# Table of Contents

<table>
<thead>
<tr>
<th>Introduction and Features</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation and Management</td>
<td>5</td>
</tr>
<tr>
<td>Survival Guide</td>
<td>97</td>
</tr>
<tr>
<td>Modifier Lay Terms and</td>
<td>119</td>
</tr>
<tr>
<td>Explanations</td>
<td>123</td>
</tr>
<tr>
<td>Introduction to Surgical Coding and Surgical Terms</td>
<td>126</td>
</tr>
<tr>
<td>Procedure Eponyms</td>
<td>128</td>
</tr>
<tr>
<td>Basic Types of Anesthesia</td>
<td>131</td>
</tr>
<tr>
<td>Vital Signs and Normal Lab Values</td>
<td>183</td>
</tr>
<tr>
<td>Billing, Coding, and Reimbursement Terms</td>
<td>191</td>
</tr>
<tr>
<td>Abbreviations</td>
<td>227</td>
</tr>
<tr>
<td>Anatomical Illustrations</td>
<td>241</td>
</tr>
<tr>
<td>Lay Terms for Procedures and Services</td>
<td>279</td>
</tr>
<tr>
<td>· Evaluation and Management (99091-99499)</td>
<td>281</td>
</tr>
<tr>
<td>· Anesthesia (00100-01999)</td>
<td>311</td>
</tr>
<tr>
<td>· Surgery</td>
<td>311</td>
</tr>
<tr>
<td>· Surgery/General (10004-10021)</td>
<td>345</td>
</tr>
<tr>
<td>· Surgery/Integumentary System (10030-19499)</td>
<td>435</td>
</tr>
<tr>
<td>· Surgery/Musculoskeletal System (20100-29999)</td>
<td>463</td>
</tr>
<tr>
<td>· Surgery/Respiratory System (30000-32999)</td>
<td>533</td>
</tr>
<tr>
<td>· Surgery/Cardiovascular System (33016-37799)</td>
<td>539</td>
</tr>
<tr>
<td>· Surgery/Hemic and Lymphatic Systems (38100-38999)</td>
<td>541</td>
</tr>
<tr>
<td>· Surgery/Mediastinum and Diaphragm (39000-39599)</td>
<td>607</td>
</tr>
<tr>
<td>· Surgery/Digestive System (40490-49999)</td>
<td>607</td>
</tr>
<tr>
<td>· Surgery/Urinary System (50010-53899)</td>
<td>639</td>
</tr>
<tr>
<td>· Surgery/Male Genital System (54000-55899)</td>
<td>651</td>
</tr>
<tr>
<td>· Surgery/Reproductive System (55920)</td>
<td>653</td>
</tr>
<tr>
<td>· Surgery/Intersex (55970-55980)</td>
<td>655</td>
</tr>
<tr>
<td>· Surgery/Female Genital System (56405-58999)</td>
<td>747</td>
</tr>
<tr>
<td>· Surgery/Maternity Care and Delivery (59000-59899)</td>
<td>767</td>
</tr>
<tr>
<td>· Surgery/Endocrine System (60000-60699)</td>
<td>775</td>
</tr>
<tr>
<td>· Surgery/Nervous System (61000-64999)</td>
<td>777</td>
</tr>
<tr>
<td>· Surgery/Eye and Ocular Adnexa (65091-68899)</td>
<td>835</td>
</tr>
<tr>
<td>· Surgery/Auditory System (69000-69979)</td>
<td>835</td>
</tr>
<tr>
<td>· Surgery/Operating Microscope (69990)</td>
<td>1021</td>
</tr>
<tr>
<td>· Radiology Procedures (70010-79999)</td>
<td>1107</td>
</tr>
<tr>
<td>· Pathology and Laboratory Procedures (80047-89398)</td>
<td>1145</td>
</tr>
<tr>
<td>· Medicine Services and Procedures (0001A-99607)</td>
<td>1145</td>
</tr>
<tr>
<td>· Category III Codes (0042T-0713T)</td>
<td>1145</td>
</tr>
<tr>
<td>Medical Terms Glossary</td>
<td>1145</td>
</tr>
</tbody>
</table>

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Thank you for your purchase! We are pleased to offer you our unique resource for coding procedures and services, which is based on the AMA’s Current Procedural Terminology (CPT®) coding system. The code set in this book is compliant with the Health Information Portability and Accountability Act (HIPAA) for coding procedures and services.

This book goes above and beyond to help you to better understand how providers perform services and procedures so that you can choose the most accurate code. **You’ll find our easy-to-read descriptions of procedures and services, including step-by-step explanations.** In addition to including the lay term descriptions for Category I and Category III codes, we’ve crafted a select set of bonus features based on requests from coders in the field as well as the recommendations from our core group of veteran coding educators.

Our goal was to apply our unique approach to focusing on the practical understanding of the codes to this lay term guide. That’s why you’ll find a **glossary of hundreds of medical terms** in this book that provide you with definitions of terms to enhance your understanding of a lay term description of a code.

This code book is also packed with a set of bonus features that you’ll benefit from page after page, including the following:

- G code crosswalks listed under relevant CPT® codes
- Detailed anatomical illustrations
- 60 tabs bound in the book to mark each section of the book
- Evaluation and management survival guide to help you code all types of E/M services, including the 2021 updates
- Modifier lay terms and explanations to clear up the confusion of when and how to apply CPT® modifiers
- Introduction to surgical coding and surgical terms to have a solid understanding of coding surgical procedures and common terminology
- Procedure eponyms for procedures named after a person
- Basic types of anesthesia walk-through explanations
- Normal lab values and vital signs so you know what is considered to be the normal or abnormal result
- Billing, coding, and reimbursement terms help you to become familiar with the current terms and regulatory organizations
- Common abbreviations you’ll find in medical charts
- Illustrations of various body systems to guide you as you read lay term descriptions for services and procedures
Evaluation and Management Survival Guide

Note: The information in this guide is provided to use for coding services. It is not a guarantee of payment and not meant to replace an individual coder's judgment. Updates to the E/M codes are listed at the end of this guide and are not necessarily found throughout the guide. Check with individual payers for their guidelines on coding, billing, and reimbursement for E/M codes. Note that the code ranges in the table of contents match the AMA CPT® code book; however, not all codes within a specific range will be covered within this survival guide.

