The University of Kansas Health System

CPT Updates for 2023

The University of Kansas Health System

Housekeeping

Today's session is being recorded

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Housekeeping

You must attend the entire session and pass the post-session quiz with a score of 70% or greater to receive CEUs.

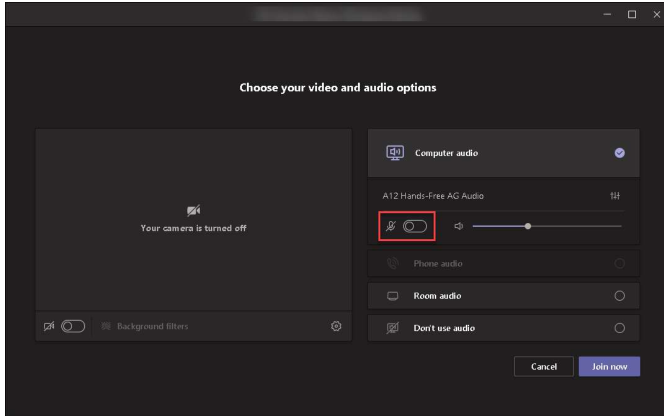
You'll find the link for the post-session quiz in Helix. Helix will generate your CEU certificate after you have passed your test. (For best results, use Microsoft Edge.)

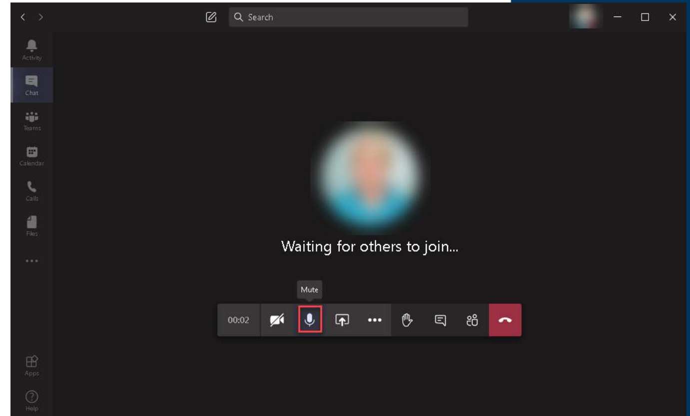
If you have questions, please email Cathy Jennings at cjennings3@kumc.edu or Chelsea Troyer at ctroyer-calbeck@kumc.edu or Karen Deitchler at kdeitchler@kumc.edu.

THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Housekeeping

Please mute your computer and your phone.





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Disclaimer

This program is intended to be informational only. Attendees are advised to reference payer specific provider manuals, online or otherwise, for verification prior to making changes to their coding, documentation, and/or billing practices. Attendees are also advised to consult their managers or compliance before making changes to coding practices.

Not every change to guidelines and parenthetical notes is included in this presentation. Always review those guideline changes and changed parenthetical notes for the codes you use the most often every year. Do not forget that code changes also often lead to changes in NCCI policy.

The University of Kansas Health System

Agenda

General Information for Updates

Code Updates

12/15/2022

Agenda

General Information for Updates

THE UNIVERSITY OF KANSAS HEALTH SYSTEM

What to watch for

►We'll talk about the changes to the codes themselves, but those aren't the only changes in the code set. Watch for any text in the book, especially the guidelines and parenthetical notes, that is listed in green with triangles at each end like this paragraph.◄

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Parentheticals are changed in relation to any added or deleted codes too.

Guides for Use

Most of the updates in this presentation are effective January 1, 2023, but CPT updates more than annually now.

In this presentation,

additions are in green,

deletions are in ~~red~~,

revisions are in blue, and

items in black are unchanged from 2022 and only included for context.

+ = Add-on Code

Don't forget to always watch the parenthetical behind add on codes that tell you the codes you are allowed to use the add on code with.

Notice that I don't have # on this slide, but many codes are now out of sequence as you will see during the presentation.

AMA CPT Website Links

Early Release Schedule	
Category III Codes	www.ama-assn.org/cpt-cat-iii-codes
Vaccine Codes	www.ama-assn.org/cpt-cat-i-vaccine-codes
PLA Codes	www.ama-assn.org/cpt-pla-codes
Administrative MAAA Codes	www.ama-assn.org/maaa-code
Molecular Pathology Tier 2 Codes	www.ama-assn.org/mo-path-tier-2-codes
Technical Corrections/Errata	
www.ama-assn.org/practice-management/cpt/errata-technical-corrections	
CPT E/M Office Visit Microsite	
www.ama-assn.org/cpt-office-visits	

Current CPT Release Schedule

Overview

	Added	Deleted	Revised
Evaluation & Management	1	26	50
Anesthesia	0	0	0
Surgery	33	19	20
Radiology	1	0	5
Pathology & Lab	12	0	4
Medicine	38	0	9
Category II	0	0	0
Category III	70	23	1
PLA	70	7	4
Total	225	75	93

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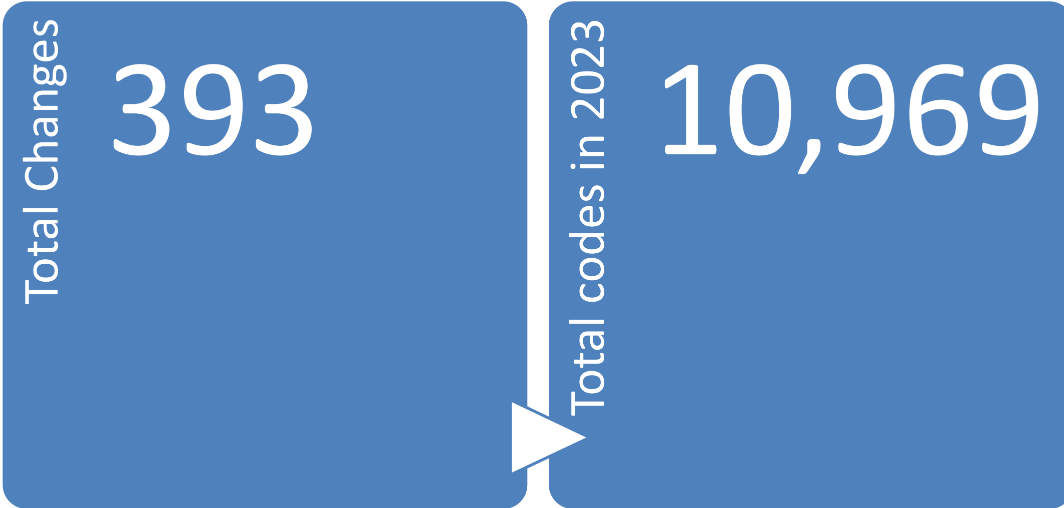
Overview



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The University of Kansas Health System

Other Updates From CMS

New G-Codes

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, 99415, 99416). (do not report G0316 for any time unit less than 15 minutes)

G0317 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, 99418). (Do not report G0317 for any time unit less than 15 minutes)

G0318 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)

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New prolonged service codes for revised E/M codes for hospital inpatient/outpatient, nursing facility, and home/residence. CMS will not follow time tables in CPT similar to G2212.

From CMS presentation at AMA CPT Symposium.

- We are concerned that the revised CPT prolonged service framework will allow for duplicative or unwarranted billing, pose barriers to oversight, and increase administrative complexity compared to the predecessor codes.
- Therefore, we finalized creation of Medicare-specific coding for payment of Other E/M prolonged services, similar to what CMS adopted in CY 2021 for payment of Office/Outpatient prolonged services. These services will be reported with three separate Medicare-specific G codes.

Other Updates From CMS

New G-Codes

G0320 Home health services furnished using synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system

G0321 Home health services furnished using synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system

G0322 The collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency (i.e., remote patient monitoring)

G0323 Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month. These services include the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, coordination with and/or referral to physicians and practitioners who are authorized by medicare to prescribe medications and furnish e/m services, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team)

Other Updates From CMS

New G-Codes

G0330 Facility services for dental rehabilitation procedure(s) performed on a patient who requires monitored anesthesia (e.g., general, intravenous sedation (monitored anesthesia care) and use of an operating room

G3002 Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (When using G3002, 30 minutes must be met or exceeded.)

G3003 Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month. (list separately in addition to code for G3002. when using G3003, 15 minutes must be met or exceeded.)

