

Current Procedural Coding Expert

CPT[®] codes with Medicare essentials
for enhanced accuracy

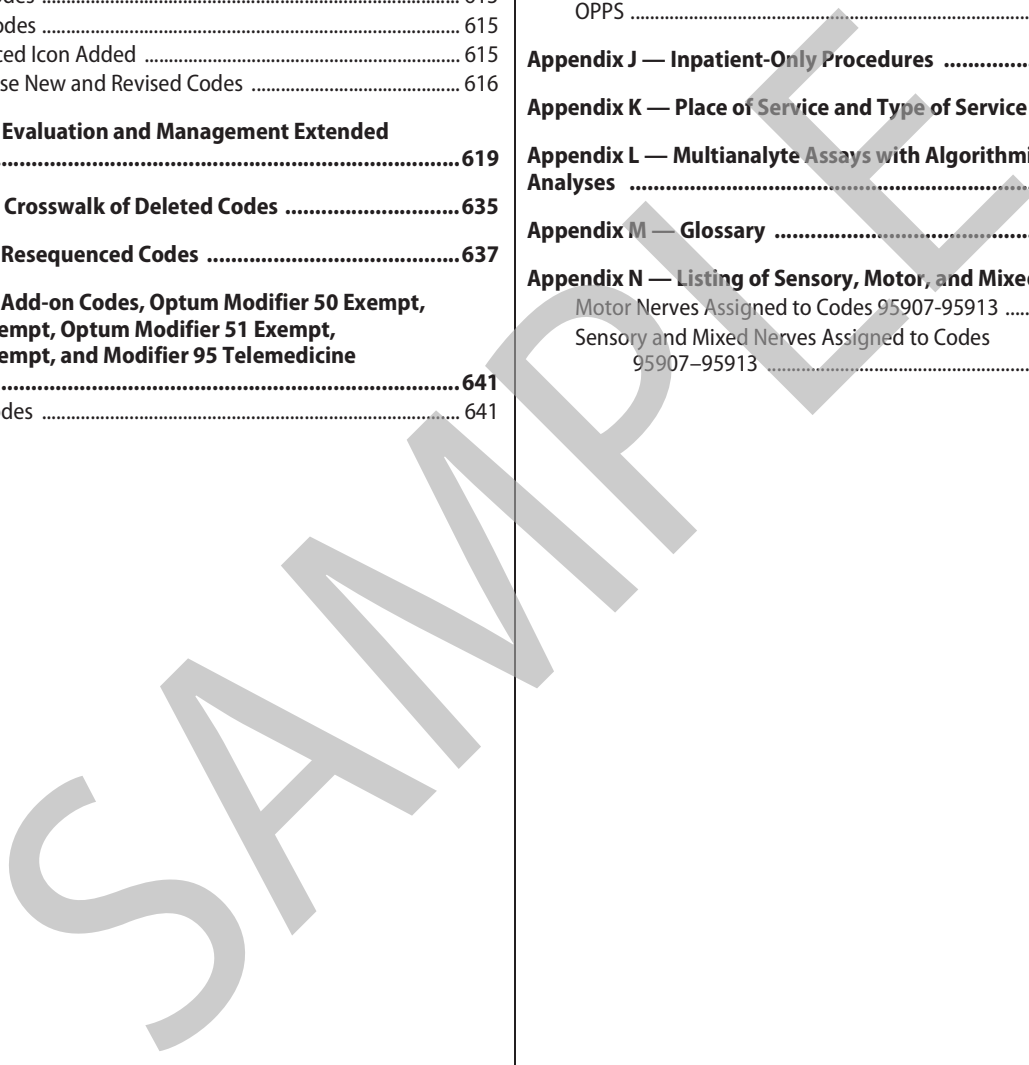
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Introduction

Welcome to Optum360's *Current Procedural Coding Expert, Professional Edition*, an exciting Medicare coding and reimbursement tool and 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.

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 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, Professional Edition* provides the best in Medicare procedure reporting.

Current Procedural Coding Expert, Professional Edition 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 *Current Procedural Coding Expert, Professional Edition* includes effective codes that will not be published in the AMA's Current Procedural Terminology (CPT) book until the following year.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>. National and local coverage determinations (NCDs and LCDs) provide universal and individual contractor guidelines for specific services. The existence of a procedure code does not imply coverage under any given insurance plan.

