



Errata and Technical Corrections – CPT® 2021
Date: June 7, 2021

The information that follows is sourced to either a publication errata or a technical correction by the CPT Editorial Panel. An errata (denoted as **E**) for the current edition of the CPT code set will publish information that was approved by the CPT Editorial Panel and inadvertently excluded from the current code set. Technical corrections (denoted as **T**) are clarifications of original Panel intent for the current code structure. All items below are errata if they are not designated as a technical correction in the right-hand column. The order of the entries on this document is by code order. Additionally, each entry shows the date of publication to this document. The links immediately following are provided as a guide to the most recently added items. **The effective date for each item is January 1, 2021.** Updates to this document are made as issues surface requiring clarification.

Most recent entries added to *Errata and Technical Corrections - CPT® 2021*

- Revise parenthetical notes in the Evaluation and Management Case Management Services and Chronic Care Management Services subsections.
- Relocate the second parenthetical note following code 64455.
- Remove “tropomyosin” from the code descriptor for code 81194.
- Add and revise parenthetical notes throughout the Cardiac Catheterization subsection.
- Outdented the term “Vitreous” in the CPT Index.

<p>Category I Evaluation and Management Guidelines Common to All E/M Services Time</p> <p>Physician/other qualified health care professional time includes the following activities, when performed:</p> <ul style="list-style-type: none"> ▪ preparing to see the patient (eg, review of tests) ▪ obtaining and/or reviewing separately obtained history ▪ performing a medically appropriate examination and/or evaluation ▪ counseling and educating the patient/family/caregiver ▪ ordering medications, tests, or procedures ▪ referring and communicating with other health care professionals (when not separately reported) ▪ documenting clinical information in the electronic or other health record ▪ independently interpreting results (not separately reported) and communicating results to the patient/ family/caregiver ▪ care coordination (not separately reported) <p>▶ <u>Do not count time spent on the following:</u></p> <ul style="list-style-type: none"> ▪ <u>the performance of other services that are reported separately</u> ▪ <u>travel</u> ▪ <u>teaching that is general and not limited to discussion that is required for the management of a specific patient</u> ◀ 	<p>Posted 3/09/2021 T</p>
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<p>Add new bulleted list to clarify use of the Office or Other Outpatient Services codes 99202-99215 in the E/M Time subsection.</p> <p>Category I Evaluation and Management Guidelines Common to All E/M Services Services Reported Separately</p> <p>▶ Any specifically identifiable procedure or service (ie, identified with a specific CPT code) performed on the date of E/M services may be reported separately.</p> <p>The <u>ordering and</u> actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when <u>the professional interpretation of those tests/studies is reported separately by the physician or other qualified health care professional reporting the E/M service. Tests that do not require separate interpretation (eg, tests that are results only) and are analyzed as part of MDM do not count as an independent interpretation, but may be counted as ordered or reviewed for selecting an MDM level.</u> Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. The physician’s interpretation of the results of diagnostic tests/studies (ie, professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended. If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of MDM. ◀</p> <p>Revise guideline to clarify use of the Office or Other Outpatient Services codes 99202-99215 in the E/M Services Reported Separately subsection.</p>	<p>Posted 3/09/2021 T</p>
<p>Category I Evaluation and Management Guidelines for Office or Other Outpatient E/M Services Number and Complexity of Problems Addressed at the Encounter</p> <p>▶ One element used in selecting the level of office or other outpatient services is the number and complexity of the problems that are addressed at an encounter. Multiple new or established conditions may be addressed at the same time and may affect MDM. Symptoms may cluster around a specific diagnosis and each symptom is not necessarily a unique condition. Comorbidities/underlying diseases, in and of themselves, are not considered in selecting a level of E/M services unless they are addressed, and their presence increases the amount and/or complexity of data to be reviewed and analyzed or the risk of complications and/or morbidity or mortality of patient management. The final diagnosis for a condition does not, in and of itself, determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition. <u>Therefore, presenting symptoms that are likely to represent a highly morbid condition may “drive” MDM even when the ultimate diagnosis is not highly morbid. The evaluation and/or treatment should be consistent with the likely nature of the condition.</u> Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.</p> <p><u>The term “risk” as used in these definitions relates to risk from the condition. While condition risk and management risk may often correlate, the risk from the condition is distinct from the risk of the management.</u></p> <p>Definitions for the elements of MDM (see Table 2, Levels of Medical Decision Making) for other office or other outpatient services are:</p> <p>Problem: A problem is a disease, condition, illness, injury, symptom, sign, finding, complaint, or other matter addressed at the encounter, with or without a diagnosis being established at the time of the encounter.</p>	<p>Posted 3/09/2021 T</p>

