

Disclaimer

Coding decisions should not be made based solely upon information within this study guide. All judgments impacting career, and/or an employer must be based upon individual circumstances including legal and ethical considerations, local conditions, payer policies within the geographic area, and new or pending government regulations, etc.

AAPC does not accept responsibility or liability for any adverse outcome from using this study program for any reason including undetected inaccuracy, opinion, and analysis that might prove erroneous or amended, or the coder's misunderstanding or misapplication of topics.

Application of the information in this text does not imply or guarantee claims payment. Inquiries of your local carrier(s)' bulletins, policy announcements, etc., should be made to resolve local billing requirements. Payers' interpretations may vary from those in this program. Finally, the law, applicable regulations, payers' instructions, interpretations, enforcement, etc., may change at any time in any particular area. Information in this program is solely based on CPT®, ICD-10-CM, and HCPCS Level II rules and regulations.

AAPC has obtained permission from various individuals and companies to include their material in this manual. These agreements do not extend beyond this program. It may not be copied, reproduced, dismantled, quoted, or presented without the expressed written approval of AAPC and the sources contained within.

No part of this publication covered by the copyright herein may be reproduced, stored in a retrieval system or transmitted in any form or by any means (graphically, electronically, or mechanically, including photocopying, recording or taping) without the expressed written permission from AAPC and the sources contained within.

Clinical Examples Used in this Study Guide

AAPC believes it is important in training and testing to reflect as accurate a coding setting as possible to students and examinees. All examples and case studies used in our study guides and exams are *actual*, *redacted* office visit and procedure notes donated by AAPC members.

To preserve the *real world* quality of these notes for educational purposes, we have not re-written or edited the notes to the stringent grammatical or stylistic standards found in the text of our products. Some minor changes have been made for clarity or to correct spelling errors originally in the notes, but essentially, they are as one would find them in a coding setting.

AMA Disclaimer

CPT® copyright 2018 American Medical Association (AMA). All rights reserved.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT®, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CPT® is a registered trademark of the AMA.

© 2018 AAPC

2233 South Presidential Drive, Suites F–C, Salt Lake City, Utah 84120

800-626-2633, Fax 801-236-2258, www.aapc.com

Updated 12/21/2018. All rights reserved.

ISBN 978-1-626886-421

CPC®, CIC™, COC™, CPC-P®, CPMA®, CPCO™, and CPPM® are trademarks of AAPC.

Contents

Chapter 1—Medical Terminology 1

Introduction.	1
Word Root.	1
Abbreviations.	2
Prefixes	5
Suffixes.	5

Chapter 2—ICD-10-CM. 9

Introduction.	9
Medical Necessity	9
ICD-10-CM Conventions and Terms.	10
Conventions	10
Table of Neoplasms	14
Table of Drugs and Chemicals	16
Adverse Effect.	16
Poisoning	16
Underdosing.	17
External Cause Codes.	18
Z Codes	18
Selecting the Correct ICD-10-CM Diagnosis.	20

Chapter 3—Payment Methodologies and the Outpatient Prospective Payment System 21

Introduction.	21
Billing for Outpatient Facilities.	21
Medicare Program Instructions.	21
Outpatient Hospital Departments	22
Hospital Emergency Department.	22
Outpatient Hospital Clinics.	22
Outpatient Therapy Departments.	22
Outpatient Cancer Center	22
Dialysis Services.	22
Outpatient Radiology Department.	23
Hospital Ambulatory Surgery Center (ASC) (Outpatient Facility).	23
Administrative Departments	23
Admitting Office	23
Health Information Management Department	23
Business Office.	24
Typical Outpatient Flow.	24
Other Types of Outpatient Facilities	24
Freestanding Ambulatory Surgical Centers	24
Teaching Hospitals	24
Graduate Medical Education	24
Comprehensive Outpatient Rehabilitation Facility (CORF).	25
Partial Hospitalization.	25