Current Procedural Coding Expert, Professional Edition is based on the AMA's Current Procedural Terminology coding system, which is copyrighted and owned by the physician organization. The CPT codes are the nation's official, Health Information Portability and Accountability Act (HIPAA) compliant code set for procedures and services provided by physicians, ambulatory surgery centers (ASCs), and hospital outpatient services, as well as laboratories, imaging centers, physical therapy clinics, urgent care centers, and others.

Getting Started with *Current Procedural Coding Expert, Professional Edition*

Current Procedural Coding Expert, Professional Edition is an exciting tool combining the most current material at the time of our publication from the AMA's CPT 2021, CMS's online manual system, the Correct Coding initiative, CMS fee schedules, official Medicare guidelines for reimbursement and coverage, the Integrated Outpatient Code Editor (I/OCE), and Optum360's own coding expertise.

These coding rules and guidelines are incorporated into more specific section notes and code notes. Section notes are listed under a range of codes and apply to all codes in that range. Code notes are found under individual codes and apply to the single code.

Material is presented in a logical fashion for those billing Medicare, Medicaid, and many private payers. The format, based on customer comments, better addresses what customers tell us they need in a comprehensive Medicare procedure coding guide.

Designed to be easy to use and full of information, this product is an excellent companion to your AMA CPT manual, and other Optum360 and Medicare resources.

For mid-year code updates, official errata changes, correction notices, and any other changes pertinent to the information in *Current Procedural*

Coding Expert, Professional Edition, see our product update page at <https://www.optum360coding.com/ProductUpdates/>. The password for 2021 is PROCEDURE2021.

Note: The AMA releases code changes quarterly as well as errata or corrections to CPT codes and guidelines and posts them on their web site. Some of these changes may not appear in the AMA's CPT book until the following year. *Current Procedural Coding Expert, Professional Edition* incorporates the most recent errata or release notes found on the AMA's web site at our publication time, including new, revised and deleted codes. *Current Procedural Coding Expert, Professional Edition* 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. For the next year's edition of *Current Procedural Coding Expert, Professional Edition*, 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. CPT codes that were new for 2020 and appeared in the 2020 *Current Procedural Coding Expert, Professional Edition* but did not appear in the AMA's CPT code book until 2021 are identified in appendix B as "Web Release New and Revised Codes."

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) 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 resequence the codes. In other words, it will assign 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, Professional Edition* 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

In *Current Procedural Coding Expert, Professional Edition* 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 range that contains the resequenced code and description, rather than to a specific location.

O-Numeric

-10, 11-Epoxide, [80161]
3-Beta-Hydroxysteroid Dehydrogenase Type II Deficiency, 81404
3-Methylcrotonyl-CoA Carboxylase 1, 81406
5,10-Methylenetetrahydrofolate Reductase, [81291]

A

A, C, Y, W-135 Combined Vaccine, 90733-90734
A Vitamin, 84590
Abbe-Estlander Procedure, 40527, 40761
ABBI Biopsy, 19081-19086
ABCA4, 81408
ABCC8, 81401, 81407
ABCD1, 81405
Abdomen, Abdominal
 Abscess, 49020, 49040
 Incision and Drainage
 Skin and Subcutaneous Tissue, 10060-10061
 Open, 49040
 Peritoneal, 49020
 Peritonitis, Localized, 49020
 Retroperitoneal, 49060
 Subdiaphragmatic, 49040
 Subphrenic, 49040
 Angiography, 74175, 75635
Aorta
 Aneurysm, 34701-34712 [34717, 34718], 34813, 34830-34832, 34841-34848, 35081-35103
 Angiography, 75635
 Aortography, 75625, 75630
 Thromboendarterectomy, 35331
 Aortic Aneurysm, 34701-34712 [34717, 34718], 34813, 34830-34832, 34841-34848, 35081-35103
Artery
 Ligation, 37617
Biopsy
 Incisional, 11106-11107
 Open, 49000
 Percutaneous, 49180
 Punch, 11104-11105
 Skin, Tangential, 11102-11103
 Bypass Graft, 35907
Cannula/Catheter
 Insertion, 49419, 49421
 Removal, 49422
Catheter
 Removal, 49422
 Celiotomy, 49000
 CT Scan, 74150-74178, 75635
Cyst
 Destruction/Excision, 49203-49205
 Sclerotherapy, 49185
Delivery
 After Attempted Vaginal Delivery
 Delivery Only, 59620
 Postpartum Care, 59622
 Routine Care, 59618
 Delivery Only, 59514
 Peritoneal Abscess
 Open, 49020
 Peritonitis, Localized, 49020
 Postpartum Care, 59515
 Routine Care, 59510
 Tubal Ligation at Time of, 58611 with Hysterectomy, 59525
Drainage, 49020, 49040
 Fluid, 49082-49083
 Retroperitoneal
 Open, 49060
 Skin and Subcutaneous Tissue, 10060-10061
 Subdiaphragmatic
 Open, 49040
 Subphrenic
 Open, 49040
 Ectopic Pregnancy, 59130
 Endometrioma, 49203-49205
 Destruction/Excision, 49203-49205
Excision
 Excess Skin, 15830

