

2020

PROCEDURE DESK

REFERENCE

CPT[®] Codes Explained for the Medical Coder



Table of Contents

| | | | |
|---|------------|---|-------------|
| Introduction and Features | 3 | ▪ Surgery/Hemic and Lymphatic Systems - 38100-38999 | 633 |
| Evaluation and Management Survival Guide | 5 | ▪ Surgery/Mediastinum and Diaphragm - 39000-39599 | 639 |
| Modifier Lay Terms and Explanations | 77 | ▪ Surgery/Digestive System - 40490-49999 | 641 |
| Introduction to Surgical Coding and Surgical Terms | 99 | ▪ Surgery/Urinary System - 50010-53899 | 707 |
| Procedure Eponyms. | 103 | ▪ Surgery/Male Genital System - 54000-55899 | 739 |
| Basic Types of Anesthesia | 106 | ▪ Surgery/Reproductive System - 55920 | 751 |
| Vital Signs | 108 | ▪ Surgery/Intersex - 55970-55980 | 753 |
| Normal Lab Values | 109 | ▪ Surgery/Female Genital System - 56405-58999 | 755 |
| Billing, Coding, and Reimbursement Terms | 239 | ▪ Surgery/Maternity Care and Delivery - 59000-59899 | 783 |
| Abbreviations | 291 | ▪ Surgery/Endocrine System - 60000-60699 | 795 |
| Anatomical Illustrations. | 299 | ▪ Surgery/Nervous System - 61000-64999 | 799 |
| Lay Terms for Procedures and Services | | ▪ Surgery/Eye and Ocular Adnexa - 65091-68899 | 847 |
| • Evaluation and Management Services - 99091-99499 | 335 | ▪ Surgery/Auditory System - 69000-69979 | 867 |
| • Anesthesia - 00100-01999 | 347 | ▪ Surgery/Operating Microscope - 69990 | 875 |
| • Surgery | | • Radiology - 70010-79999 | 877 |
| ▪ Surgery/General - 10004-10021 | 383 | • Pathology and Laboratory Procedures - 80047-89398 | 935 |
| ▪ Surgery/Integumentary System - 10030-19499 | 385 | • Medicine Services and Procedures - 90281-99607 | 1115 |
| ▪ Surgery/Musculoskeletal System - 20100-29999 | 415 | • Category III Codes - 0042T-0593T | 1195 |
| ▪ Surgery/Respiratory System - 30000-32999 | 537 | | |
| ▪ Surgery/Cardiovascular System - 33016-37799 | 565 | | |
| | | Medical Terms Glossary | 1225 |

Introduction and Features

Thank you for your purchase! We are pleased to offer you our unique resource for coding procedures and services, which is based on the AMA's Current Procedural Terminology (CPT®) coding system. The code set in this book is compliant with the Health Information Portability and Accountability Act (HIPAA) for coding procedures and services.

This book goes above and beyond to help you to better understand how providers perform services and procedures so that you can choose the most accurate code. **You'll find our easy-to-read descriptions of procedures and services, including step-by-step explanations.** In addition to including the lay term descriptions for Category I and Category III codes, we've crafted a select set of bonus features based on requests from coders in the field as well as the recommendations from our core group of veteran coding educators.

Our goal was to apply our unique approach to focusing on the practical understanding of the codes to this lay term manual. That's why you'll find a **glossary of hundreds of medical terms** in this book that provide you with definitions of terms to enhance your understanding of a lay term description of a code.

This manual is also packed with a set of bonus features that you'll benefit from page after page, including the following:

- **G code crosswalks listed under relevant CPT® codes**
- **Detailed anatomical illustrations**
- **60 tabs bound in the book to mark each section of the book**
- **Evaluation and Management survival guide to help you code all types of E/M services, including the 2020 updates**
- **Modifier lay terms and explanations to clear up the confusion of when and how to apply CPT® modifiers**
- **Introduction to surgical coding and surgical terms to have a solid understanding of coding surgical procedures and common terminology**
- **Procedure eponyms for procedures named after a person**
- **Basic types of anesthesia walk-through explanations**
- **Normal lab values and vital signs so you know what is considered to be the normal or abnormal result**
- **Billing, coding, and reimbursement terms help you to become familiar with the current terms and regulatory organizations**
- **Common abbreviations you'll find in medical charts**
- **Illustrations of various body systems to guide you as you read lay term descriptions for services and procedures**

Evaluation and Management Survival Guide

Note: The information in this guide is provided to use for coding services. It is not a guarantee of payment and not meant to replace an individual coder's judgment. Updates to the E/M codes are listed at the end of this guide and are not found throughout the guide. Check with individual payers for their guidelines on coding, billing, and reimbursement for E/M codes. Note that the code ranges in the table of contents match the AMA CPT® manual, however, not all codes within a specific range will be covered within this Survival Guide.

Contents

| | |
|---|----|
| Introduction: Evaluation and Management (E/M) Services Guidelines..... | 6 |
| Chapter 1: Office or Other Outpatient Services (99201-99215)..... | 12 |
| Chapter 2: New vs. Established Patients | 15 |
| Chapter 3: Hospital Observation Services (99217-99220, 99224-99226, 99234-99236)..... | 17 |
| Chapter 4: Initial Hospital Care (99221-99223)..... | 20 |
| Chapter 5: Hospital Discharge Services (99238-99239)..... | 23 |
| Chapter 6: Consultations (99241-99255) | 26 |
| Chapter 7: Emergency Department Services (99281-99288) | 32 |
| Chapter 8: Critical Care Services (99291-99292) | 35 |
| Chapter 9: Nursing Facility Services (99304-99318) | 37 |
| Chapter 10: Domiciliary, Rest Home, or Custodial Care Services (99324-99328, 99334-99337) | 39 |
| Chapter 11: Home Services (99341-99350)..... | 40 |
| Chapter 12: Prolonged Services: Face-To-Face (+99354-+99357, +99415-+99416)..... | 42 |
| Chapter 13: Prolonged Physician Services: Without Direct Patient Contact (+99358, +99359)..... | 45 |
| Chapter 14: Standby Services (99360) | 46 |
| Chapter 15: Case Management Services (99366-99368)..... | 47 |
| Chapter 16: Care Plan Oversight Services (99339-99340, 99374-99380)..... | 48 |
| Chapter 17: Preventive Medicine Services (99381-99429)..... | 52 |
| Chapter 18: Non-Face-to-Face Services (99441-99458)..... | 53 |
| Chapter 19: Special E/M Services (99450-99456, 99473-99474) | 55 |
| Chapter 20: Newborn Care Services (99460-99463)..... | 56 |
| Chapter 21: Pediatric Critical Care Patient Transport (99466, 99467, 99485, 99486) | 57 |
| Chapter 22: Inpatient Neonatal and Pediatric Critical Care (99468-99476) | 59 |
| Chapter 23: Initial and Continuing Intensive Care Services (99477-99480) | 60 |
| Chapter 24: Chronic Care Management Services (99490-99491)..... | 62 |
| Chapter 25: Concurrent Care | 63 |
| Chapter 26: Family Conferences..... | 65 |
| Chapter 27: Second Opinions | 66 |
| Chapter 28: Shared E/M Visits..... | 67 |
| Chapter 29: Time | 69 |
| Chapter 30: 2020 Coding Updates | 71 |
| Appendix A: E/M Audit Tool..... | 73 |

