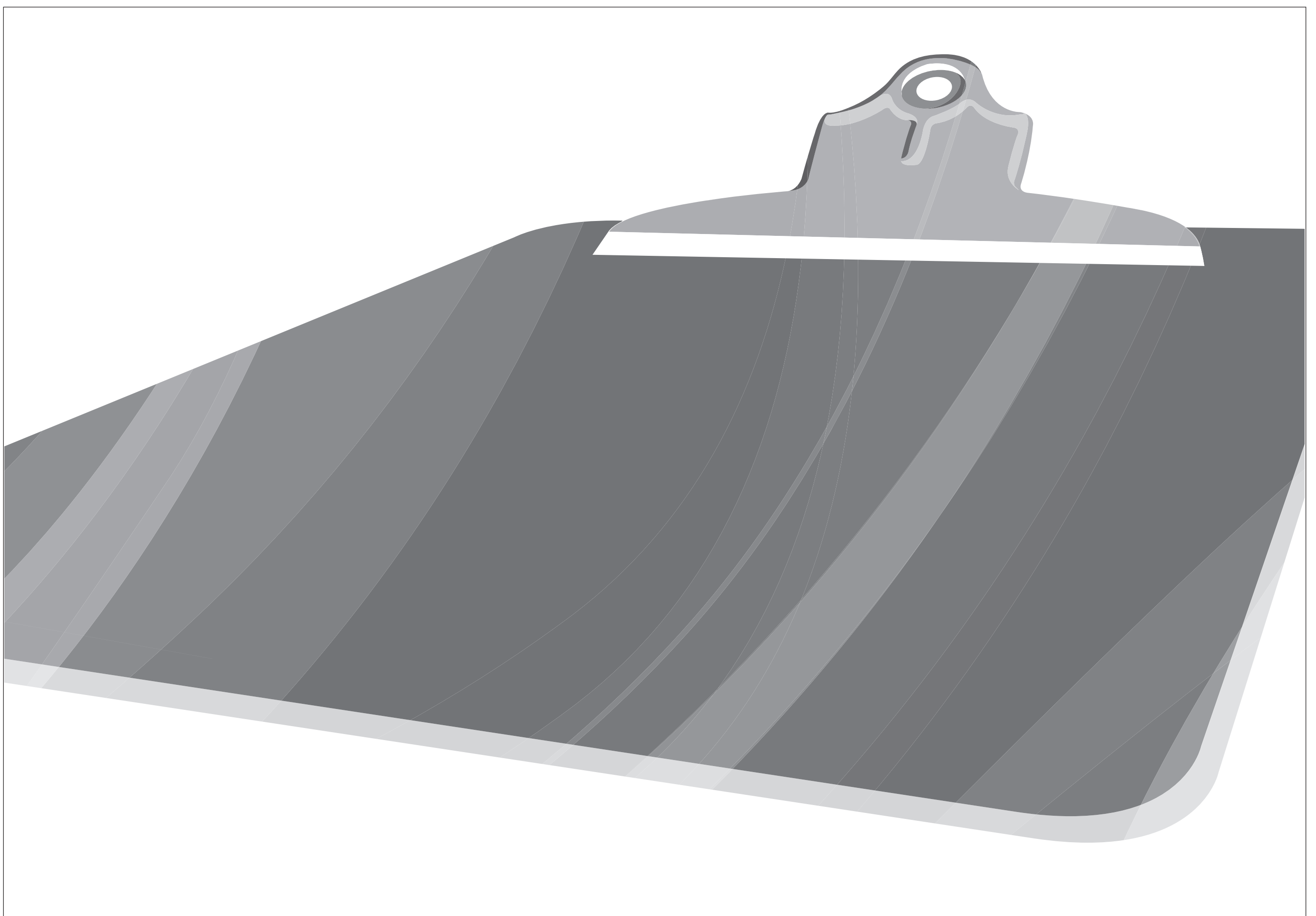
contexo | media
a division of Access Intelligence

Plain English Descriptions for

Procedures



2011

Contents

Introduction i
Prefixes and Suffixes 1
Anatomy 3
Surgery: Integumentary/Skin 23
Surgery: Breast 45
Surgery: Musculoskeletal System 51
Surgery: Respiratory System 147
Surgery: Cardiovascular System 177
Surgery: Hemic and Lymphatic Systems 257
Surgery: Mediastinum and Diaphragm 263
Surgery: Digestive System 265
Surgery: Urinary System 345
Surgery: Male/Female Genital Systems 369
Maternity Care / Delivery, Endocrine System 405
Surgery: Nervous System 415
Surgery: Eye and Ocular Adnexa 437
Surgery: Auditory System 453
Radiology 463
Pathology and Laboratory 515
Medicine 589
Category III 659
Evaluation and Management 669

Introduction

The 2011 *Plain English Descriptions for Procedures* was created to provide the coder with an accurate clinical description of each CPT® code, written in plain English that can be understood by everyone. Billing accuracy can be greatly increased when the coder fully understands the medical relevance of assigned CPT codes for billing purposes, which can save both time and money.

Format

Plain English Descriptions for Procedures is presented in a two column format with sequential code descriptions presented for a single code standing alone or for a logical grouping of codes. The CPT code(s) is given, followed by the code description, and the Plain English Descriptions in lay person terms. Reading the entire lay description will help ensure the best possible code choice. Chapter headers and individual page ends identify the chapter and code ranges to provide a quick reference guide. The chapter divisions in the *Plain English Descriptions for Procedures* correspond to CPT chapters.

New and revised codes are marked with standard icon identifiers. *Plain English Descriptions for Procedures* also contains a listing of prefixes and suffixes found in general medical terminology. A section of anatomy charts is also included.

Plain English Descriptions for Procedures will be most useful if used in conjunction with the official CPT code book and a comprehensive medical dictionary. Using all of these resources in tandem will enable the coder to make the most accurate code selection.

© 2010 Contexo Media CPT © 2009 American Medical Association. All Rights Reserved.

Musculoskeletal System 20005–29907

20005

20005 Incision and drainage of soft tissue abscess, subfascial (ie, involves the soft tissue below the deep fascia)

Plain English Description

The physician creates an incision over an abscess and examines the affected area. The site is debrided and drained (20000). If the abscess is deep or complicated (20005) the physician will thoroughly debride and irrigate the area. The site is drained and the underlying tissues and bones are examined for any further signs of infection. Any dead bone or tissue is removed. The site is closed.

20100-20103

20100 Exploration of penetrating wound (separate procedure); neck

Plain English Description

The physician explores a penetrating wound. This wound is often made by a bullet or knife. The area is debrided and irrigated. Any foreign bodies are removed and the physician examines the nerves, muscles, bones, and connective tissues surrounding the area. The wound is either cleaned and closed, or packed open if contaminated. Code 20100 for exploration of a penetrating wound of the neck; 20101 for the chest; 20102 for the abdomen/flank/back; and 20103 for an extremity.