We finalized the creation of new HCPCS codes G3002 and G3003 and valuation for chronic pain management and treatment services (CPM) for CY 2023. We believe the CPM HCPCS codes will improve payment accuracy for these services, prompt more practitioners to welcome Medicare beneficiaries with chronic pain into their practices, and encourage practitioners already treating Medicare beneficiaries who have chronic pain to spend the time to help them manage their condition within a trusting, supportive, and ongoing care partnership.

Other Updates From CMS

Dental Exams

- Effective for CY 2023, we 1) finalized our proposal to clarify and codify certain aspects of the current Medicare FFS payment policies for dental services when that service is an integral part of specific treatment of a beneficiary's primary medical condition, and 2) other clinical scenarios under which Medicare Part A and Part B payment can be made for dental services, such as dental exams and necessary treatments prior to, or contemporaneously with, organ transplants, cardiac valve replacements, and valvuloplasty procedures. We also finalized payment for dental exams and necessary treatments prior to the treatment for head and neck cancers starting in CY 2024, and finalizing a process in CY 2023 to review and consider public recommendations for Medicare payment for dental service in other potentially analogous clinical scenarios.

Other Updates From CMS

Audiology – Modifier AB

- We finalized a policy to allow beneficiaries direct access to an audiologist without an order from a physician or NPP for non acute hearing conditions.
- The finalized policy will allow the use of a new modifier — instead of using a new HCPCS G code as we proposed — because we were persuaded by the commenters that a modifier would allow for better accuracy of reporting and reduce burden for audiologist. The service(s) can be billed using the codes audiologists already use with the new modifier and include only those personally furnished by the audiologist.
- The finalized direct access policy will allow beneficiaries to receive care for non acute hearing assessments that are unrelated to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids. This modification in our finalized policy necessitates multiple changes to our claims processing systems, which will take some time to fully operationalize, but audiologists may use modifier AB, along with the finalized list of 36 CPT codes, for dates of service on and after January 1, 2023.
- We finalized the proposal to permit audiologists to bill for this direct access (without a physician or practitioner order) once every 12 months, per beneficiary. Medically reasonable and necessary tests ordered by a physician or other practitioner and personally provided by audiologists will not be affected by the direct access policy, including the modifier and frequency limitation.

Other CPT Updates

Appendix A – Modifier

63 Procedure Performed on Infants less than 4 kg

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

Other CPT Updates

~~Appendix C – Clinical Examples~~

Deleted

Other CPT Updates

Appendix S – Artificial Intelligence Taxonomy for Medical Services and Procedures

Other CPT Updates

Appendix T – Audio Only Services

CPT Updates - Introduction

Add-on Codes

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**.

CPT Updates - Introduction

Code Symbols

CPT add-on codes are annotated by the **+** symbol and are listed in **Appendix D**. The symbol ⦸ is used to identify codes that are exempt form the use of modifier 51 but have not been designated as CPT add-on procedures or services. A list of codes exempt from modifier 51 usage is included in **Appendix E**. The ⚡ symbol is used to identify codes for vaccines that are ending FDA approval (see **Appendix K**). The **#** symbol is used to identify codes that are listed out of numerical sequence (see **Appendix N**). The ★ symbol is used to identify codes that may be used to report telemedicine services when appended by modifier 95 (see **Appendix P**). The 🔈 symbol is used to identify codes that may be used to report audio-only telemedicine services when appended by modifier 93 (see **Appendix T**).

Agenda

Code Updates

Introduction, Symbols, and Modifiers

OPTUM360° EncoderPro.com Expert

Code Set Search · Image Search · Index Only Search

All Code Sets | Search | Help with Search?

Coding | Policy Lookup | Reimbursement | Add-ons | Available Add-ons

- Current Procedural Coding Expert
- Current Procedural Coding Expert Index
- HCPCS
- HCPCS Index
- ICD-9-CM Dx
- ICD-9-CM Index
- ICD-9-CM Px
- ICD-9-CM Px Index
- ICD-10-PCS
- ICD-10-CM Dx
- ICD-10-CM Index
- Future Codes
- Modifier List
- Hierarchical Condition Categories(HCC)
- The Merck Manual

- CPT Codes
- New Codes
- Revised Codes
- Reinstated Codes
- Resequenced Codes
- Deleted Codes
- Color Codes

- Contents
- Introduction
- Index
- Evaluation and Management Notes
- Evaluation and Management
- Anesthesia
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine - Part 1
- Medicine - Part 2
- Category II Codes
- Category III Codes
- Appendix A - Modifiers
- Appendix B - New Codes
- Appendix B - Revised Codes
- Appendix B - Deleted Codes
- Appendix C - Evaluation and Management Extended Guidelines
- Appendix D - Crosswalk of Deleted Codes
- Appendix E - Resequenced Codes
- Appendix F - Add-on, Modifier 51, 63, and Telemedicine Services
- Appendix G - Medicare Internet-only Manuals
- Appendix H - MIPS - Quality Performance Category Measures
- Appendix I - Medically Unlikely Edits

- ICD-9-CM Section 1 - Index to Diseases
  - Hypertension Table
  - Neoplasm Table
- ICD-9-CM Section 2 - Table of Drugs and Chemicals
- ICD-9-CM Section 3 - Index to External Causes (E Codes)
- ICD-9-CM Index to Procedures
- ICD-10-CM Index to Diseases and Injuries
  - Neoplasm Table
- ICD-10-CM Table of Drugs and Chemicals
- ICD-10-CM Index to External Causes
- ICD-10-PCS Index to Procedures

CCI Check

What's New?

What's New? content & training

Click here for FREE TRAINING & a summary of code ...

Encoder Pro.com Expert News

EncoderPro.com News product in...

You Asked, We Listened. New ICD10-CM Code Note Edits
06/28/2019
EncoderPro.com users have long come to depend on the cla... review tool could be better is to assist them with improved IC... become a priority for EncoderPro.com users. So, we have re... edit). We have added the additional following ICD10-CM edit... This edit checks for ICD10 codes that have an "Excludes 2" r... ICDUA - This is a "Use Additional Code" rule. - ICDCA - This... information only, as they may not produce a claim denial, but... HCC coding to capture the full clinical picture of the patient t...

CCI Edits
06/27/2019
Beginning July 1, 2019 modifiers 59 and X(EPSU) may be ap... not affect the way the NCCI/CCI data is released by the Cent... allowed to override an edit. See Transmittal 2259 for more in...

2019 Optum360 Maintenance Release Calendar
10/29/2018
The maintenance release calendar for 2019 is available. It sh... the page below for more information.

Evaluation & Management

Evaluation & Management

- There is a big overhaul to this section for almost all face-to-face services.
- History and physical exam are no longer determining factors for the level of visit.
- The MDM table is revised and is part of CPT rather than separate CMS guidelines. There were some revisions to that table for 2023 that will also apply to Office and Other Outpatient Services.
- Compliance is providing full training – I will only provide a summary here.

Compliance provided the full training for the 2023 E&M changes so I won't really cover them here.

The University of Kansas Health System

Evaluation & Management

Summary of Updates

- E/M Introductory Guidelines related to Hospital Inpatient and Observation Care Services codes 99221-99223, 99231-99239, Consultations codes 99242-99245, 99252-99255, Emergency Department Services codes 99281-99285, Nursing Facility Services codes 99304-99310, 99315, 99316, Home or Residence Services codes 99341, 99342, 99344, 99345, 99347-99350
- Deletion of Hospital Observation Services E/M codes 99217-99220
- Revision of Hospital Inpatient and Observation Care Services E/M codes 99221-99223, 99231-99239 and guidelines
- Deletion of Consultations E/M codes 99241 and 99251
- Revision of Consultations E/M codes 99242-99245, 99252-99255 and guidelines
- Revision of Emergency Department Services E/M codes 99281-99285 and guidelines

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Compliance provided the full training for the 2023 E&M changes so I won’t really cover them here.

Evaluation & Management

Summary of Updates (continued)

- Deletion of Nursing Facility Services E/M code 99318
- Revision of Nursing Facility Services E/M codes 99304-99310, 99315, 99316 and guidelines
- Deletion of Domiciliary, Rest Home (eg, Boarding Home), or Custodial Care Services E/M codes 99324-99238, 99334-99337, 99339, 99340
- Deletion of Home or Residence Services E/M code 99343
- Revision of Home or Residence Services E/M codes 99341, 99342, 99344, 99345, 99347-99350 and guidelines
- Deletion of Prolonged Services E/M codes 99354-99357
- Revision of guidelines for Prolonged Services E/M codes 99358, 99359, 99415, 99416
- Revision of Prolonged Services E/M code 99417 and guidelines
- Establishment of Prolonged Services E/M code 993X0 and guidelines

Compliance provided the full training for the 2023 E&M changes so I won’t really cover them here.

