CHAPTER 5 – NON-E/M CPT CODES

Although all physicians need to know some E/M service codes in detail, the number and which non-E/M codes they need to know depend on their specialty and subspecialty. Given that there are thousands of non-E/M codes to cover and that each specialty/subspecialty uses its own CPT codes, this chapter will provide only a superficial discussion of common non-E/M CPT codes used by different pediatricians. I strongly recommend that physicians take their time and scroll through the pages of a CPT code book and the AAP billing for pediatrics book to see which non-E/M CPT codes can be reported in their practice. You will be surprised by how many CPT codes you didn't know about that can be used to increase RVU generation. We will divide this chapter into the practice settings and subspecialties.

Please note that only a few sample codes are listed below without code descriptors or much explanation, just to demonstrate other potential code groups. One needs to read more about these codes before using them. A short list of frequently used non-E/M service codes was provided in tables at the end of the chapter.

OFFICE/OUTPATIENT PRACTICE

Depending on individual physicians' comfort levels, pediatricians can perform and report many surgical procedures in the office. These procedures include incision and drainage, removal of skin tags including congenital accessory digits, wedge excision of skin of nail fold for ingrown toe nail, laceration repairs, suture removal, simple burn care, destruction of benign lesions/warts, chemical cauterization of granulation tissue, foreign body removal from skin/eye/ear/nose, controlling nose bleed, venipuncture or blood sampling for diagnostic study, replacement of gastrostomy tube, urinary catheterization, labial adhesion lysis, newborn circumcision and removal of impacted cerumen.

Office physicians can also report the professional component of radiological studies, such as CXRs, if there is no radiologist read. Laboratory tests performed in the office, such as urine analysis and rapid strep/influenza/RSV, also needed to be reported with CPT codes.

The most important medicine codes that pediatricians need to know are vaccine administration codes. There are 6 different codes for vaccine administration. The first group applies specifically to pediatric patients and involves physician counseling on the benefits and side effects of each vaccine component. So if you discuss a pentavalent vaccine with family, you have provided 5 different counseling on 5 different infectious agents.

90460: *immunization administration through 18 years of age via any route of administration, with counseling by physician; first or only component of* ***each vaccine*** *or toxoid* is used for each vaccination injection

90461: each additional vaccine or toxoid component.

These 2 codes can only be used when the patient is under 18 years old and counseling is provided. If the patient is older than 18 years or if the physician did not provide counseling, then these codes cannot be reported.

Example: a 15-month-old patient receives physician counseling and DTap-IPV/Hib, PCV13, and influenza vaccines. 3 units of 90460 are reported for each vaccine as stated in the code. The physician counseled on 7 different infectious agents, and a total of 7 agents were administered. 3 of the

counseling/administration are covered in 3 units of 90460; the remaining 4 are reported with 4 units of 90461.

The remainder of vaccine administration codes are for patients over the age of 18 or patients of any age who didn't receive counseling on vaccines from a physician.

90471: Immunization administration (includes PC, ID, SQ or IM); 1 vaccine (single or combination)

90472: each additional (single or combination) vaccine administered

90473: Immunization administration by intranasal or oral route; 1 vaccine (single or combination)

90474: ; each additional vaccine (single or combination)

90471/90472 is used for parenteral vaccines. 90473/90474 is used for nasal or oral vaccines. A big difference between 90460 and 90471/90473 is that the 90460 group covers all components of the vaccine, whereas the 90471/90473 group only covers each shot or administration, but not the components. Because of this, reimbursement is more with the 90460 group (99460-99461).

Example: a 15-month-old patient receives no physician counseling (nurse visit for vaccines) and receives DTap-IPV/Hib, PCV13, and influenza vaccines. 1 unit of 90471 is reported for the first vaccine, and 2 units of 90472 are reported for the remaining 2 vaccines.

Each vaccine has a unique CPT code. This unique vaccine code must also be reported with the administration codes. CPT code for PCV 13 is 90670.

Other medicine CPT codes that office physicians can use include immunoglobulins like tetanus Ig and its administration codes, hearing and vision screen, EKG, inhaler/nebulization treatments, pulse oximetry, and IV infusion. Hearing and vision screening codes can be reported with well-child check visits.

There are codes that can be used when care is delivered to a patient when the office is not supposed to be open or when care is delivered on an emergency basis. When these codes are used, reimbursement may be higher. There are 3 codes that may bring higher RVU in this category.

