CODERS' SPECIALTY GUIDE

Neurology & Neurosurgery

2027

AAPC

Your essential illustrated coding guide for neurology & neurosurgery, including CPT®, HCPCS Level II, tips, CPT® to ICD-10-CM Cross References, NCCI edits, and RVU information

Contents

Anesthesia

00210

Anesthesia for intracranial procedures; not otherwise specified

Clinical Responsibility

The anesthesia provider performs a pre-operative evaluation of the patient. The anesthesia provider induces the patient and monitors the patient during an intracranial procedure that a different provider performs. The anesthesia provider notes any types and amounts of medications administered, all forms of monitoring used, patient responses, and the start and stop times of anesthesia care. Following the procedure, the anesthesia provider oversees the patient's transfer to post-anesthesia care. The services represented by anesthesia codes 00100 to 01999 include a pre- and post-operative visit to assess the patient, anesthesia care during the procedure, the administration of fluids and/or blood as necessary, and standard monitoring services such as ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry. Standard anesthesia services do not include unusual forms of monitoring such as the use of Swan-Ganz catheters, intra-arterial lines, or central venous lines, and you therefore may code those separately when sufficient supporting documentation is available.

Coding Tips

Anesthesia time is the period of time when the anesthesia provider is present with the patient. It starts when the anesthesia provider prepares the patient for anesthesia induction in the operating room or procedure room, not during the preanesthesia evaluation. The anesthesia provider's time associated with the patient's care ends when the anesthesia provider no longer renders services to the patient or another provider assumes responsibility for the patient's postoperative care. Payers typically use anesthesia time as part of the unit calculation for the anesthesia service. For instance, a payer may count each 15-minute block of time as a single unit, so you'd divide the total anesthesia minutes by 15 to determine the time units. Other payers may require the use of an eight minute or 10-minute block of time. You then add the time units to the number of base units the payer assigns to the anesthesia code to determine the total units. The anesthesia provider documents total anesthesia time in the patient's anesthesia medical record. Report the total units of time in block 24G of the CMS 1500 form.

When coding and billing for multiple anesthesia services for the same patient during the same encounter, assign the most complex anesthesia procedure code with the highest base unit value, a number that represents the complexity level of anesthesia, risk to the patient, and the level of the anesthesia provider's skills needed to perform the service. Add the anesthesia time for all procedures combined, then divide it by the time unit increment the payer uses to determine the total units to bill on the claim form. Bill the payer for the combined dollar amount for all anesthesia services for the patient.

Assign a qualifying circumstances code to complex anesthesia cases including 99100, Anesthesia for patient of extreme age, younger than one year and older than 70; 99116, Anesthesia complicated by utilization of total body hypothermia; 99135, Anesthesia complicated by utilization of controlled hypotension; and 99140, Anesthesia complicated by emergency conditions.

The anesthesia provider, not the coder, typically assigns a physical status modifier of P1 to P6 to describe the patient's health status for anesthesia services.

Append the appropriate HCPCS Level II modifiers to the anesthesia codes for Medicare and for other payers requiring the modifiers to describe anesthesia services the physician or CRNA renders, including AA, AD, QK, QY, GC, QX, and QZ.

Append the appropriate HCPCS Level II modifiers to the anesthesia codes for Medicare and for other payers requiring the modifiers to describe monitored anesthesia care (MAC) including G8, G9, and QS.

Medicare reimburses anesthesia services for the following types of providers: qualified anesthesiologist, doctor of medicine or osteopathy other than an anesthesiologist, dentist, oral surgeon, or podiatrist who is qualified to administer anesthesia under state law, certified registered nurse anesthetist (CRNA) under the supervision of an operating surgeon or an anesthesiologist who is immediately available if needed, or anesthesiologist assistant (AA), working under the supervision of an anesthesiologist who is immediately available if needed.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor : N/A, Facility Fee: N/A, Non Facility Fee: N/A; Non-QP Conversion Factor $33.4009, Facility Fee: $0.00, Non Facility Fee: $0.00
RVU (Facility): Work 0, PE 0, Mal 0, Total 0.00
RVU (Non-Facility): Work 0, PE 0, Mal 0, Total 0.00
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: J, PC/TC Indicator: 9, Endoscopic Base Code: None
Practitioner MUE: 0

Modifier Allowances

23, 53, 76, 77, AA, AD, CR, ET, G8, G9, GA, GC, GJ, GR, KX, P1, P2, P3, P4, P5, P6, Q5, Q6, QK, QS, QX, QY, QZ

NCCI Alerts (version 32.0)

01996[1], 0213T[1], 0216T[1], 0333T[0], 0464T[0], 0632T[1], 0708T[0], 0709T[0], 0903T[1], 0904T[1], 0905T[1], 31505[1], 31515[1], 31527[1], 31622[1], 31634[1], 31645[1], 31647[1], 36000[1], 36010[0], 36011[1], 36012[1], 36013[1], 36014[1], 36015[1], 36400[1], 36405[1], 36406[1], 36410[1], 36420[1], 36425[1], 36430[1], 36440[1], 36591[0], 36592[0], 36600[1], 36640[1], 43752[1], 43753[1], 43754[1], 61026[1], 61055[1], 62280[1], 62281[1], 62282[1], 62284[1], 62320[1], 62321[1], 62322[1], 62323[1], 62324[1], 62325[1], 62326[1], 62327[1], 64400[1], 64405[1], 64408[1], 64415[1], 64416[1], 64417[1], 64418[1], 64420[1], 64421[1], 64425[1], 64430[1], 64435[1], 64445[1], 64446[1], 64447[1], 64448[1], 64449[1], 64450[1], 64451[1], 64454[1], 64461[1], 64463[1], 64466[1], 64467[1], 64468[1], 64469[1], 64473[1], 64474[1], 64479[1], 64483[1], 64486[1], 64487[1], 64488[1], 64489[1], 64490[1], 64493[1], 64505[1], 64510[1], 64517[1], 64520[1], 64530[1], 64553[1], 64555[1], 67500[1], 76000[1], 76998[0], 77002[0], 90865[1], 92511[1], 92512[1], 92516[1], 92520[1], 92537[1], 92538[1], 92652[0], 92653[0], 92950[1], 92953[1],

