CODERS' SPECIALTY GUIDE

Pediatrics

2027

AAPC

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

Contents

Integumentary System

10040

Extraction (eg, marsupialization, opening or removal of multiple milia, comedones, cysts, pustules)

Advice

CPT® revises 10040 by changing the descriptor to refer to "extraction" rather than "acne surgery." The new language better reflects the actual procedure, which may involve marsupialization (creating a surgical opening to drain fluid), or the opening or removal of multiple milia (small, white bumps), comedones (blackheads and whiteheads), cysts (fluid-filled sacs), or pustules (inflamed, pus-filled bumps).

Effective date of this revision: Jan. 1, 2027.

Clinical Responsibility

After preparing and cleansing the skin, the provider identifies lesions for extraction. For example, for a milia (a small, white bump caused by trapped keratin), the provider may make a tiny opening to remove the contents. For a comedone (a clogged pore, such as a blackhead or whitehead), the provider may use a tool or small incision to clear the blockage. For a cyst (a sac under the skin filled with fluid or semi-solid material) or a pustule (a red, inflamed bump filled with pus), the provider may open, drain, or remove the lesion. In some cases, the provider performs marsupialization, meaning they create a small surgical opening to help drain fluid from the lesion. This service may involve treating multiple lesions during the same session.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $42.63, Non Facility Fee: $113.79; Non-QP Conversion Factor $33.4009, Facility Fee: $42.42, Non Facility Fee: $113.23
RVU (Facility): Work 0.89, PE 0.3, Mal 0.08, Total 1.27
RVU (Non-Facility): Work 0.89, PE 2.42, Mal 0.08, Total 3.39
MPFS Payment Policy Indicators: Global Period 10, Preop 10.00%, Intraop 80.00%, Postop 10.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

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

NCCI Alerts (version 32.0)

0213T^{0}, 0216T^{0}, 0596T^{1}, 0597T^{1}, 0903T^{1}, 0904T^{1}, 0905T^{1}, 11000^{1}, 11001^{1}, 11004^{1}, 11005^{1}, 11006^{1}, 11042^{1}, 11043^{1}, 11044^{1}, 11045^{1}, 11046^{1}, 11047^{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^{1}, 64451^{0}, 64454^{1}, 64461^{0}, 64462^{0}, 64463^{0}, 64466^{1}, 64467^{1}, 64468^{1}, 64469^{1}, 64473^{1}, 64474^{1}, 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}, 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}, 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^{0}, 99496^{0}, G0463^{1}, G0471^{1}

ICD-10-CM Cross References

L02.11, L02.821, L02.828, L02.831, L02.838, L03.221, L03.222, L70.0, L70.1, L70.3, L70.4, L70.5, L70.8, L70.9, L72.0-L72.3, L72.8, L72.9, L73.0, L85.3

10060

Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single

Clinical Responsibility

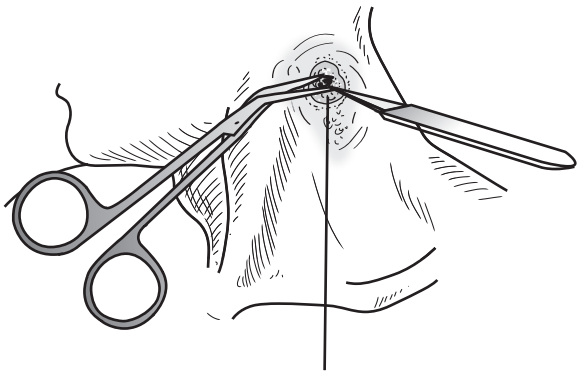
When the patient is appropriately prepped and anesthetized, the provider makes a circumferential incision over the target area of abscess. He makes an incision through skin and down to the level of abscess cavity. The provider then opens the abscess and removes the inflamed fatty and dead tissues within the cavity and drains the pus completely. When the provider successfully accomplishes the procedure, he may leave this wound open for continuous discharge of fluids and may use woven cotton cloth to soak up fluids and blood. The provider may use a small surgical clamp to break up any loculations within the cavity and may insert gauze or other material to pack the abscess cavity.

Coding Tips

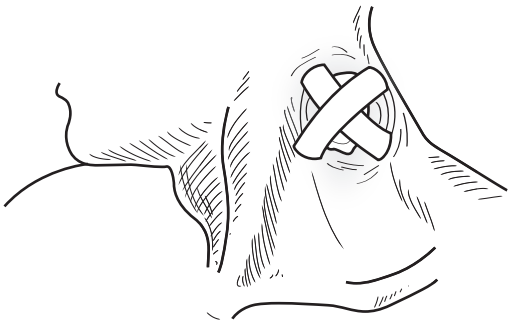
Report this code if the provider performs incision and drainage of an abscess for a simple or single capsule like cyst. For a complicated I&D or multiple I&Ds, report 10061.

This code is not used for I&D of pilonidal cysts, hematomas, foreign bodies, or wound infections. See codes 10080 to 10180 to report those services.

Illustration



Incision of abscess



10060

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $101.04, Non Facility Fee: $129.23; Non-QP Conversion Factor $33.4009, Facility Fee: $100.54, Non Facility Fee: $128.59
RVU (Facility): Work 1.19, PE 1.69, Mal 0.13, Total 3.01
RVU (Non-Facility): Work 1.19, PE 2.53, Mal 0.13, Total 3.85
MPFS Payment Policy Indicators: Global Period 10, Preop 10.00%, Intraop 80.00%, Postop 10.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

22, 51, 52, 53, 54, 55, 56, 58, 59, 73, 74, 76, 77, 78, 79, 99, AG, AQ, AR, E1, E2, E3, E4, F1, F2, F3, F4, F5, F6, F7, F8, F9, FA, GA, GC, GJ, GR, KX, LT, PD, Q5, Q6, QJ, RT, SA, T1, T2, T3, T4, T5, T6, T7, T8, T9, TA, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T[0], 0216T[0], 0596T[1], 0597T[1], 0903T[1], 0904T[1], 0905T[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], 11730[1], 11740[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], 30000[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[1], 64451[0], 64454[1], 64461[0], 64462[0], 64463[0], 64466[1], 64467[1], 64468[1], 64469[1], 64473[0], 64474[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], 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], 99495[0], 99496[0], G0127[1], G0463[1], G0471[1], J0670[1]

ICD-10-CM Cross References

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

10061

Incision and drainage of abscess (eg, carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or multiple

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider makes a circumferential incision over the target area of abscess. He deepens the incision through the vascular inner layer of skin and down to the deep level of abscess cavity. The provider then opens the abscess and excises the inflamed fatty and dead tissues within the cavity and drains the pus completely. When the provider successfully accomplishes the procedure, he may leave this wound open for continuous discharge of fluids and may use woven cotton cloth to soak up fluids and blood. The provider may use a small surgical clamp to break up any loculations within the cavity and may insert gauze or other material to pack the abscess cavity. The provider may repeat this procedure for additional lesions. Some lesions may require placement of a drain for continued drainage. This procedure takes more time than a simple I&D and requires more extensive incisions and/or a more complicated closure.

Coding Tips

Report this code if the provider performs incision and drainage of an abscess for complex or severe and multiple capsules like cysts. A complicated I&D takes more time than usual and involves multiple incisions, drain placements, extensive packing, and subsequent wound closure.

H72.00, H72.2X9, H72.819, H72.829, H72.90, H73.10, H73.819, H74.09, H74.19, H74.20, H74.319, H74.329, H74.399, H74.40, H74.8X9, H74.90, H80.03, H80.23, H80.83, H80.93, H81.09, H83.3X9, H90.0-H90.3, H90.11, H90.12, H90.41, H90.42, H90.5, H90.6, H90.71, H90.72, H90.8, H91.01-H91.09, H91.10-H91.13, H91.20-H91.23, H91.3, H91.8X1-H91.8X3, H91.8X9, H91.90-H91.93, H93.011-H93.019, H93.099, H93.11-H93.19, H93.211-H93.219, H93.221-H93.229, H93.231-H93.239, H93.241-H93.249, H93.291-H93.299, H93.3X1-H93.3X3, H93.3X9, H93.8X1-H93.8X3, H93.8X9, H93.90-H93.93, H93.A1-H93.A9, H94.00-H94.03, H94.80-H94.83, P09.6, R68.89, T70.0XXA, Z00.00, Z00.01, Z01.10, Z01.110, Z01.118, Z01.12, Z73.82

92587

Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report

Clinical Responsibility

The provider has a computer with an ear probe tip. She places the ear probe tip into the patient's ear canal. For the distortion product otoacoustic emission test, the probe emits pairs of tones at specific frequencies, typically three to six frequency levels. For the transient evoked otoacoustic emissions test, the probe emits broad frequency range clicks or brief bursts of pure tone. The sound passes through the tympanic membrane, the middle ear and the inner ear. At the inner ear, the sound is picked up by the hair cells of the cochlea. The computer records the echo off the cochlea hair cells. When the test is complete, the provider interprets the findings and prepares a report.

