

# **Emergency Department Coding Handbook**



# just Jcoding

# Emergency Department Coding Handbook



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# Contents

About the Author	v
Introduction	1
Chapter 1: Evaluation and Management Presenting Problem The Challenge of Undercoding Critical Care	3 4 6 7
Chapter 2: Integumentary System Anatomy of the Skin Incision and Drainage (10060–10180) Debridement (11000–11001), (11004–11008),	11 12 12
(11010–11012), ((11042–11047) [11045, 11046]) Wound Repairs (12001–13160) Burns, Local Treatment (16000–16036)	13 19 22
Chapter 3: Musculoskeletal System. Injection (Tendons, Muscles, Trigger Point) (20526–20553) Arthrocentesis (20600–20611) Fractures Dislocations Shoulder (23500–23680) Humerus (Upper Arm) and Elbow (24500–24685) Forearm and Wrist (25500–25695) Hands and Fingers (26600–26785) Pelvic and Hip Joint (27193–27269) Femur (Thigh Region) and Knee Joint (27500–27566) Leg (Tibia and Fibula) and Ankle Joint (27750–27848) Foot and Toes (28400–28675) Application of Casts and Strapping (29000–29799).	27 28 29 32 34 34 40 42 44 46 49 51 52

# About the Author

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**Nena Scott, MSEd, RHIA, CCS, CCS-P, CCDS,** AHIMA-approved ICD-10-CM/PCS trainer, has served as an educator in the healthcare industry across numerous organizations over the past two decades. Her experience includes the creation and successful implementation of a Registered Health Information Technology program at a community college in Northern Mississippi where she served as the program director and lead instructor for more than a decade.

Her current role with TrustHCS as director of education includes overseeing ICD-10 educational offerings. As a professional educator, Scott's experience spans a wide range of health information topics including coding, auditing, reimbursement, and healthcare law and ethics. She has trained coding staff and served in a management capacity within the HIM department. Throughout her years educating, she kept a part-time job as an auditor and coder in order to stay abreast of coding and regulatory changes and updates. Throughout her career, she has also performed coding compliance audits.

Scott is in the process of obtaining a doctoral degree in education. She has been honored by the Mississippi Health Information Management Association with the Champion Award (2010), Educator Award (2009), and Distinguished Member Award (2007).

# Introduction

The emergency department (ED) is a fast-paced environment that can present documentation and cases that can lead to unique coding and billing challenges. JustCoding's *Emergency Department Coding Handbook* will help coders by clearly explaining how to interpret CPT® codes and guidelines in order to report procedures accurately.

This easy-to-use handbook includes an explanation of evaluation and management codes for the ED and how to deal with the challenges of undercoding. The handbook also offers details on how to determine critical care in order to choose the most accurate code.

In the second chapter, the handbook reviews the anatomy of the integumentary system and common procedures performed on the skin. The book covers topics such as incision and drainage, debridement, wound repair, and burns.

Finally, the third chapter details the anatomy of the musculoskeletal system and how to report procedures on those areas. Coding tips are included to tackle common questions that coders in the ED face. This chapter also reviews injection and arthrocentesis procedures, as well as application of casts and strapping.

# Evaluation and Management

Because the Centers for Medicare & Medicaid Services (CMS) has not created any national emergency department (ED) evaluation and management (E/M) guidelines, providers must create their own criteria for each visit level. CMS has developed a list of 11 criteria that it uses when auditing facility E/M criteria. According to CMS, E/M guidelines should do the following:

- Follow the intent of the CPT<sup>®</sup> code descriptor: Guidelines should be designed to reasonably relate the intensity of hospital resources required to the different levels of effort represented by the code
- 2. Be based on hospital facility resources, not physician resources
- 3. Be clear so that they facilitate accurate payments, and be usable for compliance purposes and audits
- 4. Meet the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements

- 5. Require documentation that is clinically necessary for patient care
- 6. Not facilitate upcoding or gaming
- 7. Be written or recorded and well-documented, and provide the basis for selection of a specific code
- 8. Be applied consistently across patients in the clinic or ED to which they apply
- 9. Not change with great frequency
- 10. Be readily available for fiscal intermediary or MAC review
- 11. Result in coding decisions that can be verified by other hospital staff, as well as by outside sources

Note that ED E/M codes do not distinguish between new and established patients. Additionally, because E/M services in the ED vary so widely in intensity, time is not used as a descriptive component of the codes.

# **Presenting Problem**

A patient's presenting problem is the disease, condition, illness, injury, symptom, sign, finding, complaint, or other reason for which he or she visits the ED. This problem may be a significant indicator of medical necessity and may support the need for ED treatment, the underlying reason for the ED course, and the medical necessity of diagnostic tests and therapeutic services.

The nature of the presenting problem is one of the three essential elements in determining the level of medical decision-making and

medical necessity for the ED visit. There are five levels of presenting problems, with guidelines and CPT codes defined as follows:

- Self-limited or minor (99281): a problem that runs a definite and prescribed course, is transient, and is not likely to permanently alter the patient's health status or has a good prognosis with management/compliance.
- Low severity (99282): a problem in which the risk of morbidity without treatment is low, there is little to no risk of mortality without treatment, and full recovery without functional impairment is expected.
- Moderate severity (99283): a problem in which the risk of morbidity without treatment is moderate, there is moderate risk of mortality without treatment, or there is an uncertain prognosis or increased probability of prolonged functional impairment.
- 4. High severity, requires urgent evaluation by the physician but does not pose threat to life or physiologic function (99284): A problem in which the risk of morbidity (illness, disease) without treatment is high to extreme, there is a moderate to high risk of mortality (death) without treatment, or a high probability of severe, prolonged functional impairment.
- 5. High severity, poses an immediate significant threat to life or physiologic function (99285): A problem in which the risk of morbidity (i.e., illness, disease) without treatment is high to extreme, there is a moderate to high risk of mortality (death) without treatment, or a high probability of severe, prolonged functional impairment.

