - T22.542A initial encounter
 - T22.542D subsequent encounter
 - T22.542S sequela
 - T22.549 Corrosion of first degree of unspecified axilla
 - T22.549A initial encounter
 - T22.549D subsequent encounter
 - T22.549S sequela
- T22.55 Corrosion of first degree of shoulder
 - T22.551 Corrosion of first degree of right shoulder
 - T22.551A initial encounter
 - T22.551D subsequent encounter
 - T22.551S sequela
 - T22.552 Corrosion of first degree of left shoulder
 - T22.552A initial encounter
 - T22.552D subsequent encounter
 - T22.552S sequela
 - T22.559 Corrosion of first degree of unspecified shoulder
 - T22.559A initial encounter
 - T22.559D subsequent encounter

- T22.559S sequela
- T22.56 Corrosion of first degree of scapular region
 - T22.561 Corrosion of first degree of right scapular region
 - T22.561A initial encounter
 - T22.561D subsequent encounter
 - T22.561S sequela
 - T22.562 Corrosion of first degree of left scapular region
 - T22.562A initial encounter
 - T22.562D subsequent encounter
 - T22.562S sequela
 - T22.569 Corrosion of first degree of unspecified scapular region
 - T22.569A initial encounter
 - T22.569D subsequent encounter
 - T22.569S sequela
- T22.59 Corrosion of first degree of multiple sites of shoulder and upper limb, except wrist and hand
 - T22.591 Corrosion of first degree of multiple sites of right shoulder and upper limb, except wrist and hand
 - T22.591A initial encounter
 - T22.591D subsequent encounter
 - T22.591S sequela
 - T22.592 Corrosion of first degree of multiple sites of left shoulder and upper limb, except wrist and hand
 - T22.592A initial encounter
 - T22.592D subsequent encounter
 - T22.592S sequela
 - T22.599 Corrosion of first degree of multiple sites of unspecified shoulder and upper limb, except wrist and hand
 - T22.599A initial encounter
 - T22.599D subsequent encounter
 - T22.599S sequela
- T22.6 Corrosion of second degree of shoulder and upper limb, except wrist and hand

- T22.60 Corrosion of second degree of shoulder and upper limb, except wrist and hand, unspecified site
 - T22.60XA initial encounter
 - T22.60XD subsequent encounter
 - T22.60XS sequela
- T22.61 Corrosion of second degree of forearm
 - T22.611 Corrosion of second degree of right forearm
 - T22.611A initial encounter
 - T22.611D subsequent encounter
 - T22.611S sequela
 - T22.612 Corrosion of second degree of left forearm
 - T22.612A initial encounter
 - T22.612D subsequent encounter
 - T22.612S sequela
 - T22.619 Corrosion of second degree of unspecified forearm
 - T22.619A initial encounter
 - T22.619D subsequent encounter
 - T22.619S sequela
- T22.62 Corrosion of second degree of elbow
 - T22.621 Corrosion of second degree of right elbow
 - T22.621A initial encounter
 - T22.621D subsequent encounter
 - T22.621S sequela
 - T22.622 Corrosion of second degree of left elbow
 - T22.622A initial encounter
 - T22.622D subsequent encounter
 - T22.622S sequela
 - T22.629 Corrosion of second degree of unspecified elbow
 - T22.629A initial encounter
 - T22.629D subsequent encounter
 - T22.629S sequela
- T22.63 Corrosion of second degree of upper arm
 - T22.631 Corrosion of second degree of right upper arm

- T22.631A initial encounter
- T22.631D subsequent encounter
- T22.631S sequela
- T22.632 Corrosion of second degree of left upper arm
 - T22.632A initial encounter
 - T22.632D subsequent encounter
 - T22.632S sequela
- T22.639 Corrosion of second degree of unspecified upper arm
 - T22.639A initial encounter
 - T22.639D subsequent encounter
 - T22.639S sequela
- T22.64 Corrosion of second degree of axilla
 - T22.641 Corrosion of second degree of right axilla
 - T22.641A initial encounter
 - T22.641D subsequent encounter
 - T22.641S sequela
 - T22.642 Corrosion of second degree of left axilla
 - T22.642A initial encounter
 - T22.642D subsequent encounter
 - T22.642S sequela
 - T22.649 Corrosion of second degree of unspecified axilla
 - T22.649A initial encounter
 - T22.649D subsequent encounter
 - T22.649S sequela
- T22.65 Corrosion of second degree of shoulder
 - T22.651 Corrosion of second degree of right shoulder
 - T22.651A initial encounter
 - T22.651D subsequent encounter
 - T22.651S sequela
 - T22.652 Corrosion of second degree of left shoulder
 - T22.652A initial encounter
 - T22.652D subsequent encounter

- T22.652S sequela
- T22.659 Corrosion of second degree of unspecified shoulder
- T22.659A initial encounter
- T22.659D subsequent encounter
- T22.659S sequela
- T22.66 Corrosion of second degree of scapular region
 - T22.661 Corrosion of second degree of right scapular region
 - T22.661A initial encounter
 - T22.661D subsequent encounter
 - T22.661S sequela
 - T22.662 Corrosion of second degree of left scapular region
 - T22.662A initial encounter
 - T22.662D subsequent encounter
 - T22.662S sequela
 - T22.669 Corrosion of second degree of unspecified scapular region
 - T22.669A initial encounter
 - T22.669D subsequent encounter
 - T22.669S sequela
- T22.69 Corrosion of second degree of multiple sites of shoulder and upper limb, except wrist and hand
 - T22.691 Corrosion of second degree of multiple sites of right shoulder and upper limb, except wrist and hand
 - T22.691A initial encounter
 - T22.691D subsequent encounter
 - T22.691S sequela
 - T22.692 Corrosion of second degree of multiple sites of left shoulder and upper limb, except wrist and hand
 - T22.692A initial encounter
 - T22.692D subsequent encounter
 - T22.692S sequela
 - T22.699 Corrosion of second degree of multiple sites of unspecified shoulder and upper limb, except wrist and hand
 - T22.699A initial encounter
 - T22.699D subsequent encounter

- T22.699S sequela

- T22.7 Corrosion of third degree of shoulder and upper limb, except wrist and hand
 - T22.70 Corrosion of third degree of shoulder and upper limb, except wrist and hand, unspecified site
 - T22.70XA initial encounter
 - T22.70XD subsequent encounter
 - T22.70XS sequela
 - T22.71 Corrosion of third degree of forearm
 - T22.711 Corrosion of third degree of right forearm
 - T22.711A initial encounter
 - T22.711D subsequent encounter
 - T22.711S sequela
 - T22.712 Corrosion of third degree of left forearm
 - T22.712A initial encounter
 - T22.712D subsequent encounter
 - T22.712S sequela
 - T22.719 Corrosion of third degree of unspecified forearm
 - T22.719A initial encounter
 - T22.719D subsequent encounter
 - T22.719S sequela
 - T22.72 Corrosion of third degree of elbow
 - T22.721 Corrosion of third degree of right elbow
 - T22.721A initial encounter
 - T22.721D subsequent encounter
 - T22.721S sequela
 - T22.722 Corrosion of third degree of left elbow
 - T22.722A initial encounter
 - T22.722D subsequent encounter
 - T22.722S sequela
 - T22.729 Corrosion of third degree of unspecified elbow
 - T22.729A initial encounter
 - T22.729D subsequent encounter

- T22.729S sequela
- T22.73 Corrosion of third degree of upper arm
 - T22.731 Corrosion of third degree of right upper arm
 - T22.731A initial encounter
 - T22.731D subsequent encounter
 - T22.731S sequela
 - T22.732 Corrosion of third degree of left upper arm
 - T22.732A initial encounter
 - T22.732D subsequent encounter
 - T22.732S sequela
 - T22.739 Corrosion of third degree of unspecified upper arm
 - T22.739A initial encounter
 - T22.739D subsequent encounter
 - T22.739S sequela
- T22.74 Corrosion of third degree of axilla
 - T22.741 Corrosion of third degree of right axilla
 - T22.741A initial encounter
 - T22.741D subsequent encounter
 - T22.741S sequela
 - T22.742 Corrosion of third degree of left axilla
 - T22.742A initial encounter
 - T22.742D subsequent encounter
 - T22.742S sequela
 - T22.749 Corrosion of third degree of unspecified axilla
 - T22.749A initial encounter
 - T22.749D subsequent encounter
 - T22.749S sequela
- T22.75 Corrosion of third degree of shoulder
 - T22.751 Corrosion of third degree of right shoulder
 - T22.751A initial encounter
 - T22.751D subsequent encounter
 - T22.751S sequela

- T22.752 Corrosion of third degree of left shoulder
 - T22.752A initial encounter
 - T22.752D subsequent encounter
 - T22.752S sequela
- T22.759 Corrosion of third degree of unspecified shoulder
 - T22.759A initial encounter
 - T22.759D subsequent encounter
 - T22.759S sequela
- T22.76 Corrosion of third degree of scapular region
 - T22.761 Corrosion of third degree of right scapular region
 - T22.761A initial encounter
 - T22.761D subsequent encounter
 - T22.761S sequela
 - T22.762 Corrosion of third degree of left scapular region
 - T22.762A initial encounter
 - T22.762D subsequent encounter
 - T22.762S sequela
 - T22.769 Corrosion of third degree of unspecified scapular region
 - T22.769A initial encounter
 - T22.769D subsequent encounter
 - T22.769S sequela
- T22.79 Corrosion of third degree of multiple sites of shoulder and upper limb, except wrist and hand
 - T22.791 Corrosion of third degree of multiple sites of right shoulder and upper limb, except wrist and hand
 - T22.791A initial encounter
 - T22.791D subsequent encounter
 - T22.791S sequela
 - T22.792 Corrosion of third degree of multiple sites of left shoulder and upper limb, except wrist and hand
 - T22.792A initial encounter
 - T22.792D subsequent encounter
 - T22.792S sequela

- T22.799 Corrosion of third degree of multiple sites of unspecified shoulder and upper limb, except wrist and hand
 - T22.799A initial encounter
 - T22.799D subsequent encounter
 - T22.799S sequela

- T26 Burn and corrosion confined to eye and adnexa
 - T26.0 Burn of eyelid and periocular area
 - T26.00 Burn of unspecified eyelid and periocular area
 - T26.00XA initial encounter
 - T26.00XD subsequent encounter
 - T26.00XS sequela
 - T26.01 Burn of right eyelid and periocular area
 - T26.01XA initial encounter
 - T26.01XD subsequent encounter
 - T26.01XS sequela
 - T26.02 Burn of left eyelid and periocular area
 - T26.02XA initial encounter
 - T26.02XD subsequent encounter
 - T26.02XS sequela
 - T26.1 Burn of cornea and conjunctival sac
 - T26.10 Burn of cornea and conjunctival sac, unspecified eye
 - T26.10XA initial encounter
 - T26.10XD subsequent encounter
 - T26.10XS sequela
 - T26.11 Burn of cornea and conjunctival sac, right eye
 - T26.11XA initial encounter
 - T26.11XD subsequent encounter
 - T26.11XS sequela
 - T26.12 Burn of cornea and conjunctival sac, left eye
 - T26.12XA initial encounter
 - T26.12XD subsequent encounter
 - T26.12XS sequela

