

# Introduction to CPT<sup>®</sup>, Surgery Guidelines, HCPCS, and Modifiers



## The Current Procedural Terminology (CPT<sup>®</sup>)

- Copyrighted and maintained by American Medical Association (AMA)
- Used with other codes sets to report healthcare services performed in the United States
- Established as an indexing/coding system to standardize terminology among physicians and other providers



## Introduction to CPT®

- Instructions for use of the CPT® code book
  - Unlisted procedure
  - CPT® use by any qualified health care professional
  - Parenthetical notes
  - Accuracy and quality of coding
    - Related guidelines
    - Parenthetical instructions
    - Other coding resources



## Introduction to CPT®

- The CPT® code set includes three categories of medical nomenclature with descriptors.
  - Category I
  - Category II
  - Category III



## Category I CPT® Codes

- Five-digit numerical code, eg 12345
- Over 7,000 service codes, plus titles and modifiers
- Reviewed and updated annually
- Mandatory to report for services and reimbursement



## Category I CPT® Codes

The CPT® coding manual divides Category I CPT® codes into six main section titles:

- Evaluation and Management (99201–99499)
- Anesthesiology (00100-01999)
- Surgery (10021-69990)
- Radiology (70010-79999)
- Pathology and Laboratory (80047-89398)
- Medicine (90281-99607)



## Category I CPT® Codes

- Section titles have subsections divided by anatomic location, procedure, condition, or descriptor subheadings.
- The subheadings, structured by CPT® conventions, may list alternate coding suggestions in parenthetical instructions.
- Example:
  - Section: Surgery (10021-69990)
  - Subsection: Integumentary System
  - Subheading: Skin, Subcutaneous and Accessory Structures
  - Category: Debridement
    - » (For dermabrasions, see 15780 – 15783)
    - » (For nail debridement, see 11720-11721)
    - » (For burn(s), see 16000-16035)
    - » (For pressure ulcers, see 15920-15999)

Alternate  
coding  
suggestions



## Category I CPT® Codes

Specific guidelines presented at the beginning of each section identify correct coding protocols.

Example:

Section, **Surgery**

Subsection: **Cardiovascular System** (33010-37799)

Guideline:

Selective vascular catheterizations should be coded to include introduction and all lesser order selective catheterizations used in the approach (e.g., the description for a selective right middle cerebral artery catheterization includes the introduction and placement catheterization of the right common and internal carotid arteries).



## Category II CPT® Codes

- Alphanumeric format, with the letter “F” in the last position, eg, 0001F
- Optional “performance measurement” tracking codes
- Physician Quality Reporting System (PQRS)
- Example:
  - A physician counsels a patient regarding prescribed Statin therapy for coronary artery disease.
  - Report:
    - 4013F Statin therapy, prescribed (CAD)
    - Appropriate level office visit code (99211–99215).



## Category II CPT® Codes

Due to the constant expansion of identifiable measures for quality patient care, the AMA lists criteria on their website:

<http://www.ama-assn.org/ama/pub/physician-resources/solutions-managing-your-practice/coding-billing-insurance/cpt/about-cpt/category-ii-codes.shtml>

Physician Quality Reporting Initiative (PQRS)

<http://www.cms.gov/PQRS/>



## Category III CPT® codes

- Temporary codes
- Alphanumeric structure, with a “T” in the last position, eg, 1234T
- Can be reported alone, without an additional Category I code
- Example
  - A patient has gastric stimulation electrodes implanted in the lesser curvature of the stomach via laparotomy for the treatment of morbid obesity.
  - Report code 0256T which is the implantation of catheter-delivered prosthetic aortic heart valve by endovascular approach.



## Category III CPT® codes

- Updated twice a year
  - January 1
  - July 1
- Implemented six months after
- Updates are published on AMA’s website:  
<http://www.ama-assn.org/go/CPT>



## Category III CPT® codes

If a Category III code is available,  
this code must be reported  
instead of a Category I unlisted code



## The CPT® Coding Manual

- CPT® Sections
- Section Guidelines
- Section Table of Contents
- Notes
- Category II codes (0001F – 7025F)
- Category III codes (0019T – 0290T)
- Appendices A-N
- Alphabetic Index



## CPT® Guidelines

- Referenced in the introduction of each section and subsection of the CPT® manual
- Applicable to the section being referenced
- Define the information necessary for choosing the correct code



## CPT® Conventions and Iconography

Used throughout the CPT® manual and include:

