

Coders' Desk Reference for Procedures

Answers to your toughest CPT® coding questions

2023

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Introduction

Coding is a complicated business. It's not enough to have a current copy of a CPT® book. Medical coders also need dictionaries and specialty texts if they are to accurately translate physicians' operative reports or patient charts into CPT codes.

That's why Optum360 originally developed *Coders' Desk Reference*—now known as *Coders' Desk Reference for Procedures*—to provide a resource with answers to CPT coding questions. We polled the medical reimbursement community and our technical staff to determine the issues causing bottlenecks in a coder's workload.

We know that experienced coders are frustrated by limited definitions accompanying many CPT codes. Beginning coders need guidelines on the use of CPT codes and basic information about medical and reimbursement issues. Everyone requires up-to-date information about the anticipated changes in procedural coding.

Coders' Desk Reference for Procedures (CDR) answers the questions of both experienced and novice medical coders. Coders, physicians, registered nurses, physician assistants, and physical therapists contributed to the technical information contained in CDR. The result is a compendium of answers to a wide variety of CPT coding questions.

Since the first release of CDR in 1995, coders' corrections, suggestions, and tips have been incorporated into every printing, making this book as informative and useful as possible. Changes reflecting the dynamic world of coding are ongoing, and Optum360 encourages input for inclusion in future editions of the book. Information in CDR has been updated to reflect 2022 CPT codes.

Format

CDR is divided into convenient sections for easy use, with each section organized in alphabetic or numeric order. Simply access the section by thumbing through the convenient tabbing system to find the specific item of interest.

Using CPT Codes

For the new coder, and even for the veteran, this chapter provides an overview of the CPT book: what it is and how best to use this coding system for identifying procedures.

Using CPT Modifiers

Modifiers augment CPT codes to the satisfaction of private and government payers. Optum360 coding experts interpret CPT modifiers and identify their advantage in reimbursement.

Using E/M Codes

Although some of the most commonly used codes by physicians of all specialties, evaluation and management (E/M) codes are amongst the least understood. These codes, introduced in the 1992 CPT book, were designed to increase accuracy and consistency in the reporting of non-procedural encounters. This section contains new 2022 guidelines and a summary of E/M services and guidelines, along with information from the 1995 and 1997 documentation guidelines.

Reimbursement Terms

In order to get reimbursed in a timely manner, it is important to have a clear understanding of the terminology used by major insurers and the federal government. This section includes up-to-date terminology that will help coders have a better understanding of the complex reimbursement climate.

Clinical Abbreviations, Prefixes, Suffixes, and Acronyms

The medical profession has its own shorthand for documentation. Here, acronyms, abbreviations, and symbols commonly seen on operative reports or medical charts are listed for easy reference.

The uniquely efficient language of medicine is based on prefixes and suffixes attached to root words to modify the meaning. Medical prefixes and suffixes evolved from the Greek and Latin used by pioneering physicians.

Procedural Eponyms

What is the Mitrofanoff operation? What is the Binet test? Eponyms honor the developer of a procedure or test, but do little to clarify what the procedure is. Subject matter experts have researched the procedural eponyms found in the index of the CPT book or used by surgeons and other medical personnel in medical reports, and provide simplified explanations of what the procedures are, along with applicable CPT codes.

Using CPT® Modifiers

Modifiers allow coders to indicate that a service was altered in some way from the stated CPT® description without actually changing the basic definition of the service. Modifiers are considered an essential component of accurate coding. Some modifiers impact reimbursement and others identify special circumstances. Modifiers can indicate the following:

- A service or procedure represents only a professional or technical component
- A service or procedure was performed by more than one physician
- Only part of a service was performed
- An adjunctive service was performed
- A bilateral procedure was performed
- A service or procedure was provided more than once
- Unusual events occurred
- A procedure or service was more difficult or took longer or was less involved or required less time

Physical status modifiers, P1-P6, specifically used for anesthesia services, are not discussed in this chapter. HCPCS modifiers, beginning with an alpha character, may be appended to CPT codes in specific circumstances and are also not discussed in this chapter.

22 Increased Procedural Services

Modifier 22 is not appropriate for CPT codes with the term “simple” as part of the code description, nor should it be appended to a code for an E/M service. Rather, modifier 22 is used to indicate that a procedure was complicated, complex, difficult, or took significantly more time than usually required by the provider to complete the procedure. Documentation, including notations to the amount of time involved, should be provided with the billing and kept in the medical record when this modifier is used. Time notations in the documentation should include start and stop times, as well as the total amount of additional time required to complete the procedure. The provider should clearly state *specifically*, and in detail, what issues made the procedure more complex rather than simply using vague statements such as, “The patient had a lot of adhesions.” When modifier 22 is used, an operative report should always be attached to the claim.

