Optum

Coding Companion

Internal Medicine/ Endocrinology/ Rheumatology

A comprehensive illustrated guide to coding and reimbursement

2025

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Contents

Getting Started with Coding Companion

Coding Companion for Internal Medicine/Endocrinology/ Rheumatology is designed to be a guide to the specialty procedures classified in the CPT® book. It is structured to help coders understand procedures and translate physician narrative into correct CPT codes by combining many clinical resources into one, easy-to-use source book.

The book also allows coders to validate the intended code selection by providing an easy-to-understand explanation of the procedure and associated conditions or indications for performing the various procedures. As a result, data quality and reimbursement will be improved by providing code-specific clinical information and helpful tips regarding the coding of procedures.

CPT/HCPCS Codes

For ease of use, evaluation and management codes related to internal medicine/endocrinology/rheumatology are listed first in the *Coding Companion*. All other CPT codes in *Coding Companion* are listed in ascending numeric order. Included in the code set are all surgery, radiology, laboratory, and medicine codes pertinent to the specialty. Each CPT/HCPCS code is followed by its official CPT code description.

Resequencing of CPT Codes

The American Medical Association (AMA) employs a resequenced numbering methodology. According to the AMA, there are instances where a new code is needed within an existing grouping of codes, but an unused code number is not available to keep the range sequential. In the instance where the existing codes were not changed or had only minimal changes, the AMA assigned a code out of numeric sequence with the other related codes being grouped together. The resequenced codes and their descriptions have been placed with their related codes, out of numeric sequence.

CPT codes within the Optum *Coding Companion* series display in their resequenced order. **Resequenced codes are enclosed in brackets [ ] for easy identification.**

ICD-10-CM

The most current ICD-10-CM codes are provided, each listed with their full official description. Refer to the ICD-10-CM book for more ICD-10-CM coding information.

Detailed Code Information

One or more columns are dedicated to each procedure or service or to a series of similar procedures/services. Following the specific CPT code and its narrative, is a combination of features.

Appendix Codes and Descriptions

Some CPT/HCPCS codes are presented in a less comprehensive format in the appendix. The CPT/HCPCS codes appropriate to the specialty are included in the appendix with the official CPT/HCPCS code description, followed by an easy-to-understand explanation.

The codes in the appendix are presented in the following order:

- HCPCS
- E/M
- Surgery
- Radiology
- Pathology and Laboratory
- Medicine Services
- Category III

Category II codes are not published in this book. Refer to the CPT book for code descriptions.

CCI Edits, RVUs, HCPCS, and Other Coding Updates

The *Coding Companion* includes the list of codes from the official Centers for Medicare and Medicaid Services' National Correct Coding Policy Manual for Part B Medicare Contractors that are considered to be an integral part of the comprehensive code or mutually exclusive of it and should not be reported separately. The codes in the Correct Coding Initiative (CCI) section are from version 29.3, the most current version available at press time. CCI edits are updated quarterly and will be posted on the product updates page listed below. The website address is http://www.optumcoding.com/ProductUpdates/. The 2025 edition password is: **XXXXXX.** Log in frequently to ensure you receive the most current updates.

Index

A comprehensive index is provided for easy access to the codes. The index entries have several axes. A code can be looked up by its procedural name or by the diagnoses commonly associated with it. Codes are also indexed anatomically. For example:

65205 Removal of foreign body, external eye; conjunctival superficial

could be found in the index under the following main terms:

Conjunctiva
Foreign Body Removal, 65205-65210

or **Eye**
Removal
Foreign Body
Superficial, 65205

or **Foreign Body**
Removal
External Eye, 65205

General Guidelines

Providers

The AMA advises coders that while a particular service or procedure may be assigned to a specific section, it is not limited to use only by that specialty group (see paragraphs two and three under "Instructions for Use of the CPT Codebook" on page xv of the CPT Book). Additionally, the procedures and services listed throughout the book are for use by any qualified physician or other qualified health care professional or entity (e.g., hospitals, laboratories, or home health agencies). Keep in mind that there may be other policies or guidance that can affect who may report a specific service.

Supplies

Some payers may allow physicians to separately report drugs and other supplies when reporting the place of service as office or other nonfacility setting. Drugs and supplies are to be reported by the facility only when performed in a facility setting.

Professional and Technical Component

Radiology and some pathology codes often have a technical and a professional component. When physicians do not own their own equipment and send their patients to outside testing facilities, they should append modifier 26 to the procedural code to indicate they performed only the professional component.

Sample Page and Key

The following pages provide a sample page from the book displaying the format of *Coding Companion* with each element identified and explained.

11055-11057

11055 Paring or cutting of benign hyperkeratotic lesion (eg, corn or callus); single lesion
11056 2 to 4 lesions
11057 more than 4 lesions

Depiction of a single corn-like lesion on a common location of the foot

Explanation

The physician removes a benign hyperkeratotic skin lesion such as a corn or callus by cutting, clipping, or paring. Report 11055 when one lesion is removed; 11056 when two to four lesions are removed; and 11057 when more than four lesions are removed.

Coding Tips

Routine foot care, which includes the paring or cutting of corns and calluses, is not covered by Medicare unless the patient suffers from a condition that puts him/her at risk when these services are performed by a nonprofessional. Medicare requires the use of specific HCPCS Level II modifiers Q7–Q9 to indicate clinical findings indicative of severe peripheral involvement warranting the medical necessity of providing foot care, such as nail debridement or trimming, that would usually be considered routine and for which benefits would not be provided. For destruction of a benign or a premalignant lesion, see 17000–17111. For a routine E/M service and foot care of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS), see G0245–G0246. For diabetic foot care including debridement of corns and calluses, see G0247. Some non-Medicare payers may require that HCPCS Level II code S0390 be reported for this service when provided as routine foot care or as preventive maintenance in specific medical conditions. For physician offices, supplies may be reported with the appropriate HCPCS Level II code. Check with the specific payer to determine coverage.

