Optum

Expert

Current Procedural Coding Expert

CPT® codes with Medicare essentials for enhanced accuracy

2025

optumcoding.com

Contents

Introduction

Note: All data current as of November 1, 2024.

Welcome to Optum's *Current Procedural Coding Expert*, an exciting Medicare coding and reimbursement tool and definitive procedure coding source that combines the work of the Centers for Medicare and Medicaid Services (CMS), American Medical Association (AMA), and Optum experts with the technical components you need for proper reimbursement and coding accuracy.

This approach to CPT® Medicare coding utilizes innovative and intuitive ways of communicating the information you need to code claims accurately and efficiently. ***Includes* and *Excludes* notes**, similar to those found in the ICD-10-CM manual, help determine what services are related to the codes you are reporting. Icons help you crosswalk the code you are reporting to laboratory and radiology procedures necessary for proper reimbursement. CMS-mandated icons and relative value units (RVUs) help you determine which codes are most appropriate for the service you are reporting. Add to that additional information identifying age and sex edits, ambulatory surgery center (ASC) and ambulatory payment classification (APC) indicators, and Medicare coverage and payment rule citations, and *Current Procedural Coding Expert* provides the best in Medicare procedure reporting.

Current Procedural Coding Expert includes the information needed to submit claims to federal contractors and most commercial payers, and is correct at the time of printing. However, CMS, federal contractors, and commercial payers may change payment rules at any time throughout the year. Commercial payers will announce changes through monthly news or information posted on their websites. CMS will post changes in policy on its website at http://www.cms.gov/transmittals. National and local coverage determinations (NCDs and LCDs) provide universal and individual contractor guidelines for specific services. The existence of a procedure code does not imply coverage under any given insurance plan.

Current Procedural Coding Expert is based on the AMA's Current Procedural Terminology coding system, which is copyrighted and owned by the physician organization. The CPT codes are the nation's official, Health Information Portability and Accountability Act (HIPAA) compliant code set for procedures and services provided by physicians, ambulatory surgery centers (ASCs), and hospital outpatient services, as well as laboratories, imaging centers, physical therapy clinics, urgent care centers, and others.

Getting Started with *Current Procedural Coding Expert*

Current Procedural Coding Expert is an exciting tool combining the most current material at the time of our publication from the AMA's CPT 2024, CMS's online manual system, the Correct Coding initiative, CMS fee schedules, official Medicare guidelines for reimbursement and coverage, the Integrated Outpatient Code Editor (I/OCE), and Optum's own coding expertise.

These coding rules and guidelines are incorporated into more specific section notes and code notes. Section notes are listed under a range of codes and apply to all codes in that range. Code notes are found under individual codes and apply to the single code.

Material is presented in a logical fashion for those billing Medicare, Medicaid, and many private payers. The format, based on customer comments, better addresses what customers tell us they need in a comprehensive Medicare procedure coding guide.

Designed to be easy to use and full of information, this product is an excellent companion to your AMA CPT manual, and other Optum and Medicare resources.

For mid-year code updates, correction notices, and any other changes pertinent to the information in *Current Procedural Coding Expert*, see our product update page at https://www.optumcoding.com/ProductUpdates/. The password for 2025 is XXXXXX.

Note: The AMA releases code changes quarterly as well as errata or corrections to CPT codes and guidelines and posts them on their website. Some of these changes may not appear in the AMA's CPT book until the following year. *Current Procedural Coding Expert* incorporates the most recent errata or release notes found on the AMA's website at our publication time, including new, revised and deleted codes. *Current Procedural Coding Expert* identifies these new or revised codes from the AMA website errata or release notes with an icon similar to the AMA's current new ● and revised ▲ icons. For purposes of this publication, new CPT codes and revisions that won't be in the AMA book until the next edition are indicated with a ● and a ▲ icon. CPT codes that are new or revised during 2023 or 2024 but do not appear in the AMA's CPT code book until 2026 are identified in appendix B as "Web Release New, Revised, and Deleted Codes." For the next year's edition of *Current Procedural Coding Expert*, these codes will appear with standard black new or revised icons, as appropriate, to correspond with those changes as indicated in the AMA's CPT book.

General Conventions

Many of the sources of information in this book can be determined by color.

- All CPT codes and descriptions and the Evaluation and Management guidelines from the American Medical Association are in **black text**.
- Includes, Excludes, and other notes appear in **blue text**. The resources used for this information are a variety of Medicare policy manuals, the *National Correct Coding Initiative Policy Manual* (NCCI), AMA resources and guidelines, and specialty association resources and our Optum clinical experts.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a numbering methodology of resequencing, which is the practice of displaying codes outside of their numerical order according to the description relationship. According to the AMA, there are instances in which a new code is needed within an existing grouping of codes, but an unused code number is not available. In these situations, the AMA will resequence the codes. In other words, it will assign a code that is not in numeric sequence with the related codes.

An example of resequencing from *Current Procedural Coding Expert* follows:

	21555	**Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm**
#	**21552**	**3 cm or greater**
	21556	**Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm**
#	**21554**	**5 cm or greater**

In *Current Procedural Coding Expert* the resequenced codes are listed twice. They appear in their resequenced position as shown above as well as in their original numeric position with a note indicating that the code is out of numerical sequence and where it can be found. (See example below.)

	21554	**Resequenced code. See code following 21556.**

This differs from the AMA CPT book, in which the coder is directed to a code range that contains the resequenced code and description, rather than to a specific location.

Resequenced codes will appear in brackets in the headers, section notes, and code ranges. For example:

> 27327-27339 [27329, 27337, 27339] Excision Soft Tissue Tumors Femur/Knee. Codes [27329, 27337, 27339] are included in section 27327-27339 in their resequenced positions.
>
> Code also toxoid/vaccine (91304-90759 [90584, 90589, 90611, 90619, 90620, 90621, 90622, 90623, 90625, 90626, 90627, 90630, 90644, 90672, 90673, 90674, 90677, 90683, 90694, 90750, 90756, 90758, 90759, 91304, 91318, 91319, 91320, 91321, 91322])
>
> This shows codes 90584, 90589, 90611, 90619, 90620, 90621, 90622, 90623, 90625, 90626, 90627, 90630, 90644, 90672, 90673, 90674, 90677, 90683, 90694, 90750, 90756, 90758, 90759, 91304, 91318, 91319, 91320, 91321, and 91322 are resequenced in this range of codes.

A list of all resequenced codes, in numeric order, and the page numbers they can be found on is located in appendix E.

Code Ranges for Medicare Billing

Optum will display the resequenced coding as assigned by the AMA in its CPT products so that the user may understand the code description relationships.

Each particular group of CPT codes in *Current Procedural Coding Expert* is organized in a more intuitive fashion for Medicare billing, being grouped by the Medicare rules and regulations as found in the official CMS online

manuals that govern payment of these particular procedures and services, as in this example:

99221-99233 Inpatient Hospital Visits: Initial and Subsequent
CMS: 100-04,11,40.1.3 Independent Attending Physician Services; 100-04,12,30.6.10 Consultation Services; 100-04,12,30.6.4 Services Furnished Incident to Physician's Service; 100-04,12,30.6.8 Payment for Hospital Observation Services; 100-04,12,30.6.9 Swing Bed Visits

Icons

● **New Codes**
Codes that have been added since the last edition of the AMA CPT book was printed.

▲ **Revised Codes**
Codes that have been revised since the last edition of the AMA CPT book was printed.

● **New Web Release**
Codes that are new for the current year but will not be in the AMA CPT book until 2025.

▲ **Revised Web Release**
Codes that have been revised for the current year, but will not be in the AMA CPT book until 2025.

Resequenced Codes
Codes that are out of numeric order but apply to the appropriate category.

Audio-only Services
Codes that may be reported for audio-only services. Modifier 93 must be appended to code.

★ **Telemedicine Services**
Codes that may be reported for telemedicine services. Modifier 95 must be appended to code.

❍ **Reinstated Code**
Codes that have been reinstated since the last edition of the book was printed.

Pink Color Bar—Not Covered by Medicare
Services and procedures identified by this color bar are never covered benefits under Medicare. Services and procedures that are not covered may be billed directly to the patient at the time of the service.

Gray Color Bar—Unlisted Procedure
Unlisted CPT codes report procedures that have not been assigned a specific code number. An unlisted code delays payment due to the extra time necessary for review.

Green Color Bar—Resequenced Codes
Resequenced codes are codes that are out of numeric sequence—they are indicated with a green color bar. They are listed twice, in their resequenced position as well as in their original numeric position with a note that the code is out of numerical sequence and where the resequenced code and description can be found.

Note: For codes that may require additional coding instruction, the term "Note" will appear in purple font preceding the instructional notes. This note is intended to alert the user to important information that does not fall into a standard instructional note.

