AAPC

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

CODERS' SPECIALTY GUIDE

Emergency Medicine

2026

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General Surgical Procedures

+10004

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

Clinical Responsibility

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

Coding Tips

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

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $42.05, Non Facility Fee: $51.75
RVU (Facility): Work RVU 0.80, Practice Exp. RVU 0.37, Malpractice RVU 0.13, Total RVU 1.30
RVU (Non-Facility): Work RVU 0.80, Practice Exp. RVU 0.67, Malpractice RVU 0.13, Total RVU 1.60
MPFS Payment Policy Indicators: Global Period ZZZ, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 3

Modifier Allowances

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

NCCI Alerts (version 31.0)

0213T[1], 0216T[1], 10012[1], 10035[1], 19281[1], 19283[1], 19285[1], 19287[1], 36000[1], 36410[1], 36591[0], 36592[0], 61650[1], 62324[1], 62325[1], 62326[1], 62327[1], 64415[1], 64416[1], 64417[1], 64450[1], 64454[1], 64486[1], 64487[1], 64488[1], 64489[1], 64490[1], 64493[1], 76000[1], 76380[1], 76942[1], 76998[1], 77001[1], 77002[1], 77012[1], 77021[1], 96360[1], 96365[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0]

ICD-10-CM Cross References

C00.3, C01, C02.9, C04.1, C06.9, C07, C08.0, C12, C13.9, C15.9, C22.0-C22.4, C22.7, C22.8, C32.1, C32.8, C34.30-C34.32, C43.20-C43.22, C43.30-C43.39, C43.51-C43.59, C43.60-C43.62, C46.0, C50.011-C50.019, C50.111-C50.119, C50.211-C50.219, C50.411-C50.419, C50.811-C50.819, C50.911-C50.919, C51.9, C76.0, C76.1, C77.0, C77.3, C79.2, C79.81, C79.89, C79.9, C82.50, C82.51, C82.55, C82.59, C83.31-C83.35, C84.90, C84.91, C84.95, C84.99, C84.9A, C84.A0, C84.A1, C84.A5, C84.A9, C84.AA, C84.Z0, C84.Z1, C84.Z5, C84.Z9, C84.ZA, C85.10, C85.11, C85.15, C85.19, C85.1A, C85.20, C85.21, C85.25, C85.29, C85.2A, C85.80, C85.81, C85.85, C85.89, C85.8A, C85.90, C85.91, C85.95, C85.99, C85.9A, C86.00, C86.01, C86.40, C86.41, C88.80, C88.81, C94.40-C94.42, C94.6, D03.20-D03.22, D03.30, D03.39, D03.51-D03.59, D03.60-D03.62, D05.00-D05.02, D05.10-D05.12, D05.80-D05.82, D05.90-D05.92, D11.0-D11.9, D17.0, D17.1, D17.20-D17.24, D17.30, D17.39, D17.72, D17.79, D17.9, D19.7, D21.0, D22.5, D22.70-D22.72, D23.5, D23.70-D23.72, D36.0, D36.7, D37.030-D37.039, D44.0-D44.2, D44.9, D47.1, D47.2, D47.9, D47.Z9, D48.0-D48.2, D48.60-D48.62, D48.7, D48.9, D49.0-D49.7, D49.9, D64.9, D75.9, D78.01, D78.02, D78.21, D78.22, D89.2, E01.0-E01.2, E03.4, E03.9, E04.0-E04.9, E06.0, E07.89, E07.9, E35, E36.01, E36.02, E65, E78.71, E89.820-E89.823, G97.31, G97.32, G97.51, G97.52, G97.63, G97.64, H66.10-H66.13, H69.80-H69.83, H93.8X1-H93.8X9, H94.80-H94.83, H95.21, H95.22, H95.41, H95.42, H95.53, H95.54, I42.0-I42.5, I42.8, I42.9, I70.235, I70.245, I70.335, I70.345, I70.435, I70.445, I70.535, I70.545, I70.635, I70.645, I70.735, I70.745, I82.91, I88.1-I88.9, I89.8, I97.410-I97.418, I97.42, I97.610-I97.618, I97.622, I97.640-I97.648, J95.61, J95.62, J95.830, J95.831, J95.862, J95.863, J98.4, K11.20-K11.23, K11.3-K11.6, K11.9, K91.61, K91.62, K91.840, K91.841, K91.870-K91.873, L02.31, L02.415, L02.416, L02.419, L02.91, L03.115, L03.116, L03.119, L03.125, L03.126, L03.129, L03.317, L03.327, L03.90, L03.91, L57.0, L76.01, L76.02, L76.21, L76.22, L76.31-L76.34, L97.501-L97.504, L97.509, L97.511-L97.514, L97.519, L97.521-L97.524, L97.529, L98.3, L98.7, M54.2, M70.20-M70.22, M71.30, M77.10-M77.12, M79.4, M81.0, M96.810, M96.811, M96.830, M96.831, M96.840-M96.843, N60.01-N60.09, N60.11-N60.19, N61.0, N62, N63.0, N63.10-N63.15, N63.20-N63.25, N63.31, N63.32, N63.41, N63.42, N64.1, N64.4, N99.61, N99.62, N99.820, N99.821, N99.840-N99.843, Q18.0-Q18.9, Q87.2, Q87.3, Q87.5, Q87.81, Q87.89, Q89.2, Q89.8, R13.0, R13.10, R18.8, R19.02, R20.8, R20.9, R22.0-R22.2, R22.30-R22.33, R22.40-R22.43, R22.9, R29.4, R59.0-R59.9, R68.89, R69, R90.0, R92.1, R92.8, R99, S90.421D, S90.422D, S90.423D, S90.424D, S90.425D, S90.426D, S90.521D, S90.522D, S90.529D, S90.821D, S90.822D, S90.829D, S90.869A, Z00.6, Z12.89, Z85.21, Z85.3, Z85.6, Z86.79

10005

Fine needle aspiration biopsy, including ultrasound guidance; first lesion

Clinical Responsibility

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

Coding Tips

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

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

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

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

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $70.19, Non Facility Fee: $129.06
RVU (Facility): Work RVU 1.46, Practice Exp. RVU 0.55, Malpractice RVU 0.16, Total RVU 2.17
RVU (Non-Facility): Work RVU 1.46, Practice Exp. RVU 2.37, Malpractice RVU 0.16, Total RVU 3.99
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

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

NCCI Alerts (version 31.0)

0213T[1], 0216T[1], 10004[1], 10008[1], 10010[1], 10011[1], 10012[1], 10021[1], 10035[1], 11102[1], 11103[1], 11104[1], 11105[1], 11106[1], 11107[1], 19281[1], 19283[1], 19285[1], 19287[1], 36000[1], 36410[1], 36591[0], 36592[0], 61650[1], 62324[1], 62325[1], 62326[1], 62327[1], 64415[1], 64416[1], 64417[1], 64450[1], 64454[1], 64486[1], 64487[1], 64488[1], 64489[1], 64490[1], 64493[1], 76000[1], 76380[1], 76942[1], 76998[1], 77001[1], 77002[1], 77012[1], 77021[1], 96360[1], 96365[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[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.

