Introduction

Current Procedural Terminology (CPT®), Fourth Edition, is a set of codes, descriptions, and guidelines intended to describe procedures and services performed by physicians and other health care professionals, or entities. Each procedure or service is identified with a five-digit code. The use of CPT codes simplifies the reporting of procedures and services. In the CPT code set, the term "procedure" is used to describe services, including diagnostic tests.

Inclusion of a descriptor and its associated five-digit code number in the CPT Category I code set is based on whether the procedure or service is consistent with contemporary medical practice and is performed by many practitioners in clinical practice in multiple locations. Inclusion in the CPT code set does not represent endorsement by the American Medical Association (AMA) of any particular diagnostic or therapeutic procedure or service. Inclusion or exclusion of a procedure or service does not imply any health insurance coverage or reimbursement policy.

The CPT code set is published annually in the late summer or early fall as both electronic data files and books. The release of CPT data files on the Internet typically precedes the book by several weeks. In any case, January 1 is the effective date for use of the update of the CPT code set. The interval between the release of the update and the effective date is considered the implementation period and is intended to allow physicians and other providers, payers, and vendors to incorporate CPT changes into their systems. The exceptions to this schedule of release and effective dates are CPT Category III and vaccine product codes, which are released twice a year on January 1 or July 1 with effective dates for use six months later, and CPT Category II codes. Changes to the CPT code set are meant to be applied prospectively from the effective date.

The main body of the Category I section is listed in six sections. Each section is divided into subsections with anatomic, procedural, condition, or descriptor subheadings. The procedures and services with their identifying codes are presented in numeric order with one exception—the entire **Evaluation and Management** section (99201-99499) appears at the beginning of the listed procedures. These items are used by most physicians in reporting a significant portion of their services.

Section Numbers and Their Sequences

Evaluation and Management 99201-99499

Anesthesiology............ 00100-01999, 99100-99140

Surgery.............................. 10021-69990

Radiology (Including Nuclear Medicine and Diagnostic Ultrasound) 70010-79999

Pathology and Laboratory.............. 80047-89398

Medicine (except Anesthesiology)....... 90281-99199, 99500-99607

The first and last code numbers and the subsection name of the items appear at the top margin of most pages (eg, "11010-11306 Surgery/Integumentary System"). The continuous pagination of the CPT codebook is found on the lower margin of each page along with explanation of any code symbols that are found on that page.

Instructions for Use of the CPT Codebook

Select the name of the procedure or service that accurately identifies the service performed. Do not select a CPT code that merely approximates the service provided. If no such specific code exists, then report the service using the appropriate unlisted procedure or service code. In surgery, it may be an operation; in medicine, a diagnostic or therapeutic procedure; in radiology, a radiograph. Other additional procedures performed or pertinent special services are also listed. When necessary, any modifying or extenuating circumstances are added. Any service or procedure should be adequately documented in the medical record.

It is equally important to recognize that as techniques in medicine and surgery have evolved, new types of services, including minimally invasive surgery, as well as endovascular, percutaneous, and endoscopic interventions have challenged the traditional distinction of Surgery vs Medicine. Thus, the listing of a service or procedure in a specific section of this book should not be interpreted as strictly classifying the service or procedure as "surgery" or "not surgery" for insurance or other purposes. The placement of a given service in a specific section of the book may reflect historical or other considerations (eg, placement of the percutaneous peripheral vascular endovascular interventions in the Surgery/Cardiovascular System section, while the percutaneous coronary interventions appear in the Medicine/Cardiovascular section).

When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the exact same specialty and exact same subspecialties as the physician. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed 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. Other policies may also affect who may report specific services.

Throughout the CPT code set the use of terms such as "physician," "qualified health care professional," or "individual" is not intended to indicate that other entities may not report the service. In selected instances, specific instructions may

Evaluation and Management (E/M) Services Guidelines

In addition to the information presented in the Introduction, several other items unique to this section are defined or identified here.

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories such as office visits, hospital visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes. This classification is important because the nature of work varies by type of service, place of service, and the patient's status.

The basic format of the levels of E/M services is the same for most categories. First, a unique code number is listed. Second, the place and/or type of service is specified, eg, office consultation. Third, the content of the service is defined, eg, comprehensive history and comprehensive examination. (See "Levels of E/M Services," page 6, for details on the content of E/M services.) Fourth, the nature of the presenting problem(s) usually associated with a given level is described. Fifth, the time typically required to provide the service is specified. (A detailed discussion of time is provided on page 7.)

Definitions of Commonly Used Terms

Certain key words and phrases are used throughout the E/M section. The following definitions are intended to reduce the potential for differing interpretations and to increase the consistency of reporting by physicians in differing specialties. E/M services may also be reported by other qualified health care professionals who are authorized to perform such services within the scope of their practice.

New and Established Patient

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services from the physician/qualified health care professional or another physician/qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree.

In the instance where a physician/qualified health care professional is on call for or covering for another physician/qualified health care professional, the patient's encounter will be classified as it would have been by the physician/qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians they are considered as working in the exact same specialty and exact same subspecialties as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The decision tree on page 5 is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

►(Do not report 97607, 97608 in conjunction with 97605, 97606)◄

97610 Low frequency, non-contact, non-thermal ultrasound, including topical application(s), when performed, wound assessment, and instruction(s) for ongoing care, per day

➲ *CPT Assistant* Jun 14:11; *CPT Changes: An Insider's View* 2014

Tests and Measurements

Requires direct one-on-one patient contact.

(For muscle testing, manual or electrical, joint range of motion, electromyography, or nerve velocity determination, see 95831-95857, 95860-95872, 95885-95887, 95907-95913)

97750 Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes

➲ *CPT Assistant* Summer 95:5, Feb 97:10, Aug 98:11, Mar 00:11, Nov 01:5, May 02:18, Apr 03:28, Dec 03:7, Feb 04:5, Feb 07:12, May 08:9, Aug 13:7

97755 Assistive technology assessment (eg, to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes

➲ *CPT Changes: An Insider's View* 2004, 2013

(To report augmentative and alternative communication devices, see 92605, 92607)

Orthotic Management and Prosthetic Management

97760 Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(s), lower extremity(s) and/or trunk, each 15 minutes

➲ *CPT Assistant* Dec 05:8, 11, Feb 07:8; *CPT Changes: An Insider's View* 2006

(Code 97760 should not be reported with 97116 for the same extremity)

