



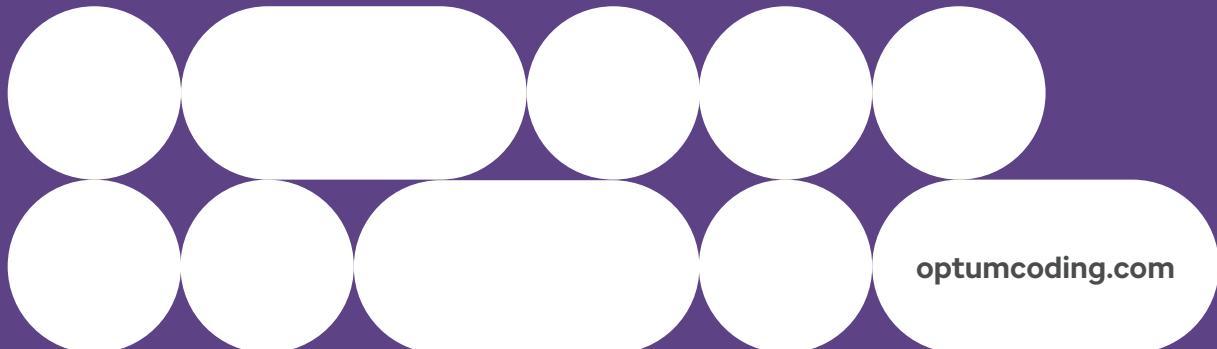
Expert

Current Procedural Coding Expert

CPT® codes with Medicare essentials
for enhanced accuracy

SAMPLE

2027

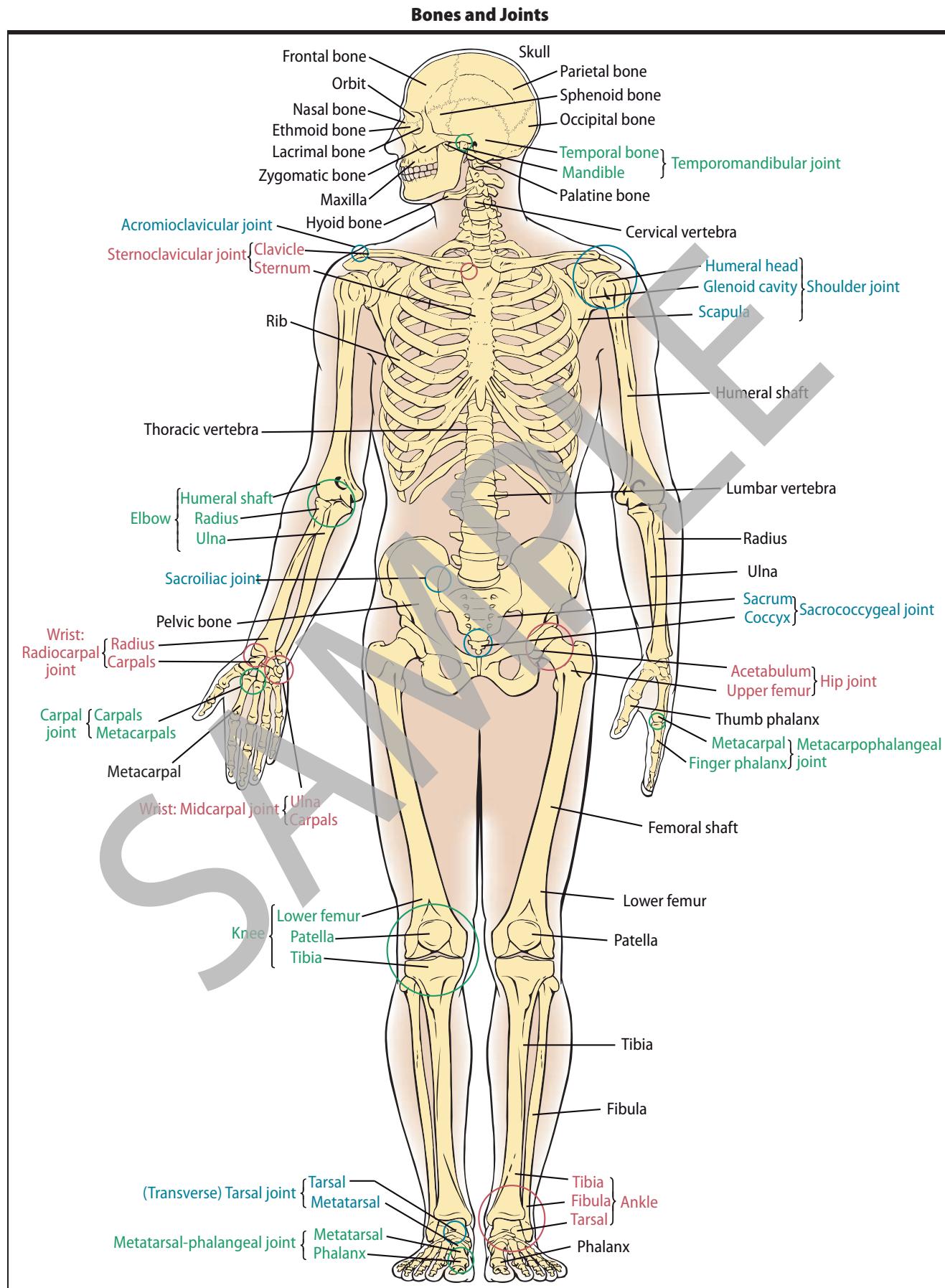


Contents

Introduction	iii	Lymphatic Capillaries.....	xxiv
Getting Started with <i>Current Procedural Coding Expert</i> .....	....	Lymphatic System of Head and Neck	xxiv
General Conventions .....	....	Lymphatic Drainage.....	xxiv
Resequencing of CPT Codes .....	....	Spleen Internal Structures	xxv
Code Ranges for Medicare Billing .....	....	Spleen External Structures.....	xxv
Icons	iv	Digestive System.....	....
Appendices	vi	Gallbladder .....	....
Anatomical Illustrations	vii	Stomach .....	....
Body Planes and Movements.....	vii	Mouth (Upper) .....	....
Integumentary System.....	viii	Mouth (Lower) .....	....
Skin and Subcutaneous Tissue	viii	Pancreas .....	....
Nail Anatomy	viii	Liver .....	....
Assessment of Burn Surface Area.....	viii	Anus.....	....
Musculoskeletal System.....	ix	Genitourinary System.....	....
Bones and Joints	ix	Urinary System.....	....
Muscles	x	Nephron .....	....
Head and Facial Bones.....	xi	Male Genitourinary .....	....
Nose.....	xi	Testis and Associated Structures.....	....
Shoulder (Anterior View)	xi	Male Genitourinary System .....	....
Shoulder (Posterior View)	xi	Female Genitourinary .....	....
Shoulder Muscles	xi	Female Reproductive System .....	....
Elbow (Anterior View)	xii	Female Bladder.....	....
Elbow (Posterior View)	xii	Female Breast.....	....
Elbow Muscles	xii	Endocrine System.....	....
Elbow Joint	xii	Structure of an Ovary .....	....
Lower Arm	xii	Thyroid and Parathyroid Glands .....	....
Hand	xii	Adrenal Gland .....	....
Hip (Anterior View)	xiii	Thyroid.....	....
Hip (Posterior View)	xiii	Thymus .....	....
Knee (Anterior View)	xiii	Nervous System.....	....
Knee (Posterior View)	xiii	Brain .....	....
Knee Joint (Anterior View)	xiii	Cranial Nerves .....	....
Knee Joint (Lateral View)	xiii	Spinal Cord and Spinal Nerves.....	....
Lower Leg.....	xiv	Nerve Cell .....	....
Ankle Ligament (Lateral View).....	xiv	Eye .....	....
Ankle Ligament (Posterior View)	xiv	Eye Structure .....	....
Foot Tendons	xiv	Posterior Pole of Globe/Flow of Aqueous Humor.....	....
Foot Bones	xiv	Eye Musculature .....	....
Respiratory System.....	xv	Eyelid Structures.....	....
Upper Respiratory System	xv	Ear and Lacrimal System .....	....
Nasal Turbinates	xv	Ear Anatomy .....	....
Paranasal Sinuses	xvi	Lacrimal System .....	....
Lower Respiratory System	xvi	Index	Index-1
Lung Segments	xvi	Tabular	1
Alveoli	xvi	Anesthesia .....	....
Arterial System	xvii	Integumentary System .....	....
Internal Carotid Arteries and Branches.....	xviii	Musculoskeletal System .....	....
External Carotid Arteries and Branches	xviii	Respiratory System .....	....
Upper Extremity Arteries.....	xviii	Cardiovascular, Hemic, and Lymphatic .....	....
Lower Extremity Arteries.....	xviii	Digestive System.....	....
Venous System	xix	Urinary System .....	....
Head and Neck Veins.....	xx	Genital System .....	....
Upper Extremity Veins	xx	Endocrine System .....	....
Venae Comitantes	xx	Nervous System .....	....
Venuous Blood Flow	xx	Eye, Ocular Adnexa, and Ear .....	....
Abdominal Veins	xx	Radiology .....	....
Cardiovascular System.....	xxi	Medical Decision Making Table for Pathology Clinical	
Coronary Veins	xxi	Consultations .....	....
Anatomy of the Heart	xxi	Pathology and Laboratory .....	....
Heart Cross Section.....	xxi	Medicine .....	....
Heart Valves	xxi	Evaluation and Management (E/M) Services Guidelines .....	....
Heart Conduction System	xxii	Evaluation and Management .....	....
Coronary Arteries	xxii	Category II Codes .....	....
Lymphatic System	xxiii		
Axillary Lymph Nodes	xxiv		