+10006

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

Clinical Responsibility

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

Coding Tips

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

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

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $47.87, Non Facility Fee: $58.22
RVU (Facility): Work RVU 1.00, Practice Exp. RVU 0.38, Malpractice RVU 0.10, Total RVU 1.48
RVU (Non-Facility): Work RVU 1.00, Practice Exp. RVU 0.70, Malpractice RVU 0.10, Total RVU 1.80
MPFS Payment Policy Indicators: Global Period ZZZ, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 3

Modifier Allowances

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

NCCI Alerts (version 31.0)

0213T[1], 0216T[1], 10004[1], 10035[1], 19281[1], 19283[1], 19285[1], 19287[1], 36000[1], 36410[1], 36591[0], 36592[0], 61650[1], 62324[1], 62325[1], 62326[1], 62327[1], 64415[1], 64416[1], 64417[1], 64450[1], 64454[1], 64486[1], 64487[1], 64488[1], 64489[1], 64490[1], 64493[1], 76000[1], 76380[1], 76942[1], 76998[1], 77001[1], 77002[1], 77012[1], 77021[1], 96360[1], 96365[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[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.

10007

Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion

Clinical Responsibility

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

Coding Tips

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

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

Integumentary System

10030

Image-guided fluid collection drainage by catheter (eg, abscess, hematoma, seroma, lymphocele, cyst), soft tissue (eg, extremity, abdominal wall, neck), percutaneous

Clinical Responsibility

The provider inserts a catheter through the skin using imaging to view the fluid. He then drains the fluid from the soft tissue in cases such as abscess, hematoma, seroma, lymphocele, or cyst. Imaging guidance for needle and catheter placement can be by ultrasound, fluoroscopy, or computed tomography. This procedure can be done by using a catheter that is mounted on a sharp trocar, which is placed through a small skin incision made next to a guiding needle, or by inserting a hollow needle into the cavity and passing a guidewire through the needle to create a path for the drainage catheter. The area is drained, and the catheter, which is left in place, ensures continued drainage.

Coding Tips

For the same procedure on an organ, such as kidney, liver, spleen, or lung or mediastinum, see 49405.

For the same procedure on a fluid collection in the peritoneal or retroperitoneal space, see 49406.

For a fluid collection procedure on the peritoneal or retroperitoneal space but through a vaginal or rectal access route, see 49407.

For incision and drainage of a hematoma, seroma or fluid collection, see 10140.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $129.06, Non Facility Fee: $600.35
RVU (Facility): Work RVU 2.75, Practice Exp. RVU 0.95, Malpractice RVU 0.29, Total RVU 3.99
RVU (Non-Facility): Work RVU 2.75, Practice Exp. RVU 15.52, Malpractice RVU 0.29, Total RVU 18.56
MPFS Payment Policy Indicators: Global Period 000, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 9, Endoscopic Base Code: None
Practitioner MUE: 2

Modifier Allowances

22, 47, 51, 52, 53, 58, 59, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AF, AG, AQ, AR, AS, GA, GC, GZ, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0213T^{0}, 0216T^{0}, 0596T^{1}, 0597T^{1}, 10060^{1}, 10061^{1}, 10080^{1}, 10081^{1}, 10140^{1}, 10160^{1}, 11055^{1}, 11056^{1}, 11057^{1}, 11401^{1}, 11402^{1}, 11403^{1}, 11404^{1}, 11406^{1}, 11421^{1}, 11422^{1}, 11423^{1}, 11424^{1}, 11426^{1}, 11441^{1}, 11442^{1}, 11443^{1}, 11444^{1}, 11446^{1}, 11450^{1}, 11451^{1}, 11462^{1}, 11463^{1}, 11470^{1}, 11471^{1}, 11600^{1}, 11601^{1}, 11602^{1}, 11603^{1}, 11604^{1}, 11606^{1}, 11620^{1}, 11621^{1}, 11622^{1}, 11623^{1}, 11624^{1}, 11626^{1}, 11640^{1}, 11641^{1}, 11642^{1}, 11643^{1}, 11644^{1}, 11646^{1}, 11719^{1}, 11720^{1}, 11721^{1}, 11765^{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}, 20500^{1}, 29580^{1}, 29581^{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}, 61650^{1}, 62320^{0}, 62321^{0}, 62322^{0}, 62323^{0}, 62324^{0}, 62325^{0}, 62326^{0}, 62327^{0}, 64400^{0}, 64405^{0}, 64408^{0}, 64415^{0}, 64416^{0}, 64417^{0}, 64418^{0}, 64420^{0}, 64421^{0}, 64425^{0}, 64430^{0}, 64435^{0}, 64445^{0}, 64446^{0}, 64447^{0}, 64448^{0}, 64449^{0}, 64450^{1}, 64451^{0}, 64454^{1}, 64461^{0}, 64462^{0}, 64463^{0}, 64479^{0}, 64480^{0}, 64483^{0}, 64484^{0}, 64486^{0}, 64487^{0}, 64488^{0}, 64489^{0}, 64490^{0}, 64491^{0}, 64492^{0}, 64493^{0}, 64494^{0}, 64495^{0}, 64505^{0}, 64510^{0}, 64517^{0}, 64520^{0}, 64530^{0}, 69990^{0}, 75989^{1}, 76000^{1}, 76380^{1}, 76942^{1}, 76998^{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}, 95955^{1}, 96360^{1}, 96361^{1}, 96365^{1}, 96366^{1}, 96367^{1}, 96368^{1}, 96372^{1}, 96374^{1}, 96375^{1}, 96376^{1}, 96377^{1}, 96523^{0}, 97597^{1}, 97598^{1}, 97602^{1}, 97605^{1}, 97606^{1}, 97607^{1}, 97608^{1}, 99155^{0}, 99156^{0}, 99157^{0}, 99211^{1}, 99212^{1}, 99213^{1}, 99214^{1}, 99215^{1}, 99221^{1}, 99222^{1}, 99223^{1}, 99231^{1}, 99232^{1}, 99233^{1}, 99234^{1}, 99235^{1}, 99236^{1}, 99238^{1}, 99239^{1}, 99242^{1}, 99243^{1}, 99244^{1}, 99245^{1}, 99252^{1}, 99253^{1}, 99254^{1}, 99255^{1}, 99291^{1}, 99292^{1}, 99304^{1}, 99305^{1}, 99306^{1}, 99307^{1}, 99308^{1}, 99309^{1}, 99310^{1}, 99315^{1}, 99316^{1}, 99347^{1}, 99348^{1}, 99349^{1}, 99350^{1}, 99374^{1}, 99375^{1}, 99377^{1}, 99378^{1}, 99446^{0}, 99447^{0}, 99448^{0}, 99449^{0}, 99451^{0}, 99452^{0}, G0127^{1}, G0463^{1}, G0471^{1}, J0670^{1}

