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AAPC

Procedure Desk Reference

CPT® Codes Explained for the Medical Coder

2027

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2027 E/M Survival Guide

Note: The information in this guide is provided to use for coding services. It is not a guarantee of payment and not meant to replace an individual coder's judgment. Check with individual payers for their guidelines on coding, billing, and reimbursement for E/M codes. Note that this survival guide covers the most used CPT® codes but is not an all encompassing guide. Please refer to the AMA CPT® code book for additional information.

Contents

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Chapter 2: New vs. Established, Initial vs. Subsequent Patients

Generally, you should consider a patient to be established if any physician or QHP in your group practice (or more precisely, any physician or QHP of the same specialty or subspecialty billing under the same group number) has seen that patient for a face-to-face service within the past 36 months.

Location isn't the issue: If your practice has multiple locations and a provider in location A sees the patient in January while a physician at location B sees the patient in December, the patient is still established. The need to create a new chart is inconsequential.

For instance: A primary-care physician recommends that a 65-year-old male see a cardiologist for a full workup. One of the physicians in the cardiologist's practice provided an interpretation of an EKG for the same patient the previous year when they were in the emergency department but provided no face-to-face service.

In this case, the cardiologist can still consider the patient to be new when selecting an initial E/M code because no physician within the practice provided the patient with a face-to-face service within the past three years.

Another example: A patient comes to your office complaining of low back and stomach pains. Although this is the physician's as first time meeting the patient, another doctor in the same group practice saw the patient two years ago for a similar complaint.

In this case, you should consider the patient to be established.

Different Specialties Allow for Exceptions

The new patient rule applies only when providers in the same practice are also of the same specialty.

Translation: If your practice is big enough and provides services for more than one specialty, two providers may see a patient for completely different reasons. This could allow you to report a new patient visit even though two providers in the same practice saw the same patient within a three-year period.

Example: A patient has been seeing an internist of a multispecialty group for the past three years for primary care, particularly their hypertension (I10). The internist identified some suspicious lesions in January 2021.

The internist sends the patient to a general surgeon in the same practice to evaluate removing the lesions. Although the patient was a new patient to the internist in 2018, the patient is a new patient to the general surgeon in 2021 because they are a different specialty, and the internist and the general surgeon are treating different problems.

Because the internist and general surgeon (who are obviously of different specialties) saw the patient for completely unrelated problems (this is key), you may report the general surgeon's initial visit with the patient using the new patient codes.

Note: You do not need to decide if a patient is new or established when reporting emergency department (ED) services. You can use the ED E/M codes for patients who are new to the ED or who have been seen there before.

Previous Service During Admission/ Stay Means Subsequent

Not all E/M categories identify patients as new or established. You'll instead report some services based on whether the provider or QHP or another provider or QHP of the exact same specialty and subspecialty in the same group has previously provided professional services to the patient during the same stay (inpatient, observation, or nursing home).

Note: In the CPT® guidelines, AMA defines professional services as "those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services."

If one provider is on call for another provider, you'll report the covering provider's services just as you would have reported the unavailable provider's services. If the unavailable provider saw the patient before during the same stay, you'll report a subsequent E/M code even if the covering physician has never seen the patient before.

Define "same stay": According to CPT® guidelines, for hospital inpatient and observation services, you should consider a transition from observation to inpatient status to be a single stay. The same logic applies in levels of nursing facility care: If a patient transitions between nursing facility and skilled nursing facility during a stay, the clock does not reset. Count the transitions as one stay.

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Chapter 17: Care Plan Oversight Services (99374-99380)

Care plan oversight (CPO) is the physician supervision of patients under the care of home health agencies or hospices that require complex or multidisciplinary care modalities, according to Medicare Benefit Policy Manual (MBPM), which involves:

- Regular physician development and/or revision of care plans
- Review of subsequent reports of patient status
- Review of related laboratory and other studies
- Communication with other health professionals not employed in the same practice who are involved in the patient's care
- Integration of new information into the medical treatment plan
- Adjustment of medical therapy

Important: Medicare does not recognize 99374-99380 for CPO services. Codes 99339 and 99340 were deleted for 2023.

CMS payers will recognize care plan oversight services only for patients under the care of Medicare-covered home health agency or Medicare-approved hospice. Medicare will not cover CPO services for patients of skilled nursing facilities (SNFs), nursing home facilities or hospitals.

Only one physician may bill CPO each month, and only the physician who performed and signed the certification for Medicare covered home health services or hospice care may be the physician billing for the CPO.

You must submit CPO claims to Medicare payers using the following Medicare-specific codes:

- **G0179** — *Physician re-certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per re-certification period*
- **G0180** — *Physician certification for Medicare-covered home health services under a home health plan of care (patient not present), including contacts with home health agency and review of reports of patient status required by physicians to affirm the initial implementation of the plan of care that meets patient's needs, per certification period*
- **G0181** — *Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more*
- **G0182** — *Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.*

Important: CPO services are time-based; E/M services that include many tasks that doctor regularly perform for the long-term management of home-health agency, hospice, or nursing-facility patients under their care. Physicians might provide such services for spinal injury patients who are wheelchair-bound or accident victims recovering from multiple traumatic injuries.

Effective Jan. 1, 2011, physicians (or NPPs) who order home health care must personally examine the patient during a face-to-face visit. The physician must document that the physician or NPP saw the patient, and document how the patient's clinical condition supports a homebound status and need for skilled services, CMS says. The face-to-face encounter must occur within the 90 days prior to the start of home health care, or within the 30 days after the start of care.

Ongoing, Complex Care a Requirement

The first and most basic requirement for reporting CPO is that the patient must require complex or multi-disciplinary care modalities requiring ongoing physician involvement, according to the *Medicare Claims Processing Manual*.

In other words: Designation and coordination of the patient's care plan must require the skills of a physician on a continuing basis.

In addition, the physician who bills CPO must be the same physician who signed the home health or hospice plan of care, and only one physician may report CPO per month.

Nonphysician practitioners (NPPs) can be also paid for CPO activities as long as it is within their state scope of practice.

NPPs can only bill for G0181. Hospice CPO or G0182 is limited to nurse practitioners only and requires a GV modifier (*Attending physician not employed or paid under arrangement by the patient's hospice provider*).

In all cases, however, a physician must perform the certification or recertification of the plan of care.

Hospice Employees Aren't Eligible for CPO

Physicians reporting CPO cannot have a significant financial or contractual interest in the home health agency for which they are designing a plan of care, nor should a physician who is an employee of a hospice, including a volunteer medical director, report such services, according to Medicare guidelines.

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Chapter 19: Non-Face-to-Face Services (99421-99458)

Online Digital Medical Evaluation Services (99421-99423)

Coding caution: Restrictions apply to code 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*). Any online digital E/M service that is the result of a previous, or that results in a subsequent, E/M visit, is not separately reported, and the online digital E/M service is incorporated into the related E/M visit.

In addition, CPT® has a seven-day cumulative time limitation on 99421, plus the code is time-dependent. You should use 99421 if your provider spends between five and 10 minutes on the asynchronous communication with the patient in that time; you should report longer time increments with 99422 (*… 11-20 minutes*) or 99423 (*… 21 or more minutes*).

Remember '7' for Cumulative Service Time

Question: *When our providers perform online digital E/M services (99421-99423) services, what activities count toward cumulative service time?*

Answer: According to CPT®, the physician's cumulative service time includes:

- Reviewing the patient's initial inquiry, which is when the seven-day period begins.
- Reviewing patient records or data relevant to assessing their problem.
- Personal physician or other qualified healthcare professional (QHP) interaction with the clinical staff that focuses on the patient's problem.
- Developing management plans, which include writing prescriptions and ordering tests.

Any subsequent communication with the patient through online, telephone, email, or other digitally supported communication does not otherwise represent a separately reported E/M service.

Important: "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," per CPT®.

Interprofessional Telephone/ Internet/Electronic Health Record Consultations (99446-99449)

CPT® includes four codes that describe the work of two medical professionals who discuss a patient's condition via phone or internet, as follows:

- 99446 (*Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional,* 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*)
- 99447 (*… 11-20 minutes of medical consultative discussion and review*)
- 99448 (*… 21-30 minutes of medical consultative discussion and review*)
- 99449 (*… 31 minutes or more of medical consultative discussion and review*).

These codes are consultative in nature, which means you must provide a written report back to the requesting physician to qualify for the code, as indicated by the phrase "including a verbal and written report".

Remote Physiologic Monitoring Services

CPT® has five codes to describe the work involved with remote physiologic monitoring and digitally stored data services.

- 99091 (*Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/ regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days*)
- 99445 (*Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate); device(s) supply with daily recording(s) or programmed alert(s) transmission, 2-15 days in a 30-day period*)
- 99453 (*… initial set-up and patient education on use of equipment*)
- 99454 (*… device(s) supply with daily recording(s) or programmed alert(s) transmission, 16-30 days in a 30-day period*)
- 99473 (*Self-measured blood pressure using a device validated for clinical accuracy; patient education/training and device calibration*)
- 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*)

These codes capture the initial set up and patient education for various physiological monitoring equipment as well as the collection of the data and interpretation of the data.

Code 99470 (*Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring 1 real-time interactive communication with the patient/caregiver during the calendar month; first 10 minutes)* is being added for 2026. You will use this code when the results of the data gathered from remote physiologic monitoring are used to manage a patient's specific treatment plan. Report services between 10-19 minutes using 99470.

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CPT® Category II Modifiers

Mod	Modifier Description, Definition, Explanation, and Tips
1P	**Performance Measure Exclusion Modifier due to Medical Reasons** **Definition:** Append modifier 1P to a quality reporting code to indicate the patient's medical status prevents the provider from performing the action specified by a quality measure. **Explanation:** You should append modifier 1P to a quality reporting code when medical reasons keep the provider from completing the action a quality measure requires. For instance, if the measure tracks performance of a test on a limb, but the patient no longer has that limb because of amputation, you should append 1P to the appropriate quality code to indicate medical reasons stopped the provider from performing the action. Similarly, you should append 1P if the measure tracks prescription of a drug that the provider doesn't prescribe because the patient is allergic to it. You should not use modifier 1P unless listed as a reportable option for the specific quality code you're reporting. **Tips:** This modifier is called an exclusion modifier because it excludes the patient from a quality measure's denominator, which is the eligible patient population. Various exclusion modifiers are available for quality reporting: 1P, Performance Measure Exclusion Modifier due to Medical Reasons 2P, Performance Measure Exclusion Modifier due to Patient Reasons 3P, Performance Measure Exclusion Modifier due to System Reasons For 1P, medical reasons may include a contraindication based on the patient's specific medical history. For 2P, an example of a patient reason is that the patient refuses a service because he does not want to pay for it. An example of the system reasons under 3P is that the entity does not have the equipment needed for the service. Append modifier 8P, Performance Measure Reporting Modifier, Action Not Performed, Reason Not Otherwise Specified, when a provider does not perform the action for an eligible patient and does not document the reason why. You should not use any of these modifiers unless the modifier is listed as a reportable option for a specific quality code.
2P	**Performance Measure Exclusion Modifier due to Patient Reasons** **Definition:** Append modifier 2P to a quality reporting code to indicate that patient reasons, such as refusal, prevent the provider from performing the action specified by a quality measure. **Explanation:** You should append modifier 2P to a quality reporting code when patient reasons keep the provider from completing the action a quality measure requires. For instance, if a measure requires a test or service that the patient refuses to have because of financial or religious reasons, you would append 2P to the appropriate quality code to indicate patient reasons stopped the provider from performing the action. You should not use modifier 2P unless listed as a reportable option for the specific quality code you're reporting. **Tips:** This modifier is called an exclusion modifier because it excludes the patient from a quality measure's denominator, which is the eligible patient population. Various exclusion modifiers are available for quality reporting: 1P, Performance Measure Exclusion Modifier due to Medical Reasons 2P, Performance Measure Exclusion Modifier due to Patient Reasons 3P, Performance Measure Exclusion Modifier due to System Reasons For 1P, medical reasons may include a contraindication based on the patient's specific medical history. For 2P, an example of a patient reason is that the patient refuses a service because he does not want to pay for it. An example of the system reasons under 3P is that the entity does not have the equipment needed for the service. Append modifier 8P, Performance Measure Reporting Modifier, Action Not Performed, Reason Not Otherwise Specified, when a provider does not perform the action for an eligible patient and does not document the reason why. You should not use any of these modifiers unless the modifier is listed as a reportable option for a specific quality code.

