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On the topic:
CPT Code
Updates: Effective
January 1
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CPT Code Updates
Effective January 1

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Evaluation and Management Critical Care Services

• For reporting by professionals, the following services are included in critical care when performed during the critical period by the physicians(s) providing critical care: the interpretation of cardiac output measurements (93561, 93562), chest X rays (71045, 71046), pulse oximetry (94760, 94761, 94762), blood gases, and collection and interpretation of physiologic data (eg, ECGs, blood pressure, hematologic data); gastric intubation (43752, 43753); temporary transcutaneous pacing (92953); ventilatory management (94002-94004, 94660, 94662); and vascular access procedures (36000, 3640, 36415, 36591, 36600). Any services performed that are not included in this listing should be reported separately, Facilities may report the above services separately.
Critical Care Services

- Time spent in activities that occur outside of the unit or off the floor (e.g., telephone calls whether taken at home, in the office, or elsewhere in the hospital) may not be reported as critical care since the individual is not immediately available to the patient. Time spent in activities that do not directly contribute to the treatment of the patient may not be reported as critical care, even if they are performed in the critical care unit (e.g., participation in administrative meetings or telephone calls to discuss other patients). Time spent performing separately reportable procedures or services should not be included in the time reported as critical care time.

Home Services

- The following codes are used to report evaluation and management services provided in a home. Home may be defined as a private residence, temporary lodging, or short term accommodation (e.g., hotel, campground, hostel, or cruise ship).
Interprofessional Telephone/Internet/Electronic Health Record Consultations

• The consultant should use codes 99446, 99447, 99448, 99449, 99451 to report interprofessional telephone/Internet/electronic health record consultations. An interprofessional telephone/Internet/electronic health record consultation is an assessment and management service in which a patient's treating (e.g., attending or primary) physician or other qualified health care professional requests the opinion and/or treatment advice of a physician with specific specialty expertise (the consultant) to assist the treating physician or other qualified health care professional in the diagnosis and/or management of the patient's problem without patient face-to-face contact with the consultant.

• The patient for whom the interprofessional telephone/Internet/electronic health record consultation is requested may be either a new patient to the consultant or an established patient with a new problem or an exacerbation of an existing problem. However, the consultant should not have seen the patient in a face-to-face encounter within the last 14 days. When the telephone/Internet/electronic health record consultation leads to a transfer of care or other face-to-face service (e.g., a surgery, a hospital visit, or a scheduled office evaluation of the patient) within the next 14 days or next available appointment date of the consultant, these codes are not reported.
• Review of pertinent medical records, laboratory studies, imaging studies, medication profile, pathology specimens, etc is included in the telephone/Internet/electronic health record consultation service and should not be reported separately when reporting 99446, 99447, 99448, 99449, 99451. The majority of the service time reported (greater than 50%) must be devoted to the medical consultative verbal or Internet discussion. If greater that 50% of the time for the service is devoted to data review and/or analysis, 99446, 99447, 99448, 99449 should not be reported. However, the service time for 99451 is based on total review and interprofessional-communication time.

• If more than one telephone/Internet/electronic health record contact(s) is required to complete the consultation request (eg, discussion of test results), the entirety of the service and the cumulative discussion and information review time should be reported with a single code. Codes 99446, 99447, 99448, 99449, 99451 should not be reported more than once within a seven-day interval.

• The written or verbal request for telephone/Internet/electronic health record advice by the treating/requesting physician or other qualified health care professional should be documented in the patient's medical record, including the reason for the request. Codes 99446, 99447, 99448, 99449 conclude with a verbal opinion report and written report from the consultant to the treating/requesting physician or other qualified health care professional. Code 99451 concludes with only a written report.
• Telephone/Internet/electronic health record consultations of less than five minutes should not be reported. Consultant communications with the patient and/or family may be reported using 98966, 98967, 98968, 98969, 99441, 99442, 99443, 99444, and the time related to these services is not used in reporting 99446, 99447, 99448, 99449. Do not report 99358, 99359 for any time within the service period, If reporting 99446, 99447, 99448, 99449, 99451.

• When the sole purpose of the telephone/Internet/electronic health record communication is to arrange a transfer of care or other face-to-face service, these codes are not reported.

• The treating/requesting physician or other qualified health care professional may report 99452 if spending 16-30 minutes in a service day preparing for the referral and/or communicating with the consultant. Do not report 99452 more than once in a 14-day period. The creating/requesting physician or other qualified health care professional may report the prolonged service codes 99354, 99355, 99356, 99357 for the time spent on the interprofessional telephone/Internet/electronic health record discussion with the consultant (eg, specialist) if the time exceeds 30 minutes beyond the typical time of the appropriate E/M service performed and the patient is present (on-site) and accessible to the treating/requesting physician or other qualified health care professional.
• If the interprofessional telephone/Internet/electronic health record assessment and management service occurs when the patient is not present and the time spent in a day exceeds 30 minutes, then the non-face-to-face prolonged service codes 99358, 99359 may be reported by the treating/requesting physician or other qualified health care professional.

Digitally Stored Data Services/Remote Physiologic Monitoring

• Codes 99453 and 99454 are used to report remote physiologic monitoring services (eg, weight, blood pressure, pulse oximetry) during a 30-day period. To report 99453, 99454, the device used must be a medical device as defined by the FDA, and the service must be ordered by a physician or other qualified health care professional. Code 99453 may be used to report the setup and patient education on use of the device(s). Code 99454 may be used to report supply of the device for daily recording or programmed alert transmissions. Codes 99453, 99454 are not reported if monitoring is less than 16 days. Do not report 99453, 99454 when these services are included in other codes for the duration of time of the physiologic monitoring service (eg, 95250 for continuous glucose monitoring requires a minimum of 72 hours of monitoring).
Digitally Stored Data Services/Remote Physiologic Monitoring

- Code 99091 should be reported no more than once in a 30-day period to include the physician or other qualified health care professional time involved with data accession, review and interpretation, modification of care plan as necessary (including communication to patient and/or caregiver), and associated documentation.

- If the services described by 99091 are provided on the same day the patient presents for an Evaluation and Management (E/M) service, these services should be considered part of the E/M service and not reported separately.

- Do not report 99091 in the same calendar month as care plan oversight services (99374, 99375, 99377, 99378, 99379, 99380), home, domiciliary, or rest home care plan oversight services (99339, 99340), and remote physiologic monitoring services (99457). Do not report 99091 if other more specific codes exist (e.g., 93227, 93272 for cardiographic services; 95250 for continuous glucose monitoring). Do not report 99091 for transfer and interpretation of data from hospital or clinical laboratory computers.

- Code 99453 is reported for each episode of care. For coding remote monitoring of physiologic parameters, an episode of care is defined as beginning when the remote monitoring physiologic service is initiated, and ends with attainment of targeted treatment goals.
Remote Physiologic Monitoring Treatment Management Services

- Remote physiologic monitoring treatment management services are provided when clinical staff/physician/other qualified health care professional use the results of remote physiological-monitoring to manage a patient under a specific treatment plan. To report remote physiological monitoring, the device used must be a medical device as defined by the FDA, and the service must be ordered by a physician or other qualified health care professional. Use 99457 for time spent managing care when patients or the practice do not meet the requirements to report more specific services. Code 99457 may be reported during the same service period as chronic care management services (99487, 99489, 99490), transitional care management services (99495, 99496), and behavioral health integration services (99484, 99492, 99493, 99494).

- However, time spent performing these services should remain separate and no time should be counted toward the required time for both services in a single month. Code 99457 requires a live, interactive communication with the patient/caregiver and 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month. Report 99491 one time regardless of the number of physiologic monitoring modalities performed in a given calendar month.

- Do not count any time on a day when the physician or other qualified health care professional reports an E/M service (office or other outpatient services 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, domiciliary, rest home services 99324, 99325, 99326, 99327, 99328, 99334, 99335, 99336, 99337, home services 99341, 99342, 99343, 99344, 99345, 99347, 99348, 99349, 99350). Do not count any time related to other reported services (eg. 93290).
Care Management Services

• Care management services are management and support services provided by clinical staff, under the direction of a physician or other qualified health care professional, or may be provided personally by a physician or other qualified health care professional to a patient residing at home or in a domiciliary, rest home, or assisted living facility. Services include establishing, implementing, revising, or monitoring the care plan, coordinating the care of other professionals and agencies, and educating the patient or caregiver about the patient's condition, care plan, and prognosis. The physician or other qualified health care professional provides or oversees the management and/or coordination of services, as needed, for all medical conditions, psychosocial needs, and activities of daily living.