ICD-10-CM Cross References

D78.01, D78.02, D78.21, D78.22, E36.01, E36.02, E89.820, E89.821, G97.31, G97.32, G97.51, G97.52, H59.111-H59.119, H59.121-H59.129, H59.311-H59.319, H59.321-H59.329, H95.21, H95.22, H95.41, H95.42, I89.8, I97.410-I97.418, I97.42, I97.610-I97.618, I97.620, I97.621, I97.630-I97.638, J95.61, J95.62, J95.830, J95.831, K68.11, K91.61, K91.62, K91.840, K91.841, K91.870, K91.871, L02.811, L02.818, L02.91, L03.811, L03.818, L03.891, L03.898, L03.90, L03.91, L72.0-L72.3, L72.8, L72.9, L76.01, L76.02, L76.21, L76.22, L76.31, L76.32, L98.3, L98.7, M72.8, M79.81, M96.810, M96.811, M96.830, M96.831, M96.840-M96.843, N99.61, N99.62, N99.820, N99.821, N99.840-N99.843, O91.011-O91.019, O91.02, O91.03, O91.111-O91.119, O91.12, O91.13, T79.2XXA, T87.89

10035

Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; first lesion

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider uses image guidance to view the exact location of the lesion in the affected soft tissue. The provider then uses a needle introducer to place the localization device through the skin to the

target tissue. After placing the device, the provider uses image guidance to ensure the correct position of the device, closes the site, and applies a bandage.

Coding Tips

This code is for the initial placement of a localization device for the first lesion; for each additional device placed, use +10036 in addition to code for primary procedure.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $80.22, Non Facility Fee: $339.96
RVU (Facility): Work RVU 1.70, Practice Exp. RVU 0.62, Malpractice RVU 0.16, Total RVU 2.48
RVU (Non-Facility): Work RVU 1.70, Practice Exp. RVU 8.65, Malpractice RVU 0.16, Total RVU 10.51
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, 47, 50, 51, 52, 58, 59, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AF, AG, AS, CT, GA, GC, GY, GZ, KX, LT, Q5, Q6, QJ, RT, XE, XP, XS, XU

NCCI Alerts (version 31.0)

00400^{0}, 0213T^{0}, 0216T^{0}, 0596T^{1}, 0597T^{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}, 19281^{1}, 19282^{1}, 19283^{1}, 19284^{1}, 19285^{1}, 19286^{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}, 36680^{1}, 43752^{1}, 49412^{1}, 51701^{1}, 51702^{1}, 51703^{1}, 62320^{0}, 62321^{0}, 62322^{0}, 62323^{0}, 62324^{0}, 62325^{0}, 62326^{0}, 62327^{0}, 64400^{0}, 64405^{0}, 64408^{0}, 64415^{0}, 64416^{0}, 64417^{0}, 64418^{0}, 64420^{0}, 64421^{0}, 64425^{0}, 64430^{0}, 64435^{0}, 64445^{0}, 64446^{0}, 64447^{0}, 64448^{0}, 64449^{0}, 64450^{1}, 64451^{0}, 64454^{1}, 64461^{0}, 64462^{0}, 64463^{0}, 64479^{0}, 64480^{0}, 64483^{0}, 64484^{0}, 64486^{0}, 64487^{0}, 64488^{0}, 64489^{0}, 64490^{0}, 64491^{0}, 64492^{0}, 64493^{0}, 64494^{0}, 64495^{0}, 64505^{0}, 64510^{0}, 64517^{0}, 64520^{0}, 64530^{0}, 69990^{0}, 76000^{1}, 76380^{1}, 76942^{1}, 76998^{1}, 77002^{1}, 77011^{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}, 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}, G0463^{1}, G0471^{1}, J0670^{1}

ICD-10-CM Cross References

C43.52, C44.501, C44.511, C44.521, C44.591, C44.90, C49.0-C49.6, C49.10-C49.12, C49.20-C49.22, C49.8, C49.9, C4A.52, C50.011-C50.019, C50.021-C50.029, C50.111-C50.119, C50.121-C50.129, C50.211-C50.219, C50.221-C50.229, C50.311-C50.319, C50.321-C50.329, C50.411-C50.419, C50.421-C50.429, C50.511-C50.519, C50.521-C50.529, C50.611-C50.619, C50.621-C50.629, C50.811-C50.819, C50.821-C50.829, C50.911-C50.919, C50.921-C50.929, C77.0-C77.4, C77.8, C77.9, C79.2, C79.81, C79.89, D03.52, D04.9, D05.00-D05.02, D05.10-D05.12, D05.80-D05.82, D05.90-D05.92, D09.20-D09.22, D21.0-D21.3, D21.10-D21.12, D21.20-D21.22, D21.5, D21.6, D21.9, D23.9, D24.1-D24.9, D31.60-D31.62, D36.0, D48.5, D48.60-D48.62, D48.7, D49.2, D49.3, D49.6, D49.89, M79.5

+10036

Placement of soft tissue localization device(s) (eg, clip, metallic pellet, wire/needle, radioactive seeds), percutaneous, including imaging guidance; each additional lesion (List separately in addition to code for primary procedure)

Clinical Responsibility

After placement of the first localization device and at the same session, the provider uses image guidance to view the exact location of the lesion in the affected soft tissue. The provider then uses a needle introducer to place an additional localization device through the skin to the target tissue. After placing the device, the provider uses image guidance to ensure the correct position of the device, closes the site, and applies a bandage.