- T26.2 Burn with resulting rupture and destruction of eyeball
 - T26.20 Burn with resulting rupture and destruction of unspecified eyeball
 - T26.20XA initial encounter
 - T26.20XD subsequent encounter
 - T26.20XS sequela
 - T26.21 Burn with resulting rupture and destruction of right eyeball
 - T26.21XA initial encounter
 - T26.21XD subsequent encounter
 - T26.21XS sequela
 - T26.22 Burn with resulting rupture and destruction of left eyeball
 - T26.22XA initial encounter
 - T26.22XD subsequent encounter
 - T26.22XS sequela
- T26.3 Burns of other specified parts of eye and adnexa
 - T26.30 Burns of other specified parts of unspecified eye and adnexa
 - T26.30XA initial encounter
 - T26.30XD subsequent encounter
 - T26.30XS sequela
 - T26.31 Burns of other specified parts of right eye and adnexa
 - T26.31XA initial encounter
 - T26.31XD subsequent encounter
 - T26.31XS sequela
 - T26.32 Burns of other specified parts of left eye and adnexa
 - T26.32XA initial encounter
 - T26.32XD subsequent encounter
 - T26.32XS sequela
- T26.4 Burn of eye and adnexa, part unspecified
 - T26.40 Burn of unspecified eye and adnexa, part unspecified
 - T26.40XA initial encounter
 - T26.40XD subsequent encounter
 - T26.40XS sequela
 - T26.41 Burn of right eye and adnexa, part unspecified

- T26.41XA initial encounter
- T26.41XD subsequent encounter
- T26.41XS sequela
- T26.42 Burn of left eye and adnexa, part unspecified
- T26.42XA initial encounter
- T26.42XD subsequent encounter
- T26.42XS sequela
- T26.5 Corrosion of eyelid and periocular area
 - T26.50 Corrosion of unspecified eyelid and periocular area
 - T26.50XA initial encounter
 - T26.50XD subsequent encounter
 - T26.50XS sequela
 - T26.51 Corrosion of right eyelid and periocular area
 - T26.51XA initial encounter
 - T26.51XD subsequent encounter
 - T26.51XS sequela
 - T26.52 Corrosion of left eyelid and periocular area
 - T26.52XA initial encounter
 - T26.52XD subsequent encounter
 - T26.52XS sequela
- T26.6 Corrosion of cornea and conjunctival sac
 - T26.60 Corrosion of cornea and conjunctival sac, unspecified eye
 - T26.60XA initial encounter
 - T26.60XD subsequent encounter
 - T26.60XS sequela
 - T26.61 Corrosion of cornea and conjunctival sac, right eye
 - T26.61XA initial encounter
 - T26.61XD subsequent encounter
 - T26.61XS sequela
 - T26.62 Corrosion of cornea and conjunctival sac, left eye
 - T26.62XA initial encounter
 - T26.62XD subsequent encounter

- T26.62XS sequela
- T26.7 Corrosion with resulting rupture and destruction of eyeball
 - T26.70 Corrosion with resulting rupture and destruction of unspecified eyeball
 - T26.70XA initial encounter
 - T26.70XD subsequent encounter
 - T26.70XS sequela
 - T26.71 Corrosion with resulting rupture and destruction of right eyeball
 - T26.71XA initial encounter
 - T26.71XD subsequent encounter
 - T26.71XS sequela
 - T26.72 Corrosion with resulting rupture and destruction of left eyeball
 - T26.72XA initial encounter
 - T26.72XD subsequent encounter
 - T26.72XS sequela
- T26.8 Corrosions of other specified parts of eye and adnexa
 - T26.80 Corrosions of other specified parts of unspecified eye and adnexa
 - T26.80XA initial encounter
 - T26.80XD subsequent encounter
 - T26.80XS sequela
 - T26.81 Corrosions of other specified parts of right eye and adnexa
 - T26.81XA initial encounter
 - T26.81XD subsequent encounter
 - T26.81XS sequela
 - T26.82 Corrosions of other specified parts of left eye and adnexa
 - T26.82XA initial encounter
 - T26.82XD subsequent encounter
 - T26.82XS sequela
- T26.9 Corrosion of eye and adnexa, part unspecified
 - T26.90 Corrosion of unspecified eye and adnexa, part unspecified
 - T26.90XA initial encounter
 - T26.90XD subsequent encounter
 - T26.90XS sequela

- T26.91 Corrosion of right eye and adnexa, part unspecified
 - T26.91XA initial encounter
 - T26.91XD subsequent encounter
 - T26.91XS sequela
- T26.92 Corrosion of left eye and adnexa, part unspecified
 - T26.92XA initial encounter
 - T26.92XD subsequent encounter
 - T26.92XS sequela

- T27 Burn and corrosion of respiratory tract
 - T27.0 Burn of larynx and trachea
 - T27.0XXA initial encounter
 - T27.0XXD subsequent encounter
 - T27.0XXS sequela
 - T27.1 Burn involving larynx and trachea with lung
 - T27.1XXA initial encounter
 - T27.1XXD subsequent encounter
 - T27.1XXS sequela
 - T27.2 Burn of other parts of respiratory tract
 - T27.2XXA initial encounter
 - T27.2XXD subsequent encounter
 - T27.2XXS sequela
 - T27.3 Burn of respiratory tract, part unspecified
 - T27.3XXA initial encounter
 - T27.3XXD subsequent encounter
 - T27.3XXS sequela
 - T27.4 Corrosion of larynx and trachea
 - T27.4XXA initial encounter
 - T27.4XXD subsequent encounter
 - T27.4XXS sequela
 - T27.5 Corrosion involving larynx and trachea with lung
 - T27.5XXA initial encounter

- T27.5XXD subsequent encounter
- T27.5XXS sequela
- T27.6 Corrosion of other parts of respiratory tract
 - T27.6XXA initial encounter
 - T27.6XXD subsequent encounter
 - T27.6XXS sequela
- T27.7 Corrosion of respiratory tract, part unspecified
 - T27.7XXA initial encounter
 - T27.7XXD subsequent encounter
 - T27.7XXS sequela

- T28 Burn and corrosion of other internal organs
 - T28.0 Burn of mouth and pharynx
 - T28.0XXA initial encounter
 - T28.0XXD subsequent encounter
 - T28.0XXS sequela
 - T28.1 Burn of esophagus
 - T28.1XXA initial encounter
 - T28.1XXD subsequent encounter
 - T28.1XXS sequela
 - T28.2 Burn of other parts of alimentary tract
 - T28.2XXA initial encounter
 - T28.2XXD subsequent encounter
 - T28.2XXS sequela
 - T28.3 Burn of internal genitourinary organs
 - T28.3XXA initial encounter
 - T28.3XXD subsequent encounter
 - T28.3XXS sequela
 - T28.4 Burns of other and unspecified internal organs
 - T28.40 Burn of unspecified internal organ
 - T28.40XA initial encounter
 - T28.40XD subsequent encounter

- T28.40XS sequela
- T28.41 Burn of ear drum
 - T28.411 Burn of right ear drum
 - T28.411A initial encounter
 - T28.411D subsequent encounter
 - T28.411S sequela
 - T28.412 Burn of left ear drum
 - T28.412A initial encounter
 - T28.412D subsequent encounter
 - T28.412S sequela
 - T28.419 Burn of unspecified ear drum
 - T28.419A initial encounter
 - T28.419D subsequent encounter
 - T28.419S sequela
- T28.49 Burn of other internal organ
 - T28.49XA initial encounter
 - T28.49XD subsequent encounter
 - T28.49XS sequela
- T28.5 Corrosion of mouth and pharynx
 - T28.5XXA initial encounter
 - T28.5XXD subsequent encounter
 - T28.5XXS sequela
- T28.6 Corrosion of esophagus
 - T28.6XXA initial encounter
 - T28.6XXD subsequent encounter
 - T28.6XXS sequela
- T28.7 Corrosion of other parts of alimentary tract
 - T28.7XXA initial encounter
 - T28.7XXD subsequent encounter
 - T28.7XXS sequela
- T28.8 Corrosion of internal genitourinary organs
 - T28.8XXA initial encounter

- T28.8XXD subsequent encounter
 - T28.8XXS sequela
 - T28.9 Corrosions of other and unspecified internal organs
 - T28.90 Corrosions of unspecified internal organs
 - T28.90XA initial encounter
 - T28.90XD subsequent encounter
 - T28.90XS sequela
 - T28.91 Corrosions of ear drum
 - T28.911 Corrosions of right ear drum
 - T28.911A initial encounter
 - T28.911D subsequent encounter
 - T28.911S sequela
 - T28.912 Corrosions of left ear drum
 - T28.912A initial encounter
 - T28.912D subsequent encounter
 - T28.912S sequela
 - T28.919 Corrosions of unspecified ear drum
 - T28.919A initial encounter
 - T28.919D subsequent encounter
 - T28.919S sequela
 - T28.99 Corrosions of other internal organs
 - T28.99XA initial encounter
 - T28.99XD subsequent encounter
 - T28.99XS sequela
- T30 Burn and corrosion, body region unspecified
 - T30.0 Burn of unspecified body region, unspecified degree
 - T30.4 Corrosion of unspecified body region, unspecified degree
- T31 Burns classified according to extent of body surface involved
 - T31.0 Burns involving less than 10% of body surface
 - T31.1 Burns involving 10-19% of body surface

- T31.10 with 0% to 9% third degree burns
- T31.11 with 10-19% third degree burns
- T31.2 Burns involving 20-29% of body surface
 - T31.20 with 0% to 9% third degree burns
 - T31.21 with 10-19% third degree burns
 - T31.22 with 20-29% third degree burns
- T31.3 Burns involving 30-39% of body surface
 - T31.30 with 0% to 9% third degree burns
 - T31.31 with 10-19% third degree burns
 - T31.32 with 20-29% third degree burns
 - T31.33 with 30-39% third degree burns
- T31.4 Burns involving 40-49% of body surface
 - T31.40 with 0% to 9% third degree burns
 - T31.41 with 10-19% third degree burns
 - T31.42 with 20-29% third degree burns
 - T31.43 with 30-39% third degree burns
 - T31.44 with 40-49% third degree burns
- T31.5 Burns involving 50-59% of body surface
 - T31.50 with 0% to 9% third degree burns
 - T31.51 with 10-19% third degree burns
 - T31.52 with 20-29% third degree burns
 - T31.53 with 30-39% third degree burns
 - T31.54 with 40-49% third degree burns
 - T31.55 with 50-59% third degree burns
- T31.6 Burns involving 60-69% of body surface
 - T31.60 with 0% to 9% third degree burns
 - T31.61 with 10-19% third degree burns
 - T31.62 with 20-29% third degree burns
 - T31.63 with 30-39% third degree burns
 - T31.64 with 40-49% third degree burns
 - T31.65 with 50-59% third degree burns
 - T31.66 with 60-69% third degree burns

- T31.7 Burns involving 70-79% of body surface
 - T31.70 with 0% to 9% third degree burns
 - T31.71 with 10-19% third degree burns
 - T31.72 with 20-29% third degree burns
 - T31.73 with 30-39% third degree burns
 - T31.74 with 40-49% third degree burns
 - T31.75 with 50-59% third degree burns
 - T31.76 with 60-69% third degree burns
 - T31.77 with 70-79% third degree burns
- T31.8 Burns involving 80-89% of body surface
 - T31.80 with 0% to 9% third degree burns
 - T31.81 with 10-19% third degree burns
 - T31.82 with 20-29% third degree burns
 - T31.83 with 30-39% third degree burns
 - T31.84 with 40-49% third degree burns
 - T31.85 with 50-59% third degree burns
 - T31.86 with 60-69% third degree burns
 - T31.87 with 70-79% third degree burns
 - T31.88 with 80-89% third degree burns
- T31.9 Burns involving 90% or more of body surface
 - T31.90 with 0% to 9% third degree burns
 - T31.91 with 10-19% third degree burns
 - T31.92 with 20-29% third degree burns
 - T31.93 with 30-39% third degree burns
 - T31.94 with 40-49% third degree burns
 - T31.95 with 50-59% third degree burns
 - T31.96 with 60-69% third degree burns
 - T31.97 with 70-79% third degree burns
 - T31.98 with 80-89% third degree burns
 - T31.99 with 90% or more third degree burns
- T32 Corrosions classified according to extent of body surface involved

