AAPC

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

CODERS' SPECIALTY GUIDE

Pulmonology

2026

Contents

General Surgical Procedures

+10004

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

Clinical Responsibility

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

Coding Tips

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

Fee Schedule Information

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

Modifier Allowances

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

NCCI Alerts (version 31.0)

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

ICD-10-CM Cross References

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

10005

Fine needle aspiration biopsy, including ultrasound guidance; first lesion

Clinical Responsibility

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

Coding Tips

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

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

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

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

Fee Schedule Information

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

Modifier Allowances

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

NCCI Alerts (version 31.0)

0213T[1], 0216T[1], 10004[1], 10008[1], 10010[1], 10011[1], 10012[1], 10021[1], 10035[1], 11102[1], 11103[1], 11104[1], 11105[1], 11106[1], 11107[1], 19281[1], 19283[1], 19285[1], 19287[1], 36000[1], 36410[1], 36591[0], 36592[0], 61650[1], 62324[1], 62325[1], 62326[1], 62327[1], 64415[1], 64416[1], 64417[1], 64450[1], 64454[1], 64486[1], 64487[1], 64488[1], 64489[1], 64490[1], 64493[1], 76000[1], 76380[1], 76942[1], 76998[1], 77001[1], 77002[1], 77012[1], 77021[1], 96360[1], 96365[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0]

ICD-10-CM Cross References

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

+10006

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

Clinical Responsibility

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

Coding Tips

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

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

Fee Schedule Information

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

Modifier Allowances

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

NCCI Alerts (version 31.0)

0213T[1], 0216T[1], 10004[1], 10035[1], 19281[1], 19283[1], 19285[1], 19287[1], 36000[1], 36410[1], 36591[0], 36592[0], 61650[1], 62324[1], 62325[1], 62326[1], 62327[1], 64415[1], 64416[1], 64417[1], 64450[1], 64454[1], 64486[1], 64487[1], 64488[1], 64489[1], 64490[1], 64493[1], 76000[1], 76380[1], 76942[1], 76998[1], 77001[1], 77002[1], 77012[1], 77021[1], 96360[1], 96365[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0]

ICD-10-CM Cross References

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

10007

Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion

Clinical Responsibility

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

Coding Tips

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

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

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Musculoskeletal System

21554

Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); 5 cm or greater

Clinical Responsibility

The physician makes a longitudinal incision over the tumor and dissects into the muscle where the tumor lies. He identifies the mass and dissects it off the muscles to which it is attached, ligating and incising any feeding vessels or arteries and protecting any nerves. He then irrigates the wound and places a drain, then closes the incision in layers.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $719.39, Non Facility Fee: $719.39
RVU (Facility): Work RVU 11.13, Practice Exp. RVU 8.73, Malpractice RVU 2.38, Total RVU 22.24
RVU (Non-Facility): Work RVU 11.13, Practice Exp. RVU 8.73, Malpractice RVU 2.38, Total RVU 22.24
MPFS Payment Policy Indicators: Global Period 090, Preop 10.00%, Intraop 69.00%, Postop 21.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 2

Modifier Allowances

22, 47, 51, 52, 53, 54, 55, 56, 58, 59, 63, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, GA, GC, GR, KX, PD, Q5, Q6, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0213T^{0}, 0216T^{0}, 0596T^{1}, 0597T^{1}, 0708T^{1}, 0709T^{1}, 10005^{1}, 10007^{1}, 10009^{1}, 10011^{1}, 10021^{1}, 10030^{1}, 10060^{1}, 10140^{1}, 10160^{1}, 11000^{1}, 11001^{1}, 11004^{1}, 11005^{1}, 11006^{1}, 11010^{1}, 11011^{1}, 11012^{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}, 21501^{1}, 21550^{1}, 21552^{1}, 21555^{1}, 21556^{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}, 38500^{1}, 38505^{1}, 38510^{1}, 38520^{1}, 38531^{1}, 38542^{1}, 38550^{1}, 38555^{1}, 38700^{1}, 38720^{1}, 38724^{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}, 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

C47.0-C47.3, C47.6, C49.0-C49.3, C49.6, C49.8, C4A.4, C4A.52, C4A.59, C76.0, C76.1, C79.89, C79.9, C7B.1, D09.3, D09.8, D17.1, D17.79, D21.0, D21.3, D48.110-D48.112, D49.2, D49.89, L98.9, R22.1, R22.2, T81.40XA-T81.40XS

21601

Excision of chest wall tumor including rib(s)

Clinical Responsibility

The provider incises the skin of the chest wall and dissects down to fascia and chest muscles, depending upon the tumor's size and extent. He excises the tumor in its entirety along with surrounding soft tissues, adjacent ribs above and below the tumor, and intercostal muscles. Following the excision, he controls bleeding with electrocautery or ligation and closes the surgical wound with layered sutures. He may place a drain into the depths of the wound and bring it out through the skin for drainage and better healing of the wound.

Coding Tips

For excision of a chest wall tumor involving the ribs with plastic reconstruction, see 21602 (if mediastinal lymphadenopathy is not present) or 21603 (if mediastinal lymphadenopathy is present).

Do not report 21601, 21602, or 21603 in conjunction with 32503 or 32504 for resection of an apical lung tumor; chest resection, chest reconstruction, and rib resection are included in both these codes, and chest wall reconstruction is included in 32504.

Most health insurance policies cover reconstructive plastic surgery, as opposed to cosmetic plastic surgery, although coverage may vary. Check with the payer to determine their coverage and requirements for submitting codes for reimbursement for plastic reconstructive procedures.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $1,114.98, Non Facility Fee: $1,114.98
RVU (Facility): Work RVU 17.78, Practice Exp. RVU 12.32, Malpractice RVU 4.37, Total RVU 34.47
RVU (Non-Facility): Work RVU 17.78, Practice Exp. RVU 12.32, Malpractice RVU 4.37, Total RVU 34.47
MPFS Payment Policy Indicators: Global Period 090, Preop 10.00%, Intraop 71.00%, Postop 19.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 2

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Modifier Allowances

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

NCCI Alerts (version 31.0)

00400[0], 0213T[0], 0216T[0], 0596T[1], 0597T[1], 0708T[1], 0709T[1], 10035[1], 11000[1], 11001[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], 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], 13100[1], 13101[1], 13102[1], 13120[1], 13121[1], 13122[1], 13131[1], 13132[1], 13133[1], 19081[1], 19083[1], 19085[1], 19100[1], 19120[1], 19281[1], 19283[1], 19285[1], 19287[1], 32556[1], 32557[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[1], 64461[0], 64462[0], 64463[0], 64479[0], 64480[0], 64483[0], 64484[0], 64486[0], 64487[0], 64488[0], 64489[0], 64490[0], 64491[0], 64492[0], 64493[0], 64494[0], 64495[0], 64505[0], 64510[0], 64517[0], 64520[0], 64530[0], 69990[0], 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

C41.3, C47.3, C49.3, C50.911-C50.919, C76.1, C77.1, C79.51, C79.52, C79.89, C79.9, D09.3, D09.8, D19.7, D36.7, D48.0, D48.111, D48.112, D48.2, D49.2, R22.2, T81.40XA-T81.40XS, Z15.09, Z80.3, Z85.3, Z90.10-Z90.13

21602

Excision of chest wall tumor involving rib(s), with plastic reconstruction; without mediastinal lymphadenectomy

Clinical Responsibility

With the patient appropriately prepped and under general anesthesia, the provider accesses the tumor through an incision in the chest wall. He dissects down through subcutaneous tissues, fascia, and muscle. He excises the tumor in its entirety along with surrounding soft tissues and adjacent ribs above and below the tumor. Following the excision, the provider reconstructs the chest wall using myocutaneous flaps taken from the pectoralis major, latissimus dorsi, rectus abdominis, or serratus anterior muscles. Autogenous rib grafts or prosthetic materials such as Prolene® or Marlex® mesh and acrylic fiber are used to repair the bone defect. He controls bleeding with electrocautery or ligation and closes the surgical wound with layered sutures. He may place a drain into the depths of the wound and bring it out through the skin for drainage and better healing of the wound.

Coding Tips

For excision of a chest wall tumor involving the ribs with plastic reconstruction when mediastinal lymphadenopathy is present, see 21603.

For excision of chest wall tumor including ribs, without plastic reconstruction, see 21601.

Do not report 21601, 21602, or 21603 in conjunction with 32503 or 32504 for resection of an apical lung tumor; chest resection, chest reconstruction, and rib resection are included in both these codes, and chest wall reconstruction is included in 32504.