Coding Tips

Because +10036 is an add-on code, payers will not reimburse you if you report it without the appropriate primary code, 10035 for the first lesion.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $40.76, Non Facility Fee: $276.24
RVU (Facility): Work RVU 0.85, Practice Exp. RVU 0.31, Malpractice RVU 0.10, Total RVU 1.26
RVU (Non-Facility): Work RVU 0.85, Practice Exp. RVU 7.59, Malpractice RVU 0.10, Total RVU 8.54
MPFS Payment Policy Indicators: Global Period ZZZ, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 2

Modifier Allowances

47, 52, 58, 59, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AF, AG, AS, CT, GA, GC, GY, GZ, KX, LT, Q5, Q6, QJ, RT, XE, XP, XS, XU

NCCI Alerts (version 31.0)

00400^{0}, 0213T^{0}, 0216T^{0}, 0596T^{1}, 0597T^{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}, 19281^{1}, 19282^{1}, 19283^{1}, 19284^{1}, 19286^{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}, 36680^{1}, 43752^{1}, 51701^{1}, 51702^{1}, 51703^{1}, 62320^{0}, 62321^{0}, 62322^{0}, 62323^{0}, 62324^{0}, 62325^{0},

Nervous System

61000

Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; initial

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider stretches the skin and inserts a subdural needle or intravenous catheter into the skin where the fontanelle and coronal meet. He advances the needle slowly through the skin to the subdural level. He then removes the needle, and the fluid drains through the attached catheter. The provider collects the fluid and sends a sample for testing. He then repeats the procedure on the other side as needed. The procedure is complete when the area becomes soft or concave, and the provider applies a gentle pressure dressing to the site.

Coding Tips

Report code 61001 for subsequent subdural taps.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $112.24, Non Facility Fee: $112.24
RVU (Facility): Work RVU 1.58, Practice Exp. RVU 1.25, Malpractice RVU 0.64, Total RVU 3.47
RVU (Non-Facility): Work RVU 1.58, Practice Exp. RVU 1.25, Malpractice RVU 0.64, Total RVU 3.47
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, 47, 51, 52, 53, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AQ, AR, CR, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0213T^{0}, 0216T^{0}, 0333T^{0}, 0464T^{0}, 0596T^{1}, 0597T^{1}, 0708T^{1}, 0709T^{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}, 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^{0}, 62321^{0}, 62322^{0}, 62323^{0}, 62324^{0}, 62325^{0}, 62326^{0}, 62327^{0}, 64400^{0}, 64405^{0}, 64408^{0}, 64415^{0}, 64416^{0}, 64417^{0}, 64418^{0}, 64420^{0}, 64421^{0}, 64425^{0}, 64430^{0}, 64435^{0}, 64445^{0}, 64446^{0}, 64447^{0}, 64448^{0}, 64449^{0}, 64450^{0}, 64451^{0}, 64454^{0}, 64461^{0}, 64462^{0}, 64463^{0}, 64479^{0}, 64480^{0}, 64483^{0}, 64484^{0}, 64486^{0}, 64487^{0}, 64488^{0}, 64489^{0}, 64490^{0}, 64491^{0}, 64492^{0}, 64493^{0}, 64494^{0}, 64495^{0}, 64505^{0}, 64510^{0}, 64517^{0}, 64520^{0}, 64530^{0}, 69990^{0}, 92012^{1}, 92014^{1}, 92652^{0}, 92653^{0}, 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^{0}, 95829^{1}, 95860^{0}, 95861^{0}, 95863^{0}, 95864^{0}, 95865^{0}, 95866^{0}, 95867^{0}, 95868^{0}, 95869^{0}, 95870^{0}, 95907^{0}, 95908^{0}, 95909^{0}, 95910^{0}, 95911^{0}, 95912^{0}, 95913^{0}, 95925^{0}, 95926^{0}, 95927^{0}, 95928^{0}, 95929^{0}, 95930^{0}, 95933^{0}, 95937^{0}, 95938^{0}, 95939^{0}, 95940^{0}, 95955^{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}, G0453^{0}, G0463^{1}, G0471^{1}

ICD-10-CM Cross References

G03.9, G06.0, G91.0-G91.3, G91.8, G91.9, P10.0, P10.1, P10.4, P10.8, P10.9, P11.0-P11.2, P11.9, Q03.0-Q03.9, Q04.4-Q04.6, Q04.8, Q04.9, Q05.0, Q06.9, Q07.9

61001

Subdural tap through fontanelle, or suture, infant, unilateral or bilateral; subsequent taps

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider performs a repeat insertion of a subdural needle or intravenous catheter into the skin where the fontanelle and coronal meet. He advances the needle slowly through the skin to the subdural level. He then removes the needle, and the fluid drains through the attached catheter. The provider collects the fluid and a sample is sent for testing. He then repeats the procedure on the other side as needed. The procedure is complete when the area becomes soft or concave, and the provider applies a gentle pressure dressing to the site.