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Procedure	Specialty	Definition
Heineke–Mikulicz pyloroplasty	Upper gastrointestinal surgery	A procedure in which the provider makes a lengthwise incision through the pylorus and sutures the pylorus transversely to treat a pyloric ulcer or problems with gastric emptying following other procedures on the stomach.
Heller myotomy	Upper gastrointestinal surgery	Incision into the lower esophageal sphincter to allow food to pass into the stomach; the procedure treats esophageal achalasia, a condition in which the esophageal muscles weaken and cannot propel food down the esophagus.
Homans operation	Vascular surgery	Ligation of the femoral vein to prevent pulmonary embolism in patients with deep venous thrombosis; A rarely performed procedure for lymphedema or massive edema which involves debulking of subcutaneous tissues and skin.
Ivor Lewis esophagogastrectomy	Upper gastrointestinal surgery	A procedure to treat esophageal and or stomach cancer in which the provider excises the esophagus and part of the stomach and anastomoses, or joins, the remnant to the duodenum or jejunum; they may use a transthoracic approach or a laparotomy.
Jaboulay's pyloroplasty	Upper gastrointestinal surgery	Actually not a pyloroplasty at all but a procedure in which the provider creates a side to side anastomosis, or joining, between the stomach and duodenum, creating a large opening to treat problems with gastric emptying and bypass the pylorus.
Jaboulay–Winkelmann operation	Urology	A hydrocelectomy in which the sac is mostly excised and the edges of the remnant sewn together behind the spermatic cord.
Kausch–Whipple procedure	Upper gastrointestinal surgery	A procedure to treat pancreatic cancer in which the provider excises the head of the pancreas, the duodenum, and adjacent structures, such as the gallbladder and common bile duct; the procedure may include a partial gastrectomy if the stomach is involved; also called a radical pancreaticoduodenectomy.
Killian's operation	Otolaryngology	Excision of part or all of the anterior wall of the frontal sinus such that the sinus opens into the nose; the procedure treats frontal sinusitis.
Lisfranc's amputation	Orthopedic surgery	Amputation of the foot distal to the tarsal bones due to tumor involvement of the metatarsals.
Lord's procedure for hemorrhoids	Colorectal surgery	An outdated procedure that involves manual dilation of the anal canal to treat hemorrhoids and anal fissure.
Lord's procedure for hydrocele	Urology	A procedure to treat a hydrocele that involves plication, or suturing, of the hydrocele sac to reduce its size.
Miles operation	Colorectal surgery	A radical procedure to treat rectal cancer that involves excision of the portion of the colon above the rectum, the rectum, the anal canal, adjacent lymph nodes, and muscles.
Nissen fundoplication	Upper gastrointestinal surgery, laparoscopic surgery	A procedure to treat gastroesophageal reflux disease in which the provider lifts the fundus of the stomach up and wraps it 360 degrees around the lower part of the esophagus.
Paul's operation	Colorectal surgery	An outdated procedure that involves extraperitoneal colon resection for colorectal cancer.
Polya gastrectomy	Upper gastrointestinal surgery	A procedure to treat recurrent duodenal ulceration following prior vagotomy that involves resection of two thirds of the stomach and anastomosis, or joining, of the remnant to the jejunum with closing off of the duodenum until it heals; the procedure is a modification of a Billroth II procedure.
Roux-en-Y anastomosis	Upper gastrointestinal surgery	A surgical procedure that involves gastrojejunal, duodenojejunal, or jejunojejunal anastomosis; the procedure is used to treat cancer and prevent gastric reflux in patients who undergo gastric bypass procedures.
Smith's operation	Ophthalmology	An outdated procedure for the intracapsular extraction of an immature cataract that involves a muscle hook on the external eye to break the fibers holding the lens in place and expel it through a limbal incision.
Syme's amputation	Orthopedic surgery	Foot amputation at the ankle level with amputation of the medial and lateral malleoli.
Tommy John surgery	Orthopedic surgery	Surgical repair of tears of the ulnar collateral ligament at the elbow; also called UCL reconstruction.
Toupet fundoplication	Upper gastrointestinal surgery	A procedure to treat gastroesophageal reflux disease in which the provider lifts the fundus of the stomach up and wraps it 270 degrees posteriorly around the lower part of the esophagus and creation of a reflux valve.
Trendelenburg's operation	Cardiothoracic surgery	An outdated procedure for the treatment of a pulmonary embolism that involves a thoracotomy, resection of ribs, incision into the pulmonary artery, and extraction of the embolus with forceps.

Billing, Coding, and Reimbursement Terms

Billing/Coding/Reimbursement Term	Definition
A "TIER"	A specific list of drugs. Your plan may have several tiers, and your copayment amount depends upon which tier your drug is listed. Plans can choose their own tiers, so members should refer to their benefit booklet or contact the plan for more information.
ABSTRACT	The collection of information from the medical record via hard copy or electronic instrument.
ABUSE	A range of the following improper behaviors or billing practices including, but not limited to: Billing for a non-covered service; Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered); or Inappropriately allocating costs on a cost report.
ABUSE (PERSONAL)	When another person does something on purpose that causes you mental or physical harm or pain.
ACCESS	Your ability to get needed medical care and services.
ACCESSIBILITY OF SERVICES	Your ability to get medical care and services when you need them.
ACCESSORY DWELLING UNIT (ADU)	A separate housing arrangement within a single-family home. The ADU is a complete living unit and includes a private kitchen and bath.
ACCREDITATION	An evaluative process in which a healthcare organization undergoes an examination of its policies, procedures and performance by an external organization ("accrediting body") to ensure that it is meeting predetermined criteria. It usually involves both on- and off-site surveys.
ACCREDITATION CYCLE FOR M+C DEEMING	The duration of CMS's recognition of the validity of an accrediting organization's determination that a Medicare + Choice organization (M+CO) is "fully accredited."
ACCREDITATION FOR DEEMING	Some states use the findings of private accreditation organizations, in part or in whole, to supplement or substitute for State oversight of some quality related standards. This is referred to as "deemed compliance" with a standard.
ACCREDITATION FOR PARTICIPATION	State requirement that plans must be accredited to participate in the Medicaid managed care program.
ACCREDITED (ACCREDITATION)	Means having a seal of approval. Being accredited means that a facility or healthcare organization has met certain quality standards. These standards are set by private, nationally recognized groups that check on the quality of care at healthcare facilities and organizations. Organizations that accredit Medicare Managed Care Plans include the National Committee for Quality Assurance, The Joint Commission, and the American Accreditation HealthCare Commission/URAC.
ACCREDITED STANDARDS COMMITTEE	An organization that has been accredited by ANSI for the development of American National Standards.
ACT/LAW/STATUTE	Term for legislation that passed through Congress and was signed by the President or passed over his veto.
ACTIVITIES OF DAILY LIVING (ADL)	Activities you usually do during a normal day such as getting in and out of bed, dressing, bathing, eating, and using the bathroom.
ACTUAL CHARGE	The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves. (See "Approved Amount"; "Assignment.")
ACTUARIAL BALANCE	The difference between the summarized income rate and the summarized cost rate over a given valuation period.
ACTUARIAL DEFICIT	A negative actuarial balance.
ACTUARIAL RATES	One half of the expected monthly cost of the SMI program for each aged enrollee (for the aged actuarial rate) and one half of the expected monthly cost for each disabled enrollee (for the disabled actuarial rate) for the duration the rate is in effect.
ACTUARIAL SOUNDNESS	A measure of the adequacy of Hospital Insurance and Supplementary Medical Insurance financing as determined by the difference between trust fund assets and liabilities for specified periods.
ACTUARIAL STATUS	A measure of the adequacy of the financing as determined by the difference between assets and liabilities at the end of the periods for which financing was established.

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BRM	bilateral radical mastectomy
BS	breath, or bowel sounds
BSD	bedside drainage
BSE	breast self-exam
BSO	bilateral salpingo-oophorectomy
BSA	body surface area
BTB	bone tendon bone
BUN	blood urea nitrogen
BUS	Bartholin, urethral, Skene's
BV	bacterial vaginosis
Bx	biopsy

