CPT® CHANGES 2023

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1

CPT® DISCLAIMER

The information is based upon what is available at the time of the presentation. It is not a complete nor in depth listing of all of the changes. Always refer to the current/appropriate years manual.

2

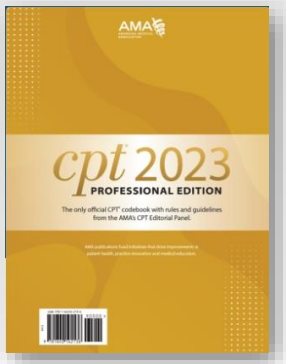
OBJECTIVES

- Overview of the New, Revised, and Deleted CPT® codes for 2023
- Review guideline and parenthetical changes affecting documentation requirements for the new codes

3

CPT 2023

- New 225 (249)
- Revised 93 (93)
- Deleted 75 (62)
- Numerous guideline and parenthetical revisions



4

2023 – What's New?

Section	Added	Deleted	Revised
E/M	1	26	50
Anesthesia	0	0	0
Surgery	33	19	20
Radiology	1	0	5
Path/Lab	12	0	3
Medicine	76	0	18
Category II	0	0	0
Category III	68	22	3
PLA	70	7	4

393 Total Changes

Total codes 10, 969

New Symbol

5

Unchanged for 2023

- Anesthesia, Heme/Lymph, Mediastinum, Female Genital/Maternity, Endocrine
- Category II

6

KEY TO SYMBOLS

- • New Code
- ▲ Revised Code
- # Resequenced Code
- ⌁ FDA Approval Pending
- + Add-on
- ★ Telemedicine
- ♓ Duplicate PLA test
- 🔈 Audio-only (telemedicine services w/modifier 93)

NEW APPENDICES

- Appendix S Artificial Intelligence Taxonomy for Medical Services and Procedures
- Appendix T CPT Codes That May Be Used For Synchronous Real-Time Interactive Audio-Only Telemedicine Services

INTRODUCTORY GUIDELINES

►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. A "physician or other qualified health care professional" is an individual who is qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service. These professionals are distinct from "clinical staff." A clinical staff member is a person who works under the supervision of a physician or other qualified health care professional and who is allowed by law, regulation, and facility policy to perform or assist in the performance of a specified professional service but who does not individually report that professional service. Other policies may also affect who may report specific services.◄

9

INTRODUCTORY GUIDELINES

➢Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. The inclusionary parenthetical notes following the add-on codes are designed to include the typical base code(s) and not every possible reportable code combination. When the add-on procedure can be reported bilaterally and is performed bilaterally, the appropriate add-on code is reported twice, unless the code descriptor, guidelines, or parenthetical instructions for that particular add-on code instructs otherwise. Do not report modifier 50, Bilateral procedures, in conjunction with add-on codes. All add-on codes in the CPT code set are exempt from the multiple procedure concept. See the definitions of modifier 50 and 51 in Appendix A.

10

E/M

CPT 2023

11

E/M

- 1 new 50 revised 2 Deleted
- Numerous Guideline and parenthetical revisions
- Revised E/M table
- Revised and added definitions

12

GUIDELINE DIFFERENCES

Components for Code Selection	2021 Guidelines	Before 2021 Guidelines
History and Exam	As medically appropriate (not used in code selection)	Use key components (history, exam, MDM)
Medical Decision Making (MDM)	May use MDM or total time on date of encounter	Use key components (history, exam, MDM)
Time	May use MDM or total time on date of encounter	May use Face-to-Face time or time at the bedside and on the patient's floor/unit when counseling and/or coordination of care dominates the service
MDM Elements	--Number and complexity of problems addressed at encounter --Amount and/or complexity of data to be reviewed and analyzed --Risk of complications and/or morbidity or mortality of patient management	--Number of diagnoses or management options --Amount and/or complexity of data reviewed --Risk of complication and/or morbidity or mortality

13

E/M DELETED

- 99217-99226 Observation Care Initial, Subsequent and Discharge
- 99241 Office Consultation
- 99251 Inpatient Consultation
- 99319 Nursing facility
- 99324-99340 Domicillary care
- 99343 Home care
- 99354-99357 Prolonged services

14

TIME BASED OFFICE OR OUTPATIENT

New Patient Office Visits	Total Time Day of Visit	Established Patient Office Visits	Total Time Day of Visit
99201	Deleted in 2021	99211	Time Removed
99202	15-29 Minutes	99212	10-19 Minutes
99203	30-44 Minutes	99213	20-29 Minutes
99204	45-59 Minutes	99214	30-39 Minutes
99205	60-74 Minutes	99215	40-54 Minutes

For time spent beyond the total time of 99205/99215 use 99417 or G2212

15

HOSPITAL INPATIENT AND OBSERVATION CARE SERVICES

- ★▲**99221** Initial hospital inpatient or observation care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision ~~these 3 key components~~:
  - ~~A detailed or comprehensive history;~~
  - ~~A detailed or comprehensive examination; and~~
  - ~~Medical decision making that is straightforward or of low complexity.~~

~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~

~~Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.~~

- When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded.

16

TIME BASED INPATIENT/OBSERVATION

Observation Visits	Total Time Prior to 2023	Total Time Day of Visit	In-Patient / Observation Visits	Total Time Prior to 2023	Total Time Day of Visit
99217	Not Time Based	Deleted – Use 99238 or 99239	99238	Less than 30 Minutes	Less than 30 Minutes
			99239	More than 30 Minutes	More than 30 Minutes
99218	30 Minutes	Deleted – Use 99221	99221	30 Minutes	40 Minutes
99219	50 Minutes	Deleted – Use 99222	99222	50 Minutes	55 Minutes
99220	70 Minutes	Deleted – Use 99223	99223	70 Minutes	75 Minutes
99224	15 Minutes	Deleted – Use 99231	99231	15 Minutes	25 Minutes
99225	25 Minutes	Deleted – Use 99232	99232	25 Minutes	35 Minutes
99226	35 Minutes	Deleted – Use 99233	99233	35 Minutes	50 Minutes

For time spent beyond the total time of 99223/99233 use 99418

17

HOSPITAL INPATIENT OR OBSERVATION CARE

1/1/2023 Code		MDM Level	Time prior to 2023	Threshold Time Value to Meet or Exceed
Hospital inpatient or observation care	99234	SF/Low	40	45 minutes must be met or exceeded
	99235	Moderate	50	70 minutes must be met or exceeded
	99236	High	55	85 minutes must be met or exceeded

- Includes admit and discharge on same date
  - Two encounters must occur (one for admit, one for discharge) (99234-99236)
- For patient who is admitted and discharged on different dates, use 99221-99223, 99231-99233, 99238-99239
- For patient admitted and discharged at same encounter (same date), use 99221-99223
- For time spent beyond the total time use 99236,99418

18

Initial Hospital Inpatient or Observation

- When a patient is admitted to the hospital as an inpatient or observation status in the course of an encounter in another site of service, the services in the initial site may be reported separately with a Modifier 25
- When the services provided in a separate site are reported and the initial inpatient/observation care services is a consultation, do not report 99221-99223 or 99252-99255. The consultant reports the subsequent hospital inpatient/observation care codes (99231-99233) for the second service on the same date.
- If a consultation is performed in anticipation of, or related to, an admission by another provider, then the initial code billed for inpatient/observation by the consulting provider should be the established care codes (99231-99233)

19

CMS Final Rule Inpatient/Observation

Hospital Length of Stay	Discharge On	Code(s) to Bill
< 8 hours	Same calendar date as admission or start of observation	99221-99223
8 hours or more	Same calendar date as admission or start of observation	99234-99236
< 8 hours	Different calendar date than admission or start of observation	99221-99223
8 hours or more	Different calendar date than admission or start of observation	99221-99223 and 99238-99239

20

CONSULTATIONS

- May be reported only once by a consultant per admission of a patient who is in hospital inpatient/observation status.
- For subsequent consultation services during the same admission, report 99231-99233 or 99307-99310 depending on facility.
- For Non-Face-to-Face consultations, report the appropriate new patient / inpatient / observation consultation code
- Services that constitute transfer of care are reported with the appropriate new or established codes for office or other outpatient visits (home/residence)
- Use 99242-99245 for services in the office, or other outpatient site (home/residence, or emergency department)
- Use 99252-99255 for services in the inpatient, observation, nursing facilities, or partial hospital settings

21

TIME BASED CONSULTS

Office or Outpatient Consult	Total Time Prior to 2023	Total Time Day of Visit	In-Patient or Observation Consult	Total Time Prior to 2023	Total Time Day of Visit
99241		Deleted	99251		Deleted
99242	30 Minutes	20 Minutes	99252	40 Minutes	35 Minutes
99243	40 Minutes	30 Minutes	99253	55 Minutes	45 Minutes
99244	60 Minutes	40 Minutes	99254	80 Minutes	60 Minutes
99245	80 Minutes	55 Minutes	99255	110 Minutes	80 Minutes

For time spent beyond the total time of 99245 use 99417 / G2212

For time spent beyond the total time of 99255 use 99418

22

EMERGENCY DEPARTMENT

- 99281 has been revised to decrease the level of service to align with the service level of 99211 (may not require the presence of a physician/QHCP)
- Time may not be used to select levels of E/M
- Critical care and ED services may be reported on the same day, if the condition of the patient changes after the initiation of the ED services and critical care is required/provided
- Consultations may be provided and coded using 99241-99245
- Site of service may not solely determine the appropriate codes to report.
  - Critical care services done in the ED without first initiating ED services
  - Physician convenience would not necessitate being seen in the ED

EMERGENCY DEPARTMENT SERVICES

1/1/2023 Code		MDM Level
Emergency Department Services	99281	N/A
	99282	SF
	99283	Low
	99284	Moderate
	99285	High

Time is not used to determine ED Services, only MDM

NURSING FACILITY

- Clarification was given on the service settings (who may provide and where)
  - Nursing facilities
  - Skilled nursing facilities
  - Psychiatric residential treatment centers
  - Immediate care facility for Individuals with intellectual disabilities
- New term: Multiple morbidities requiring intensive management
  - Introduced and defined solely for use with nursing facility services when MDM is used to determine service level
  - See guidelines for specific instruction for use
- 99318 (annual nursing facility assessment) was deleted
- 99324-99328, 99334-99337, 99339-99340 (Domiciliary, Rest Home, Custodial Care, and Home Care Plan Oversight) were deleted

25

TIME BASED NURSING FACILITY

Nursing Facility Visits	Total Time Prior to 2023	Total Time Day of Visit
99304	25 Minutes	25 Minutes
99305	35 Minutes	35 Minutes
99306	45 Minutes	45 Minutes
99307	10 Minutes	10 Minutes
99308	15 Minutes	15 Minutes
99309	25 Minutes	30 Minutes
99310	35 Minutes	60 Minutes
99318	30 Minutes	Deleted – Use 99307-99310

For time spent beyond the total time of 99307/99310 use 99418

26

HOME/RESIDENCE SERVICES

- Deleted 99324-99328 and 99334-99334 Domiciliary, Rest Home, or Custodial Care services. Use 99341-99350 to report instead (Home or Resident Services)
- Deleted 99339-99340 Domiciliary, Rest Home, or Home Care plan Oversight Services. Use 99437, 993491, 99424, or 99425 to report instead
- Home is defined as private residence, temporary lodging, or short-term accommodations (hotel, campground, hostel, cruise ship), assisted living facility, group home, custodial care facility, or residential substance abuse treatment facility
- Do not count travel time as part of total time
- Note: 99343 was deleted in following with the leveling structure (minimal, low, moderate, high)

