Optum

Coding Companion

Internal Medicine/ Endocrinology/ Rheumatology

A comprehensive illustrated guide to coding and reimbursement

SAMPLE

2024

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Getting Started with Coding Companion

Coding Companion for Internal Medicine/Endocrinology/Rheumatology is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to internal medicine/endocrinology/rheumatology are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT/HCPCS code is followed by its official CPT code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum *Coding Companion* series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features.

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT code description, followed by an easy-to-understand explanation.

The codes in the appendix are presented in the following order:

- HCPCS
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 28.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2024 edition password is: **XXXXX.** Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

65205 Removal of foreign body, external eye; conjunctival superficial

could be found in the index under the following main terms:

Conjunctiva
Foreign Body Removal, 65205-65210

or **Eye**
Removal
Foreign Body
Superficial, 65205

or **Foreign Body**
Removal
External Eye, 65205

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xiv of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

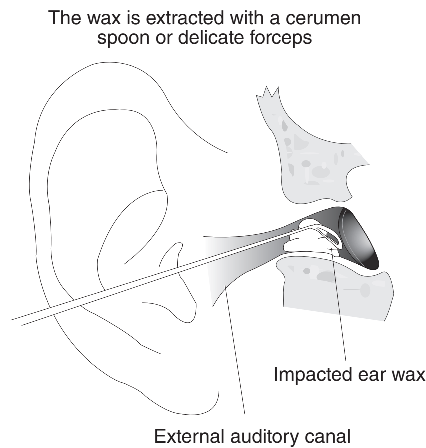
The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

SAMPLE

69209-69210

1

69209 Removal impacted cerumen using irrigation/lavage, unilateral
69210 Removal impacted cerumen requiring instrumentation, unilateral



2

Explanation

3

Under direct visualization, the physician removes impacted cerumen (ear wax) using irrigation or lavage (69209), or via suction, a cerumen spoon, or delicate forceps (69210). A typical solution used for lavage is water and saline, warmed to body temperature to avoid causing dizziness, placed in the ear approximately 15 to 30 minutes prior to removal. When instrumentation is used and no infection is present, the ear canal may also be irrigated.

Coding Tips

4

These codes describe removal of cerumen impaction. Report unimpacted cerumen removal with the appropriate E/M service code. Do not report these codes together when performed on the same ear. These codes describe unilateral procedures. If performed bilaterally, some payers require that the service be reported twice with modifier 50 appended to the second code while others require identification of the service only once with modifier 50 appended. Check with individual payers. Medicare allows only one unit of this code to be billed even if both ears are treated. Medicare and some other payers may require that HCPCS Level II code G0268 be reported for removal of impacted cerumen (one or both ears) by a physician on the same date of service as audiologic function testing. Code 69210 should not be reported for removal of PE tubes. For removal of a foreign body from the external auditory canal, without general anesthesia, see 69200.

ICD-10-CM Diagnostic Codes

5

H61.21 Impacted cerumen, right ear ☑
H61.22 Impacted cerumen, left ear ☑
H61.23 Impacted cerumen, bilateral ☑

Associated HCPCS Codes

6

G0268 Removal of impacted cerumen (one or both ears) by physician on same date of service as audiologic function testing

AMA: 69209 2016,Mar; 2016,Feb; 2016,Jan **69210** 2016,Mar; 2016,Feb;

7

Relative Value Units/Medicare Edits

8

Non-Facility RVU	Work	PE	MP	Total
69209	0.0	0.44	0.01	0.45
69210	0.61	0.7	0.09	1.4
Facility RVU	**Work**	**PE**	**MP**	**Total**
69209	0.0	0.44	0.01	0.45
69210	0.61	0.27	0.09	0.97

	FUD	Status	MUE	Modifiers				IOM Reference
69209	0	A	1(2)	51	50	N/A	N/A	None
69210	0	A	1(2)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

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cerumen. Wax-like substance secreted by the ceruminous glands in the external ear canal. If it becomes firm and blocks the ear canal it may interfere with hearing and require removal.

impaction. State of being tightly wedged or lodged into or between something.

irrigation. To wash out or cleanse a body cavity, wound, or tissue with water or other fluid.

lavage. Washing.

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1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2023.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2023.
- ▲ This CPT code description is revised for 2023.
- + This CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.