Problem addressed: A problem is addressed or managed when it is evaluated or treated at the encounter by the physician or other qualified health care professional reporting the service. This includes consideration of further testing or treatment that may not be elected by virtue of risk/benefit analysis or patient/parent/guardian/ surrogate choice. Notation in the patient's medical record that another professional is managing the problem without additional assessment or care coordination documented does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service. Referral without evaluation (by history, examination, or diagnostic study[ies]) or consideration of treatment does not qualify as being addressed or managed by the physician or other qualified health care professional reporting the service.

Minimal problem: A problem that may not require the presence of the physician or other qualified health care professional, but the service is provided under the physician's or other qualified health care professional's supervision (see 99211).

Self-limited or minor problem: A problem that runs a definite and prescribed course, is transient in nature, and is not likely to permanently alter health status.

Stable, chronic illness: A problem with an expected duration of at least one year or until the death of the patient. For the purpose of defining chronicity, conditions are treated as chronic whether or not stage or severity changes (eg, uncontrolled diabetes and controlled diabetes are a single chronic condition). "Stable" for the purposes of categorizing MDM is defined by the specific treatment goals for an individual patient. A patient who is not at his or her treatment goal is not stable, even if the condition has not changed and there is no short-term threat to life or function. For example, in a patient with persistently poorly controlled blood pressure for whom better control is a goal is not stable, even if the pressures are not changing and the patient is asymptomatic, the risk of morbidity without treatment is significant. Examples may include well-controlled hypertension, noninsulin-dependent diabetes, cataract, or benign prostatic hyperplasia.

Acute, uncomplicated illness or injury: A recent or new short-term problem with low risk of morbidity for which treatment is considered. There is little to no risk of mortality with treatment, and full recovery without functional impairment is expected. A problem that is normally self-limited or minor but is not resolving consistent with a definite and prescribed course is an acute, uncomplicated illness. Examples may include cystitis, allergic rhinitis, or a simple sprain.

Chronic illness with exacerbation, progression, or side effects of treatment: A chronic illness that is acutely worsening, poorly controlled, or progressing with an intent to control progression and requiring additional supportive care or requiring attention to treatment for side effects but that does not require consideration of hospital level of care.

Undiagnosed new problem with uncertain prognosis: A problem in the differential diagnosis that represents a condition likely to result in a high risk of morbidity without treatment. An example may be a lump in the breast.

Acute illness with systemic symptoms: An illness that causes systemic symptoms and has a high risk of morbidity without treatment. For systemic general symptoms, such as fever, body aches, or fatigue in a minor illness that may be treated to alleviate symptoms, shorten the course of illness, or to prevent complications, see the definitions **for self-limited or minor problem** or **acute, uncomplicated illness or injury**. Systemic symptoms may not be general but may be single system. Examples may include pyelonephritis, pneumonitis, or colitis.

Acute, complicated injury: An injury which requires treatment that includes evaluation of body systems that are not directly part of the injured organ, the injury is extensive, or the treatment options

are multiple and/or associated with risk of morbidity. An example may be a head injury with brief loss of consciousness.

Chronic illness with severe exacerbation, progression, or side effects of treatment: The severe exacerbation or progression of a chronic illness or severe side effects of treatment that have significant risk of morbidity and may require hospital level of care.