• Codes 99487, 99489, 99490, 99491 are reported only once per calendar month and may only be reported by the single physician or other qualified health care professional who assumes the care management role with a particular patient for the calendar month.
• For 99487, 99489, 99490 the face-to-face and non-face-to-face time spent by the clinical staff in communicating with the patient and/or family, caregivers, other professionals, and agencies; creating, revising, documenting, and implementing the care plan; or teaching self-management is used in determining the care management clinical staff time for the month.
• Only the time of the clinical staff of the reporting professional is counted. Only count the time of one clinical staff member when two or more clinical staff members are meeting about the patient. For 99491, only count the time personally spent by the physician or other qualified health care professional. Do not count any of the clinical staff time spent on the day of an initiating visit (the creation of the care plan, initial explanation to the patient and/or caregiver, and obtaining consent).

• E/M services may be reported separately by the same physician or other qualified health care professional during the same calendar month. A physician or other qualified health care professional who reports codes 99487, 99489, 99490, may not report care plan oversight services (99339, 99340, 99374-99380), prolonged services without direct patient contact (99358, 99359), home and outpatient INR monitoring (93792, 93793), medical team conferences (99366, 99367, 99368), education and training (98960; 98961, 98962, 99071, 99078), telephone services (99366, 99367, 99368, 99441, 99442, 99443), on-line medical evaluation (98969, 99444), preparation of special reports (99080), analysis of data (99091), transitional care management services (99495, 99496), medication therapy management services (99605, 99606, 99607) and, if performed, these services may not be reported separately during the month for which 99487, 99489, 99490 are reported.

• All other services may be reported. Do not report 99487, 99489, 99490, 99491 if reporting ESRD services (90951-90970) during the same month. If the care management services are performed within the postoperative period of a reported surgery, the same individual may not report 99487, 99489, 99490, 99491.

• Care management may be reported in any calendar month during which the clinical staff time or physician or other qualified health care professional personal time requirements are met. If care management resumes after a discharge during a new month, start a new period or report transitional care management services (99495, 99496) as appropriate. If discharge occurs in the same month, continue the reporting period or report Transitional Care Management Services. Do not report 99487, 99489, 99490 for any post-discharge care management services for any days within 30 days of discharge, if reporting 99495, 99496.

• When behavioral or psychiatric collaborative care management services are also provided, 99484, 99492, 99493, 99494 may be reported in addition.
Chronic Care Management Services

- Chronic care management services are provided when medical and/or psychosocial needs of the patient require establishing, implementing, revising, or monitoring the care plan. Patients who receive chronic care management services have two or more chronic continuous or episodic health conditions that are expected to last at least 12 months, or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Code 99490 is reported when, during the calendar month, at least 20 minutes of clinical staff time is spent in care management activities. Code 99491 is reported when 30 minutes of physician or other qualified health care professional personal time is spent in care management activities. Do not report 99490 in the same month as 99491.

Psychiatric Collaborative Care Management Services

- Psychiatric collaborative care services are provided under the direction of a treating physician or other qualified health care professional during a calendar month. These services are reported by the treating physician or other qualified health care professional and include the services of the treating physician or other qualified health care professional, the behavioral health care manager, and the psychiatric consultant, who has contracted directly with the treating physician or other qualified health care professional, to provide consultation.
• Patients directed to the behavioral health care manager typically have behavioral health signs and/or symptoms or a newly diagnosed behavioral health condition, may need help in engaging in treatment, have not responded to standard care delivered in a non-psychiatric setting, or require further assessment and engagement, prior to consideration of referral to a psychiatric care setting.

• These services are provided when a patient requires a behavioral health care assessment; establishing, implementing, revising, or monitoring a care plan and provision of brief interventions.

Psychiatric Collaborative Care Management Services

• Definitions
  – Episode of care
    • Failure to attain targeted treatment goals culminating in referral to psychiatric care provider for ongoing treatment of the behavioral health condition; or
Evaluation and Management
Code Updates Excerpts

#●99451: Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient’s treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time

#●99452: Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes

#●99453: Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment

(Do not report 99453 more than once per episode of care)
(Do not report 99453 for monitoring of less than 16 days)
● **99454**: device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days
  
  (For physiologic monitoring treatment management services, use 99457)
  
  (Do not report 99454 for monitoring of less than 16 days)
  
  (Do not report 99453, 99454 in conjunction with codes for more specific physiologic parameters [eg, 93296, 94760])

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● **99457**: Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month.

  (Report 99457 once each 30 days, regardless of the number of parameters monitored)

  (Do not report 969457 in conjunction with 99091)
#99491: Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient;
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline;
- comprehensive care plan established, implemented, revised, or monitored.

(Do not report 99491 in the same calendar month as 99487, 99489, 99490)
(Do not report 99491 in conjunction with 99339, 99340)

Surgery – General
Fine Needle Aspiration (FNA) Biopsy

- A fine needle aspiration (FNA) biopsy is performed when material is aspirated with a fine needle and the cells are examined cytologically. A core needle biopsy is typically performed with a larger bore needle to obtain a core sample of tissue for histopathologic evaluation. FNA biopsy procedures are performed with or without imaging guidance. Imaging guidance codes (eg, 76942, 77002, 77012, 77021) may not be reported separately with 10004, 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012, 10021. Codes 10004, 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012, 10021 are reported once per lesion sampled in a single session. When more than one FNA biopsy is performed on separate lesions at the same session, same day, same imaging modality, use the-appropriate imaging modality add-on code for the second and subsequent lesion(s).
Fine Needle Aspiration (FNA) Biopsy

- When more than one FNA biopsy is performed on separate lesions, same session, same day, using different imaging modalities, report the corresponding primary code with modifier 59 for each additional imaging modality and corresponding add-on codes for subsequent lesions sampled. This instruction applies regardless of whether the lesions are ipsilateral or contralateral to each other, and/or whether they are in the same or different organs/structures. When FNA biopsy and core needle biopsy both are performed on the same lesion, same session, same day using the same type of imaging guidance, do not separately report the imaging guidance for the core needle biopsy.

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Fine Needle Aspiration (FNA) Biopsy

- When FNA biopsy is performed on one lesion and core needle biopsy is performed on a separate lesion, same session, same day using the same type of imaging guidance, both the core needle biopsy and the imaging guidance for the core needle biopsy may be reported separately with modifier 59. When FNA biopsy is performed on one lesion and core needle biopsy is performed on a separate lesion, same session, same day using different types of imaging guidance, both the core needle biopsy and the imaging guidance for the core needle biopsy may be reported with modifier 59.

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Surgery – Integumentary System
Skin, Subcutaneous, and Accessory Structures – Biopsy

• The use of a biopsy procedure code (eg, 11102, 11103, 11104, 11105, 11106, 11107) indicates that the procedure to obtain tissue solely for diagnostic histopathologic examination was performed independently, or was unrelated or distinct from other procedures/services provided at that time. Biopsies performed on different lesions or different sites on the same date of service may be reported separately, as they are not considered components of other procedures.

Biopsy

• During certain surgical procedures in the integumentary system, such as excision, destruction, or shave removals, the removed tissue is often submitted for pathologic examination. The obtaining of tissue for pathology during the course of these procedures is a routine component of such procedures. This obtaining of tissue is not considered a separate biopsy procedure and is not separately reported.

• Partial-thickness biopsies are those that sample a portion of the thickness of skin or mucous membrane and do not penetrate below the dermis or lamina propria. Full thickness biopsies penetrate into tissue deep to the dermis or lamina propria, into the subcutaneous or submucosal space.
• An appropriate biopsy technique is selected based on optimal tissue-sampling considerations for the type of neoplastic, inflammatory, or other lesion requiring a tissue diagnosis. Biopsy of the skin is reported under three distinct techniques:

• **Tangential biopsy (eg, shave, scoop, saucerize, curette)** is performed with a sharp blade, such as a flexible biopsy blade, obliquely oriented scalpel or curette to remove a sample of epidermal tissue with or without portions of underlying dermis. The intent of a tangential biopsy (11102, 11103) is to obtain a tissue sample from a lesion for the purpose of diagnostic pathologic examination. Biopsy of lesions by tangential technique (11102, 11103) is not considered an excision. Tangential biopsy technique may be represented by a superficial sample and does not involve the full thickness of the dermis, which could result in portions of the lesion remaining in the deeper layers of the dermis.

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**Tangential biopsy**

• For therapeutic removal of epidermal or dermal lesion(s) using shave technique, see 11300-11313.

• An indication for a shave removal (11300-11313) procedure may include a symptomatic lesion that rubs on waistband or bra, or any other reason why an elevated lesion is being completely removed with the shave technique, suggesting a therapeutic intent. It is the responsibility of the physician or qualified health care professional performing the procedure to clearly indicate the purpose of the procedure.
Biopsy

• **Punch biopsy** requires a punch tool to remove a full-thickness cylindrical sample of skin. The intent of a punch biopsy (11104, 11105) is to obtain a cylindrical tissue sample of a cutaneous lesion for the purpose of diagnostic pathologic examination. Simple closure of the defect is included in the service. Manipulation of the biopsy defect to improve wound approximation is included in simple closure.

