AAPC

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

CODERS' SPECIALTY GUIDE

Obstetrics & Gynecology

2026

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General Surgical Procedures

+10004

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

Clinical Responsibility

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

Coding Tips

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

Fee Schedule Information

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

Modifier Allowances

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

NCCI Alerts (version 31.0)

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

ICD-10-CM Cross References

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

10005

Fine needle aspiration biopsy, including ultrasound guidance; first lesion

Clinical Responsibility

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

Coding Tips

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

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

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

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

Fee Schedule Information

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

Modifier Allowances

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

NCCI Alerts (version 31.0)

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

ICD-10-CM Cross References

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

+10006

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

Clinical Responsibility

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

Coding Tips

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

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

Fee Schedule Information

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

Modifier Allowances

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

NCCI Alerts (version 31.0)

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

ICD-10-CM Cross References

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

10007

Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion

Clinical Responsibility

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

Coding Tips

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

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

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: $86.04, Non Facility Fee: $294.03
RVU (Facility): Work RVU 1.81, Practice Exp. RVU 0.62, Malpractice RVU 0.23, Total RVU 2.66
RVU (Non-Facility): Work RVU 1.81, Practice Exp. RVU 7.05, Malpractice RVU 0.23, Total RVU 9.09
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, 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], 10005[1], 10006[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.

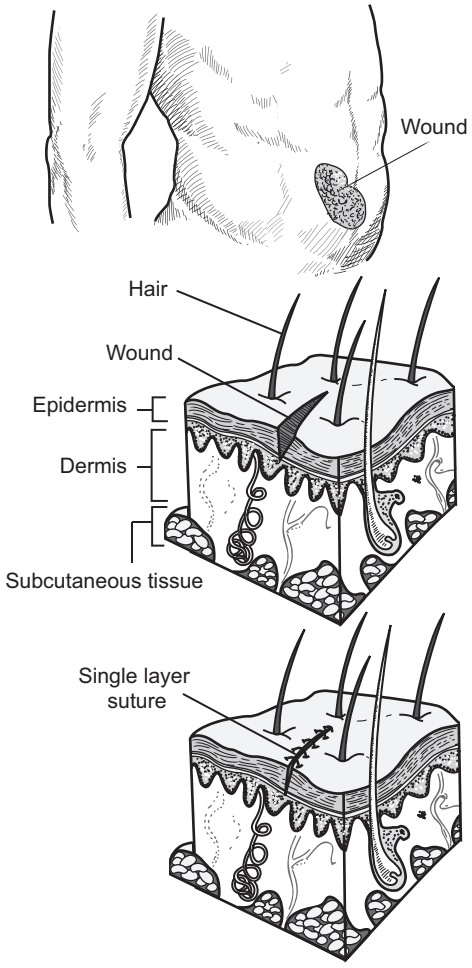
12020

Treatment of superficial wound dehiscence; simple closure

Clinical Responsibility

After proper sterilization and cleansing, the physician reopens the wound dehiscence margin (wound which is not healing properly). After removal of sutures, the physician debrides the wound and irrigates the area with an antimicrobial agent. The wound edges are sutured again in a simple linear fashion.

Illustration



12020

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $185.02, Non Facility Fee: $290.47
RVU (Facility): Work RVU 2.67, Practice Exp. RVU 2.62, Malpractice RVU 0.43, Total RVU 5.72
RVU (Non-Facility): Work RVU 2.67, Practice Exp. RVU 5.88, Malpractice RVU 0.43, Total RVU 8.98
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: 2

Modifier Allowances

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

NCCI Alerts (version 31.0)

0213T^{0}, 0216T^{0}, 0543T^{1}, 0544T^{1}, 0545T^{1}, 0569T^{1}, 0570T^{1}, 0571T^{1}, 0572T^{1}, 0573T^{1}, 0574T^{1}, 0580T^{1}, 0581T^{1}, 0582T^{1}, 0655T^{1}, 11000^{1}, 11001^{1}, 11004^{1}, 11005^{1}, 11006^{1}, 11042^{1}, 11043^{1}, 11044^{1}, 11045^{1}, 11046^{1}, 11047^{1}, 11900^{1}, 11901^{1}, 12021^{1}, 15772^{1}, 15774^{1}, 20560^{1}, 20561^{1}, 20700^{1}, 20701^{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}, 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^{1}, 64479^{0}, 64480^{0}, 64483^{0}, 64484^{0}, 64490^{0}, 64491^{0}, 64492^{0}, 64493^{0}, 64494^{0}, 64495^{0}, 64505^{0}, 64510^{0}, 64517^{0}, 64520^{0}, 64530^{0}, 66987^{1}, 66988^{1}, 69990^{0}, 92012^{1}, 92014^{1}, 93000^{1}, 93005^{1}, 93010^{1}, 93040^{1}, 93041^{1}, 93042^{1}, 93318^{1}, 93355^{1}, 94002^{1}, 94200^{1}, 94680^{1}, 94681^{1}, 94690^{1}, 95812^{1}, 95813^{1}, 95816^{1}, 95819^{1}, 95822^{1}, 95829^{1}, 95955^{1}, 96360^{1}, 96361^{1}, 96365^{1}, 96366^{1}, 96367^{1}, 96368^{1}, 96372^{1}, 96374^{1}, 96375^{1}, 96376^{1}, 96377^{1}, 96523^{0}, 97597^{1}, 97598^{1}, 97602^{1}, 97605^{1}, 97606^{1}, 97607^{1}, 97608^{1}, 99155^{0}, 99156^{0}, 99157^{0}, 99211^{1}, 99212^{1}, 99213^{1}, 99214^{1}, 99215^{1}, 99221^{1}, 99222^{1}, 99223^{1}, 99231^{1}, 99232^{1}, 99233^{1}, 99234^{1}, 99235^{1}, 99236^{1}, 99238^{1}, 99239^{1}, 99242^{1}, 99243^{1}, 99244^{1}, 99245^{1}, 99252^{1}, 99253^{1}, 99254^{1}, 99255^{1}, 99291^{1}, 99292^{1}, 99304^{1}, 99305^{1}, 99306^{1}, 99307^{1}, 99308^{1}, 99309^{1}, 99310^{1}, 99315^{1}, 99316^{1}, 99347^{1}, 99348^{1}, 99349^{1}, 99350^{1}, 99374^{1}, 99375^{1}, 99377^{1}, 99378^{1}, 99446^{0}, 99447^{0}, 99448^{0}, 99449^{0}, 99451^{0}, 99452^{0}, 99495^{0}, 99496^{0}, G0168^{1}, G0463^{1}, G0471^{1}, J0670^{1}

ICD-10-CM Cross References

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

12021

Treatment of superficial wound dehiscence; with packing

Clinical Responsibility

After proper sterilization, the physician reopens the wound dehiscence margin (wound which is not healing properly). After removal of sutures, the physician debrides the wounds and irrigates the area with an antimicrobial agent. The physician does not resuture the wound but leaves the wound open for healing and packs it with gauze.