Based on 2 out of 3 elements of MDM			
Elements of MDM			
Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed	Risk of Complications and/or Morbidity or Mortality of Patient Management	Level of MDM
Minimal/Nurse Visit	N/A	N/A	N/A
Minimal ED Visit	N/A	N/A	N/A
Straightforward • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk** of morbidity from additional testing or treatment Examples only: Rest, Gargles, Superficial dressing	**Straightforward**
Low • 2 or more self-limited or minor problems; OR • 1 stable chronic illness; OR • 1 acute, uncomplicated illness or injury OR • 1 stable, acute illness OR • 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care	**Low** - (Must meet the requirements of at least 1 categories below) Category 1: Tests and documents **• Any combination of 2 from the following:** • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test Category 2: Assessment requiring an independent historian(s) (For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)	**Low risk** of morbidity from additional diagnostic testing or treatment Examples only: • OTC drugs • Decision regarding minor surgery with no identified risk factors • PT or OT	**Low**
Moderate • 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment OR • 2 or more stable chronic illnesses; OR • 1 undiagnosed new problem with uncertain prognosis OR • 1 acute illness with systemic symptoms OR • 1 acute complicated injury	**Moderate** - (Must meet the requirements of at least 1 categories below) Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s) Category 2: Independent interpretation of tests • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk** of morbidity from additional diagnostic testing or treatment Examples only: • Prescription drug management • Decision regarding minor surgery with identified patient or procedure risk factors • Decision regarding elective major surgery without identified patient or procedure risk factors • Diagnosis or treatment significantly limited by social determinants of health	**Moderate**
High • 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; OR • 1 acute or chronic illness or injury that poses a threat to life or bodily function	**High - (Must meet the requirements of at least 2 categories)** Category 1: Tests, documents, or independent historian(s) • Any combination of 3 from the following: • Review of prior external note(s) from each unique source; • Review of the result(s) of each unique test; • Ordering of each unique test; • Assessment requiring an independent historian(s) Category 2: Independent interpretation of test • Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) Category 3: Discussion of management or test interpretation • Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**High risk** of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major surgery with identified patient or procedure risk factors • Decision regarding emergency major surgery • Decision regarding hospitalization or escalation of hospital-level of care • Decision not to resuscitate or to de-escalate care because of poor prognosis • Parenteral controlled substances	**High**

Anesthesia

Anesthesia

No new, deleted, or revised codes.

Surgery – Integumentary System

Surgery – Integumentary System

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)

Surgery – Integumentary System

~~15850 Removal of sutures under anesthesia (other than local), same surgeon~~
(15850 has been deleted. To report, use 15851)

15851 Removal of sutures **or** staples ~~under~~ requiring anesthesia (ie, general anesthesia, moderate sedation) ~~(other than local), other surgeon~~
(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)
(Use 15854 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 15854 in conjunction with 15853)

- Previously, codes 15850 and 15851 differentiated between “same surgeon” and “other surgeon”
  - “Same surgeon” vs “other surgeon” is not relevant to the suture removal
- Code 15851 was revised to specify that general anesthesia or moderate sedation **is** required and to remove reference to “other surgeon”
  - In accordance with these revisions, code 15850 was deleted
- Two add-on codes (15853, 15854) were added for reporting suture removal (**not** requiring anesthesia or sedation) in the office or other outpatient site outside of the global period
  - Captures additional practice expense related to suture or staple removal not inherent to an

evaluation and management (E/M) code

Surgery – Musculoskeletal System

Surgery – Musculoskeletal System

22857 Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar

(Do not report 22857 in conjunction with 22558, 22845, 22853, 22854, 22859, 49010 when performed at the same level)

~~(For additional interspace, use Category III code 0163T)~~

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)

- Code 22860 has been added to report total disc arthroplasty of a second interspace performed via anterior approach.
- Code 22857 has been revised to be a “parent” code to accommodate the addition of new code 22860.
- Code 22860 is intended to be reported for the second interspace in conjunction with code 22857. If more than two interspaces are treated, then unlisted code 22899 is reported for the entire procedure.

Surgery – Musculoskeletal System

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)

(To report bilateral procedure, report 27280 with modifier 50)

Surgery – Respiratory System

Surgery – Respiratory System

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)

- Currently, repair of nasal valve collapse with radiofrequency remodeling is reported with unlisted code 30999 (Unlisted procedure, nose).
- The procedure has been performed since 2017 with increasing frequency that is indicative of clinical need.
- New Current Procedural Terminology (CPT®) code 30469:
  - is specific to utilizing radiofrequency energy for subcutaneous/submucosal remodeling
  - allows procedure utilization and patient outcomes tracking
  - reflects physician work and equipment required to perform standalone procedure

- Radiofrequency wand
- “Remodeling”
- Intranasal wand is not applied outside the nose
- Use of headlight and topical anesthesia via cottonoid or pledget
- Sometimes performed in conjunction with other ablative procedures of the nose, such as inferior turbinate ablation •
- Typically not performed using nasal endoscope

Surgery – Cardiovascular System

Surgery – Cardiovascular System

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)

- Addition of five Category I codes (33900-33904) for reporting percutaneous pulmonary artery revascularization procedures by stent placement
    - Pulmonary artery revascularization procedures using balloon angioplasty reported with codes 92997 and 92998
- Pulmonary arterial stent procedures differentiated based on:
    - Underlying cardiac anatomy: “normal” connections vs “abnormal connections”
    - Laterality of the procedure: unilateral vs bilateral pulmonary artery stenting

Surgery – Cardiovascular System

<table>
<tr><th></th><th>Normal Connections</th><th>Abnormal Connections</th><th></th></tr>
<tr><td>Unilateral Stent</td><td>33900</td><td>33902</td><td rowspan="3">Do not report 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 PA stent procedure</td></tr>
<tr><td>Bilateral Stent</td><td>33901</td><td>33903</td></tr>
<tr><td>Additional Stent</td><td>33904</td><td>33904</td></tr>
<tr><td>PA Balloon Angioplasty</td><td>92997</td><td>92997</td><td rowspan="2">Balloon angioplasty (92997, 92998) within the same target lesion as stent implant, either before or after stent deployment, is not separately reported</td></tr>
<tr><td>PA Balloon Angioplasty, Additional Vessel</td><td>92998</td><td>92998</td></tr>
</table>

Surgery – Cardiovascular System

35883 Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous patch graft (eg, ~~Dacron~~ polyester, ePTFE, bovine pericardium)

(For bilateral procedure, use modifier 50)

(Do not report 35883 in conjunction with 35700, 35875, 35876, 35884)

The University of Kansas Health System

Surgery – Cardiovascular System

36836 Percutaneous arteriovenous fistula creation, upper extremity, single access of both the 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

(Do not report 36836 in conjunction with 36005, 36140, 36215, 36216, 36217, 36218, 36245, 36245, 36246, 36247, 36837, 36901, 36902, 36903, 36904, 36905, 36906, 36907, 36908, 36909, 37236, 37238, 37241, 37242, 37246, 37248, 37252, 75710, 75716, 75820, 75822, 75894, 75898, 76937, 77001)

(For arteriovenous fistula creation via an open approach, see 36800, 36810, 36815, 36818, 36819, 36820, 36821)

(For percutaneous arteriovenous fistula creation in any location other than the upper extremity, us 37799)

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

(Do not report 36837 in conjunction with 36005, 36140, 36215, 36216, 36217, 36218, 36245, 36245, 36246, 36247, 36837, 36901, 36902, 36903, 36904, 36905, 36906, 36907, 36908, 36909, 37236, 37238, 37241, 37242, 37246, 37248, 37252, 75710, 75716, 75820, 75822, 75894, 75898, 76937, 77001)

(For arteriovenous fistula creation via an open approach, see 36800, 36810, 36815, 36818, 36819, 36820, 36821)

(For percutaneous arteriovenous fistula creation in any location other than the upper extremity, us 37799)

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- Codes 36836 and 36837 have been added for reporting percutaneous arteriovenous (AV) fistula creation:
  - via a single access site, usually via an arm vein (36836)
  - via two separate access sites into a peripheral artery and peripheral vein (36837)
- These codes are for the upper extremity only; use an unlisted code for the lower extremity
- Previously there were only codes for AV fistula creation via an open approach
- New introductory guidelines have also been established
- New and revised parenthetical notes have also been added or updated for many codes in the Surgery and Radiology subsections

