CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 3220	**Date: March 16, 2015**
	Change Request 8524

Transmittal 3028, dated August 15, 2014, is being rescinded and replaced by Transmittal 3220 to restore information from CR 8556 in chapter 5, sections 10.3 and 20.2 that was erroneously overwritten. All other information remains the same.

SUBJECT: Update to Pub. 100-04, Chapters 5 and 6 to Provide Language-Only Changes for Updating ICD-10, ASC X12, and Medicare Administrative Contractor (MAC) Implementation

I. SUMMARY OF CHANGES: This CR contains language-only changes for updating ICD-10, ASC X12, and MAC language in Pub 100-04, Chapters 5 and 6. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE:

ICD-10: Upon Implementation of ICD-10
ASC-X12: January 1, 2012

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: October 1, 2014

ICD-10: Upon Implementation of ICD-10
ASC X12: September 16, 2014

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/Table of Contents
R	5/10/Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services – General
R	5/10.3/Application of Financial Limitations
R	5/10/7/Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services
R	5/20.2/Reporting of Service Units With HCPCS
R	5/20.4/Coding Guidance for Certain CPT Codes - All Claims
R	5/100.1/General

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/100.5/Off-Site CORF Services
R	5/100.6/Notifying Patient of Service Denial
R	5/100.8/Billing for DME, Prosthetic and Orthotic Devices, and Surgical Dressings
N	5/Addendum A - Chapter 5, Section 20.4 - Coding Guidance for Certain CPT Codes - All Claims
R	6/10.1/Consolidated Billing Requirement for SNFs
R	6/30/Billing SNF PPS Services
R	6/40.5/Billing Procedures for Periodic Interim Payment (PIP) Method of Payment
R	6/40.6/Total and Noncovered Charges
R	6/40.6.1/Services in Excess of Covered Services
R	6/40.6.3/Reporting Accommodations on Claims
R	6/40.6.4/Bills with Covered and Noncovered Days
R	6/40.8/Billing in Benefits Exhaust and No-Payment Situations
R	6/40.9/Other Billing Situations

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 3220	Date: March 16, 2015	Change Request: 8524

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**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: October 1, 2014
ICD-10: Upon Implementation of ICD-10
ASC X12: September 16, 2014

I. GENERAL INFORMATION

A. Background: This CR contains language-only changes for updating ICD-10, ASC X12, and MAC language in Pub 100-04, Chapters 5 and 6.

B. Policy: There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
8524.1	MACs which received bills from Part B Outpatient Facilities and Comprehensive Outpatient Rehabilitation Facilities shall be aware of the changes in the attached instructions in Pub 100-04, Chapter 5.	X	X		X					
8524.2	MACs which received SNF inpatient Part A bills shall be aware of the changes in the attached instructions in Pub 100-04, Chapter 6.	X								

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Not Applicable

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

Medicare Claims Processing Manual
Chapter 5 - Part B Outpatient Rehabilitation and CORF/OPT Services

Table of Contents
(Rev. 3220, Issued: 03-16-15)

10 - Part B Outpatient Rehabilitation and Comprehensive Outpatient Rehabilitation Facility (CORF) Services - General

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

Language in this section is defined or described in Pub. 100-02, chapter 15, sections 220 and 230.

Section 4541(a)(2) of the Balanced Budget Act (BBA) (P. L. 105-33), which added §1834(k)(5) to the Social Security Act (the Act), required that all claims for outpatient rehabilitation services and comprehensive outpatient rehabilitation facility (CORF) services, be reported using a uniform coding system. The CMS chose HCPCS (Healthcare Common Procedure Coding System) as the coding system to be used for the reporting of these services. This coding requirement is effective for all claims for outpatient rehabilitation services and CORF services submitted on or after April 1, 1998.

The BBA also required payment under a prospective payment system for outpatient rehabilitation services including CORF services. Effective for claims with dates of service on or after January 1, 1999, the Medicare Physician Fee Schedule (MPFS) became the method of payment for outpatient therapy services furnished by:

- Comprehensive outpatient rehabilitation facilities (CORFs);
- Outpatient physical therapy providers (OPTs);
- Other rehabilitation facilities (ORFs);
- Hospitals (to outpatients and inpatients who are not in a covered Part A stay);
- Skilled nursing facilities (SNFs) (to residents not in a covered Part A stay and to nonresidents who receive outpatient rehabilitation services from the SNF); and
- Home health agencies (HHAs) (to individuals who are not homebound or otherwise are not receiving services under a home health plan of care (POC)).

NOTE: No provider or supplier other than the SNF will be paid for therapy services during the time the beneficiary is in a covered SNF Part A stay. For information regarding SNF consolidated billing see chapter 6, section 10 of this manual.

Similarly, under the HH prospective payment system, HHAs are responsible to provide, either directly or under arrangements, all outpatient rehabilitation therapy services to beneficiaries receiving services under a home health POC. No other provider or supplier will be paid for these services during the time the beneficiary is in a covered Part A stay. For information regarding HH consolidated billing see chapter10, section 20 of this manual.

Section 143 of the Medicare Improvements for Patients and Provider's Act of 2008 (MIPPA) authorizes the Centers for Medicare & Medicaid Services (CMS) to enroll speech-language pathologists (SLP) as suppliers of Medicare services and for SLPs to begin billing Medicare for outpatient speech-language pathology services furnished in private practice beginning July 1, 2009. Enrollment will allow SLPs in private practice to bill Medicare and receive direct payment for their services. Previously, the Medicare program could only pay SLP services if an institution, physician or nonphysician practitioner billed them.

In Chapter 23, as part of the CY 2009 Medicare Physician Fee Schedule Database, the descriptor for PC/TC indicator "7", as applied to certain HCPCS/CPT codes, is described as specific to the services of privately practicing therapists. Payment may not be made if the service is provided to either a hospital outpatient or a hospital inpatient by a physical therapist, occupational therapist, or speech-language pathologist in private practice.

The MPFS is used as a method of payment for outpatient rehabilitation services furnished under arrangement with any of these providers.

In addition, the MPFS is used as the payment system for CORF services identified by the HCPCS codes in §20. Assignment is mandatory.

The Medicare **allowed charge** for the services is the lower of the actual charge or the MPFS amount. The Medicare payment for the services is 80 percent of the allowed charge after the Part B deductible is met. Coinsurance is made at 20 percent of the lower of the actual charge or the MPFS amount. The general coinsurance rule (20 percent of the actual charges) does not apply when making payment under the MPFS. This is a final payment.

The MPFS does **not** apply to outpatient rehabilitation services furnished by critical access hospitals (CAHs). CAHs are to be paid on a reasonable cost basis.

Contractors process outpatient rehabilitation claims from hospitals, including CAHs, SNFs, HHAs, CORFs, outpatient rehabilitation agencies, and outpatient physical therapy providers for which they have received a tie in notice from the RO. These provider types submit their claims to the contractors using the *ASC X12* 837 *i*nstitutional claim format or the *CMS-1450* paper form when permissible. Contractors also process claims from physicians, certain nonphysician practitioners (NPPs), therapists in private practices (TPPs), (which are limited to physical and occupational therapists, and speech-language pathologists in private practices), and physician-directed clinics that bill for services furnished incident to a physician's service (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 15, for a definition of "incident to"). These provider types submit their claims to the contractor using the *ASC X 12* 837 *p*rofessional claim format or the CMS-1500 paper form when permissible.

There are different fee rates for nonfacility and facility services. Chapter 23 describes the differences in these two rates. (See fields 28 and 29 of the record therein described). Facility rates apply to professional services performed in a facility other than the professional's office. Nonfacility rates apply when the service is performed

in the professional's office. The nonfacility rate (that is paid when the provider performs the services in its own facility) accommodates overhead and indirect expenses the provider incurs by operating its own facility. Thus it is somewhat higher than the facility rate.

Contractors pay the nonfacility rate on institutional claims for services performed in the provider's facility. Contractors may pay professional claims using the facility or nonfacility rate depending upon where the service is performed (place of service on the claim), and the provider specialty.

Contractors pay the codes in §20 under the MPFS on professional claims regardless of whether they may be considered rehabilitation services. However, contractors must use this list for institutional claims to determine whether to pay under outpatient rehabilitation rules or whether payment rules for other types of service may apply, e.g., OPPS for hospitals, reasonable costs for CAHs.

Note that because a service is considered an outpatient rehabilitation service does not automatically imply payment for that service. Additional criteria, including coverage, plan of care and physician certification must also be met. These criteria are described in Pub. 100-02, Medicare Benefit Policy Manual, chapters 1 and 15.

Payment for rehabilitation services provided to Part A inpatients of hospitals or SNFs is included in the respective PPS rate. Also, for SNFs (but not hospitals), if the beneficiary has Part B, but not Part A coverage (e.g., Part A benefits are exhausted), the SNF must bill for any rehabilitation service.

Payment for rehabilitation therapy services provided by home health agencies under a home health plan of care is included in the home health PPS rate. HHAs may submit bill type 34X and be paid under the MPFS if there are no home health services billed under a home health plan of care at the same time, and there is a valid rehabilitation POC (e.g., the patient is not homebound).

An institutional employer (other than a SNF) of the TPPs, or physician performing outpatient services, (e.g., hospital, CORF, etc.), or a clinic billing on behalf of the physician or therapist may bill the contractor on a professional claim.

The MPFS is the basis of payment for outpatient rehabilitation services furnished by TPPs, physicians, and certain nonphysician practitioners or for diagnostic tests provided incident to the services of such physicians or nonphysician practitioners. (See Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, for a definition of "incident to, therapist, therapy and related instructions.") Such services are billed to the contractor on the professional claim format. Assignment is mandatory.

The following table identifies the provider and supplier types, and identifies which claim format they may use to submit bills to the contractor.

"Provider/Supplier Service" Type	**Format**	**Bill Type**	**Comment**
Inpatient hospital Part A	Institutional	11X	Included in PPS
Inpatient SNF Part A	Institutional	21X	Included in PPS
Inpatient hospital Part B	Institutional	12X	Hospital may obtain services under arrangements and bill, or rendering provider may bill.
Inpatient SNF Part B (audiology tests are not included)	Institutional	22X	SNF must provide and bill, or obtain under arrangements and bill.
Outpatient hospital	Institutional	13X	Hospital may provide and bill or obtain under arrangements and bill, or rendering provider may bill.
Outpatient SNF	Institutional	23X	SNF must provide and bill or obtain under arrangements and bill.
HHA billing for services rendered under a Part A or Part B home health plan of care.	Institutional	32X	Service is included in PPS rate. CMS determines whether payment is from Part A or Part B trust fund.
HHA billing for services not rendered under a Part A or Part B home health plan of care, but rendered under a therapy plan of care.	Institutional	34X	Service not under home health plan of care.
Other Rehabilitation Facility (ORF)	Institutional	74X	Paid MPFS for outpatient rehabilitation services effective January 1, 1999, and all other services except drugs effective July 1, 2000. Starting April 1, 2002, drugs are paid 95% of the AWP. For claims with dates of service on or after July 1, 2003, drugs and biologicals do not apply in an OPT setting. Therefore, *A/B MACs (A)* are to advise their OPTs not to bill for them.
Comprehensive Outpatient Rehabilitation Facility (CORF)	Institutional	75X	Paid MPFS for outpatient rehabilitation services effective January 1, 1999, and all other services except drugs effective July 1, 2000. Starting April 1, 2002, drugs are paid 95% of the AWP.
Physician, NPPs, TPPs, (service in hospital or SNF)	Professional	See Chapter 26 for place	Payment may not be made for therapy services to Part A

"Provider/Supplier Service" Type	Format	Bill Type	Comment
		of service, and type of service coding.	inpatients of hospitals or SNFs, or for Part B SNF residents. Otherwise, suppliers bill to the contractor using the professional claim format. **NOTE**: services of a physician/ NPP/TPP employee of a facility may be billed by the facility to a contractor.
Physician/NPP/TPPs office, independent clinic or patient's home	Professional	See Chapter 26 for place of service, and type of service coding.	Paid via *MPFS*.
Critical Access Hospital - inpatient Part A	Institutional	11X	Rehabilitation services are paid at cost.
Critical Access Hospital - inpatient Part B	Institutional	85X	Rehabilitation services are paid at cost.
Critical Access Hospital – outpatient Part B	Institutional	85X	Rehabilitation services are paid at cost.

Complete claim form completion requirements are contained in chapters 25 and 26.

For a list of the outpatient rehabilitation HCPCS codes see §20.

If a contractor receives an institutional claim for one of these HCPCS codes with dates of service on or after July 1, 2003, that does not appear on the supplemental file it currently uses to pay the therapy claims, it contacts its professional claims area to obtain the non-facility price in order to pay the claim.

NOTE: The list of codes in §20 contains commonly utilized codes for outpatient rehabilitation services. Contractors may consider other codes on institutional claims for payment under the MPFS as outpatient rehabilitation services to the extent that such codes are determined to be medically reasonable and necessary and could be performed within the scope of practice of the therapist providing the service.

10.3 - Application of Financial Limitations

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

(Additions, deletions or changes to the therapy code list are updated via a Recurring Update Notification.)

Financial limitations on outpatient therapy services, as described above, began for therapy services rendered on or after on January 1, 2006. References and polices relevant to the exceptions process in this chapter apply only when exceptions to

therapy caps are in effect. For dates of service before October 1, 2012, limits apply to outpatient Part B therapy services furnished in all settings except outpatient hospitals, including hospital emergency departments. These excluded hospital services are reported on types of bill 12x or 13x, or 85x. Effective for dates of service on or after October 1, 2012, the limits also apply to outpatient Part B therapy services furnished in outpatient hospitals other than Critical Access Hospitals. During this period, only type of bill 12x claims with a CMS certification number in the Critical Access Hospital range and type of bill 85x claims are excluded. Effective for dates of service on or after January 1, 2014, the limits also apply to Critical Access Hospitals.

Contractors apply the financial limitations to the MPFS amount (or the amount charged if it is smaller) for therapy services for each beneficiary.

As with any Medicare payment, beneficiaries pay the coinsurance (20 percent) and any deductible that may apply. Medicare will pay the remaining 80 percent of the limit after the deductible is met. These amounts will change each calendar year.

Medicare shall apply these financial limitations in order, according to the dates when the claims were received. When limitations apply, the Common Working File (CWF) tracks the limits. Shared system maintainers are not responsible for tracking the dollar amounts of incurred expenses of rehabilitation services for each therapy limit.

In processing claims where Medicare is the secondary payer, the shared system takes the lowest secondary payment amount from MSPPAY and sends this amount on to CWF as the amount applied to therapy limits.

A. Exceptions to Therapy Caps - General

The following policies concerning exceptions to caps due to medical necessity apply only when the exceptions process is in effect. Except for the requirement to use of the KX modifier, the guidance in this section concerning medical necessity applies as well to services provided before caps are reached.

Provider and supplier information concerning exceptions is in this chapter and in Pub. 100-02, chapter 15, section 220.3. Exceptions shall be identified by a modifier on the claim and supported by documentation.

The beneficiary may qualify for use of the cap exceptions process at any time during the episode when documented medically necessary services exceed caps. All covered and medically necessary services qualify for exceptions to caps. All requests for exception are in the form of a KX modifier added to claim lines. (See subsection D for use of the KX modifier.)

Use of the exception process does not exempt services from manual or other medical review processes as described in Pub. 100-08. Rather, atypical use of the exception process may invite contractor scrutiny, for example, when the KX modifier is applied to all services on claims that are below the therapy caps or when the KX modifier is used for all beneficiaries of a therapy provider. To substantiate the medical necessity of the therapy services, document in the medical record (see Pub. 100-02, chapter 15, sections 220.2, 220.3, and 230).

The KX modifier, described in subsection D, is added to claim lines to indicate that the clinician attests that services at and above the therapy caps are medically necessary and justification is documented in the medical record.

B. Exceptions Process

An exception may be made when the patient's condition is justified by documentation indicating that the beneficiary requires continued skilled therapy, i.e., therapy beyond the amount payable under the therapy cap, to achieve their prior functional status or maximum expected functional status within a reasonable amount of time.

No special documentation is submitted to the contractor for exceptions. The clinician is responsible for consulting guidance in the Medicare manuals and in the professional literature to determine if the beneficiary may qualify for the exception because documentation justifies medically necessary services above the caps. The clinician's opinion is not binding on the Medicare contractor who makes the final determination concerning whether the claim is payable.

Documentation justifying the services shall be submitted in response to any Additional Documentation Request (ADR) for claims that are selected for medical review. Follow the documentation requirements in Pub. 100-02, chapter 15, section 220.3. If medical records are requested for review, clinicians may include, at their discretion, a summary that specifically addresses the justification for therapy cap exception.

In making a decision about whether to utilize the exception, clinicians shall consider, for example, whether services are appropriate to--

- The patient's condition, including the diagnosis, complexities, and severity;
- The services provided, including their type, frequency, and duration;
- The interaction of current active conditions and complexities that directly and significantly influence the treatment such that it causes services to exceed caps.

In addition, the following should be considered before using the exception process:

1. Exceptions for Evaluation Services

Evaluation - The CMS will except therapy evaluations from caps after the therapy caps are reached when evaluation is necessary, e.g., to determine if the current status of the beneficiary requires therapy services. For example, the following CPT codes for evaluation procedures may be appropriate:

92521, 92522 , 92523, 92524, 92597, 92506, 92597, 92607, 92608, 92610, 92611, 92612, 92614, 92616, 96105, 96125, 97001, 97002, 97003, 97004.

These codes will continue to be reported as outpatient therapy procedures as listed in the Annual Therapy Update for the current year at:

http://www.cms.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage. They are not diagnostic tests. Definitions of evaluations and documentation are found in Pub. 100-02, sections 220 and 230.

Other Services - There are a number of sources that suggest the amount of certain services that may be typical, either per service, per episode, per condition, or per discipline. For example, see the CSC - Therapy Cap Report, 3/21/2008, and CSC – Therapy Edits Tables 4/14/2008 at http://www.cms.hhs.gov/TherapyServices/Studies and Reports.html, or more recent utilization reports. Professional literature and guidelines from professional associations also provide a basis on which to estimate whether the type, frequency, and intensity of services are appropriate to an individual. Clinicians and contractors should utilize available evidence related to the patient's condition to justify provision of medically necessary services to individual beneficiaries, especially when they exceed caps. Contractors shall not limit medically necessary services that are justified by scientific research applicable to the beneficiary. Neither contractors nor clinicians shall utilize professional literature and scientific reports to justify payment for continued services after an individual's goals have been met earlier than is typical. Conversely, professional literature and scientific reports shall not be used as justification to deny payment to patients whose needs are greater than is typical or when the patient's condition is not represented by the literature.

2. Exceptions for Medically Necessary Services

Clinicians may utilize the process for exception for any diagnosis or condition for which they can justify services exceeding the cap. Regardless of the diagnosis or condition, the patient must also meet other requirements for coverage.

Bill the most relevant diagnosis. As always, when billing for therapy services, the *diagnosis* code that best relates to the reason for the treatment shall be on the claim, unless there is a compelling reason to report another diagnosis code. For example, when a patient with diabetes is being treated with therapy for gait training due to amputation, the preferred diagnosis is abnormality of gait (which characterizes the treatment). Where it is possible in accordance with State and local laws and the contractors' local coverage determinations, avoid using vague or general diagnoses. When a claim includes several types of services, or where the physician/NPP must supply the diagnosis, it may not be possible to use the most relevant therapy diagnosis code in the primary position. In that case, the relevant diagnosis code should, if possible, be on the claim in another position.

Codes representing the medical condition that caused the treatment are used when there is no code representing the treatment. Complicating conditions are preferably used in non-primary positions on the claim and are billed in the primary position only in the rare circumstance that there is no more relevant code.

The condition or complexity that caused treatment to exceed caps must be related to the therapy goals and must either be the condition that is being treated or a complexity that directly and significantly impacts the rate of recovery of the condition being treated such that it is appropriate to exceed the caps. Documentation for an exception

should indicate how the complexity (or combination of complexities) directly and significantly affects treatment for a therapy condition.

If the contractor has determined that certain codes do not characterize patients who require medically necessary services, providers/suppliers may not use those codes, but must utilize a billable diagnosis code allowed by their contractor to describe the patient's condition. Contractors shall not apply therapy caps to services based on the patient's condition, but only on the medical necessity of the service for the condition. If a service would be payable before the cap is reached and is still medically necessary after the cap is reached, that service is excepted.

Contact your contractor for interpretation if you are not sure that a service is applicable for exception.

It is very important to recognize that most conditions would not ordinarily result in services exceeding the cap. Use the KX modifier only in cases where the condition of the individual patient is such that services are APPROPRIATELY provided in an episode that exceeds the cap. Routine use of the KX modifier for all patients with these conditions will likely show up on data analysis as aberrant and invite inquiry. Be sure that documentation is sufficiently detailed to support the use of the modifier.

In justifying exceptions for therapy caps, clinicians and contractors should not only consider the medical diagnoses and medical complications that might directly and significantly influence the amount of treatment required. Other variables (such as the availability of a caregiver at home) that affect appropriate treatment shall also be considered. Factors that influence the need for treatment should be supportable by published research, clinical guidelines from professional sources, and/or clinical or common sense. See Pub. 100-02, chapter 15, section 220.3 for information related to documentation of the evaluation, and section 220.2 on medical necessity for some factors that complicate treatment.

NOTE: The patient's lack of access to outpatient hospital therapy services alone, when outpatient hospital therapy services are excluded from the limitation, does not justify excepted services. Residents of skilled nursing facilities prevented by consolidated billing from accessing hospital services, debilitated patients for whom transportation to the hospital is a physical hardship, or lack of therapy services at hospitals in the beneficiary's county may or may not qualify as justification for continued services above the caps. The patient's condition and complexities might justify extended services, but their location does not. For dates of service on or after October 1, 2012, therapy services furnished in an outpatient hospital are not excluded from the limitation.

C. Appeals Related to Disapproval of Cap Exceptions

Disapproval of Exception from Caps. When a service beyond the cap is determined to be medically necessary, it is covered and payable. But, when a service provided beyond the cap (outside the benefit) is determined to be NOT medically necessary, it is denied as a benefit category denial. Contractors may review claims with KX modifiers to determine whether the services are medically necessary, or for other

reasons. Services that exceed therapy caps but do not meet Medicare criteria for medically necessary services are not payable even when clinicians recommend and furnish these services.

Services without a Medicare benefit may be billed to Medicare with a GY modifier for the purpose of obtaining a denial that can be used with other insurers. See Pub. 100-04, chapter 1, section 60.4 for appropriate use of modifiers.

APPEALS – If a beneficiary whose excepted services do not meet the Medicare criteria for medical necessity elects to receive such services and a claim is submitted for such services, the resulting determination would be subject to the administrative appeals process. Further details concerning appeals are found in Pub. 100-04, Chapter 29.

D. Use of the KX Modifier for Therapy Cap Exceptions

When exceptions are in effect and the beneficiary qualifies for a therapy cap exception, the provider shall add a KX modifier to the therapy HCPCS code subject to the cap limits. The KX modifier shall not be added to any line of service that is not a medically necessary service; this applies to services that, according to a local coverage determination by the contractor, are not medically necessary services.

The codes subject to the therapy cap tracking requirements for a given calendar year are listed at: http://www.cms.hhs.gov/TherapyServices/05_Annual_Therapy_Update.asp#TopOfPage.

The GN, GO, or GP therapy modifiers are currently required to be appended to therapy services. In addition to the KX modifier, the GN, GP and GO modifiers shall continue to be used. Providers may report the modifiers on claims in any order. If there is insufficient room on a claim line for multiple modifiers, additional modifiers may be reported in the remarks field. Follow the routine procedure for placing HCPCS modifiers on a claim as described below.

- For professional claims, sent to the A/B MAC *(B)*, refer to:
    - Pub.100-04, Medicare Claims Processing Manual, chapter 26, for more detail regarding completing Form *CMS*-1500, including the placement of HCPCS modifiers. **NOTE**: Form CMS-1500 currently has space for providing *four* modifiers in block 24D, but, if the provider has more than *four* to report, he/she can do so by placing the -99 modifier (which indicates multiple modifiers) in block 24D and placing the additional modifiers in block 19.
    - The ASC X12 837 Health Care Claim: Professional *Claim* Implementation Guide for more detail regarding how to electronically submit a health care claim transaction, including the placement of HCPCS modifiers. The ASC X12 837 implementation guides are the standards adopted under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for submitting health care claims

electronically. Copies of the ASC X12 837 implementation guides may be obtained from the Washington Publishing Company.

- For claims paid by an A/B MAC *(B)*, it is only appropriate to append the KX modifier to a service that reasonably may exceed the cap. Use of the KX modifier when there is no indication that the cap is likely to be exceeded is abusive. For example, use of the KX modifier for low cost services early in an episode when there is no evidence of a previous episode that might have exceeded the cap is inappropriate.