Modifier: 0 = not allowed, 1 = allowed

92960[1], 92961[1], 93000[1], 93005[1], 93010[1], 93040[1], 93041[1], 93042[1], 93050[0], 93303[0], 93304[0], 93306[1], 93307[1], 93308[1], 93312[1], 93313[1], 93314[1], 93315[1], 93316[1], 93317[1], 93318[0], 93351[1], 93355[0], 93451[1], 93456[1], 93457[1], 93598[0], 93701[0], 93922[1], 93923[1], 93924[1], 93925[1], 93926[1], 93930[1], 93931[1], 93970[1], 93971[1], 93975[1], 93976[1], 93978[1], 93979[1], 93980[1], 93981[1], 93985[1], 93986[1], 94002[1], 94004[1], 94200[1], 94640[1], 94644[1], 94660[1], 94680[1], 94681[1], 94690[1], 94760[0], 94761[0], 94762[1], 95700[0], 95705[0], 95706[0], 95707[0], 95708[0], 95709[0], 95710[0], 95711[0], 95712[0], 95713[0], 95714[0], 95715[0], 95716[0], 95717[0], 95718[0], 95719[0], 95720[0], 95721[0], 95722[0], 95723[0], 95724[0], 95725[0], 95726[0], 95812[0], 95813[0], 95816[0], 95819[0], 95822[0], 95829[0], 95860[0], 95861[0], 95863[0], 95864[0], 95865[0], 95866[0], 95867[0], 95868[0], 95869[0], 95870[0], 95907[0], 95908[0], 95909[0], 95910[0], 95911[0], 95912[0], 95913[0], 95925[0], 95926[0], 95927[0], 95928[0], 95929[0], 95930[0], 95933[0], 95937[0], 95938[0], 95939[0], 95940[0], 95955[0], 95957[0], 96360[0], 96365[0], 96372[0], 96373[0], 96374[0], 96375[0], 96376[0], 96377[0], 96523[0], 99151[0], 99152[0], 99153[0], 99155[0], 99156[0], 99157[0], 99202[0], 99203[0], 99204[0], 99205[0], 99211[0], 99212[0], 99213[0], 99214[0], 99215[0], 99221[0], 99222[0], 99223[0], 99231[0], 99232[0], 99233[0], 99234[0], 99235[0], 99236[0], 99238[0], 99239[0], 99281[0], 99282[0], 99283[0], 99284[0], 99285[0], 99304[0], 99305[0], 99306[0], 99307[0], 99308[0], 99309[0], 99310[0], 99315[0], 99341[0], 99342[0], 99347[0], 99348[0], 99349[0], 99358[0], 99359[0], 99415[0], 99416[0], 99418[0], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99466[0], 99468[0], 99469[0], 99471[0], 99472[0], 99475[0], 99476[0], 99477[0], 99478[0], 99479[0], 99480[0], 99483[0], 99485[0], 99497[0], C8921[1], C8922[1], C8923[1], C8924[1], C8925[1], C8926[1], C8927[0], C8929[1], C8930[1], G0380[1], G0381[1], G0382[1], G0383[1], G0384[1], G0406[0], G0407[0], G0408[0], G0425[0], G0426[0], G0427[0], G0453[0], G0463[0], G0500[0], G0508[0], G0509[0]

ICD-10-CM Cross References

ICD-10-CM contains hundreds of matches for this code. Please check individual payer guidelines for specific coverage determinations.

00211

Anesthesia for intracranial procedures; craniotomy or craniectomy for evacuation of hematoma

Clinical Responsibility

The anesthesia provider performs a pre-operative evaluation of the patient. The anesthesia provider induces the patient and monitors the patient during the intracranial surgery that a different provider performs that involves removing a small portion of skull bone through craniotomy or craniectomy to take out a hematoma. The anesthesia provider notes any types and amounts of medications administered, all forms of monitoring used, patient responses, and the start and stop times of anesthesia care. Following the procedure, the anesthesia provider oversees the patient's transfer to post-anesthesia care. The services represented by anesthesia codes 00100 to 01999 include a pre- and post-operative visit to assess the patient, anesthesia care during the procedure, the administration of fluids and/or blood as necessary, and standard monitoring services such as ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry. Standard anesthesia services do not include unusual forms of monitoring such as the use of Swan-Ganz catheters, intra-arterial lines, or central venous lines, and you therefore may code those separately when sufficient supporting documentation is available.

Coding Tips

Anesthesia time is the period of time when the anesthesia provider is present with the patient. It starts when the anesthesia provider prepares the patient for anesthesia induction in the operating room or procedure room, not during the preanesthesia evaluation. The anesthesia provider's time associated with the patient's care ends when the anesthesia provider no longer renders services to the patient or another provider assumes responsibility for the patient's postoperative care. Payers typically use anesthesia time as part of the unit calculation for the anesthesia service. For instance, a payer may count each 15-minute block of time as a single unit, so you'd divide the total anesthesia minutes by 15 to determine the time units. Other payers may require the use of an eight minute or 10-minute block of time. You then add the time units to the number of base units the payer assigns to the anesthesia code to determine the total units. The anesthesia provider documents total anesthesia time in the patient's anesthesia medical record. Report the total units of time in block 24G of the CMS 1500 form.

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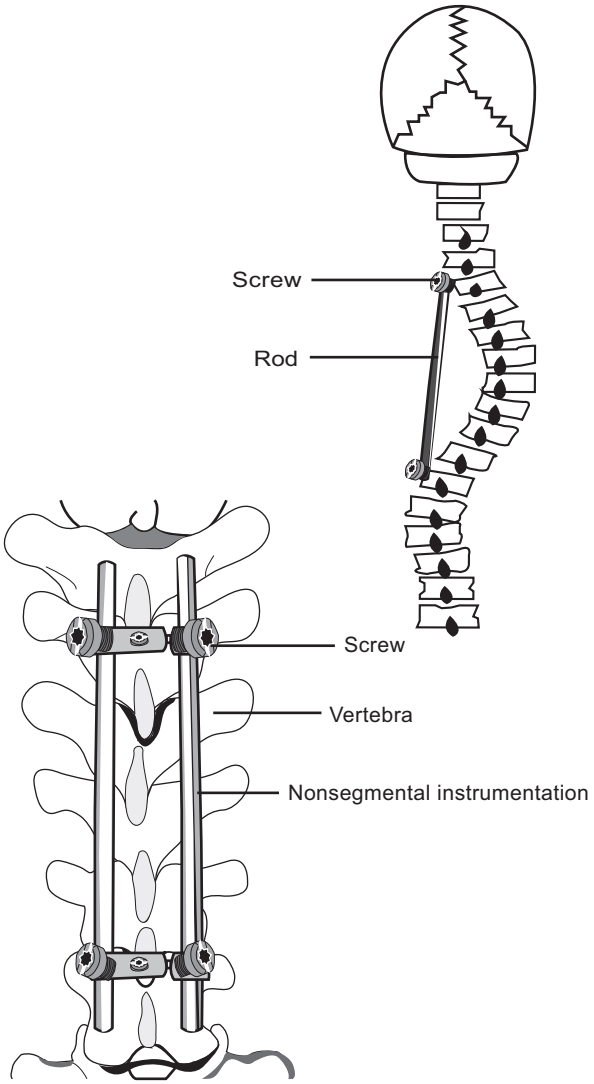
the operating room for removal, append modifier 78, Unplanned return to the operating or procedure room by the same provider following initial procedure for a related procedure during the postoperative period.

