PROCEDURE DESCRIPTIONS

RTI CODE CPT CODE DECRIPTION GLOBAL PERIOD

NON BILLABLE SERVICES

0009 Scribe attestation missing

0034 Private MD visit

(seen in ER by one's own physician with NO ERMD involvement)

0038 Unlicensed student practitioner/scribe

0039 NP Non-billable

0040 PA Non-billable

0041 Resident non billable

(Medicare charts without proper attestation)

0065 Non-billable MLP w/o MD co-signature

0077 Unable to locate MD notes

(unable to locate MD notes)

0078 Missing T sheet

(externally suspended chart is returned with T sheet still missing)

0083 Dead on arrival

0085 Insufficient inpatient charge documentation

0091 Void

0098 Insufficient MD documentation

(For all payors when missing one or more of the 3 key

components-history, physical exam, and/or medical decision making)

0108 Nonbill wound check/dressing change

0109 Suture removal

0125 Left without being seen

0509 Simple suture removal – nursing only; no ERMD/MLP involvement

EVALUATION & MANAGEMENT SERVICES (SICKNESS)

9016 99281 Emergency medical evaluation & management level 1

9028 99282 Emergency medical evaluation & management level 2

9039 99283 Emergency medical evaluation & management level 3

9046 99284 Emergency medical evaluation & management level 4

9055 99285 Emergency medical evaluation & management level 5

EVALUATION & MANAGEMENT SERVICES (INJURY)

9077 99281 Emergency medical evaluation & management level 1

9081 99282 Emergency medical evaluation & management level 2

9090 99283 Emergency medical evaluation & management level 3

9103 99284 Emergency medical evaluation & management level 4

9120 99285 Emergency medical evaluation & management level 5

OBSERVATION CARE SERVICES Admit and Discharge Same Day

9234 99234 Initial observation care level 1

9235 99235 Initial observation care level 2

9236 99236 Initial observation care level 3

SUBSEQUENT OBSERVATION CARE SERVICES

9244 99224 Subsequent observation 1 – 15 min

9245 99225 Subsequent observation 2 – 25 min

9246 99226 Subsequent observation 3 – 35 min

OBSERVATION CARE SERVICES More than one calendar date

9218 99218 Initial observation care level 1 – 30 min at bedside and on floor

9219 99219 Initial observation care level 2 – 50 min at bedside and on floor

9220 99220 Initial observation care level 3 – 70 min at bedside and on floor

9217 99217 Observation care discharge day summary

RTI CODE CPT CODE DECRIPTION GLOBAL PERIOD

CRITICAL CARE

9225 (Sickness) 99291 Critical care services 30 minutes to 74 minutes in duration

9325 (Injury) 99291 Critical care services 30 minutes to 74 minutes in duration

9233 99292 Critical care services each increment up to 30 minutes over the initial 74 minutes

9274 92950 CPR (includes defibrillation) - performed on patients in cardiac arrest

9266 92960 Cardioversion - Electrical conversion of a cardiac arrhythmia; performed for patients with heart irregularities or arrhythmias, billable with CCT and CPR when indicated and performed

9241 99288 MD directed EMS/ALS (pre-hospital)

INVASIVE PROCEDURES

ARTERIAL/VENOUS ACCESS

3004 36420 Venous cutdown in patient LT 1 year of age 0 days

3012 36425 Venous cutdown in patient one + years of age 0 days

(Incision made in skin over vein - needle inserted into vein to wiithdraw blood or to infuse medications or fluids)

3025 36555 Insertion of a non-tunneled centrally inserted venous catheter 0 days in patient LT5 years of age

(venous catheter inserted directly through skin into vein)

3026 36556 Insertion of a non-tunneled centrally inserted venous catheter 0 days in patient GT5 years of age

3027 36557 Insertion of a tunneled centrally inserted venous catheter in 0-10 days patient LT5 years of age

(venous catheter is threaded through a surgically created subcutaneous tunnel and then into vein)

3028 36558 Insertion of a tunneled centrally inserted venous catheter in 0 days patient GT5 years of age

3030 36571 Insert PICC catheter – 5+ years 0 days

3040 36491 Insert PICCC catheter –GT 2 YRS

3046 36410 Physician venipuncture in patient GT 3 years of age 0 days

(nursing procedure; ERMD must state medical necessity and

"performed by me")

3053 36600 Arterial puncture for blood gases 0 days

3142 36140 Arterial introduction of a needle/intra-catheter 0 days

("A-Line")

3139 36680 Placement of needle for intra-osseous infusion 0 days

(needle inserted into bone marrow to administer medications/fluids)

3129 36000 Insert peripheral IV, unilateral 0 days

(nursing procedure; billable when ERMD performs and

documents procedure)

3137 36000 Insert peripheral IV, bilateral 0 days

3145 36400 Venipuncture, jugular or femoral in patient -LT 3 years of age 0 days

3152 36405 Venipuncture, scalp in patient -LT 3 years of age 0 days

3154 36406 Venipuncture other vein – LT 3 years of age 0 days

3591 36591 Collection of blood specimen from a completely implantable 0 days

venous access device

3592 36592 Collection of blood specimen using established central or peripheral 0 days

catheter, venous, not otherwise specified

3593 36593 Declotting by thrombolytic agent of implanted vascular access device 0 days

or catheter

CARDIOTHORACIC

3061 33210 Insert temporary transvenous pacemaker 0 days

(pacer wire inserted through subclavian or jugular vein)

3087 33016 Pericardiocentesis, including imaging guidance, when performed 0 days

(drainage of fluid from pericardial space)

3554 32554 Thoracentesis, without imaging guidance 0 days

(puncture of pleural cavity for aspiration, initial or subsequent)