Most health insurance policies cover reconstructive plastic surgery, as opposed to cosmetic plastic surgery, although coverage may vary. Check with the payer to determine their coverage and requirements for submitting codes for reimbursement for plastic reconstructive procedures.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $1,502.82, Non Facility Fee: $1,502.82
RVU (Facility): Work RVU 22.19, Practice Exp. RVU 18.92, Malpractice RVU 5.35, Total RVU 46.46
RVU (Non-Facility): Work RVU 22.19, Practice Exp. RVU 18.92, Malpractice RVU 5.35, Total RVU 46.46
MPFS Payment Policy Indicators: Global Period 090, Preop 10.00%, Intraop 71.00%, Postop 19.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

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

NCCI Alerts (version 31.0)

00400[0], 0213T[0], 0216T[0], 0596T[1], 0597T[1], 0708T[1], 0709T[1], 10035[1], 11000[1], 11001[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], 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], 13100[1], 13101[1], 13102[1], 13120[1], 13121[1], 13122[1], 13131[1], 13132[1], 13133[1], 19081[1], 19083[1], 19085[1], 19100[1], 19120[1], 19281[1], 19283[1], 19285[1], 19287[1], 21601[1], 32556[1], 32557[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[1], 64461[0], 64462[0], 64463[0], 64479[0], 64480[0], 64483[0], 64484[0], 64486[0], 64487[0], 64488[0], 64489[0], 64490[0], 64491[0], 64492[0], 64493[0], 64494[0], 64495[0], 64505[0], 64510[0], 64517[0], 64520[0], 64530[0], 69990[0], 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],

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30430

Rhinoplasty, secondary; minor revision (small amount of nasal tip work)

Clinical Responsibility

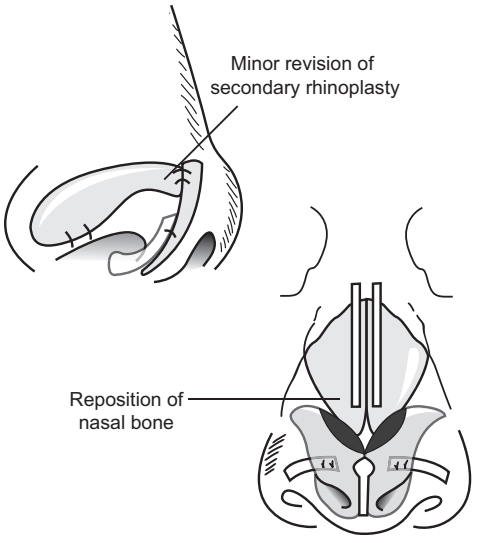
When the patient is appropriately prepped and anesthetized, the provider uses either an open or closed approach to perform rhinoplasty, changing the shape of the nose for functional or cosmetic reasons. This procedure is secondary rhinoplasty, meaning the patient has had a previous rhinoplasty, and this procedure may address issues caused by or not resolved by the previous surgery. Open rhinoplasty, also known as external rhinoplasty, involves small, visible incisions, such as the transcolumellar incision that goes through the skin of the columella, the tissue that separates the nostrils and connects the tip of the nose to the base. After making one or more incisions, the provider can fold the nasal skin upward to visualize the nasal skeleton. Open rhinoplasty may allow for easier surgical access than closed rhinoplasty, which is also known as endonasal rhinoplasty. The closed approach involves making surgical incisions inside the nostrils, preventing visible scarring. In either approach, the provider makes the necessary changes to the cartilage and soft tissue as desired to complete a minor revision, typically a small amount of work on the nasal tip. The procedure may involve graft placement. (Obtaining tissues for grafts may be separately reportable.) The provider completes the surgery and closes the incisions.

Coding Tips

This code is specific to secondary rhinoplasty, which is surgery after a previous rhinoplasty, often because the previous rhinoplasty resulted in a complication, did not achieve the desired functional or cosmetic results, or did not treat the patient's issues properly.

Obtaining tissues for grafts may be separately reportable. Check coding guidelines.

Illustration



30430

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $1,039.94, Non Facility Fee: $1,039.94
RVU (Facility): Work RVU 8.24, Practice Exp. RVU 22.40, Malpractice RVU 1.51, Total RVU 32.15
RVU (Non-Facility): Work RVU 8.24, Practice Exp. RVU 22.40, Malpractice RVU 1.51, Total RVU 32.15
MPFS Payment Policy Indicators: Global Period 090, Preop 10.00%, Intraop 76.00%, Postop 14.00%, MPFS Status Indicator: R, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

22, 47, 51, 52, 53, 54, 55, 56, 58, 63, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, GY, GZ, KX, PD, Q5, Q6, QJ

NCCI Alerts (version 31.0)

0213T^{0}, 0216T^{0}, 0596T^{1}, 0597T^{1}, 0708T^{1}, 0709T^{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}, 30460^{0}, 36000^{1}, 36400^{1}, 36405^{1}, 36406^{1}, 36410^{1}, 36420^{1}, 36425^{1}, 36430^{1}, 36440^{1}, 36591^{0}, 36592^{0}, 36600^{1}, 36640^{1}, 43752^{1}, 51701^{1}, 51702^{1}, 51703^{1}, 62320^{0}, 62321^{0}, 62322^{0}, 62323^{0}, 62324^{0}, 62325^{0}, 62326^{0}, 62327^{0}, 64400^{0}, 64405^{0}, 64408^{0}, 64415^{0}, 64416^{0}, 64417^{0}, 64418^{0}, 64420^{0}, 64421^{0}, 64425^{0}, 64430^{0}, 64435^{0}, 64445^{0}, 64446^{0}, 64447^{0}, 64448^{0}, 64449^{0}, 64450^{0}, 64451^{0}, 64454^{0}, 64461^{0}, 64462^{0}, 64463^{0}, 64479^{0}, 64480^{0}, 64483^{0}, 64484^{0}, 64486^{0}, 64487^{0}, 64488^{0}, 64489^{0}, 64490^{0}, 64491^{0}, 64492^{0}, 64493^{0}, 64494^{0}, 64495^{0}, 64505^{0}, 64510^{0}, 64517^{0}, 64520^{0}, 64530^{0}, 69990^{0}, 92012^{1}, 92014^{1}, 92502^{0}, 93000^{1}, 93005^{1}, 93010^{1}, 93040^{1}, 93041^{1}, 93042^{1}, 93318^{1}, 93355^{1}, 94002^{1}, 94200^{1}, 94680^{1}, 94681^{1}, 94690^{1}, 95812^{1}, 95813^{1}, 95816^{1}, 95819^{1}, 95822^{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}, J0670^{1}

ICD-10-CM Cross References

C30.0, C41.0, C43.30-C43.39, C76.0, D03.30, D03.39, D04.30, D04.39, D14.0, D16.4, D23.30, D23.39, J34.8200-J34.8202, J34.8210-J34.8212, J34.829, M95.0, Q30.1-Q30.3, Q30.8, Q30.9, Q67.0, Q67.4, S01.90XS, S02.2XXA-S02.2XXB, S02.2XXS, S07.9XXS, T20.00XS, T20.40XS, T85.692A, T85.698A, T85.79XA, T86.820, T86.821, Z42.8

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30435

Rhinoplasty, secondary; intermediate revision (bony work with osteotomies)

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider uses either an open or closed approach to perform rhinoplasty, changing the shape of the nose for functional or cosmetic reasons. This procedure is secondary rhinoplasty, meaning the patient has had a previous rhinoplasty, and this procedure may address issues caused by or not resolved by the previous surgery. Open rhinoplasty, also known as external rhinoplasty, involves small, visible incisions, such as the transcolumellar incision that goes through the skin of the columella, the tissue that separates the nostrils and connects the tip of the nose to the base. After making one or more incisions, the provider can fold the nasal skin upward to visualize the nasal skeleton. Open rhinoplasty may allow for easier surgical access than closed rhinoplasty, which is also known as endonasal rhinoplasty. The closed approach involves making surgical incisions inside the nostrils, preventing visible scarring. In either approach, the provider makes the necessary changes to the bone and tissues to complete an intermediate revision. The provider performs one or more osteotomies, cutting the bone to realign or reshape it. The procedure may involve graft placement. (Obtaining tissues for grafts may be separately reportable.) The provider completes the surgery and closes the incisions.

Coding Tips

This code is specific to secondary rhinoplasty, which is surgery after a previous rhinoplasty, often because the previous rhinoplasty resulted in a complication, did not achieve the desired functional or cosmetic results, or did not treat the patient's issues properly.

Obtaining tissues for grafts may be separately reportable. Check coding guidelines.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $1,299.04, Non Facility Fee: $1,299.04
RVU (Facility): Work RVU 12.73, Practice Exp. RVU 25.10, Malpractice RVU 2.33, Total RVU 40.16
RVU (Non-Facility): Work RVU 12.73, Practice Exp. RVU 25.10, Malpractice RVU 2.33, Total RVU 40.16
MPFS Payment Policy Indicators: Global Period 090, Preop 10.00%, Intraop 76.00%, Postop 14.00%, MPFS Status Indicator: R, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

22, 47, 51, 52, 53, 54, 55, 56, 58, 63, 73, 74, 76, 77, 78, 79, 80, 81, 82, 99, AQ, AR, AS, CR, ET, GA, GC, GJ, GR, GY, GZ, KX, PD, Q5, Q6, QJ

NCCI Alerts (version 31.0)

0213T^{0}, 0216T^{0}, 0596T^{1}, 0597T^{1}, 0708T^{1}, 0709T^{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}, 30400^{0}, 30430^{0}, 30460^{0}, 30465^{1}, 30468^{1}, 30469^{1}, 36000^{1}, 36400^{1}, 36405^{1}, 36406^{1}, 36410^{1}, 36420^{1}, 36425^{1}, 36430^{1}, 36440^{1}, 36591^{0}, 36592^{0}, 36600^{1}, 36640^{1}, 43752^{1}, 51701^{1}, 51702^{1}, 51703^{1}, 62320^{0}, 62321^{0}, 62322^{0}, 62323^{0}, 62324^{0}, 62325^{0}, 62326^{0}, 62327^{0}, 64400^{0}, 64405^{0}, 64408^{0}, 64415^{0}, 64416^{0}, 64417^{0}, 64418^{0}, 64420^{0}, 64421^{0}, 64425^{0}, 64430^{0}, 64435^{0}, 64445^{0}, 64446^{0}, 64447^{0}, 64448^{0}, 64449^{0}, 64450^{0}, 64451^{0}, 64454^{0}, 64461^{0}, 64462^{0}, 64463^{0}, 64479^{0}, 64480^{0}, 64483^{0}, 64484^{0}, 64486^{0}, 64487^{0}, 64488^{0}, 64489^{0}, 64490^{0}, 64491^{0}, 64492^{0}, 64493^{0}, 64494^{0}, 64495^{0}, 64505^{0}, 64510^{0}, 64517^{0}, 64520^{0}, 64530^{0}, 69990^{0}, 92012^{1}, 92014^{1}, 92502^{0}, 93000^{1}, 93005^{1}, 93010^{1}, 93040^{1}, 93041^{1}, 93042^{1}, 93318^{1}, 93355^{1}, 94002^{1}, 94200^{1}, 94680^{1}, 94681^{1}, 94690^{1}, 95812^{1}, 95813^{1}, 95816^{1}, 95819^{1}, 95822^{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}, J0670^{1}

