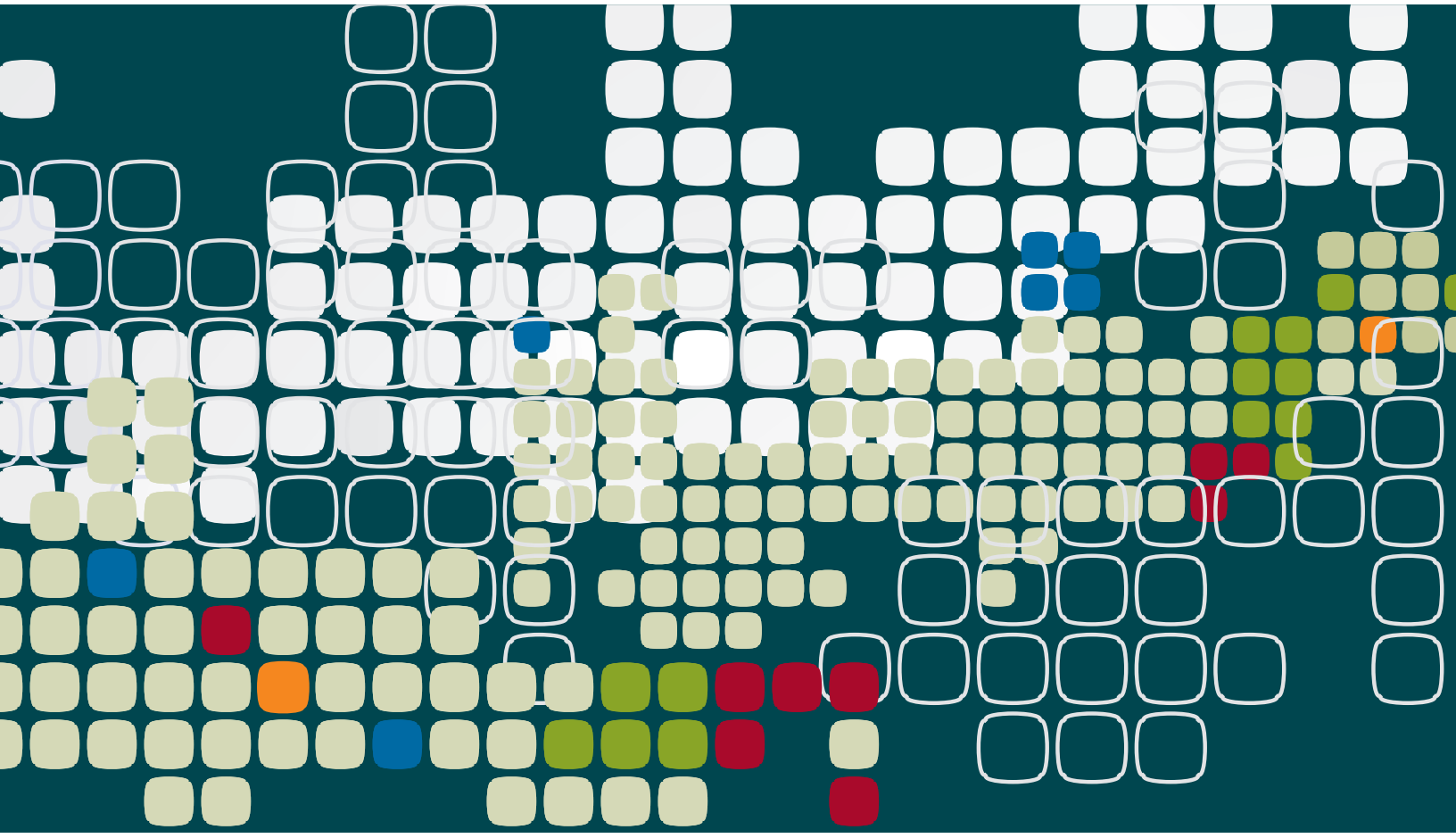
AAPC Workshops

Complete 2023 Procedure Coding Updates



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2022

Complete 2023 Procedure Coding Updates

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Rae has over 26 years' experience in the healthcare industry. She is a nationally recognized speaker and thought leader in the business of healthcare. She serves as a coding liaison to the AMA CPT® Editorial Panel. Over the past 12 years at AAPC she has held a variety of responsibilities including leading the development of certification exams and exam preparation materials, overseeing the operations for the exam, distance learning and education licensing program departments. As the SVP of product, she oversees all AAPC product lines.

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Introduction

Every autumn, the American Medical Association (AMA) releases a revised CPT® code set for implementation the following January 1. This workbook summarizes the CPT® 2023 code changes announced September 2022. Subsequent changes released as addenda or errata will be posted on the AAPC website (www.aapc.com).

This guide is not comprehensive and is not a replacement for the 2023 CPT® code book. Always use the current CPT® code book.

Checklist for Updating Your Codes

(√) Begin reviewing 2023 CPT® code changes, using this guide.

- ☐ Order 2023 code books.
- ☐ Review all changes to guidelines, notes, and instructions in your book.
- ☐ Highlight and review changes in the book's index, pertinent to your specialty.
- ☐ Highlight and review changes in the book's tabular (numeric) section, pertinent to your specialty.
- ☐ Review and update superbills, chargemasters, or fee schedules, etc.
- ☐ Upload software changes.
- ☐ Train coding, billing, and clinical staff on changes.
- ☐ Check regularly for addenda or errata to the 2023 code set; share any changes with coding and clinical staff.
- ☐ Alert payer and provider representatives regarding reimbursement and coverage issues.
- ☐ Archive your 2022 code books by April 1, 2023.

CPT® 2023 Revisions

CPT® 2023 includes 223 new Category I, Category III codes and PLA codes, 103 revised code descriptors, and 75 deleted codes — plus revised introductory guidelines, and new and revised parenthetical references.

Section Guidelines

New section guidelines (printed in green ink, for easy identification) occur throughout the CPT® 2023 code book.

Modifiers

AMA has added one new CPT® modifier for 2022 that was not included in 2022 AMA CPT code book. Modifier 93 is added

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Evaluation and Management Services

	~~**99217**~~	~~**Observation care discharge** day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.])~~ **AAPC Rationale** CPT® deletes 99217, which represented services provided to a patient being discharged from observation status on a date other than the observation start date. In place of 99217, you should use revised hospital inpatient or observation discharge codes 99238 (30 minutes or less) and 99239 (more than 30 minutes). The deletion of 99217 is part of a major revision to the evaluation and management (E/M) section of CPT®. Effective date of this deletion: January 1, 2023.
	~~**99218**~~	~~**Initial observation care,** per day, for the evaluation and management of a patient which requires these 3 key components:~~ ~~• **A detailed or comprehensive history;**~~ ~~• **A detailed or comprehensive examination; and**~~ ~~• **Medical decision making that is straightforward or of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ **AAPC Rationale** CPT® deletes 99218, 99219, and 99220, which represented initial observation care to a patient. In place of 99218-99220, you should use revised initial hospital inpatient or observation care codes 99221 (low medical decision making [MDM] or at least 40 minutes total time), 99222 (moderate MDM or at least 55 minutes total time), and 99223 (high MDM or at least 75 minutes total time). The deletion of 99218-99220 is part of a major revision to the evaluation and management (E/M) section of CPT®. Effective date of this deletion: January 1, 2023.

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	~~99219~~	**~~Initial observation care,~~** ~~per day, for the evaluation and management of a patient, which requires these 3 key components:~~ • **~~A comprehensive history;~~** • **~~A comprehensive examination; and~~** • **~~Medical decision making of moderate complexity.~~** ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ **AAPC Rationale** CPT® deletes 99218, 99219, and 99220, which represented initial observation care to a patient. In place of 99218-99220, you should use revised initial hospital inpatient or observation care codes 99221 (low medical decision making [MDM] or at least 40 minutes total time), 99222 (moderate MDM or at least 55 minutes total time), and 99223 (high MDM or at least 75 minutes total time). The deletion of 99218-99220 is part of a major revision to the evaluation and management (E/M) section of CPT®. Effective date of this deletion: January 1, 2023.
	~~99220~~	**~~Initial observation care,~~** ~~per day, for the evaluation and management of a patient, which requires these 3 key components:~~ • **~~A comprehensive history;~~** • **~~A comprehensive examination; and~~** • **~~Medical decision making of high complexity.~~** ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission to outpatient hospital "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ **AAPC Rationale** CPT® deletes 99218, 99219, and 99220, which represented initial observation care to a patient. In place of 99218-99220, you should use revised initial hospital inpatient or observation care codes 99221 (low medical decision making [MDM] or at least 40 minutes total time), 99222 (moderate MDM or at least 55 minutes total time), and 99223 (high MDM or at least 75 minutes total time). The deletion of 99218-99220 is part of a major revision to the evaluation and management (E/M) section of CPT®. Effective date of this deletion: January 1, 2023.

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	~~99224~~	**~~Subsequent observation care,~~** ~~per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:~~ • **~~Problem focused interval history;~~** • **~~Problem focused examination;~~** • **~~Medical decision making that is straightforward or of low complexity.~~** ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ **AAPC Rationale** CPT® deletes 99224, 99225, and 99226, which represented subsequent observation care for a patient. In place of 99224-99226, you should use revised subsequent hospital inpatient or observation care codes 99231 (straightforward or low medical decision making [MDM] or at least 25 minutes total time), 99232 (moderate MDM or at least 35 minutes total time), and 99233 (high MDM or at least 50 minutes total time). The deletion of 99224-99226 is part of a major revision to the evaluation and management (E/M) section of CPT®. Effective date of this deletion: January 1, 2023.
	~~99225~~	**~~Subsequent observation care,~~** ~~per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:~~ • **~~An expanded problem focused interval history;~~** • **~~An expanded problem focused examination;~~** • **~~Medical decision making of moderate complexity.~~** ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ **AAPC Rationale** CPT® deletes 99224, 99225, and 99226, which represented subsequent observation care for a patient. In place of 99224-99226, you should use revised subsequent hospital inpatient or observation care codes 99231 (straightforward or low medical decision making [MDM] or at least 25 minutes total time), 99232 (moderate MDM or at least 35 minutes total time), and 99233 (high MDM or at least 50 minutes total time). The deletion of 99224-99226 is part of a major revision to the evaluation and management (E/M) section of CPT®. Effective date of this deletion: January 1, 2023.

	~~99226~~	**~~Subsequent observation care,~~** ~~per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components:~~ • **~~A detailed interval history;~~** • **~~A detailed examination;~~** • **~~Medical decision making of high complexity~~**~~.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ **AAPC Rationale** CPT® deletes 99224, 99225, and 99226, which represented subsequent observation care for a patient. In place of 99224-99226, you should use revised subsequent hospital inpatient or observation care codes 99231 (straightforward or low medical decision making [MDM] or at least 25 minutes total time), 99232 (moderate MDM or at least 35 minutes total time), and 99233 (high MDM or at least 50 minutes total time). The deletion of 99224-99226 is part of a major revision to the evaluation and management (E/M) section of CPT®. Effective date of this deletion: January 1, 2023.

▲	**99221**	**Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level medical decision making. ~~these 3 key components:~~ • ~~A detailed or comprehensive history;~~ • ~~A detailed or comprehensive examination; and~~ • ~~Medical decision making that is straightforward or of low complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99221, 99222, and 99223 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99221-99223 previously represented initial hospital care requiring specific levels of the three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised codes represent initial hospital inpatient or observation care. The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99221 requires straightforward of low MDM or at least 40 minutes of total time. Effective date of this revision: January 1, 2023.

▲	**99222**	**Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~these 3 key components:~~ • ~~A comprehensive history;~~ • ~~A comprehensive examination; and~~ • ~~Medical decision making of moderate complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99221, 99222, and 99223 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99221-99223 previously represented initial hospital care requiring specific levels of the three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised codes represent initial hospital inpatient or observation care. The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99222 requires moderate MDM or at least 55 minutes of total time. Effective date of this revision: January 1, 2023.

▲	**99223**	**Initial hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making. ~~these 3 key components~~: • ~~A comprehensive history;~~ • ~~A comprehensive examination; and~~ • ~~Medical decision making of high complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99221, 99222, and 99223 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99221-99223 previously represented initial hospital care requiring specific levels of the three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised codes represent initial hospital inpatient or observation care. The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99223 requires high MDM or at least 75 minutes of total time. Effective date of this revision: January 1, 2023.

★ ▲	**99231**	**Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making. ~~at least 2 of these 3 key components:~~ • ~~A problem focused interval history;~~ • ~~A problem focused examination;~~ • ~~Medical decision making that is straightforward or of low complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99231, 99232, and 99233 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99231-99233 previously represented subsequent hospital care requiring specific levels of two of three key components (interval history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised codes represent subsequent hospital inpatient or observation care. The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99231 requires straightforward or low MDM or at least 25 minutes of total time. Effective date of this revision: January 1, 2023.

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★ ▲	**99232**	**Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.~~at least 2 of these 3 key components:~~ • ~~An expanded problem focused interval history;~~ • ~~An expanded problem focused examination;~~ • ~~Medical decision making of moderate complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99231, 99232, and 99233 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99231-99233 previously represented subsequent hospital care requiring specific levels of two of three key components (interval history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised codes represent subsequent hospital inpatient or observation care. The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99232 requires moderate MDM or at least 35 minutes of total time. Effective date of this revision: January 1, 2023.

★ ▲	**99233**	**Subsequent hospital inpatient or observation care,** per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.~~at least 2 of these 3 key components:~~ • ~~A detailed interval history;~~ • ~~A detailed examination;~~ • ~~Medical decision making of high complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 50 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99231, 99232, and 99233 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99231-99233 previously represented subsequent hospital care requiring specific levels of two of three key components (interval history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised codes represent subsequent hospital inpatient or observation care. The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99233 requires high MDM or at least 50 minutes of total time. Effective date of this revision: January 1, 2023.

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▲	**99234**	**Hospital inpatient or ~~O~~observation ~~or inpatient hospital~~ care,** for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.~~these 3 key components:~~ • ~~A detailed or comprehensive history;~~ • ~~A detailed or comprehensive examination; and~~ • ~~Medical decision making that is straightforward or of low complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually the presenting problem(s) requiring admission are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99234, 99235, and 99236 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99234-99236 previously represented observation or inpatient hospital care with admission and discharge on the same date, requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised codes also represent observation or inpatient hospital care with admission and discharge on the same date. The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the service date. Code 99234 requires straightforward or low MDM or at least 45 minutes of total time. Effective date of this revision: January 1, 2023.

▲	**99235**	**Hospital inpatient or ~~O~~observation ~~or inpatient hospital~~ care,** for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and moderate level of medical decision making.~~these 3 key components:~~ ● ~~A comprehensive history;~~ ● ~~A comprehensive examination; and~~ ● ~~Medical decision making of moderate complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 70 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99234, 99235, and 99236 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99234-99236 previously represented observation or inpatient hospital care with admission and discharge on the same date, requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised codes also represent observation or inpatient hospital care with admission and discharge on the same date. The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the service. Code 99235 requires moderate MDM or at least 70 minutes of total time. Effective date of this revision: January 1, 2023.

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▲	**99236**	**Hospital inpatient or ~~O~~observation ~~or inpatient hospital~~ care,** for the evaluation and management of a patient including admission and discharge on the same date, which requires a medically appropriate history and/or examination and high level of medical decision making.~~these 3 key components:~~ • ~~A comprehensive history;~~ • ~~A comprehensive examination; and~~ • ~~Medical decision making of high complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually the presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 85 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99234, 99235, and 99236 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99234-99236 previously represented observation or inpatient hospital care with admission and discharge on the same date, requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised codes also represent observation or inpatient hospital care with admission and discharge on the same date. The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the service. Code 99236 requires high MDM or at least 85 minutes of total time. Effective date of this revision: January 1, 2023.
▲	**99238**	**Hospital inpatient or observation discharge day management;** 30 minutes or less on the date of the encounter **AAPC Rationale** CPT® revises 99238 and 99239 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99238 and 99239 previously represented hospital discharge day management. The revised codes represent hospital inpatient or observation discharge day management. You will continue to use 99238 for 30 minutes or less and 99239 for more than 30 minutes. Effective date of this revision: January 1, 2023.

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▲	**99239**	**Hospital inpatient or observation discharge day management;** more than 30 minutes on the date of the encounter **AAPC Rationale** CPT® revises 99238 and 99239 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99238 and 99239 previously represented hospital discharge day management. The revised codes represent hospital inpatient or observation discharge day management. You will continue to use 99238 for 30 minutes or less and 99239 for more than 30 minutes. Effective date of this revision: January 1, 2023.
	~~**99241**~~	~~**Office consultation** for a new or established patient, which requires these 3 key components:~~ • ~~**A problem focused history;**~~ • ~~**A problem focused examination; and**~~ • ~~**Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.~~ **AAPC Rationale** CPT® deletes 99241, which represented a low-level office consultation. In place of 99241, you should use revised code 99242, which requires straightforward medical decision making (just as 99241 did) or 20 minutes of total time on the encounter date. The deletion of 99241 is part of a major revision to the evaluation and management (E/M) section of CPT®. Effective date of this deletion: January 1, 2023.

★ ▲	**99242**	**Office or other outpatient consultation** for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.~~these 3 key components:~~ • ~~An expanded problem focused history;~~ • ~~An expanded problem focused examination; and~~ • ~~Straightforward medical decision making.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99242-99245 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99242-99245 previously referenced office consultation requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "office or other outpatient." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99242 requires straightforward MDM or at least 20 minutes of total time. CPT® also deletes 99241, which represented a low-level office consultation with straightforward MDM. In place of 99241, you should use revised code 99242. See revised codes 99252-99255 for inpatient or observation consultations. Effective date of this revision: January 1, 2023.

★ ▲	**99243**	**Office or other outpatient consultation** for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. ~~these 3 key components:~~ • ~~A detailed history;~~ • ~~A detailed examination; and~~ • ~~Medical decision making of low complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99242-99245 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99242-99245 previously referenced office consultation requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "office or other outpatient." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99243 requires low MDM or at least 30 minutes of total time. See 99252-99255 for inpatient or observation consultations. Effective date of this revision: January 1, 2023.

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★ ▲	**99244**	**Office or other outpatient consultation** for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.~~these 3 key components:~~ • ~~A comprehensive history;~~ • ~~A comprehensive examination; and~~ • ~~Medical decision making of moderate complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99242-99245 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99242-99245 previously referenced office consultation requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "office or other outpatient." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99244 requires moderate MDM or at least 40 minutes of total time. See 99252-99255 for inpatient or observation consultations. Effective date of this revision: January 1, 2023.

★ ▲	**99245**	**Office or other outpatient consultation** for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.~~these 3 key components:~~ • ~~A comprehensive history;~~ • ~~A comprehensive examination; and~~ • ~~Medical decision making of high complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99242-99245 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99242-99245 previously referenced office consultation requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "office or other outpatient." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99245 requires high MDM or at least 55 minutes of total time. See 99252-99255 for inpatient or observation consultations. Effective date of this revision: January 1, 2023.
	~~**99251**~~	~~**Inpatient consultation** for a new or established patient, which requires these 3 key components:~~ • ~~**A problem focused history;**~~ • ~~**A problem focused examination; and**~~ • ~~**Straightforward medical decision making.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are self limited or minor. Typically, 20 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ **AAPC Rationale** CPT® deletes 99251, which represented a low-level inpatient consultation. In place of 99251, you should use revised code 99252, which applies to inpatient or observation consultations with straightforward medical decision making (just as 99251 did) or at least 35 minutes of total time on the encounter date. The deletion of 99251 is part of a major revision to the evaluation and management (E/M) section of CPT®. Effective date of this deletion: January 1, 2023.

★ ▲	**99252**	**Inpatient or observation consultation** for a new or established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.~~these 3 key components:~~ • ~~An expanded problem focused history;~~ • ~~An expanded problem focused examination; and~~ • ~~Straightforward medical decision making.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99252-99255 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99252-99255 previously referenced inpatient consultation requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "inpatient or observation." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99252 requires straightforward MDM or at least 35 minutes of total time. CPT® also deletes 99251, which represented a low-level inpatient consultation. In place of 99251, you should use revised code 99252. Effective date of this revision: January 1, 2023.

★ ▲	**99253**	**Inpatient or observation consultation** for a new or established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.~~these 3 key components:~~ • ~~A detailed history;~~ • ~~A detailed examination; and~~ • ~~Medical decision making of low complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99252-99255 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99252-99255 previously referenced inpatient consultation requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "inpatient or observation consultation." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99253 requires low MDM or at least 45 minutes of total time. Effective date of this revision: January 1, 2023.

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★ ▲	**99254**	**Inpatient or observation consultation** for a new or established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.~~these 3 key components:~~ • ~~A comprehensive history;~~ • ~~A comprehensive examination; and~~ • ~~Medical decision making of moderate complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 80 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99252-99255 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99252-99255 previously referenced inpatient consultation requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "inpatient or observation consultation." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99254 requires moderate MDM or at least 60 minutes of total time. Effective date of this revision: January 1, 2023.

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★ ▲	**99255**	**Inpatient or observation consultation** for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.~~these 3 key components:~~ • ~~A comprehensive history;~~ • ~~A comprehensive examination; and~~ • ~~Medical decision making of high complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 110 minutes are spent at the bedside and on the patient's hospital floor or unit.~~ When using total time on the date of the encounter for code selection, 80 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99252-99255 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99252-99255 previously referenced inpatient consultation requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "inpatient or observation consultation." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99255 requires high MDM or at least 80 minutes of total time. Effective date of this revision: January 1, 2023.

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▲	**99281**	**Emergency department visit** for the evaluation and management of a patient~~, which requires these 3 key components:~~ that may not require the presence of a physician or other qualified health care professional • ~~A problem focused history;~~ • ~~A problem focused examination; and~~ • ~~Straightforward medical decision making.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are self limited or minor.~~ **AAPC Rationale** CPT® revises 99281-99285 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99281-99285 previously referenced an emergency department visit requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level. The revised code descriptors for 99282-99285 now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM. Note that you do not choose emergency department codes based on time. Code 99281 differs from the other codes in the range because the descriptor does not offer an MDM level. Instead, the descriptor states the service "may not require the presence of a physician or other qualified healthcare professional." Effective date of this revision: January 1, 2023.

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▲	**99282**	**Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making~~which requires these 3 key components:~~ • ~~An expanded problem focused history;~~ • ~~An expanded problem focused examination; and~~ • ~~Medical decision making of low complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low to moderate severity.~~ **AAPC Rationale** CPT® revises 99281-99285 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99281-99285 previously referenced an emergency department visit requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level. Revised code 99281 differs from the other codes in the range because the descriptor does not offer an MDM level. Instead, it states the service "may not require the presence of a physician or other qualified healthcare professional." The revised code descriptors for 99282-99285 now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM. Note that you do not choose emergency department codes based on time. Code 99282 requires straightforward MDM. Effective date of this revision: January 1, 2023.

▲	**99283**	**Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making~~which requires these 3 key components:~~ • ~~An expanded problem focused history;~~ • ~~An expanded problem focused examination; and~~ • ~~Medical decision making of moderate complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate severity.~~ **AAPC Rationale** CPT® revises 99281-99285 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99281-99285 previously referenced an emergency department visit requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level. Revised code 99281 differs from the other codes in the range because the descriptor does not offer an MDM level. Instead, it states the service "may not require the presence of a physician or other qualified healthcare professional." The revised code descriptors for 99282-99285 now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM. Note that you do not choose emergency department codes based on time. Code 99283 requires low MDM. Effective date of this revision: January 1, 2023.

▲	**99284**	**Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making~~which requires these 3 key components~~: ● ~~A detailed history;~~ ● ~~A detailed examination; and~~ ● ~~Medical decision making of moderate complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.~~ **AAPC Rationale** CPT® revises 99281-99285 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99281-99285 previously referenced an emergency department visit requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level. Revised code 99281 differs from the other codes in the range because the descriptor does not offer an MDM level. Instead, it states the service "may not require the presence of a physician or other qualified healthcare professional." The revised code descriptors for 99282-99285 now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM. Note that you do not choose emergency department codes based on time. Code 99284 requires moderate MDM. Effective date of this revision: January 1, 2023.

▲	**99285**	**Emergency department visit** for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making~~which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status:~~ • ~~A comprehensive history;~~ • ~~A comprehensive examination; and~~ • ~~Medical decision making of high complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.~~ **AAPC Rationale** CPT® revises 99281-99285 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99281-99285 previously referenced an emergency department visit requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level. Revised code 99281 differs from the other codes in the range because the descriptor does not offer an MDM level. Instead, it states the service "may not require the presence of a physician or other qualified healthcare professional." The revised code descriptors for 99282-99285 now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM. Note that you do not choose emergency department codes based on time. Code 99285 requires high MDM. Effective date of this revision: January 1, 2023.

▲	**99304**	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward or low level of medical decision making.~~these 3 key components:~~ • ~~A detailed or comprehensive history;~~ • ~~A detailed or comprehensive examination; and~~ • ~~Medical decision making that is straightforward or of low complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 25 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99304-99306 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99304-99306 previously represented initial nursing facility care requiring specific levels of the three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99304 requires straightforward or low MDM or at least 25 minutes of total time. Effective date of this revision: January 1, 2023.

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▲	**99305**	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. ~~these 3 key components:~~ • ~~A comprehensive history;~~ • ~~A comprehensive examination; and~~ • ~~Medical decision making of moderate complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 35 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99304-99306 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99304-99306 previously represented initial nursing facility care requiring specific levels of the three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99305 requires moderate MDM or at least 35 minutes of total time. Effective date of this revision: January 1, 2023.

▲	**99306**	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.~~these 3 key components:~~ • ~~A comprehensive history;~~ • ~~A comprehensive examination; and~~ • ~~Medical decision making of high complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99304-99306 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99304-99306 previously represented initial nursing facility care requiring specific levels of the three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99306 requires high MDM or at least 45 minutes of total time. Effective date of this revision: January 1, 2023.

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★ ▲	**99307**	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.~~at least 2 of these 3 key components~~: • ~~A problem focused interval history;~~ • ~~A problem focused examination;~~ • ~~Straightforward medical decision making.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 10 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99307-99310 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99307-99310 previously represented subsequent nursing facility care requiring specific levels of two of the three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99307 requires straightforward MDM or at least 10 minutes of total time. Effective date of this revision: January 1, 2023.

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★ ▲	**99308**	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making.~~at least 2 of these 3 key components:~~ • ~~An expanded problem focused interval history;~~ • ~~An expanded problem focused examination;~~ • ~~Medical decision making of low complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99307-99310 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99307-99310 previously represented subsequent nursing facility care requiring specific levels of two of the three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99308 requires low MDM or at least 15 minutes of total time. Effective date of this revision: January 1, 2023.

★ ▲	**99309**	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.~~at least 2 of these 3 key components~~: • ~~A detailed interval history;~~ • ~~A detailed examination;~~ • ~~Medical decision making of moderate complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99307-99310 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99307-99310 previously represented subsequent nursing facility care requiring specific levels of two of the three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99309 requires moderate MDM or at least 30 minutes of total time. Effective date of this revision: January 1, 2023.

★ ▲	**99310**	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making.~~at least 2 of these 3 key components:~~ • ~~A comprehensive interval history;~~ • ~~A comprehensive examination;~~ • ~~Medical decision making of high complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.~~ When using total time on the date of the encounter for code selection, 45 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99307-99310 as part of a major revision to the evaluation and management (E/M) section of the code set. Codes 99307-99310 previously represented subsequent nursing facility care requiring specific levels of two of the three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99310 requires high MDM or at least 45 minutes of total time. Effective date of this revision: January 1, 2023.
▲	**99315**	Nursing facility discharge ~~day~~ management; 30 minutes or less total time on the date of the encounter **AAPC Rationale** CPT® revises 99315-99316 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99315-99316 previously referred to nursing facility "discharge day management" with 99315 for "30 minutes or less" and 99316 for "more than 30 minutes." The revised descriptors remove the term "day" and clarify that the total time is on the encounter date. Guidelines with the codes state you should base code selection on "total time on the date of the discharge management face-to-face encounter," even when that encounter occurs before the date the patient leaves the facility. Code 99315 continues to apply when the service is 30 minutes or less, and 99316 continues to apply when the time is more than 30 minutes. Effective date of this revision: January 1, 2023.

▲	**99316**	Nursing facility discharge ~~day~~ management; more than 30 minutes total time on the date of the encounter **AAPC Rationale** CPT® revises 99315-99316 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99315-99316 previously referred to nursing facility "discharge day management" with 99315 for "30 minutes or less" and 99316 for "more than 30 minutes." The revised descriptors remove the term "day" and clarify that the total time is on the encounter date. Guidelines with the codes state you should base code selection on "total time on the date of the discharge management face-to-face encounter," even when that encounter occurs before the date the patient leaves the facility. Code 99315 continues to apply when the service is 30 minutes or less, and 99316 continues to apply when the time is more than 30 minutes. Effective date of this revision: January 1, 2023.
	~~99318~~	~~Evaluation and management of a patient involving an annual nursing facility assessment, which requires these 3 key components:~~ • ~~**A detailed interval history;**~~ • ~~**A comprehensive examination; and**~~ • ~~**Medical decision making that is of low to moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is stable, recovering, or improving. Typically, 30 minutes are spent at the bedside and on the patient's facility floor or unit.~~ **AAPC Rationale** CPT® deletes 99318, which represented an annual nursing facility assessment requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptor also stated a usual severity level and a typical amount of time. In place of 99318, you should use revised subsequent nursing facility care codes 99307-99310. Code selection is based on MDM or total time. The deletion of 99318 is part of a major revision to the evaluation and management (E/M) section of CPT®. Effective date of this deletion: January 1, 2023.

	~~99324~~	~~Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:~~ • **~~A problem focused history;~~** • **~~A problem focused examination; and~~** • **~~Straightforward medical decision making.~~** ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent with the patient and/or family or caregiver.~~ **AAPC Rationale** CPT® deletes 99324-99328, which represented domiciliary or rest home visits for the evaluation and management (E/M) of a new patient. The codes required specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. In place of 99324-99328, you should use revised codes 99341, 99342, 99344, and 99345, which apply to home or residence E/M visits for a new patient. Code selection is based on MDM or total time. The deletion of 99324-99328 is part of a major revision to the E/M section of CPT®. Effective date of this deletion: January 1, 2023.
	~~99325~~	~~Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:~~ • **~~An expanded problem focused history;~~** • **~~An expanded problem focused examination; and~~** • **~~Medical decision making of low complexity.~~** ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent with the patient and/or family or caregiver.~~ **AAPC Rationale** CPT® deletes 99324-99328, which represented domiciliary or rest home visits for the evaluation and management (E/M) of a new patient. The codes required specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. In place of 99324-99328, you should use revised codes 99341, 99342, 99344, and 99345, which apply to home or residence E/M visits for a new patient. Code selection is based on MDM or total time. The deletion of 99324-99328 is part of a major revision to the E/M section of CPT®. Effective date of this deletion: January 1, 2023.

	~~99326~~	~~Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:~~ • **~~A detailed history;~~** • **~~A detailed examination; and~~** • **~~Medical decision making of moderate complexity.~~** ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent with the patient and/or family or caregiver.~~ **AAPC Rationale** CPT® deletes 99324-99328, which represented domiciliary or rest home visits for the evaluation and management (E/M) of a new patient. The codes required specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. In place of 99324-99328, you should use revised codes 99341, 99342, 99344, and 99345, which apply to home or residence E/M visits for a new patient. Code selection is based on MDM or total time. The deletion of 99324-99328 is part of a major revision to the E/M section of CPT®. Effective date of this deletion: January 1, 2023.
	~~99327~~	~~Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:~~ • **~~A comprehensive history;~~** • **~~A comprehensive examination; and~~** • **~~Medical decision making of moderate complexity.~~** ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent with the patient and/or family or caregiver.~~ **AAPC Rationale** CPT® deletes 99324-99328, which represented domiciliary or rest home visits for the evaluation and management (E/M) of a new patient. The codes required specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. In place of 99324-99328, you should use revised codes 99341, 99342, 99344, and 99345, which apply to home or residence E/M visits for a new patient. Code selection is based on MDM or total time. The deletion of 99324-99328 is part of a major revision to the E/M section of CPT®. Effective date of this deletion: January 1, 2023.

