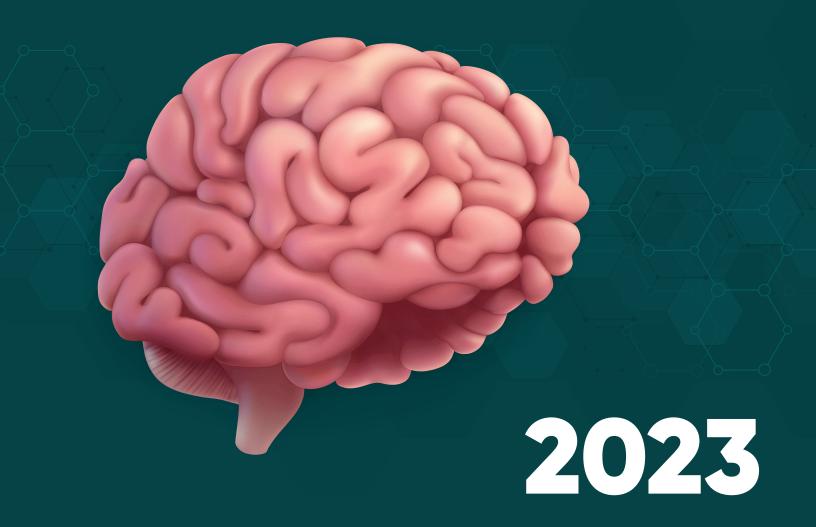


Your essential illustrated coding guide for neurology/neurosurgery including CPT®, HCPCS Level II, tips, CPT® to ICD-10 CrossRef, CCI edits, and RVU information.

CODERS' SPECIALTY GUIDE

Neurology & Neurosurgery



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Anesthesia **01937** — **01937**

01937

Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; cervical or thoracic

Advice

CPT® adds 01937-01942 to replace deleted codes 01935 (diagnostic) and 01936 (therapeutic) for anesthesia for percutaneous image-guided procedures on the spine and spinal cord. The descriptors for the new codes vary based on anatomic area and procedure type. Code 01937 is specific to percutaneous image-guided injection, drainage, or aspiration procedures on the cervical or thoracic spine or spinal cord.

Effective date of this code: January 1, 2022.

Clinical Responsibility

The anesthesia provider performs a pre-operative evaluation of the patient. The anesthesia provider induces the patient and monitors the patient during the percutaneous image-guided injection, drainage, or aspiration procedures on the cervical or thoracic spine or spinal cord that a different provider performs. The anesthesia provider notes any types and amounts of medications administered, all forms of monitoring used, patient responses, and the start and stop times of anesthesia care. Following the procedure, the anesthesia provider oversees the patient's transfer to post-anesthesia care.

The services represented by anesthesia codes 00100-01999 include a pre- and post-operative visit to assess the patient, anesthesia care during the procedure, the administration of fluids and/or blood as necessary, and standard monitoring services such as ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry. Standard anesthesia services do not include unusual forms of monitoring such as the use of Swan-Ganz catheters, intra-arterial lines, or central venous lines, and you therefore may code those separately when sufficient supporting documentation is available.

Coding Tips

Anesthesia time is the period of time when the anesthesia provider is present with the patient. It starts when the anesthesia provider prepares the patient for anesthesia induction in the operating room or procedure room, not during the pre-anesthesia evaluation. The anesthesia provider's time associated with the patient's care ends when the anesthesia provider no longer renders services to the patient or another provider assumes responsibility for the patient's postoperative care. Payers typically use anesthesia time as part of the unit calculation for the anesthesia service. For instance, a payer may count each 15-minute block of time as a single unit, so you'd divide the total anesthesia minutes by 15 to determine the time units. Other payers may require the use of an 8-minute or 10-minute block of time. You then add the time units to the number of base units the payer assigns to the anesthesia code to determine the total units. The anesthesia provider documents total anesthesia time in the patient's anesthesia medical record. Report the total units of time in block 24G of the CMS-1500 form.

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

Assign a qualifying circumstances code to complex anesthesia cases including 99100, Anesthesia for patient of extreme age, younger than 1 year and older than 70; 99116, Anesthesia complicated by utilization of total body hypothermia; 99135, Anesthesia complicated by utilization of controlled hypotension; and 99140, Anesthesia complicated by emergency conditions.

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

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

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

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

e anesthesia provider performs a pre-operative evaluation of the patient. The anesthesia provider induces the patient and monitors the patient during the percutaneous image-guided injection, drainage, or aspiration procedures on the cervical or thoracic spine or spinal cord that a different provider performs. The anesthesia provider notes any types and amounts of medications administered, all forms of monitoring used, patient responses, and the start and stop times of anesthesia care. Following the procedure, the anesthesia provider oversees the patient's transfer to post-anesthesia care.

The services represented by anesthesia codes 00100-01999 include a pre- and post-operative visit to assess the patient, anesthesia care during the procedure, the administration of fluids and/or blood as necessary, and standard monitoring services such as ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry. Standard anesthesia services do not include unusual forms of monitoring such as the use of Swan-Ganz catheters, intra-arterial lines, or central venous lines, and you therefore may code those separately when sufficient supporting documentation is available.

Fee Schedule

Medicare Fees National Conversion Factor: 34.8931, Facility: \$0.00, Non Facility: \$0.00, OPPS Facility: \$0.00, OPPS Non Facility: \$0.00 **RVU Facility** Work RVU: 0.00, PE RVU: 0.00, Malpractice RVU: 0.00, Total RVU: 0.00

RVU Non-Facility Work RVU: 0.00, PE RVU: 0.00, Malpractice RVU: 0.00, Total RVU: 0.00

Indicators Preoperative: 0.00, Intraoperative: 0.00, Postoperative: 0.00, Total RVU: 0, Global Period: 0, Radiology Diagnostic Test: 0, Code Status: 0, PC/TC Indicator: 0, Endoscopic Base Code: None, MUE: 0

Modifier Allowances 23, AA, AD, G8, G9, GC, P1, P2, P3, P4, P5, P6, QK, QS, QX, QY, QZ

CCI Alerts (version 27.3)

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

ICD-10 CrossRef

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

01938

Anesthesia for percutaneous image-guided injection, drainage or aspiration procedures on the spine or spinal cord; lumbar or sacral

Advice

CPT® adds 01937-01942 to replace deleted codes 01935 (diagnostic) and 01936 (therapeutic) for anesthesia for percutaneous image-guided procedures on the spine and spinal cord. The descriptors for the new codes vary based on anatomic area and procedure type. Code 01938 is specific to percutaneous image-guided injection, drainage, or aspiration procedures on the lumbar or sacral spine or spinal cord.

Effective date of this code: January 1, 2022.