1. For institutional claims, sent to the A/B MAC *(A)*:

   - When the cap is exceeded by at least one line on the claim, use the KX modifier on all of the lines on that institutional claim that refer to the same therapy cap (PT/SLP or OT), regardless of whether the other services exceed the cap. For example, if one PT service line exceeds the cap, use the KX modifier on all the PT and SLP service lines (also identified with the GP or GN modifier) for that claim. When the PT/SLP cap is exceeded by PT services, the SLP lines on the claim may meet the requirements for an exception due to the complexity of two episodes of service.

   - Use the KX modifier on either all or none of the SLP lines on the claim, as appropriate. In contrast, if all the OT lines on the claim are below the cap, do not use the KX modifier on any of the OT lines, even when the KX modifier is appropriately used on all of the PT lines. Refer to Pub.100-04, Medicare Claims Processing Manual, chapter 25, for more detail.

By appending the KX modifier, the provider is attesting that the services billed:

- Are reasonable and necessary services that require the skills of a therapist; (See Pub. 100-02, chapter 15, section 220.2); and

- Are justified by appropriate documentation in the medical record, (See Pub. 100-02, chapter 15, section 220.3); and

- Qualify for an exception using the automatic process exception.

If this attestation is determined to be inaccurate, the provider/supplier is subject to sanctions resulting from providing inaccurate information on a claim.

When the KX modifier is appended to a therapy HCPCS code, the contractor will override the CWF system reject for services that exceed the caps and pay the claim if it is otherwise payable.

Providers and suppliers shall continue to append correct coding initiative (CCI) HCPCS modifiers under current instructions.

If a claim is submitted without KX modifiers and the cap is exceeded, those services will be denied. In cases where appending the KX modifier would have been appropriate, contractors may reopen and/or adjust the claim, if it is brought to their attention.

Services billed after the cap has been exceeded which are not eligible for exceptions may be billed for the purpose of obtaining a denial using condition code 21.

E. Therapy Cap Manual Review Threshold

For calendar year 2012, there shall be two total therapy service thresholds of $3700 per year: one annual threshold each for

1. Occupational therapy services, and
2. Physical therapy services and speech-language pathology services combined.

Services shall accrue toward the thresholds beginning with claims with dates of service on and after January 1, 2012. The thresholds shall apply to both services showing the KX modifier and those without the modifier. Beginning with claims with dates of service on and after October 1, 2012, contractors shall apply the thresholds to claims exceeding it by suspending the claim for manual review. Instructions regarding the manual review process may be found in the Program Integrity Manual.

F. Identifying the Certifying Physician

Therapy plans of care must be certified by a physician or non-physician practitioner (NPP), per the requirements in Pub.100-02, Medicare Benefit Policy Manual, chapter 15, section 220.1.3. Further, the National Provider Identifier (NPI) of the certifying physician/NPP identified for a therapy plan of care must be included on the therapy claim.

For the purposes of processing professional claims, the certifying physician/NPP is considered a referring provider. At the time the certifying physician/NPP is identified for a therapy plan of care, private practice therapists (PPTs), physicians or NPPs, as appropriate, submitting therapy claims, are to treat it as if a referral has occurred for purposes of completing the claim and to follow the instructions in the appropriate ASC X12 837 Professional Health Care Claim Technical Report 3 (TR3) for reporting a referring provider (for paper claims, they are to follow the instructions for identifying referring providers per chapter 26 of this manual) . These instructions include requirements for reporting NPIs.

Currently, in the 5010 version of the ASC X12 837 Professional Health Care Claim TR3, referring providers are first reported at the claim level; additional referring providers are reported at the line level only when they are different from that identified at the claim level. Therefore, there will be at least one referring provider identified at the claim level on the ASC X12 837 professional claim for therapy services. However, because of the hierarchical nature of the ASC X12 837 health care claim transaction, and the possibility of other types of referrals applying to the claim, the number of referring providers identified on a professional claim may vary. For example, on a claim where one physician/NPP has certified all the therapy plans of care, and there are no other referrals, there would be only one referring provider

identified at the claim level and none at the line levels. Conversely, on a claim also containing a non-therapy referral made by a different physician/NPP than the one certifying the therapy plan of care, the billing provider may elect to identify either the nontherapy or the therapy referral at the claim level, with the other referral(s) at the line levels. Similarly, on a claim having different certifying physician/NPPs for different therapy plans of care, only one of these physician/NPPs will be identified at the claim level, with the remainder identified at the line levels. These scenarios are only examples: there may be other patterns of representing referring providers at the claim and line levels depending upon the circumstances of the care and the manner in which the provider applies the requirements of the ASC X12 837 Professional Health Care Claim TR3.

For situations where the physician/NPP is both the certifier of the plan of care and furnishes the therapy service, he/she supplies his/her own information, including the NPI, in the appropriate referring provider loop (or, appropriate block on Form CMS-1500). This is applicable to those therapy services that are personally furnished by the physician/NPP as well as to those services that are furnished incident to their own and delivered by "qualified personnel" (see section 230.5 of this manual for qualifications for incident to personnel).

Contractors shall edit to ensure that there is at least one claim-level referring provider identified on professional therapy claims, and shall use the presence of the therapy modifiers (GN, GP, GO) to identify those claims subject to this requirement.

For the purposes of processing institutional claims, the certifying physician/NPP and their NPI are reported in the Attending Provider fields on institutional claim formats. Since the physician/NPP is certifying the therapy plan of care for the services on the claim, this is consistent with the National Uniform Billing Committee definition of the Attending Provider as "the individual who has overall responsibility for the patient's medical care and treatment" that is reported on the claim. In cases where a patient is receiving care under more than one therapy plan of care (OT, PT, or SLP) with different certifying physicians/NPPs, the second certifying physicians/NPP and their NPI are reported in the Referring Physician fields on institutional claim formats.

G. MSN Messages

Existing MSN messages 38.18, 17.13, 17.18 and 17.19 shall be issued on all claims containing outpatient rehabilitation services as noted in this manual. Contractors add the applied amount for individual beneficiaries and the generic limit amount to all MSNs that require them. For details of these MSNs, see: http://www.cms.gov/MSN/02_MSN%20Messages.asp

10.7 - Multiple Procedure Payment Reductions for Outpatient Rehabilitation Services

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

Medicare applies a multiple procedure payment reduction (MPPR) to the practice expense (PE) payment of select therapy services. The reduction applies to the

HCPCS codes contained on the list of "always therapy" services (see section 20), excluding *A/B MAC (B)*-priced, bundled and add-on codes, regardless of the type of provider or supplier that furnishes the services.

Medicare applies an MPPR to the PE payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The MPPR applies to all therapy services furnished to a patient on the same day, regardless of whether the services are provided in one therapy discipline or multiple disciplines, for example, physical therapy, occupational therapy, or speech-language pathology.

Full payment is made for the unit or procedure with the highest PE payment.

For subsequent units and procedures with dates of service prior to April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment is made for the PE for services submitted on professional claims (any claim submitted using the *ASC X12* 837 *p*rofessional *claim* format or the CMS-1500 paper claim form) and 75 percent payment is made for the PE for services submitted on institutional claims *(ASC X12* 837 *i*nstitutional *claim format or Form CMS-1450)*.

For subsequent units and procedures with dates of service on or after April 1, 2013, furnished to the same patient on the same day, full payment is made for work and malpractice and 50 percent payment is made for the PE for services submitted on either professional or institutional claims.

To determine which services will receive the MPPR, contractors shall rank services according to the applicable PE relative value units (RVU) and price the service with the highest PE RVU at 100% and apply the appropriate MPPR to the remaining services. When the highest PE RVU applies to more than one of the identified services, contractors shall additionally sort and rank these services according to highest total fee schedule amount, and price the service with the highest total fee schedule amount at 100% and apply the appropriate MPPR to the remaining services.

The therapy payment amount that has been reduced by the MPPR is applied toward the therapy caps described in section 10.2. As a result, the MPPR may increase the amount of medically necessary therapy services a beneficiary may receive before exceeding the caps. The reduced amount is also used to calculate the beneficiary's coinsurance and deductible amounts.

Contractors indicate services have been subject to the MPPR using the following coding on the provider's remittance advice:

- Group code CO and
- Claim adjustment reason code 59 - Processed based on multiple or concurrent procedure rules. (For example multiple surgery or diagnostic imaging, concurrent anesthesia.)

Contractors shall use the following message on Medicare Summary Notices for claims subject to the MPPR:

- 30.1 The approved amount is based on a special payment method, or
- 30.1 La cantidad aprobada está basada en un método especial de pago.

20.2 - Reporting of Service Units With HCPCS

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

A. General

Effective with claims submitted on or after April 1, 1998, providers billing on *the ASC X12 837 institutional claim format or* Form CMS-1450 were required to report the number of units for outpatient rehabilitation services based on the procedure or service, e.g., based on the HCPCS code reported instead of the revenue code. This was already in effect for billing on the Form CMS-1500, and CORFs were required to report their full range of CORF services on the *institutional claim*. These unit-reporting requirements continue with the standards required for electronically submitting health care claims under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) - the currently adopted version of the ASC X12 837 transaction standards and implementation guides. The Administrative Simplification Compliance Act mandates that claims be sent to Medicare electronically unless certain exceptions are met.

B. Timed and Untimed Codes

When reporting service units for HCPCS codes where the procedure is not defined by a specific timeframe ("untimed" HCPCS), the provider enters "1" in the field labeled units. For untimed codes, units are reported based on the number of times the procedure is performed, as described in the HCPCS code definition (often once per day).

EXAMPLE: A beneficiary received a speech-language pathology evaluation represented by HCPCS "untimed" code 92521. Regardless of the number of minutes spent providing this service only one unit of service is appropriately billed on the same day.

Several CPT codes used for therapy modalities, procedures, and tests and measurements specify that the direct (one on one) time spent in patient contact is 15 minutes. Providers report procedure codes for services delivered on **any single calendar day** using CPT codes and the appropriate number of 15 minute units of service.

EXAMPLE: A beneficiary received occupational therapy (HCPCS "timed" code 97530 which is defined in 15 minute units) for a total of 60 minutes. The provider would then report revenue code 043X and 4 units.

C. Counting Minutes for Timed Codes in 15 Minute Units

When only one service is provided in a day, providers should not bill for services performed for less than 8 minutes. For any single timed CPT code in the same day measured in 15 minute units, providers bill a single 15-minute unit for treatment greater than or equal to 8 minutes through and including 22 minutes. If the duration of a single modality or procedure in a day is greater than or equal to 23 minutes, through and including 37 minutes, then 2 units should be billed. Time intervals for 1 through 8 units are as follows:

Units	**Number of Minutes**
1 unit:	≥ 8 minutes through 22 minutes
2 units:	≥ 23 minutes through 37 minutes
3 units:	≥ 38 minutes through 52 minutes
4 units:	≥ 53 minutes through 67 minutes
5 units:	≥ 68 minutes through 82 minutes
6 units:	≥ 83 minutes through 97 minutes
7 units:	≥ 98 minutes through 112 minutes
8 units:	≥ 113 minutes through 127 minutes

The pattern remains the same for treatment times in excess of 2 hours.

If a service represented by a 15 minute timed code is performed in a single day for at least 15 minutes, that service shall be billed for at least one unit. If the service is performed for at least 30 minutes, that service shall be billed for at least two units, etc. It is not appropriate to count all minutes of treatment in a day toward the units for one code if other services were performed for more than 15 minutes. See examples 2 and 3 below.

When more than one service represented by 15 minute timed codes is performed in a single day, the total number of minutes of service (as noted on the chart above) determines the number of timed units billed. See example 1 below.

If any 15 minute timed service that is performed for 7 minutes or less than 7 minutes on the same day as another 15 minute timed service that was also performed for 7 minutes or less and the total time of the two is 8 minutes or greater than 8 minutes, then bill one unit for the service performed for the most minutes. This is correct because the total time is greater than the minimum time for one unit. The same logic is applied when three or more different services are provided for 7 minutes or less than 7 minutes. See example 5 below.

The expectation (based on the work values for these codes) is that a provider's direct patient contact time for each unit will average 15 minutes in length. If a provider has

a consistent practice of billing less than 15 minutes for a unit, these situations should be highlighted for review.

If more than one 15 minute timed CPT code is billed during a single calendar day, then the total number of timed units that can be billed is constrained by the total treatment minutes for that day. See all examples below.

Pub. 100-02, Medicare Benefit Policy Manual, Chapter 15, Section 220.3B, Documentation Requirements for Therapy Services, indicates that the amount of time for each specific intervention/modality provided to the patient is not required to be documented in the Treatment Note. However, the total number of timed minutes must be documented. These examples indicate how to count the appropriate number of units for the total therapy minutes provided.

Example 1 –

24 minutes of neuromuscular reeducation, code 97112,
23 minutes of therapeutic exercise, code 97110,
Total timed code treatment time was 47 minutes.

See the chart above. The 47 minutes falls within the range for 3 units = 38 to 52 minutes.

Appropriate billing for 47 minutes is only 3 timed units. Each of the codes is performed for more than 15 minutes, so each shall be billed for at least 1 unit. The correct coding is 2 units of code 97112 and one unit of code 97110, assigning more timed units to the service that took the most time.

Example 2 –

20 minutes of neuromuscular reeducation (97112)
20 minutes therapeutic exercise (97110),
40 Total timed code minutes.

Appropriate billing for 40 minutes is 3 units. Each service was done at least 15 minutes and should be billed for at least one unit, but the total allows 3 units. Since the time for each service is the same, choose either code for 2 units and bill the other for 1 unit. Do not bill 3 units for either one of the codes.

Example 3 –

33 minutes of therapeutic exercise (97110),
7 minutes of manual therapy (97140),
40 Total timed minutes

Appropriate billing for 40 minutes is for 3 units. Bill 2 units of 97110 and 1 unit of 97140. Count the first 30 minutes of 97110 as two full units. Compare the remaining time for 97110 (33-30 = 3 minutes) to the time spent on 97140 (7 minutes) and bill the larger, which is 97140.

Example 4 –

18 minutes of therapeutic exercise (97110),
13 minutes of manual therapy (97140),

10 minutes of gait training (97116),
8 minutes of ultrasound (97035),
49 Total timed minutes

Appropriate billing is for 3 units. Bill the procedures you spent the most time providing. Bill 1 unit each of 97110, 97116, and 97140. You are unable to bill for the ultrasound because the total time of timed units that can be billed is constrained by the total timed code treatment minutes (i.e., you may not bill 4 units for less than 53 minutes regardless of how many services were performed). You would still document the ultrasound in the treatment notes.

Example 5 –
7 minutes of neuromuscular reeducation (97112)
7 minutes therapeutic exercise (97110)
7 minutes manual therapy (97140)
21 Total timed minutes

Appropriate billing is for one unit. The qualified professional (See definition in Pub. 100-02, chapter 15, section 220) shall select one appropriate CPT code (97112, 97110, 97140) to bill since each unit was performed for the same amount of time and only one unit is allowed.

NOTE: The above schedule of times is intended to provide assistance in rounding time into 15-minute increments. It does not imply that any minute until the eighth should be excluded from the total count. The total minutes of active treatment counted for all 15 minute timed codes includes all direct treatment time for the timed codes. Total treatment minutes-- including minutes spent providing services represented by untimed codes— are also documented. For documentation in the medical record of the services provided see Pub. 100-02, chapter 15, section 220.3.

D. Specific Limits for HCPCS

The Deficit Reduction Act of 2005, section 5107 requires the implementation of clinically appropriate code edits to eliminate improper payments for outpatient therapy services. The following codes may be billed, when covered, only at or below the number of units indicated on the chart per treatment day. When higher amounts of units are billed than those indicated in the table below, the units on the claim line that exceed the limit shall be denied as medically unnecessary (according to 1862(a)(1)(A)). Denied claims may be appealed and an ABN is appropriate to notify the beneficiary of liability.

This chart does not include all of the codes identified as therapy codes; refer to section 20 of this chapter for further detail on these and other therapy codes. For example, therapy codes called “always therapy” must always be accompanied by therapy modifiers identifying the type of therapy plan of care under which the service is provided.

Use the chart in the following manner:

The codes that are allowed one unit for "Allowed Units" in the chart below may be billed no more than once per provider, per discipline, per date of service, per patient.

The codes allowed 0 units in the column for "Allowed Units", may not be billed under a plan of care indicated by the discipline in that column. Some codes may be billed by one discipline (e.g., PT) and not by others (e.g., OT or SLP).

When physicians/NPPs bill "always therapy" codes they must follow the policies of the type of therapy they are providing e.g., utilize a plan of care, bill with the appropriate therapy modifier (GP, GO, GN), bill the allowed units on the chart below for PT, OT or SLP depending on the plan. A physician/NPP shall not bill an "always therapy" code unless the service is provided under a therapy plan of care. Therefore, NA stands for "Not Applicable" in the chart below.

When a "sometimes therapy" code is billed by a physician/NPP, but as a medical service, and not under a therapy plan of care, the therapy modifier shall not be used, but the number of units billed must not exceed the number of units indicated in the chart below per patient, per provider/supplier, per day.

HCPCS	Code Description and Claim Line Outlier/Edit Details	Timed or Untimed	PT Allowed units	OT Allowed units	SLP Allowed units	Physician/ NPP NOT under Therapy POC
92521	Evaluation of speech fluency	Untimed	0	0	1	NA
92522	Evaluation of speech sound production	Untimed	0	0	1	NA
92523	Evaluation of language comprehension and expression	Untimed	0	0	1	NA
92524	Behavioral and qualitative analysis of voice and resonance	Untimed	0	0	1	NA
92597	Oral speech device eval	Untimed	0	1	1	NA
92607	Ex for speech device rx, 1hr	Timed	0	1	1	NA
92611	Motion fluroscopy/swallow	Untimed	0	1	1	1
92612	Endoscope swallow test (fees)	Untimed	0	1	1	1

HCPCS	Code Description and Claim Line Outlier/Edit Details	Timed or Untimed	PT Allowed units	OT Allowed units	SLP Allowed units	Physician/ NPP NOT under Therapy POC
92614	Laryngoscopic sensory test	Untimed	0	1	1	1
92616	Fees w/laryngeal sense test	Untimed	0	1	1	1
95833	Limb muscle testing, manual	Untimed	1	1	0	1
95834	Limb muscle testing, manual	Untimed	1	1	0	1
96110	Developmental test, lim	Untimed	1	1	1	1
96111	Developmental test, extend	Untimed	1	1	1	1
97001	PT evaluation	Untimed	1	0	0	NA
97002	PT re-evaluation	Untimed	1	0	0	NA
97003	OT evaluation	Untimed	0	1	0	NA
97004	OT re-evaluation	Untimed	0	1	0	NA

20.4 - Coding Guidance for Certain CPT Codes - All Claims

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

The following provides guidance about the use of codes 96105, 97026, 97150, 97545, 97546, and G0128.

- CPT Codes 96105, 97545, and 97546.

Providers report code 96105, assessment of aphasia with interpretation and report in 1-hour units. This code represents formal evaluation of aphasia with an instrument such as the Boston Diagnostic Aphasia Examination. If this formal assessment is performed during treatment, it is typically performed only once during treatment and its medical necessity should be documented. If the test is repeated during treatment, the medical necessity of the repeat administration of the test must also be documented. It is common practice for regular assessment of a patient's progress in therapy to be documented in the chart, and this may be done using test items taken from the formal examinations. This is considered to be part of the treatment and should not be billed as 96105 unless a full, formal assessment is completed.

Other timed physical medicine codes are 97545 and 97546. The interval for code 97545 is 2 hours and for code 97546, 1 hour. These are specialized codes to be used in the context of rehabilitating a worker to return to a job. The expectation is that the **entire** time period specified in the codes 97545 or 97546 would be the treatment

period, since a shorter period of treatment could be coded with another code such as codes 97110, 97112, or 97537. (Codes 97545 and 97546 were developed for reporting services to persons in the worker's compensation program, thus *CMS does* not expect to see them reported for Medicare patients except under very unusual circumstances. Further, *CMS* would not expect to see code 97546 without also seeing code 97545 on the same claim. Code 97546, when used, is used in conjunction with 97545.)

- CPT Code 97026

Effective for services performed on or after October 24, 2006, the Centers for Medicare & Medicaid Services announce a NCD stating the use of infrared and/or near-infrared light and/or heat, including monochromatic infrared energy (MIRE), is non-covered for the treatment, including symptoms such as pain arising from these conditions, of diabetic and/or non-diabetic peripheral sensory neuropathy, wounds and/or ulcers of the skin and/or subcutaneous tissues in Medicare beneficiaries. Further coverage guidelines can be found in the National Coverage Determination Manual (Pub. 100-03), section 270.6.

Contractors shall deny claims with CPT 97026 (infrared therapy incident to or as a PT/OT benefit) and HCPCS E0221 or A4639, if the claim contains any of the following *diagnosis* codes:

ICD-9-CM

250.60 - 250.63

354.4, 354.5, 354.9

355.1 - 355.4

355.6 - 355.9

356.0, 356.2-356.4, 356.8-356.9

357.0 - 357.7

674.10, 674.12, 674.14, 674.20, 674.22, 674.24

707.00 -707.07, 707.09-707.15, 707.19

870.0 - 879.9

880.00 - 887.7

890.0 - 897.7

998.31 - 998.32

ICD-10-CM

See Addendum A Chapter 5, Section 20.4 (at end of this chapter) for the list of ICD 10-CM diagnosis codes that require denial with the above HCPCD codes.

Contractors can use the following messages when denying the service:

- Medicare Summary Notice # 21.11 "This service was not covered by Medicare at the time you received it."

- Reason Claim Adjustment Code #50 "These are noncovered services because this is not deemed a medical necessity by the payer."

Advanced Beneficiary Notice (ABN):

Physicians, physical therapists, occupational therapists, outpatient rehabilitation facilities (ORFs), comprehensive outpatient rehabilitation facilities (CORFs), home health agencies (HHA), and hospital outpatient departments are liable if the service is performed, unless the beneficiary signs an ABN.

Similarly, DME suppliers and HHA are liable for the devices when they are supplied, unless the beneficiary signs an ABN.

100.1 - General

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

The Omnibus Reconciliation Act of 1980 (Public Law 96-499, Section 933) defines CORFs (Comprehensive Outpatient Rehabilitation Facilities) as a distinct type of Medicare provider and adds CORF services as a benefit under Medicare Part B. The Balance Budget Act (P.L.105-33) requires payment under a prospective system for all CORF services.

See chapter 1, for the policy on *A/B MAC (A)* Designations governing CORFs.

See the Medicare Benefit Policy Manual, chapter 12, for a description of covered CORF services.

Physicians' diagnostic and therapeutic services furnished to a CORF patient are not considered CORF physician's services. The physician must bill the area *A/B MAC (B)* for these services. If they are covered, the *A/B MAC (B)* reimburses them via the MPFS.

However, other services are considered CORF services to be billed by the CORF to the *A/B MAC (A)*, and are also considered included in the fee amount under the MPFS. These services include such services as administrative services provided by the physician associated with the CORF, examinations for the purpose of establishing and reviewing the plan of care, consultation with and medical supervision of nonphysician staff, team conferences, case reviews, and other facility staff medical and facility administration activities relating to the services described in Medicare

Benefit Policy Manual, chapter 12. Related supplies are also included in the MPFS fee amount.

The CORFs bill Medicare with the *ASC X12 837 institutional claim or* Form CMS-1450 using HCPCS codes and Revenue Codes. Usually the zero level revenue code is used. Payment is based on the HCPCS code and related MPFS amount.

Requirements in §§10 - 50 apply to CORF billing. In addition the following requirements apply.

100.5 - Off-Site CORF Services

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

The CORFs may provide physical therapy, speech-language pathology and occupational therapy off the CORF's premises in addition to the home evaluation. Services provided offsite are billed separately and identified as "offsite" on *the claim in remarks.* The charges for offsite visits include any additional charge for providing the services at a place other than the CORF premises. There is no change in the payment method for offsite services.

100.6 - Notifying Patient of Service Denial

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

Services may be noncovered because they are statutorily excluded from coverage under Medicare, or because they are not medically reasonable and necessary.

If a service is excluded by statute, the CORF may submit a claim for them to Medicare to obtain a denial prior to billing another insurance carrier. It shows the charges as noncovered, and includes Condition Code 21. It may bill the beneficiary for the excluded services, and need not issue an advance beneficiary notice (ABN). However, when providing therapy services under the financial limitations, the CORF should provide the beneficiary with the Notice of Exclusion of Medicare Benefits (NEMB). The Medicare Claims Processing Manual, Chapter 30, "Limitation on Liability," discusses ABNs for *A/B MAC (A)* processed claims for Part B services.

If, after reviewing the plan of care, the CORF determines that the services to be furnished to the patient are not medically reasonable or necessary, it immediately provides the beneficiary with an ABN. If the patient signs an ABN, the *claim* includes occurrence code 32 "Date Beneficiary Notified of Intent to Bill (Procedures or Treatments)" along with the date the ABN was signed.

If the beneficiary insists that a claim be submitted for payment, the CORF must indicate on the bill (billed separately from bills with covered charges) that it is being submitted at the beneficiary's request. This is done by using condition code 20.