Category III Codes	577	Appendix H — Quality Payment Program	656
Proposed 2025 Changes	656		
Appendix A — Modifiers and Expanded Guidance	615	Appendix I — Inpatient-Only Procedures	657
Introduction to Modifiers	615		
CPT Modifiers (Professional)	616	Appendix J — Place of Service and Type of Service	663
Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use	622	Place-of-Service Codes for Professional Claims	663
Regulatory and Coding Guidance	625	Type of Service	665
Appendix B — New, Revised, and Deleted Codes	630	Appendix K — Multianalyte Assays with Algorithmic Analyses	666
New Codes	630		
Revised Codes	636	Appendix L — Listing of Sensory, Motor, and Mixed Nerves	691
Deleted Codes	637	Motor Nerves Assigned to Codes 95907–95913	691
Resequenced Icon Added	637	Sensory and Mixed Nerves Assigned to Codes 95907–95913	691
Web Release New, Revised, and Deleted Codes	637		
Appendix C — Evaluation and Management Extended Guidelines	638	Appendix M — Digital Medicine Services	693
Introduction to Evaluation and Management Coding	638		
Classification of E/M Services	639	Appendix N — Artificial Intelligence Taxonomy for Medical Services and Procedures	694
Categories of E/M Services	639		
Summary of Recent Changes to the E/M Codes	639	Appendix O — Social Determinants of Health	695
Determining the Level of E/M Service for Office or Other Outpatient Services, Telemedicine Services, Hospital Inpatient and Observation Care, Consultations, Emergency Department Services, Nursing Facility, and Home or Residence Services	639		
Split or Shared E/M Services	643	Appendix P — Glossary	697
Multiple E/M Services on Same Date	643		
Quick Comparison of E/M Services	643	Appendix Q — Vascular Families	711
		Arterial Vascular Family	711
		Venous Vascular Family	713
Appendix D — Crosswalk of Deleted Codes	651	Appendix R — Interventional Radiology Illustrations	715
		Internal Carotid and Vertebral Arterial Anatomy	715
Appendix E — Resequenced Codes	652	Cerebral Venous Anatomy	716
		Normal Aortic Arch and Branch Anatomy—Transfemoral Approach	716
Appendix F — Add-on Codes, Modifier 51 Exempt, Optum Modifier 51 Exempt, Modifier 63 Exempt, Modifier 95 Telemedicine, and Modifier 93 Audio-Only Services	654	Superior and Inferior Mesenteric Arteries and Branches	717
Add-on Codes	654	Renal Artery Anatomy—Femoral Approach	718
AMA Modifier 51 Exempt Codes	654	Central Venous Anatomy	719
Optum Modifier 51 Exempt Codes	654	Portal System (Arterial)	719
Modifier 63 Exempt Codes	654	Portal System (Venous)	720
Telemedicine Services Codes	654	Pulmonary Artery Angiography	721
Audio-Only Services Codes	655	Upper Extremity Arterial Anatomy—Transfemoral or Contralateral Approach	722
Appendix G — Medicare Internet-only Manuals (IOMs)	655	Lower Extremity Arterial Anatomy—Contralateral, Axillary or Brachial Approach	723
		Lower Extremity Venous Anatomy	724
		Coronary Arteries Anterior View	725
		Left Heart Catheterization	725
		Right Heart Catheterization	726
		Heart Conduction System	726

Musculoskeletal System



Abscess

Abscess — *continued*

- Bartholin's Gland — *continued*
 - Puncture Aspiration, 10160
- Bladder, 49406, 51080
- Brain
 - Burr Hole, 61150, 61151
 - Craniotomy/Craniectomy, 61320, 61321
 - Excision, 61514, 61522
- Breast, 19020
- Carpals, 25035
- Clavicle, 23170
- Contrast Injection, 49424
- Ear, External, 69000-69005
- Elbow, 23930
 - Bone Abscess, 23935
 - Sequestrectomy, 24136-24138
- Epididymis, 54700
- Eyelid, 67700
- Facial Bone(s), 21026
- Femur, 27301
 - Bone Abscess, 27303
- Finger, 26010-26011
 - Bone Abscess, 26034
- Foot, 28005
- Gums, 41800
- Hand, 26034
- Hip, 26990
 - Bone Abscess, 26992
- Humerus, 23935
 - Humeral Head, 23174
- Sequestrectomy, 24134
- Kidney
 - Open, 50020
 - Percutaneous, 49405
- Knee, 27301
 - Bone Abscess, 27303
- Leg
 - Lower, 27603
 - Bone Abscess, 27607
 - Upper, 27301
 - Bone Abscess, 27303
- Liver
 - Injection, 47015
 - Marsupialization, 47300
 - Open, 47010
 - Percutaneous, 49405
- Lung
 - Endoscopic, 31645-31646
 - Open, 32200
 - Percutaneous, 49405
- Lymph Node, 38300, 38305
- Mandible, 21025
- Mouth
 - Dentoalveolar, 41800
 - Floor of Mouth
 - Extraoral, 41015-41018
 - Intraoral, 41000-41009
 - Vestibule, 40800-40801
- Nasal, 30000, 30020
- Nasal Septum, 30020
- Neck, 21501-21502
- Nose, 30000, 30020
- Olecranon Process, 23930
 - Sequestrectomy, 24138
- Ovary
 - Abdominal Approach, 58822
 - Vaginal Approach, 58820
- Palate, 42000
- Parauethral Gland, 53060
- Parotid Gland, 42300, 42305
- Pelvis, 26990
 - Bone Abscess, 26992
 - Transrectal, 45000, 49407
- Perineal, 56405
- Perirenal or Renal, 50020
 - Percutaneous, 49405
- Peritoneal, 49020, 49406-49407
- Pharynx, 42700-42725
- Posterior Spine, 22010, 22015
- Prostate, 55720-55725
 - Transurethral, 52700
- Radius, 25028
 - Bone Abscess, 25035
 - Sequestrectomy, 24136
- Rectum, 45005, 45020, 46040, 46060
- Retropertitoneal, 49060