Biopsy

• **Incisional biopsy** requires the use of a sharp blade (not a punch tool) to remove a full-thickness sample of tissue via a vertical incision or wedge, penetrating deep to the dermis, into the subcutaneous space. The intent of an incisional biopsy (11106, 11107) is to obtain a full thickness tissue sample of a skin lesion for the purpose of diagnostic pathologic examination. This type of biopsy may sample subcutaneous fat, such as those performed for the evaluation of panniculitis. Although closure is usually performed on incisional biopsies, simple closure is not separately reported.

• (For complete lesion excision with margins, see 11400-11646)
Incisional biopsy

- When multiple biopsy techniques are performed during the same encounter, only one primary lesion biopsy code (11102, 11104, 11106) is reported. Additional biopsy codes should be selected based on the following convention:
  - If multiple biopsies of the same type are performed, the primary code for that biopsy should be used along with the corresponding add-on code(s).
  - If an incisional biopsy is performed, report 11106 in combination with a tangential (11103), punch (11105), or incisional biopsy (11107) for the additional biopsy procedures.
  - If a punch biopsy is performed, report 11104 in combination with a tangential (11103), or punch (11105), for the additional biopsy procedures.

Incisional biopsy

- If multiple tangential biopsies are performed, report tangential biopsy (11102) in combination with 11103 for the additional tangential biopsy procedures.
- When two or more biopsies of the same technique (ie, tangential, punch, or incisional) are performed on separate/additional lesions, use the appropriate add-on code (11103, 11105, 11107) to specify each additional biopsy. When two or three different biopsy techniques (ie, tangential, punch, or incisional) are performed to sample separate/additional lesions, select the appropriate biopsy code (11102, 11104, 11106) plus an additional add-on code (11103, 11105, 11107) for each additional biopsy performed.
The following table provides an illustration of the appropriate use of these codes for multiple biopsies:

<table>
<thead>
<tr>
<th>Procedures Performed</th>
<th>CPT Code(s) Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 tangential biopsies</td>
<td>11102 X 1, 11103 X 1</td>
</tr>
<tr>
<td>3 punch biopsies</td>
<td>11104 X 1, 11105 X 2</td>
</tr>
<tr>
<td>2 incisional biopsies</td>
<td>11106 X 1, 11107 X 1</td>
</tr>
<tr>
<td>1 incisional biopsy, 1 tangential</td>
<td>11106 X 1, 11103 X 1, 11105 X 1</td>
</tr>
<tr>
<td>biopsy and 1 punch biopsy</td>
<td></td>
</tr>
<tr>
<td>1 punch biopsy and 2</td>
<td>11104 X 1, 11103 X 2</td>
</tr>
<tr>
<td>tangential biopsies</td>
<td></td>
</tr>
</tbody>
</table>

Repair (Closure) – Skin Replacement Surgery Definitions

- **Skin substitute grafts** include non-autologous human skin (dermal or epidermal, cellular and acellular) grafts (eg, homograft, allograft), non-human skin substitute grafts (ie, xenograft), and biological products that form a sheet scaffolding for skin growth. These codes are not to be reported for application of non-graft wound dressings (eg, gel, powder, ointment, foam, liquid) or injected skin substitutes. Application of non-graft wound dressings is not separately reportable. Removal of current graft and/or simple cleansing of the wound is included, when performed. Do not report 97602. Debridement is considered a separate procedure only when gross contamination requires prolonged cleansing, when appreciable amounts of devitalized or contaminated tissue are removed, or when debridement is carried out separately without immediate primary closure.
Skin substitute grafts

- Select the appropriate code from 15271-15278 based upon location and size of the defect. For multiple wounds, sum the surface area of all wounds from all anatomic sites that are grouped together into the same code descriptor. For example, sum the surface area of all wounds on the trunk and arms. Do not sum wounds from different groupings of anatomic sites (e.g., face and arms). The supply of skin substitute graft(s) should be reported separately in conjunction with 15271, 15272, 15273, 15274, 15275, 15276, 15277, 15278. For biologic implant for soft tissue reinforcement, use 15777 in conjunction with code for primary procedure.

Destruction – Mohs Micrographic Surgery

- If repair is performed, use separate repair, flap, or graft codes. If a biopsy of a suspected skin cancer is performed on the same day as Mohs surgery because there was no prior pathology confirmation of a diagnosis, the report a diagnostic skin biopsy (11102, 11104, 11106) and frozen section pathology (88331) with modifier 59 to distinguish from the subsequent definitive surgical procedure of Mohs surgery.
Surgery – Integumentary System – Code Updates Excerpts

▲ 10021: Fine needle aspiration biopsy, without imaging guidance; without imaging guidance first lesion

10022: with imaging guidance
(10022 has been deleted. To report, see 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012)

#+● 10004: each additional lesion
(List separately in addition to code for primary procedure)
(Use 10004 in conjunction with 10021)
(Do not report 10004, 10021 in conjunction with 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012 for the same lesion)
(For evaluation of fine needle aspirate, see 88172, 88173, 88177)
#●10005: Fine needle aspiration biopsy, including ultrasound guidance; first lesion

#+●10006: each additional lesion
(List separately in addition to code for primary procedure)

(Use 10006 in conjunction with 10005)
(Do not report 10005, 10006 in conjunction with 76942)
(For evaluation of fine needle aspirate, see 88172, 88173, 88177)

#●10007: Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion

#+●10008: each additional lesion
(List separately in addition to code for primary procedure)

(Use 10008 in conjunction with 10007)
(Do not report 10007, 10008, in conjunction with 77002)
(For evaluation of fine needle aspirate, see 88172, 88173, 88177)
#10009: Fine needle aspiration biopsy, including CT guidance; first lesion

#+#10010: each additional lesion
(List separately in addition to code for primary procedure)
(Use 10010 in conjunction with 10009)
(Do not report 10009, 10010 in conjunction with 77012)
(For evaluation of fine needle aspirate, see 88172, 88173, 88177)

#10011: Fine needle aspiration biopsy, including MR guidance; first lesion

#+#10012: each additional lesion
(List separately in addition to code for primary procedure)
(Use 10012 in conjunction with 10011)
(Do not report 10011, 10012 in conjunction with 77021)
(For evaluation of fine needle aspirate, see 88172, 88173, 88177)
(For percutaneous image-guided fluid collection drainage by catheter of soft tissue [eg, extremity, abdominal wall, neck] use 10030)
Surgery – Musculoskeletal System

No guideline changes other than code specific usage changes.

Surgery – Respiratory System

No guideline changes other than code specific usage changes.

Surgery – Cardiovascular System

Heart and Pericardium – Pacemaker or Implantable Defibrillator

• A leadless cardiac pacemaker system includes a pulse generator with built-in battery and electrode for implantation in a cardiac chamber via a transcatheter approach. For implantation of a leadless pacemaker system, use 33274. Insertion, replacement, or removal of a leadless pacemaker system includes insertion of a catheter into the right ventricle.

• Right heart catheterization (93451, 93453, 93456, 93457, 93460, 93461, 93530, 93531, 93532, 93533) may not be reported in conjunction with leadless pacemaker insertion and removal codes 33274, 33275 unless complete right heart catheterization is performed for an indication distinct from the leadless pacemaker procedure.
Pacemaker or Implantable Defibrillator

- Device evaluation codes 93260, 93261, 93279-93299 for pacemaker system with lead(s) may not be reported in conjunction with pulse generator and lead insertion or revision codes 33206-33249, 33262, 33263, 33264, 33270, 33271, 33272, 33273. For leadless pacemaker systems, device evaluation codes 93279, 93286, 93288, 93294, 93296 may not be reported in conjunction with leadless pacemaker insertion and removal codes 33274, 33275. Defibrillator threshold testing (DFT) during transvenous implantable defibrillator insertion or replacement may be separately reported using 93640, 93641. DFT testing during subcutaneous implantable defibrillator system insertion is not separately reportable. DFT testing for transvenous or subcutaneous implantable defibrillator in follow-up or at the time of replacement may be separately reported using 93642 or 93644.

- Radiological supervision and interpretation related to the pacemaker or implantable defibrillator procedure is included in 33206-33249, 33262, 33263, 33264, 33270, 33271, 33272, 33273, 33274, 33275. Fluoroscopy (76000, 77002), ultrasound guidance for vascular access (76937), right ventriculography (93566), and femoral venography (75820) are included in 33274, 33275, when performed). To report fluoroscopic guidance for diagnostic lead evaluation without lead insertion, replacement, or revision procedures, use 76000.
Heart and Pericardium – Subcutaneous Cardiac Rhythm Monitor

• A subcutaneous cardiac rhythm monitor, also known as a cardiac event recorder or implantable/insertable loop recorder (ILR), is a subcutaneously placed device that continuously records the electrocardiographic rhythm, triggered automatically by rapid, irregular and/or slow heart rates or by the patient during a symptomatic episode. A subcutaneous cardiac rhythm monitor is placed using a small parasternal incision followed by insertion of the monitor into a small subcutaneous pre-pectoral pocket, followed by closure of the incision.