INCLUDES **Includes notes**
Includes notes identify procedures and services that would be bundled in the procedure code. These are derived from AMA, CMS, NCCI, and Optum coding guidelines. This is not meant to be an all-inclusive list.

EXCLUDES **Excludes notes**
Excludes notes may lead the user to other codes. They may identify services that are not bundled and may be separately reported, OR may lead the user to another more appropriate code. These are derived from AMA, CMS, NCCI, and Optum coding guidelines. This is not meant to be an all-inclusive list.

Code Also This note identifies an additional code that should be reported with the service and may relate to another CPT code or an appropriate HCPCS code(s) that should be reported along with the CPT code when appropriate.

Code First Found under add-on codes, this note identifies codes for primary procedures that should be reported first, with the add-on code reported as a secondary code.

Laboratory/Pathology Crosswalk
This icon denotes CPT codes in the laboratory and pathology section of CPT that may be reported separately with the primary CPT code.

Radiology Crosswalk
This icon denotes codes in the radiology section that may be used with the primary CPT code being reported.

TC **Technical Component Only**
Codes with this icon represent only the technical component (staff and equipment costs) of a procedure or service. Do not use either modifier 26 (professional component) or TC (technical component) with these codes.

26 **Professional Component**
Only codes with this icon represent the physician's work or professional component of a procedure or service. Do not use either modifier 26 (professional component) or TC (technical component) with these codes.

50 **Bilateral Procedure**
This icon identifies codes that can be reported bilaterally when the same surgeon provides the service for the same patient on the same date. Medicare allows payment for both procedures at 150 percent of the usual amount for one procedure. The modifier does not apply to bilateral procedures inclusive to one code.

80 **Assist-at-Surgery Allowed**
Services noted by this icon are allowed an assistant at surgery with a Medicare payment equal to 16 percent of the allowed amount for the global surgery for that procedure. No documentation is required.

80 **Assist-at-Surgery Allowed with Documentation**
Services noted by this icon are allowed an assistant at surgery with a Medicare payment equal to 16 percent of the allowed amount for the global surgery for that procedure. Documentation is required.

Add-on Codes
This icon identifies procedures reported in addition to the primary procedure. The icon "✚" denotes add-on codes. An add-on code is neither a stand-alone code nor subject to multiple procedure rules since it describes work in addition to the primary procedure.

According to Medicare guidelines, add-on codes may be identified in the following ways:

- The code is found on Change Request (CR) 7501 or successive CRs as a Type I, Type II, or Type III add-on code.
- The add-on code most often has a global period of "ZZZ" in the Medicare Physician Fee Schedule Database.
- The code is found in the CPT book with the icon "✚" appended. Add-on code descriptors typically include the phrases "each additional" or "(List separately in addition to primary procedure)."

Optum Modifier 50 Exempt
Codes identified by this icon indicate that the procedure should not be reported with modifier 50 (Bilateral procedures).

Modifier 51 Exempt
Codes identified by this icon indicate that the procedure should not be reported with modifier 51 (Multiple procedures).

51 **Optum Modifier 51 Exempt**
Codes identified by this Optum icon indicate that the procedure should not be reported with modifier 51 (Multiple procedures). Any code with this icon is backed by official AMA guidelines but was not identified by the AMA with their modifier 51 exempt icon.

Correct Coding Initiative (CCI)
Current Procedural Coding Expert identifies those codes with corresponding CCI edits. The CCI edits define correct coding practices that serve as the basis of the national Medicare policy for paying claims. The code noted is the major service/ procedure. The code may represent a column 1 code within the column 1/column 2

correct coding edits table or a code pair that is mutually exclusive of each other.

CLIA Waived Test
This symbol is used to distinguish those laboratory tests that can be performed using test systems that are waived from regulatory oversight established by the Clinical Laboratory Improvement Amendments of 1988 (CLIA). The applicable CPT code for a CLIA waived test may be reported by providers who perform the testing but do not hold a CLIA license.

Modifier 63 Exempt
This icon identifies procedures performed on infants that weigh less than 4 kg. Due to the complexity of performing procedures on infants less than 4 kg, modifier 63 may be added to the surgery codes to inform the payers of the special circumstances involved.

A2–Z3 **ASC Payment Indicators**
This icon identifies ASC status payment indicators. They indicate how the ASC payment rate was derived and/or how the procedure, item, or service is treated under the revised ASC payment system. For more information about these indicators and how they affect billing, consult Optum's *Revenue Cycle Pro*.

The ASC payment indicators contained in this publication were effective as of October 1, 2023. Once released by CMS, the table with data effective January 1, 2024, will be available on our product update page at www.optumcoding.com/ProductUpdates/.

- A2 Surgical procedure on ASC list in 2007; payment based on OPPS relative payment weight.
- B5 Alternative code may be available; no payment made.
- D5 Deleted/discontinued code; no payment made.
- E4 Corneal tissue acquisition; hepatitis B vaccine; paid at reasonable cost.
- G2 Non-office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.
- H2 Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
- J7 OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.
- J8 Device-intensive procedure; paid at adjusted rate.
- K2 Drugs and biologicals paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.
- K7 Unclassified drugs and biologicals; payment contractor-priced.
- L1 Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment made.
- L6 New technology intraocular lens (NTIOL); special payment.
- N1 Packaged service/item; no separate payment made.
- P2 Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility practice expense (PE) RVUs; payment based on OPPS relative payment weight.
- P3 Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs.
- R2 Office-based surgical procedure added to ASC list in CY 2008 or later without MPFS nonfacility PE RVUs; payment based on OPPS relative payment weight.
- Z2 Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.
- Z3 Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.

A **Age Edit**
This icon denotes codes intended for use with a specific age group, such as neonate, newborn, pediatric, and adult. This edit is based on age specifications in the CPT code descriptors, the product/service represented by the code *may* have age restrictions, and/or updates from the Integrated Outpatient Code Editor (I/OCE). Carefully review the code description to ensure the code you report most appropriately reflects the patient's age.

M **Maternity**
This icon identifies procedures that by definition should be used only for maternity patients generally between 9 and 64 years of age based on CMS I/OCE designations.

♀ **Female Only**
This icon identifies procedures designated by CMS for females only based on CMS I/OCE designations.

♂ **Male Only**
This icon identifies procedures designated by CMS for males only based on CMS I/OCE designations.

Facility RVU
This icon precedes the facility RVU from CMS's physician fee schedule (PFS). It can be found under the code description.

New codes include no RVU information.

Nonfacility RVU
This icon precedes the nonfacility RVU from CMS's PFS. It can be found under the code description.

New codes include no RVU information.

FUD: Global days are sometimes referred to as "follow-up days" or FUDs. The global period is the time following surgery during which routine care by the physician is considered postoperative and included in the surgical fee. Office visits or other routine care related to the original surgery cannot be separately reported if provided during the global period. The statuses are:

- 000 No follow-up care included in this procedure
- 010 Normal postoperative care is included in this procedure for 10 days
- 090 Normal postoperative care is included in the procedure for 90 days
- MMM Maternity codes; usual global period does not apply
- XXX The global concept does not apply to the code
- YYY The carrier is to determine whether the global concept applies and establishes postoperative period, if appropriate, at time of pricing
- ZZZ The code is related to another service and is always included in the global period of the other service

The RVUs and FUDs contained in this publication were effective as of October 1, 2024. Once released by CMS, the table with data effective January 1, 2025, will be available on our product update page at www.optumcoding.com/ProductUpdates/.

MUE: Optum includes the Practitioner MUE at the code level. This notation indicates the maximum number of units allowed by Medicare. However, it is also important to note that not every code has a Medically Unlikely Edit (MUE). Medicare has assigned some MUE values that are not available. If there is no information in the MUE column for a particular code, this does not mean that there is no MUE; it may simply mean that CMS has not released information on that MUE. Watch the remittance advice for possible details on MUE denials related to those codes. If there is no published MUE, a dash will display in the field.

An additional component of the MUE is the MUE Adjudication Indicator (MAI). This edit is the result of an audit by the Office of Inspector General (OIG) that identified inappropriate billing practices that bypassed the MUEs. These include inappropriate reporting of bilateral services and split billing.