	~~99328~~	~~Domiciliary or rest home visit for the evaluation and management of a new patient, which requires these 3 key components:~~ • **~~A comprehensive history;~~** • **~~A comprehensive examination; and~~** • **~~Medical decision making of high complexity.~~** ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent with the patient and/or family or caregiver.~~ **AAPC Rationale** CPT® deletes 99324-99328, which represented domiciliary or rest home visits for the evaluation and management (E/M) of a new patient. The codes required specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. In place of 99324-99328, you should use revised codes 99341, 99342, 99344, and 99345, which apply to home or residence E/M visits for a new patient. Code selection is based on MDM or total time. The deletion of 99324-99328 is part of a major revision to the E/M section of CPT®. Effective date of this deletion: January 1, 2023.
	~~99334~~	~~Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:~~ • **~~A problem focused interval history;~~** • **~~A problem focused examination;~~** • **~~Straightforward medical decision making.~~** ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver.~~ **AAPC Rationale** CPT® deletes 99334-99337, which represented domiciliary or rest home visits for the evaluation and management (E/M) of an established patient. The codes required specific levels of two of the three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. In place of 99334-99337, you should use revised codes 99347-99350, which apply to home or residence E/M visits for an established patient. Code selection is based on MDM or total time. The deletion of 99334-99337 is part of a major revision to the E/M section of CPT®. Effective date of this deletion: January 1, 2023.

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	99335	~~Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:~~ • ~~**An expanded problem focused interval history;**~~ • ~~**An expanded problem focused examination;**~~ • ~~**Medical decision making of low complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.~~ **AAPC Rationale** CPT® deletes 99334-99337, which represented domiciliary or rest home visits for the evaluation and management (E/M) of an established patient. The codes required specific levels of two of the three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. In place of 99334-99337, you should use revised codes 99347-99350, which apply to home or residence E/M visits for an established patient. Code selection is based on MDM or total time. The deletion of 99334-99337 is part of a major revision to the E/M section of CPT®. Effective date of this deletion: January 1, 2023.
	99336	~~Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:~~ • ~~**A detailed interval history;**~~ • ~~**A detailed examination;**~~ • ~~**Medical decision making of moderate complexity.**~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient and/or family or caregiver.~~ **AAPC Rationale** CPT® deletes 99334-99337, which represented domiciliary or rest home visits for the evaluation and management (E/M) of an established patient. The codes required specific levels of two of the three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. In place of 99334-99337, you should use revised codes 99347-99350, which apply to home or residence E/M visits for an established patient. Code selection is based on MDM or total time. The deletion of 99334-99337 is part of a major revision to the E/M section of CPT®. Effective date of this deletion: January 1, 2023.

	~~99337~~	~~Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components:~~ • **~~A comprehensive interval history;~~** • **~~A comprehensive examination;~~** • **~~Medical decision making of moderate to high complexity.~~** ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent with the patient and/or family or caregiver.~~ **AAPC Rationale** CPT® deletes 99334-99337, which represented domiciliary or rest home visits for the evaluation and management (E/M) of an established patient. The codes required specific levels of two of the three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. In place of 99334-99337, you should use revised codes 99347-99350, which apply to home or residence E/M visits for an established patient. Code selection is based on MDM or total time. The deletion of 99334-99337 is part of a major revision to the E/M section of CPT®. Effective date of this deletion: January 1, 2023.
	~~99339~~	~~Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 15-29 minutes~~ **AAPC Rationale** CPT® deletes 99339 and 99340, which represented domiciliary, rest home (such as an assisted living facility), or home care plan oversight services. In place of 99339 and 99340, you should use chronic care management codes 99491 and +99437, or principal care management codes 99424 and +99425. The deletion of 99339-99340 is part of a major revision to the evaluation and management (E/M) section of CPT®. Effective date of this deletion: January 1, 2023.

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	~~99340~~	~~Individual physician supervision of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living facility) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication (including telephone calls) for purposes of assessment or care decisions with health care professional(s), family member(s), surrogate decision maker(s) (eg, legal guardian) and/or key caregiver(s) involved in patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month; 30 minutes or more~~ **AAPC Rationale** CPT® deletes 99339 and 99340, which represented domiciliary, rest home (such as an assisted living facility), or home care plan oversight services. In place of 99339 and 99340, you should use chronic care management codes 99491 and +99437, or principal care management codes 99424 and +99425. The deletion of 99339-99340 is part of a major revision to the evaluation and management (E/M) section of CPT®. Effective date of this deletion: January 1, 2023.
▲	**99341**	**Home <u>or residence</u> visit** for the evaluation and management of a new patient, which requires <u>a medically appropriate history and/or examination and straightforward medical decision making.</u> ~~these 3 key components:~~ • ~~A problem focused history;~~ • ~~A problem focused examination; and~~ • ~~Straightforward medical decision making.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.~~ <u>When using total time on the date of the encounter for code selection, 15 minutes must be met or exceeded.</u> **AAPC Rationale** CPT® revises 99341, 99342, 99344, and 99345 as part of a major revision to the evaluation and management (E/M) section of the code set. The code set also deletes 99343. The descriptors for 99341-99345 previously referred to a home visit for a new patient requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "home or residence visit." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99341 requires straightforward MDM or at least 15 minutes of total time. Effective date of this revision: January 1, 2023.

▲	**99342**	**Home or residence 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.~~these 3 key components:~~ • ~~An expanded problem focused history;~~ • ~~An expanded problem focused examination; and~~ • ~~Medical decision making of low complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99341, 99342, 99344, and 99345 as part of a major revision to the evaluation and management (E/M) section of the code set. The code set also deletes 99343. The descriptors for 99341-99345 previously referred to a home visit for a new patient requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "home or residence visit." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99342 requires low MDM or at least 30 minutes of total time. Effective date of this revision: January 1, 2023.

	~~99343~~	**~~Home visit~~** ~~for the evaluation and management of a new patient, which requires these 3 key components:~~ • **~~A detailed history;~~** • **~~A detailed examination; and~~** • **~~Medical decision making of moderate complexity.~~** ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.~~ **AAPC Rationale** CPT® deletes 99343 and revises 99341, 99342, 99344, and 99345 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99341-99345 previously referred to a home visit for a new patient requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "home or residence visit." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. In 2022, both 99343 and 99344 referenced moderate MDM. Because you may choose the code based on MDM in 2023, only one code (99344) for moderate MDM was needed. Effective date of this deletion: January 1, 2023.

▲	**99344**	**Home or residence 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. ~~these 3 key components:~~ • ~~A comprehensive history;~~ • ~~A comprehensive examination; and~~ • ~~Medical decision making of moderate complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99341, 99342, 99344, and 99345 as part of a major revision to the evaluation and management (E/M) section of the code set. The code set also deletes 99343. The descriptors for 99341-99345 previously referred to a home visit for a new patient requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "home or residence visit." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99344 requires moderate MDM or at least 60 minutes of total time. Effective date of this revision: January 1, 2023.

▲	**99345**	**Home or residence 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.~~these 3 key components:~~ ● ~~A comprehensive history;~~ ● ~~A comprehensive examination; and~~ ● ~~Medical decision making of high complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 75 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99341, 99342, 99344, and 99345 as part of a major revision to the evaluation and management (E/M) section of the code set. The code set also deletes 99343. The descriptors for 99341-99345 previously referred to a home visit for a new patient requiring specific levels of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "home or residence visit." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99345 requires high MDM or at least 75 minutes of total time. Effective date of this revision: January 1, 2023.

▲	**99347**	**Home or residence visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.~~at least 2 of these 3 key components:~~ • ~~A problem focused interval history;~~ • ~~A problem focused examination;~~ • ~~Straightforward medical decision making.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 20 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99347, 99348, 99349, and 99350 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99347-99350 previously referred to a home visit for an established patient requiring specific levels of two of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "home or residence visit." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99347 requires straightforward MDM or at least 20 minutes of total time. Effective date of this revision: January 1, 2023.

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▲	**99348**	**Home or residence visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making ~~at least 2 of these 3 key components:~~ • ~~An expanded problem focused interval history;~~ • ~~An expanded problem focused examination;~~ • ~~Medical decision making of low complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99347, 99348, 99349, and 99350 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99347-99350 previously referred to a home visit for an established patient requiring specific levels of two of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "home or residence visit." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99348 requires low MDM or at least 30 minutes of total time. Effective date of this revision: January 1, 2023.

▲	**99349**	**Home or residence visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.~~at least 2 of these 3 key components:~~ • ~~A detailed interval history;~~ • ~~A detailed examination;~~ • ~~Medical decision making of moderate complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 40 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99347, 99348, 99349, and 99350 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99347-99350 previously referred to a home visit for an established patient requiring specific levels of two of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "home or residence visit." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99349 requires moderate MDM or at least 40 minutes of total time. Effective date of this revision: January 1, 2023.

▲	**99350**	**Home or residence visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making ~~at least 2 of these 3 key components~~: • ~~A comprehensive interval history;~~ • ~~A comprehensive examination;~~ • ~~Medical decision making of moderate to high complexity.~~ ~~Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.~~ ~~Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.~~ When using total time on the date of the encounter for code selection, 60 minutes must be met or exceeded. **AAPC Rationale** CPT® revises 99347, 99348, 99349, and 99350 as part of a major revision to the evaluation and management (E/M) section of the code set. The descriptors for 99347-99350 previously referred to a home visit for an established patient requiring specific levels of two of three key components (history, exam, and medical decision making [MDM]). The descriptors also stated a usual severity level and a typical amount of time. The revised code descriptors refer to "home or residence visit." The codes now include a medically appropriate history, exam, or both, but those elements are not involved in selecting the E/M level. You will select the appropriate code based on MDM or total time on the date of the encounter. Code 99350 requires high MDM or at least 60 minutes of total time. Effective date of this revision: January 1, 2023.
	~~**99354**~~	~~Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (List separately in addition to code for outpatient **Evaluation and Management** or psychotherapy service, except with office or other outpatient services [99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215])~~ **AAPC Rationale** CPT® deletes outpatient prolonged services codes +99354 and +99355 as part of a major revision to the evaluation and management (E/M) section of CPT®. In place of these codes, you'll report revised code +99417. Codes +99354 (first hour) and +99355 (each additional 30 minutes) required direct patient contact and did not apply to office/outpatient E/M codes 99202-99215. You will report revised code +99417 once per 15 minutes of total time, and the codes apply to prolonged time with or without direct patient contact. Appropriate primary codes include office/outpatient E/M codes 99205 and 99215, office/outpatient consult code 99245, home or residence visit codes 99345 and 99350, and care planning for a patient with cognitive impairment code 99483. Use +99417 only when you select the primary code using total time. Effective date of this deletion: January 1, 2023.

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	~~99355~~	~~Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)~~ **AAPC Rationale** CPT® deletes outpatient prolonged services codes +99354 and +99355 as part of a major revision to the evaluation and management (E/M) section of CPT®. In place of these codes, you'll report revised code +99417. Codes +99354 (first hour) and +99355 (each additional 30 minutes) required direct patient contact and did not apply to office/outpatient E/M codes 99202-99215. You will report revised code +99417 once per 15 minutes of total time, and the codes apply to prolonged time with or without direct patient contact. Appropriate primary codes include office/outpatient E/M codes 99205 and 99215, office/outpatient consult code 99245, home or residence visit codes 99345 and 99350, and care planning for a patient with cognitive impairment code 99483. Use +99417 only when you select the primary code using total time. Effective date of this deletion: January 1, 2023.
	~~99356~~	~~Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient or observation **Evaluation and Management** service)~~ **AAPC Rationale** CPT® deletes inpatient or observation prolonged services codes +99356 and +99357 as part of a major revision to the evaluation and management (E/M) section of CPT®. In place of these codes, you'll report new code +99418. Codes +99356 (first hour) and +99357 (each additional 30 minutes) required unit or floor time beyond the usual service. You will report new code +99418 once per 15 minutes of total time, and the codes apply to prolonged time with or without direct patient contact beyond the primary service's required time. Appropriate primary codes include hospital inpatient or observation care codes 99223, 99233, and 99236; inpatient or observation consult code 99255; and nursing facility care codes 99306 and 99310. Use +99417 only when you select the primary code using total time. Effective date of this deletion: January 1, 2023.
	~~99357~~	~~Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)~~ **AAPC Rationale** CPT® deletes inpatient or observation prolonged services codes +99356 and +99357 as part of a major revision to the evaluation and management (E/M) section of CPT®. In place of these codes, you'll report new code +99418. Codes +99356 (first hour) and +99357 (each additional 30 minutes) required unit or floor time beyond the usual service. You will report new code +99418 once per 15 minutes of total time, and the codes apply to prolonged time with or without direct patient contact beyond the primary service's required time. Appropriate primary codes include hospital inpatient or observation care codes 99223, 99233, and 99236; inpatient or observation consult code 99255; and nursing facility care codes 99306 and 99310. Use +99417 only when you select the primary code using total time. Effective date of this deletion: January 1, 2023.

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# ★ ✚ ▲	**99417**	Prolonged ~~office or other~~ outpatient evaluation and management service(s) time with or without direct patient contact beyond the ~~minimum~~ required time of the primary service ~~procedure which~~ when the primary service level has been selected using total time, ~~requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service,~~ each 15 minutes of total time (List separately in addition to ~~codes 99205, 99215 for office or other~~ the code of the outpatient **Evaluation and Management** services) **AAPC Rationale** CPT® revises prolonged outpatient evaluation and management (E/M) code +99417 as part of a major revision to the E/M section. Previously, the only appropriate primary codes for +99417 were office and other outpatient E/M codes 99205 and 99215. Now, appropriate primary codes include 99205 and 99215, office or other outpatient consult code 99245, home or residence visit codes 99345 and 99350, and care planning for a patient with cognitive impairment code 99483. CPT® deletes outpatient prolonged services codes +99354 and +99355. As before, the CPT® rule for reporting +99417 is that it is appropriate only when you select the primary service code based on time, and you may report +99417 once the service has exceeded the time required to report the primary service by 15 minutes. For instance, office E/M code 99205 represents 60-74 minutes of total time. You may report +99417 once the service reaches 75 minutes of total time, which is the minimum of 60 minutes plus 15 minutes. Note that payers may have different codes and rules for reporting prolonged services. Effective date of this revision: January 1, 2023.
# ★ ✚ ●	**99418**	Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation **Evaluation and Management** service) **AAPC Rationale** CPT® adds prolonged inpatient and observation evaluation and management (E/M) code +99418 as part of a major revision to the E/M section. Appropriate primary codes include hospital inpatient or observation care codes 99223, 99233, and 99236; inpatient or observation consult code 99255; and nursing facility care codes 99306 and 99310. CPT® deletes inpatient and observation prolonged services codes +99356 and +99357. The CPT® rule for reporting +99418 is that it is appropriate only when you select the primary service code based on time, and you may report +99418 once the service has exceeded the time required to report the primary service by 15 minutes. For instance, the descriptor for inpatient or observation care code 99223 states "75 minutes must be met or exceeded." You may report +99418 once the service reaches 90 minutes of total time, which is 75 minutes plus 15 minutes. Effective date of this code: January 1, 2023.

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▲	**99446**	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review **AAPC Rationale** CPT® revises 99446-99449 and 99451, which apply to interprofessional telephone/internet/electronic health record consultations. The revision changes the phrase "provided by a consultative physician" to "provided by a consultative physician or other qualified health care professional." CPT® defines a qualified healthcare professional (QHP) as an individual "qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service." QHPs are distinct from clinical staff who can't individually report services. Effective date of this revision: January 1, 2023.
▲	**99447**	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review **AAPC Rationale** CPT® revises 99446-99449 and 99451, which apply to interprofessional telephone/internet/electronic health record consultations. The revision changes the phrase "provided by a consultative physician" to "provided by a consultative physician or other qualified health care professional." CPT® defines a qualified healthcare professional (QHP) as an individual "qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service." QHPs are distinct from clinical staff who can't individually report services. Effective date of this revision: January 1, 2023.
▲	**99448**	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review **AAPC Rationale** CPT® revises 99446-99449 and 99451, which apply to interprofessional telephone/internet/electronic health record consultations. The revision changes the phrase "provided by a consultative physician" to "provided by a consultative physician or other qualified health care professional." CPT® defines a qualified healthcare professional (QHP) as an individual "qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service." QHPs are distinct from clinical staff who can't individually report services. Effective date of this revision: January 1, 2023.

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▲	**99449**	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review **AAPC Rationale** CPT® revises 99446-99449 and 99451, which apply to interprofessional telephone/internet/electronic health record consultations. The revision changes the phrase "provided by a consultative physician" to "provided by a consultative physician or other qualified health care professional." CPT® defines a qualified healthcare professional (QHP) as an individual "qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service." QHPs are distinct from clinical staff who can't individually report services. Effective date of this revision: January 1, 2023.
# ▲	**99451**	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician or other qualified health care professional, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time **AAPC Rationale** CPT® revises 99446-99449 and 99451, which apply to interprofessional telephone/internet/electronic health record consultations. The revision changes the phrase "provided by a consultative physician" to "provided by a consultative physician or other qualified health care professional." CPT® defines a qualified healthcare professional (QHP) as an individual "qualified by education, training, licensure/regulation (when applicable), and facility privileging (when applicable) who performs a professional service within his/her scope of practice and independently reports that professional service." QHPs are distinct from clinical staff who can't individually report services. Effective date of this revision: January 1, 2023.

▲	**99483**	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination, • Medical decision making of moderate or high complexity, Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity, Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]), Medication reconciliation and review for high-risk medications, Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s), Evaluation of safety (eg, home), including motor vehicle operation, Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks, Development, updating or revision, or review of an Advance Care Plan, Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, ~~50~~60 minutes of total time is ~~are~~ spent on the date of the encounter. ~~face-to-face with the patient and/or family or caregiver.~~ **AAPC Rationale** CPT® revises 99483, which applies to assessment of and care planning for a patient with cognitive impairment. The update changes the typical time from 50 minutes face-to-face with the patient and/or family or caregiver to a new typical time of 60 minutes of total time on the encounter date. The change is part of a major revision to the evaluation and management (E/M) section of the code set. Effective date of this revision: January 1, 2023.

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★ ▲	**99495**	**Transitional ~~C~~care ~~M~~management Sservices** with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge • ~~Medical decision making of a~~ At least moderate level of ~~complexity~~ medical decision making during the service period Face-to-face visit, within 14 calendar days of discharge **AAPC Rationale** CPT® revises transitional care management codes 99495 and 99496 with minor editorial changes. For 99495, the descriptor replaces "medical decision making of at least moderate complexity" with "at least moderate level of medical decision making." These updates are part of a larger revision to the evaluation and management (E/M) section of the code set. Effective date of this revision: January 1, 2023.
★ ▲	**99496**	**Transitional ~~C~~care ~~M~~management Sservices** with the following required elements: Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge • ~~Medical decision making of h~~High level of ~~complexity~~ medical decision making during the service period Face-to-face visit, within 7 calendar days of discharge **AAPC Rationale** CPT® revises transitional care management codes 99495 and 99496 with minor editorial changes. For 99496, the descriptor replaces "medical decision making of high complexity" with "high level of medical decision making." These updates are part of a larger revision to the evaluation and management (E/M) section of the code set. Effective date of this revision: January 1, 2023.

Surgery

●	**15778**	Implantation of absorbable mesh or other prosthesis for delayed closure of defect(s) (ie, external genitalia, perineum, abdominal wall) due to soft tissue infection or trauma **AAPC Rationale** CPT® adds 15778 for implanting absorbable mesh or another prosthesis to assist with delayed closure of one or more defects in the external genitalia, perineum (area between the anus and the scrotum or vulva), and/or abdominal wall. The soft tissue defect may be the result of infection or trauma. Effective date of this code: January 1, 2023.
	~~15850~~	~~Removal of sutures under anesthesia (other than local), same surgeon~~ **AAPC Rationale** CPT® deletes 15850, which represented suture removal under anesthesia by the same surgeon. The code did not apply to the use of local anesthesia. Related to this update, CPT® revises 15851. In 2022, 15851 applied to suture removal under nonlocal anesthesia by a different surgeon. In 2023, the code applies to removal of either sutures or staples, requiring general anesthesia or moderate sedation. The code set also adds +15853 for suture or staple removal not requiring anesthesia and +15854 for removal of both sutures and staples not requiring anesthesia. You'll use +15853 and +15854 in addition to evaluation and management (E/M) codes. Effective date of this deletion: January 1, 2023.
▲	**15851**	Removal of sutures **or** staples ~~under~~ requiring anesthesia (ie, general anesthesia, moderate sedation) ~~(other than local), other surgeon~~ **AAPC Rationale** CPT® revises 15851 as part of a group of updates to suture and staple removal codes. CPT® deletes 15850, which represented suture removal under nonlocal anesthesia by the same surgeon. In 2022, 15851 applied to suture removal under nonlocal anesthesia by a different surgeon. In 2023, the revised code applies to removal of sutures or staples, requiring general anesthesia or moderate sedation. The code set also adds +15853 for suture or staple removal not requiring anesthesia and +15854 for removal of both sutures and staples not requiring anesthesia. You'll use +15853 and +15854 in addition to evaluation and management (E/M) codes. Effective date of this revision: January 1, 2023.
# ✚ ●	**15853**	Removal of sutures **or** staples not requiring anesthesia (List separately in addition to E/M code) **AAPC Rationale** CPT® adds +15853 as part of a group of updates to suture and staple removal codes. CPT® deletes 15850, which represented suture removal under nonlocal anesthesia by the same surgeon. In 2022, 15851 applied to suture removal under nonlocal anesthesia by a different surgeon. In 2023, the revised code applies to removal of sutures or staples, requiring general anesthesia or moderate sedation. The code set also adds +15853 for suture or staple removal not requiring anesthesia and +15854 for removal of both sutures and staples not requiring anesthesia. You'll use +15853 and +15854 in addition to evaluation and management (E/M) codes. Effective date of this code: January 1, 2023.

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# ✚ ●	**15854**	Removal of sutures **and** staples not requiring anesthesia (List separately in addition to E/M code) **AAPC Rationale** CPT® adds +15854 as part of a group of updates to suture and staple removal codes. CPT® deletes 15850, which represented suture removal under nonlocal anesthesia by the same surgeon. In 2022, 15851 applied to suture removal under nonlocal anesthesia by a different surgeon. In 2023, the revised code applies to removal of sutures or staples, requiring general anesthesia or moderate sedation. The code set also adds +15853 for suture or staple removal not requiring anesthesia and +15854 for removal of both sutures and staples not requiring anesthesia. You'll use +15853 and +15854 in addition to evaluation and management (E/M) codes. Effective date of this code: January 1, 2023.
▲	**22857**	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression);; single interspace, lumbar **AAPC Rationale** CPT® revises total disc arthroplasty code 22857, which represents restoring spine joint function by placing an artificial disc. CPT® changes the comma before the phrase "single interspace, lumbar" to a semicolon. This small change allows 22857 to share the first part of its descriptor with new code +22860, which you'll use for the "second interspace, lumbar." These changes are related to the deletion of +0163T. The descriptor for +22860 is almost identical to +0163T, except new code +22860 specifies "second interspace" while deleted code +0163T used the phrase "each additional interspace." This difference is important because CPT® now instructs you to use 22899 for more than two interspaces. Effective date of this revision: January 1, 2023.
▲	**22630**	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace;; lumbar **AAPC Rationale** CPT® revises 22630 and +22632 as part of a larger revision to arthrodesis (joint fusion) and decompression codes. The descriptors for these two spinal arthrodesis codes share the portion of their descriptors before the semicolon. In the revision, the semicolon moves from before "lumbar" to after to clarify that +22632 is also specific to lumbar services. Report these codes per interspace. CPT® defines a vertebral interspace, in part, as "the non-bony compartment between two adjacent vertebral bodies." Effective date of this revision: January 1, 2022.
▲	**22632**	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace;, lumbar; each additional interspace (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® revises 22630 and +22632 as part of a larger revision to arthrodesis (joint fusion) and decompression codes. The descriptors for these two spinal arthrodesis codes share the portion of their descriptors before the semicolon. In the revision, the semicolon moves from before "lumbar" to after to clarify that +22632 is also specific to lumbar services. Report these codes per interspace. CPT® defines a vertebral interspace, in part, as "the non-bony compartment between two adjacent vertebral bodies." Effective date of this revision: January 1, 2022.

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▲	**22633**	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace;, lumbar **AAPC Rationale** CPT® revises 22633 and +22634 as part of a larger revision to arthrodesis (joint fusion) and decompression codes. CPT® revises spinal arthrodesis codes 22600-+22614, 22633, and +22634 to use the term interspace, rather than level or segment. CPT® defines a vertebral interspace, in part, as "the non-bony compartment between two adjacent vertebral bodies." Specifically, 22633 changes from "single interspace and segment; lumbar" to "single interspace, lumbar;" — which also includes moving the semicolon to be after "lumbar." The descriptors for arthrodesis codes 22633 and +22634 share the portion of their descriptors before the semicolon, so the revision clarifies that +22634 is also specific to lumbar services. The descriptor for +22634 also removes the phrase "and segment" so that the descriptor now specifies "each additional interspace." Note that the semicolon change for both codes and deletion of "and segment" from +22634 were announced in the CPT® Errata and Technical Corrections document. Effective date of this revision: January 1, 2022.
▲	**22634**	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace, lumbar; each additional interspace (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® revises 22633 and +22634 as part of a larger revision to arthrodesis (joint fusion) and decompression codes. CPT® revises spinal arthrodesis codes 22600-+22614, 22633, and +22634 to use the term interspace, rather than level or segment. CPT® defines a vertebral interspace, in part, as "the non-bony compartment between two adjacent vertebral bodies." Specifically, 22633 changes from "single interspace and segment; lumbar" to "single interspace, lumbar;" — which also includes moving the semicolon to be after "lumbar." The descriptors for arthrodesis codes 22633 and +22634 share the portion of their descriptors before the semicolon, so the revision clarifies that +22634 is also specific to lumbar services. The descriptor for +22634 also removes the phrase "and segment" so that the descriptor now specifies "each additional interspace." Note that the semicolon change for both codes and deletion of "and segment" from +22634 were announced in the CPT® Errata and Technical Corrections document. Effective date of this revision: January 1, 2022.

✚ ●	**22860**	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression);; second interspace, lumbar (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds +22860 as part of a group of changes to total disc arthroplasty codes that involve restoring spine joint function by placing an artificial disc. CPT® revises total disc arthroplasty code 22857 by changing the comma before the phrase "single interspace, lumbar" to a semicolon. This small change allows 22857 to share the first part of its descriptor with new code +22860, which you'll use for the "second interspace, lumbar." These changes are related to the deletion of +0163T. The descriptor for +22860 is almost identical to +0163T, except new code +22860 specifies "second interspace" while deleted code +0163T used the phrase "each additional interspace." This difference is important because CPT® now instructs you to use 22899 for more than two interspaces. Effective date of this code: January 1, 2023.
▲	**27280**	Arthrodesis, ~~open,~~ sacroiliac joint, open, ~~including~~includes obtaining bone graft, including instrumentation, when performed **AAPC Rationale** CPT® revises sacroiliac (SI) joint arthrodesis code 27280 with minor editorial changes, such as rearranging word order for clarification. Code 27280 is for an open approach. Do not confuse 27280 with new code 0775T for percutaneous placement of implants in the sacroiliac (SI) joint for arthrodesis or with existing percutaneous/minimally invasive code 27279, which represents transfixing the SI joint by passing devices through the ilium of the pelvis, across the SI joint, and into the sacrum at the base of the spine. Effective date of this revision: January 1, 2023.
●	**30469**	Repair of nasal valve collapse with low energy, temperature-controlled (ie, radiofrequency) subcutaneous/submucosal remodeling **AAPC Rationale** CPT® adds 30469 for nasal valve repair using radiofrequency energy. The energy, applied using a small wand placed in the nostrils, reshapes the tissues inside the nose to improve the patient's breathing. An instructional note with the code indicates 30469 is a bilateral procedure. Effective date of this code: January 1, 2023.

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●	**33900**	Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, unilateral **AAPC Rationale** CPT® adds 33900-+33904 for pulmonary artery stenting using a percutaneous (minimally invasive through the skin) approach. Codes 33900 (unilateral) and 33901 (bilateral) apply to stent placement via normal native connections. Codes 33902 (unilateral) and 33903 (bilateral) apply to stent placement via abnormal connections or through postsurgical shunts. You'll report add-on code +33904 for each additional vessel or separate lesion beyond the primary vessel or lesion, whether using normal or abnormal connections. These codes include necessary services for a percutaneous procedure, such as vascular access, catheter manipulation, fluoroscopy, angiography for roadmapping and postimplant evaluation, and angioplasty within the same lesion as the stent implant. Effective date of this code: January 1, 2023.
●	**33901**	Percutaneous pulmonary artery revascularization by stent placement, initial; normal native connections, bilateral **AAPC Rationale** CPT® adds 33900-+33904 for pulmonary artery stenting using a percutaneous (minimally invasive through the skin) approach. Codes 33900 (unilateral) and 33901 (bilateral) apply to stent placement via normal native connections. Codes 33902 (unilateral) and 33903 (bilateral) apply to stent placement via abnormal connections or through postsurgical shunts. You'll report add-on code +33904 for each additional vessel or separate lesion beyond the primary vessel or lesion, whether using normal or abnormal connections. These codes include necessary services for a percutaneous procedure, such as vascular access, catheter manipulation, fluoroscopy, angiography for roadmapping and postimplant evaluation, and angioplasty within the same lesion as the stent implant. Effective date of this code: January 1, 2023.
●	**33902**	Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, unilateral **AAPC Rationale** CPT® adds 33900-+33904 for pulmonary artery stenting using a percutaneous (minimally invasive through the skin) approach. Codes 33900 (unilateral) and 33901 (bilateral) apply to stent placement via normal native connections. Codes 33902 (unilateral) and 33903 (bilateral) apply to stent placement via abnormal connections or through postsurgical shunts. You'll report add-on code +33904 for each additional vessel or separate lesion beyond the primary vessel or lesion, whether using normal or abnormal connections. These codes include necessary services for a percutaneous procedure, such as vascular access, catheter manipulation, fluoroscopy, angiography for roadmapping and postimplant evaluation, and angioplasty within the same lesion as the stent implant. Effective date of this code: January 1, 2023.

●	**33903**	Percutaneous pulmonary artery revascularization by stent placement, initial; abnormal connections, bilateral **AAPC Rationale** CPT® adds 33900-+33904 for pulmonary artery stenting using a percutaneous (minimally invasive through the skin) approach. Codes 33900 (unilateral) and 33901 (bilateral) apply to stent placement via normal native connections. Codes 33902 (unilateral) and 33903 (bilateral) apply to stent placement via abnormal connections or through postsurgical shunts. You'll report add-on code +33904 for each additional vessel or separate lesion beyond the primary vessel or lesion, whether using normal or abnormal connections. These codes include necessary services for a percutaneous procedure, such as vascular access, catheter manipulation, fluoroscopy, angiography for roadmapping and postimplant evaluation, and angioplasty within the same lesion as the stent implant. Effective date of this code: January 1, 2023.
✚ ●	**33904**	Percutaneous pulmonary artery revascularization by stent placement, each additional vessel or separate lesion, normal or abnormal connections (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds 33900-+33904 for pulmonary artery stenting using a percutaneous (minimally invasive through the skin) approach. Codes 33900 (unilateral) and 33901 (bilateral) apply to stent placement via normal native connections. Codes 33902 (unilateral) and 33903 (bilateral) apply to stent placement via abnormal connections or through postsurgical shunts. You'll report add-on code +33904 for each additional vessel or separate lesion beyond the primary vessel or lesion, whether using normal or abnormal connections. These codes include necessary services for a percutaneous procedure, such as vascular access, catheter manipulation, fluoroscopy, angiography for roadmapping and postimplant evaluation, and angioplasty within the same lesion as the stent implant. Effective date of this code: January 1, 2023.
▲	**35883**	Revision, femoral anastomosis of synthetic arterial bypass graft in groin, open; with nonautogenous patch graft (eg, ~~Dacron~~polyester, ePTFE, bovine pericardium) **AAPC Rationale** CPT® revises 35883 by making a small editorial change. The code describes open revision of a femoral anastomosis of a synthetic arterial bypass graft. The update changes the list of examples of nonautogenous patch grafts by replacing the trade name Dacron® with the more generic term polyester. Nonautogenous means the graft is not made from the patient's own tissue. Effective date of this revision: January 1, 2023.