Acute or chronic illness or injury that poses a threat to life or bodily function: An acute illness with systemic symptoms, an acute complicated injury, or a chronic illness or injury with exacerbation and/or progression or side effects of treatment, that poses a threat to life or bodily function in the near term without treatment. Examples may include acute myocardial infarction, pulmonary embolus, severe respiratory distress, progressive severe rheumatoid arthritis, psychiatric illness with potential threat to self or others, peritonitis, acute renal failure, or an abrupt change in neurologic status.

Analyzed: the process of using the data as part of the MDM. The data element itself may not be subject to analysis (eg, glucose), but it is instead included in the thought processes for diagnosis, evaluation, or treatment. Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter. Tests that are ordered outside of an encounter may be counted in the encounter in which they are analyzed. In the case of a recurring order, each new result may be counted in the encounter in which it is analyzed. For example, an encounter that includes an order for monthly prothrombin times would count for one prothrombin time ordered and reviewed. Additional future results, if analyzed in a subsequent encounter, may be counted as a single test in that subsequent encounter. Any service for which the professional component is separately reported by the physician or other qualified health care professional reporting the E/M services is not counted as a data element ordered, reviewed, analyzed, or independently interpreted for the purposes of determining the level of MDM.

Test: Tests are imaging, laboratory, psychometric, or physiologic data. A clinical laboratory panel (eg, basic metabolic panel [80047]) is a single test. The differentiation between single or multiple unique tests is defined in accordance with the CPT code set. For the purposes of data reviewed and analyzed, pulse oximetry is not a test.

Unique: A unique test is defined by the CPT code set. When multiple results of the same unique test (eg, serial blood glucose values) are compared during an E/M service, count it as one unique test. Tests that have overlapping elements are not unique, even if they are identified with distinct CPT codes. For example, a CBC with differential would incorporate the set of hemoglobin, CBC without differential, and platelet count. A unique source is defined as a physician or qualified health care professional in a distinct group or different specialty or subspecialty, or a unique entity. Review of all materials from any unique source counts as one element toward MDM.

Combination of Data Elements: A combination of different data elements, for example, a combination of notes reviewed, tests ordered, tests reviewed, or independent historian, allows these elements to be summed. It does not require each item type or category to be represented. A unique test ordered, plus a note reviewed and an independent historian would be a combination of three elements.

External: External records, communications and/or test results are from an external physician, other qualified health care professional, facility, or health care organization.

External physician or other qualified health care professional: An external physician or other qualified health care professional who is not in the same group practice or is of a different specialty or subspecialty. This includes licensed professionals who are practicing independently. The individual may also be a facility or organizational provider such as from a hospital, nursing facility, or home health care agency.

Discussion: Discussion requires an interactive exchange. The exchange must be direct and not through intermediaries (eg, clinical staff or trainees). Sending chart notes or written exchanges that are within progress notes does not qualify as an interactive exchange. The discussion does not need to be on the date of the encounter, but it is counted only once and only when it is used in the decision making of the encounter. It may be asynchronous (ie, does not need to be in person), but it must be initiated and completed within a short time period (eg, within a day or two).

Independent historian(s): An individual (eg, parent, guardian, surrogate, spouse, witness) who provides a history in addition to a history provided by the patient who is unable to provide a complete or reliable history (eg, due to developmental stage, dementia, or psychosis) or because a confirmatory history is judged to be necessary. In the case where there may be conflict or poor communication between multiple historians and more than one historian is needed, the independent historian requirement is met. The independent history does not need to be obtained in person but does need to be obtained directly from the historian providing the independent information.

Independent interpretation: The interpretation of a test for which there is a CPT code and an interpretation or report is customary. This does not apply when the physician or other qualified health care professional is reporting the service or has previously reported the service for the patient. A form of interpretation should be documented but need not conform to the usual standards of a complete report for the test.