The fee reported for modifier 22 should be the usual and customary amount for the procedure plus an additional amount for the unusual circumstances. If

modifier 22 is appended to a code that is not the primary code, and modifier 51 has been appended, modifier 22 should be paid in addition to the cut contract rate paid for the code.

Modifier 22 often produces an automatic review or audit by payers. If the operative report attached to the claim does not indicate appropriate use of the modifier, the increase in payment will be denied. Periodic training for all involved in the coding process is important from both a legal and reimbursement perspective.

Because modifier 22 is often used when complications are encountered during surgical procedures, medical necessity is substantiated by additional diagnostic codes that identify the complication. These diagnostic codes should reflect the operative condition and the complication(s) encountered during the surgery.

23 Unusual Anesthesia

This modifier is used by anesthesiologists to indicate that this procedure is normally performed under local anesthesia or regional block but due to unusual circumstances, general anesthesia is needed. This modifier is not appropriate for use with codes that include the term “without anesthesia” in the descriptor, or for procedures normally performed under general anesthesia.

24 Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period

This modifier reports that an unrelated E/M service was provided by the surgeon within the global period. Use of this modifier needs to be correlated to a diagnosis code that is unrelated to the surgical diagnosis code.

25 Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service

This modifier indicates that on the same day a procedure or service identified by a CPT code is performed, the patient’s condition required a significant, separately identifiable E/M code beyond the usual level of service required for the procedure. In addition, the modifier denotes that the patient’s condition required services that were over and above

Using E/M Codes

This section provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. This set of guidelines represents the most complete discussion of the elements of the currently accepted versions. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may employ when treating a given patient, the true indications of the level of this work may be difficult to recognize without some explanation.

At first glance, selecting an E/M code may appear to be difficult, but the system of coding clinical visits may be mastered once the requirements for code selection are learned and used.

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group (see paragraphs 2 and 3 under “Instructions for Use of the CPT® Codebook” on page xiii of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies).

The use of the phrase “physician or other qualified health care professional” (OQHCP) was adopted to identify a health care provider other than a physician. This type of provider is further described in CPT as an individual “qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable).” State licensure guidelines determine the scope of practice and a qualified health care professional must practice within these guidelines, even if more restrictive than the CPT guidelines. The qualified health care professional may report services independently or under incident-to

guidelines. The professionals within this definition are separate from “clinical staff” and are able to practice independently. CPT defines clinical staff as “a person who works under the supervision of a physician or other qualified health care professional and who is allowed, by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service.” Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office/other outpatient services
- Hospital observation and inpatient services
- Consultations
- Emergency department services
- Critical care services
- Nursing facility services
- Domiciliary, rest home (boarding home), or custodial care services
- Domiciliary, rest home (assisted living facility), or home care plan oversight services
- Home services
- Prolonged services
- Case management services
- Care plan oversight services
- Preventive medicine services
- Non-face-to-face services
- Special evaluation and management services
- Newborn care services
- Delivery/birthing room attendance and resuscitative services
- Inpatient neonatal intensive care services and pediatric/neonatal critical care services
- Cognitive assessment and care plan services
- Care management services
- Psychiatric collaborative care management services
- Transitional care management services
- Advance care planning
- General behavioral health integration care management
- Other evaluation and management services

Reimbursement Terms

AAPA. American Academy of Physician Assistants.

AAPC. American Academy of Professional Coders. National organization for coders and billers offering certification examinations based on physician-, facility-, payer-specific guidelines, or coding documentation. Upon successful completion of the selected examination, the credential for that examination is obtained.

AAPCC. Adjusted average per capita cost. Estimated average cost of Medicare benefits for an individual based upon criteria such as age, sex, institutional status, Medicaid, disability, and end-stage renal failure.

abstractor. Person who selects and extracts specific data from the medical record and enters the information into computer files.

accountable care organization. Recognized legal entity under state law comprised of providers of services and suppliers with an established mechanism for shared governance who work together to coordinate care for Medicare fee-for-service beneficiaries. Section 3022 of the Affordable Care Act required CMS to develop a shared savings program to promote coordination and cooperation among providers for the purposes of improving the quality of care for Medicare fee-for-service beneficiaries and minimize costs.

accreditation. Evaluative process in which a health care organization undergoes an examination of its policies, procedures, and performance by an external organization to ensure it is meeting predetermined criteria. It usually involves both on- and off-site surveys.

