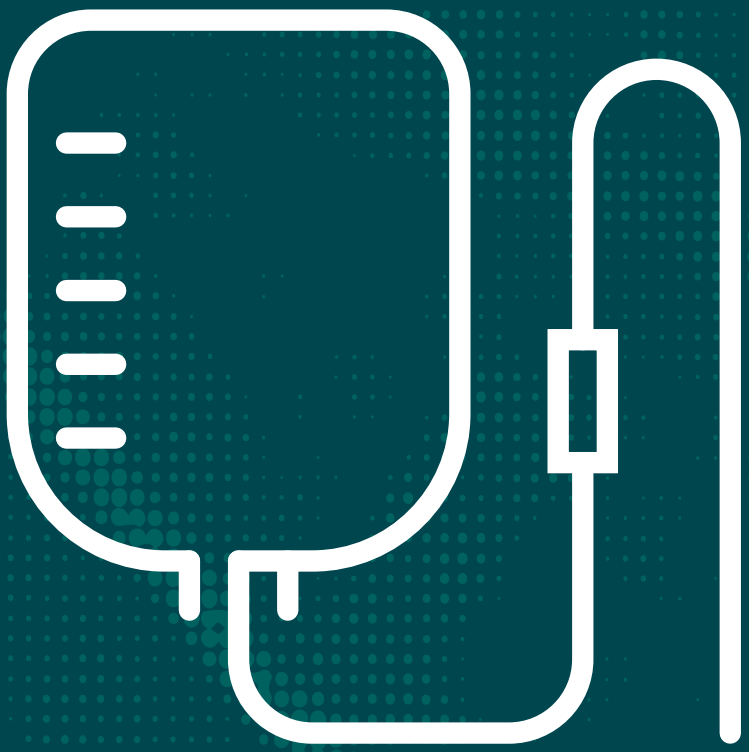
CODERS' SPECIALTY GUIDE

Pain Management



2027

AAPC

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

Contents

Musculoskeletal System

20526

Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel

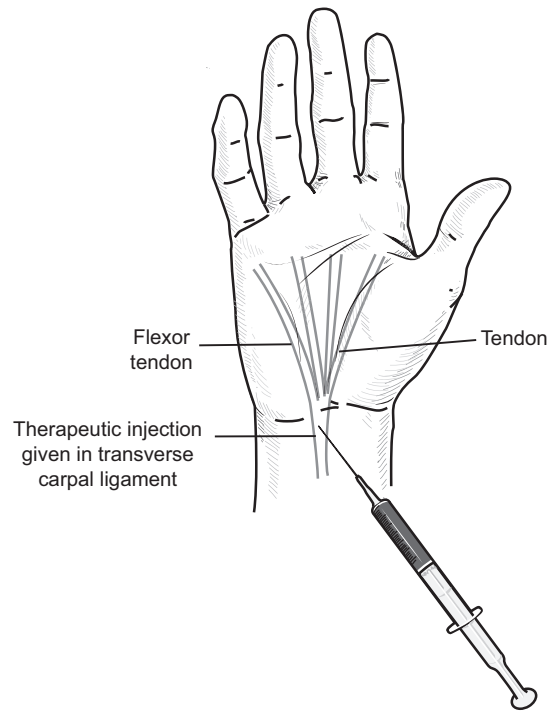
Clinical Responsibility

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.

Coding Tips

Best practice documentation for 20526 should include the patient's response to previous CTS treatments. The claim should indicate all methods of nonoperative treatment that have been tried prior to the decision that the procedure was needed. If the payer needs additional information at that point, submit office notes or any other information to support medical necessity. Examples include the dates of therapy for night time wrist splinting, weekly physical therapy sessions, strength and stretching regimens, and steroid therapy.

Illustration



20526

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $49.68, Non Facility Fee: $88.62; Non-QP Conversion Factor $33.4009, Facility Fee: $49.43, Non Facility Fee: $88.18
RVU (Facility): Work 0.92, PE 0.39, Mal 0.17, Total 1.48
RVU (Non-Facility): Work 0.92, PE 1.55, Mal 0.17, Total 2.64
MPFS Payment Policy Indicators: Global Period 0, 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

22, 50, 51, 52, 53, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AQ, AR, CR, ET, GA, GC, GJ, GR, GZ, KX, LT, PD, Q5, Q6, QJ, RT, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T[1], 0216T[1], 0596T[1], 0597T[1], 0903T[1], 0904T[1], 0905T[1], 10030[1], 10160[1], 11900[1], 11901[1], 20500[1], 29075[1], 29105[1], 29125[1], 29260[1], 29584[1], 36000[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], 51701[1], 51702[1], 51703[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], 64461[0], 64462[0], 64463[0], 64466[1], 64467[1], 64468[1], 64469[1], 64473[1], 64474[1], 64479[1], 64480[0], 64483[1], 64484[0], 64486[0], 64487[0], 64488[0], 64489[0], 64490[1], 64491[0], 64492[0], 64493[1], 64494[0], 64495[0], 64505[1], 64510[1], 64517[1], 64520[1], 64530[1], 69990[0], 76000[1], 77001[1], 92012[1], 92014[1], 93000[1], 93005[1], 93010[1], 93040[1], 93041[1], 93042[1], 93318[1], 93355[1], 94002[1], 94200[1], 94680[1], 94681[1], 94690[1], 95812[1], 95813[1], 95816[1], 95819[1], 95822[1], 95829[1], 95955[1], 96360[1], 96361[1], 96365[1], 96366[1], 96367[1], 96368[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0], 99155[0], 99156[0], 99157[0], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99221[1], 99222[1], 99223[1], 99231[1], 99232[1], 99233[1], 99234[1], 99235[1], 99236[1], 99238[1], 99239[1], 99242[1], 99243[1], 99244[1], 99245[1], 99252[1], 99253[1], 99254[1], 99255[1], 99291[1], 99292[1], 99304[1], 99305[1], 99306[1], 99307[1], 99308[1], 99309[1], 99310[1], 99315[1], 99316[1], 99347[1], 99348[1], 99349[1], 99350[1], 99374[1], 99375[1], 99377[1], 99378[1], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99495[1], 99496[1], G0463[1], G0471[1], J0670[1]

ICD-10-CM Cross References

G56.00-G56.03, G56.10-G56.12, S66.991D, S66.992D, S66.999D

20550

Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")

Clinical Responsibility

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.

Coding Tips

Clinical Scenario 1:

Question: How should I code tendon injections to both of the patient's thumbs and both third digits during the same visit? She is a Medicare patient.

Answer: The correct injection code is 20550 but you also need to specify which joints the physician treated to distinguish the injections from each other. Document specific joints in Box 19 of the claim form, and some coders say including the designations with the procedure code helps clarify the procedure.

Report the third digit injections as 20550 with 50, Bilateral procedure and F2, Left hand, third digit and 20550 50 F7, Right hand, third digit.

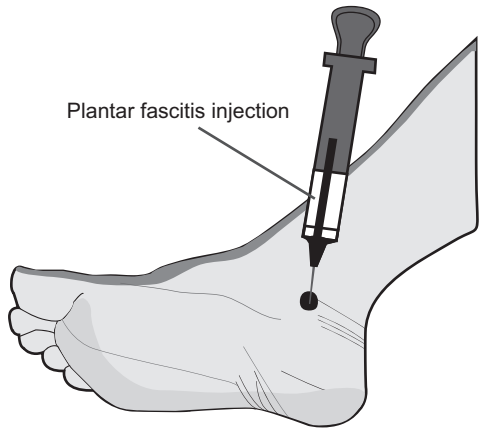
Report the thumb injections as 20550 50 59 Distinct procedural service and F5, Right hand, thumb and 20550 50 59 FA, Left hand, thumb.

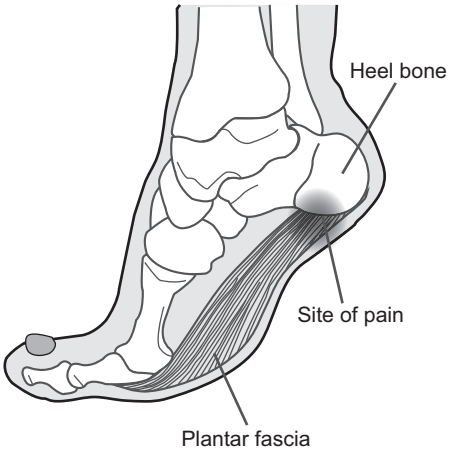
Clinical Scenario 2:

Question: What is the correct code for an injection into the wrist compartment for de Quervain's disease?

Answer: The provider injects around the tendon sheath when he treats de Quervain's disease, so choose 20550. Some coders lean toward 20551, Injections; single tendon origin/insertion, but the injection location around the tendon sheath makes 20550 a better choice.