The provider performs the test to assess the presence or absence of a hearing disorder.

Coding Tips

Before you file another claim for 92587, check that the tests meet this criterion: an audiologist or other qualified healthcare provider administers them. Reporting these codes would be inappropriate if they are performed by a computer instead of a healthcare professional.

New technology opened the door to potential misuse of 92587. This code's descriptors and valuations do not take into account automated administration of these tests.

Using the traditional codes for automated tests overcompensates you by paying you for non-performed work. Computer-administered tests do not rely on the administration and oversight of a professional to determine the outcome. After the patient has the earphones placed and some introductory instructions, these tests can be self-administered. The computer administers each test, automatically determines the accuracy of the outcome, scores the results where scoring is necessary, and prints the results in a written output.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $22.15, Non Facility Fee: $22.15; Non-QP Conversion Factor $33.4009, Facility Fee: $22.04, Non Facility Fee: $22.04

RVU (Facility): Work 0.35, PE 0.29, Mal 0.02, Total 0.66
RVU (Non-Facility): Work 0.35, PE 0.29, Mal 0.02, Total 0.66
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: 1

Modifier Allowances

26, 33, 52, 53, 59, 76, 77, 79, 80, 81, 82, 99, AB, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, GW, KX, LT, PD, Q5, Q6, QJ, RT, TC, XE, XP, XS, XU

NCCI Alerts (version 32.0)

36591^0, 36592^0, 69209^0, 69210^0, 92558^0, 96523^0

ICD-10-CM Cross References

B02.0, C71.7, C79.31, C79.49, D33.0-D33.3, D33.9, D43.0-D43.2, D43.4, D49.6, E83.00-E83.09, G23.0-G23.2, G23.8, G23.9, G32.89, G35.A, G35.B0-G35.B2, G35.C0-G35.C2, G35.D, G51.2-G51.4, G51.8, G52.7, G90.3, G96.89, G98.0, G98.8, G99.8, H83.3X1-H83.3X3, H83.3X9, H90.0-H90.3, H90.11, H90.12, H90.41, H90.42, H90.5, H90.6, H90.71, H90.72, H90.8, H90.A11, H90.A12, H90.A21, H90.A22, H90.A31, H90.A32, H91.10-H91.13, H91.23, H91.8X1-H91.8X3, H91.8X9, H93.011-H93.019, H93.19, H93.211-H93.219, H93.221-H93.229, H93.231-H93.239, H93.241-H93.249, H93.291-H93.299, H93.3X1-H93.3X3, H93.3X9, H94.00-H94.03, P09.6, Q93.82, Q99.818, Q99.819, S04.60XA-S04.60XS, S04.61XA-S04.61XS, S04.62XA-S04.62XS

92588

Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report

Clinical Responsibility

The provider uses a computer with an ear probe tip. She places the ear probe tip into the patient's ear canal. This probe emits either a distortion product which are two closely spaced, simultaneous, pure tone frequencies, given at a moderate intensity level or a transient sound, which are very brief noises, such as clicks or tone bursts. The sound passes through the tympanic membrane, the middle ear, and the inner ear. The inner ear then picks up the sound in the hair cells of the cochlea, and the computer records the echo off the cochlear hair cells, a technique called quantitative analysis of outer hair cell function by cochlear mapping. The provider repeats the test at different intensity levels and for at least twelve ranges of frequencies, and the computer records the results. The provider then compares the results to normative data, interprets results, and prepares a report.

The provider performs the test to assess the presence or absence of a hearing disorder.

Coding Tips

This service includes testing of both ears. Use modifier 52, reduced services, if a test is applied to one ear instead of both.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $33.90, Non Facility Fee: $33.90; Non-QP Conversion Factor $33.4009, Facility Fee: $33.73, Non Facility Fee: $33.73
RVU (Facility): Work 0.55, PE 0.44, Mal 0.02, Total 1.01
RVU (Non-Facility): Work 0.55, PE 0.44, Mal 0.02, Total 1.01
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: 1

Modifier Allowances

26, 33, 52, 53, 59, 76, 77, 79, 80, 81, 82, 99, AB, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, GW, KX, LT, PD, Q5, Q6, QJ, RT, TC, XE, XP, XS, XU

NCCI Alerts (version 32.0)

36591^{0}, 36592^{0}, 69209^{0}, 69210^{0}, 92558^{0}, 92587^{1}, 96523^{0}

ICD-10-CM Cross References

B02.0, C71.7, C79.31, C79.49, D33.0-D33.3, D33.9, D43.0-D43.2, D43.4, D49.6, E83.00-E83.09, G23.0-G23.2, G23.8, G23.9, G32.89, G35.B0-G35.B2, G35.C0-G35.C2, G35.D, G51.2-G51.4, G51.8, G52.7, G90.3, G96.89, G98.0, G98.8, G99.8, H83.3X1-H83.3X3, H83.3X9, H90.0-H90.3, H90.11, H90.12, H90.41, H90.42, H90.5, H90.6, H90.71, H90.72, H90.8, H90.A11, H90.A12, H90.A21, H90.A22, H90.A31, H90.A32, H91.10-H91.13, H91.8X1-H91.8X3, H91.8X9, H93.011-H93.019, H93.211-H93.219, H93.221-H93.229, H93.231-H93.239, H93.241-H93.249, H93.291-H93.299, H93.3X1-H93.3X3, H93.3X9, H94.00-H94.03, P09.6, Q93.82, Q99.818, Q99.819, S04.60XA-S04.60XS, S04.61XA-S04.61XS, S04.62XA-S04.62XS

92601

Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming

Clinical Responsibility

The provider starts by placing a transmitter magnet opposite the cochlear implant's receiver, which is under the patient's skin. The patient is under the age of 7. The provider makes sure the patient is comfortable and confirms the magnet isn't preventing blood flow or causing problems at the implant site. He then connects the transmitter, microphone, and cable to the external speech processor. He places the speech processor under computer control for programming. The provider ensures that the stimulator system is working properly and that all electrodes in the cochlea are properly positioned. The provider adjusts the implant settings, such as the volume and the stimulator according the patient's specific needs. The provider activates the electrodes in succession, while continuing to assess the patient's comfort level. He counsels the family on how to use the external speech processor controls, position the microphone and transmitter, insert the batteries, and recharge the system. He also instructs them to keep a daily record of the patient's experiences with the implant for the provider to review and take into account during future reprogramming. The provider compiles and records the data.

Coding Tips

Code 92601 is for initial programming of a single implant on a patient younger than 7.

See 92602 for subsequent testing on a patient younger than 7.