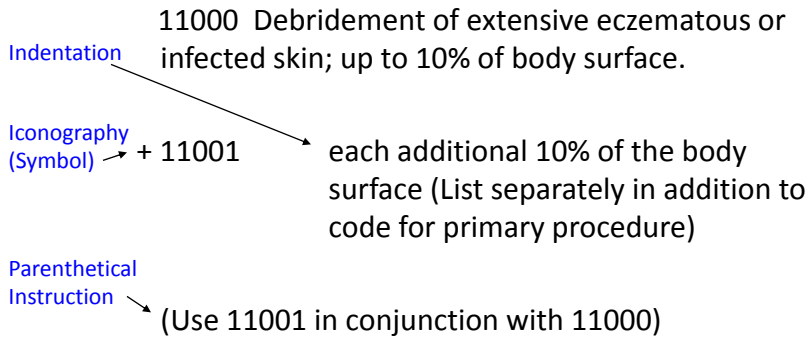
- Indentations
- Code symbols - iconology
- Parenthetical instructions





## CPT® Conventions and Iconography

### Example:



## CPT® Conventions and Iconography

; The semicolon and the conventional use of indentions

The use of the semicolon divides the description of a code into two parts:

- The “stand-alone” code or the “common procedure” code descriptor.
- The indented descriptor is dependent on the preceding “stand-alone” code



## CPT® Conventions and Iconography

### Example:

00160    Anesthesia for procedures on nose and accessory sinuses; not otherwise specified  
00162        radical surgery  
00164        biopsy, soft tissue

### Interpreted:

00160    Anesthesia for procedures on nose and accessory sinuses; not otherwise specified.  
00162    Anesthesia for procedures on nose and accessory sinuses; radical surgery  
00164    Anesthesia for procedures on nose and accessory sinuses; biopsy, soft tissue



## CPT® Conventions and Iconography

+        The “add-on” code symbol - Add-on codes are never reported alone

### Example:

+43283 Laparoscopy, surgical, esophageal lengthening procedure (eg, Collis gastroplasty or wedge gastroplasty) (List separately in addition to code        for primary procedure)

(Use 43283 in conjunction with 43280, 43281, 43282)



## CPT® Conventions and Iconography

- The red circle - new procedure code

Example:

- 33221 Insertion of pacemaker pulse generator only; with existing multiple leads.

- ▲ The (blue) triangle - code revision

Example:

- ▲ 32440 Removal of lung, pneumonectomy

Appendix B: 32440 Removal of ~~total~~ lung, pneumonectomy



## CPT® Conventions and Iconography

- ▶◀ The facing triangles - indicate new and revised text other than the procedure descriptors

- Example:

43882 Revision or removal of gastric neurostimulator

- ▶ (For open implantation, revision, or removal of gastric neurostimulator electrodes, lesser curvature [morbid obesity], use 43999) ◀



## CPT® Conventions and Iconography

- ⊘ The circle with a line through it - exempt from the use of modifier 51

Example:

- ⊘ 93612 Intraventricular pacing



## CPT® Conventions and Iconography

- ⦿ The bulls eye - includes moderate sedation

Example:

- ⦿ 43200 Esophagoscopy, rigid or flexible; diagnostic, with or without collection of specimen(s) by brushing or washing (separate procedure)



## CPT® Conventions and Iconography

The lightening bolt symbol - codes for vaccines that are pending FDA approval.

Example:

90661 Influenza virus vaccine, derived from cell cultures, subunit, preservative and antibiotic free, for intramuscular use

AMA CPT® “Category I Vaccine Codes” website:

[www.ama-assn.org](http://www.ama-assn.org)



## CPT® Conventions and Iconography

# The number symbol – Resequenced, out of numerical order

Example:

**46947** Code is out of numerical sequence.  
See 46700-46947.

# 46947 Hemorrhoidopexy (for prolapsing internal hemorrhoids) by stapling



## CPT® Code Basics

- Review medical documentation thoroughly and gather additional reports
- Reference the alphabetical index for a CPT® numerical code and/or code range.
  - Condition
  - Procedure or service
  - Anatomic site
  - Synonyms, eponyms and abbreviations
- Review the numerical code and/or code range for specific descriptions
- Follow CPT® Guidelines, Conventions and Iconology



## CPT® Code Basics

- Index:
  - Ear Wax  
see Cerumen
  - Cerumen  
Removal.....69210
  - Removal  
Cerumen.....69210
- Auditory System  
69210 Removal impacted cerumen (separate procedure), one or both ears