C

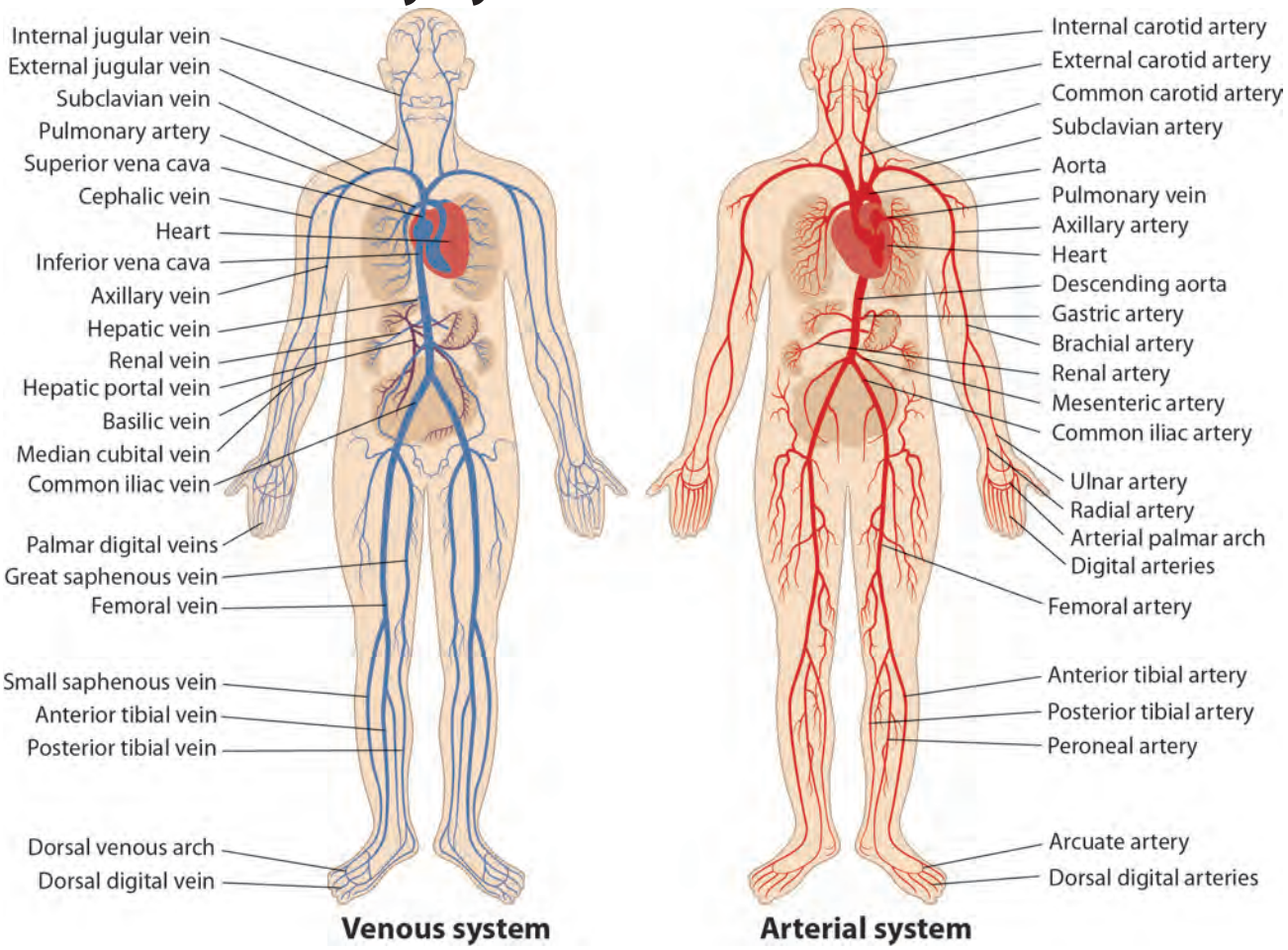
Ca	calcium, or cancer
CA	coronary artery
CABG	coronary artery bypass graft
CAD	coronary artery disease
CAT	computed axial tomography
Cath	catheterize
CBC	complete blood count
CBR	complete bed rest
CC	chief complaint, or costochondral
CCI	Correct Coding Initiative
CCPD	continuous cycling peritoneal dialysis
CCT	cardiac computed tomography
CCU	critical care unit
C/D/I	clean/dry/intact (referring to incision)
CEA	carcinoembryonic antigen
CF	cystic fibrosis
CH	cholesterol
CHF	congestive heart failure
CIDA	chronic iron deficiency anemia
CIN	cervical intraepithelial neoplasia
Circ.	circumcision
CIS	carcinoma in situ
CISH	classic intrafascial supracervical hysterectomy
CL	central line
CLO	cleft lip only
CLP or CL/P	cleft lip and palate
cm	centimeter
cm^2	centimeters squared
CMC	carpometacarpal
CMG	cystometrogram
CMN	certificate of medical necessity
CMRI	cardiovascular magnetic resonance imaging
CMS	Centers for Medicare & Medicaid Services
CNAP	continuous negative airway pressure
CNS	central nervous system
cont.	continue
c/o	complains of
CO	cardiac output
COPD	chronic obstructive pulmonary disease
CP	cerebral palsy, or chest pain
CPD	cephalopelvic disproportion
CPK	creatine phosphokinase
CPO	cleft palate only
CPR	cardiopulmonary resuscitation
CR	creatine
CRF	chronic renal failure
CRG	cardiorespirography
CRIT	hematocrit
CRP	canalith repositioning procedure
CRPS	complex regional pain syndrome
C&S	culture and sensitivity
CS	corticosteroid, or cesarean section
CSF	cerebrospinal fluid
CST	contraction stress test
CT	computed tomography
CTR	carpal tunnel release
CTS	carpal tunnel syndrome
Ctx	contractions
CVA	cerebral vascular accident, or costovertebral angle
CVC	central venous catheter
CVL	central venous line
CVP	central venous pressure
CVS	chorionic villus sampling
CXR	chest X-ray
Cysto	cystoscopy

D

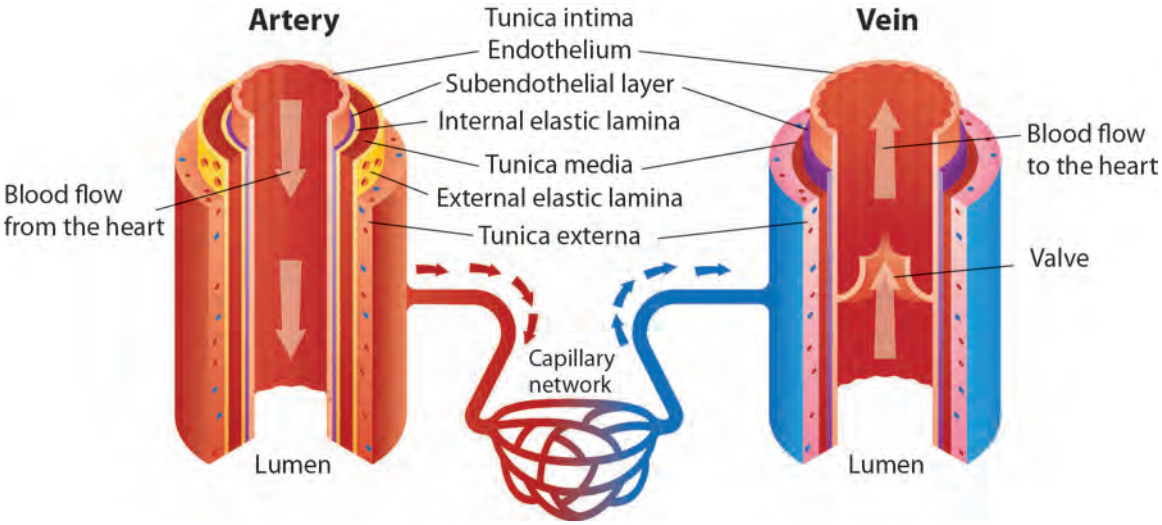
DB&C	deep breathing and coughing
D/C	discharge or discontinue
D&C	dilation and curettage
DDH	developmental dysplasia of hip
DE	dose equivalent
Def.	deficient or deficiency
Del	delivery
Dep.	dependent
DES	diethylstilbestrol
DEXA	dual energy X-ray absorptiometry
DIC	disseminated intravascular coagulation
DIEP	deep inferior epigastric perforator flap
DIF	direct immunofluorescence
DIP	distal interphalangeal
DISH	diffuse idiopathic skeletal hyperostosis
DJD	degenerative joint disease
DKA	diabetic ketoacidosis
DM	diabetes mellitus

Anatomical Illustrations

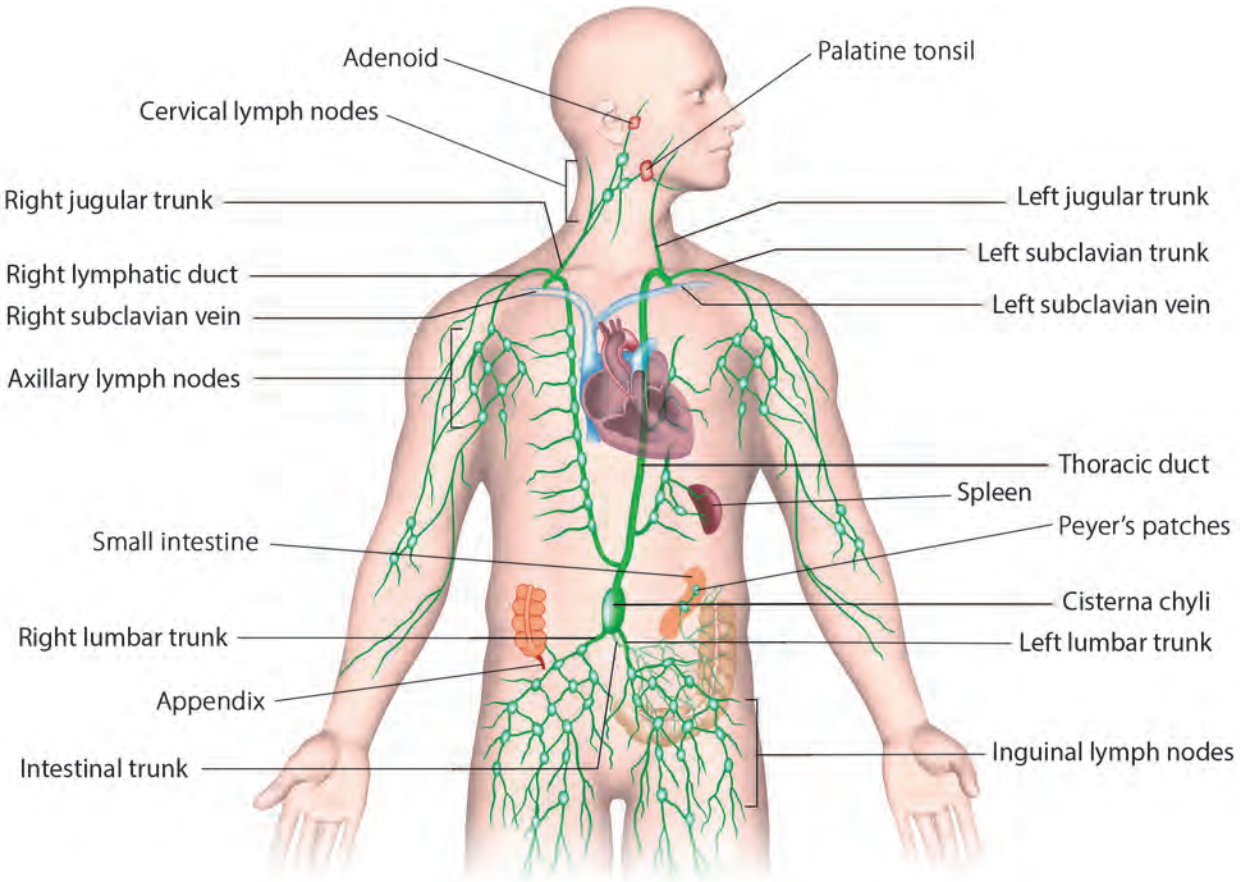
Circulatory System — Arteries and Veins



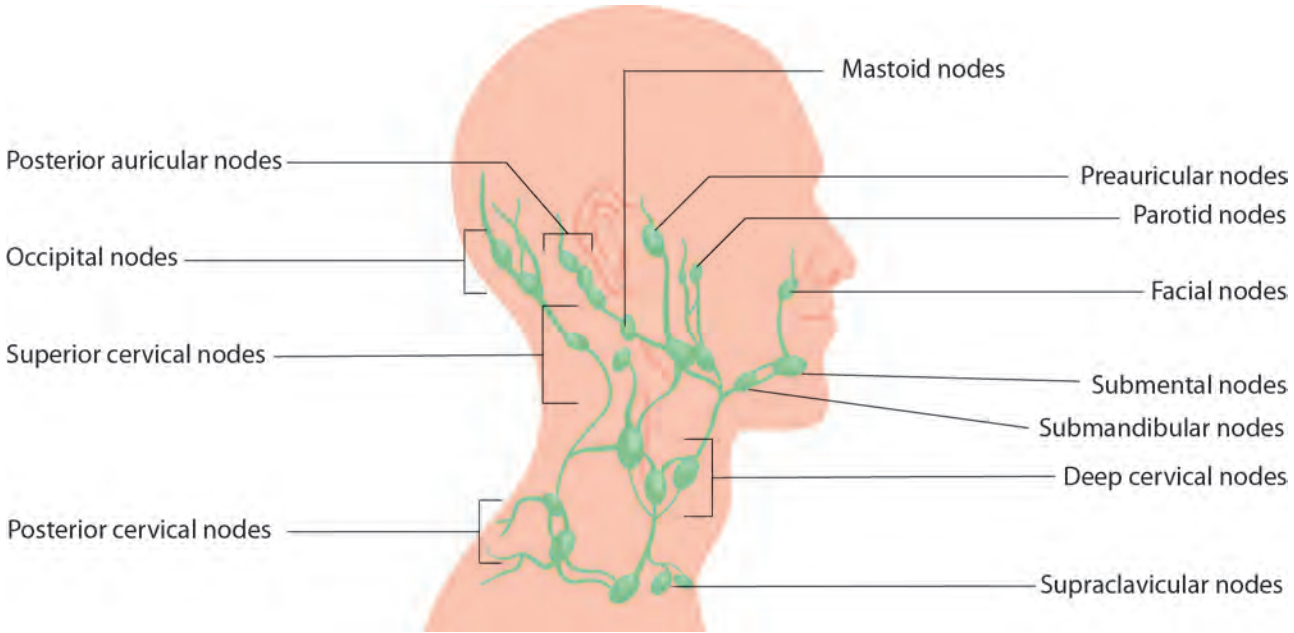
Circulatory System — Artery and Vein Anatomy