CMS instructs Type A EDs to report E/M levels with these CPT codes. CMS defines a Type A ED as an ED that is available 24 hours

a day, 7 days a week and is either licensed by the state in which it is located under applicable state law as an ED, or 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.

Coders will use HCPCS level II codes G0380–G0384 to report E/M visits for Type B EDs. CMS defines a Type B ED as an ED that meets the definition of a "dedicated emergency department" as defined in 42 CFR 489.24 under the Emergency Medical Treatment and Active Labor Act regulations. It must meet at least one of the following requirements:

- It is licensed by the state in which it is located under applicable state law as an emergency room or emergency department
- 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
- 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

# The Challenge of Undercoding

In the ED, undercoding is more of a problem than overcoding. It's common for the nurses who design the criteria not to fully understand the coding rules and other elements that go into the orders that they get from their physicians. Likewise, the coder designing the criteria may have good background in the clinical ED piece of the puzzle, but he or she may not understand some of the triggers for these services. In either case, lack of information can lead to undercoding.

To properly determine E/M levels, it's important to understand the presenting problem, history, and findings of the physical examination. Taken together, these elements determine the level of medical decision-making. They present a more complete picture of the problem and the care required during the ED stay or the level of follow-up/disposition required.

It's also important to understand that facility E/M levels and physician E/M levels do not always align. Physician and nursing rules and resources, which play a part in determining E/M levels, are different in the ED than they are in other settings. For example, physicians generally don't provide one-on-one care to a difficult patient, but in the ED, a nurse may have to stay at that patient's bedside for an extended period of time.

To code properly for a visit, coders also have to look at the times of interventions—that is, how long patients spend with the nurses. Is the patient receiving one-on-one nursing care, or is one nurse responsible for several patients? Facilities also need to define what is considered observation or assessment.

Finally, consider the intensity of the resources used. Some services don't take a lot of time but require an incredible amount of intensity.

# **Critical Care**

Coders may report critical care provided in the ED. Critical care is defined as the direct delivery of medical care by a physician or provider to a critically ill or injured patient. Typically, in such a case,

one or more vital organs or organ systems are impaired, and the patient's condition has a high probability of immediate deterioration. In addition, if critical services are not immediately rendered, the patient faces a high probability of death.

Delivering critical care in a moment of crisis or upon being called to the patient's bedside emergently is not the only criterion for providing critical care services. While not necessarily emergent, treatment and management of a patient's condition under threat of imminent deterioration also meets the requirement. In such a case, failure to initiate interventions on an urgent basis would likely result in sudden, clinically significant, or life-threatening deterioration in the patient's condition.

The CPT Manual provides two codes for critical care services:

- 99291, critical care for a patient with high probability of imminent deterioration causing a threat to life or limb; first 30–74 minutes
- 99292, critical care, each additional 30 minutes

Because critical care codes are time-based, providers must document time not just for proper reporting but also so the facility can bill for its part of the services. CMS only pays for critical care if at least 30 minutes of critical care services are provided and documented. If the facility does not provide at least 30 minutes of critical care, coders should report a level 4 or 5 ED visit, depending on the facility's E/M criteria.

Some of the CMS rules may make it more difficult for coders to count critical care time for the facility. Under the OPPS, the time spent by physicians and/or hospital staff engaged in active, faceto-face critical care of a critically ill or critically injured patient is counted. If the physician and hospital staff are simultaneously engaged in this care, that time can only be counted once. As a result, if a physician and a nurse are both providing critical care during the same 30-minute time span, coders can only report a total of 30 minutes of critical care time, not 60 minutes (30 for the physician and 30 for the nurse).

Consider a slightly different scenario: A nurse provides 15 minutes of critical care and leaves. A physician comes in and provides 15 minutes of critical care and leaves. The nurse then returns to provide an additional 15 minutes of care. Because none of the care overlapped, coders would add each time together and report 45 minutes of critical care.

# 2

# Integumentary System





# Anatomy of the Skin

Skin is composed of three layers:

- Epidermis—thin, outermost layer; composed of squamous epithelium
- Dermis-dense/fibrous middle layer; contains connective tissue
- Subcutaneous—innermost layer; thick and mainly composed of fatty tissue

Fascia is composed of two layers and is located under the skin and subcutaneous tissue:

- Superficial fascia layer—wrapped in subcutaneous fat and cutaneous nerve, vessels, and adnexal structures
- Deep fascia-tough and less pliable; enclosed in muscle

Do not add HCPCS level II modifiers -LT and -RT to CPT codes for skin and subcutaneous tissue because the skin and subcutaneous tissue are not paired organs.

# Incision and Drainage (10060–10180)

Incision and drainage—physician uses a knife/scalpel and makes an incision of a lesion to drain the contents:

- Describes incision and drainage of abscesses of the skin only.
- CPT does not define simple, extensive, or complicated; the AMA instructs the physician to choose the term based on the level of difficulty involved in the procedure.
- Provider's documentation should clearly state that the procedure was complicated. Look for terms such as "difficult," "multiple," "significant amount of time," "extreme," "complicated," "very large," "extended," etc.

- 10061 should only be reported in the following cases:
  - Only one abscess was treated and the documentation supports a complicated procedure
  - Multiple abscesses were treated, even if they were not complicated
  - It has not already been reported for this procedure; 10061 should only be reported one time, regardless of the number of abscesses treated

CPT codes for Incision and drainage of abscesses of other body parts are coded as follows:

- 23030, incision and drainage, shoulder area; deep abscess or hematoma
- 26010, drainage of finger abscess; simple
- 26011, drainage of finger abscess; complicated (e.g., felon)
- 30000, drainage abscess or hematoma, nasal, internal approach
- 42700, incision and drainage abscess; peritonsillar
- 67700, blepharotomy, drainage of abscess, eyelid

Note: Anatomic-specific Incision and Drainage codes take precedence over the integumentary Incision and Drainage codes 10060 and 10061.

## Debridement (11000–11001), (11004–11008), (11010–11012), ((11042–11047) [11045, 11046])

In CPT 2011, comprehensive changes were made to the Excision and Debridement subsection of the Integumentary System (codes

11000–11047). See *CPT Assistant* May 2011, Volume 21, Issue 5, p. 3 for more information.