Coding Tips

Report code 61000 for the initial subdural tap.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $106.74, Non Facility Fee: $106.74
RVU (Facility): Work RVU 1.49, Practice Exp. RVU 1.20, Malpractice RVU 0.61, Total RVU 3.30
RVU (Non-Facility): Work RVU 1.49, Practice Exp. RVU 1.20, Malpractice RVU 0.61, Total RVU 3.30
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, 47, 51, 52, 53, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AQ, AR, CR, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0213T[0], 0216T[0], 0333T[0], 0464T[0], 0596T[1], 0597T[1], 0708T[1], 0709T[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], 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], 61000[1], 62320[0], 62321[0], 62322[0], 62323[0], 62324[0], 62325[0], 62326[0], 62327[0], 64400[0], 64405[0], 64408[0], 64415[0], 64416[0], 64417[0], 64418[0], 64420[0], 64421[0], 64425[0], 64430[0], 64435[0], 64445[0], 64446[0], 64447[0], 64448[0], 64449[0], 64450[0], 64451[0], 64454[0], 64461[0], 64462[0], 64463[0], 64479[0], 64480[0], 64483[0], 64484[0], 64486[0], 64487[0], 64488[0], 64489[0], 64490[0], 64491[0], 64492[0], 64493[0], 64494[0], 64495[0], 64505[0], 64510[0], 64517[0], 64520[0], 64530[0], 69990[0], 92012[1], 92014[1], 92652[0], 92653[0], 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[0], 95829[1], 95860[0], 95861[0], 95863[0], 95864[0], 95865[0], 95866[0], 95867[0], 95868[0], 95869[0], 95870[0], 95907[0], 95908[0], 95909[0], 95910[0], 95911[0], 95912[0], 95913[0], 95925[0], 95926[0], 95927[0], 95928[0], 95929[0], 95930[0], 95933[0], 95937[0], 95938[0], 95939[0], 95940[0], 95955[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], G0453[0], G0463[1], G0471[1]

ICD-10-CM Cross References

G03.9, G06.0, G91.0-G91.3, G91.8, G91.9, P10.0, P10.1, P10.4, P10.8, P10.9, P11.0-P11.2, P11.9, Q03.0-Q03.9, Q04.4-Q04.6, Q04.8, Q04.9, Q05.0, Q06.9, Q07.9

62270

Spinal puncture, lumbar, diagnostic

Clinical Responsibility

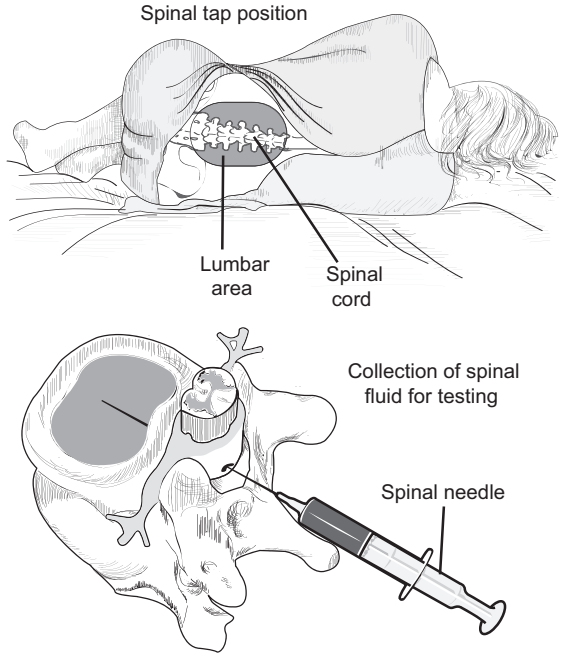
When the patient is prepped and anesthetized, the provider identifies the space between the second and third or third and fourth lumbar vertebrae and marks it using a surgical marker. The provider inserts a spinal needle, taking care to avoid any injury to the nearby blood vessels. He advances the needle until CSF starts to leak out of it. The provider collects approximately 8 to 15 mL of CSF and sends it to pathology for further analysis. The provider then flushes the site with sterile saline and applies gauze at the site of needle insertion. Sometimes, if the procedure fails, the provider performs the procedure again under fluoroscopic guidance; this happens most commonly in obese patients.

Coding Tips

Providers most commonly perform this procedure either at the L2 to L3 level or L3 to L4 level of the lumbar spine.

Code 62270 for diagnostic lumbar puncture and code 62272 for therapeutic spinal puncture do not include imaging guidance. If the provider uses imaging guidance, do **not** report these codes with an imaging guidance code. Instead, see 62328 for diagnostic lumbar spinal puncture with fluoroscopic or CT guidance and 62329 for therapeutic spinal puncture for drainage of cerebrospinal fluid by needle or catheter with fluoroscopic or CT guidance.

Illustration



62270

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $62.43, Non Facility Fee: $141.68
RVU (Facility): Work RVU 1.22, Practice Exp. RVU 0.43, Malpractice RVU 0.28, Total RVU 1.93
RVU (Non-Facility): Work RVU 1.22, Practice Exp. RVU 2.88, Malpractice RVU 0.28, Total RVU 4.38
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, 51, 52, 53, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AG, AQ, AR, CR, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 31.0)

00635[0], 01937[0], 01938[0], 01939[0], 01940[0], 01941[0], 01942[0], 0213T[0], 0216T[0], 0596T[1], 0597T[1], 0708T[1], 0709T[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],

Radiology

70010

Myelography, posterior fossa, radiological supervision and interpretation

Clinical Responsibility

This code represents the technical and professional components of a service. The provider performs radiographic diagnostic study of the posterior cranial fossa while utilizing fluoroscopy imaging for the assessment of any intracranial pathology. He performs a lumbar puncture and injects contrast material into the subarachnoid space to enhance image sequences. He supervises the performance of the entire radiological procedure and interprets the findings. The provider who performs imaging supervision and interpretation for this procedure reports this code.

Coding Tips

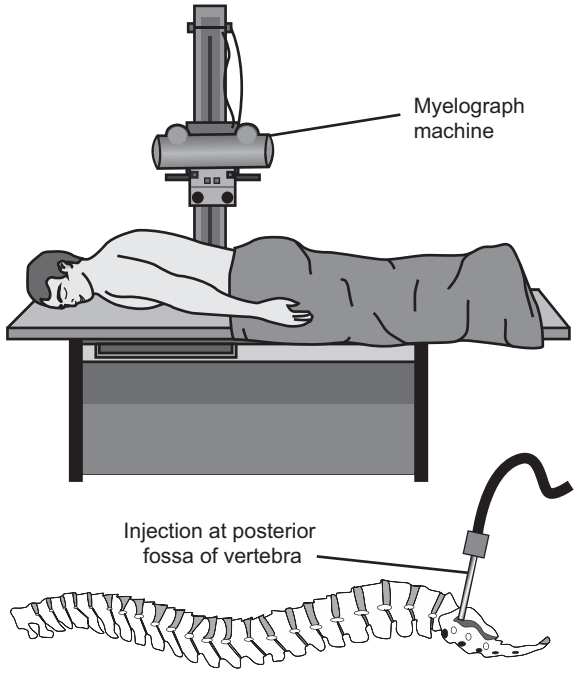
There may be rare instances where one provider supervises the radiology service and another provider interprets it. According to Medicare guidelines, each provider should report the radiology code and append reduced service modifier 52. Each should also append modifier 26 to the code to report only the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

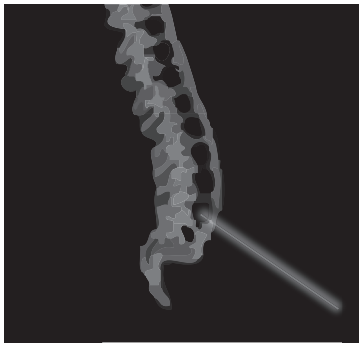
To assign a code whose descriptor includes contrast, the contrast must be intravascular, intraarticular, or intrathecal.

