Current Procedural Coding Expert

CPT® codes with Medicare essentials for enhanced accuracy

2023
<table>
<thead>
<tr>
<th>Contents</th>
<th>Current Procedural Coding Expert</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pathology and Laboratory ................................................. 357</td>
<td>Appendix J — Inpatient-Only Procedures ........................................ 711</td>
</tr>
<tr>
<td>Medicine ........................................................................ 453</td>
<td>Appendix K — Place of Service and Type of Service ..................... 719</td>
</tr>
<tr>
<td>Evaluation and Management Services Guidelines ....................... 535</td>
<td>Appendix L — Multianalyte Assays with Algorithmic Analyses ........ 723</td>
</tr>
<tr>
<td>Evaluation and Management ................................................ 544</td>
<td>Appendix M — Glossary ................................................................. 739</td>
</tr>
<tr>
<td>Category II Codes .................................................................. 567</td>
<td>Appendix N — Listing of Sensory, Motor, and Mixed Nerves .......... 751</td>
</tr>
<tr>
<td>Category III Codes ............................................................... 583</td>
<td>Motor Nerves Assigned to Codes 95907–95913 .......................... 751</td>
</tr>
<tr>
<td>Appendix A — Modifiers ........................................................ 609</td>
<td>Sensory and Mixed Nerves Assigned to Codes 95907–95913 ............ 752</td>
</tr>
<tr>
<td>CPT Modifiers ................................................. 609</td>
<td>Appendix O — Vascular Families .................................................. 753</td>
</tr>
<tr>
<td>Modifiers Approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use .................................................. 611</td>
<td>Arterial Vascular Family ......................................................... 753</td>
</tr>
<tr>
<td>Appendix B — New, Revised, and Deleted Codes ....................... 615</td>
<td>Venous Vascular Family .......................................................... 755</td>
</tr>
<tr>
<td>New Codes ........................................................................ 615</td>
<td>Appendix P — Interventional Radiology Illustrations .................. 757</td>
</tr>
<tr>
<td>Revised Codes .................................................................... 621</td>
<td>Internal Carotid and Vertebral Arterial Anatomy ......................... 757</td>
</tr>
<tr>
<td>Deleted Codes .................................................................... 625</td>
<td>Cerebral Venous Anatomy ......................................................... 758</td>
</tr>
<tr>
<td>Resequenced Icon Added ...................................................... 625</td>
<td>Normal Aortic Arch and Branch Anatomy—Transfemoral Approach ...... 759</td>
</tr>
<tr>
<td>Web Release New, Revised, and Deleted Codes ......................... 625</td>
<td>Superior and Inferior Mesenteric Arteries and Branches ............... 760</td>
</tr>
<tr>
<td>Appendix C — Evaluation and Management Extended Guidelines ........ 627</td>
<td>Renal Artery Anatomy—Femoral Approach .................................... 761</td>
</tr>
<tr>
<td>Appendix D — Crosswalk of Deleted Codes ............................ 643</td>
<td>Central Venous Anatomy ........................................................... 762</td>
</tr>
<tr>
<td>Appendix E — Resequenced Codes .......................................... 645</td>
<td>Portal System (Arterial) ............................................................. 763</td>
</tr>
<tr>
<td>Appendix F — Add-on Codes, Optum Modifier 50 Exempt, Modifier 51 Exempt, Optum Modifier 51 Exempt, Modifier 63 Exempt, and Modifier 95 Telemedicine Services .................................................. 651</td>
<td>Portal System (Venous) .............................................................. 764</td>
</tr>
<tr>
<td>Add-on Codes ............................................................. 651</td>
<td>Pulmonary Artery Angiography ................................................. 765</td>
</tr>
<tr>
<td>Optum Modifier 50 Exempt Codes ........................................ 651</td>
<td>Upper Extremity Arterial Anatomy—Transfemoral or Contralateral Approach .................................................. 766</td>
</tr>
<tr>
<td>AMA Modifier 51 Exempt Codes ........................................ 651</td>
<td>Lower Extremity Arterial Anatomy—Contralateral, Axillary or Brachial Approach .................................................. 767</td>
</tr>
<tr>
<td>Optum Modifier 51 Exempt Codes ........................................ 651</td>
<td>Lower Extremity Venous Anatomy .............................................. 768</td>
</tr>
<tr>
<td>Modifier 63 Exempt Codes ............................................... 651</td>
<td>Coronary Arteries Anterior View .............................................. 769</td>
</tr>
<tr>
<td>Telemedicine Services Codes ............................................. 652</td>
<td>Left Heart Catheterization ....................................................... 769</td>
</tr>
<tr>
<td>Appendix G — Medicare Internet-only Manuals (IOMs) ............. 653</td>
<td>Right Heart Catheterization ..................................................... 770</td>
</tr>
<tr>
<td>Appendix H — Quality Payment Program .............................. 655</td>
<td>Heart Conduction System ......................................................... 770</td>
</tr>
<tr>
<td>Proposed 2022/2023 Changes ................................................ 655</td>
<td>Appendix Q — Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) Vaccine and Administration Codes .................................. 771</td>
</tr>
<tr>
<td>Appendix I — Medically Unlikely Edits (MUEs) ..................... 657</td>
<td>Appendix R — Digital Medicine Services ................................. 773</td>
</tr>
</tbody>
</table>
| Practitioner OPPS .................................................. 657 | OPPS 2021 American Medical Association. All Rights Reserved. 2021 Optum360, LLC
Introduction