99050: Services provided in the office at times other than regularly scheduled office hours, when office is normally closed (holidays, Saturday, Sunday), in addition to the basic service.

99051: services provided in the office during regularly scheduled evening, weekend or holiday office hours, in addition to the basic service.

99058: Services provided on an emergency basis in the office, disrupting other scheduled services, in addition to the basic service

INPATIENT PRACTICE

Many of the surgical procedures listed under outpatient may also be performed by hospitalists, but in a hospital setting, these procedures are most often performed by consulting physicians. IO insertion, venipuncture requiring physician skills, bladder aspiration with needle, foley insertion, LP, bone marrow aspiration, and moderate sedation are among the few procedures pediatric hospitalists may perform

and report with appropriate CPT codes. If a hospitalist uses propofol for procedural sedation, then anesthesia codes should be reported.

SUBDIVISIONS

Pediatric and neonatal intensivist may report the same procedural codes used by outpatient and hospitalist but on top of that they may need to report codes for intubation, CPR, cardioversion, placement of various central lines including PICC and umbilical lines, placement of arterial line, IO insertion, anesthesia codes when deep sedation is used, moderate sedation, g-tube or tracheostomy change, tracheostomy, bronchoscopy, thoracentesis, pericardiocentesis, chest tube placement, ECMO codes, exchange transfusion, LP, initiation of hypothermia. Intensivists may use radiology codes for procedures that require imaging guidance, such as ultrasound-guided vascular access or needle placement.

Pulmonologists may use codes from the respiratory section of surgery (30, 31, 32 thousand series), like codes for various forms of bronchoscopy, and the respiratory section of medicine (94 thousand series), like codes for pulmonary function tests, inhaler/nebulizer administration, or evaluation/teaching.

Cardiologists may use codes from the cardiovascular section of surgery (33 to 37 thousand series), like codes for pericardiocentesis, insertion of transvenous pacemaker, and under the cardiovascular section of medicine (92, 93 thousand series), like codes for EKG, ECHO, ASD closure, various cardiac catheterizations, and stent placement.

Gastroenterologists may use codes from the digestive section of surgery (40 thousand series), such as codes for upper/lower endoscopies and liver biopsy, as well as codes from the gastroenterology section under medicine (91 thousand series), such as codes for GI motility studies and acid reflux tests.

Endocrinologists may use codes from the endocrine section of medicine (95 thousand series), like codes for ambulatory continuous glucose monitoring.

Neurologists may use codes from the neurology section of surgery (61 to 64 thousand series), like code for LP, and may use codes from the neurology section of medicine (95 thousand series), like codes for sleep study, EEG, and nerve conduction studies.

Hematologists/Oncologists may use codes from the hematology section of surgery (38 thousand series), like codes for bone marrow transplantation and chemotherapy administration codes under medicine (96 thousand series.

Nephrologists may use codes from the urinary section of surgery (50 to 53 thousand series), like codes for renal biopsy, Foley insertion, and may use codes from the dialysis section of medicine (90 thousand series), like codes for various dialysis care services.

Adolescent medicine may use IUD insertion code under female reproductive system/surgery and behavioral evaluation codes under medicine.

Rheumatologists may use codes from the musculoskeletal section of surgery (20 thousand series), like codes for various joint injections, and may use codes from medicine, like codes for various immune globulin and biologic drug administrations.

Allergist/Immunologist may use codes from the allergy section of medicine (95 thousand series), like codes for various allergy testing and immunotherapy.

Geneticists may use codes from the genetic section of medicine (96 thousand series), like codes for various genetic counseling services.

There are probably not many specific procedures for **Infectious Disease** physician because all cultures and lab work are reported by the hospital/pathologist.

Emergency Medicine specialists care for a very broad patient population and a wide range of pathologies. Given this ER physicians may use most of the codes listed for other subspecialties and more.

Developmental/Behavioral specialists may use codes from the behavioral section of medicine (96 thousand series), like codes for behavioral screen and evaluation.

Child psychiatry specialists may use codes from the psychiatry section of medicine (90 thousand series), like codes for various psychiatric services.

Obviously, the above list for each subspecialty is a significant underestimate, given concern for space and the fact that it was written by a pediatric intensivist. It's quite likely that plenty more potential codes would be identified when each subspecialist scrolls through the pages of the CPT code book. At least the above list gives each subspecialist a clue about where to look for the codes that may relate to their practice.