- T32.0 Corrosions involving less than 10% of body surface
- T32.1 Corrosions involving 10-19% of body surface
 - T32.10 with 0% to 9% third degree corrosion
 - T32.11 with 10-19% third degree corrosion
- T32.2 Corrosions involving 20-29% of body surface
 - T32.20 with 0% to 9% third degree corrosion
 - T32.21 with 10-19% third degree corrosion
 - T32.22 with 20-29% third degree corrosion
- T32.3 Corrosions involving 30-39% of body surface
 - T32.30 with 0% to 9% third degree corrosion
 - T32.31 with 10-19% third degree corrosion
 - T32.32 with 20-29% third degree corrosion
 - T32.33 with 30-39% third degree corrosion
- T32.4 Corrosions involving 40-49% of body surface
 - T32.40 with 0% to 9% third degree corrosion
 - T32.41 with 10-19% third degree corrosion
 - T32.42 with 20-29% third degree corrosion
 - T32.43 with 30-39% third degree corrosion
 - T32.44 with 40-49% third degree corrosion
- T32.5 Corrosions involving 50-59% of body surface
 - T32.50 with 0% to 9% third degree corrosion
 - T32.51 with 10-19% third degree corrosion
 - T32.52 with 20-29% third degree corrosion
 - T32.53 with 30-39% third degree corrosion
 - T32.54 with 40-49% third degree corrosion
 - T32.55 with 50-59% third degree corrosion
- T32.6 Corrosions involving 60-69% of body surface
 - T32.60 with 0% to 9% third degree corrosion
 - T32.61 with 10-19% third degree corrosion
 - T32.62 with 20-29% third degree corrosion
 - T32.63 with 30-39% third degree corrosion
 - T32.64 with 40-49% third degree corrosion

- T32.65 with 50-59% third degree corrosion
- T32.66 with 60-69% third degree corrosion
- T32.7 Corrosions involving 70-79% of body surface
 - T32.70 with 0% to 9% third degree corrosion
 - T32.71 with 10-19% third degree corrosion
 - T32.72 with 20-29% third degree corrosion
 - T32.73 with 30-39% third degree corrosion
 - T32.74 with 40-49% third degree corrosion
 - T32.75 with 50-59% third degree corrosion
 - T32.76 with 60-69% third degree corrosion
 - T32.77 with 70-79% third degree corrosion
- T32.8 Corrosions involving 80-89% of body surface
 - T32.80 with 0% to 9% third degree corrosion
 - T32.81 with 10-19% third degree corrosion
 - T32.82 with 20-29% third degree corrosion
 - T32.83 with 30-39% third degree corrosion
 - T32.84 with 40-49% third degree corrosion
 - T32.85 with 50-59% third degree corrosion
 - T32.86 with 60-69% third degree corrosion
 - T32.87 with 70-79% third degree corrosion
 - T32.88 with 80-89% third degree corrosion
- T32.9 Corrosions involving 90% or more of body surface
 - T32.90 with 0% to 9% third degree corrosion
 - T32.91 with 10-19% third degree corrosion
 - T32.92 with 20-29% third degree corrosion
 - T32.93 with 30-39% third degree corrosion
 - T32.94 with 40-49% third degree corrosion
 - T32.95 with 50-59% third degree corrosion
 - T32.96 with 60-69% third degree corrosion
 - T32.97 with 70-79% third degree corrosion
 - T32.98 with 80-89% third degree corrosion
 - T32.99 with 90% or more third degree corrosion

- **J96 Respiratory failure, not elsewhere classified**

- J96.0 Acute respiratory failure
 - J96.00 unspecified whether with hypoxia or hypercapnia
 - J96.01 with hypoxia
 - J96.02 with hypercapnia
- J96.1 Chronic respiratory failure
 - J96.10 unspecified whether with hypoxia or hypercapnia
 - J96.11 with hypoxia
 - J96.12 with hypercapnia
- J96.2 Acute and chronic respiratory failure
 - J96.20 unspecified whether with hypoxia or hypercapnia
 - J96.21 with hypoxia
 - J96.22 with hypercapnia
- J96.9 Respiratory failure, unspecified
 - J96.90 unspecified whether with hypoxia or hypercapnia
 - J96.91 with hypoxia
 - J96.92 with hypercapnia

D62 Acute post hemorrhagic anemia

- D63 Anemia in chronic diseases classified elsewhere
- D63.0 Anemia in neoplastic disease
- D63.1 Anemia in chronic kidney disease
- D63.8 Anemia in other chronic diseases classified elsewhere

D50 Iron deficiency anemia

- D50.0 Iron deficiency anemia secondary to blood loss (chronic)**
- D50.1 Sideropenic dysphagia
- D50.8 Other iron deficiency anemias
- D50.9 Iron deficiency anemia, unspecified
- D51 Vitamin B12 deficiency anemia
- D51.0 Vitamin B12 deficiency anemia due to intrinsic factor deficiency
- D51.1 Vitamin B12 deficiency anemia due to selective vitamin B12 malabsorption with proteinuria
- D51.2 Transcobalamin II deficiency
- D51.3 Other dietary vitamin B12 deficiency anemia
- D51.8 Other vitamin B12 deficiency anemias
- D51.9 Vitamin B12 deficiency anemia, unspecified

L76 Intraoperative and post procedural complications of skin and subcutaneous tissue

L76.0 Intraoperative hemorrhage and hematoma of skin and subcutaneous tissue complicating a procedure

L76.01 Intraoperative hemorrhage and hematoma of skin and subcutaneous tissue complicating a dermatologic procedure

L76.02 Intraoperative hemorrhage and hematoma of skin and subcutaneous tissue complicating other procedure

L76.1 Accidental puncture and laceration of skin and subcutaneous tissue during a procedure

L76.11 Accidental puncture and laceration of skin and subcutaneous tissue during a dermatologic procedure

L76.12 Accidental puncture and laceration of skin and subcutaneous tissue during other procedure

L76.2 Post procedural hemorrhage of skin and subcutaneous tissue following a procedure

L76.21 Post procedural hemorrhage of skin and subcutaneous tissue following a dermatologic procedure

L76.22 Post procedural hemorrhage of skin and subcutaneous tissue following other procedure

L76.3 Post procedural hematoma and seroma of skin and subcutaneous tissue following a procedure

L76.31 Post procedural hematoma of skin and subcutaneous tissue following a dermatologic procedure

Cellulitis/Lymphangitis

- L03 Cellulitis and acute lymphangitis
 - L03.0 Cellulitis and acute lymphangitis of finger and toe
 - L03.01 Cellulitis of finger
 - L03.011 Cellulitis of right finger
 - L03.012 Cellulitis of left finger
 - L03.019 Cellulitis of unspecified finger
 - L03.02 Acute lymphangitis of finger
 - L03.021 Acute lymphangitis of right finger
 - L03.022 Acute lymphangitis of left finger
 - L03.029 Acute lymphangitis of unspecified finger
 - L03.03 Cellulitis of toe
 - L03.031 Cellulitis of right toe
 - L03.032 Cellulitis of left toe
 - L03.039 Cellulitis of unspecified toe
 - L03.04 Acute lymphangitis of toe
 - L03.041 Acute lymphangitis of right toe
 - L03.042 Acute lymphangitis of left toe
 - L03.049 Acute lymphangitis of unspecified toe
 - L03.1 Cellulitis and acute lymphangitis of other parts of limb

- L03.11 Cellulitis of other parts of limb
 - L03.111 Cellulitis of right axilla
 - L03.112 Cellulitis of left axilla
 - L03.113 Cellulitis of right upper limb
 - L03.114 Cellulitis of left upper limb
 - L03.115 Cellulitis of right lower limb
 - L03.116 Cellulitis of left lower limb
 - L03.119 Cellulitis of unspecified part of limb
- L03.12 Acute lymphangitis of other parts of limb
 - L03.121 Acute lymphangitis of right axilla
 - L03.122 Acute lymphangitis of left axilla
 - L03.123 Acute lymphangitis of right upper limb
 - L03.124 Acute lymphangitis of left upper limb
 - L03.125 Acute lymphangitis of right lower limb
 - L03.126 Acute lymphangitis of left lower limb
 - L03.129 Acute lymphangitis of unspecified part of limb
- L03.2 Cellulitis and acute lymphangitis of face and neck
 - L03.21 Cellulitis and acute lymphangitis of face
 - L03.211 Cellulitis of face
 - L03.212 Acute lymphangitis of face
 - L03.213 Periorbital cellulitis
 - L03.22 Cellulitis and acute lymphangitis of neck
 - L03.221 Cellulitis of neck
 - L03.222 Acute lymphangitis of neck
- L03.3 Cellulitis and acute lymphangitis of trunk
 - L03.31 Cellulitis of trunk
 - L03.311 Cellulitis of abdominal wall
 - L03.312 Cellulitis of back [any part except buttock]
 - L03.313 Cellulitis of chest wall
 - L03.314 Cellulitis of groin
 - L03.315 Cellulitis of perineum
 - L03.316 Cellulitis of umbilicus

- L03.317 Cellulitis of buttock
- L03.319 unspecified
- L03.32 Acute lymphangitis of trunk
 - L03.321 Acute lymphangitis of abdominal wall
 - L03.322 Acute lymphangitis of back [any part except buttock]
 - L03.323 Acute lymphangitis of chest wall
 - L03.324 Acute lymphangitis of groin
 - L03.325 Acute lymphangitis of perineum
 - L03.326 Acute lymphangitis of umbilicus
 - L03.327 Acute lymphangitis of buttock
 - L03.329 unspecified
- L03.8 Cellulitis and acute lymphangitis of other sites
 - L03.81 Cellulitis of other sites
 - L03.811 Cellulitis of head [any part, except face]
 - L03.818 Cellulitis of other sites
 - L03.89 Acute lymphangitis of other sites
 - L03.891 Acute lymphangitis of head [any part, except face]
 - L03.898 Acute lymphangitis of other sites
- L03.9 Cellulitis and acute lymphangitis, unspecified
 - L03.90 Cellulitis, unspecified
 - L03.91 Acute lymphangitis, unspecified

Complications of Trauma

- T79 Certain early complications of trauma, not elsewhere classified
 - T79.0 Air embolism (traumatic)
 - T79.0XXA initial encounter
 - T79.0XXD subsequent encounter
 - T79.0XXS sequela
 - T79.1 Fat embolism (traumatic)
 - T79.1XXA initial encounter
 - T79.1XXD subsequent encounter
 - T79.1XXS sequela
 - T79.2 Traumatic secondary and recurrent hemorrhage and seroma

- T79.2XXA initial encounter
- T79.2XXD subsequent encounter
- T79.2XXS sequela
- T79.4 Traumatic shock
 - T79.4XXA initial encounter
 - T79.4XXD subsequent encounter
 - T79.4XXS sequela
- T79.5 Traumatic anuria
 - T79.5XXA initial encounter
 - T79.5XXD subsequent encounter
 - T79.5XXS sequela
- T79.6 Traumatic ischemia of muscle
 - T79.6XXA initial encounter
 - T79.6XXD subsequent encounter
 - T79.6XXS sequela
- T79.7 Traumatic subcutaneous emphysema
 - T79.7XXA initial encounter
 - T79.7XXD subsequent encounter
 - T79.7XXS sequela
- T79.A Traumatic compartment syndrome
 - T79.A0 Compartment syndrome, unspecified
 - T79.A0XA initial encounter
 - T79.A0XD subsequent encounter
 - T79.A0XS sequela
 - T79.A1 Traumatic compartment syndrome of upper extremity
 - T79.A11 Traumatic compartment syndrome of right upper extremity
 - T79.A11A initial encounter
 - T79.A11D subsequent encounter
 - T79.A11S sequela
 - T79.A12 Traumatic compartment syndrome of left upper extremity
 - T79.A12A initial encounter
 - T79.A12D subsequent encounter