The Centers for Medicare and Medicaid Services (CMS) have identified additional services that may be performed via telehealth. Due to the COVID-19 public health emergency (PHE), some services have been designated as temporarily appropriate for telehealth. These CMS approved services are identified in the coding tips where appropriate. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 93 or 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services, when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96160	96161	97802	97803	97804
99406	99407	99408	99409	99497	99498	

2. Illustrations

The illustrations that accompany the *Coding Companion* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most pages will have an illustration, there will be some pages that do not.

3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes the most common method of performing each procedure.

4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- N Newborn: 0
- P Pediatric: 0-17
- M Maternity: 9-64
- A Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

6. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

7. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2022.

The 2023 Medicare edits were not available at the time this book went to press. Updated 2023 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2023 edition password is **23SPECIALTY**.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled

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Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

▶The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service◀

Classification of Evaluation and Management (E/M) Services

▶The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care 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 inpatient and observation care 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.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.◀

AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

New and Established Patients

▶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. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

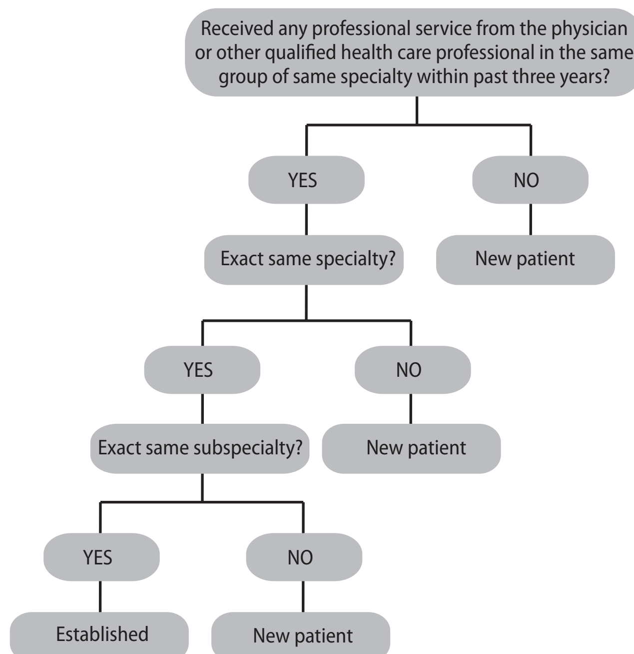
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the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

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other 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 subspecialty** 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 for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



SAMPLE

99202-99205

★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, 15 to 29 minutes of total time is spent on the day of encounter. Report 99203 for a visit requiring a low level of MDM or 30 to 44 minutes of total time; 99204 for a visit requiring a moderate level of MDM or 45 to 59 minutes of total time; and 99205 for a visit requiring a high level of MDM or 60 to 74 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternately, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. For office or other outpatient services for an established patient, see 99211-99215. For patients admitted and discharged from inpatient or observation care on the same date, see 99234-99236. For prolonged services with 99205, see 99417; for Medicare, see G2212. Medicare has identified these codes as telehealth/telemedicine services. Commercial payers should be contacted regarding their coverage guidelines. Telemedicine services may be reported by the performing provider by adding modifier 95 to these procedure codes and using the appropriate place of service. Services at the origination site are reported with HCPCS Level II code Q3014.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99203** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99204** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan **99205** 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun; 2016,Dec; 2016,Mar; 2016,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.12	0.09	2.14
99203	1.6	1.52	0.17	3.29
99204	2.6	2.06	0.24	4.9
99205	3.5	2.66	0.32	6.48
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.09	1.43
99203	1.6	0.67	0.17	2.44
99204	2.6	1.11	0.24	3.95
99205	3.5	1.54	0.32	5.36

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	None
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

new patient. Patient who is receiving face-to-face care from a physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice for the first time in three years. For OPPS hospitals, a patient who has not been registered as an inpatient or outpatient, including off-campus provider-based clinic or emergency department, within the past three years.

SAMPLE

99288

99288 Physician or other qualified health care professional direction of emergency medical systems (EMS) emergency care, advanced life support

Explanation

This code is used to report qualified clinician direction of emergency medical systems (EMS) emergency care or advanced life support in the emergency department (ED). This can involve the clinician communicating via a two-way voice system with emergency medical technicians in an ambulance or with other rescue personnel who are outside of the hospital emergency department. Clinician direction of the performance of medically necessary procedures includes, but is not limited to, telemetry of cardiac rhythm; cardiac and/or pulmonary resuscitation; endotracheal or esophageal obturator airway intubation; administration of intravenous (IV) fluids and/or intramuscular (IM), intra-tracheal, or subcutaneous drugs; and/or electrical conversion of cardiac arrhythmia.

