

CODERS' SPECIALTY GUIDE

Obstetrics & Gynecology



2027



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

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General Surgical Procedures

+10004

Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure)

Clinical Responsibility

With the patient properly prepared and anesthetized (typically with local anesthesia) and following FNA of an initial lesion, the provider inserts a needle, such as an 18- to 25-gauge needle with an attached syringe, into an additional suspicious lesion or area of tissue and withdraws cells, tissue, or fluid for laboratory analysis. The provider may make several passes to obtain an adequate specimen. The provider then sends the aspirate to the pathology lab for analysis.

Coding Tips

For FNA of an initial lesion using imaging guidance, see 10005 (ultrasound), 10007 (fluoroscopy), 10009 (CT), and 10011 (MRI) and +10006, +10008, +10010 and +10012 for each additional lesion respectively.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor \$: 33.5675, Facility Fee: \$36.92, Non Facility Fee: \$53.37; Non-QP Conversion Factor \$33.4009, Facility Fee: \$36.74, Non Facility Fee: \$53.11

RVU (Facility): Work 0.78, PE 0.19, Mal 0.13, Total 1.10

RVU (Non-Facility): Work 0.78, PE 0.68, Mal 0.13, Total 1.59

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: 3

Modifier Allowances

52, 53, 58, 59, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, GA, GC, GZ, LT, PD, Q6, QJ, RT, SC, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T¹, 0216T¹, 10012¹, 10035¹, 19281¹, 19283¹, 19285¹, 19287¹, 36000¹, 36410¹, 36591⁰, 36592⁰, 61650¹, 62324¹, 62325¹, 62326¹, 62327¹, 64415¹, 64416¹, 64417¹, 64450¹, 64454¹, 64486¹, 64487¹, 64488¹, 64489¹, 64490¹, 64493¹, 76000¹, 76380¹, 76942¹, 76998¹, 77001¹, 77002¹, 77012¹, 77021¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 96377¹, 96523⁰

ICD-10-CM Cross References

C00.3, C01, C02.9, C04.1, C06.9, C07, C08.0, C12, C13.9, C15.9, C22.0-C22.4, C22.7, C22.8, C32.1, C32.8, C34.30-C34.32, C43.20-C43.22, C43.30-C43.39, C43.51-C43.59, C43.60-C43.62, C46.0, C50.011-C50.019, C50.111-C50.119, C50.211-C50.219, C50.411-C50.419, C50.811-C50.819, C50.911-C50.919, C51.9, C76.0, C76.1, C77.0, C77.3, C79.2, C79.81, C79.89, C79.9, C82.50, C82.51, C82.55, C82.59, C83.31-C83.35, C84.90, C84.91, C84.95, C84.99, C84.9A, C84.A0, C84.A1, C84.A5, C84.A9, C84.AA, C84.Z0, C84.Z1,

C84.Z5, C84.Z9, C84.ZA, C85.10, C85.11, C85.15, C85.19, C85.1A, C85.20, C85.21, C85.25, C85.29, C85.2A, C85.80, C85.81, C85.85, C85.89, C85.8A, C85.90, C85.91, C85.95, C85.99, C85.9A, C86.00, C86.01, C86.40, C86.41, C88.80, C88.81, C94.40-C94.42, C94.6, D03.20-D03.22, D03.30, D03.39, D03.51-D03.59, D03.60-D03.62, D05.00-D05.02, D05.10-D05.12, D05.80-D05.82, D05.90-D05.92, D11.0-D11.9, D17.0, D17.1, D17.20-D17.24, D17.30, D17.39, D17.72, D17.79, D17.9, D19.7, D21.0, D22.5, D22.70-D22.72, D23.5, D23.70-D23.72, D36.0, D36.7, D37.030-D37.039, D44.0-D44.2, D44.9, D47.1, D47.2, D47.9, D47.Z9, D48.0-D48.2, D48.60-D48.62, D48.7, D48.9, D49.0-D49.7, D49.9, D64.9, D75.9, D78.01, D78.02, D78.21, D78.22, D89.2, E01.0-E01.2, E03.4, E03.9, E04.0-E04.9, E06.0, E07.89, E07.9, E35, E36.01, E36.02, E65, E78.71, E89.820-E89.823, G97.31, G97.32, G97.51, G97.52, G97.63, G97.64, H66.10-H66.13, H69.80-H69.83, H93.8X1-H93.8X9, H94.80-H94.83, H95.21, H95.22, H95.41, H95.42, H95.53, H95.54, I42.0-I42.5, I42.8, I42.9, I70.235, I70.245, I70.335, I70.345, I70.435, I70.445, I70.535, I70.545, I70.635, I70.645, I70.735, I70.745, I82.91, I88.1-I88.9, I89.8, I97.410-I97.418, I97.42, I97.610-I97.618, I97.622, I97.640-I97.648, J95.61, J95.62, J95.830, J95.831, J95.862, J95.863, J98.4, K11.20-K11.23, K11.3-K11.6, K11.9, K91.61, K91.62, K91.840, K91.841, K91.870-K91.873, L02.31, L02.415, L02.416, L02.419, L02.91, L03.115, L03.116, L03.119, L03.125, L03.126, L03.129, L03.317, L03.327, L03.90, L03.91, L57.0, L76.01, L76.02, L76.21, L76.22, L76.31-L76.34, L97.501-L97.504, L97.509, L97.511-L97.514, L97.519, L97.521-L97.524, L97.529, L98.3, L98.7, M54.2, M70.20-M70.22, M71.30, M77.10-M77.12, M79.4, M81.0, M96.810, M96.811, M96.830, M96.831, M96.840-M96.843, N60.01-N60.09, N60.11-N60.19, N61.0, N62, N63.0, N63.10-N63.15, N63.20-N63.25, N63.31, N63.32, N63.41, N63.42, N64.1, N64.4, N99.61, N99.62, N99.820, N99.821, N99.840-N99.843, Q18.0-Q18.9, Q87.2, Q87.3, Q87.5, Q87.81, Q87.89, Q89.2, Q87.81-Q87.89, R13.0, R13.10, R18.8, R19.02, R20.8, R20.9, R22.0-R22.2, R22.30-R22.33, R22.40-R22.43, R22.9, R29.4, R59.0-R59.9, R68.89, R69, R90.0, R92.1, R92.8, R99, S90.421D, S90.422D, S90.423D, S90.424D, S90.425D, S90.426D, S90.521D, S90.522D, S90.529D, S90.821D, S90.822D, S90.829D, S90.869A, Z00.6, Z12.89, Z85.21, Z85.3, Z85.6, Z86.79

10005

Fine needle aspiration biopsy, including ultrasound guidance; first lesion

Clinical Responsibility

With the patient properly prepared and anesthetized (typically with local anesthesia), the provider inserts a needle, such as an 18- to 25-gauge needle with an attached syringe, under ultrasound imaging guidance into a suspicious lesion or area of tissue and withdraws cells, tissue, or fluid for laboratory analysis. The provider may make several passes to obtain an adequate specimen. The provider then sends the aspirate to the pathology lab for analysis.

Coding Tips

Report +10006 for each additional lesion in addition to the primary code 10005.

For FNA of an initial lesion using other types of imaging guidance, see 10007 (fluoroscopy), 10009 (CT), and 10011 (MRI) and +10008, +10010 and +10012 for each additional lesion respectively.

If different imaging guidance modalities are used for separate lesions, add modifier 59, Distinct procedural service, to the appropriate primary code.

For FNA without imaging guidance, report 10021 for the initial lesion and +10004 for each additional lesion.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor \$: 33.5675, Facility Fee: \$62.77, Non Facility Fee: \$132.93; Non-QP Conversion Factor \$33.4009, Facility Fee: \$62.46, Non Facility Fee: \$132.27

RVU (Facility): Work 1.42, PE 0.28, Mal 0.17, Total 1.87

RVU (Non-Facility): Work 1.42, PE 2.37, Mal 0.17, Total 3.96

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

51, 52, 53, 58, 59, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AG, AQ, AR, AS, GA, GC, GZ, LT, PD, Q6, QJ, RT, SC, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T¹, 0216T¹, 10004¹, 10008¹, 10010¹, 10011¹, 10012¹, 10021¹, 10035¹, 11102¹, 11103¹, 11104¹, 11105¹, 11106¹, 11107¹, 19281¹, 19283¹, 19285¹, 19287¹, 36000¹, 36410¹, 36591⁰, 36592⁰, 61650¹, 62324¹, 62325¹, 62326¹, 62327¹, 64415¹, 64416¹, 64417¹, 64450¹, 64454¹, 64473¹, 64474¹, 64486¹, 64487¹, 64488¹, 64489¹, 64490¹, 64493¹, 76000¹, 76380¹, 76942¹, 76998¹, 77001¹, 77002¹, 77012¹, 77021¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 96377¹, 96523⁰

ICD-10-CM Cross References

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

+10006

Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)

Clinical Responsibility

With the patient properly prepared and anesthetized (typically with local anesthesia) and following FNA of an initial lesion, the provider inserts a needle, such as an 18- to 25-gauge needle with an attached syringe, under ultrasound imaging guidance into an additional suspicious lesion or area of tissue and withdraws cells, tissue, or fluid for laboratory analysis. The provider may make several passes to obtain an adequate specimen. The provider then sends the aspirate to the pathology lab for analysis.

Coding Tips

For FNA of an initial lesion using other types of imaging guidance, see 10007 (fluoroscopy), 10009 (CT), and 10011 (MRI) and +10008, +10010 and +10012 for each additional lesion respectively.