9282 93503 Swanz-Ganz placement 0 days

(Catheter threaded through femoral vein to heart to monitor

cardiac pressures)

3555 32555 Thoracentesis with insertion of tube, includes water seal with imaging 0 days

guidance

(eg. for pneumothorax), when performed, separate procedure

3550 32550 Insertion of indwelling tunneled pleural catheter with cuff 0 days

3551 32551 Tube thoracostomy, includes water seal 0 days

(eg. for abscess, hemothorax ,empyema) when performed, separate

procedure

3560 32560 Chemical pleurodesis for recurrent or persistent pneumothorax 0 days

3119 32110 Thoracotomy, major, with control of traumatic hemorrhage 0-90 days

(chest is surgically opened)

3125 32160 Thoracotomy, major, with cardiac massage 0-90 days

(chest is surgically opened with internal massage of heart)

FOREIGN BODY REMOVAL

2014 28190 Removal of foreign body, subcutaneous foot 0-10 days

(incision must be made to bill procedure)

2029 20102 Exploration of a penetrating wound, abdomen/back/flank 0-10 days

6007 65220 Removal of foreign body, cornea, simple 0 days

(removed by beveled edge needle)

6015 65222 Removal of a foreign body, cornea, complex 0 days

(removed with eye spud/eye burr, slit lamp)

6017 65235 Removal of a foreign body, deep cornea 0-90 days

(incision made between cornea and sclera- rarely done by ERMD)

6023 65205 Removal of a foreign body, conjunctiva, superficial 0 days

(removed by irrigation, cotton swab, or needle)

6031 65210 Removal of a foreign body, conjunctiva, embedded 0 days

(may require a small incision)

3228 30300 Rhinoscopy/foreign body removal from nasal passage 0-10 days

(requires removal by forceps or suction)

6049 69200 Otoscopy/foreign body removal from external ear canal 0 days

(requires removal by forceps, cerumen scoop, suction, or

irrigation;if removed by irrigation, ERMD must state that he

did the procedure)

4044 46608 Anoscopy with foreign body removal from anal canal 0 days

1107 10120 Removal of a foreign body from subcutaneous tissue, simple 0-10 days

(incision must be made into skin, skin may or may not be

sutured after removal)

1115 10121 Removal of a foreign body from subcutaneous tissue, complex 0-10 days

(incision must be made into the skin for embedded foreign

body requiring deep tissue dissection)

3290 42809 Removal of a foreign body, pharynx 0-10 days

(topical anesthetic to mouth and pharynx; foreign body

removed with forceps)

EARS, NOSE, AND THROAT (ENT)

3160 30901 Control nose bleed, anterior, simple, limited cautery, unilateral 0 days

(electrical or chemical coagulation, silver nitrate, epinephrine

soaked pledgets, topical cocaine, may require some packing)

3178 30901 Control nose bleed, anterior, simple, limited cautery, bilateral 0 days

3194 30903 Control nose bleed, anterior, complex, any method, unilateral 0 days

(nose bleed not responsive to simple coagulation or packing,

requires extensive electrical coagulation and/or packing)

3202 30903 Control nose bleed, anterior, complex, any method, bilateral 0 days

3210 30905 Control nose bleed with posterior packs, initial, any method 0 days

(MD must document posterior bleeding and packing)

3236 31505 Indirect laryngoscopy (diagnostic) 0 days

(laryngeal mirror used to exam larynx and tongue, often used

to evalforeign body sensation)

3240 31525 Direct laryngoscopy (diagnostic), other than newborn, rigid 0 days

(laryngoscope used to examine larynx)

3244 31511 Indirect laryngoscopy with foreign body removal 0 days

3291 41250 Simple laceration repair anterior 2/3 tongue/floor of mouth 0-10 days

2.5cm. or less

2394 41251 Simple laceration repair posterior 1/3 tongue 2.5 cm. or less 0-10 days

6054 69209 Removal impacted cerumen using irrigation/lavage, unilateral

Add modifier 50 for bilateral procedure. Do not code with 6056

6056 69210 Remove impacted cerumen using suction, cerumen spoon, 0 days

forceps unilateral Add modifier 50 for bilateral procedure.

Do not code with 6054

AIRWAY/RESPIRATORY

3233 31502 Change tracheostomy tube 0 days

(used to bill replacement of dislodged tracheostomy tube)

3251 31500 Endotracheal intubation 0 days

(orally or nasally) (Modifier 51 exempt)

3269 31603 Tracheostomy, emergent 0 days

(surgical opening into trachea)

3277 31605 Cricothyroidostomy, emergent 0 days

(large bore needle inserted into cricothyroid membrane to

maintain airway)

3279 32405 Biopsy, lung or mediastinum, percutaneous needle

9337 94656 Ventilator management (note:inpatient charge only) 0 days

(MD must document ventilator settings and/or changes)

31632 Bronchoscopy, rigid or flexible, including fluoroscopic guidance,

When performed; with transbronchial lung biopsy(s), each additional

Lobe (list separately in addition to code for primary procedure)

31633 With transbronchial needle aspiration biopsy(s), each additional

Lobe (list separately in addition to code for primary procedure)

GASTROINTESTINAL

4001 43762 Change gastrostomy tube, percutaneous, without imaging or 0 days

endoscopic guidance

4003 43761 Repositioning of the gastric feeding tube, through the duodenum 0 days

for enteric nutrition

4004 43763 Replace gastric feeding tube requiring revision (complex). Includes incision 0 days

Into the skin and fascia.