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# ●	**36836**	Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation **AAPC Rationale** CPT® adds 36836 and 36837 for percutaneous creation of an arteriovenous (AV) fistula in the upper extremity. An AV fistula is a surgically created connection between an artery and vein for hemodialysis. Use 36836 when the provider uses a single access site and 36837 when the provider uses two access sites for the peripheral artery and peripheral vein. These codes include services necessary for the percutaneous procedure, such as vascular access and imaging guidance. The codes also include, but don't require, maturation procedures, like balloon angioplasty, that encourage blood to flow through the fistula. Effective date of this code: January 1, 2023.
# ●	**36837**	Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation **AAPC Rationale** CPT® adds 36836 and 36837 for percutaneous creation of an arteriovenous (AV) fistula in the upper extremity. An AV fistula is a surgically created connection between an artery and vein for hemodialysis. Use 36836 when the provider uses a single access site and 36837 when the provider uses two access sites for the peripheral artery and peripheral vein. These codes include services necessary for the percutaneous procedure, such as vascular access and imaging guidance. The codes also include, but don't require, maturation procedures, like balloon angioplasty, that encourage blood to flow through the fistula. Effective date of this code: January 1, 2023.
# ●	**43290**	Esophagogastroduodenoscopy, flexible, transoral; with deployment of intragastric bariatric balloon **AAPC Rationale** CPT® adds 43290 and 43291 for endoscopic services related to intragastric bariatric balloons. The balloons are weight-loss devices. Typically, the provider inserts (43290) the balloon into the stomach and fills the balloon with saline. After a set amount of time, such as six months, that allows for weight loss and habit change, the provider removes (43291) the contents of the balloon and the balloon itself. Effective date of this code: January 1, 2023.

# ●	**43291**	Esophagogastroduodenoscopy, flexible, transoral; with removal of intragastric bariatric balloon(s) **AAPC Rationale** **Advice** CPT® adds 43290 and 43291 for endoscopic services related to intragastric bariatric balloons. The balloons are weight-loss devices. Typically, the provider inserts (43290) the balloon into the stomach and fills the balloon with saline. After a set amount of time, such as six months, that allows for weight loss and habit change, the provider removes (43291) the contents of the balloon and the balloon itself. Effective date of this code: January 1, 2023.
	~~49560~~	~~Repair initial incisional or ventral hernia; reducible~~ **AAPC Rationale** CPT® deletes 49560 and 49561 for initial repair of an incisional or ventral hernia. This change is part of a major update to hernia repair coding. Instead of 49560 (for reducible hernia) and 49561 (for incarcerated or strangulated hernia), you'll choose from new codes 49591-49596. The new codes apply to initial anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Codes 49591, 49593, and 49595 are specific to reducible hernias. Codes 49592, 49594, and 49596 are for incarcerated or strangulated hernias. You choose among the codes based on the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.
	~~49561~~	~~Repair initial incisional or ventral hernia; incarcerated or strangulated~~ **AAPC Rationale** CPT® deletes 49560 and 49561 for initial repair of an incisional or ventral hernia. This change is part of a major update to hernia repair coding. Instead of 49560 (for reducible hernia) and 49561 (for incarcerated or strangulated hernia), you'll choose from new codes 49591-49596. The new codes apply to initial anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Codes 49591, 49593, and 49595 are specific to reducible hernias. Codes 49592, 49594, and 49596 are for incarcerated or strangulated hernias. You choose among the codes based on the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.

	~~49565~~	~~Repair recurrent incisional or ventral hernia; reducible~~ **AAPC Rationale** CPT® deletes 49565 and 49566 for repair of a recurrent incisional or ventral hernia. This change is part of a major update to hernia repair coding. Instead of 49565 (for reducible hernia) and 49566 (for incarcerated or strangulated hernia), you'll choose from new codes 49613-49618. The new codes apply to recurrent anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Codes 49613, 49615, and 49617 are specific to reducible hernias. Codes 49614, 49616, and 49618 are for incarcerated or strangulated hernias. You choose among the codes based on the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.
	~~49566~~	~~Repair recurrent incisional or ventral hernia; incarcerated or strangulated~~ **AAPC Rationale** CPT® deletes 49565 and 49566 for repair of a recurrent incisional or ventral hernia. This change is part of a major update to hernia repair coding. Instead of 49565 (for reducible hernia) and 49566 (for incarcerated or strangulated hernia), you'll choose from new codes 49613-49618. The new codes apply to recurrent anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Codes 49613, 49615, and 49617 are specific to reducible hernias. Codes 49614, 49616, and 49618 are for incarcerated or strangulated hernias. You choose among the codes based on the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.
	~~49568~~	~~Implantation of mesh or other prosthesis for open incisional or ventral hernia repair or mesh for closure of debridement for necrotizing soft tissue infection (List separately in addition to code for the incisional or ventral hernia repair)~~ **AAPC Rationale** CPT® deletes mesh or other prosthesis implantation code +49568, which was an add-on code reported in conjunction with incisional or ventral hernia repair. This change is part of a major update to hernia repair coding. New anterior abdominal hernia repair codes 49591-49596 and 49613-49618 include, but do not require, mesh or other prosthesis implantation. Because the new hernia repair codes include implantation, when performed, you should no longer report that implantation service separately. Effective date of this deletion: January 1, 2023.

	~~49570~~	~~Repair epigastric hernia (eg, preperitoneal fat); reducible (separate procedure)~~ **AAPC Rationale** CPT® deletes 49570 and 49572 for repair of an epigastric hernia. This change is part of a major update to hernia repair coding. Instead of 49570 (for reducible hernia) and 49572 (for incarcerated or strangulated hernia), you'll choose from new codes 49591-49596 and 49613-49618. The new codes apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.
	~~49572~~	~~Repair epigastric hernia (eg, preperitoneal fat); incarcerated or strangulated~~ **AAPC Rationale** CPT® deletes 49570 and 49572 for repair of an epigastric hernia. This change is part of a major update to hernia repair coding. Instead of 49570 (for reducible hernia) and 49572 (for incarcerated or strangulated hernia), you'll choose from new codes 49591-49596 and 49613-49618. The new codes apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.
	~~49580~~	~~Repair umbilical hernia, younger than age 5 years; reducible~~ **AAPC Rationale** CPT® deletes umbilical hernia repair codes 49580, 49582, 49585, and 49587. This change is part of a major update to hernia repair coding. Instead of these codes, you'll choose from new codes 49591-49596 and 49613-49618. The new codes apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Deleted codes 49580 (for reducible hernias) and 49582 (for incarcerated or strangulated hernias) were appropriate for patients younger than 5. Deleted codes 49585 (reducible) and 49587 (incarcerated or strangulated) were for patients 5 and older. The new codes do not vary based on the patient's age. Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.

	~~49582~~	~~Repair umbilical hernia, younger than age 5 years; incarcerated or strangulated~~ **AAPC Rationale** CPT® deletes umbilical hernia repair codes 49580, 49582, 49585, and 49587. This change is part of a major update to hernia repair coding. Instead of these codes, you'll choose from new codes 49591-49596 and 49613-49618. The new codes apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Deleted codes 49580 (for reducible hernias) and 49582 (for incarcerated or strangulated hernias) were appropriate for patients younger than 5. Deleted codes 49585 (reducible) and 49587 (incarcerated or strangulated) were for patients 5 and older. The new codes do not vary based on the patient's age. Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.
	~~49585~~	~~Repair umbilical hernia, age 5 years or older; reducible~~ **AAPC Rationale** CPT® deletes umbilical hernia repair codes 49580, 49582, 49585, and 49587. This change is part of a major update to hernia repair coding. Instead of these codes, you'll choose from new codes 49591-49596 and 49613-49618. The new codes apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Deleted codes 49580 (for reducible hernias) and 49582 (for incarcerated or strangulated hernias) were appropriate for patients younger than 5. Deleted codes 49585 (reducible) and 49587 (incarcerated or strangulated) were for patients 5 and older. The new codes do not vary based on the patient's age. Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.

	~~49587~~	~~Repair umbilical hernia, age 5 years or older; incarcerated or strangulated~~ **AAPC Rationale** CPT® deletes umbilical hernia repair codes 49580, 49582, 49585, and 49587. This change is part of a major update to hernia repair coding. Instead of these codes, you'll choose from new codes 49591-49596 and 49613-49618. The new codes apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Deleted codes 49580 (for reducible hernias) and 49582 (for incarcerated or strangulated hernias) were appropriate for patients younger than 5. Deleted codes 49585 (reducible) and 49587 (incarcerated or strangulated) were for patients 5 and older. The new codes do not vary based on the patient's age. Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.
	~~49590~~	~~Repair spigelian hernia~~ **AAPC Rationale** CPT® deletes spigelian hernia repair code 49590. This change is part of a major update to hernia repair coding. Instead of 49590, you'll choose from new codes 49591-49596 and 49613-49618. The new codes apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.
●	**49591**	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible **AAPC Rationale** CPT® adds 49591 as part of a major update to hernia repair coding. New codes 49591-49596 and 49613-49618 apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). The codes include, but do not require, mesh or other prosthesis implantation. Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired, measured before opening the hernia defect(s). When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Use 49591 for initial repair of one or more reducible hernias with a total distance of less than 3 cm. Effective date of this code: January 1, 2023.

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●	**49592**	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated **AAPC Rationale** CPT® adds 49592 as part of a major update to hernia repair coding. New codes 49591-49596 and 49613-49618 apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). The codes include, but do not require, mesh or other prosthesis implantation. Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired, measured before opening the hernia defect(s). When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Use 49592 for initial repair of one or more incarcerated or strangulated hernias with a total distance of less than 3 cm. Effective date of this code: January 1, 2023.
●	**49593**	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible **AAPC Rationale** CPT® adds 49593 as part of a major update to hernia repair coding. New codes 49591-49596 and 49613-49618 apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). The codes include, but do not require, mesh or other prosthesis implantation. Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired, measured before opening the hernia defect(s). When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Use 49593 for initial repair of one or more reducible hernias with a total distance of 3 cm to 10 cm. Effective date of this code: January 1, 2023.

●	**49594**	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated **AAPC Rationale** CPT® adds 49594 as part of a major update to hernia repair coding. New codes 49591-49596 and 49613-49618 apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). The codes include, but do not require, mesh or other prosthesis implantation. Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired, measured before opening the hernia defect(s). When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Use 49594 for initial repair of one or more incarcerated or strangulated hernias with a total distance of 3 cm to 10 cm. Effective date of this code: January 1, 2023.
●	**49595**	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible **AAPC Rationale** CPT® adds 49595 as part of a major update to hernia repair coding. New codes 49591-49596 and 49613-49618 apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). The codes include, but do not require, mesh or other prosthesis implantation. Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired, measured before opening the hernia defect(s). When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Use 49595 for initial repair of one or more reducible hernias with a total distance of greater than 10 cm. Effective date of this code: January 1, 2023.

●	**49596**	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), initial, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated **AAPC Rationale** CPT® adds 49596 as part of a major update to hernia repair coding. New codes 49591-49596 and 49613-49618 apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). The codes include, but do not require, mesh or other prosthesis implantation. Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired, measured before opening the hernia defect(s). When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Use 49596 for initial repair of one or more incarcerated or strangulated hernias with a total distance of greater than 10 cm. Effective date of this code: January 1, 2023.
# ●	**49613**	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, reducible **AAPC Rationale** CPT® adds 49613 as part of a major update to hernia repair coding. New codes 49591-49596 and 49613-49618 apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). The codes include, but do not require, mesh or other prosthesis implantation. Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired, measured before opening the hernia defect(s). When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Use 49613 for recurrent repair of one or more reducible hernias with a total distance of less than 3 cm. Effective date of this code: January 1, 2023.

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# ●	**49614**	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); less than 3 cm, incarcerated or strangulated **AAPC Rationale** CPT® adds 49614 as part of a major update to hernia repair coding. New codes 49591-49596 and 49613-49618 apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). The codes include, but do not require, mesh or other prosthesis implantation. Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired, measured before opening the hernia defect(s). When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Use 49614 for recurrent repair of one or more incarcerated or strangulated hernias with a total distance of less than 3 cm. Effective date of this code: January 1, 2023.
# ●	**49615**	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, reducible **AAPC Rationale** CPT® adds 49615 as part of a major update to hernia repair coding. New codes 49591-49596 and 49613-49618 apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). The codes include, but do not require, mesh or other prosthesis implantation. Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired, measured before opening the hernia defect(s). When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Use 49615 for recurrent repair of one or more reducible hernias with a total distance of 3 cm to 10 cm. Effective date of this code: January 1, 2023.

# ●	**49616**	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); 3 cm to 10 cm, incarcerated or strangulated **AAPC Rationale** CPT® adds 49616 as part of a major update to hernia repair coding. New codes 49591-49596 and 49613-49618 apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). The codes include, but do not require, mesh or other prosthesis implantation. Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired, measured before opening the hernia defect(s). When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Use 49616 for recurrent repair of one or more incarcerated or strangulated hernias with a total distance of less 3 cm to 10 cm. Effective date of this code: January 1, 2023.
# ●	**49617**	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, reducible **AAPC Rationale** CPT® adds 49617 as part of a major update to hernia repair coding. New codes 49591-49596 and 49613-49618 apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). The codes include, but do not require, mesh or other prosthesis implantation. Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired, measured before opening the hernia defect(s). When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Use 49617 for recurrent repair of one or more reducible hernias with a total distance of greater than 10 cm. Effective date of this code: January 1, 2023.

# ●	**49618**	Repair of anterior abdominal hernia(s) (ie, epigastric, incisional, ventral, umbilical, spigelian), any approach (ie, open, laparoscopic, robotic), recurrent, including implantation of mesh or other prosthesis when performed, total length of defect(s); greater than 10 cm, incarcerated or strangulated **AAPC Rationale** CPT® adds 49618 as part of a major update to hernia repair coding. New codes 49591-49596 and 49613-49618 apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). The codes include, but do not require, mesh or other prosthesis implantation. Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired, measured before opening the hernia defect(s). When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Use 49618 for recurrent repair of one or more incarcerated or strangulated hernias with a total distance of greater than 10 cm. Effective date of this code: January 1, 2023.
# ●	**49621**	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; reducible **AAPC Rationale** CPT® adds 49621 as part of a major update to hernia repair coding. New codes 49621 (for reducible hernia) and 49622 (for incarcerated or strangulated hernia) apply to parastomal hernia repair using any approach (open, laparoscopic, or robotic). A parastomal hernia occurs when the intestines press outward near a stoma, such as an opening created through the skin for a colostomy appliance. The codes include, but do not require, mesh or other prosthesis implantation. The hernia may be initial or recurrent. Effective date of this code: January 1, 2023.
# ●	**49622**	Repair of parastomal hernia, any approach (ie, open, laparoscopic, robotic), initial or recurrent, including implantation of mesh or other prosthesis, when performed; incarcerated or strangulated **AAPC Rationale** CPT® adds 49622 as part of a major update to hernia repair coding. New codes 49621 (for reducible hernia) and 49622 (for incarcerated or strangulated hernia) apply to parastomal hernia repair using any approach (open, laparoscopic, or robotic). A parastomal hernia occurs when the intestines press outward near a stoma, such as an opening created through the skin for a colostomy appliance. The codes include, but do not require, mesh or other prosthesis implantation. The hernia may be initial or recurrent. Effective date of this code: January 1, 2023.

# ✚ ●	**49623**	Removal of total or near total non-infected mesh or other prosthesis at the time of initial or recurrent anterior abdominal hernia repair or parastomal hernia repair, any approach (ie, open, laparoscopic, robotic) (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds +49623 as part of a major update to hernia repair coding. The code represents total or near total removal of mesh or another prosthesis when infection is not present. You will report +49623 as an add-on code with new hernia repair codes 49591-49596 (initial abdominal hernia repair), 49613-49618 (recurrent abdominal hernia repair), and 49621-49622 (parastomal hernia repair). Effective date of this code: January 1, 2023.
	~~49652~~	~~Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); reducible~~ **AAPC Rationale** CPT® deletes ventral, umbilical, spigelian, or epigastric hernia repair codes 49652 (for reducible hernia) and 49653 (for incarcerated or strangulated hernia). The codes were specific to a laparoscopic approach. This change is part of a major update to hernia repair coding. Instead of these codes, you'll choose from new codes 49591-49596 and 49613-49618. The new codes apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.
	~~49653~~	~~Laparoscopy, surgical, repair, ventral, umbilical, spigelian or epigastric hernia (includes mesh insertion, when performed); incarcerated or strangulated~~ **AAPC Rationale** CPT® deletes ventral, umbilical, spigelian, or epigastric hernia repair codes 49652 (for reducible hernia) and 49653 (for incarcerated or strangulated hernia). The codes were specific to a laparoscopic approach. This change is part of a major update to hernia repair coding. Instead of these codes, you'll choose from new codes 49591-49596 and 49613-49618. The new codes apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.

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	~~49654~~	~~Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); reducible~~ **AAPC Rationale** CPT® deletes incisional hernia repair codes 49654 (for reducible hernia), 49655 (for incarcerated or strangulated hernia), 49656 (for reducible recurrent hernia), and 49657 (for incarcerated or strangulated recurrent hernia). The codes were specific to a laparoscopic approach. This change is part of a major update to hernia repair coding. Instead of these codes, you'll choose from new codes 49591-49596 and 49613-49618. The new codes apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.
	~~49655~~	~~Laparoscopy, surgical, repair, incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated~~ **AAPC Rationale** CPT® deletes incisional hernia repair codes 49654 (for reducible hernia), 49655 (for incarcerated or strangulated hernia), 49656 (for reducible recurrent hernia), and 49657 (for incarcerated or strangulated recurrent hernia). The codes were specific to a laparoscopic approach. This change is part of a major update to hernia repair coding. Instead of these codes, you'll choose from new codes 49591-49596 and 49613-49618. The new codes apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.

	~~49656~~	~~Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); reducible~~ **AAPC Rationale** CPT® deletes incisional hernia repair codes 49654 (for reducible hernia), 49655 (for incarcerated or strangulated hernia), 49656 (for reducible recurrent hernia), and 49657 (for incarcerated or strangulated recurrent hernia). The codes were specific to a laparoscopic approach. This change is part of a major update to hernia repair coding. Instead of these codes, you'll choose from new codes 49591-49596 and 49613-49618. The new codes apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.
	~~49657~~	~~Laparoscopy, surgical, repair, recurrent incisional hernia (includes mesh insertion, when performed); incarcerated or strangulated~~ **AAPC Rationale** CPT® deletes incisional hernia repair codes 49654 (for reducible hernia), 49655 (for incarcerated or strangulated hernia), 49656 (for reducible recurrent hernia), and 49657 (for incarcerated or strangulated recurrent hernia). The codes were specific to a laparoscopic approach. This change is part of a major update to hernia repair coding. Instead of these codes, you'll choose from new codes 49591-49596 and 49613-49618. The new codes apply to anterior abdominal hernia repair (epigastric, incisional, ventral, umbilical, or spigelian) using any approach (open, laparoscopic, or robotic). Codes 49591-49596 are specific to initial hernia repair. Codes 49613-49618 are for recurrent hernia repair. You choose among the codes based on whether the hernia is reducible or incarcerated/strangulated, and the distance between the outer margins of all defects repaired. When the provider repairs both reducible and incarcerated or strangulated hernias at the same session, report a repair code that specifies "incarcerated or strangulated." Effective date of this deletion: January 1, 2023.

▲	**50080**	Percutaneous nephrolithotomy~~nephrostolithotomy~~ or pyelolithotomy~~pyelostolithotomy, with or without dilation, endoscopy,~~ lithotripsy, ~~stenting, or~~ stone ~~basket~~ extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (eg, stone[s] up to 2 cm in single location of kidney or renal pelvis, nonbranching stones) **AAPC Rationale** CPT® revises nephrolithotomy (stone removal from kidney) and pyelolithotomy (stone removal from renal pelvis) codes 50080 and 50081. The codes share the first part of their descriptors. The first revision is a terminology change from "Percutaneous nephrostolithotomy or pyelostolithotomy" to "Percutaneous nephrolithotomy or pyelolithotomy." The new descriptors remove the phrase "with or without dilation." Guidelines with the updated codes state percutaneous access creation or tract dilation "to accommodate large endoscopic instruments used in stone removals (50436, 50437) is not included in 50080, 50081, and may be reported separately, if performed." In place of the old descriptors' "endoscopy, lithotripsy, stenting, or basket extraction," the new descriptors state "lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed." The phrasing helps clarify the antegrade ("downhill") nature of the service and that nephrostomy tube placement is included. The new codes also include imaging guidance, when performed, so you should not report that guidance using a separate code. Code 50080 previously specified "up to 2 cm," and the previous 50081 descriptor specified "over 2 cm." The updated code descriptors will allow you to differentiate between simple (50080) and complex (50081) procedures based on factors such as stone size, number of locations, whether the stones are branching, and whether ureters or complicated anatomy are involved. Effective date of this code: January 1, 2023.

▲	**50081**	Percutaneous nephrolithotomy~~nephrostolithotomy~~ or pyelolithotomy~~pyelostolithotomy, with or without dilation, endoscopy,~~ lithotripsy, ~~stenting, or~~ stone ~~basket~~ extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; complex (eg, stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy)~~over 2 cm~~ **AAPC Rationale** CPT® revises nephrolithotomy (stone removal from kidney) and pyelolithotomy (stone removal from renal pelvis) codes 50080 and 50081. The codes share the first part of their descriptors. The first revision is a terminology change from "Percutaneous nephrostolithotomy or pyelostolithotomy" to "Percutaneous nephrolithotomy or pyelolithotomy." The new descriptors remove the phrase "with or without dilation." Guidelines with the updated codes state percutaneous access creation or tract dilation "to accommodate large endoscopic instruments used in stone removals (50436, 50437) is not included in 50080, 50081, and may be reported separately, if performed." In place of the old descriptors' "endoscopy, lithotripsy, stenting, or basket extraction," the new descriptors state "lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed." The phrasing helps clarify the antegrade ("downhill") nature of the service and that nephrostomy tube placement is included. The new codes also include imaging guidance, when performed, so you should not report that guidance using a separate code. Code 50080 previously specified "up to 2 cm," and the previous 50081 descriptor specified "over 2 cm." The updated code descriptors will allow you to differentiate between simple (50080) and complex (50081) procedures based on factors such as stone size, number of locations, whether the stones are branching, and whether ureters or complicated anatomy are involved. Effective date of this code: January 1, 2023.
●	**55867**	Laparoscopy, surgical prostatectomy, simple subtotal (including control of postoperative bleeding, vasectomy, meatotomy, urethral calibration and/or dilation, and internal urethrotomy), includes robotic assistance, when performed **AAPC Rationale** CPT® adds 55867 for laparoscopic, subtotal prostate excision. The code includes various additional services, specifically vasectomy, meatotomy (making an incision to enlarge the opening of the urethra), urethral calibration (measuring urethral diameter) and/or dilation, internal urethrotomy (incision of the urethra, such as to treat narrowing), and control of bleeding after surgery. The code also includes robotic assistance when the provider uses it. Effective date of this code: January 1, 2023.
▲	**63053**	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional vertebral segment (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® revises 63053 to include "vertebra" in the code descriptor.

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▲	**64415**	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed **AAPC Rationale** CPT® revises 64415-64417 and 64445-64448 by adding "including imaging guidance, when performed." Previously, you could separately report imaging guidance used for these anesthetic and steroid injection procedures. But now that the injection code includes imaging guidance, you should not report the imaging guidance using a separate code. Code 64415 still applies to one or more brachial plexus injections. Effective date of this revision: January 1, 2023.
▲	**64416**	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed **AAPC Rationale** CPT® revises 64415-64417 and 64445-64448 by adding "including imaging guidance, when performed." Previously, you could separately report imaging guidance used for these anesthetic and steroid injection procedures. But now that the injection code includes imaging guidance, you should not report the imaging guidance using a separate code. Code 64416 still applies to the brachial plexus and continuous infusion by catheter. Effective date of this revision: January 1, 2023.
▲	**64417**	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed **AAPC Rationale** CPT® revises 64415-64417 and 64445-64448 by adding "including imaging guidance, when performed." Previously, you could separately report imaging guidance used for these anesthetic and steroid injection procedures. But now that the injection code includes imaging guidance, you should not report the imaging guidance using a separate code. Code 64417 still applies to one or more axillary nerve injections. Effective date of this revision: January 1, 2023.
▲	**64445**	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed **AAPC Rationale** CPT® revises 64415-64417 and 64445-64448 by adding "including imaging guidance, when performed." Previously, you could separately report imaging guidance used for these anesthetic and steroid injection procedures. But now that the injection code includes imaging guidance, you should not report the imaging guidance using a separate code. Code 64445 still applies to one or more sciatic nerve injections. Effective date of this revision: January 1, 2023.

▲	**64446**	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed **AAPC Rationale** CPT® revises 64415-64417 and 64445-64448 by adding "including imaging guidance, when performed." Previously, you could separately report imaging guidance used for these anesthetic and steroid injection procedures. But now that the injection code includes imaging guidance, you should not report the imaging guidance using a separate code. Code 64446 still applies to the sciatic nerve and continuous infusion by catheter. Effective date of this revision: January 1, 2023.
▲	**64447**	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed **AAPC Rationale** CPT® revises 64415-64417 and 64445-64448 by adding "including imaging guidance, when performed." Previously, you could separately report imaging guidance used for these anesthetic and steroid injection procedures. But now that the injection code includes imaging guidance, you should not report the imaging guidance using a separate code. Code 64447 still applies to one or more femoral nerve injections. Effective date of this revision: January 1, 2023.
▲	**64448**	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed **AAPC Rationale** CPT® revises 64415-64417 and 64445-64448 by adding "including imaging guidance, when performed." Previously, you could separately report imaging guidance used for these anesthetic and steroid injection procedures. But now that the injection code includes imaging guidance, you should not report the imaging guidance using a separate code. Code 64448 still applies to the femoral nerve and continuous infusion by catheter. Effective date of this revision: January 1, 2023.
▲	**66174**	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); without retention of device or stent **AAPC Rationale** CPT® revises eye codes 66174 and 66175, which apply to aqueous outflow canal dilation. The revisions add the term canaloplasty as an example of a procedure the codes represent. Canaloplasty uses a microcatheter or tube to place a suture that enlarges the Canal of Schlemm (the natural drainage for healthy eyes). This relieves pressure inside the eye, which can help patients with glaucoma. Effective date of this revision: January 1, 2023.

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▲	**66175**	Transluminal dilation of aqueous outflow canal (eg, canaloplasty); with retention of device or stent **AAPC Rationale** CPT® revises eye codes 66174 and 66175, which apply to aqueous outflow canal dilation. The revisions add the term canaloplasty as an example of a procedure the codes represent. Canaloplasty uses a microcatheter or tube to place a suture that enlarges the Canal of Schlemm (the natural drainage for healthy eyes). This relieves pressure inside the eye, which can help patients with glaucoma. Effective date of this revision: January 1, 2023.
# ▲	**69716**	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or resulting in removal of less than 100 sq mm surface area of bone deep to the outer cranial cortex **AAPC Rationale** CPT® revises 69716 as part of a larger update to codes for services related to osseointegrated (bone-anchored) skull implants that treat hearing loss when coupled to a speech processor and vibratory element. The coupling may be percutaneous (skin is penetrated) or transcutaneous (skin remains intact). For the codes that apply to percutaneous attachment, implant removal and replacement code 69717 deletes the phrase "Revision or" from the descriptor, and removal code 69726 clarifies that it applies to "entire" removal of the implant. For removing only the abutment that protrudes through the skin, you'll use an evaluation and management (E/M) code. For the codes that apply to magnetic transcutaneous attachment, the update revises implantation code 69716 to specify that it applies to implantation when the service is within the mastoid (bone just behind the ear) and/or results in removal of under 100 sq mm surface area of bone. Removal and replacement code 69719 deletes "Revision or" from the descriptor, and it adds that the code applies when the service is within the mastoid and/or involves a bony defect of under 100 sq mm. Similarly, removal code 69727 adds "entire" to describe removal, and it adds that the code is appropriate when the implant is in the mastoid and/or involves a bony defect under 100 sq mm. When the implant with magnetic transcutaneous coupling is outside the mastoid and involves a bony defect with a surface area of 100 sq mm or more, you'll use new codes 69729 (implantation), 69730 (removal and replacement), and 69728 (removal). Effective date of this revision: January 1, 2023.

# ●	**69729**	Implantation, osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside of the mastoid and resulting in removal of greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex **AAPC Rationale** CPT® adds 69729 as part of a larger update to codes for services related to osseointegrated (bone-anchored) skull implants that treat hearing loss when coupled to a speech processor and vibratory element. The coupling may be percutaneous (skin is penetrated) or transcutaneous (skin remains intact). For the codes that apply to percutaneous attachment, implant removal and replacement code 69717 deletes the phrase "Revision or" from the descriptor, and removal code 69726 clarifies that it applies to "entire" removal of the implant. For removing only the abutment that protrudes through the skin, you'll use an evaluation and management (E/M) code. For the codes that apply to magnetic transcutaneous attachment, the update revises implantation code 69716 to specify that it applies to implantation when the service is within the mastoid (bone just behind the ear) and/or results in removal of under 100 sq mm surface area of bone. Removal and replacement code 69719 deletes "Revision or" from the descriptor, and it adds that the code applies when the service is within the mastoid and/or involves a bony defect of under 100 sq mm. Similarly, removal code 69727 adds "entire" to describe removal, and it adds that the code is appropriate when the implant is in the mastoid and/or involves a bony defect under 100 sq mm. When the implant with magnetic transcutaneous coupling is outside the mastoid and involves a bony defect with a surface area of 100 sq mm or more, you'll use new codes 69729 (implantation), 69730 (removal and replacement), and 69728 (removal). Effective date of this code: January 1, 2023.

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# ▲	**69717**	~~Revision or r~~Replacement (including removal of existing device), osseointegrated implant, skull; with percutaneous attachment to external speech processor **AAPC Rationale** CPT® revises 69717 as part of a larger update to codes for services related to osseointegrated (bone-anchored) skull implants that treat hearing loss when coupled to a speech processor and vibratory element. The coupling may be percutaneous (skin is penetrated) or transcutaneous (skin remains intact). For the codes that apply to percutaneous attachment, implant removal and replacement code 69717 deletes the phrase "Revision or" from the descriptor, and removal code 69726 clarifies that it applies to "entire" removal of the implant. For removing only the abutment that protrudes through the skin, you'll use an evaluation and management (E/M) code. For the codes that apply to magnetic transcutaneous attachment, the update revises implantation code 69716 to specify that it applies to implantation when the service is within the mastoid (bone just behind the ear) and/or results in removal of under 100 sq mm surface area of bone. Removal and replacement code 69719 deletes "Revision or" from the descriptor, and it adds that the code applies when the service is within the mastoid and/or involves a bony defect of under 100 sq mm. Similarly, removal code 69727 adds "entire" to describe removal, and it adds that the code is appropriate when the implant is in the mastoid and/or involves a bony defect under 100 sq mm. When the implant with magnetic transcutaneous coupling is outside the mastoid and involves a bony defect with a surface area of 100 sq mm or more, you'll use new codes 69729 (implantation), 69730 (removal and replacement), and 69728 (removal). Effective date of this revision: January 1, 2023.

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# ▲	**69719**	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex **AAPC Rationale** CPT® revises 69719 as part of a larger update to codes for services related to osseointegrated (bone-anchored) skull implants that treat hearing loss when coupled to a speech processor and vibratory element. The coupling may be percutaneous (skin is penetrated) or transcutaneous (skin remains intact). For the codes that apply to percutaneous attachment, implant removal and replacement code 69717 deletes the phrase "Revision or" from the descriptor, and removal code 69726 clarifies that it applies to "entire" removal of the implant. For removing only the abutment that protrudes through the skin, you'll use an evaluation and management (E/M) code. For the codes that apply to magnetic transcutaneous attachment, the update revises implantation code 69716 to specify that it applies to implantation when the service is within the mastoid (bone just behind the ear) and/or results in removal of under 100 sq mm surface area of bone. Removal and replacement code 69719 deletes "Revision or" from the descriptor, and it adds that the code applies when the service is within the mastoid and/or involves a bony defect of under 100 sq mm. Similarly, removal code 69727 adds "entire" to describe removal, and it adds that the code is appropriate when the implant is in the mastoid and/or involves a bony defect under 100 sq mm. When the implant with magnetic transcutaneous coupling is outside the mastoid and involves a bony defect with a surface area of 100 sq mm or more, you'll use new codes 69729 (implantation), 69730 (removal and replacement), and 69728 (removal). Effective date of this revision: January 1, 2023.