27

TIME BASED HOME/RESIDENCE

Domiciliary /Rest Home	Total Time Prior to 2023	Total Time Day of Visit	Home / Residence	Total Time Prior to 2023	Total Time Day of Visit
99324	20 Minutes	Deleted – Use 99341	99341	20 Minutes	15 Minutes
99325	30 Minutes	Deleted – Use 99342	99342	30 Minutes	30 Minutes
99326	45 Minutes	Deleted – Use 99344	99343	45 Minutes	Deleted
99327	60 Minutes	Deleted – Use 99344	99344	60 Minutes	60 Minutes
99328	75 Minutes	Deleted – Use 99345	99345	75 Minutes	75 Minutes
99334	15 Minutes	Deleted – Use 99347	99347	15 Minutes	20 Minutes
99335	25 Minutes	Deleted – Use 99348	99348	25 Minutes	30 Minutes
99336	40 Minutes	Deleted – Use 99349	99349	40 Minutes	40 Minutes
99337	60 Minutes	Deleted – Use 99350	99350	60 Minutes	60 Minutes

For time spent beyond the total time of 99255 use 99418

28

PROLONGED E/M SERVICE BEFORE AND/OR AFTER DIRECT PATIENT CARE

Code	Patient Contact	Minimum Reportable Prolonged Services Time (Single Date of Service)	Use in Conjunction With	Do Not Report With	Other Reportable Prolonged Services on Same Date
99358	Non f-t-f only	First 60 minutes	Must relate to a service in which face-to-face-care has or will occur. This is not an add-on code and is not used in conjunction with a base code.	On same date of service: 99202-99205, 99212-99215, 99221-99223, 99231-99236, 99242-99245, 99252-99255, 99281-99285, 99304-99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99417, 99418, 99483	N/A
99359	Non f-t-f only	Each additional 30 minutes (Beyond the time assigned in code 99358)	99358	On same date of service: 99202-99205, 99212-99215, 99221-99223, 99231-99236, 99242-99245, 99252-99255, 99281-99285, 99304-99310, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350, 99417, 99418, 99483	N/A

Total Duration	Codes
Less than 30 minutes	Not reported separately
30-74 minutes	99358 x 1
75-104 minutes	99358 x1, 99359 x1
100 minutes or more	99358 x1, 99359 x2 or more for each addtl. 30 minutes

29

PROLONGED SERVICE

99417 AMA EFFECTIVE 1/1/2023

- Prolonged ~~office or other~~ outpatient evaluation and management service(s) time with or without direct patient contact beyond the ~~minimum~~ required time of the primary service ~~procedure~~ ~~which~~ when the primary service has been selected using total time, ~~requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service~~, each 15 minutes of total time

G2212 CMS

- Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact.

(List separately in addition to codes 99205, 99215 for office or other outpatient E/M services)

Code	Patient Contact	Minimum Reportable Prolonged Services Time (Single Date of Service)	Use in Conjunction With	Do Not Report With	Other Reportable Prolonged Services on Same Date
99417	Face to face and non-face to face	Reported with 99205 – 75 minutes or more Reported with 99215 – 55 minutes or more Total time on date of the encounter	99205 99215 99245 99345 99350 99483	On same date of service: 90833, 90836, 90838, 99358, 99359, 99415, 99416	99418

30

99417/G2212 Prolonged Service

99417 AMA

Duration of Prolonged Service	Report Codes for Outpatient 99205 (60-74 minutes)
Less than 75 minutes	99205 (99417 not separately reported)
75 - 89 minutes	99205, 99417
90 – 104 minutes	99205, 99417 x2
105 minutes or more	99205, 99417 x3 (or appropriate units for ea. addtl. 15 minutes)

Duration of Prolonged Service	Report Codes for Outpatient 99215 (40-54 minutes)
Less than 55 minutes	99215 (99417 not separately reported)
55 - 69 minutes	99215, 99417
70 - 84 minutes	99215, 99417 x2
85 minutes or more	99215, 99417 x3 (or appropriate units for ea. addtl. 15 minutes)

G2212 CMS

Duration of Prolonged Service	Report Codes for Outpatient 99205 (60-74 minutes)
Less than 89 minutes	99205 (G2212 not separately reported)
89 - 103 minutes	99205, G2212
104 - 119 minutes	99205, G2212 x2
120 minutes or more	99205, G2212 x3 (or appropriate units for ea. addtl. 15 minutes)

Duration of Prolonged Service	Report Codes for Outpatient 99215 (40-54 minutes)
Less than 69 minutes	99215 (G2212 not separately reported)
69 - 83 minutes	99215, G2212
84 - 99 minutes	99215, G2212 x2
100 minutes or more	99215, G2212 x3 (or appropriate units for ea. addtl. 15 minutes)

Prolonged Services – 99417

Total Duration (use with 99245)	Outpatient Consultation Code(s)
Less than 50 minutes	Not reported separately
70-84 minutes	99245 x 1, 99417 x 1
80-99 minutes	99245 x 1, 99417 x 2
100 minutes or more	99245 x 1, 99417 x 3 or more for each addtl. 15 minutes

Total Duration (use with 99350)	Home or Residence Visit (Established) Code(s)
Less than 70 minutes	Not reported separately
70-84 minutes	99245 x 1, 99417 x 1
80-99 minutes	99245 x 1, 99417 x 2
100 minutes or more	99245 x 1, 99417 x 3 or more for each addtl. 15 minutes

Total Duration (use with 99345)	Home or Residence Visit (New) Code(s)
Less than 70 minutes	Not reported separately
70-84 minutes	99245 x 1, 99417 x 1
80-99 minutes	99245 x 1, 99417 x 2
100 minutes or more	99245 x 1, 99417 x 3 or more for each addtl. 15 minutes

Total Duration (use with 99483)	Assessment & Care Planning Patient w/Cognitive Impairment Code(s)
Less than 70 minutes	Not reported separately
70-84 minutes	99245 x 1, 99417 x 1
80-99 minutes	99245 x 1, 99417 x 2
100 minutes or more	99245 x 1, 99417 x 3 or more for each addtl. 15 minutes

Prolonged Services – 99418

NEW

#★✚●**99418** Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service)

(Use 99418 in conjunction with 99223, 99233, 99236, 99255, 99306, 99310)

Code	Patient Contact	Minimum Reportable Prolonged Services Time (Single Date of Service)	Use in Conjunction With	Do Not Report With	Other Reportable Prolonged Services on Same Date
99418	Face to face and/or non-face to face	Reported with 99283 - 85 minutes or more Reported with 99310- 50 minutes or more Total time on date of the encounter	99223 99233 99236 99255 99306 99310	On same date of service: 90833, 90836, 90838, 99358, 99359,	99415 99416 99417

PROLONGED SERVICES – MEDICARE HOSPITAL

➢**G0316** Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (Do not report G0316 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418). (Do not report G0316 for any time unit less than 15 minutes) less than 15 minutes).

Primary E/M	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
99223	105 minutes	Date of visit
99233	80 minutes	Date of visit
99236	125 minutes	Date of visit to three days after

PROLONGED SERVICES MEDICARE NURSING FACILITY

- **G0317** (Prolonged nursing facility evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99306, 99310 for nursing facility evaluation and management services). (Do not report G0317 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 993X0,). (Do not report G0317 for any time unit less than 15 minutes))

Primary E/M	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
99306	95 minutes	1 day before visit + date of visit +3 days after
99310	85 minutes	1 day before visit + date of visit +3 days after

35

PROLONGED SERVICES MEDICARE HOME/RESIDENCE

- **G0318** (Prolonged home or residence evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99345, 99350 for home or residence evaluation and management services). (Do not report G0318 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99417). (Do not report G0318 for any time unit less than 15 minutes))

Primary E/M	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
99345	141 minutes	3 days before visit + date of visit + 7 days after
99350	112 minutes	3 days before visit + date of visit + 7 days after

36

TABLE 24: Required Time Thresholds to Report Other E/M Prolonged Services

Primary E/M Service	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Initial IP/Obs. Visit (99223)	G0316	105 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	G0316	80 minutes	Date of visit
IP/Obs. Same-Day Admission/Discharge (99236)	G0316	125 minutes	Date of visit to 3 days after
IP/Obs. Discharge Day Management (99238-9)	n/a	n/a	n/a
Emergency Department Visits	n/a	n/a	n/a
Initial NF Visit (99306)	G0317	95 minutes	1 day before visit + date of visit +3 days after
Subsequent NF Visit (99310)	G0317	85 minutes	1 day before visit + date of visit +3 days after
NF Discharge Day Management	n/a	n/a	n/a
Home/Residence Visit New Pt (99345)	G0318	140 minutes	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. Pt (99350)	G0318	110 minutes	3 days before visit + date of visit + 7 days after
Cognitive Assessment and Care Planning (99483)	G2212	100 minutes	3 days before visit + date of visit + 7 days after
Consults	n/a	n/a	n/a

* Time must be used to select visit level. Prolonged service time can be reported when furnished on any date within the primary visit's surveyed timeframe, and includes time with or without direct patient contact by the physician or NPP. Consistent with CPT's approach, we do not assign a frequency limitation.

https://public-inspection.federalregister.gov/2022-23873.pdf

37

SURGERY

CPT 2023

38

INTEGUMENTARY

39

INTEGUMENTARY

- 3new, 1 revised, 1 deleted

NEW

- ● **15778** Implantation of absorbable mesh or other prosthesis for delayed closure of defect(s) (ie, external genitalia, perineum, abdominal wall) due to soft tissue infection or trauma
  - (For repair of anorectal fistula with plug [eg, porcine small intestine submucosa {SIS}], use 46707)
  - (For implantation of mesh or other prosthesis for anterior abdominal hernia repair or parastomal hernia repair, see 49591-49622)
  - (For insertion of mesh or other prosthesis for repair of pelvic floor defect, use 57267)
  - (For implantation of non-biologic or synthetic implant for fascial reinforcement of the abdominal wall, use 0437T)

40

INTEGUMENTARY

- ▲ 15851 Removal of sutures or staples requiring anesthesia (ie, general anesthesia, moderate sedation)

  ▶(Do not report 15851 for suture and/or staple removal to re-open a wound prior to performing another procedure through the same incision)◀
- #✚● **15853** Removal of sutures or staples not requiring anesthesia (List separately in addition to E/M code)

  ▶(Use 15853 in conjunction with 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215, 99281, 99282, 99283, 99284, 99285, 99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350)◀

  ▶(Do not report 15853 in conjunction with 15854)◀
- #✚● **15854** Removal of sutures and staples not requiring anesthesia (List separately in addition to E/M code)
  - Same parenthetical added

41

INTEGUMENTARY CATEGORY III

-

42

INTEGUMENTARY CATEGORY III

43

MUSCULOSKELETAL

44

MUSCULOSKELETAL

- 1 new, 2 revised, 0 deleted
- Guideline and parenthetical revisions

45

DRUG DELIVERY DEVICE 2023 GUIDELINES

- Manual preparation involves the mixing and preparation of antibiotics or other therapeutic agent(s) with a carrier substance by the physician or other qualified health care professional during the surgical procedure and then shaping the mixture into a drug-delivery device(s) (eg, beads, nails, spacers) for placement in the deep (eg, subfascial), intramedullary, or intra-articular space(s). Codes 20700, 20702, 20704 are add-on codes for the manual preparation and insertion of the drug-delivery device(s) ~~during the associated primary surgical procedure listed with each add-on code~~. They may be used with any open procedure code except those that include the placement of a "spacer" (eg, 27091, 27488). The add-on codes may be used when infection is present, suspected, or anticipated during the surgery. The location of the primary service determines which of the insertion codes may be selected. If the primary surgery is in the deep (subfascial) region, add-on code 20700 may be reported. If the primary surgery is within the bone or "intramedullary," add-on code 20702 may be reported. If the primary surgery is within the joint, add-on code 20704 may be reported.