Introduction

Evaluation and Management (E/M) Services Guidelines

Before we explore the Evaluation and Management (E/M) services guidelines, let's highlight a very important change from CMS, that although made in 2010 continues to cause confusion. The change pertains to "**Consultation services.**" Effective from January 2010, Medicare no longer recognizes the consultation services (99241-99255) and requires the use of appropriate office or inpatient visit codes (99201-99215 & 99221-99233) in place of these services. However, the consultation codes have not been removed from the CPT® manual and it is at the discretion of other payers to decide to accept these services. A coder might still need the guidelines for consultation services if the payer agrees to pay for them. Therefore, the general guidelines pertaining to consultations are still available. Moreover, we have added the changes in rules pertaining to those services to help the coding community understand the changes and the impact those changes have on reimbursement. The word "**Consultation**" may occur multiple times, and the reader is advised to follow the guidelines pertaining to them in the relevant chapter, i.e., **Chapter 6: Consultations (99241-99255).**

In 2013 there were significant changes made by the AMA. The changes include the definition of New vs. Established Patient, Concurrent Care and Transfer of Care, Time, and many more.

Evaluation and management (E/M) services refer to patient visits and consultations provided by physicians or residents under their supervision, as well as nonphysician providers both under a physician's supervision in an incident-to situation and operating without supervision when billing under their own provider identification. The AMA has assigned each of these services a CPT® code, the Health Care Financing Administration (HCFA) — now the Centers for Medicare and Medicaid Services (CMS) — implemented them in 1992 as part of the resource-based Medicare fee schedule payment system.

Like all CPT® codes, E/M codes are universal and used by Medicare, Medicaid, and most other payers for processing claims for a physician's professional services. You should also use E/M service codes for billing facility services on an outpatient basis.

Because evaluation and management services are high-volume provider activities, the E/M codes are the most frequently used by physicians and nonphysician providers in daily practice.

Know Your Guidelines

To help providers distinguish between the various E/M service levels, CMS issued E/M documentation guidelines in 1995 and again in 1997, with the section on examinations being the main difference between the two sets.

The 1995 guidelines allow physicians to conduct either a general multisystem or single-system exam and defined the levels of examination based on body areas and organ systems. The guidelines neglect, however, to specifically define what constitutes a single-system comprehensive exam.

In addition, the 1995 guidelines created confusion by describing both an expanded problem-focused exam and a detailed exam as encompassing two to seven body areas or organ systems — although the guidelines state that an expanded problem-focused

exam includes a limited exam of the areas, while a detailed exam includes an expanded exam of at least one area.

The CMS-issued 1997 guidelines create more specific audit criteria by including the number of examination elements that a provider must perform and document at each level and by outlining the elements of the multisystem general exam and 10 single-organ system exams: cardiovascular, ear/nose/throat, eye, genitourinary, hematologic/lymphatic/immunologic, musculoskeletal, neurological, psychiatric, respiratory, and skin.

Important: Providers can use either the 1995 or the 1997 guidelines. Providers may not, however, mix and match guidelines for the same patient encounter.

Commonly Used E/M Terms

When you're reviewing E/M rules and regulations, there are certain terms that you'll see frequently, including the following:

- **Provider** — A provider is a physician or licensed nonphysician provider who may provide services incident to the physician or independently under his or her own provider number (PIN or NPI).
- **Professional Services** — Professional services are those face-to-face services rendered by physicians and other qualified healthcare professionals reported by a specific CPT® code(s).
- **New Patient** — A new patient is one who has not received any professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.
- **Established Patient** — An established patient is one who has received professional services from the physician/qualified healthcare professional or another physician/qualified healthcare professional of the exact same specialty and subspecialty who belongs to the same group practice, within the past three years.

For example, when a physician/qualified healthcare professional is on call or covering for another physician/qualified healthcare professional, the patient's encounter/visit will be classified as that of an established patient because it would have been by the physician or qualified healthcare professional who is unavailable. When Advanced Practice Nurses (APNs) and Physician Assistants (PAs) are working with physicians, PAs and APNs are considered to be working in both exact specialty and subspecialties as the physicians.

CPT® Note: If a provider is on-call or covering for another provider, you should classify the services as if the regular provider were available; also, there is no distinction between new and established patients for emergency department visits.

- **Chief Complaint** — the symptom, problem, condition, diagnosis or other factor that is the reason for the patient's visit (Important: Every E/M visit must have a chief complaint.)
- **Concurrent Care** — the provision of similar services to the same patient by more than one physician or other qualified healthcare professional on the same day (primarily during hospital visits)

Basic Types of Anesthesia

Anesthesia is a medical specialty where providers administer anesthesia to patients during procedures so that they remain free of any pain. Anesthesia also keeps the patient still during the procedure and can be used in combination with other drugs to minimize the patient's anxiety. Anesthesia care includes meeting with the patient prior to anesthesia administration, monitoring the patient's condition, including vital signs, and safety during the procedure, and postoperative care after the procedure.

Depending on the type of anesthesia given and the type of procedure performed, the patient may be conscious, semi-conscious, or unconscious during the procedure. You can find anesthesia codes in the second section of the CPT® manual under the anesthesia code range of 00100-01999.

There are many different methods that anesthesia providers use to administer anesthesia.

The anesthesia provider determines the method of anesthesia that will be required by considering the procedure to be performed and the level of consciousness that is required.

Types of anesthesia include:

- Local and regional
- Nerve blocks
- Patient-controlled analgesia
- Moderate or conscious sedation
- General anesthesia
- Monitored anesthesia care (MAC)

Local and Regional Anesthesia

Local and regional anesthesia keeps patients from feeling pain in a specific area of the body, with local anesthesia affecting a smaller area than regional anesthesia. The patient is awake during procedures using local and regional anesthesia, giving the patient the ability to remember the procedure and communicate with the provider if needed. Local anesthesia is also known as conduction anesthesia and can be administered via an ointment, spray, or solution.

Nerve Blocks

A nerve block, also called block anesthesia, is used to block pain by injecting an anesthetic around or into a nerve. Analgesia blocks pain receptors in the central and/or peripheral nervous system without the patient losing consciousness.