Contents

Introduction........................................................................................................................................... 6
Chapter 1: E/M Guidelines....................................................................................................................... 7
Chapter 2: Office or Other Outpatient Visits (99202-99215) ................................................................. 12
Chapter 3: New vs. Established Patients .................................................................................................. 15
Chapter 4: Hospital Observation (99217-99220, 99224-99226, 99234-99236) ....................................... 17
Chapter 5: Initial Hospital Care (99221-99223) ....................................................................................... 21
Chapter 6: Hospital Discharge Services (99238-99239) ........................................................................ 24
Chapter 7: Consultations (99241-99255) .................................................................................................. 28
Chapter 8: Emergency Department Services (99281-99285, 99288) .................................................... 35
Chapter 9: Critical Care-Adult (99291-99292) ......................................................................................... 42
Chapter 10: Nursing Facility Services (99304-99318) ......................................................................... 46
Chapter 11: Rest Home Services (99334-99337) .................................................................................. 48
Chapter 12: Home Services (99341-99350) .......................................................................................... 49
Chapter 13: Prolonged Service Face-To-Face (+99354-+99357) ......................................................... 51
Chapter 14: Prolonged Services Without Direct Patient Contact (99358, +99359) .................................. 54
Chapter 15: Standby Services (99360) ................................................................................................... 55
Chapter 16: Medical Team Conferences (99366-99368) ...................................................................... 57
Chapter 17: Care Plan Oversight Services (99374-99380) .................................................................... 58
Chapter 18: Preventive Medicine (99381-99429) ................................................................................. 62
Chapter 19: Telephone Services (99421-99423, 99441-99443, 99446-99449) ...................................... 66
Chapter 20: Special E/M Services and Remote Patient Monitoring (99450-99458) .............................. 67
Chapter 21: Newborn Care (99460-99463) ........................................................................................... 68
Chapter 22: Pediatric Patient Transport (99466-99467) .................................................................... 69
Chapter 23: Critical Care-Neonatal and Pediatric (99468-99469, 99471-99472, 99475-99476) ............. 71
Chapter 24: Initial and Continuing Intensive Care Infant (99477-99480) ............................................. 73
Chapter 25: Concurrent Care ................................................................................................................ 76
Chapter 26: Family Conferences ............................................................................................................ 78
Chapter 27: Second Opinions ............................................................................................................... 79
Chapter 28: Shared E/M Visits .............................................................................................................. 80
Chapter 29: Time .................................................................................................................................... 82
Chapter 30: Modifiers ............................................................................................................................ 83
Chapter 31: Advance Care Planning (99497+99498) ........................................................................... 87
Chapter 32: Telehealth Services ......................................................................................................... 91
Chapter 33: Transitional Care Management (99495-99496) ................................................................. 93
Chapter 34: 2022 Coding Updates ......................................................................................................... 95

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Chapter 1: E/M Guidelines

Evaluation and management (E/M) services refer to patient visits and consultations provided by physicians or residents under their supervision, as well as nonphysician providers both under a physician’s supervision in an incident-to situation and operating without supervision when billing under their own provider identification. The AMA has assigned each of these services a CPT® code, the Health Care Financing Administration (HCFA) — now the Centers for Medicare and Medicaid Services (CMS) — implemented them in 1992 as part of the resource-based Medicare fee schedule payment system.

Like all CPT® codes, E/M codes are universal payers for processing claims and used by Medicare, Medicaid, and most other physician’s professional services. You should also use E/M service codes for billing facility services on an outpatient basis.

Because E/M services are high-volume provider activities, the E/M codes are the most frequently used by physicians and nonphysician providers in daily practice.

Know Your Guidelines

The following guidance applies to E/M codes except 99202-99215, which are discussed in Chapter 2 of this guide. To help providers distinguish between the various E/M service levels, CMS issued E/M documentation guidelines in 1995 and again in 1997, with the section on examinations being the main difference between the two sets.

The 1995 guidelines allow physicians to conduct either a general multisystem or single-system exam and defined the levels of examination based on body areas and organ systems. The guidelines neglect, however, to specifically define what constitutes a single-system comprehensive exam.

In addition, the 1995 guidelines created confusion by describing both an expanded problem-focused exam and a detailed exam as encompassing two to seven body areas or organ systems — although the guidelines state that an expanded problem-focused exam includes a limited exam of the areas, while a detailed exam includes an expanded exam of at least one area.

The CMS-issued 1997 guidelines create more specific audit criteria by including the number of examination elements that a provider must perform and document at each level and by outlining the elements of the multisystem general exam and 10 single-organ system exams: cardiovascular, ear/nose/throat, eye, genitourinary, hematologic/lymphatic/immunologic, musculoskeletal, neurological, psychiatric, respiratory, and skin.

Important: Providers can use either the 1995 or the 1997 guidelines.

Commonly Used E/M Terms

When you’re reviewing E/M rules and regulations, there are certain terms that you’ll see frequently, including the following:

Provider — A provider is a physician or licensed nonphysician provider who may provide services incident to the physician or independently under his or her own provider number (PIN or NPI).

Professional Services — Professional Services are those face-to-face services rendered by physicians and other qualified healthcare professionals reported by a specific CPT® code(s).

New Patient — A new patient is one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

Established Patient — An established patient is one who has received professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

For example, when a physician/qualified healthcare professional is on call or covering for another physician/qualified healthcare professional, the patient’s encounter/visit will be classified as that of an established patient because it would have been by the physician or qualified healthcare professional who is unavailable. When Advanced Practice Nurses (APNs) and Physician Assistants (PAs) are working with physicians, PAs and APNs are considered to be working in both exact specialty and subspecialties as the physicians.

CPT® Note: If a provider is on-call or covering for another provider, you should classify the services as if the regular provider were available; also, there is no distinction between new and established patients for emergency department visits.

Chief Complaint — the symptom, problem, condition, diagnosis or other factor that is the reason for the patient’s visit (Important: Every E/M visit must have a chief complaint.)

Concurrent Care — the provision of similar services to the same patient by more than one physician or other qualified healthcare professional on the same day (primarily during hospital visits)

Transfer of Care — a process through which a physician or other qualified healthcare professional who gives up this responsibility to another physician or other qualified health professional who agrees to take on this responsibility and who, from the initial visit, is not providing consultative services.

Remember: Consultation codes (99241-99255) should not be reported by the provider who has already agreed to accept transfer of care before an initial visit, but it can be appropriate to report if the decision to accept transfer of care can’t be made until after the initial consultation evaluation, in spite of the type of service.

Counseling — a discussion with a patient and/or family concerning one or more of the following:

- Diagnostic results, impressions, and/or recommended diagnostic studies
- Prognosis
- Risks and benefits of treatment options
- Instructions for treatment and/or follow-up
- Importance of compliance with chosen treatment options
- Risk factor reduction
- Patient and family education
- Patient or family questions

Family History — a review of medical events in the patient’s family that includes significant information about the following:

- The health status or cause of death of parents, siblings, and children

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Basic Types of Anesthesia

Anesthesia is a medical specialty where providers administer anesthesia to patients during procedures so that they remain free of any pain. Anesthesia also keeps the patient still during the procedure and can be used in combination with other drugs to minimize the patient’s anxiety. Anesthesia care includes meeting with the patient prior to anesthesia administration, monitoring the patient’s condition, including vital signs, and safety during the procedure, and postoperative care after the procedure. Depending on the type of anesthesia given and the type of procedure performed, the patient may be conscious, semi-conscious, or unconscious during the procedure. You can find anesthesia codes in the second section of the CPT® code book under the anesthesia code range of 00100-01999. There are many different methods that anesthesia providers use to administer anesthesia. The anesthesia provider determines the method of anesthesia that will be required by considering the procedure to be performed and the level of consciousness that is required.