Coding Tips

If repair of wound dehiscence occurs during the postoperative (or global surgical) period of a previous procedure, be sure to append modifier 78 to the appropriate repair code. This explains to the payer that the procedure is the result of a complication arising from an earlier procedure.

"Dehiscence" refers to a splitting open or bursting. As such, wound dehiscence usually describes the opening of a previously sutured area (for example, an incision following surgery, wound repair, etc.). If a wound becomes infected, it will more likely dehisce due to the natural inflammatory process. Wound dehiscence code

12020 (Treatment of superficial wound dehiscence; simple closure) describes repair when there is no sign of infection. In this case, the surgeon simply debrides and irrigates the wound and closes it in a single layer. If infection is evident, the surgeon may prefer to clean the wound and pack it with gauze strips, leaving the wound open to allow infection to drain. In this case, 12021 (... with packing) is the better choice. If the dehiscence has opened and requires closure in multiple layers, report 13160 (Secondary closure of surgical wound or dehiscence, extensive or complicated).

Note: Code 13160 can also describe secondary closure of surgical wounds (that is, the surgeon intentionally defers closure following surgery). Many payers define "primary" closure as the first or initial closure of a surgical wound, whether it occurs at the time of surgery or during the postoperative period, thereby limiting use of the secondary closure code.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $137.47, Non Facility Fee: $171.44
RVU (Facility): Work RVU 1.89, Practice Exp. RVU 2.06, Malpractice RVU 0.30, Total RVU 4.25
RVU (Non-Facility): Work RVU 1.89, Practice Exp. RVU 3.11, Malpractice RVU 0.30, Total RVU 5.30
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: 3

Modifier Allowances

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

NCCI Alerts (version 31.0)

0213T^{0}, 0216T^{0}, 0543T^{1}, 0544T^{1}, 0569T^{1}, 0570T^{1}, 0571T^{1}, 0572T^{1}, 0573T^{1}, 0574T^{1}, 0580T^{1}, 0581T^{1}, 0582T^{1}, 0655T^{1}, 11042^{1}, 11900^{1}, 11901^{1}, 20560^{1}, 20561^{1}, 20700^{1}, 20701^{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}, 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^{1}, 64479^{0}, 64480^{0}, 64483^{0}, 64484^{0}, 64490^{0}, 64491^{0}, 64492^{0}, 64493^{0}, 64494^{0}, 64495^{0}, 64505^{0}, 64510^{0}, 64517^{0}, 64520^{0}, 64530^{0}, 66987^{1}, 66988^{1}, 69990^{0}, 92012^{1}, 92014^{1}, 93000^{1}, 93005^{1}, 93010^{1}, 93040^{1}, 93041^{1}, 93042^{1}, 93318^{1}, 93355^{1}, 94002^{1}, 94200^{1}, 94680^{1}, 94681^{1}, 94690^{1}, 95812^{1}, 95813^{1}, 95816^{1}, 95819^{1}, 95822^{1}, 95829^{1}, 95955^{1}, 96360^{1}, 96361^{1}, 96365^{1}, 96366^{1}, 96367^{1}, 96368^{1}, 96372^{1}, 96374^{1}, 96375^{1}, 96376^{1}, 96377^{1}, 96523^{0}, 97597^{1}, 97598^{1}, 97602^{1}, 97605^{1}, 97606^{1}, 97607^{1}, 97608^{1}, 99155^{0}, 99156^{0}, 99157^{0}, 99211^{1}, 99212^{1}, 99213^{1}, 99214^{1}, 99215^{1}, 99221^{1}, 99222^{1}, 99223^{1}, 99231^{1}, 99232^{1}, 99233^{1}, 99234^{1}, 99235^{1}, 99236^{1}, 99238^{1}, 99239^{1}, 99242^{1}, 99243^{1}, 99244^{1}, 99245^{1}, 99252^{1}, 99253^{1}, 99254^{1}, 99255^{1}, 99291^{1}, 99292^{1}, 99304^{1}, 99305^{1}, 99306^{1}, 99307^{1}, 99308^{1}, 99309^{1}, 99310^{1}, 99315^{1}, 99316^{1}, 99347^{1}, 99348^{1}, 99349^{1}, 99350^{1}, 99374^{1}, 99375^{1}, 99377^{1}, 99378^{1}, 99446^{0}, 99447^{0}, 99448^{0}, 99449^{0}, 99451^{0}, 99452^{0}, 99495^{0}, 99496^{0}, G0168^{1}, G0463^{1}, G0471^{1}

ICD-10-CM Cross References

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

12041

Repair, intermediate, wounds of neck, hands, feet and/or external genitalia; 2.5 cm or less

Clinical Responsibility

Code 12041 includes the intermediate repair of wounds (2.5 cm or less) of the neck, hands, feet, and/or external genitalia

After informed consent, the patient is brought to the operating room. Prep and drape of operative site is done in the usual sterile manner, and administration of local anesthesia is done. After inspection, the wound is irrigated with normal saline, and proper debridement of the wound is performed. Contaminated single-layered wounds need extensive cleaning to remove particulate matter. Now attention turns to repair of the wound. The wound edges are brought together to form a linear closure. Suture of the inner layer of skin (subcutaneous, dermis, and/or superficial fascia) with absorbable suture is done. External layer is sutured in a linear fashion. Dermabond is applied to the wound.

Note: Report 12041 when the length of the repaired wound is up to 2.5 cm.

Coding Tips

Look for layer descriptions in your physician's chart notes

To properly choose between simple (12001-12021) and intermediate (12031-12057) repair codes, you'll have to rely on your physician's chart notes to make the right selection. To make your job easier, encourage your physician to use specific terms to describe the kind of laceration he or she repaired. Your physician should use terms such as "deeper layers of subcutaneous and superficial (nonmuscle) fascia," "layered closure," or "deep layer suturing" to indicate that he or she performed an intermediate repair.

Document extensive cleaning to up complexity

Make sure your physician documents the extent of the debridement he or she performs. Although intermediate repair usually requires layered closure, you can report appropriate intermediate codes if your physician performs a single-layer closure of heavily contaminated wounds that require extensive cleaning or removal of particulate matter, according to CPT® guidelines.

But your physician may forget to include the cleaning details when recording laceration services. Therefore, you would not know that the repair qualifies for an intermediate repair code and will use a simple repair code instead.

Get to know the multiple-laceration formula

Although reporting a single or intermediate repair may now seem simple, learning the multiple-laceration formula will require you to ratchet up your coding skills. Don't be too quick to blame poor chart notes for all of your coding mistakes. To effectively report

Male Genital System

54150

Circumcision, using clamp or other device with regional dorsal penile or ring block

Clinical Responsibility

The patient is placed on his back. His arms and legs may be strapped down to prevent any unwanted movement during the procedure. The skin of the perineum and thighs are prepared with Betadine liquid (an antiseptic) and the area is draped in a sterile fashion. Examples of devices the provider may use include the Gomco® clamp, Mogen clamp, or PlastiBell®.