Abscess — *continued*

- Salivary Gland, 42300-42320
- Scapula, 23172
- Scrotum, 54700, 55100
- Shoulder, 23030
 - Bone Abscess, 23035
- Skene's Gland, 53060
- Skin, 10060-10061
 - Puncture Aspiration, 10160
- Soft Tissue Catheter Drainage, 10030
- Spine, 22010-22015
- Spleen, 49405
 - Subdiaphragmatic, 49040
 - Sublingual Gland, 42310, 42320
 - Submaxillary Gland, 42310, 42320
 - Subphrenic, 49040
 - Percutaneous, 49406
- Testis, 54700
- Thigh, 27301
 - Bone Abscess, 27303
- Thoracostomy, 32551
- Thorax, 21501-21502
 - Bone Abscess, 21510
- Throat, 42700-42725
- Tongue, 41000-41009
- Tonsil, 42700
- Ulna, 25035
- Urethra, 53040
- Uvula, 42000
- Vagina, 57010
- Visceral, 49405
- Vulva, 56405
- Wrist, 25028
 - Bone Abscess, 25035
 - Sequestrectomy, 25145
- X-ray, 75989, 76080

Absolute Neutrophil Count (ANC), 85048**Absolute Quantitation Myocardial Blood Flow (AQMBF), 0742T****Absorptiometry**

- Dual Energy, 77080
- Bone
 - Appendicular Skeleton, 77081
 - Axial Skeleton, 77078, 77080
 - Vertebral, 77080, [77086]
- Ordered and Documented (PQRS), 3095F-3096F

Dual Photon**Bone**

- 78351
- Single Photon
 - Bone, 78350

Absorption Spectrophotometry, 82190**Atomic, 82190****ACADM, 81400-81401****ACADS, 81404-81405****ACADVL, 81406****ACB, 82045****ACBE (Air Contrast Barium Enema), 74280****Access**

- Small Bowel via Biliary Tree, Percutaneous, 47541

Accessory Nerve**Incision, 63191****Section, 63191****Accessory, Toes, 28344****ACD, 63075, 63076****ACE (Angiotensin Converting Enzyme)**

- See Angiotensin

Acetabuloplasty, 27120, 27122, [29915]**Acetabulum****Fracture**

- Closed, 27220, 27222

- Open, 27226-27228

- Reconstruction, 27210

- with Resection, Femoral Head, 27122

Tumor

- Excision, 27076

Acetaminophen, [80329, 80330, 80331]**Assay, 80143****Acetic Anhydrides, 84600****Acetone**

- Blood or Urine, 82009, 82010

Acetone Body, 82009, 82010**Acetylcholine Receptor (AChR) Antibody, [86041], [86042], [86043]****Acetylcholinesterase****Blood or Urine, 82013****AcG, 85220****Achilles Tendon**

- Incision, 27605, 27606

- Lengthening, 27612

- Repair, 27650-27654

Achillotomy, 27605-27606**ACI, 27412, 29870****Acid**

- Adenylic, 82030

Amino

- Blood or Urine, 82127-82139

Aminolevulinic

- Urine or Blood, 82135

Ascorbic

- Blood, 82180

Bile, 82239

- Blood, 82240

Deoxyribonucleic

- Antibody, 86225-86226

Diethylamide, Lysergic, 80299**Fast Bacilli (AFB)**

- Culture, 87116

Fast Stain, 88312**Fatty**

- Blood, 82725

- Very Long Chain, 82726

Folic, 82746

- RBC, 82747

Gastric, 82930**Glycolic, 82240****Lactic, 83605****N-Acetylneurameric, 84275****Perfusion Test**

- Esophagus, 91013, 91030

Phenylethylbarbituric

- Assay, 80184

Phosphatase, 84060-84066**Probes, Nucleic**

- See Nucleic Acid Probe

Reflux Test, 91034-91038**Salt, 84275****Uric**

- Blood, 84550

- Other Source, 84560

- Urine, 84560

Acidity/Aalkinity**Blood Gasses, 82800-82805****Body Fluid, Not Otherwise Specified, 83986****Exhaled Breath Condensate, 83987****ACL Repair**

- Arthroscopy Aided, 29888

- Open, 27407, 27409

Acne Surgery**Incision and Drainage**

- Abscess, 10060, 10061

Puncture Aspiration, 10160**Bulla**

- Puncture Aspiration, 10160

Comedones, 10040

- Cyst, 10040

- Puncture Aspiration, 10160

Milia, Multiple, 10040

- Pustules, 10040

Exfoliation

- Chemical, 17360

Acoustic

- Evoked Brain Stem Potential, [92650], [92651],

- [92652], [92653]

Heart Sounds

- with Computer Analysis, 93799

Immittance Testing, 92570**Neuroma**

- Brain Tumor Excision, 61510, 61518,

- 61520, 61521, 61526, 61530,

- 61545

Brainstem

- Biopsy, 61575, 61576

- Decompression, 61575, 61576

Acoustic — *continued***Neuroma** — *continued***Brainstem** — *continued*

- Evoked Potentials, [92650], [92651],

- [92652], [92653]

Lesion Excision, 61575, 61576**Skull Base Surgery**

- Anterior Cranial Fossa

- Bicoronal Approach, 61586

- Craniofacial Approach, 61580-

- 61583

- Extradural, 61600, 61601

- LeFort I Osteotomy Approach,

- 61586

- Orbitocranial Approach,

- 61584, 61585

- Transzygomatic Approach,

- 61586

- Carotid Aneurysm, 61613

- Craniotomy, 62121

- Dura

- Repair of Cerebrospinal

- Fluid Leak, 61618, 61619

- Middle Cranial Fossa

- Extradural, 61605-61607

- Infratemporal Approach,

- 61590, 61591

- Intradural, 61506-61608

- Orbitocranial Zygomatic Ap-

- proach, 61592

- Posterior Cranial Fossa

- Extradural, 61615

- Intradural, 61616

- Transcondylar Approach,

- 61596, 61597

- Transpetrosal Approach,

- 61598

- Transtemporal Approach,

- 61595

- Recording

- Heart Sounds, 93799

- Waveform, Cardiac, 07167

- ACP, 84060-84066

- Acromioclavicular Joint

- Arthrocentesis, 20605-20606

- Arthrotomy, 23044

- with Biopsy, 23101

- Dislocation, 23540-23552

- Open Treatment, 23550, 23552

- X-ray, 73050

- Acromion

- Excision
</

20100-20103 Exploratory Surgery of Traumatic Wound

INCLUDES Debridement
Expanded dissection wound for exploration
Extraction foreign material
Open examination
Tying or coagulation small vessels

EXCLUDES Cutaneous/subcutaneous incision and drainage procedures (10060-10061)
Laparotomy (49000-49010)
Repair major vessels:
Abdomen (35221, 35251, 35281)
Chest (35211, 35216, 35241, 35246, 35271, 35276)
Extremity (35206-35207, 35226, 35236, 35256, 35266, 35286)
Neck (35201, 35231, 35261)
Thoracotomy (32100-32160)

20100 Exploration of penetrating wound (separate procedure); neck
17.99 17.99 FUD 010 MUE 2(3) T 80 50

20101 chest
6.30 17.25 FUD 010 MUE 2(3) T

20102 abdomen/flank/back
7.71 18.39 FUD 010 MUE 3(3) T

AMA: 2020,Jan
20103 extremity
10.38 16.96 FUD 010 MUE 3(3) JI G2 80

AMA: 2023,Oct

20150 Epiphyseal Bar Resection

20150 Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision
30.28 30.28 FUD 090 MUE 2(3) JI G2 80 50

20200-20206 Muscle Biopsy

INCLUDES Removal of muscle tumor (see appropriate anatomic section)

20200 Biopsy, muscle; superficial
2.86 6.50 FUD 000 MUE 2(3) JI A2

20205 deep
4.66 9.15 FUD 000 MUE 3(3) JI A2

20206 Biopsy, muscle, percutaneous needle
EXCLUDES Fine needle aspiration (10021, [10004, 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012])
(76942, 77002, 77012, 77021)
(88172-88173)
1.69 6.55 FUD 000 MUE 3(3) JI A2

AMA: 2019,Apr

20220-20225 Percutaneous Bone Biopsy

EXCLUDES Bone marrow aspiration(s) or biopsy(ies) (88220-38222)

20220 Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)
(77002, 77012, 77021)
2.57 6.93 FUD 000 MUE 3(3) JI A2

