INGENIX®

# Coding Companion for Primary Care

*A comprehensive illustrated guide to coding and reimbursement*

# Contents

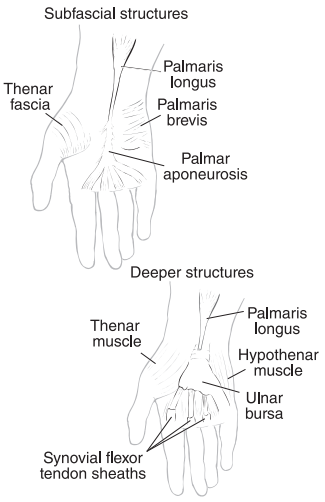
# 26115-26116 (26111, 26113)

**26115** Excision, tumor or vascular malformation, soft tissue of hand or finger, subcutaneous; less than 1.5 cm

**26111** 1.5 cm or greater

**26116** Excision, tumor, soft tissue, or vascular malformation, of hand or finger, subfascial (eg, intramuscular); less than 1.5 cm

**26113** 1.5 cm or greater




Report 26115 or 26111 for subcutaneous excision and 25116 or 26113 for subfascial excision of a soft tissue tumor of the hand or fingers

## Explanation

The physician removes a tumor or vascular malformation from the soft tissue of the hand or finger that is located in the subcutaneous tissue in 26111 and 26115 and in the deep soft tissue below the fascial plane, or within the muscle, in 26113 or 26116. With the proper anesthesia administered, the physician makes an incision in the skin overlying the mass and dissects down to the tumor or malformation. The extent of the tumor is identified and a dissection is undertaken all the way around the tumor. The blood vessels are ligated and the defective tissue of the vascular malformation is excised. A portion of neighboring soft tissue may also be removed to ensure adequate removal of all tumor tissue. A drain may be inserted, and the incision is repaired with layers of sutures, staples, or Steri-strips. Report 26115 for excision of subcutaneous tumors less than 1.5 cm and 26111 for excision of subcutaneous tumors 1.5 cm or greater. Report 26116 for excision of subfascial or intramuscular tumors less than 1.5 cm and 26113 for excision of subfascial or intramuscular tumors 1.5 cm or greater.

## Coding Tips

Codes 26111 and 26113 are new for 2010. They are resequenced codes and will not display in numeric order. Codes 26115 and 26116 have been revised for 2010 in the official CPT description. According to CPT guidelines, cast application or strapping (including removal) is only reported as a replacement procedure or when the cast application or strapping is an initial service performed without a restorative treatment or procedure. See "Application of Casts and Strapping" in the CPT book in the Surgery Section, under the Musculoskeletal system. Local anesthesia is included in this service. However, this procedure may be performed under general anesthesia, depending on the age and/or condition of the patient.

## ICD-9-CM Procedural

82.21 Excision of lesion of tendon sheath of hand

82.22 Excision of lesion of muscle of hand

82.29 Excision of other lesion of soft tissue of hand

83.49 Other excision of soft tissue

86.3 Other local excision or destruction of lesion or tissue of skin and subcutaneous tissue

86.4 Radical excision of skin lesion

## Anesthesia

**26111** 00400, 01810, 01840, 01850

**26113** 01810, 01840, 01850

**26115** 00400, 01840, 01850

**26116** 01810

## ICD-9-CM Diagnostic

171.2 Malignant neoplasm of connective and other soft tissue of upper limb, including shoulder

173.6 Other malignant neoplasm of skin of upper limb, including shoulder

195.4 Malignant neoplasm of upper limb

198.89 Secondary malignant neoplasm of other specified sites

209.33 Merkel cell carcinoma of the upper limb

209.75 Secondary Merkel cell carcinoma

214.1 Lipoma of other skin and subcutaneous tissue

215.2 Other benign neoplasm of connective and other soft tissue of upper limb, including shoulder

228.01 Hemangioma of skin and subcutaneous tissue

238.1 Neoplasm of uncertain behavior of connective and other soft tissue

239.2 Neoplasms of unspecified nature of bone, soft tissue, and skin

686.1 Pyogenic granuloma of skin and subcutaneous tissue — (Use additional code to identify any infectious organism: 041.0-041.8)

727.02 Giant cell tumor of tendon sheath

728.79 Other fibromatoses of muscle, ligament, and fascia

747.63 Congenital upper limb vessel anomaly

747.69 Congenital anomaly of other specified site of peripheral vascular system

782.2 Localized superficial swelling, mass, or lump

## CCI Version 15.3

Also not with 26115: 01810, 10060, 10140, 10160, 11010-11012❖, 12041, 20526-20553, 25259, 26055-26110, 26160, 26185, 26340, 26520-26525, 29086, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 37618, 43752, 51701-51703, 62310-62319, 64400-64435, 64445-64450, 64470, 64475, 64479, 64483, 64505-64530, 64702-64704, 69990, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150

Also not with 26116: 01810, 10060, 10140, 10160, 11012❖, 12001-12007, 12020-12021, 12041-12047, 13121, 13131-13132, 20526-20553, 25259, 26055, 26070-26080, 26160, 26185, 26340, 26520-26525, 29086, 36000, 36400-36410, 36420-36430, 36440, 36600, 36640, 37202, 37618, 43752, 51701-51703, 62310-62319, 64400-64435, 64445-64450, 64470, 64475, 64479, 64483, 64505-64530, 64702-64704, 93000-93010, 93040-93042, 93318, 94002, 94200, 94250, 94680-94690, 94770, 95812-95816, 95819, 95822, 95829, 95955, 96360, 96365, 96372, 96374-96376, 99148-99149, 99150