## Separate Procedure

Example:

69210 Removal impacted cerumen (separate procedure), one or both ears

69222 Debridement, mastoidectomy cavity, complex (eg, with anesthesia or more than routine cleaning).



## National Correct Coding Initiative (CCI)

- Implemented by CMS
- Promotes correct coding methodologies
- Controls the improper assignment of codes that results in inappropriate reimbursement

Medicare publishes CCI:

<http://www.cms.hhs.gov/NationalCorrectCodInitEd/>



Column1/Column 2 Edits					
Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable
11042	0213T		20100701	*	0
11042	0216T		20100701	*	0
11042	0228T		20101001	*	0
11042	0230T		20101001	*	0
11042	10060		19960101	*	1
11042	11000		19960101	*	1
11042	11001		19960101	19960101	9
11042	11040	*	19960101	*	1
11042	11041	*	19960101	*	1
11042	11100		19970101	*	1



## Sequencing

- Based on RBRVS
  - Physician Work
  - Practice Expense
  - Professional Liability/Malpractice Insurance

- Highest RBRVS listed first.

[www.cms.hhs.gov/PhysicianFee-Sched/](http://www.cms.hhs.gov/PhysicianFee-Sched/)





## *CPT® Assistant*

- Articles answering everyday coding questions
- CCI bundling information
- E/M billing guidance
- Current code use and interpretation
- Case studies demonstrating practical application of codes
- Anatomical illustration charts and graphs for quick reference
- Information for appealing insurance denials
- Information to validate code usage when audited



## CPT® Appendices

### Appendix A - Modifiers categorized as:

- Modifiers applicable to CPT® codes
- Anesthesia Physical Status Modifiers
- CPT® Level I Modifiers approved for Ambulatory Surgery Center (ASC) Hospital Outpatient Use
- Level II (HCPCS/National) Modifiers



## CPT® Appendices

- Appendix B - changes and additions to the CPT® codes from the previous year
- Appendix C - clinical E/M examples for different specialties
- Appendix D – Add-on Codes



## CPT® Appendices

- Appendix E – Exempt from the use of modifier 51 (multiple procedures)
- Appendix F – Exempt from the use of Modifier 63 (procedures performed on infants less than 4kg)
- Appendix G – Include Moderate (Conscious) Sedation



## CPT® Appendices

- Appendix H – Alphabetic Index of Performance Measures by Clinical Condition or Topic
  - Available only on the AMA website
  - [www.ama-assn.org](http://www.ama-assn.org).
- Appendix I – Genetic Testing Code Modifiers
  - Molecular laboratory procedures related to genetic testing
  - Use in conjunction with CPT® and HCPCS codes to provide diagnostic granularity of service



## CPT® Appendices

- Appendix J - Electrodiagnostic Medicine Listing of Sensory, Motor, and Mixed Nerves
  - Assigns each sensory, motor, and mixed nerve with its appropriate nerve conduction study code
  - Table containing maximum number of studies
- Appendix K - Product Pending FDA Approval
  - Identified throughout the CPT® book with a lightening bolt symbol
  - For updated vaccine approvals by the FDA, visit the AMA CPT® Category I Vaccine Code information on their website:  
[www.ama-assn.org/ama/pub/category/10902.html](http://www.ama-assn.org/ama/pub/category/10902.html)



## CPT® Appendices

- Appendix L - Vascular Families
  - Based on the assumption that a vascular catheterization has a starting point of the aorta
  - Illustrates vascular “families” that emerge from the aorta using brackets to identify the order of vessels.
- Appendix M - Crosswalk to Deleted CPT® Codes
  - Crosswalks noting the deleted CPT® codes and descriptors from the previous year to the current year.
  - Essential when updating charge masters, charge capture documents, etc.



## CPT® Appendices

### Appendix N - Summary of Re-sequenced CPT® Codes -

This listing is a summary of CPT® codes not appearing in numeric sequence. This allows for existing codes to be relocated to an appropriate location.