AMA: 2023,Jan

20225 deep (eg, vertebral body, femur)
EXCLUDES When performed at same level:
Percutaneous sacral augmentation (sacropathy) (0200T-0201T)
Percutaneous vertebroplasty (22510-22515)
(77002, 77012, 77021)
3.81 11.32 FUD 000 MUE 2(3) JI A2

AMA: 2023,Jan

20240-20251 Open Bone Biopsy

INCLUDES Sequestrectomy or incision and drainage of bone abscess of:
Calcaneus (28120)
Carpal bone (25145)
Clavicle (23170)
Humeral head (23174)
Humerus (24134)
Olecranon process (24138)
Radius (24136, 25145)
Scapula (23172)
Skull (61501)
Talus (28120)
Ulna (24138, 24145)

20240 Biopsy, bone, open; superficial (eg, sternum, spinous process, rib, patella, olecranon process, calcaneus, tarsal, metatarsal, carpal, metacarpal, phalanx)
4.18 4.18 FUD 000 MUE 4(3) JI A2

AMA: 2023,May; 2023,Apr; 2021,Sep

20245 deep (eg, humeral shaft, ischium, femoral shaft)
10.25 10.25 FUD 000 MUE 3(3) JI A2

AMA: 2023,Apr; 2021,Sep

20250 Biopsy, vertebral body, open; thoracic
11.84 11.84 FUD 010 MUE 1(3) JI G2

AMA: 2023,Apr; 2021,Sep

20251 lumbar or cervical
12.66 12.66 FUD 010 MUE 2(3) JI A2 80

AMA: 2023,Apr; 2021,Sep

20500-20501 Injection Fistula/Sinus Tract

INCLUDES Arthrography injection of:
Ankle (27648)
Elbow (24220)
Hip (27093, 27095)
Sacroiliac joint (27096)
Shoulder (23350)
Temporomandibular joint (TMJ) (21116)
Wrist (25246)

20500 Injection of sinus tract; therapeutic (separate procedure)
(76080)
2.69 3.73 FUD 010 MUE 2(3) JI P3

20501 diagnostic (sinogram)

EXCLUDES Contrast injection or injections for radiological evaluation existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube from percutaneous approach (49465)
(76080)
1.07 4.23 FUD 000 MUE 2(3) JI M1

20520-20525 Foreign Body Removal

20520 Removal of foreign body in muscle or tendon sheath; simple
4.47 6.58 FUD 010 MUE 2(3) JI P3

AMA: 2023,Jan

20525 deep or complicated
7.45 13.95 FUD 010 MUE 4(3) JI A2

AMA: 2023,Jan

20526-20561 [20560, 20561] Therapeutic Injections: Tendons, Trigger Points

20526 Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel
1.70 2.48 FUD 000 MUE 1(2) JI P3 50

AMA: 2023,Jan

20527 Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)
EXCLUDES Post injection palmar fascial cord manipulation (26341)
1.97 2.64 FUD 000 MUE 2(3) JI P3 50

30430

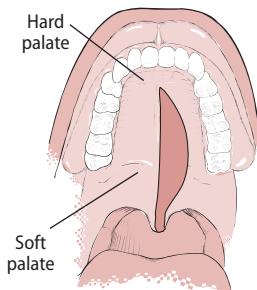
Respiratory System

30430	Rhinoplasty, secondary; minor revision (small amount of nasal tip work)	32.40	32.40	FUD 090	MUE 1(2)	J1 A2 B0
30435	intermediate revision (bony work with osteotomies)	40.34	40.34	FUD 090	MUE 1(2)	J1 A2 B0
30450	major revision (nasal tip work and osteotomies)	52.62	52.62	FUD 090	MUE 1(2)	J1 A2 B0
30460	Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only	24.95	24.95	FUD 090	MUE 1(2)	J1 A2 B0

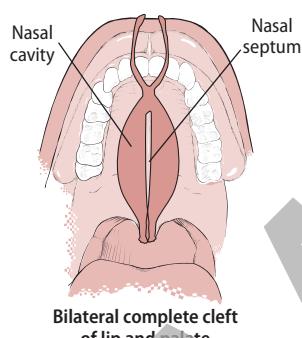
Cleft lip and cleft palate are described according to length of cleft and whether bilateral or unilateral



Complete unilateral cleft lip



Isolated unilateral complete cleft of palate



Bilateral complete cleft of lip and palate

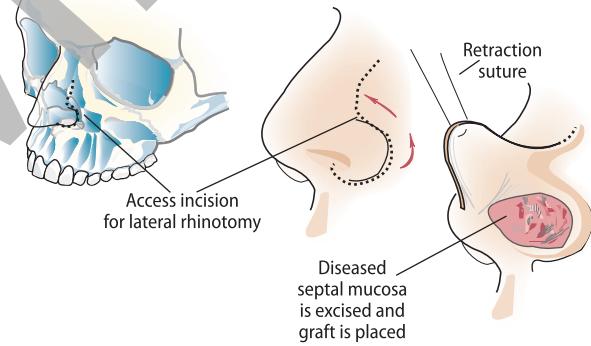
30462	tip, septum, osteotomies	47.91	47.91	FUD 090	MUE 1(2)	J1 A2 B0
30465 Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)						
	INCLUDES Bilateral procedure					
EXCLUDES Repair nasal valve collapse using lateral wall implants, same side during same operative session (30468) Repair nasal valve collapse using radiofrequency, same side during same operative session (30469) Repair nasal vestibular stenosis without graft, implant, or reconstruction lateral wall (30999)						
	Code also graft harvest ([15769], 20900-20902, 20910-20912, 20920-20922, 20924, 21210, 21235)					
Code also modifier 52 for unilateral procedure						
	31.00	31.00	FUD 090	MUE 1(2)	J1 A2 B0	
AMA: 2024, Mar; 2023, Feb; 2020, Sep						

30468	Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)	5.06	74.98	FUD 000	MUE 1(2)	J1 J8
INCLUDES Bilateral procedure						
EXCLUDES Repair nasal valve collapse using radiofrequency, same side during same operative session (30469) Repair nasal valve collapse without graft, implant, or reconstruction lateral wall (30999)						
Repair nasal vestibular stenosis, same side during same operative session (30465)						

Code also modifier 52 for unilateral procedure
5.06 74.98 FUD 000 MUE 1(2)
J1 J8

AMA: 2024, Mar; 2023, Feb

30469	Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling	20.43	20.43	FUD 090	MUE 1(2)	J1 A2 B0
INCLUDES Bilateral procedure						
EXCLUDES Repair nasal valve collapse using lateral wall implants, same side during same operative session (30468) Repair nasal valve collapse without graft, implant, or reconstruction lateral wall (30999)						
Repair nasal vestibular stenosis, same side during same operative session (30465)						
	Code also modifier 52 for unilateral procedure	4.51	73.29	FUD 000	MUE 1(2)	J1 J8
AMA: 2023, Feb						
30520	Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft	20.43	20.43	FUD 090	MUE 1(2)	J1 A2 B0
EXCLUDES Turbinate resection (30140)						
	20.43 20.43 FUD 090 MUE 1(2)					
AMA: 2023, Jul; 2023, Feb; 2021, Jan; 2019, Jul						
30540	Repair choanal atresia; intranasal	22.36	22.36	FUD 090	MUE 1(2)	J1 A2 B0
30545	transpalatine	30.27	30.27	FUD 090	MUE 1(2)	J1 A2 B0
30560	Lysis intranasal synchia	4.58	9.69	FUD 010	MUE 1(2)	J1 A2 B0
30580	Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)	13.84	18.30	FUD 090	MUE 2(3)	J1 A2 B0
30600	oronasal	11.56	15.55	FUD 090	MUE 1(3)	J1 A2 B0
30620	Septal or other intranasal dermatoplasty (does not include obtaining graft)	20.42	20.42	FUD 090	MUE 1(2)	J1 A2 B0