#### Four levels of debridement

In order to construct and categorize codes by surface area and depth, the codes were split into four levels of depth:

- 1. Wound surface biofilm/epidermis/dermis
- 2. Subcutaneous tissue
- 3. Muscle or fascia
- 4. Bone

#### 11000-11001

Debridement codes in the first group describe debridement of eczematous and/or infected skin. These codes are based on the percentage of the body surface debrided:

- 11000 is only for up to 10% of the body surface
- 11001 should be reported for each additional 10%
- 11001 has the + symbol preceding it, which indicates that it is an add-on code (and should be used in addition to code 11000)
- Description for 11001 includes the phrase "or part thereof," which means that the code is reported for up to and including each additional 10% of the body surface

#### 11004-11008

Debridement codes in the second group describe debridement specifically due to necrotizing skin infections:

- Necrotizing soft tissue infections are a broad category of bacterial and fungal skin infections
- Because necrotizing skin infections begin in deep tissue, the epidermis may appear relatively unscathed until late in the course of infection
- Descriptive terms differ based on the location, depth, and extent of infection, called necrotizing fasciitis (i.e., deep subcutaneous infection)
- Code selection is based on the anatomical location treated:
  - External genitalia and perineum
  - Abdominal wall
  - External genitalia, perineum, and abdominal wall
- CPT codes 11004–11006 describe debridement related to necrotizing skin infections of the external genitalia, abdomen, and perineum
- CPT code 11008 is an add-on code to be listed in addition to codes 11004–11006 when prosthetic material or mesh is removed from the abdominal wall
- Note that 11004–11008 are status indicator C (inpatient-only procedure not paid under OPPS)

#### Coding tips

- Report skin grafts or flaps separately when performed for closure at the same session as 11004–11008
- When insertion of mesh is used for closure, report 49568 in addition

• Do not report 11008 with debridement codes 11000–11001 or 11010–11044

#### 11010-11012

Debridement codes in the third group describe extensive debridement procedures associated with fractures:

- CPT codes 11010–11012 describe debridement related to open fractures or dislocations.
- Code selection is made based on the depth of the debridement as specified in the physician documentation.
- *CPT Assistant* (March 1997) states that if debridement is necessary as a result of a closed fracture or any other blunt or penetrating injury, then these codes are appropriate, as long as the documentation supports that the debridement needed was more extensive than that performed with debridement codes 11040–11044.
- Debridement codes 11010–11012 are to be used for open fracture or open dislocation management. Other bone debridement codes remain in the musculoskeletal system (e.g., 21627, 21750, 28289), and they represent debridement of bone for conditions other than open fractures and open dislocations. (*CPT Assistant* May 2011, Volume 21, Issue 5, p. 3).
- Add modifier -59 (distinct procedural service) or the appropriate -X{EPSU} to the CPT code for each site treated if multiple injuries occur and multiple debridements are performed.

## 11042–11047 [11045, 11046]

Debridement codes in the fourth group are used for all other types of debridement (e.g., stasis ulcers, superficial infected wounds, gangrene, avascular necrotic tissue):

- CPT codes 11042–11047 describe debridement of the skin, subcutaneous tissue, muscle, or bone.
- Debridement guidelines:
  - Report by the depth of tissue removed and by the surface area of the wound.
  - Report when the intent is not to perform a primary closure, except when debridement is related to a repair that is the primary intent of the services (see Repair Closure guidelines).
  - Single wound: Report to deepest depth of tissue removed.
  - Multiple wounds: When debridement at the same depth is performed on two or more wounds, the surface areas of the wounds are combined. When the depth of debridement is not the same, the surfaces are not combined.
  - Do not report 11042–11047 with active care and management of same wound (97597–97602).
  - Modifier -59 can be appended for additional wound debridement.

- 11042
  - Includes debridement of the first 20 sq cm or less of subcutaneous tissue debrided, regardless of the number of wounds debrided at this depth
  - Includes the debridement of epidermis and dermis, if performed
  - Reported by the total wound area debrided at the deepest level, not for each wound debrided when multiple wounds are involved (See *CPT Assistant* May 2011, Volume 21, Issue 5, p. 3)

#### 11043

- Includes debridement of the first 20 sq cm or less of muscle and/or fascial tissue, regardless of the number of wounds debrided at this depth
- Includes debridement of epidermis, dermis, and subcutaneous tissue, if performed
- Reported by the total wound area debrided at the deepest level, not for each wound debrided when multiple wounds are involved (See *CPT Assistant* May 2011, Volume 21, Issue 5, p. 3)

#### 11044

- Includes debridement of the first 20 sq cm or less of bone tissue debrided regardless of the number of wounds debrided at this depth
- Includes debridement of epidermis, dermis, subcutaneous tissue, muscle, and fascia, if performed

• Reported by the total wound area debrided at the deepest level, not for each wound debrided when multiple wounds are involved (See *CPT Assistant* May 2011, Volume 21, Issue 5, p. 3)

For example, when wounds that are treated have a total debridement area that is greater than 20 sq cm, three add-on codes are used for each surface area depth. New add-on codes, 11045 (debridement of subcutaneous tissue), 11046 (debridement of muscle and/ or fascia), and 11047 (debridement of bone), are to be reported for each additional 20 sq cm, or part thereof, for the respective surface area depth. Because these add-on codes are out of numerical order, they follow the resequencing principle (*CPT Assistant* May 2011, Volume 21, Issue 5, p. 3).

## Wound Repairs (12001–13160)

#### Repairs of multiple wounds

When multiple wounds are repaired using the same technique (e.g., simple), add together the lengths of those in the same body categories or sites (e.g., cheek and nose) as designated by the CPT code description in the *CPT Manual*. Do not add lengths of repairs from different body categories or sites (e.g., face and hand).

Do not add together lengths of wound repairs using different repair techniques (e.g., simple and intermediate), such as for repair of hand lacerations. Note that wounds closed by simple repair that require extensive cleaning or removal of particulate matter constitutes, and supports the coding of, an intermediate repair.

