Optum

Professional

Current Procedural Coding Expert

CPT® codes with Medicare essentials for enhanced accuracy

2026

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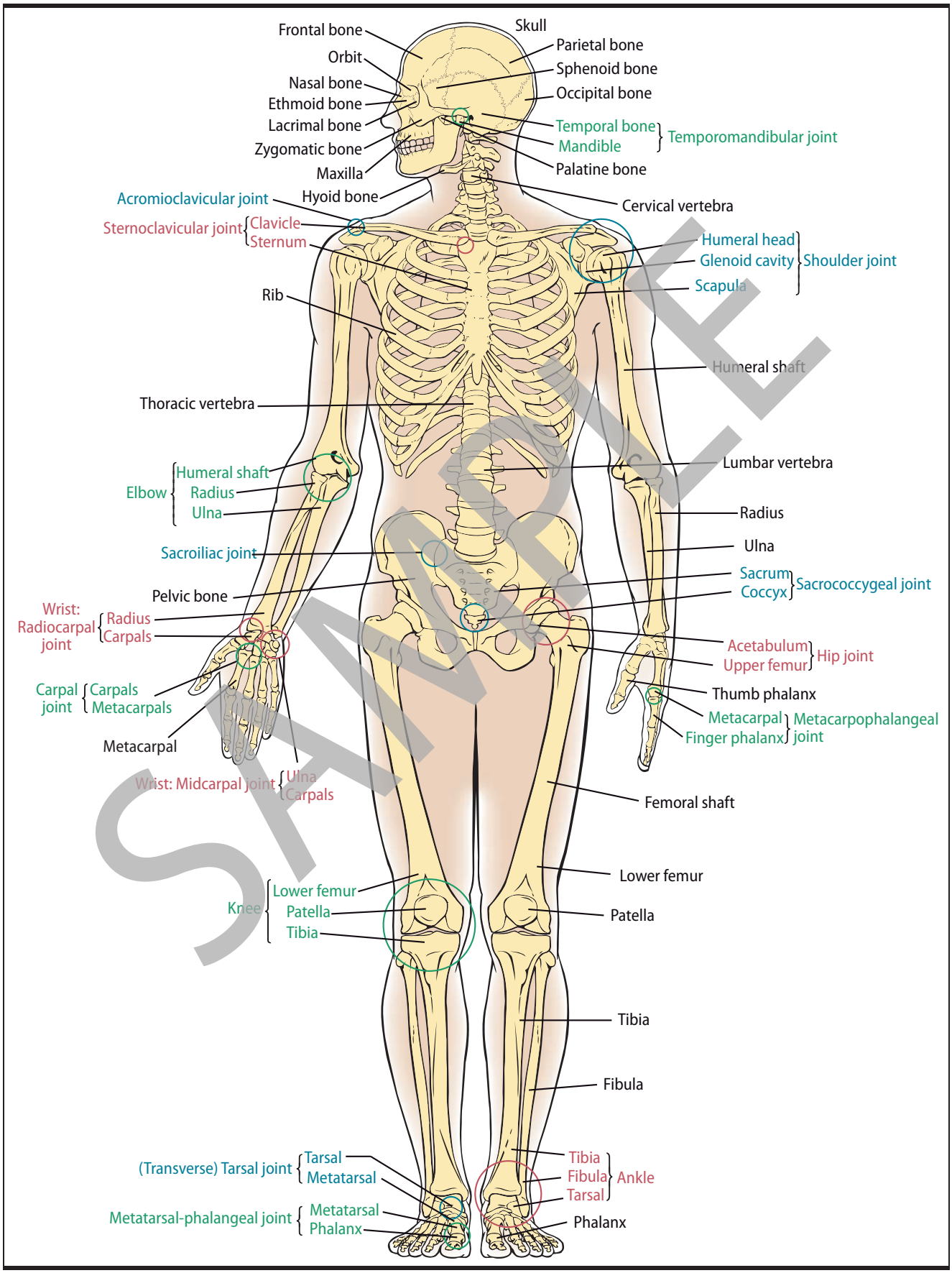
Musculoskeletal System

Bones and Joints



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20100-20103 Exploratory Surgery of Traumatic Wound