46

DRUG DELIVERY DEVICE 2023 GUIDELINES

➢► Codes 20701, 20703, 20705 are add-on codes used to report ~~for the~~ removal of drug-delivery device(s) ~~during the associated primary surgical procedures listed in the parenthetical codes associated with each add on code~~. These codes may be typically associated with specific surgeries if the infection has been eradicated. For removal of a drug-delivery device from a deep (subfascial) space performed in conjunction with a primary procedure (ie, complex wound closure [13100-13160], adjacent tissue transfer [14000-14350], or a flap closure [15570-15758]), add-on code 20701 may be reported. For infection that has not been eradicated, see the tissue debridement codes (eg, 11011, 11012, 11042, 11043, 11044, 11045, 11046, 11047) for the primary procedure. If a subsequent new drug-delivery device is placed, 20700 may be additionally reported.◄

47

DRUG DELIVERY DEVICE 2023 GUIDELINES

➢► Similarly, for add-on code 20703, removal of drug delivery device from the bone may be associated with different procedures. If the infection has been eradicated and the drug delivery device removal is the only procedure being performed, report 20680 (removal of deep hardware). Bony reconstruction performed in conjunction with eradication of infection may be reported using the reconstruction as the primary procedure. Persistent infection that is treated using an additional bony debridement procedure (eg, 11012, 23180, 23182, 23184, 24140, 24145, 25150, 25151, 26230, 26235, 26236, 27070, 27071, 27360, 27640, 27641, 28122, 28124) may be reported using the debridement as the primary procedure. Amputation (eg, 27290, 27590, 27598) performed in conjunction with delivery of a new, manually prepared drug delivery device may be reported with add-on code 20702.◄

48

DRUG DELIVERY DEVICE 2023 GUIDELINES

➢► When joint infection is present, suspected, or anticipated, add-on code 20704 (for manual preparation of an intra-articular drug delivery device) may be reported. Code 20704 may not be reported when the placement of a spacer is included in the code (eg, 27091, 27488) or when antibiotic cement is used for implant fixation.◄

DRUG DELIVERY DEVICE 2023 GUIDELINES

➢Add-on code 20705 (for removal of a manually prepared intra-articular drug delivery device) may be typically used in conjunction with a joint stabilization procedure such as arthrodesis (eg, 22532, 22533, 22534, 22548, 22551, 22552, 22554, 22556, 22558, 22585, 22586, 22590, 22595, 22600, 22610, 22614, 22634, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22853, 22854, 22899, 24800, 24802, 25800, 25805, 25810, 25825, 25830, 26841, 26842, 26843, 26844, 26850, 26852, 26860, 26861, 26862, 26863, 27279, 27280, 27282, 27284, 27286, 27580, 27870, 27871, 28295, 28296, 28298, 28299, 28705, 28715, 28725, 28730, 28735, 28737, 28740, 28750, 28755, 28760, 29907) and revision joint arthroplasties (eg, 23473, 23474 [shoulder], 24370, 24371 [elbow], 25449 [wrist], 27134 [hip], 27487 [knee], and 27703 [ankle]). In the rare circumstance in which only part of the joint is destroyed by infection, a partial arthroplasty may be reported (eg, 23470, 24360, 24361, 24362, 24365, 24366, 25441, 25442, 25443, 25444, 25445, 27125, 27236, 27438, 27440, 27441, 27442, 27443, and 27446).

➢If no primary service is associated with add-on code 20705 and the joint is left without remaining cartilage or stabilization (ie, flail joint), only 20680 may be reported.◄

DRUG DELIVERY DEVICE 2023

- +20700 Manual preparation and insertion of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)

►(Do not report 20700 in conjunction with any services that include placement of a spacer [eg, 11981, 27091, 27488])◄

51

DRUG DELIVERY DEVICE 2023

- +20701 Removal of drug-delivery device(s), deep (eg, subfascial) (List separately in addition to code for primary procedure)

►(Use 20701 in conjunction with 11010, 11011, 11012, 11043, 11044, 11046, 11047, 13100-13160, 14000-14350, 15570, 15572, 15574, 15576, 15736, 15738, 15740, 15750, 15756, 15757, 15758, ~~20240, 20245, 20250, 20251, 21010, 21025, 21026, 21501, 21502, 21510, 21627, 21630, 22010, 22015, 23030, 23031, 23035, 23040, 23044, 23170, 23172, 23174, 23180, 23182, 23184, 23334, 23335, 23930, 23931, 23935, 24000, 24134, 24136, 24138, 24140, 24147, 24160, 25031, 25035, 25040, 25145, 25150, 25151, 26070, 26230, 26235, 26236, 26990, 26991, 26992, 27030, 27070, 27071, 27090, 27301, 27303, 27310, 27360, 27603, 27604, 27610, 27640, 27641, 28001, 28002, 28003, 28020, 28120, 28122~~)◄

►(For removal of a deep drug-delivery device only, use 20680)◄

52

DRUG DELIVERY DEVICE 2023

➢+20702 Manual preparation and insertion of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)

►(Do not report 20702 in conjunction with 11981, 27091, 27488)◄

DRUG DELIVERY DEVICE 2023

➢+20703 Removal of drug-delivery device(s), intramedullary (List separately in addition to code for primary procedure)

► Use 20703 in conjunction with ~~20690, 20692, 20694, 20802, 20805, 20838, 21510, 23035, 23170, 23180, 23184, 23515, 23615, 23935, 24134, 24138, 24140, 24147~~, 23485, 24430, 24435, ~~24516, 25035, 25145, 25150, 25151~~, 25400, 25405, 25415, 25420, 255425, ~~25515, 25525, 25526, 25545, 25574, 25575, 27245, 27259, 27360,~~ 27470, 27472, ~~27506, 27640~~, 27720, 27722, 27724, 27725)◄

► (For removal of an intramedullary drug-delivery device as a stand-alone procedure, use 20680)◄

DRUG DELIVERY DEVICE 2023

➢+20704 Manual preparation and insertion of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)

► Use 20704 in conjunction with 22864, 22865, 23040, 23044, 23334, 23335, 23473, 23474, 24000, 24160, 24370, 24371, 25040, 25250, 25251, 25449, 26070, ~~26075, 26080~~, 26990, 27030, 27090, 27132, 27134. 27137, 27138, 27301, 27310, 27487,27603, 27610, 27703, 28020)◄

DRUG DELIVERY DEVICE 2023

➢ +20705 Removal of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure)

► (Use 20705 in conjunction with 22864, 22865, 23040, 23044, 23334, 23473, 23474, 24000, 24160, 24370, 24371, 25040, 25250, 25251, 25449, 26070, 26075, 26080, 26990, 27030, 27090, 27132, 27134, 27137, 27138, 27301, 27310, 27487, 27603, 27610,27703, 28020)◄

► (Do not report 20705 in conjunction with 11982, ~~23335, 27091, 27125~~, 27130, ~~27134, 27137, 27138, 27236, 27438, 27446~~, 27447, 27486, ~~27487, 27488~~)◄

DRUG DELIVERY DEVICE 2023

- +20705 Removal of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure) contd.
- ▶(For arthrodesis after eradicated infection, see 22532, 22533, 22534, 22548, 22551, 22552, 22554, 22556, 22558, 22585, 22586, 22590, 22595, 22600, 22610, 22614, 22634, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22853, 22854, 22899, 24800, 24802, 25800, 25805, 25810, 25825, 25830, 26841, 26842, 26843, 26844, 26850, 26852, 26860, 26861, 26862, 26863, 27279, 27280, 27282, 27284, 27286, 27580, 27870, 27871, 28295, 28296, 28298, 28299, 28705, 28715, 28725, 28730, 28735, 28737, 28740, 28750, 28755, 28760, 29907)◀
- ▶(For implant removal after failed drug delivery device placement, see 22862, 22864, 23334, 23335, 24160, 25250, 25251, 27090, 27091, 27488, 27704)◀

DRUG DELIVERY DEVICE 2023

- +20705 Removal of drug-delivery device(s), intra-articular (List separately in addition to code for primary procedure) contd
- ▶(For partial replacement after successful eradication of infection with removal of drug delivery implant, see 23470, 24360, 24361, 24362, 24365, 24366, 25441, 25442, 25443, 25444, 25445, 27125, 27236, 27438, 27440, 27441, 27442, 27443, 27446)◀

SPINE

- Revised
  - ▲ **22857** Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar
- NEW
  - ✚● **22860** …second interspace, lumbar (List separately in addition to code for primary procedure)

    (Use 22860 in conjunction with 22857)

    (For total disc arthroplasty, anterior approach, lumbar, more than two interspaces, use 22899)

59

PELVIS

- New guideline

  ►Code 27279 describes percutaneous arthrodesis of the sacroiliac joint using a minimally invasive technique to place an internal fixation device(s) that passes through the ilium, across the sacroiliac joint and into the sacrum, thus transfixing the sacroiliac joint. Report 0775T for the percutaneous placement of an intra-articular stabilization device into the sacroiliac joint using a minimally invasive technique that does not transfix the sacroiliac joint. For percutaneous arthrodesis of the sacroiliac joint utilizing both a transfixation device and intra-articular implant(s), use 27299◄
- ▲ **27280** Arthrodesis, ~~open~~ sacroiliac joint, open ~~including~~ includes obtaining bone graft, including instrumentation, when performed

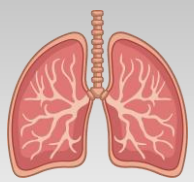
  ►(Do not report 27280 in conjunction with 0775T)◄

  ►(For percutaneous/minimally invasive arthrodesis of the sacroiliac joint without fracture and/or dislocation, utilizing a transfixation device, use 27279)◄
- Parentheticals added under 27279

60

CATEGORY III

61



RESPIRATORY 30000-32999

62

RESPIRATORY

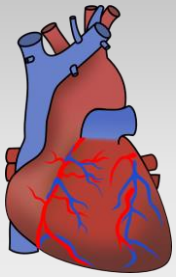
- 1 new, 0 revised, 0 deleted,
  - Parenthetical changes 30465 repair nasal stenosis, 30468 repair nasal valve collapse

63

RESPIRATORY

- **30469** Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling
  - (Do not report 30469 in conjunction with 30465, 30468, when performed on the ipsilateral side)
  - (For repair of nasal vestibular stenosis [eg, spreader grafting, lateral nasal wall reconstruction], use 30465)
  - (For repair of nasal vestibular lateral wall collapse with subcutaneous/submucosal lateral wall implant[s], use 30468)
  - (For repair of nasal vestibular stenosis or collapse without cartilage graft, lateral wall reconstruction, or subcutaneous/submucosal implant [eg, lateral wall suspension or stenting without graft or subcutaneous/submucosal implant], use 30999)
  - (30469 is used to report a bilateral procedure. For unilateral procedure, use modifier 52)

64



CARDIOVASCULAR 33016-37799

65

CARDIOVASCULAR

- 7 new, 1 revised, 0 deleted,
  - Numerous parenthetical and guideline changes primarily due to code changes and bilateral guidelines
  - Multiple new guidelines

66

CARDIOVASCULAR

- Pulmonary Valve Guideline
  - Revised due to the addition of 93569-93575
- Shunting procedures Guideline revised due to new codes93569-93575 and existing codes 93451-93461 with 33741, 33745, 33746

67

CARDIOVASCULAR

Codes 33900, 33901, 33902, 33903, 33904 describe endovascular repair of pulmonary artery stenosis by stent placement. Codes 33900, 33901 describe stent placement within the pulmonary arteries via normal native connections, defined as superior vena cava/inferior vena cava to right atrium, then right ventricle, then pulmonary arteries. Codes 33902, 33903 describe stent placement within the pulmonary arteries, ductus arteriosus, or within a surgical shunt, via abnormal connections or through post-surgical shunts (eg, Blalock-Taussig shunt, Sano shunt, or post Glenn or Fontan procedures). Code 33904 is an add-on code that describes placement of stent(s) in additional vessels or lesions beyond the primary vessel or lesion treated whether access is via normal or abnormal connection.