Lymphatic System Anatomy



Lymphatic System — Lymph Nodes of the Head and Neck



98000

The provider performs an evaluation and management (E/M) service for a new patient using synchronous audio-visual technology, meaning the provider and patient see and hear each other in real time. The total time spent on the date of the encounter is 15 or more minutes, and/or the level of medical decision-making (MDM) is straightforward. Total time includes both face-to-face and non-face-to-face activities on the encounter date. Examples include, but are not limited to, reviewing tests and otherwise preparing for the patient visit, performing the evaluation, counseling and educating the patient or caregiver, ordering tests, communicating with other healthcare providers, documenting the encounter, interpreting and communicating results, and coordinating care. Elements of MDM include the number and complexity of problems addressed; the amount and/or complexity of data to review and analyze; and the risk of complications, morbidity, and mortality related to patient management.

The visit also may include taking a patient history and performing an examination. The provider determines the nature and extent of the history and/or exam appropriate for the encounter.

98001

The provider performs an evaluation and management (E/M) service for a new patient using synchronous audio-visual technology, meaning the provider and patient see and hear each other in real time. The total time spent on the date of the encounter is 30 or more minutes, and/or the level of medical decision-making (MDM) is low. Total time includes both face-to-face and non-face-to-face activities on the encounter date. Examples include, but are not limited to, reviewing tests and otherwise preparing for the patient visit, performing the evaluation, counseling and educating the patient or caregiver, ordering tests, communicating with other healthcare providers, documenting the encounter, interpreting and communicating results, and coordinating care. Elements of MDM include the number and complexity of problems addressed; the amount and/or complexity of data to review and analyze; and the risk of complications, morbidity, and mortality related to patient management.

The visit also may include taking a patient history and performing an examination. The provider determines the nature and extent of the history and/or exam appropriate for the encounter.

98002

The provider performs an evaluation and management (E/M) service for a new patient using synchronous audio-visual technology, meaning the provider and patient see and hear each other in real time. The total time spent on the date of the encounter is 45 or more minutes, and/or the level of medical decision-making (MDM) is moderate. Total time includes both face-to-face and non-face-to-face activities on the encounter date. Examples include, but are not limited to, reviewing tests and otherwise preparing for the patient visit, performing the evaluation, counseling and educating the patient or caregiver, ordering tests, communicating with other healthcare providers, documenting the encounter, interpreting and communicating results, and coordinating care. Elements of MDM include the number and complexity of problems addressed; the amount and/or complexity of data to review and analyze; and the risk of complications, morbidity, and mortality related to patient management.

The visit also may include taking a patient history and performing an examination. The provider determines the nature and extent of the history and/or exam appropriate for the encounter.

98003

The provider performs an evaluation and management (E/M) service for a new patient using synchronous audio-visual technology, meaning the provider and patient see and hear each other in real time. The total time spent on the date of the encounter is 60 or more minutes, and/or the level of medical decision-making (MDM) is high. Total time includes both face-to-face and non-face-to-face activities on the encounter date. Examples include, but are not limited to, reviewing tests and otherwise preparing for the patient visit, performing the evaluation, counseling and educating the patient or caregiver, ordering tests, communicating with other healthcare providers, documenting the encounter, interpreting and communicating results, and coordinating care. Elements of MDM include the number and complexity of problems addressed; the amount and/or complexity of data to review and analyze; and the risk of complications, morbidity, and mortality related to patient management.

The visit also may include taking a patient history and performing an examination. The provider determines the nature and extent of the history and/or exam appropriate for the encounter.

98004

The provider performs an evaluation and management (E/M) service for an established patient using synchronous audio-visual technology, meaning the provider and patient see and hear each other in real time. The total time spent on the date of the encounter is 10 or more minutes, and/or the level of medical decision-making (MDM) is straightforward. Total time includes both face-to-face and non-face-to-face activities on the encounter date. Examples include, but are not limited to, reviewing tests and otherwise preparing for the patient visit, performing the evaluation, counseling and educating the patient or caregiver, ordering tests, communicating with other healthcare providers, documenting the encounter, interpreting and communicating results, and coordinating care. Elements of MDM include the number and complexity of problems addressed; the amount and/or complexity of data to review and analyze; and the risk of complications, morbidity, and mortality related to patient management.

The visit also may include taking a patient history and performing an examination. The provider determines the nature and extent of the history and/or exam appropriate for the encounter.

98005

The provider performs an evaluation and management (E/M) service for an established patient using synchronous audio-visual technology, meaning the provider and patient see and hear each other in real time. The total time spent on the date of the encounter is 20 or more minutes, and/or the level of medical decision-making (MDM) is low. Total time includes both face-to-face and non-face-to-face activities on the encounter date. Examples include, but are not limited to, reviewing tests and otherwise preparing for the patient visit, performing the evaluation, counseling and educating the patient or caregiver, ordering tests, communicating with other healthcare providers, documenting the encounter, interpreting and communicating results, and coordinating care. Elements of MDM include the number and complexity of problems addressed; the amount and/or complexity of data to review and analyze; and the risk of complications, morbidity, and mortality related to patient management.

The visit also may include taking a patient history and performing an examination. The provider determines the nature and extent of the history and/or exam appropriate for the encounter.

98006

The provider performs an evaluation and management (E/M) service for an established patient using synchronous audio-visual technology, meaning the provider and patient see and hear each other in real time. The total time spent on the date of the encounter is 30 or more minutes, and/or the level of medical decision-making (MDM) is moderate. Total time includes both face-to-face and non-face-to-face activities on the encounter date. Examples include, but are not limited to, reviewing tests and otherwise preparing for the patient visit, performing the evaluation, counseling and educating the patient or caregiver, ordering tests, communicating with other healthcare providers, documenting the encounter, interpreting and communicating results, and coordinating care. Elements of MDM include the number and complexity of problems addressed; the amount and/or complexity of data to review and analyze; and the risk of complications, morbidity, and mortality related to patient management.

The visit also may include taking a patient history and performing an examination. The provider determines the nature and extent of

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99465

The provider performs cardiopulmonary resuscitation of a newborn infant in distress, using a ventilation device, like a bag mask, along with chest compressions.

99466

The provider attends a critically ill or injured child during transport between facilities for at least 30 minutes and less than 74, providing hands on care.

99467

The provider attends a critically ill or injured child during transport between facilities, where transport time exceeds 74 minutes, providing hands on care.

99468

The provider evaluates and manages the initial critical care services to a critically ill or injured newborn, 28 days or younger, in a neonatal intensive care unit setting. She devises a critical care intervention and management plan for premature infants, infants with low births weight, or those with congenital abnormalities.

99469

The provider evaluates and manages the subsequent critical care services to a critically ill or injured newborn, 28 days or younger, in a neonatal intensive care unit setting, after the first day. She carries out a critical care intervention and management plan for premature infants, infants with low birth weight, or those with congenital abnormalities.

99470

The provider or clinical staff reviews and interprets remote physiologic monitoring (RPM) data collected by one or more Food and Drug Administration (FDA)-defined medical devices under a plan of care ordered by a physician or other qualified healthcare professional. RPM may cover areas such as weight, blood pressure, oxygen saturation (the amount of oxygen in the blood), or respiratory flow rate (how much air moves in and out of the lungs). They use this information to adjust treatment, counsel the patient or caregiver, and coordinate ongoing management. The service must include at least one real-time interactive communication with the patient or caregiver during the calendar month. Report this code when a minimum of 10 minutes of staff or provider time is completed.

99471

The provider evaluates and manages a critically ill patient, age 29 days through 24 months, in an inpatient setting. He evaluates and prepares a management plan, typically involving the care of a premature or low birth weight infant or a child with a congenital abnormality.

99472

The provider provides follow up care to a critically ill patient, age 29 days through 24 months, in an inpatient setting. He monitors the patient and carries out the management plan, typically involving the care of a premature or low birth weight infant or a child with a congenital abnormality.

99473

The provider calibrates a home blood pressure monitoring device that has been validated for clinical accuracy and trains the patient on how to use it to monitor hypertension.

99474

The provider prepares a treatment plan for a patient with hypertension based on the patient's self-measured blood pressures using a validated device. The patient takes her two blood pressure readings one minute apart twice a day, recording at least 12 readings over a 30-day periods and reports these to the provider. The provider then averages the systolic and diastolic readings and prepares a report, after which he discusses his evaluation and treatment plan with the patient.

99475

The provider evaluates and manages a critically ill patient, age two to five years, in an inpatient setting. He evaluates the patient and prepares a management plan.

99476

The provider performs follow up care of a critically ill patient, age two to five years, in an inpatient setting. He evaluates the patient and carries out the management plan.

99477

The provider evaluates and manages care of a neonate who is 28 days of age or younger and requires frequent intensive care services. The patient is not critically ill but requires services such as intensive cardiac, respiratory, lab, and vital sign monitoring; heat maintenance; nutritional adjustments; and constant observation. This code represents the initial day of inpatient care.

99478

The provider directs the continuing intensive care of a low birth weight infant, whose current weight is less than 1500 g, who doesn't require critical care services but requires intensive observations and frequent interventions. Use this code for subsequent care after the first day.

99479

The provider directs the continuing intensive care of a low birth weight infant, whose current weight is between 1500 and 2500 g, who doesn't require critical care services but requires intensive observations and frequent interventions. Use this code for each subsequent day of care after the first day.

99480

The provider directs the continuing intensive care of a low birth weight infant, whose current weight is between 2501 and 5000 g, who doesn't require critical care services but requires intensive observations and frequent interventions. Use this code for each subsequent day of intensive care after the first.