There are three MUE adjudication indicators as follows:

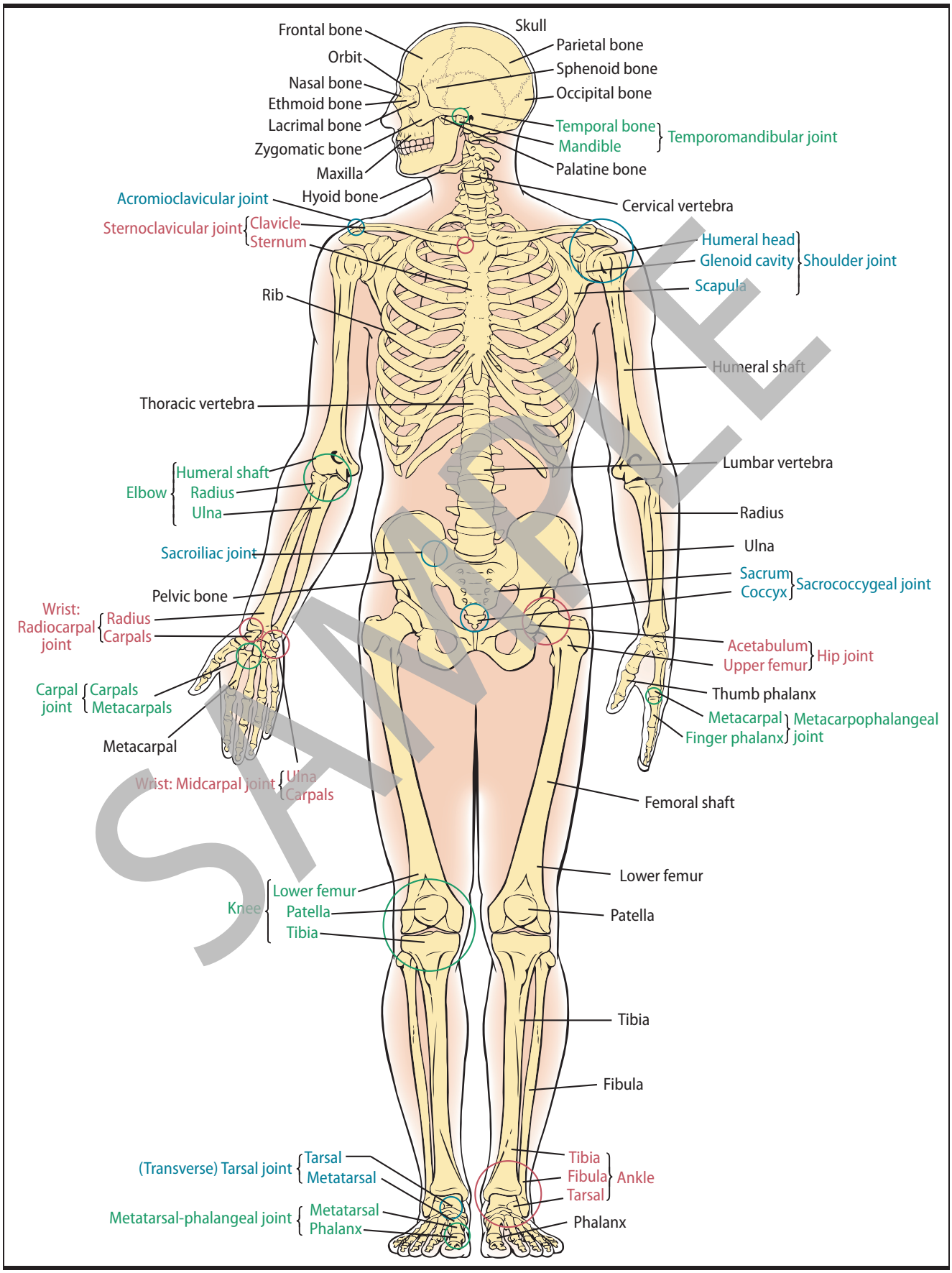
1 Line Edit
2 Date of Service Edit: Policy
3 Date of Service Edit: Clinical

The MAI is listed following the MUE value. For example, code 90834 has an MUE value of 2 and an MAI value of 3. This displays in the MUE field as "MUE 2(3)."

The complete January 2024 MUE tables with Practitioner and OPPS data can be found on our product update page. Quarterly updates

Musculoskeletal System

Bones and Joints



B

[Resequenced]

10030-10180 Treatment of Lesions: Skin and Subcutaneous Tissues

EXCLUDES *Excision benign lesion (11400-11471)*

10030 **Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous**

INCLUDES Radiologic guidance (75989, 76942, 77002-77003, 77012, 77021)

EXCLUDES *Percutaneous drainage with imaging guidance:*
Peritoneal or retroperitoneal collections (49406)
Visceral collections (49405)
Transvaginal or transrectal drainage with imaging guidance peritoneal or retroperitoneal collections (49407)

Code also each fluid collection drained using separate catheter (10030)

3.98 19.50 **FUD** 000 **MUE** 2(3) T G2 80

AMA: 2023,Jan; 2022,Feb; 2019,Apr; 2017,Aug

10035 **Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion**

INCLUDES Radiologic guidance (76942, 77002, 77012, 77021)

EXCLUDES *Reporting code more than one time per site, regardless number markers used*
Sites with more specific code descriptor, such as breast

Code also each additional target on same or opposite side (10036)

2.50 11.13 **FUD** 000 **MUE** 1(2) T N1 80 50

AMA: 2022,Feb

\+ **10036** **each additional lesion (List separately in addition to code for primary procedure)**

INCLUDES Radiologic guidance (76942, 77002, 77012, 77021)

EXCLUDES *Reporting code more than one time per site, regardless number markers used*
Sites with more specific code descriptor, such as breast

Code first (10035)

1.26 9.25 **FUD** ZZZ **MUE** 2(3) N N1 80

AMA: 2022,Feb

10040 **Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)**

1.54 3.49 **FUD** 010 **MUE** 1(2) Q1 N1

AMA: 2022,Feb

10060 **Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single**

3.14 3.76 **FUD** 010 **MUE** 1(2) T P3

AMA: 2023,Apr; 2022,Feb; 2021,Oct

10061 **complicated or multiple**

5.47 6.37 **FUD** 010 **MUE** 1(2) T P3

AMA: 2023,Apr; 2022,Feb; 2021,Oct

10080 **Incision and drainage of pilonidal cyst; simple**

3.12 7.58 **FUD** 010 **MUE** 1(3) T P3

AMA: 2022,Feb

10081 **complicated**

EXCLUDES *Excision pilonidal cyst (11770-11772)*

5.10 10.35 **FUD** 010 **MUE** 1(3) T P3

AMA: 2022,Feb

10120 **Incision and removal of foreign body, subcutaneous tissues; simple**

3.14 4.54 **FUD** 010 **MUE** 3(3) T P3

AMA: 2022,Feb

10121 **complicated**

EXCLUDES *Debridement associated with fracture or dislocation (11010-11012)*
Exploration penetrating wound (20100-20103)

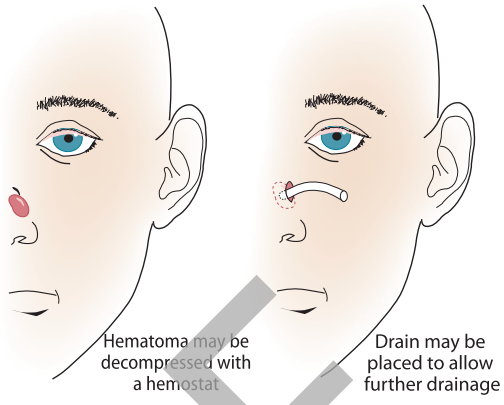
5.47 7.93 **FUD** 010 **MUE** 2(3) J1 A2

AMA: 2022,Feb

10140 **Incision and drainage of hematoma, seroma or fluid collection**

3.51 5.07 **FUD** 010 **MUE** 2(3) J1 P3

AMA: 2022,Feb



10160 **Puncture aspiration of abscess, hematoma, bulla, or cyst**

(76942, 77002, 77012, 77021)

2.88 3.90 **FUD** 010 **MUE** 3(3) T P3

AMA: 2023,Jan; 2022,Feb; 2021,Aug; 2017,Aug; 2017,May

10180 **Incision and drainage, complex, postoperative wound infection**

EXCLUDES *Wound dehiscence (12020-12021, 13160)*

5.34 7.91 **FUD** 010 **MUE** 2(3) J1 A2

AMA: 2022,Feb

11000-11012 Removal of Foreign Substances and Infected/Devitalized Tissue

EXCLUDES *Debridement:*
Burns (16000-16030)
Deeper tissue (11042-11047 [11045, 11046])
Nails (11720-11721)
Nonelective debridement/active care management (97597-97598)
Wounds (11042-11047 [11045, 11046])
Dermabrasions (15780-15783)
Pressure ulcer excision (15920-15999)

11000 **Debridement of extensive eczematous or infected skin; up to 10% of body surface**

EXCLUDES *Necrotizing soft tissue infection:*
Abdominal wall (11005-11006)
External genitalia and perineum (11004, 11006)

0.80 1.73 **FUD** 000 **MUE** 1(2) T P3

AMA: 2023,Jun; 2022,Feb; 2018,Feb

\+ **11001** **each additional 10% of the body surface, or part thereof (List separately in addition to code for primary procedure)**

