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On the topic:

Summary of What's New in CPT
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Summary of What's New in CPT

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Major Sections

Evaluation and Management Services 99201 – 99499
Anesthesiology 00100 – 01999, 99100 – 99140
Surgery 10021 – 89990
Radiology 70010 – 79999
(Radioisotope Diagnostic Ultrasound)
Pathology and Laboratory 80047 – 89398, 0001U – 0138U
Medicine 90281 – 99199, 99500 – 99607
Category II Codes 0001F – 9007F
Category III Codes 0042T – 0593T

CPT® Symbols

- New Codes
- Revised Codes
- Deleted language
- New text
- Vaccines pending FDA approval
- # Resequenced codes
- + CPT add-on codes
- ☇ Exempt from use of modifier 51
- ★ May be used to report telemedicine services
Evaluation and Management (99201-99499)

- The E/M section is divided into broad categories such as office visits, hospital visits, and consultations.
- Most of the categories are further divided into two or more subcategories of E/M services.
- The subcategories of E/M services are further classified into level of E/M services that are identified by specific codes.
- This classification is important because the nature of the work varies by type of service, place of service, and the patient’s status.

Evaluation and Management Code Updates – Online Digital E/M

- **#99421**: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
  - **#99422**: 11-20 minutes
  - **#99423**: 21 more minutes
  - ▶ (Report 99421, 99422, 99423 once per 7-day period) ◄
  - ▶ (Clinical staff time is not calculated as part of cumulative time for 99421, 99422, 99423) ◄
  - ▶ (Do not report online digital E/M services for cumulative service time less than 5 minutes) ◄
  - ▶ (Do not count 99421 99422 99423 time otherwise reported with other services) ◄
  - ▶ Do not report 99421, 99422, 99423 on a day when the physician or other qualified health care professional reports E/M services [99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245]) ◄
► (Do not report 99421, 99422, 99423, when using 99091, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99487, 99489, 99495, 99496 for the same communication[s]) ◄

► (Do not report 99422, 99423 for home and outpatient INR monitoring when reporting 93972, 93973) ◄

► (99444 has been deleted. To Report, see 99421, 99422, 99423) ◄

99444: Online evaluation and management service provided by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient or guardian, not originating from a related E/M service provided with the previous 7 days, using the internet or similar electronic communications network.

#99473: Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration

► (Do not report 99473 more than once per device) ◄

► (For ambulatory blood pressure monitoring, see 93784, 93786, 93788, 93790) ◄

#99474: Separate self-measurements of two readings one minute apart, twice daily over a 30-day period (minimum of 12 readings), collection of data reported by the patient and/or caregiver to the physician or other qualified health care professional, with report of average systolic and diastolic pressures and subsequent communication of a treatment plan to the patient

► (Do not report 99473, 99474 in the same calendar month as 93782, 93786, 93788, 93790, 99091, 99453, 99454, 99457, 99487, 99490, 99491) ◄

► (Do not report 99474 more than once per calendar month) ◄

#99457: Remote physiological 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; first 20 minutes
Online Digital Evaluation and Management Services

- Online digital evaluation and management (E/M) services (99421, 99422, 99423) are patient-initiated services with physicians or other qualified health care professionals (QHPs).
- Online digital E/M services require physician or other QHP’s evaluation, assessment, and management of the patient.
  - These services are not for the non-evaluative electronic communication of test results, scheduling of appointments, or other communication that does not include E/M.
  - While the patient’s problem may be new to the physician or other QHP, the patient is an established patient.
  - Patients initiate these services through Health Insurance Portability and Accountability Act (HIPAA)-compliant secure platforms, such as electronic health record (EHR) portals, secure email, or other digital applications, which allow digital communication with the physician or other QHP.
• **Online digital E/M services are reported once** for the physician’s or other QHP’s cumulative time devoted to the service during a seven-day period.
• The seven-day period begins with the physician’s or other QHP’s initial, personal review of the patient-generated inquiry.
• Physician’s or other QHP’s cumulative service time includes review of the initial inquiry, review of patient records or data pertinent to assessment of the patient’s problem, personal physician or other QHP interaction with clinical staff focused on the patient’s problem, development of management plans, including physician or other QHP generation of prescriptions or ordering of tests, and subsequent communication with the patient through online, telephone, email, or other digitally supported communication, which does not otherwise represent a separately reported E/M service.
• All professional decision making, assessment, and subsequent management by physicians or other QHPs in the same group practice contribute to the cumulative service time of the patient’s online digital E/M service.
Online digital E/M services require permanent documentation storage (electronic or hard copy) of the encounter.

• If within seven days of the initiation of an online digital E/M service, a separately reported E/M visit occurs, then the physician or other QHP work devoted to the online digital E/M service is incorporated into the separately reported E/M visit (e.g., additive of visit time for a time-based E/M visit or additive of decision-making complexity for a key component-based E/M visit).
• This includes E/M visits and procedures that are provided through synchronous telemedicine visits using interactive audio and video telecommunication equipment, which are reported with modifier 95 appended to the E/M service code.
• If that patient initiates an online digital inquiry for the same or a related problem within seven days of a previous E/M service, the online digital visit is not reported.
ONLINE DIGITAL E/M

• If the online digital inquiry is related to a surgical procedure and occurs during the postoperative period of a previously completed procedure, then the online digital E/M service is not reported separately.
• If the patient generates the initial online digital inquiry for a new problem within seven days of a previous E/M visit that addressed a different problem, the online digital E/M service may be reported separately.
• If the patient presents a new, unrelated problem during the seven-day period of an online digital E/M service, then the physician’s or other QHP’s time spent on evaluation, assessment, and management of the additional problem is added to the cumulative service time of the online digital E/M service for that seven-day period.

Revised Chapter Guidelines for 2020 Telephone Services

• Telephone services are non-face-to-face evaluation and management (E/M) services provided to a patient using the telephone by a physician or other qualified health care professional, who may report evaluation and management services.
  • These codes are used to report episodes of patient care initiated by an established patient or guardian of an established patient.
  • If the telephone service ends with a decision to see the patient within 24 hours or next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the pre-service work of the subsequent E/M service, procedure, and visit.
  • Likewise, if the telephone call refers to an E/M service performed and reported by that individual within the previous seven days (either requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) is considered part of that previous E/M service or procedure.
  • (Do not report 99441-99443, if 99421, 99422, 99423 have been reported by the same provider in the previous seven days for the same problem.)
Interprofessional Telephone/Internet/Electronic Health Record Consultations

- 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, 99421, 99422, 99423, 99441, 99442, 99443, 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.

Digitally Stored Data Services/Remote Physiologic Monitoring

If the services described by 99091 or 99474 are provided on the same day the patient presents for an evaluation and management (E/M) service to the same provider, these services should be considered part of the E/M service and not reported separately.

TELEPHONE E/M TO ESTABLISHED PATIENT, PARENT OR GUARDIAN NOT ORIGINATION FROM A RELATED E/M

- 99441 - Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion (Non-facility Medicare Allowable - $ 13.69) (Not covered by Medicare)
- 99442 - Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion (Non-facility Medicare Allowable - $ 26.66) (Not covered by Medicare)
- 99443 - Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion (Non-facility Medicare Allowable - $ 39.33) (Not covered by Medicare)
### TELEPHONE/INTERNET/ELECTRONIC HEALTH RECORD ASSESSMENT AND MANAGEMENT – REVISED CODES 01/01/2019

- **99446** - Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review (Non-Facility Mcr Allowable - $ 17.92)

- **99447** - Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review (Non-Facility Mcr Allowable - $ 35.50)

- **99448** - Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review (Non-Facility Mcr Allowable - $ 53.42)

- **99449** - Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review (Non-Facility Mcr Allowable - $ 71.00)

### TELEPHONE/ELECTRONIC HEALTH RECORD ASSESSMENT/MANAGEMENT BY A CONSULTATIVE PHYSICIAN – NEW CODES 2019

- **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, (Non-Facility – Mcr Allowable - $ 36.47).

- **99452** - Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes (Non-Facility – Mcr Allowable - $ 36.47)
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.
  - Do not use 99457, 99458 for time that can be reported using more specific monitoring services (eg, for the patient that requires reevaluation of medication regimen and/or changes in treatment).
- Codes 99457, 99458 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.
- Codes 99457, 99458 require a live, interactive communication with the patient/caregiver. For the first 20 minutes of clinical staff/physician/other qualified health care professional time in a calendar month report 99457, and report 99458 for each additional 20 minutes.
  - Do not report services of less than 20 minutes. Report 99457 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, inpatient services 99221, 99222, 99223, 99231, 99232, 99233, 99251, 99252, 99253, 99254, 99255).
- Do not count any time related to other reported services (eg, 93290, 93793, 99291, 99292).
Care Management Services

- 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 service 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 (99441, 99442, 99443), 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.
- When reporting 99487, 99489, 99490, do not report 99421, 99422, 99423 during the same time.

Transitional Care Management Services

- A physician or other qualified health care professional who reports codes 99495, 99496 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 (99366-99368), education and training (98960-98962, 99071, 99078), telephone services (98966-98968, 99441-99443), end stage renal disease services (90951-90970), preparation of special reports (99080), analysis of data (99091), complex chronic care coordination services (99487-99489), medication therapy management services (99605-99607), during the time period covered by the transitional care management services code.
- When reporting 99495, 99496, do not report 99421, 99422, 99423 during the same time period.
Surgery – General (10004-10021)

• This section describes fine needle aspiration codes.
• Revised Chapter Guidelines for 2020
  • No guideline changes.

Surgery – Integumentary System (10030-19499)
Revised Chapter Guidelines for 2020

Repair (Closure)

• Intermediate repair includes the repair of wounds that, in addition to the above, require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (non-muscle) fascia, in addition to the skin (epidermal and dermal) closure.
• It includes limited undermining (defined as a distance less than the maximum width of the defect, measure perpendicular to the closure line, along at least one entire edge of the defect).
• Single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter also constitutes intermediate repair.
• **Complex repair** includes the repair of wounds that in addition to the requirements for intermediate repair, require at least one of the following:
  • exposure of bone, cartilage, tendon, or name neurovascular structure; debridement of wound edges (eg, traumatic lacerations or avulsions);
  • extensive undermining (defined as a distance greater than or equal to the maximum width of the defect, measure perpendicular to the closure line along at least one entire edge of the defect);
  • involvement of free margins or helical rim, vermilion border, or nostril rim; placement of retention sutures.
  • Necessary preparation includes creation of a limited defect for repairs or the debridement of complicated lacerations or avulsions.
  • **Complex repair does not include** excision of benign (11400-11446) or malignant (11600-11646) lesions, excisional preparation of a wound bed (15002-15005) or debridement of an open fracture or open dislocation.

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**Surgery – Integumentary System – Code Updates – New Codes**

#15769: Grafting of autologous soft tissue, other, harvested by direct excision (eg, fat, dermis, fascia)

► (For injection[s] of platelet-rich plasma, use 0232T) ◄

15771: Grafting of autologous fat harvested by liposuction technique to trunk, breasts, scalp, arms, and/or legs; 50 cc or less injectate

► (Report 15771 only once per session) ◄

15772: each additional 50 cc injectate, or part thereof (List separately in addition to code for primary procedure)

► (Use 15772 in conjunction with 15771) ◄
• **15773**: Grafting of autologous fat harvested by liposuction technique to face, eyelids, mouth, neck, ears, orbits, genitalia, hands, and/or feet; 25 cc or less injectate
  
  ► (Report 15773 only once per session) ◄

  +• **15774**: each additional 25 cc injectate, or part thereof (List separately in addition to code for primary procedure) ◄

  ► (Use 15774 in conjunction with 15773) ◄

  ► (Do not report 15769, 15771, 15772, 15773, 15774 in conjunction with 15876, 15877, 15878, 15879, 0232T, 0481T, 0489T, 0490T) ◄

  ► (For injections[s], autologous white blood cell concentrate [autologous protein solution], any site, including image guidance, harvesting and preparation, when performed, use 04817) ◄

  **19260**: Excision of chest wall tumor including ribs

  **19274**: Excision of chest wall tumor involving ribs, with plastic reconstruction, without mediastinal lymphadenectomy

  **19272**: with mediastinal lymphadenectomy

  **19304**: Mastectomy, subcutaneous
Other Flaps and Grafts

- **Code 15769** may be used to report autologous soft tissue grafts, such as fat, dermis, fascia, or other soft tissues, which are harvested from the patient using an excisional technique.
  - The autologous soft tissue grafts are then placed into a defect during the same operation.
  - Autologous grafts that are already defined in the CPT code set, including skin, bone, nerve, tendon fascia lata or vessels, should be reported with the specific codes for each tissue type.
  - For harvesting, preparation or injections(s) of platelet-rich plasma, use 0232T.
- **Codes 15771, 15772, 15773, 15774** may be used to report autologous fat grafting when the adipose cells are harvested via a liposuction technique, prepared with minimal manipulation, and then injected via cannula in multiple small aliquots to the defect.
  - The regions listed refer to the recipient area (not the donor site).
  - Volumes are based on total injectate.
  - For multiple sites of injection, sum the total volume of injectate to anatomic sites that are grouped together into the same code descriptor.
  - Do not report 11950, 11951, 11952, 11954 in conjunction with 15771, 15772, 15773, 15774, for the same anatomic site.

