Section 25

Hospital (Medical/Surgical Acute Care Facility)

25.1 General Information .................................................. 25-3
   25.1.1 Introduction ...................................................... 25-3
   25.1.2 Provider Cost and Reporting ................................. 25-3
   25.1.3 Third Party Liability Reporting ............................. 25-3
   25.1.4 Medicaid Relationship to Medicare ......................... 25-4
   25.1.5 Nursing Facility Admission ................................. 25-4

25.2 Inpatient ............................................................. 25-4
   25.2.1 Enrollment ..................................................... 25-4
      25.2.1.1 Hospital Eligibility Through Change of Ownership ...... 25-4
      25.2.1.2 Psychiatric Hospital/Facility (THSteps-CCP) ............ 25-4
      25.2.1.3 Hospital Ambulance .................................... 25-5
      25.2.1.4 Certified Registered Nurse Anesthetist (CRNA) Services 25-5
      25.2.1.5 Medicaid Managed Care Enrollment ..................... 25-5
      25.2.1.6 Hospital Transplant Centers ............................ 25-5
   25.2.2 Reimbursement .................................................. 25-5
      25.2.2.1 Prospective Payment Methodology .................... 25-5
      25.2.2.2 Client Transfers ....................................... 25-5
      25.2.2.3 Observation Status to Inpatient Admission ............ 25-6
      25.2.2.4 Outliers .................................................. 25-6
      25.2.2.5 Children’s Hospitals .................................. 25-6
      25.2.2.6 Hospital Transplant Center Approval ................... 25-7
   25.2.3 Benefits and Limitations .................................... 25-7
      25.2.3.1 Hysterectomy Services ................................ 25-8
      25.2.3.2 Newborn Services ..................................... 25-8
      25.2.3.3 Psychiatric Services .................................... 25-9
      25.2.3.4 Rehabilitation Services ............................... 25-9
      25.2.3.5 Organ/Tissue Transplant Services ..................... 25-10
   25.2.4 Utilization Review ............................................. 25-12
      25.2.4.1 Responsibilities ....................................... 25-12
      25.2.4.2 Utilization Review Process ........................... 25-12
      25.2.4.3 Recommendations to Enhance Compliance with Texas Medicaid Fee-for-Service Hospital Billing ................................. 25-14
      25.2.4.4 Hospitals Reimbursed Under TEFRA .................... 25-14
      25.2.4.5 Technical Denials (DRG Prospective Payment and TEFRA) 25-14
      25.2.4.6 Acknowledgment of Penalty Notice .................... 25-15
      25.2.4.7 Sanctions ................................................. 25-15
      25.2.4.8 Utilization Review Appeals ........................... 25-15
   25.2.5 Claims Information ............................................ 25-15
      25.2.5.1 Claim Filing Resources ............................... 25-15

25.3 Outpatient ............................................................ 25-15
   25.3.1 Enrollment ..................................................... 25-15
      25.3.1.1 Hospital Ambulatory Surgical Center .................. 25-16
      25.3.1.2 Hospital Ambulance .................................... 25-16
      25.3.1.3 Certified Registered Nurse Anesthetist ............... 25-16
25.3.1.4 Medicaid Managed Care Enrollment ........................................ 25-16
25.3.2 Reimbursement ................................................................. 25-16
  25.3.2.1 Day Surgery .............................................................. 25-16
  25.3.2.2 Revenue Codes (Outpatient Hospital) .......................... 25-19
25.3.3 Benefits and Limitations ................................................... 25-24
  25.3.3.1 Emergency Department Services ................................. 25-24
  25.3.3.2 Hospital Outpatient Observation Room Services ............ 25-25
  25.3.3.3 Outpatient Total Parenteral Hyperalimentation ............. 25-26
  25.3.3.4 Aerosol Treatment ................................................... 25-26
  25.3.3.5 Pentamidine Aerosol ............................................... 25-27
  25.3.3.6 Pulmonary Function Studies ...................................... 25-28
  25.3.3.7 Chemotherapy Administration .................................. 25-28
  25.3.3.8 Bacillus Calmette-Guerin (BCG) Vaccine ..................... 25-28
  25.3.3.9 Tetanus Injections, Acute Care .................................. 25-28
  25.3.3.10 Deep Brain Stimulators ......................................... 25-75
  25.3.3.11 Hospital Laboratory Services .................................. 25-76
  25.3.3.12 Helicobacter Pylori (H. Pylori) .................................. 25-77
  25.3.3.13 Colorectal Cancer Screening ................................... 25-77
  25.3.3.14 Pap Smears ......................................................... 25-77
  25.3.3.15 Nonstress Testing and Contraction Stress Test ............. 25-77
  25.3.3.16 Hospital Radiology Services ................................... 25-82
  25.3.3.17 Computerized Tomography ...................................... 25-93
  25.3.3.18 Technetium TC 99M Tetrofosmin ............................... 25-93
  25.3.3.19 Gamma Knife Radiosurgery ..................................... 25-96
  25.3.3.20 Hospital Radiation Therapy Services ......................... 25-97
  25.3.3.21 Hyperbaric Oxygen Therapy (HBO) ............................. 25-98
  25.3.3.22 Implantable Contraceptive Capsules ......................... 25-109
  25.3.3.23 Occupational and Physical Therapy Services ............... 25-109
  25.3.3.24 Osteopathic Manipulation Treatments (OMT) ............... 25-111
  25.3.3.25 Psychiatric Services ........................................... 25-111
  25.3.3.26 Psychological and Neuropsychological Testing ............. 25-113
  25.3.3.27 Sterilization Services .......................................... 25-113
25.3.4 Utilization Review ......................................................... 25-113
  25.3.4.1 Responsibilities .................................................. 25-113
25.3.5 Claims Information ......................................................... 25-114
  25.3.5.1 Claim Filing Resources .......................................... 25-114
25.1 General Information

25.1.1 Introduction

The information in this section is intended for traditional Texas Medicaid hospital (medical/surgical acute care facility) providers. The section provides information about the Texas Medicaid Program’s benefits, policies, and procedures applicable to acute care hospitals in the inpatient and outpatient setting.

Note: Although Medicaid Managed Care providers must provide all medically necessary Medicaid-covered services to eligible clients, these providers must refer to the respective health plan documentation for specific information about hospital services, claims filing, etc.

Refer to: “PCCM Expansion” on page 7-21.

While this section contains some claims filing and appeals information, hospitals should continue to refer to “Claims Filing” on page 5-1 and “Appeals” on page 6-1 for more comprehensive information about these subjects. An effort has been made to provide comprehensive information about hospital services in this section; however, hospital providers are encouraged to review other sections of the manual for specific requirements for special programs such as the Texas Health Steps-Comprehensive Care Program (THSteps-CCP) and other pertinent material impacting health care providers rendering care in the hospital setting.

Refer to: “Procedure Codes Requiring Prior Authorization” on page 36-343 for a list of procedures requiring prior authorization. Also, review the index and individual sections for other information about prior authorization requirements.

25.1.2 Provider Cost and Reporting

The method of determining reasonable cost is similar to that used by Title XVIII (Medicare). Hospitals must include inpatient and outpatient costs in the cost reports submitted annually. The provider must prepare one copy of the applicable Centers for Medicare & Medicaid Services (CMS) Cost Report Form.

If a change of ownership or provider termination occurs, the cost report is due within five months after the date of the change in ownership or termination. Any request for an extension of time to file should be made on or before the cost report due date and sent to TMHP Medicaid Audit at the address indicated under “Written Communication with TMHP” on page xi. For questions or assistance call TMHP Medicaid Audit at 1-512-514-3648.

Annual cost reports must be filed as follows:

• Submit one copy of the cost report to TMHP Medicaid Audit within five months of the end of the hospital’s fiscal year along with any amount due to the Texas Medicaid Program.
• TMHP Medicaid Audit performs a desk review of the cost report and makes a tentative settlement with the hospital. A tentative settlement letter requests payment for any balance due to the Texas Medicaid Program or instructs TMHP to pay the amount due to the provider. Interim payment rates are changed at this time based on the cost report.

• Field audits are conducted when necessary.
• Medicaid final settlement is made after a copy of all the following information is received from the provider or the Medicare intermediary:
  • Audited or settled without audit Medicare Cost Report
  • Medicare Notice of Amount of Program Reimbursement
  • Medicare Audit Adjustment Report, if applicable

Medicaid hospitals may request copies of their claim summaries for their cost reporting fiscal year. The summaries for tentative settlements include three additional months of claim payments for the fiscal year. The summaries for final settlements include ten months of claim payments for the fiscal year. TMHP Medicaid Audit uses this data to determine the tentative and final settlements and interim rates.

The Medicaid claim summary data are only generated once each month, and the logs are received by the 15th of the following month. Requests for tentative settlement logs are submitted within 30 days after the fiscal year-end. Final settlement log requests are submitted within nine months after the fiscal year-end.

The Medicaid logs can be requested on microfiche or paper by mailing a “Medicaid Audit Request for Claims Summary” on page B-54 to the following address:

Texas Medicaid & Healthcare Partnership
Medicaid Audit
PO Box 200345
Austin, TX 78720-0345

Allow 45 days for receipt of these logs.

25.1.3 Third Party Liability Reporting

Hospitals and providers enrolled in the Texas Medicaid Program are required to inform TMHP about circumstances that may result in third party liability for health care claims. After receiving this information, TMHP pursues reimbursement from responsible third parties.

Hospitals and Providers should mail or fax the Tort Response Form for accidents and Other insurance Form for Health Insurance to the following address:

Texas Medicaid & Healthcare Partnership
TPR Correspondence
Third Party Resources Unit PO Box 202948
Austin, TX 78720-9981
Fax: 1-512-514-4225

Refer to: “Third Party Resources” on page 4-13 for more information.

“Tort Response Form” on page B-114.
“Other Insurance Form” on page B-62.
### 25.2 Inpatient

#### 25.2.1 Enrollment

To be eligible to participate in the Texas Medicaid Program, a hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process. All providers of laboratory services must comply with Clinical Laboratory Improvement Amendments (CLIA) rules and regulations. Providers not complying with CLIA will not be reimbursed for laboratory services.

Refer to: “Provider Enrollment” on page 1-2 for more information about enrollment procedures. “Clinical Laboratory Improvement Amendments (CLIA)” on page 26-2 for more information about CLIA.

#### 25.2.1.1 Hospital Eligibility Through Change of Ownership

Under procedures set forth by CMS and the United States Department of Health and Human Services (HHS), a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued if the hospital obtains recertification as a Title XVIII (Medicare) hospital and a new Title XIX (Medicaid) agreement between the hospital and HHSC.

Contact the TMHP Contact Center at 1-800-925-9126 to obtain the Medicaid hospital participation agreement.

#### 25.2.1.2 Psychiatric Hospital/Facility (THSteps-CCP)

Refer to: “Psychiatric Hospital/Facility (Freestanding) (THSteps-CCP Only)” on page 43-71 for enrollment and other program information.

---

### 25.1.4 Medicaid Relationship to Medicare

The Texas Medicaid Program makes coinsurance and deductible payments on valid, assigned Part A (hospital) and Part B (medical) Medicare claims.

**Exception:** If the Medicare payment amount equals or exceeds the Medicaid payment rate, HHSC is not required to pay the Medicare Part A and/or Part B deductible/coinsurance/copay on a crossover claim.

The Texas Medicaid Program provides 30 inpatient benefit days per spell of illness. When the 30 days coincide with the first 30 days of the Medicare benefit period and the client is eligible for both Medicare and Medicaid, Medicaid pays the:

- Inpatient hospital deductible under Medicare Part A
- Medicare Part A deductible for the first three pints of whole blood or packed red cells

When the client only has Medicare Part B coverage, the hospital must follow these guidelines:

- Submit to Medicare the charges for certain inpatient ancillary services on a Medicare Claim Form 1483 for payment under the client’s Part B coverage. The ancillary charges include the following:
  - Diagnostic X-ray tests, diagnostic laboratory tests, and other diagnostic tests
  - X-ray, radium, and radioactive isotope therapy, including materials and services of technicians
  - Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations
  - Prosthetic devices (other than dental) that replace all or part of an internal body organ or member (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ or member including replacement or repairs of such devices (e.g., cardiac pacemakers, breast prostheses, maxillofacial devices, colostomy bags, and prosthetic lenses)
  - Leg, arm, back and neck braces, and artificial legs, arms, and eyes, including replacements and adjustments (if required) because of a change in the client’s physical condition
  - Physical therapy services
  - Speech pathology services
  - Dialysis treatments
- Submit to Medicaid the remaining Part A charges on a HCFA-1450 (UB-92) claim form (or its electronic equivalent) indicating in Block 84 that the client is eligible for Medicare Part B benefits only. The client’s health insurance claim (HIC) number must appear on the Medicaid claim in Block 84. TMHP must receive these charges within 95 days of the last date of service on the claim.

Refer to: “Medicare Crossover Reimbursement” on page 2-8 for more information.
25.2.1.3 Hospital Ambulance
A hospital supplying ambulance services must enroll separately from the hospital.
Refer to: “Enrollment” on page 8-2 for ambulance enrollment requirements.

25.2.1.4 Certified Registered Nurse Anesthetist (CRNA) Services
CRNAs must enroll and bill according to the instructions given in “Certified Registered Nurse Anesthetist (CRNA)” on page 15-1. Hospitals cannot bill for CRNA services using their hospital ambulatory surgical center (HASC) or hospital provider identifier.

25.2.1.5 Medicaid Managed Care Enrollment
Certain providers may be required to enroll with Medicaid Managed Care to be reimbursed for services provided to Medicaid Managed Care clients. Contact the individual health plan for enrollment information.
Refer to: “Medicaid Managed Care” on page 7-4 for more information.

25.2.1.6 Hospital Transplant Centers
Hospital providers can refer to “Enrollment” on page 25-4 for enrollment and other related information.

25.2.2 Reimbursement

25.2.2.1 Prospective Payment Methodology
Inpatient hospital stays except in children’s hospitals and psychiatric facilities (THSteps-CCP) are reimbursed according to a prospective payment methodology based on diagnosis-related groups (DRGs). The reimbursement method itself does not affect inpatient benefits and limitations. Inpatient admissions must be medically necessary and are subject to the Texas Medicaid Program’s utilization review requirements.

The DRG reimbursement includes all facility charges (for example, laboratory, radiology, and pathology). Hospital-based laboratories and laboratory providers who deliver referred services outside the hospital setting must obtain reimbursement for the technical portion from the hospital. The technical portion includes the handling of specimens and the automated or technician-generated reading and reporting of results. The technical services are not billable to Medicaid clients.

Medicaid does not distinguish types of beds or units within the same acute care facility for the same inpatient stay (i.e., psychiatric or rehabilitation). Because all Medicaid inpatient hospitalizations are included in the DRG database that determines the DRG payment schedule, psychiatric and rehabilitation admissions are not excluded from the DRG payment methodology. To ensure accurate payment, Medicaid requires that only one claim be submitted for each inpatient stay with appropriate diagnosis and procedure code sequencing.

Discharge and admission hours (military time) are required on the HCFA-1450 (UB-92) claim form, to be considered for payment.

Prior authorization is not required for psychiatric admissions to acute care hospitals for reimbursement; however, admissions must be medically necessary and are subject to retrospective utilization review by HHSC.

Reimbursement to acute care hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). Claims may be subject to retrospective review, which may result in recoupment. This limitation does not apply to services related to certain organ transplants or services to THSteps clients when provided through CCP.

In accordance with legislative direction included in the 2006-2007 General Appropriations Act (Article II, Section 49, S.B. 1, 79th Legislature, Regular Session, 2005), a rate reduction will be applied to inpatient hospital services rendered to non-Medicare Supplemental Security Income (SSI) and SSI-related Medicaid clients. The rate reduction will affect hospital providers within the Bexar, Dallas, El Paso, Lubbock, Tarrant, Nueces, Harris, and Travis service areas that are reimbursed by DRG.

Hospitals with 100 or fewer licensed beds are currently reimbursed the greater of the amount the hospital received under the prospective payment system (the DRG) or the amount the hospital would have received under the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 principles of reimbursement. If the reimbursement under TEFRA principles is greater than the amount of reimbursement received under the DRG system, the difference is reimbursed to the hospital. This determination is made with a tentative settlement and subsequent adjustments if applicable. A final cost settlement of the hospital’s fiscal year-end applies to hospital fiscal years beginning on or after September 1, 1989.

A new provider is given a reimbursement inpatient interim rate of 50 percent until a cost audit has been performed. A default standard dollar amount (SDA) rate is assigned for newly enrolled providers or newly constructed facilities.

Payment is calculated by multiplying the SDA for the hospital’s payment division indicator times the relative weight associated with the DRG assigned by Grouper.
Refer to: “Children’s Hospitals” on page 25-6.
“Psychiatric Hospital/Facility (Freestanding) (THSteps-CCP Only)” on page 43-71 for more reimbursement information.

25.2.2.2 Client Transfers
When more than one hospital provides care for the same client, the hospital providing the most significant amount of care receives consideration for a full DRG payment. The other hospitals are paid a per diem rate based on the lesser of the mean length of stay for the DRG or eligible days in the facility. Services must be medically necessary and are subject to the Texas Medicaid Program’s utilization review requirements.
HHSC performs a postpayment review to determine if the hospital providing the most significant amount of care received the full DRG. If the review reveals that the hospital providing the most significant amount of care did not receive the full DRG, an adjustment is initiated.

Client transfers within the same facility are considered one continuous stay and receive only one DRG payment. Medicaid does not recognize specialty units within the same hospital as separate entities; therefore, these transfers must be billed as one admission under the provider identifier. Admissions billed inappropriately are identified and denied during the utilization review process and may result in intensified review.

**Note:** To ensure correct payer identification, providers that receive transfer patients from another hospital must put the admit date of the billing hospital in Block 17 on the UB-92.

### 25.2.2.3 Observation Status to Inpatient Admission

When a client’s status changes from observation to inpatient admission, the date of the inpatient admission is the date the client was placed on observation status. This rule always applies regardless of the length of time the client was in observation (less than 24 hours) or whether the date of inpatient admission is the following day. All charges including the observation room are billed on the inpatient claim (type of bill [TOB] 111).

### 25.2.2.4 Outliers

TMHP makes outlier payment adjustments to DRG hospitals for admissions that meet the criteria for exceptionally high costs or exceptionally long lengths of stay for clients younger than 21 years of age as of the date of the inpatient admission. If a client’s admission qualifies for both a day and a cost outlier, the outlier resulting in the higher payment to the hospital is paid. The R&S report reflects the outlier reimbursement payment and defines the type of outlier paid.

**Day Outliers**

The following criteria must be met to qualify for a day outlier payment. Inpatient days must exceed the DRG day threshold for the specific DRG. Additional payment is based on inpatient days that exceed the DRG day threshold multiplied by 70 percent of the per diem amount of a full DRG payment. The per diem amount is established by dividing the full DRG payment amount by the arithmetic mean length of stay for the DRG.

Hospitals should use the following formula to calculate the day outliers for dates of admission on or after September 1, 2002. To calculate the day outlier payment amount, the number of outlier days must first be determined:

#### Number of Days Allowed-DRGs Threshold = Outlier Days

\[
\text{SDA} \times \text{DRG relative weight} \times \text{Outlier} \times 0.70 = \text{outlier Days}
\]

\[
\text{Mean length of stay} \times \text{outlier amount}
\]

### 25.2.2.5 Children’s Hospitals

Inpatient hospital stays in designated children’s hospitals are reimbursed according to the TEFRA reimbursement principles on a reasonable cost basis. Designated children’s hospitals are reimbursed on a percentage of the hospital’s standard charges derived from the hospital’s most recent tentative or final Medicaid cost report settlement.

To be designated as a children’s hospital, the hospital must have a provider agreement with Medicare and be engaged in delivering services to patients who are predominantly younger than 18 years of age. A designated children’s hospital is excluded from the Medicare/Medicaid prospective payment system per 42 Code of Federal Regulations (CFR) (Subsection) 412.23.

**Note:** Children’s hospitals that are reimbursed according to the TEFRA methodology may submit interim claims before discharge and must submit an interim claim if the client remains in the hospital past the hospital’s fiscal year end.

### Cost Outliers

To establish a cost outlier, TMHP determines the outlier threshold by using the full DRG payment amount multiplied by 1.5 or an amount determined by selecting the lesser of the universal mean of the current base year data multiplied by 11.14 or the hospital’s SDA multiplied by 11.14. The calculation that yields the amount is used in calculating the actual cost outlier payment. The outlier threshold is subtracted from the amount of reimbursement for the admission established under TEFRA principles, and the remainder multiplied by 70 percent to determine the actual amount of the cost outlier payment.

Hospitals should use the following formulas to calculate the day outliers for dates of admission on or after September 1, 2002. Effective September 1, 2002, (date of admission) the Universal Mean is $3,328.89. To calculate the cost outlier amount, the cost threshold must first be determined. Three calculations and two comparisons are necessary:

A) \[11.14 \times \text{Universal Mean} (3,328.89) = 37,083.83\]

B) \[11.14 \times \text{SDA} = \text{Comparison 1: Take lesser of number A or B.}\]

C) \[1.5 \times \text{DRG Relative Weight} \times \text{SDA} = \text{Comparison 2: Greater of number C and Comparison 1 is the cost threshold}\]

Allowed amount \times \text{reimbursement rate} = \text{__________}

Result of A minus cost threshold = \text{__________}

Result of B \times 0.70 = \text{cost outlier amount}
25.2.2.6 Hospital Transplant Center Approval

In-State Facility Approval Process

All facilities choosing to participate in the Texas Medicaid Transplant Program will be monitored and approved by HHSC. The transplant facility should be approved by Medicare as a transplant center before applying to the Texas Medicaid Program unless the transplant facility is in a designated Children’s Hospital. Texas Medicaid will not reimburse for transplants in the hospitals that do not have current approval by HHSC. Exception(s) may be considered if the transplant type is not available in Texas.

All transplant facilities who wish to perform organ transplants for clients of the Texas Medicaid Program must have current certification and be in continuous compliance with the criteria set forth by the Organ Procurement and Transportation Network (OPTN) criteria, receive certification from the United Network for Organ Sharing (UNOS) or the National Marrow Donor Program (NMDP). The Texas Medicaid Program does not approve or reimburse transplants in facilities that are not certified and in “good standing” with these credentialing organizations.

Those facilities whose status of “good standing” has been suspended for any reason by the national credentialing bodies will not be approved by the Texas Medicaid Program to provide transplant services until this status has been restored.

Important: The facility must notify HHSC within three working days of any change in compliance or certification status from UNOS and NMDP. Failure to notify HHSC within three working days of any changes in compliance or certification status may result in disapproval of current and pending transplant requests or recoupment of reimbursement. Submit notification information to:

Texas Health and Human Services Commission
1100 West 49th Street, H-310
Austin, TX 78756
Attn: Medicaid/CHIP Benefits–Transplant Facility Approvals

Out-of-State Facilities

The Texas Medicaid Program requires that all transplant facilities requesting approval to perform transplants for Texas Medicaid clients must provide proof of transplant facility certification. HHSC approval is dependent upon compliance with the transplant facility criteria of the OPTN and certification from the UNOS or the NMDP. In order for the Texas Medicaid Program to pay for an out-of-state transplant, the facility and professional providers must be enrolled as Texas Medicaid providers. The out-of-state transplant facilities must submit documentation about relevant transplant facility UNOS or NMDP certification as required by HHSC.

Texas licensed physicians may request prior authorization for transplant services to be performed at out-of-state facilities when the:

• Facilities are nationally recognized as Centers of Excellence.
• Required organ transplants are not available in Texas.

• Services are medically necessary, reasonable, and federally allowable.
• The client is enrolled in the Texas Medicaid Program.

25.2.3 Benefits and Limitations

Inpatient hospital services include medically necessary items and services ordinarily furnished by a Medicaid hospital or by an approved out-of-state hospital under the direction of a physician for the care and treatment of patients. The Medicaid program also reimburses for medically necessary services in the outpatient setting to include day surgery and outpatient observation. Services must be medically necessary and are subject to the Texas Medicaid Program’s utilization review requirements. Services must also be billed to TMHP per Medicaid policy and procedures.

Inpatient hospital services include the following items and services:

• Bed and board in semiprivate accommodations or in an intensive care or coronary care unit including meals, special diets, and general nursing services; and an allowance for bed and board in private accommodations including meals, special diets, and general nursing services up to the hospital’s charge for its most prevalent semiprivate accommodations. Bed and board in private accommodations are provided in full if required for medical reasons as certified by the physician. The authorized signature in Block 85 of the HCFA-1450 (UB-92) claim form certifies that the billing hospital has a record on file that the services provided were ordered by a physician. Additionally, the hospital must document the medical necessity for a private room such as the existence of a critical or contagious illness or a condition that could result in disturbance to other patients. This type of information should be included in Block 84 or attached to the claim.

• Whole blood and packed red cells reasonable and necessary for treatment of illness or injury if they are not available without cost

• Maternity care (includes usual and customary care for all female clients)

• All medically necessary services and supplies ordered by a physician to include laboratory, radiology, and pathology

• Newborn care (includes routine newborn care, routine screenings, and specialized nursery care for newborns with specific problems)

Circumstances requiring the mother and newborn to remain in the hospital longer than two days for a routine vaginal delivery or four days for a Cesarean section must be documented. Continuation of hospitalization is covered for the infant when the mother is required to remain hospitalized for medical reasons and must be documented.

Take-home drugs, self-administered drugs, or personal comfort items are not benefits of the Medicaid program nor THSteps-CCP, except when received by prescription through the Vendor Drug Program.
Reimbursement to hospitals for inpatient services is limited to the Medicaid spell of illness. The spell of illness is defined as 30 days of inpatient hospital care, which may accrue intermittently or consecutively. After 30 days of inpatient care is provided, reimbursement for additional inpatient care is not considered until the client has been out of an acute care facility for 60 consecutive days.

Exceptions to the spell of illness are the following:

- A prior-approved transplant that is medically necessary because of an emergent, life-threatening condition. This exception allows an additional 30 days of inpatient care that begins with the date of the transplant. For example, if the transplant occurs on the 15th day of an inpatient stay, the additional 30 days would allow a total of 45 days.
- THSteps-eligible clients when a medically necessary condition exists.
- Some Medicaid Managed Care clients. See “Medicaid Managed Care” on page 7-4.

**Important:** Medicaid reimbursement for services cannot exceed the limitations.

Reimbursement to acute care hospitals for inpatient services is limited to $200,000 per client, per benefit year (November 1 through October 31). Claims are reviewed retrospectively, and payments exceeding $200,000 are recouped. This limitation does not apply to services related to certain organ transplants or services to THSteps clients when provided through CCP.

**Note:** Dollar or day limitations are not applicable for clients younger than 21 years of age.

### 25.2.3.1 Hysterectomy Services

Medically necessary hysterectomies are reimbursable when the physician obtains an appropriate acknowledgment statement from the client. Medicaid does not reimburse for hysterectomies performed for the sole purpose of sterilization.

The physician’s signature acknowledging the client’s sterility is not required on the claim. The acknowledgment statement must be maintained in the physician’s files and is subject to retrospective review. A modifier, PM or PS, must continue to be submitted on the claim or a copy of the signed certification may be attached to the paper claim.

When TMHP receives a valid acknowledgment statement, the client’s eligibility file is updated to reflect receipt. Subsequent claims TMHP receives for the hysterectomy are referenced to the acknowledgment statement.

**Refer to:** “Hysterectomy Acknowledgment Form” on page B-52.

### 25.2.3.2 Newborn Services

**Eligibility Process**

A child is deemed eligible for Medicaid for up to 12 months of age if the mother is receiving Medicaid at the time of the child’s birth, the child continues to live with the mother, and the mother continues to be eligible for Medicaid or would be eligible for Medicaid if she were pregnant. Therefore, it is not acceptable for a hospital to require a deposit for newborn care from a Medicaid client. The child’s eligibility ends if the mother relinquishes her parental rights or if it is determined that the child is no longer part of the mother’s household.

Hospitals should complete the HHSC Form 7484, “Hospital Report (Newborn Child or Children) HHSC Form 7484” on page B-51, to provide information about each child born to a mother eligible for Medicaid. If the newborn’s name is known, the name must be on the form. The use of Baby Boy or Baby Girl delays the assignment of a number. Filing this form will expedite the assignment of a Medicaid client number for the newborn child. The form should not be completed for stillbirths. The form should be completed by the hospital within five days of the child’s birth and should be sent to HHSC at the address identified on the form. The five-day time frame is not mandatory; however, prompt submission expedites the process of determining the child’s eligibility. Hospitals should duplicate the form as needed. HHSC, DADS, and TMHP do not supply the forms.

**Note:** Providers may call the HHSC Bureau of Vital Statistics at 1-800-452-9115 for details on how to transmit newborn information electronically.

After receiving a completed form, HHSC verifies the mother’s eligibility and within 10 days sends notices to the hospital, mother, caseworker, and attending physician if identified. The notice includes the child’s Medicaid client number and the effective date of coverage. After the child has been added to the eligibility file, HHSC issues a Medicaid Identification Form (Form H3087).

Providers should submit address changes to the following address:

Texas Medicaid & Healthcare Partnership
Provider Enrollment
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727

The attending physician’s notification letter is sent to the address on file by license number at the Texas Medical Board. It is imperative the address be kept current to ensure timely notification of attending physicians. Physicians should submit address changes to the following address:

Texas Medical Board
Customer Information, MC-240
PO Box 2018
Austin, TX 78767-2018

Claims submitted for services provided to a newborn child eligible for Medicaid are filed using the newborn child’s Medicaid client number.

**Note:** When billing for a Medicaid Managed Care client, providers must adhere to the Medicaid Managed Care health plans’ guidelines for newborn billing.
Screening
A newborn hearing screening must be offered to all newborns as part of their newborn hospital stay. This screening procedure is not diagnostic and will not reimburse separately from the usual newborn delivery payment. Special investigations and examination codes are not appropriate for use with hearing screening of infants.

For more information about newborn hearing screening contact:

Bureau of Children’s Health
1100 West 49th Street
Austin, TX 78756
1-512-458-7726
www.dshs.state.tx.us/audio/default.shtm

All newborns who have abnormal screening results should be referred to a local Program for Amplification for Children in Texas (PACT) provider for follow-up care. PACT provides services and hearing aids for children from birth through 20 years of age who have permanent hearing loss and are eligible for Medicaid. Obtain a current list of PACT providers at www.dshs.state.tx.us/audio/program.shtm or the following address:

DSHS
PACT Health Screening Branch
1100 West 49th Street, MC-1918
Austin, TX 78756-3199
1-800-252-8023

Refer newborns with suspected genetic disorders or with a positive newborn screening test for a genetic work-up as appropriate.

Refer to: “Genetic Services” on page 22-1.

Hepatitis B Immunizations
Newborns should be given the first dose of hepatitis B vaccine before discharge from the hospital or birthing center. Hepatitis B vaccine for newborns is provided by the Texas Vaccines for Children (TVFC) Program. Hospitals and birthing centers may obtain vaccine at no cost by enrolling in the TVFC Program. For more information on enrolling in the TVFC Program, refer to “Texas Vaccines for Children Program Packet” on page H-6 or call the DSHS Immunization Division toll-free at 1-800-252-9152.

The recommended administration of the hepatitis B vaccine to newborns before discharge from the hospital has been established as the standard of care and should not be considered as a reason to upcode to a different DRG. The reimbursement for the administration of hepatitis B vaccine to newborns is included in the DRG payment. The Texas Medicaid Program will not reimburse for the cost of the vaccine for newborns. Providers must enroll in the TVFC Program to obtain vaccine at no cost. Consult the vaccine package insert for information on proper administration and dosing.

25.2.3.3 Psychiatric Services
Inpatient admissions for adults and children to acute care hospitals for psychiatric conditions are a benefit of the Texas Medicaid Program. Admissions must be medically necessary and are subject to the Texas Medicaid Program’s retrospective utilization review (UR) requirements. The UR requirements are applicable regardless of the hospital’s designation of the psychiatric unit versus medical/surgical unit.

Admissions for the single diagnosis of chemical dependency or abuse (such as alcohol, opioids, barbiturates, and amphetamines) without an accompanying medical complication are not a benefit of the Texas Medicaid Program. Additionally, admissions for chronic diagnoses such as mental retardation, organic brain syndrome, or chemical dependency or abuse are not covered benefits for acute care hospitals without an accompanying medical complication or medical condition. The HCFA-1450 (UB-92) claim form must indicate all relevant diagnoses that necessitate the inpatient stay.

Additional coverage may be allowed for clients who are eligible for Medicaid and younger than 21 years of age through THSteps-CCP.

Note: NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. Psychiatrists who provide behavioral health services to clients in NorthSTAR must be members of the NorthSTAR behavioral health organization (BHO).

Refer to: “THSteps-Comprehensive Care Program (CCP)” on page 43-33 for more information.

“Medicaid Managed Care” on page 7-4 for more information or contact the client’s BHO.

Providers rendering services to STAR and STAR+PLUS clients must contact the respective managed care plan.

25.2.3.4 Rehabilitation Services
Inpatient rehabilitation services are covered benefits when provided in a general acute care hospital setting with an acute condition or an acute exacerbation of a chronic illness in which rehabilitation services are medically necessary in the usual course, treatment, and management of the illness.

All services must be documented as medically necessary and ordered by a physician. When submitting the claim, the hospital must include the physician’s written treatment plan supporting the medical necessity of the hospitalization and services.

All rehabilitation services are subject to Medicaid benefit limitations including the spell of illness. Extensions beyond the regular scope of Medicaid may be offered under THSteps-CCP.

Refer to: “Physical Therapists/Independent Practitioners” on page 35-1 for more information.

“Benefits and Limitations” on page 43-14.
**25.2.3.5 Organ/Tissue Transplant Services**

**Prior Authorization**

Prior authorization for a transplant is mandatory and approved only if the physician indicates the transplant will be performed in an approved Texas Medicaid transplant facility. If the facility indicated on the original authorization request is not a Medicaid-approved transplant facility, the physician needs to designate a different approved facility before the authorization is given. Transplant facilities are reviewed for approval each year. TMHP issues prior authorizations for dates within the facility approval period.

**Note:** If the client is a Medicaid Managed Care client, all prior authorizations for transplants will need to be obtained from the client’s health plan.

If the transplant has not been performed by the end of the authorization period, physicians need to apply for an extension. Fax inquiries for authorization extensions to TMHP Special Medical Prior Authorization at 1-512-514-4213. Prior authorization is required for the following services (this noninclusive list is subject to change):

- Stem cell transplant
- Heart transplant
- Single lung transplant with bronchial anastomosis
- Double sequential lung transplant with bilateral bronchial anastomosis
- Combined heart/lung transplant
- Liver transplant
- Kidney transplant

The prior authorization number (PAN) must be entered in Block 63 (Treatment Authorization Code) of the HCFA-1450 (UB-92) claim form.

Cornea transplants do not require prior authorization. Documentation supplied with the prior authorization request should include a complete history and physical, a statement of the client’s current medical problems and status, and meet the criteria specified in the individual transplant policy for which the facility is requesting prior authorization.

If a solid organ transplant is not prior authorized, services directly related to the transplant within the three day preoperative and six weeks postoperative period also will be denied, regardless of who provides the service, (i.e., laboratory services, status-post visits, and radiology services). Services unrelated to the transplant surgery will be paid separately.

A transplant request signed by a physician associated with one of the Texas Medicaid Program approved transplant facilities is considered for prior authorization after the client has been evaluated and meets the guidelines of the institution’s transplant protocol.

All supporting documentation must be included with the request for authorization. Send requests and documentation to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

**Heart Transplants**

Heart transplant candidates must be limited to those patients who, based on sound patient selection criteria, would most likely benefit from the heart transplant procedure on a long-term basis. In order to be reimbursed by the Texas Medicaid Program, the facility must document a critical medical need with the New York Heart Association (NYHA) Class III or IV cardiac disease as shown below:

- **Class III.** Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity (e.g., mild exertion) causes fatigue, palpitation, dyspnea, or anginal pain

- **Class IV.** Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency or of the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

Or the facility must document:

- Congenital heart disease
- Valvular heart disease
- Viral cardiomyopathy
- Familial or restrictive cardiomyopathy
- Heart transplant will result in a return to improved functional independence

- Absence of comorbidities, such as:
  - Severe pulmonary hypertension
  - End-stage renal, hepatic, or other organ dysfunction unrelated to primary disorder
  - Uncontrolled HIV infection or AIDS-defining illness
  - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure

Documented psychiatric instability is a contraindication for transplant if severe enough to jeopardize incentive for adherence to medical regimen

Prior authorization for a heart/lung transplant must follow criteria for both heart and lung transplants. Requests for a heart/lung transplant will be considered on an individual basis.

**Heart Transplants**

- Stem cell transplant
- Heart transplant
- Single lung transplant with bronchial anastomosis
- Double sequential lung transplant with bilateral bronchial anastomosis
- Combined heart/lung transplant
- Liver transplant
- Kidney transplant

The prior authorization number (PAN) must be entered in Block 63 (Treatment Authorization Code) of the HCFA-1450 (UB-92) claim form.

Cornea transplants do not require prior authorization. Documentation supplied with the prior authorization request should include a complete history and physical, a statement of the client’s current medical problems and status, and meet the criteria specified in the individual transplant policy for which the facility is requesting prior authorization.

If a solid organ transplant is not prior authorized, services directly related to the transplant within the three day preoperative and six weeks postoperative period also will be denied, regardless of who provides the service, (i.e., laboratory services, status-post visits, and radiology services). Services unrelated to the transplant surgery will be paid separately.

A transplant request signed by a physician associated with one of the Texas Medicaid Program approved transplant facilities is considered for prior authorization after the client has been evaluated and meets the guidelines of the institution’s transplant protocol.
All heart transplant services provided by facilities and professionals must be prior authorized by HHSC or its designee.

Documentation supplied with the prior authorization request must address the criteria above and must be medically necessary, reasonable, and federally-allowable.

**Liver Transplants**

Authorization of liver transplantation requires documentation of life-threatening complications of acute liver failure or chronic end-stage liver disease.

Liver transplant candidates must be limited to those patients who, based on sound patient selection criteria, would most likely benefit from the liver transplant procedure on a long-term basis. In order to be reimbursed by the Texas Medicaid Program, the facility must document the following:

- A critical medical need with a likelihood of a successful clinical outcome
- Liver disease in these categories:
  - Primary cholestatic liver disease
  - Other cirrhosis: alcoholic, hepatitis C (non-A, non-B), hepatitis B
  - Fulminant hepatic failure
  - Metabolic diseases
  - Malignant neoplasms
  - Benign neoplasms
  - Biliary atresia
- Absence of comorbidities such as:
  - End-stage cardiac, pulmonary, or renal disease unrelated to primary disorder
  - Multiple organ compromise secondary to infection, malignancy, or condition with no known cure
- Documented compliance with other medical treatment regimens and plan of care. Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen

Documented psychiatric instability is a contraindication for transplant if it is severe enough to jeopardize incentive for adherence to medical regimen.

Payment for liver transplant professional services will be made under procedure code 2/8-47135 or 2/8-47136. These procedures include six months of professional postoperative care. Separate charges for a choledochojejunostomy (Roux-en-y) should be denied as part of the liver transplant. Parenteral immunosuppressant therapy is approved for a period of 12 months following the date of discharge from the hospital, conditional upon the Medicaid-eligibility of the client.

Two assistant surgeons will be allowed for liver transplant surgery using procedure codes 2/8-47135 and 2/8-47136.

**Lung Transplants**

Lung transplant candidates must be limited to those patients who, based on sound patient selection criteria, would most likely benefit from the lung (single or double) transplant procedure on a long-term basis. In order to be reimbursed by the Texas Medicaid Program, the facility must document the following:

- A critical medical need with a likelihood of a successful clinical outcome
- Symptoms at rest that are directly related to chronic pulmonary disease and which result in severe functional limitation
- End-stage pulmonary diseases in these categories:
  - Obstructive lung disease
  - Restrictive lung disease
  - Cystic fibrosis
  - Pulmonary hypertension
- Absence of comorbidities such as:
  - End-stage renal, hepatic, or other organ dysfunction unrelated to primary disorder
  - Multiple organ compromise secondary to infection, malignancy, or a condition with no known cure
- Documented compliance with other medical treatment regimens and plan of care. Documented compliance includes no active alcohol or chemical dependency that interferes with compliance to a medical regimen

Documented psychiatric instability is a contraindication for transplant if it is severe enough to jeopardize incentive for adherence to medical regimen.

Prior authorization for a heart/lung transplant must follow criteria for both heart and lung transplants. Requests for a heart/lung transplant will be considered on an individual basis.

**Program Limitations**

If a transplant has been prior authorized as medically necessary by HHSC or its designee because of an emergent, life-threatening situation, a maximum of 30 days of inpatient hospital services during Title XIX spell of illness may be covered, beginning with the actual first day of the transplant. This coverage is in addition to covered inpatient hospital days provided before the actual first day of the transplant. This 30-day period is considered a separate inpatient hospital admission for reimbursement purposes, but is included under one hospital stay. Physician services that HHSC or its designee determines to be reasonable and medically necessary also are covered during the 30-day period. Day limitations do not apply for clients under 21 years of age.

Expenses for a single inpatient hospital admission for an authorized transplant are not included in the annual $200,000.00 inpatient expenditure cap. Dollar limitations do not apply for clients under 21 years of age.

All program coverage limits are applied.
The above guidelines also apply to one subsequent retransplant, because of rejection, as a lifetime benefit. A subsequent transplant is not included in the prior authorization for the initial transplant; it must be prior authorized separately.

Reimbursement for transplant is limited to an initial transplant as a lifetime benefit and one subsequent retransplant because of rejection.

Transplants also are covered under the Medicare program; therefore, for clients eligible for Medicare and Medicaid, Medicaid will pay only the deductible or coinsurance portion as applicable. Prior authorization must be obtained for Medicaid only clients; authorization will not be given for Medicare/Medicaid-eligible clients. Medicaid will not pay a transplant service denied by Medicare for a Medicare-eligible client.

If a Medicaid client receives a transplant in a facility that is not approved by the Texas Medicaid Program, the client must be discharged from the facility to be considered to receive other medical and hospital benefits under the Texas Medicaid Program. Coverage for other services needed as a result of complications of the transplant may be considered when medically necessary, reasonable, and federally allowable. Texas Medicaid will not pay for routine post-transplant services for transplant patients in facilities that are not approved by the Texas Medicaid Program. Services unrelated to the transplant surgery will be paid separately.

Important: Benefits are not available for any experimental or investigational services (including xenotransplantation and artificial/bioartificial liver transplants), supplies, or procedures.

The DRG payment for the transplant includes procurement of the organ and services associated with the organ procurement. Medicaid does not pay for solid organs procured by a facility for supply to an organ procurement organization (OPO). The Omnibus Budget Reconciliation Act of 1986 (OBRA 86) Public Law 99-509 added Section 1138 of the Social Security Act, which defines conditions of participation for institutions in the organ procurement program. Organ procurement costs are not reimbursed to a hospital that fails to meet the conditions of participation. The specific guidelines may be found in the appropriate areas of 42 CFR Parts 405, 413, 441, 482, and 485. Documentation of organ procurement must be maintained in the hospital’s medical record. Expenses incurred by a living donor for transplants will not be reimbursed separately.

Refer to: “Reimbursement” on page 2-2.

25.2.4 Utilization Review

Utilization review activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system or TEFRA are required by Title XIX of the Social Security Act, Sections 19-02 and 19-03. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need, of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to utilization review monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of the Texas Medicaid Program.

Utilization review may also occur by an examination of particular claims or services not within the usual screening review when a specific utilization review is requested by HHSC or the Texas Attorney General’s Office.

25.2.4.1 Responsibilities

The HHSC Office of Inspector General (OIG)/Utilization Review (UR) Unit is responsible for retrospective review of inpatient DRG and TEFRA admissions. These reviews are accomplished through onsite visits or a mail-in basis.

25.2.4.2 Utilization Review Process

The inpatient utilization review process for admissions reimbursed under the DRG prospective payment system consists of sampling medical records of paid Medicaid claims. The review process consists of three major components:

- Admission review. Determination of the medical necessity of the admission. For purposes of the Texas Medical Review Program (TMRP) and TEFRA, medical necessity means the client has a condition requiring treatment that can be safely provided only in the inpatient setting.
- Quality review. Assessment of the quality of care provided to determine if it meets generally accepted standards of medical and hospital care practices or puts the client at risk of unnecessary injury or death. Quality of care review includes the use of discharge screens and generic quality screens.
- DRG validation. Determination that the critical elements necessary to assign a DRG are present in the medical record and the diagnosis and procedures are sequenced correctly. The critical elements are age, sex, admission date, discharge date, discharge status, principal diagnosis, secondary diagnosis (complications or comorbidity), and principal and secondary procedures.

The HHSC OIG UR Unit staff reviews the complete medical record to make decisions about the medical necessity of the admission, validity of the DRG, and quality of care. The medical record must reflect that any services reimbursed
by the Texas Medicaid Program were ordered by the attending physician, certified nurse-midwife, or nurse practitioner.

**Important:** All services, supplies, or items billed are medically necessary for the client’s diagnosis or treatment as certified on claim submission.

**Refer to:** “Provider Certification/Assignment” on page 1-8

When an admission denial or a denial of continued stay is issued, or when a technical denial becomes final, all money is recouped from the hospital for the admission or the days of stay denied. When a DRG is reassigned as a result of utilization review, the payment to the hospital is adjusted.

If an inpatient admission is denied, but a physician’s order is present documenting the client originally was placed in observation, the UR unit may authorize the rebilling of services rendered during the first 23 hours on an outpatient claim.

**Admission Review**

Review personnel assess the medical necessity of an admission by comparing documentation present in the medical record with elements in the TMRP Hospitalization Screening Criteria. For an admission to be approved, an indication for hospitalization and treatment criteria must be met. Cases that do not meet both screening criteria are referred to a physician consultant for determination of the medical necessity of the inpatient admission. If the TMRP Hospitalization Screening Criteria are met but the medical necessity of the admission is still questionable, the case is referred to a physician consultant for a determination. If a physician consultant determines the admission is not medically necessary, a denial is issued.

**Important:** Compliance with the DRG prospective payment system and aspects of the review as stated above are evaluated quarterly. Identified problems may result in an educational visit or action such as recoupment or referral to HHSC OIG Medicaid Program Integrity (MPI) for determination of a sanction.

**Important:** Effective for admissions on or after September 1, 2006, the HHSC/OIG/UR Unit will use evidence-based guidelines to perform retrospective utilization reviews of inpatient hospital claims for Medicaid clients.

**Readmission Review**

If a hospital admission or readmission occurs within 30 days of a previous discharge from the same or a different hospital for the same or closely related diagnosis, or for a condition identified during the previous admission, it may be reviewed for medical necessity.

Transfers from one facility to another and readmissions are also subject to review.

**HASC Surgical Procedures**

Inpatient admissions for surgical procedures listed as ambulatory surgical codes in the current fee schedule are denied if documentation does not support the need for the inpatient admission.

**Quality Review**

Each Medicaid case is evaluated for quality client care, adequacy of discharge planning, and medical stability of the patient at discharge. To accomplish this review, CMS Generic Quality Screens and discharge screens included in the TMRP Hospitalization Screening Criteria are used. Potential quality of care issues are identified by the physician. HHSC contracts with physician consultants to review medical records for quality of care. Physician consultants, of the specialty related to the care rendered, may make clinical recommendations or determine corrective actions when deemed appropriate. Child and adolescent psychiatrists may make recommendations based on review of inpatient psychiatric services provided to Medicaid clients younger than 21 years of age. Failure to verify completion of any corrective action recommendation within the specified time frame may result in referral of the case to the HHSC OIG, MPI section, for possible payment hold (withholding Medicaid claims payments until verification of the completed corrective action has been received) and/or exclusion from the Texas Medicaid Program.

**Diagnosis-Related Group Validation**

Each medical record is reviewed to validate the elements critical to the DRG assignment. These elements are the client’s age, sex, admission date, discharge date, discharge status, principal diagnosis, secondary diagnoses (complications or comorbidities), and principal and secondary procedures. Documentation of these critical DRG elements in the medical record is evaluated for the correlation to the information provided on the claim form.

The principal diagnosis is the diagnosis (condition) established after study to be chiefly responsible for causing the admission of the client to the hospital for care. The principal diagnosis must be treated or evaluated during this admission to the hospital.

The secondary diagnoses are conditions that affect patient care in terms of requiring clinical evaluation, therapeutic treatment, diagnostic procedures, extended length of hospital stay, increased nursing care and/or monitoring, or has clinically significant implications for future healthcare needs.

The coding of diagnoses that have clinically significant implications for future health care needs applies only to newborns and must be identified by the physician. Normal newborn conditions or routine procedures are not to be considered as complications or comorbidities for DRG assignment.

**Refer to:** “Medicaid Program Limitations and Exclusions” on page 1-17

If the principal diagnosis, secondary diagnoses (complications or co-morbidities), or procedures are not substantiated in the medical record; sequenced correctly; or have been omitted, codes may be deleted, changed, or added. All diagnosis/procedure coding changes potentially resulting in a DRG change are referred to a physician consultant. When it is determined that the diagnoses and procedures are substantiated and sequenced correctly,
the information will be entered into the applicable version of the Grouper software for a DRG determination. The CMS-approved DRG software considers each diagnosis and procedure and the combination of all codes and elements to make a determination of the final DRG assignment. When the DRG is reassigned, the payment to the provider is adjusted.

25.2.4.3 Recommendations to Enhance Compliance with Texas Medicaid Fee-for-Service Hospital Billing

The following information highlights an area for physician and hospital providers where collaboration in client care delivery exists but can improve. The Texas Medicaid Program, through its hospital utilization review activities, has identified this area for both compliance with provider responsibilities and the reduction of the submission of inappropriate inpatient hospital claims. To enhance compliance with Texas Medicaid fee-for-service hospital billing and decrease the submission of inappropriate inpatient hospital claims, adhere to the following suggestions:

- Physicians and hospital personnel, primarily case managers, utilization review, and billing staff, should become familiar with the Hospital Inpatient Screening Criteria used by the HHSC staff in performing reviews of hospital medical records related to paid, inpatient hospital claims. The criteria provide guidelines for review staff to assist with the determination of medical necessity of inpatient stays. The Medicaid Hospital Inpatient Screening Criteria is available on the HHSC website at www.hhs.state.tx.us/OIG/screen/SC_TOC.shtml.

- Initially admit clients in observation status if the physician feels that it is reasonable to expect that the client may be able to be discharged within 24 hours. If the client is initially admitted in observation status (per physician order), the stay is more than 24 hours, and the hospital submits an inpatient claim, the hospital is given the opportunity to rebill the first 24 hours of services on an outpatient claim if the inpatient claim is subsequently denied per retrospective utilization review.

- When a client is admitted to the hospital as an inpatient and is discharged in less than 24 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This billing practice is acceptable when the physician makes the changes to the admitting order before the hospital submits the claim for payment.

- This correction in admission status avoids errors in billing and the potential need for a more lengthy appeal process. If the physician admitting orders do not accurately reflect the services provided, the hospital inpatient claim may be denied and the inappropriate payment recovered from both the hospital and the admitting physician.

25.2.4.4 Hospitals Reimbursed Under TEFRA

For all Medicaid admissions identified for review, the TEFRA review process consists of the following major components:

- Admission review. Determination of the medical necessity of the admission. For purposes of the TMRP and TEFRA, medical necessity means the client has a condition requiring treatment that can be safely provided only in the inpatient setting.

- Continued stay review. Determination of the medical necessity of each day of stay.

- Quality of care review. Assessment of the quality of care provided to determine if it meets generally accepted standards of medical and hospital care practices or puts the client at risk of unnecessary injury or death. Quality of care review includes the use of discharge screens and generic quality screens.

Important: TEFRA Hospitals are required to submit all charges.

HHSC OIG UR Unit staff review the complete medical record to make decisions about the medical necessity of the admission, continued stay, and quality of care.

25.2.4.5 Technical Denials (DRG Prospective Payment and TEFRA)

On Site Reviews

The following information describes on site reviews:

- If the complete medical record is not made available during the on site review, a preliminary technical denial is issued on site. The hospital is allowed 60 calendar days from the date of the exit conference to provide the complete medical record to HHSC. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

- If a complete medical record is made available on site, but a copy is required for further review, and the copy is not received by HHSC within the specified time frame, a preliminary technical denial is issued by certified mail or fax machine. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

Note: A notarized business record affidavit is required for paper and electronic copies of requested medical records. A provider failing to provide this documentation must resubmit the requested records with the affidavit.

Refer to: "Retention of Records and Access to Records and Premises" on page 1-6

Mail-In Reviews

If the complete medical record is not received by HHSC within the specified time frame, a preliminary technical denial is issued by certified mail or fax machine. The hospital has 60 calendar days from the date of receipt of the notice to submit the complete medical record. If the
complete medical record is not received by HHSC within this specified time frame, a final technical denial is issued and payment is recouped.

Hospital inpatient claim payments that have been recouped because of a technical denial may not be rebilled on an outpatient claim.

**Note:** A notarized business record affidavit is required for paper and electronic copies of requested medical records. A provider who fails to provide this documentation must resubmit the requested records with the affidavit.

Refer to: “Retention of Records and Access to Records and Premises” on page 1-6

### 25.2.4.6 Acknowledgment of Penalty Notice

Hospitals must have on file a signed acknowledgment from the physician stating that the physician received the following notice:

**Notice to Physicians:** Medicaid payment to hospitals is based, in part, on each client’s principal and secondary diagnoses and the major procedures performed on the client, as attested to by the client’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of federal or state funds, may be subject to fine, imprisonment, or civil penalty under applicable federal and state laws.

**Important:** The acknowledgment of penalty notice must be specific to the Texas Medicaid Program. Medicare penalty notices are not accepted.

### 25.2.4.7 Sanctions

Compliance with the DRG prospective payment system and aspects of the review as stated above are evaluated quarterly. Identified problems may result in an educational visit or action such as recoupment or referral to HHSC OIG MPI for determination of a sanction.

### 25.2.4.8 Utilization Review Appeals

Hospital providers may appeal adverse decisions by HHSC’s UR unit to the HHSC UR/Medical Appeals unit. A UR/Medical Appeals decision is the final administrative decision of HHSC. Neither HHSC’s UR unit nor TMHP are responsible for UR appeals.

Refer to: “Utilization Review Appeals” on page 6-7.

### 25.2.5 Claims Information

Inpatient hospital services must be submitted to TMHP in an approved electronic format or on a HCFA-1450 (UB-92) claim form. Providers must purchase HCFA-1450 claim forms from the vendor of their choice; TMHP does not supply them.

Hospitals may submit information only claims to TMHP when one of the following situations exists. Hospitals should use TOB 110 to file these claims:

- Payment made by a third party resource/other insurance exceeds the Medicaid allowed amount.

Refer to: “HCFA-1450 (UB-92) Claim Filing Instructions” on page 5-32 for claims completion instructions.

### 25.2.5.1 Claim Filing Resources

Refer to the following sections and forms on the page numbers listed below when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>xiii</td>
</tr>
<tr>
<td>TMHP Electronic Data Interchange (EDI)</td>
<td>3-1</td>
</tr>
<tr>
<td>HCFA-1450 (UB-92) Claim Filing Instructions</td>
<td>5-32</td>
</tr>
<tr>
<td>TMHP Electronic Claims Submission</td>
<td>5-10</td>
</tr>
<tr>
<td>Communication Guide</td>
<td>A-1</td>
</tr>
<tr>
<td>Medicaid Audit Request for Claims Summary</td>
<td>B-54</td>
</tr>
<tr>
<td>Hospital Report (Newborn Child or Children) HHSC Form 7484</td>
<td>B-51</td>
</tr>
<tr>
<td>Hospital-Based ASC Claim Example</td>
<td>D-17</td>
</tr>
<tr>
<td>Hospital Inpatient Claim Example</td>
<td>D-18</td>
</tr>
<tr>
<td>Hospital Outpatient</td>
<td>D-18</td>
</tr>
<tr>
<td>Acronym Dictionary</td>
<td>F-1</td>
</tr>
</tbody>
</table>

### 25.3 Outpatient

#### 25.3.1 Enrollment

To be eligible to participate in the Texas Medicaid Program, a hospital must be certified by Medicare, have a valid provider agreement with HHSC, and have completed the TMHP enrollment process.

All providers of laboratory services must comply with CLIA rules and regulations. Providers not complying with CLIA will not be reimbursed for laboratory services.

**Hospital Eligibility Through Change of Ownership**

Under procedures set forth by CMS and HHS, a change in ownership of a hospital does not terminate Medicare eligibility; therefore, Medicaid participation may be continued if the hospital obtains recertification as a Title XVIII (Medicare) hospital and a new Title XIX (Medicaid) agreement between the hospital and HHSC.

Contact the TMHP Contact Center at 1-800-925-9126 to obtain the Medicaid hospital participation agreement.
25.3.1.1 Hospital Ambulatory Surgical Center
Hospitals certified and enrolled in the Texas Medicaid Program are assigned a nine-digit HASC provider identifier exclusively for billing day surgeries.
Refer to: “Day Surgery” on page 25-16.
“Ambulatory Surgical Center (ASC)” on page 9-1 for more information.

25.3.1.2 Hospital Ambulance
A hospital supplying ambulance services must enroll separately from the hospital.
Refer to: “Enrollment” on page 8-2 for ambulance enrollment requirements.

25.3.1.3 Certified Registered Nurse Anesthetist
Hospital-employed CRNAs must enroll and bill according to instructions in “Certified Registered Nurse Anesthetist (CRNA)” on page 15-1.
Note: Hospitals cannot bill for CRNA services using their HASC or hospital provider identifier.

25.3.1.4 Medicaid Managed Care Enrollment
To be reimbursed for services provided to Medicaid Managed Care clients, hospital providers must enroll with the Medicaid Managed Care health plan in which the clients are enrolled.
Refer to: “Medicaid Managed Care” on page 7-4 for more information.

25.3.2 Reimbursement
Outpatient services are reimbursed on a reasonable cost based on a percentage of the hospital’s most recent tentative Medicaid cost report settlement.
Reimbursement for outpatient hospital services for high-volume providers is 84.48 percent of allowable cost. For the remaining providers, reimbursement for outpatient hospital services is 80.3 percent of allowable cost. A high-volume provider is defined as one that paid at least $200,000 during calendar year 2000.
All clinical laboratory services are reimbursed at 60 percent of the prevailing charge except for those hospitals identified by Medicare as sole community hospitals. These hospitals are reimbursed at 62 percent of the prevailing charges for services provided to clients in the outpatient setting and 60 percent to clients in the inpatient setting. Clinical pathology consultations continue to be allowed for reimbursement.
Refer to: “Provider Cost and Reporting” on page 25-3 for more information about the calculation of the interim rate.
“Clinical Laboratory Improvement Amendments (CLIA)” on page 26-2 for important information.