EXCLUDES *Necrotizing soft tissue infection:*
Abdominal wall (11005-11006)
External genitalia and perineum (11004, 11006)

Code first (11000)

0.44 0.82 **FUD** ZZZ **MUE** 1(3) N N1

AMA: 2023,Jun; 2022,Feb; 2018,Feb

11004 **Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum**

Code also skin grafts or flaps, when performed (14000-14350, 15040-15770 [15769], 15771-15776)

16.80 16.80 **FUD** 000 **MUE** 1(2) C

AMA: 2023,Jun; 2022,Aug; 2022,Feb; 2019,Nov; 2018,Feb

11005 **abdominal wall, with or without fascial closure**

Code also skin grafts or flaps, when performed (14000-14350, 15040-15770 [15769], 15771-15776)

22.89 22.89 **FUD** 000 **MUE** 1(2) C 80

AMA: 2023,Jun; 2022,Aug; 2022,Feb; 2019,Nov; 2018,Feb

30901-30920 Control Nose Bleed

30901 **Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method**
1.69 4.75 **FUD** 000 **MUE** 1(3) Q1 N1 50
AMA: 2020,Oct; 2020,Jul

30903 **Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method**
2.31 7.44 **FUD** 000 **MUE** 1(3) T A2 50
AMA: 2020,Oct; 2020,Jul

30905 **Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial**
3.16 10.64 **FUD** 000 **MUE** 1(2) T A2
AMA: 2020,Oct; 2020,Jul

30906 **subsequent**
3.97 11.28 **FUD** 000 **MUE** 1(3) T A2
AMA: 2020,Oct; 2020,Jul

30915 **Ligation arteries; ethmoidal**
EXCLUDES *External carotid artery (37600)*
18.27 18.27 **FUD** 090 **MUE** 1(3) T A2

30920 **internal maxillary artery, transantral**
EXCLUDES *External carotid artery (37600)*
26.42 26.42 **FUD** 090 **MUE** 1(3) T A2

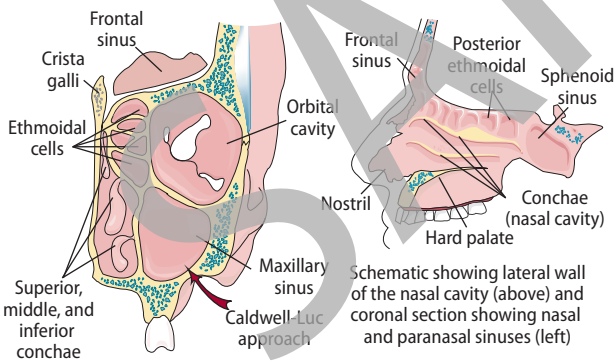
30930-30999 Other and Unlisted Procedures of Nose

30930 **Fracture nasal inferior turbinate(s), therapeutic**
EXCLUDES *Excision inferior turbinate, partial or complete, any method (30130)*
Fracture superior or middle turbinate(s) (30999)
Submucous resection inferior turbinate, partial or complete, any method (30140)
3.55 3.55 **FUD** 010 **MUE** 1(2) J1 A2

30999 **Unlisted procedure, nose**
0.00 0.00 **FUD** YYY **MUE** 1(3) T 80
AMA: 2023,Feb; 2022,Jan; 2021,Jan; 2020,Sep; 2019,Nov

31000-31230 Opening Sinuses

31000 **Lavage by cannulation; maxillary sinus (antrum puncture or natural ostium)**
3.32 5.61 **FUD** 010 **MUE** 1(2) T P2 50



Schematic showing lateral wall of the nasal cavity (above) and coronal section showing nasal and paranasal sinuses (left)

31002 **sphenoid sinus**
5.78 5.78 **FUD** 010 **MUE** 1(2) T R2 80 50

31020 **Sinusotomy, maxillary (antrotomy); intranasal**
10.71 13.20 **FUD** 090 **MUE** 1(2) J1 A2 50

31030 **radical (Caldwell-Luc) without removal of antrochoanal polyps**
15.39 19.20 **FUD** 090 **MUE** 1(2) J1 A2 50

31032 **radical (Caldwell-Luc) with removal of antrochoanal polyps**
18.02 18.02 **FUD** 090 **MUE** 1(2) J1 A2 50

31040 **Pterygomaxillary fossa surgery, any approach**
EXCLUDES *Transantral ligation internal maxillary artery (30920)*
24.37 24.37 **FUD** 090 **MUE** 1(2) J1 R2 50

31050 **Sinusotomy, sphenoid, with or without biopsy;**
15.69 15.69 **FUD** 090 **MUE** 1(2) J1 A2 50

31051 **with mucosal stripping or removal of polyp(s)**
21.07 21.07 **FUD** 090 **MUE** 1(2) J1 A2 50

31070 **Sinusotomy frontal; external, simple (trephine operation)**
INCLUDES Killian operation
EXCLUDES *Intranasal frontal sinusotomy (31276)*
14.48 14.48 **FUD** 090 **MUE** 1(2) J1 A2 50

31075 **transorbital, unilateral (for mucocele or osteoma, Lynch type)**
25.09 25.09 **FUD** 090 **MUE** 1(2) J1 A2 80 50

31080 **obliterative without osteoplastic flap, brow incision (includes ablation)**
INCLUDES Ridell sinusotomy
33.02 33.02 **FUD** 090 **MUE** 1(2) J1 A2 80 50

31081 **obliterative, without osteoplastic flap, coronal incision (includes ablation)**
35.36 35.36 **FUD** 090 **MUE** 1(2) J1 A2 80 50

31084 **obliterative, with osteoplastic flap, brow incision**
36.57 36.57 **FUD** 090 **MUE** 1(2) J1 A2 80 50

31085 **obliterative, with osteoplastic flap, coronal incision**
37.72 37.72 **FUD** 090 **MUE** 1(2) J1 J8 80 50

31086 **nonobliterative, with osteoplastic flap, brow incision**
35.64 35.64 **FUD** 090 **MUE** 1(2) J1 A2 80 50

31087 **nonobliterative, with osteoplastic flap, coronal incision**
33.89 33.89 **FUD** 090 **MUE** 1(2) J1 A2 80 50

31090 **Sinusotomy, unilateral, 3 or more paranasal sinuses (frontal, maxillary, ethmoid, sphenoid)**
33.60 33.60 **FUD** 090 **MUE** 1(2) J1 A2 50

31200 **Ethmoidectomy; intranasal, anterior**
18.83 18.83 **FUD** 090 **MUE** 1(2) J1 A2 50

31201 **intranasal, total**
24.12 24.12 **FUD** 090 **MUE** 1(2) J1 A2 50

31205 **extranasal, total**
28.20 28.20 **FUD** 090 **MUE** 1(2) J1 A2 80 50

31225 **Maxillectomy; without orbital exenteration**
54.10 54.10 **FUD** 090 **MUE** 1(2) C 80 50

31230 **with orbital exenteration (en bloc)**
EXCLUDES *Orbital exenteration without maxillectomy (65110-65114)*
Skin grafts (15120-15121)
60.32 60.32 **FUD** 090 **MUE** 1(2) C 80 50

31231-31235 Nasal Endoscopy, Diagnostic

INCLUDES Complete sinus exam (e.g., nasal cavity, turbinates, sphenoethmoidal recess)
Code also stereotactic navigation, when performed (61782)

31231 **Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)**
1.93 5.70 **FUD** 000 **MUE** 1(2) T P2
AMA: 2021,Apr; 2018,Apr; 2017,Jul; 2017,Jan

31233 **Nasal/sinus endoscopy, diagnostic; with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)**
EXCLUDES *When performed on same side:*
Dilation of maxillary sinus ostium (31295)
Maxillary antrostomy (31256, 31267)
4.02 8.28 **FUD** 000 **MUE** 1(2) T A2 80 50
AMA: 2018,Apr

52325 with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique)

INCLUDES Cystourethroscopy (separate procedure) (52000)

9.34 9.34 FUD 000 MUE 1(3) J1 A2 50

52327 with subureteric injection of implant material

INCLUDES Cystourethroscopy (separate procedure) (52000)

7.56 7.56 FUD 000 MUE 1(2) J1 J8 50

52330 with manipulation, without removal of ureteral calculus

INCLUDES Cystourethroscopy (separate procedure) (52000)

7.68 18.09 FUD 000 MUE 1(2) J1 A2 50

52332 Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

INCLUDES Cystourethroscopy (separate procedure) (52000)

EXCLUDES *Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy when performed on same side with (52353, [52356])*

4.55 12.05 FUD 000 MUE 1(2) J1 A2 50

AMA: 2023,Jul; 2019,Dec

52334 Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde

INCLUDES Cystourethroscopy (separate procedure) (52000)