Clinical Responsibility

The anesthesia provider performs a pre-operative evaluation of the patient. The anesthesia provider induces the patient and monitors the patient during the percutaneous image-guided injection, drainage, or aspiration procedures on the lumbar or sacral spine or spinal cord that a different provider performs. The anesthesia provider notes any types and amounts of medications administered, all forms of monitoring used, patient responses, and the start and stop times of anesthesia care. Following the procedure, the anesthesia provider oversees the patient's transfer to post-anesthesia care.

The services represented by anesthesia codes 00100-01999 include a pre- and post-operative visit to assess the patient, anesthesia care during the procedure, the administration of fluids and/or blood as necessary, and standard monitoring services such

as ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry. Standard anesthesia services do not include unusual forms of monitoring such as the use of Swan-Ganz catheters, intra-arterial lines, or central venous lines, and you therefore may code those separately when sufficient supporting documentation is available.

Coding Tips

Anesthesia time is the period of time when the anesthesia provider is present with the patient. It starts when the anesthesia provider prepares the patient for anesthesia induction in the operating room or procedure room, not during the pre-anesthesia evaluation. The anesthesia provider's time associated with the patient's care ends when the anesthesia provider no longer renders services to the patient or another provider assumes responsibility for the patient's postoperative care. Payers typically use anesthesia time as part of the unit calculation for the anesthesia service. For instance, a payer may count each 15-minute block of time as a single unit, so you'd divide the total anesthesia minutes by 15 to determine the time units. Other payers may require the use of an 8-minute or 10-minute block of time. You then add the time units to the number of base units the payer assigns to the anesthesia code to determine the total units. The anesthesia provider documents total anesthesia time in the patient's anesthesia medical record. Report the total units of time in block 24G of the CMS-1500 form.

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

Assign a qualifying circumstances code to complex anesthesia cases including 99100, Anesthesia for patient of extreme age, younger than 1 year and older than 70; 99116, Anesthesia complicated by utilization of total body hypothermia; 99135, Anesthesia complicated by utilization of controlled hypotension; and 99140, Anesthesia complicated by emergency conditions.

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

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

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

Medicare reimburses anesthesia services for the following types of providers: qualified anesthesiologist, doctor of medicine or osteopathy other than an anesthesiologist, dentist, oral surgeon,

22850

Removal of posterior nonsegmental instrumentation (eg, Harrington rod)

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider makes a longitudinal incision over the affected area. He dissects the surrounding muscles and tissues to expose the instrumentation completely. He removes the screws and or other fixation from either end of the nonsegmental instrumentation device and detaches it. The provider then irrigates the area with antibiotics, checks for bleeding, removes any instruments, and closes the incision.

Coding Tips

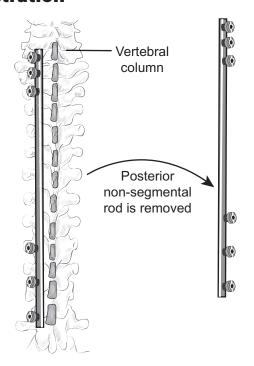
There are ten codes you can choose from when you report spinal instrumentation from the section 22840 to 22870, Spinal instrumentation procedures on the spine, vertebral column. Identify the correct code beginning with the approach for the instrumentation, anterior or posterior. Next, determine if the device is segmental or nonsegmental. Count the fixation points. Irrespective of the span, if the instrumentation is done to only two vertebral segments, consider the instrumentation to be nonsegmental. If, however, the instrumentation involves three or more vertebral segments, the instrumentation is considered segmental. If there is a proximal and distal fixation point with at least one intervening fixation point, the fixation is considered to be segmental. Confirm the removal of vertebral portions. Know the difference between segments and levels; count one vertebra per segment, two vertebrae per level.

You can report instrumentation removal if the provider removes the instrumentation for damage or rejection. You can also report the instrumentation removal if your provider did it to adjust the instrumentation. If, however, the provider does the removal to explore the spinal fusion, you cannot report the instrumentation removal.

Confirm with your payer which modifiers are approved for spinal instrumentation services, as not all may be accepted. Some will permit modifier 59, Distinct procedural service, to demonstrate that the provider did the instrumentation at separate anatomic locations.

When your provider is removing the instrumentation in the global period and an infection necessitates the return of the patient to the operating room for removal, append modifier 78, Unplanned return to the operating or procedure room by the same provider following initial procedure for a related procedure during the postoperative period.

Illustration



22850

Fee Schedule

Medicare Fees National Conversion Factor: 34.8931, Facility: \$756.13, Non Facility: \$756.13, OPPS Facility: \$342.65, OPPS Non Facility: \$342.65

RVU Facility Work RVU: 9.82, PE RVU: 9.11, Malpractice RVU: 2.74, Total RVU: 21.67

RVU Non-Facility Work RVU: 9.82, PE RVU: 9.11, Malpractice RVU: 2.74, Total RVU: 21.67

Indicators Preoperative: 10.00, Intraoperative: 69.00, Postoperative: 21.00, Total RVU: 100, Global Period: 090, Radiology Diagnostic Test: 99, Code Status: A, PC/TC Indicator: 0, Endoscopic Base Code: None MUE: 1

Modifier Allowances 22, 47, 51, 52, 53, 54, 55, 56, 58, 59, 62, 63, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, KX, Q5, Q6, QJ, XE, XP, XS, XU

CCI Alerts (version 27.3)

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0213T°, 0216T°, 0333T°, 0464T°, 0596T¹, 0597T¹, 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, 13101¹, 13102¹, 13120¹, 13121¹, 13122¹, 13131¹, 13132¹, 13133¹, 13151¹, 13152¹, 13153¹, 20650¹, 22010¹, 22015¹, 22505°, 22830¹, 22841°, 22848¹, 29000°, 29010°, 29015°, 29035°, 29040°, 29044°, 29046°, 29200°, 36000¹, 36400¹, 36400¹, 36400¹, 36400¹, 36400¹, 36400¹, 36400¹, 36400¹, 36400¹, 36600¹, 36600¹, 36640¹, 38220°, 38232°, 38232°, 62323°, 62324°, 51701¹, 51702¹, 51703¹, 62320°, 62321°, 62322°, 62323°, 62324°,
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62325°, 62326°, 62327°, 63707°, 63709°, 64400°, 64405°, 64408°, 64415°, 64416°, 64417°, 64418°, 64420°, 64421°, 64425°, 64430°, 64435°, 64445°, 64446°, 64447°, 64448°, 64449°, 64450°, 64451°, 64454¹, 64461⁰, 64462⁰, 64463⁰, 64479⁰, 64480⁰, 64483⁰, 64484⁰, 64486⁰, 64487⁰, 64488⁰, 64489⁰, 64490⁰, 64491⁰, 64492⁰, 64493⁰, 64494⁰, 64495⁰, 64505⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 76000¹, 77001¹, 77002¹, 92012¹, 92014¹, 92652⁰, 92653⁰, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 93355¹, 94002¹, 94200¹, 94680¹, 94681¹, 94690¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822⁰, 95829¹, 95860⁰, 95861⁰, 95863⁰, 95864⁰, 95865⁰, 95866⁰, 95867⁰, 958680, 958690, 958700, 959070, 959080, 959090, 959100, 959110, 959120, 959130, 959250, 959260, 959270, 959280, 959290, 959300, 95933⁰, 95937⁰, 95938⁰, 95939⁰, 95940⁰, 95955¹, 96360¹, 96361¹, 96365¹, 96366¹, 96367¹, 96368¹, 96372¹, 96374¹, 96375¹, 96376¹, 96377¹, 96523⁰, 97597¹, 97598¹, 97602¹, 99155⁰, 99156⁰, 99157⁰, 99211¹, 99212¹, 99213¹, 99214¹, 99215¹, 99217¹, 99218¹, 99219¹, 99220¹, 99221¹, 99222¹, 99223¹, 99231¹, 99232¹, 99233¹, 99234¹, 992351, 992361, 992381, 992391, 992411, 992421, 992431, 992441, 99245¹, 99251¹, 99252¹, 99253¹, 99254¹, 99255¹, 99291¹, 99292¹, 99304¹, 99305¹, 99306¹, 99307¹, 99308¹, 99309¹, 99310¹, 99315¹, 99316¹, 99334¹, 99335¹, 99336¹, 99337¹, 99347¹, 99348¹, 99349¹, 99350¹, 99374¹, 99375¹, 99377¹, 99378¹, 99446⁰, 99447⁰, 99448⁰, 99449⁰, 99451⁰, 99452⁰, 99495⁰, 99496⁰, G0453⁰, G0463¹, G0471¹