# ●	**69730**	Replacement (including removal of existing device), osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex **AAPC Rationale** CPT® adds 69730 as part of a larger update to codes for services related to osseointegrated (bone-anchored) skull implants that treat hearing loss when coupled to a speech processor and vibratory element. The coupling may be percutaneous (skin is penetrated) or transcutaneous (skin remains intact). For the codes that apply to percutaneous attachment, implant removal and replacement code 69717 deletes the phrase "Revision or" from the descriptor, and removal code 69726 clarifies that it applies to "entire" removal of the implant. For removing only the abutment that protrudes through the skin, you'll use an evaluation and management (E/M) code. For the codes that apply to magnetic transcutaneous attachment, the update revises implantation code 69716 to specify that it applies to implantation when the service is within the mastoid (bone just behind the ear) and/or results in removal of under 100 sq mm surface area of bone. Removal and replacement code 69719 deletes "Revision or" from the descriptor, and it adds that the code applies when the service is within the mastoid and/or involves a bony defect of under 100 sq mm. Similarly, removal code 69727 adds "entire" to describe removal, and it adds that the code is appropriate when the implant is in the mastoid and/or involves a bony defect under 100 sq mm. When the implant with magnetic transcutaneous coupling is outside the mastoid and involves a bony defect with a surface area of 100 sq mm or more, you'll use new codes 69729 (implantation), 69730 (removal and replacement), and 69728 (removal). Effective date of this revision: January 1, 2023.

# ▲	**69726**	Removal, entire osseointegrated implant, skull; with percutaneous attachment to external speech processor **AAPC Rationale** CPT® revises 69726 as part of a larger update to codes for services related to osseointegrated (bone-anchored) skull implants that treat hearing loss when coupled to a speech processor and vibratory element. The coupling may be percutaneous (skin is penetrated) or transcutaneous (skin remains intact). For the codes that apply to percutaneous attachment, implant removal and replacement code 69717 deletes the phrase "Revision or" from the descriptor, and removal code 69726 clarifies that it applies to "entire" removal of the implant. For removing only the abutment that protrudes through the skin, you'll use an evaluation and management (E/M) code. For the codes that apply to magnetic transcutaneous attachment, the update revises implantation code 69716 to specify that it applies to implantation when the service is within the mastoid (bone just behind the ear) and/or results in removal of under 100 sq mm surface area of bone. Removal and replacement code 69719 deletes "Revision or" from the descriptor, and it adds that the code applies when the service is within the mastoid and/or involves a bony defect of under 100 sq mm. Similarly, removal code 69727 adds "entire" to describe removal, and it adds that the code is appropriate when the implant is in the mastoid and/or involves a bony defect under 100 sq mm. When the implant with magnetic transcutaneous coupling is outside the mastoid and involves a bony defect with a surface area of 100 sq mm or more, you'll use new codes 69729 (implantation), 69730 (removal and replacement), and 69728 (removal). Effective date of this revision: January 1, 2023.

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# ▲	**69727**	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, within the mastoid and/or involving a bony defect less than 100 sq mm surface area of bone deep to the outer cranial cortex **AAPC Rationale** CPT® revises 69727 as part of a larger update to codes for services related to osseointegrated (bone-anchored) skull implants that treat hearing loss when coupled to a speech processor and vibratory element. The coupling may be percutaneous (skin is penetrated) or transcutaneous (skin remains intact). For the codes that apply to percutaneous attachment, implant removal and replacement code 69717 deletes the phrase "Revision or" from the descriptor, and removal code 69726 clarifies that it applies to "entire" removal of the implant. For removing only the abutment that protrudes through the skin, you'll use an evaluation and management (E/M) code. For the codes that apply to magnetic transcutaneous attachment, the update revises implantation code 69716 to specify that it applies to implantation when the service is within the mastoid (bone just behind the ear) and/or results in removal of under 100 sq mm surface area of bone. Removal and replacement code 69719 deletes "Revision or" from the descriptor, and it adds that the code applies when the service is within the mastoid and/or involves a bony defect of under 100 sq mm. Similarly, removal code 69727 adds "entire" to describe removal, and it adds that the code is appropriate when the implant is in the mastoid and/or involves a bony defect under 100 sq mm. When the implant with magnetic transcutaneous coupling is outside the mastoid and involves a bony defect with a surface area of 100 sq mm or more, you'll use new codes 69729 (implantation), 69730 (removal and replacement), and 69728 (removal). Effective date of this revision: January 1, 2023.

# ●	**69728**	Removal, entire osseointegrated implant, skull; with magnetic transcutaneous attachment to external speech processor, outside the mastoid and involving a bony defect greater than or equal to 100 sq mm surface area of bone deep to the outer cranial cortex **AAPC Rationale** CPT® adds 69728 as part of a larger update to codes for services related to osseointegrated (bone-anchored) skull implants that treat hearing loss when coupled to a speech processor and vibratory element. The coupling may be percutaneous (skin is penetrated) or transcutaneous (skin remains intact). For the codes that apply to percutaneous attachment, implant removal and replacement code 69717 deletes the phrase "Revision or" from the descriptor, and removal code 69726 clarifies that it applies to "entire" removal of the implant. For removing only the abutment that protrudes through the skin, you'll use an evaluation and management (E/M) code. For the codes that apply to magnetic transcutaneous attachment, the update revises implantation code 69716 to specify that it applies to implantation when the service is within the mastoid (bone just behind the ear) and/or results in removal of under 100 sq mm surface area of bone. Removal and replacement code 69719 deletes "Revision or" from the descriptor, and it adds that the code applies when the service is within the mastoid and/or involves a bony defect of under 100 sq mm. Similarly, removal code 69727 adds "entire" to describe removal, and it adds that the code is appropriate when the implant is in the mastoid and/or involves a bony defect under 100 sq mm. When the implant with magnetic transcutaneous coupling is outside the mastoid and involves a bony defect with a surface area of 100 sq mm or more, you'll use new codes 69729 (implantation), 69730 (removal and replacement), and 69728 (removal). Effective date of this code: January 1, 2023.

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Radiology

▲	**76882**	Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation **AAPC Rationale** CPT® revises limited ultrasound code 76882 by changing "joint or other nonvascular extremity structure(s)" to "joint or focal evaluation of other nonvascular extremity structure(s)." This change helps emphasize the limited nature of the ultrasound service. CPT® also adds 76883 for comprehensive ultrasound of one or more nerves and the accompanying structures through their entire anatomic course in one extremity. Effective date of this revision: January 1, 2023.
●	**76883**	Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity **AAPC Rationale** CPT® adds 76883 for comprehensive ultrasound of one or more nerves and the accompanying structures through their entire anatomic course in one extremity. The service includes real-time cine (movie) imaging and image documentation. CPT® also revises limited ultrasound code 76882 by changing "joint or other nonvascular extremity structure(s)" to "joint or focal evaluation of other nonvascular extremity structure(s)." This change helps emphasize the limited nature of the ultrasound service, which applies to focal evaluation of structures such as one or more nerves, tendons, muscles, other soft tissue structures, or soft tissue masses. Effective date of this code: January 1, 2023.
▲	**78803**	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), single area (eg, head, neck, chest, pelvis) or acquisition, single day imaging **AAPC Rationale** CPT® revises radiopharmaceutical localization SPECT codes 78803 and 78830-78832 to differentiate reporting separate acquisitions. Instead of applying to just a single area on a single day, 78803 (SPECT) and 78830 (SPECT-CT) now apply to a single area or acquisition on a single day. Codes 78831 (SPECT) and 78832 (SPECT-CT) previously applied to a minimum of two areas in a single day or a single area over two or more days. the codes now additionally apply to at least two separate acquisitions (such as lung ventilation and perfusion) on a single day or a single acquisition over two or more days. The update also changes one of the examples in 78831 and 78832. The "2 areas" example "abdomen and pelvis" changed to "chest and abdomen." This change offers areas distinct from the other example of "pelvis and knees." Effective date of this revision: January 1, 2023.

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# ▲	**78830**	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest, pelvis) or acquisition, single day imaging **AAPC Rationale** CPT® revises radiopharmaceutical localization SPECT codes 78803 and 78830-78832 to differentiate reporting separate acquisitions. Instead of applying to just a single area on a single day, 78803 (SPECT) and 78830 (SPECT-CT) now apply to a single area or acquisition on a single day. Codes 78831 (SPECT) and 78832 (SPECT-CT) previously applied to a minimum of two areas in a single day or a single area over two or more days. the codes now additionally apply to at least two separate acquisitions (such as lung ventilation and perfusion) on a single day or a single acquisition over two or more days. The update also changes one of the examples in 78831 and 78832. The "2 areas" example "abdomen and pelvis" changed to "chest and abdomen." This change offers areas distinct from the other example of "pelvis and knees." Effective date of this revision: January 1, 2023.
# ▲	**78831**	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, chest and abdomen ~~and pelvis~~) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition~~imaging~~ over 2 or more days **AAPC Rationale** CPT® revises radiopharmaceutical localization SPECT codes 78803 and 78830-78832 to differentiate reporting separate acquisitions. Instead of applying to just a single area on a single day, 78803 (SPECT) and 78830 (SPECT-CT) now apply to a single area or acquisition on a single day. Codes 78831 (SPECT) and 78832 (SPECT-CT) previously applied to a minimum of two areas in a single day or a single area over two or more days. the codes now additionally apply to at least two separate acquisitions (such as lung ventilation and perfusion) on a single day or a single acquisition over two or more days. The update also changes one of the examples in 78831 and 78832. The "2 areas" example "abdomen and pelvis" changed to "chest and abdomen." This change offers areas distinct from the other example of "pelvis and knees." Effective date of this revision: January 1, 2023.

# ▲	**78832**	Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s) (includes vascular flow and blood pool imaging, when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, chest and abdomen ~~and pelvis~~) or separate acquisitions (eg, lung ventilation and perfusion), single day imaging, or single area or acquisition~~imaging~~ over 2 or more days **AAPC Rationale** CPT® revises radiopharmaceutical localization SPECT codes 78803 and 78830-78832 to differentiate reporting separate acquisitions. Instead of applying to just a single area on a single day, 78803 (SPECT) and 78830 (SPECT-CT) now apply to a single area or acquisition on a single day. Codes 78831 (SPECT) and 78832 (SPECT-CT) previously applied to a minimum of two areas in a single day or a single area over two or more days. the codes now additionally apply to at least two separate acquisitions (such as lung ventilation and perfusion) on a single day or a single acquisition over two or more days. The update also changes one of the examples in 78831 and 78832. The "2 areas" example "abdomen and pelvis" changed to "chest and abdomen." This change offers areas distinct from the other example of "pelvis and knees." Effective date of this revision: January 1, 2023.

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Pathology and Laboratory

# ●	**81418**	Drug metabolism (eg, pharmacogenomics) genomic sequence analysis panel, must include testing of at least 6 genes, including *CYP2C19, CYP2D6,* and *CYP2D6* duplication/deletion analysis **AAPC Rationale** CPT® adds 81418 to the genomic sequencing procedures section to describe a test for at least six genes, including CYP2C19, CYP2D6, and CYP2D6 duplication/deletion analysis to evaluate common mutations that impact metabolism of many therapeutic drugs. The test may help clinicians determine appropriate dosage for medications. Prior to the addition of this code, labs may have reported a similar test with codes such as CYP2D6 gene analysis code 81226 and/or unlisted procedure code 81479. Effective date of this code: January 1, 2023.
# ●	**81441**	Inherited bone marrow failure syndromes (IBMFS) (eg, Fanconi anemia, dyskeratosis congenita, Diamond-Blackfan anemia, Shwachman-Diamond syndrome, GATA2 deficiency syndrome, congenital amegakaryocytic thrombocytopenia) sequence analysis panel, must include sequencing of at least 30 genes, including *BRCA2, BRIP1, DKC1, FANCA, FANCB, FANCC, FANCD2, FANCE, FANCF, FANCG, FANCI, FANCL, GATA1, GATA2, MPL, NHP2, NOP10, PALB2, RAD51C, RPL11, RPL35A, RPL5, RPS10, RPS19, RPS24, RPS26, RPS7, SBDS, TERT,* and *TINF2* **AAPC Rationale** CPT® adds 81441 to the genomic sequencing procedures section to describe a test for at least 30 genes, including those listed in the code, to evaluate mutations associated with inherited bone marrow failure syndromes (IBMFS). These are blood disorders involving failure of the bone marrow to produce blood cells. Before the addition of this code, labs may have reported a similar test using unlisted procedure code 81479. Effective date of this code: January 1, 2023.
▲	**81445**	Targeted genomic sequence analysis panel, solid organ neoplasm~~, DNA analysis, and RNA analysis when performed~~, 5-50 genes (eg, *ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, MET, NRAS, MET, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET*), interrogation for sequence variants and copy number variants or rearrangements, if performed; DNA analysis or combined DNA and RNA analysis **AAPC Rationale** CPT® revises 81445 to make it the parent code for new code 81449 by changing the order of certain words and phrases. The revision should not alter how you use the code, which describes a genomic sequence analysis panel to evaluate DNA and possibly RNA alterations in five to 50 genes known to impact solid organ cancers. Effective date of this revision: January 1, 2023.

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●	**81449**	Targeted genomic sequence analysis panel, solid organ neoplasm~~, DNA analysis, and RNA analysis when performed~~, 5-50 genes (eg, *ALK, BRAF, CDKN2A, EGFR, ERBB2, KIT, KRAS, MET, NRAS, MET, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET*), interrogation for sequence variants and copy number variants or rearrangements, if performed; RNA analysis **AAPC Rationale** CPT® adds 81449 as a child code under 81445 to describe a genomic sequence analysis panel to evaluate RNA alterations in five to 50 genes known to impact solid organ cancers. Effective date of this code: January 1, 2023.
▲	**81450**	Targeted genomic sequence analysis panel, hematolymphoid neoplasm or disorder~~, DNA analysis, and RNA analysis when performed~~, 5-50 genes (eg, *BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, KIT, MLL, NRAS, NPM1, NOTCH1, NPM1, NRAS*), interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis **AAPC Rationale** CPT® revises 81450 to make it the parent code for new code 81451 by changing the order of certain words and phrases. The revision should not alter how you use the code, which describes a genomic sequence analysis panel to evaluate DNA and possibly RNA alterations in five to 50 genes known to impact blood or lymph system cancers or disorders. Effective date of this revision: January 1, 2023.
●	**81451**	Targeted genomic sequence analysis panel, hematolymphoid neoplasm or disorder~~, DNA analysis, and RNA analysis when performed~~, 5-50 genes (eg, *BRAF, CEBPA, DNMT3A, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, KIT, MLL, NRAS, NPM1, NOTCH1, NPM1, NRAS*), interrogation for sequence variants, and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; RNA analysis **AAPC Rationale** CPT® adds 81451 as a child code under 81450 to describe a genomic sequence analysis panel to evaluate RNA alterations in five to 50 genes known to relate to blood or lymph (hematolymphoid) cancers or disorders. Effective date of this code: January 1, 2023.
▲	**81455**	Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm or disorder, ~~DNA analysis, and RNA analysis when performed,~~ 51 or greater genes (eg, *ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MET, MLL, NOTCH1, NPM1, NRAS, MET, NOTCH1, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET*), interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; DNA analysis or combined DNA and RNA analysis **AAPC Rationale** CPT® revises 81455 to make it the parent code for new code 81456 by changing the order of certain words and phrases. The revision should not alter how you use the code, which describes a genomic sequence analysis panel to evaluate DNA and possibly RNA alterations in 51 or more genes known to relate to solid organ cancers or blood or lymph cancers or disorders. Effective date of this revision: January 1, 2023.

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●	**81456**	Targeted genomic sequence analysis panel, solid organ or hematolymphoid neoplasm or disorder, ~~DNA analysis, and RNA analysis when performed,~~ 51 or greater genes (eg, *ALK, BRAF, CDKN2A, CEBPA, DNMT3A, EGFR, ERBB2, EZH2, FLT3, IDH1, IDH2, JAK2, KIT, KRAS, MET, MLL, NOTCH1, NPM1, NRAS, MET, NOTCH1, PDGFRA, PDGFRB, PGR, PIK3CA, PTEN, RET*), interrogation for sequence variants and copy number variants or rearrangements, or isoform expression or mRNA expression levels, if performed; RNA analysis **AAPC Rationale** CPT® adds 81456 as a child code under 81455 to describe a genomic sequence analysis panel to evaluate RNA alterations in 51 or more genes known to relate to solid organ tumors or blood or lymph (hematolymphoid) cancers or disorders. Effective date of this code: January 1, 2023.
# ●	**84433**	Thiopurine S-methyltransferase (TPMT) **AAPC Rationale** CPT® adds 84433 to the chemistry section to describe a test for thiopurine S-methyltransferase (TPMT), which is an enzyme that can be inhibited by certain drugs. Clinicians may test for TPMT levels before prescribing thiopurine drugs to avoid possible decreased bone marrow blood cell production in susceptible individuals. Prior to the addition of this code, labs may have reported the test using enzyme activity code 82657. Effective date of this code: January 1, 2023.
●	**87467**	Hepatitis B surface antigen (HBsAg), quantitative **AAPC Rationale** CPT® adds 87467 to the microbiology section to describe a test to quantify the level of hepatitis B surface antigen (HBsAg) in the patient serum specimen. A common lab method for this test is chemiluminescence immunoassay. Prior to addition of this code, labs may have reported this test using the nonspecific chemiluminescent assay method code 82397. Clinicians may order this test to help monitor the progression of chronic Hepatitis B and possibly the response to antiviral therapy. Effective date of this code: January 1, 2023.
●	**87468**	Infectious agent detection by nucleic acid (DNA or RNA); Anaplasma phagocytophilum, amplified probe technique **AAPC Rationale** CPT® adds 87468 to the microbiology section to describe a test to detect the presence of an infectious agent, *Anaplasma phagocytophilum*, in the patient blood specimen. Prior to addition of this code, labs may have reported this test using the nonspecific amplified probe nucleic acid method code 87798. Clinicians may order this test to identify *Anaplasma phagocytophilum* infection, which causes a tickborne disease called anaplasmosis. Effective date of this code: January 1, 2023.

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●	**87469**	Babesia microti, amplified probe technique **AAPC Rationale** CPT® adds 87469 to the microbiology section to describe a test to detect the presence of an infectious agent, *Babesia microti*, in the patient blood specimen. Prior to addition of this code, labs may have reported this test using the nonspecific amplified probe nucleic acid method code 87798. Clinicians may order this test to identify *Babesia microti* infection, which causes a tickborne disease called babesiosis. Effective date of this code: January 1, 2023.
●	**87478**	Borrelia miyamotoi, amplified probe technique **AAPC Rationale** CPT® adds 87478 to the microbiology section to describe a test to detect the presence of an infectious agent, *Borrelia miyamotoi*, in the patient blood specimen. Prior to addition of this code, labs may have reported this test using the nonspecific amplified probe nucleic acid method code 87798. Clinicians may order this test to identify *Borrelia miyamotoi* infection, which is one of a group of bacteria in the genus *Borrelia* that cause a tickborne disease called tickborne relapsing fever (TBRF). Effective date of this code: January 1, 2023.
# ●	**87484**	Ehrlichia chaffeensis, amplified probe technique **AAPC Rationale** CPT® adds 87484 to the microbiology section to describe a test to detect the presence of an infectious agent, *Ehrlichia chaffeensis*, in the patient blood specimen. Prior to addition of this code, labs may have reported this test using the nonspecific amplified probe nucleic acid method code 87798. Clinicians may order this test to identify *Ehrlichia chaffeensis* infection, which causes a tickborne disease called human monocytic ehrlichiosis (HME). Effective date of this code: January 1, 2023.
●	**87593**	Infectious agent detection by nucleic acid (DNA or RNA); orthopoxvirus (eg, monkeypox virus, cowpox virus, vaccinia virus), amplified probe technique, each **AAPC Rationale** CPT® adds 87593 for a nucleic acid test to detect the presence of an orthopoxvirus organism in the patient specimen, such as monkeypox virus, cowpox virus, or vaccinia virus. The code can describe the Centers for Disease Control and Prevention (CDC) test cleared by the Food and Drug Administration (FDA) in response to the monkeypox outbreak. The test detects most nonvariola (nonsmallpox) related orthopoxviruses, including monkeypox. Effective date of this code: July 26, 2022.

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# ●	**87913**	Infectious agent genotype analysis by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]), mutation identification in targeted region(s) **AAPC Rationale** CPT® adds 87913, which is out of numerical sequence, as a part of the 87910 code family. Each code in the family describes infectious agent genotype analysis for a specific organism. Code 87913 describes genotype analysis for the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus to help identify mutations that could impact disease transmissibility or severity. SARS-CoV-2 causes COVID-19. Effective date of this code: Feb. 21, 2022.
	~~0012U~~	~~Germline disorders, gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood, report of specific gene rearrangement(s)~~ **AAPC Rationale** CPT® deletes 0012U, which was reported only for MatePair Targeted Rearrangements, Congenital, from Mayo Clinic. Mayo Clinic no longer performs this test. Report any performance of this assay on or after the effective deletion date using unlisted code 81479 for genomic procedures. Effective date of this deletion: October 1, 2022.
	~~0013U~~	~~Oncology (solid organ neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, fresh or frozen tissue or cells, report of specific gene rearrangement(s)~~ **AAPC Rationale** CPT® deletes 0013U, which was reported only for MatePair Targeted Rearrangements, Oncology, from Mayo Clinic. Mayo Clinic no longer performs this test. Report any performance of this assay on or after the effective deletion date using unlisted code 81479 for genomic procedures. Effective date of this deletion: October 1, 2022.
	~~0014U~~	~~Hematology (hematolymphoid neoplasia), gene rearrangement detection by whole genome next-generation sequencing, DNA, whole blood or bone marrow, report of specific gene rearrangement(s)~~ **AAPC Rationale** CPT® deletes 0014U, which was reported only for MatePair Targeted Rearrangements, Hematologic, from Mayo Clinic. Mayo Clinic no longer performs this test. Report any performance of this assay on or after the effective deletion date using unlisted code 81479 for genomic procedures. Effective date of this deletion: October 1, 2022.

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▲	**0022U**	Targeted genomic sequence analysis panel, cholangiocarcinoma and non-small cell lung neoplasia, DNA and RNA analysis, 1-23 genes, interrogation for sequence variants and rearrangements, reported as presence/absence of variants and associated therapy(ies) to consider **AAPC Rationale** CPT® revises 0022U, to be reported only for Oncomine™ Dx Target Test from Thermo Fisher Scientific. The code previously described a genomic sequence analysis panel only for non-small cell lung cancer, but the revision also allows for a cholangiocarcinoma neoplasia panel. The code previously specified the number of genes interrogated as 23, but the revision specifies that the analysis interrogates a range of one to 23 genes. Effective date of this revision: January 1, 2022.
	~~0056U~~	~~Hematology (acute myelogenous leukemia), DNA, whole genome next-generation sequencing to detect gene rearrangement(s), blood or bone marrow, report of specific gene rearrangement(s)~~ **AAPC Rationale** CPT® deletes 0056U, which was reported only for MatePair Acute Myeloid Leukemia Panel from Mayo Clinic. Mayo Clinic no longer performs this test. Report any performance of this assay on after the effective deletion date using unlisted code 81479 for genomic procedures. Effective date of this deletion: October 1, 2022.
▲	**0090U**	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 23 genes (14 content and 9 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a categorical result (ie, benign, intermediate~~indeterminate~~, malignant) **AAPC Rationale** CPT® revises 0090U, reported only for myPath® Melanoma test from Castle Biosciences Inc. The revision adds the parenthetic abbreviation (FFPE) for formalin-fixed paraffin-embedded tissue and changes the word “indeterminate” to “intermediate” to describe one possible categorical result for the test. The revisions should not alter how you use the code. Effective date of this revision: January 1, 2022.

	~~0097U~~	~~Gastrointestinal pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 22 targets (Campylobacter [C. jejuni/C. coli/C. upsaliensis], Clostridium difficile [C. difficile] toxin A/B, Plesiomonas shigelloides, Salmonella, Vibrio [V. parahaemolyticus/V. vulnificus/V. cholerae], including specific identification of Vibrio cholerae, Yersinia enterocolitica, Enteroaggregative Escherichia coli [EAEC], Enteropathogenic Escherichia coli [EPEC], Enterotoxigenic Escherichia coli [ETEC] lt/st, Shiga-like toxin-producing Escherichia coli [STEC] stx1/stx2 [including specific identification of the E. coli O157 serogroup within STEC], Shigella/Enteroinvasive Escherichia coli [EIEC], Cryptosporidium, Cyclospora cayetanensis, Entamoeba histolytica, Giardia lamblia [also known as G. intestinalis and G. duodenalis], adenovirus F 40/41, astrovirus, norovirus GI/GII, rotavirus A, sapovirus [Genogroups I, II, IV, and V])~~ **AAPC Rationale** CPT® deletes 0097U, which describes only the Proprietary Laboratory Analyses (PLA) test BioFire® FilmArray® Gastrointestinal (GI) Panel from BioFire® Diagnostics. Report any performance of this assay after the effective deletion date using the code for detection of multiple infectious agents, not otherwise specified, by amplified probe nucleic acid testing (87801). Effective date of this deletion: April 1, 2022.
	~~0151U~~	~~Infectious disease (bacterial or viral respiratory tract infection), pathogen specific nucleic acid (DNA or RNA), 33 targets, real-time semi-quantitative PCR, bronchoalveolar lavage, sputum, or endotracheal aspirate, detection of 33 organismal and antibiotic resistance genes with limited semi-quantitative results~~ **AAPC Rationale** CPT® deletes 0151U, which describes only the Proprietary Laboratory Analyses (PLA) test BioFire® FilmArray® Pneumonia Panel from BioFire® Diagnostics. Report any performance of this assay after the effective deletion date using the code for unlisted molecular pathology procedures, 81479. Effective date of this deletion: April 1, 2022.
	~~0208U~~	~~Oncology (medullary thyroid carcinoma), mRNA, gene expression analysis of 108 genes, utilizing fine needle aspirate, algorithm reported as positive or negative for medullary thyroid carcinoma~~ **AAPC Rationale** CPT® deletes 0208U, which describes only the Proprietary Laboratory Analyses (PLA) test Afirma Medullary Thyroid Carcinoma (MTC) Classifier from Veracyte Inc. Report any performance of this assay after the effective deletion date using the unlisted code for Multianalyte Assay with Algorithmic Analysis (MAAA), 81599. Effective date of this deletion: January 1, 2022.
▲	**0229U**	*BCAT1 (Branched chain amino acid transaminase 1)* ~~or~~ and *IKZF1 (IKAROS family zinc finger 1)* (eg, colorectal cancer) promoter methylation analysis **AAPC Rationale** CPT® revises 0229U by changing the word "or" to "and." The change indicates that the test is for BCAT1 and IKZF1 promoter methylation analysis, not for just one gene or the other. The test performance includes methylation analysis of both genes, so the descriptor change is a correction and should not alter how you use the code. Effective date of this revision: July 1, 2022.

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▲	**0276U**	Hematology (inherited thrombocytopenia), genomic sequence analysis of ~~23~~42 genes, blood, buccal swab, or amniotic fluid **AAPC Rationale** CPT® revises 0276U, which is reported only for Versiti™ Inherited Thrombocytopenia Panel from Versiti™ Diagnostic Laboratories, performed on a specimen such as blood, buccal swab, or amniotic fluid. The prior descriptor indicated the genomic sequence analysis for 23 genes, but the revision specifies 42 genes. The test can aid in diagnosis of familial risk assessment for inherited thrombocytopenia, which is a diverse group of blood clotting disorders characterized by low platelet count and excessive bleeding symptoms. Effective date of this revision: October 1, 2022.
●	**0285U**	Oncology, response to radiation, cell-free DNA, quantitative branched chain DNA amplification, plasma, reported as a radiation toxicity score **AAPC Rationale** CPT® adds 0285U to be reported only for RadTox™ cfDNA test from DiaCarta Inc. The test evaluates a plasma specimen for the level of certain DNA sequences that circulate in the blood outside of cells, and reports the findings as an indicator of the patient's toxicity response to radiation cancer therapy. Effective date of this code: January 1, 2022.
●	**0286U**	*CEP72 (centrosomal protein, 72-KDa), NUDT15 (nudix hydrolase 15)* and *TPMT (thiopurine S-methyltransferase)* (eg, drug metabolism) gene analysis, common variants **AAPC Rationale** CPT® adds 0286U to be reported only for CNT (CEP72, TPMT, and NUDT15) genotyping panel from RPRD Diagnostics. The test uses a blood or saliva specimen to evaluate mutations in three genes (CEP72, NUDT15, and TPMT) that provide therapeutic dosing information for thiopurines and vincristine medications to treat acute lymphoblastic leukemia (ALL) or inflammatory bowel disease (IBD). Effective date of this code: January 1, 2022.
●	**0287U**	Oncology (thyroid), DNA and mRNA, next-generation sequencing analysis of 112 genes, fine needle aspirate or formalin-fixed paraffin-embedded (FFPE) tissue, algorithmic prediction of cancer recurrence, reported as a categorical risk result (low, intermediate, high) **AAPC Rationale** CPT® adds 0287U to be reported only for ThyroSeq® CRC from CBLPath Inc. and University of Pittsburgh Medical Center. The test evaluates a fine needle aspiration (FNA) or formalin-fixed paraffin-embedded (FFPE) thyroid specimen using next-generation sequencing (NGS) for analysis of 112 genes and uses an algorithmic analysis to report a cancer-recurrence risk of low, intermediate, or high. Effective date of this code: January 1, 2022.

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●	**0288U**	Oncology (lung), mRNA, quantitative PCR analysis of 11 genes *(BAG1, BRCA1, CDC6, CDK2AP1, ERBB3, FUT3, IL11, LCK, RND3, SH3BGR, WNT3A)* and 3 reference genes *(ESD, TBP, YAP1),* formalin-fixed paraffin-embedded (FFPE) tumor tissue, algorithmic interpretation reported as a recurrence risk score **AAPC Rationale** CPT® adds 0288U to be reported only for DetermaRx™ from Oncocyte Corporation. The test evaluates a formalin-fixed paraffin-embedded (FFPE) tissue specimen from a non-small cell lung cancer (NSCLC) tumor to analyze expression of 11 genes listed in the code using polymerase chain reaction (PCR). The test includes an algorithmic analysis of findings to report a recurrence risk score for NSCLC. Effective date of this code: January 1, 2022.
●	**0289U**	Neurology (Alzheimer disease), mRNA, gene expression profiling by RNA sequencing of 24 genes, whole blood, algorithm reported as predictive risk score **AAPC Rationale** CPT® adds 0289U to be reported only for MindX Blood Test™ - Memory/Alzheimer's, MindX Sciences™ Laboratory, from MindX Sciences™ Inc. The test uses a blood specimen for gene expression profiling of 24 genes and an algorithmic analysis of the findings to report a predictive risk score for Alzheimer's or other memory conditions. Effective date of this code: January 1, 2022.
●	**0290U**	Pain management, mRNA, gene expression profiling by RNA sequencing of 36 genes, whole blood, algorithm reported as predictive risk score **AAPC Rationale** CPT® adds 0290U to be reported only for MindX Blood Test™ - Pain, MindX Sciences™ Laboratory, from MindX Sciences™ Inc. The test uses a blood specimen for gene expression profiling of 36 genes and an algorithmic analysis of the findings to report a predictive risk score for the propensity for pain. Effective date of this code: January 1, 2022.
●	**0291U**	Psychiatry (mood disorders), mRNA, gene expression profiling by RNA sequencing of 144 genes, whole blood, algorithm reported as predictive risk score **AAPC Rationale** CPT® adds 0291U to be reported only for MindX Blood Test™ - Mood, MindX Sciences™ Laboratory, from MindX Sciences™ Inc. The test uses a blood specimen for gene expression profiling of 144 genes and algorithmic analysis of the findings to report a predictive risk score for mood disorders such as depression and bipolar disorder. Effective date of this code: January 1, 2022.

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●	**0292U**	Psychiatry (stress disorders), mRNA, gene expression profiling by RNA sequencing of 72 genes, whole blood, algorithm reported as predictive risk score **AAPC Rationale** CPT® adds 0292U to be reported only for MindX Blood Test™ - Stress, MindX Sciences™ Laboratory, from MindX Sciences™ Inc. The test uses a blood specimen for gene expression profiling of 72 genes and algorithmic analysis of the findings to report a predictive risk score for post-traumatic stress disorder (PTSD). Effective date of this code: January 1, 2022.
●	**0293U**	Psychiatry (suicidal ideation), mRNA, gene expression profiling by RNA sequencing of 54 genes, whole blood, algorithm reported as predictive risk score **AAPC Rationale** CPT® adds 0293U to be reported only for MindX Blood Test™ - Suicidality, MindX Sciences™ Laboratory, from MindX Sciences™ Inc. The test uses a blood specimen for gene expression profiling of 54 genes and an algorithmic analysis of the findings to report a predictive risk score for the propensity for suicidal ideation. Effective date of this code: January 1, 2022.
●	**0294U**	Longevity and mortality risk, mRNA, gene expression profiling by RNA sequencing of 18 genes, whole blood, algorithm reported as predictive risk score **AAPC Rationale** CPT® adds 0294U to be reported only for MindX Blood Test™ - Longevity, MindX Sciences™ Laboratory, from MindX Sciences™ Inc. The test uses a blood specimen for gene expression profiling of 18 genes and an algorithmic analysis of the findings to report a predictive risk score for mortality/longevity. Effective date of this code: January 1, 2022.
●	**0295U**	Oncology (breast ductal carcinoma in situ), protein expression profiling by immunohistochemistry of 7 proteins (COX2, FOXA1, HER2, Ki-67, p16, PR, SIAH2), with 4 clinicopathologic factors (size, age, margin status, palpability), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a recurrence risk score **AAPC Rationale** CPT® adds 0295U to be reported only for DCISionRT®, PreludeDX™ from Prelude Corporation. The test involves immunohistochemistry (IHC) staining of formalin-fixed paraffin-embedded (FFPE) ductal carcinoma in situ (DCIS) breast tissue for seven protein biomarkers listed in the code. The test couples the IHC findings with four clinical/pathologic factors listed in the code descriptor for an algorithmic analysis to report a risk score for breast cancer recurrence and guide decision for radiation therapy. Effective date of this code: January 1, 2022.

