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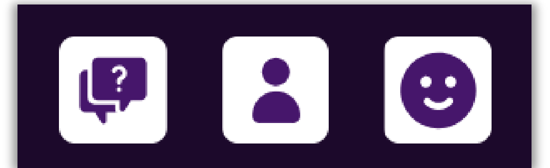

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Thanks for joining us today—see you at 11 a.m. CT!

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CPT® Content in Action: How to Build Coding Expertise With AMA Resources

July 1, 2025

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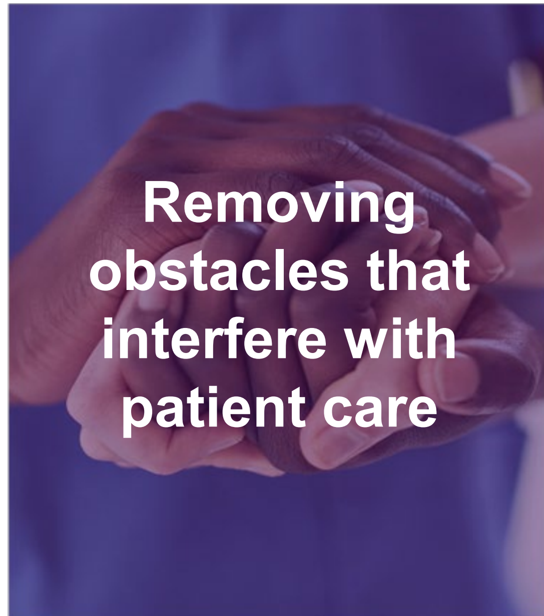
AMA: The Physicians' Powerful Ally in Patient Care



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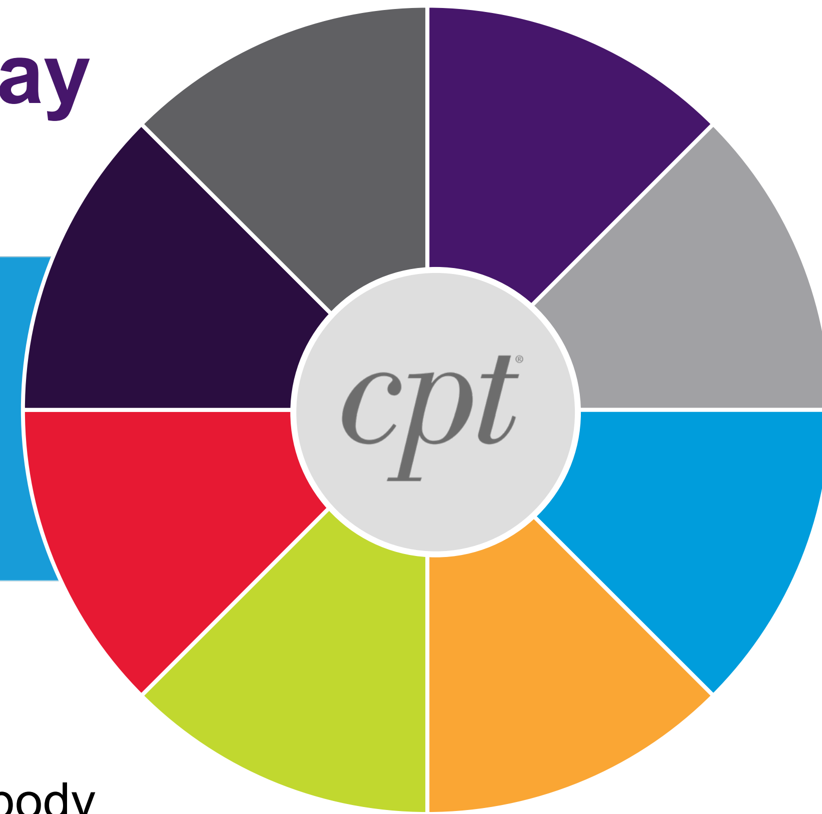
CPT®: The Language of Medicine Today
The Code to Its Future



Current Procedural Terminology (CPT®): a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians and other qualified healthcare professionals.

- Provides a uniform language that accurately describes medical, surgical and diagnostic services
- Managed by the independent CPT Editorial Panel: a 21-member body convened by the AMA
- Accepted medical nomenclature, used across the health care ecosystem, to accurately describe and record the clinical care delivered to patients, regardless of the care delivery or payment model

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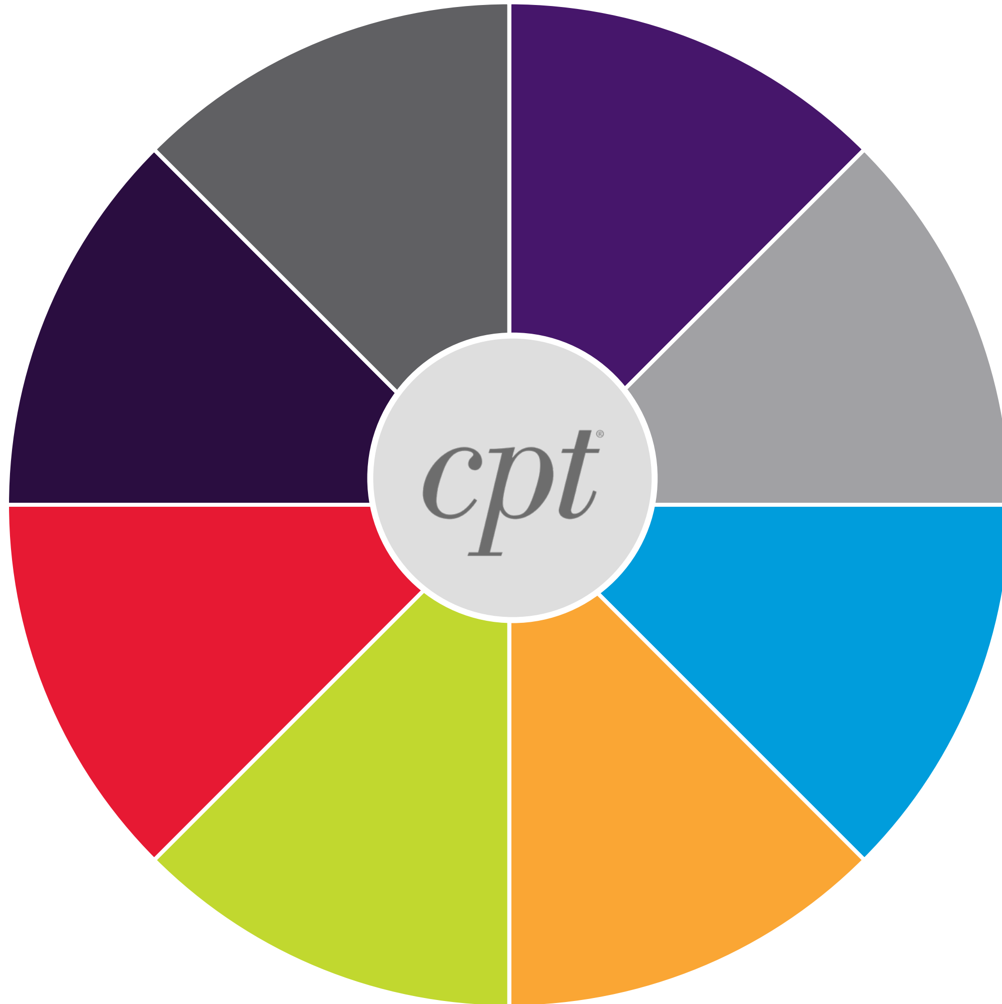
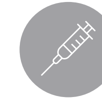
The Importance of CPT® Codes Within the Health Care Ecosystem



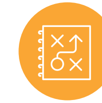
Medical Code Set Terminology Standard

Claims-Based Reporting


Preventive Medicine

AI/Digital Medicine

Quality Management


Alternative Payment Models

Interoperability

Research

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Coding Questions Need Trusted Answers

80–87%*

of medical coders surveyed by the AMA indicated that they consistently have questions in the course of their work

*This data is the result of a survey medical coders who attended the CPT® & RBRVS Annual Symposium in 2023.