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

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

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

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

20102 **abdomen/flank/back**
7.71 18.39 **FUD** 010 **MUE** 3(3) T
AMA: 2020,Jan

20103 **extremity**
10.38 16.96 **FUD** 010 **MUE** 3(3) J1 G2 80
AMA: 2023,Oct

20150 Epiphyseal Bar Resection

20150 **Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision**
30.28 30.28 **FUD** 090 **MUE** 2(3) J1 G2 80 50

20200-20206 Muscle Biopsy

EXCLUDES *Removal of muscle tumor (see appropriate anatomic section)*

20200 **Biopsy, muscle; superficial**
2.86 6.50 **FUD** 000 **MUE** 2(3) J1 A2

20205 **deep**
4.66 9.15 **FUD** 000 **MUE** 3(3) J1 A2

20206 **Biopsy, muscle, percutaneous needle**
EXCLUDES *Fine needle aspiration (10021, [10004, 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012])*
(76942, 77002, 77012, 77021)
(88172-88173)
1.69 6.55 **FUD** 000 **MUE** 3(3) J1 A2
AMA: 2019,Apr

20220-20225 Percutaneous Bone Biopsy

EXCLUDES *Bone marrow aspiration(s) or biopsy(ies) (38220-38222)*

20220 **Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)**
(77002, 77012, 77021)
2.57 6.93 **FUD** 000 **MUE** 3(3) J1 A2
AMA: 2023,Jan

20225 **deep (eg, vertebral body, femur)**
EXCLUDES *When performed at same level:*
Percutaneous sacral augmentation (sacroplasty) (0200T-0201T)
Percutaneous vertebroplasty (22510-22515)
(77002, 77012, 77021)
3.81 11.32 **FUD** 000 **MUE** 2(3) J1 A2
AMA: 2023,Jan

20240-20251 Open Bone Biopsy

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

20240 **Biopsy, bone, open; superficial (eg, sternum, spinous process, rib, patella, olecranon process, calcaneus, tarsal, metatarsal, carpal, metacarpal, phalanx)**
4.18 4.18 **FUD** 000 **MUE** 4(3) J1 A2
AMA: 2023,May; 2023,Apr; 2021,Sep

20245 **deep (eg, humeral shaft, ischium, femoral shaft)**
10.25 10.25 **FUD** 000 **MUE** 3(3) J1 A2
AMA: 2023,Apr; 2021,Sep

20250 **Biopsy, vertebral body, open; thoracic**
11.84 11.84 **FUD** 010 **MUE** 1(3) J1 G2
AMA: 2023,Apr; 2021,Sep

20251 **lumbar or cervical**
12.66 12.66 **FUD** 010 **MUE** 2(3) J1 A2 80
AMA: 2023,Apr; 2021,Sep

20500-20501 Injection Fistula/Sinus Tract

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

20500 **Injection of sinus tract; therapeutic (separate procedure)**
(76080)
2.69 3.73 **FUD** 010 **MUE** 2(3) J1 P3

20501 **diagnostic (sinogram)**
EXCLUDES *Contrast injection or injections for radiological evaluation existing gastrostomy, duodenostomy, jejunostomy, gastro-jejunostomy, or cecostomy (or other colonic) tube from percutaneous approach (49465)*
(76080)
1.07 4.23 **FUD** 000 **MUE** 2(3) N N1

20520-20525 Foreign Body Removal

20520 **Removal of foreign body in muscle or tendon sheath; simple**
4.47 6.58 **FUD** 010 **MUE** 2(3) J1 P3
AMA: 2023,Jan

20525 **deep or complicated**
7.45 13.95 **FUD** 010 **MUE** 4(3) J1 A2
AMA: 2023,Jan

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

20526 **Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel**
1.70 2.48 **FUD** 000 **MUE** 1(2) T P3 50
AMA: 2023,Jan

20527 **Injection, enzyme (eg, collagenase), palmar fascial cord (ie, Dupuytren's contracture)**
EXCLUDES *Post injection palmar fascial cord manipulation (26341)*
1.97 2.64 **FUD** 000 **MUE** 2(3) T P3 50

30430 **Rhinoplasty, secondary; minor revision (small amount of nasal tip work)**
32.40 32.40 **FUD** 090 **MUE** 1(2) J1 A2 80