25.3.2.1 Day Surgery
Reimbursement for outpatient hospital surgery is limited to the lesser of the amount reimbursed to an ambulatory surgical center (ASC) for similar services, the hospital’s actual charge, or the allowable cost determined by HHSC. Hospitals must bill all scheduled day surgeries under their HASC provider identifier using TOB 131.
To avoid delays in claims processing payment, file scheduled outpatient surgical procedures using the hospital’s ASC/HASC provider identifier and appropriate type of service (TOS) F-Healthcare Common Procedure Coding System (HCPCS) procedure code. ASC/HASC providers indicate the appropriate TOS F-HCPCS facility procedure code in Block 44 of the HCFA-1450 (UB-92) claim form, instead of the International Classification of Diseases Ninth Revision Clinical Modification (ICD-9-CM) procedure code in Block 80 of the HCFA-1450 (UB-92) claim form.
File claims for emergency, unscheduled outpatient surgical procedures with separate charges (lab, radiology, anesthesia, and emergency room) for all services using TOB 131 and the hospital’s provider identifier.
Reimbursement of ASC/HASC procedures is based on the CMS-approved Ambulatory Surgical Code Groupings (1 through 9 per CMS and Group 10 per HHSC) payment schedule. Providers are sent a list of these codes and payment categories after enrollment with the Texas Medicaid Program and when periodic updates occur. The rates implemented by Medicaid on April 1, 1995, remain in effect. To acquire a list of approved procedures, call the TMHP Contact Center at 1-800-925-9126.
Refer to: “Day Surgery” on page 25-16 for more information on day surgery and outpatient observation.
“Procedure Codes Requiring Prior Authorization” on page 36-343.
“TMHP Website” on page 3-2 for more information on obtaining fee schedules.

ASC/HASC Global Services
The ASC/HASC payment represents a global payment and includes room charges and supplies. Covered services provided are billed as one inclusive charge. All facility services provided in conjunction with the surgery (for example, laboratory, radiology, anesthesia supplies, medical supplies) are considered part of the global payment and cannot be itemized or billed separately.
Routine X-ray and laboratory services, directly related to the surgical procedure being performed, are not reimbursed separately. All nonroutine laboratory and X-ray services, provided with emergency conditions, may be billed separately with documentation that the complicating condition arose after the initiation of the surgery.
No separate payment outside of the ASC/HASC reimbursement rate will be made for prosthetic devices. Medical and prosthetic devices such as implantable pumps and intraocular lenses, may be supplied by the ASC/HASC and implanted, inserted or otherwise applied during a covered surgical procedure.
Multiple surgeries
When multiple surgical procedures are performed on the same day, only the procedure with the highest surgical code grouping is reimbursed. Surgical procedures performed in the hospital’s outpatient departments (emergency or treatment rooms) are to be billed under the hospital’s provider identifier, using TOB 131 (outpatient claim).

Elective/Scheduled Day Surgeries
These procedures are for clients who are scheduled for a day surgery procedure and are not inpatient at the time the day surgery is performed. Providers must bill (TOB 131) the scheduled day surgery as an outpatient procedure using the HASC provider identifier.

Complications following Elective/Scheduled Day Surgeries
If a condition of the scheduled day surgery requires additional care beyond the recovery period, the client may be placed in outpatient observation (stay less than 24 hours). The observation period must be billed on an outpatient claim (TOB 131) using the hospital’s provider identifier. If the client requires inpatient admission following the observation stay, the admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation placement (excluding the surgical procedure) should be included on the inpatient claim (TOB 111) using the hospital’s provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure should still be billed as an outpatient procedure under the HASC provider identifier. Specific guidelines for billing observation placement as an outpatient claim are found under “Hospital Outpatient Observation Room Services” on page 25-25.

Inpatient Admissions After Day Surgery
If a complication occurs for which the client requires inpatient admission immediately following the day surgery (no observation period), the day surgery must be billed as an outpatient procedure (TOB 131), using the hospital’s HASC provider identifier. The inpatient admission is to be billed as an inpatient claim (TOB 111), using the hospital’s provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery procedure should not be included on the inpatient claim. The inpatient admission must be medically necessary and is subject to retrospective review.

Emergency/Unscheduled Day Surgeries
These procedures are for clients who require an unscheduled (emergency) day surgery procedure and are not inpatient at the time the day surgery is performed. If a client is first treated in the emergency room and then requires emergency surgery as an outpatient, claims for emergency, unscheduled outpatient surgical procedures should be filed itemizing each service, such as room charge, laboratory, radiology, anesthesia, and supplies. Providers must bill unscheduled day surgery procedures and emergency services as outpatient procedures. If a condition of the unscheduled day surgery requires additional care beyond the recovery period, the client may be placed on outpatient observation status. The observation period must be billed on the same outpatient claim.

Providers must bill the unscheduled day surgery procedures and emergency services as outpatient procedures (TOB 131) using the hospital’s provider identifier. If a condition of the unscheduled day surgery requires additional care beyond the recovery period, the client may be placed on outpatient observation status (stay less than 24 hours). The observation period must be billed on the same outpatient claim (TOB 131) using the hospital’s provider identifier. Specific guidelines for billing observation placement as an outpatient claim are found under “Hospital Outpatient Observation Room Services” on page 25-25.

Complications following Emergency/Unscheduled Day Surgery
If the client requires inpatient admission following the observation stay, the admission date for the inpatient claim is the date the client was placed in observation. All charges for services provided from the time of observation status (excluding surgical procedures and emergency services) should be included on the inpatient claim (TOB 111) using the hospital’s provider identifier. The principal diagnosis to be used on the inpatient claim is the complication of the surgery that necessitated the extended stay. The day surgery and emergency services should not be included on the inpatient claim since they are to be billed (TOB 131) as outpatient procedures under the hospital’s provider identifier. Specific guidelines for billing observation placement as an outpatient claim are found under “Hospital Outpatient Observation Room Services” on page 25-25.

ASA Physical Status and Heart Disease Classifications
If a client is admitted for a day surgery procedure—whether scheduled or emergency—and has either an American Society of Anesthesiologists (ASA) Classification of Physical Status of III, IV, or V or Classification of Heart Disease III or IV (refer to Texas Medicaid Hospital Screening Criteria), the procedure may be considered an inpatient procedure and billed on an inpatient claim (TOB 111) using the hospital’s provider identifier. The reason for the surgery (principal diagnosis), any additional substantiated conditions, and the procedure must be included on one inpatient claim.

The ASA classifications of physical status consist of five classes:

- **Class I.** A patient who has no organic disease or in whom the disease is localized and causes no systemic disturbance.

- **Class II.** A patient exhibiting mild to moderate systemic disturbance that may or may not be associated with the surgical complaint and that interferes only moderately with the patient’s regular activities and general physiologic equilibrium.

**Example:** Non- or only slightly-limiting organic heart disease, mild diabetes, hypoglycemia, essential hypertension, or anemia; extreme obesity; chronic
bronchitis.

- **Class III.** A patient exhibiting severe systemic disturbance that may or may not be associated with the surgical complaint and that seriously interferes with the patient’s activities.

**Example:** Severely limiting organic heart disease, severe diabetes with vascular complications; moderate to severe degrees of pulmonary insufficiency; angina pectoris or healed myocardial infarction.

- **Class IV.** A patient exhibiting extreme systemic disturbance that may or may not be associated with the surgical complaint, that interferes with the patient’s regular activities, and that has already become life-threatening.

**Example:** Organic heart disease with marked signs of cardiac insufficiency present (for example, cardiac decompensation); persistent anginal syndrome, or active myocarditis; advanced degrees of pulmonary, hepatic, renal, or endocrine insufficiency present.

- **Class V.** The rare person who is moribund (in a dying state) before operation, whose preoperative condition is such that he or she is expected to die within 24 hours even though not subjected to the additional strain of operation.

**Example:** Burst abdominal aneurysm with profound shock; major cerebral trauma with rapidly increasing intracranial pressure; massive embolus.

The Classification of Heart Disease consists of four classes:

- **Class I.** No limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.

- **Class II.** Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.

- **Class III.** Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.

- **Class IV.** Unable to carry on any physical activity without discomfort. Symptoms of cardiac insufficiency, or of the anginal syndrome, may be present even at rest. If any physical activity is undertaken, discomfort occurs.

Inpatients may occasionally require a surgery that has been designated as an outpatient procedure. The physician must document the need for this surgery as an inpatient procedure before the procedure is performed. These claims are subject to retrospective review.

**Incomplete Day Surgeries**

When ASC/HASC providers bill the Texas Medicaid Program for an incomplete surgical procedure, the following information must be included on the claim:

- Modifier 73 or 74

- Facilities must use either the following diagnosis codes or modifier to indicate an incomplete surgical procedure, TOS F:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V641</td>
<td>Surgical or other procedure not carried out because of contraindication</td>
</tr>
<tr>
<td>V642</td>
<td>Surgical or other procedure not carried out because of patient’s decision</td>
</tr>
<tr>
<td>V643</td>
<td>Procedure not carried out for other reasons</td>
</tr>
</tbody>
</table>

Claims billed with diagnosis codes V641, V642, V643 and modifier 73 and 74 suspend for review of the medical documentation submitted with the claim. Providers must submit the operative report, the anesthesia report, and state why the operation was not completed.

Reimbursement to ASC/HASC facilities for canceled or incomplete surgeries because of patient complications, is made according to the following criteria, depending on the extent to which the anesthesia or surgery proceeded:

- Reimburse at 0 percent of ASC group payment schedule for a procedure that is terminated for nonmedical or medical reasons before the facility has expended substantial resources

- Reimburse at 33 percent of ASC group payment schedule up to the administration of anesthesia

- Reimburse at 50 percent of ASC group payment schedule after the administration of anesthesia but before incision

- Reimburse at 100 percent of ASC group payment schedule after incision

Surgeries canceled because of incomplete preoperative procedures are not reimbursed.
### 25.3.2.2 Revenue Codes (Outpatient Hospital)

UB-92 revenue codes must be used to bill outpatient hospital facility services. In some instances, a HCPCS procedure code is required in addition to the revenue code for accurate claims processing:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-250</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>B-251</td>
<td>Generic drugs</td>
<td></td>
</tr>
<tr>
<td>B-252</td>
<td>Non-generic drugs</td>
<td></td>
</tr>
<tr>
<td>B-253</td>
<td>Take Home drugs</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-254</td>
<td>Drugs incident to other diagnostic services</td>
<td></td>
</tr>
<tr>
<td>B-255</td>
<td>Drugs incident to radiology</td>
<td></td>
</tr>
<tr>
<td>B-256</td>
<td>Experimental drugs</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-257</td>
<td>Nonprescription drugs</td>
<td></td>
</tr>
<tr>
<td>B-258</td>
<td>IV solutions</td>
<td></td>
</tr>
<tr>
<td>B-259</td>
<td>Other pharmacy</td>
<td></td>
</tr>
<tr>
<td>B-630</td>
<td>Drugs requiring specific identification</td>
<td>HCPCS code required</td>
</tr>
<tr>
<td>B-631</td>
<td>Single source drug</td>
<td>HCPCS code required</td>
</tr>
<tr>
<td>B-632</td>
<td>Multiple source drug</td>
<td>HCPCS code required</td>
</tr>
<tr>
<td>B-633</td>
<td>Restrictive prescription</td>
<td>HCPCS code required</td>
</tr>
<tr>
<td>B-634</td>
<td>Erythropoietin (EPO) less than 10,000 units</td>
<td>HCPCS code required</td>
</tr>
<tr>
<td>B-635</td>
<td>Erythropoietin (EPO) 10,000 or more units</td>
<td>HCPCS code required</td>
</tr>
<tr>
<td>B-636</td>
<td>Drugs requiring detailed coding</td>
<td>HCPCS code required</td>
</tr>
<tr>
<td>B-637</td>
<td>Self-administrable drugs</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-260</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>B-261</td>
<td>Infusion pump</td>
<td></td>
</tr>
<tr>
<td>B-262</td>
<td>IV therapy/pharmacy services</td>
<td></td>
</tr>
<tr>
<td>B-263</td>
<td>IV therapy/drug/supply delivery</td>
<td></td>
</tr>
<tr>
<td>B-264</td>
<td>IV therapy/supplies</td>
<td></td>
</tr>
<tr>
<td>B-269</td>
<td>Other IV therapy</td>
<td></td>
</tr>
<tr>
<td>B-270</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>B-271</td>
<td>Nonsterile supply</td>
<td></td>
</tr>
<tr>
<td>B-272</td>
<td>Sterile supply</td>
<td></td>
</tr>
<tr>
<td>B-273</td>
<td>Take-home supplies</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-274</td>
<td>Prosthetic/orthotic devices</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-275</td>
<td>Pacemaker</td>
<td></td>
</tr>
<tr>
<td>B-276</td>
<td>Intraocular lens</td>
<td></td>
</tr>
<tr>
<td>B-277</td>
<td>Oxygen–take-home</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-278</td>
<td>Other implants</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-279</td>
<td>Other supplies/devices</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-620</td>
<td>Medical/surgical supplies</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-621</td>
<td>Supplies incident to radiology</td>
<td></td>
</tr>
<tr>
<td>B-622</td>
<td>Supplies incident to other diagnostic services</td>
<td></td>
</tr>
</tbody>
</table>

* HCPCS procedure code is required in addition to revenue code for accurate claims processing.
<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-623</td>
<td>Surgical dressings</td>
<td></td>
</tr>
<tr>
<td>B-624</td>
<td>FDA investigational devices</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

### Oncology

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-280</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>B-289</td>
<td>Other oncology</td>
<td></td>
</tr>
</tbody>
</table>

### Laboratory

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-300</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-301</td>
<td>Chemistry</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-302</td>
<td>Immunology</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-303</td>
<td>Renal patient (home)</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-304</td>
<td>Nonroutine dialysis</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-305</td>
<td>Hematology</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-306</td>
<td>Bacteriology and microbiology</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-307</td>
<td>Urology</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-309</td>
<td>Other laboratory</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

#### Laboratory Pathological

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-310</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-311</td>
<td>Cytology</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-312</td>
<td>Histology</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-314</td>
<td>Biopsy</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-319</td>
<td>Other pathology</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

#### Radiology–Diagnostic

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-320</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-321</td>
<td>Angiocardiography</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-322</td>
<td>Arthrography</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-323</td>
<td>Arteriography</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-324</td>
<td>Chest X-ray</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-329</td>
<td>Other diagnostic radiology</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

#### Radiology–Therapeutic

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-330</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-331</td>
<td>Chemotherapy–injected</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-332</td>
<td>Chemotherapy–oral</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-333</td>
<td>Chemotherapy–radiation therapy</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-335</td>
<td>Chemotherapy–IV</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-339</td>
<td>Other therapeutic radiology</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

### Nuclear Medicine

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-340</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-341</td>
<td>Diagnostic</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-342</td>
<td>Therapeutic</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-349</td>
<td>Other nuclear medicine</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

#### Computerized Tomography (CT) Scan

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-350</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

* HCPCS procedure code is required in addition to revenue code for accurate claims processing.
<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-351</td>
<td>Head scan</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-352</td>
<td>Body scan</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-359</td>
<td>Other CT scans</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

### Operating Room Services

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-360</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>B-361</td>
<td>Minor surgery</td>
<td></td>
</tr>
<tr>
<td>B-369</td>
<td>Other operating room services</td>
<td></td>
</tr>
</tbody>
</table>

### Anesthesia

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-370</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>B-371</td>
<td>Anesthesia incident to radiology</td>
<td></td>
</tr>
<tr>
<td>B-372</td>
<td>Anesthesia incident to other diagnostic services</td>
<td></td>
</tr>
<tr>
<td>B-374</td>
<td>Acupuncture</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-379</td>
<td>Other anesthesia</td>
<td></td>
</tr>
</tbody>
</table>

### Blood

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-380</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-381</td>
<td>Packed red cells</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-382</td>
<td>Whole blood</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-383</td>
<td>Plasma</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-384</td>
<td>Platelets</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-385</td>
<td>Leucocytes</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-386</td>
<td>Other components</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-387</td>
<td>Other derivatives (cryoprecipitates)</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-389</td>
<td>Other blood</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

### Blood Storage and Processing

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-390</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>B-391</td>
<td>Blood administration</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-399</td>
<td>Other blood storage and processing</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

### Other Imaging Services

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-400</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-401</td>
<td>Diagnostic mammography</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-402</td>
<td>Ultrasound</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-403</td>
<td>Screening mammography</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-404</td>
<td>Positron emission tomography</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-409</td>
<td>Other imaging services</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

### Respiratory Services

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-410</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>B-412</td>
<td>Inhalation services</td>
<td></td>
</tr>
<tr>
<td>B-413</td>
<td>Hyperbaric oxygen therapy</td>
<td></td>
</tr>
<tr>
<td>B-419</td>
<td>Other respiratory services</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

### Physical Therapy

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-420</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-421</td>
<td>Visit charge</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

* HCPCS procedure code is required in addition to revenue code for accurate claims processing.
<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-422</td>
<td>Hourly charge</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-423</td>
<td>Group rate</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-424*</td>
<td>Evaluation or re-evaluation</td>
<td>HCPSCS code required</td>
</tr>
<tr>
<td>B-429</td>
<td>Other physical therapy</td>
<td>Not a benefit</td>
</tr>
<tr>
<td></td>
<td><strong>Occupational Therapy</strong></td>
<td></td>
</tr>
<tr>
<td>B-430</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-431</td>
<td>Visit charge</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-432</td>
<td>Hourly charge</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-433</td>
<td>Group rate</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-434</td>
<td>Evaluation or re-evaluation</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-439</td>
<td>Other occupational therapy</td>
<td>Not a benefit</td>
</tr>
<tr>
<td></td>
<td><strong>Speech-Language Pathology</strong></td>
<td></td>
</tr>
<tr>
<td>B-440</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-441</td>
<td>Visit charge</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-442</td>
<td>Hourly charge</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-443</td>
<td>Group rate</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-444*</td>
<td>Evaluation or re-evaluation</td>
<td>HCPSCS code required</td>
</tr>
<tr>
<td>B-449</td>
<td>Other speech-language pathology</td>
<td>Not a benefit</td>
</tr>
<tr>
<td></td>
<td><strong>Emergency Room</strong></td>
<td></td>
</tr>
<tr>
<td>B-450</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>B-456</td>
<td>Urgent care</td>
<td></td>
</tr>
<tr>
<td>B-459</td>
<td>Other emergency room</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Pulmonary Function</strong></td>
<td></td>
</tr>
<tr>
<td>B-460</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-469</td>
<td>Other pulmonary function</td>
<td>Not a benefit</td>
</tr>
<tr>
<td></td>
<td><strong>Audiology</strong></td>
<td></td>
</tr>
<tr>
<td>B-470</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-471</td>
<td>Diagnostic</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-472</td>
<td>Treatment</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-479</td>
<td>Other Audiology</td>
<td>Not a benefit</td>
</tr>
<tr>
<td></td>
<td><strong>Cardiology</strong></td>
<td></td>
</tr>
<tr>
<td>B-480</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-481</td>
<td>Cardiac cath lab</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-482</td>
<td>Stress test</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-489</td>
<td>Other cardiology</td>
<td>Not a benefit</td>
</tr>
<tr>
<td></td>
<td><strong>Clinic</strong></td>
<td></td>
</tr>
<tr>
<td>B-510</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>B-511</td>
<td>Chronic pain center</td>
<td></td>
</tr>
<tr>
<td>B-512</td>
<td>Dental clinic</td>
<td></td>
</tr>
<tr>
<td>B-513</td>
<td>Psychiatric clinic</td>
<td></td>
</tr>
<tr>
<td>B-514</td>
<td>OB-GYN clinic</td>
<td></td>
</tr>
<tr>
<td>B-515</td>
<td>Pediatric clinic</td>
<td></td>
</tr>
</tbody>
</table>

* HCPSCS procedure code is required in addition to revenue code for accurate claims processing.
<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-516</td>
<td>Urgent Care clinic</td>
<td></td>
</tr>
<tr>
<td>B-517</td>
<td>Family Practice clinic</td>
<td></td>
</tr>
<tr>
<td>B-519</td>
<td>Other clinic</td>
<td></td>
</tr>
</tbody>
</table>

**Freestanding Clinic**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-520</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>B-523</td>
<td>Family practice clinic</td>
<td></td>
</tr>
<tr>
<td>B-526</td>
<td>Urgent care clinic</td>
<td></td>
</tr>
<tr>
<td>B-529</td>
<td>Other freestanding clinic</td>
<td></td>
</tr>
</tbody>
</table>

**Magnetic Resonance Technology (MRT)**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-610</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-611</td>
<td>Magnetic Resonance Imaging (MRI) brain (including brainstem)</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-612</td>
<td>MRI spinal cord (including spine)</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-619</td>
<td>Other MRT</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

**Cast Room**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>B-700</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>B-709</td>
<td>Other cast room</td>
<td></td>
</tr>
</tbody>
</table>

**Recovery Room**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>B-710</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>B-719</td>
<td>Other recovery room</td>
<td></td>
</tr>
</tbody>
</table>

**Labor Room/Delivery**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>B-720</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>B-721</td>
<td>Labor</td>
<td></td>
</tr>
<tr>
<td>B-722</td>
<td>Delivery</td>
<td></td>
</tr>
<tr>
<td>B-723</td>
<td>Circumcision</td>
<td></td>
</tr>
<tr>
<td>B-724</td>
<td>Birthing center</td>
<td></td>
</tr>
<tr>
<td>B-729</td>
<td>Other labor room/delivery</td>
<td></td>
</tr>
</tbody>
</table>

**EKG/ECG (Electrocardiogram)**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-730</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-731</td>
<td>Holter monitor</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-732</td>
<td>Telemetry</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-739</td>
<td>Other EKG/ECG</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

**EEG (Electroencephalogram)**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-740</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-749</td>
<td>Other EEG</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

**Gastrointestinal Services**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>B-750</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>B-759</td>
<td>Other gastrointestinal</td>
<td></td>
</tr>
</tbody>
</table>

**Treatment or Observation Room**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>B-760</td>
<td>General classification</td>
<td></td>
</tr>
<tr>
<td>B-761</td>
<td>Treatment room</td>
<td></td>
</tr>
<tr>
<td>B-762</td>
<td>Observation room</td>
<td></td>
</tr>
</tbody>
</table>

* HCPCS procedure code is required in addition to revenue code for accurate claims processing.
Section 25

25.3.3 Benefits and Limitations

Outpatient hospital services are diagnostic, therapeutic, and rehabilitative services that are provided to clients by or under the direction of a physician in a licensed hospital setting.

Benefits do not include drugs and biologicals taken home by the client. Supplies provided by a hospital supply room for use in physicians’ offices in the treatment of clients in the outpatient setting are not reimbursable.

Take-home drugs and supplies are covered in the outpatient setting for outpatients when supplied by prescription through the Vendor Drug Program.

Outpatient hospital services include those services performed in the emergency room (ER) clinic or observation room. In instances of sudden illness or injury, the client may receive treatment in the emergency room and be discharged, placed on observation status, or admitted as an inpatient. If a client goes from the emergency room to an observation room, the hospital is reimbursed only for the observation room charges: not the emergency room charges. If a client visits the emergency room more than once in one day, the times must be given for each visit. If the client ultimately is admitted as an inpatient within 24 hours of treatment in the emergency room or clinic, the emergency room or clinic charges must be billed on the inpatient hospital claim form as an ancillary charge. The date of inpatient admission is the date the client initially was seen in the emergency room or clinic.

Outpatient hospital services must be itemized by date of service. Procedure repeated over a period of time should be billed for each separate date of service. Do not combine multiple dates of service on the same line detail.

Medicaid pays the clinic registration fee in lieu of other benefits when a hospital provides outpatient services without charge, and if the fee is less than what the Medicaid payment would be for the service.

Refer to: “Medicaid Program Limitations and Exclusions” on page 1-17 for more information about noncovered items/services.

### 25.3.3.1 Emergency Department Services

An emergency department is defined as an organized hospital-based facility for the provision of unscheduled episodic services to clients who present for immediate medical attention. The facility must be available 24 hours a day. Hospital-based emergency departments are reimbursed for services based on a reasonable cost, based on the hospital’s most recent tentative Medicaid cost report settlement. The reasonable cost is reduced by a percentage determined by the state.

---

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-769</td>
<td>Other treatment/observation room</td>
<td></td>
</tr>
</tbody>
</table>

**Preventive Care Services**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-770</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-771</td>
<td>Vaccine administration</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-779</td>
<td>Other preventive care services</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

**Lithotripsy**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-790</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-799</td>
<td>Other lithotripsy</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

**Other Diagnostic Services**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-920</td>
<td>General classification</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-921</td>
<td>Peripheral vascular lab</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-922</td>
<td>Electromyelogram</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-923</td>
<td>Pap smear</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-924</td>
<td>Allergy test</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-925</td>
<td>Pregnancy test</td>
<td>Not a benefit</td>
</tr>
<tr>
<td>B-929</td>
<td>Other diagnostic service</td>
<td>Not a benefit</td>
</tr>
</tbody>
</table>

* HCPCS procedure code is required in addition to revenue code for accurate claims processing.
Emergency department room charges may be billed using the following revenue codes:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-450 or B456 or B-459</td>
<td>Emergency room or Emergency room, urgent care or Emergency room—other</td>
</tr>
<tr>
<td>B-761</td>
<td>Treatment room</td>
</tr>
<tr>
<td>B-762</td>
<td>Observation room</td>
</tr>
</tbody>
</table>

Emergency department ancillary services include laboratory services, radiology services, respiratory therapy services, and diagnostic studies, such as EKGs, CT scans, and supplies. Ancillary services should be billed on a HCFA-1450 (UB-92) claim form using the appropriate procedure codes such as the Current Procedural Terminology (CPT) code or the HCPCS code indicating the procedures or services performed.

According to federal legislation, if any individual presents at the hospital’s emergency department requesting an examination or treatment, the hospital must provide an appropriate medical screening examination and stabilization services within the capability of the hospital’s emergency department, including ancillary services routinely available to the emergency department, to determine whether an emergency medical condition exists.

Medicaid claims administrators and Medicaid Managed Care Organizations (MCOs) are prohibited from requiring prior authorization or primary care provider notification for emergency services including those that are needed to evaluate or stabilize an emergency medical condition or emergency behavioral health condition.

The Texas Medicaid Program provides that certain undocumented aliens and legalized aliens who require treatment of an emergency medical condition or emergency behavioral health condition are eligible to receive that treatment. After the emergency condition requiring care is stabilized and no longer an emergency, the coverage ends. If the alien continues to receive ongoing treatment after the emergency ceases, the ongoing treatment is not covered.

The Texas Medicaid Program provides for medical services for eligible clients while out-of-state. The attending physician or other provider must document that the client was treated for an emergency condition. Out-of-state emergency services are covered also when the client’s health would be in danger if he or she were required to travel back to Texas.

Emergency department services are subject to retrospective review.

25.3.3.2 Hospital Outpatient Observation Room Services

Outpatient means a client is in an organized medical facility, and receives, professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the client remains in the facility past midnight.

Some patients, while not requiring an inpatient hospital admission, may require an extended period of observation (less than 24 hours) in the hospital environment on an outpatient basis. The client is considered an outpatient if he or she remains in the hospital for less than 24 consecutive hours and is discharged to home from an outpatient observation status.

Observation services may be provided in any part of the hospital where a patient can be assessed, examined, monitored, or treated.

If a physician’s order for outpatient observation is present in the patient’s medical record, per Title 1 Texas Administrative Code (TAC) §371.206(b), the Texas Medicaid Program considers reimbursement to the hospital for outpatient observation services based on the facility’s reimbursement rate.

Hospitals may bill medically necessary outpatient services provided during the initial period of observation on TOB 131. The hospital outpatient observation room service commences with the first clinical contact of the client by professional/licensed staff of the hospital.

Because the unit associated with the observation room charge (B-762) is considered to be hours, claims submitted with observation room units exceeding 23 hours are denied with EOB code 643, Claim indicates outpatient charges in excess of 23 hours. Facilities should resubmit these outpatient claims as appeals with charges for the initial 23 hours only.

Any service ordered within the initial 24 hour period may be included on the outpatient claim if a physician’s order for the service is within the observation period time frame but hospital scheduling limitations prevent the service from being performed before 23-hours has expired. Any services ordered after the initial 24 hours must not be included on the outpatient claim nor billed to the client.

To receive reimbursement for physician-ordered services that are medically necessary and exceed the 24-hour period from the initial point of contact, the claim may be submitted as an inpatient stay. All observation room charges, outpatient charges (except ambulatory surgical procedure codes as listed in the current ASC/HASC fee schedule), and emergency room charges for an inpatient claim are included in the reimbursement methodology and are not reimbursed separately (charges for an observation room on an inpatient claim should be coded with revenue code 760).

It is important to realize that any inpatient stay billed to the Texas Medicaid Program is subject to retrospective review by the HHSC UR unit with the possibility for denial if the admission is determined not medically necessary. If the inpatient admission is denied as not medically necessary, UR may allow services rendered during the
first 23 hours (less than 24 hours) to be rebilled to TMHP as an outpatient claim if a physician’s order for outpatient observation is present in the hospital medical record (per Title 1 TAC §371.206(b)). The claim must be submitted to THMP within 120 days from the date of the UR notification letter.

The following documentation must accompany the revised bill:

- Revised HCFA-1450 (UB-92) claim form containing the required data for outpatient billing for medically necessary outpatient services
- Copy of the UR notification letter indicating services may be rebilled

When a client is admitted to the hospital as an inpatient and is discharged in less than 24 hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This billing practice is acceptable under the Texas Medicaid Program when the physician makes the changes to the admitting order from inpatient status to outpatient observation status before the hospital submits the claim for reimbursement. A hospital is not allowed to convert a patient from observation status to inpatient admission status without a physician’s order.

### 25.3.3.3 Outpatient Total Parenteral Hyperalimentation

Outpatient parenteral hyperalimentation may be administered only as a life-sustaining measure, and the procedure must be prior authorized in writing. Claims for hyperalimentation therapy administered as a nutritional supplement are denied.

### 25.3.3.4 Aerosol Treatment

Aerosol treatments, including vaporizers, humidifiers, nebulizers, and inhalers are covered by the Texas Medicaid Program. These treatments must be coded with revenue code B-412, Respiratory services—inhalation services.

Effective April 1, 2004, the following revised diagnosis codes will be payable for aerosol treatments:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>042</td>
<td>Human immunodeficiency virus (HIV) disease</td>
</tr>
<tr>
<td>0796</td>
<td>Respiratory syncytial virus (RSV)</td>
</tr>
<tr>
<td>1363</td>
<td>Pneumocystosis</td>
</tr>
<tr>
<td>27700</td>
<td>Cystic fibrosis, without mention of meconium ileus</td>
</tr>
<tr>
<td>27701</td>
<td>Cystic fibrosis with meconium ileus</td>
</tr>
<tr>
<td>46400</td>
<td>Acute laryngitis without mention of obstruction</td>
</tr>
<tr>
<td>46401</td>
<td>Acute laryngitis with obstruction</td>
</tr>
<tr>
<td>46410</td>
<td>Acute tracheitis without mention of obstruction</td>
</tr>
<tr>
<td>46411</td>
<td>Acute tracheitis with obstruction</td>
</tr>
<tr>
<td>46420</td>
<td>Acute laryngotracheitis without mention of obstruction</td>
</tr>
<tr>
<td>46421</td>
<td>Acute laryngotracheitis with obstruction</td>
</tr>
<tr>
<td>46430</td>
<td>Acute epiglottitis without mention of obstruction</td>
</tr>
<tr>
<td>46431</td>
<td>Acute epiglottitis with obstruction</td>
</tr>
<tr>
<td>4644</td>
<td>Croup</td>
</tr>
<tr>
<td>46450</td>
<td>Supraglottitis unspecified without obstruction</td>
</tr>
<tr>
<td>46451</td>
<td>Supraglottitis unspecified with obstruction</td>
</tr>
<tr>
<td>4660</td>
<td>Acute bronchitis</td>
</tr>
<tr>
<td>46611</td>
<td>Acute bronchiolitis due to RSV</td>
</tr>
<tr>
<td>46619</td>
<td>Acute bronchiolitis due to other infectious organisms</td>
</tr>
<tr>
<td>4786</td>
<td>Edema of larynx</td>
</tr>
<tr>
<td>47875</td>
<td>Laryngeal spasm</td>
</tr>
<tr>
<td>4788</td>
<td>Upper respiratory tract hypersensitivity reaction, site unspecified</td>
</tr>
<tr>
<td>48284</td>
<td>Pneumonia due to legionnaires’ disease</td>
</tr>
<tr>
<td>490</td>
<td>Bronchitis, not specified as acute or chronic</td>
</tr>
<tr>
<td>4910</td>
<td>Simple chronic bronchitis</td>
</tr>
<tr>
<td>4911</td>
<td>Mucopurulent chronic bronchitis</td>
</tr>
</tbody>
</table>
Revenue code B-412, Inhalation services, billed for aerosol therapy in the recovery room after outpatient surgery (billed on an outpatient claim) is also allowable as it is a necessary adjunct to the postoperative recovery of a client who has undergone general anesthesia.

Revenue code B-412 includes the inhalers listed below and is payable in the outpatient setting (place of service [POS] 5) when it is the only therapy billed on that day:

- Beclomethasone dipropionate (Vanceril or Beclovent oral inhalers)
- Isoproterenol sulfate (Iso-Autohaler, Luf-Iso Inhaler, Medihaler-Isol, Norisodrine Aerohaler)
- Isoproterenol Hydrochloride (Iprenol, Vapo-Iso inhalers)
- Albuterol (Proventil or Ventolin inhalers)
- Metaproterenol Sulfate (Alupent Metered Dose inhaler, Metaprel inhaler, Alupent 10 mL, Alupent 30 mL)
- Epinephrine Bitartrate (Medihaler-Epi and Primatene Mist Suspension inhaler)
- Phenylephrine Bitartrate (Duo-Medihaler)
- Isoetharine Mesylate inhalation aerosol (Bronkometer)
- Dexamethasone Sodium Phosphate (Turbinaire or Respihaler)

When revenue code B-412, Respiratory services–inhalation services, is billed on the same day for both aerosol therapy and inhalers, only one service is allowed, not both.

Intermittent positive pressure breathing (IPPB) treatments have been determined to be inappropriate for the treatment of most respiratory problems and are denied.

### 25.3.3.5 Pentamidine Aerosol

Aerosol pentamidine treatments will be reimbursed using procedure code 1-94642.

Additionally, the provider may also be reimbursed for the medication using procedure code 1-J2545.

Payment for aerosol pentamidine treatments is limited to the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>042</td>
<td>HIV disease</td>
</tr>
<tr>
<td>07951</td>
<td>Human t-cell lymphotrophic virus, type I (HTLV-I)</td>
</tr>
<tr>
<td>07952</td>
<td>Human t-cell lymphotrophic virus, type II (HTLV-II)</td>
</tr>
<tr>
<td>07953</td>
<td>Human immunodeficiency virus, type 2 (HIV-2)</td>
</tr>
<tr>
<td>1363</td>
<td>Pneumocystosis</td>
</tr>
<tr>
<td>48284</td>
<td>Pneumonia due to legionnaires’ disease</td>
</tr>
<tr>
<td>5186</td>
<td>Allergic bronchopulmonary aspergillosis</td>
</tr>
</tbody>
</table>

Aerosol pentamidine treatments are limited to one treatment every 28 days.
25.3.3.6 Pulmonary Function Studies
When CPT codes 5-94014 and 5-94015 are billed together, CPT code 5-94015 denies as part of CPT code 5-94014.

25.3.3.7 Chemotherapy Administration
Hospitals submit outpatient charges using the appropriate revenue codes for room charges, supplies, IV equipment, and pharmacy.

Use the following revenue codes when administering chemotherapy in the following settings:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B-264</td>
<td>IV therapy, IV therapy/supplies</td>
</tr>
<tr>
<td>B-450 or B456 or B-459</td>
<td>Emergency room or Emergency room, urgent care or Emergency room–other</td>
</tr>
<tr>
<td>B-510 or B-511 or B-512 or B-514 or B-515 or B-516 or B-517 or B-519</td>
<td>Clinic or Clinic–chronic pain center or Clinic–dental or Clinic; OB/GYN or Clinic; pediatric or Clinic, urgent care clinic or Clinic, family practice clinic or Clinic–other</td>
</tr>
<tr>
<td>B-761</td>
<td>Treatment room</td>
</tr>
<tr>
<td>B-762</td>
<td>Observation room</td>
</tr>
</tbody>
</table>

Intravesical BCG vaccines will autodeny for all other diagnoses.

Procedure code 1-90585, is a covered benefit of the Texas Medicaid Program for diagnosis code V032, Need for prophylactic vaccination and inoculation against BCG.

25.3.3.9 Tetanus Injections, Acute Care
Tetanus toxoid absorbed and Tetanus immune globulin, human, are benefits of the Texas Medicaid Program. These injections are diagnosis-restricted to cover injuries listed in the diagnosis table below.

Tetanus toxoid absorbed is an immunization used to prevent tetanus. It produces immunity to tetanus by promoting antibody production. The tetanus immune globulin provides a passive immunity for injuries that are over 24 hours old, extensively contaminated and/or for the client who has had less than two tetanus toxoid injections in a lifetime. Therefore, both of these injections can be given on the same day for the same injury event.

Tetanus toxoid and tetanus immune globulin should be billed with procedure codes 1-11670 and 1-90703.

Tetanus toxoid and tetanus immune globulin injections are covered for injuries, such as puncture wounds, burns or abrasions. These injections are restricted to the diagnosis codes listed in the following table:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1885</td>
<td>Malignant neoplasm of bladder neck</td>
</tr>
<tr>
<td>1886</td>
<td>Malignant neoplasm of ureteric orifice</td>
</tr>
<tr>
<td>1887</td>
<td>Malignant neoplasm of urachus</td>
</tr>
<tr>
<td>1888</td>
<td>Malignant neoplasm of other specified sites of bladder</td>
</tr>
<tr>
<td>1889</td>
<td>Malignant neoplasm of bladder, part unspecified</td>
</tr>
<tr>
<td>2337</td>
<td>Carcinoma in-situ of the bladder</td>
</tr>
</tbody>
</table>