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Agenda

Today we will cover:

- What's inside the AMA's core CPT® resources
- How to use CPT resources to gain clarity within a variety of coding scenarios
- Q&A with our CPT experts
- Educational opportunities on the horizon

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CPT® Content in Action

Leslie Prellwitz, MBA, CCS, CCS-P
Director of CPT Content Management & Development
American Medical Association

Charniece J. Martin, MBA, RHIA, CCS, CCS-P, CRCR
Senior Manager of CPT Education
American Medical Association

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Core CPT® Resources

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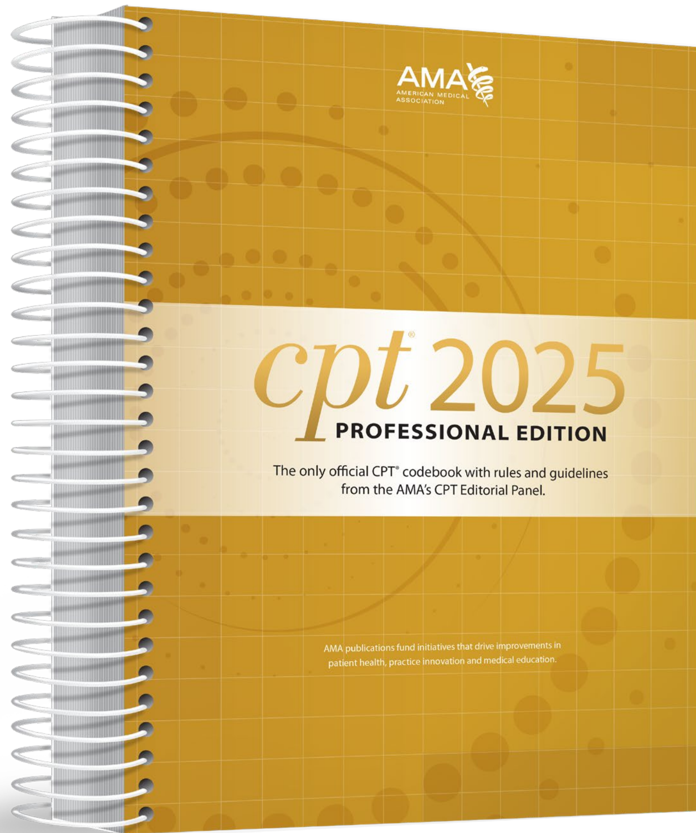
CPT® 2025 Professional Edition

The only official CPT codebook with rules and guidelines from the AMA's CPT Editorial Panel.



Key Features

- **Cross-referenced citations** (*CPT Changes*, *CPT Assistant* and *Clinical Examples in Radiology*) — Enhance understanding with links to popular AMA resources.
- **Comprehensive index** — Quickly find codes by procedure, service, anatomy, condition or abbreviation.
- **Anatomical and procedural illustrations** — Improve coding accuracy with visual aids.
- **Overall and section-specific table of contents** — Easily navigate the entire codebook and its subsections.
- **Code changes summary** — View all additions, deletions and revisions in the CPT 2025 code set for quick reference.
- **Multiple appendices** — Access extra guidance on modifiers, add-on codes, AI taxonomy, telemedicine services and more.
- **E/M code selection tables** — Simplify choosing the correct evaluation and management codes.
- **Notes pages** — Jot down important details in designated areas at the end of sections.

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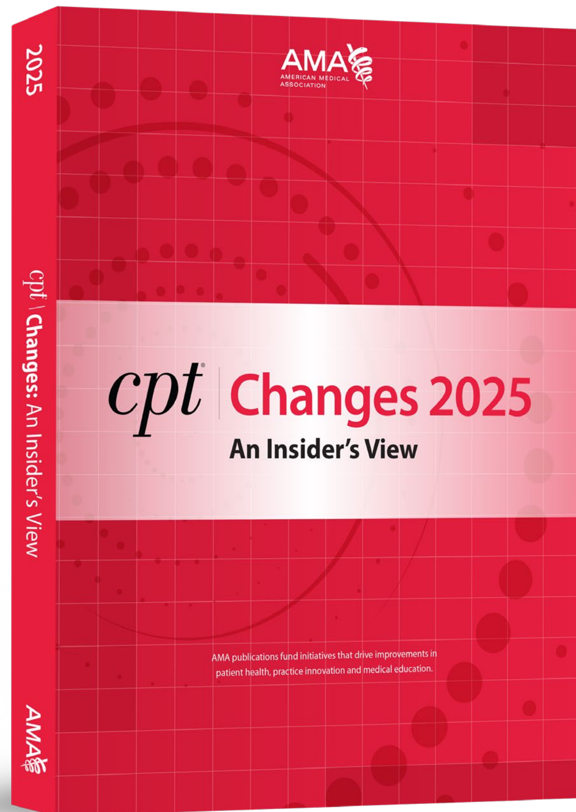
CPT® Changes 2025: An Insider's View

The only codebook with official AMA rationales.



Key Features

- **Organizational structure matches the CPT codebook** — Allows coders to easily conduct a side-by-side read of *CPT Changes* with the *CPT Professional.*
- **Official AMA rationales** — Provide detailed explanations for the code or guideline changes.
- **Clinical examples, procedural descriptions and tables** — Help explain the practical application for each change.
- **At-a-glance summary table of the 2025 changes in each section** — Shows the extent of all changes for the section and specialty.

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Audience Poll #1

Which format do you prefer for your CPT® coding resources?