ICD-10 CrossRef

M96.0, T84.216A, T84.226A, T84.296A, T84.418A, T84.428A, T84.498A, T84.63XA, T84.7XXA, T84.84XA, T84.85XA, T84.86XA, T84.89XA, T84.9XXA, Z47.2, Z98.1

22852

Removal of posterior segmental instrumentation

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider makes a longitudinal incision over the affected area. He dissects the surrounding muscles and tissues to expose the instrumentation completely. He removes the screws and/or other fixation from each vertebral segment and detaches it. The provider then irrigates the area with antibiotics, checks for bleeding, removes any instruments, and closes the incision.

Coding Tips

There are ten codes you can choose from when you report spinal instrumentation from the section 22840 to 22870, Spinal instrumentation procedures on the spine, vertebral column. Identify the correct code beginning with the approach for the instrumentation, anterior or posterior. Next, determine if the device is segmental or nonsegmental. Count the fixation points. Irrespective of the span, if the instrumentation is done to only two vertebral segments, consider the instrumentation to be nonsegmental. If, however, the instrumentation involves three or more vertebral segments, the instrumentation is considered segmental. If there is a proximal and distal fixation point with at least one intervening fixation point, the fixation is considered to be segmental. Confirm the removal of vertebral portions. Know

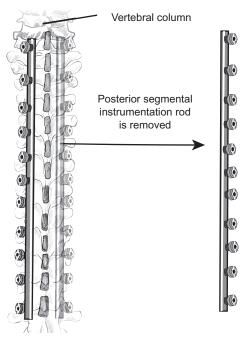
the difference between segments and levels; count one vertebra per segment, two vertebrae per level.

You can report instrumentation removal if the provider removes the instrumentation for damage or rejection. You can also report the instrumentation removal if your provider did it to adjust the instrumentation. If, however, the provider does the removal to explore the spinal fusion, you cannot report the instrumentation removal.

Confirm with your payer which modifiers are approved for spinal instrumentation services, as not all may be accepted. Some will permit modifier 59, Distinct procedural service, to demonstrate that the provider did the instrumentation at separate anatomic locations.

When your provider is removing the instrumentation in the global period and an infection necessitates the return of the patient to the operating room for removal, append modifier 78, Unplanned return to the operating or procedure room by the same provider following initial procedure for a related procedure during the postoperative period.

Illustration



22852

Fee Schedule

Medicare Fees National Conversion Factor: 34.8931, Facility: \$727.17, Non Facility: \$727.17, OPPS Facility: \$326.95, OPPS Non Facility: \$326.95

RVU Facility Work RVU: 9.37, PE RVU: 8.88, Malpractice RVU: 2.59, Total RVU: 20.84

RVU Non-Facility Work RVU: 9.37, PE RVU: 8.88, Malpractice RVU: 2.59, Total RVU: 20.84

63050

Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments

Clinical Responsibility

Under anesthesia, the physician makes an incision into the skin of the back of the neck. A groove created in one side of the cervical vertebrae. The other side of the vertebrae is then cut all the way through. Then the physician removes the tips of the vertebrae. After that, the back of each vertebrae is opened which takes pressure off of the spinal cord and nerve root. Finally, small wedges are created from bone that is placed in the open space.

Fee Schedule

Medicare Fees National Conversion Factor: 34.8931, Facility: \$1,540.88, Non Facility: \$1,540.88, OPPS Facility: \$768.00, OPPS Non Facility: \$768.00

RVU Facility Work RVU: 22.01, PE RVU: 15.83, Malpractice RVU: 6.32, Total RVU: 44.16

RVU Non-Facility Work RVU: 22.01, PE RVU: 15.83, Malpractice RVU: 6.32, Total RVU: 44.16

Indicators Preoperative: 11.00, Intraoperative: 76.00, Postoperative: 13.00, Total RVU: 100, Global Period: 090, Radiology Diagnostic Test: 99, Code Status: A, PC/TC Indicator: 0, Endoscopic Base Code: None, MUE: 1

Modifier Allowances 22, 51, 52, 53, 54, 55, 56, 58, 59, 62, 63, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, KX, Q5, Q6, QJ, XE, XP, XS, XU

CCI Alerts (version 27.3)