Illustration





20550

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $33.57, Non Facility Fee: $60.76; Non-QP Conversion Factor $33.4009, Facility Fee: $33.40, Non Facility Fee: $60.46
RVU (Facility): Work 0.73, PE 0.18, Mal 0.09, Total 1.00
RVU (Non-Facility): Work 0.73, PE 0.99, Mal 0.09, Total 1.81
MPFS Payment Policy Indicators: Global Period 0, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 5

Modifier Allowances

22, 50, 51, 52, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AG, AQ, AR, CR, ET, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, GA, GC, GJ, GR, GZ, KX, LT, PD, Q5, Q6, QJ, RT, SA, T1, T2, T3, T4, T5, T6, T7, T8, T9, TA, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0232T[1], 0481T[1], 0490T[1], 0596T[1], 0597T[1], 0903T[1], 0904T[1], 0905T[1], 10030[1], 10160[1], 11010[1], 11900[1], 11901[1], 12032[1], 12042[1], 20500[1], 20526[1], 20551[1], 20552[1], 20553[1], 20560[1], 20561[1], 29075[1], 29105[1], 29125[1], 29130[1], 29260[1], 29405[1], 29425[1], 29450[1], 29515[1], 29530[1], 29540[1], 29550[1], 29580[1], 29581[1], 29584[1], 36000[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], 51701[1], 51702[1], 51703[1], 62320[1], 62321[1], 62322[1], 62323[1], 62324[1], 62325[1], 62326[1], 62327[1], 64408[1], 64435[1], 64455[1], 64461[0], 64463[0], 64466[1], 64467[1], 64468[1], 64469[1], 64480[0], 64484[0], 64486[0], 64487[0], 64488[0], 64489[0], 64494[0], 64495[0], 64505[1], 64510[1], 64517[1], 64520[1], 64530[1], 64714[1], 69990[0], 72240[1], 72265[1], 72295[1], 76000[1], 77001[1], 87076[0], 87077[0], 87102[0], 92012[1], 92014[1], 93000[1], 93005[1], 93010[1], 93040[1], 93041[1], 93042[1], 93318[1], 93355[1], 94002[1], 94200[1], 94680[1], 94681[1], 94690[1], 95812[1], 95813[1], 95816[1], 95819[1], 95822[1], 95829[1], 95907[1], 95908[1], 95909[1], 95910[1], 95911[1], 95912[1], 95913[1], 95955[1], 96360[1], 96361[1], 96365[1], 96366[1], 96367[1], 96368[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0], 99155[0], 99156[0], 99157[0], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99221[1], 99222[1], 99223[1], 99231[1], 99232[1], 99233[1], 99234[1], 99235[1], 99236[1], 99238[1], 99239[1], 99242[1], 99243[1], 99244[1], 99245[1], 99252[1], 99253[1], 99254[1], 99255[1], 99291[1], 99292[1], 99304[1], 99305[1], 99306[1], 99307[1], 99308[1], 99309[1], 99310[1], 99315[1], 99316[1], 99347[1], 99348[1], 99349[1], 99350[1], 99374[1], 99375[1], 99377[1], 99378[1], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99495[1], 99496[1], G0463[1], G0471[1], J0670[1]

ICD-10-CM Cross References

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

20551

Injection(s); single tendon origin/insertion

Clinical Responsibility

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.

Coding Tips

For single or multiple injections to the same tendon origin or insertion site, report 20551, Injections, single tendon origin or insertion, only one time. For injections to multiple different tendon origin or insertion sites, report this code one time for each injection.

Report code 20551, Injections, single tendon origin or insertion, only for injections into the tendon origin or insertion site and not for an injection directly into a tendon sheath.

For elbow epicondylitis, also called tennis elbow, coding guidelines direct you to 20550, Injections, single tendon sheath, or ligament, aponeurosis, i.e., plantar fascia; however, if your provider treats this condition by injecting the tendon insertion, report code 20551, Injections, single tendon origin or insertion. Carefully check the provider's documentation to determine the specific injection site and select the correct code.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $33.23, Non Facility Fee: $60.76; Non-QP Conversion Factor $33.4009, Facility Fee: $33.07, Non Facility Fee: $60.46
RVU (Facility): Work 0.73, PE 0.18, Mal 0.08, Total 0.99
RVU (Non-Facility): Work 0.73, PE 1, Mal 0.08, Total 1.81
MPFS Payment Policy Indicators: Global Period 0, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 5

Modifier Allowances

22, 51, 52, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AQ, AR, CR, ET, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, GA, GC, GJ, GR, GZ, KX, LT, PD, Q5, Q6, QJ, RT, T1, T2, T3, T4, T5, T6, T7, T8, T9, TA, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0232T[1], 0481T[1], 0490T[1], 0596T[1], 0597T[1], 0903T[1], 0904T[1], 0905T[1], 10030[1], 10160[1], 11000[1], 11001[1], 11004[1], 11005[1], 11006[1], 11042[1], 11043[1], 11044[1], 11045[1], 11046[1], 11047[1], 11900[1], 11901[1], 20500[1], 20526[1], 20552[1], 20553[1], 20560[1], 20561[1], 29075[1], 29105[1], 29125[1], 29130[1], 29260[1], 29405[1], 29425[1], 29450[1], 29515[1], 29530[1], 29540[1], 29550[1], 29580[1], 29581[1], 29584[1], 36000[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], 51701[1], 51702[1], 51703[1], 62320[1], 62321[1], 62322[1], 62323[1], 62324[1], 62325[1], 62326[1], 62327[1], 64408[1], 64435[1], 64455[1], 64461[0], 64463[0], 64466[1], 64467[1], 64468[1], 64469[1], 64480[0], 64484[0], 64486[0], 64487[0], 64488[0], 64489[0], 64494[0], 64495[0], 64505[1], 64510[1], 64517[1], 64520[1], 64530[1], 69990[0], 76000[1], 77001[1], 92012[1], 92014[1], 93000[1], 93005[1], 93010[1], 93040[1], 93041[1], 93042[1], 93318[1], 93355[1], 94002[1], 94200[1], 94680[1], 94681[1], 94690[1], 95812[1], 95813[1], 95816[1], 95819[1], 95822[1], 95829[1], 95955[1], 96360[1], 96361[1], 96365[1], 96366[1], 96367[1], 96368[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0], 97597[1], 97598[1], 97602[1], 99155[0], 99156[0], 99157[0], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99221[1], 99222[1], 99223[1], 99231[1], 99232[1], 99233[1], 99234[1], 99235[1], 99236[1], 99238[1], 99239[1], 99242[1], 99243[1], 99244[1], 99245[1], 99252[1], 99253[1], 99254[1], 99255[1], 99291[1], 99292[1], 99304[1], 99305[1], 99306[1], 99307[1], 99308[1], 99309[1], 99310[1], 99315[1], 99316[1], 99347[1], 99348[1], 99349[1], 99350[1], 99374[1], 99375[1], 99377[1], 99378[1], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99495[1], 99496[1], G0463[1], G0471[1], J0670[1]

ICD-10-CM Cross References

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

20552

Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)

Clinical Responsibility

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.

Coding Tips

Trigger point codes are grouped to reflect the total number of muscles treated, not how many injections the provider performs. When the provider treats one or two muscles with injections, regardless of the number of injections, report 20552, Injections, single or multiple trigger points, one or two muscles. When the provider performs trigger points on three or more muscles, report 20553, Injections, single or multiple trigger points, three or more muscles.

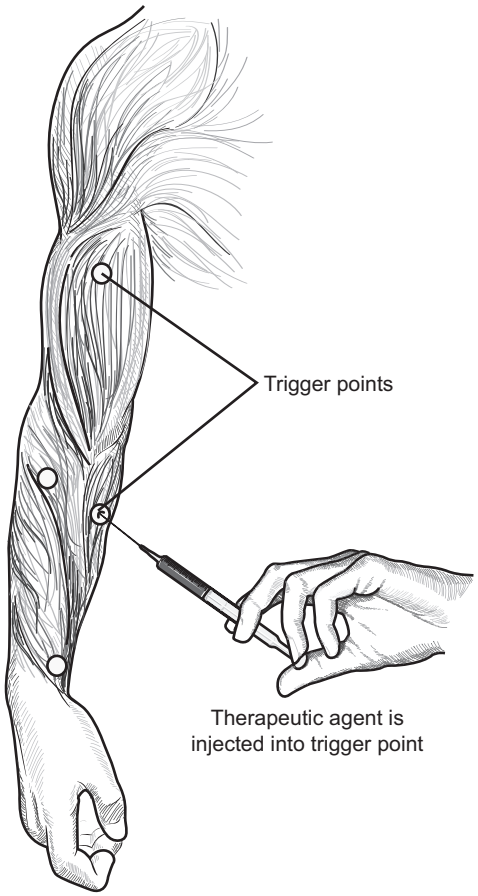
Report 20552 for trigger point injections of one or two muscles. For more than two muscles, report 20553, Injections, single or multiple trigger points, 3 or more muscles.

Coding examples include:

A patient presents with neck and shoulder pain. The provider performs six injections on the patient's trapezius muscle and three on the levator scapulae. Report 20552, Injections, single or multiple trigger points, 1 or 2 muscles, because the provider performed TPIs on two muscles.