## CPT® Global Surgical Package

- Includes a standard package of preoperative, intraoperative, and postoperative services
- Payer policies may vary
- May be furnished in any service location
  - For example, a hospital, an ambulatory surgical center (ASC), or physician office



## CPT® Global Surgical Package

Included in the surgery package and not separately billable:

- Inclusive
- Local infiltration, metacarpal/metatarsal/digital block or topical anesthesia
  - Subsequent to the decision for surgery, one related E/M encounter on the date immediately prior to or on the date of procedure (including history and physical)
  - Immediate postoperative care, including dictating operative notes, talking with the family and other physicians
  - Evaluating the patient in the postanesthesia recovery area
  - Writing orders
  - Typical postoperative follow-up care



## CMS Global Surgical Package

- Major Surgery: Has a preoperative period of 1 day with 90 days for the postoperative period.
- Minor Surgery: The preoperative period is the day of the procedure with a postoperative period of either 0 or 10 days depending on the procedure.



## CMS Global Surgical Package

HCPCS	DESCRIPTION	GLOB DAYS	PRE OP	INTRA OP	POST OP
22521	Percut vertebroplasty	10	0.1	0.8	0.1
22522	Percut vertebroplasty	ZZZ	0	0	0
22523	Percut kyphoplasty t	10	0.1	0.8	0.1
22524	Percut kyphoplasty l	10	0.1	0.8	0.1
22525	Percut kyphoplasty a	ZZZ	0	0	0
22526	Idet single level	10	0.1	0.8	0.1
22527	Idet 1 or more levels	ZZZ	0	0	0
22532	Lat thorax spine fusio	90	0.1	0.69	0.21
22533	Lat lumbar spine fusi	90	0.1	0.69	0.21
22534	Lat thor/lumb addl se	ZZZ	0	0	0
22548	Neck spine fusion	90	0.1	0.69	0.21
22551	Neck spine fuse&ren	90	0.1	0.69	0.21
22552	Addl neck spine fusi	ZZZ	0	0	0

Source: [www.cms.gov](http://www.cms.gov), RVU12A



## CMS Global Surgical Package

- MMM and XXX
  - Global concept does not apply
- YYY
  - Subject to individual pricing
- ZZZ
  - Always included in the global period

Global period days for Medicare patients may be accessed on the CMS website:

[http://www.cms.hhs.gov/pfslookup/02\\_PFSsearch.asp](http://www.cms.hhs.gov/pfslookup/02_PFSsearch.asp)



## Global Package Modifiers

- 54 Surgical care only
- 55 Postoperative management only
- 56 Preoperative management only

HCPCS	DESCRIPTION	GLOB DAYS	PRE OP	INTRA OP	POST OP
22521	Percut vertebroplasty	10	0.1	0.8	0.1
22548	Neck spine fusion	90	0.1	0.69	0.21



## Global Package Modifiers

- 24 Unrelated E/M by the same physician during a postoperative period
- 25 Significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or other service
- 57 Decision for surgery



## Global Package Modifiers

- 58 Staged or related procedure or service by the same physician during the postoperative period
- 78 Unplanned return to the operating/ procedure room by the same physician following initial procedure for a related procedure during the postoperative period
- 79 Unrelated procedure or service by the same physician during the postoperative period





## Global Package Modifiers

- 58 Staged or related procedure or service by the same physician during the postoperative period
- Example:
  - March 2 – Breast Biopsy
  - March 6 – Modified radical mastectomy
  - Add modifier 58 to the modified radical mastectomy



## Global Package Modifiers

- 78 Unplanned return to the operating/ procedure room by the same physician following initial procedure for a related procedure during the postoperative period
- Example:
  - January – Gastric bypass (90 day global period)
  - March – Incisional hernia on the bypass incision, taken back to the operating room for incisional hernia repair.
  - Add modifier 78 to the hernia repair



## Global Package Modifiers

- 79 Unrelated procedure or service by the same physician during the postoperative period
- Example:
  - January – Amputated DIP joint (finger)
  - March – Below the knee amputation
  - Add modifier 79 to the below the knee amputation



## Surgical Modifiers

- 22 – Increased Procedural Service
- 50 - Bilateral Procedure
- 51 - Multiple Procedures
- 52 - Reduced Services
- 53 - Discontinued Procedure



## Modifier 22 - Increased Procedural Service

- Services required to perform the procedure are significantly greater than usually reported with the procedure
- Bill with the operative report



## Modifier 22 - Increased Procedural Service

### Example:

A patient has a colonoscopy and a polyp is removed. The removal of the polyp causes excessive bleeding and an extra 30 minutes is spent controlling the bleeding. Modifier 22 would be added to the surgical code and the operative report and/or letter would be sent with the claim to the payer.