ICD-10-CM Cross References

C30.0, C41.0, C43.30-C43.39, C76.0, D03.30, D03.39, D04.30, D04.39, D14.0, D16.4, D23.30, D23.39, J34.8200-J34.8202, J34.8210-J34.8212, J34.829, M95.0, Q30.1-Q30.3, Q30.8, Q30.9, Q67.0, Q67.4, S01.90XS, S02.2XXA-S02.2XXB, S02.2XXS, S07.9XXS, T20.00XS, T20.40XS, T85.692A, T85.698A, T85.79XA, T86.820, T86.821, Z42.8

30450

Rhinoplasty, secondary; major revision (nasal tip work and osteotomies)

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider uses either an open or closed approach to perform rhinoplasty, changing the shape of the nose for functional or cosmetic reasons. This procedure is secondary rhinoplasty, meaning the patient has had a previous rhinoplasty, and this procedure may address issues caused by or not resolved by the previous surgery. Open rhinoplasty, also known as external rhinoplasty, involves small, visible incisions, such as the transcolumellar incision that goes through the skin of the columella, the tissue that separates the nostrils and connects the tip of the nose to the base. After making one or more incisions, the provider can fold the nasal skin upward to visualize the nasal skeleton. Open rhinoplasty may allow for easier surgical access than closed rhinoplasty, which is also known as endonasal rhinoplasty. The closed approach involves making surgical incisions inside the nostrils, preventing visible scarring. In either approach, the provider makes the necessary changes to the bone and tissues to complete a major revision. The provider performs one or more osteotomies, cutting the bone to realign or reshape it. The provider also performs work on the nasal tip, such as altering

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30802

Ablation, soft tissue of inferior turbinates, unilateral or bilateral, any method (eg, electrocautery, radiofrequency ablation, or tissue volume reduction); intramural (ie, submucosal)

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider chooses from various possible ablation methods to shrink the submucosal layer of the inferior turbinates. As an example, in bipolar cautery the provider inserts a needle, approximately 2 mm deep in the front of the tip of the inferior turbinates. He then passes current through the needles to reduce the hypertrophy of the turbinates. The provider then removes the needles.

Coding Tips

Report 30802 if the provider performs submucosal ablation of the inferior turbinates and 30801 if she performs superficial ablation of the turbinates.

Report unlisted procedure code 30999 for ablation of superior or middle turbinates. Coding guidelines require you to report an unlisted procedure code when there is not a precise code available for the procedure.

Report 30130 if the provider excises the inferior turbinates.

Report 30140 if the provider performs submucous resection of the inferior turbinates.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $195.37, Non Facility Fee: $269.45
RVU (Facility): Work RVU 2.08, Practice Exp. RVU 3.67, Malpractice RVU 0.29, Total RVU 6.04
RVU (Non-Facility): Work RVU 2.08, Practice Exp. RVU 5.96, Malpractice RVU 0.29, Total RVU 8.33
MPFS Payment Policy Indicators: Global Period 010, 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, 47, 51, 52, 53, 54, 55, 56, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AQ, AR, CR, ET, GA, GC, GJ, GR, GY, GZ, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0213T^{0}, 0216T^{0}, 0596T^{1}, 0597T^{1}, 0708T^{1}, 0709T^{1}, 12001^{1}, 12002^{1}, 12004^{1}, 12005^{1}, 12006^{1}, 12007^{1}, 12011^{1}, 12013^{1}, 12014^{1}, 12015^{1}, 12016^{1}, 12017^{1}, 12018^{1}, 12020^{1}, 12021^{1}, 12031^{1}, 12032^{1}, 12034^{1}, 12035^{1}, 12036^{1}, 12037^{1}, 12041^{1}, 12042^{1}, 12044^{1}, 12045^{1}, 12046^{1}, 12047^{1}, 12051^{1}, 12052^{1}, 12053^{1}, 12054^{1}, 12055^{1}, 12056^{1}, 12057^{1}, 13100^{1}, 13101^{1}, 13102^{1}, 13120^{1}, 13121^{1}, 13122^{1}, 13131^{1}, 13132^{1}, 13133^{1}, 13151^{1}, 13152^{1}, 13153^{1}, 30200^{1}, 30801^{0}, 30930^{1}, 36000^{1}, 36400^{1}, 36405^{1}, 36406^{1}, 36410^{1}, 36420^{1}, 36425^{1}, 36430^{1}, 36440^{1}, 36591^{0}, 36592^{0}, 36600^{1}, 36640^{1}, 43752^{1}, 51701^{1}, 51702^{1}, 51703^{1}, 62320^{0}, 62321^{0}, 62322^{0}, 62323^{0}, 62324^{0}, 62325^{0}, 62326^{0}, 62327^{0}, 64400^{0}, 64405^{0}, 64408^{0}, 64415^{0}, 64416^{0}, 64417^{0}, 64418^{0}, 64420^{0}, 64421^{0}, 64425^{0}, 64430^{0}, 64435^{0}, 64445^{0}, 64446^{0}, 64447^{0}, 64448^{0}, 64449^{0}, 64450^{0}, 64451^{0}, 64454^{0}, 64461^{0}, 64462^{0}, 64463^{0}, 64479^{0}, 64480^{0}, 64483^{0}, 64484^{0}, 64486^{0}, 64487^{0}, 64488^{0}, 64489^{0}, 64490^{0}, 64491^{0}, 64492^{0}, 64493^{0}, 64494^{0}, 64495^{0}, 64505^{0}, 64510^{0}, 64517^{0}, 64520^{0}, 64530^{0}, 69990^{0}, 92012^{1}, 92014^{1}, 92502^{0}, 93000^{1}, 93005^{1}, 93010^{1}, 93040^{1}, 93041^{1}, 93042^{1}, 93318^{1}, 93355^{1}, 94002^{1}, 94200^{1}, 94680^{1}, 94681^{1}, 94690^{1}, 95812^{1}, 95813^{1}, 95816^{1}, 95819^{1}, 95822^{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^{0}, 99496^{0}, G0463^{1}, G0471^{1}, J0670^{1}

ICD-10-CM Cross References

G47.30, G47.33, J31.0, J32.0-J32.9, J33.8, J34.0-J34.3, J34.89, J34.9, M95.0, R04.0, R06.00, R06.09, R06.3, R06.83, R06.89, R09.81

30901

Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method

Clinical Responsibility

When the patient is appropriately prepped and anesthetized as needed, the provider uses a nasal speculum to locate the site of bleeding. She cleans and dries the site with a cotton tip applicator. She then applies continuous pressure, inserts pledgets soaked with an anesthetic-vasoconstrictor solution into the nasal cavity, performs chemical cautery with a silver nitrate stick, administers nasal spray to anesthetize/shrink nasal mucosa, or uses another minor cautery or packing method to control the bleeding. The provider then again inspects the site to check for bleeding. The goal of the procedure is to control bleeding of the anterior nose.

Coding Tips

This code represents a unilateral service, meaning performed on one side. Depending on payer preference, you may need to report the code once with modifier 50, twice with modifier 50 appended to the second code, or with RT/LT if the provider performs the procedure bilaterally. Check with the payer to determine their preference and avoid delays or rebilling.

Report 30901 when the provider controls the bleeding through simple methods and 30903 when he controls bleeding through complex methods.

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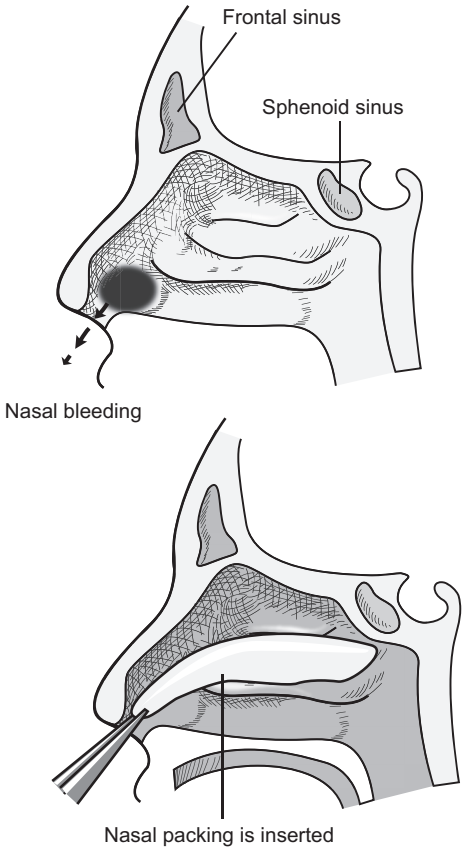
Illustration



30901

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $54.67, Non Facility Fee: $151.06
RVU (Facility): Work RVU 1.10, Practice Exp. RVU 0.41, Malpractice RVU 0.18, Total RVU 1.69
RVU (Non-Facility): Work RVU 1.10, Practice Exp. RVU 3.39, Malpractice RVU 0.18, Total RVU 4.67
MPFS Payment Policy Indicators: Global Period 000, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