Appropriate source: For the purpose of the discussion of management data element (see Table 2, Levels of Medical Decision Making), an appropriate source includes professionals who are not health care professionals but may be involved in the management of the patient (eg, lawyer, parole officer, case manager, teacher). It does not include discussion with family or informal caregivers.

One element used in selecting the level of service is the risk of complications and/or morbidity or mortality of patient management at an encounter. This is distinct from the risk of the condition itself.

Risk: The probability and/or consequences of an event. The assessment of the level of risk is affected by the nature of the event under consideration. For example, a low probability of death may be high risk, whereas a high chance of a minor, self-limited adverse effect of treatment may be low risk. Definitions of risk are based upon the usual behavior and thought processes of a physician or other qualified health care professional in the same specialty. Trained clinicians apply common language usage meanings to terms such as high, medium, low, or minimal risk and do not require quantification for these definitions (though quantification may be provided when evidence-based medicine has established probabilities). For the purposes of MDM, level of risk is based upon consequences of the problem(s) addressed at the encounter when appropriately treated. Risk also includes MDM related to the need to initiate or forego further testing, treatment, and/or hospitalization. The risk of patient management criteria applies to the patient management decisions made by the reporting physician or other qualified health care professional as part of the reported encounter.

Morbidity: A state of illness or functional impairment that is expected to be of substantial duration during which function is limited, quality of life is impaired, or there is organ damage that may not be transient despite treatment.

Social determinants of health: Economic and social conditions that influence the health of people and communities. Examples may include food or housing insecurity.

Surgery (minor or major, elective, emergency, procedure or patient risk):

Surgery—Minor or Major: The classification of surgery into minor or major is based on the common meaning of such terms when used by trained clinicians, similar to the use of the term “risk.” These terms are not defined by a surgical package classification.

Surgery—Elective or Emergency: Elective procedures and emergent or urgent procedures describe the timing of a procedure when the timing is related to the patient’s condition. An elective procedure is typically planned in advance (eg, scheduled for weeks later), while an emergent procedure is typically performed immediately or with minimal delay to allow for patient stabilization. Both elective and emergent procedures may be minor or major procedures.

Surgery—Risk Factors, Patient or Procedure: Risk factors are those that are relevant to the patient and procedure. Evidence-based risk calculators may be used, but are not required, in assessing patient and procedure risk.

Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient-specific in some cases. Intensive monitoring may be long-term or short-term. Long-term intensive monitoring is not performed less than quarterly. The monitoring may be performed with a laboratory test, a physiologic test, or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of MDM in an encounter in which it is considered in the management of the patient. Examples may include monitoring for cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis. Examples of monitoring that do not qualify include monitoring glucose levels during insulin therapy, as the primary reason is the therapeutic effect (even if unless severe hypoglycemia is a current, significant concern); or annual electrolytes and renal function for a patient on a diuretic, as the frequency does not meet the threshold. ◀

New and revised guidelines to clarify use of the Office or Other Outpatient Services codes 99202-99215 in the E/M Number and Complexity of Problems Addressed at the Encounter subsection.

**Category I
Evaluation and Management
Instructions for Selecting a Level of Office or Other Outpatient E/M Services
Medical Decision Making**

► MDM includes establishing diagnoses, assessing the status of a condition, and/or selecting a management option. MDM in the office or other outpatient services codes is defined by three elements:

- The number and complexity of problem(s) that are addressed during the encounter.
- The amount and/or complexity of data to be reviewed and analyzed. These data include medical records, tests, and/or other information that must be obtained, ordered, reviewed, and analyzed for the encounter. This includes information obtained from multiple sources or interprofessional communications that are not reported separately and interpretation of tests that are not reported separately. Ordering a test is included in the category of test result(s) and the review of the test result is part of the encounter and not a subsequent encounter. Ordering a test may include those considered, but not selected after shared decision making. For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required. Alternatively, a test may normally be performed, but due to the risk for a specific patient it is not ordered. These considerations must be documented. Data are divided into three categories:
 - Tests, documents, orders, or independent historian(s). (Each unique test, order, or document is counted to meet a threshold number.)
 - Independent interpretation of tests.
 - Discussion of management or test interpretation with external physician or other qualified health care professional or appropriate source.
- The risk of complications and/or morbidity or mortality of patient management decisions made at the visit, associated with the patient’s problem(s), the diagnostic procedure(s), treatment(s). This