If during the course of the patient's treatment the *A/B MAC (A)* advises the CORF that covered care has ceased, the CORF must notify the beneficiary (or the beneficiary's representative) immediately.

NOTE: Information regarding the form locator numbers that correspond to these data element names is found in Chapter 25.

100.8 - Billing for DME, Prosthetic and Orthotic Devices, and Surgical Dressings

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

The CORFs bill DME to the DME *MAC with the ASC X12 professional claim format or Form CMS-1500* except for claims for implanted DME, which are billed to the local *A/B MAC (B)*. If the CORF does not have a supplier billing number from the National Supplier Clearinghouse (NSC), it may contact the NSC to secure one. If the local *A/B MAC (B)* has issued the CORF a provider number for billing physician services, the CORF may not use the same number when billing for DME

Addendum A - Chapter 5, Section 20.4 – Coding Guidance for Certain CPT Codes – All Claims
(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

ICD-10-CM - Code and Description

A52.15 Late syphilitic neuropathy

E08.40 Diabetes mellitus due to underlying condition with diabetic neuropathy, unspecified

E08.41 Diabetes mellitus due to underlying condition with diabetic mononeuropathy

E08.42 Diabetes mellitus due to underlying condition with diabetic polyneuropathy

E09.40 Drug or chemical induced diabetes mellitus with neurological complications with diabetic neuropathy, unspecified

E09.41 Drug or chemical induced diabetes mellitus with neurological complications with diabetic mononeuropathy

E09.42 Drug or chemical induced diabetes mellitus with neurological complications with diabetic polyneuropathy

E10.40 Type 1 diabetes mellitus with diabetic neuropathy, unspecified

E10.41 Type 1 diabetes mellitus with diabetic mononeuropathy

E10.42 Type 1 diabetes mellitus with diabetic polyneuropathy

E10.43 Type 1 diabetes mellitus with diabetic autonomic (poly)neuropathy

E10.44 Type 1 diabetes mellitus with diabetic amyotrophy

E10.49 Type 1 diabetes mellitus with other diabetic neurological complication

E10.610 Type 1 diabetes mellitus with diabetic neuropathic arthropathy

E11.40 Type 2 diabetes mellitus with diabetic neuropathy, unspecified

E11.41 Type 2 diabetes mellitus with diabetic mononeuropathy

E11.42 Type 2 diabetes mellitus with diabetic polyneuropathy

E11.43 Type 2 diabetes mellitus with diabetic autonomic (poly)neuropathy

E11.44 Type 2 diabetes mellitus with diabetic amyotrophy

E11.49 Type 2 diabetes mellitus with other diabetic neurological complication

E11.610 Type 2 diabetes mellitus with diabetic neuropathic arthropathy

E13.40 Other specified diabetes mellitus with diabetic neuropathy, unspecified

E13.41 Other specified diabetes mellitus with diabetic mononeuropathy

E13.42 Other specified diabetes mellitus with diabetic polyneuropathy

E13.43 Other specified diabetes mellitus with diabetic autonomic (poly)neuropathy

E13.44 Other specified diabetes mellitus with diabetic amyotrophy

E13.49 Other specified diabetes mellitus with other diabetic neurological complication

E13.610 Other specified diabetes mellitus with diabetic neuropathic arthropathy

G13.0 Paraneoplastic neuromyopathy and neuropathy

ICD-10-CM - Code and Description

G13.1 Other systemic atrophy primarily affecting central nervous system in neoplastic disease

G56.40 Causalgia of unspecified upper limb

G56.41 Causalgia of right upper limb

G56.42 Causalgia of left upper limb

G56.90 Unspecified mononeuropathy of unspecified upper limb

G56.91 Unspecified mononeuropathy of right upper limb

G56.92 Unspecified mononeuropathy of left upper limb

G57.10 Meralgia paresthetica, unspecified lower limb

G57.11 Meralgia paresthetica, right lower limb

G57.12 Meralgia paresthetica, left lower limb

G57.20 Lesion of femoral nerve, unspecified lower limb

G57.21 Lesion of femoral nerve, right lower limb

G57.22 Lesion of femoral nerve, left lower limb

G57.30 Lesion of lateral popliteal nerve, unspecified lower limb

G57.31 Lesion of lateral popliteal nerve, right lower limb

G57.32 Lesion of lateral popliteal nerve, left lower limb

G57.40 Lesion of medial popliteal nerve, unspecified lower limb

G57.41 Lesion of medial popliteal nerve, right lower limb

G57.42 Lesion of medial popliteal nerve, left lower limb

G57.60 Lesion of plantar nerve, unspecified lower limb

G57.61 Lesion of plantar nerve, right lower limb

G57.62 Lesion of plantar nerve, left lower limb

G57.70 Causalgia of unspecified lower limb

G57.71 Causalgia of right lower limb

G57.72 Causalgia of left lower limb

G57.80 Other specified mononeuropathies of unspecified lower limb

G57.81 Other specified mononeuropathies of right lower limb

G57.82 Other specified mononeuropathies of left lower limb

G57.90 Unspecified mononeuropathy of unspecified lower limb

G57.91 Unspecified mononeuropathy of right lower limb

G57.92 Unspecified mononeuropathy of left lower limb

G58.7 Mononeuritis multiplex

G58.8 Other specified mononeuropathies

G58.9 Mononeuropathy, unspecified

G59 Mononeuropathy in diseases classified elsewhere

G60.0 Hereditary motor and sensory neuropathy

ICD-10-CM - Code and Description

G60.1 Refsum's disease

G60.2 Neuropathy in association with hereditary ataxia

G60.3 Idiopathic progressive neuropathy

G60.8 Other hereditary and idiopathic neuropathies

G60.9 Hereditary and idiopathic neuropathy, unspecified

G61.0 Guillain-Barre syndrome

G61.1 Serum neuropathy

G62.0 Drug-induced polyneuropathy

G62.1 Alcoholic polyneuropathy

G62.2 Polyneuropathy due to other toxic agents

G62.82 Radiation-induced polyneuropathy

G63 Polyneuropathy in diseases classified elsewhere

G65.0 Sequelae of Guillain-Barré syndrome

G65.1 Sequelae of other inflammatory polyneuropathy

G65.2 Sequelae of toxic polyneuropathy

I70.231 Atherosclerosis of native arteries of right leg with ulceration of thigh

I70.232 Atherosclerosis of native arteries of right leg with ulceration of calf

I70.233 Atherosclerosis of native arteries of right leg with ulceration of ankle

I70.234 Atherosclerosis of native arteries of right leg with ulceration of heel and midfoot

I70.235 Atherosclerosis of native arteries of right leg with ulceration of other part of foot

I70.238 Atherosclerosis of native arteries of right leg with ulceration of other part of lower right leg

I70.239 Atherosclerosis of native arteries of right leg with ulceration of unspecified site

I70.241 Atherosclerosis of native arteries of left leg with ulceration of thigh

I70.242 Atherosclerosis of native arteries of left leg with ulceration of calf

I70.243 Atherosclerosis of native arteries of left leg with ulceration of ankle

I70.244 Atherosclerosis of native arteries of left leg with ulceration of heel and midfoot

I70.245 Atherosclerosis of native arteries of left leg with ulceration of other part of foot

I70.248 Atherosclerosis of native arteries of left leg with ulceration of other part of lower left leg

I70.249 Atherosclerosis of native arteries of left leg with ulceration of unspecified site

I70.331 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of thigh

I70.332 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of calf

I70.333 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of ankle

ICD-10-CM - Code and Description

I70.334 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of heel and midfoot

I70.335 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of other part of foot

I70.338 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of other part of lower leg

I70.339 Atherosclerosis of unspecified type of bypass graft(s) of the right leg with ulceration of unspecified site

I70.341 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of thigh

I70.342 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of calf

I70.343 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of ankle

I70.344 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of heel and midfoot

I70.345 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of other part of foot

I70.348 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of other part of lower leg

I70.349 Atherosclerosis of unspecified type of bypass graft(s) of the left leg with ulceration of unspecified site

I70.431 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of thigh

I70.432 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of calf

I70.433 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of ankle

I70.434 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of heel and midfoot

I70.435 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of other part of foot

I70.438 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of other part of lower leg

I70.439 Atherosclerosis of autologous vein bypass graft(s) of the right leg with ulceration of unspecified site

I70.441 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of thigh

I70.442 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of calf

I70.443 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of ankle

ICD-10-CM - Code and Description

I70.444 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of heel and midfoot

I70.445 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of other part of foot

I70.448 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of other part of lower leg

I70.449 Atherosclerosis of autologous vein bypass graft(s) of the left leg with ulceration of unspecified site

I70.531 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of thigh

I70.532 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of calf

I70.533 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of ankle

I70.534 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of heel and midfoot

I70.535 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of other part of foot

I70.538 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of other part of lower leg

I70.539 Atherosclerosis of nonautologous biological bypass graft(s) of the right leg with ulceration of unspecified site

I70.541 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of thigh

I70.542 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of calf

I70.543 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of ankle

I70.544 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of heel and midfoot

I70.545 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of other part of foot

I70.548 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of other part of lower leg

I70.549 Atherosclerosis of nonautologous biological bypass graft(s) of the left leg with ulceration of unspecified site

I70.631 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of thigh

I70.632 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of calf

I70.633 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of ankle

ICD-10-CM - Code and Description

I70.634 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of heel and midfoot

I70.635 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of other part of foot

I70.638 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of other part of lower leg

I70.639 Atherosclerosis of nonbiological bypass graft(s) of the right leg with ulceration of unspecified site

I70.641 Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of thigh

I70.642 Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of calf

I70.643 Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of ankle

I70.644 Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of heel and midfoot

I70.645 Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of other part of foot

I70.648 Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of other part of lower leg

I70.649 Atherosclerosis of nonbiological bypass graft(s) of the left leg with ulceration of unspecified site

I70.731 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of thigh

I70.732 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of calf

I70.733 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of ankle

I70.734 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of heel and midfoot

I70.735 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of other part of foot

I70.738 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of other part of lower leg

I70.739 Atherosclerosis of other type of bypass graft(s) of the right leg with ulceration of unspecified site

I70.741 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of thigh

I70.742 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of calf

I70.743 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of ankle

ICD-10-CM - Code and Description

I70.744 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of heel and midfoot

I70.745 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of other part of foot

I70.748 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of other part of lower leg

I70.749 Atherosclerosis of other type of bypass graft(s) of the left leg with ulceration of unspecified site

L89.000 Pressure ulcer of unspecified elbow, unstageable

L89.001 Pressure ulcer of unspecified elbow, stage 1

L89.002 Pressure ulcer of unspecified elbow, stage 2

L89.003 Pressure ulcer of unspecified elbow, stage 3

L89.004 Pressure ulcer of unspecified elbow, stage 4

L89.009 Pressure ulcer of unspecified elbow, unspecified stage

L89.010 Pressure ulcer of right elbow, unstageable

L89.011 Pressure ulcer of right elbow, stage 1

L89.012 Pressure ulcer of right elbow, stage 2

L89.013 Pressure ulcer of right elbow, stage 3

L89.014 Pressure ulcer of right elbow, stage 4

L89.019 Pressure ulcer of right elbow, unspecified stage

L89.020 Pressure ulcer of left elbow, unstageable

L89.021 Pressure ulcer of left elbow, stage 1

L89.022 Pressure ulcer of left elbow, stage 2

L89.023 Pressure ulcer of left elbow, stage 3

L89.024 Pressure ulcer of left elbow, stage 4

L89.029 Pressure ulcer of left elbow, unspecified stage

L89.100 Pressure ulcer of unspecified part of back, unstageable

L89.101 Pressure ulcer of unspecified part of back, stage 1

L89.102 Pressure ulcer of unspecified part of back, stage 2

L89.103 Pressure ulcer of unspecified part of back, stage 3

L89.104 Pressure ulcer of unspecified part of back, stage 4

L89.109 Pressure ulcer of unspecified part of back, unspecified stage

L89.110 Pressure ulcer of right upper back, unstageable

L89.111 Pressure ulcer of right upper back, stage 1

L89.112 Pressure ulcer of right upper back, stage 2

L89.113 Pressure ulcer of right upper back, stage 3

L89.114 Pressure ulcer of right upper back, stage 4

L89.119 Pressure ulcer of right upper back, unspecified stage

ICD-10-CM - Code and Description

L89.120 Pressure ulcer of left upper back, unstageable
L89.121 Pressure ulcer of left upper back, stage 1
L89.122 Pressure ulcer of left upper back, stage 2
L89.123 Pressure ulcer of left upper back, stage 3
L89.124 Pressure ulcer of left upper back, stage 4
L89.129 Pressure ulcer of left upper back, unspecified stage
L89.130 Pressure ulcer of right lower back, unstageable
L89.131 Pressure ulcer of right lower back, stage 1
L89.132 Pressure ulcer of right lower back, stage 2
L89.133 Pressure ulcer of right lower back, stage 3
L89.134 Pressure ulcer of right lower back, stage 4
L89.139 Pressure ulcer of right lower back, unspecified stage
L89.140 Pressure ulcer of left lower back, unstageable
L89.141 Pressure ulcer of left lower back, stage 1
L89.142 Pressure ulcer of left lower back, stage 2
L89.143 Pressure ulcer of left lower back, stage 3
L89.144 Pressure ulcer of left lower back, stage 4
L89.149 Pressure ulcer of left lower back, unspecified stage
L89.150 Pressure ulcer of sacral region, unstageable
L89.151 Pressure ulcer of sacral region, stage 1
L89.152 Pressure ulcer of sacral region, stage 2
L89.153 Pressure ulcer of sacral region, stage 3
L89.154 Pressure ulcer of sacral region, stage 4
L89.159 Pressure ulcer of sacral region, unspecified stage
L89.200 Pressure ulcer of unspecified hip, unstageable
L89.201 Pressure ulcer of unspecified hip, stage 1
L89.202 Pressure ulcer of unspecified hip, stage 2
L89.203 Pressure ulcer of unspecified hip, stage 3
L89.204 Pressure ulcer of unspecified hip, stage 4
L89.209 Pressure ulcer of unspecified hip, unspecified stage
L89.210 Pressure ulcer of right hip, unstageable
L89.211 Pressure ulcer of right hip, stage 1
L89.212 Pressure ulcer of right hip, stage 2
L89.213 Pressure ulcer of right hip, stage 3
L89.214 Pressure ulcer of right hip, stage 4
L89.219 Pressure ulcer of right hip, unspecified stage
L89.220 Pressure ulcer of left hip, unstageable

ICD-10-CM - Code and Description

L89.221 Pressure ulcer of left hip, stage 1
L89.222 Pressure ulcer of left hip, stage 2
L89.223 Pressure ulcer of left hip, stage 3
L89.224 Pressure ulcer of left hip, stage 4
L89.229 Pressure ulcer of left hip, unspecified stage
L89.300 Pressure ulcer of unspecified buttock, unstageable
L89.301 Pressure ulcer of unspecified buttock, stage 1
L89.302 Pressure ulcer of unspecified buttock, stage 2
L89.303 Pressure ulcer of unspecified buttock, stage 3
L89.304 Pressure ulcer of unspecified buttock, stage 4
L89.309 Pressure ulcer of unspecified buttock, unspecified stage
L89.310 Pressure ulcer of right buttock, unstageable
L89.311 Pressure ulcer of right buttock, stage 1
L89.312 Pressure ulcer of right buttock, stage 2
L89.313 Pressure ulcer of right buttock, stage 3
L89.314 Pressure ulcer of right buttock, stage 4
L89.319 Pressure ulcer of right buttock, unspecified stage
L89.320 Pressure ulcer of left buttock, unstageable
L89.321 Pressure ulcer of left buttock, stage 1
L89.322 Pressure ulcer of left buttock, stage 2
L89.323 Pressure ulcer of left buttock, stage 3
L89.324 Pressure ulcer of left buttock, stage 4
L89.329 Pressure ulcer of left buttock, unspecified stage
L89.40 Pressure ulcer of contiguous site of back, buttock and hip, unspecified stage
L89.41 Pressure ulcer of contiguous site of back, buttock and hip, stage 1
L89.42 Pressure ulcer of contiguous site of back, buttock and hip, stage 2
L89.43 Pressure ulcer of contiguous site of back, buttock and hip, stage 3
L89.44 Pressure ulcer of contiguous site of back, buttock and hip, stage 4
L89.45 Pressure ulcer of contiguous site of back, buttock and hip, unstageable
L89.500 Pressure ulcer of unspecified ankle, unstageable
L89.501 Pressure ulcer of unspecified ankle, stage 1
L89.502 Pressure ulcer of unspecified ankle, stage 2
L89.503 Pressure ulcer of unspecified ankle, stage 3
L89.504 Pressure ulcer of unspecified ankle, stage 4
L89.509 Pressure ulcer of unspecified ankle, unspecified stage
L89.510 Pressure ulcer of right ankle, unstageable
L89.511 Pressure ulcer of right ankle, stage 1

ICD-10-CM - Code and Description

L89.512 Pressure ulcer of right ankle, stage 2
L89.513 Pressure ulcer of right ankle, stage 3
L89.514 Pressure ulcer of right ankle, stage 4
L89.519 Pressure ulcer of right ankle, unspecified stage
L89.520 Pressure ulcer of left ankle, unstageable
L89.521 Pressure ulcer of left ankle, stage 1
L89.522 Pressure ulcer of left ankle, stage 2
L89.523 Pressure ulcer of left ankle, stage 3
L89.524 Pressure ulcer of left ankle, stage 4
L89.529 Pressure ulcer of left ankle, unspecified stage
L89.600 Pressure ulcer of unspecified heel, unstageable
L89.601 Pressure ulcer of unspecified heel, stage 1
L89.602 Pressure ulcer of unspecified heel, stage 2
L89.603 Pressure ulcer of unspecified heel, stage 3
L89.604 Pressure ulcer of unspecified heel, stage 4
L89.609 Pressure ulcer of unspecified heel, unspecified stage
L89.610 Pressure ulcer of right heel, unstageable
L89.611 Pressure ulcer of right heel, stage 1
L89.612 Pressure ulcer of right heel, stage 2
L89.613 Pressure ulcer of right heel, stage 3
L89.614 Pressure ulcer of right heel, stage 4
L89.619 Pressure ulcer of right heel, unspecified stage
L89.620 Pressure ulcer of left heel, unstageable
L89.621 Pressure ulcer of left heel, stage 1
L89.622 Pressure ulcer of left heel, stage 2
L89.623 Pressure ulcer of left heel, stage 3
L89.624 Pressure ulcer of left heel, stage 4
L89.629 Pressure ulcer of left heel, unspecified stage
L89.810 Pressure ulcer of head, unstageable
L89.811 Pressure ulcer of head, stage 1
L89.812 Pressure ulcer of head, stage 2
L89.813 Pressure ulcer of head, stage 3
L89.814 Pressure ulcer of head, stage 4
L89.819 Pressure ulcer of head, unspecified stage
L89.890 Pressure ulcer of other site, unstageable
L89.891 Pressure ulcer of other site, stage 1
L89.892 Pressure ulcer of other site, stage 2

ICD-10-CM - Code and Description

L89.893 Pressure ulcer of other site, stage 3

L89.894 Pressure ulcer of other site, stage 4

L89.899 Pressure ulcer of other site, unspecified stage

L89.90 Pressure ulcer of unspecified site, unspecified stage

L89.91 Pressure ulcer of unspecified site, stage 1

L89.92 Pressure ulcer of unspecified site, stage 2

L89.93 Pressure ulcer of unspecified site, stage 3

L89.94 Pressure ulcer of unspecified site, stage 4

L89.95 Pressure ulcer of unspecified site, unstageable

L97.101 Non-pressure chronic ulcer of unspecified thigh limited to breakdown of skin

L97.102 Non-pressure chronic ulcer of unspecified thigh with fat layer exposed

L97.103 Non-pressure chronic ulcer of unspecified thigh with necrosis of muscle

L97.104 Non-pressure chronic ulcer of unspecified thigh with necrosis of bone

L97.109 Non-pressure chronic ulcer of unspecified thigh with unspecified severity

L97.111 Non-pressure chronic ulcer of right thigh limited to breakdown of skin

L97.112 Non-pressure chronic ulcer of right thigh with fat layer exposed

L97.113 Non-pressure chronic ulcer of right thigh with necrosis of muscle

L97.114 Non-pressure chronic ulcer of right thigh with necrosis of bone

L97.119 Non-pressure chronic ulcer of right thigh with unspecified severity

L97.121 Non-pressure chronic ulcer of left thigh limited to breakdown of skin

L97.122 Non-pressure chronic ulcer of left thigh with fat layer exposed

L97.123 Non-pressure chronic ulcer of left thigh with necrosis of muscle

L97.124 Non-pressure chronic ulcer of left thigh with necrosis of bone

L97.129 Non-pressure chronic ulcer of left thigh with unspecified severity

L97.201 Non-pressure chronic ulcer of unspecified calf limited to breakdown of skin

L97.202 Non-pressure chronic ulcer of unspecified calf with fat layer exposed

L97.203 Non-pressure chronic ulcer of unspecified calf with necrosis of muscle

L97.204 Non-pressure chronic ulcer of unspecified calf with necrosis of bone

L97.209 Non-pressure chronic ulcer of unspecified calf with unspecified severity

L97.211 Non-pressure chronic ulcer of right calf limited to breakdown of skin

L97.212 Non-pressure chronic ulcer of right calf with fat layer exposed

L97.213 Non-pressure chronic ulcer of right calf with necrosis of muscle

L97.214 Non-pressure chronic ulcer of right calf with necrosis of bone

L97.219 Non-pressure chronic ulcer of right calf with unspecified severity

L97.221 Non-pressure chronic ulcer of left calf limited to breakdown of skin

L97.222 Non-pressure chronic ulcer of left calf with fat layer exposed

L97.223 Non-pressure chronic ulcer of left calf with necrosis of muscle

ICD-10-CM - Code and Description

L97.224 Non-pressure chronic ulcer of left calf with necrosis of bone

L97.229 Non-pressure chronic ulcer of left calf with unspecified severity

L97.301 Non-pressure chronic ulcer of unspecified ankle limited to breakdown of skin

L97.302 Non-pressure chronic ulcer of unspecified ankle with fat layer exposed

L97.303 Non-pressure chronic ulcer of unspecified ankle with necrosis of muscle

L97.304 Non-pressure chronic ulcer of unspecified ankle with necrosis of bone

L97.309 Non-pressure chronic ulcer of unspecified ankle with unspecified severity

L97.311 Non-pressure chronic ulcer of right ankle limited to breakdown of skin

L97.312 Non-pressure chronic ulcer of right ankle with fat layer exposed

L97.313 Non-pressure chronic ulcer of right ankle with necrosis of muscle

L97.314 Non-pressure chronic ulcer of right ankle with necrosis of bone

L97.319 Non-pressure chronic ulcer of right ankle with unspecified severity

L97.321 Non-pressure chronic ulcer of left ankle limited to breakdown of skin

L97.322 Non-pressure chronic ulcer of left ankle with fat layer exposed

L97.323 Non-pressure chronic ulcer of left ankle with necrosis of muscle

L97.324 Non-pressure chronic ulcer of left ankle with necrosis of bone

L97.329 Non-pressure chronic ulcer of left ankle with unspecified severity

L97.401 Non-pressure chronic ulcer of unspecified heel and midfoot limited to breakdown of skin

L97.402 Non-pressure chronic ulcer of unspecified heel and midfoot with fat layer exposed

L97.403 Non-pressure chronic ulcer of unspecified heel and midfoot with necrosis of muscle

L97.404 Non-pressure chronic ulcer of unspecified heel and midfoot with necrosis of bone

L97.409 Non-pressure chronic ulcer of unspecified heel and midfoot with unspecified severity

L97.411 Non-pressure chronic ulcer of right heel and midfoot limited to breakdown of skin

L97.412 Non-pressure chronic ulcer of right heel and midfoot with fat layer exposed

L97.413 Non-pressure chronic ulcer of right heel and midfoot with necrosis of muscle

L97.414 Non-pressure chronic ulcer of right heel and midfoot with necrosis of bone

L97.419 Non-pressure chronic ulcer of right heel and midfoot with unspecified severity

L97.421 Non-pressure chronic ulcer of left heel and midfoot limited to breakdown of skin

L97.422 Non-pressure chronic ulcer of left heel and midfoot with fat layer exposed

L97.423 Non-pressure chronic ulcer of left heel and midfoot with necrosis of muscle

L97.424 Non-pressure chronic ulcer of left heel and midfoot with necrosis of bone

L97.429 Non-pressure chronic ulcer of left heel and midfoot with unspecified severity

ICD-10-CM - Code and Description

L97.501 Non-pressure chronic ulcer of other part of unspecified foot limited to breakdown of skin

L97.502 Non-pressure chronic ulcer of other part of unspecified foot with fat layer exposed

L97.503 Non-pressure chronic ulcer of other part of unspecified foot with necrosis of muscle

L97.504 Non-pressure chronic ulcer of other part of unspecified foot with necrosis of bone