Further explanations of each non-E/M service CPT code group and a short list of procedures commonly used by pediatric providers are given below. CPT codes are written with a – sign between the numbers to make them easier to read **(not in the original CPT code).** CPT codes look less confusing with the – sign placed after the first two digits.

Anesthesia CPT codes

Any CPT code that starts with 0 is an anesthesia code. These codes are not reserved for anesthesiologists and must be used by pediatric intensivists or hospitalists when providing deep sedation for the procedures listed below.

ANESTHESIA CPT CODES	
Head/Neck	
00-104	Anesthesia for electroconvulsive therapy
00-124	Anesthesia for otoscopy
00-148	Anesthesia for ophthalmoscopy
Thorax/Intrathoracic	
00-410	Anesthesia for…… electrical conversion of arrythmias
00-520	Anesthesia for closed chest procedures (including bronchoscopy)
00-524	Anesthesia for pneumocentesis (thoracentesis)
00-532	Anesthesia for access to central venous circulation
00-540	Anesthesia for thoracotomy procedures …. - - - > *(for chest tube insertion!)*
00-560	Anesthesia for procedures on the heart, pericardial sac …. - -> *(for pericardiocentesis!)*

Spine	
00-635	Anesthesia for diagnostic/therapeutic LP
Abdomen	
00-702	Anesthesia for percutaneous liver biopsy
00-731	Anesthesia for upper GI endoscopic procedures
00-732	Anesthesia for ERCP
00-811	Anesthesia for lower intestinal endoscopic procedures
00-813	Anesthesia for combined upper/lower intestinal endoscopy
00-840	Anesthesia for intraperitoneal procedures in lower abdomen, NOS
Pelvis	
01-112	Anesthesia for bone marrow aspiration and or biopsy
Upper leg	
01-220	Anesthesia for all closed procedures involving upper 2/3 femur
Knee/popliteal	
01-420	Anesthesia for all cast applications, knee
Lower leg	
01-490	Anesthesia for lower leg cast application
Shoulder/Axilla	
01-680	Anesthesia for shoulder cast application
Upper arm/elbow	
01-730	Anesthesia for all closed procedures on humerus and elbow
Fore arm, wrist, hand	
01-860	Anesthesia for forearm, wrist, hand cast application removal…..
Radiological procedures	
01-922	Anesthesia for noninvasive imaging or radiation therapy
Burn	
01-951	Anesthesia for 2nd and 3rd degree burn excision, <4% BSA

Surgical CPT codes

CPT codes starting with 1 to 6 (10 thousand to 60 thousand series) are surgical codes. Non-surgical physicians, including pediatricians, use many of these surgical codes. A unique feature of surgical CPT codes is the surgical package. A surgical package simply means that other services are bundled within the procedure. The surgical package is also known as the global surgical period or postoperative period.

Surgical package contains:

1. E/M services subsequent to the decision to surgery on the day before and/or on the day of surgery (including history and examination).
2. Local or topical anesthesia.
3. Immediate post-operative care, writing orders, evaluation of patient in the recovery area.
4. Typical postoperative follow-up care.

Per CPT, complications, exacerbations, recurrences, and other unrelated diseases or pathologies are not included in the surgical package. The surgical package for a diagnostic procedure, such as an endoscopy, ends when the patient recovers from the procedure. Per CMS, all post-operative care, including complications related to the procedure itself, is included in the surgical package and not billed separately, except for complications requiring a return to the OR.

Apart from diagnostic procedures, CPT does not specify the duration of the surgical package. CMS has defined 3 surgical packages, or global surgical periods, that set the standard for the entire healthcare industry. These periods are 0, 10, and 90 days of the surgical package or post-operative periods. Procedures with O and 10 days of post-operative periods are called minor procedures, and procedures with a 90-day post-operative period are called major procedures.

CMS rules for additional related E/M services are given in the table below. Unrelated E/M services are never in the surgical period and may be reported separately with the modifier of 24.

