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# Current Procedural Coding Expert

CPT® codes with Medicare essentials for enhanced accuracy




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# Contents

# Introduction

Welcome to Optum360's *Current Procedural Coding Expert, Professional Edition*, 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 Optum360 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, Professional Edition* provides the best in Medicare procedure reporting.

*Current Procedural Coding Expert, Professional Edition* 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. *Current Procedural Coding Expert, Professional Edition* includes effective codes that will not be published in the AMA's Current Procedural Terminology (CPT) book until the following year.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, Professional Edition* 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, Professional Edition*

*Current Procedural Coding Expert, Professional Edition* is an exciting tool combining the most current material at the time of our publication from the AMA's CPT 2022, 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 Optum360'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 Optum360 and Medicare resources.

In anticipation of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (COVID-19) vaccines receiving Emergency Use Authorization (EUA) and/or FDA approval, and in order to expedite the availability of codes for coding and reimbursement, the AMA released a set of codes (0001A–0104A, 91300–91310) to be utilized upon receipt of EUA or FDA approval. In *Current Procedural Coding Expert, Professional Edition* these codes have been designated as placeholders and **PLACEHOLDER ONLY** appears next to the code. When the AMA releases an official code descriptor, Optum360 will update the corresponding electronic files and will provide updates to customers to allow them to update their *Current Procedural Coding Expert, Professional Edition* book.

For mid-year code updates, official errata changes, correction notices, and any other changes pertinent to the information in *Current Procedural Coding Expert, Professional Edition*, see our product update page at https://www.optum360coding.com/ProductUpdates/. The password for 2022 is PROCEDURE2022.

**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, Professional Edition* 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, Professional Edition* 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 2021 but do not appear in the AMA's CPT code book until 2023 are identified in appendix B as "Web Release New, Revised, and Deleted Codes." For the next year's edition of *Current Procedural Coding Expert, Professional Edition*, 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 Optum360 clinical experts.

## Resequencing of CPT Codes

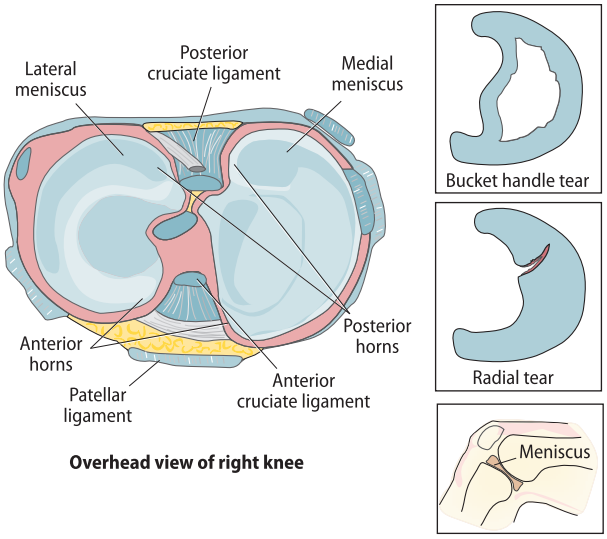
The American Medical Association (AMA) employs a numbering methodology of resequencing, which is the practice of displaying codes outside of their numerical order according to the description relationship. According to the AMA, there are instances in which a new code is needed within an existing grouping 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, Professional Edition* 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** |

*[Resequenced]*

**27332** **Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral**
18.5 18.5 FUD 090 J A2 80 50
AMA: 2018,Sep,7



Overhead view of right knee

**27333** **medial AND lateral**
16.9 16.9 FUD 090 J A2 80 50
AMA: 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

**27334** **Arthrotomy, with synovectomy, knee; anterior OR posterior**
19.7 19.7 FUD 090 J A2 80 50
AMA: 2018,Sep,7

**27335** **anterior AND posterior including popliteal area**
22.0 22.0 FUD 090 J A2 80 50
AMA: 2018,Sep,7

***27337*** **Resequenced code. See code following 27327.**

***27339*** **Resequenced code. See code before 27330.**

**27340** **Excision, prepatellar bursa**
10.6 10.6 FUD 090 J A2 50
AMA: 2018,Sep,7

**27345** **Excision of synovial cyst of popliteal space (eg, Baker's cyst)**
13.9 13.9 FUD 090 J A2 80 50
AMA: 2018,Sep,7

**27347** **Excision of lesion of meniscus or capsule (eg, cyst, ganglion), knee**
15.1 15.1 FUD 090 J A2 80 50
AMA: 2018,Sep,7