For FNA without imaging guidance, report 10021 for the initial lesion and +10004 for each additional lesion.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor \$: 33.5675, Facility Fee: \$43.30, Non Facility Fee: \$60.42; Non-QP Conversion Factor \$33.4009, Facility Fee: \$43.09, Non Facility Fee: \$60.12

RVU (Facility): Work 0.98, PE 0.2, Mal 0.11, Total 1.29

RVU (Non-Facility): Work 0.98, PE 0.71, Mal 0.11, Total 1.80

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: 3

Modifier Allowances

52, 53, 58, 59, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, GA, GC, GZ, LT, PD, Q6, QJ, RT, SC, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T¹, 0216T¹, 10004¹, 10035¹, 19281¹, 19283¹, 19285¹, 19287¹, 36000¹, 36410¹, 36591⁰, 36592⁰, 61650¹, 62324¹, 62325¹, 62326¹, 62327¹, 64415¹, 64416¹, 64417¹, 64450¹, 64454¹, 64486¹, 64487¹, 64488¹, 64489¹, 64490¹, 64493¹, 76000¹, 76380¹, 76942¹, 76998¹, 77001¹, 77002¹, 77012¹, 77021¹, 96360¹, 96365¹, 96372¹, 96374¹, 96375¹, 96376¹, 96377¹, 96523⁰

ICD-10-CM Cross References

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

10007

Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion

Clinical Responsibility

With the patient properly prepared and anesthetized (typically with local anesthesia), the provider inserts a needle, such as an 18- to 25-gauge needle with an attached syringe, under fluoroscopic imaging guidance into a suspicious lesion or area of tissue and withdraws cells, tissue, or fluid for laboratory analysis. The provider may make several passes to obtain an adequate specimen. The provider then sends the aspirate to the pathology lab for analysis.

Coding Tips

Report +10008 for each additional lesion in addition to the primary code 10007.

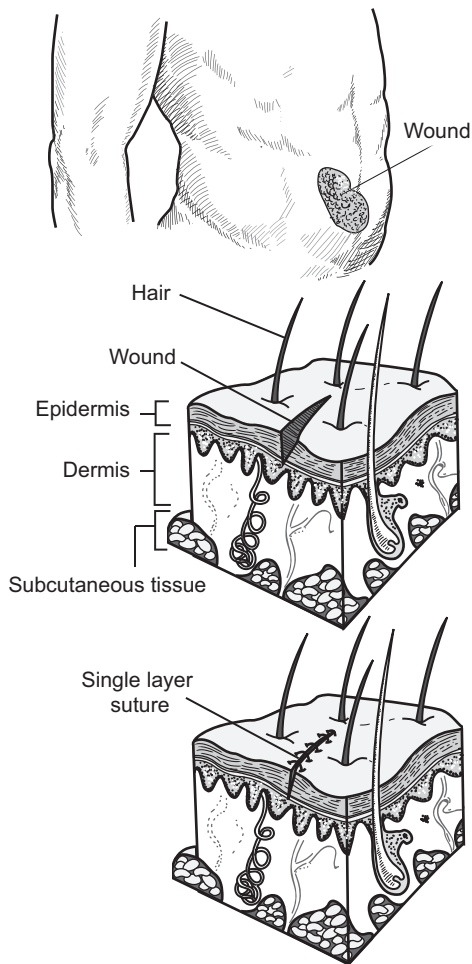
For FNA of an initial lesion using other types of imaging guidance, see 10005 (ultrasound), 10009 (CT), and 10011 (MRI) and +10006, +10010 and +10012 for each additional lesion respectively.

12020

Treatment of superficial wound dehiscence; simple closure

Clinical Responsibility

After proper sterilization and cleansing, the physician reopens the wound dehiscence margin (wound which is not healing properly). After removal of sutures, the physician debrides the wound and irrigates the area with an antimicrobial agent. The wound edges are sutured again in a simple linear fashion.

Illustration

12020

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor \$: 33.5675, Facility Fee: \$179.59, Non Facility Fee: \$318.22; Non-QP Conversion Factor \$33.4009, Facility Fee: \$178.69, Non Facility Fee: \$316.64

RVU (Facility): Work 2.6, PE 2.32, Mal 0.43, Total 5.35

RVU (Non-Facility): Work 2.6, PE 6.45, Mal 0.43, Total 9.48

MPFS Payment Policy Indicators: Global Period 10, Preop 10.00%, Intraop 80.00%, Postop 10.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None

Practitioner MUE: 2

Modifier Allowances

22, 51, 52, 53, 54, 55, 56, 58, 59, 73, 74, 76, 77, 78, 79, 99, AG, AQ, AR, ET, GA, GC, GJ, GR, KX, LT, PD, Q5, Q6, QJ, RT, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T⁰, 0216T⁰, 0543T¹, 0544T¹, 0545T¹, 0569T¹, 0570T¹, 0571T¹, 0572T¹, 0573T¹, 0574T¹, 0580T¹, 0581T¹, 0582T¹, 0655T¹, 0903T¹, 0904T¹, 0905T¹, 11000¹, 11001¹, 11004¹, 11005¹, 11006¹, 11042¹, 11043¹, 11044¹, 11045¹, 11046¹, 11047¹, 11900¹, 11901¹, 12021¹, 15772¹, 15774¹, 20560¹, 20561¹, 20700¹, 20701¹, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36591⁰, 36592⁰, 36600¹, 36640¹, 43752¹, 51701¹, 51702¹, 51703¹, 51721¹, 64400⁰, 64405⁰, 64408⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450¹, 64451¹, 64479⁰, 64480⁰, 64483⁰, 64484⁰, 64490⁰, 64491⁰, 64492⁰, 64493⁰, 64494⁰, 64495⁰, 64505⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 66987¹, 66988¹, 69990⁰, 92012¹, 92014¹, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 93355¹, 94002¹, 94200¹, 94680¹, 94681¹, 94690¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96361¹, 96365¹, 96366¹, 96367¹, 96368¹, 96372¹, 96374¹, 96375¹, 96376¹, 96377¹, 96523⁰, 97597¹, 97598¹, 97602¹, 97605¹, 97606¹, 97607¹, 97608¹, 99155⁰, 99156⁰, 99157⁰, 99211¹, 99212¹, 99213¹, 99214¹, 99215¹, 99221¹, 99222¹, 99223¹, 99231¹, 99232¹, 99233¹, 99234¹, 99235¹, 99236¹, 99238¹, 99239¹, 99242¹, 99243¹, 99244¹, 99245¹, 99252¹, 99253¹, 99254¹, 99255¹, 99291¹, 99292¹, 99304¹, 99305¹, 99306¹, 99307¹, 99308¹, 99309¹, 99310¹, 99315¹, 99316¹, 99347¹, 99348¹, 99349¹, 99350¹, 99374¹, 99375¹, 99377¹, 99378¹, 99446⁰, 99447⁰, 99448⁰, 99449⁰, 99451⁰, 99452⁰, 99495⁰, 99496⁰, G0168¹, G0463¹, G0471¹, J0670¹

ICD-10-CM Cross References

ICD-10-CM contains hundreds of matches for this code.

Please check individual payer guidelines for specific coverage determinations.

12021

Treatment of superficial wound dehiscence; with packing

Clinical Responsibility

After proper sterilization, the physician reopens the wound dehiscence margin (wound which is not healing properly). After removal of sutures, the physician debrides the wounds and irrigates the area with an antimicrobial agent. The physician does not resuture the wound but leaves the wound open for healing and packs it with gauze.

Coding Tips

If repair of wound dehiscence occurs during the postoperative (or global surgical) period of a previous procedure, be sure to append modifier 78 to the appropriate repair code. This explains to the payer that the procedure is the result of a complication arising from an earlier procedure.

"Dehiscence" refers to a splitting open or bursting. As such, wound dehiscence usually describes the opening of a previously sutured area (for example, an incision following surgery, wound repair, etc.). If a wound becomes infected, it will more likely dehisce due to the natural inflammatory process. Wound dehiscence code

12020 (Treatment of superficial wound dehiscence; simple closure) describes repair when there is no sign of infection. In this case, the surgeon simply debrides and irrigates the wound and closes it in a single layer. If infection is evident, the surgeon may prefer to clean the wound and pack it with gauze strips, leaving the wound open to allow infection to drain. In this case, 12021 (... with packing) is the better choice. If the dehiscence has opened and requires closure in multiple layers, report 13160 (Secondary closure of surgical wound or dehiscence, extensive or complicated).

Note: Code 13160 can also describe secondary closure of surgical wounds (that is, the surgeon intentionally defers closure following surgery). Many payers define "primary" closure as the first or initial closure of a surgical wound, whether it occurs at the time of surgery or during the postoperative period, thereby limiting use of the secondary closure code.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor \$: 33.5675, Facility Fee: \$135.28, Non Facility Fee: \$186.64; Non-QP Conversion Factor \$33.4009, Facility Fee: \$134.61, Non Facility Fee: \$185.71

RVU (Facility): Work 1.84, PE 1.86, Mal 0.33, Total 4.03

RVU (Non-Facility): Work 1.84, PE 3.39, Mal 0.33, Total 5.56

MPFS Payment Policy Indicators: Global Period 10, Preop 10.00%, Intraop 80.00%, Postop 10.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None

Practitioner MUE: 3

Modifier Allowances

22, 51, 52, 53, 54, 55, 56, 58, 59, 73, 74, 76, 77, 78, 79, 99, AQ, AR, ET, GA, GC, GJ, GR, KX, LT, PD, Q5, Q6, QJ, RT, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T⁰, 0216T⁰, 0543T¹, 0544T¹, 0569T¹, 0570T¹, 0571T¹, 0572T¹, 0573T¹, 0574T¹, 0580T¹, 0581T¹, 0582T¹, 0655T¹, 0903T¹, 0904T¹, 0905T¹, 11042¹, 11900¹, 11901¹, 20560¹, 20561¹, 20700¹, 20701¹, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36591⁰, 36592⁰, 36600¹, 36640¹, 43752¹, 51701¹, 51702¹, 51703¹, 51721¹, 64400⁰, 64405⁰, 64408⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450¹, 64451¹, 64479⁰, 64480⁰, 64483⁰, 64484⁰, 64490⁰, 64491⁰, 64492⁰, 64493⁰, 64494⁰, 64495⁰, 64505⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 66987¹, 66988¹, 69990⁰, 92012¹, 92014¹, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 93355¹, 94002¹, 94200¹, 94680¹, 94681¹, 94690¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96361¹, 96365¹, 96366¹, 96367¹, 96368¹, 96372¹, 96374¹, 96375¹, 96376¹, 96377¹, 96523⁰, 97597¹, 97598¹, 97602¹, 97605¹, 97606¹, 97607¹, 97608¹, 99155⁰, 99156⁰, 99157⁰, 99211¹, 99212¹, 99213¹, 99214¹, 99215¹, 99221¹, 99222¹, 99223¹, 99231¹, 99232¹, 99233¹, 99234¹, 99235¹, 99236¹, 99238¹, 99239¹, 99242¹, 99243¹, 99244¹, 99245¹, 99252¹, 99253¹, 99254¹, 99255¹, 99291¹, 99292¹, 99304¹, 99305¹, 99306¹, 99307¹, 99308¹, 99309¹, 99310¹, 99315¹, 99316¹, 99347¹, 99348¹, 99349¹, 99350¹, 99374¹, 99375¹, 99377¹, 99378¹, 99446⁰, 99447⁰, 99448⁰, 99449⁰, 99451⁰, 99452⁰, 99495⁰, 99496⁰, G0168¹, G0463¹, G0471¹

ICD-10-CM Cross References

ICD-10-CM contains hundreds of matches for this code.