Illustration



+22840

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $671.69, Non Facility Fee: $671.69; Non-QP Conversion Factor $33.4009, Facility Fee: $668.35, Non Facility Fee: $668.35
RVU (Facility): Work 12.21, PE 4.04, Mal 3.76, Total 20.01
RVU (Non-Facility): Work 12.21, PE 4.04, Mal 3.76, Total 20.01
MPFS Payment Policy Indicators: Global Period ZZZ, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

47, 52, 53, 58, 59, 62, 63, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, KX, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0202T[1], 0333T[0], 0464T[0], 0596T[1], 0597T[1], 20650[1], 22505[0], 22841[1], 22850[1], 22852[1], 22869[1], 22870[1], 36591[0], 36592[0], 38220[0], 38222[0], 38230[0], 38232[0], 51701[1], 51702[1], 51703[1], 62320[0], 62321[0], 62324[0], 62325[0], 63295[1], 63707[1], 63709[1], 64479[1], 92652[0], 92653[0], 95822[0], 95860[0], 95861[0], 95863[0], 95864[0], 95865[0], 95866[0], 95867[0], 95868[0], 95869[0], 95870[0], 95907[0], 95908[0], 95909[0], 95910[0], 95911[0], 95912[0], 95913[0], 95925[0], 95926[0], 95927[0], 95928[0], 95929[0], 95930[0], 95933[0], 95937[0], 95938[0], 95939[0], 95940[0], 96523[0], G0453[0], G0471[1]

ICD-10-CM Cross References

A18.01, M43.00-M43.09, M43.10-M43.19, M43.27, M43.28, M43.5X2, M47.21-M47.23, M47.26, M47.27, M47.28, M47.811-M47.813, M47.816, M47.817, M47.818, M47.891-M47.893, M47.896, M47.897, M47.898, M48.07, M50.20, M50.21, M50.23, M51.14-M51.17, M51.26, M51.27, M51.34, M51.35, M51.360-M51.369, M51.370-M51.379, M53.2X1-M53.2X8, M53.2X4, M53.2X5, M53.2X6, M53.2X7, M53.2X8, M53.86-M53.88, M54.14-M54.17, M99.23, M99.33, M99.43, M99.53, M99.63, M99.73, Q76.2

+22841

Internal spinal fixation by wiring of spinous processes (List separately in addition to code for primary procedure)

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, and while undergoing a spinal surgery, the provider drills a hole at the base of each spinous process at the target vertebral segment level. He passes a wire through the holes and applies buttons. He fixes the buttons at the base of the spinous processes to hold the fixation system tightly. He may apply hooks and clamps to hold the wiring system securely. The provider then continues the primary procedure to completion, closing the wound.

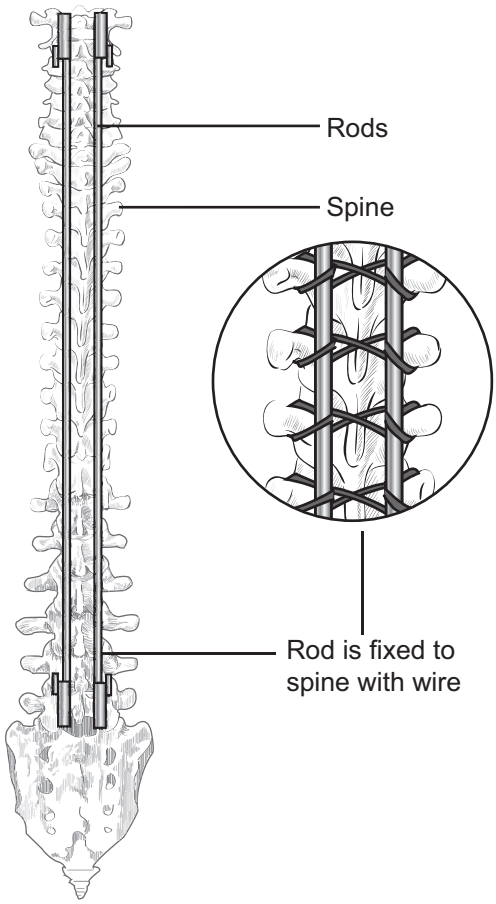
Coding Tips

This is an add-on code and must be reported with an appropriate primary procedure.

Although coding guidelines define instrumentation procedures according to vertebral segments, fusion, or arthrodesis, procedures, which must accompany instrumentation claims, are defined according to vertebral interspaces. Count one vertebra per segment, two vertebrae per level.

Generally, the type of instrumentation will correspond to the surgical approach, anterior or posterior. The provider's documentation should explicitly state the type of instrumentation she places. If the provider's operative report does not specify, be sure to ask.

Illustration



+22841

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor : N/A, Facility Fee: N/A, Non Facility Fee: N/A; Non-QP Conversion Factor $33.4009, Facility Fee: $0.00, Non Facility Fee: $0.00
RVU (Facility): Work 0, PE 0, Mal 0, Total 0.00
RVU (Non-Facility): Work 0, PE 0, Mal 0, Total 0.00
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: B, PC/TC Indicator: 9, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

52, 53, 59, 63, 76, 77, 79, 99, AQ, AR, CR, ET, GA, GC, GJ, GR, GY, GZ, KX, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 32.0)

20650[1], 36591[0], 36592[0], 38220[0], 38222[0], 38230[0], 38232[0], 63707[1], 63709[1], 96523[0]

ICD-10-CM Cross References

T84.226A

+22842

Posterior segmental instrumentation (eg, pedicle fixation, dual rods with multiple hooks and sublaminar wires); 3 to 6 vertebral segments (List separately in addition to code for primary procedure)

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, and while undergoing a spinal surgery, the provider identifies the target segments and detaches surrounding tissues and ligaments. He drills the posterior cortex, or bony covering, directly posterior to the pedicle. He enters the pedicle with imaging guidance. He places screws through the pedicle into the vertebral body on each side of each vertebra to be segmentally fixed. He may apply hooks and clamps near transverse processes and laminae at the chosen vertebrae. He bends the rod or plate to get the desired shape of for the spine and attaches it to the segmental fixation at each segment with nuts or screws. He checks the alignment on imaging. The provider then continues the primary procedure to completion, closing the wound.

Coding Tips

This is an add-on code and must be reported with an appropriate primary procedure.

Although coding guidelines define instrumentation procedures according to vertebral segments, fusion, or arthrodesis, procedures, which must accompany instrumentation claims, are defined according to vertebral interspaces. So, you must be careful to avoid confusion.

Generally, the type of instrumentation will correspond to the surgical approach, anterior or posterior. The provider's documentation should explicitly state the type of instrumentation she places. If the provider's operative report does not specify, be sure to ask.

Operating Microscope

+69990

Microsurgical techniques, requiring use of operating microscope (List separately in addition to code for primary procedure)

Clinical Responsibility

The provider employs very small instruments and microsurgical techniques to carry out a surgical procedure while viewing the surgical field through an operating microscope.

Coding Tips

Knowing payer guidelines is the key to operating microscope reimbursement. Report this code separately in addition to reporting only one primary procedure per operative session, which means that no matter how many times you use the operating microscope while in the OR, you can report 69990 only once, as the code is eligible for reimbursement once per operative session and not per procedure code. Because 69990 is an add-on code, you do not need to append modifier 51, Multiple procedures, with this procedure code.

This rule applies even if the provider uses the operating microscope for several procedures during the same session. Therefore, if the provider bills three surgical codes on one date, you can still only bill 69990 once, not three times.