25.3.3.8 Bacillus Calmette-Guerin (BCG) Vaccine
Procedure code 1-J9031, is a covered benefit of the Texas Medicaid Program for the diagnosis codes listed below. Procedure code 1-90586, is also a covered benefit of the Texas Medicaid Program for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1880</td>
<td>Malignant neoplasm of trigone of urinary bladder</td>
</tr>
<tr>
<td>1881</td>
<td>Malignant neoplasm of dome of urinary bladder</td>
</tr>
<tr>
<td>1882</td>
<td>Malignant neoplasm of lateral wall of urinary bladder</td>
</tr>
<tr>
<td>1883</td>
<td>Malignant neoplasm of anterior wall of urinary bladder</td>
</tr>
<tr>
<td>1884</td>
<td>Malignant neoplasm of posterior wall of urinary bladder</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>80005</td>
<td>Closed fracture of vault of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80006</td>
<td>Closed fracture of vault of skull without mention of intracranial injury, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80009</td>
<td>Closed fracture of vault of skull without mention of intracranial injury, with concussion, unspecified</td>
</tr>
<tr>
<td>80010</td>
<td>Closed fracture of vault of skull with cerebral laceration and contusion, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80011</td>
<td>Closed fracture of vault of skull with cerebral laceration and contusion, with no loss of consciousness</td>
</tr>
<tr>
<td>80012</td>
<td>Closed fracture of vault of skull with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80013</td>
<td>Closed fracture of vault of skull with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80014</td>
<td>Closed fracture of vault of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80015</td>
<td>Closed fracture of vault of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80016</td>
<td>Closed fracture of vault of skull with cerebral laceration and contusion, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80019</td>
<td>Closed fracture of vault of skull with cerebral laceration and contusion, with concussion, unspecified</td>
</tr>
<tr>
<td>80020</td>
<td>Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80021</td>
<td>Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness</td>
</tr>
<tr>
<td>80022</td>
<td>Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80023</td>
<td>Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80024</td>
<td>Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80025</td>
<td>Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80026</td>
<td>Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80029</td>
<td>Closed fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified</td>
</tr>
<tr>
<td>80030</td>
<td>Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80031</td>
<td>Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with no loss of consciousness</td>
</tr>
<tr>
<td>80032</td>
<td>Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80033</td>
<td>Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80034</td>
<td>Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80035</td>
<td>Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80036</td>
<td>Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80039</td>
<td>Closed fracture of vault of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>80040</td>
<td>Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80041</td>
<td>Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with no loss of consciousness</td>
</tr>
<tr>
<td>80042</td>
<td>Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80043</td>
<td>Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80044</td>
<td>Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80045</td>
<td>Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80046</td>
<td>Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80049</td>
<td>Closed fracture of vault of skull with intracranial injury of other and unspecified nature, with concussion, unspecified</td>
</tr>
<tr>
<td>80050</td>
<td>Open fracture of vault of skull without mention of intracranial injury, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80051</td>
<td>Open fracture of vault of skull without mention of intracranial injury, with no loss of consciousness</td>
</tr>
<tr>
<td>80052</td>
<td>Open fracture of vault of skull without mention of intracranial injury, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80053</td>
<td>Open fracture of vault of skull without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80054</td>
<td>Open fracture of vault of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80055</td>
<td>Open fracture of vault of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80056</td>
<td>Open fracture of vault of skull without mention of intracranial injury, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80059</td>
<td>Open fracture of vault of skull without mention of intracranial injury, with concussion, unspecified</td>
</tr>
<tr>
<td>80060</td>
<td>Open fracture of vault of skull with cerebral laceration and contusion, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80061</td>
<td>Open fracture of vault of skull with cerebral laceration and contusion, with no loss of consciousness</td>
</tr>
<tr>
<td>80062</td>
<td>Open fracture of vault of skull with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80063</td>
<td>Open fracture of vault of skull with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80064</td>
<td>Open fracture of vault of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80065</td>
<td>Open fracture of vault of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80066</td>
<td>Open fracture of vault of skull with cerebral laceration and contusion, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80069</td>
<td>Open fracture of vault of skull with cerebral laceration and contusion, with concussion, unspecified</td>
</tr>
<tr>
<td>80070</td>
<td>Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80071</td>
<td>Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness</td>
</tr>
<tr>
<td>80072</td>
<td>Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80073</td>
<td>Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80074</td>
<td>Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>80075</td>
<td>Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80076</td>
<td>Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80079</td>
<td>Open fracture of vault of skull with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified</td>
</tr>
<tr>
<td>80080</td>
<td>Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80081</td>
<td>Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with no loss of consciousness</td>
</tr>
<tr>
<td>80082</td>
<td>Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80083</td>
<td>Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80084</td>
<td>Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80085</td>
<td>Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80086</td>
<td>Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80089</td>
<td>Open fracture of vault of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified</td>
</tr>
<tr>
<td>80090</td>
<td>Open fracture of vault of skull with intracranial injury of other and unspecified nature, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80091</td>
<td>Open fracture of vault of skull with intracranial injury of other and unspecified nature, with no loss of consciousness</td>
</tr>
<tr>
<td>80092</td>
<td>Open fracture of vault of skull with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80093</td>
<td>Open fracture of vault of skull with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80094</td>
<td>Open fracture of vault of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80096</td>
<td>Open fracture of vault of skull with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80099</td>
<td>Open fracture of vault of skull with intracranial injury of other and unspecified nature, with concussion, unspecified</td>
</tr>
<tr>
<td>80100</td>
<td>Closed fracture of base of skull without mention of intracranial injury, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80101</td>
<td>Closed fracture of base of skull without mention of intracranial injury, with no loss of consciousness</td>
</tr>
<tr>
<td>80102</td>
<td>Closed fracture of base of skull without mention of intracranial injury, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80103</td>
<td>Closed fracture of base of skull without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80104</td>
<td>Closed fracture of base of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80105</td>
<td>Closed fracture of base of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80106</td>
<td>Closed fracture of base of skull without mention of intracranial injury, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80109</td>
<td>Closed fracture of base of skull without mention of intracranial injury, with concussion, unspecified</td>
</tr>
<tr>
<td>80110</td>
<td>Closed fracture of base of skull with cerebral laceration and contusion, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80111</td>
<td>Closed fracture of base of skull with cerebral laceration and contusion, with no loss of consciousness</td>
</tr>
<tr>
<td>80112</td>
<td>Closed fracture of base of skull with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>80113</td>
<td>Closed fracture of base of skull with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80114</td>
<td>Closed fracture of base of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80115</td>
<td>Closed fracture of base of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80116</td>
<td>Closed fracture of base of skull with cerebral laceration and contusion, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80119</td>
<td>Closed fracture of base of skull with cerebral laceration and contusion, with concussion, unspecified</td>
</tr>
<tr>
<td>80120</td>
<td>Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80121</td>
<td>Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness</td>
</tr>
<tr>
<td>80122</td>
<td>Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80123</td>
<td>Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80124</td>
<td>Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80125</td>
<td>Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80126</td>
<td>Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80129</td>
<td>Closed fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80130</td>
<td>Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80131</td>
<td>Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with no loss of consciousness</td>
</tr>
<tr>
<td>80132</td>
<td>Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80133</td>
<td>Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80134</td>
<td>Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80135</td>
<td>Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80136</td>
<td>Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80139</td>
<td>Closed fracture of base of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified</td>
</tr>
<tr>
<td>80140</td>
<td>Closed fracture of base of skull with intracranial injury of other and unspecified nature, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80141</td>
<td>Closed fracture of base of skull with intracranial injury of other and unspecified nature, with no loss of consciousness</td>
</tr>
<tr>
<td>80142</td>
<td>Closed fracture of base of skull with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80143</td>
<td>Closed fracture of base of skull with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80144</td>
<td>Closed fracture of base of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>80145</td>
<td>Closed fracture of base of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80146</td>
<td>Closed fracture of base of skull with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80149</td>
<td>Closed fracture of base of skull with intracranial injury of other and unspecified nature, with concussion, unspecified</td>
</tr>
<tr>
<td>80150</td>
<td>Open fracture of base of skull without mention of intracranial injury, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80151</td>
<td>Open fracture of base of skull without mention of intracranial injury, with no loss of consciousness</td>
</tr>
<tr>
<td>80152</td>
<td>Open fracture of base of skull without mention of intracranial injury, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80153</td>
<td>Open fracture of base of skull without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80154</td>
<td>Open fracture of base of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80155</td>
<td>Open fracture of base of skull without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80156</td>
<td>Open fracture of base of skull without mention of intracranial injury, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80159</td>
<td>Open fracture of base of skull without mention of intracranial injury, with concussion, unspecified</td>
</tr>
<tr>
<td>80160</td>
<td>Open fracture of base of skull with cerebral laceration and contusion, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80161</td>
<td>Open fracture of base of skull with cerebral laceration and contusion, with no loss of consciousness</td>
</tr>
<tr>
<td>80162</td>
<td>Open fracture of base of skull with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80163</td>
<td>Open fracture of base of skull with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80164</td>
<td>Open fracture of base of skull with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80165</td>
<td>Open fracture of base of skull with cerebral laceration and contusion, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80166</td>
<td>Open fracture of base of skull with cerebral laceration and contusion, with concussion, unspecified</td>
</tr>
<tr>
<td>80169</td>
<td>Open fracture of base of skull with cerebral laceration and contusion, with concussion, unspecified</td>
</tr>
<tr>
<td>80170</td>
<td>Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80171</td>
<td>Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness</td>
</tr>
<tr>
<td>80172</td>
<td>Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80173</td>
<td>Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80174</td>
<td>Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80175</td>
<td>Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80176</td>
<td>Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80179</td>
<td>Open fracture of base of skull with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified</td>
</tr>
<tr>
<td>80180</td>
<td>Open fracture of base of skull with other and unspecified intracranial hemorrhage, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80181</td>
<td>Open fracture of base of skull with other and unspecified intracranial hemorrhage, with no loss of consciousness</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>80182</td>
<td>Open fracture of base of skull with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80183</td>
<td>Open fracture of base of skull with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80184</td>
<td>Open fracture of base of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80185</td>
<td>Open fracture of base of skull with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80186</td>
<td>Open fracture of base of skull with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80189</td>
<td>Open fracture of base of skull with other and unspecified intracranial hemorrhage, with concussion, unspecified</td>
</tr>
<tr>
<td>80190</td>
<td>Open fracture of base of skull with intracranial injury of other and unspecified nature, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80191</td>
<td>Open fracture of base of skull with intracranial injury of other and unspecified nature, with no loss of consciousness</td>
</tr>
<tr>
<td>80192</td>
<td>Open fracture of base of skull with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80193</td>
<td>Open fracture of base of skull with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80194</td>
<td>Open fracture of base of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80195</td>
<td>Open fracture of base of skull with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80196</td>
<td>Open fracture of base of skull with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80199</td>
<td>Open fracture of base of skull with intracranial injury of other and unspecified nature, with concussion, unspecified</td>
</tr>
<tr>
<td>8020</td>
<td>Closed fracture of nasal bones</td>
</tr>
<tr>
<td>8021</td>
<td>Open fracture of nasal bones</td>
</tr>
<tr>
<td>80220</td>
<td>Closed fracture of unspecified site of mandible</td>
</tr>
<tr>
<td>80221</td>
<td>Closed fracture of condylar process of mandible</td>
</tr>
<tr>
<td>80222</td>
<td>Closed fracture of subcondylar process of mandible</td>
</tr>
<tr>
<td>80223</td>
<td>Closed fracture of coronoid process of mandible</td>
</tr>
<tr>
<td>80224</td>
<td>Closed fracture of unspecified part of ramus of mandible</td>
</tr>
<tr>
<td>80225</td>
<td>Closed fracture of angle of jaw</td>
</tr>
<tr>
<td>80226</td>
<td>Closed fracture of symphysis of body of mandible</td>
</tr>
<tr>
<td>80227</td>
<td>Closed fracture of alveolar border of body of mandible</td>
</tr>
<tr>
<td>80228</td>
<td>Closed fracture of other and unspecified part of body of mandible</td>
</tr>
<tr>
<td>80229</td>
<td>Closed fracture of multiple sites of mandible</td>
</tr>
<tr>
<td>80230</td>
<td>Open fracture of unspecified site of mandible</td>
</tr>
<tr>
<td>80231</td>
<td>Open fracture of condylar process of mandible</td>
</tr>
<tr>
<td>80232</td>
<td>Open fracture of subcondylar process of mandible</td>
</tr>
<tr>
<td>80233</td>
<td>Open fracture of coronoid process of mandible</td>
</tr>
<tr>
<td>80234</td>
<td>Open fracture of unspecified part of ramus of mandible</td>
</tr>
<tr>
<td>80235</td>
<td>Open fracture of angle of jaw</td>
</tr>
<tr>
<td>80236</td>
<td>Open fracture of symphysis of body of mandible</td>
</tr>
<tr>
<td>80237</td>
<td>Open fracture of alveolar border of body of mandible</td>
</tr>
<tr>
<td>80238</td>
<td>Open fracture of body of mandible, other and unspecified</td>
</tr>
<tr>
<td>80239</td>
<td>Open fracture of multiple sites of mandible</td>
</tr>
<tr>
<td>8024</td>
<td>Closed fracture of malar and maxillary bones</td>
</tr>
<tr>
<td>8025</td>
<td>Closed fracture of malar and maxillary bones</td>
</tr>
<tr>
<td>8026</td>
<td>Closed fracture of orbital floor (blow-out)</td>
</tr>
<tr>
<td>8027</td>
<td>Open fracture of orbital floor (blow-out)</td>
</tr>
<tr>
<td>8028</td>
<td>Closed fracture of other facial bones</td>
</tr>
<tr>
<td>8029</td>
<td>Open fracture of other facial bones</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>80300</td>
<td>Other closed skull fracture without mention of intracranial injury, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80301</td>
<td>Other closed skull fracture without mention of intracranial injury, with no loss of consciousness</td>
</tr>
<tr>
<td>80302</td>
<td>Other closed skull fracture without mention of intracranial injury, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80303</td>
<td>Other closed skull fracture without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80304</td>
<td>Other closed skull fracture without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80305</td>
<td>Other closed skull fracture without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80306</td>
<td>Other closed skull fracture without mention of intracranial injury, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80309</td>
<td>Other closed skull fracture without mention of intracranial injury, with concussion, unspecified</td>
</tr>
<tr>
<td>80310</td>
<td>Other closed skull fracture with cerebral laceration and contusion, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80311</td>
<td>Other closed skull fracture with cerebral laceration and contusion, with no loss of consciousness</td>
</tr>
<tr>
<td>80312</td>
<td>Other closed skull fracture with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80313</td>
<td>Other closed skull fracture with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80314</td>
<td>Other closed skull fracture with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80315</td>
<td>Other closed skull fracture with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80316</td>
<td>Other closed skull fracture with cerebral laceration and contusion, with loss of consciousness of unspecified duration</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80319</td>
<td>Other closed skull fracture with cerebral laceration and contusion, with concussion, unspecified</td>
</tr>
<tr>
<td>80320</td>
<td>Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80321</td>
<td>Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness</td>
</tr>
<tr>
<td>80322</td>
<td>Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80323</td>
<td>Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80324</td>
<td>Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80325</td>
<td>Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80326</td>
<td>Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80329</td>
<td>Other closed skull fracture with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified</td>
</tr>
<tr>
<td>80330</td>
<td>Other closed skull fracture with other and unspecified intracranial hemorrhage, with state of unconsciousness unspecified</td>
</tr>
<tr>
<td>80331</td>
<td>Other closed skull fracture with other and unspecified intracranial hemorrhage, with no loss of consciousness</td>
</tr>
<tr>
<td>80332</td>
<td>Other closed skull fracture with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80333</td>
<td>Other closed skull fracture with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80334</td>
<td>Other closed skull fracture with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>80335</td>
<td>Other closed skull fracture with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80336</td>
<td>Other closed skull fracture with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80339</td>
<td>Other closed skull fracture with other and unspecified intracranial hemorrhage, with concussion, unspecified</td>
</tr>
<tr>
<td>80340</td>
<td>Other closed skull fracture with intracranial injury of other and unspecified nature, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80341</td>
<td>Other closed skull fracture with intracranial injury of other and unspecified nature, with no loss of consciousness</td>
</tr>
<tr>
<td>80342</td>
<td>Other closed skull fracture with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80343</td>
<td>Other closed skull fracture with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80344</td>
<td>Other closed skull fracture with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80345</td>
<td>Other site of closed skull fracture with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80346</td>
<td>Other site of closed skull fracture with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80349</td>
<td>Other site of closed skull fracture with intracranial injury of other and unspecified nature, with concussion, unspecified</td>
</tr>
<tr>
<td>80350</td>
<td>Other open skull fracture without mention of injury, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80351</td>
<td>Other open skull fracture without mention of intracranial injury, with no loss of consciousness</td>
</tr>
<tr>
<td>80352</td>
<td>Other open skull fracture without mention of intracranial injury, with brief (less than one hour) loss of consciousness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>80353</td>
<td>Other open skull fracture without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80354</td>
<td>Other open skull fracture without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80355</td>
<td>Other open skull fracture without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80356</td>
<td>Other open skull fracture without mention of intracranial injury, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80359</td>
<td>Other open skull fracture without mention of intracranial injury, with concussion, unspecified</td>
</tr>
<tr>
<td>80360</td>
<td>Other open skull fracture with cerebral laceration and contusion, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80361</td>
<td>Other open skull fracture with cerebral laceration and contusion, with no loss of consciousness</td>
</tr>
<tr>
<td>80362</td>
<td>Other open skull fracture with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80363</td>
<td>Other open skull fracture with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80364</td>
<td>Other open skull fracture with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80365</td>
<td>Other open skull fracture with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80366</td>
<td>Other open skull fracture with cerebral laceration and contusion, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80369</td>
<td>Other open skull fracture with cerebral laceration and contusion, with concussion, unspecified</td>
</tr>
<tr>
<td>80370</td>
<td>Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80371</td>
<td>Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>80372</td>
<td>Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80373</td>
<td>Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80374</td>
<td>Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80375</td>
<td>Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80376</td>
<td>Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80379</td>
<td>Other open skull fracture with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified</td>
</tr>
<tr>
<td>80380</td>
<td>Other open skull fracture with other and unspecified intracranial hemorrhage, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80381</td>
<td>Other open skull fracture with other and unspecified intracranial hemorrhage, with no loss of consciousness</td>
</tr>
<tr>
<td>80382</td>
<td>Other open skull fracture with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80383</td>
<td>Other open skull fracture with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80384</td>
<td>Other open skull fracture with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80385</td>
<td>Other open skull fracture with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80386</td>
<td>Other open skull fracture with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80389</td>
<td>Other open skull fracture with other and unspecified intracranial hemorrhage, with concussion, unspecified</td>
</tr>
<tr>
<td>80390</td>
<td>Other open skull fracture with intracranial injury of other and unspecified nature, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80391</td>
<td>Other open skull fracture with intracranial injury of other and unspecified nature, with no loss of consciousness</td>
</tr>
<tr>
<td>80392</td>
<td>Other open skull fracture with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80393</td>
<td>Other open skull fracture with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80394</td>
<td>Other open skull fracture with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80395</td>
<td>Other open skull fracture with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80396</td>
<td>Other open skull fracture with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80399</td>
<td>Other open skull fracture with intracranial injury of other and unspecified nature, with concussion, unspecified</td>
</tr>
<tr>
<td>80400</td>
<td>Closed fractures involving skull or face with other bones, without mention of intracranial injury, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80401</td>
<td>Closed fractures involving skull or face with other bones, without mention of intracranial injury, with no loss of consciousness</td>
</tr>
<tr>
<td>80402</td>
<td>Closed fractures involving skull or face with other bones, without mention of intracranial injury, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80403</td>
<td>Closed fractures involving skull or face with other bones, without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80404</td>
<td>Closed fractures involving skull or face with other bones, without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>80405</td>
<td>Closed fractures involving skull of face with other bones, without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80406</td>
<td>Closed fractures involving skull of face with other bones, without mention of intracranial injury, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80409</td>
<td>Closed fractures involving skull of face with other bones, without mention of intracranial injury, with concussion, unspecified</td>
</tr>
<tr>
<td>80410</td>
<td>Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80411</td>
<td>Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with no loss of consciousness</td>
</tr>
<tr>
<td>80412</td>
<td>Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80413</td>
<td>Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80414</td>
<td>Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80415</td>
<td>Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80416</td>
<td>Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80419</td>
<td>Closed fractures involving skull or face with other bones, with cerebral laceration and contusion, with concussion, unspecified</td>
</tr>
<tr>
<td>80420</td>
<td>Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80421</td>
<td>Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness</td>
</tr>
<tr>
<td>80422</td>
<td>Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80423</td>
<td>Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80424</td>
<td>Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80425</td>
<td>Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80426</td>
<td>Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80429</td>
<td>Closed fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified</td>
</tr>
<tr>
<td>80430</td>
<td>Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80431</td>
<td>Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with no loss of consciousness</td>
</tr>
<tr>
<td>80432</td>
<td>Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80433</td>
<td>Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80434</td>
<td>Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>80435</td>
<td>Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80436</td>
<td>Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80439</td>
<td>Closed fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with concussion, unspecified</td>
</tr>
<tr>
<td>80440</td>
<td>Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80441</td>
<td>Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with no loss of consciousness</td>
</tr>
<tr>
<td>80442</td>
<td>Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80443</td>
<td>Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80444</td>
<td>Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80445</td>
<td>Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80446</td>
<td>Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80449</td>
<td>Closed fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with concussion, unspecified</td>
</tr>
<tr>
<td>80450</td>
<td>Open fractures involving skull or face with other bones, without mention of intracranial injury, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80451</td>
<td>Open fractures involving skull or face with other bones, without mention of intracranial injury, with no loss of consciousness</td>
</tr>
<tr>
<td>80452</td>
<td>Open fractures involving skull or face with other bones, without mention of intracranial injury, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80453</td>
<td>Open fractures involving skull or face with other bones, without mention of intracranial injury, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80454</td>
<td>Open fractures involving skull or face with other bones, without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80455</td>
<td>Open fractures involving skull or face with other bones, without mention of intracranial injury, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80456</td>
<td>Open fractures involving skull or face with other bones, without mention of intracranial injury, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80459</td>
<td>Open fractures involving skull or face with other bones, without mention of intracranial injury, with concussion, unspecified</td>
</tr>
<tr>
<td>80460</td>
<td>Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80461</td>
<td>Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with no loss of consciousness</td>
</tr>
<tr>
<td>80462</td>
<td>Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80463</td>
<td>Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80464</td>
<td>Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80465</td>
<td>Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>80466</td>
<td>Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80469</td>
<td>Open fractures involving skull or face with other bones, with cerebral laceration and contusion, with concussion, unspecified</td>
</tr>
<tr>
<td>80470</td>
<td>Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80471</td>
<td>Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with no loss of consciousness</td>
</tr>
<tr>
<td>80472</td>
<td>Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80473</td>
<td>Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80474</td>
<td>Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80475</td>
<td>Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80476</td>
<td>Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80479</td>
<td>Open fractures involving skull or face with other bones with subarachnoid, subdural, and extradural hemorrhage, with concussion, unspecified</td>
</tr>
<tr>
<td>80480</td>
<td>Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80481</td>
<td>Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with no loss of consciousness</td>
</tr>
<tr>
<td>80482</td>
<td>Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80483</td>
<td>Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80484</td>
<td>Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80485</td>
<td>Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with prolonged (more than 24 hours) loss consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>80486</td>
<td>Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80489</td>
<td>Open fractures involving skull or face with other bones, with other and unspecified intracranial hemorrhage, with concussion, unspecified</td>
</tr>
<tr>
<td>80490</td>
<td>Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with state of consciousness unspecified</td>
</tr>
<tr>
<td>80491</td>
<td>Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with no loss of consciousness</td>
</tr>
<tr>
<td>80492</td>
<td>Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>80493</td>
<td>Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>80494</td>
<td>Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>80495</td>
<td>Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with prolonged (more than 24 hours) loss of consciousness without return to pre-existing conscious level</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>80496</td>
<td>Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>80499</td>
<td>Open fractures involving skull or face with other bones, with intracranial injury of other and unspecified nature, with concussion, unspecified</td>
</tr>
<tr>
<td>80500</td>
<td>Closed fracture of cervical vertebra, unspecified level</td>
</tr>
<tr>
<td>80501</td>
<td>Closed fracture of first cervical vertebra</td>
</tr>
<tr>
<td>80502</td>
<td>Closed fracture of second cervical vertebra</td>
</tr>
<tr>
<td>80503</td>
<td>Closed fracture of third cervical vertebra</td>
</tr>
<tr>
<td>80504</td>
<td>Closed fracture of fourth cervical vertebra</td>
</tr>
<tr>
<td>80505</td>
<td>Closed fracture of fifth cervical vertebra</td>
</tr>
<tr>
<td>80506</td>
<td>Closed fracture of sixth cervical vertebra</td>
</tr>
<tr>
<td>80507</td>
<td>Closed fracture of seventh cervical vertebra</td>
</tr>
<tr>
<td>80508</td>
<td>Closed fracture of multiple cervical vertebrae</td>
</tr>
<tr>
<td>80510</td>
<td>Open fracture of cervical vertebra, unspecified level</td>
</tr>
<tr>
<td>80511</td>
<td>Open fracture of first cervical vertebra</td>
</tr>
<tr>
<td>80512</td>
<td>Open fracture of second cervical vertebra</td>
</tr>
<tr>
<td>80513</td>
<td>Open fracture of third cervical vertebra</td>
</tr>
<tr>
<td>80514</td>
<td>Open fracture of fourth cervical vertebra</td>
</tr>
<tr>
<td>80515</td>
<td>Open fracture of fifth cervical vertebra</td>
</tr>
<tr>
<td>80516</td>
<td>Open fracture of sixth cervical vertebra</td>
</tr>
<tr>
<td>80517</td>
<td>Open fracture of seventh cervical vertebra</td>
</tr>
<tr>
<td>80518</td>
<td>Open fracture of multiple cervical vertebrae</td>
</tr>
<tr>
<td>8052</td>
<td>Closed fracture of dorsal (thoracic) vertebra without mention of spinal cord injury</td>
</tr>
<tr>
<td>8053</td>
<td>Open fracture of dorsal (thoracic) vertebra without mention of spinal cord injury</td>
</tr>
<tr>
<td>8054</td>
<td>Closed fracture of lumbar vertebra without mention of spinal cord injury</td>
</tr>
<tr>
<td>8055</td>
<td>Open fracture of lumbar vertebra without mention of spinal cord injury</td>
</tr>
<tr>
<td>8056</td>
<td>Closed fracture of sacrum and coccyx without mention of spinal cord injury</td>
</tr>
<tr>
<td>8057</td>
<td>Open fracture of sacrum and coccyx without mention of spinal cord injury</td>
</tr>
<tr>
<td>8058</td>
<td>Closed fracture of unspecified part of vertebral column without mention of spinal cord injury</td>
</tr>
<tr>
<td>8059</td>
<td>Open fracture of unspecified part of vertebral column without mention of spinal cord injury</td>
</tr>
<tr>
<td>80600</td>
<td>Closed fracture of C1-C4 level with unspecified spinal cord injury</td>
</tr>
<tr>
<td>80601</td>
<td>Closed fracture of C1-C4 level with complete lesion of cord</td>
</tr>
<tr>
<td>80602</td>
<td>Closed fracture of C1-C4 level with anterior cord syndrome</td>
</tr>
<tr>
<td>80603</td>
<td>Closed fracture of C1-C4 level with central cord syndrome</td>
</tr>
<tr>
<td>80604</td>
<td>Closed fracture of C1-C4 level with other specified spinal cord injury</td>
</tr>
<tr>
<td>80605</td>
<td>Closed fracture of C5-C7 level with unspecified spinal cord injury</td>
</tr>
<tr>
<td>80606</td>
<td>Closed fracture of C5-C7 level with complete lesion of cord</td>
</tr>
<tr>
<td>80607</td>
<td>Closed fracture of C5-C7 level with anterior cord syndrome</td>
</tr>
<tr>
<td>80608</td>
<td>Closed fracture of C5-C7 level with central cord syndrome</td>
</tr>
<tr>
<td>80609</td>
<td>Closed fracture of C5-C7 level with other specified spinal cord injury</td>
</tr>
<tr>
<td>80610</td>
<td>Open fracture of C1-C4 level with unspecified spinal cord injury</td>
</tr>
<tr>
<td>80611</td>
<td>Open fracture of C1-C4 level with complete lesion of cord</td>
</tr>
<tr>
<td>80612</td>
<td>Open fracture of C1-C4 level with anterior cord syndrome</td>
</tr>
<tr>
<td>80613</td>
<td>Open fracture of C1-C4 level with central cord syndrome</td>
</tr>
<tr>
<td>80614</td>
<td>Open fracture of C1-C4 level with other specified spinal cord injury</td>
</tr>
<tr>
<td>80615</td>
<td>Open fracture of C5-C7 level with unspecified spinal cord injury</td>
</tr>
<tr>
<td>80616</td>
<td>Open fracture of C5-C7 level with complete lesion of cord</td>
</tr>
<tr>
<td>80617</td>
<td>Open fracture of C5-C7 level with anterior cord syndrome</td>
</tr>
<tr>
<td>80618</td>
<td>Open fracture of C5-C7 level with central cord syndrome</td>
</tr>
<tr>
<td>80619</td>
<td>Open fracture of C5-C7 level with other specified spinal cord injury</td>
</tr>
<tr>
<td>80620</td>
<td>Closed fracture of T1-T6 level with unspecified spinal cord injury</td>
</tr>
<tr>
<td>80621</td>
<td>Closed fracture of T1-T6 level with complete lesion of cord</td>
</tr>
<tr>
<td>80622</td>
<td>Closed fracture of T1-T6 level with anterior cord syndrome</td>
</tr>
<tr>
<td>80623</td>
<td>Closed fracture of T1-T6 level with central cord syndrome</td>
</tr>
<tr>
<td>80624</td>
<td>Closed fracture of T1-T6 level with other specified spinal cord injury</td>
</tr>
<tr>
<td>80625</td>
<td>Closed fracture of T7-T12 level with unspecified spinal cord injury</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>80626</td>
<td>Closed fracture of T7-T12 level with complete lesion of cord</td>
</tr>
<tr>
<td>80627</td>
<td>Closed fracture of T7-T12 level with anterior cord syndrome</td>
</tr>
<tr>
<td>80628</td>
<td>Closed fracture of T7-T12 level with central cord syndrome</td>
</tr>
<tr>
<td>80629</td>
<td>Closed fracture of T7-T12 level with other specified spinal cord injury</td>
</tr>
<tr>
<td>80630</td>
<td>Open fracture of T1-T6 level with unspecified spinal cord injury</td>
</tr>
<tr>
<td>80631</td>
<td>Open fracture of T1-T6 level with complete lesion of cord</td>
</tr>
<tr>
<td>80632</td>
<td>Open fracture of T1-T6 level with anterior cord syndrome</td>
</tr>
<tr>
<td>80633</td>
<td>Open fracture of T1-T6 level with central cord syndrome</td>
</tr>
<tr>
<td>80634</td>
<td>Open fracture of T1-T6 level with other specified spinal cord injury</td>
</tr>
<tr>
<td>80635</td>
<td>Open fracture of T7-T12 level with unspecified spinal cord injury</td>
</tr>
<tr>
<td>80636</td>
<td>Open fracture of T7-T12 level with complete lesion of cord</td>
</tr>
<tr>
<td>80637</td>
<td>Open fracture of T7-T12 level with anterior cord syndrome</td>
</tr>
<tr>
<td>80638</td>
<td>Open fracture of T7-T12 level with central cord syndrome</td>
</tr>
<tr>
<td>80639</td>
<td>Open fracture of T7-T12 level with other specified spinal cord injury</td>
</tr>
<tr>
<td>8064</td>
<td>Closed fracture of lumbar spine with spinal cord injury</td>
</tr>
<tr>
<td>8065</td>
<td>Open fracture of lumbar spine with spinal cord injury</td>
</tr>
<tr>
<td>80660</td>
<td>Closed fracture of sacrum and coccyx with unspecified spinal cord injury</td>
</tr>
<tr>
<td>80661</td>
<td>Closed fracture of sacrum and coccyx with complete cauda equina lesion</td>
</tr>
<tr>
<td>80662</td>
<td>Closed fracture of sacrum and coccyx with other cauda equina injury</td>
</tr>
<tr>
<td>80669</td>
<td>Closed fracture of sacrum and coccyx with other spinal cord injury</td>
</tr>
<tr>
<td>80670</td>
<td>Open fracture of sacrum and coccyx with unspecified spinal cord injury</td>
</tr>
<tr>
<td>80671</td>
<td>Open fracture of sacrum and coccyx with complete cauda equina lesion</td>
</tr>
<tr>
<td>80672</td>
<td>Open fracture of sacrum and coccyx with other cauda equina injury</td>
</tr>
<tr>
<td>80679</td>
<td>Open fracture of sacrum and coccyx with other spinal cord injury</td>
</tr>
<tr>
<td>8068</td>
<td>Closed fracture of unspecified vertebra with spinal cord injury</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8069</td>
<td>Open fracture of unspecified vertebra with spinal cord injury</td>
</tr>
<tr>
<td>80700</td>
<td>Closed fracture of rib(s), unspecified</td>
</tr>
<tr>
<td>80701</td>
<td>Closed fracture of one rib</td>
</tr>
<tr>
<td>80702</td>
<td>Closed fracture of two ribs</td>
</tr>
<tr>
<td>80703</td>
<td>Closed fracture of three ribs</td>
</tr>
<tr>
<td>80704</td>
<td>Closed fracture of four ribs</td>
</tr>
<tr>
<td>80705</td>
<td>Closed fracture of five ribs</td>
</tr>
<tr>
<td>80706</td>
<td>Closed fracture of six ribs</td>
</tr>
<tr>
<td>80707</td>
<td>Closed fracture of seven ribs</td>
</tr>
<tr>
<td>80708</td>
<td>Closed fracture of eight or more ribs</td>
</tr>
<tr>
<td>80709</td>
<td>Closed fracture of multiple ribs, unspecified</td>
</tr>
<tr>
<td>80710</td>
<td>Open fracture of rib(s), unspecified</td>
</tr>
<tr>
<td>80711</td>
<td>Open fracture of one rib</td>
</tr>
<tr>
<td>80712</td>
<td>Open fracture of two ribs</td>
</tr>
<tr>
<td>80713</td>
<td>Open fracture of three ribs</td>
</tr>
<tr>
<td>80714</td>
<td>Open fracture of four ribs</td>
</tr>
<tr>
<td>80715</td>
<td>Open fracture of five ribs</td>
</tr>
<tr>
<td>80716</td>
<td>Open fracture of six ribs</td>
</tr>
<tr>
<td>80717</td>
<td>Open fracture of seven ribs</td>
</tr>
<tr>
<td>80718</td>
<td>Open fracture of eight or more ribs</td>
</tr>
<tr>
<td>80719</td>
<td>Open fracture of multiple ribs, unspecified</td>
</tr>
<tr>
<td>8072</td>
<td>Closed fracture of sternum</td>
</tr>
<tr>
<td>8073</td>
<td>Open fracture of sternum</td>
</tr>
<tr>
<td>8074</td>
<td>Flail chest</td>
</tr>
<tr>
<td>8075</td>
<td>Closed fracture of larynx and trachea</td>
</tr>
<tr>
<td>8076</td>
<td>Open fracture of larynx and trachea</td>
</tr>
<tr>
<td>8080</td>
<td>Closed fracture of acetabulum</td>
</tr>
<tr>
<td>8081</td>
<td>Open fracture of acetabulum</td>
</tr>
<tr>
<td>8082</td>
<td>Closed fracture of pubis</td>
</tr>
<tr>
<td>8083</td>
<td>Open fracture of pubis</td>
</tr>
<tr>
<td>80841</td>
<td>Closed fracture of ilium</td>
</tr>
<tr>
<td>80842</td>
<td>Closed fracture of ischium</td>
</tr>
<tr>
<td>80843</td>
<td>Multiple closed pelvic fractures with disruption of pelvic circle</td>
</tr>
<tr>
<td>80849</td>
<td>Closed fracture of other specified part of pelvis</td>
</tr>
<tr>
<td>80851</td>
<td>Open fracture of ilium</td>
</tr>
<tr>
<td>80852</td>
<td>Open fracture of ischium</td>
</tr>
<tr>
<td>80853</td>
<td>Multiple open pelvic fractures with disruption of pelvic circle</td>
</tr>
<tr>
<td>80859</td>
<td>Open fracture of other specified part of pelvis</td>
</tr>
<tr>
<td>8088</td>
<td>Unspecified closed fracture of pelvis</td>
</tr>
<tr>
<td>8089</td>
<td>Unspecified open fracture of pelvis</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>8090</td>
<td>Fracture of bones of trunk, closed</td>
</tr>
<tr>
<td>8091</td>
<td>Fracture of bones of trunk, open</td>
</tr>
<tr>
<td>81000</td>
<td>Closed fracture of clavicle, unspecified part</td>
</tr>
<tr>
<td>81001</td>
<td>Closed fracture of sternal end of clavicle</td>
</tr>
<tr>
<td>81002</td>
<td>Closed fracture of acromial end of clavicle</td>
</tr>
<tr>
<td>81010</td>
<td>Open fracture of clavicle, unspecified part</td>
</tr>
<tr>
<td>81011</td>
<td>Open fracture of sternal end of clavicle</td>
</tr>
<tr>
<td>81012</td>
<td>Open fracture of shaft of clavicle</td>
</tr>
<tr>
<td>81013</td>
<td>Open fracture of acromial end of clavicle</td>
</tr>
<tr>
<td>81100</td>
<td>Closed fracture of scapula, unspecified part</td>
</tr>
<tr>
<td>81101</td>
<td>Closed fracture of acromial process of scapula</td>
</tr>
<tr>
<td>81102</td>
<td>Closed fracture of coracoid process of scapula</td>
</tr>
<tr>
<td>81103</td>
<td>Closed fracture of glenoid cavity and neck of scapula</td>
</tr>
<tr>
<td>81109</td>
<td>Closed fracture of other part of scapula</td>
</tr>
<tr>
<td>81110</td>
<td>Open fracture of scapula, unspecified part</td>
</tr>
<tr>
<td>81111</td>
<td>Open fracture of acromial process of scapula</td>
</tr>
<tr>
<td>81112</td>
<td>Open fracture of coracoid process</td>
</tr>
<tr>
<td>81113</td>
<td>Open fracture of glenoid cavity and neck of scapula</td>
</tr>
<tr>
<td>81119</td>
<td>Open fracture of other part of scapula</td>
</tr>
<tr>
<td>81200</td>
<td>Fracture of unspecified part of upper end of humerus, closed</td>
</tr>
<tr>
<td>81201</td>
<td>Fracture of surgical neck of humerus, closed</td>
</tr>
<tr>
<td>81202</td>
<td>Fracture of anatomical neck of humerus, closed</td>
</tr>
<tr>
<td>81203</td>
<td>Fracture of greater tuberosity of humerus, closed</td>
</tr>
<tr>
<td>81209</td>
<td>Other closed fractures of upper end of humerus</td>
</tr>
<tr>
<td>81210</td>
<td>Fracture of unspecified part of upper end of humerus, open</td>
</tr>
<tr>
<td>81211</td>
<td>Fracture of surgical neck of humerus, open</td>
</tr>
<tr>
<td>81212</td>
<td>Fracture of anatomical neck of humerus, open</td>
</tr>
<tr>
<td>81213</td>
<td>Fracture of greater tuberosity of humerus, open</td>
</tr>
<tr>
<td>81219</td>
<td>Other open fracture of upper end of humerus</td>
</tr>
<tr>
<td>81220</td>
<td>Fracture of unspecified part of humerus, closed</td>
</tr>
<tr>
<td>81221</td>
<td>Fracture of shaft of humerus, closed</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>81317</td>
<td>Other and unspecified open fractures of proximal end of radius (alone)</td>
</tr>
<tr>
<td>81318</td>
<td>Fracture of radius with ulna, upper end (any part), open</td>
</tr>
<tr>
<td>81320</td>
<td>Fracture of shaft of radius or ulna, unspecified, closed</td>
</tr>
<tr>
<td>81321</td>
<td>Fracture of shaft of radius (alone), closed</td>
</tr>
<tr>
<td>81322</td>
<td>Fracture of shaft of ulna (alone), closed</td>
</tr>
<tr>
<td>81323</td>
<td>Fracture of shaft of radius with ulna, closed</td>
</tr>
<tr>
<td>81330</td>
<td>Fracture of shaft of radius or ulna, unspecified, open</td>
</tr>
<tr>
<td>81331</td>
<td>Fracture of shaft of radius (alone), open</td>
</tr>
<tr>
<td>81332</td>
<td>Fracture of shaft of ulna (alone), open</td>
</tr>
<tr>
<td>81333</td>
<td>Fracture of shaft of radius with ulna, open</td>
</tr>
<tr>
<td>81340</td>
<td>Closed fracture of lower end of forearm, unspecified</td>
</tr>
<tr>
<td>81341</td>
<td>Colles’ fracture, closed</td>
</tr>
<tr>
<td>81342</td>
<td>Other closed fractures of distal end of radius (alone)</td>
</tr>
<tr>
<td>81343</td>
<td>Fracture of distal end of ulna (alone), closed</td>
</tr>
<tr>
<td>81344</td>
<td>Fracture of lower end of radius with ulna, closed</td>
</tr>
<tr>
<td>81345</td>
<td>Torus fracture of radius</td>
</tr>
<tr>
<td>81350</td>
<td>Open fracture of lower end of forearm, unspecified</td>
</tr>
<tr>
<td>81351</td>
<td>Colles’ fracture, open</td>
</tr>
<tr>
<td>81352</td>
<td>Other open fractures of distal end of radius (alone)</td>
</tr>
<tr>
<td>81353</td>
<td>Fracture of distal end of ulna (alone), open</td>
</tr>
<tr>
<td>81354</td>
<td>Fracture of lower end of radius with ulna, open</td>
</tr>
<tr>
<td>81380</td>
<td>Closed fracture of unspecified part of forearm</td>
</tr>
<tr>
<td>81381</td>
<td>Fracture of unspecified part of radius (alone), closed</td>
</tr>
<tr>
<td>81382</td>
<td>Fracture of unspecified part of ulna (alone), closed</td>
</tr>
<tr>
<td>81383</td>
<td>Fracture of unspecified part of radius with ulna, closed</td>
</tr>
<tr>
<td>81390</td>
<td>Fracture of unspecified part of forearm, open</td>
</tr>
<tr>
<td>81391</td>
<td>Fracture of unspecified part of radius (alone), open</td>
</tr>
<tr>
<td>81392</td>
<td>Fracture of unspecified part of ulna (alone), open</td>
</tr>
<tr>
<td>81393</td>
<td>Fracture of unspecified part of radius with ulna, open</td>
</tr>
<tr>
<td>81400</td>
<td>Closed fracture of carpal bone, unspecified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81401</td>
<td>Closed fracture of navicular (scaphoid) bone of wrist</td>
</tr>
<tr>
<td>81402</td>
<td>Closed fracture of lunate (semilunar) bone of wrist</td>
</tr>
<tr>
<td>81403</td>
<td>Closed fracture of triquetral (cuneiform) bone of wrist</td>
</tr>
<tr>
<td>81404</td>
<td>Closed fracture of pisiform bone of wrist</td>
</tr>
<tr>
<td>81405</td>
<td>Closed fracture of trapezium bone (larger multangular) of wrist</td>
</tr>
<tr>
<td>81406</td>
<td>Closed fracture of trapezoid bone (smaller multangular) of wrist</td>
</tr>
<tr>
<td>81407</td>
<td>Closed fracture of capitate bone (os magnum) of wrist</td>
</tr>
<tr>
<td>81408</td>
<td>Closed fracture of hamate (unciform) bone of wrist</td>
</tr>
<tr>
<td>81409</td>
<td>Closed fracture of other bone of wrist</td>
</tr>
<tr>
<td>81410</td>
<td>Open fracture of carpal bone, unspecified</td>
</tr>
<tr>
<td>81411</td>
<td>Open fracture of navicular (scaphoid) bone of wrist</td>
</tr>
<tr>
<td>81412</td>
<td>Open fracture of lunate (semilunar) bone of wrist</td>
</tr>
<tr>
<td>81413</td>
<td>Open fracture of triquetral (cuneiform) bone of wrist</td>
</tr>
<tr>
<td>81414</td>
<td>Open fracture of pisiform bone of wrist</td>
</tr>
<tr>
<td>81415</td>
<td>Open fracture of trapezium bone (larger multangular) of wrist</td>
</tr>
<tr>
<td>81416</td>
<td>Open fracture of trapezoid bone (smaller multangular) of wrist</td>
</tr>
<tr>
<td>81417</td>
<td>Open fracture of capitate bone (os magnum) of wrist</td>
</tr>
<tr>
<td>81418</td>
<td>Open fracture of hamate (unciform) bone of wrist</td>
</tr>
<tr>
<td>81419</td>
<td>Open fracture of other bone of wrist</td>
</tr>
<tr>
<td>81500</td>
<td>Closed fracture of metacarpal bone(s), site unspecified</td>
</tr>
<tr>
<td>81501</td>
<td>Closed fracture of base of thumb (first) metacarpal</td>
</tr>
<tr>
<td>81502</td>
<td>Closed fracture of base of other metacarpal bone(s)</td>
</tr>
<tr>
<td>81503</td>
<td>Closed fracture of shaft of metacarpal bone(s)</td>
</tr>
<tr>
<td>81504</td>
<td>Closed fracture of neck of metacarpal bone(s)</td>
</tr>
<tr>
<td>81509</td>
<td>Closed fracture of multiple sites of metacarpus</td>
</tr>
<tr>
<td>81510</td>
<td>Open fracture of metacarpal bone(s), site unspecified</td>
</tr>
<tr>
<td>81511</td>
<td>Open fracture of base of thumb (first) metacarpal</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>81512</td>
<td>Open fracture of base of other metacarpal bone(s)</td>
</tr>
<tr>
<td>81513</td>
<td>Open fracture of shaft of metacarpal bone(s)</td>
</tr>
<tr>
<td>81514</td>
<td>Open fracture of neck of metacarpal bone(s)</td>
</tr>
<tr>
<td>81519</td>
<td>Open fracture of multiple sites of metacarpus</td>
</tr>
<tr>
<td>81600</td>
<td>Closed fracture of phalanx or phalanges of hand, unspecified</td>
</tr>
<tr>
<td>81601</td>
<td>Closed fracture of middle or proximal phalanx or phalanges of hand</td>
</tr>
<tr>
<td>81602</td>
<td>Closed fracture of distal phalanx or phalanges of hand</td>
</tr>
<tr>
<td>81603</td>
<td>Closed fracture of multiple sites of phalanx or phalanges of hand</td>
</tr>
<tr>
<td>81610</td>
<td>Open fracture of phalanx or phalanges of hand, unspecified</td>
</tr>
<tr>
<td>81611</td>
<td>Open fracture of middle or proximal phalanx or phalanges of hand</td>
</tr>
<tr>
<td>81612</td>
<td>Open fracture of distal phalanx or phalanges of hand</td>
</tr>
<tr>
<td>81613</td>
<td>Open fracture of multiple sites of phalanx or phalanges of hand</td>
</tr>
<tr>
<td>8170</td>
<td>Multiple closed fractures of hand bones</td>
</tr>
<tr>
<td>8171</td>
<td>Multiple open fractures of hand bones</td>
</tr>
<tr>
<td>8180</td>
<td>Ill-defined closed fractures of upper limb</td>
</tr>
<tr>
<td>8181</td>
<td>Ill-defined open fractures of upper limb</td>
</tr>
<tr>
<td>8190</td>
<td>Multiple closed fractures involving both upper limbs, and upper limb with rib(s) and sternum</td>
</tr>
<tr>
<td>8191</td>
<td>Multiple open fractures involving both upper limbs, and upper limb with rib(s) and sternum</td>
</tr>
<tr>
<td>82000</td>
<td>Fracture of unspecified intracapsular section of neck of femur, closed</td>
</tr>
<tr>
<td>82001</td>
<td>Fracture of epiphysis (separation) (upper) of neck of femur, closed</td>
</tr>
<tr>
<td>82002</td>
<td>Fracture of midcervical section of femur, closed</td>
</tr>
<tr>
<td>82003</td>
<td>Fracture of base of neck of femur, closed</td>
</tr>
<tr>
<td>82009</td>
<td>Other transcervical fracture of femur, closed</td>
</tr>
<tr>
<td>82010</td>
<td>Fracture of unspecified intracapsular section of neck of femur, open</td>
</tr>
<tr>
<td>82011</td>
<td>Fracture of epiphysis (separation) (upper) of neck of femur, open</td>
</tr>
<tr>
<td>82012</td>
<td>Fracture of midcervical section of femur, open</td>
</tr>
<tr>
<td>82013</td>
<td>Fracture of base of neck of femur, open</td>
</tr>
<tr>
<td>82019</td>
<td>Other transcervical fracture of femur, open</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>82020</td>
<td>Fracture of unspecified trochanteric section of femur, closed</td>
</tr>
<tr>
<td>82021</td>
<td>Fracture of intertrochanteric section of femur, closed</td>
</tr>
<tr>
<td>82022</td>
<td>Fracture of subtrochanteric section of femur, closed</td>
</tr>
<tr>
<td>82030</td>
<td>Fracture of unspecified trochanteric section of femur, open</td>
</tr>
<tr>
<td>82031</td>
<td>Fracture of intertrochanteric section of femur, open</td>
</tr>
<tr>
<td>82032</td>
<td>Fracture of subtrochanteric section of femur, open</td>
</tr>
<tr>
<td>8208</td>
<td>Fracture of unspecified part of neck of femur, closed</td>
</tr>
<tr>
<td>8209</td>
<td>Fracture of unspecified part of neck of femur, open</td>
</tr>
<tr>
<td>82100</td>
<td>Fracture of unspecified part of femur, closed</td>
</tr>
<tr>
<td>82101</td>
<td>Fracture of shaft of femur, closed</td>
</tr>
<tr>
<td>82110</td>
<td>Fracture of unspecified part of femur, open</td>
</tr>
<tr>
<td>82111</td>
<td>Fracture of shaft of femur, open</td>
</tr>
<tr>
<td>82120</td>
<td>Fracture of lower end of femur, unspecified part, closed</td>
</tr>
<tr>
<td>82121</td>
<td>Fracture of femoral condyle, closed</td>
</tr>
<tr>
<td>82122</td>
<td>Fracture of lower epiphysis of femur, closed</td>
</tr>
<tr>
<td>82123</td>
<td>Supracondylar fracture of femur, closed</td>
</tr>
<tr>
<td>82129</td>
<td>Other fracture of lower end of femur, closed</td>
</tr>
<tr>
<td>82130</td>
<td>Fracture of lower end of femur, unspecified part, open</td>
</tr>
<tr>
<td>82131</td>
<td>Fracture of femoral condyle, open</td>
</tr>
<tr>
<td>82132</td>
<td>Fracture of lower epiphysis of femur, open</td>
</tr>
<tr>
<td>82133</td>
<td>Supracondylar fracture of femur, open</td>
</tr>
<tr>
<td>82139</td>
<td>Other fracture of lower end of femur, open</td>
</tr>
<tr>
<td>8220</td>
<td>Closed fracture of patella</td>
</tr>
<tr>
<td>8221</td>
<td>Open fracture of patella</td>
</tr>
<tr>
<td>82300</td>
<td>Closed fracture of upper end of tibia</td>
</tr>
<tr>
<td>82301</td>
<td>Closed fracture of upper end of fibula</td>
</tr>
<tr>
<td>82302</td>
<td>Closed fracture of upper end of fibula with tibia</td>
</tr>
<tr>
<td>82310</td>
<td>Open fracture of upper end of tibia</td>
</tr>
<tr>
<td>82311</td>
<td>Open fracture of upper end of fibula</td>
</tr>
<tr>
<td>82312</td>
<td>Open fracture of upper end of fibula with tibia</td>
</tr>
<tr>
<td>82320</td>
<td>Closed fracture of shaft of tibia</td>
</tr>
<tr>
<td>82321</td>
<td>Closed fracture of shaft of fibula</td>
</tr>
<tr>
<td>82322</td>
<td>Closed fracture of shaft of fibula with tibia</td>
</tr>
<tr>
<td>82330</td>
<td>Open fracture of shaft of tibia</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>82331</td>
<td>Open fracture of shaft of fibula</td>
</tr>
<tr>
<td>82332</td>
<td>Open fracture of shaft of fibula with tibia</td>
</tr>
<tr>
<td>8234</td>
<td>Torus fracture</td>
</tr>
<tr>
<td>82340</td>
<td>Torus fracture, tibia alone</td>
</tr>
<tr>
<td>82341</td>
<td>Torus fracture, fibula alone</td>
</tr>
<tr>
<td>82342</td>
<td>Torus fracture, fibula with tibia</td>
</tr>
<tr>
<td>82380</td>
<td>Closed fracture of unspecified part of tibia</td>
</tr>
<tr>
<td>82381</td>
<td>Closed fracture of unspecified part of fibula</td>
</tr>
<tr>
<td>82382</td>
<td>Closed fracture of unspecified part of fibula with tibia</td>
</tr>
<tr>
<td>82390</td>
<td>Open fracture of unspecified part of tibia</td>
</tr>
<tr>
<td>82391</td>
<td>Open fracture of unspecified part of fibula</td>
</tr>
<tr>
<td>82392</td>
<td>Open fracture of unspecified part of fibula with tibia</td>
</tr>
<tr>
<td>8240</td>
<td>Fracture of medial malleolus, closed</td>
</tr>
<tr>
<td>8241</td>
<td>Fracture of medial malleolus, open</td>
</tr>
<tr>
<td>8242</td>
<td>Fracture of lateral malleolus, closed</td>
</tr>
<tr>
<td>8243</td>
<td>Fracture of lateral malleolus, open</td>
</tr>
<tr>
<td>8244</td>
<td>Bimalleolar fracture, closed</td>
</tr>
<tr>
<td>8245</td>
<td>Bimalleolar fracture, open</td>
</tr>
<tr>
<td>8246</td>
<td>Trimalleolar fracture, closed</td>
</tr>
<tr>
<td>8247</td>
<td>Trimalleolar fracture, open</td>
</tr>
<tr>
<td>8248</td>
<td>Unspecified fracture of ankle, closed</td>
</tr>
<tr>
<td>8249</td>
<td>Unspecified fracture of ankle, open</td>
</tr>
<tr>
<td>8250</td>
<td>Fracture of calcaneus, closed</td>
</tr>
<tr>
<td>8251</td>
<td>Fracture of calcaneus, open</td>
</tr>
<tr>
<td>82520</td>
<td>Fracture of unspecified bone(s) of foot (except toes), closed</td>
</tr>
<tr>
<td>82521</td>
<td>Fracture of astragalus, closed</td>
</tr>
<tr>
<td>82522</td>
<td>Fracture of navicular (scaphoid) bone of foot, closed</td>
</tr>
<tr>
<td>82523</td>
<td>Fracture of cuboid bone, closed</td>
</tr>
<tr>
<td>82524</td>
<td>Fracture of cuneiform bone of foot, closed</td>
</tr>
<tr>
<td>82525</td>
<td>Fracture of metatarsal bone(s), closed</td>
</tr>
<tr>
<td>82529</td>
<td>Other fracture of tarsal and metatarsal bones, closed</td>
</tr>
<tr>
<td>82530</td>
<td>Fracture of unspecified bone(s) of foot (except toes), open</td>
</tr>
<tr>
<td>82531</td>
<td>Fracture of astragalus, open</td>
</tr>
<tr>
<td>82532</td>
<td>Fracture of navicular (scaphoid) bone of foot, open</td>
</tr>
<tr>
<td>82533</td>
<td>Fracture of cuboid bone, open</td>
</tr>
<tr>
<td>82534</td>
<td>Fracture of cuneiform bone of foot, open</td>
</tr>
<tr>
<td>82535</td>
<td>Fracture of metatarsal bone(s), open</td>
</tr>
<tr>
<td>82539</td>
<td>Other fractures of tarsal and metatarsal bones, open</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8260</td>
<td>Closed fracture of one or more phalanges of foot</td>
</tr>
<tr>
<td>8261</td>
<td>Open fracture of one or more phalanges of foot</td>
</tr>
<tr>
<td>8270</td>
<td>Other, multiple and ill-defined fractures of lower limb, closed</td>
</tr>
<tr>
<td>8271</td>
<td>Other, multiple and ill-defined fractures of lower limb, open</td>
</tr>
<tr>
<td>8280</td>
<td>Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum, closed</td>
</tr>
<tr>
<td>8281</td>
<td>Multiple fractures involving both lower limbs, lower with upper limb, and lower limb(s) with rib(s) and sternum, open</td>
</tr>
<tr>
<td>8290</td>
<td>Fracture of unspecified bone, closed</td>
</tr>
<tr>
<td>8291</td>
<td>Fracture of unspecified bone, open</td>
</tr>
<tr>
<td>8300</td>
<td>Closed dislocation of jaw</td>
</tr>
<tr>
<td>8301</td>
<td>Open dislocation of jaw</td>
</tr>
<tr>
<td>83100</td>
<td>Closed dislocation of shoulder, unspecified site</td>
</tr>
<tr>
<td>83101</td>
<td>Closed anterior dislocation of humerus</td>
</tr>
<tr>
<td>83102</td>
<td>Closed posterior dislocation of humerus</td>
</tr>
<tr>
<td>83103</td>
<td>Closed inferior dislocation of humerus</td>
</tr>
<tr>
<td>83104</td>
<td>Closed dislocation of acromioclavicular (joint)</td>
</tr>
<tr>
<td>83109</td>
<td>Closed dislocation of other site of shoulder</td>
</tr>
<tr>
<td>83110</td>
<td>Open dislocation of shoulder, unspecified</td>
</tr>
<tr>
<td>83111</td>
<td>Open anterior dislocation of humerus</td>
</tr>
<tr>
<td>83112</td>
<td>Open posterior dislocation of humerus</td>
</tr>
<tr>
<td>83113</td>
<td>Open inferior dislocation of humerus</td>
</tr>
<tr>
<td>83114</td>
<td>Open dislocation of acromioclavicular (joint)</td>
</tr>
<tr>
<td>83119</td>
<td>Open dislocation of other site of shoulder</td>
</tr>
<tr>
<td>83200</td>
<td>Closed dislocation of elbow, unspecified site</td>
</tr>
<tr>
<td>83201</td>
<td>Closed anterior dislocation of elbow</td>
</tr>
<tr>
<td>83202</td>
<td>Closed posterior dislocation of elbow</td>
</tr>
<tr>
<td>83203</td>
<td>Closed medial dislocation of elbow</td>
</tr>
<tr>
<td>83204</td>
<td>Closed lateral dislocation of elbow</td>
</tr>
<tr>
<td>83209</td>
<td>Closed dislocation of other site of elbow</td>
</tr>
<tr>
<td>83210</td>
<td>Open dislocation of elbow, unspecified site</td>
</tr>
<tr>
<td>83211</td>
<td>Open anterior dislocation of elbow</td>
</tr>
<tr>
<td>83212</td>
<td>Open posterior dislocation of elbow</td>
</tr>
<tr>
<td>83213</td>
<td>Open medial dislocation of elbow</td>
</tr>
<tr>
<td>83214</td>
<td>Open lateral dislocation of elbow</td>
</tr>
<tr>
<td>83219</td>
<td>Open dislocation of other site of elbow</td>
</tr>
<tr>
<td>83300</td>
<td>Closed dislocation of wrist, unspecified part</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>83301</td>
<td>Closed dislocation of radioulnar (joint), distal</td>
</tr>
<tr>
<td>83302</td>
<td>Closed dislocation of radiocarpal (joint)</td>
</tr>
<tr>
<td>83303</td>
<td>Closed dislocation of midcarpal (joint)</td>
</tr>
<tr>
<td>83304</td>
<td>Closed dislocation of carpometacarpal (joint)</td>
</tr>
<tr>
<td>83305</td>
<td>Closed dislocation of metacarpal (bone), proximal end</td>
</tr>
<tr>
<td>83309</td>
<td>Closed dislocation of other part of wrist</td>
</tr>
<tr>
<td>83310</td>
<td>Open dislocation of wrist, unspecified part</td>
</tr>
<tr>
<td>83311</td>
<td>Open dislocation of radioulnar (joint), distal</td>
</tr>
<tr>
<td>83312</td>
<td>Open dislocation of radiocarpal (joint)</td>
</tr>
<tr>
<td>83313</td>
<td>Open dislocation of midcarpal (joint)</td>
</tr>
<tr>
<td>83314</td>
<td>Open dislocation of carpometacarpal (joint)</td>
</tr>
<tr>
<td>83315</td>
<td>Open dislocation of metacarpal (bone), proximal end</td>
</tr>
<tr>
<td>83319</td>
<td>Open dislocation of other part of wrist</td>
</tr>
<tr>
<td>83400</td>
<td>Closed dislocation of finger, unspecified part</td>
</tr>
<tr>
<td>83401</td>
<td>Closed dislocation of metacarpophalangeal (joint)</td>
</tr>
<tr>
<td>83402</td>
<td>Closed dislocation of interphalangeal (joint), hand</td>
</tr>
<tr>
<td>83410</td>
<td>Open dislocation of finger, unspecified part</td>
</tr>
<tr>
<td>83411</td>
<td>Open dislocation of metacarpophalangeal (joint)</td>
</tr>
<tr>
<td>83412</td>
<td>Open dislocation interphalangeal (joint), hand</td>
</tr>
<tr>
<td>83500</td>
<td>Closed dislocation of hip, unspecified site</td>
</tr>
<tr>
<td>83501</td>
<td>Closed posterior dislocation of hip</td>
</tr>
<tr>
<td>83502</td>
<td>Closed obturator dislocation of hip</td>
</tr>
<tr>
<td>83503</td>
<td>Other closed anterior dislocation of hip</td>
</tr>
<tr>
<td>83510</td>
<td>Open dislocation of hip, unspecified site</td>
</tr>
<tr>
<td>83511</td>
<td>Open posterior dislocation of hip</td>
</tr>
<tr>
<td>83512</td>
<td>Open obturator dislocation of hip</td>
</tr>
<tr>
<td>83513</td>
<td>Other open anterior dislocation of hip</td>
</tr>
<tr>
<td>8360</td>
<td>Tear of medial cartilage or meniscus of knee, current</td>
</tr>
<tr>
<td>8361</td>
<td>Tear of lateral cartilage or meniscus of knee, current</td>
</tr>
<tr>
<td>8362</td>
<td>Other tear of cartilage or meniscus of knee, current</td>
</tr>
<tr>
<td>8363</td>
<td>Dislocation of patella, closed</td>
</tr>
<tr>
<td>8364</td>
<td>Dislocation of patella, open</td>
</tr>
<tr>
<td>83650</td>
<td>Closed dislocation of knee, unspecified part</td>
</tr>
<tr>
<td>83651</td>
<td>Anterior dislocation of tibia, proximal end, closed</td>
</tr>
<tr>
<td>83652</td>
<td>Posterior dislocation of tibia, proximal end, closed</td>
</tr>
<tr>
<td>83653</td>
<td>Medial dislocation of tibia, proximal end, closed</td>
</tr>
<tr>
<td>83654</td>
<td>Lateral dislocation of tibia, proximal end, closed</td>
</tr>
<tr>
<td>83659</td>
<td>Other dislocation of knee, closed</td>
</tr>
<tr>
<td>83660</td>
<td>Dislocation of knee, unspecified part, open</td>
</tr>
<tr>
<td>83661</td>
<td>Anterior dislocation of tibia, proximal end, open</td>
</tr>
<tr>
<td>83662</td>
<td>Posterior dislocation of tibia, proximal end, open</td>
</tr>
<tr>
<td>83663</td>
<td>Medial dislocation of tibia, proximal end, open</td>
</tr>
<tr>
<td>8370</td>
<td>Closed dislocation of ankle</td>
</tr>
<tr>
<td>8371</td>
<td>Open dislocation of ankle</td>
</tr>
<tr>
<td>83800</td>
<td>Closed dislocation of foot, unspecified part</td>
</tr>
<tr>
<td>83801</td>
<td>Closed dislocation of tarsal (bone), joint unspecified</td>
</tr>
<tr>
<td>83802</td>
<td>Closed dislocation of midtarsal (joint)</td>
</tr>
<tr>
<td>83803</td>
<td>Closed dislocation of tarsometatarsal</td>
</tr>
<tr>
<td>83804</td>
<td>Closed dislocation of metatarsal (bone), joint unspecified</td>
</tr>
<tr>
<td>83805</td>
<td>Closed dislocation of metatarsophalangeal (joint)</td>
</tr>
<tr>
<td>83806</td>
<td>Closed dislocation of interphalangeal (joint), foot</td>
</tr>
<tr>
<td>83809</td>
<td>Closed dislocation of other part of foot</td>
</tr>
<tr>
<td>83810</td>
<td>Open dislocation of foot, unspecified part</td>
</tr>
<tr>
<td>83811</td>
<td>Open dislocation of tarsal (bone), joint unspecified</td>
</tr>
<tr>
<td>83812</td>
<td>Open dislocation of midtarsal (joint)</td>
</tr>
<tr>
<td>83813</td>
<td>Open dislocation of tarsometatarsal (joint)</td>
</tr>
<tr>
<td>83814</td>
<td>Open dislocation of metatarsal (bone), joint unspecified</td>
</tr>
<tr>
<td>83815</td>
<td>Open dislocation of metatarsophalangeal (joint)</td>
</tr>
<tr>
<td>83816</td>
<td>Open dislocation of interphalangeal (joint), foot</td>
</tr>
<tr>
<td>83819</td>
<td>Open dislocation of other part of foot</td>
</tr>
<tr>
<td>83900</td>
<td>Closed dislocation, cervical vertebra, unspecified</td>
</tr>
<tr>
<td>83901</td>
<td>Closed dislocation, first cervical vertebra</td>
</tr>
<tr>
<td>83902</td>
<td>Closed dislocation, second cervical vertebra</td>
</tr>
<tr>
<td>83903</td>
<td>Closed dislocation, third cervical vertebra</td>
</tr>
<tr>
<td>83904</td>
<td>Closed dislocation, fourth cervical vertebra</td>
</tr>
<tr>
<td>83905</td>
<td>Closed dislocation, fifth cervical vertebra</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>83906</td>
<td>Closed dislocation, sixth cervical vertebra</td>
</tr>
<tr>
<td>83907</td>
<td>Closed dislocation, seventh cervical vertebra</td>
</tr>
<tr>
<td>83908</td>
<td>Closed dislocation, multiple cervical vertebrae</td>
</tr>
<tr>
<td>83910</td>
<td>Open dislocation, cervical vertebra, unspecified</td>
</tr>
<tr>
<td>83911</td>
<td>Open dislocation, first cervical vertebra</td>
</tr>
<tr>
<td>83912</td>
<td>Open dislocation, second cervical vertebra</td>
</tr>
<tr>
<td>83913</td>
<td>Open dislocation, third cervical vertebra</td>
</tr>
<tr>
<td>83914</td>
<td>Open dislocation, fourth cervical vertebra</td>
</tr>
<tr>
<td>83915</td>
<td>Open dislocation, fifth cervical vertebra</td>
</tr>
<tr>
<td>83916</td>
<td>Open dislocation, sixth cervical vertebra</td>
</tr>
<tr>
<td>83917</td>
<td>Open dislocation, seventh cervical vertebra</td>
</tr>
<tr>
<td>83918</td>
<td>Open dislocation, multiple cervical vertebrae</td>
</tr>
<tr>
<td>83920</td>
<td>Closed dislocation, lumbar vertebra</td>
</tr>
<tr>
<td>83921</td>
<td>Closed dislocation, thoracic vertebra</td>
</tr>
<tr>
<td>83930</td>
<td>Open dislocation, lumbar vertebra</td>
</tr>
<tr>
<td>83931</td>
<td>Open dislocation, thoracic vertebra</td>
</tr>
<tr>
<td>83940</td>
<td>Closed dislocation, vertebra, unspecified site</td>
</tr>
<tr>
<td>83941</td>
<td>Closed dislocation, coccyx</td>
</tr>
<tr>
<td>83942</td>
<td>Closed dislocation, sacrum</td>
</tr>
<tr>
<td>83949</td>
<td>Closed dislocation, other vertebra</td>
</tr>
<tr>
<td>83950</td>
<td>Open dislocation, vertebra, unspecified site</td>
</tr>
<tr>
<td>83951</td>
<td>Open dislocation, coccyx</td>
</tr>
<tr>
<td>83952</td>
<td>Open dislocation, sacrum</td>
</tr>
<tr>
<td>83959</td>
<td>Open dislocation, other vertebra</td>
</tr>
<tr>
<td>83961</td>
<td>Closed dislocation, sternum</td>
</tr>
<tr>
<td>83969</td>
<td>Closed dislocation, other location</td>
</tr>
<tr>
<td>83971</td>
<td>Open dislocation, sternum</td>
</tr>
<tr>
<td>83979</td>
<td>Open dislocation, other location</td>
</tr>
<tr>
<td>8398</td>
<td>Closed dislocation, multiple and ill-defined sites</td>
</tr>
<tr>
<td>8399</td>
<td>Open dislocation, multiple and ill-defined sites</td>
</tr>
<tr>
<td>8400</td>
<td>Acromioclavicular (joint) (ligament) sprain</td>
</tr>
<tr>
<td>8401</td>
<td>Coracoclavicular (ligament) sprain</td>
</tr>
<tr>
<td>8402</td>
<td>Coracohumeral (ligament) sprain</td>
</tr>
<tr>
<td>8403</td>
<td>Infraspinatus (muscle) (tendon) sprain</td>
</tr>
<tr>
<td>8404</td>
<td>Rotator cuff (capsule) sprain</td>
</tr>
<tr>
<td>8405</td>
<td>Subscapularis (muscle) sprain</td>
</tr>
<tr>
<td>8406</td>
<td>Supraspinatus (muscle) sprain</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>8460</td>
<td>Lumbosacral (joint) (ligament) sprain</td>
</tr>
<tr>
<td>8461</td>
<td>Sacroiliac (ligament) sprain</td>
</tr>
<tr>
<td>8462</td>
<td>Sacrospinosus (ligament) sprain</td>
</tr>
<tr>
<td>8463</td>
<td>Sacrotuberous (ligament) sprain</td>
</tr>
<tr>
<td>8468</td>
<td>Other specified sites of sacroiliac region sprain</td>
</tr>
<tr>
<td>8469</td>
<td>Unspecified site of sacroiliac region sprain</td>
</tr>
<tr>
<td>8470</td>
<td>Neck sprain</td>
</tr>
<tr>
<td>8471</td>
<td>Thoracic sprain</td>
</tr>
<tr>
<td>8472</td>
<td>Lumbar sprain</td>
</tr>
<tr>
<td>8473</td>
<td>Sprain of sacrum</td>
</tr>
<tr>
<td>8474</td>
<td>Sprain of coccyx</td>
</tr>
<tr>
<td>8479</td>
<td>Sprain of unspecified site of back</td>
</tr>
<tr>
<td>8480</td>
<td>Sprain of septal cartilage of nose</td>
</tr>
<tr>
<td>8481</td>
<td>Jaw sprain</td>
</tr>
<tr>
<td>8482</td>
<td>Thyroid region sprain</td>
</tr>
<tr>
<td>8483</td>
<td>Sprain of ribs</td>
</tr>
<tr>
<td>84840</td>
<td>Sternum sprain, unspecified part</td>
</tr>
<tr>
<td>84841</td>
<td>Sternoclavicular (joint) (ligament) sprain</td>
</tr>
<tr>
<td>84842</td>
<td>Chondrosternal (joint) sprain</td>
</tr>
<tr>
<td>84849</td>
<td>Other sprain of sternum</td>
</tr>
<tr>
<td>8485</td>
<td>Pelvic sprain</td>
</tr>
<tr>
<td>8488</td>
<td>Other specified sites of sprains and strains</td>
</tr>
<tr>
<td>8489</td>
<td>Unspecified site of sprain and strain</td>
</tr>
<tr>
<td>8500</td>
<td>Concussion with no loss of consciousness</td>
</tr>
<tr>
<td>85011</td>
<td>Concussion, with loss of consciousness of 30 minutes or less</td>
</tr>
<tr>
<td>85012</td>
<td>Concussion with loss of consciousness from 31 minutes to 59 minutes</td>
</tr>
<tr>
<td>8502</td>
<td>Concussion with moderate loss of consciousness</td>
</tr>
<tr>
<td>8503</td>
<td>Concussion with prolonged loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>8504</td>
<td>Concussion with prolonged loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>8505</td>
<td>Concussion with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>8509</td>
<td>Concussion, unspecified</td>
</tr>
<tr>
<td>85100</td>
<td>Cortex (cerebral) contusion without mention of open intracranial wound, state of consciousness unspecified</td>
</tr>
<tr>
<td>85101</td>
<td>Cortex (cerebral) contusion without mention of open intracranial wound, with no loss of consciousness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>85102</td>
<td>Cortex (cerebral) contusion without mention of open intracranial wound, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>85103</td>
<td>Cortex (cerebral) contusion without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85104</td>
<td>Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85105</td>
<td>Cortex (cerebral) contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>85106</td>
<td>Cortex (cerebral) contusion without mention of open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85109</td>
<td>Cortex (cerebral) contusion without mention of open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>85110</td>
<td>Cortex (cerebral) contusion with open intracranial wound, without mention of specific state of consciousness</td>
</tr>
<tr>
<td>85111</td>
<td>Cortex (cerebral) contusion with open intracranial wound, with no loss of consciousness</td>
</tr>
<tr>
<td>85112</td>
<td>Cortex (cerebral) contusion with open intracranial wound, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>85113</td>
<td>Cortex (cerebral) contusion with open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85114</td>
<td>Cortex (cerebral) contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85115</td>
<td>Cortex (cerebral) contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>85116</td>
<td>Cortex (cerebral) contusion with open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85119</td>
<td>Cortex (cerebral) contusion with open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>85120</td>
<td>Cortex (cerebral) laceration without mention of open intracranial wound, with state of consciousness unspecified</td>
</tr>
<tr>
<td>85121</td>
<td>Cortex (cerebral) laceration without mention of open intracranial wound, with no loss of consciousness</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>85122</td>
<td>Cortex (cerebral) laceration without mention of open intracranial wound, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>85123</td>
<td>Cortex (cerebral) laceration without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85124</td>
<td>Cortex (cerebral) laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85125</td>
<td>Cortex (cerebral) laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>85126</td>
<td>Cortex (cerebral) laceration without mention of open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85129</td>
<td>Cortex (cerebral) laceration without mention of open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>85130</td>
<td>Cortex (cerebral) laceration with open intracranial wound, with state of consciousness unspecified</td>
</tr>
<tr>
<td>85131</td>
<td>Cortex (cerebral) laceration with open intracranial wound, with no loss of consciousness</td>
</tr>
<tr>
<td>85132</td>
<td>Cortex (cerebral) laceration with open intracranial wound, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>85133</td>
<td>Cortex (cerebral) laceration with open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85134</td>
<td>Cortex (cerebral) laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85135</td>
<td>Cortex (cerebral) laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>85136</td>
<td>Cortex (cerebral) laceration with open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85139</td>
<td>Cortex (cerebral) laceration with open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>85140</td>
<td>Cerebellar or brain stem contusion without mention of open intracranial wound, with state of consciousness unspecified</td>
</tr>
<tr>
<td>85141</td>
<td>Cerebellar or brain stem contusion without mention of open intracranial wound, with no loss of consciousness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>85142</td>
<td>Cerebellar or brain stem contusion without mention of open intracranial wound, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>85143</td>
<td>Cerebellar or brain stem contusion without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85144</td>
<td>Cerebellar or brain stem contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85145</td>
<td>Cerebellar or brain stem contusion without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>85146</td>
<td>Cerebellar or brain stem contusion without mention of open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85149</td>
<td>Cerebellar or brain stem contusion without mention of open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>85150</td>
<td>Cerebellar or brain stem contusion with open intracranial wound, with state of consciousness unspecified</td>
</tr>
<tr>
<td>85151</td>
<td>Cerebellar or brain stem contusion with open intracranial wound, with no loss of consciousness</td>
</tr>
<tr>
<td>85152</td>
<td>Cerebellar or brain stem contusion with open intracranial wound, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>85153</td>
<td>Cerebellar or brain stem contusion with open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85154</td>
<td>Cerebellar or brain stem contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85155</td>
<td>Cerebellar or brain stem contusion with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>85156</td>
<td>Cerebellar or brain stem contusion with open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85159</td>
<td>Cerebellar or brain stem contusion with open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>85160</td>
<td>Cerebellar or brain stem laceration without mention of open intracranial wound, with state of consciousness unspecified</td>
</tr>
<tr>
<td>85161</td>
<td>Cerebellar or brain stem laceration without mention of open intracranial wound, with no loss of consciousness</td>
</tr>
<tr>
<td>85162</td>
<td>Cerebellar or brain stem laceration without mention of open intracranial wound, with brief (less than 1 hour) loss of consciousness</td>
</tr>
<tr>
<td>85163</td>
<td>Cerebellar or brain stem laceration without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85164</td>
<td>Cerebellar or brain stem laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85165</td>
<td>Cerebellar or brain stem laceration without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>85166</td>
<td>Cerebellar or brain stem laceration without mention of open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85169</td>
<td>Cerebellar or brain stem laceration without mention of open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>85170</td>
<td>Cerebellar or brain stem laceration with open intracranial wound, with state of consciousness unspecified</td>
</tr>
<tr>
<td>85171</td>
<td>Cerebellar or brain stem laceration with open intracranial wound, with no loss of consciousness</td>
</tr>
<tr>
<td>85172</td>
<td>Cerebellar or brain stem laceration with open intracranial wound, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>85173</td>
<td>Cerebellar or brain stem laceration with open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85174</td>
<td>Cerebellar or brain stem laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85175</td>
<td>Cerebellar or brain stem laceration with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>85176</td>
<td>Cerebellar or brain stem laceration with open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85179</td>
<td>Cerebellar or brain stem laceration with open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>85180</td>
<td>Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with state of consciousness unspecified</td>
</tr>
<tr>
<td>85181</td>
<td>Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with no loss of consciousness</td>
</tr>
<tr>
<td>85182</td>
<td>Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>85183</td>
<td>Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85184</td>
<td>Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85185</td>
<td>Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>85186</td>
<td>Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85189</td>
<td>Other and unspecified cerebral laceration and contusion, without mention of open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>85190</td>
<td>Other and unspecified cerebral laceration and contusion, with open intracranial wound, with state of consciousness unspecified</td>
</tr>
<tr>
<td>85191</td>
<td>Other and unspecified cerebral laceration and contusion, with open intracranial wound, with no loss of consciousness</td>
</tr>
<tr>
<td>85192</td>
<td>Other and unspecified cerebral laceration and contusion, with open intracranial wound, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>85193</td>
<td>Other and unspecified cerebral laceration and contusion, with open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85194</td>
<td>Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85195</td>
<td>Other and unspecified cerebral laceration and contusion, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>85196</td>
<td>Other and unspecified cerebral laceration and contusion, with open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85199</td>
<td>Other and unspecified cerebral laceration and contusion, with open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>85200</td>
<td>Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified</td>
</tr>
<tr>
<td>85201</td>
<td>Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness</td>
</tr>
<tr>
<td>85202</td>
<td>Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>85203</td>
<td>Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85204</td>
<td>Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85205</td>
<td>Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>85206</td>
<td>Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85209</td>
<td>Subarachnoid hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>85210</td>
<td>Subarachnoid hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified</td>
</tr>
<tr>
<td>85211</td>
<td>Subarachnoid hemorrhage following injury, with open intracranial wound, with no loss of consciousness</td>
</tr>
<tr>
<td>85212</td>
<td>Subarachnoid hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>85213</td>
<td>Subarachnoid hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85214</td>
<td>Subarachnoid hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85215</td>
<td>Subarachnoid hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>85216</td>
<td>Subarachnoid hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85219</td>
<td>Subarachnoid hemorrhage following injury, with open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>85220</td>
<td>Subdural hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified</td>
</tr>
<tr>
<td>85221</td>
<td>Subdural hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness</td>
</tr>
<tr>
<td>85222</td>
<td>Subdural hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>85223</td>
<td>Subdural hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85224</td>
<td>Subdural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85225</td>
<td>Subdural hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>85226</td>
<td>Subdural hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85229</td>
<td>Subdural hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>85230</td>
<td>Subdural hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified</td>
</tr>
<tr>
<td>85231</td>
<td>Subdural hemorrhage following injury, with open intracranial wound, with no loss of consciousness</td>
</tr>
<tr>
<td>85232</td>
<td>Subdural hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>85233</td>
<td>Subdural hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85234</td>
<td>Subdural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85235</td>
<td>Subdural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>85236</td>
<td>Subdural hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>85239</td>
<td>Subdural hemorrhage following injury, with open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>85240</td>
<td>Extracranial hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified</td>
</tr>
<tr>
<td>85241</td>
<td>Extracranial hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness</td>
</tr>
<tr>
<td>85242</td>
<td>Extracranial hemorrhage following injury, without mention of open intracranial wound, with brief (less than 1 hour) loss of consciousness</td>
</tr>
<tr>
<td>85243</td>
<td>Extracranial hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85244</td>
<td>Extracranial hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85245</td>
<td>Extracranial hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>85246</td>
<td>Extracranial hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85249</td>
<td>Extracranial hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>85250</td>
<td>Extracranial hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified</td>
</tr>
<tr>
<td>85251</td>
<td>Extracranial hemorrhage following injury, with open intracranial wound, with no loss of consciousness</td>
</tr>
<tr>
<td>85252</td>
<td>Extracranial hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>85253</td>
<td>Extracranial hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85254</td>
<td>Extracranial hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85255</td>
<td>Extracranial hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85256</td>
<td>Extracranial hemorrhage following injury, with open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85259</td>
<td>Extracranial hemorrhage following injury, with open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>85300</td>
<td>Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with state of consciousness unspecified</td>
</tr>
<tr>
<td>85301</td>
<td>Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with no loss of consciousness</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>85302</td>
<td>Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>85303</td>
<td>Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85304</td>
<td>Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85305</td>
<td>Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>85306</td>
<td>Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85309</td>
<td>Other and unspecified intracranial hemorrhage following injury, without mention of open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>85310</td>
<td>Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with state of consciousness unspecified</td>
</tr>
<tr>
<td>85311</td>
<td>Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with no loss of consciousness</td>
</tr>
<tr>
<td>85312</td>
<td>Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with brief (less than one hour) loss of consciousness</td>
</tr>
<tr>
<td>85313</td>
<td>Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with moderate (1-24 hours) loss of consciousness</td>
</tr>
<tr>
<td>85314</td>
<td>Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85315</td>
<td>Other and unspecified intracranial hemorrhage following injury, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>85414</td>
<td>Intracranial injury of other and unspecified nature, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness and return to pre-existing conscious level</td>
</tr>
<tr>
<td>85415</td>
<td>Intracranial injury of other and unspecified nature, with open intracranial wound, with prolonged (more than 24 hours) loss of consciousness, without return to pre-existing conscious level</td>
</tr>
<tr>
<td>85416</td>
<td>Intracranial injury of other and unspecified nature, with open intracranial wound, with loss of consciousness of unspecified duration</td>
</tr>
<tr>
<td>85419</td>
<td>Intracranial injury of other and unspecified nature, with open intracranial wound, with concussion, unspecified</td>
</tr>
<tr>
<td>8600</td>
<td>Traumatic pneumothorax without mention of open wound into thorax</td>
</tr>
<tr>
<td>8601</td>
<td>Traumatic pneumothorax with open wound into thorax</td>
</tr>
<tr>
<td>8602</td>
<td>Traumatic hemothorax without mention of open wound into thorax</td>
</tr>
<tr>
<td>8603</td>
<td>Traumatic hemothorax with open wound into thorax</td>
</tr>
<tr>
<td>8604</td>
<td>Traumatic pneumohemothorax without mention of open wound into thorax</td>
</tr>
<tr>
<td>8605</td>
<td>Traumatic pneumohemothorax with open wound into thorax</td>
</tr>
<tr>
<td>86100</td>
<td>Unspecified injury of heart without mention of open wound into thorax</td>
</tr>
<tr>
<td>86101</td>
<td>Contusion of heart without mention of open wound into thorax</td>
</tr>
<tr>
<td>86102</td>
<td>Laceration of heart without penetration of heart chambers or open wound into thorax</td>