Accredited Standards Committee. Organization accredited by the American National Standards Institute (ANSI) for the development of American national standards.

accrual. Amount of money set aside to cover a health care benefit plan's expenses based upon estimates using a combination of data, including the claims system and the plan's prior history. In facility accounting, accrual accounting records the expenses as they are incurred and the revenue as it is generated. This contrasts with cash accounting where expenses are recorded only when payment is made or revenues are recorded only when payment is received.

ACH. Automated clearinghouse. Entity that processes or facilitates the processing of information received from another entity in a nonstandard format or

containing nonstandard data content into standard data elements or a standard transaction, or that receives a standard transaction from another entity and processes or facilitates the processing of that information into nonstandard format or nonstandard data content for a receiving entity.

ACLS. Advanced cardiac life support. Certification for health care professionals who have achieved proficiency in providing emergent care of cardiac and respiratory systems and medication management.

ACO. Accountable Care Organization.

ACR. 1) Adjusted community rate. Calculation of what premium the plan charges to provide Medicare-covered benefits for greater frequency of use by participants. **2)** American College of Radiology. **3)** American College of Rheumatology.

activities of daily living. Self-care activities often used to determine a patient's level of function, such as bathing, dressing, using a toilet, transferring in and out of bed or a chair, continence, eating, and walking.

actual charge. Charge a physician or supplier bills for a service rendered or a supply item.

actuarial assumptions. Characteristics used in calculating the risks and costs of a plan, including age, sex, and occupation of enrollees; location; utilization rates; and service costs.

acute care facility. Health care institution primarily engaged in providing treatment to inpatients and diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons who are in an acute phase of illness.

add-on code. Code representing a procedure performed in addition to the primary procedure and is represented with a + in the CPT book. Add-on codes are never reported for stand-alone services but are reported secondarily in addition to the primary procedure.

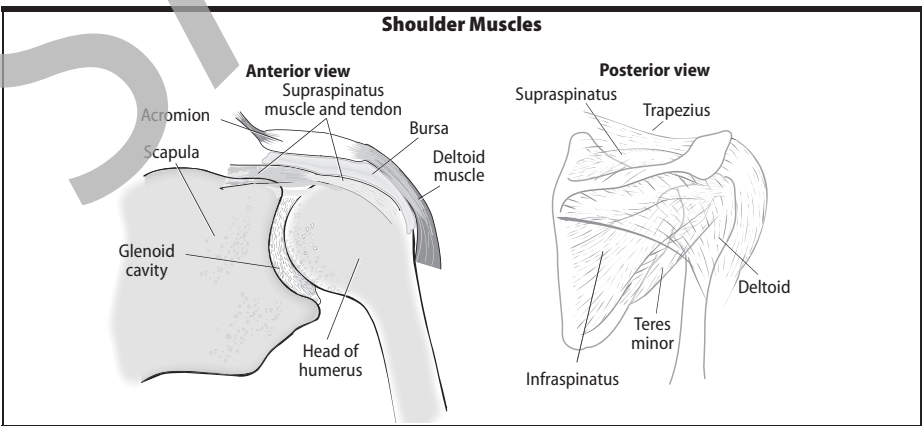
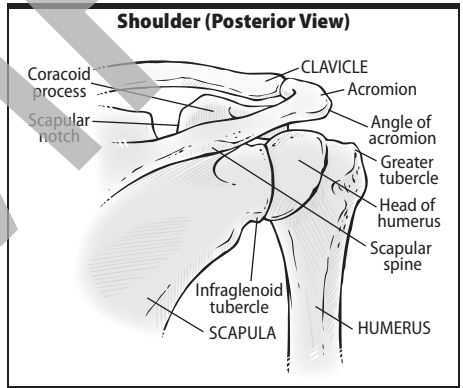
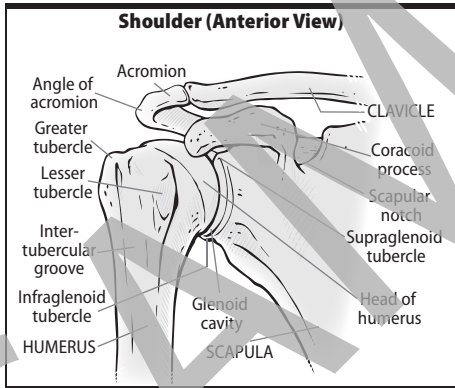
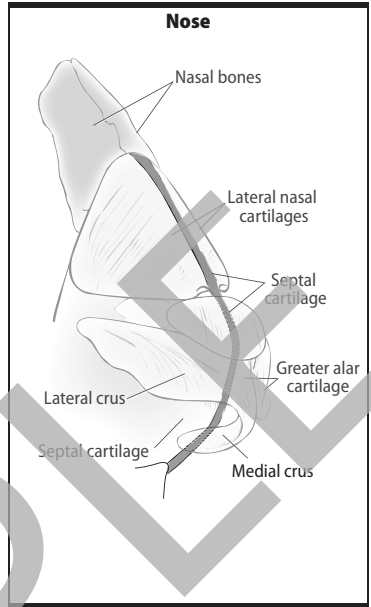
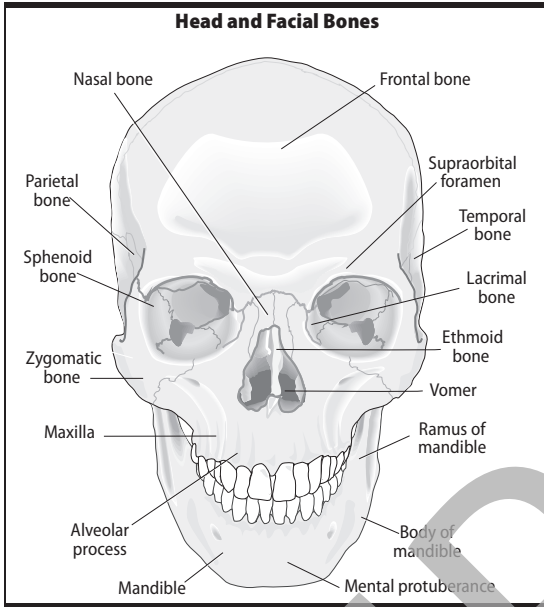
additional development request. Formal request from a Medicare contractor for additional information needed to determine if a claim is covered and/or payable