If your provider documents in the op note that he used the operating microscope for microsurgery, you must determine whether your payer follows CPT® or CMS guidelines and cross-check the payer's guidelines to see whether it allows you to report the service with 69990. Some payers will provide you with a list of which codes they'll allow with 69990. Key documentation you may find in the op report can include terms such as Weck® scope, Zeiss® scope or Leica®. Do not report 69990 when the provider uses loupes or vision correction. Some procedures include the use of the operating microscope; check the Official Descriptor and do not use this code with those codes.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $199.06, Non Facility Fee: $199.06; Non-QP Conversion Factor $33.4009, Facility Fee: $198.07, Non Facility Fee: $198.07
RVU (Facility): Work 3.37, PE 1.17, Mal 1.39, Total 5.93
RVU (Non-Facility): Work 3.37, PE 1.17, Mal 1.39, Total 5.93
MPFS Payment Policy Indicators: Global Period ZZZ, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: R, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

52, 53, 59, 63, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GC, GJ, GR, GY, GZ, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0543T^0, 0544T^0, 0569T^0, 0570T^0, 0571T^0, 0572T^0, 0573T^0, 0574T^0, 0580T^0, 0581T^0, 0582T^0, 0583T^0, 0655T^0, 15772^0, 15774^0, 20560^0, 20561^0, 20700^0, 20701^0, 36591^0, 36592^0, 51721^0, 62329^0, 64451^0, 64625^0, 66987^0, 66988^0, 96523^0

ICD-10-CM Cross References

H65.90-H65.93, H66.90-H66.93, H71.90-H71.93, H72.90-H72.93, H90.71, H90.72, M71.30

Modifier: 0 = not allowed, 1 = allowed

Radiology

70010

Myelography, posterior fossa, radiological supervision and interpretation

Clinical Responsibility

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.

Coding Tips

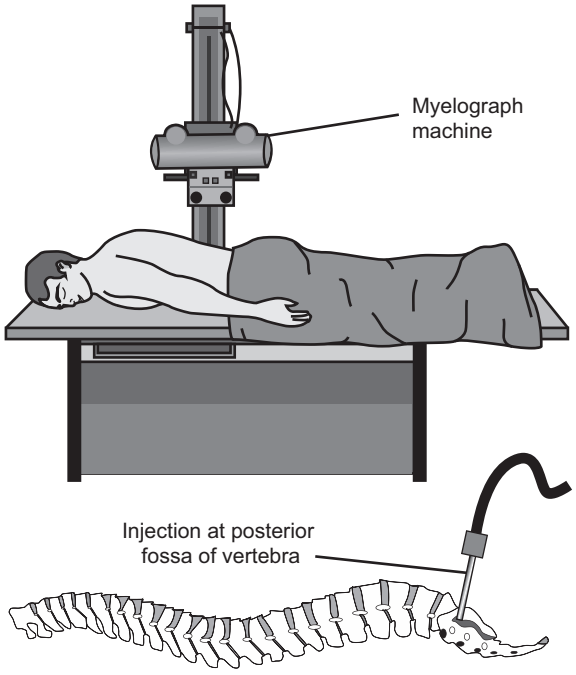
There may be rare instances where one provider supervises the radiology service and another provider interprets it. According to Medicare guidelines, each provider should report the radiology code and append reduced service modifier 52. Each should also append modifier 26 to the code to report only the professional component.

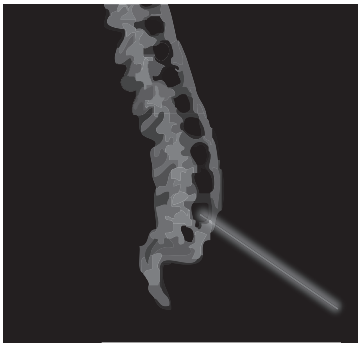
To assign a code whose descriptor includes contrast, the contrast must be intravascular, intraarticular, or intrathecal.

Depending on the payer's guidelines, providers who supply contrast may also separately report the contrast using a 99070 supply code or a HCPCS Level II code. Check individual payers' policies for contrast coverage and reportable supply codes.

If you are reporting only the interpretation or professional component for X-rays taken using portable equipment, you should report the same service code from the 70010 to 79999, Radiology procedures, range that you would report for nonportable services. Report a place of service, or POS, code reflecting where the doctor performed his service.

Illustration





70010

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $49.68, Non Facility Fee: $49.68; Non-QP Conversion Factor $33.4009, Facility Fee: $49.43, Non Facility Fee: $49.43
RVU (Facility): Work 1.16, PE 0.21, Mal 0.11, Total 1.48
RVU (Non-Facility): Work 1.16, PE 0.21, Mal 0.11, Total 1.48
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

52, 53, 76, 77, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, FX, FY, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ

NCCI Alerts (version 32.0)

0708T[1], 0709T[1], 36000[1], 36406[1], 36410[1], 36591[0], 36592[0], 76000[1], 77001[1], 77002[1], 77003[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0]

ICD-10-CM Cross References

C71.5, C71.8, C72.9, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C7A.00, C7A.1, C7A.8, C7B.00, C7B.03, D3A.00, D3A.098, D3A.8, D42.0-D42.9, D43.0-D43.2, D43.4, D48.2, D49.2, G02, G06.2, G07, G91.0, G91.1, G91.3, G91.8, G91.9, G93.2, G96.00-G96.09, G96.12, G96.198, G96.810-G96.819, G97.48, G97.49, G97.81-G97.84, H53.2, M48.40XA, M48.41XA, M48.42XA, M54.10, M54.18, M79.2, M84.30XA, M84.38XA, Q04.9, Q05.0-Q05.3, Q07.9, Q85.00-Q85.09, R29.2, R93.7, R94.131, S14.109S, T85.09XA, T85.190A, T85.192A, T85.193A, T85.199A, T85.730A, T85.731A, T85.732A, T85.733A, T85.734A, T85.735A, T85.738A, T85.810A, T85.820A, T85.830A, T85.840A, T85.850A, T85.860A, T85.890A, T88.8XXA, Z98.2

70015

Cisternography, positive contrast, radiological supervision and interpretation

Clinical Responsibility

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.

Coding Tips

There may be rare instances where one provider supervises the radiology service and another provider interprets it. According to Medicare guidelines, each provider should report the radiology code and append reduced service modifier 52. Each should also append modifier 26 to the code to report only the professional component.

To assign a code whose descriptor includes contrast, the contrast must be intravascular, intraarticular, or intrathecal.

Depending on the payer's guidelines, providers who supply contrast may also separately report the contrast using a 99070 supply code or a HCPCS Level II code. Check individual payers' policies for contrast coverage and reportable supply codes.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $161.12, Non Facility Fee: $161.12; Non-QP Conversion Factor $33.4009, Facility Fee: $160.32, Non Facility Fee: $160.32
RVU (Facility): Work 1.16, PE 3.56, Mal 0.08, Total 4.80
RVU (Non-Facility): Work 1.16, PE 3.56, Mal 0.08, Total 4.80
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 1, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

26, 52, 76, 77, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, FX, FY, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, TC

NCCI Alerts (version 32.0)

0708T[1], 0709T[1], 36000[1], 36011[1], 36406[1], 36410[1], 36591[0], 36592[0], 76000[1], 77001[1], 77002[1], 77003[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0]

ICD-10-CM Cross References

A17.89, A50.49, C70.0, C70.9, C71.5, C72.9, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C7A.1, C7A.8, C7B.09, C7B.8, D33.0-D33.2, D3A.00, D3A.8, D42.0-D42.9, D43.0-D43.2, D43.4, D48.2, D49.6, D49.89, G31.01, G31.09, G31.83, G91.0, G91.1, G91.3, G91.8, G91.9, G95.89, G96.00-G96.09, G96.12, G96.198, G96.810-G96.819, G97.2, G97.48, G97.49, G97.81-G97.84, Q03.8, Q03.9, Q05.0-Q05.3, Q85.01-Q85.03, Q85.09, R93.6, R93.7, Z08, Z09, Z92.21, Z92.22, Z98.2