A patient complains of severe lower back pain. The provider performs a single TPI to the patient's quadratus lumborum, and two injections each to the gluteus maximus and gluteus medius. Report 20553, Injections, single or multiple trigger points, 3 or more muscles, because the provider performed TPIs on three muscles.

Illustration



20552

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $35.92, Non Facility Fee: $52.03; Non-QP Conversion Factor $33.4009, Facility Fee: $35.74, Non Facility Fee: $51.77
RVU (Facility): Work 0.64, PE 0.36, Mal 0.07, Total 1.07
RVU (Non-Facility): Work 0.64, PE 0.84, Mal 0.07, Total 1.55
MPFS Payment Policy Indicators: Global Period 0, 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

22, 51, 52, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AG, AQ, AR, CR, ET, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, GA, GC, GJ, GR, GZ, KX, LT, PD, Q5, Q6, QJ, RT, SA, T1, T2, T3, T4, T5, T6, T7, T8, T9, TA, XE, XP, XS, XU

NCCI Alerts (version 32.0)

01991[0], 01992[0], 0213T[1], 0216T[1], 0490T[1], 0596T[1], 0597T[1], 0903T[1], 0904T[1], 0905T[1], 10030[1], 10160[1], 11900[1], 11901[1], 20500[1], 20526[1], 20560[1], 20561[1], 29075[1], 29105[1], 29125[1], 29130[1], 29260[1], 29405[1], 29425[1], 29450[1], 29515[1], 29530[1], 29540[1], 29550[1], 29580[1], 29581[1], 29584[1], 36000[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], 51701[1], 51702[1], 51703[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], 64455[1], 64461[1], 64462[1], 64463[1], 64466[1], 64467[1], 64468[1], 64469[1], 64473[1], 64474[1], 64479[1], 64480[1], 64483[1], 64484[1], 64486[0], 64487[0], 64488[0], 64489[0], 64490[1], 64491[1], 64492[1], 64493[1], 64494[1], 64495[1], 64505[1], 64517[1], 64530[1], 69990[0], 76000[1], 76998[1], 77001[1], 77012[1], 92012[1], 92014[1], 93000[1], 93005[1], 93010[1], 93040[1], 93041[1], 93042[1], 93318[1], 93355[1], 94002[1], 94200[1], 94680[1], 94681[1], 94690[1], 95812[1], 95813[1], 95816[1], 95819[1], 95822[1], 95829[1], 95955[1], 96360[1], 96361[1], 96365[1], 96366[1], 96367[1], 96368[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0], 99155[0], 99156[0], 99157[0], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99221[1], 99222[1], 99223[1], 99231[1], 99232[1], 99233[1], 99234[1], 99235[1], 99236[1], 99238[1], 99239[1], 99242[1], 99243[1], 99244[1], 99245[1], 99252[1], 99253[1], 99254[1], 99255[1], 99291[1], 99292[1], 99304[1], 99305[1], 99306[1], 99307[1], 99308[1], 99309[1], 99310[1], 99315[1], 99316[1], 99347[1], 99348[1], 99349[1], 99350[1], 99374[1], 99375[1], 99377[1], 99378[1], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99495[1], 99496[1], G0463[1], G0471[1], J0670[1]

ICD-10-CM Cross References

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

20553

Injection(s); single or multiple trigger point(s), 3 or more muscles

Clinical Responsibility

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.

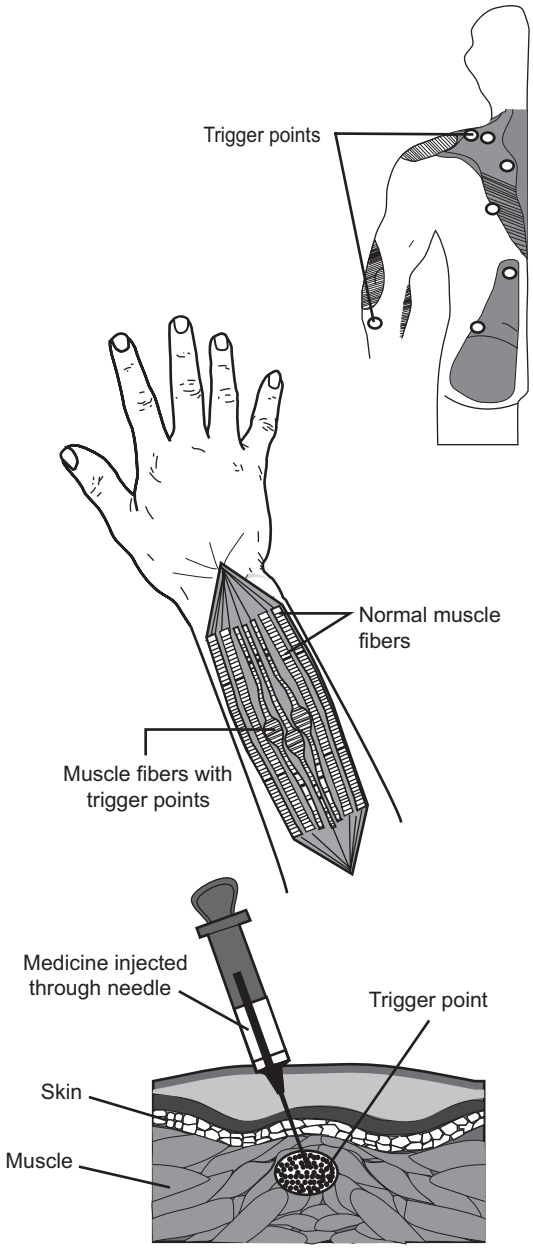
Coding Tips

Trigger point codes are grouped to reflect the total number of muscles treated, not how many injections the provider performs. When the provider treats one or two muscles with injections, regardless of the number of injections, report 20552, Injections, single or multiple trigger points, one or two muscles. When the provider performs trigger points on three or more muscles, report 20553, Injections, single or multiple trigger points, three or more muscles.

Coding examples include:

A patient with a history of back problems reports to the emergency department complaining of sharp lower back pain and aching legs. The provider discovers three trigger points in the patient's longissimus muscle, which is one of the deep muscles in the back and performs therapeutic injections at each trigger point. Do not report 20553, Injections, single or multiple trigger points, three or more muscles, because the provider treated only one muscle. For this encounter, report 20552, Injections, single or multiple trigger points, one or two muscles.

Illustration



20553

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $40.95, Non Facility Fee: $60.09; Non-QP Conversion Factor $33.4009, Facility Fee: $40.75, Non Facility Fee: $59.79
RVU (Facility): Work 0.73, PE 0.41, Mal 0.08, Total 1.22
RVU (Non-Facility): Work 0.73, PE 0.98, Mal 0.08, Total 1.79
MPFS Payment Policy Indicators: Global Period 0, 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

22, 51, 52, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AG, AQ, AR, CR, ET, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, GA, GC, GJ, GR, GZ, KX, LT, PD, Q5, Q6, QJ, RT, T1, T2, T3, T4, T5, T6, T7, T8, T9, TA, XE, XP, XS, XU

NCCI Alerts (version 32.0)

01991[0], 01992[0], 0213T[1], 0216T[1], 0490T[1], 0596T[1], 0597T[1], 0903T[1], 0904T[1], 0905T[1], 10030[1], 10160[1], 11900[1], 11901[1], 20500[1], 20526[1], 20552[0], 20560[1], 20561[1], 29075[1], 29105[1], 29125[1], 29130[1], 29260[1], 29405[1], 29425[1], 29450[1], 29515[1], 29530[1], 29540[1], 29550[1], 29580[1], 29581[1], 29584[1], 36000[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], 51701[1], 51702[1], 51703[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], 64455[1], 64461[1], 64462[1], 64463[1], 64466[1], 64467[1], 64468[1], 64469[1], 64473[1], 64474[1], 64479[1], 64480[1], 64483[1], 64484[1], 64486[0], 64487[0], 64488[0], 64489[0], 64490[1], 64491[1], 64492[1], 64493[1], 64494[1], 64495[1], 64505[1], 64510[1], 64517[1], 64520[1], 64530[1], 69990[0], 76000[1], 76998[1], 77001[1], 77012[1], 92012[1], 92014[1], 93000[1], 93005[1], 93010[1], 93040[1], 93041[1], 93042[1], 93318[1], 93355[1], 94002[1], 94200[1], 94680[1], 94681[1], 94690[1], 95812[1], 95813[1], 95816[1], 95819[1], 95822[1], 95829[1], 95955[1], 96360[1], 96361[1], 96365[1], 96366[1], 96367[1], 96368[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0], 99155[0], 99156[0], 99157[0], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99221[1], 99222[1], 99223[1], 99231[1], 99232[1], 99233[1], 99234[1], 99235[1], 99236[1], 99238[1], 99239[1], 99242[1], 99243[1], 99244[1], 99245[1], 99252[1], 99253[1], 99254[1], 99255[1], 99291[1], 99292[1], 99304[1], 99305[1], 99306[1], 99307[1], 99308[1], 99309[1], 99310[1], 99315[1], 99316[1], 99347[1], 99348[1], 99349[1], 99350[1], 99374[1], 99375[1], 99377[1], 99378[1], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99495[1], 99496[1], G0463[1], G0471[1], J0670[1]

ICD-10-CM Cross References

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

20560

Needle insertion(s) without injection(s); 1 or 2 muscle(s)

Clinical Responsibility

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.

