CODEX

CODING DECODED

Integumentary System

Category I Codes, Integumentary System Guidelines & Breast Biopsy Coding

CODING DECODED

1. Introduction to the CPT Book

The CPT (Current Procedural Terminology) book organizes codes into three categories:

Category	Description
Category I	Five-digit numeric codes covering E&M, Anesthesia, Surgery, Radiology, Pathology & Laboratory, and Medicine.
Category II	Four digits followed by the letter F; optional codes used for performance measurement and quality reporting.
Category III	Four digits followed by the letter T; temporary codes for emerging technology — reported instead of an unlisted code when available.

Category I — Section Numbers and Sequences

Section	Code Range
1. E&M	99201 – 99499
2. Anesthesia	00100 – 01999, 99100 – 99140
3. Surgery	10021 – 69990
4. Radiology	70010 – 79999
5. Pathology	80047 – 89398
6. Medicine	90281 – 99199, 99500 – 99607

How to Use the Book

Select the procedure code from the alphabetic index at the end of the CPT book. There are four primary classes of main entries:

- Procedure / Service — e.g., Endoscopy, Splint
- Organ / Anatomic Site — e.g., Colon, Tibia
- Condition — e.g., Abscess, Tetralogy of Fallot
- Abbreviation — e.g., EEG

Refer to the CPT description along with the parenthetical notes given below the code, and the related CPT guidelines (specific guidelines appear at the beginning of each section). If no CPT code exactly describes the service provided, don't select a near-approximate code — instead, report the appropriate unlisted procedure code.

CPT codes are arranged as a stand-alone code followed by one or more indented codes.

Example

CPT 73120 — Radiologic examination of hand; 2 views. CPT 73130 — Minimum of three views. CPT 73130 should be read as: “Radiologic examination of hand; minimum of three views,” since the indented code inherits the stand-alone code's description up to the semicolon.

Symbols Used in the CPT Book

Symbol	Meaning
+	Add-on code
●	New code
▲	Revised code
‣ / ◂	New or revised text
⊘	Exempt from modifier 51
#	Out-of-numerical-sequence code

Add-On Codes

- Always performed in addition to a primary service or procedure — must never be reported as a stand-alone code.
- Never append modifier 51 to an add-on code.
- The add-on code concept applies only when the add-on service/procedure is performed by the same physician as the primary procedure.

Category II Codes

Used for performance measurement.

Category III Codes

Temporary codes for emerging technology — must be reported instead of an unlisted code when a Category III code is available.

2. Skin Replacement Surgery

Skin replacement surgery consists of two components: (1) surgical preparation of the wound bed, and (2) placement of a graft — either an autograft (including tissue-cultured autograft) or a skin substitute graft (homograft, allograft, or xenograft).

If performed in the office setting, routine dressing changes are not reported separately.

Measurements apply to the size of the recipient area: for patients age 10 or younger, use percentage of body surface; for patients older than 10, use square centimeters (sq cm).

For procedures involving the wrist or ankle, use the code that includes “arm” or “leg” in its description. If a primary procedure requires a skin autograft or skin substitute graft for closure, report CPT 15100–15278 as an additional procedure alongside the primary procedure (e.g., following deep tumor removal).

Surgical Preparation — CPT 15002–15005

This is the initial service: preparing a clean, viable wound surface for placement of an autograft, flap, or skin substitute graft, or for negative pressure wound therapy. Do not report 15002–15005 for removal of nonviable tissue/debris in a chronic wound left to heal by secondary intention — refer to the debridement or active-wound-management codes instead.

Code selection is based on: (1) location, and (2) size of the defect. For multiple wounds, sum the surface area of all wounds from anatomic sites that are grouped together into the same code descriptor.

Example

Surgical preparation of a 25 sq cm wound on the scalp and a 15 sq cm wound on the face (40 sq cm total) → CPT 15004 (covers up to 40 sq cm).

Surgical preparation of a 75 sq cm wound on the trunk and a 75 sq cm wound on the right thigh (150 sq cm total) → CPT 15002 (first 100 sq cm) + 15003 (remaining 50 sq cm).

Note: If all wounds are prepared on the same day, append modifier 59 with the appropriate additional CPT code.

1) Autograft — CPT 15040–15261

Includes the harvest (15040) and/or application of an autologous skin graft. Repair of the donor site requiring a skin graft or local flap is coded separately.

Code selection is based on: type of autograft (split-thickness, epidermal, dermal, tissue-cultured, full-thickness), location (hand, feet, trunk, etc.), and size of the defect.

General Information

- Autograft: a graft of tissue moved from one point to another on the same individual's body.
- Split-thickness skin graft (STSG): includes the epidermis and part of the dermis.
- Full-thickness skin graft (FTSG): includes the epidermis and the entire thickness of the dermis.
- Tissue-cultured: cells maintained or grown in an incubator after removal from the body — an alternative for treating full-thickness wounds or wounds covering large body-surface areas.

2) Skin Substitute Graft — CPT 15271–15278

Covers non-autologous human skin grafts, non-human skin substitute grafts, and biological products for skin growth. Do not report skin substitute graft codes for application of a non-graft wound dressing (gel, ointment, foam) or for injected skin substitutes.

General Information

- Skin substitutes provide temporary coverage of raw skin surfaces and are usually later replaced by a split-thickness skin graft.
- Autologous: derived from the same individual. Nonautologous: not from the same individual.
- Common biological substitutes worldwide include cadaveric skin allograft, porcine skin xenograft, and amnion.

- Porcine: a skin graft using pig skin. Xenograft / heterograft: a tissue graft or organ transplant from a donor of a different species than the recipient.

Code selection is based on: location (hand, feet, trunk, etc.) and size of the defect — less than 100 sq cm: 15271, 15272 & 15275, 15276; greater than 100 sq cm: 15273, 15274 & 15277, 15278. Code the supply of the skin substitute graft in conjunction with 15271–15278.

General Guidelines for Grafts

- For multiple wounds, sum the surface area of wounds from anatomic sites grouped into the same code descriptor (e.g., trunk and arms).
- Do not sum wounds from different anatomic groupings (e.g., face and arms).
- Removal of the current graft and/or simple wound cleaning is included.

Example

A 55-year-old male is admitted with burns on the trunk (140 sq cm), arm (100 sq cm), neck (70 sq cm), and face (60 sq cm). Surgical excision of the burn tissue was performed two days earlier (reported separately). He now undergoes skin substitute graft application on the trunk, arm, neck, and face.

Answer: 15273, +15274 x2, 15277, +15278.

Rationale: Different anatomic groupings cannot be combined, but sites within the same grouping can. Trunk + arm = 240 sq cm; neck + face = 130 sq cm.

Trunk & arm (240 sq cm): 15273 (first 100 sq cm) + 15274 (additional 100 sq cm) + 15274 (additional 40 sq cm).

Neck & face (130 sq cm): 15277 (first 100 sq cm) + 15278 (additional 30 sq cm).

3. Surgery — General: Biopsy Procedures (FNA & Core Biopsy)

FNA (fine needle aspiration) uses a small-gauge needle (22–25 gauge). Core biopsy uses a larger-circumference needle (14, 16, or 18 gauge).

1. Without Imaging Guidance

CPT 10021 (primary) & 10004 (add-on, each additional).

2. With Imaging Guidance (first lesion and each additional)

Guidance Modality	Codes
Ultrasound	10005, 10006
Fluoroscopic	10007, 10008
CT	10009, 10010
MRI	10011, 10012

All of the above codes include the guidance (ultrasound, fluoroscopy, CT, or MRI). Append modifier 59 for a different modality performed at the same session. If core and FNA biopsies are performed at the same site or a different site, bill both procedures and append modifier 59 to the FNA code.

If the biopsy procedure was not performed using FNA, use the respective chapter-specific codes:

- Breast (19081–19086)
- Muscle (20206)
- Pleura (32400)
- Lung (32405)
- Salivary gland (42400)
- Liver (47000)
- Pancreas (48102)
- Abdominal or retroperitoneal (49180)
- Kidney (50200)
- Testis (54500)
- Epididymis (54800)
- Thyroid (60100)
- Nucleus pulposus, IVD, paravertebral (62267)
- Spinal cord (62269)

Note: With proper supporting documentation, both fine-needle and core needle biopsies can be coded, with the appropriate modifier.

4. Integumentary System — Debridement (CPT 11042–11047)

Debridement of skin, subcutaneous tissue, and accessory structures is coded based on the depth of tissue removed and the surface area of the wound.

- Debridement of a single wound: report the deepest level only.
- Multiple wounds: sum the surface area of wounds at the same depth — do not combine different depths.

Sample Chart

Example

Debridement of bone from an 8 sq cm foot ulcer and an 8 sq cm back ulcer → CPT 11044 (first 20 sq cm or less).

Debridement of subcutaneous tissue — an 18 sq cm trunk wound and a 10 sq cm thigh wound → CPT 11042 (first 20 sq cm) + 11045 (remaining 8 sq cm).

5. Integumentary System — Biopsy of Skin

Code	Description
11102	Tangential biopsy of the skin (scoop, curette, shave) — single lesion
11103	+ each additional / separate lesion
11104	Punch biopsy of the skin (includes simple closure) — single lesion
11105	+ each additional / separate lesion
11106	Incisional biopsy of the skin (wedge, includes simple closure) — single lesion
11107	+ each additional / separate lesion

Code biopsies based on the method of removal:

- Tangential biopsies use a sharp blade to remove a small portion of epidermal tissue.
- Punch biopsies use a punch tool to remove a cylindrical, full-thickness skin sample; simple closure is included.
- Incisional biopsies use a sharp blade to remove a full-thickness wedge or vertical-incision sample, penetrating into the dermis; simple closure is included.

Tips to Remember

- Only one primary biopsy code should be reported if more than one biopsy is performed at the same visit.
- If multiple biopsies use the same technique, report the primary biopsy code plus the add-on code for each additional lesion.
- If the entire lesion is excised, use excision codes 11400–11646 (benign or malignant) instead of a biopsy code.

Excision, destruction, or shave removal of a skin lesion includes biopsy of the skin at the same site.

Note: If the procedure is performed on a different site, or on a different lesion on the same date, report it separately with modifier 59.

Shave Technique

Shaving removes epidermal and dermal lesions by transverse incision or horizontal slicing, without a full-thickness dermal excision. It does not require suture closure (includes local anesthesia, chemical or electrocauterization). CPT 11300–11313; codes are selected by anatomical site and lesion size, and each shaved lesion is reported separately.

Note: *A shave removal may vary in depth and width and can completely remove a lesion in the upper or mid-dermis. Complete removal alone does not make it an excision — if the removal does not go through the full thickness of the dermis, it is not an "excision."*

6. Integumentary System — Excision

Excision procedures fall into two groups: benign lesions (CPT 11400–11446) and malignant lesions (CPT 11600–11646).

Benign Lesions (neoplasm, cyst, fibrous, inflammatory, congenital)

- Full-thickness (dermal) removal of the lesion including margins (includes simple closure & local anesthesia).
- Code each benign lesion excised separately.
- Code selection is based on lesion diameter plus narrow margins.
- Any intermediate/complex closure is reported separately along with the excision code (simple closure is included in the excision and is not coded separately).
- If a lesion excision (11400–11446) is combined with adjacent tissue transfer, code only the adjacent tissue transfer (ATT).