L97.509 Non-pressure chronic ulcer of other part of unspecified foot with unspecified severity

L97.511 Non-pressure chronic ulcer of other part of right foot limited to breakdown of skin

L97.512 Non-pressure chronic ulcer of other part of right foot with fat layer exposed

L97.513 Non-pressure chronic ulcer of other part of right foot with necrosis of muscle

L97.514 Non-pressure chronic ulcer of other part of right foot with necrosis of bone

L97.519 Non-pressure chronic ulcer of other part of right foot with unspecified severity

L97.521 Non-pressure chronic ulcer of other part of left foot limited to breakdown of skin

L97.522 Non-pressure chronic ulcer of other part of left foot with fat layer exposed

L97.523 Non-pressure chronic ulcer of other part of left foot with necrosis of muscle

L97.524 Non-pressure chronic ulcer of other part of left foot with necrosis of bone

L97.529 Non-pressure chronic ulcer of other part of left foot with unspecified severity

L97.801 Non-pressure chronic ulcer of other part of unspecified lower leg limited to breakdown of skin

L97.802 Non-pressure chronic ulcer of other part of unspecified lower leg with fat layer exposed

L97.803 Non-pressure chronic ulcer of other part of unspecified lower leg with necrosis of muscle

L97.804 Non-pressure chronic ulcer of other part of unspecified lower leg with necrosis of bone

L97.809 Non-pressure chronic ulcer of other part of unspecified lower leg with unspecified severity

L97.811 Non-pressure chronic ulcer of other part of right lower leg limited to breakdown of skin

L97.812 Non-pressure chronic ulcer of other part of right lower leg with fat layer exposed

L97.813 Non-pressure chronic ulcer of other part of right lower leg with necrosis of muscle

L97.814 Non-pressure chronic ulcer of other part of right lower leg with necrosis of bone

L97.819 Non-pressure chronic ulcer of other part of right lower leg with unspecified

ICD-10-CM - Code and Description

severity

L97.821 Non-pressure chronic ulcer of other part of left lower leg limited to breakdown of skin

L97.822 Non-pressure chronic ulcer of other part of left lower leg with fat layer exposed

L97.823 Non-pressure chronic ulcer of other part of left lower leg with necrosis of muscle

L97.824 Non-pressure chronic ulcer of other part of left lower leg with necrosis of bone

L97.829 Non-pressure chronic ulcer of other part of left lower leg with unspecified severity

L97.901 Non-pressure chronic ulcer of unspecified part of unspecified lower leg limited to breakdown of skin

L97.902 Non-pressure chronic ulcer of unspecified part of unspecified lower leg with fat layer exposed

L97.903 Non-pressure chronic ulcer of unspecified part of unspecified lower leg with necrosis of muscle

L97.904 Non-pressure chronic ulcer of unspecified part of unspecified lower leg with necrosis of bone

L97.909 Non-pressure chronic ulcer of unspecified part of unspecified lower leg with unspecified severity

L97.911 Non-pressure chronic ulcer of unspecified part of right lower leg limited to breakdown of skin

L97.912 Non-pressure chronic ulcer of unspecified part of right lower leg with fat layer exposed

L97.913 Non-pressure chronic ulcer of unspecified part of right lower leg with necrosis of muscle

L97.914 Non-pressure chronic ulcer of unspecified part of right lower leg with necrosis of bone

L97.919 Non-pressure chronic ulcer of unspecified part of right lower leg with unspecified severity

L97.921 Non-pressure chronic ulcer of unspecified part of left lower leg limited to breakdown of skin

L97.922 Non-pressure chronic ulcer of unspecified part of left lower leg with fat layer exposed

L97.923 Non-pressure chronic ulcer of unspecified part of left lower leg with necrosis of muscle

L97.924 Non-pressure chronic ulcer of unspecified part of left lower leg with necrosis of bone

L97.929 Non-pressure chronic ulcer of unspecified part of left lower leg with unspecified severity

M05.50 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified site

M05.511 Rheumatoid polyneuropathy with rheumatoid arthritis of right shoulder

ICD-10-CM - Code and Description

M05.512 Rheumatoid polyneuropathy with rheumatoid arthritis of left shoulder

M05.519 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified shoulder

M05.521 Rheumatoid polyneuropathy with rheumatoid arthritis of right elbow

M05.522 Rheumatoid polyneuropathy with rheumatoid arthritis of left elbow

M05.529 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified elbow

M05.531 Rheumatoid polyneuropathy with rheumatoid arthritis of right wrist

M05.532 Rheumatoid polyneuropathy with rheumatoid arthritis of left wrist

M05.539 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified wrist

M05.541 Rheumatoid polyneuropathy with rheumatoid arthritis of right hand

M05.542 Rheumatoid polyneuropathy with rheumatoid arthritis of left hand

M05.549 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified hand

M05.551 Rheumatoid polyneuropathy with rheumatoid arthritis of right hip

M05.552 Rheumatoid polyneuropathy with rheumatoid arthritis of left hip

M05.559 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified hip

M05.561 Rheumatoid polyneuropathy with rheumatoid arthritis of right knee

M05.562 Rheumatoid polyneuropathy with rheumatoid arthritis of left knee

M05.569 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified knee

M05.571 Rheumatoid polyneuropathy with rheumatoid arthritis of right ankle and foot

M05.572 Rheumatoid polyneuropathy with rheumatoid arthritis of left ankle and foot

M05.579 Rheumatoid polyneuropathy with rheumatoid arthritis of unspecified ankle and foot

M05.59 Rheumatoid polyneuropathy with rheumatoid arthritis of multiple sites

M34.83 Systemic sclerosis with polyneuropathy

O90.0 Disruption of cesarean delivery wound

O90.1 Disruption of perineal obstetric wound

S01.00XA Unspecified open wound of scalp, initial encounter

S01.01XA Laceration without foreign body of scalp, initial encounter

S01.02XA Laceration with foreign body of scalp, initial encounter

S01.03XA Puncture wound without foreign body of scalp, initial encounter

S01.04XA Puncture wound with foreign body of scalp, initial encounter

S01.05XA Open bite of scalp, initial encounter

S01.101A Unspecified open wound of right eyelid and periocular area, initial encounter

S01.102A Unspecified open wound of left eyelid and periocular area, initial encounter

S01.109A Unspecified open wound of unspecified eyelid and periocular area, initial encounter

S01.111A Laceration without foreign body of right eyelid and periocular area, initial encounter

S01.112A Laceration without foreign body of left eyelid and periocular area, initial

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encounter

S01.119A Laceration without foreign body of unspecified eyelid and periocular area, initial encounter

S01.119A Laceration without foreign body of unspecified eyelid and periocular area, initial encounter

S01.121A Laceration with foreign body of right eyelid and periocular area, initial encounter

S01.122A Laceration with foreign body of left eyelid and periocular area, initial encounter

S01.129A Laceration with foreign body of unspecified eyelid and periocular area, initial encounter

S01.129A Laceration with foreign body of unspecified eyelid and periocular area, initial encounter

S01.131A Puncture wound without foreign body of right eyelid and periocular area, initial encounter

S01.132A Puncture wound without foreign body of left eyelid and periocular area, initial encounter

S01.139A Puncture wound without foreign body of unspecified eyelid and periocular area, initial encounter

S01.141A Puncture wound with foreign body of right eyelid and periocular area, initial encounter

S01.142A Puncture wound with foreign body of left eyelid and periocular area, initial encounter

S01.149A Puncture wound with foreign body of unspecified eyelid and periocular area, initial encounter

S01.151A Open bite of right eyelid and periocular area, initial encounter

S01.152A Open bite of left eyelid and periocular area, initial encounter

S01.159A Open bite of unspecified eyelid and periocular area, initial encounter

S01.20XA Unspecified open wound of nose, initial encounter

S01.21XA Laceration without foreign body of nose, initial encounter

S01.22XA Laceration with foreign body of nose, initial encounter

S01.23XA Puncture wound without foreign body of nose, initial encounter

S01.24XA Puncture wound with foreign body of nose, initial encounter

S01.25XA Open bite of nose, initial encounter

S01.301A Unspecified open wound of right ear, initial encounter

S01.302A Unspecified open wound of left ear, initial encounter

S01.309A Unspecified open wound of unspecified ear, initial encounter

S01.311A Laceration without foreign body of right ear, initial encounter

S01.312A Laceration without foreign body of left ear, initial encounter

S01.319A Laceration without foreign body of unspecified ear, initial encounter

ICD-10-CM - Code and Description

S01.321A Laceration with foreign body of right ear, initial encounter

S01.322A Laceration with foreign body of left ear, initial encounter

S01.329A Laceration with foreign body of unspecified ear, initial encounter

S01.331A Puncture wound without foreign body of right ear, initial encounter

S01.332A Puncture wound without foreign body of left ear, initial encounter

S01.339A Puncture wound without foreign body of unspecified ear, initial encounter

S01.341A Puncture wound with foreign body of right ear, initial encounter

S01.342A Puncture wound with foreign body of left ear, initial encounter

S01.349A Puncture wound with foreign body of unspecified ear, initial encounter

S01.351A Open bite of right ear, initial encounter

S01.352A Open bite of left ear, initial encounter

S01.359A Open bite of unspecified ear, initial encounter

S01.401A Unspecified open wound of right cheek and temporomandibular area, initial encounter

S01.402A Unspecified open wound of left cheek and temporomandibular area, initial encounter

S01.409A Unspecified open wound of unspecified cheek and temporomandibular area, initial encounter

S01.411A Laceration without foreign body of right cheek and temporomandibular area, initial encounter

S01.412A Laceration without foreign body of left cheek and temporomandibular area, initial encounter

S01.419A Laceration without foreign body of unspecified cheek and temporomandibular area, initial encounter

S01.421A Laceration with foreign body of right cheek and temporomandibular area, initial encounter

S01.422A Laceration with foreign body of left cheek and temporomandibular area, initial encounter

S01.429A Laceration with foreign body of unspecified cheek and temporomandibular area, initial encounter

S01.431A Puncture wound without foreign body of right cheek and temporomandibular area, initial encounter

S01.432A Puncture wound without foreign body of left cheek and temporomandibular area, initial encounter

S01.439A Puncture wound without foreign body of unspecified cheek and temporomandibular area, initial encounter

S01.441A Puncture wound with foreign body of right cheek and temporomandibular area, initial encounter

S01.442A Puncture wound with foreign body of left cheek and temporomandibular area, initial encounter

ICD-10-CM - Code and Description

S01.449A Puncture wound with foreign body of unspecified cheek and temporomandibular area, initial encounter

S01.451A Open bite of right cheek and temporomandibular area, initial encounter

S01.452A Open bite of left cheek and temporomandibular area, initial encounter

S01.459A Open bite of unspecified cheek and temporomandibular area, initial encounter

S01.501A Unspecified open wound of lip, initial encounter

S01.502A Unspecified open wound of oral cavity, initial encounter

S01.511A Laceration without foreign body of lip, initial encounter

S01.512A Laceration without foreign body of oral cavity, initial encounter

S01.521A Laceration with foreign body of lip, initial encounter

S01.522A Laceration with foreign body of oral cavity, initial encounter

S01.531A Puncture wound without foreign body of lip, initial encounter

S01.532A Puncture wound without foreign body of oral cavity, initial encounter

S01.541A Puncture wound with foreign body of lip, initial encounter

S01.542A Puncture wound with foreign body of oral cavity, initial encounter

S01.551A Open bite of lip, initial encounter

S01.552A Open bite of oral cavity, initial encounter

S01.80XA Unspecified open wound of other part of head, initial encounter

S01.81XA Laceration without foreign body of other part of head, initial encounter

S01.82XA Laceration with foreign body of other part of head, initial encounter

S01.83XA Puncture wound without foreign body of other part of head, initial encounter

S01.84XA Puncture wound with foreign body of other part of head, initial encounter

S01.85XA Open bite of other part of head, initial encounter

S01.90XA Unspecified open wound of unspecified part of head, initial encounter

S01.91XA Laceration without foreign body of unspecified part of head, initial encounter

S01.92XA Laceration with foreign body of unspecified part of head, initial encounter

S01.93XA Puncture wound without foreign body of unspecified part of head, initial encounter

S01.94XA Puncture wound with foreign body of unspecified part of head, initial encounter

S01.95XA Open bite of unspecified part of head, initial encounter

S02.5XXA Fracture of tooth (traumatic), initial encounter for closed fracture

S02.5XXB Fracture of tooth (traumatic), initial encounter for open fracture

S03.2XXA Dislocation of tooth, initial encounter

S05.20XA Ocular laceration and rupture with prolapse or loss of intraocular tissue, unspecified eye, initial encounter

S05.21XA Ocular laceration and rupture with prolapse or loss of intraocular tissue, right eye, initial encounter

ICD-10-CM - Code and Description

S05.22XA Ocular laceration and rupture with prolapse or loss of intraocular tissue, left eye, initial encounter

S05.30XA Ocular laceration without prolapse or loss of intraocular tissue, unspecified eye, initial encounter

S05.31XA Ocular laceration without prolapse or loss of intraocular tissue, right eye, initial encounter

S05.32XA Ocular laceration without prolapse or loss of intraocular tissue, left eye, initial encounter

S05.40XA Penetrating wound of orbit with or without foreign body, unspecified eye, initial encounter

S05.41XA Penetrating wound of orbit with or without foreign body, right eye, initial encounter

S05.42XA Penetrating wound of orbit with or without foreign body, left eye, initial encounter

S05.50XA Penetrating wound with foreign body of unspecified eyeball, initial encounter

S05.51XA Penetrating wound with foreign body of right eyeball, initial encounter

S05.52XA Penetrating wound with foreign body of left eyeball, initial encounter

S05.60XA Penetrating wound without foreign body of unspecified eyeball, initial encounter

S05.61XA Penetrating wound without foreign body of right eyeball, initial encounter

S05.62XA Penetrating wound without foreign body of left eyeball, initial encounter

S05.70XA Avulsion of unspecified eye, initial encounter

S05.71XA Avulsion of right eye, initial encounter

S05.72XA Avulsion of left eye, initial encounter

S05.8X1A Other injuries of right eye and orbit, initial encounter

S05.8X2A Other injuries of left eye and orbit, initial encounter

S05.8X9A Other injuries of unspecified eye and orbit, initial encounter

S05.90XA Unspecified injury of unspecified eye and orbit, initial encounter

S05.91XA Unspecified injury of right eye and orbit, initial encounter

S05.92XA Unspecified injury of left eye and orbit, initial encounter

S08.0XXA Avulsion of scalp, initial encounter

S08.111A Complete traumatic amputation of right ear, initial encounter

S08.112A Complete traumatic amputation of left ear, initial encounter

S08.119A Complete traumatic amputation of unspecified ear, initial encounter

S08.121A Partial traumatic amputation of right ear, initial encounter

S08.122A Partial traumatic amputation of left ear, initial encounter

S08.129A Partial traumatic amputation of unspecified ear, initial encounter

S08.811A Complete traumatic amputation of nose, initial encounter

S08.812A Partial traumatic amputation of nose, initial encounter

ICD-10-CM - Code and Description

S08.89XA Traumatic amputation of other parts of head, initial encounter
S09.12XA Laceration of muscle and tendon of head, initial encounter
S09.20XA Traumatic rupture of unspecified ear drum, initial encounter
S09.21XA Traumatic rupture of right ear drum, initial encounter
S09.22XA Traumatic rupture of left ear drum, initial encounter
S09.301A Unspecified injury of right middle and inner ear, initial encounter
S09.302A Unspecified injury of left middle and inner ear, initial encounter
S09.309A Unspecified injury of unspecified middle and inner ear, initial encounter
S09.311A Primary blast injury of right ear, initial encounter
S09.312A Primary blast injury of left ear, initial encounter
S09.313A Primary blast injury of ear, bilateral, initial encounter
S09.319A Primary blast injury of unspecified ear, initial encounter
S09.391A Other specified injury of right middle and inner ear, initial encounter
S09.392A Other specified injury of left middle and inner ear, initial encounter
S09.399A Other specified injury of unspecified middle and inner ear, initial encounter
S09.8XXA Other specified injuries of head, initial encounter
S09.90XA Unspecified injury of head, initial encounter
S09.91XA Unspecified injury of ear, initial encounter
S09.93XA Unspecified injury of face, initial encounter
S11.011A Laceration without foreign body of larynx, initial encounter
S11.012A Laceration with foreign body of larynx, initial encounter
S11.013A Puncture wound without foreign body of larynx, initial encounter
S11.014A Puncture wound with foreign body of larynx, initial encounter
S11.015A Open bite of larynx, initial encounter
S11.019A Unspecified open wound of larynx, initial encounter
S11.021A Laceration without foreign body of trachea, initial encounter
S11.022A Laceration with foreign body of trachea, initial encounter
S11.023A Puncture wound without foreign body of trachea, initial encounter
S11.024A Puncture wound with foreign body of trachea, initial encounter
S11.025A Open bite of trachea, initial encounter
S11.029A Unspecified open wound of trachea, initial encounter
S11.031A Laceration without foreign body of vocal cord, initial encounter
S11.032A Laceration with foreign body of vocal cord, initial encounter
S11.033A Puncture wound without foreign body of vocal cord, initial encounter
S11.034A Puncture wound with foreign body of vocal cord, initial encounter
S11.035A Open bite of vocal cord, initial encounter
S11.039A Unspecified open wound of vocal cord, initial encounter

ICD-10-CM - Code and Description

S11.10XA Unspecified open wound of thyroid gland, initial encounter

S11.11XA Laceration without foreign body of thyroid gland, initial encounter

S11.12XA Laceration with foreign body of thyroid gland, initial encounter

S11.13XA Puncture wound without foreign body of thyroid gland, initial encounter

S11.14XA Puncture wound with foreign body of thyroid gland, initial encounter

S11.15XA Open bite of thyroid gland, initial encounter

S11.20XA Unspecified open wound of pharynx and cervical esophagus, initial encounter

S11.21XA Laceration without foreign body of pharynx and cervical esophagus, initial encounter

S11.22XA Laceration with foreign body of pharynx and cervical esophagus, initial encounter

S11.23XA Puncture wound without foreign body of pharynx and cervical esophagus, initial encounter

S11.24XA Puncture wound with foreign body of pharynx and cervical esophagus, initial encounter

S11.25XA Open bite of pharynx and cervical esophagus, initial encounter

S11.80XA Unspecified open wound of other specified part of neck, initial encounter

S11.81XA Laceration without foreign body of other specified part of neck, initial encounter

S11.82XA Laceration with foreign body of other specified part of neck, initial encounter

S11.83XA Puncture wound without foreign body of other specified part of neck, initial encounter

S11.84XA Puncture wound with foreign body of other specified part of neck, initial encounter

S11.85XA Open bite of other specified part of neck, initial encounter

S11.89XA Other open wound of other specified part of neck, initial encounter

S11.90XA Unspecified open wound of unspecified part of neck, initial encounter

S11.91XA Laceration without foreign body of unspecified part of neck, initial encounter

S11.92XA Laceration with foreign body of unspecified part of neck, initial encounter

S11.93XA Puncture wound without foreign body of unspecified part of neck, initial encounter

S11.94XA Puncture wound with foreign body of unspecified part of neck, initial encounter

S11.95XA Open bite of unspecified part of neck, initial encounter

S16.2XXA Laceration of muscle, fascia and tendon at neck level, initial encounter

S21.001A Unspecified open wound of right breast, initial encounter

S21.002A Unspecified open wound of left breast, initial encounter

S21.009A Unspecified open wound of unspecified breast, initial encounter

S21.011A Laceration without foreign body of right breast, initial encounter

ICD-10-CM - Code and Description

S21.012A Laceration without foreign body of left breast, initial encounter

S21.019A Laceration without foreign body of unspecified breast, initial encounter

S21.021A Laceration with foreign body of right breast, initial encounter

S21.022A Laceration with foreign body of left breast, initial encounter

S21.029A Laceration with foreign body of unspecified breast, initial encounter

S21.031A Puncture wound without foreign body of right breast, initial encounter

S21.032A Puncture wound without foreign body of left breast, initial encounter

S21.039A Puncture wound without foreign body of unspecified breast, initial encounter

S21.041A Puncture wound with foreign body of right breast, initial encounter

S21.042A Puncture wound with foreign body of left breast, initial encounter

S21.049A Puncture wound with foreign body of unspecified breast, initial encounter

S21.051A Open bite of right breast, initial encounter

S21.052A Open bite of left breast, initial encounter

S21.059A Open bite of unspecified breast, initial encounter

S21.101A Unspecified open wound of right front wall of thorax without penetration into thoracic cavity, initial encounter

S21.102A Unspecified open wound of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.109A Unspecified open wound of unspecified front wall of thorax without penetration into thoracic cavity, initial encounter

S21.111A Laceration without foreign body of right front wall of thorax without penetration into thoracic cavity, initial encounter

S21.112A Laceration without foreign body of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.119A Laceration without foreign body of unspecified front wall of thorax without penetration into thoracic cavity, initial encounter

S21.121A Laceration with foreign body of right front wall of thorax without penetration into thoracic cavity, initial encounter

S21.122A Laceration with foreign body of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.129A Laceration with foreign body of unspecified front wall of thorax without penetration into thoracic cavity, initial encounter

S21.131A Puncture wound without foreign body of right front wall of thorax without penetration into thoracic cavity, initial encounter

S21.132A Puncture wound without foreign body of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.139A Puncture wound without foreign body of unspecified front wall of thorax without penetration into thoracic cavity, initial encounter

S21.141A Puncture wound with foreign body of right front wall of thorax without penetration into thoracic cavity, initial encounter

ICD-10-CM - Code and Description

S21.142A Puncture wound with foreign body of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.149A Puncture wound with foreign body of unspecified front wall of thorax without penetration into thoracic cavity, initial encounter

S21.151A Open bite of right front wall of thorax without penetration into thoracic cavity, initial encounter

S21.152A Open bite of left front wall of thorax without penetration into thoracic cavity, initial encounter

S21.159A Open bite of unspecified front wall of thorax without penetration into thoracic cavity, initial encounter

S21.201A Unspecified open wound of right back wall of thorax without penetration into thoracic cavity, initial encounter

S21.202A Unspecified open wound of left back wall of thorax without penetration into thoracic cavity, initial encounter

S21.209A Unspecified open wound of unspecified back wall of thorax without penetration into thoracic cavity, initial encounter

S21.211A Laceration without foreign body of right back wall of thorax without penetration into thoracic cavity, initial encounter

S21.212A Laceration without foreign body of left back wall of thorax without penetration into thoracic cavity, initial encounter

S21.219A Laceration without foreign body of unspecified back wall of thorax without penetration into thoracic cavity, initial encounter

S21.221A Laceration with foreign body of right back wall of thorax without penetration into thoracic cavity, initial encounter

S21.222A Laceration with foreign body of left back wall of thorax without penetration into thoracic cavity, initial encounter

S21.229A Laceration with foreign body of unspecified back wall of thorax without penetration into thoracic cavity, initial encounter

S21.231A Puncture wound without foreign body of right back wall of thorax without penetration into thoracic cavity, initial encounter

S21.232A Puncture wound without foreign body of left back wall of thorax without penetration into thoracic cavity, initial encounter

S21.239A Puncture wound without foreign body of unspecified back wall of thorax without penetration into thoracic cavity, initial encounter

S21.241A Puncture wound with foreign body of right back wall of thorax without penetration into thoracic cavity, initial encounter

S21.242A Puncture wound with foreign body of left back wall of thorax without penetration into thoracic cavity, initial encounter

S21.249A Puncture wound with foreign body of unspecified back wall of thorax without penetration into thoracic cavity, initial encounter

S21.251A Open bite of right back wall of thorax without penetration into thoracic cavity, initial encounter

ICD-10-CM - Code and Description

S21.252A Open bite of left back wall of thorax without penetration into thoracic cavity, initial encounter

S21.259A Open bite of unspecified back wall of thorax without penetration into thoracic cavity, initial encounter

S21.90XA Unspecified open wound of unspecified part of thorax, initial encounter

S21.91XA Laceration without foreign body of unspecified part of thorax, initial encounter

S21.92XA Laceration with foreign body of unspecified part of thorax, initial encounter

S21.93XA Puncture wound without foreign body of unspecified part of thorax, initial encounter

S21.94XA Puncture wound with foreign body of unspecified part of thorax, initial encounter

S21.95XA Open bite of unspecified part of thorax, initial encounter

S28.1XXA Traumatic amputation (partial) of part of thorax, except breast, initial encounter

S28.211A Complete traumatic amputation of right breast, initial encounter

S28.212A Complete traumatic amputation of left breast, initial encounter

S28.219A Complete traumatic amputation of unspecified breast, initial encounter

S28.221A Partial traumatic amputation of right breast, initial encounter

S28.222A Partial traumatic amputation of left breast, initial encounter

S28.229A Partial traumatic amputation of unspecified breast, initial encounter

S29.021A Laceration of muscle and tendon of front wall of thorax, initial encounter