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<p>includes the possible management options selected and those considered but not selected, after shared MDM with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment.</p> <p>Four types of MDM are recognized: straightforward, low, moderate, and high. The concept of the level of MDM does not apply to 99211. Shared MDM involves eliciting patient and/or family preferences, patient and/or family education, and explaining risks and benefits of management options. MDM may be impacted by role and management responsibility. When the physician or other qualified health care professional is reporting a separate CPT code that includes interpretation and/or report, the interpretation and/or report should not count toward the MDM when selecting a level of office or other outpatient services. When the physician or other qualified health care professional is reporting a separate service for discussion of management with a physician or another qualified health care professional, the discussion is not counted toward the MDM when selecting a level of office or other outpatient services. ◀</p> <p>Revise guideline to clarify use of the Office or Other Outpatient Services codes 99202-99215 in the E/M Medical Decision Making subsection.</p>	
<p>Category I Evaluation and Management Case Management Services Medical Team Conference, Direct (Face-to-Face) Contact With Patient and/or Family</p> <p>99366 Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by nonphysician qualified health care professional</p> <p>(Team conference services of less than 30 minutes duration are not reported separately)</p> <p>(For team conference services by a physician with patient and/or family present, see Evaluation and Management services)</p> <p>▶ (Do not report 99366 during for the same month with time reported for 99439, 99487, 99489, 99490, 99491) ◀</p> <p>Revise the third parenthetical note following code 99366 by replacing “during” with “for” and “month with” with “time reported for”.</p>	<p>Posted 6/07/2021 T</p>
<p>Category I Evaluation and Management Preventive Medicine Services</p> <p>▶ Vaccine/toxoid products, immunization administrations, ancillary studies involving laboratory, radiology, other procedures, or screening tests (eg, vision, hearing, developmental) identified with a specific CPT code are reported separately. For immunization administration and vaccine risk/benefit counseling, see 90460, 90461, 90471-90474, 0001A, 0002A, 0011A, 0012A, 0021A, 0022A, 0031A. For vaccine/toxoid products, see 90476-90749<u>90756</u>, 91300, 91301, 91302, 91303. ◀</p> <p>Revise guideline to replace code 90749 with code 90756 to update the vaccine code range.</p>	<p>Posted 3/09/2021 E</p>
<p>Category I Evaluation and Management Care Management Services Chronic Care Management Services</p>	<p>Posted 6/07/2021 T</p>

<p>#99491 Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements:</p> <ul style="list-style-type: none"> ▪ multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; ▪ chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; ▪ comprehensive care plan established, implemented, revised, or monitored. <p>(Do not report 99491 in the same calendar month with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99439, 99487, 99489, 99490, 99605, 99606, 99607)</p> <p>(Do not report 99491 for service time reported with 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443)</p> <p>▶ (Do not report 99491 when performed during for the <u>same</u> service time of as 99495, 99496, if reporting 99495, 99496) ◀</p> <p>Revise the third parenthetical note following code 99491 by: 1) replacing “when performed during” with “for”; 2) adding the term “same and replacing “of” with “as”; and 3) deleting “if reporting 99495, 99496”.</p>	
<p>Category I Evaluation and Management Care Management Services Complex Chronic Care Services</p> <p>+▲99489 each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)</p> <p>(Report 99489 in conjunction with 99487)</p> <p>(Do not report 99489 for care management services of less than 30 minutes additional to the first 60 minutes of complex chronic care management services during a calendar month)</p> <p>▶ (Do not report 99487, 99489 during the same calendar month with 90951-90970, 99339, 99340, 99374, 99375, 99377, 99378, 99379, 99380, 99439, 99490, 99491, 99605, 99606, 99607) ◀</p> <p>▶ (Do not report 99487, 99489 for service time reported with 93792, 93793, 98960, 98961, 98962, 98966, 98967, 98968, 98969, 98970, 98971, 98972, 99071, 99078, 99080, 99091, 99358, 99359, 99366, 99367, 99368, 99421, 99422, 99423, 99441, 99442, 99443, 99605, 99606, 99607) ◀</p> <p>Revise the parenthetical note following code 99489 to remove deleted code 98969.</p>	<p>Posted 10/01/2020 E</p>
<p>Category I Surgery Cardiovascular System Shunting Procedures</p> <p>●33745 Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for</p>	<p>Posted 4/01/2021 E</p>