20150

20150 Excision of epiphyseal bar, with or without autogenous soft tissue graft obtained through same fascial incision

Plain English Description

The physician excises the epiphyseal bar to correct a partial epiphyseal arrest, where the patient has significant growth remaining in a long bone (e.g., femur, tibia). Under general anesthesia, the patient is placed in the supine position. The physician excises part of the injured epiphyseal plate, to encourage bone growth. This is a major surgery and often requires weeks in the hospital for recovery. An autogenous soft tissue graft may be used to fill in the void after excision. Care is taken to preserve muscle and nerve health during the procedure. The site is closed with sutures and dressed with compressive bandages, to reduce the formation of hematomas. The affected limb is immobilized.

20200-20205

20200 Biopsy, muscle; superficial

Plain English Description

The physician creates an incision over the suspicious muscle. A sample of tissue is obtained and the site is closed with sutures in layers. Code 20200 if the biopsy is obtained from a superficial muscle and code 20205 if the biopsy is obtained from a deep muscle.

20206

20206 Biopsy, muscle, percutaneous needle

Plain English Description

A percutaneous needle muscle biopsy is performed. This procedure is typically done to diagnose diseases involving muscle tissue, such as muscular dystrophy, myasthenia gravis, polymyositis, dermatomyositis, amyotrophic lateral sclerosis (ALS), Friedreich's ataxia, and parasitic infections of the muscles. Common biopsy sites include the bicep, deltoid, or quadriceps muscles. The planned biopsy site is cleansed. A biopsy needle is then inserted into the muscle and a small tissue sample obtained. This may be repeated multiple times at various sites along the muscle to obtain an adequate sample. The tissue sample is then sent for separately reportable pathology examination.

20220-20225

20220 Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)

20225 Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)

Plain English Description

Under local anesthesia (occasionally, general anesthesia) the physician obtains a biopsy of a bone. A large needle is placed into the spinous process or superficial bone and the tissue is removed. If a biopsy of a deep bone is performed (20225), an exploration needle is positioned, and then a smaller one is inserted through the exploration one to obtain a sample. Different approaches are used for vertebral biopsy. No closure is usually necessary.

20240-20245

20240 Biopsy, bone, open; superficial (eg, ilium, sternum, spinous process, ribs, trochanter of femur)

20245 Biopsy, bone, open; deep (eg, humerus, ischium, femur)

Plain English Description

The physician obtains a bone biopsy through an incision. Under general anesthesia, the patient is positioned appropriately, depending on the site to be biopsied, and a deep incision is made to the bone. A bone sample is obtained and the site is closed with layered sutures. Code 20240 if a superficial bone (e.g., ilium, sternum, spinous process, ribs) is biopsied, and 20245 if a deep bone (e.g., femur, ischium) is biopsied.

20250-20251

20250 Biopsy, vertebral body, open; thoracic

20251 Biopsy, vertebral body, open; lumbar or cervical

Plain English Description

Under general anesthesia, the patient is placed in a prone position. An incision is created above the vertebra to be biopsied. The muscles surrounding the vertebra are dissected tested for testing and diagnosis. Tissue is excised and the muscles are repositioned. The incision is closed in layers. Code 20250 for a thoracic vertebral biopsy and 20251 for a lumbar or cervical vertebral biopsy.

© 2010 Contexo Media CPT © 2009 American Medical Association. All Rights Reserved.

20500

20500 Injection of sinus tract; therapeutic (separate procedure)

Plain English Description

The physician injects a chemical agent or antibiotic into the sinus tract. The term sinus tract refers not to the sinuses in the skull, but rather any pathway that leads to an abscess. Any x-rays taken are reported separately.

20501

20501 Injection of sinus tract; diagnostic (sinogram)

Plain English Description

The physician injects radiopaque agent into the sinus tract. The term sinus tract refers not to the sinuses in the skull, but rather any pathway that leads to an abscess. This area is x-rayed to determine the presence and size of a cyst or abscess. Any x-rays taken are reported separately.

20526

20526 Injection, therapeutic (eg, local anesthetic, corticosteroid), carpal tunnel

Plain English Description

A therapeutic injection using a local anesthetic or corticosteroid is performed to treat symptoms of carpal tunnel syndrome. This procedure is referred to as a carpal tunnel or median nerve injection. The flexor carpi radialis (FCR) and palmaris longus (PL) tendons are located. The skin over the planned needle insertion site is cleansed. The needle is inserted just proximal to the most proximal wrist crease and medial to the PL tendon. The needle is directed toward the ring finger and advanced until the PL tendon is encountered. The syringe is retrated to ensure that the needle is clear of all blood vessels. The local anesthetic or steroid solution is injected. The needle is removed and the local anesthetic or steroid is allowed to disperse distally using gravity and finger motion.

20550-20551

20550 Injection(s); single tendon sheath, or ligament, aponeurosis (eg, plantar "fascia")
20551 Injection(s); single tendon origin/insertion

Plain English Description

The physician injects a single tendon sheath, ligament, or aponeurosis (20550) or a single tendon origin or insertion (20551). In 20550, the site of maximum tenderness is identified by palpation. The needle is advanced into the tendon sheath, ligament, or aponeurosis and an anesthetic, steroid, or other therapeutic substance is injected. More than one injection to the same tendon sheath or ligament may be administered. In 20551, the tendon origin or insertion is located. A needle is advanced into the origin or insertion and an anesthetic, steroid, or other therapeutic substance is injected.

20552-20553

20552 Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s)
20553 Injection(s); single or multiple trigger point(s), 3 or more muscle(s)

Plain English Description

The physician injects a single or multiple trigger points in one or two muscles (20552) or three or more muscles (20553). Trigger points are tiny contraction knots that develop in a muscle when it is injured or overworked. The physician identifies the trigger points by palpating the muscle. The needle is advanced into the muscle and an anesthetic, steroid, or other therapeutic substance is injected. This is repeated until all trigger points on all involved muscles have been treated.

20555

20555 Placement of needles or catheters into muscle and/or soft tissue for subsequent interstitial radioelement application (at the time of or subsequent to the procedure)

Plain English Description

Needles or catheters are placed in the muscle and/or soft tissue for subsequent interstitial radioelement application. This may be performed at the time of or following another separately reportable procedure such as removal of a mass or tumor. This code reports the placement of the needles or catheters only. The interstitial radioelement application (brachytherapy) is reported separately. Tumor margins in the muscle and/or soft tissue are marked. The needle or catheter implant sites are determined and entrance and exit sites are marked on the skin surface. The first needle or catheter is introduced through the previously marked entrance site. Typically, a needle is first introduced and then a catheter is introduced through the needle. The catheter is positioned and secured and the needle is removed through a separate predetermined exit site. This is repeated until all catheters are in place. Drains with multiple drainage holes are then placed perpendicular to the catheters and each catheter is threaded through a drain hole. The stiff leader portion of the catheter is removed and a dressing is applied.