#### Coding tips

Do not append anatomical modifiers to repair codes because the code description indicates that the code applies to multiple body parts. Refer to *Program Memorandum A-00-73*.

No repair code should be reported for repair using adhesive strips (e.g., Steri-strips).

Code separately for repair of nerves, blood vessels, and tendons.

Simple exploration of nerves, blood vessels, or tendons exposed in an open wound is considered part of essential treatment.

Simple ligation of vessels in an open wound is considered part of the wound closure.

Code debridement and/or decontamination separately only when one of the following is true:

- Gross contamination requires prolonged cleansing
- Significant amounts of devitalized or contaminated tissue are debrided
- Debridement is performed without immediate primary closure

If reporting more than one classification of wound repair, apply modifier -59 to the less complicated procedure code.

#### Simple, intermediate, and complex repairs

Simple, intermediate, and complex repairs are reported based on the following:

- Extent of the repair(s) (simple, intermediate, or complex)
- Anatomic site(s)
- Length of laceration(s)

#### Simple wound repairs (12001–12021)

These codes describe the simple repair of superficial wounds. Codes for simple repair include the following:

- Simple exploration of nerves, blood vessels, and/or tendons
- Simple vessel ligation
- Routine debridement and decontamination
- Simple one-layer closure
- Superficial tissue
- Sutures, staples, tissue adhesives
- Total length of several repairs in same code category

#### Intermediate wound repairs (12031–12057)

According to the CMS definition, intermediate closure must include one or more fascial layers in addition to the skin and subcutaneous tissue. Codes for intermediate repair include the following:

- Closure of contaminated single-layer wound
- Layer closure (e.g., subcutaneous tissue, superficial fascia)
- Removal of foreign material (e.g., gravel, glass)
- Routine debridement and decontamination
- Simple exploration of nerves, blood vessels, and/or tendons
- Wounds that are closed by simple repair but that require extensive cleaning or removal of particulate matter constitutes, and supports the coding of, an intermediate repair

Wounds that require closure of subcutaneous tissue or more than one layer of tissue beneath the dermis should be coded as intermediate repairs, unless the criteria for a complex closure are met (*CPT Assistant* August 2006).

#### Complex wound repairs (13100–13160)

These codes describe the complex repair of wounds. Complex repair involves wounds that require more than layered closure. Codes for complicated wound repairs include the following:

- Wounds that involve undermining, stents, or retention sutures
- Creating of a limited defect for repair
- Debridement of complicated wounds/avulsions
- More complicated than layer closure
- Extensive undermining is performed to release the dermis and superficial fascia from their deeper attachments, allowing the wound edge to be brought together with less force. It also allows for the proper plane between the superficial fascia and deep fascia (muscle). (*CPT Assistant* August 2006)

## Burns, Local Treatment (16000–16036)

The overall goals of medical and/or surgical management of burn(s) are to do the following:

- Prevent local or systemic infection
- Remove devitalized tissue
- Prepare a healthy tissue bed
- Conduct a grafting process
- Limit scarring and contractures
- Provide nutritional support to offset large caloric losses and assist in healing

Assignment of burn codes depends on the following characteristics:

- Depth of the burn (i.e., first, second, third, or fourth degree)
- Percentage of the total body surface area involved

• Code descriptors categorize the size of the burn as small, medium, or large

#### Rule of nines

The rule of nines is a way to estimate the percentage of a body's surface that is burned: It is calculated by dividing the total body surface into 9% segments. With an infant or child, however, the rule deviates because of the relatively larger surface area of the child's head at the younger ages. This relationship varies with age, making it crucial to know the patient's age to correctly estimate the size of the child's burn.

For both children and adults, the percentage of the head includes the neck, while the arm encompasses the shoulder to the fingertips, and the leg encompasses the groin to the toes.

It is important that the physician document the percentage of body surface involved as well as the depth of the burn in order to correctly use the rule of nines to estimate the percentage of the body affected. When selecting a code in this series, the depth of the burn wound is not used exclusively.

#### Lund-Browder classification method

The Lund-Browder classification method is used for estimating the extent, depth, and percentage of burns, allowing for the varying proportion of body surface in persons of different ages (*CPT Assistant* October 2012, Volume 22, Issue 10, p. 3).

#### Removal of foreign body

ED physicians routinely remove foreign bodies from patients. They may remove anything from a toy lodged in a child's nose to a steel bar in a patient's abdomen.

To code removal procedures, coders need to know where the foreign body is located. For example, if a child comes in with a cotton swab lodged in her ear, coders would report 69200. If the physician uses anesthesia to conduct the removal, coders would report 69205. Removal of foreign bodies that do not require an incision, such as a fish hook or tick, would be reported in the E/M level.

Many of the codes for foreign body removal include additional details, such as depth. When a physician removes a foreign body from the muscle or tendon sheath, coders will report 20520 for a simple procedure or 20525 for a deep or complicated procedure.

Other anatomical locations include but are not limited to the following:

- Lower arm (25248)
- Upper arm (24200 subcutaneous, 24201 deep)
- Elbow (24000, 24101, 24200, 24201)
- Eye:
  - Anterior chamber (65235)
  - Cornea (65222 with slit lamp, 65220 without slit lamp)
  - Eyelid (67938)
  - Exterior eye (65205 conjunctival superficial, 65210 conjunctival embedded)
  - Posterior segment (65260 magnetic extraction, 65265 nonmagnetic extraction)

- Finger (26075–26080)
- Foot (28190–28193)
- Upper leg (27372)
- Nose (30300 without anesthesia, 30310 with anesthesia)
- Orbit (67413 with bone flap, 67430 without bone flap)
- Shoulder (23330 subcutaneous, 23333 subfascial or intramuscular)
- Subcutaneous tissue (10120 simple, 10121 complex)

# 3

# Musculoskeletal System

### Injection (Tendons, Muscles, Trigger Point) (20526–20553)

Report enzyme injections of the palmar fascial cord (e.g., a Dupuytren's contracture) with 20527, but for manipulation of the palmar fascial cord after an enzyme injection, report 26341.