22, 47, 50, 51, 52, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AG, AQ, AR, CR, ET, GA, GC, GJ, GR, GY, GZ, KX, LT, PD, Q5, Q6, QJ, RT, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0213T[0], 0216T[0], 0596T[1], 0597T[1], 0708T[1], 0709T[1], 12001[1], 12002[1], 12004[1], 12005[1], 12006[1], 12007[1], 12011[1], 12013[1], 12014[1], 12015[1], 12016[1], 12017[1], 12018[1], 12020[1], 12021[1], 12031[1], 12032[1], 12034[1], 12035[1], 12036[1], 12037[1], 12041[1], 12042[1], 12044[1], 12045[1], 12046[1], 12047[1], 12051[1], 12052[1], 12053[1], 12054[1], 12055[1], 12056[1], 12057[1], 13100[1], 13101[1], 13102[1], 13120[1], 13121[1], 13122[1], 13131[1], 13132[1], 13133[1], 13151[1], 13152[1], 13153[1], 30801[0], 30802[1], 30906[1], 36000[1], 36400[1], 36405[1], 36406[1], 36410[1], 36420[1], 36425[1], 36430[1], 36440[1], 36591[0], 36592[0], 36600[1], 36640[1], 43752[1], 51701[1], 51702[1], 51703[1], 62320[0], 62321[0], 62322[0], 62323[0], 62324[0], 62325[0], 62326[0], 62327[0], 64400[0], 64405[0], 64408[0], 64415[0], 64416[0], 64417[0], 64418[0], 64420[0], 64421[0], 64425[0], 64430[0], 64435[0], 64445[0], 64446[0], 64447[0], 64448[0], 64449[0], 64450[0], 64451[0], 64454[0], 64461[0], 64462[0], 64463[0], 64479[0], 64480[0], 64483[0], 64484[0], 64486[0], 64487[0], 64488[0], 64489[0], 64490[0], 64491[0], 64492[0], 64493[0], 64494[0], 64495[0], 64505[0], 64510[0], 64517[0], 64520[0], 64530[0], 69705[1], 69706[1], 69990[0], 92012[1], 92014[1], 92502[0], 92511[1], 93000[1], 93005[1], 93010[1], 93040[1], 93041[1], 93042[1], 93318[1], 93355[1], 94002[1], 94200[1], 94680[1], 94681[1], 94690[1], 95812[1], 95813[1], 95816[1], 95819[1], 95822[1], 95829[1], 95955[1], 96360[1], 96361[1], 96365[1], 96366[1], 96367[1], 96368[1], 96372[1], 96374[1], 96375[1], 96376[1], 96377[1], 96523[0], 99155[0], 99156[0], 99157[0], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99221[1], 99222[1], 99223[1], 99231[1], 99232[1], 99233[1], 99234[1], 99235[1], 99236[1], 99238[1], 99239[1], 99242[1], 99243[1], 99244[1], 99245[1], 99252[1], 99253[1], 99254[1], 99255[1], 99291[1], 99292[1], 99304[1], 99305[1], 99306[1], 99307[1], 99308[1], 99309[1], 99310[1], 99315[1], 99316[1], 99347[1], 99348[1], 99349[1], 99350[1], 99374[1], 99375[1], 99377[1], 99378[1], 99446[0], 99447[0], 99448[0], 99449[0], 99451[0], 99452[0], 99495[1], 99496[1], G0463[1], G0471[1], J0670[1]

ICD-10-CM Cross References

I78.8, I78.9, J95.61, J95.62, J95.71, J95.72, J95.830, J95.831, P54.8, R04.0

30903

Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method

Clinical Responsibility

When the patient is appropriately prepped and anesthetized as needed, the provider places the patient in the proper position and uses a nasal speculum to locate the site of bleeding. She cleans and dries the site with a cotton tip applicator. She then uses extensive methods like packing with petroleum jelly or using nasal cautery to control bleeding. The provider sometimes may apply epinephrine and lidocaine HCl injections into the nasal cavity to control complex bleeds.

Coding Tips

This code represents a unilateral service, meaning performed on one side. Depending on payer preference, you may need to report the code once with modifier 50, twice with modifier 50 appended to the second code, or with RT/LT if the provider performs the procedure bilaterally. Check with the payer to determine their preference and avoid delays or rebilling.

Report 30901 for control of bleeding through simple methods and 30903 for bleeding control through complex methods.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $75.04, Non Facility Fee: $233.54
RVU (Facility): Work RVU 1.54, Practice Exp. RVU 0.51, Malpractice RVU 0.27, Total RVU 2.32
RVU (Non-Facility): Work RVU 1.54, Practice Exp. RVU 5.41, Malpractice RVU 0.27, Total RVU 7.22
MPFS Payment Policy Indicators: Global Period 000, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

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Radiology

71045

Radiologic examination, chest; single view

Clinical Responsibility

The provider positions the patient so that the X-ray beam focuses on the chest. The patient remains still so that the image is not blurred. During the examination, an X-ray machine sends a beam of radiation through the chest area, and a computer or a special film records the image. Dense body parts such as bones appear white on the X-ray image as they absorb much of the radiation. Softer body tissues, such as muscles and fat, allow the X-ray beams to pass through them and appear darker.

The different views of chest are anteroposterior, or front to back view; posteroanterior, or back to front view; a lateral, or side-to-side view; or right and left oblique views, which are views done at approximately a 45-degree angle. The provider may also perform other views of the chest, such as decubitus, or lying on the side that helps detect fluid, lordotic that helps to visualize the apex of the lung, and expiratory, after blowing the breath out.

Coding Tips

If you are reporting only the physician's interpretation for the radiology service, you should append professional component modifier 26 to the radiology code.

If you are reporting only the technical component for the radiology service, you would append modifier TC to the radiology code. Note, however, that payer policy may exempt hospitals from appending modifier TC because the hospital's portion is inherently technical.

Do not append a professional or technical modifier to the radiology code when reporting a global service in which one provider renders both the professional and technical components.

If the provider performs radiological examination of 2 views of chest, report code 71046; for 3 views, report 71047; and for 4 or more views, report 71048.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $25.23, Non Facility Fee: $25.23
RVU (Facility): Work RVU 0.18, Practice Exp. RVU 0.58, Malpractice RVU 0.02, Total RVU 0.78
RVU (Non-Facility): Work RVU 0.18, Practice Exp. RVU 0.58, Malpractice RVU 0.02, Total RVU 0.78
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: 4

Modifier Allowances

26, 52, 53, 59, 76, 77, 79, 80, 81, 82, 99, AI, AQ, AR, AS, CC, CR, ET, EY, FX, FY, GA, GC, GJ, GK, GR, GU, GY, GZ, KX, PD, Q5, Q6, QJ, SC, TC, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0175T[1], 36591[0], 36592[0], 96523[0]

ICD-10-CM Cross References

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

71046

Radiologic examination, chest; 2 views

Clinical Responsibility

The provider positions the patient so that the X-ray beam focuses on the chest. The patient remains still so that the image is not blurred. During the examination, an X-ray machine sends a beam of radiation through the chest area, and a computer or a special film records the image. Dense body parts such as bones appear white on the X-ray image as they absorb much of the radiation. Softer body tissues, such as muscles and fat, allow the X-ray beams to pass through them and appear darker.

The different views of chest are anteroposterior, or front to back view; posteroanterior, or back to front view; a lateral, or side-to-side view; or right and left oblique views, which are views done at approximately a 45-degree angle. The provider may also perform other views of the chest, such as decubitus, or lying on the side that helps detect fluid, lordotic that helps to visualize the apex of the lung, and expiratory, after blowing the breath out.

Coding Tips

If you are reporting only the physician's interpretation for the radiology service, you should append professional component modifier 26 to the radiology code.

If you are reporting only the technical component for the radiology service, you would append modifier TC to the radiology code. Note, however, that payer policy may exempt hospitals from appending modifier TC because the hospital's portion is inherently technical.

Do not append a professional or technical modifier to the radiology code when reporting a global service in which one provider renders both the professional and technical components.

If the provider performs radiological examination of a single view chest, report code 71045; for 3 views, report 71047; and for 4 or more views, report 71048.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $32.67, Non Facility Fee: $32.67
RVU (Facility): Work RVU 0.22, Practice Exp. RVU 0.77, Malpractice RVU 0.02, Total RVU 1.01
RVU (Non-Facility): Work RVU 0.22, Practice Exp. RVU 0.77, Malpractice RVU 0.02, Total RVU 1.01

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MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 1, Endoscopic Base Code: None
Practitioner MUE: 2

Modifier Allowances

26, 52, 53, 59, 76, 77, 79, 80, 81, 82, 99, AI, AQ, AR, AS, CC, CR, ET, EY, FX, FY, GA, GC, GJ, GK, GR, GU, GY, GZ, KX, PD, Q5, Q6, QJ, SC, TC, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0175T[1], 36591[0], 36592[0], 71045[1], 96523[0]

ICD-10-CM Cross References

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

71047

Radiologic examination, chest; 3 views

Clinical Responsibility

The provider positions the patient so that the X-ray beam focuses on the chest. The patient remains still so that the image is not blurred. During the examination, an X-ray machine sends a beam of radiation through the chest area, and a computer or a special film records the image. Dense body parts such as bones appear white on the X-ray image as they absorb much of the radiation. Softer body tissues, such as muscles and fat, allow the X-ray beams to pass through them and appear darker.

The different views of chest are anteroposterior, or front to back view; posteroanterior, or back to front view; a lateral, or side-to-side view; or right and left oblique views, which are views done at approximately a 45-degree angle. The provider may also perform other views of the chest, such as decubitus, or lying on the side that helps detect fluid, lordotic that helps to visualize the apex of the lung, and expiratory, after blowing the breath out.

Coding Tips

If you are reporting only the physician's interpretation for the radiology service, you should append professional component modifier 26 to the radiology code.

If you are reporting only the technical component for the radiology service, you would append modifier TC to the radiology code. Note, however, that payer policy may exempt hospitals from appending modifier TC because the hospital's portion is inherently technical.

Do not append a professional or technical modifier to the radiology code when reporting a global service in which one provider renders both the professional and technical components.