Welcome to Optum360’s Current Procedural Coding Expert, an exciting Medicare coding and reimbursement tool and definitive procedure coding source that combines the work of the Centers for Medicare and Medicaid Services (CMS), American Medical Association (AMA), and Optum360 experts with the technical components you need for proper reimbursement and coding accuracy. Handy snap in tabs are included to indicate those sections used most often for easy reference.

This approach to CPT® Medicare coding utilizes innovative and intuitive ways of communicating the information you need to code claims accurately and efficiently. Includes and Excludes notes, similar to those found in the ICD-10-CM manual, help determine what services are related to the codes you are reporting. Icons help you crosswalk the codes you are reporting to laboratory and radiology procedures necessary for proper reimbursement. CMS-mandated icons and relative value units (RVUs) help you determine which codes are most appropriate for the service you are reporting. Add to that additional information identifying age and sex edits, ambulatory surgery center (ASC) and ambulatory payment classification (APC) indicators, and Medicare coverage and payment rule citations, and Current Procedural Coding Expert provides the best in Medicare procedure reporting.

Current Procedural Coding Expert includes the information needed to submit claims to federal contractors and most commercial payers, and is correct at the time of printing. However, CMS, federal contractors, and commercial payers may change payment rules at any time throughout the year. Current Procedural Coding Expert includes effective codes that will not be published in the AMA’s Current Procedural Terminology (CPT) book until the following year. Commercial payers will announce changes through monthly news or information posted on their websites. CMS will post changes in policy on its website at http://www.cms.gov/transmittals. Monthly news or information posted on their websites. CMS will post changes in policy on its website at http://www.cms.gov/transmittals.


Note: The AMA releases code changes quarterly as well as errata or corrections to CPT codes and guidelines and posts them on their website. Some of these changes may not appear in the AMA’s CPT book until the following year. Current Procedural Coding Expert incorporates the most recent errata or release notes found on the AMA’s website at the time of publication, including new, revised, and deleted codes. Current Procedural Coding Expert identifies these new or revised codes from the AMA website errata or release notes with an icon similar to the AMA’s current new ▲ and revised ▲ icons. For purposes of this publication, new CPT codes and revisions that won’t be in the AMA book until the next edition are indicated with a ● and a ◆ icon. CPT codes that are new or revised during 2021 but do not appear in the AMA’s CPT code book until 2022 are identified in appendix B as “Web Release New, Revised, and Deleted Codes.” For the next year’s edition of Current Procedural Coding Expert, these codes will appear with standard black new or revised icons, as appropriate, to correspond with those changes as indicated in the AMA’s CPT book.

General Conventions

Many of the sources of information in this book can be determined by color. All CPT codes and descriptions and the Evaluation and Management guidelines from the American Medical Association are in black text. Includes, Excludes, and other notes appear in blue text. The resources used for this information are a variety of Medicare policy manuals, the National Correct Coding Initiative Policy Manual (NCCI), AMA resources and guidelines, and specialty association resources and our Optum360 clinical experts.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a numbering methodology of resequencing, which is the practice of displaying codes outside of their numerical order according to the description relationship. According to the AMA, there are instances in which a new code is needed within an existing grouping of codes, but an unused code number is not available. In these situations, the AMA will resequence the codes. In other words, it will assign a code that is not in numeric sequence with the related code.