97761 Prosthetic training, upper and/or lower extremity(s), each 15 minutes

➲ *CPT Assistant* Dec 05:8, 11, Feb 07:8; *CPT Changes: An Insider's View* 2006

97762 Checkout for orthotic/prosthetic use, established patient, each 15 minutes

➲ *CPT Assistant* Dec 05:8, 11, Feb 07:8; *CPT Changes: An Insider's View* 2006

Other Procedures

(For extracorporeal shock wave musculoskeletal therapy, see Category III codes 0019T, 0101T, 0102T)

97799 Unlisted physical medicine/rehabilitation service or procedure

➲ *CPT Assistant* Summer 95:5, Oct 99:10

Medical Nutrition Therapy

97802 Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes

➲ *CPT Assistant* Apr 03:10, Nov 03:1, Feb 09:13; *CPT Changes: An Insider's View* 2001

97803 re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes

➲ *CPT Assistant* Apr 03:10, Nov 03:1, Feb 09:13; *CPT Changes: An Insider's View* 2001

97804 group (2 or more individual(s)), each 30 minutes

➲ *CPT Assistant* Apr 03:10, Nov 03:1, Feb 09:13; *CPT Changes: An Insider's View* 2001

(Physicians and other qualified health care professionals who may report evaluation and management services should use the appropriate evaluation and management codes)

Acupuncture

Acupuncture is reported based on 15-minute increments of personal (face-to-face) contact with the patient, not the duration of acupuncture needle(s) placement.

If no electrical stimulation is used during a 15-minute increment, use 97810, 97811. If electrical stimulation of any needle is used during a 15-minute increment, use 97813, 97814.

Only one code may be reported for each 15-minute increment. Use either 97810 or 97813 for the initial 15-minute increment. Only one initial code is reported per day.

Evaluation and management services may be reported in addition to acupuncture procedures when performed by physicians or other health care professionals, who may report evaluation and management services, including new or established patient office or other outpatient services (99201-99215), hospital observation care (99217-99220, 99224-99226), hospital care (99221-99223, 99231-99233), office or other outpatient consultations (99241-99245), inpatient consultations (99251-99255), critical care services (99291, 99292), inpatient neonatal intensive care services and pediatric and neonatal critical care services (99466-99480), emergency department services (99281-99285), nursing facility services (99304-99318), domiciliary, rest home, or custodial care services (99324-99337), and home services (99341-99350) may be reported separately using modifier 25 if the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and postservice work associated with the acupuncture services. The time of the E/M service is not included in the time of the acupuncture service.

(For manipulation under general anesthesia, see appropriate anatomic section in **Musculoskeletal System**)

(For osteopathic manipulative treatment [OMT], see 98925-98929)

►(Do not report 97150 in conjunction with 0366T, 0367T, 0372T)◄

97530 Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes

➲ *CPT Assistant* Summer 95:9, Dec 01:6, Apr 03:26, Jul 03:15, Aug 05:11, May 08:13, Mar 14:15; *CPT Changes: An Insider's View* 2013

97532 Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes

➲ *CPT Assistant* Dec 01:1, Mar 14:15; *CPT Changes: An Insider's View* 2001, 2013

►(Do not report 97532 in conjunction with 0364T, 0365T, 0368T, 0369T)◄

97533 Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes

➲ *CPT Assistant* Dec 01:1, Mar 14:15; *CPT Changes: An Insider's View* 2001, 2013

97535 Self-care/home management training (eg, activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes

➲ *CPT Assistant* Sep 96:7, Apr 00:11, Dec 03:6, Mar 14:15; *CPT Changes: An Insider's View* 2002, 2013

97537 Community/work reintegration training (eg, shopping, transportation, money management, avocational activities and/or work environment/modification analysis, work task analysis, use of assistive technology device/adaptive equipment), direct one-on-one contact, each 15 minutes

➲ *CPT Assistant* Sep 96:7, Dec 03:6, Mar 14:15; *CPT Changes: An Insider's View* 2004, 2013

(For wheelchair management/propulsion training, use 97542)

97542 Wheelchair management (eg, assessment, fitting, training), each 15 minutes

➲ *CPT Assistant* Sep 96:8, Mar 14:15; *CPT Changes: An Insider's View* 2006

97545 Work hardening/conditioning; initial 2 hours

➲ *CPT Assistant* Apr 03:26, Jul 03:15, May 08:13, Mar 14:15

+ 97546 each additional hour (List separately in addition to code for primary procedure)

➲ *CPT Assistant* Mar 14:15

(Use 97546 in conjunction with 97545)

Active Wound Care Management

Active wound care procedures are performed to remove devitalized and/or necrotic tissue and promote healing. Services require direct (one-on-one) contact with the patient.

(Do not report 97597-97602 in conjunction with 11042-11047 for the same wound)

(For debridement of burn wounds, see 16020-16030)

97597 Debridement (eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps), open wound, (eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm), including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less

➲ *CPT Assistant* Jun 05:1, 10, Nov 09:10, Jun 10:8, Nov 10:9, May 11:3, Sep 11:11, Jan 12:8, Mar 12:11, Oct 12:3, Jun 14:11; *CPT Changes: An Insider's View* 2005, 2011

+ 97598 each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)

➲ *CPT Assistant* Jun 05:1, 10, May 11:3, Sep 11:11, Jan 12:8, Mar 12:11, Jun 14:11; *CPT Changes: An Insider's View* 2005, 2011

(Use 97598 in conjunction with 97597)

97602 Removal of devitalized tissue from wound(s), non-selective debridement, without anesthesia (eg, wet-to-moist dressings, enzymatic, abrasion), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session

➲ *CPT Assistant* May 02:5, Jun 05:1, 10, Sep 08:11, May 11:4, Aug 11:7, Jan 12:9, Mar 12:11, Dec 12:15, Jun 14:11; *CPT Changes: An Insider's View* 2001

▲ 97605 Negative pressure wound therapy (eg, vacuum assisted drainage collection), utilizing durable medical equipment (DME), including topical application(s), wound assessment, and instruction(s) for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters

➲ *CPT Assistant* Apr 05:13, Jun 05:1, 10, May 11:4; *CPT Changes: An Insider's View* 2005, 2015

▲ 97606 total wound(s) surface area greater than 50 square centimeters

➲ *CPT Assistant* Apr 05:13, Jun 05:1, 10, May 11:4; *CPT Changes: An Insider's View* 2005, 2015

● 97607 Negative pressure wound therapy, (eg, vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area less than or equal to 50 square centimeters

➲ *CPT Changes: An Insider's View* 2015

● 97608 total wound(s) surface area greater than 50 square centimeters

➲ *CPT Changes: An Insider's View* 2015

The use of the time based add-on codes requires that the primary evaluation and management service have a typical or specified time published in the CPT codebook.