Inpatient Services	25
Compliance Plans for Hospitals	26
Privacy and Confidentiality.	26
The Outpatient Prospective Payment System	27
History	27
Status Indicators	28
ADDENDUM D1—FINAL OPPTS PAYMENT STATUS INDICATORS FOR CY	30
Ambulatory Payment Classification System	33
Example of APC Assignment by Category/Grouping	34
APC Structure.	35
Composite APCs.	35
Comprehensive APC Payment Groups (C-APCs)	37
Packaging	40
Revenue Codes.	40
Revenue Codes and CPT®.	41
Charge Description Master (CDM)	41
CDM Review Tasks	42
10 Steps to a Successful Chargemaster Review.	42
National Correct Coding Initiative	44
Transitional Pass-through Drugs and Devices.	45
Transitional Pass-through Devices.	46
New Technology APCs.	47
Partial Hospitalization Services.	48
Evaluation and Management Coding for Outpatient Facilities.	48
Hospital Emergency Departments.	49
Observation Services.	51
Outpatient Facility Reimbursement.	52
Inpatient Reimbursement-Medicare Severity Diagnostic Related Groups (MS-DRG)	53
Diagnostic Related Groups	53
Major Diagnostic Categories.	54
Inpatient Claim Form.	55
Prior Authorization and Concurrent Review	55
Advance Beneficiary Notice (ABN).	57
Proper Notice	57
ABN Timeliness.	57
Preparation of ABN.	58
Beneficiary Changes His or Her Mind	58
Patient Refusals	58
Routine ABN Notice	58
Period of Effectiveness	59
Emergency Treatment.	59
Standard ABN Forms	59
Categorical Denials	59
HCPCS Modifiers with ABN.	62
Medicare—Appeals Process	62
Quality Reporting (QR) Programs	64
Terminology	64

Chapter 4—HCPCS	73
Introduction	73
Level I HCPCS Codes—CPT® Codes	73
Procedure Code Assignment	73
HCPCS Level II—National Codes	73
HCPCS Modifiers	74
Conclusion	76
Chapter 5—CPT® Coding	77
Introduction	77
CPT® Format	77
Evaluation and Management	77
Anesthesia	77
Surgery	77
Radiology	78
Pathology and Laboratory	78
Medicine	78
Category II	78
Category III	78
Symbols	78
Guidelines	79
Subsection Guidelines	79
Appendices	80
Index	80
Format	81
Unlisted Procedure Codes	81
CPT® Coding Terminology	82
Coding Outpatient Hospital Claims	82
Chapter 6—CPT® Surgery	85
Introduction	85
Definition of Surgery	85
CPT® and Surgery	85
Unbundling	86
Types of Procedures	86
Diagnostic Services vs. Therapeutic Services	87
Coding from an Operative Report	88
Modifiers	89
APC Services and Procedures	92
Integumentary System	92
Coding Tips for the Integumentary System	92
Biopsies	92
Lesion Excisions	93
Documentation	93
Destructions	94
Repairs	94
Skin Tags	95
Skin Replacement Surgery	95
Breast	95

Musculoskeletal System	95
Arthrocentesis	96
Trigger Point Injections (20552–20553)	96
Aspiration/Injection: Joint Size	97
Fracture Care: Overview	97
Types of Fractures/Dislocations	98
Endoscopy/Arthroscopy (29800–29999)	100
Summary: Procedures	101
Respiratory System Checklist	102
Bronchoscopy	103
Cardiovascular System	103
Vascular System	104
Embolectomy/Thrombectomy	104
Sclerotherapy	106
Endovascular Revascularization	106
Ligation and Other Procedures	106
Digestive System	106
Endoscopy	106
Hernia Repair	107
Urinary System	108
Drainage of an Abscess	108
Excision	108
Introduction	109
Laparoscopy	109
Introduction	109
Cystourethroscopy	109
Genitourinary System	110
Incision and Drainage of Abscess	111
Vaginal Delivery, Antepartum, and Postpartum Care	113
Endocrine System	113
Nervous System	113
Endovascular Therapy	114
Neurostimulators	114
Reservoir/Pump Implantation (62360–62370)	114
Introduction/Injection of Anesthetic Agent (Nerve Block), Diagnostic or Therapeutic (64400–64530)	114
Peripheral Nerve	114
Destruction by Neurolytic Agent	115
Eye and Ocular Adnexa	115
Laceration Repairs	115
Ear	118
Introduction	118
Excision (69100–69155)	118
Foreign Body Removal (69200–69205)	119
Repair	119
Myringotomy (69420–69424)	119
Tympanostomy (69433–69436)	119
Mastoidectomy (69501–69511)	119
Operating Microscope	119