After injecting a regional anesthetic into the top of the penis or in a ring around the penis and with the patient appropriately prepped, the provider makes a dorsal slit and separates the foreskin from the glans penis. As an example of the procedure, the bell portion of the clamp is then placed over the glans, and the foreskin is pulled over the bell through the plate and yoke of the clamp. The nut of the clamp is tightened onto the bell so that it holds the foreskin in place. The Gomco® clamp compresses the foreskin between the metal clamp and bell, allowing it to be cut and removed with minimal bleeding. After the foreskin is excised, the clamp and bell are removed.

Patients may undergo the procedure because of potential preventive benefits, such as reducing the risk of urinary tract infection in the first year of life and reducing the risk of acquiring or transmitting sexually transmitted infections.

Coding Tips

If the provider doesn't administer dorsal penile or ring anesthetic block, report this code with modifier 52 to indicate reduced services.

For circumcision using surgical excision other than a clamp, other devices, or dorsal slit, report 54160 for a neonate 28 days old or less and 54161 for a patient older than 28 days.

The procedure described by 54150 is likely to be performed using a Gomco® clamp, Mogen clamp, or PlastiBell®, but other devices have been developed, such as Zhenxi rings, Tara Klamp, SmartKlamp, Shang Ring®, and PrePex®.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $92.83, Non Facility Fee: $143.94
RVU (Facility): Work RVU 1.90, Practice Exp. RVU 0.73, Malpractice RVU 0.24, Total RVU 2.87
RVU (Non-Facility): Work RVU 1.90, Practice Exp. RVU 2.31, Malpractice RVU 0.24, Total RVU 4.45
MPFS Payment Policy Indicators: Global Period 000, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 1

Modifier Allowances

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

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}, 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^{0}, 51702^{0}, 51703^{1}, 54000^{0}, 54001^{0}, 54100^{1}, 54162^{1}, 54163^{1}, 54164^{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}, 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^{0}, J0670^{1}

ICD-10-CM Cross References

A63.0, N47.0-N47.2, N47.5, N47.6, N47.8, N48.0, N48.1, N48.29, N48.5, N48.6, N48.82, N48.89, N48.9, N50.1, Q55.63, Q55.64, Q55.69, Q64.5, Q64.6, Q64.71-Q64.75, Q64.79, Z41.2, Z87.710

Female Genital System

56405

Incision and drainage of vulva or perineal abscess

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider locates the exact site of the abscess and makes an incision over it. He uses a scalpel, a cutting instrument, to incise the abscess and drain pus. The provider then irrigates the area, checks for bleeding, and packs the wound with gauze to allow drainage while it heals.

Coding Tips

If the provider performs incision and drainage of a Bartholin's gland, report 56420, Incision and drainage of the Bartholin's gland.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $124.53, Non Facility Fee: $141.68
RVU (Facility): Work RVU 1.49, Practice Exp. RVU 2.09, Malpractice RVU 0.27, Total RVU 3.85
RVU (Non-Facility): Work RVU 1.49, Practice Exp. RVU 2.62, Malpractice RVU 0.27, Total RVU 4.38
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: 2

Modifier Allowances

22, 47, 51, 52, 53, 54, 55, 56, 58, 59, 62, 63, 73, 74, 76, 77, 78, 79, 99, AG, AQ, AR, CR, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 31.0)

00940[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], 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], 56440[1], 56605[0], 56810[0], 56820[0], 57100[1], 57180[1], 57500[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], 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

D28.0, K61.31, L02.215, L03.319, L03.329, L03.90, L03.91, L08.89, L98.9, N75.0, N75.1, N75.9, N76.0-N76.5, N76.3, N76.4, N76.5, N76.89, N90.61, N90.69, N90.7, N90.89, R22.9, Z01.411, Z01.419

56420

Incision and drainage of Bartholin's gland abscess

Clinical Responsibility

When the patient is appropriately prepped and anesthetized, the provider locates the exact site of abscess in one of the Bartholin's glands and makes an incision over it. She uses a scalpel, a cutting instrument, to incise the abscess and drain pus. The provider then irrigates the area, checks for bleeding, and packs the wound with gauze to allow drainage while it heals.

Coding Tips

If the provider performs incision and drainage in the vulva or perineum, use 56405, Incision and drainage of the vulva or perineal abscess.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $107.39, Non Facility Fee: $178.88
RVU (Facility): Work RVU 1.44, Practice Exp. RVU 1.64, Malpractice RVU 0.24, Total RVU 3.32
RVU (Non-Facility): Work RVU 1.44, Practice Exp. RVU 3.85, Malpractice RVU 0.24, Total RVU 5.53
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, AG, AQ, AR, CR, ET, GA, GC, GJ, GR, KX, PD, Q5, Q6, QJ, XE, XP, XS, XU

NCCI Alerts (version 31.0)

00940[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], 36000[1], 36400[1], 36405[1], 36406[1], 36410[1], 36420[1], 36425[1], 36430[1], 36440[1], 36591[0], 36592[0],

Maternity Care and Delivery

59000

Amniocentesis; diagnostic

Clinical Responsibility

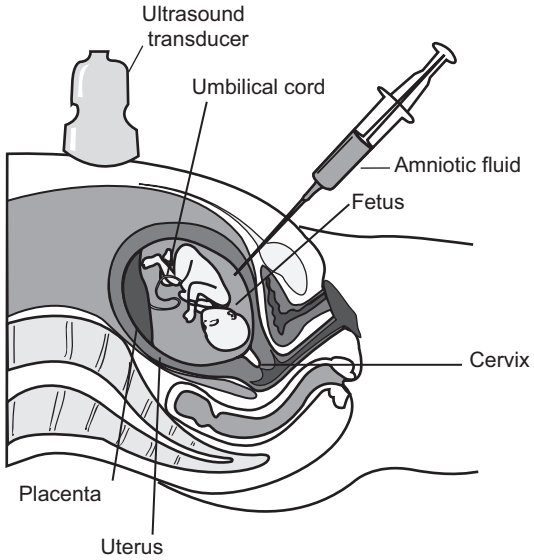
The provider first drapes and preps the patient's abdominal area. Using ultrasound guidance, he identifies the needle insertion site, and he slowly inserts a needle into the amniotic sac. The provider, working with an assistant, attaches the needle to tubing. While the provider holds the needle in place, the assistant attaches the needle to a drainage system. Using continuous ultrasonic guidance, the provider then carefully removes fluid until there is enough for a sample. When the procedure is complete, the provider slowly and cautiously removes the needle.

Coding Tips

Code 59000 does not include ultrasound guidance, but the provider almost always uses ultrasound imaging to guide the needle into position and withdraw the fluid. Because the Resource Based Relative Value Scale, or RBRVS, does not value the code including ultrasound guidance, report the code 76946, Unlisted fluoroscopic procedure, e.g., diagnostic, interventional, in addition to 59000. Be sure that the provider documents the findings as coding requires for billing of the ultrasound guidance.

For services paid under OPPS, Medicare does not pay hospitals separately for supervision and interpretation codes deemed to be ancillary and supportive services to primary diagnostic or therapeutic services. OPPS hospitals should still report the code when performed for statistical purposes.