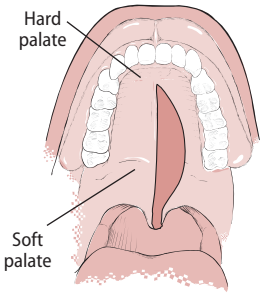
30435 **intermediate revision (bony work with osteotomies)**
40.34 40.34 **FUD** 090 **MUE** 1(2) J1 A2 80

30450 **major revision (nasal tip work and osteotomies)**
52.62 52.62 **FUD** 090 **MUE** 1(2) J1 A2 80

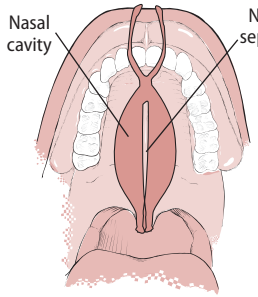
30460 **Rhinoplasty for nasal deformity secondary to congenital cleft lip and/or palate, including columellar lengthening; tip only**
24.95 24.95 **FUD** 090 **MUE** 1(2) J1 A2 80

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

Complete unilateral cleft lip



Isolated unilateral complete cleft of palate



Bilateral complete cleft of lip and palate

30462 **tip, septum, osteotomies**
47.91 47.91 **FUD** 090 **MUE** 1(2) J1 A2 80

30465 **Repair of nasal vestibular stenosis (eg, spreader grafting, lateral nasal wall reconstruction)**
INCLUDES Bilateral procedure
EXCLUDES *Repair nasal valve collapse using lateral wall implants, same side during same operative session (30468)*
Repair nasal valve collapse using radiofrequency, same side during same operative session (30469)
Repair nasal vestibular stenosis without graft, implant, or reconstruction lateral wall (30999)
Code also graft harvest ([15769], 20900-20902, 20910-20912, 20920-20922, 20924, 21210, 21235)
Code also modifier 52 for unilateral procedure
31.00 31.00 **FUD** 090 **MUE** 1(2) J1 A2 80
AMA: 2024,Mar; 2023,Feb; 2020,Sep

30468 **Repair of nasal valve collapse with subcutaneous/submucosal lateral wall implant(s)**
INCLUDES Bilateral procedure
EXCLUDES *Repair nasal valve collapse using radiofrequency, same side during same operative session (30469)*
Repair nasal valve collapse without graft, implant, or reconstruction lateral wall (30999)
Repair nasal vestibular stenosis, same side during same operative session (30465)
Code also modifier 52 for unilateral procedure
5.06 74.98 **FUD** 000 **MUE** 1(2) J1 J8
AMA: 2024,Mar; 2023,Feb

30469 **Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling**
INCLUDES Bilateral procedure
EXCLUDES *Repair nasal valve collapse using lateral wall implants, same side during same operative session (30468)*
Repair nasal valve collapse without graft, implant, or reconstruction lateral wall (30999)
Repair nasal vestibular stenosis, same side during same operative session (30465)
Code also modifier 52 for unilateral procedure
4.51 73.29 **FUD** 000 **MUE** 1(2) J1 J8
AMA: 2023,Feb

30520 **Septoplasty or submucous resection, with or without cartilage scoring, contouring or replacement with graft**
EXCLUDES *Turbinate resection (30140)*
20.43 20.43 **FUD** 090 **MUE** 1(2) J1 A2
AMA: 2023,Jul; 2023,Feb; 2021,Jan; 2019,Jul

30540 **Repair choanal atresia; intranasal**
22.36 22.36 **FUD** 090 **MUE** 1(2) 63 J1 A2 80

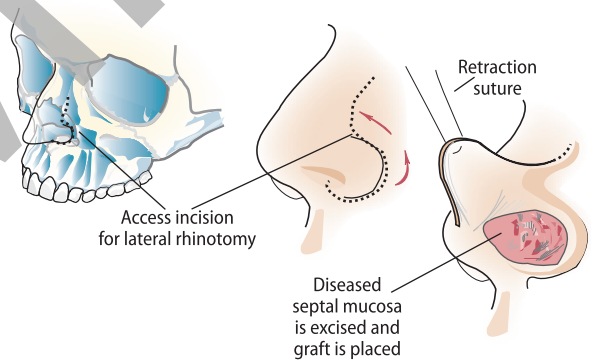
30545 **transpalatine**
30.27 30.27 **FUD** 090 **MUE** 1(2) 63 J1 A2 80