70240

Radiologic examination, sella turcica

Clinical Responsibility

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.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $32.22, Non Facility Fee: $32.22; Non-QP Conversion Factor $33.4009, Facility Fee: $32.06, Non Facility Fee: $32.06
RVU (Facility): Work 0.19, PE 0.75, Mal 0.02, Total 0.96
RVU (Non-Facility): Work 0.19, PE 0.75, Mal 0.02, Total 0.96
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 1, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

26, 52, 76, 77, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, FX, FY, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, TC

NCCI Alerts (version 32.0)

36591[0], 36592[0], 96523[0]

ICD-10-CM Cross References

C41.0, C71.9, C79.51, C79.52, D16.4, E22.0-E22.9, E23.0-E23.2, E23.6, E34.4, E89.3, G06.0, G45.9, I67.841, I67.848, M95.2, N91.0-N91.2, Q04.9, Q07.9, T75.89XD, T75.89XS

HCPCS Level II Codes

Outpatient PPS

C1607

Neurostimulator, integrated (implantable), rechargeable with all implantable and external components including charging system

Clinical Responsibility

This code represents the supply of an implantable, integrated neurostimulator system designed as an all-in-one unit. An integrated neurostimulator contains the pulse generator or receiver and the electrode array together in a single device. A neurostimulator delivers controlled electrical impulses to targeted nerves or the spinal cord to help manage neurological conditions. The complete system includes the implantable integrated unit, any required implantable accessories, and external components such as the charging system used to recharge the device through the skin.

BETOS

P1G: Major procedure - other

C1826

Generator, neurostimulator (implantable), includes closed feedback loop leads and all implantable components, with rechargeable battery and charging system

Clinical Responsibility

This code represents an implantable neurostimulator generator, including closed feedback loop leads and all implantable components, with a rechargeable battery and charging system. An implantable generator is like a battery pack for the neurostimulator, which delivers electrical impulses to nerve structures, such as for pain relief. This code includes the system's rechargeable battery and charging system. The code also includes closed feedback loop leads (electrode technology that allows the device to communicate with the spinal cord neurons and adjust the dose of stimulation accordingly) and all implantable components.

BETOS

D1A: Medical/surgical supplies

C1827

Generator, neurostimulator (implantable), non-rechargeable, with implantable stimulation lead and external paired stimulation controller

Clinical Responsibility

This code represents an implantable neurostimulator generator, including the implantable stimulation lead and external paired stimulation controller. The generator is not rechargeable. An implantable generator is like a battery pack for the neurostimulator, which delivers electrical impulses to nerve structures, such as for pain relief. This code includes the system's implantable stimulation lead (electrode to deliver electric pulses) and external paired stimulation controller (a handheld device to control to adjust stimulation strength).

BETOS

D1A: Medical/surgical supplies

C7551

Excision of major peripheral nerve neuroma, except sciatic, with implantation of nerve end into bone or muscle

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider incises the skin over the location of a neuroma (a growth in nerve tissue) located on one of the major peripheral nerves of the body other than the sciatic nerve. Peripheral nerves connect the brain and spinal cord to the body. The provider exposes the neuroma, dissects it free of surrounding tissue, and excises the neuroma. The provider then implants the nerve end into bone or muscle. The provider closes the surgical site.

BETOS

P5E: Ambulatory procedures - other

C9101

Injection, oliceridine, 0.1 mg

Clinical Responsibility

The standard dosage of oliceridine is individualized, with a cumulative daily dose not exceeding 27 mg. It is administered intravenously (into a vein). It is supplied as 1 mg/mL and 2 mg/2 mL single-dose vials and 30 mg/30 mL single-patient-use vials.

Providers may use this opioid agonist for pain management in patients who require intravenous pain medication. An opioid

ICD-10-CM Cross Reference Details

A01.01 Typhoid meningitis
A01.09 Typhoid fever with other complications
A02.21 Salmonella meningitis
A05.1 Botulism food poisoning
A06.6 Amebic brain abscess
A15.5 Tuberculosis of larynx, trachea and bronchus
A17.0 Tuberculous meningitis
A17.1 Meningeal tuberculoma
A17.81 Tuberculoma of brain and spinal cord
A17.82 Tuberculous meningoencephalitis
A17.83 Tuberculous neuritis
A17.89 Other tuberculosis of nervous system
A17.9 Tuberculosis of nervous system, unspecified
A18.01 Tuberculosis of spine
A18.03 Tuberculosis of other bones
A18.50 Tuberculosis of eye, unspecified
A18.51 Tuberculous episcleritis
A18.52 Tuberculous keratitis
A18.54 Tuberculous iridocyclitis
A18.59 Other tuberculosis of eye
A18.6 Tuberculosis of (inner) (middle) ear
A20.3 Plague meningitis
A21.1 Oculoglandular tularemia
A27.81 Aseptic meningitis in leptospirosis
A32.11 Listerial meningitis
A32.12 Listerial meningoencephalitis
A32.7 Listerial sepsis
A32.81 Oculoglandular listeriosis
A35 Other tetanus
A36.0 Pharyngeal diphtheria
A36.1 Nasopharyngeal diphtheria
A36.2 Laryngeal diphtheria
A36.89 Other diphtheritic complications
A38.8 Scarlet fever with other complications
A39.0 Meningococcal meningitis
A39.2 Acute meningococcemia
A39.3 Chronic meningococcemia
A39.4 Meningococcemia, unspecified
A39.81 Meningococcal encephalitis
A39.82 Meningococcal retrobulbar neuritis
A40.3 Sepsis due to Streptococcus pneumoniae
A41.51 Sepsis due to Escherichia coli [E. coli]
A41.54 Sepsis due to Acinetobacter baumannii
A42.81 Actinomycotic meningitis
A42.82 Actinomycotic encephalitis
A50.41 Late congenital syphilitic meningitis
A50.42 Late congenital syphilitic encephalitis
A50.43 Late congenital syphilitic polyneuropathy
A50.49 Other late congenital neurosyphilis
A51.41 Secondary syphilitic meningitis
A52.05 Other cerebrovascular syphilis
A52.11 Tabes dorsalis
A52.12 Other cerebrospinal syphilis
A52.13 Late syphilitic meningitis
A52.14 Late syphilitic encephalitis
A52.15 Late syphilitic neuropathy
A52.17 General paresis
A52.19 Other symptomatic neurosyphilis
A52.2 Asymptomatic neurosyphilis
A52.3 Neurosyphilis, unspecified
A54.41 Gonococcal spondylopathy
A54.81 Gonococcal meningitis
A54.82 Gonococcal brain abscess
A69.21 Meningitis due to Lyme disease
A79.82 Anaplasmosis [A. phagocytophilum]
A80.0 Acute paralytic poliomyelitis, vaccine-associated
A80.1 Acute paralytic poliomyelitis, wild virus, imported
A80.2 Acute paralytic poliomyelitis, wild virus, indigenous
A80.39 Other acute paralytic poliomyelitis
A80.4 Acute nonparalytic poliomyelitis
A81.00 Creutzfeldt-Jakob disease, unspecified
A81.01 Variant Creutzfeldt-Jakob disease
A81.09 Other Creutzfeldt-Jakob disease
A81.1 Subacute sclerosing panencephalitis
A81.2 Progressive multifocal leukoencephalopathy
A81.81 Kuru
A81.82 Gerstmann-Straussler-Scheinker syndrome
A81.83 Fatal familial insomnia
A81.89 Other atypical virus infections of central nervous system
A81.9 Atypical virus infection of central nervous system, unspecified
A83.0 Japanese encephalitis
A83.1 Western equine encephalitis
A83.2 Eastern equine encephalitis
A83.3 St Louis encephalitis
A83.4 Australian encephalitis
A83.5 California encephalitis
A83.8 Other mosquito-borne viral encephalitis
A83.9 Mosquito-borne viral encephalitis, unspecified
A84.0 Far Eastern tick-borne encephalitis [Russian spring-summer encephalitis]
A84.1 Central European tick-borne encephalitis
A84.89 Other tick-borne viral encephalitis
A84.9 Tick-borne viral encephalitis, unspecified
A85.0 Enteroviral encephalitis
A85.1 Adenoviral encephalitis
A85.2 Arthropod-borne viral encephalitis, unspecified
A85.8 Other specified viral encephalitis
A86 Unspecified viral encephalitis
A87.0 Enteroviral meningitis
A87.1 Adenoviral meningitis
A87.2 Lymphocytic choriomeningitis
A87.8 Other viral meningitis
A87.9 Viral meningitis, unspecified
A92.31 West Nile virus infection with encephalitis
A92.39 West Nile virus infection with other complications
B00.3 Herpesviral meningitis
B00.4 Herpesviral encephalitis
B00.50 Herpesviral ocular disease, unspecified
B00.53 Herpesviral conjunctivitis
B00.59 Other herpesviral disease of eye
B00.82 Herpes simplex myelitis
B01.0 Varicella meningitis
B01.11 Varicella encephalitis and encephalomyelitis
B01.12 Varicella myelitis
B01.89 Other varicella complications
B01.9 Varicella without complication
B02.0 Zoster encephalitis
B02.1 Zoster meningitis
B02.21 Postherpetic geniculate ganglionitis
B02.22 Postherpetic trigeminal neuralgia
B02.23 Postherpetic polyneuropathy
B02.24 Postherpetic myelitis
B02.29 Other postherpetic nervous system involvement
B02.30 Zoster ocular disease, unspecified
B02.31 Zoster conjunctivitis
B02.34 Zoster scleritis
B02.39 Other herpes zoster eye disease
B02.7 Disseminated zoster
B02.8 Zoster with other complications
B02.9 Zoster without complications
B05.0 Measles complicated by encephalitis
B05.1 Measles complicated by meningitis
B05.3 Measles complicated by otitis media
B05.4 Measles with intestinal complications
B05.89 Other measles complications
B05.9 Measles without complication