Codes 33900, 33901, 33902, 33903, 33904 include vascular access and all catheter and guidewire manipulation, fluoroscopy to guide the intervention, any post-diagnostic angiography for roadmapping purposes and post-implant evaluation, stent positioning and balloon inflation for stent delivery, and radiologic supervision and interpretation of the intervention. Angiography at the same session, as part of a diagnostic cardiac catheterization, may be reported with the appropriate angiographic codes from the Radiology or Medicine/Cardiovascular/Cardiac Catheterization/Injection Procedures sections.

68

GUIDELINES ENDOVASCULAR CONGENITAL

Diagnostic cardiac catheterization and diagnostic angiography codes (93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563, 93566, 93567, 93568, 93593, 93594, 93596, 93597, 93598) should not be used with 33900, 33901, 33902, 33903, 33904 to report:

1. Contrast injections, angiography, roadmapping, and/or fluoroscopic guidance for the TPVI,
2. Pulmonary conduit angiography for guidance of TPVI, or
3. Right heart catheterization for hemodynamic measurements before, during, and after TPVI for guidance of TPVI.

69

GUIDELINES ENDOVASCULAR CONGENITAL

Diagnostic right and left heart catheterization codes (93451, 93452, 93453, 93456, 93457, 93458, 93459, 93460, 93461, 93593, 93594, 93595, 93596, 93597, 93598), diagnostic coronary angiography codes (93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563, 93564), and diagnostic angiography codes 93565, 93566, 93567, 93568 may be separately reported in conjunction with 33900, 33901, 33902, 33903, 33904, representing separate and distinct services from pulmonary artery revascularization, if:

1. No prior study is available and a full diagnostic study is performed, or
2. A prior study is available, but as documented in the medical record:

a. There is inadequate visualization of the anatomy and/or pathology, or

b. The patient's condition with respect to the clinical indication has changed since the prior study, or

c. There is a clinical change during the procedure that requires new evaluation.

70

GUIDELINES ENDOVASCULAR CONGENITAL

Do not report 33900, 33901, 33902, 33903, 33904 in conjunction with 76000, 93451, 93452, 93453, 93454, 93455, 93456, 93457, 93458, 93459, 93460, 93461, 93563, 93564, 93565, 93566, 93567, 93568, 93593, 93594, 93596, 93597, 93598 for catheterization and angiography services intrinsic to the procedure.

Balloon angioplasty (92997, 92998) within the same target lesion as stent implant, either before or after stent deployment, is not separately reported.

For balloon angioplasty at the same session as 33900, 33901, 33902, 33903, 33904, but for a distinct lesion or in a different artery, see 92997, 92998.

To report percutaneous pulmonary artery revascularization by stent placement in conjunction with diagnostic congenital cardiac catheterization, see 33900, 33901, 33902, 33903, 33904.

For transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, see 33745, 33746.◀

CARDIOVASCULAR

- **33900** Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, unilateral
- **33901** …normal native connections, bilateral
- **33902** …abnormal connections, unilateral
- **33903** …abnormal connections, bilateral
- **+ 33904** Percutaneous pulmonary artery revascularization by stent placement, **each additional vessel or separate lesion**, normal or abnormal connections (List separately in addition to code for primary procedure)

(Use 33904 in conjunction with 33900, 33901, 33902, 33903)

CARDIOVASCULAR

Revised

- **35883** Revision, remofal anastomosis of synthetic arterial bypass fraft in groin, open; with nonautogenous patch graft (e.g. ~~Dacron~~ polyester, ePTFE, bovine, pericardium

73

CARDIOVASCULAR HEMODIALYSIS

►Codes 36836, 36837 describe percutaneous arteriovenous fistula creation in the upper extremity for hemodialysis access, including image-guided percutaneous access into a peripheral artery and peripheral vein via single access (36836) or two separate access sites (36837). The artery and vein are approximated and then energy (eg, thermal) is applied to establish the fistulous communication between the two vessels. Fistula maturation procedures promote blood flow through the newly created fistula by augmentation (eg, angioplasty) or redirection (eg, coil embolization of collateral pathways) of blood flow. Codes 36836, 36837 include all vascular access, angiography, imaging guidance, and blood flow redirection or maturation techniques (eg, transluminal balloon angioplasty, coil embolization) performed for fistula creation. These procedures may not be reported separately with 36836, 36837, when performed at the same operative session.◄

New

- **#36836** Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation
- **#36837** Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation

74

GI 40490-49999

75

DIGESTIVE

- 15 new, 0 revised, 18 deleted,
- Parenthetical changes due to code changes

76

HERNIA REPAIRS

Deleted

- 49560 Repair initial incisional or ventral hernia; reducible
- 49561 incarcerated or strangulated
- 49565 Repair recurrent incisional or ventral hernia; reducible
- 49566 incarcerated or strangulated
- +49568 Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)
- 49570 Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)
- 49572 incarcerated or strangulated
- 49580 Repair umbilical hernia, younger than age 5 years; reducible
- 49582 incarcerated or strangulated
- 49585 Repair umbilical hernia, age 5 years or older; reducible
- 49587 incarcerated or strangulated
- 49590 Repair spigelian hernia
- 49652 Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible
- 49653 incarcerated or strangulated
- 49654 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible
- 49655 incarcerated or strangulated
- 49656 Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible
- 49657 incarcerated or strangulated

77

HERNIA

►The hernia repair codes in this section are categorized primarily by the type of hernia (inguinal, femoral, lumbar, omphalocele, anterior abdominal, parastomal).◄

Some types of hernias are further categorized as “initial” or “recurrent” based on whether or not the hernia has required previous repair(s).

Additional variables accounted for by some of the codes include patient age and clinical presentation (reducible vs. incarcerated or strangulated).

The excision/repair of strangulated organs or structures such as testicle(s), intestine, ovaries are reported by using the appropriate code for the excision/repair (eg, 44120, 54520, and 58940) in addition to the appropriate code for the repair of the strangulated hernia.

For debridement of abdominal wall, see 11042, 11043)

(For reduction and repair of intra-abdominal hernia, use 44050)

►(49491-49557, 49600, 49605, 49606, 49610, 49611, 49650, 49651 are unilateral procedures. For bilateral procedure, use modifier 50)◄

►(Do not report modifier 50 in conjunction with 49591-49622)◄

78

HERNIA GUIDELINES

►Codes 49591-49618 describe repair of an anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian) by any approach (ie, open, laparoscopic, robotic). Codes 49591-49618 are reported only once, based on the total defect size for one or more anterior abdominal hernia(s), measured as the maximal craniocaudal or transverse distance between the outer margins of all defects repaired. For example, "Swiss cheese" defects (ie, multiple separate defects) would be measured from the superior most aspect of the upper defect to the inferior most aspect of the lowest defect. In addition, the hernia defect size should be measured prior to opening the hernia defect(s) (ie, during repair the fascia will typically retract creating a falsely elevated measurement).

When both reducible and incarcerated or strangulated anterior abdominal hernias are repaired at the same operative session, all hernias are reported as incarcerated or strangulated. For example, one 2-cm reducible initial incisional hernia and one 4-cm incarcerated initial incisional hernia separated by 2 cm would be reported as an initial incarcerated hernia repair with a maximum craniocaudal distance of 8 cm (49594).

79

HERNIA GUIDELINES

Inguinal, femoral, lumbar, omphalocele, and/or parastomal hernia repair may be separately reported when performed at the same operative session as anterior abdominal hernia repair by appending modifier 59, as appropriate.

Codes 49621, 49622 describe repair of a parastomal hernia (initial or recurrent) by any approach (ie, open, laparoscopic, robotic). Code 49621 is reported for repair of a reducible parastomal hernia, and code 49622 is reported for an incarcerated or strangulated parastomal hernia.

Implantation of mesh or other prosthesis, when performed, is included in 49591-49622 and may not be separately reported. For total or near total removal of non-infected mesh when performed, use 49623 in conjunction with 49591-49622. For removal of infected mesh, use 11008.◄

80

HERNIA REPAIRS

NEW

Approach → Location → Size → Initial or recurrent

- 49591 Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), **initial**, *including implantation of mesh or other prosthesis when performed*, total length of defect(s); less than 3 cm, reducible
- 49592 less than 3 cm, incarcerated or strangulated
- 49593 3 cm to 10 cm, reducible
- 49594 3 cm to 10 cm, incarcerated or strangulated
- 49595 greater than 10 cm, reducible
- 49596 greater than 10 cm, incarcerated or strangulated

81

HERNIA REPAIRS

NEW

Approach → Location → Size → Initial or recurrent

- 49613 Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), **recurrent**, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible
- 49614 …less than 3 cm, incarcerated or strangulated
- 49615 …3 cm to 10 cm, reducible
- 49616 …3 cm to 10 cm, incarcerated or strangulated
- 49617 …greater than 10 cm, reducible
- 49618 …greater than 10 cm, incarcerated or strangulated

82

HERNIA REPAIRS

NEW

Approach → Location → Size → Initial or recurrent

● 49621 Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; reducible

● 49622 …incarcerated or strangulated

#+● 49623 Removal of total or near total non-infected mesh or other prosthesis anterior abdominal hernia repair or parastomal hernia repair, any approach (ie, open, laparoscopic, robotic) at the time of initial or recurrent (List separately in addition to code for primary procedure)

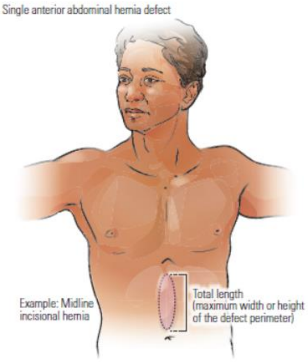
83

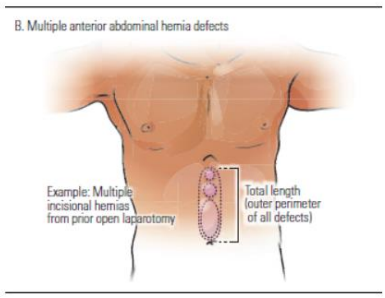
Measuring Total Length of Anterior Abdominal Hernia Defect(s)
49591-49618

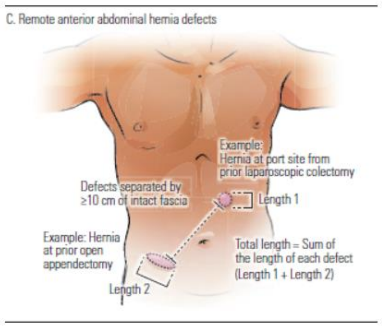
Hernia measurements are performed either in the transverse or craniocaudal dimension. The total length of the defect(s) corresponds to the maximum width or height of an oval drawn to encircle the outer perimeter of all repaired defects. If the defects are not contiguous and are separated by greater than or equal to 10 cm of intact fascia, total defect size is the sum of each defect measured individually.

