Current Procedural Coding Expert

CPT® codes with Medicare essentials for enhanced accuracy

2025
optumcoding.com
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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 (IOCE), and Optum’s 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 does not fit in its numerical sequence with the related codes.

An example of resequencing from Current Procedural Coding Expert follows:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21553</td>
<td>Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm</td>
</tr>
<tr>
<td>21552</td>
<td>3 cm or greater</td>
</tr>
<tr>
<td>21556</td>
<td>Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm</td>
</tr>
<tr>
<td>21554</td>
<td>5 cm or greater</td>
</tr>
</tbody>
</table>

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 toxioid/vaccine (91304-90759 [90584, 90589, 90611, 90619, 90620, 90621, 90622, 90623, 90625, 90626, 90627, 90630, 90644, 90672, 90673, 90674, 90677, 90601, 90603, 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
Introduction

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 93 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 not 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 for 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 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 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

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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.
- **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.
- **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.
- **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.
- **Assistant-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.
- **Assistant-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).
- **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
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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.

- **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/](http://www.optumcoding.com/ProductUpdates/).

- **Surgical procedure on ASC list in 2007; payment based on OPPS relative payment weight.**
- **Alternative code may be available; no payment made.**
- **Deleted/discontinued code; no payment made.**
- **Corneal tissue acquisition; hepatitis B vaccine; paid at reasonable cost.**
- **Non-office-based surgical procedure added in CY 2008 or later; payment based on OPPS relative payment weight.**
- **Brachytherapy source paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.**
- **OPPS pass-through device paid separately when provided integral to a surgical procedure on ASC list; payment contractor-priced.**
- **Device-intensive procedure; paid at adjusted rate.**
- **Drugs and biologics paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS rate.**
- **Unclassified drugs and biologics; payment contractor-priced.**
- **Influenza vaccine; pneumococcal vaccine. Packaged item/service; no separate payment code.**
- **New technology intraocular lens (NTIOL); special payment.**
- **Packaged follow-up day (FUD); no separate payment made.**
- **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.**
- **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.**
- **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.**
- **Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on OPPS relative payment weight.**
- **Radiology or diagnostic service paid separately when provided integral to a surgical procedure on ASC list; payment based on MPFS nonfacility PE RVUs.**

- **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.

- **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.

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

- **FUD:**
  Global days are sometimes referred to as “follow-up days” or FUDs. The global period is the time following a 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
  - **XX** 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, 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/](http://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**

- **Skull**
  - Frontal bone
  - Parietal bone
  - Nasal bone
  - Ethmoid bone
  - Lacrimal bone
  - Zygomatic bone
  - Temporal bone
  - Mandible
  - Occipital bone
  - Sphenoid bone
  - Nasal bone
  - Ethmoid bone
  - Lacrimal bone
  - Zygomatic bone
  - Ethmoid bone
  - Lacrimal bone
  - Zygomatic bone
  - Temporal bone
  - Mandible
  - Occipital bone
  - Sphenoid bone

- **Cervical vertebra**
- **Thoracic vertebra**
- **Lumbar vertebra**
- **Pelvic bone**
- **Sacrum**
  - Acetabulum
- **Upper femur**
  - Femoral shaft
  - Patella
  - Tibia
  - Lower femur
  - Medial malleolus
  - Anterior superior iliac spine
  - Anterior superior iliac spine
  - Femoral neck

- **Acromioclavicular joint**
- **Sternoclavicular joint**
- **Humeral head**
- **Glenoid cavity**
- **Shoulder joint**
- **Radius**
- **Ulna**
- **Carpals**
  - Thumb phalanx
  - Finger phalanx
- **Metacarpals**
  - Metacarpophalangeal joint
- **Wrist**
  - Radial carpal joint
  - Distal carpal joint
  - Midcarpal joint
- **Metacarpalphalangeal joint**
  - Phalanx
- **Tarsals**
  - Tarsal-metatarsal joint
  - Metatarsal-phalangeal joint
  - Phalanx
  - (Transverse) TARSAL joint
  - TARSAL joint

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### 10030 - 10180 Treatment of Lesions: Skin and Subcutaneous Tissues