30630	Repair nasal septal perforations	20.24	20.24	FUD 090	MUE 1(2)	J1 A2 B0
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30801-30802 Turbinate Destruction						
EXCLUDES Ablation middle/superior turbinates (30999) Cautery to stop nasal bleeding (30901-30906) Excision inferior turbinate, partial or complete, any method (30130) Submucous resection inferior turbinate, partial or complete, any method (30140)						
30801 Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial						
EXCLUDES Submucosal ablation inferior turbinates (30802) 4.60 6.59 FUD 010 MUE 1(2)						

30802	intramural (ie, submucosal)	6.12	8.38	FUD 010	MUE 1(2)	J1 A2 B0
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AMA: 2023, Feb; 2019, Jul						
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47531-47532 Injection/Insertion Procedures of Biliary Tract

INCLUDES Contrast material injection
Radiologic supervision and interpretation
EXCLUDES *Intraoperative cholangiography (74300-74301)*
Procedures performed via same access (47490, 47533-47541)

47531 Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access

⌚ 2.06 💧 12.48 FUD 000 MUE 2(3)

② NI

AMA: 2023, Feb

47532 new access (eg, percutaneous transhepatic cholangiogram)

⌚ 6.14 💧 24.76 FUD 000 MUE 1(3)

② NI

47533-47544 Percutaneous Procedures of the Biliary Tract

47533 Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; external

EXCLUDES *Conversion to internal-external drainage catheter (47535)*

Percutaneous placement stent bile duct (47538)

Placement stent bile duct, new access (47540)

Replacement existing internal drainage catheter (47536)

⌚ 7.64 💧 34.25 FUD 000 MUE 1(3)

② NI

47534 internal-external

EXCLUDES *Conversion to external only drainage catheter (47536)*

Percutaneous placement stent bile duct (47538)

Placement stent bile duct, new access (47540)

⌚ 10.69 💧 37.62 FUD 000 MUE 2(3)

② NI

47535 Conversion of external biliary drainage catheter to internal-external biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation

⌚ 5.68 💧 26.08 FUD 000 MUE 1(3)

② NI

47536 Exchange of biliary drainage catheter (eg, external, internal-external, or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation

INCLUDES *Exchange one drainage catheter*

EXCLUDES *Placement stent(s) into bile duct, percutaneous (47538)*

Code also exchange additional catheters same session with modifier 59 (47536)

⌚ 3.83 💧 18.68 FUD 000 MUE 2(3)

② NI

47537 Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (eg, with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation

EXCLUDES *Placement stent(s) into bile duct via same access (47538)*

Removal without fluoroscopic guidance; report with appropriate E/M service code

⌚ 2.81 💧 14.46 FUD 000 MUE 1(3)

② NI

47538 Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; existing access

EXCLUDES *Drainage catheter inserted following stent placement (47536)*

Procedures performed via same access (47536-47537)

Treatment same lesion same operative session ([43277], 47542, 47555-47556)

Code also multiple stents placed during same session when: (47538-47540)

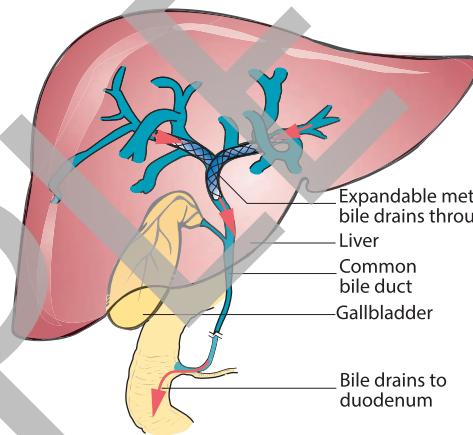
Serial stents placed within same bile duct

Stent placement via two or more percutaneous access sites or space between two other stents

Two or more stents inserted through same percutaneous access

⌚ 6.80 💧 109.95 FUD 000 MUE 2(3)

① J8



47539

new access, without placement of separate biliary drainage catheter

EXCLUDES *Treatment same lesion same operative session ([43277], 47542, 47555-47556)*

Code also multiple stents placed during same session when: (47538-47540)

Serial stents placed within same bile duct

Stent placement via two or more percutaneous access sites or space between two other stents

Two or more stents inserted through same percutaneous access

⌚ 12.35 💧 123.63 FUD 000 MUE 2(3)

① J2

47540

new access, with placement of separate biliary drainage catheter (eg, external or internal-external)

EXCLUDES *Procedures performed via same access (47533-47534)*

Treatment same lesion same operative session ([43277], 47542, 47555-47556)

Code also multiple stents placed during same session when: (47538-47540)

Serial stents placed within same bile duct

Stent placement via two or more percutaneous access sites or space between two other stents

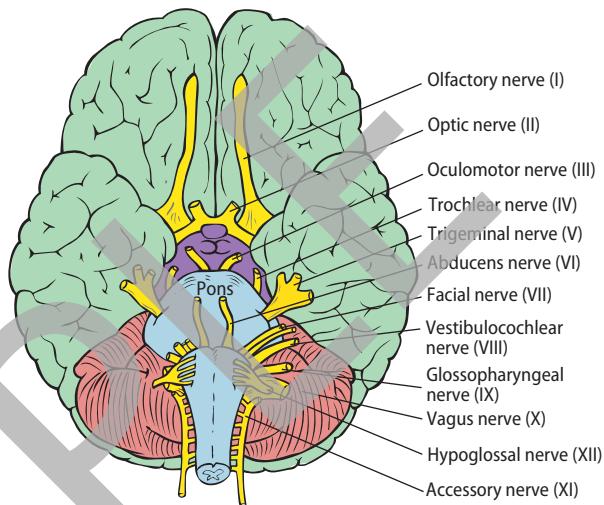
Two or more stents inserted through same percutaneous access

⌚ 12.72 💧 123.37 FUD 000 MUE 2(3)

① J8

61305	infratentorial (posterior fossa)	EXCLUDES Other craniectomy/craniotomy procedures when performed same anatomical site and during same surgical encounter 61.09 61.09 FUD 090 MUE 1(3)   
61312	Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural	62.99 62.99 FUD 090 MUE 2(3)   
61313	intracerebral	60.52 60.52 FUD 090 MUE 2(3)   
61314	Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural	55.63 55.63 FUD 090 MUE 2(3)   
61315	intracerebellar	63.03 63.03 FUD 090 MUE 1(3)   
+ 61316	Incision and subcutaneous placement of cranial bone graft (List separately in addition to code for primary procedure)	Code first (61304, 61312-61313, 61322-61323, 61340, 61570-61571, 61680-61705) 2.63 2.63 FUD ZZZ MUE 1(3)  
61320	Craniectomy or craniotomy, drainage of intracranial abscess; supratentorial	57.64 57.64 FUD 090 MUE 2(3)   
61321	infratentorial	64.68 64.68 FUD 090 MUE 1(3)   
61322	Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; without lobectomy	EXCLUDES Craniectomy or craniotomy for evacuation hematoma (61313) Subtemporal decompression (61340) 72.53 72.53 FUD 090 MUE 1(3)    AMA: 2020,May; 2018,Aug
61323	with lobectomy	EXCLUDES Craniectomy or craniotomy for evacuation hematoma (61313) Subtemporal decompression (61340) 72.70 72.70 FUD 090 MUE 1(3)   
61330-61530 Craniectomy/Craniotomy/Decompression Brain By Surgical Approach/Specific Area of Brain		
	EXCLUDES Injection for:	
	Cerebral angiography (36100-36218) Pneumoencephalography (61055) Ventriculography (61026, 61120)	
61330	Decompression of orbit only, transcranial approach	INCLUDES Naffziger operation 54.72 54.72 FUD 090 MUE 1(2)     
61333	Exploration of orbit (transcranial approach); with removal of lesion	61.37 61.37 FUD 090 MUE 1(2)   
61340	Subtemporal cranial decompression (pseudotumor cerebri, slit ventricle syndrome)	EXCLUDES Decompression craniotomy or craniectomy for intracranial hypertension, without hematoma removal (61322-61323) 43.97 43.97 FUD 090 MUE 1(2)    AMA: 2020,May
61343	Craniectomy, suboccipital with cervical laminectomy for decompression of medulla and spinal cord, with or without dural graft (eg, Arnold-Chiari malformation)	66.69 66.69 FUD 090 MUE 1(2)   
61345	Other cranial decompression, posterior fossa	EXCLUDES Kroenlein procedure Orbital decompression using lateral wall approach (67445) 62.22 62.22 FUD 090 MUE 1(3)   