Codes 49591-49618 are reported only once, based on the total defect size for one or more anterior abdominal hernia(s), measured as the maximal craniocaudal or transverse distance between the outer margins of all defects repaired.

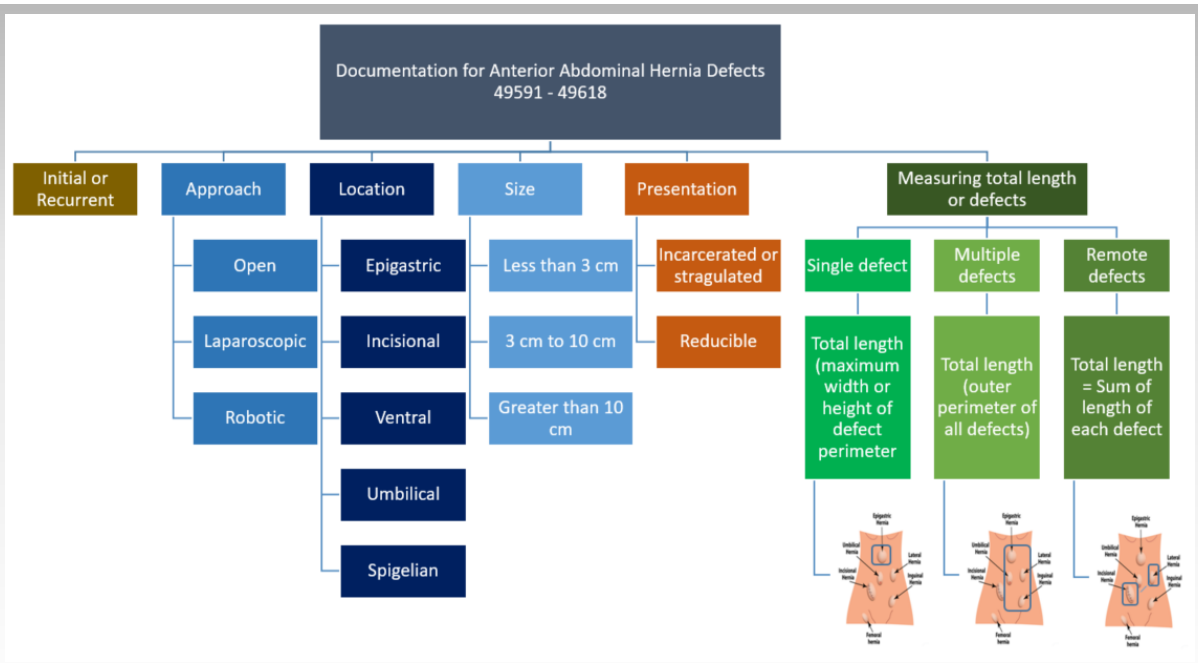
A. Single anterior abdominal hernia defect







84



85

PHARYNX, ADENOIDS AND TONSILS

- **42975** Drug-induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep-disordered breathing, flexible, diagnostic
  - Do not report in conjunction with 31231 (nasal endoscopy), unless performed for a separate condition [ie, other than sleep-disordered breathing] and using a separate endoscope
  - Do not report in conjunction with 31575, 92511

86

GU 50010-53899

87

GENITOURINARY

- 0 new, 2 revised, 0 deleted

88

GENITOURINARY

Revised

- ▲ **50080** Percutaneous nephrolithotomy ~~nephrostolithotomy~~ or pyelolithotomy, ~~pyelostolithotomy with or without dilation endoscopy.~~ lithotripsy, ~~stenting or~~ stone ~~basket~~ extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (eg, stone[s] up to 2 cm in single location of kidney or renal pelvis, nonbranching stones)
- ▲ 50081 …complex (eg, stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy) ~~over 2 cm~~

  ▶(50080, 50081 may only be reported once per side. For bilateral procedure, report 50080, 50081 with modifier 50)◀

  ▶(Do not report 50080, 50081 in conjunction with 50430, 50431, 50433, 50434, 50435, if performed on the same side)◀

  ▶(For establishment of nephrostomy without nephrolithotomy, see 50040, 50432, 50433, 52334)◀

  ▶(For dilation of an existing percutaneous access for an endourologic procedure, use 50436)◀

  ▶(For dilation of an existing percutaneous access for an endourologic procedure with new access into the collecting system, use 50437; for additional new access into the kidney, use 50437 for each new access that is dilated for an endourologic procedure)◀

  ▶(For removal of stone without lithotripsy, use 50561)◀

  ▶(For cystourethroscopy with insertion of ureteral guidewire through kidney to establish a percutaneous nephrostomy, retrograde, use 52334)◀

89

GUIDELINE REVISION NEPHROLITHOTOMY

▶Nephrolithotomy is the surgical removal of stones from the kidney, and pyelolithotomy is the surgical removal of stones from the renal pelvis. This section of the guidelines refers to the removal of stones from the kidney or renal pelvis using a percutaneous antegrade approach. Breaking and removing stones is separate from accessing the kidney (ie, 50040, 50432, 50433, 52334), accessing the kidney with dilation of the tract to accommodate an endoscope used in an endourologic procedure (ie, 50437), or dilation of a previously established tract to accommodate an endoscope used in an endourologic procedure (ie, 50436). These procedures include the antegrade removal of stones in the calyces, renal pelvis, and/or ureter with the antegrade placement of catheters, stents, and tubes, but do not include retrograde placement of catheters, stents, and tubes.

Code 50080 describes nephrolithotomy or pyelolithotomy using a percutaneous antegrade approach with endoscopic instruments to break and remove kidney stones of 2 cm or smaller

90

Code 50081 includes the elements of 50080, but it is reported for stones larger than 2 cm, branching, stones in multiple locations, ureteral stones, or in patients with complicated anatomy.

Creation of percutaneous access or dilation of the tract to accommodate large endoscopic instruments used in stone removals (50436, 50437) is not included in 50080, 50081, and may be reported separately, if performed. Codes 50080, 50081 include placement of any stents or drainage catheters that remain indwelling after the procedure.

Report one unit of 50080 or 50081 per side (ie, per kidney), regardless of the number of stones broken and/or removed or locations of the stones. For bilateral procedure, report 50080, 50081 with modifier 50. When 50080 is performed on one side and 50081 is performed on the contralateral side, modifier 50 is not applicable. Placement of additional accesses, if needed, into the kidney, and removal of stones through other approaches (eg, open or retrograde) may be reported separately, if performed.◀

91

MALE GENITAL 54000-55899

92

MALE GENITAL SYSTEM

- 1 new, 0 revised, 0 deleted
- ● **55867** Laparoscopy, surgical prostatectomy, **simple subtotal** (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed
  - For open subtotal prostatectomy, see 55821, 55831
- Parenthetical added under 55831, 55866

93

NEURO 61000-64999

94

NERVOUS SYSTEM

- 0 new, 7 revised, 0 deleted
- Revisions in somatic nerve injections guidelines and parentheticals to reflect imaging guidance and proper use

►Imaging guidance and localization may be reported separately for 64400, 64405, 64408, 64420, 64421, 64425, 64430, 64435, 64449, 64450. Imaging guidance and any injection of contrast are inclusive components of 64415, 64416, 64417, 64445, 64446, 64447, 64448, 64451, 64454.◄

NEURO INJECTIONS

Revised Injection(s), anesthetic agent(s) and/or steroid;

- ▲ 64415 …brachial plexus, <u>including imaging guidance, when performed</u>
- ▲ 64416 …brachial plexus, continuous infusion by catheter (including catheter placement), <u>including imaging guidance, when performed</u>
- ▲ 64417 …axillary nerve, <u>including imaging guidance, when perfo</u>rmed
- ▲ 64445 …sciatic nerve, <u>including imaging guidance, when performed</u>
- ▲ 64446 …sciatic nerve, continuous infusion by catheter (including catheter placement), <u>including imaging guidance, when performed</u>
- ▲ 64447 …femoral nerve, <u>including imaging guidance, when performed</u>
- ▲ 64448 …femoral nerve, continuous infusion by catheter (including catheter placement), <u>including imaging guidance, when performed</u>
- Parentheticals added excluding reporting of all image guidance codes

NEURO PARAVERTEBRAL NERVES

- Guideline changes

►Codes 64490, 64491, 64492, 64493, 64494, 64495 describe the introduction/injection of a diagnostic or therapeutic agent into the paravertebral facet joint or into the nerves that innervate that joint by level. Facet joints are paired joints with one pair at each vertebral level. Imaging guidance and localization are required for the performance of paravertebral facet joint injections described by 64490, 64491, 64492, 64493, 64494, 64495. If imaging is not used, report 20552, 20553. If ultrasound guidance is used, report 0213T, 0214T, 0215T, 0216T, 0217T, 0218T.

When determining a level, count the number of facet joints injected, not the number of nerves injected. Therefore, if multiple nerves of the same facet joint are injected, it would be considered as a single level. The add-on codes are reported when second, third, or additional levels are injected during the same session.

When the procedure is performed bilaterally at the same level, report one unit of the primary code with modifier 50.

97

NEURO PARAVERTEBRAL NERVES

When the procedure is performed on the left side at one level and the right side at a different level in the same region, report one unit of the primary procedure and one unit of the add-on code.

When the procedure is performed bilaterally at one level and unilaterally at a different level(s), report one unit of the primary procedure for each level and append modifier 50 for the bilateral procedure. If the procedure is performed unilaterally at different levels, report one unit of the primary procedure and the appropriate add-on code(s).◄

- Revised table on pg 479

98

NEURO PARAVERTEBRAL NERVES

►Procedure	Cervical/Thoracic	Lumbar/Sacral
Multiple nerves injected at the same level	64490 X 1	64493 X 1
1 level injected unilaterally	64490 X 1	64493 X 1
1 level injected bilaterally	64490 50 X 1	64493 50 X 1
1 level injected bilaterally and 1 level injected unilaterally	64490 50 X 1 64491 X 1	64493 50 X 1 64494 X 1
2 levels injected unilaterally	64490 X 1 64491 X 1	64493 X 1 64494 X 1
2 levels injected bilaterally	64490 50 X 1 64491 X 2	64493 50 X 1 64494 X 2
3 or more levels injected unilaterally	64490 X 1 64491 X 1 64492 X 1	64493 X 1 64494 X 1 64495 X 1
3 or more levels injected bilaterally	64490 50 X 1 64491 X 2 64492 X 2	64493 50 X 1 64494 X 2 64495 X 2◄

New pg 480

99

EYE AND OCULAR ADENEXA

100

EYE

- 0 new, 3 revised, 0 deleted
- Revised
  - ▲ 66174 Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without retention of device or stent
  - ▲ 66175 with retention of device or stent
  - ▲ 69716 with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or resulting in removal of less than 100 sq mm surface area of bone deep to the outer cranial cortex

AUDITORY 69000-69979

AUDITORY

- 3 new, 4 revised, 0 deleted
- Introductory guideline revision

►The following codes are for implantation of an osseointegrated implant into the skull. These devices treat hearing loss through surgical placement of an abutment or device into the skull that facilitates transduction of acoustic energy to be received by the better-hearing inner ear or both inner ears when the implant is coupled to a speech processor and vibratory element. This coupling may occur in a percutaneous or a transcutaneous fashion. Other middle ear and mastoid procedures (69501-69676) may be performed for different indications and may be reported separately, when performed.◄