- T79.A12S sequela
- T79.A19 Traumatic compartment syndrome of unspecified upper extremity
 - T79.A19A initial encounter
 - T79.A19D subsequent encounter
 - T79.A19S sequela
- T79.A2 Traumatic compartment syndrome of lower extremity
 - T79.A21 Traumatic compartment syndrome of right lower extremity
 - T79.A21A initial encounter
 - T79.A21D subsequent encounter
 - T79.A21S sequela
 - T79.A22 Traumatic compartment syndrome of left lower extremity
 - T79.A22A initial encounter
 - T79.A22D subsequent encounter
 - T79.A22S sequela
 - T79.A29 Traumatic compartment syndrome of unspecified lower extremity
 - T79.A29A initial encounter
 - T79.A29D subsequent encounter
 - T79.A29S sequela
- T79.A3 Traumatic compartment syndrome of abdomen
 - T79.A3XA initial encounter
 - T79.A3XD subsequent encounter
 - T79.A3XS sequela
- T79.A9 Traumatic compartment syndrome of other sites
 - T79.A9XA initial encounter
 - T79.A9XD subsequent encounter
 - T79.A9XS sequela
- T79.8 Other early complications of trauma
 - T79.8XXA initial encounter
 - T79.8XXD subsequent encounter
 - T79.8XXS sequela
- T79.9 Unspecified early complication of trauma
 - T79.9XXA initial encounter

- T79.9XXD subsequent encounter
- T79.9XXS sequela

Respiratory Complications

- J95.811 Post procedural pneumothorax
- J95.812 Post procedural air leak
- J95.82 Post procedural respiratory failure
- J95.821 Acute post procedural respiratory failure
- J95.822 Acute and chronic post procedural respiratory failure
- J95.83 Post procedural hemorrhage of a respiratory system organ or structure following a procedure
- J95.830 Post procedural hemorrhage of a respiratory system organ or structure following a respiratory system procedure
- J95.831 Post procedural hemorrhage of a respiratory system organ or structure following other procedure
- J95.84 Transfusion-related acute lung injury (TRALI)
- J95.85 Complication of respirator [ventilator]
- J95.850 Mechanical complication of respirator**
- J95.851 Ventilator associated pneumonia
- J95.859 Other complication of respirator [ventilator]
- J95.86 Post procedural hematoma and seroma of a respiratory system organ or structure following a procedure
- J95.860 Post procedural hematoma of a respiratory system organ or structure following a respiratory system procedure
- J95.861 Post procedural hematoma of a respiratory system organ or structure following other procedure
- J95.862 Post procedural seroma of a respiratory system organ or structure following a respiratory system procedure
- J95.863 Post procedural seroma of a respiratory system organ or structure following other procedure
- J95.88 Other intraoperative complications of respiratory system, not elsewhere classified
- J95.89 Other post procedural complications and disorders of respiratory system, not elsewhere classified
- J96 Respiratory failure, not elsewhere classified

Septicemia

- A40 Streptococcal sepsis
 - A40.0 Sepsis due to streptococcus, group A
 - A40.1 Sepsis due to streptococcus, group B
 - A40.3 Sepsis due to Streptococcus pneumoniae
 - A40.8 Other streptococcal sepsis
 - A40.9 Streptococcal sepsis, unspecified
- A41 Other sepsis
 - A41.0 Sepsis due to Staphylococcus aureus

- A41.01 Sepsis due to Methicillin Susceptible Staphylococcus aureus
- A41.02 Sepsis due to Methicillin Resistant Staphylococcus aureus
- A41.1 Sepsis due to other specified staphylococcus
- A41.2 Sepsis due to unspecified staphylococcus
- A41.3 Sepsis due to Hemophilus influenzae
- A41.4 Sepsis due to anaerobes
- A41.5 Sepsis due to other Gram-negative organisms
 - A41.50 Gram-negative sepsis, unspecified
 - A41.51 Sepsis due to Escherichia coli [E. coli]
 - A41.52 Sepsis due to Pseudomonas
 - A41.53 Sepsis due to Serratia
 - A41.59 Other Gram-negative sepsis
- A41.8 Other specified sepsis
 - A41.81 Sepsis due to Enterococcus
 - A41.89 Other specified sepsis
- A41.9 Sepsis, unspecified organism

Metabolic diagnoses

- E86 Volume depletion
 - E86.0 Dehydration
 - E86.1 Hypovolemia
 - E86.9 Volume depletion, unspecified
- E87 Other disorders of fluid, electrolyte and acid-base balance
 - E87.0 Hyperosmolality and hypernatremia
 - E87.1 Hypo-osmolality and hyponatremia
 - E87.2 Acidosis
 - E87.3 Alkalosis
 - E87.4 Mixed disorder of acid-base balance
 - E87.5 Hyperkalemia
 - E87.6 Hypokalemia
 - E87.7 Fluid overload
 - E87.70 unspecified

- E87.71 Transfusion associated circulatory overload
- E87.79 Other fluid overload
- E87.8 Other disorders of electrolyte and fluid balance, not elsewhere classified

Category Ranges for Injuries

- S00-S09
Injuries to the head
- S10-S19
Injuries to the neck
- S20-S29
Injuries to the thorax
- S30-S39
Injuries to the abdomen, lower back, lumbar spine, pelvis and external genitals
- S40-S49
Injuries to the shoulder and upper arm
- S50-S59
Injuries to the elbow and forearm
- S60-S69
Injuries to the wrist, hand and fingers
- S70-S79
Injuries to the hip and thigh
- S80-S89
Injuries to the knee and lower leg
- S90-S99
Injuries to the ankle and foot
- T07-T07
Injuries involving multiple body regions

T85.693 Other mechanical complication of artificial skin graft and decellularized allodermis

T85.693A initial encounter

T85.693D subsequent encounter

T85.693S sequela

Appendix VII: 2018 Medicare Physician Fee Schedule Relative Values

Medicare annually revises and publishes the Medicare Physician Fee Schedule in a Federal Register Final Rule, usually issued in November for implementation January 1 of the following year. Many private and workers' compensation payers have adopted this fee schedule and update it annually with the issuance of the Federal Register. Burn surgeons are advised to obtain fee schedules from all non-Medicare payers in their locality, e.g., Medicaid, Medicaid MCOs, Workers Compensation, managed care plans, BCBS, and others.

Here are some helpful descriptions of the columns contained in the CMS files.

Column 1	HCPSC/CPT code
Column 2	Code description
Column 3	Status of code (e.g., A=active, B=bundled code, C=carrier's price the code, X=statutory exclusion)
Column 4	RVU: Transitioned Non-facility total RVUs (RVU for procedure not performed in a facility, e.g., procedure performed in physician 's office)
Column 5	RVU: Transitioned Facility total RVUs (RVU for procedure performed in a facility)
Column 6	Global Days: Number of days included in the postoperative follow up period, i.e., the global surgery period. Note that "ZZZ" is used with add-on codes and indicates that the procedure is always included in the global period of the other, primary procedure with which the add-on may be reported.
Column 7	Preoperative Percentage: The percent of the global package reimbursement allocated to the preoperative portion of the procedure. Used for split-care situations where 1 surgeon provides preoperative and intraoperative services (performs the procedure) and another physician provides postoperative care.
Column 8	Intraoperative Percentage: The percent of the global package reimbursement allocated to the intraoperative portion of the procedure. Used for 2 purposes. First, for split-care situations where 1 surgeon provides preoperative and intraoperative services (performs the procedure) and another physician provides postoperative care. Second, for reimbursement calculation for a related surgical procedure (e.g., for complication arising from the previous surgery) performed during the postoperative period of a previous global surgery procedure. Medicare allows only the intraoperative percent for these procedures when a CPT code is available to describe it. Medicare identifies these procedures when the code is submitted with modifier 78.
Column 9	Postoperative Percentage: The percent of the global package reimbursement allocated to the postoperative portion of the procedure.

Used for split-care situations where 1 surgeon provides preoperative and intraoperative services (performs the procedure) and another physician provides postoperative care.

Column 10 Assistant Surgeon: Indicator specifies whether assistant surgeon is allowed for the procedure. Indicators are:
 0=Payment restriction for assistants at surgery applies to this procedure unless supporting documentation is submitted to establish medical necessity
 1=Statutory payment restriction for assistants at surgery applies to this procedure. Assistant at surgery may not be paid.
 2=Payment restriction for assistants at surgery does not apply to this procedure. Assistant at surgery may be paid.
 9=Concept does not apply.

Below is the link to the 2018 Relative Value Files:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files-Items/RVU18A.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=descending>

The best way to find a particular CPT code is to do a find in that column.

Index

INDEX

- Abdominal compartment syndrome
 - diagnosis codes for, 129
- Abdominal decompression
 - compartment syndrome, diagnosis codes for, 129
 - diagnosis coding for, 129
 - physician service, 129
 - reporting guidelines, 129
- Abuse
 - defined, 67
- Abuse, claims billing
 - avoiding, 67
- Add-on codes
 - identifying in CPT, 52
- Add-on codes (outpatient hospital service)
 - defined, 299
 - identifying in CPT, 300
 - modifier 59 and, 300
 - reporting, 300
 - separate encounters, same day, 300
- Add-on codes (physician, non-physician practitioner)
 - defined, 54
 - modifier 51 and, 54
 - modifier 59 and, 54
 - reporting, 54
- Ambulatory Payment Classifications
 - Medicare
 - coding for, 294
- Amputation
 - physician service
 - reporting guidelines, 130
- Anesthesia
 - CPT codes including
 - with anesthesia
 - AMA definition of, 126
- APCs
 - Medicare
 - coding for, 295
 - packaging of services per APC, 296
- Appeals
 - Medicare and other payers, 251
 - Medicare process
 - first level appeal, 254
 - fourth and fifth levels of appeal, 256
 - institutional and physician claims, 251
 - overview of steps in process, 252
 - where to file, 252
 - levels of appeal, 254
 - physician appeals, assignment effect on, 252
 - re-determination, 254
 - second level appeal, 255
 - Table of appeal levels and time limits, 253
 - Table of time limits by level of appeal, 253
 - third level appeal, 255
 - payer response to, 256
- Appendices, 364
 - Appendix I CMS
 - 1500 Claim Form, 365
 - Appendix II, CPT surgical package procedures
 - Included and excluded services, 366
 - Appendix III, Medicare global surgery package,
 - major and minor procedures, 367
 - Appendix IV, Modifiers, physician services
 - table of all CPT and HCPCS modifiers with
 - guidelines, 368
 - Appendix V, E/M levels of service, code selection
 - and audit tables, 384
 - Appendix VI, list of burn diagnosis codes 393
 - Appendix VII
 - Medicare physician fee schedule
 - assistant surgeon allowed procedures, 424
 - burn surgeon services, 423
- Arterial line
 - physician service
 - insertion of, 131
 - reporting guidelines, 131
- Assistant at surgery (physician)
 - defined, 66, 237
 - modifier 80, 61
 - teaching physician guidelines, 237
 - qualified resident not available, 237
- Assistant surgeon
 - defined, 66
 - Medicare coverage, 66
 - indicators, Appendix VII, 66
- Assistant surgeon, qualified resident unavailable (physician)
 - modifier, 61
- Biobrane
 - dressing change
 - application of, included in, 170, 327
 - included in, 170, 327
 - dressing for excision
 - application of, not reportable, 170, 327
 - application of, not reportable, 170
- Biopsy, skin
 - definition, 132
 - physician service
 - reporting guidelines, 132
- Biopsy, skin (outpatient hospital service)
 - definition, 308
 - reporting guidelines, 308
- Bronchoscopy
 - physician service
 - conscious sedation included, 132
 - diagnostic, 132
 - reporting guidelines, 133
 - surgical, 133
- Bundling
 - defined, 20
 - coding
 - guidelines