99483

G Code Crosswalk G0515

The provider uses standardized instruments to assess a cognitively impaired patient's comprehension and understanding (cognition) and the patient's abilities to carry out activities of daily living (functional assessment), develops a documented care plan, and obtains a history from the patient and/or caregiver. This assessment may be performed in an office or other outpatient setting, the patient's home, or in a rest home. The encounter must meet all of the required elements to qualify for 99483.

The encounter must include a history and physical examination relevant to the patient's cognitive impairment/dementia. The provider must employ moderate or high complexity medical decision-making, evaluating the disease's progress and the patient's need for assistance services. The provider must assess activities of daily living, including the patient's ability to make decisions. The provider must stage the patient's dementia using standardized evaluation materials. The encounter must include reconciling the patient's medications (essentially comparing medication orders to what the patient has been taking), including review of any high-risk medications the patient might be on. The provider must evaluate the patient for depression or other neuropsychiatric/ behavioral conditions with standardized instruments. The provider must evaluate safety issues, particularly things such as driving and home safety issues, and identify caregiver(s) and their willingness and ability to provide what the patient needs. The provider must carry out advance care planning which may include developing, revising, or reviewing the plan. The provider also must create and document a plan of care, including treatment for any neuropsychiatric problems, referral to any needed community resources, and/or education and support for caregivers.

The provider typically spends 60 minutes total time on this service on the encounter date.

99484

One or more clinical staff members spend at least 20 minutes in a month performing care management services for a patient with behavioral health conditions. A physician or other qualified healthcare professional directs the clinical staff. The patient must have a treatment plan, but it does not need to be comprehensive. The reporting provider, patient, and clinical staff must have an ongoing relationship, with the clinical staff able to meet the patient face-to-face. Behavioral integration care management involves an initial assessment with follow-up monitoring; planning specific to the patient's behavioral/ psychiatric health conditions with revisions if the patient has a change in status or is not progressing; coordination and support of relevant treatment; and continuity of care for the patient.99485

The provider supervises the interfacility transport of a critically ill or injured child 24 months of age or younger for up to 30 minutes. He accepts primary responsibility for the patient's care until the receiving facility relieves him. The team consists of the pediatric provider, nurse, and trained respiratory therapists. The provider maintains two-way communications with the transport team at the referring facility and throughout the transport. He interprets data obtained during transport and prepares a report. This code is for the first 30 minutes of supervision during transport.

99486

The provider supervises the interfacility transport of a critically ill or injured child 24 months of age or younger for an additional 30-minute period of time. He accepts primary responsibility for

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10030

The provider inserts a catheter through the skin using imaging to view the fluid. He then drains the fluid from the soft tissue in cases such as abscess, hematoma, seroma, lymphocele, or cyst. Imaging guidance for needle and catheter placement can be by ultrasound, fluoroscopy, or computed tomography. This procedure can be done by using a catheter that is mounted on a sharp trocar, which is placed through a small skin incision made next to a guiding needle, or by inserting a hollow needle into the cavity and passing a guidewire through the needle to create a path for the drainage catheter. The area is drained, and the catheter, which is left in place, ensures continued drainage.

10035

When the patient is appropriately prepped and anesthetized, the provider uses image guidance to view the exact location of the lesion in the affected soft tissue. The provider then uses a needle introducer to place the localization device through the skin to the target tissue. After placing the device, the provider uses image guidance to ensure the correct position of the device, closes the site, and applies a bandage.

10036

After placement of the first localization device and at the same session, the provider uses image guidance to view the exact location of the lesion in the affected soft tissue. The provider then uses a needle introducer to place an additional localization device through the skin to the target tissue. After placing the device, the provider uses image guidance to ensure the correct position of the device, closes the site, and applies a bandage.

10040

After preparing and cleansing the skin, the provider identifies lesions for extraction. For example, for a milia (a small, white bump caused by trapped keratin), the provider may make a tiny opening to remove the contents. For a comedone (a clogged pore, such as a blackhead or whitehead), the provider may use a tool or small incision to clear the blockage. For a cyst (a sac under the skin filled with fluid or semi-solid material) or a pustule (a red, inflamed bump filled with pus), the provider may open, drain, or remove the lesion. In some cases, the provider performs marsupialization, meaning they create a small surgical opening to help drain fluid from the lesion. This service may involve treating multiple lesions during the same session.

10060

When the patient is appropriately prepped and anesthetized, the provider makes a circumferential incision over the target area of abscess. He makes an incision through skin and down to the level of abscess cavity. The provider then opens the abscess and removes the inflamed fatty and dead tissues within the cavity and drains the pus completely. When the provider successfully accomplishes the procedure, he may leave this wound open for continuous discharge of fluids and may use woven cotton cloth to soak up fluids and blood. The provider may use a small surgical clamp to break up any loculations within the cavity and may insert gauze or other material to pack the abscess cavity.

10061

When the patient is appropriately prepped and anesthetized, the provider makes a circumferential incision over the target area of abscess. He deepens the incision through the vascular inner layer of skin and down to the deep level of abscess cavity. The provider then opens the abscess and excises the inflamed fatty and dead tissues within the cavity and drains the pus completely. When the provider successfully accomplishes the procedure, he may leave this wound open for continuous discharge of fluids and may use woven cotton cloth to soak up fluids and blood. The provider may use a small surgical clamp to break up any loculations within the cavity and may insert gauze or other material to pack the abscess cavity. The provider may repeat this procedure for additional lesions. Some lesions may require placement of a drain for continued drainage. This procedure takes more time than a simple I&D and requires more extensive incisions and/or a more complicated closure.

10080

The lesion is cleaned and prepped, and then a small scalpel incision is made, and the provider expresses a small amount of pus.

A pilonidal cyst is a cyst or abscess near or at the bottom of the coccyx (tip of the spine) just above the buttock crease that contains hair and skin debris; pilonidal means nest of hair; also referred to as a pilonidal abscess or pilonidal sinus.

10081

After appropriate preparation and anesthesia, with the patient lying in the prone (face down) position, the provider incises the area over a pilonidal cyst just above the central buttock crease. She opens the cyst and drains or scrapes out the contents. If the cyst is extremely enlarged, as it would likely be to require a complicated incision and drainage (I&D), it may require a layered closure and drain. She irrigates the wound thoroughly and sutures the incision, in layers if necessary. She may pack the wound with gauze and allow it to heal by secondary intention or leave a tube inserted into the wound before closing, which will be attached to a pump to help drain any fluid that continues to form.

A pilonidal cyst is a cyst or abscess near or at the bottom of the coccyx (tip of the spine) just above the buttock crease that contains hair and skin debris; pilonidal means nest of hair; also referred to as a pilonidal abscess or pilonidal sinus.

10120

When the patient is appropriately prepped and anesthetized, the provider uses appropriate instrumentation to remove the foreign body. As this is a simple incision, it is not complicated; therefore, this type of foreign body removal requires no dissection. The provider incises the skin around the foreign body to better expose it and then removes it with forceps. The provider closes the incision and cleans and dresses the wound.

10121

When the patient is appropriately prepped and anesthetized, the provider uses appropriate instrumentation to remove the foreign body. The provider incises the skin around the foreign body to better expose it. He may perform extended exploration around the wound site, sometimes with the need to use visualization and localization techniques such X-ray or CT scan. The provider controls any bleeding, irrigates the wound, and closes the incision. If deep, the incision may need to be closed in layers. He then cleans and dresses the wound.

10140

When the patient is appropriately prepped and anesthetized, the provider makes an incision into a hematoma, seroma, or other collection of fluids and bluntly penetrates it to allow the fluid to evacuate, with or without the necessity of packing. The provider closes the incision primarily, meaning at that session, or he leaves the incision to heal without closure. The provider may place pressure dressing over the skin.

10160

The provider cleans and isolates the area on the skin and inserts a needle into the fluid deposit area. He then withdraws the fluid or pus through the needle aspiration device. The provider applies antibiotics and dressing. The provider may place a pressure dressing over the area.

10180

The provider cleans the operative site with an antiseptic and may inject a local anesthetic such as lidocaine. Then, he incises the area of wound infection and drains it of fluid collection. He performs copious irrigation of the abscess cavity with something like normal saline solution to adequately remove debris from the wound cavity. This also facilitates subsequent breakup of cavities or compartments of fluid. After complete removal of the pus, he irrigates the wound with an antibiotic solution and packs it with gauze to prevent leakage of cellular fluid from the noninfected tissues surrounding the abscess. Loose packing or gauze allows continued drainage and healing by secondary intention. Alternatively, he may close the wound in layers around a drain. A complicated procedure generally takes longer to perform and requires more extensive expertise and technique on the part of the provider.

11000

When the patient is appropriately prepped and anesthetized, the provider cleans the area of infected skin. The provider then performs debridement by cutting away the dead tissue using surgical instruments like a scalpel or scissors.

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the muscle or tendon sheath, she inspects the area and removes the foreign body. She closes the surgical opening with sutures after thoroughly cleaning the site. The provider may rely on X-ray images taken prior to the procedure to locate the foreign body in the soft tissue and a postprocedure image to ensure the complete removal of all foreign bodies.

20525

When the patient is appropriately prepped and the area anesthetized, the provider incises the skin over the targeted area and separates the tissues. When she reaches the muscle or tendon sheath, the depth of the foreign body or presence of infection may require more difficult dissection or removal of necrotic, or dead, tissue. She removes the foreign body and closes the surgical opening with sutures after thoroughly cleaning the site. The provider may rely on X-ray images taken prior to the procedure to locate the foreign body in the soft tissue and a postprocedure image to ensure the complete removal of all foreign bodies.

20526

When the patient is appropriately prepped and the area anesthetized, the provider locates the injection site on the wrist area between the flexor tendon and the palmar muscle. She injects the appropriate amount of anesthetic or corticosteroid.

20527

When the patient is appropriately prepped and anesthetized, the provider locates the planned injection site. He injects the appropriate amount of collagenase into three different but nearby positions of the Dupuytren's contracture. If necessary, he extends the patient's fingers manually to disrupt the abnormal fascial cord.

20550

After administration of adequate anesthesia and prep and drape, the provider locates the injection site. The appropriate amount of corticosteroid, anesthetic, or anti-inflammatory drug is then injected into the aponeurosis of the tendon sheath and/or ligament.

20551

When the patient is appropriately prepped and the area anesthetized, the provider prepares the site for injection. She may use radiological guidance to identify the tendon origin when it is not possible to visually locate the site of drug delivery. She injects the appropriate amount of corticosteroid, anesthetic, or anti-inflammatory drug directly at the tendon origin or insertion and then withdraws the syringe. The provider observes the patient for any adverse reaction.

20552

When the patient is appropriately prepped and the area anesthetized, the provider palpates, or touches, the muscle to determine the location of a trigger point. She applies firm pressure to the trigger point to assess for referred pain and a twitch response. Then, she slowly injects the appropriate amount of corticosteroid or anesthetic into the trigger point.

20553

When the patient is appropriately prepped and the area anesthetized, the provider palpates the muscle to determine the location of a trigger point. He applies firm pressure to the trigger point to assess for the presence of referred pain and a twitch response. After proper localization, he slowly injects the appropriate amount of corticosteroid or anesthetic into the trigger point of each muscle.