Please check individual payer guidelines for specific coverage determinations.

12041

Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less

Clinical Responsibility

Code 12041 includes the intermediate repair of wounds (2.5 cm or less) of the neck, hands, feet, and/or external genitalia

After informed consent, the patient is brought to the operating room. Prep and drape of operative site is done in the usual sterile manner, and administration of local anesthesia is done. After inspection, the wound is irrigated with normal saline, and proper debridement of the wound is performed. Contaminated single-layered wounds need extensive cleaning to remove particulate matter. Now attention turns to repair of the wound. The wound edges are brought together to form a linear closure. Suture of the inner layer of skin (subcutaneous, dermis, and/or superficial fascia) with absorbable suture is done. External layer is sutured in a linear fashion. Dermabond is applied to the wound.

Note: Report 12041 when the length of the repaired wound is up to 2.5 cm.

Coding Tips

Look for layer descriptions in your physician's chart notes

To properly choose between simple (12001-12021) and intermediate (12031-12057) repair codes, you'll have to rely on your physician's chart notes to make the right selection. To make your job easier, encourage your physician to use specific terms to describe the kind of laceration he or she repaired. Your physician should use terms such as "deeper layers of subcutaneous and superficial (nonmuscle) fascia," "layered closure," or "deep layer suturing" to indicate that he or she performed an intermediate repair.

Document extensive cleaning to up complexity

Make sure your physician documents the extent of the debridement he or she performs. Although intermediate repair usually requires layered closure, you can report appropriate intermediate codes if your physician performs a single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter, according to CPT® guidelines.

But your physician may forget to include the cleaning details when recording laceration services. Therefore, you would not know that the repair qualifies for an intermediate repair code and will use a simple repair code instead.

Get to know the multiple-laceration formula

Although reporting a single or intermediate repair may now seem simple, learning the multiple-laceration formula will require you to ratchet up your coding skills. Don't be too quick to blame poor chart notes for all of your coding mistakes. To effectively report

Male Genital System

54150

Circumcision, using clamp or other device with regional dorsal penile or ring block

Clinical Responsibility

The patient is placed on his back. His arms and legs may be strapped down to prevent any unwanted movement during the procedure. The skin of the perineum and thighs are prepared with Betadine liquid (an antiseptic) and the area is draped in a sterile fashion. Examples of devices the provider may use include the Gomco® clamp, Mogen clamp, or PlastiBell®.

After injecting a regional anesthetic into the top of the penis or in a ring around the penis and with the patient appropriately prepped, the provider makes a dorsal slit and separates the foreskin from the glans penis. As an example of the procedure, the bell portion of the clamp is then placed over the glans, and the foreskin is pulled over the bell through the plate and yoke of the clamp. The nut of the clamp is tightened onto the bell so that it holds the foreskin in place. The Gomco® clamp compresses the foreskin between the metal clamp and bell, allowing it to be cut and removed with minimal bleeding. After the foreskin is excised, the clamp and bell are removed.

Patients may undergo the procedure because of potential preventive benefits, such as reducing the risk of urinary tract infection in the first year of life and reducing the risk of acquiring or transmitting sexually transmitted infections.

Coding Tips

If the provider doesn't administer dorsal penile or ring anesthetic block, report this code with modifier 52 to indicate reduced services.

For circumcision using surgical excision other than a clamp, other devices, or dorsal slit, report 54160 for a neonate 28 days old or less and 54161 for a patient older than 28 days.

The procedure described by 54150 is likely to be performed using a Gomco® clamp, Mogen clamp, or PlastiBell®, but other devices have been developed, such as Zhenxi rings, Tara Klamp, SmartKlamp, Shang Ring®, and PrePex®.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor \$: 33.5675, Facility Fee: \$84.59, Non Facility Fee: \$152.73; Non-QP Conversion Factor \$33.4009, Facility Fee: \$84.17, Non Facility Fee: \$151.97

RVU (Facility): Work 1.85, PE 0.43, Mal 0.24, Total 2.52

RVU (Non-Facility): Work 1.85, PE 2.46, Mal 0.24, Total 4.55

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, 47, 51, 52, 53, 58, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ

NCCI Alerts (version 32.0)

0213T⁰, 0216T⁰, 0596T¹, 0597T¹, 0708T¹, 0709T¹, 0903T¹, 0904T¹, 0905T¹, 12001¹, 12002¹, 12004¹, 12005¹, 12006¹, 12007¹, 12011¹, 12013¹, 12014¹, 12015¹, 12016¹, 12017¹, 12018¹, 12020¹, 12021¹, 12031¹, 12032¹, 12034¹, 12035¹, 12036¹, 12037¹, 12041¹, 12042¹, 12044¹, 12045¹, 12046¹, 12047¹, 12051¹, 12052¹, 12053¹, 12054¹, 12055¹, 12056¹, 12057¹, 13100¹, 13101¹, 13102¹, 13120¹, 13121¹, 13122¹, 13131¹, 13132¹, 13133¹, 13151¹, 13152¹, 13153¹, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36591⁰, 36592⁰, 36600¹, 36640¹, 43752¹, 51701⁰, 51702⁰, 51703¹, 54000⁰, 54001⁰, 54100¹, 54162¹, 54163¹, 54164¹, 62320⁰, 62321⁰, 62322⁰, 62323⁰, 62324⁰, 62325⁰, 62326⁰, 62327⁰, 64400⁰, 64405⁰, 64408⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64451⁰, 64454⁰, 64461⁰, 64462⁰, 64463⁰, 64466¹, 64467¹, 64468¹, 64469¹, 64473¹, 64474¹, 64479⁰, 64480⁰, 64483⁰, 64484⁰, 64486⁰, 64487⁰, 64488⁰, 64489⁰, 64490⁰, 64491⁰, 64492⁰, 64493⁰, 64494⁰, 64495⁰, 64505⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 92012¹, 92014¹, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 93355¹, 94002¹, 94200¹, 94680¹, 94681¹, 94690¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96361¹, 96365¹, 96366¹, 96367¹, 96368¹, 96372¹, 96374¹, 96375¹, 96376¹, 96377¹, 96523⁰, 99155⁰, 99156⁰, 99157⁰, 99211¹, 99212¹, 99213¹, 99214¹, 99215¹, 99221¹, 99222¹, 99223¹, 99231¹, 99232¹, 99233¹, 99234¹, 99235¹, 99236¹, 99238¹, 99239¹, 99242¹, 99243¹, 99244¹, 99245¹, 99252¹, 99253¹, 99254¹, 99255¹, 99291¹, 99292¹, 99304¹, 99305¹, 99306¹, 99307¹, 99308¹, 99309¹, 99310¹, 99315¹, 99316¹, 99347¹, 99348¹, 99349¹, 99350¹, 99374¹, 99375¹, 99377¹, 99378¹, 99446⁰, 99447⁰, 99448⁰, 99449⁰, 99451⁰, 99452⁰, 99495¹, 99496¹, G0463¹, G0471⁰, J0670¹

ICD-10-CM Cross References

A63.0, N47.0-N47.2, N47.5, N47.6, N47.8, N48.0, N48.1, N48.29, N48.5, N48.6, N48.82, N48.89, N48.9, N50.1, Q55.63, Q55.64, Q55.69, Q64.5, Q64.6, Q64.71-Q64.75, Q64.79, Z41.2, Z87.710

Female Genital System

56405

Incision and drainage of vulva or perineal abscess

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider locates the exact site of the abscess and makes an incision over it. He uses a scalpel, a cutting instrument, to incise the abscess and drain pus. The provider then irrigates the area, checks for bleeding, and packs the wound with gauze to allow drainage while it heals.

Coding Tips

If the provider performs incision and drainage of a Bartholin's gland, report 56420, Incision and drainage of the Bartholin's gland.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor \$: 33.5675, Facility Fee: \$117.49, Non Facility Fee: \$146.69; Non-QP Conversion Factor \$33.4009, Facility Fee: \$116.90, Non Facility Fee: \$145.96

RVU (Facility): Work 1.45, PE 1.79, Mal 0.26, Total 3.50

RVU (Non-Facility): Work 1.45, PE 2.66, Mal 0.26, Total 4.37

MPFS Payment Policy Indicators: Global Period 10, Preop 10.00%, Intraop 80.00%, Postop 10.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None

Practitioner MUE: 2

Modifier Allowances

22, 47, 51, 52, 53, 54, 55, 56, 58, 59, 62, 63, 73, 74, 76, 77, 78, 79, 99, AG, AQ, AR, CR, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 32.0)

00940⁰, 0213T⁰, 0216T⁰, 0596T¹, 0597T¹, 0708T¹, 0709T¹, 0903T¹, 0904T¹, 0905T¹, 12001¹, 12002¹, 12004¹, 12005¹, 12006¹, 12007¹, 12011¹, 12013¹, 12014¹, 12015¹, 12016¹, 12017¹, 12018¹, 12020¹, 12021¹, 12031¹, 12032¹, 12034¹, 12035¹, 12036¹, 12037¹, 12041¹, 12042¹, 12044¹, 12045¹, 12046¹, 12047¹, 12051¹, 12052¹, 12053¹, 12054¹, 12055¹, 12056¹, 12057¹, 13100¹, 13101¹, 13102¹, 13120¹, 13121¹, 13122¹, 13131¹, 13132¹, 13133¹, 13151¹, 13152¹, 13153¹, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36591⁰, 36592⁰, 36600¹, 36640¹, 43752¹, 51701¹, 51702¹, 51703¹, 56440¹, 56605⁰, 56810⁰, 56820⁰, 57100¹, 57180¹, 57500¹, 62320⁰, 62321⁰, 62322⁰, 62323⁰, 62324⁰, 62325⁰, 62326⁰, 62327⁰, 64400⁰, 64405⁰, 64408⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64451⁰, 64454⁰, 64461⁰, 64462⁰, 64463⁰, 64466¹, 64467¹, 64468¹, 64469¹, 64473¹, 64474¹, 64479⁰, 64480⁰, 64483⁰, 64484⁰, 64486⁰, 64487⁰, 64488⁰, 64489⁰, 64490⁰, 64491⁰, 64492⁰, 64493⁰, 64494⁰, 64495⁰, 64505⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 92012¹, 92014¹, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 93355¹, 94002¹, 94200¹, 94680¹, 94681¹, 94690¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96361¹, 96365¹, 96366¹, 96367¹, 96368¹, 96372¹, 96374¹, 96375¹, 96376¹, 96377¹, 96523⁰, 99155⁰, 99156⁰, 99157⁰, 99211¹, 99212¹, 99213¹, 99214¹, 99215¹, 99221¹, 99222¹, 99223¹, 99231¹, 99232¹,

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ICD-10-CM Cross References

D28.0, K61.31, L02.215, L03.319, L03.329, L03.90, L03.91, L08.89, L98.9, N75.0, N75.1, N75.9, N76.0-N76.5, N76.3, N76.4, N76.5, N76.89, N90.61, N90.69, N90.7, N90.89, R22.9, Z01.411, Z01.419

56420

Incision and drainage of Bartholin's gland abscess

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider locates the exact site of abscess in one of the Bartholin's glands and makes an incision over it. She uses a scalpel, a cutting instrument, to incise the abscess and drain pus. The provider then irrigates the area, checks for bleeding, and packs the wound with gauze to allow drainage while it heals.