Illustration



59000

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $78.28, Non Facility Fee: $114.83
RVU (Facility): Work RVU 1.30, Practice Exp. RVU 0.73, Malpractice RVU 0.39, Total RVU 2.42
RVU (Non-Facility): Work RVU 1.30, Practice Exp. RVU 1.86, Malpractice RVU 0.39, Total RVU 3.55
MPFS Payment Policy Indicators: Global Period 000, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 2

Modifier Allowances

22, 47, 51, 52, 58, 59, 63, 73, 74, 76, 77, 78, 79, 99, AG, AQ, AR, CR, ET, GA, GC, GJ, GR, HD, KX, PD, Q5, Q6, QJ, TH, 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}, 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^{0}, 51702^{0}, 51703^{1}, 57410^{0}, 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}, 76000^{1}, 76942^{1}, 76998^{1}, 77001^{1}, 77002^{1}, 92012^{1}, 92014^{1}, 93000^{1}, 93005^{1}, 93010^{1}, 93040^{1}, 93041^{1}, 93042^{1}, 93318^{1}, 93355^{1}, 94002^{1}, 94200^{1}, 94680^{1}, 94681^{1}, 94690^{1}, 95812^{1}, 95813^{1}, 95816^{1}, 95819^{1}, 95822^{1}, 95829^{1}, 95955^{1}, 96360^{1}, 96361^{1}, 96365^{1}, 96366^{1}, 96367^{1}, 96368^{1}, 96372^{1}, 96374^{1}, 96375^{1}, 96376^{1}, 96377^{1}, 96523^{0}, 99155^{0}, 99156^{0}, 99157^{0}, 99211^{1}, 99212^{1}, 99213^{1}, 99214^{1}, 99215^{1}, 99221^{1}, 99222^{1}, 99223^{1}, 99231^{1}, 99232^{1}, 99233^{1}, 99234^{1}, 99235^{1}, 99236^{1}, 99238^{1}, 99239^{1}, 99242^{1}, 99243^{1}, 99244^{1}, 99245^{1}, 99252^{1}, 99253^{1}, 99254^{1}, 99255^{1}, 99291^{1}, 99292^{1}, 99304^{1}, 99305^{1}, 99306^{1}, 99307^{1}, 99308^{1}, 99309^{1}, 99310^{1}, 99315^{1}, 99316^{1}, 99347^{1}, 99348^{1}, 99349^{1}, 99350^{1}, 99374^{1}, 99375^{1}, 99377^{1}, 99378^{1}, 99446^{0}, 99447^{0}, 99448^{0}, 99449^{0}, 99451^{0}, 99452^{0}, 99495^{1}, 99496^{1}, G0463^{1}, G0471^{0}

ICD-10-CM Cross References

D61.03, O09.10-O09.13, O09.291-O09.299, O09.511-O09.519, O09.521-O09.529, O09.621-O09.629, O09.70-O09.73, O09.811-O09.819, O09.821-O09.829, O09.891-O09.899, O09.90-O09.93, O09.A0-O09.A3, O12.04, O12.05, O12.14, O12.15, O12.24, O12.25, O13.4, O13.5, O16.4, O16.5, O28.0-O28.9, O33.7XX0-O33.7XX9, O35.00X0-O35.00X9, O35.01X0-O35.01X9, O35.02X0-O35.02X9, O35.03X0-O35.03X9, O35.04X0-O35.04X9, O35.05X0-O35.05X9, O35.06X0-O35.06X9, O35.07X0-O35.07X9, O35.08X1-O35.08X5, O35.08X9, O35.09X0-O35.09X9, O35.0XX0-

O35.0XX5, O35.0XX9, O35.10X0-O35.10X9, O35.11X0-O35.11X9, O35.12X0-O35.12X9, O35.13X0-O35.13X9, O35.14X0-O35.14X9, O35.15X0-O35.15X9, O35.19X0-O35.19X9, O35.1XX0-O35.1XX5, O35.1XX9, O35.2XX0-O35.2XX9, O35.3XX0-O35.3XX9, O35.4XX0-O35.4XX9, O35.8XX0-O35.8XX9, O35.9XX0-O35.9XX9, O36.0110-O36.0119, O36.0120-O36.0129, O36.0130-O36.0139, O36.0190, O36.21X0-O36.21X9, O36.22X0-O36.22X9, O36.23X0-O36.23X9, O36.90X0, O36.91X0-O36.91X9, O36.92X0-O36.92X9, O36.93X0-O36.93X9, O40.1XX0-O40.1XX9, O40.2XX0-O40.2XX9, O40.3XX0-O40.3XX9, O40.9XX0, O41.00X0, O41.01X0-O41.01X9, O41.02X0-O41.02X9, O41.03X0-O41.03X9, O41.1010-O41.1019, O41.1020-O41.1029, O41.1030-O41.1039, O41.1090, O41.8X10-O41.8X19, O41.8X20-O41.8X29, O41.8X30-O41.8X39, O41.8X90, Z03.71, Z13.71, Z13.79, Z14.1, Z14.8, Z36.0-Z36.5, Z36.81-Z36.8A, Z36.9, Z84.81

59001

Amniocentesis; therapeutic amniotic fluid reduction (includes ultrasound guidance)

Clinical Responsibility

The provider first drapes and preps the patient's abdominal area. Using ultrasound guidance, he identifies the needle insertion site, and he slowly inserts a needle into the amniotic sac. The provider, working with an assistant, attaches the needle to tubing. While the provider holds the needle in place, the assistant attaches the needle to a drainage system. Using continuous ultrasonic guidance, the provider removes the fluid until a normal amount of amniotic fluid is seen on the ultrasound. The provider remains in constant communication with the ultrasound technician regarding the status of the fetus or fetuses and the fluid level. He does this because continual monitoring of the needle location is necessary to avoid injury to the fetus or placenta because the uterine shape changes as the he removes the fluid. Once he obtains a normal fluid level, the provider removes the needle.

Coding Tips

Unlike code 59000, Amniocentesis; diagnostic, code 59001 includes ultrasound guidance so do not report code 76942, Ultrasonic guidance for needle placement, eg, biopsy, aspiration, injection, localization device, imaging supervision and interpretation, in addition to 59001.

The provider may need to reduce the amniotic fluid volume on a regular basis, so he will repeat the procedure on an ongoing basis as necessary.