20555

When the patient is appropriately prepped and anesthetized, the provider inserts catheters or needles at the site of a malignancy with the help of radiological guidance. He uses the needle or catheter as the delivery route for the radiotherapy elements or seeds, inserting seeds at this time or on a subsequent encounter. He secures the catheters or needles in place. He adds or remove seeds throughout the treatment phase.

20560

After appropriate cleansing of the site, the provider, usually a physical therapist, inserts a fine filiform disposable needle into a trigger point in 1 or 2 muscles. No medication is injected. This technique is used to treat pain, impaired movement, fibromyalgia, and tension headaches. Although not the same as traditional Chinese acupuncture, this technique may be referred to as trigger point acupuncture or dry needling.

20561

After appropriate cleansing of the site, the provider, usually a physical therapist, inserts a fine filiform disposable needle into a trigger point in 3 or more muscles. No medication is injected. This technique is used to treat pain, impaired movement, fibromyalgia, and tension headaches. Dry needling is not the same as traditional Chinese acupuncture.

20600

When the patient is appropriately prepped and anesthetized, the provider inserts a needle through the skin into the joint or bursa. He then uses a syringe with the needle to remove fluid from the joint or bursa. After he aspirates the joint or bursa, he sends the fluid sample to the laboratory for further examination. He may also inject a drug into the joint or bursa for therapeutic purposes such as pharmacotherapy or lavage. He then removes the needle and applies pressure to stop any bleeding. He does not use ultrasound guidance to perform this procedure. Use this code only when the provider performs aspiration or injection in a small joint or bursa without ultrasound guidance.

20604

When the patient is appropriately prepped and anesthetized, the provider inserts a needle through the skin into the joint or bursa, typically the fingers or toes. Under ultrasound guidance, he then uses a syringe with the needle to remove fluid from the joint or bursa. The provider also permanently records the findings. After he aspirates the joint or bursa, he sends the fluid sample to the laboratory for further examination. He may also inject a drug into the joint or bursa for therapeutic purposes such as for pharmacotherapy or lavage. He then removes the needle and applies pressure to stop any bleeding.

20605

When the patient is appropriately prepped and anesthetized, the provider inserts a needle through the skin into the joint or bursa. He then uses a syringe with the needle to remove fluid from the joint or bursa. After he aspirates the joint or bursa, he sends the fluid sample to the laboratory for further examination. He may also inject a drug into the joint or bursa for therapeutic purposes such as pharmacotherapy or lavage. He then removes the needle and applies pressure to stop any bleeding. He does not use ultrasound guidance to perform this procedure. Use this code only when the provider performs an aspiration or injection in an intermediate joint or bursa without ultrasound guidance.

20606

When the patient is appropriately prepped and anesthetized, the provider inserts a needle through the skin and into the medium sized joint or bursa typically the temporomandibular, acromioclavicular, wrist, elbow, ankle, or olecranon bursa. Under ultrasound guidance, he then uses a syringe with the needle to remove fluid from the joint or bursa. The provider also permanently records the findings. After he aspirates the joint or bursa, he sends the fluid sample to the laboratory for further examination. He may also inject a drug into the joint or bursa for therapeutic purposes such as pharmacotherapy or lavage. He then removes the needle and applies pressure to stop any bleeding.

20610

When the patient is appropriately prepped and anesthetized, the provider inserts a needle through the skin into the joint or bursa. He then uses a syringe with the needle to remove fluid from the joint or bursa. After he aspirates the joint or bursa, he sends the fluid sample to the laboratory for further examination. He may also inject a drug into the joint or bursa for therapeutic purposes such as pharmacotherapy or lavage. He then removes the needle and applies pressure to stop any bleeding. He does not use ultrasound guidance to perform this procedure. Use this code only when the provider performs aspiration or injection in a major joint or bursa without ultrasound guidance.

20611

When the patient is appropriately prepped and anesthetized, the provider inserts a needle through the skin and into the large sized joint or bursa typically the shoulder, hip, knee, or subacromial bursa. Under ultrasound guidance, he then uses a syringe with the needle to remove fluid from the joint or bursa. The provider also permanently records the findings. After he aspirates the joint or bursa, he sends the fluid sample to the laboratory for further examination. He may also inject a drug into the joint or bursa for therapeutic purposes such as pharmacotherapy or lavage. He then removes the needle and applies pressure to stop any bleeding.

20612

When the patient is appropriately prepped and the area anesthetized, the provider inserts a sharp needle through the external skin

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33016

When the patient is appropriately prepped and anesthetized, the provider selects a site typically between the xiphoid process and the left sternocostal margin. The provider may create a small incision to reduce needle resistance and then advances a needle attached to a syringe or suction device into the pericardial space. The provider often uses fluoroscopic or ultrasound imaging guidance to ensure accuracy of the needle placement. The provider identifies the proper location and then aspirates fluid from the pericardial sac into the syringe, after which he withdraws the needle.

Pericardiocentesis may be performed to relieve pericardial effusion or cardiac tamponade as well as for diagnostic, palliative, or prophylactic purposes.

33017

This procedure is performed on a patient who is 6 years old or older and who does not have a congenital cardiac anomaly. When the patient is appropriately prepped and anesthetized, the provider selects a site typically between the xiphoid process and the left sternocostal margin. The provider may create a small incision to reduce needle resistance and then advances a needle attached to a syringe or suction device into the pericardial space. The provider often uses fluoroscopic or ultrasound imaging guidance to ensure accuracy of the needle placement. The provider identifies the proper location and then aspirates fluid from the pericardial sac into the syringe, after which he withdraws the needle. He then inserts a catheter through the same puncture site, which he leaves indwelling for further drainage in case the fluid builds up again.

Pericardial drainage may be performed to relieve pericardial effusion or cardiac tamponade as well as for diagnostic, palliative, or prophylactic purposes.

33018

This procedure is performed on a patient who is a newborn up through 5 years old or any patient of any age with a congenital cardiac anomaly. When the patient is appropriately prepped and anesthetized, the provider selects a site typically between the xiphoid process and the left sternocostal margin. The provider may create a small incision to reduce needle resistance and then advances a needle attached to a syringe or suction device into the pericardial space. The provider usually uses fluoroscopic or ultrasound imaging guidance to ensure accuracy of the needle placement and assess the congenital cardiac anomaly. The provider identifies the proper location and then aspirates fluid from the pericardial sac into the syringe, after which he withdraws the needle. He then inserts a catheter through the same puncture site, which he leaves indwelling for further drainage in case the fluid builds up again.

Pericardial drainage may be performed to relieve pericardial effusion or cardiac tamponade as well as for diagnostic, palliative, or prophylactic purposes.

33019

When the patient is appropriately prepped and anesthetized, the provider selects a site typically between the xiphoid process and the left sternocostal margin. The provider may create a small incision to reduce needle resistance and then advances a needle attached to a syringe or suction device into the pericardial space. The provider may use CT imaging guidance to ensure accuracy of the needle placement. The provider identifies the proper location and then aspirates fluid from the pericardial sac into the syringe, after which he withdraws the needle. He then inserts a catheter through the same puncture site, which he leaves indwelling for further drainage in case the fluid builds up again.

Pericardial drainage may be performed to relieve pericardial effusion or cardiac tamponade as well as for diagnostic, palliative, or prophylactic purposes.

33020

When the patient is appropriately prepped and anesthetized, the provider chooses an approach to expose the pericardium, such as making a small incision by excising the xiphoid process and retracting the diaphragm downward. She then makes an incision in the pericardium, allowing access for removal of the clot or foreign body. The provider closes the wound by sutures.

33025

When the patient is appropriately prepped and anesthetized, the provider makes an incision through the sternum such as by median sternotomy to reach the pericardium. The provider then creates an opening by removing a section of the pericardium, facilitating drainage. The provider then closes the incision and dresses the wound.

This code represents drainage of pericardial fluid when there is a large accumulation of pericardial fluid resulting in too much pressure on the pericardium and pleural space.

33030

When the patient is appropriately prepped and anesthetized, the provider makes an incision, typically on the front of the chest, known as median sternotomy, or on the side, known as anterolateral thoracotomy, and uses a rib spreader to spread the ribs apart. She then excises the damaged pericardial tissue. The provider then closes the incisions and dresses the wound.

33031

When the patient is appropriately prepped and anesthetized, the provider makes an incision over the sternum, dividing it, and enters into the chest cavity. He gains access to the pericardium, which is the outer most covering of the heart. The provider may excise the layer either completely or partially. During the procedure the provider uses a device called a cardiopulmonary bypass unit, which temporarily takes on the functions of heart and lung so that the heart and lungs are motionless while the provider performs the procedure. After the procedure, the provider restores the natural circulation of blood via the heart, wires the sternum to let it join naturally, and closes the incision with sutures.

33050

When the patient is appropriately prepped and anesthetized, the provider makes an incision, typically on the front of the chest, known as median sternotomy, or on the side, known as anterolateral thoracotomy, to approach the pericardium. She excises the mass with margins. She may use a bovine pericardial patch to close the defect. The provider closes the surgical incisions and dresses the sternal wound.

33120

When the patient is appropriately prepped and anesthetized, the provider makes an incision on the sternum, known as full median sternotomy, to access the heart. She institutes cardiopulmonary bypass, often by cannulating blood vessels through this incision. The provider then performs tumor resection, or removal, through the right atrium and across the intra-atrial septum; or the provider goes through the tricuspid valve to excise the tumor. The provider then closes the incision and dresses the wound, ensuring the patient's normal cardiac and pulmonary functions have returned.

33130

When the patient is appropriately prepped and anesthetized, the provider makes an incision on the sternum, known as full median sternotomy, to access the heart. She then opens the pericardium and removes the tumor. The provider may use a patch to cover the defect. She then closes the incision and dresses the wound.

33140

When the patient is appropriately prepped and anesthetized, the provider approaches the heart via thoracotomy, opens the pericardium, and identifies the ischemic area. She then places a laser probe in contact with the epicardium and vaporizes the myocardium in its path. A small channel extends from the heart's surface to the ventricular cavity. The provider may or may not perform the procedure using cardiopulmonary bypass. The provider closes the incisions by sutures and dresses the wound.

This code represents services involving transmyocardial revascularization by thoracotomy.

33141

When the patient is appropriately prepped and anesthetized, at the same encounter as another open cardiac procedure, the provider performs this service as a separately reportable procedure. The provider approaches the heart via thoracotomy, opens the pericardium, and identifies the ischemic area. She then places a laser probe in contact with the epicardium and vaporizes the myocardium in its path. A small channel extends from the heart's surface to the ventricular cavity.

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bypass (CPB). The provider opens the right atrium and examines the first ventricular septal defect. He closes it with a patch or sutures. He locates the second ventricular septal defect and closes it with either a patch or sutures. Locating the defect may require a separate incision. He repeats these steps for any additional defects. He excises the pulmonary artery band and removes scar tissue. He then connects the ends of the artery or uses a gusset or patch to reconstruct the pulmonary artery. The provider closes the incisions in the heart, takes the patient off CPB, checks for bleeding, removes any instruments, and finally closes the incision in the chest.

33681

When the patient is appropriately prepped and anesthetized, the provider makes an incision in the chest to access the heart. He places the patient on cardiopulmonary bypass (CPB). The provider opens the heart, typically through the pulmonary artery, and examines the ventricular septal defect. He determines whether to take an atrial or ventricular approach. He closes the defect with a patch or sutures. He takes the patient off CPB. The provider closes the incisions in the heart, checks for bleeding, removes any instruments, and finally closes the incision in the chest.