Types of nerve blocks include:

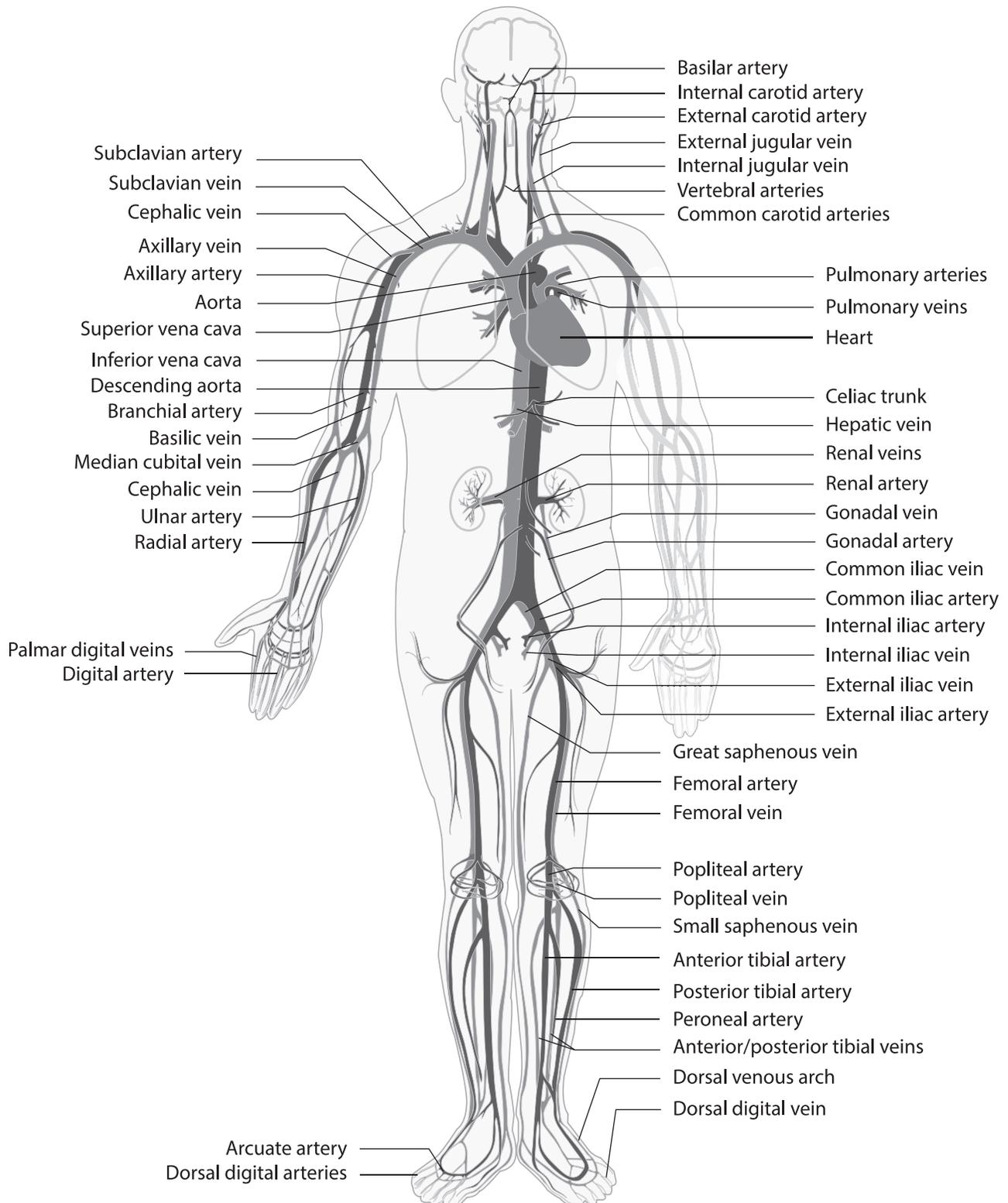
- **Axillary block** for procedures on the arm and hand – anesthesia is injected into the armpit.
- **Bier block** for pain management or for procedures on the extremities – anesthesia is injected into a vein in the extremity, numbing

peripheral nerves and nerve endings. A tourniquet inflated around the extremity prevents the anesthesia from spreading farther.

- **Epidural block** for procedures of the lower half of the body such as the pelvis and legs. It is also used to numb labor pain for pregnant women – anesthesia is delivered into the epidural space into the patient's back, numbing the nerves in the spinal cord, via a catheter (small tube) that is inserted by the anesthesia provider. The catheter is left in place to deliver more anesthetic as needed for the duration of the procedure.
- **Epidural blood patch** for relieving headaches caused by epidural anesthesia or a lumbar puncture (spinal tap).
- **Epidural nerve block** to decrease pain from spinal stenosis, a herniated disk, or other disorders – the provider injects a corticosteroid into the epidural space in the spinal cord.
- **Field block** for additional anesthesia around the procedure site – the provider injects anesthesia into the surrounding area.
- **Infraclavicular block** for procedures on the elbow, forearm, and wrist – the provider injects anesthesia below the clavicle toward the brachial plexus.
- **Interscalene block** for procedures on the arm or shoulder – the provider injects anesthesia into the neck.
- **Intrapleural block** for biopsy of the pleura or a thoracotomy – the provider injects anesthesia between the visceral pleura and the parietal pleura.
- **Intraarticular block** for procedures on a joint – the provider injects anesthesia directly into the joint.
- **Peripheral nerve block** for procedures on arms and legs – the provider injects anesthesia into the peripheral nerves of the arm or leg.
- **Plexus block** for procedures near a network of nerves (nerve plexus) such as the pelvic plexus – the provider injects anesthesia into the nerve plexus.
- **Rescue block** for the patient's postsurgical comfort – the provider injects anesthesia after surgery to help the patient remain without pain.
- **Saddle block** (caudal block) for procedures on the buttocks or legs – the provider injects anesthesia into the lower spine.
- **Spinal block** for procedures on the lower body, urinary systems, and genitals – the provider injects anesthesia into the cerebrospinal fluid (CSF).

Anatomical Illustrations

Circulatory System — Arteries and Veins



Title: Circulatory System Labels Biology Diagram, License: CC0 Creative Commons (Free for commercial use No attribution required), URL link: <https://pixabay.com/en/circulatory-system-labels-biology-41523/>

examination, and medical decision-making. When reporting 99222, the admitting physician should perform a comprehensive history; a comprehensive examination; and the medical decision-making should be of moderate complexity. The physician spends about 50 minutes that includes face-to-face time with the patient and the time spent in coordination of care.

99223

Initial hospital care is reported for a patient who is admitted to the hospital as an inpatient. The level of service is decided based on the three key components of history, examination, and medical decision-making. For reporting 99223, the admitting physician should perform a comprehensive history; a comprehensive examination; and the medical decision-making should be of high complexity. The physician spends about 70 minutes that includes face-to-face time with the patient and the time spent in coordination of care.

99224

For CPT® code 99224, the provider spends an average of 15 minutes face-to-face with the observation patient at the bedside or on the patient's hospital floor or unit. Report this code for each subsequent day of a patient's observation care, other than the first day of observation and the day of discharge from observation care. The code applies to either a new patient or an established patient. There must be at least two of three key components met to support the service level.

99225

For CPT® code 99225, the provider spends an average of 25 minutes face-to-face with the observation patient at the bedside or on the patient's hospital floor or unit. Report this code for each subsequent day of a patient's observation care, other than the first day of observation and the day of discharge from observation care. The code applies to either a new patient or an established patient. There must be at least two of three key components met to support the service level.

99226

For CPT® code 99226, the provider spends an average of 35 minutes face-to-face with the observation patient at the bedside or on the patient's hospital floor or unit. Report this code for each subsequent day of a patient's

observation care, other than the first day of observation and the day of discharge from observation care. The code applies to either a new patient or an established patient. There must be at least two of three key components met to support the service level.

99231

The physician reviews the medical records, results of diagnostic studies and changes in the patient's condition since the doctor's last assessment. The physician usually spends 15 minutes at patient's bedside and on patient's hospital floor.