Fee Schedule Information

Medicare Fees (National): Conversion Factor $32.3465, Facility Fee: $172.73, Non Facility Fee: $172.73
RVU (Facility): Work RVU 3.00, Practice Exp. RVU 1.44, Malpractice RVU 0.90, Total RVU 5.34
RVU (Non-Facility): Work RVU 3.00, Practice Exp. RVU 1.44, Malpractice RVU 0.90, Total RVU 5.34
MPFS Payment Policy Indicators: Global Period 000, Preop 0.00%, Intraop 0.00%, Postop 0.00%, MPFS Status Indicator: A, PC/TC Indicator: 0, Endoscopic Base Code: None
Practitioner MUE: 2

Modifier Allowances

22, 47, 51, 52, 58, 63, 73, 74, 76, 77, 78, 79, 99, AQ, AR, CR, ET, GA, GC, GJ, GR, HD, KX, PD, Q5, Q6, QJ, TH

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}, 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^{0}, 51702^{0}, 51703^{1}, 57410^{0}, 59000^{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}, 76941^{1}, 76942^{1}, 76945^{1}, 76946^{1}, 76998^{1}, 92012^{1}, 92014^{1}, 93000^{1}, 93005^{1}, 93010^{1}, 93040^{1}, 93041^{1}, 93042^{1}, 93318^{1}, 93355^{1}, 94002^{1}, 94200^{1}, 94680^{1}, 94681^{1}, 94690^{1}, 95812^{1}, 95813^{1}, 95816^{1}, 95819^{1}, 95822^{1}, 95829^{1}, 95955^{1}, 96360^{1}, 96361^{1}, 96365^{1}, 96366^{1}, 96367^{1}, 96368^{1}, 96372^{1}, 96374^{1}, 96375^{1}, 96376^{1}, 96377^{1}, 96523^{0}, 99155^{0}, 99156^{0}, 99157^{0}, 99211^{1}, 99212^{1}, 99213^{1}, 99214^{1}, 99215^{1}, 99221^{1}, 99222^{1}, 99223^{1}, 99231^{1}, 99232^{1}, 99233^{1}, 99234^{1}, 99235^{1}, 99236^{1}, 99238^{1}, 99239^{1}, 99242^{1}, 99243^{1}, 99244^{1}, 99245^{1}, 99252^{1}, 99253^{1}, 99254^{1}, 99255^{1}, 99291^{1}, 99292^{1}, 99304^{1}, 99305^{1}, 99306^{1}, 99307^{1}, 99308^{1}, 99309^{1}, 99310^{1}, 99315^{1}, 99316^{1}, 99347^{1}, 99348^{1}, 99349^{1}, 99350^{1}, 99374^{1}, 99375^{1}, 99377^{1}, 99378^{1}, 99446^{0}, 99447^{0}, 99448^{0}, 99449^{0}, 99451^{0}, 99452^{0}, 99495^{1}, 99496^{1}, G0463^{1}, G0471^{0}

ICD-10-CM Cross References

D61.03, O09.A0-O09.A3, O12.04, O12.05, O12.14, O12.15, O12.24, O12.25, O13.4, O13.5, O16.4, O16.5, O33.7XX0-O33.7XX9, O40.1XX0-O40.1XX9, O40.2XX0-O40.2XX9, O40.3XX0-O40.3XX9, O40.9XX0-O40.9XX9, P02.78

59012

Cordocentesis (intrauterine), any method

Clinical Responsibility

The provider first drapes and preps the patient's abdominal area. Using ultrasound guidance, the provider then identifies the needle insertion site. Still using ultrasonic guidance, she inserts a needle through the abdomen and uterine walls to the umbilical cord and removes fetal blood from the cord. Once she completes the fetal blood sampling, the provider withdraws the needle and sends the sample to the laboratory for examination.

Coding Tips

Cordocentesis does not include ultrasound guidance, but the provider almost always uses ultrasound imaging to guide the needle into position and withdraw the blood. Therefore, report 76941, Ultrasonic guidance for intrauterine fetal transfusion or

Proprietary Laboratory Analyses

0455U

Infectious agents (sexually transmitted infection), Chlamydia trachomatis, Neisseria gonorrhoeae, and Trichomonas vaginalis, multiplex amplified probe technique, vaginal, endocervical, gynecological specimens, oropharyngeal swabs, rectal swabs, female or male urine, each pathogen reported as detected or not detected

Advice

CPT® adds 0455U to be reported only for Abbott Alinity™ m STI Assay from Abbott Molecular Inc. The test evaluates vaginal swabs, endocervical swabs, gynecological specimens, oropharyngeal swabs, rectal swabs, female urine, or male urine using a multiplex amplified probe technique to detect Chlamydia trachomatis, Neisseria gonorrhoeae, and Trichomonas vaginalis, which cause common sexually transmitted infections (STIs).

Effective date of this code: July 1, 2025.

Clinical Responsibility

The lab analyst processes the specimen, such as a vaginal swab, endocervical swab, gynecological specimen, oropharyngeal swab, rectal swab, or female or male urine, using an instrument. The automated system extracts DNA and uses reverse transcription polymerase chain reaction (RT-PCR) to amplify (increase the number of) target genes to detect and differentiate Chlamydia trachomatis, Neisseria gonorrhoeae, and Trichomonas vaginalis. The procedure uses multiplex probe technique (able to simultaneously evaluate multiple analytes in a single procedure) and reports the findings for each organism as detected or not detected.

Clinicians may order this test for male or female patients exhibiting symptoms, such as pain, sores, odor, or discharge, of a sexually transmitted infection (STI).

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.

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

Modifier Allowances

33, 90, 91, 99, GA, GC, GR, GU, GX, GY, GZ, Q0, Q1, QJ, QP, SC

Modifier: 0 = not allowed, 1 = allowed

NCCI Alerts (version 31.0)

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

ICD-10-CM Cross References

A51.0-A51.2, A54.00-A54.09, A54.1, A54.22-A54.24, A54.29, A54.86, A54.89, A54.9, A55, A56.00-A56.09, A56.11, A56.19, A56.2, A56.3, A56.8, A57, A59.00-A59.09, A59.9, A60.00-A60.09, A60.1, A60.9, A63.8, A64, A74.89, A74.9, B10.89, R87.0, R87.1, Z11.3, Z11.8

0463U

Oncology (cervix), mRNA gene expression profiling of 14 biomarkers (E6 and E7 of the highest-risk human papillomavirus [HPV] types 16, 18, 31, 33, 45, 52, 58), by real-time nucleic acid sequence-based amplification (NASBA), exo- or endocervical epithelial cells, algorithm reported as positive or negative for increased risk of cervical dysplasia or cancer for each biomarker

Advice

CPT® adds 0463U to be reported only for Proofer '7 HPV mRNA E6 and E7 Biomarker Test from Global Diagnostics Labs LLC and PreTect AS, a Mel-Mont Medical Inc. wholly owned subsidiary. Using a cervical specimen, the test evaluates gene activity (expression) of E6/E7 oncogenes. The test can identify overexpression of E6/E7, which indicates infection with one of the high-risk human papilloma virus (HPV) types and increased risk for cervical cancer.

Effective date of this code: July 1, 2024.