Abdomen, Abdominal — continued

Excision — *continued*
 Tumor, Abdominal Wall, 22900
 Exploration, 49000-49084
 Blood Vessel, 35840
 Staging, 58960
 Hernia Repair, 49491-49590, 49650-49659
 Incision, 49000-49084
 Staging, 58960
 Incision and Drainage
 Pancreatitis, 48000
 Infraumbilical Panniculectomy, 15830
 Injection
 Air, 49400
 Contrast Material, 49400
 Insertion
 Catheter, 49324, 49418-49421
 Venous Shunt, 49425
 Intraoperative
 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, 49320-49329
Laparotomy
 Exploration, 47015, 49000-49002, 58960
 Hemorrhage Control, 49002
 Reopening, 49002
 Second Look, 58960
 Staging, 58960
 with Biopsy, 49000
 Lymphangiogram, 75805, 75807
 Magnetic Resonance Imaging (MRI), 74181-74183
 Fetal, 74712-74713
 Needle Biopsy
 Mass, 49180
 Pancreatitis, 48000
 Paracentesis, 49082-49083
 Peritoneal Abscess, 49020
 Peritoneal Lavage, 49084
 Placement Guidance Devices, 49411-49412
 Radical Resection, 51597
 Repair
 Blood Vessel, 35221
 with
 Other Graft, 35281
 Vein Graft, 35251
 Hernia, 49491-49590, 49650-49659
 Suture, 49900
 Revision
 Venous Shunt, 49426
 Suture, 49900
Tumor
 Destruction/Excision, 49203-49205
 Tumor Staging, 58960
 Ultrasound, 76700, 76705, 76706
 Unlisted Services and Procedures, 49999
Wall
 See Abdomen, X-ray
 Debridement
 Infected, 11005-11006
Implant
 Fascial Reinforcement, 0437T
 Reconstruction, 49905
Removal
 Mesh, 11008
 Prosthesis, 11008
Repair
 Hernia, 49491-49590
 by Laparoscopy, 49650-49651
 Surgery, 22999
Tumor
 Excision, 22900-22905
 Wound Exploration
 Penetrating, 20102
 X-ray, 74018-74022
Abdominal Plane Block
 Bilateral, 64488-64489
 Unilateral, 64486-64487

Abdominohysterectomy

Radical, 58210
 Resection of Ovarian Malignancy, 58951, 58953-58954, 58956
 Supracervical, 58180
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 with Colpo-Urethroscopy, 58152
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Abdominoplasty, 15830, 15847, 17999
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Ablation
 Anal
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 Tumor, 46615
 Atria, 33254-33259
 Bone Tumor, 20982-20983
 Breast Tumor, 0581T
 Colon
 Polyp(s) or Tumor(s), [44401], [45346], [45388]
 Cryosurgical
 Breast Tumor, 0581T
 Fibroadenoma, 19105
 Liver Tumor(s), 47381
 Nerve, 0440T-0442T
 Renal Mass, 50250
 Renal Tumor
 Percutaneous, 50593
 CT Scan Guidance, 77013
 Endometrial, 58353, 58356, 58563
 Endometrium
 Ultrasound Guidance, 58356
 Endoscopic
 Duodenum/Jejunum, [43270]
 Esophagus, 43229, [43270]
 Hepatobiliary System, [43278]
 Stomach, [43270]
 Endovenous, 0524T, 36473-36479 [36482, 36483]
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 Percutaneous, 0632T
 Open Wound, 0491T-0492T
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 High-energy Water Vapor Thermotherapy, 0582T
 Transurethral Waterjet, 0421T
Pulmonary Tumor
 Cryoablation, [32994]
 Radiofrequency, 32998
Radiofrequency
 Liver Tumor(s), 47382
 Lung Tumor(s), 32998
 Renal Tumor(s), 50592
 Tongue Base, 41530