- Print book – Spiral bound
- Print book – Soft bound
- Print book and eBook
- EMR / encoder / RCM system
- Print book and EMR / encoder / RCM system

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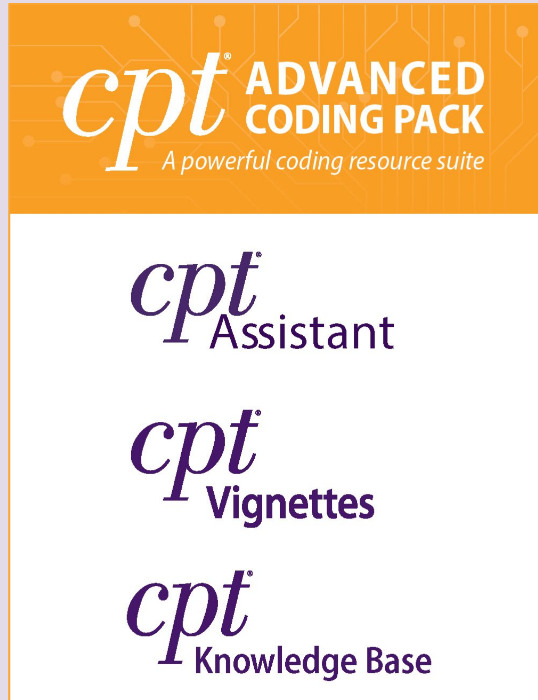
CPT® Advanced Coding Pack



The CPT Advanced Coding Pack, a powerful coding resource suite, combines the trusted foundation of CPT® Vignettes* with the invaluable insights of *CPT® Assistant* and the dynamic contents of CPT® Knowledge Base.*

* For distributors, CPT Knowledge Base and CPT Vignettes are exclusively included in the CPT Advanced Coding Pack and are not available separately. Features and functions of the product may be subject to change.

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CPT® Assistant

THE OFFICIAL CPT CODING GUIDANCE

Navigate the complexities of medical coding effectively with the official source for CPT® coding guidance.

Key Features

- **Incorporate expert guidance**: Integrate more than 1,950 expert articles and Q&As into your training sessions, learning management systems and appeals packets, enhancing your team's knowledge and proficiency in CPT coding.
- **Expert insights:** Benefit from expert explanations reviewed and vetted by the CPT Assistant Editorial Board. Gain valuable insights and understand the “why” to promote proper coding.
- **Expanded coverage:** Now includes *Clinical Examples in Radiology* content—updated quarterly with archived issues dating back to 2002.
- **Curated for excellence:** This resource is authored by physicians and experts to address key topics that require explanation and insight, making the coding journey smoother and convenient.

Typical Use Case

***CPT® Assistant* contains over 30 years of educational content**, updated monthly to provide detailed explanations, coding tips and clinical examples for the proper application of CPT codes.

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CPT® Knowledge Base

Q&A OF CPT CODING

Access authoritative answers to a wide range of coding questions to keep you informed.

Key Features	Typical Use Case
• **A centralized database of over 4,000 commonly asked coding questions** thoughtfully answered by CPT® experts and meticulously curated to inform precise medical coding across the spectrum of specialties. • **Trusted guidance from AMA experts** which include the CPT Assistant Editorial Board and the AMA CPT Advisory Committee. • **Stay ahead of the curve with the latest industry knowledge**	CPT® Knowledge Base responses provide answers to detailed, **specific questions and scenarios from across the CPT ecosystem**.

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cpt® Vignettes

COMPLETE SERVICE DESCRIPTIONS

Excel at the art of precise medical coding with comprehensive CPT® code clinical examples.

Key Features	Typical Use Case
• **Over 5,500 expertly crafted CPT® Vignettes** for detailed insights into specific CPT codes. • **Continuously updated with 300–400 new vignettes each year** to reflect the evolving medical landscape. • **Real-world examples for navigating complex coding decisions**. • **Concise and comprehensive descriptions of the services or procedures** involved in each CPT code to support accurate coding.	CPT Vignettes provide the **authoritative clinical coding scenario** and comprehensive descriptions of the services or procedures involved in each CPT code for the typical patient, providing clarity on the intended use of the CPT code for end users.

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How AMA Resources Work for Coders: Several CPT® Code Examples

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Audience Poll #2

According to CMS, which Evaluation and Management (E/M) code accounted for the highest amount of projected improper payments for FY 2024 as a result of insufficient documentation or incorrect coding?

1. **99214,** OFFICE/OUTPATIENT ESTABLISHED MOD MDM 30 MIN
2. **99223**, 1ST HOSPITAL IP/OBS CARE HIGH MDM 75 MINUTES
3. **99285**, EMERGENCY DEPARTMENT VISIT HIGH MDM
4. **99291**, CRITICAL CARE ILL/INJURED PATIENT INIT 30-74 MIN

Source: 2024 Medicare Fee-forService Supplemental Improper Payment Data. U.S. Department of Health and Human Services. *www.cms.gov/files/document/2024-medicare-fee-service-supplemental-improper-payment-data.pdf*. Last accessed May 23, 2025.

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CPT® CODE 99214

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CPT® CODE 99214

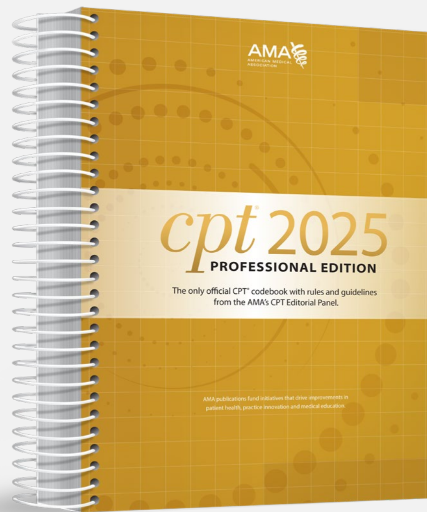
What is the CPT coding scenario?

The provider I work for previously received a message from a patient mentioning they've had a cough, fever, chest tightness and extreme fatigue. After three days, the patient reached out again via the portal and the provider suggested the patient come into the office for an evaluation.

The patient comes in and the provider spends 20 minutes with the patient. During this visit, the patient also receives a B12 injection.

After reading through the note, the medical decision making (MDM) supports 99214, but the time doesn't. **Can I use a 99214 code then?**

Also, can I report the CPT code and the injection?



Evaluation and Management (E/M) Services Guidelines — CPT 2025

Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed at the Encounter	Amount and/or Complexity of Data to Be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
	Elements of Medical Decision Making		
Moderate	**Moderate** ■ **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or** ■ **2** or more stable, chronic illnesses; **or** ■ **1** undiagnosed new problem with uncertain prognosis; **or** ■ **1** acute illness with systemic symptoms; **or** ■ **1** acute, complicated injury	**Moderate** *(Must meet the requirements of at least 1 out of 3 categories)* **Category 1: Tests, documents, or independent historian(s)** ■ **Any combination of 3 from the following:** • Review of prior external note(s) from each unique source*; • Review of the result(s) of each unique test*; • Ordering of each unique test*; • Assessment requiring an independent historian(s) **or** **Category 2: Independent interpretation of tests** ■ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported); **or** **Category 3: Discussion of management or test interpretation** ■ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)	**Moderate risk of morbidity from additional diagnostic testing or treatment** *Examples only:* ■ Prescription drug management ■ Decision regarding minor surgery with identified patient or procedure risk factors ■ Decision regarding elective major surgery without identified patient or procedure risk factors ■ Diagnosis or treatment significantly limited by social determinants of health

99214 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using total time on the date of the encounter for code selection, 30 minutes must be met or exceeded.

