OPTUM360®

PROFESSIONAL

Current Procedural Coding Expert

CPT® codes with Medicare essentials for enhanced accuracy

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Contents

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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 *Current Procedural Coding Expert, Professional Edition* includes effective codes that will not be published in the AMA's Current Procedural Terminology (CPT) book until the following year.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.

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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

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

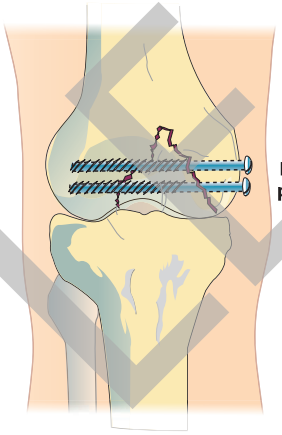
27503 Closed treatment of supracondylar or transcondylar femoral fracture with or without intercondylar extension, with manipulation, with or without skin or skeletal traction
23.1 23.1 FUD 090 J A2 80 50
AMA: 2018,Sep,7

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

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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, cystotomy 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, cystotomy with removal of calculus, without vesical neck resection
13.6 13.6 FUD 090 J A2 80
AMA: 2014,Jan,11

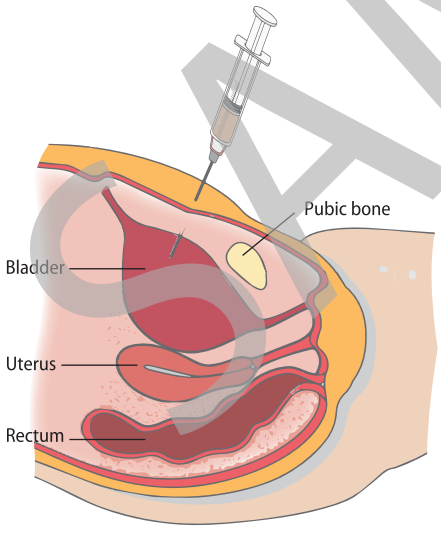
51060 Transvesical ureterolithotomy
16.8 16.8 FUD 090 J 80
AMA: 2014,Jan,11

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 G2 80 50
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

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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.

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