ICD-10-CM Diagnostic Codes

B07.0 Plantar wart
B07.8 Other viral warts
L11.0 Acquired keratosis follicularis
L84 Corns and callosities
L85.1 Acquired keratosis [keratoderma] palmaris et plantaris
L85.2 Keratosis punctata (palmaris et plantaris)
L86 Keratoderma in diseases classified elsewhere
L87.0 Keratosis follicularis et parafollicularis in cutem penetrans

Associated HCPCS Codes

G0247 Routine foot care by a physician of a diabetic patient with diabetic sensory neuropathy resulting in a loss of protective sensation (LOPS) to include the local care of superficial wounds (i.e., superficial to muscle and fascia) and at least the following, if present: (1) local care of superficial wounds, (2) debridement of corns and calluses, and (3) trimming and debridement of nails

AMA: **11055** 2022,Feb **11056** 2022,Feb **11057** 2022,Feb

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
11055	0.35	1.76	0.04	2.15
11056	0.5	1.93	0.04	2.47
11057	0.65	2.0	0.04	2.69
Facility RVU	**Work**	**PE**	**MP**	**Total**
11055	0.35	0.08	0.04	0.47
11056	0.5	0.11	0.04	0.65
11057	0.65	0.15	0.04	0.84

	FUD	Status	MUE	Modifiers				IOM Reference
11055	0	R	1(2)	51	N/A	N/A	N/A	None
11056	0	R	1(2)	51	N/A	N/A	N/A	
11057	0	R	1(2)	51	N/A	N/A	N/A	

* with documentation

Terms To Know

callosities. Localized, hardened patches of overgrowth on the epidermis caused by friction or pressure.

callus. Tissue formation at the site of a fracture that establishes continuity between the fractured ends of the bone. The initial provisional callus, which is comprised of fibrous tissue and cartilage, is eventually absorbed and replaced by osseous tissue (definitive callus).

diabetes mellitus. Endocrine disease manifested by high blood glucose levels and resulting in the inability to successfully metabolize carbohydrates, proteins, and fats, due to defects in insulin production and secretion, insulin action, or both.

hyperkeratosis. Thickening of the outer layer of the skin because of overproduction of the protein keratin.

keratoderma. Excessive growth of a horny, callous layer on the skin in three typical patterns: diffused over the palm and sole, focal with large keratin masses at points of friction, and punctate with tiny drops of keratin on the palmoplantar surface.

keratosis. Skin condition characterized by a wart-like or callus-type localized overgrowth, hardening, or thickening of the upper skin layer as a result of overproduction of the protein keratin.

1. CPT/HCPCS Codes and Descriptions

This edition of *Coding Companion* is updated with CPT and HCPCS codes for year 2024.

The following icons are used in *Coding Companion:*

- ● This CPT code is new for 2024.
- ▲ This CPT code description is revised for 2024.
- ✚ This CPT code is an add-on code.

Add-on codes are not subject to bilateral or multiple procedure rules, reimbursement reduction, or appending modifier 50 or 51. Add-on codes describe additional intraservice work associated with the primary procedure performed by the same physician on the same date of service and are not reported as stand-alone procedures. Add-on codes for procedures performed on bilateral structures are reported by listing the add-on code twice.

- ★ This CPT code is identified by CPT as appropriate for audio-visual telemedicine services.

The Centers for Medicare and Medicaid Services (CMS) have identified services that may be performed via telehealth. Payers may require telehealth/telemedicine to be reported with place of service 02 Telehealth Provided Other than the Patient's Home or 10 Telehealth Provided in Patient's Home and modifier 93 or 95 appended. If specialized equipment is used at the originating site, HCPCS Level II code Q3014 may be reported. Individual payers should be contacted for additional or different guidelines regarding telehealth/telemedicine services. Documentation should include the type of technology used for the treatment in addition to the patient evaluation, treatment, and consents.

According to CPT guidelines, the codes listed below may be used for reporting audio-only telemedicine services, when modifier 93 Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System, is appended. These procedures involve electronic communication using interactive telecommunications equipment that at a minimum includes audio.

90785	90791	90792	90832	90833	90834	90836
90837	90838	90839	90840	90845	90846	90847
92507	92508	92521	92522	92523	92524	96040
96110	96116	96121	96156	96158	96159	96160
96161	96164	96165	96167	96168	96170	96171
97802	97803	97804	99406	99407	99408	99409
99497	99498					

2. Illustrations

The illustrations that accompany the *Coding Companion* series provide coders a better understanding of the medical procedures referenced by the codes and data. The graphics offer coders a visual link between the technical language of the operative report and the cryptic descriptions accompanying the codes. Although most pages will have an illustration, there will be some pages that do not.

3. Explanation

Every CPT code or series of similar codes is presented with its official CPT code description. However, sometimes these descriptions do not provide the coder with sufficient information to make a proper code selection. In *Coding Companion*, an easy-to-understand step-by-step clinical description of the procedure is provided. Technical language that might be used by the physician is included and defined. *Coding Companion* describes the most common method of performing each procedure.

4. Coding Tips

Coding tips provide information on how the code should be used, provides related CPT codes, and offers help concerning common billing errors, modifier usage, and anesthesia. This information comes from consultants and subject matter experts at Optum and from the coding guidelines provided in the CPT book and by the Centers for Medicare and Medicaid Services (CMS).

5. ICD-10-CM Diagnostic Codes

ICD-10-CM diagnostic codes listed are common diagnoses or reasons the procedure may be necessary. This list in most cases is inclusive to the specialty. Some ICD-10-CM codes are further identified with the following icons:

- 🅽 Newborn: 0
- 🅿 Pediatric: 0-17
- Ⓜ Maternity: 9-64
- 🅰 Adult: 15-124
- ♂ Male only
- ♀ Female Only
- ☑ Laterality

Please note that in some instances the ICD-10-CM codes for only one side of the body (right) have been listed with the CPT code. The associated ICD-10-CM codes for the other side and/or bilateral may also be appropriate. Codes that refer to the right or left are identified with the ☑ icon to alert the user to check for laterality. In some cases, not every possible code is listed and the ICD-10-CM book should be referenced for other valid codes.

6. Associated HCPCS Codes

Medicare and some other payers require the use of HCPCS Level II codes and not CPT codes when reporting certain services. The HCPCS codes and their description are displayed in this field. If there is not a HCPCS code for this service, this field will not be displayed.

7. AMA References

The AMA references for *CPT Assistant* are listed by CPT code, with the most recent reference listed first. Generally only the last six years of references are listed.

8. Relative Value Units/Medicare Edits

Medicare edits are provided for most codes. These Medicare edits were current as of November 2023.

The 2024 Medicare edits were not available at the time this book went to press. Updated 2024 values will be posted at https://www.optumcoding.com/ProductUpdates/. The 2025 edition password is **XXXXXX**.