●	**0296U**	Oncology (oral and/or oropharyngeal cancer), gene expression profiling by RNA sequencing of at least 20 molecular features (eg, human and/or microbial mRNA), saliva, algorithm reported as positive or negative for signature associated with malignancy **AAPC Rationale** CPT® adds 0296U to be reported only for mRNA CancerDetect from Viome Life Sciences Inc. The test involves RNA sequencing of human and microbial markers in a saliva specimen with an algorithmic analysis to report the findings as positive or negative for oral or throat cancer. Effective date of this code: January 1, 2022.
●	**0297U**	Oncology (pan tumor), whole genome sequencing of paired malignant and normal DNA specimens, fresh or formalin-fixed paraffin-embedded (FFPE) tissue, blood or bone marrow, comparative sequence analyses and variant identification **AAPC Rationale** CPT® adds 0297U to be reported only for Praxis Somatic Whole Genome Sequencing from Praxis Genomics LLC. The test evaluates paired normal and malignant (tumor) specimens such as blood, bone marrow, or fresh or formalin-fixed paraffin-embedded (FFPE) tissue for whole genome DNA sequence analysis associated with various types of cancer. Effective date of this code: Jan. 1, 2022.
●	**0298U**	Oncology (pan tumor), whole transcriptome sequencing of paired malignant and normal RNA specimens, fresh or formalin-fixed paraffin-embedded (FFPE) tissue, blood or bone marrow, comparative sequence analyses and expression level and chimeric transcript identification **AAPC Rationale** CPT® adds 0298U to be reported only for Praxis Somatic Transcriptome from Praxis Genomics LLC. The test evaluates paired normal and malignant (tumor) specimens, such as blood, bone marrow, or fresh or formalin-fixed paraffin-embedded (FFPE) tissue for gene expression (activity) using transcriptome analysis to identify the functional impact of DNA mutations previously identified in a malignant (tumor) specimen. Transcriptome is the collection of messenger RNA (mRNA) expressed by an organism, or by a particular type of cell or tissue. Effective date of this code: January 1, 2022.
●	**0299U**	Oncology (pan tumor), whole genome optical genome mapping of paired malignant and normal DNA specimens, fresh frozen tissue, blood, or bone marrow, comparative structural variant identification **AAPC Rationale** CPT® adds 0299U to be reported only for Praxis Somatic Optical Genome Mapping from Praxis Genomics LLC. The test evaluates paired normal and malignant (tumor) specimens such as blood, bone marrow, or frozen tissue for a whole genome study using optical genome mapping (OGM) to identify large genetic structural variant(s) that may be associated with various types of cancer. Effective date of this code: January 1, 2022.

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●	**0300U**	Oncology (pan tumor), whole genome sequencing and optical genome mapping of paired malignant and normal DNA specimens, fresh tissue, blood, or bone marrow, comparative sequence analyses and variant identification **AAPC Rationale** CPT® adds 0300U to be reported only for Praxis Somatic Combined Whole Genome Sequencing and Optical Genome Mapping from Praxis Genomics LLC. The test evaluates paired normal and malignant (tumor) specimens such as blood, bone marrow, or frozen tissue using next-generation sequencing (NGS) to sequence the whole genome, and optical genome mapping (OGM) to identify structural variants to aid in diagnosis and treatment of various types of cancer. Effective date of this code: January 1, 2022.
●	**0301U**	Infectious agent detection by nucleic acid (DNA or RNA), Bartonella henselae and Bartonella quintana, droplet digital PCR (ddPCR); **AAPC Rationale** CPT® adds 0301U to be reported only for Bartonella ddPCR from Galaxy Diagnostics Inc. The test uses a specimen such as blood for infectious agent detection of *Bartonella* sp. using a proprietary nucleic acid (DNA or RNA) detection method called droplet digital PCR (ddPCR). Effective date of this code: January 1, 2022.
●	**0302U**	Infectious agent detection by nucleic acid (DNA or RNA), Bartonella henselae and Bartonella quintana, droplet digital PCR (ddPCR); following liquid enrichment **AAPC Rationale** CPT® adds 0302U to be reported only for Bartonella Digital ePCR™ from Galaxy Diagnostics Inc. The test uses an enriched specimen from a source such as blood for infectious agent detection of *Bartonella* sp. using a proprietary nucleic acid (DNA or RNA) detection method called droplet digital PCR (ddPCR). Effective date of this code: January 1, 2022. CPT® adds 0303U to be reported only for Hypoxic BioChip Adhesion from BioChip Labs™. The test uses a whole blood specimen under low oxygen conditions to evaluate adhesion of red blood cells (RBCs) to specific molecules found in blood vessel lining. Effective date of this code: January 1, 2022.
●	**0303U**	Hematology, red blood cell (RBC) adhesion to endothelial/subendothelial adhesion molecules, functional assessment, whole blood, with algorithmic analysis and result reported as an RBC adhesion index; hypoxic **AAPC Rationale** CPT® adds 0303U to be reported only for Hypoxic BioChip Adhesion from BioChip Labs™. The test uses a whole blood specimen under low oxygen conditions to evaluate adhesion of red blood cells (RBCs) to specific molecules found in blood vessel lining. Effective date of this code: January 1, 2022.

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●	**0304U**	Hematology, red blood cell (RBC) adhesion to endothelial/subendothelial adhesion molecules, functional assessment, whole blood, with algorithmic analysis and result reported as an RBC adhesion index; normoxic **AAPC Rationale** CPT® adds 0304U to be reported only for Normoxic BioChip Adhesion from BioChip Labs™. The test uses a whole blood specimen under normal oxygen conditions to evaluate adhesion of red blood cells (RBCs) to specific molecules found in blood vessel lining. Effective date of this code: January 1, 2022.
●	**0305U**	Hematology, red blood cell (RBC) functionality and deformity as a function of shear stress, whole blood, reported as a maximum elongation index **AAPC Rationale** CPT® adds 0305U to be reported only for Ektacytometry from BioChip Labs™. The test uses a whole blood specimen to evaluate how red blood cells (RBCs) deform in shape (elongate) under shear stress, which is force acting parallel to the cell surface. Effective date of this code: January 1, 2022.
●	**0306U**	Oncology (minimal residual disease [MRD]), next-generation targeted sequencing analysis, cell-free DNA, initial (baseline) assessment to determine a patient-specific panel for future comparisons to evaluate for MRD **AAPC Rationale** CPT® adds 0306U to be reported only for Invitae PCM Tissue Profiling and MRD Baseline Assay from Invitae Corporation. The test maps the DNA sequence of a tumor specimen to develop a tumor profile that serves as the baseline for subsequent testing to determine minimal residual disease (MRD), which is the level of cancer cells in the blood following treatment. Effective date of this code: April 1, 2022.
●	**0307U**	Oncology (minimal residual disease [MRD]), next-generation targeted sequencing analysis of a patient-specific panel, cell-free DNA, subsequent assessment with comparison to previously analyzed patient specimens to evaluate for MRD **AAPC Rationale** CPT® adds 0307U to be reported only for Invitae PCM MRD Monitoring from Invitae Corporation. The test evaluates a patient blood specimen for circulating tumor DNA (ctDNA) related to the patient's tumor profile identified in a prior test (0306U). Clinicians may use the test to identify the presence of cancer cells following treatment (minimal residual disease, or MRD) and to monitor patients for cancer recurrence. Effective date of this code: April 1, 2022.

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●	**0308U**	Cardiology (coronary artery disease [CAD]), analysis of 3 proteins (high sensitivity [hs] troponin, adiponectin, and kidney injury molecule-1 [KIM-1]), plasma, algorithm reported as a risk score for obstructive CAD **AAPC Rationale** CPT® adds 0308U to be reported only for HART CADhs® from Prevencio Inc. The test assesses a plasma specimen for the level of the three proteins named in the code. Using an algorithmic analysis of the results and patient data, the test provides a risk score for stenosis (narrowing) or obstruction of a coronary artery. Effective date of this code: April 1, 2022.
●	**0309U**	Cardiology (cardiovascular disease), analysis of 4 proteins (NT-proBNP, osteopontin, tissue inhibitor of metalloproteinase-1 [TIMP-1], and kidney injury molecule-1 [KIM-1]), plasma, algorithm reported as a risk score for major adverse cardiac event **AAPC Rationale** CPT® adds 0309U to be reported only for HART CVE® from Prevencio Inc. The test assesses a plasma specimen for the level of the four proteins named in the code. Using an algorithmic analysis of the results, the test provides a risk score for major adverse cardiovascular events, such as heart attack or stroke. Effective date of this code: April 1, 2022.
●	**0310U**	Pediatrics (vasculitis, Kawasaki disease [KD]), analysis of 3 biomarkers (NTproBNP, C-reactive protein, and T-uptake), plasma, algorithm reported as a risk score for KD **AAPC Rationale** CPT® adds 0310U to be reported only for HART KD® from Prevencio Inc. The test assesses a plasma specimen for the level of the three biomarkers named in the code. Using an algorithmic analysis of the results, the test provides a risk score for Kawasaki Disease (KD), which is a pediatric condition of unknown origin that may have the serious complication of causing damage to coronary arteries. Effective date of this code: April 1, 2022.
●	**0311U**	Infectious disease (bacterial), quantitative antimicrobial susceptibility reported as phenotypic minimum inhibitory concentration (MIC)–based antimicrobial susceptibility for each organism identified **AAPC Rationale** CPT® adds 0311U to be reported only for Accelerate PhenoTest® BC kit, AST configuration from Accelerate Diagnostics Inc. The test is a new configuration of the Accelerate PhenoTest® BC kit described by 0086U. This new configuration provides rapid antimicrobial susceptibility testing (AST) reported as minimum inhibitory concentration (MIC) for positive blood cultures when the lab already has a rapid infectious organism identification system. MIC refers to the lowest concentration of an antimicrobial agent that inhibits microorganism growth. Effective date of this code: April 1, 2022.

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●	**0312U**	Autoimmune diseases (eg, systemic lupus erythematosus [SLE]), analysis of 8 IgG autoantibodies and 2 cell-bound complement activation products using enzyme-linked immunosorbent immunoassay (ELISA), flow cytometry and indirect immunofluorescence, serum, or plasma and whole blood, individual components reported along with an algorithmic SLE-likelihood assessment **AAPC Rationale** CPT® adds 0312U to be reported only for Avise® Lupus from Exagen Inc. Using a specimen such as serum or plasma and whole blood, the test identifies 10 biomarkers to aid in the differential diagnosis of systemic lupus erythematosus (SLE). The biomarkers include eight IgG autoantibodies associated with SLE and two cell-bound complement activation products (CB-CAPs). CB-CAPs are traces of cell-surface proteins activated as part of the complement immune system, which is the body's first line of defense against foreign invaders. Effective date of this code: April 1, 2022.
●	**0313U**	Oncology (pancreas), DNA and mRNA next-generation sequencing analysis of 74 genes and analysis of CEA (CEACAM5) gene expression, pancreatic cyst fluid, algorithm reported as a categorical result (ie, negative, low probability of neoplasia or positive, high probability of neoplasia) **AAPC Rationale** CPT® adds 0313U to be reported only for PancreaSeq® Genomic Classifier from University of Pittsburgh Medical Center Molecular and Genomic Pathology Laboratory. Using fluid from a pancreatic cyst identified by imaging, the test uses next-generation sequencing (NGS) analysis of 74 genes and gene expression (RNA) analysis of a gene known as carcinoembryonic antigen (CEA) or carcinoembryonic antigen-related cell adhesion molecule 5 (CEACAM5), which is a biomarker for gastrointestinal cancers. Using an algorithmic analysis of the results, the test provides a probability score of negative (low probability) or positive (high probability) that the cyst harbors genetic changes that could lead to cancer. Effective date of this code: April 1, 2022.
●	**0314U**	Oncology (cutaneous melanoma), mRNA gene expression profiling by RT-PCR of 35 genes (32 content and 3 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a categorical result (ie, benign, intermediate, malignant) **AAPC Rationale** CPT® adds 0314U to be reported only for DecisionDx® DiffDx™ Melanoma from Castle Biosciences Inc. Using formalin-fixed paraffin-embedded (FFPE) tissue from a skin lesion suspicious for cutaneous melanoma, the test uses reverse-transcription polymerase chain reaction (RT-PCR) gene expression profiling to analyze the specimen for the activity of 35 genes (32 content and three housekeeping). An algorithmic analysis of the findings categorizes the lesion as benign, intermediate, or malignant. Effective date of this code: April 1, 2022.

●	**0315U**	Oncology (cutaneous squamous cell carcinoma), mRNA gene expression profiling by RT-PCR of 40 genes (34 content and 6 housekeeping), utilizing formalin-fixed paraffin-embedded (FFPE) tissue, algorithm reported as a categorical risk result (ie, Class 1, Class 2A, Class 2B) **AAPC Rationale** CPT® adds 0315U to be reported only for DecisionDx®-SCC from Castle Biosciences Inc. Using formalin-fixed paraffin-embedded (FFPE) tissue from a skin lesion diagnosed as squamous cell carcinoma (SCC), the test uses reverse-transcription polymerase chain reaction (RT-PCR) gene expression profiling to analyze the specimen for the activity of 40 genes (34 content and six housekeeping). An algorithmic analysis of the findings categorizes the risk of metastasis as Class 1 (low risk), Class 2A (moderate risk), and Class 2B (high risk). Effective date of this code: April 1, 2022.
●	**0316U**	Borrelia burgdorferi (Lyme disease), OspA protein evaluation, urine **AAPC Rationale** CPT® adds 0316U to be reported only for Lyme Borrelia Nanotrap® Urine Antigen Test from Galaxy Diagnostics Inc. The test uses specialized nanoparticles (Nanotrap®) to capture outer surface protein A (OspA) present in urine of a patient infected with *Borrelia species*, the organism that causes Lyme disease. Following sample enrichment to ensure detection of small quantities of OspA, the test uses Western blot to quantify the protein as an indicator of active infection. Effective date of this code: April 1, 2022.
●	**0317U**	Oncology (lung cancer), four-probe FISH (3q29, 3p22.1, 10q22.3, 10cen) assay, whole blood, predictive algorithm-generated evaluation reported as decreased or increased risk for lung cancer **AAPC Rationale** CPT® adds 0317U to be reported only for LungLB® from LungLife AI®. The test evaluates a blood specimen from a patient with an indeterminate lung nodule identified by imaging. Using four fluorescence in situ hybridization (FISH) probes for rare target cells related to lung cancer, the test can stratify nodules as benign or cancerous and aid the clinician's decision for biopsy or noninvasive monitoring. Effective date of this code: April 1, 2022.
●	**0318U**	Pediatrics (congenital epigenetic disorders), whole genome methylation analysis by microarray for 50 or more genes, blood **AAPC Rationale** CPT® adds 0318U to be reported only for EpiSign Complete from Greenwood Genetic Center. Using a blood specimen, the test evaluates the pediatric patient's genetic material (whole genome) using microarray technology to look for specific methylation changes in 50 or more genes. The pattern of methyl groups in the genes could aid in diagnosing the cause of observed developmental delays and features related to specific disorders present from birth. Effective date of this code: April 1, 2022.

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●	**0319U**	Nephrology (renal transplant), RNA expression by select transcriptome sequencing, using pretransplant peripheral blood, algorithm reported as a risk score for early acute rejection **AAPC Rationale** CPT® adds 0319U to be reported only for Clarava™ from Verici Dx Inc. Using a patient blood specimen prior to kidney transplant, the test uses next-generation sequencing (NGS) of specific parts of the transcriptome (mRNA transcribed from DNA) to evaluate gene expression related to immune response. The test uses an algorithmic analysis of the findings to report a score for risk of early acute transplant rejection. Effective date of this code: April 1, 2022.
●	**0320U**	Nephrology (renal transplant), RNA expression by select transcriptome sequencing, using posttransplant peripheral blood, algorithm reported as a risk score for acute cellular rejection **AAPC Rationale** CPT® adds 0320U to be reported only for Tuteva™ from Verici Dx Inc. Using a blood specimen from a patient following a kidney transplant, the test uses next-generation sequencing (NGS) of specific parts of the transcriptome (mRNA transcribed from DNA) to evaluate gene expression related to immune response. The test uses an algorithmic analysis of the findings to report a risk score for acute or sub-clinical graft rejection. Effective date of this code: April 1, 2022.
●	**0321U**	Infectious agent detection by nucleic acid (DNA or RNA), genitourinary pathogens, identification of 20 bacterial and fungal organisms and identification of 16 associated antibiotic-resistance genes, multiplex amplified probe technique **AAPC Rationale** CPT® adds 0321U to be reported only for Bridge Urinary Tract Infection Detection and Resistance Test from Bridge Diagnostics. Using multiple nucleic acid probes to identify any of 20 specific bacterial or fungal organisms that may be present in a urine specimen, the test may help clinicians diagnose the causative organism for a urinary tract infection. The test also includes probes for 16 associated antibiotic resistance genes, and the results may help guide clinician choice of antibiotic treatment or identify the need for further testing. Effective date of this code: April 1, 2022.
●	**0322U**	Neurology (autism spectrum disorder [ASD]), quantitative measurements of 14 acyl carnitines and microbiome-derived metabolites, liquid chromatography with tandem mass spectrometry (LC-MS/MS), plasma, results reported as negative or positive for risk of metabolic subtypes associated with ASD **AAPC Rationale** CPT® adds 0322U to be reported only for NPDX ASD Test Panel III from Stemina Biomarker Discovery, NeuroPointDX division. The test evaluates a plasma specimen for a metabolic chemical profile and performs an algorithmic analysis to report the findings as positive or negative for a pattern associated with autism spectrum disorder (ASD). Prior to the addition of this code, clinicians may have ordered a similar test using 0139U, which CPT® deleted Oct. 1, 2021. Effective date of this code: April 1, 2022.

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●	**0323U**	Infectious agent detection by nucleic acid (DNA and RNA), central nervous system pathogen, metagenomic next-generation sequencing, cerebrospinal fluid (CSF), identification of pathogenic bacteria, viruses, parasites, or fungi **AAPC Rationale** CPT® adds 0323U to be reported only for Johns Hopkins Metagenomic Next Generation Sequencing Assay for Infectious Disease Diagnostics from Johns Hopkins Medical Microbiology Laboratory. The test uses next-generation sequencing (NGS) of a cerebrospinal fluid (CSF) specimen in a patient with a central nervous system infection of unknown origin to identify the presence of pathogenic (disease-causing) organism(s). Effective date of this code: July 1, 2022.
●	**0324U**	Oncology (ovarian), spheroid cell culture, 4-drug panel (carboplatin, doxorubicin, gemcitabine, paclitaxel), tumor chemotherapy response prediction for each drug **AAPC Rationale** CPT® adds 0324U to be reported only for 3D Predict™ Ovarian Doublet Panel from Kiyatec® Inc. The test evaluates spheroid cell cultures created from an ovarian cancer tissue specimen for response to four chemotherapy drugs listed in the code. The results can help determine an individualized optimum chemotherapy treatment for the patient. Effective date of this code: July 1, 2022.
●	**0325U**	Oncology (ovarian), spheroid cell culture, poly (ADP-ribose) polymerase (PARP) inhibitors (niraparib, olaparib, rucaparib, velparib), tumor response prediction for each drug **AAPC Rationale** CPT® adds 0325U to be reported only for 3D Predict™ Ovarian PARP Panel from Kiyatec® Inc. The test evaluates spheroid cell cultures created from an ovarian cancer tissue specimen for response to four poly (ADP-ribose) polymerase (PARP) inhibitors listed in the code to help determine which, if any, enhance tumor cell death. Effective date of this code: July 1, 2022.
●	**0326U**	Targeted genomic sequence analysis panel, solid organ neoplasm, cell-free circulating DNA analysis of 83 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden **AAPC Rationale** CPT® adds 0326U to be reported only for Guardant360® from Guardant Health Inc. The test involves a targeted sequence analysis panel to evaluate cell-free circulating DNA from a blood specimen for 83 or more genes associated with solid-organ neoplasms. Effective date of this code: July 1, 2022.

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●	**0327U**	Fetal aneuploidy (trisomy 13, 18, and 21), DNA sequence analysis of selected regions using maternal plasma, algorithm reported as a risk score for each trisomy, includes sex reporting, if performed **AAPC Rationale** CPT® adds 0327U to be reported only for Vasistera™ from Natera Inc. Using cell-free DNA (cfDNA) from a maternal plasma specimen, the test analyzes select DNA sequences on an automated platform and uses an algorithm to calculate the likelihood of fetal aneuploidy, such as trisomy 21 (Down syndrome), trisomy 13 (Edwards syndrome), and trisomy 18 (Patau syndrome). The test is a noninvasive prenatal test (NIPT) available early in pregnancy to evaluate for these conditions. Effective date of this code: July 1, 2022.
●	**0328U**	Drug assay, definitive, 120 or more drugs and metabolites, urine, quantitative liquid chromatography with tandem mass spectrometry (LC-MS/MS), includes specimen validity and algorithmic analysis describing drug or metabolite and presence or absence of risks for a significant patient-adverse event, per date of service **AAPC Rationale** CPT® adds 0328U to be reported only for CareView360 from Newstar Medical Laboratories LLC. The test screens for 120 or more drugs and metabolites (breakdown products) in a urine specimen using liquid chromatography with tandem mass spectrometry (LC-MS/MS). The evaluation includes an algorithmic analysis of the drugs and metabolites identified to report the presence or absence of risk for a significant adverse drug event (ADE). The procedure includes specimen validity testing. Effective date of this code: July 1, 2022.
●	**0329U**	Oncology (neoplasia), exome and transcriptome sequence analysis for sequence variants, gene copy number amplifications and deletions, gene rearrangements, microsatellite instability and tumor mutational burden utilizing DNA and RNA from tumor with DNA from normal blood or saliva for subtraction, report of clinically significant mutation(s) with therapy associations **AAPC Rationale** CPT® adds 0329U to be reported only for Oncomap™ ExTra from Genomic Health Inc., a wholly owned subsidiary of Exact Sciences Inc. The test evaluates tumor tissue using next-generation sequencing (NGS) for DNA sequencing of all genes associated with solid tumor mutations (whole exome) and expression of RNA (whole transcriptome). The procedure also sequences DNA from blood or saliva to rule out any mutations not associated with the tumor. Effective date of this code: July 1, 2022.
●	**0330U**	Infectious agent detection by nucleic acid (DNA or RNA), vaginal pathogen panel, identification of 27 organisms, amplified probe technique, vaginal swab **AAPC Rationale** CPT® adds 0330U to be reported only for Bridge Women's Health Infectious Disease Detection Test from Bridge Diagnostics. This nucleic acid amplification test (NAAT) evaluates a vaginal swab specimen for the presence or absence of 27 vaginal pathogens such as Gardnerella vaginalis and other bacteria, Candida spp. (yeast), and Trichomonas vaginalis (TV). Effective date of this code: July 1, 2022.

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●	**0331U**	Oncology (hematolymphoid neoplasia), optical genome mapping for copy number alterations and gene rearrangements utilizing DNA from blood or bone marrow, report of clinically significant alterations **AAPC Rationale** CPT® adds 0331U to be reported only for Augusta Hematology Optical Genome Mapping, from Georgia Esoteric and Molecular (GEM) Laboratory LLC, on a specimen such as blood or bone marrow. The test uses optical genome mapping (OGM) to identify copy number variants (CNVs) and gene rearrangements implicated in hematolymphoid neoplasia, which are blood and bone-marrow cancers. Effective date of this code: July 1, 2022.
●	**0332U**	Oncology (pan-tumor), genetic profiling of 8 DNA-regulatory (epigenetic) markers by quantitative polymerase chain reaction (qPCR), whole blood, reported as a high or low probability of responding to immune checkpoint–inhibitor therapy **AAPC Rationale** CPT® adds 0332U to be reported only for EpiSwitch® CiRT (Checkpoint-inhibitor Response Test) from Next Bio-Research Services LLC and Oxford BioDynamics PLC. Using a whole blood specimen from a cancer patient, the test identifies and quantifies eight biomarkers of non-gene (epigenetic) factors that could impact patient response to specific cancer drugs called immune checkpoint inhibitors. Effective date of this code: October 1, 2022.
●	**0333U**	Oncology (liver), surveillance for hepatocellular carcinoma (HCC) in high-risk patients, analysis of methylation patterns on circulating cell-free DNA (cfDNA) plus measurement of serum of AFP/AFP-L3 and oncoprotein des-gamma-carboxy-prothrombin (DCP), algorithm reported as normal or abnormal result **AAPC Rationale** CPT® adds 0333U to be reported only for HelioLiver™ Test from Fulgent Genetics LLC and Helio Health Inc. The blood test evaluates cell-free DNA (cfDNA) and protein tumor markers to help detect early liver cancer in patients at high risk for developing the disease. Effective date of this code: October 1, 2022.
●	**0334U**	Oncology (solid organ), targeted genomic sequence analysis, formalin-fixed paraffin-embedded (FFPE) tumor tissue, DNA analysis, 84 or more genes, interrogation for sequence variants, gene copy number amplifications, gene rearrangements, microsatellite instability and tumor mutational burden **AAPC Rationale** CPT® adds 0334U to be reported only for Guardant360 TissueNext™ from Guardant Health Inc. The test uses next-generation sequencing (NGS) to evaluate formalin-fixed paraffin-embedded (FFPE) solid tumor tissue for DNA analysis of 84 or more genes for structural variants and other measures of genetic mutation that could impact treatment decisions. Effective date of this code: October 1, 2022.

●	**0335U**	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis, including small sequence changes, copy number variants, deletions, duplications, mobile element insertions, uniparental disomy (UPD), inversions, aneuploidy, mitochondrial genome sequence analysis with heteroplasmy and large deletions, short tandem repeat (STR) gene expansions, fetal sample, identification and categorization of genetic variants **AAPC Rationale** CPT® adds 0335U to be reported only for IriSight™ Prenatal Analysis - Proband from Variantyx Inc. Using a fetal sample, the test is a whole genome sequence analysis to identify genetic variants that may be related to clinical fetal or pregnancy symptoms, or variants that could indicate rare heritable disorders. Effective date of this code: October 1, 2022.
●	**0336U**	Rare diseases (constitutional/heritable disorders), whole genome sequence analysis, including small sequence changes, copy number variants, deletions, duplications, mobile element insertions, uniparental disomy (UPD), inversions, aneuploidy, mitochondrial genome sequence analysis with heteroplasmy and large deletions, short tandem repeat (STR) gene expansions, blood or saliva, identification and categorization of genetic variants, each comparator genome (eg, parent) **AAPC Rationale** CPT® adds 0336U to be reported only for IriSight™ Prenatal Analysis - Comparator from Variantyx Inc. Using a blood or saliva sample, the test is a whole genome sequence analysis to identify genetic variants that may be related to clinical fetal or pregnancy symptoms, or variants that could indicate rare heritable disorders that the parent may have passed on to the fetus. Effective date of this code: October 1, 2022.
●	**0337U**	Oncology (plasma cell disorders and myeloma), circulating plasma cell immunologic selection, identification, morphological characterization, and enumeration of plasma cells based on differential CD138, CD38, CD19, and CD45 protein biomarker expression, peripheral blood **AAPC Rationale** CPT® adds 0337U to be reported only for CELLSEARCH® Circulating Multiple Myeloma Cell (CMMC) test from Menarini Silicon Biosystems Inc. The test identifies, isolates, and counts circulating multiple myeloma cells (CMMC) from a peripheral blood specimen to help manage patients with multiple myeloma (MM) Effective date of this code: October 1, 2022.
●	**0338U**	Oncology (solid tumor), circulating tumor cell selection, identification, morphological characterization, detection and enumeration based on differential EpCAM, cytokeratins 8, 18, and 19, and CD45 protein biomarkers, and quantification of HER2 protein biomarker–expressing cells, peripheral blood **AAPC Rationale** CPT® adds 0338U to be reported only for CELLSEARCH® HER2 Circulating Tumor Cell (CTC-HER2) Test from Menarini Silicon Biosystems Inc. The test identifies, isolates, and counts HER2 circulating tumor cells (CTCs) from a peripheral blood specimen to help manage patients with breast cancer. Effective date of this code: October 1, 2022.

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●	**0339U**	Oncology (prostate), mRNA expression profiling of *HOXC6* and *DLX1*, reverse transcription polymerase chain reaction (RT-PCR), first-void urine following digital rectal examination, algorithm reported as probability of high-grade cancer **AAPC Rationale** CPT® adds 0339U to be reported only for SelectMDx® for Prostate Cancer from MDxHealth® Inc. Using a urine specimen, the test evaluates the activity (gene expression) of two genes: HOXC6 and DLX1. An algorithmic analysis of the findings reports a probability score for the likelihood that the patient has high-grade prostate cancer. Effective date of this code: October 1, 2022.
●	**0340U**	Oncology (pan-cancer), analysis of minimal residual disease (MRD) from plasma, with assays personalized to each patient based on prior next-generation sequencing of the patient's tumor and germline DNA, reported as absence or presence of MRD, with disease-burden correlation, if appropriate **AAPC Rationale** CPT® adds 0340U to be reported only for Signatera™ from Natera Inc. The test uses a cancer patient's plasma specimen for a targeted sequence analysis using circulating tumor DNA (ctDNA). The targeted DNA is based on a prior next-generation sequence (NGS) analysis of the patient's tumor and germline (inherited) DNA for a customized evaluation of minimal residual disease (MRD). Effective date of this code: October 1, 2022.
●	**0341U**	Fetal aneuploidy DNA sequencing comparative analysis, fetal DNA from products of conception, reported as normal (euploidy), monosomy, trisomy, or partial deletion/duplication, mosaicism, and segmental aneuploid **AAPC Rationale** CPT® adds 0341U to be reported only for Single Cell Prenatal Diagnosis (SCPD) Test from Luna Genetics Inc. The test uses a maternal blood sample early in pregnancy to isolate fetal cells for DNA sequencing. The assay evaluates fetal cells for various aneuploidies (abnormal chromosome number), duplication/deletion variants, and mosaicism (cells with different genotypes). Effective date of this code: October 1, 2022.
●	**0342U**	Oncology (pancreatic cancer), multiplex immunoassay of C5, C4, cystatin C, factor B, osteoprotegerin (OPG), gelsolin, IGFBP3, CA125 and multiplex electrochemiluminescent immunoassay (ECLIA) for CA19-9, serum, diagnostic algorithm reported qualitatively as positive, negative, or borderline **AAPC Rationale** CPT® adds 0342U to be reported only for IMMray® PanCan-d from Immunovia Inc. The test evaluates a serum specimen using two different immunoassays (biochemical tests) for the nine biomarkers listed in the code. The procedure includes an algorithm using the test results and other patient data to report the findings as positive, negative, or borderline for pancreatic cancer. Effective date of this code: October 1, 2022.