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVU</th>
<th>AMA:</th>
<th>MUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>10030</td>
<td>Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous</td>
<td>3.98</td>
<td>2023,Jan;2022,Feb;2019,Apr;2017,Aug</td>
<td>1(2)</td>
</tr>
<tr>
<td>10035</td>
<td>Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radiative seeds), percutaneous, including imaging guidance, first lesion</td>
<td>2.50</td>
<td>2022,Feb</td>
<td>1(2)</td>
</tr>
<tr>
<td>10036</td>
<td>Locating device(s) for fluid drainage (eg, extremity, abdominal wall, neck), percutaneous</td>
<td>1.26</td>
<td>2022,Feb</td>
<td>1(2)</td>
</tr>
<tr>
<td>10040</td>
<td>Acne surgery (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)</td>
<td>1.54</td>
<td>2022,Feb</td>
<td>1(2)</td>
</tr>
<tr>
<td>10041</td>
<td>Incision and drainage of abscess (eg, carbuncle, supplicative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or multiple</td>
<td>3.12</td>
<td>2022,Feb</td>
<td>1(3)</td>
</tr>
<tr>
<td>10060</td>
<td>Incision and drainage of abscess (eg, carbuncle, supplicative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or multiple</td>
<td>6.37</td>
<td>2022,Feb</td>
<td>2(2)</td>
</tr>
<tr>
<td>10080</td>
<td>Incision and drainage of pilonidal cyst; simple or multiple</td>
<td>1.95</td>
<td>2022,Feb</td>
<td>1(3)</td>
</tr>
<tr>
<td>10081</td>
<td>Incision and removal of foreign body, subcutaneous tissues; simple</td>
<td>3.14</td>
<td>2022,Feb</td>
<td>3(3)</td>
</tr>
<tr>
<td>10120</td>
<td>Incision and removal of foreign body, subcutaneous tissues; simple</td>
<td>3.14</td>
<td>2022,Feb</td>
<td>3(3)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>RVU</th>
<th>AMA:</th>
<th>MUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.51</td>
<td>2022,Feb</td>
<td>2(3)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>RVU</th>
<th>AMA:</th>
<th>MUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.88</td>
<td>2023,Apr;2022,Feb;2021,Feb;2017,Aug</td>
<td>1(3)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVU</th>
<th>AMA:</th>
<th>MUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>11000</td>
<td>Debridement of extensive eczematous or infected skin; up to 10% of body surface</td>
<td>3.76</td>
<td>2023,Aug;2021,Feb</td>
<td>1(2)</td>
</tr>
<tr>
<td>11001</td>
<td>Debridement of extensive eczematous or infected skin; up to 10% of body surface</td>
<td>5.34</td>
<td>2023,Aug;2021,Feb</td>
<td>2(3)</td>
</tr>
</tbody>
</table>

### 11004 Debridement of skin, subcutaneous tissue, muscle and fascia

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVU</th>
<th>AMA:</th>
<th>MUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>11004</td>
<td>Debridement of skin, subcutaneous tissue, muscle and fascia for necrotizing soft tissue infection; external genitalia and perineum</td>
<td>3.76</td>
<td>2023,Aug;2021,Feb</td>
<td>1(2)</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>RVU</th>
<th>AMA:</th>
<th>MUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>11005</td>
<td>abdominal wall, with or without fascial closure</td>
<td>22.89</td>
<td>2023,Aug;2021,Feb</td>
<td>1(2)</td>
</tr>
</tbody>
</table>
Respiratory System 31233

30901-30920 Control Nose Bleed

30901  Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method
AMA: 2020, Oct; 2020, Jul

30903  Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method
AMA: 2020, Oct; 2020, Jul

30905  Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; initial
AMA: 2020, Oct; 2020, Jul