Code 20550 is used for injections in a single tendon sheath, ligament, or aponeurosis, such as the plantar fascia. For injections of a Morton's neuroma, see 64455 or 64632.

Injections of platelet-rich plasma are reported with 0232T and should not be reported with either 20550 or 20551.

Codes 20552 and 20553 for injections of single or multiple trigger points do not include imaging guidance. If imaging guidance is performed with these procedures, see codes 76942, 77002, and 77021.

# Arthrocentesis (20600-20611)

Arthrocentesis involves using a syringe to collect synovial fluid from a joint capsule. It is also known as joint aspiration. The size of the joint involved will determine the code reported:

- For a small joint or bursa (e.g., fingers, toes) report 20600
- For an intermediate joint or bursa (e.g., temporomandibular, acromioclavicular, wrist, elbow, ankle, olecranon bursa), use code 20605
- For a major joint or bursa (e.g., shoulder, hip, knee joint, subacromial bursa), report code 20610

Example: A patient underwent aspiration of fluid from his left knee joint. The physician then injected an anesthetic/steroid mixture into the same joint. Report 20610-LT.

These codes do not include ultrasound guidance. To report arthrocentesis that includes ultrasound guidance for small, intermediate, or major joints, report codes 20604, 20606, or 20611, respectively. If fluoroscopic, CT, or MRI guidance is performed, see codes 77002, 77012, 77021.

#### Coding tips

- Apply the appropriate modifier: either -LT, -RT or -50 (bilateral procedure).
- Report these codes only once per joint regardless of the number of injections or if an arthrocentesis or aspiration is performed in conjunction with an injection.
- Do not use these codes for aspiration or injection of ganglion cysts; instead, see code 20612. Do not use these codes for injections to the carpal tunnel; instead, see code 20526.

### Fractures

ED physicians commonly treat fractures. A fracture can be the result of a traumatic injury, such as a fall, or may be pathologic (i.e., due to a disease process). In general, fractures can be classified as open or closed, displaced or non-displaced.

Figure 3.1 | Types of Bone Fractures



## Types of fractures

- Buckled fracture: Also known as an impacted fracture, a buckled fracture is one whose ends are driven into each other. This is commonly seen in arm fractures in children.
- Colles fracture: A fracture that occurs at the lower end of the radius, near the wrist joint. It is commonly caused by a fall onto an outstretched hand.
- Comminuted fracture: A fracture in which the bone is splintered or crushed into several pieces.
- Compression fracture: Occurs mainly in the vertebrae where the bone is compressed.

- Greenstick fracture: An incomplete fracture in which the bone is bent and occurs most often in children.
- Transverse fracture: A fracture in which the broken piece of bone is at a right angle to the bone's axis.
- Oblique fracture: A fracture in which the break has a curved or sloped pattern.
- Pathologic fracture: A fracture caused by a disease that weakens the bones.
- Stress fracture: A hairline crack.

#### Treatment

The type of treatment will vary based on the location and severity of the fracture. In many cases, the physician will use either a splint or a cast to immobilize the broken bone. The physician may also use manipulation or attempted reduction to maneuver the bone back into proper alignment. The physician may bend, rotate, pull, or guide the bone back into position. The physician may do an open or closed reduction.

Alternatively, the physician may use traction, the application of pulling force to hold a bone in alignment. Skeletal traction involves the use of internal devices, such as pins, screws, or wires. The devices are inserted into the bone through the skin, with ends of the pins, screws, or wires sticking out through the skin, so that traction devices can be attached. Skin traction involves strapping, elastic wrap, or tape that is fastened to the skin or wrapped around the limb. Weights are then attached to apply force to the fracture.

External fixation involves inserting multiple skeletal pins and attaching a stabilization device that remains on the outside of the skin. Closed treatment (skin remains intact), however, is used to describe procedures that treat fractures by one of three methods:

- Without manipulation
- With manipulation
- With or without traction

Percutaneous skeletal fixation is fracture treatment that is neither open nor closed. Fixation devices are inserted percutaneously with x-ray imaging guidance.

Open treatment is when the fractured bone is open to view and internal fixation (pins, screws, etc.) may be used. For example, the physician may decide to use open treatment of a greater humeral tuberosity fracture that includes internal fixation (CPT code 23630). The surgeon opens the site, reduces the fracture, and applies internal fixation as needed to maintain anatomic position of the fracture.

If the physician performs closed treatment without manipulation, the physician immobilizes the bone with a splint, cast, or other device but without having to manipulate the fracture into alignment.

Consider this case: A patient has a broken but stable radial shaft that is not displaced, and the physician only applies a cast. Report code 25500. The initial casting or splinting is included in the fracture care, but supplies used are not. Initial casting or splinting performed by another physician are the only services that can be reported by that physician.

If the cast needs to be removed and reapplied during the global period, the surgeon that charged the global fee may report the cast/splint application with 29000–29799 and append modifier -58 (staged or related procedure/service). Only charge for cast removal

without reapplication if the physician or physician group is not assuming care for the fracture.

When the physician has to reduce a fracture, he or she will perform closed treatment with manipulation.

For example, a patient has a displaced nose that the physician manipulated back into normal position. The physician then applies external and/or internal splints to immobilize the nose. For this case, report code 21320. CPT has multiple fracture code descriptions with the language "includes internal fixation." Therefore, external fixation should be coded separately when performed (see *CPT Assistant* January 2008 for additional guidance).

#### Coding tips

- The type of fracture (i.e., open, compound, or closed) does not correlate in any way with the type of treatment that is rendered. For example, a closed fracture may be treated by open, closed, or percutaneous skeletal fixation treatment.
- The codes for fractures and dislocation treatment are categorized by the type of manipulation (reduction) and stabilization (fixation).
- Codes for obtaining autogenous bone grafts, cartilage, tendon, fascia lata grafts, or other tissues through separate incision are to be used only when the graft is not listed as part of the basic procedure.