99232

In this service level, the physician reviews the medical records, the results of diagnostic studies and notes any changes in the patient's condition since the doctor's last assessment. The physician usually spends 25 minutes at patient's bedside and on patient's hospital floor.

99233

In this service level, the physician reviews the medical records, the results of diagnostic studies and notes any changes in the patient's condition since the doctor's last assessment. The physician usually spends 35 minutes at patient's bedside and on patient's hospital floor.

99234

For CPT® code 99234, the provider spends an average of 40 minutes face-to-face with the patient at the bedside and/or on the patient's hospital floor or unit. The provider indicates this code when he discharges a patient from observation or an inpatient stay on the same date as he admits the patient to observation or inpatient care, and the patient stay is at least 8 hours, but less than 24 hours long. There must be three of three key components met to support the service level.

99235

When selecting an E/M service level for observation or inpatient hospital care, there are three key components that must be met in order to report the code appropriately. These components are in addition to the medical necessity for performing the procedure(s).

For CPT® code 99235, the provider spends an average of 50 minutes face-to-face with the patient at the bedside or on the

patient's hospital floor or unit. The provider reports this code when he discharges a patient from observation or an inpatient stay on the same date as he admits the patient to observation or inpatient care, and the patient stay is at least 8 hours, but less than 24 hours long. The code applies to either a new patient or an established patient.

99236

For CPT® code 99236, the provider spends an average of 55 minutes face-to-face with the patient at the bedside or on the patient's hospital floor or unit. This code is used to report services for both a new patient and an established patient. The provider indicates this code when he discharges a patient from observation or an inpatient stay on the same date as he admits the patient to observation or inpatient care, and the patient stay is at least 8 hours, but less than 24 hours long. There must be three of three key components met to support the service level.

99238

In this procedure, the provider spends 30 minutes or less with the patient on his date of discharge from the hospital to provide services like final examination of the patient, review and discussion of the hospital stay, coordination and instruction for ongoing care with caregiving agencies, preparation of final discharge records, prescriptions, and referral forms. The total time spent may or may not be continuous and need not be in direct contact with the patient.

99239

For 99239, the provider spends more than 30 minutes with the patient on his date of discharge from the hospital to provide services like final examination of the patient, review and discussion of the hospital stay, coordination and instruction for ongoing care with caregiving agencies, preparation of final discharge records, prescriptions, and referral forms. The total time spent may or may not be continuous and need not be in direct contact with the patient.

99241

For CPT® code 99241, the provider spends an average of 15 minutes face-to-face with a new or established patient. There must be three of three key components met to support the service level.

99242

For CPT® code 99242, the provider spends an average of 30 minutes face-to-face with a new or established patient.

Note: Usually, the presenting problem(s) are of low severity.

99243

For CPT® code 99243, the provider spends an average of 40 minutes face-to-face with a new or established patient.

There must be three of three key components met to support the service level.

99244

For CPT® code 99244, the provider spends an average of 60 minutes face-to-face with a new or established patient.

There must be three of three key components met to support the service level.

99245

For CPT® code 99245, the provider spends an average of 80 minutes face-to-face with a new or established patient.

There must be three of three key components met to support the service level.

99251

For CPT® code 99251, the provider spends an average of 20 minutes face-to-face with a new or established patient.

There must be three of three key components met to support the service level.

99252

For CPT® code 99252, the provider spends an average of 40 minutes face-to-face with a new or established patient.

There must be three of three key components met to support the service level.

99253

For CPT® code 99253, the provider spends an average of 55 minutes face-to-face with a new or established patient.

There must be three of three key components met to support the service level.

99254

For CPT® code 99254, the provider spends an average of 80 minutes face-to-face with a new or established patient.

There must be three of three key components met to support the service level.

Surgery/Musculoskeletal System (20100-29999)

20100

When the patient is appropriately prepped and the area anesthetized, the provider assesses the extent of damage to internal organs or tissues from the penetrating wound. He cleanses the wound and debrides, or removes, damaged tissues. He looks for and removes any foreign material, such as fragments of glass, metal, or cloth. He ties off or repairs small blood vessels. The provider then irrigates the area, checks for bleeding, removes any instruments, and closes the wound.

20101

When the patient is appropriately prepped and anesthetized, the provider assesses the extent of damage to internal organs or tissues of the chest by thoroughly exploring the penetrating wound. Treatment may follow to include cleansing, debridement, removal and repair of damaged tissue, removal of foreign bodies, if any, ligation and repair of small blood vessels in subcutaneous tissues and fascia, and finally, closure of the wound.

20102

When the patient is appropriately prepped and anesthetized, the provider assesses the extent of damage to internal organs or tissues of the abdomen, flank, or back by exploring the penetrating wound. Treatment may follow to include cleansing, debridement, removal and repair of damaged tissue, removal of foreign bodies, if any, ligation and repair of small blood vessels in subcutaneous tissues and fascia, and finally, closure of the wound.

20103

When the patient is appropriately prepped and anesthetized, the provider assesses the extent of damage to the tissues and structures in the extremity by exploring the penetrating wound. Treatment may follow to include cleansing, debridement, removal and repair of damaged tissue, removal of foreign bodies, if any, ligation and repair of small blood vessels in subcutaneous tissues and fascia, and finally, closure of the wound.

20150

When the patient is appropriately prepped and anesthetized and placed in the supine position, the provider places a tourniquet on

the patient's leg, and the provider makes a drill hole through the metaphysis into the epiphyseal bar. He removes a wedge-shaped piece of metaphysis and uses a high-speed bur drill to resect the epiphyseal bar completely. He uses an image intensifier to identify the exact location and depth of the bar. After resecting the epiphyseal bar, he uses a curette to remove the cancellous bone from physis until he reaches normal cartilage. He fills the defect with a fat graft harvested from the nearby tissues. He returns the wedge-shaped metaphyseal piece and screws it into position. He then closes the wound with sutures and applies a cast to immobilize the extremity for faster healing.

20200

When the patient is appropriately prepped and anesthetized, the provider examines the area to be biopsied. Using a scalpel, he makes a small incision in the targeted area. He further expands the incision to visualize the muscle. Once he visualizes the upper surface of muscle, the provider removes a small sample of muscle tissue, which he preserves and processes for further laboratory examination. The provider then closes the incision.

20205

When the patient is appropriately prepped and anesthetized, the provider examines the area to be biopsied. Using a scalpel, he makes a small incision in the targeted area. He further extends the incision and dissects the tissues in the area to visualize the targeted muscle. Once he visualizes the upper surface of muscle, the provider removes a small sample of muscle tissue, which he preserves and processes for further laboratory examination. The provider then closes the incision in a layered fashion.

20206

When the patient is appropriately prepped and anesthetized, the provider examines the area to be biopsied. Using a scalpel, he makes a small percutaneous incision over the targeted area. He advances a large diameter biopsy needle through this percutaneous stab incision. After proper localization of the biopsy needle at the muscular level, he pulls up soft muscular tissue using the needle. He preserves and processes the muscle sample for further laboratory examination. The provider then closes the incision.