30560 **Lysis intranasal synechia**
4.58 9.69 **FUD** 010 **MUE** 1(2) T A2

30580 **Repair fistula; oromaxillary (combine with 31030 if antrotomy is included)**
13.84 18.30 **FUD** 090 **MUE** 2(3) J1 A2

30600 **oronasal**
11.56 15.55 **FUD** 090 **MUE** 1(3) J1 A2 80

30620 **Septal or other intranasal dermatoplasty (does not include obtaining graft)**
20.42 20.42 **FUD** 090 **MUE** 1(2) J1 A2



30630 **Repair nasal septal perforations**
20.24 20.24 **FUD** 090 **MUE** 1(2) J1 A2 80

30801-30802 Turbinate Destruction

EXCLUDES *Ablation middle/superior turbinates (30999)*
Cautery to stop nasal bleeding (30901-30906)
Excision inferior turbinate, partial or complete, any method (30130)
Submucous resection inferior turbinate, partial or complete, any method (30140)

30801 **Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); superficial**
EXCLUDES *Submucosal ablation inferior turbinates (30802)*
4.60 6.59 **FUD** 010 **MUE** 1(2) J1 A2
AMA: 2019,Jul

30802 **intramural (ie, submucosal)**
EXCLUDES *Superficial ablation inferior turbinates (30801)*
6.12 8.38 **FUD** 010 **MUE** 1(2) J1 A2
AMA: 2023,Feb; 2019,Jul

47531-47532 Injection/Insertion Procedures of Biliary Tract

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

47531 **Injection procedure for cholangiography, percutaneous, complete diagnostic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation; existing access**
2.06 12.48 **FUD** 000 **MUE** 2(3) Q2 N1
AMA: 2023,Feb

47532 **new access (eg, percutaneous transhepatic cholangiogram)**
6.14 24.76 **FUD** 000 **MUE** 1(3) Q2 N1

47533-47544 Percutaneous Procedures of the Biliary Tract

47533 **Placement of biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, ultrasound and/or fluoroscopy), and all associated radiological supervision and interpretation; external**
EXCLUDES *Conversion to internal-external drainage catheter (47535)*
Percutaneous placement stent bile duct (47538)
Placement stent bile duct, new access (47540)
Replacement existing internal drainage catheter (47536)
7.64 34.25 **FUD** 000 **MUE** 1(3) J1 G2

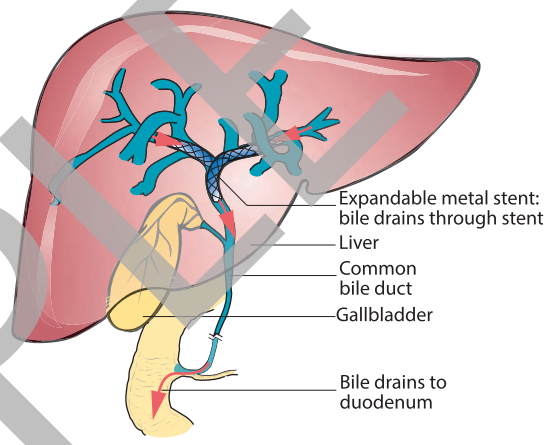
47534 **internal-external**
EXCLUDES *Conversion to external only drainage catheter (47536)*
Percutaneous placement stent bile duct (47538)
Placement stent bile duct, new access (47540)
10.69 37.62 **FUD** 000 **MUE** 2(3) J1 G2

47535 **Conversion of external biliary drainage catheter to internal-external biliary drainage catheter, percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation**
5.68 26.08 **FUD** 000 **MUE** 1(3) J1 G2

47536 **Exchange of biliary drainage catheter (eg, external, internal-external, or conversion of internal-external to external only), percutaneous, including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation**
INCLUDES Exchange one drainage catheter
EXCLUDES *Placement stent(s) into bile duct, percutaneous (47538)*
Code also exchange additional catheters same session with modifier 59 (47536)
3.83 18.68 **FUD** 000 **MUE** 2(3) J1 G2

