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Introduction

Welcome to Optum360’s *Current Procedural Coding Expert*, an exciting Medicare coding and reimbursement tool that definitive procedure coding source that combines the work of the Centers for Medicare and Medicaid Services, American Medical Association, 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 walk the code 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.


This differs from the AMA CPT book, in which the coder is directed to a code category that contains the resequenced code and description, rather than to a specific location. Resequenced codes will appear in brackets in the headers, section notes, and code ranges. For example:

```
# 21554 5 cm or greater
21556 Excision, tumor, soft tissue of neck or anterior thorax, subfascial (eg, intramuscular); less than 5 cm

In *Current Procedural Coding Expert* the resequenced codes are listed twice. They appear in their resequenced position as shown above as well as in their original numeric position with a note indicating that the code is out of numerical sequence and where it can be found. (See example below.)

```

Resequencing of CPT Codes

The American Medical Association (AMA) uses 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 resquence the codes. In other words, it assigns a code that is not in numeric sequence with the related codes. However, the code and description will appear in the CPT manual with the other related codes.

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, subcutaneous; less than 5 cm
# 21554 5 cm or greater

In *Current Procedural Coding Expert* the resequenced codes are listed twice. They appear in their resequenced position as shown above as well as in their original numeric position with a note indicating that the code is out of numerical sequence and where it can be found. (See example below.)

```

```
21554 Resequenced code. See code following 21556.