Coding Tips

For needle insertion without injection of 3 or more muscles, report 20561.

For acupuncture codes, see 97810 to 97814, and for osteopathic manipulative treatment, see 98928, 98929, 98940, 98941.

76999

Unlisted ultrasound procedure (eg, diagnostic, interventional)

Clinical Responsibility

The provider performs an ultrasound procedure that is not represented by any of the standard and active CPT® codes available. This service includes ultrasound that the provider uses to perform a diagnostic procedure to diagnose a condition or an interventional procedure to treat a condition. Ultrasound imaging uses high-frequency sound waves to view tissues in order to diagnose or manage conditions.

Consult the provider, if possible, to ensure that proper documentation has been done before billing for an unlisted procedure.

Coding Tips

CPT® guidelines instruct that you should not choose a code that merely approximates the service provided. You should report the service using only the appropriate unlisted procedure code if no such specific procedure or service code exists.

You must report a Category III code when available in place of an unlisted procedure code.

When reporting a procedure with an unlisted code, submit a cover letter explaining the reason for choosing the unlisted code instead of a defined, active code. Include one or more similar codes and compare your service to those codes to justify the claim amount you are billing. Also include the operative notes or other relevant documentation to strengthen the claim and to avoid a possible denial. Your payers will consider claims with unlisted procedure codes on a case by case basis, and they will determine payment based on the documentation you provide.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $0.00, Non Facility Fee: $0.00; 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: C, PC/TC Indicator: 1, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

26, 59, 76, 77, 79, 80, 81, 82, AR, AS, GY, GZ, KX, PD, TC, XE, XP, XS, XU

NCCI Alerts (version 32.0)

96523[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.

+77002

Fluoroscopic guidance for needle placement (eg, biopsy, aspiration, injection, localization device) (List separately in addition to code for primary procedure)

Clinical Responsibility

When the patient is appropriately prepped and draped, the patient is placed under the fluoroscope in the supine or prone position. The provider then places the tip of the needle or catheter at the introduction site. Using fluoroscopy to guide him, he inserts the needle into the desired region, advancing it slowly to the designated location inside the body. Once the needle reaches the appropriate level, he injects contrast material at the site to confirm the proper needle placement. The provider then may perform diagnostic or therapeutic procedures via the needle or catheter, such as localizing or identifying a specific area of interest or location of a structure in the body, taking samples of tissue or withdrawing small amounts of cells or fluid to send for further analysis, or injecting a substance to treat a condition such as acute or chronic pain.

Fluoroscopy displays live X-ray images on a fluorescent screen television monitor; providers often use fluoroscopy to view body structures while performing procedures.

Coding Tips

Because +77002 is an add-on code, payers will not reimburse it unless it is reported with an appropriate primary code. However, fluoroscopic guidance is included with many procedure codes, so do not report for any procedure code that includes fluoroscopic guidance. Do not report with arthrography radiological supervision and interpretation codes.

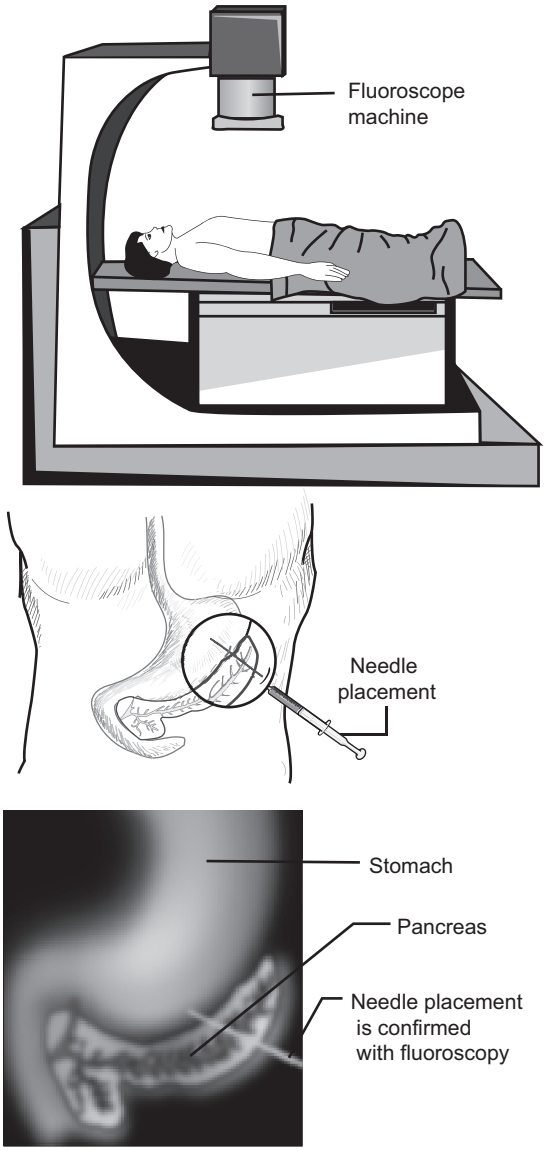
If the provider uses fluoroscopic guidance for placement of a needle or catheter tip in the spine or paraspinous region, use 77003.

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 modifier 52 (Reduced services). Each should also append modifier 26 to the code to indicate they are reporting only the professional portion of the service.

If you are reporting only the technical component for the radiology service, you would append modifier TC to the radiology code. Note, however, that payer policy may exempt hospitals from appending modifier TC because the hospital's portion is inherently technical.

Do not append a professional or technical modifier to the radiology code when reporting a global service in which one provider renders both the professional and technical components.

Illustration



77002

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $121.85, Non Facility Fee: $121.85; Non-QP Conversion Factor $33.4009, Facility Fee: $121.25, Non Facility Fee: $121.25
RVU (Facility): Work 0.53, PE 3.06, Mal 0.04, Total 3.63
RVU (Non-Facility): Work 0.53, PE 3.06, Mal 0.04, Total 3.63
MPFS Payment Policy Indicators: Global Period ZZZ, 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, 59, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, GA, GC, GR, KX, LT, PD, Q5, Q6, RT, SC, TC, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0570T[1], 0571T[1], 0572T[1], 0573T[1], 0574T[1], 0581T[1], 0582T[1], 0584T[1], 0585T[1], 0586T[1], 0587T[1], 0588T[1], 0655T[1], 0901T[0], 36591[0], 36592[0], 76000[1], 76125[1], 77003[1], 96523[0], 99446[1], 99447[1], 99448[1], 99449[1], 99451[1], 99452[1]

ICD-10-CM Cross References

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

+77003

Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid) (List separately in addition to code for primary procedure)

Clinical Responsibility

After the provider appropriately preps and drapes the patient; the patient is placed under the fluoroscope in the prone (face down) position. The physician places the tip of the needle or catheter at the introduction site in the desired region. A contrast agent is injected. The provider then moves the needle or catheter as necessary to obtain the desired location inside the body with the help of the fluoroscopic guidance. Once the device tip reaches the desired site, for example, the epidural or subarachnoid space, and the location is confirmed, the provider delivers a diagnostic/therapeutic substance via the needle or catheter.

Fluoroscopy is an X-ray procedure that provides real-time moving images to the physician/surgeon during a procedure.

Coding Tips

Code 77003 is an add-on code and should be reported in addition to a code for the primary procedure (61050, 61055, 62267, 62273, 62280, 62281, 62282, 62284, 64449, 64510, 64517, 64520, 64610, 96450); it should be used only for the spine and paraspinous area.