See 92603-92604 for patients 7 and older.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $98.69, Non Facility Fee: $155.08; Non-QP Conversion Factor $33.4009, Facility Fee: $98.20, Non Facility Fee: $154.31
RVU (Facility): Work 2.3, PE 0.63, Mal 0.01, Total 2.94
RVU (Non-Facility): Work 2.3, PE 2.31, Mal 0.01, Total 4.62
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 7, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

52, 53, 76, 77, 79, 80, 81, 82, 99, AB, AQ, AR, AS, CR, ET, GA, GC, GN, GR, KX, LT, PD, Q5, Q6, QJ, RT

NCCI Alerts (version 32.0)

0208T^{0}, 0209T^{0}, 0210T^{0}, 0211T^{0}, 0212T^{0}, 0485T^{1}, 0486T^{1}, 0728T^{0}, 0729T^{0}, 36591^{0}, 36592^{0}, 92507^{1}, 92508^{1}, 92521^{1}, 92522^{1}, 92523^{1}, 92524^{1}, 92550^{1}, 92552^{0}, 92553^{0}, 92555^{0}, 92556^{0}, 92557^{0}, 92558^{0}, 92562^{0}, 92563^{0}, 92565^{0}, 92567^{1}, 92568^{1}, 92570^{1}, 92571^{0}, 92572^{0}, 92575^{0}, 92576^{0}, 92577^{0}, 92579^{0}, 92582^{0}, 92583^{0}, 92584^{0}, 92587^{0}, 92588^{0}, 92596^{0}, 92597^{0}, 92602^{1}, 92603^{0}, 92604^{0}, 92626^{1}, 92650^{1}, 92651^{1}, 92652^{1}, 92653^{1}, 96523^{0}, 97755^{0}

ICD-10-CM Cross References

H90.3, H90.41, H90.42, H90.5, Z45.31, Z45.320-Z45.328, Z45.49, Z46.2, Z96.20, Z96.21, Z96.29, Z96.89, Z96.9

92602

Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming

Clinical Responsibility

In a patient younger than 7 years of age, the provider checks a cochlear implant placed and programmed earlier, measuring and adjusting the external transmitter and reprogramming the internal stimulator. He reviews the patient's experiences with the current settings. The provider makes sure the patient is comfortable and confirms the magnet isn't preventing blood flow or causing problems at the implant site. He places the speech processor under computer control for programming. The provider ensures that the stimulator system is working properly and that all electrodes in the cochlea are properly positioned. The provider adjusts the implant settings, such as the volume and the stimulator according the patient's specific needs. The provider activates the electrodes in succession, while continuing to assess the patient's comfort level. He counsels the family on how to use the external speech processor controls, position the microphone and transmitter, insert the batteries, and recharge the system.

He also instructs them to continue to keep a daily record of the patient's experiences with the implant for the provider to review and take into account during future reprogramming. The provider compiles and records the data.

Coding Tips

Code 92602 is for subsequent testing of a cochlear implant on a patient younger than 7.

See 92601 for initial programming of a single implant on a patient younger than 7.

See 92603-92604 for patients 7 and older.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $56.06, Non Facility Fee: $97.68; Non-QP Conversion Factor $33.4009, Facility Fee: $55.78, Non Facility Fee: $97.20
RVU (Facility): Work 1.3, PE 0.36, Mal 0.01, Total 1.67
RVU (Non-Facility): Work 1.3, PE 1.6, Mal 0.01, Total 2.91
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 7, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

52, 53, 59, 76, 77, 79, 80, 81, 82, 99, AB, AQ, AR, AS, CR, ET, GA, GC, GN, GR, KX, LT, PD, Q5, Q6, QJ, RT, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0208T^{0}, 0209T^{0}, 0210T^{0}, 0211T^{0}, 0212T^{0}, 0485T^{1}, 0486T^{1}, 0729T^{0}, 36591^{0}, 36592^{0}, 92507^{1}, 92508^{1}, 92521^{1}, 92522^{1}, 92523^{1}, 92524^{1}, 92550^{1}, 92552^{0}, 92553^{0}, 92555^{0}, 92556^{0}, 92557^{0}, 92558^{0}, 92562^{0}, 92563^{0}, 92565^{0}, 92567^{1}, 92568^{1}, 92570^{1}, 92571^{0}, 92572^{0}, 92575^{0}, 92576^{0}, 92577^{0}, 92579^{0}, 92582^{0}, 92583^{0}, 92584^{0}, 92587^{0}, 92588^{0}, 92596^{0}, 92597^{0}, 92604^{0}, 92626^{1}, 92650^{1}, 92651^{1}, 92652^{1}, 92653^{1}, 96523^{0}, 97755^{0}

ICD-10-CM Cross References

H90.3, H90.41, H90.42, H90.5, Z45.31, Z45.320-Z45.328, Z45.49, Z46.2, Z96.20, Z96.21, Z96.29, Z96.89, Z96.9

92603

Diagnostic analysis of cochlear implant, age 7 years or older; with programming

Clinical Responsibility

The provider starts by placing a transmitter magnet opposite the cochlear implant's receiver, which is under the patient's skin. The patient is 7 years of age or older. The provider makes sure the patient is comfortable and confirms the magnet isn't preventing blood flow or causing problems at the implant site. He then connects the transmitter, microphone, and cable to the external speech processor. He places the speech processor under computer control for programming. The provider ensures that the stimulator system is working properly and that all electrodes in the cochlea are properly positioned. The provider adjusts the implant settings, such as the volume and the stimulator according the patient's specific needs. The provider activates the electrodes in succession, while continuing to assess the patient's comfort level. He counsels the patient and/or family on how to use the external speech processor controls, position the microphone and transmitter, insert the batteries, and recharge the system. He also instructs them to keep a daily record of the patient's experiences with the implant for the provider to review and take into account during future reprogramming. The provider finally compiles and records the data.

Coding Tips

Codes 92603-92604 are for patients 7 and older.

See 92601 for initial programming of a single implant on a patient younger than 7 and 92602 for subsequent testing of a cochlear implant on a patient younger than 7.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $96.34, Non Facility Fee: $146.35; Non-QP Conversion Factor $33.4009, Facility Fee: $95.86, Non Facility Fee: $145.63
RVU (Facility): Work 2.25, PE 0.61, Mal 0.01, Total 2.87
RVU (Non-Facility): Work 2.25, PE 2.1, Mal 0.01, Total 4.36
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 7, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

52, 53, 76, 77, 79, 80, 81, 82, 99, AB, AQ, AR, AS, CR, ET, GA, GC, GN, GO, GR, KX, LT, PD, Q5, Q6, QJ, RT

NCCI Alerts (version 32.0)

0208T^{0}, 0209T^{0}, 0210T^{0}, 0211T^{0}, 0212T^{0}, 0485T^{1}, 0486T^{1}, 0728T^{1}, 0729T^{1}, 36591^{0}, 36592^{0}, 92507^{1}, 92508^{1}, 92521^{1}, 92522^{1}, 92523^{1}, 92524^{1}, 92550^{1}, 92552^{0}, 92553^{0}, 92555^{0}, 92556^{0}, 92557^{0}, 92558^{0}, 92562^{0}, 92563^{0}, 92565^{0}, 92567^{1}, 92568^{1}, 92570^{1}, 92571^{0}, 92572^{0}, 92575^{0}, 92576^{0}, 92577^{0}, 92579^{0}, 92582^{0}, 92583^{0}, 92584^{0}, 92587^{0}, 92588^{0}, 92596^{0}, 92597^{0}, 92602^{0}, 92604^{1}, 92626^{1}, 92650^{1}, 92651^{1}, 92652^{1}, 92653^{1}, 96523^{0}, 97755^{0}

ICD-10-CM Cross References

H90.3, H90.41, H90.42, H90.5, Z45.31, Z45.320-Z45.328, Z45.49, Z46.2, Z96.20, Z96.21, Z96.29, Z96.89, Z96.9

92604

Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming

Clinical Responsibility

In a patient 7 years of age or older, the provider checks a cochlear implant placed and programmed earlier, measuring and adjusting the external transmitter and reprogramming the internal stimulator. He reviews the patient's experiences with the current settings. The provider makes sure the patient is comfortable and confirms the magnet isn't preventing blood flow or causing problems at the implant site. He places the

speech processor under computer control for programming. The provider ensures that the stimulator system is working properly and that all electrodes in the cochlea are properly positioned. The provider adjusts the implant settings, such as the volume and the stimulator according the patient's specific needs. The provider activates the electrodes in succession, while continuing to assess the patient's comfort level. He counsels the patient and/or family on how to use the external speech processor controls, position the microphone and transmitter, insert the batteries, and recharge the system. He also instructs them to continue to keep a daily record of the patient's experiences with the implant for the provider to review and take into account during future reprogramming. The provider compiles and records the data.

Coding Tips

Codes 92603-92604 are for patients 7 and older.