- inpatient hospital, 262
- outpatient hospital, 343
- CPT code changes, annual
 - affecting burn surgeons, 15
- diagnosis codes, list of (Appendix VI), 393
- diagnosis coding
 - inpatient hospital, 260
 - outpatient hospital, 260
 - physicians, non-physician professionals, 201
- DRGs
 - coding for MS-DRGs. *See*
 - coding for MS-DRGs 928 & 929, 298
 - coding guidelines, official inpatient
 - excerpts, general, 278
 - procedures, excerpts, 280
 - replacement by burn MS-DRGs, 266
 - Table of relative weights & lengths of stay,
 - current year, 267
- MS-DRGs, 267
- official coding guidelines
 - inpatient hospital, 260
 - outpatient hospital, 260
- Calciphylaxis
 - diagnosis coding, 222
 - pathophysiology, 222
- Central venous access
 - physician service
 - central insertion method, 134
 - central insertion of, 134
 - code categories, 135
 - definition of, 134
 - exchange, reporting guidelines, 138
 - exchange, same access site, 138
 - imaging guidance for, 139
 - insertion codes, reporting guidelines, 136
 - insertion of, 136
 - peripheral insertion method, 135
 - peripheral insertion of, 135
 - removal non-tunneled device, 133
 - removal with insertion, new site, 133
 - reporting guidelines, 133
 - repositioning, 139
- Claim
 - payable
 - defined, 17
 - payment criteria, 17
 - physician
 - services must be performed by physician, 67
 - no exception for supervision of hospital nursing staff, 67
 - two exceptions, 67
 - supervision of hospital nursing staff
 - fraud and, 67
 - not billable, 67
- Claim form
 - physicians
 - CMS 1500, paper or electronic, 21, *See* Appendix I
- Clinic visit (outpatient hospital service)
 - coding guidelines, 319
- Clysis, subeschar
 - physician service
 - reporting guidelines, 193
- Codes, CPT
 - revised
 - burn surgery 15
- Coding
 - defined, 11, 258
 - facility (hospital) services, 275
 - facility (Hospital) services
 - inpatient, official guidelines for, 275
 - outpatient, 262
 - outpatient, official guidelines for, 360
 - physician services, 11
- Coding guidelines
 - inpatient hospital
 - burns, 275, 364
 - CMS official, excerpted, 275
 - MS-DRGs, 264
 - Official, excerpts, 275
 - procedures
 - debridement, 276
 - procedures, CMS official, excerpts, 276
 - official
 - mandated use of, 262
 - outpatient hospital
 - burns, 204, 347
 - CMS official diagnosis, excerpted, 347
 - Official, excerpts, 347
 - physician service
 - diagnoses, Official, excerpts, 201
- Coding guidelines, official
 - inpatient hospital
 - burns, 204
 - outpatient hospital
 - burns, 347
- Coding systems
 - annual updates, effective dates, 14, 262
 - diagnosis
 - inpatient or outpatient, 275
 - hospital
 - diagnosis, 275
 - procedure, inpatient, 276
 - procedure, outpatient, 307
 - types used by, 258
 - inpatient hospital
 - diagnoses (ICD-10-CM), 262

- procedure, 276
- outpatient hospital
 - CPT, 259, 307
 - diagnoses (ICD-10-CM), 262
 - HCPCS, 259, 309
 - Medicare requirements, 308
 - diagnoses, 343
 - procedures, 307
 - procedure, 259, 307
 - supplies & other services or procedures, 259, 295
- physicians, non-physician professionals
 - CPT, 14
 - diagnoses (ICD-10-CM), 16
 - procedure, 13
 - HCPCS Level II, 12
 - ICD-10-CM
 - diseases, conditions, diagnoses, 13
- Compartment pressure measurement
 - physician service
 - reporting guidelines, 141
- Compartment syndrome
 - abdominal, 129
- Conscious sedation
 - definition of, 126
 - procedures that *do not* include
 - reporting guidelines, 126
 - procedures that include
 - CPT Appendix G, 127
 - reporting guidelines, 127
 - provided by burn surgeon at bedside
 - for procedures performed by hospital staff nurse, 120
 - codes 99151-99157, 128
 - documentation required, 126
 - reporting guidelines, 126
 - physician, hospital-based, 128
 - physicians, office-based, 127
 - time, reporting of, 126
 - services included in, 126
- Contracture release
 - outpatient hospital service, 308
 - excision with primary closure, 309
 - hand scar, 312
 - incisional release and skin graft, 311
 - removal and skin graft, 311
 - removal with adjacent tissue transfer, 310
 - physician service, 142
 - excision with primary closure, 142
 - hand scar, 145
 - incisional release and skin graft, 144
 - removal and skin graft, 144
 - removal with adjacent tissue transfer, 143
- CPT add-on codes
 - outpatient hospital
 - defined, 313
 - modifier 59 and, 314
 - reporting, 314
 - separate encounters, same day, 313
 - physician, non-physician practitioner, 64
 - defined, 64
 - identifying in CPT, 64
 - modifier 51 and, 65
 - modifier 59 and, 65
 - reporting, 64
 - separate encounters, same day, 64
- CPT add-on codes (outpatient hospital service)
 - identifying in CPT, 299
- CPT codes
 - used to report physician services, supplies, 11
- Critical care
 - outpatient hospital service
 - coding guidelines, 305
 - outpatient hospital services
 - procedures not separately billable with code 99291, 306
 - physician service
 - in ER, guidelines, 89
 - inpatient neonatal, 113
 - inpatient neonatal, bundled procedures, 114
 - inpatient neonatal, reportable procedures, 109
 - inpatient neonatal, reporting guidelines, 109
 - inpatient pediatric, 105
 - inpatient pediatric, bundled procedures, 105
 - inpatient pediatric, reportable procedures, 106
 - inpatient pediatric, reporting guidelines, 107
 - Medicare guidelines, pre and postoperative care, 101
 - Medicare, use of pre and post -operative modifiers *together* [Editorial Note], 101
 - procedures not separately billable with 99291-99292, 101
 - procedures separately billable with 99291-99292, 102
 - reporting guidelines, 100
- Debridement
 - coding variances by performing clinician, 146, 326
 - non-physician service, 147
 - outpatient hospital service, 326–35
 - coding variances by performing clinician, 327
 - physician service, 147
 - versus excision
 - distinctions, definitions, 148, 162, 329, 339
- Debridement (non-surgical), non-physician
 - professional, 146
 - burn wound
 - coding guidelines, 156
 - non-burn wounds
 - coding guidelines, 158
- Debridement (non-surgical), outpatient hospital
 - service
 - burn wound, by non-physician professional (PT/OT), 318
 - payment for under therapy plan of care, 319
 - payment for w/o therapy plan of care, 319

- therapy plan of care, modifier requirements, 319
- non-burn wound, by non-physician professional (PT/OT)
 - payment for under therapy plan of care, 319
 - payment for w/o therapy plan of care, 319
 - therapy plan of care, modifier requirements, 319
- Debridement (outpatient hospital service)
 - surgical, definition of, 313
- Debridement (physician service)
 - surgical, 146
 - surgical, definition of, 146
- Debridement, non-physician practitioner
 - burn wound
 - reporting guidelines, 157
 - burn wound and, 157
 - non-burn wound
 - reporting guidelines, 147
 - non-burn wound and, 158
- Debridement, outpatient hospital service
 - burn wound by physician or non-physician practitioner
 - reporting guidelines, 313
 - burn wound versus excision, 315
 - burn wound, by physician/non-physician practitioner, 316
 - non-burn wound
 - by non-physician professional (PT/OT), 320
 - by physician/non-physician practitioner, 330
 - prosthetic mesh insertion with, 332
 - non-burn wound by physician or non-physician practitioner
 - reporting guidelines, 317
 - non-burn wounds
 - prosthetic mesh removal with, 317
 - surgical, 326
- Debridement, physician service
 - burn wound, 147
 - CPT surgical package and, 150
 - Medicare global surgery and, 149
 - reporting guidelines, 152
 - burn wound versus excision, 148
 - non-burn wound
 - CPT surgical package and, 150
 - Medicare global surgery and, 149
 - prosthetic mesh insertion with, 154
 - non-burn wounds, 151
 - prosthetic mesh removal with, 153
 - reporting guidelines, 153
- Declotting
 - implanted vascular access device/catheter thrombolytic agent. *See*
- Degloving injuries
 - diagnosis coding, 224
 - pathophysiology, 223
- Diagnosis coding
 - abdominal compartment syndrome, 129
 - burns, burn cases
 - additional diagnosis codes used in, 206
 - sepsis, SIRS, septicemia, 209
 - table of additional diagnosis codes used in, 393
 - burns, diagnosis codes used in
 - list of (Appendix VI), 393
 - burns, hospital, inpatient or outpatient
 - official coding guidelines, 205
 - inpatient hospital
 - burns, 283–91
 - burns, burn cases
 - additional diagnosis coding for, 393
 - sepsis, SIRS, septicemia, 209
 - table of additional diagnosis codes used in, 393
 - burns, sequencing codes for, 205
 - MS-DRGs 928 & 929, coding for, 274
 - non-physician practitioner, 204
 - burns, 204 burns, burn cases
 - of additional diagnosis codes used in, 393
 - burns, sequencing codes for, 205
 - CMS official coding guidelines, ICD-10-CM, 202
 - outpatient hospital
 - burns, 349, 365
 - burns, burn cases
 - additional diagnosis codes used in, 368
 - table of, 369
 - burns, sequencing codes for, 349
 - CMS official guidelines, 343
 - late effect of burns, 213
 - probable, suspected, questionable, rule out diagnostic statements, 345
 - physician, non-physician professionals
 - burns, burn cases
 - additional diagnosis codes used in, 393
 - sepsis, SIRS, septicemia, 211, 287
 - table of additional diagnosis codes used in, 393
 - burns, sequencing codes for, 206
 - CMS official coding guidelines, 202
 - ICD-10-CM, physicians, non-physician professionals
 - probable, suspected, questionable, rule out diagnostic statements, 345
- Distinct procedural service (physician)
 - modifier, 25, 57
- Documentation
 - burn
 - as basis for payment, 18
 - how payers use, 18
 - payer review of, 18