61450	Craniectomy, subtemporal, for section, compression, or decompression of sensory root of gasserian ganglion	INCLUDES Frazier-Spiller procedure Hartley-Krause Krause decompression Taarnhoj procedure 58.47 58.47 FUD 090 MUE 1(3)   
61458	Craniectomy, suboccipital; for exploration or decompression of cranial nerves	INCLUDES Jannetta decompression 61.24 61.24 FUD 090 MUE 1(2)   
61460	for section of 1 or more cranial nerves	64.14 64.14 FUD 090 MUE 1(2)   
61500	Craniectomy; with excision of tumor or other bone lesion of skull	39.44 39.44 FUD 090 MUE 1(3)   
61501	for osteomyelitis	34.32 34.32 FUD 090 MUE 1(3)   
61510	Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	Code also placement applicator for intraoperative radiation therapy, when performed (0735T) 67.11 67.11 FUD 090 MUE 1(3)   
61512	for excision of meningioma, supratentorial	Code also placement applicator for intraoperative radiation therapy, when performed (0735T) 77.60 77.60 FUD 090 MUE 1(3)   
61514	for excision of brain abscess, supratentorial	58.32 58.32 FUD 090 MUE 2(3)   
61516	for excision or fenestration of cyst, supratentorial	EXCLUDES Craniopharyngioma (61545) Pituitary tumor removal (61546, 61548) 57.14 57.14 FUD 090 MUE 1(3)   
+ 61517	Implantation of brain intracavitary chemotherapy agent (List separately in addition to code for primary procedure)	EXCLUDES Intracavity radioelement source or ribbon implantation (77770-77772) Code first (61510, 61518) 2.62 2.62 FUD ZZZ MUE 1(3)   
61518	Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull	Code also placement applicator for intraoperative radiation therapy, when performed (0735T) 84.27 84.27 FUD 090 MUE 1(3)   



78012-78099 Nuclear Radiology: Thyroid, Parathyroid, Adrenal

EXCLUDES Diagnostic services (see appropriate sections)

Follow-up care (see appropriate section)

Code also radiopharmaceutical(s) and/or drug(s) supplied

78012 Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)
⌚ 2.43 ⚡ 2.43 FUD XXX MUE 1(3) S 72 80

78013 Thyroid imaging (including vascular flow, when performed);
⌚ 5.14 ⚡ 5.14 FUD XXX MUE 1(3) S 72 80

78014 with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)
⌚ 6.53 ⚡ 6.53 FUD XXX MUE 1(2) S 72 80

78015 Thyroid carcinoma metastases imaging; limited area (eg, neck and chest only)
⌚ 6.36 ⚡ 6.36 FUD XXX MUE 1(3) S 72 80

78016 with additional studies (eg, urinary recovery)
⌚ 7.58 ⚡ 7.58 FUD XXX MUE 1(3) S 72 80

78018 whole body
⌚ 8.52 ⚡ 8.52 FUD XXX MUE 1(2) S 72 80

+ 78020 Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure)
Code first (78018)
⌚ 2.34 ⚡ 2.34 FUD ZZZ MUE 1(3) N 72 80

78070 Parathyroid planar imaging (including subtraction, when performed);
EXCLUDES Distribution radiopharmaceutical agents or tumor localization (78800-78802, [78804], 78803)
Radiopharmaceutical quantification measurements ([78835])
SPECT with concurrently acquired CT transmission scan ([78830, 78831, 78832])
⌚ 8.08 ⚡ 8.08 FUD XXX MUE 1(2) S 72 80

AMA: 2020,Oct

78071 with tomographic (SPECT)
EXCLUDES Distribution radiopharmaceutical agents or tumor localization (78800-78802, [78804], 78803)
Radiopharmaceutical quantification measurements ([78835])
SPECT with concurrently acquired CT transmission scan ([78830, 78831, 78832])
⌚ 9.61 ⚡ 9.61 FUD XXX MUE 1(3) S 72 80

AMA: 2020,Oct

78072 with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization
EXCLUDES Distribution radiopharmaceutical agents or tumor localization (78800-78802, [78804], 78803)
Radiopharmaceutical quantification measurements ([78835])
SPECT with concurrently acquired CT transmission scan ([78830, 78831, 78832])
⌚ 11.92 ⚡ 11.92 FUD XXX MUE 1(3) S 72 80

AMA: 2020,Oct

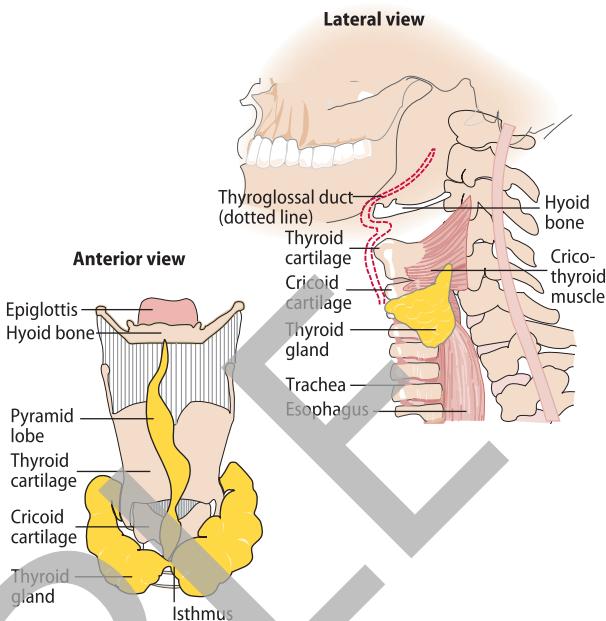
78075 Adrenal imaging, cortex and/or medulla
⌚ 12.17 ⚡ 12.17 FUD XXX MUE 1(2) S 72 80

78099 Unlisted endocrine procedure, diagnostic nuclear medicine

⌚ 0.00 ⚡ 0.00 FUD XXX MUE 1(3)

AMA: 2024,Jan

S 72 80



78102-78199 Nuclear Radiology: Blood Forming Organs

EXCLUDES Diagnostic services (see appropriate sections)

Follow-up care (see appropriate section)

Radioimmunoassays (82009-84999 [82042, 82652])

Code also radiopharmaceutical(s) and/or drug(s) supplied

78102 Bone marrow imaging; limited area
⌚ 4.81 ⚡ 4.81 FUD XXX MUE 1(2) S 72 80

78103 multiple areas
⌚ 5.13 ⚡ 5.13 FUD XXX MUE 1(2) S 72 80

78104 whole body
⌚ 6.89 ⚡ 6.89 FUD XXX MUE 1(2) S 72 80

78110 Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling
⌚ 2.07 ⚡ 2.07 FUD XXX MUE 1(2) S 72 80

78111 multiple samplings
⌚ 2.19 ⚡ 2.19 FUD XXX MUE 1(2) S 72 80

78120 Red cell volume determination (separate procedure); single sampling
⌚ 2.12 ⚡ 2.12 FUD XXX MUE 1(2) S 72 80

78121 multiple samplings
⌚ 2.31 ⚡ 2.31 FUD XXX MUE 1(2) S 72 80

78122 Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique)
⌚ 2.94 ⚡ 2.94 FUD XXX MUE 1(2) S 72 80

78130 Red cell survival study
⌚ 3.72 ⚡ 3.72 FUD XXX MUE 1(2) S 72 80

78140 Labeled red cell sequestration, differential organ/tissue (eg, splenic and/or hepatic)
⌚ 3.28 ⚡ 3.28 FUD XXX MUE 1(3) S 72 80

78185 Spleen imaging only, with or without vascular flow
EXCLUDES Liver imaging (78215-78216)
⌚ 4.64 ⚡ 4.64 FUD XXX MUE 1(2) S 72 80

78191 Platelet survival study
⌚ 3.72 ⚡ 3.72 FUD XXX MUE 1(2) S 72 80

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

► In the **Evaluation and Management** section (98000-98016, 99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Telemedicine Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact same specialty and subspecialty** who belongs to the same group practice, within the past three years.