Heart and Pericardium – Implantable Hemodynamic Monitors

• Transcatheter implantation of a wireless pulmonary artery pressure sensor (33289) establishes an intravascular device used for long-term remote monitoring of pulmonary artery pressures (93264). The hemodynamic data derived from this device is used to guide management of patients with heart failure. Code 33289 includes deployment and calibration of the sensor, right heart catheterization, selective pulmonary artery catheterization, radiological supervision and interpretation, and pulmonary artery angiography, when performed.
Heart and Pericardium – Cardiac Valves – Pulmonary Valve

• Code 33477 includes all cardiac catheterization(s), intraprocedural contrast injection(s), fluoroscopic radiological supervision and interpretation, and imaging guidance performed to complete the pulmonary valve procedure. Do not report 33477 in conjunction with 76000, 93451, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93530, 93531, 93532, 93533, 93563, 93566, 93567, 93568 for angiography intrinsic to the procedure.

Heart and Pericardium – Thoracic Aortic Aneurysm

• When ascending aortic disease involves the aortic arch, an aortic hemiarch graft may be necessary in conjunction with the ascending aortic graft and may be reported with add-on code 33866 in conjunction with the appropriate ascending aortic graft code (33860, 33863, 33864). Aortic hemiarch graft requires all of the following components:
  1. Either total circulatory arrest or isolated cerebral perfusion (retrograde or antegrade);
  2. Incision into the transverse arch extending under one or more of the arch vessels (eg, innominate, left common carotid, or left subclavian arteries); and
Heart and Pericardium – Thoracic Aortic Aneurysm

3. Extension of the ascending aortic graft under the aortic arch by construction of a beveled anastomosis to the distal ascending aorta and aortic arch without a crossclamp (an open anastomosis).

- An ascending aortic repair with a beveled anastomosis into the arch with a cross-damp cannot be reported separately as a hemiarch graft using 33866. Use 33866 for aortic hemiarch graft when performed in conjunction with the ascending aortic graft codes 33860, 33863, 33864.

Arteries and Veins – Vascular Injection Procedures – Central Venous Access Procedures

- To qualify as a central venous access catheter or device, the tip of the catheter/device must terminate in the subclavian, brachiocephalic (innominate) or iliac veins, the superior or inferior vena cava, or the right atrium. The venous access device may be either centrally inserted (jugular, subclavian, femoral vein or inferior vena cava catheter entry site) or peripherally inserted (eg, basilic, cephalic, or saphenous vein entry site), the device may be accessed for use either via exposed catheter (external to the skin), via a subcutaneous port or via a subcutaneous pump.
Central Venous Access Procedures

• When imaging guidance is used for centrally inserted central venous catheters, for gaining access to the venous entry site and/or for manipulating the catheter into final central position, imaging guidance codes (eg, 76937, 77001) may be reported separately. Do not use 76937, 77001 in conjunction with 36568, 36569, 36572, 36573, 36584.

Arteries and Veins – Vascular Injection Procedures – Insertion of Tunneled Central Venous Catheter

• Peripherally inserted central venous catheters (PICCs) may be placed or replaced with or without imaging guidance. When performed without imaging guidance, report using 36568 or 36569. When imaging guidance (eg, ultrasound, fluoroscopy) is used for PICC placement or repositioning, bundled service codes 36572, 36573, 36584 include all imaging necessary to complete the procedure, image documentation (representative images from all modalities used are stored to patient's permanent record), associated radiological supervision and interpretation, venography performed through the same venous puncture, and documentation of final central position of the catheter with imaging. Ultrasound guidance for PICC placement should include documentation of evaluation of the potential puncture sites, patency of the entry vein, and real-time ultrasound visualization of needle entry into the vein.
Insertion of Tunneled Central Venous Catheter

• Codes 71045, 71046, 71047, 71048 should not be reported for the purpose of documenting the final catheter position on the same day of service as 36572, 36573, 36584. Codes 36572, 36573, 36584 include confirmation of catheter tip location. The physician or other qualified health care professional reporting image-guided PICC insertion cannot report confirmation of catheter tip location separately (eg, via X ray, ultrasound). Report 36572, 36573, 36584 with modifier 52 when performed without confirmation of catheter tip location.

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Insertion of Tunneled Central Venous Catheter

• “Midline” catheters by definition terminate in the peripheral venous system. They are not central venous access devices and may not be reported as a PICC service. Midline catheter placement may be reported with 36400, 36405, 36406, or 36410. PICCs placed using magnetic guidance or any other guidance modality that does not include imaging or image documentation are reported with 36568, 36569.

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Arteries and Veins – Transcatheter Procedures – Arterial mechanical Thrombectomy

• Arterial mechanical thrombectomy may be performed as a “primary” transcatheter procedure with pretreatment planning, performance of the procedure, and postprocedure evaluation focused on providing this service. Typically, the diagnosis of thrombus has been made prior to the procedure, and a mechanical thrombectomy is planned preoperatively. Primary mechanical thrombectomy is reported per vascular family using 37184 for the initial vessel treated and 37185 for second or all subsequent vessel(s) within the same vascular family. To report mechanical thrombectomy of an additional vascular family treated through a separate access site, use modifier 59 in conjunction with the primary service code (37184) for the mechanical transluminal thrombectomy.

Surgery – Cardiovascular System – Code Updates Excerpts

#•36572: Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age.

(For placement of centrally inserted non-tunneled central venous catheter, without subcutaneous port or pump, younger than 5 years of age, use 36555)

(For placement of peripherally inserted non-tunneled central venous catheter, without subcutaneous port or pump, without imaging guidance, younger than 5 years of age, use 36568)
**#36573**: ages 5 years or older
(For placement of centrally inserted non-tunneled central venous catheter, without subcutaneous port or pump, age 5 years or older, use 36556)
(For placement of peripherally inserted non-tunneled central venous catheter, without subcutaneous port or pump, without imaging guidance, age 5 years or older, use 36569)
(Do not report 36572, 36573 in conjunction with 76937, 77001)

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**Surgery – Digestive System**

*No guideline changes other than code specific usage changes.*
Surgery – Digestive System – Code Updates Excerpts

43760: Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance

(43760 has been deleted. To report replacement of gastrostomy tube without imaging or endoscopy, see 43762, 43763)

•43762: Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract

•43763: requiring revision of gastrostomy tract

(For percutaneous replacement of gastrostomy tube under fluoroscopic guidance, use 49450)

(For endoscopically directed placement of gastrostomy tube, use 43246)
Surgery – Urinary System

Kidney – Introduction – Other Introduction (Injection/Change/Removal) Procedures

• Percutaneous genitourinary procedures are performed with imaging guidance (eg, fluoroscopy and/or ultrasound). Diagnostic nephrostogram and/or ureterogram are typically performed with percutaneous genitourinary procedures and are included in 50432, 50433, 50434, 50435, 50436, 50437, 50693, 50694, 50695.

• Code 50436 describes enlargement of an existing percutaneous tract to the renal collecting system to accommodate large instruments used in an endourologic procedure. Code 50436 includes predilation urinary tract imaging, postprocedure nephrostomy tube placement, when performed, and includes all radiological supervision and interpretation and imaging guidance (eg, ultrasound, fluoroscopy). Code 50436 may not be reported with 50432, 50433, 52334 for basic dilation of a percutaneous tract during initial placement of a catheter or device.

• Code 50437 includes all elements of 50436, but also includes new access into the renal collecting system performed in the same session when a pre-existing tract is not present.
Surgery – Male Genital System

No guideline changes other than code specific usage changes.

Surgery – Female Genital System

No guideline changes other than code specific usage changes.

Surgery – Nervous System

Skull, Meninges, and Brain – Surgery of Skull Base – Definitive Procedures – Base of Middle Cranial Fossa

• Code 61611 is reported in addition to code(s) for primary procedure(s) 61605-61608. Report only one transection or ligation of carotid artery code per operative session.
Skull, Meninges, and Brain – Neurostimulators (Intracranial)

- For electronic analysis with programming, when performed, of cranial nerve and brain neurostimulator pulse generator/transmitters, see codes 95970, 95976, 95977, 95983, 95984. Test stimulation to confirm correct target site placement of the electrode array(s) and/or to confirm the functional status of the system is inherent to placement and is not separately reported as electronic analysis or programming of the neurostimulator system. Electronic analysis (95970) at the time of implantation is not separately reported.

