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Lower Extremity Arterial Anatomy—Contralateral, Axillary or Brachial Approach

- External iliac artery 32646 (2nd order)
- Profunda femoris 36247 artery (3rd order)
- Perforating artery branches 36247 (3rd order)
- Superior lateral genicular artery 36247 (3rd order)
- Popliteal artery 36247 (3rd order)
- Inferior lateral genicular artery 36247 (3rd order)
- Peroneal artery 36247 (3rd order)
- Posterior tibial artery 36247 (3rd order)
- Anterior tibial artery 36247 (3rd order)
- Lateral anterior malleolar artery 36247 (3rd order)
- Medial anterior malleolar artery 36247 (3rd order)
- Pedis dorsalis artery 36247 (3rd order)
- Common iliac artery 36245 (1st order)
- Common femoral artery 36246 (2nd order)
- Internal iliac artery (aka hypogastric) 36246 (2nd order)
- Superficial femoral artery 36247 (3rd order)
- Common femoral artery 36246 (2nd order)
- Popliteal artery 36247 (3rd order)
- Anterior tibial artery 36247 (3rd order)
- Peroneal artery 36247 (3rd order)
- Posterior tibial artery 36247 (3rd order)
- Pedis dorsalis artery 36247 (3rd order)
The kidneys remove waste products of protein metabolism and other excess materials and fluids from the blood. Variations in kidney anatomy are fairly common, though abnormalities can complicate procedures. “Pyelo” refers to the renal pelvis, an important access site to the inner kidney. Each kidney is imbedded in a mass of peritoneal fat that helps to enclose and position it.
For the purposes of these CPT definitions, the following body areas are recognized:

- Head, including the face
- Neck
- Chest, including breasts and axilla
- Abdomen
- Genitalia, groin, buttocks
- Back
- Each extremity

For the purposes of these CPT definitions, the following organ systems are recognized:

- Eyes
- Ears, nose, mouth, and throat
- Cardiovascular
- Respiratory
- Gastrointestinal
- Genitourinary
- Musculoskeletal
- Skin
- Neurologic
- Psychiatric
- Hematologic/lymphatic/immunologic

Determine the Complexity of Medical Decision Making

Medical decision making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed
- The risk of significant complications, morbidity, and/or mortality, as well as complications, associated with the patient’s presenting problem(s), the diagnostic procedure(s), and/or the possible management options

Four types of medical decision making are recognized: straightforward, low complexity, moderate complexity, and high complexity. To qualify for a given type of decision making, two of the three elements in Table 1 must be met or exceeded.

Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless their presence significantly increases the complexity of the medical decision making.

Select the Appropriate Level of E/M Services Based on the Following

1. For the following categories/subcategories, all of the key components, ie, history, examination, and medical decision making, must meet or exceed the stated requirements to qualify for a particular level of E/M service: office, new patient; hospital observation services; initial hospital care; office consultations; initial inpatient consultations; emergency department services; initial nursing facility care; domiciliary care, new patient; and home, new patient.

2. For the following categories/subcategories, two of the three key components (ie, history, examination, and medical decision making) must meet or exceed the stated requirements to qualify for a particular level of E/M services: office, established patient; subsequent hospital care; subsequent nursing facility care; domiciliary care, established patient; and home, established patient.

3. When counseling and/or coordination of care dominates (takes up more than 50 percent of) the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting or floor/unit time in the hospital or nursing facility), then time shall be considered the key or controlling factor to qualify for a particular level of E/M services. This includes time spent with parties responsible for the care of the patient or decision making whether or not they are family members (eg, foster parents, person acting in loco parentis, legal guardian). The extent of counseling and/or coordination of care must be documented in the medical record.

### TABLE 1

<table>
<thead>
<tr>
<th>Complexity of Medical Decision Making</th>
<th>Number of Diagnoses or Management Options</th>
<th>Amount and/or Complexity of Data to be Reviewed</th>
<th>Risk of Complications and/or Morbidity or Mortality</th>
<th>Type of Decision Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal</td>
<td>Minimal</td>
<td>Minimal or none</td>
<td>Minimal or none</td>
<td>Straightforward</td>
</tr>
<tr>
<td>Limited</td>
<td>Limited</td>
<td>Limited or moderate</td>
<td>Limited or moderate</td>
<td>Low complexity</td>
</tr>
<tr>
<td>Multiple</td>
<td>Multiple</td>
<td>Multiple or extensive</td>
<td>Multiple or extensive</td>
<td>Moderate complexity</td>
</tr>
<tr>
<td>Substantial</td>
<td>Substantial</td>
<td>Substantial or high</td>
<td>Substantial or high</td>
<td>High complexity</td>
</tr>
</tbody>
</table>

### CONSULTATION CODES AND MEDICARE REIMBURSEMENT

The Centers for Medicare and Medicaid Services (CMS) have proceeded with their proposal from July to no longer pay for the consultation CPT codes. CMS has reestablished the value of the consultation codes across the other E/M codes for Medicare services. CMS retained values for codes 99241–99255 in the Medicare Physician Fee Schedule for those private payers who utilize this data for reimbursement. Note that private payers may choose to follow CMS or CPT guidelines, and the use of consultation codes should be verified with individual payers.
Appendix M — Inpatient Only Procedures

Inpatient Only Procedures—This appendix identifies services with the status indicator C. Medicare will pay an OPPS hospital or ASC when they are performed on a Medicare patient as an outpatient. Physicians should refer to this list when scheduling Medicare patients for surgical procedures. CMS updates this list quarterly.

APPENDIX M — INPATIENT ONLY PROCEDURES

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