Malignant Lesions (basal cell carcinoma, squamous cell carcinoma, melanoma)

- Full-thickness (dermal) removal of the lesion including margins (includes simple closure & local anesthesia).
- Code each malignant lesion excised separately.
- Code selection is based on lesion diameter plus narrow margins.
- Any intermediate/complex closure is reported separately along with the excision code (simple closure is included in the excision and is not coded separately).
- If a lesion excision (11600–11646) is combined with adjacent tissue transfer, code only the adjacent tissue transfer.
- Use only one code to report the additional excision/re-excision, based on the final widest excised diameter required for complete tumor removal at the same operative session.
- To report a re-excision performed to widen margins at a subsequent operative session, use 11600–11646 as appropriate.
- Append modifier 58 if the re-excision is performed during the postoperative period of the primary excision procedure.

7. Integumentary System — Repair (Closure)

Wound closures are classified as simple (CPT 12001–12021), intermediate (CPT 12031–12057), or complex (CPT 13100–13153).

Simple Repair (one-layer closure)

For superficial wounds involving primarily the dermis, epidermis, or subcutaneous tissue; includes local anesthesia.

Intermediate Repair (layered closure)

Closure involving the epidermis, dermis, subcutaneous tissue, and superficial fascia. Exception: single-layer closure of heavily contaminated wounds requiring extensive cleaning or removal of particulate matter is also coded as intermediate.

Complex Repair

More extensive than a layered closure.

Coding Guidelines

- When multiple wounds are repaired, add together the lengths of those in the same classification (simple with simple) from anatomic sites grouped into the same code descriptor.
- Do not add together lengths from different classifications (simple & complex) or from different anatomic groupings (e.g., trunk & face).
- When more than one classification of wound is repaired, list the more complicated repair as the primary procedure and the less complicated as a secondary procedure with modifier 59.
- Simple ligation of vessels in an open wound is considered part of the wound closure.

8. Adjacent Tissue Transfer & Mohs Micrographic Surgery

Adjacent Tissue Transfer / Rearrangement — CPT 14000–14302

Techniques such as Z-plasty, W-plasty, V-Y plasty, rotation flap, random island flap, and advancement flap are reported with CPT 14000–14302 (excision and/or repair by adjacent tissue transfer). Do not code excision (11400–11446, 11600–11646) along with adjacent tissue transfer. A skin graft used to close a secondary defect is an additional procedure.

Mohs Micrographic Surgery

- If two different providers perform the procedure, code separately.
- The Mohs surgeon removes the tumor tissue, maps and divides it into pieces, and embeds each piece into an individual tissue block for histopathologic examination.
- If repair is performed, use a separate code for the repair, flap, or graft.
- If a biopsy of suspected skin cancer is performed on the same day as Mohs surgery, without a prior study, report the skin biopsy with modifier 59.
- If a frozen section is performed, report it with modifier 59.

9. Integumentary Surgery — Practice Quiz

1. A patient presents with a bilateral thyroid nodule. After obtaining consent, the physician applies local anesthesia and inserts a fine needle to take tissue samples from the right and left lobes of the thyroid gland under ultrasound guidance, then sends the specimen to pathology. Dressing is done at the operative site. How would you report this service?

A. 10021, 10004 B. 10005, 10006 C. 10005, 10006, 76942 D. 10005 x2

2. A 64-year-old female presents with a basal cell carcinoma on her forehead. After sterile prepping, the physician removes the carcinoma and divides it into 7 tissue blocks for examination. Microscopic examination shows positive margins, so the physician removes the positive margin with another excision, divided into 4 tissue blocks; margins are then negative. What is the appropriate coding?

A. 17311, 17312, 17315 x2 B. 17311, 17312, 17315 x7 C. 17313, 17314, 17315 x2 D. 17311, 17312, 17315

3. Preoperative Diagnosis: Mass in the right and left breast. Procedure: ultrasound-guided bilateral breast biopsy. The needle was passed under ultrasound guidance to obtain samples from the left breast, then the same procedure was repeated on the right. Pathology is pending. How would you report the service?

A. 19083, 19084, 76942-26 B. 19100, 76942 C. 19083, 19084 D. 19285, 19286

4. A 70-year-old female has chronic ulcers on her left hip (4 sq cm), left heel (3 sq cm), right elbow (3 sq cm), and left elbow (4 sq cm). Using sharp dissection, the ulcer was debrided down to the bone at the hip, heel, and right elbow, and subcutaneous tissue was debrided from the left elbow. What CPT code should be reported?

A. 11044, 11042-59 B. 11044, 11042 C. 11044, 11042-51 D. 11012

5. A 58-year-old male presents for removal of 2 lesions on his face and neck. Using a 3-mm punch, a biopsy was taken from the face; the neck lesion was shaved at the level of the epidermis. What are the codes for these procedures?

A. 11104, 11102-59 B. 11104, 11103-59 C. 11102, 11105-59 D. 11104, 11103-51

6. A 72-year-old patient had a squamous cell carcinoma on his left arm measuring 2 cm; the margin required to adequately excise the lesion is 0.5 cm, and the resulting 4 cm wound required layered closure. What are the codes for these procedures?

A. 11603, 12032-59 B. 11602, 12002-51 C. 11603, 12032-51 D. 11623, 12032-51

7. A 39-year-old male has a melanoma excised from his right cheek with reconstruction by advancement flap. The 2.5 cm lesion plus a 0.5 cm margin totals a 4.5 cm primary defect. A 6 sq cm adjacent tissue transfer was advanced into the primary defect. What are the codes for these procedures?

A. 14041 B. 14040 C. 14041, 11646-51 D. 11644, 14041-51

8. A 55-year-old male was admitted with third-degree burns on his thighs and trunk. Surgical excision of burn tissue was performed, followed by application of 225 sq cm of skin substitute graft on the thighs and 150 sq cm on the trunk. What are the codes for these procedures?

A. 15002, 15003, 15273, 15274 B. 15002, 15003 x2, 15273, 15274 x2 C. 15002, 15003 x3, 15271, 15272 x3 D. 15002, 15003 x3, 15273, 15274 x3

9. A 16-year-old male has one benign lesion on his nose (1.6 cm) and one benign lesion on his neck (2.1 cm); a laser was used for destruction of both lesions. How should the procedures be coded?

A. 17110 B. 17273, 17272 C. 17273, 17282 D. 17000, 17003

10. A 14-year-old male fell off his bicycle, lacerating his forehead (4 cm) and left leg (3 cm). The ED physician cleaned the contaminated forehead wound and closed it with sutures; the leg was repaired with superficial sutures. What are the codes for these procedures?

A. 12052, 12002-59 B. 12052, 12002-51 C. 12052, 12002 D. None of the above

Answer Key

Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
B	A	C	A	B	C	A	D	A	A

10. Breast Biopsy Coding Guidelines

Ultrasound-Guided Breast Biopsy

If a breast biopsy is performed using ultrasound guidance, assign CPT 19083 (first lesion) and 19084 (each additional lesion biopsied). There is no need to add a separate ultrasound guidance code — it is inclusive of the surgical procedure.

Code	Description
19083	Biopsy, breast, with placement of breast localization device(s), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including ultrasound guidance.
+19084	...each additional lesion, including ultrasound guidance (list separately in addition to the primary procedure code). MUE: 2 units.

- Localization device placement and specimen imaging are not required for these codes, but are included if performed.
- These codes include ultrasound guidance.

How to Code Ultrasound-Guided Breast Biopsy

Scenario	Codes
Single lesion	19083
Two lesions	19083, 19084
Three lesions	19083, 19084 x2

Note: No need to add CPT 76942 (ultrasound) — it's included with CPT 19083.

Ultrasound-Guided Breast Cyst Aspiration

If breast cyst aspiration is performed using ultrasound guidance, assign CPT 19000 (first cyst); for additional cysts, use CPT 19001. These codes should be followed by the guidance code — e.g., CPT 76942 (ultrasound guidance).

Code	Description
19000	Puncture aspiration of cyst of the breast; first cyst.
+19001	...each additional cyst (list separately in addition to the primary procedure code). MUE: 5 units.

- If the provider performs the procedure under image guidance, use the appropriate guidance code — CPT 76942 for ultrasound or CPT 77021 for MRI — along with CPT 19000.

How to Code Ultrasound-Guided Breast Cyst Aspiration

Scenario	Codes
Single cyst	19000, 76942
Two cysts	19000, 19001, 76942
Three cysts	19000, 19001 x2, 76942

How to Code MRI-Guided Breast Cyst Aspiration

Scenario	Codes
Single cyst	19000, 77021
Two cysts	19000, 19001, 77021
Three cysts	19000, 19001 x2, 77021

Note: For ultrasound-guided FNA (fine needle aspiration), use CPT 10005 & 10006.

Ultrasound-Guided Placement of Localization Device

Code	Description
19285	Placement of breast localization device(s) (e.g., clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including ultrasound guidance.
+19286	...each additional lesion, including ultrasound guidance (list separately in addition to the primary procedure code). MUE: 2 units.

- These codes include ultrasound guidance.

How to Code

Scenario	Codes
Single lesion	19285
Two lesions	19285, 19286
Three lesions	19285, 19286 x2

Note: No need to add CPT 76942 (ultrasound) — it's included with CPT 19285.

Stereotactic-Guided Breast Biopsy

Code	Description
19081	Biopsy, breast, with placement of breast localization device(s), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including stereotactic guidance.
+19082	...each additional lesion, including stereotactic guidance (list separately in addition to the primary procedure code). MUE: 2 units.

Note: When a provider performs more than one breast biopsy using the same imaging modality, use the add-on code regardless of whether the additional service is on the same or contralateral breast. If additional biopsies use a different imaging modality, report another primary code for each additional modality.

- These codes include stereotactic guidance.

How to Code

Scenario	Codes
Single lesion	19081
Two lesions	19081, 19082
Three lesions	19081, 19082 x2

Stereotactic-Guided Placement of Localization Device

Code	Description
19283	Placement of breast localization device(s), percutaneous; first lesion, including stereotactic guidance.
+19284	...each additional lesion, including stereotactic guidance (list separately in addition to the primary procedure code). MUE: 2 units.

- These codes include stereotactic guidance.

How to Code

Scenario	Codes
Single lesion	19283
Two lesions	19283, 19284
Three lesions	19283, 19284 x2

MRI-Guided Breast Biopsy

Code	Description
19085	Biopsy, breast, with placement of breast localization device(s), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including MRI guidance.
19086	...each additional lesion, including MRI guidance (list separately in addition to the primary procedure code). MUE: 2 units.

- These codes include MRI guidance.

How to Code

Scenario	Codes
Single lesion	19085
Two lesions	19085, 19086
Three lesions	19085, 19086 x2

MRI-Guided Placement of Localization Device

Code	Description
19287	Placement of breast localization device(s), percutaneous; first lesion, including MRI guidance.
19288	...each additional lesion, including MRI guidance (list separately in addition to the primary procedure code). MUE: 2 units.