Other Procedures

- Breast biopsy procedures may be performed via a percutaneous or open approach and with or without imaging guidance.
• **Percutaneous image-guided breast biopsies**, including the placement of breast localization device(s), when performed, are reported with:
  - 19081 (NF-$628.19; F-$169.46), 19082 (NF-$510.85; F-$85.25), 19083 (NF-$615.02; F-$159.67), 19084 (NF-$492.97; F-$79.72), 19085 (NF-$942.81; F-$185.66), 19086 ($745.94; F-$92.83).
  - Imaging codes 76098, 76942, 77002, 77021 may not be separately reported for the same lesion.
  - When more than one percutaneous breast biopsy with or without localization device placement is performed using the same imaging modality, use an addon code whether the additional service(s) is on the same or contralateral breast.
  - If additional percutaneous biopsies with or without localization device placements are performed using different imaging modalities, report another primary code for each additional biopsy with or without localization device placement performed using a different image guidance modality.

• **To report bilateral image-guided breast biopsies**, report 19081, 19083, 19085 for the initial biopsy.
• The contralateral and each additional breast image-guided biopsy are then reported with 19082, 19084, 19086.
• **Percutaneous breast biopsies without imaging guidance** are reported with 19100 (NF-$147.34).

• **Open incisional breast biopsy** (19101) does not include imaging guidance. (NF-$329.36; F-$219.49)
  - However, if an open incisional biopsy is performed after image-guided placement of a localization device, the appropriate image-guided localization device placement code (19281 (NF-$236.80; F-$101.92), 19282 (NF-$164.71; F-$51.13), 19283, 19284, 19285, 19286, 19287, 19288) may also be reported.
  - **Percutaneous cryosurgical ablation of a fibroadenoma** (19105; NF-$2724.97; F-$210.91) includes ultrasound guidance and, therefore, 76940. 76942 may not be separately reported.
  - Code 19105 may only be reported once per cryoprobe insertion site, even if several adjacent lesions are ablated.
  - **Open excision of a breast lesion** (eg, lesions of breast duct[s], cyst[s], benign or malignant tumor[s]), without specific attention to adequate surgical margins, with or without the preoperative placement of radiological markers are reported with 19110 (NF-$476.36; F-$340.46), 19112, 19120, 19125, 19126.
  - If an open excision of a breast lesion is performed after image-guided placement of a localization device, the appropriate image-guided localization device placement code (19281, 19282, 19283, 19284, 19285, 19286, 19287, 19288) may also be reported.
Breast (Introduction)

- Percutaneous image-guided placement of breast localization device(s) without image-guided breast biopsy(ies) is reported with 19281 (NF-$ 236.80; F-$ 101.92), 19282 (NF-$ 164.71; F-$ 51.13), 19283 19284 19285 19286 19287 19288.

- When more than one localization device placement without image-guided biopsy is performed using the same imaging modality, report an add-on code whether the additional service(s) is on the same or contralateral breast.

- If additional localization device placements without image-guided biopsy(ies) are performed using different imaging modalities, report another primary code for each additional localization device placement without image-guided biopsy performed using a different imaging guidance modality.

- When an open breast biopsy or open excision of a breast lesion is performed after image-guided percutaneous placements of a localization device placement code (19281, 19282, 19284, 19283, 19284, 19285, 19286, 19287, 19288) may also be reported.

- Codes 19296, 19297, 19298 describe placement of radiotherapy catheters (afterloading expandable or afterloading brachytherapy) into the breast for interstitial radionuclide application either concurrent or on a separate date from a partial mastectomy procedure. Imaging guidance is included and many not be separately reported.

Mastectomy Procedures

- Mastectomy procedures (with the exception of gynecomastia [19300]) (NF-$ 524.73; F-$ 410.47) are performed either for treatment or prevention of breast cancer.

- Code 19301 (NF: $647.96; F: $647.96) describes a partial mastectomy where only a portion of the ipsilateral breast tissue is removed (eg, lumpectomy, tylectomy, quadrantectomy, segmentectomy).

- When a complete axillary lymphadenectomy is performed in addition to a partial mastectomy, report 19302 (NF & F-$ 892.7)

- When breast tissue is removed for breast-size reduction and not for treatment or prevention of breast cancer, report 19318 (reduction mammoplasty).
Mastectomy Procedures

- **Code 19303** describes total removal of ipsilateral breast tissue with or without removal of skin and/or nipples (eg, nipple-sparing), for treatment or prevention of breast cancer. **Code 19303 does not include excision of pectoral muscle(s) and/or axillary and internal mammary lymph nodes.** When a total mastectomy is performed for gynecomastia, report 19300.

- **Codes 19305, 19306, 19307** describe radical procedures that include total removal of the ipsilateral breast tissue, including the nipple for treatment of breast cancer and excision of pectoral muscle(s) and/or axillary lymph nodes and/or internal mammary lymph nodes.

- To report bilateral procedures for 19300, 19301, 19302, 19303, 19305, 19306, 19307, report modifier 50 with the procedure code.

Surgery – Musculoskeletal System (20100-29999)
Revised Chapter Guidelines for 2020
Grafts (or Implants)

- **Codes for obtaining autogenous bone, cartilage, tendon, fascia lata grafts, bone marrow, or other tissues through separate skin/fascial incisions should be reported separately, unless the code descriptor references the harvesting of the graft or implant (eg, includes obtaining graft).**

- Autologous grafts that are already defined in the CPT code set, including skin, bone, nerve, tendon, fascia lata, or vessels, should be reported with the more specific codes for each tissue type.

- **Code 15769 may be used for other autologous soft tissue grafts harvested by direct excision.**

- See 15771, 15772, 15773, 15774 for autologous fat grafting harvested by liposuction technique.
Surgery – Musculoskeletal System – Code Updates

#•20560: Needle insertion(s) without injection(s); 1 or 2 muscles

#•20561: 3 or more muscles

++20700: Manual preparation and insertion of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)

► (Use 20700 in conjunction with 11010, 11011, 11012, 11043, 11044, 11046, 11047, 20240, 20245, 20250, 20251, 21010, 21025, 21026, 21501, 21502, 21510, 21627, 21630, 22010, 22015, 23030, 23031, 23035, 23040, 23044, 23170, 23172, 23174, 23180, 23182, 23184, 23334, 23335, 23930, 23931, 23935, 24000, 24134, 24136, 24138, 24140, 24147, 24160, 25031, 25035, 25040, 25145, 25150, 25151, 26070, 26230, 26235, 26236, 26990, 26991, 26992, 27030, 27070, 27071, 27090, 27301, 27303, 27310, 27360, 27603, 27604, 27610, 27640, 27641, 28001, 28002, 28003, 28020, 28120, 28122) ▼

► (Do not report 20700 in conjunction with 11981) ▼

++20701: Removal of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)

► (Use 20701 in conjunction with 11010, 11011, 11012, 11043, 11044, 11046, 11047, 20240, 20245, 20250, 20251, 21010, 21025, 21026, 21501, 21502, 21510, 21627, 21630, 22010, 22015, 23030, 23031, 23035, 23040, 23044, 23170, 23172, 23174, 23180, 23182, 23184, 23334, 23335, 23930, 23931, 23935, 24000, 24134, 24136, 24138, 24140, 24147, 24160, 25031, 25035, 25040, 25145, 25150, 25151, 26070, 26230, 26235, 26236, 26990, 26991, 26992, 27030, 27070, 27071, 27090, 27301, 27303, 27310, 27360, 27603, 27604, 27610, 27640, 27641, 28001, 28002, 28003, 28020, 28120, 28122) ▼

► (Do not report 20701 in conjunction with 11982) ▼
**20702**: Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)

- (Use 20702 in conjunction with 20680, 20690, 20692, 20694, 20802, 20805, 20838, 21510, 23035, 23170, 23180, 23184, 23515, 23615, 23935, 24134, 24138, 24140, 24147, 24430, 24516, 25035, 25145, 25150, 25151, 25400, 25515, 25525, 25526, 25545, 25574, 25575, 27245, 27259, 27360, 27470, 27506, 27640, 27720)

- (Do not report 20702 in conjunction with 11981)

**20703**: Removal of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)

- (Use 20703 in conjunction with 20680, 20690, 20692, 20694, 20802, 20805, 20838, 21510, 23035, 23170, 23180, 23184, 23515, 23615, 23935, 24134, 24138, 24140, 24147, 24430, 24516, 25035, 25145, 25150, 25151, 25400, 25515, 25525, 25526, 25545, 25574, 25575, 27245, 27259, 27380, 27470, 27506, 27640, 27720)

- (Do not report 20703 in conjunction with 11982)

**20704**: Manual preparation and insertion of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)

- (Use 20704 in conjunction with 22864, 22865, 23040, 23044, 23334, 24000, 24160, 25040, 25250, 25251, 26070, 26075, 26080, 26990, 27030, 27090, 27301, 27310, 27603, 27610, 28020)

- (Do not report 20704 in conjunction with 11981, 27091, 27488)

**20705**: Removal of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)

- (Use 20705 in conjunction with 22864, 22865, 23040, 23044, 23334, 24000, 24160, 25040, 25250, 25251, 26070, 26075, 26080, 26990, 27030, 27090, 27301, 27310, 27603, 27610, 28020)

- (Do not report 20705 in conjunction with 11982, 23335, 27091, 27125, 27130, 27134, 27137, 27138, 27236, 27438, 27446, 27486, 27487, 27488)
20926: Tissue grafts, other (eg, paratenon, fat, dermis)
  • 21601: excision of chest wall tumor including rib(s)
  • 21602: Excision of chest wall tumor involving ribs, with plastic reconstruction; without 
    mediastinal lymphadenectomy
  • 21603: with mediastinal lymphadenectomy

  (Do not report 21601, 21602, 21603, in conjunction with 32100, 32503, 32504, 32551, 32554, 32555)

Surgery – Respiratory System
(30000-32999)

Revised Chapter Guidelines for 2020

• No guideline changes other than code specific usage changes.
Surgery – Respiratory System – Code Updates

▲31233: Nasal/sinus endoscopy, diagnostic with maxillary sinusoscopy (via inferior meatus or canine fossa puncture); with maxillary sinusoscopy (via inferior meatus or canine fossa puncture)

► (Do not report 31233 in conjunction with 31256, 31267, 31295, when performed on the ipsilateral side) ▼

▲31235: with sphenoid sinusoscopy (via puncture of sphenoidal face or cannulation of ostium)

► (Do not report 31235 in conjunction with 31257, 31259, 31287, 31288, 31297, 31298, when performed on the ipsilateral side) ▼

▲31292: Nasal/sinus endoscopy, surgical, with orbital decompression; with medial or inferior orbital wall decompression

► (Do not report 31292 in conjunction with 31237, 31253, 31254, 31255, 31257, 31259, 31293, 31296, when performed on the ipsilateral side) ▼

▲31293: with medial orbital wall and inferior orbital wall decompression

► (Do not report 31293 in conjunction with 31237, 31253, 31254, 31255, 31257, 31259, 31292, when performed on the ipsilateral side) ▼

▲31294: Nasal/sinus endoscopy, surgical, with optic nerve decompression; with optic nerve decompression

► (Do not report 31294 in conjunction with 31237, 31253, 31254, 31255, 31257, 31259, 31287, 31288, when performed on the ipsilateral side) ▼
Surgery – Cardiovascular System (33016-37799)
Revised Chapter Guidelines for 2020
Pericardium

• In order to report pericardial drainage with insertion of indwelling catheter (33017, 33018, 33019), the catheter need to remain in place when the procedure is completed.

• Codes 33017, 33018, 33019 should not be reported when a catheter is placed to aspirate fluid and then removed at the conclusion of the procedure.

• Congenital cardiac anomaly for reporting percutaneous pericardial drainage with insertion of indwelling catheter is defined as abnormal situs (heterotaxy, dextrocardia, mesocardia), single ventricle anomaly/physiology, or any patient in the first 90-day postoperative period after repair of a congenital anomaly.
Pacemaker or Implantable Defibrillator

- Like a pacemaker system, an implantable defibrillator system includes a pulse generator and electrodes.
- Three general categories of implantable defibrillators exist: transvenous implantable pacing cardioverter-defibrillator (ICD), subcutaneous implantable defibrillator (S-ICD), and substernal implantable cardioverter-defibrillator.
- Implantable pacing cardioverter-defibrillator devices use a combination of antitachycardia pacing, low-energy cardioversion or defibrillating shocks to treat ventricular tachycardia or ventricular fibrillation.
- The implantable defibrillator uses a single subcutaneous electrode to treat ventricular tachyarrhythmias.
- The substernal implantable cardioverter-defibrillator includes cardioversion, and antitachycardia pacing.
- Subcutaneous implantable defibrillators differ from transvenous implantable pacing cardioverter-defibrillators in that subcutaneous defibrillators do not provide antitachycardia pacing of chronic pacing.
- Substernal implantable defibrillators differ from both subcutaneous and transvenous implantable pacing cardioverter-defibrillators in that they provide antitachycardia pacing, but not chronic pacing.

