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

CODERS' SPECIALTY GUIDE

Pain Management

2026

Contents

Musculoskeletal System

20526

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

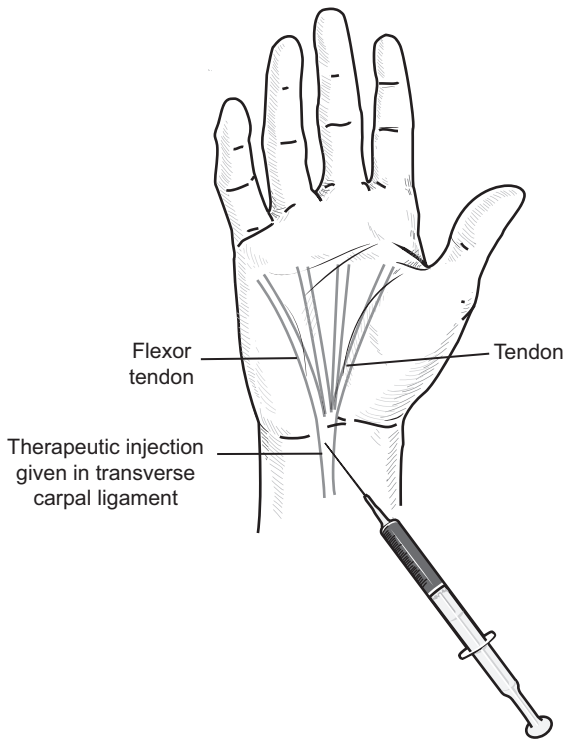
Clinical Responsibility

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): Conversion Factor $32.3465, Facility Fee: $55.31, Non Facility Fee: $80.87

RVU (Facility): Work RVU 0.94, Practice Exp. RVU 0.61, Malpractice RVU 0.16, Total RVU 1.71
RVU (Non-Facility): Work RVU 0.94, Practice Exp. RVU 1.40, Malpractice RVU 0.16, Total RVU 2.50
MPFS Payment Policy Indicators: Global Period 000, 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 31.0)

0213T[1], 0216T[1], 0596T[1], 0597T[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], 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.

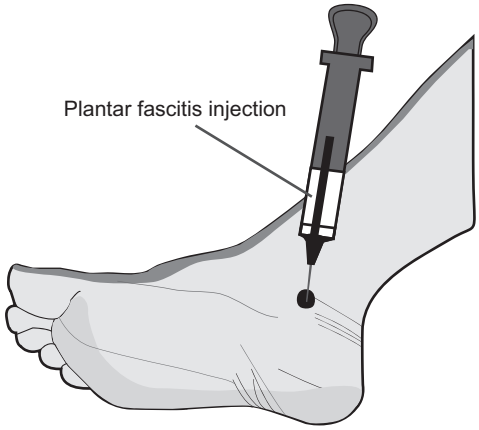
Report the thumb injections as 20550 50 59 Distinct procedural service and F5, Right hand, thumb and 20550 50 59 FA, Left hand, thumb.

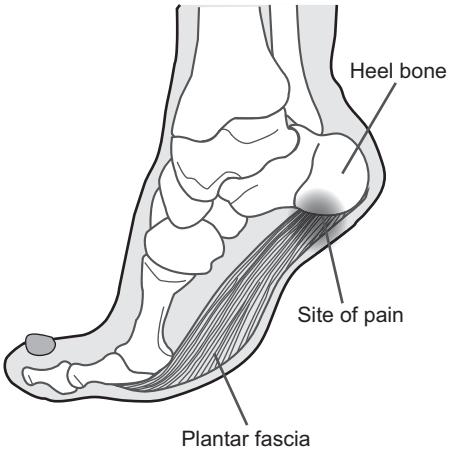
Clinical Scenario 2:

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): Conversion Factor $32.3465, Facility Fee: $37.85, Non Facility Fee: $56.61
RVU (Facility): Work RVU 0.75, Practice Exp. RVU 0.32, Malpractice RVU 0.10, Total RVU 1.17
RVU (Non-Facility): Work RVU 0.75, Practice Exp. RVU 0.90, Malpractice RVU 0.10, Total RVU 1.75
MPFS Payment Policy Indicators: Global Period 000, 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 31.0)

0232T[1], 0481T[1], 0490T[1], 0596T[1], 0597T[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], 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.