For needle placement not specific to a particular body area, see add-on code 77002.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $105.07, Non Facility Fee: $105.07; Non-QP Conversion Factor $33.4009, Facility Fee: $104.54, Non Facility Fee: $104.54
RVU (Facility): Work 0.59, PE 2.49, Mal 0.05, Total 3.13
RVU (Non-Facility): Work 0.59, PE 2.49, Mal 0.05, Total 3.13
MPFS Payment Policy Indicators: Global Period ZZZ, 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, 59, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, GA, GC, GR, KX, PD, Q5, Q6, SC, TC, XE, XP, XS, XU

G90.521-G90.529, G90.59, G96.89, G97.81, G98.8, I63.81, I63.89, I67.850, I70.221-I70.229, M47.24-M47.28, M47.814-M47.818, M47.894-M47.898, M50.10, M50.11, M50.120-M50.123, M50.13, M50.90, M50.91, M50.93, M51.14-M51.17, M51.24-M51.27, M51.34, M51.35, M51.360-M51.369, M51.370-M51.379, M51.9, M54.10-M54.18, M54.2, M62.85, M79.12, M79.18, M79.2, M96.1, N39.3, N39.41, R15.9, R33.9, R35.0, R39.14, R56.1, R56.9, S34.21XA-S34.21XS, S34.3XXA-S34.3XXS, T85.01XA-T85.01XS, T85.02XA-T85.02XS, T85.03XA-T85.03XS, T85.09XA-T85.09XS, T85.110A-T85.110S, T85.111A-T85.111S, T85.112A-T85.112S, T85.113A, T85.118A-T85.118S, T85.120A-T85.120S, T85.121A-T85.121S, T85.122A-T85.122S, T85.123A, T85.128A-T85.128S, T85.190A-T85.190S, T85.191A-T85.191S, T85.192A-T85.192S, T85.193A, T85.199A-T85.199S, T85.615A, T85.625A, T85.635A, T85.695A, T85.698A-T85.698S, T85.731A, T85.732A, T85.733A, T85.734A, T85.738A, T85.79XA-T85.79XS, T85.820A, T85.828A, T85.830A, T85.838A, T85.840A, T85.850A, T85.860A, T85.890A, Z45.42, Z96.82

95971

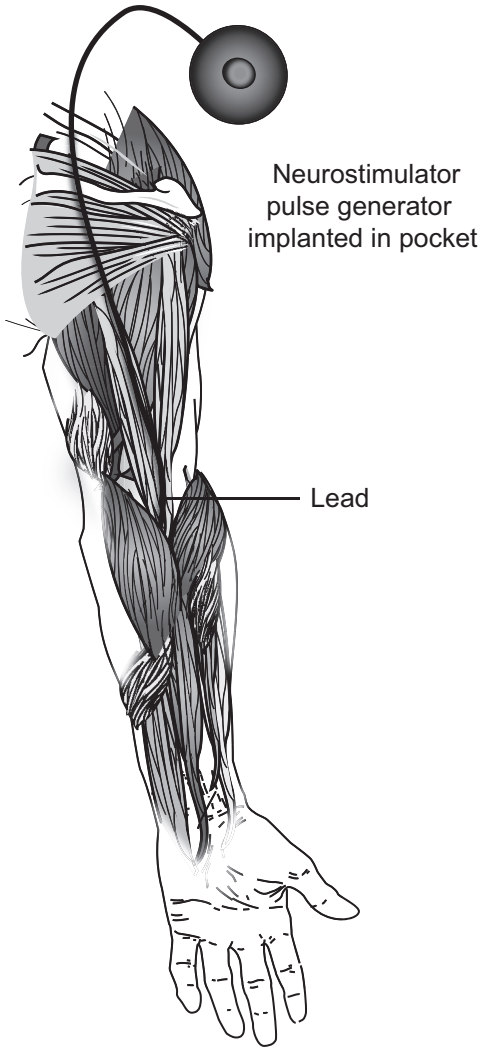
Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple spinal cord or peripheral nerve (eg, sacral nerve) neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional

Clinical Responsibility

A neurostimulator pulse generator/transmitter system is a battery-powered device designed to deliver electrical stimulation to the brain, spinal cord, or peripheral nerves to treat certain neurological disorders.

The provider checks the system's programming to ensure correct functioning of the brain, spinal cord, or peripheral nerve neurostimulator. The provider tests the following features without reprogramming: contact group(s), interleaving, strength or intensity of stimulation (amplitude), duration of pulse in microseconds (pulse width), rate/pulses per second (Hz; frequency), cycling on and off, burst (stimulation pulses in rapid succession), magnet mode (to turn stimulation off and on), dose lockout (a period in which stimulation cannot be activated), patient-selectable parameters, responsive neurostimulation, detection algorithms (mathematical formulas for sensing), closed loop parameters (bidirectional sensing and responding), and passive parameters (nonresponsive stimulation settings). Based on his testing, the provider makes simple programming changes to the neurostimulator device.

Illustration



95971

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $34.57, Non Facility Fee: $50.69; Non-QP Conversion Factor $33.4009, Facility Fee: $34.40, Non Facility Fee: $50.44
RVU (Facility): Work 0.78, PE 0.18, Mal 0.07, Total 1.03
RVU (Non-Facility): Work 0.78, PE 0.66, Mal 0.07, Total 1.51
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, 59, 76, 77, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0587T[0], 0588T[0], 0589T[0], 0590T[0], 0788T[0], 0789T[0], 0911T[0], 36591[0], 36592[0], 95970[0], 95976[0], 96523[0]

0328U

Drug assay, definitive, 120 or more drugs and metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS), includes specimen validity and algorithmic analysis describing drug or metabolite and presence or absence of risks for a significant patient-adverse event, per date of service

Clinical Responsibility

The test uses quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS) to screen for the presence of 120 or more drugs or drug metabolites (breakdown products) in urine specimens. In addition, the test uses multiple reaction monitoring and an algorithmic analysis to identify potential drug interactions or adverse drug events (ADE). The procedure includes specimen validation, such as using genomic sequencing methods to definitively match the urine and buccal cells from a cheek swab to ensure that the specimen is human urine taken from the intended patient.

Clinicians may order this test to screen for illicit drug use, monitor medication compliance, and evaluate the presence of various drugs, over-the-counter ingredients, and metabolites, while ensuring specimen authenticity. The algorithmic analysis provides clinicians with actionable risk assessment for the patient having an ADE.

Coding Tips

Use this code only for the appropriate proprietary test; report one unit of this code for a single specimen analyzed on a single date of service.

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 0.00, PE 0.00, Mal 0.00, Total 0.00
RVU (Non-Facility): Work 0.00, PE 0.00, Mal 0.00, Total 0.00
MPFS Payment Policy Indicators: Global Period 0, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: 0, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

33, 59, 90, 91, 99, GA, GY, GZ, QJ, SC, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0011U[0], 0051U[0], 0054U[0], 0093U[0], 0110U[0], 0116U[0], 0119U[1], 0251U[1], 80305[0], 80306[0], 80307[0], 80320[0], 80321[0], 80322[0], 80323[0], 80324[0], 80325[0], 80326[0], 80327[0], 80328[0], 80329[0], 80330[0], 80331[0], 80332[0], 80333[0], 80334[0], 80335[0], 80336[0], 80337[0], 80338[0], 80339[0], 80340[0], 80341[0], 80342[0], 80343[0], 80344[0], 80345[0], 80346[0], 80347[0], 80348[0], 80349[0], 80350[0], 80351[0], 80352[0], 80353[0], 80354[0], 80355[0], 80356[0], 80357[0], 80358[0], 80359[0], 80360[0], 80361[0], 80362[0], 80363[0], 80364[0], 80365[0], 80366[0], 80367[0], 80368[0], 80369[0], 80370[0], 80371[0], 80372[0], 80373[0], 80374[0], 80375[0], 80376[0], 80377[0], 80503[1], 80504[1], 80505[1], 80506[1], 81000[1], 81001[1], 81002[1], 81003[1], 81005[1], 82542[1], 82570[1], 83516[1], 83518[1], 83519[1], 83520[1], 83789[1], 83986[1], 83992[0], 84156[1], 84311[1], 96523[0], G0480[0], G0481[0], G0482[0], G0483[0], G0659[0]

Modifier: 0 = not allowed, 1 = allowed

ICD-10-CM Cross References

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

HCPCS Level II Codes

Outpatient PPS

C9810

Water circulating motorized cold therapy device (e.g., iceman) including all system components (e.g. pads, console, disposable parts), non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)

Clinical Responsibility

This code represents the supply of a water circulating motorized cold therapy device, including the control unit, pads, and any disposable parts or other system components. The device uses a motor to circulate chilled water through pads that are placed on or around the surgical site. The cold temperature helps reduce swelling and pain after surgery. As a nonopioid medical device, it helps manage postsurgical pain without the use of opioid medications. This code applies to products that qualify under Medicare rules as nonopioid medical devices for postsurgical pain relief. Section 4135 of the Consolidated Appropriations Act (CAA), 2023, provides for separate, temporary Medicare payments for certain nonopioid pain relief treatments in hospital outpatient departments and ambulatory surgical centers.

BETOS

P1G: Major procedure - other

C9811

Electronic ambulatory infusion pump (e.g. sapphire pump), including all pump components, including disposable components , non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)

Clinical Responsibility

This code represents the supply of an electronic ambulatory infusion pump system, including the pump itself and all required components, including disposable components. An ambulatory infusion pump is a portable device that delivers medication at a controlled rate while allowing the patient to move around. In the postsurgical setting, providers may use this type of pump to deliver nonopioid medications continuously or intermittently to help control pain. This code applies to products that qualify under Medicare rules as nonopioid medical devices for postsurgical pain relief. Section 4135 of the Consolidated Appropriations Act (CAA), 2023, provides for separate, temporary Medicare payments for certain nonopioid pain relief treatments in hospital outpatient departments and ambulatory surgical centers.