4440 49440 Insertion of gastrostomy tube, percutaneous, under fluoroscopic 0 days

guidance including contrast injection(s), image documentation

and report

4441 49441 Insertion of duodenostomy or jejunostomy tube, percutaneous, 0 days

under fluoroscopic guidance including contrast injection(s), image

documentation and report

4442 49442 Insertion of cecostomy or other coplonic tube, percutaneous, under 0 days

fluoroscopic guidance

4446 49446 Conversion of gastrostomy tube to gastro-jejunostomy tube, percutaneous 0 days
under fluoroscopic guidance including contrast injection(s), image documentation

4450 49450 Replacement of gastrostomy or cecostomy (or other colonic) tube, 0 days
percutaneous, under fluoroscopic guidance including contrast injection(s),
image documentation and report

4451 49451 Replacement of duodenostomy or jejunostomy tube, percutaneous, under 0 days
fluoroscopic guidance including contrast injection(s), image documentation
and report

4460 49460 Mechanical removal of obstructive material from gastrostomy, duodenostomy, 0 days
jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube, any
method, under fluoroscopic guidance including contrast injection(s), if performed,
image documentation and report

4465 49465 Contrast injection(s) for radiological evacuation of existing gastrostomy, duo- 0 days
enostomy, jejunostomy, gastro-jejunostomy or cecostomy (or other colonic) tube,
from a percutaneous approach including image documentation and report

4011 49082 Abdominal pericentesis, peritoneal lavage, initial 0 days
(needle inserted into abdominal cavity to withdraw and/or
infuse fluids, without imaging guidance)

4948 49083 Abdominal pericentesis, peritoneal lavage, initial 0 days
(needle inserted into abdominal cavity to withdraw and/or
infuse fluids, with imaging guidance)

4036 46600 Anoscopy, diagnostic 0 days
(exam of anal canal and rectal mucosa)

4051 45300 Proctosigmoidoscopy 0 days
(diagnostic exam of the sigmoid colon, commonly done to eval

GI bleed)

4067 46320 Enucleation of external thrombotic hemorrhoid 0-10 days

(incision and removal of clot or removal of hemorrhoid)

46945 Hemorrhoidectomy, internal, by ligation other than rubber band; single 0 days

hemorrhoid column/group, without imaging guidance

46946 Hemorrhoidectomy, internal, by ligation other than rubber band; 2 or more 0 days

hemorrhoid columns/groups, without imaging guidance

46948 Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization; 2 or 0 days

more hemorrhoid columns/groups, including ultrasound guidance, with

mucopexy, when performed

4028 45915 Fecal disimpaction under anesthesia 0-10 days

(MD must do the disimpaction)

9307 91105 Gastric intubation lavage for treatment 0 days

(NG tube or Ewald tube placed for lavage; MD must state that

he did the procedure)

INCISION AND DRAINAGE

6022 Complicated ear abcess

3295 Plate abcess

4048 46040 I&D perirectal abscess 0-90 days

4065 46083 I&D thrombosed external hemorrhoid 0-10 days

4077 46050 I&D perianal abscess, superficial 0-10 days

5024 55100 I&D Scrotal abscess 0-10 days

5030 56405 I&D vulva or perineal abscess 0-10 days

5033 56420 I&D Bartholin's gland cyst 0-10 days

6028 67700 I&D eyelid abscess 0-10 days

6033 69000 I&D external ear abscess or hematoma, simple 0-10 days

(ear lobe, pinna)

6044 69020 I&D external auditory canal abscess 0-10 days

1008 10080 I&D pilonidal cyst/abscess 0-10 days

1016 10060 I&D abscess, single, paronychia, carbuncle, sebaceous cyst 0-10 days

(wound usually left open for continued drainage)

1018 10061 I&D abscess, complicated or multiple sites 0-10 days

(drain or gauze packing placed to allow continued drainage)

1073 19020 I&D breast abscess (mastotomy) 0-90 days

1099 11740 I&D subungal hematoma (evacuation) 0-10 days

(releasing hematoma under fingernail or toenail; done usually

done by drilling or burning a hole to release blood)

1230 10140 I&D hematoma, seroma, or fluid collection 0-10 days

(may include drain, packing, and/or pressure dressing)

2006 26011 I&D felon 0-10 days

(abscess of deep subcutaneous tissue of a finger, requiring

debridement and irrigation)

2025 26010 I&D finger abscess, simple 0-10 days

(abscess of cutaneous tissue, does not require debridement

and irrigation)

3285 38300 I&D lymph node abscess 0-10 days

(wound is irrigated and closed with sutures or steri strips)

3293 41800 I&D dental abscess 0-10 days

4075 42700 I&D peritonsillar abscess 0-10 days

1081 10160 Puncture aspiration of hematoma, abscess, etc. 0-10 days

(fluid is drained by large bore needle, no incision)

4233 42330 Sialolithotomy, uncomplicated, intraoral 0-10 days

(removal of a stone from submandibular, sublingual, or

parotid duct)

GENITOURINARY

5058 51702 Insert urethral catheter, simple 0 days

(nursing procedure; ERMD must state medical necessity and

"performed by me")

4341 53620 Dilation of urethral stricture, male 0 days

5100 51100 Aspiration of bladder by needle 0 days

(urine withdrawn from bladder for drainage)

5101 51101 Aspiration of bladder by trochar or catheter 0 days

(trochar or intracatheter inserted into bladder for drainage)

5017 51102 Suprapubic tube is placed into bladder (simple cystostomy/suprapubic tube

replacement) 0-10 days

4309 50398 Change nephrostomy or pyelostomy tube 0 days

5385 50385 Removal (via snare/capture) and replacement of internally dwelling 0 days

ureteral stent via transurethral approach, without use of cystoscopy,

including radiological supervision and interpretation

5386 50386 Removal (via snare/capture) of internally dwelling ureteral stent via 0 days

transurethral approach, without use of cystoscopy, including radiological

supervision and interpretation

51705 Change cystostomy tube, the MD uses a guidewire to insert the tube then 0 days

sutures it into place.