- These codes include MRI guidance.

How to Code

Scenario	Codes
Single lesion	19287
Two lesions	19287, 19288
Three lesions	19287, 19288 x2

Note: To report bilateral image-guided breast biopsies, report 19081, 19083, or 19085 for the initial biopsy. The contralateral and each additional image-guided biopsy is then reported with 19082, 19084, or 19086.

Breast biopsies performed without image guidance are reported with CPT 19100 (percutaneous, needle core) and CPT 19101 (open, incisional).

- CPT 19100: percutaneous, needle core, not using imaging guidance (separate procedure). MUE: 4 units. When the provider biopsies more than one site on the same side, report the subsequent biopsies with modifier 59.
- CPT 19101: open, incisional. MUE: 3 units. An incisional biopsy removes only a small portion of a lump for pathology; an excisional biopsy removes the entire lump.

Points to Remember

- When more than one biopsy or localization device placement is performed using the same imaging modality, use an add-on code regardless of whether the additional service is on the same or contralateral breast.
- If additional biopsies or localization device placements are performed using different imaging modalities, report another primary code for each additional procedure performed under a different guidance modality.
- Do not report 19281–19288 in conjunction with 19081–19086, 76942, 77002, and 77021 for the same lesion.

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Musculoskeletal System Surgery CPT Coding Guidelines

Section Rules, Worked Examples & CPC-Style Practice Quiz

1. Musculoskeletal System Surgery — Coding Guidelines Overview

The Musculoskeletal System surgery section of CPT is divided by anatomical site (General, Head, Neck, Back, etc.). Within each site, subsections are organized by the type of procedure performed:

- Incision (a surgical cut)
- Excision (removing)
- Manipulation (reduction)
- Introduction/Removal, Repair/Reconstruction (Arthrography / Arthroplasty)
- Fracture/Dislocation, Arthrodesis (surgical fusion)
- Amputation (surgical cutting) procedures

General Guidelines — Anesthesia

Local anesthesia administered by a physician to perform any musculoskeletal procedure is considered an inclusive part of that procedure and should not be billed separately.

2. Wound Exploration (20100 – 20103)

These codes apply to traumatic wounds that result from penetrating trauma, such as a gunshot or stabbing.

These Codes Describe

- Surgical exploration and enlargement of the wound
- Extension of dissection to determine the depth of penetration
- Debridement / foreign body removal
- Ligation and coagulation of minor blood vessels

These codes cover both exploration and repair of the wound area.

Note: If a simple, intermediate, or complex repair is performed that does not require wound enlargement, report the specific closure/repair codes from the Integumentary system instead. If a thoracotomy or laparotomy is performed, wound exploration is included and not separately billable.

3. Excision

Biopsy

A biopsy is the examination of tissue removed from the living body.

- If a biopsy is performed along with any excision, repair, destruction, or removal-of-internal-fixation procedure at the same site, it is considered an inclusive procedure and the biopsy should not be billed separately.
- If the biopsy is performed at a different site, it is a separately billable service.

Biopsy Procedures Are Divided By

- Type of biopsy (muscle / bone)
- Depth (superficial / deep)

- Method (open / percutaneous)

Excision of Soft Tissue & Bone Tumors

Code selection for tumor excision depends on the plane of resection, the nature of the tumor, its location, and size:

A. Subcutaneous Soft Tissue Tumors

Simple or marginal resection of tumors from subcutaneous tissue, above the deep fascia.

- Usually benign in nature
- Resection does not include surrounding normal tissue
- Code by location and size (greatest diameter, with the most narrow margin required)
- Complex repair to close the wound is reported additionally — simple and intermediate repair is included

B. Fascial / Subfascial Soft Tissue Tumors

Simple or marginal resection of tumors from the fascia or below the deep fascia, above the bone.

- Usually benign / intramuscular
- Resection does not include surrounding normal tissue
- Code by location and size (greatest diameter, with the most narrow margin required)
- Complex repair reported additionally — simple/intermediate repair is included

C. Radical Resection — Soft Connective Tissue Tumors

Resection of a subcutaneous / subfascial tumor with wide margins of normal tissue.

- Usually malignant or aggressive benign tumors
- Includes removal of surrounding normal tissue from one or more layers
- Code by location and size (greatest diameter, most narrow margin)
- Complex repair reported additionally — simple/intermediate repair is included

D. Radical Resection — Bone Tumors

Resection of a bone tumor with wide margins of normal tissue.

- Usually malignant or aggressive benign tumors
- Includes removal of surrounding normal tissue from one or more layers
- Code by location (size still measured as greatest diameter, most narrow margin)
- Complex repair reported additionally — simple/intermediate repair is included

Note: If the surrounding soft tissue is removed during a bone tumor procedure, do not additionally report a radical resection of soft-tissue-tumor code.

4. Introduction or Removal

Injection Of

- Sinus tract
- Tendon
- Trigger point
- Joints (arthrocentesis / aspiration / injection)

Arthrocentesis / Aspiration / Injection of Joint or Bursa (CPT 20600 – 20611)

- Codes are based on the size of the joint — small, intermediate, or large
- Also based on whether ultrasound guidance was utilized

- Different techniques performed in a single joint and its surrounding structure are considered a single unit of service — e.g., arthrocentesis of the RT knee with aspiration of the RT knee bursa is coded as one unit of 20610 or 20611
- If procedures are performed on more than one joint, code each joint separately
- Injection of a substance does not include the drug itself — the drug should be billed separately using HCPCS Level II codes

Example: The provider injected 40 mg of Kenalog into the left knee joint and removed 4 cc of fluid from the right knee using ultrasound guidance.

Answer: 20611, 20611–59, J3301 x 4

SI Joint Injection — CPT 27096 (Includes Guidance Code)

- If CT or fluoroscopic imaging is used → code 27096
- If CT or fluoroscopic imaging is not used → code 20552
- Bilateral sacroiliac joint injection → append modifier 50 to the CPT code

Arthrography

Arthrography is the radiographic visualization of a joint after injecting a contrast agent. Fluoroscopy — a special form of X-ray — is used to guide and evaluate the injection of contrast material directly into the joint cavity; ultrasound is sometimes used as well.

Q: What is the difference between Arthrography and an MRI study?

In an MRI, contrast is administered into a vein. In Arthrography, contrast is injected directly into the joint under imaging guidance (fluoroscopy).

Q: What is Supervision and Interpretation (S&I)?

A radiologist can perform a percutaneous procedure alone, or guide a surgeon technically using imaging guidance (ultrasound / fluoroscopy / CT / MRI).
• If the radiologist bills a procedure done solely by them, bill both the surgery code and the S&I code.
• If the radiologist only guides the surgeon, bill only the S&I code with modifier 52 — the surgeon bills separately for the procedure performed.
• Some procedure codes already include the guidance codes — the radiologist should not bill guidance separately in those cases.

Arthrography Coding Guidelines

1. If fluoroscopy is utilized without interpretation — code arthrography with the fluoroscopy codes.
2. If both guidance and interpretation are performed — code arthrography with the S&I codes.

Note: All S&I codes include the guidance (fluoroscopy) codes.

5. Replantation (20802 – 20838)

These codes are selected based on anatomical location, for cases involving complete amputation.

Note: For repair of an incomplete amputation, assign the specific replantation code with modifier 52.

6. Repair / Revision / Reconstruction

Arthroplasty — Surgical Reconstruction / Replacement of a Joint

Arthroplasty is an open surgical procedure in which the articular surface of a joint is replaced by an artificial prosthesis.

- Most common in the knee or hip — the damaged surface is completely removed and replaced with an artificial prosthesis
- May be complete (both articular surfaces) or partial (one articular surface)

Reconstruction of Ligaments

A surgical procedure to replace torn ligaments using a graft.

7. Fracture / Dislocation

Term	Definition
Fracture	Break in the continuity of a bone — may be traumatic or pathological.
Dislocation	Displacement of a bone from its normal position.

Fractures are treated by closed, open, or percutaneous methods. The type of fracture does not have any coding correlation with the type of treatment used.

Fracture Treatment Types

1. Closed Treatment

The fracture site is not surgically opened.

- Treated with or without manipulation
- Treated with or without traction

2. Open Treatment

An incision is made and the fracture site is surgically opened.

- Treated with internal fixation
- Treated with an intramedullary nail across the fracture site

3. Percutaneous Skeletal Fixation

Fracture fragments are not visualized directly.

- Fixation pins are placed across the fracture site using x-ray imaging

Codes for the treatment of fractures and dislocations are categorized by the type of manipulation and stabilization performed (fixation or immobilization).

Traction & Fixation — Key Terms

- Skeletal Traction — application of force to a limb segment via a pin attached to the bone
- Skin Traction — application of force using strapping applied directly to the skin
- External Fixation — use of skeletal pins, with the device attached externally to treat acute or chronic conditions

Note: Re-reduction of a fracture or dislocation by the same physician is identified by adding modifier 76.

Throughout this subsection, “manipulation” specifically means reduction/restoration to normal anatomic alignment by application of manual forces.

Billing Rules to Remember

- Removal of external devices in the postoperative period is generally included with the application of external immobilization devices (casts, strapping, splints).
- Removal of a superficial or deep implant (pin/rod/buried wire) requires a surgical procedure and is billed with the appropriate CPT (20670–20680). If another procedure is necessary at the same site during implant removal, it cannot be coded separately.
- If a closed fracture treatment procedure fails and is followed by an open procedure at the same session, code only the open procedure.
- CPT codes for closed, percutaneous, or open treatment of fractures/dislocations include the application and removal of a cast, strap, or splint — these should not be billed separately.

Cast and Strapping (29000 – 29584)

These codes are billed only when:

- The physician treats the fracture or dislocation with a cast or splint only, without a restorative treatment or procedure to stabilize it. (The initial cast/strap/splint is included in the fracture/dislocation treatment code when performed at the same session.)
- The cast or splint is applied during follow-up care
- Dynamic Splint — allows movement with stability
- Static Splint — prevents movement

Note: Procedures performed on fingers are reported with modifiers FA, F1–F9; procedures on toes are reported with modifiers TA, T1–T9.

8. Arthrodesis

Arthrodesis is the fusion of two bones to prevent movement — a surgical procedure performed on joints such as the ankle, carpals, tarsals, and spine. The ends of two bones are fused together using screws and bone graft.

Spine Arthrodesis — Surgical Fusion Between Vertebrae

Three key terms to note in spine arthrodesis:

1. Approach and location
2. Bone graft
3. Instrumentation

Approach

- Lateral extracavitary approach (22532 – 22534)
- Anterior or anterolateral approach
- Posterior, postero-lateral, or lateral transverse process technique

Anterior (or Anterolateral) Approach — CPT 22548 – 22586

- CPT 22554–22558 is for a single interspace; for each additional interspace, use add-on code +22585

- Vertebral interspace — the non-bony compartment between two adjacent vertebral bodies (contains the disc)
- Vertebral segment — a single, complete vertebral bone
- CPT 22586 — arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, posterior instrumentation, and image guidance; includes bone graft when performed, for the L5–S1 interspace (don't separately report bone graft, instrumentation, or fluoroscopy guidance with this code)
- If two surgeons work together as primary surgeons performing distinct parts of the procedure, each reports their distinct work by appending modifier 62

Modifier 62 Notes

Bone graft procedures are reported separately in addition to arthrodesis — but modifier 62 is not used with bone graft codes (20930–20938).
Instrumentation is also reported separately in addition to arthrodesis — but modifier 62 is not used with definitive or add-on spinal instrumentation codes (22840–22848, 22850, 22852, 22853, 22854, 22859).
When arthrodesis is performed with another procedure (fracture care, laminectomy, osteotomy, vertebral corpectomy), bill arthrodesis with modifier 51 — except for add-on codes.