additional documentation request. When contractors cannot make a coverage or coding determination based upon the information on the claim and its attachments, the contractors may solicit additional documentation from the provider by issuing an ADR. Contractors must ensure that all records requested are from the period under review.

Clinical Abbreviations, Prefixes, Suffixes, and Acronyms

The acronyms, abbreviations, prefixes, suffixes, and symbols used by health care providers speed communications. The following list includes the most often seen acronyms, abbreviations, and symbols. In some cases, abbreviations have more than one meaning. Multiple interpretations are separated by a slash (/). Abbreviations of Latin phrases are punctuated.

-agra	Severe pain.	-oplasty	Surgical repair.
-algia	Pain.	-orrhaphy	Suturing.
-ase	Denoting an enzyme.	-orrhagia	Hemorrhage.
-asthenia	Weakness.	-orrhaphy	Suturing.
-atresia	Closure, occlusion.	-oscopy	To examine.
-blast	Incomplete cellular development.	-osis	Condition, process.
-centesis	Puncture.	-ostomy	Indicates a surgically created artificial opening.
-cephal	Relating to the head.	-otomy	Indicates a cutting.
-cle	Small or little.	-otripsy	Crushing, destroying.
-cyte	Having to do with cells.	-pagus	Indicates fixed or joined together.
-dactyl	Relating to the fingers or toes.	-paraeisis	Indicates weakness.
-desis	Binding or fusion.	-pathic	Indicates a feeling, diseased condition, or therapy.
-ectomy	Excision, removal.	-penia	Indicates a deficiency, less than normal.
-emia	Blood.	-pexy	Fixation.
-ferous	Produces, causes, or brings about.	-philia	Inordinate love of or craving for something.
-fuge	Drive out or expel.	-phobia	Abnormal fear of or aversion to.
-genic	Production, causation, generation.	-plasia	Indicates growth, growing.
-gram	Drawn, written, and recorded.	-plasty	Indicates surgically formed or molded.
-graphic	Written or drawn.	-plegia	Indicates a stroke or paralysis.
-ia	State of being, condition (abnormal).	-pnea	Relating to breath, breathing.
-iasis	Condition.	-poietic	Indicates producing or making.
-itis	Inflammation.	-praxis	Indicates activity, action, condition, or use.
-lysis	Release, free, reduction of.	-rhage	Indicates bleeding or other fluid discharge.
-lytic	Destroy, breakdown.	-rhaphy	Indicates a suture or seam joining two structures.
-metry	Scientific measurement.	-rrhagia	Indicates an abnormal or excessive fluid discharge.
-odynia	Indicates pain or discomfort.	-rrhesis	Splitting or breaking.
-oid	Indicates likeness or resemblance.	-sarcoma	Malignant tumor of flesh or connective tissue.
-ology	Study of.	-spasm	Contraction.
-oma	Tumor.	-taxy	Arrangement, grouping.
-opathy	Relating to disease.	-tomy	Incision.
-opexy	Surgical fixation.	-trophy	Relating to food or nutrition.