Types of anesthesia include:
- Local and regional
- Nerve blocks
- Patient-controlled analgesia
- Moderate or conscious sedation
- General anesthesia
- Monitored anesthesia care (MAC)

Local and Regional Anesthesia

Local and regional anesthesia keeps patients from feeling pain in a specific area of the body, with local anesthesia affecting a smaller area than regional anesthesia. The patient is awake during procedures using local and regional anesthesia, giving the patient the ability to remember the procedure and communicate with the provider if needed. Local anesthesia is also known as conduction anesthesia and can be administered via an ointment, spray, or solution.

Nerve Blocks

A nerve block, also called block anesthesia, is used to block pain by injecting an anesthetic around or into a nerve. Analgesia blocks pain receptors in the central and/or peripheral nervous system without the patient losing consciousness.

Types of nerve blocks include:
- Axillary block for procedures on the arm and hand – anesthesia is injected into the armpit.
- Bier block for pain management or for procedures on the extremities – anesthesia is injected into a vein in the extremity, numbing peripheral nerves and nerve endings. A tourniquet inflated around the extremity prevents the anesthesia from spreading farther.
- Epidural block for procedures of the lower half of the body such as the pelvis and legs. It is also used to numb labor pain for pregnant women – anesthesia is delivered into the epidural space into the patient’s back, numbing the nerves in the spinal cord, via a catheter that is inserted by the anesthesia provider. The catheter is left in place to deliver more anesthetic as needed for the duration of the procedure.
- Epidural blood patch for relieving headaches caused by epidural anesthesia or a lumbar puncture (spinal tap).
- Epidural nerve block to decrease pain from spinal stenosis, a herniated disk, or other disorders – the provider injects a corticosteroid into the epidural space in the spinal cord.
- Field block for additional anesthesia around the procedure site – the provider injects anesthesia into the surrounding area.
- Infracavicular block for procedures on the elbow, forearm, and wrist – the provider injects anesthesia below the clavicle toward the brachial plexus.
- Interscalene block for procedures on the arm or shoulder – the provider injects anesthesia into the neck.
- Intrapleural block for biopsy of the pleura or a thoracotomy – the provider injects anesthesia between the visceral pleura and the parietal pleura.
- Intraarticular block for procedures on a joint – the provider injects anesthesia directly into the joint.
- Peripheral nerve block for procedures on arms and legs – the provider injects anesthesia into the peripheral nerves of the arm or leg.
- Plexus block for procedures near a network of nerves (nerve plexus) such as the pelvic plexus – the provider injects anesthesia into the nerve plexus.
- Rescue block for the patient’s postsurgical comfort – the provider injects anesthesia after surgery to help the patient remain without pain.
- Saddle block (caudal block) for procedures on the buttocks or legs – the provider injects anesthesia into the lower spine.
- Spinal block for procedures on the lower body, urinary systems, and genitals – the provider injects anesthesia into the cerebrospinal fluid (CSF).
## Billing, Coding, and Reimbursement Terms