- The electrodes (leads) of an implantable defibrillator system may be positioned within the aerial and/or ventricular chambers of the heart via the venous system (transvenously), or placed on the surface of the heart (epicardial), or positioned under the skin overlying the heart (subcutaneous).
- Electrode positioning on the epicardial surface of the heart requires a thoracotomy or thoroscopic placement of the leads.
- Epicardial placement of electrode(s) may be separately reported using 33202, 33203.
- The electrode (lead) of a subcutaneous implantable defibrillator system is tunneled under the skin to the left parasternal margin.
  - Subcutaneous placement of electrode may be reported using 33270 or 33271.
  - In certain circumstances, an additional electrode may be required to achieve pacing of the left ventricle (bi-ventricular pacing). In this event, transvenous (cardiac vein) placement of the electrode may be separately reported using 33224 or 33225.
• **Device evaluation codes 93260, 93261, 93279-93298** 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.

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**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 (33858, 33859, 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
Thoracic Aortic Aneurysm

3. Extension of the ascending aortic graft under the aortic arch by construction of a beveled anastomosis and the distal ascending aorta and aortic arch without a cross-clamp (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 33858, 33859, 33863, 33864.**
- **Code 33871 describes a complete transverse arch graft placement and is not used to report an aortic hemiarch graft procedure.**

Endovascular Repair of Abdominal Aorta and/or Iliac Arteries

- **Add-on code 34717 is reported at the time aortoiliac artery endograft placement (34703, 34704, 34705, 34706) for deployment of a bifurcated endograft in the common iliac artery with extension(s) into both the internal iliac and external iliac arteries, when performed to maintain perfusion in both vessels for treatment of iliac artery pathology (with or without rupture), such as aneurysm, pseudoaneurysm, dissection, penetrating ulcer, arteriovenous malformation, or traumatic disruption.**
- **The iliac branched endograft is a multi-piece system consisting of a bifurcated device that is placed in the common iliac artery and then additional extension(s) are place into both the internal iliac artery and external iliac/common femoral arteries as needed, as well as a proximal extension that overlaps with an aorto-iliac endograft, when performed.**
- **All additional extension proximally into the common iliac artery or distally into the external iliac and/or common femoral arteries are inherent to these codes.**
- **Report 34705 or 34706 for simultaneous bilateral iliac artery aneurysm repairs with aorto-bi-iliac endograft.**
- **For isolated bilateral iliac artery repair using iliac artery tube endografts, report 34707 or 34708 with modifier 50 appended.**
The treatment zone for endograft procedures is defined by those vessels that contain an endograft(s) (main body, docking limb(s) and/or extension(s)) deployed during that operative session.

Adjunctive procedures outside the treatment zone may be separately reported (eg, angioplasty, endovascular stent placement, embolization).

- For example, when an endograft terminates in the common iliac artery, any additional treatment performed in the external and/or internal iliac artery may be separately reportable.
- Placement of a docking limb is inherent to a modular endograft(s), and, therefore, 34709 may not be reported separately if the docking limb extends into the external iliac artery.
- In addition, any interventions (eg, angioplasty, stenting, additional stent graft extension(s)) in the external iliac artery where the docking limb terminates may not be reported separately.
- Any catheterization or treatment of the internal iliac artery, such as embolization, may be separately reported.
- For 34705 and 34706, the abdominal aortic treatment zone is typically defined as the infrarenal aorta and both common iliac arteries.
- For 34707, 34708, 34717, 34718, the treatment zone is defined as the portion of the iliac artery(ies) (eg, common, internal, external iliac arteries) that contains the endograft.

If an aorto-iliac artery endograft (34703, 34704, 34705, 34706) is not being placed during the same operative session, 34718 may be reported for placement of a bifurcated endograft in the common iliac artery with extension(s) into both the internal iliac and external iliac arteries, to maintain perfusion in both vessels for treatment of iliac artery pathology (without rupture), such as aneurysm, pseudoaneurysm, dissection, arteriovenous malformation.

The iliac branched endograft is a multi-piece system consisting of a bifurcated device that is placed in the common iliac artery and then additional extension(s) are placed into both the internal iliac artery and external iliac/common femoral arteries as needed as well as a proximal extension that overlaps with an aorto-iliac endograft, when performed.

- All additional extensions placed proximally into the common iliac artery or distally into the external iliac and/or common femoral arteries are inherent to these codes.
- For isolated bilateral iliac artery repair using iliac artery branched endograft, use 34718 with modifier 50 appended.
- Codes 34709, 34710, 34711 may not be separately reported with 34717, 34718 for ipsilateral extension prosthesis(es).

However, 34709, 34710, 34711 may be reported separately for extension prosthesis(es) in the iliac/femoral arteries contralateral to the iliac branched endograft.
Selective arterial catheterization of the internal and external iliac arteries (eg, 36245, 36246, 36247, 36248) ipsilateral to an iliac branched endograft is included in 34717, 34718 and not separately reported.

However, selective catheterization of the renal artery(ies), the contralateral hypogastric artery, and/or arterial families outside the treatment zone of the graft may be separately reported. Intravascular ultrasound (37252, 37253) performed during endovascular aneurysm repair may be separately reported.

Balloon angioplasty within the target treatment zone of the endograft, either before or after endograft deployment, is not separately reported.

Fluoroscopic guidance and radiological supervision and interpretation performed in conjunction with endovascular iliac branched repair is not separately reported.

Endovascular iliac branched repair includes all intraprocedural imaging (eg, angiography, rotational CT) of the aorta and its branches prior to deployment of the endovascular device, fluoroscopic guidance in the delivery of the endovascular components, and intraprocedural arterial angiography (eg, confirm position, detect endoleak, evaluate runoff) performed at the time of the endovascular aorto-iliac repair.

Vascular Injection Procedures

When bilateral carotid and/or vertebral arterial catheterization and imaging is performed, report 36222, 36223, 36224, 36225, 36226 with modifier 50, and report add-on codes 36227, 36228 twice (do not report modifier 50 in conjunction with 36227, 36228) if the same procedure is performed on both sides.

For example, bilateral extracranial carotid angiography with selective catheterization of each common carotid artery would be reported with 36222 and modifier 50.

However, when different territory(ies) is studied in the same session on both sides of the body, modifiers may be required to report the imaging performed.

Use modifier 59 to denote that different carotid and/or vertebral arteries are being studied.

For example, when selective right internal carotid artery catheterization accompanied by right extracranial and intracranial carotid angiography is followed by selective left common carotid artery catheterization with left extracranial carotid angiography, use 36224 to report the right side and 36222-59 to report the left side.
Surgery – Cardiovascular System – Code Updates

33010: Pericardiocentesis, initial

33011: subsequent

33015: tube pericardiostomy

• 33016: Pericardiocentesis, including imaging guidance, when performed
  ▶ (Do not report 33016 in conjunction with 76942, 77002, 77012, 77021) ◄

• 33017: Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; 6 years and older without congenital cardiac anomaly

• 33018: birth through 5 years of age or any age with congenital cardiac anomaly
  ▶ (Do not report 33017, 33018 in conjunction with 75989, 76942, 77002, 77012, 77021) ◄

(Do not report 33016, 33017, 33018 in conjunction with 93303-93325 when echocardiography is performed solely for the purpose of pericardiocentesis guidance) ◄

▶ (For CT-guided pericardial drainage, use 33019) ◄

• 33019: Pericardial drainage with insertion of indwelling catheter, percutaneous, including CT guidance
  ▶ (Do not report 33019 in conjunction with 75989, 76942, 77002, 77012, 77021) ◄

#▲ 33275: Transcatheter removal of permanent leadless pacemaker, right ventricular, including imaging guidance (eg, fluoroscopy, venous ultrasound, ventriculography, femoral venography), when performed

• 33858: Ascending aorta graft, with cardiopulmonary bypass, includes valve suspension, when performed; for aortic dissection

• 33859: for aortic disease other than dissection (eg, aneurysm)

33860: Ascending aortic graft, with cardiopulmonary bypass, includes valve suspension, when performed
33870: Transverse arch graft, with cardiopulmonary bypass

- 33871: Transverse aortic arch graft, with cardiopulmonary bypass, with profound hyperthermia, total circulatory arrest and isolated cerebral perfusion with reimplantation of arch vessel(s) (eg, island pedicle or individual arch vessel reimplantation)
  
  ▶ (Do not report 33871 for aortic hemiarch graft)

  ▶ (Do not report 33871 in conjunction with 33866)

  ▶ (For aortic hemiarch graft performed in conjunction with ascending aortic graft [33858, 33859, 33863, 33864], use 33866)

### 34717: Endovascular repair of iliac artery at the time of aortoiliac artery endograft placement by deployment of an iliac branched endograft including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision and interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for rupture or other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer, traumatic disruption, unilateral (List separately in addition to code for primary procedure)

- 34717 in conjunction with 34703, 34704, 34705, 34706

- (34717 may only be reported once per side. For bilateral procedure, report 34717 twice. Do not report modifier 50 in conjunction with 34717)

- (Do not report 34717 in conjunction with 34709 on the same side)

- (Do not report 34717 in conjunction with 34710, 34711)

- (For placement of an iliac branched endograft at a separate setting then aortoiliac endograft placement use 34718)

### 34718: Endovascular repair of iliac artery, not associated with placement of an aortoiliac artery endograft at the same session, by deployment of an iliac branched endograft, including pre-procedure sizing and device selection, all ipsilateral selective iliac artery catheterization(s), all associated radiological supervision an interpretation, and all endograft extension(s) proximally to the aortic bifurcation and distally in the internal iliac, external iliac, and common femoral artery(ies), and treatment zone angioplasty/stenting, when performed, for other than rupture (eg, for aneurysm, pseudoaneurysm, dissection, arteriovenous malformation, penetrating ulcer unilateral)
► (For bilateral placement of an iliac branched endograft, report modifier 50)
► (Do not report 34718 in conjunction with 34701, 34702, 34703, 34704, 34705, 34706, 34707, 34708, 34709, 34717)
► (Do not report 34718 in conjunction with 34710, 34711 on the same side)
► (For placement of an iliac branched endograft in the same setting as aorto-iliac endograft placement, use 34717)
► (For placement of an isolated iliac branched endograft for rupture, use 37799)

▲ 35701: Exploration (not followed by surgical repair), with or without lysis of artery; neck (eg. carotid artery, subclavian)
► (Do not report 35701 in conjunction with 35201, 35231, 35261, 35800, when performed on the same side of the neck)
    • 35702: upper extremity (eg, axillary, brachial, radial, ulnar)

► 35703: lower extremity (eg, common femoral, deep femoral, superficial femoral, popliteal, tibial, peroneal)
► (When additional surgical procedures are performed at the same setting by the same surgeon, 35701, 35702, 35703 may only be reported when a nonvascular surgical procedure is performed and only when the artery exploration is performed through a separate incision)
► (Do not report 35702, 35703 in conjunction with 35206, 35207, 35236, 35256, 35268, 35286, 35860 in the same extremity)
► (Do not report 35701, 35702, 357032 explore an identifier recipient artery [eg, carotid artery] when performed in conjunction with 15756, 15757, 15758, 20955, 20956, 20957, 20962, 20969, 20970, 20972, 20973, 43496, 49906)
► (35721, 35741 have been deleted)
► (To report exploration of lower extremity artery, use 35703)
► (35761 has been deleted)
Surgery – Hemic and Lymphatic Systems (38100-38999)

Revised Chapter Guidelines for 2020

• No guideline changes other than code specific usage changes.
Anus

• For incision of the thrombosed external hemorrhoid, use 46083. For ligation of internal hemorrhoid(s), see 46221, 46946, 46946. For excision of internal and/or external hemorrhoid(s), see 46250-46262, 46320. For injection of hemorrhoid(s), use 46500. For destruction of internal hemorrhoid(s) by thermal energy, use 46930. For destruction of hemorrhoid(s) by cryosurgery, use 46999. For transanal hemorrhoidal dearterialization, including ultrasound guidance, with mucopexy, when performed, use 46948. For hemorrhoidopexy, use 46947. Do no report 46600 in conjunction with 46020-46947, 0184T, during the same operative session.

Surgery – Digestive System
 Revised Chapter Guidelines for 2020

#▲46945: Hemorrhoidectomy, internal, allegation other than rubber band; single hemorrhoid column/group, without imaging guidance

#▲46946: 2 or more hemorrhoid columns/groups, without imaging guidance

► (Do not report 46221, 46945, 46946 in conjunction with 46948) ◄

► (Do not report 46945, 46946 in conjunction with 76872, 76942, 76998) ◄

#•46948: Hemorrhoidectomy, internal, by transanal hemorrhoidal dearterialization, 2 or more hemorrhoid columns/groups, including ultrasound guidance with mucopexy, when performed
• (Do not report 46948 in conjunction with 76872, 76942, 76998)

• (For transanal hemorrhoidal dearterialization, single hemorrhoid column/group, use 46999)

• **49013**: Preperitoneal pelvic packing for hemorrhage associated with pelvic trauma, including local exploration

• **49014**: Re-exploration of pelvic wound with removal of preperitoneal pelvic packing, including repacking, when performed

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**Surgery – Urinary System (50010-53899)**

Revised Chapter Guidelines for 2020

• *No guideline changes other than code specific usage changes.*

**Surgery – Male Genital System (54000-55899)**

Revised Chapter Guidelines for 2020

• *No guideline changes other than code specific usage changes.*
Surgery – Male Genital System – Code Updates

▲ 54640: Orchiopexy, inguinal approach, with or without hernia repairs scrotal approach

Surgery – Intersex Surgery (55970-55980)

This section covers sex change surgery. Only two codes exist in this section. Historically, these services are not covered by third party carriers.