# Dislocations

A dislocation is a separation of two bones where they meet at a joint. Dislocations are usually caused by a sudden impact to the joint, which usually occurs following a blow, fall, or other trauma. A dislocation may occur in conjunction with a fracture or on its own. A partial dislocation is referred to as a subluxation.

#### Treatment

Initial treatment of a dislocation includes rest, ice, compression, and elevation. In some dislocations, the bone ends may go back into place by themselves. For those dislocations that do not, the physician will need to place the joint back into its proper position so it will heal.

Additional treatment may include the following:

- Splint or cast to immobilize the dislocated area to promote alignment and healing; such immobilization protects the injured area from motion or use
- Traction to stretch the muscles and tendons around the bone ends to help reduce the dislocation
- Surgery (especially for reoccurring dislocations or if a muscle, tendon, or ligament is badly torn)

# Shoulder (23500-23680)

Figure 3.2 | Shoulder



The shoulder girdle has the widest and most varied range of motion of any joint in the human body. That also makes it one of the most unstable. Three separate joints make up the shoulder girdle, and they are kept in place by a system of muscles, ligaments, and tendons.

The shoulder girdle is made up of three distinct joints:

- Glenohumeral (GH) joint
- Acromioclavicular (AC) joint
- Sternoclavicular (SC) joint

The bones of the shoulder girdle include the humerus, scapula, and clavicle:

• The humerus is the upper arm bone. The head of the humerus is the ball within the ball-and-socket GH joint. Below the head are the greater and lesser tubercles, where the four rotator cuff muscles attach to the humerus.

- The scapula, also called the shoulder blade, is a large triangular bone that floats on the rib cage and is anchored by muscles, rather than being a true joint. The spine, acromion, and coracoid processes serve as landmarks on the scapula. The acromion, a bony process on the scapula, forms the roof of the GH joint. It also forms the AC joint where it joins the clavicle. The spine divides the back of the scapula into two sections, and the scapula forms the back portion of the shoulder girdle.
- The clavicle begins at the sternum (breastbone) just above the first rib and is the only bony attachment between the trunk and the arm. The clavicle forms the front part of the shoulder girdle.

Any of the bones of the shoulder can break, and any of the joints can be dislocated. *The CPT Manual* divides the codes into the type of injury (fracture or dislocation) and the body part involved (the specific joint or bone). The appropriate CPT is assigned based on the bone or joint being repaired and the type of treatment being performed based on the physician operative note.

#### Fracture of clavicle (23500–23515)

- Includes codes for closed treatment, with and without manipulation, and open treatment
- For open treatment, internal fixation is included when performed

#### Sternoclavicular dislocation (23502–23532)

- Includes codes for open or closed treatment of the dislocation.
- Use different codes for closed treatment with manipulation (23525) or without (23520).

• For open treatment, coders report the same code whether the dislocation is acute or chronic (23530). However, if the physician uses a graft to repair the dislocation, use code 23532, which includes the graft harvest.

#### Acromioclavicular dislocation (23540-23552)

- Includes codes for open or closed treatment of the dislocation.
- Use different codes for closed treatment with manipulation (23545) or without (23540).
- For open treatment, coders report the same code whether the dislocation is acute or chronic (23550). However, if the physician uses a graft to repair the dislocation, use code 23552, which includes the graft harvest.

#### Scapular fracture (23570-23575)

- Includes codes for closed and open treatment
- Closed treatment with or without manipulation
- With closed treatment with manipulation, coders report the same code regardless of whether the physician uses skeletal traction
- Code 23585 for open treatment includes the use of internal fixation when performed

#### Proximal humeral fracture (23585-23605)

- Includes codes for closed and open treatment
- Closed treatment with or without manipulation
- With closed treatment with manipulation, coders report the same code regardless of whether the physician uses skeletal traction

- For open treatment, internal fixation is included when performed
- This series includes an additional code to report when the physician replaces the proximal humerus (23616)

Greater humeral tuberosity fracture (23620-23630)

- Includes codes for closed treatment, with and without manipulation, and open treatment
- For open treatment, internal fixation is included when performed

Shoulder dislocation (23650–23680)

- Different codes provided for closed treatment and open treatment
- Closed treatment always includes manipulation
- Separate codes identify whether anesthesia was required
- Report different codes for open treatment of acute dislocation and chronic dislocation
- Additional codes available for closed treatment of dislocation with fracture of greater humeral tuberosity with manipulation (23665) or internal fixation (23670)

In addition, codes 23675 (closed treatment) and 23680 (open treatment) are used to report shoulder dislocation with surgical or anatomical neck fracture.

## Humerus (Upper Arm) and Elbow (24500– 24685)

Figure 3.3 | Right Humerus, Anterior View



The humerus, the longest bone in the arm, extends from the shoulder to the elbow and is connected by muscles and tendons to the other bones at its distal (furthest from body) end.

The elbow is a complex hinge joint formed by three bones: the humerus, radius, and ulna. It allows the forearm to extend and rotate. The elbow joint also consists of three ligaments: ulnar collateral ligament, annular ligament, and radial collateral ligament.

The appropriate CPT is assigned based on the bone or joint being repaired and the type of treatment being performed based on the physician operative note. Codes for fractures of the humerus specify open or closed treatment, whether the physician manipulated the bone, and whether the physician placed any fixation devices. Open treatment codes specify type of fixation (percutaneous or internal). Codes are divided into the following groups:

- 24500–24516, humeral shaft fractures
- 24530–24546, supracondyle or transcondylar humeral fracture
- 24560–24575, humeral epicondylar fracture
- 24576–24582, humeral condylar fracture
  - Same code is used for medial or lateral fracture

In some cases a patient suffers both a fracture and an elbow dislocation. CPT includes codes 24586 and 24587 to describe a periarticular fracture and/or elbow dislocation.

Three CPT codes are used to report only an elbow dislocation:

- 24600, treatment of closed dislocation without anesthesia
- 24605, treatment of closed dislocation with anesthesia
- 24615, open treatment, acute or chronic dislocation

Some patients may suffer a Monteggia-type fracture dislocation at the elbow. In these cases, the patient fractures the proximal end of the ulna and dislocates the radial head. CPT provides codes 24620 (closed treatment) and 24635 (open treatment) for these injuries.