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0213T<sup>0</sup>, 0216T<sup>0</sup>, 0274T<sup>1</sup>, 0333T<sup>0</sup>, 0464T<sup>0</sup>, 0565T<sup>1</sup>, 0596T<sup>1</sup>, 0597T<sup>1</sup>,
11000<sup>1</sup>, 11001<sup>1</sup>, 11004<sup>1</sup>, 11005<sup>1</sup>, 11006<sup>1</sup>, 11042<sup>1</sup>, 11043<sup>1</sup>, 11044<sup>1</sup>,
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12007<sup>1</sup>, 12011<sup>1</sup>, 12013<sup>1</sup>, 12014<sup>1</sup>, 12015<sup>1</sup>, 12016<sup>1</sup>, 12017<sup>1</sup>, 12018<sup>1</sup>,
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12053<sup>1</sup>, 12054<sup>1</sup>, 12055<sup>1</sup>, 12056<sup>1</sup>, 12057<sup>1</sup>, 13100<sup>1</sup>, 13101<sup>1</sup>, 13102<sup>1</sup>,
13120<sup>1</sup>, 13121<sup>1</sup>, 13122<sup>1</sup>, 13131<sup>1</sup>, 13132<sup>1</sup>, 13133<sup>1</sup>, 13151<sup>1</sup>, 13152<sup>1</sup>,
13153<sup>1</sup>, 15769<sup>1</sup>, 22100<sup>1</sup>, 22505<sup>0</sup>, 22600<sup>1</sup>, 22614<sup>1</sup>, 36000<sup>1</sup>, 36400<sup>1</sup>,
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36592<sup>0</sup>, 36600<sup>1</sup>, 36640<sup>1</sup>, 38220<sup>0</sup>, 38222<sup>0</sup>, 38230<sup>0</sup>, 38232<sup>0</sup>, 43752<sup>1</sup>,
51701<sup>1</sup>, 51702<sup>1</sup>, 51703<sup>1</sup>, 61783<sup>1</sup>, 62320<sup>0</sup>, 62321<sup>0</sup>, 62322<sup>0</sup>, 62323<sup>0</sup>,
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63045<sup>1</sup>, 63048<sup>1</sup>, 63295<sup>1</sup>, 63707<sup>1</sup>, 63709<sup>1</sup>, 64400<sup>0</sup>, 64405<sup>0</sup>, 64408<sup>0</sup>,
644150, 644160, 644170, 644180, 644200, 644210, 644250, 644300,
64435°, 64445°, 64446°, 64447°, 64448°, 64449°, 64450°, 64451°,
64454<sup>0</sup>, 64461<sup>0</sup>, 64462<sup>0</sup>, 64463<sup>0</sup>, 64479<sup>0</sup>, 64480<sup>0</sup>, 64483<sup>0</sup>, 64484<sup>0</sup>,
64486<sup>0</sup>, 64487<sup>0</sup>, 64488<sup>0</sup>, 64489<sup>0</sup>, 64490<sup>0</sup>, 64491<sup>0</sup>, 64492<sup>0</sup>, 64493<sup>0</sup>,
64494<sup>0</sup>, 64495<sup>0</sup>, 64505<sup>0</sup>, 64510<sup>0</sup>, 64517<sup>0</sup>, 64520<sup>0</sup>, 64530<sup>0</sup>, 69990<sup>0</sup>,
76000<sup>1</sup>, 77001<sup>1</sup>, 77002<sup>1</sup>, 92012<sup>1</sup>, 92014<sup>1</sup>, 92652<sup>0</sup>, 92653<sup>0</sup>, 93000<sup>1</sup>,
93005<sup>1</sup>, 93010<sup>1</sup>, 93040<sup>1</sup>, 93041<sup>1</sup>, 93042<sup>1</sup>, 93318<sup>1</sup>, 93355<sup>1</sup>, 94002<sup>1</sup>,
94200<sup>1</sup>, 94680<sup>1</sup>, 94681<sup>1</sup>, 94690<sup>1</sup>, 95812<sup>1</sup>, 95813<sup>1</sup>, 95816<sup>1</sup>, 95819<sup>1</sup>,
95822<sup>0</sup>, 95829<sup>1</sup>, 95860<sup>0</sup>, 95861<sup>0</sup>, 95863<sup>0</sup>, 95864<sup>0</sup>, 95865<sup>0</sup>, 95866<sup>0</sup>,
95867°, 95868°, 95869°, 95870°, 95907°, 95908°, 95909°, 95910°,
95911°, 95912°, 95913°, 95925°, 95926°, 95927°, 95928°, 95929°,
95930°, 95933°, 95937°, 95938°, 95939°, 95940°, 95955¹, 96360¹,
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96361<sup>1</sup>, 96365<sup>1</sup>, 96366<sup>1</sup>, 96367<sup>1</sup>, 96368<sup>1</sup>, 96372<sup>1</sup>, 96374<sup>1</sup>, 96375<sup>1</sup>, 96376<sup>1</sup>, 96377<sup>1</sup>, 96523<sup>0</sup>, 97597<sup>1</sup>, 97598<sup>1</sup>, 97602<sup>1</sup>, 99155<sup>0</sup>, 99156<sup>0</sup>, 99157<sup>0</sup>, 99211<sup>1</sup>, 99212<sup>1</sup>, 99213<sup>1</sup>, 99214<sup>1</sup>, 99215<sup>1</sup>, 99217<sup>1</sup>, 99218<sup>1</sup>, 99234<sup>1</sup>, 99232<sup>1</sup>, 99232<sup>1</sup>, 99232<sup>1</sup>, 99233<sup>1</sup>, 99234<sup>1</sup>, 99235<sup>1</sup>, 99236<sup>1</sup>, 99238<sup>1</sup>, 99239<sup>1</sup>, 99241<sup>1</sup>, 99242<sup>1</sup>, 99243<sup>1</sup>, 99244<sup>1</sup>, 99245<sup>1</sup>, 99251<sup>1</sup>, 99252<sup>1</sup>, 99253<sup>1</sup>, 99255<sup>1</sup>, 99291<sup>1</sup>, 99292<sup>1</sup>, 99304<sup>1</sup>, 99305<sup>1</sup>, 99306<sup>1</sup>, 99307<sup>1</sup>, 99308<sup>1</sup>, 99309<sup>1</sup>, 99310<sup>1</sup>, 99315<sup>1</sup>, 99316<sup>1</sup>, 99334<sup>1</sup>, 99335<sup>1</sup>, 99336<sup>1</sup>, 99377<sup>1</sup>, 99378<sup>1</sup>, 99347<sup>1</sup>, 99348<sup>1</sup>, 99349<sup>1</sup>, 99350<sup>1</sup>, 99374<sup>1</sup>, 99375<sup>1</sup>, 99377<sup>1</sup>, 99378<sup>1</sup>, 99446<sup>0</sup>, 99447<sup>0</sup>, 99448<sup>0</sup>, 99449<sup>0</sup>, 99451<sup>0</sup>, 99452<sup>0</sup>, 99495<sup>0</sup>, 99496<sup>0</sup>, G0453<sup>0</sup>, G0463<sup>1</sup>, G0471<sup>1</sup>
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ICD-10 CrossRef

G95.20, G95.89, G95.9, M08.1, M43.02, M43.03, M43.12, M43.13, M43.22, M43.23, M45.2, M45.3, M47.012, M47.013, M47.022, M47.12, M47.13, M47.22, M47.23, M47.812, M47.813, M47.892, M47.893, M48.02, M48.03, M48.52XA, M48.52XG, M48.53XA, M48.53XG, M48.8X2, M48.8X3, M50.00, M50.01, M50.020-M50.023, M50.03, M50.10, M50.11, M50.120-M50.123, M50.13, M50.20, M50.21, M50.23, M50.30, M50.31, M50.33, M50.80, M50.81, M50.820-M50.823, M50.83, M50.90, M50.91, M50.920-M50.923, M50.93, M53.82, M53.83, M54.12, M54.13, M54.2

63051

Laminoplasty, cervical, with decompression of the spinal cord, 2 or more vertebral segments; with reconstruction of the posterior bony elements (including the application of bridging bone graft and non-segmental fixation devices [eg, wire, suture, mini-plates], when performed)

Clinical Responsibility

The provider repairs the cervical lamina and decompresses the spinal cord for two or more vertebral segments with reconstruction of the posterior bony elements. Under anesthesia, the physician makes an incision into the skin of the back of the neck. A groove created in one side of the cervical vertebrae. The other side of the vertebrae is then cut all the way through. Then the physician removes the tips of the vertebrae. After that, the back of each vertebrae is opened which takes pressure off of the spinal cord and nerve root. Finally, small wedges are created from bone that is placed in the open space.