Single access system (eg, Ellipsys™)
- Access via a single percutaneous puncture into an arm vein
- A catheter is passed through the vein wall into the proximal radial artery (AV fistula)
- Duplex ultrasound guidance only no fluoroscopy
- Produces a connection between the artery and vein via thermal energy

Two access system (eg, WavelinQ 4F™)
- An arterial catheter is introduced through the brachial artery
- A venous catheter (with a radiofrequency [RF] electrode) is introduced through an upper extremity vein
- Guided by fluoroscopy
- Magnets are used to hold the artery and vein together

- The RF electrode is then used to create a connection between the artery and the vein (AV fistula)

- Coil embolization of extra venous outflow channels may be used to increase flow through the fistula
- Balloon dilation of the connection may be used to increase the size of the communication to increase blood flow
- All of these steps when done in the same session are included in the single bundled code (refer to the exclusionary parentheticals)

Surgery – Digestive System

Surgery – Digestive System

43290 Esophogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon

(Do not report 43290 in conjunction with 43197, 43198, 43235, 43241, 43247)

43291 with removal of intragastric bariatric balloon(s)

(Do not report 43291 in conjunction with 43197, 43198, 43235, 43247)

- Codes 43290 and 43291 been added to report esophagogastroduodenoscopy with deployment and removal of an intragastric bariatric balloon device(s).
- This procedure is used to assist in the treatment of conditions such as weight loss for the morbid obesity population.
- Code 43290 describes the procedure with deployment of intragastric bariatric balloon, and code 43291 describes the removal of intragastric bariatric balloon(s).

- Do not use code 43247 for bariatric balloon since it has its own code.

The University of Kansas Health System

Surgery – Digestive System

~~49560 Repair initial incisional or ventral hernia; reducible~~

~~49561 incarcerated or strangulated~~

(49560, 49561 have been deleted. For repair of initial incisional or ventral hernia, see 49591, 49592, 49594, 49595, 49596)

~~49565 Repair recurrent incisional or ventral hernia; reducible~~

~~49566 incarcerated or strangulated~~

(49595, 49566 have been deleted. For repair of recurrent incisional or ventral hernia, see 49613, 49614, 49615, 49616, 49617, 49618)

~~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~~

(49568 has been deleted. For implantation of mesh or other prosthesis for anterior abdominal hernia repair, see 49591 49618)

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- To reflect current clinical practice, the Hernioplasty, Herniorrhaphy, Herniotomy subsection has been updated with:
  - The deletion of hernia repair codes49560-49561, 49565-49566, 49570, 49572, 49580, 49582, 49585, 49587, 49590, 49652-49657
  - The addition of 15 codes:○49591-49596 –For **initial** repair of a reducible, incarcerated, or strangulated **anterior abdominal hernia** <3 cm to >10 cm
    - 49613-49618 –For **recurrent** repair of a reducible, incarcerated, or strangulated **anterior abdominal hernia**<3 cm to >10 cm
    - 49621-49622 –For **initial or recurrent**

repair of a reducible, incarcerated, or strangulated **parastomal hernia**

- 49623 –For **removal** of total or near total **non-infected mesh** or other prosthesis **during anterior abdominal or parastomal hernia** repair

Surgery – Digestive System

~~49570 Repair epigastric hernia (eg, preperitoneal fat); reducible~~

~~49572 incarcerated or strangulated~~

(49570, 49572 have been deleted. For epigastric hernia repair, see 49591 49618)

~~49580 Repair umbilical hernia, younger than age 5 years; reducible~~

~~49582 incarcerated or strangulated~~

(49580, 49582 have been deleted. For umbilical hernia repair, younger than age 5 years, see 49591 49618)

~~49585 Repair umbilical hernia, age 5 years or older; reducible~~

~~49587 incarcerated or strangulated~~

(49585, 49587 have been deleted. For umbilical hernia repair, age 5 years and older, see 49591 49618)

~~49590 Repair spigelian hernia~~

(49590 has been deleted. For spigelian hernia repair, see 49591-49618)

Surgery – Digestive System

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 3cm, 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

Surgery – Digestive System

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

Surgery – Digestive System

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 at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach (ie, open, laparoscopic, robotic) (List separately in addition to code for primary procedure)

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Surgery – Digestive System

~~49652 Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (include mesh insertion, when performed); reducible~~

~~49653 incarcerated or strangulated~~

(49652, 49653 have been deleted. To report laparoscopic repair of ventral, umbilical, spigelian, or epigastric hernia, see 49591-49618)

~~49654 Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible~~

~~49655 incarcerated or strangulated~~

(49654, 49655 have been deleted. To report laparoscopic repair of incisional hernia, see 49591-49618)

~~49656 Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible~~

~~49657 incarcerated or strangulated~~

(49656, 49657 have been deleted. To report laparoscopic repair of recurrent incisional hernia, see 49613, 49614, 49615, 49616, 49617, 49618)

Surgery – Digestive System

	Size	Severity of Hernia	Anterior Abdominal Hernia(s) Repair Code
Initial	< 3 cm	Reducible	49591
		Incarcerated/Strangulated	49592
Recurrent	< 3 cm	Reducible	49613
		Incarcerated/Strangulated	49614
Initial	3 cm to 10 cm	Reducible	49593
		Incarcerated/Strangulated	49594
Recurrent	3 cm to 10 cm	Reducible	49615
		Incarcerated/Strangulated	49616
Initial	> 10 cm	Reducible	49595
		Incarcerated/Strangulated	49596
Recurrent	> 10 cm	Reducible	49617
		Incarcerated/Strangulated	49618

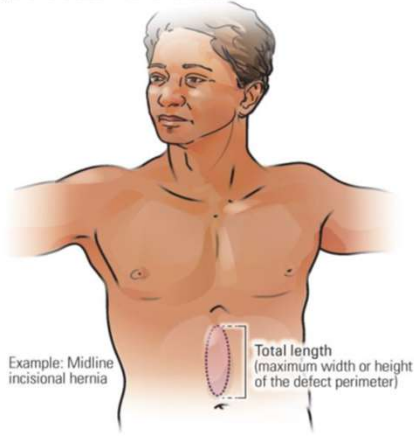
Surgery – Digestive System

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.

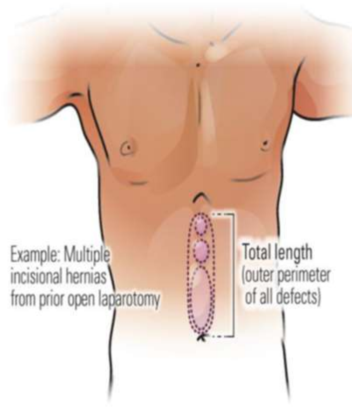
Codes 49591-49618 are reported only once, based on the total defect size for one or more anterior abdominal hernia(s), measured as the maximal craniocaudal or transverse distance between the outer margins of all defects repaired.

Surgery – Digestive System

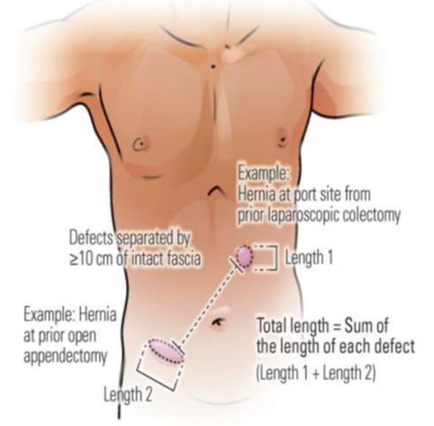
A. Single anterior abdominal hernia defect



B. Multiple anterior abdominal hernia defects



C. Remote anterior abdominal hernia defects

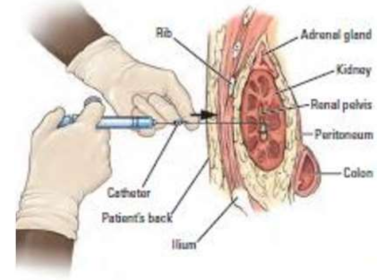


Surgery – Urinary System

Surgery – Urinary System

50080 Percutaneous nephrolithotomy ~~nephrostolithotomy~~ or pyelolithotomy ~~pyelostolithothomy, with or without dilation, endoscopy;~~ lithotripsy, ~~stenting, or~~ stone ~~basket~~ extraction, antegrade urethroscopy, 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 location, ureter stones, complicated ~~over 2 cm~~



- Prior to 2023, codes 50080 and 50081 described percutaneous nephrostolithotomy or pyelostolithotomy with or without dilation, endoscopy, lithotripsy, stenting, or basket extraction. The terms “nephrostolithotomy” and “pyelostolithotomy” are no longer used in current clinical practice. In addition, the terminology describing some of the components of the procedure (ie, dilation, endoscopy, stenting, basket extraction) no longer accurately describe how these procedures are performed.
- New introductory guidelines have been added in the Surgery section to clarify reporting of these services.
- To provide clarity in reporting, parenthetical notes were added, deleted, and revised following codes 50081, 50436, 50437, 52334, and 75984.