Source: *CPT® 2025 Professional Edition*

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CPT® CODE 99214

I have two questions, let me look in CPT® Knowledge Base to see if I can get my questions answered.

The provider I work for previously received a message from a patient mentioning they've had a cough, fever, chest tightness and extreme fatigue. After three days, the patient reached out again via the portal and the provider suggested the patient come into the office for an evaluation.

The patient comes in and the provider spends 20 minutes with the patient. During this visit, the patient also receives a B12 injection.

After reading through the note, the medical decision making (MDM) supports 99214, but the time doesn't. **Can I use a 99214 code then?**

Also, can I report the CPT® code and the injection?

CPT® Knowledge Base (KB)

The CPT Knowledge Base contains questions and answers (Q & As) that address a variety of CPT coding topics, as well as clinical examples and descriptions of procedure (vignettes) for a given code.

To begin your search, type in a single keyword or a CPT code number. Note that you must enter one CPT code number at a time. If you wish to view a clinical example and description of procedure (vignette) for a specific CPT code, select this option. Vignettes have not been developed for all CPT codes; therefore, you may not obtain a match for the code you enter.

Search Criteria

Enter Keyword or CPT Code: 99214 Search

Content Type: KB QAs 9 / Clinical Examples/Description of Procedure 4

CPT Section: All CPT Sections (KB only)

CPT Sub-Sections: All CPT Sub-Sections

Filter by Year: 2015 2, 2019 1, 2020 1, 2021 1, 2022 3, 2024 1

Showing 1 - 9 of 9 Results

Tags	KB#	Publish Date	Section	Sub-Section	Question	Answer
Digital Medicine KB Exclusive	7925	10/30/2024	Medicine	Non-Face-to-Face Nonphysician Services	What is the difference between reporting established patient-initiated online digital services (non-face-to-face) codes 98970-98972 and 99421-99423?	The difference between reporting established patient-initiated Qualified No[...] Health Care Professional Online Digital Assessment and Management Servic[...] 98972 and established patient-initiated Online Digital Evaluation and Manag[...] codes 99421-99423 is determined by whether a physician/other qualified he[...] professional or a qualified nonphysician health care professional is providing[...] Qualified nonphysician health care professional online digital assessment a[...] services (98970-98972) are patient-initiated digital services with a qualified [...] health care professional. Online digital evaluation and management (E/M) s[...] 99422, 99423) are patient-initiated services with a physician or other qualified health care professional (QHP) who may report E/M services. Evaluation and Management Non-Face-to-Face Services #99421 Online digital evaluation and management service, for an established patien...
	7523	11/01/2022	Evaluation and Management	Office or Other Outpatient Services	Question: A patient presents with calf pain and the physician orders a STAT ultrasound to rule out deep vein thrombosis (DVT). Following the review of the test results, the physician later documents that the patient is stable enough that there is no concern for pulmonary embolism. Does this scenario meet a moderate MDM (99214, 99204) based on the number and/or complexity of problems addressed and risk of complications and/or morbidity or mortality of patient management due to the need to initiate or forego further testing, treatment, and/or hospitalization?	Answer: The risk and complexity does not change with the outcome of a diagnostic test. The level of risk would be based on the physician's initial assessment of the patient during the visit. Based on that assessment, which described a potential high risk of morbidity or mortality requiring the STAT ultrasound to evaluate for potential DVT, this would likely be moderate to high risk and should be documented accordingly in the patient's chart. For help in determining and selecting the appropriate code(s), refer to Table 2: Levels of Medical Decision Making (MDM) in the CPT 2022 code set. In addition, refer to the 2021 CPT® 2021 Errata and Technical Corrections, which is available at https://www.ama-assn.org/system/files/cpt-corrections-errata-2021.pdf for corrections and clarifications.
KB Exclusive	7517	10/05/2022	Evaluation	Office or Other	If multiple physicians with different specialties meet with a patient concurrently to discuss	No, special reporting is not required for concurrent care. The following exce[...]

Source: CPT Knowledge Base

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Physicians' powerful ally in patient care

CPT® CODE 99214

Not only did I clarify my questions…

but I also found an area of improvement!

Great news, based off my search, I can answer **both of my questions**. YES, I can bill a 99214 based on the MDM and I may need to use the 25 modifier on the E/M code to be able to bill for the visit and the injection.

Oh—one other thing I would have forgotten without the CPT® Knowledge Base article is the CPT code 96372, for the actual intramuscular injection, and I need to find the HCPCS code for the substance being injected.

cpt® Knowledge Base

KB #: 7241
Date: 04/05/2021

Evaluation and Management

Office or Other Outpatient Services

Question:
A physician documents 20 minutes of time, which supports E/M code 99213; however, the medical decision making (MDM) involved supports a moderate-level code (99214). May the higher-level code be reported because the MDM guidelines state to choose either total time on the date of the encounter or MDM?

Answer:
Yes, it is appropriate to report code 99214 if the MDM supports it. The selected methodology chosen should be based on the most appropriate and relevant elements for a given patient encounter. The choice to select a code level based on time or MDM will vary depending on the presenting concerns of the patient, the time spent, and the complexity of the encounter. The CPT E/M guidelines for office or other outpatient visits do not designate the advantages of either MDM or time. Instead, the code-level selection and the determination to use either time or MDM should reflect the time and level of services provided for the patient's presenting problem(s). Therefore, the code-level selection depends entirely on the nature of the visit.

Office or Other Outpatient Services

Tags: KB Exclusive

Question:
Can we report E/M codes along with an administration code for injections (eg 99214, J3420, 96372)? Is there a modifier/modifiers that could be used to show they are separate components at the same visit?

Answer:
The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed (e.g., skin lesion biopsy), the patient is condition required a significant, separately identifiable Evaluation and Management service above and beyond the other service provided or beyond the usual preoperative and postoperative care associated with the procedure that was performed. The physician must meet the key components listed in the code descriptor for a given level of E/M service. When reporting an E/M service on the same day as another procedure or service, modifier 25 should be appended to the Evaluation and Management Services code to identify this as a significant, separately identifiable service. The descriptor nomenclature of code 96372, Therapeutic, prophylactic, or diagnostic injection (specify substance or drug); subcutaneous or intramuscular, represents a single injection. The appropriate HCPCS Level II code for the supply of the drug may be reported in addition to reflect the drug administered.

Source: CPT Knowledge Base

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CPT® CODE 99214

Last step:

Making sure I understand the complexity of the CPT code

Now that my workflow for this scenario is established, I want to **understand** the typical patient for this CPT code and assess its complexity by reviewing the **CPT® Vignette.**

cpt® Vignettes

Vignette

Office visit for an established patient with a progressing illness or acute injury that requires medical management or potential surgical treatment.

Pre-Service

N/A

Intra-Service

Within 3 Days Prior to Visit: Review interval correspondence, referral notes, medical records, and diagnostic data generated since the last visit. Query the PMP, HIE, and other registries, as required. Communicate with other members of the health care team regarding the visit.