20220

When the patient is appropriately prepped and anesthetized, the provider examines the area to be biopsied. Using a scalpel, he makes a small skin incision over the targeted area. He advances a large diameter biopsy needle or bone trocar through the percutaneous stab incision. After proper localization of the biopsy tool at the bone level, he debrides the tissue and pulls up soft bone tissue in the needle or trocar. He preserves and processes the bone sample for further laboratory examination. The provider then closes the incision.

20225

When the patient is appropriately prepped and anesthetized, the provider examines the area to be biopsied. He makes a small stab incision in the skin over the targeted area. He inserts a large diameter biopsy needle or trocar through the stab incision and advances it down into the bone. He confirms the correct position of the biopsy tool and extracts a sample of tissue and submits it for laboratory examination. He closes the incision.

20240

When the patient is appropriately prepped and anesthetized, the provider examines the area to be biopsied. Using a scalpel, he makes a small percutaneous incision in the targeted area and carries out sharp dissection with a blade, through fascia and muscle to approach the targeted bone. Once he identifies the bony process, he uses a rongeur or bone shaver to minimally debride the bone or bony process. He removes the debrided bone tissue as a biopsy sample. Once he obtains a satisfactory bone sample, he closes the incision by suturing it in a layered fashion.

20245

The provider examines the area to be biopsied. Using a scalpel, she incises the skin through a small percutaneous incision over the targeted area of the humerus, ischium, or femur. She performs sharp dissection through fascia and muscle to approach the targeted bone. Once she identifies the bony process, she uses a rongeur or bone shaver to access the deep bone cavity. She debrides the deep internal layer of bone and excises it as a biopsy specimen. Once she obtains a satisfactory bone sample,

she sutures the incision in a layered fashion.

20250

When the patient is appropriately prepped and anesthetized and in a prone position, the provider incises the skin of the thoracic spine over the suspected lesion site. She accesses the tumor or abnormal tissue of the vertebral body by parting the soft tissue and muscle layers. If necessary, she refers to radiological studies to aid in locating the lesion. Using a precision cutting tool, the provider obtains a small sample of the diseased tissue from the vertebra. She repositions the soft tissues and muscles and then closes the surgical incision with layered sutures.

20251

When the patient is appropriately prepped and anesthetized and in a prone position, the provider incises the skin of the lumbar or cervical spine over the suspected lesion site. She accesses the tumor or abnormal tissue of the vertebral body by parting the soft tissue and muscle layers. If necessary, she refers to radiological studies to aid in locating the lesion. Using a precision cutting tool, the provider obtains a small sample of the diseased tissue from the vertebra. She repositions the soft tissues and muscles and then closes the surgical incision with layered sutures.

20500

When the patient is appropriately prepped and the area anesthetized, the provider identifies the opening of the sinus tract. She injects the appropriate amount of a therapeutic agent directly into the sinus tract. She may use imaging guidance as an aid in the injection process.

20501

When the patient is appropriately prepped and the area anesthetized, the provider identifies the opening of the sinus tract. She injects a diagnostic agent, such as fluoroscopic dye or contrast material, directly into the sinus tract. She may make use of imaging guidance as an aid in the injection process.

20520

When the patient is appropriately prepped and the area anesthetized, the provider incises the skin over the targeted area and separates the tissues. When she reaches

the muscle or tendon sheath, she inspects the area and removes the foreign body. She closes the surgical opening with sutures after thoroughly cleaning the site. The provider may rely on X-ray images taken prior to the procedure to locate the foreign body in the soft tissue and a postprocedure image to ensure the complete removal of all foreign bodies.

20525

When the patient is appropriately prepped and the area anesthetized, the provider incises the skin over the targeted area and separates the tissues. When she reaches the muscle or tendon sheath, the depth of the foreign body or presence of infection may require more difficult dissection or removal of necrotic, or dead, tissue. She removes the foreign body and closes the surgical opening with sutures after thoroughly cleaning the site. The provider may rely on X-ray images taken prior to the procedure to locate the foreign body in the soft tissue and a postprocedure image to ensure the complete removal of all foreign bodies.

20526

When the patient is appropriately prepped and the area anesthetized, the provider locates the injection site on the wrist area between the flexor tendon and the palmar muscle. She injects the appropriate amount of anesthetic or corticosteroid.

20527

When the patient is appropriately prepped and anesthetized, the provider locates the planned injection site. He injects the appropriate amount of collagenase into three different but nearby positions of the Dupuytren's contracture. If necessary, he extends the patient's fingers manually to disrupt the abnormal fascial cord.

20550

After administration of adequate anesthesia and prep and drape, the provider locates the injection site. The appropriate amount of corticosteroid, anesthetic, or anti-inflammatory drug is then injected into the aponeurosis of the tendon sheath and/or ligament.

20551

When the patient is appropriately prepped and the area anesthetized, the provider prepares the site for injection. She may use radiological guidance to identify the tendon origin when it is not possible to visually locate the site of drug

delivery. She injects the appropriate amount of corticosteroid, anesthetic, or anti-inflammatory drug directly at the tendon origin or insertion and then withdraws the syringe. The provider observes the patient for any adverse reaction.

20552

When the patient is appropriately prepped and the area anesthetized, the provider palpates, or touches, the muscle to determine the location of a trigger point. She applies firm pressure to the trigger point to assess for referred pain and a twitch response. Then, she slowly injects the appropriate amount of corticosteroid or anesthetic into the trigger point.

20553

When the patient is appropriately prepped and the area anesthetized, the provider palpates the muscle to determine the location of a trigger point. He applies firm pressure to the trigger point to assess for the presence of referred pain and a twitch response. After proper localization, he slowly injects the appropriate amount of corticosteroid or anesthetic into the trigger point of each muscle.

20555

When the patient is appropriately prepped and anesthetized, the provider inserts catheters or needles at the site of a malignancy with the help of radiological guidance. He uses the needle or catheter as the delivery route for the radiotherapy elements or seeds, inserting seeds at this time or on a subsequent encounter. He secures the catheters or needles in place. He adds or remove seeds throughout the treatment phase.

20560

After appropriate cleansing of the site, the provider, usually a physical therapist, inserts a fine filiform disposable needle into a trigger point in 1 or 2 muscles. No medication is injected. This technique is used to treat pain, impaired movement, fibromyalgia, and tension headaches. Although not the same as traditional Chinese acupuncture, this technique may be referred to as trigger point acupuncture or dry needling.

20561

After appropriate cleansing of the site, the provider, usually a physical therapist, inserts a fine filiform disposable needle into a trigger point in 3 or more muscles. No medication is injected. This technique is used to treat pain,

impaired movement, fibromyalgia, and tension headaches. Dry needling is not the same as traditional Chinese acupuncture.

20600

When the patient is appropriately prepped and anesthetized, the provider inserts a needle through the skin into the joint or bursa. He then uses a syringe with the needle to remove fluid from the joint or bursa. After he aspirates the joint or bursa, he sends the fluid sample to the laboratory for further examination. He may also inject a drug into the joint or bursa for therapeutic purposes such as pharmacotherapy or lavage. He then removes the needle and applies pressure to stop any bleeding. He does not use ultrasound guidance to perform this procedure. Use this code only when the provider performs aspiration or injection in a small joint or bursa without ultrasound guidance.