OSSEOINTEGRATED IMPLANTS

Revised

- #▲ 69716 Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor within the mastoid and/or resulting in removal of less than 100 sq mm surface area of bone deep to the outer cranial cortex
- #▲ 69717 ~~Revision or r~~Replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor
- #▲ 69719 with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex

OSSEOINTEGRATED IMPLANTS

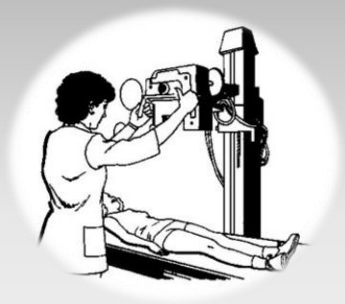
Revised and New

- #▲ 69726 Removal, entire osseointegrated implant, skull; with percutaneous attachment to external speech processor
- #▲ 69727 … with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex
- #● **69728** with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex

OSSEOINTEGRATED IMPLANTS

New

- #● **69729** Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex
- #● **69730** Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex



RADIOLOGY 77010-79999

107

RADIOLOGY

- 5 new, 5 revised, 0 deleted
- Multiple parenthetical changes in Vascular Procedures section due to addition of codes 36836, 36837, 93569-93575
- Introductory Guideline revision

►Code 76882 represents a limited evaluation of a joint or ~~an~~ focal evaluation of a structure(s) in an extremity other than a joint (eg, soft-tissue mass, fluid collection, or nerve[s]). Limited evaluation of a joint includes assessment of a specific anatomic structure(s) (eg, joint space only [effusion] or tendon, muscle, and/or other soft-tissue structure[s] that surround the joint) that does not assess all of the required elements included in 76881. Code 76882 also requires permanently recorded images and a written report containing a description of each of the elements evaluated.

Comprehensive evaluation of a nerve is defined as evaluation of the nerve throughout its course in an extremity. Documentation of the entire course of a nerve throughout an extremity includes the acquisition and permanent archive of cine clips and static images to demonstrate the anatomy.◄

108

RADIOLOGY

- Extremity nonvascular ultrasound
  - ▲ 76882 Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation
  - ● **76883** Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity

RADIOLOGY

Revised

- #▲ 78830 Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), single area (eg, head, neck, chest, pelvis) or acquisition, single day imaging
- #▲ 78831... tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, chest and abdomen ~~and pelvis~~) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition ~~imaging~~ over 2 or more days
- #▲ 78832 … tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, chest and abdomen ~~and pelvis~~) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition ~~imaging~~ over 2 or more days

PATH AND LAB

111

PATHOLOGY AND LABORATORY

- 82 new, 3 revised, 8 deleted
- 70 related to Proprietary Lab Analysis not reviewed in this presentation
- Revisions to genome sequencing guidelines with code additions and revisions not reviewed in this presentation

112

PATHOLOGY AND LABORATORY

Chemistry

- # ● 84433 Thiopurine S-methyltransferase (TPMT)

Microbiology

- ● 87467 Hepatitis B surface antigen (HBsAg), quantitative
- ● 87468 Infectious agent detection by nucleic acid (DNA or RNA); Anaplasma phagocytophilum, amplified probe technique
- ● 87469 Babesia microti, amplified probe technique
- ● 87478 Borrelia miyamotoi, amplified probe technique
- # ● 87484 Ehrlichia chaffeensis, amplified probe technique
- # ● 87913 Hepatitis C virus severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), mutation identification in targeted region(s)

113

MEDICINE

Section	Added	Deleted	Revised
E/M	1	26	50
Anesthesia	0	0	0
Surgery	33	19	20
Radiology	1	0	5
Path/Lab	12	0	3
Medicine	76	0	18
Category II	0	0	0
Category III	68	22	3
PLA	70	7	4

- Immunization/vaccines 20 new 12 revised
- Ophthalmology 1 new, 2 revised
- Cardiac 4 new, 1 revised
- Neuro 1 new
- Non face-to-face 5 new, 0 revised, 0 deleted
- Special 1 new, 0 revised/deleted

114

MEDICINE – IMMUNIZATIONS

Vaccine Code		Vaccine Administration Code(s)	►Patient Age◄	Vaccine Manufacturer	Vaccine Name(s)	NDC 10/NDC 11 Labeler Product ID (Vial)	Dosing Interval
#91300	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, diluent reconstituted, for intramuscular use	0001A (1st Dose) 0002A (2nd Dose) ●0003A (3rd Dose) ●0004A (Booster)	►12 years and older◄	Pfizer, Inc	Pfizer-BioNTech COVID-19 Vaccine/Comirnaty	59267-1000-1 59267-1000-01	►1st Dose to 2nd Dose: 21 Days 2nd Dose to 3rd Dose: 180 or More Days (CDC recommended population[s] [eg, immunocompromised]): 28 or More Days Booster: Refer to FDA/CDC Guidance◄
#●91305	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use	#●0051A (1st Dose) #●0052A (2nd Dose) #●0053A (3rd Dose) #●0054A (Booster)	►12 years and older◄	►Pfizer, Inc◄	►Pfizer-BioNTech COVID-19 Vaccine/Comirnaty◄	►59267-1025-1 59267-1025-01 00069-2025-1 00069-2025-01◄	►1st Dose to 2nd Dose: 21 Days 2nd Dose to 3rd Dose (CDC recommended population[s] [eg, immunocompromised]): 28 or More Days Booster: Refer to FDA/CDC Guidance◄
#●91307	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use	#●0071A (1st Dose) #●0072A (2nd Dose) #●0073A (3rd Dose) #●0074A (Booster)	►5 years through 11 years◄	►Pfizer, Inc◄	►Pfizer-BioNTech COVID-19 Vaccine◄	►59267-1055-1 59267-1055-01◄	►1st Dose to 2nd Dose:21 Days 2nd Dose to 3rd Dose (CDC recommended population[s] [eg, immunocompromised]): 28 or More Days Booster: Refer to FDA/CDC Guidance◄
#●91308	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use	#●0081A (1st Dose) #●0082A (2nd Dose) #●0083A (3rd Dose)	►6 months through 4 years◄	►Pfizer, Inc◄	►Pfizer-BioNTech COVID-19 Vaccine◄	►59267-0078-1 59267-0078-01 59267-0078-4 59267-0078-04◄	►1st Dose to 2nd Dose: 21 Days 2nd Dose to 3rd Dose: Refer to FDA/CDC Guidance◄
#91301	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5 mL dosage, for intramuscular use	0011A (1st Dose) 0012A (2nd Dose) ●0013A (3rd Dose)	►12 years and older◄	Moderna, Inc	Moderna COVID-19 Vaccine	80777-273-10 80777-0273-10	►1st Dose to 2nd Dose: 28 Days 2nd Dose to 3rd Dose (CDC recommended population[s] [eg, immunocompromised]): 28 or More Days◄

115

#●91306	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.25 mL dosage, for intramuscular use	#●0064A (Booster)	►18 years and older◄	►Moderna, Inc◄	►Moderna COVID-19 Vaccine◄	►80777-273-10 80777-0273-10◄	►Refer to FDA/CDC Guidance◄
#●91311	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 25 mcg/0.25 mL dosage, for intramuscular use	●0111A (1st Dose) ●0112A (2nd Dose)	►6 months through 5 years◄	►Moderna, Inc◄	►Moderna COVID-19 Vaccine◄	►80777-279-05 80777-0279-057◄	►1st Dose to 2nd Dose: 1 Month◄
#●91309	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use	#●0094A (Booster)	►18 years and older◄	►Moderna, Inc◄	►Moderna COVID-19 Vaccine◄	►80777-275-05 80777-0275-05◄	►Booster: Refer to FDA/CDC Guidance◄
#✓91302	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, $5x10^{10}$ viral particles/0.5 mL dosage, for intramuscular use	0021A (1st Dose) 0022A (2nd Dose)	►18 years and older◄	AstraZeneca, Plc	AstraZeneca COVID-19 Vaccine	0310-1222-10 00310-1222-10	28 Days
#91303	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, $5x10^{10}$ viral particles/0.5 mL dosage, for intramuscular use	▲0031A (Single Dose) ●0034A (Booster)	►18 years and older◄	Janssen	Janssen COVID-19 Vaccine	59676-580-05 59676-0580-05	►Booster: Refer to FDA/CDC Guidance◄
#91304	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5 mL dosage, for intramuscular use	0041A (1st Dose) 0042A (2nd Dose)	►18 years and older◄	Novavax, Inc	Novavax COVID-19 Vaccine	80631-100-01 80631-1000-01	21 Days
#✓●91310	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, monovalent, preservative free, 5 mcg/0.5 mL dosage, adjuvant AS03 emulsion, for intramuscular use	●0104A (Booster)	►18 years and older◄	►Sanofi Pasteur◄	►Sanofi Pasteur COVID-19 Vaccine, (Adjuvanted For Booster Immunization)◄	►49281-618-20 49281-0618-20◄	►Booster: Refer to FDA/CDC Guidance◄

116

MEDICINE IMMUNIZATION ADMINISTRATION

- ▲ 0031A Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5 mL dosage; single dose
- ▲ 90739 Hepatitis B vaccine (HepB), CpG-adjuvanted, adult dosage, 2 dose or 4 dose schedule, for intramuscular use

MEDICINE OPHTHALMOLOGY

- 1 new, 2 revised, 0 deleted
- ▲ 92065 Orthoptic training; performed by a physician or other qualified health care professional
- • 92066 …under supervision of a physician or other qualified health care professional
- ▲ 92229 Imaging of retina for detection or monitoring of disease; point-of-care autonomous ~~automated~~ analysis and report, unilateral or bilateral
- ▲ 92284 Diagnostic dark adaptation examination with interpretation and report

MEDICINE CARDIOVASCULAR

Revised

➢+▲ 93568 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for nonselective pulmonary arterial angiography (List separately in addition to code for primary procedure)

New

Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report;

- + ● 93569 for selective pulmonary **arterial** angiography, **unilateral** (List separately in addition to code for primary procedure)
- #+ ● 93573 for selective pulmonary arterial angiography, **bilateral** (List separately in addition to code for primary procedure)
- #+ ● 93574 for selective pulmonary venous angiography of **each distinct pulmonary** vein during cardiac catheterization (List separately in addition to code for primary procedure)
- #+ ● 93575 for selective pulmonary angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its systemic branches, during cardiac catheterization for congenital heart defects, each distinct vessel (List separately in addition to code for primary procedure)

119

NEUROLOGY

New

➢● 95919 Quantitative pupillometry with physician or other qualified health care professional interpretation and report, unilateral or bilateral

120

BEHAVIORAL MANAGEMENT

- ▶ Behavior modification is defined as the process of altering human-behavior patterns over a long-term period using various motivational techniques, namely, consequences and rewards. More simply, behavior modification is the method of changing the way a person reacts either physically or mentally to a given stimulus.

Behavior modification treatment is based on the principles of operant conditioning. The intended clinical outcome for this treatment approach is to replace unwanted or problematic behaviors with more positive, desirable behaviors through the use of evidence-based techniques and methods.