Revised Chapter Guidelines for 2020

No guideline changes.

Surgery – Female Genital System (56405-58999)

This section covers procedures on the vulva, perineum and introitus, vagina, cervix uteri, corpus uteri, oviduct/ovary, and in vitro fertilization.

Revised Chapter Guidelines for 2020

No guideline changes.
Surgery – Nervous System (61000-64999)

Revised Chapter Guidelines for 2020

Injection, Drainage, or Aspiration

• Injection of contrast during fluoroscopic guidance and localization is an inclusive component of:
  – 62263, 62264, 62267, 62273, 62280, 62281, 62282, 62302, 62303, 62304, 62305, 62321, 62323, 62325, 62327, 62328, 62329.
  – Fluoroscopic guidance and localization are reported with 77003, unless a formal contrast study (myelography, epidurography, or arthrography) is performed. In which case the use of fluoroscopy is included in the supervision and interpretation codes or the myelography via lumbar injection code.
  – Image guidance and the injection of contrast are inclusive components and are required for the performance of myelography, as described by codes 62302, 62303, 62304, 62305.
Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic

Somatic Nerves
- Codes 64400-64489 describe the introduction/injection of an anesthetic agent and/or steroid into the somatic nervous system for diagnostic or therapeutic purposes.
  - For injection of destruction of genicular nerve branches, see 64454, 64624, respectively.
- Codes 64400-64450, 64454 describe the injection of an anesthetic agent(s) and/or steroid into a nerve plexus, nerve or branch. These codes are reported once per nerve plexus, nerve, or branch as described in the descriptor regardless of the number or injections performed along the nerve plexus, nerve, or branch described by the code.
- Image guidance and localization may be reported separately for 64400-64450.
- Image guidance and any injection of contrast are inclusive components of 64451 and 64454.

- Codes 64455, 64479, 64480, 64483, 64484 are reported for single or multiple injections on the same site.
  - For 64479 64480 64483 64484, image guidance (fluoroscopy or CT) and any injection of contrast are inclusive components and are not reported separately.
  - For 64455, image guidance (ultrasound, fluoroscopy, CT) and localization may be reported separately.
- Codes 64461, 64462, 64463 describe injection of a paravertebral block (PVB).
- Codes 64486, 64487, 64488, 64489 describe injection of a transversus abdominis plane (TAP) block.
- Imaging guidance and any injection of contrast are inclusive components of 64461, 64462, 64463, 64486, 64487, 64488, 64489 and or not reported separately.
Surgery – Nervous System – Code Updates

▲62270 Spinal puncture, lumbar, diagnostic;

#•62328 with fluoroscopic of CT guidance

► (Do not report 62270, 62328 in conjunction with 77003, 77012) ◄

► (If ultrasound or MRI guidance is performed, see 76942, 77021) ◄

▲62272 Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter);

#•62329 with fluoroscopic of CT guidance

► (Do not report 62272, 62329 in conjunction with 77003, 77012) ◄

► (If ultrasound or MRI guidance is performed, see 76942, 77021) ◄

▲64400 Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, any division or branch; each branch (ie, ophthalmic, maxillary, mandibular)
(64402 has been deleted. To report injection of anesthetic agent and/or steroid to the facial nerve, use 64999) ▲

64402 facial nerve

▲ 64405 greater occipital nerve

▲ 64408 vagus nerve

(64410, 64413 have been deleted. To report injection of anesthetic agent and/or steroid to the phrenic nerve, cervical plexus, used 64999) ▲

64410 phrenic nerve

64413 cervical plexus

▲ 64415 brachial plexus, single

▲ 64416 Brachial plexus, continuous infusion by catheter (including catheter placement)

▲ 64417 axillary nerve

▲ 64418 suprascapular nerve

▲ 64420 intercostal nerve, single level

▲ 64421 intercostal nerve, multiple, regional block each additional level (List separately in addition to code for primary procedure)

(Use 64421 in conjunction with 64420) ▲

▲ 64425 ilioinguinal, iliohypogastric nerves

▲ 64430 pudendal nerve

▲ 64435 paracervical (uterine) nerve

▲ 64445 sciatic nerve, single

▲ 64446 sciatic nerve, continuous infusion by catheter (including catheter placement)
▲64447 femoral nerve, single
▲64448 femoral nerve, continuous infusion by catheter (including catheter placement)
▲64449 lumbar plexus, posterior approach, continuous infusion by catheter (including catheter placement)
▲64450 other peripheral nerve or branch
► (For injection, anesthetic agent, nerves innervating the sacroiliac joint, use 64451)
►64451 nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
► (Do not report 64451 in conjunction with 64493, 64494, 64495, 77002, 77003, 77012, 95673, 95874)
► (For injection, anesthetic agent, nerves innervating the sacroiliac joint, with ultrasound, use 76999)

► (For bilateral procedure, report 64451 with modifier 50)
►64454 genicular nerve branches, including imaging guidance, when performed
► (Do not report 64454 in conjunction with 64624)
► (64454 requires injecting all of the following genicular nerve branches: suprolateral, superomedial, and inferomedial. If all 3 of these genicular nerve branches are not injected, report 64454 with modifier 52)

#64624 Destruction by neurolytic agent, genicular nerve branches including imaging guidance, when performed
► (Do not report 64624 in conjunction with 64454)
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Surgery – Eye and Ocular Adnexa

(65091-68899)

Revised Chapter Guidelines for 2020

• No guideline changes other than code specific usage changes.
Surgery – Eye and Ocular Adnexa – Code Updates

▲ 66711 cyclophotocoagulation, endoscopic, without concomitant removal of crystalline lens

► (For endoscopic cyclophotocoagulation performed at the same encounter as extracapsular cataract removal with interocular lens insertion, see 66987, 66988) ◄

▲ 66982 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration of phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage, without endoscopic cyclophotocoagulation

► (For complex extracapsular cataract removal with concomitant endoscopic cyclophotocoagulation, use 66987) ◄

#● 66987 with endoscopic cyclophotocoagulation

► (For complex extracapsular cataract removal without endoscopic cyclophotocoagulation, use 66982) ◄

► (For insertion of ocular telescope prosthesis including removal of crystalline lens, use 0308T) ◄

▲ 66984 Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration of phacoemulsification), without endoscopic cyclophotocoagulation

► (For complex extracapsular cataract removal with concomitant endoscopic cyclophotocoagulation, use 66988) ◄

#● 66988 with endoscopic cyclophotocoagulation
(For complex extracapsular cataract removal without endoscopic cyclophotocoagulation, use 66984)

(For complex extracapsular cataract removal with endoscopic cyclophotocoagulation, use 66987)

(For insertion of ocular telescope prosthesis including removal of crystalline lens, use 0308T)

Surgery – Auditory System (69000-69979)

Revised Chapter Guidelines for 2020

• No guideline changes other than code specific usage changes
Surgery – Operating Microscope
(69990)

Revised Chapter Guidelines for 2020

- The surgical microscope is employed when the surgical services are performed using the techniques of microsurgery. Code 69990 should be reported (without modifier 51 appended) in addition to the code for the primary procedure performed. Do not use 69990 for visualization with magnifying loupes or corrected vision. Do not report 69990 in addition to procedures where use of the operating microscope is an inclusive component (15756-15758, 15842, 19364, 19368, 20955-20962, 20969-20973, 22551, 22552, 22856-22861, 26551-26554, 26556, 31526, 31531, 31536, 31541, 31545, 31546, 31561, 31571, 43116, 43180, 43496, 46601, 46607, 49906, 61548, 63075-63078, 64727, 64820-64823, 64912, 64913, 65091-68850, 0184T, 0308T, 0402T, 0583T).

Radiology
Revised Chapter Guidelines for 2020
Cardiovascular System

- Myocardial perfusion (SPECT and PET) and cardiac blood pool imaging studies may be performed at rest and/or during stress. When performed during exercise and/or pharmacologic stress, the appropriate stress testing code from the 93015-93018 series may be reported in addition to 78430, 78431, 78432, 78433, 784 51-78454, 78472, 78491, 78492. PET can be performed on either a dedicated PET machine (which uses a PET source for attenuation correction) or a combination PET/CT camera (78429, 78430, 78431, 78433). A cardiac PET study performed on a PET/CT camera includes examination of the CT transmission images for review of anatomy in the field of view.
Radiology Code Updates

▲74022 Radiologic examination, abdomen; complete acute abdomen series, including 2 or more views of the abdomen (eg, supine, erect, and/or decubitus views), and a single view chest

▲74210 Radiologic examination, pharynx and or cervical esophagus, including scout neck radiograph(s) and delayed image(s), when performed, contrast barium study; pharynx and/or cervical esophagus

▲74220 Radiologic examination, esophagus, including scout chest radiographs and delayed image(s), when performed; esophagus single contrast (eg, barium) study

► (Do not report 74220 in conjunction with 74221, 74240, 74246, 74248) ◄
  ◗74221 double-contrast (eg, high-density barium and effervescent agent) study

► (Do not report 74221 in conjunction with 74220, 74240, 74246, 74248) ◄

▲74230 Swallowing Radiologic examination, swallowing function, with cineradiography videoradiography, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study

► (For otolaryngologic services fluoroscopic evaluation of swallowing function, use 92611) ◄

▲74240 Radiologic examination, upper gastrointestinal tract, including scout abdominal radiographs and delayed images(s), upper when performed; with or without delayed images single-contrast (eg, without KUB barium) study

► (Do not report 74240 in conjunction with 74220, 74221, 74246) ◄
<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>74244</td>
<td>With or without delayed images, with KUB</td>
</tr>
<tr>
<td>74245</td>
<td>With small intestine, includes multiple serial images</td>
</tr>
<tr>
<td>74246</td>
<td>With or without delayed images double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, without KUB when administered</td>
</tr>
<tr>
<td>74247</td>
<td>With or without delayed images, with KUB</td>
</tr>
</tbody>
</table>

**74248** Radiologic small intestine follow-through study, including multiple serial images (List separately in addition to code for primary procedure for upper GI radiologic examination)

| (Use 74248 in conjunction with 74240, 74246) |

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>74249</td>
<td>With small intestine follow-through</td>
</tr>
<tr>
<td>74250</td>
<td>Radiologic examination, small intestine, includes including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study</td>
</tr>
<tr>
<td>74251</td>
<td>(Do not report 74250 in conjunction with 74248, 74251)</td>
</tr>
</tbody>
</table>

| (Do not report 74250 in conjunction with 74250, 74251) |

| (74249 has been deleted. To report, see 74246, 74248) |

| (Use 74249 in conjunction with 74250, 74251) |

| (Do not report 74248 in conjunction with 74250, 74251) |

| (74249 has been deleted. To report, see 74246, 74248) |

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| (Use 74249 in conjunction with 74250, 74251) |

| (Do not report 74248 in conjunction with 74250, 74251) |

| (74249 has been deleted. To report, see 74246, 74248) |

| (Use 74249 in conjunction with 74250, 74251) |
▲74270 Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed: single contrast (e.g., barium) enema, with or without KUB study
  ▶ (Do not report 74270 in conjunction with 74280)

▲74280 air-double contrast with specific (e.g., high density barium and air) study, with or without glucagon-including glucagon, when administered
  ▶ (Do not report 78240 in conjunction with 74270)

78930 Ultrasonic guidance for pericardiocentesis, imaging supervision and interpretation

78208 Liver imaging (SPECT)
  78206 with vascular flow
  78320 tomographic (SPECT)

▲78459 Myocardial imaging, positron emission tomography (PET) metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s] when performed); single study

#•78429 with concurrently acquired computed tomography transmission scan
  ▶ (For CT coronary calcium scoring, use 75571)
  ▶ (CT performed for other than attenuation correction and anatomical localization is reported using the appropriate site specific CT code with modifier 59)

▲78491 Myocardial imaging, positron emission tomography (PET), perfusion study (including ventricular wall motion[s] and/or ejection fraction[s], when performed); single study at rest or stress (exercise or pharmacologic)
  #•78430 single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan
  ▲78492 multiple studies at rest and/or stress (exercise or pharmacologic)
  #•78431 multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan
  #•78432 Myocardial imaging, positron emission tomography (PET), combined perfusion with metabolic evaluation study (including ventricular wall motion[s] and/or ejection fraction[s], when performed), dual radiotracer myocardial viability;
**#78433** with concurrently acquired computed tomography transmission scan

- (CT performed for other than attenuation correction and anatomical localization is reported using the appropriate site-specific CT code with modifier 59)

**#78434** Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography (PET), rest and pharmacologic stress (List separately in addition to code for primary procedure)

- (Use 78434 in conjunction with 784 through 1, 78492)
- (For CT coronary calcium scoring, use 75571)
- (For myocardial imaging by planar or SPECT, see 78451, 78452, 78453, 78454)