33684

When the patient is appropriately prepped and anesthetized, the provider makes an incision in the chest to access the heart. He places the patient on cardiopulmonary bypass (CPB). The provider opens the heart through the pulmonary artery or right ventricle. He examines the ventricular septal defect. He determines whether to take an atrial or ventricular approach. He closes the defect with a patch or sutures. He makes incisions in the pulmonary valve at the junction of the leaflets and removes any obstruction to the right ventricular outflow tract caused by infundibular muscle. He takes the patient off CPB and closes the incisions in the heart, checks for bleeding, removes any instruments, and finally closes the incision in the chest.

33688

When the patient is appropriately prepped and anesthetized, the provider makes an incision in the chest to access the heart. He places the patient on cardiopulmonary bypass (CPB). The provider opens the heart and examines the ventricular septal defect. He determines whether to take an atrial or ventricular approach. He closes the defect with a patch or sutures. He excises the pulmonary artery band and removes scar tissue and connects the ends of the artery or uses a patch to reconstruct the pulmonary artery. The provider takes the patient off CPB, closes the incisions in the heart, checks for bleeding, removes any instruments, and finally closes the incision in the chest.

33690

When the patient is appropriately prepped and anesthetized, the provider makes an incision in the chest to access the heart, typically a left anterior thoracotomy, which exposes the main pulmonary artery and aorta. She prepares the band and chooses a location in the mid portion of the main pulmonary trunk. She places the band, taking care not to injure the artery. She uses sutures and pledgets to prevent movement of the band and uses hemoclips to adjust band circumference. The provider checks for bleeding, removes any instruments, and finally closes the incision in the chest.

33692

When the patient is appropriately prepped and anesthetized, the provider makes an incision in the chest to access the heart, typically a median sternotomy. She places the patient on cardiopulmonary bypass (CPB). She approaches the ventricular septal defect either through the atrium or the ventricle and closes the defect, typically with a polytetrafluoroethylene (PTFE) patch graft. She removes muscle as needed to relieve the right ventricular outflow tract obstruction. The provider then takes the patient off CPB, closes the incisions in the heart, checks for bleeding, removes any instruments, and finally closes the incision in the chest.

33694

When the patient is appropriately prepped and anesthetized, the provider makes an incision in the chest to access the heart, such as by median sternotomy. She places the patient on cardiopulmonary bypass (CPB). She approaches the ventricular septal defect either through the atrium or the ventricle and closes the defect, typically with a polytetrafluoroethylene (PTFE) patch graft. She removes infundibular muscle as needed to relieve the right ventricular outflow tract obstruction. She examines the pulmonary anulus and enlarges it as appropriate for the patient, using incisions and suturing a patch to the pulmonary artery and ventricle incisions. The provider takes the patient off CPB, closes the incisions in the heart, checks for bleeding, removes any instruments, and finally closes the incision in the chest.

33697

When the patient is appropriately prepped and anesthetized, the provider makes an incision in the chest to access the heart, typically a median sternotomy. She places the patient on cardiopulmonary bypass (CPB). She approaches the ventricular septal defect either through the atrium or the ventricle and closes the defect, typically with a polytetrafluoroethylene (PTFE) patch graft. She examines the right ventricular outflow tract and decides to place a conduit, or tube-shaped graft, from the right ventricle to the distal pulmonary artery. She makes incisions in the pulmonary artery and in the right ventricle, and then connects the ends of the conduit to the artery and ventricle incisions. The provider takes the patient off CPB, closes the incisions in the heart, checks for bleeding, removes any instruments, and finally closes the incision in the chest.

33702

When the patient is appropriately prepped and anesthetized, the provider makes an incision in the chest to access the heart, typically a median sternotomy. He initiates cardiopulmonary bypass. He exposes the fistula by making an incision in the heart. He uses sutures and patches as needed to repair the abnormal opening. The provider closes the incisions in the heart, checks for bleeding, removes any instruments, and finally closes the incision in the chest.

33710

When the patient is appropriately prepped and anesthetized, the provider incises the chest wall to access the heart. He usually opens the chest through a median sternotomy incision, an approach in which he incises the sternum (breastbone) in the midline to open the chest. When appropriate, the provider places the patient on cardiopulmonary bypass. He exposes the sinus of Valsalva fistula by making an incision in the heart, and then he assesses the patient's anatomy to decide how to repair. He uses a patch or graft to repair the abnormal connection. He next assesses the ventricular septal defect and uses another patch or graft to repair the hole. He then discontinues the cardiopulmonary bypass and restarts the heart. Finally, he stops all bleeding and closes the chest wall by suturing the tissues in layers.

33720

When the patient is appropriately prepped and anesthetized, the provider incises the chest wall to access the heart. He usually opens the chest through a median sternotomy incision, an approach in which he incises the sternum (breastbone) in the midline to open the chest. When appropriate, the provider places the patient on cardiopulmonary bypass. He exposes the sinus of Valsalva aneurysm by making an incision in the heart, and then he assesses the patient's anatomy for the best way to repair it. Next, he makes an incision in the aorta and closes the neck of the aneurysm with stitches. Then, he repairs or replaces the nonfunctional aortic valve. He replaces the aortic valve with either a mechanical or biological aortic valve. He then discontinues the cardiopulmonary bypass and restarts the heart. Finally, he stops all bleeding and closes the chest wall by suturing the tissues in layers.

33724

When the patient is appropriately prepped and anesthetized, the provider incises the chest wall to access the heart. He usually opens the chest through a median sternotomy incision, an approach in which he incises the sternum (breastbone) in the midline to open the chest. Next, he incises the right atrium and opens the atrial septum, near the pulmonary veins that are draining abnormally into the right atrium. He creates a baffle, or an alternate pathway, to direct the veins to drain to the left atrium across the opening he creates in the atrial septum. Alternatively, he may use a patch, or graft, to enlarge the joining of the inferior or superior vena cava with the right atrium and to divert the anomalous, or abnormal, pulmonary veins from the right to the left atrium. Then he closes the atrium by suturing the incision line. Finally, he stops all bleeding and closes the chest wall by suturing the tissues in layers.

33726

When the patient is appropriately prepped and anesthetized, the provider incises the chest wall to access the pulmonary vein in the heart. She usually opens the chest through a median sternotomy incision, an approach in which she incises the sternum (breastbone) in

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70010

This code represents the technical and professional components of a service. The provider performs radiographic diagnostic study of the posterior cranial fossa while utilizing fluoroscopy imaging for the assessment of any intracranial pathology. He performs a lumbar puncture and injects contrast material into the subarachnoid space to enhance image sequences. He supervises the performance of the entire radiological procedure and interprets the findings. The provider who performs imaging supervision and interpretation for this procedure reports this code.

70015

This code represents the technical and professional components of a service in which the provider performs radionuclide imaging of the basal cisterns of the brain to determine abnormal CSF flow or leak. He performs a lumbar puncture and injects contrast material in the form of radioisotopes into the subarachnoid space. He supervises the performance of the entire radiological procedure and interprets the findings. The provider who performs imaging supervision and interpretation for this procedure reports this code.

70030

The provider takes a plain X-ray of the eye to determine whether the patient has a foreign body in the eye.

70100

The provider takes plain X-rays of the lower jaw bone. He obtains one, two, or three views of the mandible from different angles or projections.

70110

The provider takes plain X-rays of the lower jaw bone. He obtains four or more views of the mandible from different angles, or projections.

70120

The provider takes plain X-rays that consist of 1 or 2 projections of the mastoid portion of temporal bone unilaterally, or on one side.

70130

The provider takes plain X-rays, 3 or more views, of the mastoid portion of the temporal bone unilaterally, or on one side.

70134

The provider takes plain X-rays of the internal auditory meati of the inner ears in multiple projections to diagnose abnormalities in the hearing apparatus.

70140

The provider takes plain X-rays of the facial bones, 1 or 2 views, to diagnose fracture or injury. The preferred examination includes the acquisition of Waters, or occipitomental, PA, or lateral views or projections.

70150

The provider takes plain X-rays of the facial bones, 3 or more views, to diagnose a fracture or injury. The preferred examination includes the acquisition of Waters, or occipitomental, PA, or lateral views or projections.

70160

The provider X-rays the nasal bones, with a minimum of three views, to diagnose a nasal fracture or nasal septal deformity. The preferred examination includes the acquisition of Waters, or occipitomental, PA, and lateral nasal views or projections.

70170

This code represents the technical and professional components of a service in which the provider performs or supervision and interpretation of radiographic examination of the lacrimal sacs and ducts. The patient undergoes separately reportable injection of contrast medium through the inferior canaliculus after administration of local anesthesia. The provider supervises the performance of the entire radiological procedure and interprets the findings. The provider who performs imaging supervision and interpretation for this procedure reports this code.

70190

The provider performs X-ray examination of the optic foramina to diagnose any pathology in optic nerve and ophthalmic artery. X-ray of optic foramina is usually performed to identify any serious injury, abnormal growth of tissue in the optic nerve, or foreign bodies.

70200

The provider takes a minimum of four images of the injured eye, along with images of the unaffected eye for comparison purposes, for detailed visualization of multiple eye parts. This exam includes optic canal projections. Usually, lateral, PA, base view, and half axial projections are taken after adequate positioning of the patient. The provider performs the procedure for assessment of orbital fractures or foreign body.

70210

The provider performs X-ray examination of paranasal sinuses by obtaining one or two views through single and or multiple sinus projections. The provider also detects the presence of fluids, if any, in the frontal, maxillary, sphenoid, or ethmoid sinuses. He performs the procedure for the assessment of sinusitis.

70220

The provider performs X-ray examination of the paranasal sinuses by obtaining a minimum of three views through multiple sinus projections. The provider also detects the presence of fluids, if any, in the frontal, maxillary, sphenoid, or ethmoid sinuses.

70240

The provider performs AP and lateral X-ray views of the sella turcica. The technique involves focusing the X-ray beam on the sphenoid bone to generate radiologic images.

70250

The provider performs skull X-rays to examine the skull, nose, sinuses, and facial bones for fracture or intracranial injury. The preferred examination of the skull includes anteroposterior, or front to back; posteroanterior, or back to front; and lateral views or projections. Report this code if radiological examination of patient's skull includes fewer than 4 views.

70260

The provider performs skull X-rays to examine the skull, nose, sinuses, and facial bones. The preferred examination of the skull includes anteroposterior, or front to back; posteroanterior, or back to front; inferior views; and lateral views or projections. Report this code if radiological examination of patient's skull includes 4 or more views.

70300

The provider takes a single view of the patient's teeth. Structures that are dense, such as silver fillings or metal restoration, block most of the photons and appear white on developed film. Structures containing air appear black on film, and teeth, tissue, and fluid appear as shades of gray.

70310

The test is performed in the dentist's office. The provider performs an X-ray of only a part of the mouth (not total) to identify abnormalities in teeth and surrounding tissue. Structures that are dense (silver fillings or metal restoration) block most of the photons and appear white on developed film. Structures containing air appear black on film, and teeth, tissue, and fluid appear as shades of gray.