Children may suffer a radial head subluxation, also called nursemaid's elbow. Code 24640 specifies closed treatment of this partial dislocation and also includes the word "child."

## Forearm and Wrist (25500–25695)

Figure 3.4 | Right Radius and Ulna, Anterior View



The radius and ulna, the two long bones of the forearm, join the humerus at their promixal (closest to the body) ends. The radius, the shorter of the two bones, is located on the thumb side of the body and runs parallel to the ulna. The bone's broad distal end joins with the ulna and upper bones of the wrist at the radial styloid process. The eight bones in the wrist are known as the carpals. They are arranged in two rows of four across the hand. Codes for fractures of the forearm specify the bone involved, open or closed treatment, whether the physician manipulated the bone, and whether the physician placed any fixation devices. Note that CPT includes combination codes when both the radius and the ulna are fractured.

Codes are divided into the following groups:

- 24650–24666, radial head or neck fracture
- 24670–24685, ulnar fracture, proximal end
- 25500–25526, radial shaft fracture
- 25530–25545, ulnar shaft fracture
- 25560–25575, radial and ulnar shaft fractures
- 25600–25609, distal radial fracture or epiphyseal separation

Codes for fractures of the wrist specify the bone involved:

- 25622–25628, carpal scaphoid (navicular)
- 25630–25645, carpal bone excluding scaphoid
- 25650–25652, ulnar styloid

Radiocarpal or intercarpal dislocations are reported with codes 25660 (closed treatment) and 25670 (open treatment), regardless of the number of bones involved.

Codes for distal radioulnar dislocations (25671–25676) identify the type of treatment, including the use of manipulation and percutaneous skeletal fixation.

CPT includes additional codes for closed (25680) and open (25685) treatment of trans-scaphoperilunar dislocations and for closed (25690) and open (25695) lunate dislocation.

# Hands and Fingers (26600–26785)

Figure 3.5 | Left Wrist and Hand, Dorsal View



The five bones that form the palm of the hand are the metacarpals. They are simply named first through fifth, beginning with the bone closest to the thumb.

Each hand has 14 phalanges, small bones that comprise each finger. The thumb consists of two phalanges, while the other four fingers each contain three phalanges. The phalanx closest to the wrist is called the proximal phalanx, the second is called the middle phalanx, and the third is the distal phalanx.

The codes for treatment of fractures and dislocations of the hands and fingers are divided by the type of reduction and stabilization (fixation or immobilization). Report the same code regardless of whether the fracture or joint injury is open or closed. The appropriate CPT is assigned based on the bone or joint being repaired and the type of treatment being performed based on the physician operative note.

Report codes 26600–26615 (metacarpal fracture) once for each bone involved. For example, if a physician performs closed treatment of two metacarpal fractures without manipulation, report code 26600x2. If the physician performs closed treatment of one metacarpal bone with manipulation and treats a second without manipulation, report codes 26600 and 26605.

Other codes related to the hand include the following:

- 26641–26665, carpometacarpal dislocation fractures. For these codes, be sure that the physician identifies which digit is involved. CPT includes separate codes for the thumb.
- 26670–26686, carpometacarpal dislocations. Codes are reported once per joint. Also look for use of anesthesia and fixation devices.
- 26700–26715, metacarpophalangeal dislocation.
- 26720–26735, phalangeal shaft fractures. These codes specify the middle or proximal phalanx of the thumb or finger. Report the code once for each finger involved.
- 26740–26746, articular fractures involving the metacarpophalangeal or interphalangeal joint.
- 26750–26765, which describe various treatment options for distal phalangeal fractures of the thumb and fingers. Report the code once for each fracture.
- 26770-26785, interphalangeal joint dislocations.

# Pelvic and Hip Joint (27193–27269)

Figure 3.6 | Pelvis and Pelvic Fractures



The pelvic girdle consists of two symmetrical hip bones, the sacrum, and the coccyx. The coccyx, more commonly known as the tail bone, represents the lower end of the vertebral column. The coccyx articulates at the top with the sacrum. At the widest points of the triangular sacrum, the sacroiliac joint articulates with the ilium, the largest part of the pelvic bone, on each side. Each pelvic, or hip, bone consists of three fused bones: the ilium, pubis, and ischium.

In addition to the sacrum, the ilium articulates at the bottom with the ball-shaped head of the femur to form the hip joint. This surface is known as the acetabulum. The upper part of the femur also includes two bony protrusions, the greater and lesser trochanter. The ischium is a U-shaped portion of the pelvic bone located on the lower, posterior end. The ischium also forms part of the acetabulum, articulating with the head of the femur. The pubis, the third part of the hip bone, also has a U shape that joins with the ischium to form a closed loop.

Codes in this section are categorized by the type of manipulation and stabilization method (e.g., fixed or immobilization). Codes can apply to either open or closed fractures or injuries, and are assigned based on the bone or joint being repaired.

#### 27193-27228; 27246-27266

Codes in these sections are used to report fractures and dislocations of the following:

- Acetabulum
- Anterior and posterior pelvic bone
- Coccyx
- Greater trochanter
- Hip
- Ilium
- Pelvic ring

While many fracture and dislocation codes distinguish either with or without manipulation or with or without anesthesia, code 27254 for treatment of a spontaneous hip dislocation by abduction specifies without anesthesia and without manipulation. Code 27257 is used to report this procedure with anesthesia and manipulation.

## 27230-27245; 27267-27269

These codes are used to report open and closed treatment of femoral fractures. The codes describe procedures to the proximal end of the femur, but they distinguish between the head and the neck.

# Femur (Thigh Region) and Knee Joint (27500– 27566)

Figure 3.7 | Right Femur, Anterior View



The femur, or thigh bone, is the longest bone in the body. The lower end joins with the tibia at the lateral condyle to form the knee joint. Above the shaft of the femur, which is angled inward slightly to bring the knee under the body, is the head at the upper end.