<table>
<thead>
<tr>
<th>Billing/Coding/Reimbursement Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>A “TIER”</td>
<td>A specific list of drugs. Your plan may have several tiers, and your copayment amount depends upon which tier your drug is listed. Plans can choose their own tiers, so members should refer to their benefit booklet or contact the plan for more information.</td>
</tr>
<tr>
<td>ABSTRACT</td>
<td>The collection of information from the medical record via hard copy or electronic instrument.</td>
</tr>
<tr>
<td>ABUSE</td>
<td>A range of the following improper behaviors or billing practices including, but not limited to: Billing for a non-covered service; Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered); or Inappropriately allocating costs on a cost report.</td>
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<tr>
<td>ABUSE (PERSONAL)</td>
<td>When another person does something on purpose that causes you mental or physical harm or pain.</td>
</tr>
<tr>
<td>ACCESS</td>
<td>Your ability to get needed medical care and services.</td>
</tr>
<tr>
<td>ACCESSIBILITY OF SERVICES</td>
<td>Your ability to get medical care and services when you need them.</td>
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<tr>
<td>ACCESSORY DWELLING UNIT (ADU)</td>
<td>A separate housing arrangement within a single-family home. The ADU is a complete living unit and includes a private kitchen and bath.</td>
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<tr>
<td>ACCREDITATION</td>
<td>An evaluative process in which a healthcare organization undergoes an examination of its policies, procedures and performance by an external organization (“accrediting body”) to ensure that it is meeting predetermined criteria. It usually involves both on- and off-site surveys.</td>
</tr>
<tr>
<td>ACCREDITATION CYCLE FOR M+C DEEMING</td>
<td>The duration of CMS’s recognition of the validity of an accrediting organization’s determination that a Medicare + Choice organization (M+CO) is &quot;fully accredited.&quot;</td>
</tr>
<tr>
<td>ACCREDITATION FOR DEEMING</td>
<td>Some states use the findings of private accreditation organizations, in part or in whole, to supplement or substitute for State oversight of some quality related standards. This is referred to as “deemed compliance” with a standard.</td>
</tr>
<tr>
<td>ACCREDITATION FOR PARTICIPATION</td>
<td>State requirement that plans must be accredited to participate in the Medicaid managed care program.</td>
</tr>
<tr>
<td>ACCREDITED (ACCREDITATION)</td>
<td>Means having a seal of approval. Being accredited means that a facility or healthcare organization has met certain quality standards. These standards are set by private, nationally recognized groups that check on the quality of care at healthcare facilities and organizations. Organizations that accredit Medicare Managed Care Plans include the National Committee for Quality Assurance, The Joint Commission, and the American Accreditation HealthCare Commission/URAC.</td>
</tr>
<tr>
<td>ACCREDITED STANDARDS COMMITTEE</td>
<td>An organization that has been accredited by ANSI for the development of American National Standards.</td>
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<tr>
<td>ACT/LAW/STATUTE</td>
<td>Term for legislation that passed through Congress and was signed by the President or passed over his veto.</td>
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<tr>
<td>ACTIVITIES OF DAILY LIVING (ADL)</td>
<td>Activities you usually do during a normal day such as getting in and out of bed, dressing, bathing, eating, and using the bathroom.</td>
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<tr>
<td>ACTUAL CHARGE</td>
<td>The amount of money a doctor or supplier charges for a certain medical service or supply. This amount is often more than the amount Medicare approves. (See “Approved Amount”; “Assignment.”)</td>
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<tr>
<td>ACTUARIAL BALANCE</td>
<td>The difference between the summarized income rate and the summarized cost rate over a given valuation period.</td>
</tr>
<tr>
<td>ACTUARIAL DEFICIT</td>
<td>A negative actuarial balance.</td>
</tr>
<tr>
<td>ACTUARIAL RATES</td>
<td>One half of the expected monthly cost of the SMI program for each aged enrollee (for the aged actuarial rate) and one half of the expected monthly cost for each disabled enrollee (for the disabled actuarial rate) for the duration the rate is in effect.</td>
</tr>
<tr>
<td>ACTUARIAL SOUNDNESS</td>
<td>A measure of the adequacy of Hospital Insurance and Supplementary Medical Insurance financing as determined by the difference between trust fund assets and liabilities for specified periods.</td>
</tr>
<tr>
<td>ACTUARIAL STATUS</td>
<td>A measure of the adequacy of the financing as determined by the difference between assets and liabilities at the end of the periods for which financing was established.</td>
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<tr>
<td>Billing/Coding/Reimbursement Term</td>
<td>Definition</td>
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<td>ELECTRONIC COMMERCE</td>
<td>The exchange of business information by electronic means.</td>
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<td>ELECTRONIC DATA INTERCHANGE</td>
<td>Refers to the exchange of routine business transactions from one computer to another in a standard format, using standard communications protocols.</td>
</tr>
<tr>
<td>ELECTRONIC HEALTHCARE NETWORK ACCREDITATION COMMISSION</td>
<td>An organization that tests transactions for consistency with the HIPAA requirements, and that accredits healthcare clearinghouses.</td>
</tr>
<tr>
<td>ELECTRONIC MEDIA CLAIMS</td>
<td>A flat file format used to transmit or transport claims, such as the 192-byte UB-92 Institutional EMC format and the 320-byte Professional EMC NSF.</td>
</tr>
<tr>
<td>ELECTRONIC MEDIA QUESTIONNAIRE</td>
<td>A process that large employers can use to complete their requirements for supplying IRS/SSA/HCFA Data Match information electronically.</td>
</tr>
<tr>
<td>ELECTRONIC REMITTANCE ADVICE</td>
<td>Any of several electronic formats for explaining the payments of healthcare claims.</td>
</tr>
<tr>
<td>ELIGIBILITY</td>
<td>Refers to the process whereby an individual is determined to be eligible for healthcare coverage through the Medicaid program. Eligibility is determined by the State. Eligibility data are collected and managed by the State or by its Fiscal Agent. In some managed care waiver programs, eligibility records are updated by an Enrollment Broker, who assists the individual in choosing a managed care plan to enroll in.</td>
</tr>
<tr>
<td>ELIGIBILITY/MEDICARE PART A</td>
<td>You are eligible for premium-free (no cost) Medicare Part A (Hospital Insurance) if: you are 65 or older and you are receiving, or are eligible for, retirement benefits from Social Security or the Railroad Retirement Board, or you are under 65 and you have received Railroad Retirement disability benefits for the prescribed time and you meet the Social Security Act disability requirements, or you or your spouse had Medicare-covered government employment, or you are under 65 and have End-Stage Renal Disease (ESRD). If you are not eligible for premium-free Medicare Part A, you can buy Part A by paying a monthly premium if: you are age 65 or older, and you are enrolled in Part B, and you are a resident of the United States, and are either a citizen or an alien lawfully admitted for permanent residence who has lived in the United States continuously during the 5 years immediately before the month in which you apply.</td>
</tr>
<tr>
<td>ELIGIBILITY/MEDICARE PART B</td>
<td>You are automatically eligible for Part B if you are eligible for premium-free Part A. You are also eligible for Part B if you are not eligible for premium-free Part A, but are age 65 or older AND a resident of the United States or a citizen or an alien lawfully admitted for permanent residence. In this case, you must have lived in the United States continuously during the 5 years immediately before the month during which you enroll in Part B.</td>
</tr>
<tr>
<td>EMERGENCY CARE</td>
<td>Care given for a medical emergency when you believe that your health is in serious danger when every second counts.</td>
</tr>
<tr>
<td>EMERGENCY ROOM (HOSPITAL)</td>
<td>A portion of the hospital where emergency diagnosis and treatment of illness or injury is provided.</td>
</tr>
<tr>
<td>EMPLOYEE</td>
<td>For purposes of the Medicare Secondary Payer (MSP) provisions, an employee is an individual who works for an employer, whether on a full- or part-time basis, and receives payment for his/her work.</td>
</tr>
<tr>
<td>EMPLOYER</td>
<td>Individuals and organizations engaged in a trade or business, plus entities exempt from income tax such as religious, charitable, and educational institutions, the governments of the United States, Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, and the District of Columbia, and the agencies, instrumentalities, and political subdivisions of these governments.</td>
</tr>
<tr>
<td>EMPLOYER BULLETIN BOARD SERVICE</td>
<td>An electronic bulletin board service offered by the COB Contractor. Employers that have to report on less than 500 workers can fulfill their requirements under the Internal Revenue Service/Social Security Administration/Healthcare Financing Administration (IRS/SSA/HCFA) Data Match law by downloading a questionnaire entry application from the bulletin board. The information will be processed through several logic and consistency edits. Once the employer has completed the information, he or she will return the completed file through the bulletin board.</td>
</tr>
<tr>
<td>EMPLOYER GROUP HEALTH PLAN (GHP)</td>
<td>A GHP is a health plan that gives health coverage to employees, former employees, and their families, and is from an employer or employee organization.</td>
</tr>
</tbody>
</table>
Anatomical Illustrations

Circulatory System — Arteries and Veins

- Basilar artery
- Internal carotid artery
- External carotid artery
- External jugular vein
- Internal jugular vein
- Vertebral arteries
- Common carotid arteries
- Pulmonary arteries
- Pulmonary veins
- Heart
- Celiac trunk
- Hepatic vein
- Renal veins
- Renal artery
- Gonadal vein
- Gonadal artery
- Common iliac vein
- Common iliac artery
- Internal iliac artery
- Internal iliac vein
- External iliac vein
- External iliac artery
- Great saphenous vein
- Femoral artery
- Femoral vein
- Popliteal artery
- Popliteal vein
- Small saphenous vein
- Anterior tibial artery
- Posterior tibial artery
- Peroneal artery
- Anterior/posterior tibial veins
- Dorsal venous arch
- Dorsal digital vein

Title: Circulatory System Labels Biology Diagram, License: CC0 Creative Commons (Free for commercial use No attribution required), URL link: https://pixabay.com/en/circulatory-system-labels-biology-41523/
Circulatory System — Artery and Vein Anatomy

Artery

Vein

Circulatory System — Heart Anatomy and Cardiac Cycle

Brachiocephalic trunk
Ascending aorta
Right pulmonary artery
Superior vena cava
Pulmonary trunk
Right pulmonary veins
Right atrium
Right coronary artery
Right ventricle
Inferior vena cava

Left common carotid artery
Left subclavian artery
Aortic arch
Ligamentum arteriosum
Left pulmonary artery
Left pulmonary veins
Left atrium
Circumflex artery
Left coronary artery
Left ventricle
Anterior interventricular artery

Diastole (Filling)

Pulmonary Artery
From Lungs
Pulmonary Veins
From Lungs
Left Atrium
Aortic Valve
(opened)
Left Ventricle

Systole (Pumping)

Pulmonary Artery
To Lungs
Superior Vena Cava
To Body
Right Atrium
Right Ventricle
(closed)
Inferior Vena Cava

Semilunar Valves
(opened)

Apex
Evaluation and Management (99091-99499)

99091
The provider receives an electronic communication containing physiologic data (e.g., ECG result, blood pressures, or blood glucose test results) from a patient and/or the caregiver. He reviews the data and interprets the results, spending at least 30 minutes doing so each 30-day period.