## Modifier 50 - Bilateral Procedure

Check with payers on how to submit:

- One line item with modifier 50  
Example: 20610-50
- Two line items with modifier 50 on the second code  
Example: 20610  
20610-50
- Two lines using RT/LT  
Example: 20610-RT  
20610-LT



## Modifier 50 - Bilateral Procedure

- Pay close attention to code descriptions.
- Some codes specify 'unilateral' and include a parenthetical statement.  
Example: 50592 – Ablation, 1 or more renal tumor(s), percutaneous, unilateral, radiofrequency
- Some codes say 1 or both.  
Example: 69210 – Removal impacted cerumen (separate procedure), 1 or both ears



## Modifier 51 - Multiple Procedures

- More than one procedure performed at the same session by the same provider
- Not used on E/M services, Physical Medicine or Rehabilitation Services, the provision of supplies such as vaccines or codes designated as 'add-on' codes.

### Example:

An orthopedic surgeon performs a closed treatment of a femoral shaft fracture on the left leg and a closed treatment of a right knee dislocation during the same operative session. It would be coded as 27500-LT and 27552-51-RT.



## Modifier 52 - Reduced Services

- Procedure partially reduced at physician discretion
- Service not completed in its entirety
- Example:  
43770 Laparoscopy, surgical, gastric restrictive procedure; placement of adjustable gastric restrictive device

(For individual component placement, report 43770 with modifier 52)



## Modifier 53 - Discontinued Services

- Procedure terminated due to:
  - Extenuating circumstances
  - Circumstances threatening the well-being of the patient
- Do not use:
  - Elective cancellation prior to induction of anesthesia

### Example:

A patient who is having a surgical procedure and after the administration of general anesthetic exhibits unstable vital signs. At the recommendation of the anesthesiologist the surgeon decides to terminate the procedure.



## Modifier 59 - Distinct Procedural Service

- Procedures not normally reported together
- Different Session or Patient Encounter
- Different Procedure or Surgery
- Different Site or Organ System
- Separate Incision/Excision
- Separate Lesion



## Modifier 59 - Distinct Procedural Service

### Example:

A patient had a colonoscopy and a lesion is removed proximal to the splenic flexure. During the same colonoscopy a biopsy is taken of a different lesion. Both codes are reportable using modifier 59 on the second procedure.



## Modifier 63 - Procedures Performed on Infants Less than 4kg

- Increased work intensity
  - Temperature control
  - Obtaining IV access
  - Maintenance of homeostasis
- Read the “Note” in the description to make sure you’re using the modifier correctly



## Modifier 76 - Repeat Procedure or Service by Same Physician

### Example:

A patient who goes to the Emergency Room with a trauma to the chest. A two-view chest x-ray is taken that shows a pneumothorax. After a chest tube is placed a repeat two-view chest x-ray is taken to verify the placement of the chest tube. You would report 71020 and 71020-76.



## Modifier 77 - Repeat Procedure or Service by Another Physician

### Example:

A patient who sees the family practitioner for chest pain and the physician does an EKG and then refers the patient to a cardiologist. The patient is able to see the cardiologist on the same day and the cardiologist performs a repeat EKG. The second EKG would be reported with modifier 77.





## Multiple Surgeon Modifiers

- 62 – Two Surgeons
  - Work together as primary surgeons
  - Perform distinct parts of a procedure
  - Dictate op report of their distinct part
  - Each will submit the same code and append modifier 62
- 66 – Surgical Team
  - Highly complex procedures
  - Require differently specialties
  - Modifier 66 appended to procedures coded by the surgical team



## Assistant Surgeon Modifiers

- 80 – Assistant Surgeon
  - Assistant surgeon present for entire or substantial portion of the operation
  - Reports the same surgical procedure with modifier 80 appended
- 81 – Minimum Assistant Surgeon
  - Circumstances present that require the services of an asst surgeon for a short time. Minimal assistance.
  - Reports the same surgical procedure with modifier 81 appended
- 82 – Assistant Surgeon (when qualified resident surgeon not available)
  - Used in a teaching hospital that employs residents
  - No residents available and another surgeon is used



## Ancillary Modifiers

- Global – a procedure containing both a technical and a professional component
- Modifier 26 – Professional Component
- Modifier TC – Technical Component



## Ancillary Modifiers

### Example:

A patient comes to the office with wheezing and congestion. The physician takes a 2-view chest X-ray using his or her own equipment and sends it out to be read by a radiologist. The office would code 71020-TC for the use of the equipment (technical)