47537 **Removal of biliary drainage catheter, percutaneous, requiring fluoroscopic guidance (eg, with concurrent indwelling biliary stents), including diagnostic cholangiography when performed, imaging guidance (eg, fluoroscopy), and all associated radiological supervision and interpretation**
EXCLUDES *Placement stent(s) into bile duct via same access (47538)*
Removal without fluoroscopic guidance; report with appropriate E/M service code
2.81 14.46 **FUD** 000 **MUE** 1(3) Q2 G2

47538 **Placement of stent(s) into a bile duct, percutaneous, including diagnostic cholangiography, imaging guidance (eg, fluoroscopy and/or ultrasound), balloon dilation, catheter exchange(s) and catheter removal(s) when performed, and all associated radiological supervision and interpretation; existing access**
EXCLUDES *Drainage catheter inserted following stent placement (47536)*
Procedures performed via same access (47536-47537)
Treatment same lesion same operative session ([43277], 47542, 47555-47556)
Code also multiple stents placed during same session when: (47538-47540)
Serial stents placed within same bile duct
Stent placement via two or more percutaneous access sites or space between two other stents
Two or more stents inserted through same percutaneous access
6.80 109.95 **FUD** 000 **MUE** 2(3) J1 J8



47539 **new access, without placement of separate biliary drainage catheter**
EXCLUDES *Treatment same lesion same operative session ([43277], 47542, 47555-47556)*
Code also multiple stents placed during same session when: (47538-47540)
Serial stents placed within same bile duct
Stent placement via two or more percutaneous access sites or space between two other stents
Two or more stents inserted through same percutaneous access
12.35 123.63 **FUD** 000 **MUE** 2(3) J1 G2

47540 **new access, with placement of separate biliary drainage catheter (eg, external or internal-external)**
EXCLUDES *Procedures performed via same access (47533-47534)*
Treatment same lesion same operative session ([43277], 47542, 47555-47556)
Code also multiple stents placed during same session when: (47538-47540)
Serial stents placed within same bile duct
Stent placement via two or more percutaneous access sites or space between two other stents
Two or more stents inserted through same percutaneous access
12.72 123.37 **FUD** 000 **MUE** 2(3) J1 J8

61305 **infratentorial (posterior fossa)**
EXCLUDES *Other craniectomy/craniotomy procedures when performed same anatomical site and during same surgical encounter*
61.09 61.09 **FUD** 090 **MUE** 1(3) C 80

61312 **Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural**
62.99 62.99 **FUD** 090 **MUE** 2(3) C 80

61313 **intracerebral**
60.52 60.52 **FUD** 090 **MUE** 2(3) C 80

61314 **Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural**
55.63 55.63 **FUD** 090 **MUE** 2(3) C 80

61315 **intracerebellar**
63.03 63.03 **FUD** 090 **MUE** 1(3) C 80

\+ **61316** **Incision and subcutaneous placement of cranial bone graft (List separately in addition to code for primary procedure)**
Code first (61304, 61312-61313, 61322-61323, 61340, 61570-61571, 61680-61705)
2.63 2.63 **FUD** ZZZ **MUE** 1(3) C

61320 **Craniectomy or craniotomy, drainage of intracranial abscess; supratentorial**
57.64 57.64 **FUD** 090 **MUE** 2(3) C 80

61321 **infratentorial**
64.68 64.68 **FUD** 090 **MUE** 1(3) C 80

61322 **Craniectomy or craniotomy, decompressive, with or without duraplasty, for treatment of intracranial hypertension, without evacuation of associated intraparenchymal hematoma; without lobectomy**
EXCLUDES *Craniectomy or craniotomy for evacuation hematoma (61313)*
Subtemporal decompression (61340)
72.53 72.53 **FUD** 090 **MUE** 1(3) C 80
AMA: 2020,May; 2018,Aug

61323 **with lobectomy**
EXCLUDES *Craniectomy or craniotomy for evacuation hematoma (61313)*
Subtemporal decompression (61340)
72.70 72.70 **FUD** 090 **MUE** 1(3) C 80

61330-61530 Craniectomy/Craniotomy/Decompression Brain By Surgical Approach/Specific Area of Brain

EXCLUDES *Injection for:*
Cerebral angiography (36100-36218)
Pneumoencephalography (61055)
Ventriculography (61026, 61120)