30915  Ligation arteries; ethmoidal

30920  Internal maxillary artery, transcranial

30930-30999 Other and Unlisted Procedures of Nose

30930  Fracture nasal inferior turbinate(s), therapeutic

30999  Unlisted procedure, nose
AMA: 2023, Feb; 2022, Jan; 2021, Jan; 2020, Sep; 2019, Dec

31000-31230 Opening Sinuses

31000  Lavage by cannulation; maxillary sinuses (antrum puncture or natural ostium)

31002  Sphenoid sinus

31020  Sinusotomy, maxillary (antrotoomy); intranasal

31030  Radical (Caldwell-Luc) without removal of antrochoanal polyps

31032  Radical (Caldwell-Luc) with removal of antrochoanal polyps

31040  Pterygomaxillary fossa surgery, any approach

31050  Sinusotomy, sphenoid, with or without biopsy;

31051  with mucosal stripping or removal of polyp(s)

31070  Sinusotomy frontal; external, simple (trephine operation)

31075  transorbital, unilateral (for mucocoele or osteoma, Lynch-type)

31080  Obliterative, without osteoplastic flap, brow incision (includes ablation)

31081  Obliterative, without osteoplastic flap, coronal incision (includes ablation)

31084  Obliterative, with osteoplastic flap, brow incision

31085  Obliterative, with osteoplastic flap, coronal incision

31086  Nonobliterative, with osteoplastic flap, brow incision

31087  Nonobliterative, with osteoplastic flap, coronal incision

31090  Sinusotomy, unilateral, 3 or more paranasal sinuses (frontal, maxillary, ethmoid, sphenoid)

31200  Ethmoidectomy; intranasal, anterior

31201  Intranasal, total

31205  Extranasal, total

31225  Maxillectomy; without orbital exenteration

31230  With orbital exenteration (en bloc)

31231-31235 Nasal Endoscopy, Diagnostic

31231  Nasal endoscopy, diagnostic, unilateral or bilateral (separate procedure)
AMA: 2021, Apr; 2018, Apr; 2017, Jul; 2017, Jan

31233  Nasal/sinus endoscopy, diagnostic with maxillary sinuscopy (via inferior meatus or canine fossa puncture)

31235  When performed on same side:

Dilation of maxillary sinus ostium (31295)

Maxillary antrostomy (31256, 31267)

4.02, 8.28 FUD 000 MUE 1(2)

AMA: 2018, Apr
| Code     | Description                                                                                           | AMA: Date       | FUD | MUE | |---|---|---|---|---|---|---|
| 52325   | with fragmentation of ureteral calculus (eg, ultrasonic or electro-hydraulic technique)               | 2023,Jul       | 9.34| 5.35| 1(2) |
| 52327   | with subureteric injection of implant material                                                        | 2023,Jul       | 7.56| 4.55| 1(2) |
| 52330   | with manipulation, without removal of ureteral calculus                                               | 2023,Jul       | 7.68| 18.09| 1(2) |
| 52332   | Cystourethroscopy, with insertion of indwelling ureteral stent (eg, Gibbons or double-J type)        | 2023,Jul       | 5.35| 5.35| 1(2) |
| 52334   | Cystourethroscopy with insertion of ureteral guide wire through kidney to establish a percutaneous nephrostomy, retrograde | 2023,Jul       | 5.35| 5.35| 1(2) |
| 52341   | Cystourethroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision) | 2019,Dec       | 8.30| 8.30| 1(2) |
| 52342   | with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision) | 2023,Jul       | 9.01| 9.01| 1(2) |
| 52343   | with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)   | 2023,Jul       | 10.04| 10.04| 1(2) |
| 52344   | Cystourethroscopy with ureteroscopy; with treatment of ureteral stricture (eg, balloon dilation, laser, electrocautery, and incision) | 2023,Jul       | 10.75| 10.75| 1(2) |
| 52345   | with treatment of ureteropelvic junction stricture (eg, balloon dilation, laser, electrocautery, and incision) | 2023,Jul       | 10.75| 10.75| 1(2) |
| 52346   | with treatment of intra-renal stricture (eg, balloon dilation, laser, electrocautery, and incision)   | 2019,Dec       | 13.00| 13.00| 1(2) |
| 52351   | Cystourethroscopy, with ureteroscopy and/or pyeloscopy; diagnostic                                  | 2023,Jul       | 11.49| 11.49| 1(2) |
| 52352   | with removal or manipulation of calculus (ureteral catheterization is included)                       | 2023,Jul       | 10.33| 10.33| 1(2) |
| 52353   | with lithotripsy (ureteral catheterization is included)                                               | 2019,Dec       | 11.43| 11.43| 1(2) |
| 52356   | with lithotripsy including insertion of indwelling ureteral stent (eg, Gibbons or double-J type)     | 2022,Feb       | 12.11| 12.11| 1(2) |
| 52354   | with biopsy and/or fulguration of ureteral or renal pelvic lesion                                     | 2019,Dec       | 12.15| 12.15| 1(3) |
70332  Temporomandibular joint arthrography, radiological supervision and interpretation