Global Period	**0 day**	**10 days**	**90days**
Related E/M services before the date of procedure	Not included	Not included	All related service 1 day before surgery if after decision for surgery
Related E/M services on the date of procedure	E/M services typically included	E/M services typically included	All related service except E/M service at which decision for surgery is made
Related Postoperative E/M services	Same day (day 0 only)	All related care for 10 days	All related care for 90 days

Based on the above table, any related E/M service you provide on the day of a minor procedure is bundled in the procedure and not reported separately unless it is significantly beyond the pre-service time of that procedure. For major surgeries, surgeons can use the modifier 57 (decision to surgery) to indicate that E/M service was separate and beyond the pre-service time of the surgery.

Pediatricians rarely perform major procedures, so only 0 and 10 days of the surgical package are relevant for our practice and will affect how we report these codes. For example, you saw a 1-year-old with fussiness, obtained a complete history, performed a full system examination, and, to your surprise, found an ear foreign body, which you removed, and the fussiness resolved. How do you code for your services? Do you bill both for the office code (99212) and the procedure code (69200)? In this example, because you did not know the problem initially and performed an E/M service to find it, both the E/M service code and the procedure code can be reported together. Modifier 25 is added to 99212 to indicate that this EM service was separate from the procedure.

What if the patient is 10 years old and comes to you with a complaint of ear pain? You obtain a limited history and perform only an ear examination, find a foreign body, and remove it. How do you code for this encounter? In this case, the E/M service you provided, which is limited history and exam, is considered within the preservice of ear foreign body removal, and it makes sense. You should report only the procedure or the office code, not both at the same time. You can determine whether the office code or the procedure code has a higher RVU and report only the code with the higher RVU.

Another example, you saw a patient with ADHD and adjusted medications. The patient also complained about ear pain, and you identified and removed a foreign body. In this case, because ADH is unrelated to foreign body removal, both services should be reported simultaneously. (99214 with modifier 25 and 69200). Foreign body removal from the ear, or impacted cerumen removal, has a 0-day post-operative period and covers only the day of the procedure.

You reduced a nursemaid's elbow, which has a 10-day post-operative period, and the child came back 5 days later with an ear infection. In this situation, you should add modifier 24 to your office code, like 99213, to show that this E/M service was unrelated to nursemaid's elbow reduction.

SURGICAL CPT CODES	
Skin/Integumentary	
10-030	Image guided fluid collection drainage (eg, abscess, hematoma, cyst) soft tissue, percutaneous
10-060	I&D of abscess, simple or single (nonspecific location)
10-061	I&D of abscess, complicated or multiple
10-120	Incision and removal of foreign body, subcutaneous tissue; simple
10-121	Incision and removal of foreign body, subcutaneous tissue; complicated
11-100	Biopsy of skin SQ tissue, mucus membrane
10-120	Incision and removal of foreign body, SQ tissues, simple
10-160	Puncture aspiration of abscess, hematoma, bulla or cyst
11-200	Removal of skin tags (up to 15 by with scissor, ligature strangulation, electrocautery, chemical) *(removal of 6th digit)*
11-765	Wedge excision of skin of nail fold (for ingrown toe nail)
12-001	Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and or extremities (including hand and feet); 2.5cm or less
12-011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips and/or mucous membranes; 2.5 cm or less
15-853	Removal of sutures or staples not requiring anesthesia
15-854	Removal of sutures and staples not requiring anesthesia
16-000	Initial treatment of 1st degree burn, when no more than local treatment is needed
16-020	Dressing and/or debridement of partial thickness burns, initial or subsequent; small <5%TBSA
16-025	Medium, 5-10% TBSA
17-110	Destruction (eg, cryosurgery, electrosurgery, chemosurgery, surgical curettement) of benign lesions other than skin tags (*eg warts);* up to 14 lesions
17-111	; 15or more lesions
17-250	Chemical cauterization of granulation tissue
Musculoskeletal	
20-610	Arthrocentesis, aspiration and/or injection major joint or bursa (shoulder, hip, knee) without imaging guidance
20-950	Monitoring of interstitial pressure (includes insertion of device) in detection of compartment syndrome
23-500	Closed treatment of clavicular fracture; without manipulation