Coding Tips

If the provider performs incision and drainage in the vulva or perineum, use 56405, Incision and drainage of the vulva or perineal abscess.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor \$: 33.5675, Facility Fee: \$100.70, Non Facility Fee: \$182.94; Non-QP Conversion Factor \$33.4009, Facility Fee: \$100.20, Non Facility Fee: \$182.03

RVU (Facility): Work 1.4, PE 1.36, Mal 0.24, Total 3.00

RVU (Non-Facility): Work 1.4, PE 3.81, Mal 0.24, Total 5.45

MPFS Payment Policy Indicators: Global Period 10, Preop 10.00%, Intraop 80.00%, Postop 10.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None

Practitioner MUE: 1

Modifier Allowances

22, 47, 51, 52, 53, 54, 55, 56, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AG, AQ, AR, CR, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 32.0)

00940⁰, 0213T⁰, 0216T⁰, 0596T¹, 0597T¹, 0708T¹, 0709T¹, 0903T¹, 0904T¹, 0905T¹, 12001¹, 12002¹, 12004¹, 12005¹, 12006¹, 12007¹, 12011¹, 12013¹, 12014¹, 12015¹, 12016¹, 12017¹, 12018¹, 12020¹, 12021¹, 12031¹, 12032¹, 12034¹, 12035¹, 12036¹, 12037¹, 12041¹, 12042¹, 12044¹, 12045¹, 12046¹, 12047¹, 12051¹, 12052¹, 12053¹, 12054¹, 12055¹, 12056¹, 12057¹, 13100¹, 13101¹, 13102¹, 13120¹, 13121¹, 13122¹, 13131¹, 13132¹, 13133¹, 13151¹, 13152¹, 13153¹, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36591⁰, 36592⁰, 36600¹, 36640¹, 43752¹, 51701¹, 51702¹,

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ICD-10-CM Cross References

K61.31, N75.0-N75.9

56440

Marsupialization of Bartholin's gland cyst

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider tapes back the labia so that the entire opening is visible. The provider makes an incision over the mucosa of the Bartholin's cyst and expels the contents of the cyst. The provider then clamps and sutures the walls of the cyst into the hollow opening, creating an open pouch. The provider then irrigates the area, checks for bleeding, removes any instruments, and dresses the wound.

Coding Tips

If the provider performs incision and drainage of an abscess in a Bartholin's gland, report 56420.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor \$: 33.5675, Facility Fee: \$164.48, Non Facility Fee: \$164.48; Non-QP Conversion Factor \$33.4009, Facility Fee: \$163.66, Non Facility Fee: \$163.66

RVU (Facility): Work 2.82, PE 1.6, Mal 0.48, Total 4.90

RVU (Non-Facility): Work 2.82, PE 1.6, Mal 0.48, Total 4.90

MPFS Payment Policy Indicators: Global Period 10, Preop 10.00%, Intraop 80.00%, Postop 10.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None

Practitioner MUE: 1

Modifier Allowances

22, 47, 51, 52, 53, 54, 55, 56, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AQ, AR, CR, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 32.0)

00940⁰, 0213T⁰, 0216T⁰, 0596T¹, 0597T¹, 0708T¹, 0709T¹, 0903T¹, 0904T¹, 0905T¹, 12001¹, 12002¹, 12004¹, 12005¹, 12006¹, 12007¹, 12011¹, 12013¹, 12014¹, 12015¹, 12016¹, 12017¹, 12018¹, 12020¹, 12021¹, 12031¹, 12032¹, 12034¹, 12035¹, 12036¹, 12037¹, 12041¹, 12042¹, 12044¹, 12045¹, 12046¹, 12047¹, 12051¹, 12052¹, 12053¹, 12054¹, 12055¹, 12056¹, 12057¹, 13100¹, 13101¹, 13102¹, 13120¹, 13121¹, 13122¹, 13131¹, 13132¹, 13133¹, 13151¹, 13152¹, 13153¹, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36591⁰, 36592⁰, 36600¹, 36640¹, 43752¹, 51701¹, 51702¹, 51703¹, 56605⁰, 56820⁰, 57100¹, 57180¹, 57500¹, 62320⁰, 62321⁰, 62322⁰, 62323⁰, 62324⁰, 62325⁰, 62326⁰, 62327⁰, 64400⁰, 64405⁰, 64408⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64451⁰, 64454⁰, 64461⁰, 64462⁰, 64463⁰, 64466¹, 64467¹, 64468¹, 64469¹, 64473¹, 64474¹, 64479⁰, 64480⁰, 64483⁰, 64484⁰, 64486⁰, 64487⁰, 64488⁰, 64489⁰, 64490⁰, 64491⁰, 64492⁰, 64493⁰, 64494⁰, 64495⁰, 64505⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 92012¹, 92014¹, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 93355¹, 94002¹, 94200¹, 94680¹, 94681¹, 94690¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96361¹, 96365¹, 96366¹, 96367¹, 96368¹, 96372¹, 96374¹, 96375¹, 96376¹, 96377¹, 96523⁰, 99155⁰, 99156⁰, 99157⁰, 99211¹, 99212¹, 99213¹, 99214¹, 99215¹, 99221¹, 99222¹, 99223¹, 99231¹, 99232¹, 99233¹, 99234¹, 99235¹, 99236¹, 99238¹, 99239¹, 99242¹, 99243¹, 99244¹, 99245¹, 99252¹, 99253¹, 99254¹, 99255¹, 99291¹, 99292¹, 99304¹, 99305¹, 99306¹, 99307¹, 99308¹, 99309¹, 99310¹, 99315¹, 99316¹, 99347¹, 99348¹, 99349¹, 99350¹, 99374¹, 99375¹, 99377¹, 99378¹, 99446⁰, 99447⁰, 99448⁰, 99449⁰, 99451⁰, 99452⁰, 99495⁰, 99496⁰, G0463¹, G0471¹

ICD-10-CM Cross References

N75.0-N75.9

56441

Lysis of labial adhesions

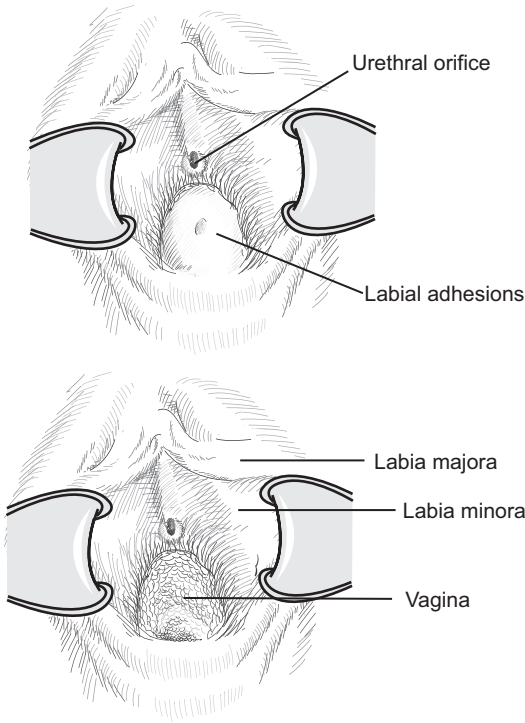
Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider breaks the fibrous adhesions of the labia majora and minora using sharp and or blunt dissection. The provider then irrigates the area, checks for bleeding, and places a few sutures if necessary.

Coding Tips

This is a bilateral procedure, so you should report it only once even if the provider performs it on both the left and right sides of the genital area.