- purpose of, 18
- burn surgeon
 - self audit, 17
- CMS, for E/M level of service, 72
- defensible
 - audit protection, 17
 - code match, 17
 - defined, 17
 - use of CPT terms in, 17
- key components
 - examination, 72
 - history, 72
 - medical decision making, 72
- time option
 - E/M level of service, 73
- Double billing
 - example, 21
 - unbundling and, 21
- Dressing
 - outpatient hospital service, 321
 - burn wounds
 - coding guidelines, 336
 - reporting guidelines, 336
 - grafts
 - coding guidelines, 322
 - reporting guidelines, 322
 - non-burn wounds, 323
 - coding guidelines, 323
 - physician service
 - burn wounds, 160
 - by different physician, same group, postop, 158
 - coding, 160
 - CPT surgical package guidelines, 162
 - Medicare global surgery guidelines, 161
 - reporting guidelines, 160
 - grafts, 163
 - coding guidelines, 163
 - CPT surgical package guidelines, 164
 - Medicare global surgery guidelines, 164
 - non-burn wounds, 165
 - coding, 165
- Dressings
 - physician service, 159
- DRGs
 - background, 264
 - burns
 - coding for MS-DRGs, 274
 - coding guidelines, official inpatient
 - excerpts, general, 275
 - procedures, excerpts, 276
 - Major Diagnostic Category (MDC) 22, 265
 - MS-DRG weights, 267
 - Table of relative weights & lengths of stay, current year, 267
 - defined, 264
 - inpatient hospital
 - tips for code abstraction, 290
 - mechanical ventilation (invasive)
 - defined, 290
 - mechanical ventilation (invasive) 96+ hours
 - affecting, 290
 - mechanical ventilation (invasive) and, 290
 - guidelines for coding
 - endotracheal, 290
 - tracheostomy, 290
 - Medicare Severity Adjusted (MS-DRGs)
 - burn DRGs, 266
 - burn MS-DRGs
 - 2 of 6 divided into CC subclasses, 268
 - CC exclusions list, 266
 - CC list, divided into 3 levels, 266
 - CC list, extensive required revisions of, 267
 - current MS-DRG
 - weights, 267
 - defined, 264
 - development process, 264
 - MS-DRGs
 - Hospital Acquired Conditions rule
 - effect on payment for, 268
 - summary of coding for, 268
 - Table of conditions included in, 272
 - reimbursement for, 264
 - E/M service, separately identifiable (physician)
 - modifier, 62
 - Escharotomy
 - outpatient hospital service, 337
 - reporting guidelines, 337
 - physician service, 165
 - documentation of, 165
 - reporting guidelines, 166
 - Evaluation & management (physician)
 - shared service with non-physician practitioner
 - place of service and, 79
 - Evaluation and Management
 - Medicare outpatient hospital reporting guidelines, 301
 - Evaluation and management (non-physician practitioner)
 - consultations. *See also* Evaluation and management (physician), consultation
 - CPT definition
 - new patient, 244
 - definitions
 - established patient, 244
 - new patient, 244

- inpatient hospital care. *See also* Evaluation and management (physician), admit, critical care, discharge day management, inpatient daily care, etc.
- Medicare definition
 - new patient, 244
- office/outpatient clinic visit, 245
- one per day. *See also* Evaluation and management (physician), one per day
- shared evaluation and management service. *See also* Evaluation and management (physician), shared service with non-physician
- shared service with physician, 80
 - hospital, 80
 - Medicare guideline summary, 82
 - office, 82
- Evaluation and management (outpatient hospital service)
 - basis for code selection
 - AMA/CMS Documentation Guidelines, 301
 - hospital-specific written criteria, 301
 - clinic visit
 - coding guidelines, 305
 - critical care, 305
 - coding guidelines, 305
 - emergency department visit, 303
 - procedure and
 - modifier 25 requirement, 303
 - reporting critical care in lieu of, 303
 - surgical procedure and, 303
 - established patient, Medicare
 - defined, 301
 - Medicare definitions
 - established patient, 301
 - new patient, 301
 - multiple clinicians, concurrent visit
 - same day, clinic, 302
 - multiple visits
 - same day, different clinics, 302
 - new patient, Medicare
 - defined, 301
 - observation services
 - coding guidelines, Medicare, 304
 - Medicare restrictions on billing for, 304
 - service and procedure, same day
 - modifier 25 requirement, 305
 - surgical procedure
 - emergency department visit and, 303
- Evaluation and management (physician)
 - admit H&P, 97
 - surgical procedure, same day, 97
 - burns, typical services, 89
 - CMS requirements
 - CMS documentation, 72
 - CPT documentation, 72
 - CMS requirements for code selection, 72
 - code types
 - level of service, 71
 - other, 71
 - time-defined, 71
 - codes categories of
 - preventive, 71
 - codes, categories of
 - problem-oriented, 71
 - consultation, 94
 - documentation of, 94
 - emergency department, 89,92
 - inpatient, 93
 - one per inpatient stay, 93
 - patient or family requested, 91
 - requirements, CPT, 90
 - critical care, 99
 - content of care100
 - defined, 100
 - hourly, 100, 109
 - neonatal, 113, 107
 - pediatric, 113
 - bundledprocedures,101
 - coding by time, 102
 - coding summary, 109
 - conditions for reporting, 100
 - diagnosis coding, 107
 - documentation example, 107
 - documenting services, 99
 - ER reporting of, by patient age, 89, 104
 - in ER & inpatient admission, guidelines, 109
 - in ER, guidelines, 104
 - Medicare regulations & modifiers required, 104
 - Medicare regulations, excerpt, 106
 - non-critical patient in unit, 101
 - postoperative, general, 105
 - postoperative, Medicare, 105
 - preoperative, general, 104
 - preoperative, Medicare, 104
 - reportable procedures, 102
 - reportable services, 101
 - reporting time by code, 103
 - teaching physician presence and, 107
 - undocumented time and, 106
 - definition
 - established patient, 70
 - definition (CPT)
 - new patient, 70
 - definition (Medicare)
 - new patient, 70
 - definition, CPT
 - new patient, 70
 - definition, Medicare
 - new patient, 70
 - definitions
 - established patient, 70
 - face-to-face time, 70
 - floor/unit time, 70
 - discharge day management
 - defined, 119
 - discharge planning, summary, 120
 - in postoperative period, 120
 - documentation, 70
 - documentation for
 - E/M and minor procedure, 77

- E/M and minor procedure
 - 25 modifier and, 77
 - documenting, 77
 - payer bundling and, 77
 - separation concept, 77
- emergency department, 89
 - admission and, 89
 - critical care and, 89
 - discharge with, 89
- established patient
 - defined, 70
- face-to-face time
 - defined, 70
- floor/unit time
 - defined, 70
- inpatient daily care
 - postoperative, 110
- inpatient daily visits
 - medical, preoperative, 110
- level of service
 - key components, 71
 - time option, 71
- multidisciplinary rounds, 116
 - applicable codes, 116
 - clinical example, 119
 - reporting guidelines, 117
- neonatal critical care, 113
 - bundled procedures, 114
 - definitions, 113
 - reportable procedures, 115
 - reporting guidelines, 115
- new patient (CPT)
 - defined, 70
- new patient (Medicare)
 - defined, 70
- office/outpatient clinic visit
 - nurse visit (99211), 122
 - postoperative, 121
- office/outpatient clinic visits
 - preoperative, 121
 - preoperative, CPT guidelines & modifiers, 121
 - preoperative, Medicare guidelines & modifiers, 121
- one per day 73
- exceptions, 74
 - Medicare exception for different diagnosis, 74
- pediatric critical care, 110
 - bundled procedures, 110
 - conditions for reporting, 110
 - definitions, 110
 - reportable procedures, 112
 - reporting guidelines, 110
- postoperative
 - CPT guidelines, 76
 - Medicare guidelines, 76
- preoperative, 75
 - CPT guidelines, 75
 - Medicare guidelines, 75
- reporting guidelines, 73
- selecting code level, 72
- Selecting E/M level of service
 - Table of criteria for (Appendix V), 384
- shared service with non-physician practitioner
 - different employers, 88
 - documentation, 87
 - hospital, 80
 - Medicare guideline summary, 82
 - office, 80
 - payment, 83
 - same group, 81
 - selecting code level, 87
- surgical package and, 75
- teaching physician
 - documentation guidelines, key components, 231
 - documentation guidelines, time based codes, 234
- Evaluation and management (physicians)
 - readmissions, 98
- Evaluation and management (teaching physician)
 - documentation guidelines, key components, 231
 - documentation guidelines, time based codes, 234
- Evaluation and management (non-physician practitioner)
 - Selecting E/M level of service
 - Table of criteria for (Appendix V), 408
- Excision, burn wound
 - outpatient hospital service, 324
 - coding, 326
 - reporting guidelines, 327
 - physician service, 167
 - coding, 168
 - reporting guidelines, 169
- Excision, non-burn wound
 - physician service, 168
- Excision, wound
 - physician service
 - coding, 168
 - reporting guidelines, 169
- Fasciotomy
 - outpatient hospital service
 - reporting guidelines, 328
 - reporting guidelines, fasciotomy closure, 328
 - table of codes, 330
 - physician service, 172
 - reporting guidelines, 172
 - reporting guidelines, fasciotomy closure, 172
 - table of codes, 174-75
- Fee schedule,
 - physician, 460
- Fournier's gangrene, Fournier's disease
 - pathophysiology, 224
- Fournier's gangrene, Fournier's disease
 - pathophysiology, 224
- Fraud
 - avoiding, 67
- Functional
 - Ablative Laser
 - 198

- GI tubes
 - physician service
 - feeding tubes, 175
 - gastrostomy, endoscopic, 177
 - gastrostomy, laparoscopic, 177
 - gastrostomy, open method, 178
 - gastrostomy, percutaneous, 177
 - gastrostomy/jejunostomy, 176
 - jejunostomy, intraoperative, 178
 - jejunostomy, laparoscopic method, 179
 - jejunostomy, open method, 179
 - Global periods
 - Medicare
 - global surgery package, 28
 - defined, 28
 - postoperative services and, 29
 - postoperative visits and, 29
 - preoperative visits and, 30
 - unrelated preoperative visits and, 31
 - global surgery package
 - modifiers for, 30
 - global surgery package
 - preoperative visits
 - modifier 57 and, 30
 - global surgery package
 - preoperative visits
 - modifier 25, 30
 - global surgery package
 - major and minor procedures, included and excluded services (Appendix III), 367
 - outpatient hospital services, Medicare APCs, 293
 - definition of, 293
 - Global surgery periods
 - CPT
 - major procedures (CPT surgical package), 29
 - surgical package
 - included and excluded services (Appendix II), 366
 - surgical package
 - excluded services, 30
 - surgical package defined, 28
 - surgical package, included services, 28
 - global surgery package, 28
 - defined, 28
 - follow up days, 28
 - payer variances, 28
 - Medicare
 - burn surgery
 - case studies
 - using codes and modifiers correctly, 38
 - case study 1.0**, 37
 - case study 2.0, 48
 - global surgery package
 - major and minor procedures, included and excluded services, 30
 - major and minor procedures, included and excluded services (Appendix III), 366
 - surgical procedures during global period of previous surgery
 - modifiers required, 33
- outpatient hospital services, Medicare APCs, 293
 - definition of, 293
- Grafts
 - outpatient hospital (outpatient hospital service)
 - skin replacement products, HCPCS codes for, 199
 - outpatient hospital service
 - skin replacements & substitutes, acellular
 - dermal replacement, 332
 - skin replacements & substitutes,
 - autograft/tissue cultured autograft, 334
 - skin replacements & substitutes, clinical case examples, 337
 - skin replacements & substitutes, definitions for, 345
 - skin replacements & substitutes, full thickness graft, 336
 - skin replacements & substitutes, table of, 332
 - skin replacements and substitutes, 332
 - reporting guidelines, 332
 - outpatient hospital service
 - clinical case examples, 337
 - physician service
 - autografts
 - anatomic source of, 174
 - clinical case examples, 188
 - skin grafts, documentation, 182
 - skin replacements & substitutes, 174–88
 - skin replacements & substitutes, acellular dermal replacement, 180
 - skin replacements & substitutes, allograft, tissue cultured allogeneic skin substitute, 181
 - skin replacements & substitutes,
 - autograft/tissue cultured autograft, 178
 - skin replacements & substitutes, clinical case examples, 185
 - skin replacements & substitutes, definitions for, 174
 - skin replacements & substitutes, full thickness graft, 185
 - skin replacements & substitutes, reporting guidelines, 181
 - skin replacements & substitutes, table of, 181
 - source of origin, 174
- HCPCS codes
 - national level II, 12, 260, 295
 - guidelines, 12
 - update period, 15, 260, 295
- Hidradenitis Suppurativa