61330 **Decompression of orbit only, transcranial approach**
INCLUDES Naffziger operation
54.72 54.72 **FUD** 090 **MUE** 1(2) J1 G2 80 50

61333 **Exploration of orbit (transcranial approach); with removal of lesion**
61.37 61.37 **FUD** 090 **MUE** 1(2) C 80 50

61340 **Subtemporal cranial decompression (pseudotumor cerebri, slit ventricle syndrome)**
EXCLUDES *Decompression craniotomy or craniectomy for intracranial hypertension, without hematoma removal (61322-61323)*
43.97 43.97 **FUD** 090 **MUE** 1(2) C 80 50
AMA: 2020,May

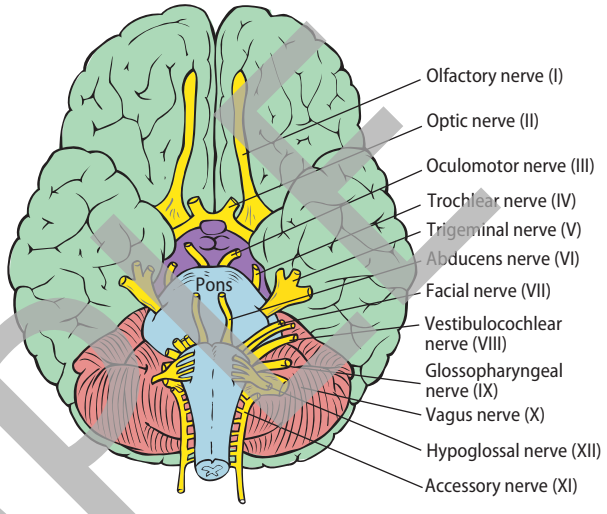
61343 **Craniectomy, suboccipital with cervical laminectomy for decompression of medulla and spinal cord, with or without dural graft (eg, Arnold-Chiari malformation)**
66.69 66.69 **FUD** 090 **MUE** 1(2) C 80

61345 **Other cranial decompression, posterior fossa**
EXCLUDES *Kroenlein procedure*
Orbital decompression using lateral wall approach (67445)
62.22 62.22 **FUD** 090 **MUE** 1(3) C 80

61450 **Craniectomy, subtemporal, for section, compression, or decompression of sensory root of gasserian ganglion**
INCLUDES Frazier-Spiller procedure
Hartley-Krause
Krause decompression
Taarnhoj procedure
58.47 58.47 **FUD** 090 **MUE** 1(3) C 80

61458 **Craniectomy, suboccipital; for exploration or decompression of cranial nerves**
INCLUDES Jannetta decompression
61.24 61.24 **FUD** 090 **MUE** 1(2) C 80

61460 **for section of 1 or more cranial nerves**
64.14 64.14 **FUD** 090 **MUE** 1(2) C 80



61500 **Craniectomy; with excision of tumor or other bone lesion of skull**
39.44 39.44 **FUD** 090 **MUE** 1(3) C 80

61501 **for osteomyelitis**
34.32 34.32 **FUD** 090 **MUE** 1(3) C 80

61510 **Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma**
Code also placement applicator for intraoperative radiation therapy, when performed (0735T)
67.11 67.11 **FUD** 090 **MUE** 1(3) C 80

61512 **for excision of meningioma, supratentorial**
Code also placement applicator for intraoperative radiation therapy, when performed (0735T)
77.60 77.60 **FUD** 090 **MUE** 1(3) C 80

61514 **for excision of brain abscess, supratentorial**
58.32 58.32 **FUD** 090 **MUE** 2(3) C 80

61516 **for excision or fenestration of cyst, supratentorial**
EXCLUDES *Craniopharyngioma (61545)*
Pituitary tumor removal (61546, 61548)
57.14 57.14 **FUD** 090 **MUE** 1(3) C 80

\+ **61517** **Implantation of brain intracavitary chemotherapy agent (List separately in addition to code for primary procedure)**
EXCLUDES *Intracavity radioelement source or ribbon implantation (77770-77772)*
Code first (61510, 61518)
2.62 2.62 **FUD** ZZZ **MUE** 1(3) C