24-640	Closed treatment of radial head subluxation in child, nursemaid elbow, with manipulation
26-010	Drainage of finger abscess, simple
26-011	Drainage of finger abscess; complicated (eg, felon)
29-125	Application of short arm splint
Respiratory	
30-100	Biopsy intranasal
30-300	Removal foreign body, intranasal, office type procedure
30-310	Removal foreign body, requiring general anesthesia
30-901	Control nasal hemorrhage, anterior, simple (limited cautery and/or packing) any method
30-903	Control nasal hemorrhage, anterior, complex (extensive cautery and/or packing) any method
31-231	Nasal endoscopy, unilateral or bilateral
31-500	Intubation, endotracheal, emergency procedure
31-502	Tracheostomy tube change, prior to establishment of fistula tract
31-505	Laryngoscopy, indirect, diagnostic
31-515	Laryngoscopy direct, for aspiration
31-603	Tracheostomy, emergency procedure, trans tracheal
31-605	Tracheostomy, emergency procedure; cricothyroid membrane
31-612	Tracheal puncture, percutaneous with transtracheal aspiration and/or injection
31-622	Bronchoscopy, rigid or flexible
31-624	Bronchoscopy, rigid or flexible, with BAL
31-635	Bronchoscopy, rigid or flexible , with removal of foreign body
32-551	Tube thoracostomy, open *(Chest tube insertion, surgical)*
32-554	Thoracentesis, needle or catheter aspiration of pleural space; without imaging guidance
32-555	Thoracentesis, needle or catheter aspiration of pleural space; with imaging guidance
32-556	Pleural drainage, percutaneous, with insertion of indwelling catheter; without imaging guidance *(Pigtail insertion)*
32-557	;with imaging guidance *(Pigtail insertion)*
Cardiovascular/Heme	
33-016	Pericardiocentesis including imaging guidance, when performed
33-210	Insertion of temporary transvenous single chamber pacemaker catheter
33-211	Insertion of temporary transvenous dual chamber pacemaker catheter
33-619	Norwood procedure
33-946	VV ECMO initiation (1st day)
33-947	VA ECMO initiation (1st day)
33-948	VV ECMO, daily management each day (subsequent)
33-949	VA ECMO, daily management each day (subsequent)
36-000	Introduction of needle or intracatheter, vein
36-400	Venipuncture, younger than 3 years, necessitating skill of physician, not to be used for routine venipuncture; femoral or jugular vein
36-405	; scalp vein
36-406	; other vein

36-410	Venipuncture, age 3 years or older, necessitating skill of physician, for diagnostic or therapeutic purposes (not to be used for routine venipuncture)
36-415	Collection of venous blood by venipuncture
36-416	Collection of capillary blood specimen
36-420	Venipuncture, cutdown, ,<1year
36-425	Venipuncture, cutdown, ,>1year
36-430	Transfusion, blood or blood components *(report only if required to be infused by physician)*
36-440	Push transfusion, blood, 2 years and younger *(report only if required to be pushed by physician)*
36-450	Exchange transfusion, blood; newborn
36-455	Exchange transfusion, blood; other than newborn
36-456	Partial exchange transfusion, blood, plasma or crystalloid necessitating skill of a physician or other QHCP, newborn
36-510	Umbilical vein catheterization
36-511	Therapeutic apheresis; for WBC
36-512	Therapeutic apheresis; for RBC
36-513	Therapeutic apheresis; for Platelets
36-514	Therapeutic apheresis; for plasmapheresis
36-555	Insertion of non-tunneled centrally inserted CVC; < age 5years
36-556	; age 5years or older
36-557	Insertion of tunneled centrally inserted CVC without sq port/pump; < age 5yrs
36-558	; age 5years or older
36-568	Insertion of PICC without subcutaneous port/pump, without imaging guidance; <age 5 yr
36-569	; age 5years or older
36-572	Insertion of PICC without subcutaneous port/pump, with imaging guidance; <age 5 years
36-573	; age 5years or older
36-580	Replacement, complete, of a non-tunneled centrally inserted CVC, through same venous access
36-584	Replacement, complete, PICC, through same venous access
36-589	Removal of tunneled CVC, without subcutaneous pump/port
36-592	Collection of blood specimen using established central or peripheral catheter, venous
36-593	Declotting by thrombolytic agent of implanted vascular access device or catheter
36-600	Arterial puncture, withdrawal of blood for diagnosis
36-620	Arterial catheterization or cannulation for sampling, monitoring, percutaneous
36-660	Umbilical artery catheterization, newborn
36-680	Placement of needle for intraosseous infusion
37-191	Insertion of vena cava filter
38-220	Diagnostic bone marrow; aspiration(s)
38-221	Diagnostic bone marrow, biopsy(ies)
38-222	Diagnostic bone marrow, biopsy(ies) and aspiration(s)
Digestive system	
41-010	Incision of lingual frenum (frenotomy)