- diagnosis coding, 225
- pathophysiology, 226
- Hospital Acquired Conditions Rule
 - effect on MS-DRG payment, 269
 - Present on Admission
 - coding for, 270
 - official rules' summary, 272
 - summary excerpts from official reporting guidelines, 270
 - summary of guidelines, 272
- Hospital inpatient
 - burn MS-DRGs, 267
 - coding guidelines
 - burns, 205
 - procedures, 276
 - debridement, 280
 - coding guidelines, official CMS
 - excerpts, general, 275
 - procedures, excerpts, 280
 - coding systems
 - procedure (ICD-10-PCS), 276
 - DRGs background, 264
 - Burn MS-DRGs (Table)**, 267
 - defined, 264
 - Medicare Severity Adjusted (MS-DRGs)
 - development process, 264
 - MS-DRGs, 267
 - tips for code abstraction, 290
 - official coding guidelines
 - burns, 205
 - procedure coding, 276
 - procedure coding definitions
 - principal procedure, 276
 - significant procedure, 296
 - procedure coding requirements, 276
- Hospital Inpatient
 - DRGs
 - burns
 - Table of relative weights & lengths of stay, current year, 270
- Hospital outpatient
 - APCs
 - packaging of
 - by Medicare, 307
 - coding
 - payer variances, 307
 - coding guidelines
 - burns, 347
 - CMS official, for diagnoses, 343
 - probable, suspected, questionable, rule out diagnostic statements, 362
 - coding guidelines, official diagnosis, CMS excerpts, general, 343
 - E/M services
 - Medicare selection criteria for, 301
 - official coding guidelines
 - burns, 280
 - reimbursement
- Infusion
 - physician service
 - intraosseous needle placement for, 191
- Insertion, Swan-Ganz
 - physician service
 - reporting guidelines, 195
- K-wire insertion
 - outpatient hospital service, 191
 - reporting guidelines, 191
 - physician service, 189
 - reporting guidelines, 189
- MDC (Major Diagnostic Category)
 - MDC 22, burns, 265
- Measurement, compartment pressure
 - physician service
 - reporting guidelines, 141
- Medical necessity
 - defined, 19
 - diagnosis and, 19
 - establishing, 19
 - linking diagnoses and procedures, 19
- Medically Unlikely Edits (MUEs)
 - Definition, function, exceptions to, 22
- Medicare
 - global surgery package
 - carrier denial
 - unrelated inpatient postoperative visits, 31
 - case studies, burn surgery
 - using codes, modifiers correctly, 37
 - case study 1.0**, 37
 - case study 2.0, 48
 - group practice billing requirements
 - billing as single physician, 34
 - modifiers required, 32
 - modifier 78 and, 35
 - payment for, 35
 - procedures (postoperative) not requiring return to OR, 35
 - procedures (postoperative) requiring return to OR, 35
 - separately billable procedures
 - during global period
 - modifiers for payment, 33
 - during postoperative period
 - modifiers for payment, 33
 - modifiers for payment, 33
 - separately billable procedures during, 33
 - surgeons in group practice billing requirements, 34
 - unrelated postoperative visits

- carrier payment for, 31
 - denial policy eliminated, 31
 - unrelated postoperative visits and, 31
 - unrelated postoperative visits, conditions for payment, 32
- Medicare global surgery package
 - major procedures, 30
 - preoperative visits
 - modifier 57 and, 30
 - minor procedures, 30
 - preoperative visits
 - modifier 25 and, 30
 - postoperative visits
 - modifiers for, 31
 - preoperative visits
 - modifiers for, 30
- Medicare outpatient hospital prospective payment system
 - APCs
 - coding for, 307
- Medicare physician fee schedule
 - 460
- Medicare physician services
 - case studies**
 - case study 1.0**, 37
 - case study 2.0, 47
 - case studies, burn surgery
 - using codes and modifiers correctly, 37
- Modifiers
 - burns
 - table of most commonly used, 54
 - CPT, 56
 - defined, 56
 - HCPCS, 56
 - payer acceptance of
 - HIPAA requirements, 56
- Modifiers (outpatient hospital)
 - 25 modifier, separately identifiable E/M service, 362
 - 50 modifier, bilateral procedure, 355
 - 52 modifier, reduced service (radiology), 358
 - 58 modifier, staged or related procedure, 375
 - 59 modifier, distinct procedural service (radiology), 358
 - 73 modifier, discontinued procedure, prior to anesthesia, 356
 - 74 modifier, discontinued procedure after administration of anesthesia, 356
 - 76 modifier, repeat procedure, same physician, 356
 - 76 modifier, repeat procedure, same physician (radiology), 359
 - 77 modifier, repeat procedure, different physician, 357
 - 77 modifier, repeat procedure, different physician (radiology), 359
 - 78 modifier, return to the OR, related procedure, 357
 - 79 modifier, unrelated procedure, same physician, during postoperative period, 357
 - CMS approved, 355
 - guidelines, HCPCS Level II, 352
 - Medicare guidelines, 351
 - table of all modifiers, outpatient hospital reporting, 355
 - table of approved HCPCS Level II modifiers, 355
 - E1-E4 modifiers, eyelids, 358
 - FA-F9 modifiers, fingers, 358
 - RT or LT modifiers, right or left side (radiology), 359
 - RT or LT modifiers, right or left sides, 358
 - TA-T9 modifiers, toes, 358
- Modifiers (physician)
 - Appendix IV, 368
 - assistant at surgery, 61,
 - assistant surgeon, qualified resident unavailable, 61
 - bilateral procedure, 370
 - burns, commonly applicable to
 - E/M, 61
 - surgical, 56
 - claim payment and, 53
 - co-surgeons, 58,376
 - decision for surgery, 63, 374
 - discontinued procedure, 372
 - distinct procedural service, 57, 375
 - E/M service, separately identifiable, 62, 369
 - essential concepts, 53
 - HCPCS Level II, 382
 - eyelid, 382
 - fingers, 382
 - toes, 382
 - HIPAA requirements, 54
 - Increase service, 368
 - Medicare global surgery package
 - separately billable procedures during, 33
 - modifiers for, 33
 - Medicare global surgery package and, 30
 - preoperative E/M services, 32
 - major procedures, 34
 - minor procedures, 34
 - related postoperative visits during global period, 35
 - unrelated visits during postoperative 35,368
 - multiple procedures, 371
 - payer acceptance of, 55
 - postoperative care only, 372
 - preoperative care only, 373
 - procedure on infants less than 4 kg, 378
 - reduced services, 371
 - related procedure, return to OR, 60, 379
 - repeat procedure, different physician, 379
 - repeat procedure, same physician, 379
 - reporting guidelines
 - CPT and HCPCS Level II, list of (Appendix IV), 392–407
 - staged or related procedure, 57 ,374
 - surgical care only, 372

- team surgery, 378
- unrelated E/M during postoperative period, 392
- unrelated E/M service during postoperative period, 61
- unrelated procedure, 61, 380
- unusual procedural services, 57, 392
- MS-DRGs, 264–77
 - 928 & 929
 - coding for, 298
- MUEs (Medically Unlikely Edits)
 - Definition, function, exceptions to, 27
- Mutually exclusive procedures
 - unbundling, 27
- Necrotizing fasciitis
 - diagnosis coding, 226
 - pathophysiology, 226
- Non-burn conditions
 - calciphylaxis
 - diagnosis coding, 222
 - pathophysiology, 220
 - degloving injuries
 - diagnosis coding, 223
 - pathophysiology, 222
 - Fournier's gangrene (disease)
 - diagnosis coding, 224
 - pathophysiology, 223
 - hidradenitis suppurativa
 - pathophysiology, 225
 - procedure coding, 225
 - necrotizing fasciitis
 - pathophysiology, 226
 - purpura fulminans (Waterhouse-Friderichsen syndrome)
 - pathophysiology, 227
 - Table of diagnosis codes for, 372
 - toxic epidermal necrolysis (TEN)
 - pathophysiology, 227
 - toxic epidermal necrolysis (TENS)
 - diagnosis coding, 228
- Non-burn conditions
 - hidradenitis suppurativa
 - diagnosis coding, 225
- Non-burn conditions
 - necrotizing fasciitis
 - diagnosis coding, 226
- Non-burn conditions
 - purpura fulminans (Waterhouse-Friderichsen syndrome)
 - diagnosis coding, 227
- Non-burn conditions (physician service)
 - coding for, 220–29
 - procedure coding, 220
 - professional services, coding for, 220
- Non-physician practitioners (NP, PA, CNS), 239–50
 - coding and payer issues
 - inconsistency, complexity by states, payers, 239
 - consultation, shared
 - Medicare billing prohibition, 81, 84, 88, 245, 247
 - CPT coding guidelines, 243
 - diagnosis coding, 250, *See also* Diagnosis coding, physician, non-physician professionals
 - evaluation and management
 - consultations, 247
 - inpatient hospital care, 248
 - office/outpatient clinic visit, 245
 - evaluation and management guidelines, 244
 - global surgery package
 - Medicare, 248
 - global surgery periods
 - CPT, 248
 - Medicare, 248
 - licensing, scope of practice issues, 239
 - Medicare
 - "incident to" regulations, 241
 - Medicare regulations, selected, 240
 - provider numbers
 - National Provider Identifier (NPI), 80, 241
 - recommendations, practitioner-specific information, 242
 - shared evaluation and management service. *See also* Evaluation and management (physician), shared service with non-physician
 - shared evaluation and management service, with physician, 245
 - surgical package
 - CPT, 248
 - surgical procedures
 - assistant at surgery and, 250
 - assistant at surgery, Medicare, 250
 - global periods, guidelines, 248
 - global surgery package
 - Medicare, 249
 - surgical package
 - CPT, 249
 - Observation services (outpatient hospital service)
 - coding
 - Medicare guidelines, 296
 - Medicare billing restrictions for, 296
 - Packaging APCs
 - Medicare outpatient hospital payment and, 296
 - Physician fee schedule (Medicare)
 - burn surgery
 - assistant surgeon allowed procedures, 424
 - global periods, 423
 - relative values, 423
 - Present on Admission (POA)
 - Hospital Acquired Conditions Rule
 - official reporting guidelines, 299
 - official reporting guidelines, summary excerpts, 299
 - Procedure coding
 - inpatient hospital, 291–97
 - Procedures (outpatient hospital service)
 - reporting guidelines, Medicare
 - unbundling and, 321
 - units of service, Medicare
 - reporting, 321
 - Prosthesis, oral or maxillofacial
 - physician service, 193
 - Purpura fulminans (Waterhouse-Friderichsen syndrome)