**27350** **Patellectomy or hemipatellectomy**
18.8 18.8 FUD 090 J A2 80 50
AMA: 2018,Sep,7

**27355** **Excision or curettage of bone cyst or benign tumor of femur;**
17.4 17.4 FUD 090 J A2 80 50
AMA: 2018,Sep,7

**27356** **with allograft**
21.3 21.3 FUD 090 J G2 80 50
AMA: 2019,May,7; 2018,Sep,7

**27357** **with autograft (includes obtaining graft)**
23.5 23.5 FUD 090 J A2 80 50
AMA: 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

\+ **27358** **with internal fixation (List in addition to code for primary procedure)**
Code first (27355-27357)
8.03 8.03 FUD ZZZ N N1 80
AMA: 2018,Sep,7

**27360** **Partial excision (craterization, saucerization, or diaphysectomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess)**
24.7 24.7 FUD 090 J A2 80 50
AMA: 2018,Sep,7

## 27329-27365 [27329] Radical Resection Tumor Knee/Thigh

INCLUDES Any necessary elevation tissue planes or dissection
Excision adjacent soft tissue during bone tumor resection
Measurement tumor and necessary margin at greatest diameter prior to excision
Radical resection bone tumor: resection tumor (may include entire bone) and wide margins normal tissue primarily for malignant or aggressive benign tumors
Radical resection soft tissue tumor: wide resection tumor involving substantial margins normal tissue that may include tissue removal from one or more layers; most often malignant or aggressive benign
Simple and intermediate repairs
EXCLUDES *Complex repair*
*Radical resection cutaneous tumors (eg, melanoma) (11600-11606)*
*Significant vessel exploration, neuroplasty, reconstruction, or complex bone repair*

\# **27329** **Radical resection of tumor (eg, sarcoma), soft tissue of thigh or knee area; less than 5 cm**
30.1 30.1 FUD 090 J G2 80 50
AMA: 2018,Sep,7

**27364** **5 cm or greater**
45.2 45.2 FUD 090 J G2 80 50
AMA: 2018,Sep,7

**27365** **Radical resection of tumor, femur or knee**
EXCLUDES *Soft tissue tumor excision thigh or knee area (27329, 27364)*
59.6 59.6 FUD 090 C 80 50
AMA: 2019,May,7; 2018,Sep,7

## 27369 Injection for Arthrogram of Knee

EXCLUDES *Arthrocentesis, aspiration and/or injection, knee (20610-20611)*
*Arthroscopy, knee (29871)*

**27369** **Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography**
Code also fluoroscopic guidance, when performed for CT/MRI arthrography (73701-73702, 73722-73723, 77002)
(73580, 73701-73702, 73722-73723)
1.17 4.06 FUD 000 N1 50
AMA: 2019,Aug,7

## 27372 Foreign Body Removal Femur or Knee

EXCLUDES *Arthroscopic procedures (29870-29887)*
*Removal knee prosthesis (27488)*

**27372** **Removal of foreign body, deep, thigh region or knee area**
11.4 17.0 FUD 090 J A2 80 50
AMA: 2018,Sep,7

## 27380-27499 Repair/Reconstruction of Femur or Knee

**27380** **Suture of infrapatellar tendon; primary**
17.5 17.5 FUD 090 J A2 80 50
AMA: 2018,Sep,7

**27381** **secondary reconstruction, including fascial or tendon graft**
23.0 23.0 FUD 090 J J8 80 50
AMA: 2018,Sep,7

**27385** **Suture of quadriceps or hamstring muscle rupture; primary**
16.9 16.9 FUD 090 J A2 80 50
AMA: 2018,Sep,7; 2018,Jan,8; 2017,Aug,9

**33335** **with cardiopulmonary bypass**
54.6 54.6 FUD 090
AMA: 2018,Jun,11; 2017,Dec,3

## 33340 Closure Left Atrial Appendage

EXCLUDES *Cardiac catheterization except for reasons other than closure left atrial appendage (93451-93453, 93456, 93458-93461, 93462, 93593-93598)*
Code also intracardiac echocardiography, if performed (93662)
Code also transvascular ventricular support, when performed:
Balloon pump (33967, 33968, 33970-33974)
Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) (33946-33949)
Ventricular assist device (33975-33983, [33995], 33990-33993 [33997])