Chapter 7—Radiology 123

Introduction.....	123
Composite APCs	123
Sample of HCPCS Level I Codes	
Assigned to Composite APC 2016	124
Positions	124
Views	124
Technical vs. Professional Component	124
Laterality.....	125
Contrast Material	125
General Diagnostic Radiology	125
Computerized Tomography (CT).....	125
Magnetic Resonance Imaging (MRI).....	125
Magnetic Resonance Angiography (MRA).....	125
PET Scans	125
Chest (71045–71555).....	126
Gastrointestinal Tract (74210–74363)	126
Urinary Tract (74400–74485)	126
Tomography	126
Gynecological and Obstetrical (74710–74775).....	126
Vascular Procedures (75600–75893)	126
Transcatheter Procedures (75894–75989).....	126
Diagnostic Ultrasound Procedures (76506–76999).....	126
Obstetrical Pelvis (76801–76828)	127
Non Obstetrical Pelvis (76830–76857).....	127
Radiologic Guidance (77001–77022)	127
Radiation Oncology (77261–77799).....	127
Hospitals	127
Radiation Oncology Terminology	127
Initiation of Radiation Therapy.....	129
Therapeutic Radiology Simulation (77280–77299)	129
Medical Radiation Physics, Dosimetry, Treatment	
Devices, and Special Services (77295–77370).....	129
Isodose Plan (77306–77321).....	129
Brachytherapy Isodose Plan (77316–77318)	130
Treatment Devices (77332–77334)	131
Stereotactic Radiation	
Treatment Delivery (77371–77373).....	131
Radiation Treatment Delivery (77401–77425).....	132
Neutron Beam Treatment Delivery (77423)	133
Radiation Treatment Management (77427–77499)	133
Proton Beam Treatment Delivery (77520–77525)	134
Hyperthermia (77600–77615)	134
Clinical Brachytherapy (77750–77799)	134
Nuclear Medicine (78012–79999).....	134

Chapter 8—Pathology and Laboratory 137

Introduction.....	137
Modifiers Used in Laboratory and Pathology Services ...	137
Code Location	137

Organ or Disease Oriented Panels (80047–80081)	138
Drug Assay (80305–80377)	138
Therapeutic Drug Assays (80150–80377)	138
Evocative/Suppression Testing (80400–80439)	139
Consultations (Clinical Pathology) (80500–80502)	139
Urinalysis (81000–81099)	139
Molecular Pathology (81170–81471)	139
Tier 1 Molecular Pathology Procedures (81105–81383) ..	139
Tier 2 Molecular Pathology Procedures (81400–81408) ..	139
Multianalyte Assays with	
Algorithmic Analyses (81490–81599)	139
Chemistry (82009–84999).....	139
Hemoccult Testing (82270–82274)	139
Hematology and Coagulation (85002–85999)	140
Immunology (86000–86804)	140
Transfusion Medicine (86850–86999).....	141
Microbiology (87003–87999)	141
Streptococcal Testing Techniques (87650–87653)	141
Anatomic Pathology (88000–88099).....	141
Cytopathology (88104–88199)	141
Surgical Pathology (88300–88399).....	142
Frozen Sections (Rapid Examinations) (88331–88332) ..	142

Chapter 9—Medicine 145

Introduction.....	145
Immune Globulins (90281–90399).....	145
Immunization Administration	
for Vaccines/Toxoids (90460–90474).....	145
Vaccines, Toxoids (90476–90749).....	145
Psychiatry (90785–90899)	146
Dialysis (90935–90999)	147
Gastroenterology (91010–91299)	147
Ophthalmology (92002–92499)	147
Otorhinolaryngology Services (92502–92700).....	147
Cardiovascular (92920–93799).....	147
Therapeutic Services (92920–92998)	147
Thrombolysis (92975–92977).....	148
Cardiography (93000–93050)	149
Echocardiography (93303–93355).....	149
Cardiac Catheterization (93451–93592).....	149
Intracardiac Electrophysiological	
Procedures (93600–93662).....	150
Pulmonary (94002–94799)	150
Allergy and Clinical Immunology (95004–95199)	151
Allergen Immunotherapy (95115–95199)	151
Neurology and Neuromuscular	
Procedures (95782–96020)	151
Hydration (96360–96361)	151
Therapeutic, Prophylactic, and Diagnostic Injections and	
Infusions (96365–96379)	152