5025 57020 Colpocentesis 0 days

(aspiration of fluid from peritoneum through vaginal wall)

5074 59409 Vaginal delivery only (ED or hosp setting) 0 days

(vaginal delivery of an infant and placenta; includes

episiotomy)

5041 59410 Vaginal delivery inc PP care 0 days

(Vag delivery including post-partum care – hosp only)

4366 59414 Delivery of placenta 0 days

(performed to remove retained placenta after delivery)

7587 50690 Injection for visualization- ileal conduit 0 days

(x-ray study of kidneys using contrast medium)

INJECTIONS

5023 54220 Priapism

6068 Optical nerve block

6050 64999 Injection of anesthetic agent to the cervical plexus use (Auricular block)

6085 Sciatic nerve block

6024 64415 Interscalene Brachial Plexus nerve block

6064 62270 Spinal puncture, lumbar, diagnostic 0 days

62328 Spinal puncture, lumbar, diagnostic with fluoroscopic or CT guidance 0 days

62272 Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle 0 days

or catheter)

62329 Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle 0 days

or catheter) with fluoroscopic or CT guidance

6066 64402 Injection of a facial nerve 0 days

6060 64400 Injection(s), anesthetic agent(s) and/or steroid of trigeminal nerve 0 days

(dental block)

6072 64450 Peripheral nerve block, digital (finger/toe) 0 days

(included in global procedures, not billable to Medicare)

6070 64421 Intercostal nerve block 0 days

(block chest wall pain; each additional level; list separately in addition to

Code for primary procedure)

64461 Paravertebral block (PVB) (paraspinous block), thoracic;

single injection site (includes imaging guidance, when performed)

64462 Second and any additional injection site(s) (including imaging guidance,

when perfomed) (List separately in addition to code for primary procedure)

64463 Continuous infusion by catheter (includes imaging guidance, when performed)

2061 19101 Biopsy of breast, incisional 0-10 days

2030 20600 Arthrocentesis, small joint (fingers, toes) , bursa, or ganglion cyst 0 days

(fluid may be withdrawn or medication injected into the joint)

20604 Arthrocentesis, aspiration and/or injection small joint or bursa, with

Ultrasound guidance 0 days

2048 20605 Arthrocentesis, medium joint (wrist, elbow), bursa, ganglion cyst 0 days

2049 20606 Arthrocentesis, aspiration and/or injection intermediate joint or bursa,

With ultrasound guidance 0 days

2052 20552 Injection, trigger point – 1 or 2 muscles 0 days

2053 20553 Injection, trigger point – GT 3 muscles 0 days

2055 20610 Arthrocentesis, large joint (shoulder, hip, knee), bursa, 0 days

ganglion cyst

2056 20611 Arthrocentesis, aspiration and/or injection major joint or bursa, with

Ultrasound guidance 0 days

2063 20550 Injection, tendon sheath, ligament 0 days

MODERATE SEDATION

9151 99151 moderate sedation - LT 5 yrs old; same physician; 10 min or more 0 days

(Modifier 51 exempt)

9152 99152 moderate sedation - 5 + yrs old; same physician; 10 min or more 0 days

(Modifier 51 exempt)

9153 99153 moderate sedation; same physician; Add'l 15 minutes 0 days

9161 99155 moderate sedation – LT 5 yrs old; different physician; 10 min or more 0 days

9162 99156 moderate sedation 5 + yrs old; different physician; 10 min or more 0 days

9163 99157 moderate sedation; different physician; Add'l 15 minutes 0 days

NAILS & SKIN

2148 11760 Repair of nail bed/nail matrix 0-10 days

(removal of nail and digital block is included)

2151 11762 Reconstruction of nail bed with graft 0-10 days

1136 11752 Excision nail bed with amputation of distal phalynx tuft 0-10 days

1123 11750 Nail excision, partial/complete for permanent removal, non 0-10 days

traumatic

(ingrown toenail)

1119 11730 Avulsion of nail, partial, complete, traumatic 0-10 days

(removal of avulsed nail)

1128 11765 Wedge excision of skin of nail fold 0-10 days

(skin around nail)

1131 11401 Excision benign lesion 0.6-1.0 cm, trunk, limbs 0-10 days

1133 11403 Excision benign lesion 2.1-3.0 cm, trunk, limbs 0-10 days

1149 11421 Excision benign lesion 0.6-1.0 cm, scalp, hands, feet 0-10 days

1156 11442 Excision benign lesion 1.0-2.5 cm face, ears 0-10 days

(excludes skin tags)

1116 11200 Skin tag removal 0-10 days

1161 11000 Debridement -LT10 PCT of body surface 0 days

(ERMD removes dead or damaged surface skin, such as with

abrasions, minor burns) other debridement codes listed with burns

1171 17250 Chemical cauterization of granulation tissue 0 days

(cauterization of healing wound tissue)

1172 15851 Removal of sutures from another MD with anesthesia or sedation 0 days

8255 12020 Wound dehiscence repair 0-10 days

(Simple repair; single layer closure)

BURNS Burn treatment will not be billed if the procedure is

performed by nursing staff

1198 16000 Treat 1st degree burn (unbroken skin), local treatment only 0 days

(must be performed by the physician; treatment includes

cleansing and application of ointment with or w/o dressing)

1206 16020 Treat 2nd

- 3

rd degree small burn (broken skin, blistering, partial thickness) 0 days

(treatment includes cleansing, debridement and/or application of

ointment or cream w or w/o dressing)

1214 16025 Treat 2

nd

-3

rd degree medium burn (whole face or entire extremity) w/o 0 days

anesthesia

(includes cleansing, debridement, application of ointment and/or cream

with or w/o dressing)