Coding Tips

This code is used by a facility-based practitioner (emergency department, critical care unit) who is directing remote emergency care or advanced life support in the urgent care of the patient. Time is not a factor when selecting this E/M service. This service may be reported in addition to other E/M services on the same date when documented in the patient record.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: 99288 2022,Nov; 2022,Aug; 2022,Jul; 2022,May; 2021,Jan; 2019,Jul; 2017,Aug; 2017,Jun; 2016,Nov

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99288	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
99288	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
99288	N/A	B	0(3)	N/A	N/A	N/A	N/A	100-04,12,100

* with documentation

99291-99292

99291 Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes

\+ **99292** each additional 30 minutes (List separately in addition to code for primary service)

Explanation

Critical care services are reported by a physician or other qualified health care provider for critically ill or injured patients. Critical illnesses or injuries are defined as those with impairment to one or more vital organ systems with an increased risk of rapid or imminent health deterioration. Critical care services require direct patient/provider involvement with highly complex decision making in order to evaluate, control, and support vital systems functions to treat one or more vital organ system failures and/or to avoid further decline of the patient's condition. Vital organ system failure includes, but is not limited to, failure of the central nervous, circulatory, or respiratory systems; kidneys; liver; shock; and other metabolic processes. Generally, critical care services necessitate the interpretation of many physiologic parameters and/or other applications of advanced technology as available in a critical care unit, pediatric intensive care unit, respiratory care unit, in an emergency facility, patient room or other hospital department; however, in emergent situations, critical care may be provided where these elements are not available. Critical care may be provided so long as the patient's condition continues to warrant the level of care according to the criteria described. Care provided to patients residing in a critical care unit but not fitting the criteria for critical care is reported using other E/M codes, as appropriate. These codes are time based codes, meaning the total time spent must be documented and includes direct patient care bedside or time spent on the patient's floor or unit (reviewing laboratory results or imaging studies and discussing the patient's care with medical staff, time spent with family members, caregivers, or other surrogate decision makers to gather information on the patient's medical history, reviewing the patient's condition or prognosis, and discussing various treatment options or limitations of treatment), as long as the clinician is immediately available and not providing services to any other patient during the same time period. Time spent outside of the patient's unit or floor, including telephone calls, caregiver discussions, or time spent in actions that do not directly contribute to the patient's care rendered in the critical unit are not reported as critical care. Report these codes for attendance of the patient during transport for patients 24 months of age or older to or from a facility. Code 99291 represents the first 30 to 74 minutes of critical care and is reported once per day. Additional time beyond the first 74 minutes is reported in 30 minute increments with 99292.

Coding Tips

These codes are used to report critical care services. These are time-based services and the total time spent providing critical care must be documented in the medical record. All time spent providing critical care on the same date of service is added together and does not need to be contiguous. Time is reported for practitioner time spent in care of the critically ill or injured patient at the patient's bedside and on the floor/unit. Time spent off the patient unit, even if related to patient care, is not counted. Do not report critical care for patients who may be in the critical care unit but are not currently critically ill. The following services are considered inclusive to the critical care codes when reported by the clinician: interpretation of cardiac output measurements, chest x-rays, pulse oximetry, blood gases, collection and interpretation of physiologic data, computer data such as ECGs, gastric intubation, vascular access, and ventilation management. Code 99291 is reported once per day. Code 99292 is reported in addition to code 99291. Medicare and some other payers may allow 99292 to be reported alone when critical care is reported by another physician of the same group and specialty the same date as another provider reporting 99291. For care of the critically ill neonate, see 99468-99469;

SAMPLE

[99424, 99425, 99426, 99427]

99424 Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally by a physician or other qualified health care professional, per calendar month.

+ **99425** Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; each additional 30 minutes provided personally by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

99426 Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.