The following examples illustrate the correct reporting of prolonged physician or other qualified health care professional service with direct patient contact in the office setting:

Total Duration of Prolonged Services	Code(s)
less than 30 minutes	Not reported separately
30-74 minutes (30 minutes - 1 hr. 14 min.)	99354 X 1
75-104 minutes (1 hr. 15 min. - 1 hr. 44 min.)	99354 X 1 AND 99355 X 1
105 or more (1 hr. 45 min. or more)	99354 X 1 AND 99355 X 2 or more for each additional 30 minutes.

Coding Tip

Reporting Service of Less than 30 Minutes

Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the evaluation and management codes.

CPT Coding Guidelines, Evaluation and Management, Prolonged Physician Service with Direct (Face-to-Face) Patient Contact

+ 99354 Prolonged service in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient **Evaluation and Management** service)

➲ *CPT Assistant* Spring 94:30, 32, May 97:3, Sep 98:5, Sep 00:2, Jul 01:2, May 05:1, Nov 05:10, Jun 08:12, Sep 08:3, Jul 09:8, Apr 12:10, Aug 12:3, 4, 5, May 13:12, Jun 13:3, Oct 13:11, Apr 14:6, Jun 14:14; *CPT Changes: An Insider's View* 2009, 2012

(Use 99354 in conjunction with 90837, 99201-99215, 99241-99245, 99324-99337, 99341-99350)

+ 99355 each additional 30 minutes (List separately in addition to code for prolonged service)

➲ *CPT Assistant* Spring 94:30, 32, May 97:3, Sep 98:5, Sep 00:2, Jul 01:2, Nov 05:10, Jun 08:12, Sep 08:3, Jul 09:8, Apr 12:10, Aug 12:3, 4, 5, May 13:12, Jun 13:3, Oct 13:11, Apr 14:6, Jun 14:14; *CPT Changes: An Insider's View* 2009, 2012

(Use 99355 in conjunction with 99354)

+ 99356 Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient **Evaluation and Management** service)

➲ *CPT Assistant* Spring 94:30, 32, Apr 97:3, May 97:3, Sep 98:5, Sep 00:2, Jul 01:2, Nov 05:10, Jun 08:12, Sep 08:3, Jul 09:8, Jun 11:3, Aug 11:11, Jul 12:11, Aug 12:3, 4, 5, May 13:12, Jun 13:3, Oct 13:11, Apr 14:6, Jun 14:14; *CPT Changes: An Insider's View* 2009, 2012

(Use 99356 in conjunction with 90837, 99218-99220, 99221-99223, 99224-99226, 99231-99233, 99234-99236, 99251-99255, 99304-99310)

+ 99357 each additional 30 minutes (List separately in addition to code for prolonged service)

➲ *CPT Assistant* Spring 94:34, Apr 97:3, May 97:3, Sep 98:5, Sep 00:2, Jul 01:2, Nov 05:10, Jun 08:12, Sep 08:3, Jul 09:8, Jun 11:3, Aug 11:11, Jul 12:11, Aug 12:3, 4, 5, May 13:12, Jun 13:3, Oct 13:11, Apr 14:6, Jun 14:14; *CPT Changes: An Insider's View* 2009, 2012

(Use 99357 in conjunction with 99356)

Prolonged Service Without Direct Patient Contact

Codes 99358 and 99359 are used when a prolonged service is provided that is neither face-to-face time in the office or outpatient setting, nor additional unit/floor time in the hospital or nursing facility setting during the same session of an evaluation and management service and is beyond the usual physician or other qualified health care professional service time.

This service is to be reported in relation to other physician or other qualified health care professional services, including evaluation and management services at any level. This prolonged service may be reported on a different date than the primary service to which it is related. For example, extensive record review may relate to a previous evaluation and management service performed earlier and commences upon receipt of past records. However, it must relate to a service or patient where (face-to-face) patient care has occurred or will occur and relate to ongoing patient management. A typical time for the primary service need not be established within the CPT code set.

Codes 99358 and 99359 are used to report the total duration of non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service, even if the time spent by the physician or other qualified health care professional on that date is not continuous. Code 99358 is used to report the first hour of prolonged service on a given date regardless of the place of service. It should be used only once per date.

Prolonged service of less than 30 minutes total duration on a given date is not separately reported.

Code 99359 is used to report each additional 30 minutes beyond the first hour regardless of the place of service. It may also be used to report the final 15 to 30 minutes of prolonged service on a given date.

Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.

Do not report 99358, 99359 for time spent in care plan oversight services (99339, 99340, 99374-99380), anticoagulant management (99363, 99364), medical team conferences (99366-99368), on-line medical evaluations (99444), or other non-face-to-face services that have more specific codes and no upper time limit in the CPT code set. Codes 99358, 99359 may be reported when related to other non-face-to-face services codes that have a published maximum time (eg, telephone services).

99358 **Prolonged evaluation and management service** before and/or after direct patient care; first hour

CPT Assistant Spring 94:34, Nov 98:3, Sep 00:3, Nov 05:10, Jun 08:12, Sep 08:3, Aug 12:3, 4, 5, Apr 13:3, Oct 13:11, Nov 13:3; *CPT Changes: An Insider's View* 2010, 2012

+ **99359** each additional 30 minutes (List separately in addition to code for prolonged service)

CPT Assistant Spring 94:34, Sep 00:3, Nov 05:10, Jun 08:12, Sep 08:3, Aug 12:3, 4, 5, Apr 13:3, Oct 13:11, Nov 13:3; *CPT Changes: An Insider's View* 2010, 2012

(Use 99359 in conjunction with 99358)

(Do not report 99358, 99359 during the same month with 99487-99489)

(Do not report 99358, 99359 when performed during the service time of codes 99495 or 99496)

Standby Services

Code 99360 is used to report physician or other qualified health care professional standby services that are requested by another individual and that involve prolonged attendance without direct (face-to-face) patient contact. Care or services may not be provided to other patients during this period. This code is not used to report time spent proctoring another individual. It is also not used if the period of standby ends with the performance of a procedure, subject to a surgical package by the individual who was on standby.

Code 99360 is used to report the total duration of time spent on a given date on standby. Standby service of less than 30 minutes total duration on a given date is not reported separately.

Second and subsequent periods of standby beyond the first 30 minutes may be reported only if a full 30 minutes of standby was provided for each unit of service reported.