Bone Graft

During spinal fusion, a solid bridge is formed between two vertebral segments to stop movement in that section of the spine. Bone graft, or bone graft substitute, creates the environment for that solid bridge to form and allows new bone to fuse the spinal section together.

- Autograft — graft taken from one site and moved to another site on the same individual
- Allograft — graft from a donor of the same species, sometimes from a cadaver

Note: “Morselized” means the process of dividing bone graft into small portions. During spine fusion surgery, the same incision — or a separate incision — is made to remove bone graft from the patient's body (usually the iliac bone, ribs, or spine), a process called harvesting.

Instrumentation

Hardware implants used in spine surgery include:

- Rods
- Hooks
- Plates
- Screws
- Interbody cages

There are two types of spinal instrumentation procedures:

- Segmental — stabilizes the spine by attaching to each individual segment that was fused
- Non-segmental — does not attach at each level; a curved rod is attached at the top and bottom (there are no codes for anterior non-segmental instrumentation)

Worked Coding Examples

#	Clinical Scenario	Answer
1	Posterior arthrodesis of L4–L5 for degenerative disc disease (DDD), utilizing morselized autogenous iliac bone graft harvested through a separate fascial incision.	22612, 20937

#	Clinical Scenario	Answer
2	Posterior arthrodesis of L4–S1, utilizing morselized autogenous iliac bone graft harvested through a separate fascial incision and pedicle screw fixation.	22612, 22614, 22842, 20937
3	L2 burst fracture treated by corpectomy, followed by arthrodesis of L1–L3 using anterior instrumentation (L1–L3) and structural allograft.	63090, 22558-51, 22585, 22845, 20931 (don't append modifier 51 to add-on codes)
4	A 53-year-old man with posttraumatic DDD at L3–L4 and L4–L5. Surgeon A performed an anterior exposure with mobilization of the great vessels; Surgeon B performed anterior discectomy and fusion at L3–L4 and L4–L5 using an anterior interbody technique.	Surgeon A: 22558-62, 22585-62 Surgeon B: 22558-62, 22585-62, 20931 (bone graft — no modifier 62)

Arthrodesis for Spinal Deformity (Scoliosis / Kyphosis)

Codes are based on the surgical approach and the vertebral segments involved:

- Posterior approach (22800 – 22804)
- Anterior approach (22808 – 22812)

Percutaneous Vertebroplasty & Vertebral Augmentation — CPT 22510 – 22515 (Includes Bone Biopsy)

- Vertebroplasty — injecting material (cement) into the vertebral body to reinforce its structure, using imaging guidance
- Vertebral Augmentation — creating a cavity followed by injection of material (cement), under imaging guidance
- Sacroplasty — 0200T – 0201T

Note: Vertebral augmentation includes vertebroplasty.

9. Arthroscopy — Look Within the Joint

Arthroscopy is a minimally invasive surgical procedure on a joint. The orthopedic surgeon views the joint without making a large cut through the skin and other soft tissues — an endoscope is inserted into the joint through small incisions.

- Surgical arthroscopy includes diagnostic arthroscopy
- Arthroscopy is inclusive with an open procedure performed at the same site
- Arthroscopy and an open procedure at a different site are coded with the appropriate modifier
- If arthroscopy is performed along with arthrotomy, append modifier 51

10. Musculoskeletal Surgery — Practice Quiz

Ten CPC-style scenario questions covering this section. Work through each, then check your answers against the key at the end.

1. A 63-year-old female with right OA knee is scheduled for an intra-articular steroid injection for pain relief. After sterile prep and local anesthesia, using ultrasound guidance, the needle is placed into the right knee joint space and 40 mg of Kenalog is injected. The patient tolerated the procedure well. How would you report the service?

- **A.** 20610, 76942-26
- **B.** 20611
- **C.** 20610, 76942
- **D.** 20611, 76942

2. A 54-year-old male has a soft tissue tumor on his right forearm near the elbow, and another in the posterior aspect of the right forearm near the wrist. The surgeon performs a radical resection of the tumor near the elbow (3.8 cm) and an excision of the posterior intramuscular tumor near the wrist (2.8 cm). What are the correct codes?

- **A.** 25078, 25075-59
- **B.** 25078, 25076-59
- **C.** 25071, 25076-59
- **D.** 24077, 25076-59

3. A 34-year-old male sustains a midshaft fracture of the left tibia after an accident. He is taken to the OR for an IM nailing procedure; after general anesthesia and standard prep, intramedullary rodding is performed with proximal and distal locking screws. The incision is closed and a long leg cast applied. What is the correct CPT for this procedure?

- **A.** 27759
- **B.** 27759, 29345-51
- **C.** 27756
- **D.** 27756, 29345-51

4. A 49-year-old patient with lumbar disc herniation at L2–L3 and L4–L5 undergoes arthrodesis using an interbody technique. The surgeon performs anterior arthrodesis with morselized iliac bone graft harvested through a separate incision, plus anterior instrumentation (L2–L5). How would you report these services?

- **A.** 22554, 22558, 22845, 20930
- **B.** 22551, 22552, 22845, 20930
- **C.** 22554, 22558, 22846, 20937
- **D.** 22551, 22552, 22846, 20937

5. A 62-year-old female falls and is unable to move her right leg; ED x-ray shows a femoral neck fracture requiring replacement with an artificial joint prosthesis. The orthopedic surgeon removes the damaged bone and replaces both articulating surfaces with a prosthetic implant. How would you report the surgeon's service?

- **A.** 27093
- **B.** 27130
- **C.** 27125
- **D.** 27134

6. A 37-year-old patient sustains a stab injury to the right thigh. After standard prep and drape, the surgeon widens the wound for visualization, performs debridement and ligation of minor blood vessels, then closes and dresses the wound. What is the correct code for this procedure?

A. 20103, 11042, 12001
B. 20103, 12001-51
C. 20103, 11042-51
D. 20103

7. A 48-year-old male with chronic neck pain undergoes trigger point injection with ultrasound guidance — two injections into the trapezius muscle and three into the levator scapulae. How would you report these services?

A. 20552
B. 20553
C. 20552, 76942
D. 20553, 76942

8. A 59-year-old woman with right elbow pain and swelling after a fall; x-ray shows posterior dislocation of the elbow joint. The orthopedic surgeon performs closed reduction and applies a POP cast. Due to her age and history of diabetes, anesthesia was not provided. How would you report this service?

A. 24600
B. 24605
C. 24615
D. 24655

9. A 42-year-old male with two months of chronic shoulder pain undergoes shoulder arthrography in the ASC. Under fluoroscopic guidance, a needle is placed into the joint space, contrast is injected, and images are taken showing a severe rotator cuff tear with mild degeneration. How would you report this service?

A. 23350, 77002-26
B. 23350, 73040-26, 77002-26
C. 23350, 73040
D. 23350, 73040-26

10. A 21-year-old female with knee swelling and pain is brought to the ED after a fall from a cycle. The orthopedic surgeon diagnoses a ligament sprain of the left knee and places a long leg cast (thigh to toes), instructing the patient to follow up in clinic. How would you report the service?

A. 29355
B. 29345
C. 29358
D. 29405

Answer Key

Q1	Q2	Q3	Q4	Q5
Q1 **B**	Q2 **B**	Q3 **A**	Q4 **D**	Q5 **B**

Q6	Q7	Q8	Q9	Q10
Q6 **D**	Q7 **C**	Q8 **A**	Q9 **D**	Q10 **B**

CODEX
CODING DECODED

Cardiovascular & Respiratory Coding Guidelines

CPT Series 3 · Cardiovascular System & Respiratory System Coding Guidelines

1. Central Venous Access Procedure — Guidelines

by Coding Info · June 23, 2020 · CPC Exam Tips — Cardiovascular System Surgery Coding Guidelines

Inserting a catheter into a blood vessel to deliver medication or draw blood from a patient's body — the central venous access procedure is performed for patients who require long-term medications. To understand these procedures, we need to watch the **entry site** and **terminating site** of the catheter.

A. Entry Site

- **Centrally inserted —** Jugular, subclavian, femoral vein, or IVC.
- **Peripherally inserted —** Basilic or cephalic vein, or saphenous vein.

B. Terminating Site (catheter tip position)

Subclavian, brachiocephalic, iliac vein, SVC / IVC, or at the right atrium.

The Device May Be Accessed Via

1. Exposed catheter (external to the skin)
2. Subcutaneous port
3. Subcutaneous pump

Five Main Categories

1. **Insertion**
2. **Repair**
3. **Partial replacement** (only the catheter component)
4. **Complete replacement** (entire device)
5. **Removal**

Insertion — Placement of Catheter via a Newly Created Venous Access

CPT codes 36555 – 36571 — these codes are divided based on:

- Age of the patient
- Central or peripheral access

Access Type	Configuration	CPT Codes
Centrally inserted	Non-tunneled	36555, 36556
Centrally inserted	Tunneled	36557, 36558
Centrally inserted	Port	36560, 36561
Centrally inserted	Pump	36563
Peripherally inserted	Without imaging guidance	36568, 36569
Peripherally inserted	With imaging guidance	36572, 36573
Peripherally inserted	With port	36570, 36571

For Repair / Replacement / Removal

- Look for central or peripheral inserted catheter.
- Look for tunneled or non-tunneled.
- Look for with or without port / pump.

To check the catheter using contrast: CPT **36598** (including the guidance).

Coding Guidelines

- **If an existing device is removed and a new one is placed via a separate venous access site —** code both (removal of old and insertion of new).
- **If imaging guidance is used for gaining access and manipulating the catheter into final position —** use 76937 and 77001 (can code both if performed).
- A **chest X-ray** for the purpose of confirming the final catheter position on the same day of service should **not** be coded with 36572, 36573, 36584. If the catheter tip location is **not confirmed** — add modifier 52 with 36572, 36573, 36584.
- **Midline catheters** are not central venous access devices — use 36400, 36406, or 36410.
- PICC placed using MRI or any guidance that does not include image documentation is reported with CPT **36568 / 36569**.

2. Coronary Artery Bypass Coding Guidelines

by Coding Info · June 21, 2020 · CPC Exam Tips — Cardiovascular System Surgery Coding Guidelines

There are three sets of codes available in the CPT book. Codes are based on:

- **A.** Type of graft
- **B.** Number of grafts

Graft Type	CPT Codes
Venous grafting only	33510 – 33516
Arterial graft	33533 – 33536
Combined arterial with vein graft	33517 – 33523

These combined arterial & vein graft codes are used with arterial graft codes only, to indicate the number of vein grafts utilized during the same encounter.