**33340** **Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation**
22.9 22.9 FUD 000
AMA: 2018,Jan,8; 2017,Jul,3

## 33361-33369 Transcatheter Aortic Valve Replacement

CMS: 100-03,20.32 Transcatheter Aortic Valve Replacement (TAVR); 100-04,32,290.3 Claims Processing TAVR Inpatient; 100-04,32,290.4 Payment of TAVR for MA Plan Participants

INCLUDES Access and implantation aortic valve (33361-33366)
Access sheath placement
Advancement valve delivery system
Arteriotomy closure
Balloon aortic valvuloplasty
Cardiac or open arterial approach
Deployment of valve
Percutaneous access
Radiology procedures:
Angiography during and after procedure
Assessment access site for closure
Documentation intervention completion
Guidance for valve placement
Supervision and interpretation
Temporary pacemaker
Valve repositioning when necessary
EXCLUDES *Cardiac catheterization procedures included in TAVR/TAVI service (93452-93453, 93458-93461, 93567)*
*Percutaneous coronary interventional procedures*
Code also cardiac catheterization services for purposes other than TAVR/TAVI
Code also diagnostic coronary angiography at different session from interventional procedure
Code also diagnostic coronary angiography same time as TAVR/TAVI when:
Previous study available, but documentation states patient's condition has changed since previous study, visualization anatomy/pathology inadequate, or change occurs during procedure warranting additional evaluation outside current target area
No previous catheter-based coronary angiography study available, and full diagnostic study performed, with decision to perform intervention based on that study
Code also modifier 59 when diagnostic coronary angiography procedures performed as separate and distinct procedural services on same day or session as TAVR/TAVI
Code also modifier 62 as all TAVI/TAVR procedures require work two physicians
Code also transvascular ventricular support, when performed:
Balloon pump (33967, 33970, 33973)
Ventricular assist device (33975-33976, [33995], 33990-33993 [33997])

**33361** **Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach**
Code also cardiopulmonary bypass when performed (33367-33369)
39.4 39.4 FUD 000
AMA: 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

**33362** **open femoral artery approach**
Code also cardiopulmonary bypass when performed (33367-33369)
43.1 43.1 FUD 000
AMA: 2018,Jan,8; 2017,Dec,3; 2017,Jan,8; 2016,Jan,13

**33363** **open axillary artery approach**
Code also cardiopulmonary bypass when performed (33367-33369)
44.6 44.6 FUD 000
AMA: 2018,Jan,8; 2017,Dec,3; 2017,Jan,8; 2016,Jan,13

**33364** **open iliac artery approach**
Code also cardiopulmonary bypass when performed (33367-33369)
46.1 46.1 FUD 000
AMA: 2018,Jan,8; 2017,Dec,3; 2017,Jan,8; 2016,Jan,13

**33365** **transaortic approach (eg, median sternotomy, mediastinotomy)**
Code also cardiopulmonary bypass when performed (33367-33369)
51.8 51.8 FUD 000
AMA: 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

**33366** **transapical exposure (eg, left thoracotomy)**
Code also cardiopulmonary bypass when performed (33367-33369)
45.7 45.7 FUD 000
AMA: 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

\+ **33367** **cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels) (List separately in addition to code for primary procedure)**
EXCLUDES *Cardiopulmonary bypass support with open or central arterial and venous cannulation (33368-33369)*
*Cerebral embolic protection device (33370)*
Code first (33361-33366, 33418, 33477, 0483T-0484T, 0544T, 0545T, [0643T], 0569T, 0570T, 0644T)
18.2 18.2 FUD ZZZ
AMA: 2018,Jan,8; 2017,Jan,8; 2016,Mar,5; 2016,Jan,13

\+ **33368** **cardiopulmonary bypass support with open peripheral arterial and venous cannulation (eg, femoral, iliac, axillary vessels) (List separately in addition to code for primary procedure)**
EXCLUDES *Cardiopulmonary bypass support with percutaneous or central arterial and venous cannulation (33367, 33369)*
Code first (33361-33366, 33418, 33477, 0483T-0484T, 0544T, 0545T, [0643T], 0569T, 0570T, 0644T)
21.7 21.7 FUD ZZZ
AMA: 2018,Jan,8; 2017,Jan,8; 2016,Mar,5; 2016,Jan,13

\+ **33369** **cardiopulmonary bypass support with central arterial and venous cannulation (eg, aorta, right atrium, pulmonary artery) (List separately in addition to code for primary procedure)**
EXCLUDES *Cardiopulmonary bypass support with percutaneous or open arterial and venous cannulation (33367-33368)*
Code first (33361-33366, 33418, 33477, 0483T-0484T, 0544T, 0545T, [0643T], 0569T-0570T, 0644T)
28.6 28.6 FUD ZZZ
AMA: 2018,Jan,8; 2017,Jan,8; 2016,Mar,5; 2016,Jan,13