<table>
<thead>
<tr>
<th>Procedure Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>78607</td>
<td>Brain imagine, tomographic (SPECT)</td>
</tr>
<tr>
<td>78647</td>
<td>Tomographic (SPECT)</td>
</tr>
</tbody>
</table>

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**78740** tomographic (SPECT)

**▲78800** Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed), limited planar, single area (eg, head, neck, chest, pelvis), single day imaging

- **▲78801** multiple planar, 2 or more areas (eg, abdomen and pelvis, head and chest), 1 or more days imaging or single area imaging over 2 or more days
- **▲78802** planar, whole body, single day imaging
- **▲78804** planar, whole body, requiring 2 or more days, imaging
- **▲78803** tomographic (SPECT), single area (eg, head, neck, chest, pelvis), single day imaging

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>78805</td>
<td>Radiopharmaceutical localization of inflammatory process; limited area</td>
</tr>
<tr>
<td>78806</td>
<td>Whole body</td>
</tr>
<tr>
<td>78807</td>
<td>Tomographic (SPECT)</td>
</tr>
</tbody>
</table>
#78830 tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis), single day imaging

#78831 tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days

#78832 Tomographic (SPECT) With concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day imaging, or single area imaging over 2 or more days

➤ (For cerebral spinal fluid studies that require injection procedure, see 61055, 61070, 62320, 62321, 62322, 62323) ➤

#78835 Radiopharmaceutical quantification measurement(s) single area (List separately in addition to code for primary procedure)

➤ (Use 78835 in conjunction with 78830, 78832) ➤

➤ (Report multiple units of 78835 if quantitation is more than one area or more than one day imaging) ➤

➤ (Report myocardial SPECT imaging with 78451, 78452, 78469, 78494) ➤

➤ (For all nuclear medicine codes, select the organ/system-specific code[s] first; if there is no organ system-specific code[s], see 78800, 78801, 78802, 78803, 78830, 78831, 78832) ➤

➤ (For parathyroid imaging, see 78070, 78071, 78072) ➤
Pathology and Laboratory
Revised Chapter Guidelines for 2020
Proprietary Laboratory Analyses

• Unless specifically noted, even though the Proprietary Laboratory Analyses section of the code set is located at the end of the Pathology and Laboratory section of the code set, a PLA code does not fulfill Category I code criteria. PLA codes are not required to fulfill the Category I criteria. The standards for inclusion in the PLA section are:

• The test must be commercially available in the United States for use on human specimens and
• The clinical laboratory or manufacturer that offers the test must request the code.

Proprietary Laboratory Analyses

• All PLA tests will have assigned codes in the PLA section of the code set. Any PLA coded test(s) that satisfies Category I criteria and has been accepted by the CPT Editorial Panel will be designated by the addition of the symbol to the existing PLA code and will remain in the PLA section of the code set.

• If a proprietary test has already been accepted for a Category I code and a code has not been published, subsequent application for a PLA code will take precedence. The code will only be placed in the PLA section.
Pathology and Laboratory Code Updates

● 80145 Adalimumab
# 80230 Infliximab
# 80235 Lacosamide
● 80187 Posaconazole
# 80280 Vedolizumab
# 80285 Voriconazole

# 81277 Cytogenomic neoplasia (genome-wide) microarray analysis, interrogation of genomic regions for copy number and loss-of-heterozygosity variants for chromosomal abnormalities

► (Do not report specific molecular pathology procedures separately when the specific analytes are included as part of this cytogenomic microarray analysis for neoplasia)

► (Do not report 88271 where performing cytogenomic microarray analysis)

# 81307 PALB2 (partner and localizer of BRCA2) (eg, breast and pancreatic cancer) gene analysis; full gene sequence

# 81308 known familial variant

# 81309 PIK3CA (phosphatidylinositol-4, 5-biphosphate 3-kinase, catalytic subunit alpha) (eg, colorectal and breast cancer) gene analysis, targeted sequence analysis (eg, exons 7, 9, 20)


▲ 81404 Molecular pathology procedure, level 5 (eg, analysis of 2-5 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 6-10 exons, or characterization of a dynamic mutation disorder/triplet repeat by Southern blot analysis)

PIK3CA (phosphatidylinositol-4, 5-biphosphate 3-kinase catalytic subunit alpha) (eg, colorectal cancer), targeted sequence analysis (eg, exons 9 and 20)
**UGT1A1** (UDP glucuronosyltransferase 1 family, polypeptide A1) (eg, hereditary unconjugated hyperbilirubinemia [Crigler-Najjar syndrome]) full gene sequence

▲ **81406** Molecular pathology procedure, Level 7 (eg, analysis of 11-25 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of 26-50 exons, cytogenomic microarray analysis for neoplasia)

Cytogenomic microarray analysis, neoplasia (eg, interrogation of copy number, and loss of heterozygosity via single nucleotide polymorphism (SNP)-based comparative genomic hybridization [CGH] microarray analysis)

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**PALB2** (partner and localizer of BRCA2) (eg, breast and pancreatic cancer), full gene sequence

▲ **81407** Molecular pathology procedure, Level 8 (eg, analysis of 26-50 exons by DNA sequence analysis, mutation scanning or duplication/deletion variants of >50 exons, sequence analysis of multiple genes on one platform)

**APOB** (apolipoprotein B) (eg, familial hypercholesterolemia type B) full gene sequence

# • **81522** Oncology (breast), mRNA, gene expression profiling by RT-PCR of 12 genes (8 content and 4 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as recurrence risk score

• **81452** Oncology (prostate), mRNA, microarray gene expression profiling of 2 content genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as metastasis risk score

• **81552** Oncology (uveal melanoma), mRNA, gene expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis

• **87563** Mycoplasma genitalium, amplified probe technique
Proprietary Laboratory Analyses
Code Updates

▲ 008U  Helicobacter pylori detection and antibiotic resistance, DNA, 16S and 23S rRNA, gyrA, ppx1, rdxA and rpOB, next generation sequencing, formalin-fixed paraffin-embedded or fresh tissue or fecal sample, predictive, reported as positive or negative for resistance to clarithromycin, fluoroquinolones, metronidazole, amoxicillin, tetracycline, and rifabutin

0020U  Drug test(s), presumptive, with definitive confirmation of positive results, and a number of drug classes, herein, with specimen verification including DNA authentication in comparison to buccal DNA, per date of service

0028U  CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, copy number variants, common variants with reflex to targeted sequence analysis

0057U  Oncology (solid organ neoplasia), mRNA, gene expression profiling by massively parallel sequencing for analysis of 51 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a normalized percentile rank

- 0062U  Autoimmune (systemic lupus erythematosus), IgG and IgM analysis or 80 biomarkers, utilizing serum, algorithm reported with a risk score

- 0063U  Neurology (autism), 32 amines by LC-MS/MS, using plasma, algorithm reported as metabolic signature associated with autism spectrum disorder

- 0064U  Antibody, Treponema pallidum, total and rapid plasma reagin (RPR), immunoassay, qualitative

- 0065U  Syphilis test, non-treponemal antibody, immunoassay, qualitative (RPR)

- 0066U  Placental alpha-micro globulin-1 (PAMG-1), immunoassay with direct optical observation, cervico-vaginal fluid, each specimen

- 0067U  Oncology (breast), immunohistochemistry, protein expression of profiling of 4 biomarkers (matrix metalloproteinase-1 [MMP-1], carcinoembryonic antigen-related cell adhesion molecule 6 [CEACAM6], hyaluronoglucosaminidase [HYAL1], highly expressed in cancer protein [HEC1]), formalin-fixed paraffin-embedded precancerous breast tissue, algorithm reported as carcinoma risk score

- 0068U  Candida species panel C. albicans, C. glabrata, C. parapsilosis, C. krusei, C. tropicalis, and C. auris), amplified probe technique with qualitative report of the presence or absence of each species
<table>
<thead>
<tr>
<th></th>
<th>Oncology (colorectal), microRNA, RT-PCR expression profiling of miR-31-3p, formalin-fixed paraffin-embedded tissue, algorithm reported as an expression score</th>
</tr>
</thead>
<tbody>
<tr>
<td>0070U</td>
<td>CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, full gene sequence (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>0071U</td>
<td>(Use 0071U in conjunction with 0070U)</td>
</tr>
<tr>
<td>0072U</td>
<td>CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, CYP2D6-2D7 hybrid gene) (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>0073U</td>
<td>(Use 0073U in conjunction with 0070U)</td>
</tr>
<tr>
<td>0074U</td>
<td>CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, non-duplicated gene when duplication/multiplication is trans) (List separately in addition to code for primary procedure)</td>
</tr>
<tr>
<td>0075U</td>
<td>(Use 0075U in conjunction with 0070U)</td>
</tr>
</tbody>
</table>
**0076U** CYP2D6 (cytochrome P450, family 2, subfamily D, polypeptide 6) (eg, drug metabolism) gene analysis, targeted sequence analysis (ie, 3' gene duplication/multiplication) (List separately in addition to code for primary procedure)

- (Use 0076U in conjunction with 0070U)

**0077U** Immunoglobulin paraprotein (m-protein), qualitative, immunoprecipitation and mass spectrometry, blood or urine, including isotype

**0078U** Pain management (opioid-use disorder) genotyping panel, 12 common variants (ie, ABCB1, COMT, D 81, DBH, DOR, DRD1, DRD2, DRT4, GABA, GAL, HTR2A, HTLPR, MTHFR, MU0R, OPR K1, OP RM-1), buccal swab or other germline tissue sample, algorithm reported as positive or negative risk of opioid-use disorder

**0079U** Comparative DNA analysis using multiple selected single-nucleotide polymorphisms (SNPs), urine and buccal DNA, for specimen identity verification

**0080U** Oncology (lung) mass spectrometric analysis of galectin-2-binding protein and scavenger receptor cysteine-rich type 1 protein M120, with five clinical risk factors (age, smoking status, nodule diameter, nodule-spiculation status and nodule location), utilizing plasma, algorithm reported as categorical probability of malignancy

- (0081U has been deleted. To report, use 81552)

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**0081U** Oncology (uveal melanoma), mRNA, gene expression profiling by real-time RT-PCR of 15 genes (12 content and 3 housekeeping genes), utilizing fine needle aspirate or formalin-fixed paraffin-embedded tissue, algorithm reported as risk of metastasis

**0082U** Drug test(s), definitive, 90 or more drugs or substances, definitive chromatography with mass spectrometry, and presumptive, any number of drug classes, by instrument chemistry analyzer (utilizing immunoassay), urine, report of presence or absence of each drug, drug metabolite or substance with description and severity of significant interactions per date of service

**0083U** Oncology, response to chemotherapy drugs using motility contrast demography, fresh or frozen tissue, reported as likelihood of sensitivity or resistance to drugs or drug combinations

**0084U** Red blood cell antigen typing, DNA, genotyping of 10 blood groups with phenotype prediction of 37 red blood cell antigens

**0085U** Cytotoxic distending toxin B (CdtB) and vinculin 1gG antibodies by immunoassay (ie, ELISA)
● 0086U Infectious disease (bacterial and fungal, organism identification, blood culture, using rRNA FISH, 6 or more organism targets, reported as positive or negative with phenotypic minimum inhibitory concentration (MIC)-based antimicrobial susceptibility

● 0087U Cardiology (heart transplant), mRNA gene expression profiling by microarray of 1283 genes, transplant biopsy tissue, allograft rejection and injury algorithm reported as a probability score

● 0088U Transplantation of medicine (kidney allograft rejection), microarray gene expression profiling of 1494 genes, utilizing transplant biopsy tissue, algorithm reported as a probability score for rejection

● 0089U Oncology (melanoma), gene expression profiling by RTqPCR, PRAME and LINCO00518, superficial collection using adhesive patch(es)

● 0090U Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 23 genes (12 content and 9 housekeeping), utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as a categorical result (ie, benign, indeterminate, malignant)

● 0091U Oncology (colorectal) screening, cell enumeration of circulating tumor cells, utilizing whole blood, algorithm, for the presence of adenoma or cancer, reported as a positive or negative result

● 0092U Oncology (lung), three protein biomarkers, immunoassay using magnetic nanosensor technology, plasma, algorithm reported as risk or for likelihood of malignancy

● 0093U Prescription drug monitoring, evaluation of 85 common drugs by LC-MS/MS, urine, each drug reported detected or not detected

● 0094U Genome (eg, unexplained constitutional or heritable disorder or syndrome), rapid sequence analysis

● 0095U Inflammation (eosinophilic esophagitis), ELISA analysis or eotaxin-3 (CCL26 [C-C motif chemokine ligand 26]) and major basic protein (PRG2 [proteoglycan 2, pro eosinophil major basic protein]), specimen obtained by swallowed nylon string, algorithm reported is predicted probability index for active eosinophilic esophagitis