EXCLUDES *Cystourethroscopy with incision/fulguration/resection congenital posterior urethral valves/obstructive hypertrophic mucosal folds (52400)*
Cystourethroscopy with pyeloscopy and/or ureteroscopy (52351-52353 [52356])
Dilation nephroureteral catheter tract ([50436], [50437])
Percutaneous:
Nephrolithotomy (50080, 50081)
Nephrostomy tract establishment only ([50432, 50433])

5.35 5.35 FUD 000 MUE 1(2) J1 A2

AMA: 2023,Sep

52341 Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)

INCLUDES Diagnostic cystourethroscopy (52351)

EXCLUDES *Balloon dilation with imaging guidance (50706)*
Cystourethroscopy, separate procedure (52000)

(74485)

8.30 8.30 FUD 000 MUE 1(2) J1 A2 50

52342 with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

INCLUDES Diagnostic cystourethroscopy (52351)

EXCLUDES *Balloon dilation with imaging guidance (50706)*
Cystourethroscopy (separate procedure) (52000)

(74485)

9.01 9.01 FUD 000 MUE 1(2) J1 A2 50

52343 with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)

INCLUDES Diagnostic cystourethroscopy (52351)

EXCLUDES *Balloon dilation with imaging guidance (50706)*
Cystourethroscopy (separate procedure) (52000)

(74485)

10.04 10.04 FUD 000 MUE 1(2) J1 A2 50

52344 Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision)

INCLUDES Diagnostic cystourethroscopy (52351)

EXCLUDES *Balloon dilation, ureteral stricture (50706)*
Cystourethroscopy with transurethral resection or incision ejaculatory ducts (52402)

(74485)

10.75 10.75 FUD 000 MUE 1(2) J1 A2 50

52345 with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision)

INCLUDES Diagnostic cystourethroscopy (52351)

EXCLUDES *Balloon dilation, ureteral stricture (50706)*
Cystourethroscopy with transurethral resection or incision ejaculatory ducts (52402)

(74485)

11.49 11.49 FUD 000 MUE 1(2) J1 A2 80 50

52346 with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)

INCLUDES Diagnostic cystourethroscopy (52351)

EXCLUDES *Balloon dilation with imaging guidance (50706)*
Cystourethroscopy with transurethral resection or incision ejaculatory ducts (52402)

(74485)

13.00 13.00 FUD 000 MUE 1(2) J1 A2 80 50

52351 Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic

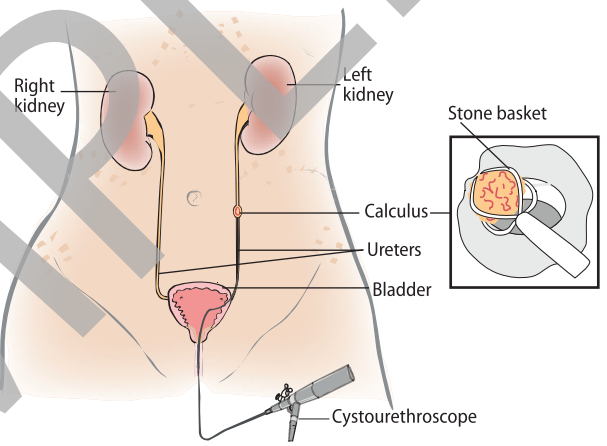
EXCLUDES *Cystourethroscopy (52341-52346, 52352-52355 [52356])*

8.82 8.82 FUD 000 MUE 1(3) J1 A2

52352 with removal or manipulation of calculus (ureteral catheterization is included)

INCLUDES Diagnostic cystourethroscopy (52351)

10.33 10.33 FUD 000 MUE 1(2) J1 A2 50



52353 with lithotripsy (ureteral catheterization is included)

INCLUDES Diagnostic cystourethroscopy (52351)

EXCLUDES *Cystourethroscopy when performed on same side (52332, [52356])*

11.43 11.43 FUD 000 MUE 1(2) J1 A2 50

AMA: 2019,Dec

52356 with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)

INCLUDES Diagnostic cystourethroscopy (52351)

EXCLUDES *Cystourethroscopy (separate procedure) (52000)*
When performed on same side:
Cystourethroscopy, with insertion indwelling ureteral stent (e.g., Gibbons or double-J type) (52332)
Cystourethroscopy, with ureteroscopy and/or pyeloscopy; with lithotripsy (ureteral catheterization is included) (52353)

12.11 12.11 FUD 000 MUE 1(2) J1 G2 50

AMA: 2022,Feb; 2019,Dec

52354 with biopsy and/or fulguration of ureteral or renal pelvic lesion

INCLUDES Diagnostic cystourethroscopy (52351)

EXCLUDES *Image guided biopsy without endoscopic guidance (50606)*

12.15 12.15 FUD 000 MUE 1(3) J1 A2 50

70332 Temporomandibular joint arthrography, radiological supervision and interpretation
INCLUDES Fluoroscopic guidance (77002)
2.55 2.55 FUD XXX MUE 2(3) Q2 N1 80

70336 Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)
8.31 8.31 FUD XXX MUE 1(3) Q3 Z2 80
AMA: 2022,Jul

70350 Cephalogram, orthodontic
0.49 0.49 FUD XXX MUE 1(3) Q1 N1 80

70355 Orthopantogram (eg, panoramic x-ray)
0.54 0.54 FUD XXX MUE 1(3) Q1 N1 80

70360 Radiologic examination; neck, soft tissue
0.95 0.95 FUD XXX MUE 2(3) Q1 N1 80
AMA: 2022,Dec

70370 pharynx or larynx, including fluoroscopy and/or magnification technique
3.06 3.06 FUD XXX MUE 1(3) Q1 N1 80
AMA: 2022,Dec

70371 Complex dynamic pharyngeal and speech evaluation by cine or video recording
EXCLUDES *Laryngeal computed tomography (70490-70492)*
3.25 3.25 FUD XXX MUE 1(2) Q1 N1 80

70380 Radiologic examination, salivary gland for calculus
1.13 1.13 FUD XXX MUE 2(3) Q1 N1 80
AMA: 2022,Dec

70390 Sialography, radiological supervision and interpretation
3.55 3.55 FUD XXX MUE 2(3) Q2 N1 80

70450-70492 Computerized Tomography: Head, Neck, Face

CMS: 100-04,4,250.16 Multiple Procedure Payment Reduction: Certain Diagnostic Imaging Procedures Rendered by Physicians

INCLUDES Imaging using tomographic technique enhanced by computer imaging to create cross-sectional body plane view

EXCLUDES *3D rendering (76376-76377)*
Quantitative CT tissue characterization same gland, organ, tissue, or target area during same session (0721T)

Code also quantitative CT tissue characterization when performed with concurrent CT exam (0722T)

70450 Computed tomography, head or brain; without contrast material
3.29 3.29 FUD XXX MUE 3(3) Q3 Z2 80

70460 with contrast material(s)
4.59 4.59 FUD XXX MUE 1(3) Q3 Z2 80

70470 without contrast material, followed by contrast material(s) and further sections
5.40 5.40 FUD XXX MUE 2(3) Q3 Z2 80

70480 Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material
4.92 4.92 FUD XXX MUE 1(3) Q3 Z2 80

70481 with contrast material(s)
5.62 5.62 FUD XXX MUE 1(3) Q3 Z2 80

70482 without contrast material, followed by contrast material(s) and further sections
6.56 6.56 FUD XXX MUE 1(3) Q3 Z2 80

70486 Computed tomography, maxillofacial area; without contrast material
3.98 3.98 FUD XXX MUE 1(3) Q3 Z2 80

70487 with contrast material(s)
4.72 4.72 FUD XXX MUE 1(3) Q3 Z2 80

70488 without contrast material, followed by contrast material(s) and further sections
5.75 5.75 FUD XXX MUE 1(3) Q3 Z2 80

70490 Computed tomography, soft tissue neck; without contrast material
EXCLUDES *CT cervical spine (72125)*
4.66 4.66 FUD XXX MUE 1(3) Q3 Z2 80

70491 with contrast material(s)
EXCLUDES *CT cervical spine (72125)*
5.74 5.74 FUD XXX MUE 1(3) Q3 Z2 80

70492 without contrast material followed by contrast material(s) and further sections
EXCLUDES *CT cervical spine (72125)*
6.90 6.90 FUD XXX MUE 1(3) Q3 Z2 80

70496-70498 Computerized Tomographic Angiography: Head and Neck

CMS: 100-04,4,250.16 Multiple Procedure Payment Reduction: Certain Diagnostic Imaging Procedures Rendered by Physicians

INCLUDES Computed tomography to visualize arterial and venous vessels

EXCLUDES *Noninvasive arterial plaque analysis non-coronary computerized tomography angiography (0710T-0713T)*

70496 Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing
8.59 8.59 FUD XXX MUE 2(3) Q3 Z2 80