</tr>
<tr>
<td>86103</td>
<td>Laceration of heart with penetration of heart chambers, without mention of open wound into thorax</td>
</tr>
<tr>
<td>86110</td>
<td>Unspecified injury of heart with open wound into thorax</td>
</tr>
<tr>
<td>86111</td>
<td>Contusion of heart with open wound into thorax</td>
</tr>
<tr>
<td>86112</td>
<td>Laceration of heart without penetration of heart chambers, with open wound into thorax</td>
</tr>
<tr>
<td>86113</td>
<td>Laceration of heart with penetration of heart chambers and open wound into thorax</td>
</tr>
<tr>
<td>86120</td>
<td>Unspecified injury of lung without open wound into thorax</td>
</tr>
<tr>
<td>86121</td>
<td>Contusion of lung without open wound into thorax</td>
</tr>
<tr>
<td>86122</td>
<td>Laceration of lung without open wound into thorax</td>
</tr>
<tr>
<td>86130</td>
<td>Unspecified injury of lung with open wound into thorax</td>
</tr>
<tr>
<td>86131</td>
<td>Contusion of lung with open wound into thorax</td>
</tr>
<tr>
<td>86132</td>
<td>Laceration of lung with open wound into thorax</td>
</tr>
<tr>
<td>8620</td>
<td>Injury to diaphragm without mention of open wound into cavity</td>
</tr>
<tr>
<td>8621</td>
<td>Injury to diaphragm with open wound into cavity</td>
</tr>
<tr>
<td>86221</td>
<td>Injury to bronchus without open wound into cavity</td>
</tr>
<tr>
<td>86222</td>
<td>Injury to esophagus without mention of open wound into cavity</td>
</tr>
<tr>
<td>86229</td>
<td>Injury to other specified intrathoracic organs without mention of open wound into cavity</td>
</tr>
<tr>
<td>86231</td>
<td>Injury to bronchus with open wound into cavity</td>
</tr>
<tr>
<td>86232</td>
<td>Injury to esophagus with open wound into cavity</td>
</tr>
<tr>
<td>86239</td>
<td>Injury to other specified intrathoracic organs with open wound into cavity</td>
</tr>
<tr>
<td>8628</td>
<td>Injury to multiple and unspecified intrathoracic organs without mention of open wound into cavity</td>
</tr>
<tr>
<td>8629</td>
<td>Injury to multiple and unspecified intrathoracic organs with open wound into cavity</td>
</tr>
<tr>
<td>8630</td>
<td>Injury to stomach without mention of open wound into cavity</td>
</tr>
<tr>
<td>8631</td>
<td>Injury to stomach with open wound into cavity</td>
</tr>
<tr>
<td>86320</td>
<td>Injury to small intestine, unspecified site, without open wound into cavity</td>
</tr>
<tr>
<td>86321</td>
<td>Injury to duodenum without open wound into cavity</td>
</tr>
<tr>
<td>86329</td>
<td>Other injury to small intestine without open wound into cavity</td>
</tr>
<tr>
<td>86330</td>
<td>Injury to small intestine, unspecified site, with open wound into cavity</td>
</tr>
<tr>
<td>86331</td>
<td>Injury to duodenum with open wound into cavity</td>
</tr>
<tr>
<td>86339</td>
<td>Other injury to small intestine with open wound into cavity</td>
</tr>
<tr>
<td>86340</td>
<td>Injury to colon, unspecified site, without mention of open wound into cavity</td>
</tr>
<tr>
<td>86341</td>
<td>Injury to ascending (right) colon without open wound into cavity</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>86342</td>
<td>Injury to transverse colon without open wound into cavity</td>
</tr>
<tr>
<td>86343</td>
<td>Injury to descending (left) colon without open wound into cavity</td>
</tr>
<tr>
<td>86344</td>
<td>Injury to descending (left) colon without open wound into cavity</td>
</tr>
<tr>
<td>86345</td>
<td>Injury to rectum without open wound into cavity</td>
</tr>
<tr>
<td>86346</td>
<td>Injury to multiple sites in colon and rectum without open wound into cavity</td>
</tr>
<tr>
<td>86349</td>
<td>Other injury to colon and rectum, without open wound into cavity</td>
</tr>
<tr>
<td>86350</td>
<td>Injury to colon, unspecified site, with open wound into cavity</td>
</tr>
<tr>
<td>86351</td>
<td>Injury to ascending (right) colon with open wound into cavity</td>
</tr>
<tr>
<td>86352</td>
<td>Injury to transverse colon with open wound into cavity</td>
</tr>
<tr>
<td>86353</td>
<td>Injury to descending (left) colon with open wound into cavity</td>
</tr>
<tr>
<td>86354</td>
<td>Injury to sigmoid colon with open wound into cavity</td>
</tr>
<tr>
<td>86355</td>
<td>Injury to rectum with open wound into cavity</td>
</tr>
<tr>
<td>86356</td>
<td>Injury to multiple sites in colon and rectum with open wound into cavity</td>
</tr>
<tr>
<td>86359</td>
<td>Other injury to colon and rectum with open wound into cavity</td>
</tr>
<tr>
<td>86380</td>
<td>Injury to gastrointestinal tract, unspecified site, without open wound into cavity</td>
</tr>
<tr>
<td>86381</td>
<td>Injury to pancreas head without mention of open wound into cavity</td>
</tr>
<tr>
<td>86382</td>
<td>Injury to pancreas body without mention of open wound into cavity</td>
</tr>
<tr>
<td>86383</td>
<td>Injury to pancreas tail without mention of open wound into cavity</td>
</tr>
<tr>
<td>86384</td>
<td>Injury to pancreas, multiple and unspecified sites, without open wound into cavity</td>
</tr>
<tr>
<td>83685</td>
<td>Injury to appendix without open wound into cavity</td>
</tr>
<tr>
<td>86389</td>
<td>Injury to other and unspecified gastrointestinal sites without open wound into cavity</td>
</tr>
<tr>
<td>86390</td>
<td>Injury to gastrointestinal tract, unspecified site, with open wound into cavity</td>
</tr>
<tr>
<td>86391</td>
<td>Injury to pancreas head with open wound into cavity</td>
</tr>
<tr>
<td>86392</td>
<td>Injury to pancreas body with open wound into cavity</td>
</tr>
<tr>
<td>86393</td>
<td>Injury to pancreas tail with open wound into cavity</td>
</tr>
<tr>
<td>86394</td>
<td>Injury to pancreas, multiple and unspecified sites, with open wound into cavity</td>
</tr>
<tr>
<td>86395</td>
<td>Injury to appendix with open wound into cavity</td>
</tr>
<tr>
<td>86399</td>
<td>Injury to other and unspecified gastrointestinal sites with open wound into cavity</td>
</tr>
<tr>
<td>86400</td>
<td>Unspecified injury to liver without mention of open wound into cavity</td>
</tr>
<tr>
<td>86401</td>
<td>Hematoma and contusion of liver without mention of open wound into cavity</td>
</tr>
<tr>
<td>86402</td>
<td>Laceration of liver, minor, without mention of open wound into cavity</td>
</tr>
<tr>
<td>86403</td>
<td>Laceration of liver, moderate, without mention of open wound into cavity</td>
</tr>
<tr>
<td>86404</td>
<td>Laceration of liver, major, without mention of open wound into cavity</td>
</tr>
<tr>
<td>86405</td>
<td>Laceration of liver, unspecified, without mention of open wound into cavity</td>
</tr>
<tr>
<td>86409</td>
<td>Other injury to liver without mention of open wound into cavity</td>
</tr>
<tr>
<td>86410</td>
<td>Unspecified injury to liver with open wound into cavity</td>
</tr>
<tr>
<td>86411</td>
<td>Hematoma and contusion of liver with open wound into cavity</td>
</tr>
<tr>
<td>86412</td>
<td>Laceration of liver, minor, with open wound into cavity</td>
</tr>
<tr>
<td>86413</td>
<td>Laceration of liver, moderate, with open wound into cavity</td>
</tr>
<tr>
<td>86414</td>
<td>Laceration of liver, major, with open wound into cavity</td>
</tr>
<tr>
<td>86415</td>
<td>Laceration of liver, unspecified, with open wound into cavity</td>
</tr>
<tr>
<td>86419</td>
<td>Other injury to liver with open wound into cavity</td>
</tr>
<tr>
<td>86500</td>
<td>Unspecified injury to spleen without mention of open wound into cavity</td>
</tr>
<tr>
<td>86501</td>
<td>Hematoma of spleen, without rupture of capsule, without mention of open wound into cavity</td>
</tr>
<tr>
<td>86502</td>
<td>Capsular tears to spleen, without major disruption of parenchyma, without mention of open wound into cavity</td>
</tr>
<tr>
<td>86503</td>
<td>Laceration of spleen extending into parenchyma without mention of open wound into cavity</td>
</tr>
<tr>
<td>86504</td>
<td>Massive parenchymal disruption of spleen without mention of open wound into cavity</td>
</tr>
<tr>
<td>86509</td>
<td>Other injury into spleen without mention of open wound into cavity</td>
</tr>
<tr>
<td>86510</td>
<td>Unspecified injury to spleen with open wound into cavity</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>86511</td>
<td>Hematoma of spleen, without rupture of capsule, with open wound into cavity</td>
</tr>
<tr>
<td>86512</td>
<td>Capsular tears to spleen, without major disruption of parenchyma, with open wound into cavity</td>
</tr>
<tr>
<td>86513</td>
<td>Laceration of spleen extending into parenchyma, with open wound into cavity</td>
</tr>
<tr>
<td>86514</td>
<td>Massive parenchyma disruption of spleen with open wound into cavity</td>
</tr>
<tr>
<td>86519</td>
<td>Other injury to spleen with open wound into cavity</td>
</tr>
<tr>
<td>86600</td>
<td>Unspecified injury to kidney without mention of open wound into cavity</td>
</tr>
<tr>
<td>86601</td>
<td>Hematoma of kidney, without rupture of capsule, without mention of open wound into cavity</td>
</tr>
<tr>
<td>86602</td>
<td>Laceration of kidney without mention of open wound into cavity</td>
</tr>
<tr>
<td>86603</td>
<td>Complete disruption of kidney parenchyma, without mention of open wound into cavity</td>
</tr>
<tr>
<td>86610</td>
<td>Unspecified injury to kidney with open wound into cavity</td>
</tr>
<tr>
<td>86611</td>
<td>Hematoma of kidney, without rupture of capsule, with open wound into cavity</td>
</tr>
<tr>
<td>86612</td>
<td>Laceration of kidney with open wound into cavity</td>
</tr>
<tr>
<td>86613</td>
<td>Complete disruption of kidney parenchyma, with open wound into cavity</td>
</tr>
<tr>
<td>8670</td>
<td>Injury to bladder and urethra without mention of open wound into cavity</td>
</tr>
<tr>
<td>8671</td>
<td>Injury to bladder and urethra with open wound into cavity</td>
</tr>
<tr>
<td>8672</td>
<td>Injury to ureter without mention of open wound into cavity</td>
</tr>
<tr>
<td>8673</td>
<td>Injury to ureter with open wound into cavity</td>
</tr>
<tr>
<td>8674</td>
<td>Injury to uterus without mention of open wound into cavity</td>
</tr>
<tr>
<td>8675</td>
<td>Injury to uterus with open wound into cavity</td>
</tr>
<tr>
<td>8676</td>
<td>Injury to other specified pelvic organs without mention of open wound into cavity</td>
</tr>
<tr>
<td>8677</td>
<td>Injury to other specified pelvic organs with open wound into cavity</td>
</tr>
<tr>
<td>8678</td>
<td>Injury to unspecified pelvic organ without mention of open wound into cavity</td>
</tr>
<tr>
<td>8679</td>
<td>Injury to unspecified pelvic organ with open wound into cavity</td>
</tr>
<tr>
<td>86800</td>
<td>Injury to unspecified intra-abdominal organ without mention of open wound into cavity</td>
</tr>
<tr>
<td>86801</td>
<td>Injury to adrenal gland without mention of open wound into cavity</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>86802</td>
<td>Injury to bile duct and gallbladder without mention of open wound into cavity</td>
</tr>
<tr>
<td>86803</td>
<td>Injury to peritoneum without mention of open wound into cavity</td>
</tr>
<tr>
<td>86804</td>
<td>Injury to retroperitoneum without mention of open wound into cavity</td>
</tr>
<tr>
<td>86809</td>
<td>Injury to other and multiple intra-abdominal organs without mention of open wound into cavity</td>
</tr>
<tr>
<td>86810</td>
<td>Injury to unspecified intra-abdominal organ, with open wound into cavity</td>
</tr>
<tr>
<td>86811</td>
<td>Injury to adrenal gland, with open wound into cavity</td>
</tr>
<tr>
<td>86812</td>
<td>Injury to bile duct and gallbladder, with open wound into cavity</td>
</tr>
<tr>
<td>86813</td>
<td>Injury to peritoneum with open wound into cavity</td>
</tr>
<tr>
<td>86814</td>
<td>Injury to retroperitoneum with open wound into cavity</td>
</tr>
<tr>
<td>86819</td>
<td>Injury to other and multiple intra-abdominal organs, with open wound into cavity</td>
</tr>
<tr>
<td>8690</td>
<td>Internal injury to unspecified or ill-defined organs without mention of open wound into cavity</td>
</tr>
<tr>
<td>8691</td>
<td>Internal injury to unspecified or ill-defined organs with open wound into cavity</td>
</tr>
<tr>
<td>8700</td>
<td>Laceration of skin of eyelid and periocular area</td>
</tr>
<tr>
<td>8701</td>
<td>Laceration of eyelid, full-thickness, not involving lacrimal passages</td>
</tr>
<tr>
<td>8702</td>
<td>Laceration of eyelid involving lacrimal passages</td>
</tr>
<tr>
<td>8703</td>
<td>Penetrating wound of orbit, without mention of foreign body</td>
</tr>
<tr>
<td>8704</td>
<td>Penetrating wound of orbit with foreign body</td>
</tr>
<tr>
<td>8708</td>
<td>Other specified open wounds of ocular adnexa</td>
</tr>
<tr>
<td>8709</td>
<td>Unspecified open wound of ocular adnexa</td>
</tr>
<tr>
<td>8710</td>
<td>Ocular laceration without prolapse of intraocular tissue</td>
</tr>
<tr>
<td>8711</td>
<td>Ocular laceration with prolapse or exposure of intraocular tissue</td>
</tr>
<tr>
<td>8712</td>
<td>Rupture of eye with partial loss of intraocular tissue</td>
</tr>
<tr>
<td>8713</td>
<td>Avulsion of eye</td>
</tr>
<tr>
<td>8714</td>
<td>Unspecified laceration of eye</td>
</tr>
<tr>
<td>8715</td>
<td>Penetration of eyeball with magnetic foreign body</td>
</tr>
<tr>
<td>8716</td>
<td>Penetration of eyeball with (nonmagnetic) foreign body</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>8717</td>
<td>Unspecified ocular penetration</td>
</tr>
<tr>
<td>8719</td>
<td>Unspecified open wound of eyeball</td>
</tr>
<tr>
<td>87200</td>
<td>Open wound of external ear, unspecified site, uncomplicated</td>
</tr>
<tr>
<td>87201</td>
<td>Open wound of auricle, uncomplicated</td>
</tr>
<tr>
<td>87202</td>
<td>Open wound of auditory canal, uncomplicated</td>
</tr>
<tr>
<td>87210</td>
<td>Open wound of external ear, unspecified site, complicated</td>
</tr>
<tr>
<td>87211</td>
<td>Open wound of auricle, complicated</td>
</tr>
<tr>
<td>87212</td>
<td>Open wound of auditory canal, complicated</td>
</tr>
<tr>
<td>87261</td>
<td>Open wound of ear drum, uncomplicated</td>
</tr>
<tr>
<td>87262</td>
<td>Open wound of ossicles, uncomplicated</td>
</tr>
<tr>
<td>87263</td>
<td>Open wound of eustachian tube, uncomplicated</td>
</tr>
<tr>
<td>87264</td>
<td>Open wound of cochlea, uncomplicated</td>
</tr>
<tr>
<td>87266</td>
<td>Open wound of other and multiple sites, uncomplicated</td>
</tr>
<tr>
<td>87269</td>
<td>Open wound of other and multiple sites, uncomplicated</td>
</tr>
<tr>
<td>87271</td>
<td>Open wound of ear drum, complicated</td>
</tr>
<tr>
<td>87272</td>
<td>Open wound of ossicles, complicated</td>
</tr>
<tr>
<td>87273</td>
<td>Open wound of eustachian tube, complicated</td>
</tr>
<tr>
<td>87274</td>
<td>Open wound of cochlea, complicated</td>
</tr>
<tr>
<td>87279</td>
<td>Open wound of other and multiple sites, complicated</td>
</tr>
<tr>
<td>8728</td>
<td>Open wound of ear, part unspecified, without mention of complication</td>
</tr>
<tr>
<td>8729</td>
<td>Open wound of ear, part unspecified, complicated</td>
</tr>
<tr>
<td>8730</td>
<td>Open wound of scalp, without mention of complication</td>
</tr>
<tr>
<td>8731</td>
<td>Open wound of scalp, complicated</td>
</tr>
<tr>
<td>87320</td>
<td>Open wound of nose, unspecified site, uncomplicated</td>
</tr>
<tr>
<td>87321</td>
<td>Open wound of nasal septum, uncomplicated</td>
</tr>
<tr>
<td>87322</td>
<td>Open wound of nasal cavity, uncomplicated</td>
</tr>
<tr>
<td>87323</td>
<td>Open wound of nasal sinus, uncomplicated</td>
</tr>
<tr>
<td>87329</td>
<td>Open wound of multiple sites, uncomplicated</td>
</tr>
<tr>
<td>87330</td>
<td>Open wound of nose, unspecified site, complicated</td>
</tr>
<tr>
<td>87331</td>
<td>Open wound of nasal septum, complicated</td>
</tr>
<tr>
<td>87332</td>
<td>Open wound of nasal cavity, complicated</td>
</tr>
<tr>
<td>87333</td>
<td>Open wound of nasal sinus, complicated</td>
</tr>
<tr>
<td>87339</td>
<td>Open wound of multiple sites, complicated</td>
</tr>
<tr>
<td>Code</td>
<td>Description</td>
</tr>
<tr>
<td>--------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>87402</td>
<td>Open wound of trachea, uncomplicated</td>
</tr>
<tr>
<td>87410</td>
<td>Open wound of larynx with trachea, complicated</td>
</tr>
<tr>
<td>87411</td>
<td>Open wound of larynx, complicated</td>
</tr>
<tr>
<td>87412</td>
<td>Open wound of trachea, complicated</td>
</tr>
<tr>
<td>8742</td>
<td>Open wound of thyroid gland, without mention of complication</td>
</tr>
<tr>
<td>8743</td>
<td>Open wound of thyroid gland, complicated</td>
</tr>
<tr>
<td>8744</td>
<td>Open wound of pharynx, without mention of complication</td>
</tr>
<tr>
<td>8745</td>
<td>Open wound of pharynx, complicated</td>
</tr>
<tr>
<td>8748</td>
<td>Open wound of other and unspecified parts of neck, without mention of complication</td>
</tr>
<tr>
<td>8749</td>
<td>Open wound of other and unspecified parts of neck, complicated</td>
</tr>
<tr>
<td>8750</td>
<td>Open wound of chest (wall), without mention of complication</td>
</tr>
<tr>
<td>8751</td>
<td>Open wound of chest (wall), complicated</td>
</tr>
<tr>
<td>8760</td>
<td>Open wound of back, without mention of complication</td>
</tr>
<tr>
<td>8761</td>
<td>Open wound of back, complicated</td>
</tr>
<tr>
<td>8770</td>
<td>Open wound of buttock, without mention of complication</td>
</tr>
<tr>
<td>8771</td>
<td>Open wound of buttock, complicated</td>
</tr>
<tr>
<td>8780</td>
<td>Open wound of penis, without mention of complication</td>
</tr>
<tr>
<td>8781</td>
<td>Open wound of penis, complicated</td>
</tr>
<tr>
<td>8782</td>
<td>Open wound of scrotum and testes, without mention of complication</td>
</tr>
<tr>
<td>8783</td>
<td>Open wound of scrotum and testes, complicated</td>
</tr>
<tr>
<td>8784</td>
<td>Open wound of vulva, without mention of complication</td>
</tr>
<tr>
<td>8785</td>
<td>Open wound of vulva, complicated</td>
</tr>
<tr>
<td>8786</td>
<td>Open wound of vagina, without mention of complication</td>
</tr>
<tr>
<td>8787</td>
<td>Open wound of vagina, complicated</td>
</tr>
<tr>
<td>8788</td>
<td>Open wound of other and unspecified parts of genital organs, without mention of complication</td>
</tr>
<tr>
<td>8789</td>
<td>Open wound of other and unspecified parts of genital organs, complicated</td>
</tr>
<tr>
<td>8790</td>
<td>Open wound of breast, without mention of complication</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>88120</td>
<td>Open wound of forearm, with tendon involvement</td>
</tr>
<tr>
<td>88121</td>
<td>Open wound of elbow, with tendon involvement</td>
</tr>
<tr>
<td>88122</td>
<td>Open wound of wrist, with tendon involvement</td>
</tr>
<tr>
<td>8820</td>
<td>Open wound of hand except fingers alone, without mention of complication</td>
</tr>
<tr>
<td>8821</td>
<td>Open wound of hand except fingers alone, complicated</td>
</tr>
<tr>
<td>8822</td>
<td>Open wound of hand except fingers alone, with tendon involvement</td>
</tr>
<tr>
<td>8830</td>
<td>Open wound of fingers, without mention of complication</td>
</tr>
<tr>
<td>8831</td>
<td>Open wound of fingers, complicated</td>
</tr>
<tr>
<td>8832</td>
<td>Open wound of fingers, with tendon involvement</td>
</tr>
<tr>
<td>8840</td>
<td>Multiple and unspecified open wound of upper limb, without mention of complication</td>
</tr>
<tr>
<td>8841</td>
<td>Multiple and unspecified open wound of upper limb, complicated</td>
</tr>
<tr>
<td>8842</td>
<td>Multiple and unspecified open wound of upper limb, with tendon involvement</td>
</tr>
<tr>
<td>8850</td>
<td>Traumatic amputation of thumb (complete) (partial), without mention of complication</td>
</tr>
<tr>
<td>8851</td>
<td>Traumatic amputation of thumb (complete) (partial), complicated</td>
</tr>
<tr>
<td>8860</td>
<td>Traumatic amputation of other finger(s) (complete) (partial), without mention of complication</td>
</tr>
<tr>
<td>8861</td>
<td>Traumatic amputation of other finger(s) (complete) (partial), complicated</td>
</tr>
<tr>
<td>8870</td>
<td>Traumatic amputation of arm and hand (complete) (partial), unilateral, below elbow, without mention of complication</td>
</tr>
<tr>
<td>8871</td>
<td>Traumatic amputation of arm and hand (complete) (partial), unilateral, below elbow, complicated</td>
</tr>
<tr>
<td>8872</td>
<td>Traumatic amputation of arm and hand (complete) (partial), unilateral, at or above elbow, without mention of complication</td>
</tr>
<tr>
<td>8873</td>
<td>Traumatic amputation of arm and hand (complete) (partial), unilateral, at or above elbow, complicated</td>
</tr>
<tr>
<td>8874</td>
<td>Traumatic amputation of arm and hand (complete) (partial), unilateral, level not specified, without mention of complication</td>
</tr>
<tr>
<td>8875</td>
<td>Traumatic amputation of arm and hand (complete) (partial), unilateral, level not specified, complicated</td>
</tr>
<tr>
<td>8876</td>
<td>Traumatic amputation of arm and hand (complete) (partial), bilateral (any level), without mention of complication</td>
</tr>
<tr>
<td>8877</td>
<td>Traumatic amputation of arm and hand (complete) (partial), bilateral (any level), complicated</td>
</tr>
<tr>
<td>8900</td>
<td>Open wound of hip and thigh, without mention of complication</td>
</tr>
<tr>
<td>8901</td>
<td>Open wound of hip and thigh, complicated</td>
</tr>
<tr>
<td>8902</td>
<td>Open wound of hip and thigh, with tendon involvement</td>
</tr>
<tr>
<td>8910</td>
<td>Open wound of knee, leg (except thigh), and ankle, without mention of complication</td>
</tr>
<tr>
<td>8911</td>
<td>Open wound of knee, leg (except thigh), and ankle, complicated</td>
</tr>
<tr>
<td>8912</td>
<td>Open wound of knee, leg (except thigh), and ankle, with tendon involvement</td>
</tr>
<tr>
<td>8920</td>
<td>Open wound of foot except toe(s) alone, without mention of complication</td>
</tr>
<tr>
<td>8921</td>
<td>Open wound of foot except toe(s) alone, complicated</td>
</tr>
<tr>
<td>8922</td>
<td>Open wound of foot except toe(s) alone, with tendon involvement</td>
</tr>
<tr>
<td>8930</td>
<td>Open wound of toe(s), without mention of complication</td>
</tr>
<tr>
<td>8931</td>
<td>Open wound of toe(s), complicated</td>
</tr>
<tr>
<td>8932</td>
<td>Open wound of toe(s), with tendon involvement</td>
</tr>
<tr>
<td>8940</td>
<td>Multiple and unspecified open wound of lower limb, without mention of complication</td>
</tr>
<tr>
<td>8941</td>
<td>Multiple and unspecified open wound of lower limb, complicated</td>
</tr>
<tr>
<td>8942</td>
<td>Multiple and unspecified open wound of lower limb, with tendon involvement</td>
</tr>
<tr>
<td>8950</td>
<td>Traumatic amputation of toe(s) (complete) (partial), without mention of complication</td>
</tr>
<tr>
<td>8951</td>
<td>Traumatic amputation of toe(s) (complete) (partial), complicated</td>
</tr>
<tr>
<td>8960</td>
<td>Traumatic amputation of foot (complete) (partial), unilateral, without mention of complication</td>
</tr>
<tr>
<td>8961</td>
<td>Traumatic amputation of foot (complete) (partial), unilateral, complicated</td>
</tr>
<tr>
<td>8962</td>
<td>Traumatic amputation of foot (complete) (partial), bilateral, without mention of complication</td>
</tr>
<tr>
<td>8963</td>
<td>Traumatic amputation of foot (complete) (partial), bilateral, complicated</td>
</tr>
<tr>
<td>8970</td>
<td>Traumatic amputation of leg(s) (complete) (partial), unilateral, below knee, without mention of complication</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>8971</td>
<td>Traumatic amputation of leg(s) (complete) (partial), unilateral, below knee, complicated</td>
</tr>
<tr>
<td>8972</td>
<td>Traumatic amputation of leg(s) (complete) (partial), unilateral, at or above knee, without mention of complication</td>
</tr>
<tr>
<td>8973</td>
<td>Traumatic amputation of leg(s) (complete) (partial), unilateral, at or above knee, complicated</td>
</tr>
<tr>
<td>8974</td>
<td>Traumatic amputation of leg(s) (complete) (partial), unilateral, level not specified, without mention of complication</td>
</tr>
<tr>
<td>8975</td>
<td>Traumatic amputation of leg(s) (complete) (partial), unilateral, level not specified, complicated</td>
</tr>
<tr>
<td>8976</td>
<td>Traumatic amputation of leg(s) (complete) (partial), bilateral (any level), without mention of complication</td>
</tr>
<tr>
<td>8977</td>
<td>Traumatic amputation of leg(s) (complete) (partial), bilateral (any level), complicated</td>
</tr>
<tr>
<td>90000</td>
<td>Injury to carotid artery, unspecified</td>
</tr>
<tr>
<td>90001</td>
<td>Injury to common carotid artery</td>
</tr>
<tr>
<td>90002</td>
<td>Injury to external carotid artery</td>
</tr>
<tr>
<td>90003</td>
<td>Injury to internal carotid artery</td>
</tr>
<tr>
<td>9001</td>
<td>Injury to internal jugular vein</td>
</tr>
<tr>
<td>90081</td>
<td>Injury to external jugular vein</td>
</tr>
<tr>
<td>90082</td>
<td>Injury to multiple blood vessels of head and neck</td>
</tr>
<tr>
<td>90089</td>
<td>Injury to other specified blood vessels of head and neck</td>
</tr>
<tr>
<td>9009</td>
<td>Injury to unspecified blood vessel of head and neck</td>
</tr>
<tr>
<td>9010</td>
<td>Injury to thoracic aorta</td>
</tr>
<tr>
<td>9011</td>
<td>Injury to innominate and subclavian arteries</td>
</tr>
<tr>
<td>9012</td>
<td>Injury to superior vena cava</td>
</tr>
<tr>
<td>9013</td>
<td>Injury to innominate and subclavian veins</td>
</tr>
<tr>
<td>90140</td>
<td>Injury to pulmonary vessel(s), unspecified</td>
</tr>
<tr>
<td>90141</td>
<td>Injury to pulmonary artery</td>
</tr>
<tr>
<td>90142</td>
<td>Injury to pulmonary vein</td>
</tr>
<tr>
<td>90181</td>
<td>Injury to intercostal artery or vein</td>
</tr>
<tr>
<td>90182</td>
<td>Injury to internal mammary artery or vein</td>
</tr>
<tr>
<td>90183</td>
<td>Injury to multiple blood vessels of thorax</td>
</tr>
<tr>
<td>90189</td>
<td>Injury to other specified blood vessels of thorax</td>
</tr>
<tr>
<td>9019</td>
<td>Injury to unspecified blood vessel of thorax</td>
</tr>
<tr>
<td>9020</td>
<td>Injury to abdominal aorta</td>
</tr>
<tr>
<td>90210</td>
<td>Injury to inferior vena cava, unspecified</td>
</tr>
<tr>
<td>90211</td>
<td>Injury to hepatic veins</td>
</tr>
<tr>
<td>90219</td>
<td>Injury to other specified branches of inferior vena cava</td>
</tr>
<tr>
<td>90220</td>
<td>Injury to celiac and mesenteric arteries, unspecified</td>
</tr>
<tr>
<td>90221</td>
<td>Injury to gastric artery</td>
</tr>
<tr>
<td>90222</td>
<td>Injury to hepatic artery</td>
</tr>
<tr>
<td>90223</td>
<td>Injury to splenic artery</td>
</tr>
<tr>
<td>90224</td>
<td>Injury to other specified branches of celiac axis</td>
</tr>
<tr>
<td>90225</td>
<td>Injury to superior mesenteric artery (trunk)</td>
</tr>
<tr>
<td>90226</td>
<td>Injury to primary branches of superior mesenteric artery</td>
</tr>
<tr>
<td>90227</td>
<td>Injury to inferior mesenteric artery</td>
</tr>
<tr>
<td>90229</td>
<td>Injury to other celiac and mesenteric arteries</td>
</tr>
<tr>
<td>90231</td>
<td>Injury to superior mesenteric vein and primary subdivisions</td>
</tr>
<tr>
<td>90232</td>
<td>Injury to inferior mesenteric vein</td>
</tr>
<tr>
<td>90233</td>
<td>Injury to portal vein</td>
</tr>
<tr>
<td>90234</td>
<td>Injury to splenic vein</td>
</tr>
<tr>
<td>90239</td>
<td>Injury to other portal and splenic veins</td>
</tr>
<tr>
<td>90240</td>
<td>Injury to renal vessel(s), unspecified</td>
</tr>
<tr>
<td>90241</td>
<td>Injury to renal artery</td>
</tr>
<tr>
<td>90242</td>
<td>Injury to renal vein</td>
</tr>
<tr>
<td>90249</td>
<td>Injury to other renal blood vessels</td>
</tr>
<tr>
<td>90250</td>
<td>Injury to iliac vessel(s), unspecified</td>
</tr>
<tr>
<td>90251</td>
<td>Injury to hypogastric artery</td>
</tr>
<tr>
<td>90252</td>
<td>Injury hypogastric vein</td>
</tr>
<tr>
<td>90253</td>
<td>Injury to iliac artery</td>
</tr>
<tr>
<td>90254</td>
<td>Injury to iliac vein</td>
</tr>
<tr>
<td>90255</td>
<td>Injury to uterine artery</td>
</tr>
<tr>
<td>90256</td>
<td>Injury to uterine vein</td>
</tr>
<tr>
<td>90259</td>
<td>Injury to other iliac blood vessels</td>
</tr>
<tr>
<td>90281</td>
<td>Injury to ovarian artery</td>
</tr>
<tr>
<td>90282</td>
<td>Injury to ovarian vein</td>
</tr>
<tr>
<td>90287</td>
<td>Injury to multiple blood vessels of abdomen and pelvis</td>
</tr>
<tr>
<td>90289</td>
<td>Injury to other specified blood vessels of abdomen and pelvis</td>
</tr>
<tr>
<td>90300</td>
<td>Injury to axillary vessel(s), unspecified</td>
</tr>
<tr>
<td>90301</td>
<td>Injury to axillary artery</td>
</tr>
<tr>
<td>90302</td>
<td>Injury to axillary vein</td>
</tr>
<tr>
<td>9031</td>
<td>Injury to brachial blood vessels</td>
</tr>
<tr>
<td>9032</td>
<td>Injury to radial blood vessels</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>9033</td>
<td>Injury to ulnar blood vessels</td>
</tr>
<tr>
<td>9034</td>
<td>Injury to palmar artery</td>
</tr>
<tr>
<td>9035</td>
<td>Injury to digital blood vessels</td>
</tr>
<tr>
<td>9038</td>
<td>Injury to other specified blood vessels of upper extremity</td>
</tr>
<tr>
<td>9039</td>
<td>Injury to unspecified blood vessel of upper extremity</td>
</tr>
<tr>
<td>9040</td>
<td>Injury to common femoral artery</td>
</tr>
<tr>
<td>9041</td>
<td>Injury to superficial femoral artery</td>
</tr>
<tr>
<td>9042</td>
<td>Injury to femoral veins</td>
</tr>
<tr>
<td>9043</td>
<td>Injury to saphenous veins</td>
</tr>
<tr>
<td>90440</td>
<td>Injury to popliteal vessel(s), unspecified</td>
</tr>
<tr>
<td>90441</td>
<td>Injury to popliteal vessel(s), unspecified</td>
</tr>
<tr>
<td>90442</td>
<td>Injury to popliteal vein</td>
</tr>
<tr>
<td>90450</td>
<td>Injury to tibial vessel(s), unspecified</td>
</tr>
<tr>
<td>90451</td>
<td>Injury to anterior tibial artery</td>
</tr>
<tr>
<td>90452</td>
<td>Injury to anterior tibial vein</td>
</tr>
<tr>
<td>90453</td>
<td>Injury to posterior tibial artery</td>
</tr>
<tr>
<td>90454</td>
<td>Injury to posterior tibial vein</td>
</tr>
<tr>
<td>9046</td>
<td>Injury to deep plantar blood vessels</td>
</tr>
<tr>
<td>9047</td>
<td>Injury to other specified blood vessels of lower extremity</td>
</tr>
<tr>
<td>9048</td>
<td>Injury to unspecified blood vessel of lower extremity</td>
</tr>
<tr>
<td>9049</td>
<td>Injury to blood vessels of unspecified site</td>
</tr>
<tr>
<td>9050</td>
<td>Late effect of fracture of skull and face bones</td>
</tr>
<tr>
<td>9051</td>
<td>Late effect of fracture of spine and trunk without mention of spinal cord lesion</td>
</tr>
<tr>
<td>9052</td>
<td>Late effect of fracture of upper extremities</td>
</tr>
<tr>
<td>9053</td>
<td>Late effect of fracture of neck of femur</td>
</tr>
<tr>
<td>9054</td>
<td>Late effect of fracture of lower extremities</td>
</tr>
<tr>
<td>9055</td>
<td>Late effect of fracture of multiple and unspecified bones</td>
</tr>
<tr>
<td>9056</td>
<td>Late effect of dislocation</td>
</tr>
<tr>
<td>9057</td>
<td>Late effect of sprain and strain without mention of tendon injury</td>
</tr>
<tr>
<td>9058</td>
<td>Late effect of tendon injury</td>
</tr>
<tr>
<td>9059</td>
<td>Late effect of traumatic amputation</td>
</tr>
<tr>
<td>9060</td>
<td>Late effect of open wound of head, neck, and trunk</td>
</tr>
<tr>
<td>9061</td>
<td>Late effect of open wound of extremities without mention of tendon injury</td>
</tr>
<tr>
<td>9062</td>
<td>Late effect of superficial injury</td>
</tr>
<tr>
<td>9063</td>
<td>Late effect of contusion</td>
</tr>
<tr>
<td>9064</td>
<td>Late effect of crushing</td>
</tr>
<tr>
<td>9065</td>
<td>Late effect of burn of eye, face, head, and neck</td>
</tr>
<tr>
<td>9066</td>
<td>Late effect of burn of wrist and hand</td>
</tr>
<tr>
<td>9067</td>
<td>Late effect of burn of other extremities</td>
</tr>
<tr>
<td>9068</td>
<td>Late effect of burns of other specified sites</td>
</tr>
<tr>
<td>9069</td>
<td>Late effect of burn of unspecified site</td>
</tr>
<tr>
<td>9070</td>
<td>Late effect of intracranial injury without mention of skull fracture</td>
</tr>
<tr>
<td>9071</td>
<td>Late effect of injury to cranial nerve</td>
</tr>
<tr>
<td>9072</td>
<td>Late effect of spinal cord injury</td>
</tr>
<tr>
<td>9073</td>
<td>Late effect of injury to nerve root(s), spinal plexus(es), and other nerves of trunk</td>
</tr>
<tr>
<td>9074</td>
<td>Late effect of injury to peripheral nerve of shoulder girdle and upper limb</td>
</tr>
<tr>
<td>9075</td>
<td>Late effect of injury to peripheral nerve of pelvic girdle and lower limb</td>
</tr>
<tr>
<td>9079</td>
<td>Late effect of injury to other and unspecified nerve</td>
</tr>
<tr>
<td>9080</td>
<td>Late effect of internal injury to chest</td>
</tr>
<tr>
<td>9081</td>
<td>Late effect of internal injury to intra-abdominal organs</td>
</tr>
<tr>
<td>9082</td>
<td>Late effect of internal injury to other internal organs</td>
</tr>
<tr>
<td>9083</td>
<td>Late effect of injury to blood vessel of head, neck, and extremities</td>
</tr>
<tr>
<td>9084</td>
<td>Late effect of injury to blood vessel of thorax, abdomen, and pelvis</td>
</tr>
<tr>
<td>9085</td>
<td>Late effect of foreign body in orifice</td>
</tr>
<tr>
<td>9086</td>
<td>Late effect of certain complications of trauma</td>
</tr>
<tr>
<td>9089</td>
<td>Late effect of unspecified injury</td>
</tr>
<tr>
<td>9090</td>
<td>Late effect of poisoning due to drug, medicinal or biological substance</td>
</tr>
<tr>
<td>9091</td>
<td>Late effect of toxic effects of nonmedical substances</td>
</tr>
<tr>
<td>9092</td>
<td>Late effect of radiation</td>
</tr>
<tr>
<td>9093</td>
<td>Late effect of complications of surgical and medical care</td>
</tr>
<tr>
<td>9094</td>
<td>Late effect of certain other external causes</td>
</tr>
<tr>
<td>9095</td>
<td>Late effect of adverse effect of drug, medicinal or biological substance</td>
</tr>
<tr>
<td>9099</td>
<td>Late effect of other and unspecified external causes</td>
</tr>
<tr>
<td>9100</td>
<td>Abrasion or friction burn of face, neck, and scalp except eye, without mention of infection</td>
</tr>
<tr>
<td>9101</td>
<td>Abrasion or friction burn of face, neck, and scalp except eye, infected</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>9102</td>
<td>Blister of face, neck, and scalp except eye, without mention of infection</td>
</tr>
<tr>
<td>9103</td>
<td>Blister of face, neck, and scalp except eye, infected</td>
</tr>
<tr>
<td>9104</td>
<td>Insect bite, nonvenomous of face, neck, and scalp except eye, without mention of infection</td>
</tr>
<tr>
<td>9105</td>
<td>Insect bite, nonvenomous of face, neck, and scalp except eye, infected</td>
</tr>
<tr>
<td>9106</td>
<td>Superficial foreign body (splinter) of face, neck, and scalp except eye, without major open wound and without mention of infection</td>
</tr>
<tr>
<td>9107</td>
<td>Superficial foreign body (splinter) of face, neck, and scalp except eye, without major open wound, infected</td>
</tr>
<tr>
<td>9108</td>
<td>Other and unspecified superficial injury of face, neck, and scalp, without mention of infection</td>
</tr>
<tr>
<td>9109</td>
<td>Other and unspecified superficial injury of face, neck, and scalp, infected</td>
</tr>
<tr>
<td>9110</td>
<td>Abrasion or friction burn of trunk, without mention of infection</td>
</tr>
<tr>
<td>9111</td>
<td>Abrasion or friction burn of trunk, infected</td>
</tr>
<tr>
<td>9112</td>
<td>Blister of trunk, without mention of infection</td>
</tr>
<tr>
<td>9113</td>
<td>Blister of trunk, infected</td>
</tr>
<tr>
<td>9114</td>
<td>Insect bite, nonvenomous of trunk, without mention of infection</td>
</tr>
<tr>
<td>9115</td>
<td>Insect bite, nonvenomous of trunk, infected</td>
</tr>
<tr>
<td>9116</td>
<td>Superficial foreign body (splinter) of trunk, without major open wound and without mention of infection</td>
</tr>
<tr>
<td>9117</td>
<td>Superficial foreign body (splinter) of trunk, without major open wound, infected</td>
</tr>
<tr>
<td>9118</td>
<td>Other and unspecified superficial injury of trunk, without mention of infection</td>
</tr>
<tr>
<td>9119</td>
<td>Other and unspecified superficial injury of trunk, infected</td>
</tr>
<tr>
<td>9120</td>
<td>Abrasion or friction burn of shoulder and upper arm, without mention of infection</td>
</tr>
<tr>
<td>9121</td>
<td>Abrasion or friction burn of shoulder and upper arm, infected</td>
</tr>
<tr>
<td>9122</td>
<td>Blister of shoulder and upper arm, without mention of infection</td>
</tr>
<tr>
<td>9123</td>
<td>Blister of shoulder and upper arm, infected</td>
</tr>
<tr>
<td>9124</td>
<td>Insect bite, nonvenomous of shoulder and upper arm, without mention of infection</td>
</tr>
<tr>
<td>9125</td>
<td>Insect bite, nonvenomous of shoulder and upper arm, infected</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9126</td>
<td>Superficial foreign body (splinter) of shoulder and upper arm, without major open wound and without mention of infection</td>
</tr>
<tr>
<td>9127</td>
<td>Superficial foreign body (splinter) of shoulder and upper arm, without major open wound, infected</td>
</tr>
<tr>
<td>9128</td>
<td>Other and unspecified superficial injury of shoulder and upper arm, without mention of infection</td>
</tr>
<tr>
<td>9129</td>
<td>Other and unspecified superficial injury of shoulder and upper arm, infected</td>
</tr>
<tr>
<td>9130</td>
<td>Abrasion or friction burn of elbow, forearm, and wrist, without mention of infection</td>
</tr>
<tr>
<td>9131</td>
<td>Abrasion or friction burn of elbow, forearm, and wrist, infected</td>
</tr>
<tr>
<td>9132</td>
<td>Blister of elbow, forearm, and wrist, without mention of infection</td>
</tr>
<tr>
<td>9133</td>
<td>Blister of elbow, forearm, and wrist, infected</td>
</tr>
<tr>
<td>9134</td>
<td>Insect bite, nonvenomous of elbow, forearm, and wrist, without mention of infection</td>
</tr>
<tr>
<td>9135</td>
<td>Insect bite, nonvenomous, of elbow, forearm, and wrist, infected</td>
</tr>
<tr>
<td>9136</td>
<td>Superficial foreign body (splinter) of elbow, forearm, and wrist, without major open wound and without mention of infection</td>
</tr>
<tr>
<td>9137</td>
<td>Superficial foreign body (splinter) of elbow, forearm, and wrist, without major open wound, infected</td>
</tr>
<tr>
<td>9138</td>
<td>Other and unspecified superficial injury of elbow, forearm, and wrist, without mention of infection</td>
</tr>
<tr>
<td>9139</td>
<td>Other and unspecified superficial injury of elbow, forearm, and wrist, infected</td>
</tr>
<tr>
<td>9140</td>
<td>Abrasion or friction burn of hand(s) except finger(s) alone, without mention of infection</td>
</tr>
<tr>
<td>9141</td>
<td>Abrasion or friction burn of hand(s) except finger(s) alone, infected</td>
</tr>
<tr>
<td>9142</td>
<td>Blister of hand(s) except finger(s) alone, without mention of infection</td>
</tr>
<tr>
<td>9143</td>
<td>Blister of hand(s) except finger(s) alone, infected</td>
</tr>
<tr>
<td>9144</td>
<td>Insect bite, nonvenomous, of hand(s) except finger(s) alone, without mention of infection</td>
</tr>
<tr>
<td>9145</td>
<td>Insect bite, nonvenomous, of hand(s) except finger(s) alone, infected</td>
</tr>
<tr>
<td>9146</td>
<td>Superficial foreign body (splinter) of hand(s) except finger(s) alone, without major open wound and without mention of infection</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>9147</td>
<td>Superficial foreign body (splinter) of hand(s) except finger(s) alone, without major open wound, infected</td>
</tr>
<tr>
<td>9148</td>
<td>Other and unspecified superficial injury of hand(s) except finger(s) alone, without mention of infection</td>
</tr>
<tr>
<td>9149</td>
<td>Other and unspecified superficial injury of hand(s) except finger(s) alone, infected</td>
</tr>
<tr>
<td>9150</td>
<td>Abrasion or friction burn of fingers, without mention of infection</td>
</tr>
<tr>
<td>9151</td>
<td>Abrasion or friction burn of fingers, infected</td>
</tr>
<tr>
<td>9152</td>
<td>Blister of fingers, without mention of infection</td>
</tr>
<tr>
<td>9153</td>
<td>Blister of fingers, infected</td>
</tr>
<tr>
<td>9154</td>
<td>Insect bite, nonvenomous, of fingers, without mention of infection</td>
</tr>
<tr>
<td>9155</td>
<td>Insect bite, nonvenomous of fingers, infected</td>
</tr>
<tr>
<td>9156</td>
<td>Superficial foreign body (splinter) of fingers, without major open wound and without mention of infection</td>
</tr>
<tr>
<td>9157</td>
<td>Superficial foreign body (splinter) of fingers, without major open wound, infected</td>
</tr>
<tr>
<td>9158</td>
<td>Other and unspecified superficial injury of fingers without mention of infection</td>
</tr>
<tr>
<td>9159</td>
<td>Other and unspecified superficial injury of fingers, infected</td>
</tr>
<tr>
<td>9160</td>
<td>Abrasion or friction burn of hip, thigh, leg, and ankle, without mention of infection</td>
</tr>
<tr>
<td>9161</td>
<td>Abrasion or friction burn of hip, thigh, leg, and ankle, infected</td>
</tr>
<tr>
<td>9162</td>
<td>Blister of hip, thigh, leg, and ankle, without mention of infection</td>
</tr>
<tr>
<td>9163</td>
<td>Blister of hip, thigh, leg, and ankle, infected</td>
</tr>
<tr>
<td>9164</td>
<td>Insect bite, nonvenomous, of hip, thigh, leg, and ankle, without mention of infection</td>
</tr>
<tr>
<td>9165</td>
<td>Insect bite, nonvenomous of hip, thigh, leg, and ankle, infected</td>
</tr>
<tr>
<td>9166</td>
<td>Superficial foreign body (splinter) of hip, thigh, leg, and ankle, without major open wound and without mention of infection</td>
</tr>
<tr>
<td>9167</td>
<td>Superficial foreign body (splinter) of hip, thigh, leg, and ankle, without major open wound, infected</td>
</tr>
<tr>
<td>9168</td>
<td>Other and unspecified superficial injury of hip, thigh, leg, and ankle, without mention of infection</td>
</tr>
<tr>
<td>9169</td>
<td>Other and unspecified superficial injury of hip, thigh, leg, and ankle, infected</td>
</tr>
<tr>
<td>9170</td>
<td>Abrasion or friction burn of foot and toe(s), without mention of infection</td>
</tr>
<tr>
<td>9172</td>
<td>Blister of foot and toe(s), without mention of infection</td>
</tr>
<tr>
<td>9173</td>
<td>Blister of foot and toe(s), infected</td>
</tr>
<tr>
<td>9174</td>
<td>Insect bite, nonvenomous, of foot and toe(s), without mention of infection</td>
</tr>
<tr>
<td>9175</td>
<td>Insect bite, nonvenomous, of foot and toe(s), infected</td>
</tr>
<tr>
<td>9176</td>
<td>Superficial foreign body (splinter) of foot and toe(s), without major open wound and without mention of infection</td>
</tr>
<tr>
<td>9177</td>
<td>Superficial foreign body (splinter) of foot and toe(s), without major open wound, infected</td>
</tr>
<tr>
<td>9178</td>
<td>Other and unspecified superficial injury of foot and toes, without mention of infection</td>
</tr>
<tr>
<td>9179</td>
<td>Other and unspecified superficial injury of foot and toes, infected</td>
</tr>
<tr>
<td>9180</td>
<td>Superficial injury of eyelids and periocular area</td>
</tr>
<tr>
<td>9181</td>
<td>Superficial injury of cornea</td>
</tr>
<tr>
<td>9182</td>
<td>Superficial injury of conjunctiva</td>
</tr>
<tr>
<td>9183</td>
<td>Other and unspecified superficial injuries of eye</td>
</tr>
<tr>
<td>9190</td>
<td>Abrasion or friction burn of other, multiple, and unspecified sites, without mention of infection</td>
</tr>
<tr>
<td>9191</td>
<td>Abrasion or friction burn of other, multiple, and unspecified sites, infected</td>
</tr>
<tr>
<td>9192</td>
<td>Blister of other, multiple, and unspecified sites, without mention of infection</td>
</tr>
<tr>
<td>9193</td>
<td>Blister of other, multiple, and unspecified sites, infected</td>
</tr>
<tr>
<td>9194</td>
<td>Insect bite, nonvenomous, of other, multiple, and unspecified sites, without mention of infection</td>
</tr>
<tr>
<td>9195</td>
<td>Insect bite, nonvenomous, of other, multiple, and unspecified sites, infected</td>
</tr>
<tr>
<td>9196</td>
<td>Superficial foreign body (splinter) of other, multiple, and unspecified sites, without major open wound and without mention of infection</td>
</tr>
<tr>
<td>9197</td>
<td>Superficial foreign body (splinter) of other, multiple, and unspecified sites, without major open wound, infected</td>
</tr>
<tr>
<td>9198</td>
<td>Other and unspecified superficial injury of other, multiple, and unspecified sites, without mention of infection</td>
</tr>
<tr>
<td>9199</td>
<td>Other and unspecified superficial injury of other, multiple, and unspecified sites, infected</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>920</td>
<td>Contusion of face, scalp, and neck except eye(s)</td>
</tr>
<tr>
<td>9210</td>
<td>Black eye, not otherwise specified</td>
</tr>
<tr>
<td>9211</td>
<td>Contusion of eyelids and periocular area</td>
</tr>
<tr>
<td>9212</td>
<td>Contusion of orbital tissues</td>
</tr>
<tr>
<td>9213</td>
<td>Contusion of eyeball</td>
</tr>
<tr>
<td>9219</td>
<td>Unspecified contusion of eye</td>
</tr>
<tr>
<td>9220</td>
<td>Contusion of breast</td>
</tr>
<tr>
<td>9221</td>
<td>Contusion of chest wall</td>
</tr>
<tr>
<td>9222</td>
<td>Contusion of abdominal wall</td>
</tr>
<tr>
<td>92231</td>
<td>Contusion of back</td>
</tr>
<tr>
<td>92232</td>
<td>Contusion of buttock</td>
</tr>
<tr>
<td>92233</td>
<td>Contusion of interscapular region</td>
</tr>
<tr>
<td>9224</td>
<td>Contusion of genital organs</td>
</tr>
<tr>
<td>9228</td>
<td>Contusion of multiple sites of trunk</td>
</tr>
<tr>
<td>9229</td>
<td>Contusion of unspecified part of trunk</td>
</tr>
<tr>
<td>92300</td>
<td>Contusion of shoulder region</td>
</tr>
<tr>
<td>92301</td>
<td>Contusion of scapular region</td>
</tr>
<tr>
<td>92302</td>
<td>Contusion of axillary region</td>
</tr>
<tr>
<td>92303</td>
<td>Contusion of upper arm</td>
</tr>
<tr>
<td>92309</td>
<td>Contusion of multiple sites of shoulder and upper arm</td>
</tr>
<tr>
<td>92310</td>
<td>Contusion of forearm</td>
</tr>
<tr>
<td>92311</td>
<td>Contusion of elbow</td>
</tr>
<tr>
<td>92320</td>
<td>Contusion of hand(s)</td>
</tr>
<tr>
<td>92321</td>
<td>Contusion of wrist</td>
</tr>
<tr>
<td>9233</td>
<td>Contusion of finger</td>
</tr>
<tr>
<td>9238</td>
<td>Contusion of multiple sites of upper limb</td>
</tr>
<tr>
<td>9239</td>
<td>Contusion of unspecified part of upper limb</td>
</tr>
<tr>
<td>92400</td>
<td>Contusion of thigh</td>
</tr>
<tr>
<td>92401</td>
<td>Contusion of hip</td>
</tr>
<tr>
<td>92410</td>
<td>Contusion of lower leg</td>
</tr>
<tr>
<td>92411</td>
<td>Contusion of knee</td>
</tr>
<tr>
<td>92420</td>
<td>Contusion of foot</td>
</tr>
<tr>
<td>92421</td>
<td>Contusion of ankle</td>
</tr>
<tr>
<td>9243</td>
<td>Contusion of toe</td>
</tr>
<tr>
<td>9244</td>
<td>Contusion of multiple sites of lower limb</td>
</tr>
<tr>
<td>9245</td>
<td>Contusion of unspecified part of lower limb</td>
</tr>
<tr>
<td>9248</td>
<td>Contusion of multiple sites, not elsewhere classified</td>
</tr>
<tr>
<td>9249</td>
<td>Contusion of unspecified site</td>
</tr>
<tr>
<td>9251</td>
<td>Crushing injury of face and scalp</td>
</tr>
<tr>
<td>9252</td>
<td>Crushing injury of neck</td>
</tr>
<tr>
<td>9260</td>
<td>Crushing injury of external genitalia</td>
</tr>
<tr>
<td>92611</td>
<td>Crushing injury of back</td>
</tr>
<tr>
<td>92612</td>
<td>Crushing injury of buttoc</td>
</tr>
<tr>
<td>92619</td>
<td>Crushing injury of other specified sites of trunk</td>
</tr>
<tr>
<td>9268</td>
<td>Crushing injury of multiple sites of trunk</td>
</tr>
<tr>
<td>9269</td>
<td>Crushing injury of unspecified site of trunk</td>
</tr>
<tr>
<td>92700</td>
<td>Crushing injury of shoulder region</td>
</tr>
<tr>
<td>92701</td>
<td>Crushing injury of scapular region</td>
</tr>
<tr>
<td>92702</td>
<td>Crushing injury of axillary region</td>
</tr>
<tr>
<td>92703</td>
<td>Crushing injury of upper arm</td>
</tr>
<tr>
<td>92709</td>
<td>Crushing injury of multiple sites of upper arm</td>
</tr>
<tr>
<td>92710</td>
<td>Crushing injury of forearm</td>
</tr>
<tr>
<td>92711</td>
<td>Crushing injury of elbow</td>
</tr>
<tr>
<td>92720</td>
<td>Crushing injury of hand(s)</td>
</tr>
<tr>
<td>92721</td>
<td>Crushing injury of wrist</td>
</tr>
<tr>
<td>92723</td>
<td>Crushing injury of finger(s)</td>
</tr>
<tr>
<td>9278</td>
<td>Crushing injury of multiple sites of upper limb</td>
</tr>
<tr>
<td>9279</td>
<td>Crushing injury of unspecified site of upper limb</td>
</tr>
<tr>
<td>92800</td>
<td>Crushing injury of thigh</td>
</tr>
<tr>
<td>92801</td>
<td>Crushing injury of hip</td>
</tr>
<tr>
<td>92810</td>
<td>Crushing injury of lower leg</td>
</tr>
<tr>
<td>92811</td>
<td>Crushing injury of knee</td>
</tr>
<tr>
<td>92820</td>
<td>Crushing injury of foot</td>
</tr>
<tr>
<td>92821</td>
<td>Crushing injury of ankle</td>
</tr>
<tr>
<td>9283</td>
<td>Crushing injury of toe(s)</td>
</tr>
<tr>
<td>9288</td>
<td>Crushing injury of multiple sites of lower limb</td>
</tr>
<tr>
<td>9289</td>
<td>Crushing injury of unspecified site of lower limb</td>
</tr>
<tr>
<td>9290</td>
<td>Crushing injury of multiple sites, not elsewhere classified</td>
</tr>
<tr>
<td>9299</td>
<td>Crushing injury of unspecified site</td>
</tr>
<tr>
<td>9300</td>
<td>Corneal foreign body</td>
</tr>
<tr>
<td>9301</td>
<td>Foreign body in conjunctival sac</td>
</tr>
<tr>
<td>9302</td>
<td>Foreign body in lacrimal punctum</td>
</tr>
<tr>
<td>9308</td>
<td>Foreign body in other and combined sites on external eye</td>
</tr>
<tr>
<td>9309</td>
<td>Foreign body in unspecified site on external eye</td>
</tr>
<tr>
<td>931</td>
<td>Foreign body in ear</td>
</tr>
<tr>
<td>932</td>
<td>Foreign body in nose</td>
</tr>
<tr>
<td>9330</td>
<td>Foreign body in pharynx</td>
</tr>
<tr>
<td>9331</td>
<td>Foreign body in larynx</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>9340</td>
<td>Foreign body in trachea</td>
</tr>
<tr>
<td>9341</td>
<td>Foreign body in main bronchus</td>
</tr>
<tr>
<td>9348</td>
<td>Foreign body in other specified parts bronchus and lung</td>
</tr>
<tr>
<td>9349</td>
<td>Foreign body in respiratory tree, unspecified</td>
</tr>
<tr>
<td>9350</td>
<td>Foreign body in mouth</td>
</tr>
<tr>
<td>9351</td>
<td>Foreign body in esophagus</td>
</tr>
<tr>
<td>9352</td>
<td>Foreign body in stomach</td>
</tr>
<tr>
<td>936</td>
<td>Foreign body in intestine and colon</td>
</tr>
<tr>
<td>937</td>
<td>Foreign body in anus and rectum</td>
</tr>
<tr>
<td>938</td>
<td>Foreign body in digestive system, unspecified</td>
</tr>
<tr>
<td>9390</td>
<td>Foreign body in bladder and urethra</td>
</tr>
<tr>
<td>9391</td>
<td>Foreign body in uterus, any part</td>
</tr>
<tr>
<td>9392</td>
<td>Foreign body in vulva and vagina</td>
</tr>
<tr>
<td>9393</td>
<td>Foreign body in penis</td>
</tr>
<tr>
<td>9399</td>
<td>Foreign body in unspecified site in genitourinary tract</td>
</tr>
<tr>
<td>9400</td>
<td>Chemical burn of eyelids and periorcular area</td>
</tr>
<tr>
<td>9401</td>
<td>Other burns of eyelids and periorcular area</td>
</tr>
<tr>
<td>9402</td>
<td>Alkaline chemical burn of cornea and conjunctival sac</td>
</tr>
<tr>
<td>9403</td>
<td>Acid chemical burn of cornea and conjunctival sac</td>
</tr>
<tr>
<td>9404</td>
<td>Other burn of cornea and conjunctival sac</td>
</tr>
<tr>
<td>9405</td>
<td>Burn with resulting rupture and destruction of eyeball</td>
</tr>
<tr>
<td>9409</td>
<td>Unspecified burn of eye and adnexa</td>
</tr>
<tr>
<td>94100</td>
<td>Burn of unspecified degree of unspecified site of face and head</td>
</tr>
<tr>
<td>94101</td>
<td>Burn of unspecified degree of ear (any part)</td>
</tr>
<tr>
<td>94102</td>
<td>Burn of unspecified degree of eye (with other parts of face, head, and neck)</td>
</tr>
<tr>
<td>94103</td>
<td>Burn of unspecified degree of lip(s)</td>
</tr>
<tr>
<td>94104</td>
<td>Burn of unspecified degree of chin</td>
</tr>
<tr>
<td>94105</td>
<td>Burn of unspecified degree of nose (septum)</td>
</tr>
<tr>
<td>94106</td>
<td>Burn of unspecified degree of scalp (any part)</td>
</tr>
<tr>
<td>94107</td>
<td>Burn of unspecified degree of forehead and cheek</td>
</tr>
<tr>
<td>94108</td>
<td>Burn of unspecified degree of neck</td>
</tr>
<tr>
<td>94109</td>
<td>Burn of unspecified degree of multiple sites (except with eye) of face, head, and neck</td>
</tr>
<tr>
<td>94110</td>
<td>Erythema due to burn (first degree) of unspecified site of face and head</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>94111</td>
<td>Erythema due to burn (first degree) of ear (any part)</td>
</tr>
<tr>
<td>94112</td>
<td>Erythema due to burn (first degree) of eye (with other parts face, head, and neck)</td>
</tr>
<tr>
<td>94113</td>
<td>Erythema due to burn (first degree) of lip(s)</td>
</tr>
<tr>
<td>94114</td>
<td>Erythema due to burn (first degree) of chin</td>
</tr>
<tr>
<td>94115</td>
<td>Erythema due to burn (first degree) of nose (septum)</td>
</tr>
<tr>
<td>94116</td>
<td>Erythema due to burn (first degree) of scalp (any part)</td>
</tr>
<tr>
<td>94117</td>
<td>Erythema due to burn (first degree) of forehead and cheek</td>
</tr>
<tr>
<td>94118</td>
<td>Erythema due to burn (first degree) of neck</td>
</tr>
<tr>
<td>94119</td>
<td>Erythema due to burn (first degree) of multiple sites (except with eye) of face, head, and neck</td>
</tr>
<tr>
<td>94120</td>
<td>Blisters, with epidermal loss due to burn (second degree) of face and head, unspecified site</td>
</tr>
<tr>
<td>94121</td>
<td>Blisters, with epidermal loss due to burn (second degree) of ear (any part)</td>
</tr>
<tr>
<td>94122</td>
<td>Blisters, with epidermal loss due to burn (second degree) of eye (with other parts of face, head, and neck)</td>
</tr>
<tr>
<td>94123</td>
<td>Blisters, with epidermal loss due to burn (second degree) of lip(s)</td>
</tr>
<tr>
<td>94124</td>
<td>Blisters, with epidermal loss due to burn (second degree) of chin</td>
</tr>
<tr>
<td>94125</td>
<td>Blisters, with epidermal loss due to burn (second degree) of nose (septum)</td>
</tr>
<tr>
<td>94126</td>
<td>Blisters, with epidermal loss due to burn (second degree) of scalp (any part)</td>
</tr>
<tr>
<td>94127</td>
<td>Blisters, with epidermal loss due to burn (second degree) of forehead and cheek</td>
</tr>
<tr>
<td>94128</td>
<td>Blisters, with epidermal loss due to burn (second degree) of neck</td>
</tr>
<tr>
<td>94129</td>
<td>Blisters, with epidermal loss due to burn (second degree) of multiple sites (except with eye) of face, head, and neck</td>
</tr>
<tr>
<td>94130</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of unspecified site of face and head</td>
</tr>
<tr>
<td>94131</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of ear (any part)</td>
</tr>
<tr>
<td>94132</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of eye (with other parts of face, head, and neck)</td>
</tr>
<tr>
<td>94133</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of lip(s)</td>
</tr>
<tr>
<td>94134</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of chin</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>94135</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of nose (septum)</td>
</tr>
<tr>
<td>94136</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of scalp (any part)</td>
</tr>
<tr>
<td>94137</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of forehead and cheek</td>
</tr>
<tr>
<td>94138</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of neck</td>
</tr>
<tr>
<td>94139</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of multiple sites (except with eye) of face, head, and neck</td>
</tr>
<tr>
<td>94140</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of face and head, without mention of loss of body part</td>
</tr>
<tr>
<td>94141</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), without mention of loss of ear</td>
</tr>
<tr>
<td>94142</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), without mention of loss of body part</td>
</tr>
<tr>
<td>94143</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), without mention of loss of lip(s)</td>
</tr>
<tr>
<td>94144</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of chin, without mention of loss of chin</td>
</tr>
<tr>
<td>94145</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), without mention of loss of nose</td>
</tr>
<tr>
<td>94146</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), without mention of loss of scalp</td>
</tr>
<tr>
<td>94147</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, without mention of loss of forehead and cheek</td>
</tr>
<tr>
<td>94148</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of neck, without mention of loss of neck</td>
</tr>
<tr>
<td>94149</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except with eye) of face, head, and neck, without mention of loss of a body part</td>
</tr>
<tr>
<td>94150</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of face and head, unspecified site, with loss of body part</td>
</tr>
<tr>
<td>94151</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), with loss of ear</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>94220</td>
<td>Blisters with epidermal loss due to burn (second degree) of unspecified site of trunk</td>
</tr>
<tr>
<td>94221</td>
<td>Blisters with epidermal loss due to burn (second degree) of breast</td>
</tr>
<tr>
<td>94222</td>
<td>Blisters with epidermal loss due to burn (second degree) of chest wall, excluding breast and nipple</td>
</tr>
<tr>
<td>94223</td>
<td>Blisters with epidermal loss due to burn (second degree) of abdominal wall</td>
</tr>
<tr>
<td>94224</td>
<td>Blisters with epidermal loss due to burn (second degree) of back (any part)</td>
</tr>
<tr>
<td>94225</td>
<td>Blisters with epidermal loss due to burn (second degree) of genitalia</td>
</tr>
<tr>
<td>94229</td>
<td>Blisters with epidermal loss due to burn (second degree) of other and multiple sites of trunk</td>
</tr>
<tr>
<td>94230</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of unspecified site of trunk</td>
</tr>
<tr>
<td>94231</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of breast</td>
</tr>
<tr>
<td>94232</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of chest wall, excluding breast and nipple</td>
</tr>
<tr>
<td>94233</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of abdominal wall</td>
</tr>
<tr>
<td>94234</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of back (any part)</td>
</tr>
<tr>
<td>94235</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of genitalia</td>
</tr>
<tr>
<td>94239</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of other and multiple sites of trunk</td>
</tr>
<tr>
<td>94240</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of trunk, unspecified site, without mention of loss of body part</td>
</tr>
<tr>
<td>94241</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of breast, without mention of loss of breast</td>
</tr>
<tr>
<td>94242</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of chest wall, excluding breast and nipple, without mention of loss of chest wall</td>
</tr>
<tr>
<td>94243</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of abdominal wall, without mention of loss of abdominal wall</td>
</tr>
<tr>
<td>94244</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of back (any part), without mention of loss of back</td>
</tr>
<tr>
<td>94245</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of genitalia, without mention of loss of genitalia</td>
</tr>
<tr>
<td>94249</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of other and multiple sites of trunk, without mention of loss of body part</td>
</tr>
<tr>
<td>94250</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of trunk, with loss of body part</td>
</tr>
<tr>
<td>94251</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of breast, with loss of breast</td>
</tr>
<tr>
<td>94252</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of chest wall, excluding breast and nipple, with loss of chest wall</td>
</tr>
<tr>
<td>94253</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of abdominal wall with loss of abdominal wall</td>
</tr>
<tr>
<td>94254</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of back (any part), with loss of back</td>
</tr>
<tr>
<td>94255</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of genitalia, with loss of genitalia</td>
</tr>
<tr>
<td>94259</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of other and multiple sites of trunk, with loss of a body part</td>
</tr>
<tr>
<td>94300</td>
<td>Burn of unspecified degree of unspecified site of upper limb</td>
</tr>
<tr>
<td>94301</td>
<td>Burn of unspecified degree of forearm</td>
</tr>
<tr>
<td>94302</td>
<td>Burn of unspecified degree of elbow</td>
</tr>
<tr>
<td>94303</td>
<td>Burn of unspecified degree of upper arm</td>
</tr>
<tr>
<td>94304</td>
<td>Burn of unspecified degree of axilla</td>
</tr>
<tr>
<td>94305</td>
<td>Burn of unspecified degree of shoulder</td>
</tr>
<tr>
<td>94306</td>
<td>Burn of unspecified degree of scapular region</td>
</tr>
<tr>
<td>94309</td>
<td>Burn of unspecified degree multiple sites of upper limb, except wrist and hand</td>
</tr>
<tr>
<td>94310</td>
<td>Erythema due to burn (first degree) of unspecified site of upper limb</td>
</tr>
<tr>
<td>94311</td>
<td>Erythema due to burn (first degree) of forearm</td>
</tr>
<tr>
<td>94312</td>
<td>Erythema due to burn (first degree) of elbow</td>
</tr>
<tr>
<td>94313</td>
<td>Erythema due to burn (first degree) of upper arm</td>
</tr>
<tr>
<td>94314</td>
<td>Erythema due to burn (first degree) of axilla</td>
</tr>
<tr>
<td>94315</td>
<td>Erythema due to burn (first degree) of shoulder</td>
</tr>
<tr>
<td>94316</td>
<td>Erythema due to burn (first degree) of scapular region</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>94319</td>
<td>Erythema due to burn (first degree) of multiple sites of upper limb, except wrist and hand</td>
</tr>
<tr>
<td>94320</td>
<td>Blisters with epidermal loss due to burn (second degree) of unspecified site of upper limb</td>
</tr>
<tr>
<td>94321</td>
<td>Blisters with epidermal loss due to burn (second degree) of forearm</td>
</tr>
<tr>
<td>94322</td>
<td>Blisters with epidermal loss due to burn (second degree) of elbow</td>
</tr>
<tr>
<td>94323</td>
<td>Blisters with epidermal loss due to burn (second degree) of upper arm</td>
</tr>
<tr>
<td>94324</td>
<td>Blisters with epidermal loss due to burn (second degree) of axilla</td>
</tr>
<tr>
<td>94325</td>
<td>Blisters with epidermal loss due to burn (second degree) of shoulder</td>
</tr>
<tr>
<td>94326</td>
<td>Blisters with epidermal loss due to burn (second degree) of scapular region</td>
</tr>
<tr>
<td>94329</td>
<td>Blisters with epidermal loss due to burn (second degree) of multiple sites of upper limb, except wrist and hand</td>
</tr>
<tr>
<td>94330</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of unspecified site of upper limb</td>
</tr>
<tr>
<td>94331</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of forearm</td>
</tr>
<tr>
<td>94332</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of elbow</td>
</tr>
<tr>
<td>94333</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of upper arm</td>
</tr>
<tr>
<td>94334</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of axilla</td>
</tr>
<tr>
<td>94335</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of shoulder</td>
</tr>
<tr>
<td>94336</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of scapular region</td>
</tr>
<tr>
<td>94339</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of multiple sites of upper limb, except wrist and hand</td>
</tr>
<tr>
<td>94340</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of upper limb, without mention of loss of a body part</td>
</tr>
<tr>
<td>94341</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, without mention of loss of forearm</td>
</tr>
<tr>
<td>94342</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, without mention of loss of elbow</td>
</tr>
<tr>
<td>94343</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, without mention of loss of upper arm</td>
</tr>
<tr>
<td>94344</td>
<td>Deep necrosis of underlying tissues due to burn of axilla, without mention of loss of axilla</td>
</tr>
<tr>
<td>94345</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, without mention of loss of shoulder</td>
</tr>
<tr>
<td>94346</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, without mention of loss of scapula</td>
</tr>
<tr>
<td>94349</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of upper limb, except wrist and hand, without mention of loss of upper limb</td>
</tr>
<tr>
<td>94350</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of upper limb, with loss of a body part</td>
</tr>
<tr>
<td>94351</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, with loss of forearm</td>
</tr>
<tr>
<td>94352</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, with loss of elbow</td>
</tr>
<tr>
<td>94353</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, with loss of upper arm</td>
</tr>
<tr>
<td>94354</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of axilla, with loss of axilla</td>
</tr>
<tr>
<td>94355</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, with loss of shoulder</td>
</tr>
<tr>
<td>94356</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, with loss of scapula</td>
</tr>
<tr>
<td>94359</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of upper limb, except wrist and hand, with loss of upper limb</td>
</tr>
<tr>
<td>94400</td>
<td>Burn of unspecified degree of unspecified site of hand</td>
</tr>
<tr>
<td>94401</td>
<td>Burn of unspecified degree of single digit (finger (nail) other than thumb</td>
</tr>
<tr>
<td>94402</td>
<td>Burn of unspecified degree of thumb (nail)</td>
</tr>
<tr>
<td>94403</td>
<td>Burn of unspecified degree of two or more digits of hand, not including thumb</td>
</tr>
<tr>
<td>94404</td>
<td>Burn of unspecified degree of two or more digits of hand, including thumb</td>
</tr>
<tr>
<td>94405</td>
<td>Burn of unspecified degree of palm of hand</td>
</tr>
<tr>
<td>94406</td>
<td>Burn of unspecified degree of back of hand</td>
</tr>
<tr>
<td>94407</td>
<td>Burn of unspecified degree of wrist</td>
</tr>
<tr>
<td>94408</td>
<td>Burn of unspecified degree of multiple sites of wrist(s) and hand(s)</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>94410</td>
<td>Erythema due to burn (first degree) of unspecified site of hand</td>
</tr>
<tr>
<td>94411</td>
<td>Erythema due to burn (first degree) of single digit (finger [nail]) other than thumb</td>
</tr>
<tr>
<td>94412</td>
<td>Erythema due to burn (first degree) of thumb (nail)</td>
</tr>
<tr>
<td>94413</td>
<td>Erythema due to burn (first degree) of two or more digits of hand, not including thumb</td>
</tr>
<tr>
<td>94414</td>
<td>Erythema due to burn (first degree) of two or more digits of hand including thumb</td>
</tr>
<tr>
<td>94415</td>
<td>Erythema due to burn (first degree) of palm of hand</td>
</tr>
<tr>
<td>94416</td>
<td>Erythema due to burn (first degree) of back of hand</td>
</tr>
<tr>
<td>94417</td>
<td>Erythema due to burn (first degree) of wrist</td>
</tr>
<tr>
<td>94418</td>
<td>Erythema due to burn (first degree) of multiple sites of wrist(s) and hand(s)</td>
</tr>
<tr>
<td>94420</td>
<td>Blisters with epidermal loss due to burn (second degree) of unspecified site of hand</td>
</tr>
<tr>
<td>94421</td>
<td>Blisters with epidermal loss due to burn (second degree) of single digit (finger [nail]) other than thumb</td>
</tr>
<tr>
<td>94422</td>
<td>Blisters with epidermal loss due to burn of (second degree) of thumb (nail)</td>
</tr>
<tr>
<td>94423</td>
<td>Blisters with epidermal loss due to burn (second degree) of two or more digits of hand, not including thumb</td>
</tr>
<tr>
<td>94424</td>
<td>Blisters with epidermal loss due to burn (second degree) of two or more digits of hand including thumb</td>
</tr>
<tr>
<td>94425</td>
<td>Blisters with epidermal loss due to burn (second degree) of palm of hand</td>
</tr>
<tr>
<td>94426</td>
<td>Blisters with epidermal loss due to burn (second degree) of back of hand</td>
</tr>
<tr>
<td>94427</td>
<td>Blisters with epidermal loss due to burn (second degree) of wrist</td>
</tr>
<tr>
<td>94428</td>
<td>Blisters with epidermal loss due to burn (second degree) of multiple sites of wrist(s) and hand(s)</td>
</tr>
<tr>
<td>94430</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of unspecified site of hand</td>
</tr>
<tr>
<td>94431</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of single digit (finger [nail]) other than thumb</td>
</tr>
<tr>
<td>94432</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of thumb (nail)</td>
</tr>
<tr>
<td>94433</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of two or more digits of hand, not including thumb</td>
</tr>
<tr>
<td>94434</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of two or more digits of hand including thumb</td>
</tr>
<tr>
<td>94435</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of palm of hand</td>
</tr>
<tr>
<td>94436</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of back of hand</td>
</tr>
<tr>
<td>94437</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of wrist</td>
</tr>
<tr>
<td>94438</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of multiple sites of wrist(s) and hand(s)</td>
</tr>
<tr>
<td>94440</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of hand, without mention of loss of hand</td>
</tr>
<tr>
<td>94441</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of single digit (finger [nail]) other than thumb, without mention of loss of finger</td>
</tr>
<tr>
<td>94442</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of thumb (nail), without mention of loss of thumb</td>
</tr>
<tr>
<td>94443</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand, not including thumb, without mention of loss of fingers</td>
</tr>
<tr>
<td>94444</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand including thumb, without mention of loss of fingers</td>
</tr>
<tr>
<td>94445</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of palm of hand, without mention of loss of palm</td>
</tr>
<tr>
<td>94446</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of back of hand, without mention of loss of back of hand</td>
</tr>
<tr>
<td>94447</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, without mention of loss of wrist</td>
</tr>
<tr>
<td>94448</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of wrist(s) and hand(s), without mention of loss of a body part</td>
</tr>
<tr>
<td>94450</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of hand, with loss of hand</td>
</tr>
<tr>
<td>94451</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of single digit (finger [nail]) other than thumb, with loss of finger</td>
</tr>
<tr>
<td>94452</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of thumb (nail), with loss of thumb</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>94453</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand, not including thumb, with loss of fingers</td>
</tr>
<tr>
<td>94454</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand including thumb, with loss of fingers</td>
</tr>
<tr>
<td>94455</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of palm of hand, with loss of palm of hand</td>
</tr>
<tr>
<td>94456</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of back of hand, with loss of back of hand</td>
</tr>
<tr>
<td>94457</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, with loss of wrist</td>
</tr>
<tr>
<td>94458</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of wrist(s) and hand(s), with loss of a body part</td>
</tr>
<tr>
<td>94500</td>
<td>Burn of unspecified degree of unspecified site of lower limb (leg)</td>
</tr>
<tr>
<td>94501</td>
<td>Burn of unspecified degree of toe(s) (nail)</td>
</tr>
<tr>
<td>94502</td>
<td>Burn of unspecified degree of foot</td>
</tr>
<tr>
<td>94503</td>
<td>Burn of unspecified degree of ankle</td>
</tr>
<tr>
<td>94504</td>
<td>Burn of unspecified degree of lower leg</td>
</tr>
<tr>
<td>94505</td>
<td>Burn of unspecified degree of knee</td>
</tr>
<tr>
<td>94506</td>
<td>Burn of unspecified degree of thigh (any part)</td>
</tr>
<tr>
<td>94509</td>
<td>Burn of unspecified degree of multiple sites of lower limb(s)</td>
</tr>
<tr>
<td>94510</td>
<td>Erythema due to burn (first degree) of unspecified site of lower limb (leg)</td>
</tr>
<tr>
<td>94511</td>
<td>Erythema due to burn (first degree) of toe(s) (nail)</td>
</tr>
<tr>
<td>94512</td>
<td>Erythema due to burn (first degree) of foot</td>
</tr>
<tr>
<td>94513</td>
<td>Erythema due to burn (first degree) of ankle</td>
</tr>
<tr>
<td>94514</td>
<td>Erythema due to burn (first degree) of lower leg</td>
</tr>
<tr>
<td>94515</td>
<td>Erythema due to burn (first degree) of knee</td>
</tr>
<tr>
<td>94516</td>
<td>Erythema due to burn (first degree) of thigh (any part)</td>
</tr>
<tr>
<td>94519</td>
<td>Erythema due to burn (first degree) of multiple sites of lower limb(s)</td>
</tr>
<tr>
<td>94520</td>
<td>Blisters, epidermal loss (second degree) of unspecified site of lower limb (leg)</td>
</tr>
<tr>
<td>94521</td>
<td>Blisters with epidermal loss due to burn (second degree) of toe(s) (nail)</td>
</tr>
<tr>
<td>94522</td>
<td>Blisters with epidermal loss due to burn (second degree) of foot</td>
</tr>
<tr>
<td>94523</td>
<td>Blisters with epidermal loss due to burn (second degree) of ankle</td>
</tr>
<tr>
<td>94524</td>
<td>Blisters with epidermal loss due to burn (second degree) of lower leg</td>
</tr>
<tr>
<td>94525</td>
<td>Blisters with epidermal loss due to burn (second degree) of knee</td>
</tr>
<tr>
<td>94526</td>
<td>Blisters with epidermal loss due to burn (second degree) of thigh (any part)</td>
</tr>
<tr>
<td>94529</td>
<td>Blisters with epidermal loss due to burn (second degree) of multiple sites of lower limb(s)</td>
</tr>
<tr>
<td>94530</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of unspecified site of lower limb</td>
</tr>
<tr>
<td>94531</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of toe(s) (nail)</td>
</tr>
<tr>
<td>94532</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of foot</td>
</tr>
<tr>
<td>94533</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of ankle</td>
</tr>
<tr>
<td>94534</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of lower leg</td>
</tr>
<tr>
<td>94535</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of knee</td>
</tr>
<tr>
<td>94536</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of thigh (any part)</td>
</tr>
<tr>
<td>94539</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of multiple sites of lower limb(s)</td>
</tr>
<tr>
<td>94540</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of lower limb (leg), without mention of loss of a body part</td>
</tr>
<tr>
<td>94541</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of toe(s) (nail), without mention of loss of toe(s)</td>
</tr>
<tr>
<td>94542</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of foot, without mention of loss of foot</td>
</tr>
<tr>
<td>94543</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of ankle, without mention of loss of ankle</td>
</tr>
<tr>
<td>94544</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, without mention of loss of lower leg</td>
</tr>
<tr>
<td>94545</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of knee, without mention of loss of knee</td>
</tr>
<tr>
<td>94546</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), without mention of loss of thigh</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>94549</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of lower limb(s), without mention of loss of a body part</td>
</tr>
<tr>
<td>94550</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site lower limb (leg), with loss of a body part</td>
</tr>
<tr>
<td>94551</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of toe(s) (nail), with loss of toe(s)</td>
</tr>
<tr>
<td>94552</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of foot, with loss of foot</td>
</tr>
<tr>
<td>94553</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of ankle, with loss of ankle</td>
</tr>
<tr>
<td>94554</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, with loss of lower leg</td>
</tr>
<tr>
<td>94555</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of knee, with loss of knee</td>
</tr>
<tr>
<td>94556</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), with loss of thigh</td>
</tr>
<tr>
<td>94559</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of lower limb(s), with loss of a body part</td>
</tr>
<tr>
<td>9460</td>
<td>Burns of multiple specified sites, unspecified degree</td>
</tr>
<tr>
<td>9461</td>
<td>Erythema due to burn (first degree) of multiple specified sites</td>
</tr>
<tr>
<td>9462</td>
<td>Blisters with epidermal loss due to burn (second degree) of multiple specified sites</td>
</tr>
<tr>
<td>9463</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of multiple specified sites</td>
</tr>
<tr>
<td>9464</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple specified sites, without mention of loss of a body part</td>
</tr>
<tr>
<td>9465</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple specified sites, with loss of a body part</td>
</tr>
<tr>
<td>9470</td>
<td>Burn of mouth and pharynx</td>
</tr>
<tr>
<td>9471</td>
<td>Burn of larynx, trachea, and lung</td>
</tr>
<tr>
<td>9472</td>
<td>Burn of esophagus</td>
</tr>
<tr>
<td>9473</td>
<td>Burn of gastrointestinal tract</td>
</tr>
<tr>
<td>9474</td>
<td>Burn of vagina and uterus</td>
</tr>
<tr>
<td>9478</td>
<td>Burn of other specified sites of internal organs</td>
</tr>
<tr>
<td>9479</td>
<td>Burn of internal organs, unspecified site</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>94800</td>
<td>Burn (any degree) involving less than 10 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94810</td>
<td>Burn (any degree) involving 10-19 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94811</td>
<td>Burn (any degree) involving 10-19 percent of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>94820</td>
<td>Burn (any degree) involving 20-29 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94821</td>
<td>Burn (any degree) involving 20-29 percent of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>94822</td>
<td>Burn (any degree) involving 20-29 percent of body surface with third degree burn of 20-29 percent</td>
</tr>
<tr>
<td>94830</td>
<td>Burn (any degree) involving 30-39 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94831</td>
<td>Burn (any degree) involving 30-39 percent of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>94832</td>
<td>Burn (any degree) involving 30-39 percent of body surface with third degree burn of 20-29 percent</td>
</tr>
<tr>
<td>94833</td>
<td>Burn (any degree) involving 30-39 percent of body surface with third degree burn of 30-39 percent</td>
</tr>
<tr>
<td>94840</td>
<td>Burn (any degree) involving 40-49 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94841</td>
<td>Burn (any degree) involving 40-49 percent of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>94842</td>
<td>Burn (any degree) involving 40-49 percent of body surface with third degree burn of 20-29 percent</td>
</tr>
<tr>
<td>94843</td>
<td>Burn (any degree) involving 40-49 percent of body surface with third degree burn of 30-39 percent</td>
</tr>
<tr>
<td>94844</td>
<td>Burn (any degree) involving 40-49 percent of body surface with third degree burn of 40-49 percent</td>
</tr>
<tr>
<td>94850</td>
<td>Burn (any degree) involving 50-59 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94851</td>
<td>Burn (any degree) involving 50-59 percent of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>94852</td>
<td>Burn (any degree) involving 50-59 percent of body surface with third degree burn of 20-29 percent</td>
</tr>
<tr>
<td>94853</td>
<td>Burn (any degree) involving 50-59 percent of body surface with third degree burn of 30-39 percent</td>
</tr>
<tr>
<td>94854</td>
<td>Burn (any degree) involving 50-59 percent of body surface with third degree burn of 40-49 percent</td>
</tr>
<tr>
<td>94855</td>
<td>Burn (any degree) involving 50-59 percent of body surface with third degree burn of 50-59 percent</td>
</tr>
<tr>
<td>94860</td>
<td>Burn (any degree) involving 60-69 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94861</td>
<td>Burn (any degree) involving 60-69 percent of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>94862</td>
<td>Burn (any degree) involving 60-69 percent of body surface with third degree burn of 20-29 percent</td>
</tr>
<tr>
<td>94863</td>
<td>Burn (any degree) involving 60-69 percent of body surface with third degree burn of 30-39 percent</td>
</tr>
<tr>
<td>94864</td>
<td>Burn (any degree) involving 60-69 percent of body surface with third degree burn of 40-49 percent</td>
</tr>
<tr>
<td>94865</td>
<td>Burn (any degree) involving 60-69 percent of body surface with third degree burn of 50-59 percent</td>
</tr>
<tr>
<td>94866</td>
<td>Burn (any degree) involving 60-69 percent of body surface with third degree burn of 60-69 percent</td>
</tr>
<tr>
<td>94870</td>
<td>Burn (any degree) involving 70-79 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94871</td>
<td>Burn (any degree) involving 70-79 percent of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>94872</td>
<td>Burn (any degree) involving 70-79 percent of body surface with third degree burn of 20-29 percent</td>
</tr>
<tr>
<td>94873</td>
<td>Burn (any degree) involving 70-79 percent of body surface with third degree burn of 30-39 percent</td>
</tr>
<tr>
<td>94874</td>
<td>Burn (any degree) involving 70-79 percent of body surface with third degree burn of 40-49 percent</td>
</tr>
<tr>
<td>94875</td>
<td>Burn (any degree) involving 70-79 percent of body surface with third degree burn of 50-59 percent</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>94876</td>
<td>Burn (any degree) involving 70-79 percent of body surface with third degree burn of 60-69 percent</td>
</tr>
<tr>
<td>94877</td>
<td>Burn (any degree) involving 70-79 percent of body surface with third degree burn of 70-79 percent</td>
</tr>
<tr>
<td>94880</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94881</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>94882</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of 20-29 percent</td>
</tr>
<tr>
<td>94883</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of 30-39 percent</td>
</tr>
<tr>
<td>94884</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of 40-49 percent</td>
</tr>
<tr>
<td>94885</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of 50-59 percent</td>
</tr>
<tr>
<td>94886</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of 60-69 percent</td>
</tr>
<tr>
<td>94887</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of 70-79 percent</td>
</tr>
<tr>
<td>94888</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of 80-89 percent</td>
</tr>
<tr>
<td>94890</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94891</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>94892</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 20-29 percent</td>
</tr>
<tr>
<td>94893</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 30-39 percent</td>
</tr>
<tr>
<td>94894</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 40-49 percent</td>
</tr>
<tr>
<td>94895</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 50-59 percent</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>94896</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 60-69 percent</td>
</tr>
<tr>
<td>94897</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 70-79 percent</td>
</tr>
<tr>
<td>94898</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 80-89 percent</td>
</tr>
<tr>
<td>94899</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 90 percent or more of body surface</td>
</tr>
<tr>
<td>9490</td>
<td>Burn of unspecified site, unspecified degree</td>
</tr>
<tr>
<td>9491</td>
<td>Erythema due to burn (first degree), unspecified site</td>
</tr>
<tr>
<td>9492</td>
<td>Blisters with epidermal loss due to burn (second degree), unspecified site</td>
</tr>
<tr>
<td>9493</td>
<td>Full-thickness skin loss due to burn (third degree NOS), unspecified site</td>
</tr>
<tr>
<td>9494</td>
<td>Deep necrosis of underlying tissue due to burn (deep third degree), unspecified site without mention of loss of a body part</td>
</tr>
<tr>
<td>9495</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree, unspecified site with loss of a body part</td>
</tr>
<tr>
<td>9500</td>
<td>Optic nerve injury</td>
</tr>
<tr>
<td>9501</td>
<td>Injury to optic chiasm</td>
</tr>
<tr>
<td>9502</td>
<td>Injury to optic pathways</td>
</tr>
<tr>
<td>9503</td>
<td>Injury to visual cortex</td>
</tr>
<tr>
<td>9509</td>
<td>Injury to unspecified optic nerve and pathways</td>
</tr>
<tr>
<td>9510</td>
<td>Injury to oculomotor nerve</td>
</tr>
<tr>
<td>9511</td>
<td>Injury to trochlear nerve</td>
</tr>
<tr>
<td>9512</td>
<td>Injury to trigeminal nerve</td>
</tr>
<tr>
<td>9513</td>
<td>Injury to abducens nerve</td>
</tr>
<tr>
<td>9514</td>
<td>Injury to facial nerve</td>
</tr>
<tr>
<td>9515</td>
<td>Injury to acoustic nerve</td>
</tr>
<tr>
<td>9516</td>
<td>Injury to accessory nerve</td>
</tr>
<tr>
<td>9517</td>
<td>Injury to hypoglossal nerve</td>
</tr>
<tr>
<td>9518</td>
<td>Injury to other specified cranial nerves</td>
</tr>
<tr>
<td>9519</td>
<td>Injury to unspecified cranial nerve</td>
</tr>
<tr>
<td>95200</td>
<td>C1-C4 level spinal cord injury, unspecified</td>
</tr>
<tr>
<td>95201</td>
<td>C1-C4 level with complete lesion of spinal cord</td>
</tr>
<tr>
<td>95202</td>
<td>C1-C4 level with anterior cord syndrome</td>
</tr>
<tr>
<td>95203</td>
<td>C1-C4 level with central cord syndrome</td>
</tr>
<tr>
<td>95204</td>
<td>C1-C4 level with other specified spinal cord injury</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>95205</td>
<td>C5-C7 level spinal cord injury, unspecified</td>
</tr>
<tr>
<td>95206</td>
<td>C5-C7 level with complete lesion of spinal cord</td>
</tr>
<tr>
<td>95207</td>
<td>C5-C7 level with anterior cord syndrome</td>
</tr>
<tr>
<td>95208</td>
<td>C5-C7 level with central cord syndrome</td>
</tr>
<tr>
<td>95209</td>
<td>C5-C7 level with other specified spinal cord injury</td>
</tr>
<tr>
<td>95210</td>
<td>T1-T6 level spinal cord injury, unspecified</td>
</tr>
<tr>
<td>95211</td>
<td>T1-T6 level with complete lesion of spinal cord</td>
</tr>
<tr>
<td>95212</td>
<td>T1-T6 level with anterior cord syndrome</td>
</tr>
<tr>
<td>95213</td>
<td>T1-T6 level with central cord syndrome</td>
</tr>
<tr>
<td>95214</td>
<td>T1-T6 level with other specified spinal cord injury</td>
</tr>
<tr>
<td>95215</td>
<td>T7-T12 level spinal cord injury, unspecified</td>
</tr>
<tr>
<td>95216</td>
<td>T7-T12 level with complete lesion of spinal cord</td>
</tr>
<tr>
<td>95217</td>
<td>T7-T12 level with anterior cord syndrome</td>
</tr>
<tr>
<td>95218</td>
<td>T7-T12 level with central cord syndrome</td>
</tr>
<tr>
<td>95219</td>
<td>T7-T12 level with other specified spinal cord injury</td>
</tr>
<tr>
<td>9522</td>
<td>Lumbar spinal cord injury without spinal bone injury</td>
</tr>
<tr>
<td>9523</td>
<td>Sacral spinal cord injury without spinal bone injury</td>
</tr>
<tr>
<td>9524</td>
<td>Cauda equina spinal cord injury without spinal bone injury</td>
</tr>
<tr>
<td>9528</td>
<td>Multiple sites of spinal cord injury without spinal bone injury</td>
</tr>
<tr>
<td>9529</td>
<td>Unspecified site of spinal cord injury without spinal bone injury</td>
</tr>
<tr>
<td>9530</td>
<td>Injury to cervical nerve root</td>
</tr>
<tr>
<td>9531</td>
<td>Injury to dorsal nerve root</td>
</tr>
<tr>
<td>9532</td>
<td>Injury to lumbar nerve root</td>
</tr>
<tr>
<td>9533</td>
<td>Injury to sacral nerve root</td>
</tr>
<tr>
<td>9534</td>
<td>Injury to brachial plexus</td>
</tr>
<tr>
<td>9535</td>
<td>Injury to lumbosacral plexus</td>
</tr>
<tr>
<td>9538</td>
<td>Injury to multiple sites of nerve roots and spinal plexus</td>
</tr>
<tr>
<td>9539</td>
<td>Injury to unspecified site of nerve roots and spinal plexus</td>
</tr>
<tr>
<td>9540</td>
<td>Injury to cervical sympathetic nerve, excluding shoulder and pelvic girdles</td>
</tr>
<tr>
<td>9541</td>
<td>Injury to other sympathetic nerve, excluding shoulder and pelvic girdles</td>
</tr>
<tr>
<td>9548</td>
<td>Injury to other specified nerve(s) of trunk, excluding shoulder and pelvic girdles</td>
</tr>
</tbody>
</table>
The following diagnosis codes are payable for Tetanus, injections, acute care:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>9549</td>
<td>Injury to unspecified nerve of trunk, excluding shoulder and pelvic girdles</td>
</tr>
<tr>
<td>9550</td>
<td>Injury to axillary nerve</td>
</tr>
<tr>
<td>9551</td>
<td>Injury to median nerve</td>
</tr>
<tr>
<td>9552</td>
<td>Injury to ulnar nerve</td>
</tr>
<tr>
<td>9553</td>
<td>Injury to radial nerve</td>
</tr>
<tr>
<td>9554</td>
<td>Injury to musculocutaneous nerve</td>
</tr>
<tr>
<td>9555</td>
<td>Injury to cutaneous sensory nerve, upper limb</td>
</tr>
<tr>
<td>9556</td>
<td>Injury to digital nerve, upper limb</td>
</tr>
<tr>
<td>9557</td>
<td>Injury to other specified nerve(s) of shoulder girdle and upper limb</td>
</tr>
<tr>
<td>9558</td>
<td>Injury to multiple nerves of shoulder girdle and upper limb</td>
</tr>
<tr>
<td>9559</td>
<td>Injury to unspecified nerve of shoulder girdle and upper limb</td>
</tr>
<tr>
<td>9560</td>
<td>Injury to sciatic nerve</td>
</tr>
<tr>
<td>9561</td>
<td>Injury to femoral nerve</td>
</tr>
<tr>
<td>9562</td>
<td>Injury to posterior tibial nerve</td>
</tr>
<tr>
<td>9563</td>
<td>Injury to peroneal nerve</td>
</tr>
<tr>
<td>9564</td>
<td>Injury to cutaneous sensory nerve, lower limb</td>
</tr>
<tr>
<td>9565</td>
<td>Injury to other specified nerve(s) of pelvic girdle and lower limb</td>
</tr>
<tr>
<td>9568</td>
<td>Injury to multiple nerves of pelvic girdle and lower limb</td>
</tr>
<tr>
<td>9569</td>
<td>Injury to unspecified nerve of pelvic girdle and lower limb</td>
</tr>
<tr>
<td>9570</td>
<td>Injury to superficial nerves of head and neck</td>
</tr>
<tr>
<td>9571</td>
<td>Injury to other specified nerve(s)</td>
</tr>
<tr>
<td>9578</td>
<td>Injury to multiple nerves in several parts</td>
</tr>
<tr>
<td>9579</td>
<td>Injury to nerves, unspecified site</td>
</tr>
<tr>
<td>9580</td>
<td>Air embolism as an early complication of trauma</td>
</tr>
<tr>
<td>9581</td>
<td>Fat embolism as an early complication of trauma</td>
</tr>
<tr>
<td>9582</td>
<td>Secondary and recurrent hemorrhage as an early complication of trauma</td>
</tr>
<tr>
<td>9583</td>
<td>Posttraumatic wound infection not elsewhere classified</td>
</tr>
<tr>
<td>9584</td>
<td>Traumatic shock</td>
</tr>
<tr>
<td>9585</td>
<td>Traumatic anuria</td>
</tr>
<tr>
<td>9586</td>
<td>Volkmann’s ischemic contracture</td>
</tr>
<tr>
<td>9587</td>
<td>Traumatic subcutaneous emphysema</td>
</tr>
<tr>
<td>9588</td>
<td>Other early complications of trauma</td>
</tr>
<tr>
<td>95901</td>
<td>Other and unspecified injury to head</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>95909</td>
<td>Other and unspecified injury to face and neck</td>
</tr>
<tr>
<td>95911</td>
<td>Other injury of chest wall</td>
</tr>
<tr>
<td>95912</td>
<td>Other injury of abdomen</td>
</tr>
<tr>
<td>95913</td>
<td>Fracture of corpus cavernosum penis</td>
</tr>
<tr>
<td>95914</td>
<td>Other injury of external genitals</td>
</tr>
<tr>
<td>95919</td>
<td>Other injury of other sites of trunk</td>
</tr>
<tr>
<td>9592</td>
<td>Other and unspecified injury to shoulder and upper arm</td>
</tr>
<tr>
<td>9593</td>
<td>Other and unspecified injury to elbow, forearm, and wrist</td>
</tr>
<tr>
<td>9594</td>
<td>Other and unspecified injury to hand, except finger</td>
</tr>
<tr>
<td>9595</td>
<td>Other and unspecified injury to finger</td>
</tr>
<tr>
<td>9596</td>
<td>Other and unspecified injury to hip and thigh</td>
</tr>
<tr>
<td>9597</td>
<td>Other and unspecified injury to knee, leg, ankle, and foot</td>
</tr>
<tr>
<td>9598</td>
<td>Other and unspecified injury to other specified sites, including multiple</td>
</tr>
<tr>
<td>9599</td>
<td>Other and unspecified injury to unspecified site</td>
</tr>
</tbody>
</table>