Dental X-rays show a normal number, structure, and position of the teeth and jaw bones. Dental X-rays can reveal dental cavities (tooth decay) before they are visible even to the dentist. There are two main types of dental X-rays:

Intraoral: They are the most common type of dental X-ray taken. They allow a dentist to find cavities, check the health of the tooth root and bone surrounding the tooth, check the status of developing teeth.

Extraoral: These X-rays show teeth, but their main focus is the jaw and skull. Extraoral X-rays are used to look for impacted teeth and to identify potential problems between teeth and jaws.

70310 reports a partial examination.

70320

The test is performed in the dentist's office. The provider performs a full mouth radiograph (X-ray) to identify abnormalities in teeth and surrounding tissue. Structures that are dense (silver fillings or metal restoration) block most of the photons and appear white on developed film. Structures containing air appear black on film, and teeth, tissue, and fluid appear as shades of gray.

70328

The provider takes X-rays from one side of the temporomandibular joint, or TMJ, with the mouth open and closed. He performs the procedure in patients who have arthralgia of the TMJ or whose TMJ makes abnormal clicking noises when opening and closing the jaw, which could indicate an articular disc disorder.

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biological compound throughout the heart muscle. The provider may also evaluate ventricular wall motion (the pumping action of the heart) and the ejection fraction (the percentage of blood pumped out of a filled ventricle with each heartbeat). These images help the provider in metabolic evaluation. He can draw inferences about whether the heart muscle is functioning normally or not. After evaluating the heart function, the provider prepares a report.

78466

Nuclear medicine imaging involves administering radiopharmaceuticals to the patient; the radiopharmaceutical emits radiation that a scanner detects and produces an image that helps the provider to diagnose, manage, and treat diseases. The goal of this procedure is to assess the flow of blood to the heart muscle, typically within three days of an MI, or myocardial infarction. When the patient is appropriately prepped for the test, the provider injects a radioactive tracer into the vein of the patient. This radioactive tracer travels toward the heart muscle. The radioactive part of the tracer gives off gamma radiations detected by a gamma camera that produces two dimensional images of the radioactive substance throughout the heart muscle. The provider uses these images to determine the location and extent of infarct in the heart muscle.

78468

Nuclear medicine imaging involves administering radiopharmaceuticals to the patient; the radiopharmaceutical emits radiation that a scanner detects and produces an image that helps the provider to diagnose, manage, and treat diseases. The goal of this procedure is to assess the flow of blood to the heart muscle, typically within three days of a myocardial infarction. Myocardial infarction, or MI, is the irreversible damage of the myocardium or heart muscle due to ischemia caused by a blood clot. When the patient is appropriately prepped for the test, the provider injects a radioactive tracer into the vein of the patient. This radioactive tracer travels toward the heart muscle. The radioactive part of the tracer gives off gamma radiations detected by a gamma camera that produces two dimensional images of the distribution of the radioactive substance throughout the heart muscle. In first pass technique, the provider uses these images to determine the ejection fraction from the ventricles of the heart by measuring the change in radioactivity as the radioactive substance passes through the heart. For first pass, the camera visualizes the radiopharmaceutical as it passes from the patient's venous system through the heart and lungs. The provider performs this imaging as the agent makes its first pass through the heart. Ejection fraction is the amount of blood that a ventricle of the heart pumps out with each contraction.

78469

SPECT, single photon emission computed tomography, is a nuclear imaging test that combines two technologies, computed tomography and a tracer, which is a radioactive material. The goal of this procedure is to assess the flow of blood to the heart muscle, typically within three days of an MI. When the patient is appropriately prepped for the test, the provider injects a radioactive tracer into the vein of the patient. This radioactive tracer travels toward the heart muscle. The radioactive part of the tracer gives off gamma radiations detected by multi-headed gamma cameras that rotate around the patient. SPECT is different from the conventional planar imaging using a gamma camera as SPECT can provide 3-dimensional images of the heart by adding together the 2-dimensional cross-sectional images obtained through the camera. You should not report same session planar imaging separately. SPECT imaging reveals the distribution of the radioactive tracer revealing the relative blood flow to the different regions of the myocardium.

78472

Before images are taken, a radionuclide is injected into the bloodstream. The images are taken through a gamma camera at different intervals during the cardiac cycle. A MUGA scan is performed while the patient is at rest and again while stressed. Report 78472 if the procedure is performed as a single study at rest or stress, but not both. If a stress study is performed, stress may involve the patient exercising on a treadmill or the injection of a drug to stimulate the heart as though the patient were exercising.

78473

Before images are taken, a radionuclide is injected into the bloodstream. The images are taken through a gamma camera at different intervals during the cardiac cycle. A MUGA scan is performed while the patient is at rest and again while stressed. Report 78473, if the procedure is performed at both rest and stress. Stress may involve either exercise or pharmacologic stress, which requires the injection of a drug that causes the heart to beat more forcefully as though exercising.

78481

Cardiac blood pool imaging, also known as radionuclide ventriculography, is a diagnostic test for evaluating left ventricular function. The function of the left ventricle is to pump blood and distribute the blood throughout the body. The goal of this test is to evaluate how well the heart is pumping blood to the rest of the body by checking the heart wall motion and ejection fraction. When the patient is appropriately prepped for the test, the provider injects a bolus of radioactive tracer into the vein of the patient. This radioactive tracer travels toward the heart. The radioactive part of the tracer gives off gamma radiations as it travels through the heart and lungs. The provider uses a gamma camera that detects the gamma radiations given off by the tracer. The computer uses this data to form images. The provider uses a first pass technique in which he performs imaging as the blood passes through the heart and lungs the first time. This provider performs the study with the patient either at rest or with exercise or drug induced stress. Use this code when the provider performs a single study, either at rest or with stress.

78483

Cardiac blood pool imaging, also known as radionuclide ventriculography, is a diagnostic test for evaluating the left ventricular function. The function of the left ventricle is to pump blood and distribute the blood throughout the body. The goal of this test is to evaluate how well the heart is pumping blood to the rest of the body by checking the heart wall motion and ejection fraction. When the patient is appropriately prepped for the test, the provider injects a bolus of radioactive tracer into the vein of the patient. This radioactive tracer travels toward the heart. The radioactive part of the tracer gives off gamma radiations as it travels through the heart and lungs. The provider uses a gamma camera that detects the gamma radiations given off by the tracer. The computer uses this data to form images. The provider uses a first pass technique in which he performs imaging as the blood passes through the heart and lungs the first time. This provider performs the study with the patient at rest and with exercise or drug induced stress. Use this code when the provider performs multiple studies, such as both at rest and with stress.

78491

Myocardial imaging by positron emission tomography (PET) scan is a diagnostic nuclear medicine imaging procedure that produces three-dimensional images to show how the heart is working. The provider injects a radioactive tracer or radionuclide into the bloodstream of the patient. This radionuclide is created by applying a radioactive atom to any biological compound or drug. The radionuclide travels in the bloodstream to the heart and breaks in the target area into tiny positively charged particles called positrons, which emit gamma rays. The provider uses a special device called a PET scanner that detects the gamma rays given off by the radioactive substance. The computer then processes the emitted data to produce multidimensional images of the distribution of the drug or biological compound throughout the heart muscle. The provider obtains three-dimensional images of the heart at rest on the monitor that reveal how blood flows through the heart (perfusion). She also induces stress, using a drug or exercise, and obtains more images, which further help the provider evaluate the perfusion of the heart. The provider may also evaluate ventricular wall motion (the pumping action of the heart) and the ejection fraction (the percentage of blood pumped out of a filled ventricle with each heartbeat). After evaluating the heart function, the provider prepares a report.

78492

A PET scan provides three-dimensional images of the scanned area that makes it easy to detect an area of the heart that has poor blood flow indicating diseased vessels or poorly functioning ventricles. The provider injects the patient with a radiopharmaceutical tracer called fluorodeoxyglucose (FDG), a radioactive substance containing glucose, about one hour before the imaging is scheduled to begin. The radiotracer spreads in the body through the bloodstream and gets absorbed by the cells and starts emitting small amounts of energy (positrons). The positrons collide with electrons resulting in

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Medical Terms Glossary

Medical Term	Description
11 deoxycortisol	A precursor of cortisol; a steroid hormone, also known as compound S.
23 valent	A vaccine that contains 23 of the most common types of pneumococcal bacteria to help prevent infection.
Ab externo	Outside the eye; indicates a surgical procedure starting from the eye's exterior and proceeding to the anterior chamber.
Abbe-Estlander operation	Transfer of a full-thickness section of one lip to the other lip to correct a defect.
Abdominal aorta	Largest artery supplying the abdominal cavity, part of the aorta and continuation of the descending aorta from the thorax; it divides further into the iliac arteries.
Abdominal aortic aneurysm, or AAA	Widening of the abdominal aorta due to weakening in the wall of the aorta.
Abdominal approach	Surgical incision in the abdomen to perform an abdominal operation.
Abdominal paracentesis	Surgical puncture of the abdominal cavity for the removal of fluid for diagnosis or treatment.
Abdominal pregnancy	Implantation of a fertilized egg in the peritoneal cavity, including on the omentum, the abdominal wall, or on the outside of the uterus.
Abdominal wall	Refers to the muscles covering the abdomen or to the skin, fascia, muscle, and membranes marking the boundaries of the abdominal cavity.
Abdominoperineal	Refers to the abdomen and the perineum.
Abdominoperineal pull-through procedure	A surgical procedure that involves two approaches, one through the abdomen and a second through the perineum.
Abdominoperineal resection, or APR	The surgical removal of the anus, rectum, and part of the sigmoid colon, along with regional lymph nodes, through incisions made in the abdomen and perineum.
Abduction	Movement of a body part away from the medial line of the body.
Abduction pillow	A medical device used to immobilize an extremity after a surgical procedure to help decrease the risk of a dislocation; also known as an abduction splint.
Abductor	Muscle that draws a body part away from the midline of the body.
Abductor hallucis muscle	Muscle running along the inside of the foot.
Aberrant	Unusual or abnormal.
Aberrant vessel	Blood vessel having an unusual origin or course.
Ablation	Removal of tissue, a body part, or an organ or destruction of its function; to ablate.
ABO incompatibility	An abnormal transfusion reaction between blood cells of incompatible blood types A, B, AB or O, resulting in destruction of blood cells and the formation of clumps.
Abortion	Clinical term for the termination of a pregnancy before the age of viability, usually before 20 completed weeks of gestation; an induced abortion is also known as a therapeutic abortion, or TAB; a spontaneous abortion is commonly known as a miscarriage.
Above knee amputation, or AKA	Surgical removal of the lower leg above the level of the knee joint.
Abrasion	Removal of superficial layers of skin.
Abrasion arthroplasty	Refinishing the surfaces of a joint through a grinding process.
Abscess	A collection of pus in a walled off sac or pocket, the result of infection.
Abscess cavity	Pocket formed due to the accumulation of purulent material, or pus.
Absorption	Taking in of substances by tissues.
Acceleration and deceleration forces	Excessive strain put on the muscles, tendons, and joints, primarily of the spine, due to a body moving at high speed and coming to a sudden, rapid stop.
Accelerometer	Device to measure motion of a body.
Accessory navicular bone	An extra bone on the inner side of the foot that can cause irritation and require removal.
Accessory nerve	One of a pair of motor nerves that primarily supply the pharynx and muscles of the upper chest, back, and shoulders.

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