121

BEHAVIORAL MANAGEMENT

- The purpose of the group-based behavioral management/modification training services is to teach the parent(s)/guardian(s)/caregiver(s) interventions that they can independently use to effectively manage the identified patient's illness(es) or disease(s). Codes 96202, 96203 are used to report the total duration of face-to-face time spent by the physician or other qualified health care professional providing group-based parent(s)/ guardian(s)/caregiver(s) behavioral management/modification training services. This service involves behavioral treatment training provided to a multiple-family group of parent(s)/guardian(s)/caregiver(s), without the patient present. These services emphasize active engagement and involvement of the parent(s)/guardian(s)/caregiver(s) in the treatment of a patient with a mental or physical health diagnosis. These services do not represent preventive medicine counseling and risk factor reduction interventions.

122

BEHAVIORAL MANAGEMENT

During these sessions, the parent(s)/guardian(s)/caregiver(s) are trained, using verbal instruction, video and live demonstrations, and feedback from physician or other qualified health care professional or other parent(s)/guardian(s)/caregiver(s) in group sessions, to use skills and strategies to address behaviors impacting the patient's mental or physical health diagnosis. These skills and strategies help to support compliance with the identified patient's treatment and the clinical plan of care.

For counseling and education provided by a physician or other qualified health care professional to a patient and/or family, see the appropriate evaluation and management codes, including office or other outpatient services (99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215), hospital inpatient and observation care services (99221, 99222, 99223, 99231, 99232, 99233, 99234, 99235, 99236), new or established patient office or other outpatient consultations (99242, 99243, 99244, 99245), inpatient or observation consultations (99252, 99253, 99254, 99255), emergency department services (99281, 99282, 99283, 99284, 99285), nursing facility services (99304, 99305, 99306, 99307, 99308, 99309, 99310, 99315, 99316), home or residence services (99341, 99342, 99344, 99345, 99347, 99348, 99349, 99350), and counseling risk factor reduction and behavior change intervention (99401-99429). See also Instructions for Use of the CPT Codebook for definition of reporting qualifications.

123

BEHAVIORAL MANAGEMENT

Counseling risk factor reduction and behavior change intervention codes (99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412) are included and may not be separately reported on the same day as parent(s)/guardian(s)/caregiver(s) training services codes 96202, 96203 by the same provider.

Medical nutrition therapy (97802, 97803, 97804) provided to the identified patient may be reported on the same date of service as parent(s)/guardian(s)/caregiver(s) training service.◀

▶(For health behavior assessment and intervention that is not part of a standardized curriculum, see 96156, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171)◀

▶(For educational services that use a standardized curriculum provided to patients with an established illness/disease, see 98960, 98961, 98962)◀

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

124

BEHAVIORAL MANAGEMENT

➢ ● **96202** Multiple-family group behavior management/ modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes

►(Do not report 96202 for behavior management services to the patient and the parent[s]/guardian[s]/ caregiver[s] during the same session)◄

►(Do not report 96202 for less than 31 minutes of service)◄

➢+● **96203**…each additional 15 minutes (List separately in addition to code for primary service)

►(Use 96203 in conjunction with 96202)◄

►(Do not report 96202, 96203 in conjunction with 97151, 97152, 97153, 97154, 97155, 97156, 97157, 97158, 0362T, 0373T)◄

►(For educational services [eg, prenatal, obesity, or diabetic instructions] rendered to patients in a group setting, use 99078)◄

►(For counseling and/or risk factor reduction intervention provided by a physician or other qualified health care professional to patient[s] without symptoms or established disease, see 99401, 99402, 99403, 99404, 99406, 99407, 99408, 99409, 99411, 99412)◄

REMOTE THERAPEUTIC MONITORING

➢Revised

- ▲98975 Remote therapeutic monitoring (eg, ~~respiratory system status, musculoskeletal system status~~, therapy adherence, therapy response); initial set-up and patient education on use of equipment
- ▲ 98976 device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor **respiratory** system, each 30 days
- ▲ 98977 device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor **musculoskeletal** system, each 30 days

New

Remote therapeutic monitoring (eg, therapy adherence, therapy response);

- ● 98978 …device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor **cognitive behavioral therapy**, each 30 days

CATEGORY III

- 68 new, 3 revised, 22 deleted

127

+● 0715T Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Use 0715T in conjunction with 92920, 92924, 92928, 92933, 92937, 92941, 92943, 92975)◄

● 0716T Cardiac acoustic waveform recording with automated analysis and generation of coronary artery disease risk score
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023

● 0717T Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; adipose tissue harvesting, isolation and preparation of harvested cells, including incubation with cell dissociation enzymes, filtration, washing, and concentration of ADRCs
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Do not report 0717T in conjunction with 15769, 15771, 15772, 15773, 15774, 15876, 15877, 15878, 15879, 20610, 20611, 76942, 77002, 0232T, 0481T, 0489T, 0565T)◄

● 0718T injection into supraspinatus tendon including ultrasound guidance, unilateral
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Do not report 0718T in conjunction with 20610, 20611, 76942, 77002, 0232T, 0481T, 0490T, 0566T)◄

● 0719T Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Do not report 0719T in conjunction with 22840, 63005, 63012, 63017, 63030, 63042, 63047, 63056, 76000, 76496)◄

● 0720T Percutaneous electrical nerve field stimulation, cranial nerves, without implantation
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023

● 0721T Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023

128

● **0720T** Percutaneous electrical nerve field stimulation, cranial nerves, without implantation
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023

● **0721T** Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Do not report 0721T in conjunction with 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 71250, 71260, 71270, 71271, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72192, 72193, 72194, 73200, 73201, 73202, 73700, 73701, 73702, 74150, 74160, 74170, 74176, 74177, 74178, 74261, 74262, 74263, 75571, 75572, 75573, 76497, 0722T, when performed on the same anatomy)◄

+● **0722T** Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset (List separately in addition to code for primary procedure)
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Use 0722T in conjunction with 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 71250, 71260, 71270, 71271, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72192, 72193, 72194, 73200, 73201, 73202, 73700, 73701, 73702, 74150, 74160, 74170, 74176, 74177, 74178, 74261, 74262, 74263, 75571, 75572, 75573, 76497, 0721T)◄

● **0723T** Quantitative magnetic resonance cholangiopancreatography (QMRCP), including data preparation and transmission, interpretation and report, obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Do not report 0723T in conjunction with 74181, 74182, 74183, 76376, 76377, 0724T, when also evaluating same organ, gland, tissue, or target structure)◄

+● **0724T** Quantitative magnetic resonance cholangiopancreatography (QMRCP), including data preparation and transmission, interpretation and report, obtained with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) (List separately in addition to code for primary procedure)
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Use 0724T in conjunction with 74181, 74182, 74183, when also evaluating same organ, gland, tissue, or target structure)◄
►(Do not report 0724T in conjunction with 76376, 76377, 0723T)◄

129

● **0727T** Removal and replacement of implanted vestibular device, unilateral
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Do not report 0727T in conjunction with 69501, 69502, 69505, 69511, 69601, 69602, 69603, 69604)◄
►(For cochlear device implantation, with or without mastoidectomy, use 69930)◄

● **0728T** Diagnostic analysis of vestibular implant, unilateral; with initial programming
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023

● **0729T** with subsequent programming
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(For initial and subsequent diagnostic analysis and programming of cochlear implant, see 92601, 92602, 92603, 92604)◄

● **0730T** Trabeculotomy by laser, including optical coherence tomography (OCT) guidance
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Do not report 0730T in conjunction with 65850, 65855, 92132, 0621T, 0622T)◄

● **0731T** Augmentative AI-based facial phenotype analysis with report
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023

● **0732T** Immunotherapy administration with electroporation, intramuscular
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023

▲ **0733T** Remote real-time, motion capture–based neurorehabilitative therapy ordered by a physician or other qualified health care professional; supply and technical support, per 30 days
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023

▲ **0734T** treatment management services by a physician or other qualified health care professional, per calendar month
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023

+● **0735T** Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with primary craniotomy (List separately in addition to code for primary procedure)

130

● **0736T** Colonic lavage, 35 or more liters of water, gravity-fed, with induced defecation, including insertion of rectal catheter
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023

● **0737T** Xenograft implantation into the articular surface
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Use 0737T once per joint)◄
►(Do not report 0737T in conjunction with 27415, 27416)◄

● **0738T** Treatment planning for magnetic field induction ablation of malignant prostate tissue, using data from previously performed magnetic resonance imaging (MRI) examination
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Do not report 0738T in conjunction with 0739T on the same date of service)◄

● **0739T** Ablation of malignant prostate tissue by magnetic field induction, including all intraprocedural, transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring, thermal dosimetry, bladder irrigation, and magnetic field nanoparticle activation
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Do not report 0739T in conjunction with 51700, 51702, 72192, 72193, 72194, 72195, 72196, 72197, 74176, 74177, 74178, 76497, 76498, 76856, 76857, 76872, 76873, 76940, 76942, 76998, 76999, 77011, 77012, 77013, 77021, 77022, 77600, 77605, 77610, 77615, 77620)◄

● **0740T** Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Do not report 0740T in conjunction with 95249, 95250, 95251, 98975, 99453)◄

● **0741T** provision of software, data collection, transmission, and storage, each 30 days
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Do not report 0741T in conjunction with 95249, 95250, 95251, 99091, 99454)◄
►(Do not report 0741T for data collection less than 16 days)◄

131

✚● **0742T** Absolute quantitation of myocardial blood flow (AQMBF), single-photon emission computed tomography (SPECT), with exercise or pharmacologic stress, and at rest, when performed (List separately in addition to code for primary procedure)
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Use 0742T in conjunction with 78451, 78452)◄
►(For absolute quantification of myocardial blood flow [AQMBF] with positron emission tomography [PET], use 78434)◄

● **0743T** Bone strength and fracture risk using finite element analysis of functional data and bone mineral density (BMD), with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and BMD and classification of any vertebral fractures, with overall fracture-risk assessment, interpretation and report
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Do not report 0743T in conjunction with 0554T, 0555T, 0556T, 0557T, 0691T)◄

#● **0749T** Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone strength and fracture risk and BMD, interpretation and report;
Sunset January 2028
➔ CPT Changes: An Insider's View 2023
►(When the data from a concurrently performed wrist or hand X ray obtained for another purpose is used for the digital DXR-BMD analysis, use the appropriate X-ray code in conjunction with 0749T. If a single-view digital X ray of the hand is used as a data source, use 0750T)◄

#● **0750T** with single-view digital X-ray examination of the hand taken for the purpose of DXR-BMD
Sunset January 2028
➔ CPT Changes: An Insider's View 2023

● **0744T** Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium), when performed
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
►(Do not report 0744T in conjunction with 34501, 34510, 76998, 93971)◄

● **0745T** Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization and mapping of arrhythmia site (nidus), derived from anatomical image data (eg, CT, MRI, or myocardial perfusion scan) and electrical data (eg, 12-lead ECG data), and identification of areas of avoidance
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023

132

● **0746T** conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023

● **0747T** delivery of radiation therapy, arrhythmia
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023

● **0748T** Injections of stem cell product into perianal perifistular soft tissue, including fistula preparation (eg, removal of setons, fistula curettage, closure of internal openings)
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023

133

▶Digital Pathology Digitization Procedures◀

▶Digital pathology is a dynamic, image-based environment that enables the acquisition, management, and interpretation of pathology information generated from digitized glass microscope slides.

Glass microscope slides are scanned by clinical staff, and captured images (either in real-time or stored in a computer server or cloud-based digital image archival and communication system) are used for digital examination for pathologic diagnosis distinct from direct visualization through a microscope.