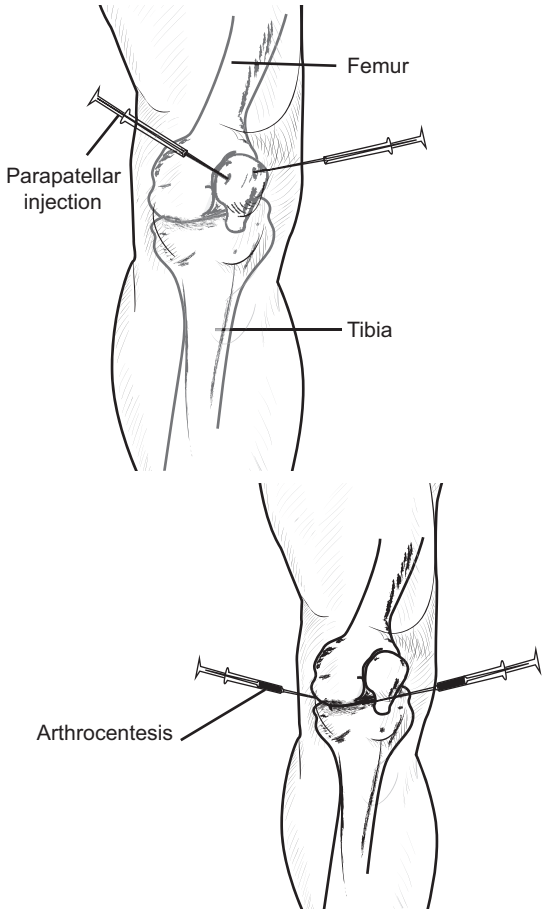
20610

Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance

Clinical Responsibility

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

Illustration



20610

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $43.99, Non Facility Fee: $63.40
RVU (Facility): Work RVU 0.79, Practice Exp. RVU 0.44, Malpractice RVU 0.13, Total RVU 1.36
RVU (Non-Facility): Work RVU 0.79, Practice Exp. RVU 1.04, Malpractice RVU 0.13, Total RVU 1.96
MPFS Payment Policy Indicators: Global Period 000, 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, 50, 51, 52, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AG, AQ, AR, CR, ET, GA, GC, GJ, GR, GZ, KX, LT, PD, Q5, Q6, QJ, RT, XE, XP, XS, XU

NCCI Alerts (version 31.0)

00400^{0}, 01380^{0}, 0232T^{1}, 0481T^{1}, 0596T^{1}, 0597T^{1}, 10030^{1}, 10060^{1}, 10061^{1}, 10140^{1}, 10160^{1}, 11010^{1}, 11900^{1}, 12001^{1}, 12002^{1}, 12020^{1}, 12031^{1}, 12044^{1}, 15851^{1}, 20500^{1}, 20501^{1}, 20527^{1}, 20550^{1}, 20551^{1}, 20552^{1}, 20553^{1}, 20560^{1}, 20561^{1}, 24300^{1}, 25259^{1}, 26340^{1}, 29065^{1}, 29075^{1}, 29085^{1}, 29105^{1}, 29125^{1}, 29130^{1}, 29240^{1}, 29260^{1}, 29345^{1}, 29355^{1}, 29365^{1}, 29405^{1}, 29425^{1}, 29505^{1}, 29515^{1}, 29530^{1}, 29540^{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}, 64461^{1}, 64462^{1}, 64463^{0}, 64480^{1}, 64484^{1}, 64486^{1}, 64487^{1}, 64488^{1}, 64489^{1}, 64494^{1}, 64495^{1}, 64505^{1}, 64510^{1}, 64517^{1}, 64520^{1}, 64530^{1}, 69990^{0}, 72255^{1}, 72265^{1}, 72295^{1}, 76000^{1}, 76080^{1}, 76881^{1}, 76882^{1}, 76942^{1}, 76998^{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}, 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}, G0168^{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.