B06.00 Rubella with neurological complication, unspecified
B06.01 Rubella encephalitis
B06.02 Rubella meningitis
B06.09 Other neurological complications of rubella
B06.89 Other rubella complications
B06.9 Rubella without complication
B08.21 Exanthema subitum [sixth disease] due to human herpesvirus 6
B08.22 Exanthema subitum [sixth disease] due to human herpesvirus 7
B10.01 Human herpesvirus 6 encephalitis
B10.09 Other human herpesvirus encephalitis
B10.81 Human herpesvirus 6 infection
B10.82 Human herpesvirus 7 infection
B10.89 Other human herpesvirus infection
B20 Human immunodeficiency virus [HIV] disease
B25.2 Cytomegaloviral pancreatitis
B26.1 Mumps meningitis
B26.2 Mumps encephalitis
B26.84 Mumps polyneuropathy
B26.89 Other mumps complications
B26.9 Mumps without complication
B27.00 Gammaherpesviral mononucleosis without complication
B27.01 Gammaherpesviral mononucleosis with polyneuropathy
B27.02 Gammaherpesviral mononucleosis with meningitis
B27.09 Gammaherpesviral mononucleosis with other complications
B27.10 Cytomegaloviral mononucleosis without complications
B27.11 Cytomegaloviral mononucleosis with polyneuropathy
B27.12 Cytomegaloviral mononucleosis with meningitis
B27.19 Cytomegaloviral mononucleosis with other complication
B27.80 Other infectious mononucleosis without complication
B27.81 Other infectious mononucleosis with polyneuropathy
B27.82 Other infectious mononucleosis with meningitis
B27.89 Other infectious mononucleosis with other complication
B27.90 Infectious mononucleosis, unspecified without complication
B27.91 Infectious mononucleosis, unspecified with polyneuropathy
B27.92 Infectious mononucleosis, unspecified with meningitis
B27.99 Infectious mononucleosis, unspecified with other complication
B34.2 Coronavirus infection, unspecified
B37.5 Candidal meningitis
B38.4 Coccidioidomycosis meningitis
B39.4 Histoplasmosis capsulati, unspecified
B39.5 Histoplasmosis duboisii
B39.9 Histoplasmosis, unspecified
B40.81 Blastomycotic meningoencephalitis
B43.1 Pheomycotic brain abscess
B45.1 Cerebral cryptococcosis
B45.8 Other forms of cryptococcosis
B45.9 Cryptococcosis, unspecified
B50.0 Plasmodium falciparum malaria with cerebral complications
B51.8 Plasmodium vivax malaria with other complications
B51.9 Plasmodium vivax malaria without complication
B52.8 Plasmodium malariae malaria with other complications
B52.9 Plasmodium malariae malaria without complication
B57.41 Meningitis in Chagas' disease
B57.42 Meningoencephalitis in Chagas' disease
B58.2 Toxoplasma meningoencephalitis
B60.11 Meningoencephalitis due to Acanthamoeba (culbertsoni)
B77.0 Ascariasis with intestinal complications
B77.89 Ascariasis with other complications
B83.2 Angiostrongyliasis due to Parastrongylus cantonensis
B88.01 Infestation by Demodex mites
B88.09 Other acariasis
B91 Sequelae of poliomyelitis
B94.1 Sequelae of viral encephalitis
B95.3 Streptococcus pneumoniae as the cause of diseases classified elsewhere
B96.20 Unspecified Escherichia coli [E. coli] as the cause of diseases classified elsewhere
B96.21 Shiga toxin-producing Escherichia coli [E. coli] [STEC] O157 as the cause of diseases classified elsewhere
B96.22 Other specified Shiga toxin-producing Escherichia coli [E. coli] [STEC] as the cause of diseases classified elsewhere
B96.23 Unspecified Shiga toxin-producing Escherichia coli [E. coli] [STEC] as the cause of diseases classified elsewhere
B96.29 Other Escherichia coli [E. coli] as the cause of diseases classified elsewhere
B96.83 Acinetobacter baumannii as the cause of diseases classified elsewhere
B97.10 Unspecified enterovirus as the cause of diseases classified elsewhere
B97.19 Other enterovirus as the cause of diseases classified elsewhere
B97.21 SARS-associated coronavirus as the cause of diseases classified elsewhere
B97.29 Other coronavirus as the cause of diseases classified elsewhere
B97.35 Human immunodeficiency virus, type 2 [HIV 2] as the cause of diseases classified elsewhere
B97.4 Respiratory syncytial virus as the cause of diseases classified elsewhere
C00.1 Malignant neoplasm of external lower lip
C00.2 Malignant neoplasm of external lip, unspecified
C00.3 Malignant neoplasm of upper lip, inner aspect
C00.4 Malignant neoplasm of lower lip, inner aspect
C00.5 Malignant neoplasm of lip, unspecified, inner aspect
C00.6 Malignant neoplasm of commissure of lip, unspecified
C00.8 Malignant neoplasm of overlapping sites of lip
C00.9 Malignant neoplasm of lip, unspecified
C01 Malignant neoplasm of base of tongue
C02.0 Malignant neoplasm of dorsal surface of tongue
C02.2 Malignant neoplasm of ventral surface of tongue
C02.3 Malignant neoplasm of anterior two-thirds of tongue, part unspecified
C02.4 Malignant neoplasm of lingual tonsil
C02.8 Malignant neoplasm of overlapping sites of tongue
C02.9 Malignant neoplasm of tongue, unspecified
C03.1 Malignant neoplasm of lower gum
C03.9 Malignant neoplasm of gum, unspecified
C04.1 Malignant neoplasm of lateral floor of mouth
C04.8 Malignant neoplasm of overlapping sites of floor of mouth
C04.9 Malignant neoplasm of floor of mouth, unspecified
C05.0 Malignant neoplasm of hard palate
C05.1 Malignant neoplasm of soft palate
C05.2 Malignant neoplasm of uvula
C06.1 Malignant neoplasm of vestibule of mouth
C06.2 Malignant neoplasm of retromolar area
C06.80 Malignant neoplasm of overlapping sites of unspecified parts of mouth
C06.89 Malignant neoplasm of overlapping sites of other parts of mouth
C06.9 Malignant neoplasm of mouth, unspecified
C07 Malignant neoplasm of parotid gland
C08.0 Malignant neoplasm of submandibular gland
C08.1 Malignant neoplasm of sublingual gland
C08.9 Malignant neoplasm of major salivary gland, unspecified
C09.0 Malignant neoplasm of tonsillar fossa
C09.1 Malignant neoplasm of tonsillar pillar (anterior) (posterior)
C10.0 Malignant neoplasm of vallecula
C10.2 Malignant neoplasm of lateral wall of oropharynx
C10.3 Malignant neoplasm of posterior wall of oropharynx
C10.4 Malignant neoplasm of branchial cleft
C10.8 Malignant neoplasm of overlapping sites of oropharynx
C11.1 Malignant neoplasm of posterior wall of nasopharynx
C11.2 Malignant neoplasm of lateral wall of nasopharynx
C11.3 Malignant neoplasm of anterior wall of nasopharynx
C11.9 Malignant neoplasm of nasopharynx, unspecified
C12 Malignant neoplasm of pyriform sinus
C13.0 Malignant neoplasm of postcricoid region
C13.1 Malignant neoplasm of aryepiglottic fold, hypopharyngeal aspect
C13.2 Malignant neoplasm of posterior wall of hypopharynx
C13.8 Malignant neoplasm of overlapping sites of hypopharynx
C13.9 Malignant neoplasm of hypopharynx, unspecified
C14.0 Malignant neoplasm of pharynx, unspecified