99360 **Standby service,** requiring prolonged attendance, each 30 minutes (eg, operative standby, standby for frozen section, for cesarean/high risk delivery, for monitoring EEG)

CPT Assistant Spring 94:32, Apr 97:10, Aug 97:18, Nov 97:8, Nov 99:5-6, Aug 00:3, Sep 00:3, May 05:1, Nov 05:10, Nov 06:23, Mar 08:14, Feb 11:3, May 13:8, Apr 14:5, 11; *CPT Changes: An Insider's View* 2013

(For hospital mandated on call services, see 99026, 99027)

(99360 may be reported in addition to 99460, 99465 as appropriate)

(Do not report 99360 in conjunction with 99464)

Case Management Services

Case management is a process in which a physician or another qualified health care professional is responsible for direct care of a patient and, additionally, for coordinating, managing access to, initiating, and/or supervising other health care services needed by the patient.

Anticoagulant Management

Anticoagulant services are intended to describe the outpatient management of warfarin therapy, including ordering, review, and interpretation of International Normalized Ratio (INR) testing, communication with patient, and dosage adjustments as appropriate.

When reporting these services, the work of anticoagulant management may not be used as a basis for reporting an evaluation and management (E/M) service or care plan oversight time during the reporting period. Do not report these services with 98966-98969, 99441-99444 when telephone or on-line services address anticoagulation with warfarin management. If a significant, separately identifiable E/M service is performed, report the appropriate E/M service code using modifier 25.

These services are outpatient services only. When anticoagulation therapy is initiated or continued in the inpatient or observation setting, a new period begins after discharge and is reported with 99364. Do not report 99363-99364 with 99217-99239, 99291-99292, 99304-99318, 99471-99480 or other code(s) for physician review, interpretation, and patient management of home INR testing for a patient with mechanical heart valve(s).

Any period less than 60 continuous outpatient days is not reported. If less than the specified minimum number of services per period are performed, do not report the anticoagulant management services (99363-99364).

99363 Anticoagulant management for an outpatient taking warfarin, physician review and interpretation of International Normalized Ratio (INR) testing, patient instructions, dosage adjustment (as needed), and ordering of additional tests; initial 90 days of therapy (must include a minimum of 8 INR measurements)

CPT Assistant Sep 07:1, Jul 09:5, Apr 13:3, Nov 13:3; *CPT Changes: An Insider's View* 2007

97810 Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient

➲ *CPT Assistant* Jan 05:16-17, Jun 05:5, Jun 06:20, Aug 06:4; *CPT Changes: An Insider's View* 2005

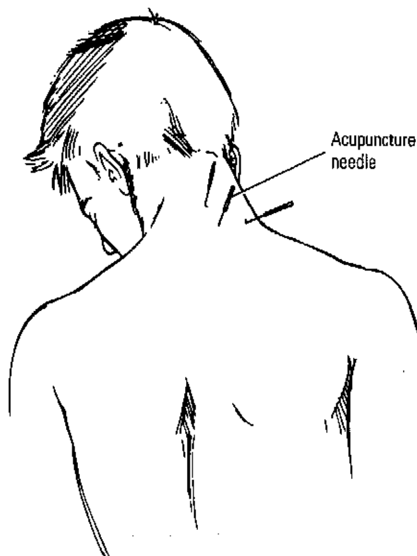
(Do not report 97810 in conjunction with 97813)

+ 97811 without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)

➲ *CPT Assistant* Jan 05:16, Jun 05:5, Aug 06:4; *CPT Changes: An Insider's View* 2005, 2006

(Use 97811 in conjunction with 97810, 97813)

Acupuncture, Needle
97810-97811



97813 with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient

➲ *CPT Assistant* Jan 05:16-18, Jun 05:5, Jun 06:20, Aug 06:4; *CPT Changes: An Insider's View* 2005, 2006

(Do not report 97813 in conjunction with 97810)

+ 97814 with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s) (List separately in addition to code for primary procedure)

➲ *CPT Assistant* Jan 05:16, Jun 05:5, Aug 06:4; *CPT Changes: An Insider's View* 2005, 2006

(Use 97814 in conjunction with 97810, 97813)

Osteopathic Manipulative Treatment

Osteopathic manipulative treatment (OMT) is a form of manual treatment applied by a physician or other qualified health care professional to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques.

Evaluation and Management services including new or established patient office or other outpatient services (99201-99215), hospital observation care (99217-99220, 99224-99226), hospital care (99221-99223, 99231-99233), critical care services (99291, 99292), observation or inpatient care services (99234-99236), office or other outpatient consultations (99241-99245), emergency department services (99281-99285), nursing facility services (99304-99318), domiciliary, rest home, or custodial care services (99324-99337), and home services (99341-99350) may be reported separately using modifier 25 if the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and postservice work associated with the procedure. The E/M service may be caused or prompted by the same symptoms or condition for which the OMT service was provided. As such, different diagnoses are not required for the reporting of the OMT and E/M service on the same date.

Body regions referred to are: head region; cervical region; thoracic region; lumbar region; sacral region; pelvic region; lower extremities; upper extremities; rib cage region; abdomen and viscera region.

98925 Osteopathic manipulative treatment (OMT); 1-2 body regions involved

➲ *CPT Assistant* May 96:10, Jan 97:8, 10, Jul 98:10, Aug 00:11, Dec 00:15, Oct 09:10

98926 3-4 body regions involved

➲ *CPT Assistant* May 96:10, Jan 97:8, Aug 00:11, Dec 00:15, Oct 09:10

98927 5-6 body regions involved

➲ *CPT Assistant* May 96:10, Jan 97:8, Aug 00:11, Dec 00:15, Oct 09:10

98928 7-8 body regions involved

➲ *CPT Assistant* May 96:10, Jan 97:8, Aug 00:11, Dec 00:15, Oct 09:10, Mar 12:14, May 12:14

98929 9-10 body regions involved

➲ *CPT Assistant* May 96:10, Jan 97:8, 10, Aug 00:11, Oct 09:10

Chiropractic Manipulative Treatment

Chiropractic manipulative treatment (CMT) is a form of manual treatment to influence joint and neurophysiological function. This treatment may be accomplished using a variety of techniques.

The chiropractic manipulative treatment codes include a pre-manipulation patient assessment. Additional evaluation and management services including office or other outpatient services (99201-99215), subsequent observation care (99224-99226), subsequent hospital care

(99231-99233), office or other outpatient consultations (99241-99245), subsequent nursing facility services (99307-99310), domiciliary, rest home, or custodial care services (99324-99337), and home services (99341-99350) may be reported separately using modifier 25 if the patient's condition requires a significant, separately identifiable E/M service above and beyond the usual preservice and postservice work associated with the procedure. The E/M service may be caused or prompted by the same symptoms or condition for which the CMT service was provided. As such, different diagnoses are not required for the reporting of the CMT and E/M service on the same date.