20611

Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); with ultrasound guidance, with permanent recording and reporting

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider inserts a needle through the skin and into the large sized joint or bursa typically the shoulder, hip, knee, or subacromial bursa. Under ultrasound guidance, he then uses a syringe with the needle to remove fluid from the joint or bursa. The provider also permanently records the findings. After he aspirates the joint or bursa, he sends the fluid sample to the laboratory for further

examination. He may also inject a drug into the joint or bursa for therapeutic purposes such as pharmacotherapy or lavage. He then removes the needle and applies pressure to stop any bleeding.

Coding Tips

Report 20611 only for joints or bursae of a large size, such as the shoulder, hip, knee, or the olecranon bursa.

When the provider performs arthrocentesis, aspiration and or injection of a major joint or bursa and he does not use ultrasound guidance in the performance of the procedure, use code 20610, Arthrocentesis, aspiration and/or injection, major joint or bursa (eg, shoulder, hip, knee, subacromial bursa); without ultrasound guidance.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $57.25, Non Facility Fee: $96.39
RVU (Facility): Work RVU 1.10, Practice Exp. RVU 0.51, Malpractice RVU 0.16, Total RVU 1.77
RVU (Non-Facility): Work RVU 1.10, Practice Exp. RVU 1.72, Malpractice RVU 0.16, Total RVU 2.98
MPFS Payment Policy Indicators: Global Period 000, 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, 50, 51, 52, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AG, AQ, AR, CR, ET, GA, GC, GJ, GR, GZ, KX, LT, PD, Q5, Q6, QJ, RT, SA, XE, XP, XS, XU

NCCI Alerts (version 31.0)

00400[0], 01380[0], 0213T[1], 0216T[1], 0232T[1], 0481T[1], 0596T[1], 0597T[1], 10030[1], 10060[1], 10061[1], 10140[1], 10160[1], 11900[1], 12001[1], 12002[1], 12004[1], 12005[1], 12006[1], 12007[1], 12011[1], 12013[1], 12014[1], 12015[1], 12016[1], 12017[1], 12018[1], 12020[1], 12021[1], 12031[1], 12032[1], 12034[1], 12035[1], 12036[1], 12037[1], 12041[1], 12042[1], 12044[1], 12045[1], 12046[1], 12047[1], 12051[1], 12052[1], 12053[1], 12054[1], 12055[1], 12056[1], 12057[1], 13100[1], 13101[1], 13102[1], 13120[1], 13121[1], 13122[1], 13131[1], 13132[1], 13133[1], 13151[1], 13152[1], 13153[1], 15851[1], 20500[1], 20501[1], 20527[1], 20550[1], 20551[1], 20552[1], 20553[1], 20560[1], 20561[1], 20610[1], 24300[1], 25259[1], 26340[1], 29065[1], 29075[1], 29085[1], 29105[1], 29125[1], 29130[1], 29240[1], 29260[1], 29345[1], 29355[1], 29365[1], 29405[1], 29425[1], 29505[1], 29515[1], 29530[1], 29540[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], 64400[1], 64405[1], 64408[1], 64415[1], 64416[1], 64417[1], 64418[1], 64420[1], 64421[1], 64425[1], 64430[1], 64435[1], 64445[1], 64446[1], 64447[1], 64448[1], 64449[1], 64450[1], 64451[1], 64454[1], 64461[1], 64462[1], 64463[0], 64479[1], 64480[0], 64483[1], 64484[1], 64486[1], 64487[1], 64488[1], 64489[1], 64490[1], 64491[0], 64492[0], 64493[1], 64494[0], 64495[0], 64505[1], 64510[1], 64517[1], 64520[1], 64530[1], 69990[0], 72255[1], 72265[1], 72295[1], 76000[1], 76080[1], 76380[1], 76881[1], 76882[1], 76942[1], 76998[1], 77001[1], 77002[1], 77003[1], 77012[1], 77021[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], 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], G0168[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.