An example of resequencing from Current Procedural Coding Expert follows:

21555 Excision, tumor, soft tissue of neck or anterior thorax, subcutaneous; less than 3 cm

# 21552 3 cm or greater

21556 Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm

# 21554 5 cm or greater
27332  Arthrotomy, with excision of semilunar cartilage (meniscectomy) knee; medial OR lateral

27333  medial AND lateral

27334  Arthrotomy, with synovectomy, knee; anterior OR posterior

27335  anterior AND posterior including popliteal area.

27337  Resequenced code. See code following 27337.

27339  Resequenced code. See code before 27339.

27340  Excision, prepatellar bursa

27345  Excision of synovial cyst of popliteal space (eg, Baker’s cyst)

27347  Excision of lesion of meniscal or capsule (eg, cyst, ganglion), knee

27350  Patellectomy or hemipatellectomy

27355  Excision or curettage of bone cyst or benign tumor of femur;

27356  with allograft

27357  with autograft (includes obtaining graft)

27358  with internal fixation (List in addition to code for primary procedure)

27360  Partial excision (craterization, saucерization, or diaphyseotomy) bone, femur, proximal tibia and/or fibula (eg, osteomyelitis or bone abscess)

27364  5 cm or greater

27365  Radical resection of tumor, femur or knee

27369  Injection for Arthrogram of Knee

27372  Removal of foreign body, deep, thigh region or knee area

27380-27499  Repair/Reconstruction of Femur or Knee

27385  Suture of quadriceps or hamstring muscle rupture; primary
Cardiovascular, Hemic, and Lymphatic

### 33335

**with cardiopulmonary bypass**

- **AMA:** 2018, Jan 11; 2017, Dec 3

### 33340 Closure Left Atrial Appendage

**Cardiac catheterization except for reasons other than closure left atrial appendage** (93451-93453, 93456, 93458-93461, 93662, 93593-93598)

Code also intracardiac echocardiography, if performed (93662)

Code also transvascular ventricular support, when performed:
- Balloon pump (33367, 33968, 33970-33974)
- Extracorporeal membrane oxygenation (ECMO)/extracorporeal life support (ECLS) (33946-33949)
- Ventricular assist device (33975-33983, 33995, 33990-33993 [33997])

### 33340 Percutaneous transcatheter closure of the left atrial appendage with endocardial implant, including fluoroscopy, transseptal puncture, catheter placement(s), left atrial angiography, left atrial appendage angiography, when performed, and radiological supervision and interpretation

- **AMA:** 2018, Jan 8; 2017, Jul 13

### 33361-33369 Transcatheter Aortic Valve Replacement

**CMS:** 100-04, 20.32 Transcatheter Aortic Valve Replacement (TAVR); 100-04.32, 200.4 Payment of TAVR for MA Plan Participants

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
</table>
| Access and implantation aortic valve | 33361-33366 | Access sheath placement, advancement valve delivery system, arteriotomy closure, balloon aortic valvuloplasty, cardiac or open arterial approach, deployment of valve, percutaneous access, radiology procedures:
| Angiography during and after procedure | 33361-33366 | Assessment access site for closure, documentation intervention completion, guidance for valve placement, supervision and interpretation, temporary pacemaker, valve repositioning when necessary |
| Percutaneous coronary interventional procedures | 33361-33366 | Cardiac catheterization procedures included in TAVR/TAVI service (33367-33967, 33968-33969, 33976) |
| Percutaneous coronary interventional procedures | 33361-33366 | Code also cardia catheterization services for purposes other than TAVR/TAVI |
| Cardiac catheterization and coronary angiography at a different session from interventional procedure | 33361-33366 | Code also diagnostic coronary angiography at different session from interventional procedure |
| Cardiac catheterization and coronary angiography at the same time as TAVR/TAVI | 33361-33366 | Previous study available, but documentation shows patient’s condition has changed since previous study, visualization angiography is not adequate, or change occurs during procedure warranting additional evaluation outside current target area |
| No previous catheter-based coronary angiography study available and full diagnostic study performed, with decision to perform intervention based on that study | 33361-33366 | Code also modifier 59 when diagnostic coronary angiography procedures performed as separate and distinct procedural sessions on the same day or session as TAVR/TAVI |
| Balloon pump (33976, 33970, 33973) | 33361-33366 | Ventricular assist device (33975-33976, 33995, 33990-33993 [33997]) |

### 33361 Transcatheter aortic valve replacement (TAVR/TAVI) with prosthetic valve; percutaneous femoral artery approach

- **Code also cardiopulmonary bypass when performed** (33367-33369)