Surgery – Male Genital System

Surgery – Male Genital System

55867 Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), include robotic assistance, when performed

(For open subtotal prostatectomy, see 55821, 55831)

- New Code 55867 has been established to report laparoscopic simple prostatectomy.
- A corresponding parenthetical note has been added following code 55867 to instruct users to report code 55821 or 55831 for open subtotal prostatectomy.

Surgery – Female Genital System

Surgery – Female Genital System

No new, deleted, or revised codes.

Surgery – Nervous System

Surgery – Nervous System

64415 Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed
(Do not report 64415 in conjunction with 76942, 77002, 77003)

64416 brachial plexus, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed
(Do not report 64416 in conjunction with 01996, 76942, 77002, 77003)

64417 axillary nerve, including imaging guidance, when performed
(Do not report 64417 in conjunction with 76942, 77002, 77003)

64445 sciatic nerve, including imaging guidance, when performed
(Do not report 64445 in conjunction with 76942, 77002, 77003)

64446 sciatic nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed
(Do not report 64446 in conjunction with 01996, 76942, 77002, 77003)

64447 femoral nerve, including imaging guidance, when performed
(Do not report 64447 in conjunction with 01996, 76942, 77002, 77003)

64448 femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed
(Do not report 64448 in conjunction with 01996, 76942, 77002, 77003)

Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System			
Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic			
Code(s)	**Unit**	**Imaging Guidance Included**	**Imaging Guidance Separately Reported, When Performed**
Somatic Nerve			
64400-64408	1 unit per plexus, nerve, or branch injected regardless of the number of injections		X
64415-64417	1 unit per plexus, nerve, or branch injected regardless of the number of injections	X	
64418-64435	1 unit per plexus, nerve, or branch injected regardless of the number of injections		X
64445-64448	1 unit per plexus, nerve, or branch injected regardless of the number of injections	X	
64449	1 unit per plexus, nerve, or branch injected regardless of the number of injections		X
64450	1 unit per plexus, nerve, or branch injected regardless of the number of injections		X
64451	1 unit for any number of nerves innervating the sacroiliac joint injected regardless of the number of injections	X	
64454	1 unit for any number of genicular nerve branches, with a required minimum of three nerve branches	X	
64455	1 or more injections per level		X
64479	1 or more injections per level	X	
+64480	1 or more additional injections per level (add-on)	X	
64483	1 or more injections per level	X	
+64484	1 or more additional injections per level (add-on)	X	

There are other updates on this table but it was too big to show on a slide.

Surgery – Eye and Ocular Adnexa

Surgery – Eye and Ocular Adnexa

66174 Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without retention of device or stent

(Do not report 66174 in conjunction with 65820)

66175 with retention of device or stent

- Codes 66174 and 66175 have been revised to include the term "canaloplasty" as an example prefaced with " eg.eg." In Current Procedural Terminology (CPT ®) code descriptors, the use of "eg" indicates several procedures may complete the same work, and when methodologies will change over time as technology changes.
- This revision now aligns with US Food and Drug Administration (FDA) terminology for the approved form of transluminal dilation of aqueous outflow canal.

Surgery – Auditory System

The University of Kansas Health System

Surgery – Auditory System

69714 Implantation, osseointegrated implant, skull; with percutaneous attachment to external speech processor

(69715 has been deleted. To report mastoidectomy performed at the same operative session as osseointegrated implant placement, revision, replacement, or removal, see 69501-69676)

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

69729 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 are of bone deep to the outer cranial cortex

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- In the CPT 2022 code set, four codes (69716, 69719, 69726, 69727) were added to report implantation and removal of an osseointegrated implant into the skull.
- In the CPT 2023 code set, new and revised codes were established to more accurately describe the intraservice work involved in magnetic transcutaneous osseointegrated implantations performed within and outside the mastoid.
  - Distinction was made based on location (inside or outside of mastoid) and amount of bone removed.
  - Mirror implantation, replacement, and removal codes were created.

Surgery – Auditory System

69717 Replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor

(69718 has been deleted. To report mastoidectomy performed at the same operative session as osseointegrated implant placement, revision, replacement, or removal, see 69501-69676)

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

69730 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

THE UNIVERSITY OF KANSAS HEALTH SYSTEM

Surgery – Auditory System

69726 Removal, entire osseointegrated implant, skull; with percutaneous attachment to external speech processor

(To report partial removal of the device [ie, abutment only], use appropriate evaluation and management code)

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

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- Existing code 69726 was revised to report the entire removal of the osseointegrated implant.
  - An instructional parenthetical note following code 69726 was established to direct users how to report the partial removal of an implant (ie, abutment only).

Radiology

The University of Kansas Health System

Radiology

76882 Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, periarticular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation

(Do not report 76882 in conjunction with 76883)

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

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- Prior to 2023, code 76882 described limited ultrasound of a joint or other nonvascular extremity structure and was intended to describe a focused ultrasound evaluation (ie, evaluation of a specific location on or around a specific structure, such as a cyst) of structures in the extremity such as a joint space or nerve.
- Diagnostic ultrasound code 76882 has been revised to differentiate it from a new code for a comprehensive nerve ultrasound.
- Code 76883 requires evaluation of the entire course of the nerve in the extremity.
- Code 76883 does not describe a focal evaluation of a nerve.
- Report one code or the other not both.

- Code 76883 has been established to report ultrasound of nerve(s) and accompanying structures in a single extremity.
- The Diagnostic Ultrasound/Extremities subsection guidelines have been revised.
- To provide clarity in reporting, a new parenthetical note has been added following code 76882 to prevent co reporting.

- Code 76883 describes visualizing the nerve throughout the entire anatomic course in the extremity
- Visualizing only one or two points in the extremity is still reported with code 76882

Radiology

78803 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

78830 tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, 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 of acquisition ~~imaging~~ over 2 or more days

(For cerebrospinal fluid studies that require injection procedure, see 61055, 61070, 62320, 62321, 62322, 62323)

- Codes 78803 and 78830-78832 have been editorially revised.
- The goal of the revision was to clarify the intention of this family of codes and to differentiate
    - single area or single acquisition examinations versus
    - two or more separate acquisitions with two different radiopharmaceuticals on the same date of service or over two or more days.
- The intent and use of these codes remain the same.

- Previously, these codes did not identify “acquisitions” that is, separately obtained images with different radiopharmaceuticals, even if they were obtained on the same day and from the same anatomic site.
- Adding the term “acquisition” to the code descriptors allows for more specific reporting (ie, according to anatomic area or acquisitions performed) and maintain uniformity in the code family.
- This allows better differentiation when reporting codes 78831 and 78832.
    - The term “separate acquisition” was added to codes 78831 and 78832 to allow separate reporting when single area, same day images are performed for different reasons (eg, perfusion versus ventilation for the same lung).