- The radiologist would bill 71020-26 for his/her interpretation and report (professional service).
- If the office took the X-ray and also did the interpretation and report, they would code 71020 – without any modifiers – to indicate they did the global service.....both the technical and professional components



## Laboratory Modifiers

- 90 – Reference (Outside) Laboratory
  - Used to bill for lab services purchased from an outside lab
- 91 – Repeat Clinical Diagnostic Lab Test
  - Not used to confirm results
  - Not used to repeat a test due to equipment malfunction
- 92 – Alternative Lab Platform Testing
  - Single use
  - HIV testing



## Anesthesia Modifiers

- 23 - Unusual Anesthesia
- 47 – Anesthesia by Surgeon
- Physical Status Modifiers



## HCPCS Level II

- Level I HCPCS is CPT®
  - Maintained by AMA
  - Identify services and procedures
- Level II HCPCS
  - Maintained by CMS
  - Identify products, supplies, and services not included in CPT®



## HCPCS Level II

- A Codes ~ Transportation Services, Med/Surg Supplies, Admin
- B Codes ~ Enteral and Parenteral Therapy
- C Codes ~ Pass-Through Items
- D Codes ~ Dental Procedures
- E Codes ~ Durable Medical Equipment
- G Codes ~ Procedures/Professional Services
- H Codes ~ Alcohol and Drug Abuse Treatment Services
- J Codes ~ Drugs Admin Other Than Oral Method/Chemotherapy Drugs
- K Codes ~ DME Supplies
- L Codes ~ Orthotic/Prosthetic Procedures
- M Codes ~ Medical Services
- P Codes ~ Lab/Path
- Q Codes ~ Temporary Codes
- R Codes ~ Diagnostic Radiology
- S Codes ~ Temporary National Codes (Non-Medicare)
- T Codes ~ Nat'l Codes for State Medicaid Agencies
- V Codes ~ Vision/Hearing Services



## HCPCS Level II

- Types of Level II Codes
  - Permanent National Codes maintained by the CMS HCPCS Workgroup
    - Responsible for additions, deletions, revisions
    - Updated annually
  - Temporary National Codes maintained by the CMS HCPCS Workgroup
    - Responsible for additions, deletions, revisions
    - Updated quarterly



## HCPCS Level II

### Types of Temporary Codes

- G codes
  - Professional health care procedures/services with no CPT<sup>®</sup> codes
  - Example:
    - G0412 – G0415 – unilateral or bilateral
    - 27215 – 27218 – unilateral only, use modifier 50 for bilateral
- H codes
  - Used by State Medicaid Agencies for mental health services such as alcohol and drug treatment services



## HCPCS Level II

### Dental Codes

- Current Dental Terminology or CDT®
- Separate category of national codes
- Used for billing dental procedures and supplies
- Copyright by the American Dental Association
- Additions, deletions and revisions made by the ADA



## HCPCS Level II

### Coding Conventions

- Bullet indicates new code
- Triangle indicates code description has been revised
- X with line through code and code description means code has been deleted
- Color Coded Symbols



## HCPCS Level II

### Format:

- Alphabetic Index
- Tabular Index
  - Divided into different alpha-numeric sections
- Table of Contents
  - List of alpha sections with code ranges and page numbers



## HCPCS Level II

### Appendices:

- Level II modifiers
  - May be used with some CPT® codes, i.e., LT/RT
- Table of Drugs
  - Names of Drugs, dosage, delivery method, J code
- Medicare References
- Jurisdiction List
- Deleted Code Crosswalk



## HCPCS Level II Modifiers

- Two alpha characters:

Example:      RT – right  
                  LT - left

- One alpha and one numeric character:

Example:      F1 – Left hand, second digit  
                  F2 – Left hand, third digit  
                  F3 – Left hand, fourth digit  
                  F4 – Left hand, fifth digit

Left Hand



## HCPCS Level II Table of Drugs

- Alphabetized by drug name
- Dose/Unit
- Route of administration
- Code(s)





## HCPCS Level II

- Finding a Code
  - Depo Provera 150mg IM for contraception
- Two ways to find it
  - Table of Drugs
  - Alphabetic Index
- J1055 - Depo Provera 150 mg IM



## HCPCS Level II

- Finding a Code
  - Orthopedic Shoes
- Two ways to find it
  - Table of Contents
  - Alphabetic Index
- L3204 - High-top orthopedic shoe with pronator for an infant



## HCPCS

- Fewer codes than CPT® and ICD-9-CM
- Smaller textbook

Care still needs to be taken when making a code selection



## The End