See 92601 for initial programming of a single implant on a patient younger than 7 and 92602 for subsequent testing of cochlear implant on a patient younger than 7.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $53.71, Non Facility Fee: $87.95; Non-QP Conversion Factor $33.4009, Facility Fee: $53.44, Non Facility Fee: $87.51
RVU (Facility): Work 1.25, PE 0.34, Mal 0.01, Total 1.60
RVU (Non-Facility): Work 1.25, PE 1.36, Mal 0.01, Total 2.62
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 7, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

52, 53, 59, 76, 77, 79, 80, 81, 82, 99, AB, AQ, AR, AS, CR, ET, GA, GC, GN, GO, GR, KX, LT, PD, Q5, Q6, QJ, RT, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0208T^{0}, 0209T^{0}, 0210T^{0}, 0211T^{0}, 0212T^{0}, 0485T^{1}, 0486T^{1}, 0729T^{1}, 36591^{0}, 36592^{0}, 92507^{1}, 92508^{1}, 92521^{1}, 92522^{1}, 92523^{1}, 92524^{1}, 92550^{1}, 92552^{0}, 92553^{0}, 92555^{0}, 92556^{0}, 92557^{0}, 92558^{0}, 92562^{0}, 92563^{0}, 92565^{0}, 92567^{1}, 92568^{1}, 92570^{1}, 92571^{0}, 92572^{0}, 92575^{0}, 92576^{0}, 92577^{0}, 92579^{0}, 92582^{0}, 92583^{0}, 92584^{0}, 92587^{0}, 92588^{0}, 92596^{0}, 92597^{0}, 92626^{1}, 92650^{1}, 92651^{1}, 92652^{1}, 92653^{1}, 96523^{0}, 97755^{0}

ICD-10-CM Cross References

H90.3, H90.41, H90.42, H90.5, Z45.31, Z45.320-Z45.328, Z45.49, Z46.2, Z96.20, Z96.21, Z96.29, Z96.89, Z96.9

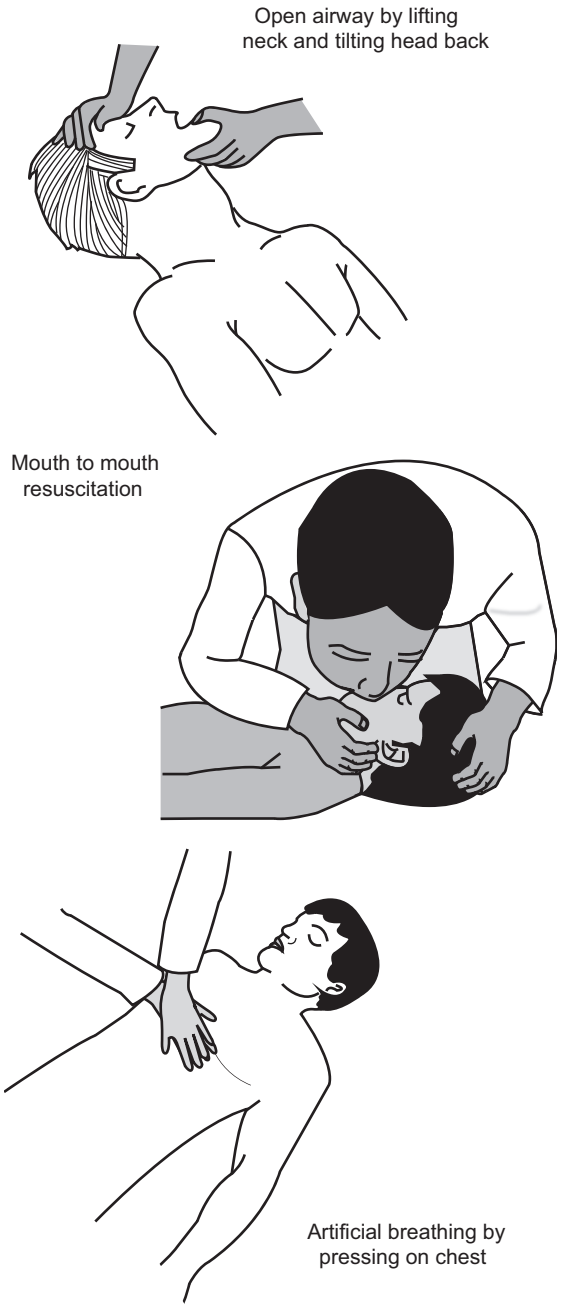
92950

Cardiopulmonary resuscitation (eg, in cardiac arrest)

Clinical Responsibility

The provider presses the chest of the patient in a rhythmic manner to make the heart pump blood to the vital organs. He may also employ mouth to mouth breathing, bag and mask, or other artificial means, along with chest compression to ensure oxygen supply to the lungs.

Illustration



92950

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $171.19, Non Facility Fee: $380.99; Non-QP Conversion Factor $33.4009, Facility Fee: $170.34, Non Facility Fee: $379.10
RVU (Facility): Work 3.9, PE 0.76, Mal 0.44, Total 5.10
RVU (Non-Facility): Work 3.9, PE 7.01, Mal 0.44, Total 11.35

MPFS Payment Policy Indicators: Global Period 0, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 2

Modifier Allowances

22, 52, 58, 59, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0596T[1], 0597T[1], 0708T[1], 0709T[1], 0903T[1], 0904T[1], 0905T[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], 64466[1], 64467[1], 64468[0], 64469[0], 64473[1], 64474[1], 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], 92012[1], 92014[1], 92961[1], 93000[1], 93005[1], 93010[1], 93040[1], 93041[1], 93042[1], 93318[1], 93355[1], 94002[1], 94200[1], 94680[1], 94681[1], 94690[1], 95812[1], 95813[1], 95816[1], 95819[1], 95822[1], 95829[1], 95955[1], 96360[1], 96361[1], 96365[1], 96366[1], 96367[1], 96368[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0], 99155[0], 99156[0], 99157[0], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99221[1], 99222[1], 99223[1], 99231[1], 99232[1], 99233[1], 99234[1], 99235[1], 99236[1], 99238[1], 99239[1], 99242[1], 99243[1], 99244[1], 99245[1], 99252[1], 99253[1], 99254[1], 99255[1], 99291[1], 99292[1], 99304[1], 99305[1], 99306[1], 99307[1], 99308[1], 99309[1], 99310[1], 99315[1], 99316[1], 99347[1], 99348[1], 99349[1], 99350[1], 99374[1], 99375[1], 99377[1], 99378[1], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99495[1], 99496[1], G0463[1], G0471[1]

ICD-10-CM Cross References

I46.2-I46.9, I97.120, I97.121, I97.710, I97.711, J80, J95.1-J95.3, J95.821, J95.822, J95.87, J96.00-J96.02, J96.20-J96.22, J96.90-J96.92, M96.A1-M96.A9, O03.36, O03.86, O04.86, O07.36, O08.81, O29.111-O29.119, P29.81, R00.0-R00.2, R06.02, R07.2, R07.89, R07.9, R10.13, R40.4, R42, R55, R61, R94.30-R94.39, T82.817A, T82.827A, T82.837A, T82.847A, T82.855A, T82.857A, T82.867A, T82.897A, T82.9XXA, U07.1, Z05.0, Z13.6, Z82.49, Z86.74, Z86.79, Z95.1, Z95.5, Z95.810-Z95.818, Z98.61