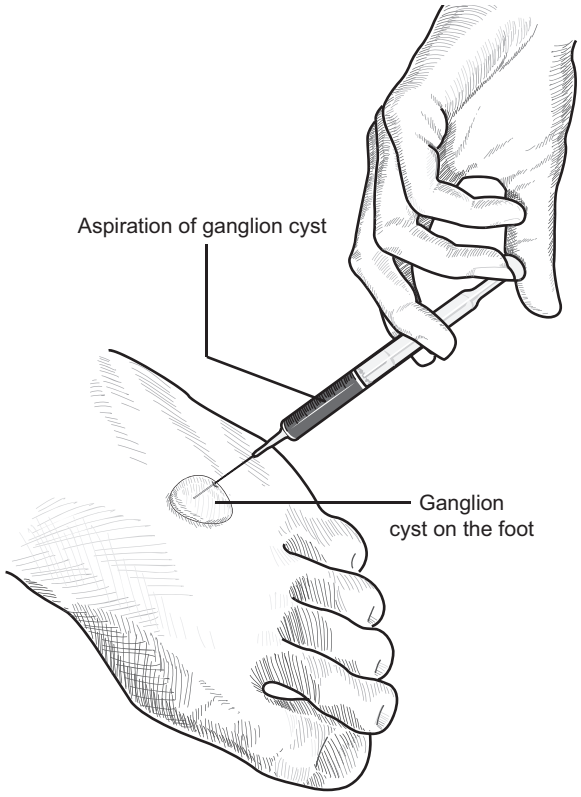
20612

Aspiration and/or injection of ganglion cyst(s) any location

Clinical Responsibility

When the patient is appropriately prepped and the area anesthetized, the provider inserts a sharp needle through the external skin surface and into the ganglion cyst. Using a syringe, he aspirates the cyst to drain it of the colorless jellylike material inside. He may submit a sample to a laboratory for inspection. In some cases, the provider may inject a destructive or anti-inflammatory substance into the ganglion cyst.

Illustration



20612

Pathology and Laboratory

80305

Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only (eg, utilizing immunoassay [eg, dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service

Clinical Responsibility

The lab analyst performs all the technical steps of test(s) on a patient specimen, such as urine or blood, to test for any number of drug classes as presumptive screening. Presumptive refers to drug test results that indicate possible but not definitive presence of drugs and/or metabolites. The lab analyst may use any method capable of being read by direct optical observation only, often utilizing immunoassay, including dipsticks, cups, cards, and cartridges.

The lab analyst may also perform tests to validate that the specimen is urine and is from the patient, such as urinalysis, creatinine, or pH.

Although not limited to testing for a specific condition, clinicians may order this test for cases of suspected drug overdose or as a screening test for possible drug abuse. The test provides qualitative results, and the clinician may order follow-up testing to quantify the amount of a substance in the patient specimen for any drug class(es) that yield a positive result on this screening test.

Coding Tips

Report just one unit of 80305 per date of service.

Some payers may pay separately for collecting the specimen using a code such as 36415.

Do not separately bill for sample validation, which involves testing to ensure that the specimen is urine, as well as protocols to ensure that the specimen is from the patient. For instance, the lab analyst may perform additional tests such as urinalysis (81003, Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy) or creatinine (82570, Creatinine; other source) or pH (83986, pH; body fluid, not otherwise specified), but you should not bill those codes in addition to the presumptive drug test code.

For a similar presumptive drug test that uses instrument assistance, report 80306 (Drug test[s], presumptive, any number of drug classes, any number of devices or procedures, [e.g., immunoassay]; read by instrument assisted direct optical observation [e.g., dipsticks, cups, cards, cartridges], includes sample validation when performed, per date of service).