+ **99427** Principal care management services, for a single high-risk disease, with the following required elements: one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, the condition requires development, monitoring, or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, ongoing communication and care coordination between relevant practitioners furnishing care; each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)

Explanation

Principal care management services are provided to patients for a single high-risk disease. There is one complex condition that is chronic and expected to last a minimum of three months that puts the patient at substantial risk of exacerbation, functional decline, hospitalization, or death. The disease-specific care plan related to this condition requires on-going development, monitoring, or revising. Frequent adjustments to the medication regimen are required, or patient comorbidities increase the complexity of the condition's management. Communication and care coordination between those furnishing care is required on an ongoing basis. Report 99424 once per calendar month for the first 30 minutes of care provided personally by a physician or other qualified health care professional (QHP); report 99425 for each additional 30 minutes. Report 99426 once per calendar month for the first 30 minutes of clinical staff time when directed by a physician or other QHP; for each additional 20 minutes, report 99427.

Coding Tips

These codes are used to report care management services provided by the clinical staff under the direction of a qualified health care professional or directly by a physician or other qualified health care professional to a patient residing at home or in an assisted living facility, domiciliary, or rest home. These are time-based codes and total time spent performing care management services during the calendar month should be documented in the patient record. Do not report these codes if all elements listed in the code description are not performed. If the physician provides face-to-face E/M visits in the same calendar month, these visits may be reported separately. Do not count clinical staff time for a particular day if the physician reports an E/M service on that day. Do not report 99424 if less than 30 minutes of principal care management is provided in the calendar month. Code 99425 should be reported in addition to 99424 for each additional 30 minutes of physician time provided. Report 99426 when more than 30 minutes of principal care management is provided by the clinical staff in the same calendar month. Code 99427 should be reported in addition to 99426 for each additional 30 minutes of clinical staff time. Do not report these codes with 90951-90970 for ESRD services or in the postoperative period of a reported surgery. Do not report these codes with 99374-99380, 99426-99427, 99437, 99439, 99487, 99489, 99490-99491, or 99605-99607 in the same calendar month. Do not report these codes for service time reported with 93792-93793, 98960-98962, 98966-98968, 98970-98972, 99071, 99078, 99080, 99091, 99358-99359, 99366-99368, 99421-99423, 99441-99443, or 99605-99607.

ICD-10-CM Diagnostic Codes

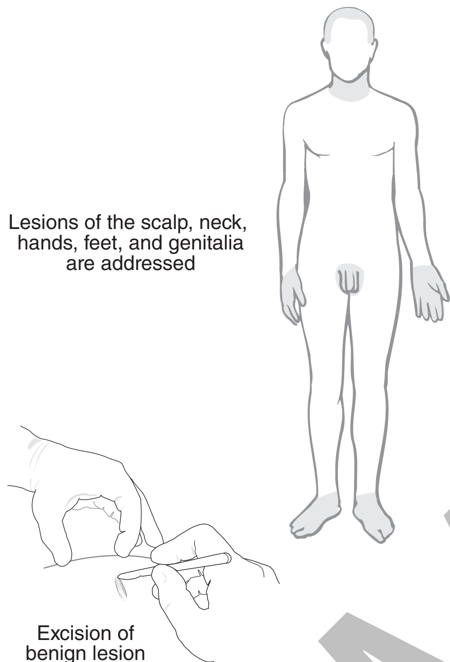
The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99424** 2022,Nov; 2022,Aug; 2022,Jul; 2022,Apr; 2022,Jan **99425** 2022,Nov; 2022,Aug; 2022,Jul; 2022,Apr; 2022,Jan **99426** 2022,Nov; 2022,Jul; 2022,Apr; 2022,Jan **99427** 2022,Nov; 2022,Jul; 2022,Apr; 2022,Jan

SAMPLE

11420-11426

11420 Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 0.5 cm or less
11421 excised diameter 0.6 to 1.0 cm
11422 excised diameter 1.1 to 2.0 cm
11423 excised diameter 2.1 to 3.0 cm
11424 excised diameter 3.1 to 4.0 cm
11426 excised diameter over 4.0 cm



Explanation

The physician removes a benign skin lesion located on the scalp, neck, hands, feet, or genitalia. After administering a local anesthetic, the physician makes a full thickness incision through the dermis with a scalpel, usually in an elliptical shape around and under the lesion. The lesion and a margin of normal tissue are removed. The wound is repaired using a single layer of sutures, chemical or electrocauterization. Complex or layered closure is reported separately, if required. Each lesion removed is reported separately. Report 11420 for an excised diameter 0.5 cm or less; 11421 for 0.6 cm to 1 cm; 11422 for 1.1 cm to 2 cm; 11423 for 2.1 cm to 3 cm; 11424 for 3.1 cm to 4 cm; and 11426 if the excised diameter is greater than 4 cm.