Clinical Responsibility

A lab analyst carries out a test related to cervical cancer, known as mRNA gene expression profiling. This test looks for 14 specific markers, including E6 and E7 from the most dangerous types of human papillomavirus (HPV), types 16, 18, 31, 33, 45, 52, and 58. The specimen is from the patient's cervix. These can be either exocervical (from the outer surface of the cervix) or endocervical (from the inner surface or canal of the cervix) epithelial cells. Epithelial cells are a type of cell that line the surfaces of the body. These cells contain messenger RNA (mRNA), which carries genetic instructions from the DNA in the cell's control center (nucleus) to the rest of the cell. The analyst uses a method called real-time nucleic acid sequence-based amplification (NASBA) to make many copies of the parts of the mRNA that match the 14 markers. This involves making a DNA copy (complementary DNA or cDNA) of the mRNA, and then using this cDNA as a pattern to make more copies of the original mRNA. The "real-time" part means that the making and detecting of the mRNA copies can be watched as it happens. Once the mRNA has been copied many times, the analyst can measure the amounts of each marker in the sample. This is done by comparing the amount of cDNA for each marker to a known reference amount. Finally, the results are analyzed using a special calculation process (algorithm), which decides whether the amounts of each marker suggest a higher risk of changes in the

HCPCS Level II Codes

Procedures/Professional Services

G0064

Certified nurse midwife mips specialty set

Clinical Responsibility

This code is specific to the Certified Nurse Midwife MIPS Specialty Set. Medicare develops and maintains specialty measure sets to assist Merit-based Incentive Payment System (MIPS) eligible clinicians with selecting quality measures that are most relevant to their scope of practice.

BETOS

Z2: Undefined codes

G0076

Brief (20 minutes) care management home visit for a new patient. for use only in a Medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)

Clinical Responsibility

The CMMI provider sees a new patient face-to-face for a brief care management visit of 20 minutes in their home or other place of residence. The provider typically reviews the patient's history, performs a brief physical examination, and decides on a care management plan or makes adjustments in an existing one. The provider documents the reason why the patient is being seen at their private residence and not at the office and the time spent with the patient and activities he performs.

Coding Tips

For the same service for visits lasting more than 20 minutes, report G0077 (30 minutes), G0078 (45 minutes), G0079 (60 minutes), or G0080 (75 minutes).

The provider must be enrolled in a Medicare-approved Center for Medicare and Medicaid Innovation (CMMI) model program. Select the code to report based not only on time but on complexity of the care management services provided.

Use this code only to report services given to patients at their private home, apartment, town home, or other non-shared place of residence or at shared living facility such as an assisted living facility, adult living facility, nursing home, or rest home. Travel time to and from the patient's place of residence is not include in the code.

Service level is based on the complexity of the medical decision-making and the time spent with the patient.

A new patient is defined as a patient who has never seen the physician or qualified healthcare practitioner of the same specialty in the same group practice billing under the same group number or has not seen the physician or qualified healthcare practitioner of the same specialty in the same group practice for the past 36 months.

BETOS

M4A: Home visit

G0077

Limited (30 minutes) care management home visit for a new patient. for use only in a Medicare-approved cmmi model. (services must be furnished within a beneficiary's home, domiciliary, rest home, assisted living and/or nursing facility)

Clinical Responsibility

The CMMI provider sees a new patient face-to-face for a limited care management visit of 30 minutes in their home or other place of residence. The provider typically reviews the patient's history, performs a brief physical examination, and decides on a care management plan or makes adjustments in an existing one. The provider documents the reason why the patient is being seen at their private residence and not at the office and the time spent with the patient and activities he performs.

Coding Tips

For the same service for visits lasting less than 30 minutes, report G0076 (20 minutes), and for more than 30 minutes, report G0078 (45 minutes), G0079 (60 minutes), or G0080 (75 minutes).

The provider must be enrolled in a Medicare-approved Center for Medicare and Medicaid Innovation (CMMI) model program. Select the code to report based not only on time but on complexity of the care management services provided.

Use this code only to report services given to patients at their private home, apartment, town home, or other non-shared place of residence or at shared living facility such as an assisted living facility, adult living facility, nursing home, or rest home. Travel time to and from the patient's place of residence is not include in the code.

Service level is based on the complexity of the medical decision-making and the time spent with the patient.

A new patient is defined as a patient who has never seen the physician or qualified healthcare practitioner of the same specialty in the same group practice billing under the same group number or has not seen the physician or qualified healthcare practitioner of the same specialty in the same group practice for the past 36 months.

ICD-10-CM Cross Reference Details

A06.82 Other amebic genitourinary infections
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
A18.10 Tuberculosis of genitourinary system, unspecified
A18.17 Tuberculous female pelvic inflammatory disease
A18.18 Tuberculosis of other female genital organs
A18.39 Retroperitoneal tuberculosis
A34 Obstetrical tetanus
A36.0 Pharyngeal diphtheria
A36.1 Nasopharyngeal diphtheria
A36.2 Laryngeal diphtheria
A36.3 Cutaneous diphtheria
A36.81 Diphtheritic cardiomyopathy
A36.82 Diphtheritic radiculomyelitis
A36.83 Diphtheritic polyneuritis
A36.84 Diphtheritic tubulo-interstitial nephropathy
A36.85 Diphtheritic cystitis
A36.86 Diphtheritic conjunctivitis
A36.89 Other diphtheritic complications
A36.9 Diphtheria, unspecified
A37.00 Whooping cough due to Bordetella pertussis without pneumonia
A37.01 Whooping cough due to Bordetella pertussis with pneumonia
A37.10 Whooping cough due to Bordetella parapertussis without pneumonia
A37.11 Whooping cough due to Bordetella parapertussis with pneumonia
A37.80 Whooping cough due to other Bordetella species without pneumonia
A37.81 Whooping cough due to other Bordetella species with pneumonia
A37.90 Whooping cough, unspecified species without pneumonia
A37.91 Whooping cough, unspecified species with pneumonia
A41.3 Sepsis due to Hemophilus influenzae
A41.54 Sepsis due to Acinetobacter baumannii
A49.2 Hemophilus influenzae infection, unspecified site
A49.3 Mycoplasma infection, unspecified site
A51.0 Primary genital syphilis
A51.1 Primary anal syphilis
A51.2 Primary syphilis of other sites
A51.42 Secondary syphilitic female pelvic disease
A52.73 Symptomatic late syphilis of other respiratory organs
A52.76 Other genitourinary symptomatic late syphilis
A52.79 Other symptomatic late syphilis
A54.00 Gonococcal infection of lower genitourinary tract, unspecified
A54.01 Gonococcal cystitis and urethritis, unspecified
A54.02 Gonococcal vulvovaginitis, unspecified
A54.03 Gonococcal cervicitis, unspecified
A54.09 Other gonococcal infection of lower genitourinary tract
A54.1 Gonococcal infection of lower genitourinary tract with periurethral and accessory gland abscess
A54.21 Gonococcal infection of kidney and ureter
A54.22 Gonococcal prostatitis
A54.23 Gonococcal infection of other male genital organs
A54.24 Gonococcal female pelvic inflammatory disease
A54.29 Other gonococcal genitourinary infections
A54.30 Gonococcal infection of eye, unspecified
A54.31 Gonococcal conjunctivitis
A54.40 Gonococcal infection of musculoskeletal system, unspecified
A54.49 Gonococcal infection of other musculoskeletal tissue
A54.6 Gonococcal infection of anus and rectum
A54.86 Gonococcal sepsis
A54.89 Other gonococcal infections
A54.9 Gonococcal infection, unspecified
A55 Chlamydial lymphogranuloma (venereum)
A56.00 Chlamydial infection of lower genitourinary tract, unspecified
A56.01 Chlamydial cystitis and urethritis
A56.02 Chlamydial vulvovaginitis
A56.09 Other chlamydial infection of lower genitourinary tract
A56.11 Chlamydial female pelvic inflammatory disease
A56.19 Other chlamydial genitourinary infection
A56.2 Chlamydial infection of genitourinary tract, unspecified
A56.3 Chlamydial infection of anus and rectum
A56.8 Sexually transmitted chlamydial infection of other sites
A57 Chancroid
A58 Granuloma inguinale
A59.00 Urogenital trichomoniasis, unspecified
A59.01 Trichomonal vulvovaginitis
A59.02 Trichomonal prostatitis
A59.03 Trichomonal cystitis and urethritis
A59.09 Other urogenital trichomoniasis
A59.9 Trichomoniasis, unspecified
A60.00 Herpesviral infection of urogenital system, unspecified
A60.01 Herpesviral infection of penis
A60.02 Herpesviral infection of other male genital organs
A60.03 Herpesviral cervicitis
A60.04 Herpesviral vulvovaginitis
A60.09 Herpesviral infection of other urogenital tract
A60.1 Herpesviral infection of perianal skin and rectum
A60.9 Anogenital herpesviral infection, unspecified
A63.0 Anogenital (venereal) warts
A63.8 Other specified predominantly sexually transmitted diseases
A64 Unspecified sexually transmitted disease
A74.89 Other chlamydial diseases
A74.9 Chlamydial infection, unspecified
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
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
B02.0 Zoster encephalitis
B02.1 Zoster meningitis
B02.30 Zoster ocular disease, unspecified
B02.31 Zoster conjunctivitis