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

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

Illustration





70010

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $56.61, Non Facility Fee: $56.61
RVU (Facility): Work RVU 1.19, Practice Exp. RVU 0.44, Malpractice RVU 0.12, Total RVU 1.75
RVU (Non-Facility): Work RVU 1.19, Practice Exp. RVU 0.44, Malpractice RVU 0.12, Total RVU 1.75
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

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

NCCI Alerts (version 31.0)

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

ICD-10-CM Cross References

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

70030

Radiologic examination, eye, for detection of foreign body

Clinical Responsibility

The provider takes a plain X-ray of the eye to determine whether the patient has a foreign body in the eye.

Coding Tips

Be sure that the provider's documentation clearly describes each view taken in a radiology service. Check the documentation for the patient's body position and projection of the X-ray to assign the correct number of views.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $32.02, Non Facility Fee: $32.02
RVU (Facility): Work RVU 0.18, Practice Exp. RVU 0.79, Malpractice RVU 0.02, Total RVU 0.99
RVU (Non-Facility): Work RVU 0.18, Practice Exp. RVU 0.79, Malpractice RVU 0.02, Total RVU 0.99
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 1, Endoscopic Base Code: None
Practitioner MUE: 2

Modifier Allowances

26, 50, 52, 76, 77, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, FX, FY, GA, GC, GJ, GR, KX, LT, PD, Q5, Q6, QJ, RT, TC

NCCI Alerts (version 31.0)

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

ICD-10-CM Cross References

H05.50-H05.53, H44.601-H44.609, H44.611-H44.619, H44.631-H44.639, H44.641-H44.649, H44.651-H44.659, H44.711-H44.719, H44.721-H44.729, H44.731-H44.739, H44.741-H44.749, H44.751-H44.759, H57.8A1-H57.8A9, H59.351-H59.359, R09.A9, S02.121D-S02.121G, S02.121K, S02.121S, S02.122D-S02.122G, S02.122K, S02.122S, S02.129D-S02.129G, S02.129K, S02.129S, S02.831D-S02.831G, S02.831K, S02.831S, S02.832D-S02.832G, S02.832K, S02.832S, S02.839D-S02.839G, S02.839K, S02.839S, S02.841D-S02.841G, S02.841K, S02.841S, S02.842D-S02.842G, S02.842K, S02.842S, S02.849D-S02.849G, S02.849K, S02.849S, S02.85XD-S02.85XG, S02.85XK, S02.85XS, T75.89XD, T75.89XS, T81.513D, T81.513S, T81.533D, T81.533S, T81.69XD, T81.69XS, Z03.823, Z18.09, Z18.10, Z18.11, Z18.2

70100

Radiologic examination, mandible; partial, less than 4 views

Clinical Responsibility

The provider takes plain X-rays of the lower jaw bone. He obtains one, two, or three views of the mandible from different angles or projections.

Coding Tips

Be sure that the provider's documentation clearly describes each view taken in a radiology service. Check the documentation for the patient's body position and projection of the X-ray to assign the correct number of views.

If a provider orders and performs a three-view mandible X-ray to diagnose a fracture and then a four- view X-ray to check for proper alignment following closed reduction, the appropriate code for the first service, a three-view mandible X-ray, is 70100, The second service, the four-view mandible X-ray, merits 70110, Radiologic examination, mandible; complete, minimum of four views. However, billing edits bundle 70100 into 70110 and a modifier cannot be used to override the edit. So, if the provider performs the services on the same date, the payer may consider only 70110 reportable and payable.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $37.52, Non Facility Fee: $37.52
RVU (Facility): Work RVU 0.18, Practice Exp. RVU 0.96, Malpractice RVU 0.02, Total RVU 1.16
RVU (Non-Facility): Work RVU 0.18, Practice Exp. RVU 0.96, Malpractice RVU 0.02, Total RVU 1.16
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 1, Endoscopic Base Code: None
Practitioner MUE: 2

Modifier Allowances

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

NCCI Alerts (version 31.0)

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

ICD-10-CM Cross References

C41.1, C41.9, D16.5, K08.21-K08.23, M26.20-M26.25, M26.211-M26.213, M26.220, M26.221, M26.50-M26.55, M26.57, M26.69, M27.0-M27.2, M27.40, M27.49, M27.9, R68.84, S02.600A,

HCPCS Level II Codes

Medical and Surgical Supplies

A2011

Supra sdrm, per square centimeter

Clinical Responsibility

This code describes the supply of Supra SDRM®, a skin substitute that is fully synthetic, with polylactic acid (a type of polyester) as the main component. The provider may apply this product on a wound, such as an ulcer or burn, to assist healing. The provider reports this code for each square centimeter.

BETOS

P5A: Ambulatory procedures - skin

A2012

Suprathel, per square centimeter

Clinical Responsibility

This code describes the supply of Suprathel®, a synthetic skin substitute. The provider may apply this product on a wound, such as an ulcer or burn, to assist healing. The provider reports this code for each square centimeter.

BETOS

P5A: Ambulatory procedures - skin

A2013

Innovamatrix fs, per square centimeter

Clinical Responsibility

This code describes the supply of InnovaMatrix® FS, a skin substitute made of an extracellular matrix (ECM) derived from pig placenta. ECM is a material secreted by cells that provides a supportive framework for surrounding cells. The provider may apply this product on a wound, such as an ulcer, surgical wound, or trauma wound, to assist healing. The provider reports this code for each square centimeter.