● 0096U Human papillomavirus (HPV), high-risk types (ie, 16, 18, 31, 33, 35, 39, 45, 51, 52, 56, 58, 59, 66, 68) male urine
0097U Gastrointestinal pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 22 targets (Campylobacter [C. jejuni/C. coli/C. upsaliensis], Clostridium difficile [C. difficile] toxin A/B, Plesiomonas shigelloides, Salmonella, Vibrio [V. parahaemolyticus/V. V. vulnificus/V. cholerae], including specific identification of Vibrio cholerae, Yersinia enterocolitica, Enteraggregative Escherichia coli [EAEC], Enteropathogenic Escherichia coli [EPEC], Enterotoxigenic Escherichia coli [ETEC] It/st, Shigella-like toxin-producing Escherichia coli [STEC] stx1/stx2 [including specific identification of the E. coli 0157 serogroup within STEC], Shigella/Enteroinvasive Escherichia coli [EIEC], Cryptosporidium, Cyclospora cayetanensis, Entamoeba histolytica, Giardia lamblia [also known as G. intestinalis and G. duodenalis], adenovirus F 40/41, astrovirus, norovirus GI/II, rotavirus A, sapovirus [Genogroups I, II, IV, and V])

0098U Respiratory pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 14 targets (adenovirus, coronavirus, human metapneumovirus, influenza A, influenza A subtype H1, influenza A subtype H3, influenza A subtype H1-2009, influenza B, parainfluenza virus, human rhinovirus/enterovirus, respiratory syncytial virus, Bordetella pertussis, Chlamydia pneumoniae, Mycoplasma pneumoniae)

0099U Respiratory pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 20 targets (adenovirus, coronavirus 229E, coronavirus HKU1, coronavirus, coronavirus OC43, human metapneumovirus, influenza A, influenza A subtype, influenza A subtype H3, influenza A subtype H1-2009, influenza, parainfluenza virus, parainfluenza virus 3, parainfluenza virus 4, human rhinovirus/enterovirus, respiratory syncytial virus, Bordetella pertussis, Chlamydia pneumoniae, Mycoplasma pneumoniae)

0100U Respiratory pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 21 targets (adenovirus, coronavirus 229E, coronavirus HKU1, coronavirus NL63, coronavirus OC43, human metapneumovirus, human rhinovirus/enterovirus, influenza A, including subtypes H1, H1-2009, and H3, influenza B, parainfluenza virus 1, parainfluenza virus 2, parainfluenza virus 3, parainfluenza virus 4, respiratory syncytial virus, Bordetella parapertussis (BS1001), Bordetella pertussis [ptxP], Chlamydia pneumoniae, Mycoplasma pneumoniae)

0101U Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome, Cowden syndrome, familial adenomatosis polyposis), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (15 genes [sequencing and deletion/duplication], EPCAM and GREM1 [deletion/duplication only])
**0102U** Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (17 genes [sequencing and deletion/duplication])

**0103U** Hereditary ovarian cancer (e.g., hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (24 genes [sequencing and deletion/duplication], *EPCAM* [deletion/duplication only])

► (0104U has been deleted) ◄

**0104U** Hereditary pancreas cancer (e.g., hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), genomic sequence analysis panel utilizing a combination of NGS, Sanger, MLPA, and array CGH, with mRNA analytics to resolve variants of unknown significance when indicated (32 genes [sequencing and deletion/duplication], *EPCAM* and *GREM1* [deletion/duplication]) only

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**0105U** Nephrology (chronic kidney disease), multiplex electrochemiluminescence immunoassay (ECLIA) of tumor necrosis factor receptor 1A, receptor superfamily 2 (TNFR1, TNFR2), and kidney injury molecule-1 (KIM-1) combined with longitudinal clinical data, including *APOL1* genotype if available, and plasma (isolated fresh or frozen), algorithm reported as probability score for rapid kidney function decline (RKFD)

**0106U** Gastric emptying, serial collection of 7 timed breath specimens, non-radioisotope carbon-13 (13C) spirulina substrate, analysis of each specimen by gas isotope ratio mass spectrometry, reported as rate of 13CO2 excretion

**0107U** Clostridium difficile toxin(s) antigen detection by immunoassay technique, stool, qualitative, multiple-step method

**0108U** Gastroenterology (Barrett's esophagus), whole slide-digital imaging, including morphometric analysis, computer-assisted quantitative immunolabeling of 9 protein biomarkers (p16, AMACR, p53, CD68, COX-2, CD45RO, HIF1α, HER-2, K20) and morphology, formalin-fixed paraffin-embedded tissue, algorithm reported as risk of progression to high-grade dysplasia or cancer

**0109U** Infectious disease (Aspergillus species), real-time PCR for detection of DNA from 4 species (*A. fumigatus, A. terreus, A. niger, and A. flavus*), blood, lavage fluid, or tissue, qualitative reporting of presence or absence of each species
0110U Prescription drug monitoring, one or more oral oncology drug(s) and substances, definitive tandem mass spectrometry with chromatography, serum or plasma from capillary blood or venous blood, quantitative report with steady-state range for the prescribed drug(s) when detected

0111U Oncology (colon cancer), targeted KRAS (codons 12, 13, and 61) and NRAS (codons 12, 13, and 61) gene analysis, utilizing formalin-fixed paraffin-embedded tissue

0112U Infectious agent detection and identification targeted sequence analysis (16S and 18S rRNA genes) with drug-resistance gene

0113U Oncology (prostate), measurement of PCA3 and TMPRSS2-ERG in urine and PSA in serum following prostatic massage, by RNA amplification and fluorescence-based detection, algorithm reported as risk score

0114U Gastroenterology (Barrett's esophagus), VIM and CCNA1 methylation analysis, esophageal cells, algorithm reported as likelihood for Barrett's esophagus

0115U Respiratory infectious agent detection by nucleic acid (DNA and RNA), 18 viral types and subtypes and 2 bacterial targets, amplified probe technique, including multiplex reverse transcription for RNA targets, each analyte reported as detected or not detected

0116U Prescription drug monitoring, enzyme immunoassay of 35 or more drugs confirmed with LC-MS/MS, oral fluid, algorithm results reported as a patient-compliance measurement with risk of drug to drug interactions for prescribed medications

0117U Pain management. analysis of 11 endogenous analytes (methylmalonic acid, xanthurenic acid, homocysteine, pyroglutamic acid, vanilmandelate, 5-hydroxyindoleacetic acid, hydroxymethylglutarate, ethylmalonate, 3-hydroxypropyl mercapturic acid (3-HPMA), quinolinic acid, kynurenic acid), LC-MS/MS, urine, algorithm reported as a pain-index score with likelihood of atypical biochemical function associated with pain

0118U Transplantation medicine, quantification of donor-derived cell-free DNA using whole genome next-generation sequencing, plasma, reported as percentage of donor-derived cell-free DNA in the total cell-free DNA

0119U Cardiology, ceramides by liquid chromatography-tandem mass spectrometry, plasma, quantitative report with risk score for major cardiovascular events

0120U Oncology (B-cell lymphoma classification), mRNA, gene expression profiling by fluorescent probe hybridization of 58 genes (45 content and 13 housekeeping genes), formalin-fixed paraffin-embedded tissue, algorithm reported as likelihood for primary mediastinal B-cell lymphoma (PMBCL) and diffuse large B-cell lymphoma (DLBCL) with cell of origin subtyping in the latter
• 0121U Sickle cell disease, microfluidic flow adhesion (VCAM-1), whole blood

• 0122U Sickle cell disease, microfluidic flow adhesion (P-Selectin), whole blood

• 0123U Mechanical fragility, RBC, shear stress and spectral analysis profiling

• 0124U Fetal congenital abnormalities, biochemical assays of 3 analytes (free beta-hCG, PAPP-A, AFP), time-resolved fluorescence immunoassay, maternal dried-blood spot, algorithm reported as risk scores for fetal trisomies 13/18 and 21

• 0125U Fetal congenital abnormalities and perinatal complications, biochemical assays of 5 analytes (free beta-hCG, PAPP-A, AFP, placental growth factor, and inhibit-A), time-resolved fluorescence immunoassay, maternal serum, algorithm reported as risk scores for fetal trisomies 13/18, 21, and preeclampsia

• 0126U Fetal congenital abnormalities and perinatal complications, biochemical assays of 5 analytes (free beta-hCG, PAPP-A, AFP, placental growth factor, and inhibit-A), time-resolved fluorescence immunoassay, includes qualitative assessment of Y chromosome in cell-free fetal DNA, maternal serum and plasma, predictive algorithm reported as risk scores for fetal trisomies 3/18, 21, and preeclampsia

• 0127U Obstetrics (preeclampsia), biochemical assays of 3 analytes (PAPP-A, AFP, and placental growth factor), time-resolved fluorescence immunoassay, maternal serum, predictive algorithm reported as a risk score for preeclampsia

• 0128U Obstetrics (preeclampsia), biochemical assays of 3 analytes (PAPP-A, AFP, and placental growth factor), time-resolved fluorescence immunoassay, includes qualitative assessment of Y chromosome in cell-free fetal DNA, maternal serum and plasma, predictive algorithm reported as a risk score for preeclampsia

• 0129U Hereditary breast cancer-related disorders (eg, hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), genomic sequence analysis and deletion/duplication analysis panel (ATM, BRCA1, BRCA2, CDH1, CHEK2, PALB2, PTEN, and TP53)

• 0130U Hereditary colon cancer disorders (eg, Lynch syndrome, PTEN hamartoma syndrome. Cowden syndrome, familial adenomatosis polyposis), targeted mRNA sequence analysis panel (APC, CDH1, CHEK2, MLH1, MSH2, MSH6, MUTYH, PMS2, PTEN, and TP53) (List separately in addition to code for primary procedure)

  ➤ (Use 0130U in conjunction with 81435, 0101U) ➤
0131U Hereditary breast cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (13 genes) (List separately in addition to code for primary procedure)

► (Use 0131U in conjunction with 81162, 81432, 0102U) ◄

0132U Hereditary ovarian cancer-related disorders (e.g., hereditary breast cancer, hereditary ovarian cancer, hereditary endometrial cancer), targeted mRNA sequence analysis panel (17 genes) (List separately in addition to code for primary procedure)

► (Use 0132U in conjunction with 81162, 81432, 0103U) ◄

0133U Hereditary prostate cancer-related disorders, targeted mRNA sequence analysis panel (11 genes) (List separately in addition to code for primary procedure)

► (Use 0133U in conjunction with 81162) ◄

0134U Hereditary pan cancer (e.g., hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (18 genes) (List separately in addition to code for primary procedure)

► (Use 0134U in conjunction with 81162, 81432, 81435) ◄

0135U Hereditary gynecological cancer (e.g., hereditary breast and ovarian cancer, hereditary endometrial cancer, hereditary colorectal cancer), targeted mRNA sequence analysis panel (12 genes) (List separately in addition to code for primary procedure)

► (Use 0135U in conjunction with 81162) ◄

0136U *ATM (ataxia telangiectasia mutated)* (e.g., ataxia telangiectasia) mRNA sequence analysis (List separately in addition to code for primary procedure)

► (Use 0136U in conjunction with 81408) ◄
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, 93279-93278** 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.**
  - **Codes 93297, 93298** are reported no more than once up to every 30 days, per patient.
  - **Do not report 93297, 93298 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 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.

• Do not report 93268-93272 when performing 93260, 93261, 93279-93289, 93291-93296, or 93298. Do not report 93040, 93041, 93042 when performing 93260, 93261, 93279-93289, 93291-93296, or 93298.

Intracardiac Electrophysiological Procedures/Studies

• Modifier 51 should not be appended to 93600-93603, 93610,93612,93615-93618.

Home and Outpatient International Normalized Ratio (INR) Monitoring Services

• Do not report 93792, 93793 in conjunction with 98966, 98967, 98968, 99421, 99423, 99441, 99442, 99443, when telephone or online digital evaluation and management services address home and outpatient INR monitoring.
Extremity Arterial-Venous Studies
- A complete extremity duplex scan (93985, 93986) includes evaluation of both arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access.
  - If only an arterial extremity duplex scan is performed, see 93925, 93926, 93930, 93931.
  - If only a venous extremity duplex scan is performed, see 93970, 93971.
  - If a physiologic arterial evaluation of extremities is performed, see 93922, 93923, 93924.

Pulmonary Diagnostic Testing and Therapies
- Measurement of lung volumes may be performed using plethysmography, helium dilution or nitrogen washout. Plethysmography (94726) is utilized to determine total lung capacity, residual volume, functional residual capacity, and airway resistance.
- Nitrogen washout or helium dilution (94727) may be used to measure lung volumes, distribution of ventilation and closing volume.
- Oscillometry (94728) assesses airway resistance and may be reported in addition to gas dilution techniques.
- Spirometry (94010, 94060) and bronchial provocation (94070) are not included in 94726 and 94727 and may be reported separately.

Neurology and Neuromuscular Procedures
- The electroencephalogram (EEG), video electroencephalogram (VEEG), autonomic function, evoked potential, reflex tests, electromyography (EMG), nerve conduction velocity (NCV), and magnetoencephalography (MEG) services (95700-95726, 95812-95829, and 95860-95967) include recording, interpretation and report by a physician or other qualified health care professional.
  - For interpretation only, use modifier 26 with 95812-95829, 95860-95967.
  - For interpretation only for long-term EEG services, report 95717, 95718, 95719, 95720, 95721, 95722, 95723, 95724, 95725, 95726.
- Codes 95700-95726 and 95812-95822 use EEG/VEEG recording time as a basis for code use.
  - Recording time is when the recording is underway and diagnostic EEG data is being collected.
  - Recording time excludes set up and take down time.
  - If diagnostic EEG recording is disrupted, recording time stops until diagnostic EEG recording is resumed.
- Codes 95961-95962 use physician or other qualified health care professional attendance time as a basis for code use.
Special EEG Tests

- Codes 95961 and 95962 use physician or other qualified health care professional time as a basis for unit of service.
  - Report 95961 for the first hour of attendance.
  - Use modifier 52 with 95961 for 30 minutes or less.
  - Report 95962 for each additional hour of attendance.
  - Codes 95961, 95962 may be reported with 95700-95726 when functional cortical or subcortical mapping is performed with long-term EEG monitoring.