BETOS

P1G: Major procedure - other

C9812

Echogenic nerve block needles (e.g. sonoplex, sonoblock, sonotap), non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)

Clinical Responsibility

This code represents the supply of echogenic nerve block needles designed to be clearly visible under ultrasound. Echogenic means the needle has surface features or coatings that reflect ultrasound waves, making the needle tip easier to see on the ultrasound screen. Providers use these needles to perform nerve blocks, which involve injecting local anesthetic near a nerve or nerve plexus (nerve network) to numb a specific area of the body. Nerve blocks can provide targeted, nonopioid pain control after surgery. This code applies to products that qualify under Medicare rules as nonopioid medical devices for postsurgical pain relief. Section 4135 of the Consolidated Appropriations Act (CAA), 2023, provides for separate, temporary Medicare payments for certain nonopioid pain relief treatments in hospital outpatient departments and ambulatory surgical centers.

BETOS

P1G: Major procedure - other

C9813

Perforated continuous infusion catheter set (e.g. infiltralong), including all components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)

Clinical Responsibility

This code represents the supply of a perforated continuous infusion catheter set, including the catheter and associated components. A perforated catheter has multiple small openings (perforations) along its length, allowing medication to be delivered evenly over a broader area. Providers may place the catheter near a surgical site or nerve region and connect it to an infusion pump that delivers local anesthetic or other nonopioid medication continuously over time. This continuous delivery helps control pain after surgery without relying solely on opioid medications. This code applies to products that qualify under Medicare rules as nonopioid medical devices for postsurgical pain relief. Section 4135 of the Consolidated Appropriations Act (CAA), 2023, provides for separate, temporary Medicare payments for certain nonopioid pain relief treatments in hospital outpatient departments and ambulatory surgical centers.

BETOS

P1G: Major procedure - other

C9814

Continuous anesthesia echogenic conduction catheter set (e.g. sonolong), non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)

Clinical Responsibility

This code represents the supply of a continuous anesthesia echogenic conduction catheter set used for ongoing nerve block or regional anesthesia. The catheter is echogenic, meaning it is designed to be easily seen under ultrasound guidance, helping the provider place it accurately near a nerve or nerve bundle. Once placed, the catheter can deliver local anesthetic continuously or intermittently to maintain regional anesthesia and provide sustained pain relief after surgery. This code applies to products that qualify under Medicare rules as nonopioid medical devices for postsurgical pain relief. Section 4135 of the Consolidated Appropriations Act (CAA), 2023, provides for separate, temporary Medicare payments for certain nonopioid pain relief treatments in hospital outpatient departments and ambulatory surgical centers.

BETOS

P1G: Major procedure - other

C9815

Linear peristaltic pain management infusion pump (e.g. cadd-solis ambulatory infusion pump), and all disposable system components, non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)

Clinical Responsibility

This code represents the supply of a linear peristaltic pain management infusion pump system, including the pump and all necessary disposable tubing and components. A peristaltic pump uses rollers or a similar mechanism to squeeze flexible tubing in a controlled way, pushing medication forward at a set rate. In an ambulatory pain management setting, providers may program the pump to deliver local anesthetics or other nonopioid medications continuously or in programmed doses to help control pain after surgery while allowing the patient to remain mobile. This code applies to products that qualify under Medicare rules as nonopioid medical devices for postsurgical pain relief. Section 4135 of the Consolidated Appropriations Act (CAA), 2023, provides for separate, temporary Medicare payments for certain nonopioid pain relief treatments in hospital outpatient departments and ambulatory surgical centers.

BETOS

P1G: Major procedure - other

C9816

Rotary peristaltic infusion pump (e.g., reusable ambit pump) including all disposable system components, reusable non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)

Clinical Responsibility

This code represents the supply of a rotary peristaltic infusion pump system used for pain management, including the reusable pump unit and disposable tubing or other single-use components. A rotary peristaltic pump uses a rotating mechanism with rollers to compress tubing and move fluid at a controlled rate. Providers may use this type of pump to deliver nonopioid medications, such as local anesthetics, continuously or intermittently after surgery to help manage pain. The pump itself is reusable, while the attached tubing and similar parts are disposable. This code applies to products that qualify under Medicare rules as nonopioid medical devices for postsurgical pain relief. Section 4135 of the Consolidated Appropriations Act (CAA), 2023, provides for separate, temporary Medicare payments for certain nonopioid pain relief treatments in hospital outpatient departments and ambulatory surgical centers.

BETOS

P1G: Major procedure - other

C9817

Electronic cryo-pneumatic compression, pain management system (e.g. game ready grpro 2.1 system), including control unit, anatomically correct wrap(s), and other system component(s), non-opioid medical device (must be a qualifying medicare non-opioid medical device for post-surgical pain relief in accordance with section 4135 of the caa, 2023)

Clinical Responsibility

This code represents the supply of an electronic cryo-pneumatic compression system for pain management, including the central control unit, anatomically correct wraps designed to fit specific body parts, and other necessary components. Cryo- refers to cold therapy, while pneumatic compression refers to the use of air pressure to gently squeeze the limb or joint. The device circulates cold fluid through the wraps while applying intermittent or continuous compression. Together, cold and compression help reduce swelling, pain, and tissue irritation after surgery. This code applies to products that qualify under Medicare rules as nonopioid medical devices for postsurgical pain relief. Section 4135 of the Consolidated Appropriations Act (CAA), 2023, provides for separate, temporary Medicare payments for certain nonopioid pain relief treatments in hospital outpatient departments and ambulatory surgical centers.

BETOS

P1G: Major procedure - other

Procedures/Professional Services

G0316

Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT® codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (do not report g0316 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418, 99415, 99416). (do not report g0316 for any time unit less than 15 minutes)

Clinical Responsibility

In addition to the required total time for an inpatient or observation evaluation and management (E/M) service, the physician or qualified healthcare professional spends additional time on that E/M service. The primary service (99223, 99233, or 99236) is one coded based on total time with and without patient contact. This code applies to each 15 minutes of prolonged service time. Do not report this code for any time unit of less than 15 minutes.

Coding Tips

You must report this code in addition to an appropriate primary service code.

Confirm whether payers accept this code rather than a similar code, such as +99418.

Check payer rules regarding minimum time required to report the code (such as 30 minutes beyond the primary service's minimum time requirement) and the relevant time period for counting total time (such as the encounter date or within three days following the encounter).

BETOS

Y1: Other - Medicare fee schedule

G0317

Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT® codes 99306, 99310 for nursing facility evaluation and management services). (do not report g0317 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418). (do not report g0317 for any time unit less than 15 minutes)

Clinical Responsibility

In addition to the required total time for a nursing facility evaluation and management (E/M) service, the physician or qualified healthcare professional spends additional time on that E/M service. The primary service (99306 or 99310) is one coded based on total time with and without patient contact. This code applies to each 15 minutes of prolonged service time. Do not report this code for any time unit of less than 15 minutes.

Coding Tips

You must report this code in addition to an appropriate primary service code.

Confirm whether payers accept this code rather than a similar code, such as +99418.

Check payer rules regarding minimum time required to report the code (such as 50 minutes beyond the primary service's minimum time requirement) and the relevant time period for counting total time (such as from one day before to three days following the encounter).

BETOS

Y1: Other - Medicare fee schedule

G0318

Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT® codes 99345, 99350 for home or residence evaluation and management services). (do not report g0318 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99417). (do not report g0318 for any time unit less than 15 minutes)

Clinical Responsibility

In addition to the required total time for a home or residence evaluation and management (E/M) service, the physician or qualified healthcare professional spends additional time on that E/M service. The primary service (99345 or 99350) is one coded based on total time with and without patient contact. This code applies to each 15 minutes of prolonged service time. Do not report this code for any time unit of less than 15 minutes.

Coding Tips

You must report this code in addition to an appropriate primary service code.

Confirm whether payers accept this code rather than a similar code, such as +99417.

Check payer rules regarding minimum time required to report the code (such as 66 minutes beyond the primary service's minimum time requirement) and the relevant time period for counting total time (such as from three days before to seven days following the encounter).