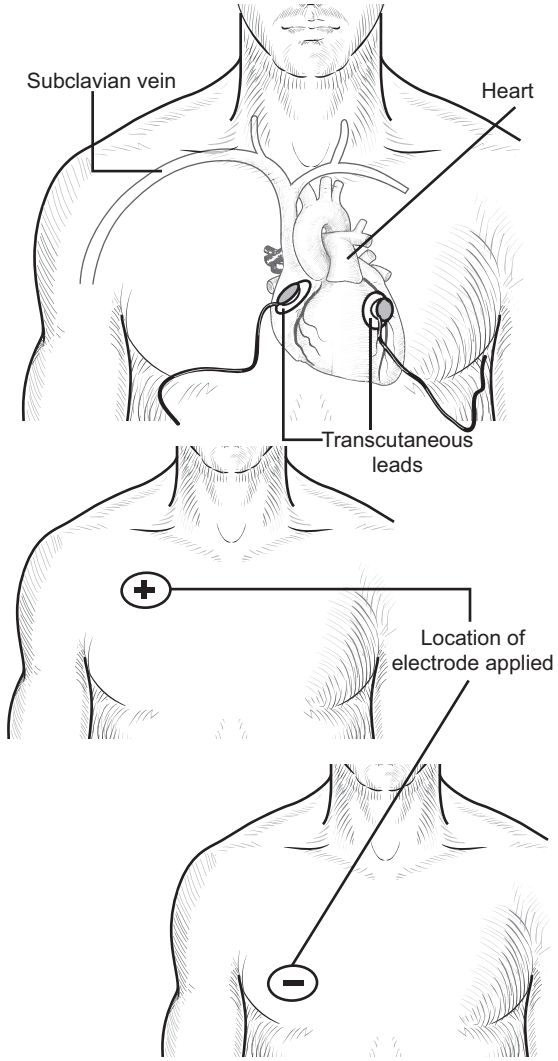
92953

Temporary transcutaneous pacing

Clinical Responsibility

When the patient is appropriately prepped and anesthetized and laid in the supine position with the chest exposed, the provider attaches monitoring electrodes to the patient's chest which connect to an electrocardiogram machine after noting down the baseline cardiac output rates. These baseline cardiac output rates illustrate the abnormality in the heart rate, which helps to analyze the intensity of electrical shock that the provider will deliver. He then turns on the pacemaker in the patient's chest using the electrocardiogram machine, which sends out electrical impulses through the chest into the heart and stabilizes the cardiac output rhythm.

Illustration



92953

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $1.01, Non Facility Fee: $1.01; Non-QP Conversion Factor $33.4009, Facility Fee: $1.00, Non Facility Fee: $1.00
RVU (Facility): Work 0.01, PE 0.01, Mal 0.01, Total 0.03
RVU (Non-Facility): Work 0.01, PE 0.01, Mal 0.01, Total 0.03
MPFS Payment Policy Indicators: Global Period 0, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 2

Modifier Allowances

22, 52, 58, 59, 63, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T[0], 0216T[0], 0596T[1], 0597T[1], 0708T[1], 0709T[1], 0903T[1], 0904T[1], 0905T[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], 64466[1], 64467[1], 64468[0], 64469[0], 64473[1], 64474[1], 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[1], 64510[1], 64517[1], 64520[1], 64530[1], 92012[1], 92014[1], 92960[1], 92961[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], 99304[1], 99305[1], 99306[1], 99307[1], 99308[1], 99309[1], 99310[1], 99315[1], 99316[1], 99347[1], 99348[1], 99349[1], 99350[1], 99374[1], 99375[1], 99377[1], 99378[1], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99495[1], 99496[1], G0463[1], G0471[1]

ICD-10-CM Cross References

I44.0-I44.2, I44.30, I44.39, I45.2, I45.3, I49.5, Q20.5, R00.0-R00.2, R06.02, R07.2, R07.89, R07.9, R10.13, R40.4, R42, R55, R61, R94.30-R94.39, T82.817A, T82.827A, T82.837A, T82.847A, T82.855A, T82.857A, T82.867A, T82.897A, T82.9XXA, Z05.0, Z13.6, Z82.49, Z86.74, Z86.79, Z95.1, Z95.5, Z95.810-Z95.818, Z98.61

92960

Cardioversion, elective, electrical conversion of arrhythmia; external

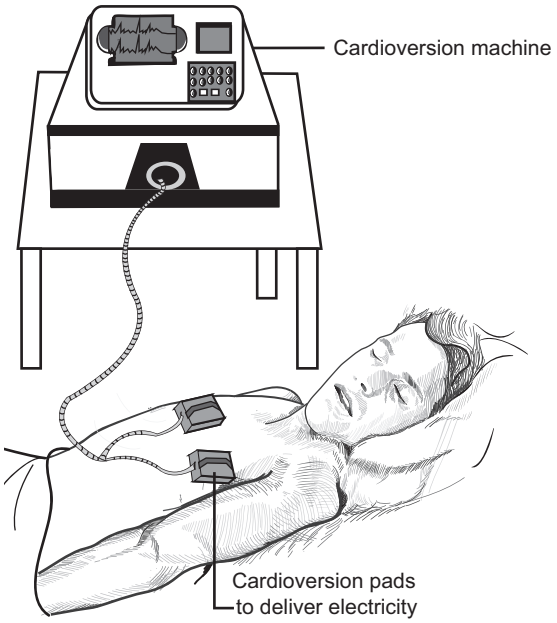
Clinical Responsibility

When the patient is appropriately prepped and anesthetized and laid in the supine position with the chest exposed, the provider attaches cardioversion pads onto the patient's chest or on the chest and the back after noting down the baseline cardiac output rates. These baseline cardiac output rates illustrate the abnormality in the heart rate, which helps to analyze the intensity of electrical shock that the provider will deliver. He connects these pads to an external defibrillator, which monitors the patient's heart rhythm and also delivers the electrical shock. This electric shock brings back the heart rate and rhythm to normal.

Coding Tips

Use code 92961 if the provider performs internal cardioversion using drugs.

Illustration



92960

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $95.33, Non Facility Fee: $155.42; Non-QP Conversion Factor $33.4009, Facility Fee: $94.86, Non Facility Fee: $154.65
RVU (Facility): Work 1.95, PE 0.74, Mal 0.15, Total 2.84
RVU (Non-Facility): Work 1.95, PE 2.53, Mal 0.15, Total 4.63
MPFS Payment Policy Indicators: Global Period 0, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 2

Modifier Allowances

22, 52, 58, 59, 63, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 32.0)

0213T[0], 0216T[0], 0521T[1], 0522T[1], 0575T[1], 0576T[1], 0578T[1], 0596T[1], 0597T[1], 0708T[1], 0709T[1], 0903T[1], 0904T[1], 0905T[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],

Clinical Responsibility

The provider, typically a qualified nutrition professional, assesses the medical condition of the patient, performs a nutrition screen, and initiates a specific dietary plan for the patient. The provider designs the diet in such a way that it improves the health and quality of life of the patient. The provider spends 15 minutes with the individual patient and also advises the patient about long term eating habits and health.

Coding Tips

Use 97803 if the provider reassesses the patient for medical nutrition therapy on subsequent visits for each 15 minutes.

Report 97804 for medical nutrition therapy offered in groups for each 30 minutes.

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $26.52, Non Facility Fee: $36.92; Non-QP Conversion Factor $33.4009, Facility Fee: $26.39, Non Facility Fee: $36.74
RVU (Facility): Work 0.53, PE 0.25, Mal 0.01, Total 0.79
RVU (Non-Facility): Work 0.53, PE 0.56, Mal 0.01, Total 1.10
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: 12

Modifier Allowances

33, 53, 59, 76, 77, 79, 80, 81, 82, 93, 95, 97, 99, AE, AQ, AR, AS, CR, ET, FQ, FR, G0, GA, GC, GJ, GQ, GR, GT, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 32.0)

36591[0], 36592[0], 96523[0], 97803[0], 97804[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.

97803

Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

Clinical Responsibility

The provider, typically a qualified nutrition professional, reassesses the medical condition of the patient, performs a nutrition screen, and reviews the specific dietary plan for the patient. The provider reevaluates the diet in such a way that it improves the health and quality of life of the patient. The provider spends 15 minutes with the individual patient and also advises the patient about long term eating habits and health.

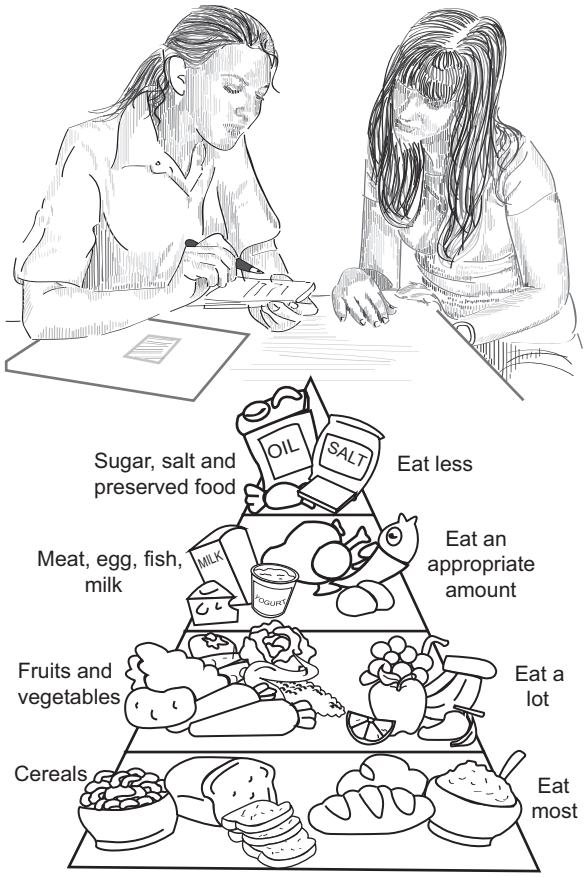
Coding Tips

Report 97803 for each 15 minutes of face-to-face service when the provider reassesses a patient for medical nutrition therapy on subsequent visits after the initial assessment.