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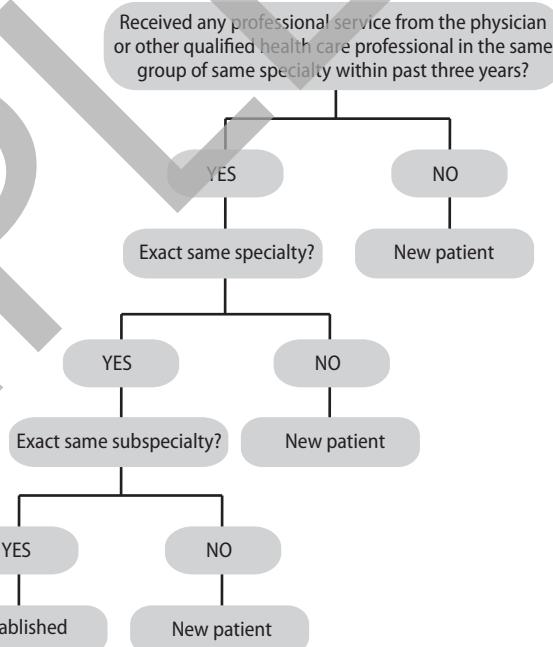
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact same specialty and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact same specialty and subspecialty** as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the inpatient, observation, or nursing facility admission and stay.

A subsequent service is when the patient has received professional service(s) from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice, during the admission and stay.

In the instance when a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not

Appendix A — Modifiers and Expanded Guidance

This appendix identifies modifiers. A modifier is a two-position alphabetic or alphanumeric code appended to a CPT® code to clarify the service being reported. Modifiers provide a means by which a service can be altered without changing the procedure code. They add more information, such as anatomical site, to the code. In addition, they help eliminate the appearance of duplicate billing and unbundling. Modifiers are appended to increase the accuracy in reimbursement and coding consistency, ease editing, and capture payment data.

This appendix has three sections:

- *Introduction to Modifiers* section, providing general information about modifiers
- A list of commonly used modifiers, including for ambulatory surgery center (ASC) use, with the official descriptor from the AMA, and HCPCS Level II modifiers commonly used when coding procedures. Select modifiers have additional instructional notes from Optum inside gray boxes below the official descriptor to assist with appropriate reporting
- Additional regulatory and coding guidance for appropriate reporting of modifiers

Introduction to Modifiers

Over the years, physicians and hospitals have learned that coding and billing are inextricably entwined processes. Coding provides the common language through which the physician and hospital can communicate—or report—their services to third-party payers, including managed care organizations, the federal Medicare program, and state Medicaid programs.

The use of modifiers is an important part of coding and billing for health care services. Modifier use has increased as various commercial payers, who in the past did not incorporate modifiers into their reimbursement protocol, recognize and accept codes appended with these specialized billing flags. Correct modifier use is also an important part of avoiding fraud and abuse or noncompliance issues, especially in coding and billing processes involving the federal and state governments. One of the top 10 billing errors determined by federal, state, and private payers involves the incorrect use of modifiers.

Modifiers give Medicare and commercial payers additional information needed to process a claim. This includes HCPCS Level I (Physicians' Current Procedural Terminology [CPT]) and HCPCS Level II codes.

There are two levels of modifiers within the HCPCS coding system. Level I (CPT) and Level II (HCPCS Level II) modifiers apply nationally for many third-party payers and all Medicare Part B claims. Level I, or CPT, modifiers are developed by the AMA, and HCPCS Level II modifiers are developed by the Centers for Medicare and Medicaid Services (CMS). The Health Insurance Portability and Accountability Act (HIPAA) guidelines indicate that all codes and modifiers are to be standardized. However, some coding and modifier information issued by CMS differs from the AMA's coding advice in the CPT book; a clear understanding of each payer's rules is necessary to assign such modifiers correctly.

The reporting physician appends a modifier to indicate special circumstances that affect the service provided without affecting the service or procedure description itself. When applicable, the appropriate two-character modifier code should be appended to the usual procedure code number to identify the modifying circumstance.

The CPT code book, *CPT 2025*, lists the following examples of when a modifier may be appropriate, including, but not limited to:

- Service/procedure is a global service comprising both a professional and technical component and only a single component is being reported
- Service/procedure involves more than a single provider and/or multiple locations
- Service/procedure was either more involved or did not require the degree of work specified in the code descriptor
- Service/procedure entailed completion of only a segment of the total service/procedure
- An extra or additional service was provided
- Service/procedure was performed on a mirror image body parts (eyes, extremities, kidneys, lungs) and not unilaterally

- Service/procedure was repeated
- Uncommon and atypical events occurred during the course of procedure/service

This appendix lists 36 modifiers valid for use with CPT codes by physicians and health care professionals, and 14 CPT modifiers valid for use with CPT codes for ASCs and outpatient hospital departments. Six anesthesia physical status modifiers are also listed in the appendix as well as some current HCPCS Level II modifiers reported by ASCs and hospital outpatient departments, valid for use with the appropriate CPT or HCPCS Level II codes. However, it is not a complete listing of the HCPCS Level II modifiers for physicians' and other health care professionals' reporting.

Some coders may infer that modifiers can be appended to all CPT codes. However, there are limitations on reporting certain modifiers with specific CPT codes. For instance, modifier 57 (Decision for surgery) can be appended only to appropriate evaluation and management (E/M) codes and certain ophthalmological service codes found in the medicine section of the CPT book.

Placement of a modifier following a CPT or HCPCS code does not ensure reimbursement. A special report may be necessary if the service is rarely provided, increased, unusual, variable, or new. The special report should contain pertinent information and an adequate definition or description of the nature, extent, and need for the procedure/service. The report should also describe the complexity of the patient's symptoms, pertinent history and physical findings, diagnostic and therapeutic procedures, final diagnosis and associated conditions, and follow-up care.

Some modifiers are informational only (e.g., 24 and 25) but can, however, determine whether the service will be reimbursed or denied. Other modifiers such as modifier 22 (Increased procedural services), increase reimbursement under the protocol for many third-party payers if the documentation supports the modifier's use. Modifier 52 (Reduced services) typically equates to a reduction in payment.

For example, in general, a surgical service involves a physician evaluation of the patient before surgery, the surgery itself, and the postoperative follow-up care. Included in the CPT code book is the AMA's description of what makes up the global surgery package, including standard postoperative care, following a surgery or procedure. The AMA does not further define the postoperative period in the CPT code book by indicating an appropriate number of postoperative days for each procedure.

However, CMS and most other payers have segmented surgical procedures into major, minor, or endoscopic surgery, and Medicare has its own definition of a global surgery package. To complicate matters further, the global package for a major surgery differs from that of a minor surgery. For example, the package of services for major surgery includes preoperative visits after the decision has been made to perform surgery, the intraoperative services, complications following surgery that do not require a return to the operating room, postoperative visits within 90 days after surgery, postsurgical pain management, supplies, and other miscellaneous services such as dressing changes. Medicare includes all defined services related to the surgical procedure in the amount reimbursed to the provider, including complications not requiring a return to the operating room.

The postoperative period is the amount of time following a procedure that is considered included in the reimbursement for the surgery. In other words, when a physician is paid for a particular surgery, he or she is also paid for a designated amount of time after the surgery in which he or she continues to treat the patient in follow-up visits related to the surgery. Payment for services not requiring a return to the operating room during the postoperative period is considered included in the initial reimbursement. Under Medicare guidelines, the 90-day postoperative period for a major surgery includes all routine care of the patient for surgery-related services. These services should not be separately reported to Medicare for reimbursement. Medicare has three different postoperative periods for procedures performed: 0 days, 10 days, and 90 days. A listing of global period assignment for procedures can be found in the Medicare Physician Fee Schedule Database (MPFSDB).