61518 **Craniectomy for excision of brain tumor, infratentorial or posterior fossa; except meningioma, cerebellopontine angle tumor, or midline tumor at base of skull**
Code also placement applicator for intraoperative radiation therapy, when performed (0735T)
84.27 84.27 **FUD** 090 **MUE** 1(3) C 80

78012-78099 Nuclear Radiology: Thyroid, Parathyroid, Adrenal

EXCLUDES *Diagnostic services (see appropriate sections)*
Follow-up care (see appropriate section)
Code also radiopharmaceutical(s) and/or drug(s) supplied

78012 **Thyroid uptake, single or multiple quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)**
2.43 2.43 FUD XXX MUE 1(3) S Z2 80

78013 **Thyroid imaging (including vascular flow, when performed);**
5.14 5.14 FUD XXX MUE 1(3) S Z2 80

78014 **with single or multiple uptake(s) quantitative measurement(s) (including stimulation, suppression, or discharge, when performed)**
6.53 6.53 FUD XXX MUE 1(2) S Z2 80

78015 **Thyroid carcinoma metastases imaging; limited area (eg, neck and chest only)**
6.36 6.36 FUD XXX MUE 1(3) S Z2 80

78016 **with additional studies (eg, urinary recovery)**
7.58 7.58 FUD XXX MUE 1(3) S Z2 80

78018 **whole body**
8.52 8.52 FUD XXX MUE 1(2) S Z2 80

\+ **78020** **Thyroid carcinoma metastases uptake (List separately in addition to code for primary procedure)**
Code first (78018)
2.34 2.34 FUD ZZZ MUE 1(3) N N1 80

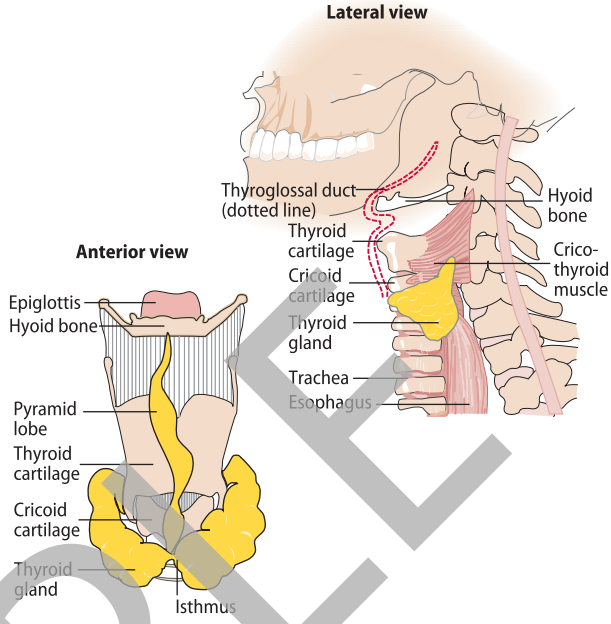
78070 **Parathyroid planar imaging (including subtraction, when performed);**
EXCLUDES *Distribution radiopharmaceutical agents or tumor localization (78800-78802, [78804], 78803)*
Radiopharmaceutical quantification measurements ([78835])
SPECT with concurrently acquired CT transmission scan ([78830, 78831, 78832])
8.08 8.08 FUD XXX MUE 1(2) S Z2 80
AMA: 2020,Oct

78071 **with tomographic (SPECT)**
EXCLUDES *Distribution radiopharmaceutical agents or tumor localization (78800-78802, [78804], 78803)*
Radiopharmaceutical quantification measurements ([78835])
SPECT with concurrently acquired CT transmission scan ([78830, 78831, 78832])
9.61 9.61 FUD XXX MUE 1(3) S Z2 80
AMA: 2020,Oct

78072 **with tomographic (SPECT), and concurrently acquired computed tomography (CT) for anatomical localization**
EXCLUDES *Distribution radiopharmaceutical agents or tumor localization (78800-78802, [78804], 78803)*
Radiopharmaceutical quantification measurements ([78835])
SPECT with concurrently acquired CT transmission scan ([78830, 78831, 78832])
11.92 11.92 FUD XXX MUE 1(3) S Z2 80
AMA: 2020,Oct