Coding Tips

Local anesthesia is included in these services. These procedures include simple (non-layered) repair of the skin and/or subcutaneous tissues. If the wound requires layered closure, it must be reported separately with intermediate repair codes 12031–12047 or complex repair codes 13120–13133. For destruction of benign or premalignant lesions, see 17000–17111. For excision of a malignant lesion, see 11620–11626. When these codes are performed with another separately identifiable procedure, the highest dollar value code is listed as the primary procedure and subsequent procedures are appended with modifier 51. If specimen is transported to an outside laboratory, report 99000 for handling or conveyance. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

D17.0	Benign lipomatous neoplasm of skin and subcutaneous tissue of head, face and neck
D22.4	Melanocytic nevi of scalp and neck
D23.4	Other benign neoplasm of skin of scalp and neck
D48.5	Neoplasm of uncertain behavior of skin
I78.1	Nevus, non-neoplastic
L72.0	Epidermal cyst
L72.11	Pilar cyst
L72.12	Trichodermal cyst
L72.2	Steatocystoma multiplex
L72.3	Sebaceous cyst
L72.8	Other follicular cysts of the skin and subcutaneous tissue
L73.2	Hidradenitis suppurativa
L82.0	Inflamed seborrheic keratosis
L92.2	Granuloma faciale [eosinophilic granuloma of skin]
L92.3	Foreign body granuloma of the skin and subcutaneous tissue

AMA: 11420 2022,Nov; 2022,Feb; 2021,Aug; 2019,Nov; 2018,Sep; 2018,Feb; 2016,Apr **11421** 2022,Nov; 2022,Feb; 2021,Aug; 2019,Nov; 2018,Sep; 2018,Feb; 2016,Apr **11422** 2022,Nov; 2022,Feb; 2021,Aug; 2019,Nov; 2018,Sep; 2018,Feb; 2016,Apr **11423** 2022,Nov; 2022,Feb; 2021,Aug; 2019,Nov; 2018,Sep; 2018,Feb; 2016,Apr **11424** 2022,Nov; 2022,Feb; 2021,Aug; 2019,Nov; 2018,Sep; 2018,Feb; 2016,Apr **11426** 2022,Nov; 2022,Feb; 2021,Aug; 2019,Nov; 2018,Sep; 2018,Feb; 2016,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11420	1.03	2.68	0.1	3.81
11421	1.47	3.13	0.17	4.77
11422	1.68	3.46	0.21	5.35
11423	2.06	3.77	0.27	6.1
11424	2.48	4.16	0.35	6.99
11426	4.09	5.18	0.65	9.92
Facility RVU	**Work**	**PE**	**MP**	**Total**
11420	1.03	1.28	0.1	2.41
11421	1.47	1.56	0.17	3.2
11422	1.68	2.08	0.21	3.97
11423	2.06	2.23	0.27	4.56
11424	2.48	2.38	0.35	5.21
11426	4.09	3.26	0.65	8.0

	FUD	Status	MUE	Modifiers				IOM Reference
11420	10	A	3(3)	51	N/A	N/A	N/A	None
11421	10	A	3(3)	51	N/A	N/A	N/A	
11422	10	A	3(3)	51	N/A	N/A	N/A	
11423	10	A	2(3)	51	N/A	N/A	N/A	
11424	10	A	2(3)	51	N/A	N/A	N/A	
11426	10	A	2(3)	51	N/A	N/A	N/A	

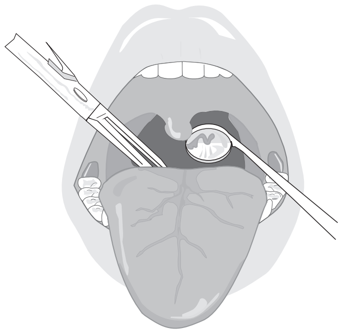
* with documentation

Integumentary

SAMPLE

31511-31512

31511 Laryngoscopy, indirect; with removal of foreign body
31512 with removal of lesion



Forceps may be used to remove a foreign body

Explanation

The physician administers a topical anesthetic to the oral cavity, pharynx, and larynx and positions the patient's head and laryngoscopic mirror so as to view the larynx through the reflection. In 31511, a foreign body is identified and withdrawn by grasping it with forceps. In 31512, a lesion is identified and excised.