For purposes of CMT, the five spinal regions referred to are: cervical region (includes atlanto-occipital joint); thoracic region (includes costovertebral and costotransverse joints); lumbar region; sacral region; and pelvic (sacro-iliac joint) region. The five extraspinal regions referred to are: head (including temporomandibular joint, excluding atlanto-occipital) region; lower extremities; upper extremities; rib cage (excluding costotransverse and costovertebral joints) and abdomen.

98940 Chiropractic manipulative treatment (CMT); spinal, 1-2 regions

➲ *CPT Assistant* Jan 97:7, 11, Feb 99:10, Dec 00:15, Mar 06:15, Dec 07:16, 17, Oct 09:10, May 10:9, Dec 13:15

98941 spinal, 3-4 regions

➲ *CPT Assistant* Jan 97:7, 11, Mar 97:10, Feb 99:10, Dec 00:15, Mar 06:15, Dec 07:16, 17, Oct 09:10, May 10:9

98942 spinal, 5 regions

➲ *CPT Assistant* Jan 97:7, 11, Feb 99:10, Dec 00:15, Mar 06:15, Dec 07:16, 17, Oct 09:10, May 10:9

98943 extraspinal, 1 or more regions

➲ *CPT Assistant* Jan 97:7, 11, Mar 97:10, Feb 99:10, Dec 00:15, Mar 06:15, Dec 07:16, 17, Oct 09:10, May 10:9, Dec 13:15

Education and Training for Patient Self-Management

The following codes are used to report educational and training services prescribed by a physician or other qualified health care professional and provided by a qualified, nonphysician health care professional using a standardized curriculum to an individual or a group of patients for the treatment of established illness(s)/disease(s) or to delay comorbidity(s). Education and training for patient self-management may be reported with these codes only when using a standardized curriculum as described below. This curriculum may be modified as necessary for the clinical needs, cultural norms and health literacy of the individual patient(s).

The purpose of the educational and training services is to teach the patient (may include caregiver[s]) how to effectively self-manage the patient's illness(s)/disease(s) or delay disease comorbidity(s) in conjunction with the patient's professional healthcare team. Education and training related to subsequent reinforcement or due to changes in the patient's condition or treatment plan are reported in the same manner as the original education and training. The type of education and training provided for the patient's clinical condition will be identified by the appropriate diagnosis code(s) reported.

The qualifications of the nonphysician healthcare professionals and the content of the educational and training program must be consistent with guidelines or standards established or recognized by a physician society, nonphysician healthcare professional society/association, or other appropriate source.

(For counseling and education provided by a physician to an individual, see the appropriate evaluation and management codes including office or other outpatient services [99201-99215], hospital observation care [99217-99220, 99224-99226], hospital care [99221-99223, 99231-99233], new or established patient office or other outpatient consultations [99241-99245], inpatient consultations [99251-99255], emergency department services [99281-99285], nursing facility services [99304-99318], domiciliary, rest home, or custodial care services [99324-99337], home services [99341-99350], and counseling risk factor reduction and behavior change intervention [99401-99429]. See also **Instructions for Use of the CPT Codebook** for definition of reporting qualifications)

(For counseling and education provided by a physician to a group, use 99078)

(For counseling and/or risk factor reduction intervention provided by a physician to patient[s] without symptoms or established disease, see 99401-99412)

(For medical nutrition therapy, see 97802-97804)

(For health and behavior assessment/intervention that is not part of a standardized curriculum, see 96150-96155)

(For education provided as genetic counseling services, use 96040. For education to a group regarding genetic risks, see 98961, 98962)

98960 Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient

➲ *CPT Assistant* Apr 13:3, Nov 13:3; *CPT Changes: An Insider's View* 2006

98961 2-4 patients

➲ *CPT Assistant* Aug 07:9, Aug 08:3, Feb 09:13, Apr 13:3; *CPT Changes: An Insider's View* 2006

98962 5-8 patients

➲ *CPT Assistant* Aug 07:9, Aug 08:3, Feb 09:13, Apr 13:3, Nov 13:3; *CPT Changes: An Insider's View* 2006

97014 electrical stimulation (unattended)

➲ *CPT Assistant* Summer 95:5, Apr 96:11, Nov 97:47, May 98:10, Nov 01:5, Jan 02:11, Apr 02:18, Aug 02:11, Dec 03:4, Nov 09:10, Jun 10:8, Aug 10:13, Nov 10:8, Aug 11:6

(For acupuncture with electrical stimulation, see 97813, 97814)

97016 vasopneumatic devices

➲ *CPT Assistant* Summer 95:6, Apr 96:11, Dec 98:1, Nov 01:5, Aug 02:11, May 05:14, Jun 10:8, Aug 10:13, Nov 10:8

97018 paraffin bath

➲ *CPT Assistant* Summer 95:6, Apr 96:11, Dec 98:1, Nov 01:5, Aug 02:11, Nov 09:10, Jun 10:8, Aug 10:13, Nov 10:8

97022 whirlpool

➲ *CPT Assistant* Summer 95:6, Apr 96:11, May 98:10, Dec 98:1, Nov 01:5, Aug 02:11, Nov 09:10, Jun 10:8, Aug 10:13, Nov 10:8

97024 diathermy (eg, microwave)

➲ *CPT Assistant* Summer 95:6, Apr 96:11, Dec 98:1, Nov 01:5, Aug 02:11, Nov 09:10, Jun 10:8, Aug 10:13, Nov 10:8; *CPT Changes: An Insider's View* 2006

97026 infrared

➲ *CPT Assistant* Summer 95:6, Apr 96:11, Dec 98:1, Nov 01:5, Aug 02:11, Nov 09:10, Feb 10:12, Jun 10:8, Aug 10:13, Nov 10:8

97028 ultraviolet

➲ *CPT Assistant* Summer 95:6, Apr 96:11, Dec 98:1, Nov 01:5, Aug 02:11, Nov 09:10, Jun 10:8, Aug 10:13, Nov 10:8

Constant Attendance

The application of a modality that requires direct (one-on-one) patient contact.