The knee is a complex joint, larger than any other in the human body. It is formed by the articulation of the femur where it meets the tibia and patella, as a synovial hinge joint, though it also allows some rotation. It is considered a compound joint, since it involves more than two bones.

The femur is at the top of the joint, while the tibia is part of the lower leg and provides weight-bearing support for the joint. The patella, also known as the knee cap, is connected by ligaments and tendons to the femur.

Codes in this section are categorized by the type of manipulation and stabilization method (e.g., fixed or immobilization). Codes can apply to either open or closed fractures or injuries, and are assigned based on the bone or joint being repaired.

#### 27500-27519

Codes in this section are used to report closed and open treatment of fractures and dislocations to the shaft and distal end of the femur.

#### 27520-27540

These codes are used to report procedures for open and closed treatment of patellar, tibial, and tuberosity fractures. For arthroscopic treatment of intercondylar spines and tuberosity fractures, coders should see 29850–29851. For arthroscopic treatment of tibial fractures, see codes 29855–29856.

#### 27550-27566

Coders should use these codes to report procedures relating to open and closed treatment of knee and patellar dislocations, noting the different codes for procedures requiring anesthesia. For recurrent patellar dislocations, see codes 27420–27424.

## Leg (Tibia and Fibula) and Ankle Joint (27750– 27848)

Figure 3.9 | Right Tibia and Fibula, Anterior View



In addition to the patella, the lower leg includes the tibia and fibula. The tibia is the main weight-bearing bone, while the fibula forms part of the ankle joint and attaches to muscles of the shin and calf. At the head of the tibia, near the knee, are two protrusions known as the medial (inner) condyle and lateral (outer) condyle.

The neck of the fibula is located in the upper end. The ankle is a hinge joint, with the lower ends of the tibia and fibula forming a joint with the talus, a bone of the foot. The bottom of the tibia is the medial malleolus, while the lower end of the fibula is the lateral malleolus.

Codes in this section are categorized by the type of manipulation and stabilization method (e.g., fixed or immobilization). Codes can apply to either open or closed fractures or injuries, and are assigned based on the bone or joint being repaired.

#### 27750-27759

These codes are used to report open, closed, and percutaneous treatment of tibial shaft fractures, and they can be reported with or without fibular fractures. Codes for reporting fractures to the fibula at the proximal or distal ends, as well as the shaft, are located from 27780–27792.

#### 27760-27769

These codes are used to report open and closed treatment of medial and posterior malleolus fractures. These codes should not be reported in conjunction with 27808–27823, the codes to report bimalleolar and trimalleolar ankle fractures.

#### 27824-27828

Codes in this range describe procedures for open and closed treatment of fractures to weight-bearing articular portions of the distal tibia. Separate codes exist for open treatment of the fibula only (27826), tibia only (27827), and both bones (27828).



Of the 26 bones in the foot, 14 are the phalanges, located in the toes. Each toe has three phalanges, except for the great toe, also known as the hallux, which has only two. The phalanges closest to the body are known as proximal, while those furthest away are known as distal. The middle phalanges are called medial.

Each toe also has one metatarsal bone, which is connected to the proximal phalanx. The midfoot, which contains bones that form the arch of the foot, includes three cuneiform bones, the cuboid bone, and the navicular bone. The hindfoot, which helps form the heel and ankle, is made from the talus bone and the calcaneus. Also known as the heel bone, the calcaneus is the largest bone in the foot.

The calcaneus can be affected by several types of fractures. A fracture of the anterior process of the calcaneus occurs when the small projection that extends toward the navicular bone breaks. Intraarticular and extraarticular fractures are classified by their location relative to the subtalar joint. Fractures of the tuberosity of the calcaneus

typically involve the posterior of the bone's projection, commonly thought of as the heel.

#### 28400-28675

Codes in this section are categorized by the type of manipulation and stabilization method (e.g., fixed or immobilization). Codes can apply to either open or closed fractures or injuries and are assigned based on the bone or joint being repaired. All procedures include open or closed treatment, with several including options for percutaneous treatment.

Coders should note that many procedures for closed treatment include two options: with or without manipulation and with or without anesthesia.

Code 28446 for an open osteochondral autograft of the talus should not be reported along with the codes for osteotomy of the tibia (27705) and fibula (27707). For an arthroscopic osteochondral talus graft, coders should report 29892.

# Application of Casts and Strapping (29000–29799)

Fracture care codes include the application and removal of the first cast or traction device. When providers perform some sort of restorative treatment (e.g., traction, manipulation) to the fracture and then place a cast, coders should report only the CPT code for the fracture care, because the application of the cast is inherent in the procedure. However, if the physician places the cast as a replacement procedure during or after the period of follow-up care, coders may report the code for casting and strapping. The codes for the application of casts and strapping are also located in codes 29000–29799. Per CPT guidelines, report casting and strapping codes for the following situations:

- When the cast application or strapping is a replacement procedure that occurs during or after the period of follow-up care
- When the cast application or strapping is an initial service performed without a restorative treatment or procedure(s) to stabilize or protect a fracture, injury, or dislocation and/or to afford comfort to the patient
- If the physician provides the cast or strapping as an initial service, and the physician rendering the initial care does not perform or expect to perform any other procedure or treatment

The codes for casts, splints, and strapping are divided by body and upper extremity (29000–29280) and lower extremity (29305–29584). Cast codes specify the site and type of cast placed.

Codes for splints (29105–29131) are limited to the arm (long or short splints), fingers (static or dynamic), and leg (long or short splint).

Codes for strapping are also divided by anatomical location.

# just Jcoding

# **Emergency Department Coding Handbook**

Nena Scott, MSEd, RHIA, CCS, CCS-P, CCDS, AHIMA-Approved ICD-10-CM/PCS Trainer

This handbook is a quick reference guide for coders in emergency department (ED) settings. It guides coders through assigning visit levels and documentation requirements for a variety of common ED services. The handbook also includes anatomical illustrations for fractures.

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- Determine how to report consistent visit levels based on accepted standards
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