Fee Schedule

Medicare Fees National Conversion Factor: 34.8931, Facility: \$1,748.14, Non Facility: \$1,748.14, OPPS Facility: \$890.12, OPPS Non Facility: \$890.12

RVU Facility Work RVU: 25.51, PE RVU: 17.51, Malpractice RVU: 7.08, Total RVU: 50.10

RVU Non-Facility Work RVU: 25.51, PE RVU: 17.51, Malpractice RVU: 7.08, Total RVU: 50.10

Indicators Preoperative: 11.00, Intraoperative: 76.00, Postoperative: 13.00, Total RVU: 100, Global Period: 090, Radiology Diagnostic Test: 99, Code Status: A, PC/TC Indicator: 0, Endoscopic Base Code: None, MUE: 1

Modifier Allowances 22, 51, 52, 53, 54, 55, 56, 58, 59, 62, 63, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, KX, Q5, Q6, QJ, XE, XP, XS, XU

CCI Alerts (version 27.3)

0213T⁰, 0216T⁰, 0274T¹, 0333T⁰, 0464T⁰, 0565T¹, 0596T¹, 0597T¹, 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, 13101¹, 13102¹, 13120¹, 13121¹, 13122¹, 13131¹, 13132¹, 13133¹, 13151¹, 13152¹, 13153¹, 15769¹, 22100¹, 22505⁰, 22600¹, 22614¹, 36000¹, 36400¹, 36405¹, 36406¹, 36410¹, 36420¹, 36425¹, 36430¹, 36440¹, 36591⁰, 36592⁰, 36600¹, 36640¹, 38220⁰, 38222⁰, 38230⁰, 38232⁰, 43752¹, $51701^1, 51702^1, 51703^1, 61783^1, 62320^0, 62321^0, 62322^0, 62323^0,$ $62324^{\circ}, 62325^{\circ}, 62326^{\circ}, 62327^{\circ}, 63001^{1}, 63015^{1}, 63020^{1}, 63040^{1},$ 63045¹, 63048¹, 63050¹, 63055¹, 63265¹, 63295¹, 63707¹, 63709¹, 64400°, 64405°, 64408°, 64415°, 64416°, 64417°, 64418°, 64420°, 64421°, 64425°, 64430°, 64435°, 64445°, 64446°, 64447°, 64448°, 644490, 644500, 644510, 644540, 644610, 644620, 644630, 644790, $64480^{0}, 64483^{0}, 64484^{0}, 64486^{0}, 64487^{0}, 64488^{0}, 64489^{0}, 64490^{0}, 64480^{0}$ 64491⁰, 64492⁰, 64493⁰, 64494⁰, 64495⁰, 64505⁰, 64510⁰, 64517⁰, 64520⁰, 64530⁰, 69990⁰, 76000¹, 77001¹, 77002¹, 92012¹, 92014¹, 92652⁰, 92653⁰, 93000¹, 93005¹, 93010¹, 93040¹, 93041¹, 93042¹, 93318¹, 93355¹, 94002¹, 94200¹, 94680¹, 94681¹, 94690¹, 95812¹, 95813¹, 95816¹, 95819¹, 95822⁰, 95829¹, 95860⁰, 95861⁰, 95863⁰, 958640, 958650, 958660, 958670, 958680, 958690, 958700, 959070, 95908⁰, 95909⁰, 95910⁰, 95911⁰, 95912⁰, 95913⁰, 95925⁰, 95926⁰, 95927°, 95928°, 95929°, 95930°, 95933°, 95937°, 95938°, 95939°, 95940°, 95955¹, 96360¹, 96361¹, 96365¹, 96366¹, 96367¹, 96368¹, 96372¹, 96374¹, 96375¹, 96376¹, 96377¹, 96523⁰, 97597¹, 97598¹, $97602^{1}, 99155^{0}, 99156^{0}, 99157^{0}, 99211^{1}, 99212^{1}, 99213^{1}, 99214^{1},$ 99215¹, 99217¹, 99218¹, 99219¹, 99220¹, 99221¹, 99222¹, 99223¹, 99231¹, 99232¹, 99233¹, 99234¹, 99235¹, 99236¹, 99238¹, 99239¹, 99241¹, 99242¹, 99243¹, 99244¹, 99245¹, 99251¹, 99252¹, 99253¹, 99254¹, 99255¹, 99291¹, 99292¹, 99304¹, 99305¹, 99306¹, 99307¹, 99308¹, 99309¹, 99310¹, 99315¹, 99316¹, 99334¹, 99335¹, 99336¹, 99337¹, 99347¹, 99348¹, 99349¹, 99350¹, 99374¹, 99375¹, 99377¹, 99378¹, 99446⁰, 99447⁰, 99448⁰, 99449⁰, 99451⁰, 99452⁰, 99495⁰, 99496⁰, G0453⁰, G0463¹, G0471¹

ICD-10 CrossRef

G95.20, G95.89, G95.9, M08.1, M43.02, M43.03, M43.12, M43.13, M43.22, M43.23, M45.2, M45.3, M47.012, M47.013, M47.022, M47.12, M47.13, M47.22, M47.23, M47.812, M47.813, M47.892, M47.893, M48.02, M48.03, M48.52XA, M48.52XG, M48.53XA, M48.53XG, M48.8X2, M48.8X3, M50.00, M50.01, M50.020-M50.023, M50.03, M50.10, M50.11, M50.120-M50.123, M50.13, M50.20, M50.21, M50.23, M50.30, M50.31, M50.33, M50.80, M50.81, M50.820-M50.823, M50.83, M50.90, M50.91, M50.920-M50.923, M50.93, M53.82, M53.83, M54.12, M54.13

+63052

Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)

Advice

CPT® adds +63052 and +63053 to represent decompression laminectomy, facetectomy, or foraminotomy during lumbar posterior interbody arthrodesis (joint fusion). Use +63052 for a single vertebral segment and +63053 for each additional segment. CPT® states a vertebral segment is the basic part the spine can be divided into, meaning one complete vertebral bone. The +63052 and +63053 descriptors are almost identical to the descriptors for 63045-+63048, but new codes +63052 and +63053 must accompany lumbar posterior interbody arthrodesis.

Effective date of this revision: January 1, 2022.