ICD-10-CM Cross Reference Details

A05.1 Botulism food poisoning
A15.5 Tuberculosis of larynx, trachea and bronchus
A17.81 Tuberculoma of brain and spinal cord
A18.01 Tuberculosis of spine
A18.03 Tuberculosis of other bones
A31.0 Pulmonary mycobacterial infection
A35 Other tetanus
A39.82 Meningococcal retrobulbar neuritis
A50.43 Late congenital syphilitic polyneuropathy
A52.11 Tabes dorsalis
A52.15 Late syphilitic neuropathy
A52.19 Other symptomatic neurosyphilis
A52.2 Asymptomatic neurosyphilis
A52.3 Neurosyphilis, unspecified
A79.82 Anaplasmosis [A. phagocytophilum]
B00.82 Herpes simplex myelitis
B01.12 Varicella myelitis
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
B02.7 Disseminated zoster
B02.8 Zoster with other complications
B02.9 Zoster without complications
B20 Human immunodeficiency virus [HIV] disease
B25.2 Cytomegaloviral pancreatitis
B26.84 Mumps polyneuropathy
B27.01 Gammaherpesviral mononucleosis with polyneuropathy
B27.11 Cytomegaloviral mononucleosis with polyneuropathy
B27.81 Other infectious mononucleosis with polyneuropathy
B27.91 Infectious mononucleosis, unspecified with polyneuropathy
B34.2 Coronavirus infection, unspecified
B45.1 Cerebral cryptococcosis
B88.01 Infestation by Demodex mites
B88.09 Other acariasis
B97.21 SARS-associated coronavirus as the cause of diseases classified elsewhere
B97.29 Other coronavirus as the cause of diseases classified elsewhere
B97.4 Respiratory syncytial virus as the cause of diseases classified elsewhere
C01 Malignant neoplasm of base of tongue
C02.0 Malignant neoplasm of dorsal surface of tongue
C02.1 Malignant neoplasm of border 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
C03.0 Malignant neoplasm of upper gum
C03.1 Malignant neoplasm of lower gum
C03.9 Malignant neoplasm of gum, unspecified
C04.0 Malignant neoplasm of anterior floor of mouth
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
C05.9 Malignant neoplasm of palate, unspecified
C06.0 Malignant neoplasm of cheek mucosa
C06.1 Malignant neoplasm of vestibule of mouth
C06.2 Malignant neoplasm of retromolar area
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)
C09.9 Malignant neoplasm of tonsil, unspecified
C10.0 Malignant neoplasm of vallecula
C10.1 Malignant neoplasm of anterior surface of epiglottis
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
C10.9 Malignant neoplasm of oropharynx, unspecified
C11.0 Malignant neoplasm of superior wall of nasopharynx
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
C11.8 Malignant neoplasm of overlapping sites 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
C14.2 Malignant neoplasm of Waldeyer's ring
C14.8 Malignant neoplasm of overlapping sites of lip, oral cavity and pharynx
C15.3 Malignant neoplasm of upper third of esophagus
C15.4 Malignant neoplasm of middle third of esophagus
C15.5 Malignant neoplasm of lower third of esophagus
C15.8 Malignant neoplasm of overlapping sites of esophagus
C15.9 Malignant neoplasm of esophagus, unspecified
C16.9 Malignant neoplasm of stomach, unspecified
C17.9 Malignant neoplasm of small intestine, unspecified
C18.8 Malignant neoplasm of overlapping sites of colon
C18.9 Malignant neoplasm of colon, unspecified
C19 Malignant neoplasm of rectosigmoid junction
C20 Malignant neoplasm of rectum
C21.0 Malignant neoplasm of anus, unspecified
C21.2 Malignant neoplasm of cloacogenic zone
C21.8 Malignant neoplasm of overlapping sites of rectum, anus and anal canal
C22.0 Liver cell carcinoma
C23 Malignant neoplasm of gallbladder
C24.9 Malignant neoplasm of biliary tract, unspecified
C25.0 Malignant neoplasm of head of pancreas
C25.1 Malignant neoplasm of body of pancreas
C25.2 Malignant neoplasm of tail of pancreas
C25.3 Malignant neoplasm of pancreatic duct
C25.4 Malignant neoplasm of endocrine pancreas
C25.7 Malignant neoplasm of other parts of pancreas
C25.8 Malignant neoplasm of overlapping sites of pancreas
C25.9 Malignant neoplasm of pancreas, unspecified
C26.0 Malignant neoplasm of intestinal tract, part unspecified
C26.9 Malignant neoplasm of ill-defined sites within the digestive system
C31.0 Malignant neoplasm of maxillary sinus
C31.1 Malignant neoplasm of ethmoidal sinus
C31.2 Malignant neoplasm of frontal sinus
C31.3 Malignant neoplasm of sphenoid sinus
C31.8 Malignant neoplasm of overlapping sites of accessory sinuses
C32.0 Malignant neoplasm of glottis
C32.1 Malignant neoplasm of supraglottis
C32.2 Malignant neoplasm of subglottis

C32.3 Malignant neoplasm of laryngeal cartilage
C32.8 Malignant neoplasm of overlapping sites of larynx
C32.9 Malignant neoplasm of larynx, unspecified
C34.00 Malignant neoplasm of unspecified main bronchus
C34.01 Malignant neoplasm of right main bronchus
C34.02 Malignant neoplasm of left main bronchus
C34.10 Malignant neoplasm of upper lobe, unspecified bronchus or lung
C34.11 Malignant neoplasm of upper lobe, right bronchus or lung
C34.12 Malignant neoplasm of upper lobe, left bronchus or lung
C34.2 Malignant neoplasm of middle lobe, bronchus or lung
C34.30 Malignant neoplasm of lower lobe, unspecified bronchus or lung
C34.31 Malignant neoplasm of lower lobe, right bronchus or lung
C34.32 Malignant neoplasm of lower lobe, left bronchus or lung
C34.80 Malignant neoplasm of overlapping sites of unspecified bronchus and lung
C34.81 Malignant neoplasm of overlapping sites of right bronchus and lung
C34.82 Malignant neoplasm of overlapping sites of left bronchus and lung
C34.90 Malignant neoplasm of unspecified part of unspecified bronchus or lung
C34.91 Malignant neoplasm of unspecified part of right bronchus or lung
C34.92 Malignant neoplasm of unspecified part of left bronchus or lung
C37 Malignant neoplasm of thymus
C38.1 Malignant neoplasm of anterior mediastinum
C38.2 Malignant neoplasm of posterior mediastinum
C38.3 Malignant neoplasm of mediastinum, part unspecified
C38.4 Malignant neoplasm of pleura
C38.8 Malignant neoplasm of overlapping sites of heart, mediastinum and pleura
C40.00 Malignant neoplasm of scapula and long bones of unspecified upper limb
C40.01 Malignant neoplasm of scapula and long bones of right upper limb
C40.02 Malignant neoplasm of scapula and long bones of left upper limb
C40.10 Malignant neoplasm of short bones of unspecified upper limb
C40.11 Malignant neoplasm of short bones of right upper limb
C40.12 Malignant neoplasm of short bones of left upper limb
C40.20 Malignant neoplasm of long bones of unspecified lower limb
C40.21 Malignant neoplasm of long bones of right lower limb
C40.22 Malignant neoplasm of long bones of left lower limb
C40.30 Malignant neoplasm of short bones of unspecified lower limb
C40.31 Malignant neoplasm of short bones of right lower limb
C40.32 Malignant neoplasm of short bones of left lower limb
C40.80 Malignant neoplasm of overlapping sites of bone and articular cartilage of unspecified limb
C40.81 Malignant neoplasm of overlapping sites of bone and articular cartilage of right limb
C40.82 Malignant neoplasm of overlapping sites of bone and articular cartilage of left limb
C40.90 Malignant neoplasm of unspecified bones and articular cartilage of unspecified limb
C40.91 Malignant neoplasm of unspecified bones and articular cartilage of right limb
C40.92 Malignant neoplasm of unspecified bones and articular cartilage of left limb
C41.0 Malignant neoplasm of bones of skull and face
C41.1 Malignant neoplasm of mandible
C41.2 Malignant neoplasm of vertebral column
C41.3 Malignant neoplasm of ribs, sternum and clavicle
C41.4 Malignant neoplasm of pelvic bones, sacrum and coccyx
C41.9 Malignant neoplasm of bone and articular cartilage, unspecified
C43.0 Malignant melanoma of lip
C43.10 Malignant melanoma of unspecified eyelid, including canthus
C43.20 Malignant melanoma of unspecified ear and external auricular canal
C43.21 Malignant melanoma of right ear and external auricular canal
C43.22 Malignant melanoma of left ear and external auricular canal
C43.30 Malignant melanoma of unspecified part of face
C43.31 Malignant melanoma of nose
C43.39 Malignant melanoma of other parts of face
C43.4 Malignant melanoma of scalp and neck
C43.51 Malignant melanoma of anal skin
C43.59 Malignant melanoma of other part of trunk
C43.60 Malignant melanoma of unspecified upper limb, including shoulder
C43.61 Malignant melanoma of right upper limb, including shoulder
C43.62 Malignant melanoma of left upper limb, including shoulder
C43.70 Malignant melanoma of unspecified lower limb, including hip
C43.71 Malignant melanoma of right lower limb, including hip
C43.72 Malignant melanoma of left lower limb, including hip
C44.101 Unspecified malignant neoplasm of skin of unspecified eyelid, including canthus
C44.111 Basal cell carcinoma of skin of unspecified eyelid, including canthus
C44.121 Squamous cell carcinoma of skin of unspecified eyelid, including canthus
C44.191 Other specified malignant neoplasm of skin of unspecified eyelid, including canthus
C45.0 Mesothelioma of pleura
C45.1 Mesothelioma of peritoneum
C45.2 Mesothelioma of pericardium
C45.7 Mesothelioma of other sites
C45.9 Mesothelioma, unspecified
C46.50 Kaposi's sarcoma of unspecified lung
C46.51 Kaposi's sarcoma of right lung
C46.52 Kaposi's sarcoma of left lung
C47.0 Malignant neoplasm of peripheral nerves of head, face and neck
C47.10 Malignant neoplasm of peripheral nerves of unspecified upper limb, including shoulder
C47.11 Malignant neoplasm of peripheral nerves of right upper limb, including shoulder
C47.12 Malignant neoplasm of peripheral nerves of left upper limb, including shoulder
C47.20 Malignant neoplasm of peripheral nerves of unspecified lower limb, including hip
C47.21 Malignant neoplasm of peripheral nerves of right lower limb, including hip
C47.22 Malignant neoplasm of peripheral nerves of left lower limb, including hip
C47.3 Malignant neoplasm of peripheral nerves of thorax
C47.4 Malignant neoplasm of peripheral nerves of abdomen
C47.5 Malignant neoplasm of peripheral nerves of pelvis
C47.6 Malignant neoplasm of peripheral nerves of trunk, unspecified
C47.8 Malignant neoplasm of overlapping sites of peripheral nerves and autonomic nervous system
C47.9 Malignant neoplasm of peripheral nerves and autonomic nervous system, unspecified
C48.0 Malignant neoplasm of retroperitoneum
C48.1 Malignant neoplasm of specified parts of peritoneum
C48.2 Malignant neoplasm of peritoneum, unspecified
C48.8 Malignant neoplasm of overlapping sites of retroperitoneum and peritoneum
C49.0 Malignant neoplasm of connective and soft tissue of head, face and neck
C49.10 Malignant neoplasm of connective and soft tissue of unspecified upper limb, including shoulder
C49.11 Malignant neoplasm of connective and soft tissue of right upper limb, including shoulder
C49.12 Malignant neoplasm of connective and soft tissue of left upper limb, including shoulder
C49.20 Malignant neoplasm of connective and soft tissue of unspecified lower limb, including hip
C49.21 Malignant neoplasm of connective and soft tissue of right lower limb, including hip
C49.22 Malignant neoplasm of connective and soft tissue of left lower limb, including hip