Ablation — continued

Renal
 Cyst, 50541
 Mass, 50542
 Radiofrequency, 50592
 Tumor, 50593
 Cryotherapy
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 Supraventricular Arrhythmic Focus, 33250-33251
Tongue Base
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Tumor
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Ultrasound
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 Uterine Tumor, 0071T-0072T
Uterus
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Vein
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Abortion
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 Incomplete, 59812
 Induced by
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 Drainage, 49020, 49040
 Peritoneal
 Open, 49020
 Peritonitis, Localized, 49020
 Retroperitoneal
 Open, 49060
 Skin and Subcutaneous Tissue
 Complicated, 10061
 Multiple, 10061
 Simple, 10060
 Single, 10060
 Subdiaphragmatic
 Open, 49040
 Subphrenic, 49040
 Incision and Drainage
 Open, 49040
Anal
 Incision and Drainage, 46045, 46050
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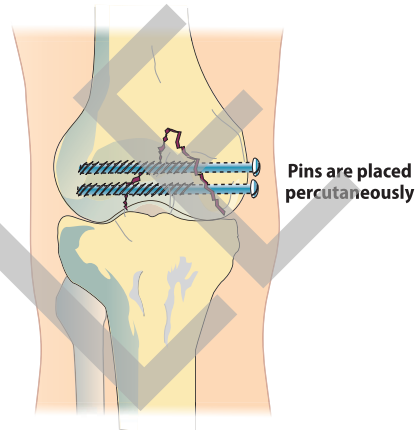
- 27485 **Arrest, hemiepiphyseal, distal femur or proximal tibia or fibula (eg, genu varus or valgus)**
🔪 19.3 🔪 19.3 **FUD 090** J 50 📄
 AMA: 2018,Sep,7
- 27486 **Revision of total knee arthroplasty, with or without allograft; 1 component**
🔪 40.6 🔪 40.6 **FUD 090** C 80 50 📄
 AMA: 2018,Sep,7; 2018,Apr,10; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jul,10; 2015,Jan,16
- 27487 **femoral and entire tibial component**
🔪 50.8 🔪 50.8 **FUD 090** C 80 50 📄
 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**
🔪 34.7 🔪 34.7 **FUD 090** C 80 50 📄
 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**
🔪 32.5 🔪 32.5 **FUD 090** C 80 50 📄
 AMA: 2018,Sep,7
- 27496 **Decompression fasciotomy, thigh and/or knee, 1 compartment (flexor or extensor or adductor);**
🔪 15.7 🔪 15.7 **FUD 090** J A2 50 📄
 AMA: 2018,Sep,7
- 27497 **with debridement of nonviable muscle and/or nerve**
🔪 16.7 🔪 16.7 **FUD 090** J A2 80 50 📄
 AMA: 2018,Sep,7
- 27498 **Decompression fasciotomy, thigh and/or knee, multiple compartments;**
🔪 18.8 🔪 18.8 **FUD 090** J A2 80 50 📄
 AMA: 2018,Sep,7
- 27499 **with debridement of nonviable muscle and/or nerve**
🔪 20.2 🔪 20.2 **FUD 090** J A2 80 50 📄
 AMA: 2018,Sep,7

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

I **INCLUDES** Closed, percutaneous, and open treatment fractures and dislocations