99202
The provider performs an evaluation and management (E/M) service for a new patient in the provider's office or in another outpatient setting. The total time spent on the date of the encounter is 15-29 minutes and/or the level of medical decision-making (MDM) involved is straightforward. Total time includes both face-to-face and non-face-to-face activities on the encounter date. Examples include, but are not limited to, reviewing tests and otherwise preparing for the patient visit, performing the exam or evaluation, counseling and educating the patient or caregiver, ordering tests, communicating with other healthcare providers, documenting the encounter, interpreting and communicating results, and coordinating care. Elements of MDM include the number and complexity of problems addressed; the amount and/or complexity of data to review and analyze; and the risk of complications, morbidity, and mortality related to patient management. The visit also may include taking a patient history and performing a physical examination. The provider determines the nature and extent of the history and/or exam appropriate for the encounter.

99204
The provider performs an evaluation and management (E/M) service for a new patient in the provider's office or in another outpatient setting. The total time spent on the date of the encounter is 45-59 minutes and/or the level of medical decision-making (MDM) involved is moderate. Total time includes both face-to-face and non-face-to-face activities on the encounter date. Examples include, but are not limited to, reviewing tests and otherwise preparing for the patient visit, performing the exam or evaluation, counseling and educating the patient or caregiver, ordering tests, communicating with other healthcare providers, documenting the encounter, interpreting and communicating results, and coordinating care. Elements of MDM include the number and complexity of problems addressed; the amount and/or complexity of data to review and analyze; and the risk of complications, morbidity, and mortality related to patient management. The visit also may include taking a patient history and performing a physical examination. The provider determines the nature and extent of the history and/or exam appropriate for the encounter.

99211
The provider, often a nurse, provides a service to an established patient. This service does not require a physician or other qualified healthcare professional to see the patient. A physician or "other qualified healthcare professional" is someone qualified by education, training, applicable licensing rules and regulations, and applicable facility privileging rules who performs a professional service in their scope of practice. Physicians and qualified healthcare professionals can independently report professional services. In contrast, a clinical staff member works under the supervision of a physician or other qualified healthcare professional. Law, regulation, and facility policy allow clinical staff to perform or assist in the performance of a specific professional service. But a clinical staff member cannot report that professional service.

99213
The provider performs an evaluation and management (E/M) service for an established patient in the provider's office or in another outpatient setting. The total time spent on the date of the encounter is 20-29 minutes and/or the level of medical decision-making (MDM) involved is low. Total time includes both face-to-face and non-face-to-face activities on the encounter date. Examples include, but are not limited to, reviewing tests and otherwise preparing for the patient visit, performing the exam or evaluation, counseling and educating the patient or caregiver, ordering tests, communicating with other healthcare providers, documenting the encounter, interpreting and communicating results, and coordinating care. Elements of MDM include the number and complexity of problems addressed; the amount and/or complexity of data to review and analyze; and the risk of complications, morbidity, and mortality related to patient management. The visit also may include taking a patient history and performing a physical examination. The provider determines the nature and extent of the history and/or exam appropriate for the encounter.

99215
The provider performs an evaluation and management (E/M) service for a new patient in the provider's office or in another outpatient setting. The total time spent on the date of the encounter is 30-44 minutes and/or the level of medical decision-making (MDM) involved is low. Total time includes both face-to-face and non-face-to-face activities on the encounter date. Examples include, but are not limited to, reviewing tests and otherwise preparing for the patient visit, performing the exam or evaluation, counseling and educating the patient or caregiver, ordering tests, communicating with other healthcare providers, documenting the encounter, interpreting and communicating results, and coordinating care. Elements of MDM include the number and complexity of problems addressed; the amount and/or complexity of data to review and analyze; and the risk of complications, morbidity, and mortality related to patient management. The visit also may include taking a patient history and performing a physical examination. The provider determines the nature and extent of the history and/or exam appropriate for the encounter.

99212
The provider performs an evaluation and management (E/M) service for an established patient in the provider's office or in another outpatient setting. The total time spent on the date of the encounter is 10-19 minutes and/or the level of medical decision-making (MDM) involved is straightforward. Total time includes both face-to-face and non-face-to-face activities on the encounter date. Examples include, but are not limited to, reviewing tests and otherwise preparing for the patient visit, performing the exam or evaluation, counseling and educating the patient or caregiver, ordering tests, communicating with other healthcare providers, documenting the encounter, interpreting and communicating results, and coordinating care. Elements of MDM include the number and complexity of problems addressed; the amount and/or complexity of data to review and analyze; and the risk of complications, morbidity, and mortality related to patient management. The visit also may include taking a patient history and performing a physical examination. The provider determines the nature and extent of the history and/or exam appropriate for the encounter.

99214
The provider performs an evaluation and management (E/M) service for an established patient in the provider's office or in another outpatient setting. The total time spent on the date of the encounter is 30-39 minutes and/or the level of medical decision-making (MDM)
perform CC services — Critical care requires high-complexity decision-making to assess, manipulate, and support vital system functions to treat single or multiple vital organ system failure or to prevent further life-threatening deterioration of the patient’s condition. Critical care services require a cumulative time of at least 30 minutes on a given date of service — Time can be continuous or intermittent on the date of service and must be clearly documented in the medical record. The total time can be calculated by the time spent evaluating, managing, and providing critical care services to a critically ill or injured person. The time to be billed for CC must be spent at the immediate bedside or elsewhere on the floor as long as the physician is available to the patient. Full attention of a physician must be paid towards the CC service — i.e., the physician cannot provide services to any other patient during that same period of time.

The physician may provide the critical service to a patient at a “critical care area” like a CCU, ICU, respiratory care unit, or emergency room. But medical documentation must support the shear necessity to provide the critical care service. Three mandatory criteria must be met in order to bill for critical care service:

1. The patient must meet the definition of critically ill / injured (vital organ failure; life-threatening health condition). The physician must perform critical care services. Critical care requires high-complexity decision-making to assess, manipulate, and support vital system functions to treat single or multiple vital organ system failure or to prevent further life-threatening deterioration of the patient’s condition. Critical care services require a cumulative time of at least 30 minutes on a given date of service. Time can be continuous or intermittent on the date of service and must be clearly documented in the medical record. The total time can be calculated by the time spent evaluating, managing, and providing critical care services to a critically ill or injured person. The time to be billed for critical care must be spent at the immediate bedside or elsewhere on the floor as long as the physician is available to the patient. Full attention of a physician must be paid towards the CC service — i.e., the physician cannot provide services to any other patient during that same period of time.