Illustration



56441

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor \$: 33.5675, Facility Fee: \$141.32, Non Facility Fee: \$183.28; Non-QP Conversion Factor \$33.4009, Facility Fee: \$140.62, Non Facility Fee: \$182.37

RVU (Facility): Work 1.97, PE 1.9, Mal 0.34, Total 4.21

RVU (Non-Facility): Work 1.97, PE 3.15, Mal 0.34, Total 5.46

MPFS Payment Policy Indicators: Global Period 10, Preop 10.00%, Intraop 80.00%, Postop 10.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None

Practitioner MUE: 1

Modifier Allowances

22, 47, 51, 52, 53, 54, 55, 56, 58, 59, 63, 73, 74, 76, 77, 78, 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)

00940⁰, 0213T⁰, 0216T⁰, 0596T¹, 0597T¹, 0708T¹, 0709T¹, 0903T¹, 0904T¹, 0905T¹, 12001¹, 12002¹, 12004¹, 12005¹, 12006¹, 12007¹, 12011¹, 12013¹, 12014¹, 12015¹, 12016¹, 12017¹, 12018¹, 12020¹, 12021¹, 12031¹, 12032¹, 12034¹, 12035¹, 12036¹, 12037¹, 12041¹, 12042¹, 12044¹, 12045¹, 12046¹, 12047¹, 12051¹, 12052¹, 12053¹, 12054¹, 12055¹, 12056¹, 12057¹, 13100¹, 13101¹, 13102¹, 13120¹, 13121¹, 13122¹, 13131¹, 13132¹, 13133¹, 13151¹, 13152¹, 13153¹, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36591⁰, 36592⁰, 36600¹, 36640¹, 43752¹, 51701¹, 51702¹, 51703¹, 56820⁰, 57100¹, 57180¹, 57500¹, 62320⁰, 62321⁰, 62322⁰, 62323⁰, 62324⁰, 62325⁰, 62326⁰, 62327⁰, 64400⁰, 64405⁰, 64408⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64451⁰, 64454⁰, 64461⁰, 64462⁰, 64463⁰, 64466¹, 64467¹, 64468¹, 64469¹,

64473¹, 64474¹, 64479⁰, 64480⁰, 64483⁰, 64484⁰, 64486⁰, 64487⁰, 64488⁰, 64489⁰, 64490⁰, 64491⁰, 64492⁰, 64493⁰, 64494⁰, 64495⁰, 64505⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 92012¹, 92014¹, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 93355¹, 94002¹, 94200¹, 94680¹, 94681¹, 94690¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96361¹, 96365¹, 96366¹, 96367¹, 96368¹, 96372¹, 96374¹, 96375¹, 96376¹, 96377¹, 96523⁰, 99155⁰, 99156⁰, 99157⁰, 99211¹, 99212¹, 99213¹, 99214¹, 99215¹, 99221¹, 99222¹, 99223¹, 99231¹, 99232¹, 99233¹, 99234¹, 99235¹, 99236¹, 99238¹, 99239¹, 99242¹, 99243¹, 99244¹, 99245¹, 99252¹, 99253¹, 99254¹, 99255¹, 99291¹, 99292¹, 99304¹, 99305¹, 99306¹, 99307¹, 99308¹, 99309¹, 99310¹, 99315¹, 99316¹, 99347¹, 99348¹, 99349¹, 99350¹, 99374¹, 99375¹, 99377¹, 99378¹, 99446⁰, 99447⁰, 99448⁰, 99449⁰, 99451⁰, 99452⁰, 99495⁰, 99496⁰, G0463¹, G0471¹, J0670¹

ICD-10-CM Cross References

N90.89, N94.10-N94.19, Q52.5

56442

Hymenotomy, simple incision

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider uses a circular incision to broaden the aperture, or opening, of the hymen. He takes care to avoid any injury to the urethra. The provider then irrigates the area and checks for bleeding.

Coding Tips

If the provider partially removes the hymenal membrane or repairs the hymenal ring use 56700, Partial hymenectomy or revision of hymenal ring.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor \$: 33.5675, Facility Fee: \$43.97, Non Facility Fee: \$43.97; Non-QP Conversion Factor \$33.4009, Facility Fee: \$43.76, Non Facility Fee: \$43.76

RVU (Facility): Work 0.66, PE 0.53, Mal 0.12, Total 1.31

RVU (Non-Facility): Work 0.66, PE 0.53, Mal 0.12, Total 1.31

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, 47, 51, 52, 53, 58, 59, 63, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 32.0)

00940⁰, 0213T⁰, 0216T⁰, 0596T¹, 0597T¹, 0708T¹, 0709T¹, 0903T¹, 0904T¹, 0905T¹, 11000¹, 11001¹, 11004¹, 11005¹, 11006¹, 11042¹, 11043¹, 11044¹, 11045¹, 11046¹, 11047¹, 12001¹, 12002¹, 12004¹, 12005¹, 12006¹, 12007¹, 12011¹, 12013¹, 12014¹, 12015¹, 12016¹, 12017¹, 12018¹, 12020¹, 12021¹, 12031¹, 12032¹, 12034¹, 12035¹, 12036¹, 12037¹, 12041¹, 12042¹, 12044¹, 12045¹, 12046¹, 12047¹, 12051¹, 12052¹, 12053¹, 12054¹, 12055¹, 12056¹, 12057¹, 13100¹,

Maternity Care and Delivery

59000

Amniocentesis; diagnostic

Clinical Responsibility

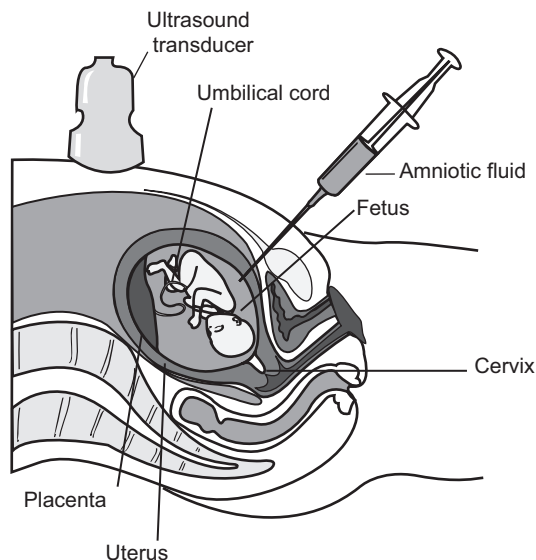
The provider first drapes and preps the patient's abdominal area. Using ultrasound guidance, he identifies the needle insertion site, and he slowly inserts a needle into the amniotic sac. The provider, working with an assistant, attaches the needle to tubing. While the provider holds the needle in place, the assistant attaches the needle to a drainage system. Using continuous ultrasonic guidance, the provider then carefully removes fluid until there is enough for a sample. When the procedure is complete, the provider slowly and cautiously removes the needle.

Coding Tips

Code 59000 does not include ultrasound guidance, but the provider almost always uses ultrasound imaging to guide the needle into position and withdraw the fluid. Because the Resource Based Relative Value Scale, or RBRVS, does not value the code including ultrasound guidance, report the code 76946, Unlisted fluoroscopic procedure, e.g., diagnostic, interventional, in addition to 59000. Be sure that the provider documents the findings as coding requires for billing of the ultrasound guidance.

For services paid under OPPS, Medicare does not pay hospitals separately for supervision and interpretation codes deemed to be ancillary and supportive services to primary diagnostic or therapeutic services. OPPS hospitals should still report the code when performed for statistical purposes.

Illustration



59000

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor \$: 33.5675, Facility Fee: \$73.18, Non Facility Fee: \$120.51; Non-QP Conversion Factor \$33.4009, Facility Fee: \$72.81, Non Facility Fee: \$119.91

RVU (Facility): Work 1.27, PE 0.5, Mal 0.41, Total 2.18

RVU (Non-Facility): Work 1.27, PE 1.91, Mal 0.41, Total 3.59

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: 2

Modifier Allowances

22, 47, 51, 52, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AG, AQ, AR, CR, ET, GA, GC, GJ, GR, HD, KX, PD, Q5, Q6, QJ, TH, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T⁰, 0216T⁰, 0596T¹, 0597T¹, 0708T¹, 0709T¹, 0903T¹, 0904T¹, 0905T¹, 12001¹, 12002¹, 12004¹, 12005¹, 12006¹, 12007¹, 12011¹, 12013¹, 12014¹, 12015¹, 12016¹, 12017¹, 12018¹, 12020¹, 12021¹, 12031¹, 12032¹, 12034¹, 12035¹, 12036¹, 12037¹, 12041¹, 12042¹, 12044¹, 12045¹, 12046¹, 12047¹, 12051¹, 12052¹, 12053¹, 12054¹, 12055¹, 12056¹, 12057¹, 13100¹, 13101¹, 13102¹, 13120¹, 13121¹, 13122¹, 13131¹, 13132¹, 13133¹, 13151¹, 13152¹, 13153¹, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36591⁰, 36592⁰, 36600¹, 36640¹, 43752¹, 51701⁰, 51702⁰, 51703¹, 57410⁰, 62320⁰, 62321⁰, 62322⁰, 62323⁰, 62324⁰, 62325⁰, 62326⁰, 62327⁰, 64400⁰, 64405⁰, 64408⁰, 64415⁰, 64416⁰, 64417⁰, 64418⁰, 64420⁰, 64421⁰, 64425⁰, 64430⁰, 64435⁰, 64445⁰, 64446⁰, 64447⁰, 64448⁰, 64449⁰, 64450⁰, 64451⁰, 64454⁰, 64461⁰, 64462⁰, 64463⁰, 64466¹, 64467¹, 64468¹, 64469¹, 64473¹, 64474¹, 64479⁰, 64480⁰, 64483⁰, 64484⁰, 64486⁰, 64487⁰, 64488⁰, 64489⁰, 64490⁰, 64491⁰, 64492⁰, 64493⁰, 64494⁰, 64495⁰, 64505⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 76000¹, 76942¹, 76998¹, 77001¹, 77002¹, 92012¹, 92014¹, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 93355¹, 94002¹, 94200¹, 94680¹, 94681¹, 94690¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822¹, 95829¹, 95955¹, 96360¹, 96361¹, 96365¹, 96366¹, 96367¹, 96368¹, 96372¹, 96374¹, 96375¹, 96376¹, 96377¹, 96523⁰, 99155⁰, 99156⁰, 99157⁰, 99211¹, 99212¹, 99213¹, 99214¹, 99215¹, 99221¹, 99222¹, 99223¹, 99231¹, 99232¹, 99233¹, 99234¹, 99235¹, 99236¹, 99238¹, 99239¹, 99242¹, 99243¹, 99244¹, 99245¹, 99252¹, 99253¹, 99254¹, 99255¹, 99291¹, 99292¹, 99304¹, 99305¹, 99306¹, 99307¹, 99308¹, 99309¹, 99310¹, 99315¹, 99316¹, 99347¹, 99348¹, 99349¹, 99350¹, 99374¹, 99375¹, 99377¹, 99378¹, 99446⁰, 99447⁰, 99448⁰, 99449⁰, 99451⁰, 99452⁰, 99495¹, 99496¹, G0463¹, G0471⁰

ICD-10-CM Cross References

D61.03, O09.10-O09.13, O09.291-O09.299, O09.511-O09.519, O09.521-O09.529, O09.621-O09.629, O09.70-O09.73, O09.811-O09.819, O09.821-O09.829, O09.891-O09.899, O09.90-O09.93, O09.A0-O09.A3, O12.04, O12.05, O12.14, O12.15, O12.24, O12.25, O13.4, O13.5, O16.4, O16.5, O28.0-O28.9, O33.7XX0-O33.7XX9, O35.00X0-O35.00X9, O35.01X0-O35.01X9, O35.02X0-O35.02X9, O35.03X0-O35.03X9, O35.04X0-O35.04X9, O35.05X0-O35.05X9, O35.06X0-O35.06X9, O35.07X0-O35.07X9,

Proprietary Laboratory Analyses

0455U

Infectious agents (sexually transmitted infection), Chlamydia trachomatis, Neisseria gonorrhoeae, and Trichomonas vaginalis, multiplex amplified probe technique, vaginal, endocervical, gynecological specimens, oropharyngeal swabs, rectal swabs, female or male urine, each pathogen reported as detected or not detected

Clinical Responsibility

The lab analyst processes the specimen, such as a vaginal swab, endocervical swab, gynecological specimen, oropharyngeal swab, rectal swab, or female or male urine, using an instrument. The automated system extracts DNA and uses reverse transcription polymerase chain reaction (RT-PCR) to amplify (increase the number of) target genes to detect and differentiate Chlamydia trachomatis, Neisseria gonorrhoeae, and Trichomonas vaginalis. The procedure uses multiplex probe technique (able to simultaneously evaluate multiple analytes in a single procedure) and reports the findings for each organism as detected or not detected.