1222 16030 Treat 2

nd

-3

rd degree large burn (more than one entire extremity) w/o 0 days

anesthesia

MUSCULOSKELETAL

2017 26410 Repair extensor tendon, hand, primary repair, w/o graft 0-90 days

(incision must be made)

2022 26418 Repair extensor tendon, finger, primary repair, w/o graft 0-90 days

(incision must be made)

2028 26432 Repair extensor tendon, finger, with splinting 0-90 days

(No incision made; finger is splinted in an extended position)

2225 26951 Amputation, finger or thumb, primary, joint or phalynx, single 0-90 days

with direct closure

(MD removes bone following an acute injury)

NON-INVASIVE PROCEDURES

DISLOCATIONS

9253 92532 Hallpike maneuver

Valsalva maneuver – It would be included in E/M

9592 Epley maneuvers

5054 Phimosis Reduction

9237 98925 Osteopathic Manipulation

5023 Periprism

2071 21480-54 Treat closed temporomandibular dislocation, initial or 0 days

subsequent (manual reduction)

2089 23520-54 Treat closed sternoclavicular dislocation , no reduction 0-90 days

(splint or brace applied, no manual manipulation)

2097 23540-54 Treat closed acromioclavicular dislocation (AC separation), 0-90 days

no reduction

(affected shoulder or arm placed in a sling or other brace)

2170 23545-54 Reduce acromioclavicular dislocation 0-90 days

2105 26670-54 Reduce carpometacarpal dislocation (other than the thumb), 0-90 days

single (Bennett fx)

2113 23650-54 Reduce closed shoulder dislocation 0-90 days

2125 23665-54 Reduce closed shoulder dislocation w/ fracture of greater 0-90 days

tuberosity

2139 24600-54 Reduce closed elbow dislocation 0-90 days

(manual reduction, elbow placed in splint or brace)

2220 26770-54 Reduce interphalangeal joint dislocation 0-90 days

2162 24640-54 Reduce radial head dislocation in child, nursemaid's elbow or 0-10 days

subluxation (partially dislocated)

(often reduces spontaneously)

2329 25675-54 Reduce distal radius and/or ulna (wrist) dislocation 0-90 days

2188 26700-54 Reduce metacarpophalangeal (knuckle) dislocation 0-90 days

2253 27560-54 Reduce closed patellar dislocation 0-90 days

2265 27250-54 Reduce closed hip dislocation, traumatic 0-90 days

2267 27265-54 Reduce closed post hip arthroplasty dislocation 0-90 days

2279 27840-54 Reduce ankle dislocation 0-90 days

(cast or brace is applied after reduction)

2287 28630-54 Reduce metatarsophalangeal (foot) dislocation 0-10 days

2311 28660-54 Reduce toe dislocation 0-10 days

FRACTURE CARE

2263 27200-54 Treat coccyx fracture, no reduction 0-90 days

(bed rest, use of rubber ring, may require closed

manipulation)

2342 21450-54 Treat closed mandibular fracture, no reduction 0-90 days

(close observation, soft diet, and/or restriction of activity

2337 21310-54 Closed treatment of non-displaced nasal fracture 0 days

(Treatment includes external agents, i.e. ice therapy and

pharmacological agents for pain control.)

2335 Nasal Fracture with manupulation

2394 21820-54 Treat sternum (breast bone) fracture, no reduction 0-90 days

(modify activity)

UPPER EXTREMITIES

2352 23500-54 Treat clavicle fracture, without manipulation 0-90 days

(clavicle brace, strap, or splint applied)

2360 23505-54 Reduce clavicle fracture, with manipulation 0-90 days

2386 23570-54 Treat closed scapular (shoulder blade) fracture, without 0-90 days

manipulation

(affected shoulder put in sling or brace)

2387 Treat closed scapular (shoulder blade) fracture, with manipulation

2410 23600-54 Treat closed humeral neck (prox humerus) fracture, without 0-90 days

manipulation

(sling applied)

2411 Treat closed humeral neck (prox humerus) fracture, with manipulation

2415 23620-54 Treat closed greater tuberosity fracture, without manipulation 0-90 days

2418 Treat closed greater tuberosity fracture, with manipulation

2428 24500-54 Treat closed humeral shaft fracture, without manipulation 0-90 days

2431 24505-54 Treat closed humeral shaft fracture, with manipulation 0-90 days

2412 24530-54 Treat closed humeral supracondylar or transcondylar fracture, 0-90 days without manipulation

2413 Treat closed humeral supracondylar or transcondylar fracture, with manipulation

2402 24560-54 Treat closed epicondylar (medial or lateral condyle), (distal 0-90 days humerus), elbow, without manipulation

2126 24565-54 Treat humeral epidondylar fracture,(medial or lateral condyle) 0-90 days (distal humerus), with manipulation

2436 24650-54 Treat closed radial head or neck fracture, without manipulation 0-90 days

2439 Treat closed radial head or neck fracture, with manipulation

2444 24670-54 Treat closed ulnar fracture, proximal end (olecranon process, 0-90 days elbow) without manipulation

2447 Treat closed ulnar fracture, proximal end (olecranon process, elbow) with manipulation

2469 25600-54 Treat closed distal radial fracture (colles, smith fracture) with 0-90 days or without fracture of distal ulna, without manipulation

2496 25650-54 Treat closed distal ulnar fracture, without manipulation 0-90 days

2477 25605-54 Reduce closed distal radial fracture with or without fracture of 0-90 days distal ulna

2493 25530-54 Treat closed ulnar shaft (forearm) fracture, without manipulation 0-90 days