If the provider performs radiological examination of a single view chest, report code 71045; for 2 views, report 71046; and for 4 or more views, report 71048.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $40.76, Non Facility Fee: $40.76
RVU (Facility): Work RVU 0.27, Practice Exp. RVU 0.97, Malpractice RVU 0.02, Total RVU 1.26
RVU (Non-Facility): Work RVU 0.27, Practice Exp. RVU 0.97, Malpractice RVU 0.02, Total RVU 1.26
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, 52, 53, 59, 76, 77, 79, 80, 81, 82, 99, AI, AQ, AR, AS, CC, CR, ET, EY, FX, FY, GA, GC, GJ, GK, GR, GU, GY, GZ, KX, PD, Q5, Q6, QJ, SC, TC, XE, XP, XS, XU

NCCI Alerts (version 31.0)

0175T[1], 36591[0], 36592[0], 71045[1], 71046[1], 71101[1], 96523[0]

ICD-10-CM Cross References

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

71048

Radiologic examination, chest; 4 or more views

Clinical Responsibility

The provider positions the patient so that the X-ray beam focuses on the chest. The patient remains still so that the image is not blurred. During the examination, an X-ray machine sends a beam of radiation through the chest area, and a computer or a special film records the image. Dense body parts such as bones appear white on the X-ray image as they absorb much of the radiation. Softer body tissues, such as muscles and fat, allow the X-ray beams to pass through them and appear darker.

The different views of chest are anteroposterior, or front to back view; posteroanterior, or back to front view; a lateral, or side-to-side view; or right and left oblique views, which are views done at approximately a 45-degree angle. The provider may also perform other views of the chest, such as decubitus, or lying on the side that helps detect fluid, lordotic that helps to visualize the apex of the lung, and expiratory, after blowing the breath out.

Coding Tips

If you are reporting only the physician's interpretation for the radiology service, you should append professional component modifier 26 to the radiology code.

If you are reporting only the technical component for the radiology service, you would append modifier TC to the radiology code. Note, however, that payer policy may exempt hospitals from appending modifier TC because the hospital's portion is inherently technical.

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Medicine

90378

Respiratory syncytial virus, monoclonal antibody, recombinant, for intramuscular use, 50 mg, each

Clinical Responsibility

In this procedure, the provider administers a respiratory syncytial virus immune globulin (RSV-Ig). The provider slowly administers 50 mg injections into the patient's muscle using an appropriately sized needle to provide a desired pharmacological action. The injection is done once a month to produce a short-term immunity during the peak infective period of the virus, as the antibodies from the injection of this complex protein circulate through the body and help the body protect itself from the respiratory syncytial virus.

Coding Tips

Report this code for each 50-mg injection that the provider performs.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $0.00, Non Facility Fee: $0.00
RVU (Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00
RVU (Non-Facility): Work RVU 0.00, Practice Exp. RVU 0.00, Malpractice RVU 0.00, Total RVU 0.00
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: X, PC/TC Indicator: 9, Endoscopic Base Code: None
Practitioner MUE: 4

Modifier Allowances

52, 53, 79, 99, AR, GA, GC, GR, GY, GZ, KX, Q6, QJ

NCCI Alerts (version 31.0)

36000[1], 36410[1], 36591[0], 36592[0], 96523[0]

ICD-10-CM Cross References

B97.4, J20.5, R06.03, Z20.6, Z20.820, Z20.828, Z23, Z29.11, Z86.005

90460

Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first or only component of each vaccine or toxoid administered

Clinical Responsibility

The provider administers a single live attenuated vaccine through a parenteral, oral, intranasal, intramuscular, or intravenous to a patient up to 18 years of age. When the patient is prepped, the provider administers a single vaccine or mix of vaccines or toxoids. He counsels the patient, providing instructions and precautions before immunization.

Coding Tips

If the provider administers more than one vaccine, use +90461, Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered, for each additional vaccine or toxoid component.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $22.32, Non Facility Fee: $22.32
RVU (Facility): Work RVU 0.24, Practice Exp. RVU 0.43, Malpractice RVU 0.02, Total RVU 0.69
RVU (Non-Facility): Work RVU 0.24, Practice Exp. RVU 0.43, Malpractice RVU 0.02, Total RVU 0.69
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: 9

Modifier Allowances

33, 52, 79, 80, 81, 82, AS, GA, KX, PD, Q6

NCCI Alerts (version 31.0)

0591T[1], 0592T[1], 0593T[1], 0708T[1], 0709T[1], 36591[0], 36592[0], 90471[0], 90473[0], 96160[1], 96161[1], 96372[1], 96377[1], 96523[0], 99202[1], 99203[1], 99204[1], 99205[1], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99242[1], 99243[1], 99244[1], 99245[1], 99281[1], 99282[1], 99283[1], 99284[1], 99285[1], 99381[1], 99382[1], 99383[1], 99384[1], 99385[1], 99386[1], 99387[1], 99391[1], 99392[1], 99393[1], 99394[1], 99395[1], 99396[1], 99397[1], 99401[1], 99402[1], 99403[1], 99404[1], 99406[1], 99407[1], 99408[1], 99409[1], 99411[1], 99412[1], 99483[1], 99497[1], G0008[1], G0009[1], G0010[1], G0442[1], G0443[1], G0444[1], G0445[1], G0463[1]

ICD-10-CM Cross References

A15.0-A15.9, A17.0, A17.1, A17.81-A17.89, A17.9, A36.0-A36.3, A36.81-A36.89, A36.9, A37.00, A37.01, A37.10, A37.11, A37.80, A37.81, A37.90, A37.91, A49.2, A80.0-A80.2, A80.30, A80.39, A80.4, A80.9, A81.00-A81.09, A81.1, A81.2, A81.81-A81.89, A81.9, B01.0-B01.2, B01.11, B01.12, B01.81, B01.89, B01.9, B05.0-B05.4, B05.81, B05.89, B05.9, B06.00-B06.09, B06.81-B06.89, B06.9, B16.0-B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, B96.3, G00.1, G14, J09.X1-J09.X9, J10.00-J10.08, J10.1, J10.2, J10.81-J10.89, J11.00, J11.08, J11.1, J11.2, J11.81-J11.89, J12.2, J14, J20.1, J20.4, M00.10-M00.19, M00.111-M00.119, M00.121-M00.129, M00.131-M00.139, M00.141-M00.149, M00.151-M00.159, M00.161-M00.169, M00.171-M00.179, T50.A16A-T50.A16S, T50.B16A-T50.B16S, T50.B96A-T50.B96S, T50.Z96A-T50.Z96S, Z20.821, Z23, Z28.83, Z29.89, Z71.84, Z71.85

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+90461

Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; each additional vaccine or toxoid component administered (List separately in addition to code for primary procedure)

Clinical Responsibility

The provider administers an additional live attenuated vaccine either via a parenteral, oral, intranasal, intramuscular, or intravenous to a patient up to 18 years of age after the administration of the first vaccine. After injection of a single or initial vaccine, the provider during the same session, preps the patient for an additional live attenuated vaccine. The provider administers a mix of vaccines or toxoids during immunization. She counsels the patient, providing instructions and precautions before immunization.

Coding Tips

Because +90461 is an add-on code, payers will not reimburse you if you report it without the appropriate primary vaccine administration code 90460.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $8.41, Non Facility Fee: $8.41
RVU (Facility): Work RVU 0.18, Practice Exp. RVU 0.07, Malpractice RVU 0.01, Total RVU 0.26
RVU (Non-Facility): Work RVU 0.18, Practice Exp. RVU 0.07, Malpractice RVU 0.01, Total RVU 0.26
MPFS Payment Policy Indicators: Global Period ZZZ, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 8

Modifier Allowances

33, 52, 79, 80, 81, 82, AS, GA, KX, PD, Q6, Q7

NCCI Alerts (version 31.0)

0591T[1], 0592T[1], 0593T[1], 36591[0], 36592[0], 96160[1], 96161[1], 96523[0], 99202[1], 99203[1], 99204[1], 99205[1], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99242[1], 99243[1], 99244[1], 99245[1], 99281[1], 99282[1], 99283[1], 99284[1], 99285[1], 99381[1], 99382[1], 99383[1], 99384[1], 99385[1], 99386[1], 99387[1], 99391[1], 99392[1], 99393[1], 99394[1], 99395[1], 99396[1], 99397[1], 99401[1], 99402[1], 99403[1], 99404[1], 99406[1], 99407[1], 99408[1], 99409[1], 99411[1], 99412[1], 99483[1], 99497[1], G0442[1], G0443[1], G0444[1], G0445[1], G0463[1]

ICD-10-CM Cross References

A15.0-A15.9, A17.0, A17.1, A17.81-A17.89, A17.9, A36.0-A36.3, A36.81-A36.89, A36.9, A37.00, A37.01, A37.10, A37.11, A37.80, A37.81, A37.90, A37.91, A49.2, A80.0-A80.2, A80.30, A80.39, A80.4, A80.9, A81.00-A81.09, A81.1, A81.2, A81.81-A81.89, A81.9, B01.0-B01.2, B01.11, B01.12, B01.81, B01.89, B01.9, B05.0-B05.4, B05.81, B05.89, B05.9, B06.00-B06.09, B06.81-B06.89, B06.9, B16.0-B16.9, B17.0, B18.0, B18.1, B19.10, B19.11, B96.3, G00.1, G14, J09.X1-J09.X9, J10.00-J10.08, J10.1, J10.2, J10.81-J10.89, J11.00, J11.08, J11.1, J11.2, J11.81-J11.89, J12.2, J14, J20.1, J20.4, M00.10-M00.19, M00.111-M00.119, M00.121-M00.129, M00.131-M00.139, M00.141-M00.149, M00.151-M00.159, M00.161-M00.169, M00.171-M00.179, T50.A16A-T50.A16S, T50.B16A-T50.B16S, T50.B96A-T50.B96S, T50.Z96A-T50.Z96S, Z20.821, Z23, Z28.83, Z29.89, Z71.84, Z71.85

90471

Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)

Clinical Responsibility

When the patient is prepped, the provider administers a single vaccine or mix of vaccines or toxoids during a single immunization via percutaneous, intradermal, subcutaneous, or intramuscular route.