- Codes 95700-95726 describe long-term continuous recording services for electroencephalography (EEG), which are performed to differentiate seizures from other abnormalities, determine type or location of seizures, monitor treatment of seizures and status epilepticus, establish if the patient is a candidate for epilepsy surgery, and/or screen for adverse change in critically ill patients.

- The set of codes that describe long-term continuous recording EEG services (95700-95726) is divided into two major groups:
  - (1) technical services, and (2) professional services.
  - Codes 95700-95726 may be reported for any site of services.
  - The technical component of the services is reported with 95717, 95718, 95719, 95720, 95721, 95722, 95723, 95724, 95725, 95726.
  - Diagnostic EEG recording time of less than 2 hours (ie, 1 minute, up to 1 hour and 59 minutes) is not reported separately as a long-term EEG service.

- Long-term continuous recording EEG services (95700-95726) are different than routine EEGs (95812, 95813, 95816, 95819, 95822).
  - Routine EEGs capture brainwave activity within a short duration of testing, defined as less than 2 hours.
  - Long-term continuous recording EEGs capture brain-wave activity for durations of time equal to or greater than 2 hours. The length of recording is based on a number of factors, including the clinical indication for the rest and the frequency of seizures.
  - Use of automated spike and seizure detection and trending software is included in 95700-95726, when performed.
  - Do not report 95957 for use of automated software.
Definitions

- **EEG technologist**: An individual who is qualified by education, training, licensure/certification/regulation (when applicable) in seizure recognition.
- An EEG technologist(s) performs EEG setup, takedown when performed, patient education, technical description, maintenance, and seizure recognition when within his or her scope of practice and as allowed by law, regulation, and facility policy (when applicable).
- **Intermittent monitoring (remote or on-site)**: Requires an EEG technologist(s) to perform and document real-time review of data at least every 2 hours during the entire recording period to assure the integrity and quality of the recording (ie, EEG, VEEG), identify the need for maintenance, and, when necessary, notify the physician or other qualified health care professional of clinical issues. For intermittent monitoring, a single EEG technologist may monitor a maximum of 12 patients concurrently. If the number of intermittently monitored patients exceeds 12, then all of the studies are reported as unmonitored.

- **Continuous real-time monitoring (may be provided remotely)**: Requires all elements of intermittent monitoring. In addition, the EEG technologist(s) performs and documents real-time concurrent monitoring of the EEG data and video (when performed) during the entire recording period. The EEG technologist(s) identifies when events occur and notifies, as instructed, the physician or other qualified health care professional. For continuous monitoring, a single EEG technologist may monitor a maximum of four patients concurrently. If the number of concurrently monitored patients exceeds four, then all of the studies are reported as either unmonitored or intermittent studies. If there is a break in the real-time monitoring of the EEG recording, the study is an intermittent study.
- **Technical description:** The EEG technologist(s)'s written documentation of the reviewed EEG/VEEG data, including technical interventions. The technical description is based on the EEG technologist(s)'s review of data and includes the following required elements: uploading and/or transferring EEG/VEEG data from EEG equipment to a server or storage device; reviewing raw EEG/VEEG data and events and automated detection, as well as patient activations; and annotating, editing, and archiving EEG/VEEG data for review by the physician or other qualified health care professional. For unmonitored services, the EEG technologist(s) annotates the recording for review by the physician or other qualified health care professional and creates a single summary.

- **Maintenance of long-term EEG equipment:** Performed by the EEG technologist(s) and involves ensuring the integrity and quality of the recording(s) (eg, camera position, electrode placement, and impedances).

- **Setup:** Performed in person by the EEG technologist(s) and includes preparing supplies and equipment and securing electrodes using the 10/20 system. Code 95700 is reported only once per recording period on the date the setup was performed. "In person" means that the EEG technologist(s) must be physically present with the patient.
Technical Component Services

- Code 95700 describes any long-term continuous EEG/VEEG recording, setup, takedown when performed, and patient/caregiver education by the EEG technologist(s).
- To report 95700, the setup must include a minimum of eight channels of EEG. Services with fewer than eight channels may be reported using 95999. Eight to 15 channels are typically used for neonates and when electrodes cannot be placed on certain regions of the scalp chat are sterile. Twenty or more channels are typically used for children and adults. If setup is performed by someone who does not meet the definition of an EEG technologist(s), report 95999.

- Codes 95705-95716 describe monitoring, maintenance, review of data, and creating a summary technical description. These codes are divided into four groups based on duration and whether video is utilized. Key elements in determining the appropriate technical code (95705-95716) for long-term EEG continuous recording are: (1) whether diagnostic video recording is captured in conjunction and simultaneously with the EEG service, which is referred to as video EEG (VEEG), and (2) technologist monitored, or continuously monitored. Codes 95711, 95712, 95713, 95714, 95715, 95716 are reported if diagnostic video of the patient is recorded minimum of 80% of the time of the entire long-term VEEG service, concurrent with diagnostic EEG recording (ie, the entire study is reported as an EEG without video if concurrent diagnostic video occurs less than 80% of the entire study). Diagnostic EEG recording is an essential component of all long-term EEG services. If diagnostic EEG recording stops, timing stops until the diagnostic EEG is resumed.
Codes 95705-95706, 95707, 95711, 95712, 95713 are reported when total diagnostic recording time is between 2 and 12 hours, or to capture the final increment of a multiple-day service when the final increment extends 2 to 12 hours beyond the time reported by the appropriate greater-than-12-hour-up-to-26-hour code(s) (95708, 95709, 95710, 95714, 95715, 95716). A maximum of one 2-12 hour codes may be reported for an entire long-term EEG service. For example, if the testing lasts 48 hours, but diagnostic recording occurs only in the initial 11 hours and the final 11 hours of the testing period, a single greater-than-12-hour-up-to-16-hour technical code is reported, rather than two 2-12 hour codes for the 48-hour service (see the Long-Term EEG Monitoring Table).

Professional Component Services

Codes 95717, 95718, 95719, 95720, 95721, 95722, 95723, 95724, 95725, 95726, describe the professional services performed by a physician or other qualified health care professional for reviewing, analyzing, interpreting, and reporting the results of the continuous recording EEG/VEEG with recommendations based on the findings of the studies. These codes do not include E/M service, which may be reported separately.

Codes 95719, 95720 are used for greater than 12 hours (ie, 12 hours and 1 minute) up to 26 hours of recording. Code selection for professional interpretation for long-term EEG is based on: (1) length of the recording being interpreted, and (2) when the physician or other qualified health care professional reports are generated (ie, whether diagnostic interpretation and reports are made daily during the study, or whether the entire professional interpretation is performed after the entire study is completed). Codes 95717, 95718, 95719, 95720 are reported when (1) daily professional reports are generated during the long-term recording, even if the entire study extends over multiple days or (2) the time of recording for the entire study is between 2 hours and 36 hours.
• Codes 95717, 95718 are reported once for each 2-12 hour recording and reported a maximum of once for an entire long-term EEG services. Codes 95719, 95720 are reported once for each greater-than-12-hours-up-to-26h-hours recording period. Studies lasting 26-36 hours or longer are reported using building blocks and reported using on or more of the greater-than-12-hours-up-to-26-hour code with one 2-12-hour code. The recorded data are reviewed, interpreted, and reported daily by the physician or other qualified health care professional, and summary reports are made for the entire multiple-day study. The summary reports are included in each code (95717 95718 95719 95720 95721 95722 95723 95724 95725 95726) and not reported separately (see the Long-Term EEG Monitoring Table).

• For 95721, 95722, 95723, 95724, 95725, 95726, the entire professional interpretation (including retrospective daily reports and a summary report) is made after the entire study is recorded and downloaded at the completion of the study. When the entire professional interpretation is provided for a multiple-day study that is greater than 36 hours, 95721, 95722, 95723, 95724, 95725, 95726 are used to report the entire professional service with the appropriate code determined by the span of diagnostic recording time, as defined by the codes. A single code (95721, 95722, 95723, 95724, 95725, 95726) is reported for the multiple-day study. For example, a long-Term EEG recording that spans three days with a total of 50 hours of VEEG recording would be reported with 95722. Sixty hours and one minute of diagnostic VEEG recording is reported with 95724 (see the long-Term EEG Monitoring Table).

<table>
<thead>
<tr>
<th>Duration of Long-Term EEG/VEEG Recording</th>
<th>Professional Services</th>
<th>Technical Services</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>With report each 24 hours</td>
<td>With report at conclusion of entire recording period</td>
</tr>
<tr>
<td>Less than 120 minutes (w/ video or w/o video)</td>
<td>Not reported separately</td>
<td>See 95812/58813</td>
</tr>
<tr>
<td>2 to 12 hours (w/o video)</td>
<td>95717 x 1</td>
<td>95705 x 1</td>
</tr>
<tr>
<td>2 to 12 hours (w/ video)</td>
<td>95718 x 1</td>
<td>95711 x 1</td>
</tr>
<tr>
<td>12 hours and 1 minute to 26 hours (w/o video)</td>
<td>95719 x 1</td>
<td>95708 x 1</td>
</tr>
<tr>
<td>12 hours and 1 minute to 26 hours (w/ video)</td>
<td>95720 x 1</td>
<td>95714 x 1</td>
</tr>
<tr>
<td>24 hours and 1 minute to 36 hours (w/o video)</td>
<td>95719 x 1 and 95717 x 1</td>
<td>95708 x 1 and 95705 x 1</td>
</tr>
<tr>
<td>24 hours and 1 minute to 36 hours (w/ video)</td>
<td>95720 x 1 and 95718 x 1</td>
<td>95714 x 1 and 95711 x 1</td>
</tr>
<tr>
<td>36 hours and 1 minute to 50 hours (w/o video)</td>
<td>95719 x 2</td>
<td>95721 x 1</td>
</tr>
<tr>
<td>36 hours and 1 minute to 50 hours (w/ video)</td>
<td>95720 x 2</td>
<td>95722 x 1</td>
</tr>
<tr>
<td>50 hours and 1 minute to 60 hours (w/o video)</td>
<td>95719 x 2 and 95717 x 1</td>
<td>95721 x 1</td>
</tr>
<tr>
<td>50 hours and 1 minute to 60 hours (w/ video)</td>
<td>95720 x 2 and 95718 x 1</td>
<td>95714 x 2 and 95711 x 1</td>
</tr>
</tbody>
</table>
Health Behavior Assessment and Intervention

- Health behavior assessment and intervention services are used to identify and address the psychological, behavioral, emotional, cognitive, and interpersonal factors important to the assessment, treatment, or management of physical health problems.
- The patient's primary diagnosis is physical in nature and the focus of the assessment and intervention is on factors complicating medical conditions and treatments. These codes describe assessments and interventions to improve the patient's health and well-being utilizing psychological and/or psychosocial interventions designed to ameliorate specific disease-related problems.
- **Health behavior assessment:** includes evaluation of the patient's responses to disease, illness or injury, outlook, coping strategies, motivation, and adherence to medical treatment. Assessment is conducted through health-focused clinical interviews, observation, and clinical decision making.
• **Health behavior intervention**: includes promotion of functional improvement, minimizing psychological and/or psychosocial barriers to recovery, and management of and improved coping with medical conditions. These services emphasize active patient/family engagement and involvement. These interventions may be provided individually, to a group (two or more patients), and/or to the family, with or without the patient present.

• Codes 96156, 96158, 96159, 96164, 96165, 96168, 96170, 96171 describe services offered to patients who present with primary physical illnesses, diagnoses, or symptoms and may benefit from assessments and interventions that focus on the psychological and/or psychosocial factors related to the patient's health status. These services do not represent preventive medicine counseling and risk factor reduction interventions.

• For patients that require psychiatric services (90785-90899), adaptive behavior services (97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T) as well as health behavior assessment and intervention (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171), report the predominant service performed. Do not report 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171 in conjunction with 90785-90899 on the same date.

• 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 behavior assessment and intervention codes 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171 by the same provider.

• Health behavior assessment and intervention services (96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171) can occur and be reported on the same date of service as evaluation and management services (including counseling risk factor reduction and behavior change intervention [99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 994121]), as long as the health behavior assessment and intervention service is reported by a physician or other qualified health care professional and the evaluation and management service is performed by a physician or other qualified health care professional who may report evaluation and management services.

• Do not report 96158, 96164, 96167, 96170 for less than 16 minutes of service.
Acupuncture

• For needle insertion(s) without injection(s) (eg, dry needling, trigger point acupuncture), see 20560, 20561.