20604

When the patient is appropriately prepped and anesthetized, the provider inserts a needle through the skin into the joint or bursa, typically the fingers or toes. Under ultrasound guidance, he then uses a syringe with the needle to remove fluid from the joint or bursa. The provider also permanently records the findings. After he aspirates the joint or bursa, he sends the fluid sample to the laboratory for further examination. He may also inject a drug into the joint or bursa for therapeutic purposes such as for pharmacotherapy or lavage. He then removes the needle and applies pressure to stop any bleeding.

20605

When the patient is appropriately prepped and anesthetized, the provider inserts a needle through the skin into the joint or bursa. He then uses a syringe with the needle to remove fluid from the joint or bursa. After he aspirates the joint or bursa, he sends the fluid sample to the laboratory for further examination. He may also inject a drug into the joint or bursa for therapeutic purposes such as pharmacotherapy or lavage. He then removes the needle and applies pressure to stop any bleeding. He does not use ultrasound guidance to perform this procedure. Use this code only when the provider performs an aspiration or injection in an intermediate joint or bursa without ultrasound guidance.

20606

When the patient is appropriately prepped and anesthetized, the provider inserts a needle through the skin and into the medium sized joint or bursa typically the temporomandibular, acromioclavicular, wrist, elbow, ankle, or olecranon bursa. Under ultrasound guidance, he then uses a syringe with the needle to remove fluid from the joint or bursa. The provider also permanently records the findings. After he aspirates the joint or bursa, he sends the fluid sample to the laboratory for further examination. He may also inject a drug into the joint or bursa for therapeutic purposes such as pharmacotherapy or lavage. He then removes the needle and applies pressure to stop any bleeding.

20610

When the patient is appropriately prepped and anesthetized, the provider inserts a needle through the skin into the joint or bursa. He then uses a syringe with the needle to remove fluid from the joint or bursa. After he aspirates the joint or bursa, he sends the fluid sample to the laboratory for further examination. He may also inject a drug into the joint or bursa for therapeutic purposes such as pharmacotherapy or lavage. He then removes the needle and applies pressure to stop any bleeding. He does not use ultrasound guidance to perform this procedure. Use this code only when the provider performs aspiration or injection in a major joint or bursa without ultrasound guidance.

20611

When the patient is appropriately prepped and anesthetized, the provider inserts a needle through the skin and into the large sized joint or bursa typically the shoulder, hip, knee, or subacromial bursa. Under ultrasound guidance, he then uses a syringe with the needle to remove fluid from the joint or bursa. The provider also permanently records the findings. After he aspirates the joint or bursa, he sends the fluid sample to the laboratory for further examination. He may also inject a drug into the joint or bursa for therapeutic purposes such as pharmacotherapy or lavage. He then removes the needle and applies pressure to stop any bleeding.

20612

When the patient is appropriately prepped and the area anesthetized, the provider inserts a sharp needle through the external skin

80047

The lab analyst performs a test to measure the blood level of eight chemicals including ionized calcium, sodium, potassium, chloride, carbon dioxide, glucose, blood urea nitrogen, and creatinine. Notice in this code, the clinician measures ionized calcium, which is the active, or free form of calcium in the blood that is not attached to proteins. A typical specimen is serum, or blood. The lab analyst may perform collection of the specimen, and if necessary she inserts a needle into the vein of the patient and withdraws a blood sample for analysis. Carefully review the code descriptor to identify the specific tests the panel includes. The code requires performance of all eight components to report. The eight panel tests include: 82330 for ionized calcium; 82374 for carbon dioxide, or bicarbonate; 82435 for chloride; 82565, creatinine; 82947, glucose; 84132 for potassium; 84295 for sodium, and 84520, blood urea nitrogen (BUN). The lab analyst may use a variety of methods to perform each of the tests in the panel.

A provider orders this test to assess a range of different acute and chronic health conditions. It is done often during routine health exams or in the emergency department to check on a person's kidneys, their electrolyte and acid to base balance, as well as their blood glucose and calcium levels.

80048

The lab analyst performs a test to measure the blood level of eight chemicals including a total calcium, sodium, potassium, chloride, carbon dioxide, glucose, blood urea nitrogen, and creatinine. Notice in this code, the clinician measures total calcium, or both the active (or free) form of calcium in the blood that is not attached to proteins and the calcium bound to a protein such as albumin. A typical specimen is serum, or blood. The lab analyst may perform collection of the specimen, and if necessary she inserts a needle into the vein of the patient and withdraws the blood sample for analysis. Carefully review the code descriptor to identify the specific tests the panel includes. The code requires the performance of all eight components to report. The eight panel tests include: 82310 for total calcium; 82374 for carbon dioxide, or bicarbonate; 82435 for

chloride; 82565, creatinine; 82947, glucose; 84132 for potassium; 84295 for sodium, and 84520, blood urea nitrogen (BUN). The lab analyst may use a variety of methods to perform each of the panel tests.

The clinician orders these tests to assess the range of different acute and chronic health conditions. The panel may be done during routine health checks or in the emergency department to check on the patient's kidneys, electrolyte and fluid balance, as well as the glucose and calcium levels in the blood.

80050

The lab analyst performs the technical steps to complete each of the tests the general health panel requires. The analyst may perform collection of the specimens, typically whole blood and serum, needed for this group of tests. Carefully review the code descriptor to identify the specific tests the panel includes. The code requires three components. The first two are 80053, Comprehensive metabolic panel, and 84443, Thyroid stimulating hormone, TSH. The third component is a blood count with manual or automated differential. Various tests qualify for this third component. One possibility is 85025, Blood count; complete, CBC, automated, Hgb, Hct, RBC, WBC and platelet count, and automated differential WBC count. Another possibility is a combination of 85027, Blood count; complete, CBC, automated, Hgb, Hct, RBC, WBC and platelet count, along with 85004, Blood count; automated differential WBC count. You may also see a combination of 85027 for automated complete blood count along with 85007, Blood count; blood smear, microscopic examination with manual differential WBC count. A final option for this third component is 85027 for automated complete blood count along with 85009, Blood count; manual differential WBC count, buffy coat.

The lab analyst must perform each of these three components to report the general health panel. A single component may require multiple tests. The lab analyst may use a variety of methods to perform each of the required panel tests.

Clinicians may order this panel for a comprehensive general health screening review, as results provide information related to the patient's

metabolic processes, state of the blood, and state of the thyroid.

80051

The lab analyst performs all technical steps to measure the sodium, potassium, chloride and carbon dioxide (CO₂), in a specimen. These electrolytes are electrically charged minerals that affect important body processes such as blood acidity and muscle function. The typical specimen is serum. The lab analyst may collect the specimen in a separate procedure. Carefully review the code descriptor to identify the specific tests the panel includes. The code requires performance of all four components to report the panel: sodium 84295, potassium 84132, chloride 82435, and carbon dioxide 82374. The lab analyst may use a variety of methods to perform each of the tests on the panel.

An electrolyte panel is a set of blood tests that measures electrolyte levels to assess the general functioning of the patient's organ systems. Clinicians may measure electrolytes in routine blood work or as a diagnostic tool when a patient presents with a variety of symptoms. The result of an electrolyte panel can help the clinician make a diagnosis or help monitor the progress of treatment.