- 27500 **Closed treatment of femoral shaft fracture, without manipulation**
🔪 13.8 🔪 15.0 **FUD 090** T A2 50 📄
 AMA: 2018,Sep,7
- 27501 **Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, without manipulation**
🔪 14.3 🔪 14.5 **FUD 090** T A2 80 50 📄
 AMA: 2018,Sep,7
- 27502 **Closed treatment of femoral shaft fracture, with manipulation, with or without skin or skeletal traction**
🔪 21.9 🔪 21.9 **FUD 090** J A2 50 📄
 AMA: 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16
- 27503 **Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, with manipulation, with or without skin or skeletal traction**
🔪 23.1 🔪 23.1 **FUD 090** J A2 80 50 📄
 AMA: 2018,Sep,7
- 27506 **Open treatment of femoral shaft fracture, with or without external fixation, with insertion of intramedullary implant, with or without cerclage and/or locking screws**
🔪 38.6 🔪 38.6 **FUD 090** C 80 50 📄
 AMA: 2018,Sep,7; 2018,Jan,8; 2017,Jan,8; 2016,Jan,13; 2015,Jan,16

- 27507 **Open treatment of femoral shaft fracture with plate/screws, with or without cerclage**
🔪 28.0 🔪 28.0 **FUD 090** C 80 50 📄
 AMA: 2018,Sep,7
- 27508 **Closed treatment of femoral fracture, distal end, medial or lateral condyle, without manipulation**
🔪 14.3 🔪 15.0 **FUD 090** T A2 50 📄
 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 epiphyseal separation**
🔪 18.6 🔪 18.6 **FUD 090** J A2 80 50 📄
 AMA: 2018,Dec,10; 2018,Dec,10; 2018,Sep,7



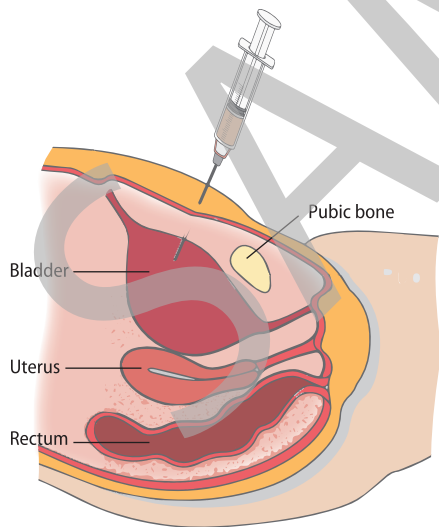
- 27510 **Closed treatment of femoral fracture, distal end, medial or lateral condyle, with manipulation**
🔪 19.6 🔪 19.6 **FUD 090** J A2 50 📄
 AMA: 2018,Sep,7
- 27511 **Open treatment of femoral supracondylar or transcondylar fracture without intercondylar extension, includes internal fixation, when performed**
🔪 28.8 🔪 28.8 **FUD 090** C 80 50 📄
 AMA: 2018,Sep,7
- 27513 **Open treatment of femoral supracondylar or transcondylar fracture with intercondylar extension, includes internal fixation, when performed**
🔪 35.9 🔪 35.9 **FUD 090** C 80 50 📄
 AMA: 2018,Sep,7
- 27514 **Open treatment of femoral fracture, distal end, medial or lateral condyle, includes internal fixation, when performed**
🔪 27.9 🔪 27.9 **FUD 090** C 80 50 📄
 AMA: 2018,Sep,7
- 27516 **Closed treatment of distal femoral epiphyseal separation; without manipulation**
🔪 13.8 🔪 14.7 **FUD 090** T A2 50 📄
 AMA: 2018,Sep,7
- 27517 **with manipulation, with or without skin or skeletal traction**
🔪 19.6 🔪 19.6 **FUD 090** J A2 80 50 📄
 AMA: 2018,Sep,7
- 27519 **Open treatment of distal femoral epiphyseal separation, includes internal fixation, when performed**
🔪 25.7 🔪 25.7 **FUD 090** C 80 50 📄
 AMA: 2018,Sep,7
- 27520 **Closed treatment of patellar fracture, without manipulation**
🔪 8.54 🔪 9.25 **FUD 090** T A2 50 📄
 AMA: 2018,Sep,7