2494 25535 Treat closed ulnar shaft (forearm) fracture, with manipulation

2451 25500-54 Treat closed radial shaft (forearm) fracture, without manipulation 0-90 days

2519 25560-54 Treat closed radial and ulnar shaft fracture, without manipulation 0-90 days

2455 25505-54 Treat closed radial shaft fracture, with manipulation 0-90 days

2521 25565-54 Treat closed radial and ulnar shaft fracture, with manipulation 0-90 days

2527 25630-54 Treat closed carpal bone fracture, each bone, without manipulation 0-90 days

(triquettrium, trapezium, hamate, capitate, lunate, and

episiform bones only)

2535 25622-54 Treat closed carpal scaphoid (navicular bone) fracture, without 0-90 days

Manipulation

2524 Treat closed carpal scaphoid (navicular bone) fracture, with manipulation

2543 26600-54 Treat closed metacarpal fracture, without manipulation 0-90 days

2550 26605-54 Treat closed metacarpal fracture, with manipulation 0-90 days

2560 26645-54 Treat closed carpometacarpal fracture dislocation,with manipulation 0-90 days

2568 26720-54 Treat closed proximal or middle phalangeal shaft fracture, 0-90 days

each, (finger/thumb), without manipulation

2576 26725-54 Treat closed proximal or middle phalangeal shaft fracture, each 0-90 days

each (finger/thumb), with manipulation

2592 26750-54 Treat closed distal phalangeal fracture, each, (finger/thumb) 0-90 days

without manipulation

2600 26755-54 Treat closed distal phalangeal fracture, each, (finger/thumb) 0-90 days

with manipulation

LOWER EXTREMITIES

2620 27508-54 Treat condylar fracture (distal femur), without manipulation 0-90 days

2623 Treat condylar fracture (distal femur), with manipulation

2626 27520-54 Treat closed patella fracture, without manipulation 0-90 days

2727 27267-54 Treat closed femoral fracture, proximal end, head: 0-90 days

without manipulation

2728 27268-54 Treat closed femoral fracture, proximal end; with manipulation 0-90 days

2636 27501-54 Treat closed supracondylar fracture (distal femur), without manipulation 0-90 days

2634 27500-54 Treat femoral shaft fracture, without manipulation 0-90 days

2638 27502-54 Treat femoral shaft fracture, with manipulation 0-90 days

2808 27530-54 Treat tibial plateau fracture (proximal tibia), without manipulation 0-90 days

2650 Treat tibial plateau fracture (proximal tibia), with manipulation

2667 27760-54 Treat closed distal tibia (medial malleolus, ankle) fracture, without 0-90 days manipulation

2670 27762-54 Treat closed distal tibia (medial malleolus, ankle) fracture, with 0-90 days manipulation

2675 27780-54 Treat closed fibula fracture, proximal or shaft, without manipulation 0-90 days

2677 Treat closed fibula fracture, proximal or shaft, with manipulation

2683 27788-54 Treat closed distal fibular fracture (lateral malleolus, ankle) 0-90 days with manipulation

2684 27786-54 Treat closed distal fibular fracture (lateral malleolus, ankle), 0-90 days withoutmanipulation

2777 27767-54 Treat closed posterior malleolus fracture; without manipulation 0-90 days

2778 27768-54 Treat closed posterior malleolus fracture; with manipulation

2659 27750-54 Treat closed tibial shaft fracture with or without fibular shaft, 0-90 days without manipulation

2660 Treat closed tibial shaft fracture with or without fibular shaft, with manipulation

2709 27808-54 Treat closed distal fibular and tibial fracture (bimalleolar, 0-90 days medial and lateral malleolus, ankle includes Potts fracture), without manipulation

2715 27810-54 Treat closed distal fibular and tibial fracture (bimalleolar, 0-90 days medial and lateral malleolus, ankle), (includes Potts fracture) with manipulation

2677 Fibular shaft FX

2790 27816-54 Treat closed trimalleolar (lateral, medial, and posterior 0-90 days malleoli, ankle), without manipulation

2795 27818-54 Treat closed trimalleolar (lateral, medial, and posterior 0-90 days malleoli, ankle), with manipulation

2717 28400-54 Treat closed calcaneous (heel) fracture, without manipulation 0-90 days

2725 28430-54 Treat closed talus (ankle) fracture, without manipulation 0-90 days

2729 Treat closed talus (ankle) fracture, with manipulation

2733 28450-54 Treat closed tarsal bone fracture, without manipulation 0-90 days

(navicular, cuboid, and cuneiform only)

2741 28530-54 Treat closed sesamoid (foot) fracture, without manipulation 0-90 days

2758 28470-54 Treat closed metatarsal (foot) fracture, without manipulation 0-90 days

2766 28475-54 Treat closed metatarsal fracture, with manipulation 0-90 days

2774 28510-54 Treat closed toe fracture (other than great toe), without manipulation 0-90 days

2782 28515-54 Treat closed toe fracture (other than great toe), with manipulation 0-90 days

2816 28490-54 Treat great toe fracture, without manipulation 0-90 days

2824 28495-54 Treat great toe fracture, with manipulation 0-90 days

SPLINTS AND STRAPS

Splint	Splinting	FX Care
ace-wrap	yes	yes
air-cast	yes	yes
air splint	yes	yes
brace	no	yes
buddy-tape	no	yes
crutch	no	yes
OCL	yes	yes
ortho-boot	no	yes
ortho-glass	yes	yes
post-operative shoe	no	yes
sling	no	yes
spica	yes	yes

MD MUST APPLY THE SPLINT OR CHECK PLACEMENT AND/OR NEUROVASCULAR STATUS DISTAL TO SPLINT AFTER APPLICATION BY NURSE, TECH, ETC. MEDICARE: THE PHYSICIAN MUST APPLY.