Pathology and Laboratory

Pathology and Laboratory

81418 Drug metabolism (eg, pharmacogenomics) genomic sequence analysis panel, must include testing of at least 6 genes, including CYP2C19, CYP2D6, and CYP2D6 duplication/deletion analysis

81441 Inherited bone marrow failure syndromes (IBMFS) (eg, Fanconi anemia, dyskeratosis congenita, Diamond-Blackfan anemia, Shwachman-Diamond syndrome, GATA2 deficiency syndrome, congenital amegakarocytic thrombocytopenia) sequence analysis panel, must include sequencing of at least 30 genes, including BRCA2, BRIP1, DKC1, FANCA, FANCB, FANCC, FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, GATA1, GATA2, MPL, NHP2, NOP10, PALB2, RAD51C, RPL11, PRL35A, RPL5, PRS10, RPS19, RPS24, RPS26, RPS7, SBDS, TERT, and TINF2

81445 Targeted genomic sequence analysis panel, solid organ neoplasm~~, DNA analysis, and RNA analysis when performed~~, 5-50 genes (eg, ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, MET, NRAS, ~~MET,~~ PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants and copy number variants of rearrangement, if performed; DNA analysis or combined DNA and RNA analysis

81449 RNA analysis

(For copy number assessment by microarray, use 81406)

Pathology and Laboratory

81450 Targeted genomic sequence analysis panel, hematolymphoid neoplasm or disorder~~, DNA analysis, and RNA analysis when performed~~, 5-50 genes (eg, BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, ~~KIT,~~ MLL, ~~NRAS, NPM1,~~ NOTCH1, NPM1, NRAS), interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression of mRNA expression levels, if performed; DNA analysis or combined DNA or RNA analysis

81451 RNA analysis

(For copy number assessment by microarray, use 81406)

81455 Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm or disorder, ~~DNA analysis and RNA analysis when performed,~~ 51 or greater genes (eg, ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MET, MLL, NOTCH1, NPM1, NRAS, ~~MET, NOTCH1~~ PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET), interrogation for sequence variants or rearrangements or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis

81456 RNA analysis

(For copy number assessment by microarray, use 81406)

Pathology and Laboratory

84433 Thiopurine S-methyltransferase (TPMT)

Thiopurine S-methyltransferase (TPMT) deficiency is a condition characterized by significantly reduced activity of an enzyme that helps the body process drugs called thiopurines. These drugs, which include 6-thioguanine, 6-mercaptopurine, and azathioprine, inhibit (suppress) the body's immune system. Thiopurine drugs are used to treat some autoimmune disorders, including Crohn disease and rheumatoid arthritis, which occur when the immune system malfunctions. These drugs are also used to treat several forms of cancer, particularly cancers of blood-forming tissue (leukemias) and cancers of immune system cells (lymphomas). Additionally, thiopurine drugs are used in organ transplant recipients to help prevent the immune system from attacking the transplanted organ.

The University of Kansas Health System

Pathology and Laboratory

87467 Infectious agent antigen detection by immunoassay technique (eg, enzyme immunoassay [EIA], enzyme-linked immunosorbent assay [ELISA], fluorescence immunoassay [FIA], immunochemiluminometric assay [IMCA]), qualitative or semiqualitative; hepatitis B surface antigen (HBsAg), quantitative

(For qualitative hepatitis B surface antigen (HBsAg), use 87340)

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

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Codes 87468-87484 are for tick-borne organisms detected by PCR.

Medicine

Medicine

Vaccine Code Resources

- All COVID-19-related codes – www.ama-assn.org/practice-management/cpt/covid-19-coding-and-guidance
- COVID-19 vaccine-specific CPT codes (including brand names to help with code selection) – www.ama-assn.org/practice-management/cpt/covid-19-cpt-vaccine-and-immunization-codes

Some of the following codes were added throughout 2022.

Medicine

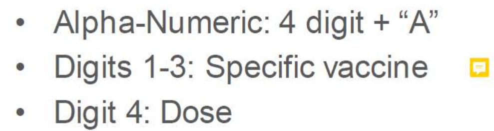
COVID-19 Vaccine Code Structure Refresher

Vaccine

913XX code series

Vaccine Administration

Code construction:



Example:

91301

0011A ← *Administration Code*

Specific Vaccine

1st (or single) dose

Medicine

0003A Immunization administration by intramuscular injection of 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; third dose

0004A booster dose

0051A Immunization administration by intramuscular injection of 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; first dose

0052A second dose

0053A third dose

0054A booster dose

0071A Immunization administration by intramuscular injection of 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, tri-sucrose formulation; first dose

0072A second dose

0073A third dose

0074A booster dose

0081A Immunization administration by intramuscular injection of 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, tri-sucrose formulation; first dose

0082A second dose

0083A third dose

Medicine

0013A Immunization administration by intramuscular injection of 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; third dose

0064A Immunization administration by intramuscular injection of 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; booster dose

0094A Immunization administration by intramuscular injection of 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; booster dose

0031A Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x10^{10} viral particles/0.5 mL dosage~~,~~; single dose

0034A booster dose

0104A Immunization administration by intramuscular injection of 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; booster dose

0111A Immunization administration by intramuscular injection of 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, tris-sucrose formulation; first dose

0112A second dose

Medicine

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

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

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

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

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

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

91310 Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 5 mcg/0.5 mL dosage, adjuvant AS03 emulsion, for intramuscular use

Medicine

90584 Dengue vaccine, quadrivalent, live, 2 dose schedule, for subcutaneous use

90678 Respiratory syncytial virus vaccine, preF, subunit, bivalent, for intramuscular use

90739 Hepatitis B vaccine (HepB), CpG-adjuvanted, adult dosage, 2 dose or 4 dose schedule, for intramuscular use

The dengue and RSV vaccines is not yet FDA approved. The codes will be active after FDA approval.

Medicine

92065 Orthoptic training; performed by a physician or other qualified healthcare professional

(Do not report 92065 in conjunction with 92066, 0687T, 0688T, when performed on the same day)

92066 under supervision of a physician or other qualified health care professional

(Do not report 92066 in conjunction with 92065, 0687T, 0688T, when performed on the same day)

92229 Imaging of retina for detection or monitoring of disease; point-of-care autonomous ~~automated~~ analysis and report, unilateral or bilateral

(Do not report 92229 in conjunction with 92133, 92134, 92227, 92228, 92250)

92284 Diagnostic dark adaptation examination with interpretation and report

- Code 92065 has been revised to a parent code, and a new child code (92066) has been added under code 92065 to describe the individual providing the orthoptic training.
- Code 92065 now specifies that the service is performed by a physician or other qualified health care professional (QHP). Previously, code 92065 identified orthoptic training and did not differentiate who was performing the service.
- New code 92066 describes orthoptic training performed under the supervision of a physician or other QHP.
- While there may be some overlapping of service, two exclusionary parenthetical notes following codes 92065 and 92066 have been added to prohibit the reporting of code 92065 in conjunction with codes 92066, 0687T, and 0688T , when performed on the same day. As well as restricting new code 92066 from being reported with codes 92065, 0687T, and 0688T, when performed on the same day.

- For code 92229, the term “automated” was removed and “autonomous” has been added to provide clarity of the true depiction of the service. The work performed is autonomous when the machine automatically interprets the data.

- For code 92284, the RUC referred code 92284 back to the CPT Editorial Panel to editorially revise the code descriptor to include “diagnostic” to assist in valuing the code.

Medicine

+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)

(Use 93568 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33419, 33477, 33741, 33745, 33894, 33895, 33900, 33901, 33902, 33903, 33904, 37187, 37188, 37236, 37237, 37238, 37246, 37248, 92997, 92998, 93451, 93453, 93456, 93457, 93460, 93461, 93580, 93581, 93582, 93583, 93593, 93594, 93595, 93596, 93597)

(Do not report 93568 in conjunction with 0632T)

(For selective unilateral or bilateral pulmonary arterial angiography, use 93569, 93573, which include catheter placement, injection, and radiologic supervision and interpretation)

+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)

(Use 93569, 93573 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33419, 33477, 33741, 33745, 33894, 33895, 33900, 33901, 33902, 33903, 33904, 37187, 37188, 37236, 37237, 37238, 37246, 37248, 92997, 92998, 93451, 93453, 93456, 93457, 93460, 93461, 93580, 93581, 93582, 93583, 93593, 93594, 93595, 93596, 93597)

- Prior to 2023, the Current Procedural Terminology (CPT®) code set did not provide a mechanism to differentiate between angiography of the pulmonary arteries and pulmonary veins when performed during cardiac catheterization procedures.
- Prior to 2023, the CPT code set did not include a specific CPT code to report angiography of major aortopulmonary collateral arteries (MAPCAs) when performed during cardiac catheterization procedures.
- Add-on codes 93569 and 93573 93575 were established to allow proper reporting of angiography of the pulmonary arteries, the pulmonary veins, and MAPCAs when performed during cardiac catheterization procedures.

- Add-on codes 93569 and 93573 93575 include:
  - Selective introduction and positioning of the angiographic catheter
  - Injection, and radiologic supervision and interpretation
- Introductory language for code 93574 clarifies that a distinct named pulmonary vein must be selectively cannulated and selective venous angiography of that vein performed for each instance that 93574 is reported.
- Introductory language for code 93575 clarifies that a distinct MAPCA must be selectively cannulated and selective venous angiography of that MAPCA performed for each instance code 93575 is reported.