Relative Value Units

In a resource based relative value scale (RBRVS), services are ranked based on the relative costs of the resources required to provide those services as opposed to the average fee for the service, or average prevailing Medicare charge. The Medicare RBRVS defines three distinct components affecting the value of each service or procedure:

- Physician work component, reflecting the physician's time and skill
- Practice expense (PE) component, reflecting the physician's rent, staff, supplies, equipment, and other overhead
- Malpractice (MP) component, reflecting the relative risk or liability associated with the service
- Total RVUs are a sum of the work, PE, and MP RVUs

There are two groups of RVUs listed for each CPT code. The first RVU group is for facilities (Facility RVU), which includes provider services performed in hospitals, ambulatory surgical centers, or skilled nursing facilities. The second RVU group is for nonfacilities (Non-Facility RVU), which represents provider services performed in physician offices, patient's homes, or other nonhospital settings. The appendix includes RVU components for facility and non-facility. Because no values have been established by CMS for the Category III codes, no relative value unit/grids are identified. Refer to the RBRVS tool or guide for the RVUs

Evaluation and Management (E/M) Services Guidelines

E/M Guidelines Overview

The E/M guidelines have sections that are common to all E/M categories and sections that are category specific. Most of the categories and many of the subcategories of service have special guidelines or instructions unique to that category or subcategory. Where these are indicated, eg, "Hospital Inpatient and Observation Care," special instructions are presented before the listing of the specific E/M services codes. It is important to review the instructions for each category or subcategory. These guidelines are to be used by the reporting physician or other qualified health care professional to select the appropriate level of service. These guidelines do not establish documentation requirements or standards of care. The main purpose of documentation is to support care of the patient by current and future health care team(s). These guidelines are for services that require a face-to-face encounter with the patient and/or family/caregiver. (For 99211 and 99281, the face-to-face services may be performed by clinical staff.)

In the **Evaluation and Management** section (99202-99499), there are many code categories. Each category may have specific guidelines, or the codes may include specific details. These E/M guidelines are written for the following categories:

- Office or Other Outpatient Services
- Hospital Inpatient and Observation Care Services
- Consultations
- Emergency Department Services
- Nursing Facility Services
- Home or Residence Services
- Prolonged Service With or Without Direct Patient Contact on the Date of an Evaluation and Management Service

Classification of Evaluation and Management (E/M) Services

The E/M section is divided into broad categories, such as office visits, hospital inpatient or observation care visits, and consultations. Most of the categories are further divided into two or more subcategories of E/M services. For example, there are two subcategories of office visits (new patient and established patient) and there are two subcategories of hospital inpatient and observation care visits (initial and subsequent). The subcategories of E/M services are further classified into levels of E/M services that are identified by specific codes.

The basic format of codes with levels of E/M services based on medical decision making (MDM) or time is the same. First, a unique code number is listed. Second, the place and/or type of service is specified (eg, office or other outpatient visit). Third, the content of the service is defined. Fourth, time is specified. (A detailed discussion of time is provided in the Guidelines for Selecting Level of Service Based on Time.)

The place of service and service type are defined by the location where the face-to-face encounter with the patient and/or family/caregiver occurs. For example, service provided to a nursing facility resident brought to the office is reported with an office or other outpatient code.

New and Established Patients

Solely for the purposes of distinguishing between new and established patients, **professional services** are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. A new patient is one who has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years.

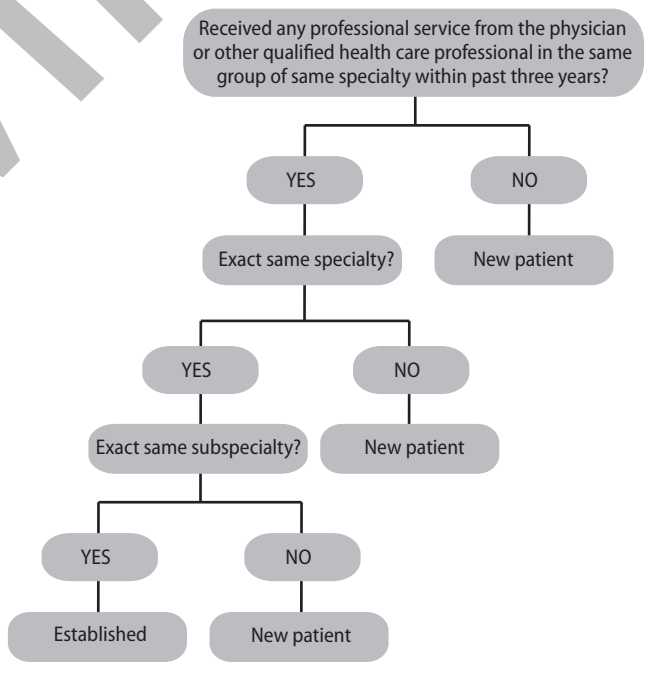
An established patient is one who has received professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **exact** same specialty **and subspecialty** who belongs to the same group practice, within the past three years. See Decision Tree for New vs Established Patients.

In the instance where a physician or other qualified health care professional is on call for or covering for another physician or other qualified health care professional, the patient's encounter will be classified as it would have been by the physician or other qualified health care professional who is not available. When advanced practice nurses and physician assistants are working with physicians, they are considered as working in the **exact** same specialty **and subspecialty** as the physician.

No distinction is made between new and established patients in the emergency department. E/M services in the emergency department category may be reported for any new or established patient who presents for treatment in the emergency department.

The Decision Tree for New vs Established Patients is provided to aid in determining whether to report the E/M service provided as a new or an established patient encounter.

Decision Tree for New vs Established Patients



Initial and Subsequent Services

Some categories apply to both new and established patients (eg, hospital inpatient or observation care). These categories differentiate services by whether the service is the initial service or a subsequent service. For the purpose of distinguishing between initial or subsequent visits, professional services are those face-to-face services rendered by physicians and other qualified health care professionals who may report evaluation and management services. An initial service is when the patient has not received any professional services from the physician or

AMA CPT® Evaluation and Management (E/M) Services Guidelines reproduced with permission of the American Medical Association.

▶ ◀ = Contains new or revised text

99202-99205

▲★**99202** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.

▲★**99203** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

▲★**99204** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded.

▲★**99205** Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded.

Explanation

Providers report these codes for new patients being seen in the doctor's office, a multispecialty group clinic, or other outpatient environment. All require a medically appropriate history and/or examination. Code selection is based on the level of medical decision making (MDM) or total time personally spent by the physician and/or other qualified health care professional(s) on the date of the encounter. Factors to be considered in MDM include the number and complexity of problems addressed during the encounter, amount and complexity of data requiring review and analysis, and the risk of complications and/or morbidity or mortality associated with patient management. The most basic service is represented by 99202, which entails straightforward MDM. If time is used for code selection, a total time of 15 minutes must be met or exceeded on the day of the encounter. Report 99203 for a visit requiring a low level of MDM or meeting or exceeding 30 minutes of total time; 99204 for a visit requiring a moderate level of MDM or meeting or exceeding 45 minutes of total time; and 99205 for a visit requiring a high level of MDM or meeting or exceeding 60 minutes of total time.