Anatomical Illustrations

one adjacent rib above or below the tumor site and any associated intercostal muscles. It may also include rib cage resection and/or an en bloc resection of muscles, including the pectoralis minor or major, the serratus anterior, or the latissimus dorsi. The physician ligates or cauterizes bleeding vessels. A chest tube may be placed to re-expand the lung. The incision is repaired with layered closure and a pressure dressing is applied to the wound.

21602-21603

The physician excises a chest wall tumor, involving ribs, with plastic reconstruction. The physician makes an incision in the skin of the chest overlying the tumor. The tumor and surrounding tissue are excised and includes at least one adjacent rib above and below the tumor site and all intervening intercostal muscles. It may also include an en bloc resection of muscles, including the pectoralis minor or major, the serratus anterior, or the latissimus dorsi. In 21603, lymphatic tissue lying within the mediastinum is also removed. The physician ligates or cauterizes bleeding vessels. A chest tube may be placed to re-expand the lung. Plastic reconstruction is done and may involve rib grafts and/or a myocutaneous flap. A pressure dressing is applied to the wound.

21610

The physician resects the costovertebral joint. The physician makes a posterior incision overlying the joint. The tissues are dissected from the joint and the transverse process is cut from the vertebral body. The physician removes all or a portion of the adjacent rib. The incision is sutured in layers.

21615-21616

The physician performs surgery to remove the first rib and/or an extraneous cervical rib. With the patient under anesthesia, an incision is made in the skin just above the clavicle on the affected side and carried deep to the rib. The rib is identified and the attached soft tissues are dissected from the bone. The physician excises the rib using a saw and other surgical instruments. The rib is freed from its articulation and removed. The wound is irrigated and closed in layers. A dressing is applied. Report 21616 if a sympathetic nerve pathway is cut during the procedure.

21620

The physician removes a portion of the sternum from the chest. With the patient under anesthesia, the physician makes an incision in the skin overlying the sternum. This is carried deep through the subcutaneous tissues to the bone. The sternum is identified and the attached soft tissues are dissected from the bone. The physician marks the portion of the sternum to be removed. The bone is cut in the appropriate places using a saw and other surgical instruments. The remaining portion of the bone is irrigated and smoothed as needed. The wound is closed in layers and a dressing is applied.

21627

The physician performs a debridement of the sternum. With the patient under anesthesia, the physician makes an incision in the skin overlying the sternum. The incision is carried deep to the bone. The sternum is debrided as warranted using any of a variety of hand or powered surgical instruments. Irrigation is used so that debridement can be completed as extensively as indicated. The wound may be loosely packed and a dressing applied or it may be closed in layers and a dressing applied.

21630-21632

The physician removes most or all of the sternum from the chest. With the patient under anesthesia, the physician makes a long incision overlying the sternum and anterior chest. This is carried deep to the bone. Dissection is performed around the sternum. Ribs are disarticulated as needed and thorough debridement is accomplished. Using saws and other surgical instruments, the physician removes the bone. Internal fixation devices (reported separately) are often needed to support the ribs and chest wall. The wound is irrigated and closed in layers. Report 21632 if a mediastinal lymphadenectomy is performed during the procedure.

21685

The hyoid bone is a small C-shaped bone in the neck above the Adam's apple, or thyroid cartilage, with muscles of the tongue and throat attached to it. Hyoid myotomy and suspension is done to open the oropharyngeal airway for correcting breathing in sleep apnea. It involves repositioning and fixating the hyoid bone to improve the airway. A submental incision is made to expose the hyoid bone in the neck. The muscles below the hyoid are transected and separated to expose a small, isolated, mid-portion of the hyoid bone. Strips of fascia lata (bands of fibrous tissue), nonresorbable suture, or other strong materials are wrapped around the body of the hyoid and used to pull it forward and secure it to the inferior mandibular border. An alternative method pulls the hyoid downward to the voicebox cartilage for thyro-hyoid suspension, and secures it there.