20600-20610

20600 Arthrocentesis, aspiration and/or injection; small joint or bursa (eg, fingers, toes)
20605 Arthrocentesis, aspiration and/or injection; intermediate joint or bursa (eg, temporomandibular, acromioclavicular, wrist, elbow or ankle, olecranon bursa)
20610 Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa)

Plain English Description

The physician administers local anesthesia and inserts a needle into a joint or bursa. Fluid is aspirated and/or injected. Code 20600 for arthrocentesis of a small joint or bursa (e.g., fingers, toes); 20605 for arthrocentesis of an intermediate joint or bursa (e.g., wrist, elbow, ankle); 20610 for arthrocentesis of a major joint or bursa (e.g., knee, shoulder, hip). Report any imaging guidance separately.

20612

20612 Aspiration and/or injection of ganglion cyst(s) any location

Plain English Description

The physician administers local anesthesia and inserts a needle into one or more ganglion cysts at any location. Fluid is aspirated and/or injected. A ganglion cyst is a small, benign cystic tumor, composed of ganglion cells, containing viscous fluid and connected either with a joint membrane or a tendon sheath.

20615

20615 Aspiration and injection for treatment of bone cyst

Plain English Description

The physician administers local anesthesia and inserts a needle into a bone cyst. Fluid is aspirated and medication is injected. A bone cyst is a one-chambered cyst containing serous fluid and lined with a thin layer of connective tissue. Bone cysts usually occur in the shaft of a long bone in a child.

CPT © 2009 American Medical Association. All Rights Reserved. © 2010 Contexo Media

32605-32606

32605 Thoracoscopy, diagnostic (separate procedure); mediastinal space, without biopsy
32606 Thoracoscopy, diagnostic (separate procedure); mediastinal space, with biopsy

Plain English Description

Diagnostic thoracoscopy is performed to visualize the mediastinal space. The patient is placed in lateral decubitus position. Using one lung ventilation, the contralateral lung is collapsed. Two or three small incisions are made in the chest for introduction of the thoracoscope and surgical instruments. The thoracoscope may be placed at the VI or VII intercostal space at the middle axillary line or at the anterior or posterior axillary lines. The thoracic cavity is visualized and examined. The mediastinal pleura is then opened and mediastinal space examined. Fluid may be aspirated. Any abnormalities are noted. Photographs may be taken of lesions. Use 32606 if biopsies are taken. This may include tissue samples of any of the mediastinal structures including the thymus, lymph nodes, or any masses or lesions.

32650

32650 Thoracoscopy, surgical; with pleurodesis (eg, mechanical or chemical)

Plain English Description

Surgical thoracoscopy, also referred to as video assisted thoracoscopic surgery (VATS), is performed for mechanical or chemical pleurodesis. Three small incisions are made, one at the 7th or 8th intercostal space along the mid-axillary line, one in the posterior chest wall under the tip of the scapula, and one in the anterior chest wall at the 5th or 6th intercostal space. A videothoracoscope is inserted through one of the incisions and surgical instruments are inserted through the other incisions. Alternatively, the procedure is sometimes performed through a single incision. When a single incision technique is used, the procedure may be referred to as a pleuroscopy and both the scope and surgical instruments are passed through the single incision. The pleura is inspected, a chest tube is placed, and the pleural space is injected with a chemical sclerosing agent that causes irritation and inflammation of the pleurae, causing them to adhere to each other. The chest tube is temporarily closed, allowing the sclerosing agent to spread through the pleural space. The chest tube is then opened and the sclerosing agent is suctioned out of the chest tube. Alternatively, the pleura can be mechanically abraded, which also causes inflammation resulting in the pleurae adhering to each other. The chest tube may be left in place for several days to allow fluid to drain from the chest.

32651-32652

32651 Thoracoscopy, surgical; with partial pulmonary decortication
32652 Thoracoscopy, surgical; with total pulmonary decortication, including intrapleural pneumonolysis

Plain English Description

Partial pulmonary decortication (32651) or total pulmonary decortication including intrapleural pneumonolysis (32652) is performed by surgical thoracoscopy, also referred to as video assisted thoracoscopic surgery (VATS). A small posterolateral incision is made between the ribs usually at the fifth or sixth intercostal space just below the tip of the scapula. The pleura is identified by digital palpation, a trocar inserted, and the thoracoscope introduced into the pleural space. Fluid is aspirated and the pleural space explored. Two or more additional portal incisions are made for the introduction of surgical instruments. The physician then removes or strips the thickened fibrin layer, also called the rind or peel, from the outer pleural surface of part of the lung in 32651 or the entire lung in 32652. The fibrin layer is incised and the correct decortication plane determined. The fibrin layer is then grasped and dissected from the underlying visceral pleura. All portions of the lung encased by the thickened fibrin layer are addressed. In 32652, adhesions between the lung and the chest wall are also lysed. This is accomplished by the introduction of a cautery device which is used to severe the adhesions. Following completion of the procedure, one or more chest tubes are placed and the incisions are closed.

32653

32653 Thoracoscopy, surgical; with removal of intrapleural foreign body or fibrin deposit

Plain English Description

Removal of intrapleural foreign body or fibrin deposit is performed by surgical thoracoscopy, also referred to as video assisted thoracoscopic surgery (VATS). A small posterolateral incision is made between the ribs usually at the fifth or sixth intercostal space just below the tip of the scapula. The pleura is identified by digital palpation; a trocar is inserted; and the thoracoscope is introduced. Fluid is aspirated and the thoracic cavity is explored. The foreign body or fibrin deposit is located. Two or more additional portal incisions are made for the introduction of surgical instruments to grasp and remove the foreign body or fibrin deposit. The pleural space is flushed with saline. A large bore chest tube is introduced as needed for drainage.

32654

32654 Thoracoscopy, surgical; with control of traumatic hemorrhage

Plain English Description

Control of traumatic hemorrhage of the thorax is performed by surgical thoracoscopy, also referred to as video assisted thoracoscopic surgery (VATS). A small posterolateral incision is made between the ribs usually at the fifth or sixth intercostal space just below the tip of the scapula. A trocar is inserted and the thoracoscope is introduced. Blood and fluid are aspirated from the thorax and the thoracic cavity is explored to rule out cardiovascular or other injury requiring thoracotomy. The bleeding site is located. In the case of blunt trauma, the bleeding is usually found to be from an injury to intercostal vessels or from a lung laceration. Perforating trauma may result in injury to tissues of the mediastinum or other sites. Two or more additional portal incisions are made for the introduction of surgical instruments. The bleeding is controlled using diathermy, clips, and or staples. Chest tubes are placed as needed and the incisions are closed.