S29.022A Laceration of muscle and tendon of back wall of thorax, initial encounter

S29.029A Laceration of muscle and tendon of unspecified wall of thorax, initial encounter

S31.000A Unspecified open wound of lower back and pelvis without penetration into retroperitoneum, initial encounter

S31.010A Laceration without foreign body of lower back and pelvis without penetration into retroperitoneum, initial encounter

S31.020A Laceration with foreign body of lower back and pelvis without penetration into retroperitoneum, initial encounter

S31.030A Puncture wound without foreign body of lower back and pelvis without penetration into retroperitoneum, initial encounter

S31.040A Puncture wound with foreign body of lower back and pelvis without penetration into retroperitoneum, initial encounter

S31.050A Open bite of lower back and pelvis without penetration into retroperitoneum, initial encounter

S31.100A Unspecified open wound of abdominal wall, right upper quadrant without penetration into peritoneal cavity, initial encounter

S31.101A Unspecified open wound of abdominal wall, left upper quadrant without penetration into peritoneal cavity, initial encounter

ICD-10-CM - Code and Description

S31.102A Unspecified open wound of abdominal wall, epigastric region without penetration into peritoneal cavity, initial encounter

S31.103A Unspecified open wound of abdominal wall, right lower quadrant without penetration into peritoneal cavity, initial encounter

S31.104A Unspecified open wound of abdominal wall, left lower quadrant without penetration into peritoneal cavity, initial encounter

S31.105A Unspecified open wound of abdominal wall, periumbilic region without penetration into peritoneal cavity, initial encounter

S31.109A Unspecified open wound of abdominal wall, unspecified quadrant without penetration into peritoneal cavity, initial encounter

S31.110A Laceration without foreign body of abdominal wall, right upper quadrant without penetration into peritoneal cavity, initial encounter

S31.111A Laceration without foreign body of abdominal wall, left upper quadrant without penetration into peritoneal cavity, initial encounter

S31.112A Laceration without foreign body of abdominal wall, epigastric region without penetration into peritoneal cavity, initial encounter

S31.113A Laceration without foreign body of abdominal wall, right lower quadrant without penetration into peritoneal cavity, initial encounter

S31.114A Laceration without foreign body of abdominal wall, left lower quadrant without penetration into peritoneal cavity, initial encounter

S31.115A Laceration without foreign body of abdominal wall, periumbilic region without penetration into peritoneal cavity, initial encounter

S31.119A Laceration without foreign body of abdominal wall, unspecified quadrant without penetration into peritoneal cavity, initial encounter

S31.120A Laceration of abdominal wall with foreign body, right upper quadrant without penetration into peritoneal cavity, initial encounter

S31.121A Laceration of abdominal wall with foreign body, left upper quadrant without penetration into peritoneal cavity, initial encounter

S31.122A Laceration of abdominal wall with foreign body, epigastric region without penetration into peritoneal cavity, initial encounter

S31.123A Laceration of abdominal wall with foreign body, right lower quadrant without penetration into peritoneal cavity, initial encounter

S31.124A Laceration of abdominal wall with foreign body, left lower quadrant without penetration into peritoneal cavity, initial encounter

S31.125A Laceration of abdominal wall with foreign body, periumbilic region without penetration into peritoneal cavity, initial encounter

S31.129A Laceration of abdominal wall with foreign body, unspecified quadrant without penetration into peritoneal cavity, initial encounter

S31.130A Puncture wound of abdominal wall without foreign body, right upper quadrant without penetration into peritoneal cavity, initial encounter

S31.131A Puncture wound of abdominal wall without foreign body, left upper quadrant without penetration into peritoneal cavity, initial encounter

ICD-10-CM - Code and Description

S31.132A Puncture wound of abdominal wall without foreign body, epigastric region without penetration into peritoneal cavity, initial encounter

S31.133A Puncture wound of abdominal wall without foreign body, right lower quadrant without penetration into peritoneal cavity, initial encounter

S31.134A Puncture wound of abdominal wall without foreign body, left lower quadrant without penetration into peritoneal cavity, initial encounter

S31.135A Puncture wound of abdominal wall without foreign body, periumbilic region without penetration into peritoneal cavity, initial encounter

S31.139A Puncture wound of abdominal wall without foreign body, unspecified quadrant without penetration into peritoneal cavity, initial encounter

S31.140A Puncture wound of abdominal wall with foreign body, right upper quadrant without penetration into peritoneal cavity, initial encounter

S31.141A Puncture wound of abdominal wall with foreign body, left upper quadrant without penetration into peritoneal cavity, initial encounter

S31.142A Puncture wound of abdominal wall with foreign body, epigastric region without penetration into peritoneal cavity, initial encounter

S31.143A Puncture wound of abdominal wall with foreign body, right lower quadrant without penetration into peritoneal cavity, initial encounter

S31.144A Puncture wound of abdominal wall with foreign body, left lower quadrant without penetration into peritoneal cavity, initial encounter

S31.145A Puncture wound of abdominal wall with foreign body, periumbilic region without penetration into peritoneal cavity, initial encounter

S31.149A Puncture wound of abdominal wall with foreign body, unspecified quadrant without penetration into peritoneal cavity, initial encounter

S31.150A Open bite of abdominal wall, right upper quadrant without penetration into peritoneal cavity, initial encounter

S31.151A Open bite of abdominal wall, left upper quadrant without penetration into peritoneal cavity, initial encounter

S31.152A Open bite of abdominal wall, epigastric region without penetration into peritoneal cavity, initial encounter

S31.153A Open bite of abdominal wall, right lower quadrant without penetration into peritoneal cavity, initial encounter

S31.154A Open bite of abdominal wall, left lower quadrant without penetration into peritoneal cavity, initial encounter

S31.155A Open bite of abdominal wall, periumbilic region without penetration into peritoneal cavity, initial encounter

S31.159A Open bite of abdominal wall, unspecified quadrant without penetration into peritoneal cavity, initial encounter

S31.20XA Unspecified open wound of penis, initial encounter

S31.21XA Laceration without foreign body of penis, initial encounter

S31.22XA Laceration with foreign body of penis, initial encounter

S31.23XA Puncture wound without foreign body of penis, initial encounter

ICD-10-CM - Code and Description

S31.24XA Puncture wound with foreign body of penis, initial encounter

S31.25XA Open bite of penis, initial encounter

S31.30XA Unspecified open wound of scrotum and testes, initial encounter

S31.31XA Laceration without foreign body of scrotum and testes, initial encounter

S31.32XA Laceration with foreign body of scrotum and testes, initial encounter

S31.33XA Puncture wound without foreign body of scrotum and testes, initial encounter

S31.34XA Puncture wound with foreign body of scrotum and testes, initial encounter

S31.35XA Open bite of scrotum and testes, initial encounter

S31.40XA Unspecified open wound of vagina and vulva, initial encounter

S31.41XA Laceration without foreign body of vagina and vulva, initial encounter

S31.42XA Laceration with foreign body of vagina and vulva, initial encounter

S31.43XA Puncture wound without foreign body of vagina and vulva, initial encounter

S31.44XA Puncture wound with foreign body of vagina and vulva, initial encounter

S31.45XA Open bite of vagina and vulva, initial encounter

S31.501A Unspecified open wound of unspecified external genital organs, male, initial encounter

S31.502A Unspecified open wound of unspecified external genital organs, female, initial encounter

S31.511A Laceration without foreign body of unspecified external genital organs, male, initial encounter

S31.512A Laceration without foreign body of unspecified external genital organs, female, initial encounter

S31.521A Laceration with foreign body of unspecified external genital organs, male, initial encounter

S31.522A Laceration with foreign body of unspecified external genital organs, female, initial encounter

S31.531A Puncture wound without foreign body of unspecified external genital organs, male, initial encounter

S31.532A Puncture wound without foreign body of unspecified external genital organs, female, initial encounter

S31.541A Puncture wound with foreign body of unspecified external genital organs, male, initial encounter

S31.542A Puncture wound with foreign body of unspecified external genital organs, female, initial encounter

S31.551A Open bite of unspecified external genital organs, male, initial encounter

S31.552A Open bite of unspecified external genital organs, female, initial encounter

S31.801A Laceration without foreign body of unspecified buttock, initial encounter

S31.802A Laceration with foreign body of unspecified buttock, initial encounter

S31.803A Puncture wound without foreign body of unspecified buttock, initial encounter

ICD-10-CM - Code and Description

S31.804A Puncture wound with foreign body of unspecified buttock, initial encounter

S31.805A Open bite of unspecified buttock, initial encounter

S31.809A Unspecified open wound of unspecified buttock, initial encounter

S31.811A Laceration without foreign body of right buttock, initial encounter

S31.812A Laceration with foreign body of right buttock, initial encounter

S31.813A Puncture wound without foreign body of right buttock, initial encounter

S31.814A Puncture wound with foreign body of right buttock, initial encounter

S31.815A Open bite of right buttock, initial encounter

S31.819A Unspecified open wound of right buttock, initial encounter

S31.821A Laceration without foreign body of left buttock, initial encounter

S31.822A Laceration with foreign body of left buttock, initial encounter

S31.823A Puncture wound without foreign body of left buttock, initial encounter

S31.824A Puncture wound with foreign body of left buttock, initial encounter

S31.825A Open bite of left buttock, initial encounter

S31.829A Unspecified open wound of left buttock, initial encounter

S31.831A Laceration without foreign body of anus, initial encounter

S31.832A Laceration with foreign body of anus, initial encounter

S31.833A Puncture wound without foreign body of anus, initial encounter

S31.834A Puncture wound with foreign body of anus, initial encounter

S31.835A Open bite of anus, initial encounter

S31.839A Unspecified open wound of anus, initial encounter

S38.211A Complete traumatic amputation of female external genital organs, initial encounter

S38.212A Partial traumatic amputation of female external genital organs, initial encounter

S38.221A Complete traumatic amputation of penis, initial encounter

S38.222A Partial traumatic amputation of penis, initial encounter

S38.231A Complete traumatic amputation of scrotum and testis, initial encounter

S38.232A Partial traumatic amputation of scrotum and testis, initial encounter

S38.3XXA Transection (partial) of abdomen, initial encounter

S39.021A Laceration of muscle, fascia and tendon of abdomen, initial encounter

S39.022A Laceration of muscle, fascia and tendon of lower back, initial encounter

S39.023A Laceration of muscle, fascia and tendon of pelvis, initial encounter

S41.001A Unspecified open wound of right shoulder, initial encounter

S41.002A Unspecified open wound of left shoulder, initial encounter

S41.009A Unspecified open wound of unspecified shoulder, initial encounter

S41.011A Laceration without foreign body of right shoulder, initial encounter

S41.012A Laceration without foreign body of left shoulder, initial encounter

ICD-10-CM - Code and Description

S41.019A Laceration without foreign body of unspecified shoulder, initial encounter

S41.021A Laceration with foreign body of right shoulder, initial encounter

S41.022A Laceration with foreign body of left shoulder, initial encounter

S41.029A Laceration with foreign body of unspecified shoulder, initial encounter

S41.031A Puncture wound without foreign body of right shoulder, initial encounter

S41.032A Puncture wound without foreign body of left shoulder, initial encounter

S41.039A Puncture wound without foreign body of unspecified shoulder, initial encounter

S41.041A Puncture wound with foreign body of right shoulder, initial encounter

S41.042A Puncture wound with foreign body of left shoulder, initial encounter

S41.049A Puncture wound with foreign body of unspecified shoulder, initial encounter

S41.051A Open bite of right shoulder, initial encounter

S41.052A Open bite of left shoulder, initial encounter

S41.059A Open bite of unspecified shoulder, initial encounter

S41.101A Unspecified open wound of right upper arm, initial encounter

S41.102A Unspecified open wound of left upper arm, initial encounter

S41.109A Unspecified open wound of unspecified upper arm, initial encounter

S41.111A Laceration without foreign body of right upper arm, initial encounter

S41.112A Laceration without foreign body of left upper arm, initial encounter

S41.119A Laceration without foreign body of unspecified upper arm, initial encounter

S41.121A Laceration with foreign body of right upper arm, initial encounter

S41.122A Laceration with foreign body of left upper arm, initial encounter

S41.129A Laceration with foreign body of unspecified upper arm, initial encounter

S41.131A Puncture wound without foreign body of right upper arm, initial encounter

S41.132A Puncture wound without foreign body of left upper arm, initial encounter

S41.139A Puncture wound without foreign body of unspecified upper arm, initial encounter

S41.141A Puncture wound with foreign body of right upper arm, initial encounter

S41.142A Puncture wound with foreign body of left upper arm, initial encounter

S41.149A Puncture wound with foreign body of unspecified upper arm, initial encounter

S41.151A Open bite of right upper arm, initial encounter

S41.152A Open bite of left upper arm, initial encounter

S41.159A Open bite of unspecified upper arm, initial encounter

S46.021A Laceration of muscle(s) and tendon(s) of the rotator cuff of right shoulder, initial encounter

S46.022A Laceration of muscle(s) and tendon(s) of the rotator cuff of left shoulder, initial encounter

S46.029A Laceration of muscle(s) and tendon(s) of the rotator cuff of unspecified

ICD-10-CM - Code and Description

shoulder, initial encounter

S46.121A Laceration of muscle, fascia and tendon of long head of biceps, right arm, initial encounter

S46.122A Laceration of muscle, fascia and tendon of long head of biceps, left arm, initial encounter

S46.129A Laceration of muscle, fascia and tendon of long head of biceps, unspecified arm, initial encounter

S46.221A Laceration of muscle, fascia and tendon of other parts of biceps, right arm, initial encounter

S46.222A Laceration of muscle, fascia and tendon of other parts of biceps, left arm, initial encounter

S46.229A Laceration of muscle, fascia and tendon of other parts of biceps, unspecified arm, initial encounter

S46.321A Laceration of muscle, fascia and tendon of triceps, right arm, initial encounter

S46.322A Laceration of muscle, fascia and tendon of triceps, left arm, initial encounter

S46.329A Laceration of muscle, fascia and tendon of triceps, unspecified arm, initial encounter

S46.821A Laceration of other muscles, fascia and tendons at shoulder and upper arm level, right arm, initial encounter

S46.822A Laceration of other muscles, fascia and tendons at shoulder and upper arm level, left arm, initial encounter

S46.829A Laceration of other muscles, fascia and tendons at shoulder and upper arm level, unspecified arm, initial encounter

S46.921A Laceration of unspecified muscle, fascia and tendon at shoulder and upper arm level, right arm, initial encounter

S46.922A Laceration of unspecified muscle, fascia and tendon at shoulder and upper arm level, left arm, initial encounter

S46.929A Laceration of unspecified muscle, fascia and tendon at shoulder and upper arm level, unspecified arm, initial encounter

S48.011A Complete traumatic amputation at right shoulder joint, initial encounter

S48.012A Complete traumatic amputation at left shoulder joint, initial encounter

S48.019A Complete traumatic amputation at unspecified shoulder joint, initial encounter

S48.021A Partial traumatic amputation at right shoulder joint, initial encounter

S48.022A Partial traumatic amputation at left shoulder joint, initial encounter

S48.029A Partial traumatic amputation at unspecified shoulder joint, initial encounter

S48.111A Complete traumatic amputation at level between right shoulder and elbow, initial encounter

S48.112A Complete traumatic amputation at level between left shoulder and elbow, initial encounter

S48.119A Complete traumatic amputation at level between unspecified shoulder and

ICD-10-CM - Code and Description

elbow, initial encounter

S48.121A Partial traumatic amputation at level between right shoulder and elbow, initial encounter

S48.122A Partial traumatic amputation at level between left shoulder and elbow, initial encounter

S48.129A Partial traumatic amputation at level between unspecified shoulder and elbow, initial encounter

S48.911A Complete traumatic amputation of right shoulder and upper arm, level unspecified, initial encounter

S48.912A Complete traumatic amputation of left shoulder and upper arm, level unspecified, initial encounter

S48.919A Complete traumatic amputation of unspecified shoulder and upper arm, level unspecified, initial encounter

S48.921A Partial traumatic amputation of right shoulder and upper arm, level unspecified, initial encounter

S48.922A Partial traumatic amputation of left shoulder and upper arm, level unspecified, initial encounter

S48.929A Partial traumatic amputation of unspecified shoulder and upper arm, level unspecified, initial encounter

S51.001A Unspecified open wound of right elbow, initial encounter

S51.002A Unspecified open wound of left elbow, initial encounter

S51.009A Unspecified open wound of unspecified elbow, initial encounter

S51.011A Laceration without foreign body of right elbow, initial encounter

S51.012A Laceration without foreign body of left elbow, initial encounter

S51.019A Laceration without foreign body of unspecified elbow, initial encounter

S51.021A Laceration with foreign body of right elbow, initial encounter

S51.022A Laceration with foreign body of left elbow, initial encounter

S51.029A Laceration with foreign body of unspecified elbow, initial encounter

S51.031A Puncture wound without foreign body of right elbow, initial encounter

S51.032A Puncture wound without foreign body of left elbow, initial encounter

S51.039A Puncture wound without foreign body of unspecified elbow, initial encounter

S51.041A Puncture wound with foreign body of right elbow, initial encounter

S51.042A Puncture wound with foreign body of left elbow, initial encounter

S51.049A Puncture wound with foreign body of unspecified elbow, initial encounter

S51.051A Open bite, right elbow, initial encounter

S51.052A Open bite, left elbow, initial encounter

S51.059A Open bite, unspecified elbow, initial encounter

S51.801A Unspecified open wound of right forearm, initial encounter

S51.802A Unspecified open wound of left forearm, initial encounter

ICD-10-CM - Code and Description

S51.809A Unspecified open wound of unspecified forearm, initial encounter

S51.811A Laceration without foreign body of right forearm, initial encounter

S51.812A Laceration without foreign body of left forearm, initial encounter

S51.819A Laceration without foreign body of unspecified forearm, initial encounter

S51.821A Laceration with foreign body of right forearm, initial encounter

S51.822A Laceration with foreign body of left forearm, initial encounter

S51.829A Laceration with foreign body of unspecified forearm, initial encounter

S51.831A Puncture wound without foreign body of right forearm, initial encounter

S51.832A Puncture wound without foreign body of left forearm, initial encounter

S51.839A Puncture wound without foreign body of unspecified forearm, initial encounter

S51.841A Puncture wound with foreign body of right forearm, initial encounter

S51.842A Puncture wound with foreign body of left forearm, initial encounter

S51.849A Puncture wound with foreign body of unspecified forearm, initial encounter

S51.851A Open bite of right forearm, initial encounter

S51.852A Open bite of left forearm, initial encounter

S51.859A Open bite of unspecified forearm, initial encounter

S56.021A Laceration of flexor muscle, fascia and tendon of right thumb at forearm level, initial encounter

S56.022A Laceration of flexor muscle, fascia and tendon of left thumb at forearm level, initial encounter

S56.029A Laceration of flexor muscle, fascia and tendon of unspecified thumb at forearm level, initial encounter

S56.121A Laceration of flexor muscle, fascia and tendon of right index finger at forearm level, initial encounter

S56.122A Laceration of flexor muscle, fascia and tendon of left index finger at forearm level, initial encounter

S56.123A Laceration of flexor muscle, fascia and tendon of right middle finger at forearm level, initial encounter

S56.124A Laceration of flexor muscle, fascia and tendon of left middle finger at forearm level, initial encounter

S56.125A Laceration of flexor muscle, fascia and tendon of right ring finger at forearm level, initial encounter

S56.126A Laceration of flexor muscle, fascia and tendon of left ring finger at forearm level, initial encounter

S56.127A Laceration of flexor muscle, fascia and tendon of right little finger at forearm level, initial encounter

S56.128A Laceration of flexor muscle, fascia and tendon of left little finger at forearm level, initial encounter

S56.129A Laceration of flexor muscle, fascia and tendon of unspecified finger at

ICD-10-CM - Code and Description

forearm level, initial encounter

S56.221A Laceration of other flexor muscle, fascia and tendon at forearm level, right arm, initial encounter

S56.222A Laceration of other flexor muscle, fascia and tendon at forearm level, left arm, initial encounter

S56.229A Laceration of other flexor muscle, fascia and tendon at forearm level, unspecified arm, initial encounter

S56.321A Laceration of extensor or abductor muscles, fascia and tendons of right thumb at forearm level, initial encounter

S56.322A Laceration of extensor or abductor muscles, fascia and tendons of left thumb at forearm level, initial encounter

S56.329A Laceration of extensor or abductor muscles, fascia and tendons of unspecified thumb at forearm level, initial encounter

S56.421A Laceration of extensor muscle, fascia and tendon of right index finger at forearm level, initial encounter

S56.422A Laceration of extensor muscle, fascia and tendon of left index finger at forearm level, initial encounter

S56.423A Laceration of extensor muscle, fascia and tendon of right middle finger at forearm level, initial encounter

S56.424A Laceration of extensor muscle, fascia and tendon of left middle finger at forearm level, initial encounter

S56.425A Laceration of extensor muscle, fascia and tendon of right ring finger at forearm level, initial encounter

S56.426A Laceration of extensor muscle, fascia and tendon of left ring finger at forearm level, initial encounter

S56.427A Laceration of extensor muscle, fascia and tendon of right little finger at forearm level, initial encounter

S56.428A Laceration of extensor muscle, fascia and tendon of left little finger at forearm level, initial encounter

S56.429A Laceration of extensor muscle, fascia and tendon of unspecified finger at forearm level, initial encounter

S56.521A Laceration of other extensor muscle, fascia and tendon at forearm level, right arm, initial encounter

S56.522A Laceration of other extensor muscle, fascia and tendon at forearm level, left arm, initial encounter

S56.529A Laceration of other extensor muscle, fascia and tendon at forearm level, unspecified arm, initial encounter

S56.821A Laceration of other muscles, fascia and tendons at forearm level, right arm, initial encounter

S56.822A Laceration of other muscles, fascia and tendons at forearm level, left arm, initial encounter

S56.829A Laceration of other muscles, fascia and tendons at forearm level, unspecified

ICD-10-CM - Code and Description

arm, initial encounter

S56.921A Laceration of unspecified muscles, fascia and tendons at forearm level, right arm, initial encounter

S56.922A Laceration of unspecified muscles, fascia and tendons at forearm level, left arm, initial encounter

S56.929A Laceration of unspecified muscles, fascia and tendons at forearm level, unspecified arm, initial encounter

S58.011A Complete traumatic amputation at elbow level, right arm, initial encounter

S58.012A Complete traumatic amputation at elbow level, left arm, initial encounter

S58.019A Complete traumatic amputation at elbow level, unspecified arm, initial encounter

S58.021A Partial traumatic amputation at elbow level, right arm, initial encounter

S58.022A Partial traumatic amputation at elbow level, left arm, initial encounter

S58.029A Partial traumatic amputation at elbow level, unspecified arm, initial encounter

S58.111A Complete traumatic amputation at level between elbow and wrist, right arm, initial encounter

S58.112A Complete traumatic amputation at level between elbow and wrist, left arm, initial encounter

S58.119A Complete traumatic amputation at level between elbow and wrist, unspecified arm, initial encounter

S58.121A Partial traumatic amputation at level between elbow and wrist, right arm, initial encounter

S58.122A Partial traumatic amputation at level between elbow and wrist, left arm, initial encounter

S58.129A Partial traumatic amputation at level between elbow and wrist, unspecified arm, initial encounter

S58.911A Complete traumatic amputation of right forearm, level unspecified, initial encounter

S58.912A Complete traumatic amputation of left forearm, level unspecified, initial encounter

S58.919A Complete traumatic amputation of unspecified forearm, level unspecified, initial encounter

S58.921A Partial traumatic amputation of right forearm, level unspecified, initial encounter

S58.922A Partial traumatic amputation of left forearm, level unspecified, initial encounter

S58.929A Partial traumatic amputation of unspecified forearm, level unspecified, initial encounter

S61.001A Unspecified open wound of right thumb without damage to nail, initial encounter

ICD-10-CM - Code and Description

S61.002A Unspecified open wound of left thumb without damage to nail, initial encounter

S61.009A Unspecified open wound of unspecified thumb without damage to nail, initial encounter

S61.011A Laceration without foreign body of right thumb without damage to nail, initial encounter

S61.012A Laceration without foreign body of left thumb without damage to nail, initial encounter

S61.019A Laceration without foreign body of unspecified thumb without damage to nail, initial encounter

S61.021A Laceration with foreign body of right thumb without damage to nail, initial encounter

S61.022A Laceration with foreign body of left thumb without damage to nail, initial encounter

S61.029A Laceration with foreign body of unspecified thumb without damage to nail, initial encounter

S61.031A Puncture wound without foreign body of right thumb without damage to nail, initial encounter

S61.032A Puncture wound without foreign body of left thumb without damage to nail, initial encounter

S61.039A Puncture wound without foreign body of unspecified thumb without damage to nail, initial encounter

S61.041A Puncture wound with foreign body of right thumb without damage to nail, initial encounter

S61.042A Puncture wound with foreign body of left thumb without damage to nail, initial encounter