- Fluoroscopic guidance (77002)
  - 2.55  2.55  FUD XXX  MUE 2(3)

70336  Magnetic resonance (eg, proton) imaging, temporomandibular joint(s)

- 8.31  8.31  FUD XXX  MUE 1(3)

AMA: 2022, Jul

70350  Cephalogram, orthodontic

- 0.49  0.49  FUD XXX  MUE 1(3)

70355  Orthopantomogram (eg, panoramic x-ray)

- 0.54  0.54  FUD XXX  MUE 1(3)

70360  Radiologic examination; neck, soft tissue

- 0.95  0.95  FUD XXX  MUE 1(3)

AMA: 2022, Dec

70370  Pharynx or larynx, including fluoroscopy and/or magnification technique

- 3.06  3.06  FUD XXX  MUE 1(3)

AMA: 2022, Dec

70371  Complex dynamic pharyngeal and speech evaluation by cine or video recording

- 3.25  3.25  FUD XXX  MUE 1(2)

70380  Radiologic examination, salivary gland for calculus

- 1.13  1.13  FUD XXX  MUE 2(3)

AMA: 2022, Dec

70390  Sialography, radiological supervision and interpretation

- 3.55  3.55  FUD XXX  MUE 2(3)

70450-70492  Computed Tomography: Head, Neck, Face

CMS: 100-04,4,250-16 Multiple Procedure Payment Reduction: Certain Diagnostic Imaging Procedures Rendered by Physicians

- Imaging using tomographic technique enhanced by computer imaging to create cross-sectional body plane view
- 3D rendering (76370-76377)
- Quantitative CT tissue characterization same gland, organ, tissue, or target area during same session (07217)

Code also quantitative CT tissue characterization when performed with concurrent CT exam (07227)

70450  Computed tomography, head or brain; without contrast material

- 3.29  3.29  FUD XXX  MUE 1(3)

70460  with contrast material(s)

- 4.59  4.59  FUD XXX  MUE 1(3)

70470  without contrast material, followed by contrast material(s) and further sections

- 5.40  5.40  FUD XXX  MUE 1(3)

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)

70481  with contrast material(s)

- 5.62  5.62  FUD XXX  MUE 1(3)

70482  without contrast material, followed by contrast material(s) and further sections

- 6.56  6.56  FUD XXX  MUE 1(3)

70486  Computed tomography, maxillofacial area; without contrast material

- 3.98  3.98  FUD XXX  MUE 1(3)

70487  with contrast material(s)

- 4.72  4.72  FUD XXX  MUE 1(3)

70488  without contrast material, followed by contrast material(s) and further sections

- 5.75  5.75  FUD XXX  MUE 1(3)

70490  Computed tomography, soft tissue neck; without contrast material

- 4.66  4.66  FUD XXX  MUE 1(3)

70491  with contrast material(s)

- 5.74  5.74  FUD XXX  MUE 1(3)

70492  without contrast material followed by contrast material(s) and further sections

- 6.90  6.90  FUD XXX  MUE 1(3)

70496-70498  Computed Tomographic Angiography: Head and Neck

CMS: 100-04,4,250-16 Multiple Procedure Payment Reduction: Certain Diagnostic Imaging Procedures Rendered by Physicians

- Reporting code with following unless separate diagnostic MRI performed (70551-70553)
- Noninvasive arterial plaque analysis non-coronary computed tomography angiography (07170T-07173T)