Medicine

+93574 for selective pulmonary venous angiography of each distinct pulmonary vein during cardiac catheterization (List separately in addition to code for primary procedure)

(Use 93574 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33419, 33477, 33741, 33745, 33894, 33895, 33900, 33901, 33902, 33903, 33904, 37187, 37188, 37236, 37237, 37238, 37246, 37248, 92997, 92998, 93451, 93453, 93456, 93457, 93460, 93461, 93580, 93581, 93582, 93583, 93593, 93594, 93595, 93596, 93597)

+93575 for selective pulmonary arterial 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)

(Use 93575 in conjunction with 33361, 33362, 33363, 33364, 33365, 33366, 33418, 33419, 33477, 33741, 33745, 33894, 33895, 33900, 33901, 33902, 33903, 33904, 37187, 37188, 37236, 37237, 37238, 37246, 37248, 92997, 92998, 93451, 93453, 93456, 93457, 93460, 93461, 93580, 93581, 93582, 93583, 93593, 93594, 93595, 93596, 93597)

(93569, 93573, 93574, 93575 include the selective introduction and positioning of the angiographic catheter, injection, and radiologic supervision and interpretation)

Medicine

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

- New code 95919 describes the quantitative pupillometry, performed unilaterally or bilaterally. This includes the work involved in the interpretation and generation of a report.
- This code has been structurally placed in the CPT code set to precede code 95921, which involves the rapid, noninvasive measurement of autonomic nervous system function.
- Previously, this service has been reported with unlisted code 95999.

The University of Kansas Health System

Medicine

+96202 Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patient 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 patient(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 instruction] rendered to patient 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)

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- A new subsection was added in the Medicine section titled "Behavior Management Services," that includes new guidelines, new parenthetical notes, and two new codes established for behavior management services.
- Codes 96202 and 96203 report physician or other qualified health care professional (QHP) administered multiple family group behavior management or modification training for parent(s)/guardian(s)/ caregiver(s) of patients with a mental or physical health diagnosis.

The University of Kansas Health System

Medicine

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

(Do not report 98975 more than once per episode of care)

(Do not report 98975 for monitoring or less than 16 days)

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

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

(Do not report 98975, 98976, 98977, 98978 in conjunction with codes for more specific physiologic parameters [93296, 94760, 99453, 99454])

(Do not report 98976, 98977, 98978 for monitoring of less than 16 days)

(For therapeutic monitoring treatment management services, use 98980)

(For remote physiological monitoring, see 99453, 99454)

(For physiologic monitoring treatment management services, use 99457)

(For self-measured blood pressure monitoring, see 99473, 99474)

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- Code 98975 is reported for each episode of care. For reporting remote therapeutic monitoring parameters, an episode of care is defined as beginning when the remote therapeutic monitoring service is initiated and ends with attainment of targeted treatment goals

Category II

No deleted, revised, or new codes.

Category II

No new, deleted, or revised codes.

Category III

Parenthetical notes are not listed for new codes.

Category III

Deleted Codes

~~0163T Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar~~

(To report total disc arthroplasty [artificial disc], anterior approach, lumbar, see 22857, 22860)

~~0312T Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming~~

~~0313T laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator~~

~~0314T laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator~~

~~0315T removal of pulse generator~~

~~0316T replacement of pulse generator~~

~~0317T neurostimulator pulse generator electronic analysis, includes reprogramming when performed~~

(For laparoscopic implantation, revision, replacement, or removal of vagus nerve blocking neurostimulator electrode array and/or pulse generator at the esophagogastric junction, use 64999)

Category III

Deleted Codes

~~0470T Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition interpretation, and report; first session~~

~~0471T each additional lesion~~

(For optical coherence tomography [OCT] for microstructural and morphological imaging of skin, use 96999)

~~0475T Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording and storage, data scanning with signal extraction, technical analysis and result, as well as supervision, review, and interpretation of report by a physician or other qualified health care professional~~

~~0476T patient recording, data scanning, with raw electronic signal transfer of data and storage~~

~~0477T signal extraction, technical analysis, and result~~

~~0478T review, interpretation, report by physician and other qualified health care professional~~

(For recording of fetal magnetic cardiac signal, data scanning, transfer data, signal extraction, review, and interpretation and report, use 93799)

~~0487T Biomechanical mapping, transvaginal, with report~~

(For transvaginal biomechanical mapping, use 58999)

Category III

Deleted Codes

0491T ~~Ablative laser treatment, non-contact, full field and fractional ablation, open wound, per day, total treatment surface area; first 20 sq cm or less~~

0492T ~~each additional 20 sq cm, or part thereof~~

(For non-contact full-field and fractional ablative laser treatment of an open wound, use 17999)

0493T ~~Contact near-infrared spectroscopy studies of lower extremity wounds (eg, for oxyhemoglobin measurement)~~

(For transcutaneous oxyhemoglobin measurement in a lower extremity wound by near-infrared spectroscopy, use 93998)

0497T ~~External patient-activated, physician- or other qualified health care professional-prescribed, electrocardiographic rhythm derived event recorder without 24-hour attended monitoring; in-office connection~~

0498T ~~review and interpretation by a physician or other qualified health care professional per 30 days with at least one patient-generated triggered event~~

(For in-office connection or review and interpretation of an external patient-activated electrocardiographic rhythm-derived event recorder without 24-hour attended monitoring, use 93799)

0499T ~~Cystourethroscopy, with mechanical dilation and urethral therapeutic drub delivery for urethral stricture or stenosis, including fluoroscopy, when performed~~

(For cystourethroscopy with urethral therapeutic drug delivery, use 53899)

0514T ~~Intraoperative visual axis identification using patient fixation~~

The University of Kansas Health System

Category III

0402T Collagen cross-linking of cornea, including removal of the corneal epithelium, when performed, and intraoperative pachymetry, when performed ~~(Report medication separately)~~

0714T Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance

+0715T Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure)

0716T Cardiac acoustic waveform recording with automated analysis and generation of coronary artery disease risk score

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

0718T Injection into supraspinatus tendon including ultrasound guidance, unilateral

0719T Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spin, single segment

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Code 0402T has been revised to include "when performed" in the code descriptor. This revision clarifies that removal of the corneal epithelium is included when performed. The phrase "Report medication separately" has been removed from the code descriptor and placed as new parenthetical.

Code 0714T has been established to report transperineal laser ablation of benign prostatic hyperplasia. This procedure is an alternative to surgical excision and describes a minimally invasive intervention that includes imaging guidance as an inclusive service.

Code 0715T was created for reporting procedures performed in addition to coronary and bypass graft diagnostic interventional services.

Code 0716T was added to report cardiac acoustic waveform recording with automated analysis and generation of coronary artery disease risk score. Noninvasive sensor placed on patient's chest to assess for coronary artery disease risk. May be used to report for patients experiencing: Shortness of breath, Fatigue, Atypical chest discomfort

Code 0717T, 0718T established to report autologous adipose derived regenerative cell (ADRC) therapy for partial thickness rotator cuff repair. This procedure was not previously described with a specific code. Procedure includes injecting the supraspinatus tendon defect and surrounding area with a prepared mixture of autologous regenerative cell mix from acquired adipose tissue.

Code 0719T has been added to report posterior vertebral joint replacement. Posterior vertebral joint replacement also includes bilateral facetectomy, laminectomy, and radical discectomy and imaging guidance (lumbar spine, single segment), which are bundled together as part of the service.

Category III

0720T Percutaneous electrical nerve field simulation, cranial nerves, without implantation

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

+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

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

+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) during the same session (List separately in addition to code for primary procedure)

Code 0720T is used for functional abdominal pain in pediatrics, but the code is not limited to that. The intent of this procedure involves placement of a noninvasive device that delivers percutaneous electrical nerve field stimulation (PENFS) to the external ear.

Codes 0721T, 0722T have been established to report quantitative computed tomography (CT) tissue characterization. 0721T - Quantitative CT tissue characterization performed retrospectively on a previously acquired CT scan. 0722T - Quantitative CT tissue characterization performed as an add on to be used with a concurrently obtained CT scan.

Codes 0723T and 0724T have been established to report quantitative magnetic resonance cholangiopancreategory procedures. These new procedures provide the ability to quantitatively evaluate pancreatobiliary structure anatomy derived from magnetic resonance images (MRI) by producing quantitative metrics of the biliary tree and pancreatic ducts. QMRCP is a new diagnostic procedure that is not previously included in the Current Procedural Terminology (CPT ®) code set.