This differs from the AMA CPT book, in which the coder is directed to a code category that contains the resequenced code and description, rather than to a specific location. Resequenced codes will appear in brackets in the headers, section notes, and code ranges. For example:

```
Abdominal, Abdominal — continued
Excision — continued
Tumor, Abdominal Wall, 22900
Exploration, 49000-49084
Blood Vessel, 35840
Staging, 85960
Hernia Repair, 49419-49590, 49650-49659
Incision, 49000-49084
Staging, 85960
Incision and Drainage
Percutaneous, 48000
Intraabdominal, 85630
Intraperitoneal
Catheter Exit Site, 49436
Catheter Insertion, 49324, 49418-49421, 49425, 49435
Catheter Removal, 49422
Catheter Revision, 49325
Shunt
Insertion, 49425
Ligation, 49428
Removal, 49429
Revision, 49426
Laparoscopy, 49202-49239
Laparotomy
Expulsion, 47015, 49000-49020, 59890
Hemorrhage Control, 49002
Reopening, 49020
Second Look, 59860
Staging, 85960
with Biopsy, 49000
Lymphangiography, 75805, 75807
Magnetic Resonance Imaging (MRI), 74181-74183
Fetal, 74712-74713
Needle Biopsy
Mass, 49190
Percutaneous, 49800
Paracentesis, 49082-49083
Peritoneal Abscess, 49320
Peritoneal Lavage, 49084
Placement Guidance Devices, 49411-49412
Radical Resection, 49397
Repair
Blood Vessel, 35221
with Other Graft, 35281
Venous (Graft), 35361
Hernia, 49419-49590, 49650-49659
Suturing, 49600
Excision
Varicosity, 49426
Swelling, 49990
Tumor
Ligation, 49990
Lymphangiography, 76700, 76705, 76706
Lymphatic and Peritoneal Procedures, 49999
Wall
See Abdomen, X-ray
Debridement
Infected, 11005-11006
Implant
Fascial Reinforcement, 40373
Reconstruction, 49905
Removal
Mesh, 11108
Prosthesis, 11108
Repair
Hernia, 49419-49590
by Laparoscopy, 49650-49651
Spreading, 22999
Tumor
Excision, 22900-22905
Wound Exploration
Penetration, 20101
X-ray, 74018-74022
Abdominal Plane Block
Bilateral, 64488-64489
Unilateral, 64486-64487
Abdominal hysterectomy
Radical, 58210
Resection of Ovarian Malignancy, 58951, 58953-58954, 58956
Suprapelvic, 58180
Total, 58150, 58200
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15830, 15847, 17999
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Percutaneous, 48000
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Ablation
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78530
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75635
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Subphrenic
Open, 49060
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Excision
Excess Skin, 15830

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(Reindexed)
### Musculoskeletal System

#### 27500-27566 Treatment of Fracture/Dislocation of Femur/Knee

**27507** Open treatment of femoral shaft fracture with plate/screws, with or without cerclage
- **CPT Code**: 28.0
- **AMA**: 2018, Sep, 7

**27508** Closed treatment of femoral fracture, distal end, medial or lateral condyle, without manipulation
- **CPT Code**: 14.3
- **AMA**: 2018, Sep, 7

**27509** Percutaneous skeletal fixation of femoral fracture, distal end, medial or lateral condyle, or supracondylar or transcondylar, with or without intercondylar extension, or distal femoral epiphysisal separation
- **CPT Code**: 18.6
- **AMA**: 2018, Dec, 10; 2018, Dec, 10; 2018, Sep, 7

**27510** Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation
- **CPT Code**: 19.6
- **AMA**: 2018, Sep, 7

**27511** Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed
- **CPT Code**: 28.8
- **AMA**: 2018, Sep, 7

**27513** Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed
- **CPT Code**: 35.9
- **AMA**: 2018, Sep, 7

**27514** Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed
- **CPT Code**: 27.9
- **AMA**: 2018, Sep, 7

**27516** Closed treatment of distal femoral epiphysal separation; without manipulation
- **CPT Code**: 19.6
- **AMA**: 2018, Sep, 7

**27517** Open treatment of distal femoral epiphysal separation, includes internal fixation, when performed
- **CPT Code**: 25.7
- **AMA**: 2018, Sep, 7

**27520** Closed treatment of patellar fracture, without manipulation
- **CPT Code**: 8.54
- **AMA**: 2018, Sep, 7

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**27486** Revision of total knee arthroplasty, with or without allograft; 1 component
- **CPT Code**: 40.6
- **AMA**: 2018, Sep, 7; 2018, Apr, 10; 2018, Jan, 8; 2017, Jan, 8; 2016, Jan, 13; 2015, Jul, 10; 2015, Jan, 16

**27487** Femoral and entire tibial component
- **CPT Code**: 50.8
- **AMA**: 2018, Sep, 7; 2018, Jan, 8; 2017, Jan, 8; 2016, Jan, 13; 2015, Jan, 16

**27488** Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee
- **CPT Code**: 34.7
- **AMA**: 2018, Sep, 7; 2018, Jan, 8; 2017, Jan, 8; 2016, Jan, 13; 2015, Jan, 16

**27495** Prophylactic treatment (nailing, pinning, plating, or wiring) with or without methylmethacrylate, femur
- **CPT Code**: 32.5
- **AMA**: 2018, Sep, 7

**27496** Decompression fasciotomy, thigh and/or knee, 1 compartment (flexor or extensor or adductor);
- **CPT Code**: 15.7
- **AMA**: 2018, Sep, 7