Coding Tips

These codes are used to report office or other outpatient services for a new patient. A medically appropriate history and physical examination, as determined by the treating provider, should be documented. The level of history and physical examination are not considered when determining the level of service. Codes should be selected based upon the current CPT Medical Decision Making table. Alternatively, time alone may be used to select the appropriate level of service. Total time for reporting these services includes face-to-face and non-face-to-face time personally spent by the physician or other qualified health care professional on the date of the encounter. Medicare and the CPT codebook have identified these codes as telehealth/telemedicine services. Telemedicine services may be reported by the performing provider by adding modifier 95 to the procedure code and/or using the appropriate place of service (POS) indicator; POS 02 for telehealth when the originating site is not the patient's home and POS 10 for telehealth services when the originating site is the patient's home. For prolonged services applicable to 99205, see 99417; for Medicare, see G2212. Medicare and commercial payers should be contacted regarding their coverage guidelines. For office or other outpatient services for an established patient, see 99211-99215.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99202** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99203** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99204** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun **99205** 2023,Nov; 2023,Oct; 2023,Sep; 2023,Aug; 2023,May; 2023,Apr; 2023,Mar; 2022,Dec; 2022,Nov; 2022,Oct; 2022,Sep; 2022,Aug; 2022,Jul; 2022,Jun; 2022,Apr; 2022,Feb; 2022,Jan; 2021,Nov; 2021,Oct; 2021,Sep; 2021,Aug; 2021,Jul; 2021,Jun; 2021,May; 2021,Apr; 2021,Mar; 2021,Feb; 2021,Jan; 2020,Dec; 2020,Nov; 2020,Oct; 2020,Sep; 2020,Jun; 2020,May; 2020,Mar; 2020,Feb; 2020,Jan; 2019,Oct; 2019,Jul; 2019,Jun; 2019,Feb; 2019,Jan; 2018,Oct; 2018,Sep; 2018,Apr; 2018,Mar; 2017,Aug; 2017,Jun

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99202	0.93	1.14	0.08	2.15
99203	1.6	1.56	0.17	3.33
99204	2.6	2.11	0.23	4.94
99205	3.5	2.71	0.31	6.52
Facility RVU	**Work**	**PE**	**MP**	**Total**
99202	0.93	0.41	0.08	1.42
99203	1.6	0.68	0.17	2.45
99204	2.6	1.11	0.23	3.94
99205	3.5	1.54	0.31	5.35

	FUD	Status	MUE	Modifiers				IOM Reference
99202	N/A	A	1(2)	N/A	N/A	N/A	80*	100-04,11,40.1.3; 100-04,12,30.6.4; 100-04,12,30.6.10; 100-04,12,190.7; 100-04,12,230; 100-04,12,230.1; 100-04,18,80.2; 100-04,32,12.1
99203	N/A	A	1(2)	N/A	N/A	N/A	80*	
99204	N/A	A	1(2)	N/A	N/A	N/A	80*	
99205	N/A	A	1(2)	N/A	N/A	N/A	80*	

* with documentation

99384-99387

99384 Initial comprehensive preventive medicine evaluation and management of an individual including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient; adolescent (age 12 through 17 years)

99385 18-39 years

99386 40-64 years

99387 65 years and older

Explanation

Initial preventive medicine services are typically well-patient examinations for new patients with code selection dependent upon the patient's age. These services include applicable patient history and examination, guidance/recommendation regarding personal risk factors, and any laboratory and/or diagnostic procedures ordered. Clinicians are not required to report minor or self-limiting problems or complaints noted during the preventive examination when those problems do not require any additional work or necessitate performing the key components of a problem-oriented E/M service. Report 99384 for adolescents12 to 17 years of age; 99385 for adult patients 18 to 39 years of age; 99386 for patients 40 to 64 years of age; and 99387 for patients 65 years of age and older.

Coding Tips

These codes are used to report preventive medicine services for a new patient. Time is not a factor when selecting these E/M services. Code selection is determined based on whether the patient is new or established and the age of the patient. When documentation supports that a significant, separately identifiable problem-oriented evaluation and management (E/M) service is rendered, the appropriate code for the E/M service may be reported separately. Append modifier 25 to the service code selected to indicate that a separately identifiable E/M service was provided on the same date of service as the preventive medicine service. Immunizations and vaccines including counseling when provided, and ancillary services, including laboratory, radiology, or screening tests, performed at the time of the preventive service may be reported separately. Preventive medicine services are not covered by Medicare. For preventive services provided to an established patient, see 99391-99397.

ICD-10-CM Diagnostic Codes

The application of this code is too broad to adequately present ICD-10-CM diagnostic code links here. Refer to your ICD-10-CM book.

AMA: **99384** 2022,Dec; 2022,Nov; 2022,Jul; 2021,Nov; 2021,Feb; 2021,Jan; 2019,Jul **99385** 2022,Dec; 2022,Nov; 2022,Jul; 2021,Nov; 2021,Feb; 2021,Jan; 2019,Jul **99386** 2022,Dec; 2022,Nov; 2022,Jul; 2021,Nov; 2021,Feb; 2021,Jan; 2019,Jul **99387** 2022,Dec; 2022,Nov; 2022,Jul; 2021,Nov; 2021,Feb; 2021,Jan; 2019,Jul

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
99384	2.0	1.82	0.12	3.94
99385	1.92	1.79	0.12	3.83
99386	2.33	1.94	0.14	4.41
99387	2.5	2.13	0.17	4.8
Facility RVU	**Work**	**PE**	**MP**	**Total**
99384	2.0	0.77	0.12	2.89
99385	1.92	0.74	0.12	2.78
99386	2.33	0.9	0.14	3.37
99387	2.5	0.96	0.17	3.63

	FUD	Status	MUE	Modifiers				IOM Reference
99384	N/A	N	0(3)	N/A	N/A	N/A	N/A	100-04,12,30.6.2; 100-04,12,30.6.4
99385	N/A	N	0(3)	N/A	N/A	N/A	N/A	
99386	N/A	N	0(3)	N/A	N/A	N/A	N/A	
99387	N/A	N	0(3)	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

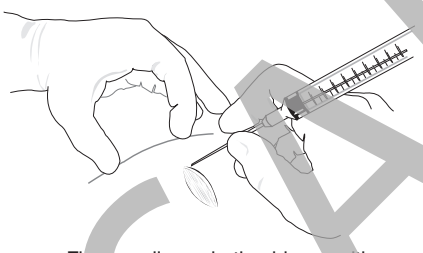
new patient. Patient who is receiving face-to-face care from a physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice for the first time in three years. For OPPS hospitals, a patient who has not been registered as an inpatient or outpatient, including off-campus provider-based clinic or emergency department, within the past three years.