## 33370 Cerebral Embolic Protection Device

● \+ **33370** **Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging, and radiological supervision and interpretation, percutaneous (List separately in addition to code for primary procedure)**
INCLUDES Angiography (75710)
Aortography (75600)
Ultrasound guidance (76937)
EXCLUDES *Additional or multiple filter placement*
Code first transcatheter aortic valve replacement (TAVR/TAVI) (33361-33366)
0.00 0.00 FUD 000

62368 with reprogramming

EXCLUDES *Maintenance and refilling infusion pumps for CNS drug therapy (95990-95991)*

1.01 1.57 FUD XXX S P3

AMA: 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

62369 with reprogramming and refill

EXCLUDES *Maintenance and refilling infusion pumps for CNS drug therapy (95990-95991)*

1.01 3.34 FUD XXX S P3

AMA: 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

62370 with reprogramming and refill (requiring skill of a physician or other qualified health care professional)

EXCLUDES *Maintenance and refilling infusion pumps for CNS drug therapy (95990-95991)*

1.33 3.47 FUD XXX S P3

AMA: 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

## 62380 Endoscopic Decompression/Laminectomy/Laminotomy

EXCLUDES *Open decompression (63030, 63056)*
*Percutaneous decompression (62267, 0274T-0275T)*

62380 Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar

0.00 0.00 FUD 090 J G2 80 50

AMA: 2018,Jan,8; 2017,Feb,12

## 63001-63053 [63052, 63053] Posterior Midline Approach: Laminectomy/Laminotomy/Decompression

INCLUDES Endoscopic assistance through open and direct visualization

EXCLUDES *Arthrodesis (22590-22614)*
*Percutaneous decompression (62287, 0274T, 0275T)*

63001 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), 1 or 2 vertebral segments; cervical

35.7 35.7 FUD 090 J G2 80

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63003 thoracic

35.7 35.7 FUD 090 J G2 80

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63005 lumbar, except for spondylolisthesis

34.4 34.4 FUD 090 J G2 80

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Feb,9; 2017,Jan,8; 2016,Jan,13

63011 sacral

31.6 31.6 FUD 090 J G2 80

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63012 Laminectomy with removal of abnormal facets and/or pars inter-articularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)

34.6 34.6 FUD 090 J G2 80

AMA: 2019,Dec,12; 2018,Jan,8; 2017,Mar,7; 2017,Feb,9; 2017,Jan,8; 2016,Jan,13

63015 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discectomy (eg, spinal stenosis), more than 2 vertebral segments; cervical

42.7 42.7 FUD 090 J G2 80

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63016 thoracic

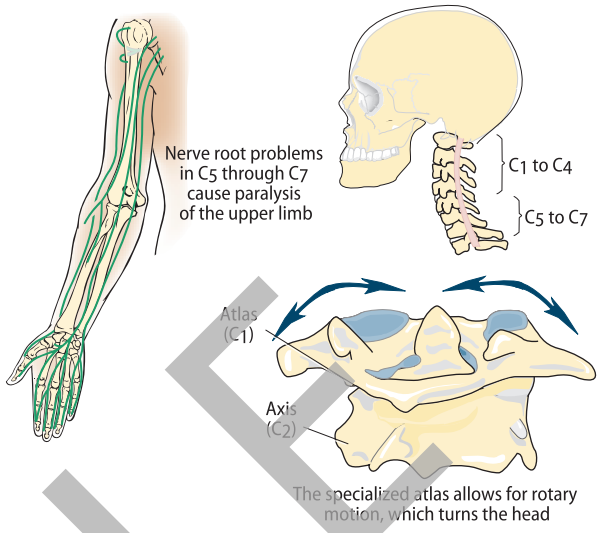
44.3 44.3 FUD 090 J G2 80

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63017 lumbar

36.7 36.7 FUD 090 J G2 80

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Feb,9; 2017,Jan,8; 2016,Jan,13




63020 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical

33.4 33.4 FUD 090 J G2 80 50

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63030 1 interspace, lumbar

EXCLUDES *Laminectomy at same session as posterior interbody fusion for:*
*Decompression nerves or spinal components ([63052])*
*Preparation of interspace (22630, 22633)*