Chemotherapy Administration (96401–96549)	152	Answer Sheet	179
Special Dermatological Procedures (96900–96999)	152	Practice Examination	181
Physical Medicine and Rehabilitation (97161–97799)	152	Medical Terminology	181
Active Wound Care Management (97597–97610)	152	ICD-10-CM Coding	182
Osteopathic Manipulative Treatment (98925–98929)	153	Payment Methodologies	185
Chiropractic Manipulative Treatment (98940–98943)	153	General CPT®	186
Moderate Conscious Sedation (99151–99157)	153	Surgical Procedures	190
Category III Codes (0042T–0542T)	154	Miscellaneous	199
Answers for Section Reviews	157	Answers for Practice Examination	201
Chapter 1	157	Medical Terminology	201
Chapter 2	157	ICD-10-CM	201
Chapter 3	158	Payment Methodologies	201
Chapter 4	159	General CPT®	201
Chapter 5	159	Surgical Procedures	201
Chapter 6	159	Miscellaneous	201
Chapter 7	160	Index	203
Chapter 8	160		
Chapter 9	160		
Case Studies	161		
Operative Reports	165		
Answers for Case Studies and Operative Reports	175		
Case Studies	175		
Operative Reports	175		
Medical Terminology	179		
ICD-10-CM	179		
Payment Methodologies	179		
General CPT®	179		
Surgical Procedures	179		
Miscellaneous	179		



Introduction

Pathology and laboratory CPT® coding includes services primarily reported to evaluate specimens obtained from patients (body fluids, cytological specimens, or tissue specimens obtained by invasive/surgical procedures) to provide information to the treating physician. This information, coupled with information obtained from history and examination findings and other data, provides the physician with the background for the decision making component of the evaluation and management codes.

Pathology and laboratory services are broken down into distinct category groupings according to procedure classification, and coders should become familiar with the various subcategories contained in CPT®. As with any other sections of CPT®, all introductory paragraphs and parenthetical notes should be carefully reviewed prior to code assignment. In general, clinical laboratory services are considered technical only and should be coded and billed by the facility. Very few modifiers are required for reporting clinical laboratory services.

CPT® laboratory services are delineated into distinct category groupings according to procedure classification. When locating or identifying a specific lab test for coding accuracy, it is essential to be familiar with the various lab subgroupings. They are listed as follows:

- Organ/Disease Panels
- Drug Assay
- Therapeutic Drug Assays
- Evocative/Suppression Testing
- Consultations (Clinical Pathology)
- Urinalysis
- Molecular Pathology
- Genomic Sequencing (GSPs) and Other Molecular Multianalyte Assays
- Multianalyte Assays with Algorithmic Analyses
- Chemistry
- Hematology and Coagulation
- Immunology
- Transfusion Medicine
- Microbiology
- Anatomic Pathology
- Cytopathology
- Cytogenetic Studies

- Surgical Pathology
- In Vivo Laboratory Procedures
- Other Procedures
- Reproductive Medicine Procedures
- Proprietary Laboratory Analyses

Pathology and laboratory procedures are typically paid based on a fee schedule (status indicator A) or not paid under Outpatient Prospective Payment System (OPPS) for hospital facilities when services are performed in the hospital (status indicators B, E, and M). Some procedures in this section of CPT® are paid if they are not reported with another code that has a status indicator of S, T, or V with a status indicator of Q1. Other procedures in this section are paid under the Clinical Laboratory Fee Schedule when not reported with another code that has a status indicator of J1, J2, S, T, V, Q1, Q2, or Q3 with a status indicator of Q4 or packaged under a more extensive procedure with a status indicator of N.