25.3.3.10 Deep Brain Stimulators

Implantation of neurostimulator electrodes for the treatment of intractable tremors, diagnosis code 3320, idiopathic Parkinson’s Disease, and diagnosis code 3331, Essential tremor, are payable benefits. One of these diagnoses must appear on the claim for reimbursement to be considered. The actual deep brain stimulator device is payable only under the DRG or ASC/HASC reimbursement rate. No separate payment outside of the DRG or ASC/HASC reimbursement rate will be made for the device.

When billing for procedures related to the implantation of a deep brain stimulator, use the following codes. The types of service for which these codes are payable are listed with each code. TOS F should be used by the ASC/HASC.

Professional services for these codes are:
- Payable in the inpatient and outpatient settings
- Subject to the global surgical fee policy, with three weeks precare and six weeks postcare days assigned
Subject to multiple surgery guidelines

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Types of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>F-61880</td>
<td>2, 8</td>
</tr>
<tr>
<td>F-61885</td>
<td>2</td>
</tr>
<tr>
<td>F-61888</td>
<td>2, 8</td>
</tr>
</tbody>
</table>

The following procedure codes are payable without prior authorization for the electronic analysis of the implanted neurostimulator pulse generator:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-95970</td>
</tr>
<tr>
<td>5-95974</td>
</tr>
<tr>
<td>5-95975</td>
</tr>
<tr>
<td>5-95978</td>
</tr>
<tr>
<td>5-95979</td>
</tr>
</tbody>
</table>

**25.3.3.11 Hospital Laboratory Services**

The American Medical Association (AMA) has discontinued the following general multichannel automated panel codes:

<table>
<thead>
<tr>
<th>Discontinued Panel Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-80002</td>
</tr>
<tr>
<td>5-80006</td>
</tr>
<tr>
<td>5-80010</td>
</tr>
<tr>
<td>5-80014</td>
</tr>
<tr>
<td>5-80018</td>
</tr>
<tr>
<td>5-G0060</td>
</tr>
</tbody>
</table>

These panel codes are being discontinued because the panel does not define exactly what tests are performed. The new organ and disease panel codes 5-80048, 5-80051, 5-80053, 5-80069, and 5-80076 must be used instead of the general multichannel automated panel codes in the table above.

The CPT codes in the table above should not be used as billing codes, but the payment amounts associated with pricing of these automated profiles will continue.

For example, if two automated profile tests are performed, the individual codes for the two automated tests must be billed instead of code 5-80002. For pricing, count the number of automated profile tests billed, and payment will be at the same rate as the former code 5-80002. CMS continues to provide updated pricing for the deleted profiles of automated tests.

The new organ or disease panels include the following codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
<th>Types of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>5-800048 - Basic metabolic panel includes:</td>
<td>5-82310 5-82345 5-82565 5-82568 5-84295 5-84450</td>
</tr>
<tr>
<td>5-80050 - General health panel includes:</td>
<td>5-80053 5-85027 or 5-85025 5-84443</td>
</tr>
<tr>
<td>5-80051 - Electrolyte panel includes:</td>
<td>5-82374 5-82435 5-84132 5-84295</td>
</tr>
</tbody>
</table>

Outpatient and inpatient claims for laboratory services must reflect only tests actually performed by the hospital laboratory.

**Exception:** Hospital laboratories may bill for all the tests performed on a specimen if some but not all the tests are done by another laboratory on referral from the hospital submitting the claim.

The billing hospital must enter the name and provider identifier of the performing laboratory in Block 84 of the HCFA-1450 (UB-92) claim form and must enter the performing laboratory’s nine-digit provider identifier next to the service provided by the performing laboratory.

Hospitals may bill a handling fee procedure code (1-99001) for collecting and forwarding a specimen to a referral laboratory if the specimen is collected by venipuncture or catheterization. Only one handling fee may be charged per day, per client, unless specimens are sent to two or more different laboratories; this must be documented on the claim.

Laboratory tests generally performed as a panel (chemistries, CBC, urinalyses) must be billed with the appropriate HCPCS panel code. The policy applies to laboratory tests performed by a hospital laboratory.

**Modifier 91**

Modifier 91 should be used for repeat clinical diagnostic tests as follows:
• Modifier 91 must not be used when billing the initial procedure. It must be used to indicate the clinical diagnostic retest.
• If more than two services are billed on the same day by the same provider regardless of the use of modifier 91, the claim or detail is denied.
• If a clinical diagnostic retest is performed by the same provider on the same day and is billed without modifier 91, it is denied as a duplicate procedure.
• If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures/services must be documented on appeal.
• Modifier 91 is not required and must not be used when billing multiple quantities of a supply (for example, disposable diapers or sterile saline).

When appealing claims with modifier 91 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, or documentation of times for each repeated procedure.

Modifier 76
The use of modifier 76 is limited as follows:
• Modifier 76 must not be used when billing the initial procedure, it must be used to indicate the repeated procedure.
• If more than two services are billed on the same day by the same provider regardless of the use of modifier 76, the claim or detail is denied.
• If a repeated procedure performed by the same provider on the same day is billed without modifier 76, it is denied as a duplicate procedure.
• If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures/services must be documented on appeal.
• Modifier 76 is not required and must not be used when billing multiple quantities of a supply (for example, disposable diapers or sterile saline).

Certain procedure codes have been removed from modifier 76 auditing for dates of service on or after April 3, 1998. These procedure codes have been identified as routinely being performed at the same time, more than twice per day for each antigen (e.g., agglutinins, febrile, [e.g., brucella, francisella, murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus], each antigen). Providers may still appeal claims for that have been denied for documentation of time. Most procedure codes initially requiring modifier 76 will continue to be audited for the 76 modifier.

When appealing claims with modifier 76 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, or documentation of times for each repeated procedure.

Refer to: “Laboratory Paneling” on page 26-5 for more information about laboratory paneling procedures.

25.3.3.12 Helicobacter Pylori (H. Pylori)
The following procedure codes are covered services: 5-83013, 5-83014, 5-78338, and 5-87339. These codes are considered to be clinical lab services and must be billed using TOS 5. The interpretation/professional component TOS I is not separately reimbursed. Refer to: “Helicobacter Pylori (H. Pylori)” on page 36-58 for more information.

25.3.3.13 Colorectal Cancer Screening
The following procedure codes are covered services:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2/F-G0104</td>
</tr>
<tr>
<td>4/I/T-G0106</td>
</tr>
</tbody>
</table>

Procedure code 2-G0121 is limited to diagnosis code V7651, Special screening for malignant neoplasms-colon. Procedure codes G0104, G0105, G0106, and G0120 are no longer limited for diagnosis codes 5582, Toxic gastroenteritis), and 5583, Allergic gastroenteritis and colitis. Procedure codes G0104 and G0106 are a benefit when billed with diagnosis code V7651 (limited to once every 5 years). Procedure code 4/I/T-G0122 is not covered by Medicaid.

Refer to: “Cancer Screening, Colorectal” on page 36-28 for more information.

25.3.3.14 Pap Smears
Pap or estrogen smears are benefits of the Texas Medicaid Program. Pap smears completed for family planning purposes in the outpatient department should be billed using diagnosis code V2509. Encounter for other contraceptive management. If a specimen is sent to an outside laboratory for processing, the outside laboratory must bill for the test. The hospital is not reimbursed for a collection or handling fee.

Refer to: “Cytopathology Studies – Gynecological, Pap Smears” on page 36-35 for more information on Pap smears.