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $0.00, Non Facility Fee: $0.00

RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00
RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: X, PC/TC Indicator: 9, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

59, 90, 91, 92, 99, AR, CR, ET, GA, GC, GR, GY, GZ, KX, Q0, Q5, Q6, QJ, QP, QW, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0119U[1], 0251U[1], 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], 84156[1], 84311[1], 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.

80306

Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation (eg, utilizing immunoassay [eg, dipsticks, cups, cards, or cartridges]), includes sample validation when performed, per date of service

Clinical Responsibility

The lab analyst performs all the technical steps of tests on a patient specimen, such as urine or blood, to test for any number of drug classes as presumptive screening. Presumptive refers to drug test results that indicate possible but not definitive presence of drugs and/or metabolites. The lab analyst may use any method read by instrument-assisted direct optical observation only, including dipsticks, cups, cards, and cartridges.

The lab analyst may also perform tests to validate that the specimen is urine and is from the patient, such as urinalysis, creatinine, or pH.

Although not limited to testing for a specific condition, clinicians may order this test for cases of suspected drug overdose or as a screening test for possible drug abuse. The test provides qualitative results, and the clinician may order follow-up testing to quantify the amount of a substance in the patient specimen for any drug class or classes that yield a positive result on this screening test.

Coding Tips

Report just one unit of 80306 per date of service.

Some payers may pay separately for collecting the specimen using a code such as 36415.

Do not separately bill for sample validation, which involves testing to ensure that the specimen is urine, as well as protocols to ensure that the specimen is from the patient. For instance, the lab analyst may perform additional tests such as urinalysis (81003, Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy) or creatinine (82570, Creatinine; other source) or pH (83986, pH; body fluid, not otherwise specified), but you should not bill those codes in addition to the presumptive drug test code.

For a similar presumptive drug test that does not use instrument assistance, report 80305 (Drug test[s], presumptive, any number of drug classes, any number of devices or procedures [e.g., immunoassay]; capable of being read by direct optical observation only [e.g., dipsticks, cups, cards, cartridges] includes sample validation when performed, per date of service).

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $0.00, Non Facility Fee: $0.00
RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00
RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: X, PC/TC Indicator: 9, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

59, 90, 91, 92, 99, AR, CR, ET, GA, GC, GR, GY, GZ, KX, Q0, Q5, Q6, QJ, QP, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0119U[1], 0251U[1], 80305[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], 84156[1], 84311[1], 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.

80307

Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service

Clinical Responsibility

The lab analyst performs all the technical steps of drug screening procedure(s) to presumptively identify any drug classes using instrumented chemistry analysis. Examples of lab methods that fit this code include immunoassays, such as enzyme-linked immunosorbent assay (ELISA) or any other immunoassay, including the many examples listed in the code. Other methods described by this code include chromatography, such as gas chromatography (GC) or liquid chromatography (LC), which separates components by passing the mixture through a mobile phase in which the components move at different rates. Still other methods include mass spectrometry (MS), which is a technique to identify the components and amounts of a mixture by ionizing, separating by mass to charge ratio, and detecting the components. The lab analyst might also use one of several specialized mass spectrometry procedures such as time of flight (TOF), matrix assisted laser desorption ionization (MALDI), laser diode thermal desorption (LDTD), and desorption electrospray ionization (DESI).

Although not limited to testing for a specific condition, clinicians may order this test for cases of suspected drug overdose or as a screening test for possible drug abuse. The clinician may order follow-up testing to for definitive results and to quantify the amount of a substance in the patient specimen for any drug class or classes that yield a positive result on this screening test.

Coding Tips

Report just one unit of 80307 per date of service.

Some payers may pay separately for collecting the specimen using a code such as 36415.

Do not separately bill for sample validation, which involves testing to ensure that the specimen is urine, as well as protocols to ensure that the specimen is from the patient. For instance, the lab analyst may perform additional tests such as urinalysis (81003, Urinalysis, by dip stick or tablet reagent for bilirubin, glucose, hemoglobin, ketones, leukocytes, nitrite, pH, protein, specific gravity, urobilinogen, any number of these constituents; automated, without microscopy) or creatinine (82570, Creatinine; other source) or pH (83986, pH; body fluid, not otherwise specified), but you should not bill those codes in addition to the presumptive drug test code.