BETOS

P5A: Ambulatory procedures - skin

A2014

Omeza collagen matrix, per 100 mg

Clinical Responsibility

This code represents the supply of Omeza® Collagen Matrix, a collagen-based wound care matrix made of fish collagen, cod liver oil, and other oils and waxes. Collagen is an insoluble fibrous protein that is the chief component of connective tissue. The provider may apply this product on a wound, such as an ulcer, surgical wound, or trauma wound, as part of wound care. The provider reports this code for each 100 mg.

BETOS

P5A: Ambulatory procedures - skin

A2015

Phoenix wound matrix, per square centimeter

Clinical Responsibility

This code represents the supply of Phoenix Wound Matrix®, a synthetic wound care matrix. The provider may apply this product on a wound, such as an ulcer, surgical wound, or trauma wound, as part of wound care. The provider reports this code for each square centimeter.

Coding Tips

HCPCS Level II codes that begin with A represent ambulance and transport services and supplies; medical and surgical supplies; and administrative, miscellaneous, and investigational services.

BETOS

P5A: Ambulatory procedures - skin

A2016

Permeaderm b, per square centimeter

Clinical Responsibility

This code represents the supply of PermeaDerm® B, which is a biosynthetic wound covering made of nylon, a slitted silicone membrane, porcine (pig) gelatin, and aloe vera. The provider may apply this product to cover areas such as partial thickness burn wounds, donor sites, or meshed autografts as part of wound care. The provider reports this code for each square centimeter.

BETOS

P5A: Ambulatory procedures - skin

A2017

Permeaderm glove, each

Clinical Responsibility

This code represents the supply of a PermeaDerm® Glove, which is a biosynthetic wound covering made of nylon, a slitted silicone membrane, porcine (pig) gelatin, and aloe vera. The provider may apply this glove to partial thickness hand burns as part of wound care. The provider reports this code for each glove.

BETOS

P5A: Ambulatory procedures - skin

A2018

Permeaderm c, per square centimeter

Clinical Responsibility

This code represents the supply of PermeaDerm® C, which is a biosynthetic wound covering made of nylon, a slitted silicone membrane, porcine (pig) gelatin, and aloe vera. The provider may apply this product on a wound, such as an ulcer, surgical wound, or trauma wound, as part of wound care. The provider reports this code for each square centimeter.

BETOS

P5A: Ambulatory procedures - skin

A4100

Skin substitute, fda cleared as a device, not otherwise specified

Clinical Responsibility

This code describes the supply of a skin substitute that the Food and Drug Administration (FDA) has cleared as a device. The provider may apply this product on a wound, such as an ulcer, surgical wound, or trauma wound, to assist healing. As a "not otherwise specified" code, this code applies when no more specific code is appropriate for the skin substitute used.

BETOS

P5A: Ambulatory procedures - skin

A4321

Therapeutic agent for urinary catheter irrigation

Clinical Responsibility

The provider adds acetic acid or hydrogen peroxide mixed with normal saline or sterile water to make an irrigation solution for a urinary catheter. This therapeutic solution treats or prevents catheter obstruction and or protects the skin in the genital area, or perineum.

Coding Tips

This code represents medical and surgical supplies.

Routine irrigation procedures to prevent obstruction are considered medically unnecessary, so A4321 is generally not covered. Intermittent irrigation to clear an active obstruction is medically necessary, but the use of any added therapeutic agent is included in the allowance for normal saline, reported as A4217, Sterile water and or saline, 500 mL.

For antibiotic and or chemotherapeutic agents added to an irrigation solution, report A9270, Noncovered item or service, and are not usually denied. Check with your payer for confirmation.

When water or saline is used alone without a therapeutic agent, report code A4217, Sterile water and or saline, 500 mL.

BETOS

D1F: Prosthetic/Orthotic devices

A4565

Slings

Clinical Responsibility

Report this code for the supply of the sling that a provider applies to support and restrain movement of an injured body part. Slings reduce pain, help prevent further injury, or damage, and reduce the risk of opening a closed injury. Slings come in different styles, such as an arm sling, elevating sling collar, and cuff sling.

Coding Tips

Use A codes to represent transportation services, medical and surgical supplies, and radiopharmaceuticals, a combination of a radioactive compound with a pharmaceutical compound.

If provider uses a prefabricated shoulder sling or vest design, use A4566, Shoulder sling or vest design, abduction restrainer, with or without swathe control, prefabricated, includes fitting and adjustment.

BETOS

D1A: Medical/surgical supplies

A4566

Shoulder sling or vest design, abduction restrainer, with or without swathe control, prefabricated, includes fitting and adjustment

Clinical Responsibility

Report this code when the patient receives a prefabricated shoulder sling or sling vest that restrains abduction, with or without a swathe. The code covers fitting and adjustment. Slings support and restrain movement of an injured body part. They reduce pain, help prevent further injury or damage, and reduce the risk of opening a closed injury.

Modifier Descriptors

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

Modifier	Description
78	Unplanned Return to the Operating/Procedure Room by the Same Physician or Other Qualified Health Care Professional Following Initial Procedure for a Related Procedure During the Postoperative Period
79	Unrelated Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period
80	Assistant Surgeon
81	Minimum Assistant Surgeon
82	Assistant Surgeon (when qualified resident surgeon not available)
90	Reference (Outside) Laboratory
91	Repeat Clinical Diagnostic Laboratory Test
92	Alternative Laboratory Platform Testing
93	Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System
95	Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System
96	Habilitative Services
97	Rehabilitative Services
99	Multiple Modifiers
CPT® Category II Modifiers	
1P	Performance Measure Exclusion Modifier due to Medical Reasons
2P	Performance Measure Exclusion Modifier due to Patient Reasons
3P	Performance Measure Exclusion Modifier due to System Reasons
8P	Performance Measure Reporting Modifier - Action Not Performed, Reason Not Otherwise Specified
HCPCS Level II Modifiers	
A1	Dressing for one wound
A2	Dressing for two wounds
A3	Dressing for three wounds
A4	Dressing for four wounds
A5	Dressing for five wounds
A6	Dressing for six wounds
A7	Dressing for seven wounds
A8	Dressing for eight wounds
A9	Dressing for nine or more wounds
AA	Anesthesia services performed personally by anesthesiologist