S61.049A Puncture wound with foreign body of unspecified thumb without damage to nail, initial encounter

S61.051A Open bite of right thumb without damage to nail, initial encounter

S61.052A Open bite of left thumb without damage to nail, initial encounter

S61.059A Open bite of unspecified thumb without damage to nail, initial encounter

S61.101A Unspecified open wound of right thumb with damage to nail, initial encounter

S61.102A Unspecified open wound of left thumb with damage to nail, initial encounter

S61.109A Unspecified open wound of unspecified thumb with damage to nail, initial encounter

S61.109A Unspecified open wound of unspecified thumb with damage to nail, initial encounter

S61.111A Laceration without foreign body of right thumb with damage to nail, initial encounter

S61.112A Laceration without foreign body of left thumb with damage to nail, initial encounter

ICD-10-CM - Code and Description

S61.119A Laceration without foreign body of unspecified thumb with damage to nail, initial encounter

S61.121A Laceration with foreign body of right thumb with damage to nail, initial encounter

S61.122A Laceration with foreign body of left thumb with damage to nail, initial encounter

S61.129A Laceration with foreign body of unspecified thumb with damage to nail, initial encounter

S61.131A Puncture wound without foreign body of right thumb with damage to nail, initial encounter

S61.132A Puncture wound without foreign body of left thumb with damage to nail, initial encounter

S61.139A Puncture wound without foreign body of unspecified thumb with damage to nail, initial encounter

S61.141A Puncture wound with foreign body of right thumb with damage to nail, initial encounter

S61.142A Puncture wound with foreign body of left thumb with damage to nail, initial encounter

S61.149A Puncture wound with foreign body of unspecified thumb with damage to nail, initial encounter

S61.151A Open bite of right thumb with damage to nail, initial encounter

S61.152A Open bite of left thumb with damage to nail, initial encounter

S61.159A Open bite of unspecified thumb with damage to nail, initial encounter

S61.200A Unspecified open wound of right index finger without damage to nail, initial encounter

S61.201A Unspecified open wound of left index finger without damage to nail, initial encounter

S61.202A Unspecified open wound of right middle finger without damage to nail, initial encounter

S61.203A Unspecified open wound of left middle finger without damage to nail, initial encounter

S61.204A Unspecified open wound of right ring finger without damage to nail, initial encounter

S61.205A Unspecified open wound of left ring finger without damage to nail, initial encounter

S61.206A Unspecified open wound of right little finger without damage to nail, initial encounter

S61.207A Unspecified open wound of left little finger without damage to nail, initial encounter

S61.208A Unspecified open wound of other finger without damage to nail, initial encounter

S61.209A Unspecified open wound of unspecified finger without damage to nail, initial

ICD-10-CM - Code and Description

encounter

S61.209A Unspecified open wound of unspecified finger without damage to nail, initial encounter

S61.210A Laceration without foreign body of right index finger without damage to nail, initial encounter

S61.211A Laceration without foreign body of left index finger without damage to nail, initial encounter

S61.212A Laceration without foreign body of right middle finger without damage to nail, initial encounter

S61.213A Laceration without foreign body of left middle finger without damage to nail, initial encounter

S61.214A Laceration without foreign body of right ring finger without damage to nail, initial encounter

S61.215A Laceration without foreign body of left ring finger without damage to nail, initial encounter

S61.216A Laceration without foreign body of right little finger without damage to nail, initial encounter

S61.217A Laceration without foreign body of left little finger without damage to nail, initial encounter

S61.218A Laceration without foreign body of other finger without damage to nail, initial encounter

S61.219A Laceration without foreign body of unspecified finger without damage to nail, initial encounter

S61.220A Laceration with foreign body of right index finger without damage to nail, initial encounter

S61.221A Laceration with foreign body of left index finger without damage to nail, initial encounter

S61.222A Laceration with foreign body of right middle finger without damage to nail, initial encounter

S61.223A Laceration with foreign body of left middle finger without damage to nail, initial encounter

S61.224A Laceration with foreign body of right ring finger without damage to nail, initial encounter

S61.225A Laceration with foreign body of left ring finger without damage to nail, initial encounter

S61.226A Laceration with foreign body of right little finger without damage to nail, initial encounter

S61.227A Laceration with foreign body of left little finger without damage to nail, initial encounter

S61.228A Laceration with foreign body of other finger without damage to nail, initial encounter

S61.229A Laceration with foreign body of unspecified finger without damage to nail,

ICD-10-CM - Code and Description

initial encounter

S61.230A Puncture wound without foreign body of right index finger without damage to nail, initial encounter

S61.231A Puncture wound without foreign body of left index finger without damage to nail, initial encounter

S61.232A Puncture wound without foreign body of right middle finger without damage to nail, initial encounter

S61.233A Puncture wound without foreign body of left middle finger without damage to nail, initial encounter

S61.234A Puncture wound without foreign body of right ring finger without damage to nail, initial encounter

S61.235A Puncture wound without foreign body of left ring finger without damage to nail, initial encounter

S61.236A Puncture wound without foreign body of right little finger without damage to nail, initial encounter

S61.237A Puncture wound without foreign body of left little finger without damage to nail, initial encounter

S61.238A Puncture wound without foreign body of other finger without damage to nail, initial encounter

S61.239A Puncture wound without foreign body of unspecified finger without damage to nail, initial encounter

S61.240A Puncture wound with foreign body of right index finger without damage to nail, initial encounter

S61.241A Puncture wound with foreign body of left index finger without damage to nail, initial encounter

S61.242A Puncture wound with foreign body of right middle finger without damage to nail, initial encounter

S61.243A Puncture wound with foreign body of left middle finger without damage to nail, initial encounter

S61.244A Puncture wound with foreign body of right ring finger without damage to nail, initial encounter

S61.245A Puncture wound with foreign body of left ring finger without damage to nail, initial encounter

S61.246A Puncture wound with foreign body of right little finger without damage to nail, initial encounter

S61.247A Puncture wound with foreign body of left little finger without damage to nail, initial encounter

S61.248A Puncture wound with foreign body of other finger without damage to nail, initial encounter

S61.249A Puncture wound with foreign body of unspecified finger without damage to nail, initial encounter

S61.250A Open bite of right index finger without damage to nail, initial encounter

ICD-10-CM - Code and Description

S61.251A Open bite of left index finger without damage to nail, initial encounter

S61.252A Open bite of right middle finger without damage to nail, initial encounter

S61.253A Open bite of left middle finger without damage to nail, initial encounter

S61.254A Open bite of right ring finger without damage to nail, initial encounter

S61.255A Open bite of left ring finger without damage to nail, initial encounter

S61.256A Open bite of right little finger without damage to nail, initial encounter

S61.257A Open bite of left little finger without damage to nail, initial encounter

S61.258A Open bite of other finger without damage to nail, initial encounter

S61.259A Open bite of unspecified finger without damage to nail, initial encounter

S61.300A Unspecified open wound of right index finger with damage to nail, initial encounter

S61.301A Unspecified open wound of left index finger with damage to nail, initial encounter

S61.302A Unspecified open wound of right middle finger with damage to nail, initial encounter

S61.303A Unspecified open wound of left middle finger with damage to nail, initial encounter

S61.304A Unspecified open wound of right ring finger with damage to nail, initial encounter

S61.305A Unspecified open wound of left ring finger with damage to nail, initial encounter

S61.306A Unspecified open wound of right little finger with damage to nail, initial encounter

S61.307A Unspecified open wound of left little finger with damage to nail, initial encounter

S61.308A Unspecified open wound of other finger with damage to nail, initial encounter

S61.309A Unspecified open wound of unspecified finger with damage to nail, initial encounter

S61.310A Laceration without foreign body of right index finger with damage to nail, initial encounter

S61.311A Laceration without foreign body of left index finger with damage to nail, initial encounter

S61.312A Laceration without foreign body of right middle finger with damage to nail, initial encounter

S61.313A Laceration without foreign body of left middle finger with damage to nail, initial encounter

S61.314A Laceration without foreign body of right ring finger with damage to nail, initial encounter

S61.315A Laceration without foreign body of left ring finger with damage to nail, initial encounter

S61.316A Laceration without foreign body of right little finger with damage to nail,

ICD-10-CM - Code and Description

initial encounter

S61.317A Laceration without foreign body of left little finger with damage to nail, initial encounter

S61.318A Laceration without foreign body of other finger with damage to nail, initial encounter

S61.319A Laceration without foreign body of unspecified finger with damage to nail, initial encounter

S61.320A Laceration with foreign body of right index finger with damage to nail, initial encounter

S61.321A Laceration with foreign body of left index finger with damage to nail, initial encounter

S61.322A Laceration with foreign body of right middle finger with damage to nail, initial encounter

S61.323A Laceration with foreign body of left middle finger with damage to nail, initial encounter

S61.324A Laceration with foreign body of right ring finger with damage to nail, initial encounter

S61.325A Laceration with foreign body of left ring finger with damage to nail, initial encounter

S61.326A Laceration with foreign body of right little finger with damage to nail, initial encounter

S61.327A Laceration with foreign body of left little finger with damage to nail, initial encounter

S61.328A Laceration with foreign body of other finger with damage to nail, initial encounter

S61.329A Laceration with foreign body of unspecified finger with damage to nail, initial encounter

S61.330A Puncture wound without foreign body of right index finger with damage to nail, initial encounter

S61.331A Puncture wound without foreign body of left index finger with damage to nail, initial encounter

S61.340A Puncture wound with foreign body of right index finger with damage to nail, initial encounter

S61.341A Puncture wound with foreign body of left index finger with damage to nail, initial encounter

S61.342A Puncture wound with foreign body of right middle finger with damage to nail, initial encounter

S61.343A Puncture wound with foreign body of left middle finger with damage to nail, initial encounter

S61.344A Puncture wound with foreign body of right ring finger with damage to nail, initial encounter

S61.345A Puncture wound with foreign body of left ring finger with damage to nail,

ICD-10-CM - Code and Description

initial encounter

S61.346A Puncture wound with foreign body of right little finger with damage to nail, initial encounter

S61.347A Puncture wound with foreign body of left little finger with damage to nail, initial encounter

S61.348A Puncture wound with foreign body of other finger with damage to nail, initial encounter

S61.349A Puncture wound with foreign body of unspecified finger with damage to nail, initial encounter

S61.401A Unspecified open wound of right hand, initial encounter

S61.402A Unspecified open wound of left hand, initial encounter

S61.409A Unspecified open wound of unspecified hand, initial encounter

S61.411A Laceration without foreign body of right hand, initial encounter

S61.412A Laceration without foreign body of left hand, initial encounter

S61.419A Laceration without foreign body of unspecified hand, initial encounter

S61.421A Laceration with foreign body of right hand, initial encounter

S61.422A Laceration with foreign body of left hand, initial encounter

S61.429A Laceration with foreign body of unspecified hand, initial encounter

S61.431A Puncture wound without foreign body of right hand, initial encounter

S61.432A Puncture wound without foreign body of left hand, initial encounter

S61.439A Puncture wound without foreign body of unspecified hand, initial encounter

S61.441A Puncture wound with foreign body of right hand, initial encounter

S61.442A Puncture wound with foreign body of left hand, initial encounter

S61.449A Puncture wound with foreign body of unspecified hand, initial encounter

S61.451A Open bite of right hand, initial encounter

S61.452A Open bite of left hand, initial encounter

S61.459A Open bite of unspecified hand, initial encounter

S61.501A Unspecified open wound of right wrist, initial encounter

S61.502A Unspecified open wound of left wrist, initial encounter

S61.509A Unspecified open wound of unspecified wrist, initial encounter

S61.511A Laceration without foreign body of right wrist, initial encounter

S61.512A Laceration without foreign body of left wrist, initial encounter

S61.519A Laceration without foreign body of unspecified wrist, initial encounter

S61.521A Laceration with foreign body of right wrist, initial encounter

S61.522A Laceration with foreign body of left wrist, initial encounter

S61.529A Laceration with foreign body of unspecified wrist, initial encounter

S61.531A Puncture wound without foreign body of right wrist, initial encounter

S61.532A Puncture wound without foreign body of left wrist, initial encounter

ICD-10-CM - Code and Description

S61.539A Puncture wound without foreign body of unspecified wrist, initial encounter

S61.541A Puncture wound with foreign body of right wrist, initial encounter

S61.542A Puncture wound with foreign body of left wrist, initial encounter

S61.549A Puncture wound with foreign body of unspecified wrist, initial encounter

S61.551A Open bite of right wrist, initial encounter

S61.552A Open bite of left wrist, initial encounter

S61.559A Open bite of unspecified wrist, initial encounter

S66.021A Laceration of long flexor muscle, fascia and tendon of right thumb at wrist and hand level, initial encounter

S66.022A Laceration of long flexor muscle, fascia and tendon of left thumb at wrist and hand level, initial encounter

S66.029A Laceration of long flexor muscle, fascia and tendon of unspecified thumb at wrist and hand level, initial encounter

S66.120A Laceration of flexor muscle, fascia and tendon of right index finger at wrist and hand level, initial encounter

S66.121A Laceration of flexor muscle, fascia and tendon of left index finger at wrist and hand level, initial encounter

S66.122A Laceration of flexor muscle, fascia and tendon of right middle finger at wrist and hand level, initial encounter

S66.123A Laceration of flexor muscle, fascia and tendon of left middle finger at wrist and hand level, initial encounter

S66.124A Laceration of flexor muscle, fascia and tendon of right ring finger at wrist and hand level, initial encounter

S66.125A Laceration of flexor muscle, fascia and tendon of left ring finger at wrist and hand level, initial encounter

S66.126A Laceration of flexor muscle, fascia and tendon of right little finger at wrist and hand level, initial encounter

S66.127A Laceration of flexor muscle, fascia and tendon of left little finger at wrist and hand level, initial encounter

S66.128A Laceration of flexor muscle, fascia and tendon of other finger at wrist and hand level, initial encounter

S66.129A Laceration of flexor muscle, fascia and tendon of unspecified finger at wrist and hand level, initial encounter

S66.221A Laceration of extensor muscle, fascia and tendon of right thumb at wrist and hand level, initial encounter

S66.222A Laceration of extensor muscle, fascia and tendon of left thumb at wrist and hand level, initial encounter

S66.229A Laceration of extensor muscle, fascia and tendon of unspecified thumb at wrist and hand level, initial encounter

S66.320A Laceration of extensor muscle, fascia and tendon of right index finger at wrist and hand level, initial encounter

ICD-10-CM - Code and Description

S66.321A Laceration of extensor muscle, fascia and tendon of left index finger at wrist and hand level, initial encounter

S66.322A Laceration of extensor muscle, fascia and tendon of right middle finger at wrist and hand level, initial encounter

S66.323A Laceration of extensor muscle, fascia and tendon of left middle finger at wrist and hand level, initial encounter

S66.324A Laceration of extensor muscle, fascia and tendon of right ring finger at wrist and hand level, initial encounter

S66.325A Laceration of extensor muscle, fascia and tendon of left ring finger at wrist and hand level, initial encounter

S66.326A Laceration of extensor muscle, fascia and tendon of right little finger at wrist and hand level, initial encounter

S66.327A Laceration of extensor muscle, fascia and tendon of left little finger at wrist and hand level, initial encounter

S66.328A Laceration of extensor muscle, fascia and tendon of other finger at wrist and hand level, initial encounter

S66.329A Laceration of extensor muscle, fascia and tendon of unspecified finger at wrist and hand level, initial encounter

S66.421A Laceration of intrinsic muscle, fascia and tendon of right thumb at wrist and hand level, initial encounter

S66.422A Laceration of intrinsic muscle, fascia and tendon of left thumb at wrist and hand level, initial encounter

S66.429A Laceration of intrinsic muscle, fascia and tendon of unspecified thumb at wrist and hand level, initial encounter

S66.520A Laceration of intrinsic muscle, fascia and tendon of right index finger at wrist and hand level, initial encounter

S66.521A Laceration of intrinsic muscle, fascia and tendon of left index finger at wrist and hand level, initial encounter

S66.522A Laceration of intrinsic muscle, fascia and tendon of right middle finger at wrist and hand level, initial encounter

S66.523A Laceration of intrinsic muscle, fascia and tendon of left middle finger at wrist and hand level, initial encounter

S66.524A Laceration of intrinsic muscle, fascia and tendon of right ring finger at wrist and hand level, initial encounter

S66.525A Laceration of intrinsic muscle, fascia and tendon of left ring finger at wrist and hand level, initial encounter

S66.526A Laceration of intrinsic muscle, fascia and tendon of right little finger at wrist and hand level, initial encounter

S66.527A Laceration of intrinsic muscle, fascia and tendon of left little finger at wrist and hand level, initial encounter

S66.528A Laceration of intrinsic muscle, fascia and tendon of other finger at wrist and hand level, initial encounter

ICD-10-CM - Code and Description

S66.529A Laceration of intrinsic muscle, fascia and tendon of unspecified finger at wrist and hand level, initial encounter

S66.821A Laceration of other specified muscles, fascia and tendons at wrist and hand level, right hand, initial encounter

S66.822A Laceration of other specified muscles, fascia and tendons at wrist and hand level, left hand, initial encounter

S66.829A Laceration of other specified muscles, fascia and tendons at wrist and hand level, unspecified hand, initial encounter

S66.921A Laceration of unspecified muscle, fascia and tendon at wrist and hand level, right hand, initial encounter

S66.922A Laceration of unspecified muscle, fascia and tendon at wrist and hand level, left hand, initial encounter

S66.929A Laceration of unspecified muscle, fascia and tendon at wrist and hand level, unspecified hand, initial encounter

S68.011A Complete traumatic metacarpophalangeal amputation of right thumb, initial encounter

S68.012A Complete traumatic metacarpophalangeal amputation of left thumb, initial encounter

S68.019A Complete traumatic metacarpophalangeal amputation of unspecified thumb, initial encounter

S68.021A Partial traumatic metacarpophalangeal amputation of right thumb, initial encounter

S68.022A Partial traumatic metacarpophalangeal amputation of left thumb, initial encounter

S68.029A Partial traumatic metacarpophalangeal amputation of unspecified thumb, initial encounter

S68.110A Complete traumatic metacarpophalangeal amputation of right index finger, initial encounter

S68.111A Complete traumatic metacarpophalangeal amputation of left index finger, initial encounter

S68.112A Complete traumatic metacarpophalangeal amputation of right middle finger, initial encounter

S68.113A Complete traumatic metacarpophalangeal amputation of left middle finger, initial encounter

S68.114A Complete traumatic metacarpophalangeal amputation of right ring finger, initial encounter

S68.115A Complete traumatic metacarpophalangeal amputation of left ring finger, initial encounter

S68.116A Complete traumatic metacarpophalangeal amputation of right little finger, initial encounter

S68.117A Complete traumatic metacarpophalangeal amputation of left little finger, initial encounter

ICD-10-CM - Code and Description

S68.118A Complete traumatic metacarpophalangeal amputation of other finger, initial encounter

S68.119A Complete traumatic metacarpophalangeal amputation of unspecified finger, initial encounter

S68.120A Partial traumatic metacarpophalangeal amputation of right index finger, initial encounter

S68.121A Partial traumatic metacarpophalangeal amputation of left index finger, initial encounter

S68.122A Partial traumatic metacarpophalangeal amputation of right middle finger, initial encounter

S68.123A Partial traumatic metacarpophalangeal amputation of left middle finger, initial encounter

S68.124A Partial traumatic metacarpophalangeal amputation of right ring finger, initial encounter

S68.125A Partial traumatic metacarpophalangeal amputation of left ring finger, initial encounter

S68.126A Partial traumatic metacarpophalangeal amputation of right little finger, initial encounter

S68.127A Partial traumatic metacarpophalangeal amputation of left little finger, initial encounter

S68.128A Partial traumatic metacarpophalangeal amputation of other finger, initial encounter

S68.129A Partial traumatic metacarpophalangeal amputation of unspecified finger, initial encounter

S68.411A Complete traumatic amputation of right hand at wrist level, initial encounter

S68.412A Complete traumatic amputation of left hand at wrist level, initial encounter

S68.419A Complete traumatic amputation of unspecified hand at wrist level, initial encounter

S68.421A Partial traumatic amputation of right hand at wrist level, initial encounter

S68.422A Partial traumatic amputation of left hand at wrist level, initial encounter

S68.429A Partial traumatic amputation of unspecified hand at wrist level, initial encounter

S68.511A Complete traumatic transphalangeal amputation of right thumb, initial encounter

S68.512A Complete traumatic transphalangeal amputation of left thumb, initial encounter

S68.519A Complete traumatic transphalangeal amputation of unspecified thumb, initial encounter

S68.521A Partial traumatic transphalangeal amputation of right thumb, initial encounter

S68.522A Partial traumatic transphalangeal amputation of left thumb, initial encounter

ICD-10-CM - Code and Description

S68.529A Partial traumatic transphalangeal amputation of unspecified thumb, initial encounter

S68.610A Complete traumatic transphalangeal amputation of right index finger, initial encounter

S68.611A Complete traumatic transphalangeal amputation of left index finger, initial encounter

S68.612A Complete traumatic transphalangeal amputation of right middle finger, initial encounter

S68.613A Complete traumatic transphalangeal amputation of left middle finger, initial encounter

S68.614A Complete traumatic transphalangeal amputation of right ring finger, initial encounter

S68.615A Complete traumatic transphalangeal amputation of left ring finger, initial encounter

S68.616A Complete traumatic transphalangeal amputation of right little finger, initial encounter

S68.617A Complete traumatic transphalangeal amputation of left little finger, initial encounter

S68.618A Complete traumatic transphalangeal amputation of other finger, initial encounter

S68.619A Complete traumatic transphalangeal amputation of unspecified finger, initial encounter

S68.620A Partial traumatic transphalangeal amputation of right index finger, initial encounter

S68.621A Partial traumatic transphalangeal amputation of left index finger, initial encounter

S68.622A Partial traumatic transphalangeal amputation of right middle finger, initial encounter

S68.623A Partial traumatic transphalangeal amputation of left middle finger, initial encounter

S68.624A Partial traumatic transphalangeal amputation of right ring finger, initial encounter

S68.625A Partial traumatic transphalangeal amputation of left ring finger, initial encounter

S68.626A Partial traumatic transphalangeal amputation of right little finger, initial encounter

S68.627A Partial traumatic transphalangeal amputation of left little finger, initial encounter

S68.628A Partial traumatic transphalangeal amputation of other finger, initial encounter

S68.629A Partial traumatic transphalangeal amputation of unspecified finger, initial encounter

ICD-10-CM - Code and Description

S68.711A Complete traumatic transmetacarpal amputation of right hand, initial encounter

S68.712A Complete traumatic transmetacarpal amputation of left hand, initial encounter

S68.719A Complete traumatic transmetacarpal amputation of unspecified hand, initial encounter

S68.721A Partial traumatic transmetacarpal amputation of right hand, initial encounter

S68.722A Partial traumatic transmetacarpal amputation of left hand, initial encounter

S68.729A Partial traumatic transmetacarpal amputation of unspecified hand, initial encounter

S71.001A Unspecified open wound, right hip, initial encounter

S71.002A Unspecified open wound, left hip, initial encounter

S71.009A Unspecified open wound, unspecified hip, initial encounter

S71.011A Laceration without foreign body, right hip, initial encounter

S71.012A Laceration without foreign body, left hip, initial encounter

S71.019A Laceration without foreign body, unspecified hip, initial encounter

S71.021A Laceration with foreign body, right hip, initial encounter

S71.022A Laceration with foreign body, left hip, initial encounter

S71.029A Laceration with foreign body, unspecified hip, initial encounter

S71.031A Puncture wound without foreign body, right hip, initial encounter

S71.032A Puncture wound without foreign body, left hip, initial encounter

S71.039A Puncture wound without foreign body, unspecified hip, initial encounter

S71.041A Puncture wound with foreign body, right hip, initial encounter

S71.042A Puncture wound with foreign body, left hip, initial encounter

S71.049A Puncture wound with foreign body, unspecified hip, initial encounter

S71.051A Open bite, right hip, initial encounter

S71.052A Open bite, left hip, initial encounter

S71.059A Open bite, unspecified hip, initial encounter

S71.101A Unspecified open wound, right thigh, initial encounter

S71.102A Unspecified open wound, left thigh, initial encounter

S71.109A Unspecified open wound, unspecified thigh, initial encounter

S71.111A Laceration without foreign body, right thigh, initial encounter

S71.112A Laceration without foreign body, left thigh, initial encounter

S71.119A Laceration without foreign body, unspecified thigh, initial encounter

S71.121A Laceration with foreign body, right thigh, initial encounter

S71.122A Laceration with foreign body, left thigh, initial encounter

S71.129A Laceration with foreign body, unspecified thigh, initial encounter

S71.131A Puncture wound without foreign body, right thigh, initial encounter

ICD-10-CM - Code and Description

S71.132A Puncture wound without foreign body, left thigh, initial encounter

S71.139A Puncture wound without foreign body, unspecified thigh, initial encounter