Day of Visit: Confirm patient's identity. Review the medical history form completed by the patient as well as the prior clinical note. Review vital signs obtained by clinical staff. Obtain a medically appropriate history, including the response to any treatment initiated or continued at the last visit. Update pertinent components of the social history, family history, review of systems, and allergies that have changed since the last visit. Reconcile the medication list. Perform a medically appropriate examination. Synthesize the relevant history, physical examination, and data elements to formulate one or more differential diagnoses, diagnostic strategies, or treatment plans (requiring moderate level of MDM), consulting point of care resources as needed. Discuss the diagnoses, workup options, and treatment options (including the risks, complications, and alternatives of medical and surgical treatments) with the patient and family, incorporating their values in creation of the plan. Provide patient education and respond to questions from the patient and/or family. Electronically prescribe medications, making changes as needed based on payer formulary. Arrange diagnostic testing and referral if necessary. Document the encounter in the medical record, spending time to further refine the differential diagnosis, workup, or treatment plan as necessary. In concert with the clinical staff, complete prior authorizations for medications and other orders, when performed. Coordinate care by discussing the case with other physicians and members of the health care team and write letters of referral if necessary. Perform electronic data capture and reporting to comply with quality payment program and other electronic mandates.

Within 7 Days After Visit: Answer follow-up questions from patient and/or family and respond to treatment failures or complications, or adverse reactions to medications that may occur within 7 days after the visit. Review and analyze interval testing results and refine the differential diagnosis, workup, and treatment plan based on these results. Order additional testing based on these results. Communicate results and plan modifications with patient and/or family. Respond to queries from the pharmacy regarding changes in medications due to formulary or other issues.

Post-Service

N/A

Source: CPT Vignettes via RBRVS DataManager Online

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CPT® CODE RANGE 49186–49190

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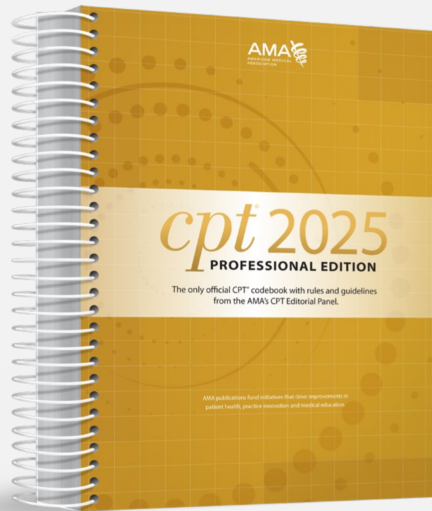
CPT® CODE RANGE 49203–49205

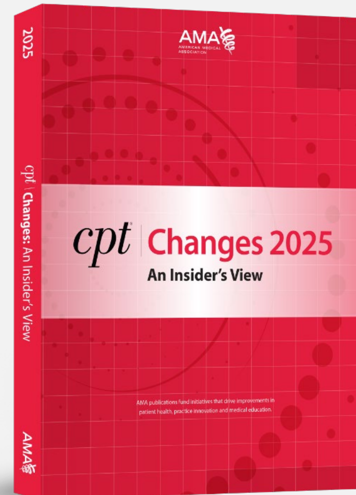
What is the CPT coding scenario?

I have been using the same codes for **tumor excision of the abdomen** for the last 30 years, and they were deleted.

Now, how do I decide?

What are the best resources and how do I start?





cpt Vignettes

cpt Assistant

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CPT® CODE RANGE 49203–49205

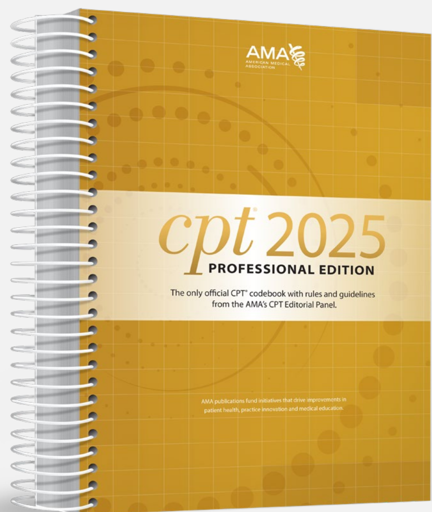
What is the CPT coding scenario?

I have been using the same codes for **tumor excision of the abdomen** for the last 30 years, and they were deleted.

Now, how do I decide?

Excision, Tumor

Thorax
Tumor 21552, 21554-21556
Thromboendarterectomy
See Thromboendarterectomy
Thrombus
See Thrombectomy
Thymus Gland 60520-60522
Thyroglossal Duct
Cyst 60280, 60281
Thyroid Gland
See also Thyroidectomy
Lobectomy
Partial 60210, 60212
Total 60220, 60225
Tumor 60200
Tibia 27360, 27640
Cyst 27635, 27637, 27638
Osteochondral Defect 29891
Tumor 27635, 27637, 27638
Toe
Lesion 28092
Tumor 28039, 28041, 28043, 28045, 28175
Tongue
See also Glossectomy
Lesion 41110, 41112-41114
Lingual Frenum 41115
Tonsils 42820, 42821, 42825, 42826
Lingual 42870
Radical Resection 42842, 42844, 42845
Tag 42860
Torus Mandibularis 21031
Trachea
Stenosis and Anastomosis 31780, 31781
Tumor 31785, 31786
Tricuspid Valve 33460
Tumor
Abdomen 49186-49190
Abdominal Wall 22900-22903



Index

Find Procedure or Service

Navigate to Location

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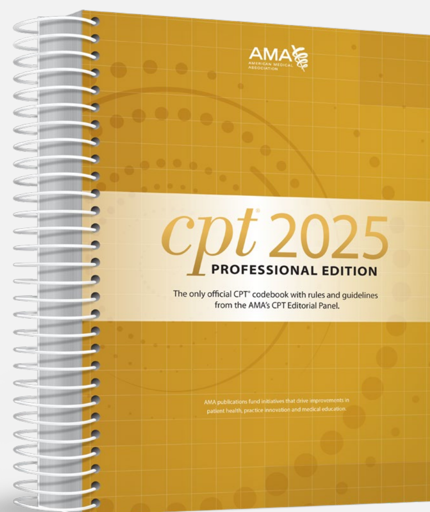
CPT® CODE RANGE 49186–49190

Wow, now they’re 5 new codes, to replace the 3

I have identified the new code range, but now I need to understand the **section and subsection guidelines.**



▶Codes 49186, 49187, 49188, 49189, 49190 describe excision or destruction of intra-abdominal primary or secondary tumor(s) or cyst(s) via an open approach. Excision or destruction of intra-abdominal primary or secondary tumor(s) or cyst(s) via an open approach includes cytoreduction, debulking, or other methods of removal of the tumor(s) or cyst(s). Codes 49186, 49187, 49188, 49189, 49190 are reported based on the sum of the maximum length of each tumor or cyst excised or destroyed (eg, ultrasound desiccation). Only the tumor(s) and cyst(s) are measured, not the tissue (eg, mesentery) in which the tumor(s) and cyst(s) may be implanted. If only a portion of a tumor or cyst is excised or destroyed, then only the excised or destroyed portion is measured. The tumor(s) and cyst(s) should be measured in situ before excision or destruction and documented in the operative report. Measurement includes only the tumor(s) and cyst(s) and not the margins. Codes 49186, 49187, 49188, 49189, 49190 are reported when the resected or destroyed intra-abdominal tumor(s) and cyst(s) do not directly arise from a resected organ (eg, small bowel mass, renal mass, liver mass) or soft tissue that may be separately reportable. When the tumors arise directly from an organ or soft tissue, only the organ or soft tissue resection or destruction procedure code from which the tumors arise is reported. For example, if a partial ascending colon resection, including small tumor implants, is performed and a separate excision of multiple small tumor implants in the mesentery of the descending colon is also performed, the appropriate colectomy code (eg, 44140) would be reported for the partial ascending colon resection and the excision of the tumor implants in the mesentery of the descending colon would be separately reported with an appropriate tumor excision code (49186, 49187, 49188, 49189, 49190). The implants that were part of the ascending colon resection would not be included in the measurement for reporting the tumor excision code (49186, 49187, 49188, 49189, 49190).