70498 Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing
8.58 8.58 FUD XXX MUE 2(3) Q3 Z2 80

70540-70543 Magnetic Resonance Imaging: Face, Neck, Orbits

CMS: 100-04,4,250.16 Multiple Procedure Payment Reduction: Certain Diagnostic Imaging Procedures Rendered by Physicians

INCLUDES Three-dimensional imaging that measures response atomic nuclei in soft tissues to high-frequency radio waves when strong magnetic field applied

EXCLUDES *Magnetic resonance angiography head/neck (70544-70549)*
Procedure performed more than one time per session

70540 Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)
7.08 7.08 FUD XXX MUE 1(3) Q3 Z2 80
AMA: 2022,May

70542 with contrast material(s)
8.41 8.41 FUD XXX MUE 1(3) Q3 Z2 80
AMA: 2022,Jul; 2022,May

70543 without contrast material(s), followed by contrast material(s) and further sequences
10.62 10.62 FUD XXX MUE 1(3) Q3 Z2 80
AMA: 2022,May

70544-70549 Magnetic Resonance Angiography: Head and Neck

CMS: 100-04,13,40.1.1 Magnetic Resonance Angiography; 100-04,13,40.1.2 HCPCS Coding Requirements; 100-04,4,250.16 Multiple Procedure Payment Reduction: Certain Diagnostic Imaging Procedures Rendered by Physicians

INCLUDES Magnetic fields and radio waves to produce detailed cross-sectional internal body structure images

EXCLUDES *Reporting code with following unless separate diagnostic MRI performed (70551-70553)*

70544 Magnetic resonance angiography, head; without contrast material(s)
6.72 6.72 FUD XXX MUE 2(3) Q3 Z2 80

70545 with contrast material(s)
7.10 7.10 FUD XXX MUE 1(3) Q3 Z3 80

70546 without contrast material(s), followed by contrast material(s) and further sequences
10.29 10.29 FUD XXX MUE 1(3) Q3 Z2 80

70547 Magnetic resonance angiography, neck; without contrast material(s)
6.73 6.73 FUD XXX MUE 1(3) Q3 Z2 80

90281-90399 Immunoglobulin Products

INCLUDES Immune globulin product only
Anti-infectives
Antitoxins
Isoantibodies
Monoclonal antibodies
Code also (96365-96372, 96374-96375)

90281 **Immune globulin (Ig), human, for intramuscular use**
INCLUDES Gamastan
0.00 0.00 FUD XXX MUE 0(3) 51 EI
AMA: 2020,Nov; 2020,Jan

90283 **Immune globulin (IgIV), human, for intravenous use**
0.00 0.00 FUD XXX MUE 0(3) 51 EI
AMA: 2020,Nov; 2020,Jan

90284 **Immune globulin (SCIg), human, for use in subcutaneous infusions, 100 mg, each**
0.00 0.00 FUD XXX MUE 0(3) 51 EI
AMA: 2020,Nov; 2020,Jan

90287 **Botulinum antitoxin, equine, any route**
0.00 0.00 FUD XXX MUE 0(3) 51 EI
AMA: 2020,Nov; 2020,Jan

90288 **Botulism immune globulin, human, for intravenous use**
0.00 0.00 FUD XXX MUE 0(3) 51 EI
AMA: 2020,Nov; 2020,Jan

90291 **Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use**
INCLUDES Cytogram
0.00 0.00 FUD XXX MUE 0(3) 51 EI
AMA: 2020,Nov; 2020,Jan

90296 **Diphtheria antitoxin, equine, any route**
0.00 0.00 FUD XXX MUE 1(2) 51 EI
AMA: 2020,Nov; 2020,Jan

90371 **Hepatitis B immune globulin (HBIg), human, for intramuscular use**
INCLUDES HBIG
0.00 0.00 FUD XXX MUE 10(3) 51 K K2
AMA: 2020,Nov; 2020,Jan

90375 **Rabies immune globulin (RIg), human, for intramuscular and/or subcutaneous use**
INCLUDES HyperRAB
0.00 0.00 FUD XXX MUE 20(3) 51 K K2
AMA: 2020,Nov; 2020,Jan

90376 **Rabies immune globulin, heat-treated (RIg-HT), human, for intramuscular and/or subcutaneous use**
0.00 0.00 FUD XXX MUE 20(3) 51 K K2
AMA: 2020,Nov; 2020,Jan

90377 **Rabies immune globulin, heat- and solvent/detergent-treated (RIg-HT S/D), human, for intramuscular and/or subcutaneous use**
0.00 0.00 FUD XXX MUE 20(3) 51 K2
AMA: 2020,Nov

90378 **Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each**
INCLUDES Synagis
0.00 0.00 FUD XXX MUE 4(3) 51 K K2
AMA: 2020,Nov; 2020,Jan

● **90380** **Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use**

● **90381** **1 mL dosage, for intramuscular use**

90384 **Rho(D) immune globulin (RhIg), human, full-dose, for intramuscular use**
0.00 0.00 FUD XXX MUE 0(3) 51 EI
AMA: 2020,Nov; 2020,Jan

90385 **Rho(D) immune globulin (RhIg), human, mini-dose, for intramuscular use**
0.00 0.00 FUD XXX MUE 1(2) 51 EI
AMA: 2020,Nov; 2020,Jan

90386 **Rho(D) immune globulin (RhIgIV), human, for intravenous use**
0.00 0.00 FUD XXX MUE 0(3) 51 EI
AMA: 2020,Nov; 2020,Jan

90389 **Tetanus immune globulin (TIg), human, for intramuscular use**
INCLUDES HyperTET S/D (Tetanus Immune Globulin)
0.00 0.00 FUD XXX MUE 0(3) 51 EI
AMA: 2020,Nov; 2020,Jan

90393 **Vaccinia immune globulin, human, for intramuscular use**
0.00 0.00 FUD XXX MUE 1(2) 51 EI
AMA: 2020,Nov; 2020,Jan

90396 **Varicella-zoster immune globulin, human, for intramuscular use**
INCLUDES VariZIG
0.00 0.00 FUD XXX MUE 1(2) 51 K K2
AMA: 2020,Nov; 2020,Jan

90399 **Unlisted immune globulin**
0.00 0.00 FUD XXX MUE 0(3) 51 EI
AMA: 2020,Nov; 2020,Jan

90460-90480 [90480] Vaccine/Toxoid Administration

INCLUDES All components influenza vaccine, report one time only
Combination vaccines which comprise multiple vaccine components
Components (all antigens) in vaccines to prevent disease due to specific organisms
Counseling by physician or other qualified health care professional
Multivalent antigens or multiple antigen serotypes against single organisms considered one component
EXCLUDES *Administration influenza and pneumococcal vaccine for Medicare patients (G0008-G0009)*
Allergy testing (95004-95028)
Bacterial/viral/fungal skin tests (86485-86580)
Immune globulins/monoclonal antibodies immunizations and administration (90281-90399, 96365-96374)
Code also significant, separately identifiable E/M service when appropriate

90460 **Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered** A
INCLUDES Patient/family face-to-face counseling by doctor or qualified health care professional for patients age 18 years and younger
EXCLUDES *Administration vaccine without counseling (90471-90474)*
Reporting with severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine when not administered with separately identifiable vaccine/toxoid ([91304], [91318, 91319, 91320, 91321, 91322])
Code also:
Each additional component in vaccine (e.g., 5-year-old receives DtaP-IPV IM administration, and MMR/Varicella vaccines SQ administration. Report initial component two times, and additional components six times)
Toxoid/vaccine (91304-90759 [90584, 90589, 90611, 90619, 90620, 90621, 90622, 90623, 90625, 90626, 90627, 90630, 90644, 90672, 90673, 90674, 90677, 90683, 90694, 90750, 90756, 90758, 90759, 91304, 91318, 91319, 91320, 91321, 91322])
0.67 0.67 FUD XXX MUE 9(3) B 80
AMA: 2023,Jul; 2023,May; 2022,Jul; 2021,Dec; 2021,Oct; 2021,Jun; 2021,May; 2021,Apr; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Jan; 2018,Nov