97032 Application of a modality to 1 or more areas; electrical stimulation (manual), each 15 minutes

➲ *CPT Assistant* Summer 95:6, Dec 98:1, Nov 01:5, Apr 02:18, Jul 04:14, Nov 09:10, Jun 10:8, Aug 10:13, Nov 10:8

(For transcutaneous electrical modulation pain reprocessing [TEMPR/scrambler therapy], use 0278T)

97033 iontophoresis, each 15 minutes

➲ *CPT Assistant* Summer 95:7, Dec 98:1, Nov 01:5, Nov 09:10, Jun 10:8, Aug 10:13, Nov 10:8

97034 contrast baths, each 15 minutes

➲ *CPT Assistant* Summer 95:7, Dec 98:1, Nov 01:5, Jun 10:8, Aug 10:13, Nov 10:8

97035 ultrasound, each 15 minutes

➲ *CPT Assistant* Summer 95:7, Sep 96:10, Dec 98:1, Nov 01:5, Nov 09:10, Jun 10:8, Aug 10:13, Nov 10:8

97036 Hubbard tank, each 15 minutes

➲ *CPT Assistant* Summer 95:7, Dec 98:1, Nov 01:5, Nov 09:10, Jun 10:8, Aug 10:13, Nov 10:8

97039 Unlisted modality (specify type and time if constant attendance)

➲ *CPT Assistant* Summer 95:7, May 98:10, Dec 98:1, Jan 00:10, Nov 01:5, May 05:14, Nov 09:10, Feb 10:12, Jun 10:8, Aug 10:13, Nov 10:8

Therapeutic Procedures

A manner of effecting change through the application of clinical skills and/or services that attempt to improve function.

Physician or other qualified health care professional (ie, therapist) required to have direct (one-on-one) patient contact.

97110 Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility

➲ *CPT Assistant* Summer 95:7, Feb 97:10, Nov 98:37, Dec 99:11, Mar 05:11, Apr 05:14, Aug 05:11, Dec 05:8, Mar 06:15, Aug 06:11, May 08:13, Dec 09:15, May 10:9, Mar 12:9, Mar 14:15

97112 neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities

➲ *CPT Assistant* Summer 95:7, Feb 97:10, Apr 05:14, Aug 05:11, Mar 06:15, Aug 06:11, May 08:13, Oct 09:10, May 10:9, Mar 12:9, Mar 14:15; *CPT Changes: An Insider's View* 2002

97113 aquatic therapy with therapeutic exercises

➲ *CPT Assistant* Summer 95:7, Feb 97:10, Apr 05:14, Mar 06:15, Aug 06:11, Oct 09:10, May 10:9, Mar 14:15

97116 gait training (includes stair climbing)

➲ *CPT Assistant* Summer 95:8, Sep 96:7, Feb 97:10, Jun 03:3, Apr 05:14, Mar 06:15, Aug 06:11, Oct 09:10, May 10:9, Mar 14:15

(Use 96000-96003 to report comprehensive gait and motion analysis procedures)

97124 massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)

➲ *CPT Assistant* Summer 95:8, May 96:10, Feb 97:10, Dec 99:7, Apr 05:14, May 05:14, Mar 06:15, Aug 06:11, Oct 09:10, May 10:9, Mar 14:15

(For myofascial release, use 97140)

97139 Unlisted therapeutic procedure (specify)

➲ *CPT Assistant* Summer 95:8, Feb 97:10, Apr 05:14, Aug 06:11, Mar 14:15

97140 Manual therapy techniques (eg, mobilization/ manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes

➲ *CPT Assistant* Nov 98:37, Feb 99:10, Mar 99:1, Jul 99:11, Aug 01:10, Dec 03:5, May 09:9, Oct 09:10, Mar 14:15

(Do not report 97140 in conjunction with 29581-29584)

97150 Therapeutic procedure(s), group (2 or more individuals)

➲ *CPT Assistant* Summer 95:8, Dec 96:10, Feb 97:10, Oct 99:10, Nov 99:54-55, Dec 99:11, Apr 05:14, Aug 06:11, Mar 14:15

(Report 97150 for each member of group)

(Group therapy procedures involve constant attendance of the physician or other qualified health care professional [ie, therapist], but by definition do not require one-on-one patient contact by the same physician or other qualified health care professional)

- The procedure or service satisfies the category-specific criteria set forth below.

Category-Specific Requirements

Category I Criteria

A proposal for a new or revised Category I code must satisfy all of the following criteria:

- All devices and drugs necessary for performance of the procedure or service have received FDA clearance or approval when such is required for performance of the procedure or service.
- The procedure or service is performed by many physicians or other qualified health care professionals across the United States.
- The procedure or service is performed with frequency consistent with the intended clinical use (ie, a service for a common condition should have high volume, whereas a service commonly performed for a rare condition may have low volume).
- The procedure or service is consistent with current medical practice.
- The clinical efficacy of the procedure or service is documented in literature that meets the requirements set forth in the CPT code change application.

Category III Criteria

The following **criteria** are used by the CPT/HCPAC Advisory Committee and the CPT Editorial Panel for evaluating Category III code **applications**:

- The procedure or service is currently or recently performed in humans; ***and***

At least one of the following additional criteria has been met:

- The application is supported by at least one CPT or HCPAC advisor representing practitioners who would use this procedure or service; ***or***
- The actual or potential clinical efficacy of the specific procedure or service is supported by peer reviewed literature, which is available in English for examination by the CPT Editorial Panel; ***or***
- There is (a) at least one Institutional Review Board–approved protocol of a study of the procedure or service being performed; (b) a description of a current and ongoing United States trial outlining the efficacy of the procedure or service; or (c) other evidence of evolving clinical utilization.

Guidelines

Specific guidelines are presented at the beginning of each of the sections. These guidelines define items that are necessary to appropriately interpret and report the procedures and services contained in that section. For example, in the **Medicine** section, specific instructions are provided for handling unlisted services or procedures, special reports, and supplies and materials provided. Guidelines also provide explanations regarding terms that apply only to a particular section. For instance, **Radiology Guidelines** provide a definition of the unique term, "radiological supervision and interpretation." While in **Anesthesia**, a discussion of reporting time is included.

Add-on Codes

Some of the listed procedures are commonly carried out in addition to the primary procedure performed. These additional or supplemental procedures are designated as add-on codes with the ✚ symbol and they are listed in **Appendix D** of the CPT codebook. Add-on codes in *CPT 2015* can be readily identified by specific descriptor nomenclature that includes phrases such as "each additional" or "(List separately in addition to primary procedure)."

The add-on code concept in *CPT 2015* applies only to add-on procedures or services performed by the same physician. Add-on codes describe additional intra-service work associated with the primary procedure, eg, additional digit(s), lesion(s), neurorrhaphy(s), vertebral segment(s), tendon(s), joint(s).

Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. All add-on codes found in the CPT codebook are exempt from the multiple procedure concept (see the modifier 51 definition in **Appendix A**).