- **AMA:** 2018, Jan 8; 2017, Jan 8; 2016, Jan 13

### 33362 Open femoral artery approach

- **Code also cardiopulmonary bypass when performed** (33367-33369)

- **AMA:** 2018, Jan 8; 2017, Dec 3; 2017, Jan 8; 2016, Jan 13

### 33363 Open axillary artery approach

- **Code also cardiopulmonary bypass when performed** (33367-33369)

- **AMA:** 2018, Jan 8; 2017, Dec 3; 2017, Jan 8; 2016, Jan 13

### 33364 Open iliac artery approach

- **Code also cardiopulmonary bypass when performed** (33367-33369)

- **AMA:** 2018, Jan 8; 2017, Dec 3; 2017, Jan 8; 2016, Jan 13

### 33365 Transaortic approach (eg, median sternotomy, mediastinotomy)

- **Code also cardiopulmonary bypass when performed** (33367-33369)

- **AMA:** 2018, Jan 8; 2017, Jan 8; 2016, Jan 13

### 33366 Transapical approach (eg, left thoracotomy)

- **Code also cardiopulmonary bypass when performed** (33367-33369)

- **AMA:** 2018, Jan 8; 2017, Jan 8; 2016, Jan 13

### 33367 Cardiopulmonary bypass support with percutaneous peripheral arterial and venous cannulation (eg, femoral vessels)

- **Code first** (33361-33366, 33418, 33477, 0483T-0484T, 0544T, 0545T, [0643T], 0569T, 0570T, 0644T)

- **AMA:** 2018, Jan 8; 2017, Jan 8; 2016, Mar 5; 2016, Jan 13

### 33369 Cardiopulmonary bypass support with percutaneous or open arterial and venous cannulation (eg, femoral, iliac, axillary vessels)

- **Code first** (33361-33366, 33418, 33477, 0483T-0484T, 0544T, 0545T, [0643T], 0569T, 0570T, 0644T)

- **AMA:** 2018, Jan 8; 2017, Jan 8; 2016, Mar 5; 2016, Jan 13

### 33370 Cardiopulmonary bypass support with percutaneous or open arteriovenous cannulation (33367-33369)

- **Code first** (33361-33366, 33418, 33477, 0483T-0484T, 0544T, 0545T, [0643T], 0569T, 0570T, 0644T)

- **AMA:** 2018, Jan 8; 2017, Jan 8; 2016, Mar 5; 2016, Jan 13

### 33370 Cardiopulmonary bypass support with percutaneous or open arterial and venous cannulation (33367-33369)

- **Code first** (33361-33366, 33418, 33477, 0483T-0484T, 0544T, 0545T, [0643T], 0569T, 0570T, 0644T)

- **AMA:** 2018, Jan 8; 2017, Jan 8; 2016, Mar 5; 2016, Jan 13

### 33370 Cerebral Embolic Protection Device

- **Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging, and radiological supervision and interpretation, percutaneous (List separately in addition to code for primary procedure)**

- **Code first** (75710, 75720)

- **AMA:** 2018, Jan 8; 2017, Jan 8; 2016, Jan 13

### 33370 Transcatheter placement and subsequent removal of cerebral embolic protection device(s), including arterial access, catheterization, imaging, and radiological supervision and interpretation, percutaneous (List separately in addition to code for primary procedure)**

- **Code first** (75710, 75720)

- **AMA:** 2018, Jan 8; 2017, Jan 8; 2016, Jan 13
62368 with reprogramming

Maintenance and refilling infusion pumps for CNS drug therapy (95990-95999)

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

62369 with reprogramming and refill

Maintenance and refilling infusion pumps for CNS drug therapy (95990-95999)

AMA: 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

62370 with reprogramming and refill (requiring skill of a physician or other qualified health care professional)

Maintenance and refilling infusion pumps for CNS drug therapy (95990-95999)

AMA: 2018,Jan,8; 2017,Jan,8; 2016,Jan,13

62380 Endoscopic Decompression/Laminectomy/Laminotomy

Open decompression (63030, 63056)

Percutaneous decompression (62287, 0274T, 0275T)

62380 Endoscopic decompression of spinal cord, nerve root(s), including laminotomy, partial facetectomy, foraminotomy, discosectomy and/or excision of herniated intervertebral disc, 1 interspace, lumbar