Coding Guidelines — Vein Graft

Use these codes if only a vein graft is utilized. Procurement of the saphenous vein graft is included in CPT codes 33510 – 33516.

Additional billable services along with bypass:

- Harvesting of an upper extremity vein — **35500**
- Harvesting of the femoropopliteal vein — **35572**
- Percutaneous VAD — **33990 – 33993**

Note: Surgical assistant for graft procurement — modifier 80.

Coding Guidelines — Artery Graft

Procurement of the artery graft is included in CPT codes 33533 – 33536.

Additional billable service along with bypass: harvesting of an upper extremity artery — **35600**.

Note: Surgical assistant for graft procurement — modifier 80.

The **combined graft add-on code for the vein (33517 – 33523)** is used only with the artery graft codes (33533 – 33536) if artery and vein grafts are both used for the coronary bypass procedure.

Add-on Codes Used With Bypass Procedure Codes

Add-on CPT	Description
+33508	Endoscopy — video-assisted harvest of the vein(s) for coronary artery bypass procedure
+33530	Reoperation — coronary bypass procedure or valve procedure more than 1 month after an original operation
+33572	Coronary endarterectomy, open, of LAD, circumflex, or right coronary artery, performed in conjunction with CABG, each vessel

3. Endovascular Repair Coding Guidelines

by Coding Info · May 19, 2018 · CPC Exam Tips — Cardiovascular System Surgery Coding Guidelines

For Reporting Purposes: Aorta Anatomy

1. **Thoracic aorta —** from the aortic valve to proximal to the celiac artery origin.
2. **Upper abdominal aorta —** contains the celiac, superior mesenteric, and renal arteries (visceral aorta).

Endovascular Repair of Descending Thoracic Aorta

Placement of an endovascular graft for repair of the descending thoracic aorta (aneurysm, pseudoaneurysm, dissection, penetrating ulcer, traumatic disruption, and intramural hematoma).

CPT Code	Description
33880	Endovascular repair of descending thoracic aorta — graft covers the left subclavian artery origin
33881	Not involving coverage of the left subclavian artery origin

Note: CPT 33880 and 33881 include placement of all distal extensions (33886). Only proximal extensions (33883 & 33884) can be billed separately if needed.

For radiologic S&I — CPT 75956 to 75959.

These procedures include:

- All device introduction
- Manipulation
- Positioning
- Deployment
- Balloon angioplasty and stent deployment before/after endograft

Additionally billable services:

- Open arterial exposure and closure of the arteriotomy site — **34812, 34820, 34833, 34834**
- Introduction of guidewires and catheters — **36140, 36200 – 36218**
- Extensive repair/replacement of an artery — **35226, 35286**
- Transposition of the subclavian artery to carotid, and carotid-carotid bypass performed in conjunction (**33889, 33891**) should be coded separately.
- Other interventional procedures (e.g., innominate, carotid, subclavian, visceral, iliac artery angioplasty, stent, embolization, intravascular ultrasound) should be additionally reported.

Note: For transcatheter placement of the wireless physiologic sensor in aneurysmal sac — 34806.

For analysis, interpretation, and report of the implanted wireless pressure sensor — 93982.

Endovascular Repair of an Abdominal Aorta and/or Iliac Arteries

Infrarenal abdominal aorta, with or without extension into the iliac artery — CPT **34701, 34702, 34703, 34704, 34705, 34706** describe introduction, positioning, and deployment of an endograft for treatment of abdominal aortic pathology (with or without rupture) — e.g., aneurysm, pseudoaneurysm, dissection, penetrating ulcer, or traumatic disruption.

The endograft may be:

1. Aortic tube device
2. A bifurcated unibody device
3. A modular bifurcated docking system with docking limbs
4. An aorto-uni-iliac device

Iliac artery alone — CPT **34707 and 34708** describe introduction, positioning, and deployment of an endograft for treatment of iliac artery pathology (with or without rupture) — e.g., aneurysm, pseudoaneurysm, arteriovenous malformation/trauma.

Condition	CPT Codes
Atherosclerotic occlusive disease — iliac arteries, covered stent placement	37221, 37223
Atherosclerotic occlusive disease — aorta, covered stent placement	37236, 37237
Isolated bilateral iliac artery repair	34707 or 34708 with modifier 50
Bilateral iliac artery repair with aorto-bi-iliac endograft	34705 or 34706

Treatment Zone

The vessel that contains the endograft (main body, docking limbs, and/or extension). Other interventional procedures (balloon, stent, embolization, etc.) outside the treatment zone may be reported separately.

CPT Codes	Treatment Zone
34701 and 34702	Infrarenal aorta
34703 and 34704	Infrarenal aorta with an ipsilateral common iliac artery
34705 and 34706	Infrarenal aorta with both common iliac arteries
34708 and 34709	Iliac arteries

For a bifurcated iliac branch device — **0254T**.

A **chronic contained rupture** is considered a pseudoaneurysm and should be reported as a **without rupture** code (34701/34703/34705/34707).

An **acute hemorrhage** should be considered a rupture — CPT 34702/34704/34706/34708.

CPT **34709** — extension prosthesis in the internal iliac, external iliac, or common femoral artery, or in the abdominal aorta proximal to the renal artery. It should be reported once per vessel treated.

Endograft distal extensions that terminate in the common iliac artery are included in CPT 34703, 34704, 34705, 34706, 34707, and 34708. Similarly, a proximal extension that terminates in the aorta below the renal artery is also included in CPT 34703, 34704, 34705, 34706.

CPT **34710 and 34711** — delayed placement of distal/proximal extensions.

Included services:

1. Pre-procedure sizing and device selection
2. All nonselective catheterization
3. All associated radiological S&I
4. Treatment zone angioplasty / stent — CPT 34710 and 34711 should be reported once per vessel treated (multiple endograft extensions placed in the same vessel are reported once)

Included and Excluded Services

1. Nonselective catheterization is included in CPT 34701 – 34708. CPT 34709, 34710, 34711 include the nonselective introduction of guidewires and catheters into the treatment zone from peripheral artery access.
2. **Balloon and stent** within the treatment zone of the endograft, either before or after endograft deployment, is included.
3. Fluoroscopic guidance, radiological S&I, and all intraprocedural imaging and completion angiography (confirm position, detect endoleak) in conjunction with endograft repair are included.
4. Selective catheterization of the hypogastric artery, renal artery, and/or families outside the treatment zone can be coded separately.
5. Intravascular ultrasound (CPT **37252, 37253**) performed during endovascular aneurysm repair can be coded separately.
6. Any open arterial exposure should be coded separately (**34713, 34714, 34715, 34716, 34812, 34820, 34833, 34834**).
7. Extensive repair of the artery should be coded separately (**35226, 35286, 35371**).
8. The cardiovascular bypass should be coded separately. If a conduit is converted into a bypass, report the bypass (**CPT 35665**).
9. Arterial embolization to facilitate the endovascular procedure should be coded separately (**CPT 37242**).

CPT 34712 — Transcatheter delivery of accessory enhanced fixation devices to the endograft (e.g., anchor, screw), including all associated S&I. Reported once per operative session.

CPT 34713 — Percutaneous access and closure of a femoral arteriotomy for delivery of an endovascular prosthesis through a large sheath (12 French or larger). Smaller than 12 French is included in procedure codes 34701–34712. Ultrasound guidance code 76937 is included in CPT 34713.

Open Repair of Infrarenal Aortic Aneurysm

CPT Code	Description
34830	Tube prosthesis — open repair of infrarenal aorta following unsuccessful endovascular repair
34831	Aorto-bi-iliac prosthesis
34832	Aorto-bifemoral prosthesis

Fenestrated Endovascular Repair

Based on the extent of the aorta treated, there are two sets of codes:

- **A.** For fenestrated endovascular repair of the visceral aorta (34841 – 34844)
- **B.** For fenestrated endovascular repair of the visceral aorta and concomitant infrarenal abdominal aorta (34845 – 34848)

CPT 34839 — Physician planning and sizing for a patient-specific fenestrated visceral aortic endograft. Documentation should support a minimum of 90 minutes of physician time in planning (need not be continuous) and should not be reported on the day before or day of the fenestrated endovascular repair procedure.

Fenestrated endovascular repair of the visceral aorta (34841 – 34844): proximal endoprosthesis spanning from the visceral aortic component to one, two, three, or four visceral artery origins, with the distal extent limited to the infrarenal aorta.

CPT Code	Coverage
34841	One visceral artery
34842	Two visceral arteries
34843	Three visceral arteries
34844	Four or more visceral arteries

Fenestrated endovascular repair of the visceral aorta and concomitant infrarenal abdominal aorta (34845 – 34848): fenestrated endoprosthesis spanning from the visceral aorta through the infrarenal aorta into the common iliac arteries. The infrarenal component may be a bifurcated unibody device, a modular bifurcated docking system with docking limbs, or an aorto-uni-iliac or aorto-uni-femoral device.

CPT Code	Coverage
34845	One visceral artery
34846	Two visceral arteries
34847	Three visceral arteries
34848	Four or more visceral arteries

- CPT 34845 – 34848 includes placement of unilateral or bilateral docking limbs.
- Additional stent graft extensions that terminate in the common iliac artery are included in CPT 34845 – 34848.
- If the distal extension prosthesis terminates in the internal iliac, external iliac, or common femoral artery — CPT **34825 and 34826** would be reported separately.

Included services with CPT 34841 – 34848:

- Introduction of guidewire and catheters in the aorta and visceral and/or renal arteries is included. Exception: catheterization of the hypogastric artery and/or arterial families outside the treatment zone of the graft may be separately reported.
- Balloon angioplasty within the target treatment zone of the endograft, either before or after endograft deployment, is included.
- Fluoroscopic guidance and radiological S&I in conjunction with fenestrated endovascular aortic repair are included.

Additionally billable services:

- Exposure of the access vessels (e.g., **34812**)
- Extensive repair of an artery (e.g., **35226, 35286**)
- Concomitant endovascular treatment of the descending thoracic aorta (**33880 – 33886 and 75956 – 75959**) reported with 34841 – 34848
- Other interventional procedures performed at the time of fenestrated endovascular abdominal aortic aneurysm repair should be coded additionally (e.g., balloon angioplasty, stenting, arterial embolization, or intravascular ultrasound of an artery outside the endoprosthesis target zone, done before or after graft deployment).

CPT Code	Description
34841 – 34844	Visceral aorta, endovascular repair (see table above)
34845 – 34848	Visceral & infrarenal abdominal aorta, endovascular repair (see table above)
35001 – 35152	Direct repair of aneurysm

4. Cardiovascular Surgery Quiz

by Coding Info · August 14, 2020 · CPC Sample Questions

Q1. A 66 yrs old male patient is brought to the operating room for pacemaker placement. The cardiologist inserted two leads via a subclavian vein and the electrodes are placed in the right atrium and another one in the right ventricle. Both leads are connected to the generator. He created a skin pocket in the right side of the chest below the clavicle to keep the pulse generator. Finally closed all the area with sterile technique. The patient tolerated the procedure well. Assign the appropriate CPT codes for this procedure.