B02.32 Zoster iridocyclitis
B02.33 Zoster keratitis
B02.34 Zoster scleritis
B02.39 Other herpes zoster eye disease
B02.7 Disseminated zoster
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
B07.8 Other viral warts
B07.9 Viral wart, unspecified
B08.1 Molluscum contagiosum
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
B37.31 Acute candidiasis of vulva and vagina
B37.32 Chronic candidiasis of vulva and vagina
B37.41 Candidal cystitis and urethritis
B80 Enterobiasis
B87.81 Genitourinary myiasis
B90.1 Sequelae of genitourinary tuberculosis
B91 Sequelae of poliomyelitis
B96.3 Hemophilus influenzae [H. influenzae] as the cause of diseases classified elsewhere
B96.83 Acinetobacter baumannii as the cause of diseases classified elsewhere
B97.35 Human immunodeficiency virus, type 2 [HIV 2] as the cause of diseases classified elsewhere
B97.7 Papillomavirus as the cause of diseases classified elsewhere
C07 Malignant neoplasm of parotid gland
C08.0 Malignant neoplasm of submandibular gland
C08.1 Malignant neoplasm of sublingual gland
C08.9 Malignant neoplasm of major salivary gland, unspecified
C10.2 Malignant neoplasm of lateral wall of oropharynx
C10.3 Malignant neoplasm of posterior wall of oropharynx
C10.4 Malignant neoplasm of branchial cleft
C10.8 Malignant neoplasm of overlapping sites of oropharynx
C10.9 Malignant neoplasm of oropharynx, unspecified
C11.0 Malignant neoplasm of superior wall of nasopharynx
C11.1 Malignant neoplasm of posterior wall of nasopharynx
C11.2 Malignant neoplasm of lateral wall of nasopharynx
C11.3 Malignant neoplasm of anterior wall of nasopharynx
C11.8 Malignant neoplasm of overlapping sites of nasopharynx
C11.9 Malignant neoplasm of nasopharynx, unspecified
C12 Malignant neoplasm of pyriform sinus
C13.0 Malignant neoplasm of postcricoid region
C13.2 Malignant neoplasm of posterior wall of hypopharynx
C13.8 Malignant neoplasm of overlapping sites of hypopharynx
C13.9 Malignant neoplasm of hypopharynx, unspecified
C14.0 Malignant neoplasm of pharynx, unspecified
C14.2 Malignant neoplasm of Waldeyer's ring
C15.3 Malignant neoplasm of upper third of esophagus
C15.4 Malignant neoplasm of middle third of esophagus
C15.5 Malignant neoplasm of lower third of esophagus
C15.8 Malignant neoplasm of overlapping sites of esophagus
C15.9 Malignant neoplasm of esophagus, unspecified
C16.1 Malignant neoplasm of fundus of stomach
C16.2 Malignant neoplasm of body of stomach
C16.3 Malignant neoplasm of pyloric antrum
C16.5 Malignant neoplasm of lesser curvature of stomach, unspecified
C16.8 Malignant neoplasm of overlapping sites of stomach
C16.9 Malignant neoplasm of stomach, unspecified
C17.1 Malignant neoplasm of jejunum
C17.3 Meckel's diverticulum, malignant
C17.8 Malignant neoplasm of overlapping sites of small intestine
C17.9 Malignant neoplasm of small intestine, unspecified
C19 Malignant neoplasm of rectosigmoid junction
C20 Malignant neoplasm of rectum
C21.0 Malignant neoplasm of anus, unspecified
C21.1 Malignant neoplasm of anal canal
C21.2 Malignant neoplasm of cloacogenic zone
C21.8 Malignant neoplasm of overlapping sites of rectum, anus and anal canal
C22.0 Liver cell carcinoma
C22.1 Intrahepatic bile duct carcinoma
C22.2 Hepatoblastoma
C22.3 Angiosarcoma of liver
C22.4 Other sarcomas of liver
C22.7 Other specified carcinomas of liver
C22.8 Malignant neoplasm of liver, primary, unspecified as to type
C22.9 Malignant neoplasm of liver, not specified as primary or secondary
C23 Malignant neoplasm of gallbladder
C24.0 Malignant neoplasm of extrahepatic bile duct
C24.1 Malignant neoplasm of ampulla of Vater
C24.8 Malignant neoplasm of overlapping sites of biliary tract
C24.9 Malignant neoplasm of biliary tract, unspecified
C25.1 Malignant neoplasm of body of pancreas
C25.2 Malignant neoplasm of tail of pancreas
C25.7 Malignant neoplasm of other parts of pancreas
C25.8 Malignant neoplasm of overlapping sites of pancreas
C25.9 Malignant neoplasm of pancreas, unspecified
C26.0 Malignant neoplasm of intestinal tract, part unspecified
C26.1 Malignant neoplasm of spleen
C26.9 Malignant neoplasm of ill-defined sites within the digestive system
C30.0 Malignant neoplasm of nasal cavity
C30.1 Malignant neoplasm of middle ear
C31.0 Malignant neoplasm of maxillary sinus
C31.1 Malignant neoplasm of ethmoidal sinus
C31.2 Malignant neoplasm of frontal sinus
C31.3 Malignant neoplasm of sphenoid sinus
C31.8 Malignant neoplasm of overlapping sites of accessory sinuses
C31.9 Malignant neoplasm of accessory sinus, unspecified
C32.0 Malignant neoplasm of glottis
C32.1 Malignant neoplasm of supraglottis
C32.2 Malignant neoplasm of subglottis
C32.3 Malignant neoplasm of laryngeal cartilage
C32.8 Malignant neoplasm of overlapping sites of larynx
C32.9 Malignant neoplasm of larynx, unspecified
C33 Malignant neoplasm of trachea
C34.00 Malignant neoplasm of unspecified main bronchus
C34.01 Malignant neoplasm of right main bronchus
C34.02 Malignant neoplasm of left main bronchus
C34.10 Malignant neoplasm of upper lobe, unspecified bronchus or lung
C34.11 Malignant neoplasm of upper lobe, right bronchus or lung
C34.12 Malignant neoplasm of upper lobe, left bronchus or lung
C34.2 Malignant neoplasm of middle lobe, bronchus or lung