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, and at the same session as lumbar posterior interbody arthrodesis (lower-back joint fusion), the provider performs laminectomy, facetectomy, or foraminotomy on a single vertebral segment for decompression. A vertebral segment is the basic part the spine can be divided into, meaning one complete vertebral bone, with articular processes (projections that fit with adjacent vertebrae) and laminae (the broad plates of bone on either side of the spinous process that complete the "arch" of the vertebrae and enclose the spinal cord). The services can be unilateral or bilateral. For laminectomy, the provider performs excision of a vertebral lamina. The term often refers to removal of the posterior arch. For facetectomy, the provider excises the facet joint between two vertebral bodies. Each vertebral segment has two facet joints. For foraminotomy, the provider excises bone to widen the intervertebral foramen (the bony hollow archway spinal nerves run through). The provider performs nerve decompression, peeling elastic tissue (ligamentum flavum) away from the dura (spinal cord's outer lining). The provider frees the nerve root canals. Compression is relieved by removal of any bony or tissue overgrowth around the foramen. The provider completes the separately reportable lumbar posterior interbody arthrodesis, removes instruments, repositions tissues, and closes the incision in layers.

Coding Tips

Because this code is an add-on code, payers will not reimburse you unless you report it with an appropriate primary code.

Fee Schedule

Medicare Fees National Conversion Factor: 34.8931, Facility: \$0.00, Non Facility: \$0.00, OPPS Facility: \$0.00, OPPS Non Facility: \$0.00 RVU Facility Work RVU: 0.00, PE RVU: 0.00, Malpractice RVU: 0.00, Total RVU: 0.00

RVU Non-Facility Work RVU: 0.00, PE RVU: 0.00, Malpractice RVU: 0.00, Total RVU: 0.00

time required for blood to clot, in comparison to the average of normal reference samples.

Report this code when a physician or other healthcare professional provides face-to-face patient or caregiver training on how to obtain a blood sample and monitor and report the results of INR using an INR monitoring device as well as how to care for the device. The provider documents the patient's or caregiver's ability to perform these procedures after training.

Fee Schedule

Medicare Fees National Conversion Factor: 34.8931, Facility: \$67.69, Non Facility: \$67.69, OPPS Facility: \$0.00, OPPS Non Facility: \$0.00 **RVU Facility** Work RVU: 0.00, PE RVU: 1.90, Malpractice RVU: 0.04, Total RVU: 1.94

RVU Non-Facility Work RVU: 0.00, PE RVU: 1.90, Malpractice RVU: 0.04, Total RVU: 1.94

Indicators Preoperative: 0.00, Intraoperative: 0.00, Postoperative: 0.00, Total RVU: 0, Global Period: XXX, Radiology Diagnostic Test: 99, Code Status: A, PC/TC Indicator: 3, Endoscopic Base Code: None, MUF: 1

Modifier Allowances 22, 52, 59, 79, 80, 81, 82, 99, AF, AG, AK, AQ, AS, GC, GR, GY, GZ, HC, KX, Q5, Q6, SC, XE, XP, XS, XU

CCI Alerts (version 27.3)

36591°, 36592°, 96523°, 98970°, 98971°, 98972°, G0248°

ICD-10 CrossRef

124.8, 124.9, 125.10, 125.110-125.119, 125.3, 125.700-125.709, 125.710-125.719, 125.720-125.729, 125.730-125.739, 125.750-125.759, 125.760-125.769, 125.790-125.799, 125.810-125.812, 125.83, 125.84, 125.89, 125.9, 127.1, 127.22, 127.89, 127.9, 139, 145.5, 150.20-150.23, 150.30-150.33, 150.40-150.43, 150.810-150.814, 150.82-150.84, 150.89, 150.9, 151.89, 151.9, 152, 167.2, 170.0, 170.1, 170.201-170.209, 170.211-170.219, 170.221-170.229, 170.231-170.239, 170.241-170.249, 170.25, 170.261-170.269, 170.291-170.299, 170.301-170.309, 170.311-170.319, 170.321-170.329, 170.331-170.339, 170.341-170.349, 170.35, 170.361-170.369, 170.391-170.399, 170.401-170.409, 170.411-170.419, 170.421-170.429, 170.431-170.439, 170.441-170.449, 170.45, 170.461-170.469, 170.491-170.499, 170.501-170.509, 170.511-170.519, 170.521-170.529, 170.531-170.539, 170.541-170.549, 170.55, 170.561-170.569, 170.591-170.599, 170.601-170.609, 170.611-170.619, 170.621-170.629, 170.631-170.639, 170.641-170.649, 170.65, 170.661-170.669, 170.691-170.699, 170.701-170.709, 170.711-170.719, 170.721-170.729, 170.731-170.739, 170.741-170.749, 170.75, 170.761-170.769, 170.791-170.799, 170.8, 170.90, 170.91, 175.81, I97.130, I97.131, O10.111-O10.119, O10.12, O10.13, O10.211-O10.219, O10.22, O10.23, O10.311

93793

Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ratio (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed

Clinical Responsibility

The provider reviews and interprets a new INR test result obtained during patient home monitoring, office monitoring, or test result returned from a lab. He adjusts the dosage of the anticoagulant warfarin if necessary, conveys the test results to the patient and instructs the patient regarding changes in dosage if he sees any specific patterns in the test study. The provider may also schedule additional tests.

Coding Tips

Report 93792 for home international normalized ratio (INR) initiation, face-to-face training, and documentation of the patient's or caregiver's ability to obtain blood samples, perform testing, and report results.

Fee Schedule

Medicare Fees National Conversion Factor: 34.8931, Facility: \$11.51, Non Facility: \$11.51, OPPS Facility: \$6.28, OPPS Non Facility: \$6.28 RVU Facility Work RVU: 0.18, PE RVU: 0.14, Malpractice RVU: 0.01, Total RVU: 0.33

RVU Non-Facility Work RVU: 0.18, PE RVU: 0.14, Malpractice RVU: 0.01, Total RVU: 0.33

Indicators Preoperative: 0.00, Intraoperative: 0.00, Postoperative: 0.00, Total RVU: 0, Global Period: XXX, Radiology Diagnostic Test: 99, Code Status: A, PC/TC Indicator: 2, Endoscopic Base Code: None, MUE: 1

Modifier Allowances 22, 52, 59, 79, 80, 81, 82, 95, 99, AF, AG, AK, AQ, AS, GO, GC, GQ, GR, GT, GY, GZ, HC, KX, Q5, Q6, SC, XE, XP, XS, XU

CCI Alerts (version 27.3)