AMA: 2018,Jan,8; 2017,Feb,12

63001-63053 [63052, 63053] Posterior Midline Approach: Laminectomy/Laminotomy/Decompression

Endoscopic assistance through open and direct visualization Arthrodesis (22590-22614)

Percutaneous decompression (62287, 0274T, 0275T)

63001 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discosectomy (eg, spinal stenosis), 1 or 2 vertebral segments; cervical

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63003 thoracic

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63005 lumbar, except for spondylolisthesis

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63011 cervical

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63012 Laminectomy with removal of abnormal facets and/or pars interarticularis with decompression of cauda equina and nerve roots for spondylolisthesis, lumbar (Gill type procedure)

AMA: 2019,Jan,8; 2018,Jan,8; 2017,Mar,7; 2017,Feb,9; 2017,Jan,8; 2016,Jan,13

63015 Laminectomy with exploration and/or decompression of spinal cord and/or cauda equina, without facetectomy, foraminotomy or discosectomy (eg, spinal stenosis), more than 2 vertebral segments; cervical

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63016 thoracic

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63017 lumbar

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Feb,9; 2017,Jan,8; 2016,Jan,13

63020 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63030 1 interspace, lumbar

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63035 each additional interspace, cervical or lumbar (List separately in addition to code for primary procedure)

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63040 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; reexploration, single interspace; cervical

AMA: 2020,May,13; 2019,Nov,14; 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,May,13; 2016,Jan,13

63042 lumbar

AMA: 2020,May,13; 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

Code first (63020-63030)

AMA: 2018,Jan,8; 2017,Feb,9; 2017,Jan,8; 2016,Jan,13

63044 Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; reexploration, multiple interspace; cervical

AMA: 2020,May,13; 2019,Nov,14; 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

Preparation of interspace (22630, 22633) Reporting with modifier 50. Report once for each side when performed bilaterally

63081 Nervous System

Maintenance and refilling infusion pumps for CNS drug therapy (95990-95999)

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63081 non-FDA drug

Maintenance and refilling infusion pumps for CNS drug therapy (95990-95999)

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63081 telemedicine

Maintenance and refilling infusion pumps for CNS drug therapy (95990-95999)

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63081 maternity

Maintenance and refilling infusion pumps for CNS drug therapy (95990-95999)

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63081 age edit

Maintenance and refilling infusion pumps for CNS drug therapy (95990-95999)

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63081 non-FDA drug

Maintenance and refilling infusion pumps for CNS drug therapy (95990-95999)

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63081 telemedicine

Maintenance and refilling infusion pumps for CNS drug therapy (95990-95999)

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63081 maternity

Maintenance and refilling infusion pumps for CNS drug therapy (95990-95999)

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63081 age edit

Maintenance and refilling infusion pumps for CNS drug therapy (95990-95999)

AMA: 2018,Jan,8; 2017,Mar,7; 2017,Jan,8; 2016,Jan,13

63081 non-FDA drug
Influenza virus vaccine, quadrivalent (IVV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use

Afluria Quadrivalent

Fluarix Quadrivalent

Flulaval Quadrivalent

Fluzone Quadrivalent

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90677

Resequenced code. See code following 90670.

90675

Influenza virus vaccine, quadrivalent (IVV4), inactivated, 0.5 mL dosage, for intramuscular use

Fluzone Quadrivalent

Fluvax Quadrivalent

Fluzone Quadrivalent

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90680

Influenza virus vaccine, quadrivalent (IVV4), split virus, 0.5 mL dosage, for intramuscular use

Fluvax Quadrivalent

Fluzone Quadrivalent

Fluzone Quadrivalent

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90681

Influenza virus vaccine, quadrivalent (IVV4), split virus, adjuvanted, for intramuscular use

Fluzone Quadrivalent

Fluzone Quadrivalent

Fluzone Quadrivalent

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90682

Influenza virus vaccine, quadrivalent (IVV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use

Fluzone Quadrivalent

Fluzone Quadrivalent

Fluzone Quadrivalent

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90683

Influenza virus vaccine, quadrivalent (IVV4), 0.5 mL dosage, for intramuscular use

Fluzone Quadrivalent

Fluzone Quadrivalent

Fluzone Quadrivalent

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90684

Influenza virus vaccine, quadrivalent (IVV4), 0.25 mL dosage, for intramuscular use

Fluzone Quadrivalent

Fluzone Quadrivalent

Fluzone Quadrivalent

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90694

Resequenced code. See code following 90671.