2. There must be at least two of three key components met to support the service.

3. There must be three of three key components met to support the service level.
When the patient is appropriately prepped and anesthetized, the provider makes an incision at the limbus using a surgical blade and excises the cornea with curved scissors. He then removes the intraocular contents using an evisceration spoon and closes the scleral wound with sutures. He applies antibiotic drops. He closes Tenon’s capsule and the conjunctiva in separate overlying layers.

65093
When the patient is appropriately prepped and anesthetized, the provider makes an incision at the limbus using a surgical blade and excises the cornea with curved scissors. He then removes the intraocular contents using an evisceration spoon. He makes small incisions in the sclera and places the implant, using an insertion device and forceps, or pincers, in the scleral shell. He closes the sclera with nonabsorbable suture and closes Tenon’s capsule and the conjunctiva in separate overlying layers. Finally, he places an orbital conformer behind the eyelids and applies a pressure patch.

65101
When the patient is appropriately prepped and anesthetized, the provider performs a limbal peritomy, an incision around the perimeter of the cornea, while preserving as much of the conjunctiva and Tenon’s capsule as possible. He removes the eye from the socket and places gauze soaked in saline solution into the socket to control bleeding. He places a temporary orbital conformer, which helps preserve the shape of the eyelids until a final prosthesis is made. Finally, he applies a pressure patch over the eyelid.

65103
When the patient is appropriately prepped and anesthetized, the provider performs a limbal peritomy, an incision around the perimeter of the cornea while preserving as much of the conjunctiva and Tenon’s capsule as possible. He removes the eye from the socket and places gauze soaked in saline solution into the socket to control bleeding. He selects and inserts an appropriately sized nonintegrated implant. He then attaches conjunctiva and Tenon’s capsule and sutures them in place. Finally, he uses an absorbable suture to close the conjunctiva and applies a pressure patch.

65114
When the patient is appropriately prepped and anesthetized, the provider passes a suture through the eyelid skin and orbicularis and then passes it through the tarsal plate and secures the lids together. He makes an incision approximately close to the lid margin to spare the eyelids in this procedure. He selects an appropriately sized implant and places it in the socket. He then applies a pressure patch over the eyelid.

65110
When the patient is appropriately prepped and anesthetized, the provider performs a limbal peritomy, an incision around the perimeter of the cornea, while preserving as much of the conjunctiva and Tenon’s capsule as possible. He removes the eye from the socket and places gauze soaked in saline solution into the socket to control bleeding. He selects and inserts an appropriately sized nonintegrated implant. He then applies a pressure patch over the eyelid.

65125
When the patient is appropriately prepped and anesthetized, the provider cleanses the empty eye socket and places a suture in the eyelid to hold it open. He debrides, or scrapes out, the empty socket and irrigates it with an antibiotic, or infection inhibiting, solution. He prepares the implant and then inserts it deep into the socket. He then closes Tenon’s capsule and the conjunctiva in separate overlying layers over the implant and places an orbital conformer.

65140
When the patient is appropriately prepped and anesthetized, the provider cleanses the empty eye socket and places a suture in the eyelid to hold it open. He debrides, or scrapes out, the empty socket and irrigates it with an antibiotic, or infection inhibiting, solution. He prepares the implant and then inserts it deep into the socket. He then closes Tenon’s capsule and the conjunctiva in separate overlying layers over the implant and places an orbital conformer.

65150
When the patient is appropriately prepped and anesthetized, the provider opens the scleral shell, which had been closed in a previous evisceration or enucleation procedure. He reinserts the implant. He closes the conjunctival membrane over the implant, applying a graft, if necessary, to close the defect.

65155
When the patient is appropriately prepped and anesthetized, the provider opens the scleral shell, which had been closed in a previous evisceration or enucleation procedure. He reinserts the implant. He uses suture or graft tissue to attach the muscles or reinforce them. He closes the conjunctival membrane over the implant.

65175
When the patient is appropriately prepped and anesthetized, the provider places an ocular speculum into the eye socket. She then carefully lifts the implant, and excises and retracts any conjunctival tissue and Tenon’s capsule that may be covering the prosthesis. The provider then carefully removes the implant excising any extraocular muscle attachment and avoiding damage to the surrounding tissue. This procedure may be done due to recurring, long standing or extensive implant exposure with an infection that is resistant to treatment. The
The eye that needs treatment is prepped and draped in the usual sterile fashion. The treatment area is irrigated and cleaned with an antiseptic solution. The provider removes the diseased and necrotic epithelium. Amniotic membrane is trimmed and gently spread on the ocular surface. Some amniotic membrane grafts designed for this purpose have “clips” that secure the graft to the eye. This is still referred to as a sutureless repair. The provider applies topical antibiotics to the treatment area.

Growth factors in amniotic membrane stimulate wound healing and tissue repair and discourage unwanted vessel formation. The healing effects of amniotic membrane grafts do not last, and the procedure may need to be repeated.

The eye that needs treatment is prepped and draped in the usual sterile fashion. The treatment area is irrigated and cleaned with an antiseptic solution. The provider removes the diseased and necrotic epithelium. Amniotic membrane is trimmed and gently spread on the ocular surface to cover the lesion. The graft is secured in place using interrupted sutures to the cornea.

Growth factors in amniotic membrane stimulate wound healing and tissue repair and discourage unwanted vessel formation. The healing effects of amniotic membrane grafts do not last, and the procedure may need to be repeated.

When the patient is appropriately prepped and anesthetized, the provider uses an eyelid speculum to hold the patient’s eye open. He then incises the cornea and removes wedge-shaped sections and closes the defects with sutures. He then places a bandage contact lens.

The provider uses an eyelid speculum to hold the patient’s eye open. He then incises the cornea and removes wedge-shaped sections and closes the defects with sutures. He then places a bandage contact lens.

He repeats the process to create multiple layers of the graft to cover the surface of the defect. He then secures the graft.

When the patient is appropriately prepped and anesthetized, the provider prepares the graft from a living or cadaveric donor. He removes the conjunctiva from the limbus and exposes the sclera, or outer white part of the eye. He excises the diseased or damaged corneal epithelium. He then fits the limbal graft over the defect and sutures it into position. He then applies antibiotic ointment and steroid cream to the eye and then applies an eye patch and shield for protection.

The white outer coating of the eyeball is called the limbus where some important cells exist, known as limbal cells. The provider may transplant the limbal stem cells from a cadaver or donor. If a donor graft is used, the provider harvests limbal cells from an eye of donor. Limbal stem cells give rise to the corneal epithelial cells. When the limbus is damaged or destroyed, the corneal surface becomes abnormal. Once a limbal stem cell transplant is completed, it will produce a new epithelial cells layer.