Digitization of glass microscope slides enables remote examination by the pathologist and/or in conjunction with the use of artificial intelligence (AI) algorithms. Category III add-on codes 0751T-0763T may be reported in addition to the appropriate Category I service code when the digitization procedure of glass microscope slides is performed and reported in conjunction with the Category I code for the primary service.

Do not report the Category III codes in this subsection solely for archival purposes (eg, after the Category I service has already been performed and reported), solely for educational purposes (eg, when services are not used for individual patient reporting), solely for developing a database for training or validation of AI algorithms, or solely for clinical conference presentations (eg, tumor board interdisciplinary conferences).◀

+● **0751T** Digitization of glass microscope slides for level II, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
▶(Use 0751T in conjunction with 88302)◀

+● **0752T** Digitization of glass microscope slides for level III, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
▶(Use 0752T in conjunction with 88304)◀

+● **0753T** Digitization of glass microscope slides for level IV, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)
Sunset January 2028
➔ *CPT Changes: An Insider's View* 2023
▶(Use 0753T in conjunction with 88305)◀

134

+● **0754T** Digitization of glass microscope slides for level V, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)
Sunset January 2028
CPT Changes: An Insider's View 2023
►Use 0754T in conjunction with 88307)◄

+● **0755T** Digitization of glass microscope slides for level VI, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Use 0755T in conjunction with 88309)◄

+● **0756T** Digitization of glass microscope slides for special stain, including interpretation and report, group I, for microorganisms (eg, acid fast, methenamin silver) (List separately in addition to code for primary procedure)
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Use 0756T in conjunction with 88312)◄

+● **0757T** Digitization of glass microscope slides for special stain, including interpretation and report, group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry (List separately in addition to code for primary procedure)
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Use 0757T in conjunction with 88313)◄

+● **0758T** Digitization of glass microscope slides for special stain, including interpretation and report, histochemical stain on frozen tissue block (List separately in addition to code for primary procedure)
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Use 0758T in conjunction with 88314)◄

+● **0759T** Digitization of glass microscope slides for special stain, including interpretation and report, group III, for enzyme constituents (List separately in addition to code for primary procedure)
Sunset January 2028
CPT Changes: An Insider's View 2023

135

+● **0760T** Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, initial single antibody stain procedure (List separately in addition to code for primary procedure)
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Use 0760T in conjunction with 88342)◄

+● **0761T** Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, each additional single antibody stain procedure (List separately in addition to code for primary procedure)
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Use 0761T in conjunction with 88341)◄

+● **0762T** Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, each multiplex antibody stain procedure (List separately in addition to code for primary procedure)
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Use 0762T in conjunction with 88344)◄

+● **0763T** Digitization of glass microscope slides for morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure, manual (List separately in addition to code for primary procedure)
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Use 0763T in conjunction with 88360)◄

+● **0764T** Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to concurrently performed electrocardiogram (List separately in addition to code for primary procedure)
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Use 0764T in conjunction with 93000, 93010)◄
►(Use 0764T only once for each unique, concurrently performed electrocardiogram tracing)◄

● **0765T** related to previously performed electrocardiogram
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Use 0765T only once for each unique, previously performed electrocardiogram tracing)◄

136

● **0766T** Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, initial treatment, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve
Sunset January 2028
CPT Changes: An Insider's View 2023

+● **0767T** each additional nerve (List separately in addition to code for primary procedure)
Sunset January 2028
CPT Changes: An Insider's View 2023

►(Use 0767T in conjunction with 0766T)◄

►(Do not report 0766T, 0767T in conjunction with 95885, 95886, 95887, 95905, 95907, 95908, 95909, 95910, 95911, 95912, 95913, for nerve conduction used as guidance for transcutaneous magnetic stimulation therapy)◄

►(Do not report 0766T, 0767T in conjunction with 64566, 90867, 90868, 90869, 97014, 97032, 0278T, for the same nerve)◄

● **0768T** Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, subsequent treatment, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve
Sunset January 2028
CPT Changes: An Insider's View 2023

+● **0769T** each additional nerve (List separately in addition to code for primary procedure)
Sunset January 2028
CPT Changes: An Insider's View 2023

►(Use 0769T in conjunction with 0768T)◄

►Virtual reality (VR) technology may be integrated into multiple types of patient therapy as an adjunct to the base therapy. Code 0770T is an add-on code that represents the practice expense for the software used for the VR technology and may be reported for each session for which the VR technology is used. VR technology is incorporated into the base therapy session and is used to enhance the training or teaching of a skill upon which the therapy is focused. Code 0770T does not incur any additional reported therapist time beyond that already reported with the base therapy code.◄

+● **0770T** Virtual reality technology to assist therapy (List separately in addition to code for primary procedure)
Sunset January 2028
CPT Changes: An Insider's View 2023

►(Use 0770T only in conjunction with 90832, 90833, 90834, 90836, 90837, 90838, 90847, 90849, 90853, 92507, 92508, 96158, 96159, 96164, 96165, 96167, 96168, 96170, 96171, 97110, 97112, 97129, 97150, 97153, 97154, 97155, 97158, 97530, 97533, 97535, 97537)◄

►(Do not report 0770T more than once per session)◄

137

►Virtual Reality Patient Procedural Dissociation◄

►Virtual reality (VR) procedural dissociation is a VR-based state of altered consciousness that supports and optimizes the patient's comfort, increases procedural tolerance, and decreases the patient's pain during the associated procedure. VR procedural dissociation establishes a computer-generated audio, visual, and proprioceptive immersive environment in which patients respond purposefully to verbal commands and stimuli, either alone or accompanied by light tactile stimulation. VR procedural dissociation does not involve interventions to maintain cardiovascular function, patent airway, or spontaneous ventilation.

VR procedural dissociation codes 0771T, 0772T, 0773T, 0774T are not used to report administration of medications for pain control, minimal sedation (anxiolysis), moderate sedation (99151, 99152, 99153, 99155, 99156, 99157), deep sedation, or monitored anesthesia care (00100-01999). Time spent administering VR procedural dissociation cannot be used to report moderate sedation or anesthesia services. VR procedural dissociation is not reported for patients younger than 5 years of age.

For 0771T, 0772T, the independent, trained observer is an individual who is qualified to monitor the patient during the procedure and has no other duties (eg, assisting at surgery) during the procedure. This individual has undergone training in immersive technologies and can adjust the technology under the supervision of the physician or other qualified health care professional who is performing the procedure. If the physician or other qualified health care professional who provides the VR also performs the procedure supported by VR (0771T, 0772T), the physician or other qualified health care professional will supervise and direct the independent, trained observer who will assist in monitoring the patient's level of consciousness, procedural disassociation, and physiological status throughout the procedure.

Intraservice time is used to determine the appropriate code to report VR procedural dissociation and is defined as:

- beginning with the administration of the immersive VR technology, which at a minimum, includes audio, video, and proprioceptive feedback;
- requiring continuous face-to-face attendance of the physician or other qualified health care professional. Once continuous face-to-face time with the patient has ended, additional face-to-face time with the patient is not added to the intraservice time;
- ending when the procedure and the administration of the VR technology ends and the physician or other qualified health care professional is no longer continuously face-to-face with the patient;
- requiring monitoring patient response to the VR procedural dissociation, including:
- periodic assessment of the patient;
- monitoring of procedural tolerance, oxygen saturation, heart rate, pain, neurological status, and global anxiety;
- altering of and/or adjustment of the VR program to optimize the dissociated state based on patient tolerance of the associated.

138

- Optimization techniques include:
  - changing the VR baseline software program and/or adjustment of program volume;
  - adjusting the visual virtual environment;
  - altering the visual virtual position of the VR program to enable patient repositioning;
  - changing an embedded video programming in the virtual environment to maintain the dissociated state; and
  - utilizing and adjusting a proprioception, olfactory, or tactile feedback loop that corresponds to the VR program to achieve a proper and/or deeper dissociated state.

Preservice work and time are not reported separately and include the initial ordering and selecting of the VR program, describing VR procedural dissociation to the patient and/or family, and applying the VR device to the patient prior to starting the procedure. Postservice work and time is not reported separately and begins with the end of the procedure, the termination of the VR technology, and when the physician or other qualified health care professional is no longer continuously face-to-face with the patient.◄

		►Virtual reality (VR) procedural dissociation by physician or other qualified health care professional (same physician or other qualified health care professional performing the procedure the VR is supporting)	Virtual reality (VR) procedural dissociation by different physician or other qualified health care professional (not the physician or other qualified health care professional who is performing the procedure the VR is supporting)
Total Intraservice Time for VR Procedural Dissociation	**Patient Age**	**Code(s)**	**Code(s)**
Less than 10 minutes	< 5 years	Not reported separately	Not reported separately
	5 years or older	Not reported separately	Not reported separately
10-22 minutes	5 years or older	0771T	0773T
23-37 minutes	5 years or older	0771T+ 0772T X 1	0773T + 0774T X 1
38-52 minutes	5 years or older	0771T + 0772T X 2	0773T + 0774T X 2
53-67 minutes	5 years or older	0771T + 0772T X 3	0773T + 0774T X 3◄

139

0771T Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older
Sunset January 2028
CPT Changes: An Insider's View 2023

+0772T each additional 15 minutes intraservice time (List separately in addition to code for primary service)
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Use 0772T in conjunction with 0771T)◄

0773T Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time, patient age 5 years or older
Sunset January 2028
CPT Changes: An Insider's View 2023

+0774T each additional 15 minutes intraservice time (List separately in addition to code for primary service)
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Use 0774T in conjunction with 0773T)◄

140

● **0775T** Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s])
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Do not report 0775T in conjunction with 27279, 27280)◄
►(For percutaneous arthrodesis, sacroiliac joint, with transfixation device, use 27279)◄
►(For removal or replacement of sacroiliac intra-articular implant[s], use 27299)◄
►(For bilateral procedure, report 0775T with modifier 50)◄

● **0776T** Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (eg, vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Do not report 0776T more than once per day)◄
►(For initiation of selective head or total body hypothermia in the critically ill neonate, use 99184)◄

+● **0777T** Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure)
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Use 0777T in conjunction with 62320, 62321, 62322, 62323, 62324, 62325, 62326, 62327)◄

141

● **0778T** Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Do not report 0778T in conjunction with 96000, 96004, 98975, 98977, 98980, 98981)◄

● **0779T** Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Do not report 0779T in conjunction with 91020, 91022, 91112, 91117, 91122, 91132, 91133)◄

● **0780T** Instillation of fecal microbiota suspension via rectal enema into lower gastrointestinal tract
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Do not report 0780T in conjunction with 44705, 44799, 45999, 74283)◄

● **0781T** Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi
Sunset January 2028
CPT Changes: An Insider's View 2023

● **0782T** unilateral mainstem bronchus
Sunset January 2028
CPT Changes: An Insider's View 2023
►(Use 0781T, 0782T only once, regardless of the number of treatments per bronchus)◄
►(Do not report 0781T, 0782T in conjunction with 31622-31638, 31640, 31641, 31643, 31645, 31646, 31647, 31648, 31649, 31651, 31652, 31653, 31654, 31660, 31661)◄
►(For bronchial thermoplasty, see 31660, 31661)◄

● **0783T** Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment
Sunset January 2028
CPT Changes: An Insider's View 2023

142

MODIFIERS

143

MODIFIER 93

Effective January 1, 2022 Added to Book 2023

- Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System:

Synchronous telemedicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the course of the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction.

144

RESOURCES

- AMA 2023 CPT® Professional
- CPT Changes 2023
- CPT Symposium

145

146