90698

Rabies vaccine, for intradermal use

RabAvert

RabAvert

RabAvert

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90699

Typhoid vaccine, live, oral

Vivotif

Vivotif

Vivotif

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90700

Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use

Prevnar 13

Prevnar 13

Prevnar 13

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90701

Resequenced code. See code following 90686.

90704

Resequenced code. See code following 90660.

90706

Influenza virus vaccine, quadrivalent (IVV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for oral use

Afluria Quadrivalent

Fluarix Quadrivalent

Flulaval Quadrivalent

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90707

Resequenced code. See code following 90660.

90711

Pneumococcal conjugate vaccine, 15 valent (PCV15), for intramuscular use

Prevnar 13

Prevnar 13

Prevnar 13

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90721

Resequenced code. See code following 90670.

90724

Resequenced code. See code following 90660.

90750

Influenza virus vaccine, quadrivalent (IVV4), split virus, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use

Afluria Quadrivalent

Fluarix Quadrivalent

Flulaval Quadrivalent

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90770

Resequenced code. See code following 90671.

90773

Resequenced code. See code before 90662.

90774

Resequenced code. See code following 90661.

90777

Resequenced code. See code following 90671.

90780

Rotavirus vaccine, pentavalent (RV5), 3 dose schedule, live, for oral use

RotaTeq

RotaTeq

RotaTeq

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90781

Rotavirus vaccine, human, attenuated (RV1), 2 dose schedule, live, for oral use

Rotarix

Rotarix

Rotarix

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90782

Influenza virus vaccine, quadrivalent (IVV4), derived from recombinant DNA, hemagglutinin (HA) protein only, preservative and antibiotic free, for intramuscular use

Flublok Quadrivalent

Flublok Quadrivalent

Flublok Quadrivalent

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90785

Influenza virus vaccine, quadrivalent (IVV4), split virus, preservative free, 0.25 mL, for intramuscular use

Afluria Quadrivalent

Fluarix Quadrivalent

Flulaval Quadrivalent

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90788

Influenza virus vaccine, quadrivalent (IVV4), split virus, 0.25 mL dosage, for intramuscular use

Afluria Quadrivalent

Fluarix Quadrivalent

Flulaval Quadrivalent

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90790

Typhoid vaccine, Vi capsular polysaccharide (VICP), for intramuscular use

Typhim Vi

Typhim Vi

Typhim Vi

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90794

Resequenced code. See code following 90689.

90796

Diphtheria, tetanus toxoids, acellular pertussis vaccine and inactivated poliovirus vaccine (DTaP-IPV), when administered to children 4 through 6 years of age, for intramuscular use

KINRIX Quadracel

KINRIX Quadracel

KINRIX Quadracel

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan

90797

Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HeP8), for intramuscular use

0.00  0.00  0.00  0.00

AMA: 2020, Dec; 2020, Nov; 2019, Jul; 2018, Jan; 2017, Jan
Appendix A — Modifiers

CPT Modifiers
A modifier is a two-position alpha or numeric code appended to a CPT® code to clarify the services being billed. Modifiers provide a means by which a service can be altered without changing the procedure code. They add more information, such as the anatomical site, to the code. In addition, they help to eliminate the appearance of duplicate billing and unbundling. Modifiers are used to increase accuracy in reimbursement, coding consistency, editing, and to capture payment data.

22 Increased Procedural Services: When the work required to provide a service is substantially greater than typically required, it may be identified by adding modifier 22 to the usual procedure code. Documentation must support the substantial additional work and the reason for the additional work (e.g., increased intensity, time, technical difficulty of procedure, severity of patient’s condition, physical and mental effort required).

Note: This modifier should not be appended to an E/M service.

23 Unusual Anesthesia: Occasionally, a procedure, which usually requires either no anesthesia or local anesthesia, because of unusual circumstances must be done under general anesthesia. This circumstance may be reported by adding modifier 23 to the procedure code of the basic service.

24 Unrelated Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional During a Postoperative Period: The physician or other qualified health care professional may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the usual procedure number.

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: It may be necessary to indicate that on the day a procedure or service identified by a CPT code was performed, the patient’s condition required a significant, separately identifiable E/M service above and beyond the other services provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. A significant, separately identifiable E/M service is defined or substantiated by documentation that satisfies the relevant criteria for the respective E/M service to be reported (see Evaluation and Management Services Guidelines for instructions on determining level of E/M service). The E/M service may be prompted by the symptom or condition for which the procedure and/or service was provided. As such, different diagnoses are not required for reporting of the E/M service on the same date. This circumstance may be reported by adding modifier 25 to the appropriate level of E/M service.