Spine and Spinal Cord – Neurostimulators (Spinal)

- For electronic analysis with programming, when performed, of spinal cord neurostimulator pulse generator/transmitters, see code 95970, 95971, 95972. Test simulation to confirm correct target site placement of the electrode array(s) and/or to confirm the functional status of the system is inherent to placement, and is not separately reported as electronic analysis or programming of the neurostimulator system. Electronic analysis (95970) at the time of implantation is not separately reported.
Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System – Neurostimulators (Peripheral Nerve)

- For electronic analysis with programming, when performed, of peripheral nerve neurostimulator pulse generator/transmitters, see codes 95970, 95971, 95972. An electrode array is a catheter or other device with more than one contact. The function of each contact may be capable of being adjusted during programming services. Test stimulation to confirm correct target site placement of the electrode array(s) and/or to confirm the functional status of the system is inherent to placement, and is not separately reported as electronic analysis or programming of the neurostimulator system. Electronic analysis (95970) at the time of implantation is not separately reported.
- Codes 64553, 64555, and 64561 may be used to report both temporary and permanent placement of percutaneous electrode arrays.

Surgery – Eye and Ocular Adnexa

No guideline changes other than code specific usage changes.

Surgery – Auditory System

No guideline changes other than code specific usage changes.

Surgery – Operating Microscope

No guideline changes other than code specific usage changes.
Radiology
Guidelines – Supervision and Interpretation, Imaging Guidance

• Imaging may be required during the performance of certain procedures or certain imaging procedures may require surgical procedures to access the imaged area. Many services include image guidance, and imaging guidance is not separately reportable when it is included in the base service. The CPT code set typically defines in descriptors and/or guidelines when imaging guidance is included. When imaging is not included in a surgical procedure or procedure from the Medicine section, image guidance codes or codes labeled "radiological supervision and interpretation" (RS&I) may be reported for the portion of the service that requires imaging.

Supervision and Interpretation, Imaging Guidance

• All imaging guidance codes require: (1) image documentation in the patient record and (2) description of imaging guidance in the procedure report. All RS&I codes require: (1) image documentation in the patient's permanent record and (2) a procedure report or separate imaging report that includes written documentation of interpretive findings of information contained in the images and radiologic supervision of the service.
• (The RS&I codes are not applicable to the Radiation Oncology subsection.)
Guidelines – Written Report(s)

• With regard to CPT descriptors for imaging services, "images" must contain anatomic information unique to the patient for which the imaging service is provided. "Images" refer to those acquired in either an analog (ie, film) or digital (ie, electronic) manner.

Radiology Code Updates
Excerpts

• **77046**: Magnetic resonance imaging, breast, without contrast material; unilateral
  • **77047**: bilateral
• **77048**: Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD real-time lesion detection, characterization and pharmacokinetic analysis), when performed; unilateral
  • **77049**: bilateral
Pathology and Laboratory Molecular Pathology

- **DNA methylation**: the process of adding methyl groups to a DNA sequence, specifically adenine and cytosine nucleotides, thereby affecting transcription of that sequence. DNA hyper-methylation in a gene promoter typically represses gene transcription. DNA methylation serves as a regulatory mechanism in numerous scenarios including development, chromosome inactivation, and carcinogenesis.

Molecular Pathology

- **DNA methylation analysis**: analytical protocols are designed to evaluate the degree of DNA methylation related to specific disease processes. This analysis has various applications, qualitative or quantitative, and could be gene specific or encompass global degrees of methylation. All assays employ specific maneuvers (eg, chemical, enzymatic) that allow for distinguishable evaluation of methylated and non-methylated sequences.

- **Gene expression**: the sequence of events that results in the production and assembly of a protein product corresponding to the information encoded in a specific gene. The process begins with the transcription of gene sequences to produce an mRNA intermediary, which is subsequently translated to produce a specific protein product.
Pathology and Laboratory Code Updates Excerpts

- **81171**: AFF2 *(AF4/FMR2 family, member 2 [FMR2])* (eg, fragile X mental retardation 2 [FRAXE]) gene analysis; evaluation to detect abnormal (eg, expanded) alleles
  - **81172**: characterization of alleles (eg, expanded size and methylation status)
- **81204**: AR *(androgen receptor)* (eg, spinal and bulbar muscular atrophy, Kennedy disease, X chromosome inactivation) gene analysis; characterization of alleles (eg, expanded size or methylation status)
  - **81173**: full gene sequence
  - **81174**: known familial variant
- **81177**: ATN1 *(atrophin 1)* (eg, dentatorubral-pallidoluysian atrophy) gene analysis, evaluation to detect abnormal (eg, expanded) alleles
- **81178**: ATXN1 *(ataxin 1)* (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles
- **81179**: ATXN2 *(ataxin 2)* (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles
- **81180**: ATXN3 *(ataxin 3)* (eg, spinocerebellar ataxia, Machado-Joseph disease) gene analysis, evaluation to detect abnormal (eg, expanded) alleles
81181: ATXN7 (ataxin 7) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles

81182: ATXN8O8S (ATXN8 opposite strand [non-protein coding]) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles

81183: ATXN10 (ataxin 10) (eg, spinocerebellar ataxia) gene analysis, evaluation to detect abnormal (eg, expanded) alleles

83718 (not new; provided for reference):
Lipoprotein, direct measurement; high density cholesterol (EDL cholesterol)

83722: small dense LDL cholesterol

Medicine
Guidelines – Imaging Guidance

- When imaging guidance or imaging supervision and interpretation is included in a procedure, guidelines for image documentation and report, included in the guidelines for Radiology (including Nuclear Medicine and Diagnostic Ultrasound) will apply. Imaging guidance should not be reported for use of a non-imaging guided tracking or localizing system (eg, radar signals, electromagnetic signals). Imaging guidelines should only be reported when an imaging modality (eg, radiography, fluoroscopy, ultrasonography, magnetic resonance imaging, computed tomography, or nuclear medicine) is used and is appropriately documented.
Special Ophthalmological Services – Other Specialized Services

- Electroretinography (ERG) is used to evaluate function of the retina and optic nerve of the eye, including photoreceptors and ganglion cells. A number of techniques are used which target different areas of the eye, including full field (flash and flicker) (92273) for a global response of photoreceptors of the retina, multifocal (92274) for photoreceptors in multiple separate locations in the retina including the macula, and pattern (0509T) for retinal ganglion cells. Multiple additional terms and techniques are used to describe various types of ERG. If the technique used is not specifically named in the code descriptors for 92273, 92274, or 0509T, use the unlisted procedure code 92499.

Cardiovascular Monitoring Services

*Mobile cardiovascular telemetry (MCT)*

- ECG rhythm derived elements are distinct from physiologic data, even when the same device is capable of producing both. Implantable cardiovascular physiologic monitor device services are always separately reported from implantable cardioverter-defibrillator (ICD) service.
Implantable, Insertable, and Wearable Cardiac Device Evaluations

- Cardiac device evaluation services are diagnostic medical procedures using in-person and remote technology to assess device therapy and cardiovascular physiologic data. Codes 93260, 93261, 93279-93299 describe this technology and technical/professional and service center practice, Codes 93260, 93261, 93279-93292 are reported per procedure. Codes 93293, 93294, 93295, 93296 are reported no more than once every 90 days. Do not report 93293, 93294, 93295, 93296, if the monitoring period is less than 30 days. Code 93297, 93298 are reported no more than once up to every 30 days, per patient. Do not report 93297-93299, if the monitoring period is less than 10 days. Do not report 93264 if the monitoring period is less than 30 days. Code 93264 is reported no more than once up to every 30 days, per patient.

- A service center may report 93296 or 93299 during a period in which a physician or other qualified health care professional performs an in-person interrogation device evaluation. The same individual may not report an in-person and remote interrogation of the same device during the same period. Report only remote services when an in-person interrogation device evaluation is performed during a period of remote interrogation device evaluation.
• A period is established by the initiation of the remote monitoring or the 91st day of a pacemaker or implantable defibrillator monitoring or the 31st day of monitoring a subcutaneous cardiac rhythm monitor or implantable cardiovascular physiologic monitor, and extends for the subsequent 90 or 30 days respectively, for which remote monitoring is occurring. Programming device evaluations and in-person interrogation device evaluations may not be reported on the same date by the same individual. Programming device evaluations and remote interrogation device evaluations may both be reported during the remote interrogation device evaluation period.

Implantable, Insertable, and Wearable Cardiac Device Evaluations

• ECG rhythm derived elements are distinct from physiologic data, even when the same device is capable of producing both. Implantable cardiovascular physiologic monitor services are always separately reported from implantable defibrillator services. When cardiac rhythm data are derived from an implantable defibrillator or pacemaker, do not report subcutaneous cardiac rhythm monitor services with pacemaker or implantable defibrillator services.
• **Attended surveillance**: the immediate availability of a remote technician to respond to rhythm or device alert transmissions from a patient, either from an implanted, inserted, or wearable monitoring or therapy device, as they are generated and transmitted to the remote surveillance location or center.