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●	**0343U**	Oncology (prostate), exosome-based analysis of 442 small noncoding RNAs (sncRNAs) by quantitative reverse transcription polymerase chain reaction (RT-qPCR), urine, reported as molecular evidence of no-, low-, intermediate- or high-risk of prostate cancer **AAPC Rationale** CPT® adds 0343U to be reported only for miR Sentinel™ Prostate Cancer Test from miR Scientific LLC. The test extracts and analyzes relevant small RNA segments from a urine specimen and performs an algorithmic analysis to classify and monitor prostate cancer risk without invasive procedures such as biopsy. Effective date of this code: October 1, 2022.
●	**0344U**	Hepatology (nonalcoholic fatty liver disease [NAFLD]), semiquantitative evaluation of 28 lipid markers by liquid chromatography with tandem mass spectrometry (LC-MS/MS), serum, reported as at-risk for nonalcoholic steatohepatitis (NASH) or not NASH **AAPC Rationale** CPT® adds 0344U to be reported only for OWLiver® from CIMA Sciences LLC. The test evaluates a serum specimen for 28 lipid (fat) biomarkers using liquid chromatography with tandem mass spectrometry (LC-MS/MS) and an algorithmic analysis to report findings as not nonalcoholic steatohepatitis (NASH) or at risk for NASH. Effective date of this code: October 1, 2022.
●	**0345U**	Psychiatry (eg, depression, anxiety, attention deficit hyperactivity disorder [ADHD]), genomic analysis panel, variant analysis of 15 genes, including deletion/duplication analysis of *CYP2D6* **AAPC Rationale** CPT® adds 0345U to be reported only for GeneSight® Psychotropic from Assurex Health Inc. and Myriad Genetics Inc. The test uses a buccal (cheek) swab specimen to analyze 15 genes. The test includes an algorithmic analysis and reports a list of all psychotropic (mental health) medications with an indication of possible interactions with the patient's genes. Effective date of this code: October 1, 2022.
●	**0346U**	Beta amyloid, Aβ40 and Aβ42 by liquid chromatography with tandem mass spectrometry (LC-MS/MS), ratio, plasma **AAPC Rationale** CPT® adds 0346U to be reported only for QUEST AD-Detect™, Beta-Amyloid 42/40 Ratio from Quest Diagnostics. The test evaluates a plasma specimen for levels of beta amyloid 40 and 42 using liquid chromatography with tandem mass spectrometry (LC-MS/MS) and reports the 42/40 ratio as a biomarker of Alzheimer's disease (AD). Effective date of this code: October 1, 2022.

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●	**0347U**	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 16 gene report, with variant analysis and reported phenotypes **AAPC Rationale** CPT® adds 0347U as part of a series of four new codes, 0347U through 0350U, for RightMed® drug metabolism tests. Report 0347U only for RightMed® PGx16 Test from OneOme® LLC. The test uses next-generation sequencing (NGS) of a whole blood or buccal (cheek) swab specimen to analyze 16 genes for variants relevant to drug metabolism and processing. Effective date of this code: October 1, 2022.
●	**0348U**	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 25 gene report, with variant analysis and reported phenotypes **AAPC Rationale** CPT® adds 0348U as part of a series of four new codes, 0347U through 0350U, for RightMed® drug metabolism tests. Report 0348U only for RightMed® Comprehensive Test Exclude F2 and F5 from OneOme® LLC. The test uses next-generation sequencing (NGS) of a whole blood or buccal (cheek) swab specimen to analyze 25 genes for variants relevant to drug metabolism and function. Effective date of this code: October 1, 2022.
●	**0349U**	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 27 gene report, with variant analysis, including reported phenotypes and impacted gene-drug interactions **AAPC Rationale** CPT® adds 0349U as part of a series of four new codes, 0347U through 0350U, for RightMed® drug metabolism tests. Report 0349U only for RightMed® Comprehensive Test from OneOme® LLC. The test uses next-generation sequencing (NGS) of a whole blood or buccal (cheek) swab specimen to analyze 27 genes for variants relevant to drug metabolism and function. The test also includes a pharmacogenomic analysis comparing the genetic results to a database of biomarkers for specific drugs. Effective date of this code: October 1, 2022.
●	**0350U**	Drug metabolism or processing (multiple conditions), whole blood or buccal specimen, DNA analysis, 27 gene report, with variant analysis and reported phenotypes **AAPC Rationale** CPT® adds 0350U as part of a series of four new codes, 0347U through 0350U, for RightMed® drug metabolism tests. Report 0350U only for RightMed® Gene Report from OneOme® LLC. The test uses next-generation sequencing (NGS) of a whole blood or buccal (cheek) swab specimen to analyze 27 genes for variants relevant to drug metabolism and function. Effective date of this code: October 1, 2022.

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●	**0351U**	Infectious disease (bacterial or viral), biochemical assays, tumor necrosis factor-related apoptosis-inducing ligand (TRAIL), interferon gamma-induced protein-10 (IP-10), and C-reactive protein, serum, algorithm reported as likelihood of bacterial infection **AAPC Rationale** CPT® adds 0351U to be reported only for MeMed BV® from MeMed Diagnostics Ltd. The test evaluates a serum specimen for levels of three immune-response biomarkers listed in the code. Using a special desktop point-of-care instrument, the test performs rapid multiplex protein measurement of the three biomarkers and performs an algorithmic analysis to report a score of the likelihood that the patient has a bacterial infection. Effective date of this code: October 1, 2022.
●	**0352U**	Infectious disease (bacterial vaginosis and vaginitis), multiplex amplified probe technique, for detection of bacterial vaginosis–associated bacteria (BVAB-2, Atopobium vaginae, and Megasphera type 1), algorithm reported as detected or not detected and separate detection of Candida species (C. albicans, C. tropicalis, C. parapsilosis, C. dubliniensis), Candida glabrata/Candida krusei, and trichomonas vaginalis, vaginal-fluid specimen, each result reported as detected or not detected **AAPC Rationale** CPT® adds 0352U to be reported only for Xpert® Xpress MVP from Cepheid®. The test evaluates a vaginal specimen using a multiplex amplified probe technique to detect three bacteria listed in the code that are associated with vaginal infection. The test also detects multiple Candida species, if present. Effective date of this code: October 1, 2022.
●	**0353U**	Infectious agent detection by nucleic acid (DNA), Chlamydia trachomatis and Neisseria gonorrhoeae, multiplex amplified probe technique, urine, vaginal, pharyngeal, or rectal, each pathogen reported as detected or not detected **AAPC Rationale** CPT® adds 0353U to be reported only for Xpert® CT/NG from Cepheid®. The test evaluates a vaginal, pharyngeal, rectal, or urine specimen using a multiplex amplified probe technique to detect Chlamydia trachomatis and Neisseria gonorrhoeae, which cause common sexually transmitted infections (STIs). Effective date of this code: October 1, 2022.
●	**0354U**	Human papilloma virus (HPV), high-risk types (ie, 16, 18, 31, 33, 45, 52 and 58) qualitative mRNA expression of E6/E7 by quantitative polymerase chain reaction (qPCR) **AAPC Rationale** CPT® adds 0354U to be reported only for PreTect HPV-Proofer' 7 from GenePace Laboratories LLC. Using a cervical specimen, the test evaluates gene activity (expression) of E6/E7 oncogenes. The test can identify overproduction of E6/E7, which indicates infection with one of the high-risk human papilloma virus (HPV) types and increased risk for cervical cancer. Effective date of this code: October 1, 2022.

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Medicine

●	**0003A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, diluent reconstituted; third dose **AAPC Rationale** CPT® adds 0003A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 30 mcg/0.3 mL. Use 0001A for administration of the first dose, 0002A for administration of the second dose, and 0003A for administration of the third dose. Code 91300 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Pfizer-BioNTech COVID-19 vaccine. Effective date of this code: August 12, 2021.
●	**0004A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, diluent reconstituted; booster dose **AAPC Rationale** CPT® adds 0004A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 30 mcg/0.3 mL. Use 0004A for administration of a booster dose. Codes 0001A, 0002A, and 0003A represent administration of the first, second, and third doses, respectively. Code 91300 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Pfizer-BioNTech COVID-19 vaccine/Comirnaty. Do not use this code for the Pfizer-BioNTech tris-sucrose formulation (91305). Effective date of this code: September 22, 2021.
# ●	**0051A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; first dose **AAPC Rationale** CPT® adds 0051A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 30 mcg/0.3 mL. Codes 0051A-0054A represent administration of the first, second, third, and booster dose, respectively. Code 91305 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the tris-sucrose formulation of the Pfizer-BioNTech COVID-19 vaccine. Do not use this code for the phosphate formulation Pfizer-BioNTech COVID-19 vaccine/Comirnaty (91300). Effective date of this code: October 29, 2021.

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# ●	**0052A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; second dose **AAPC Rationale** CPT® adds 0052A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 30 mcg/0.3 mL. Codes 0051A-0054A represent administration of the first, second, third, and booster dose, respectively. Code 91305 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the tris-sucrose formulation of the Pfizer-BioNTech COVID-19 vaccine. Do not use this code for the phosphate formulation Pfizer-BioNTech COVID-19 vaccine/Comirnaty (91300). Effective date of this code: October 29, 2021.
# ●	**0053A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; third dose **AAPC Rationale** CPT® adds 0053A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 30 mcg/0.3 mL. Codes 0051A-0054A represent administration of the first, second, third, and booster dose, respectively. Code 91305 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the tris-sucrose formulation of the Pfizer-BioNTech COVID-19 vaccine. Do not use this code for the phosphate formulation Pfizer-BioNTech COVID-19 vaccine/Comirnaty (91300). Effective date of this code: October 29, 2021.
# ●	**0054A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation; booster dose **AAPC Rationale** CPT® adds 0054A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 30 mcg/0.3 mL. Codes 0051A-0054A represent administration of the first, second, third, and booster dose, respectively. Code 91305 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the tris-sucrose formulation of the Pfizer-BioNTech COVID-19 vaccine. Do not use this code for the phosphate formulation Pfizer-BioNTech COVID-19 vaccine/Comirnaty (91300). Effective date of this code: October 29, 2021.

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# ●	**0071A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; first dose **AAPC Rationale** CPT® adds 0071A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 10 mcg/0.2 mL. Code 0071A represents administration of the first dose, and 0072A represents administration of the second dose. Code 91307 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for a tris-sucrose formulation of the Pfizer-BioNTech COVID-19 vaccine. This is the pediatric dosage formulation. Do not use this code for the 30 mcg/0.3 mL dosage (see 91305 and 0051A-0054A for that dosage). Effective date of this code: October 29, 2021.
# ●	**0072A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; second dose **AAPC Rationale** CPT® adds 0072A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 10 mcg/0.2 mL. Code 0071A represents administration of the first dose, and 0072A represents administration of the second dose. Code 91307 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for a tris-sucrose formulation of the Pfizer-BioNTech COVID-19 vaccine. This is the pediatric dosage formulation. Do not use this code for the 30 mcg/0.3 mL dosage (see 91305 and 0051A-0054A for that dosage). Effective date of this code: October 29, 2021.
# ●	**0073A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; third dose **AAPC Rationale** CPT® adds 0073A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 10 mcg/0.2 mL. Code 0071A represents administration of the first dose, 0072A represents administration of the second dose, and 0073A represents administration of the third dose. Code 91307 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for a tris-sucrose formulation of the Pfizer-BioNTech COVID-19 vaccine. This is the pediatric dosage formulation. Do not use this code for the 30 mcg/0.3 mL dosage (see 91305 and 0051A-0054A for that dosage). Effective date of this code: January 3, 2022.

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# ●	**0074A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; booster dose **AAPC Rationale** CPT® adds 0074A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 10 mcg/0.2 mL. Code 0074A represents administration of the booster dose. Code 91307 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for a tris-sucrose formulation of the Pfizer-BioNTech COVID-19 vaccine. This is the pediatric dosage formulation. Effective date of this code: May 17, 2022.
# ●	**0081A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; first dose **AAPC Rationale** CPT® adds 0081A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 3 mcg/0.2 mL. Code 0081A represents administration of the first dose, and 0082A represents administration of the second dose. Code 91308 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for a tris-sucrose formulation of the Pfizer-BioNTech COVID-19 vaccine. This is a pediatric dosage formulation, designed for patients ages 6 months to 4 years. Effective date of this code: June 17, 2022.
# ●	**0082A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; second dose **AAPC Rationale** CPT® adds 0082A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 3 mcg/0.2 mL. Code 0081A represents administration of the first dose, and 0082A represents administration of the second dose. Code 91308 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for a tris-sucrose formulation of the Pfizer-BioNTech COVID-19 vaccine. This is a pediatric dosage formulation, designed for patients ages 6 months to 4 years. Effective date of this code: Effective date of this code: June 17, 2022.

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# ●	**0083A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation; third dose **AAPC Rationale** CPT® adds 0083A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 3 mcg/0.2 mL. Code 0083A represents administration of the third dose. Code 91308 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for a tris-sucrose formulation of the Pfizer-BioNTech COVID-19 vaccine. This is a pediatric dosage formulation, designed for patients ages 6 months to 4 years. Effective date of this code: June 17, 2022.
●	**0013A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5 mL dosage; third dose **AAPC Rationale** CPT® adds 0013A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 100 mcg/0.5 mL. Use 0011A for administration of the first dose, 0012A for administration of the second dose, and 0013A for administration of the third dose. Code 91301 represents the vaccine product. A new CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Moderna COVID-19 vaccine. Effective date of this code: August 12, 2021.
# ●	**0064A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.25 mL dosage, booster dose **AAPC Rationale** CPT® adds 0064A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 50 mcg/0.25 mL. Code 91306 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Moderna COVID-19 vaccine booster. For non-booster Moderna vaccine coding, see 91301 and 0011A-0013A. Effective date of this code: October 20, 2021.
# ●	**0091A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage; first dose, when administered to individuals 6 through 11 years **AAPC Rationale** CPT® adds 0091A-0093A to report intramuscular administration of a SARS-CoV-2 vaccine to patients ages 6 to 11 years. The dose is 50 mcg/0.5 mL. New codes 0091A, 0092A, and 0093A apply respectively to administration of doses one, two, and three. Code 91309 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Moderna COVID-19 vaccine. Effective date of this code: June 17, 2022

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# ●	**0092A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage; second dose, when administered to individuals 6 through 11 years **AAPC Rationale** CPT® adds 0091A-0093A to report intramuscular administration of a SARS-CoV-2 vaccine to patients ages 6 to 11 years. The dose is 50 mcg/0.5 mL. New codes 0091A, 0092A, and 0093A apply respectively to administration of doses one, two, and three. Code 91309 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Moderna COVID-19 vaccine. Effective date of this code: June 17, 2022
# ●	**0093A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage; third dose, when administered to individuals 6 through 11 years **AAPC Rationale** CPT® adds 0091A-0093A to report intramuscular administration of a SARS-CoV-2 vaccine to patients ages 6 to 11 years. The dose is 50 mcg/0.5 mL. New codes 0091A, 0092A, and 0093A apply respectively to administration of doses one, two, and three. Code 91309 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Moderna COVID-19 vaccine. Effective date of this code: June 17, 2022
# ▲	**0094A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage, booster dose **AAPC Rationale** CPT® adds 0094A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 50 mcg/0.5 mL. Code 91309 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Moderna COVID-19 vaccine booster. Effective date of this code: March 29, 2022.
▲	**0031A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, $5x10^{10}$ viral particles/0.5 mL dosage;; single dose **AAPC Rationale**

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●	**0034A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5 mL dosage; booster dose **AAPC Rationale** CPT® adds 0034A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 5x1010 viral particles/0.5 mL. Use 0034A for administration of a booster dose. Code 91303 represents the vaccine product. See 0031A for administration of the initial (single) dose. A CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Janssen COVID-19 vaccine. Effective date of this code: October 20, 2021.
●	**0044A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5 mL dosage; booster dose **AAPC Rationale** CPT® adds 0044A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 5 mcg/0.5 mL. Use 0044A for administration of the booster dose. Code 0041A applies to administration of the first dose, and 0042A is for administration of the second dose. Code 91304 represents the vaccine product. A CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Novavax COVID-19 vaccine. Effective date of this code: Based on Emergency Use Authorization or approval from the Food and Drug Administration.
●	**0104A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, monovalent, preservative free, 5 mcg/0.5 mL dosage, adjuvant AS03 emulsion, booster dose **AAPC Rationale** CPT® adds 0104A to report intramuscular administration of a SARS-CoV-2 vaccine. The dose is 5 mcg/0.5 mL. Code 0104A is specific to a booster dose. Code 91310 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Sanofi Pasteur COVID-19 vaccine, adjuvanted for booster immunization. An adjuvant is an ingredient added to a vaccine that helps create a stronger immune response. The intent is for providers to administer this vaccine as a booster for patients who completed a primary series of another approved COVID-19 vaccine. Effective date of this code: Based on emergency use authorization or approval from the Food and Drug Administration.

●	**0111A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 25 mcg/0.25 mL dosage; first dose **AAPC Rationale** CPT® adds 0111A (first dose) and 0112A (second dose) to report intramuscular administration of a SARS-CoV-2 vaccine. The dosage is 25 mcg/0.25 mL. Code 91311 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Moderna COVID-19 vaccine for patients 6 months to 5 years of age. Effective date of this code: June 17, 2022.
●	**0112A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 25 mcg/0.25 mL dosage; second dose **AAPC Rationale** CPT® adds 0111A (first dose) and 0112A (second dose) to report intramuscular administration of a SARS-CoV-2 vaccine. The dosage is 25 mcg/0.25 mL. Code 91311 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Moderna COVID-19 vaccine for patients 6 months to 5 years of age. Effective date of this code: June 17, 2022.
●	**0113A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 25 mcg/0.25 mL dosage; third dose **AAPC Rationale** CPT® adds 0113A (third dose) to report intramuscular administration of a SARS-CoV-2 vaccine. The dosage is 25 mcg/0.25 mL. Code 91311 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Moderna COVID-19 vaccine for patients 6 months to 5 years of age. Effective date of this code: June 17, 2022.
# ●	**0124A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, booster dose **AAPC Rationale** CPT® adds 0124A to report intramuscular administration of a SARS-CoV-2 vaccine booster. The dose is 30 mcg/0.3 mL. Code 91312 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Pfizer-BioNTech COVID-19 bivalent vaccine. Bivalent refers to the vaccine having messenger RNA components of both the original strain of SARS-CoV-2 and the omicron variant. Patient age is typically 12 years and older for this dosage formulation. Effective date of this code: August 31, 2022

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# ●	**0154A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, booster dose **AAPC Rationale** CPT® adds 0154A to report intramuscular administration of a SARS-CoV-2 vaccine booster. The dose is 10 mcg/0.2 mL. Code 91315 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Pfizer-BioNTech COVID-19 bivalent vaccine. Bivalent refers to the vaccine having messenger RNA components of both the original strain of SARS-CoV-2 and the omicron variant. Patient age is typically 5 to 11 years for this dosage formulation. Effective date of this code: Based on emergency use authorization or approval from the Food and Drug Administration.
# ●	**0134A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 50 mcg/0.5 mL dosage, booster dose **AAPC Rationale** CPT® adds 0134A to report intramuscular administration of a SARS-CoV-2 vaccine booster. The dose is 50 mcg/0.5 mL. Code 91313 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Moderna COVID-19 bivalent vaccine. Bivalent refers to the vaccine having messenger RNA components of both the original strain of SARS-CoV-2 and the omicron variant. Patient age is typically 18 years or older for this dosage formulation. Effective date of this code: August 31, 2022.
# ●	**0144A**	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 25 mcg/0.25 mL dosage, booster dose **AAPC Rationale** CPT® adds 0144A to report intramuscular administration of a SARS-CoV-2 vaccine booster. The dose is 25 mcg/0.25 mL. Code 91314 represents the vaccine product. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Moderna COVID-19 bivalent vaccine. Bivalent refers to the vaccine having messenger RNA components of both the original strain of SARS-CoV-2 and the omicron variant. Patient age is typically 6 to 11 years for this dosage formulation. Effective date of this code: Based on emergency use authorization or approval from the Food and Drug Administration.

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# ●	**91305**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use **AAPC Rationale** CPT® adds 91305 to report supply of a SARS-CoV-2 vaccine product. The dose is 30 mcg/0.3 mL. Use 0051A-0054A to report administration. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the tris-sucrose formulation of the Pfizer-BioNTech COVID-19 vaccine. For the original phosphate formulation Pfizer-BioNTech COVID-19 vaccine/Comirnaty, see 91300 and 0001A-0004A. Effective date of this code: October 29, 2021.
# ●	**91307**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use **AAPC Rationale** CPT® adds 91307 to report supply of a SARS-CoV-2 vaccine product. The dosage is 10 mcg/0.2 mL. Use 0071A for administration of the first dose and 0072A for administration of the second dose. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for a tris-sucrose formulation of the Pfizer-BioNTech COVID-19 vaccine. This is the pediatric dosage formulation. Do not use this code for the 30 mcg/0.3 mL dosage (see 91305 and 0051A-0054A for that dosage). Effective date of this code: October 29, 2021.
# ●	**91308**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use **AAPC Rationale** CPT® adds 91308 to report supply of a SARS-CoV-2 vaccine product. The dosage is 3 mcg/0.2 mL. Use 0081A for administration of the first dose and 0082A for administration of the second dose. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for a tris-sucrose formulation of the Pfizer-BioNTech COVID-19 vaccine. This is a pediatric dosage formulation, designed for patients ages 6 months to 4 years. Effective date of this code: June 17, 2022.
# ●	**91306**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.25 mL dosage, for intramuscular use **AAPC Rationale** CPT® adds 91306 to report supply of a SARS-CoV-2 vaccine product. The dose is 50 mcg/0.25 mL. Use 0064A for administration of this booster dose. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Moderna COVID-19 vaccine booster. For non-booster Moderna vaccine coding, see 91301 and 0011A-0013A. Effective date of this code: October 20, 2021.

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# ●	**91311**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 25 mcg/0.25 mL dosage, for intramuscular use **AAPC Rationale** CPT® adds 91311 to report supply of a SARS-CoV-2 vaccine product. The dose is 25 mcg/0.25 mL. Use 0111A for administration of the first dose and 0112A for administration of the second dose. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Moderna COVID-19 vaccine for patients 6 months to 5 years of age. Effective date of this code: June 17, 2022.
# ↗ ●	**91312**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 30 mcg/0.3 mL dosage, tris-sucrose formulation, for intramuscular use **AAPC Rationale** CPT® adds 91312 to report supply of a SARS-CoV-2 vaccine product. The dosage is 30 mcg/0.3 mL. Use 0124A for administration of a booster dose. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Pfizer-BioNTech COVID-19 bivalent vaccine. Bivalent refers to the vaccine having messenger RNA components of both the original strain of SARS-CoV-2 and the omicron variant. Patient age is typically 12 years and older for this dosage formulation. Effective date of this code: August 31, 2022
# ↗ ●	**91315**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, bivalent spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation, for intramuscular use **AAPC Rationale** CPT® adds 91315 to report supply of a SARS-CoV-2 vaccine product. The dosage is 10 mcg/0.2 mL. Use 0154A for administration of a booster dose. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Pfizer-BioNTech COVID-19 bivalent vaccine. Bivalent refers to the vaccine having messenger RNA components of both the original strain of SARS-CoV-2 and the omicron variant. Patient age is typically 5 to 11 years for this dosage formulation. Effective date of this code: Based on emergency use authorization or approval from the Food and Drug Administration.
# ↗ ●	**91313**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use **AAPC Rationale** CPT® adds 91313 to report supply of a SARS-CoV-2 vaccine product. The dosage is 50 mcg/0.5 mL. Use 0134A for administration of a booster dose. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Moderna COVID-19 bivalent vaccine. Bivalent refers to the vaccine having messenger RNA components of both the original strain of SARS-CoV-2 and the omicron variant. Patient age is typically 18 years or older for this dosage formulation. Effective date of this code: August 31, 2022.

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# ↗ ●	**91314**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, bivalent, preservative free, 25 mcg/0.25 mL dosage, for intramuscular use **AAPC Rationale** CPT® adds 91314 to report supply of a SARS-CoV-2 vaccine product. The dosage is 25 mcg/0.25 mL. Use 0144A for administration of the booster dose. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Moderna COVID-19 bivalent vaccine. Bivalent refers to the vaccine having messenger RNA components of both the original strain of SARS-CoV-2 and the omicron variant. Patient age is typically 6 to 11 years for this dosage formulation. Effective date of this code: Based on emergency use authorization or approval from the Food and Drug Administration.
# ●	**91309**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage, for intramuscular use **AAPC Rationale** CPT® adds 91309 to report supply of a SARS-CoV-2 vaccine product. The dose is 50 mcg/0.5 mL. Use 0094A for administration of this booster dose. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Moderna COVID-19 vaccine booster. Don't confuse 0094A/91309 (50 mcg/0.5 mL dosage) with existing Moderna booster codes 0064A/91306 (50 mcg/0.25 mL dosage). Effective date of this code: March 29, 2022.
# ↗ ●	**91310**	Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, monovalent, preservative free, 5 mcg/0.5 mL dosage, adjuvant AS03 emulsion, for intramuscular use **AAPC Rationale** CPT® adds 91310 to report supply of a SARS-CoV-2 vaccine product. The dose is 5 mcg/0.5 mL. Use 0104A for administration of this vaccine. The CPT® appendix for SARS-CoV-2 vaccines indicates these codes are appropriate for the Sanofi Pasteur COVID-19 vaccine, adjuvanted for booster immunization. An adjuvant is an ingredient added to a vaccine that helps create a stronger immune response. The intent is for providers to administer this vaccine as a booster for patients who completed a primary series of another approved COVID-19 vaccine. Effective date of this code: Based on emergency use authorization or approval from the Food and Drug Administration.
# ↗ ●	**90584**	Dengue vaccine, quadrivalent, live, 2 dose schedule, for subcutaneous use **AAPC Rationale** CPT® adds 90584 to report supply of a vaccine product that protects against dengue virus, which causes dengue disease. The vaccine is quadrivalent, meaning it protects against four types of the virus. The vaccine includes a weakened version of the live virus. This vaccine has a two-dose schedule, and the provider performs separately reportable subcutaneous administration. Effective date of this code: July 1, 2022.

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# ●	**90611**	Smallpox and monkeypox vaccine, attenuated vaccinia virus, live, non-replicating, preservative free, 0.5 mL dosage, suspension, for subcutaneous use **AAPC Rationale** CPT® adds 90611 to report supply of a smallpox and monkeypox combined vaccine product. The dosage is 0.5 mL. You may see Jynneos, Imvamune, or Imnavex vaccines referred to for the vaccine product related to 90611. CPT® adds this code at the same time as 90622 for a smallpox vaccine product (which may help protect against monkeypox) and 87593 for lab testing for orthopoxvirus, such as monkeypox. You should use existing codes 90460, 90461, 90471, and 90472 to report the administration of these vaccine products. Effective date of this code: July 26, 2022.
# ●	**90622**	Vaccinia (smallpox) virus vaccine, live, lyophilized, 0.3 mL dosage, for percutaneous use **AAPC Rationale** CPT® adds 90622 to report supply of a smallpox vaccine product. The dosage is 0.3 mL. You may see ACAM2000 referred to for the vaccine product related to 90622. CPT® adds this code at the same time as 90611 for a combined smallpox and monkeypox vaccine product and 87593 for lab testing for orthopoxvirus, such as monkeypox. You should use existing codes 90460, 90461, 90471, and 90472 to report the administration of these vaccine products. Effective date of this code: July 26, 2022.
↗ ●	**90678**	Respiratory syncytial virus vaccine, preF, subunit, bivalent, for intramuscular use **AAPC Rationale** CPT® adds 90678 to report supply of a vaccine product that protects against respiratory syncytial virus (RSV), a common respiratory virus that can be serious, especially for infants and older adults. The vaccine is bivalent, meaning the vaccine protects against two strains of the virus. The vaccine is composed of two prefusion F (preF) proteins to improve protection against RSV A and B strains. PreF is a form of the viral fusion protein (F) that RSV uses to enter human cells. Antibodies specific to preF may block virus infection. The provider performs separately reportable intramuscular administration. Effective date of this code: January 1, 2023.
▲	**90739**	Hepatitis B vaccine (HepB), CpG-adjuvanted, adult dosage, 2 dose or 4 dose schedule, for intramuscular use **AAPC Rationale** CPT® revises 90739 to state that the hepatitis B vaccine product is CpG-adjuvanted, meaning CpG (a synthetic form of DNA) has been added to the vaccine to increase the body's immune response. Also, the revision adds that the product may have a two-dose or four-dose schedule. Previously the code descriptor referred only to a two-dose schedule. Effective date of this revision: July 1, 2022.

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▲	**92065**	Orthoptic training; performed by a physician or other qualified health care professional **AAPC Rationale** CPT® revises orthoptic training (vision therapy exercises) code 92065 by specifying that a physician or other qualified healthcare professional (QHP) performs the service. This addition distinguishes 92065 from new code 92066, which is specific to training under the supervision of a physician or other QHP. Effective date of this revision: January 1, 2023.
●	**92066**	Orthoptic training; under supervision of a physician or other qualified health care professional **AAPC Rationale** CPT® adds 92066 for orthoptic training (vision therapy exercises) under the supervision of a physician or other qualified healthcare professional (QHP). Related to this addition, CPT® revises orthoptic training code 92065 by specifying that a physician or other QHP performs the service. Effective date of this revision: January 1, 2023.
▲	**92229**	Imaging of retina for detection or monitoring of disease; point-of-care autonomous~~automated~~ analysis and report, unilateral or bilateral **AAPC Rationale** CPT® revises point-of-care retinal imaging code 92229 by changing "automated analysis" to "autonomous analysis." According to a CPT® appendix, autonomous means the machine automatically interprets data and produces conclusions that are clinically relevant. The change helps match code descriptor terminology to the way CPT® categorizes artificial intelligence. Effective date of this revision: January 1, 2023.
▲	**92284**	Diagnostic ~~D~~dark adaptation examination with interpretation and report **AAPC Rationale** CPT® revises dark adaptation eye exam code 92284 by adding the term diagnostic to clarify the point of the service. Effective date of this revision: January 1, 2023.

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✚ ▲	**93568**	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for nonselective pulmonary arterial angiography (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® revises pulmonary angiography injection procedure code +93568 as part of a larger change to coding for this procedure, which is performed during cardiac catheterization. For existing code +93568, CPT® changes "pulmonary angiography" to "nonselective pulmonary arterial angiography." This change is because CPT® also adds several related codes for pulmonary angiography during cardiac catheterization. You'll use new codes +93569 (unilateral) and +93573 (bilateral) for selective pulmonary arterial angiography. You'll use new code +93574 for selective pulmonary venous angiography of each distinct pulmonary vein. New code +93575 applies to selective pulmonary angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its systemic branches. You'll report this last code during cardiac catheterization for congenital heart defects and report the code once per each distinct vessel. Effective date of this revision: January 1, 2023.
✚ ●	**93569**	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, unilateral (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds pulmonary angiography injection procedure code +93569 as part of a larger change to coding for this procedure, which is performed during cardiac catheterization. For existing code +93568, CPT® changes "pulmonary angiography" to "nonselective pulmonary arterial angiography." This change is because CPT® also adds several related codes for pulmonary angiography during cardiac catheterization. You'll use new codes +93569 (unilateral) and +93573 (bilateral) for selective pulmonary arterial angiography. You'll use new code +93574 for selective pulmonary venous angiography of each distinct pulmonary vein. New code +93575 applies to selective pulmonary angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its systemic branches. You'll report this last code during cardiac catheterization for congenital heart defects and report the code once per each distinct vessel. Effective date of this code: January 1, 2023.

# ✚ ●	**93573**	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary arterial angiography, bilateral (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds pulmonary angiography injection procedure code +93573 as part of a larger change to coding for this procedure, which is performed during cardiac catheterization. For existing code +93568, CPT® changes "pulmonary angiography" to "nonselective pulmonary arterial angiography." This change is because CPT® also adds several related codes for pulmonary angiography during cardiac catheterization. You'll use new codes +93569 (unilateral) and +93573 (bilateral) for selective pulmonary arterial angiography. You'll use new code +93574 for selective pulmonary venous angiography of each distinct pulmonary vein. New code +93575 applies to selective pulmonary angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its systemic branches. You'll report this last code during cardiac catheterization for congenital heart defects and report the code once per each distinct vessel. Effective date of this code: January 1, 2023.
# ✚ ●	**93574**	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary venous angiography of each distinct pulmonary vein during cardiac catheterization (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds pulmonary angiography injection procedure code +93574 as part of a larger change to coding for this procedure, which is performed during cardiac catheterization. For existing code +93568, CPT® changes "pulmonary angiography" to "nonselective pulmonary arterial angiography." This change is because CPT® also adds several related codes for pulmonary angiography during cardiac catheterization. You'll use new codes +93569 (unilateral) and +93573 (bilateral) for selective pulmonary arterial angiography. You'll use new code +93574 for selective pulmonary venous angiography of each distinct pulmonary vein. New code +93575 applies to selective pulmonary angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its systemic branches. You'll report this last code during cardiac catheterization for congenital heart defects and report the code once per each distinct vessel. Effective date of this code: January 1, 2023.