preventive medicine service. Evaluation and management service provided as a periodic health screening and/or prophylactic service that does not typically include management of new or existing diagnoses or problems.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

10021 [10004, 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012]

10021 Fine needle aspiration biopsy, without imaging guidance; first lesion
\+ **10004** Fine needle aspiration biopsy, without imaging guidance; each additional lesion (List separately in addition to code for primary procedure)
10005 Fine needle aspiration biopsy, including ultrasound guidance; first lesion
\+ **10006** Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion (List separately in addition to code for primary procedure)
10007 Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion
\+ **10008** Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion (List separately in addition to code for primary procedure)
10009 Fine needle aspiration biopsy, including CT guidance; first lesion
\+ **10010** Fine needle aspiration biopsy, including CT guidance; each additional lesion (List separately in addition to code for primary procedure)
10011 Fine needle aspiration biopsy, including MR guidance; first lesion
\+ **10012** Fine needle aspiration biopsy, including MR guidance; each additional lesion (List separately in addition to code for primary procedure)



Fine needle aspiration biopsy with or without imaging guidance

Explanation

Fine needle aspiration (FNA) is a diagnostic percutaneous procedure that uses a fine gauge needle (often 22 or 25 gauge) and a syringe to sample fluid from a cyst or remove clusters of cells from a solid mass. The skin is cleansed. If a lump can be felt, the radiologist or surgeon guides a needle into the area by palpating the lump. If the lump is non-palpable, the FNA procedure is performed using ultrasound, fluoroscopy, computed tomography (CT), or MR imaging with the patient positioned according to the area of concern. Ultrasonography-guided aspiration biopsy involves inserting an aspiration catheter needle device through the accessory channel port of the echoendoscope; the needle is placed into the area to be sampled under endoscopic ultrasonographic guidance. After the needle is placed into the region of the lesion, a vacuum is created and multiple in and out needle motions are performed. Several needle insertions are usually required to ensure that an adequate tissue sample is taken. In fluoroscopic guidance, intermittent fluoroscopy guides the advancement of the needle. CT image guidance allows computer-assisted targeting of the area to be sampled. At the completion of the procedure, the needle is withdrawn and a small bandage is placed over the area. MR image guidance involves the use of a magnetic field, radiowaves, and computer-assisted targeting to identify the area for biopsy without the use of ionizing radiation. Report 10021 for fine needle aspiration of the initial lesion performed without imaging guidance; for each subsequent lesion, report 10004. Report 10005 for FNA of the first lesion using ultrasound guidance; for each additional lesion, report 10006. Report 10007 for FNA of the first lesion using fluoroscopy; for each additional lesion, report 10008. Report 10009 for FNA of the first lesion utilizing CT imaging; for each subsequent lesion, report 10010. Report 10011 when MR imaging is used for the initial lesion; for each additional lesion, report 10012.

Coding Tips

If biopsies are performed on two or more lesions during the same session using the same imaging source, report the appropriate imaging code for the second and subsequent lesions; if using a different imaging source, report the additional add-on lesion biopsy codes and the code for each separate imaging source used. When FNA biopsy and core needle biopsies are performed during the same session on separate lesions using the same imaging source, both the core needle biopsy and the imaging guidance are reported separately using modifier 59. When FNA biopsy and core needle biopsies are performed during the same session on separate lesions using a different imaging source, both the core needle biopsy and the imaging guidance are reported separately using modifier 59. Report 10004 in addition to 10021; 10006 in addition to 10005; 10008 in addition to 10007; 10010 in addition to 10009; and 10012 in addition to 10011. Do not report 10004 or 10021 with 10005–10012. Imaging guidance codes 76942, 77002, 77012, and 77021 should not be reported separately. For evaluation of fine needle aspirate, see 88172–88173 and 88177. For image-guided percutaneous fluid collection drainage of soft tissue via catheter, see 10030.

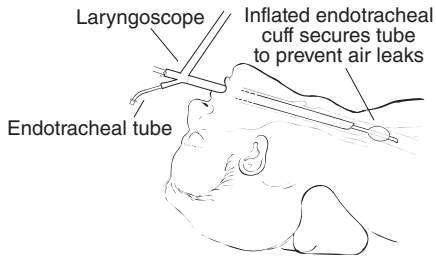
ICD-10-CM Diagnostic Codes

C37 Malignant neoplasm of thymus
C46.0 Kaposi's sarcoma of skin
C46.1 Kaposi's sarcoma of soft tissue
C46.2 Kaposi's sarcoma of palate
C50.011 Malignant neoplasm of nipple and areola, right female breast ♀ ☑
C50.021 Malignant neoplasm of nipple and areola, right male breast ♂ ☑
C50.111 Malignant neoplasm of central portion of right female breast ♀ ☑
C50.121 Malignant neoplasm of central portion of right male breast ♂ ☑
C50.211 Malignant neoplasm of upper-inner quadrant of right female breast ♀ ☑
C50.221 Malignant neoplasm of upper-inner quadrant of right male breast ♂ ☑
C50.311 Malignant neoplasm of lower-inner quadrant of right female breast ♀ ☑
C50.321 Malignant neoplasm of lower-inner quadrant of right male breast ♂ ☑
C50.411 Malignant neoplasm of upper-outer quadrant of right female breast ♀ ☑
C50.421 Malignant neoplasm of upper-outer quadrant of right male breast ♂ ☑
C50.511 Malignant neoplasm of lower-outer quadrant of right female breast ♀ ☑
C50.521 Malignant neoplasm of lower-outer quadrant of right male breast ♂ ☑
C50.611 Malignant neoplasm of axillary tail of right female breast ♀ ☑
C50.621 Malignant neoplasm of axillary tail of right male breast ♂ ☑

 N Newborn: 0 **P Pediatric: 0-17** **M Maternity: 9-64** **A Adult: 15-124** ♂ **Male Only** ♀ **Female Only**

31500

31500 Intubation, endotracheal, emergency procedure



An emergency endotracheal intubation is performed

Explanation

The physician places an endotracheal tube to provide air passage in emergency situations. The patient is ventilated with a mask and bag and positioned by extending the neck anteriorly and the head posteriorly. The physician places the laryngoscope into the patient's mouth and advances the blade toward the epiglottis until the vocal cords are visible. An endotracheal tube is inserted between the vocal cords and advanced to the proper position. The cuff of the endotracheal tube is inflated.