28.2 28.2 FUD 090 J G2 80 50

AMA: 2020,May,13; 2019,Nov,14; 2018,Jan,8; 2017,Mar,7; 2017,Feb,12; 2017,Feb,9; 2017,Jan,8; 2016,May,13; 2016,Jan,13

+ 63035 each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)

EXCLUDES *Laminectomy at same session as posterior interbody fusion for:*
*Decompression nerves or spinal components ([63053])*
*Preparation of interspace (22632, 22634)*
*Reporting with modifier 50. Report once for each side when performed bilaterally*

Code first (63020-63030)

5.55 5.55 FUD ZZZ N N1 80

AMA: 2018,Jan,8; 2017,Feb,9; 2017,Jan,8; 2016,Jan,13

63040 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; cervical

40.4 40.4 FUD 090 J G2 80 50

AMA: 2020,May,13; 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63042 lumbar

EXCLUDES *Laminectomy at same session as posterior interbody fusion for:*
*Decompression nerves or spinal components ([63052])*
*Preparation of interspace (22630, 22633)*

37.5 37.5 FUD 090 J G2 80 50

AMA: 2020,May,13; 2018,Jan,8; 2017,Mar,7; 2017,Feb,9; 2017,Jan,8; 2016,Jan,13

**90666** **Influenza virus vaccine (IIV), pandemic formulation, split virus, preservative free, for intramuscular use**
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

**90667** **Influenza virus vaccine (IIV), pandemic formulation, split virus, adjuvanted, for intramuscular use**
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

**90668** **Influenza virus vaccine (IIV), pandemic formulation, split virus, for intramuscular use**
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

**90670** **Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use**
INCLUDES Prevnar 13
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

● **90671** **Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use**
0.00 0.00 FUD XXX

● # **90677** **Pneumococcal conjugate vaccine, 20 valent (PCV20), for intramuscular use**
0.00 0.00 FUD XXX

***90672*** **Resequenced code. See code following 90660.**

***90673*** **Resequenced code. See code before 90662.**

***90674*** **Resequenced code. See code following 90661.**

**90675** **Rabies vaccine, for intramuscular use**
INCLUDES Imovax
RabAvert
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

**90676** **Rabies vaccine, for intradermal use**
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

***90677*** **Resequenced code. See code following 90671.**

**90680** **Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use**
INCLUDES RotaTeq
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

**90681** **Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use**
INCLUDES Rotarix
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

**90682** **Influenza virus vaccine, quadrivalent (RIV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use**
INCLUDES Flublok Quadrivalent
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2018,Nov,7; 2018,Jan,8; 2017,Jan,8

**90685** **Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.25 mL, for intramuscular use** A
INCLUDES Afluria Quadrivalent
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2018,Jan,8; 2017,Jan,8; 2016,Oct,6; 2016,May,9; 2016,Jan,13

**90686** **Influenza virus vaccine, quadrivalent (IIV4), split virus, preservative free, 0.5 mL dosage, for intramuscular use** A
INCLUDES Afluria Quadrivalent
Fluarix Quadrivalent
Flulaval Quadrivalent
Fluzone Quadrivalent
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2018,Jan,8; 2017,Jan,8; 2016,Oct,6; 2016,May,9; 2016,Jan,13

**90687** **Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.25 mL dosage, for intramuscular use** A
INCLUDES Afluria Quadrivalent
Fluzone Quadrivalent
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2018,Jan,8; 2017,Jan,8; 2016,Oct,6; 2016,May,9; 2016,Jan,13

**90688** **Influenza virus vaccine, quadrivalent (IIV4), split virus, 0.5 mL dosage, for intramuscular use** A
INCLUDES Afluria Quadrivalent
Fluzone Quadrivalent
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2020,Jul,11; 2018,Jan,8; 2017,Jan,8; 2016,Oct,6; 2016,May,9; 2016,Jan,13

**90689** **Influenza virus vaccine quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25 mL dosage, for intramuscular use**
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2020,Jul,11; 2019,Jul,10; 2018,Nov,7

# **90694** **Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use**
INCLUDES Fluad Quadrivalent
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2020,Jul,11

**90690** **Typhoid vaccine, live, oral**
INCLUDES Vivotif
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2020,Jul,11; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

**90691** **Typhoid vaccine, Vi capsular polysaccharide (ViCPs), for intramuscular use**
INCLUDES Typhim Vi
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2020,Jul,11; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

***90694*** **Resequenced code. See code following 90689.**

**90696** **Diphtheria, tetanus toxoids, acellular pertussis vaccine and inactivated poliovirus vaccine (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use** A
INCLUDES KINRIX
Quadracel
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

**90697** **Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use**
0.00 0.00 FUD XXX
AMA: 2020,DecSE,1; 2020,DecSE,1; 2020,NovSE,1; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

# Appendix A — Modifiers

## CPT Modifiers

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

**22** **Increased Procedural Services:** When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (ie, increased intensity, time, technical difficulty of procedure, severity of patient's condition, physical and mental effort required).
**Note:** This modifier should not be appended to an E/M service.