36591°, 36592°, 96523°, 98970°, 98971°, 98972°, 99605¹, 99606¹, 99607¹, G0250°

ICD-10 CrossRef

124.8, 124.9, 125.10, 125.110-125.119, 125.3, 125.700-125.709, 125.710-125.719, 125.720-125.729, 125.730-125.739, 125.750-125.759, 125.760-125.769, 125.790-125.799, 125.810-125.812, 125.83, 125.84, 125.89, 125.9, 127.1, 127.22, 127.89, 127.9, 139, 145.5, 150.20-150.23, 150.30-150.33, 150.40-150.43, 150.810-150.814, 150.82-150.84, 150.89, 150.9, 151.89, 151.9, 152, 167.2, 170.0, 170.1, 170.201-170.209, 170.211-170.219, 170.221-170.229, 170.231-170.239, 170.241-170.249, 170.25, 170.261-170.269, 170.291-170.299, 170.301-170.309, 170.311-170.319, 170.321-170.329, 170.331-170.339, 170.341-170.349, 170.35, 170.361-170.369, 170.391-170.399, 170.401-170.409, 170.411-170.419, 170.421-170.429, 170.431-170.439, 170.441-170.449, 170.45, 170.461-170.469, 170.491-170.499, 170.501-170.509, 170.511-170.519, 170.521-170.529, 170.531-170.539, 170.541-170.549, 170.55, 170.561-170.569, 170.591-170.599, 170.601-170.609, 170.611-170.619, 170.621-170.629, 170.631-170.639, 170.641-170.649, 170.65, 170.661-170.669, 170.691-170.699, 170.701-170.709, 170.711-170.719, 170.721-170.729, 170.731-170.739, 170.741-170.749, 170.75, 170.761-170.769, 170.791-170.799, 170.8, 170.90, 170.91, I75.81, I97.130, I97.131, O10.111-O10.119, O10.12, O10.13, 010.211-010.219, 010.22, 010.23, 010.311-010.319, 010.32, O10.33, T45.516D, T45.516S, T86.20-T86.23, T86.23, T86.298, T86.30-T86.39, U09.9, Z48.21, Z48.280, Z94.1, Z94.3, Z95.2-Z95.4, Z95.811, Z95.812

93880

Duplex scan of extracranial arteries; complete bilateral study

Clinical Responsibility

The physician or a technician performs the duplex scanning procedure by holding a probe on the skin surface. The probe emits short ultrasonic pulses which travel into the body. When the ultrasound pulse collides with a soft tissue, it gets reflected and arrives back to the probe as an echo. Echoes from stationary structures come back to the probe with the same frequency, but in moving targets, echoes return with a higher or lower frequency. The scanner can detect even minute changes in frequency and can calculate the speed and direction of blood flow. Successive pulses from the probe and echoes generated through the body together create an image of a targeted plane in the body. During this procedure, the physician examines vascular flow of both sides of the head and neck.

Coding Tips

National Correct Coding Initiative edits don't prevent you from reporting carotid Doppler (93880) on the same day as venous Doppler (93970 and 93971), but your payer may question the medical necessity of performing both services on the same day. Doctors don't usually order both of these exams for the same patient on the same date of service.

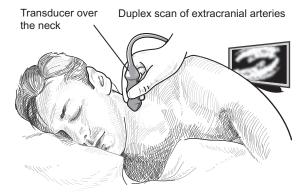
Code 93880: Indications for noninvasive physiologic cerebrovascular studies (including 93880, Duplex scan of extracranial arteries ...) include neck trauma, stroke and pulsatile tinnitus.

The studies may also be appropriate before a patient with systemic atherosclerosis has coronary artery bypass grafting or after a patient has carotid surgery.

Codes 93970 and 93971: Indications for peripheral venous exams (93970-93971, Duplex scan of extremity veins ...)" are separated into three major categories: deep vein thrombosis, chronic venous insufficiency, and vein selection for arterial surgery. Studies, which are medically necessary to determine subsequent treatment, are covered."

Check with the referring physician to identify the reasons why the patient needs both exams.

Illustration





Ultrasound image of extracranial arteries

93880

Fee Schedule

Medicare Fees National Conversion Factor: 34.8931, Facility: \$204.12, Non Facility: \$204.12, OPPS Facility: \$269.37, OPPS Non Facility: \$269.37

RVU Facility Work RVU: 0.80, PE RVU: 4.97, Malpractice RVU: 0.08, Total RVU: 5.85

RVU Non-Facility Work RVU: 0.80, PE RVU: 4.97, Malpractice RVU: 0.08, Total RVU: 5.85

Indicators Preoperative: 0.00, Intraoperative: 0.00, Postoperative: 0.00, Total RVU: 0, Global Period: XXX, Radiology Diagnostic Test: 99, Code Status: A, PC/TC Indicator: 1, Endoscopic Base Code: None. MUE: 1

Modifier Allowances 22, 26, 51, 52, 59, 76, 77, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, GZ, KX, PD, Q5, Q6, QJ, TC, XE, XP, XS, XU

CCI Alerts (version 27.3)