Even though CMS sets national guidelines, individual contractors are allowed to interpret many of these guidelines for their own region. This means that services/procedures allowed by one contractor may not be allowed by another. For example, modifier 57 (Decision for surgery) can be particularly confusing when it comes to conflicting guidelines. While the CPT code book

Classification of E/M Services

The E/M section is divided into broad categories such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified.

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, a service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

Categories of E/M Services

Codes for E/M services are categorized by the place of service (e.g., office or hospital) or type of service (e.g., critical care, preventive medicine services). Many of the categories are further divided by the status of the medical visit (e.g., new vs. established patient or initial vs. subsequent care).

New and Established Patients

A **new patient** is defined by the American Medical Association (AMA) as one who has *not* received any professional services from a provider or other qualified healthcare professional (OQHP) of the exact same specialty and subspecialty from the same group practice within the last three years. An **established patient** is defined as one who *has* received a professional service from a provider or OQHP of the exact same specialty and subspecialty from the same group practice within the last three years. If the patient is seen by a physician or OQHP who is covering for another physician or OQHP, the patient is considered the same as if seen by the physician or OQHP who is unavailable.

Initial and Subsequent Services

An **initial** service is defined by the AMA as one who *has not* received professional services from a provider or OQHP of the exact same specialty and subspecialty from the same group practice during an inpatient, observation, or nursing facility admission. A **subsequent** service is defined as one who *has* received professional services from a provider or OQHP of the exact same specialty and subspecialty from the same group practice, during an inpatient, observation, or nursing facility admission. If the patient is seen by a physician or OQHP who is covering for another physician or OQHP, the patient is considered the same as if seen by the physician or OQHP who is unavailable.

Note: Per the CY 2023 physician fee schedule (PFS) final rule, CMS is adopting these definitions with one exception: CMS does not recognize subspecialties and has left "subspecialty" out of their definitions.

Services Reported Separately

Any specifically identifiable procedure or service (i.e., identified with a specific CPT code) performed on the date of E/M services may be reported separately.

The ordering and actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when the professional interpretation of those tests/studies is reported separately by the physician or other qualified healthcare professional reporting the E/M service. Tests that do not require separate interpretation (e.g., tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but may be counted as ordered or reviewed for selecting an MDM level.

Summary of Recent Changes to the E/M Codes

New E/M Telemedicine Services Section

For the CY2025 update, the CPT Editorial Panel has added a new Telemedicine Services section within the Evaluation and Management (E/M) section of the CPT codebook.

Telemedicine services are synchronous, real-time, interactive encounters between a physician or other qualified health care professional (QHP) and a patient utilizing either combined audio-video or audio-only telecommunication.

Seventeen new telehealth codes have been added for reporting synchronous audio-video visits and synchronous audio-only visits for new or established patients. These include:

- **Synchronous Audio-Video E/M Services**
 - New Patient—98000-98003
 - Established Patient—98004-98007
- **Synchronous Audio-Only E/M Services**
 - New Patient—98008-98011
 - Established Patient—98012-98015
- **Brief Synchronous Communication Technology-Based Service**
 - Established Patient—98016

Determining the Level of E/M Service for Office or Other Outpatient Services, Telemedicine Services, Hospital Inpatient and Observation Care, Consultations, Emergency Department Services, Nursing Facility, and Home or Residence Services

For these services, a medically appropriate history and/or physical examination should be documented, but the nature and extent of the history and/or physical examination are determined by the treating clinician based on clinical judgment and what is deemed as reasonable, necessary, and clinically appropriate.

Selecting the level of service for these E/M categories should be based on the levels of MDM or total time spent by the clinician on the day of the encounter, including face-to-face and non-face-to-face activities. Keep in mind that medical necessity is still the overarching criterion for selecting a level of service in addition to the individual requirements of the E/M code.

Medical Decision Making

MDM is used to establish diagnoses, assess the status of a condition, and select a management option(s). MDM for these services is defined by three elements detailed in the MDM table published in the CPT E/M guidelines. The new and established patient levels are scored the same and new and established codes require two out of three elements for any given code.

The three elements of the table are:

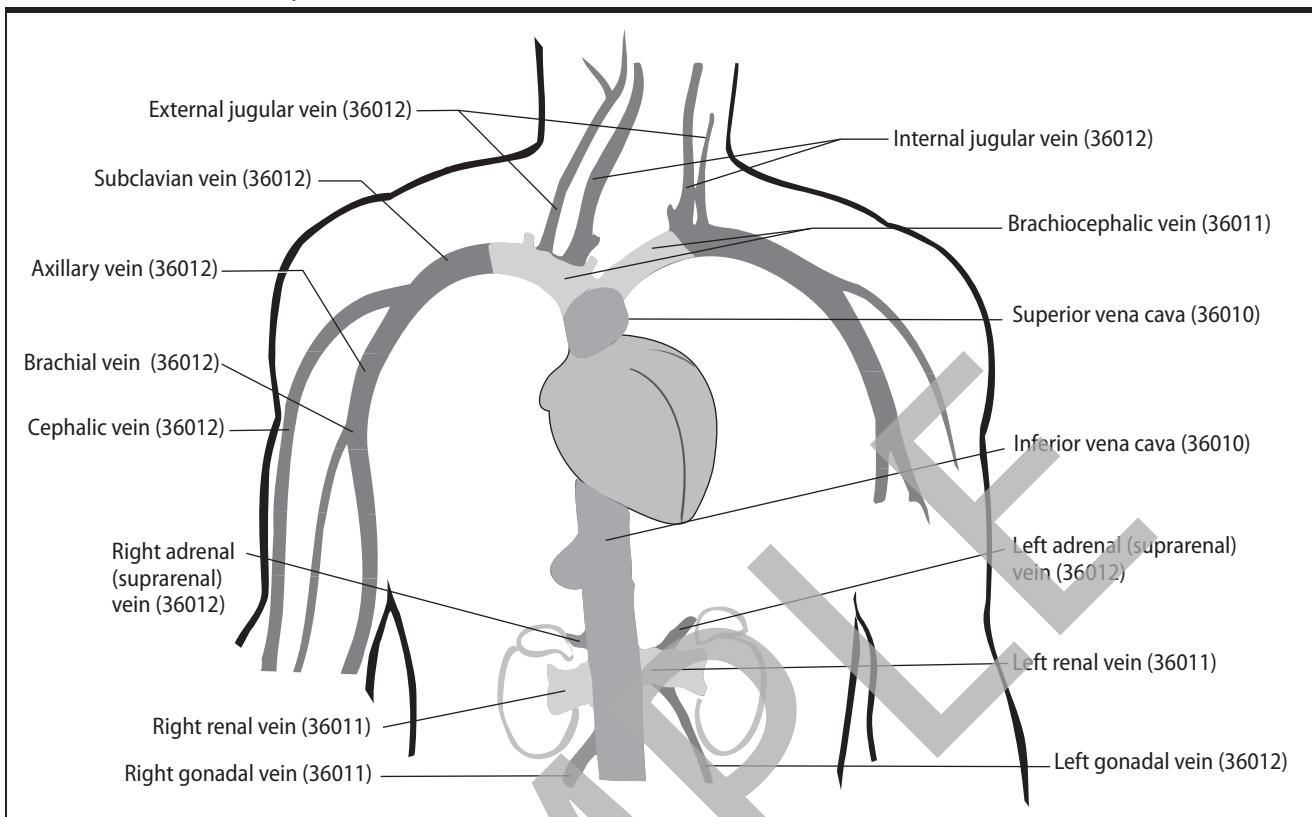
- Number and complexity of problems addressed during the encounter
- Amount and/or complexity of data to be reviewed and analyzed
- Risk of complications and/or morbidity or mortality of patient management

These elements are defined in the E/M guidelines and explained below.

Number and Complexity of Problems Addressed During the Encounter

The first element used in selecting these levels of E/M services is the number and complexity of problems addressed during the encounter. Several new or established problems may be addressed at the same time and may affect MDM.

Symptoms may cluster around a specific diagnosis, and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M service unless they are addressed and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. Risk in this element relates to

Central Venous Anatomy**Portal System (Arterial)**