Modifier Descriptors

Modifier	Description
CPT® Modifiers	
22	Increased Procedural Services
23	Unusual Anesthesia
24	Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period
25	Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service
26	Professional Component
27	Multiple Outpatient Hospital E/M Encounters on the Same Date
32	Mandated Services
33	Preventive Services
47	Anesthesia by Surgeon
50	Bilateral Procedure
51	Multiple Procedures
52	Reduced Services
53	Discontinued Procedure
54	Surgical Care Only
55	Postoperative Management Only
56	Preoperative Management Only
57	Decision for Surgery
58	Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
59	Distinct Procedural Service
62	Two Surgeons
63	Procedure Performed on Infants less than 4 kg
66	Surgical Team
73	Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure Prior to the Administration of Anesthesia
74	Discontinued Out-Patient Hospital/Ambulatory Surgery Center (ASC) Procedure After Administration of Anesthesia
76	Repeat Procedure or Service by Same Physician or Other Qualified Health Care Professional
77	Repeat Procedure by Another Physician or Other Qualified Health Care Professional

Modifier	Description
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available)
90	Reference (Outside) Laboratory
91	Repeat Clinical Diagnostic Laboratory Test
92	Alternative Laboratory Platform Testing
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
96	Habilitative Services
97	Rehabilitative Services
99	Multiple Modifiers
CPT® Category II Modifiers	
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
8P	Performance Measure Reporting Modifier - Action Not Performed, Reason Not Otherwise Specified
HCPCS Level II Modifiers	
A1	Dressing for one wound
A2	Dressing for two wounds
A3	Dressing for three wounds
A4	Dressing for four wounds
A5	Dressing for five wounds
A6	Dressing for six wounds
A7	Dressing for seven wounds
A8	Dressing for eight wounds
A9	Dressing for nine or more wounds
AA	Anesthesia services performed personally by anesthesiologist

Modifier	Description
AB	Audiology service furnished personally by an audiologist without a physician/npp order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids; service may be performed once every 12 months, per beneficiary
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures
AE	Registered dietician
AF	Specialty physician
AG	Primary physician
AH	Clinical psychologist
AI	Principal physician of record
AJ	Clinical social worker
AK	Non participating physician
AM	Physician, team member service
AO	Alternate payment method declined by provider of service
AP	Determination of refractive state was not performed in the course of diagnostic ophthalmological examination
AQ	Physician providing a service in an unlisted health professional shortage area (HPSA)
AR	Physician provider services in a physician scarcity area
AS	Physician assistant, nurse practitioner, or clinical nurse specialist services for assistant at surgery
AT	Acute treatment (this modifier should be used when reporting service 98940, 98941, 98942)
AU	Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
AV	Item furnished in conjunction with a prosthetic device, prosthetic or orthotic
AW	Item furnished in conjunction with a surgical dressing
AX	Item furnished in conjunction with dialysis services
AY	Item or service furnished to an ESRD patient that is not for the treatment of ESRD
AZ	Physician providing a service in a dental health professional shortage area for the purpose of an electronic health record incentive payment
BA	Item furnished in conjunction with parenteral enteral nutrition (PEN) services
BL	Special acquisition of blood and blood products
BO	Orally administered nutrition, not by feeding tube
BP	The beneficiary has been informed of the purchase and rental options and has elected to purchase the item
BR	The beneficiary has been informed of the purchase and rental options and has elected to rent the item
BU	The beneficiary has been informed of the purchase and rental options and after 30 days has not informed the supplier of his/her decision
CA	Procedure payable only in the inpatient setting when performed emergently on an outpatient who expires prior to admission
CB	Service ordered by a renal dialysis facility (RDF) physician as part of the ESRD beneficiary's dialysis benefit, is not part of the composite rate, and is separately reimbursable
CC	Procedure code change (use 'CC' when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed)
CD	AMCC test has been ordered by an ESRD facility or MCP physician that is part of the composite rate and is not separately billable
CE	AMCC test has been ordered by an ESRD facility or MCP physician that is a composite rate test but is beyond the normal frequency covered under the rate and is separately reimbursable based on medical necessity
CF	AMCC test has been ordered by an ESRD facility or MCP physician that is not part of the composite rate and is separately billable
CG	Policy criteria applied
CH	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CJ	At least 20 percent but less than 40 percent impaired, limited or restricted
CK	At least 40 percent but less than 60 percent impaired, limited or restricted
CL	At least 60 percent but less than 80 percent impaired, limited or restricted
CM	At least 80 percent but less than 100 percent impaired, limited or restricted
CN	100 percent impaired, limited or restricted
CO	Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
CQ	Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
CR	Catastrophe/disaster related
CS	Cost-sharing waived for specified COVID-19 testing-related services that result in and order for or administration of a COVID-19 test and/or used for cost-sharing waived preventive services furnished via telehealth in rural health clinics and federally qualified health centers during the COVID-19 public health emergency