32655-32656

32655 Thoracoscopy, surgical; with excision-plication of bullae, including any pleural procedure
32656 Thoracoscopy, surgical; with parietal pleurectomy

Plain English Description

Excision-plication of bullae including any pleural procedure (32655) or parietal pleurectomy (32656) is performed by surgical thoracoscopy, also referred to as video assisted thoracoscopic surgery (VATS). A small posterolateral incision is made between the ribs usually at the fifth or sixth intercostal space just below the tip of the scapula. The pleura is identified by digital palpation, a trocar inserted, and the thoracoscope introduced. Two or more additional portal incisions are made for the introduction of surgical instruments. In 32655, one or more bleb(s) or bulla(e) are treated by excision-plication. The pleura is inspected thoracoscopically and any pleural adhesions taken down using diathermy or sharp and blunt dissection. Sterile saline is instilled to identify the leaking bleb or bulla. The bleb or bulla is grasped using an endoscopic grasper or forceps and a linear endoscopic stapler and cutter inserted. Excision-plication of the bleb or bulla is accomplished by placing several lines of staples at the site of the bleb or bulla. Following the excision-plication procedure, the physician may need to perform additional pleural procedures such as a parietal pleurectomy which are included in 32655. In 32656, a parietal pleurectomy is performed by surgical thoracoscopy. A forceps is inserted through the anterior incision into the extrapleural plane under video control. The portion of parietal pleura to be removed is identified. The forceps are used to grasp the parietal pleura and strip it off the chest wall. The pleura is then wrapped around the forceps using a twisting motion and gentle traction is employed to remove the sheet of pleura through the portal incision.

© 2010 Contexo Media CPT © 2009 American Medical Association. All Rights Reserved.

32657

32657 Thoracoscopy, surgical; with wedge resection of lung, single or multiple

Plain English Description

Wedge resection of the lung is performed by surgical thoracoscopy, also referred to as video assisted thoracoscopic surgery (VATS). Wedge resection may be performed through a single portal incision. The incision site and placement of the thoracoscope are dependent on the site of the lesion. Under thoracoscopic control, the lesion is identified and an endograsper is introduced. The lesion is grasped and suspended. An endostapler is then introduced deeply into the lung parenchyma containing the lesion, which is positioned between the jaws of the endostapler using the endograsper. The jaws are then closed around the lung lesion and the endostapler is fired. The jaws are opened and this process repeated until the entire wedge of parenchyma has been separated from the lung. Endoscissors may also be used to separate the lung tissue. Once the wedge of lung tissue has been resected, an endobag is introduced and the wedge is removed after being placed in the bag. The physician may perform single or multiple wedge resections on one of the lungs. Bleeding is controlled; instruments are removed; and a chest tube is placed through the same portal incision.

32658

32658 Thoracoscopy, surgical; with removal of clot or foreign body from pericardial sac

Plain English Description

The physician removes a clot or foreign body from the pericardial sac using surgical thoracoscopy, also referred to as video assisted thoracoscopic surgery (VATS). The pericardium is the fibrous membrane that covers the heart. A small incision is made between the ribs usually at the sixth or seventh intercostal space along the anterior axillary line and the videothoracoscope is introduced. Two additional portal incisions are made for the introduction of surgical instruments at the posterior axillary line usually at the fifth and eighth intercostal spaces. One lung is collapsed. The inferior pulmonary ligament is divided. The phrenic nerve is identified and protected. In the case of blunt trauma resulting in pericardial blood clot, the pericardium is grasped and retracted away from the heart. Endoscopic scissors are introduced; the pericardium is nicked; and blood and fluid are evacuated. The pericardium is examined and the blood clot is located and removed or a foreign body is identified and removed. Bleeding is controlled, chest tubes are placed as needed, and the incisions are closed.

32659-32660

32659 Thoracoscopy, surgical; with creation of pericardial window or partial resection of pericardial sac for drainage
32660 Thoracoscopy, surgical; with total pericardiectomy

Plain English Description

The physician creates a pericardial window or performs a partial resection of the pericardial sac for drainage using surgical thoracoscopy, also referred to as video assisted thoracoscopic surgery (VATS). The pericardium is the fibrous membrane that covers the heart. A small incision is made between the ribs usually at the sixth or seventh intercostal space along the anterior axillary line and the videothoracoscope is introduced. Two additional portal incisions are made for the introduction of surgical instruments at the posterior axillary line usually at the fifth and eighth intercostal spaces. The inferior pulmonary ligament is divided. The phrenic nerve is identified and protected. The pericardium is grasped and retracted away from the heart. Endoscopic scissors are introduced and the pericardium is nicked and blood and fluid evacuated. A pericardial window or partial resection of the pericardial sac is then performed. This is accomplished by resecting a three to four cm section of the pericardial sac. The pericardium is examined and a sponge introduced to break up loculations. A second window may be created in the same manner. A chest tube is placed into the pericardial window to drain the pericardial space. A second chest tube is placed in the pleural space. In 32660, a total pericardiectomy is performed using surgical thoracoscopy. Port placement is performed as described above. The phrenic nerve is identified and protected. An incision is made in the pericardium anterior or posterior to the phrenic nerve using endoscopic sharp-tip, right-angle scissors. A long right angle clamp is used to grasp the pericardium. Using the scissors and electrocautery, the pericardium is resected as extensively as possible. Chest tubes are placed and the incisions closed.

32661

32661 Thoracoscopy, surgical; with excision of pericardial cyst, tumor, or mass

Plain English Description

The physician excises a pericardial cyst, tumor, or mass using surgical thoracoscopy, also referred to as video assisted thoracoscopic surgery (VATS). The pericardium is the fibrous membrane that covers the heart. A small incision is made between the ribs usually at the sixth or seventh intercostal space along the anterior axillary line and the videothoracoscope is introduced. The thoracic cavity is inspected and the cyst, tumor, or mass located. Two additional portal incisions are made for the introduction of surgical instruments at the posterior axillary line usually at the fifth and eighth intercostal spaces. The inferior pulmonary ligament is divided. The phrenic nerve is identified and protected. If the lesion is a cyst, it may be opened and fluid and debris evacuated. The cyst, tumor, or mass is then dissected free of surrounding tissue and removed along with a margin of healthy pericardium. The defect in the pericardium may be covered with a synthetic patch or left open to drain. If it is left open, a chest tube is placed into the defect. A second chest tube is placed in the pleural space.