Coding Tips

When an indirect laryngoscopy is performed, the physician uses mirrors to visualize the larynx. A direct laryngoscopy allows the physician to see the larynx through a scope in the throat (directly). Report the appropriate endoscopy for each anatomic site examined. Surgical endoscopy includes a diagnostic endoscopy; however, diagnostic endoscopy can be identified separately when performed at the same surgical session as an open procedure. If specimen is transported to an outside laboratory, report 99000 for handling or conveyance. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

C73 Malignant neoplasm of thyroid gland
D09.3 Carcinoma in situ of thyroid and other endocrine glands
S10.15XA Superficial foreign body of throat, initial encounter

Relative Value Units/Medicare Edits

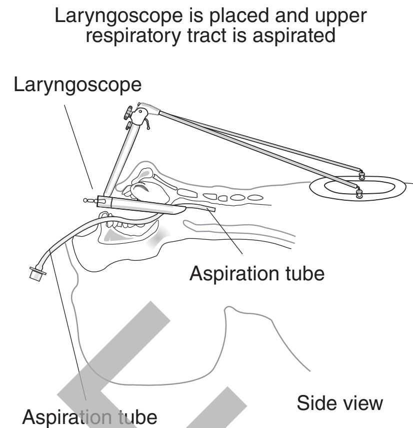
Non-Facility RVU	Work	PE	MP	Total
31511	2.16	3.85	0.33	6.34
31512	2.07	4.09	0.28	6.44
Facility RVU	**Work**	**PE**	**MP**	**Total**
31511	2.16	1.39	0.33	3.88
31512	2.07	1.42	0.28	3.77

	FUD	Status	MUE	Modifiers				IOM Reference
31511	0	A	1(3)	51	N/A	N/A	N/A	None
31512	0	A	1(3)	51	N/A	N/A	80*	

* with documentation

31515

31515 Laryngoscopy direct, with or without tracheoscopy; for aspiration



Explanation

The physician uses an aspirator to remove excess saliva or semi-solid foreign material from the larynx. After applying topical anesthesia to the oral cavity and pharynx, the physician inserts the laryngoscope through the patient's mouth. An aspirator is fed through the laryngoscope and the larynx is cleared of saliva and semi-solid foreign material. If a tracheoscopy is performed, a bronchoscope is inserted through the laryngoscope for microscopic visualization of the trachea and bronchi. No other procedure is performed.

Coding Tips

A direct laryngoscopy allows the physician to see the larynx through a scope in the throat. When an indirect laryngoscopy is performed, the physician uses mirrors to visualize the larynx. Report the appropriate endoscopy for each anatomic site examined. Surgical endoscopy includes a diagnostic endoscopy; however, diagnostic endoscopy can be identified separately when performed at the same surgical session as an open procedure. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

J95.01 Hemorrhage from tracheostomy stoma
J95.02 Infection of tracheostomy stoma
J95.09 Other tracheostomy complication
J95.89 Other postprocedural complications and disorders of respiratory system, not elsewhere classified
R04.2 Hemoptysis
T81.41XA Infection following a procedure, superficial incisional surgical site, initial encounter
T81.42XA Infection following a procedure, deep incisional surgical site, initial encounter
T81.49XA Infection following a procedure, other surgical site, initial encounter

AMA: 31515 2020,Dec; 2019,Sep

Respiratory

SAMPLE

90660 [90672]

90660 Influenza virus vaccine, trivalent, live (LAIV3), for intranasal use
90672 Influenza virus vaccine, quadrivalent, live (LAIV4), for intranasal use

Explanation

A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of the antibody production pattern for long-term protection. A suspension of the prevalent strains of influenza virus is prepared for intranasal use. This live vaccination (LAIV3, LAIV4) contains the actual pathogen that has been weakened. Report these codes with the appropriate administration code. Report 90660 when the vaccine contains three strains. Report 90672 if the vaccine is comprised of four strains.

Coding Tips

Report these codes with the appropriate administration code. Administration codes should only be reported when the clinician renders face-to-face counseling to the patient and/or family at the time the immunization is being administered. For administration of a vaccine without the face-to-face clinician counseling service for patients 18 years of age and older, see 90471–90474. Separately identifiable E/M services may be reported in addition to the vaccine and toxoid administration codes.