# ✚ ●	**93575**	Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective pulmonary angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its systemic branches, during cardiac catheterization for congenital heart defects, each distinct vessel (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds pulmonary angiography injection procedure code +93575 as part of a larger change to coding for this procedure, which is performed during cardiac catheterization. For existing code +93568, CPT® changes "pulmonary angiography" to "nonselective pulmonary arterial angiography." This change is because CPT® also adds several related codes for pulmonary angiography during cardiac catheterization. You'll use new codes +93569 (unilateral) and +93573 (bilateral) for selective pulmonary arterial angiography. You'll use new code +93574 for selective pulmonary venous angiography of each distinct pulmonary vein. New code +93575 applies to selective pulmonary angiography of major aortopulmonary collateral arteries (MAPCAs) arising off the aorta or its systemic branches. You'll report this last code during cardiac catheterization for congenital heart defects and report the code once per each distinct vessel. Effective date of this code: January 1, 2023.
●	**95919**	Quantitative pupillometry with physician or other qualified health care professional interpretation and report, unilateral or bilateral **AAPC Rationale** CPT® adds 95919 for quantitative pupillometry. Quantitative pupillometry refers to objective measurement of pupil size and reactivity. The provider typically uses a small device that emits light and records the pupil reaction. Providers may use this, for instance, to evaluate pupil response in patients with traumatic brain injury or in a coma. The service requires interpretation and report by a physician or other qualified healthcare professional. The code applies whether the service is unilateral or bilateral. Effective date of this code: January 1, 2023.
●	**96202**	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); initial 60 minutes **AAPC Rationale** CPT® adds 96202 (initial 60 minutes) and +96203 (each additional 15 minutes) for multiple-family group behavior management and modification training. During the session, the provider trains parents, guardians, and caregivers without the patient present. The provider covers areas such as how to create an environment that supports desired behaviors and adherence to the patient's plan of care while reducing the negative impacts of the patient's diagnosis on their daily life. A physician or other qualified healthcare provider administers the training, which is face-to-face. Effective date of this code: January 1, 2023.

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✚ ●	**96203**	Multiple-family group behavior management/modification training for parent(s)/guardian(s)/caregiver(s) of patients with a mental or physical health diagnosis, administered by physician or other qualified health care professional (without the patient present), face-to-face with multiple sets of parent(s)/guardian(s)/caregiver(s); each additional 15 minutes (List separately in addition to code for primary service) **AAPC Rationale** CPT® adds 96202 (initial 60 minutes) and +96203 (each additional 15 minutes) for multiple-family group behavior management and modification training. During the session, the provider trains parents, guardians, and caregivers without the patient present. The provider covers areas such as how to create an environment that supports desired behaviors and adherence to the patient's plan of care while reducing the negative impacts of the patient's diagnosis on their daily life. A physician or other qualified healthcare provider administers the training, which is face-to-face. Effective date of this code: January 1, 2023.
▲	**98975**	Remote therapeutic monitoring (eg, ~~respiratory system status, musculoskeletal system status,~~ therapy adherence, therapy response); initial set-up and patient education on use of equipment **AAPC Rationale** CPT® revises remote therapeutic monitoring (RTM) codes 98975-98977. Code 98975 continues to apply to equipment setup and education. Codes 98976 (respiratory system) and 98977 (musculoskeletal system) continue to represent RTM device supply with recording/alert transmission. The update removes the examples of respiratory system status and musculoskeletal system status from the part of the descriptor that this family of codes shares. These examples are still valid, but removing them avoids confusion as more types of RTM are added to the code set. Related to this change, CPT® adds 98978 for device supply with recording/alert transmission to monitor cognitive behavioral therapy, per 30 days. CPT® deletes temporary codes 0702T (supply and technical support) and 0703T (professional management services), which previously represented RTM of a cognitive behavioral therapy program. Effective date of this revision: January 1, 2023.
▲	**98976**	Remote therapeutic monitoring (eg, ~~respiratory system status, musculoskeletal system status,~~ therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days **AAPC Rationale** CPT® revises remote therapeutic monitoring (RTM) codes 98975-98977. Code 98975 continues to apply to equipment setup and education. Codes 98976 (respiratory system) and 98977 (musculoskeletal system) continue to represent RTM device supply with recording/alert transmission. The update removes the examples of respiratory system status and musculoskeletal system status from the part of the descriptor that this family of codes shares. These examples are still valid, but removing them avoids confusion as more types of RTM are added to the code set. Related to this change, CPT® adds 98978 for device supply with recording/alert transmission to monitor cognitive behavioral therapy, per 30 days. CPT® deletes temporary codes 0702T (supply and technical support) and 0703T (professional management services), which previously represented RTM of a cognitive behavioral therapy program. Effective date of this revision: January 1, 2023.

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▲	**98977**	Remote therapeutic monitoring (eg, ~~respiratory system status, musculoskeletal system status,~~ therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days **AAPC Rationale** CPT® revises remote therapeutic monitoring (RTM) codes 98975-98977. Code 98975 continues to apply to equipment setup and education. Codes 98976 (respiratory system) and 98977 (musculoskeletal system) continue to represent RTM device supply with recording/alert transmission. The update removes the examples of respiratory system status and musculoskeletal system status from the part of the descriptor that this family of codes shares. These examples are still valid, but removing them avoids confusion as more types of RTM are added to the code set. Related to this change, CPT® adds 98978 for device supply with recording/alert transmission to monitor cognitive behavioral therapy, per 30 days. CPT® deletes temporary codes 0702T (supply and technical support) and 0703T (professional management services), which previously represented RTM of a cognitive behavioral therapy program. Effective date of this revision: January 1, 2023.
●	**98978**	Remote therapeutic monitoring (eg, ~~respiratory system status, musculoskeletal system status,~~ therapy adherence, therapy response); device(s) supply with scheduled (eg, daily) recording(s) and/or programmed alert(s) transmission to monitor cognitive behavioral therapy, each 30 days **AAPC Rationale** CPT® adds 98978 for remote therapeutic monitoring (RTM) of cognitive behavioral therapy, per 30 days. The code is specific to device supply with scheduled recording and/or programmed alert transmission. Related to this change, CPT® deletes temporary codes 0702T (supply and technical support) and 0703T (professional management services), which previously represented RTM of a cognitive behavioral therapy program. CPT® also revises RTM codes 98975-98977. Code 98975 continues to apply to equipment setup and education. Codes 98976 (respiratory system) and 98977 (musculoskeletal system) continue to represent RTM device supply with recording/alert transmission. The update removes the examples of respiratory system status and musculoskeletal system status from the part of the descriptor that this family of codes shares. These examples are still valid, but removing them avoids confusion as more types of RTM are added to the code set. Effective date of this code: January 1, 2023

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Category III Codes

	~~0163T~~	~~Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression), each additional interspace, lumbar (List separately in addition to code for primary procedure)~~ **AAPC Rationale** CPT® deletes +0163T, which was an add-on code representing total disc arthroplasty of each additional lumbar interspace using an anterior approach and discectomy. Related to this deletion, CPT® revises primary code 22857 (single lumbar interspace) by adding a semicolon to make it a parent code for new code +22860. The descriptor for +22860 is almost identical to +0163T, except new code +22860 specifies "second interspace" while deleted code 0163T used the phrase "each additional interspace." For more than two interspaces, CPT® instructs you to use 22899. Effective date of this deletion: January 1, 2023.
	~~0312T~~	~~Vagus nerve blocking therapy (morbid obesity); laparoscopic implantation of neurostimulator electrode array, anterior and posterior vagal trunks adjacent to esophagogastric junction (EGJ), with implantation of pulse generator, includes programming~~ **AAPC Rationale** CPT® deletes 0312T to 0317T, which represented vagus nerve blocking therapy. The goal of the service is to control hunger in a patient with morbid obesity. The CPT® Editorial Panel accepted deletion of these codes, which were scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.
	~~0313T~~	~~Vagus nerve blocking therapy (morbid obesity); laparoscopic revision or replacement of vagal trunk neurostimulator electrode array, including connection to existing pulse generator~~ **AAPC Rationale** CPT® deletes 0312T to 0317T, which represented vagus nerve blocking therapy. The goal of the service is to control hunger in a patient with morbid obesity. The CPT® Editorial Panel accepted deletion of these codes, which were scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.
	~~0314T~~	~~Vagus nerve blocking therapy (morbid obesity); laparoscopic removal of vagal trunk neurostimulator electrode array and pulse generator~~ **AAPC Rationale** CPT® deletes 0312T to 0317T, which represented vagus nerve blocking therapy. The goal of the service is to control hunger in a patient with morbid obesity. The CPT® Editorial Panel accepted deletion of these codes, which were scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.

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	~~0315T~~	~~Vagus nerve blocking therapy (morbid obesity); removal of pulse generator~~ **AAPC Rationale** CPT® deletes 0312T to 0317T, which represented vagus nerve blocking therapy. The goal of the service is to control hunger in a patient with morbid obesity. The CPT® Editorial Panel accepted deletion of these codes, which were scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.
	~~0316T~~	~~Vagus nerve blocking therapy (morbid obesity); replacement of pulse generator~~ **AAPC Rationale** CPT® deletes 0312T to 0317T, which represented vagus nerve blocking therapy. The goal of the service is to control hunger in a patient with morbid obesity. The CPT® Editorial Panel accepted deletion of these codes, which were scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.
	~~0317T~~	~~Vagus nerve blocking therapy (morbid obesity); neurostimulator pulse generator electronic analysis, includes reprogramming when performed~~ **AAPC Rationale** CPT® deletes 0312T to 0317T, which represented vagus nerve blocking therapy. The goal of the service is to control hunger in a patient with morbid obesity. The CPT® Editorial Panel accepted deletion of these codes, which were scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.
▲	**0402T**	Collagen cross-linking of cornea, including removal of the corneal epithelium, when performed, and intraoperative pachymetry, when performed ~~(Report medication separately)~~ **AAPC Rationale** CPT® revises 0402T to clarify that corneal epithelium removal (removing the thin layer over the eye's surface) is included when performed but is not required to report the code. The revision also deletes the wording "(Report medication separately)" from the descriptor and moves that text to be a parenthetical instruction under the code. Effective date of this revision: July 1, 2022.
# ●	**0714T**	Transperineal laser ablation of benign prostatic hyperplasia, including imaging guidance **AAPC Rationale** CPT® adds 0714T to represent laser ablation (destruction) of benign prostatic hyperplasia, which is noncancerous enlargement of the prostate gland. The approach is transperineal, meaning through the perineum, the area between the scrotum and anus. The code includes imaging guidance used for the procedure. Effective date of this code: July 1, 2022.

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	~~0470T~~	~~Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; first lesion~~ **AAPC Rationale** CPT® deletes 0470T (first lesion) and +0471T (each additional lesion), which represented optical coherence tomography for skin imaging, which uses low-power infrared light to visualize minute details in form and structure of the skin. The CPT® Editorial Panel accepted deletion of these codes, which were scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.
	~~0471T~~	~~Optical coherence tomography (OCT) for microstructural and morphological imaging of skin, image acquisition, interpretation, and report; each additional lesion (List separately in addition to code for primary procedure)~~ **AAPC Rationale** CPT® deletes 0470T (first lesion) and +0471T (each additional lesion), which represented optical coherence tomography for skin imaging, which uses low-power infrared light to visualize minute details in form and structure of the skin. The CPT® Editorial Panel accepted deletion of these codes, which were scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.
	~~0475T~~	~~Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording and storage, data scanning with signal extraction, technical analysis and result, as well as supervision, review, and interpretation of report by a physician or other qualified health care professional~~ **AAPC Rationale** CPT® deletes 0475T to 0478T, which represented fetal magnetic cardiac signal recording, a noninvasive method of assessing and monitoring the cardiac status of a fetus. The CPT® Editorial Panel accepted deletion of these codes, which were scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.
	~~0476T~~	~~Recording of fetal magnetic cardiac signal using at least 3 channels; patient recording, data scanning, with raw electronic signal transfer of data and storage~~ **AAPC Rationale** CPT® deletes 0475T to 0478T, which represented fetal magnetic cardiac signal recording, a noninvasive method of assessing and monitoring the cardiac status of a fetus. The CPT® Editorial Panel accepted deletion of these codes, which were scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.

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	~~0477T~~	~~Recording of fetal magnetic cardiac signal using at least 3 channels; signal extraction, technical analysis, and result~~ **AAPC Rationale** CPT® deletes 0475T to 0478T, which represented fetal magnetic cardiac signal recording, a noninvasive method of assessing and monitoring the cardiac status of a fetus. The CPT® Editorial Panel accepted deletion of these codes, which were scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.
	~~0478T~~	~~Recording of fetal magnetic cardiac signal using at least 3 channels; review, interpretation, report by physician or other qualified health care professional~~ **AAPC Rationale** CPT® deletes 0475T to 0478T, which represented fetal magnetic cardiac signal recording, a noninvasive method of assessing and monitoring the cardiac status of a fetus. The CPT® Editorial Panel accepted deletion of these codes, which were scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.
	~~0487T~~	~~Biomechanical mapping, transvaginal, with report~~ **AAPC Rationale** CPT® deletes 0487T, which represented transvaginal biomechanical mapping, which involves using a probe that senses pelvic muscle contractions and relaxation, and sends the data to a computer to interpret the data and map pelvic floor muscle function. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.
	~~0491T~~	~~Ablative laser treatment, non-contact, full field and fractional ablation, open wound, per day, total treatment surface area; first 20 sq cm or less~~ **AAPC Rationale** CPT® deletes 0491T and 0492T, which represented noncontact ablative laser treatment of an open wound. The CPT® Editorial Panel accepted deletion of these codes, which were scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.
	~~0492T~~	~~Ablative laser treatment, non-contact, full field and fractional ablation, open wound, per day, total treatment surface area; each additional 20 sq cm, or part thereof (List separately in addition to code for primary procedure)~~ **AAPC Rationale** CPT® deletes 0491T and 0492T, which represented noncontact ablative laser treatment of an open wound. The CPT® Editorial Panel accepted deletion of these codes, which were scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.

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	~~0493T~~	~~Contact near-infrared spectroscopy studies of lower extremity wounds (eg, for oxyhemoglobin measurement)~~ **AAPC Rationale** CPT® deletes 0493T, which represented a provider examining a lower extremity wound by exposing the tissue to near-infrared light and analyzing the absorption and emission of light by the tissue. This code was specific to contact studies, meaning spectrometer sensors have direct contact with the skin. The CPT® Editorial Panel accepted deletion of this code, which was scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. For noncontact near-infrared spectroscopy studies, you will continue to use 0640T, 0641T, and 0642T. Effective date of this deletion: January 1, 2023.
	~~0497T~~	~~External patient-activated, physician- or other qualified health care professional-prescribed, electrocardiographic rhythm derived event recorder without 24-hour attended monitoring; in-office connection~~ **AAPC Rationale** CPT® deletes 0497T and 0498T, which represented services for a patient-activated electrocardiographic (ECG) rhythm derived event recorder without 24-hour attended monitoring. The patient wears the device on the body and activates it when experiencing symptoms such as chest pain; the device transmits the ECG tracing. The CPT® Editorial Panel accepted deletion of these codes, which were scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.
	~~0498T~~	~~External patient-activated, physician- or other qualified health care professional-prescribed, electrocardiographic rhythm derived event recorder without 24-hour attended monitoring; review and interpretation by a physician or other qualified health care professional per 30 days with at least one patient-generated triggered event~~ **AAPC Rationale** CPT® deletes 0497T and 0498T, which represented services for a patient-activated electrocardiographic (ECG) rhythm derived event recorder without 24-hour attended monitoring. The patient wears the device on the body and activates it when experiencing symptoms such as chest pain; the device transmits the ECG tracing. The CPT® Editorial Panel accepted deletion of these codes, which were scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.

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	~~0499T~~	~~Cystourethroscopy, with mechanical dilation and urethral therapeutic drug delivery for urethral stricture or stenosis, including fluoroscopy, when performed~~ **AAPC Rationale** CPT® deletes 0499T, which represented cystourethroscopy (endoscopy of the urinary bladder via the urethra), with mechanical dilation and drug delivery to treat urethral stricture or stenosis (narrowing). The urethra is the tube from the bladder to the outside of the body. The CPT® Editorial Panel accepted deletion of this code, which was scheduled for sundown. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.
	~~0514T~~	~~Intraoperative visual axis identification using patient fixation (List separately in addition to code for primary procedure)~~ **AAPC Rationale** CPT® deletes 0514T, which represented using specialized equipment with a light source to identify the visual axis during an intraocular procedure, such as cataract removal. Use an unlisted code if no more specific code represents the service you're reporting. Effective date of this deletion: January 1, 2023.
	~~0702T~~	~~Remote therapeutic monitoring of a standardized online digital cognitive behavioral therapy program ordered by a physician or other qualified health care professional; supply and technical support, per 30 days~~ **AAPC Rationale** CPT® deletes 0702T (supply and technical support) and 0703T (professional management services), which represented services for remote therapeutic monitoring (RTM) of a standardized online digital cognitive behavioral therapy program. Related to this change, CPT® adds 98978 for device supply with scheduled recording or programmed alert transmission to monitor cognitive behavioral therapy, per 30 days. See revised code 98975 for initial equipment setup and patient education. Effective date of this deletion: January 1, 2023.
	~~0703T~~	~~Remote therapeutic monitoring of a standardized online digital cognitive behavioral therapy program ordered by a physician or other qualified health care professional; management services by physician or other qualified health care professional, per calendar month~~ **AAPC Rationale** CPT® deletes 0702T (supply and technical support) and 0703T (professional management services), which represented services for remote therapeutic monitoring (RTM) of a standardized online digital cognitive behavioral therapy program. Related to this change, CPT® adds 98978 for device supply with scheduled recording or programmed alert transmission to monitor cognitive behavioral therapy, per 30 days. See revised code 98975 for initial equipment setup and patient education. Effective date of this deletion: January 1, 2023.

✚ ●	**0715T**	Percutaneous transluminal coronary lithotripsy (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds +0715T for percutaneous transluminal coronary lithotripsy performed at the same encounter as certain primary procedures. Transluminal coronary lithotripsy involves breaking up calcifications in a coronary (heart) vessel. The approach is percutaneous, which is a minimally invasive approach through the skin. Effective date of this code: July 1, 2022.
●	**0716T**	Cardiac acoustic waveform recording with automated analysis and generation of coronary artery disease risk score **AAPC Rationale** CPT® adds 0716T for cardiac acoustic waveform (heart sound) recording. The service includes automated analysis and creation of a coronary artery disease (CAD) risk score. For instance, the provider may use a device that applies artificial intelligence algorithms to identify sounds from the recording associated with CAD and combines that data with clinical risk factors to determine a score. Effective date of this code: July 1, 2022.
●	**0717T**	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; adipose tissue harvesting, isolation and preparation of harvested cells, including incubation with cell dissociation enzymes, filtration, washing, and concentration of ADRCs **AAPC Rationale** CPT® adds 0717T and 0718T for autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear. Code 0717T represents harvesting the adipose (fatty) tissue from the patient, and isolating and preparing the cells using various steps. Code 0718T represents injecting the ADRCs into that same patient's supraspinatus tendon (part of the rotator cuff muscles of the shoulder) on one side of the body under ultrasound guidance. Effective date of this code: July 1, 2022.
●	**0718T**	Autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear; injection into supraspinatus tendon including ultrasound guidance, unilateral **AAPC Rationale** CPT® adds 0717T and 0718T for autologous adipose-derived regenerative cell (ADRC) therapy for partial thickness rotator cuff tear. Code 0717T represents harvesting the adipose (fatty) tissue from the patient, and isolating and preparing the cells using various steps. Code 0718T represents injecting the ADRCs into that same patient's supraspinatus tendon (part of the rotator cuff muscles of the shoulder) on one side of the body under ultrasound guidance. Effective date of this code: July 1, 2022.

●	**0719T**	Posterior vertebral joint replacement, including bilateral facetectomy, laminectomy, and radical discectomy, including imaging guidance, lumbar spine, single segment **AAPC Rationale** CPT® adds 0719T for posterior vertebral joint replacement of a single segment in the lumbar spine. The code includes bilateral facetectomy (facet joint removal), laminectomy (removing the back part of the vertebrae), radical discectomy (removal of disc material), and imaging guidance. The procedure is a total joint replacement, replacing the disc and facet joints to preserve motion in the lower back. Effective date of this code: July 1, 2022.
●	**0720T**	Percutaneous electrical nerve field stimulation, cranial nerves, without implantation **AAPC Rationale** CPT® adds 0720T for percutaneous electrical nerve field stimulation of the cranial nerves. This typically involves placing a device on the skin behind the ear and positioning electrodes on the external ear's surface near cranial nerve branches. The device is placed on the skin, such as by adhesive, but not implanted. The device electrically stimulates the nerve branches, which may assist with alleviating pain and withdrawal symptoms. Effective date of this code: July 1, 2022.
●	**0721T**	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained without concurrent CT examination of any structure contained in previously acquired diagnostic imaging **AAPC Rationale** CPT® adds 0721T and +0722T to represent using computed tomography (CT) software to quantitatively analyze tissue characteristics, including an interpretation and report. Quantitative tissue characterization refers to objective analysis using computer algorithms, as opposed to subjective assessment based on provider visualization. Report 0721T when the service is performed without concurrent CT of a structure included in prior diagnostic imaging. You should not report 0721T with a CT code when both are performed on the same anatomy. When there is concurrent CT, use +0722T as an add-on code with the appropriate CT code. You may report 0721T and +0722T together, but not when performed on the same anatomy. Effective date of this code: July 1, 2022.

✚ ●	**0722T**	Quantitative computed tomography (CT) tissue characterization, including interpretation and report, obtained with concurrent CT examination of any structure contained in the concurrently acquired diagnostic imaging dataset (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds 0721T and +0722T to represent using computed tomography (CT) software to quantitatively analyze tissue characteristics, including an interpretation and report. Quantitative tissue characterization refers to objective analysis using computer algorithms, as opposed to subjective assessment based on provider visualization. Report 0721T when the service is performed without concurrent CT of a structure included in prior diagnostic imaging. You should not report 0721T with a CT code when both are performed on the same anatomy. When there is concurrent CT, use +0722T as an add-on code with the appropriate CT code. You may report 0721T and +0722T together, but not when performed on the same anatomy. Effective date of this code: July 1, 2022.
●	**0723T**	Quantitative magnetic resonance cholangiopancreatography (QMRCP), including data preparation and transmission, interpretation and report, obtained without diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) during the same session **AAPC Rationale** CPT® adds 0723T and +0724T to represent using magnetic resonance cholangiopancreatography data and software to quantitatively assess the biliary system (bile ducts and organs such as the liver, gallbladder, and pancreas). Quantitative in this case refers to objective analysis using computer algorithms, as opposed to subjective assessment based on provider visualization. Report 0723T when the service is not performed in conjunction with diagnostic MRI of the same anatomy. When there is diagnostic MRI of the same anatomy, use +0724T as an add-on code to the appropriate MRI code. Both 0723T and +0724T include preparation and transmission of data as well as interpretation and report by the provider. Effective date of this code: July 1, 2022.
✚ ●	**0724T**	Quantitative magnetic resonance cholangiopancreatography (QMRCP), including data preparation and transmission, interpretation and report, obtained with diagnostic magnetic resonance imaging (MRI) examination of the same anatomy (eg, organ, gland, tissue, target structure) (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds 0723T and +0724T to represent using magnetic resonance cholangiopancreatography data and software to quantitatively assess the biliary system (bile ducts and organs such as the liver, gallbladder, and pancreas). Quantitative in this case refers to objective analysis using computer algorithms, as opposed to subjective assessment based on provider visualization. Report 0723T when the service is not performed in conjunction with diagnostic MRI of the same anatomy. When there is diagnostic MRI of the same anatomy, use +0724T as an add-on code to the appropriate MRI code. Both 0723T and +0724T include preparation and transmission of data as well as interpretation and report by the provider. Effective date of this code: July 1, 2022.

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●	**0725T**	Vestibular device implantation, unilateral **AAPC Rationale** CPT® adds 0725T to 0729T for implantable vestibular device services. Use 0725T for implant, 0726T for removal, 0727T for removal and replacement, 0728T for diagnostic analysis with initial programming, and 0729T for diagnostic analysis with subsequent programming. Each code is unilateral. The vestibular system contributes to the sense of balance. An implant can help artificially restore lost vestibular function. Effective date of this code: July 1, 2022.
●	**0726T**	Removal of implanted vestibular device, unilateral **AAPC Rationale** CPT® adds 0725T to 0729T for implantable vestibular device services. Use 0725T for implant, 0726T for removal, 0727T for removal and replacement, 0728T for diagnostic analysis with initial programming, and 0729T for diagnostic analysis with subsequent programming. Each code is unilateral. The vestibular system contributes to the sense of balance. An implant can help artificially restore lost vestibular function. Effective date of this code: July 1, 2022.
●	**0727T**	Removal and replacement of implanted vestibular device, unilateral **AAPC Rationale** CPT® adds 0725T to 0729T for implantable vestibular device services. Use 0725T for implant, 0726T for removal, 0727T for removal and replacement, 0728T for diagnostic analysis with initial programming, and 0729T for diagnostic analysis with subsequent programming. Each code is unilateral. The vestibular system contributes to the sense of balance. An implant can help artificially restore lost vestibular function. Effective date of this code: July 1, 2022.
●	**0728T**	Diagnostic analysis of vestibular implant, unilateral; with initial programming **AAPC Rationale** CPT® adds 0725T to 0729T for implantable vestibular device services. Use 0725T for implant, 0726T for removal, 0727T for removal and replacement, 0728T for diagnostic analysis with initial programming, and 0729T for diagnostic analysis with subsequent programming. Each code is unilateral. The vestibular system contributes to the sense of balance. An implant can help artificially restore lost vestibular function. Effective date of this code: July 1, 2022.

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●	**0729T**	Diagnostic analysis of vestibular implant, unilateral; with subsequent programming **AAPC Rationale** CPT® adds 0725T to 0729T for implantable vestibular device services. Use 0725T for implant, 0726T for removal, 0727T for removal and replacement, 0728T for diagnostic analysis with initial programming, and 0729T for diagnostic analysis with subsequent programming. Each code is unilateral. The vestibular system contributes to the sense of balance. An implant can help artificially restore lost vestibular function. Effective date of this code: July 1, 2022.
●	**0730T**	Trabeculotomy by laser, including optical coherence tomography (OCT) guidance **AAPC Rationale** CPT® adds 0730T for using a laser to cut into the trabecular meshwork that drains most of the aqueous humor (fluid) from the eye. Creating a surgical opening assists this flow and lowers intraocular pressure. The provider uses optical coherence tomography (OCT) for guidance. OCT is a noninvasive imaging technique that uses light waves and can provide three-dimensional images of tissue. Effective date of this code: July 1, 2022.
●	**0731T**	Augmentative AI-based facial phenotype analysis with report **AAPC Rationale** CPT® adds 0731T for using artificial intelligence (AI) technology to analyze a patient's facial features, such as to help identify rare genetic syndromes with specific facial characteristics. The code descriptor refers to augmentative AI. According to CPT®, augmentative AI has a primary objective of analyzing and/or quantifying data in a way that is clinically meaningful. The technology does not provide an independent diagnosis or management decision, but it does analyze data. Provider interpretation and report is required. Effective date of this code: July 1, 2022.
●	**0732T**	Immunotherapy administration with electroporation, intramuscular **AAPC Rationale** CPT® adds 0732T to report administration of immunotherapy into a muscle with electroporation. Immunotherapy is treatment of a disease by suppressing or otherwise manipulating the immunity of the body. Electroporation uses electric pulses to increase the permeability of cell membranes. Effective date of this code: July 1, 2022.

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▲	**0733T**	Remote real-time, motion capture–based neurorehabilitative~~body and limb kinematic measurement-based~~ therapy ordered by a physician or other qualified health care professional; supply and technical support, per 30 days **AAPC Rationale** CPT® revises 0733T and 0734T to specify "Remote real-time, motion capture-based neurorehabilitative therapy" instead of "Remote body and limb kinematic measurement-based therapy." The descriptors keep the requirement that a qualified healthcare professional must order the therapy. You will continue to report 0733T once per 30 days for supply and technical support, and report 0734T once per calendar month for treatment management by the provider. Effective date of this revision: January 1, 2023.
▲	**0734T**	Remote real-time, motion capture–based neurorehabilitative~~body and limb kinematic measurement-based~~ therapy ordered by a physician or other qualified health care professional; treatment management services by a physician or other qualified health care professional, per calendar month **AAPC Rationale** CPT® revises 0733T and 0734T to specify "Remote real-time, motion capture-based neurorehabilitative therapy" instead of "Remote body and limb kinematic measurement-based therapy." The descriptors keep the requirement that a qualified healthcare professional must order the therapy. You will continue to report 0733T once per 30 days for supply and technical support, and report 0734T once per calendar month for treatment management by the provider. Effective date of this revision: January 1, 2023.
✚ ●	**0735T**	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with primary craniotomy (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds add-on code +0735T to report placing a radiation therapy applicator for radiation therapy during a primary craniotomy procedure. The code includes preparing the tumor cavity. Effective date of this code: July 1, 2022.
●	**0736T**	Colonic lavage, 35 or more liters of water, gravity-fed, with induced defecation, including insertion of rectal catheter **AAPC Rationale** CPT® adds 0736T to represent insertion of a catheter into the patient's rectum and performance of colonic lavage (washing out) with 35 or more liters of water to induce defecation. This procedure may help clear the colon in patients with constipation or preparing for surgeries that require evacuation of the colon. Effective date of this code: July 1, 2022.

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●	**0737T**	Xenograft implantation into the articular surface **AAPC Rationale** CPT® adds 0737T to represent implantation of a xenograft (tissue graft from a nonhuman species) into the surface of a joint. You should report the code only once per joint. Effective date of this code: July 1, 2022.
●	**0738T**	Treatment planning for magnetic field induction ablation of malignant prostate tissue, using data from previously performed magnetic resonance imaging (MRI) examination **AAPC Rationale** CPT® adds 0738T and 0739T for services related to malignant prostate tissue ablation (destruction) by magnetic field induction. The provider introduces magnetic nanoparticles into the tumor or tumor-area and uses an alternating magnetic field to heat the nanoparticles, which destroys cancer cells. Code 0738T applies to treatment planning using existing MRI data. Report 0739T for the ablation service. Effective date of this code: January 1, 2023.
●	**0739T**	Ablation of malignant prostate tissue by magnetic field induction, including all intraprocedural, transperineal needle/catheter placement for nanoparticle installation and intraprocedural temperature monitoring, thermal dosimetry, bladder irrigation, and magnetic field nanoparticle activation **AAPC Rationale** CPT® adds 0738T and 0739T for services related to malignant prostate tissue ablation (destruction) by magnetic field induction. The provider introduces magnetic nanoparticles into the tumor or tumor-area and uses an alternating magnetic field to heat the nanoparticles, which destroys cancer cells. Code 0738T applies to treatment planning using existing MRI data. Report 0739T for the ablation service. Effective date of this code: January 1, 2023.
●	**0740T**	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; initial set-up and patient education **AAPC Rationale** CPT® adds 0740T and 0741T for services related to a remote autonomous algorithm-based recommendation system for insulin dose calculation and titration. As an autonomous system, it can function and perform certain tasks without human control, including insulin dose calculation and titration for a patient with diabetes. Insulin titration adjusts the dose based on blood glucose data to get the patient to goal levels. Code 0740T applies to the initial system setup and patient education. Code 0741T is appropriate for providing software and collecting, transmitting, and storing data. Code 0741T covers 30 days of service, with a minimum of 16 days required. Effective date of this code: January 1, 2023.

●	**0741T**	Remote autonomous algorithm-based recommendation system for insulin dose calculation and titration; provision of software, data collection, transmission, and storage, each 30 days **AAPC Rationale** CPT® adds 0740T and 0741T for services related to a remote autonomous algorithm-based recommendation system for insulin dose calculation and titration. As an autonomous system, it can function and perform certain tasks without human control, including insulin dose calculation and titration for a patient with diabetes. Insulin titration adjusts the dose based on blood glucose data to get the patient to goal levels. Code 0740T applies to the initial system setup and patient education. Code 0741T is appropriate for providing software and collecting, transmitting, and storing data. Code 0741T covers 30 days of service, with a minimum of 16 days required. Effective date of this code: January 1, 2023.
✚ ●	**0742T**	Absolute quantitation of myocardial blood flow (AQMBF), single-photon emission computed tomography (SPECT), with exercise or pharmacologic stress, and at rest, when performed (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds +0742T for SPECT absolute quantitation of myocardial blood flow (AQMBF) performed as an add-on service to a primary myocardial (heart muscle) perfusion imaging service. Quantitative assessment of myocardial blood flow provides more accurate assessment of coronary artery disease (CAD) and may help with quantifying and identifying other cardiac diseases. Effective date of this code: January 1, 2023.
●	**0743T**	Bone strength and fracture risk using finite element analysis of functional data and bone mineral density (BMD), with concurrent vertebral fracture assessment, utilizing data from a computed tomography scan, retrieval and transmission of the scan data, measurement of bone strength and BMD and classification of any vertebral fractures, with overall fracture-risk assessment, interpretation and report **AAPC Rationale** CPT® adds 0743T to report using computer analysis known as finite element analysis to assess bone strength and fracture risk. This service also includes vertebral fracture assessment, which makes it different from similar codes 0554T-0557T. Effective date of this code: January 1, 2023.