21700-21705

The physician performs a surgical procedure where the scalenus anticus muscle is divided, usually for the purpose of treating thoracic outlet syndrome. With the patient under anesthesia, the physician makes an incision overlying the scalene muscle. This incision is carried deep to the muscle. The muscle is exposed and identified. A dissection of the muscle is performed in line of the fibers. This relieves the pressure on the neurovascular structures. The wound is irrigated and closed in layers. Report 21700 if the procedure does not include resection of the cervical rib. Report 21705 if resection of the cervical rib is performed during the procedure.

Respiratory

30000-30020

The physician makes an incision to decompress and drain a collection of pus or blood in the nasal mucosa for 30000 or septal mucosa for 30020. A hemostat bluntly penetrates the pockets and allows the fluid to evacuate. Once decompressed, a small latex drain may be placed into the incision site. This allows an escape for any fluids that may continue to enter the pocket. If a drain is used, it is removed within 48 hours. The nasal cavity may be packed with gauze or Telfa to provide pressure against the mucosa and assist decompression after drainage. The incision may be closed primarily or may be left to granulate without closure.

30100

The physician removes mucosa from inside the nose for biopsy. This biopsy is performed when the mucosa is suspicious for disease. Some normal tissue adjacent to the diseased mucosa is also removed during the biopsy. This allows the pathologist to compare diseased versus nondiseased tissues. The excision site may be closed primarily with sutures or may be allowed to granulate without closure.

30110

The physician removes a polyp from inside the nose. Nasal polyps may obstruct both the airway passages and sinus drainage ducts in the nose. The area is approached intranasally. Topical vasoconstrictive agents are applied to the nasal mucosa. Local anesthesia is injected underneath and around the polyp. A scalpel or biting forceps excise the polyp. Small polyps may leave mucosal defects that do not require closure. With larger defects, the mucosa is closed with sutures in a single layer. The physician may place Telfa to pack the nasal cavity during the first 24 hours.

30115

The physician removes complicated nasal polyps in a hospital setting. Nasal polyps may obstruct both the airway passages and sinus drainage ducts in the nose. The area is approached intranasally. Topical vasoconstrictive agents are applied to the nasal mucosa. Local anesthesia is injected underneath and around the polyp. Large polyps are removed with a wire snare stretching the polyp base; the snare or a scalpel can be used to detach the polyp from its mucosal base. A scalpel or biting forceps excise smaller polyps. Small polyps may leave mucosal defects that do not require closure. With larger defects, the mucosa is closed with sutures in a single layer. The physician may place Telfa to pack the nasal cavity during the first 24 hours.

30117-30118

The physician removes or destroys intranasal soft tissue lesions using techniques such as surgical excision,

cryosurgery, chemical application, or laser surgery. The lesion is approached intranasally in 30117. The physician performs a lateral rhinotomy by retracting the lateral ala to expose the internal nose in 30118. Surgical excision can be utilized to remove the lesion. Cryosurgery freezes and kills soft tissue lesions. Laser surgery vaporizes and emulsifies the lesions. Chemical application of topical vasoconstrictive agents and local anesthesia cauterizes vessels and limits postsurgical hemorrhage. Postoperative wound closure or intranasal packing may not be necessary.

30120

Rhinophyma describes a chronic skin disorder categorized under part of an advanced staged rosacea called phymatous rosacea, identified with significant disfigurement from severe redness and a bulbous nose caused by hypertrophy and hyperplasia of the sebaceous nasal glands. The condition can also seriously impact the function of the nose and without surgery may produce a functional airway compromise (airway obstruction). The physician surgically removes diseased tissue caused by rhinophyma from the external nasal tip. Local anesthesia is injected into the nasal tip. The excess tissue is removed by carving and recontouring hyperplastic tissue from the area. Scalpels, dermabrasion (planing with fine sandpaper or wire brushes), and lasers are common methods of removing this excess tissue. A thin layer of epithelium is maintained over the nasal cartilages to ensure adequate healing. Separately reportable skin grafting may be necessary for very large lesions.

30124-30125

The physician removes a dermoid (developmental) cyst of the nose that may be associated with the soft tissue only in 30124 or may extend into bone and/or cartilage in 30125. If associated with the nasal bone, the usual location is at the bone-cartilage junction. Dependent on the size and location, the cyst may be removed using skin or intranasal incisions. A fistula opening may be present and its tract would be excised. Commonly, an incision is made overlying the cyst in the nasal skin. The cyst is removed from its cavity using curettes. The defect size dictates post-removal cavity packing and/or separately reportable reconstruction. Incisions may be closed in single and layers.