For a presumptive drug test that provides a result only by direct optical observation with or without instrument assistance, don't use 80307 but choose the appropriate code 80305 (Drug test[s], presumptive, any number of drug classes, any number of devices or procedures [e.g., immunoassay]; capable of being read by direct optical observation only [e.g., dipsticks, cups, cards, cartridges] includes sample validation when performed, per date of service) or 80306 (…read by instrument assisted direct optical observation [e.g., dipsticks, cups, cards, cartridges], includes sample validation when performed, per date of service).

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $0.00, Non Facility Fee: $0.00
RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00

HCPCS Level II Codes

Procedures/Professional Services

G0031

Palliative care services given to patient any time during the measurement period

Clinical Responsibility

Documentation for a patient indicates the patient received palliative care at any time during the relevant program measure's measurement period. Palliative care is the treatment or relief of symptoms of a condition that does not cure the disease or condition.

This is a tracking code for performance measurement.

BETOS

Z2: Undefined codes

G0034

Patients receiving palliative care during the measurement period

Clinical Responsibility

Documentation for a patient indicates the patient received palliative care during the relevant program measure's measurement period. Palliative care is the treatment or relief of symptoms of a condition that does not cure the disease or condition.

This is a tracking code for performance measurement.

BETOS

Z2: Undefined codes

G0048

Patients who receive palliative care services any time during the intake period through the end of the measurement year

Clinical Responsibility

Documentation for a patient indicates the patient received palliative care at any time during the intake period through the end of the relevant program measure's measurement year. Palliative care is the treatment or relief of symptoms of a condition that does not cure the disease or condition.

This is a tracking code for performance measurement.

BETOS

Z2: Undefined codes

G0068

Professional services for the administration of anti-infective, pain management, chelation, pulmonary hypertension, inotropic, or other intravenous infusion drug or biological (excluding chemotherapy or other highly complex drug or biological) for each infusion drug administration calendar day in the individual's home, each 15 minutes

Clinical Responsibility

A skilled provider performs professional services needed for the administration of the specified home infusion drugs. Report the code once for each 15 minutes of professional services in a calendar infusion day. This code applies only to a subsequent visit, not the initial visit.

Professional services vary based on patient needs, but could include items like nursing services, patient evaluation and assessment, training and education, and evaluating medication administration.

Anti-infective drugs may include antibiotics (to treat bacteria) or antivirals (to treat viral infections). Pain management may require opioid (narcotic) drugs like morphine and fentanyl. Chelation drugs are agents that bind to toxic material, which then can be flushed out to remove the toxic substances from the body. Vasodilators that dilate (widen) the blood vessels to treat vasoconstriction (narrowing of the blood vessels) are the types of drugs used to treat pulmonary hypertension. Pulmonary hypertension refers to elevated blood pressure in the pulmonary artery circulation, typically due to excessive blood flow or obstruction. Inotropic agents are drugs that change the force of the heart, some of which strengthen the heart's contractions (positive inotropes) while some weaken the heart's contractions (negative inotropes).

Coding Tips

For initial services, see G0088.

Check payer guidelines regarding rules for this code, including what time threshold must be met to report 1 unit.

BETOS

M4A: Home visit

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 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 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

G3002

Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (when using g3002, 30 minutes must be met or exceeded.)

Clinical Responsibility

Report this code for the first 30 minutes of chronic pain management and treatment services personally provided by a physician or other qualified healthcare professional in a calendar month. The monthly bundle includes many components, such as diagnosis, assessment and monitoring, and administering a validated pain rating scale or tool. The monthly bundle also includes developing, implementing, revising, and/or maintaining a care plan specific to the patient that includes strengths, goals, clinical needs, and desired outcomes. The provider also provides overall treatment management, facilitates and coordinates behavioral health treatment, manages the patient's medication, counsels the patient to improve their pain and health literacy, and provides crisis care related to chronic pain. The provider is also involved in communication and care coordination between relevant practitioners furnishing care. This may include physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, depending on patient needs. Chronic pain management and treatment services require a physician or other qualified health professional to provide an initial face-to-face visit lasting at least 30 minutes.