Coding Tips

Emergency endotracheal intubation may be reported separately when performed in connection with critical care. See 99291, 99292, and notes for definitions of critical care and other procedures that may be reported. Do not report anesthesia services separately; intubation is included in these services. Do not report 31500 with neonatal (99468–99469) or pediatric (99471–99476) critical care services, as well as neonatal or pediatric intensive care services (99477–99480).

ICD-10-CM Diagnostic Codes

I11.0	Hypertensive heart disease with heart failure
I26.01	Septic pulmonary embolism with acute cor pulmonale
I26.02	Saddle embolus of pulmonary artery with acute cor pulmonale
I26.09	Other pulmonary embolism with acute cor pulmonale
I27.82	Chronic pulmonary embolism
I50.21	Acute systolic (congestive) heart failure
I50.22	Chronic systolic (congestive) heart failure
I50.23	Acute on chronic systolic (congestive) heart failure
I50.811	Acute right heart failure
I50.812	Chronic right heart failure
I97.131	Postprocedural heart failure following other surgery
J12.89	Other viral pneumonia
J13	Pneumonia due to Streptococcus pneumoniae
J14	Pneumonia due to Hemophilus influenzae
J15.0	Pneumonia due to Klebsiella pneumoniae
J15.1	Pneumonia due to Pseudomonas
J15.211	Pneumonia due to Methicillin susceptible Staphylococcus aureus
J15.212	Pneumonia due to Methicillin resistant Staphylococcus aureus
J15.29	Pneumonia due to other staphylococcus
J15.3	Pneumonia due to streptococcus, group B
J15.4	Pneumonia due to other streptococci
J15.5	Pneumonia due to Escherichia coli
J15.61	Pneumonia due to Acinetobacter baumannii
J15.69	Pneumonia due to other Gram-negative bacteria
J44.0	Chronic obstructive pulmonary disease with (acute) lower respiratory infection
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation
J45.22	Mild intermittent asthma with status asthmaticus
J45.32	Mild persistent asthma with status asthmaticus
J45.42	Moderate persistent asthma with status asthmaticus
J45.51	Severe persistent asthma with (acute) exacerbation
J45.52	Severe persistent asthma with status asthmaticus
J68.0	Bronchitis and pneumonitis due to chemicals, gases, fumes and vapors
J68.1	Pulmonary edema due to chemicals, gases, fumes and vapors
J68.4	Chronic respiratory conditions due to chemicals, gases, fumes and vapors
J80	Acute respiratory distress syndrome
J81.0	Acute pulmonary edema
J82.81	Chronic eosinophilic pneumonia
J82.82	Acute eosinophilic pneumonia
J82.83	Eosinophilic asthma
J84.114	Acute interstitial pneumonitis
J85.1	Abscess of lung with pneumonia
J95.821	Acute postprocedural respiratory failure
J95.822	Acute and chronic postprocedural respiratory failure
J96.01	Acute respiratory failure with hypoxia

AMA: 31500 2021,Jul; 2018,Jun

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
31500	3.0	0.74	0.43	4.17
Facility RVU	**Work**	**PE**	**MP**	**Total**
31500	3.0	0.74	0.43	4.17

	FUD	Status	MUE	Modifiers				IOM Reference
31500	0	A	2(3)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

cor pulmonale. Heart-lung disease appearing in identifiable forms as chronic or acute. The chronic form of this heart-lung disease is marked by dilation and hypertrophy failure of the right ventricle due to a disease that has affected the function of the lungs, excluding congenital or left heart diseases and is also called chronic cardiopulmonary disease. The acute form is an overload of the right ventricle from a rapid onset of pulmonary hypertension, usually arising from a pulmonary embolism.

embolism. Obstruction of a blood vessel resulting from a clot or foreign substance.

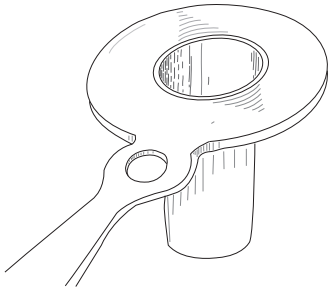
intubation. Insertion of a tube into a hollow organ, canal, or cavity within the body.

 N Newborn: 0 P Pediatric: 0-17 M Maternity: 9-64 A Adult: 15-124 ♂ Male Only ♀ Female Only

46600

46600 Anoscopy; diagnostic, including collection of specimen(s) by brushing or washing, when performed (separate procedure)

Hirschman type anoscope



Any of several types of scopes may be inserted into the anal-rectal column. The anus and distal rectum are visualized

Explanation

The physician performs anoscopy and may obtain brushings or washings. The physician inserts the anoscope into the anus and advances the scope. The anal canal and distal rectal mucosa are visualized, and brushings or washings may be obtained. The anoscope is withdrawn at the completion of the procedure.

Coding Tips

This separate procedure by definition is usually a component of a more complex service and is not identified separately. When performed alone or with other unrelated procedures/services it may be reported; if performed with other procedures/services, list the code and append modifier 59 or an X{EPSU} modifier. Report the appropriate endoscopy for each anatomical site examined. Surgical endoscopy always includes diagnostic endoscopy. However, diagnostic endoscopy can be identified separately when performed at the same surgical session as an open procedure. For diagnostic high resolution anoscopy (HRA), see 46601. Do not report 69990 separately.

ICD-10-CM Diagnostic Codes

A63.0	Anogenital (venereal) warts
C20	Malignant neoplasm of rectum
C21.1	Malignant neoplasm of anal canal
C21.2	Malignant neoplasm of cloacogenic zone
C49.A5	Gastrointestinal stromal tumor of rectum
C78.5	Secondary malignant neoplasm of large intestine and rectum
C7A.026	Malignant carcinoid tumor of the rectum
D01.2	Carcinoma in situ of rectum
D01.3	Carcinoma in situ of anus and anal canal
D12.8	Benign neoplasm of rectum
D12.9	Benign neoplasm of anus and anal canal
D37.5	Neoplasm of uncertain behavior of rectum
K51.20	Ulcerative (chronic) proctitis without complications
K51.211	Ulcerative (chronic) proctitis with rectal bleeding
K51.212	Ulcerative (chronic) proctitis with intestinal obstruction
K51.214	Ulcerative (chronic) proctitis with abscess
K51.218	Ulcerative (chronic) proctitis with other complication
K59.01	Slow transit constipation
K59.02	Outlet dysfunction constipation
K59.03	Drug induced constipation
K59.04	Chronic idiopathic constipation
K59.09	Other constipation
K59.4	Anal spasm
K60.0	Acute anal fissure
K60.1	Chronic anal fissure
K60.3	Anal fistula
K60.4	Rectal fistula
K60.5	Anorectal fistula
K61.0	Anal abscess
K61.1	Rectal abscess
K61.2	Anorectal abscess
K61.31	Horseshoe abscess
K61.39	Other ischiorectal abscess
K61.4	Intrasphincteric abscess
K61.5	Supralevator abscess
K62.0	Anal polyp
K62.1	Rectal polyp
K62.2	Anal prolapse
K62.3	Rectal prolapse
K62.4	Stenosis of anus and rectum
K62.5	Hemorrhage of anus and rectum
K62.6	Ulcer of anus and rectum
K62.82	Dysplasia of anus
K62.89	Other specified diseases of anus and rectum
K64.0	First degree hemorrhoids
K64.1	Second degree hemorrhoids
K64.2	Third degree hemorrhoids
K64.3	Fourth degree hemorrhoids
K64.4	Residual hemorrhoidal skin tags
K64.5	Perianal venous thrombosis
K64.8	Other hemorrhoids
K92.1	Melena