<p>congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt</p> <p>Correct the misspelling of catheterization by adding “te” in the code descriptor for code 33745.</p>	
<p>Category I Surgery Nervous System Extracranial Nerves, Peripheral Nerves, and Autonomic Nervous System Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic Somatic Nerves</p> <p>64400 Injection(s), anesthetic agent(s) and/or steroid; trigeminal nerve, each branch (ie, ophthalmic, maxillary, mandibular)</p> <p>▲64455 plantar common digital nerve(s) (eg, Morton’s neuroma)</p> <p>(Do not report 64455 in conjunction with 64632)</p> <p>(Imaging guidance [fluoroscopy or CT] and any injection of contrast are inclusive components of 64479-64484. Imaging guidance and localization are required for the performance of 64479-64484)</p> <p>(64470-64476 have been deleted. To report, see 64490-64495)</p> <p>✚▲64484 transforaminal epidural, with imaging guidance (fluoroscopy or CT) lumbar or sacral, each additional level (List separately in addition to code for primary procedure)</p> <p>(Use 64484 in conjunction with 64483)</p> <p>(64479-64484 are unilateral procedures. For bilateral procedures, report 64479, 64483 with modifier 50. Report add-on codes 64480, 64484 twice, when performed bilaterally. Do not report modifier 50 in conjunction with 64480, 64484)</p> <p>▶(Imaging guidance [fluoroscopy or CT] and any injection of contrast are inclusive components of 64479-64484. Imaging guidance and localization are required for the performance of 64479-64484)◀</p> <p>Relocate the second parenthetical note following code 64455 to follow code 64484.</p>	<p>Posted 6/07/2021 T</p>
<p>Category I Pathology and Laboratory Molecular Pathology Tier 1 Molecular Pathology Procedures</p> <p>#●81194 NTRK (neurotrophic-tropomyosin receptor tyrosine kinase 1, 2, and 3) (eg, solid tumors) translocation analysis</p> <p>(For translocation analysis <i>NTRK1</i>, <i>NTRK2</i>, and <i>NTRK3</i> using a single assay, use 81194)</p> <p>Remove “tropomyosin” from the code descriptor for code 81194.</p>	<p>Posted 6/07/2021 T</p>
<p>Category I Medicine Immunization Administration for Vaccines/Toxoids</p> <p>▶ Report vaccine immunization administration codes (90460, 90461, 90471-90474, 0001A, 0002A, 0011A, 0012A, 0021A, 0022A, 0031A) in addition to the vaccine and toxoid code(s) (90476-90749, 90756, 91300, 91301, 91302, 91303).◀</p>	<p>Posted 3/09/2021 E</p>