**27497** with debridement of nonviable muscle and/or nerve
- **CPT Code**: 16.7
- **AMA**: 2018, Sep, 7

**27498** Decompression fasciotomy, thigh and/or knee, multiple compartments;
- **CPT Code**: 18.8
- **AMA**: 2018, Sep, 7

**27499** with debridement of nonviable muscle and/or nerve
- **CPT Code**: 20.2
- **AMA**: 2018, Sep, 7

---

**27485** Arrest, hemipiphysesal, distal femur or proximal tibia or fibula (eg, genu varus or valgus)
- **CPT Code**: 19.3
- **AMA**: 2018, Sep, 7

**27481** Femoral and entire tibial component
- **CPT Code**: 50.8
- **AMA**: 2018, Sep, 7; 2018, Jan, 8; 2017, Jan, 8; 2016, Jan, 13; 2015, Jan, 16

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51020-S1080 Open Incisional Procedures of Bladder

51020 Cystotomy or cystoscopy; with fulguration and/or insertion of radioactive material
13.5 13.5 13.5 FUD 090
AMA: 2014, Jan, 11

51030 with cryosurgical destruction of intravesical lesion
13.6 13.6 13.6 FUD 090
AMA: 2014, Jan, 11

51040 Cystotomy, cystoscopy with drainage
8.36 8.36 FUD 090
AMA: 2014, Jan, 11

51045 Cystotomy, with insertion of ureteral catheter or stent (separate procedure)
13.6 13.6 13.6 FUD 090
AMA: 2014, Jan, 11

51050 Cystolithotomy, cystotomy with removal of calculus, without vesical neck resection
13.6 13.6 13.6 FUD 090
AMA: 2014, Jan, 11

51060 Transvesical ureterolithotomy
16.8 16.8 16.8 FUD 090
AMA: 2014, Jan, 11

51065 Cystotomy, with calculus basket extraction and/or ultrasonic or electrohydraulic fragmentation of ureteral calculus
16.7 16.7 16.7 FUD 090
AMA: 2014, Jan, 11; 2002, May, 7

51080 Drainage of perivesical or prevesical space abscess
11.8 11.8 11.8 FUD 090
AMA: 2014, Jan, 11

51100-51102 Bladder Aspiration Procedures

51100 Aspiration of bladder; by needle
(76942, 77002, 77012)
1.12 1.95 FUD 000
AMA: 2018, Jan, 8; 2017, Jan, 8; 2016, Jan, 13; 2015, Jan, 16

51101 by trocar or intracatheter
(76942, 77002, 77012)
1.50 3.79 FUD 000
AMA: 2018, Jan, 8; 2017, Jan, 8; 2016, Jan, 13; 2015, Jan, 16

51102 with insertion of suprapubic catheter
(76942, 77002, 77012)
4.18 6.60 FUD 000
AMA: 2018, Jan, 8; 2017, Jan, 8; 2016, Jan, 13; 2015, Jan, 16

51500-51597 Open Excisional Procedures of Bladder

51500 Excision of urachal cyst or sinus, with or without umbilical hernia repair
18.4 18.4 FUD 090
AMA: 2014, Jan, 11

51520 Cystotomy; for simple excision of vesical neck (separate procedure)
17.2 17.2 FUD 090
AMA: 2014, Jan, 11

51525 for excision of bladder diverticulum, single or multiple (separate procedure)
Transurethral resection (52305)
FUD 090
AMA: 2014, Jan, 11

51530 for excision of bladder tumor
Transurethral resection (52234–52240, 52305)
22.5 22.5 FUD 090
AMA: 2014, Jan, 11

51535 Cystotomy for excision, incision, or repair of ureteroceles
Transurethral excision (52300)
22.5 22.5 FUD 090
AMA: 2014, Jan, 11; 1993, Sum, 25

51550 Cystectomy, partial; simple
27.9 27.9 FUD 090
AMA: 2014, Jan, 11

51555 for excision of urachal cyst or sinus, with or without umbilical hernia incision
36.6 36.6 FUD 090
AMA: 2014, Jan, 11

51565 Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy)
37.5 37.5 FUD 090
AMA: 2014, Jan, 11

51570 Cystectomy, complete; (separate procedure)
42.6 42.6 FUD 090
AMA: 2014, Jan, 11; 1993, Spr, 34

51575 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
52.7 52.7 FUD 090
AMA: 2014, Jan, 11; 1993, Spr, 34

51580 Cystectomy, complete, with ureratosigmoidostomy or ureterocutaneous transplantsations;
54.8 54.8 FUD 090
AMA: 2014, Jan, 11; 1993, Spr, 34

51585 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
61.0 61.0 FUD 090
AMA: 2014, Jan, 11; 1993, Spr, 34

51590 Cystectomy, complete, with ureterocutaneous conduit or sigmoid bladder, including intestine anastomosis;
55.9 55.9 FUD 090
AMA: 2014, Jan, 11; 2002, May, 7

51595 with bilateral pelvic lymphadenectomy, including external iliac, hypogastric, and obturator nodes
63.3 63.3 FUD 090
AMA: 2014, Jan, 11; 2002, May, 7

51596 Cystectomy, complete, with continent diversion, any open technique, using any segment of small and/or large intestine to construct neobladder
68.1 68.1 FUD 090
AMA: 2014, Jan, 11; 2002, May, 7
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 (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 unrelated to the original procedure. This circumstance may be reported by adding modifier 24 to the E/M service.

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 usual 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 services 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. For significant, separately identifiable non-E/M services, see modifier 59.

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 (eg, 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 modifier 33 to the procedure. For separately reported services statutorily 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 (eg, vaccines), are performed at the same session by 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 or 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 63 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.