Open resection of recurrent ovarian, endometrial, tubal, or primary peritoneal gynecological malignancies without lymphadenectomy should be reported with 49186, 49187, 49188, 49189, 49190. All other open resection of initial or recurrent ovarian, endometrial, tubal, or primary peritoneal gynecologic malignancies should be reported with 58943, 58950, 58951, 58952, 58953, 58954, 58956, 58958, 58960.◀

● **49186** Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 5 cm or less
CPT Changes: An Insider's View 2025

● **49187** 5.1 to 10 cm
CPT Changes: An Insider's View 2025

● **49188** 10.1 to 20 cm
CPT Changes: An Insider's View 2025

● **49189** 20.1 to 30 cm
CPT Changes: An Insider's View 2025

● **49190** greater than 30 cm
CPT Changes: An Insider's View 2025

▶(Do not report 49186, 49187, 49188, 49189, 49190 in conjunction with 49000, 49010, 49215, 58943, 58950, 58951, 58952, 58953, 58954, 58956, 58958, 58960)◀

Source: *CPT® 2025 Professional Edition*

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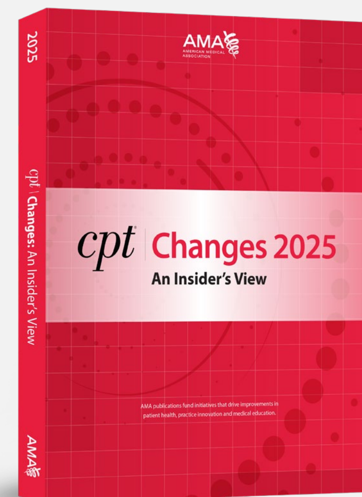
CPT® CODE RANGE 49186–49190

Revised CPT code? Where do I find more information?

1. Check your *CPT® 2025 Professional Edition* codebook.
2. **Check *CPT® Changes 2025: An Insider's View* to find the official AMA rationale.**
3. Validate understandings with CPT® Vignettes.



● 49186 Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 5 cm or less

● 49187 5.1 to 10 cm

● 49188 10.1 to 20 cm

● 49189 20.1 to 30 cm

● 49190 greater than 30 cm

►(Do not report 49186, 49187, 49188, 49189, 49190 in conjunction with 49000, 49010, 49215, 58943, 58950, 58951, 58952, 58953, 58954, 58956, 58958, 58960)◄

►(For excision of perinephric cyst, use 50290)◄

►(49203, 49204, 49205 have been deleted. For open excision or destruction of intra-abdominal [ie, peritoneal, mesenteric, retroperitoneal] primary or secondary tumor[s] or cyst[s], see 49186, 49187, 49188, 49189, 49190)◄

Rationale

Codes 49203-49205 and 58957 and their related parenthetical notes have been deleted, and Category I codes 49186-49190 have been established to report open excision or destruction of intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal) primary or secondary tumors or cysts. In addition, guidelines and parenthetical notes have been added and revised to provide instruction regarding intended reporting and to accommodate the addition of the new codes. This procedure is for peritoneal surface malignancies (PSMs), which are terminal cancers with limited therapeutic options.

To accommodate the development of the new codes, codes 49203-49205, which are based on the excision or destruction of the single largest tumor, have been deleted.

The guidelines provide specific instructions on how codes 49186-49190 may be reported, which includes reporting based on the sum of the maximum length of each tumor or cyst excised or destroyed (eg, ultrasound desiccation) and not the tissue (eg, mesentery) in which the tumor(s) and cyst(s) may be implanted. In addition, if only a portion of a tumor or cyst is excised or destroyed, only the excised or destroyed portion is measured. The tumor(s) and cyst(s) should be measured in situ before the excision or destruction, and the measurements should not include the margins. Finally, if both an organ and tumor(s) are removed as part of the procedural resection, then any tumor removed as part of the organ removal is not separately reported. If a separate resection is performed that requires separate efforts to remove the tumor, that tumor resection may be separately reported using the new codes.

Cross-reference parenthetical notes have been added and revised throughout the CPT 2025 code set to accommodate the addition of the new codes by directing users to the appropriate codes for other procedures and clarifying when other codes may or may not be reported. Parenthetical notes have also been added to direct users to the appropriate codes to report for deleted codes that are now obsolete.

Source: *CPT Changes 2025: An Insiders View*

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CPT® CODE 49203 & 49186

New CPT code?
Where do I find more information?

1. Check your CPT® *2025 Professional Edition* codebook.
2. Check CPT® *Changes 2025: An Insider's View* to find the official AMA rationale.
3. **Validate understandings with CPT® Vignettes.**

	49203	49186
Intra-Service	…..Inspect the small bowel mesentery and palpate for the presence of lymphadenopathy. Inspect and palpate the cecum; appendix; and ascending, transverse, and descending colon. Inspect and palpate the cul-de-sac and pelvic contents. Carefully insert a self-retaining retractor while avoiding injury or entrapment of abdominal contents. Confirm the location and extent of the primary lesions. Pack away the abdominal contents, to the exclusion of the right colon, using laparotomy pads and place additional retractors for optimal exposure. Mobilize the right colon lateral to medial by incising the line of Toldt. Resect individually three 2- to 3-cm implanted masses using cautery. During this dissection, identify the right ureter and place a vessel loop for continual identification and protection of the ureter. In addition, four other 1-cm nodules are identified in the paracolic gutter. Resect each of them individually using electrocautery. Irrigate the abdominal cavity copiously with antibiotic solution. Obtain hemostasis. Inspect the abdomen for injury and the presence of any instruments or lap pads (ie, a first count is made). Remove and account for the retractor components. Return the abdominal organs to normal anatomical position. Drape the omentum over the abdominal contents. Close the fascia with running suture. Conduct a second instrument, needle, sponge, and lap pad count. Irrigate and approximate the subcutaneous tissues and close the skin.	…..Inspect the small bowel mesentery and palpate for the presence of lymphadenopathy. A large mass is identified in the mesentery of the distal small bowel. Inspect and palpate the cecum and appendix, ascending, transverse, and descending colon. Inspect and palpate the cul-de-sac and pelvic contents. Carefully insert a self-retaining retractor, while avoiding injury or entrapment of abdominal contents. Confirm the location and extent of the primary lesion. Pack away the abdominal contents, with the exclusion of the right colon, using laparotomy pads, and place additional retractors for optimal exposure. Mobilize the right colon and distal small bowel lateral to medial by incising the line of Toldt. Identify the small bowel mesentery containing the mass and the corresponding loop of small bowel. Resect the 4-cm mass along with the corresponding mesentery, avoiding division of the blood supply to the corresponding small bowel loop and right colon. During this dissection, identify the right ureter and place a vessel loop for continual identification and protection of the ureter. Irrigate the abdominal cavity copiously with antibiotic solution. Obtain hemostasis. Inspect the abdomen for injury and the presence of any instruments or lap pads (ie, conduct a count). Remove and count all the retractor components to ensure all components are accounted for. Return the abdominal organs to normal anatomical position. Drape the omentum over the abdominal contents. Place drain(s) as required. Close the fascia with running suture. Conduct a second count of the instrument, needle, sponge, and lap pad. Irrigate and approximate the subcutaneous tissues and close the skin.