ICD-10-CM Diagnostic Codes

Z23 Encounter for immunization
Z29.8 Encounter for other specified prophylactic measures

AMA: **90660** 2021,Jun; 2021,May; 2021,Apr; 2020,Nov; 2016,Oct **90672** 2021,Jun; 2021,May; 2021,Apr; 2020,Nov; 2016,Oct

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90660	0.0	0.0	0.0	0.0
90672	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90660	0.0	0.0	0.0	0.0
90672	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
90660	N/A	X	1(2)	N/A	N/A	N/A	N/A	None
90672	N/A	X	1(2)	N/A	N/A	N/A	N/A	

* with documentation

90661

90661 Influenza virus vaccine, trivalent (ccIIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage, for intramuscular use

Explanation

A vaccine produces active immunization by inducing the immune system to build its own antibodies against specific microorganisms/viruses. The body retains memory of the antibody production pattern for long-term protection. A suspension of the prevalent strain of influenza virus that has been derived from cell cultures is prepared for intramuscular use. Cell culture-derived vaccines are those in which the virus is grown in mammalian cells rather than egg-derived. The vaccine provides active immunity to the highly contagious infection of the respiratory tract caused by a myxovirus and transmitted by airborne droplet infection. This vaccine (ccIIV3) is preservative and antibiotic-free. This code reports a subunit in a 0.5 mL dose and should be reported with the appropriate administration code.

Coding Tips

Report this code with the appropriate administration code. Administration codes should only be reported when the clinician renders face-to-face counseling to the patient and/or family at the time the immunization is being administered. For administration of a vaccine without the face-to-face clinician counseling service for patients 18 years of age and older, see 90471–90474. Separately identifiable E/M services may be reported in addition to the vaccine and toxoid administration codes.

ICD-10-CM Diagnostic Codes

Z23 Encounter for immunization
Z29.8 Encounter for other specified prophylactic measures

AMA: **90661** 2021,Jun; 2021,May; 2021,Apr; 2020,Nov; 2016,Oct

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90661	0.0	0.0	0.0	0.0
Facility RVU	**Work**	**PE**	**MP**	**Total**
90661	0.0	0.0	0.0	0.0

	FUD	Status	MUE	Modifiers				IOM Reference
90661	N/A	X	1(2)	N/A	N/A	N/A	N/A	None

* with documentation

SAMPLE

93000-93010

93000 Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93005 tracing only, without interpretation and report
93010 interpretation and report only

Explanation

Multiple electrodes are placed on a patient's chest to record the electrical activity of the heart. A physician interprets the findings. Report 93000 for the combined technical and professional components of an ECG; 93005 for the technical component only; and 93010 for the professional component only.

Coding Tips

Do not report these codes with Category III codes 0525T-0532T.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

Associated HCPCS Codes

G0403 Electrocardiogram, routine ECG with 12 leads; performed as a screening for the initial preventive physical examination with interpretation and report

G0404 Electrocardiogram, routine ECG with 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive physical examination

G0405 Electrocardiogram, routine ECG with 12 leads; interpretation and report only, performed as a screening for the initial preventive physical examination

AMA: **93000** 2020,Dec; 2017,Oct **93005** 2020,Dec; 2017,Oct **93010** 2021,May; 2020,Dec; 2016,Apr

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
93000	0.17	0.23	0.02	0.42
93005	0.0	0.17	0.01	0.18
93010	0.17	0.06	0.01	0.24
Facility RVU	**Work**	**PE**	**MP**	**Total**
93000	0.17	0.23	0.02	0.42
93005	0.0	0.17	0.01	0.18
93010	0.17	0.06	0.01	0.24

	FUD	Status	MUE	Modifiers				IOM Reference
93000	N/A	A	3(3)	N/A	N/A	N/A	80*	100-03,160.17; 100-04,18,80.2
93005	N/A	A	3(3)	N/A	N/A	N/A	80*	
93010	N/A	A	5(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

EKG. Electrocardiogram. Graphic recording of the changes in electrical voltage and polarity caused by the heart muscle's electrical excitation. The tracing follows atrial and ventricular activity over time, captured through electrodes placed on the skin.

interpretation. Professional health care provider's review of data with a written or verbal opinion.