Coding Tips

If the provider administers more than one vaccine, use +90472, Immunization administration, includes percutaneous, intradermal, subcutaneous, or intramuscular injections; each additional vaccine, for each additional vaccine or toxoid component.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $20.05, Non Facility Fee: $20.05
RVU (Facility): Work RVU 0.17, Practice Exp. RVU 0.44, Malpractice RVU 0.01, Total RVU 0.62
RVU (Non-Facility): Work RVU 0.17, Practice Exp. RVU 0.44, Malpractice RVU 0.01, Total RVU 0.62
MPFS Payment Policy Indicators: Global Period XXX, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 5, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

33, 52, 53, 79, 80, 81, 82, 99, AR, AS, GA, GC, GR, KX, PD, Q6, QJ, SY

NCCI Alerts (version 31.0)

0591T[1], 0592T[1], 0593T[1], 36591[0], 36592[0], 90473[0], 96160[1], 96161[1], 96523[0], 99202[1], 99203[1], 99204[1], 99205[1], 99211[1], 99212[1], 99213[1], 99214[1], 99215[1], 99242[1], 99243[1], 99244[1], 99245[1], 99281[1], 99282[1], 99283[1], 99284[1], 99285[1], 99381[1], 99382[1], 99383[1], 99384[1], 99385[1], 99386[1], 99387[1], 99391[1], 99392[1], 99393[1], 99394[1], 99395[1], 99396[1], 99397[1], 99401[1], 99402[1], 99403[1], 99404[1], 99406[1], 99407[1], 99408[1], 99409[1], 99411[1], 99412[1], 99483[1], 99497[1], G0008[1], G0009[1], G0010[1], G0442[1], G0443[1], G0444[1], G0445[1], G0463[1]

ICD-10-CM Cross References

P35.4, T50.A16A-T50.A16S, T50.B16A-T50.B16S, T50.B96A-T50.B96S, T50.Z96A-T50.Z96S, Z20.821, Z23, Z28.83, Z29.89, Z71.84

+90472

Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

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Proprietary Laboratory Analyses

0223U

Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), qualitative RT-PCR, nasopharyngeal swab, each pathogen reported as detected or not detected

Clinical Responsibility

QIAstat-Dx® Respiratory SARS CoV-2 Panel is an automated laboratory panel that generates a result of "detected" or "not detected" for 22 respiratory pathogens in a single report, including SARS-CoV-2. The lab analyst receives the nasopharyngeal swab specimen in transport media, and processes the sample using a QIAstat-Dx® Respiratory SARS CoV-2 Panel, which is an automated multiplex PCR analyzer that incorporates sample preparation, nucleic acid amplification, target detection, analysis, and reporting in a single platform.

Clinicians order this test for patients with respiratory infection symptoms to detect and differentiate nucleic acid of SARS-CoV-2, the organism that causes COVID-19, from multiple other common respiratory viral and bacterial pathogens.

QIAstat-Dx® Respiratory SARS CoV-2 Panel test is authorized by the FDA under the Emergency Use Authorization (EUA) for use by authorized laboratories for the duration of the COVID-19 emergency declaration.

Coding Tips

Use this code only for the appropriate proprietary test; report one unit of this code for a single specimen analyzed on a single date of service.

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

Fee Schedule Information

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

Modifier Allowances

33, 90, 91, 92, CR, CS, ET, GY, GZ, Q0, Q1, QJ, SC

NCCI Alerts (version 31.0)

80503[1], 80504[1], 80505[1], 80506[1], 96523[0]

ICD-10-CM Cross References

B34.2, B97.21, B97.29, J00, J12.81, J15.61, J15.69, J44.81, J44.89, J4A.0-J4A.9, R50.2, R50.81, R50.9, U07.1

0224U

Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), includes titer(s), when performed

Clinical Responsibility

The lab analyst performs all the technical steps necessary to test the patient's plasma or serum for SARS-CoV-2 antibodies using two serial direct enzyme-linked immunosorbent assays (ELISA). Testing may include one or more titers to determine the concentration of antibodies in the blood, but titers are not required.

SARS-CoV-2 antibody tests identify individuals with an adaptive immune response to SARS-CoV-2, indicating recent or prior infection, by detecting antibodies to SARS-CoV-2 in human blood specimens.

Clinicians may order this test to determine if the patient had COVID-19. In addition, these test results may aid in identifying individuals who can donate convalescent plasma, which may serve as a possible treatment for those who are seriously ill from COVID-19. Healthcare workers and first-responders also may have this test.

Mount Sinai's COVID-19 Antibody Test is authorized by the FDA under the Emergency Use Authorization (EUA) for use by authorized laboratories for the duration of the COVID-19 emergency declaration.

Coding Tips

Use this code only for the appropriate proprietary test; report one unit of this code for a single specimen analyzed on a single date of service.

Do not report 0224U in conjunction with 86769.

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

Fee Schedule Information

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

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HCPCS Level II Codes

Medical and Surgical Supplies

A4614

Peak expiratory flow rate meter, hand held

Clinical Responsibility

Peak expiratory flow is a measurement in liters per minute of how fast air comes out from the lungs of a patient when he exhales forcibly.

The provider measures the peak flow rate in a patient with a condition such as asthma or other respiratory disease, using a peak flow rate meter. The patient forcibly exhales into the mouthpiece of the device and the provider obtains the peak expiratory flow reading. The peak flow rate meter can be of various design, use this code for a hand held peak expiratory flow rate meter.

Coding Tips

The Healthcare Common Procedure Coding System, or HCPCS, codes that begin with an A represents medical and surgical supplies and transportation services such as ambulance.

BETOS

Z2: Undefined codes

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Procedures/Professional Services

G0031

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

Clinical Responsibility

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

This is a tracking code for performance measurement.

BETOS

Z2: Undefined codes

G0034

Patients receiving palliative care during the measurement period

Clinical Responsibility

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

This is a tracking code for performance measurement.

BETOS

Z2: Undefined codes

G0048

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

Clinical Responsibility

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

This is a tracking code for performance measurement.

BETOS

Z2: Undefined codes

G0237

Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)

Clinical Responsibility

The provider, usually a respiratory therapist, offers services to the patient with chronic lung disease or a pulmonary disorder to improve their quality of life. The service includes training for pursed lip breathing, diaphragmatic breathing, and strengthening of the diaphragm through breathing tubes to enhance the strength and stamina of the respiratory muscles. The code also involves monitoring of the muscles through electrocardiogram and pulse oximetry.

Coding Tips

Use G codes to represent temporary procedures and professional services. Medicare covers G codes for the services that replace CPT® codes.

To report other therapeutic procedures to improve respiratory function, report G0238, Therapeutic procedures to improve respiratory function.

To report the use of therapeutic procedures in two or more individuals, report G0239, Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals, includes monitoring.

BETOS

P6C: Minor procedures - other (Medicare fee schedule)

G0238

Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)

Clinical Responsibility

The provider, usually a respiratory therapist, offers services to the patient with chronic lung disease or a pulmonary disorder to improve their quality of life. The service includes training the patient to perform a task with less respiratory effort. It also includes graded activity training to increase strength and stamina of both upper and lower extremities. The code also involves monitoring of the respiratory function through peak respiratory flow rate, pulse oximetry, or electrocardiogram.

Coding Tips

Use G codes to represent temporary procedures and professional services. Medicare covers G codes for the services that replace CPT® codes.

For therapeutic procedures to improve respiratory strength or endurance, report G0237, Therapeutic procedures to increase

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strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes, includes monitoring.

To report the use of therapeutic procedures in two or more individuals, report G0239, Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals, includes monitoring.

BETOS

P6C: Minor procedures - other (Medicare fee schedule)

G0239

Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)

Clinical Responsibility

The provider, usually a respiratory therapist, offers services to patients with chronic lung disease or pulmonary disorders to improve their quality of life. The service includes training for pursed lip breathing and diaphragmatic breathing, or strengthening of the diaphragm with breathing tubes. Other activities include training to perform a task with less breathing effort and a graded activity program to increase strength and stamina in both upper and lower extremities. The code also involves monitoring of the respiratory function through peak respiratory flow rate, pulse oximetry, or electrocardiogram. Report this code if the provider offers the service to two or more patients in a group.

Coding Tips

Use G codes to represent temporary procedures and professional services. Medicare covers G codes for the services that replace CPT® codes.

To report this same procedure for only one patient, use G0237, Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes, includes monitoring.

To report other therapeutic procedures for improvement of respiratory function in one patient, report G0238, Therapeutic procedures to improve respiratory function.

BETOS

P6C: Minor procedures - other (Medicare fee schedule)

G0296

Counseling visit to discuss need for lung cancer screening (ldct) using low dose ct scan (service is for eligibility determination and shared decision making)

Clinical Responsibility

Low-dose CT scanning (LDCT) can detect early-stage lung cancers in heavy smokers. Before the first lung cancer LDCT screening occurs, the provider meets with the patient to discuss this preventive service. Shared decision making may include the use of one more decision aids along with the discussion of both the benefit and harm of screening, the need for follow-up diagnostic testing, the possibility of over-diagnosis, the false positive rate, and total radiation exposure and its risks. The provider counsels the patient on the importance of adherence to annual lung cancer LDCT screening, the impact of co-morbidities (other medical conditions the patient has), and the patient's ability or willingness to undergo diagnosis and treatment. In addition, the provider counsels the patient on the importance of maintaining cigarette smoking abstinence (if a former smoker) and the importance of smoking cessation and tobacco cessation intervention information (if a current smoker).