A. 33208, 33202 – 51
B. 33206
C. 33208
D. 33213, 33217 – 51

Q2. A 73 yrs old male patient is brought to the operating room for a CABG procedure. Following general anesthesia, a median sternotomy incision is made and cardiopulmonary bypass is initiated. The saphenous vein is harvested from his right leg and two vein grafts are prepared — one to the right posterior descending artery and one to the marginal artery. A branch of the subclavian artery is brought down to the left circumflex and anastomosed. The patient is weaned from bypass and closed in the usual fashion. Assign the appropriate CPT codes for this service.

A. 33511
B. 33533, 33518
C. 33533, 33511
D. 33533, 33518, 35500

Q3. A 58 yrs old patient is brought to the operating room for an angiography procedure. Access: right femoral artery. Catheter advanced into the aorta, images taken following dye — normal anatomy. Catheter manipulated into the celiac trunk, dye injected, angiogram performed — patent artery. Catheter then moved to the common hepatic artery, dye injected, images show 40% stenosis. Assign the appropriate CPT codes for this service.

A. 36246, 75726 – 26, 75774 – 26
B. 36246, 75726 – 26
C. 36246, 36248, 75726 – 26
D. 36245, 36246, 75726 – 26, 75774 – 26

Q4. A 55 yrs female patient with a history of breast cancer requires a port-a-cath for administration of anti-neoplastic drugs. At the bedside, using ultrasound guidance, the right subclavian vein was located and a needle/guidewire placed. After tunnelling, the introducer was placed over the guidewire and the port line was placed; the tip of the catheter was placed in the right atrium under fluoroscopic guidance and connected to the port device, which was secured in a subcutaneous pocket. What is the appropriate CPT coding for the procedure performed?

A. 36571, 76937 – 26, 77001 – 26
B. 36571, 76937, 77001
C. 36560, 76942 – 26, 77001 – 26
D. 36561, 76937 – 26, 77001 – 26

Q5. A 67 yr old male patient is brought to the operating room for a re-vascularization procedure for severe atherosclerotic plaque in his right anterior tibial and posterior tibial arteries. A catheter is advanced from the right femoral artery to the right anterior tibial artery; angiography confirms stenosis, pre-dilation with balloon is performed followed by a bare-metal stent; the same is repeated in the posterior tibial artery. What are the appropriate CPT codes for the procedure performed?

A. 37230
B. 37230, 37234
C. 37231, 37234
D. 37230, 37232, 37234

Q6. A 71 yr old patient is brought to the operating room for a re-vascularization procedure for severe stenosis in the left femoral and popliteal artery. A catheter advanced from the right femoral artery in retrograde fashion into the left iliac system and to the left femoral artery; angiography confirms stenosis, pre-dilation with balloon followed by stent placement in the femoral artery. The catheter is then advanced to the popliteal artery crossing the stenosis and a stent is deployed. What are the appropriate CPT codes for the procedure performed?

A. 37230, 37234
B. 37226, 37226 – 59
C. 37226, 37224 – 59
D. 37226

Q7. A patient with severe occlusive disease in the inferior mesenteric artery undergoes percutaneous transluminal thrombectomy and stent placement. A catheter is advanced from the right femoral artery to the aorta; aortography shows a patent vessel and the catheter is moved into the inferior mesenteric artery at the site of occlusion, where a short segment embolus is removed, followed by successful stent placement. What are the appropriate CPT codes for the procedure performed?

A. 37238, 37184
B. 37236, 37184
C. 37236, 37286
D. 37221, 37286

Q8. A female patient with vaginal bleeding due to a ruptured aneurysm undergoes a vascular embolization procedure. Via the right femoral artery, the catheter is advanced into the internal iliac artery and further into its branches, and embolization coils are placed distal to the third-order branch of the iliac vascular family; follow-up images show cessation of bleeding and vessel occlusion. What are the appropriate CPT codes for the procedure performed?

A. 37244
B. 37242
C. 37244, 37244 – 59
D. 37242, 37244 – 59

Q9. A 69 yr old female patient with bilateral leg swelling is admitted. After sterile prep, the physician injects dye into the webbing between the first and second toes of each foot, cannulates a lymphatic channel on each side, and injects contrast under fluoroscopy — images show stenosis on either side. How would you report the physician's service?

A. 38790 – 50, 75803 – 26
B. 38790, 75803 – 26
C. 38790 – 50, 75803
D. 38790, 75801 – 26

Q10. A 47 yr old male patient with prostate cancer undergoes a biopsy of axillary lymph nodes due to abnormal enlargement of the right axillary lymph nodes. Under local anesthesia, the physician inserts a 16-gauge needle under CT guidance to take 3 samples from three axillary lymph nodes, all sent to pathology. How would you report the physician's service?

A. 38525
B. 38525 x 3
C. 38505, 77012 – 26
D. 38505 x 3, 77012 – 26

Answer Key

Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Q9	Q10
C	B	A	D	B	D	C	A	A	C

5. Respiratory System Surgery Guidelines

by Coding Info · July 20, 2017 · CPC Exam Tips — Respiratory System Surgery Coding Guidelines

Biopsy

Biopsy is part of the excision / destruction / other type of removal of a lesion, either endoscopically or surgically, at the same session — hence biopsy should not be reported separately. Even for multiple identical/similar lesions at different areas, the biopsy code is not separately reported.

Example: Patient with multiple nasal polyps, nasal obstruction, and sinus obstruction. Procedure: polypectomy and ethmoidectomy, endoscopy.

In this case, CPT **31237** (nasal endoscopy/surgical, with biopsy/polypectomy) should not be reported along with CPT **31255** (nasal endoscopy/surgical, with ethmoidectomy) — biopsy is part of the procedure.

Diagnostic Endoscopy

Diagnostic endoscopy of the respiratory system includes the access region, and a separate code should not be used for this routine evaluation.

Example 1: Anterior ethmoidectomy is performed endoscopically. It is routine to evaluate the access region — diagnostic nasal endoscopy is part of the procedure and should not be billed separately (CPT 31231–31235).

Example 2: Fiberoptic bronchoscopy. It is routine to evaluate the access region (nasal cavity, pharynx, and larynx) — only the bronchoscopy code is reported. Don't code nasal endoscopy & laryngoscopy; they're included in bronchoscopy.

- When laryngoscopy is required to perform endotracheal tube placement — code CPT **31500** (intubation, endotracheal, emergency procedure).
- Laryngoscopy required to perform a tracheostomy (code 31603 – 31614) — don't code laryngoscopy separately.
- CPT **31600** tracheostomy placement includes routine laryngotomy, laryngectomy, and laryngoplasty codes.
- Diagnostic endoscopy converted into an open surgical procedure — code only the open procedure.
- An open surgical procedure accompanied by an endoscopy at the same session to evaluate the surgical field — the surgical endoscopy is not separately reported.
- Diagnostic endoscopy (sinus endoscopy, laryngoscopy, bronchoscopy, pleuroscopy, etc.) is included in surgical endoscopy performed at the same encounter.

Note: If diagnostic endoscopy is performed and a decision is made to perform surgical endoscopy in the post-operative period, append modifier 58 as a staged procedure.

Example: Patient with aspiration of a foreign body. Bronchoscopy is performed indicating a foreign body obstruction and an attempt is made to remove it bronchoscopically — code only **31635** (surgical bronchoscopy with removal of foreign body); CPT 31622 (diagnostic bronchoscopy) is included.

If unsuccessful and a planned thoracotomy is decided upon, diagnostic bronchoscopy could be separately coded in addition to the thoracotomy. Modifier 58 may be used as a staged procedure.

Surgical sinus endoscopy includes a sinusotomy and diagnostic endoscopy.

Note: Bleeding control during a procedure is part of the endoscopy procedure and should not be billed separately (CPT 30901 — control of hemorrhage — is part of nasal endoscopy 31235).

If bleeding is a late effect requiring a procedure in the post-operative period, it would be billed with the appropriate CPT and modifier 78 (related procedure).

When endoscopy procedures are performed, the most comprehensive code describing the service rendered should be reported. If multiple procedures are performed and are not adequately described by a single CPT code, bill the services with the appropriate CPT and modifier 51 (multiple procedures) on the secondary services.

CODEX

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Digestive System Coding Guidelines

CPC Exam Tips — Digestive System Coding Guidelines

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1. Endoscopy Procedures — Overview

Endoscopy procedures of the digestive system are grouped below by the region examined and the CPT code range that applies to each. Use this table as a quick index before reading the detailed guidelines that follow.

Procedure	CPT Range
A. Esophagoscopy	43191 – 43232
B. Esophagogastroduodenoscopy (EGD)	43235 – 43210
C. Esophagus to Jejunum	44360 – 44373
D. Esophagus to Ileum	44376 – 44379
E. Ileoscopy through a stoma	44380 – 44384
F. Colonoscopy through a stoma	44388 – 44408
G. Proctosigmoidoscopy	45300 – 45327
H. Sigmoidoscopy	45330 – 45347
I. Colonoscopy	45378 – 45398
J. Anoscopy	46600 – 46615

2. Endoscopy Procedures — Definitions

Esophagoscopy

Visualization of the esophagus via a thin, tube-like instrument (**rigid** type or **flexible** type). Examination covers the cricopharyngeus muscle to the gastroesophageal junction, and it may also include a proximal region of the stomach. The instrument is inserted orally (**transoral**) or through the nose (**transnasal**).

CPT codes: 43191 – 43232

Esophagogastroduodenoscopy (EGD)

Visualization of the esophagus, stomach, and duodenum. A **flexible** instrument is inserted **transorally**. If the duodenum is deliberately not examined, append modifier 52 or 53 based on whether a repeat exam is planned.

Scenario	Modifier
No repeat exam is planned	Append modifier 52
Repeat exam is planned	Append modifier 53

CPT codes: 43235 – 43210

Small Intestine (Enteroscopy) Endoscopy

1. Antegrade Transoral

Route	CPT Range
Esophagus to Jejunum	44360 – 44373
Esophagus to Ileum	44376 – 44379

2. Retrograde via anal/colon stoma — **44799** (Unlisted procedure)

Note: If an endoscope cannot be advanced at least **50 cm beyond the pylorus**, code the procedure as an

Esophagogastroduodenoscopy.

Stomal Endoscopy

Examination of the intestine performed via the stoma.

Procedure	CPT Range
Ileoscopy through a stoma	44380 – 44384
Colonoscopy through a stoma	44388 – 44408

Proctosigmoidoscopy

Examination of the rectum, which may include examination of a portion of the sigmoid colon.

CPT codes: 45300 – 45327

Sigmoidoscopy

Examination of the rectum and sigmoid colon, which may include examination of a portion of the descending colon.

CPT codes: 45330 – 45347

Colonoscopy

Examination of the entire colon (rectum to cecum), which may include examination of the terminal ileum.