70496  Computed tomographic angiography, head, with contrast material(s), including noncontrast images, if performed, and image postprocessing

- 8.39  8.39  FUD XXX  MUE 2(3)

70498  Computed tomographic angiography, neck, with contrast material(s), including noncontrast images, if performed, and image postprocessing

- 8.59  8.59  FUD XXX  MUE 2(3)

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

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

70540  Magnetic resonance (eg, proton) imaging, orbit, face, and/or neck; without contrast material(s)

- 7.08  7.08  FUD XXX  MUE 1(3)

AMA: 2022, May

70542  with contrast material(s)

- 8.41  8.41  FUD XXX  MUE 1(3)

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)

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

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

70545  with contrast material(s)

- 7.10  7.10  FUD XXX  MUE 1(3)

70546  without contrast material(s), followed by contrast material(s) and further sequences

- 10.29  10.29  FUD XXX  MUE 1(3)

70547  Magnetic resonance angiography, neck; without contrast material(s)

- 6.73  6.73  FUD XXX  MUE 1(3)
90281-90399 Immunoglobulin Products

90281 Immune globulin (Ig), human, for intramuscular use

90283 Immune globulin (IgIV), human, for intravenous use

90284 Immune globulin (SCig), human, for use in subcutaneous infusions, 100 mg, each

90287 Botulinum antitoxin, equine, any route

90288 Botulism immune globulin, human, for intramuscular use

90291 Cytomegalovirus immune globulin (CMV-IgIV), human, for intravenous use

90296 Diphtheria antitoxin, equine, any route

90371 Hepatitis B immune globulin (HBIG), human, for intramuscular use

90375 Rabies immune globulin (RIG), human, for intramuscular and/or subcutaneous use

90376 Rabies immune globulin, heat-treated (RIG-HT), human, for intramuscular and/or subcutaneous use

90377 Rabies immune globulin, heat- and solvent/detergent-treated (RIG-HT S/D), human, for intramuscular and/or subcutaneous use

90378 Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each

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

90385 Rho(D) immune globulin (RhIG), human, mini-dose, for intramuscular use

90386 Rho(D) immune globulin (RhIGIV), human, for intravenous use

90389 Tetanus immune globulin (TIG), human, for intramuscular use

90393 Vaccinia immune globulin, human, for intramuscular use

90396 Varicella-zoster immune globulin, human, for intramuscular use

90399 Unlisted immune globulin

90460-90480 (90480) Vaccine/Toxoid Administration

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

90461 Patient/family face-to-face counseling by doctor or other qualified health care professional for patients age 18 years and younger

90470 Administration vaccine without counseling

90471 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, 91320, 91321, 91322)

90477 FUD

90480 Not Covered

90485 Unlisted

90486 New Code

90487 Revised Code

90488 Reinstated

90489 New Web Release

90490 Revised Web Release

90491 Add-on

90492 Optum Mod 50 Exempt

90493 AMA Mod 51 Exempt

90494 Optum Mod 51 Exempt

90495 Mod 63 Exempt

90496 Code also:

90498 Optum 360, LLC

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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 Residential 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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Evaluation and Management (E/M) Services Guidelines

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

- Received any professional service from the physician or other qualified health care professional in the same group of same specialty within past three years?
  - YES
    - Exact same specialty?
      - YES
      - New patient
      - NO
      - New patient
    - NO
      - Established
  - NO
    - New patient

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
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>99245</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>99252</td>
<td>Inpatient or observation consultation for a new or established patient, which requires a medically appropriate history and 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.</td>
<td>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.</td>
</tr>
<tr>
<td>99253</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>99254</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>99255</td>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>

**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 - 99229), 100-04,12,30,6.1 Subsequent Hospital Inpatient or Observation Care Visit and Hospital Inpatient or Observation Discharge Day Management (Codes 99231 - 99239)
- 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

**Consultation prompted by patient/family or not requested by physician or QHP**
- Inpatient consultation (99232-99233, 99308-99310)
- Observation consultation (99234-99239, 99309-99314)
- 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