Terminology

Terminology	Explanation
Abduction	Raising arms held at the sides, straight up to the side to shoulder height.
Ablation	To destroy.
Abscess	A localized accumulation of pus that collects in the body usually as a result of an infection.
Acetylcholinesterase	An enzyme that breaks up acetylcholine, a neurotransmitter.
Acromioclavicular, or AC, joint	Union of the acromion, or shoulder blade, and the clavicle, or collar bone.
Activities of daily living (ADLs)	Basic daily activities of life such as eating, bathing, dressing, toileting and walking.
Acute	A medical condition or injury of sudden onset, sometimes severe in nature, and typically lasts a short period of time; opposite of chronic.
Adaptive	Able to adjust to situations or environment.
Adductor muscle	Any muscle that draws a body part away from the body or an extremity.
Adductor tenotomy	Procedure where the tendon of the adductor muscle is snipped to release the muscle.
Adhesiolysis	Severing of adhesive bands.
Adhesion	Fibrous bands that form between tissues and organs, often as a result of injury during surgery; they may be thought of as internal scar tissue.
Adhesions	Fibrous bands, which typically result from inflammation or injury during surgery, that form between tissues and organs; they may be thought of as internal scar tissue.
Adipose tissue	Loose connective tissue which stores the fat cells in the form of droplets.
Adrenergic	Related to adrenaline or noradrenaline.
Advance directive	A document which enables a person to make provision for his health care decisions in case if in the future, he becomes unable to make those decisions; include documents such as a living will and a medical power of attorney.
Allograft	A tissue graft from a donor.
A-mode, amplitude mode	A one-dimensional ultrasonic measurement.
Amplification	Making more copies of desired gene for study by processes such as polymerase chain reaction, called PCR, or transcription of DNA to RNA and reverse transcription from RNA to make an additional copy of the DNA.
Amplitude	Size of response from a nerve after electrical stimulation.
Amygdalohippocampectomy	Resection of the amygdala and hippocampus structures of the brain.
Analgesic	Relief or absence of pain.
Anastomosis	A surgical connection made between two structures that do not naturally connect.
Anesthetic agent	Substance that reduces sensitivity to pain.
Aneurysm	Weakness in the wall of a blood vessel which requires surgical excision or repair to prevent rupture.
Angiography	A medical imaging technique used to visualize the lumen, or inside, of blood vessels and organs of the body; an angiogram is a record of the image.
Angioplasty	Repair or unblocking of a blood vessel.
Annulus fibrosus	Exterior of the intervertebral disc.
Anomaly	A deviation from normal; a defect.
Anterior	Closer to the front part of the body or a structure.
Anterior approach	Surgical approach from the front, in this case from the front of the spine.
Anterior instrumentation	Spinal fixation device that attaches to the front of the spine.
Anterior spinal artery	Blood vessel that transports blood to the anterior spinal cord.
Anteroposterior view	The X-ray projection travels from front to back, abbreviated as AP.
Antibiotic	Substance that inhibits infection.
Antihistamine	A drug that blocks the action of histamine in the body; histamine is responsible for allergic symptoms.

Terminology	Explanation
Anti-inflammatory	Substance that reduces pain, swelling, and inflammation.
Antipyretic	A drug that prevents or reduces fever.
Antisense oligonucleotide	Chemically modified, synthetic single-stranded deoxyribonucleic acid (DNA) or ribonucleic acid (RNA) molecules that bind to RNA and reduce the expression of the target RNA.
Antispasmodic	A substance that relieves convulsions or spasms.
Arachnoid membrane	The middle of the three meninges, or membranes, that protect the spinal cord and brain.
Arnold-Chiari malformation	A malformation where brain tissue extends into the spinal canal.
Arterial access	Situated or occurring within an artery.
Arteries	Vessels that carry oxygen rich blood away from the heart to the rest of the body.
Arteriovenous malformation, or AVM	Abnormal connection of the arteries and veins along with the absence of capillaries that may cause intense pain and bleeding.
Arthritis	Joint inflammation due to infectious, metabolic, or constitutional causes.
Arthrocentesis	A procedure in which the provider using a needle and a syringe drains or withdraws fluid from the joint.
Arthrodesis	Surgical procedure involving fusion of vertebrae over the joint space.
Arthroplasty	The surgical repair of a joint.
Arthroplasty device	Device used to replace or reconstruct a joint.
Aspirate	Small amount of cells or fluid from a cyst or mass.
Aspiration	Removal of fluid, gas, or other material through a tube attached to a suction device, often combined with irrigation, the instillation of fluid to clean a wound or to wash out a cavity such as the abdomen or stomach.
Atherosclerosis	A disease characterized by deposition of fatty material on the inner walls of the arteries.
Atherosclerotic burden	The sum or extent of atherosclerotic disease.
Atlantoaxial transarticular screw fixation	Spinal fixation across the atlantoaxial joint, the union of the first and second cervical vertebrae.
Atria	The upper chambers of the heart.
Atrial fibrillation	A heart rhythm disorder where the atrial appendage, a small pouch in the heart, does not squeeze rhythmically with the left atrium, causing blood inside the pouch to become stagnant and prone to produce blood clots.
Auricle	An ear-shaped pouch that is an appendage to a heart's atrial chamber; also called the left atrial appendage or right atrial appendage.
Auricular processes	The ear shaped projection of the atria.
Autograft	Any tissue from one part of the body moved to another location on the same patient; also known as an autologous graft.
Autonomic nervous system	One part of the nervous system that controls involuntary body functions by innervating muscles of the organs and glands.
Avulsion	Forcibly pulling or tearing away.
Axial muscles	Muscles attached to head, neck, and vertebral column.
Axillae	Armpit.
Axillary nerve	Large nerve arising from the brachial plexus at the armpit, with nerve fibers from the cervical nerves C5 and C6, that supplies sensory and motor nerves to the deltoid or muscle of the shoulder, the teres minor, one of the rotator cuff muscles and the skin of the shoulder; also known as the circumflex nerve.
Basal cistern	A wide space between the temporal lobes covered by the arachnoid membrane; it contains the circle of Willis, an area at the base of the brain where the carotid arteries branch off and supply blood to most of the brain; also called the interpeduncular cistern or cisterna interpeduncularis.
Basilar artery	One of the arteries that supply blood to the brain.

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