Note: This modifier is not used to report an E/M service that resulted in a decision to perform surgery. See modifier 57.

26 Professional Component: Certain procedures are a combination of a physician or other qualified health care professional component and a technical component. When the physician or other qualified health care professional component is reported separately, the service may be identified by adding modifier 26 to the usual procedure number.

32 Mandated Services: Services related to mandated consultation and/or related services (e.g., third party payer, governmental, legislative or regulatory requirement) may be identified by adding modifier 32 to the basic procedure.

33 Preventive Services: When the primary purpose of the service is the delivery of an evidence based service in accordance with a US Preventive Services Task Force A or B rating in effect and other preventive services identified in preventive services mandates (legislative or regulatory), the service may be identified by adding 33 to the procedure. For separately reported services specifically identified as preventive, the modifier should not be used.

47 Anesthesia by Surgeon: Regional or general anesthesia provided by the surgeon may be reported by adding modifier 47 to the basic service. (This does not include local anesthesia.)

Note: Modifier 47 would not be used as a modifier for the anesthesia procedures.

50 Bilateral Procedure: Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code.

Note: This modifier should not be appended to designated “add-on” codes (see Appendix F).

51 Multiple Procedures: When multiple procedures, other than E/M services, Physical Medicine and Rehabilitation services or provision of supplies (e.g., vaccine), are performed at the same session, for the same individual, the primary procedure or service may be reported as listed. The additional procedure(s) or service(s) may be identified by appending modifier 51 to the additional procedure or service code(s).

Note: This modifier should not be appended to designated “add-on” codes (see Appendix F).

52 Reduced Services: Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician, other qualified health care professional. Under these circumstances, the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service.

Note: For hospital outpatient reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

53 Discontinued Procedure: Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure.

Note: This modifier is not used to report the elective cancellation of a procedure prior to the patient’s anesthesia induction and/or surgical preparation in the operating suite. For outpatient hospital/ambulatory surgery center (ASC) reporting of a previously scheduled procedure/service that is partially reduced or cancelled as a result of extenuating circumstances or those that threaten the well-being of the patient prior to or after administration of anesthesia, see modifiers 73 and 74 (see modifiers approved for ASC hospital outpatient use).

54 Surgical Care Only: When 1 physician or other qualified health care professional performs a surgical procedure and another provides preoperative and/or postoperative management, surgical services may be identified by adding modifier 54 to the usual procedure number.

55 Postoperative Management Only: When 1 physician or other qualified health care professional performed the postoperative management and another performed the surgical procedure, the postoperative component may be identified by adding modifier 55 to the usual procedure number.

56 Preoperative Management Only: When 1 physician or other qualified health care professional performed the preoperative care and evaluation and another performed the surgical procedure, the preoperative component may be identified by adding modifier 56 to the usual procedure number.

57 Decision for Surgery: An evaluation and management service that resulted in the initial decision to perform the surgery may be identified by adding modifier 57 to the appropriate level of E/M service.
Appendix C — Evaluation and Management Extended Guidelines

This appendix provides an overview of evaluation and management (E/M) services, tables that identify the documentation elements associated with each code, the 2021 changes to some E/M services, and the federal documentation guidelines with emphasis on the 1997 exam guidelines. The 1997 version identifies both general multi-system physical examinations and single-system examinations, but providers may also use the original 1995 version of the E/M guidelines; both are currently supported by the Centers for Medicare and Medicaid Services (CMS) for audit purposes when reporting 99217–99499.

The levels of E/M services define the wide variations in skill, effort, and time and are required for preventing and/or diagnosing and treating illness or injury, and promoting optimal health. These codes are intended to represent physician work, and because much of this work involves the amount of training, experience, expertise, and knowledge that a provider may employ when treating a given patient, the true indications of the level of this work may be difficult to recognize without some explanation.

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, the service or procedure itself is not limited to use only by that specialty group (see paragraphs 2 and 3 under “Instructions for Use of the CPT® Codebook” on page xiv of the AMA CPT book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies).