Category III

0725T Vestibular device implantation, unilateral

0726T Removal of implanted vestibular device, unilateral

0727T Removal and replacement of implanted vestibular device, unilateral

0728T Diagnostic analysis of vestibular implant, unilateral; with initial programming

0729T with subsequent programming

0730T Trabeculotomy by laser, including optical coherence tomography (OCT) guidance

0731T Augmentative AI-based facial phenotype analysis with report

0732T Immunotherapy administration with electroporation, intramuscular

0733T Remote real-time, motion capture-based neurorehabilitative ~~body and limb kinematic measurement-based~~ therapy ordered by a physician or other qualified health care professional; supply and technical support, per 30 days

0734T treatment management services by a physician or other qualified health care professional, per calendar month

Code 0725T-0729T –added to report vestibular implantation procedure, and the postoperative evaluation and programming of vestibular implants. Five code structure allows separate reporting of clinical scenarios in the vestibular device implantation process.

Code 0730T has been established to describe a laser trabeculotomy that directed by optical coherence tomography (OCT) guidance. This laser procedure is without incision. Therefore, the code descriptor does not include the terms “ab interno or ab externo ” used for incisional surgeries. There is an exclusionary parenthetical note following code 0730T that restricts the reporting of code 0730T with other t rabeculotomy procedures (65850, 0621T, 0622T), t rabeculoplasty

(65855), and OCT technology (92132)

Code 0732T - electroporation uses an electrical current to target cells and get that medication into those specific cells.

Category III

+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

0736T Colonic lavage, 35 or more liters of water, gravity-fed, with induced defecation, including insertion of rectal catheter

0737T Xenograft implantation into the articular surface

0738T Treatment planning for magnetic field induction ablation of malignant prostate tissue, using data from previously performed magnetic resonance imaging (MRI) examination

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

Code 0735T was added to report the preparation of a cavity left by the removal of a tumor for placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) that is performed concurrently with a craniotomy. Code 0735T is reported following the removal of a brain tumor, and the tumor bed is prepared for placement of the IORT applicator. Code 0735T is an add-on code reported in conjunction with the appropriate craniotomy code.

Code 0736T is typically performed by clinical staff under physician supervision.

Code 0737T established to report xenograft implantation into articular surface. Procedure places xenograft scaffold for osteochondral regeneration.

Code 0738T is reported for ablation treatment planning.

Code 0739T is reported for the ablation procedure.

The University of Kansas Health System

Category III

0740T	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education
0741T	provision of software, data collection, transmission, and storage, each 30 days
+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)
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
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
0750T	with single-view digital X-ray examination of the hand taken for the purpose of DXR-BMD

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Code 0742T has been established to report absolute quantitation of myocardial blood flow (AQMBF) single photon emission computed tomography (SPECT). AQMBF is a new procedure that: detects reduced coronary flow reserve, and helps to identify patients with high risk coronary artery disease. AQMBF is an emerging technology that uses different processes, software, imaging cameras, and workflow.

Code 0743T has been established to report bone strength and fracture risk assessment using finite element analysis of functional data and bone mineral density with concurrent vertebral fracture assessment.

Code 0748T was established to report injections of a stem cell product into perianal perifistular soft tissue.

Codes 0749T, 0750T have been established for reporting bone strength and fracture risk assessment using digital X ray radiogrammetry bone mineral density (DXR BMD) analysis. Code 0749T describes DXR BMD analysis of an available appropriate digital X ray (eg, hand/wrist) to assess bone strength, fracture risk, and bone mineral density. Code 0750T is reported if an appropriate digital X ray is not available, and a single digital X ray view of the hand is taken specifically to be used for DXR BMD analysis.

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Category III

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

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

0746T conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan

0747T delivery of radiation therapy, arrhythmia

0748T Injections of stem cell product into perianal perifistular soft tissue, including fistula preparation (eg, removal of setons, fistula curettage, closure of internal openings)

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Code 0744T was added to report insertion of a bioprosthetic valve in the femoral vein via an open approach. It includes imaging guidance using duplex ultrasound. The valve is single-use and meant to be permanently implanted to support blood flow from the lower extremities despite the absence of native deep venous valvular function. May be used to treat conditions such as: chronic deep vein insufficiency and reflux in the deep venous system, or leg ulcers.

Codes 0745T, 0746T, and 0747T were added to report cardiac focal ablation utilizing radiation therapy for arrhythmia. Cardiac radioablation is a new noninvasive treatment that uses functional radioablation in combination with mapping and targeting of the abnormal myocardium. It is used to treat arrhythmias, such as ventricular tachycardia.

Category III

+0751T Digitization of glass microscope slides for level II, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)

+0752T Digitization of glass microscope slides for level III, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)

+0753T Digitization of glass microscope slides for level IV, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)

+0754T Digitization of glass microscope slides for level V, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)

+0755T Digitization of glass microscope slides for level VI, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure)

+0756T Digitization of glass microscope slides for special stain, including interpretation and report, group I, for microorganisms (eg, acid fast, methenamine silver) (List separately in addition to code for primary procedure)

+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)

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.

Category III

+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)

+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)

+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)

+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)

+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)

+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)

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Category III

Cat III Code	Use	Surg Path Code
0751T	Level II surgical pathology	88302
0752T	Level III surgical pathology	88304
0753T	Level IV surgical pathology	88305
0754T	Level V surgical pathology	88307
0755T	Level VI surgical pathology	88309
0756T	Special stains, group I, microorganisms	88312
0757T	Special stains, group II, other stains	88313
0758T	Special stains on frozen tissue block	88314
0759T	Special stains, group III, enzyme constituents	88319
0760T	Immunohistochemistry, single antibody	88342
0761T	Immunohistochemistry, additional single antibody	88341
0762T	Immunohistochemistry, multiplex antibody	88344
0763T	Morphometric analysis, each single antibody	88360

Category III

+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)

0765T related to previously performed electrocardiogram

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

+0767T each additional nerve (List separately in addition to code for primary procedure)

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

+0769T each additional nerve (List separately in addition to code for primary procedure)

+0770T Virtual reality technology to assist therapy (List separately in addition to code for primary procedure)

Category III

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

+0772T each additional 15 minutes intraservice time (List separately in addition to code for primary procedure)

0773T 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; each additional 15 minutes intraservice time (List separately in addition to code for primary service)

+0774T each additional 15 minutes intraservice time (List separately in addition to code for primary service)

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Category III

0775T	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s])
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
+0777T	Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure)
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
0779T	Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report
0780T	Instillation of fecal microbiota suspension via rectal enema into lower gastrointestinal tract
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
0782T	unilateral mainstem bronchus
0783T	Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment

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Code 0775T established to allow separate reporting for percutaneous or minimally invasive arthrodesis transfixation of the sacroiliac (SI) joint. Unique method of stabilizing SI joint using a distracting intra-articular implant placed between the two bony surfaces of the iliac and sacral bones. Descriptor language for code 27279 may be misconstrued for reporting any type of percutaneous or minimally invasive arthrodesis of SI joint. Code 27279 is intended for any percutaneous SI joint fusion accomplished via transfixation of SI joint, vs code 27280 which describes an open procedure

Code 0778T established to report measurement and recording of dynamic joint motion and muscle function. Includes the incorporation of multiple inertial

measurement units (IMUs) with concurrent surface mechanomyography (sMMG) sensors. New subheading and guidelines were added preceding the code to describe its use. Code 0778T is not a remote service. Measurements are obtained in the office while the patient is physically present. Purpose of technology: To increase accuracy of measuring and recording joint motion of the axial and appendicular skeleton; To record muscle function in standardized fashion; and To decrease variability and bias of recording. In the context of injury, code 0778T is used serially, at regular intervals (biweekly or monthly), to record evolving functional status during episode of care.

Code 0779T is intended to report GI myoelectrical activity study from the stomach through the colon. This study is a noninvasive procedure that assesses motility in the GI tract from the stomach through the colon. The study may be performed over several days. Typically, this assessment is performed for GI symptoms such as gastrointestinal pain, bloating, and distension.

Code 0780T what the AMA physician presenter called “germ warfare”. The preparation of the fecal microbiota is represented in Category I code 44705, but code 44705 has a new parenthetical note – do not report 44705 in conjunction with 74283, 0780T.

Codes 0781T and 0782T are used for COPD. There is some research that shows COPD can be caused by overactive pulmonary nerves causing constriction.

Code 0783T reports transcutaneous auricular neurostimulation. The procedure involves sending electrical stimulation transcutaneously to the vagus and trigeminal nerves to aid in

the relief of opioid withdrawal symptoms.

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