Coding Tips

Time must meet or exceed 30 minutes to use this code. See G3003 for each additional 15 minutes.

BETOS

P5E: Ambulatory procedures - other

G3003

Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month. (list separately in addition to code for g3002. when using g3003, 15 minutes must be met or exceeded.)

Clinical Responsibility

Report this code for each additional 15 minutes after the first 30 minutes of chronic pain management and treatment services personally provided by a physician or other qualified healthcare professional in a calendar month. The monthly bundle includes many components, such as diagnosis, assessment and monitoring, and administering a validated pain rating scale or tool. The monthly bundle also includes developing, implementing, revising, and/or maintaining a care plan specific to the patient that includes strengths, goals, clinical needs, and desired outcomes. The provider also provides overall treatment management, facilitates and coordinates behavioral health treatment, manages the patient's medication, counsels the patient to improve their pain and health literacy, and provides crisis care related to chronic pain. The provider is also involved in communication and care coordination between relevant practitioners furnishing care. This may include physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, depending on patient needs. Chronic pain management and treatment services require a physician or other qualified health professional to provide an initial face-to-face visit lasting at least 30 minutes.

Coding Tips

See G3002 for the first 30 minutes. Report this code only once additional time reaches a full 15 minutes.

BETOS

P5E: Ambulatory procedures - other

G9902

Patient screened for tobacco use and identified as a tobacco user

Clinical Responsibility

The provider administers a written survey or questions the patient directly regarding tobacco use, and the patient acknowledges they use tobacco. The provider documents findings for the patient smoking assessment and the date of the visit in the patient's record.

Tobacco use or exposure is implicated in numerous diseases from cancers of the mouth and oral cavity, lungs, and bladder to respiratory and cardiovascular diseases such as asthma, bronchitis, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), and stroke.

BETOS

Z2: Undefined codes

G9903

Patient screened for tobacco use and identified as a tobacco non-user

Clinical Responsibility

The provider administers a written survey or questions the patient directly regarding tobacco use, and the patient states that they do not use tobacco. The provider documents findings for the patient smoking assessment and the date of the visit in the patient's record.

Tobacco use or exposure is implicated in numerous diseases from cancers of the mouth and oral cavity, lungs, and bladder to respiratory and cardiovascular diseases such as asthma, bronchitis, chronic obstructive pulmonary disease (COPD), coronary artery disease (CAD), and stroke.

BETOS

Z2: Undefined codes

G9905

Patient not screened for tobacco use

Clinical Responsibility

The provider does not administer a written survey or otherwise question the patient directly regarding tobacco use.

This is a tracking code for performance measurement.

BETOS

Z2: Undefined codes

G9906

Patient identified as a tobacco user received tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy)

Clinical Responsibility

Documentation shows that a patient identified as a tobacco user received cessation counseling and/or a prescription for drug therapy to help the patient quit using tobacco. The tobacco cessation intervention occurred during the measurement period or in the six months prior to the measurement period.

Counseling may involve educating the patient on the health effects of tobacco use and advice on how to quit using tobacco. The provider may prescribe medication to help a patient quit using tobacco. The code applies when counseling, pharmacotherapy, or both occur as tobacco cessation intervention services.

This is a tracking code for performance measurement.

BETOS

Z2: Undefined codes

G9908

Patient identified as tobacco user did not receive tobacco cessation intervention during the measurement period or in the six months prior to the measurement period (counseling and/or pharmacotherapy)

Clinical Responsibility

Documentation does not show that a patient identified as a tobacco user received cessation counseling and/or a prescription for drug therapy to help the patient quit using tobacco. The relevant timeframe is the measurement period or in the six months prior to the measurement period.