 $36591^{0}, 36592^{0}, 76998^{1}, 93882^{0}, 93895^{0}, 96523^{0}$

ICD-10 CrossRef

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

ICD-10 CrossRef Details

	7 1 116 117 11 11 11 11 11 11 11 11 11 11 11 11		
A01.09 A02.21	Typhoid fever with other complications	A52.02	Syphilitic aortitis
A02.21 A05.1	Salmonella meningitis Botulism food poisoning	A52.03 A52.05	Syphilitic endocarditis Other cerebrovascular syphilis
A06.1	Chronic intestinal amebiasis	A52.06	Other syphilitic heart involvement
A06.6	Amebic brain abscess	A52.11	Tabes dorsalis
A15.0	Tuberculosis of lung	A52.12	Other cerebrospinal syphilis
A15.4	Tuberculosis of intrathoracic lymph nodes	A52.13	Late syphilitic meningitis
A15.5	Tuberculosis of larynx, trachea and bronchus	A52.14	Late syphilitic encephalitis
A15.6 A15.8	Tuberculous pleurisy Other respiratory tuberculosis	A52.15 A52.16	Late syphilitic neuropathy Charcot's arthropathy (tabetic)
A17.0	Tuberculous meningitis	A52.17	General paresis
A17.1	Meningeal tuberculoma	A52.19	Other symptomatic neurosyphilis
A17.81	Tuberculoma of brain and spinal cord	A52.2	Asymptomatic neurosyphilis
A17.82	Tuberculous meningoencephalitis	A52.3	Neurosyphilis, unspecified
A17.83	Tuberculous neuritis	A52.78	Syphilis of other musculoskeletal tissue
A17.89 A17.9	Other tuberculosis of nervous system Tuberculosis of nervous system, unspecified	A54.41 A54.49	Gonococcal spondylopathy Gonococcal infection of other musculoskeletal tissue
A17.9 A18.01	Tuberculosis of fiel yous system, unspecified Tuberculosis of spine	A54.49 A54.81	Gonococcal meningitis
A18.02	Tuberculous arthritis of other joints	A54.82	Gonococcal brain abscess
A18.03	Tuberculosis of other bones	A54.83	Gonococcal heart infection
A18.09	Other musculoskeletal tuberculosis	A54.89	Other gonococcal infections
A18.2	Tuberculous peripheral lymphadenopathy	A69.20	Lyme disease, unspecified
A18.50 A18.51	Tuberculosis of eye, unspecified Tuberculous episcleritis	A78 A79.82	Q fever Anaplasmosis [A. phagocytophilum]
A18.52	Tuberculous episcientis Tuberculous keratitis	A79.82 A80.0	Acute paralytic poliomyelitis, vaccine-associated
A18.54	Tuberculous iridocyclitis	A80.1	Acute paralytic poliomyelitis, wild virus, imported
A18.59	Other tuberculosis of eye	A80.2	Acute paralytic poliomyelitis, wild virus, indigenous
A18.6	Tuberculosis of (inner) (middle) ear	A80.39	Other acute paralytic poliomyelitis
A18.81	Tuberculosis of thyroid gland	A80.4	Acute nonparalytic poliomyelitis
A18.84 A21.1	Tuberculosis of heart Oculoglandular tularemia	A80.9 A81.00	Acute poliomyelitis, unspecified Creutzfeldt-Jakob disease, unspecified
A21.1 A24.2	Subacute and chronic melioidosis	A81.01	Variant Creutzfeldt-Jakob disease
A27.0	Leptospirosis icterohemorrhagica	A81.09	Other Creutzfeldt-Jakob disease
A27.81	Aseptic meningitis in leptospirosis	A83.0	Japanese encephalitis
A27.89	Other forms of leptospirosis	A83.1	Western equine encephalitis
A31.0	Pulmonary mycobacterial infection	A83.2	Eastern equine encephalitis
A32.81 A35	Oculoglandular listeriosis Other tetanus	A83.3 A83.4	St Louis encephalitis Australian encephalitis
A36.0	Pharyngeal diphtheria	A83.5	California encephalitis
A36.1	Nasopharyngeal diphtheria	A83.8	Other mosquito-borne viral encephalitis
A36.2	Laryngeal diphtheria	A83.9	Mosquito-borne viral encephalitis, unspecified
A36.89	Other diphtheritic complications	A84.0	Far Eastern tick-borne encephalitis [Russian spring-summer
A38.8 A39.0	Scarlet fever with other complications Meningococcal meningitis	A84.1	encephalitis] Central European tick-borne encephalitis
A39.2	Acute meningococcemia	A84.81	Powassan virus disease
A39.3	Chronic meningococcemia	A84.89	Other tick-borne viral encephalitis
A39.4	Meningococcemia, unspecified	A84.9	Tick-borne viral encephalitis, unspecified
A39.50	Meningococcal carditis, unspecified	A85.0	Enteroviral encephalitis
A39.51 A39.52	Meningococcal endocarditis Meningococcal myocarditis	A85.1 A85.2	Adenoviral encephalitis Arthropod-borne viral encephalitis, unspecified
A39.32 A39.81	Meningococcal encephalitis	A85.8	Other specified viral encephalitis
A39.82	Meningococcal retrobulbar neuritis	A86	Unspecified viral encephalitis
A41.3	Sepsis due to Hemophilus influenzae	A87.0	Enteroviral meningitis
A42.0	Pulmonary actinomycosis	A87.1	Adenoviral meningitis
A42.2	Cervicofacial actinomycosis	A87.2	Lymphocytic choriomeningitis
A42.82 A48.52	Actinomycotic encephalitis Wound botulism	A87.8 A87.9	Other viral meningitis Viral meningitis, unspecified
A49.02	Methicillin resistant Staphylococcus aureus infection,	A92.2	Venezuelan equine fever
	unspecified site	A92.31	West Nile virus infection with encephalitis
A50.41	Late congenital syphilitic meningitis	A92.39	West Nile virus infection with other complications
A50.42	Late congenital syphilitic encephalitis	A92.5	Zika virus disease
A50.43 A50.45	Late congenital syphilitic polyneuropathy	B00.3 B00.4	Herpesviral meningitis
A50.45 A50.49	Juvenile general paresis Other late congenital neurosyphilis	B00.4 B00.50	Herpesviral encephalitis Herpesviral ocular disease, unspecified
A50.55	Late congenital syphilitic arthropathy	B00.53	Herpesviral conjunctivitis
A50.56	Late congenital syphilitic osteochondropathy	B00.59	Other herpesviral disease of eye
A51.41	Secondary syphilitic meningitis	B00.82	Herpes simplex myelitis
A51.44	Secondary syphilitic nephritis	B01.11	Varicella encephalitis and encephalomyelitis
A51.45 A51.46	Secondary syphilitic hepatitis Secondary syphilitic osteopathy	B01.12 B01.89	Varicella myelitis Other varicella complications
A31.40	Secondary syprimic osteopatriy	DU 1.03	Other varicella complications

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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		
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		

Modifier	Description
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
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
96	Habilitative Services
97	Rehabilitative Services
99	Multiple Modifiers
	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
А3	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
AD	Medical supervision by a physician: more than four concurrent anesthesia procedures
AE	Registered dietician
AF	Specialty physician
AG	Primary physician
AH	Clinical psychologist
Al	Principal physician of record

Modifier	Description	
AJ	Clinical social worker	
AK	Non participating physician	
AM	Physician, team member service	
AO	Alternate payment method declined by provider of service	
АР	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	
ВА	Item furnished in conjunction with parenteral enteral nutrition (PEN) services	
BL	Special acquisition of blood and blood products	
ВО	Orally administered nutrition, not by feeding tube	
ВР	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	
СВ	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	
СС	Procedure code change (use 'CC' when the procedure code submitted was changed either for administrative reasons or because an incorrect code was filed)	

Modifier	Description
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
СН	0 percent impaired, limited or restricted
CI	At least 1 percent but less than 20 percent impaired, limited or restricted
CI	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
со	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
СТ	Computed tomography services furnished using equipment that does not meet each of the attributes of the National Electrical Manufacturers Association (NEMA) XR-29-2013 standard
DA	Oral health assessment by a licensed health professional other than a dentist
E1	Upper left, eyelid
E2	Lower left, eyelid
E3	Upper right, eyelid
E4	Lower right, eyelid
EA	Erythropoietic stimulating agent (ESA) administered to treat anemia due to anti-cancer chemotherapy

Terminology

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

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

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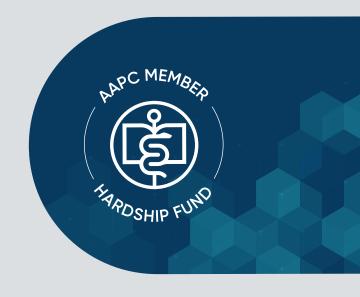
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The Hardship Fund is a financial aid program created to assist our members with:

- ✓ Maintaining their membership and certification through membership renewal dues, exam prep tools and more
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All awards are based on the availability of funds and the applicant's ability to demonstrate reasonable hardship. A portion of each book sale goes to helping more applicants through their time of need. We appreciate your contribution and your support for your fellow AAPC members.

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