2915 29130 Apply finger splint 0 days

2923 29105 Apply long arm splint (shoulder to hand) 0 days

2931 29125 Apply short arm splint (forearm to hand) 0 days

2949 29505 Apply long leg splint (thigh to ankle or toes) 0 days

2956 29515 Apply short leg splint (calf to foot) 0 days

2840 29260 Apply elbow/wrist Ace wrap 0 days

2857 29280 Apply hand/finger Ace wrap 0 days

2865 29530 Apply knee Ace wrap 0 days

2881 29540 Apply ankle Ace wrap 0 days

CASTS

2964 29705 Remove full arm or leg cast 0 days

(only when applied by another physician)

2050 29360 Apply ankle to thigh cast 0 days

2059 29425 Apply walking leg cast 0 days

2238 29405 Apply below knee to toes cast 0 days

2246 29085 Apply hand to wrist cast 0 days

2501 29075 Apply elbow to fingers cast 0 days

2972 29730 Cast windowing 0 days

(section of cast removed to assess status of wound or check for

infection)

2980 29740 Wedging of cast 0 days

(cast is cut and piece of wood or plastic is inserted into cut to

redirect pressure or correct malignment)

DIAGNOSTIC INTERPRETATIONS AND REPORTS

X-RAY INTERPRETATIONS

HEAD AND NECK

7097 70140-26 Facial bones,1-2 views

7005 70150-26 Facial bones, 3+ views

7090 70320-26 Teeth, full mouth (panorex)

7625 70355-26 Orthopantogram

7013 70160-26 Nasal bones, 3+ views

7021 70210-26 Sinuses, 1-2 views

7039 70220-26 Sinuses, 3+ views

7045 70250-26 Skull, 1-3 views

7047 70260-26 Skull, 4+ views

7054 70328-26 Temporomandibular joint, unilateral

7062 70330-26 Temporomandibular joint, bilateral

7070 70360-26 Neck, soft tissue

7088 70110-26 Mandible, 4+ views

7010 70100-26 Mandible – LT 4 views

7096 70130-26 Mastoids, 3+ views per sides

7104 70200-26 Orbits, 4+ views

7609 70310-26 Teeth, less than full mouth

CHEST

7139 71045-26 Chest, 1 view (portable)

7140 71046-26 Chest, 2 views (PA & lat)

7141 71048-26 Chest, complete 4+ views

7161 71100-26 Ribs, 2 views unilateral

7179 71101-26 Ribs, unilateral and PA chest 3 views

7112 71111-26 Ribs, bilateral and PA chest 4 views

7120 71110-26 Ribs, bilateral 3 views

7187 71120-26 Sternum, 2+ views

7732 76010 Babygram, nose to rectum

SPINE & PELVIS

7195 72040-26 Cervical spine, 2 views

7203 72050-26 Cervical spine, 4+ views

7211 72010-26 Spine survey, entire

7229 72070-26 Thoracic/dorsal spine, 2 views

7237 72080-26 Thoracolumbar spine, AP & lat

7245 72100-26 Lumbosacral spine, 2 views

7666 72114-26 Lumbosacral spine, complete – 6 views

72081-26 Spine, entire thoracis and lumbar, including skull, vervical and sacral spine if performed, 1 view

72082-26 Spine, entire thoracis and lumbar, including skull, vervical and sacral spine if performed, 2-3 views

72083-26 Spine, entire thoracis and lumbar, including skull, vervical and sacral spine if performed, 4-5 views

72084-26 Spine, entire thoracis and lumbar, including skull, vervical and sacral spine if performed, 6+ views

7252 72170-26 Pelvis, 1 view

7260 72190-26 Pelvis, complete 3+ views

7286 72220-26 Sacrum & coccyx

7682 72200-26 Sacroiliac joint, - LT 2 views

7278 72202-26 Sacroiliac joints, 3+ views

UPPER EXTREMITY

7302 73010-26 Scapula, complete

7310 73000-26 Clavicle, complete

7328 73020-26 Shoulder, 1 view

7336 73030-26 Shoulder, 2+ views

7344 73050-26 A/C joints, bilateral

7351 73060-26 Humerus, 2+ views

7355 73070-26 Elbow, AP & lat views

7369 73080-26 Elbow, 3+ views

7377 73090-26 Forearm, 2 views

7385 73092-26 Infant upper extremity, 2+ views

7393 73100-26 Wrist, 2 views

7395 73110-26 Wrist, 3 views

7399 73120-26 Hand, 2 views

7401 73130-26 Hand, 3+ views

7419 73140-26 Fingers, 2 views

LOWER EXTREMITY

7361 73501-26 Hip, unilateral, with pelvis when performed, 1 view

7362 73502-26 Hip, unilateral, with pelvis when performed, 2-3 views

7363 73503-26 Hip, unilateral, with pelvis when performed, 4+ views

7364 73521-26 Hips, bilateral, with pelvis when performed, 2 views

7365 73522-26 Hips, bilateral, with pelvis when performed, 3-4 views

7366 73523-26 Hips, bilateral, with pelvis when performed, 5+ views

7444 73551-26 Femur, 1 view

7445 73552-26 Femur, 2+ views

7468 73560-26 Knee, 2 views

7472 73562-26 Knee, 3 views

7476 73564-26 Knee and patella, complete, 4+ views

7484 73590-26 Tibia and fibula, 2 views

7492 73592-26 Infant lower extremity, 2+ views

7511 73600-26 Ankle, AP & lat

7518 73610-26 Ankle, 3+ views

7526 73620-26 Foot, 2 views

7690 73630-26 Foot, 3+ views

7534 73650-26 Calcaneus, 2+ views

7542 73660-26 Toes, 2+ views

ABDOMEN

7142 74018-26 Abdomen, 1 view (KUB)