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

Terms	Definitio
Acromioclavicular, or AC, joint	Union of the acromion, or shoulder blade, and the clavicle, or collar bone.
Acute	A medical condition or injury of sudden onset, sometimes severe in nature, and typically last a short period of time; opposite of chronic.
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.
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 harvested from one person for another; donors include cadavers and living individuals related or unrelated to the recipient; also called an allogeneic graft or homograft.
Amplitude	Size of response from a nerve after electrical stimulation.
Analgesia	Loss of ability to sense pain.
Analgesic	Relief or absence of pain.
Anesthesia	A medication induced state that reduces or eliminates sensitivity to pain, depending upon the type of anesthesia administered; general anesthesia renders the patient completely unconscious, while local or regional anesthesia reduces sensation to pain in specific areas of the body.
Anesthetic agent	Substance that reduces sensitivity to pain.
Annulus fib osus	Fibrous outer ring of the intervertebral disk, the cartilage cushion between the interlocking bones in the spine; also known as the annular ring.
Anterior interbody technique	Spinal fusion through an anterior, or front, approach, through the neck for cervical vertebrae, the chest for thoracic vertebrae, the abdomen for lumbar vertebrae.
Anticoagulant	A drug that prevents clot formation within the blood vessels and dissolves any blood clot formed previously.
Antiinflamm tory	Substance that reduces pain, swelling, and inflammation.
Antispasmodic	A substance that relieves convulsions or spasms.
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	Fusion, or permanent joining, of a joint, or point of union of two musculoskeletal structures, such as two bones
Arthrography	Series of images of a joint following the injection of contrast.
Arthroplasty	The surgical repair of a joint.
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.
Atlas	The first cervical vertebra, or C1, one of the interlocking bones in the neck; it arises as a bony projection from the top of the ring shaped axis, or second cervical vertebra, and provides a pivot point for the skull; also called the dens, the peg, and the odontoid process.
Autonomic nervous system	One part of the nervous system that controls involuntary body functions by innervating muscles of the organs and glands.
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.

Terms	Definitio
Axis	The ring shaped second cervical vertebra, or C2, one of the interlocking bones in the neck; also called the epistropheus.
Bell's palsy	A paralysis of the facial nerve causing weakness of the muscles on one side of the face.
Bilateral	On two sides; opposite of unilateral.
Biofeedback	A self-guided treatment that teaches a patient to control muscle tension, pain, body temperature, brain waves, and other bodily functions through processes such as relaxation, visualization, and other cognitive control techniques; biofeedback is also referred to as applied psychophysiological feedback.
Biopsy	This is a medical technique to collect small amount of sample of abnormal cells or tissues from the affected site in order to diagnose the disease or to confirm the normality.
Blepharospasm	Uncontrolled closing of the eyelids.
Bolus	A relatively large dose of therapeutic or diagnostic substance administered by intravenous, intramuscular, intrathecal, or subcutaneous injection.
Bone grafting	Surgical procedure that replaces missing bones with material from the patient's own body, or from an artificial, synthetic, or natural substitute.
Brachial plexus	A network of nerves created by the front branches of the lower four cervical and first thoracic nerve, the C5, C6, C7, C8, and T1 spinal nerves, that supplies the chest, shoulder, and arm.
Bronchoscopy	An endoscopic examination of the bronchial tubes that carry air to the lungs.
Bursa	Fluid filled sac that prevents joints, muscles, and tendons from rubbing together.
Bursitis	Inflammation of the small fluid filled pads, or bursa, that act as cushions between the bones, tendons and muscles near joints.
Carotid endarterectomy	Surgical removal of plaque in the carotid artery.
Carotid sinus	A dilated area present just above the division of carotid arteries that senses changes to blood pressure.
Carpal tunnel	Passageway formed by the concave carpus bone and the flexor retinaculum covering it on the palmar side of the wrist through which the median nerve passes; the carpal tunnel also houses ten flexor tendons of the hand.
Carpus	Group of small bones that form the wrist.
Cartilage	Fibrous connective tissue that is strong but flexible; it is found on the surface of joints and composes structures like the nose and ear.
Catheter	A flexible tube that can be inserted into a vessel through which instruments can be passed, blood withdrawn, or fluids instilled; also, a flexible tube inserted into a tubular structure such as the urethra to instill fluids, allow passage of urine, or examine the urethra and bladder.
Centrifugation	Process that rotates a mixture around a fixed axis at a high speed to separate it into its component parts.
Cerebrospinal flui , CSF	A clear watery fluid that originates and flows in the ventricles and all over the brain and spinal cord and helps to maintain a consistent pressure in the brain and spinal cord.
Cervical lymph nodes	Lymph nodes located in the neck.
Cervical plexus	A network of nerves created by the front branches of the first four cervical nerves, the C1, C2, C3, and C4 spinal nerves, that supplies the skin and muscles of the neck, chest, diaphragm, and part of the face.
Cervical spine	Neck, containing vertebrae enumerated C1 through C7.
Cervical vertebrae	Seven vertebrae situated within the neck, between the head and thoracic vertebrae in the spinal column, designated by the symbols C1 through C7.
Chemodenervation	A technique that uses a chemical compound to temporarily block the nerve signals to muscles.
Chromatography	Chromatography methodologies separate and analyze the level or presence of a specific analyte in a chemical mixture carried by liquid or gas.
Chronic	A condition that is long lasting, typically slow to develop, and with symptoms of less severity than an acute condition.
Clinical staff mem er	A person who works under the supervision of a provider or other qualified health care professional and who is allowed by law, regulation and facility policy to perform or assist in the performance of a specified professional service, but does not individually report that professional service; other policies may also affect who may report specified services.
Comorbidity	Existence of one or more additional diseases.

Join the biggest team in healthcare information management.

As an AAPC member, you'll be part of a global network of 250,000+ career learners and working professionals. Our credentials are among the most highly sought after in the industry — in part because AAPC members are trained for more than passing an exam. They are trained to succeed on the job from day one.

"If you want to rise in the ranks of the Healthcare business portion of the medical field, I highly suggest that you become a member of AAPC and obtain your certifications through them. They will help you to advance and open the door of opportunity for you."

- Latisha Booker, CPC

"APPC has not only provided me with the opportunity to earn multiple credentials but has also opened important doors for me in my career."

- Mary Arnold, CPC, CPMA, CRC, RMA, HR-C

"While taking classes, I was introduced to AAPC. I became a member to help boost my career, and more than 20 years later, I'm still an AAPC member."

– Bradley Miller, CPC, CRC, CDEO

Whether you're just getting started or a seasoned pro, AAPC membership will give you the support, training, tools, and resources to help you launch and advance your career successfully,

Learn more at **aapc.com**

AAPC

2027 Coders' Specialty Guide
Pain Management
9 798892 583312
Print ISBN: 979-8-892583-312