**Services provided to Medicare patients; E/M code as appropriate for place of service (99211-99215, 99221-99223, 99231-99233, 99245-99249)**
- Inpatient consultation (99232-99233, 99308-99310)
- Observation consultation (99234-99239, 99309-99314)
- 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
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- Provision written report, findings/recommendations from consultant to referring physician
- Third-party mandated consultation; append modifier 32

**Evaluation and Management**

**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 - 99229), 100-04,12,30,6.1 Subsequent Hospital Inpatient or Observation Care Visit and Hospital Inpatient or Observation Discharge Day Management (Codes 99231 - 99239)
- All consultations provided in hospital inpatient, observation, nursing facility, or partial hospital settings
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- 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
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**Consultation prompted by patient/family or not requested by physician or QHP**
- Inpatient consultation (99232-99233, 99308-99310)
- Observation consultation (99234-99239, 99309-99314)
- 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

**Services provided to Medicare patients; E/M code as appropriate for place of service (99211-99215, 99221-99223, 99231-99233, 99245-99249)**
- Inpatient consultation (99232-99233, 99308-99310)
- Observation consultation (99234-99239, 99309-99314)
- 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

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- Provision written report, findings/recommendations from consultant to referring physician
- Third-party mandated consultation; append modifier 32
Appendix A — Modifiers and Expanded Guidance

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 healthcare 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 II, or CPT, modifiers are developed by the American Medical Association (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 department services. 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, 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, and that follow surgery hospitalization. However, 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.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00176</td>
<td>Anesth pharyngeal surgery</td>
</tr>
<tr>
<td>00192</td>
<td>Anesth facial bone surgery</td>
</tr>
<tr>
<td>00211</td>
<td>Anesth craniotomy</td>
</tr>
<tr>
<td>00213</td>
<td>Anesth skull surgery</td>
</tr>
<tr>
<td>00215</td>
<td>Anesth skull repair/fracture</td>
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<td>00474</td>
<td>Anesth surgery of rib</td>
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<td>00524</td>
<td>Anesth chest drainage</td>
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<tr>
<td>00540</td>
<td>Anesth chest surgery</td>
</tr>
<tr>
<td>00552</td>
<td>Anesth abortion or termination of pregnancy</td>
</tr>
<tr>
<td>00565</td>
<td>Anesth lung chest wall surgery</td>
</tr>
<tr>
<td>00594</td>
<td>Anesth heart surgery w/pump age 1+</td>
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<tr>
<td>00567</td>
<td>Anesth cabg w/pump</td>
</tr>
<tr>
<td>00580</td>
<td>Anesth heart/lung transplant</td>
</tr>
<tr>
<td>00589</td>
<td>Anesth thoracic duct ligature</td>
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<tr>
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<td>Anesth removal of nerves</td>
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<tr>
<td>00792</td>
<td>Anesth hemorrhage/exsanguine</td>
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<tr>
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<td>Anesth pancreas removal</td>
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<tr>
<td>00796</td>
<td>Anesth for liver transplant</td>
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<td>00816</td>
<td>Anesth removal of adrenal</td>
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<tr>
<td>00846</td>
<td>Anesth hysterectomy</td>
</tr>
<tr>
<td>00848</td>
<td>Anesth pelvic organ surgery</td>
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<td>00864</td>
<td>Anesth removal of bladder</td>
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<tr>
<td>00866</td>
<td>Anesth removal of adnexal structures</td>
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<td>00868</td>
<td>Anesth kidney transplant</td>
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<td>00882</td>
<td>Anesth major vein ligation</td>
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<td>00904</td>
<td>Anesth perineal surgery</td>
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<td>Anesth penis nodes removal</td>
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<td>Anesth amputation at pelvis</td>
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<td>Anesth pelvic tumor surgery</td>
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<td>Anesth arthroplasty of elbow</td>
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<td>01756</td>
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<tr>
<td>11005</td>
<td>Debride abscess wound</td>
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<tr>
<td>11006</td>
<td>Debride genital/per/abdom wall</td>
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<tr>
<td>11036</td>
<td>Frey myo/skin flap microvasc</td>
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<td>Frey skin microvascular</td>
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<td>11576</td>
<td>Frey fascial flap microvasc</td>
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