51020-51080 Open Incisional Procedures of Bladder

- 51020 Cystotomy or cystostomy; with fulguration and/or insertion of radioactive material
🔪 13.5 🔪 13.5 **FUD 090** J A2 80 📄
 AMA: 2014,Jan,11
- 51030 with cryosurgical destruction of intravesical lesion
🔪 13.6 🔪 13.6 **FUD 090** J A2 80 📄
 AMA: 2014,Jan,11
- 51040 Cystostomy, cystostomy with drainage
🔪 8.36 🔪 8.36 **FUD 090** J A2 80 📄
 AMA: 2014,Jan,11
- 51045 Cystotomy, with insertion of ureteral catheter or stent (separate procedure)
🔪 14.2 🔪 14.2 **FUD 090** J A2 80 📄
 AMA: 2014,Jan,11
- 51050 Cystolithotomy, cystostomy with removal of calculus, without vesical neck resection
🔪 13.6 🔪 13.6 **FUD 090** J A2 80 📄
 AMA: 2014,Jan,11
- 51060 Transvesical ureterolithotomy
🔪 16.8 🔪 16.8 **FUD 090** J 80 📄
 AMA: 2014,Jan,11
- 51065 Cystotomy, with calculus basket extraction and/or ultrasonic or electrohydraulic fragmentation of ureteral calculus
🔪 16.7 🔪 16.7 **FUD 090** J A2 80 📄
 AMA: 2014,Jan,11; 2002,May,7
- 51080 Drainage of perivesical or prevesical space abscess
EXCLUDES Image-guided percutaneous catheter drainage (49406)
🔪 11.8 🔪 11.8 **FUD 090** J A2 80 📄
 AMA: 2014,Jan,11

51100-51102 Bladder Aspiration Procedures

- 51100 Aspiration of bladder; by needle
📄 (76942, 77002, 77012)
🔪 1.12 🔪 1.95 **FUD 000** T P3 📄
 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** S P3 📄
 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** J A2 📄
 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** J A2 80 📄
 AMA: 2014,Jan,11
- 51520 Cystotomy; for simple excision of vesical neck (separate procedure)
🔪 17.2 🔪 17.2 **FUD 090** J A2 80 📄
 AMA: 2014,Jan,11
- 51525 for excision of bladder diverticulum, single or multiple (separate procedure)
EXCLUDES Transurethral resection (52305)
🔪 24.8 🔪 24.8 **FUD 090** C 80 📄
 AMA: 2014,Jan,11
- 51530 for excision of bladder tumor
EXCLUDES Transurethral resection (52234-52240, 52305)
🔪 22.2 🔪 22.2 **FUD 090** C 80 📄
 AMA: 2014,Jan,11
- 51535 Cystotomy for excision, incision, or repair of ureterocele
EXCLUDES Transurethral excision (52300)
🔪 22.5 🔪 22.5 **FUD 090** J 62 80 📄
 AMA: 2014,Jan,11; 1993,Sum,25
- 51550 Cystectomy, partial; simple
🔪 27.9 🔪 27.9 **FUD 090** C 80 📄
 AMA: 2014,Jan,11
- 51555 complicated (eg, postradiation, previous surgery, difficult location)
🔪 36.6 🔪 36.6 **FUD 090** C 80 📄
 AMA: 2014,Jan,11
- 51565 Cystectomy, partial, with reimplantation of ureter(s) into bladder (ureteroneocystostomy)
🔪 37.5 🔪 37.5 **FUD 090** C 80 📄
 AMA: 2014,Jan,11
- 51570 Cystectomy, complete; (separate procedure)
🔪 42.6 🔪 42.6 **FUD 090** C 80 📄
 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** C 80 📄
 AMA: 2014,Jan,11; 1993,Spr,34
- 51580 Cystectomy, complete, with ureterosigmoidostomy or ureterocutaneous transplantations;
🔪 54.8 🔪 54.8 **FUD 090** C 80 📄
 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** C 80 📄
 AMA: 2014,Jan,11; 1993,Spr,34
- 51590 Cystectomy, complete, with ureteroileal conduit or sigmoid bladder, including intestine anastomosis;
🔪 55.9 🔪 55.9 **FUD 090** C 80 📄
 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** C 80 📄
 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** C 80 📄
 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 (ie, 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 appropriate level of 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 other service 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 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 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 (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 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.