30130

The physician removes a part of or the entire inferior nasal turbinate located on the lateral wall of the nose. The turbinate is primarily removed in cases of hypertrophy that obstruct the nasal airway. The physician places topical vasoconstrictive drugs on the turbinate to shrink the blood vessels. A mucosal incision is made around the base of the turbinate. The physician fractures the bony turbinate from the lateral nasal wall with a chisel or drill. The turbinate is excised. Electrocautery may control bleeding. The nasal mucosa is sutured in single layers. The nasal cavity may be packed with gauze.

previous codes. The physician makes an incision on the face or neck overlying the extradural portion of the other cranial nerve. The tissues are dissected and the nerve is exposed. The nerve is destroyed. The incision is sutured in layers.

64772

The physician cuts or avulses another spinal nerve, such as branch nerves of major nerves not listed in other codes. The physician incises the skin overlying the nerve from C1 to S4. The tissues are dissected and the nerve is exposed. The nerve is destroyed. The incision is sutured in layers. This procedure is also characterized as anterior or posterior interosseous neurectomy (AIN or PIN) when performed on the wrist.

64774-64778

The physician excises a neuroma of a peripheral nerve. A neuroma is a benign tumor formed secondarily by trauma to the nerve. In 64774, the physician incises the skin and locates and excises the neuroma in the subcutaneous tissue. In 64776, the physician incises the skin over the digital nerve and excises the neuroma. Report 64778 for each additional neuroma of a separate digit.

64782-64783

The physician excises a neuroma of a peripheral nerve (except digital nerve) of the hand or foot. A neuroma is a benign tumor formed secondarily by trauma to the nerve. The physician incises the affected area in a hand or foot. After locating the nerve with the symptomatic neuroma, the physician excises the tumor. The incision is sutured in layers. Report 64783 for additional neuromas of the hand or foot.

64784-64786

The physician excises a neuroma of a major peripheral nerve. A neuroma is a benign tumor formed secondarily by trauma to the nerve. In 64784, the physician incises the area over the affected major peripheral nerve except sciatic. After locating the nerve with the symptomatic neuroma, the physician excises the tumor. The incision is sutured in layers. In 64786, the physician incises the skin at the back of the upper leg or buttocks near the symptomatic neuroma and locates the tumor on the sciatic nerve. After locating the nerve with the symptomatic neuroma, the physician excises the tumor. The incision is sutured in layers.

64787

The physician implants a nerve into a bone or muscle to prevent neuroma formation after excision of a neuroma. In bony implantation, the physician drills a small hole in the bone to implant the nerve. The surrounding tissue is brought together around the nerve to secure the nerve to the bone. In muscle implantation the nerve is sutured into muscle bed. The surrounding tissue is brought together and sutured to secure the nerve in the muscle.

64788-64792

The physician excises a neurofibroma or a neurolemmoma. A neurofibroma is a tumor of peripheral nerves caused by abnormal proliferation of Schwann cells. A neurolemmoma is a tumor of a peripheral nerve sheath. To remove the tumor, the physician incises the skin over the tumor and dissects the surrounding tissue. The tumor is freed and excised from the nerve, without damaging the nerve when possible. The incision is sutured in layers. In 64788, the tumor is located on a cutaneous nerve. In 64790, the tumor lies on a major peripheral nerve. In 64792, an extensive excision is required due to size or malignancy.

64795

The physician biopsies a nerve. The physician makes an incision overlying the suspect nerve. The tissues are dissected to locate the nerve, and a biopsy specimen is obtained. The incision is sutured in layers.

64802-64804

The physician performs a cervical sympathectomy or cervical thoracic sympathectomy. The cervical sympathetic chain supplies sympathetic innervation to the head, neck, and upper extremities. The thoracic chain supplies sympathetic innervation to the chest and its contents. In 64802, the physician makes a midlateral incision of the neck and dissects the tissues to locate the sympathetic chain. In 64804, the physician makes a thoracotomy and dissects the tissues to locate the sympathetic chain along the vertebral bodies. The ganglia (nerve cell bodies which lay outside the spinal cord) are identified and resected. The incision is sutured in layers.