cpt® Vignettes

Source: CPT Vignettes

CPT® CODE 49186–49190

Has the AMA released any CPT Assistant articles on this?

1. Wherever I view my *CPT® Assistant* content, I search by **49186.**
2. **Here is an article from February 2025, recently released from the AMA, exactly on this topic.**

Reporting Intra-Abdominal Tumor Excision or Destruction (49186-49190, 58958)

For the Current Procedural Terminology (CPT®) 2025 code set, codes 49203-49205 and 58957 and their related parenthetical notes were deleted, and codes 49186-49190 were created to report the open excision or destruction of intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal) primary or secondary tumors or cysts. Code 58958 was revised by removing the semicolon because it is no longer a child code with the deletion of code 58957. In addition, guidelines and parenthetical notes were added and revised to accommodate the addition of the new codes and to provide guidance regarding their intended reporting. Refer to the CPT 2025 code set for more detailed information regarding these codes. This article provides an overview of these changes and the intent and use of these codes.

Digestive System

Excision, Destruction

● **49186** Excision or destruction, open, intra-abdominal (ie, peritoneal, mesenteric, retroperitoneal), primary or secondary tumor(s) or cyst(s), sum of the maximum length of tumor(s) or cyst(s); 5 cm or less

● **49187** 5.1 to 10 cm

● **49188** 10.1 to 20 cm

● **49189** 20.1 to 30 cm

Current Procedural Terminology (CPT®) is copyright 2025 by the American Medical Association. All rights reserved.

● **49190** greater than 30 cm

►(Do not report 49186, 49187, 49188, 49189, 49190 in conjunction with 49000, 49010, 49215, 58943, 58950, 58951, 58952, 58953, 58954, 58956, 58958, 58960)

►(For excision of perinephric cyst, use 50290)◄

►(49203, 49204, 49205 have been deleted. For open excision or destruction of intra-abdominal [ie, peritoneal, mesenteric, retroperitoneal] primary or secondary tumor[s] or cyst[s], see 49186, 49187, 49188, 49189, 49190)◄

►(For excision or destruction of endometriomas, open method, use 58999)◄

Codes 49203-49205, which were reported based on the excision or destruction of the largest tumor, were deleted to accommodate the establishment of codes 49186-49190.

Subsection guidelines were added to clarify how to report codes 49186-49190 based on the sum of the maximum length of each tumor or cyst excised or destroyed (eg, ultrasound desiccation), which should not include the tissue (eg, mesentery) in which the tumor(s) and cyst(s) were embedded. According to the guidelines, the tumor(s) and cyst(s) should be measured in situ before the excision or destruction. If only a portion of a tumor or cyst is excised or destroyed, only the excised or destroyed portion is measured, and the measurements should not include the margins. If both an organ and tumor(s) are removed as part of the resection, any tumor(s) removed as part of the organ removal is not separately reported. In contrast, if a separate resection that requires distinctly separate efforts to remove the tumor is performed, then the tumor resection may be separately reported using the new codes.

Cross-reference parenthetical notes were added and revised throughout the CPT 2025 code set to accommodate the addition of these new codes, to direct users to the appropriate codes for other

procedures, and to clarify when other codes may or may not be reported. In addition, parenthetical notes were added to direct users to the appropriate codes in place of the deleted codes.

Coding Tip

An open resection of recurrent ovarian, endometrial, tubal, or primary peritoneal gynecological malignancies without lymphadenectomy may be reported with codes 49186-49190. All other open resections of initial or recurrent ovarian, endometrial, tubal, or primary peritoneal gynecological malignancies should be reported with code 58943, 58950-58954, 58956, 58958, or 58960. For an open excision or destruction of endometriomas, report code 58999.

Source: *CPT Assistant February / Volume 35 (02) 2025*

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CPT® CODE RANGES 93886–93888 and 93896–93898

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CPT® CODE RANGES 93886–93888 and 93896–93898

What is the CPT coding scenario?

The provider performed a **Transcranial Doppler** study on **two** territories of the brain, what is the correct CPT code?

Also, is there an additional code to highlight that the provider also performed a **vasoreactivity study** during the TCD study? Previously I would have used 93890 but that was deleted in 2025.

cpt Assistant

cpt Knowledge Base

cpt Vignettes

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CPT® CODE RANGES 93886–93888 and 93896–93898

Has the AMA released any *CPT® Assistant* articles on this?

I’m going to start in the resource I know best, ***CPT® Assistant*** and **CPT® Knowledge Base** within my encoder. I have limited time per encounter, so I would prefer to not context-switch between platforms.

cpt® Assistant

cpt Assistant
Official source for CPT coding guidance

AMA CPT®Assistant and Clinical Examples in Radiology

93890 | Search

Time frame | All articles

1 Article

Reporting New Transcranial Doppler Study Codes (93896-93898)
CPT Assistant, January, 2025

Reporting New Transcranial Doppler Study Codes (93896-93898)

For the CPT 2025 code set, significant changes were made in the Cerebrovascular Arterial Studies subsection due to the American Medical Association (AMA)/Specialty Society Relative Value Scale (RVS) Update Committee (RUC) Relativity Assessment Workgroup (RAW) screen for codes whose services are inherently performed together. It was determined that a coding solution was necessary to eliminate the duplicate reporting of services when a complete transcranial Doppler (TCD) study is performed with a vasoreactivity study, with an emboli detection but without intravenous microbubble injection, or with a venous-arterial shunt detection with intravenous microbubble injection. These changes include the establishment of three new codes (93896-93898), the deletion of code 93890, and the revision of code 93893 and the Cerebrovascular Arterial Studies subsection guidelines. This article provides an overview of these changes.