• **Device, leadless**: a leadless cardiac pacemaker system that includes a pulse generator with built-in battery and electrode for implantation into the cardiac chamber via transcatheter approach.

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**Implantable cardiovascular physiologic monitor**:

• an implantable cardiovascular device used to assist the physician or other qualified health care professional in the management of non rhythm related cardiac conditions such as heart failure. The device collects longitudinal physiologic cardiovascular data elements from one or more internal sensors (such as right ventricular pressure, pulmonary artery pressure, left atrial pressure, or an index of lung water) and/or external sensors (such as blood pressure or body weight) for patient assessment and management. The data are stored and transmitted by either local telemetry or remotely to an Internet-based file server or surveillance technician.
**Implantable cardiovascular physiologic monitor**

- The function of the implantable cardiovascular physiologic monitor may be an additional function of an implantable cardiac device (e.g., implantable defibrillator) or a function of a standalone device. When implantable cardiovascular physiologic monitor functionality is included in an implantable defibrillator device or pacemaker, the implantable cardiovascular physiologic monitor data and the implantable defibrillator or pacemaker, heart rhythm data such as sensing, pacing, and tachycardia detection therapy are distinct and, therefore, the monitoring processes are distinct.

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**Implantable defibrillator:**

- Two general categories of implantable defibrillators exist: transvenous implantable pacing cardioverter-defibrillator (ICD) and subcutaneous implantable defibrillator (SICD). An implantable pacing cardioverter-defibrillator device provides high-energy and low-energy stimulation to one or more chambers of the heart to terminate rapid heart rhythms called tachycardia or fibrillation. Implantable pacing cardioverter-defibrillators also have pacemaker functions to treat slow heart rhythms called bradycardia. In addition to the tachycardia and bradycardia functions, the implantable pacing cardioverter-defibrillator may or may not include the functionality of an implantable cardiovascular physiologic monitor or a subcutaneous cardiac rhythm monitor.
Implantable defibrillator

- The subcutaneous implantable defibrillator uses a single subcutaneous electrode to treat ventricular tachyarrhythmias. Subcutaneous implantable defibrillators differ from transvenous implantable pacing cardioverter-defibrillators in that subcutaneous implantable defibrillators do not provide antitachycardia pacing or chronic pacing. For subcutaneous implantable defibrillator device evaluation, see 93260, 93261.

Interrogation device evaluation:

- an evaluation of an implantable device such as a cardiac pacemaker, implantable defibrillator, implantable cardiovascular physiologic monitor, or subcutaneous cardiac rhythm monitor. Using an office, hospital, or emergency room instrument or via a remote interrogation system, stored and measured information about the lead(s) when present, sensor(s) when present, battery and the implanted device function, as well as data collected about the patient's heart rhythm and heart rate is retrieved. The retrieved information is evaluated to determine the current programming of the device and to evaluate certain aspects of the device function such as battery voltage, lead impedance, tachycardia detection settings, and rhythm treatment settings.
The components that must be evaluated for the various types of implantable or insertable cardiac devices are listed below. (The required components for both remote and in-person interrogations are the same.)

- **Pacemaker**: programmed parameters, with or without lead(s), battery, capture and sensing function and heart rhythm.

- **Implantable cardiovascular physiologic monitor**: programmed parameters and analysis of at least one recorded physiologic cardiovascular data element from either internal or external sensors.

- **Subcutaneous cardiac rhythm monitor**: programmed parameters and the heart rate and rhythm during recorded episodes from both patient initiated and device algorithm detected events, when present.

**Interrogation device evaluation (remote)**: a procedure performed for patients with pacemakers, implantable defibrillators, or subcutaneous cardiac rhythm monitors using data obtained remotely. All device functions, including the programmed parameters, lead(s), battery, capture and sensing function, presence or absence of therapy for ventricular tachyarrhythmias (for implantable defibrillators) and underlying heart rhythm are evaluated.

The components that must be evaluated for the various types of implantable or insertable cardiac devices are listed below. (The required components for both remote and in-person interrogations are the same.)

- **Pacemaker**: programmed parameters, with or without lead(s), battery, capture and sensing function, and heart rhythm.
• **Implantable cardiovascular physiologic monitor:** programmed parameters and analysis of at least one recorded physiologic cardiovascular data element from either internal or external sensors.

• **Subcutaneous cardiac rhythm monitor:** programmed parameters and the heart rate and rhythm during recorded episodes from both patient-initiated and device algorithm detected events, when present.

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**Pacemaker:**

• an implantable device that provides low energy localized stimulation to one or more chambers of the heart to initiate contraction in that chamber. Two general categories of pacemakers exist: (1) pacemakers with a subcutaneous generator plus transvenous/epicardial lead(s); and (2) leadless pacemakers. A leadless pacemaker does not require a subcutaneous pocket for the generator. It combines a miniaturized generator with an integrated electrode for implantation in a heart chamber via a transcatheter approach.
**Peri-procedural device evaluation and programming:**

• an evaluation of an implantable device system (either a pacemaker or implantable defibrillator) to adjust the device to settings appropriate for the patient prior to a surgery, procedure, or test. The device system data are interrogated to evaluate the lead(s) when present, sensor(s), and battery in addition to review of stored information, including patient and system measurements. The device is programmed to settings appropriate for the surgery, procedure, or rest, as required, a second evaluation and programming are performed after the surgery, procedure, or test to provide settings appropriate to the post-procedural situation, as required. If one performs both the pre- and post-evaluation and programming service, the appropriate code, either 93286 or 93287, would be reported two times. If one performs the pre-surgical service and a separate individual performs the post-surgical service, each reports either 93286 or 93287 only one time.

**Programming device evaluation (in person):**

• a procedure performed for patients with a pacemaker, implantable defibrillator, or subcutaneous cardiac rhythm monitor. All device functions, including the battery, programmable settings and lead(s), when present, are evaluated. To assess capture thresholds, iterative adjustments (e.g., progressive changes in pacing output of a pacing lead) of the programmable parameters are conducted. The iterative adjustments provide information that permits the operator to assess and select the most appropriate final program parameters to provide for consistent delivery of the appropriate therapy and to verify the function of the device. The final program parameters may or may not change after evaluation.
• **Pacemaker:** programmed parameters, lead(s) when present, battery, capture and sensing function, and heart rhythm. Often, but not always, the sensor rate response, lower and upper heart rates, AV intervals, pacing voltage and pulse duration, sensing value, and diagnostics will be adjusted during a programming evaluation.

• **Subcutaneous cardiac rhythm monitor:** programmed parameters and the heart rhythm during recorded episodes from both patient initiated and device algorithm detected events. Often, but not always, the tachycardia and bradycardia detection criteria will be adjusted during a programming evaluation.

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**Subcutaneous cardiac rhythm monitor:**

- an implantable or insertable device that continuously records the electrocardiographic rhythm triggered automatically by rapid, irregular, and/or slow heart rates or by the patient during a symptomatic episode. The cardiac rhythm monitor function may be the only function of the device or it may be part of pacemaker or implantable defibrillator device. The data are stored and transmitted by either local telemetry or remotely to an Internet-based file server or surveillance technician/extraction of data and compilation or report for physician or qualified health care professional interpretation is usually performed in the office setting.
**Transtelephonic rhythm strip pacemaker evaluation:**

- service of transmission of an electrocardiographic rhythm strip over the telephone by the patient using a transmitter and recorded by a receiving location using a receiver/recorder (also commonly known as transtelephonic pacemaker monitoring). The electrocardiographic rhythm strip is recorded both with and without a magnet applied over the pacemaker. The rhythm strip is evaluated for heart rate and rhythm, atrial and ventricular capture (if observed) and aerial and ventricular sensing (if observed). In addition, the battery status of the pacemaker is determined by measurement of the paced rate on the electrocardiographic rhythm strip recorded with the magnet applied. For remote monitoring of an implantable wireless pulmonary artery pressure sensor, use 93264.

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**Implantable wireless pulmonary artery sensor:**

- an implantable cardiovascular device used to assist the physician or other qualified health care professional in monitoring heart failure. The device collects longitudinal physiologic cardiovascular data elements from an internal sensor located in the pulmonary artery. The data are transmitted and stored remotely to an Internet-based file server.
Electrocorticography

• Electrocorticography (ECoG) is the recording of EEG from electrodes directly on or in the brain.
• Code 95829 describes intraoperative recordings of ECoG from electrode arrays implanted in or placed directly on the brain exposed during surgery. Code 95829 includes review and interpretation during surgery.