32662

32662 Thoracoscopy, surgical; with excision of mediastinal cyst, tumor, or mass

Plain English Description

An excision of a mediastinal cyst, tumor, or mass is performed by surgical thoracoscopy, also referred to as video assisted thoracoscopic surgery (VATS). The patient is placed in lateral decubitus position and three or more trocars are placed depending on the location of the lesion. A pneumothorax is created to aid in visualization. With the thoracoscope in place, the cyst, tumor, or mass is evaluated as to its site and relationship to adjacent structures. The pleura over the cyst, tumor, or mass is incised and the lesion is dissected off the pleura. If the procedure is performed to excise a cyst, the cystic cavities are opened, aspirated, and decompressed. Complete excision of the cyst wall is then performed using blunt dissection and traction. If it is necessary to leave small remnants of the cyst that are adherent to vital structures, the cyst mucosa is cauterized to help prevent recurrence. If the procedure is for a solid tumor, it is dissected free of surrounding structures; the chest incision is widened, and the mass is placed in an extracting bag to prevent contamination of the chest wall with tumor cells. A chest tube is then placed; trocars are removed; and incisions are closed.

32663

32663 Thoracoscopy, surgical; with lobectomy, total or segmental

Plain English Description

A total or segmental lobectomy is performed by surgical thoracoscopy, also referred to as video assisted thoracoscopic surgery (VATS). Single lung ventilation is initiated and the thoracoscope is placed at the anterior or posterior axillary line depending on whether the lobe or lobe segment being removed is on the right or left side. Additional trocars are placed for the introduction of surgical instruments. A lung clamp is used to retract the lung and allow visualization of the pulmonary vein and artery. A larger utility incision is made over the superior pulmonary vein for an upper lobe lobectomy or over the third or fourth interspace for a middle or lower lobe lobectomy. The pulmonary vein is dissected free of overlying pleura and divided. The main pulmonary artery is identified and the arterial branch for the lobe being removed is located. Lymph nodes overlying that artery are excised to allow better access and the artery is then clamped and transected using a vascular stapler. The bronchus is exposed and transected. Once all the structures to the lobe have been divided, the fissure is exposed and the lung is divided along both minor and

CPT © 2009 American Medical Association. All Rights Reserved. © 2010 Contexo Media

54324

54324 1-stage distal hypospadias repair (with or without chordee or circumcision); with urethroplasty by local skin flaps (eg, flip-flap, prepucial flap)

Plain English Description

The physician performs a one stage procedure to fix a birth defect in which the urethra opens on the bottom of the penis near the head. The physician may repair an abnormal curvature of the penis or remove the foreskin. The urethra is reconstructed with skin from the genitals.

54326

54326 1-stage distal hypospadias repair (with or without chordee or circumcision); with urethroplasty by local skin flaps and mobilization of urethra

Plain English Description

The physician performs a one stage procedure to fix a birth defect in which the urethra opens on the bottom of the penis near the head. The physician may repair an abnormal curvature of the penis or remove the foreskin. The urethra is moved to its proper position and repaired with skin flaps from the genitals.

54328

54328 1-stage distal hypospadias repair (with or without chordee or circumcision); with extensive dissection to correct chordee and urethroplasty with local skin flaps, skin graft patch, and/or island flap

Plain English Description

The physician performs a one stage procedure to fix a birth defect in which the urethra opens on the bottom of the penis near the head. The physician may remove the foreskin. The physician must perform extensive work to correct an abnormal curvature of the penis. The urethra is reconstructed with skin flaps from the genitals, a skin graft, and/or a patch of skin connected only in the middle to its new location.

54332

54332 1-stage proximal penile or penoscrotal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap

Plain English Description

The physician performs a one stage procedure to fix a birth defect in which the urethra opens on the base of the penis near the scrotum. The physician must perform extensive work to correct an abnormal curvature of the penis and to move the urethra to its new location. The urethra is reconstructed with a tube of skin and/or a patch of skin connected only in the middle to its new location.

54336

54336 1-stage perineal hypospadias repair requiring extensive dissection to correct chordee and urethroplasty by use of skin graft tube and/or island flap

Plain English Description

The physician performs a one stage procedure to fix a birth defect in which the urethra opens in the area between the rectum and the anus. The physician may remove the foreskin. The physician must perform extensive work to correct an abnormal curvature of the penis. The urethra is reconstructed with skin flaps from the genitals, a skin graft, and/or a patch of skin connected only in the middle to its new location.

54340-54348

54340 Repair of hypospadias complications (ie, fistula, stricture, diverticula); by closure, incision, or excision, simple

54344 Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring mobilization of skin flaps and urethroplasty with flap or patch graft

54348 Repair of hypospadias complications (ie, fistula, stricture, diverticula); requiring extensive dissection and urethroplasty with flap, patch or tubed graft (includes urinary diversion)

Plain English Description

The physician repairs any complications to a procedure in which birth defect in which the urethra opens somewhere besides the tip of the penis is fixed. The complications which may be fixed include any abnormal passages, any tissue that is sticking together, or any abnormal sacs or pouches. The physician may fix these defects by closing them, cutting them, or removing them. Code 54344 if in order to fix these defects, the physician must use skin flaps. Additionally, the urethra must be repaired with flaps or patches of skin. Code 54348 if the physician must perform extensive procedures to fix the defects, including repairing the urethra with a patch, flap, or tube of skin.

54352

54352 Repair of hypospadias cripple requiring extensive dissection and excision of previously constructed structures including re-release of chordee and reconstruction of urethra and penis by use of local skin as grafts and island flaps and skin brought in as flaps or grafts

Plain English Description

The physician fixes an extensive deformity of the penis that is the result of surgery to repair a birth defect in which the urethra opens somewhere besides the tip of the penis. Some of the repairs that were done during the original surgery must be reversed. The physician must perform extensive procedures to fix the defects, including repairing the urethra with a patch, flap, or tube of skin.

54390

54390 Plastic operation on penis for epispadias distal to external sphincter; with exstrophy of bladder

Plain English Description

The physician repairs a birth defect in which the upper part of the urethra is not fully formed. This operation is performed on the top of the penis. The physician also fixes a condition in which the bladder is turned inside out.

54405

54405 Insertion of multi-component, inflatable penile prosthesis, including placement of pump, cylinders, and reservoir

Plain English Description

A multi-component inflatable device is installed in the penis, allowing the patient to increase penile rigidity for intercourse. The device consists of an two inflatable cylinders in the penis, a liquid reservoir, and a pump located in the scrotum.

54410

54410 Removal and replacement of all component(s) of a multi-component, inflatable penile prosthesis at the same operative session

Plain English Description

The physician replaces all of the components of a multi-component inflatable device. The two inflatable cylinders, the reservoir, and the pump mechanism are all removed and replaced, along with the connective tubing. The entire replacement is done during one operative session.