Modifiers

A modifier provides the means to report or indicate that a service or procedure that has been performed has been altered by some specific circumstance but not changed in its definition or code. Modifiers also enable health care professionals to effectively respond to payment policy requirements established by other entities. The judicious application of modifiers obviates the necessity for separate procedure listings that may describe the modifying circumstance. Modifiers may be used to indicate to the recipient of a report that:

- A service or procedure had both a professional and technical component.
- A service or procedure was performed by more than one physician or other health care professional and/or in more than one location.
- A service or procedure was increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A bilateral procedure was performed.
- A service or procedure was provided more than once.
- Unusual events occurred.

Example

A physician providing diagnostic or therapeutic radiology services, ultrasound, or nuclear medicine services in a hospital would add modifier 26 to report the professional component.

73090 with modifier 26 = Professional component only for an X-ray of the forearm

Example

Two surgeons may be required to manage a specific surgical problem. When two surgeons work together as primary sur-

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 73 and 74 (see modifiers approved for ASC hospital outpatient use).

➲ *CPT Assistant* Mar 09:11, Apr 09:5, May 09:8, Jun 09:10; *CPT Changes: An Insider's View* 2013

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 individual 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).

➲ *CPT Assistant* Feb 14:11; *CPT Changes: An Insider's View* 2013

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.

➲ *CPT Changes: An Insider's View* 2013

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.

➲ *CPT Changes: An Insider's View* 2013

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.

➲ *CPT Changes: An Insider's View* 2013

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.

➲ *CPT Assistant* May 09:9

58 Staged or Related Procedure or Service by the Same Physician or Other Qualified Health Care Professional During the Postoperative Period: It may be necessary to indicate that the performance of a procedure or service during the postoperative period was: (a) planned or anticipated (staged); (b) more extensive than the original procedure; or (c) for therapy following a surgical procedure. This circumstance may be reported by adding modifier 58 to the staged or related procedure. **Note:** For treatment of a problem that requires a return to the operating/procedure room (eg, unanticipated clinical condition), see modifier 78.

➲ *CPT Changes: An Insider's View* 2008, 2013

59 ►Distinct Procedural Service: Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-E/M services performed on the same day. Modifier 59 is used to identify procedures/services, other than E/M services, that are not normally reported together, but are appropriate under the circumstances. Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual. However, when another already established modifier is appropriate it should be used rather than modifier 59. Only if no more descriptive modifier is available, and the use of modifier 59 best explains the circumstances, should modifier 59 be used. **Note:** Modifier 59 should not be appended to an E/M service. To report a separate and distinct E/M service with a non-E/M service performed on the same date, see modifier 25. See also page 684, Level II HCPCS/National Modifiers listing.◄

➲ *CPT Assistant* Feb 09:17, Apr 09:4,8, May 09:6, Jun 09:8; *CPT Changes: An Insider's View* 2008

62 Two Surgeons: When 2 surgeons work together as primary surgeons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated add-on code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. If additional procedure(s) (including add-on procedure(s) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. **Note:** If a co-surgeon acts as an assistant in the performance of additional procedure(s), other than those reported with the modifier 62, during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate.

➲ *CPT Changes: An Insider's View* 2013

Appendix A

91 Repeat Clinical Diagnostic Laboratory Test: In the course of treatment of the patient, it may be necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results. Under these circumstances, the laboratory test performed can be identified by its usual procedure number and the addition of modifier 91. **Note:** This modifier may not be used when tests are rerun to confirm initial results; due to testing problems with specimens or equipment; or for any other reason when a normal, one-time, reportable result is all that is required. This modifier may not be used when other code(s) describe a series of test results (eg, glucose tolerance tests, evocative/suppression testing). This modifier may only be used for laboratory test(s) performed more than once on the same day on the same patient.

Level II (HCPCS/National) Modifiers

E1 Upper left, eyelid

E2 Lower left, eyelid

E3 Upper right, eyelid

E4 Lower right, eyelid

F1 Left hand, second digit

F2 Left hand, third digit

F3 Left hand, fourth digit

F4 Left hand, fifth digit

F5 Right hand, thumb

F6 Right hand, second digit

F7 Right hand, third digit

F8 Right hand, fourth digit

F9 Right hand, fifth digit

FA Left hand, thumb

GG Performance and payment of a screening mammogram and diagnostic mammogram on the same patient, same day

GH Diagnostic mammogram converted from screening mammogram on same day

LC Left circumflex coronary artery

LD Left anterior descending coronary artery

LM Left main coronary artery

LT Left side (used to identify procedures performed on the left side of the body)

QM Ambulance service provided under arrangement by a provider of services

QN Ambulance service furnished directly by a provider of services

RC Right coronary artery

RI Ramus intermedius coronary artery

RT Right side (used to identify procedures performed on the right side of the body)

T1 Left foot, second digit

T2 Left foot, third digit

T3 Left foot, fourth digit

T4 Left foot, fifth digit

T5 Right foot, great toe

T6 Right foot, second digit

T7 Right foot, third digit

T8 Right foot, fourth digit

T9 Right foot, fifth digit

TA Left foot, great toe

XE Separate Encounter *

XS Separate Structure *

XP Separate Practitioner *

XU Unusual Non-Overlapping Service *

(*HCPCS modifiers for selective identification of subsets of Distinct Procedural Services [-59 modifier])

geons performing distinct part(s) of a procedure, each surgeon should report his/her distinct operative work by adding modifier 62 to the procedure code and any associated code(s) for that procedure as long as both surgeons continue to work together as primary surgeons. Each surgeon should report the co-surgery once using the same procedure code. Modifier 62 would be applicable. For instance, a neurological surgeon and an otolaryngologist are working as co-surgeons in performing transphenoidal excision of a pituitary neoplasm.

The first surgeon would report:

61548 62 = Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic + two surgeons modifier

and the second surgeon would report:

61548 62 = Hypophysectomy or excision of pituitary tumor, transnasal or transseptal approach, nonstereotactic + two surgeons modifier

If additional procedure(s) (including add-on procedure[s]) are performed during the same surgical session, separate code(s) may also be reported with modifier 62 added. It should be noted that if a co-surgeon acts as an assistant in the performance of additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with modifier 80 or modifier 82 added, as appropriate. A complete listing of modifiers is found in **Appendix A**.

Place of Service and Facility Reporting

Some codes have specified places of service (eg, evaluation and management codes are specific to a setting). Other services and procedures may have instructions specific to the place of service (eg, therapeutic, prophylactic, and diagnostic injections and infusions). The CPT code set is designated for reporting physician and qualified health care professional services. It is also the designated code set for reporting services provided by organizations or facilities (eg, hospitals) in specific circumstances. Throughout the CPT code set, the use of terms such as "physician," "qualified health care professional," or "individual" is not intended to indicate that other entities may not report the service. In selected instances, specific instructions may define a service as limited to professionals or limited to other entities (eg, hospital or home health agency). The CPT code set uses the term "facility" to describe such providers and the term "nonfacility" to describe services settings or circumstances in which no facility reporting may occur. Services provided in the home by an agency are facility services. Services provided in the home by a physician or other qualified health care professional who is not a representative of the agency are nonfacility services.