Clinicians may order this test for male or female patients exhibiting symptoms, such as pain, sores, odor, or discharge, of a sexually transmitted infection (STI).

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: 3

Modifier Allowances

33, 90, 91, 99, GA, GC, GR, GU, GX, GY, GZ, Q0, Q1, QJ, QP, SC

NCCI Alerts (version 32.0)

Medicare does not provide NCCI edits for this code. Please check individual payer guidelines for specific coverage determinations.

ICD-10-CM Cross References

A51.0-A51.2, A54.00-A54.09, A54.1, A54.22-A54.24, A54.29, A54.86, A54.89, A54.9, A55, A56.00-A56.09, A56.11, A56.19, A56.2, A56.3, A56.8, A57, A59.00-A59.09, A59.9, A60.00-A60.09, A60.1, A60.9, A63.8, A64, A74.89, A74.9, B10.89, R87.0, R87.1, Z11.3, Z11.8

0463U

Oncology (cervix), mRNA gene expression profiling of 14 biomarkers (E6 and E7 of the highest-risk human papillomavirus [HPV] types 16, 18, 31, 33, 45, 52, 58), by real-time nucleic acid sequence-based amplification (NASBA), exo- or endocervical epithelial cells, algorithm reported as positive or negative for increased risk of cervical dysplasia or cancer for each biomarker

Clinical Responsibility

A lab analyst carries out a test related to cervical cancer, known as mRNA gene expression profiling. This test looks for 14 specific markers, including E6 and E7 from the most dangerous types of human papillomavirus (HPV), types 16, 18, 31, 33, 45, 52, and 58. The specimen is from the patient's cervix. These can be either exocervical (from the outer surface of the cervix) or endocervical (from the inner surface or canal of the cervix) epithelial cells. Epithelial cells are a type of cell that line the surfaces of the body. These cells contain messenger RNA (mRNA), which carries genetic instructions from the DNA in the cell's control center (nucleus) to the rest of the cell. The analyst uses a method called real-time nucleic acid sequence-based amplification (NASBA) to make many copies of the parts of the mRNA that match the 14 markers. This involves making a DNA copy (complementary DNA or cDNA) of the mRNA, and then using this cDNA as a pattern to make more copies of the original mRNA. The "real-time" part means that the making and detecting of the mRNA copies can be watched as it happens. Once the mRNA has been copied many times, the analyst can measure the amounts of each marker in the sample. This is done by comparing the amount of cDNA for each marker to a known reference amount. Finally, the results are analyzed using a special calculation process (algorithm), which decides whether the amounts of each marker suggest a higher risk of changes in the cervix (cervical dysplasia) or cervical cancer. The results are then reported as either positive or negative for each marker.

Clinicians may order this test to help identify women at risk for cervical cancer. Over-production of E6/E7 indicates that the patient is infected with one of the listed high-risk HPV types, which is associated with an increased risk of developing cervical cancer.

Coding Tips

Use this code only for the appropriate proprietary test.

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

HCPCS Level II Codes

Procedures/Professional Services

G0064

Certified nurse midwife mips specialty set

Clinical Responsibility

This code is specific to the Certified Nurse Midwife MIPS Specialty Set. Medicare develops and maintains specialty measure sets to assist Merit-based Incentive Payment System (MIPS) eligible clinicians with selecting quality measures that are most relevant to their scope of practice.

BETOS

Z2: Undefined codes

G0076

Brief (20 minutes) care management home visit for a new patient. for use only in a Medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)

Clinical Responsibility

The CMMI provider sees a new patient face-to-face for a brief care management visit of 20 minutes in their home or other place of residence. The provider typically reviews the patient's history, performs a brief physical examination, and decides on a care management plan or makes adjustments in an existing one. The provider documents the reason why the patient is being seen at their private residence and not at the office and the time spent with the patient and activities he performs.

Coding Tips

For the same service for visits lasting more than 20 minutes, report G0077 (30 minutes), G0078 (45 minutes), G0079 (60 minutes), or G0080 (75 minutes).

The provider must be enrolled in a Medicare-approved Center for Medicare and Medicaid Innovation (CMMI) model program. Select the code to report based not only on time but on complexity of the care management services provided.

Use this code only to report services given to patients at their private home, apartment, town home, or other non-shared place of residence or at shared living facility such as an assisted living facility, adult living facility, nursing home, or rest home. Travel time to and from the patient's place of residence is not include in the code.

Service level is based on the complexity of the medical decision-making and the time spent with the patient.

A new patient is defined as a patient who has never seen the physician or qualified healthcare practitioner of the same specialty in the same group practice billing under the same group number or has not seen the physician or qualified healthcare practitioner of the same specialty in the same group practice for the past 36 months.

BETOS

M4A: Home visit

G0077

Limited (30 minutes) care management home visit for a new patient. for use only in a Medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)

Clinical Responsibility

The CMMI provider sees a new patient face-to-face for a limited care management visit of 30 minutes in their home or other place of residence. The provider typically reviews the patient's history, performs a brief physical examination, and decides on a care management plan or makes adjustments in an existing one. The provider documents the reason why the patient is being seen at their private residence and not at the office and the time spent with the patient and activities he performs.

Coding Tips

For the same service for visits lasting less than 30 minutes, report G0076 (20 minutes), and for more than 30 minutes, report G0078 (45 minutes), G0079 (60 minutes), or G0080 (75 minutes).

The provider must be enrolled in a Medicare-approved Center for Medicare and Medicaid Innovation (CMMI) model program. Select the code to report based not only on time but on complexity of the care management services provided.

Use this code only to report services given to patients at their private home, apartment, town home, or other non-shared place of residence or at shared living facility such as an assisted living facility, adult living facility, nursing home, or rest home. Travel time to and from the patient's place of residence is not include in the code.

Service level is based on the complexity of the medical decision-making and the time spent with the patient.

A new patient is defined as a patient who has never seen the physician or qualified healthcare practitioner of the same specialty in the same group practice billing under the same group number or has not seen the physician or qualified healthcare practitioner of the same specialty in the same group practice for the past 36 months.

BETOS

M4A: Home visit

G0078

Moderate (45 minutes) care management home visit for a new patient. for use only in a Medicare-approved cmml model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)

Clinical Responsibility

The CMMI provider sees a new patient face-to-face for a moderate care management visit of 45 minutes in their home or other place of residence. The provider typically reviews the patient's history, performs a brief physical examination, and decides on a care management plan or makes adjustments in an existing one. The provider documents the reason why the patient is being seen at their private residence and not at the office and the time spent with the patient and activities he performs.

Coding Tips

For the same service for visits lasting less than 45 minutes, report G0076 (20 minutes), or G0077 (30 minutes), and for more than 45 minutes, report G0079 (60 minutes), or G0080 (75 minutes).

The provider must be enrolled in a Medicare-approved Center for Medicare and Medicaid Innovation (CMMI) model program. Select the code to report based not only on time but on complexity of the care management services provided.

Use this code only to report services given to patients at their private home, apartment, town home, or other non-shared place of residence or at shared living facility such as an assisted living facility, adult living facility, nursing home, or rest home. Travel time to and from the patient's place of residence is not include in the code.

Service level is based on the complexity of the medical decision-making and the time spent with the patient.

A new patient is defined as a patient who has never seen the physician or qualified healthcare practitioner of the same specialty in the same group practice billing under the same group number or has not seen the physician or qualified healthcare practitioner of the same specialty in the same group practice for the past 36 months.

BETOS

M4A: Home visit

G0079

Comprehensive (60 minutes) care management home visit for a new patient. for use only in a Medicare-approved cmml model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)

Clinical Responsibility

The CMMI provider sees a new patient face-to-face for a comprehensive care management visit of 60 minutes in their home or other place of residence. The provider typically reviews the patient's history, performs a brief physical examination, and decides on a care management plan or makes adjustments in an existing one. The provider documents the reason why the patient is being seen at their private residence and not at the office and the time spent with the patient and activities he performs.

Coding Tips

For the same service for visits lasting less than 60 minutes, report G0076 (20 minutes), G0077 (30 minutes), or G0078 (45 minutes), and for more than 60 minutes, report G0080 (75 minutes).

The provider must be enrolled in a Medicare-approved Center for Medicare and Medicaid Innovation (CMMI) model program. Select the code to report based not only on time but on complexity of the care management services provided.

Use this code only to report services given to patients at their private home, apartment, town home, or other non-shared place of residence or at shared living facility such as an assisted living facility, adult living facility, nursing home, or rest home. Travel time to and from the patient's place of residence is not include in the code.

Service level is based on the complexity of the medical decision-making and the time spent with the patient.

A new patient is defined as a patient who has never seen the physician or qualified healthcare practitioner of the same specialty in the same group practice billing under the same group number or has not seen the physician or qualified healthcare practitioner of the same specialty in the same group practice for the past 36 months.

BETOS

M4A: Home visit

G0080

Extensive (75 minutes) care management home visit for a new patient. for use only in a Medicare-approved cmml model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)

Clinical Responsibility

The CMMI provider sees a new patient face-to-face for an extensive care management visit of 75 minutes in their home or other place of residence. The provider typically reviews the patient's history, performs a brief physical examination, and decides on a care management plan or makes adjustments in an existing one. The provider documents the reason why the patient is being seen at their private residence and not at the office and the time spent with the patient and activities he performs.