Modifier Descriptors

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

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

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

Terminology

Terminology	Explanation
Abdominal pregnancy	When the fetus begins to grow within the peritoneal cavity; it can be located anywhere including the omentum, the abdominal wall, or the outside of the body of the uterus; a primary abdominal pregnancy means that the fertilization of the ovum takes place outside the entrance to the fallopian tube and the fertilized egg then travels to a close source of tissue, which it attaches to; a secondary abdominal pregnancy means that the fertilized ruptures from the tube and then implants in the abdominal cavity.
Abdominoperineal resection	The surgical removal of the anus, rectum, and part of the sigmoid colon, along with regional lymph nodes, through incisions made in the abdomen and perineum.
Ablation	A surgical technique that removes tissue or a body part or destroys its function.
Abortion	The clinical term for the termination of a pregnancy before the age of viability, usually before twenty completed weeks of gestation; the provider removes the uterine contents surgically or by inducing labor, or the pregnancy may be expelled spontaneously; when it ends spontaneously, it is referred to as a miscarriage.
Abscess	Sac or pocket formed due to the accumulation of purulent material, or pus, in the soft tissues.
Acute	A medical condition or injury of sudden onset, sometimes severe in nature, and typically lasts a short period of time; opposite of chronic.
Adhesions	Fibrous bands of internal scar tissue that connect tissues that do not normally connect, often as a result of injury during surgery; when they develop in the uterus, they are referred to as uterine synechiae.
Adjuvant	A substance added to the vaccine to boost body's immune response to the vaccine.
Adnexal structures	Organs that adjoin the uterus such as the ovaries and the fallopian tubes.
Adolescent	Teenager.
Algorithm	A specific set of step by step calculations using defined inputs at each step to produce a useful output; specifically for MAAAs, the output involves some sort of diagnostic or prognostic information about treatment options or disease outcomes.
Amniocentesis	A procedure in which a small sample of amniotic fluid is drawn out of the uterus through a needle inserted in the abdomen.
Amnioinfusion	The instillation of warm fluid into the amniotic cavity.
Amnion	Inner membrane of the sac that covers the fetus.
Amnioscope	A type of endoscope that allows the provider to see the amniotic sac and fetus.
Amniotic fluid	A clear, slightly yellowish liquid that surrounds the fetus during pregnancy and helps to protect it from mechanical injury.
Amniotic sac	A bag of fluid inside the uterus where the fetus develops and grows; it is sometimes called the membranes because the sac is made of two membranes called the amnion and the chorion.
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	Surgical connection or joining of vessels or organs.
Anatomy	Branch of science that deals with the study of the structure of an organism.
Angiography	A medical imaging technique in which the provider injects a dye into blood vessels and uses plain X-rays, computed tomography (CT), or magnetic resonance imaging (MRI) to visualize the inside (lumen) of the vessels; more specific terms include arteriography when performed on the arteries or venography when performed on the veins; angiography can also be used to study blood supply to organs such as the heart, kidneys, and liver.
Anhydramnios	The absence of any amniotic fluid around the fetus.
Anomaly	Not normal structurally or functionally, out of place; typically describes a congenital deformity, one present at birth.
Antenatal testing	Tests a provider offers a mother to check on the health of the baby and mother.
Antepartum period	Period from confirmation of pregnancy to delivery of the baby.

Terminology	Explanation
Anterior rectus sheath	Portion of the rectus abdominis muscles, the two parallel vertically aligned muscles on each side of the anterior wall of the abdomen surrounded by layers of flat broad tendons.
Antibody	Also called immunoglobulin; a protein that the body produces in the blood as part of the immune response to neutralize specific invaders such as bacteria or viruses, but occasionally reacts to the patient's own body; lab tests may utilize reactions between antibodies and antigens to identify a substance in a patient specimen.
Anticoagulant	A drug that prevents clot formation within the blood vessels and dissolves any blood clot formed previously.
Antigen	Foreign bodies, such as bacteria, that enter the human body, or substances that form within the body, that cause an immune response, such as antibody production, and possibly infection; lab tests may utilize reactions between antibodies and antigens to identify a substance in a patient specimen.
Anus	External opening of the rectum where the gastrointestinal tract ends.
Arcus tendineus fascia pelvis (ATFP)	Also referred to as the white line, this is the attachment point for the pubocervical fascia to support the anterior walls of the vagina that have prolapsed; it is a thick band of the fascia over the obturator internus muscles running in an arching line from the pubis to the ischial spine.
Artificial insemination	The introduction of semen into the cervical canal, uterus, [BC1] or fallopian tube to achieve pregnancy without intercourse.
Aspirate	Small amount of cells or fluid from a cyst or mass.
Aspiration	Removal of fluid, gas, or other material through a tube attached to a suction device, often combined with irrigation, the instillation of fluid to clean a wound or to wash out a cavity such as the abdomen or stomach.
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	Any tissue from one part of the body moved to another location on the same patient; also known as an autologous graft.
Axilla	The space beneath the arm where it joins the body; also called the armpit or underarm.
Balloon catheter	A flexible tube with a balloon at the tip that can be inflated and deflated with a mechanism at the other end.
Bartholin's glands	Glands which are located on each of the labia, the vaginal lips, near the opening of the vagina. A Bartholin's cyst is a small, fluid filled, sac like growth that forms on the Bartholin's gland. The cysts commonly occur during puberty until menopause.
Baseline fetal heart rate, or FHR	The pattern of fetal heart rate between uterine contractions.
Baseline variability	Fluctuations in the fetal heart rate.
Bilateral	On two sides; opposite of unilateral.
Bimanual pelvic exam	Insertion of two fingers into the vagina to isolate the cervix.
Biophysical profile, BPP	A prenatal test that combines an ultrasound test to measure the breathing and movement of the fetus, and the volume of amniotic fluid, with monitoring of the heart rate, known as a non stress test.
Biopsy	To remove a portion or the entirety of suspicious tissue for pathologic examination; types of biopsies include excisional, incisional, punch, needle, open.
Bipolar forceps	Instruments that a provider uses to coagulate, or make solid tissue by means of an electrical current, which he fires trough the tips of the forceps.
Bladder	An organ in the body located just above the uterus which holds urine and changes size based on the amount of urine present.
Blunt dissection	Separation of tissue layers using the fingers; sharp dissection separates tissue layers using a blade.
Brachytherapy	A form of radiotherapy where a radiation source is placed inside or next to the area requiring treatment.
Breast localization device	Small devices used to mark the location of a breast abnormality to make it easier for the provider to find the target area during biopsy.

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