42-820	Tonsillectomy and adenoidectomy, <age 12 years
43-200	Esophagoscopy, flexible, trans oral, diagnostic
43-205	With band ligation of esophageal varices
43-227	With control of bleeding, any method
43-235	EGD, flexible, trans oral, diagnostic,
43-260	ERCP, diagnostic
43-752	Naso/Oro gastric tube placement requiring physician's skill and fluoroscopic guidance (includes, fluoroscopy, image documentation and report)
43-753	Gastric intubation and aspiration of therapeutic, necessitating skill of physician, (eg, GI hemorrhage) including lavage if performed
43-754	Gastric intubation and aspiration, diagnostic, single specimen (acid analysis)
43-761	Repositioning of NG/OG feeding tube, through duodenum for enteric nutrition
43-762	Replacement of G-tube, percutaneous, without imaging or endoscopy guidance
44-360	Small intestinal endoscopy
44-950	Appendectomy
45-378	Colonoscopy, flexible, diagnostic
47-000	Liver biopsy, needle, percutaneous
49-082	Abdominal paracentesis (diagnostic or therapeutic); without imaging guidance
49-083	; with imaging guidance
49-084	Peritoneal lavage (including imaging guidance when performed)
49-418	Insertion of tunneled intraperitoneal catheter
49-440	Insertion of gastrostomy tube, percutaneous, under fluoroscopy
Urinary/Genital	
50-200	Renal biopsy, percutaneous
50-590	Lithotripsy, extracorporeal shockwave
51-100	Aspiration of bladder, by needle
51-600	Injection procedure for cystography or voiding urethrocystography
51-701	Insertion of non-indwelling bladder catheter (straight catheterization)
51-702	Insertion of temporary indwelling bladder catheter; simple (foley)
51-798	Measurement of post voiding bladder capacity by ultrasound, non imaging
54-150	Circumcision, using clamp or other device
54-450	Foreskin manipulation including lysis of preputial adhesions and stretching *(with clamp,* application of manual pressure do not count)*)*
56-441	Lysis of labial adhesions (use of an instrument, application of manual pressure do not count)
58-300	Insertion of IUD
Nervous, Eye/ENT	
62-270	Spinal puncture, lumbar, diagnostic
62-272	Spinal puncture, lumbar, therapeutic for drainage of CSF
62-273	Injection, epidural, of blood or clot patch
65-205	Removal of foreign body, external eye; conjunctival superficial
65-220	Removal of foreign body, external eye; corneal without slit lamp
69-090	Ear piercing
69-200	Removal foreign body from external auditory canal; without general anesthesia
69-209	Removal of impacted cerumen using irrigation/lavage, unilateral
69-210	Removal of impacted cerumen requiring instrumentation, unilateral

Radiology CPT codes

Radiology codes start with 7 (70 thousand series). Radiology codes always have 2 components. The first one is called the technical component, and it is about the expenditure of having appropriate machines and personnel to get the images. The second one is called the professional component and involves physicians reading the imaging and putting a note in the chart. If the office has an X-ray machine and CXR is done in the office, then the CPT code for CXR (71046) can be reported without any modifier. If a CXR is performed in another office and there is no radiology report, the physician, after reading the CXR and entering a read of the CXR in the patient's chart, can report 71046 with modifier 26 to indicate that only the professional part of the radiological procedure was performed. There are many more radiology codes that office physicians can report if these images are not read by a radiologist. If a radiologist has already read these images, then other physicians cannot report additional radiology codes. If an office physician reports a radiology code, these radiological tests cannot be used toward the MDM data element. Radiology codes are rarely reported by hospital-based physicians because, most of the time, the radiologist bills the professional component of the study, and the hospital reports the technical component.

RADIOLOGY	
74-018	Radiologic examination, abdomen; 1 view
71-045	Radiologic examination, chest; 1 view
76-937	Ultrasound guidance for vascular access *(add on code to primary procedure)*
76-942	Ultrasound guidance for needle placement (biopsy, aspiration, injection)
77-001	Fluoroscopic guidance for central vascular access, (*add on code to primary procedure)*
77-002	Fluoroscopic guidance for needle placement (biopsy, aspiration, injection) (*add on code to primary procedure)*

Laboratory/Pathology CPT codes

Laboratory/pathology codes start with 8 (80 thousand series). If a test is performed in the office, it should be reported with a lab CPT code. If blood was obtained in the office and sent to an outside lab, only the phlebotomy CPT code, not the lab CPT code, needs to be reported. In a hospital setting, labs are reported by the hospital (pathologist/biochemist), so hospital physicians never report lab codes.