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# ●	**0749T**	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone strength and fracture risk and BMD, interpretation and report; **AAPC Rationale** CPT® adds 0749T and 0750T to report assessing bone strength and fracture risk using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis. Both codes include retrieving and transmitting X-ray data; assessing bone strength, fracture risk, and BMD; and interpretation and report. When the provider uses a hand or wrist X-ray taken for another purpose to perform the DXR-BMD analysis, you may report 0749T along with the X-ray code. If the provider takes and uses a single-view X-ray of the hand just for DXR-BMD, you should report 0750T. Effective date of this code: January 1, 2023.
# ●	**0750T**	Bone strength and fracture-risk assessment using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis of bone mineral density (BMD) utilizing data from a digital X ray, retrieval and transmission of digital X-ray data, assessment of bone strength and fracture risk and BMD, interpretation and report; with single-view digital X-ray examination of the hand taken for the purpose of DXR-BMD **AAPC Rationale** CPT® adds 0749T and 0750T to report assessing bone strength and fracture risk using digital X-ray radiogrammetry-bone mineral density (DXR-BMD) analysis. Both codes include retrieving and transmitting X-ray data; assessing bone strength, fracture risk, and BMD; and interpretation and report. When the provider uses a hand or wrist X-ray taken for another purpose to perform the DXR-BMD analysis, you may report 0749T along with the X-ray code. If the provider takes and uses a single-view X-ray of the hand just for DXR-BMD, you should report 0750T. Effective date of this code: January 1, 2023.
●	**0744T**	Insertion of bioprosthetic valve, open, femoral vein, including duplex ultrasound imaging guidance, when performed, including autogenous or nonautogenous patch graft (eg, polyester, ePTFE, bovine pericardium), when performed **AAPC Rationale** CPT® adds 0744T for inserting a bioprosthetic valve into the femoral vein of the leg using an open approach. Bioprosthetic valves involve animal material, such as one or more pig heart valves on a stainless-steel frame. Providers may insert the valve into the femoral vein, a large blood vessel in the thigh, to treat deep chronic venous insufficiency (CVI). The implant acts as a one-way valve to restore blood flow up the leg, returning blood back to the heart. The code also includes duplex ultrasound guidance, when performed, and patch graft, when performed. The graft may be autogenous (from the patient) or nonautogenous (from a source other than the patient). Effective date of this code: January 1, 2023.

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●	**0745T**	Cardiac focal ablation utilizing radiation therapy for arrhythmia; noninvasive arrhythmia localization and mapping of arrhythmia site (nidus), derived from anatomical image data (eg, CT, MRI, or myocardial perfusion scan) and electrical data (eg, 12-lead ECG data), and identification of areas of avoidance **AAPC Rationale** CPT® adds 0745T-0747T for treating arrhythmia (abnormal heart rhythm) using radiation therapy. Code 0745T represents localizing and mapping the arrhythmia site using image data and electrical data. Code 0746T represents converting the localization and mapping into a multidimensional radiation treatment plan. Code 0747T represents delivering the radiation therapy. Effective date of this code: January 1, 2023.
●	**0746T**	Cardiac focal ablation utilizing radiation therapy for arrhythmia; conversion of arrhythmia localization and mapping of arrhythmia site (nidus) into a multidimensional radiation treatment plan **AAPC Rationale** CPT® adds 0745T-0747T for treating arrhythmia (abnormal heart rhythm) using radiation therapy. Code 0745T represents localizing and mapping the arrhythmia site using image data and electrical data. Code 0746T represents converting the localization and mapping into a multidimensional radiation treatment plan. Code 0747T represents delivering the radiation therapy. Effective date of this code: January 1, 2023.
●	**0747T**	Cardiac focal ablation utilizing radiation therapy for arrhythmia; delivery of radiation therapy, arrhythmia **AAPC Rationale** CPT® adds 0745T-0747T for treating arrhythmia (abnormal heart rhythm) using radiation therapy. Code 0745T represents localizing and mapping the arrhythmia site using image data and electrical data. Code 0746T represents converting the localization and mapping into a multidimensional radiation treatment plan. Code 0747T represents delivering the radiation therapy. Effective date of this code: January 1, 2023.
●	**0748T**	Injections of stem cell product into perianal perifistular soft tissue, including fistula preparation (eg, removal of setons, fistula curettage, closure of internal openings) **AAPC Rationale** CPT® adds 0748T for injecting a stem cell product into the soft tissue around a perianal fistula, which is an abnormal connection (tunnel) between the anal canal and the skin around the anus. For instance, the provider may perform this procedure to aid fistula healing for a patient with Crohn's disease. The code includes preparing the fistula for the procedure. You should report the code only once per session. Effective date of this code: January 1, 2023.

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✚ ●	**0751T**	Digitization of glass microscope slides for level II, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds Category III code +0751T for clinical staff work performed to scan and digitize images from glass microscope slides for immediate or later pathologic diagnosis. This add-on code specifically describes digitization of slides prepared for a Level II surgical pathology exam (88302). Effective date of this code: January 1, 2023.
✚ ●	**0752T**	Digitization of glass microscope slides for level III, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds Category III code +0752T for clinical staff work performed to scan and digitize images from glass microscope slides for immediate or later pathologic diagnosis. This add-on code specifically describes digitization of slides prepared for a Level III surgical pathology exam (88304). Effective date of this code: January 1, 2023.
✚ ●	**0753T**	Digitization of glass microscope slides for level IV, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds Category III code +0753T for clinical staff work performed to scan and digitize images from glass microscope slides for immediate or later pathologic diagnosis. This add-on code specifically describes digitization of slides prepared for a Level IV surgical pathology exam (88305). Effective date of this code: January 1, 2023.
✚ ●	**0754T**	Digitization of glass microscope slides for level V, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds Category III code +0754T for clinical staff work performed to scan and digitize images from glass microscope slides for immediate or later pathologic diagnosis. This add-on code specifically describes digitization of slides prepared for a Level V surgical pathology exam (88307). Effective date of this code: January 1, 2023.
✚ ●	**0755T**	Digitization of glass microscope slides for level VI, surgical pathology, gross and microscopic examination (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds Category III code +0755T for clinical staff work performed to scan and digitize images from glass microscope slides for immediate or later pathologic diagnosis. This add-on code specifically describes digitization of slides prepared for a Level VI surgical pathology exam (88309). Effective date of this code: January 1, 2023.

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✚ ●	**0756T**	Digitization of glass microscope slides for special stain, including interpretation and report, group I, for microorganisms (eg, acid fast, methenamine silver) (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds Category III code +0756T for clinical staff work performed to scan and digitize images from glass microscope slides for immediate or later pathologic diagnosis. This add-on code specifically describes digitization of slides prepared for a group I (microorganism) special stain exam (88312). Effective date of this code: January 1, 2023.
✚ ●	**0757T**	Digitization of glass microscope slides for special stain, including interpretation and report, group II, all other (eg, iron, trichrome), except stain for microorganisms, stains for enzyme constituents, or immunocytochemistry and immunohistochemistry (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds Category III code +0757T for clinical staff work performed to scan and digitize images from glass microscope slides for immediate or later pathologic diagnosis. This add-on code specifically describes digitization of slides prepared for a group II (other) special stain exam (88313). Effective date of this code: January 1, 2023.
✚ ●	**0758T**	Digitization of glass microscope slides for special stain, including interpretation and report, histochemical stain on frozen tissue block (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds Category III code +0758T for clinical staff work performed to scan and digitize images from glass microscope slides for immediate or later pathologic diagnosis. This add-on code specifically describes digitization of slides prepared for a frozen tissue histochemical special stain exam (+88314). Effective date of this code: January 1, 2023.
✚ ●	**0759T**	Digitization of glass microscope slides for special stain, including interpretation and report, group III, for enzyme constituents (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds Category III code +0759T for clinical staff work performed to scan and digitize images from glass microscope slides for immediate or later pathologic diagnosis. This add-on code specifically describes digitization of slides prepared for a group III (enzyme constituents) special stain exam (88319). Effective date of this code: January 1, 2023.

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✚ ●	**0760T**	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, initial single antibody stain procedure (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds Category III code +0760T for clinical staff work performed to scan and digitize images from glass microscope slides for immediate or later pathologic diagnosis. This add-on code specifically describes digitization of slides prepared for an initial single antibody immunohistochemistry stain exam (88342). Effective date of this code: January 1, 2023.
✚ ●	**0761T**	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, each additional single antibody stain procedure (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds Category III code +0761T for clinical staff work performed to scan and digitize images from glass microscope slides for immediate or later pathologic diagnosis. This add-on code specifically describes digitization of slides prepared for an additional single antibody immunohistochemistry stain exam (+88341). Effective date of this code: January 1, 2023.
✚ ●	**0762T**	Digitization of glass microscope slides for immunohistochemistry or immunocytochemistry, per specimen, each multiplex antibody stain procedure (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds Category III code +0762T for clinical staff work performed to scan and digitize images from glass microscope slides for immediate or later pathologic diagnosis. This add-on code specifically describes digitization of slides prepared for a multiple-antibody (multiplex) immunohistochemistry stain exam (88344). Effective date of this code: January 1, 2023.
✚ ●	**0763T**	Digitization of glass microscope slides for morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semiquantitative, per specimen, each single antibody stain procedure, manual (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds Category III code +0763T for clinical staff work performed to scan and digitize images from glass microscope slides for immediate or later pathologic diagnosis. This add-on code specifically describes digitization of slides prepared for a manual quantitative/semiquantitative single antibody immunohistochemistry exam (morphometric analysis) (88360). Effective date of this code: January 1, 2023.

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✚ ●	**0764T**	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to concurrently performed electrocardiogram (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds +0764T and 0765T for assistive algorithmic electrocardiogram (ECG) risk assessment for cardiac dysfunction. These services involve ECG-based algorithms enhanced by artificial intelligence to automate data review and assess the patient's risk for certain conditions. For instance, the service may apply specific algorithms (step-by-step calculations) to ECG data to assess a patient's risk for low-ejection fraction, pulmonary hypertension, or hypertrophic cardiomyopathy. You'll use +0764T as an add-on code to ECG codes 93000 or 93010 when the assessment is related to a concurrently performed ECG. You'll use 0765T as a standalone code when the assessment uses a previously performed ECG. Effective date of this code: January 1, 2023.
●	**0765T**	Assistive algorithmic electrocardiogram risk-based assessment for cardiac dysfunction (eg, low-ejection fraction, pulmonary hypertension, hypertrophic cardiomyopathy); related to previously performed electrocardiogram **AAPC Rationale** CPT® adds +0764T and 0765T for assistive algorithmic electrocardiogram (ECG) risk assessment for cardiac dysfunction. These services involve ECG-based algorithms enhanced by artificial intelligence to automate data review and assess the patient's risk for certain conditions. For instance, the service may apply specific algorithms (step-by-step calculations) to ECG data to assess a patient's risk for low-ejection fraction, pulmonary hypertension, or hypertrophic cardiomyopathy. You'll use +0764T as an add-on code to ECG codes 93000 or 93010 when the assessment is related to a concurrently performed ECG. You'll use 0765T as a standalone code when the assessment uses a previously performed ECG. Effective date of this code: January 1, 2023.
●	**0766T**	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, initial treatment, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve **AAPC Rationale** CPT® adds 0766T-+0769T for transcutaneous magnetic stimulation to treat chronic nerve pain. Codes 0766T (first nerve) and +0767T (each additional nerve) apply to the initial treatment. This initial service includes using magnetic stimulation to locate the injured nerve and marking the skin to make it easier to locate the correct site during future treatments. The provider also defines the amplitude of magnetic stimulation for the patient. Codes 0768T (first nerve) and +0769T (each additional nerve) apply to subsequent treatment. Both the initial and subsequent service codes include noninvasive electroneurography (nerve conduction) when the provider uses it as guidance to confirm the nerve's precise location. These codes apply to peripheral nerves. Effective date of this code: January 1, 2023.

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✚ ●	**0767T**	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, initial treatment, with identification and marking of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds 0766T-+0769T for transcutaneous magnetic stimulation to treat chronic nerve pain. Codes 0766T (first nerve) and +0767T (each additional nerve) apply to the initial treatment. This initial service includes using magnetic stimulation to locate the injured nerve and marking the skin to make it easier to locate the correct site during future treatments. The provider also defines the amplitude of magnetic stimulation for the patient. Codes 0768T (first nerve) and +0769T (each additional nerve) apply to subsequent treatment. Both the initial and subsequent service codes include noninvasive electroneurography (nerve conduction) when the provider uses it as guidance to confirm the nerve's precise location. These codes apply to peripheral nerves. Effective date of this code: January 1, 2023.
●	**0768T**	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, subsequent treatment, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve **AAPC Rationale** CPT® adds 0766T-+0769T for transcutaneous magnetic stimulation to treat chronic nerve pain. Codes 0766T (first nerve) and +0767T (each additional nerve) apply to the initial treatment. This initial service includes using magnetic stimulation to locate the injured nerve and marking the skin to make it easier to locate the correct site during future treatments. The provider also defines the amplitude of magnetic stimulation for the patient. Codes 0768T (first nerve) and +0769T (each additional nerve) apply to subsequent treatment. Both the initial and subsequent service codes include noninvasive electroneurography (nerve conduction) when the provider uses it as guidance to confirm the nerve's precise location. These codes apply to peripheral nerves. Effective date of this code: January 1, 2023.
✚ ●	**0769T**	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, subsequent treatment, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds 0766T-+0769T for transcutaneous magnetic stimulation to treat chronic nerve pain. Codes 0766T (first nerve) and +0767T (each additional nerve) apply to the initial treatment. This initial service includes using magnetic stimulation to locate the injured nerve and marking the skin to make it easier to locate the correct site during future treatments. The provider also defines the amplitude of magnetic stimulation for the patient. Codes 0768T (first nerve) and +0769T (each additional nerve) apply to subsequent treatment. Both the initial and subsequent service codes include noninvasive electroneurography (nerve conduction) when the provider uses it as guidance to confirm the nerve's precise location. These codes apply to peripheral nerves. Effective date of this code: January 1, 2023.

● New Code ▲ Revised Code # Resequenced Code ✓ FDA Approval Pending ✚ Add-on code ★ Telemedicine ⌘ Duplicate PLA test

✚ ●	**0770T**	Virtual reality technology to assist therapy (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds +0770T for the use of virtual reality (VR) technology to assist therapy. This add-on code represents the practice expense for the VR software. You may report the code once per session. The provider uses the VR technology to train or teach a skill the therapy is focused on. According to CPT® guidelines, the code does not incur additional reported therapist time beyond what you report for the base therapy code. Examples of primary services include psychotherapy, speech disorder treatment, health behavior intervention, therapy to develop strength and balance, and self-care training. Effective date of this code: January 1, 2023.
●	**0771T**	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; initial 15 minutes of intraservice time, patient age 5 years or older **AAPC Rationale** CPT® adds 0771T to +0774T for the use of virtual reality (VR) procedural dissociation to increase patient comfort during a procedure. Codes 0771T (initial 15 minutes) and +0772T (each additional 15 minutes) apply when a single qualified healthcare professional (QHP) performs both the VR service and the diagnostic or therapeutic service performed at the same session. A trained, independent observer must be present for those VR codes to be appropriate. Codes 0773T (initial 15 minutes) and +0774T (each additional 15 minutes) apply to the VR service when one QHP performs the VR service and another QHP performs the related diagnostic or therapeutic service. The provider is responsible for periodically assessing the patient, checking how well they are tolerating the procedure, and also monitoring oxygen saturation, heart rate, pain, neurological status, and global anxiety. These codes do not include administering medication for pain control and sedation. The patient is at least 5 years of age. Effective date of this code: January 1, 2023.

● New Code ▲ Revised Code # Resequenced Code ✓ FDA Approval Pending ✚ Add-on code ★ Telemedicine ⌘ Duplicate PLA test

✚ ●	**0772T**	Virtual reality (VR) procedural dissociation services provided by the same physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports, requiring the presence of an independent, trained observer to assist in the monitoring of the patient's level of dissociation or consciousness and physiological status; each additional 15 minutes intraservice time (List separately in addition to code for primary service) **AAPC Rationale** CPT® adds 0771T to +0774T for the use of virtual reality (VR) procedural dissociation to increase patient comfort during a procedure. Codes 0771T (initial 15 minutes) and +0772T (each additional 15 minutes) apply when a single qualified healthcare professional (QHP) performs both the VR service and the diagnostic or therapeutic service performed at the same session. A trained, independent observer must be present for those VR codes to be appropriate. Codes 0773T (initial 15 minutes) and +0774T (each additional 15 minutes) apply to the VR service when one QHP performs the VR service and another QHP performs the related diagnostic or therapeutic service. The provider is responsible for periodically assessing the patient, checking how well they are tolerating the procedure, and also monitoring oxygen saturation, heart rate, pain, neurological status, and global anxiety. These codes do not include administering medication for pain control and sedation. The patient is at least 5 years of age. Effective date of this code: January 1, 2023.
●	**0773T**	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; initial 15 minutes of intraservice time, patient age 5 years or older **AAPC Rationale** CPT® adds 0771T to +0774T for the use of virtual reality (VR) procedural dissociation to increase patient comfort during a procedure. Codes 0771T (initial 15 minutes) and +0772T (each additional 15 minutes) apply when a single qualified healthcare professional (QHP) performs both the VR service and the diagnostic or therapeutic service performed at the same session. A trained, independent observer must be present for those VR codes to be appropriate. Codes 0773T (initial 15 minutes) and +0774T (each additional 15 minutes) apply to the VR service when one QHP performs the VR service and another QHP performs the related diagnostic or therapeutic service. The provider is responsible for periodically assessing the patient, checking how well they are tolerating the procedure, and also monitoring oxygen saturation, heart rate, pain, neurological status, and global anxiety. These codes do not include administering medication for pain control and sedation. The patient is at least 5 years of age. Effective date of this code: January 1, 2023.

✚ ●	**0774T**	Virtual reality (VR) procedural dissociation services provided by a physician or other qualified health care professional other than the physician or other qualified health care professional performing the diagnostic or therapeutic service that the VR procedural dissociation supports; each additional 15 minutes intraservice time (List separately in addition to code for primary service) **AAPC Rationale** CPT® adds 0771T to +0774T for the use of virtual reality (VR) procedural dissociation to increase patient comfort during a procedure. Codes 0771T (initial 15 minutes) and +0772T (each additional 15 minutes) apply when a single qualified healthcare professional (QHP) performs both the VR service and the diagnostic or therapeutic service performed at the same session. A trained, independent observer must be present for those VR codes to be appropriate. Codes 0773T (initial 15 minutes) and +0774T (each additional 15 minutes) apply to the VR service when one QHP performs the VR service and another QHP performs the related diagnostic or therapeutic service. The provider is responsible for periodically assessing the patient, checking how well they are tolerating the procedure, and also monitoring oxygen saturation, heart rate, pain, neurological status, and global anxiety. These codes do not include administering medication for pain control and sedation. The patient is at least 5 years of age. Effective date of this code: January 1, 2023.
●	**0775T**	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]) **AAPC Rationale** CPT® adds 0775T for percutaneous placement of one or more stabilization implants in the sacroiliac (SI) joint, which connects the hip to the sacrum, for joint fusion (arthrodesis). The procedure does not transfix (pass through) the SI joint. In contrast, existing code 27279 is for a similar procedure, but it transfixes the SI joint by passing one or more devices through the ilium of the pelvis, across the SI joint, and into the sacrum that is at the base of the spine. Effective date of this code: January 1, 2023.
●	**0776T**	Therapeutic induction of intra-brain hypothermia, including placement of a mechanical temperature-controlled cooling device to the neck over carotids and head, including monitoring (eg, vital signs and sport concussion assessment tool 5 [SCAT5]), 30 minutes of treatment **AAPC Rationale** CPT® adds 0766T-+0769T for transcutaneous magnetic stimulation to treat chronic nerve pain. Codes 0766T (first nerve) and +0767T (each additional nerve) apply to the initial treatment. This initial service includes using magnetic stimulation to locate the injured nerve and marking the skin to make it easier to locate the correct site during future treatments. The provider also defines the amplitude of magnetic stimulation for the patient. Codes 0768T (first nerve) and +0769T (each additional nerve) apply to subsequent treatment. Both the initial and subsequent service codes include noninvasive electroneurography (nerve conduction) when the provider uses it as guidance to confirm the nerve's precise location. These codes apply to peripheral nerves. Effective date of this code: January 1, 2023.

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✚ ●	**0777T**	Real-time pressure-sensing epidural guidance system (List separately in addition to code for primary procedure) **AAPC Rationale** CPT® adds 0766T-+0769T for transcutaneous magnetic stimulation to treat chronic nerve pain. Codes 0766T (first nerve) and +0767T (each additional nerve) apply to the initial treatment. This initial service includes using magnetic stimulation to locate the injured nerve and marking the skin to make it easier to locate the correct site during future treatments. The provider also defines the amplitude of magnetic stimulation for the patient. Codes 0768T (first nerve) and +0769T (each additional nerve) apply to subsequent treatment. Both the initial and subsequent service codes include noninvasive electroneurography (nerve conduction) when the provider uses it as guidance to confirm the nerve's precise location. These codes apply to peripheral nerves. Effective date of this code: January 1, 2023.
●	**0778T**	Surface mechanomyography (sMMG) with concurrent application of inertial measurement unit (IMU) sensors for measurement of multi-joint range of motion, posture, gait, and muscle function **AAPC Rationale** CPT® adds 0766T-+0769T for transcutaneous magnetic stimulation to treat chronic nerve pain. Codes 0766T (first nerve) and +0767T (each additional nerve) apply to the initial treatment. This initial service includes using magnetic stimulation to locate the injured nerve and marking the skin to make it easier to locate the correct site during future treatments. The provider also defines the amplitude of magnetic stimulation for the patient. Codes 0768T (first nerve) and +0769T (each additional nerve) apply to subsequent treatment. Both the initial and subsequent service codes include noninvasive electroneurography (nerve conduction) when the provider uses it as guidance to confirm the nerve's precise location. These codes apply to peripheral nerves. Effective date of this code: January 1, 2023.
●	**0779T**	Gastrointestinal myoelectrical activity study, stomach through colon, with interpretation and report **AAPC Rationale** CPT® adds 0766T-+0769T for transcutaneous magnetic stimulation to treat chronic nerve pain. Codes 0766T (first nerve) and +0767T (each additional nerve) apply to the initial treatment. This initial service includes using magnetic stimulation to locate the injured nerve and marking the skin to make it easier to locate the correct site during future treatments. The provider also defines the amplitude of magnetic stimulation for the patient. Codes 0768T (first nerve) and +0769T (each additional nerve) apply to subsequent treatment. Both the initial and subsequent service codes include noninvasive electroneurography (nerve conduction) when the provider uses it as guidance to confirm the nerve's precise location. These codes apply to peripheral nerves. Effective date of this code: January 1, 2023.

●	**0780T**	Instillation of fecal microbiota suspension via rectal enema into lower gastrointestinal tract **AAPC Rationale** CPT® adds 0780T for use of a rectal enema to instill a fecal microbiota suspension in the lower gastrointestinal tract. Fecal microbiota instillation is the transplantation of fecal bacteria, or microbiota, from a healthy donor into a recipient with the aim of restoring normal function of the intestines, such as for a patient with chronic diarrhea from repeated infections. Effective date of this code: January 1, 2023.
●	**0781T**	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; bilateral mainstem bronchi **AAPC Rationale** CPT® adds 0781T (bilateral mainstem bronchi) and 0782T (unilateral) for bronchoscopic delivery of radiofrequency energy to destroy pulmonary nerves. The procedure aims to preserve lung health in patients with chronic obstructive pulmonary disease (COPD) by treating overactive airway nerves. Effective date of this code: January 1, 2023.
●	**0782T**	Bronchoscopy, rigid or flexible, with insertion of esophageal protection device and circumferential radiofrequency destruction of the pulmonary nerves, including fluoroscopic guidance when performed; unilateral mainstem bronchus **AAPC Rationale** CPT® adds 0781T (bilateral mainstem bronchi) and 0782T (unilateral) for bronchoscopic delivery of radiofrequency energy to destroy pulmonary nerves. The procedure aims to preserve lung health in patients with chronic obstructive pulmonary disease (COPD) by treating overactive airway nerves. Effective date of this code: January 1, 2023.
●	**0783T**	Transcutaneous auricular neurostimulation, set-up, calibration, and patient education on use of equipment **AAPC Rationale** CPT® adds 0783T for setup, calibration, and patient education for the use of a transcutaneous auricular neurostimulation device. The device may have an earpiece that is wired to a unit to deliver electrical stimulation, such as to the auricular branch of the vagus nerve. The earpiece attaches to the ear in a noninvasive way, such as by clip, hook, or adhesive. Effective date of this code: January 1, 2023.

Administrative Multianalyte Assays with Algorithmic Analyses (MAAA)

▲	**0016M**	Oncology (bladder), mRNA, microarray gene expression profiling of ~~209~~ 219 genes, utilizing formalin-fixed paraffin-embedded tissue, algorithm reported as molecular subtype (luminal, luminal infiltrated, basal, basal claudin-low, neuroendocrine-like) **AAPC Rationale** CPT® revises 0016M to change the test name and laboratory from Decipher Bladder, TURBT® provided by Decipher Biosciences Inc., to Decipher® Bladder provided by Veracyte. A descriptor revision changes the number of genes interrogated from 209 genes to 219 genes. Effective date of this revision: July 1, 2022.

● New Code ▲ Revised Code # Resequenced Code ✓ FDA Approval Pending ✚ Add-on code ★ Telemedicine ⌘ Duplicate PLA test

Case 1

Inpatient Hospital E/M

Re: Sarah Smith Date of Service: March 21, 20XX

MR # 300-8

CC: Pulmonary embolus

Subjective

Follow-up on patient for pulmonary embolus. No chest pain.

Objective

Vital Signs: Most Recent (Vitals In past 36 hrs; Dosing Wt and BMI this visit)

Temp C 37.6 (37.2-39.3) **SSP** 160 (156-160) **OBP** 62 (61-69) **Pulse** 86 (82-86) **RR** 18 (18-20)

Sa02 93 (92-95) **Fi02-02(L/m)** 2L /m (2l./m·2l./ml./m) **Dosing Wt** 72.3 kg **BMI** 0 [1]

General: Initially sleeping and in no apparent distress when aroused and oriented to name and not to date or place just saying "here".

HEENT: Tongue somewhat dry.

Respiratory: Lungs are dear to auscultation, Respirations are non-labored, Breath sounds are equal, Symmetrical chest wall expansion.

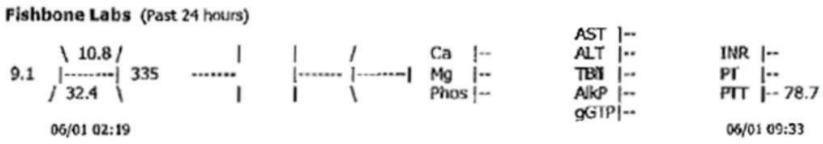
Cardiovascular: Normal rate, Regular rhythm, No gallop, No edema, 2/6 systolic ejection murmur. Mild diffuse edema of both lower legs above the ankle.

Gastrointestinal: Soft, Non-tender, Non-distended. Bowel sounds normal. No enlargement of spleen and liver.

Psychiatric: As above.

Results Review

Fishbone Labs (Past 24 hours)



Additional Labs: No qualifying labs resulted.

Assessment and Plan

Diagnosis: Pulmonary embolus, Dementia

Plan

Pulmonology and hematology and cardiology notes all reviewed. I spoke with Dr. Patel who was under the impression that the sister had elected to have the patient be on comfort measures only and not pursue a Greenfield filter or other intervention and she falls out her bed frequently. The lab results were reviewed with

Dr. Patel and no changes. I see that the hospice nurse is evaluating the patient and I have a call out to her and I left a message for her sister to call me. I would like to discuss whether to stop the heparin drip and whether to send her out on Lovenox or just strictly comfort measures only in which case we would consider whether she would be appropriate for inpatient hospice or back to her personal care home or other. Will continue the drip for now. At this time, she is stable.

Dictated by: Haylee Tolbert, MD, Authenticated by Haylee Tolbert, MD on 3/21/20XX 6:17 PM

Case 2

A 60-year-old male, who is status post-hernia repair of a 3- to 10-cm defect, undergoes removal of sutures and staples during a separately reportable office or other outpatient evaluation and management service.

Clean the area surrounding the wound(s) with normal saline or soak if crusting inhibits access to sutures/staples. Remove the sutures and staples. Observe the

wound line(s) for separation during the procedure. Obtain hemostasis with pressure as needed. Apply adhesive strips and sterile dressings as needed.

Source: Clinical example provided by AMA CPT Changes 2023

Case 3

OPERATIVE REPORT

ANESTHESIA:	General endotracheal.
PREOPERATIVE DIAGNOSIS:	Incarcerated ventral hernia.
POSTOPERATIVE DIAGNOSIS:	Incarcerated ventral hernia.
PROCEDURE PERFORMED:	Incarcerated ventral hernia repair.

OPERATIVE FINDINGS: Upon entering the abdomen through the upper midline location over the incarcerated hernia, an incarcerated hernia approximately 5-cm in diameter was identified. The hernia was reduced into the abdominal cavity and the fascial defect was identified which measured approximately 2-cm in size. A medium Ventrilex mesh was placed into the defect and sewn in place.

DESCRIPTION OF PROCEDURE: After undergoing adequate general endotracheal anesthesia and after DuraPrep prepping the abdomen and draping with cloth towels and drapes, a midline incision was made after injecting 0.25% Marcaine with epinephrine. The dissection was continued over to the incarcerated hernia, which was to the right of the midline, and the hernia sac was scored at its base and was eventually reduced into the abdominal cavity. The underlying fascia was dissected free of its surrounding tissue. The medium Ventrilex mesh was placed in the subfascial location and the straps were cut. The mesh was sewn in place with #0 Ethibond suture. The wound was irrigated with normal saline. 0.25% Marcaine was also utilized on the subcutaneous tissue and fascia to complete the anesthetic with approximately 45 cc total of local anesthetic. The dermal edges were approximated with a running #4-0 Vicryl and the skin edges were approximated with a running subcuticular #4-0 Vicryl and were further sealed with Dermabond.

The patient tolerated the procedure very well. Needle and sponge count were correct. The patient was in stable condition at the conclusion of the procedure and was taken back to the recovery unit in stable condition.

Case 4

A 59-year-old female with right mixed-hearing loss from chronic ear disease with history of surgical treatment seeks intervention for improved quality of life at work and socially. A magnetic transcutaneous bone-anchored hearing device is placed in the right retrosigmoid location because the right mastoid is contracted and inflamed.

Procedure Description:

Make an incision followed by meticulous dissection through the pericranium. Perform a subpericranial dissection and create a subpericranial pocket for the implant coil and magnet. Identify the area for the transducer using the template and mark on the outer table of the skull in the region of the sinodural angle. Then drill surgical guide and fixation holes taking care not to penetrate the sigmoid sinus or the dura overlying the temporal lobe of the brain. Measure this area for appropriate depth to accommodate the fixation screw.

Then drill the skull overlying the sinodural angle, greater than or equal to 100 sq mm, to create a well in the bone to accommodate the transducer device, again staying just superficial to the dura and sigmoid sinus. Place the entire device, including the coil, magnet, and transducer portions. Fix the device to the skull using the fixation screw to a specific torque setting. Carefully measure the thickness of the flap overlying the magnet and coil portion of the device and precisely trim to a specific thickness to allow for transcutaneous transmission. Irrigate the wound and obtain hemostasis. Close the wound in layered fashion.

Source: Clinical example provided by AMA CPT Changes 2023

Case 5

A 15-year-old male undergoes a procedure that requires VR procedural dissociation.

Procedure Description:

After the initial 15 minutes of VR procedural dissociation (reported separately with 0771T), provide additional VR procedural dissociation to complete the supported

procedure. The physician performing the procedure, who is also administering VR procedural dissociation, monitors the patient closely and delivers additional VR procedural dissociation as needed. Total VR time: 20 minutes.

Source: Clinical example provided by AMA CPT Changes 2023

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