When the patient is appropriately prepped and anesthetized, the provider excises part of the conjunctiva and any scar tissue from the recipient eye. He excises the conjunctiva from the limbus and exposes the sclera. He removes a diseased or damaged corneal epithelium. Then, the provider removes the autograft from the donor eye and dissects the conjunctival tissue and limbus. He places the autograft onto the donor eye and sutures it into position. He applies an antibiotic and steroids to the eyes and applies eye patches and shields.

The white outer coating of the eyeball is called the limbus where some important cells exist, which is also known as the limbal cells. The provider harvests a limbal conjunctival autograft from a healthy eye. Limbus contains stem cells that give rise to the corneal epithelial cells. When the limbus is damaged or destroyed, the corneal surface becomes abnormal. The provider obtains and prepares a graft of amniotic membrane, which he cuts to fit the area of the cornea for transplant. The provider then places the graft on the area of the corneal defect ensuring the graft does not go beyond the margins, or surrounding areas, of the defect. He repeats the process to create multiple layers of the graft to cover the surface of the defect. He then secures the graft.

When the patient is appropriately prepped and anesthetized, the provider prepares the graft from a living or cadaveric donor. He removes the conjunctiva from the limbus and exposes the sclera, or outer white part of the eye. He excises the diseased or damaged corneal epithelium. He then fits the limbal graft over the defect and sutures it into position. He then applies antibiotic ointment and steroid cream to the eye and then applies an eye patch and shield for protection.

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0001A
The provider confirms immunization is appropriate for the patient, counsels the patient on risks and benefits, and obtains consent to administer the vaccine against SARS-CoV-2, the virus that causes COVID-19. The provider prepares the vaccine, which is preservative free and requires reconstitution by mixing solids with a diluent (liquid). The provider prepares the area for injection and administers the first dose of the SARS-CoV-2 vaccine. The route is intramuscular, meaning into the muscle. The provider monitors the patient for adverse reaction and updates the patient's immunization record.

This is an mRNA-LNP vaccine. Messenger ribonucleic acid (mRNA) carries genetic information instructing the patient's cells to make the spike protein that the coronavirus uses to bind to a host cell. Once the patient's cells produce the spike protein, it triggers an immune response that helps protect the patient from getting COVID-19. Lipid nanoparticles (LNPs) are tiny particles that act as the delivery system for the vaccine. The dosage is 30 mcg/0.3 mL.

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This is an mRNA-LNP vaccine. Messenger ribonucleic acid (mRNA) carries genetic information instructing the patient's cells to make the spike protein that the coronavirus uses to bind to a host cell. Once the patient's cells produce the spike protein, it triggers an immune response that helps protect the patient from getting COVID-19. Lipid nanoparticles (LNPs) are tiny particles that act as the delivery system for the vaccine. The dosage is 100 mcg/0.5 mL.

0004A
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0011A
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This is an mRNA-LNP vaccine. Messenger ribonucleic acid (mRNA) carries genetic information instructing the patient's cells to make the spike protein that the coronavirus uses to bind to a host cell. Once the patient's cells produce the spike protein, it triggers an immune response that helps protect the patient from getting COVID–19. Lipid nanoparticles (LNPs) are tiny particles that act as the delivery system for the vaccine. The dosage is 100 mcg/0.5 mL.

0021A
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The vaccine administered uses viral DNA in a chimpanzee adenovirus vector. That means the gene for the spike protein the coronavirus uses to bind to host cells has been added to a modified version of a chimpanzee adenovirus. After injection into the body, the adenoviruses enter cells, instructing them to make spike proteins. The proteins trigger an immune response that helps protect the patient from getting COVID–19. The dosage is 5x10^10 viral particles/0.5 mL.

0022A
The provider confirms immunization is appropriate for the patient, counsels the patient on risks and benefits, and obtains consent to administer the vaccine against SARS–CoV–2, the virus that causes COVID–19. The provider prepares the vaccine, which is preservative free. The provider prepares the area for injection and administers the third dose of the SARS–CoV–2 vaccine. The route is intramuscular, meaning into the muscle. The provider monitors the patient for adverse reaction and updates the patient's immunization record.

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which has been enhanced with added antigens to deliver increased immunity, into the muscle belly of the upper arm to protect the patient against influenza. He counsels the patient along with providing instructions and precautions before administration of the vaccine.

90669
G Code Crosswalk G0008
When the patient is appropriately prepped, the provider administers a pandemic formulation of a live influenza vaccine into the nose to protect against influenza. He counsels the patient and or his family along with providing instructions and precautions before administration of the vaccine.

90667
G Code Crosswalk G0008
When the patient is appropriately prepped, the provider injects a pandemic formulation of a split virus, preservative-free influenza vaccine into the muscle belly of the upper arm to protect against influenza. He counsels the patient along with providing instructions and precautions before administration of the vaccine.

90671
This code represents a vaccine product administered to reduce the patient’s risk of contracting pneumococcal disease, a bacterial infection that can range from ear infections to pneumonia and bloodstream infections. This code is specific to a 15-valent pneumococcal conjugate vaccine (PCV15), meaning the vaccine contains 15 different types of pneumococcal bacteria. The provider performs separately reportable administration of the vaccine. The route is intramuscular, meaning into the muscle.

90672
G Code Crosswalk G0008
When the patient is appropriately prepped, the provider administers a quadrivalent influenza vaccine into the nose to protect against influenza. He counsels the patient and or his family along with providing instructions and precautions before administration of the vaccine.

90673
G Code Crosswalk G0008
The provider administers an intramuscular injection of influenza virus vaccine, trivalent, derived from recombinant DNA (RIV), hemagglutinin (HA) protein only, preservative and antibiotic free. Prior to administering the vaccine, the provider discusses the benefits and risks as well as aftercare procedures of the vaccination.

90674
G Code Crosswalk G0008
The provider presents the parent, guardian, or patient with the options for immunization. He reviews the risks and benefits along with the potential side effects. The provider administers the dose orally, or by mouth.

90675
When the patient is appropriately prepped, the provider administers rabies vaccine in a muscle in the arm in adults or in the upper thigh in children, usually part of a series of four injections. He counsels the patient and or his family along with providing instructions and precautions before administration of the vaccine.

90676
The provider presents the parent, guardian, or patient with the options for immunization. He reviews the risks and benefits along with the potential side effects. When the patient is appropriately prepped, the provider identifies the site and administers the vaccine intradermally. In very young or small children, the provider might administer the vaccine in an upper leg muscle. In other patients, he injects the vaccine in the deltoid muscle of the upper arm. The dosage amounts and schedule depend on the patient’s age, exposure status of the patient, i.e., pre-exposure or post-exposure, and whether the patient received other rabies vaccinations.