Non-Face-to-Face Nonphysician Services
Telephone Services

• Telephone services are non-face-to-face assessment and management services provided by a qualified health care professional to a patient using the telephone. These codes are used to report episodes of care by the qualified health care professional initiated by an established patient or guardian of an established patient. If the telephone service ends with a decision to see that patient within 24 hours or the next available urgent visit appointment, the code is not reported; rather the encounter is considered part of the preservice work of the subsequent assessment and management service, procedure, and visit. Likewise, if the telephone call refers to a service performed and reported by the qualified health care professional within the previous seven days (either qualified health care professional requested or unsolicited patient follow-up) or within the postoperative period of the previously completed procedure, then the service(s) are considered part of that previous service or procedure. (Do not report 98966-98968 if reporting 98966-98968 performed in the previous seven days).
Qualified Nonphysician Health Care Professional
Online Digital Evaluation and Management Service

• Qualified nonphysician health care professional online digital evaluation and management (E/M) services are patient-initiated digital services with qualified nonphysician health care professionals that require qualified nonphysician health care professional patient evaluation and decision making to generate an assessment and subsequent management of the patient. These services are not for the non-evaluative electronic communication of test results, scheduling appointments or other communication that does not included E/M. While the patient’s problem may be new to the qualified nonphysician health care professional, the patient is an established patient. Patients initiate these services through Health Insurance Portability and Accountability Act (HIPAA)-complaint, secure platforms, such as through the electronic health record (EHR) portal, email, or other digital applications, which allow digital communication with the qualified nonphysician health care professional.

Qualified nonphysician health care professional online digital E/M services are reported once for the qualified nonphysician health care professional’s cumulative time devoted to the service during a seven-day period. The seven-day period begins with the qualified nonphysician health care professional’s initial, personal review of the patient-generated inquiry. Qualified nonphysician health care professional cumulative service time includes review of the initial inquiry, review of patient records or data pertinent to assessment of the patient’s problem, personal qualified nonphysician health care professional interaction with clinical staff focused on the patient’s problem, development of management plans, including qualified nonphysician health care professional generation of prescriptions or ordering of tests, and subsequent communication with the patient through online, telephone, email, or other digitally supported communication. All qualified nonphysician health care professionals in the same group practice who are involved in the online digital E/M service contribute to the cumulative services time devoted to the patient’s online digital E/M service. Qualified nonphysician health care professional online digital E/M services require visit documentation and permanent storage (electronic or hard copy) of the encounter.
• If the patient generates the initial online digital inquiry within seven days of a previous treatment or E/M service and both services relate to the same problem, or the online digital inquiry occurs within the postoperative period of a previously completed procedure, then the qualified nonphysician health care professional’s online digital E/M service may not be reported separately. If the patient generates an initial online digital inquiry for a new problem within seven days of a previous service that addressed a different problem, then the qualified nonphysician health care professional online digital E/M service is reported separately. If a separately reported evaluation service occurs within seven days of the qualified nonphysician health care professional’s initial review of the online digital E/M service, 98970, 98971, 98972 are not reported. If the patient presents a new, unrelated problem during the seven-day period of an online digital E/M service, then the qualified nonphysician health care professional’s time spent on the evaluation and management of the additional problem is added to the cumulative service time of the online digital E/M service for that seven-day period.

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**Medicine Code Updates**

- **90688** Influenza virus vaccine, quadrivalent (allIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use

- **90734** Meningococcal conjugate vaccine, serogroups A, C, W, Y—and—W-135, quadrivalent (MCV4, quadrivalent, diptheria toxoid carrier (MenACWY-D) or MenACWY), CRM197 carrier (MenACWY-CRM), for intramuscular use

- **90619** Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use

- **90911** Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry

- **90912** Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minute of one-on-one physician or other qualified health care professional contact with the patient
90913 each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)

► (Use 90913 in conjunction with 90912) ◄

92201 Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (eg, for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral

92202 with drawing of optic nerve or macula (eg, for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral

92225 Ophthalmoscopy, extended, with retinal drawing (eg, for retinal detachment, melanoma), with interpretation and report, initial

92226 subsequent

92548 Computerized dynamic posturography/sensory organization test (CDP-SOT), 6 conditions (ie, eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report

92549 with motor control test (MCT) and adaptation test (ADT)

► (Do not report 92548, 92549 in conjunction with 92270) ◄

92626 Evaluation of auditory rehabilitation function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour

►► 92627 each additional 15 minutes (List separately in addition to code for primary procedure)

► (Do not report 92626, 92627 in conjunction with 92590, 92591, 92592, 92593, 92594, 92595 for hearing aid evaluation, fitting, follow-up, or selection) ◄

93299 implantable cardiovascular physiologic monitor system or subcutaneous cardiac rhythm monitor system, remote data acquisition (s), receipt of transmissions and technician review, technical support and distribution of results
#93356 Myocardial strain imaging using speckle tracking-derived assessment of myocardial mechanics (List separately in addition to codes for echocardiography imaging)

- (Use 93356 in conjunction with 93303, 93304, 93306, 93307, 93308, 93350, 93351)
- (Report 93356 once per session)

#93784 Ambulatory blood pressure monitoring, utilizing a system such as magnetic tape and/or computer disk, report-generating software, automated, worn continuously for 24 hours or longer; including recording, scanning analysis, interpretation and report

- #93786 recording only
- #93788 scanning analysis with report
- #93790 review with interpretation and report

- (For self-measured blood pressure monitoring, see 99473, 99474)

- #93985 Duplex scan of arterial inflow and venous outflow for preoperative vessel assessment prior to creation of hemodialysis access; complete bilateral study

- (Do not report 93985 in conjunction with 93925, 93930, 93970 for the same extremity(ies))

- (Do not report 93985 in conjunction with 93990 for the same extremity)

- #93986 complete unilateral study

- (Do not report 93986 in conjunction with 93926, 93931, 93971, 93990 for the same extremity)

#94728 Airway resistance by impulse oscillometry

- #95813 greater than 1-hour 61-119 minutes

- (Do not report 95813 in conjunction with 95700-95726)

- (For long term EEG services [2 hours or more], see 95700-95726)

#95827 all night recording

#95834 Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk
95832 Hand, with or without comparison with normal side
95833 Total evaluation of body, excluding hands
95834 Total evaluation of body, including hands
95950 Monitoring for identification and lateralization of cerebral seizure focus; electroencephalographic (e.g., 8-channel EEG) recording and interpretation, each 24 hours
95951 Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, combined electroencephalographic (EEG) and video recording and interpretation (e.g., for presurgical localization), each 24 hours
95953 Monitoring for localization of cerebral seizure focus by computerize portable 16 or more channel EEG, electroencephalographic (EEG) recording and interpretation, each 24 hours, unattended
95956 Monitoring for localization of cerebral seizure focus by cable or radio, 16 or more channel telemetry, electroencephalographic (EEG) recording and interpretation, each 24 hours, attended by a technologist or nurse

#*95700 Electroencephalogram (EEG) continuous recording, with video when performed, setup, patient education, and takedown when performed, administered in person by EEG technologist, minimum of 8 channels
  ➤ (95700 should be reported once per recording period)
  ➤ (For EEG using patient-placed electrode sets, use 95999)
  ➤ (For setup performed by non-EEG technologist or remotely supervised by an EEG technologist, use 95999)
#*95705 Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, 2-12 hours; unmonitored
#*95706 with intermittent monitoring and maintenance
#*95707 with continuous, real-time monitoring and maintenance
#*95708 Electroencephalogram (EEG), without video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored
#*95709 with intermittent monitoring and maintenance
#95710 with continuous, real-time monitoring and maintenance

#95711 Electroencephalogram with video (VEEG), review of data technical description by EEG technologist, 2-12 hours; unmonitored

#95712 with intermittent monitoring and maintenance

#95713 with continuous, real-time monitoring and maintenance

#95714 Electroencephalogram (EEG), with video, review of data, technical description by EEG technologist, each increment of 12-26 hours; unmonitored

#95715 with intermittent monitoring and maintenance

#95716 with continuous, real-time monitoring and maintenance

► (95705, 95706, 95707, 95711, 95712, 95713 may be reported a maximum of once for an entire longer-term EEG service to capture either the entire time of service or the final 2-12 hour increment of service extending beyond 26 hours) ◄

#95717 Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation and report. 2-12 hours of EEG recording; without video

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#95718 with video (VEEG)

► (For recording greater than 12 hours, see 95719, 95720, 95721, 95722, 95723, 95724, 95725, 95726) ◄

► (95717, 95718 may be reported a maximum of once for an entire long-term EEG service to capture either the entire time of service or the final 2-12 hour increment of service extending beyond 24 hours) ◄

#95719 Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, each increment of greater than 12 hours, up to 26 hours of EEG recording, interpretation and report after each 24-hour period; without video

#95720 with video (VEEG)

► (95719, 95720 may be reported only once for a recording period greater than 12 hours up to 26 hours. For multiple-day studies, 95719, 95720 may be reported after each 24-hour period during the extended recording period. 95719, 95720 describe reporting for a 26-hour recording period, whether done as a single report or as multiple reports during the same time) ◄
► (95717, 95718 may be reported in conjunction with 95719, 95720 for studies lasting greater than 26 hours) ◄

► (Do not report 95717, 95718, 95719, 95720 for professional interpretation of long-term EEG studies when the recording is greater than 36 hours and the entire professional report is retroactively generated, even if separate daily reports are rendered after the completion of recording) ◄

► (When the entire study includes recording greater than 36 hours, and the professional interpretation is performed after the entire recording is completed, see 95721, 95722, 95723, 95724, 95725, 95726) ◄

#95721 Electroencephalogram (EEG), continuous recording, physician or other qualified health care professional review of recorded events, analysis of spike and seizure detection, interpretation, and summary report, complete study; greater than 36 hours, up to 60 hours of EEG recording, without video

#95722 greater than 36 hours, up to 60 hours of EEG recording, with video (VEEG)

#95723 greater than 60 hours, up to 84 hours of EEG recording, without video

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#95724 greater than 60 hours, up to 84 hours of EEG recording, with video (VEEG)

#95725 greater than 84 hours of EEG recording, without video

#95726 greater than 84 hours of EEG recording, with video

► (When the entire study includes recording greater than 36 hours, and the professional interpretation is performed after the entire recording is completed, see 95721, 95722, 95723, 95724, 95725, 95726) ◄

► (Do not report 95721, 95722, 95723, 95724, 95725, 95726 in conjunction with 95717, 95718, 95719, 95720) ◄

96150 Health and behavior assessment (eg, health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires), each 15 minutes face-to-face with the patient, initial assessment

96151 re-assessment

96152 Health and behavior intervention, each 15 minutes, face-to-face, individual

96453 group (2 or more patients)
96154  family (with the patient present)
96155  family (without the patient present)

*96156 Health behavior assessment, or re-assessment (i.e., health focus clinical interview, behavioral observations, clinical decision making)

*96158 Health behavior intervention, individual, face to face; initial 30 minutes

**96159 each additional 15 minutes (List separately in addition to code for primary service)

► (Use 96159 in conjunction with 96158) ◄

#96164 Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes

#**96165 each additional 15 minutes (List separately in addition to code for primary service)

► (Use 96165 in conjunction with 96164) ◄

#96167 Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes

#**96168 each additional 15 minutes (List separately in addition to code for primary service)

► (Use 96168 in conjunction with 96167) ◄

#96170 Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes

#**96171 each additional 15 minutes (List separately in addition to code for primary service)

► (Use 96171 in conjunction with 96170) ◄

97127 Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving and/or pragmatic functions) and compensatory strategies to manage the performance of an actively (e.g., managing time or schedules, initiating, organizing and sequencing tasks), direct (one-on-one patient contact)


**97129** Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing timer schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes

- (Report 97129 only once per day)

  - **97130** each additional 15 minutes (List separately in addition to code for primary procedure)

- (Use 97130 in conjunction with 97129)

- (Do not report 97129, 97130 in conjunction with 97135, 97155)

**98969** Online assessment and management service provided by a qualified nonphysician health care professional to an established patient or guardian, not originating from a related assessment and management service provided within the previous 7 days, using the internet or similar electronic communications network

**98970** Qualified nonphysician health care professional online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes

**98971** 11-20 minutes

**98972** 21 or more minutes

- (Report 98970, 98971, 98972 once per 7-day period)

- (Do not report online digital E/M services for cumulative visit time less than 5 minutes)

- (Do not count 98970, 98971, 98972 time otherwise reported with other services)

- (Do not report 98970, 98971, 98972 for home and outpatient INR monitoring when reporting 93792, 93793)

- (Do not report 98970, 98971, 98972 when using 99091, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99487, 99489, 99495, 99496, for the same communication[s])
Modifiers
Revised for 2020

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

• ► -63 Procedure Performed on Infants less than 4kg: 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 and 92920, 92928, 92953, 92960, 92986, 92987, 92990, 92997, 92998, 93312, 93313, 93314, 93315, 93316, 93317, 93318, 93452, 93505, 93530, 93531, 93532, 93533, 93561, 93562, 93563, 93564, 93568, 93580, 93582, 93590, 93591, 93592, 93615, 93616 from the Medicine/Cardiovascular section. Modifier 63 should not be appended to any CPT codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections (other than those identified above from the Medicine/Cardiovascular section).
Questions?

• Thank you for your attendance!

• Get your questions answered: info@pmimd.com