54411

54411 Removal and replacement of all components of a multi-component inflatable penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue

Plain English Description

The physician replaces all of the components of a multi-component inflatable device through an area that has become infected. The two inflatable cylinders, the reservoir, and the pump mechanism are all removed and replaced, along with the connective tubing. The physician also treats infected tissue at the site of the operation. The entire replacement is done during one operative session.

54417

54417 Removal and replacement of non-inflatable (semi-rigid) or inflatable (self-contained) penile prosthesis through an infected field at the same operative session, including irrigation and debridement of infected tissue

Plain English Description

The physician removes and replaces two silicone rods or a self-contained inflatable prosthesis in the penis. The physician must remove and replace the device through tissue that has become infected. The removal and replacement are done during the same procedure. During the procedure, the physician treats the infected tissue.

54420

54420 Corpora cavernosa-saphenous vein shunt (priapism operation), unilateral or bilateral

Plain English Description

Blood from the fatty tissue of the penis is routed to the femoral vein in the thigh. A tube is placed in the penis, and the other end is inserted into the femoral vein in one or both legs. This is done to treat a condition in which the penis remains erect for an abnormally long length of time.

54430

54430 Corpora cavernosa-corpus spongiosum shunt (priapism operation), unilateral or bilateral

Plain English Description

Blood from the fatty tissue of the penis is routed to another area of the penis. A tube is placed in the engorged part of the penis, and the other end is inserted in another area of the penis. This is done to treat a condition in which the penis remains erect for an abnormally long length of time.

54450

54450 Foreskin manipulation including lysis of preputial adhesions and stretching

Plain English Description

This procedure may be performed for tight foreskin (phimosis) or adhesions in an uncircumcised male or adhesions between the remaining foreskin and glans pens in a circumcised male. In a circumscribed male the remaining foreskin is manually manipulated by the physician to break up adhesions. In an uncircumcised male, the foreskin is pulled back to expose the glans penis and stretched which also breaks up any adhesions.

54500-54505

54500 Biopsy of testis, needle (separate procedure)
54505 Biopsy of testis, incisional (separate procedure)

Plain English Description

A biopsy of the testis is performed. In 54500, a needle biopsy is performed. The skin over the planned puncture site is cleansed and a local anesthetic is administered as needed. A large bore needle is then inserted into the testis and a tissue sample obtained. In 54505, an incisional biopsy is performed. The skin is cleansed and a local anesthetic administered. If the biopsy is performed to evaluate a mass, the mass is exposed and a tissue sample obtained. The tissue sample is sent to the laboratory for separately reportable histological evaluation. If the biopsy is performed to evaluate the absence of living sperm in a semen sample (azoospermia), a sample of testis tissue is obtained. The tissue is placed in Bouin's fluid and sent to the infertility laboratory to determine whether sperm are present.

54512

54512 Excision of extraparenchymal lesion of testis

Plain English Description

An extraparenchymal lesion of the testis is excised. This type of lesion is located beneath the membranous covering (tunica vaginalis) of the testis and within the testicular capsule (tunica albuginea). Excision is performed for benign lesions such as fibroma, calcified pseudotumor, adenomatoid tumor, or testicular appendages. The scrotum is explored through a groin incision. The external oblique fascia is opened, taking care to protect the ilioinguinal nerve. The spermatic cord is mobilized and a tourniquet is placed around the cord. The testicle is delivered through the incision with the cord attached. The tunica vaginalis is incised and the testis and epididymis are inspected. The lesion is identified. Biopsies are obtained prior to excision and sent for separately reportable frozen section to confirm that the lesion is benign. The lesion is excised. The testis is replaced in the scrotal sac; the tourniquet around the cord is removed; the surgical wound irrigated; and the wound is closed.

54520

54520 Orchiectomy, simple (including subcapsular), with or without testicular prosthesis, scrotal or inguinal approach

Plain English Description

The physician removes a testicle from a patient in a simple procedure. The physician may put a prosthetic testicle in the scrotum. The physician may access the testicle through the groin area or directly through the scrotum.

54522

54522 Orchiectomy, partial

Plain English Description

A partial orchiectomy is performed as a conservative intervention for benign intratesticular tumor or cyst, such as benign epidermoid cyst, hamartoma, or squamous epithelial cyst. Partial orchiectomy preserves the healthy testicular tissue. The scrotum is explored through a groin incision. The external oblique fascia is opened, taking care to protect the ilioinguinal nerve. The spermatic cord is mobilized and a tourniquet is placed around the cord. The testicle is delivered through the incision with the cord attached. The tunica vaginalis is incised and the testis and epididymis are inspected. The lesion is identified. Biopsies are obtained prior to excision and sent for separately reportable frozen section to confirm that the lesion is benign. The mass is carefully excised from the surrounding germinal testicular tissue. The testicular capsule (tunica albuginea) is closed. The testis is replaced in the scrotal sac; the tourniquet around the cord is removed; the surgical wound is irrigated; and the wound is closed.

54530-54535

54530 Orchiectomy, radical, for tumor; inguinal approach
54535 Orchiectomy, radical, for tumor; with abdominal exploration

Plain English Description

The physician removes a testicle containing a tumor and all of the surrounding tissue related to that testicle. The physician performs the procedure through the groin area. Code 54535 if the physician also explores the abdominal cavity for signs that the cancer has spread.

CPT © 2009 American Medical Association. All Rights Reserved. © 2010 Contexo Media

93750

93750 Interrogation of ventricular assist device (VAD), in person, with physician analysis of device parameters (eg, drivelines, alarms, power surges), review of device function (eg, flow and volume status, septum status, recovery), with programming, if performed, and report

Plain English Description

An in-person interrogation and evaluation of a ventricular assist device (VAD) with physician analysis, review, programming, and report is performed. In-person interrogation and device evaluation may be performed on a routine basis or when the patient presents with symptoms or complaints that might be due to device malfunction or to a change in cardiac function. A connection is established between the VAD device and the interrogation device. The VAD is interrogated. The physician reviews interrogated data to assess VAD function and current programmed parameters. Parameters analyzed include drivelines, alarms, and power surges. Device function is evaluated for flow and volume status, septum, status and recovery. The physician may reprogram the device if needed. The patient is informed of the VAD interrogation findings. The physician provides a written report of findings.

93890

93890 Transcranial Doppler study of the intracranial arteries; vasoreactivity study

Plain English Description

Vasoreactivity Doppler study, used to evaluate blood flow in the cranial arteries to detect disease or weakness in the vessels. A second reading is often performed after administering certain medications to contrast flow activity.