CPT codes: 45378 – 45398

Scenario	Modifier
Diagnostic/screening colonoscopy — scope cannot be advanced to the cecum	Modifier 53
Therapeutic colonoscopy — scope cannot be advanced to the cecum	Modifier 52

Anoscopy

Examination of the anus. **CPT codes: 46600 – 46615**

3. Endoscopy Procedures — General Coding Guidelines

1. Procedures like venous access, infusion and injection, non-invasive oximetry, and anesthesia provided during endoscopy procedures are considered part of the procedure.
2. If the same therapeutic endoscopy procedure is performed repeatedly in the same area, bill the service once. If different therapeutic procedures are performed, multiple endoscopy codes can be used accordingly.
3. Diagnostic endoscopy is always included in the therapeutic endoscopy.
4. When the small intestine endoscopy CPT range 44360 – 44386 is performed as part of another major procedure, the endoscopy is considered part of that procedure and should not be billed separately along with more extensive procedures such as enterostomy.
5. When diagnostic endoscopy of the hepatic, biliary, or pancreatic system using a separate approach is performed, append modifier 51.
6. When a biopsy is performed and followed by excision, destruction, or removal of the biopsied lesion, the biopsy is considered part of the procedure and should not be billed separately.
7. If bleeding occurs as a result of an endoscopic procedure and control of bleeding occurs in the same session as another major endoscopy procedure, it is considered part of that procedure. If bleeding control is performed in a

separate session following the endoscopy procedure, append modifier 78 (postoperative return to the operating room following the related procedure).

8. When sigmoidoscopy is performed along with colonoscopy in the same session, code only the colonoscopy.
9. When sigmoidoscopy and colonoscopy are performed as part of another major procedure (e.g., colectomy), these services are considered part of the procedure and should not be billed separately.
10. If the larynx is viewed using an esophagoscope, do not bill a laryngoscopy separately.

4. ERCP — Endoscopic Retrograde Cholangiopancreatography

ERCP is a procedure that combines upper gastrointestinal (GI) endoscopy and X-rays to diagnose and/or treat problems of the bile and pancreatic ducts.

11. An ERCP is considered complete if one or more of the ductal systems (biliary/pancreas) is visualized.
12. If ERCP is attempted but with **unsuccessful cannulation** of any ductal system, report the **Esophagogastroduodenoscopy** procedure codes instead.
13. For reporting purposes — Pancreas: major and minor ducts. Biliary tree: common bile duct, right hepatic duct, left hepatic duct, cystic duct.
14. ERCP with stent placement **includes** balloon dilation in that duct.
15. ERCP with **more than one stent** placement (different duct, or side by side in the same duct) — report CPT 43274 more than once with **modifier 59**.
16. ERCP with **multiple stent exchange** — report 43276 more than once with modifier 59.
17. ERCP with balloon dilation of multiple ducts is reported with modifier 59.
18. Sphincterotomy or dilation of the ductal stricture, when required before removing a stone from the duct in the same session, may be reported separately. **Note:** Dilation that is incidental to passage of an instrument to clear a stone is included.
19. Stone destruction **includes** stone removal in the same ductal system.

5. Allotransplantation Procedures

Any organ transplantation involves three distinct components:

Component	Description
A. Donor — cadaver or living	Harvesting the organ and cold preservation.
B. Backbench work	Standard preparation prior to transplant.
C. Recipient allotransplantation, with or without recipient organ removal	Transplantation of the allograft and care of the recipient.

6. Percutaneous Biliary Procedures

Approaches: **Transhepatic** and **Transcholecystic**.

Drainage Catheter Types

Type	Definition
A. External biliary drainage	Catheter placed into a bile duct to drain only externally.
B. Internal and external biliary drainage	Two-way catheter that terminates in the small intestine, draining internally as well as externally.
C. Internal biliary drainage (stent)	Percutaneously placed device that drains internally.

Stent Codes (47538, 47539, 47540)

Reported only once when:

- One or more overlapping or serial stents are placed within a single duct.
- Bridging more than one ductal segment via a single access.

Coded more than once, with modifier 59, when:

- Stents are placed side by side (double barrel) within a single duct.
- Two or more stents are placed into separate bile ducts.
- Two or more separate accesses are used.

Related Inclusion Rules

- Diagnostic cholangiography (47531 and 47532) is included with percutaneous biliary procedures.
- Balloon dilation (47542) is included in stent placement codes.
- Incidental removal of debris is included in catheter/stent placement codes.
- Balloon dilation (47542) is included in the removal of calculi or debris (47544).

Biliary endoscopy, percutaneous via T-tube: **47552 – 47556**

7. Hernioplasty, Herniorrhaphy & Herniotomy

Hernia repair codes are based on:

- Type of hernia (inguinal, femoral, incisional, etc.).
- Initial or recurrent.
- Reducible or incarcerated/strangulated.

Post-conception age: Age at birth plus age at the time of operation — e.g., preterm birth at 25 weeks plus 15 weeks of age at the time of operation equals 40 weeks.

The excision/repair of **strangulated organs** such as testicle, intestine, or ovaries is reported using the appropriate code in addition to the hernia repair codes.

- Don't code CPT 49568 (mesh or other prostheses) along with hernia repair codes, **except** for incisional hernia repair codes (49560 – 49566).
- Codes 49491 – 49451 are **unilateral** procedures — append **modifier 50** for bilateral procedures.
- For reduction and repair of an intra-abdominal hernia — **CPT 44050**.

Omphalocele

A birth defect in which the intestine or abdominal organs are outside the body because of a hole in the belly button.

Type	Description
A. Small	A small portion of the intestine is outside the body.
B. Large	Involves organs such as the liver, spleen, and intestine.

8. Gastrostomy / Duodenostomy / Jejunostomy / Colonic Tube

A nasogastric tube or orogastric tube is included. Codes are based on the stage of the procedure:

Stage	CPT Range
A. Initial placement	49440 – 49442
B. Conversion	49446
C. Replacement	49450 – 49452
D. Removal of obstructive material	49460

Stage	CPT Range
E. Checking the tube	49465

Note: If an existing tube is removed and a new tube is placed via **separate access**, this is not considered a replacement — code it using the Initial placement codes.

- Endoscopic placement of percutaneous gastrostomy tube — **CPT 43246**.
- Change of gastrostomy tube, percutaneous, without imaging or endoscopic guidance — **CPT 43760**.
- Placement of enterostomy/cecostomy tube, open — **CPT 44300**.

9. Laparoscopy Procedures

Minimally invasive surgery in which a fibre-optic instrument is inserted through a small incision in the abdominal wall to examine or operate on the interior of the abdominal or pelvic cavities.

Rule: Surgical laparoscopy always **includes** diagnostic laparoscopy.

10. Bariatric Surgery

Weight loss is achieved by reducing the size of the stomach with a **gastric band**, or through the **removal of a portion** of the stomach (sleeve gastrectomy or biliopancreatic diversion with duodenal switch), or by **resecting and re-routing** the small intestine to a small stomach pouch (gastric bypass surgery).

11. Hemorrhoids / Piles

Swollen and inflamed veins in the rectum and anus that cause discomfort and bleeding.

- Internal hemorrhoids
- External hemorrhoids

Don't report: Anoscopy (46600) along with hemorrhoid procedures.

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Urinary System Surgery Guidelines

CPT 50100 – 53899 · General Coding Guidelines for CPC Exam Prep

1. General Coding Guidelines — Urinary System (50100 – 53899)

by Coding Info · February 14, 2018 · CPC Exam Tips — Urinary System Surgery Coding Guidelines

1. In general, both male and female urinary system surgical procedures include the placement of a urinary catheter. Catheterization codes **51701, 51702, and 51703** are not separately reported when done at, or before, other surgical procedures that require this as part of the procedure.
2. Renal allo-transplantation involves three distinct components of physician work:

A. **Cadaver / Living donor nephrectomy —** Harvesting the graft and cold preservation of the graft.

B. **Backbench work —** Standard preparation of the renal allograft prior to transplantation.

C. **Recipient renal allo-transplantation —** Transplantation of the allograft and care of the recipient.

1. **CPT 52204** (Cystourethroscopy with biopsy(s)) — this service cannot be billed with units if multiple biopsies are performed. Only one unit is allowed.
2. When a biopsy procedure is followed by destruction or excision of that particular lesion during the same session, the biopsy is included in the major procedure and should not be billed separately. Modifier **59** is allowed if the procedures are performed at different sessions or on different lesions. Multiple biopsies of the same type of lesion can be billed with a single unit.
3. **Regarding endoscopy procedures:**

- Open procedure always includes the endoscopy procedure if it is performed as part of the open procedure.
- Scout endoscopy should not be reported separately along with a diagnostic or therapeutic endoscopy procedure.
- Diagnostic endoscopy is always included in the therapeutic endoscopy.
- When multiple endoscopy procedures are performed, select the most appropriate CPT code describing all services rendered, or bill the services with modifier 51.

Example: Renal endoscopy through an established nephrostomy — biopsy of a lesion with fulguration is done along with removal of a calculus.

Answer: 50557 & 50561 – 51 (biopsy is included)

- When multiple endoscopy approaches are necessary at the same session due to different medical necessity, code separately with modifier 51.

Example: Renal endoscopy with cystourethroscopy.

Note: If multiple endoscopy approaches are necessary to perform the same procedure at the same session due to complexity of the condition, code only the successful endoscopic approach.

1. Don't report CPT **51701, 51702** (insertion of bladder catheter) & CPT **51700** (bladder irrigation) except when performed independently.
2. Don't report CPT **51784** (EMG) and CPT **51785** (needle EMG) when EMG is performed as part of biofeedback.
3. CPT codes **50740 – 50810** (ureteral anastomosis) — append modifier 50 or RT/LT if the procedures are performed in bilateral ureters.
4. Urethrorrhaphy (CPT **53502 – 53515**) is included in urethroplasty procedures — shouldn't be billed separately.
5. The insertion and removal of a temporary ureteral catheter (CPT **52005**) during diagnostic or therapeutic cystourethroscopy / pyeloscopy is included in CPT 52320 – 52356 and shouldn't be coded separately. To report insertion of a self-retaining, indwelling stent during diagnostic or therapeutic cystourethroscopy / pyeloscopy, report CPT **52332** in addition to the primary procedure (CPT 52320–52330, 52334–53252, 52354, 52355) and append modifier 51.
6. CPT **52332** is a unilateral procedure code — for bilateral procedures, use modifier 50.
7. CPT **52700** (transurethral drainage of prostatic abscess) is included in other transurethral prostatic procedures.
8. CPT **55000** (puncture aspiration of hydrocele) is included in services involving the tunica vaginalis (the serous membrane covering the testes), scrotum, vas deferens, and inguinal hernia repairs.
9. Female pelvis examination is included in gynecology procedures — shouldn't be coded separately. Similarly, CPT **57410** (pelvic exam under anesthesia) is included in gynecology procedures.

10. CPT **58660** (lysis of adhesions) is included in other major surgical laparoscopic procedures.
11. CPT **57400** (dilation of vagina) or **57800** (dilation of cervical canal) is included in vaginal approach procedures — unless the CPT description states "without cervical dilation."
12. Colposcopy (CPT **56820, 57420, 57452**) is included in surgical procedures.