Coding Tips

For the same service for visits lasting less than 75 minutes, report G0076 (20 minutes), G0077 (30 minutes), G0078 (45 minutes), or G0079 (60 minutes).

ICD-10-CM Cross Reference Details

A06.82	Other amebic genitourinary infections	A54.24	Gonococcal female pelvic inflammatory disease
A15.0	Tuberculosis of lung	A54.29	Other gonococcal genitourinary infections
A15.4	Tuberculosis of intrathoracic lymph nodes	A54.30	Gonococcal infection of eye, unspecified
A15.5	Tuberculosis of larynx, trachea and bronchus	A54.31	Gonococcal conjunctivitis
A15.6	Tuberculous pleurisy	A54.40	Gonococcal infection of musculoskeletal system, unspecified
A15.7	Primary respiratory tuberculosis	A54.49	Gonococcal infection of other musculoskeletal tissue
A15.8	Other respiratory tuberculosis	A54.6	Gonococcal infection of anus and rectum
A15.9	Respiratory tuberculosis unspecified	A54.86	Gonococcal sepsis
A17.0	Tuberculous meningitis	A54.89	Other gonococcal infections
A17.1	Meningeal tuberculoma	A54.9	Gonococcal infection, unspecified
A17.81	Tuberculoma of brain and spinal cord	A55	Chlamydial lymphogranuloma (venereum)
A17.82	Tuberculous meningoencephalitis	A56.00	Chlamydial infection of lower genitourinary tract, unspecified
A17.83	Tuberculous neuritis	A56.01	Chlamydial cystitis and urethritis
A17.89	Other tuberculosis of nervous system	A56.02	Chlamydial vulvovaginitis
A17.9	Tuberculosis of nervous system, unspecified	A56.09	Other chlamydial infection of lower genitourinary tract
A18.10	Tuberculosis of genitourinary system, unspecified	A56.11	Chlamydial female pelvic inflammatory disease
A18.17	Tuberculous female pelvic inflammatory disease	A56.19	Other chlamydial genitourinary infection
A18.18	Tuberculosis of other female genital organs	A56.2	Chlamydial infection of genitourinary tract, unspecified
A18.39	Retroperitoneal tuberculosis	A56.3	Chlamydial infection of anus and rectum
A34	Obstetrical tetanus	A56.8	Sexually transmitted chlamydial infection of other sites
A36.0	Pharyngeal diphtheria	A57	Chancroid
A36.1	Nasopharyngeal diphtheria	A58	Granuloma inguinale
A36.2	Laryngeal diphtheria	A59.00	Urogenital trichomoniasis, unspecified
A36.3	Cutaneous diphtheria	A59.01	Trichomonal vulvovaginitis
A36.81	Diphtheritic cardiomyopathy	A59.02	Trichomonal prostatitis
A36.82	Diphtheritic radiculomyelitis	A59.03	Trichomonal cystitis and urethritis
A36.83	Diphtheritic polyneuritis	A59.09	Other urogenital trichomoniasis
A36.84	Diphtheritic tubulo-interstitial nephropathy	A59.8	Trichomoniasis of other sites
A36.85	Diphtheritic cystitis	A59.9	Trichomoniasis, unspecified
A36.86	Diphtheritic conjunctivitis	A60.00	Herpesviral infection of urogenital system, unspecified
A36.89	Other diphtheritic complications	A60.01	Herpesviral infection of penis
A36.9	Diphtheria, unspecified	A60.02	Herpesviral infection of other male genital organs
A37.00	Whooping cough due to Bordetella pertussis without pneumonia	A60.03	Herpesviral cervicitis
A37.01	Whooping cough due to Bordetella pertussis with pneumonia	A60.04	Herpesviral vulvovaginitis
A37.10	Whooping cough due to Bordetella parapertussis without pneumonia	A60.09	Herpesviral infection of other urogenital tract
A37.11	Whooping cough due to Bordetella parapertussis with pneumonia	A60.1	Herpesviral infection of perianal skin and rectum
A37.80	Whooping cough due to other Bordetella species without pneumonia	A60.9	Anogenital herpesviral infection, unspecified
A37.81	Whooping cough due to other Bordetella species with pneumonia	A63.0	Anogenital (venereal) warts
A37.90	Whooping cough, unspecified species without pneumonia	A63.8	Other specified predominantly sexually transmitted diseases
A37.91	Whooping cough, unspecified species with pneumonia	A64	Unspecified sexually transmitted disease
A41.3	Sepsis due to Hemophilus influenzae	A74.89	Other chlamydial diseases
A41.54	Sepsis due to Acinetobacter baumannii	A74.9	Chlamydial infection, unspecified
A49.2	Hemophilus influenzae infection, unspecified site	A79.82	Anaplasmosis [A. phagocytophilum]
A49.3	Mycoplasma infection, unspecified site	A80.0	Acute paralytic poliomyelitis, vaccine-associated
A49.8	Other bacterial infections of unspecified site	A80.1	Acute paralytic poliomyelitis, wild virus, imported
A49.9	Bacterial infection, unspecified	A80.2	Acute paralytic poliomyelitis, wild virus, indigenous
A51.0	Primary genital syphilis	A80.30	Acute paralytic poliomyelitis, unspecified
A51.1	Primary anal syphilis	A80.39	Other acute paralytic poliomyelitis
A51.2	Primary syphilis of other sites	A80.4	Acute nonparalytic poliomyelitis
A51.42	Secondary syphilitic female pelvic disease	A80.9	Acute poliomyelitis, unspecified
A52.73	Symptomatic late syphilis of other respiratory organs	A81.00	Creutzfeldt-Jakob disease, unspecified
A52.76	Other genitourinary symptomatic late syphilis	A81.01	Variant Creutzfeldt-Jakob disease
A52.79	Other symptomatic late syphilis	A81.09	Other Creutzfeldt-Jakob disease
A54.00	Gonococcal infection of lower genitourinary tract, unspecified	A81.1	Subacute sclerosing panencephalitis
A54.01	Gonococcal cystitis and urethritis, unspecified	A81.2	Progressive multifocal leukoencephalopathy
A54.02	Gonococcal vulvovaginitis, unspecified	A81.81	Kuru
A54.03	Gonococcal cervicitis, unspecified	A81.82	Gerstmann-Straussler-Scheinker syndrome
A54.09	Other gonococcal infection of lower genitourinary tract	A81.83	Fatal familial insomnia
A54.1	Gonococcal infection of lower genitourinary tract with periurethral and accessory gland abscess	A81.89	Other atypical virus infections of central nervous system
A54.21	Gonococcal infection of kidney and ureter	A81.9	Atypical virus infection of central nervous system, unspecified
A54.22	Gonococcal prostatitis	B01.0	Varicella meningitis
A54.23	Gonococcal infection of other male genital organs	B01.11	Varicella encephalitis and encephalomyelitis
		B01.12	Varicella myelitis
		B01.2	Varicella pneumonia
		B01.81	Varicella keratitis
		B01.89	Other varicella complications
		B01.9	Varicella without complication
		B02.0	Zoster encephalitis