64809

The physician performs a sympathectomy on the thoracolumbar sympathetic nerves. The physician makes a lateral incision through the thoracic area to reach the sympathetic ganglia, which lie on the lateral border of the vertebral column. The physician determines at which level to remove the ganglia, and dissects to the vertebral bodies. The sympathetic plexus is located and resected. The wound is sutured in layers.

64818

The physician performs a sympathectomy on the lumbar sympathetic nerves. The physician makes a lateral incision through the lumbar area to reach the sympathetic ganglia, which lie on the lateral border of the vertebral column. The physician determines at which level to remove the ganglia, and dissects to the vertebral bodies. The sympathetic plexus is located and resected. The wound is sutured in layers.

64820-64823

In 64820, the physician performs a digital sympathectomy using a microscope for visualization. The physician makes an incision along the digital artery

poliovirus (DTaP-IPV) for administration to children 4 through 6 years of age. Code 90697 reports an intramuscular vaccine for diphtheria, tetanus toxoids, acellular pertussis, and inactivated poliovirus, combined with a *Haemophilus influenzae* type b PRP-OMP conjugate vaccine and Hepatitis B vaccine (DTaP-IPV-Hib-HepB). Code 90698 reports the immunization supply of diphtheria, tetanus toxoids, and acellular pertussis (synthetic form), combined with *Haemophilus influenzae* type B and inactivated poliovirus vaccine (DTaP-IPV/Hib) for intramuscular use. Code 90700 describes a vaccine for intramuscular use against diphtheria, tetanus toxoids, and acellular pertussis (DTaP) for administration to children younger than 7 years of age. The DTaP/DTP vaccinations are routine immunizations for children. Report these codes with the appropriate administration code.

90702

This code reports supply of the toxoid only. A toxoid stimulates the body's own immune system to produce specific antitoxin antibodies that destroy the toxins secreted by bacteria. This provides immunity that is effective and long lasting. This code reports toxoids against diphtheria and tetanus (DT), adsorbed for intramuscular use, for administration to individuals younger than age 7. Report this code with the appropriate administration code.

90707

A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of these antibody production patterns for long-term protection. Code 90707 reports the combined measles, mumps, and rubella (MMR) vaccine, live, for subcutaneous use. A live vaccine contains the actual pathogens. Report this code with the appropriate administration code.

90710

A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of these antibody production patterns for long-term protection. This vaccine combines measles, mumps, rubella, and varicella (MMRV) for subcutaneous use. This live vaccine contains the actual pathogens. Report this code with the appropriate administration code.

90713

A vaccine produces active immunization by inducing the immune system to manufacture its own antibodies against specific microorganisms/viruses. The body retains memory of these antibody production patterns for long-term protection. This code describes the inactivated poliovirus vaccine (IPV) for subcutaneous or intramuscular use. Report this code with the appropriate administration code.

90714

This code reports supply of the toxoid only. A toxoid stimulates the body's own immune system to produce specific antitoxin antibodies that destroy the toxins secreted by bacteria. This provides immunity that is effective and long lasting. This code reports the immunization supply of tetanus and diphtheria toxoids (Td), adsorbed, preservative free, for intramuscular administration to patients 7 years of age or older. Report this code with the appropriate administration code.

90715

This code reports the vaccine/toxoid product supply only. A toxoid stimulates the body's own immune system to produce specific antitoxin antibodies that destroy the toxins secreted by bacteria. This provides immunity that is effective and long lasting. A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of these antibody production patterns for long-term protection. This code reports the immunization supply of tetanus, diphtheria toxoids, and acellular pertussis (synthetic form) vaccine (Tdap) for intramuscular administration to patients 7 years of age or older. Report this code with the appropriate administration code.

[90626, 90627]

Tick-borne encephalitis (TBE), a viral infection of the brain and spine, can be transmitted to humans through the bite of an infected tick or, infrequently, by ingesting unpasteurized milk or milk products from infected animals. Although not currently endemic in the United States, it has been identified in over 35 countries throughout Asia and Europe. This vaccine, developed using a master "seed" virus similar to the natural TBE virus, induces neutralizing antibodies and is intended for intramuscular administration to prevent TBE in persons 1 year of age and older. Report 90626 for the 0.25 mL dosage and 90627 for the 0.5 mL dosage. Report this code with the appropriate administration code.

90716

A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of these antibody production patterns for long-term protection. This code describes a live varicella virus vaccine (VAR) for subcutaneous use. This vaccine contains the actual pathogen. Report this code with the appropriate administration code.

90717

A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of these antibody production patterns for long-term protection. This code reports the live vaccine

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