Electrocorticography

• Code 95836 describes recording of ECoG from electrodes chronically implanted on or in the brain. Chronically implanted electrodes allow for intracranial recordings to continue after the patient has been discharged from the hospital. Code 95836 includes unattended ECoG recording with storage for later review and interpretation during a single 30-day period. Code 95836 may be reported only once for each 30-day period. The dates encompassed by the 30-day period must be documented in the report.
• For report of programming for brain neurostimulator pulse generator/transmitter during the ECoG (95836) 30-day period, see 95983, 95984.
Neurostimulators, Analysis-Programming

- Electronic analysis of an implanted neurostimulator pulse generator/transmitter involves documenting settings and electrode impedances of the system parameters prior to programming. Programming involves adjusting the system parameter(s) to address clinical signs and patient symptoms. Parameters available for programming can vary between systems and may need to be adjusted multiple times during a single programming session. The iterative adjustments to parameters provide information that is required for the physician or other qualified health care professional to assess and select the most appropriate final program parameters to provide for consistent delivery of appropriate therapy. The values of the final program parameters may differ from the starting values after the programming session.

- Examples of parameters include: contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient-selectable parameters, responsive neurostimulation, detection algorithms, closed-loop parameters, and passive parameters. Not all parameters are available for programming in every neurostimulator pulse generator/transmitter.
- For coding purposes, a neurostimulator system is considered implanted when the electrode array(s) is inserted into the target area for either permanent or trial placement.
• There are several types of implantable neurostimulator pulse generator/transmitters and they are differentiated by the nervous system region that is stimulated. A brain neurostimulator may stimulate either brain surface regions (cortical stimulation) or deep brain structures (deep brain stimulation). A brain neurostimulation system consists of array(s) that targets one or more of these regions.

• A cranial nerve neurostimulator targets the fibers of the cranial nerves or their branches and divisions. There are 12 pairs of cranial nerves. Each cranial nerve has its origin in the brain and passes through one or more foramina in the skull to innervate extracranial structures. A cranial nerve neurostimulator stimulates the nerve fibers of either the extracranial or intracranial portion(s) of one or more cranial nerve(s) (eg, vagus nerve, trigeminal nerve).

• A spinal cord or peripheral nerve neurostimulator targets nerve(s) that originate in the spinal cord and exit the spine through neural foramina and gives rise to peripheral nerves. The peripheral nervous system consists of the nerves and ganglia outside of the brain and spinal cord. Peripheral nerves may give rise to independent branches or branches that combine with other peripheral nerves in neural plexuses (ie, brachial plexus, lumbosacral plexus). Under the lumbosacral plexus, the sacral nerves (specifically S2, S3, S4) are located in the lower back just above the tailbone. Neurostimulation of the sacral nerves affect pelvic floor muscles and urinary organs (eg, bladder, urinary sphincter).

• Cranial nerve, spinal cord, peripheral nerve, and sacral nerve neurostimulator analysis with programming (95971, 95972, 95976, 95977) are reported based on the number of parameters adjusted during a programming session. Brain neurostimulator analysis with programming (95983, 95984) is reported based on physician or other qualified health care professional face-to-face time.
• Code 95970 describes electronic analysis of the implanted brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve neurostimulator pulse generator/transmitter without programming. Electronic analysis is inherent to implantation codes 43647, 43648, 43881, 43882, 61850, 61860, 61863, 61864, 61867, 61868, 61870, 61880, 61885, 61886, 61888, 63650, 63655, 63661, 63662, 63663, 63664, 63685, 63688, 63693, 64535, 64553, 64555, 64561, 64566, 64568, 64569, 64570, 64575, 64580, 64581, 64585, 64590, 64595, and is not separately reportable at the same operative session.

• Codes 95971, 95972, 95976, 95977 describe electronic analysis with simple or complex programming of the implanted neurostimulator pulse generator/transmitter. Simple programming of a neurostimulator pulse generator/transmitter includes adjustment of one to three parameter(s). Complex programming includes adjustment of more than three parameters. For purposes of counting the number of parameters being programmed, a single parameter that is adjusted two or more times during a programming session counts as one parameter.

• Code 95971 describes electronic analysis with simple programming of an implanted spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter.

• Code 95972 describes electronic analysis with complex programming of an implanted spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter.

• Code 95976 describes electronic analysis with simple programming of an implanted cranial nerve neurostimulators pulse generator/transmitter.

• Code 95977 describes electronic analysis with complex programming of an implanted cranial nerve neurostimulator pulse generator/transmitter.
Codes 95983, 95984 describe electronic analysis with programming of an implanted brain neurostimulator pulse generator/transmitter. Code 95983 is reported for the first 15 minutes of physician or other qualified health care professional face-to-face time for analysis and programming. Code 95984 is reported for each additional 15 minutes. A unit of service is attained when the mid-point is passed. Physician or other qualified health care professional face-to-face time of less than eight minutes is not separately reportable.

Codes 95971, 95972, 95976, 95977, 95983, 95984 are reported when programming a neurostimulator is performed by a physician or other qualified health care professional. Programming may be performed in the operating room, postoperative care unit, inpatient, and/or outpatient setting. Programming a neurostimulator in the operating room is not inherent in the service represented by the implantation code and may be reported by either the implanting surgeon or other qualified health care professional, when performed.

Neurostimulators, Analysis-Programming

Test stimulations are typically performed during an implantation procedure (43647, 43648, 43881, 43882, 61850, 61860, 61863, 61864, 61867, 61868, 61870, 61380, 61885, 61886, 61888, 63650, 63653, 63655, 63661, 63662, 63663, 63664, 63665, 63685, 63688, 64553, 64555, 64561, 64566, 64568, 64569, 64570, 64575, 64580, 64581, 64585, 64590, 64595) to confirm correct target site placement of the electrode array(s) and/or to confirm the functional status of the system. Test stimulation is not considered electronic analysis or programming of the neurostimulator system (test stimulation is included in the service described by the implantation code) and should not be reported with 95970, 95971, 95972, 95980, 95981, 95982, 95983, 95984. Electronic analysis of a device (95970) is not reported separately at the time of implantation.
Adaptive Behavior Services

- Adaptive behavior services address deficient adaptive behaviors (e.g., impaired social, communication, or self-care skills), maladaptive behaviors (e.g., repetitive and stereotypic behaviors, behaviors that risk physical harm to the patient, others, and/or property), or other impaired functioning secondary to deficient adaptive or maladaptive behaviors, including, but not limited to, instruction-following, verbal and nonverbal communication, imitation, play and leisure, social interactions, self-care, daily living, and personal safety.

Definitions

- **Functional behavior assessment**: comprises descriptive assessment procedures designed to identify environmental events that occur just before and just after occurrences of potential target behaviors and that may influence those behaviors. That information may be gathered by interviewing the patient’s caregivers; having caregivers complete checklists, rating scales, or questionnaires; and/or observing and recording occurrences of target behaviors and environmental events in everyday situations.
Definitions

- **Functional analysis**: an assessment procedure for evaluating the separate effects of each of several environmental events on a potential target behavior by systematically presenting and withdrawing each event to a patient multiple times and observing and measuring occurrences of the behavior in response to those events. Graphed data are analyzed visually to determine which events produced relative high and low occurrences of the behavior.

Definitions

- **Standardized instruments and procedures**: include, but not limited to, behavior checklists, rating scales, and adaptive skill assessment instruments that comprise a fixed set of items and are administered and scored in a uniform way with all patients (e.g., Pervasive Developmental Disabilities Behavior Inventory, Brigance Inventory of Early Development, Vineland Adaptive Behavior Scales).
Adaptive Behavior Assessments

- **Behavior identification assessment** (97151) is conducted by the physician or other qualified health care professional and may include analysis or pertinent past data (including medical diagnosis), a detailed behavioral history, patient observation, administration of standardized and/or nonstandardized instruments and procedures, functional behavior assessment, function analysis, and/or guardian/caregiver interview to identify and describe deficient adaptive behaviors, maladaptive behaviors, and other impaired functioning secondary to deficient adaptive or maladaptive behaviors. Code 97151 includes the physician's or other qualified health care professional's scoring of assessment, interpretation of results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), preparation of report and development of plan of care, which may include behavior identification supporting assessment (97152) or behavior identification-supporting assessment with four required components (0362T).

- **Behavior identification supporting assessment** (97152) is administered by a technician under the direction of a physician or other qualified health care professional. The physician or other qualified health care professional may or may not be on site during the face-to-face assessment process. Code 97152 includes the physician’s or other qualified health care professional’s interpretation of results and may include functional behavior assessment, functional analysis, and other structured observations and/or standardized and/or nonstandardized instruments and procedures to determine levels of adaptive and maladaptive behavior.
• Codes 97152, 0362T may be reported separately with 97151 based on the time that the patient is face-to-face with one or more technician(s). Only count the time of one technician when two or more are present.

• For behavior identification-supporting assessment with four required components, use 0362T.