When the provider assesses an individual patient for medical nutrition therapy on an initial visit for each 15 minutes, use 97802.

When the provider assesses a group of two or more patients for medical nutrition therapy for each 30 minutes, use 97804.

Illustration



97803

Fee Schedule Information

Medicare Fees (National): QP Conversion Factor $: 33.5675, Facility Fee: $22.15, Non Facility Fee: $31.89; Non-QP Conversion Factor $33.4009, Facility Fee: $22.04, Non Facility Fee: $31.73
RVU (Facility): Work 0.45, PE 0.2, Mal 0.01, Total 0.66
RVU (Non-Facility): Work 0.45, PE 0.49, Mal 0.01, Total 0.95
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: 11

Modifier Allowances

33, 53, 59, 76, 77, 79, 80, 81, 82, 93, 95, 99, AE, AQ, AR, AS, CR, ET, FQ, FR, G0, GA, GC, GJ, GQ, GR, GT, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 32.0)

36591[0], 36592[0], 96523[0], 97804[0]

Coronavirus Diagnostic Panel

U0001

Cdc 2019 novel coronavirus (2019-ncov) real-time rt-pcr diagnostic panel

Clinical Responsibility

The lab analyst performs the technical steps to detect SARS-CoV-2 RNA in samples of upper and lower respiratory specimens, which can include nasopharyngeal or oropharyngeal swabs, sputum, lower respiratory tract aspirates, bronchoalveolar lavage, or nasopharyngeal wash/aspirate or nasal aspirate. He uses qualitative nucleic acid detection, which includes multiplex reverse transcription when performed, and multiplex amplified probe technique.

Nucleic acid probes permit the identification of microorganisms based on their DNA or RNA. He also performs reverse transcription in which a nucleotide sequence is copied from an RNA template during DNA synthesis. In addition, the lab analyst performs multiplex amplification probe techniques, which include polymerase chain reaction (PCR), each round of which quickly provides large numbers of target DNA up to millions of copies.

The lab analyst performs this test for the presumptive qualitative detection of nucleic acid from the SARS-CoV-2 respiratory pathogen that causes coronavirus disease 2019 (COVID-19), a severe respiratory infection. Positive results indicate active infection but do not rule out other bacterial or viral infections, meaning that the presence of the SARS-CoV-2 virus may not be the cause of the patient's respiratory infection.

Coding Tips

Report this code only for the real-time RT-PCR 2019-nCoV kit provided by the CDC. There are multiple codes related to lab testing for COVID-19, so be sure you select the correct one based on documentation and relevant guidelines.

BETOS

T1H: Lab tests - other (Non-Medicare fee schedule)

U0002

2019-ncov coronavirus, sars-cov-2/2019-ncov (covid-19), any technique, multiple types or subtypes (includes all targets), non-cdc

Clinical Responsibility

The lab analyst performs the technical steps to detect multiple types or subtypes of coronavirus, including SARS-CoV-2 RNA in samples of upper and lower respiratory specimens, which can include nasopharyngeal or oropharyngeal swabs, sputum, lower respiratory tract aspirates, bronchoalveolar lavage, or nasopharyngeal wash/aspirate or nasal aspirate. He uses qualitative nucleic acid detection, which includes multiplex reverse transcription when performed, and multiplex amplified probe technique.

Nucleic acid probes permit the identification of microorganisms based on their DNA or RNA. He also performs reverse transcription in which a nucleotide sequence is copied from an RNA template during DNA synthesis. In addition, the lab analyst performs multiplex amplification probe techniques, which include polymerase chain reaction (PCR), each round of which quickly provides large numbers of target DNA up to millions of copies.

Alternatively, the lab analyst may use a particular instrument and a process called enzyme-linked immunosorbent assay (ELISA) or immunofluorescence assay (IFA), to detect the presence of antibodies bound to specific antigens to evaluate the specimen for an antibody-antigen reaction.

The lab analyst performs this test for the presumptive qualitative detection of nucleic acid from the SARS-CoV-2 respiratory pathogen that causes coronavirus disease 2019 (COVID-19), a severe respiratory infection. Positive results indicate active infection but do not rule out other bacterial or viral infections, meaning that the presence of the SARS-CoV-2 virus may not be the cause of the patient's respiratory infection.

Coding Tips

Report this code for SARS-CoV-2 (COVID-19) tests developed by laboratories other than the CDC. There are multiple codes related to lab testing for COVID-19, so be sure you select the correct one based on documentation and relevant guidelines.

BETOS

T1H: Lab tests - other (Non-Medicare fee schedule)