7143 74019-26 Abdomen, 2 views

7144 74021-26 Abdomen, 3+ views (abdominal series)

7575 74022-26 Complete acute abdominal series (2 or more views of abdomen and 1 view chest x-ray)

7583 74400-26 IVP

7716 74430-26 Cystography

7765 74240-26 GI tract including scout abdominal radiograph and delayed images when performed single contrast (e.g. barium) study

74246-26 GI tract including scout abdominal radiograph and delayed images when performed double contrast (e.g. high-density barium and agent) study, including glucagon

BILLING FOR ULTRASOUND INTERPRETATIONS

("+" behind a code is a CPT add-on code)

7604 76604 Ultrasound Chest, thorax, upper back

7655 76642 Ultrasound Breast - Limited

7915 76815 OB Ultrasound; Limited Fetus(s)

7916 76816 OB Ultrasound; Transabdominal Approach, follow-up

7927 76817 Transvaginal Ultrasound; Obstetric

7940 76830 Transvaginal Ultrasound; Non – OB

7856 76856 Pelvis ECHO Exam; Complete

7957 76857 Pelvis ECHO Exam; Limited

7700 76700 Abdomen ECHO Exam; Complete

7945 76705 Abdomen ECHO Exam; Limited

7955 76775 Ultrasound abdominal backwall; limited

7975 76975 GI Endoscp. Ultrasound

7942 76942 ECHO Guide for Biopsy

7937 76937+ Ultrasound Guidance for Vascular Access (i.e. Central Line Placement)

[this is an add on code]

9376 93976 Limited evaluation of scrotal contents

9371 93971 Limited evaluation of extremity veins – Duplex Scan

9271 93308 ECHO Exam Chest/Heart Transthoracic Approach

7881 76882 Limited evaluation of joints or nonvascular extremities (tendon, muscle, etc.)

7605 76536 Ultrasound evaluation of head and neck

7853 76512 Limited evaluation Ophthalmic – B Scan

CT SCAN INTERPRETATIONS

7757 70460-26 CT head with contrast

7075 70450-26 CT head without contrast

7080 70480-26 CT orbits without contrast

7085 70490-26 CT neck without contrast

7633 70486-26 CT face without contrast

7641 71260-26 CT chest with contrast

7658 71270-26 CT chest without contrast

7065 72193-26 CT pelvis with contrast

7083 72192-26 CT pelvis without contrast

7708 74150-26 CT abdomen without contrast

7071 74160-26 CT abdomen with contrast

7089 72128-26 CT thoracic spine without contrast

7074 72131-26 CT lumbar spine without contrast

OTHER ANCILLARY INTERPRETATIONS/SPECIAL SERVICES

9406 99406 Smoking Cessation Counseling,GT 3 up to 10 minutes (Asymptomatic & Symptomatic)

9407 99407 Smoking Cessation Counseling, GT 10 minutes (Asymptomatic & Symptomatic)

9541 99497 Advanced Care Planning – 16 min

9542 99498 Advanced Care Planning – Add'l 30 min (at 46 minutes)

9264 96127 Suicide Risk Assessment

9324 93010 12 lead EKG interpretation

9332 93042 1-3 lead rhythm strip interpretation (cardiac monitor)

9258 94760-26 Pulse oximetry interpretation, single

9260 94761-26 Pulse oximetry interpretation, multiple

(bill only once)

9277 92953 Temporary transcutaneous pacing (TTP, external pacer)

9160 99053 Special services 10:00 pm – 8:00 am daily

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Cardiac evaluation for pericardial fluid and a

three-view abdominal evaluation for hemoperitoneum.

For evaluation of one or more of the following:

Fetal heartbeat, placental location, fetal position and/or qualitative amniotic fluid volume.

To reassess fetal size, interval growth, amniotic fluid volume or organ system determined abnormal on a previous exam.

(Repeated) For evaluation of one or more of the following:

Fetal heartbeat, placental location, fetal position and/or qualitative amniotic fluid volume.

Ultrasound exam of nonpregnant uterus for the evaluation of gynecologic complaints (e.g., pelvic pain, amenorrhea, vaginal bleeding).

Evaluation could include urinary bladder (not kidneys), prostate/seminal vesicles in males, or pelvis in females — to rule out free pelvic fluid or pelvic abscess.

Abdominal pain to rule out cholelithiasis, common bile duct obstruction, appendicitis.

Evaluation for abdominal aortic aneurysm or renal disease including renal vessels and aorta.

Add-on code note:

Used in conjunction with Central Line placement — requires an additional procedural note.

Rule out intrathoracic or pericardial abnormalities.

Assess liver, gallbladder, spleen, pancreas, and kidneys

(rather than just a limited area).

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Add-on code for needle placement

Used with paracentesis, thoracentesis, lumbar puncture, or abscess drainage (e.g., peritonsillar abscess).

Duplex study of scrotal/pelvic contents

Used to evaluate for testicular torsion.

Evaluation for DVT (Deep Vein Thrombosis)

Evaluation of muscles, tendons, joints, nerves, or soft tissues — focused exam on a specific area (e.g., lump, mass, cellulitis).

Evaluation of breast for lumps or other abnormalities.

Evaluate chest organs and structures (lungs, pleural space, mediastinum) for conditions like pneumothorax, pneumonia, effusion, etc.

Evaluate soft tissue of face/head/neck (thyroid, parotid, etc.) — for lump, cellulitis, abscess.

Evaluate eyes and nearby structures — globe perforation, retrobulbar hematoma, retinal detachment, lens issues, vitreous hemorrhage, intraocular foreign body.