Modifiers Used in Laboratory and Pathology Services

Modifier 59—Appended to the procedure code to indicate a procedure was independent from other services performed on the same day

Modifier 90—Appended to the procedure code when an entity other than the treating or reporting physician performs an outside laboratory procedure

Modifier 91—Appended to the procedure code when it is necessary to repeat the same laboratory test on the same day to obtain subsequent (multiple) test results

Modifier 92—Alternative Laboratory Platform Testing

Code Location

When determining the correct code for a specific laboratory assay, use the CPT® Index to locate the procedural code if the formal name, condition, or abbreviation of the procedure is known. See the following examples for reference:

EXAMPLE

1. Test performed
Urinalysis
2. Anatomical site
Skin, test, tuberculosis
3. Condition
Syphilis test
4. Abbreviation
RBC (red blood cell)
5. Procedure or methodology
Immunoassay
6. Organ or Disease Oriented Panel
Basic Metabolic Panel

Organ or Disease Oriented Panels (80047–80081)

These panels were developed for coding purposes only and should not be interpreted as clinical parameters. The tests listed within each panel identifies the defined components of that panel. These panel components are not intended to limit the performance of other tests. If additional tests are performed other than those specifically indicated, they should be reported separately in addition to the panel code. When billing one of these panel codes, the lab must perform all the specific tests defined in the panel. For example, CPT® code 80061 *Lipid panel* must include serum cholesterol (82465), HDL cholesterol (83718) and triglycerides (84478). When only a portion of the defined tests in a panel are performed, each test performed is billed separately, rather than the CPT® panel code. When assigning a procedure code for a combination of laboratory tests, review the test names and select the CPT® panel code, when applicable, instead of assigning a code to each individual test. The following coding guidelines apply to laboratory panels:

1. CPT® panel codes that include all the test ordered by a physician, should be coded to the CPT® panel code and not billed individually.
2. When an additional test (not included in the panel description) is performed, code the test separately.
3. When a physician does not order all the tests in a panel, the laboratory should perform and code only those individual tests ordered. Do not automatically perform all the panel tests and code a panel.

Laboratory panels and all laboratory tests must meet payer criteria for medical necessity and be ordered by the physician actively treating the patient to be reimbursed.

Drug Assay (80305–80377)

Drug screening is reported with codes in the 80305 to 80377 range. CPT® codes 80305–80307 report drug screening based on any number of drug classes, any number of devices or procedures (for example, utilizing immunoassay) or by instrument chemistry analyzers, chromatography, and mass spectrometry either with or without chromatography for testing the specimen. Codes 80320–80377 report screening of specific types of drugs – such as alcohol, amphetamines, and anabolic steroids as well as drugs or substances that are not otherwise specified.

Therapeutic Drug Assays (80150–80377)

This set of CPT® codes is used when ordering or describing quantitative determinations of therapeutic drugs. These assays are often performed frequently on a timed basis (for example, peak and trough). Regardless of specific timing, the same code is used to describe the assay, for example, a Gentamicin peak or trough is coded using CPT® code 80170.

Therapeutic drug assays should not be confused with qualitative drug testing and the following guidelines must be used when selecting the appropriate CPT® code.

1. Determine the purpose of an assay; if the assay is presumptive, definitive, or quantitative. A urine lithium assay with mass spectrometry to determine a patient's compliance with a therapy program would be coded using CPT® code 80307, which shows the presence or absence of lithium. CPT® code 80178 is a quantitative test to show how much lithium is in the specimen provided.
2. If the assay is presumptive, see CPT® codes 80305–80307. This set of tests simply identifies the presence or absence of a drug class. Definitive tests identify individual drugs.
3. If the assay is quantitative, look in the Chemistry section of the CPT® for a specific code. The manual generally contains only generic names. Quantitative assays tell how much of a substance is in the body and whether therapeutic levels of a drug have been attained.
4. If no code is found in the Chemistry section, look for a proper code in the Therapeutic Drug Assay (TDA) section.
5. If no specific code is found in the TDA section and the purpose for conducting the assay is to determine a level of drug in the patient, use CPT® code 80299.

57. **Pre- and Postoperative Diagnosis:** Nonunion, right long finger, proximal phalanx.