PATHOLOGY AND LABORATORY	
81-000	Urine analysis with dipstick; with microscopy, non-automated
81-001	Urine analysis with dipstick; with microscopy, automated
81-002	Urine analysis with dipstick; without microscopy, non-automated
81-003	Urine analysis with dipstick; without microscopy, automated
81-025	Urine pregnancy test, by visual
82-247	Total bilirubin
82-272	Blood, occult, fecal

82-962	Glucose, blood by glucose monitoring device
83-655	Lead
85-013	Spun microhematocrit
88-720	Total bilirubin, transcutaneous
86-308	Heterophile antibodies (Monospot)
86-580	Skin test; tuberculosis, intradermal (PPD)
87-804	Influenza
87-807	RSV
87-880	Streptococcus, group A

Medicine CPT codes

Medicine codes start with 9 (90 thousand series). These codes are typically used by internists, but also include some invasive procedures like Swan-Ganz catheter placement and cardiac angiography codes.

	MEDICINE
Immunoglobulins	Many different products/codes. *Reported with administration codes 96365-96375*
90-283	Immune globulin (IgIV), human, for iv use
90-371	Hepatitis B immune globulin, human, for im use
90-378	RSV, monoclonal antibody, for im use, 50mg, each
90-389	Tetanus immune globulin, human, for im use
Vaccines	More than 80 different vaccines/codes. Reported with administration codes 90460-90474
90-460	Immunization administration through 18 years of age via any route of administration, with counseling by physician; first or only component of each vaccine or toxoid administered
90-461	; each additional, vaccine or toxoid component, administered, list separately. *(for a pentavalent vaccine report one unit of 99460 and 4 unit of 90461)*
90-471	Immunization administration (includes PC, ID, SQ or IM); 1 vaccine (single or combination)
90-472	; each additional (single or combination) vaccine administered
90-473	Immunization administration by intranasal oral route; 1 vaccine (single or combination vaccine/toxoid)
90-474	; each additional vaccine (single or combination vaccine/toxoid)
90-732	Pneumococcal PSV23
Psychiatry	
90-832	Psychotherapy, 30 minutes with patient
90-880	Hypnotherapy
Biofeedback	
90-901	Biofeedback training by any modality
Dialysis/ESRD	
90-935	Hemodialysis procedure with single evaluation ..
90-937	Hemodialysis procedure with repeated evaluation ..

90-945	Dialysis procedure other than hemodialysis (eg peritoneal dialysis, hemofiltration, continuous renal replacement therapies, with single evaluation
90-947	Dialysis procedure other than hemodialysis (eg peritoneal dialysis, hemofiltration, continuous renal replacement therapies, with repeated eval
90-951	ESRD related services monthly, <2 yrs …..
90-997	Hemoperfusion
Gastroenterology	
91-020	Gastric motility (manometric) studies
91-034	Esophagus, gastroesophageal reflux test, with nasal catheter Ph electrode(s) placement, recording, analysis, interpretation
91-065	Breath hydrogen or methane test
91-110	GI tract imaging, intraluminal (capsule endoscopy) ..
ENT services	
92-551	Screening test, pure tone, air only
92-552	Pure tone audiometry
92-567	Tympanometry
Cardiovascular	
92-950	Cardiopulmonary resuscitation (eg, in cardiac arrest)
92-953	Temporary transcutaneous pacing
92-960	Cardioversion, elective, external
92-928	Percutaneous transcatheter intra coronary stent placement
93-000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report
93-005	; tracing only, without interpretation and report
93-010	; interpretation and report only
93-040	Rhythm ECG, 1-3 leads; with interpretation and report
93-041	Rhythm ECG, 1-3 leads; tracing only, without interpretation and report
93-042	Rhythm ECG, 1-3 leads; interpretation and report only
93-224	~external ecg recording up to 48 hrs ~holter
93-303	Transthoracic ECHO for congenital abnormalities, complete
93-503	Insertion and placement of flow directed catheter (swan-ganz)
Pulmonary	
94-002	Ventilation assist and management, initiation of pressure or volume preset ventilators for assisted or controlled breathing, hospital inpatient/observation, initial day *Ventilator management codes cannot be reported with any ENM code*
94-003	Hospital inpatient/observation, each subsequent day *Ventilator management codes cannot be reported with any ENM code*
94-010	Spirometry, including graphic record, total and timed vital capacity, expiratory flow rate measurements
94-150	Vital capacity, total
94-610	Intrapulmonary surfactant administration by through ET tube
94-460	Inhalation treatment for acute airway obstruction, or for sputum induction
94-660	CPAP initiation and management *Ventilator management codes cannot be reported with any ENM code*
94-662	Continuous negative pressure ventilation, initiation and management
94-664	Demonstration and/or evaluation of patient utilization of an aerosol generator, nebulizer, MDI or IPPB device