B02.1	Zoster meningitis	C10.4	Malignant neoplasm of branchial cleft
B02.30	Zoster ocular disease, unspecified	C10.8	Malignant neoplasm of overlapping sites of oropharynx
B02.31	Zoster conjunctivitis	C10.9	Malignant neoplasm of oropharynx, unspecified
B02.32	Zoster iridocyclitis	C11.0	Malignant neoplasm of superior wall of nasopharynx
B02.33	Zoster keratitis	C11.1	Malignant neoplasm of posterior wall of nasopharynx
B02.34	Zoster scleritis	C11.2	Malignant neoplasm of lateral wall of nasopharynx
B02.39	Other herpes zoster eye disease	C11.3	Malignant neoplasm of anterior wall of nasopharynx
B02.7	Disseminated zoster	C11.8	Malignant neoplasm of overlapping sites of nasopharynx
B02.8	Zoster with other complications	C11.9	Malignant neoplasm of nasopharynx, unspecified
B02.9	Zoster without complications	C12	Malignant neoplasm of pyriform sinus
B05.0	Measles complicated by encephalitis	C13.0	Malignant neoplasm of postcricoid region
B05.1	Measles complicated by meningitis	C13.2	Malignant neoplasm of posterior wall of hypopharynx
B05.2	Measles complicated by pneumonia	C13.8	Malignant neoplasm of overlapping sites of hypopharynx
B05.3	Measles complicated by otitis media	C13.9	Malignant neoplasm of hypopharynx, unspecified
B05.4	Measles with intestinal complications	C14.0	Malignant neoplasm of pharynx, unspecified
B05.81	Measles keratitis and keratoconjunctivitis	C14.2	Malignant neoplasm of Waldeyer's ring
B05.89	Other measles complications	C15.3	Malignant neoplasm of upper third of esophagus
B05.9	Measles without complication	C15.4	Malignant neoplasm of middle third of esophagus
B06.00	Rubella with neurological complication, unspecified	C15.5	Malignant neoplasm of lower third of esophagus
B06.01	Rubella encephalitis	C15.8	Malignant neoplasm of overlapping sites of esophagus
B06.02	Rubella meningitis	C15.9	Malignant neoplasm of esophagus, unspecified
B06.09	Other neurological complications of rubella	C16.1	Malignant neoplasm of fundus of stomach
B06.81	Rubella pneumonia	C16.2	Malignant neoplasm of body of stomach
B06.82	Rubella arthritis	C16.3	Malignant neoplasm of pyloric antrum
B06.89	Other rubella complications	C16.5	Malignant neoplasm of lesser curvature of stomach, unspecified
B06.9	Rubella without complication	C16.8	Malignant neoplasm of overlapping sites of stomach
B07.8	Other viral warts	C16.9	Malignant neoplasm of stomach, unspecified
B07.9	Viral wart, unspecified	C17.1	Malignant neoplasm of jejunum
B08.1	Molluscum contagiosum	C17.3	Meckel's diverticulum, malignant
B10.89	Other human herpesvirus infection	C17.8	Malignant neoplasm of overlapping sites of small intestine
B16.0	Acute hepatitis B with delta-agent with hepatic coma	C17.9	Malignant neoplasm of small intestine, unspecified
B16.1	Acute hepatitis B with delta-agent without hepatic coma	C19	Malignant neoplasm of rectosigmoid junction
B16.2	Acute hepatitis B without delta-agent with hepatic coma	C20	Malignant neoplasm of rectum
B16.9	Acute hepatitis B without delta-agent and without hepatic coma	C21.0	Malignant neoplasm of anus, unspecified
B17.0	Acute delta-(super) infection of hepatitis B carrier	C21.1	Malignant neoplasm of anal canal
B18.0	Chronic viral hepatitis B with delta-agent	C21.2	Malignant neoplasm of cloacogenic zone
B18.1	Chronic viral hepatitis B without delta-agent	C21.8	Malignant neoplasm of overlapping sites of rectum, anus and anal canal
B19.10	Unspecified viral hepatitis B without hepatic coma	C22.0	Liver cell carcinoma
B19.11	Unspecified viral hepatitis B with hepatic coma	C22.1	Intrahepatic bile duct carcinoma
B20	Human immunodeficiency virus [HIV] disease	C22.2	Hepatoblastoma
B37.31	Acute candidiasis of vulva and vagina	C22.3	Angiosarcoma of liver
B37.32	Chronic candidiasis of vulva and vagina	C22.4	Other sarcomas of liver
B37.41	Candidal cystitis and urethritis	C22.7	Other specified carcinomas of liver
B37.49	Other urogenital candidiasis	C22.8	Malignant neoplasm of liver, primary, unspecified as to type
B37.89	Other sites of candidiasis	C22.9	Malignant neoplasm of liver, not specified as primary or secondary
B37.9	Candidiasis, unspecified	C23	Malignant neoplasm of gallbladder
B80	Enterobiasis	C24.0	Malignant neoplasm of extrahepatic bile duct
B87.81	Genitourinary myiasis	C24.1	Malignant neoplasm of ampulla of Vater
B88.09	Other acariasis	C24.8	Malignant neoplasm of overlapping sites of biliary tract
B90.1	Sequelae of genitourinary tuberculosis	C24.9	Malignant neoplasm of biliary tract, unspecified
B91	Sequelae of poliomyelitis	C25.1	Malignant neoplasm of body of pancreas
B96.3	Hemophilus influenzae [H. influenzae] as the cause of diseases classified elsewhere	C25.2	Malignant neoplasm of tail of pancreas
B96.83	Acinetobacter baumannii as the cause of diseases classified elsewhere	C25.7	Malignant neoplasm of other parts of pancreas
B96.89	Other specified bacterial agents as the cause of diseases classified elsewhere	C25.8	Malignant neoplasm of overlapping sites of pancreas
B97.35	Human immunodeficiency virus, type 2 [HIV 2] as the cause of diseases classified elsewhere	C25.9	Malignant neoplasm of pancreas, unspecified
B97.7	Papillomavirus as the cause of diseases classified elsewhere	C26.0	Malignant neoplasm of intestinal tract, part unspecified
C00.3	Malignant neoplasm of upper lip, inner aspect	C26.1	Malignant neoplasm of spleen
C01	Malignant neoplasm of base of tongue	C26.9	Malignant neoplasm of ill-defined sites within the digestive system
C02.9	Malignant neoplasm of tongue, unspecified	C30.0	Malignant neoplasm of nasal cavity
C04.1	Malignant neoplasm of lateral floor of mouth	C30.1	Malignant neoplasm of middle ear
C06.9	Malignant neoplasm of mouth, unspecified	C31.0	Malignant neoplasm of maxillary sinus
C07	Malignant neoplasm of parotid gland	C31.1	Malignant neoplasm of ethmoidal sinus
C08.0	Malignant neoplasm of submandibular gland	C31.2	Malignant neoplasm of frontal sinus
C08.1	Malignant neoplasm of sublingual gland	C31.3	Malignant neoplasm of sphenoid sinus
C08.9	Malignant neoplasm of major salivary gland, unspecified	C31.8	Malignant neoplasm of overlapping sites of accessory sinuses
C10.2	Malignant neoplasm of lateral wall of oropharynx	C31.9	Malignant neoplasm of accessory sinus, unspecified
C10.3	Malignant neoplasm of posterior wall of oropharynx	C32.0	Malignant neoplasm of glottis
		C32.1	Malignant neoplasm of supraglottis

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

Modifier	Description
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
Abdominal pregnancy	When the fetus begins to grow within the peritoneal cavity; it can be located anywhere including the omentum, the abdominal wall, or the outside of the body of the uterus; a primary abdominal pregnancy means that the fertilization of the ovum takes place outside the entrance to the fallopian tube and the fertilized egg then travels to a close source of tissue, which it attaches to; a secondary abdominal pregnancy means that the fertilized ruptures from the tube and then implants in the abdominal cavity.
Abdominoperineal resection	The surgical removal of the anus, rectum, and part of the sigmoid colon, along with regional lymph nodes, through incisions made in the abdomen and perineum.
Ablation	A surgical technique that removes tissue or a body part or destroys its function.
Abortion	The clinical term for the termination of a pregnancy before the age of viability, usually before twenty completed weeks of gestation; the provider removes the uterine contents surgically or by inducing labor, or the pregnancy may be expelled spontaneously; when it ends spontaneously, it is referred to as a miscarriage.
Abscess	Sac or pocket formed due to the accumulation of purulent material, or pus, in the soft tissues.
Acute	A medical condition or injury of sudden onset, sometimes severe in nature, and typically lasts a short period of time; opposite of chronic.
Adhesions	Fibrous bands of internal scar tissue that connect tissues that do not normally connect, often as a result of injury during surgery; when they develop in the uterus, they are referred to as uterine synechiae.
Adjuvant	A substance added to the vaccine to boost body's immune response to the vaccine.
Adnexal structures	Organs that adjoin the uterus such as the ovaries and the fallopian tubes.
Adolescent	Teenager.
Algorithm	A specific set of step by step calculations using defined inputs at each step to produce a useful output; specifically for MAAs, the output involves some sort of diagnostic or prognostic information about treatment options or disease outcomes.
Amniocentesis	A procedure in which a small sample of amniotic fluid is drawn out of the uterus through a needle inserted in the abdomen.
Amnioinfusion	The instillation of warm fluid into the amniotic cavity.
Amnion	Inner membrane of the sac that covers the fetus.
Amnioscope	A type of endoscope that allows the provider to see the amniotic sac and fetus.
Amniotic fluid	A clear, slightly yellowish liquid that surrounds the fetus during pregnancy and helps to protect it from mechanical injury.
Amniotic sac	A bag of fluid inside the uterus where the fetus develops and grows; it is sometimes called the membranes because the sac is made of two membranes called the amnion and the chorion.
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.
Anastomosis	Surgical connection or joining of vessels or organs.
Anatomy	Branch of science that deals with the study of the structure of an organism.
Angiography	A medical imaging technique in which the provider injects a dye into blood vessels and uses plain X-rays, computed tomography (CT), or magnetic resonance imaging (MRI) to visualize the inside (lumen) of the vessels; more specific terms include arteriography when performed on the arteries or venography when performed on the veins; angiography can also be used to study blood supply to organs such as the heart, kidneys, and liver.
Anhydramnios	The absence of any amniotic fluid around the fetus.
Anomaly	Not normal structurally or functionally, out of place; typically describes a congenital deformity, one present at birth.
Antenatal testing	Tests a provider offers a mother to check on the health of the baby and mother.
Antepartum period	Period from confirmation of pregnancy to delivery of the baby.

Terminology	Explanation
Anterior rectus sheath	Portion of the rectus abdominis muscles, the two parallel vertically aligned muscles on each side of the anterior wall of the abdomen surrounded by layers of flat broad tendons.
Antibody	Also called immunoglobulin; a protein that the body produces in the blood as part of the immune response to neutralize specific invaders such as bacteria or viruses, but occasionally reacts to the patient's own body; lab tests may utilize reactions between antibodies and antigens to identify a substance in a patient specimen.
Anticoagulant	A drug that prevents clot formation within the blood vessels and dissolves any blood clot formed previously.
Antigen	Foreign bodies, such as bacteria, that enter the human body, or substances that form within the body, that cause an immune response, such as antibody production, and possibly infection; lab tests may utilize reactions between antibodies and antigens to identify a substance in a patient specimen.
Anus	External opening of the rectum where the gastrointestinal tract ends.
Arcus tendineus fascia pelvis (ATFP)	Also referred to as the white line, this is the attachment point for the pubocervical fascia to support the anterior walls of the vagina that have prolapsed; it is a thick band of the fascia over the obturator internus muscles running in an arching line from the pubis to the ischial spine.
Artificial insemination	The introduction of semen into the cervical canal, uterus, [BC1] or fallopian tube to achieve pregnancy without intercourse.
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.
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.
Attenuated vaccine	Vaccine made from live micro organisms that are cultured under advanced conditions retaining their ability of immunity.
Autograft	Any tissue from one part of the body moved to another location on the same patient; also known as an autologous graft.
Axilla	The space beneath the arm where it joins the body; also called the armpit or underarm.
Balloon catheter	A flexible tube with a balloon at the tip that can be inflated and deflated with a mechanism at the other end.
Bartholin's glands	Glands which are located on each of the labia, the vaginal lips, near the opening of the vagina. A Bartholin's cyst is a small, fluid filled, sac like growth that forms on the Bartholin's gland. The cysts commonly occur during puberty until menopause.
Baseline fetal heart rate, or FHR	The pattern of fetal heart rate between uterine contractions.
Baseline variability	Fluctuations in the fetal heart rate.
Bilateral	On two sides; opposite of unilateral.
Bimanual pelvic exam	Insertion of two fingers into the vagina to isolate the cervix.
Biophysical profile, BPP	A prenatal test that combines an ultrasound test to measure the breathing and movement of the fetus, and the volume of amniotic fluid, with monitoring of the heart rate, known as a non stress test.
Biopsy	To remove a portion or the entirety of suspicious tissue for pathologic examination; types of biopsies include excisional, incisional, punch, needle, open.
Bipolar forceps	Instruments that a provider uses to coagulate, or make solid tissue by means of an electrical current, which he fires through the tips of the forceps.
Bladder	An organ in the body located just above the uterus which holds urine and changes size based on the amount of urine present.
Blunt dissection	Separation of tissue layers using the fingers; sharp dissection separates tissue layers using a blade.
Brachytherapy	A form of radiotherapy where a radiation source is placed inside or next to the area requiring treatment.
Breast localization device	Small devices used to mark the location of a breast abnormality to make it easier for the provider to find the target area during biopsy.

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