<p>Revise guideline to replace code 90749 with code 90756 to update the vaccine code range.</p> <p>Category I Medicine Vaccines/Toxoids</p> <p>► Codes 90476-9074990756, 91300, 91301, 91302, 91303 identify the vaccine product only. To report the administration of a vaccine/toxoid <u>other than SARS-CoV-2 (coronavirus disease [COVID-19])</u>, the vaccine/toxoid product codes (90476-9074990756) must be used in addition to an immunization administration code(s) (90460, 90461, 90471, 90472, 90473, 90474). <u>To report the administration of a SARS-CoV-2 (coronavirus disease [COVID-19]) vaccine, the vaccine/toxoid product codes (91300, 91301, 91302, 91303) should be reported with the corresponding immunization administration code (0001A, 0002A, 0011A, 0012A, 0021A, 0022A, 0031A). All SARS-CoV-2 (coronavirus disease [COVID-19]) vaccine codes in this section are listed in Appendix Q with their associated vaccine code descriptors, vaccine administration codes, vaccine manufacturer, vaccine name(s), NDC Labeler Product ID, and interval between doses. In order to report these codes, the vaccine must fulfill the code descriptor and must be the vaccine represented by the manufacturer and vaccine name listed in Appendix Q. Modifier 51 should not be reported with vaccine/toxoid codes 90476-9074990756, 91300, 91301, 91302, 91303 when reported in conjunction with administration codes 90460, 90461, 90471, 90472, 90473, 90474, 0001A, 0002A, 0011A, 0012A, 0021A, 0022A, 0031A.</u></p> <p>The vaccine/toxoid abbreviations listed in codes 90476-9074890756, 91300, 91301, 91302, 91303 reflect the most recent US vaccine abbreviations references used in the Advisory Committee on Immunization Practices (ACIP) recommendations at the time of CPT code set publication. Interim updates to vaccine code descriptors will be made following abbreviation approval by the ACIP on a timely basis via the AMA CPT website (www.ama-assn.org/go/cpt-vaccine). The accuracy of the ACIP vaccine abbreviation designations in the CPT code set does not affect the validity of the vaccine code and its reporting function. ◀</p> <p>Revise guidelines to replace code 90749 with code 90756 to update the vaccine code range.</p>	<p>Posted 3/09/2021 E</p>
<p>Category I Medicine Cardiovascular Cardiac Catheterization</p> <p>Contrast injection to image the access site(s) for the specific purpose of placing a closure device is inherent to the catheterization procedure and not separately reportable. Closure device placement at the vascular access site is inherent to the catheterization procedure and not separately reportable.</p> <p>Please see the cardiac catheterization table located on page 682746.</p> <p>93451 Right heart catheterization including measurement(s) of oxygen saturation and cardiac output, when performed</p> <p>Revise page number from “682” to “746” in the guidelines of the Medicine Cardiac Catheterization subsection.</p>	<p>Posted 12/01/2020 E</p>
<p>Category I Medicine Cardiovascular Cardiac Catheterization</p> <p>✚93462 Left heart catheterization by transseptal puncture through intact septum or by transapical puncture (List separately in addition to code for primary procedure)</p>	<p>Posted 6/07/2021 T</p>

►(Use 93462 in conjunction with 33741, 33745, 33477, 93452, 93453, 93458, 93459, 93460, 93461, 93582, 93653, 93654)◀

(Use 93462 in conjunction with 93590, 93591 for transapical puncture performed for left heart catheterization and percutaneous transcatheter closure of paravalvular leak)

(Do not report 93462 in conjunction with 93590 for transeptal puncture through intact septum performed for left heart catheterization and percutaneous transcatheter closure of paravalvular leak)

(Do not report 93462 in conjunction with 93656)

(Do not report 93462 in conjunction with 0345T, 0544T unless transapical puncture is performed)

Injection Procedures

✚93563 Injection procedure during cardiac catheterization including imaging supervision, interpretation, and report; for selective coronary angiography during congenital heart catheterization (List separately in addition to code for primary procedure)

►(Use 93563 in conjunction with 33741, 33745, 93530-93533, 93582)◀

✚93564 for selective opacification of aortocoronary venous or arterial bypass graft(s) (eg, aortocoronary saphenous vein, free radial artery, or free mammary artery graft) to one or more coronary arteries and in situ arterial conduits (eg, internal mammary), whether native or used for bypass to one or more coronary arteries during congenital heart catheterization, when performed (List separately in addition to code for primary procedure)