**23** **Unusual Anesthesia:** Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

**24** **Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period:** The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the appropriate level of E/M service.

**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:** It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M services on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.
**Note:** This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57. For significant, separately identifiable non-E/M services, see modifier 59.

**26** **Professional Component:** Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

**32** **Mandated Services:** Services related to *mandated* consultation and/or related services (eg, third party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

**33** **Preventive Services:** When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

**47** **Anesthesia by Surgeon:** Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.)
**Note:** Modifier 47 would not be used as a modifier for the anesthesia procedures.

**50** **Bilateral Procedure:** Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5 digit code.
**Note:** This modifier should not be appended to designated "add-on" codes (see Appendix F).

**51** **Multiple Procedures:** When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (eg, vaccines), are performed at the same session by the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).
**Note:** This modifier should not be appended to designated "add-on" codes (see Appendix F).

**52** **Reduced Services:** Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.
**Note:** For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

**53** **Discontinued Procedure:** Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure.
**Note:** This modifier is not used to report the elective cancellation of a procedure prior to the patient's anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

**54** **Surgical Care Only:** When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

**55** **Postoperative Management Only:** When 1 physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

**56** **Preoperative Management Only:** When 1 physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

**57** **Decision for Surgery:** An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.

# Appendix C — Evaluation and Management Extended Guidelines

This appendix provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, the 2021 changes to some E/M services, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. 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 when reporting 99217–99499.

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.

## 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 xiv of the AMA 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 an OQHCP must practice within these guidelines, even if more restrictive than the CPT guidelines. The OQHCP 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 OQHCP 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 or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Hospital inpatient services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient
- Emergency department services
- Critical care
- Nursing facility—initial services
- Nursing facility—subsequent services
- Nursing facility—discharge and annual assessment
- Domiciliary, rest home, or custodial care—new patient
- Domiciliary, rest home, or custodial care—established patient
- Home services—new patient
- Home services—established patient
- Newborn care services
- Neonatal and pediatric interfacility transport
- Neonatal and pediatric critical care—inpatient
- Neonate and infant intensive care services—initial and continuing
- Care management

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

A new patient is a patient who has not received any face-to-face professional services from the physician or OQHCP within the past three years. An established patient is a patient who has received face-to-face professional services from the physician or OQHCP within the past three years. In the case of group practices, if a physician or OQHCP of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a physician or OQHCP is on call or covering for another physician or OQHCP, the patient's encounter is classified as it would have been by the physician or OQHCP who is not available. Thus, a locum tenens physician or OQHCP who sees a patient on behalf of the patient's attending physician or OQHCP may not bill a new patient code unless the attending physician or OQHCP has not seen the patient for any problem within three years.

Office or other outpatient services are E/M services provided in the physician or OQHCP office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient. Hospital observation services are E/M services provided to patients who are designated or admitted as "observation status" in a hospital.

Codes 99218-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the provider "admitting" the patient for observation.

Codes 99234-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and preparation of the discharge records. It should not be used when admission and discharge are on the same date of service. As mentioned above, report codes 99234-99236 to appropriately describe same day observation services.

If a patient is in observation longer than one day, subsequent observation care codes 99224-99226 should be reported. If the patient is discharged on the second day, observation discharge code 99217 should be reported. If the patient status is changed to inpatient on a subsequent date, the appropriate inpatient code, 99221-99233, should be reported.

Initial hospital care is defined as E/M services provided during the first hospital inpatient encounter with the patient by the admitting provider. (If a physician other than the admitting physician performs the initial inpatient encounter, refer to consultations or subsequent hospital care in the CPT book.) Subsequent hospital care includes all follow-up encounters with the patient by all physicians or OQHCP. As there may only be one admitting physician, HCPCS Level II modifier AI Principal physician of record, should be appended to the initial hospital care code by the attending physician or OQHCP.

A consultation is the provision of a physician or OQHCP's opinion or advice about a patient for a specific problem at the request of another physician or other appropriate source. CPT also states that a consultation may be performed when a physician or OQHCP is determining whether to accept the transfer of patient care at the request of another physician or