78075 **Adrenal imaging, cortex and/or medulla**
12.17 12.17 FUD XXX MUE 1(2) S Z2 80

78099 **Unlisted endocrine procedure, diagnostic nuclear medicine**
0.00 0.00 FUD XXX MUE 1(3) S Z2 80
AMA: 2024,Jan



78102-78199 Nuclear Radiology: Blood Forming Organs

EXCLUDES *Diagnostic services (see appropriate sections)*
Follow-up care (see appropriate section)
Radioimmunoassays (82009-84999 [82042, 82652])
Code also radiopharmaceutical(s) and/or drug(s) supplied

78102 **Bone marrow imaging; limited area**
4.81 4.81 FUD XXX MUE 1(2) S Z2 80

78103 **multiple areas**
5.13 5.13 FUD XXX MUE 1(2) S Z2 80

78104 **whole body**
6.89 6.89 FUD XXX MUE 1(2) S Z2 80

78110 **Plasma volume, radiopharmaceutical volume-dilution technique (separate procedure); single sampling**
2.07 2.07 FUD XXX MUE 1(2) S Z2 80

78111 **multiple samplings**
2.19 2.19 FUD XXX MUE 1(2) S Z2 80

78120 **Red cell volume determination (separate procedure); single sampling**
2.12 2.12 FUD XXX MUE 1(2) S Z2 80

78121 **multiple samplings**
2.31 2.31 FUD XXX MUE 1(2) S Z2 80

78122 **Whole blood volume determination, including separate measurement of plasma volume and red cell volume (radiopharmaceutical volume-dilution technique)**
2.94 2.94 FUD XXX MUE 1(2) S Z2 80

78130 **Red cell survival study**
3.72 3.72 FUD XXX MUE 1(2) S Z2 80

78140 **Labeled red cell sequestration, differential organ/tissue (eg, splenic and/or hepatic)**
3.28 3.28 FUD XXX MUE 1(3) S Z2 80

78185 **Spleen imaging only, with or without vascular flow**
EXCLUDES *Liver imaging (78215-78216)*
4.64 4.64 FUD XXX MUE 1(2) S Z2 80

78191 **Platelet survival study**
3.72 3.72 FUD XXX MUE 1(2) S Z2 80

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

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

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

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

Classification of Evaluation and Management (E/M) Services

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

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

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

New and Established Patients

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

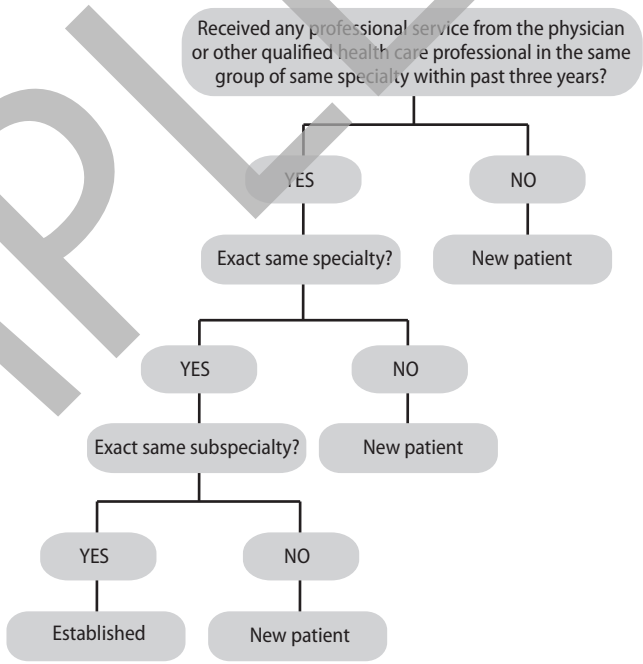
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the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

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Appendix A — Modifiers and Expanded Guidance

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

This appendix has three sections:

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

Introduction to Modifiers

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Classification of E/M Services

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

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

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

Categories of E/M Services

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

New and Established Patients

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

Initial and Subsequent Services

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

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

Services Reported Separately

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

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

Summary of Recent Changes to the E/M Codes

New E/M Telemedicine Services Section

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

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

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

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

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

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

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

Medical Decision Making

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

The three elements of the table are:

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

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

Number and Complexity of Problems Addressed During the Encounter

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

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