Unlisted Procedure or Service

It is recognized that there may be services or procedures performed by physicians or other qualified health care professionals that are not found in the CPT code set. Therefore, a number of specific code numbers have been designated for reporting unlisted procedures. When an unlisted procedure number is used, the service or procedure should be described (see specific section guidelines). Each of these unlisted procedural code numbers (with the appropriate accompanying topical entry) relates to a specific section of the book and is presented in the guidelines of that section.

In some cases alternative coding and procedural nomenclature as contained in other code sets may allow appropriate reporting of a more specific code. CPT references to use an unlisted procedure code do not preclude the reporting of an appropriate code that may be found in other code sets.

Results, Testing, Interpretation, and Report

Results are the technical component of a service. Testing leads to results; results lead to interpretation. Reports are the work product of the interpretation of test results. Certain procedures or services described in CPT involve a technical component (eg, tests) which produces "results" (eg, data, images, slides). For clinical use, some of these results require interpretation. Some CPT descriptors specifically require interpretation and reporting to report that code.

Special Report

A service that is rarely provided, unusual, variable, or new may require a special report. Pertinent information should include an adequate definition or description of the nature, extent, and need for the procedure and the time, effort, and equipment necessary to provide the service.

Time

The CPT code set contains many codes with a time basis for code selection. The following standards shall apply to time measurement, unless there are code or code-range–specific instructions in guidelines, parenthetical instructions, or code descriptors to the contrary. Time is the face-to-face time with the patient. Phrases such as "interpretation and report" in the code descriptor are not intended to indicate in all cases that report writing is part of the reported time. A unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed (more than midway between zero and sixty minutes). A second hour is attained when a total of 91 minutes have elapsed. When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used. See also the **Evaluation and Management (E/M) Services Guidelines**. When another service is performed concurrently with a time-based service, the time associated with the concurrent service should not be included in the time used for reporting the time-based service. Some services measured in units other than days extend across calendar dates. When this occurs a continuous service does not reset and create a first hour. However, any disruption in the service does create a new initial service. For example, if intravenous hydration (96360, 96361) is given from 11 PM to 2 AM, 96360 would be reported once and 96361 twice. For facility reporting on a single date of service or for continuous services that last beyond midnight (ie, over a range of dates), report the total units of time provided continuously.

▶ ◀=Contains new or revised text

Special Dermatological Procedures

See the **Evaluation and Management coding guidelines** for further instructions on reporting that is appropriate for management of dermatologic illnesses.

(For intralesional injections, see 11900, 11901)

(For Tzanck smear, see 88160-88161)

96900 Actinotherapy (ultraviolet light)
CPT Assistant Jul 12:9

(For rhinophototherapy, intranasal application of ultraviolet and visible light, use 30999)

96902 Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality
CPT Assistant Nov 97:46-47

96904 Whole body integumentary photography, for monitoring of high risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma
CPT Changes: An Insider's View 2007

96910 Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B
CPT Assistant Jul 12:9

96912 psoralens and ultraviolet A (PUVA)
CPT Assistant Jul 12:9

96913 Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)

96920 Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm
CPT Assistant Oct 10:9, Jul 12:9, May 13:12; *CPT Changes: An Insider's View* 2003

96921 250 sq cm to 500 sq cm
CPT Assistant Oct 10:9, Jul 12:9, May 13:12; *CPT Changes: An Insider's View* 2003

96922 over 500 sq cm
CPT Assistant Oct 10:9, Jul 12:9, May 13:12; *CPT Changes: An Insider's View* 2003

(For laser destruction of premalignant lesions, see 17000-17004)

(For laser destruction of cutaneous vascular proliferative lesions, see 17106-17108)

(For laser destruction of benign lesions, see 17110-17111)

(For laser destruction of malignant lesions, see 17260-17286)

96999 Unlisted special dermatological service or procedure
CPT Assistant Jul 12:9, May 13:12

Physical Medicine and Rehabilitation

Codes 97001-97755 should be used to report each distinct procedure performed. Do not append modifier 51 to 97001-97755.

The work of the physician or other qualified health care professional consists of face-to-face time with the patient (and caregiver, if applicable) delivering skilled services. For the purpose of determining the total time of a service, incremental intervals of treatment at the same visit may be accumulated.

(For muscle testing, range of joint motion, electromyography, see 95831 et seq)

(For biofeedback training by EMG, use 90901)

(For transcutaneous nerve stimulation (TNS), use 64550)

97001 Physical therapy evaluation
CPT Assistant Nov 97:47, Feb 00:11, Sep 01:10, Oct 02:11, Dec 03:4, Feb 04:5, Apr 05:13, Aug 06:11, May 08:9

97002 Physical therapy re-evaluation
CPT Assistant Nov 97:47, Feb 00:11, Sep 01:10, Oct 02:11, Dec 03:4, Feb 04:5, May 08:9

97003 Occupational therapy evaluation
CPT Assistant Nov 97:47, Oct 02:11, Feb 04:5, Aug 06:11, May 08:9, Jun 14:3

97004 Occupational therapy re-evaluation
CPT Assistant Nov 97:47, Oct 02:11, Feb 04:5, May 08:9, Jun 14:3

97005 Athletic training evaluation
CPT Assistant Jun 02:9, Feb 04:5; *CPT Changes: An Insider's View* 2002

97006 Athletic training re-evaluation
CPT Assistant Jun 02:9, Feb 04:5; *CPT Changes: An Insider's View* 2002

Modalities

Any physical agent applied to produce therapeutic changes to biologic tissue; includes but not limited to thermal, acoustic, light, mechanical, or electric energy.

Supervised

The application of a modality that does not require direct (one-on-one) patient contact.

97010 Application of a modality to 1 or more areas; hot or cold packs
CPT Assistant Summer 95:5, Apr 96:11, Nov 97:47, Dec 98:1, Nov 01:5, Aug 02:11, Aug 06:11, Nov 09:10, Jun 10:8, Aug 10:13, Nov 10:8

97012 traction, mechanical
CPT Assistant Summer 95:5, Apr 96:11, Nov 97:47, Dec 98:1, May 99:11, Nov 01:5, Aug 02:11, Dec 03:4, Oct 04:9, Jun 10:8, Aug 10:13, Nov 10:8