This is a tracking code for performance measurement.

BETOS

Z2: Undefined codes

G9928

Fda-approved anticoagulant not prescribed, reason not given

Clinical Responsibility

Documentation shows the patient has not been prescribed an anticoagulant approved by the Food and Drug Administration (FDA). Anticoagulants inhibit the clotting of blood and prevent thrombosis (blood clots). If the blood clot obstructs a blood vessel (thromboembolism), it can cause a condition such as stroke. The provider does not document a reason for not prescribing an anticoagulant.

This is a tracking code for performance measurement.

BETOS

Z2: Undefined codes

G9943

Back pain was not measured by the visual analog scale (vas) or numeric pain scale at three months (6 - 20 weeks) postoperatively

Clinical Responsibility

The visual analog scale (VAS) is a visual pain assessment scale used to assess pain intensity. It consists of a straight line that has endpoints that define extreme limits. One endpoint indicates "no pain at all" and the other indicates "pain as bad as it could be." The provider asks the patient to mark the pain level on this straight line. A verbal numeric pain scale is similar, often using a 0 to 10 scale, with 0 meaning "no pain" and 10 meaning "the worst pain imaginable."

This code indicates that the patient was not asked to assess their back pain using the VAS or numeric pain scale at approximately three months (six to 20 weeks) after surgery.

ICD-10-CM Cross Reference Details

A02.21 Salmonella meningitis
A05.1 Botulism food poisoning
A15.5 Tuberculosis of larynx, trachea and bronchus
A17.0 Tuberculous meningitis
A17.81 Tuberculoma of brain and spinal cord
A17.82 Tuberculous meningoencephalitis
A17.83 Tuberculous neuritis
A17.89 Other tuberculosis of nervous system
A17.9 Tuberculosis of nervous system, unspecified
A18.01 Tuberculosis of spine
A18.03 Tuberculosis of other bones
A27.81 Aseptic meningitis in leptospirosis
A31.0 Pulmonary mycobacterial infection
A35 Other tetanus
A36.0 Pharyngeal diphtheria
A36.1 Nasopharyngeal diphtheria
A36.2 Laryngeal diphtheria
A39.82 Meningococcal retrobulbar neuritis
A50.43 Late congenital syphilitic polyneuropathy
A51.41 Secondary syphilitic meningitis
A52.11 Tabes dorsalis
A52.13 Late syphilitic meningitis
A52.15 Late syphilitic neuropathy
A52.19 Other symptomatic neurosyphilis
A52.2 Asymptomatic neurosyphilis
A52.3 Neurosyphilis, unspecified
A54.81 Gonococcal meningitis
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
B02.39 Other herpes zoster eye disease
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
B37.5 Candidal meningitis
B38.4 Coccidioidomycosis meningitis
B45.1 Cerebral cryptococcosis
B91 Sequelae of poliomyelitis
B97.21 SARS-associated coronavirus as the cause of diseases classified elsewhere
B97.29 Other coronavirus as the cause of diseases classified elsewhere
B97.35 Human immunodeficiency virus, type 2 [HIV 2] as the cause of diseases classified elsewhere
B97.4 Respiratory syncytial virus as the cause of diseases classified elsewhere
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
C22.2 Hepatoblastoma
C22.3 Angiosarcoma of liver
C22.4 Other sarcomas of liver
C22.7 Other specified carcinomas of liver

C22.8 Malignant neoplasm of liver, primary, unspecified as to type
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
C33 Malignant neoplasm of trachea
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
C43.52 Malignant melanoma of skin of breast
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
C44.501 Unspecified malignant neoplasm of skin of breast
C44.511 Basal cell carcinoma of skin of breast
C44.521 Squamous cell carcinoma of skin of breast
C44.591 Other specified malignant neoplasm of skin of breast
C44.90 Unspecified malignant neoplasm of skin, unspecified
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

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	Definition
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 fibrosus	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.
Antiinflammatory	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	Definition
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 fluid, 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 member	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.

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