<table>
<thead>
<tr>
<th>Guide to Selection Codes 97152 and 0362T</th>
<th>97152</th>
<th>0362T</th>
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<tbody>
<tr>
<td>Physician or other qualified health care professional required to be on site</td>
<td>✔️</td>
<td></td>
</tr>
<tr>
<td>Physician or other qualified health care professional not required to be on site</td>
<td></td>
<td>✔️</td>
</tr>
<tr>
<td>Number of technicians</td>
<td>1</td>
<td>2 or more</td>
</tr>
<tr>
<td>Deficient adaptive behavior(s), maladaptive behavior(s), or other impaired functioning secondary to deficient adaptive or maladaptive behaviors</td>
<td>✔️</td>
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<tr>
<td>Destructive behavior(s)</td>
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<td>✔️</td>
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<tr>
<td>May include functional behavior assessment</td>
<td>✔️</td>
<td>✔️</td>
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<tr>
<td>May include functional analysis</td>
<td>✔️</td>
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<tr>
<td>Environment customized to patient and behavior</td>
<td>✔️</td>
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Adaptive Behavior Treatment

- **Adaptive behavior treatment** codes 97153, 97154, 97155, 97156, 97157, 97158, 0373T describe services that address specific treatment targets and goals based on results of previous assessments (see 97151, 97152, 0362T), and include ongoing assessment and adjustment of treatment protocols, targets, and goals.

- **Adaptive behavior treatment by protocol** (97153) and **group adaptive behavior treatment by protocol** (97154) are administered by a technician under the direction of a physician or other qualified health care professional, utilizing a treatment protocol designed in advance by the physician or other qualified health care professional, who may or may not provide direction during the treatment. Code 97153 describes face-to-face services with one patient and code 97154 describes face-to-face services with two or more patients. Do not report 97154 if the group has more than eight patients.

- **Adaptive behavior treatment with protocol modification** (97155) is administered by a physician or other qualified health care professional face-to-face with a single patient. The physician or other qualified health care professional resolves one or more problems with the protocol and may simultaneously direct a technician in administering the modified protocol while the patient is present. Physician or other qualified health care professional direction to the technician without the patient present is not reported separately.
• **Family adaptive behavior treatment guidance** and **multiple-family group adaptive behavior treatment guidance** (97156, 97157) are administered by a physician or other qualified health care professional face-to-face with guardian(s)/caregiver(s) and involve identifying potential treatment targets and training guardian(s)/caregiver(s) of one patient (97156) or multiple patients (97157) to implement treatment protocols designed to address deficient adaptive or maladaptive behaviors. Services described by 97156 may be performed with or without the patient present. Services described by 97157 are performed without the patient present. Do not report 97157 if the group has more than eight patients’ guardian(s)/caregiver(s).

• **Group adaptive behavior treatment with protocol modification** (97158) is administered by a physician or other qualified health care professional face-to-face with multiple patients. The physician or other qualified health care professional monitors the needs of individual patients and adjusts the treatment techniques during the group sessions, as needed. In contrast to group adaptive behavior treatment by protocol (97154), protocol adjustments are made in real time rather than for a subsequent service. Do not report 97158 if the group has more than eight patients.

• For adaptive behavior treatment with protocol modification with four required components, use 0373T.
Central Nervous System Assessments/Tests (eg, Neuro-Cognitive, Mental Status, Speech Testing)

- The following codes are used to report the services provided during testing of the central nervous system functions. The central nervous system assessments include, but are not limited to, memory, language, visual motor responses, and abstract reasoning/problem-solving abilities. It is accomplished by the combination of several types of testing procedures. Testing procedures include assessment of aphasia and cognitive performance testing, developmental screening and behavioral assessments and testing, and psychological/neuropsychological testing. The administration of these tests will generate material that will be formulated into a report or an automated result.

Definitions

- **Definitions**: Codes in this family (96105-96146) describe a number of services that are defined below:
  - **Cognitive performance testing**: assesses the patient's ability to complete specific functional tasks applicable to the patient's environment in order to identify or quantify specific cognitive deficits. The results are used to determine impairments and develop therapeutic goals and objectives.
• **Interactive feedback:** used to convey the implications of psychological or neuropsychological test findings and diagnostic formulation. Based on patient-specific cognitive and emotional strengths and weaknesses, interactive feedback may include promoting adherence to medical and/or psychological treatment plans; educating and engaging the patient about his or her condition to maximize patient collaboration in their care; addressing safety issues; facilitating psychological coping; coordinating care; and engaging the patient in planning given the expected course of illness or condition, when performed.

• **Interpretation and report:** performed by a physician or other qualified health care professional. In some circumstances, a result is generated through the use of a computer, tablet computer, or other device(s).

• **Neurobehavioral status examination:** a clinical assessment of cognitive functions and behavior, and may include an interview with the patient, other informant(s), and/or staff, as well as integration of prior history and other sources of clinical data with clinical decision making, further assessment and/or treatment planning and report. Evaluation domains may include acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities.

• **Neuropsychological testing evaluation services:** typically include integration of patient data with other sources of clinical data, interpretation, clinical decision making, and treatment planning and report. It may include interactive feedback to the patient, family member(s) or caregiver(s), when performed. Evaluation domains for neuropsychological evaluation may include intellectual function, attention, executive function, language and communication, memory, visual-spatial function, sensorimotor function, emotional and personality features, and adaptive behavior.
• **Psychological testing evaluation services:** typically include integration of patient data with other sources of clinical data, interpretation, clinical decision making, and treatment planning and report. It may include interactive feedback to the patient, family member(s) or caregiver(s), when performed. Evaluation domains for psychological evaluation may include emotional and interpersonal functioning, intellectual function, thought processes, personality, and psychopathology.

• **Standardized instruments:** used in the performance of these services. Standardized instruments are validated tests that are administered and scored in a consistent or "standard" manner consistent with their validation.

• **Testing:** administered by a physician, other qualified health care professional, and technician, or completed by the patient. The mode of completion can be manual (eg, paper and pencil) or via automated means.

• Assessment of aphasia and cognitive performance testing, which includes interpretation and report, are described by 96105, 96125.

• Developmental screening services are described by 96110. Developmental/behavioral testing services, which include interpretation and report, are described by 96112, 96113.

• Neurobehavioral status examination, which includes interpretation and report, is described by 96116, 96121.
• Psychological and neuropsychological test evaluation services, which include: integration of patient data, interpretation of test results and clinical data, treatment planning and report, and interactive feedback, are described by 96130, 96131, 96132, 96133.

• Testing and administration services (96136, 96137) are performed by a physician or other qualified health care professional. For 96136, 96137, do not include time for evaluation services (eg, integration of patient data or interpretation of test results). This time is included with psychological and neuropsychological test evaluation services (96130, 96131, 96132, 96133). Testing and administration services (96138, 96139) are performed by a technician. The tests selected, test administration and method of testing and scoring are the same, regardless whether the testing is performed by a physician, other qualified health care professional, or a technician, for 96136, 96137, 96138, 96139. Automated testing and result code 96146 describes testing performed by a single automated instrument with an automated result.

• Some of these services are typically performed together. For example, psychological/neuropsychological testing evaluation services (96130, 96131, 96132, 96133) may be reported with psychological/neuropsychological test administration and scoring services (96136, 96137, 96138, 96139).

• A requirement of testing services (96105, 96125, 96112, 96113, 96130, 96131, 96133, 96146) is that there is an interpretation and report when performed by a qualified health care professional, or a result when generated by automation. These services follow standard CPT time definitions (ie, a minimum of 16 minutes for 30 minutes codes and 31 minutes for 1-hour codes must be provided to report any per hour code). The time reported in 96116, 96121, 96130, 96131, 96132, 96133, 96125 is the face-to-face time with the patient and the time spent integrating and interpreting data.

• Report the total time at the completion of the entire episode of evaluation.
Health and Behavior Assessment/Intervention

• Evaluation and management services codes (including counseling risk factor reduction and behavior change intervention [99401-99412]), should not be reported on the same day as health and behavior assessment/intervention codes 96150, 96151, 96152, 96153, 96154, 96155.

Special Services, Procedures and Reports

• The procedures with code numbers 99000 through 99082 provide the reporting physician or other qualified health care professional with the means to identify the completion of special reports and services that are an adjunct to the basic services rendered. The specific number assigned indicates the special circumstances under which a basic procedure is performed.
Medicine Code Updates Excerpts

● 96612: Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour

+● 96113: each additional 30 minutes (list separately in addition to code for primary function)

Modifiers

• -63 Procedure Performed on Infants less than 4 kg: Procedures performed on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician or other qualified health care professional work commonly associated with these patients. This circumstance may be reported by adding modifier 63 to the procedure number. Note: Unless otherwise designated, this modifier may only be appended to procedures/services listed in the 20100-69990 code series. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections.
Questions?

• Thank you for your attendance!

• Get your questions answered on PMI's Discussion Forum:
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