This four-year-old right hand dominant male sustained a fracture to his right long finger proximal phalanx that was treated nonoperatively at an outside facility. The patient presented with a nonunion with overlap of his index and long fingers. After the risks and benefits of the surgery were discussed with the patient's parents in detail, they chose to proceed with operative fixation. The patient was taken to the operating room suite after the induction of axillary block anesthetic. He was found to have inadequate anesthesia and, therefore, this was converted to laryngeal mask anesthesia without difficulty. He had been given one gram of preoperative antibiotics. A well-padded tourniquet was placed around his proximal arm and his right upper extremity was prepped with Betadine and draped in standard sterile surgical fashion. An Esmarch bandage was used to exsanguinate his arm and the tourniquet was inflated. An incision was made dorsally along the central portion of his proximal phalanx. This was taken sharply through the skin. Subcutaneous hemostasis was achieved with electrocautery. A scalpel was used to incise the extensor tendons and the periosteum sharply. This was dissected with the freer elevator around the radial and ulnar portions of the phalanx. The site for the proposed osteotomy was planned. A plate was selected. A six-hole plate from the 1.5 cm screw set and the 2" module head set was selected. One hole of this was cut off. The proximal two holes were placed and drilled without difficulty. A mark was placed for the planned osteotomy which was through the previous fracture site. The plate was removed. An osteotomy was made with an oscillating saw without difficulty through the nonunion fracture site. Care was taken to ensure that this did not enter the flexor tendons. After the osteotomy was created, the distal fragment was dissected. There was a spike of bone on the distal palmar portion of the phalanx, which was impeding flexion. This bone was removed with the rongeur and the osteotomy was again examined. It was found to be cut in a small bit of extension and, therefore, a second cut was made taking off only a volar portion of the distal fragment. This found adequate alignment. The plate was replaced in a standard AO technique. The small piece of bone that was removed with the second cut of the osteotomy was placed in the intermedullary canal as graft. The plate was placed with compression and was found to have excellent screw purchase and all filled holes. The finger was able to go through nearly full range of motion. The PIP joint was able to flex to 90 degrees and had full extension. The wound was irrigated copiously. The periosteum was closed with interrupted 4-0 Vicryl suture. The extensor tendon cut was closed with a running 4-0 Vicryl suture and the skin was closed with a running 4-0 nylon suture. A second incision was made on the palmar side of the hand, just proximal to the wrist crease for approximately 3 cm. This was taken sharply through the skin. The flexor tendons were identified. A tendon hook was used to pull on the flexor tendon to the long finger. Both FDS and FDP were retracted and were found to have full range of motion with no evidence of adhesions. This wound was also irrigated thoroughly and was closed with subcuticular nylon. The patient was taken to the recovery room having tolerated the procedure very well. All sponge, needle and instrument counts were correct. Blood loss was minimal. The patient was released from the outpatient surgery department to home in good condition. What CPT® and ICD-10-CM codes are reported by the facility coder?

- A. 26548, S62.612A
- B. 26545, Q74.0
- C. 26546, S62.612K
- D. 26548, Q71.30

58. **Procedure Performed:** Implantation of dual chamber pacemaker.

Indications for Procedure: Sick sinus syndrome with Mobitz type II block with symptoms of fatigue.

Indications for Procedure: The risks, benefits and alternatives to the procedure were explained to the patient prior to the procedure and accepted.

Description of Procedure: The patient was brought to the Electrophysiology Lab where he received 1.5 grams of IV Cefuroxime. The left pectoral area was prepared in the usual fashion. The area was infiltrated with a 2% Xylocaine solution ordered by local anesthesia. A 4 cm incision was made in the left deltopectoral groove. The cephalic vein was isolated and ligated distally with 0 silk. Guide wire was introduced into the cephalic vein. The 9 French peel-away introducer was used to place the ventricular lead and using retained guide wire technique a 7 French peel-away introducer was used to place the atrial lead. The atrial lead was the Pacesetter 1488T/46 cm. The ventricular lead was the Pacesetter 1488T/52 cm. These were active fixation leads. Atrial and ventricular mapping was performed. Thresholds were as follows; in the atrium pacing 0.5 volts, current 1.3 ma, impedance 400 ohms, P-waves 4.6 millivolts. In the ventricle, pacing 0.5 volts, current 0.7 ma,