25.3.3.15 Nonstress Testing and Contraction Stress Test
The following diagnosis codes are payable for both nonstress and contraction stress testing:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>30393</td>
<td>Other and unspecified alcohol dependence, in remission</td>
</tr>
<tr>
<td>30403</td>
<td>Opioid type dependence, in remission</td>
</tr>
<tr>
<td>30420</td>
<td>Cocaine dependence, unspecified use</td>
</tr>
<tr>
<td>30421</td>
<td>Cocaine dependence, continuous use</td>
</tr>
<tr>
<td>30422</td>
<td>Cocaine dependence, episodic use</td>
</tr>
<tr>
<td>30423</td>
<td>Cocaine dependence, in remission</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------------------------</td>
</tr>
<tr>
<td>30430</td>
<td>Cannabis dependence, unspecified use</td>
</tr>
<tr>
<td>30431</td>
<td>Cannabis dependence, continuous use</td>
</tr>
<tr>
<td>30432</td>
<td>Cannabis dependence, episodic use</td>
</tr>
<tr>
<td>30433</td>
<td>Cannabis dependence, in remission</td>
</tr>
<tr>
<td>30440</td>
<td>Amphetamine and other psychostimulant dependence, unspecified use</td>
</tr>
<tr>
<td>30441</td>
<td>Amphetamine and other psychostimulant dependence, continuous use</td>
</tr>
<tr>
<td>30442</td>
<td>Amphetamine and other psychostimulant dependence, episodic use</td>
</tr>
<tr>
<td>30443</td>
<td>Amphetamine and other psychostimulant dependence, in remission</td>
</tr>
<tr>
<td>30450</td>
<td>Hallucinogen dependence, unspecified use</td>
</tr>
<tr>
<td>30451</td>
<td>Hallucinogen dependence, continuous use</td>
</tr>
<tr>
<td>30452</td>
<td>Hallucinogen dependence, episodic use</td>
</tr>
<tr>
<td>30453</td>
<td>Hallucinogen dependence, in remission</td>
</tr>
<tr>
<td>30460</td>
<td>Other specified drug dependence, unspecified use</td>
</tr>
<tr>
<td>30461</td>
<td>Other specified drug dependence, continuous use</td>
</tr>
<tr>
<td>30462</td>
<td>Other specified drug dependence, episodic use</td>
</tr>
<tr>
<td>30463</td>
<td>Other specified drug dependence, in remission</td>
</tr>
<tr>
<td>30470</td>
<td>Combinations of opioid type drug with any other drug dependence, unspecified use</td>
</tr>
<tr>
<td>30471</td>
<td>Combinations of opioid type drug with any other drug dependence, continuous use</td>
</tr>
<tr>
<td>30472</td>
<td>Combinations of opioid type drug with any other drug dependence, episodic use</td>
</tr>
<tr>
<td>30473</td>
<td>Combinations of opioid type drug with any other drug dependence, in remission</td>
</tr>
<tr>
<td>30480</td>
<td>Combinations of drug dependence excluding opioid type drug, unspecified use</td>
</tr>
<tr>
<td>30481</td>
<td>Combinations of drug dependence excluding opioid type drug, continuous use</td>
</tr>
<tr>
<td>30482</td>
<td>Combinations of drug dependence excluding opioid type drug, episodic use</td>
</tr>
<tr>
<td>30483</td>
<td>Combinations of drug dependence excluding opioid type drug, in remission</td>
</tr>
<tr>
<td>30490</td>
<td>Unspecified drug dependence, unspecified use</td>
</tr>
<tr>
<td>30491</td>
<td>Unspecified drug dependence, continuous use</td>
</tr>
<tr>
<td>30492</td>
<td>Unspecified drug dependence, episodic use</td>
</tr>
<tr>
<td>30493</td>
<td>Unspecified drug dependence, in remission</td>
</tr>
<tr>
<td>5851</td>
<td>Chronic kidney disease, stage I</td>
</tr>
<tr>
<td>5852</td>
<td>Chronic kidney disease, stage II (mild)</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>64251</td>
<td>Severe pre-eclampsia, with delivery</td>
</tr>
<tr>
<td>64252</td>
<td>Severe pre-eclampsia, with delivery, with mention of postpartum complication</td>
</tr>
<tr>
<td>64253</td>
<td>Severe pre-eclampsia, antepartum</td>
</tr>
<tr>
<td>64254</td>
<td>Severe pre-eclampsia, postpartum</td>
</tr>
<tr>
<td>64260</td>
<td>Eclampsia complicating pregnancy, childbirth or the puerperium, unspecified as to episode of care</td>
</tr>
<tr>
<td>64261</td>
<td>Eclampsia, with delivery</td>
</tr>
<tr>
<td>64262</td>
<td>Eclampsia, with delivery, with mention of postpartum complication</td>
</tr>
<tr>
<td>64263</td>
<td>Eclampsia, antepartum</td>
</tr>
<tr>
<td>64264</td>
<td>Eclampsia, postpartum</td>
</tr>
<tr>
<td>64270</td>
<td>Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care</td>
</tr>
<tr>
<td>64271</td>
<td>Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, with delivery</td>
</tr>
<tr>
<td>64272</td>
<td>Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, with delivery, with mention of postpartum complication</td>
</tr>
<tr>
<td>64273</td>
<td>Pre-eclampsia or eclampsia superimposed on pre-existing hypertension, antepartum</td>
</tr>
<tr>
<td>64400</td>
<td>Threatened premature labor, unspecified as to episode of care</td>
</tr>
<tr>
<td>64403</td>
<td>Threatened premature labor, antepartum</td>
</tr>
<tr>
<td>64410</td>
<td>Other threatened labor, unspecified as to episode of care</td>
</tr>
<tr>
<td>64413</td>
<td>Other threatened labor, antepartum</td>
</tr>
<tr>
<td>64510</td>
<td>Post term pregnancy, unspecified episode of care</td>
</tr>
<tr>
<td>64513</td>
<td>Post term pregnancy, antepartum condition or complication</td>
</tr>
<tr>
<td>64520</td>
<td>Prolonged pregnancy, unspecified episode of care</td>
</tr>
<tr>
<td>64523</td>
<td>Prolonged pregnancy, antepartum condition or complication</td>
</tr>
<tr>
<td>64700</td>
<td>Syphilis of mother, complicating pregnancy, childbirth or the puerperium, unspecified as to episode of care</td>
</tr>
<tr>
<td>64701</td>
<td>Syphilis of mother, complicating pregnancy, with delivery</td>
</tr>
<tr>
<td>64702</td>
<td>Syphilis of mother, complicating pregnancy, with delivery, with mention of postpartum complication</td>
</tr>
<tr>
<td>64703</td>
<td>Antepartum syphilis</td>
</tr>
<tr>
<td>64704</td>
<td>Postpartum syphilis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64710</td>
<td>Gonorrhea of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care</td>
</tr>
<tr>
<td>64711</td>
<td>Gonorrhea of mother, with delivery</td>
</tr>
<tr>
<td>64712</td>
<td>Gonorrhea of mother, with delivery, with mention of postpartum complication</td>
</tr>
<tr>
<td>64713</td>
<td>Antepartum gonorrhea</td>
</tr>
<tr>
<td>64714</td>
<td>Postpartum gonorrhea</td>
</tr>
<tr>
<td>64720</td>
<td>Other venereal diseases of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care</td>
</tr>
<tr>
<td>64721</td>
<td>Other venereal diseases of mother, with delivery</td>
</tr>
<tr>
<td>64722</td>
<td>Other venereal diseases of mother, with delivery, with mention of postpartum complication</td>
</tr>
<tr>
<td>64723</td>
<td>Other antepartum venereal diseases</td>
</tr>
<tr>
<td>64724</td>
<td>Other postpartum venereal diseases</td>
</tr>
<tr>
<td>64730</td>
<td>Tuberculosis of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care</td>
</tr>
<tr>
<td>64731</td>
<td>Tuberculosis of mother, with delivery</td>
</tr>
<tr>
<td>64732</td>
<td>Tuberculosis of mother, with delivery, with mention of postpartum complication</td>
</tr>
<tr>
<td>64733</td>
<td>Antepartum tuberculosis</td>
</tr>
<tr>
<td>64734</td>
<td>Postpartum tuberculosis</td>
</tr>
<tr>
<td>64740</td>
<td>Malaria of mother, complicating pregnancy, childbirth or the puerperium, unspecified as to episode of care</td>
</tr>
<tr>
<td>64741</td>
<td>Malaria of mother, with delivery</td>
</tr>
<tr>
<td>64742</td>
<td>Malaria of mother, with delivery, with mention of postpartum complication</td>
</tr>
<tr>
<td>64743</td>
<td>Antepartum malaria</td>
</tr>
<tr>
<td>64744</td>
<td>Postpartum malaria</td>
</tr>
<tr>
<td>64750</td>
<td>Rubella of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care</td>
</tr>
<tr>
<td>64751</td>
<td>Rubella of mother, with delivery</td>
</tr>
<tr>
<td>64752</td>
<td>Rubella of mother, with delivery, with mention of postpartum complication</td>
</tr>
<tr>
<td>64753</td>
<td>Antepartum rubella</td>
</tr>
<tr>
<td>64754</td>
<td>Postpartum rubella</td>
</tr>
<tr>
<td>64760</td>
<td>Other viral diseases of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care</td>
</tr>
<tr>
<td>64761</td>
<td>Other viral diseases of mother, with delivery</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>64762</td>
<td>Other viral diseases of mother, with delivery, with mention of postpartum complication</td>
</tr>
<tr>
<td>64763</td>
<td>Other antepartum viral diseases</td>
</tr>
<tr>
<td>64764</td>
<td>Other postpartum viral diseases</td>
</tr>
<tr>
<td>64780</td>
<td>Other specified infectious and parasitic diseases of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care</td>
</tr>
<tr>
<td>64781</td>
<td>Other specified infectious and parasitic diseases of mother, with delivery</td>
</tr>
<tr>
<td>64782</td>
<td>Other specified infectious and parasitic diseases of mother, with delivery, with mention of postpartum complication</td>
</tr>
<tr>
<td>64783</td>
<td>Other specified infectious and parasitic diseases of mother, antepartum</td>
</tr>
<tr>
<td>64800</td>
<td>Diabetes mellitus of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care</td>
</tr>
<tr>
<td>64801</td>
<td>Diabetes mellitus of mother, with delivery</td>
</tr>
<tr>
<td>64802</td>
<td>Diabetes mellitus of mother, with delivery, with mention of postpartum complication</td>
</tr>
<tr>
<td>64803</td>
<td>Antepartum diabetes mellitus</td>
</tr>
<tr>
<td>65130</td>
<td>Twin pregnancy with fetal loss and retention of one fetus, unspecified as to episode of care or not applicable</td>
</tr>
<tr>
<td>65131</td>
<td>Twin pregnancy with fetal loss and retention of one fetus, delivered, with or without mention of antepartum condition</td>
</tr>
<tr>
<td>65133</td>
<td>Twin pregnancy with fetal loss and retention of one fetus, antepartum condition or complication</td>
</tr>
<tr>
<td>65140</td>
<td>Triplet pregnancy with fetal loss and retention of one or more fetus(es), unspecified as to episode of care or not applicable</td>
</tr>
<tr>
<td>65141</td>
<td>Triplet pregnancy with fetal loss and retention of one or more fetus(es), delivered, with or without mention of antepartum condition</td>
</tr>
<tr>
<td>65143</td>
<td>Triplet pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication</td>
</tr>
<tr>
<td>65150</td>
<td>Quadruplet pregnancy with fetal loss and retention of one or more fetus(es), unspecified as to episode of care or not applicable</td>
</tr>
<tr>
<td>65151</td>
<td>Quadruplet pregnancy with fetal loss and retention of one or more fetus(es), delivered, with or without mention of antepartum condition</td>
</tr>
<tr>
<td>65153</td>
<td>Quadruplet pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication</td>
</tr>
<tr>
<td>65160</td>
<td>Other multiple pregnancy with fetal loss and retention of one or more fetus(es), unspecified as to episode of care</td>
</tr>
<tr>
<td>65161</td>
<td>Other multiple pregnancy with fetal loss and retention of one or more fetus(es), delivered, with or without mention of antepartum condition</td>
</tr>
<tr>
<td>65163</td>
<td>Other multiple pregnancy with fetal loss and retention of one or more fetus(es), antepartum condition or complication</td>
</tr>
<tr>
<td>65633</td>
<td>Fetal distress, affecting management of mother, antepartum</td>
</tr>
<tr>
<td>65650</td>
<td>Poor fetal growth, affecting management of mother, unspecified as to episode of care</td>
</tr>
<tr>
<td>65651</td>
<td>Poor fetal growth, affecting management of mother, delivered</td>
</tr>
<tr>
<td>65653</td>
<td>Poor fetal growth, affecting management of mother, antepartum condition or complication</td>
</tr>
<tr>
<td>65660</td>
<td>Excessive fetal growth, affecting management of mother, unspecified as to episode of care</td>
</tr>
<tr>
<td>65661</td>
<td>Excessive fetal growth, affecting management of mother, delivered</td>
</tr>
<tr>
<td>65663</td>
<td>Excessive fetal growth, affecting management of mother, antepartum</td>
</tr>
<tr>
<td>65840</td>
<td>Infection of amniotic cavity, unspecified as to episode of care</td>
</tr>
<tr>
<td>65841</td>
<td>Infection of amniotic cavity, delivered</td>
</tr>
<tr>
<td>65843</td>
<td>Infection of amniotic cavity, antepartum</td>
</tr>
<tr>
<td>V231</td>
<td>Supervision of high-risk pregnancy with history of trophoblastic disease</td>
</tr>
<tr>
<td>V232</td>
<td>Supervision of high-risk pregnancy with history of abortion</td>
</tr>
<tr>
<td>V233</td>
<td>Supervision of high-risk pregnancy with grand multiparity</td>
</tr>
<tr>
<td>V235</td>
<td>Supervision of high-risk pregnancy with other poor reproductive history</td>
</tr>
<tr>
<td>V237</td>
<td>Supervision of high-risk pregnancy with insufficient prenatal care</td>
</tr>
<tr>
<td>V2381</td>
<td>Supervision of high-risk pregnancy with elderly primigravida</td>
</tr>
<tr>
<td>V2382</td>
<td>Supervision of high-risk pregnancy with elderly multigravida</td>
</tr>
<tr>
<td>V2383</td>
<td>Supervision of high-risk pregnancy with young primigravida</td>
</tr>
<tr>
<td>V2384</td>
<td>Supervision of high-risk pregnancy with young multigravida</td>
</tr>
<tr>
<td>V2389</td>
<td>Supervision of other high-risk pregnancy</td>
</tr>
<tr>
<td>V239</td>
<td>Supervision of unspecified high-risk pregnancy</td>
</tr>
</tbody>
</table>
Nonstress testing is a form of fetal monitoring in which transducers are applied to the mother’s abdomen to monitor fetal heart rate. Tracings of this activity may be obtained from the fetoscope.

Nonstress testing conducted in the outpatient setting should be billed with revenue code B-729.

This revenue code is denied if it is billed more than once per day with the same provider. The provider must appeal with documentation supporting the performance of the test more than once on the same day/same provider.

Revenue code B-729 is payable for outpatient (POS 5) hospital settings and to hospital-based rural health clinics only. The inpatient hospital stay is payable under the hospital’s reimbursement methodology.

The following diagnosis codes are payable only for nonstress testing (B-729):

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64110</td>
<td>Hemorrhage from placenta previa, unspecified as to episode of care</td>
</tr>
<tr>
<td>64111</td>
<td>Hemorrhage from placenta previa, with delivery</td>
</tr>
<tr>
<td>64113</td>
<td>Hemorrhage from placenta previa, antepartum</td>
</tr>
<tr>
<td>64120</td>
<td>Premature separation of placenta, unspecified as to episode of care</td>
</tr>
<tr>
<td>64121</td>
<td>Premature separation of placenta, with delivery</td>
</tr>
<tr>
<td>64123</td>
<td>Premature separation of placenta, antepartum</td>
</tr>
<tr>
<td>64130</td>
<td>Antepartum hemorrhage associated with coagulation defects, unspecified as to episode of care</td>
</tr>
<tr>
<td>64131</td>
<td>Antepartum hemorrhage associated with coagulation defects, with delivery</td>
</tr>
<tr>
<td>64133</td>
<td>Antepartum hemorrhage associated with coagulation defects</td>
</tr>
<tr>
<td>64180</td>
<td>Other antepartum hemorrhage, unspecified as to episode of care</td>
</tr>
<tr>
<td>64181</td>
<td>Other antepartum hemorrhage, with delivery</td>
</tr>
<tr>
<td>64183</td>
<td>Other antepartum hemorrhage</td>
</tr>
<tr>
<td>64190</td>
<td>Unspecified antepartum hemorrhage, unspecified as to episode of care</td>
</tr>
<tr>
<td>64191</td>
<td>Unspecified antepartum hemorrhage, with delivery</td>
</tr>
<tr>
<td>64193</td>
<td>Unspecified antepartum hemorrhage</td>
</tr>
<tr>
<td>65420</td>
<td>Previous cesarean delivery, unspecified as to episode of care in pregnancy</td>
</tr>
<tr>
<td>65421</td>
<td>Previous cesarean delivery, with or without mention of antepartum condition</td>
</tr>
<tr>
<td>65423</td>
<td>Previous cesarean delivery, antepartum condition or complication</td>
</tr>
</tbody>
</table>

Revenue code B-729, Fetal monitoring (external) –labor room/delivery–other and fetal stress testing, is payable for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>V2381</td>
</tr>
<tr>
<td>V2382</td>
</tr>
<tr>
<td>V2383</td>
</tr>
<tr>
<td>V2384</td>
</tr>
<tr>
<td>V2389</td>
</tr>
<tr>
<td>V239</td>
</tr>
</tbody>
</table>

The contraction stress test is performed to assess the condition of the fetus in utero. This test is done by monitoring the fetus’ response to the stress of uterine contractions. Baseline recordings of the fetal heart rate are made by an electronic devise such as a Doppler. IV oxytocin is administered to produce uterine contractions. Fetal heart rate is measured during the contractions. Sustained alterations of the heart rate beyond the contractions may indicate fetal distress and the need for further intervention.

Contraction stress testing conducted in the outpatient setting should be billed with revenue code B-729, Fetal stress testing.

Revenue code B-729 (facility services) is reimbursed on the same day/different provider, without appeal. This procedure code is denied if it is billed more than once per day with the same provider. The provider must appeal with documentation supporting the performance of the test more than once on the same day/same provider.

Revenue code B-729 (facility services) is payable for outpatient hospital stays and to hospital-based rural health clinics only. The inpatient hospital stay is reimbursed under the hospital’s DRG.

The following diagnosis codes are payable only for contraction stress testing (B-729):

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2825</td>
<td>Sickle-cell trait</td>
</tr>
<tr>
<td>28263</td>
<td>Sickle-cell/HB-C disease without crisis</td>
</tr>
<tr>
<td>65613</td>
<td>Rhesus isoimmunization, affecting management of mother, antepartum condition</td>
</tr>
<tr>
<td>65623</td>
<td>Isoimmunization from other and unspecified blood-group incompatibility, affecting management of mother, antepartum</td>
</tr>
<tr>
<td>65803</td>
<td>Oligohydramnios, antepartum</td>
</tr>
</tbody>
</table>

Refer to: “Nonstress Testing, Contraction Stress Testing” on page 36-197 for related physician services.
# 25.3.3.16 Hospital Radiology Services

CPT codes T-93005 and T-93041 are payable for diagnosis codes 3373, 78071, and 78079.

Effective for dates of service on or after April 1, 2004, the following diagnosis codes will be payable for electrocardiograms:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>03282</td>
<td>Diphtheritic myocarditis</td>
</tr>
<tr>
<td>0362</td>
<td>Meningococemia</td>
</tr>
<tr>
<td>03640</td>
<td>Meningococcal carditis, unspecified</td>
</tr>
<tr>
<td>03641</td>
<td>Meningococcal pericarditis</td>
</tr>
<tr>
<td>03642</td>
<td>Meningococcal endocarditis</td>
</tr>
<tr>
<td>03643</td>
<td>Meningococcal myocarditis</td>
</tr>
<tr>
<td>07420</td>
<td>Coxsackie carditis, unspecified</td>
</tr>
<tr>
<td>07421</td>
<td>Coxsackie pericarditis</td>
</tr>
<tr>
<td>07422</td>
<td>Coxsackie endocarditis</td>
</tr>
<tr>
<td>07423</td>
<td>Coxsackie myocarditis</td>
</tr>
<tr>
<td>0860</td>
<td>Chagas’ disease with heart involvement</td>
</tr>
<tr>
<td>08881</td>
<td>Lyme disease</td>
</tr>
<tr>
<td>0930</td>
<td>Aneurysm of aorta, specified as syphilitic</td>
</tr>
<tr>
<td>0931</td>
<td>Syphilitic aortitis</td>
</tr>
<tr>
<td>09320</td>
<td>Syphilitic endocarditis of valve, unspecified</td>
</tr>
<tr>
<td>09321</td>
<td>Syphilitic endocarditis of mitral valve</td>
</tr>
<tr>
<td>09322</td>
<td>Syphilitic endocarditis of aortic valve</td>
</tr>
<tr>
<td>09323</td>
<td>Syphilitic endocarditis of tricuspid valve</td>
</tr>
<tr>
<td>09324</td>
<td>Syphilitic endocarditis of pulmonary valve</td>
</tr>
<tr>
<td>0938</td>
<td>Other specified cardiovascular syphilis</td>
</tr>
<tr>
<td>09381</td>
<td>Syphilitic pericarditis</td>
</tr>
<tr>
<td>09382</td>
<td>Syphilitic myocarditis</td>
</tr>
<tr>
<td>09389</td>
<td>Other specific cardiovascular syphilis</td>
</tr>
<tr>
<td>09883</td>
<td>Gonococcal pericarditis</td>
</tr>
<tr>
<td>09884</td>
<td>Gonococcal endocarditis</td>
</tr>
<tr>
<td>09885</td>
<td>Other gonococcal heart disease</td>
</tr>
<tr>
<td>11281</td>
<td>Candidal endocarditis</td>
</tr>
<tr>
<td>11503</td>
<td>Histoplasma capsulatum pericarditis</td>
</tr>
<tr>
<td>11504</td>
<td>Histoplasma capsulatum endocarditis</td>
</tr>
<tr>
<td>11513</td>
<td>Histoplasma duboisii pericarditis</td>
</tr>
<tr>
<td>11514</td>
<td>Histoplasma duboisii endocarditis</td>
</tr>
<tr>
<td>11593</td>
<td>Histoplasmosis pericarditis, unspecified</td>
</tr>
<tr>
<td>11594</td>
<td>Histoplasmosis endocarditis</td>
</tr>
<tr>
<td>124</td>
<td>Trichinosis</td>
</tr>
<tr>
<td>1303</td>
<td>Myocarditis due to toxoplasmosis</td>
</tr>
<tr>
<td>135</td>
<td>Sarcoidosis</td>
</tr>
<tr>
<td>1640</td>
<td>Malignant neoplasm of thymus</td>
</tr>
<tr>
<td>1641</td>
<td>Malignant neoplasm of heart</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>2504</td>
<td>Diabetes with renal manifestations</td>
</tr>
<tr>
<td>25040</td>
<td>Diabetes with renal manifestations, type II or unspecified type, not stated as uncontrolled</td>
</tr>
<tr>
<td>25041</td>
<td>Diabetes with renal manifestations, type I (juvenile type), not stated as uncontrolled</td>
</tr>
<tr>
<td>25042</td>
<td>Diabetes with renal manifestations, type II or unspecified type, uncontrolled</td>
</tr>
<tr>
<td>25043</td>
<td>Diabetes with renal manifestations, type I (juvenile type), uncontrolled</td>
</tr>
<tr>
<td>2505</td>
<td>Diabetes with ophthalmic manifestations</td>
</tr>
<tr>
<td>25050</td>
<td>Diabetes with ophthalmic manifestations, type II or unspecified type, not stated as uncontrolled</td>
</tr>
<tr>
<td>25051</td>
<td>Diabetes with ophthalmic manifestations, type I (juvenile type), not stated as uncontrolled</td>
</tr>
<tr>
<td>25052</td>
<td>Diabetes with ophthalmic manifestations, type II or unspecified type, uncontrolled</td>
</tr>
<tr>
<td>25053</td>
<td>Diabetes with ophthalmic manifestations, type I (juvenile type), uncontrolled</td>
</tr>
<tr>
<td>2506</td>
<td>Diabetes with neurological manifestations</td>
</tr>
<tr>
<td>25060</td>
<td>Diabetes with neurological manifestations, type II or unspecified type, not stated as uncontrolled</td>
</tr>
<tr>
<td>25061</td>
<td>Diabetes with neurological manifestations, type I (juvenile type), not stated as uncontrolled</td>
</tr>
<tr>
<td>25062</td>
<td>Diabetes with neurological manifestations, type II or unspecified type, uncontrolled</td>
</tr>
<tr>
<td>25063</td>
<td>Diabetes with neurological manifestations, type I (juvenile type), uncontrolled</td>
</tr>
<tr>
<td>2507</td>
<td>Diabetes with peripheral circulatory disorders</td>
</tr>
<tr>
<td>25070</td>
<td>Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled</td>
</tr>
<tr>
<td>25071</td>
<td>Diabetes with peripheral circulatory disorders, type I (juvenile type), not stated as uncontrolled</td>
</tr>
<tr>
<td>25072</td>
<td>Diabetes with peripheral circulatory disorders, type II or unspecified type, uncontrolled</td>
</tr>
<tr>
<td>25073</td>
<td>Diabetes with peripheral circulatory disorders, type I (juvenile type), uncontrolled</td>
</tr>
<tr>
<td>2508</td>
<td>Diabetes with other specified manifestations</td>
</tr>
<tr>
<td>25080</td>
<td>Diabetes with other specified manifestations, type II or unspecified type, not stated as uncontrolled</td>
</tr>
<tr>
<td>25081</td>
<td>Diabetes with other specified manifestations, type I (juvenile type), not stated as uncontrolled</td>
</tr>
<tr>
<td>25082</td>
<td>Diabetes with other specified manifestations, type II or unspecified type, uncontrolled</td>
</tr>
<tr>
<td>25083</td>
<td>Diabetes with other specified manifestations, type I (juvenile type), uncontrolled</td>
</tr>
<tr>
<td>2509</td>
<td>Diabetes with unspecified complication</td>
</tr>
<tr>
<td>25090</td>
<td>Diabetes with unspecified complication, type II or unspecified type, not stated as uncontrolled</td>
</tr>
<tr>
<td>25091</td>
<td>Diabetes with unspecified complication, type I (juvenile type), not stated as uncontrolled</td>
</tr>
<tr>
<td>25092</td>
<td>Diabetes with unspecified complication, type II or unspecified type, uncontrolled</td>
</tr>
<tr>
<td>25093</td>
<td>Diabetes with unspecified complication, type I (juvenile type), uncontrolled</td>
</tr>
<tr>
<td>2512</td>
<td>Hypoglycemia, unspecified</td>
</tr>
<tr>
<td>2720</td>
<td>Pure hypercholesterolemia</td>
</tr>
<tr>
<td>2721</td>
<td>Pure hyperglyceridemia</td>
</tr>
<tr>
<td>2722</td>
<td>Mixed hyperlipidemia</td>
</tr>
<tr>
<td>2723</td>
<td>Hyperchylomicronemia</td>
</tr>
<tr>
<td>2724</td>
<td>Other and unspecified hyperlipidemia</td>
</tr>
<tr>
<td>2725</td>
<td>Lipoprotein deficiencies</td>
</tr>
<tr>
<td>2726</td>
<td>Lipodystrophy</td>
</tr>
<tr>
<td>2727</td>
<td>Lipidoses</td>
</tr>
<tr>
<td>2728</td>
<td>Other disorders of lipid metabolism</td>
</tr>
<tr>
<td>2750</td>
<td>Disorders of iron metabolism</td>
</tr>
<tr>
<td>2752</td>
<td>Disorders of magnesium metabolism</td>
</tr>
<tr>
<td>2753</td>
<td>Disorders of phosphorus metabolism</td>
</tr>
<tr>
<td>27541</td>
<td>Hypocalcemia</td>
</tr>
<tr>
<td>27542</td>
<td>Hypercalcemia</td>
</tr>
<tr>
<td>2760</td>
<td>Hyperosmolality and/or hypernatremia</td>
</tr>
<tr>
<td>2761</td>
<td>Hyposmolality and/or hyponatremia</td>
</tr>
<tr>
<td>2762</td>
<td>Acidosis</td>
</tr>
<tr>
<td>2763</td>
<td>Alkalosis</td>
</tr>
<tr>
<td>2764</td>
<td>Mixed acid-base balance disorder</td>
</tr>
<tr>
<td>2765</td>
<td>Volume depletion disorder</td>
</tr>
<tr>
<td>27650</td>
<td>Volume depletion, unspecified</td>
</tr>
<tr>
<td>27651</td>
<td>Dehydration</td>
</tr>
<tr>
<td>27652</td>
<td>Hypovolemia</td>
</tr>
<tr>
<td>2766</td>
<td>Fluid overload disorder</td>
</tr>
<tr>
<td>2767</td>
<td>Hyperpotassemia</td>
</tr>
<tr>
<td>2768</td>
<td>Hypopotassemia</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>--------------------------------------------------</td>
</tr>
<tr>
<td>27730</td>
<td>Amyloidosis, unspecified</td>
</tr>
<tr>
<td>27739</td>
<td>Other amyloidosis</td>
</tr>
<tr>
<td>3062</td>
<td>Cardiovascular malfunction arising from mental factors</td>
</tr>
<tr>
<td>3373</td>
<td>Autonomic dysreflexia</td>
</tr>
<tr>
<td>390</td>
<td>Rheumatic fever without mention of heart involvement</td>
</tr>
<tr>
<td>391</td>
<td>Rheumatic fever with heart involvement</td>
</tr>
<tr>
<td>3910</td>
<td>Acute rheumatic pericarditis</td>
</tr>
<tr>
<td>3911</td>
<td>Acute rheumatic endocarditis</td>
</tr>
<tr>
<td>3912</td>
<td>Acute rheumatic myocarditis</td>
</tr>
<tr>
<td>3918</td>
<td>Other acute rheumatic heart disease</td>
</tr>
<tr>
<td>3919</td>
<td>Acute rheumatic heart disease, unspecified</td>
</tr>
<tr>
<td>392</td>
<td>Rheumatic chorea</td>
</tr>
<tr>
<td>3920</td>
<td>Rheumatic chorea with heart involvement</td>
</tr>
<tr>
<td>3929</td>
<td>Rheumatic chorea without mention of heart involvement</td>
</tr>
<tr>
<td>393</td>
<td>Chronic rheumatic pericarditis</td>
</tr>
<tr>
<td>394</td>
<td>Diseases of mitral valve</td>
</tr>
<tr>
<td>3940</td>
<td>Mitral stenosis</td>
</tr>
<tr>
<td>3941</td>
<td>Rheumatic mitral insufficiency</td>
</tr>
<tr>
<td>3942</td>
<td>Mitral stenosis with insufficiency</td>
</tr>
<tr>
<td>3949</td>
<td>Other and unspecified mitral valve diseases</td>
</tr>
<tr>
<td>395</td>
<td>Diseases of aortic valve</td>
</tr>
<tr>
<td>3950</td>
<td>Rheumatic aortic stenosis</td>
</tr>
<tr>
<td>3951</td>
<td>Rheumatic aortic insufficiency</td>
</tr>
<tr>
<td>3952</td>
<td>Rheumatic aortic stenosis with insufficiency</td>
</tr>
<tr>
<td>3959</td>
<td>Other and unspecified rheumatic aortic diseases</td>
</tr>
<tr>
<td>3960</td>
<td>Mitral valve stenosis and aortic valve stenosis</td>
</tr>
<tr>
<td>3961</td>
<td>Mitral valve stenosis and aortic valve insufficiency</td>
</tr>
<tr>
<td>3962</td>
<td>Mitral valve insufficiency and aortic valve stenosis</td>
</tr>
<tr>
<td>3963</td>
<td>Mitral valve insufficiency and aortic valve insufficiency</td>
</tr>
<tr>
<td>3968</td>
<td>Multiple involvement of mitral and aortic valves</td>
</tr>
<tr>
<td>3969</td>
<td>Mitral and aortic valve diseases, unspecified</td>
</tr>
<tr>
<td>397</td>
<td>Diseases of other endocardial structures</td>
</tr>
<tr>
<td>3970</td>
<td>Diseases of tricuspid valve</td>
</tr>
<tr>
<td>3971</td>
<td>Rheumatic diseases of pulmonary valve</td>
</tr>
<tr>
<td>3979</td>
<td>Rheumatic diseases of endocardium, valve unspecified</td>
</tr>
<tr>
<td>398</td>
<td>Other rheumatic heart disease</td>
</tr>
<tr>
<td>3980</td>
<td>Rheumatic myocarditis</td>
</tr>
<tr>
<td>3989</td>
<td>Other and unspecified rheumatic heart diseases</td>
</tr>
<tr>
<td>39890</td>
<td>Rheumatic heart disease, unspecified</td>
</tr>
<tr>
<td>39891</td>
<td>Rheumatic heart failure (congestive)</td>
</tr>
<tr>
<td>39899</td>
<td>Other rheumatic heart diseases</td>
</tr>
<tr>
<td>401</td>
<td>Essential hypertension</td>
</tr>
<tr>
<td>4010</td>
<td>Malignant essential hypertension</td>
</tr>
<tr>
<td>4011</td>
<td>Benign essential hypertension</td>
</tr>
<tr>
<td>4019</td>
<td>Unspecified essential hypertension</td>
</tr>
<tr>
<td>4020</td>
<td>Malignant hypertensive heart disease</td>
</tr>
<tr>
<td>40200</td>
<td>Malignant hypertensive heart disease without congestive heart failure</td>
</tr>
<tr>
<td>40201</td>
<td>Malignant hypertensive heart disease with congestive heart failure</td>
</tr>
<tr>
<td>4021</td>
<td>Benign hypertensive heart disease</td>
</tr>
<tr>
<td>40210</td>
<td>Benign hypertensive heart disease without congestive heart failure</td>
</tr>
<tr>
<td>40211</td>
<td>Benign hypertensive heart disease with congestive heart failure</td>
</tr>
<tr>
<td>4029</td>
<td>Unspecified hypertensive heart disease</td>
</tr>
<tr>
<td>40290</td>
<td>Unspecified hypertensive heart disease without congestive heart failure</td>
</tr>
<tr>
<td>40291</td>
<td>Unspecified hypertensive heart disease with congestive heart failure</td>
</tr>
<tr>
<td>40300</td>
<td>Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage I through stage IV, or unspecified</td>
</tr>
<tr>
<td>40301</td>
<td>Hypertensive chronic kidney disease, malignant, with chronic kidney disease stage V or end stage renal disease</td>
</tr>
<tr>
<td>40310</td>
<td>Hypertensive chronic kidney disease, benign, with chronic kidney disease stage I through stage IV, or unspecified</td>
</tr>
<tr>
<td>40311</td>
<td>Hypertensive chronic kidney disease, benign, with chronic kidney disease stage V or end stage renal disease</td>
</tr>
<tr>
<td>40390</td>
<td>Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage I through stage IV, or unspecified</td>
</tr>
<tr>
<td>40391</td>
<td>Hypertensive chronic kidney disease, unspecified, with chronic kidney disease stage V or end stage renal disease</td>
</tr>
<tr>
<td>40400</td>
<td>Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>40401</td>
<td>Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified</td>
</tr>
<tr>
<td>40402</td>
<td>Hypertensive heart and chronic kidney disease, malignant, without heart failure and with chronic kidney disease stage V or end stage renal disease</td>
</tr>
<tr>
<td>40403</td>
<td>Hypertensive heart and chronic kidney disease, malignant, with heart failure and with chronic kidney disease stage V or end stage renal disease</td>
</tr>
<tr>
<td>40410</td>
<td>Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified</td>
</tr>
<tr>
<td>40411</td>
<td>Hypertensive heart and chronic kidney disease, benign, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified</td>
</tr>
<tr>
<td>40412</td>
<td>Hypertensive heart and chronic kidney disease, benign, without heart failure and with chronic kidney disease stage V or end stage renal disease</td>
</tr>
<tr>
<td>40413</td>
<td>Hypertensive heart and chronic kidney disease, benign, with heart failure and chronic kidney disease stage V or end stage renal disease</td>
</tr>
<tr>
<td>40490</td>
<td>Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage I through stage IV, or unspecified</td>
</tr>
<tr>
<td>40491</td>
<td>Hypertensive heart and chronic kidney disease, unspecified, with heart failure and with chronic kidney disease stage I through stage IV, or unspecified</td>
</tr>
<tr>
<td>40492</td>
<td>Hypertensive heart and chronic kidney disease, unspecified, without heart failure and with chronic kidney disease stage V or end stage renal disease</td>
</tr>
<tr>
<td>40493</td>
<td>Hypertensive heart and chronic kidney disease, unspecified, with heart failure and chronic kidney disease stage V or end stage renal disease</td>
</tr>
<tr>
<td>40501</td>
<td>Malignant renovascular hypertension</td>
</tr>
<tr>
<td>40509</td>
<td>Other malignant secondary hypertension</td>
</tr>
<tr>
<td>40511</td>
<td>Benign renovascular hypertension</td>
</tr>
<tr>
<td>40519</td>
<td>Other benign secondary hypertension</td>
</tr>
<tr>
<td>41000</td>
<td>Acute myocardial infarction of anterolateral wall, episode of care unspecified</td>
</tr>
<tr>
<td>41001</td>
<td>Acute myocardial infarction of anterolateral wall, initial episode of care</td>
</tr>
<tr>
<td>41002</td>
<td>Acute myocardial infarction of anterolateral wall, subsequent episode of care</td>
</tr>
<tr>
<td>4101</td>
<td>Acute myocardial infarction of other anterior wall</td>
</tr>
<tr>
<td>41010</td>
<td>Acute myocardial infarction of other anterior wall, episode of care unspecified</td>
</tr>
<tr>
<td>41011</td>
<td>Acute myocardial infarction of other anterior wall, initial episode of care</td>
</tr>
<tr>
<td>41012</td>
<td>Acute myocardial infarction of other anterior wall, subsequent episode of care</td>
</tr>
<tr>
<td>4102</td>
<td>Acute myocardial infarction of inferolateral wall</td>
</tr>
<tr>
<td>41020</td>
<td>Acute myocardial infarction of inferolateral wall, episode of care unspecified</td>
</tr>
<tr>
<td>41021</td>
<td>Acute myocardial infarction of inferolateral wall, initial episode of care</td>
</tr>
<tr>
<td>41022</td>
<td>Acute myocardial infarction of inferolateral wall, subsequent episode of care</td>
</tr>
<tr>
<td>4103</td>
<td>Acute myocardial infarction of inferoposterior wall</td>
</tr>
<tr>
<td>41030</td>
<td>Acute myocardial infarction of inferoposterior wall, episode of care unspecified</td>
</tr>
<tr>
<td>41031</td>
<td>Acute myocardial infarction of inferoposterior wall, initial episode of care</td>
</tr>
<tr>
<td>41032</td>
<td>Acute myocardial infarction of inferoposterior wall, subsequent episode of care</td>
</tr>
<tr>
<td>4104</td>
<td>Acute myocardial infarction of other inferior wall</td>
</tr>
<tr>
<td>41040</td>
<td>Acute myocardial infarction of other inferior wall, episode of care unspecified</td>
</tr>
<tr>
<td>41041</td>
<td>Acute myocardial infarction of other inferior wall, initial episode of care</td>
</tr>
<tr>
<td>41042</td>
<td>Acute myocardial infarction of other inferior wall, subsequent episode of care</td>
</tr>
<tr>
<td>4105</td>
<td>Acute myocardial infarction of other lateral wall</td>
</tr>
<tr>
<td>41050</td>
<td>Acute myocardial infarction of other lateral wall, episode of care unspecified</td>
</tr>
<tr>
<td>41051</td>
<td>Acute myocardial infarction of other lateral wall, initial episode of care</td>
</tr>
<tr>
<td>41052</td>
<td>Acute myocardial infarction of other lateral wall, subsequent episode of care</td>
</tr>
<tr>
<td>4106</td>
<td>True posterior wall infarction</td>
</tr>
<tr>
<td>41060</td>
<td>True posterior wall infarction, episode of care unspecified</td>
</tr>
<tr>
<td>41061</td>
<td>True posterior wall infarction, initial episode of care</td>
</tr>
<tr>
<td>41062</td>
<td>True posterior wall infarction, subsequent episode of care</td>
</tr>
<tr>
<td>4107</td>
<td>Subendocardial infarction</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------</td>
</tr>
<tr>
<td>41070</td>
<td>Subendocardial infarction, episode of care unspecified</td>
</tr>
<tr>
<td>41071</td>
<td>Subendocardial infarction, initial episode of care</td>
</tr>
<tr>
<td>41072</td>
<td>Subendocardial infarction, subsequent episode of care</td>
</tr>
<tr>
<td>4108</td>
<td>Acute myocardial infarction of other specified sites</td>
</tr>
<tr>
<td>41080</td>
<td>Acute myocardial infarction of other specified sites, episode of care unspecified</td>
</tr>
<tr>
<td>41081</td>
<td>Acute myocardial infarction of other specified sites, initial episode of care</td>
</tr>
<tr>
<td>41082</td>
<td>Acute myocardial infarction of other specified sites, subsequent episode of care</td>
</tr>
<tr>
<td>4109</td>
<td>Acute myocardial infarction of unspecified site</td>
</tr>
<tr>
<td>41090</td>
<td>Acute myocardial infarction of unspecified site, episode of care unspecified</td>
</tr>
<tr>
<td>41091</td>
<td>Acute myocardial infarction of unspecified site, initial episode of care</td>
</tr>
<tr>
<td>41092</td>
<td>Acute myocardial infarction of unspecified site, subsequent episode of care</td>
</tr>
<tr>
<td>411</td>
<td>Other acute and subacute forms of ischemic heart disease</td>
</tr>
<tr>
<td>4110</td>
<td>Postmyocardial infarction syndrome</td>
</tr>
<tr>
<td>4111</td>
<td>Intermediate coronary syndrome</td>
</tr>
<tr>
<td>4118</td>
<td>Other acute and subacute forms of ischemic heart disease</td>
</tr>
<tr>
<td>41181</td>
<td>Other acute and subacute forms of ischemic heart disease, acute ischemic heart disease without myocardial infarction</td>
</tr>
<tr>
<td>41189</td>
<td>Other acute and subacute forms of ischemic heart disease, other</td>
</tr>
<tr>
<td>412</td>
<td>Old myocardial infarction</td>
</tr>
<tr>
<td>413</td>
<td>Angina pectoris</td>
</tr>
<tr>
<td>4130</td>
<td>Angina decubitus</td>
</tr>
<tr>
<td>4131</td>
<td>Prinzmetal angina</td>
</tr>
<tr>
<td>4139</td>
<td>Other and unspecified angina pectoris</td>
</tr>
<tr>
<td>414</td>
<td>Other forms of chronic ischemic heart disease</td>
</tr>
<tr>
<td>4140</td>
<td>Coronary atherosclerosis</td>
</tr>
<tr>
<td>41400</td>
<td>Coronary atherosclerosis of unspecified type of vessel, native or graft</td>
</tr>
<tr>
<td>41401</td>
<td>Coronary atherosclerosis of native coronary artery</td>
</tr>
<tr>
<td>41402</td>
<td>Coronary atherosclerosis of autologous vein bypass graft</td>
</tr>
<tr>
<td>41403</td>
<td>Coronary atherosclerosis of nonautologous biological bypass graft</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>4219</td>
<td>Acute endocarditis, unspecified</td>
</tr>
<tr>
<td>4220</td>
<td>Acute myocarditis in diseases classified elsewhere</td>
</tr>
<tr>
<td>4229</td>
<td>Other and unspecified acute myocarditis</td>
</tr>
<tr>
<td>42290</td>
<td>Acute myocarditis, unspecified</td>
</tr>
<tr>
<td>42291</td>
<td>Idiopathic myocarditis</td>
</tr>
<tr>
<td>42292</td>
<td>Septic myocarditis</td>
</tr>
<tr>
<td>42293</td>
<td>Toxic myocarditis</td>
</tr>
<tr>
<td>42299</td>
<td>Other acute myocarditis</td>
</tr>
<tr>
<td>4230</td>
<td>Hemopericardium</td>
</tr>
<tr>
<td>4231</td>
<td>Adhesive pericarditis</td>
</tr>
<tr>
<td>4232</td>
<td>Constrictive pericarditis</td>
</tr>
<tr>
<td>4238</td>
<td>Other specified diseases of pericardium</td>
</tr>
<tr>
<td>4239</td>
<td>Unspecified disease of pericardium</td>
</tr>
<tr>
<td>4240</td>
<td>Mitral valve disorders</td>
</tr>
<tr>
<td>4241</td>
<td>Aortic valve disorders</td>
</tr>
<tr>
<td>4242</td>
<td>Tricuspid valve disorders, specified as nonrheumatic</td>
</tr>
<tr>
<td>4243</td>
<td>Pulmonary valve disorders</td>
</tr>
<tr>
<td>42490</td>
<td>Endocarditis, valve unspecified, unspecified cause</td>
</tr>
<tr>
<td>42491</td>
<td>Endocarditis in diseases classified elsewhere</td>
</tr>
<tr>
<td>42499</td>
<td>Other endocarditis, valve unspecified</td>
</tr>
<tr>
<td>4250</td>
<td>Endomyocardial fibrosis</td>
</tr>
<tr>
<td>4251</td>
<td>Hypertrophic obstructive cardiomyopathy</td>
</tr>
<tr>
<td>4252</td>
<td>Obucose cardiomyopathy of africa</td>
</tr>
<tr>
<td>4253</td>
<td>Endocardial fibroelastosis</td>
</tr>
<tr>
<td>4254</td>
<td>Other primary cardiomyopathies</td>
</tr>
<tr>
<td>4255</td>
<td>Alcoholic cardiomyopathy</td>
</tr>
<tr>
<td>4257</td>
<td>Nutritional and metabolic cardiomyopathy</td>
</tr>
<tr>
<td>4258</td>
<td>Cardiomyopathy in other diseases classified elsewhere</td>
</tr>
<tr>
<td>4259</td>
<td>Secondary cardiomyopathy, unspecified</td>
</tr>
<tr>
<td>4260</td>
<td>Atrioventricular block, complete</td>
</tr>
<tr>
<td>42610</td>
<td>Atrioventricular block, unspecified</td>
</tr>
<tr>
<td>42611</td>
<td>First degree atrioventricular block</td>
</tr>
<tr>
<td>42612</td>
<td>Mobitz (type) II atrioventricular block</td>
</tr>
<tr>
<td>42613</td>
<td>Other second degree atrioventricular block</td>
</tr>
<tr>
<td>4262</td>
<td>Left bundle branch hemiblock</td>
</tr>
<tr>
<td>4263</td>
<td>Other left bundle branch block</td>
</tr>
<tr>
<td>4264</td>
<td>Right bundle branch block</td>
</tr>
<tr>
<td>42650</td>
<td>Bundle branch block, unspecified</td>
</tr>
<tr>
<td>42651</td>
<td>Right bundle branch block and left posterior fascicular block</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>42652</td>
<td>Right bundle branch block and left anterior fascicular block</td>
</tr>
<tr>
<td>42653</td>
<td>Other bilateral bundle branch block</td>
</tr>
<tr>
<td>42654</td>
<td>Trifascicular block</td>
</tr>
<tr>
<td>4266</td>
<td>Other heart block</td>
</tr>
<tr>
<td>4267</td>
<td>Anomalous atrioventricular excitation</td>
</tr>
<tr>
<td>42681</td>
<td>Lown-ganong-levine syndrome</td>
</tr>
<tr>
<td>42682</td>
<td>Long QT syndrome</td>
</tr>
<tr>
<td>42689</td>
<td>Other specified conduction disorders</td>
</tr>
<tr>
<td>4269</td>
<td>Conduction disorder, unspecified</td>
</tr>
<tr>
<td>4270</td>
<td>Paroxysmal supraventricular tachycardia</td>
</tr>
<tr>
<td>4271</td>
<td>Paroxysmal ventricular tachycardia</td>
</tr>
<tr>
<td>4272</td>
<td>Paroxysmal tachycardia, unspecified</td>
</tr>
<tr>
<td>42731</td>
<td>Atrial fibrillation</td>
</tr>
<tr>
<td>42732</td>
<td>Atrial flutter</td>
</tr>
<tr>
<td>42741</td>
<td>Ventricular fibrillation</td>
</tr>
<tr>
<td>42742</td>
<td>Ventricular flutter</td>
</tr>
<tr>
<td>4275</td>
<td>Cardiac arrest</td>
</tr>
<tr>
<td>42760</td>
<td>Premature beats, unspecified</td>
</tr>
<tr>
<td>42761</td>
<td>Supraventricular premature beats</td>
</tr>
<tr>
<td>42769</td>
<td>Other premature beats</td>
</tr>
<tr>
<td>42781</td>
<td>Sinoatrial node dysfunction</td>
</tr>
<tr>
<td>42789</td>
<td>Other specified cardiac dysrhythmias</td>
</tr>
<tr>
<td>4279</td>
<td>Cardiac dysrhythmia, unspecified</td>
</tr>
<tr>
<td>4280</td>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>4281</td>
<td>Left heart failure</td>
</tr>
<tr>
<td>42820</td>
<td>Unspecified systolic heart failure</td>
</tr>
<tr>
<td>42821</td>
<td>Acute systolic heart failure</td>
</tr>
<tr>
<td>42822</td>
<td>Chronic systolic heart failure</td>
</tr>
<tr>
<td>42823</td>
<td>Acute on chronic systolic heart failure</td>
</tr>
<tr>
<td>42830</td>
<td>Unspecified diastolic heart failure</td>
</tr>
<tr>
<td>42831</td>
<td>Acute diastolic heart failure</td>
</tr>
<tr>
<td>42832</td>
<td>Chronic diastolic heart failure</td>
</tr>
<tr>
<td>42833</td>
<td>Acute on chronic diastolic heart failure</td>
</tr>
<tr>
<td>42840</td>
<td>Unspecified combined systolic and diastolic heart failure</td>
</tr>
<tr>
<td>42841</td>
<td>Acute combined systolic and diastolic heart failure</td>
</tr>
<tr>
<td>42842</td>
<td>Chronic combined systolic and diastolic heart failure</td>
</tr>
<tr>
<td>42843</td>
<td>Acute on chronic combined systolic and diastolic heart failure</td>
</tr>
<tr>
<td>4289</td>
<td>Heart failure, unspecified</td>
</tr>
<tr>
<td>4290</td>
<td>Myocarditis, unspecified</td>
</tr>
<tr>
<td>4291</td>
<td>Myocardial degeneration</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>4292</td>
<td>Cardiovascular disease, unspecified</td>
</tr>
<tr>
<td>4293</td>
<td>Cardiomegaly</td>
</tr>
<tr>
<td>4294</td>
<td>Functional disturbances following cardiac surgery</td>
</tr>
<tr>
<td>4295</td>
<td>Rupture of chordae tendineae</td>
</tr>
<tr>
<td>4296</td>
<td>Rupture of papillary muscle</td>
</tr>
<tr>
<td>42971</td>
<td>Certain sequelae of myocardial infarction, not elsewhere classified, acquired cardiac septal defect</td>
</tr>
<tr>
<td>42979</td>
<td>Certain sequelae of myocardial infarction, not elsewhere classified, other</td>
</tr>
<tr>
<td>42981</td>
<td>Other disorders of papillary muscle</td>
</tr>
<tr>
<td>42982</td>
<td>Hyperkinetic heart disease</td>
</tr>
<tr>
<td>42983</td>
<td>Takotsubo syndrome</td>
</tr>
<tr>
<td>42989</td>
<td>Other ill-defined heart diseases</td>
</tr>
<tr>
<td>4299</td>
<td>Heart disease, unspecified</td>
</tr>
<tr>
<td>43300</td>
<td>Occlusion and stenosis of basilar artery without mention of cerebral infarction</td>
</tr>
<tr>
<td>43301</td>
<td>Occlusion and stenosis of basilar artery with cerebral infarction</td>
</tr>
<tr>
<td>43310</td>
<td>Occlusion and stenosis of carotid artery without mention of cerebral infarction</td>
</tr>
<tr>
<td>43311</td>
<td>Occlusion and stenosis of carotid artery with cerebral infarction</td>
</tr>
<tr>
<td>43390</td>
<td>Occlusion and stenosis of unspecified precerebral artery without mention of cerebral infarction</td>
</tr>
<tr>
<td>43391</td>
<td>Occlusion and stenosis of unspecified precerebral artery with cerebral infarction</td>
</tr>
<tr>
<td>43400</td>
<td>Cerebral thrombosis without mention of cerebral infarction</td>
</tr>
<tr>
<td>43401</td>
<td>Cerebral thrombosis with cerebral infarction</td>
</tr>
<tr>
<td>43410</td>
<td>Cerebral embolism without mention of cerebral infarction</td>
</tr>
<tr>
<td>43411</td>
<td>Cerebral embolism with cerebral infarction</td>
</tr>
<tr>
<td>43490</td>
<td>Cerebral artery occlusion, unspecified without mention of cerebral infarction</td>
</tr>
<tr>
<td>43491</td>
<td>Cerebral artery occlusion, unspecified with cerebral infarction</td>
</tr>
<tr>
<td>4359</td>
<td>Unspecified transient cerebral ischemia</td>
</tr>
<tr>
<td>4372</td>
<td>Hypertensive encephalopathy</td>
</tr>
<tr>
<td>44100</td>
<td>Dissection of aorta, unspecified site</td>
</tr>
<tr>
<td>44101</td>
<td>Dissection of aorta, thoracic</td>
</tr>
<tr>
<td>44103</td>
<td>Dissection of aorta, thoracoabdominal</td>
</tr>
<tr>
<td>4411</td>
<td>Thoracic aneurysm, ruptured</td>
</tr>
<tr>
<td>4412</td>
<td>Thoracic aneurysm without mention of rupture</td>
</tr>
<tr>
<td>4416</td>
<td>Thoracoabdominal aneurysm, ruptured</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4417</td>
<td>Thoracoabdominal aneurysm, without mention of rupture</td>
</tr>
<tr>
<td>4439</td>
<td>Peripheral vascular disease, unspecified</td>
</tr>
<tr>
<td>4440</td>
<td>Embolism and thrombosis of abdominal aorta</td>
</tr>
<tr>
<td>4441</td>
<td>Embolism and thrombosis of thoracic aorta</td>
</tr>
<tr>
<td>44421</td>
<td>Arterial embolism and thrombosis of upper extremity</td>
</tr>
<tr>
<td>44422</td>
<td>Arterial embolism and thrombosis of lower extremity</td>
</tr>
<tr>
<td>4460</td>
<td>Polyaarteritis nodosa</td>
</tr>
<tr>
<td>4467</td>
<td>Takayasu’s disease</td>
</tr>
<tr>
<td>4580</td>
<td>Orthostatic hypotension</td>
</tr>
<tr>
<td>45821</td>
<td>Hypotension of hemodialysis</td>
</tr>
<tr>
<td>4589</td>
<td>Hypotension, unspecified</td>
</tr>
<tr>
<td>4590</td>
<td>Hemorrhage, unspecified</td>
</tr>
<tr>
<td>496</td>
<td>Chronic airway obstruction, not elsewhere classified</td>
</tr>
<tr>
<td>514</td>
<td>Pulmonary congestion and hypostasis</td>
</tr>
<tr>
<td>5173</td>
<td>Acute chest syndrome</td>
</tr>
<tr>
<td>5184</td>
<td>Acute edema of lung, unspecified</td>
</tr>
<tr>
<td>5185</td>
<td>Pulmonary insufficiency following trauma and surgery</td>
</tr>
<tr>
<td>51882</td>
<td>Other pulmonary insufficiency, not elsewhere classified</td>
</tr>
<tr>
<td>51884</td>
<td>Acute and chronic respiratory failure</td>
</tr>
<tr>
<td>51919</td>
<td>Other diseases of trachea and bronchus</td>
</tr>
<tr>
<td>53081</td>
<td>Esophageal reflux</td>
</tr>
<tr>
<td>57410</td>
<td>Calculus of gallbladder with other cholecystitis, without mention of obstruction</td>
</tr>
<tr>
<td>64201</td>
<td>Benign essential hypertension with delivery</td>
</tr>
<tr>
<td>64202</td>
<td>Benign essential hypertension, with delivery, with mention of postpartum complication</td>
</tr>
<tr>
<td>64203</td>
<td>Antepartum benign essential hypertension</td>
</tr>
<tr>
<td>64204</td>
<td>Postpartum benign essential hypertension</td>
</tr>
<tr>
<td>64251</td>
<td>Severe pre-eclampsia, with delivery</td>
</tr>
<tr>
<td>64252</td>
<td>Severe pre-eclampsia, with delivery, with mention of postpartum complication</td>
</tr>
<tr>
<td>64253</td>
<td>Severe pre-eclampsia, antepartum</td>
</tr>
<tr>
<td>64254</td>
<td>Severe pre-eclampsia, postpartum</td>
</tr>
<tr>
<td>64850</td>
<td>Congenital cardiovascular disorders of mother, complicating pregnancy, childbirth, or the puerperium, unspecified as to episode of care</td>
</tr>
<tr>
<td>64851</td>
<td>Congenital cardiovascular disorders of mother, with delivery</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>64852</td>
<td>Congenital cardiovascular disorders of mother, with delivery, with mention of postpartum complication</td>
</tr>
<tr>
<td>64853</td>
<td>Congenital cardiovascular disorders of mother, antepartum</td>
</tr>
<tr>
<td>64854</td>
<td>Congenital cardiovascular disorders of mother, postpartum</td>
</tr>
<tr>
<td>65420</td>
<td>Previous cesarean delivery, unspecified as to episode of care in pregnancy</td>
</tr>
<tr>
<td>65423</td>
<td>Previous cesarean delivery, antepartum condition or complication</td>
</tr>
<tr>
<td>66810</td>
<td>Cardiac complications of anesthesia or other sedation in labor and delivery, unspecified as to episode of care</td>
</tr>
<tr>
<td>66811</td>
<td>Cardiac complications of anesthesia or other sedation in labor and delivery, delivered</td>
</tr>
<tr>
<td>66812</td>
<td>Cardiac complications of anesthesia or other sedation in labor and delivery, delivered, with mention of postpartum complication</td>
</tr>
<tr>
<td>66813</td>
<td>Cardiac complications of anesthesia or other sedation in labor and delivery, antepartum</td>
</tr>
<tr>
<td>66814</td>
<td>Cardiac complications of anesthesia or other sedation in labor and delivery, postpartum</td>
</tr>
<tr>
<td>66971</td>
<td>Cesarean delivery, without mention of indication, delivered, with or without mention of antepartum condition</td>
</tr>
<tr>
<td>67450</td>
<td>Peripartum cardiomyopathy, unspecified as to episode of care or not applicable</td>
</tr>
<tr>
<td>67451</td>
<td>Peripartum cardiomyopathy, delivered, with or without mention of antepartum condition</td>
</tr>
<tr>
<td>67452</td>
<td>Peripartum cardiomyopathy, delivered, with mention of postpartum condition</td>
</tr>
<tr>
<td>67453</td>
<td>Peripartum cardiomyopathy, antepartum condition or complication</td>
</tr>
<tr>
<td>67454</td>
<td>Peripartum cardiomyopathy, postpartum condition or complication</td>
</tr>
<tr>
<td>7100</td>
<td>Systemic lupus erythematosus</td>
</tr>
<tr>
<td>7142</td>
<td>Other rheumatoid arthritis with visceral or systemic involvement</td>
</tr>
<tr>
<td>71941</td>
<td>Pain in joint involving shoulder region</td>
</tr>
<tr>
<td>7200</td>
<td>Ankylosing spondylitis</td>
</tr>
<tr>
<td>7231</td>
<td>Cervicalgia</td>
</tr>
<tr>
<td>7295</td>
<td>Pain in limb</td>
</tr>
<tr>
<td>7336</td>
<td>Tietze’s disease</td>
</tr>
<tr>
<td>7450</td>
<td>Common truncus</td>
</tr>
<tr>
<td>7451</td>
<td>Transposition of great vessels</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>74510</td>
<td>Complete transposition of great vessels</td>
</tr>
<tr>
<td>74511</td>
<td>Double outlet right ventricle</td>
</tr>
<tr>
<td>74512</td>
<td>Corrected transposition of great vessels</td>
</tr>
<tr>
<td>74519</td>
<td>Other transposition of great vessels</td>
</tr>
<tr>
<td>7452</td>
<td>Tetralogy of fallot</td>
</tr>
<tr>
<td>7453</td>
<td>Common ventricle</td>
</tr>
<tr>
<td>7454</td>
<td>Ventricular septal defect</td>
</tr>
<tr>
<td>7455</td>
<td>Ostium secundum atrial septal defect</td>
</tr>
<tr>
<td>7456</td>
<td>Endocardial cushion defects</td>
</tr>
<tr>
<td>74560</td>
<td>Endocardial cushion defect, unspecified type</td>
</tr>
<tr>
<td>74561</td>
<td>Ostium primum defect</td>
</tr>
<tr>
<td>74569</td>
<td>Other endocardial cushion defects</td>
</tr>
<tr>
<td>7457</td>
<td>Cor biloculare</td>
</tr>
<tr>
<td>7458</td>
<td>Other bulbus cordis anomalies and anomalies of cardiac septal closure</td>
</tr>
<tr>
<td>7459</td>
<td>Unspecified defect of septal closure</td>
</tr>
<tr>
<td>746</td>
<td>Other congenital anomalies of heart</td>
</tr>
<tr>
<td>7460</td>
<td>Anomalies of pulmonary valve, congenital</td>
</tr>
<tr>
<td>74600</td>
<td>Congenital pulmonary valve anomaly, unspecified</td>
</tr>
<tr>
<td>74601</td>
<td>Atresia of pulmonary valve, congenital</td>
</tr>
<tr>
<td>74602</td>
<td>Stenosis of pulmonary valve, congenital</td>
</tr>
<tr>
<td>74609</td>
<td>Other congenital anomalies of pulmonary valve</td>
</tr>
<tr>
<td>7461</td>
<td>Tricuspid atresia and stenosis, congenital</td>
</tr>
<tr>
<td>7462</td>
<td>Ebstein’s anomaly</td>
</tr>
<tr>
<td>7463</td>
<td>Congenital stenosis of aortic valve</td>
</tr>
<tr>
<td>7464</td>
<td>Congenital insufficiency of aortic valve</td>
</tr>
<tr>
<td>7465</td>
<td>Congenital mitral stenosis</td>
</tr>
<tr>
<td>7466</td>
<td>Congenital mitral insufficiency</td>
</tr>
<tr>
<td>7467</td>
<td>Hypoplastic left heart syndrome</td>
</tr>
<tr>
<td>7468</td>
<td>Other specified congenital anomalies of heart</td>
</tr>
<tr>
<td>74681</td>
<td>Subaortic stenosis, congenital</td>
</tr>
<tr>
<td>74682</td>
<td>Cor triatriatum</td>
</tr>
<tr>
<td>74683</td>
<td>Infundibular pulmonic stenosis, congenital</td>
</tr>
<tr>
<td>74684</td>
<td>Congenital obstructive anomalies of heart, not elsewhere classified</td>
</tr>
<tr>
<td>74685</td>
<td>Coronary artery anomaly, congenital</td>
</tr>
<tr>
<td>74686</td>
<td>Congenital heart block</td>
</tr>
<tr>
<td>74687</td>
<td>Malposition of heart and cardiac apex</td>
</tr>
<tr>
<td>74689</td>
<td>Other specified congenital anomalies of heart</td>
</tr>
<tr>
<td>7469</td>
<td>Unspecified congenital anomaly of heart</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>747</td>
<td>Other congenital anomalies of circulatory system</td>
</tr>
<tr>
<td>7470</td>
<td>Patent ductus arteriosus</td>
</tr>
<tr>
<td>7471</td>
<td>Coarctation of aorta</td>
</tr>
<tr>
<td>74710</td>
<td>Coarctation of aorta (preductal) (postductal)</td>
</tr>
<tr>
<td>74711</td>
<td>Interruption of aortic arch</td>
</tr>
<tr>
<td>7472</td>
<td>Other congenital anomalies of aorta</td>
</tr>
<tr>
<td>74720</td>
<td>Congenital anomaly of aorta, unspecified</td>
</tr>
<tr>
<td>74721</td>
<td>Congenital anomalies of aortic arch</td>
</tr>
<tr>
<td>74722</td>
<td>Congenital atresia and stenosis of aorta</td>
</tr>
<tr>
<td>74729</td>
<td>Other congenital anomalies of aorta</td>
</tr>
<tr>
<td>7473</td>
<td>Congenital anomalies of pulmonary artery</td>
</tr>
<tr>
<td>7474</td>
<td>Congenital anomaly of great veins</td>
</tr>
<tr>
<td>74740</td>
<td>Congenital anomaly of great veins, unspecified</td>
</tr>
<tr>
<td>74741</td>
<td>Total anomalous pulmonary venous connection</td>
</tr>
<tr>
<td>74742</td>
<td>Partial anomalous pulmonary venous connection</td>
</tr>
<tr>
<td>74749</td>
<td>Other anomalies of great veins</td>
</tr>
<tr>
<td>7580</td>
<td>Down’s syndrome</td>
</tr>
<tr>
<td>7593</td>
<td>Situs inversus</td>
</tr>
<tr>
<td>75982</td>
<td>Marfan syndrome</td>
</tr>
<tr>
<td>78001</td>
<td>Coma</td>
</tr>
<tr>
<td>78002</td>
<td>Transient alteration of awareness</td>
</tr>
<tr>
<td>78003</td>
<td>Persistent vegetative state</td>
</tr>
<tr>
<td>78009</td>
<td>Alterations of consciousness, other</td>
</tr>
<tr>
<td>7802</td>
<td>Syncope and collapse</td>
</tr>
<tr>
<td>7804</td>
<td>Dizziness and giddiness</td>
</tr>
<tr>
<td>78079</td>
<td>Other malaise and fatigue</td>
</tr>
<tr>
<td>7808</td>
<td>Generalized hyperhidrosis</td>
</tr>
<tr>
<td>7815</td>
<td>Clubbing of fingers</td>
</tr>
<tr>
<td>7823</td>
<td>Edema</td>
</tr>
<tr>
<td>7825</td>
<td>Cyanosis</td>
</tr>
<tr>
<td>7850</td>
<td>Tachycardia, unspecified</td>
</tr>
<tr>
<td>7851</td>
<td>Palpitations</td>
</tr>
<tr>
<td>7852</td>
<td>Undiagnosed cardiac murmurs</td>
</tr>
<tr>
<td>7853</td>
<td>Other abnormal heart sounds</td>
</tr>
<tr>
<td>78550</td>
<td>Shock, unspecified</td>
</tr>
<tr>
<td>78551</td>
<td>Cardiogenic shock</td>
</tr>
<tr>
<td>78552</td>
<td>Septic shock</td>
</tr>
<tr>
<td>78559</td>
<td>Other shock without mention of trauma</td>
</tr>
<tr>
<td>78600</td>
<td>Respiratory abnormality, unspecified</td>
</tr>
<tr>
<td>78602</td>
<td>Orthopnea</td>
</tr>
<tr>
<td>78605</td>
<td>Shortness of breath</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>78609</td>
<td>Respiratory distress</td>
</tr>
<tr>
<td>78650</td>
<td>Unspecified chest pain</td>
</tr>
<tr>
<td>78651</td>
<td>Precordial pain</td>
</tr>
<tr>
<td>78652</td>
<td>Painful respiration</td>
</tr>
<tr>
<td>78659</td>
<td>Other chest pain</td>
</tr>
<tr>
<td>78701</td>
<td>Nausea with vomiting</td>
</tr>
<tr>
<td>78702</td>
<td>Nausea alone</td>
</tr>
<tr>
<td>78703</td>
<td>Vomiting alone</td>
</tr>
<tr>
<td>7871</td>
<td>Heartburn</td>
</tr>
<tr>
<td>78900</td>
<td>Abdominal pain, unspecified site</td>
</tr>
<tr>
<td>78907</td>
<td>Abdominal pain, generalized</td>
</tr>
<tr>
<td>78960</td>
<td>Abdominal tenderness, unspecified site</td>
</tr>
<tr>
<td>79001</td>
<td>Precipitous drop in hematocrit</td>
</tr>
<tr>
<td>7904</td>
<td>Nonspecific elevation of levels of transaminase or lactic acid dehydrogenase (ldh)</td>
</tr>
<tr>
<td>7905</td>
<td>Other nonspecific abnormal serum enzyme levels</td>
</tr>
<tr>
<td>7906</td>
<td>Other abnormal blood chemistry</td>
</tr>
<tr>
<td>7932</td>
<td>Nonspecific abnormal findings on radiological and other examination of other intrathoracic organs</td>
</tr>
<tr>
<td>79430</td>
<td>Unspecified abnormal function study of cardiovascular system</td>
</tr>
<tr>
<td>79431</td>
<td>Nonspecific abnormal electrocardiogram (ECG) (EKG)</td>
</tr>
<tr>
<td>79439</td>
<td>Other nonspecific abnormal function study of cardiovascular system</td>
</tr>
<tr>
<td>7944</td>
<td>Nonspecific abnormal results of function study of kidney</td>
</tr>
<tr>
<td>7945</td>
<td>Nonspecific abnormal results of function study of thyroid</td>
</tr>
<tr>
<td>7946</td>
<td>Nonspecific abnormal results of other endocrine function study</td>
</tr>
<tr>
<td>7947</td>
<td>Nonspecific abnormal results of function study of basal metabolism</td>
</tr>
<tr>
<td>7948</td>
<td>Nonspecific abnormal results of function study of liver</td>
</tr>
<tr>
<td>7949</td>
<td>Nonspecific abnormal results of other specified function study</td>
</tr>
<tr>
<td>7991</td>
<td>Respiratory arrest</td>
</tr>
<tr>
<td>8072</td>
<td>Closed fracture of sternum</td>
</tr>
<tr>
<td>8073</td>
<td>Open fracture of sternum</td>
</tr>
<tr>
<td>8074</td>
<td>Flail chest</td>
</tr>
<tr>
<td>8600</td>
<td>Traumatic pneumothorax without mention of open wound into thorax</td>
</tr>
<tr>
<td>8601</td>
<td>Traumatic pneumothorax with open wound into thorax</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>8602</td>
<td>Traumatic hemothorax without mention of open wound into thorax</td>
</tr>
<tr>
<td>8603</td>
<td>Traumatic hemothorax with open wound into thorax</td>
</tr>
<tr>
<td>8604</td>
<td>Traumatic pneumohemothorax without mention of open wound into thorax</td>
</tr>
<tr>
<td>8605</td>
<td>Traumatic pneumohemothorax with open wound into thorax</td>
</tr>
<tr>
<td>86100</td>
<td>Unspecified injury of heart without mention of open wound into thorax</td>
</tr>
<tr>
<td>86101</td>
<td>Contusion of heart without mention of open wound into thorax</td>
</tr>
<tr>
<td>86102</td>
<td>Laceration of heart without penetration of heart chambers or open wound into thorax</td>
</tr>
<tr>
<td>86103</td>
<td>Laceration of heart with penetration of heart chambers, without mention of open wound into thorax</td>
</tr>
<tr>
<td>8611</td>
<td>Heart injury with open wound into thorax</td>
</tr>
<tr>
<td>86110</td>
<td>Unspecified injury of heart with open wound into thorax</td>
</tr>
<tr>
<td>86111</td>
<td>Contusion of heart with open wound into thorax</td>
</tr>
<tr>
<td>86112</td>
<td>Laceration of heart without penetration of heart chambers, with open wound into thorax</td>
</tr>
<tr>
<td>86113</td>
<td>Laceration of heart with penetration of heart chambers and open wound into thorax</td>
</tr>
<tr>
<td>8628</td>
<td>Injury to multiple and unspecified intrathoracic organs without mention of open wound into cavity</td>
</tr>
<tr>
<td>8629</td>
<td>Injury to multiple and unspecified intrathoracic organs with open wound into cavity</td>
</tr>
<tr>
<td>9000</td>
<td>Injury to carotid artery</td>
</tr>
<tr>
<td>90000</td>
<td>Injury to carotid artery, unspecified</td>
</tr>
<tr>
<td>90001</td>
<td>Injury to common carotid artery</td>
</tr>
<tr>
<td>90002</td>
<td>Injury to external carotid artery</td>
</tr>
<tr>
<td>90003</td>
<td>Injury to internal carotid artery</td>
</tr>
<tr>
<td>9001</td>
<td>Injury to internal jugular vein</td>
</tr>
<tr>
<td>9010</td>
<td>Injury to thoracic aorta</td>
</tr>
<tr>
<td>9011</td>
<td>Injury to innominate and subclavian arteries</td>
</tr>
<tr>
<td>9012</td>
<td>Injury to superior vena cava</td>
</tr>
<tr>
<td>9013</td>
<td>Injury to innominate and subclavian veins</td>
</tr>
<tr>
<td>9014</td>
<td>Injury to pulmonary blood vessels</td>
</tr>
<tr>
<td>90140</td>
<td>Injury to pulmonary vessel(s), unspecified</td>
</tr>
<tr>
<td>90141</td>
<td>Injury to pulmonary artery</td>
</tr>
<tr>
<td>90142</td>
<td>Injury to pulmonary vein</td>
</tr>
<tr>
<td>90181</td>
<td>Injury to intercostal artery or vein</td>
</tr>
<tr>
<td>90182</td>
<td>Injury to internal mammary artery or vein</td>
</tr>
<tr>
<td>90183</td>
<td>Injury to multiple blood vessels of thorax</td>
</tr>
<tr>
<td>9221</td>
<td>Contusion of chest wall</td>
</tr>
<tr>
<td>9584</td>
<td>Traumatic shock</td>
</tr>
<tr>
<td>9607</td>
<td>Poisoning by antineoplastic antibiotics</td>
</tr>
<tr>
<td>9631</td>
<td>Poisoning by antineoplastic and immunosuppressive drugs</td>
</tr>
<tr>
<td>96509</td>
<td>Poisoning by other opiates and related narcotics</td>
</tr>
<tr>
<td>9720</td>
<td>Poisoning by cardiac rhythm regulators</td>
</tr>
<tr>
<td>9721</td>
<td>Poisoning by cardiotonic glycosides and drugs of similar action</td>
</tr>
<tr>
<td>9722</td>
<td>Poisoning by antilipemic and antiarteriosclerotic drugs</td>
</tr>
<tr>
<td>9723</td>
<td>Poisoning by ganglion-blocking agents</td>
</tr>
<tr>
<td>9724</td>
<td>Poisoning by coronary vasodilators</td>
</tr>
<tr>
<td>9725</td>
<td>Poisoning by other vasodilators</td>
</tr>
<tr>
<td>9726</td>
<td>Poisoning by other antihypertensive agents</td>
</tr>
<tr>
<td>9727</td>
<td>Poisoning by antivaricose drugs, including sclerosing agents</td>
</tr>
<tr>
<td>9728</td>
<td>Poisoning by capillary-active drugs</td>
</tr>
<tr>
<td>9729</td>
<td>Poisoning by other and unspecified agents primarily affecting the cardiovascular system</td>
</tr>
<tr>
<td>9779</td>
<td>Poisoning by unspecified drug or medicinal substance</td>
</tr>
<tr>
<td>986</td>
<td>Toxic effect of carbon monoxide</td>
</tr>
<tr>
<td>9893</td>
<td>Toxic effect of organophosphate and carbamate</td>
</tr>
<tr>
<td>9894</td>
<td>Toxic effect of other pesticides, not elsewhere classified</td>
</tr>
<tr>
<td>9895</td>
<td>Toxic effect of venom</td>
</tr>
<tr>
<td>9920</td>
<td>Heat stroke and sunstroke</td>
</tr>
<tr>
<td>9921</td>
<td>Heat syncope</td>
</tr>
<tr>
<td>9940</td>
<td>Effect of lightning</td>
</tr>
<tr>
<td>9941</td>
<td>Drowning and nonfatal submersion</td>
</tr>
<tr>
<td>9947</td>
<td>Asphyxiation and strangulation</td>
</tr>
<tr>
<td>9948</td>
<td>Electrocution and nonfatal effects of electrical current</td>
</tr>
<tr>
<td>9950</td>
<td>Other anaphylactic shock, not elsewhere classified</td>
</tr>
<tr>
<td>99522</td>
<td>Unspecified adverse effect of anesthesia</td>
</tr>
<tr>
<td>99523</td>
<td>Unspecified adverse effect of insulin</td>
</tr>
<tr>
<td>99527</td>
<td>Other drug allergy</td>
</tr>
<tr>
<td>99600</td>
<td>Mechanical complications of unspecified cardiac device, implant, and graft</td>
</tr>
<tr>
<td>99601</td>
<td>Mechanical complication due to cardiac pacemaker (electrode)</td>
</tr>
</tbody>
</table>
Section 25