- diagnosis coding, 227
- pathophysiology, 227
- References, 386
- Relative value
 - reimbursement, physicians, 21
 - update process, 21
 - physician fees. *See* Appendix VII
 - physician fees, 21
- Relative values
 - burn surgery
 - Medicare physician fee schedule, 423
- Scar revision
 - outpatient hospital service, 322
 - excision with primary closure, 323
 - hand scar, 326
 - incisional release and skin graft, 325
 - removal and skin graft, 325
 - removal with adjacent tissue transfer, 324
 - physician service, 135
 - excision with primary closure, 136
 - hand, 139
 - incisional release and skin graft, 138
 - removal and skin graft, 138
 - removal with adjacent tissue transfer, 137
- Skin biopsy
 - outpatient hospital service
 - definition, 322
 - reporting guidelines, 322
 - physician service
 - definition, 126
 - reporting guidelines, 126
- Specimen, blood
 - collection of
 - central or peripheral venous catheter. *See* implantable venous access device, 130
- Splints, custom construction in OR
 - outpatient hospital service
 - reporting guidelines, 341
 - physician service
 - reporting guidelines, 191
- Staged or related procedure (physician)
 - modifier, 57
- Supervision (physician)
 - of hospital staff nurse performing procedure
 - prohibition against billing for, 67
 - regulations, guidelines, 68
 - of procedure/service performed by physician's nurse employee
 - professional billing for, 68
- Surgical procedures (non-physician practitioner)
 - debridement, burn, 141
 - reporting guidelines, 143
 - debridement, non-burn wound
 - prosthetic mesh insertion with, 149
 - prosthetic mesh removal of, 148
 - reporting guidelines, 147
 - debridement, non-burn wounds, 146
 - global periods, guidelines. *See also* Global periods and Surgical procedures (physicians), global periods
 - global surgery package
 - CPT, 32
 - Medicare, 34, 249
 - global surgery periods, 32
 - surgical package
 - CPT, 249
- Surgical procedures (outpatient hospital service)
 - application bilaminar skin substitute/neodermis, 2006 deletion of, 321
 - biopsy of skin
 - definition, 322
 - reporting guidelines, 322
 - contracture release, 322
 - excision with primary closure, 323
 - hand scar, 326
 - incisional release and skin graft, 325
 - removal and skin graft, 325
 - removal with adjacent tissue transfer, 324
 - debridement, 326–35
 - coding variances by performing clinician, 327
 - coding variances, wound type, 327
 - definition of, 327
 - debridement, burn
 - by non-physician professional (PT/OT), 332
 - by physician/non-physician practitioner, 327
 - versus excision, 329
 - debridement, burn, by physician or non-physician practitioner
 - reporting guidelines, 329
 - debridement, non-burn wound
 - by non-physician professional (PT/OT), 334
 - by physician/non-physician practitioner, 330
 - prosthetic mesh insertion with, 332
 - debridement, non-burn wounds
 - prosthetic mesh removal with, 331
 - debridement, non-burn, by physician or non-physician practitioner
 - reporting guidelines, 331
 - dressings, 335, 337
 - burn wounds, 336
 - grafts, 336
 - non-burn wounds, 337
 - dressings, burn wounds
 - coding, 336
 - reporting guidelines, 336
 - dressings, grafts
 - coding guidelines, 336
 - reporting guidelines, 336
 - dressings, non-burn wounds
 - coding, 337
 - escharotomy, 337
 - reporting guidelines, 337
 - excision, burn wound, 338
 - application of Biobrane not reportable, 341, 347
 - application of dressings not reportable, 341, 347
 - coding, 340
 - reporting guidelines, 341
 - fasciotomy
 - reporting guidelines, 342
 - table of codes, 344
 - fasciotomy, closure
 - reporting guidelines, 343

- grafts
 - skin replacement products, HCPCS codes for, 346
- grafts, clinical case examples, 352
- grafts, skin replacements & substitutes
 - acellular dermal replacement, 350
 - allograft, tissue cultured allogeneic skin substitute, 351
 - autograft/tissue cultured autograft, 348
 - clinical case examples, 352
 - table of, 346
 - xenograft, 352
- grafts, skin replacements and substitutes
 - reporting guidelines, 345
- K-wire insertion, 357
 - reporting guidelines, 357
- scar revision, 322
 - excision with primary closure, 323
 - hand scar, 326
 - incisional release and skin graft, 325
 - removal and skin graft, 325
 - removal with adjacent tissue transfer, 324
- skin biopsy
 - definition, 322
 - reporting guidelines, 322
- skin replacements & substitutes, definitions for, 345
- skin substitute/neodermis
 - 2006 deletion of, 321
- splints, custom construction in OR
 - reporting guidelines, 358
- units of service, Medicare
 - reporting, 321
- Surgical procedures (outpatient hospital services)
 - excision, burn wound
 - application of Adaptic not reportable, 341, 347
 - application of Exudry not reportable, 341, 347
 - application of Xeroform not reportable, 341, 347
- Surgical procedures (outpatient hospital)
 - grafts, skin replacements & substitutes
 - full thickness graft, 350
- Surgical procedures (physician)
 - abdominal decompression, 129
 - compartment syndrome
 - diagnoses, coding guidelines for, 129
 - reporting guidelines, 129
 - amputation
 - reporting guidelines, 130
 - arterial line insertion, 131
 - reporting guidelines, 131
 - biopsy of skin
 - definition, 132
 - reporting guidelines, 132
 - bronchoscopy
 - diagnostic, 132
 - reporting guidelines, 133
 - surgical, 133
 - central venous access
 - central insertion method, 134
 - code categories, 135
 - definition of, 134
 - exchange, reporting guidelines, 138
 - exchange, same access site, 138
 - imaging guidance for, 139
 - insertion codes, reporting guidelines, 137
 - insertion of, 136
 - peripheral insertion method, 135
 - removal non-tunneled device, 139
 - removal with insertion, new site, 138
 - reporting guidelines, 138
 - repositioning, 136
 - types of insertion, 135
 - clysis, subeschar
 - reporting guidelines, 194
 - compartment pressure measurement
 - reporting guidelines, 141
 - contracture release, 141
 - excision with primary closure, 142
 - hand scar, 145
 - incisional release and skin graft, 144
 - removal and skin graft, 144
 - removal with adjacent tissue transfer, 143
 - debridement, 145
 - coding variances by performing clinician, 146
 - coding variances, wound type, 146
 - definition of, 146
 - debridement, burn, 147
 - CPT surgical package and, 150
 - Medicare global surgery and, 149
 - reporting guidelines, 148
 - versus excision, 148
 - debridement, non-burn
 - CPT surgical package and, 150
 - Medicare global surgery and, 149
 - debridement, non-burn wound
 - prosthetic mesh insertion with, 154
 - debridement, non-burn wounds, 146
 - prosthetic mesh removal with, 153
 - reporting guidelines, 152
 - documentation
 - operative report, 123
 - dressings, 159
 - burn wounds, 160
 - grafts, 163
 - non-burn wounds, 165
 - coding, 165
 - dressings, burn wounds
 - by different physician, same group, postop, 162
 - coding, 160
 - CPT surgical package guidelines, 162
 - Medicare global surgery guidelines, 161
 - reporting guidelines, 160
 - dressings, grafts
 - coding guidelines, 163
 - CPT surgical package guidelines, 164
 - Medicare global surgery guidelines, 164
 - escharotomy, 165
 - documentation of, 165
 - reporting guidelines, 166
 - excision, burn wound, 167
 - application of Adaptic not reportable, 170

- application of Biobrane not reportable, 147
- application of dressings not reportable, 147
- application of Exudry not reportable, 147
- application of Xeroform not reportable, 147
- coding, 168
- reporting guidelines, 16
- excision, non-burn wounds, 168
- excision, wound
 - coding, 168
 - reporting guidelines, 168
- fasciotomy, 172
 - reporting guidelines, 172
 - table of codes, 174-75
- fasciotomy closure
 - reporting guidelines, 172
- GI tubes
 - feeding tubes, 175
 - gastrostomy, endoscopic, 177
 - gastrostomy, laparoscopic, 177
 - gastrostomy, open method, 178
 - gastrostomy, percutaneous, 177
 - gastrostomy/jejunostomy, 176
 - jejunostomy, laparoscopic method, 177
 - jejunostomy, open method, 178
- global surgery package
 - CPT, 32
 - Medicare, 34
- global surgery periods, 32
- grafts
 - autografts, anatomic source of, 179
 - source of origin, 174
- grafts, clinical case examples, 185
- grafts, skin replacements & substitutes
 - acellular dermal replacement, 181
 - autograft/tissue cultured autograft, 183
 - clinical case examples, 188
 - full thickness graft, 185
 - reporting guidelines, 181
 - table of, 181
- infusion
 - intraosseous needle placement for, 188
- insert
 - arterial line, 131
- jejunostomy
 - intraoperative, 178
- K-wire insertion, 189
 - reporting guidelines, 189
- multiple, reduced payment and, 63
 - add-on codes unaffected by, 63
 - modifier 51 exempt codes unaffected by, 63
- multiple, same operative session, 63
 - example, grafts, 186
 - example, grafts and modifier 50, 186
- major procedure, determining, 64
 - Medicare case study, 45, 46, 52
 - Medicare case study and modifier 37, 47
 - modifier 51 and, 63
 - ranking on claim form, 64
 - sample claim for, 365
 - secondary procedures, determining, 64
- needle placement, intraosseous infusion, 188
- operative report documentation
 - clinical indications, 125
 - narrative, 123
 - preoperative diagnosis, 123
 - statement of procedure performed, 124
 - surgical responsibility, 123
- physician service
 - skin replacements & substitutes, definitions for, 179
- procedural services, 123
- protheses, oral or maxillofacial, 194
- scar revision, 135
 - excision with primary closure, 142
 - incisional release and skin graft, 144
 - removal and skin graft, 144
 - removal with adjacent tissue transfer, 143
- skin biopsy
 - definition, 132
 - reporting guidelines, 132
 - skin grafts
 - documentation, operative reports, 185
- splints, custom construction in OR
 - reporting guidelines, 192
- Swan-Ganz, insertion of
 - reporting guidelines, 195
- teaching physician guidelines
 - documentation guidelines, 235
- tracheostomy
 - reporting guidelines, 196
- Surgical procedures, (physician)
 - reporting
 - basic concepts of, 123
- Swan-Ganz insertion
 - physician service
 - reporting guidelines, 195
- Teaching physician guidelines, 230–38
 - assistant at surgery, 237
 - qualified resident not available, 237
- Assistant at surgery
 - defined, 237
- evaluation and management
 - key components, 231
 - time based codes, 234
- procedures
 - documentation guidelines, 235
- Teaching physician supervision
 - procedure/service performed by resident, 68
- Toxic epidermal necrolysis
 - diagnosis coding, 228
- Toxic epidermal necrolysis (TEN)
 - pathophysiology, 228
- Tracheostomy
 - physician service

- reporting guidelines, 195
- Tubes, GI
 - physician service
 - feeding tubes, 175
 - gastrostomy, endoscopic, 177
 - gastrostomy, laparoscopic, 177
 - gastrostomy, open method, 178
 - gastrostomy, percutaneous, 177
 - gastrostomy/jejunostomy, 176
 - jejunostomy, intraoperative, 178
 - jejunostomy, laparoscopic method, 179
 - jejunostomy, open method, 179
- Unbundling
 - avoiding, 21
 - Medicare's CCI and, 21
 - bypassing payer edits
 - modifier -59, 21
 - defined, 20
 - E/M services, 74
 - examples
 - coding errors, 21
 - examples, outpatient hospital services
 - coding errors, 312
 - mutually exclusive procedures, 312
 - mutually exclusive procedures, 22
 - outpatient hospital services
 - avoiding
 - checking Medicare's Correct Coding Initiative (CCI) online, 298
 - checking Medicare's Correct Coding Initiative (CCI) online, 298
 - defined, 296
 - distinguishing from "packaged" services, 296
 - payer edits, 311
 - payer edits detect, 25
 - physician services avoiding
 - checking Medicare's Correct Coding Initiative (CCI) online, 298
 - checking Medicare's Correct Coding Initiative (CCI) online, 298
 - Unrelated E/M service during postoperative period (physician)
 - modifier, 61
 - Unusual procedural service (physician)
 - modifier, 56
 - Updates, coding systems, inpatient & outpatient hospital
 - annual updates, effective dates, 263
 - Updates, coding systems, physician services
 - annual updates, effective dates, 14
 - VAC (vacuum assisted wound closure)
 - outpatient hospital service
 - definition, 342
 - reporting guidelines, 342
 - physician service
 - definition, 196
 - reporting guidelines, 196
 - Vacuum assisted wound closure (VAC)
 - outpatient hospital service
 - definition, 342
 - reporting guidelines, 342
 - physician service
 - definition, 196
 - reporting guidelines, 196