To be eligible for this service, the patient must be 55 to 77 years of age, have no signs or symptoms of lung cancer, have a tobacco smoking history of at least 30 pack-years, be a current smoker of have quit smoking within the last 15 years, and receive a written order for lung cancer screening with LDCT that meets the requirements described in the Medicare National Coverage Determination (NCD).

Coding Tips

Use G codes for professional healthcare procedures and services that would otherwise be coded in CPT® but for which there are no CPT® codes or for which Medicare requires a G code instead of a similar CPT® code.

Medicare covers lung cancer screening with low-dose computed tomography (LDCT) if all eligibility requirements listed in the NCD are met.

Medicare will deny claims for this preventive service that do not contain a diagnosis code for a personal history of tobacco use or nicotine dependence.

Code G0296 is for counseling prior to LDCT screening. Report 71271 for the LDCT screening.

BETOS

M6: Consultations

G0302

Pre-operative pulmonary surgery services for preparation for LVRS, complete course of services, to include a minimum of 16 days of services

Clinical Responsibility

The provider administers a complete course of diagnostic and therapeutic services to a patient with emphysema. Use this code to report the services that prepare a patient for LVRS, a procedure which allows the patient's remaining collapsed lung to expand and improve respiratory function. The service includes 16 to 19 preoperative sessions, which cover a comprehensive evaluation of medical, psychological, and nutritional needs, counseling, educational programs regarding emphysema and its treatment care plans, and the importance of consistency with preoperative and postoperative services. These services increase the patient's probability of successfully undergoing and recovering from the surgery.

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ICD-10-CM Cross Reference Details

A01.01 Typhoid meningitis
A01.09 Typhoid fever with other complications
A02.21 Salmonella meningitis
A06.5 Amebic lung abscess
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
A18.84 Tuberculosis of heart
A20.2 Pneumonic plague
A20.3 Plague meningitis
A20.7 Septicemic plague
A21.2 Pulmonary tularemia
A22.1 Pulmonary anthrax
A27.81 Aseptic meningitis in leptospirosis
A31.0 Pulmonary mycobacterial infection
A32.11 Listerial meningitis
A32.12 Listerial meningoencephalitis
A32.7 Listerial sepsis
A33 Tetanus neonatorum
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
A39.50 Meningococcal carditis, unspecified
A39.51 Meningococcal endocarditis
A39.52 Meningococcal myocarditis
A40.0 Sepsis due to streptococcus, group A
A40.3 Sepsis due to Streptococcus pneumoniae
A40.8 Other streptococcal sepsis
A40.9 Streptococcal sepsis, unspecified
A41.3 Sepsis due to Hemophilus influenzae
A41.51 Sepsis due to Escherichia coli [E. coli]
A41.54 Sepsis due to Acinetobacter baumannii
A42.0 Pulmonary actinomycosis
A42.81 Actinomycotic meningitis
A42.82 Actinomycotic encephalitis
A42.89 Other forms of actinomycosis
A43.0 Pulmonary nocardiosis
A43.8 Other forms of nocardiosis
A48.1 Legionnaires' disease
A49.2 Hemophilus influenzae infection, unspecified site
A50.41 Late congenital syphilitic meningitis
A51.41 Secondary syphilitic meningitis
A52.01 Syphilitic aneurysm of aorta
A52.02 Syphilitic aortitis
A52.03 Syphilitic endocarditis
A52.06 Other syphilitic heart involvement
A52.13 Late syphilitic meningitis
A52.72 Syphilis of lung and bronchus
A52.73 Symptomatic late syphilis of other respiratory organs
A54.81 Gonococcal meningitis
A54.83 Gonococcal heart infection
A69.21 Meningitis due to Lyme disease
A75.3 Typhus fever due to Rickettsia tsutsugamushi
A78 Q fever
A79.82 Anaplasmosis [A. phagocytophilum]
A80.0 Acute paralytic poliomyelitis, vaccine-associated
A80.1 Acute paralytic poliomyelitis, wild virus, imported
A80.2 Acute paralytic poliomyelitis, wild virus, indigenous
A80.30 Acute paralytic poliomyelitis, unspecified
A80.39 Other acute paralytic poliomyelitis
A80.4 Acute nonparalytic poliomyelitis
A80.9 Acute poliomyelitis, unspecified
A81.00 Creutzfeldt-Jakob disease, unspecified
A81.01 Variant Creutzfeldt-Jakob disease
A81.09 Other Creutzfeldt-Jakob disease
A81.1 Subacute sclerosing panencephalitis
A81.2 Progressive multifocal leukoencephalopathy
A81.81 Kuru
A81.82 Gerstmann-Straussler-Scheinker syndrome
A81.83 Fatal familial insomnia
A81.89 Other atypical virus infections of central nervous system
A81.9 Atypical virus infection of central nervous system, unspecified
A87.0 Enteroviral meningitis
A87.1 Adenoviral meningitis
A87.2 Lymphocytic choriomeningitis
A87.8 Other viral meningitis
A87.9 Viral meningitis, unspecified
A92.39 West Nile virus infection with other complications
B00.3 Herpesviral meningitis
B00.82 Herpes simplex myelitis
B01.0 Varicella meningitis
B01.11 Varicella encephalitis and encephalomyelitis
B01.12 Varicella myelitis
B01.2 Varicella pneumonia
B01.81 Varicella keratitis
B01.89 Other varicella complications
B01.9 Varicella without complication
B02.1 Zoster meningitis
B02.8 Zoster with other complications
B02.9 Zoster without complications
B05.0 Measles complicated by encephalitis
B05.1 Measles complicated by meningitis
B05.2 Measles complicated by pneumonia
B05.3 Measles complicated by otitis media
B05.4 Measles with intestinal complications
B05.81 Measles keratitis and keratoconjunctivitis
B05.89 Other measles complications
B05.9 Measles without complication

B06.00 Rubella with neurological complication, unspecified
B06.01 Rubella encephalitis
B06.02 Rubella meningitis
B06.09 Other neurological complications of rubella
B06.81 Rubella pneumonia
B06.82 Rubella arthritis
B06.89 Other rubella complications
B06.9 Rubella without complication
B08.21 Exanthema subitum [sixth disease] due to human herpesvirus 6
B08.22 Exanthema subitum [sixth disease] due to human herpesvirus 7
B10.01 Human herpesvirus 6 encephalitis
B10.09 Other human herpesvirus encephalitis
B10.81 Human herpesvirus 6 infection
B10.82 Human herpesvirus 7 infection
B10.89 Other human herpesvirus infection
B16.0 Acute hepatitis B with delta-agent with hepatic coma
B16.1 Acute hepatitis B with delta-agent without hepatic coma
B16.2 Acute hepatitis B without delta-agent with hepatic coma
B16.9 Acute hepatitis B without delta-agent and without hepatic coma
B17.0 Acute delta-(super) infection of hepatitis B carrier
B18.0 Chronic viral hepatitis B with delta-agent
B18.1 Chronic viral hepatitis B without delta-agent
B19.10 Unspecified viral hepatitis B without hepatic coma
B19.11 Unspecified viral hepatitis B with hepatic coma
B20 Human immunodeficiency virus [HIV] disease
B25.0 Cytomegaloviral pneumonitis
B26.1 Mumps meningitis
B26.89 Other mumps complications
B26.9 Mumps without complication
B27.00 Gammaherpesviral mononucleosis without complication
B27.02 Gammaherpesviral mononucleosis with meningitis
B27.09 Gammaherpesviral mononucleosis with other complications
B27.10 Cytomegaloviral mononucleosis without complications
B27.12 Cytomegaloviral mononucleosis with meningitis
B27.19 Cytomegaloviral mononucleosis with other complication
B27.80 Other infectious mononucleosis without complication
B27.82 Other infectious mononucleosis with meningitis
B27.89 Other infectious mononucleosis with other complication
B27.90 Infectious mononucleosis, unspecified without complication
B27.92 Infectious mononucleosis, unspecified with meningitis
B27.99 Infectious mononucleosis, unspecified with other complication
B33.20 Viral carditis, unspecified
B33.21 Viral endocarditis
B33.22 Viral myocarditis
B33.4 Hantavirus (cardio)-pulmonary syndrome [HPS] [HCPS]
B34.2 Coronavirus infection, unspecified
B37.1 Pulmonary candidiasis
B37.5 Candidal meningitis
B37.6 Candidal endocarditis
B38.0 Acute pulmonary coccidioidomycosis
B38.1 Chronic pulmonary coccidioidomycosis
B38.2 Pulmonary coccidioidomycosis, unspecified
B38.3 Cutaneous coccidioidomycosis
B38.4 Coccidioidomycosis meningitis
B39.0 Acute pulmonary histoplasmosis capsulati
B39.1 Chronic pulmonary histoplasmosis capsulati
B39.2 Pulmonary histoplasmosis capsulati, unspecified
B39.4 Histoplasmosis capsulati, unspecified
B39.5 Histoplasmosis duboisii
B40.0 Acute pulmonary blastomycosis
B40.1 Chronic pulmonary blastomycosis
B40.2 Pulmonary blastomycosis, unspecified
B40.3 Cutaneous blastomycosis
B40.7 Disseminated blastomycosis
B40.81 Blastomycotic meningoencephalitis
B40.89 Other forms of blastomycosis
B40.9 Blastomycosis, unspecified
B41.0 Pulmonary paracoccidioidomycosis
B41.7 Disseminated paracoccidioidomycosis
B41.8 Other forms of paracoccidioidomycosis
B41.9 Paracoccidioidomycosis, unspecified
B42.0 Pulmonary sporotrichosis
B42.1 Lymphocutaneous sporotrichosis
B42.7 Disseminated sporotrichosis
B42.81 Cerebral sporotrichosis
B42.82 Sporotrichosis arthritis
B42.89 Other forms of sporotrichosis
B42.9 Sporotrichosis, unspecified
B43.0 Cutaneous chromomycosis
B43.1 Pheomycotic brain abscess
B43.2 Subcutaneous pheomycotic abscess and cyst
B43.8 Other forms of chromomycosis
B43.9 Chromomycosis, unspecified
B44.0 Invasive pulmonary aspergillosis
B44.1 Other pulmonary aspergillosis
B44.2 Tonsillar aspergillosis
B44.7 Disseminated aspergillosis
B44.81 Allergic bronchopulmonary aspergillosis
B44.89 Other forms of aspergillosis
B44.9 Aspergillosis, unspecified
B45.0 Pulmonary cryptococcosis
B45.1 Cerebral cryptococcosis
B45.2 Cutaneous cryptococcosis
B45.3 Osseous cryptococcosis
B45.7 Disseminated cryptococcosis
B45.8 Other forms of cryptococcosis
B45.9 Cryptococcosis, unspecified
B46.0 Pulmonary mucormycosis
B50.0 Plasmodium falciparum malaria with cerebral complications
B51.8 Plasmodium vivax malaria with other complications
B51.9 Plasmodium vivax malaria without complication
B52.8 Plasmodium malariae malaria with other complications
B52.9 Plasmodium malariae malaria without complication
B57.0 Acute Chagas' disease with heart involvement
B57.2 Chagas' disease (chronic) with heart involvement
B57.41 Meningitis in Chagas' disease
B58.3 Pulmonary toxoplasmosis
B59 Pneumocystosis
B66.4 Paragonimiasis
B67.1 Echinococcus granulosus infection of lung
B77.0 Ascariasis with intestinal complications
B77.81 Ascariasis pneumonia
B77.89 Ascariasis with other complications
B88.9 Infestation, unspecified
B90.9 Sequelae of respiratory and unspecified tuberculosis
B91 Sequelae of poliomyelitis
B95.0 Streptococcus, group A, as the cause of diseases classified elsewhere
B95.3 Streptococcus pneumoniae as the cause of diseases classified elsewhere
B96.0 Mycoplasma pneumoniae [M. pneumoniae] as the cause of diseases classified elsewhere
B96.1 Klebsiella pneumoniae [K. pneumoniae] as the cause of diseases classified elsewhere
B96.20 Unspecified Escherichia coli [E. coli] as the cause of diseases classified elsewhere
B96.21 Shiga toxin-producing Escherichia coli [E. coli] [STEC] O157 as the cause of diseases classified elsewhere
B96.22 Other specified Shiga toxin-producing Escherichia coli [E. coli] [STEC] as the cause of diseases classified elsewhere
B96.23 Unspecified Shiga toxin-producing Escherichia coli [E. coli] [STEC] as the cause of diseases classified elsewhere
B96.29 Other Escherichia coli [E. coli] as the cause of diseases classified elsewhere
B96.3 Hemophilus influenzae [H. influenzae] as the cause of diseases classified elsewhere
B96.81 Helicobacter pylori [H. pylori] as the cause of diseases classified elsewhere
B96.83 Acinetobacter baumannii as the cause of diseases classified elsewhere