AMA: **46600** 2018,Jan

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
46600	0.55	2.95	0.1	3.6
Facility RVU	**Work**	**PE**	**MP**	**Total**
46600	0.55	0.58	0.1	1.23

	FUD	Status	MUE	Modifiers				IOM Reference
46600	0	A	1(3)	51	N/A	N/A	N/A	None

* with documentation

90380-90381

- **90380** Respiratory syncytial virus, monoclonal antibody, seasonal dose; 0.5 mL dosage, for intramuscular use
- **90381** Respiratory syncytial virus, monoclonal antibody, seasonal dose; 1 mL dosage, for intramuscular use

Explanation

These codes report a monoclonal antibody injection prepared for seasonal respiratory syncytial virus (RSV). The monoclonal antibodies (IgG) target the RSV virus, inhibiting its replication and reducing both the severity and occurrence of RSV infections. It is intended for intramuscular use in neonates and infants who are in their first RSV season and at-risk children up to 2 years of age in their second RSV season. Report 90380 for administration of the 0.5 mL dosage; 90381 for administration of the 1 mL dosage. These codes report the monoclonal antibody product only and should be reported with the appropriate administration code.

Coding Tips

Report these codes with the appropriate administration code. Administration codes should only be reported when the clinician renders face-to-face counseling to the patient and/or family at the time the immunization is being administered. For administration of a vaccine without the face-to-face clinician counseling service for patients 18 years of age and older, see 90471-90474. Separately identifiable E/M services may be reported in addition to the vaccine administration codes.

ICD-10-CM Diagnostic Codes

Z29.11 Encounter for prophylactic immunotherapy for respiratory syncytial virus (RSV)

AMA: **90380** 2023,Nov **90381** 2023,Nov

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90380				
90381				
Facility RVU	**Work**	**PE**	**MP**	**Total**
90380				
90381				

	FUD	Status	MUE	Modifiers				IOM Reference
90380	N/A		-	N/A	N/A	N/A	N/A	None
90381	N/A		-	N/A	N/A	N/A	N/A	

* with documentation

Terms To Know

vaccine. Preparation formed by microorganisms or viruses that have been altered to reduce their virulence but retain their ability to trigger the immune response.

90471-90472

90471 Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/toxoid)

\+ **90472** each additional vaccine (single or combination vaccine/toxoid) (List separately in addition to code for primary procedure)

Explanation

A physician, nurse, or medical assistant administers an injectable (percutaneous, intradermal, subcutaneous, or intramuscular) immunization to the patient. It may be a single vaccine or a combination vaccine/toxoid in one immunization administration (e.g., diphtheria, pertussis, and tetanus toxoids are in a single DPT immunization). Report 90471 for one vaccine and 90472 for each additional vaccine (single or combination vaccine/toxoid).

Coding Tips

Report these services for immunization administration of any vaccine, other than SARS-CoV-2 [COVID-19] vaccines, that does not include face-to-face physician or other qualified health care professional counseling of the patient or caregiver during vaccine administration to patients older than 18 years of age. Do not report 90471 with 90473. Report 90472 in addition to 90460, 90471, or 90473.

ICD-10-CM Diagnostic Codes

Z23 Encounter for immunization

Z29.89 Encounter for other specified prophylactic measures

AMA: **90471** 2023,May; 2023,Feb; 2022,Jul; 2021,Dec; 2021,Oct; 2021,Jun; 2021,May; 2020,Nov; 2020,Jan; 2019,Jun; 2018,Nov **90472** 2023,May; 2023,Feb; 2022,Jul; 2021,Dec; 2021,Oct; 2021,Jun; 2021,May; 2020,Nov; 2020,Jan; 2018,Nov

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
90471	0.17	0.42	0.01	0.6
90472	0.15	0.27	0.01	0.43
Facility RVU	**Work**	**PE**	**MP**	**Total**
90471	0.17	0.42	0.01	0.6
90472	0.15	0.27	0.01	0.43

	FUD	Status	MUE	Modifiers				IOM Reference
90471	N/A	A	1(2)	N/A	N/A	N/A	80*	None
90472	N/A	A	8(3)	N/A	N/A	N/A	80*	

* with documentation

Terms To Know

intramuscular. Within a muscle.

vaccine. Preparation formed by microorganisms or viruses that have been altered to reduce their virulence but retain their ability to trigger the immune response.

G0101

G0101 Cervical or vaginal cancer screening; pelvic and clinical breast examination

Explanation

This code reports a cervical or vaginal cancer screening and a pelvic and clinical breast examination. The specimen for cancer screening is collected by cervical, endocervical, or vaginal scrapings or by aspiration of vaginal fluid and cells. The pelvic and breast exams are done manually by the physician to check for abnormalities, pain, and/or any palpable lumps or masses.

Coding Tips

If a separately identifiable service is performed in addition to this procedure, an E/M service may be reported with modifier 25 appended. Some payers may require this service to be reported using CPT preventive medicine service codes: new patient, see 99384-99387; established patient, see 99394-99397. Check with specific payers to determine coverage.

ICD-10-CM Diagnostic Codes

Z01.411 Encounter for gynecological examination (general) (routine) with abnormal findings ♀

Z01.419 Encounter for gynecological examination (general) (routine) without abnormal findings ♀

Z12.39 Encounter for other screening for malignant neoplasm of breast

Z12.4 Encounter for screening for malignant neoplasm of cervix ♀

Z12.72 Encounter for screening for malignant neoplasm of vagina ♀

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0101	0.45	0.65	0.07	1.17
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0101	0.45	0.3	0.07	0.82

	FUD	Status	MUE	Modifiers				IOM Reference
G0101	N/A	A	1(2)	N/A	N/A	N/A	80*	None

* with documentation

Terms To Know

endocervix. Region of the cervix uteri that opens into the uterus or the mucous membrane lining the cervical canal.

screening test. Exam or study used by a physician to identify abnormalities, regardless of whether the patient exhibits symptoms.