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

Terminology

Terminology	Explanation
23 valent	A vaccine that contains 23 of the most common types of pneumococcal bacteria to help prevent infection.
Abdominal paracentesis	Surgical puncture of the abdominal cavity for the removal of fluid for diagnosis or treatment.
Abdominal wall	May refer to muscle covering the abdomen, or to the skin, fascia, muscle, and membranes marking the boundaries of the abdominal cavity.
Abscess	Sac or pocket formed due to the accumulation of purulent material, pus, in the soft tissue.
Acellular pertussis	Highly infectious respiratory disease; also called whooping cough.
Acetabulum	The cup shaped socket of the hip joint.
Acetic acid	A substance with antibacterial and antifungal qualities.
Acromioclavicular, or AC, joint	Union of the acromion, a bony projection on the shoulder blade, and the clavicle, or collar bone.
Activities of daily living (ADL)	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.
Acute respiratory distress	Sudden onset of difficulty breathing or periods of apnea, or failure to breathe.
Adenovirus	DNA viruses that cause infection in the lungs and eyes.
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.
Adhesive material	Cotton or a fabric coated with a covering that is used to cover minor skin injuries.
Adjuvant	A substance added to the vaccine to boost body's immune response to the vaccine.
Adolescent	Teenager.
Advanced life support	Emergency prehospital services that use invasive medical actions, such as administration of intravenous fluids or drugs, intubation, and cardioversion or defibrillation.
Affinity separation	A biochemical method of dividing substances by binding their specific antigens to specific antibodies.
Albumin	A liver protein that tells a provider about a patient's liver function and nutritional status by measuring the level of the protein in the blood.
Ambulatory	The ability to walk or suitability for walking.
Amniotic fluid	Fluid present in the amniotic sac that surrounds the fetus thereby preventing the fetus from any external injury or shock.
Amniotic sac	A sac in the uterus that has fluid which protects the fetus from any external shock during pregnancy.
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.
Anal canal	The terminal, or end portion of the digestive tube from the rectum to the anus.
Analgesic	Medicines that give relief from pain.
Anatomical neck humerus	The portion of the humerus that separates the greater and lesser tubercles from the humeral head, or the forearm muscles.
Anatomical position	The position of human body taken as a reference while explaining the orientation of body parts amongst themselves, the position includes the person standing with neck and spine erect, looking in front, square shoulders, arms by the side, and palms rotated to face forwards.
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 reduce sensation to pain in specific areas of the body.
Anesthetic	Substance that reduces sensitivity to pain.
Aneurysm	Weakness in the wall of a blood vessel or wall of a ventricle of the heart, typically the left ventricle, causing the wall to balloon out; sometimes requiring surgical excision or repair to prevent rupture.
Angioplasty	A surgical procedure to widen a narrowed or blocked artery.
Anterior	Closer to the front part of the body.
Anterolateral thoracotomy	Surgical incision through the anterior, or front, chest wall to the side.
Anteroposterior, or AP, view	The X-ray projection travels from front to back.
Antibiotic	Substance that inhibits or treats bacterial infections.
Antibiotic solution	A solution of water or saline that contains an antibiotic, a substance that inhibits infection.

Terminology	Explanation
Antibody	A protein produced by the immune system in response to an antigen; lab tests may utilize reactions between antibodies and antigens to identify a substance in a patient specimen.
Anticoagulant drug	A drug that causes a delay in clotting of blood, thus preventing the chances of myocardial infarction, stroke, blood clot in the brain, or deep vein thrombosis.
Antigen	A substance that can stimulate the immune system to produce antibodies; lab tests may utilize reactions between antibodies and antigens to identify a substance in a patient specimen.
Antispasmodic	Substance that reduces or eliminates muscle spasms.
Antitoxin	An antibody that counterbalances the toxin secreted by the antigen.
AP (Anteroposterior)	front to back.
Appendiceal	Pertaining to the appendix, a saclike structure between the small intestine and large intestine whose function is unknown.
Arrhythmia	Irregular rate or rhythm of the heartbeat.
Arterial access	Situated or occurring within an artery.
Artery	A blood vessel that carries oxygenated blood from the heart to different parts of the body.
Arthralgia	Pain in a joint.
Arthritis	An inflammatory condition affecting one or more of the body's joints, resulting in pain, swelling, and limitation of movement.
Arthrography	Radiography of a joint after injecting one or more contrast dyes into the joint; it is a diagnostic injection that visualizes an injury by means of a contrast dye and X-ray.
Arthroplasty	Reconstruction or replacement of a joint, the point of union of two musculoskeletal structures, such as two bones.
Articular	Referring to the part of the bone or other tissue constituting a joint of two or more bones.
Articular disk	A fibrocartilaginous ligament cushion between the bones of a joint.
Ascites	An abnormal collection of fluid in the abdomen.
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.
Assay	A laboratory test to find or measure the quantity of some entity, called the analyte, or to find or measure some property of the analyte, such as functional activity.
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.
Atrium (pl. atria)	One of the two upper chambers of the heart; the left atrium delivers oxygenated blood from the pulmonary veins to the left ventricle of the heart, the right receives blood from the major veins and delivers it to the right ventricle.
Atrophy	Reduction in amount of tissue.
Attenuated vaccine	A vaccine prepared from an altered form of a live virus so that it cannot cause disease but remains able to protect an individual from the disease, also live virus vaccine.
Axilla	The space beneath the arm where it joins the body; also called the armpit or underarm.
Bacteria (sing. bacterium)	Single–celled microorganisms visible only with a microscope, some of which cause infection; may also be referred to as bacilli (sing. bacillus).
Bacteriuria	A significant number of bacteria in the urine; a possible urinary tract infection.
Barium sulfate	A radiopaque contrast media; when swallowed, the barium sulfate coats the esophagus, stomach, and intestine, revealing diseased and damaged areas on X-ray or CT images.
Bartholin's gland	One of a pair of secretory glands in the female genital area, on either side of the vagina, or birth canal.
Basilic vein	Superficial vein of arm that carries impure blood from the hand and forearm.
Benign	Not malignant, generally treatable or not needing treatment.
Benign lesions	Diseased tissue that is noncancerous.
Bennett fracture	A fracture dislocation at the carpometacarpal joint at the base of the thumb, involving the first metacarpal bone.
Bicondylar	Two condyles.
Bilateral	On two sides; opposite of unilateral.
Bilirubin	Yellow substance found in hemoglobin, a product of red blood cells; excreted in urine and bile; if a patient has elevated levels of bilirubin, it may indicate disease.
Bimalleolar	Referring to the two malleoli, which are bony projections on the sides of the ankle joint.

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