Although not limited to testing for a specific condition, clinicians may order this test as part of routine blood work, or any time a patient presents to the emergency room or a provider's office with symptoms that need further investigation of electrolyte results.

80053

The lab analyst performs a test to measure the blood level of 14 chemicals the code descriptor identifies. A typical specimen is serum, or blood. The lab analyst may perform collection of the specimen and if necessary she inserts a needle into the vein of the patient and withdraws the blood sample for analysis. Carefully review the code descriptor to identify the specific tests the panel includes. The code requires performance of all 14 components to report. The services inclusive of this test are: 82040 for albumin; 82247 for a total bilirubin and 82310 for a total calcium; 82374 for carbon dioxide, or bicarbonate; 82435, chloride; 82565, creatinine; 82947 for glucose; 84075, alkaline phosphatase; 84132 for potassium;

84155 for a total protein; 84295, sodium; 84460, for alanine amino transferase, or SGPT and 84450 for aspartate amino transferase, or SGOT, and finally 84520, blood urea nitrogen, or BUN. The lab analyst may use a variety of methods to perform each of the panel tests. The clinician orders this test as part of an annual physical examination or health check. The panel is an important screening tool and baseline assessment of a patient's basic physiology. It provides information about a person's liver and kidneys, levels of blood glucose and blood proteins, and electrolyte and fluid balance. It helps to diagnose liver or kidney disease, as well as conditions like diabetes. A clinician may also order a CMP to monitor conditions, such as hypertension, and to check on people taking specific medications known to affect the kidney or liver.

80055

The lab analyst performs all technical steps to perform a variety of laboratory tests comprising an obstetric panel. The lab analyst may collect the specimen in a separate procedure. Carefully review the code descriptor to identify the specific tests the panel includes. The code requires performance of all components to report the panel.

An obstetric panel is a set of blood tests that labs perform to check the health of a woman before and during early pregnancy. A complete blood count, or CBC, with differential measures the white blood cells, red blood cells, hemoglobin, and hematocrit to screen for problems such as anemia or infection. The differential describes the percentage of each of the kinds of white cells present in the sample. This panel's test for a CBC with differential could be 85025, Blood count; complete, CBC, automated, Hgb, Hct, RBC, WBC and platelet count, and automated differential WBC count. Another possibility is a combination of 85027, Blood count; complete, CBC, automated, Hgb, Hct, RBC, WBC and platelet count, along with 85004, Blood count; automated differential WBC count. You may also see a combination of 85027 for automated complete blood count along with 85007, Blood count; blood smear, microscopic examination with manual differential WBC count. A final option for this third component

is 85027 for automated complete blood count along with 85009, Blood count; manual differential WBC count, buffy coat.

The hepatitis B surface antigen or HBsAg test 87340 describes a screening test for hepatitis B.

The rubella antibody test 86762 represents screens to make sure the patient has rubella antibodies; patients with rubella antibodies cannot get the disease again. If a patient contracts rubella while pregnant it can lead to miscarriage or birth defects.

The qualitative nontreponemal antibody syphilis test described by 86592 is a screening test for syphilis, which is a venereal disease caused by bacteria called *Treponema*; common tests used for this screening include Venereal Disease Research Laboratory (VDRL); rapid plasma reagin (RPR); and automated reagin test (ART).

The red blood cell (RBC) antibody screen by serum technique described by 86850 assesses whether the patient has antibodies present that could be incompatible with the fetal blood. Blood typing, ABO, described by 86900 and blood typing, Rh, described by 86901 respectively determine the patient's blood type, A, B, or O, and the Rh positive or negative status. If the mother is RH negative, the clinician can offer an injection to prevent the mother from producing Rh antibodies that can cause complications in current or future pregnancy.

Although not limited to testing for a specific condition, clinicians may order this panel on female patients planning to become pregnant or female patients presenting to the provider after becoming pregnant.

80061

The lab analyst performs a lipid panel test to measure to the blood level of total cholesterol, or both the high-density lipoprotein cholesterol, or HDL, and high-density lipoprotein cholesterol, or LDL, along with triglycerides. A typical specimen is serum, or blood. The lab analyst may perform collection of the specimen and if necessary she inserts a needle into the vein of the patient and withdraws the blood sample for analysis. Carefully review the code descriptor to identify the specific tests the panel includes. The code requires the performance of all three components to report. The panel tests include: 82465 for total cholesterol in serum; 83718 for a direct measurement lipoprotein, or

high-density cholesterol, or HDL, and 84478 for triglycerides.

The clinician most often will order a lipid profile to check for the risk of coronary artery disease and to monitor the condition.

80069

The lab analyst performs a renal function panel test to measure the blood level of certain chemicals the code descriptor lists for the panel including; albumin; blood urea nitrogen, or BUN; total calcium; carbon dioxide, or bicarbonate; chloride; creatinine; glucose; inorganic phosphorus, or phosphate; potassium, and sodium. A typical specimen is serum, or blood. The lab analyst may perform collection of the specimen and if necessary she inserts a needle into the vein of the patient and withdraws the blood sample for analysis. Carefully review the code descriptor to identify the specific tests the panel includes. The code requires performance of all ten components to report. The ten panel tests include: 82040 for albumin; 82310 for total calcium; 82374, carbon dioxide, or bicarbonate; 82435, chloride; 82565, creatinine; 82947 for glucose; 84100, inorganic phosphorus, or phosphate; 84132, potassium; 84295, sodium, and 84520 for blood urea nitrogen, or BUN.

The clinician orders this renal function test to ascertain the presence of any renal disease or to monitor patients who are receiving treatment for conditions affecting the kidneys.

80074

The lab analyst performs all technical steps to perform the four specific laboratory tests comprising an acute hepatitis panel. The lab analyst may collect the specimen in a separate procedure. Carefully review the code descriptor to identify the specific tests the panel includes. The code requires performance of all components to report the panel. The analyst may run the four separate tests using a variety of methods, typically with some type of immunoassay.

Hepatitis is an inflammation of the liver that hepatitis A, B, or C viruses may cause. This panel includes tests that screen for all three types of the hepatitis virus. Specifically, the panel requires the 86709 hepatitis A IgM antibody test, the 86705 hepatitis B core IgM antibody test, the 87340 hepatitis B surface antigen test, and the 86803 hepatitis C antibody test. Although not limited to testing for a specific condition, clinicians may

order this panel if a patient has jaundice, elevated liver function tests, or other symptoms suggestive of hepatitis that may include dark urine, loss of appetite, nausea, or abdominal pain; or the clinician may order this panel prior to performing a liver transplant.

80076

The lab analyst performs a test to measure the blood level of seven liver function indicators identified in the code descriptor. A typical specimen is serum, or blood. The lab analyst may perform collection of the specimen, and if necessary she inserts a needle into the vein of the patient and withdraws a blood sample for analysis. Carefully review the code descriptor to identify the specific tests the panel includes. The code requires performance of all seven components to report. The seven panel tests include: 82040 for albumin; 82247 for total bilirubin and 82248 for direct bilirubin; 84075 for alkaline phosphatase; 84155 for total protein; 84460 for alanine amino transferase, or SGPT, and 84450 for aspartate amino transferase, or SGOT.