93892

93892 Transcranial Doppler study of the intracranial arteries; emboli detection without intravenous microbubble injection

Plain English Description

Emboli (blood clot obstructing a blood vessel) detection using a Doppler ultrasound scan. Does not use microbubble injection.

93893

93893 Transcranial Doppler study of the intracranial arteries; emboli detection with intravenous microbubble injection

Plain English Description

Emboli (blood clot obstructing a blood vessel) detection using a Doppler ultrasound scan. Uses intravenously injected microbubbles to enhance the ultrasound signals, which grants greater imaging clarity.

93922

▲93922 Limited bilateral noninvasive physiologic studies of upper or lower extremity arteries, (eg, for lower extremities; ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus bidirectional; Doppler waveform recording and analysis at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus volume plethysmography at 1-2 levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries with transcutaneous oxygen tension measurement at 1-2 levels)

Plain English Description

Limited bilateral noninvasive physiologic studies of the extremity arteries, using techniques like Doppler waveform analysis to detect blockages. It is a bilateral evaluation limited up to two levels.

93923

▲93923 Complete bilateral noninvasive physiologic studies of upper or lower extremity arteries, 3 (eg, for lower extremity: ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental blood pressure measurements, with bidirectional Doppler waveform recording and analysis, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental volume plethysmography, at 3 or more levels, or ankle/brachial indices at distal posterior tibial and anterior tibial/dorsalis pedis arteries plus segmental transcutaneous oxygen tension measurements, at 3 or more level(s), or single level study with provocative functional maneuvers (eg, measurements with postural provocative tests, or measurements with reactive hyperemia)

Plain English Description

Noninvasive physiologic studies of the extremity arteries, using techniques like Doppler waveform analysis to detect blockages. These are complete bilateral evaluations using multiple levels (three or more) of measurements and postural provocative tests (changing the patient's position so as to provoke a reaction of dizziness or numbness in the limb).

93982

93982 Noninvasive physiologic study of implanted wireless pressure sensor in aneurysmal sac following endovascular repair, complete study including recording, analysis of pressure and waveform tracings, interpretation and report

Plain English Description

A noninvasive physiologic study is performed on a previously implanted wireless pressure sensor placed in an aneurysmal sac during endovascular repair of an abdominal aortic aneurysm (AAA). A complete study including recording, pressure analysis and waveform tracings is required at yearly or half-yearly intervals subsequent to the endovascular repair to ensure that there are no complications, such as repressurization or an endoleak. The highly specialized wireless sensor the size of a grain of rice measures pressure, flow, and temperature and allows for direct, noninvasive monitoring for the risk of rupture. The device uses acoustic waves, which transmit effectively through soft tissue, bone, and fluid without being absorbed, and requires very little energy for a high signal-to-noise ratio when accessing deep locations in the body. There is no battery, no antenna, and no connecting leads. The device has a special external unit that both powers the implant and receives the information directly from the implant. A technologist obtains the data from the sensor. The data is then reviewed by the physician, including waveform tracings of the activated sensor and aneurysm sac pressure measurements taken from different positions by the external unit. These are compared for pulsatility. The waveform tracings are compared with data obtained from prior studies including the presurgical study, the immediate post-operative study, and any other previously obtained post-discharge interval studies. Raw pressure measurements are normalized to the brachial systolic pressure, plotted, and then compared with previous pressure measurements. Any clinically significant change is noted. A report is dictated and the waveforms and pressure measurements to be submitted in the final report are identified.

94005

94005 Home ventilator management care plan oversight of a patient (patient not present) in home, domiciliary or rest home (eg, assisted living) requiring review of status, review of laboratories and other studies and revision of orders and respiratory care plan (as appropriate), within a calendar month, 30 minutes or more

Plain English Description

A patient's home ventilator management or respiratory care plan is overseen and coordinated without the patient present, any time within a calendar month, requiring 30 minutes or more. The patient's current status is evaluated through review of records, laboratory results, or other studies. The respiratory care plan is coordinated with caregivers and any other care the patient is currently receiving.

© 2010 Contexo Media CPT © 2009 American Medical Association. All Rights Reserved.

94011-94012

94011 Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age

94012 Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age

Plain English Description

To perform spirometric forced expiratory flow (FEF) measurement, the infant or child is given a medication before the test to induce sleep. Once asleep, the infant or child is placed in a chest compression jacket. A spirometry device consisting of a mouthpiece and tubing connected to a machine that records and displays results is used to perform the test. Air is forced into the lungs which are expanded to maximum capacity. Forced maneuvers to express the air are then performed using automatic jacket inflation and chest compression. A spirometer is used to measure FEF as the air is expelled from the lungs. The test may be performed a second time after administration of a bronchodilator medication. The test results are displayed on a graph that the physician reviews and interprets in a written report. Use 94012 for FEF performed without use of a bronchodilator on an infant or child through age 2. Use 94012 when FEF is performed before and after administration of a bronchodilator on an infant or child through age 2.

94013

94013 Measurement of lung volumes (ie, functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age

Plain English Description

Lung volumes are measured using a variety of pulmonary function tests for lung volume and capacity. In an infant or child through 2 years of age, lung volume tests require medications and additional testing equipment due to the inability of infants and young children to voluntarily perform the necessary breathing exercises. The infant or child is given a medication before the test to induce sleep. Once asleep, a spirometry device consisting of a mouthpiece and tubing connected to a machine that records and displays results is used to perform the test. Functional residual capacity measures the lung volume following a normal expiration when the respiratory muscles are completely relaxed. Not all air is exhaled during normal respiration and functional residual capacity measures the amount of remaining lung capacity following normal expiration. For other tests, the infant or child is placed in a chest compression jacket. Air is forced into the lungs which are expanded to maximum capacity. Forced maneuvers to express the air are then performed using automatic jacket inflation and chest compression. Forced vital capacity, the maximum amount of air that can be forcibly exhaled, is measured. Residual volume measures the remaining volume of the lungs following a maximal expiration. Expiratory reserve volume is a calculation of the difference between functional residual capacity and residual volume. The physician may perform other lung volume tests as needed. The test results are displayed on a graph that the physician reviews and interprets in a written report.

94014-94016

94014 Patient-initiated spirometric recording per 30-day period of time; includes reinforced education, transmission of spirometric tracing, data capture, analysis of transmitted data, periodic recalibration and physician review and interpretation

94015 Patient-initiated spirometric recording per 30-day period of time; recording (includes hook-up, reinforced education, data transmission, data capture, trend analysis, and periodic recalibration)

94016 Patient-initiated spirometric recording per 30-day period of time; physician review and interpretation only

Plain English Description

The patient is given a loaned spirometer and trained in its use so readings can be taken over a 30-day period of time. Code includes analyzing the data, the physician's interpretation and report, and recalibration of the instrument (as needed). Code 94015 if only recording is included. Code 94016 if only physician review and interpretation is included.