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

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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

Modifier	Description
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

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Terminology

Terminology	Explanation
23 valent	A vaccine that contains 23 of the most common types of pneumococcal bacteria to help prevent infection.
Ablation	Surgical destruction of abnormal tissue or organ growth.
Abscess	A localized collection of pus that collects in a cavity, usually in response to infection.
Accessory nasal sinuses	Paranasal sinuses present as a hollow cavity within the skull but open into the nasal cavity; these are lined with a mucosal membrane.
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 care	A level of service where a patient is actively treated for a brief but severe episode of illness, or injury.
Acute respiratory distress	Sudden onset of difficulty breathing or periods of apnea, or failure to breathe.
Adhesions	Band of fibrous tissue that binds two organs or tissues together.
Advance directive	A document which enables a person to make provision for his health care decisions in case if in the future, he becomes unable to make those decisions; include documents such as a living will and a medical power of attorney.
Aerosol generator	A device that produces aerosol suspensions, as for inhalation therapy.
Airway resistance	Resistance, or opposition, to flow caused by friction forces in the airways of the respiratory tract.
Albuterol	An inhaled bronchodilator.
Algorithm	A specific set of step-by-step calculations using defined inputs at each step to produce a useful output.
Allograft	A tissue graft from a donor.
Alveoli	Air sacs that are a continuation of bronchioles and are responsible for exchange of gases.
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.
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 anastomoses include end to side and side to side.
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.
Anterior	Closer to the front part of the body or a structure.
Anterior nasal bone	Two small bones that form a bridge of bones in the front.
Anterolateral	Situated in front and to one side.
Anterolateral thoracotomy	Surgical incision through the anterior, or front, chest wall to the side.
Anteroposterior view	The X-ray projection travels from front to back, abbreviated as AP.
Antibody	A protein produced by the immune system in response to an antigen; lab tests may utilize reactions between antibodies and antigens to identify a substance in a patient specimen.
Anticoagulant	A drug that prevents clot formation within the blood vessels and dissolves any blood clot formed previously.
Antigen	A substance that can stimulate the immune system to produce antibodies; lab tests may utilize reactions between antibodies and antigens to identify a substance in a patient specimen.
Antrochoanal polyp	A solitary polyp that arises in the maxillary sinus and enlarges the sinus ostium, which is the natural opening into the sinus.
Antrostomy	A surgical break into the antrum, that refers to a cavity.
Antrum	A natural cavity that may have a specific meaning in reference to organs or sites.
Aorta	Largest artery originating from heart, which supplies oxygenated blood to the body.
Apical tumor	Cancerous growth at the apex of a pyramid or rounded structure or organ, such as the heart or lung.
Arterial access	Situated or occurring within an artery.
Aryepiglottic fold	The entrance of the larynx, or the voice box, which is narrow in the front and wide behind.
Arytenoid	Cartilage present at the back of the voice box, responsible for production of specific voice sounds.
Arytenoidectomy	Surgical procedure in which the provider excises the arytenoids cartilage; it is generally performed to improve air flow through the airway.
Arytenoidopexy	Fixation or suspension of the arytenoid cartilage.

Terminology	Explanation
Arytenoids	A pair of small cartilage structures present at the back of the vocal cords to which the vocal cords are attached; responsible for the production of sound.
Aspirate	Draw fluid out by suction.
Aspiration	Removal of fluid, gas, or other material through a tube attached to a suction device, often combined with irrigation, the instillation of fluid to clean a wound or to wash out a cavity such as the abdomen or stomach.
Asthma	A disease that causes the airways of the lungs to swell and narrow, leading to wheezing, shortness of breath, chest tightness, and coughing.
Atretic plate	A plate at the end of the nasal septum that is continuous with the choanal opening, an opening between the nasal cavity and the nasopharynx.
Atrial fibrillation	A heart rhythm disorder where the atrial appendage, a small pouch in the heart, does not squeeze rhythmically with the left atrium, causing blood inside the pouch to become stagnant and prone to produce blood clots.
Attenuated vaccine	Vaccine made from live micro organisms that are cultured under advanced conditions retaining their ability of immunity.
Autograft	Placement of a tissue or an organ to a new position in the same individual; also called auto transplant.
Autologous	Surgical placement of any tissue from one part of the body to another location in the same patient, also applies to reinfusion of blood or its components to the same patient from which the blood was removed.
Bacteria	Single celled microorganisms visible only with a microscope, some of which cause infection.
Benign neoplasm	An abnormal mass of cells that lacks the ability to penetrate the neighboring tissues.
Bilateral	On two sides; opposite of unilateral.
Bilateral sequential	Occurring on one side and then subsequently on the other side.
Bilobectomy	Surgical removal of two lobes, as of the lung.
Biopsy	A procedure in which the provider excises a sample of the patient's diseased tissues; the sample is sent to a laboratory for detection of any disease condition.
Bipolar cautery	The provider passes high frequency electrical current from active to passive electrodes in tissues to control bleeding.
Bronchi	Main passageway of air into lungs.
Bronchial stent	Tube-shaped structure placed in the main airways to the lungs to treat a variety of airway diseases.
Bronchial thermoplasty	A technique to ablate airway muscles using radiofrequency to reduce the amount of smooth muscles in the airway; may help reduce a patient's asthma attacks.
Bronchial valve	A synthetic device placed inside the lungs to control airflow; used to treat air leakages due to lung disease such as emphysema, atelectasis, etc.
Bronchioles	Smaller subdivisions of bronchi that supply air to and from the lungs.
Bronchitis	Inflammation of the main passages of the lungs.
Broncho-cutaneous	The joining of the bronchus, pleural space, and subcutaneous tissue.
Bronchodilator	A drug that relaxes and widens the air passages of the lungs to increase airflow to the lungs.
Broncho-pleural	The joining of a bronchial tube and the pleura.
Bronchopleural fistula (BPF)	A condition involving an abnormal passageway between a bronchus and the pleural cavity (space between the membranes surrounding the lungs); major causes of this condition are surgery on the lung and bronchus, chemotherapy or radiotherapy for cancers, and tuberculosis.
Bronchoscopy	A technique to visualize the inside of the airways, using a viewing instrument called a bronchoscope, for diagnostic and therapeutic purposes.
Bronchus	An anatomic pathway that conveys air to and from the lungs.
Brush Biopsy	A provider uses a small brush to remove cells from airways; a trained provider looks at these cells under a microscope for any disease.
Bullae	A bubble-like pocket of fluid or air.
Bullous emphysema	Pathological accumulation of air or fluid in lung's air sacs.
Burr	A surgical instrument used to drill through the bone.
Caldwell-Luc incision	Incision in the front wall of the maxillary sinus through the upper gums.
Canine fossa	A large and deep depression on the external surface of the maxilla, which is the upper jaw.
Cannula	A thin tube set in the body, typically either to insert an implant or to drain fluid.

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