The use of the phrase “physician or other qualified health care professional” (OQHCP) was adopted to identify a health care provider other than a physician. This type of provider is further described in CPT as an individual “qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable).” State licensure guidelines determine the scope of practice and an OQHCP must practice within these guidelines, even if more restrictive than the CPT guidelines. The OQHCP may report services independently or under incident-to guidelines. The professionals within this definition are separate from “clinical staff” and are able to practice independently. CPT defines clinical staff as “a person who works under the supervision of a physician or OQHCP and who is authorized, by law, regulation, and facility policy to perform or assist in the performance of a specified professional service, but who does not individually report that professional service. Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Types of E/M Services

When approaching E/M, the first choice that a provider must make is what type of code to use. The following tables outline the E/M codes for different levels of care for:

- Office or other outpatient services—new patient
- Office or other outpatient services—established patient
- Hospital observation services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient
- Emergency department services
- Critical care
- Nursing facility—initial services
- Nursing facility—subsequent services
- Nursing facility—discharge and annual assessment
- Domiciliary, rest home, or custodial care—new patient
- Domiciliary, rest home, or custodial care—established patient
- Home services—new patient
- Home services—established patient
- Neonatal and pediatric critical care—inpatient
- Neonate and infant intensive care services—initial and continuing
- Care management
- Newborn care services
- Neonatal and pediatric interfacility transport
- Neonatal and pediatric critical care—subsequent services
- Critical care
- Emergency department services
- Consultations—inpatient
- Hospital observation services—initial care, subsequent, and discharge
- Observation or inpatient care (including admission and discharge services)
- Consultations—office or other outpatient
- Consultations—inpatient
- Emergency department services
- Critical care
- Nursing facility—initial services
- Nursing facility—subsequent services
- Nursing facility—discharge and annual assessment
- Domiciliary, rest home, or custodial care—new patient
- Domiciliary, rest home, or custodial care—established patient
- Home services—new patient
- Home services—established patient

The specifics of the code components that determine code selection are listed in the table and discussed in the next section. Before a level of service is decided upon, the correct type of service is identified.

A new patient is a patient who has not received any face-to-face professional services from the physician or OQHCP within the past three years. An established patient is a patient who has received face-to-face professional services from the physician or OQHCP within the past three years. In the case of group practice, if a physician or OQHCP of the exact same specialty or subspecialty has seen the patient within three years, the patient is considered established.

If a physician or OQHCP is on call or covering for another physician or OQHCP, the patient encounter is classified as “would have been by the physician or OQHCP if present is not available. Thus, a locum tenens physician or OQHCP who sees a patient on behalf of the patient’s attending physician or OQHCP may not bill a new patient code unless the attending physician or OQHCP has not seen the patient for any problem within three years.

Office or other outpatient services are E/M services provided in the physician or OQHCP office, the outpatient area, or other ambulatory facility. Until the patient is admitted to a health care facility, he/she is considered to be an outpatient. Hospital observation services are E/M services provided to patients who are designated or admitted as “observation status” in a hospital.

Codes 99318-99220 are used to indicate initial observation care. These codes include the initiation of the observation status, supervision of patient care including writing orders, and the performance of periodic reassessments. These codes are used only by the provider “admitting” the patient for observation.

Codes 99234-99236 are used to indicate evaluation and management services to a patient who is admitted to and discharged from observation status or hospital inpatient on the same day. If the patient is admitted as an inpatient from observation on the same day, use the appropriate level of Initial Hospital Care (99221-99223).

Code 99217 indicates discharge from observation status. It includes the final physical examination of the patient, instructions, and preparation of the discharge records. It should not be used when admission and discharge are on the same date of service. As mentioned above, report codes 99234-99236 to appropriately describe same day observation services.

If a patient is in observation longer than one day, subsequent observation care codes 99224-99226 should be reported. If the patient is discharged on the second day, observation discharge code 99217 should be reported. If the patient status is changed to inpatient on a subsequent date, the appropriate inpatient code, 99221-99223, should be reported.

Initial hospital care is defined as E/M services provided during the first hospital inpatient encounter with the patient by the admitting provider. (If a physician other than the admitting physician performs the initial inpatient encounter, refer to consultations or subsequent hospital care in the CPT book.) Subsequent hospital care includes all follow-up encounters with the patient by all physicians or OQHCP. As there may only be one admitting physician, HCPCS Level II modifier AI Principal physician of record, should be appended to the initial hospital care code by the attending physician or OQHCP.

A consultation is the provision of a physician or OQHCP’s opinion or advice about a patient for a specific problem at the request of another physician or appropriate source. CPT also states that a consultation may be performed when a physician or OQHCP is determining whether to accept the transfer of patient care at the request of another physician or