S71.141A Puncture wound with foreign body, right thigh, initial encounter

S71.142A Puncture wound with foreign body, left thigh, initial encounter

S71.149A Puncture wound with foreign body, unspecified thigh, initial encounter

S71.151A Open bite, right thigh, initial encounter

S71.152A Open bite, left thigh, initial encounter

S71.159A Open bite, unspecified thigh, initial encounter

S76.021A Laceration of muscle, fascia and tendon of right hip, initial encounter

S76.022A Laceration of muscle, fascia and tendon of left hip, initial encounter

S76.029A Laceration of muscle, fascia and tendon of unspecified hip, initial encounter

S76.121A Laceration of right quadriceps muscle, fascia and tendon, initial encounter

S76.122A Laceration of left quadriceps muscle, fascia and tendon, initial encounter

S76.129A Laceration of unspecified quadriceps muscle, fascia and tendon, initial encounter

S76.221A Laceration of adductor muscle, fascia and tendon of right thigh, initial encounter

S76.222A Laceration of adductor muscle, fascia and tendon of left thigh, initial encounter

S76.229A Laceration of adductor muscle, fascia and tendon of unspecified thigh, initial encounter

S76.321A Laceration of muscle, fascia and tendon of the posterior muscle group at thigh level, right thigh, initial encounter

S76.322A Laceration of muscle, fascia and tendon of the posterior muscle group at thigh level, left thigh, initial encounter

S76.329A Laceration of muscle, fascia and tendon of the posterior muscle group at thigh level, unspecified thigh, initial encounter

S76.821A Laceration of other specified muscles, fascia and tendons at thigh level, right thigh, initial encounter

S76.822A Laceration of other specified muscles, fascia and tendons at thigh level, left thigh, initial encounter

S76.829A Laceration of other specified muscles, fascia and tendons at thigh level, unspecified thigh, initial encounter

S76.921A Laceration of unspecified muscles, fascia and tendons at thigh level, right thigh, initial encounter

S76.922A Laceration of unspecified muscles, fascia and tendons at thigh level, left thigh, initial encounter

S76.929A Laceration of unspecified muscles, fascia and tendons at thigh level, unspecified thigh, initial encounter

S78.011A Complete traumatic amputation at right hip joint, initial encounter

ICD-10-CM - Code and Description

S78.012A Complete traumatic amputation at left hip joint, initial encounter

S78.019A Complete traumatic amputation at unspecified hip joint, initial encounter

S78.021A Partial traumatic amputation at right hip joint, initial encounter

S78.022A Partial traumatic amputation at left hip joint, initial encounter

S78.029A Partial traumatic amputation at unspecified hip joint, initial encounter

S78.111A Complete traumatic amputation at level between right hip and knee, initial encounter

S78.112A Complete traumatic amputation at level between left hip and knee, initial encounter

S78.119A Complete traumatic amputation at level between unspecified hip and knee, initial encounter

S78.121A Partial traumatic amputation at level between right hip and knee, initial encounter

S78.122A Partial traumatic amputation at level between left hip and knee, initial encounter

S78.129A Partial traumatic amputation at level between unspecified hip and knee, initial encounter

S78.911A Complete traumatic amputation of right hip and thigh, level unspecified, initial encounter

S78.912A Complete traumatic amputation of left hip and thigh, level unspecified, initial encounter

S78.919A Complete traumatic amputation of unspecified hip and thigh, level unspecified, initial encounter

S78.921A Partial traumatic amputation of right hip and thigh, level unspecified, initial encounter

S78.922A Partial traumatic amputation of left hip and thigh, level unspecified, initial encounter

S78.929A Partial traumatic amputation of unspecified hip and thigh, level unspecified, initial encounter

S81.001A Unspecified open wound, right knee, initial encounter

S81.002A Unspecified open wound, left knee, initial encounter

S81.009A Unspecified open wound, unspecified knee, initial encounter

S81.011A Laceration without foreign body, right knee, initial encounter

S81.012A Laceration without foreign body, left knee, initial encounter

S81.019A Laceration without foreign body, unspecified knee, initial encounter

S81.021A Laceration with foreign body, right knee, initial encounter

S81.022A Laceration with foreign body, left knee, initial encounter

S81.029A Laceration with foreign body, unspecified knee, initial encounter

S81.031A Puncture wound without foreign body, right knee, initial encounter

S81.032A Puncture wound without foreign body, left knee, initial encounter

ICD-10-CM - Code and Description

S81.039A Puncture wound without foreign body, unspecified knee, initial encounter

S81.041A Puncture wound with foreign body, right knee, initial encounter

S81.042A Puncture wound with foreign body, left knee, initial encounter

S81.049A Puncture wound with foreign body, unspecified knee, initial encounter

S81.051A Open bite, right knee, initial encounter

S81.052A Open bite, left knee, initial encounter

S81.059A Open bite, unspecified knee, initial encounter

S81.801A Unspecified open wound, right lower leg, initial encounter

S81.802A Unspecified open wound, left lower leg, initial encounter

S81.809A Unspecified open wound, unspecified lower leg, initial encounter

S81.811A Laceration without foreign body, right lower leg, initial encounter

S81.812A Laceration without foreign body, left lower leg, initial encounter

S81.819A Laceration without foreign body, unspecified lower leg, initial encounter

S81.821A Laceration with foreign body, right lower leg, initial encounter

S81.822A Laceration with foreign body, left lower leg, initial encounter

S81.829A Laceration with foreign body, unspecified lower leg, initial encounter

S81.831A Puncture wound without foreign body, right lower leg, initial encounter

S81.832A Puncture wound without foreign body, left lower leg, initial encounter

S81.839A Puncture wound without foreign body, unspecified lower leg, initial encounter

S81.841A Puncture wound with foreign body, right lower leg, initial encounter

S81.842A Puncture wound with foreign body, left lower leg, initial encounter

S81.849A Puncture wound with foreign body, unspecified lower leg, initial encounter

S81.851A Open bite, right lower leg, initial encounter

S81.852A Open bite, left lower leg, initial encounter

S81.859A Open bite, unspecified lower leg, initial encounter

S86.021A Laceration of right Achilles tendon, initial encounter

S86.022A Laceration of left Achilles tendon, initial encounter

S86.029A Laceration of unspecified Achilles tendon, initial encounter

S86.121A Laceration of other muscle(s) and tendon(s) of posterior muscle group at lower leg level, right leg, initial encounter

S86.122A Laceration of other muscle(s) and tendon(s) of posterior muscle group at lower leg level, left leg, initial encounter

S86.129A Laceration of other muscle(s) and tendon(s) of posterior muscle group at lower leg level, unspecified leg, initial encounter

S86.221A Laceration of muscle(s) and tendon(s) of anterior muscle group at lower leg level, right leg, initial encounter

S86.222A Laceration of muscle(s) and tendon(s) of anterior muscle group at lower leg level, left leg, initial encounter

ICD-10-CM - Code and Description

S86.229A Laceration of muscle(s) and tendon(s) of anterior muscle group at lower leg level, unspecified leg, initial encounter

S86.321A Laceration of muscle(s) and tendon(s) of peroneal muscle group at lower leg level, right leg, initial encounter

S86.322A Laceration of muscle(s) and tendon(s) of peroneal muscle group at lower leg level, left leg, initial encounter

S86.329A Laceration of muscle(s) and tendon(s) of peroneal muscle group at lower leg level, unspecified leg, initial encounter

S86.821A Laceration of other muscle(s) and tendon(s) at lower leg level, right leg, initial encounter

S86.822A Laceration of other muscle(s) and tendon(s) at lower leg level, left leg, initial encounter

S86.829A Laceration of other muscle(s) and tendon(s) at lower leg level, unspecified leg, initial encounter

S86.921A Laceration of unspecified muscle(s) and tendon(s) at lower leg level, right leg, initial encounter

S86.922A Laceration of unspecified muscle(s) and tendon(s) at lower leg level, left leg, initial encounter

S86.929A Laceration of unspecified muscle(s) and tendon(s) at lower leg level, unspecified leg, initial encounter

S88.011A Complete traumatic amputation at knee level, right lower leg, initial encounter

S88.012A Complete traumatic amputation at knee level, left lower leg, initial encounter

S88.019A Complete traumatic amputation at knee level, unspecified lower leg, initial encounter

S88.021A Partial traumatic amputation at knee level, right lower leg, initial encounter

S88.022A Partial traumatic amputation at knee level, left lower leg, initial encounter

S88.029A Partial traumatic amputation at knee level, unspecified lower leg, initial encounter

S88.111A Complete traumatic amputation at level between knee and ankle, right lower leg, initial encounter

S88.112A Complete traumatic amputation at level between knee and ankle, left lower leg, initial encounter

S88.119A Complete traumatic amputation at level between knee and ankle, unspecified lower leg, initial encounter

S88.121A Partial traumatic amputation at level between knee and ankle, right lower leg, initial encounter

S88.122A Partial traumatic amputation at level between knee and ankle, left lower leg, initial encounter

S88.129A Partial traumatic amputation at level between knee and ankle, unspecified lower leg, initial encounter

S88.911A Complete traumatic amputation of right lower leg, level unspecified, initial

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encounter

S88.912A Complete traumatic amputation of left lower leg, level unspecified, initial encounter

S88.919A Complete traumatic amputation of unspecified lower leg, level unspecified, initial encounter

S88.921A Partial traumatic amputation of right lower leg, level unspecified, initial encounter

S88.922A Partial traumatic amputation of left lower leg, level unspecified, initial encounter

S88.929A Partial traumatic amputation of unspecified lower leg, level unspecified, initial encounter

S91.001A Unspecified open wound, right ankle, initial encounter

S91.002A Unspecified open wound, left ankle, initial encounter

S91.009A Unspecified open wound, unspecified ankle, initial encounter

S91.011A Laceration without foreign body, right ankle, initial encounter

S91.012A Laceration without foreign body, left ankle, initial encounter

S91.019A Laceration without foreign body, unspecified ankle, initial encounter

S91.021A Laceration with foreign body, right ankle, initial encounter

S91.022A Laceration with foreign body, left ankle, initial encounter

S91.029A Laceration with foreign body, unspecified ankle, initial encounter

S91.031A Puncture wound without foreign body, right ankle, initial encounter

S91.032A Puncture wound without foreign body, left ankle, initial encounter

S91.039A Puncture wound without foreign body, unspecified ankle, initial encounter

S91.041A Puncture wound with foreign body, right ankle, initial encounter

S91.042A Puncture wound with foreign body, left ankle, initial encounter

S91.049A Puncture wound with foreign body, unspecified ankle, initial encounter

S91.051A Open bite, right ankle, initial encounter

S91.052A Open bite, left ankle, initial encounter

S91.059A Open bite, unspecified ankle, initial encounter

S91.101A Unspecified open wound of right great toe without damage to nail, initial encounter

S91.102A Unspecified open wound of left great toe without damage to nail, initial encounter

S91.103A Unspecified open wound of unspecified great toe without damage to nail, initial encounter

S91.104A Unspecified open wound of right lesser toe(s) without damage to nail, initial encounter

S91.105A Unspecified open wound of left lesser toe(s) without damage to nail, initial encounter

ICD-10-CM - Code and Description

S91.106A Unspecified open wound of unspecified lesser toe(s) without damage to nail, initial encounter

S91.109A Unspecified open wound of unspecified toe(s) without damage to nail, initial encounter

S91.111A Laceration without foreign body of right great toe without damage to nail, initial encounter

S91.112A Laceration without foreign body of left great toe without damage to nail, initial encounter

S91.113A Laceration without foreign body of unspecified great toe without damage to nail, initial encounter

S91.114A Laceration without foreign body of right lesser toe(s) without damage to nail, initial encounter

S91.115A Laceration without foreign body of left lesser toe(s) without damage to nail, initial encounter

S91.116A Laceration without foreign body of unspecified lesser toe(s) without damage to nail, initial encounter

S91.119A Laceration without foreign body of unspecified toe without damage to nail, initial encounter

S91.121A Laceration with foreign body of right great toe without damage to nail, initial encounter

S91.122A Laceration with foreign body of left great toe without damage to nail, initial encounter

S91.123A Laceration with foreign body of unspecified great toe without damage to nail, initial encounter

S91.124A Laceration with foreign body of right lesser toe(s) without damage to nail, initial encounter

S91.125A Laceration with foreign body of left lesser toe(s) without damage to nail, initial encounter

S91.126A Laceration with foreign body of unspecified lesser toe(s) without damage to nail, initial encounter

S91.129A Laceration with foreign body of unspecified toe(s) without damage to nail, initial encounter

S91.131A Puncture wound without foreign body of right great toe without damage to nail, initial encounter

S91.132A Puncture wound without foreign body of left great toe without damage to nail, initial encounter

S91.133A Puncture wound without foreign body of unspecified great toe without damage to nail, initial encounter

S91.134A Puncture wound without foreign body of right lesser toe(s) without damage to nail, initial encounter

S91.135A Puncture wound without foreign body of left lesser toe(s) without damage to nail, initial encounter

ICD-10-CM - Code and Description

S91.136A Puncture wound without foreign body of unspecified lesser toe(s) without damage to nail, initial encounter

S91.139A Puncture wound without foreign body of unspecified toe(s) without damage to nail, initial encounter

S91.141A Puncture wound with foreign body of right great toe without damage to nail, initial encounter

S91.142A Puncture wound with foreign body of left great toe without damage to nail, initial encounter

S91.143A Puncture wound with foreign body of unspecified great toe without damage to nail, initial encounter

S91.144A Puncture wound with foreign body of right lesser toe(s) without damage to nail, initial encounter

S91.145A Puncture wound with foreign body of left lesser toe(s) without damage to nail, initial encounter

S91.146A Puncture wound with foreign body of unspecified lesser toe(s) without damage to nail, initial encounter

S91.149A Puncture wound with foreign body of unspecified toe(s) without damage to nail, initial encounter

S91.151A Open bite of right great toe without damage to nail, initial encounter

S91.152A Open bite of left great toe without damage to nail, initial encounter

S91.153A Open bite of unspecified great toe without damage to nail, initial encounter

S91.154A Open bite of right lesser toe(s) without damage to nail, initial encounter

S91.155A Open bite of left lesser toe(s) without damage to nail, initial encounter

S91.156A Open bite of unspecified lesser toe(s) without damage to nail, initial encounter

S91.159A Open bite of unspecified toe(s) without damage to nail, initial encounter

S91.201A Unspecified open wound of right great toe with damage to nail, initial encounter

S91.202A Unspecified open wound of left great toe with damage to nail, initial encounter

S91.203A Unspecified open wound of unspecified great toe with damage to nail, initial encounter

S91.204A Unspecified open wound of right lesser toe(s) with damage to nail, initial encounter

S91.205A Unspecified open wound of left lesser toe(s) with damage to nail, initial encounter

S91.206A Unspecified open wound of unspecified lesser toe(s) with damage to nail, initial encounter

S91.209A Unspecified open wound of unspecified toe(s) with damage to nail, initial encounter

S91.211A Laceration without foreign body of right great toe with damage to nail, initial encounter

ICD-10-CM - Code and Description

S91.212A Laceration without foreign body of left great toe with damage to nail, initial encounter

S91.213A Laceration without foreign body of unspecified great toe with damage to nail, initial encounter

S91.214A Laceration without foreign body of right lesser toe(s) with damage to nail, initial encounter

S91.215A Laceration without foreign body of left lesser toe(s) with damage to nail, initial encounter

S91.216A Laceration without foreign body of unspecified lesser toe(s) with damage to nail, initial encounter

S91.219A Laceration without foreign body of unspecified toe(s) with damage to nail, initial encounter

S91.221A Laceration with foreign body of right great toe with damage to nail, initial encounter

S91.222A Laceration with foreign body of left great toe with damage to nail, initial encounter

S91.223A Laceration with foreign body of unspecified great toe with damage to nail, initial encounter

S91.224A Laceration with foreign body of right lesser toe(s) with damage to nail, initial encounter

S91.225A Laceration with foreign body of left lesser toe(s) with damage to nail, initial encounter

S91.226A Laceration with foreign body of unspecified lesser toe(s) with damage to nail, initial encounter

S91.229A Laceration with foreign body of unspecified toe(s) with damage to nail, initial encounter

S91.231A Puncture wound without foreign body of right great toe with damage to nail, initial encounter

S91.232A Puncture wound without foreign body of left great toe with damage to nail, initial encounter

S91.233A Puncture wound without foreign body of unspecified great toe with damage to nail, initial encounter

S91.234A Puncture wound without foreign body of right lesser toe(s) with damage to nail, initial encounter

S91.235A Puncture wound without foreign body of left lesser toe(s) with damage to nail, initial encounter

S91.236A Puncture wound without foreign body of unspecified lesser toe(s) with damage to nail, initial encounter

S91.239A Puncture wound without foreign body of unspecified toe(s) with damage to nail, initial encounter

S91.241A Puncture wound with foreign body of right great toe with damage to nail, initial encounter

ICD-10-CM - Code and Description

S91.242A Puncture wound with foreign body of left great toe with damage to nail, initial encounter

S91.243A Puncture wound with foreign body of unspecified great toe with damage to nail, initial encounter

S91.244A Puncture wound with foreign body of right lesser toe(s) with damage to nail, initial encounter

S91.245A Puncture wound with foreign body of left lesser toe(s) with damage to nail, initial encounter

S91.246A Puncture wound with foreign body of unspecified lesser toe(s) with damage to nail, initial encounter

S91.249A Puncture wound with foreign body of unspecified toe(s) with damage to nail, initial encounter

S91.251A Open bite of right great toe with damage to nail, initial encounter

S91.252A Open bite of left great toe with damage to nail, initial encounter

S91.253A Open bite of unspecified great toe with damage to nail, initial encounter

S91.254A Open bite of right lesser toe(s) with damage to nail, initial encounter

S91.255A Open bite of left lesser toe(s) with damage to nail, initial encounter

S91.256A Open bite of unspecified lesser toe(s) with damage to nail, initial encounter

S91.259A Open bite of unspecified toe(s) with damage to nail, initial encounter

S91.301A Unspecified open wound, right foot, initial encounter

S91.302A Unspecified open wound, left foot, initial encounter

S91.309A Unspecified open wound, unspecified foot, initial encounter

S91.311A Laceration without foreign body, right foot, initial encounter

S91.312A Laceration without foreign body, left foot, initial encounter

S91.319A Laceration without foreign body, unspecified foot, initial encounter

S91.321A Laceration with foreign body, right foot, initial encounter

S91.322A Laceration with foreign body, left foot, initial encounter

S91.329A Laceration with foreign body, unspecified foot, initial encounter

S91.331A Puncture wound without foreign body, right foot, initial encounter

S91.332A Puncture wound without foreign body, left foot, initial encounter

S91.339A Puncture wound without foreign body, unspecified foot, initial encounter

S91.341A Puncture wound with foreign body, right foot, initial encounter

S91.342A Puncture wound with foreign body, left foot, initial encounter

S91.349A Puncture wound with foreign body, unspecified foot, initial encounter

S91.351A Open bite, right foot, initial encounter

S91.352A Open bite, left foot, initial encounter

S91.359A Open bite, unspecified foot, initial encounter

S96.021A Laceration of muscle and tendon of long flexor muscle of toe at ankle and foot level, right foot, initial encounter

ICD-10-CM - Code and Description

S96.022A Laceration of muscle and tendon of long flexor muscle of toe at ankle and foot level, left foot, initial encounter

S96.029A Laceration of muscle and tendon of long flexor muscle of toe at ankle and foot level, unspecified foot, initial encounter

S96.121A Laceration of muscle and tendon of long extensor muscle of toe at ankle and foot level, right foot, initial encounter

S96.122A Laceration of muscle and tendon of long extensor muscle of toe at ankle and foot level, left foot, initial encounter

S96.129A Laceration of muscle and tendon of long extensor muscle of toe at ankle and foot level, unspecified foot, initial encounter

S96.221A Laceration of intrinsic muscle and tendon at ankle and foot level, right foot, initial encounter

S96.222A Laceration of intrinsic muscle and tendon at ankle and foot level, left foot, initial encounter

S96.229A Laceration of intrinsic muscle and tendon at ankle and foot level, unspecified foot, initial encounter

S96.821A Laceration of other specified muscles and tendons at ankle and foot level, right foot, initial encounter

S96.822A Laceration of other specified muscles and tendons at ankle and foot level, left foot, initial encounter

S96.829A Laceration of other specified muscles and tendons at ankle and foot level, unspecified foot, initial encounter

S96.921A Laceration of unspecified muscle and tendon at ankle and foot level, right foot, initial encounter

S96.922A Laceration of unspecified muscle and tendon at ankle and foot level, left foot, initial encounter

S96.929A Laceration of unspecified muscle and tendon at ankle and foot level, unspecified foot, initial encounter

S98.011A Complete traumatic amputation of right foot at ankle level, initial encounter

S98.012A Complete traumatic amputation of left foot at ankle level, initial encounter

S98.019A Complete traumatic amputation of unspecified foot at ankle level, initial encounter

S98.021A Partial traumatic amputation of right foot at ankle level, initial encounter

S98.022A Partial traumatic amputation of left foot at ankle level, initial encounter

S98.029A Partial traumatic amputation of unspecified foot at ankle level, initial encounter

S98.111A Complete traumatic amputation of right great toe, initial encounter

S98.112A Complete traumatic amputation of left great toe, initial encounter

S98.119A Complete traumatic amputation of unspecified great toe, initial encounter

S98.121A Partial traumatic amputation of right great toe, initial encounter

S98.122A Partial traumatic amputation of left great toe, initial encounter

ICD-10-CM - Code and Description

S98.129A Partial traumatic amputation of unspecified great toe, initial encounter

S98.131A Complete traumatic amputation of one right lesser toe, initial encounter

S98.132A Complete traumatic amputation of one left lesser toe, initial encounter

S98.139A Complete traumatic amputation of one unspecified lesser toe, initial encounter

S98.141A Partial traumatic amputation of one right lesser toe, initial encounter

S98.142A Partial traumatic amputation of one left lesser toe, initial encounter

S98.149A Partial traumatic amputation of one unspecified lesser toe, initial encounter

S98.211A Complete traumatic amputation of two or more right lesser toes, initial encounter

S98.212A Complete traumatic amputation of two or more left lesser toes, initial encounter

S98.219A Complete traumatic amputation of two or more unspecified lesser toes, initial encounter

S98.221A Partial traumatic amputation of two or more right lesser toes, initial encounter

S98.222A Partial traumatic amputation of two or more left lesser toes, initial encounter

S98.229A Partial traumatic amputation of two or more unspecified lesser toes, initial encounter

S98.311A Complete traumatic amputation of right midfoot, initial encounter

S98.312A Complete traumatic amputation of left midfoot, initial encounter

S98.319A Complete traumatic amputation of unspecified midfoot, initial encounter

S98.321A Partial traumatic amputation of right midfoot, initial encounter

S98.322A Partial traumatic amputation of left midfoot, initial encounter

S98.329A Partial traumatic amputation of unspecified midfoot, initial encounter

S98.911A Complete traumatic amputation of right foot, level unspecified, initial encounter

S98.912A Complete traumatic amputation of left foot, level unspecified, initial encounter

S98.919A Complete traumatic amputation of unspecified foot, level unspecified, initial encounter

S98.921A Partial traumatic amputation of right foot, level unspecified, initial encounter

S98.922A Partial traumatic amputation of left foot, level unspecified, initial encounter

S98.929A Partial traumatic amputation of unspecified foot, level unspecified, initial encounter

T81.31XA Disruption of external operation (surgical) wound, not elsewhere classified, initial encounter

T81.32XA Disruption of internal operation (surgical) wound, not elsewhere classified, initial encounter

Medicare Claims Processing Manual

Chapter 6 - SNF Inpatient Part A Billing and SNF Consolidated Billing

Table of Contents

(Rev. 3220, Issued: 03-16-15)

10.1 - Consolidated Billing Requirement for SNFs

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

Section 4432 (b) of the Balanced Budget Act (BBA) requires consolidated billing for SNFs. Under the consolidated billing requirement, the SNF must submit ALL Medicare claims for ALL the services that its residents receive under Part A, **except** for certain excluded services described in §§20.1 – 20.3, **and** for all physical, occupational and speech-language pathology services received by residents under Part B. A SNF resident is defined as a beneficiary who is admitted to a Medicare participating SNF or the participating, Medicare-certified, distinct part unit (DPU) of a larger institution. When such a beneficiary leaves the facility (or the DPU), the beneficiary's status as a SNF resident for consolidated billing purposes (along with the SNF's responsibility to furnish or make arrangements for needed services) ends. It may be triggered by any one of the following events:

- The beneficiary is admitted as an inpatient to a Medicare-participating hospital or critical access hospital (CAH), or as a resident to another SNF;
- The beneficiary dies; or
- The beneficiary is formally discharged (or otherwise departs) from the SNF or DPU, unless the beneficiary is readmitted (or returns) to that or another SNF before midnight of the same day. A "discharge" from the Medicare-certified DPU includes situations in which the beneficiary is moved from the DPU to a Medicare non-certified area within the same institution.