A

- A-scan, 126
- Abdomen, 2, 9, 36, 86, 107, 109, 126
- Abdominal
 - cavity, 102, 107, 110, 118, 119, 127, 128, 134
 - pain, 5, 9, 12, 48, 78, 90, 96, 97, 99, 107, 114, 115
- Ablation, 107
- Abscess, 79, 108, 111
- Abuse, 17, 25, 26, 73, 86
- Acronym, 11, 77, 98, 113
- Actinic keratoses, 79, 93, 94
- Actinotherapy, 152
- Acute
 - airway obstruction, 102, 150
 - mental illness, 25, 48, 146
 - myocardial infarction, 12, 51
 - urinary retention, 108
- Adenoidectomies, 106
- Admitting
 - diagnosis, 9-13, 17-20, 22, 25, 27, 34, 41, 47, 48, 51, 53, 54, 62, 64-69, 82, 88-91, 94, 96, 97, 100, 102, 103, 116, 118, 123, 139, 140, 142, 146, 150
 - physician, 10, 12, 16, 19, 20, 24-26, 28, 29, 34, 39, 44, 46, 48, 51, 52, 55, 59, 62, 63, 66-70, 73-75, 80-82, 85, 87-92, 94, 97, 99, 100, 105, 110, 116, 123-125, 127, 129-131, 133, 137, 138, 141, 142, 145, 146, 151-153
- Advance beneficiary notice (ABN), 57, 70, 75
- Adverse effect, 16
- Aftercare, 18, 19
- Algorithmic analyses, 80, 137, 139
- ALJ, 62-64
- Allergen immunotherapy, 151
- Allergy testing, 151
- Allograft, 37, 100, 101
- Alzheimer's disease, 25, 58
- AMA CPT® Assistant, 100
- Ambulance services, 23, 28-31, 34, 38, 45, 68, 73, 90
- Ambulatory surgical center, 21, 33, 75
- Amniocentesis, 113, 127
- Amputation, 2, 65, 85
- Anal
 - canal, 3, 107, 118, 119
 - polyp, 14, 88, 89
 - verge, 88, 89
- Analyte, 139
- Anemia, 12, 15, 74, 140, 141
- Anesthesia
 - codes, 9-22, 24, 28-37, 39-44, 47, 49, 50, 53-55, 61, 65-70, 73-82, 85-89, 91-119, 123-133, 137-140, 142, 145-154
 - procedures, 13, 20, 22-24, 26-30, 33-37, 40-42, 44-47, 51-55, 64-70, 73-75, 77-80, 82, 85-115, 117-119, 123-128, 132, 137-140, 145, 147, 148, 150-154
 - reimbursement, 9, 23, 24, 26-28, 32, 33, 40-42, 46, 48, 52, 55, 64-69, 74, 78, 82, 91, 94, 95, 97, 115, 133, 154
 - services, 9, 13, 18, 20-38, 40-46, 48, 49, 51-55, 57-70, 73-80, 82, 85-92, 95, 96, 102, 104, 106, 107, 110, 111, 113, 115, 119, 123-129, 131-134, 137, 139, 140, 142, 145-154
- Anesthesiologist, 23, 77, 93
- Aneurysms, 104, 125
- Angiography, 36, 115, 123-126, 148, 150
- Angioplasty, 104, 147, 148
- Antepartum care, 113
- Anti-infective immune globulins, 145
- Antigen specific antibodies, 145
- Antitoxins, 145
- Anxiety disorders, 25
- APC classification, 27, 33, 34, 41, 64, 82, 123, 149, 154
- Aponeurosis, 96
- Appendectomy, 86
- Arteriosclerotic, 2
- Arthrocentesis, 96, 97
- Arthroplasty, 41
- Arthroscopy, 81, 86, 88, 100, 101
- Arthrotomy, 81, 100
- Aspiration, 79, 95-97, 101, 103, 110, 113, 117, 127
- Asthma, 126
- Atherectomy, 106, 148
- Atherosclerosis, 125
- Audiologic function tests, 147
- Autogenous bone grafts, 101
- Autograft(s), 100
- Autologous, 100, 101

B

- B-scan, 126
- Blepharospasm, 117
- Blocked nerves, 114
- Blood banking, 140
- Brachytherapy, 32, 34, 45, 52, 127-130, 132, 134
- Brain, 113, 114, 118, 124, 128, 132, 151
- Breast(s)
 - excisions, 33, 85, 93, 95, 111, 116, 117
 - reconstruction, 33, 95, 100, 101, 115, 118
- Business office, 24
- Business policies, 26

C

- CABG, 33, 104
- Cardiac catheterization, 51, 147, 149, 150
- Cardiodefibrillator, 104
- Casting/Strapping, 99, 100