2. Percutaneous Procedures

Nephrostomy Catheter

Procedure	CPT Code	What's Included
Placement of nephrostomy catheter	50432	Diagnostic nephrostogram, imaging guidance, and S&I
Exchange of nephrostomy catheter	50435	Diagnostic nephrostogram, imaging guidance, and S&I
Conversion of nephrostomy catheter into nephroureteral catheter	50434	Diagnostic nephrostogram and/or ureterogram, imaging guidance, and S&I
Removal of nephrostomy catheter requiring fluoroscopy guidance	50389	Fluoroscopy guidance

Note: For removal without any guidance, bill the appropriate E/M service.

Nephroureteral Catheter

Procedure	CPT Code	What's Included
Placement of nephroureteral catheter	50433	Diagnostic nephrostogram and/or ureterogram, imaging guidance, and S&I
Removal and replacement of nephroureteral catheter	50387	Requires fluoroscopy guidance; includes the S&I

Note: For removal alone, without any guidance, bill the appropriate E/M service.
The above set of codes is for unilateral procedures — for bilateral procedures, append the appropriate modifier.

Ureteral Stent Procedures

Percutaneous placement of ureteral stent:

Access Route	CPT Code
Via pre-existing nephrostomy tract	50693
Via new access, without separate nephrostomy catheter	50694
Via new access, with separate nephrostomy catheter	50695

Includes: Diagnostic nephrostogram / ureterogram, imaging guidance, and all S&I.

Removal & replacement of ureteral stent:

Procedure	CPT Code
Removal and replacement — percutaneous approach	50382
Removal only — percutaneous approach	50384
Removal and replacement — transurethral approach	50385
Removal only — transurethral approach	50386

The above procedures include the S&I. For bilateral procedures, append modifier 50.

CODEX

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Nervous & Pain Management Coding Guidelines

CPC Exam Tips — Nervous System Coding Guidelines

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1. Intrathecal Catheter for Pain Management

An intrathecal catheter is a tube that is inserted into the spinal fluid; the other end is buried under the skin and comes out to allow drugs to be given through the catheter. Drugs (painkillers) are given slowly and continuously from a small pump attached to the catheter.

What Is an Intrathecal Pain Pump?

An intrathecal pump is a medical device used to deliver medications directly into the space between the spinal cord and the protective sheath surrounding the spinal cord.

What Is in a Pain Pump?

The intrathecal pump system consists of a pump/reservoir implanted between the muscle and skin of the abdomen, and a catheter that carries pain medication from the pump to the spinal cord and nerves. The pump is programmed to slowly release medication over a period of time.

Reservoir / Pump Implantation

CPT Code	Description
62360	Implantation or replacement of device for intrathecal or epidural drug infusion; a subcutaneous reservoir (10 days global).
62361	Implantation or replacement of device for intrathecal or epidural drug infusion; a nonprogrammable pump (10 days global). Device code C1891 — infusion pump, non-programmable, permanent (implantable).
62362	Implantation or replacement of device for intrathecal or epidural drug infusion; programmable pump, including preparation of pump, with or without programming (10 days global). Device code C1772 — infusion pump, programmable (implantable).

Note: Pocket creation is included with the implanted pump placement.

Removal of Reservoir or Pump

CPT 62365: Removal of subcutaneous reservoir or pump, previously implanted for intrathecal or epidural infusion (10 days global).

Analysis and/or Reprogramming of Implantable Infusion Pump

CPT Code	Description
62367	Electronic analysis of programmable, implanted pump for intrathecal or epidural drug infusion (includes evaluation of reservoir status, alarm status, drug prescription status); without reprogramming or refill (global period: XXX).
62368	Same as above; with reprogramming (global period: XXX).
62369	Same as above; with reprogramming and refill.
62370	Same as above; with reprogramming and refill, requiring the skill of a physician or other qualified healthcare professional.

According to NCCI: programmable pump analysis, with or without reprogramming, is a component of the pump placement (62361, 62362) and therefore is not reported together with it.

Refilling and Maintenance of Reservoir or Pump (Without Reprogramming)

CPT Code	Description

CPT Code	Description
95990	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular); includes electronic analysis of pump when performed.
95991	Same as above; requiring the skill of a physician or other qualified healthcare professional.

Tunnelled Catheter Placement

Report CPT 62350 / 62351 only if this is a tunnelled catheter — percutaneous placement is reported with the injection codes. Report additional codes for pump placement.

Catheter Implantation

CPT Code	Description
62350	Implantation, revision, or repositioning of tunnelled intrathecal or epidural catheter for long-term medication administration via an external pump or implantable reservoir/infusion pump; without laminectomy (10 days global).
62351	Same as above; with laminectomy (90 days global). Device code C1755 — catheter, intraspinal.

Note: CY 2011 devices for which the “FB” or “FC” modifier must be reported with the ASC procedure code when furnished at no cost, or with full or partial credit.

Removal of Intrathecal Catheter

CPT 62355: Removal of previously implanted intrathecal or epidural catheter (10 days global).

Note: Medicare provides C-codes for hospital use in billing Medicare for medical devices in the outpatient setting. Other payers may also accept C-codes, but regular HCPCS II device codes are generally used for billing non-Medicare payers. ASCs should not assign or report HCPCS II device codes for devices on claims sent to Medicare — Medicare generally does not make a separate payment for devices in the ASC; instead, payment is “packaged” into the payment for the ASC procedure. ASCs are specifically instructed not to bill HCPCS II device codes to Medicare for devices that are packaged.

2. How to Code Facet Joint Injections (64490 – 64495)

A facet joint injection is a minimally invasive procedure that can temporarily relieve neck or back pain caused by inflamed facet joints.

Facet Joint Injection Technique

The physician preps and anaesthetizes the patient, inserts the needle through the skin, and advances it to the proper position within the joint using either fluoroscopy or CT imaging guidance. The physician then injects the therapeutic or diagnostic agent, such as a steroid or anaesthetic mixture, removes the needle, and ensures that the site obtains hemostasis.

Codes by Vertebral Region

The codes are divided based on the vertebral region:

Region	CPT Range
1. Cervical or Thoracic	64490 – 64492
2. Lumbar or Sacral	64493 – 64495

Facet Joint Injection — Cervical or Thoracic Region

CPT Code	Description

CPT Code	Description
64490	Injection(s), paravertebral facet joint, with image guidance (fluoroscopy or CT), cervical or thoracic; single level.
+ 64491	Second level.
+ 64492	Third and any additional level(s).

Facet Joint Injection — Lumbar or Sacral Region

CPT Code	Description
64493	Injection(s), paravertebral facet joint, with image guidance (fluoroscopy or CT), lumbar or sacral; single level.
+ 64494	Second level.
+ 64495	Third and any additional level(s).

Ultrasound-Guided Facet Joint Injections (Category III Codes)

If ultrasound guidance is used, report 0213T – 0218T (Category III codes).

Region	CPT Code	Description
Cervical or Thoracic	0213T	Single level
Cervical or Thoracic	0214T	Second level
Cervical or Thoracic	0215T	Third and any additional level(s)
Lumbar or Sacral	0216T	Single level
Lumbar or Sacral	0217T	Second level
Lumbar or Sacral	0218T	Third and any additional level(s)

Note: Medicare won't cover Category III codes; some commercial insurance plans may cover these services. Check with your payer for coverage.

Coding Guidelines

- **A. For bilateral** paravertebral facet injection procedures, append **modifier 50** with CPT 64490 / 64493. Modifier 50 **cannot** be appended to the add-on codes 64491, 64492, 64494, 64495 — instead, bill with **unit 2** if performed bilaterally.
- **B. Image guidance** such as CT (77012) or fluoroscopy (77003) is required to perform paravertebral facet joint injections but is **inclusive** with CPT 64490 – 64495, so imaging guidance is not separately reportable. If imaging is not used, report the service with CPT 20552 – 20553.

Worked Examples

Example 1: Facet joint injections at L1-L2 and L2-L3 — two levels total. **Answer: 64493, +64494.** CPT 64493 is used for the first level and CPT 64494 for the second level.

Example 2: Facet joint injections at L1-L2, L2-L3, and L3-L4 — three levels total. **Answer: 64493, +64494, +64495.** These are not indented codes covering all levels in one code — use the primary code plus add-on codes for the second and third levels (any further levels are included in the last add-on code, 64495). Each code represents one level: 64493 (first level), 64494 (second level), 64495 (third and any additional levels). The description of +64495 is not “three levels” — it is the third level.

Example 3: Facet joint injections at L1-L2, L2-L3, L3-L4, and L4-L5 — four levels total. **Answer: 64493, +64494, +64495.** CPT 64495 includes the third and fourth level.

3. How to Code Epidural Steroid Injection

An epidural steroid injection is performed to reduce the inflammation and pain associated with nerve root compression. Nerve roots can be compressed by a disc herniation/bulge, lumbar or cervical spinal stenosis, and other spine-related conditions that lead to nerve compression.

A needle is inserted into the epidural space — the outermost part of the spinal canal, located outside the dural membrane — under imaging guidance (CT or fluoroscopy) to administer the steroid.

Injection Sites

Site	Purpose
Cervical epidural injection	Performed in the neck to provide relief to nerve roots in the neck.
Thoracic epidural injection	Performed in the thoracic region to provide relief to nerve roots in the thoracic area.
Lumbar epidural injection	Performed at the lower back to provide relief to nerve roots in the lumbar area.

A radiologist typically performs the epidural injection; however, an orthopaedic surgeon or neurosurgeon may also administer it. Any imaging performed during the epidural steroid injection procedure itself concludes with the procedure — no follow-up image interpretation is required.

Interlaminar Epidural or Subarachnoid Injection

Single Injection — Injecting substances at one or more levels and then removing the catheter.

Region	Without Imaging Guidance	With Imaging Guidance
Cervical or Thoracic	62320	62321
Lumbar or Sacral	62322	62323

Infusion (Continuous) — The catheter is left in place to deliver substances over a prolonged period.

Region	Without Imaging Guidance	With Imaging Guidance
Cervical or Thoracic	62324	62325
Lumbar or Sacral	62326	62327

Billing Guidelines — Interlaminar / Subarachnoid Injection

1. Guidance is included.
2. Coded only once, based on the region at which the needle entered the body.

Transforaminal Epidural Injections

CPT Code	Description
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level.
+ 64480	Each additional level.
64483	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); lumbar or sacral, single level.
+ 64484	Each additional level.

Billing Guidelines — Transforaminal Epidural Injections

3. Guidance is included.
4. For transforaminal epidural injection under ultrasound guidance, report 0228T – 0231T.
5. For a bilateral procedure: CPT 64479 / 64483 — add **modifier 50**, but **not** with the add-on codes (64480 or 64484) — instead, bill those twice.

4. References

- University Hospitals Birmingham — Intrathecal Catheters patient information (uhb.nhs.uk).
- doereport.com — surgical exhibit reference on intrathecal pump placement.
- AHIMA Campus — audio reference, RB040308 (ahima.org).
- National Center for Biotechnology Information — PMC2080496 (ncbi.nlm.nih.gov).
- Medtronic Professional — intrathecal drug delivery (T)DD coding reference (medtronic.com).