All medically necessary radiology services provided to hospital clients must be ordered by the client’s attending or consulting physician. These services must be documented in the client’s medical record.

The diagnoses submitted on the claim form should reflect the medical necessity of services rendered. If a diagnosis is not available, TMHP accepts signs and symptoms. TMHP monitors the diagnoses indicated for the following procedures:

- Ambulatory electroencephalograms (A/EEG)
- EKG
- Arteriography
- Venography
- Radiation therapy
- Cardiac blood pool imaging
- Chest X-rays
- Computerized axial tomography (CAT) scans
- Echography
- Magnetic Resonance Angiogram (MRA)
- Mammography
- Magnetic Resonance Imaging (MRI) mammography
- Polysomnography

**Repeat Procedures/Modifier 76**

The use of modifier 76 is limited as follows:

- Modifier 76 must not be used when billing the initial procedure. It must be used to indicate the repeated procedure.
- If more than two services are billed on the same day by the same provider regardless of the use of modifier 76, the claim or detail is denied.
- If a repeated procedure performed by the same provider on the same day is billed without modifier 76, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures/services must be documented on appeal.
- Modifier 76 is not required and must not be used when billing multiple quantities of a supply (e.g., disposable diapers or sterile saline).

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99602</td>
<td>Mechanical complication due to heart valve prosthesis</td>
</tr>
<tr>
<td>99603</td>
<td>Mechanical complication due to coronary bypass graft</td>
</tr>
<tr>
<td>99604</td>
<td>Mechanical complication of automatic implantable cardiac defibrillator</td>
</tr>
<tr>
<td>99609</td>
<td>Other mechanical complication of cardiac device, implant, and graft</td>
</tr>
<tr>
<td>99661</td>
<td>Infection and inflammatory reaction due to cardiac device, implant, and graft</td>
</tr>
<tr>
<td>99671</td>
<td>Other complications due to heart valve prosthesis</td>
</tr>
<tr>
<td>99672</td>
<td>Other complications due to other cardiac device, implant, and graft</td>
</tr>
<tr>
<td>99683</td>
<td>Complications of transplanted heart</td>
</tr>
<tr>
<td>9971</td>
<td>Cardiac complications, not elsewhere classified</td>
</tr>
<tr>
<td>9980</td>
<td>Postoperative shock, not elsewhere classified</td>
</tr>
<tr>
<td>9993</td>
<td>Other infection due to medical care, not elsewhere classified</td>
</tr>
<tr>
<td>9994</td>
<td>Anaphylactic shock due to serum, not elsewhere classified</td>
</tr>
<tr>
<td>V151</td>
<td>Personal history of surgery to heart and great vessels, presenting hazards to health</td>
</tr>
<tr>
<td>V252</td>
<td>Sterilization</td>
</tr>
<tr>
<td>V421</td>
<td>Heart replaced by transplant</td>
</tr>
<tr>
<td>V422</td>
<td>Heart valve replaced by transplant</td>
</tr>
<tr>
<td>V426</td>
<td>Lung replaced by transplant</td>
</tr>
<tr>
<td>V4321</td>
<td>Organ or tissue replaced by other means, heart assist device</td>
</tr>
<tr>
<td>V433</td>
<td>Organ or tissue replaced by other means, fully implantable artificial heart</td>
</tr>
<tr>
<td>V4500</td>
<td>Unspecified cardiac device in situ</td>
</tr>
<tr>
<td>V4501</td>
<td>Cardiac pacemaker in situ</td>
</tr>
<tr>
<td>V4502</td>
<td>Automatic implantable cardiac defibrillator in situ</td>
</tr>
<tr>
<td>V4509</td>
<td>Other specified cardiac device in situ</td>
</tr>
<tr>
<td>V4581</td>
<td>Postsurgical aortocoronary bypass status</td>
</tr>
<tr>
<td>V4582</td>
<td>Percutaneous transluminal coronary angioplasty status</td>
</tr>
<tr>
<td>V472</td>
<td>Other cardiorespiratory problems</td>
</tr>
<tr>
<td>V4983</td>
<td>Other cardiorespiratory problems</td>
</tr>
<tr>
<td>V5331</td>
<td>Fitting and adjustment of cardiac pacemaker</td>
</tr>
<tr>
<td>V5332</td>
<td>Fitting and adjustment of automatic implantable cardiac defibrillator</td>
</tr>
<tr>
<td>V5339</td>
<td>Fitting and adjustment of other cardiac device</td>
</tr>
<tr>
<td>V5844</td>
<td>Aftercare following organ transplant</td>
</tr>
<tr>
<td>V5869</td>
<td>Long-term (current) use of other medications</td>
</tr>
<tr>
<td>V717</td>
<td>Observation for suspected cardiovascular disease</td>
</tr>
<tr>
<td>V7281</td>
<td>Pre-operative cardiovascular examination</td>
</tr>
<tr>
<td>V7284</td>
<td>Pre-operative examination, unspecified</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>V5869</td>
<td>Long-term (current) use of other medications</td>
</tr>
<tr>
<td>V717</td>
<td>Observation for suspected cardiovascular disease</td>
</tr>
<tr>
<td>V7281</td>
<td>Pre-operative cardiovascular examination</td>
</tr>
<tr>
<td>V7284</td>
<td>Pre-operative examination, unspecified</td>
</tr>
</tbody>
</table>

**Aftercare following organ transplant**

**Long-term (current) use of other medications**

**Observation for suspected cardiovascular disease**

**Pre-operative cardiovascular examination**

**Pre-operative examination, unspecified**

All medically necessary radiology services provided to hospital clients must be ordered by the client’s attending or consulting physician. These services must be documented in the client’s medical record.

The diagnoses submitted on the claim form should reflect the medical necessity of services rendered. If a diagnosis is not available, TMHP accepts signs and symptoms. TMHP monitors the diagnoses indicated for the following procedures:

- Ambulatory electroencephalograms (A/EEG)
- EKG
- Arteriography
- Venography
- Radiation therapy
- Cardiac blood pool imaging
- Chest X-rays
- Computerized axial tomography (CAT) scans
- Echography
- Magnetic Resonance Angiogram (MRA)
- Mammography
- Magnetic Resonance Imaging (MRI) mammography
- Polysomnography

**Repeat Procedures/Modifier 76**

The use of modifier 76 is limited as follows:

- Modifier 76 must not be used when billing the initial procedure. It must be used to indicate the repeated procedure.
- If more than two services are billed on the same day by the same provider regardless of the use of modifier 76, the claim or detail is denied.
- If a repeated procedure performed by the same provider on the same day is billed without modifier 76, it is denied as a duplicate procedure.
- If a claim is denied for a quantity more than two or as a duplicate procedure, the times of these procedures/services must be documented on appeal.
- Modifier 76 is not required and must not be used when billing multiple quantities of a supply (e.g., disposable diapers or sterile saline).
When appealing claims with modifier 76 for repeat procedures, providers must separate the details. One detail should be appealed without the modifier and one detail with the modifier, or documentation of times for each repeated procedure.

Certain procedure codes have been removed from modifier 76 auditing. These procedure codes have been identified as routinely being performed at the same time, more than twice per day for each antigen (e.g., agglutinins, febrile [e.g., Brucella, Francisella, Murine typhus, Q fever, Rocky Mountain spotted fever, scrub typhus], each antigen). Providers may still appeal claims that have been denied for documentation of time. Most procedure codes initially requiring modifier 76 will continue to be audited for the modifier 76.

### 25.3.3.17 Computerized Tomography

Scout views and reconstruction are considered part of any CT procedure and are not reimbursed in addition to any other CT. Procedure codes 4-76375 and 4-76380, are denied when billed on the same day as any other CT. Procedure codes 4-76375 and 4-76380 are paid if billed as an independent procedure.

### 25.3.3.18 Technetium TC 99M Tetrofosmin

Procedure code 9-A9502 is a benefit without age restriction. It is payable in the office, inpatient, and outpatient settings. Payable providers are physicians, radiation treatment centers, and hospitals.

Inpatient settings are reimbursed under their DRG. Services provided in the outpatient hospital setting are paid at the Texas Medicaid Reimbursement Methodology (TMRM). Radiation treatment centers are reimbursed at a maximum fee of $112.46.

### Low Osmolar (Nonionic) Contrast Material (LOCM)

LOCM used with intrathecal, intra-arterial, and/or intravenous radiological procedures may be reimbursed separately when medically indicated for clients with but not limited to the following high-risk conditions:

- History of allergic reaction to contrast material with the exception of a heat or flushing sensation or a single episode of nausea or vomiting
- History of asthma
- Significant cardiac dysfunction including recent or imminent cardiac decompensation, severe arrhythmia, unstable angina pectoris, recent myocardial infarction, and pulmonary hypertension
- Generalized severe debilitation
- Sickle cell disease

The LOCM is reimbursed as a drug furnished as incidental to a physician’s service. Payment is limited to services performed in the office (POS 1), freestanding radiation centers (POS 6), and outpatient facilities (POS 5). LOCM used on clients in the inpatient hospital setting of a DRG reimbursed hospital is included in the DRG payment and no additional payment is made.

Radiological procedures that specify with contrast include payment for high osmolar contrast material and no additional payment is made for low osmolar contrast material. When using low osmolar contrast material for procedures, bill the codes that specify without contrast. The low osmolar contrast material should be billed separately.

MRI procedures that specify with contrast include payment for para-magnetic contrast; therefore, low osmolar contrast material is not reimbursed separately. Cardiac blood pool imaging (procedure codes 4/I/T-78472, 4/I/T-78473, 4/I/T-78481, 4/I/T-78483, 4/I/T-78494, and 4/I/T-78496) is a covered benefit for the following diagnosis codes:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3526</td>
<td>Multiple cranial nerve palsies</td>
</tr>
<tr>
<td>3940</td>
<td>Mitral stenosis</td>
</tr>
<tr>
<td>3941</td>
<td>Rheumatic mitral insufficiency</td>
</tr>
<tr>
<td>3942</td>
<td>Mitral stenosis with insufficiency</td>
</tr>
<tr>
<td>3949</td>
<td>Other and unspecified mitral valve diseases</td>
</tr>
<tr>
<td>3950</td>
<td>Rheumatic aortic stenosis</td>
</tr>
<tr>
<td>3951</td>
<td>Rheumatic aortic insufficiency</td>
</tr>
<tr>
<td>3952</td>
<td>Rheumatic aortic stenosis with insufficiency</td>
</tr>
<tr>
<td>3959</td>
<td>Other and unspecified rheumatic aortic diseases</td>
</tr>
<tr>
<td>3960</td>
<td>Mitral valve stenosis and aortic valve stenosis</td>
</tr>
<tr>
<td>3961</td>
<td>Mitral valve stenosis and aortic valve insufficiency</td>
</tr>
<tr>
<td>3962</td>
<td>Mitral valve insufficiency and aortic valve stenosis</td>
</tr>
<tr>
<td>3963</td>
<td>Mitral valve insufficiency and aortic valve insufficiency</td>
</tr>
<tr>
<td>3968</td>
<td>Multiple involvement of mitral and aortic valves</td>
</tr>
<tr>
<td>3969</td>
<td>Mitral and aortic valve diseases, unspecified</td>
</tr>
<tr>
<td>3970</td>
<td>Diseases of tricuspid valve</td>
</tr>
<tr>
<td>3971</td>
<td>Rheumatic diseases of pulmonary valve</td>
</tr>
<tr>
<td>3979</td>
<td>Rheumatic diseases of endocardium, valve unspecified</td>
</tr>
<tr>
<td>41000</td>
<td>Acute myocardial infarction of anterolateral wall, episode of care unspecified</td>
</tr>
<tr>
<td>41001</td>
<td>Acute myocardial infarction of anterolateral wall, initial episode of care</td>
</tr>
<tr>
<td>41002</td>
<td>Acute myocardial infarction of anterolateral wall, subsequent episode of care</td>
</tr>
<tr>
<td>41010</td>
<td>Acute myocardial infarction of other anterior wall, episode of care unspecified</td>
</tr>
<tr>
<td>41011</td>
<td>Acute myocardial infarction of other anterior wall, initial episode of care</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>41012</td>
<td>Acute myocardial infarction of other anterior wall, subsequent episode of care</td>
</tr>
<tr>
<td>41020</td>
<td>Acute myocardial infarction of inferolateral wall, episode of care unspecified</td>
</tr>
<tr>
<td>41021</td>
<td>Acute myocardial infarction of inferolateral wall, initial episode of care</td>
</tr>
<tr>
<td>41022</td>
<td>Acute myocardial infarction of inferolateral wall, subsequent episode of care</td>
</tr>
<tr>
<td>41030</td>
<td>Acute myocardial infarction of inferoposterior wall, episode of care unspecified</td>
</tr>
<tr>
<td>41031</td>
<td>Acute myocardial infarction of inferoposterior wall, initial episode of care</td>
</tr>
<tr>
<td>41032</td>
<td>Acute myocardial infarction of inferoposterior wall, subsequent episode of care</td>
</tr>
<tr>
<td>41040</td>
<td>Acute myocardial infarction of other inferior wall, episode of care unspecified</td>
</tr>
<tr>
<td>41041</td>
<td>Acute myocardial infarction of other inferior wall, initial episode of care</td>
</tr>
<tr>
<td>41042</td>
<td>Acute myocardial infarction of other inferior wall, subsequent episode of care</td>
</tr>
<tr>
<td>41050</td>
<td>Acute myocardial infarction of other lateral wall, episode of care unspecified</td>
</tr>
<tr>
<td>41051</td>
<td>Acute myocardial infarction of other lateral wall, initial episode of care</td>
</tr>
<tr>
<td>41052</td>
<td>Acute myocardial infarction of other lateral wall, subsequent episode of care</td>
</tr>
<tr>
<td>41060</td>
<td>True posterior wall infarction, episode of care unspecified</td>
</tr>
<tr>
<td>41061</td>
<td>True posterior wall infarction, initial episode of care</td>
</tr>
<tr>
<td>41062</td>
<td>True posterior wall infarction, subsequent episode of care</td>
</tr>
<tr>
<td>41070</td>
<td>Subendocardial infarction, episode of care unspecified</td>
</tr>
<tr>
<td>41071</td>
<td>Subendocardial infarction, initial episode of care</td>
</tr>
<tr>
<td>41072</td>
<td>Subendocardial infarction, subsequent episode of care</td>
</tr>
<tr>
<td>41080</td>
<td>Acute myocardial infarction of other specified sites, episode of care unspecified</td>
</tr>
<tr>
<td>41081</td>
<td>Acute myocardial infarction of other specified sites, initial episode of care</td>
</tr>
<tr>
<td>41082</td>
<td>Acute myocardial infarction of other specified sites, subsequent episode of care</td>
</tr>
<tr>
<td>41090</td>
<td>Acute myocardial infarction of unspecified site, episode of care unspecified</td>
</tr>
<tr>
<td>41091</td>
<td>Acute myocardial infarction of unspecified site, initial episode of care</td>
</tr>
<tr>
<td>41092</td>
<td>Acute myocardial infarction of unspecified site, subsequent episode of care</td>
</tr>
<tr>
<td>4110</td>
<td>Postmyocardial infarction syndrome</td>
</tr>
<tr>
<td>4111</td>
<td>Intermediate coronary syndrome</td>
</tr>
<tr>
<td>41181</td>
<td>Other acute and subacute forms of ischemic heart disease, acute ischemic heart disease without myocardial infarction</td>
</tr>
<tr>
<td>41189</td>
<td>Other acute and subacute forms of ischemic heart disease, other</td>
</tr>
<tr>
<td>412</td>
<td>Old myocardial infarction</td>
</tr>
<tr>
<td>4130</td>
<td>Angina decubitus</td>
</tr>
<tr>
<td>4131</td>
<td>Prinzmetal angina</td>
</tr>
<tr>
<td>4139</td>
<td>Other and unspecified angina pectoris</td>
</tr>
<tr>
<td>41400</td>
<td>Coronary atherosclerosis of unspecified type of vessel, native or graft</td>
</tr>
<tr>
<td>41401</td>
<td>Coronary atherosclerosis of native coronary artery</td>
</tr>
<tr>
<td>41402</td>
<td>Coronary atherosclerosis of autologous vein bypass graft</td>
</tr>
<tr>
<td>41403</td>
<td>Coronary atherosclerosis of nonautologous biological bypass graft</td>
</tr>
<tr>
<td>41404</td>
<td>Coronary atherosclerosis of artery bypass graft</td>
</tr>
<tr>
<td>41405</td>
<td>Coronary atherosclerosis of unspecified bypass graft</td>
</tr>
<tr>
<td>41406</td>
<td>Coronary atherosclerosis of native coronary artery of transplanted heart</td>
</tr>
<tr>
<td>41407</td>
<td>Coronary atherosclerosis, of bypass graft (artery) (vein) of transplanted heart</td>
</tr>
<tr>
<td>41410</td>
<td>Aneurysm of heart (wall)</td>
</tr>
<tr>
<td>41411</td>
<td>Aneurysm of coronary vessels</td>
</tr>
<tr>
<td>41412</td>
<td>Dissection of coronary artery</td>
</tr>
<tr>
<td>41419</td>
<td>Other aneurysm of heart</td>
</tr>
<tr>
<td>4148</td>
<td>Other specified forms of chronic ischemic heart disease</td>
</tr>
<tr>
<td>4149</td>
<td>Chronic ischemic heart disease, unspecified</td>
</tr>
<tr>
<td>4150</td>
<td>Acute cor pulmonale</td>
</tr>
<tr>
<td>41511</td>
<td>Iatrogenic pulmonary embolism and infarction</td>
</tr>
<tr>
<td>41519</td>
<td>Other pulmonary embolism and infarction</td>
</tr>
<tr>
<td>4160</td>
<td>Primary pulmonary hypertension</td>
</tr>
<tr>
<td>4161</td>
<td>Kyphoscoliotic heart disease</td>
</tr>
<tr>
<td>4168</td>
<td>Other chronic pulmonary heart diseases</td>
</tr>
<tr>
<td>4169</td>
<td>Chronic pulmonary heart disease, unspecified</td>
</tr>
<tr>
<td>4170</td>
<td>Arteriovenous fistula of pulmonary vessels</td>
</tr>
<tr>
<td>4171</td>
<td>Aneurysm of pulmonary artery</td>
</tr>
<tr>
<td>4178</td>
<td>Other specified diseases of pulmonary circulation</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------------------------------------------</td>
</tr>
<tr>
<td>4179</td>
<td>Unspecified disease of pulmonary circulation</td>
</tr>
<tr>
<td>4200</td>
<td>Acute pericarditis in diseases classified elsewhere</td>
</tr>
<tr>
<td>42090</td>
<td>Acute pericarditis, unspecified</td>
</tr>
<tr>
<td>42091</td>
<td>Acute idiopathic pericarditis</td>
</tr>
<tr>
<td>42099</td>
<td>Other acute pericarditis</td>
</tr>
<tr>
<td>4210</td>
<td>Acute and subacute bacterial endocarditis</td>
</tr>
<tr>
<td>4211</td>
<td>Acute and subacute infective endocarditis in</td>
</tr>
<tr>
<td></td>
<td>diseases classified elsewhere</td>
</tr>
<tr>
<td>4219</td>
<td>Acute endocarditis, unspecified</td>
</tr>
<tr>
<td>4220</td>
<td>Acute myocarditis in diseases classified elsewhere</td>
</tr>
<tr>
<td>42290</td>
<td>Acute myocarditis, unspecified</td>
</tr>
<tr>
<td>42291</td>
<td>Idiopathic myocarditis</td>
</tr>
<tr>
<td>42292</td>
<td>Septic myocarditis</td>
</tr>
<tr>
<td>42293</td>
<td>Toxic myocarditis</td>
</tr>
<tr>
<td>42299</td>
<td>Other acute myocarditis</td>
</tr>
<tr>
<td>4230</td>
<td>Hemopericardium</td>
</tr>
<tr>
<td>4231</td>
<td>Adhesive pericarditis</td>
</tr>
<tr>
<td>4232</td>
<td>Constrictive pericarditis</td>
</tr>
<tr>
<td>4238</td>
<td>Other specified diseases of pericardium</td>
</tr>
<tr>
<td>4239</td>
<td>Unspecified disease of pericardium</td>
</tr>
<tr>
<td>4240</td>
<td>Mitral valve disorders</td>
</tr>
<tr>
<td>4241</td>
<td>Aortic valve disorder</td>
</tr>
<tr>
<td>4242</td>
<td>Tricuspid valve disorders, specified as nonrheumatic</td>
</tr>
<tr>
<td>4243</td>
<td>Pulmonary valve disorders</td>
</tr>
<tr>
<td>42490</td>
<td>Endocarditis, valve unspecified, unspecified cause</td>
</tr>
<tr>
<td>42491</td>
<td>Endocarditis in diseases classified elsewhere</td>
</tr>
<tr>
<td>42499</td>
<td>Other endocarditis, valve unspecified</td>
</tr>
<tr>
<td>4250</td>
<td>Endomyocardial fibrosis</td>
</tr>
<tr>
<td>4251</td>
<td>Hypertrophic obstructive cardiomyopathy</td>
</tr>
<tr>
<td>4252</td>
<td>Obscure cardiomyopathy of africa</td>
</tr>
<tr>
<td>4253</td>
<td>Endocardial fibroelastosis</td>
</tr>
<tr>
<td>4254</td>
<td>Other primary cardiomyopathies</td>
</tr>
<tr>
<td>4255</td>
<td>Alcoholic cardiomyopathy</td>
</tr>
<tr>
<td>4257</td>
<td>Nutritional and metabolic cardiomyopathy</td>
</tr>
<tr>
<td>4258</td>
<td>Cardiomyopathy in other diseases classified elsewhere</td>
</tr>
<tr>
<td>4259</td>
<td>Secondary cardiomyopathy, unspecified</td>
</tr>
<tr>
<td>4260</td>
<td>Atrioventricular block, complete</td>
</tr>
<tr>
<td>42610</td>
<td>Atrioventricular block, unspecified</td>
</tr>
<tr>
<td>42611</td>
<td>First degree atrioventricular block</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>42612</td>
<td>Mobitz (type) II atrioventricular block</td>
</tr>
<tr>
<td>42613</td>
<td>Other second degree atrioventricular block</td>
</tr>
<tr>
<td>4262</td>
<td>Left bundle branch hemiblock</td>
</tr>
<tr>
<td>4263</td>
<td>Other left bundle branch block</td>
</tr>
<tr>
<td>4264</td>
<td>Right bundle branch block</td>
</tr>
<tr>
<td>42650</td>
<td>Bundle branch block, unspecified</td>
</tr>
<tr>
<td>42651</td>
<td>Right bundle branch block and left posterior</td>
</tr>
<tr>
<td></td>
<td>fascicular block</td>
</tr>
<tr>
<td>42652</td>
<td>Right bundle branch block and left anterior</td>
</tr>
<tr>
<td></td>
<td>fascicular block</td>
</tr>
<tr>
<td>42653</td>
<td>Other bilateral bundle branch block</td>
</tr>
<tr>
<td>42654</td>
<td>Trifascicular block</td>
</tr>
<tr>
<td>4266</td>
<td>Other heart block</td>
</tr>
<tr>
<td>4267</td>
<td>Anomalous atrioventricular excitation</td>
</tr>
<tr>
<td>42681</td>
<td>Lown-ganong-levine syndrome</td>
</tr>
<tr>
<td>42682</td>
<td>Long QT syndrome</td>
</tr>
<tr>
<td>42689</td>
<td>Other specified conduction disorders</td>
</tr>
<tr>
<td>4269</td>
<td>Conduction disorder, unspecified</td>
</tr>
<tr>
<td>4270</td>
<td>Paroxysmal supraventricular tachycardia</td>
</tr>
<tr>
<td>4271</td>
<td>Paroxysmal ventricular tachycardia</td>
</tr>
<tr>
<td>4272</td>
<td>Paroxysmal tachycardia, unspecified</td>
</tr>
<tr>
<td>42731</td>
<td>Atrial fibrillation</td>
</tr>
<tr>
<td>42732</td>
<td>Atrial flutter</td>
</tr>
<tr>
<td>42741</td>
<td>Ventricular fibrillation</td>
</tr>
<tr>
<td>42742</td>
<td>Ventricular flutter</td>
</tr>
<tr>
<td>4275</td>
<td>Cardiac arrest</td>
</tr>
<tr>
<td>42760</td>
<td>Premature beats, unspecified</td>
</tr>
<tr>
<td>42761</td>
<td>Supraventricular premature beats</td>
</tr>
<tr>
<td>42769</td>
<td>Other premature beats</td>
</tr>
<tr>
<td>42781</td>
<td>Sinoatrial node dysfunction</td>
</tr>
<tr>
<td>42789</td>
<td>Other specified cardiac dysrhythmias</td>
</tr>
<tr>
<td>4279</td>
<td>Cardiac dysrhythmia, unspecified</td>
</tr>
<tr>
<td>4280</td>
<td>Congestive heart failure</td>
</tr>
<tr>
<td>4281</td>
<td>Left heart failure</td>
</tr>
<tr>
<td>42820</td>
<td>Unspecified systolic heart failure</td>
</tr>
<tr>
<td>42821</td>
<td>Acute systolic heart failure</td>
</tr>
<tr>
<td>42822</td>
<td>Chronic systolic heart failure</td>
</tr>
<tr>
<td>42823</td>
<td>Acute on chronic systolic heart failure</td>
</tr>
<tr>
<td>42830</td>
<td>Unspecified diastolic heart failure</td>
</tr>
<tr>
<td>42831</td>
<td>Acute diastolic heart failure</td>
</tr>
<tr>
<td>42832</td>
<td>Chronic diastolic heart failure</td>
</tr>
<tr>
<td>42833</td>
<td>Acute on chronic diastolic heart failure</td>
</tr>
<tr>
<td>42840</td>
<td>Unspecified combined systolic and diastolic heart</td>
</tr>
<tr>
<td></td>
<td>failure</td>
</tr>
</tbody>
</table>
MRI—Additional High Dose Injection of Contrast Material

MRI, additional high dose injection of contrast material, (for example, procedure code 9-A4643, is a benefit of the Texas Medicaid Program).

A diagnostic technique has been developed in which an MRI of the central nervous system is first performed without contrast material; a second is performed with a standard dosage of contrast material; and a third is performed with a double dose of contrast material. Procedure code 9-A4643 is used for only the high dose injection given for the third MRI. The third MRI itself is not covered. Payment of high dose contrast material is limited to procedure codes 4-70553, 4-72156, 4-72157, and 4-72158. High dose contrast material administered in the inpatient setting (POS 3) is included in the DRG reimbursement, and no separate payment is made.

When submitting a claim for procedure code 9-A4643, the name of the drug and the number of cc or mL used must be indicated. If not, it will deny.

### Gamma Knife Radiosurgery

The following diagnosis codes are payable for F61793:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1700</td>
<td>Malignant neoplasm of bones of skull and face, except mandible</td>
</tr>
<tr>
<td>1701</td>
<td>Malignant neoplasm of mandible</td>
</tr>
<tr>
<td>1702</td>
<td>Malignant neoplasm of vertebral column, excluding sacrum and coccyx</td>
</tr>
<tr>
<td>1703</td>
<td>Malignant neoplasm of ribs, sternum, and clavicle</td>
</tr>
<tr>
<td>1704</td>
<td>Malignant neoplasm of scapula and long bones of upper limb</td>
</tr>
<tr>
<td>1705</td>
<td>Malignant neoplasm of short bones of upper limb</td>
</tr>
<tr>
<td>1706</td>
<td>Malignant neoplasm of pelvic bones, sacrum, and coccyx</td>
</tr>
<tr>
<td>1707</td>
<td>Malignant neoplasm of long bones of lower limb</td>
</tr>
<tr>
<td>1708</td>
<td>Malignant neoplasm of short bones of lower limb</td>
</tr>
<tr>
<td>1709</td>
<td>Malignant neoplasm of bone and articular cartilage, site unspecified</td>
</tr>
<tr>
<td>1710</td>
<td>Malignant neoplasm of connective and other soft tissue of head, face, and neck</td>
</tr>
<tr>
<td>1910</td>
<td>Malignant neoplasm of cerebrum, except lobes and ventricles</td>
</tr>
<tr>
<td>1911</td>
<td>Malignant neoplasm of frontal lobe</td>
</tr>
<tr>
<td>1912</td>
<td>Malignant neoplasm of temporal lobe</td>
</tr>
<tr>
<td>1913</td>
<td>Malignant neoplasm of parietal lobe</td>
</tr>
<tr>
<td>1914</td>
<td>Malignant neoplasm of occipital lobe</td>
</tr>
<tr>
<td>1915</td>
<td>Malignant neoplasm of ventricles</td>
</tr>
<tr>
<td>1916</td>
<td>Malignant neoplasm of cerebellum NOS</td>
</tr>
<tr>
<td>1917</td>
<td>Malignant neoplasm of brain stem</td>
</tr>
<tr>
<td>1918</td>
<td>Malignant neoplasm of other parts of brain</td>
</tr>
<tr>
<td>1919</td>
<td>Malignant neoplasm of brain, unspecified site</td>
</tr>
<tr>
<td>1944</td>
<td>Malignant neoplasm of pineal gland</td>
</tr>
<tr>
<td>1983</td>
<td>Secondary malignant neoplasm of brain and spinal cord</td>
</tr>
<tr>
<td>2251</td>
<td>Benign neoplasm of cranial nerves</td>
</tr>
<tr>
<td>2252</td>
<td>Benign neoplasm of cerebral meninges</td>
</tr>
<tr>
<td>2254</td>
<td>Benign neoplasm of spinal meninges</td>
</tr>
</tbody>
</table>
Hospital (Medical/Surgical Acute Care Facility)

25.3.3.20 Hospital Radiation Therapy Services

Outpatient radiation therapy is limited to a maximum of five facility services every seven days beginning with the first date of service.

**Important:** Take-home drugs given during the course of therapy can be reimbursed separately through the Vendor Drug Program.

Freestanding radiation therapy facilities (specialty 98) and outpatient hospitals are reimbursed only for the technical component (TOS T) for services rendered in POS 5 for the services listed in the following procedure code tables.

The following radiation therapy services provided in an outpatient setting are allowed only once per day unless documentation of medical necessity supports the need for repeated services: therapeutic radiation treatment planning, therapeutic radiology simulation-aided field setting, teletherapy, brachytherapy isodose calculation, treatment devices, proton beam delivery/treatment, intra-cavity radiation source application, interstitial radiation source application, remote afterloading high intensity brachytherapy, radiation treatment delivery, localization, and radioisotope therapy.

**Clinical Treatment Planning**

**Procedure Codes**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>T-77280</td>
</tr>
<tr>
<td>T-77285</td>
</tr>
<tr>
<td>T-77290</td>
</tr>
<tr>
<td>T-77295</td>
</tr>
</tbody>
</table>

Refer to: “Physician” on page 36-1 for further radiation therapy guidelines.

**Medical Radiation Physics, Dosimetry, Treatment Devices, and Special Services**

**Procedure Codes**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>T-77300</td>
</tr>
<tr>
<td>T-77305</td>
</tr>
<tr>
<td>T-77310</td>
</tr>
<tr>
<td>T-77315</td>
</tr>
<tr>
<td>T-77326</td>
</tr>
<tr>
<td>T-77327</td>
</tr>
<tr>
<td>T-77328</td>
</tr>
<tr>
<td>T-77332</td>
</tr>
<tr>
<td>T-77333</td>
</tr>
<tr>
<td>T-77334</td>
</tr>
<tr>
<td>T-77399</td>
</tr>
</tbody>
</table>

**Clinical Brachytherapy**

**Procedure Codes**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>T-77781</td>
</tr>
<tr>
<td>T-77782</td>
</tr>
<tr>
<td>T-77783</td>
</tr>
<tr>
<td>T-77784</td>
</tr>
<tr>
<td>T-77789</td>
</tr>
<tr>
<td>T-77799</td>
</tr>
</tbody>
</table>

**Radiation Treatment Delivery/Port Films**

**Procedure Codes**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>T-77401</td>
</tr>
<tr>
<td>T-77402</td>
</tr>
<tr>
<td>T-77403</td>
</tr>
<tr>
<td>T-77404</td>
</tr>
<tr>
<td>T-77406</td>
</tr>
<tr>
<td>T-77407</td>
</tr>
<tr>
<td>T-77408</td>
</tr>
<tr>
<td>T-77409</td>
</tr>
<tr>
<td>T-77411</td>
</tr>
<tr>
<td>T-77412</td>
</tr>
<tr>
<td>T-77413</td>
</tr>
<tr>
<td>T-77414</td>
</tr>
<tr>
<td>T-77416</td>
</tr>
<tr>
<td>T-77417</td>
</tr>
<tr>
<td>T-77421</td>
</tr>
<tr>
<td>T-77422</td>
</tr>
<tr>
<td>T-77423</td>
</tr>
</tbody>
</table>

**Contrast Materials/Radiopharmaceuticals**

Reimbursement for radiological procedures, such as MRI or CT, with descriptions that specify with contrast, include payment for high osmolar, LOCM and paramagnetic contrast materials. These contrast materials will not be reimbursed separately.

Radiopharmaceuticals, when used for therapeutic treatment, may be considered for separate reimbursement.

The following procedure codes may be billed for therapeutic radiopharmaceuticals:

**Procedure Codes**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4-79403</td>
</tr>
<tr>
<td>9-A9517</td>
</tr>
<tr>
<td>9-A9530</td>
</tr>
<tr>
<td>9-A9532</td>
</tr>
<tr>
<td>9-A9543</td>
</tr>
<tr>
<td>9-A9545</td>
</tr>
<tr>
<td>9-A9699</td>
</tr>
</tbody>
</table>

The following services are not benefits of the Texas Medicaid Program:

**Procedure Codes**

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-77321</td>
</tr>
<tr>
<td>6-77331</td>
</tr>
<tr>
<td>6-77336</td>
</tr>
<tr>
<td>6-77370</td>
</tr>
<tr>
<td>6-77470</td>
</tr>
<tr>
<td>6-77600</td>
</tr>
<tr>
<td>6-77620</td>
</tr>
<tr>
<td>6-77790</td>
</tr>
</tbody>
</table>

Procedure code T-77295, is payable to freestanding therapy facilities (specialty 98) and outpatient hospital setting (POS 5). Reimbursement for freestanding radiation treatment centers is at 28.32 relative value units (RVUs). Services provided in the outpatient hospital setting are paid at the TMRM. This code is payable on Medicare crossover claims. Procedure code T-77295 is payable once per day. Procedure codes T-77305, T-77310, and T-77315, are denied when billed on the same day as procedure code T-77295.

Texas Medicaid Program benefits include payment for the technical portion of radiation therapy services provided in an inpatient setting. Covered services include clinical
treatment planning and management and clinical brachytherapy. Hospitals use revenue code B-333, Radiation therapy, on the HCFA-1450 (UB-92) claim form when submitting charges for these services.

25.3.3.21 Hyperbaric Oxygen Therapy (HBO)

Hyperbaric oxygen therapy is a type of therapy that is intended to increase the environmental oxygen pressure to promote the movement of oxygen from the environment into the body tissues by means of pressurization that is greater than atmospheric pressure. Such treatment is performed in specially constructed hyperbaric chambers, which may hold one or several patients.

Note: Although oxygen may be administered by mask, cannula, or tube in addition to the hyperbaric treatment, the use of oxygen by mask, etc., or applied topically is not considered hyperbaric treatment in itself.

Hyperbaric oxygen therapy will be limited to one session per day, any provider using procedure code 1-99183.

Outpatient hospital clinics and hospital-based rural health centers must use revenue code B-413, Respiratory services, hyperbaric oxygen therapy, (quantity of one) for reimbursement of the technical component.

The FDA-approved indications for the hyperbaric oxygen chamber (therapy) in accordance with the guidelines established by the Undersea and Hyperbaric Medical Society are as follows:

- Air or gas embolism
- Carbon monoxide/smoke inhalation
- Compromised skin grafts and flaps
- Crush injuries/acute traumatic ischemias
- Decompression sickness
- Enhanced healing in selected problem wounds
- Exceptional blood loss (anemia)
- Gas gangrene (clostridial myonecrosis)
- Intracranial abscess
- Necrotizing soft tissue infections
- Radiation tissue damage (osteoradionecrosis)
- Refractory osteomyelitis
- Thermal burns

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of air or gas embolism the following diagnosis codes should be used:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6396</td>
<td>Embolism following abortion or ectopic and molar pregnancies</td>
</tr>
<tr>
<td>67300</td>
<td>Obstetrical air embolism, unspecified as to episode of care</td>
</tr>
</tbody>
</table>

Effective for dates of service on or after April 1, 2004, diagnosis code 78552, Septic shock, will be payable for hyperbaric oxygen therapy.

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of carbon monoxide/smoke inhalation use diagnosis code 986, Carbon monoxide poisoning and smoke inhalation.

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of compromised skin grafts and flaps the following diagnosis codes should be used:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99652</td>
<td>Mechanical complication of prosthetic graft of other tissue, not elsewhere classified</td>
</tr>
<tr>
<td>99660</td>
<td>Infection and inflammatory reaction due to unspecified device, implant, and graft</td>
</tr>
<tr>
<td>99661</td>
<td>Infection and inflammatory reaction due to cardiac device, implant, and graft</td>
</tr>
<tr>
<td>99662</td>
<td>Infection and inflammatory reaction due to other vascular device, implant, and graft</td>
</tr>
<tr>
<td>99663</td>
<td>Infection and inflammatory reaction due to nervous system device, implant, and graft</td>
</tr>
<tr>
<td>99664</td>
<td>Infection and inflammatory reaction due to indwelling urinary catheter</td>
</tr>
<tr>
<td>99665</td>
<td>Infection and inflammatory reaction due to other genitourinary device, implant, and graft</td>
</tr>
<tr>
<td>99666</td>
<td>Infection and inflammatory reaction due to internal joint prosthesis</td>
</tr>
<tr>
<td>99667</td>
<td>Infection and inflammatory reaction due to other internal orthopedic device, implant, and graft</td>
</tr>
<tr>
<td>99668</td>
<td>Infection and inflammatory reaction due to peritoneal dialysis catheter</td>
</tr>
<tr>
<td>99669</td>
<td>Infection and inflammatory reaction due to other internal prosthetic device, implant, and graft</td>
</tr>
<tr>
<td>99670</td>
<td>Other complications due to unspecified device, implant, and graft</td>
</tr>
<tr>
<td>99671</td>
<td>Other complications due to heart valve prosthesis</td>
</tr>
<tr>
<td>99672</td>
<td>Other complications due to other cardiac device, implant, and graft</td>
</tr>
<tr>
<td>99673</td>
<td>Other complications due to renal dialysis device, implant, and graft</td>
</tr>
<tr>
<td>99674</td>
<td>Other complications due to other vascular device, implant, and graft</td>
</tr>
</tbody>
</table>
When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *crush injuries/acute traumatic ischemias* the following diagnosis codes should be used:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99675</td>
<td>Other complications due to nervous system device, implant, and graft</td>
</tr>
<tr>
<td>99676</td>
<td>Other complications due to genitourinary device, implant, and graft</td>
</tr>
<tr>
<td>99677</td>
<td>Other complications due to internal joint prosthesis</td>
</tr>
<tr>
<td>99678</td>
<td>Other complications due to other internal orthopedic device, implant, and graft</td>
</tr>
<tr>
<td>99679</td>
<td>Other complications due to other internal prosthetic device, implant, and graft</td>
</tr>
<tr>
<td>V423</td>
<td>Skin replaced by transplant</td>
</tr>
</tbody>
</table>

### Diagnosis Codes

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>8690</td>
<td>Internal injury to unspecified or ill-defined organs without mention of open wound into cavity</td>
</tr>
<tr>
<td>8691</td>
<td>Internal injury to unspecified or ill-defined organs with open wound into cavity</td>
</tr>
<tr>
<td>8871</td>
<td>Traumatic amputation of arm and hand (complete) (partial), unilateral, below elbow, complicated</td>
</tr>
<tr>
<td>8873</td>
<td>Traumatic amputation of arm and hand (complete) (partial), unilateral, at or above elbow, complicated</td>
</tr>
<tr>
<td>8875</td>
<td>Traumatic amputation of arm and hand (complete) (partial), unilateral, level not specified, complicated</td>
</tr>
<tr>
<td>8877</td>
<td>Traumatic amputation of arm and hand (complete) (partial), bilateral (any level), complicated</td>
</tr>
<tr>
<td>8971</td>
<td>Traumatic amputation of leg(s) (complete) (partial), unilateral, below knee, complicated</td>
</tr>
<tr>
<td>8973</td>
<td>Traumatic amputation of leg(s) (complete) (partial), unilateral, at or above knee, complicated</td>
</tr>
<tr>
<td>8975</td>
<td>Traumatic amputation of leg(s) (complete) (partial), unilateral, level not specified, complicated</td>
</tr>
<tr>
<td>8977</td>
<td>Traumatic amputation of leg(s) (complete) (partial), bilateral (any level), complicated</td>
</tr>
<tr>
<td>9251</td>
<td>Crushing injury of face and scalp</td>
</tr>
<tr>
<td>9252</td>
<td>Crushing injury of neck</td>
</tr>
<tr>
<td>9260</td>
<td>Crushing injury of external genitalia</td>
</tr>
<tr>
<td>92611</td>
<td>Crushing injury of back</td>
</tr>
<tr>
<td>92612</td>
<td>Crushing injury of buttock</td>
</tr>
<tr>
<td>92619</td>
<td>Crushing injury of other specified sites of trunk</td>
</tr>
<tr>
<td>9268</td>
<td>Crushing injury of multiple sites of trunk</td>
</tr>
<tr>
<td>9269</td>
<td>Crushing injury of unspecified site of trunk</td>
</tr>
<tr>
<td>92700</td>
<td>Crushing injury of shoulder region</td>
</tr>
<tr>
<td>92701</td>
<td>Crushing injury of scapular region</td>
</tr>
<tr>
<td>92702</td>
<td>Crushing injury of axillary region</td>
</tr>
<tr>
<td>92703</td>
<td>Crushing injury of upper arm</td>
</tr>
<tr>
<td>92709</td>
<td>Crushing injury of multiple sites of upper arm</td>
</tr>
<tr>
<td>92710</td>
<td>Crushing injury of forearm</td>
</tr>
<tr>
<td>92711</td>
<td>Crushing injury of elbow</td>
</tr>
<tr>
<td>92720</td>
<td>Crushing injury of hand(s)</td>
</tr>
<tr>
<td>92721</td>
<td>Crushing injury of wrist</td>
</tr>
<tr>
<td>9273</td>
<td>Crushing injury of finger(s)</td>
</tr>
<tr>
<td>9277</td>
<td>Crushing injury of multiple sites of upper limb</td>
</tr>
<tr>
<td>9279</td>
<td>Crushing injury of unspecified site of upper limb</td>
</tr>
<tr>
<td>92800</td>
<td>Crushing injury of thigh</td>
</tr>
<tr>
<td>92801</td>
<td>Crushing injury of hip</td>
</tr>
<tr>
<td>92810</td>
<td>Crushing injury of lower leg</td>
</tr>
<tr>
<td>92811</td>
<td>Crushing injury of knee</td>
</tr>
<tr>
<td>92820</td>
<td>Crushing injury of foot</td>
</tr>
<tr>
<td>92821</td>
<td>Crushing injury of ankle</td>
</tr>
<tr>
<td>9283</td>
<td>Crushing injury of toe(s)</td>
</tr>
<tr>
<td>9288</td>
<td>Crushing injury of multiple sites of lower limb</td>
</tr>
<tr>
<td>9289</td>
<td>Crushing injury of unspecified site of lower limb</td>
</tr>
<tr>
<td>9290</td>
<td>Crushing injury of multiple sites, not elsewhere classified</td>
</tr>
<tr>
<td>9299</td>
<td>Crushing injury of unspecified site</td>
</tr>
<tr>
<td>99690</td>
<td>Complications of unspecified reattached extremity</td>
</tr>
<tr>
<td>99691</td>
<td>Complications of reattached forearm</td>
</tr>
<tr>
<td>99692</td>
<td>Complications of reattached hand</td>
</tr>
<tr>
<td>99693</td>
<td>Complications of reattached finger(s)</td>
</tr>
<tr>
<td>99694</td>
<td>Complications of reattached upper extremity, other and unspecified</td>
</tr>
<tr>
<td>99695</td>
<td>Complication of reattached foot and toe(s)</td>
</tr>
<tr>
<td>99696</td>
<td>Complication of reattached lower extremity, other and unspecified</td>
</tr>
<tr>
<td>99699</td>
<td>Complication of other specified reattached body part</td>
</tr>
</tbody>
</table>
When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *decompression sickness* use diagnosis code 9933, Caisson disease.