93040-93042

93040 Rhythm ECG, 1-3 leads; with interpretation and report
93041 tracing only without interpretation and report
93042 interpretation and report only

Explanation

An assistant records the electrical activity of the heart by placing one to three electrodes on a patient's chest in a predetermined pattern. Report 93040 when the physician interprets the report. Report 93041 when only the tracing is performed. Report 93042 when a physician interprets a previously acquired report.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **93040** 2020,Dec; 2020,Sep; 2017,Oct **93041** 2020,Dec; 2017,Oct **93042** 2020,Dec; 2017,Oct

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
93040	0.15	0.2	0.02	0.37
93041	0.0	0.16	0.01	0.17
93042	0.15	0.04	0.01	0.2
Facility RVU	**Work**	**PE**	**MP**	**Total**
93040	0.15	0.2	0.02	0.37
93041	0.0	0.16	0.01	0.17
93042	0.15	0.04	0.01	0.2

	FUD	Status	MUE	Modifiers				IOM Reference
93040	N/A	A	3(3)	N/A	N/A	N/A	80*	100-04,32,130.1
93041	N/A	A	2(3)	N/A	N/A	N/A	80*	
93042	N/A	A	3(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

EKG. Electrocardiogram. Graphic recording of the changes in electrical voltage and polarity caused by the heart muscle's electrical excitation. The tracing follows atrial and ventricular activity over time, captured through electrodes placed on the skin.

electrode. Electric terminal specialized for a particular electrochemical reaction that acts as a medium between a body surface and another instrument, commonly termed a lead.

SAMPLE

Correct Coding Initiative Update 28.3

❖Indicates Mutually Exclusive Edit

0732T No CCI edits apply to this code.

0740T No CCI edits apply to this code.

0741T No CCI edits apply to this code.

0770T No CCI edits apply to this code.

0771T No CCI edits apply to this code.

0772T No CCI edits apply to this code.

0773T No CCI edits apply to this code.

0774T No CCI edits apply to this code.

0001A 0591T-0593T, 36591-36592, 96160-96161, 96523, 99202-99215, 99241-99245, 99281-99285, 99381-99412, 99483, 99497, G0442-G0445, G0463

0002A 0591T-0593T, 36591-36592, 96160-96161, 96523, 99202-99215, 99241-99245, 99281-99285, 99381-99412, 99483, 99497, G0442-G0445, G0463

0003A No CCI edits apply to this code.

0004A No CCI edits apply to this code.

0011A No CCI edits apply to this code.

0012A No CCI edits apply to this code.

0013A No CCI edits apply to this code.

0021A 0591T-0593T, 36591-36592, 96160-96161, 96523, 99202-99215, 99241-99245, 99281-99285, 99381-99412, 99483, 99497, G0442-G0445, G0463

0022A 0591T-0593T, 36591-36592, 96160-96161, 96523, 99202-99215, 99241-99245, 99281-99285, 99381-99412, 99483, 99497, G0442-G0445, G0463

0031A 0591T-0593T, 36591-36592, 96160-96161, 96523, 99202-99215, 99241-99245, 99281-99285, 99381-99412, 99483, 99497, G0442-G0445, G0463

0034A No CCI edits apply to this code.

0041A 0591T-0593T, 36591-36592, 96160-96161, 96523, 99202-99215, 99241-99245, 99281-99285, 99381-99412, 99483, 99497, G0442-G0445, G0463

0042A 0591T-0593T, 36591-36592, 96160-96161, 96523, 99202-99215, 99241-99245, 99281-99285, 99381-99412, 99483, 99497, G0442-G0445, G0463

0044A No CCI edits apply to this code.

0051A No CCI edits apply to this code.

0052A No CCI edits apply to this code.

0053A No CCI edits apply to this code.

0054A No CCI edits apply to this code.

0064A No CCI edits apply to this code.

0071A No CCI edits apply to this code.

0072A No CCI edits apply to this code.

0073A No CCI edits apply to this code.

0074A No CCI edits apply to this code.

0081A No CCI edits apply to this code.

0082A No CCI edits apply to this code.

0083A No CCI edits apply to this code.

0091A No CCI edits apply to this code.

0092A No CCI edits apply to this code.

0093A No CCI edits apply to this code.

0094A No CCI edits apply to this code.

0111A No CCI edits apply to this code.

0112A No CCI edits apply to this code.

0113A No CCI edits apply to this code.

0124A No CCI edits apply to this code.

0134A No CCI edits apply to this code.

0144A No CCI edits apply to this code.

0154A No CCI edits apply to this code.

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