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

## Medicare Edits

| | Fac RVU | Non-Fac RVU | FUD | Assist |
|---|---|---|---|---|
| **26111** | 11.12 | 11.12 | 90 | 80 |
| **26113** | 14.63 | 14.63 | 90 | 80 |
| **26115** | 8.83 | 12.54 | 90 | N/A |
| **26116** | 13.86 | 13.86 | 90 | N/A |

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

## 0188T-0189T

**0188T** Remote real-time interactive video-conferenced critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

**0189T** each additional 30 minutes (List separately in addition to code for primary service)

### Explanation

The physician delivers direct medical care from an off-site location for a patient who is critically ill or critically injured. Using real-time interactive videoconferencing, this method of critical care is used in addition to on-site critical care services in situations where the patient requires more resources than are available on-site. The physician must have real-time access to the patient's medical record (medication record, nursing and progress notes, vital signs, laboratory and other diagnostic test results, and x-rays), as well as the ability to enter orders electronically, document the services provided, communicate by videoconference with on-site personnel, thoroughly assess the patient and equipment, and communicate with patients and family members on a real-time basis. Report 0188T for the first 30–74 minutes of remote real-time interactive video-conferenced critical care on a given date. This code should be reported only once per day, even though the time spent by the physician on that day may not be continuous. Report 0189T in conjunction with 0188T for each additional 30-minute period in excess of the first 74 minutes.

### Coding Tips

These codes have been revised for 2010 in the official CPT description.

## 70030

**70030** Radiologic examination, eye, for detection of foreign body

### Explanation

X-rays of the eyes are obtained to determine the location of a foreign body in the eye. After positioning the patient, either a one or two view x-ray is obtained. Transparent objects such as glass may not be good candidates for x-ray visualization. The physician supervises the procedure and interprets and reports the findings.

## 70140-70150

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

**70150** complete, minimum of 3 views

### Explanation

X-rays of the facial bones are obtained to determine an injury, fracture, or neoplasm. After positioning the patient, x-rays are taken of the facial bones. The physician supervises the procedure and interprets and reports the findings. When less than three facial x-rays are taken, report 70140. When more than three are taken, report 70150.

## 70160

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

### Explanation

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

## 71010

**71010** Radiologic examination, chest; single view, frontal

### Explanation

A radiograph is taken of the patient's chest from front to back (AP). Typically, this is done when the patient is too ill to stand or be turned to the prone position. The key element of this code is that it reports a single, frontal view.

## 71020

**71020** Radiologic examination, chest, 2 views, frontal and lateral;

### Explanation

Films are taken of the patient's chest to include a frontal and side to side (lateral) view. This code specifically reports these two views.

## 71021

**71021** Radiologic examination, chest, 2 views, frontal and lateral; with apical lordotic procedure

### Explanation

Films are taken of the patient's chest with the patient placed in a side to side (lateral) position, as well as a standard front to back position (AP). Another front to back (AP) film is also taken with the patient leaning back resting shoulders against the wall/film tray in a lordotic (arched back) position. This projection produces x-rays that demonstrate the top, or apices, of the lungs.

## 71022

**71022** Radiologic examination, chest, 2 views, frontal and lateral; with oblique projections

### Explanation

Radiographs are taken of the patient's chest with the patient in a standard front to back (AP) position, as well as side to side (laterally). In addition, right and left obliques, or angled views, are taken. The key element of this code is that it reports specifically frontal, lateral, and oblique views.

## 71030

**71030** Radiologic examination, chest, complete, minimum of 4 views;

### Explanation

Films are taken of the patient's chest, specifically a complete exam, with a minimum of four views. Typically, this would include a back to front (PA), side to side (lateral), and right and left obliques, but may include any number of specialized projections, e.g., axial (angulated) views or lateral decubitus views for fluid levels.

## 71130

**71130** Radiologic examination; sternoclavicular joint or joints, minimum of 3 views

### Explanation

Films are taken of the sternoclavicular joint or joints with a minimum of three views from posteroanterior and oblique projections.

## 72020

**72020** Radiologic examination, spine, single view, specify level

### Explanation

One film is taken of the spine that requires specification of the level examined.

## 72040-72052

**72040** Radiologic examination, spine, cervical; 2 or 3 views

**72050** minimum of 4 views

**72052** complete, including oblique and flexion and/or extension studies

### Explanation

A radiologic examination of the cervical spine is performed that includes a minimum of two views in 72040, a minimum of four views in 72050, and a complete study in 72052. The complete study includes films taken in oblique (angled) positions and in flexion and/or extension positioning.

## 72069

**72069** Radiologic examination, spine, thoracolumbar, standing (scoliosis)

### Explanation

Typically a film is taken of the thoracolumbar spine from front to back (AP) while the patient is standing erect. This film is used to detect any curvature of the spine when scoliosis or other pathology may be present.

## 72070-72074

**72070** Radiologic examination, spine; thoracic, 2 views

# Evaluation and Management

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

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

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

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

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

## Types of E/M Services

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

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services
- Hospital inpatient services—initial care
- Hospital inpatient services—subsequent care
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient

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

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

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

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

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

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

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

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