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *enhanced healing in selected problem wounds* the following diagnosis codes should be used:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25070</td>
<td>Diabetes with peripheral circulatory disorders, type II or unspecified type, not stated as uncontrolled</td>
</tr>
<tr>
<td>25071</td>
<td>Diabetes with peripheral circulatory disorders, type I (juvenile type), not stated as uncontrolled</td>
</tr>
<tr>
<td>25072</td>
<td>Diabetes with peripheral circulatory disorders, type II or unspecified type, uncontrolled</td>
</tr>
<tr>
<td>25073</td>
<td>Diabetes with peripheral circulatory disorders, type I (juvenile type), uncontrolled</td>
</tr>
<tr>
<td>44023</td>
<td>Atherosclerosis of native arteries of the extremities with ulceration</td>
</tr>
<tr>
<td>44024</td>
<td>Atherosclerosis of native arteries of the extremities with gangrene</td>
</tr>
<tr>
<td>44381</td>
<td>Peripheral angiopathy in diseases classified elsewhere</td>
</tr>
<tr>
<td>44382</td>
<td>Erythromelalgia</td>
</tr>
<tr>
<td>44389</td>
<td>Other peripheral vascular disease</td>
</tr>
<tr>
<td>4439</td>
<td>Peripheral vascular disease, unspecified</td>
</tr>
<tr>
<td>4540</td>
<td>Varicose veins of lower extremities with ulcer</td>
</tr>
<tr>
<td>4542</td>
<td>Varicose veins of lower extremities with ulcer and inflammation</td>
</tr>
<tr>
<td>68600</td>
<td>Pyoderma, unspecified</td>
</tr>
<tr>
<td>68601</td>
<td>Pyoderma gangrenosum</td>
</tr>
<tr>
<td>68609</td>
<td>Other pyoderma</td>
</tr>
<tr>
<td>70700</td>
<td>Decubitus ulcer, unspecified site</td>
</tr>
<tr>
<td>70701</td>
<td>Decubitus ulcer, elbow</td>
</tr>
<tr>
<td>70702</td>
<td>Decubitus ulcer, upper back</td>
</tr>
<tr>
<td>70703</td>
<td>Decubitus ulcer, lower back</td>
</tr>
<tr>
<td>70704</td>
<td>Decubitus ulcer, hip</td>
</tr>
<tr>
<td>70705</td>
<td>Decubitus ulcer, buttock</td>
</tr>
<tr>
<td>70706</td>
<td>Decubitus ulcer, ankle</td>
</tr>
<tr>
<td>70707</td>
<td>Decubitus ulcer, heel</td>
</tr>
<tr>
<td>70709</td>
<td>Decubitus ulcer, other site</td>
</tr>
<tr>
<td>70710</td>
<td>Unspecified ulcer of lower limb</td>
</tr>
<tr>
<td>70711</td>
<td>Ulcer of thigh</td>
</tr>
<tr>
<td>70712</td>
<td>Ulcer of calf</td>
</tr>
<tr>
<td>70713</td>
<td>Ulcer of ankle</td>
</tr>
<tr>
<td>70714</td>
<td>Ulcer of heel &amp; midfoot</td>
</tr>
</tbody>
</table>

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *exceptional blood loss* (anemia) the following diagnosis codes should be used:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>25071</td>
<td>Ulcer other part of foot</td>
</tr>
<tr>
<td>25072</td>
<td>Ulcer oth part low limb</td>
</tr>
<tr>
<td>25073</td>
<td>Chronic ulcer of other specified sites</td>
</tr>
<tr>
<td>7079</td>
<td>Chronic ulcer of unspecified site</td>
</tr>
<tr>
<td>9895</td>
<td>Toxic effect of venom</td>
</tr>
<tr>
<td>99859</td>
<td>Other postoperative infection</td>
</tr>
</tbody>
</table>

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *gas gangrene* (*clostridial myonecrosis*) the following diagnosis codes should be used:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2851</td>
<td>Acute post hemorrhagic anemia</td>
</tr>
<tr>
<td>78559</td>
<td>Other shock without mention of trauma</td>
</tr>
<tr>
<td>9584</td>
<td>Traumatic shock</td>
</tr>
<tr>
<td>9980</td>
<td>Postoperative shock, not elsewhere classified</td>
</tr>
</tbody>
</table>

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *necrotizing soft tissue infections* the following diagnosis codes should be used:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0383</td>
<td>Septicemia due to anaerobes</td>
</tr>
<tr>
<td>0400</td>
<td>Gas gangrene</td>
</tr>
</tbody>
</table>

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of *radiation tissue damage* (*osteoradionecrosis*) the following diagnosis codes should be used:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>73010</td>
<td>Chronic osteomyelitis, site unspecified</td>
</tr>
<tr>
<td>73011</td>
<td>Chronic osteomyelitis involving shoulder region</td>
</tr>
<tr>
<td>73012</td>
<td>Chronic osteomyelitis involving upper arm</td>
</tr>
<tr>
<td>73013</td>
<td>Chronic osteomyelitis involving forearm</td>
</tr>
<tr>
<td>73014</td>
<td>Chronic osteomyelitis involving hand</td>
</tr>
<tr>
<td>73015</td>
<td>Chronic osteomyelitis involving pelvic region and thigh</td>
</tr>
<tr>
<td>73016</td>
<td>Chronic osteomyelitis involving lower leg</td>
</tr>
</tbody>
</table>
When requesting reimbursement of hyperbaric oxygen therapy for the treatment of refractory osteomyelitis the following diagnosis codes should be used:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>73017</td>
<td>Chronic osteomyelitis involving ankle and foot</td>
</tr>
<tr>
<td>73018</td>
<td>Chronic osteomyelitis involving other specified sites</td>
</tr>
<tr>
<td>73019</td>
<td>Chronic osteomyelitis involving multiple sites</td>
</tr>
<tr>
<td>7854</td>
<td>Gangrene</td>
</tr>
<tr>
<td>9092</td>
<td>Late effect of radiation</td>
</tr>
<tr>
<td>990</td>
<td>Effects of radiation, unspecified</td>
</tr>
</tbody>
</table>

When requesting reimbursement of hyperbaric oxygen therapy for the treatment of thermal burns the following diagnosis codes should be used:

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>73000</td>
<td>Acute osteomyelitis, site unspecified</td>
</tr>
<tr>
<td>73001</td>
<td>Acute osteomyelitis involving shoulder region</td>
</tr>
<tr>
<td>73002</td>
<td>Acute osteomyelitis involving upper arm</td>
</tr>
<tr>
<td>73003</td>
<td>Acute osteomyelitis involving forearm</td>
</tr>
<tr>
<td>73004</td>
<td>Acute osteomyelitis involving hand</td>
</tr>
<tr>
<td>73005</td>
<td>Acute osteomyelitis involving pelvic region and thigh</td>
</tr>
<tr>
<td>73006</td>
<td>Acute osteomyelitis involving lower leg</td>
</tr>
<tr>
<td>73007</td>
<td>Acute osteomyelitis involving ankle and foot</td>
</tr>
<tr>
<td>73008</td>
<td>Acute osteomyelitis involving other specified sites</td>
</tr>
<tr>
<td>73009</td>
<td>Acute osteomyelitis involving multiple sites</td>
</tr>
<tr>
<td>73010</td>
<td>Chronic osteomyelitis, site unspecified</td>
</tr>
<tr>
<td>73011</td>
<td>Chronic osteomyelitis involving shoulder region</td>
</tr>
<tr>
<td>73012</td>
<td>Chronic osteomyelitis involving upper arm</td>
</tr>
<tr>
<td>73013</td>
<td>Chronic osteomyelitis involving forearm</td>
</tr>
<tr>
<td>73014</td>
<td>Chronic osteomyelitis involving hand</td>
</tr>
<tr>
<td>73015</td>
<td>Chronic osteomyelitis involving pelvic region and thigh</td>
</tr>
<tr>
<td>73016</td>
<td>Chronic osteomyelitis involving lower leg</td>
</tr>
<tr>
<td>73017</td>
<td>Chronic osteomyelitis involving ankle and foot</td>
</tr>
<tr>
<td>73018</td>
<td>Chronic osteomyelitis involving other specified sites</td>
</tr>
<tr>
<td>73019</td>
<td>Chronic osteomyelitis involving multiple sites</td>
</tr>
<tr>
<td>73020</td>
<td>Unspecified osteomyelitis, site unspecified</td>
</tr>
</tbody>
</table>

Osteomyelitis, periostitis, and other infections involving bone.
<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>94120</td>
<td>Blisters, with epidermal loss due to burn (second degree) of face and head, unspecified site</td>
</tr>
<tr>
<td>94121</td>
<td>Blisters, with epidermal loss due to burn (second degree) of ear (any part)</td>
</tr>
<tr>
<td>94122</td>
<td>Blisters, with epidermal loss due to burn (second degree) of eye (with other parts of face, head, and neck)</td>
</tr>
<tr>
<td>94123</td>
<td>Blisters, with epidermal loss due to burn (second degree) of lip(s)</td>
</tr>
<tr>
<td>94124</td>
<td>Blisters, with epidermal loss due to burn (second degree) of chin</td>
</tr>
<tr>
<td>94125</td>
<td>Blisters, with epidermal loss due to burn (second degree) of nose (septum)</td>
</tr>
<tr>
<td>94126</td>
<td>Blisters, with epidermal loss due to burn (second degree) of scalp (any part)</td>
</tr>
<tr>
<td>94127</td>
<td>Blisters, with epidermal loss due to burn (second degree) of forehead and cheek</td>
</tr>
<tr>
<td>94128</td>
<td>Blisters, with epidermal loss due to burn (second degree) of neck</td>
</tr>
<tr>
<td>94129</td>
<td>Blisters, with epidermal loss due to burn (second degree) of multiple sites (except with eye) of face, head, and neck</td>
</tr>
<tr>
<td>94130</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of unspecified site of face and head</td>
</tr>
<tr>
<td>94131</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of ear (any part)</td>
</tr>
<tr>
<td>94132</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of eye (with other parts of face, head, and neck)</td>
</tr>
<tr>
<td>94133</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of lip(s)</td>
</tr>
<tr>
<td>94134</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of chin</td>
</tr>
<tr>
<td>94135</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of nose (septum)</td>
</tr>
<tr>
<td>94136</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of scalp (any part)</td>
</tr>
<tr>
<td>94137</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of forehead and cheek</td>
</tr>
<tr>
<td>94138</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of neck</td>
</tr>
<tr>
<td>94139</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of multiple sites (except with eye) of face, head, and neck</td>
</tr>
<tr>
<td>94140</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of face and head, without mention of loss of body part</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>94141</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), without mention of loss of ear</td>
</tr>
<tr>
<td>94142</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), without mention of loss of body part</td>
</tr>
<tr>
<td>94143</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), without mention of loss of lip(s)</td>
</tr>
<tr>
<td>94144</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of chin, without mention of loss of chin</td>
</tr>
<tr>
<td>94145</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), without mention of loss of nose</td>
</tr>
<tr>
<td>94146</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), without mention of loss of scalp</td>
</tr>
<tr>
<td>94147</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, without mention of loss of forehead and cheek</td>
</tr>
<tr>
<td>94148</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of neck, without mention of loss of neck</td>
</tr>
<tr>
<td>94149</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except with eye) of face, head, and neck, without mention of loss of a body part</td>
</tr>
<tr>
<td>94150</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of face and head, unspecified site, with loss of body part</td>
</tr>
<tr>
<td>94151</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of ear (any part), with loss of ear</td>
</tr>
<tr>
<td>94152</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of eye (with other parts of face, head, and neck), with loss of a body part</td>
</tr>
<tr>
<td>94153</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of lip(s), with loss of lip(s)</td>
</tr>
<tr>
<td>94154</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of chin, with loss of chin</td>
</tr>
<tr>
<td>94155</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of nose (septum), with loss of nose</td>
</tr>
<tr>
<td>94156</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of scalp (any part), with loss of scalp</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>94157</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of forehead and cheek, with loss of forehead and cheek</td>
</tr>
<tr>
<td>94158</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of neck, with loss of neck</td>
</tr>
<tr>
<td>94159</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites (except eye) of face, head, and neck, with loss of a body part</td>
</tr>
<tr>
<td>94200</td>
<td>Burn of unspecified degree of unspecified site of trunk</td>
</tr>
<tr>
<td>94201</td>
<td>Burn of unspecified degree of breast</td>
</tr>
<tr>
<td>94202</td>
<td>Burn of unspecified degree of chest wall, excluding breast and nipple</td>
</tr>
<tr>
<td>94203</td>
<td>Burn of unspecified degree of abdominal wall</td>
</tr>
<tr>
<td>94204</td>
<td>Burn of unspecified degree of back (any part)</td>
</tr>
<tr>
<td>94205</td>
<td>Burn of unspecified degree of genitalia</td>
</tr>
<tr>
<td>94209</td>
<td>Burn of unspecified degree of other and multiple sites of trunk</td>
</tr>
<tr>
<td>94210</td>
<td>Erythema due to burn (first degree) of unspecified site of trunk</td>
</tr>
<tr>
<td>94211</td>
<td>Erythema due to burn (first degree) of breast</td>
</tr>
<tr>
<td>94212</td>
<td>Erythema due to burn (first degree) of chest wall, excluding breast and nipple</td>
</tr>
<tr>
<td>94213</td>
<td>Erythema due to burn (first degree) of abdominal wall</td>
</tr>
<tr>
<td>94214</td>
<td>Erythema due to burn (first degree) of back (any part)</td>
</tr>
<tr>
<td>94215</td>
<td>Erythema due to burn (first degree) of genitalia</td>
</tr>
<tr>
<td>94219</td>
<td>Erythema due to burn (first degree) of other and multiple sites of trunk</td>
</tr>
<tr>
<td>94220</td>
<td>Blisters with epidermal loss due to burn (second degree) of unspecified site of trunk</td>
</tr>
<tr>
<td>94221</td>
<td>Blisters with epidermal loss due to burn (second degree) of breast</td>
</tr>
<tr>
<td>94222</td>
<td>Blisters with epidermal loss due to burn (second degree) of chest wall, excluding breast and nipple</td>
</tr>
<tr>
<td>94223</td>
<td>Blisters with epidermal loss due to burn (second degree) of chest wall, excluding breast and nipple</td>
</tr>
<tr>
<td>94224</td>
<td>Blisters with epidermal loss due to burn (second degree) of back (any part)</td>
</tr>
<tr>
<td>94225</td>
<td>Blisters with epidermal loss due to burn (second degree) of genitalia</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>94253</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of abdominal wall with loss of abdominal wall</td>
</tr>
<tr>
<td>94254</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of back (any part), with loss of back</td>
</tr>
<tr>
<td>94255</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of genitalia, with loss of genitalia</td>
</tr>
<tr>
<td>94259</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of other and multiple sites of trunk, with loss of a body part</td>
</tr>
<tr>
<td>94300</td>
<td>Burn of unspecified degree of unspecified site of upper limb</td>
</tr>
<tr>
<td>94301</td>
<td>Burn of unspecified degree of forearm</td>
</tr>
<tr>
<td>94302</td>
<td>Burn of unspecified degree of elbow</td>
</tr>
<tr>
<td>94303</td>
<td>Burn of unspecified degree of upper arm</td>
</tr>
<tr>
<td>94304</td>
<td>Burn of unspecified degree of axilla</td>
</tr>
<tr>
<td>94305</td>
<td>Burn of unspecified degree of shoulder</td>
</tr>
<tr>
<td>94306</td>
<td>Burn of unspecified degree of scapular region</td>
</tr>
<tr>
<td>94309</td>
<td>Burn of unspecified degree multiple sites of upper limb, except wrist and hand</td>
</tr>
<tr>
<td>94310</td>
<td>Erythema due to burn (first degree) of unspecified site of upper limb</td>
</tr>
<tr>
<td>94311</td>
<td>Erythema due to burn (first degree) of forearm</td>
</tr>
<tr>
<td>94312</td>
<td>Erythema due to burn (first degree) of elbow</td>
</tr>
<tr>
<td>94313</td>
<td>Erythema due to burn (first degree) of upper arm</td>
</tr>
<tr>
<td>94314</td>
<td>Erythema due to burn (first degree) of axilla</td>
</tr>
<tr>
<td>94315</td>
<td>Erythema due to burn (first degree) of shoulder</td>
</tr>
<tr>
<td>94316</td>
<td>Erythema due to burn (first degree) of scapular region</td>
</tr>
<tr>
<td>94319</td>
<td>Erythema due to burn (first degree) of multiple sites of upper limb, except wrist and hand</td>
</tr>
<tr>
<td>94320</td>
<td>Blisters with epidermal loss due to burn (second degree) of unspecified site of upper limb</td>
</tr>
<tr>
<td>94321</td>
<td>Blisters with epidermal loss due to burn (second degree) of forearm</td>
</tr>
<tr>
<td>94322</td>
<td>Blisters with epidermal loss due to burn (second degree) of elbow</td>
</tr>
<tr>
<td>94323</td>
<td>Blisters with epidermal loss due to burn (second degree) of upper arm</td>
</tr>
<tr>
<td>94324</td>
<td>Blisters with epidermal loss due to burn (second degree) of axilla</td>
</tr>
<tr>
<td>94325</td>
<td>Blisters with epidermal loss due to burn (second degree) of shoulder</td>
</tr>
<tr>
<td>94326</td>
<td>Blisters with epidermal loss due to burn (second degree) of scapular region</td>
</tr>
<tr>
<td>94329</td>
<td>Blisters with epidermal loss due to burn (second degree) of multiple sites of upper limb, except wrist and hand</td>
</tr>
<tr>
<td>94330</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of unspecified site of upper limb</td>
</tr>
<tr>
<td>94331</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of forearm</td>
</tr>
<tr>
<td>94332</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of elbow</td>
</tr>
<tr>
<td>94333</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of upper arm</td>
</tr>
<tr>
<td>94334</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of axilla</td>
</tr>
<tr>
<td>94335</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of shoulder</td>
</tr>
<tr>
<td>94336</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of scapular region</td>
</tr>
<tr>
<td>94339</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of multiple sites of upper limb, except wrist and hand</td>
</tr>
<tr>
<td>94340</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of upper limb, without mention of loss of a body part</td>
</tr>
<tr>
<td>94341</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, without mention of loss of forearm</td>
</tr>
<tr>
<td>94342</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, without mention of loss of elbow</td>
</tr>
<tr>
<td>94343</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, without mention of loss of upper arm</td>
</tr>
<tr>
<td>94344</td>
<td>Deep necrosis of underlying tissues due to burn of axilla, without mention of loss of axilla</td>
</tr>
<tr>
<td>94345</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, without mention of loss of shoulder</td>
</tr>
<tr>
<td>94346</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, without mention of loss of scapula</td>
</tr>
<tr>
<td>94349</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of upper limb, except wrist and hand, without mention of loss of upper limb</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>94350</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of upper limb, with loss of a body part</td>
</tr>
<tr>
<td>94351</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of forearm, with loss of forearm</td>
</tr>
<tr>
<td>94352</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of elbow, with loss of elbow</td>
</tr>
<tr>
<td>94353</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of upper arm, with loss of upper arm</td>
</tr>
<tr>
<td>94354</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of axilla, with loss of axilla</td>
</tr>
<tr>
<td>94355</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of shoulder, with loss of shoulder</td>
</tr>
<tr>
<td>94356</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of scapular region, with loss of scapula</td>
</tr>
<tr>
<td>94359</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of upper limb, except wrist and hand, with loss of upper limb</td>
</tr>
<tr>
<td>94400</td>
<td>Burn of unspecified degree of unspecified site of hand</td>
</tr>
<tr>
<td>94401</td>
<td>Burn of unspecified degree of single digit (finger [nail]) other than thumb</td>
</tr>
<tr>
<td>94402</td>
<td>Burn of unspecified degree of thumb (nail)</td>
</tr>
<tr>
<td>94403</td>
<td>Burn of unspecified degree of two or more digits of hand, not including thumb</td>
</tr>
<tr>
<td>94404</td>
<td>Burn of unspecified degree of two or more digits of hand, including thumb</td>
</tr>
<tr>
<td>94405</td>
<td>Burn of unspecified degree of palm of hand</td>
</tr>
<tr>
<td>94406</td>
<td>Burn of unspecified degree of back of hand</td>
</tr>
<tr>
<td>94407</td>
<td>Burn of unspecified degree of wrist</td>
</tr>
<tr>
<td>94408</td>
<td>Burn of unspecified degree of multiple sites of wrist(s) and hand(s)</td>
</tr>
<tr>
<td>94410</td>
<td>Erythema due to burn (first degree) of unspecified site of hand</td>
</tr>
<tr>
<td>94411</td>
<td>Erythema due to burn (first degree) of single digit (finger [nail]) other than thumb</td>
</tr>
<tr>
<td>94412</td>
<td>Erythema due to burn (first degree) of thumb (nail)</td>
</tr>
<tr>
<td>94413</td>
<td>Erythema due to burn (first degree) of two or more digits of hand, not including thumb</td>
</tr>
<tr>
<td>94414</td>
<td>Erythema due to burn (first degree) of two or more digits of hand including thumb</td>
</tr>
<tr>
<td>94415</td>
<td>Erythema due to burn (first degree) of palm of hand</td>
</tr>
<tr>
<td>94416</td>
<td>Erythema due to burn (first degree) of back of hand</td>
</tr>
<tr>
<td>94417</td>
<td>Erythema due to burn (first degree) of wrist</td>
</tr>
<tr>
<td>94418</td>
<td>Erythema due to burn (first degree) of multiple sites of wrist(s) and hand(s)</td>
</tr>
<tr>
<td>94420</td>
<td>Blisters with epidermal loss due to burn (second degree) of unspecified site of hand</td>
</tr>
<tr>
<td>94421</td>
<td>Blisters with epidermal loss due to burn (second degree) of single digit (finger [nail]) other than thumb</td>
</tr>
<tr>
<td>94422</td>
<td>Blisters with epidermal loss due to burn (second degree) of thumb (nail)</td>
</tr>
<tr>
<td>94423</td>
<td>Blisters with epidermal loss due to burn (second degree) of two or more digits of hand, not including thumb</td>
</tr>
<tr>
<td>94424</td>
<td>Blisters with epidermal loss due to burn (second degree) of back of hand</td>
</tr>
<tr>
<td>94425</td>
<td>Blisters with epidermal loss due to burn (second degree) of palm of hand</td>
</tr>
<tr>
<td>94426</td>
<td>Blisters with epidermal loss due to burn (second degree) of multiple sites of wrist(s) and hand(s)</td>
</tr>
<tr>
<td>94427</td>
<td>Blisters with epidermal loss due to burn (second degree) of wrist</td>
</tr>
<tr>
<td>94428</td>
<td>Blisters with epidermal loss due to burn (second degree) of multi sites of wrist(s) and hand(s)</td>
</tr>
<tr>
<td>94430</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of unspecified site of hand</td>
</tr>
<tr>
<td>94431</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of single digit (finger [nail]) other than thumb</td>
</tr>
<tr>
<td>94432</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of thumb (nail)</td>
</tr>
<tr>
<td>94433</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of two or more digits of hand, not including thumb</td>
</tr>
<tr>
<td>94434</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of two or more digits of hand including thumb</td>
</tr>
<tr>
<td>94435</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of palm of hand</td>
</tr>
<tr>
<td>94436</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of back of hand</td>
</tr>
<tr>
<td>94437</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of wrist</td>
</tr>
<tr>
<td>94438</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of multiple sites of wrist(s) and hand(s)</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>---------------</td>
<td>-------------</td>
</tr>
<tr>
<td>94440</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of hand, without mention of loss of hand</td>
</tr>
<tr>
<td>94441</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of single digit (finger [nail]) other than thumb, without mention of loss of finger</td>
</tr>
<tr>
<td>94442</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of thumb (nail), without mention of loss of finger</td>
</tr>
<tr>
<td>94443</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand, not including thumb, without mention of fingers</td>
</tr>
<tr>
<td>94444</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand including thumb, without mention of loss of fingers</td>
</tr>
<tr>
<td>94445</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of palm of hand, without mention of loss of palm</td>
</tr>
<tr>
<td>94446</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of back of hand, without mention of loss of back of hand</td>
</tr>
<tr>
<td>94447</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, without mention of loss of wrist</td>
</tr>
<tr>
<td>94448</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, without mention of loss of wrist</td>
</tr>
<tr>
<td>94450</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of hand, with loss of hand</td>
</tr>
<tr>
<td>94451</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of single digit (finger [nail]) other than thumb, with loss of finger</td>
</tr>
<tr>
<td>94452</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of thumb (nail), with loss of thumb</td>
</tr>
<tr>
<td>94453</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand, not including thumb, with loss of fingers</td>
</tr>
<tr>
<td>94454</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of two or more digits of hand including thumb, with loss of fingers</td>
</tr>
<tr>
<td>94455</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of palm of hand, with loss of palm of hand</td>
</tr>
<tr>
<td>94456</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of back of hand, with loss of back of hand</td>
</tr>
<tr>
<td>94457</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of wrist, with loss of wrist</td>
</tr>
<tr>
<td>94458</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of wrist(s) and hand(s), with loss of a body part</td>
</tr>
<tr>
<td>94500</td>
<td>Burn of unspecified degree of unspecified site of lower limb (leg)</td>
</tr>
<tr>
<td>94501</td>
<td>Burn of unspecified degree of toe(s) (nail)</td>
</tr>
<tr>
<td>94502</td>
<td>Burn of unspecified degree of foot</td>
</tr>
<tr>
<td>94503</td>
<td>Burn of unspecified degree of ankle</td>
</tr>
<tr>
<td>94504</td>
<td>Burn of unspecified degree of lower leg</td>
</tr>
<tr>
<td>94505</td>
<td>Burn of unspecified degree of knee</td>
</tr>
<tr>
<td>94506</td>
<td>Burn of unspecified degree of thigh (any part)</td>
</tr>
<tr>
<td>94509</td>
<td>Burn of unspecified degree of multiple sites of lower limb(s)</td>
</tr>
<tr>
<td>94510</td>
<td>Erythema due to burn (first degree) of unspecified site of lower limb (leg)</td>
</tr>
<tr>
<td>94511</td>
<td>Erythema due to burn (first degree) of toe(s) (nail)</td>
</tr>
<tr>
<td>94512</td>
<td>Erythema due to burn (first degree) of foot</td>
</tr>
<tr>
<td>94513</td>
<td>Erythema due to burn (first degree) of ankle</td>
</tr>
<tr>
<td>94514</td>
<td>Erythema due to burn (first degree) of lower leg</td>
</tr>
<tr>
<td>94515</td>
<td>Erythema due to burn (first degree) of knee</td>
</tr>
<tr>
<td>94516</td>
<td>Erythema due to burn (first degree) of thigh (any part)</td>
</tr>
<tr>
<td>94519</td>
<td>Erythema due to burn (first degree) of multiple sites of lower limb(s)</td>
</tr>
<tr>
<td>94520</td>
<td>Blisters, epidermal loss (second degree) of unspecified site of lower limb (leg)</td>
</tr>
<tr>
<td>94521</td>
<td>Blisters with epidermal loss due to burn (second degree) of toe(s) (nail)</td>
</tr>
<tr>
<td>94522</td>
<td>Blisters with epidermal loss due to burn (second degree) of foot</td>
</tr>
<tr>
<td>94523</td>
<td>Blisters with epidermal loss due to burn (second degree) of ankle</td>
</tr>
<tr>
<td>94524</td>
<td>Blisters with epidermal loss due to burn (second degree) of lower leg</td>
</tr>
<tr>
<td>94525</td>
<td>Blisters with epidermal loss due to burn (second degree) of knee</td>
</tr>
<tr>
<td>94526</td>
<td>Blisters with epidermal loss due to burn (second degree) of multiple sites of lower limb(s)</td>
</tr>
<tr>
<td>94529</td>
<td>Blisters with epidermal loss due to burn (second degree) of thigh (any part)</td>
</tr>
<tr>
<td>94530</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of unspecified site of lower limb</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>94531</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of toe(s) (nail)</td>
</tr>
<tr>
<td>94532</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of foot</td>
</tr>
<tr>
<td>94533</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of ankle</td>
</tr>
<tr>
<td>94534</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of lower leg</td>
</tr>
<tr>
<td>94535</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of knee</td>
</tr>
<tr>
<td>94536</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of thigh (any part)</td>
</tr>
<tr>
<td>94539</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of multiple sites of lower limb(s)</td>
</tr>
<tr>
<td>94540</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site of lower limb (leg), without mention of loss of a body part</td>
</tr>
<tr>
<td>94541</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of toe(s) (nail), without mention of loss of toe(s)</td>
</tr>
<tr>
<td>94542</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of foot, without mention of loss of foot</td>
</tr>
<tr>
<td>94543</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of ankle, without mention of loss of ankle</td>
</tr>
<tr>
<td>94544</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, without mention of loss of lower leg</td>
</tr>
<tr>
<td>94545</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of knee, without mention of loss of knee</td>
</tr>
<tr>
<td>94546</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), without mention of loss of thigh</td>
</tr>
<tr>
<td>94549</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of lower limb(s), without mention of loss of a body part</td>
</tr>
<tr>
<td>94550</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of unspecified site lower limb (leg), with loss of a body part</td>
</tr>
<tr>
<td>94551</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of toe(s) (nail), with loss of toe(s)</td>
</tr>
<tr>
<td>94552</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of foot, with loss of foot</td>
</tr>
<tr>
<td>94553</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of ankle, with loss of ankle</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>94554</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of lower leg, with loss of lower leg</td>
</tr>
<tr>
<td>94555</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of knee, with loss of knee</td>
</tr>
<tr>
<td>94556</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of thigh (any part), with loss of thigh</td>
</tr>
<tr>
<td>94559</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple sites of lower limb(s), with loss of a body part</td>
</tr>
<tr>
<td>9460</td>
<td>Burns of multiple specified sites, unspecified degree</td>
</tr>
<tr>
<td>9461</td>
<td>Erythema due to burn (first degree) of multiple specified sites</td>
</tr>
<tr>
<td>9462</td>
<td>Blisters with epidermal loss due to burn (second degree) of multiple specified sites</td>
</tr>
<tr>
<td>9463</td>
<td>Full-thickness skin loss due to burn (third degree NOS) of multiple specified sites</td>
</tr>
<tr>
<td>9464</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple specified sites, without mention of loss of a body part</td>
</tr>
<tr>
<td>9465</td>
<td>Deep necrosis of underlying tissues due to burn (deep third degree) of multiple specified sites, with loss of a body part</td>
</tr>
<tr>
<td>9470</td>
<td>Burn of mouth and pharynx</td>
</tr>
<tr>
<td>9471</td>
<td>Burn of larynx, trachea, and lung</td>
</tr>
<tr>
<td>9472</td>
<td>Burn of esophagus</td>
</tr>
<tr>
<td>9473</td>
<td>Burn of gastrointestinal tract</td>
</tr>
<tr>
<td>9474</td>
<td>Burn of vagina and uterus</td>
</tr>
<tr>
<td>9478</td>
<td>Burn of other specified sites of internal organs</td>
</tr>
<tr>
<td>9479</td>
<td>Burn of internal organs, unspecified site</td>
</tr>
<tr>
<td>94800</td>
<td>Burn (any degree) involving less than 10 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94810</td>
<td>Burn (any degree) involving 10-19 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94811</td>
<td>Burn (any degree) involving 10-19 percent of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>94820</td>
<td>Burn (any degree) involving 20-29 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94821</td>
<td>Burn (any degree) involving 20-29 percent of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>Diagnosis Code</td>
<td>Description</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>94822</td>
<td>Burn (any degree) involving 20-29 percent of body surface with third degree burn of 20-29 percent</td>
</tr>
<tr>
<td>94830</td>
<td>Burn (any degree) involving 30-39 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94831</td>
<td>Burn (any degree) involving 30-39 percent of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>94832</td>
<td>Burn (any degree) involving 30-39 percent of body surface with third degree burn of 20-29 percent</td>
</tr>
<tr>
<td>94833</td>
<td>Burn (any degree) involving 30-39 percent of body surface with third degree burn of 30-39 percent</td>
</tr>
<tr>
<td>94840</td>
<td>Burn (any degree) involving 40-49 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94841</td>
<td>Burn (any degree) involving 40-49 percent of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>94842</td>
<td>Burn (any degree) involving 40-49 percent of body surface with third degree burn of 20-29 percent</td>
</tr>
<tr>
<td>94843</td>
<td>Burn (any degree) involving 40-49 percent of body surface with third degree burn of 30-39 percent</td>
</tr>
<tr>
<td>94844</td>
<td>Burn (any degree) involving 40-49 percent of body surface with third degree burn of 40-49 percent</td>
</tr>
<tr>
<td>94850</td>
<td>Burn (any degree) involving 50-59 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94851</td>
<td>Burn (any degree) involving 50-59 percent of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>94852</td>
<td>Burn (any degree) involving 50-59 percent of body surface with third degree burn of 20-29 percent</td>
</tr>
<tr>
<td>94853</td>
<td>Burn (any degree) involving 50-59 percent of body surface with third degree burn of 30-39 percent</td>
</tr>
<tr>
<td>94854</td>
<td>Burn (any degree) involving 50-59 percent of body surface with third degree burn of 40-49 percent</td>
</tr>
<tr>
<td>94855</td>
<td>Burn (any degree) involving 50-59 percent of body surface with third degree burn of 50-59 percent</td>
</tr>
<tr>
<td>94860</td>
<td>Burn (any degree) involving 60-69 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>94861</td>
<td>Burn (any degree) involving 60-69 percent of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>94862</td>
<td>Burn (any degree) involving 60-69 percent of body surface with third degree burn of 20-29 percent</td>
</tr>
<tr>
<td>94863</td>
<td>Burn (any degree) involving 60-69 percent of body surface with third degree burn of 30-39 percent</td>
</tr>
<tr>
<td>94864</td>
<td>Burn (any degree) involving 60-69 percent of body surface with third degree burn of 40-49 percent</td>
</tr>
<tr>
<td>94865</td>
<td>Burn (any degree) involving 60-69 percent of body surface with third degree burn of 50-59 percent</td>
</tr>
<tr>
<td>94866</td>
<td>Burn (any degree) involving 60-69 percent of body surface with third degree burn of 60-69 percent</td>
</tr>
<tr>
<td>94870</td>
<td>Burn (any degree) involving 70-79 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94871</td>
<td>Burn (any degree) involving 70-79 percent of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>94872</td>
<td>Burn (any degree) involving 70-79 percent of body surface with third degree burn of 20-29 percent</td>
</tr>
<tr>
<td>94873</td>
<td>Burn (any degree) involving 70-79 percent of body surface with third degree burn of 30-39 percent</td>
</tr>
<tr>
<td>94874</td>
<td>Burn (any degree) involving 70-79 percent of body surface with third degree burn of 40-49 percent</td>
</tr>
<tr>
<td>94875</td>
<td>Burn (any degree) involving 70-79 percent of body surface with third degree burn of 50-59 percent</td>
</tr>
<tr>
<td>94876</td>
<td>Burn (any degree) involving 70-79 percent of body surface with third degree burn of 60-69 percent</td>
</tr>
<tr>
<td>94877</td>
<td>Burn (any degree) involving 70-79 percent of body surface with third degree burn of 70-79 percent</td>
</tr>
<tr>
<td>94880</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94881</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>94882</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of 20-29 percent</td>
</tr>
</tbody>
</table>
Hyperbaric oxygen therapy that exceeds one session per day, any provider will be denied.

### 25.3.3.22 Implantable Contraceptive Capsules

ASCs and HASCs billing for removal of implantable contraceptive capsules should use procedure code F-11975, F-11976, and F-11977.

### 25.3.3.23 Occupational and Physical Therapy Services

#### Occupational and Physical Therapy Procedure Codes and Limitations

Occupational and physical therapy are benefits of the Medicaid program as outlined in the following sections. Specific codes to occupational and physical therapy as well as information about benefits can be found in these sections.

Occupational and physical therapy procedure codes are listed in the following table:

| Procedure Codes |
|-----------------|-----------------|-----------------|-----------------|
| 1-97012         | 1-97014         | 1-97016         | 1-97018         |
| 1-97020         | 1-97022         | 1-97024         | 1-97026         |
| 1-97028         | 1-97032         | 1-97033         | 1-97034         |
| 1-97035         | 1-97036         | 1-97039         | 1-97110         |
| 1-97112         | 1-97113         | 1-97116         | 1-97124         |
| 1-97139         | 1-97140         | 1-97150         | 1-97520         |
| 1-97530         | 1-97750         | 1-97799         |

The following occupational and physical therapy procedure codes are a benefit for THSteps-CCP clients only:

| Procedure Codes |
|-----------------|-----------------|-----------------|-----------------|
| 1-97504         | 1-97535         | 1-97537         | 1-97542         |
| 1-97703         |

### Diagnosis Codes

<table>
<thead>
<tr>
<th>Diagnosis Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>94883</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of 30-39 percent</td>
</tr>
<tr>
<td>94884</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of 40-49 percent</td>
</tr>
<tr>
<td>94885</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of 50-59 percent</td>
</tr>
<tr>
<td>94886</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of 60-69 percent</td>
</tr>
<tr>
<td>94887</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of 70-79 percent</td>
</tr>
<tr>
<td>94888</td>
<td>Burn (any degree) involving 80-89 percent of body surface with third degree burn of 80-89 percent</td>
</tr>
<tr>
<td>94890</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of less than 10 percent or unspecified amount</td>
</tr>
<tr>
<td>94891</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 10-19 percent</td>
</tr>
<tr>
<td>94892</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 20-29 percent</td>
</tr>
<tr>
<td>94893</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 30-39 percent</td>
</tr>
<tr>
<td>94894</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 40-49 percent</td>
</tr>
<tr>
<td>94895</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 50-59 percent</td>
</tr>
<tr>
<td>94896</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 60-69 percent</td>
</tr>
<tr>
<td>94897</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 70-79 percent</td>
</tr>
<tr>
<td>94898</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 80-89 percent</td>
</tr>
<tr>
<td>94899</td>
<td>Burn (any degree) involving 90 percent or more of body surface with third degree burn of 90 percent or more of body surface</td>
</tr>
<tr>
<td>9490</td>
<td>Burn of unspecified site, unspecified degree</td>
</tr>
<tr>
<td>9491</td>
<td>Erythema due to burn (first degree), unspecified site</td>
</tr>
</tbody>
</table>
The following procedure codes are limited to one per day:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-97012 1-97014 1-97016 1-97018</td>
</tr>
<tr>
<td>1-97022 1-97024 1-97026 1-97028</td>
</tr>
<tr>
<td>1-97150</td>
</tr>
</tbody>
</table>

The following procedure codes may be paid in multiple 15-minute quantities:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-97032 1-97033 1-97034 1-97035</td>
</tr>
<tr>
<td>1-97036 1-97039 1-97110 1-97112</td>
</tr>
<tr>
<td>1-97113 1-97116 1-97124 1-97139</td>
</tr>
<tr>
<td>1-97140 1-97504 1-97520 1-97530</td>
</tr>
<tr>
<td>1-97535 1-97537</td>
</tr>
</tbody>
</table>

Procedure code 1-97010, is not a benefit of the Texas Medicaid Program.

Procedure codes that may be billed in multiple quantities (i.e., 15 minutes each) are limited to a total of two hours per day of individual, group, or a combination of individual and group therapy.

Procedure codes 1-97703 and 1-97750 are comprehensive codes and include an office visit. If an office visit is billed the same day by the same provider, the office visit will be denied as part of another procedure billed the same day. Procedure code 1-97703 is only payable for clients younger than 21 years of age.

### Occupational Therapy Services

Occupational therapy is a payable benefit to physicians and hospitals. Occupational therapy must be billed with the AT modifier and must be provided according to the current (within 60 days) written orders of a physician and must be medically necessary. Occupational therapy is to be billed with the following CPT procedure codes as applicable:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-97003 1-97004 1-97012 1-97014</td>
</tr>
<tr>
<td>1-97016 1-97018 1-97022 1-97024</td>
</tr>
<tr>
<td>1-97026 1-97028 1-97032 1-97033</td>
</tr>
<tr>
<td>1-97034 1-97035 1-97036 1-97039</td>
</tr>
<tr>
<td>1-97110 1-97112 1-97113 1-97116</td>
</tr>
<tr>
<td>1-97124 1-97139 1-97140 1-97150</td>
</tr>
<tr>
<td>1-97530 1-97535 1-97537 1-97542</td>
</tr>
<tr>
<td>1-97750 1-97760 1-97761 1-97762</td>
</tr>
<tr>
<td>1-97799</td>
</tr>
</tbody>
</table>

The AT modifier is described as representing treatment provided for an acute condition, or an exacerbation of a chronic condition, which persists less than 180 days from the start date of therapy.

If a condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client’s condition has not become chronic and the client has not reached the point of plateauing. Plateauing is defined as the point at which maximal improvement has been documented and further improvement ceases.

Occupational therapy prescribed primarily as an adjunct to psychotherapy is not a benefit.

Procedure codes 1-97003 and 1-97004 are for occupational therapy only.

Procedure code 1-97003, is payable once per six months, any provider, same facility. Procedure code 1-97004, is payable one time per month, any provider, same facility. These codes are not payable on the same day as the following codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-97012 1-97014 1-97016 1-97018</td>
</tr>
<tr>
<td>1-97022 1-97024 1-97026 1-97028</td>
</tr>
<tr>
<td>1-97032 1-97033 1-97034 1-97035</td>
</tr>
<tr>
<td>1-97036 1-97039 1-97110 1-97112</td>
</tr>
<tr>
<td>1-97113 1-97116 1-97124 1-97139</td>
</tr>
<tr>
<td>1-97140 1-97150 1-97504 1-97520</td>
</tr>
<tr>
<td>1-97530 1-97750 1-97760 1-97761</td>
</tr>
<tr>
<td>1-97762</td>
</tr>
</tbody>
</table>

Refer to: “Physician” on page 36-1 for more guidelines.

### Physical Therapy Services

Physical therapy is the use of physical agents such as heat, massage, electricity, traction, or exercises in the treatment of disease. Payments for physical therapy are limited to acute disorders of the musculoskeletal system or exacerbations of chronic disorders necessitating physical medicine to restore function.

Physical therapy, including functional evaluations, must be provided according to the current written orders of a physician (written within 60 days) and based on medical necessity. It may be performed by auxiliary personnel under the direct supervision of the physician or the independently practicing physical therapist.

The acute modifier AT must be billed for payment to be made. The AT modifier is described as representing treatment provided for an acute condition, or an exacerbation of a chronic condition, which persists less than 180 days from the start date of therapy.

**Example:** The following may be considered acute: a new injury, therapy before or after surgery, acute exacerbations of conditions, such as rheumatoid arthritis, and interventions such as a newly implanted intrathecal pump to decrease spasticity or Botulinum Toxin Type A injections.

If a condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client’s condition has not become chronic, and the
client has not reached the point of plateauing. Plateauing is defined as the point at which maximal improvement has been documented and further improvement ceases.

Payment cannot be made to a physician or an independently practicing physical therapist who provides physical therapy to a resident of a nursing facility. These services must be made available to nursing facility residents on an as-needed basis and must be provided directly by the staff of the facility or furnished by the facility through arrangements with outside qualified resources. Nursing facilities should refrain from admitting clients who need goal-directed therapy if the facility is unable to provide these services.

Procedure codes 1-97001 and 1-97002 are for physical therapy only.

Procedure code 1-97001 is payable once per six months, any provider, same facility. Procedure code 1-97002, is payable once per month, any provider, same facility. Procedure codes 1-97001 and 1-97002 are not payable on the same day as the following codes:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-97012</td>
</tr>
<tr>
<td>1-97022</td>
</tr>
<tr>
<td>1-97032</td>
</tr>
<tr>
<td>1-97036</td>
</tr>
<tr>
<td>1-97113</td>
</tr>
<tr>
<td>1-97150</td>
</tr>
<tr>
<td>1-97750</td>
</tr>
</tbody>
</table>

The following procedure codes are limited to once per day:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-97012</td>
</tr>
<tr>
<td>1-97022</td>
</tr>
<tr>
<td>1-97150</td>
</tr>
</tbody>
</table>

The following procedure codes may be paid in multiple 15-minute quantities:

<table>
<thead>
<tr>
<th>Procedure Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-97032</td>
</tr>
<tr>
<td>1-97036</td>
</tr>
<tr>
<td>1-97113</td>
</tr>
<tr>
<td>1-97140</td>
</tr>
</tbody>
</table>

Procedure code 1-97010 is not a benefit of the Texas Medicaid Program.

Procedure codes 1-97703 and 1-97750 are comprehensive codes and include an office visit. If an office visit is billed the same day by the same provider, the office visit will be denied as part of another procedure billed the same day. Procedure code 1-97703 is only payable for clients younger than 21 years of age.

Procedure codes that may be billed in multiple quantities (i.e., 15 minutes each) are limited to a total of two hours per day of individual, group, or a combination of individual and group therapy.

Refer to: “Claim Filing Resources” on page 24-61.
“THSteps Medical and Dental Administrative Information” on page 43-5 for authorization requirements and coverage or noncoverage of the above physical therapy and rehabilitation codes.

25.3.3.24 Osteopathic Manipulation Treatments (OMT)

OMT is a covered benefit of the Texas Medicaid Program for the acute phase of the acute musculoskeletal injury or the acute phase of an acute exacerbation of a chronic musculoskeletal injury including acute musculoskeletal injury with a neurological component. The acute modifier AT must be submitted with the claim for payment to be made.

The AT modifier is described as representing treatment provided for an acute condition, or an exacerbation of a chronic condition, which persists less than 180 days from the start date of therapy. If the condition persists for more than 180 days from the start of therapy, the condition is considered chronic, and treatment is no longer considered acute. Providers may file an appeal for claims denied as being beyond the 180 days of therapy with supporting documentation that the client’s condition has not become chronic and the client has not reached the point of plateauing. Plateauing is defined as the point at which maximal improvement has been documented and further improvement ceases.

Use procedure codes 1-98925, 1-98926, 1-98927, 1-98928, and 1-98929 when billing for OMT to the head, cervical, thoracic, lumbar, sacral, pelvic, lower extremities, upper extremities, rib cage, abdominal, and visceral regions.

When multiples of procedure codes 1-98925, 1-98926, 1-98927, 1-98928, and 1-98929 are billed on the same day by the same provider, the most inclusive code is paid and the others denied.

Procedure code 1-97140 will deny as part of another service if billed on the same date of service as procedure codes 98925, 98926, 98927, 98928, or 98929.

25.3.3.25 Psychiatric Services

Each individual behavioral health practitioner is limited to a combined total of 12 hours of Medicaid reimbursement per day for behavioral health services. Each individual delegated to perform behavioral health services by a Doctor of Medicine (MD) or Doctor of Osteopathy (DO) is also limited to a combined total of 12 hours. MDs and DOs who delegate and providers who perform group therapy may possibly submit claims in excess of 12 hours in a given day.
Retrospective review may occur for both the total hours of services performed per day and for the total hours of services billed per day. If inappropriate payments are identified, the money will be recouped. Documentation requirements for all services billed are listed for each individual specialty in this manual.

Outpatient behavioral health services without prior authorization are limited to 30 encounters/visits per client per calendar year. An encounter/visit is defined as any and all outpatient behavioral health services rendered per hour by any provider, in the office, outpatient, nursing home, and home settings. This limitation includes encounters/visits by all practitioners.

The following services are not counted towards the 30 encounter/visit limitation:

- School Health and Related Services (SHARS) behavioral health rehab services
- Mental Health and Mental Retardation (MHMR) services
- Laboratory and radiology services
- Pharmacological management (19082)

Services that exceed 30 encounters/visits per calendar year per client must be prior authorized. Prior authorization must be obtained before providing the 25th service in a calendar year. Prior authorization requests in increments of up to 10 additional encounters/visits may be considered. If the client changes providers during the year and the new provider is unable to obtain complete information on the client, prior authorization may be made when the request is accompanied by an explanation as to why the provider was not able to submit the prior authorization request by the 25th encounter/visit and before rendering services. This information must be submitted in addition to the usual medical necessity information.

It is recognized that a client may change providers in the middle of the year, and the new provider may not be able to obtain complete information on the client. In these instances, prior authorization may be made before rendering services when the request is accompanied by an explanation as to why the provider was unable to submit the prior authorization request by the client’s 25th encounter/visit.

All authorization requests for extension of outpatient psychotherapy sessions beyond the annual 30-encounter/visit limitation are limited to 10 encounters/visits per request, and must be submitted on the Extended Outpatient/ Counseling Request Form. Requests must include the following:

- Client name and Medicaid number
- Provider name and provider identifier
- Clinical update, including current specific symptoms and response to past treatment, and treatment plan (measurable short term goals for the extension, specific therapeutic interventions to be used in therapy, measurable expected outcomes of therapy, length of treatment anticipated, and planned frequency of encounters/visits)

- Number and type of services requested and the dates (based on the frequency of visits) that the services will be provided
- All areas of the request must be completed with the information required on the form. If additional room is needed providers may state “see attached." The attachment must contain the specific information required in that section of the form

Prior authorization is not granted to providers who have seen a client for an extended period of time or from the start of the calendar year and who have not requested prior authorization before the 25th encounter/visit. It is recommended that a request for extension of outpatient behavioral health be submitted no sooner than 30 days before the date of service being requested, so that the most current information is provided.

The number of encounters/visits authorized is dependent on the client’s symptoms and response to past treatment. If the client requires additional extensions, the provider must submit a new request for prior authorization at the end of each extension period. The request for additional encounters/visits must include new documentation addressing the client’s current condition, treatment plan, and the therapist’s rationale supporting the medical necessity for these additional encounters/visits. Prior authorization for an extension of outpatient behavioral health services is granted when the treatment is mandated by the courts for court-ordered services. A copy of the court order for outpatient treatment signed by the judge must accompany prior authorization requests.

Mail or fax the request to the following address:

Texas Medicaid & Healthcare Partnership
Special Medical Prior Authorization
12357-B Riata Trace Parkway, Suite 150
Austin, TX 78727
Fax: 1-512-514-4213

The following psychiatric services are not covered by the Texas Medicaid Program:

- The services of a licensed chemical dependency counselor (LCDC), psychological associate (masters level psychologist), psychiatric nurse, or behavioral health worker
- Psychiatric daycare
- Recreational therapy
- Biofeedback
- Music/dance
- Thermogenic therapy
Outpatient psychiatric services for the diagnosis or treatment of a mental, psychoneurotic, or personality disorder are reimbursed at the hospital’s designated reimbursement rate as determined by the annual cost settlement.

**Note:** NorthSTAR is a managed care program in the Dallas service area that covers behavioral health services. Psychiatrists that provide behavioral health services to clients in NorthSTAR must be members of the NorthSTAR BHOs.

Refer to: “Request for Extended Outpatient Psychotherapy/Counseling Form” on page B-81.

“Medicaid Managed Care” on page 7-4 for more information or contact the client’s BHO.

### 25.3.3.26 Psychological and Neuropsychological Testing

Psychological or neuropsychological testing will be limited to a total of four hours per day per client, any provider. Documentation of medical necessity must be maintained in the client’s chart. Each hour of therapy, psychological and/or neuropsychological testing counts as one of the 30-encounter/visit limit.

Refer to: “Psychological and Neuropsychological Testing” on page 38-3 for information on outpatient psychological and neuropsychological testing, including procedure codes and diagnosis code restrictions.

### 25.3.3.27 Sterilization Services

The Texas Medicaid Program benefits include payment for elective sterilization (performed solely for the purpose of rendering the individual incapable of bearing or fathering children) of eligible clients when providers comply with HHS regulations (42 CFR 441.250, Subpart F).

Payment of elective sterilization is not made if the client is:

- Younger than 21 years of age at the time the consent form is signed
- Declared mentally incompetent for the purpose of sterilization (the individual may be adjudicated competent for the purpose of sterilization)
- Institutionalized in a correctional facility, mental hospital, or other rehabilitative facility
- Giving consent during labor or childbirth, under the influence of alcohol or other drugs, or while seeking or obtaining an abortion

**Important:** If a client eligible for Medicaid decides not to be sterilized after entering the hospital, the hospital may be reimbursed for its services. The hospital must submit a valid consent form signed by the client. The physician’s signature is not required.

TMHP must have a signed, valid sterilization consent form on file to reimburse elective sterilization procedures. Typewritten, blocked, or facsimile stamped signatures are not acceptable for signature requirements. When TMHP receives a valid consent form, the client’s eligibility file is updated to reflect receipt. Subsequent claims received by TMHP for the sterilization covered by the consent are referenced to the valid consent and reimbursed even if they are not accompanied by a valid consent. It is to the provider’s benefit to submit a consent form with claims for sterilization rather than relying on a fellow provider. A legible valid copy of the consent is acceptable.

The “Sterilization Consent Form Instructions (2 Pages)” on page B-92 and the HHS-approved form (supplied by TMHP) are the only acceptable forms. Providers may use their own consent form as long as the form has the HHS-approved language and required fields. The only exception is if the provider obtains prior approval from HHS.

Refer to: “Elective Sterilization Services” on page 20-14 for elective sterilization services requirements and instructions.

### 25.3.4 Utilization Review

Utilization review activities of all Medicaid services provided by hospitals reimbursed under the DRG prospective payment system or TEFRA are required by Title XIX of the Social Security Act, Sections 1902 and 1903. The review activities are accomplished through a series of monitoring systems developed to ensure services are appropriate to need, of optimum quality and quantity, and rendered in the most cost-effective mode. Clients and providers are subject to utilization review monitoring. The monitoring focuses on the appropriate screening activities, medical necessity of all services, and quality of care as reflected by the choice of services provided, type of provider involved, and settings in which the care was delivered. This monitoring ensures the efficient and cost-effective administration of the Texas Medicaid Program.

Utilization review may also occur by an examination of particular claims or services not within the usual screening review when a specific utilization review is requested by HHSC or the Texas Attorney General’s Office.

### 25.3.4.1 Responsibilities

TMHP is responsible for a comprehensive integrated review process to identify misuse and inappropriate billing patterns by outpatient hospitals and HASCs. All providers are subject to TMHP’s utilization review monitoring. Providers are selected for review based on a comparison of their individual resource utilization with a peer group of similar specialty and geographic locality. The main goal of the required utilization control is to identify those providers whose practice patterns are aberrant from their peers and provide the necessary educational actions to help the provider achieve Texas Medicaid Program compliance. An analysis of utilization review data is completed by a registered nurse analyst for review by the medical director and staff. If the analyst substantiates that a provider’s practice and billing patterns are incon-
sistent with the federal requirements and the Texas Medicaid Program’s scope of benefits, a TMHP representative contacts the provider. The purpose of the contact is to discuss appropriate billing guidelines and to assist the provider in resolving the inappropriate billing patterns identified in the review.

TMHP uses the following criteria when reviewing all hospital outpatient medical records. Services must be:

- Medically necessary
- Ordered by a physician, signed, and dated. Signature stamps are valid if initialed and dated by the physician
- Billed in the quantities ordered and documented as provided
- Program benefits
- Specifically identified on the charge tickets or itemized statement submitted with the claim or by the HCPCS procedure code on the claim
- Billed to Medicaid only after other medical insurance resources have been exhausted

Refer to: “Medicaid Identification (Form H3087)” on page 4-9.

- Indicated by the documentation in the medical record.

The determination of TMHP’s utilization review process may result in the following:

- Educational letters/visits
- Mail-in of medical records for review
- On-site medical record review (outpatient, ASC/HASC, or inpatient records not reviewed)
- Referral of questionable claims to HHSC or HHSC OIG
- Recoupment
- Prepayment review

The intent of these actions is to ensure the most effective and appropriate use of available services and facilities and provide appropriate, cost-effective care to clients with Medicaid coverage.

25.3.5 Claims Information

Providers must submit all required claim information on the face of the HCFA-1450 (UB-92) claim form instead of submitting attachments or charge tickets. If a claim contains more than 23 line items, continue the claim on additional UB-92s. Total each HCFA-1450 (UB-92) claim form as a stand-alone claim. If you do not total each page, your claim may be denied with EOB 472 (No more than 27 details allowed per claim). Resubmit with 27 or less details and ensure HCFA-1450 (UB-92) claim form and attached statement totals agree. Refer to Provider Manual.” TMHP uses information attached to the claim for clarification purposes only.

Providers must purchase HCFA-1450 claim form from the vendor of their choice; TMHP does not supply them. Refer to: “HCFA-1450 (UB-92) Claim Filing Instructions” on page 5-32 for claims completion instructions.

### 25.3.5.1 Claim Filing Resources

Refer to the following sections and/or forms on the page numbers listed below when filing claims:

<table>
<thead>
<tr>
<th>Resource</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Automated Inquiry System (AIS)</td>
<td>xiii</td>
</tr>
<tr>
<td>TMHP Electronic Data Interchange (EDI)</td>
<td>3-1</td>
</tr>
<tr>
<td>HCFA-1450 (UB-92) Claim Filing Instructions</td>
<td>5-32</td>
</tr>
<tr>
<td>TMHP Electronic Claims Submission</td>
<td>5-10</td>
</tr>
<tr>
<td>Communication Guide</td>
<td>A-1</td>
</tr>
<tr>
<td>Hospital Audits Request for Claims Summary</td>
<td>B-54</td>
</tr>
<tr>
<td>Hospital Report (Newborn Child or Children)</td>
<td>B-51</td>
</tr>
<tr>
<td>HHSC Form 7484</td>
<td>B-51</td>
</tr>
<tr>
<td>Sterilization Consent Form (English)</td>
<td>B-92</td>
</tr>
<tr>
<td>Sterilization Consent Form (Spanish)</td>
<td>B-94</td>
</tr>
<tr>
<td>Sterilization Consent Form Instructions</td>
<td>B-96</td>
</tr>
<tr>
<td>Hospital-Based ASC Claim Example</td>
<td>D-17</td>
</tr>
<tr>
<td>Hospital Inpatient Claim Example</td>
<td>D-18</td>
</tr>
<tr>
<td>Hospital Outpatient Claim Example</td>
<td>D-18</td>
</tr>
<tr>
<td>Acronym Dictionary</td>
<td>F-1</td>
</tr>
</tbody>
</table>