ICD-10-CM Cross Reference Details

A00.0 Cholera due to Vibrio cholerae 01, biovar cholerae
A00.1 Cholera due to Vibrio cholerae 01, biovar eltor
A00.9 Cholera, unspecified
A01.00 Typhoid fever, unspecified
A01.01 Typhoid meningitis
A01.02 Typhoid fever with heart involvement
A01.03 Typhoid pneumonia
A01.04 Typhoid arthritis
A01.05 Typhoid osteomyelitis
A01.09 Typhoid fever with other complications
A01.1 Paratyphoid fever A
A01.2 Paratyphoid fever B
A01.3 Paratyphoid fever C
A02.0 Salmonella enteritis
A02.1 Salmonella sepsis
A02.20 Localized salmonella infection, unspecified
A02.21 Salmonella meningitis
A02.22 Salmonella pneumonia
A02.23 Salmonella arthritis
A02.24 Salmonella osteomyelitis
A02.8 Other specified salmonella infections
A02.9 Salmonella infection, unspecified
A03.0 Shigellosis due to Shigella dysenteriae
A03.1 Shigellosis due to Shigella flexneri
A03.2 Shigellosis due to Shigella boydii
A03.3 Shigellosis due to Shigella sonnei
A03.8 Other shigellosis
A04.0 Enteropathogenic Escherichia coli infection
A04.1 Enterotoxigenic Escherichia coli infection
A04.2 Enteroinvasive Escherichia coli infection
A04.3 Enterohemorrhagic Escherichia coli infection
A04.4 Other intestinal Escherichia coli infections
A04.5 Campylobacter enteritis
A04.6 Enteritis due to Yersinia enterocolitica
A04.71 Enterocolitis due to Clostridium difficile, recurrent
A04.72 Enterocolitis due to Clostridium difficile, not specified as recurrent
A04.8 Other specified bacterial intestinal infections
A04.9 Bacterial intestinal infection, unspecified
A05.0 Foodborne staphylococcal intoxication
A05.1 Botulism food poisoning
A05.2 Foodborne Clostridium perfringens [Clostridium welchii] intoxication
A05.3 Foodborne Vibrio parahaemolyticus intoxication
A05.5 Foodborne Vibrio vulnificus intoxication
A05.8 Other specified bacterial foodborne intoxications
A05.9 Bacterial foodborne intoxication, unspecified
A06.0 Acute amebic dysentery
A06.1 Chronic intestinal amebiasis
A06.2 Amebic nondysenteric colitis
A06.4 Amebic liver abscess
A06.5 Amebic lung abscess
A06.82 Other amebic genitourinary infections
A07.2 Cryptosporidiosis
A07.3 Isosporiasis
A07.4 Cyclosporiasis
A08.0 Rotaviral enteritis
A08.2 Adenoviral enteritis
A08.31 Calicivirus enteritis
A08.32 Astrovirus enteritis
A08.39 Other viral enteritis
A09 Infectious gastroenteritis and colitis, unspecified
A15.0 Tuberculosis of lung
A15.4 Tuberculosis of intrathoracic lymph nodes
A15.5 Tuberculosis of larynx, trachea and bronchus
A15.6 Tuberculous pleurisy
A15.7 Primary respiratory tuberculosis
A15.8 Other respiratory tuberculosis
A15.9 Respiratory tuberculosis unspecified
A17.0 Tuberculous meningitis
A17.1 Meningeal tuberculoma
A17.81 Tuberculoma of brain and spinal cord
A17.82 Tuberculous meningoencephalitis
A17.83 Tuberculous neuritis
A17.89 Other tuberculosis of nervous system
A17.9 Tuberculosis of nervous system, unspecified
A18.01 Tuberculosis of spine
A18.02 Tuberculous arthritis of other joints
A18.03 Tuberculosis of other bones
A18.09 Other musculoskeletal tuberculosis
A18.10 Tuberculosis of genitourinary system, unspecified
A18.11 Tuberculosis of kidney and ureter
A18.12 Tuberculosis of bladder
A18.13 Tuberculosis of other urinary organs
A18.14 Tuberculosis of prostate
A18.15 Tuberculosis of other male genital organs
A18.16 Tuberculosis of cervix
A18.17 Tuberculous female pelvic inflammatory disease
A18.18 Tuberculosis of other female genital organs
A18.2 Tuberculous peripheral lymphadenopathy
A18.31 Tuberculous peritonitis
A18.32 Tuberculous enteritis
A18.39 Retroperitoneal tuberculosis
A18.4 Tuberculosis of skin and subcutaneous tissue
A18.50 Tuberculosis of eye, unspecified
A18.51 Tuberculous episcleritis
A18.52 Tuberculous keratitis
A18.53 Tuberculous chorioretinitis
A18.54 Tuberculous iridocyclitis
A18.59 Other tuberculosis of eye
A18.6 Tuberculosis of (inner) (middle) ear
A18.7 Tuberculosis of adrenal glands
A18.81 Tuberculosis of thyroid gland
A18.82 Tuberculosis of other endocrine glands
A18.83 Tuberculosis of digestive tract organs, not elsewhere classified
A18.84 Tuberculosis of heart
A18.85 Tuberculosis of spleen
A18.89 Tuberculosis of other sites
A19.0 Acute miliary tuberculosis of a single specified site
A19.1 Acute miliary tuberculosis of multiple sites
A19.2 Acute miliary tuberculosis, unspecified
A19.8 Other miliary tuberculosis
A19.9 Miliary tuberculosis, unspecified
A20.1 Cellulocutaneous plague
A20.2 Pneumonic plague
A20.3 Plague meningitis
A20.7 Septicemic plague
A20.8 Other forms of plague
A21.1 Oculoglandular tularemia
A21.2 Pulmonary tularemia
A21.3 Gastrointestinal tularemia
A21.7 Generalized tularemia
A21.8 Other forms of tularemia
A22.0 Cutaneous anthrax
A22.1 Pulmonary anthrax
A22.2 Gastrointestinal anthrax
A22.7 Anthrax sepsis
A22.8 Other forms of anthrax
A23.8 Other brucellosis
A24.0 Glanders
A24.2 Subacute and chronic melioidosis
A24.3 Other melioidosis
A24.9 Melioidosis, unspecified
A25.1 Streptobacillosis
A26.7 Erysipelothrix sepsis
A26.8 Other forms of erysipeloid

A26.9 Erysipeloid, unspecified
A27.81 Aseptic meningitis in leptospirosis
A28.0 Pasteurellosis
A28.2 Extraintestinal yersiniosis
A28.8 Other specified zoonotic bacterial diseases, not elsewhere classified
A28.9 Zoonotic bacterial disease, unspecified
A31.0 Pulmonary mycobacterial infection
A31.1 Cutaneous mycobacterial infection
A31.2 Disseminated mycobacterium avium-intracellulare complex (DMAC)
A31.8 Other mycobacterial infections
A31.9 Mycobacterial infection, unspecified
A32.11 Listerial meningitis
A32.12 Listerial meningoencephalitis
A32.7 Listerial sepsis
A32.81 Oculoglandular listeriosis
A32.82 Listerial endocarditis
A32.89 Other forms of listeriosis
A32.9 Listeriosis, unspecified
A33 Tetanus neonatorum
A34 Obstetrical tetanus
A35 Other tetanus
A36.0 Pharyngeal diphtheria
A36.1 Nasopharyngeal diphtheria
A36.2 Laryngeal diphtheria
A36.3 Cutaneous diphtheria
A36.81 Diphtheritic cardiomyopathy
A36.82 Diphtheritic radiculomyelitis
A36.83 Diphtheritic polyneuritis
A36.84 Diphtheritic tubulo-interstitial nephropathy
A36.85 Diphtheritic cystitis
A36.86 Diphtheritic conjunctivitis
A36.89 Other diphtheritic complications
A36.9 Diphtheria, unspecified
A37.00 Whooping cough due to Bordetella pertussis without pneumonia
A37.01 Whooping cough due to Bordetella pertussis with pneumonia
A37.10 Whooping cough due to Bordetella parapertussis without pneumonia
A37.11 Whooping cough due to Bordetella parapertussis with pneumonia
A37.80 Whooping cough due to other Bordetella species without pneumonia
A37.81 Whooping cough due to other Bordetella species with pneumonia
A37.90 Whooping cough, unspecified species without pneumonia
A37.91 Whooping cough, unspecified species with pneumonia
A38.0 Scarlet fever with otitis media
A38.1 Scarlet fever with myocarditis
A38.8 Scarlet fever with other complications
A38.9 Scarlet fever, uncomplicated
A39.0 Meningococcal meningitis
A39.2 Acute meningococcemia
A39.3 Chronic meningococcemia
A39.4 Meningococcemia, unspecified
A39.50 Meningococcal carditis, unspecified
A39.51 Meningococcal endocarditis
A39.52 Meningococcal myocarditis
A39.53 Meningococcal pericarditis
A39.81 Meningococcal encephalitis
A39.82 Meningococcal retrobulbar neuritis
A39.83 Meningococcal arthritis
A39.84 Postmeningococcal arthritis
A39.89 Other meningococcal infections
A39.9 Meningococcal infection, unspecified
A40.0 Sepsis due to streptococcus, group A
A40.1 Sepsis due to streptococcus, group B
A40.3 Sepsis due to Streptococcus pneumoniae
A40.8 Other streptococcal sepsis
A40.9 Streptococcal sepsis, unspecified
A41.01 Sepsis due to Methicillin susceptible Staphylococcus aureus
A41.02 Sepsis due to Methicillin resistant Staphylococcus aureus
A41.1 Sepsis due to other specified staphylococcus
A41.2 Sepsis due to unspecified staphylococcus
A41.3 Sepsis due to Hemophilus influenzae
A41.4 Sepsis due to anaerobes
A41.50 Gram-negative sepsis, unspecified
A41.51 Sepsis due to Escherichia coli [E. coli]
A41.52 Sepsis due to Pseudomonas
A41.53 Sepsis due to Serratia
A41.54 Sepsis due to Acinetobacter baumannii
A41.59 Other Gram-negative sepsis
A41.81 Sepsis due to Enterococcus
A41.89 Other specified sepsis
A41.9 Sepsis, unspecified organism
A42.0 Pulmonary actinomycosis
A42.1 Abdominal actinomycosis
A42.2 Cervicofacial actinomycosis
A42.7 Actinomycotic sepsis
A42.81 Actinomycotic meningitis
A42.82 Actinomycotic encephalitis
A42.89 Other forms of actinomycosis
A42.9 Actinomycosis, unspecified
A43.0 Pulmonary nocardiosis
A43.1 Cutaneous nocardiosis
A43.8 Other forms of nocardiosis
A43.9 Nocardiosis, unspecified
A46 Erysipelas
A48.0 Gas gangrene
A48.1 Legionnaires' disease
A48.2 Nonpneumonic Legionnaires' disease [Pontiac fever]
A48.3 Toxic shock syndrome
A48.8 Other specified bacterial diseases
A49.01 Methicillin susceptible Staphylococcus aureus infection, unspecified site
A49.02 Methicillin resistant Staphylococcus aureus infection, unspecified site
A49.2 Hemophilus influenzae infection, unspecified site
A49.3 Mycoplasma infection, unspecified site
A49.8 Other bacterial infections of unspecified site
A49.9 Bacterial infection, unspecified
A50.41 Late congenital syphilitic meningitis
A50.54 Late congenital cardiovascular syphilis
A51.41 Secondary syphilitic meningitis
A51.42 Secondary syphilitic female pelvic disease
A52.00 Cardiovascular syphilis, unspecified
A52.01 Syphilitic aneurysm of aorta
A52.02 Syphilitic aortitis
A52.03 Syphilitic endocarditis
A52.05 Other cerebrovascular syphilis
A52.06 Other syphilitic heart involvement
A52.09 Other cardiovascular syphilis
A52.11 Tabes dorsalis
A52.12 Other cerebrospinal syphilis
A52.13 Late syphilitic meningitis
A52.14 Late syphilitic encephalitis
A52.15 Late syphilitic neuropathy
A52.17 General paresis
A52.19 Other symptomatic neurosyphilis
A52.2 Asymptomatic neurosyphilis
A52.3 Neurosyphilis, unspecified
A52.74 Syphilis of liver and other viscera
A52.76 Other genitourinary symptomatic late syphilis
A54.00 Gonococcal infection of lower genitourinary tract, unspecified
A54.02 Gonococcal vulvovaginitis, unspecified
A54.03 Gonococcal cervicitis, unspecified
A54.09 Other gonococcal infection of lower genitourinary tract
A54.1 Gonococcal infection of lower genitourinary tract with periurethral and accessory gland abscess
A54.21 Gonococcal infection of kidney and ureter
A54.22 Gonococcal prostatitis
A54.23 Gonococcal infection of other male genital organs
A54.24 Gonococcal female pelvic inflammatory disease