Noninvasive Vascular Diagnostic Studies

Cerebrovascular Arterial Studies

93886 Transcranial Doppler study of the intracranial arteries; complete study

93888 limited study

►(Do not report 93888 in conjunction with 93886, 93892, 93893, 93896, 93897, 93898)◄

►(93890 has been deleted. To report vasoreactivity study, use 93896)◄

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Source: CPT Assistant Mock-up of Encoder Example

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CPT® CODE RANGES 93886–93888 and 93896–93898

What about CPT® Knowledge Base?

I have now identified one answer out of my two questions. I know I must report 93896 for the vasoreactivity study.

How do I choose between the complete study and limited study for the **transcranial doppler study**? Let's see if someone else has asked this question in **CPT® Knowledge Base**.

And they have. Since the provider only did **two territories**, I would use CPT code 93888.

Search Criteria

Enter Keyword or CPT Code: 93886 Search

Content Type: KB QAs 2 / Clinical Examples/Description of Procedure 1

CPT Section: All CPT Sections (KB only)

CPT Sub-Sections: All CPT Sub-Sections

Filter by Year

Showing 1 - 2 of 2 Results

Tags	KB#	Publish Date	Section	Sub-Section	Question	Answer
KB Exclusive	8139	03/06/2025	Medicine	Noninvasive Vascular Diagnostic Studies	What is the appropriate way to report a complete transcranial Doppler study of intracranial arteries that has been performed on the same date of service as a vasoreactivity study?	A complete transcranial Doppler (TCD) study of intracranial arteries that is performed on the same date of service as a vasoreactivity study may be reported with code 93886, Transcranial Doppler study of the intracranial arteries; complete study, in conjunction with add-on code 93896, Vasoreactivity study performed with transcranial Doppler study of intracranial arteries, complete (List separately in addition to code for primary procedure).The guidelines for the Cerebrovascular Arterial Studies codes underwent updates for CPT 2025. Please see CPT ® Changes: An Insider's View 2025 for a comprehensive overview of those changes. Additional information may also be found in the January 2025 issue of CPT Assistant. Medicine Noninvasive Vascular Diagnostic Studies 93886 Transcranial Doppler study of the intracranial arteries; complete study 93888 limited study (Do not report 93888 in conjunction with 93886, 93892, 93893, 93896, 93...
KB Exclusive	8130	03/05/2025	Medicine	Neurology and Neuromuscular Procedures	What is the difference between a complete (93886) and a limited (93888) transcranial doppler study of the intracranial arteries?	The main difference between a complete transcranial doppler (TCD) study of intracranial arteries, represented by code 93886, Transcranial Doppler study of the intracranial arteries; complete study, and a limited TCD study of the intracranial arteries, represented by code 93888, Transcranial Doppler study of the intracranial arteries; limited study, is the number of territories being evaluated. A TCD study of intracranial arteries is a non-invasive ultrasound technique that uses high-frequency sound waves to detect conditions that affect blood flow to and within the brain utilizing acoustic windows that are areas of the skull where the bone is thin enough to allow ultrasound waves to pass through and reach the cerebral arteries. The procedure represented by code 93886 is a complete TCD study with a comprehensive evaluation of the right and left anterior circulation territories and the posterior circulation territory that includes the vertebral and basilar arteries, while a limited TCD ...

KB #: 8130
Date: 03/05/2025

Medicine

Neurology and Neuromuscular Procedures

Tags: KB Exclusive

Keywords: complete study, limited study, territories, transcranial doppler, ultrasound

Question:
What is the difference between a complete (93886) and a limited (93888) transcranial doppler study of the intracranial arteries?

Answer:
The main difference between a complete transcranial doppler (TCD) study of intracranial arteries, represented by code 93886, *Transcranial Doppler study of the intracranial arteries; complete study,* and a limited TCD study of the intracranial arteries, represented by code 93888, *Transcranial Doppler study of the intracranial arteries; limited study*, is the number of territories being evaluated. A TCD study of intracranial arteries is a non-invasive ultrasound technique that uses high-frequency sound waves to detect conditions that affect blood flow to and within the brain utilizing acoustic windows that are areas of the skull where the bone is thin enough to allow ultrasound waves to pass through and reach the cerebral arteries. The procedure represented by code 93886 is a complete TCD study with a comprehensive evaluation of the right and left anterior circulation territories and the posterior circulation territory that includes the vertebral and basilar arteries, while a limited TCD study, represented by code 93888, encompasses ultrasound evaluation of only one or two of the cerebral arteries previously mentioned.

Source: CPT Knowledge Base

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CPT® CODE RANGES 93886–93888 and 93896–93898

Reinforced learnings with CPT® Vignettes

Let's search across all three CPT codes to confirm that I completely understand CPT code 93886, 93888, and the new add-on code, 93896.

	93886	93888	93896
Intra-Service	Supervise patient preparation and performance of the test by the vascular technologist as needed. Review the recorded data, including demographics, vital signs, and blood gases. Scan the right and left anterior circulation territories and the posterior circulation territory to include vertebral arteries and basilar arteries. Compare with the findings from previous examinations. Document the normal and abnormal findings. Interpret the findings and provide clinical correlation of the findings based on the patient's history. Dictate, review, and approve the report.	Supervise the vascular technologist with patient preparation and test performance as needed. Review the recorded data, including demographics, vital signs, and blood gases. **Scan two or fewer of the following territories**: the right anterior circulation territory, the left anterior circulation territory, and/or the posterior circulation territory to include vertebral arteries and basilar arteries. Compare with the findings from previous examinations. Document normal and abnormal findings. Interpret the findings and provide clinical correlation of the findings based on the patient's history. Dictate, review, and approve the report.	Supervise the vascular technologist with patient preparation and performance of the TCD test as needed. Review clinical history in relation to the safety of administering carbon dioxide (CO_2) or acetazolamide. Review the recorded data, including demographics, vital signs, and blood gases. Scan the right and left anterior circulation territories and the posterior circulation territory to include vertebral arteries and basilar arteries. Compare with findings from prior examinations. Assist technologist with the identification of vessels to insonate. **Review acquired Doppler spectral waveforms, flow direction, mean systolic and diastolic flow velocities, depth of sampling, pulsatility index values, and capnometer values throughout the duration of the CO_2 administration in the resting values for the arterial segments studied**. Document procedure results. Integrate findings with clinical presentation to formulate and document examination interpretation.

Source: CPT Vignettes

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Where to Find Early Release CPT® Codes

Make sure you're using the most current code set with these AMA resources available on the AMA website:

- Category I immunization codes
- Category III codes
- Proprietary Laboratory Analyses (PLA) codes
- CPT errata & technical corrections

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Where to Find CPT® Educational Content

For the AMA's print coding resources, visit the AMA Store:

ama-assn.org/store

For the CPT® Advanced Coding Pack, visit the AMA Intelligent Platform:

ama-assn.org/cpt-coding-pack

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Next Steps

Save the date!

Prepare for 2026 at two virtual medical coding events:

- **CPT® & RBRVS 2026 Annual Symposium**, Nov. 19–21
- **AMA/ACDIS-AHIMA Outpatient CDI Workshop**, Nov. 18

Registration will open in late July—watch your inbox to participate!

Tell us what you think

Please complete our **post-webinar survey**.

Your feedback helps us deliver expert perspective on topics you want to learn more about.

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