These requirements apply only to Medicare fee-for-service beneficiaries residing in a participating SNF or DPU.

Claims are submitted to the *A/B MAC (A)* on *the ASC X12 837 institutional format or* Form CMS-1450. All services billed by the SNF (including those furnished under arrangements with an outside supplier) for a resident of a SNF in a covered Part A stay are included in the SNF's Part A bill. If a resident is not in a covered Part A stay (Part A benefits exhausted, post hospital or level of care requirements not met), the SNF is required to bill for all physical therapy, occupational therapy, and/or speech-language pathology services provided to a SNF resident under Part B. The consolidated billing provision requires that effective for services and items furnished on or after July 1, 1998, payment is made directly to the SNF.

Thus, SNFs are no longer able to "unbundle" services to an outside supplier that can then submit a separate bill directly to an *A/B MAC (B)* or DME *MAC* for residents in a Part A stay, or for SNF residents receiving physical therapy, occupational therapy, and/or speech-language pathology services paid under Part B. Instead, the SNF must furnish the services either directly or under an arrangement with an outside supplier or provider of services in which the SNF (rather than the supplier or provider of services) bills Medicare. Medicare does not pay amounts that are due a provider to any other person under assignment, or power of attorney, or any other direct payment arrangement. As a result, the outside supplier must look to the SNF (rather than the

MAC or the beneficiary) for payment. The SNF may collect any applicable deductible or coinsurance from the beneficiary.

NOTE: The requirements for participation at 42 CFR 483.12(a)(2)(i)-(vi) specify the limited circumstances under which a resident can be involuntarily moved out of a Medicare-certified SNF or DPU. These circumstances can include situations in which the resident's health has improved to the point where he or she no longer needs SNF care. However, if a resident has exhausted Part A benefits but nevertheless continues to require SNF care, he or she cannot be moved out of the Medicare-certified SNF or DPU for reasons other than those specified in the regulations. For example, the resident cannot be moved to avoid the consolidated billing requirements, or to establish a new benefit period. The determination to move the beneficiary out of the SNF or DPU must not be made on the basis of the beneficiary having exhausted his or her benefits, but rather, on the beneficiary's lack of further need for SNF care. Once a resident of a Medicare-certified DPU ceases to require SNF care, he or she may then be moved from the DPU to the Medicare non-certified area of the institution. As discussed above, such a move would end the beneficiary's status as a SNF "resident" for consolidated billing purposes.

Enforcement of SNF consolidated billing is done through editing in Medicare claims processing systems using lists of Healthcare Common Procedure Coding System (HCPCS) codes that are subject to the consolidated billing provision of SNF PPS. In order to assure proper payment in all settings, Medicare systems must edit for services, provided to SNF beneficiaries, both included and excluded from SNF CB. Transmittals with instructions provide updates to previous lists of the exclusions, and some inclusions, to SNF CB. Such transmittals can be found on the CMS Web site at: http://www.cms.hhs.gov/manuals/

The list of HCPCS codes enforcing SNF CB may be updated each quarter. For the notice on SNF CB for the quarter beginning January, separate instructions are published for all *MAC* types. Since this is usually the only quarter in which new permanent HCPCS codes are produced, this recurring update is referred to as an annual update. Other updates for the remaining quarters of the year will occur as needed prior to the next annual update. In lieu of another update, editing based on the prior list of codes remains in effect. *The* non-January quarterly updates *will be specific about which types of MACs are affected. (i.e., A/B MAC (A), A/B MAC (B), DME MAC). Th*e applicability of the instruction will be clear in each update. All future updates will be submitted via a Recurring Update Notification form.

- **Effective July 1, 1998**, consolidated billing became effective for those services and items that were not specifically excluded by law from the SNF prospective payment system (PPS) when they were furnished to residents of a SNF in a covered Part A stay and also includes physical therapy, occupational therapy, and/or speech-language pathology services in a noncovered stay. SNFs became subject to consolidated billing once they transitioned to PPS. Due to systems limitations, consolidated billing was not implemented at that time for residents not in a Part A covered stay (Part A benefits exhausted, post-hospital or level of care requirements not met). Section 313 of the Benefits Improvement and Protection Act (BIPA) of 2000 subsequently repealed this aspect of consolidated billing altogether, except for physical therapy, occupational

therapy, and/or speech-language pathology services. In addition, for either type of resident, the following requirements were also delayed: (1) that the physicians forward the technical portions of their services to the SNF; and (2) the requirement that the physician enter the facility provider number of the SNF on the claim.

- **Effective July 1, 1998,** under 42 CFR 411.15(p)(3)(iii) published on May 12, 1998, a number of other services are excluded from consolidated billing. The hospital outpatient department will bill these services directly to the *A/B MAC (A)* when furnished on an outpatient basis by a hospital or a critical access hospital. Physician's and other practitioner's professional services will be billed directly to the *A/B MAC (B)*. Hospice care and the ambulance trip that initially conveys an individual to the SNF to be admitted as a resident, or that conveys an individual from the SNF when discharged and no longer considered a resident, are also excluded from SNF PPS consolidated billing.

- **Effective April 1, 2000**, §103 of the Balanced Budget Refinement Act (BBRA) excluded additional services and drugs from consolidated billing that therefore had to be billed directly to the *A/B MAC (B)* or DME *MAC* by the provider or supplier for payment. As opposed to whole categories of services being excluded, only certain specific services and drugs (identified by HCPCS code) were excluded in each category. These exclusions included ambulance services furnished in conjunction with renal dialysis services, certain specific chemotherapy drugs and their administration services, certain specific radioisotope services, and certain customized prosthetic devices.

- **Effective January 1, 2001**, §313 of the BIPA, restricted SNF consolidated billing to the majority of services provided to beneficiaries in a Medicare Part A covered stay and only to therapy services provided to beneficiaries in a noncovered stay.

- Effective for claims with dates of service on or after April 1, 2001, for those services and supplies that were not specifically excluded by law and are furnished to a SNF resident covered under the Part A benefit, physicians are required to forward the technical portions of any services to the SNF to be billed by the SNF to the *A/B MAC (A)* for payment.

30 - Billing SNF PPS Services

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

SNFs and hospital swing bed providers are required to report inpatient Part A PPS billing data as follows. Refer to the Medicare Claims Processing Manual, Chapter 25, "Completing and Processing the *Form* CMS-1450 Data Set," for *a description of claim* data elements.

- In addition to the required fields identified in Chapter 25, SNFs must also report occurrence span code "70" to indicate the dates of a qualifying hospital

stay of at least three consecutive days which qualifies the beneficiary for SNF services.

- Separate bills are required for each Federal fiscal year for admissions that span the annual update effective date (October 1).

- Use Type of Bill 21X for SNF inpatient services or 18X for hospital swing bed services.

- Revenue Code 0022. This code indicates that this claim is being paid under the SNF PPS. This revenue code can appear on a claim as often as necessary to indicate different HIPPS Rate Code(s) and assessment periods.

- Effective for claims with dates of service on or after January, 1 2011, there must be an occurrence code 50 (assessment date) for each assessment period represented on the claim with revenue code 0022. The date of service reported with occurrence code 50 must contain the ARD. An occurrence code 50 is not required with default HIPPS code AAAxx (where 'xx' equals varying digits). In addition, for OMRA related AIs 05, 06, 0A, 0B, 0C, 12, 13, 14, 15, 16, 17, 1A, 1B, 1C, 24, 25, 26, 2A, 2B, 2C, 34, 35, 36, 3A, 3B, 3C, 44, 45, 46, 4A, 4B, 4C, 54, 55, 56, 5A, 5B, 5C where 2 HIPPS may be produced by one assessment, providers need only report one occurrence code 50 to cover both HIPPS codes.

- HCPCS/Rates field must contain a 5-digit "HIPPS Code". The first three positions of the code contain the RUG group and the last two positions of the code contain a 2-digit assessment indicator (AI) code. See Chapter 6 of the MDS RAI manual for valid RUG codes and AI codes.

- SNF and SB PPS providers must bill the HIPPS codes on the claim form in the order in which the beneficiary received that level of care.

- Service Units must contain the number of covered days for each HIPPS rate code.

  NOTE: Fiscal Intermediary Shared System (FISS) requirement:

  > The sum of all covered units reported on all revenue code 0022 lines should be equal to the covered days field less the number of days reported in an OSC 77. (**NOTE**: The covered units field is utilized in FISS and has no mapping to the 837 or paper claim).

- Total Charges should be zero for revenue code 0022.

- When a HIPPS rate code of RUAxx, RUBxx , RUCxx, RULxx and/or RUXxx is present, a minimum of two rehabilitation therapy ancillary codes are required (revenue code 042x and/or, 043x and/or, 044x). When a HIPPS rate code of RHAxx, RHBxx, RHCxx, RHLxx, RHXxx, RLAxx, RLBxx, RLXxx, RMAxx, RMBxx, RMCxx, RMLxx, RMXxx, RVAxx, RVBxx, RVCxx, RVLxx, and/or RVXxx is present, a minimum of one rehabilitation therapy

ancillary revenue code is required (revenue code 042x, 043x, or 044x. Bills that are missing required rehabilitation therapy ancillary revenue codes are to be returned to the SNF for resubmission.

- The accommodation revenue code 018x, leave of absence is reported when the beneficiary is on a leave of absence and is not present at the midnight census taking time.

- Principal Diagnosis Code - SNFs enter the ICD-CM code for the principal diagnosis in the appropriate form locator. The code must be reported according to Official ICD-CM Guidelines for Coding and Reporting, as required by the Health Insurance Portability and Accountability Act (HIPAA), including any applicable guidelines regarding the use of V codes *for ICD-9*. The code must be the full ICD-CM diagnosis code, including all five digits *(for ICD-9) or all seven digits (for ICD-10)* where applicable.

- Other Diagnosis Codes Required – The SNF enters the full ICD-CM codes for up to eight additional conditions in the appropriate form locator. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in the ICD-CM guidelines.

40.5 - Billing Procedures for Periodic Interim Payment (PIP) Method of Payment

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

The SNFs using the PIP method of payment follow the regular billing instructions in Medicare Claim Processing Manual, Chapter 2*5*.

See the Medicare Claims Processing Manual, Chapter 1, "General Billing Requirements," §80.4, for requirements SNFs must meet and *A/B MACs (A)* must monitor to continue PIP reimbursement. Refer to the Medicare Claims Processing Manual, Chapter 25 for further information about *completing the claim*.

40.6 - Total and Noncovered Charges

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

ASC X12 837 Institutional Claim

See the related implementation guide on the Washington Publishing Company Web site at http://www.wpc-edi.com/

Form CMS -1450

For each cost center for which a separate charge is billed (type of accommodation or ancillary), a revenue code is assigned *and is entered on the claim with the related*

*charges. On Form CMS-1450 t*he appropriate numeric revenue code is entered in FL 42 to explain each charge in FL 47.

Additionally, there is no fixed "Total" line in the charge area. Instead, revenue code "0001" is always entered last in FL 42. Thus, the adjacent charge entry, in FL 47, is the sum of charges billed. This is also the same line on which noncovered charges, if any, in FL 48, are summed.

The total charge for all services, covered and noncovered, will generally be shown. See §40.6.1 below, for certain exceptions. In the "noncovered charges" column (FL48) enter the amount of any noncovered charge except where:

- The *A/B MAC (A)* has notified the SNF that payment can be made under the limitation of liability provisions; and

- A payer primary to Medicare is involved. (See the Medicare Secondary Payer [MSP] Manual, Chapter 3, "MSP Provider Billing Requirements," and Chapter 4, "Contractor Prepayment Processing Requirements.")

Where a bill is submitted for a period including both covered and noncovered days (e.g., days submitted for noncovered level of care), the SNF must list the charges for noncovered days under noncovered charges.

Refer to the Medicare Claims Processing Manual, Chapter 25 *for further information about completing the claim*.

40.6.1 - Services in Excess of Covered Services

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

Where items and services are furnished which are more expensive or in excess of the services covered by the program, the SNF will make the following entries in the Total Charges and Noncovered fields on the bill:

- If the patient did not request such excess or more expensive services, the patient may not be charged for them, and only the services covered by the program are shown in total charges. No entry is made in noncovered charges in this situation. (However, where all patients are routinely billed for such excess or more expensive items, total charges **may** reflect the excess items or services as discussed in total and noncovered charges, above.);

- If the patient did request such excess or more expensive services, the SNF may charge the patient for them. In this case, the SNF show the line item total charge (any customary charges covered by the program plus the excess charges). The excess charges that will be billed to the patient are shown in noncovered charges.

- In the same situation as above, except that the SNF will not bill the patient for the excess services. Instead the SNF will show only the customary charges for covered services in total charges and make no entry in noncovered charges.

40.6.3 - Reporting Accommodations on the Claims

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

See the Medicare Benefit Policy Manual, Chapter 1, "Inpatient Hospital Services," for an explanation of the rules when other than semi-private accommodations are furnished that apply to SNFs as well as hospitals. The type of accommodation furnished at the time of the SNF census-taking hour determines the applicable revenue code. Where a patient is admitted with the expectation that he will remain overnight, but on the same day is discharged, dies, or is transferred prior to the census, the revenue code is determined by the type of accommodation furnished at the time of the patient's discharge, death, or transfer.

Payment is based on the PPS rate, not on accommodation levels. See §40.6.1 where the patient requests more expensive accommodations or patient convenience items.

The determination of charges does not affect the determination of inpatient utilization days or when a patient may be considered an inpatient for Medicare purposes as outlined in the Medicare Benefit Policy Manual, Chapter 8, "Coverage of Extended Care (SNF) Services Under Hospital Insurance," §50 and §60.2. Refer to the Medicare Claims Processing Manual, Chapter 25 for further information about billing.

SNFs *show total* charges for accommodation for the entire billing period and charges for any noncovered days in noncovered charges.)

The accommodation days do not include the day of death or discharge, even where the discharge was late. However, where the SNF customarily makes an extra charge for a late discharge, they include this amount in *total charges with* the appropriate accommodation revenue code. The day of discharge is not included in Covered Days even though an extra charge is included. Where the late discharge was for the patient's convenience and not for any medical necessity, SNFs enter the charge for late discharge as a noncovered charge. Where the late discharge is for a medical reason, the charge is covered. (See the Medicare Benefit Policy Manual, Chapter 8, "Coverage of Extended Care (SNF) Services Under Hospital Insurance," §60.3.)

The charges for accommodations reflect only the total charges for general routine services as defined in §2202.6 and §2203.1 of the Medicare Provider Reimbursement Manual. All charges, which are charged to every patient for every patient day, are included in the routine accommodation charge.

SNFs bill ancillary charges for day of discharge, death or the day on which a leave of absence begins, under the proper revenue code.

Where the patient is discharged on his first day of entitlement or the first day of the SNF participation in the Medicare program, they submit a bill with no accommodation charge, but with ancillary charges.

Where some of the days cannot be paid under Part A because benefits were exhausted before discharge, death, or the day on which a leave of absence began, SNFs show the charges for days after benefits where exhausted under noncovered charges, and enter the appropriate occurrence code, e.g., A3, and the date benefits are exhausted. See the Medicare Claims Processing Manual, Chapter 7, "SNF Part B Billing," §10, for billing under Part B in such circumstances.

40.6.4 - Bills with Covered and Noncovered Days

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

Any combination of covered and noncovered days may be billed on the same bill. It is important to record a day or charge as covered or noncovered because of the following:

- Beneficiary utilization is recorded based upon days during which the patient received hospital or SNF accommodations, including days paid by Medicare and days for which the provider was held liable for reasons other than medical necessity or custodial care.

- The provider may claim credit on its cost report only for covered accommodations, days and charges for which actual payment is made. Provider liable days and charges are not included on the cost report. Data from the bill payment process are used in preparing the cost report.

SNFs show noncovered charges for denied or noncovered days, which will not be paid. The SNF submits the bill with occurrence span code 76 and completes the from/through dates to report periods where the beneficiary is liable. Occurrence span code 77 is used to report periods of noncovered care where the SNF is liable. If the beneficiary is receiving a skilled level of care during a period of provider liability, the provider should submit these days as covered. If applicable, the FISS system will automatically assign occurrence code A3 indicating the last date for which benefits are available or the date benefits were exhausted.

The *A/B MAC (A)* will use Occurrence Span Code 79 (a payer only code sent to CWF) to report periods of noncovered care due to lack of medical necessity or custodial care for which the provider is held liable. Periods of beneficiary liability and provider liability may be reported on one bill. Report all noncovered days.

See Chapter 25, Completing and Processing the CMS-1450 Data Set, for a complete description of *billing* data elements. See the Medicare Claims Processing Manual, Chapter 30, "Limitation on Liability," for determining SNF liability.

The provider is always liable unless the appropriate notice is issued. If the SNF issues the appropriate notice, and the beneficiary agrees to make payment either personally

or through a private insurer, the days will not be charged towards the 100-day benefit period. Notice requirements for periods of noncoverage are found in Chapter 30, §70.

40.8 - Billing in Benefits Exhaust and No-Payment Situations

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

An SNF is required to submit a bill for a beneficiary that has started a spell of illness under the SNF Part A benefit for every month of the related stay even though no benefits may be payable. CMS maintains a record of all inpatient services for each beneficiary, whether covered or not. The related information is used for national healthcare planning and also enables CMS to keep track of the beneficiary's benefit period. These bills have been required in two situations: 1) when the beneficiary has exhausted his/her 100 covered days under the Medicare SNF benefit (referred to below as benefits exhaust bills) and 2) when the beneficiary no longer needs a Medicare covered level of care (referred to below as no-payment bills).

For benefits exhaust bills, an SNF must submit monthly a benefits exhaust bill for those patients that continue to receive skilled care and also when there is a change in the level of care regardless of whether the benefits exhaust bill will be paid by Medicaid, a supplemental insure, or private payer. There are two types of benefits exhaust claims: 1) Full benefits exhaust claims: no benefit days remain in the beneficiary's applicable benefit period for the submitted statement covers from/through date of the claim and 2) Partial benefits exhaust claims: only one or some benefit days, in the beneficiary's applicable benefit period, remain for the submitted statement covers from/through date of the claim. Monthly claim submission of both types of benefits exhaust bills are required in order to extend the beneficiary's applicable benefit period posted in the Common Working File (CWF). Furthermore, when a change in level of care occurs after exhaustion of a beneficiary's covered days of care, the provider must submit the benefits exhaust bill in the next billing cycle indicating that active care has ended for the beneficiary.

NOTE: Part B 22x bill types must be submitted after the benefits exhaust claim has been submitted and processed.

In addition, SNF providers must submit no-payment bills for beneficiaries that have previously received Medicare-covered skilled care and subsequently dropped to a non-covered level of care but continue to reside in a Medicare-certified area of the facility. Consolidated Billing (CB) legislation indicates that physical therapy, occupational therapy, and speech language pathology services furnished to SNF residents are always subject to SNF CB. This applies even when a resident receives the therapy during a non-covered stay in which the beneficiary who is not eligible for Part A extended care benefit still resides in an institution (or part thereof) that is Medicare-certified as a SNF. SNF CB edits require the SNF to bill for these services on a 22x (inpatient part B) bill type. **NOTE**: Unlike with benefits exhaust claims, Part B 22x bill types may be submitted prior to the submission of bill type 210 no payment claims.

If a facility has a separate, distinct non-skilled area or wing then beneficiaries may be discharged to this area using the appropriate patient discharge status code and no-payment bills would not be required. In addition, SNF CB legislation for therapy services would not apply for these beneficiaries.

No-payment bills are not required for non-skilled beneficiary admissions. As indicated above, they are only required for beneficiaries that have previously received skilled covered care and subsequently dropped to non-covered care and continue to reside in the certified area of the facility.

NOTE: Providers may bill benefits exhaust and no payment claims using the default HIPPS code AAA00 in addition to an appropriate room & board revenue code only. No further ancillary services need be billed on these claims.

SNF providers and *A/B MACs (A)* shall follow the billing guidance provided below for the proper billing of benefits exhaust bills and no-payment bills.

1) SNF providers shall submit benefits exhaust claims for those beneficiaries that continue to receive skilled services as follows:

   a) Full or partial benefits exhaust claim. (Submitted monthly)

      i) Bill Type = Use appropriate covered bill type (i.e., 211, 212, 213 or 214 for SNF and 181, 182, 183 or 184 for Swing Bed (SB). **NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).

      ii) Occurrence Span Code 70 with the qualifying hospital stay dates.

      iii) Covered Days and Charges = Submit all covered days and charges as if beneficiary had days available.

      iv) Value Code 09 (First year coinsurance amount) 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response).

      v) Patient Status Code = Use appropriate code.

   b) Benefits exhaust claim with a drop in level of care within the month; Patient remains in the Medicare-certified area of the facility after the drop in level of care.

      i) Bill Type = Use appropriate bill type (i.e., 212 or 213 for SNF and 182 or 183 for SB. **NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).

      ii) Occurrence Span Code 70 with the qualifying hospital stay dates.

      iii) Occurrence Code 22 (date active care ended, i.e., date covered SNF level of care ended) = include the date active care ended; this should match the statement covers through date on the claim.

iv) Covered Days and Charges = Submit all covered days and charges as if the beneficiary had days available up until the date active care ended.

v) Value Code 09 (First year coinsurance amount) 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response).

vi) Patient Status Code = 30 (still patient).

c) Benefits exhaust claim with a patient discharge.

i) Bill Type = 211 or 214 for SNF and 181 or 184 for SB (**NOTE:** Bill types 210 or 180 should not be used for benefits exhaust claims submission).

ii) Covered Days and Charges = Submit all covered days and charges as if beneficiary had days available up until the date active care ended.

iii) Value Code 09 (First year coinsurance amount) 1.00 (If applicable, the FISS will assign the correct coinsurance amount based off the CWF response).

iv) Patient Status Code = Use appropriate code other than patient status code 30 (still patient).

NOTE: Billing all covered days and charges allow the Common Working File (CWF) to assign the correct benefits exhaust denial to the claim and appropriately post the claim to the patient's benefit period. Benefits exhaust bills must be submitted monthly.

2) SNF providers shall submit no-payment claims for beneficiaries that previously dropped to non-skilled care and continue to reside in the Medicare-certified area of the facility using the following options.

a) Patient previously dropped to non-skilled care. Provider needs Medicare denial notice for other insurers.

i) Bill Type = 210 (SNF no-payment bill type) or 180 (SB no-payment bill type)

ii) Statement Covers From and Through Dates = days provider is billing, which may be submitted as frequently as monthly, in order to receive a denial for other insurer purposes. No-payment billing shall start the day following the date active care ended.

iii) Days and Charges = Non-covered days and charges beginning with the day after active care ended.

iv) Condition Code 21 (billing for denial).

v) Patient Status Code = Use appropriate code.

b) Patient previously dropped to non-skilled care. In these cases, the provider must only submit the final discharge bill that may span multiple months but must be as often as necessary to meet timely filing guidelines.

i) Bill Type = 210 (SNF no-payment bill type) or 180 (SB no-payment bill type)

ii) Statement Covers From and Through Dates = days billed by the provider, which may span multiple months, in order to show final discharge of the patient. No-payment billing shall start the day following the date active care ended.

iii) Days and Charges = Non-covered days and charges beginning with the day after active care ended.

iv) Condition Code 21 (billing for denial).

v) Patient Status Code = Use appropriate code other than patient status code 30 (still patient).

NOTE: No pay bills may span both provider and Medicare fiscal year end dates.

Refer to Chapter 25for further information about billing.

40.9 - Other Billing Situations

(Rev. 3220, Issued: 03-16-15, Effective: ICD-10: Upon Implementation of ICD-10, ASC-X12: 01-01-12, Implementation: 10-01-14, ICD-10: Upon Implementation of ICD-10 ASC X12: 09-16-14)

A. Demand Bills

Where the SNF believes that a covered level of care has ended but the beneficiary disagrees, they report occurrence code 21 (UR notice received) or 22 (date active care ended) as applicable and condition code 20 indicating the beneficiary believes the services are covered beyond the occurrence date.

See the Medicare Claims Processing Manual, Chapter 1, “General Billing Requirements,” §60.3, for instructions on advance beneficiary notices and demand bills.

Refer to the Medicare Claims Processing Manual, Chapter 25 for further information about billing.

B. Request for Denial Notice for Other Insurer

The SNFs complete a noncovered bill and enter condition code 21 to indicate a request for a Medicare denial notice. Refer to Chapter 25 further information about billing.

C. Another Insurer is Primary to Medicare

See the Medicare Secondary Payer (MSP) Manual, Chapter 3, "MSP Provider Billing Requirements" and Chapter 5, "Contractor Prepayment Processing Requirements," for submitting claims for secondary benefits to Medicare. Refer to the Medicare Claims Processing Manual, Chapter 25 for further information about billing.

D. Special MSN Messages

The Medicare Prescription Drug Improvement and Modernization Act of 2003 requires that Medicare Summary Notices (including SNF claims for post-hospital extended care services provided under Part A) report the number of covered days remaining in the given spell of illness. This requirement became effective July 6, 2004.