►(Use 93564 in conjunction with 93530-93533, 93582)◀

(Do not report 93563, 93564 in conjunction with 33418, 0345T, 0483T, 0484T, 0544T, 0545T for coronary angiography intrinsic to the valve repair or annulus reconstruction procedure)

✚93565 for selective left ventricular or left atrial angiography (List separately in addition to code for primary procedure)

(Do not report 93563-93565 in conjunction with 93452-93461)

►(Use ~~93563~~ 93565 in conjunction with 33741, 33745, 93530-93533, 93582)◀

✚93566 for selective right ventricular or right atrial angiography (List separately in addition to code for primary procedure)

►(Use 93566 in conjunction with 33741, 33745, 93451, 93453, 93456, 93457, 93460, 93461, 93530-93533, 93582)◀

(Do not report 93566 in conjunction with 33274 for right ventriculography performed during leadless pacemaker insertion)

(Do not report 93566 in conjunction with 0545T for right ventricular or right atrial angiography procedures intrinsic to the annulus reconstruction procedure)

✚93567 for supravalvular aortography (List separately in addition to code for primary procedure)

►(Use 93567 in conjunction with 33741, 33745, 93451-93461, 93530-93533)◀

(For non-supravalvular thoracic aortography or abdominal aortography performed at the time of cardiac catheterization, use the appropriate radiological supervision and interpretation codes [36221, 75600-75630])

<p>✚93568 for pulmonary angiography (List separately in addition to code for primary procedure)</p> <p>► (Use 93568 in conjunction with <u>33741, 33745</u>, 93451, 93453, 93456, 93457, 93460, 93461, 93530-93533, 93582, 93583) ◀</p> <p>(Do not report 93568 in conjunction with 0632T)</p> <p>Add and revise parenthetical notes throughout the Cardiac Catheterization subsection.</p>	
<p>Index Excision Cyst Ileum Wing..... 27065-27067</p> <p>Revise term “Ileum” to “Ilium” by removing the “e” and adding the “i” in the CPT Index.</p>	<p>Posted 5/03/2021 E</p>
<p>Index Release Tendon.....24332, 25295 Vitreous.....67015 Vitreous.....67015</p> <p>Outdent the term “Vitreous” in the CPT Index.</p>	<p>Posted 6/07/2021 E</p>
<p>Short Descriptor Data File</p> <p>29806 SHO ARTHRS SRG CAPSULORPRAPHY</p> <p>80189 DRUG ASSAY ITRACONZAZOLE</p> <p>Revise the medium descriptor data file for codes 29806 and 80189.</p>	<p>Posted 10/01/2020 E</p>
<p>Medium Descriptor Data File</p> <p>80189 DRUG ASSAY ITRACONZAZOLE</p> <p>Revise the medium descriptor data file for code 80189.</p>	<p>Posted 10/01/2020 E</p>
<p>Medium Descriptor Data File</p> <p>87426 IAAD IA SEVERE AQT RESPIR SYND CORONAVIRUS</p> <p>Revise the medium descriptor data file to add a space after “AQT” and “RESPIR” for code 87426 and denote “T” to “E” for publication errata.</p>	<p>Posted 11/02/2020 TE</p>
<p>Long Descriptor Data File</p> <p>33745 Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum,</p>	<p>Posted 4/01/2021 E</p>

Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); initial intracardiac shunt

33746 Transcatheter intracardiac shunt (TIS) creation by stent placement for congenital cardiac anomalies to establish effective intracardiac flow, including all imaging guidance by the proceduralist, when performed, left and right heart diagnostic cardiac catheterization for congenital cardiac anomalies, and target zone angioplasty, when performed (eg, atrial septum, Fontan fenestration, right ventricular outflow tract, Mustard/Senning/Warden baffles); each additional intracardiac shunt location (List separately in addition to code for primary procedure)

Revise the long descriptor data file for codes 33745 and 33746.