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 (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
- 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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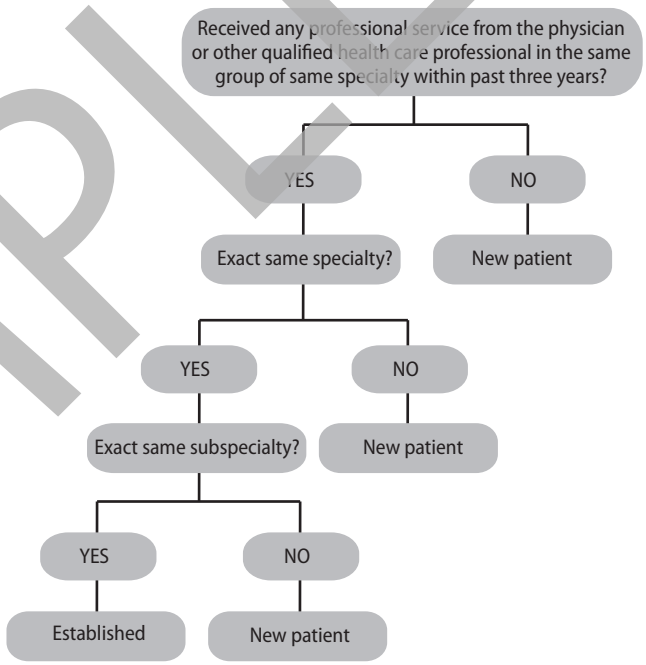
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the 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

99245 **Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded.**

INCLUDES When reporting by time, 55 minutes or longer required

Code also prolonged services (lasting 70 minutes or more) ([99417])

5.35 6.27 **FUD** XXX **MUE** 0(3) ★ E1

AMA: 2023,Oct; 2023,Mar; 2023,Feb; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,May; 2022,Apr; 2022,Feb; 2021,Oct; 2021,Mar; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Mar; 2019,Jul; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun

99252-99255 Consultations: Inpatient or Observation

CMS: 100-04,12,30.6.8 Payment for Hospital Observation Services; 100-04,12,30.6.9 Payment for Inpatient Hospital Visits - General (Codes 99221 - 99239); 100-04,12,30.6.9.1 Subsequent Hospital Inpatient or Observation Care Visit and Hospital Inpatient or Observation Discharge Day Management (Codes 99231 - 99239)

INCLUDES All consultations provided in hospital inpatient, observation, nursing facility, or partial hospital settings

Documentation consultation request from appropriate source required in medical record

Provision by physician or QHP whose advice, opinion, recommendation, suggestion, direction, or counsel, etc., requested for evaluating/treating patient since that individual's specific medical expertise beyond requesting physician knowledge

Provision written report, findings/recommendations from consultant to referring physician

Third-party mandated consultation; append modifier 32

EXCLUDES *Consultation prompted by patient/family or not requested by physician or QHP (i.e., insurance company, educator, lawyer, non-clinical social worker); report E/M codes for appropriate location*

Services provided to Medicare patients; E/M code as appropriate for place of service or HCPCS code (99202-99215, 99221-99223, 99231-99233, G0406-G0408, G0425-G0427)

Subsequent consultation services, same admission; report subsequent codes as appropriate for place of service (99231-99233, 99307-99310)

Code also admission to hospital inpatient/observation or to nursing facility as part of encounter in different setting, when performed (99221-99223, 99304-99306)

Code also diagnostic/therapeutic services initiated at consultation or subsequent visits

99252 **Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded.**

INCLUDES When reporting by time, 35 minutes or longer required

2.12 2.12 **FUD** XXX **MUE** 0(3) ★ E1

AMA: 2023,Oct; 2023,Jul; 2023,May; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,May; 2022,Apr; 2022,Feb; 2021,Oct; 2021,Jan; 2020,Dec; 2020,Sep; 2020,Mar; 2019,Jul; 2017,Aug; 2017,Jun

99253 **Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.**

INCLUDES When reporting by time, 45 minutes or longer required

2.96 2.96 **FUD** XXX **MUE** 0(3) ★ E1

AMA: 2023,Oct; 2023,Jul; 2023,May; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,May; 2022,Apr; 2022,Feb; 2021,Oct; 2021,Sep; 2021,Jan; 2020,Dec; 2020,Sep; 2020,Mar; 2019,Jul; 2017,Aug; 2017,Jun

99254 **Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.**

INCLUDES When reporting by time, 60 minutes or longer required

4.12 4.12 **FUD** XXX **MUE** 0(3) ★ E1

AMA: 2023,Oct; 2023,Jul; 2023,May; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,May; 2022,Apr; 2022,Feb; 2021,Oct; 2021,Jan; 2020,Dec; 2020,Sep; 2020,Mar; 2019,Jul; 2017,Aug; 2017,Jun

99255 **Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded.**

INCLUDES When reporting by time, 80 minutes or longer required

Code also prolonged services (lasting 95 minutes or more) ([99418])

5.52 5.52 **FUD** XXX **MUE** 0(3) ★ E1

AMA: 2023,Oct; 2023,Jul; 2023,May; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,May; 2022,Apr; 2022,Feb; 2021,Oct; 2021,Jan; 2020,Dec; 2020,Sep; 2020,Mar; 2019,Jul; 2017,Aug; 2017,Jun

99281-99288 Emergency Department Visits

CMS: 100-04,11,40.1.3 Independent Attending Physician Services; 100-04,12,30.6.11 Emergency Department Visits; 100-04,4,160 Clinic and Emergency Visits Under OPPS

INCLUDES Any time spent with patient, which usually involves multiple encounters while patient in emergency department

Care provided to new and established patients

EXCLUDES *Critical care services (99291-99292)*

Hospital inpatient or observation care and discharge services (99231-99239)

Patients seen in emergency department for convenience of physician or QHP, report appropriate office/outpatient E/M code (99202-99215)

Time as factor for reporting level of service

Code also admission to hospital inpatient/observation or to nursing facility as part of encounter in different setting, when performed (99221-99223, 99304-99306)

Code also diagnostic/therapeutic services initiated at consultation or subsequent visits

Code also separately identifiable E/M services with services provided as part of surgical package appending modifier(s) as appropriate

99281 **Emergency department visit for the evaluation and management of a patient that may not require the presence of a physician or other qualified health care professional**

0.35 0.35 **FUD** XXX **MUE** 1(3) J 80

AMA: 2023,Aug; 2023,Jul; 2023,May; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,May; 2021,Sep; 2021,May; 2021,Mar; 2021,Jan; 2020,Dec; 2020,Oct; 2020,Jul; 2019,Jul; 2017,Aug; 2017,Jun

99282 **Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making**

1.24 1.24 **FUD** XXX **MUE** 1(3) J 80

AMA: 2023,Aug; 2023,Jul; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,May; 2021,Sep; 2021,May; 2021,Mar; 2021,Jan; 2020,Dec; 2020,Oct; 2020,Jul; 2019,Jul; 2017,Aug; 2017,Jun

99283 **Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making**

2.13 2.13 **FUD** XXX **MUE** 1(3) J 80

AMA: 2023,Aug; 2023,Jul; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,May; 2021,Sep; 2021,May; 2021,Mar; 2021,Jan; 2020,Dec; 2020,Oct; 2020,Jul; 2019,Jul; 2017,Aug; 2017,Jun

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 2024*, 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

Appendix I — Inpatient-Only Procedures

Inpatient Only Procedures—This appendix identifies services with the status indicator C. Medicare will not pay an OPPS hospital or ASC when they are performed on a Medicare patient as an outpatient. Physicians should refer to this list when scheduling Medicare patients for surgical procedures. CMS updates this list quarterly. The following was updated 10/01/2023.