94-667	Manipulation of chest wall, percussing/vibrating, initial demonstration/eval
94-669	Mechanical chest wall oscillation
94-760	Non invasive ear or pulse oximetry, single determination
94-761	Multiple determinations
94-774	Pediatric home apnea monitoring ……per 30 dayqq
94-780	Car seat testing…..; first 60 minutes
Allergy immunology	
95-004	Percutaneous tests ……
95-076	Ingestion challenge test ….
95-115	Allergen immunotherapy, professional services
Endocrinology	
95-250	Ambulatory continuous glucose monitoring ….
Neurology	
95-806	Sleep study, …….
95-812	EEG, extended monitoring, 41-60 minutes
95-860	Needle electromyography
95-907	Nerve conduction studies
95-940	Intraoperative neurophysiology testing
95-992	Canalith repositioning procedure(s), (eg epley maneuver)
Genetic counseling	
96-041	Medical genetics and genetic counseling services , each 30 minutes , FTF
Behavioral screen	
96-110	Developmental screening, with scoring and documentation ….
96-127	Brief emotional/behavioral assessment (depression, ADHD) with scoring….
Injections, infusions	
96-360	IV infusion, hydration…
96-365	IV infusion for therapy, prophylaxis or diagnosis
96-369	SQ infusion therapy
96-413	Chemotherapy administration, iv
96-450	Chemotherapy administration, in to CNS (intratecheal)
Photodynamic/Derm	
96-567	Photodynamic therapy ….
Physical Med, Rehab	
97-010	Application of a modality, hot or cold packs
97-014	Electrical stimulation
97-026	Infrared
97-035	Ultrasound
Wound care	
97-602	Removal of devitalized tissues from wound …..
97-605	Negative pressure wound therapy
Nutrition therapy	
97-802	Medical nutrition therapy, initial assessment and intervention, FTF, each 15 min
Acupuncture	
97-810	Acupuncture, 1 or more needles ……
Osteopathic Manipul	
98-925	Osteopathic manipulative treatment …..

Chiropractic Manipul	
98-940	Chiropractic manipulative treatment …..
Self-Management	
98-960	Education and training for patient self-management ……
Special services	
99-026	Hospital mandated on call service, in hospital, each hour
99-050	Services in the office at times other than regularly scheduled office hours, when office is normally closed, in addition to the basic service
99-058	Services provided on an emergency basis in the office, disrupting other scheduled services, in addition to the basic service
99-070	Supplies and materials provided by physician
99-071	Educational supplies at cost to physician
99-082	Unusual travel (transportation and escort of patient)
99-173	Screening test of visual acuity, quantitative, bilateral
Anesth Qualifiers	
99-100	Anesthesia for patients of extreme age, younger than 1, older than 70 *(add on code)*
99-140	Anesthesia complicated by emergency conditions *(add on code)*
Moderate Sedation	
99-151	Moderate sedation, same physician; initial 15 minutes intraservice time, <5 yrs
99-152	; initial 15 minutes itraservice time, 5 years and older
99-153	; each additional 15 minutes itraservice time
99-155	Moderate sedation, diff physicians; initial 15 minutes intraservice time, <5 yrs
99-156	; initial 15 minutes itraservice time, 5 years and older
99-157	; each additional 15 minutes itraservice time
99-170	Anogenital examination, magnified, in childhood for suspected trauma, including image recording when performed
Other services	
99-173	Screening test of visual acuity …..
99-184	Initiation of selective head or total body hypothermia in the critically ill neonate (once per hospital stay)
99-188	Application of topical fluoride
99-195	Phlebotomy, therapeutic