90677
This code represents a vaccine product administered to reduce the patient’s risk of contracting pneumococcal disease, a bacterial infection that can range from ear infections to pneumonia and bloodstream infections. This code is specific to a 20-valent pneumococcal conjugate vaccine (PCV20), meaning the vaccine contains 20 different types of pneumococcal bacteria. The provider performs separately reportable administration of the vaccine. The route is intramuscular, meaning into the muscle.

90678
The provider presents the parent, guardian, or patient with the options for immunization. He reviews the risks and benefits along with the potential side effects. The provider injects the quadrivalent, antibiotic- and preservative-free influenza vaccine into a muscle to protect the patient against four different flu viruses.

90679
The provider presents the parent, guardian, or patient with the options for immunization. He reviews the risks and benefits along with the potential side effects. The provider administers the dose orally, or by mouth.

90680
The provider presents the parent, guardian, or patient with the options for immunization. He reviews the risks and benefits along with the potential side effects. The provider injects the quadrivalent, split virus, preservative free influenza vaccine into a muscle to protect the patient against four different flu viruses.

90681
The provider presents the parent, guardian, or patient with the options for immunization. He reviews the risks and benefits along with the potential side effects.

The provider administers the live attenuated rotavirus vaccine dose orally, or by mouth. For the two-dose vaccine, the infant typically receives the first dose at two months of age and the second dose at four months of age. Vaccination may start as early as six weeks of age or as late as 14 weeks, six days of age but no later. Four weeks must elapse between doses with completion of all doses by eight months of age.

Providers may administer rotavirus vaccine at the same time as other childhood vaccines. Attenuated means that the vaccine is 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.
# Medical Terms Glossary

<table>
<thead>
<tr>
<th>Medical Term</th>
<th>Description</th>
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<tbody>
<tr>
<td>11 deoxycortisol</td>
<td>A precursor of cortisol; a steroid hormone, also known as compound S.</td>
</tr>
<tr>
<td>23 valent</td>
<td>A vaccine that contains 23 of the most common types of pneumococcal bacteria to help prevent infection.</td>
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<tr>
<td>Ab externo</td>
<td>Outside the eye; indicates a surgical procedure starting from the eye’s exterior and proceeding to the anterior chamber.</td>
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<tr>
<td>Abbe-Estlander operation</td>
<td>Transfer of a full-thickness section of one lip to the other lip to correct a defect.</td>
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<tr>
<td>Abdominal aorta</td>
<td>Largest artery supplying the abdominal cavity, part of the aorta and continuation of the descending aorta from the thorax; it divides further into the iliac arteries.</td>
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<tr>
<td>Abdominal aortic aneurysm, or AAA</td>
<td>Widening of the abdominal aorta due to weakening in the wall of the aorta.</td>
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<tr>
<td>Abdominal approach</td>
<td>Surgical incision in the abdomen to perform an abdominal operation.</td>
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<tr>
<td>Abdominal paracentesis</td>
<td>Surgical puncture of the abdominal cavity for the removal of fluid for diagnosis or treatment.</td>
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<tr>
<td>Abdominal pregnancy</td>
<td>Implantation of a fertilized egg in the peritoneal cavity, including on the omentum, the abdominal wall, or on the outside of the uterus.</td>
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<tr>
<td>Abdominal wall</td>
<td>Refers to the muscles covering the abdomen or to the skin, fascia, muscle, and membranes marking the boundaries of the abdominal cavity.</td>
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<tr>
<td>Abdominoperineal</td>
<td>Refers to the abdomen and the perineum.</td>
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<tr>
<td>Abdominoperineal pull-through procedure</td>
<td>A surgical procedure that involves two approaches, one through the abdomen and a second through the perineum.</td>
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<tr>
<td>Abdominoperineal resection, or APR</td>
<td>The surgical removal of the anus, rectum, and part of the sigmoid colon, along with regional lymph nodes, through incisions made in the abdomen and perineum.</td>
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<tr>
<td>Abduction</td>
<td>Movement of a body part away from the medial line of the body.</td>
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<tr>
<td>Abduction pillow</td>
<td>A medical device used to immobilize an extremity after a surgical procedure to help decrease the risk of a dislocation; also known as an abduction splint.</td>
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<tr>
<td>Abductor</td>
<td>Muscle that draws a body part away from the midline of the body.</td>
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<tr>
<td>Abductor hallucis muscle</td>
<td>Muscle running along the inside of the foot.</td>
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<tr>
<td>Aberrant</td>
<td>Unusual or abnormal.</td>
</tr>
<tr>
<td>Aberrant vessel</td>
<td>Blood vessel having an unusual origin or course.</td>
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<tr>
<td>Ablation</td>
<td>Removal of tissue, a body part, or an organ or destruction of its function; to ablate.</td>
</tr>
<tr>
<td>ABO incompatibility</td>
<td>An abnormal transfusion reaction between blood cells of incompatible blood types A, B, AB or O, resulting in destruction of blood cells and the formation of clumps.</td>
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<tr>
<td>Abortion</td>
<td>Clinical term for the termination of a pregnancy before the age of viability, usually before 20 completed weeks of gestation; an induced abortion is also known as a therapeutic abortion, or TAB; a spontaneous abortion is commonly known as a miscarriage.</td>
</tr>
<tr>
<td>Above knee amputation, or AKA</td>
<td>Surgical removal of the lower leg above the level of the knee joint.</td>
</tr>
<tr>
<td>Abrasion</td>
<td>Removal of superficial layers of skin.</td>
</tr>
<tr>
<td>Abrasion arthroplasty</td>
<td>Refinishing the surfaces of a joint through a grinding process.</td>
</tr>
<tr>
<td>Abscess</td>
<td>A collection of pus in a walled off sac or pocket, the result of infection.</td>
</tr>
<tr>
<td>Abscess cavity</td>
<td>Pocket formed due to the accumulation of purulent material, or pus.</td>
</tr>
<tr>
<td>Absorption</td>
<td>Taking in of substances by tissues.</td>
</tr>
<tr>
<td>Acceleration and deceleration forces</td>
<td>Excessive strain put on the muscles, tendons, and joints, primarily of the spine, due to a body moving at high speed and coming to a sudden, rapid stop.</td>
</tr>
<tr>
<td>Accelerometer</td>
<td>Device to measure motion of a body.</td>
</tr>
<tr>
<td>Accessory navicular bone</td>
<td>An extra bone on the inner side of the foot that can cause irritation and require removal.</td>
</tr>
<tr>
<td>Accessory nerve</td>
<td>One of a pair of motor nerves that primarily supply the pharynx and muscles of the upper chest, back, and shoulders.</td>
</tr>
</tbody>
</table>
Thank You for Your Contribution to the Hardship Fund

Supporting your fellow AAPC members in need

Thanks to your book purchase, AAPC will be able to help even more members who face financial difficulty through the Hardship Fund.

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
✔ Registration for national or regional conferences
✔ Certain local chapter events

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.

To learn more about the Hardship Fund and its efforts or apply for financial assistance, visit aapc.com.