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 wall	May refer to muscle covering the abdomen, or to the skin, fascia, muscle, and membranes marking the boundaries of the abdominal cavity.
Ablation	Removal of a body part or organ or destruction of its function.
Abscess	Sac or pocket formed due to the accumulation of purulent material, or pus, in the soft tissues.
Absorption	Taking in of substances by tissues.
Acellular pertussis	Highly infectious respiratory disease; also called whooping cough.
Acid fast bacilli	Also called AFB, these bacteria resist loss of stain color when treated with a dilute acid, and are part of the taxonomic class bacillus that are typically rod shaped bacteria.
Acoustic immittance testing	A measurement of the vibration of the eardrum and the amount of air behind it, which helps to determine the cause of hearing loss.
Acoustic reflex	A measurement of the contraction of the stapedius muscle in response to loud sound.
Acromioclavicular, or AC, joint	Union of the acromion, or shoulder blade, and the clavicle, or collar bone.
Actinic keratoses	Rough, scaly patches of skin that develop from prolonged exposure to sun.
Activities of daily living (ADLs)	Basic daily activities of life such as eating, bathing, dressing, toileting and walking.
Acute	A medical condition or injury of sudden onset, sometimes severe in nature, and typically last a short period of time; opposite of chronic.
Acute respiratory distress	Sudden onset of difficulty breathing or periods of apnea, or failure to breathe.
Adaptive	Able to adjust to situations or environment.
Adenoids	Lymph tissue at the back of the throat near the base of the nose.
Adenovirus	DNA viruses that cause infection in the lungs and eyes.
Adhesion	Fibrous bands that form between tissues and organs, sometimes as a result of injury during surgery; they may be thought of as internal scar tissue.
Adjustable gastric restrictive device	A band placed around the stomach to restrict the size of the stomach; it encloses a balloon which can be adjusted by adding or removing saline via a reservoir and port attached just below the skin of the abdomen, effectively reducing or enlarging the outlet to regulate the amount of food that can pass through.
Adolescent	Teenager.
Aerobic	Indicating the presence of air or oxygen; in microbiology, referring to growth in the presence of air or oxygen.
Aerosol generator	A device that produces aerosol suspensions, as for inhalation therapy.
Agar	A gelatinous material derived from algae that labs often mix with nutrients and other desired substances for use as a solid substrate on which to culture or grow microorganisms or other cells.
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.
Albuterol	An inhaled bronchodilator.
Allergen	A substance, such as pollen, dust, dander, or venom, which triggers an allergic response.
Allergen immunotherapy	A treatment that involves periodic, gradual administration of purified allergen extracts via injection, aimed at overcoming or minimizing allergic reactions so that a patient develops tolerance to the allergens with fewer or no symptoms when exposed; allergy shots decrease the sensitivity to allergens and often lead to lasting relief of allergy symptoms.
Allergenic extract	Protein containing an extract purified from a substance that causes an allergic reaction in some individuals.
Allergic reaction	The result of the body's reaction to a specific substance that otherwise seems to be harmless but causes a severe reaction in a person allergic to the substance; also called anaphylaxis.
Alveolar ridge	A ridge like border on the upper and lower jaw from where the teeth arise.

Terminology	Explanation
Alveolus; pl. alveoli	Small sacs or air pockets in the lungs or jaws.
A-mode, amplitude mode	A one-dimensional ultrasonic measurement.
Amplification	Making more copies of desired gene for study by processes such as polymerase chain reaction, called PCR, or transcription of DNA to RNA and reverse transcription from RNA to make an additional copy of the DNA.
Amplitude electroencephalography, or EEG	Continuous monitoring of brain function via electrodes placed on the scalp and connected to a device that records brain waves graphically.
Anal canal	The terminal portion of the digestive tube from the rectum to the anus.
Anastomosis	Connection between two structures, anatomical or surgically created, such as between two blood vessels or the colon after resection of a part; types of anastomosis include end to side and side to side.
Anesthetic agent	Substance that reduces sensitivity to pain.
Aneuploidy	Chromosome mutation involving an abnormal chromosome number, such as one or three chromosome copies in the nucleus of cells that have a normal chromosome number of two.
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.
Angiography	Imaging of vessels taken after the injection of a radiographic dye.
Ankyloglossia	Also called tongue tie, is a minor defect present from birth in which the frenum is too short and it limits the movement of the tongue.
Anoscopy	A procedure in which the provider passes a medical instrument called an anoscope through the anal cavity to examine the inner wall of the anus and the rectum.
Anterior	Closer to the front part of the body.
Anterolateral	Present in front and to the side of the body.
Anteroposterior, or AP, view	The X-ray projection travels from front to back.
Antibiotic	Substance that inhibits infection.
Antibody	Also called immunoglobulin; a protein that the body produces in the blood as part of the immune response to neutralize specific invaders such as bacteria or viruses, but occasionally reacts to the patient's own body; lab tests may utilize reactions between antibodies and antigens to identify a substance in a patient specimen.
Anticoagulant	An agent or chemical that is used to prevent the blood from normal clotting. It keeps the blood in liquid form so that it does not clot as there could be a time gap between collection and testing of blood sample (example of anticoagulants: Heparin, Citrate, etc.)
Antigen	Foreign bodies, such as bacteria, that enter the human body, or substances that form within the body, that cause an immune response, such as antibody production, and possibly infection; lab tests may utilize reactions between antibodies and antigens to identify a substance in a patient specimen.
Antihistamine	A drug that blocks the action of histamine in the body; histamine is responsible for allergic symptoms.
Antimicrobial susceptibility	The testing for the microbial sensitivity to an antimicrobial agent such as an antibiotic.
Antipyretic	A drug that prevents or reduces fever.
Antisense oligonucleotide	Chemically modified, synthetic single-stranded deoxyribonucleic acid (DNA) or ribonucleic acid (RNA) molecules that bind to RNA and reduce the expression of the target RNA.
Antitoxin	An antibody that counterbalances the toxin secreted by the antigen.
Anus	External opening of the rectum where the gastrointestinal tract ends.
Aorta	The main artery that comes out of the top of the left ventricle and carries oxygenated blood to the body; it consists of an ascending and descending aorta which serve the upper and lower parts of the body respectively.
Apocrine sweat gland	A type of large, specialized sweat gland that produces fluid secretion by pinching off one end of the secreting cells, which is found at the junction of the skin (dermis) layers and subcutaneous fat.

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