G0102

G0102 Prostate cancer screening; digital rectal examination

Explanation

This code reports a prostate cancer screening performed manually by the physician as a digital rectal exam in order to palpate the prostate and check for abnormalities.

Coding Tips

This service is covered by Medicare once every 12 months for men who have attained age 50; at least 11 months must have passed following the month in which the last Medicare-covered screening digital rectal examination was performed.

ICD-10-CM Diagnostic Codes

Z12.5 Encounter for screening for malignant neoplasm of prostate ♂

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0102	0.18	0.5	0.01	0.69
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0102	0.18	0.07	0.01	0.26

	FUD	Status	MUE	Modifiers				IOM Reference
G0102	N/A	A	1(2)	N/A	N/A	N/A	N/A	None

* with documentation

Terms To Know

prostate cancer screening tests. Test that consists of any (or all) of the procedures provided for the early detection of prostate cancer to a man 50 years of age or older who has not had a test during the preceding year. The procedures are as follows: a digital rectal examination; a prostate-specific antigen blood test. After 2002, the list of procedures may be expanded as appropriate for the early detection of prostate cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and other factors.

screening test. Exam or study used by a physician to identify abnormalities, regardless of whether the patient exhibits symptoms.

G0011-G0013

- **G0011** Individual counseling for pre-exposure prophylaxis (PrEP) by physician or qualified health care professional (QHP) to prevent human immunodeficiency virus (HIV), includes HIV risk assessment (initial or continued assessment of risk HIV risk reduction and medication adherence, 15 to 30 minutes
- **G0012** Injection of pre-exposure prophylaxis (PrEP) drug for HIV prevention, under skin or into muscle
- **G0013** Individual counseling for pre-exposure prophylaxis (PrEP) by clinical staff to prevent human immunodeficiency virus (HIV), includes: HIV risk assessment (initial or continued assessment of risk), HIV risk reduction and medication adherence

Explanation

Pre-exposure prophylaxis (PrEP) for human immunodeficiency virus (HIV) involves prescription medication that is administered orally or by injection to prevent contraction of HIV during sex or from injection drug use in high-risk patients. The antiretroviral drug is administered on an ongoing basis before and after HIV exposure. Report G0011 for 15 to 30 minutes of individual counseling for PrEP by a physician or qualified health care professional with an assessment for initial or continued risk, including HIV risk reduction and medication adherence; G0012 for subcutaneous or intramuscular injection of the PrEP drug; and G0013 for individual counseling by clinical staff with an assessment for initial or continued risk, including HIV risk reduction and medication adherence.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0011				
G0012				
G0013				
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0011				
G0012				
G0013				

G0019-G0022

- **G0019** Community health integration services performed by certified or trained auxiliary personnel, including a community health worker, under the direction of a physician or other practitioner, 60 minutes per calendar month, in the following activities to address social determinants of health (SDOH) need(s) that are significantly limiting the ability to diagnose or treat problem(s) addressed in an initiating visit:
- **G0022** Community health integration services, each additional 30 minutes per calendar month (list separately in addition to G0019)

Explanation

Certified or trained auxiliary personnel provide community health integration services to address social determinants of health (SDOH) with a patient under the direction of a physician or other qualified health care professional. SDOH can limit the provider's ability to diagnose or treat a condition and the patient's ability to follow the prescribed treatment plan. The provider performs a person-centered assessment to identify the SDOH needs and the problems that need to be addressed in an initiating E/M service. This service may include information about the patient such as their life story, strengths, goals, preferences, and cultural and linguistic factors. After setting goals with the patient and developing an action plan, support is provided to the patient to continue the desired treatment plan. The provider also coordinates care with other health care professionals, facilities, and caregivers as necessary, including referrals to specialists or follow-up visits after care in a facility such as an emergency room or skilled nursing facility. The patient may require community-based social services specific to their SDOH needs (e.g., food assistance, transportation). Additional services may be necessary to support the patient in accomplishing the treatment goals. Report G0019 for the first 60 minutes of community health integration services per calendar month and G0022 for each additional 30 minutes per calendar month.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0019				
G0022				
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0019				
G0022				

G0023-G0024

- **G0023** Principal illness navigation services by certified or trained auxiliary personnel under the direction of a physician or other practitioner, including a patient navigator, 60 minutes per calendar month, in the following activities:
- **G0024** Principal illness navigation services, additional 30 minutes per calendar month (list separately in addition to G0023)

Explanation

Principal Illness Navigation (PIN) services are performed by certified or trained auxiliary personnel under the direction of a physician or other practitioner. PIN services are provided to Medicare patients with high-risk conditions who receive a patient-centered assessment to better identify their needs and connect them to clinical and support resources. High-risk conditions for which PIN services are provided include, but are not limited to, congestive heart failure (CHF), chronic kidney disease (CKD), dementia, cancer, HIV/AIDS, organ failure, substance use disorder (SUD), and mental health conditions. PIN services are provided during an initial visit and in subsequent visits to establish ongoing support and direction as the patient connects to disease-specific resources related to their high-risk condition. Examples of PIN services include establishing a comprehensive record of the patient's health history along with their cultural and linguistic identities, aligning care coordination, targeting illness-specific health education, providing health-care system navigation, building patient self-advocacy skills, and enabling access to services that address unmet social determinations of health (SDOH) needs. Report G0023 for the first 60 minutes of PIN services provided per calendar month. Report G0024 for each additional 30 minutes of PIN services provided per calendar month; list separately in addition to G0023.

Relative Value Units/Medicare Edits

Non-Facility RVU	Work	PE	MP	Total
G0023				
G0024				
Facility RVU	**Work**	**PE**	**MP**	**Total**
G0023				
G0024				

G0108-G0109

G0108 Diabetes outpatient self-management training services, individual, per 30 minutes

G0109 Diabetes outpatient self-management training services, group session (two or more), per 30 minutes

Explanation

These codes are for diabetes self-management training services, either individually or in a group of two or more. Diabetes self-management training is done to teach the diabetic how to control and monitor blood glucose levels with the

Correct Coding Initiative Update 29.3

❖Indicates Mutually Exclusive Edit

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0771T No CCI edits apply to this code.

0772T No CCI edits apply to this code.

0773T No CCI edits apply to this code.

0774T No CCI edits apply to this code.

0815T No CCI edits apply to this code.

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