00176	Anesth pharyngeal surgery
00192	Anesth facial bone surgery
00211	Anesth cran surg hemotoma
00214	Anesth skull drainage
00215	Anesth skull repair/fract
00474	Anesth surgery of rib
00524	Anesth chest drainage
00540	Anesth chest surgery
00542	Anesthesia removal pleura
00546	Anesth lung chest wall surg
00560	Anesth heart surg w/o pump
00561	Anesth heart surg <1 yr
00562	Anesth hrt surg w/pmp age 1+
00567	Anesth cabg w/pump
00580	Anesth heart/lung transplnt
00604	Anesth sitting procedure
00632	Anesth removal of nerves
00792	Anesth hemorr/excise liver
00794	Anesth pancreas removal
00796	Anesth for liver transplant
00844	Anesth pelvis surgery
00846	Anesth hysterectomy
00848	Anesth pelvic organ surg
00864	Anesth removal of bladder
00866	Anesth removal of adrenal
00868	Anesth kidney transplant
00882	Anesth major vein ligation
00904	Anesth perineal surgery
00908	Anesth removal of prostate
00932	Anesth amputation of penis
00934	Anesth penis nodes removal
00936	Anesth penis nodes removal
01140	Anesth amputation at pelvis
01150	Anesth pelvic tumor surgery
01212	Anesth hip disarticulation
01232	Anesth amputation of femur
01234	Anesth radical femur surg
01272	Anesth femoral artery surg
01274	Anesth femoral embolectomy
01404	Anesth amputation at knee
01442	Anesth knee artery surg
01444	Anesth knee artery repair
01502	Anesth lwr leg embolectomy
01634	Anesth shoulder joint amput
01636	Anesth forequarter amput
01652	Anesth shoulder vessel surg
01654	Anesth shoulder vessel surg
01656	Anesth arm-leg vessel surg
01756	Anesth radical humerus surg
01990	Support for organ donor
11004	Debride genitalia & perineum
11005	Debride abdom wall
11006	Debride genit/per/abdom wall
11008	Remove mesh from abd wall
15756	Free myo/skin flap microvasc
15757	Free skin flap microvasc
15758	Free fascial flap microvasc
15778	Impl absrb msh/prsth dly cls
16036	Escharotomy addl incision
19305	Mast radical
19306	Mast rad urban type
19361	Brst rcnstj latsms drsi flap
19364	Brst rcnstj free flap
19367	Brst rcnstj 1 pdcl tram flap
19368	Brst rcnstj 1pdcl tram anast
19369	Brst rcnstj 2 pdcl tram flap
20661	Application of head brace
20664	Application of halo
20802	Replantation arm complete
20805	Replant forearm complete
20808	Replantation hand complete
20816	Replantation digit complete
20824	Replantation thumb complete
20827	Replantation thumb complete
20838	Replantation foot complete
20955	Fibula bone graft microvasc
20956	Iliac bone graft microvasc
20957	Mt bone graft microvasc
20962	Other bone graft microvasc
20969	Bone/skin graft microvasc
20970	Bone/skin graft iliac crest
21045	Extensive jaw surgery
21145	Lefort i-1 piece w/ graft
21146	Lefort i-2 piece w/ graft
21147	Lefort i-3/> piece w/ graft
21151	Lefort ii w/bone grafts
21154	Lefort iii w/o lefort i
21155	Lefort iii w/ lefort i
21159	Lefort iii w/fhdw/o lefort i
21160	Lefort iii w/fhd w/ lefort i
21179	Reconstruct entire forehead
21180	Reconstruct entire forehead
21182	Reconstruct cranial bone
21183	Reconstruct cranial bone
21184	Reconstruct cranial bone
21188	Reconstruction of midface
21247	Reconstruct lower jaw bone
21268	Revise eye sockets
21343	Open tx dprsd front sinus fx
21344	Open tx compl front sinus fx
21348	Opn tx nasomax fx w/graft
21423	Treat mouth roof fracture
21431	Treat craniofacial fracture
21432	Treat craniofacial fracture
21433	Treat craniofacial fracture
21435	Treat craniofacial fracture
21436	Treat craniofacial fracture
21510	Drainage of bone lesion
21602	Exc ch wal tum w/o lymphadec
21603	Exc ch wal tum w/lymphadec
21615	Removal of rib
21616	Removal of rib and nerves
21620	Partial removal of sternum
21627	Sternal debridement
21630	Extensive sternum surgery
21632	Extensive sternum surgery
21705	Revision of neck muscle/rib
21740	Reconstruction of sternum
21750	Repair of sternum separation
21825	Treat sternum fracture
22010	I&d p-spine c/t/cerv-thor
22015	I&d abscess p-spine l/s/ls
22110	Remove part of neck vertebra
22112	Remove part thorax vertebra
22114	Remove part lumbar vertebra
22116	Remove extra spine segment
22206	Incis spine 3 column thorac
22207	Incis spine 3 column lumbar
22208	Incis spine 3 column adl seg
22210	Incis 1 vertebral seg cerv
22212	Incis 1 vertebral seg thorac
22214	Incis 1 vertebral seg lumbar
22216	Incis addl spine segment
22220	Osteot dsc ant 1 vrt sgm crv
22222	Osteot dsc ant 1vrt sgm thrc
22224	Osteot dsc ant 1vrt sgm lmbr
22226	Osteot dsc ant 1vrt sgm ea
22318	Treat odontoid fx w/o graft
22319	Treat odontoid fx w/graft
22325	Treat spine fracture
22326	Treat neck spine fracture
22327	Treat thorax spine fracture
22328	Treat each add spine fx
22532	Arthrd lat xtrcvtry tq thrc
22533	Arthrd lat xtrcvtry tq lmbr
22534	Arthrd lat xtrcvtry tq ea ad
22548	Arthrd ant toral/xoral c1-c2
22556	Arthrd ant ntrbd min dsc thc
22558	Arthrd ant ntrbd min dsc lum
22586	Arthrd pre-sac ntrbdy l5-s1
22590	Arthrd pst tq craniocervical
22595	Arthrd pst tq atlas-axis
22600	Arthrd pst tq 1ntrspc crv
22610	Arthrd pst tq 1ntrspc thrc
22800	Arthrd pst dfrm<6 vrt sgm
22802	Arthrd pst dfrm 7-12 vrt sgm
22804	Arthrd pst dfrm 13+ vrt sgm
22808	Arthrd ant dfrm 2-3 vrt sgm
22810	Arthrd ant dfrm 4-7 vrt sgm
22812	Arthrd ant dfrm 8+ vrt sgm
22818	Kyphectomy 1-2 segments
22819	Kyphectomy 3 or more
22830	Exploration of spinal fusion
22841	Insert spine fixation device
22843	Insert spine fixation device
22844	Insert spine fixation device
22846	Insert spine fixation device
22847	Insert spine fixation device
22848	Insert pelv fixation device
22849	Reinsert spinal fixation
22850	Remove spine fixation device
22852	Remove spine fixation device
22855	Removal anterior instrmj
22857	Tot disc arthrp 1ntrspc lmbr
22860	Tot disc arthrp 2ntrspc lmbr
22861	Rev rplcm arthrp 1ntrspc crv
22862	Rev rplcm rthrp 1ntrspc lmbr
22864	Rmvl tot arthrp 1ntrspc crv
22865	Rmvl tot arthrp 1ntrspc lmbr
23200	Resect clavicle tumor
23210	Resect scapula tumor
23220	Resect prox humerus tumor
23335	Shoulder prosthesis removal
23474	Revis reconst shoulder joint
23900	Interthoracoscplr amputation
23920	Disarticulation shoulder
24900	Amputation of upper arm
24920	Amputation of upper arm
24930	Amputation follow-up surgery
24931	Amputate upper arm & implant
24940	Revision of upper arm
25900	Amputation of forearm
25905	Amputation of forearm
25915	Amputation of forearm
25920	Amputate hand at wrist
25924	Amputation follow-up surgery
25927	Amputation of hand
26551	Great toe-hand transfer
26553	Single transfer toe-hand
26554	Double transfer toe-hand
26556	Toe joint transfer
26992	Drainage of bone lesion
27005	Incision of hip tendon
27025	Incision of hip/thigh fascia
27030	Drainage of hip joint
27036	Excision of hip joint/muscle
27054	Removal of hip joint lining
27070	Part remove hip bone super
27071	Part removal hip bone deep
27075	Resect hip tumor
27076	Resect hip tum incl acetabul
27077	Resect hip tum w/innom bone
27078	Rsect hip tum incl femur
27090	Removal of hip prosthesis
27091	Removal of hip prosthesis
27120	Reconstruction of hip socket
27122	Reconstruction of hip socket
27125	Partial hip replacement
27132	Total hip arthroplasty
27134	Revise hip joint replacement
27137	Revise hip joint replacement
27138	Revise hip joint replacement
27140	Transplant femur ridge
27146	Incision of hip bone
27147	Revision of hip bone
27151	Incision of hip bones
27156	Revision of hip bones
27158	Revision of pelvis
27161	Incision of neck of femur
27165	Incision/fixation of femur
27170	Repair/graft femur head/neck
27175	Treat slipped epiphysis
27176	Treat slipped epiphysis
27177	Treat slipped epiphysis
27178	Treat slipped epiphysis
27181	Treat slipped epiphysis
27185	Revision of femur epiphysis
27187	Reinforce hip bones
27222	Treat hip socket fracture
27226	Treat hip wall fracture
27227	Treat hip fracture(s)
27228	Treat hip fracture(s)
27232	Treat thigh fracture
27236	Treat thigh fracture
27240	Treat thigh fracture
27244	Treat thigh fracture
27245	Treat thigh fracture
27248	Treat thigh fracture
27253	Treat hip dislocation
27254	Treat hip dislocation
27258	Treat hip dislocation
27259	Treat hip dislocation
27268	Cltx thigh fx w/mnpj
27269	Optx thigh fx
27280	Arthr si jt opn b1grf instrm
27282	Arthrodesis symphysis pubis
27284	Fusion of hip joint
27286	Fusion of hip joint
27290	Amputation of leg at hip
27295	Amputation of leg at hip
27303	Drainage of bone lesion
27365	Resect femur/knee tumor
27445	Revision of knee joint
27448	Incision of thigh
27450	Incision of thigh
27454	Realignment of thigh bone
27455	Realignment of knee
27457	Realignment of knee
27465	Shortening of thigh bone
27466	Lengthening of thigh bone
27468	Shorten/lengthen thighs
27470	Repair of thigh
27472	Repair/graft of thigh