94060

94060 Bronchodilation responsiveness, spirometry as in 94010, pre- and post-bronchodilator administration

Plain English Description

Spirometry with bronchodilation responsiveness is a pulmonary function test that is used to help diagnose the cause of shortness of breath and to monitor existing pulmonary disease, such as chronic bronchitis, emphysema, pulmonary fibrosis, chronic obstructive pulmonary disease (COPD), and asthma. The test is first performed without administration of a bronchodilator. A spirometry device consisting of a mouthpiece and tubing connected to a machine that records and displays results is used to perform the test. The patient inhales deeply and then exhales through the mouthpiece. Inhalation and exhalation measurements are first taken with the patient breathing normally. The patient is then instructed to perform rapid, forceful inhalation and exhalation. The spirometer records the volume of air inhaled, exhaled, and the length of time each breath takes. A bronchodilator medication is administered and the test is repeated. The test results are displayed on a graph that the physician reviews and interprets in a written report.

94070

94070 Bronchospasm provocation evaluation, multiple spirometric determinations as in 94010, with administered agents (eg, antigen[s], cold air, methacholine)

Plain English Description

Bronchospasm (contraction of the passages of the bronchi and bronchioles) evaluation, using spirometry (see code 94010) to evaluate breathing both before and after administration of an agent such as exercise or cold air. The test is usually performed several times to determine the patients response to the agent.

94150

94150 Vital capacity, total (separate procedure)

Plain English Description

This test is performed to determine the patient's lung capacity. The amount of air that the patient can expel from their lungs is measured.

94200

94200 Maximum breathing capacity, maximal voluntary ventilation

Plain English Description

Measures the patient's maximum breathing capacity and/or maximum voluntary ventilation (the maximum that can be inhaled and exhaled in 60 seconds) on a spirometer.

CPT © 2009 American Medical Association. All Rights Reserved. © 2010 Contexo Media

Medical Decision-Making

Medical decision-making is the third component of the component-based codes. This component is most often the equivalent of the Assessment and Plan portion of the standard provider's note. The cognitive work here reflects the amount of experience, training and knowledge a provider uses to address a problem or problems in addition to the quantifiable indicators below. The CPT has defined three sub-components of decision-making and CMS has provided further guidance on decision-making indicators.

Per the CPT book, medical decision-making refers to the complexity of establishing a diagnosis and/or selecting a management option as measured by:

- The number of possible diagnoses and/or the number of management options that must be considered
- The amount and/or complexity of medical records, diagnostic tests, and/or other information that must be obtained, reviewed, and analyzed
- The risk of significant complications, morbidity, and/or mortality, as well as comorbidities, associated with the patient's presenting problem(s), the diagnostic procedure(s), and/or the possible management options

Four types of medical decision-making are recognized: straightforward; low complexity; moderate complexity; and high complexity. To qualify for a given type of decision-making, two of the three elements in the following table should be met or exceeded.

Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless their presence significantly increases the complexity of the medical decision-making.

Number of diagnoses or management options	Amount and/or complexity of data to be reviewed	Risk of complications and/or morbidity or mortality	Type of Decision Making
Minimal	Minimal or None	Minimal	Straightforward
Limited	Limited	Low	Low Complexity
Multiple	Moderate	Moderate	Moderate Complexity
Extensive	Extensive	High	High Complexity

Number of Diagnoses/Management Options

This element is based on the number and type of problems addressed during the encounter, the complexity of establishing a diagnosis, and the management decisions that must be made. The number and type of diagnostic tests may be an indicator of the number of possible diagnoses. Problems that are improving or resolving are less complex than those that are worsening are. The need to seek advice from others is another indicator of complexity of diagnostic or management problems.

DG: For each encounter, an assessment, clinical impression, or diagnosis should be documented. It may be explicitly stated or implied in documented decisions regarding management plans and/or further evaluation.

- For a presenting problem with an established diagnosis, the record should reflect whether the problem is (a) improved, well controlled, resolving, or resolved; or (b) inadequately controlled, worsening, or failing to change as expected.
- For a presenting problem without an established diagnosis, the assessment or clinical impression may be stated in the form of a differential diagnosis or as "possible," "probable," or "rule out (R/O)" diagnoses.

DG: Initiation of, or changes in, treatment should be documented. Treatment may involve a wide range of management options, including patient instructions, nursing instructions, and medications.

DG: If referrals are made or consultations requested, the record should indicate to whom or where the referral or consultation is made

CMS does not really define what a self-limited problem is, and what determines if other entries are established or new problems. Self-limited measures degree or significance while established and new pertains to time or chronicity. There is also uncertainty about what 'additional work-up' means.

Amount and/or Complexity of Data to be Reviewed

This element is based on the types of testing ordered or reviewed. A decision to obtain and review old medical records and/or obtain history from sources other than the patient increases the amount/complexity of data.

Discussion of unexpected test results with the physician who performed or interpreted the test, or if the physician who ordered a test personally reviews the image, tracing, or specimen to supplement information from the physician who prepared the report or interpretation are indicators of the complexity of the data being reviewed.

DG: If a diagnostic service is ordered, planned, scheduled, or performed at the time of the E/M encounter, the type of service should be documented.

DG: The review of tests should be documented. An entry such as "WBC elevated" or "chest x-ray unremarkable is acceptable. Or, the review may be documented by initialing and dating the report containing the test results.

DG: A decision to obtain old records or to obtain additional history from the family, caretaker, or other source to supplement that obtained from the patient should be documented.

DG: Relevant findings from the review of old records or additional history should be documented. If there is no relevant information beyond that already obtained, that fact should be documented. A notation of "old records reviewed" or additional history obtained from family" without elaboration is insufficient.

DG: The results of discussion of laboratory, endocrinology, or other tests with the physician who performed or interpreted the study should be documented.

DG: The direct visualization and independent interpretation of an image, tracing or specimen previously or subsequently interpreted by another physician should be documented.

Risk of Significant Complications/Morbidity/Mortality

This element is based on the risks associated with the presenting problem(s), the diagnostic procedure(s), and the possible management options.

DG: Comorbidities/underlying diseases or other factors that increase the complexity of medical decision-making by increasing the risk of complications, morbidity, and/or mortality should be documented.

DG: If a surgical or invasive diagnostic procedure is ordered, planned, or scheduled at the time of the E/M encounter, the type of procedure should be documented.

DG: If a surgical or invasive diagnostic procedure is performed at the time of the E/M encounter, the type of procedure should be documented.

DG: The referral or decision to perform a surgical or invasive diagnostic procedure on an urgent basis should be documented or implied.

© 2010 Contexo Media