The lab analyst may use a variety of methods to perform each of the required panel tests.

The clinician orders this test to assess a patient with symptoms of liver disease or injury. It includes diagnosis and quantitative assessment of the disease and monitoring the effects of certain medications on the liver. Quantitation refers to measuring the exact amount of a substance.

80081

The lab analyst performs all technical steps to perform a variety of laboratory tests comprising an obstetric panel. The lab analyst may collect the specimen in a separate procedure. Carefully review the code descriptor to identify the specific tests the panel includes. The code requires performance of all components to report the panel. An obstetric panel is a set of blood tests that labs perform to check the health of a woman before and during early pregnancy. A complete blood count (CBC), with differential measures the white blood cells, red blood cells, hemoglobin, and hematocrit to screen for problems such as anemia or infection. The differential describes the percentage of each of the kinds of white cells present in the sample. This panel's test for a CBC with differential could be 85025 (Blood count; complete, CBC, automated, Hgb, Hct, RBC, WBC and platelet count,

and automated differential WBC count). Another possibility is a combination of 85027 (Blood count; complete, CBC, automated, Hgb, Hct, RBC, WBC and platelet count), along with 85004 (Blood count; automated differential WBC count). You may also see a combination of 85027 for automated complete blood count along with 85007 (Blood count; blood smear, microscopic examination with manual differential WBC count). A final option for this third component is 85027 for automated complete blood count along with 85009 (Blood count; manual differential WBC count, buffy coat).

The hepatitis B surface antigen or HBsAg test 87340 describes a screening test for hepatitis B. The HIV test 87389 (Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple-step method; HIV-1 antigen or antigens, with HIV-1 and HIV-2 antibodies, single result), describes a screening test for HIV.

The rubella antibody test 86762 represents screens to make sure the patient has rubella antibodies; patients with rubella antibodies cannot get the disease again. If a patient contracts rubella (German measles) while pregnant, it can lead to miscarriage or birth defects.

The qualitative nontreponemal antibody syphilis test described by 86592 screens for syphilis, which is a venereal disease caused by a bacteria called *Treponema*; common tests used for this screening include VDRL (Venereal Disease Research Laboratory); RPR (rapid plasma reagin); and ART (automated reagin test).

The red blood cell (RBC) antibody screen by serum technique described by 86850 assesses whether the patient has antibodies present that could be incompatible with the fetal blood. Blood typing, ABO, described by 86900 and blood typing, Rh, described by 86901 respectively determine the patient's blood type, A, B, or O, and the Rh positive or negative status. If the mother is RH negative, the clinician can offer an injection to prevent the mother from producing Rh antibodies that can cause complications in a current or future pregnancy.

Although not limited to testing for a specific condition, clinicians may order this panel on female patients planning to become pregnant or female patients presenting to the provider after becoming pregnant.

Medical Terms Glossary

| Medical Term | Description |
|--|---|
| 11 deoxycortisol | A precursor of cortisol; a steroid hormone, also known as compound S. |
| 23 valent | A vaccine that contains 23 of the most common types of pneumococcal bacteria to help prevent infection. |
| Ab externo | Outside the eye; indicates a surgical procedure starting from the eye's exterior and proceeding to the anterior chamber. |
| Abbe-Estlander operation | Transfer of a full-thickness section of one lip to the other lip to correct a defect. |
| Abdominal aorta | Largest artery supplying the abdominal cavity, part of the aorta and continuation of the descending aorta from the thorax; it divides further into the iliac arteries. |
| Abdominal aortic aneurysm, or AAA | Widening of the abdominal aorta due to weakening in the wall of the aorta. |
| Abdominal approach | Surgical incision in the abdomen to perform an abdominal operation. |
| Abdominal paracentesis | Surgical puncture of the abdominal cavity for the removal of fluid for diagnosis or treatment. |
| Abdominal pregnancy | Implantation of a fertilized egg in the peritoneal cavity, including on the omentum, the abdominal wall, or on the outside of the uterus. |
| Abdominal wall | Refers to the muscles covering the abdomen or to the skin, fascia, muscle, and membranes marking the boundaries of the abdominal cavity. |
| Abdominoperineal | Refers to the abdomen and the perineum. |
| Abdominoperineal pull-through procedure | A surgical procedure that involves two approaches, one through the abdomen and a second through the perineum. |
| Abdominoperineal resection, or APR | The surgical removal of the anus, rectum, and part of the sigmoid colon, along with regional lymph nodes, through incisions made in the abdomen and perineum. |
| Abduction | Movement of a body part away from the medial line of the body. |
| Abduction pillow | A medical device used to immobilize an extremity after a surgical procedure to help decrease the risk of a dislocation; also known as an abduction splint. |
| Abductor | Muscle that draws a body part away from the midline of the body. |
| Abductor hallucis muscle | Muscle running along the inside of the foot. |
| Aberrant | Unusual or abnormal. |
| Aberrant vessel | Blood vessel having an unusual origin or course. |
| Ablation | Removal of tissue, a body part, or an organ or destruction of its function; to ablate. |
| ABO incompatibility | An abnormal transfusion reaction between blood cells of incompatible blood types A, B, AB or O, resulting in destruction of blood cells and the formation of clumps. |
| Abortion | Clinical term for the termination of a pregnancy before the age of viability, usually before 20 completed weeks of gestation; an induced abortion is also known as a therapeutic abortion, or TAB; a spontaneous abortion is commonly known as a miscarriage. |
| Above knee amputation, or AKA | Surgical removal of the lower leg above the level of the knee joint. |
| Abrasion | Removal of superficial layers of skin. |
| Abrasion arthroplasty | Refinishing the surfaces of a joint through a grinding process. |
| Abscess | A collection of pus in a walled off sac or pocket, the result of infection. |
| Abscess cavity | Pocket formed due to the accumulation of purulent material, or pus. |
| Absorption | Taking in of substances by tissues. |
| Acceleration and deceleration forces | Excessive strain put on the muscles, tendons, and joints, primarily of the spine, due to a body moving at high speed and coming to a sudden, rapid stop. |
| Accelerometer | Device to measure motion of a body. |
| Accessory navicular bone | An extra bone on the inner side of the foot that can cause irritation and require removal. |
| Accessory nerve | One of a pair of motor nerves that primarily supply the pharynx and muscles of the upper chest, back, and shoulders. |



The Business of Healthcare at Your Fingertips



Get all of your professional resources at [aapc.com](https://www.aapc.com)

- ✓ Get the latest healthcare news in our Knowledge Center
- ✓ Order tools and resources to help you navigate through your career
- ✓ Learn from industry pros in our virtual webinars and workshops
- ✓ Find free tools, including the E/M Analyzer, CPT® RVU Calculator, and more
- ✓ Discover new products and the latest deals on existing products

CPT® is a registered trademark of the American Medical Association

Create an account to receive exclusive notifications about special promotions and new resources.

Visit <https://www.aapc.com/login.aspx> and select "Join our Mailing List" today.



www.aapc.com

2020 PROCEDURE DESK REFERENCE



9 781626 887565
ISBN: 978-1-626887-565